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Evaluation of the North Yorkshire Living Well Smokefree Service

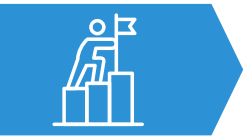
Evaluation Background and Methods

Implementation of Hybrid service

- Three service offerings:
  - ‘Face-to-face’ where stop-smoking support is offered in-person.
  - ‘Remote’ where stop-smoking support is offered via voice/video calls.
  - ‘Blended’ where stop smoking support is offered via a combination of face-to-face and remote approaches.

Mixed methods evaluation

- 16 interviews with service users & 4 group interviews with 9 service staff
- Analysis of existing service data (September 2022 - March 2023)
- Value-for-money calculation



Evaluation aim

- To see if a hybrid approach is:
  - an acceptable delivery model to service users and service staff,
  - if it is helping different groups of people access and engage in stop-smoking services,
  - and, if it is equitable and provides value-for-money.

HYBRID SERVICE REACH AND ACCESS

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Remote provision offers increased service access, reach and engagement

- Reported increased accessibility and convenience for stop-smoking support
- Noted to remove engagement barriers for those who were excluded, unable or struggling to attend face-to-face appointments during service opening times

Service users and staff prefer remote support, but there is still a need for face-to-face provision

- General preference and use of remote over face-to-face support (91% of service users chose remote support)
- But face-to-face was still desired, and seen to provide benefits and motivations which supports service engagement.

	Total	Phone support	Face-to-face support	Blended support
Referred	892			
Accessed the service	733	669 (91%)	45 (6%)	19 (3%)
Set a quit date	398	367 (92%)	23 (6%)	8 (2%)
Achieved a 4-week quit	303	279 (92%)	17 (6%)	7 (2%)
Number and Percentage of people				
Who accessed the service and who achieved a 4-week quit	303 (41%) out of 733	279 (42%) out of 669	17 (38%) out of 45	7 (37%) out of 19

HYBRID SERVICE REACH AND ACCESS

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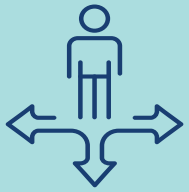

Remote support was the main provision mode selected by 'priority groups'

Phone support was predominantly used by pregnant women (98%, vs 0% face-to-face and 2% blended support), people with mental health conditions (93%, vs 5% face-to-face and 2% blended support) and people with long-term physical health conditions (91%, vs 5% face-to-face and 4% blended support).

	Set a quit date					4-week quit outcomes			
	Number of people	Percentage of people	Phone support	Face-to-face support	Blended support	Number of 4-week quits	Phone support	Face-to-face support	Blended support
Pregnancy	55	14%	54 (98%)	0	1 (2%)	42 out of 55 (76%)	41 out of 54 (76%)	0	1 out of 1 (100%)
People with mental health conditions	136	34%	127 (93%)	7 (5%)	2 (2%)	99 out of 136 (73%)	92out of 127 (72%)	6 out of 7 (86%)	1 out of 2 (50%)
People with long-term physical health conditions	159	40%	145 (91%)	8 (5%)	6 (4%)	119 out of 159 (75%)	109 out of 145 (75%)	6 out of 8 (75.0%)	4 out of 6 (67%)

There were similar 4-week quit outcomes for pregnant women (76%), people with mental health conditions (72%) and people with long-term physical health conditions (75%).

There were some slight variations in quit outcomes between the different pathways for different priority groups, but the low sample sizes in some categories must be appreciated as leading to high uncertainty in the comparisons among groups.

EFFECTIVENESS AND EFFICACY OF A HYBRID APPROACH

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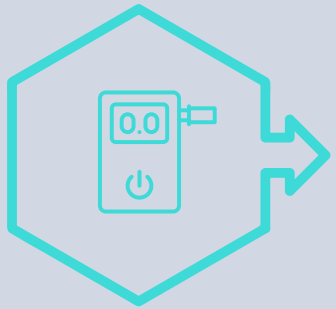
Perception of increased privacy through remote support

- Remote support was perceived to reduce potential stigmas and anxieties of face-to-face appointments (e.g., judgement when pregnant)

'It has helped not actually having to have to visit somebody face-to-face…it's a lot more beneficial to people who have anxiety and mental health issues like me.'
(service user)

