November 2021: NICE guidelines PH45 (June 2013) PH48 (November 2013) have been updated and replaced by NG209.
The recommendations labelled [2013] or [2013, amended 2021] in the updated guideline were based on these evidence reviews.

See www.nice.org.uk/guidance/NG209 for all the current recommendations and evidence reviews.

Routes to Quit Pilots

Report

March 2012

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Contents

Executive summary

Since 1999 free support has been available to all smokers through stop smoking services. This comprehensive network of services has supported over five million smokers to set a quit date and just under three million smokers to stop in the short-term as measured at four weeks.[1] Historically services have delivered the abrupt model of stop smoking support quadrupling a smoker's chances of stopping[2] and are considered to be one of the most cost-effective intervention services provided by the NHS.

However, given the fact there are still more than eight million smokers in England and considering that the majority of smokers who attempt to stop either do so unassisted[2] (do not use medication or access behavioural support) or opt for the least effective support options (i.e. NRT over the counter), smoking cessation and stop smoking services still have an important part to play in a comprehensive tobacco control approach.

The Routes to Quit (RtQ) model was developed to try and encourage a greater number of smokers, even if they are not ready to stop in the near future, to access services and engage with an evidence-based form of support. The model comprises three steps: step 1 delivery of very brief advice by health care professionals; step 2 Tailored Quit Plan (TQP) assessments; and step 3 delivery of TQP interventions by trained stop smoking advisers. Interventions include reduction approaches to quitting (rapid and gradual reduction programmes) and are offered to smokers in the order of effectiveness.

Consideration of extending the range of evidence-based support options available to smokers was included within *Healthy Lives, Healthy People: A Tobacco Control Plan for England* published by the Department of Health in 2011. The RtQ pilots were designed to form part of this process, and began to investigate how this could possibly be achieved at a local level.

In order to test the RtQ model three pilot areas were established. An interim report published in October 2010 summarised the findings from the first two sites, NHS Somerset and The Bridge, a substance misuse clinic in Solihull which tested the feasibility of the model. This report predominantly focuses upon the outcomes from the final pilot in County Durham and Darlington. A brief overview of the key points contained within this report is provided below.

- The RtQ model was piloted by NHS County Durham and NHS Darlington between 6 June – 6 December 2011.
- The pilot was promoted through a variety of communication channels over the pilot period.
- 3,691 TQP assessments were offered with a final total of 3,622 participants. This included 479 pregnant smokers and 13 prisoners.
- The abrupt model of support was chosen by 94.3% (n=3,414) participants. Those who were employed and only smoked cigarettes were more likely to choose this option.

- Service providers reported that despite initial teething problems and concerns about the amount of time and work involved, the model was less problematic to implement than originally envisioned.
- Terminology such as 'routes to quit' and 'tailored quit plan' were not easily recalled and interpreted by clients.
- Smokers appeared to have already decided their method of quitting prior to contacting the service. This appeared to be informed by previous experiences of stopping or personal beliefs about quitting rather than the scientific evidence.
- Offering more support options did not appear to prompt smokers motivated to quit abruptly to try a less effective reduction approach.
- Although the number of clients taking up a support option other than abrupt were very small, offering cut down support options appeared to offer smokers anxious about stopping a viable alternative to an abrupt quit, and legitimised the cut down support that some service providers already delivered.
- Despite an increase in quit dates set and four-week quitters compared to the same period in 2010 it was unclear whether the RtQ model had attracted more or new smokers into the services.
- It is recommended that the RtQ model is subjected to further testing through the implementation of a phased roll out approach in line with the Medical Research Council's guidelines for developing and evaluating complex interventions.
- Additional testing would help to further explore:
  - Factors that influence smokers' approaches to quitting
  - The most effective messaging and terminology, as well as imagery and communication mediums, to promote a broader range of services
  - Characteristics of smokers that may be more attracted to reduction approaches
  - Specific populations that a model such as RtQ could be most suitable for
  - The most effective methods that a smoker can use to reduce their consumption both rapidly and gradually
  - Adaptation of stop smoking service personnel training to include information regarding the effectiveness of support options other than abrupt
  - The logistics of implementing RtQ (including community advisors) at a local level as well as cost and capacity implications

Introduction

Since 1999, the NHS has provided dedicated support to all smokers wanting to stop. During this time, over five million smokers have been treated by local stop smoking services, over two million of whom stopped in the short-term (four weeks).[1] The combination of behavioural support and medication that services offer roughly quadruples a smoker's chances of quitting successfully compared with quitting 'cold turkey'.[2] However only nine per cent of smokers are supported by stop smoking services[1] and over half of all quit attempts happen without any support at all.[2] While the research evidence suggests that smokers who quit abruptly are more likely to be successful in the longer term, there is a growing awareness that not all smokers want to stop smoking immediately,[3,4] and may as a consequence, not be attracted to the current type of support offered by local stop smoking services. As a response to this, the Routes to Quit Model (RtQ) was developed to encourage greater numbers of smokers, even if they are not ready to stop in the near future, to access services and engage with an evidence-based form of support.

Policy context

Consideration of extending the range of evidence-based support options available to smokers was included within *Healthy Lives, Healthy People: A Tobacco Control Plan for England* published by the Department of Health (DH) in 2011. The RtQ pilots were designed to form part of this process, and to investigate how this could be achieved at a local level.

Currently stop smoking service provision is measured by four-week quit outcomes based upon the rationale that biochemically validated quit outcomes at four weeks can be effectively used to calculate long-term success rates.[5] Whilst abrupt quitting is proven as the most effective form of stop smoking support, this focus on four-week quits has had implications for any services considering broadening the support options available locally. The Public Health Outcomes Framework published in 2012[5] includes prevalence-based measures for tobacco control, which may allow greater flexibility at a local level when deciding priorities and designing service delivery. It is however, unknown what effect the shift of public health, including stop smoking services, to local authorities is likely to have on continued service commissioning and configuration.

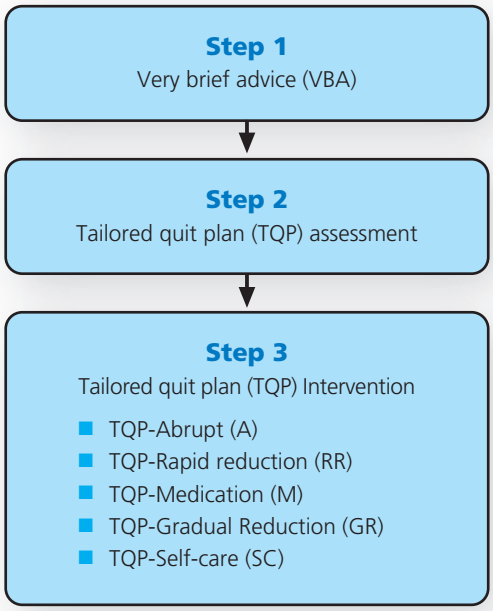
NCSCT Community Interest Company

The NCSCT Community Interest Company (NCSCT) was commissioned by the DH to test the RtQ model. The RtQ interim report, which summarised the initial findings from the first pilot in Somerset PCT and a smaller scale pilot conducted in a substance misuse service in Solihull, was published in 2011. This current report primarily focuses on the outcomes from the final pilot in County Durham and Darlington.

The Routes to Quit model

The RtQ model comprises of three steps as outlined in Figure 1.

Figure 1 – RtQ model



Step 1 – Very Brief Advice (VBA)

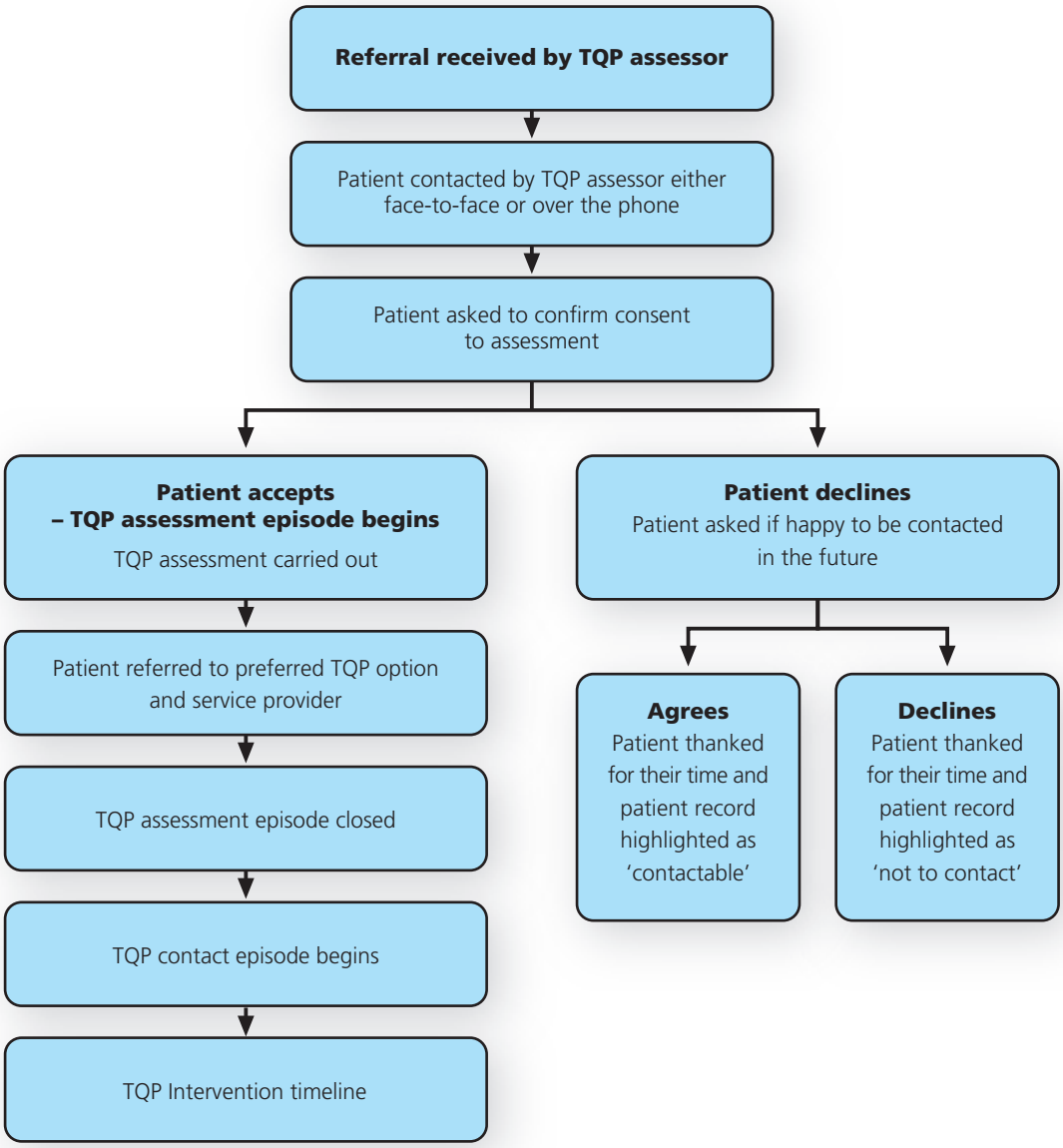
As with all stop smoking interventions the model begins and relies upon the routine and systematic identification of smokers achieved through the delivery of VBA. Consenting identified smokers are then referred onto a Tailored Quit Plan (TQP) assessor for a TQP assessment.

Step 2 – TQP assessment

Meeting the needs of an individual means having some understanding of their lifestyle and personal preferences. A choice of interventions may help to meet individual needs. It is also important however, that all options are offered to smokers accompanied by supporting information regarding the relative chances of success associated with each intervention type.

TQP assessments are delivered by trained TQP assessors and last for up to fifteen minutes. The assessment involves the recording of key information and a discussion regarding the various support options available. The options or tailored quit plans (TQPs) as listed in step 3 of Figure 1, are offered in the order of effectiveness and in line with a hierarchy of evidence. Once an option is chosen, the assessor locates and facilitates referral to the preferred provider and no further TQP options are offered. Figure 2 gives an overview of the TQP assessment process.

Figure 2 – Overview of the TQP assessment process



Assessors make three attempts to contact referred smokers and if unsuccessful send a follow-up letter to encourage the smoker to contact the assessment service.

At the end of an assessment the assessor sends a confirmation letter to the smoker which details their chosen TQP as well as the date and time of their appointment. All assessed clients are contacted by the assessor after two weeks to check whether they managed to attend their appointment or experienced any issues. This provides an ideal opportunity to re-engage any smokers who may have had second thoughts since making the original appointment or who have changed their mind about their original TQP choice.

TQP-Self-Care is the only TQP intervention provided by the TQP assessors.

