Pharmacy-based stop smoking services: optimising commissioning

July 2009
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If you click on the blue text or footnote numbers in this document, it will take you directly to the relevant web page or reference.
Smoking is the single greatest cause of preventable morbidity and premature deaths in England, with half a million hospital admissions of adults aged over 35 attributed to smoking. Smoking related diseases are currently estimated to cost the NHS around £1.5 billion a year.

Stop smoking services are one of the most cost effective of all NHS health interventions and it is one of the most frequently commissioned local enhanced service from community pharmacies.

Set firmly in the broader context of the world class commissioning programme that aims to deliver better health and well-being for the public, this guide supports the community pharmacist’s crucial role in improving the health of their local community.

The guide has been developed with the help and support of a number of key primary care stakeholders in the NHS. It helps trusts identify where they are now, where they want to be and how to deliver their organisation’s vision. It also outlines current good practice in commissioning effective stop smoking services.

We hope that this guide supports you in commissioning world class pharmacy services.

Felicity Cox
Lead negotiator – community pharmacy
NHS Employers
What is the purpose of this guide?

This guidance has been developed by NHS Employers as part of the implementation of the white paper, *Pharmacy in England: building on strengths, delivering the future*.¹ It aims to help strengthen contractual arrangements so that pharmacy-based stop smoking services show clear evidence of partnership working with local NHS stop smoking services. It also ensures that these services comply with the Department of Health’s data definitions and reporting procedures, and are in line with the quality principles set out in national guidance on commissioning stop smoking services.

It is part of a series of practical advice and tools to help primary care trusts (PCTs) become world class commissioners of primary care services. It builds on the guidance provided in the Department of Health’s *World Class Commissioning – primary care and community services: improving pharmaceutical services*,² one of the suite of documents about world class commissioning of primary care and community services. Comprehensive guidance on commissioning stop smoking services is also provided in the Department’s *NHS Stop Smoking Services: Service and Monitoring Guidance*.³

This guidance has been produced in collaboration with a steering group of PCT managers and other experts. A number of stakeholder organisations have also been consulted on the content. It has been developed for senior NHS managers who are responsible for commissioning pharmaceutical services, public health professionals and commissioners of stop smoking services. It will also be of interest to community pharmacies that provide these services and providers of core NHS stop smoking services.

The commissioning context

The most frequently commissioned local enhanced service from community pharmacies is support for people to stop smoking; numbers have increased significantly since the introduction of the new contractual framework for community pharmacy. In 2007/08, almost 45 per cent of community pharmacies in England were commissioned to provide this kind of service, an increase from 36 per cent in the previous year. However, at the same time, more than one in six PCTs reported commissioning no stop smoking services from community pharmacy.⁴

The policy context

Smoking is the main reason for the gap in life expectancy between rich and poor with smoking responsible, in men, for over half the excess risk of premature death between social classes. Smoking is implicated in cancer, coronary heart disease, stroke and other circulatory diseases, respiratory disease, stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis.

Women who smoke during pregnancy have a substantially higher risk of miscarriage and smoking can lead to complications in pregnancy and labour. Babies born to women who smoke tend to be lighter, which can increase the risk of death and disease in childhood; smoking in pregnancy increases infant mortality by about 40 per cent. Breathing second-hand smoke can exacerbate respiratory symptoms amongst non-smokers and in the longer term increases the risk of lung cancer, heart disease and stroke.
Tobacco is smoked in cigarettes, cigars and pipes, as well as in bidi and hookahs, and is chewed in paan, chaat or gutkha. Chewing tobacco increases the risk of developing oral cancer.

Beyond the well-recognised effects on health in terms of hospital admissions, tobacco also plays a role in perpetuating poverty, deprivation and health inequality.