Lack of carbon monoxide (CO) validated quits through remote provision

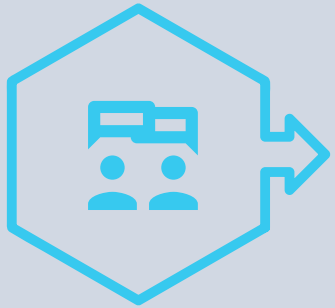
- This was noted as potentially reducing service user accountability
- It was also discussed as reducing motivation and a tangible measure of success



'It's [CO monitoring] good because it proves to myself, and to everybody else that, you know, that I'm sticking to not smoking, because you can actually see the numbers going down'.
(service user)

Abilities to develop rapport/therapeutic relationships through remote approaches

- Mixed views around the development of relationships remotely
- Suggestion that remote provision can result in less engagement for some



'The difficulty we've had with telephone support for a lot of the time was that you'd ring and they were like out doing their shopping. I mean in COVID it was different because a lot of people were stuck at home…but sometimes now, you aren't getting their full attention.'
(service staff)

ACCOMMODATION TO SERVICE USERS' NEEDS

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Remote provision offers flexibility which supports engagement

Remote provision was suggested to help accommodate and permit stop-smoking support to fit into people's personal and work lives

'It's like, booking time off work for an appointment and stuff like that, whereas doing it remotely, I could just do it at work.' (service user)

The ability to offer, and rearrange to remote appointments was noted as enabling service contact and the continuation of support, reducing the opportunity for missing appointments

'it's the best of both worlds really, so it's made it all more accessible for me… when I couldn't make a meeting due to childcare issues, I could still get my support that week.' (service user)

The importance of supportive approaches from staff

The perception and experience of non-judgmental supportive relationships from service staff were noted as crucial in engagement/rapport building

The skills of staff to develop relationships, and the levels of care, compassion and personalised support staff provided helped engagement irrespective of the modality of support

Choice in support options was valued and beneficial

Choice in provision option was discussed as an important aspect of engagement and greatly contributed to perceived service satisfaction

'I was able to pick, and it's what has helped me stop. Without that support I have, how I wanted it, I would still be smoking now. I think everyone should be given that choice'. (service user)

MAINTENANCE AND CONTINUED USE OF A HYBRID SERVICE

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Greater 'efficiency' of remote provision brings benefits and challenges for service staff

Offering more remote than face-to-face appointments can increase capacity for greater client contacts.

Increased efficiency in client contact was noted as resulting in increased caseloads and associated challenges for staff.

Additional costs of face-to-face provision

Using average referral and quitting outcome data for this period, a cost per 4-week quit of £175 can be estimated.

Such costs need to be weighed against the benefits of offering service users choice on the mode of provision they receive.

'Quantity vs quality' of quits

Achieving more 'quality' CO-validated quits through face-to-face contact was seen as balanced against the 'quantity' of quits that could be achieved through 'more efficient' remote provision.

Such trade-offs are important to consider when offering provision options. (e.g., the proportion of face-to-face/remote provision offered, the use/costs of remote CO monitors

Improving knowledge/awareness of the hybrid service offering may support engagement

Service users suggested for more/better service information to be available, advertised and disseminated, particularly around the hybrid offering and choice around treatment options, as many service users reported initially not being aware of these when starting support.

Data needed to inform service delivery decisions

Long-term data around the number of people engaging with the service and achieving quits is needed to see if there are specific populations which are continually benefiting from particular pathways. This could help inform future adaptations to service delivery, including the design and promotion of different pathways for different service users.

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see: https://phirst.nihr.ac.uk/evaluations/evaluation-of-the-north-yorkshire-county-council-living-well-smokefree-service-a-hybrid-specialist-stop-smoking-service-offering-a-blend-of-face-to-face-and-remote-service-provision/

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Lessons from virtual service delivery during Covid: Mixed opportunities?