Step 3 – Tailored Quit Plan (TQP) interventions

At the end of a TQP assessment the smoker will have chosen their preferred support option i.e. their preferred tailored quit plan (TQP).

Most of the TQP interventions share common properties (such as behavioural support, structure and the offer of approved pharmacotherapy) and they all, except TQP-Self-care, involve multiple sessions.

As already stated, the various evidence-based intervention options are offered according to a 'hierarchy of evidence' shown in Figure 1, Step 3.

1. Tailored Quit Plan – Abrupt (TQP-A)

- Model of support currently provided by the services
- Quit date set at the first session
- All NICE recommended stop smoking medicines available
- Monitored at four weeks post quit date

2. Tailored Quit Plan – Rapid Reduction (TQP-RR)

- A period of up to four weeks to reduce tobacco consumption pre quit date
- Quit date set at first session
- All NICE recommended stop smoking medicines available
- Structured cut down encouraged (Smokefree periods / Timer method)
- Monitored at four weeks post quit date

3. Tailored Quit Plan – Medication Only (TQP-MO)

- Medication via a healthcare professional without additional behavioural support
- Requires quit date to be set and fortnightly contact with CO-verification
- All NICE recommended stop smoking medicines available
- Monitored at four weeks post quit date

4. Tailored Quit Plan – Gradual Reduction (TQP-GR)

- Programme lasts for up to nine months
- To continue on the programme, the smoker must have halved consumption by week six
- Multiple quit dates allowed providing the client doesn't return to full smoking
- Structured cut down method encouraged (Smokefree periods / Timer method)
- Nicotine replacement therapy (NRT) only
- Monitored at six weeks and then four weeks after each quit date

5. Tailored Quit Plan – Self-care (TQP-SC)

- Offer of written information regarding:
  - The stop smoking services
  - Accessing stop smoking medicines on prescription
  - Buying NRT over the counter
  - Using NRT for temporary abstinence
  - Using NRT for long-term substitution
- Offer of on-going contact to keep the client engaged with the service (three months general / one month for pregnant smokers)

Evidence for reduction approaches

Abrupt cessation remains the most effective option[2] however there is a growing evidence base for reduction approaches.

Lindson et al[7] found that reduction interventions offered to smokers who want to stop smoking produce comparable quit rates to abrupt cessation, and concluded that smokers can be given the choice to stop using either of these approaches. In addition, Wang et al[8] found that cut down approaches using NRT were more effective than placebo and NRT has been found to be an effective intervention to support smokers unwilling or unable to quit abruptly to achieve long-term abstinence.[8,9] Reduction interventions have also been shown to be highly cost-effective in comparison with no quit attempt being made[8]. The need for further research into the most effective reduction models, the types of smokers who may benefit from such approaches and how cut down strategies can be integrated with abrupt services were also identified by both reviews.

Whilst uncertainty remains over the health benefits of reduction approaches with no initial focus on quitting, they may provide a step towards stopping smoking completely.[10] Reducing consumption prior to cessation is also a strategy that smokers report adopting independently.[2]

Use of NRT for cut down and harm reduction approaches

In 2005 the indication for NRT was extended by the Medicines and Healthcare products Regulatory Agency (MHRA) to include use for cutting down. A further harm reduction element was added to the NRT indication by the MHRA in 2010.

Future guidance

NICE is currently developing Public Health guidance *'Tobacco – harm-reduction approaches to smoking,'* which will consider cut down approaches as part of its scope and is expected to be made available in 2013.

http://guidance.nice.org.uk/PHG/Wave23/23

The pilots

In order to test the RtQ model three pilot areas were established. Whilst this report includes a summary of the findings from the first two sites, NHS Somerset and The Bridge in Solihull as provided below, the main focus is on the outcomes of the final pilot in County Durham and Darlington.

The aim of the pilots was to test the feasibility of the routes to quit model and in doing so to:

- Test whether the RtQ model attracts more smokers to the stop smoking services and smokers who wouldn't have previously engaged with a stop smoking service.
- Identify the key elements required to implement the RtQ model as well as the potential barriers.
- Test the RtQ model with specific smoking populations such as pregnant smokers and substance misusers.

The RtQ pilots were not intended to test the relative efficacy of the tailored quit plan interventions as these already have a growing evidence-base (see page 10).

Interim report summary

The main findings from the initial pilots in Somerset and Solihull included:

- The assessment consent rate was high (96% and 62% respectively).
- The abrupt model of support remained the most popular choice for assessed clients (95%, n=575 in Somerset and 71.4%, n=40 in Solihull).
- It was therefore suggested that the structure and content of the assessment script and the messaging used to communicate the model to smokers requires further testing to ensure this does allow client choice.
- It was also suggested that further testing was required to assess whether the RtQ model attracts smokers who would not ordinarily engage with services or who feel they are not ready to stop smoking abruptly. However, there was no evidence to suggest that the model resulted in clients, who are already motivated to stop abruptly, choosing one of the lesser effective support models.
- The level of engagement with clients at the Bridge (a substance misuse clinic) was very encouraging and indicated that smokers within this client group are interested in stopping and are open to the offer of support.
- It was also evident, however, that establishing and maintaining contact as well as commitment with this group can be challenging and services may need to adapt to increase the chances of sustained engagement.

Note: A full overview of the first two pilots is provided in the RtQ interim report.

www.ncsct.co.uk/Content/FileManager/documents/NCSCT-CIC-DeliveryProjects/RoutestoQuit/ncsct-cic-rtq-final.pdf

County Durham and Darlington

County Durham and Darlington are two adjacent unitary authorities in the North East of England. Public Health NHS County Durham and Darlington commission a provider organisation, County Durham and Darlington NHS Foundation Trust's Health Improvement Team, to deliver health improvement services, including a 'hub' stop smoking service, across the two areas. They also commission a range of independent provider GPs and pharmacists to deliver stop smoking support.

Smoking prevalence in County Durham is higher than the national average. In County Durham 26% of the adult population smoke compared to 21% nationally.[11] In comparison, smoking prevalence in Darlington had fallen sharply in recent years to 19%.[12–13] However, in both County Durham and Darlington rates of smoking in pregnancy (22% and 20% respectively) are higher than the national average of 14%.[11–12] The number of smoking related deaths in both areas is also significantly higher than the average for England.[11–12]

The hub service employs specialist stop smoking advisors to deliver individual and group support sessions across a large geographical area in various community and primary health care settings. Smokers can also access support from the majority of GP surgeries and pharmacies in the area.

This final pilot ran from 6 June 2011 to 6 December 2011.

Table 1 provides an overview of how the three elements of the model were delivered in County Durham and Darlington.

Table 1: Delivery of RtQ in County Durham and Darlington

Step 1: Identification and referral of patients who smoke	Existing referral networks were used to proactively refer clients to the service. Smokers were also encouraged to self-refer through local marketing and communication campaigns.
Step 2: TQP Assessment	Existing administration teams, working within four areas of County Durham and Darlington, provided the TQP assessment service. These teams were already responsible for answering the stop smoking service helplines and signposting smokers onto local support. All assessors were trained by the NCSCT to deliver TQP assessments. In addition specialist stop smoking advisers were trained to incorporate TQP assessments within the support provided at drop-ins in order to include this intervention type within the pilot.
Step 3: TQP Interventions	TQP-A Delivered by the core service only TQP-RR Delivered by the core service only TQP-MO Delivered by the core service only TQP-GR Delivered by the core service only TQP-SC Delivered by the TQP assessment service

Pilot exclusions

Whilst GP practices and pharmacies across County Durham and Darlington also provide stop smoking services it was decided that the RtQ model would only be piloted through the specialist stop smoking advisers working within the main service. This was in recognition of the logistics and time required to amend and agree revised commissioning contracts, deliver the level and quantity of training required and to embed RtQ in day-to-day practice within primary care settings, which would have been greater than the time available in the project.

This meant that only smokers who called the specialist service helplines would be offered RtQ and those accessing stop smoking support directly through a GP practice or pharmacy would continue to only be offered the abrupt model of support.

Staff working within GP practices and pharmacists were given information about the pilot however, and encouraged to signpost smokers to contact the specialist service if they didn't offer a stop smoking service themselves or felt that one of the other options within RtQ might be better suited to a smoker.

Prison

In total there are four prisons within County Durham and Darlington within which the specialist service provides support. It was agreed to include HMP Frankland, a category A prison, within the pilot. There were some initial concerns about offering gradual reduction within this setting due to the perceived risk of this service being abused in order to access NRT, which in turn could be used as currency amongst inmates. However, following further discussion it was agreed to include TQP-GR as a support option but that this would be closely monitored and the decision reassessed if evidence of abuse became apparent.

TQP assessments and support

Initially the intention was for the pharmacy assistants to deliver the TQP assessments within the prison but due to time and staffing constraints this element of the approach was ultimately delivered by the stop smoking adviser as part of the weekly clinic. The clinic ran as a combined 1:1 and group session whereby each prisoner was given a short individual consultation followed by a group session. Movements around the prison meant that the prisoners were moved en-masse and as a result had to be held in healthcare for at least an hour before a patrol could take them back to the wings. Therefore the semi-group structure proved the most practical way to manage the group. In addition, the stop smoking adviser had regular support from one of the prison's healthcare assistants, also trained to deliver stop smoking support, who assisted in supporting the group and acted as a chaperone for security reasons.

Pharmacotherapy

Prescriptions for pharmacotherapy were requested on a weekly basis, NRT by voucher and Champix by prescription, and given out in the following week's clinic. The majority of prisoners were allowed to possess one week's medication, unless indicated otherwise. Where this was not possible, medication was given out with the daily treatments on the wings. To monitor usage, prisoners also had to bring back their empties in order to receive a further supply.

Pregnancy

Unlike the initial RtQ pilots it was agreed that pregnant smokers would be included within the County Durham and Darlington pilot. The specialist service had an established opt-out referral pathway for pregnant smokers and a dedicated pregnancy support service.

From the service's perspective it appeared inequitable to exclude pregnant smokers although it was important to consider the evidence-base and the additional potential implications of a model such as RtQ for this group.

Whilst there is a growing evidence-base on the potential benefits of cutting down smoking before quitting using NRT, for smokers unwilling or unable to quit abruptly none of this evidence has yet been established for cutting down to quit with NRT as a route for pregnant women. This meant that it was not possible to rely on peer-reviewed, published evidence to guide service development in this area. What was known however, was that very few pregnant women currently use effective support (of the kind offered by local stop smoking services) to quit during pregnancy. Accurate figures for England are not currently available, but in Scotland, for example, it is known that just 17% of pregnant smokers accessed stop smoking services in 2009.[14] At the time of the pilot within County Durham and Darlington the referral rate of pregnant smokers was approximately 83%, 11.3% (n=63) of which set a quit date. It was therefore recognised that if more women are to be encouraged to access support and have an increased chance of quitting, new approaches are required. Pilot work to examine a more gradual approach to cessation, combined with monitored and supported NRT use, could be one such approach.

However, it was also important to take into account the evidence considered in the development of the NICE PH26 guidance,[15] which suggested that, particularly in the past, health professionals (midwives in particular) may have presented cutting down as viable *alternative* to quitting.[15] NICE guidance is clear that cessation during pregnancy, achieved either pre-conception or as early as possible during pregnancy is what is required, not cutting down alone. Therefore, it was recognised that the RtQ model for pregnant women must include stopping smoking completely as a clear outcome and that any cutting down with NRT should ideally occur pre-conception or in the early stages of pregnancy over a short, clearly-defined period. Therefore, in keeping with NICE guidance, it was decided that TQP-GR would not be offered to pregnant women and that the TQP assessment script would be amended to include a question for smokers about current pregnancy or intention to become pregnant in the near future so that the offer could be tailored accordingly.

Agreement to offer RtQ to pregnant smokers was also sought and obtained from the Smoking and Pregnancy Action Group, which included representation from a Consultant Obstetrician.

Communications and marketing

To promote the RtQ pilot a six month communications and marketing plan was developed.

Communication channels

A wide range of communication channels were used to publicise RtQ including:

- Leaflet drops in areas of high footfall across County Durham and Darlington including residential door drops and hand-outs in town centres.
- Advertisements in GP surgeries via posters and patient information screens in waiting areas
- Supplied GPs with new service information
- Case studies, advertorials and adverts in local paid for press
- Distributed service materials through the service and its outlets
- Street activities to drive service traffic
- Amended websites and search engine rankings for the service
- Advertised on regional websites either paid or through partnerships
- Placed articles in partners internal and external newsletters such as the Durham County news which goes to every single household
- Placed information on payslips that went to 10,000 NHS workers across the area.

