National Institute for Health and Clinical Excellence

PUBLIC HEALTH INTERVENTIONS – WORKPLACE SMOKING
Consultation on the draft Scope from 25th September – 23rd October 2006
Comments on the Draft Scope by 23rd October 2006

Stakeholder Comments

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Organisation:	**Faculty of Public Health**
Section number Indicate **section number** or **'general'** if your comment relates to the whole document	**Comments** Please insert each new comment in a new row.
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.
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.
general	NICE should highlight gaps in the evidence to help direct future research

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.
3a *Smoking as major cause of mortality and morbidity*	Could add: • Main proximal cause of inequalities in health • Poor healing (after 'post-operative respiratory complications')
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'
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?
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.

4.2.2 *Areas not covered – workplace health improvement programmes that do not include a smoking cessation component*	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 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). 2. 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?

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 • 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.
	• Different sectors of the workforce – types of employment (office, factory, travelling. seniority, job control or lack thereof)
Other	Provision of data on health effects (and costs to organisations) of employees' smoking, to aid engagement with uninterested organisations.
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'.

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 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.
Other sources of information	At the consultation, mention was made of nargilahs. ASH has a new fact sheet on 'water pipes' on its website.
	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.

Please add extra rows as needed

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