An evaluation of the change from face-to-face to telephone specialist smoking cessation services and its effects on hard-to -reach communities in Bedford Borough, Central Bedfordshire and Milton Keynes

OVERVIEW |

Stop Smoking Services (SSS) are experimenting with different delivery models to address service challenges yet gaps in the evidence-base exist. The present research therefore explores the relative effectiveness and cost-effectiveness of Telephone Support (TS) and Face-to-Face (F2F) and the implications of these models for specialist groups with complex needs and the most deprived groups. The views and experiences of both staff and service-users are explored via surveys and interviews. Finally, co-inquiry methods are utilised to develop insight into staff's efforts to raise awareness of the service and generate new referrals among underserved communities.

KEY POINTS |

Quit rates

- Quit rates were highest during a 'remodel' period when specialist groups received F2F support and all other smokers received TS, compared to the previous model of universal F2F and the Covid-19 pandemic, when all smokers received TS.
- Specialist groups with additional challenges (e.g., pregnant smokers) tend to be less likely to quit smoking and incur higher costs. For people receiving TS: pregnant smokers, those with a mental health condition and the most deprived groups (vs the least) were less likely to quit.

Acceptability

- Service-users ranked F2F as the preferred option overall, but specialist groups had a slight preference for TS. Service-users strongly emphasised the importance of choice and flexibility. Staff ranked TS as the preferred option but emphasised that this requires advanced communication skills to deliver effectively. Staff and service-users agreed that a disadvantage of TS is the loss of CO-reads and challenges involved in practically demonstrating products.

Community outreach

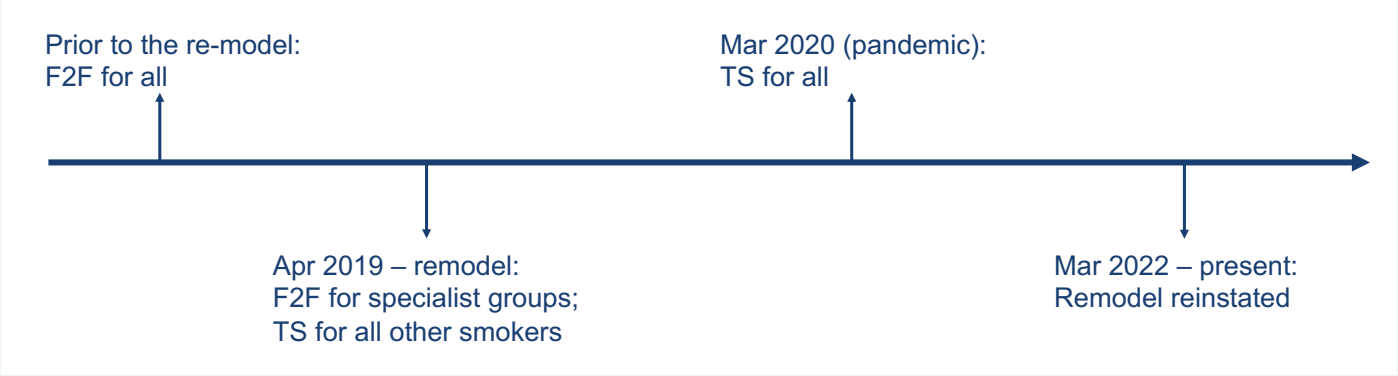
- Community outreach can generate direct referrals among people disconnected from health services but is time consuming and must be done in a 'person-centred' fashion.

BACKGROUND |

BMK SSS is a stop cessation service that spans Bedford Borough, Central Bedfordshire and Milton Keynes. Like other services, BMK SSS has undergone considerable recent change which presents a research opportunity to investigate the implications of different delivery models (see Figure 1):

- From its inception to 2019, BMK SSS offered F2F support to all.
- In April 2019, a remodel took place that introduced a new telephone 'quit line' model for most smokers: targeted F2F was retained for specialist groups, including pregnant smokers, under 18s and those with a mental health, learning disability or specific long-term condition.
- In March 2020, an exclusive TS model was adopted due to the pandemic, before F2F support was reintroduced for specialist groups in March 2022.
- In May 2022, the BMK SSS started extensive outreach activity from May onwards to raise awareness of the service offer among underserved communities.