Adam P Wagner (University of East Anglia)
Nigel Lloyd (University of Hertfordshire)
On behalf of PHIRST Connect

NHS ambition for virtual wards ("hospital at home")

- NHS ambition: deliver 40-50 virtual ward beds per 100,000 population

- Why?:
  - "…**expand** the **capacity** of the acute care sector by managing patients, who would otherwise be in hospital, remotely in their homes, **creating potential staffing efficiencies** and **providing safe and more convenient care** for patients" https://www.nice.org.uk/news/blog/supporting-nhs-england-s-ambition-for-virtual-wards

- **Opportunities for public health?**

Improving cost-effectiveness

- Cost-effectiveness considers both costs AND outcomes

- Reducing costs – eg:
  - Do less…
  - Choose less costly forms of delivery
  - Improve efficiency (do more with less)

- Improving outcomes – eg:
  - Supporting Service Users (SUs) not currently engaging
  - Increased utilization of services

Improving cost-effectiveness
…through virtual delivery?

- Cost-effectiveness considers both costs AND outcomes

- Reducing costs – eg:
  - Do less… – opportunity to refocus services
  - Choose less costly forms of delivery – reduced staff travel; no room hire
  - Improve efficiency (do more with less) – engage more service users (SUs) simultaneously
  - ?

- Improving outcomes – eg:
  - Supporting SUs not currently engaging – eg flexibility potentially increasing engagement
  - Increased utilization of services – eg SUs engage more as less time 'lost' to travel
  - ?

- …but any negatives? Unintended consequences?

National Exercise Referral Service (NERS)

NERS:

- People referred to service to increase their physical exercise
- Main offering: group exercise sessions led by staff

PHIRST Connect invited to evaluate NERS' switch to virtual/remote delivery in response to Covid – included:

- Exploring changes in service user outcomes
- Staff experience
- Service user experience
- **Exploring impact on delivery costs**

National Exercise Referral Service (NERS) evaluation: Impacts on delivery costs of virtual delivery

Safety concerns around virtual delivery:

→ required TWO staff: one leads exercise; other monitors for safety

→ maximum class size of EIGHT

Impacts:

- Virtual delivery costs **higher**: in person only requires 1 staff
- Efficiency **reduced**: two staff teaching potentially smaller groups

→ **Cost-effectiveness decreased**

National Exercise Referral Service (NERS) evaluation: Impacts on delivery costs – staff time

Less time cleaning equipment…

… but more time delivering class (eg two staff delivering)

Exercise session	Post Covid programme	
	In person	Virtual
Sub-activities	Time (mins)	Time (mins)
Set up room & equipment	10	5
Cleaning equipment – pre exercise	15	10
Exercise session	**50**	**2×45**
Cleaning equipment – post exercise	15	10
Tidy up room & equipment	10	5
Recording and entering attendance	10	10
Total time per session	110	130

National Exercise Referral Service (NERS) evaluation : Impacts on delivery costs – costings

Virtual delivery more costly

No attendance fee for virtual

Lower average attendance in person, but lower overall demand for in person – only 1-2 virtual sessions delivered weekly (*figures likely changed since*)

(No room hire fees for NERS)

Exercise session	Post Covid programme	
	In person	Virtual
Total time per session (mins)	110	130
Total cost per session (£)	£32.94	£38.93
Average attendance	4.0	5.3
Attendance income (£2/person/F2F session)	£8.07	–
Cost per service user per session*	£6.16	£7.31
Service user cost across course (32 sessions)	£197.12	£233.77

Drug and alcohol service evaluation (DASE)

- City-wide drug and alcohol support –
  commissioned by local authority and delivered by a partner organization

- (Similar to NERS evaluation)
  PHIRST Connect evaluated shift to virtual (+hybrid) delivery in response to Covid

- Included exploring delivery of group support sessions:
  - In-person v virtual (Zoom)
  - Virtual delivery more costly (£132 v £79) – two staff needed
  - Even with increased capacity, per SU cost slightly higher (£5.17 v £4.94)
  - Most suited to sharing information, rather than interactive sessions

NERS & DASE lessons for virtual cost-effectiveness: **Similarities**

- Safety a key issue:
  - Given DASE context, a particular concern
    - (Challenging with fewer visual/in person cues)

- Virtual group meetings need two staff:
  - One leads, one deals with chat/safety etc

- Additional ‘costs’:
  - Staff working in new ways – need training
  - New ‘over heads’ – eg service users contacting staff in additional new ways

