NIHR | Public Health Intervention Responsive Studies Teams

Exploring the effects of the switch from face-to-face to telephone stop smoking support with a focus on underserved communities: some preliminary findings and lessons learnt from a PHIRST South Bank evaluation

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WP1 Main Findings:

- Quit rates were highest during the re-model (F2F for specialist groups*, tel support all others) and lowest during the pandemic (tel support for all)
- For people receiving telephone support: pregnant smokers, those with a mental health condition, registering with GPs/pharmacies (vs SSS), and from the most (vs least) deprived quintile were less likely to quit

* Pregnant smokers, under 18s, those with a mental health condition, learning disability or long-term physical condition

Lessons learnt & service changes:

- Co-production requires a detailed understanding of processes, data management & storage systems from the outset
- Dedicated time from SSS staff to work with the research team is required
- PHIRST evaluations should be kept simple and focused to allow delivery within the 'rapid' NIHR timeframe
- The Bedfordshire & Milton Keynes SSS have changed their service user data management and storage systems…
- And improved the data inputting systems to ensure high quality data

Public Health Intervention Responsive Studies Teams (PHIRST):

Purpose: *"to co-produce and build capacity for public health research and evaluation at a local level as well as identifying intervention health impact and outcomes relevant locally and for learning across the public health profession."*

Overall co-produced evaluation question:

What is the effectiveness and acceptability of a telephone Stop Smoking Service (SSS) compared with face-to-face support?

Specific research questions (RQ):

1. How effective is telephone delivery compared to face-to-face delivery?
2. Was the change to telephone delivery acceptable and accessible for service-users and providers; and what were their experiences?
3. How did the switch to telephone delivery affect specialist groups and those from the lowest quintiles of deprivation?
4. How can a SSS enhance engagement with underserved communities not routinely accessing the service?
5. Is the switch to a telephone delivery model cost-effective?

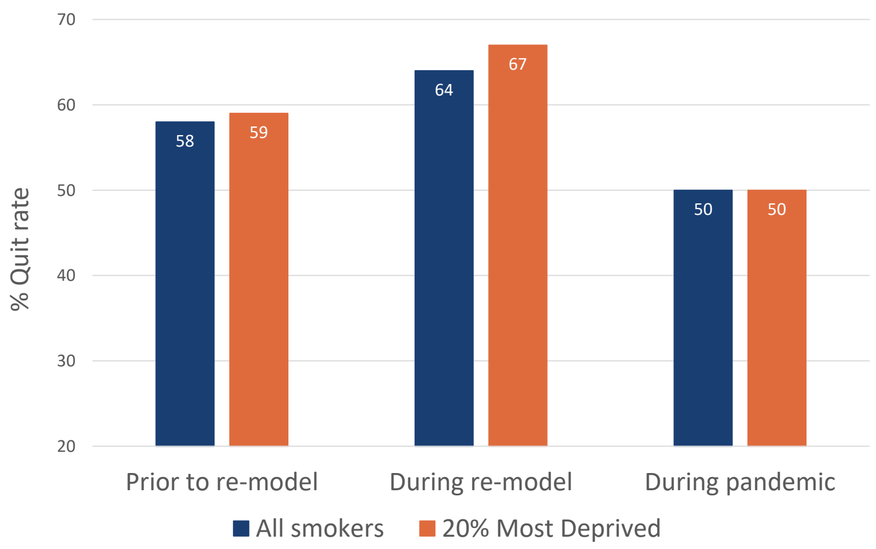
Evaluation design:

Work package (WP)	RQ	Data collection	Sample
1. Effectiveness	1, 3	SSS data: quarterly returns, Quit Manager	Secondary data on service users
2. Experiences, acceptability	2, 3	Surveys, interviews	Primary data: service users & providers
3. Underserved communities	4	Co-inquiry with staff, rapid ethnography & interviews	Primary data: special projects (non-engagers)
4. Economic analysis	5	SSS data: quarterly returns, Quit Manager	Secondary data on service users

SSS Timeline

WP1 Results:

Percentage quit rates across the three time periods (quarterly return data)



Predictors of quit success during the telephone support period (individual level data)

Predictor	OR	CI	P value
MSOA quintile 2 vs 1	0.93	0.80-1.09	0.39
MSOA quintile 3 vs 1	1.02	0.87-1.20	0.78
MSOA quintile 4 vs 1	1.05	0.89-1.24	0.55
MSOA quintile 5 vs 1	**1.26**	**1.06-1.50**	**0.008**
Provider (Other vs. SSS)	**0.67**	**0.60-0.75**	**<0.001**
SIP	**0.68**	**0.52-0.91**	**0.008**
Long-term condition	1.07	0.95-1.21	0.26
Mental health condition	**0.75**	**0.62-0.92**	**0.006**

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This research is funded by the National Institute for Health and Care Research as part of the NIHR PHIRST initiative: Centre Award: NIHR131568; Project Award ID: NIHR135509. The views expressed are those of the authors and not necessarily those of the NIHR, the NHS or the Department of Health and Social Care.

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