Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Allen Carr's Easyway To Stop Smoking		General	It should be noted that Allen Carr's Easyway To Stop Smoking (Allen Carr's Easyway International Ltd) have many years of experience in the field of smoking cessation in the workplace. Allen Carr's Easyway organisation would be extremely surprised if we were not actively involved in the actual provision of our corporate smoking cessation service to that sector via the NHS following the creation of these guidelines. There are independent published studies which verify a success rate of over 50% after 12 months AND 36 months for the method when delivered in the workplace.	Noted Noted. To expedite matters, it would be helpful if you could submit copies of these papers. If not, could you provide us with full reference details so that we can access them.
		General	We would hope that the service would not only include NRT and Zyban – most smokers will have tried these already without success. This is a tremendous opportunity to involve Allen Carr's Easyway method with a sector (employers) who are already comfortable using our service.	An assessment of effectiveness and cost effectiveness is crucial in the development of NICE recommendations. The recommendations will be developed by PHIAC once it has considered the evidence.
ASH – Action on Smoking and Health		General	Our main comment was venues for workplace smoking cessation support and services should include hospitality venues such as pubs and clubs. On reaching SMEs both DWP and the HSE have mechanisms for doing this. The Federation of Small Businesses etc. only reach a very small poportion of the total.	The scope is intended to be inclusive of the range of settings outside the workplace that are used for workplace smoking cessation support. Noted, thank you.
Bristol City PCT		General	After discussion with colleagues in the field, It is felt that the scope of this document covers all areas needed to be considered for a comprehensive guidance to be produced on this setting	Thank you.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The British Association for Stop Smoking Practitioners		4.4	In terms of outcomes, we would be keen that abstinence is not the key measure. Other factors should be taken into account, such as cutting down, no longer smoking in the house, no longer smoking in front of children, longer time to first cigarette.	Although the primary focus of the scope is smoking cessation, we would hope to include other measures of smoking behaviour change if the evidence is available.
		4.5	Key Question: How should employers support and encourage smokers to quit – this should include providing and accessing appropriate treatment e.g. NRT and Buproprion	Agreed.
British Dental Association		General	I am writing on behalf of the British Dental Association (BDA) to thank you for the opportunity to comment on the draft scope for the NICE public health interventions guidance on workplace smoking. The BDA fully supports the production of this guidance and considers the scope to be a sensible approach which covers all the issues related to smoking in the workplace. We look forward to commenting on the draft guidance in due course.	Thank you.
The British Psychological Society		Section 4.5	There is a need to identify and evaluate studies that differentiate smokers on the basis of their level of dependence on nicotine, indexed by the frequency and level of smoking. There is some evidence that occasional <less than 4-5 cigarettes/day >should respond more to smoking restrictions in the workplace, compared to heavy ,20+/day smokers. The latter group might need more intensive programmes, perhaps including nicotine replacement therapy. **Reference:** Shiffman, S & Paty, J. (2006) Smoking Patterns and Dependence: Contrasting Chippers and Heavy Smokers. *Journal of Abnormal Psychology* 115, 509-523.	Thank you for the reference. One of the key questions in the scope considers which interventions are most effective and appropriate for different sectors of the workforce.
CBI		General	We support the objectives of the guidance. Many employers have already implemented good practice in smoking cessation programmes that they can share with those who are developing the guidance. Many employers have had voluntary arrangements in place to prevent smoking in most workplaces and to allow it only in suitable designated areas. They have also provided support to help those employees who wish to cease smoking. However when the Health Act 2006 and supporting regulations are implemented, employers can only **require** employees not to smoke in enclosed or substantially enclosed workplaces. They can only	Thank you. We would be grateful if you could ask employers with examples of effective practice to contact the NICE technical and implementation teams and your comments have been noted. Thank you, the distinction is an important one.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			encourage employees to cease smoking in order better to achieve the above requirement.	
		General	We look forward to further involvement in developing and helping publicise pragmatic guidance to assist employers and their employees in promoting health at the workplace.	Noted, thank you. This will be considered as part of the support for implementation.
		General 4.1.1 4.5 4.6	The guidance will cover all smokers in employment outside their own home and is aimed at all those who are directly or indirectly involved in the implementation of smoke free workplaces etc yet the key questions are aimed at the actions that employers can take. Employers can provide encouragement, information and support to promote smoking cessation but will only be successful in helping achieving the objective for those employees who wish to stop smoking. There needs to be emphasis on the employers and employees working in partnership to achieve mutually acceptable goals The guidance must recognise this particularly at this stage when much employment and discrimination law is evolving. This can be dealt with in many ways either in the guidance title, or by addressing a key question of overcoming the barriers to successful interventions.	The review of evidence will consider factors that aid success as well as those that act as barriers. Where possible, strategies that overcome the barriers will be identified to help identify the key areas requiring implementation support.
Colchester and Tendring Stop Smoking Service North East Essex PCT		General	I would like to support Jennifer Percival's comments about the disappointment of the withdrawal of DH funding for the joint DH/RCN campaign to support nurses to quit smoking. This was expected in January 2006 and would have by now been able to inform the new NICE guidance.	Noted, thank you. NICE will engage with key partners such as the DH and RCN to identify ways to support the implementation of this guidance.
		General	I would like to suggest that access to nicotine replacement therapy is considered as part of this scope. It has been found that free NRT increases the number of smokers accessing services. Also NRT available at workplace sites via nurse prescribing or patient group direction should be considered as many manual workers may not wish to visit their GP to collect a prescription.	Noted, thank you. We cannot anticipate the findings of the review; studies that include the use of NRT will not be excluded provided they meet the inclusion criteria.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Faculty of Public Health		general	It was clear, at the stakeholder consultation meeting, that both NICE and all stakeholders are aware of the great importance of this guidance being produced as quickly as possible, as it appears that the Health Act 2006 requirement for (virtually) all workplaces to become smokefree will come into force some time between 31 May 2007 and 1 July 2007. We therefore welcome the statement that draft evidence and recommendations will be placed in the public domain as soon as possible, even if the definitive recommendations are not signed off until later. We are pleased that NICE has shortened the processes as much as possible, consistent with producing good quality guidance and inclusivity of respondents. Timeliness of responses would be expedited if NICE could email all registered stakeholders a fortnight before each consultation to alert/remind them, and also to email all consultation requests (rather than post) to allow sufficient time for respondents to plan current workloads to accommodate responding to consultations.	The new legislation will influence this intervention and working with the FPH will be key to its implementation. Thank you. Thank you for this helpful suggestion. We will try to alert stakeholders to consulations earlier in future.
		General / 4.7	Much needs to be done for effective implementation of the Health Act 2006. Some of the comments at the scoping meeting implied all implementation issues should be examined by NICE. This is obviously not the case (eg ensuring local organisations know what is already available locally) but perhaps NICE could pass on to the relevant organisations (eg DH, Health & Safety Executive, Association of Local Government, etc) issues of concern to stakeholders felt to be outwith the remit of NICE.	Stakeholders comments and NICE's responses will be posted on the NICE website so that all can be aware of those received. . NICE will engage with key partners such as the FPH to support the implementation of this guidance.
		general	NICE should highlight gaps in the evidence to help direct future research	NICE guidance includes recommendations for future research and these are passed to the relevant research councils.
		general	It is clear that extending the scope to cover all relevant aspects is incompatible with producing guidance quickly. We therefore urge NICE to consider all suggestions and to ensure that sensible suggestions which cannot be included in this guidance (due to time constraints) is proposed within a future (not too distant) set of smoking-related intervention or programme guidance.	How NICE guidance topics are chosen is explained on our website..Suggestions for future topics can be made at: www.nice.org.uk/page.aspx?o=295373
		3a *Smoking as major cause of*	Could add: • Main proximal cause of inequalities in health • Poor healing (after 'post-operative respiratory complications')	Thank you for these suggestions.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		mortality and morbidity		
		3b *Health effects of exposure to others' smoke*	Could add: • 'respiratory and ear diseases in children and sudden infant death syndrome (cot death)' • 'intra-uterine growth retardation when pregnant women are exposed to tobacco smoke pollution, as well as when they themselves smoke'	Again, thank you for these suggestions.
		4.1.1 *Inclusion*	It should be remembered that paid and voluntary workers working outside their own home may be working in someone else's home. How should their employers protect them from exposure to tobacco smoke? Is there evidence of effectiveness for different interventions aimed at the 'clients' to protect the 'employees'? Is there evidence from Ireland or Scotland, or from LAs (eg social services) or PCTs or Mental Health Trusts in England that are already dealing with this?	Some of the questions you pose will be determined to a certain extent by the specific wording of the legislation. NICE will consider all the available evidence on these issues and the Public Health Interventions Advisory Committee will use it to inform its recommendations. Subject to the final recommendations, these issues will also be considered as part of the NICE implementation support work.
		4.2.1 *Areas covered*	There was debate at the meeting whether signage was relevant to the scope. • Anecdotally, a range of signs and a range of behaviours related to smoking are seen around entrances, so this is an area where the evidence needs to be included – or research conducted if there is none. • It has been said that DH is providing free signs to employers so there will be little cost for employers in obtaining these, though some in erecting them. This also needs publicity.	NICE will not be in a position to commission primary research on this issue. We will condider any appropriate documented evidence. Signage was included in the draft scope because it was suggested to us that employers may not be aware of their legal responsibilities. It was also suggested that signs might trigger quit attempts and/or changes in knowledge and attitudes.
		4.2.2 *Areas not covered – workplace health improvement programmes that do not include a smoking*	There are two problems with this exclusion. 1. Elsewhere in the scope, it is clear that a range of interventions are envisaged as falling within the scope, not just smoking cessation. Therefore this exclusion is illogical. It should be rephrased as *workplace health improvement programmes that do not include a smoking-related component*. For example, health promotion / health education aimed at explaining the health effects of tobacco smoke pollution to the workforce will probably be very important to aid both compliance with the law and to reduce the risk of workers smoking	Thank you for pointing this out – we will amend the scope accordingly.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		cessation component	more around their children at home. Other smoking-related knowledge, attitudes and behaviours of great relevant to this guidance but without smoking cessation could include stress reduction and options other than cigarette breaks as work breaks; giving people skills to ask their colleagues in an assertive but non-aggressive way to comply with the law, etc; use of nicotine replacement therapy (NRT) as a substitute for smoking while at work (a variant of 'cut down to quit', perhaps) – depending on what evidence NICE finds for these (if any). • Perhaps to be left for the next set of smoking-related guidance – it is important to know the effect of multi- versus uni-topic health improvement programmes. Eg does a health improvement programme that omits any mention of smoking give a message that smoking is not an important health issue in that setting / for that population? This may be of particular relevance in the workplace, as we have heard that businesses with occupational health services often focus on industry-specific problems with generic health risk factors, such as smoking, low down the priority list. (This is analogous to a focus on rickets and vitamin D deficiency in South Asian populations at the expense of diabetes and coronary heart disease when considering health in relation to ethnicity.) Also, should there be guidance whether all health improvement programmes should at least mention the benefits of smoking cessation and where support can be obtained locally? Or are there overkill effects?	Thank you raising these issues. If you would like to suggest that they should be considered in future NICE guidance. this can be done by completing a short form on the NICE website at: www.nice.org.uk/page.aspx?o=233157 Please note that the independent Public Health Interventions Advisory Committee responsible for developing recommendations, receives a copy of all the comments from stakeholders as well as the effectiveness reviews.
		4.4 *Outcomes*	We strongly endorse having changes in smoking-related knowledge, attitudes and behaviours (eg where people smoke) as outcomes in addition to smoking cessation. There is good evidence that many smokers will use the legislation as a trigger to stop smoking. This is the ideal outcome, being of personal health benefit as well as ensuring compliance with the legislation and protecting their friends, family and colleagues from their smoke. Some will succeed, many will relapse. A variety of changes in knowledge, attitudes and behaviours are desirable for different groups of individuals. It may be useful for NICE to consider a grid, with the key questions to be addressed for different groups eg: • Smokers who are planning to stop	Noted, thank you. Thank you. The evidence review will include information on different sub-groups where it is available in the literature.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			• Smokers who are thinking about stopping • Smokers who have not thought about it • Smokers who are NOT going to stop but will comply with the legislation • Smokers who are NOT going to stop and MAY NOT comply with the legislation • Smokers who aren't stopping at the moment and have children at home (eg bringing together the recent evidence on the persistence of smoke in the home after smoking and health effects of exposure to smoke at home or even when smoking restricted to other rooms or outdoors) • Non-smokers – eg how to support their smoking & ex-smoking colleagues; how to enforce the legislation in a safe way; This may be too wide a scope to be manageable within the short timeframe but omitted areas should be considered in a subsequent set of guidance.	
		4.5 *Key questions*	• Which interventions work best FOR (not just 'in') workplaces where comprehensive smokefree legislation has been introduced in other jurisdictions? • Also, evidence from places with a legal requirement for smokefree workplaces may not be generalisable to workplaces introducing their own smokefree policy but there must be many examples in the other direction - where a SF policy has been brought in against the wishes of many employees where the experience/evidence of what worked well probably IS transferable.	Noted, thank you. The review will attempt to discern any differences in the learning from jurisdictions operating voluntary smokefree workplace policies and those with comprehensive smokefree legislation.
			• Different sectors of the workforce – types of employment (office, factory, travelling. seniority, job control or lack thereof)	Agreed.
		Other	Provision of data on health effects (and costs to organisations) of employees' smoking, to aid engagement with uninterested organisations.	Noted, thank you.
		Other	Where there is no evidence from workplaces or no generalisable evidence from workplaces, NICE should examine evidence from other settings and make recommendations (with caveats if necessary) both to help employers and improve the public's / employees' health, rather than concluding 'no evidence'.	Noted, thank you.
		Implementation	It has been mentioned that NRT can be given by nurses and other healthcare professionals under PGDs. It has been mentioned that this may	Thank you for raising this issue.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			not be legal for nurses employed outside the NHS (eg by private schools, even if their training and qualifications and duties are identical to those employed by the NHS). This may be an issue for private occupational heath services.	
		4.6 *Target audiences*	NICE is strongly urged to include recommendations to all agencies and organisations that have regular dealings with business and/or industry, including specific recommendations to the Health and Safety Executive.	Noted, thank you.
		Other sources of information	At the consultation, mention was made of nargilahs. ASH has a new fact sheet on 'water pipes' on its website.	Noted, thank you.
			The Tobacco Control Co-ordinating Centre has a list of countries and states worldwide that are smokefree. These (eg many cities in Canada) may be additional sources of case studies.	Thank you.
Department of Health		2 (c).	Would you please consider adding "Health, Work and Well-being - caring for our future. A strategy for the health and well-being of working age people. (DWP, DH, HSE 2005)" to your list of Government Policy Documents.	Thank you, we will amend accordingly.
		3	We would be grateful if you could add the following additional point to the existing points "(e) Reducing levels of smoking is workers will help reduce cardio-respiratory diseases, which as a group are the third largest cause of sickness absence and which results in reduced productivity and increased costs for employers in all sectors, including the NHS workforce."	We are happy to do so, if we can locate an appropriate reference.
		4.1.1	Would you please consider including here people on benefit who may be actively seeking to (re-)enter work and who may be engaged on Pathways to Work programmes of work-related activities.	Thank you for this suggestion, we will consider it.
		4.1.1	We would be grateful if you could clarify if people who are in mobile as opposed to building-based occupations, such as drivers or whose workplace is out-of-doors (for example on construction sites) is covered by this section..	These categories are included.
GlaxoSmithKline		General	It is noted that since this guidance is a Public Health Intervention Guidance it will not be enforceable by the NHS or NICE on employers. As discussed at the stakeholders meeting, it is also noted that it is not appropriate for this guidance to address HR policy. Therefore, to ensure that this document is utilised by employers and to ensure it provides all of the required information to achieve smoking	Thank you, the independent advisory committee responsible for developing recommendations will receive a copy of all the comments from stakeholders. . These issues will be addressed as part of the NICE support for the implementation of this