Key messaging and straplines

As part of the pilot planning process RtQ messaging was discussed. The outcomes from the initial RtQ pilots had suggested that the public facing messaging could be improved and that consideration should be given to broadening the messaging so that the range of support options was made more obvious. Whilst it was recognised that the promotion of the RtQ model would be an essential element of the pilot there was some reticence from the service to the idea of explicitly promoting cut down approaches and possibly losing the focus on abrupt quitting as the most effective type of support. The original design of the model also limited the opportunities to advertise the different routes in detail, the intention being that the support options would only be discussed once the smoker had contacted the service and had consented to a TQP assessment.

Given this context, a small amount of street sampling with smokers was undertaken to support the development of the promotional materials and to test the proposed straplines. As a result the preferred lines tested were:

'We will help you find your route to quit.'

'With more choices, more flexibility, more ways to stop, this could be time for you to go smokefree'

Appendix A includes a full list of the lines tested and Appendix B shows an example flyer.

Further testing

As the pilot progressed it became apparent that the number of smokers accessing support options other than abrupt was low and the possibility of using more explicit messaging about the other routes was revisited. However there were a number of issues with this as the profile of RtQ had already been comprehensively raised across County Durham and Darlington. If new materials had been released with slightly different information then there was a high risk that these changes would not have been picked up by people, having already seen materials and messages multiple times.

Furthermore, in order to test the impact of the new messaging, a re-launch would have been required in a test area using the new messaging to the same scale as the promotion already undertaken for comparison purposes. Due to the extent of the marketing already employed it was therefore agreed that it would be impossible to ensure that smokers from the test area had not already come into contact with the original message and that this had not biased their decision to contact the service.

Further testing using focus groups is therefore required to fully investigate the most effective terminology in order to successfully promote an approach such as RtQ and the consequences of unambiguously describing the different support options available.

TQP assessment script and client information

Based upon the findings from the initial pilots a revised TQP assessment script was used in an attempt to clearly introduce the notion of more than one support option being available and to allow more opportunities for smokers to go back to options previously offered during the conversation. The TQP assessment script can be found in Appendix C.

At the end of the assessment clients were sent a welcome pack that included a specific information leaflet relating to their chosen TQP. An example leaflet can also be found in Appendix D.

For quality assurance purposes, the TQP assessors were 'mystery shopped' at the beginning of the pilot and twice more during the implementation period to check adherence to the key messages within the script and core principles of the TQP assessment process. This proved to be an essential tool to help identify areas for improvement and to support the assessors to feel more confident in delivering this extended role.

Pilot findings

Data was captured using the service's existing 'Quit Manager' database and transferred to SPSS (Version 14) at the end of the pilot where it was anonymised, coded and analysed. Descriptive statistics are reported and multiple logistic regression used to predict choices of TQP and four-week quit outcomes.

Outcomes

TQP assessments

During the pilot period 3,691 TQP assessments were offered with over 99% (99.5%, n=3,672) of smokers consenting to an assessment. Less than 1% of smokers either did not consent to an assessment (0.4%, n=15) or declined to participate at all (0.1%, n=4). Out of those who originally consented to a referral 1.4% (n=50) did not complete the referral process.

At the point of assessment 28.1% (n=1018) reported being aware of RtQ, which was initially suggestive of an effective communications campaign. However, as highlighted in the qualitative evaluation (see pages 27–28 and 32–34), this should be interpreted with some caution.

In addition, over two-thirds of those assessed (66.4%, n=2,406) were recorded as a unique user to the service. It should be noted however that the current database used by the stop smoking service was only introduced in April 2010, and therefore this could only measure users who were unique to the service after this date.

Demographics and smoking characteristics

Participant demographics are shown in Table 2. The majority of participants were female (60.7%, n=2200), (except in the prison where all participants (n=13) were male), were of White British or Irish origin (88.5%, n=3207) and were employed in a routine and manual occupation (36.2%, n=1312). In total 13.2% (n=479) of participants were pregnant.

Table 2: Participant demographics – County Durham & Darlington

	% (n)	All participants (n=3622)	Pregnant smokers (n=479)	Smokers in prison (n=13)
Gender	Female	60.7 (2200)	100 (479)	–
	Male	39.3 (1422)	–	100 (13)
Age	Mean	39	23	40
	Range	12 – 90	14 – 43	26 – 56
Ethnicity	White British / Irish	88.5 (3207)	91.4 (438)	23.1 (3)
	Other Ethnic Groups	0.5 (19)	0.2 (1)	
	Unknown	10.9 (396)	8.4 (40)	76.9 (10)
Occupation	Routine & Manual	36.2 (1312)	32.8 (157)	
	Never worked / long-term unemployed	21.5 (779)	43.0 (206)	
	Retired	10.5 (380)	0.2 (1)	
	Intermediate	6.2 (226)	6.7 (32)	
	Sick / disabled and unable to work	6.2 (224)	1.3 (6)	
	Managerial/professional	5.7 (208)	4.6 (22)	
	Full-time student	4.6 (168)	4.6 (22)	
	Home carer	4.2 (152)	5.6 (27)	
	Prisoner	0.4 (13)	0 (0)	
	Unknown	4.4 (160)	1.3 (6)	
Pregnant	% of women	13.2 (479)		

Across all groups, where recorded, the majority smoked within five minutes of waking as shown in Table 3. The highest proportion of smokers smoked the equivalent of 20 or less cigarettes per day (74.8%, n=2472 of all participants) with a greater number of pregnant smokers reporting smoking 10 or less per day (50.1%, n=231). In addition, those who reported being aware of RtQ at the point of the assessment tended to smoke more than those not aware.

Table 3: Participants' smoking characteristics – County Durham & Darlington

	% (n)	All participants	Pregnant smokers	Smokers in prison
Time to first cigarette	Within 5 minutes	46.5 (1456/3130)	38.3 (173/452)	58.3 (7/12)
	6 – 30 minutes	8.1 (253/3130)	11.5 (52/452)	0 (0)
	31 – 60 minutes	38.3 (1200/3130)	34.3 (155/452)	25.0 (3/12)
	Over 60 minutes	7.1 (221/3130)	15.9 (72/452)	16.7 (2/12)
Cigarettes per day	10 or less	22.1 (731/3307)	50.1 (231/461)	16.7 (2/12)
	11 – 20	52.7 (1743/3307)	44.5 (205/461)	33.3 (4/12)
	21 – 30	17.6 (581/3307)	4.8 (22/461)	33.3 (4/12)
	31+	7.6 (252/3307)	0.7 (3/461)	16.7 (2/12)
Type of smoking product	Cigarette	80.3 (1663/2071)	84.0 (210/250)	
	Roll-ups	11.5 (238/2071)	9.6 (24/250)	100 (1/1)
	Cigarette and roll-ups	7.3 (152/2071)	6.4 (16/250)	
	Cigar	0.4 (9/2071)	0 (0)	
	Pipe	0.3 (6/2071)	0 (0)	
	Chewing tobacco	0.1 (3/2071)	0 (0)	

Choice of TQP and treatment

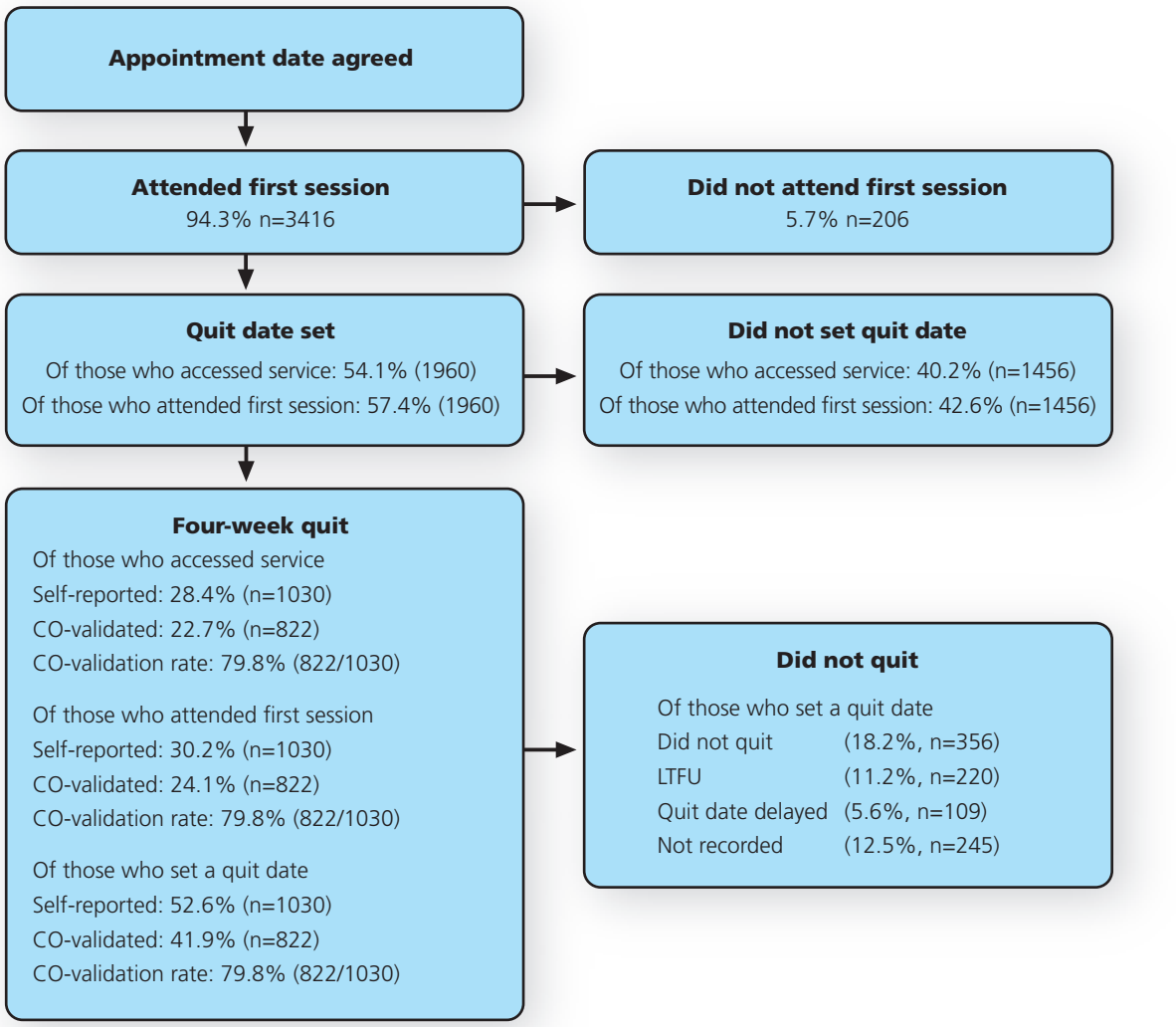
As can be seen in Table 4, 94.3% (n=3414) of clients who completed the assessment process chose TQP-Abrupt.

Table 4: Choice of TQP

% (n)	All participants (n=3622)	Pregnant Smokers (n=479)	Smokers in prison (n=13)
TQP – Abrupt	94.3 (3414)	90.8 (435)	76.9 (10)
TQP – Rapid Reduction	3.8 (139)	8.6 (41)	23.1 (3)
TQP – Medication	0.5 (19)	0.6 (3)	
TQP – Gradual Reduction	0.7 (24)		
TQP – Self Care	0.4 (13)		
None	0.4 (13)		

Figure 3 illustrates the pathway of smokers following assessment.

Figure 3: Conversion and treatment outcomes



As illustrated, a high rate of conversion from assessment to attending a first session with an adviser was achieved (94.3%, n=3416) with just under 60% of first session attenders going on to set a quit date (57.4%, n=1960). In addition, 100% (n=13) of prisoners attended a first session and set a quit date and 87.5% (n=419) of pregnant smokers attended a first session, 41.1% of which (n=172) went on to set a quit date. Smokers receiving abrupt support were most likely to set a quit date (58.6%, n=1904) whilst at the time of reporting only 8.7% (n=2) of smokers following the gradual reduction programme had set a quit date. Of those following the rapid reduction route, 34.1% (n=44) set a quit date overall, equating to 42% (n=160) of pregnant smokers and 100% (n=3) of prisoners who had chosen this option.

In total, 522 more quit dates were set and 221 more quitters achieved during the pilot period compared to the same period in 2010.

The average number of days between the first session and quit date among smokers following the rapid reduction route was 21 and the mode 28; indicating that the majority of smokers opted to rapidly reduce consumption over three to four weeks. Amongst pregnant smokers and prisoners the mean period for reduction was lower at 15.5 and 17 days respectively.

The majority of smokers (43.6%, n=1464) in all groups used NRT; 61.6% (n=295) of pregnant women and 61.5% (n=8) of prisoners. The patch was the most commonly used product (60.2%, n=951) although, due to the way medication choice was recorded, it was not possible to identify the proportion of single vs. dual NRT.