Although the number dying each year from a smoking-related disease has fallen over the last decade to about 84,000 deaths a year, there is no room for complacency. Reducing smoking remains a key priority within the Public Service Agreement (PSA) and NHS operating framework both as a target around smoking prevalence and delivery of the ‘all-age all-cause’ mortality target. Targets from the white paper Smoking Kills remain in place. Delivery of the smoking prevalence targets will also deliver the Financial Sustainability Review value-for-money savings.

### National smoking targets

**Public Service Agreement (PSA):** reduce adult smoking rates to 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less.

**Smoking Kills:** reduce smoking among 11–15 year olds to 9 per cent or less by the year 2010; reduce the percentage of women who smoke during pregnancy to 15 per cent by the year 2010.

**Financial Sustainability Review:** 0.4 per cent per annum reduction in smoking prevalence will deliver potential savings of £13m by 2010/11, through reductions in emergency hospitalisations for acute myocardial infarction and stroke. The potential impact of pre-operative smoking cessation on reducing length of stay and waiting times will deliver net savings of £25m.

**2009/10 Vital signs:** smoking prevalence among people aged 16 or over, and aged 16 or over in routine and manual groups (local targets to be set).

Smoking cessation forms one element of the Department of Health’s six-strand strategy for tobacco control:

- supporting smokers to quit
- reducing exposure to second-hand smoke
- delivering effective communication and education campaigns
- reducing tobacco advertising, marketing and promotion
- regulating tobacco products
- reducing availability and supply of tobacco products.

The effective introduction of comprehensive smoke free legislation, raising the age for purchasing tobacco products from 16 to 18 years and highly visible marketing campaigns, have all helped to tackle the smoking epidemic. Tobacco control has been supported by the publication of *Excellence in tobacco control: 10 high impact changes,* NICE guidance and
Department of Health service and monitoring guidance.\(^9\) NICE guidance on stop smoking services recommends that PCTs should aim to treat at least five per cent of the estimated local smoking population each year with a success rate at four weeks, of at least 35 per cent.\(^8\)

**Prevalence**

Smoking rates have now fallen to the lowest recorded level at 21 per cent of the population aged 16 and over.\(^9\) However in routine and manual groups, prevalence is higher at 27 per cent.\(^10\) Slightly more men than women smoke – 22 per cent of men and 20 per cent of women – and smoking is highest in the 20–24 age group (31 per cent) and lowest in those aged 60 and over (12 per cent). Almost two-fifths of adults who are current or ex-smokers started smoking before the age of 16. Two thirds of smokers report that they want to give up, with health concerns and cost the most commonly mentioned reasons for quitting.

Smoking prevalence is highest in deprived communities. Progress at reducing the level of smoking for routine and manual smokers, which comprise about half of all smokers, has historically been slower than for other groups. With quit rates lower in these groups, focus is needed on increasing access to stop smoking services for black and minority ethnic (BME) groups with high smoking rates (Bangladeshi, Irish and Pakistani males tend to have particularly high smoking rates), prisoners, those with mental health problems and pregnant smokers. People with mental illness are likely to be heavier, more dependent smokers and to have smoked for longer than smokers in the general population, leading to increased levels of smoking-related harm. Smoking is responsible for a significant proportion of the excess mortality of people with mental health problems.

| Prevalence of cigarette smoking by socio-economic classification | Percentage smoking cigarettes |
|---|---|---|
| Men | Women | Total |
| **Mangerial and professional** | | |
| Large employers and higher managerial | 16 | 14 | 15 |
| 13 | 15 | 14 |
| Higher professional | 12 | 10 | 11 |
| Lower managerial and professional | 19 | 16 | 17 |
| **Intermediate** | | |
| Intermediate | 21 | 19 | 20 |
| 20 | 17 | 18 |
| Small employers and own account | 22 | 20 | 21 |
| **Routine and manual** | | |
| Lower supervisory and technical | 29 | 25 | 27 |
| 25 | 22 | 23 |
| Semi-routine | 31 | 27 | 28 |
| Routine | 31 | 27 | 29 |
| **Total** | 22 | 20 | 21 |

One of the most cost effective of all NHS health interventions in England is stop smoking services. They are most effective when combined with a comprehensive approach that provides support for stopping smoking and wider tobacco control.