NERS & DASE lessons for virtual cost-effectiveness: **Differences**

- Within DASE, greater sense of 'good for some service users, bad for others'
  - +: Saving on travel costs significant for service users with low incomes
  - +: Distance from certain settings/other service users good for some
  - -: Harder to form effective therapeutic relationships remotely
  - -: Quality of engagement differed

- Evidence of false economy in DASE:
  - Some activities delivered more quickly (eg assessments) but in a way results in less detail being collected and additional future work required

Public involvement & impacts on service users

Key component of how PHIRST Connect works:

- Eg public contributors as partners in our evaluation teams
- NERS/DASE evaluations, particularly supported interpretation & sense checking
- Emphasised need to address the **impact on service users**

Top issues:

- ‘Digital divide’ key topic – can everyone access the internet?
- New costs?: Digital devices needed?
- New savings?: For some, travel cost savings

Virtual delivery and cost-effectiveness conclusions

Not necessarily cost saving:

- Safety issues
- New ‘overheads’? Eg:
  - Additional staff training
  - Delivering in person AND virtual?

Important to consider impact on service users:

- Digital divide
- Differential impact on outcomes

Virtual delivery may require substantial design (or re-design?);
Not necessarily as easy as in-person ‘delivered over Teams/Zoom’

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Questions?

Our thanks to the Service Users, services and wider PHIRST Connect team

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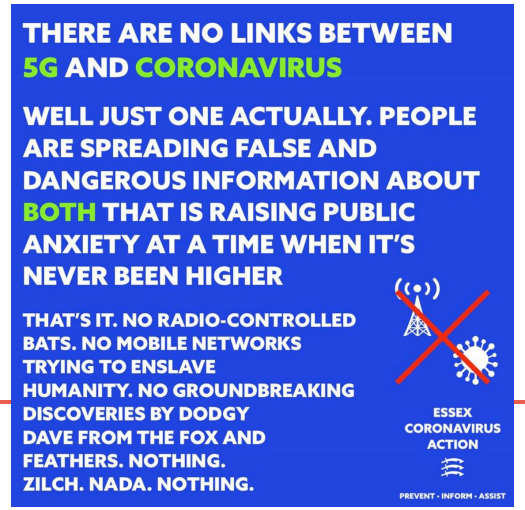
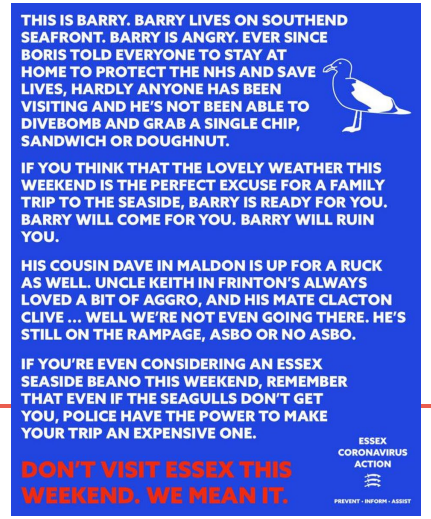
EEABS: Evaluation of the impact of Essex Coronavirus Action Support (ECAS) upon Attitudes, Behaviour and public health Systems during the COVID-19 pandemic

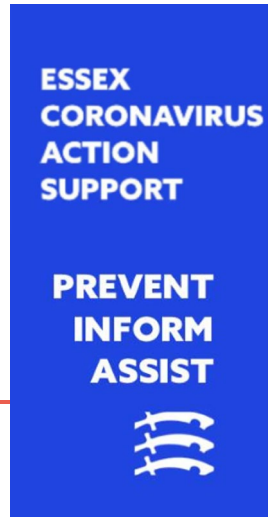
Professor Daniel Frings

About the ECAS Intervention

- Essex Coronavirus Action Support (ECAS) involves collaboration between Essex County Council (ECC) and the Essex Public Health Team as well as local Facebook groups. It focuses on three objectives: preventing the spread of infection, informing Essex residents of guidance and assisting residents who may be vulnerable.
- The ECAS Facebook page, created on 14th March 2020 (‘Essex Coronavirus Action’, 2020), was followed by 55,339 people and distributed information to the community.
- The related private group, created on 15th March 2020, had approximately 37,900 members (‘Essex Coronavirus Action Support’, 2020) and was described as a space for residents, promoting connection and discussion about issues related to the COVID-19 pandemic.
- There were 18 community admins overseeing the private group, three had a prominent role with ECC paying for their work.