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			cessation in the workplace it should serve as the initial point of reference for employers, directing employers to where appropriate guidance and information can be found.	guidance.
		4.5 Key Questions	It is important to address the question of how employers will gain access to the pharmacotherapies and behavioural therapies in order to support smoking cessation within the workplace.	Agreed.
g-Nostics	Additional References *Smoking amongst employers and employees* Nicotest *The new way to quit* *Workplace intervention for smoking cessation* ©g-Nostics Ltd. 2006 Letter from g-Nostics to Institute of directors re banning staff from taking cigarette breaks (March 2006)	2c.10)	Does the commitment of the government (and advisory powers of NICE) to Article 8 of the World Health Organization 'Framework convention on tobacco control' extend to other areas of intended practice? i.e. legislation behind the forthcoming Smoking Ban? 'Effective legislation' should include an ability to validate allegations eg. Using cotinine strips to establish exposure to tobacco smoke is useful for both smokers and non-smokers alike.	If by this you mean what steps will be taken to ensure that employees are protected from breathing secondhand smoke, PHIAC could consider the methods available for biochemically assessing exposure to tobacco smoke. Thank you for providing us with this additional information. With regard to the effectiveness of the NICOTEST, we would be happy to receive copies of the independent peer reviewed studies. Alternatively, could you provide us with a full list of references.
		3a)	Smokers also take longer to recover from surgery thus utilising beds and attendant staff for longer. See attached documents for references.	Noted, thank you.
		3e)	It is also important for employers and employees to understand that current employment legislation allows discrimination between smokers and non-smokers. In other words if employers recognise that by taking proactive decisions to support workplace intervention that they **cannot** be accused of discrimination the initiative is likely to be more widely	Thank you for these helpful comments and for the background documents.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			embraced. See attached documents for background legal review.	
		4.4)	Whilst a number of biochemical testing methods are available many are not CE marked nor provide forensic quality evidence that would withstand legal scrutiny. We would therefore recommend the use of a CE marked point of care diagnostic device, such as the NicAlert™ strip (as produced by Nymox Inc of Canada) to validate exposure to tobacco smoke accurately.	Thank you for this suggestion. The Public Health Interventions Advisory Committee is responsible for developing NICE recommendations once it has considered the evidence of effectiveness and cost effectiveness.
		4.5)	We believe that CCBT should be offered upfront as part of the 'initial' intervention and presents the most cost-effective method of intervention across the widest levels of community needs, ethnic origins and corporate environments. See attached documents.	As explained above, the development of recommendations is the responsibility of the independent advisory committee.
		4.5)	Some employers promote Employee Assistance Programmes (EAPs) but this is often limited to larger corporations. Such EAPs often include a Smoking Cessation Component but the specification is often very crude and simply refers interested parties to their local NHS clinic/ pharmacy or private healthcare plans. Since only about 20% of pharmacies are presently 'qualified' as enhanced service providers this makes the identification of a local service provider in primary care quite laborious. It would be useful for NHS Direct to provide a list of 'qualifying' service providers according to postcode to link the need with the solution.	Thank you for this suggestion. This will be considered as part of the NICE implementation support work to look at access to such programmes for smaller businesses and to explore links with NHS Direct.
		4.5)	It may serve everyone's interest to 'require' OH/EAP's to include a smoking cessation module in their offerings.	Thank you for this suggestion.
		4.5)	There is enormous disparity between various PCT remuneration levels for NHS smoking cessation services. Some offer a programme that involves 15minutes of initial time for £15 plus a few brief follow-ups and some offer half an hour of time for £95 and a more extended support programme; some offer top-up therapies and some do not; some only offer the service through GPs and not Pharmacies. Such disparity creates a free market for the intervention and places it in competition with other services being offered at different remuneration levels. We have therefore experienced that the promotion of Smoking Cessation services has fallen down the list of priorities where pharmacists or GPs can earn more (per minute) through an alternative service eg a	NICE is aware of the variation between PCTs in the remuneration of NHS smoking cessation services. The independent advisory committee responsible for developing guidance on workplace smoking cessation may want to consider whether employers should contribute towards the cost of providing smoking cessation services or treatments. We will pass your comments to the Programme