**Pharmacy-based services**

There is a strong evidence base for the effectiveness of pharmacy-led stop smoking programmes:

- community pharmacists trained in behaviour change methods are effective at helping clients to stop smoking
- involving pharmacists in smoking cessation in hospital pharmacy and prison settings are effective
- community pharmacy-based stop smoking services are cost effective
- abstinence rates from one-to-one services provided by community pharmacists are similar to those of primary care nurses.

For further information see Appendix 1.

The community pharmacy contractual framework requires all pharmacies to provide opportunistic healthy lifestyle advice to patients receiving prescriptions who appear to smoke, have diabetes or are at risk of coronary heart disease. It also requires pharmacies to provide information to people visiting the pharmacy who require further support, advice or treatment, signposting them to relevant stop smoking services. If these are not provided in-house, PCTs can also commission stop smoking services from community pharmacy as an enhanced service within the contractual framework.

Pharmacies are contractually obliged to participate in up to six public campaigns each year, organised by their PCT, so have an important role to play in local education and communication. Many PCTs use stop smoking as one of these public health campaigns, encouraging community pharmacies to proactively approach smokers. Hospital pharmacists and pharmacy technicians have contact with the majority of inpatients, so are ideally placed to provide brief stop smoking advice to smokers. Delivering stop smoking services to in-patients has a positive impact, particularly following an unplanned admission, and programmes begun during a hospital stay with follow-up after discharge, are also effective.

Other pharmacists work in areas where they come into direct contact with people, such as in GP surgeries, care homes and chronic obstructive pulmonary disease (COPD) teams. All pharmacy staff who have direct contact with the public, patients, relatives and carers have a potential role to play in helping people to quit smoking.

**Opportunities unique to community pharmacy**

Community pharmacies serve local communities and have the potential to reach and treat large numbers of people who use tobacco. They are ideally placed to provide clear and credible
information to help people make informed choices, and provide a readily available network of trusted health professionals and their teams, based in the heart of communities. They are available to promote health and well-being, support self-care, help people look after themselves better, prevent illness and provide essential treatments.

Pharmacy staff routinely have contact with people who are in good health, as well as those who are visiting a pharmacy due to illness. They are accessible to young people and those who may be less likely to attend more formal healthcare settings – one third of men between 16 and 54 years report visiting a pharmacy at least once a month.13

This allows a focus on opportunistic advice to stop smoking when signs of smoking are observed e.g. nicotine-stained fingers, buying smoker's toothpaste, repeated requests for cough remedies etc. All pharmacy staff have the opportunity to advise smokers to stop. Those commissioned to provide stop smoking services may be able to provide them with NHS funded treatment, in addition to patient funded treatment. Pharmacies which have not been commissioned to provide NHS stop smoking services are likely to undertake private sales of nicotine replacement therapy (NRT).

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<th>How pharmacy can contribute</th>
<th>Likely benefits and outcomes</th>
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<td>Opportunistic and brief advice / interventions for stopping smoking</td>
<td>Successful quitters</td>
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<td>Provision of intensive stop smoking interventions</td>
<td>Greater awareness of the range of options to support quitting</td>
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<td>Availability of over-the-counter products to support quitting</td>
<td>Potentially better health outcomes for people who quit</td>
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<td>Community-based outreach, i.e. into schools</td>
<td>Health benefits due to the reduction in secondary smoke inhalation</td>
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<tr>
<td>Supplementary and independent prescribing of medicines that help people stop smoking</td>
<td>Improved access and choice</td>
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<tr>
<td>Availability of stop smoking medicines through patient group directions</td>
<td>Increased range of enhanced services, which improve customers’ experience and encourage customer loyalty</td>
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The pharmacy white paper, *Pharmacy in England*, sets out the vision of pharmacies becoming ‘healthy living centre’ pharmacies with a greater emphasis on health and well-being, and supporting self-care. Pharmacies provide a convenient and less formal environment for those who choose not to access other kinds of health services and are open at times that suit patients and the public.
NHS stop smoking services are intended to support local smokers who want to stop smoking. They are not intended to be the main driver for reducing smoking prevalence. PCTs will have locally agreed targets for quitters within the annual operating plan. In order to set realistic targets for the number of people using these services and the proportion who successfully quit, PCTs need to have a good understanding of the demographics of the local population.