Over the pilot period spend on NRT increased by 36.9% compared to the same period in 2010.

Four-week outcomes

An overview of the four-week quit outcomes is given in Table 5. As with the previous pilots, due to the low numbers accessing the alternative TQP services (e.g. other than abrupt), no conclusions can be drawn from these quit figures and they should not be used to assess the efficacy of these models of support.

Table 5: Four-week outcomes of those setting a quit date

All participants (1960)	**% (n)**		
Self-report 4-week quit	52.6 (1030)		
CO-validated quitter	41.9 (822)		
CO-validated rate	79.8 (822/1030)		
Did not quit	18.2 (356)		
Lost to follow up	11.2 (220)		
Quit date delayed	5.6 (109)		
Not recorded	12.5 (245)		
By chosen TQP	**All participants**	**Pregnant Smokers**	**Smokers in prison**
TQP – Abrupt			
Self-reported 4-week quit	52.8 (1005)	39.4 (63)	50 (5)
CO-validation rate	79.8 (802)	73 (46)	100 (5)
TQP – Rapid Reduction			
Self-reported 4-week quit	40.9 (18)	18.2 (2)	100 (3)
CO-validation rate	88.9 (16)	100 (2)	100 (3)
TQP – Medication Only			
Self-reported 4-week quit rate	60 (6)	0 (0)	
CO-validation rate	50 (3)	0 (0)	
TQP – Gradual Reduction			
Self-reported 4-week quit rate	50 (1)		
CO-validation rate	100 (1)		
TQP – Self Care	N/A		
None	(0)		

Predicting choice of TQP-A and CO-validated four-week abstinence

In addition to the descriptive statistics provided above, two separate logistic regression analyses were also conducted to (a) investigate demographic and smoking variables that could predict whether TQP-Abrupt was chosen vs. another TQP programme and (b) to investigate which, if any, demographic, smoking or treatment variables could predict CO-validated abstinence from smoking.

For the purposes of these analyses, some categories were combined to ease interpretation and presentation: type of smoking product was combined into cigarettes only vs. all other types; occupation was combined into currently employed (managerial/ professional, intermediate, routine & manual) vs. not currently employed (never worked / long-term unemployed; retired; sick / disabled and unable to work; full-time student; home carer). Given that the study sample was overwhelmingly white, ethnicity was not included as a covariate. Prisoners and pregnant women were excluded from these analyses as their TQP choices and treatment are likely to differ from the general population. In addition, those for whom their TQP choice was missing or where no plan was chosen were also excluded.

In the first analysis predicting whether TQP-Abrupt was chosen, participant age, gender, employment status (employed vs. not), time to first cigarette, number of cigarettes smoked per day, and type of tobacco smoked (cigarettes only vs. all other types) were entered into the equation simultaneously.

Only one significant predictor of choosing RTQ-Abrupt was found: those who only smoked cigarettes were more likely to choose this route as shown in Table 6.

Table 6: Logistic regression predicting choice of TQP

		Chose RTQ-Abrupt	
		OR (95% CI)	**P – Value**
Age		1.00 (0.98 – 1.01)	.57
Gender	(reference: female)	1.31 (0.77 – 2.26)	.32
Time to first cigarette	(reference: within 5 minutes)		
	Over 60 minutes	0.79 (0.24 – 2.54)	.69
	31 – 60 minutes	0.94 (0.52 – 1.68)	.83
	6 – 30 minutes	1.78 (0.40 – 7.86)	.45
Cigarettes per day	(reference: 31+)		
	10 or less	1.68 (0.60 – 4.65)	.32
	11 – 20	1.65 (0.77 – 3.56)	.20
	21 – 30	1.51 (0.65 – 3.51)	.33
Employment status	(reference: employed)	0.62 (0.36 – 1.07)	.09
Type of tobacco smoked	(reference: cigarettes only)	0.53 (0.30 – 0.96)	.04

Cox & Snell R^2=.01, Nagelkerke R^2=.03

In the second analysis predicting CO-validated four-week abstinence from smoking, participant age, gender, occupation (employed vs. not), type of tobacco smoked (cigarettes only vs. all other types), whether RTQ-Abrupt was chosen (vs. not), whether the client reported being aware of the RtQ programme and type of medication used (Champix, NRT, Zyban, none) were entered into the equation simultaneously.

A number of significant predictors of abstinence were found: increasing age; smoking your first cigarette over 60 minutes of waking compared to within five minutes; being employed, being aware of the RtQ programme and choosing TQP-Abrupt were associated with an increased chance of abstinence. Smoking over 30 cigarettes per day compared to all other categories and using NRT or no medication compared to Champix were associated with a reduced chance of abstinence.

Table 7: Logistic regression predicting CO-verified 4-week abstinence from smoking

		CO-validated 4-week abstinence	
		OR (95% CI)	P – Value
Age		1.03 (1.02 – 1.04)	<.001
Gender	(reference: female)	0.95 (0.76 – 1.14)	.574
Time to first cigarette	(reference: within 5 minutes)		
	Over 60 minutes	1.70 (1.09 – 2.64)	.019
	31 – 60 minutes	1.02 (0.82 – 1.26)	.857
	6 – 30 minutes	1.34 (0.91 – 1.97)	.138
Cigarettes per day	(reference: 31+)		
	10 or less	1.70 (1.09 – 2.66)	.020
	11 – 20	1.82 (1.24 – 2.68)	.002
	21 – 30	1.68 (1.11 – 2.52)	.013
Employment status	(reference: employed)	0.70 (0.57 – 0.86)	.001
Type of tobacco smoked	(reference: cigarettes only)	0.86 (0.71 – 1.04)	.117
Aware of RTQ Programme?	(reference: yes)	0.79 (0.65 – 0.96)	.020
TQP plan chosen	(reference: TQP-Abrupt chosen)	0.52 (0.28 – 0.95)	.035
Type of medication used	(reference: Champix)		
NRT*		0.77 (0.63 – 0.93)	.008
Zyban		1.13 (0.33 – 3.94)	.844
None		0.02 (0.01 – 0.09)	<.001

* The proportion of single vs. dual NRT is unknown.
Cox & Snell R^2=.11, Nagelkerke R^2=.15

Process evaluation

The process evaluation was designed to support the pilot by gathering the views of service providers and clients. Qualitative research methods, including face-to-face and group interviews, were used to generate detailed and reflective data that explored service providers' and clients' descriptions, experiences and opinions of the RtQ model. This approach was designed to complement the quantitative outcome data and to assist with identifying the key facilitators and barriers to implementing the RtQ model.

Ethics and Research Management and Framework

Approval was granted for the main study by the National Research Ethics Service (NRES) Committee East Midlands – Nottingham Research Ethics Committee 2.

Approval was granted for the prison element of the study by the National Research Ethics Service (NRES) Committee North East – Northern and Yorkshire.

Service providers

Initial face-to-face meetings were held separately with the service managers, a group of specialist advisors and a group of TQP assessors. These meetings provided an opportunity to discuss the evaluation and understand the set-up and day to day running of the service. After this initial discussion, in depth follow-up telephone interviews were conducted with the service managers, specialist advisors and TQP assessors to discuss the implementation of the service, their experience of delivering TQP interventions to clients and their assessment of the service. During these interviews, service providers were encouraged to identify areas of good practice, any issues or concerns with the current model and provide explanations where appropriate. During the course of the pilot, service providers were encouraged to contact the researcher by telephone or email if they felt there were any additional events or issues to discuss.

Clients

A key contact in the service arranged for a letter, inviting clients to take part in the evaluation, to be sent to a sample of 40 clients who had used the RtQ service. Clients contacted the researcher to take part in the study. As this method only attracted a small number of participants, the key contact also arranged for specialist advisors to distribute information to clients attending return visits to stop smoking clinics, and several more clients were recruited this way. While the aim was to recruit men and women from a wide age range and ethnicities across the geographical area the final sample was pragmatic due to the low numbers of clients willing to take part in the study. No pregnant women were recruited to the study so it was not possible to explore the suitability of the RtQ model for this smoking population. In depth telephone interviews were held with clients and they were asked to describe and reflect on their experiences of the TQP assessment, using a TQP intervention to stop (or reduce) smoking, how the new service influenced their attempt(s) to stop smoking and how this compared to previous quit attempts, where appropriate.

The prison

Despite receiving ethical approval, it was not possible to secure the necessary institutional approval to access the clients attending the RtQ programme in the prison. In addition, due to long-term staff absence, interviewing the service provider who delivered the RtQ programme in the prison has also not viable. For these reasons, it was not possible to examine the feasibility and acceptability of delivering the RtQ model in the prison. Further evaluation will need to be conducted to assess whether the RtQ model is suitable for use in prison settings.

Data analysis

With the express permission of participants, all face-to-face and telephone interviews were audio-recorded on digital recorders and files were sent for transcription. All data were treated in strict confidence and all identifying information was removed from the data to preserve participant anonymity. Data were transcribed verbatim and an inductive thematic code was developed by the researchers to identify the key assumptions, ideas and experiences that shaped service providers' and clients' perception and interpretation of the RtQ model.

Findings

The findings are presented as a number of inter-related issues that shaped service providers and clients' perceptions and experiences of delivering or receiving the RtQ model. The service providers and clients are dealt with separately in this section to improve clarity, although their views and opinions are not necessarily dissimilar. It should be noted that interviews were conducted towards the end of the pilot once the service was established and any initial problems that arose during the implementation of the pilot had been dealt with.

To maintain the confidentiality and anonymity of the participants, all participants are identified by a personal identity code. Codes that begin with 'SP' indicate service providers (service managers, specialist advisors and RTQ assessors) and codes that begin with 'C' indicate clients.

Service providers

Implementing the RtQ model

County Durham and Darlington were keen to take part in the RtQ pilot because they wanted to explore new ways to engage with 'hard to reach' groups. The service providers suggested that there were several benefits to taking part in the pilot:

> *SP12: We knew there were people out there for who what we were already offering just wasn't doing it ... we knew that we had to try something different if we wanted to engage with the people who were not coming to us and not using our service. So this seemed a really good opportunity to explore whether what was being offered was too narrow a range of options ... and that this was some way to measure whether people were a) wanting a range of options, and (b) also whether it was going to engage with parts of the community that we'd never seen come to the service before. And then we'd be able to evaluate... our success with that unknown X factor of population that we've never seen.*

However, the service providers did acknowledge that it took considerable time, resources and planning to set the service up and the managers of the service suggested that it would be useful if services were given a checklist that provided a step-by-step summary of the elements to address in order to facilitate the effective and efficient implementation of the RtQ service.

Advertising

The service providers indicated that it was difficult to develop an advertising campaign to advertise the RtQ model and attract new clients into the service because it was not possible to specify the new routes available to clients:

> *SP12: I think the marketing of the campaign as a whole has been an issue for me ... because obviously there's that element of you want to sort of dangle the carrot and get people to be aware that there's new options available without telling them what they are ... and I think there's been a lot of debate around the wording of this. And even now, as I say, I think we're still, if we had it all to do again, what would we do differently, and you know I think there's an element of that where we would want to re-examine the marketing, publicity and how the campaign was done.*

Due to the restrictions in place, the service providers questioned how effective the advertising campaign could be in attracting new people into the service, as potential clients could not be informed how the RtQ model differed from the service that was offered before. The team acknowledged they had established a good track record of targeting routine and manual sections of the service prior to the RtQ pilot and the service providers believed the RtQ advertising campaign simply reminded people of the stop smoking service rather than offering them something new. As such, one provider argued that the service was "still promoting a generic service" rather than advertising something different and innovative that may be attractive to people who had not engaged with stop smoking services before. Another felt that the service was simply able to offer more options to clients who would have approached the service anyway and had little impact on hard to reach groups:

> *SP01: I don't think we've had new people, and that's what the whole idea was ... who wouldn't ordinarily have accessed our service, are now coming because we offer them more options, I don't think that that's been the case. These are people who would have come anyway; we're just giving them alternative options. We've got more tools in our toolbox basically.*

Several service providers suggested that a different advertising strategy that explained the TQP interventions in greater detail may have encouraged more people to contact the service. However, a number of other service providers expressed concern that a more detailed advertising campaign may result in people contacting the service who were not really motivated to quit:

> *SP05: I think we might have been inundated with people who just wanted to carry on smoking and not been motivated, that would have been my concern, if they advertised it too much. I think we've got a good balance of, I don't think people perhaps know about it as much as they should, but if we advertised it, we've got the risk of being inundated with people on Graduals, who don't really want to quit, and just coming along thinking that's canny [great], I can tell people I'm stopping smoking but really I can carry on.*

> *SP03: My concern would be that we, for lack of a better term, we are going to attract the 'wrong' sort of people, in that we're going to get people who really aren't that motivated to quit, but know they need to, you know they know they need to do it for health reasons or whatever, and you know they're going to be picking options like the Gradual Reduction or the Self Care. Because the reality is you know, a lot of people don't feel they need that intensive support, but they don't realise the benefits the intensive support actually has you know, coming every week.*

Service providers suggested that they believed there was the potential for clients who had health concerns to use the reduction or self-care options to convince themselves or satisfy others, such as health care professionals or family members, that they were trying to stop smoking when they had little intention of quitting. In this sense, service providers seemed to be suggesting that clients could use the gradual reduction option as a way to legitimise their smoking because they were taking steps to stop without having to commit to a quit date in the near future. As very few clients had opted for a gradual reduction approach during the pilot, however, this concern was not based on experience but rather reflected a general apprehension about the implications of offering clients the opportunity to reduce their cigarette consumption prior to quitting.