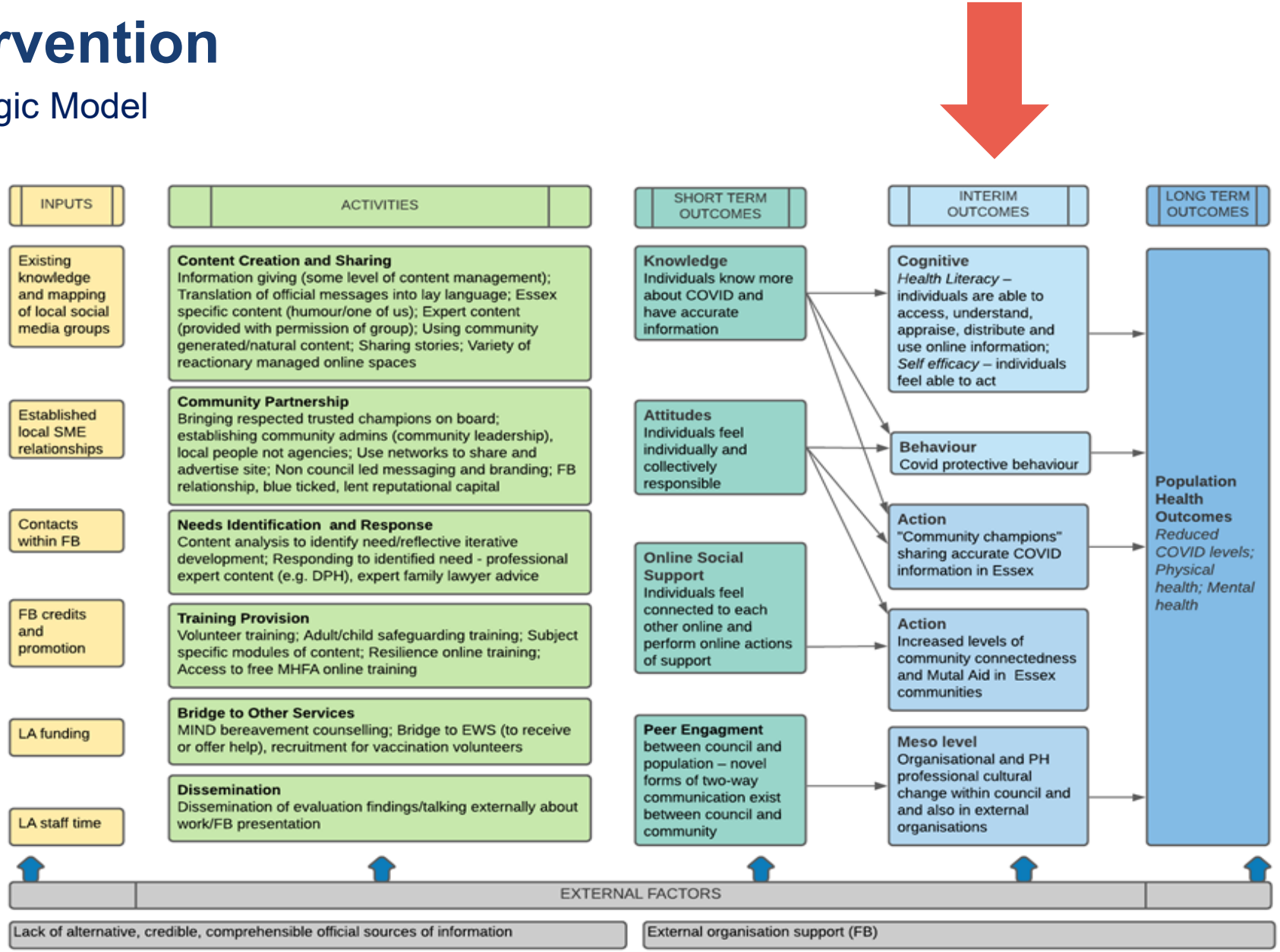




The ECAS Intervention

Figure 1: Coproduced Logic Model

The model illustrates resources, activities, outcomes and their connection and guided the evaluation of the ECAS intervention, to understand the extent to which it achieved its aims (focusing on interim outcomes) and the wider impact it had on public health system approaches.