Figure 1: Timeline of service changes

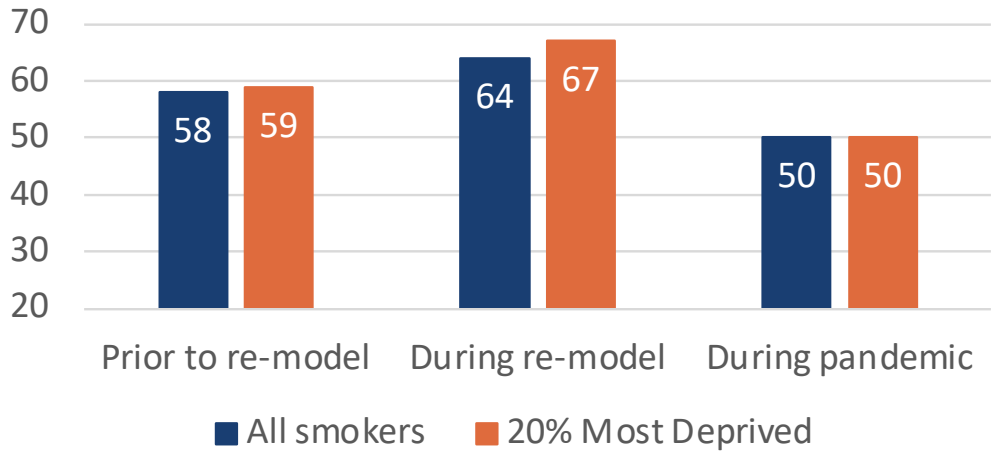


FINDINGS |

| Remodel period enhances quit rates:

Quit rates were highest during the 'remodel' period (F2F for specialist groups and TS for all other smokers). This compared favourably to the period prior to the remodel (universal F2F offer) and to exclusive TS (i.e., Covid-19 period where quit rates were lowest). All groups, including specialist groups and the 20% most deprived, fared best during the remodel (see Table 1). We also found that satisfaction with the service is associated with quit success.

Table 1: Quit rates (%) across the three time periods



| Mixed model - higher costs, lower quit rates:

Comparing TS only with those receiving a combination of TS and F2F (mixed model) revealed higher cost per 4-week quit for the mixed model (£374 vs £357) but this was due to lower quit rates in the mixed model.

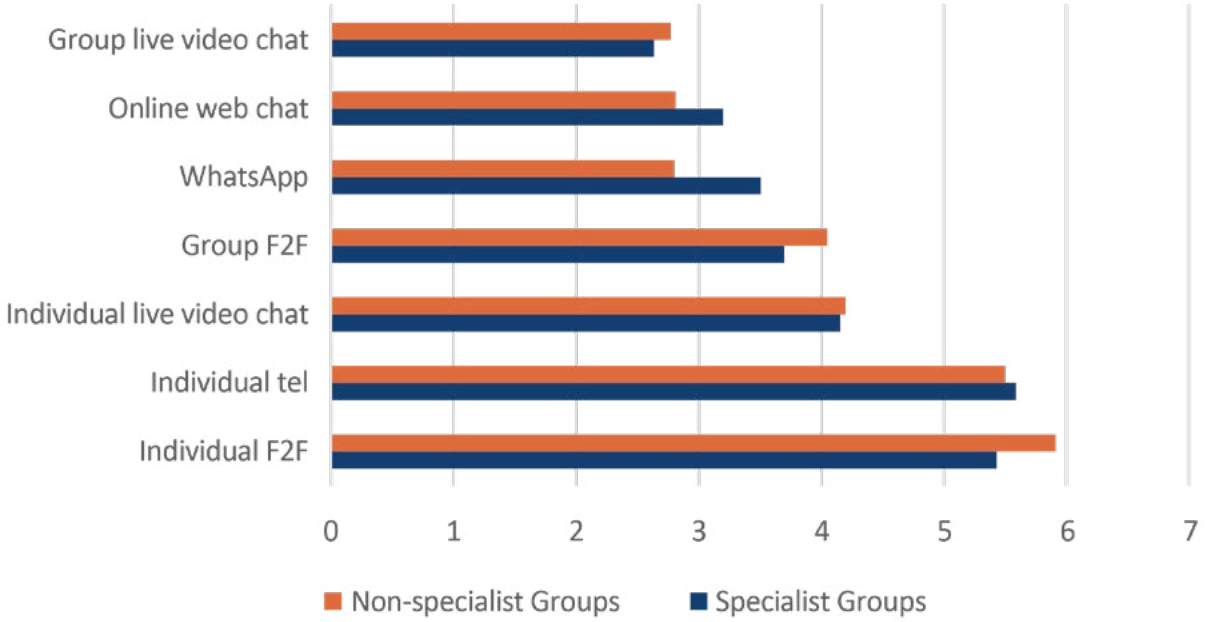
| Specialist groups – lower quit rate, higher cost:

Specialist groups with additional challenges tend to be less likely to quit smoking and incur higher costs to achieve a successful quit compared to those not facing these challenges. For people receiving telephone support: pregnant smokers, those with a mental health condition, registering with GPs/pharmacies (vs the core service), and from the most (vs least) deprived quintile were less likely to quit.

| Service-user delivery preferences:

Overall service-users ranked individual F2F as the preferred option. This pattern was similar among the 20% most deprived but specialist groups do not necessarily favour individual F2F support: looking at average scores, specialist groups had a slight preference for TS (see Table 2).