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Medicine Under review (MUR) which might command a fee of £25 for 15 minutes of initial time and limited follow-up effort. A possible solution might include nationwide payment/ reimbursement harmonisation on a time (per minute) basis to ensure one initiative is not disadvantaged over another.	Development Group developing NICE public health programme guidance for the optimal provision of smoking cessation services. For more details about this guidance visit the NICE website at: www.nice.org.uk/page.aspx?o=SmokingCessationPGMain
		4.5)	A more comprehensive proposal might include access to an online Cognitive Behavioural Therapy programme that feeds into local primary care. The value of such a programme is its broad availability and low access costs – which brings it into reach of the smaller company and self-employed. The issue is who should pay for such a service because it should be free at the point of use if it is to be most effective. See attached papers for further details.	Thank you for this suggestion. The effectiveness of on-line smoking cessation support will be included in the revew of evidence.
		4.5)	The Smoking Ban will have a significant impact on all Employers but unless they are made aware of the available cessation tools and underlying employment legislation they will find it difficult to promote internally.	Noted, thank you. These issues will be considered as part of the implementation support developed for this guidance.
HM Prisons Service		General	My comment relates to smoking cessation programmes and the effectiveness in environments where employees will still be exposed to other persons (i.e. prisoners) smoking and even exposed to second hand smoke. Essentially, there are two problems: (1) How effective will a smoking cessation programme be when staff still have to watch people smoke and breathe in second hand smoke on a daily basis (not particularly encouraging I would have thought) – what can be done in terms of a cessation programme to minimise the effects of this, and (2) What can be done to protect staff from exposure to second hand smoke in environments where they will be exposed (e.g. prisons, home carers etc.). At the meeting in the Thistle Hotel in Kensington this was touched on – and there was specific comment about the approach taken by the Scottish Prison Service, which essentially involves ventilating the cell until smoke can no longer be seen. I do not fully agree with this for several reasons:	Thank you for drawing these issues to our attention. Once the independent advisory committee has considered all the evidence , it may wish to make recommendations about protection of non-smokers even in those premises where limited smoking is permitted under the provisions of the Health Act. The draft regulations which were recently issued for consultation recommended a room can only be designated for smoking with the permission of the person in charge (see page 25 of smokefree premises