There are three key stages to mapping the baseline: assessing local needs, mapping existing services and identifying opportunities for strategic development.

**Stage 1: Assessing local needs**

The first stage is assessing the characteristics of the local population who smoke or use other forms of tobacco and the prevalence of tobacco use locally. These health needs should be captured using a combination of the Joint Strategic Needs Assessment (JSNA) and the Pharmaceutical Needs Assessment (PNA). They may also be identified through the development of Local Area Agreements (LAAs) with local authorities.

Limited information can be drawn from national data sources such as the Office for National Statistics (ONS) mid-year population estimates, Annual Population Survey, General Household Survey, Labour Force Survey and 2001 Census. These include population numbers, smoking prevalence, socio-economic group, deprivation, economic status, industry, occupation and ethnicity. Much of this data can be obtained through the Neighbourhood Statistics website\(^4\) at ward, parish, local authority, PCT and other levels. Information on smoking prevalence, the number of quitters and smoking-related conditions form part of the benchmarking data packs\(^5\) available at PCT level from the NHS Information Centre.

It may be possible to calculate local estimates of prevalence from the Quality and Outcomes Framework (QOF) smoking indicators and local public health observatories may have already undertaken local needs assessment. Information from the directed enhanced service for ethnicity and first language recording may be helpful in identifying BME target populations and, in the future, information on local prevalence will be available via the Integrated Household Survey data.

Routine and manual smokers make up 44 per cent of the overall smoking population. When assessing local needs, PCTs will want to particularly identify local communities with a high percentage of routine and manual workers because targeting this group is a priority for NHS stop smoking services.

Other groups that require similar targeting include BME, socioeconomically disadvantaged communities, pregnant women, those in prison and smokers with mental health problems. The use of geodemographic segmentation tools such as Mosaic (postcode classification analysis available from Experian and Dr Foster) can be helpful in mapping deprivation and inequalities, and targeting communities likely to have higher smoking rates.
Stage 2: Mapping existing services

World class commissioners should balance the requirement for widely accessible services with the need for high efficacy rates. They will need to ensure that a variety of intervention types (such as online or telephone support, one-to-one support and open or closed groups) are available to accommodate the needs, preferences and diversity of their local smoking population, and in particular, reach those with health and social inequality. The 2009/10 service and monitoring guidance provides detailed information on the expected efficacy rates of different intervention types.

See also Appendix 2 for details on the integrated service framework model for stop smoking services.

PCTs need to understand how services are currently being provided in order to identify any gaps that can be addressed by commissioning new or different services. This should include comparing localities within the area and comparison with similar PCTs. Examples of relevant information, by service provider, would include:

• activity data on number of people setting a quit date
• activity data on number of successful quitters
• intervention type(s) on offer
• uptake by routine and manual smokers
• rates of carbon monoxide (CO) validation of quitting
• availability and uptake of stop smoking medicines
• opening hours and service availability
• client satisfaction data, if available.

Wherever possible, it is worth mapping services at Lower Layer Super Output Area (LSOA) level (average size 1,500 residents) to produce usable data for communities. Mapping travel times from deprived communities, or those with high target populations, to pharmacy-based services can also be beneficial. The pharmacy white paper states that ninety nine per cent of the population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96 per cent by walking or using public transport.