Terminology

The service providers were asked to discuss their experiences of delivering the TQP interventions to clients. The service providers indicated that the vast majority of clients did not appear to fully understand what was meant by the terms 'Routes to Quit' and 'Tailored Quit Plan' even when they were engaged with the service and had chosen a TQP intervention.

A number of service providers suggested that clients frequently misinterpreted and confused the RtQ options with the availability and use of different pharmacotherapies. So rather than associating 'Routes to Quit' with the availability of different approaches to stopping smoking, clients thought that RtQ referred to the range of products (such as patches, inhalator, chewing gum, lozenges and medications) that clients could use to support their quit attempt:

SP02: When I say to them, have you heard of the Routes to Quit programme, they'll more often say what is that, patches and things like that?

SP03: When I've mentioned Routes to Quit maybe midway through a treatment programme or anything like that, or sometimes even in the first session where my Admin have already gone over it with them...because when I mention Routes to Quit, that's almost like a prompt for them to start saying, oh well I've heard about the Champix ... so that's what I think is kind of the biggest area as far as misinterpretation goes.

Several service providers also indicated the term 'Tailored Quit Plan' was unhelpful and tended not to be used routinely during a consultation. The service providers expressed concern that the terms RtQ and TQP were unnecessary jargon and could confuse clients who were already struggling to take on board many new concepts and terms during their initial visit.

The data therefore suggest that the current terminology (RtQ and TQP) may not be an effective way of communicating the new service or the range of support options available to clients. These terms may need to be revised to make it clear what the service offers, how the service has changed and how clients may benefit from this new service.

Delivering the TQP interventions

It was clear that service providers were complying with the guidelines and using the evidence base to discuss options in order of efficacy and only revealing further TQP options when a client requested this information:

SP01: So I don't necessarily say look these are the options, I'm going to go through every one with you. What I do is I say did you want to stop smoking or were you wanting to sort of cut down? Were you looking at other options? And they'll say, like straight away they'll say no I want to stop, or yes I want to cut down, and that's when I would go into the other options. Because we were told originally, don't give them all the options, sort of go through them one at a time and stop at the one that they choose, rather than say oh well I know that you want this, but did you know that there's also this and this, you sort of just stop at the one they choose.

As the majority of clients chose TQP-Abrupt, it was often the case that service providers only discussed this option in detail with clients. Service providers suggested that clients often came to the service with a clear idea about the way they wanted to stop smoking and the role of the service provider was to offer them guidance and support to achieve this goal:

SP08: I just think most people who come to a clinic, especially if they've come themselves, know what they want to do, so anything you're going to say it's just a little bit of guidance for them anyway, they know what they want to do, they've made their mind up.

The service providers indicated that clients who had wanted to quit abruptly prior to contacting the service had not been swayed by the availability of other options when contacting the service, which is also supported by the client data provided later in this section. Service providers also suggested that the abrupt option was the most attractive option to clients because clients were keen to quit using the most effective method.

It did however also seem that some service providers were ambivalent about offering reduction options, suggesting that in some cases smokers may opt for rapid or gradual reduction because this allowed them to prolong their smoking and delay their quit attempt:

> *SU08: When I'm working in the practice you get a lot of people who have said, my doctor says that I've got to quit smoking, and a lot of the time that's the people who, once you go through things, they'll be like, oh I can continue to smoke for a bit longer and they'll go for that. So, but whereas if somebody's really motivated to come, and you would say to them well you can continue to smoke for a bit longer, they'll say no I want to do it [quit] now.*

However, as the number of clients who chose the rapid and gradual reduction options during the pilot was so low, the data suggests this was not a widespread problem. Furthermore, it could be argued that offering reduction options in addition to the abrupt method may encourage smokers who are not sure about stopping to engage with stop smoking services and consider making a quit attempt.

Indeed, service providers suggested that the small number of clients who opted for TQP-Rapid Reduction and TQP-Gradual Reduction were typically heavy smokers who were very concerned about their ability to stop smoking abruptly. One service provider suggested that these clients were typically unsure about quitting smoking abruptly before they contacted the service and that advisors had limited capacity to convince them that an abrupt quit was the most effective way of stopping:

> *SP03: I find it's the heavier smokers who have convinced themselves that the idea of dropping from forty cigarettes a day to zero and just going for an Abrupt Quit would be extremely difficult/ impossible. You know if they've already come in with that idea in their head, then those are those are the ones who would probably benefit most from it [a reduction approach], simply because you can explain to them as much as possible the benefits of an Abrupt Quit versus Rapid Reduction, but you can just tell sometimes they're not convinced, they're not taking it in because as far as they're concerned, you know, it would just be too difficult and it doesn't matter what anyone else has managed to do with that, you know, if they feel for themselves it just wouldn't be a possibility.*

In such instances, service providers indicated that they had found it difficult to persuade clients to try an abrupt quit because clients had already convinced themselves that it would be too difficult to stop. During the RtQ pilot, service providers appeared to find it helpful to be able to offer clients a range of alternative options to ensure these clients remained engaged with the service. Presenting clients with the option to reduce their cigarette consumption in a structured way and in combination with behavioural support and pharmacotherapies, where appropriate, allowed service providers to tailor their advice to the client's needs and encourage and support clients with their quit attempt. This may in turn increase clients' willingness to continue to engage with a service that recognises and provides a structured response to their concerns about quitting abruptly.

Indeed, one advisor argued that it had been difficult in the past to retain clients who wanted to cut down before quitting because the service had previously only offered the abrupt quit model:

> *SP03: Right, I'd say, with us having been kind of a Stop Smoking service, so it's always been, sort of the Abrupt method has been the one and only way we've gone about it, there have been instances where clients would maybe come to us and they've said in the past that they don't feel comfortable just quitting straight away and they want to cut down, and so we've had to kind of talk them out of that and explain you know that's not the way we work. And I think that instantly sort of prevents kind of the rapport building, you know, it's like an instant barrier. So I feel that maybe that side of things has been taken care of now in that you know if a client is adamant that they want to cut down then we can offer them that and it's not like they're being denied what they want, which often happens with people, if they're coming in already having decided that they're going to cut down and then we kind of take the wind out of their sails a little bit by saying well that's not the way we work, that's not what we can offer, you know, straight away that's going to have implications. So I can see how there are benefits there, in that the relationship's not sort of [strained] from the outset! Because I find the rapport and the relationship is a massive part of getting someone to stop smoking, and that they keep coming back for weekly support. So I can see that side of things...would have improved for the client.*

Using the RtQ model enabled service providers to address clients' concerns about quitting and offered greater flexibility to address the different and specific needs of individual clients.

However, the service providers also said that during the pilot they had found that clients who had chosen the rapid or gradual reduction options often struggled to stick to the programme, and couldn't maintain the cut down schedule. In some cases, clients had even changed to an abrupt quit instead. Service providers were unsure why clients were finding the reduction options difficult (although the client data does offer some explanation) although one advisor did express concern that clients opted for a rapid or gradual reduction because they mistakenly thought this would be an easier option than an abrupt quit. The reasons why clients do not adhere to a reduction schedule needs to be explored and addressed as this will have implications for clients quit attempts and the overall success of this programme.

Service delivery

After the initial teething problems had been addressed and service providers had become familiar with the RtQ model, providers indicated that overall they had found it easy to incorporate the TQP model into their day-to-day work:

> *SP01: I think if you want the God's honest truth people thought oh no, more work... more paperwork, more stuff to do, we haven't got time. But the reality of it is it hasn't taken as much time as we thought it might have done. So it has been pretty easy to implement really.*

While service providers were initially concerned about the amount of work and time involved in delivering the RtQ programme, in reality the model was less problematic than originally envisioned. Moreover, service providers believed that service delivery and the client experience had improved as a result of their participation in the RtQ pilot:

> *SP14: It's [RtQ] really improved our service I think and if someone rings now I think they get a fantastic service.*

The RtQ model may therefore benefit the organisation and delivery of stop smoking services as well as improve the client experience.

Interpretations of the RtQ model

Throughout the discussions with service providers, ambivalent and often contradictory views about the RtQ model and the delivery of the TQP interventions were articulated. Although service providers recognised that not all smokers may want to quit in the same way, their interpretation of the efficacy of the model was influenced by their training, experience and their understanding of the evidence base. At the start of the pilot service providers were particularly wary about changing the service ethos from an abstinence standpoint to an approach that allowed clients to continue smoking.

Although service providers recognised that the RtQ model promoted patient choice and allowed service providers to address the needs and concerns of individual smokers, several service providers did not believe this was beneficial to their clients. The majority of the service providers in this sample viewed the abrupt quit as the 'gold standard' and the only way for smokers to quit. The other options, in contrast, were seen at best to delay a successful quit attempt and at worst to reinforce smoking behaviours:

> *SP05: I suppose it depends what angle you're coming from. From a Routes to Quit angle, let's give people lots of options, great, brilliant, you're giving patient choice, fantastic. If you want to get down to the nitty gritty and look at addiction, it doesn't work, it doesn't work, giving people options. Addiction, it's a big problem, you know, it's a psychological problem, and all you're doing [by offering options] is just reinforcing the[ir] behaviour.*

It is important to take on board the service providers views and concerns about offering clients a range of TQP interventions because this will inevitably shape service providers' willingness to promote and deliver the RtQ model. If service providers are worried that cutting down approaches will not help smokers to quit, for example, then they may be unwilling to offer this service to clients who are keen to cut down before stopping. This will have implications for the success of the RtQ model in both the short and long term.

Consolidating and Legitimising Existing Practise

Interestingly, although the service providers did raise a number of reservations about the RtQ model, the service providers did not view RtQ as a radical shift in service delivery. Rather the managers and advisors thought that RtQ 'rubber stamped' or formalised what was already happening in the service, albeit not recorded on the systems:

> *SP03: I think when engaging with clients we would always use the evidence base of you're four times more likely to quit if you set a quit date and refrain from smoking. But inevitably there were always clients that didn't want to fit into that, and so there were often discussions around, I'm not sure I can let this go now, I think I'd feel better if I could cut down. And where we couldn't like advocate that they would cut down, what a client might choose to do is go away and buy their own stuff, or try and cut down without using any product and then come back to us, or we would continue to see them and offer them support but not be able to give them a product. Whereas Routes to Quit I think is much more of a documented, official way of maybe doing what we were doing before. And I think that it quantifies it better because it's more of a record.*

Therefore, although several service providers believed that cutting down prior to quitting was not an effective way to stop, they were required on occasions to be quite flexible with the service they delivered to accommodate the clients' requests. The RtQ model provided service providers with a means to deliver structured and intensive behavioural support to clients who wanted to reduce rather than quit immediately, and maintain a record of clients' progress. The availability of different TQP interventions allowed service providers to engage with clients in different ways both to build rapport and maintain client motivation while helping to retain clients in the service.

Clients

Awareness and understanding of RtQ

During the client interviews it became apparent that there were a number of issues with the terminology and advertising of the RtQ service. Only one client interviewed was aware of the RtQ programme before contacting the service to make an appointment with an advisor. This particular client was already motivated to quit and had received some information about RtQ when they applied for a 'Stop Smoking Kit' from the local service. The remaining clients had not heard or seen anything about RtQ before speaking to a TQP assessor so had no prior knowledge of the RtQ model and the availability of different routes to quit smoking. As a result it was not possible to explore whether the availability of different routes to stop smoking attracted new clients into the service as part of the process evaluation.

