

**NICE PUBLIC HEALTH PROGRAMME GUIDANCE
Smoking Cessation Services**

**6th meeting of the Programme Development Group
Wednesday 17/ Thursday 18 January 2007,
Derwent Room, NICE**

MINUTES

Attendees:	<p>Members</p> <p>Alexander Macara (Chair), Deborah Arnott, Paul Aveyard, Ruth Bosworth, David Geldard, Ron Gould, Gerard Hastings (17 Jan only) Andrew Hayes, Paul Hooper, Carmel O’Gorman Christine Owens, Kiran Patel, Pam Rees, Mike Ward (17 Jan only), Robert West (17 Jan only)</p> <p>Reviewers (17 January) <i>West Midlands Health Technology Assessment Collaboration, University of Birmingham</i> David Moore, Martin Connock, Pelham Barton</p> <p><i>Global Dialogue for Effective Stop Smoking Campaigns</i> Karen Gutierrez</p> <p>(18 January) <i>York Health Economics Consortium</i> Matthew Taylor</p> <p>NICE Hugo Crombie, Alastair Fischer, Lesley Owen, Patti White and Tricia Younger</p> <p>Observers (17 January) Brick Lancaster Office on Smoking and Health, CDC, Atlanta, GA Val Moore, NICE Steve Sparks NICE Chris Connell NICE</p>
Apologies:	John Britton, Hilary Graham, Carmel O’Gorman, (for 18 Jan only) Gerard Hastings, Mike Ward, Robert West

ACTION POINTS UNDERLINED

Agenda Item	Minutes	Action:
<p>1 Welcome and Introductions (Alexander Macara)</p>	<p>The Chair welcomed all the members of the PDG and the review team from the West Midlands Health Technology Assessment Collaboration, University of Birmingham and Karen Gutierrez, Director of the Global Dialogue for Effective Stop Smoking Campaigns, who would present her expert paper on mass media and community</p>	

	<p>interventions for smoking cessation.</p> <p>PDG member Mike Ward had agreed to lead the discussions about the technology appraisal on 'Cut Down to Quit' and new NRT indications. Andrew Hayes would chair the session on mass media.</p>	
<p>2 Declarations of interest (Tricia Younger)</p>	<p><u>Tricia asked to be informed <i>in writing</i> about changes in declarations of interest.</u></p>	PDG
<p>3 Discussion of draft recommendations on 'Cut down to quit' (Pelham Barton, Martin Connock and David Moore) (Mike Ward chairing)</p>	<p>Martin Connock and Pelham Barton briefly reviewed the main points of the detailed presentation they had made at the previous PDG meeting. The data on Cut Down to Quit (CDTQ) was taken from seven placebo- controlled randomised trials: four on gum; two on inhaler and one on patient choice. All were looking at cutting down and quitting was a secondary outcome.</p> <p>The study authors looked at data on sustained quit; point prevalence of quitting; sustained smoking reduction and point prevalence smoking reduction. A meta-analysis of the quit results showed NRT superior to placebo. The problem would arise with 'dilution' – that is, if smokers who might have attempted to quit abruptly chose CDTQ instead.</p> <p>The economic modelling found that CDTQ was cost effective IF 'dilution' from abrupt quits formed a small proportion of CDTQ attempts. It would also be cost effective if switchers from abrupt quits maintained the same quit rate.</p> <p>Mike Ward opened the discussion. The PDG was concerned with discounting and agreed that it was a complicated issue, but it was important and possible for the guidance to explain it in a way that made sense to a non-specialist audience.</p> <p>Mike Ward set out two of the issues discussed at the last meeting: 1) that the studies from which the data on CDTQ was extrapolated were designed to investigate cutting down, but not quitting; and 2) what sort of guidance should be given about supporting smokers who might choose this method to quit smoking.</p> <p>There was a discussion of what sort of counselling might be offered to smokers using CDTQ. Would it be advisable to prescribe NRT and tell the patient at the outset that he would be expected to quit within some specified period of time (say, six months) and return at the end of that period? Or would it be better to require the patient to return once or twice during that time period? Who would do the prescribing? Either a GP, or an appropriately trained practice nurse could prescribe</p>	