Table 2: Average rankings for preferred SSS delivery method among service-users



| Importance of choice:

Service-users emphasise the importance of choice, flexibility and their relationship with, and the characteristics of, the advisor. Some service-users were concerned about the loss of accountability with TS only and limited opportunity for the practical demonstration of products. Some service-users who had relapsed would have liked a follow-up call and an option to reengage without re-registering; some service-users would prefer video-calls if this was an option.

> **"I think it's (videocalls) probably, as we've just been discussing, a nice combination of the two. You have got the formality and the informality and you could probably pick up now if I was appearing nervous and I can feel slightly more informal and relaxed because I'm in my own home so yes, that's the best of both worlds probably"**

| Staff delivery preference – Telephone Support:

Overall staff ranked TS as the preferred option although they emphasised that good communication skills are vital. Echoing service-users, staff thought that a disadvantage of TS was the absence of CO-reads and not being able to practically demonstrate products. TS was viewed as more convenient and efficient. Some staff were concerned about people who, they believed, would benefit from F2F but do not fit in a specialist category. F2F could also be a means to engage service-users' wider support networks (see quote).

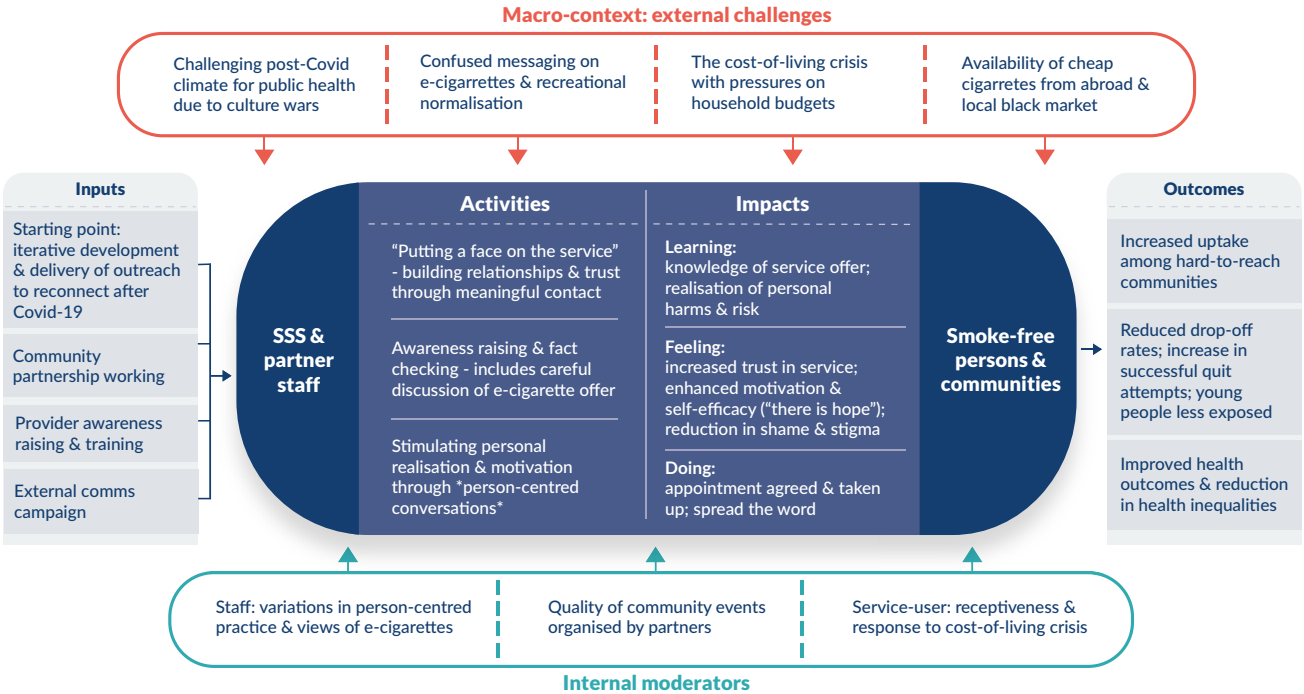
> **"F2F gives an opportunity to build rapport with their wider support network. So, if they come with a partner, you can kind of say … 'Are you really proud of them?' … I've also had people come in with partners who are still smoking and then there's an opportunity for me to say to the partner, not in a confrontational way … 'Would you be interested in … some support?' So, I think it also provides opportunities for bringing in family members and friends and support networks"**

| Community outreach to improve awareness, collaboration and access:

Community outreach can raise awareness of the service, enhance collaboration with partners and generate new referrals among people who are disconnected from health services. It must be done in 'person-centred' fashion: both staff and community members highlighted the importance of being non-judgemental when talking about smoking in community spaces. BMK SSS' e-cigarette offer prompted surprise and interest among community members. Many had questions and staff spent time explaining the harms and risks relative to cigarettes. Community outreach is, however, time consuming for staff & underpinned by the quality of the events organised by partners.
See Figure 2 for a model of 'person-centred' community outreach.