During the interviews, several clients also said they could not remember hearing about 'Routes to Quit' and did not know what was meant by the term. This is despite the fact that these clients had been enrolled on the RtQ programme and had spoken to both a TQP assessor on the telephone and attended several meetings with a specialist advisor to discuss their chosen TQP Intervention:

> *C05: I can't remember hearing that phrase, no, I'm not saying [they] didn't, but I can't remember [them] saying it.*

Other clients in the sample had heard the term 'Routes to Quit' but they were often hazy on the details, particularly the name of their chosen option and the relative effectiveness of each route:

> Can you remember what they said about Routes to Quit?
>
> *C08: There was what I would class as a rough route [abrupt quit], [where] you just stop. There was like dwindling down [rapid/gradual reduction], and there was another one, and I just wanted the rough route, I haven't got time to wait, that's it, I'm not messing about!*
>
> Can I ask you, did the [RtQ assessor] talk to you about the Routes to Quit programme?
>
> *C09: Yes.*
>
> Can you remember what they said?
>
> *C09: I can't remember exactly, but I think she said that there was four different ways, where you gradually reduce how many you smoke and then the one that I did where I cut, I think that was the one that I did, I can't remember but I know that there was about four options that they did.*

None of the clients in this sample could remember the term 'Tailored Quit Plan' being used during their interactions with the service providers.

There are a number of reasons why clients may have found it difficult to recall the details of the RTQ model. Firstly, the clients' initial contact with the service was typically several months prior to the interview and it had therefore been some time since the TQP assessment had taken place and consequently clients may have forgotten about the programme in the meantime. Secondly, clients were unfamiliar with the terminology and, as discussed earlier, service providers may not have used these terms if they thought they would confuse the client. Thirdly, it is likely that clients were focused on their quit attempt and the potential difficulties of stopping smoking, and may not have taken in the details of the programme. Finally, if clients selected the abrupt method then they may not have realised there were other options available to them, as these were only discussed if the client rejected the first option.

Terminology and messaging are fundamental elements of the RtQ model and will shape clients' understanding, interpretation and willingness to engage with the service. As the clients in this sample appeared to have some difficulty recalling and understanding the key terms used to describe both the programme and the different options, this element of the model needs to be revisited and revised to improve clarity and understanding.

The TQP assessment

The majority of clients in this sample had spoken to a TPQ assessor and taken part in a TQP assessment before being referred to a specialist advisor who would deliver their TQP intervention. All of the clients in this sample said the telephone conversation did not last longer than 10 minutes and they had not been on the telephone for an unnecessarily long period of time.

Choosing a TQP intervention

It is important to highlight that most of the clients in the sample had a clear idea about how they would like to quit smoking *before* they contacted the service. Clients understood that there were various different ways a person could approach quitting, such as quitting abruptly or cutting down and employed various strategies to evaluate the relative efficacy of each method. For example, the clients in this sample drew on their previous (in)formal quit attempts and their experiences of stopping with and without structured behavioural support, and/or pharmacotherapies when describing why they had chosen a particular method. Clients also appeared to spend considerable time reflecting on their capacity to change their smoking behaviour, including their ability to cope without cigarettes in times of boredom, temptation or stress:

> *C03: I'm very much an all or nothing sort of person and I know in the past when I've given up and I've been successful, my downfall, my route back into smoking again has always been when I've suddenly gone out for a drink and decided oh I'll be a social smoker. I'm one of these where I'm either smoking or I'm not smoking, as soon as I have one I'll be back on twenty plus a day. I know that [cutting down] doesn't work very well for me.*

The clients appeared to use these factors to create a personal 'evidence base' to help them work out the most suitable way to quit smoking. The scientific evidence seemed almost irrelevant to the individuals quit attempt and was certainly not referred to by any of the clients in this sample (although the service provider is likely to have discussed this with the client at some point). Rather, clients approached their quit attempt from a highly individualistic and strategic vantage point, spending considerable time debating the merits of different methods of quitting to determine 'what will work best for me?' In this sense, the order that TQP assessors and smoking specialist delivered TQP interventions seemed largely immaterial, as clients had already devised a quit strategy prior to attending their first appointment. This was particularly evident when clients explained their reasons for choosing their TQP option, as explored below.

Abrupt quit

The clients who chose the abrupt option suggested that once they had decided to stop smoking they wanted to get started with their quit attempt straight away rather than trying to cut down gradually:

> *C06: Because I had it in my head there and then that I wanted to, and to me, it's just the way my mind works, I think like I don't want to do it gradually, I'd rather just do it bang on, do you know what I mean? Because I keep thinking, well if I'm going to, I'll say oh I'll have another one, I'll have another one, do you know what I mean, if I did gradually stop, or it would to me. So that's why I did the straight away [abrupt quit] one.*

Often clients referred to the fact they had tried to cut down in the past and had been unsuccessful because they had been unable to resist going to buy more cigarettes once their current pack had run out:

So why did you choose the abrupt quit?

C08: Because for the weeks leading up, and the months leading up, I'd been thinking to myself, well I've only got three in this pack and once I've smoked them that's it, I'm not having any more. It doesn't work with me because once that three's gone I have, had a nervous breakdown thinking I've got none left! [LAUGHS] So the dwindling programme [rapid/gradual reduction options] wouldn't have been any good to me, I either have to do it or don't!

It is also important to underline that the clients who wanted to quit abruptly had not been swayed by the availability of other options:

So when the advisor talked to you about the different options, do you remember whether they recommended one particular option over another?

C03: I know that they said to do the abrupt stop; I know that the advisor did say that it was the most successful way of doing it and you know that that was advised.

Do you think that influenced your decision then to choose that option?

C03: No, not at all, I'd very much made up my mind what I was doing. It wouldn't have mattered really, if the other option[s] had been pushed, I still wouldn't have done it.

Overall, the clients who chose the abrupt quit route indicated that they adopted an 'all or nothing' approach and were keen to stop smoking as soon as possible. The availability of other routes to stop smoking appeared to have no discernible effect on this decision. The clients indicated that on a personal level they recognised that the reduction option would not be the right choice because they were unable to resist the temptation of smoking more cigarettes if they were given the chance to continue to smoke during a quit attempt. It was also interesting to note that several clients who had chosen the abrupt quit route were quite critical of the efficacy of the reduction options:

Do you think it's helpful to be offered different routes or options to quit smoking, such as cutting down or doing it abruptly?

C08: Personally (sighs) I don't, it's like giving a baby candy isn't it, saying go on then you smoke for another few weeks, slowly, slowly [weaning] yourself off, whereas if you want to stop doing something, you're just going to have to stop.

C03: I think abrupt quit is probably the only way to be successful, I think the other way possibly you're kidding yourself ... I think it's a bit wishy washy ... so I would say a gradual coming off cigarettes is not really doing you any good.

These views mirror the service providers concerns that reduction methods either prolong or prevent a smoker achieving a successful quit attempt. Further research is needed to determine whether this view is widespread and whether this influenced the high number of abrupt quits during the pilot period.

Reduction options

The clients who chose rapid and gradual reduction options gave a number of reasons for this choice. One client had stopped smoking abruptly in the past and had been unsuccessful, so wanted to see if the reduction option would be a more suitable method for them:

> Can I ask you why you decided to reduce, rather than stop smoking straight away?
>
> *C09: Because I think I tried stopping straight away the time before, when I was on the patches, and it didn't work.*

Another client suggested that they were apprehensive about making a quit attempt using a NRT product (patches) they had not used before. The client indicated that they wanted to have some time to get used to the product rather than trying to stop smoking straight away:

> Can I ask why you decided to reduce your smoking?
>
> *C07: I don't know, I think I was a bit scared, just like I'd not used the patches before... so I thought that way it gives me a bit of time to get used to it.*

Overall the clients in this sample who had chosen either a rapid or gradual reduction option had done so because they had concerns or anxieties about quitting, and believed that cutting down prior to making a quit attempt would help them to manage their apprehension about stopping smoking. However, clients had different experiences of cutting down before stopping. One client, for example, found it quite straightforward to cut down the number of cigarettes she smoked per day and was able to bring her quit date forward as a result:

> *C07: I think I was smoking ten a day I said on average and that first week I had to cut down to eight, eight a day. And the week after to six a day, and then four a day, and then after that I was to stop.*
>
> Right OK, and how did you find that process of cutting down then? What happened?
>
> *C07: I thought, I didn't think it was easy, but it was easier than what I expected, and I actually stopped before I was due to stop. So it actually worked well for me I think that just slowly cutting down, like it just eased me off and I was doing less and less and I just thought one day I'm not buying any more and I never!*

Other clients found it difficult to stick to the reduction schedule and decided to dramatically reduce their smoking in a very short period of time to try to stop more quickly:

> *C01: Well they said [to cut down] over a four week period but I wanted to, with me I can be impatient as well, I wanted to do it now or never kind of thing. So I actually went myself from twenty to five. They told me to cut down by maybe to two or three a day, and then you know gradually bring it down, but me, being a bit headstrong, I decided well twenty a day or five a day, and there's nothing in between.*

However, this particular client struggled to maintain a reduced level of smoking, which they attributed to cutting down so quickly, and they had not felt able to quit since. Service providers may need to reiterate the importance of cutting down in a structured manner, to ensure clients who opt for a rapid or gradual reduction set themselves realistic and achievable goals.

Other clients struggled to make the transition from a process of cutting down to actually stopping smoking entirely:

> *C04: The [advisor] I go to see is absolutely brilliant, because I go, [they've] like given me up to nine months, you know, [the advisor] says you trying to stop straight away is an impossibility. And I can go over like a nine month course. So I mean I've been going to them for three or four months now, and I go and I see them, and I've cut down to half to what I was smoking. But getting to actually stopping is, well...*

This example highlights that clients who select the reduction options will continue to require intensive behavioural support throughout the process of cutting down if they are to make a successful quit attempt. Clients who choose to cut down over a long period of time may find it difficult to remain focused on cutting down and quitting in the future. Service providers need to be aware of these issues so that they continue to motivate and support their clients to stop smoking during a rapid reduction or over a prolonged period of time.

It is also important that service providers make clients aware that their carbon monoxide (CO) levels may go up as well as down while the client is attempting to cut down. Several clients felt frustrated when their CO readings increased while they were reducing the number of cigarettes they smoked each week:

> *C01: ...what was very annoying was that I'd cut right down to five a day from twenty, right down to five, and my actual [CO] levels went up, that's what I couldn't understand! Hold on I smoked twenty cigarettes a day, because I don't go out and I don't really have anything to do in the house so I'm bored, I usually smoke because I'm bored, and when I cut down to five a day and I went down, I went down to the clinic, and they told me that my [CO] levels were just as high. And she did explain to me that cutting down so quickly I'd be smoking in a different manner kind of thing. I went hold on a minute, it's like going to Weight Watchers and they tell them that you're eating too little kind of thing. So I was a bit mixed up about that.*

> *C05: Yeah, the only thing I ever questioned was you know when I was really following the regime how, you know when I blew into the thing [CO monitor], how could [my reading] be so high when I hadn't [smoked more], I'd really kept to it, and yet the week before I'd smoked more and [my reading] was lower. And that was one thing I couldn't understand.*

Clients relied on their CO readings as a means to measure and validate their success so far in the programme. Understandably clients found it confusing and demotivating when their CO level was higher than it had been when they were smoking more cigarettes. This may affect a clients willingness to continue with a reduction programme. Service providers need to discuss changes to CO readings over the course of a reduction programme as well as once the client quits completely to ensure clients remain motivated and continue with their quit attempt.

Finally, it was interesting to note that several clients who had chosen the rapid reduction option and had not managed to quit stated they would choose to quit abruptly in the future:

If you tried to quit again, would you like to do this process of cutting down again?

C05: No, I think I would go the other way, just stop, because I believe what [the advisor] said was it's alright cutting down, but it just prolongs the wait, you know, because I mean one day I could go with nothing and not even think about them, and then the next day have my five…., and then I was really undoing everything that was being done because like [the advisor] says, it's worse for you to go longer and longer and longer because you're just waking the receptors, and it's true. Because once I had that one I wanted another one, and when I didn't smoke I didn't, it didn't bother us so much.

C01: I think the best thing for me to do would be cold turkey, because if the cigarettes are still there, if I'm cutting down to ten a day and they're still, if I take one in the morning, I know there's still nine there, do you know what I mean? I mean I am, I am going to, if there's one there I'm going to smoke it kind of thing. So I think maybe it would be the best to go cold turkey.

Both of these clients had chosen the reduction option because they were concerned that they would not be able to stop smoking abruptly. The availability of the reduction options in the RtQ model had allowed them to engage with and seek structured behavioural support from the stop smoking service to attempt to quit. However, it is interesting to note that the process of cutting down, although unsuccessful, had encouraged both to revaluate the suitability of the abrupt method and to consider using this approach to stop smoking in the future. It may be the case that the availability of reduction options allows clients to try out the method they think will be most suitable for them (informed by their anxieties about quitting) and if this fails it may prompt them to try a more effective method in the future. This finding warrants further attention because it may assist with increasing the number of successful quit attempts among smokers who are particularly anxious about stopping smoking.