	<p>as was the case in the trials. A nurse could help the patient plan the quit attempt and monitor him/her periodically.</p> <p>It was pointed out that CDTQ might impose burdens on the NHS Stop Smoking services. They were not currently set up to give guidance on this and their service targets did not take CDTQ into consideration. Moreover, although one might believe that additional counselling would make a difference to a CDTQ attempt, there was no evidence of this from the studies.</p> <p>Evidence from the field suggested that a majority of smokers reported trying to cut down on smoking, and nearly half of those were using NRT. It would be tempting to say, 'this is what smokers are doing anyway, so let them get on with it' but some members of the PDG felt that people on low incomes would not be able to afford to buy NRT, so there was an inequalities issue to be considered.</p> <p>One suggestion to try to address the inequalities issues without putting the services under strain was ask spearhead PCTs to trial one or more models of increasing the number of quitters through CDTQ.</p> <p>The problem of 'dilution' was a serious one. CDTQ, without being followed by a quit attempt was not cost effective. There had to be some guidance for practitioners to make it clear that NHS funding would not be open ended.</p> <p>The issue of the lack of targets for the NHS services beyond March 2008 arose again. The DH was thought to be looking for suggestions for how target setting could be taken forward and some members felt strongly that the PDG should make some quite concrete statements on this.</p>	
<p>5 Discussion of draft recommendations on new pharmacotherapies indications (David Moore) (Mike Ward chairing)</p>	<p>David Moore explained that the reviewers looked at the evidence that the MHRA cited when they changed the licence and then looked for further evidence.</p> <p>On adolescents, additional studies were not as positive as the ones the MHRA cited and it is not clear if NRT is as effective with adolescents as it is with adults. There were not additional safety concerns.</p> <p>On pregnancy, there were little additional data, but as mentioned previously, a large UK RCT was in progress which is due to report in 2010. This should provide much of the needed information on safety and clinical effectiveness.</p> <p>On breastfeeding, there was very little evidence on safety and effectiveness and the MHRA had recommended that</p>	

	<p>NRT was used well before any breast feeding period.</p> <p>On smokers with cardio-vascular disease, the evidence indicated that the risk associated with NRT was lower than the risk of continuing to smoke.</p> <p>The researchers identified no specific economic analysis for any of the population groups.</p> <p>With combinations of NRT the effectiveness in the short term appeared better than with a single therapy, but this effectiveness diminished over time. The researchers identified no economic analysis.</p> <p>It was noted that data collection on a large trial of bupropion vs. NRT vs. combination had just been completed and that the lead researcher might be able to supply some data. <u>The NICE team to follow this up.</u></p> <p>The PDG discussed whether, and under what conditions, the funding direction for NRT and bupropion would be maintained when the updated guidance was published. It was noted that there were concerns in the PDG and in practitioner groups beyond it about the adverse effects of losing the funding direction on NRT.</p> <p>The group split into discussion groups to consider recommendations</p>	NICE
Recommendations	<p><u>On adolescents:</u> One group concluded: 'NRT is not recommended as a first line of treatment for all adolescents. However, it may be appropriate for young smokers with well-established patterns of behaviour, at the discretion of the health professional working with the smoker.' This was supported by the other group who also felt that the offer of NRT to an adolescent should be part of a supervised regime.</p> <p>It was also felt that as much was not known about young peoples' cessation, services working with this group should collect data about the effectiveness of the use of NRT.</p> <p><u>On pregnant and breastfeeding women:</u> These women should be encouraged to quit abruptly and smoking cessation counselling should be offered.</p> <p>The PDG was ambivalent about the wording of a recommendation on NRT use to pregnant women. One suggestion was that if offered, NRT should be given along with more extensive counselling. The PDG discussed whether the recommendation should not be 'not recommended for routine use'.</p>	