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			(i) The visible component of second hand smoke only accounts for approx 8% of the total of various particulates, smoke, gases and vapours etc. Of the 1000's of constituents of second hand smoke that are dangerous (e.g. HCN gas and countless carcinogens) the majority will be invisible. Therefore how de we know that the cell is safe, even if we cannot see smoke. (ii) You might counter that if the smoke is no longer visible that the other constituents might have been ventilated as well, but the different components will behave differently physically because of their relative masses, and charged particles may become stuck to clothing or walls and may still be dangerous. I think this area leads a lot more consideration than, "wait until you cannot see any smoke". (iii) The costs to the Prison Service (and other employers) of not doing what is reasonable (which will only be defined in a court of law) are too high. ASH have already stated that they will take as many cases as they can to court. So, what are we going to do about these issues?	and vehicles consultation paper 17 July 2006 (http://www.dh.gov.uk/assetRoot/04/13/73/26/04137326.pdf) Effectiveness of ventilation in principle falls outside the scope of this guidance, although it is an important consideration in venues that have been exempted. However, this is a very important point and will need to be considered by the NICE team.
National Public Health Service for Wales		4.5	With reference to: - *what are the most effective ways of encouraging employee compliance with a smokefree policy* – we would be interested in the processes companies and organisations go through to reach their 'smoke-free' status. In the past, when many policies were voluntary agreements, the negotiation process involving staff representation and unions was seen as key to success, as was a staged calendar of dates to each final implementation. If these processes were thought of as most helpful (or even 'effective') do we have evidence for that, and would we recommend organisations go through similar processes even though the end date is set in law.	NICE is aware that the the comprehensive smokefree legislation may influence factors associated with successful adoption of voluntary policies. Evidence permitting, the effectiveness review will take account of any differences in the learning arising from 'voluntary' workplace policies and comprehensive legislation.
NHS Health Scotland	Malam, S., Barnard, H., Mackey, T., Roberts., R. *Workplace Smoking Policies in Scotland*. 2005 Edinburgh: NHS	General	Overall, this scope and resulting guidance will provide a very useful and timely contribution to smoking cessation in the workplace.	Thank you for your comment and for providing these references.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
	Health Scotland NHS Health Scotland, ASH Scotland & COSLA. *Tobacco at work: Guidelines for local authorities - achieving the best outcomes*. 2004. Edinburgh: NHS Health Scotland.			
	Scottish Executive. *Smoke-free Scotland - Guidance on smoking policies for the NHS, local authorities and care service providers*. 2005. Edinburgh: Scottish Executive.	General	There is only a limited number of relevant organisations engaged as stakeholders - staff/ professional associations, HR/Personnel, private sector, etc. These bodies would be useful in terms of implementation beyond the public sector. Would be interested in how involvement could be encouraged.	We will continue to invite relevant organisations to register as stakeholders for this guidance and we will follow up contacts recommended by existing stakeholders. NICE would also like to ask all existing stakeholders to contact other relevant bodies and encourage them to register as stakeholders via the NICE website at: www.nice.org.uk/page.aspx?o=StakeholderRegistrationFormGID We will also try to engage with these bodies as part of the implementation support developed for this guidance.
		4.2.1	Query the purpose of including signage as an example of workplace smoking cessation support.	This was included in the scope because it was suggested to us that employers may not be aware of their legal responsibilities. It was also suggested that signs might trigger quit attempts and/or changes in knowledge and attitudes.
		4.2.2	Agree that wider workplace health improvement programmes should be considered within the scope, in particular, as an enabler to effective	Noted, see response to similar comment above.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			smoking cessation support.	
		4.5	A greater focus on inequalities and smoking in the workplace would be very useful with particular reference to occupational groups and type of workplace.	Where the evidence allows, information on inequalities and occupational groups will be reported.
		4.5	Important to highlight the dilemma of universal versus targeted interventions and the possibility of further exacerbating the health divide in the workplace by adopting particular approaches.	Health inequalities are an important and underpinning consideration for all NICE public health guidance.
		4.5	The situation for employees who work with clients or patients in the exempted workplaces where their 'workplace' will not be smoke-free requires attention e.g. residential accommodation, private households.	Agreed.
		4.5	Consider how effective has the 'gold' standard message been in the workplace i.e. *smokers four times more likely to quit if behavioural support is accessed in conjunction with NRT or bupropion* in terms of awareness, signposting, accessibility of services etc?	We agree this would be useful if evidence is available.
		4.5	Include implications of implementing recommendations for employers, particularly if smoking cessation support resources are directed via the NHS.	The development of recommendations is the responsibility of the independent advisory committee.
		4.6	It may be useful to specify in more detail the target audience and settings as this may help during implementation. For example, Human Resources, Occupational Health, Staff Welfare, etc.	Thank you for this helpful suggestion.
New Ways Clinic	Please view our website for client testimonials http://www.newwaysclinic.com/nicotine.html		I would suggest adopting a stop smoking treatment better than NRT which has a 6% success rate. People have no confidence on NRT and so have little hope in stopping smoking and hence do not try. If better stop smoking treatments were adopted with much higher success rates such as bioresonance therapy then more people would be encourage to stop.	Thank you for these suggestions. Could you provide references for the methods you have mentioned so that NICE can assess them for inclusion in the review of evidence?
Nyvej Partnership Ltd	Workplace smoking Productivity Costs Model	General	It would be really helpful to have some economic formulae for productivity lost to smoking compared to cost of interventions. Could we have this broken down into: Short term costs to employer, smoker, health care services Long term costs to employer, smoker, and health care services. I currently use the estimate of each smoker taking up to half a day per week in smoking breaks. Cost to smoker based on smoking 20/day	Thank you for this helpful information which we will pass on to the team undertaking the health economics review. The guidance will consider the cost effectiveness of workplace smoking cessation interventions, but it is not possible at this point to say what will be included in the economic review.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Cost of intervention: NHS costs £183 per smoker See also formula attached. However, these may be an underestimate when you are looking at productivity. Not sure if there is any data on this but smokers tell me that productivity declines prior to a smoke as they begin experiencing withdrawal symptoms and watch the clock for the next fag break.	
			Is there evidence of relationship between guidance and implementation of legislation in workplaces and cessation interventions? I.e. what we know from Scotland and Ireland's experience. Impact of legislation on cessation and key things that help!	This will be considered in deliberations on both the intervention and programme guidance on smoking cessation services.
		4.1.1	Would like to know if there is any evidence of what works best in terms of cessation interventions with different types of workforces. I.e office, factory, road based. Small and large organisations	One of the key questions the scope considers is which interventions are most effective and appropriate for different sectors of the workforce.
		4.2.1	Would like evidence of sorts of interventions other than face to face that might provide wider spread for people who do not want to see someone. I.e. texting, web based programmes. And recommendations for evaluating new methods to enable us to reach more people. *Have just designed a tailor made 12 week quitting programme that is web based (and includes potential to email/phone support with local advisor) and am offering to businesses as well as face to face interventions.- but we need more evidence of efficacy.*	This may be beyond the remit for this guidance but the effectiveness of Internet/text/telephone support will be considered by the Programme Development Group working on the NICE public health guidance on smoking cessation services. For more information visit theNICE website at: www.nice.org.uk/page.aspx?o=SmokingCessationPGMain#stakeholders Appropriate links will be made between all the current and forthcoming NICE guidance on smoking.
		4.4	Outcomes- what are the sorts of things that help workplaces change their behaviour? i.e. why is it that some businesses do the whole thing- policy and support for staff. Some will stop at the legislation alone. How can employers do more than the basic minimum?	We will be assessing the available evidence on all these questions to inform the independent advisory committee's recommendations.
Oxfordshire PCT		**general**	Oxfordshire PCT, and the smaller PCT's of which it was previously composed until October 2006, have engaged with workplace smoking cessation since August 2003 through the work of the Oxfordshire Smoking Advice Service (OSAS). There is a full time workplace specialist within OSAS and other the work of	Thank you for this helpful information.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			other specialists within the team reaches into workplaces that are NHS Trusts, prisons and educational establishments. These comments are based on this experience of evidence-based reflective practice.	
		3. (d)	The workplace does indeed represent an opportunity to contact many who might otherwise be out of the reach of health professionals, particularly those reluctant or unable to take time off work to visit a GP surgery which would be closed during the time they are not at work. Health promotion and SC can be made more accessible in the workplace. Undertaking health work in the workplace can help to address health inequalities (as per "Priorities and planning framework 2003-2006", etc.), particularly if the employees are undertaking routine and manual tasks. Workplace SC can be delivered strategically, with health inequalities in mind, through the NHS Stop Smoking Services.	Noted, thank you.
		4.2.	It would be hoped that the guidance includes, within the scope of smoking cessation, work to prevent uptake, particularly where there may be a younger workforce. This could include display of educational materials or stands as well as positive reinforcement to non-smokers (e.g. during occupational health visits or other opportunities for Brief Advice) that they are making the right health choice.	Services or interventions designed to prevent uptake of smoking are beyond the scope of this intervention guidance , but will be the subject of NICE guidance undertaken in 2007.
		4.2	There is an argument for ensuing the scope of this guidance can reach into commenting on the culture of breaks within an organisation.	If there is evidence that the culture of work breaks affects workplace smoking cessation, PHIAC will be able to make recommendations on it.
		4.2.2	Mention is made within the scope that workplace health improvement programmes "that do not include a smoking cessation component" will not be covered by the guidelines. It can be helpful to include smoking cessation within a wider workplace health agenda. This productive link can help dispel the effect on morale that may arise if it is thought that smokers are getting special help. Workplace health programmes can also look at issues such as fitness and stress, which may impact on motivation to quit and prevention of relapse.	Noted, thank you.
		4.5	The Health Act, which represents an increased opportunity for health intervention, is merely the current context and should not be the subject of this guidance. Moreover, workplace smoking cessation has been taking place long before the advent of the Health Act. The Health Act has been presented as about where people smoke not whether they smoke. For the	The provisions of the Health Act 2006 are different from the provision of smoking cessation help in the workplace. However, the two are linked and although the guidance will be concerned with the best provision of