Discussion

The RtQ pilots, and in particular the testing conducted in County Durham and Darlington, highlight a number of important considerations relating to the promotion, implementation and delivery of alternative approaches to stopping smoking.

Messaging and terminology

It was very positive that Durham and Darlington achieved an increase in quit dates set and four-week quits over the pilot period and that 28.1% of smokers contacting the service reported being aware of RtQ. However, given the apparent issues that clients had with interpreting terminology such as 'routes to quit' it is unclear exactly what those smokers, who were reported as being aware, were actually aware of. The increase in throughput and quits therefore could have been a result of the general increase in marketing and communication about the service implemented during the pilot rather than the offer of the 'new routes' specifically. Consequently, it remains unclear as to whether the RtQ model successfully attracts more smokers as well as new smokers into local stop smoking support.

Whilst it is also positive that in all of the pilots, smokers motivated to quit abruptly did not seem to be routed into a less effective support option, it should be recognised that this may have been due to the fact that the range of support options was not clear. More explicit testing of communication including details of the support options would further assess this. This would also investigate the concept of a 'personal evidence base' as identified through the client interviews included within this report. If smokers do have preconceptions about their best way to quit, it would be useful to see whether services that obviously promote reduction support would encourage more smokers to access them and to what extent, if any, marketing and messaging can influence smokers' attitudes towards quit methods.

Further testing is therefore warranted to explore the understanding and interpretation of key terminology and messaging with smokers, and to assess whether more open communication regarding reduction support options does in fact encourage more smokers to access support or conversely, recruit smokers motivated to quit abruptly into a lesser effective type of support.

Choice of TQP

Consistently throughout the pilots the abrupt model of support proved to be the most commonly chosen. One theory at the end of the initial two pilots was that at least part of this could be a result of couching the support options in their order of effectiveness and therefore clients making a more informed choice. However the client interviews conducted as part of the final pilot question the importance of the scientific evidence base from a smoker's perspective, suggesting that it could be personal belief and previous experiences of quitting that have greater bearing on the decision of quit method. Therefore, it is likely that the high numbers of smokers choosing TQP-A was due to the fact that they were either already motivated to quit this way or were unaware that there were other support options available.

Benefits of offering a range of support options

Despite initial concerns there was no evidence that offering reduction support, particularly gradual reduction, resulted in people accessing the service for means other than quitting e.g. access to free or reduced cost NRT for use as currency or for resale purposes. This was the case even in the prison where the greatest concerns had been raised about this risk. In contrast, offering reduction support as a viable alternative to abrupt quitting appeared to offer anxious smokers an opportunity to engage more effectively with the service and structured behavioural support. It was also positive that some clients reported feeling a greater commitment to abrupt quitting following an unsuccessful attempt using the rapid reduction method and it would be useful to investigate this further. Implications for offering a range of support options to specific populations such as smokers with mental health issues, prisoners and pregnant smokers also warrants further consideration as this has not been possible to do in any detail to date .

It is also interesting that broadening the support options available allowed advisers to legitimately support smokers who felt they were unable to quit abruptly, smokers whom they would have previously been unable to help or would have supported even though this was not necessarily part of the service's protocol or official remit.

It is clear that many services have already had to adapt to accommodate smokers who are not willing or who do not feel able to quit abruptly, and offer support that falls outside of the abrupt stop treatment programme. However, this information is not currently recorded or reported so the scale to which this is already happening is unknown. Given that fewer smokers who opt for a reduction approach are likely to set a quit date than those opting for abrupt quitting, it is likely that service providers are supporting a greater number of smokers than is currently recognised. Therefore, there appears to be a missed opportunity to gather data on this to inform the harm reduction agenda.

Implementing RtQ

As shown through all of the pilots, RtQ is a complex model to implement which requires significant adaptation and change at a local level. Whilst the model is easier to introduce if key elements of service provision are already established such as; formal referral networks, efficient and coordinated stop smoking medicine pathways, robust data collection, quality assurance mechanisms and effective communication channels, it still requires considerable planning and time to embed into daily practice. Mystery shopping conducted post implementation proved a useful exercise, helping to identify improvements required; specifically in relation to the delivery of RtQ but also to the service as a whole. In terms of the TQP assessors, increased confidence in delivering the assessments over time was evident as measured through this activity.

To reduce the time needed to implement the pilots, the model was not rolled out to include community providers such as commissioned GP practices and community pharmacies and further consideration would need to be given as to how this would be best managed. It is also worth noting that to date, implementation within a tariff area has not been tested.

Understanding and beliefs of stop smoking professionals

Finally, given that the focus has been on delivering abrupt support and advisers have been trained to advise against cut down approaches it is not surprising that some concerns were raised by staff involved in the pilots about offering reduction support. This however does have direct implications for the adoption of the harm reduction agenda by both stop smoking personnel and broader health care professionals and indicates a need for further training and education on this subject.

Recommendations

It is clear that further testing of a model such as RtQ is required before it can be recommended for widespread local adoption and additional funding to support a phased roll out, in line with the Medical Research Council's guidelines[16] for developing and evaluating complex interventions, is advocated.

The results of the three RtQ pilots also support the following general recommendations that are considered to be fundamental first steps to understanding this area further:

- Further understanding of what most influences a smoker's choice of approach to quitting is required in order to identify any opportunities to positively influence this decision.
- Further testing of terminology and messaging is required with smokers to begin to understand the most effective way(s) to communicate support options. This includes testing whether more explicit promotion of reduction approaches does attract more / new smokers into evidence-based support and importantly whether it recruits those already motivated to quit abruptly into a less effective model of support.
- Further investigation into the characteristics of smokers who opt for reduction approaches to quitting is required, as this could aid the tailoring of support promotion and delivery. This would also help identify any specific populations that such approaches may be particularly suitable for.
- Investigation into the most effective reduction methods is required as well as exploration into the reasons why clients do not adhere to reduction schedules.
- Recording of the incidences of cut down support currently provided by services is recommended to inform this whole agenda.
- Training for stop smoking service personnel and health professionals in general needs to be adapted to incorporate the latest evidence regarding alternative methods of quitting and the broader harm reduction agenda.
- Further consideration needs to be given as to how the delivery of reduction approaches could be logistically implemented at a local level, working within the various local commissioning arrangements and delivery partners.
- Cost implications and local capacity issues need to be assessed in more detail as this will inform local decision making.

Finally, it is recommended that this report is shared with the NICE 'Tobacco – harm reduction' Programme Development Group.

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Appendix A:
Street tested straplines

The following lines were presented to smokers during street testing to inform the straplines used in the County Durham and Darlington pilot promotional materials.

Leading lines:

New routes to stop – designed for you

- We will help you find your route to quit or;
- New ways to stop smoking

Followed by:

- Try our new ways to stop smoking so that you can become free.
- With more choices, more flexibility, more ways to stop, this could be time for to go smokefree.
- Quit plans developed for you with the best chance of stopping in mind.
- Choose the support that is best for you.
- Try our new range of ways to help you stop. Plans developed for you, to give you the support that you need. Whatever your situation, we can help you to make the best choice for how to stop.
- 50,000 people have stopped smoking with our help. Now there are even more ways to stop.

Appendix B:
Example promotional flyer

Did you know thousands of people in your area have successfully quit smoking with the help of the NHS County Durham and Darlington Stop Smoking Service?

Now with new types of support we can help you too, even if you're not sure about quitting right now.

Finding your route to a smokefree you can be difficult, so why not make it easier?

- Get free advice about the new services available near you
- Get to choose the support you want, to fit your lifestyle
- Get stop smoking medicines to help beat cravings on prescription*, from nicotine patches and gum, to nasal sprays, inhalators and tablets
- Get motivational tips on how to stay on track
- Get the chance to use a carbon monoxide monitor, to see your recovery in action

Developed by experts and ex-smokers and delivered by professionals, our service is here to provide free advice, support* and encouragement to help you leave your smoking behind using a plan that feels right for you. We know everyone is different so there are a number of support options available all of which have been designed to offer flexible, new ways of supporting smokers just like you.

9 out of 10 smokers who use us, would recommend us.

Give us a call and we'll arrange an informal appointment at a time to suit you.

Call **0800 011 3405**
cdda-tr.stopsmoking@nhs.net
www.health-improvement.cdd.nhs.uk

(*prescription charge where applicable)

Appendix C:
TQP assessment script and example client information leaflet

TQP – assessment script

Step 1. Obtaining consent to proceed with the TQPA

[If receiving a call]

"Good morning / afternoon / evening, NHS [name] you're through to [name of assessor] how can I help?"

[Caller response]

"Thank you for calling us [caller name], can I just confirm that you're interested in finding out more about the support we offer to smokers?"

[If yes]

"Great, can I also check that it is convenient for you to discuss the options now, it should only take about 10 to 15 minutes?"

[If consent is given tick TQPA checklist, take name, date of birth and gender and conduct assessment: go to Step 2]

[If initiating the call]

"Hello, my name is [name of assessor] from NHS [name]. We've recently received a referral for you from [insert referrer]. We understand you are a current smoker and are interested in hearing about the support we can offer. Can I just check whether now would be a convenient time to discuss the options available to you? It shouldn't take more than 10 to 15 minutes."

[If consent is given tick TQPA checklist and conduct assessment: go to Step 2]

[If consent is not given]

"That's fine but could we contact you at some point in the future to see if your situation has changed and whether we can offer you some help with regards to smoking?"

[If 'no' ensure that records indicate that future contact is not to be made]

[If 'yes' ensure that records indicate that future contact can be made]

[RECORD CLIENT'S NAME, TELEPHONE CONTACT DETAILS AND ADDRESS IF NOT ALREADY PROVIDED]

"Thank you very much for your time"

Routes to Quit –Tailored Quit Plan Assessment

Step 2. Conducting the TQPA

"OK great. Can I just ask if you have heard about the new routes to quit services that we now offer?"

[If yes, record "yes"]

"OK, that's great. I'll now go through these with you..."

[If no, record "no"]

"OK that's no problem; I can give you more information about all of the support options we now offer."

Routes to Quit –Tailored Quit Plan Assessment

Step 3. Tailored Quit Plan (TQP) options

"There are a number of services that we offer that are all designed to help you manage your smoking. Before I go through them with you, can I just ask if you have ever tried to quit before?"

[If smoker has never made a previous quit attempt]

"Well, it's great that you got in touch with us so that we can help you choose the best option for you. There are basically four services that we offer, some of which allow a period of cutting down before stopping smoking completely. I'm going to talk you through the options starting with those that we know work best. Feel free to ask any questions as we go along and ask me to repeat anything you don't understand, or is not completely clear. You can then decide which service you want to try."

[If smoker has made previous quit attempts]

Note: if you can, refer to the smoker's prior experience (number of quit attempts, experience of stop smoking medication, longest time quit) when you respond

"Many smokers, as I expect you realise, make a number of quit attempts and use different methods and medicines to try and stop. This is part and parcel of being a smoker I'm afraid. The good news however is that you have come to the right place as I can now tell you about the options that will give you the best chance of stopping smoking successfully. There are basically four services that we offer, some of which allow a period of cutting down before stopping smoking completely. I'm going to talk you through the options starting with those that we know work best. You can then decide which service you want to try."

Option 1 – TQP-Abrupt (A)

"The most popular service we provide is also the most effective – in fact, you are four times more likely to stop with this service than if you try and quit cold turkey, on your own. This service involves:

- *Seeing a trained adviser every week who will support you through your quit attempt and will help find the right medication for you*
- *This can either be quitting together with a group of smokers (this is the most effective method) or on your own with the adviser*
- *This option involves setting and sticking to a quit date (a date on which you plan never to smoke again) and not smoking even one puff after this*
- *These services are offered in many locations near to you and at times to suit"*

[Allow for questions from the smoker]

"Does this sound like the service that you would like to try or would you like to hear about the next service available?"

[If they would like to hear about the next option, go to option 2]

[If they would like to go ahead with option 1]

[RECORD CLIENT'S NAME, TELEPHONE CONTACT DETAILS AND ADDRESS]

Heaviness of Smoking Index

"Typically, how many cigarettes do you smoke a day... and how soon after waking would you usually have your first cigarette of the day?"

[Record answers on TQPA checklist]

"As I have said, the most effective option is to quit with a group of other smokers, although having individual appointments to see an advisors is also successful and very popular. Which would you prefer?"

[If 'group' then book smoker in according to times and locations]

[If 'individual']

"Is there a time or place which is better for you? The nearest service to you is [name of place] at [day and time]. Does that seem suitable?"