Aims and objectives

The project aimed to evaluate ECAS via the following questions:

- How effective is a digital community development approach during a pandemic?
- Was the ECAS digital community development approach successful in achieving improved health literacy, protective health actions and community connectedness and mutual aid?
- Was the ECAS digital community development approach successful in achieving whole system change for the public health function?
- What factors were important in contributing to the outcomes?

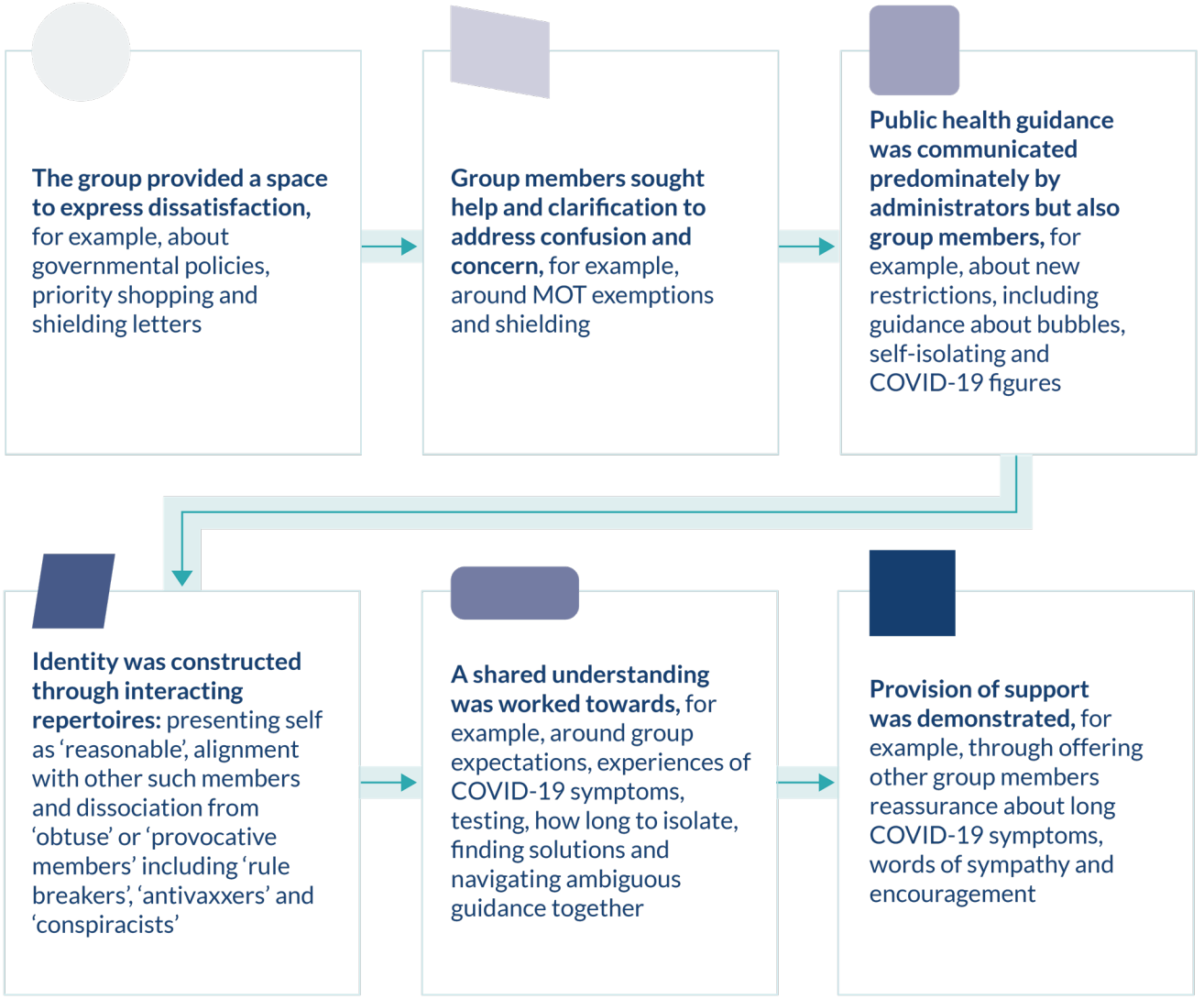
Quantitative

- Primary analyses of new survey data
- Social network analysis of existing data
- Sentiment analysis of Facebook interactions

Qualitative

- Discourse analysis of Facebook interactions
- Interviews with Essex County Council staff, Public Health Team & Facebook Admins

Social Action: What was achieved within Facebook Group interactions?