<p>6/9 Mass media interventions: expert testimony and discussion (Karen Gutierrez) (Andrew Hayes chairing)</p>	<p>Karen Gutierrez presented the highlights of her paper on global learning from mass media interventions on smoking cessation. She was complimented by the PDG on her impressive report.</p> <p>Andrew Hayes opened the discussion by getting the agreement of all present that the PDG had the right and responsibility to make recommendations about mass media. He noted that England already had a national campaign and when this was not sustained for a period in the previous year, the numbers of smokers using the NHS services fell. <u>At his suggestion, the PDG agreed that the recommendations should address the regional and local levels as well as the DH nationally.</u></p> <p><u>It was suggested that the NICE team should draft recommendations drawn on the present discussion and these could be discussed at the next PDG meeting in March. The NICE team asked PDG members to send the team any suggestions they might have for recommendations.</u></p> <p>It was suggested that the first recommendations should be around sustaining a national campaign funded by the DH.</p> <p>It was also suggested that a national campaign does not imply that everything is branded with a NHS or DH logo, it could be a 'many voices' campaign. Karen Gutierrez clarified that the most important element was that messages had to come from sources that were perceived as credible and positive. It was felt that local authorities would be reluctant to promote NHS branded messages.</p> <p>It was suggested that all PCTs should develop targeted campaigns to address health inequalities by improving access to services by 'hard to reach' groups. It was also pointed out that if mass media was being used locally and nationally, it had the potential to be confusing if not carefully coordinated. Mass media elements have to fit in with other communications that are going on and with a service delivery. The word Karen Gutierrez used was 'synergistic' .</p> <p>There was a discussion of new media, such as pod casts, and it was pointed out that although they had potential as they had an interactive element, the evidence base at the moment was very weak. It was suggested that one recommendation might be to investigate these new and innovative media on a small scale because that was what the current evidence base suggested.</p> <p>There was a discussion of the use of humour, which is generally not shown to be effective, in 'why to quit' ads. The Health Education Authority (HEA) John Cleese ads were cited as a counter example and Karen Gutierrez</p>	<p>PDG</p> <p>NICE</p> <p>PDG</p>
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	<p>pointed out that what the Cleese ads did was combine 'why to quit' and 'how to quit' and presented the smoker with a more comfortable idea about the quitting process.</p> <p>It was reiterated that DH was on the right track with its media approach, but that it was crucial that funding should be sustained. Ads that had been successful in other jurisdictions should be adapted for England for economy's sake.</p> <p>There was a suggestion that the PDG might call for an Office of Tobacco Control to maintain momentum and a joined-up approach to tobacco control in England.</p> <p>It was crucial that when smokers are ready to make an attempt to stop, they should not be turned away from sources of help. It was thought that the present national telephone helpline was not as effective as it might be. There was wide agreement that PDG should suggest improvements – for example, that the standards of the telephone helpline should be high in terms of responsiveness to calls, quality of advice and training of counsellors.</p>	
10 Minutes of the last meeting	<p>The minutes of the PDG meeting (SC5) were accepted as an accurate record.</p> <p><u>It was requested that those minutes to which amendments had been made should be re-circulated. It was agreed to do this.</u></p>	NICE
Thursday	18 January 2007	
1 Welcome and recap on yesterday's meeting	<p>The Chair welcomed the members of the PDG to the second day of the meeting. Unfortunately, because of extreme weather conditions, many trains had been cancelled or delayed and some members were not able to reach London. Matthew Taylor, who was to present the York Health Economics Consortium's paper on economic modelling was delayed, so Alastair Fischer stood in for him.</p>	
2 /3 Economic modelling report and discussion (Alastair Fischer Matthew Taylor) (Paul Aveyard chairing)	<p>Alastair explained some of the concepts in the economic modelling which members of the PDG found helpful.</p> <p>The model being presented was developed for the workplace intervention guidance. A number of elements, namely, pharmacy interventions, No Smoking Day and mass media would be added to the model to make it reflect more of the elements covered in the programme guidance. The PDG needed to determine their priorities for the economic modelling.</p> <p>In discussion, the PDG members raised a number of</p>	