[Continue until you find the most appropriate service]

Option 2 – TQP-Rapid Reduction (RR)

"The next most effective service we offer again involves seeing a trained adviser but allows you to reduce your use of tobacco (up to a maximum 4 weeks, but sooner if you prefer) before your quit date. With this service you can use nicotine replacement therapy (NRT) or the other stop smoking medicines while cutting down and after your quit date. A quit date must be set at the start and not even one puff must be smoked after the quit date. These services are offered in many locations near to you and at times to suit".

[Allow for questions from the smoker]

"Does this sound like the service that you would like to try or would you like to hear about the next option available to you or more about the previous option?"

[If they would like to hear more about the next option go to option 3]

[If they would like to hear more about the previous option go back to option 1]

[If they would like to go ahead with option 2]

[RECORD CLIENT'S NAME, TELEPHONE CONTACT DETAILS AND ADDRESS]

Heaviness of Smoking Index

"Typically, how many cigarettes do you smoke a day ... and how soon after waking would you usually have your first cigarette of the day?"

[Record answers on TQPA checklist]

"Is there a time or place which is better for you? The nearest service to you is [name of place] at [day and time]. Does that seem suitable?"

[Continue until you find the most appropriate service]

Option 3 – TQP-Medication Only (MO)

"With this service you will be in contact with a trained adviser or healthcare professional fortnightly to receive nicotine replacement therapy (NRT) or another stop smoking medicine to support you through your quit attempt. As with the other services you will be expected to set a quit date but you will not receive the same level of behavioural support as provided in the previous options. This service is much more effective than 'cold turkey' – giving you about twice the chance of quitting – but half the chance compared to the earlier services that we discussed"

[Allow for questions from the smoker]

"Does this sound like the service that you would like to try or would you like to hear about the final service that we offer? I can also go back to the previous options that we have discussed if that would be helpful?"

[If they would like to hear more about the next option and are male – go to option 4]

[If they would like to hear more about the next option, **are female and pregnancy status is unknown]**

"Can I just check if you are currently pregnant or hoping to become pregnant in the near future?"

[If yes – go straight to TQP Self-care option]

[If no – continue to option 4]

[If they would like to go back to one of the previous options, go back to option 1 and then option 2 (as appropriate)]

[If they would like to go ahead with option 3]

[RECORD CLIENT'S NAME, TELEPHONE CONTACT DETAILS AND ADDRESS]

Heaviness of Smoking Index

"Typically, how many cigarettes do you smoke a day ... and how soon after waking would you usually have your first cigarette of the day?"

[Record answers on TQPA checklist]

"Is there a time or place which is better for you? The nearest service to you is [name of place] at [day and time]. Does that seem suitable?"

[Continue until you find the most appropriate service]

Option 4 – TQP-Gradual reduction (GR)

"This service is for people who want to take a slow and steady approach to getting off tobacco. With this option you will see a trained adviser who will help you to plan and implement a gradual reduction of your tobacco use. Most people take a few weeks, but it can be for as long as nine months. Nicotine replacement therapy (NRT) can be used to assist with this reduction and your initial goal must be to half the number of tobacco you currently use within six weeks of starting the programme."

[Allow for questions from the smoker]

"Does this sound like the service that you would like to try or would you like me to go back to the previous options we have discussed?"

[If they would like to go back to the previous options, go back to options 1 – 3]

[If they don't want to go ahead with option 4 or go back to the other options, go to TQP-Selfcare]

[If they would like to go ahead with option 4]

[RECORD CLIENT'S NAME, TELEPHONE CONTACT DETAILS AND ADDRESS]

Heaviness of Smoking Index

"Typically, how many cigarettes do you smoke a day ... and how soon after waking would you usually have your first cigarette of the day?"

[Record answers on TQPA checklist]

"Is there a time or place which is better for you? The nearest service to you is [name of place] at [day and time]. Does that seem suitable?"

[Continue until you find the most appropriate service]

TQP-Self Care (SC)

"Although we haven't managed to find a service that you'd like to try today we would be more than happy to send you some information about how you can manage your tobacco use by yourself. Is that something you would like me to do?"

[If 'no' go on to offering future contact]

[If 'yes']

RECORD CLIENT'S NAME, TELEPHONE CONTACT DETAILS AND ADDRESS

Heaviness of Smoking Index

"Typically, how many cigarettes do you smoke a day ... and how soon after waking would you usually have your first cigarette of the day?"

[Record answers on TQPA checklist]

"There are a number of things you can do if none of the services I have described suits you right now. You can, of course, quit by yourself and you can also buy nicotine replacement therapy in many supermarkets and in pharmacies to help you with this. If you do this, I recommend you sign up to the manufacturers' online support programme."

[Record response on TQPA Checklist]

"If quitting is not something you would like to do right now, you can buy some of the nicotine replacement therapy products for substitution – to manage the periods of time when you are not able to smoke."

Offering future contact

"Finally, I can offer you a programme of contact from us to see how things are going, and to offer you some very basic support – really, just keeping in touch. We would aim to contact you every three months by text, phone or email. Is this something you would be interested in?"*

*if pregnant, this will be increased to once a month

[Record response on TQPA Checklist]

Step 4. Confirming client choice, establishing consent, terminating the call and making the referral

"Thank you for going through this assessment with me. Can I just confirm that:

- *You are most interested in [name of RTQ option]*
- *You would like me to refer you to [name of place] at [day and time] or you would like me to send you some more information (if opted for self-care)*
- *I will send you a letter confirming our discussion and with the details of your chosen service in writing*
- *The address to which this letter should be sent is [smoker's address]"*

"We would really like to get in touch with you in a couple of weeks time to ensure that the service you have chosen has helped you in the way that you were expecting. Would that be OK with you?"

[If 'no' then record on TQPA Checklist]

[If 'yes' then agree on date and time and record on TQPA Checklist]

Finally ask about consent to share information.

[Lines TBC]

"Thank you again for your call today – I hope it has been helpful. Is there any further information or help you would like from us today? I look forward to speaking to you soon – good luck with your plans."

[Send confirmation letter, welcome pack and relevant TQP information]

Step 5. Follow-up telephone call

"Hello, my name is [name of assessor] from [name of service]. We spoke two weeks ago about your tailored quit plan and I'm just ringing to check how you're getting on with your [chosen TQP] at [name of provider referred to]. Were you able to attend your initial appointment?"

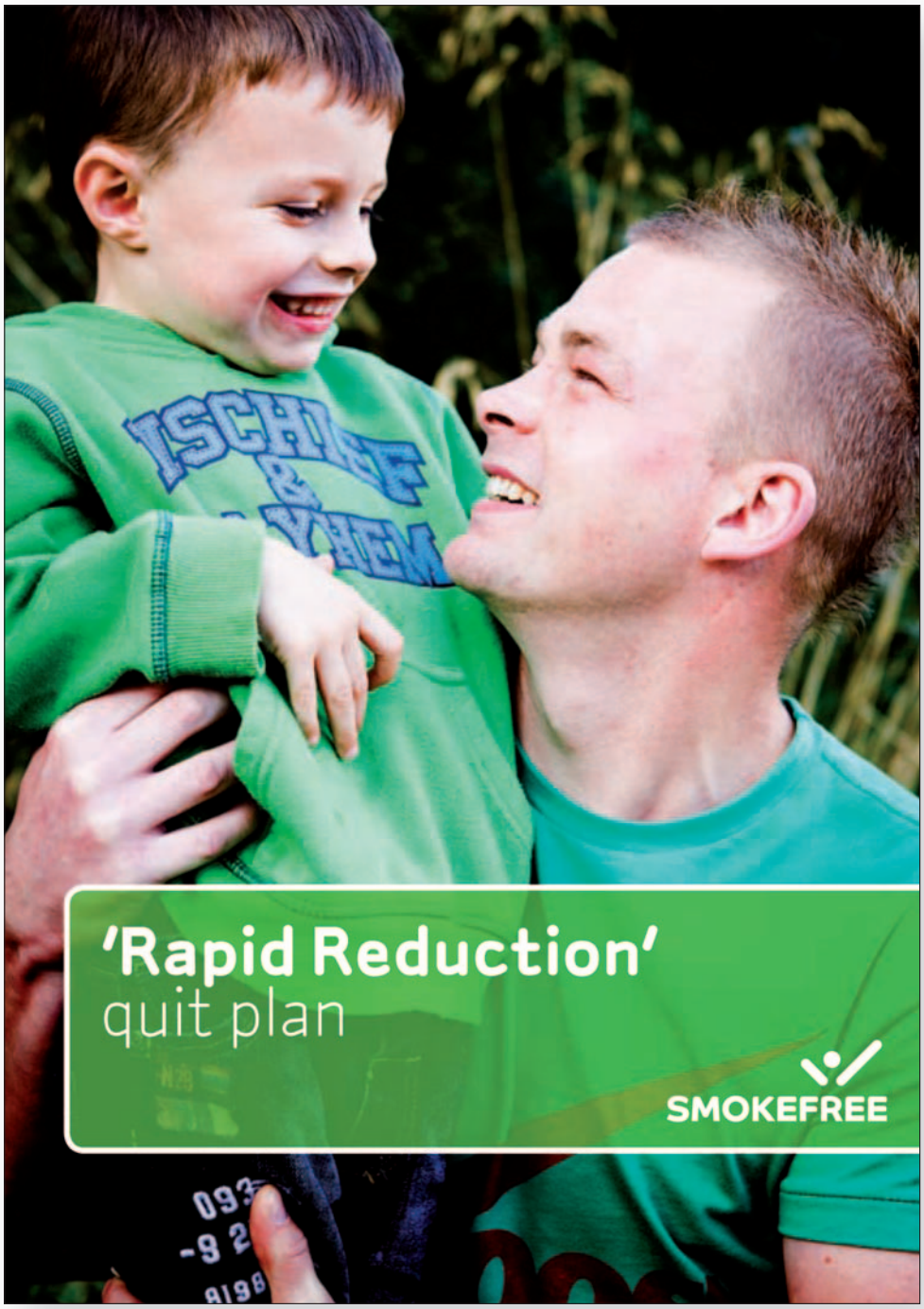
[If 'yes'] *"That's great. Best of luck in your quit attempt and please give us a call on [number] if you have any further questions."* [Record as having attended first appointment]

[If 'no'] *"Were you unable to attend or have you changed your mind about your chosen quit plan?"* [Record as not having attended first appointment]

[If unable to attend, arrange suitable alternative provider option; record & send new patient and provider letters]

[If the client has changed his or her mind, offer re-assessment – go back to Step 3 (TQP options) and record further action; send new patient & provider letters]

Appendix D:
Example client information sheet



Rapid Reduction quit plan

Well done! You've just taken your first step to a smokefree life.

To help you prepare before you meet your adviser for the first time, here's some more information about your chosen tailored quit plan - **'Rapid Reduction'**

What does the 'Rapid Reduction' service include?
This is the second most effective service available, which involves seeing a trained adviser and reducing your use of tobacco (up to a maximum 4 weeks) before you quit. During this period of rapid reduction, before you stop smoking completely, most people use nicotine replacement therapy (NRT) and this will be made available to you. A quit date must be set at your first session and not even one puff smoked after that date.

There is no need to have started to cut down your smoking or to have stopped before your first session with an adviser.

How long will the programme last?
Up to 16 weeks.

How much does the service cost?
The support offered through this service is free. Stop smoking medicines are all available on prescription so if you normally pay for prescriptions you will have to pay prescription fees.

What medication will be available to me?
There are three recommended stop smoking medicines and all are available on prescription as part of this support programme. These are, nicotine replacement therapy, Zyban and Champix. (Zyban and Champix are only available as part of this service if your quit date is within two weeks of your first session).

How long will I need to use the medication for?
You will use nicotine replacement therapy for up to 4 weeks before your quit date and up to 12 weeks after your quit date. Zyban and Champix are taken for a slightly shorter period. Your adviser will be able to give you more details about this.

What happens if I need to delay my quit date?
We would always recommend that once you set a quit date and are committed to not smoking one puff after this date that you try and stick to it. However, if following a discussion with your adviser, you feel you absolutely have to delay your quit date this can be done for up to 1 week.

What if I decide to stop before my agreed quit date?
Many people do find this happens and it's great if you decide to stop earlier than originally planned. Your trained adviser will help to revise your plan.

If I think I've chosen the wrong support option, will I be able to change it?
If you feel you would like to change support programme, discuss this with your adviser at your first session. They will be able to help you make the right decision for you.

What happens if I don't manage to quit this time?
The good news is that you've chosen the second most effective type of support so your chances of quitting have already significantly improved. Having said that it can take a few attempts before being able to stop and if this is the case for you this time round, you will be welcome to come back and have another go. There is no limit to the number of times you can use this service or any of the other support options.

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