> **"I attended a community event and … when I saw it was stop smoking, I went to walk away because I'm a smoker and I thought 'Okay, I'm not going down that road'. But the ladies were really engaging and said, 'Come back, why are you walking away?' And we had a really good chat: they were very good…**
>
> **There needs to be a presence … they [staff] need to be there to be seen and be present … But don't push out: wait to be approached … As soon as you push out, you're preaching, and smokers are just going to close-up"**

Figure 2: A model of 'person-centred' outreach



RECOMMENDATIONS |

Offer all smokers choice

Our findings suggest that SSS do not need to routinely offer F2F support to specialist groups or the most deprived groups. A mixed or 'hybrid' offer appears to work best and fits with service-users' preference for choice and flexibility. BMK SSS (which currently offers F2F to specialist groups only) may consider offering choice of TS or F2F to all service-user groups, resources permitting.

Video call to increase choice

SSS may consider introducing video-calls to provide service-users with more choice and a follow-up call.

Target specialist groups

Trends to target resources on specialist and more deprived groups appear to be warranted: more support is needed to enable smokers from these groups to successfully quit smoking, which will help reduce inequalities and improve public health.

Employ strategic community outreach

We recommend that SSS deploy community outreach strategically to raise awareness of the service, enhance collaboration with partners and facilitate direct referrals. Empowering SSS staff to engage in outreach when they consider it important is vital. Community outreach must be 'person-centred' and be developed by nurturing relationships and trust.

Robust data collection

SSS should ensure high quality and consistent data collection and storage to ensure robust evaluation can take place (e.g., acquiring service-user consent to store data for more than 2 years). This includes data collected by non-core providers.

Build research capacity

Dedicated research time is required to facilitate SSS staff involvement in research. This can provide staff with developmental opportunities and facilitate service improvement and research learning.

Information about the Study |

Methods

This was a mixed methods research study that combined the statistical analysis of routine data with survey research, qualitative interviews and co-inquiry methods.

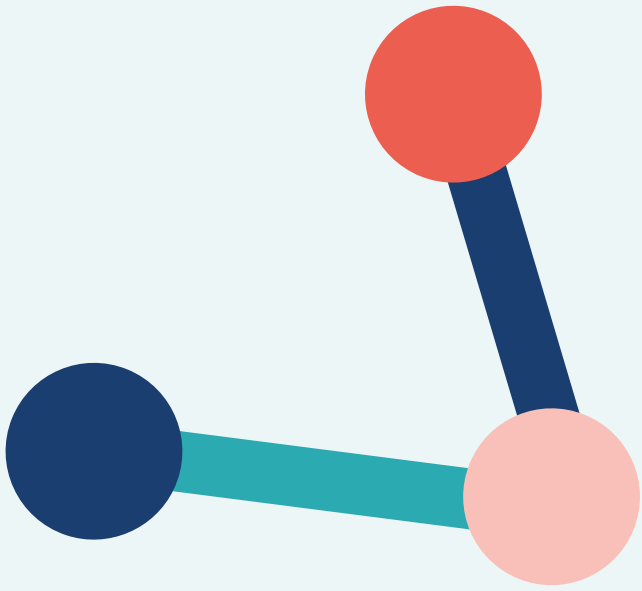
Sources for further information

An evaluation of the change from face-to-face to telephone specialist smoking cessation service and its effects on underserved communities in Bedford, Central Bedfordshire and Milton Keynes - NIHR Public Health Interventions Research Studies Teams (PHIRST)

Acknowledgements

The evaluation was undertaken by Professor Lynne Dawkins, Dr Thomas Mills, Dr Elisa Lewis, Dr Claudia Civai, Charlotte Taylor-Page, Dr Catherine Jenkins, Professor Daniel Frings and Professor Susie Sykes (Centre Director). The local partners were Ruth Dean, Oliver Mytton, Martin Westerby, Laura Martin and Martin Manly.

PPIE panel: Nicola Mcgeoghan, Paul Cave, Sharon Austin

The Public Health Intervention Responsive Studies Team (PHIRST) South Bank conceived the evaluation in collaboration with the local authority partner. All authors contributed to this process. The team would like to extend thanks to all the individuals who gave up their time to participate in this evaluation.

This evaluation was funded by the National Institute for Health and Care Research (Centre ID: NIHR131568; Project ID: NIHR135509). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.