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			practitioner, tobacco control and smoking cessation are two separate but interrelated subjects and this distinction should be maintained in the wording of the scope – as such, looking at the resource needs for enterprises in implementing smoke-free legislation should be outside the current scope and maintained as distinct from their resource needs in supporting smokers to quit. Implementing smoke-free legislation is principally about policy and signage. However, best practice when introducing no smoking policies is to simultaneously support smokers to quit, and it is how this is done – as a human resources/occupational health issue - which should be the subject of the guidance.	workplace smoking cessation in the context of a comprehensive smoking ban, the evidence review will need to assess the effectiveness and the cost effectiveness of such interventions in other contexts. We accept that this question may need to be reworded.
		4.5, general	This topic relates to the Health Act mostly because when a workplace is looking for advice on policy or being approached with advice on the Health Act and on policy, they can also receive advice about workplace smoking cessation (across the spectrum from workplace health promotion, brief intervention and on-site SC delivery.) For example, in Oxfordshire Environmental Health teams are including information about the Oxfordshire Smoking Advice Service's workplace SC in inspection packs. So this period prior to the implementation of the Health Act is one that presents an opportunity to enable wider access to smoking cessation by increasing the reach of smoking cessation into workplaces. As such Guidelines may have been more useful if published sooner and this consultation period has come at a very busy time for those working in this area who would otherwise be able to provide more supporting evidence including grey literature.	Topics for guidance are referred to NICE from the Department of Health. Because of the imminent introduction of the Health Act, NICE started work on this guidance within days of the referral from DH. Moreover, this guidance is being 'fast tracked' with the view to issuing it as quickly as possible.
		4.5	The advice to workplaces should be that the research shows that regular specialist support combined with NRT (or bupropion) achieves the best results in helping people to quit. Some employers might be tempted to spend money on other treatments for employees such as hypnotherapy which while they may help some have not been proven to be effective. It is worth businesses investing in their workforce by helping them to quit smoking but this is best done by them a) allowing time off to attend smoking cessation support, whether 1-1 or group b) subsidising NRT (or bupropion).	The Public Health Interventions Advisory Committee will be making guidance recommendations based on the evidence of effectiveness and cost effectiveness.
		4.5	If employers have occupational health staff they should be trained to Level 2 (Smoking Advisors), facilitated by the local stop smoking service. If they are to give advice or support to staff about smoking they should be linked	Noted, thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			in with the local NHS SCS to ensure quality and they can form part of a local enhanced service. Other appropriate staff to be trained may include human resources, management or even peer support. They should be trained to at least Level 1 in order to give Brief Advice on smoking.	
		4.5	There is a range of evidence to show that it is economically worthwhile for workplaces to engage with supporting employees to quit and that workplace support increases the likelihood of a positive clinical outcome. This ranges from the impacts of smokers taking breaks and sickness days (e.g. Gallop, B. (1989) Sickness absenteeism and smoking. New Zealand Medical Journal, 102 – former smokers are absent form work less than current smokers(863), 112. USDHHS (1988) the Health Consequence of Smoking: Nicotine Addiction: A Report of the Surgeon General . Rockville, Md.: US Departmment of Health and Human Services. – former smokers experience fewer days of illness) to a study showing some benefit in reimbursing costs of SC treatment. (Kaper, J. et al: A randomized controlled trial to assess the effects of reimbursing the costs of smoking cessation therapy on sustained abstinence. Addiction Volume 100 no.7 July 2005 pp. 1012-1020 (9)) and the literature also shows that a meta-analysis of 20 studies of worksite smoking cessation programmes found an average quit rate after 12 months of 13%, much higher than the national average among all smokers of 2.5% [UK 1990 data].	Thank you for these references. We will ensure that the review team is aware of them.
		4.5	It may be the case that on-line support to quit can play a role for those whose working day is spent at a computer. The NHS Together programme, launched less than 12 months ago, is yet to be evaluated.	Noted, thank you.
		4.5	There must be caution in relation to nicotine assisted reduction to stop (NARS). It has been shown that replacing some cigarettes with NRT is only of benefit to those completely opposed to quitting who then may find themselves more likely to undertake a quit attempt. References to literature on this subject may be found in “Nicotine assisted reduction to stop (NARS): guidance for health professionals on this new indication for nicotine replacement therapy”; ASH, London, October 2005. The advice to smokers should remain that their best course of action is to quit, with support, rather than use NRT to try to reduce their levels of smoking. If workplaces were to make NRT widely available to all employees without due process to ensure their motivation to quit and without setting up linked	Thank you for your comments. The new indications for nicotine replacement therapy, including NARS or ‘cut down to quit’ is the subject of an update of the NICE technology appraisal guidance no 32 on NRT/bupropion published by NICE in 2002.This is part of the public health programme guidance on smoking cessation. The scope for the guidance can be found at: www.nice.org.uk/page.aspx?o=306900

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			cessation support, this could significantly hinder those genuinely considering a quit attempt. There must be appropriate linkage between engaging with smoking cessation behavioural support and using NRT in any promotion of NRT and more widely in relation to use of NRT particularly as part of NARS. Best practice based on evidence shows that for the most effective long-term outcomes, availability of NRT should never be in isolation from Level 2 SCS delivered 1-1 or in a group setting.	
		4.5	Any routine occupational health consultation should include opportunistic Brief Advice, as recommended in the recently published NICE Guidelines on Brief Interventions. Indeed there is an argument for a 12 month review of smoking status of employees, just as in a health setting.	Noted, thank you.
		4.5	Additional support could be through brief advice, publicising SCS through staff communications including notices, intranet, payslips and staff surveys, providing facilities for SC support and by linking stop smoking work to a wider workplace health agenda.	Thank you for these comments and suggestions.
Quit		General	QUIT would like to thank NICE for the opportunity to make comment on the draft scope – Public Health Interventions: Workplace Smoking.	Noted.
		4.2.1	QUIT would like to recommend that additional wording is inserted to section 4.2.1 to include either 'clinically proven' or 'recommended' when discussing smoking cessation treatments. It will be important to ensure that the workplace smoking intervention guidance dovetails with the guidance due to be published in Summer 2007 focusing on smoking cessation services, which will be considering the use of phamacotherapies.	The Public Health Interventions Advisory Committee will only make recommendations on those interventions that show evidence of effectiveness and cost effectiveness. We will ensure that all NICE guidance on smoking cessation fits together.
		4.2.2	The draft scope highlights that work place health improvement programmes not including a smoking cessation element are not included in the areas to be covered. If there is a paucity of evidence relating to workplace health improvement programmes that do include a smoking cessation element, QUIT would like to suggest that this area be widened to accommodated other public health best practice.	Thank you for suggesting this. If the literature search indicates there is little information on workplace smoking cessation programmes, we will, of course, refine the search to look at related health programmes.
		4.6	QUIT would like to recognise the wide reaching implications of the referral from the Department of Health to commission NICE to develop Workplace Smoking Intervention Guidance. The recommendations to be made through this work will be aimed primarily at employers, which is a new audience for public health guidance.	Thank you for your comment.
		General	Whilst I would applaud any and all attempts to deal with smoking and to	The issue of encouraging employers to provide

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Royal College of General Practioners			support those stopping, I feel the draft misses one point. Whilst finding evidence for best practice, the question in my mind is who will encourage businesses to take on all this extra work? What incentive is there for companies to spend time and effort like that; I agree that companies who cherish their employees are to be applauded and no doubt reap a reward in loyal, hard working staff, but not everyone runs the Virgin business group! One example given is the use of 'no smoking' signs; even if more effective methods to help people quit is found, how will the mechanics of the scheme be run.	smoking cessation support is addressed in the key questions for the review of evidence. The independent advisory committee will consider this evidence in drawing up the guidance recommendations.
		4.5	An additional question could be 'What support from external agencies (eg primary care, telephone helpline) can maximise the effectiveness of a workplace initiative to reduce smoking'.	Thank you, this is a very important question. It is being considered as part of the programme on smoking cessation which is due to be completed in autumn 2007. The scope for the guidance can be found at: www.nice.org.uk/page.aspx?o=306900 The programme and the intervention guidance will be closely linked.
Royal College of Midwives		General	Generally the draft scope is easy to understand. It would be helpful to clarify how employers would be supported to help their staff stop smoking.	Agreed; this is one of the key questions for the review of evidence.
		1.	Gudience title very clear, the reader knows exactly what the scope is about.	Thank you.
		1.1	Short title short and to the point	Thank you.
		2	Background. Good introduction clear and concise.	Thank you.
		2.c	Clear aim and objective stated	Thank you.
			National Service Frameworks (NSF's) amend to capitals	Thank you, this version conforms to the NICE style guide.
			A good list of relevant policy documents listed to support this draft scope.	Thank you.
		3	Clear rationale for the need for guidance. The mortality rates get the message across very well.	Thank you.
		3a	Need to include references at the end of (a) to support 'cigarette smoking causes a wide range etc … and …lower survival rates and post-operative respiratory complications	Thank you, the final version will be edited to conform to the NICE style guide.
		3b	Delete speech marks ('passive smoking') this is extra information re: second-hand smoke in brackets is correct.	Thank you, we will amend.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		3c	No risk-free level of exposure – good point as is the statistics (about 617 death per year)	Thank you.
		4.4	Sould the number of employees attempting to quit and actually stopping be a measured outcome? How many attending cessation classes?	Thank you. These suggestions are captured by the draft outcome measures but they may not be reported in the literature.
			Other points discussed by J. Fyle at stakeholder meeting	