Strengths and challenges

- One of the key strengths of the approach is that it can be a powerful way of **combining different forms of social capital** to promote engagement with communities.
- The local authority brings **financial capital and symbolic capital to the collaboration in the form of being a recognised authority**. The logic of their symbolic capital builds upon values of public accountability, impartiality and fairness but participants highlighted that **negative public perceptions of local government** in general (see quotes) can be a challenge to engagement with the public.
- **Local social media influencers bring social capital** to the collaboration in the form of social networks based upon recognised individuals, local symbols and a sense of shared local references.
- **Combining the two forms of capital can be very powerful**. However, it has challenges for both parties. While a common concern for local authorities is reputational risk, local social media influencers described the risk of being seen as a 'mouthpiece' of central and local government. **Good leadership and collaboration is essential** to managing this effectively.

> *"People don't love the local authority, they really don't, they think we're about dog poo and potholes and taking your children away"*

> *"I don't necessarily feel that lay members of the public see a difference between local government and national government. Quite a lot of people see it as 'All of this government body'"*

Opportunities and risks

- Participants within the wider team identified a potential limitation that **members may be a self-selected sample** that may not attract people who are unconcerned with health risks and difficult to engage.
- While core participants generally accepted this to some extent, they highlighted that:
  - Alternative networks for engaging the public, e.g., the voluntary sector, faced the same challenges.
  - Group members were engaging with family and friends who may be difficult to engage.
  - Alternative forms of social media may be better for targeting specific groups, e.g., TikTok for teenagers unconcerned with health risks.

Features associated with perceived efficacy included:

- **Responsiveness of the administrators** and speed and agility of dissemination.
- **Consistency in moderation** and being able to manage conflict effectively and respectfully.
- Being able to produce **understandable and attractive content**, including the use of humour and local references.
- **Warmth and kindness** were important in creating a safe and welcoming community.
- Being **authentic and honest**, including being open when information was not yet available.
- Drawing on **evidence** to challenge misinformation.
- **The personalities and creativity of key individuals** who were reported to have been working around the clock when the intervention started.

Lessons learnt

1. Central to this approach is a **genuine collaboration** between the local authority and grassroots social media admins rooted in the local community.
2. It provides a **viable alternative** to a traditional model of communication where the public is conceived as an audience rather than a community and acts **as an adjunct or amplifier** rather than a complete replacement for other approaches.
3. It requires **strong and risk tolerant support** from the local authority and leadership that understands the two cultures involved in the partnership.
4. It requires **experienced social media admins who can produce high quality content, have local knowledge and possess good conflict management skills.** Ensuring a healthy work-life balance is an ongoing challenge and most difficult during crisis periods.
5. Although the intervention developed quickly in response to the COVID-19 pandemic, participants felt that the intervention has good potential to address a wider range of issues.

Doing Public Health Differently

- Key finding that has influenced ongoing work in Essex was the unique role and attributes of the admin function. The need to **capitalise on the trust of the public** where it is strongest and utilising the assets of trusted members of the community. Insights have been taken from this and applied to non-covid issues
- A legacy of the work is a focus **on talking differently** with residents. It has generated a culture change in how the Communication Teams role is understood and delivered. More emphasis on the role of Comms in working towards behaviour change as well as to inform. And upskilling of the PH team in engaging with communities.
- An outcome is more collaboration between **Comms and Public Health**. A joint Comms/PH role is being recruited to which will offer a Public Health resource, sitting in the Communities Team but part of the Communications team. Work will include mapping and building community assets and building relationships and trust.

"We might always have introduced this new Comms role, but it wouldn't have looked like this if we hadn't done this piece of work".

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Thank you to all our partners.

To see the complete set of outputs for this project visit:
https://phirst.nihr.ac.uk/evaluations/eeabs-evaluation-of-the-impact-of-essex-community-action-site-ecas-upon-attitudes-behaviour-and-public-health-systems-during-the-covid-19-pandemic-essex/