	<p>issues:</p> <ul style="list-style-type: none"> • It was important to use the best data available to inform the argument. For example, to demonstrate to employers that smoking cessation in the workplace would be cost-saving. Managers of small and medium sized enterprises (SMEs) had rapid staff turnover so had to recoup their expenditure quickly. Some PDG members expressed the view that the model had seriously underestimated the costs of smoking employees to employers. • It could be beneficial to have some sort of grading of cost effectiveness of different interventions, but it might be irrelevant since they were all very cost effective. Individuals' choice of quitting method was also important, so it was not a question of concentrating on the most effective method. • Although it might be difficult to model the effectiveness of mass media, its function as a driver of 1) smokers to quit and 2) smokers to use the services made it an extremely important component of tobacco control. • Several PDG members said that the 'gold standard' would be a determination of where the investment might be put in to get the maximum number of quitters and which combination of programmes would bring the greatest benefit. . If it was not possible to complete it as part of the programme guidance, perhaps it should be a research recommendation. 	
<p>6 Update on draft guidance on workplace smoking cessation interventions (Lesley Owen)</p>	<p>The consultation on draft recommendations on the intervention guidance was due to end the next day. There was some concern in the PDG that the recommendations to employers might not be specific enough. PHIAC recommended that employers do something to help employees to quit smoking but because of the wide variations in resources available to employers, had not wanted to be prescriptive.</p> <p>PDG members were concerned that the intervention guidance had not engaged with the issue of incentives, either to individual employees or as incentive schemes to employers to encourage them to support workers in smoking cessation. Some award schemes like the Health at Work Award, or Investors in People clearly had a role to play. It was also important that benefits to non-smoking employees would be considered. It was thought these issues should be part of a properly negotiated policy for the workplace. It was pointed out that the unions were strongly in favour of consultation between the workforce and employers.</p>	

	<p>It was thought possible that the PDG might well be able to make its recommendations in light of the final PHIAC recommendations which were due to be published in May. The PDG might wish to take forward some of the issues that had been thought beyond the scope of the intervention guidance.</p>	
<p>7 Fieldwork (Hugo Crombie)</p>	<p>The fieldwork contract had been put out to tender before Christmas. The applicants had been narrowed down to three and a contractor would be selected by the team in the following week. Fieldwork was due to be conducted in April/ May and a report presented to the PDG at its June meeting.</p>	
<p>5 Discussion of draft recommendations on NHS and Non-NHS treatment</p>	<p>On Non-NHS treatment, there was a discussion whether a research recommendation should be made for the Allan Carr Easyway method. The issue was not resolved at the meeting.</p> <p>On rapid smoking it was agreed to say that it should not be <i>routinely</i> used in the NHS.</p> <p>On glucose, it was agreed that although the effectiveness of glucose was not established, the cost was so low that its use should not be discouraged, but it should not be provided by the NHS.</p> <p>Because poor weather was causing travel delays, it was decided to end the meeting slightly earlier than planned. <u>It was agreed that NICE would circulate the latest version of the NHS recommendations by email and that members of the PDG would respond with their comments.</u></p>	<p>NICE PDG</p>
<p>8 AOB</p>	<p>There was no further business and the Chair closed the meeting at 15:00.</p>	

DATE OF NEXT MEETING: Wednesday, 7 March 2007
Royal College of Anaesthetists

PAPERS FOR THE NEXT MEETING WILL BE EMAILED: Wednesday, 28 February 2007