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Royal College of Nursing		General	The RCN welcomes the opportunity to review this document.	Noted, thank you.
		General	Whilst we consider that the scope of the guidance is adequate and will address this important area, we are concerned that there is not enough contained within the scope of the guidance that will motivate employers to adopt it.	Noted. We hope to capture information relevant to this issue with the following questions taken from the scope: • What support can employers offer smokers who are not currently ready to quit? • How can employers be encouraged to provide smoking cessation support? • What are the resource needs of large, medium and small enterprises in implementing smokefree legislation and supporting smokers to quit?
		General	The scope needs to be broadened to include information for employers that will motivate them to implement the guidance. Employers need to understand the benefit to them of reducing smoking amongst their employees. The evidence provided will need to be relevant to the employers - they cannot be expected to implement this guidance solely for reasons of corporate and social responsibility. They need to be able to justify its implementation in terms of a cost benefit as well.	Noted. We hope to gather evidence on this important issue but may be limited by what is available. .
		4.3	Using comparators is only likely to be informative/helpful where there is a transferability of location, culture etc. As stated in another section any guidance will need to be cognisant of the size and location of the workplace. If it is not possible to adopt recommendations in some workplaces, due to the size of the organisations, specific recommendations must be included, especially for small workplace/organisations.	Noted – the review of effectiveness will report on size of employer if this information is available.
		4.5	We would like to submit at the next stage of this process, strategies including the excellent example of a workplace smoking intervention that was drawn up by the RCN, with the aim of encouraging nurses to become smoke free.	NICE welcomes this submission.
Sainsbury Centre for Mental Health		4.1 – Populations	People with common mental health problems such as depression and anxiety constitute a significant cohort of the adult working population. They also have a high incidence of smoking prevalence. Please ensure that the Scope takes these groups into account when searching the literature for evidence of interventions. This will be particularly important when	Thank you for pointing out the necessity to consider the needs of this important sub population. We will discuss this with the reviewers who will search for any available evidence.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			addressing questions of how employers can best support employees to quit.	
		4.5 – Key questions	The focus should be on interventions that are effective for adults who work, not necessarily those that are delivered in workplaces. In many cases, especially for SMEs, cessation services may be provided by external agencies and the employer will merely act as a conduit to that information rather then organising to provide services in-house.	We do anticipate trying to capture that information. Section 4.2.1 refers to 'workplace cessation support delivered either 'in-house' or externally' as areas to be covered.
Shropshire PCT	Document re Help to quit seminar held on 27/06/06 at Seetlake Document: Help 2 Quit @ Work ©H2Q	General	On Tuesday 27th June 2006, Help 2 Quit (the local stop smoking service for Shropshire County and Telford & Wrekin) held a seminar to consider how successful the workplace programme, Help 2 Quit @ Work (H2Q@W) had been and how it could be taken forward in the future. H2Q@W was funded for 3 years as part of a local public service agreement to reduce the number of people smoking aged 16 years and over. A mobile clinic was leased for the duration to provide targeted smoking cessation services to workplaces. A report of the programme is attached. Due to the success of the project, clinics are still provided for workplaces but with limited resources as funding finished in 2006. Workplaces requesting a clinic is now required to co-ordinate the introduction of the service themselves, subject to the criteria attached.	Thank you for the report. It will help inform the Public Health Interventions Advisory Committee's consideration of the evidence of effectiveness and cost effectiveness of such programmes.
Sedgefield Primary Care Trust	Spreadsheet: Workplace smoking productivity costs model	General	I think this will be a very useful tool for workplaces in general. It will give clear guidelines in assisting employees to stop smoking. The only issue the draft doesn't address for me is how to work around shift patterns within workplaces. Often within large organisations, employees work to various shift patterns and therefore it can be difficult to strike a balance in terms of running groups at accessible times of the day. In terms of delivery, depending upon how many stop smoking advisors for workplaces there are in each area – will workplaces offer the services of	Noted, thank you. Thank you for pointing out the problems of shiftworkers. One of the key questions in the scope considers which interventions are most effective and appropriate for different sectors of the workforce. Temporary and casual workers are mentioned specifically, but we will consider how this question might also apply to shiftworkers. It is not possible to predict what

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			their occupational health nurses to deliver, will this document give workplaces options relating to this.	recommendations the independent advisory committee might make, but we expect that delivery of services will be considered.
Smoke Free Cambridgeshire and Peterborough		General	Who should fund NRT, training and support?	
		General	Could the recommendation include someone from within the organisation being trained as a gold standard?	Thank you for your comment, the Public Health Interventions Advisory Committee will be informed of all stakeholder comments and will make recommendations based on the evidence.
		General	Following on from the above comment we advise that a workplace should ideally nominate a champion within their workplace to lead on tobacco control/stop smoking services input.	Thank you for your comment – response as above. Identifying a champion to support implementation of NICE guidance is standard good practice promoted by NICE in the 'How to implement NICE guidance' guide and will be promoted in any topic specific implementation support provided.
		General	In any recommendations there should be a clear link made between smoke free policy development within the workplace and stop smoking support. This is not currently referenced anywhere in the draft scope. For example if a workplace are undertaking smoke free policy development this should be seen as an opportunity to provide smoking cessation support within the workplace and likewise if smoking cessation support is being provided this should be seen as an opportunity to encourage the workplace to develop or review their smoke free policy.	Thank you. While it is not possible to predict what PHIAC will decide it would be reasonable to assume that this issue is one it will wish to consider.
		General	Will the issue of charging workplaces for stop smoking services be addressed? Private companies are already doing this (e.g. Camilla Peterken-Smoke Free Working).	While it is not possible to predict what PHIAC will decide, it would be reasonable to assume that this issue is one it will wish to consider.
		4.5	Where do existing NHS Stop Smoking Services fit into providing this?	This is one of the questions that the guidance will seek to address.
Smokefree North West		4.5 What interventions work with different types of	Small to medium sized businesses. Drop in group sessions over a 6 week period (support is then reviewed after this period) or if number insufficient direct them into any of the NHS stop smoking interventions regularly offered at a variety of venues e.g. drop ins (rolling programme 6 weeks on 1 week off throughout the year), 6 week group, one to one (Advisor, GP,	Thank you for this information.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		workplace, e.g. prisons, NHS, offices, building sites?	Pharmacist, Midwife etc) or a telephone intervention.	
		4.5	The key messages would be the same for different types of workplaces. There are some types of workplace that are less likely to be smoke free than others, and it would make sense to target support at those businesses. A small proportion of workplaces may have special circumstances specific to them, such as prisons and psychiatric units. It therefore seems more appropriate that advice on providing smoke free environments and stop smoking support is provided by someone who is fully aware of the needs of those organisations.	We agree that there is a role for specialist advice in some workplaces, like prisons, that are exempted from some of the provisions of the Health Act 2006. Once the recommendations have been drafted they will be open to stakeholder consultation. It is hoped that stakeholders with a specialist knowledge in these areas will submit their comments at this stage.
		4.5	Mandatory brief intervention training in particular for prison and mental health care staff followed by training as level 2 advisers for those wishing to support colleagues and if they are supported by employees. Involvement of a 'champion' within occupational health, personnel or health and safety. Securing senior level support to deliver stop smoking services and enforcing the smoking policy	Noted, thank you.
		4.5 What incentives are there for NHS commissioners of stop smoking services to invest in this area of work?	Inclusion of smoking quit rate targets in Local Area Agreements that could be disaggregated for low-income groups or for cessation in workplace populations	Noted, thank you.
		4.5	Demonstrating the economic impact of reducing smoking prevalence in workplaces and for the NHS using structured economic impact analysis of tobacco use in local areas.	Noted, thank you. An economic evaluation of the cost effectiveness of interventions is, of course, part of all NICE guidance.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		4.5 What incentives are there for NHS commissioners of stop smoking services to invest in this area of work?	There are limited incentives as stop smoking support in workplaces is potentially time consuming and can divert resources away from high level of quits. The general experience is that commissioners have not considered this as an area of priority	Noted, thank you for this comment.
		4.5 What incentives are there for NHS commissioners of stop smoking services to invest in this area of work?	Improved floor targets on health and reducing health inequalities. It is difficult to demonstrate reduction in prevalence as there is little local prevalence data - only synthetic data from national surveys	Noted, thank you.
		4.5 What interventions should be in place to help smokers who do not want To quit smoking not to smoke at work?	Advice on coping mechanisms (i.e. cutting at work or abstaining with e.g. NRT). The provision of vending machines that sell NRT could be adopted.	Noted, thank you.
		4.5 Are there organisations or methods	Local Stop Smoking service can provide support or training to employees for them to be stop smoking advisors. Stop smoking support for employees needs to be accessible, (e.g. within	Noted, thank you.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		that employers can use to help smokers to quit at work or quit altogether?	working day, on site, etc.) General health education messages promoted in the workplace. Provide healthy alternatives to smoking, e.g. reduced gym sessions, lunchtime walks, etc. Refunding NRT costs for employees Provision of NRT through local voucher schemes A free service offered in work time and to achieve this there is a need educate employers on the benefits to their employees and the business.	
		4.5 Are there any issues relating to access to NRT?	Some staff have difficulty collecting prescriptions due to the hours they work. Trained advisors for workplaces that are available to provide stop smoking support to businesses on site and prescribe NRT would be ideal.	Thank you for your comments. We look forward to receiving your comments during the consultation on the draft recommendations which will take place in January 2007.
		General	The guidance needs to be published ASAP as May will be too late for implementation in preparation for smoke free legislation.	Topics for guidance are referred to NICE from the Department of Health. Because of the imminent introduction of the Health Act, NICE started work on this guidance within days of the referral from DH. Moreover, this guidance is being 'fast tracked' with the view to issuing it as quickly as possible.
		General	Hard to reach groups, including small business and BME small business need to be included.	Noted, thank you.
		General	Interventions guidance needs to cover different workplace populations, including manual, non-manual, age groups and different environments such as long distance lorry drivers.	As the key questions set out, the review team will be looking for evidence of the most effective and appropriate interventions for different sectors of the workforce.
		General	The guidance should include other health improvement displacement activities to replace smoking breaks.	Noted, thank you.
		General	The guidance should include the case for why workplaces should be smoke free.	Noted, thank you.
		General	The guidance should include the economic case for smoke free workplaces.	Noted, thank you.
		General	The guidance should include interventions for less severe mental health illness, such as depression. This work could link into some cognitive behaviour therapy research currently looking at reducing sick leave and benefits in this population group.	Noted, thank you.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		General	The guidance needs to include home workers and workers that undertake home visits.	Noted, thank you.
		General	The guidance needs to recognise that the Public Sector has greater smoke free workplace restrictions.	Noted, thank you.
		General	**The RCN Nursing Support Campaign needs launching.**	Noted, but this is outside our remit and control.
		General	The guidance should include evidence on how policies are currently being implemented in workplaces.	Thank you for your comment.
South Asian Health Foundation		General/4.5	There is evidence that the potential health benefits of a smoke free workplace depend on **social class, gender and ethnicity**: Although, the potential health benefits of a smoke free workplace are clear, the presence of policies that restrict smoking in the workplace is not uniform and may **vary by geographical region, occupation, and industry**. ***Delnevo CD**, Hrywna M, Lewis J. Predictors of smoke-free workplaces by employee characteristics: Who is left unprotected? Am J Ind Med 2004;**46**:196–202* Blue collar workers may have higher exposure to smoke in manufacturing and assembly workplaces because smoking restrictions are often **not strictly enforced** in these settings. ***Aakko E**, Schafer E, Gyarmathy VA, et al. Smoking policies in manufacturing and assembly workplaces. Wisconsin 1999. Wis Med J 2001;**100**:67–9* Persistent disparities exist in overall tobacco use and quit behaviours of smokers who are categorised as having low socio-economic status. ***Stamatakis KA**, Brownson RCM, Luke DA. Risk factors for exposure to environmental tobacco smoke among ethnically diverse women in the United States. J Womens Health Gend Based Med 2002;**11**:45–51* The prevalence of not having an official workplace smoking policy shows a consistent decreasing pattern by **increasing poverty**. ***Shavers VL**, Fagan P, Jouridine LA, et al. Workplace and home smoking restrictions and racial/ethnic variation in the prevalence and intensity of current cigarette smoking among women by poverty status, TUS-CPS 1998–1999 and 2001–2002. J Epidemiol Community Health 2006;**60***	Thank you for these references. It would help us to receive copies of these studies, should you have them. Evidence on gender, ethnicity and socio-economic status is very important to the formulation of the guidance.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			(Suppl 2) :ii34–43 **Housing, welfare, childcare, training, families, friendship circles and home smoking** need to be also considered.	
		4.6	Oral Tobacco Use - **Chewing Tobacco** Smoking tobacco, which is chewed alone or with betel quid/paan is common in South Asian populations in the UK and needs to be considered. This is most common in **women** and this group may need to be sought out specifically.	We will be looking for evidence on oral tobacco uses, including paan, in our literature search.
		4.6	Bangladeshi men working in the **catering industry** suffer particularly severe stress as a result of unsocial and long working hours in restaurants. Smoking has traditionally been viewed as macho among Bangladeshi men, but taboo amongst women – hence targeting workplaces with predominately male Bangladeshis may be more cost-effective. ***Bush J**, White M, Kai J, et al. Understanding influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study. BMJ 2003;**326**:962–7*	Thank you for this interesting observation and for the reference.
		4.6	There is low use of **nicotine-substitutes** amongst South Asians – workplaces may be an ideal place to distribute these.	Thank you, noted.
		4.6	In the United States, policies and regulations often exclude **workplaces of <50 employees** (e.g., bars and restaurants), yet employees in these workplaces represent a substantial workforce. The implications for the UK are similar.	We agree that it is a great benefit to public health that workplaces in England, regardless of size, will be governed by the new regulations.
		4.5	Only fully smoke-free work places are associated with higher rates of cessation attempts, successful cessation, and light smoking. Workplace policies that restrict smoking in the work area only are not associated with any significant differences in smoking and quitting behaviours. ***Farkas A**, Gilpin EA, Distefan JM, et al. The effects of household and workplace smoking restrictions on quitting behavior. Tob Control 1999;**8**:261–5.*	Noted. As you will be aware, the regulations in England are comprehensive.
South Downs Health NHS		**General**	Trade Unions should be actively involved in encouraging & supporting their members to stop smoking & to attend workplace stop smoking groups.	Noted.
			NICE should highlight the economic advantages to both workers & their	This guidance will consider the cost

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Trust			employers about employees stopping smoking & attending workplace stop smoking groups.	effectiveness of stop smoking programmes based in the workplace.
			Nicotine addiction should clearly be identified as a drug addiction.	Many people would agree with you, but this is outside the remit of this piece of work.
			All employers, small & large, should be encouraged to allow local NHS Stop Smoking Services to facilitate workplace stop smoking groups.	Noted.
			The NHS & other government run agencies should lead by good example by allowing staff to attend stop smoking groups in work time.	Noted.
			NRT/Zyban via the NHS should be offered free of any charge – smokers should be given ever help to stop smoking.	Noted. The independent advisory committee will certainly consider all the issues involved in workplace stop smoking programmes.
			NHS stop smoking targets should be extended from 1 month no smoking to 1 year no smoking & support should be on-going – 1 month free from smoking is not long enough.	As you are probably aware, there has been much discussion about monitoring the NHS stop smoking services. However, this is beyond the remit of this guidance. The monitoring issue may be considered by the Programme Development Group developing the NICE guidance on the optimal provision of stop smoking services. Visit: www.nice.org.uk/page.aspx?o=SmokingCessationPGMain
			Companies should investigate/reduce the amount of pressure/stress staff is placed under within the workplace – high levels of stress result in high levels of sickness, smoking, alcohol abuse & other drug use at work. Companies should promote quiet/chill out time away from the work/computer/clients/customers. Employers should explore ways in which staff can better manage stress.	Thank you for this observation.
UK Public Health Association		General	The UKPHA welcomes the opportunity to respond to this important consultation. Please see comments below.	Noted, thank you.
		General	The Health Act will mean that sometime in the summer of 2007 all workplaces will be required to be smokefree. This will have an immediate impact on the smoking habits of the workforce. Derek Wanless quoted in his first report that legislation of this nature could mean that up to 4% of smokers will quit as a result of this. Experience in Ireland and Scotland does indicate that smokefree legislation increased the number of people who quit. Those who quit are likely to be those who wished to quit and	Thank you for your comments. An investigation of the reasons that people smoke tobacco is beyond the remit of this guidance, however, this is just one of several guidance NICE will be producing on different aspects of smoking. You may like to look at the guidance on brief interventions for smoking cessation published in

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			required some incentive to do so. It is highly unlikely that it will influence those smokers who have no desire to cease smoking beyond reducing the hours that they are able to smoke. The question then is beyond the legislation –what other intervention in work could be provided to support smokers to quit smoking? The national policy focus is on smoking cessation services and these, of course, could be made available in workplaces for those who wish to quit. However, perhaps to ensure a broader, more holistic approach, the reasons why people smoke or feel they smoke should be identified and remedied. The reasons could be wide ranging around self-esteem and confidence, stress in work and home (the tobacco industry having provided a many year promotion that smoking helps stress- as many in public health consider to be an urban myth) financial conditions and debt, relationship problems, housing conditions and tenure, life opportunities.	March 2006 at: www.nice.org.uk/page.aspx?o=PHI001 and at the scope for guidance on smoking cessation which is in development . at: www.nice.org.uk/page.aspx?o=SmokingCessationPGMain
			Furthermore The Charity MIND has estimated that 12.8 million working days a year are now lost to work-related stress alone, with 58% of workers complaining of job stress, costing the UK economy £100bn a year. Fewer than one in 10 companies have an official policy on mental health, although 98% of respondents to a recent CBI survey felt that mental health should be a company concern. It shows that workplace stress can create mental ill health, or act as a trigger for existing mental health problems, which otherwise might have been successfully managed. This indicates that perhaps the focus on smoking reduction in the workforce should be that of promoting well-being and self esteem. Looking at mental health and stress levels, confidence and quality of life to put people in the right state of mind to be confident enough to want to quit the addictive product that has been incorporated into a coping strategy.	Thank you for your comments.
UNISON (National		**4.5**	**Re. question: "What are the most effective and appropriate interventions for different sectors of the workforce… ?"**	

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Health and Safety Unit)			UNISON completely supports the purpose behind the legislative bans currently or soon to be in place in Scotland, Wales, England, and Northern Ireland. UNISON believes that workers should not be exposed to second-hand smoke whilst at work. However, under the current Scottish ban and under the proposed bans for England, Wales, and Northern Ireland, there will remain a sector of workers still at risk from second-hand smoke. These are the various workers that have to visit someone in the course of their work either in their own private home or within some form of residential accommodation. Whilst UNISON accepts the right of those in private accommodation to smoke, there has to be recognition that there are many workers including many UNISON members who spend a considerable amount of time in private homes, and as such could have significant exposure to second-hand tobacco smoke and have their own attempts to give up smoking made more difficult. These workers include those providing health and social care, police support staff, careers advisers, and utility workers, but this list is not exhaustive. UNISON believes that these individuals also have a right to their health and a right to be supported. UNISON therefore believes that it is essential that in addition to the proposed regulations which will encompass the general ban, strong authoritative guidance must be produced for all employers whose staff make residential visits.	Thank you for making this important point. The implementation of the Health Act 2006 is beyond the remit of this guidance, but guidance on smoking cessation is concurrently being developed. This is an issue that may well be considered by the Programme Development Group. For more information visit the NICE website at: www.nice.org.uk/page.aspx?o=SmokingCessationPGMain
		4.5	UNISON is aware that many employers now agree with their clients/service users that they will not smoke in the workers presence, nor where a visit is expected - for a certain period before their arrival, and will allow the worker to ventilate the rooms they are to work in. This not only reduces exposure, but also assists those staff trying to give up. Where a client continues to smoke, some employers deal with this my conducting a risk assessment. Such agreements and official and authoritative guidance on these agreements should include support for staff where any such agreement is broken. Appropriate steps could then include a visit by a manager to explain the need for the agreement, providing the service at a place of	Thank you for your helpful comments. We look forward to hearing your views during the consultation on the draft recommendations which will take place in January 2007..

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			work rather than in the home of the person concerned, or possibly refusing to provide the service. Of course the approach would have to take into account what can reasonably be expected given the client base in question. A similar problem occurs with regard to residential accommodation. However UNISON believes that the proposed exemptions within the regulations which will cover England should be applied as narrowly as possible - designating both bedrooms and 'smoking rooms' as not smokefree should become the exception (requiring good justification) rather than the norm. This approach will still allow residents to smoke but will also offer more protection, encouragement, and support to staff trying to give up. Further protection, encouragement, and support might be granted to staff if where possible for a given residence, there is a presumption in favour of a single (or several as necessary) "communal smoking rooms" rather than having every smokers bedroom as a designated room. This might mean that when the resident is attended to, it can be done in their smokefree bedroom. UNISON therefore believes that it is essential that in addition to the regulations, strong official and authoritative guidance must be produced for all employers whose staff work in such residential units. This should cover arrangements, policies, and procedures for ensuring that their staff are not only protected, but also equally supported in their own attempts to give up. These arrangements could include requiring where possible, that residents do not smoke in the workers presence. Extra consideration must also be given to those workers who are pregnant or have health conditions and are therefore at greater risk from exposure to second-hand smoke. Whilst this is not a perfect solution as regards exposure, it does appear to be a step in the right direction of ensuring both the smokers right to privacy and the workers right to health, and support in their endeavours to quit smoking.	The implementation of the Health Act 2006 is beyond the remit of this guidance, but guidance on smoking cessation is concurrently being developed. This is an issue that may well be considered by the Programme Development Group. For details, visit the website at: www.nice.org.uk/page.aspx?o=SmokingCessationPGMain

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		4.5	UNISON is aware that some workers try to protect their health by avoiding dealing with users that smoke in instances where employers have failed to satisfactorily deal with the issue.	
		4.5	**Re. question: "What are the most effective ways of encouraging employee compliance with a smokefree policy?"** UNISON believes that a realistic approach which recognises: that smoking is an addiction, that not every worker will want to or be able to give up within a given time frame, and that workers who smoke are adults; will have far more success in securing compliance with a smokefree policy applicable to substantially enclosed or enclosed workplaces. Most employees as adults will be receptive to the idea or at the very least would grudgingly accept a ban which prevents others being exposed. However, UNISON believes that employers must be realistic when implementing workplace bans. UNISON believes that compliance problems are more likely to be suffered by employers who seek to go further than the current or proposed law by banning workers from smoking anywhere on the premises including out in the open and when at no risk to others, or during working hours, or whilst identifiable as an employee (perhaps by means of a uniform). A complete ban is more likely to be seen as "going too far" by some smokers, causing resentment, and since such employers are effectively making it impossible for them to smoke anywhere; those who wish to continue or are addicted will be forced into hiding to smoking. This ironically, may result in compliance problems with the legal ban as workers may chose to hide in quiet and isolated parts of large buildings. Not only will this allow second-hand exposure to continue, it will also present other risks such as fire because there will be no provision for the disposal of cigarettes and such areas are likely to include store rooms, archive rooms, and laundry stores with plenty of flammable materials. UNISON is aware of workplaces including the NHS, local government, and the waste sector which operate a "total" ban anywhere on the curtilage	Thank you for your comments. We look forward to hearing your views during the consultation on the draft recommendations which will take place during January 2007.

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			which means: that staff have insufficient time to eat or drink during breaks, and that staff clandestinely smoke leading to continued risks of second-hand exposure or to a new fire risk. Other workplaces with a "total" ban have experienced the difficulty of managers being unwilling to enforce a policy which they saw as draconian.	
			UNISON is also aware of one local government branch which reversed a "total" ban most likely in response to a severe fire risk from clandestine smoking being discovered. UNISON is also aware of an NHS trust which is currently reviewing its "total" ban although at present we have no further information as to the reason for this.	Thank you for your comments.
		4.5	**Re. question: "How can employers support and encourage smokers to quit?"** The key words here are "support and encourage". Employees must be treated like adults and supported and encouraged to give up by the employer offering positive inducements. Employers must not punish smokers by using a ban to prohibit them smoking anywhere on site or during working hours. Employees will be receptive to offers of help, but are more likely to become hostile if an employer attempts to "police" their activities which do not pose a risk to anyone else and are legal. UNISON is aware that some employers have encourage smokers to quit by various means including: paying for all or half of a "stop smoking" course; referring them to the local PCT for assistance with NRT including reduced prescription prices; supplying patches, gum, and counselling; and paid time off for sessions.	Thank you for these useful comments.
		4.5	**Re. question: "What support can employers offer smokers who are not currently ready to quit?"** UNISON believes that employers should recognise that they are adults who are choosing to take part in a legal activity and/or may be addicted. These smokers should not be punished by means of a requirement to work extra time to cover their smoking breaks as some employers have done. After all, don't we all take breaks, whether for a coffee, a smoke, or a chat	Thank you for your comments..

Public Health Interventions Advisory Committee

Draft Scope Consultation – Stakeholder Response Table

September to October 2006

Last Updated: 07/05/2010 Time: 09:39:14

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			to refresh ourselves? Nor should their life be made impossible by the "total" bans already mentioned Instead, employers should continue to make the positive inducements available. They should also consider and discuss alternative treatment options, and keep an "open door" for those who later decide that they would like to try and give up. A "total" ban also raises perhaps greater difficulty for those working longer shifts. UNISON is aware of one employer who relaxed a "total" ban in recognition of this fact.	
		General	**The effects of a "total" ban should also be considered when it comes to service delivery issues and staff safety.** UNISON has been advised of difficulties with stress, tension, and short tempers caused or aggravated where a smoker cannot smoke for their entire working day. This effects not only the smoker, but also their interaction with other staff and service users. One might also consider questioning the judgement or effectiveness of someone undergoing symptoms of withdrawal. UNISON has also had concerns raised about staff having to leave the site to smoke putting their personal safety at risk particularly at night and in less desirable neighbourhoods.	Thank you for your comments. It will be important for you to bring your experience to the recommendations during other consultation phases during the development of this guidance.