Stage 3: Identifying what needs to change

Finally, comparing the assessment of need with the analysis of current provision will highlight what needs to change. This may identify:

• areas where current activity data for smoking cessation does not match local prevalence
• high risk groups and priority populations who do not have good access to stop smoking services
• take-up by routine and manual smokers lower than the proportion of these groups within the local smoking population

• service providers with poor uptake or quit rates

• areas where very high service uptake among service providers suggest there may need to be additional investment, especially if quit rates are low.

In some PCTs, commissioning stop smoking services from pharmacies may have traditionally been the responsibility of the medicines management team. It is important that PCTs are assured that there is appropriate input from public health and commissioning, as well as medicines management, to ensure that pharmacy-based services are integrated with the wider provision of stop smoking services. Equally, stop smoking services should not be commissioned without any input from the PCT’s medicines management team. They will be able to make a significant contribution to the development of an appropriate service model by considering the service in the context of the wider pharmacy picture.
The PCT will need to develop a clear vision of how it sees pharmacy involved in stop smoking services, as part of its strategy for developing pharmacy services and its commissioning plan for stop smoking services. This will be informed by the baseline mapping exercise, national priorities and ongoing involvement with local people, clinicians and stakeholders. The need for an integrated partnership approach between pharmacy-based services and the local NHS stop smoking services is important to ensure a co-ordinated approach, quality assurance and consistent messages. In addition, where community pharmacies provide opportunistic advice but do not offer stop smoking services, there needs to be a clear referral route into NHS stop smoking services.

Key drivers

There are a number of key publications that can help the PCT decide how it wants pharmacy to be involved in stop smoking services and what should be commissioned.

Service and monitoring guidance

Comprehensive national guidance on NHS stop smoking services indicates that evidence-based guidelines\textsuperscript{16} and NICE\textsuperscript{6} guidance should underpin service provision and the availability of stop smoking aids. Agreements with pharmacies should be consistent with the advice in the national guidance.

This guidance encourages commissioners and service leads to commission services from...
pharmacies and to work in partnership with them to develop high-quality stop smoking services that the general public can access easily. It highlights that, unlike GP teams where payment is already made to practices for stop smoking activity under the QOF, pharmacies need to be rewarded for providing stop smoking services beyond the healthy lifestyle advice in the contractual framework.

Commissioners need to determine levels of payment according to the time and duration of interventions and treatment provided. Emphasis is given to the need to focus on specific segments of the population. The guidance provides detailed information about the intervention types, pharmacotherapy and targeting priority population groups, as well as the requirements for monitoring services. The 2009/10 national service and monitoring guidance stresses that CO validation at four weeks from the quit date, should be carried out in at least 85 per cent of cases.

**Pharmacy white paper**

The pharmacy white paper highlighted pharmacy’s extensive experience in providing stop smoking services and emphasised that local stop smoking contracts will be offered on the basis of clear criteria for service delivery and data reporting requirements. When PCTs commission stop smoking services from community pharmacies, the service level agreement should include clear quality criteria including integration with core NHS stop smoking services and data collection requirements.

The paper identifies that more pharmacy staff are expected to become accredited ‘health trainers’. It also emphasises the need for a close partnership working between stop smoking services provided in pharmacies and local NHS stop smoking services.

**Choosing health through pharmacy**

*Choosing health through pharmacy,* a strategy for pharmaceutical public health, sets out how pharmacists and their staff can improve the health of specific population groups and target particular health issues, contributing to the achievement of PSA targets. Providing support for stop smoking is seen as a key area where pharmacy can contribute to health improvement and to the achievement of the PSA targets.

The report highlights that where pharmacy staff want to become trained health advisers who give specialist behavioural advice as part of NHS stop smoking services, this needs to be integrated with other PCT services to ensure that efforts are co-ordinated and messages are consistent.

**NICE guidance**

Four current NICE guidelines relate to smoking cessation. These deal with brief interventions, workplace support for stopping smoking, stop smoking services and the use of varenicline as a stop smoking aid. The following types of smoking cessation intervention are concluded to be
cost-effective:

- brief interventions
- individual behavioural counselling
- group behaviour therapy
- pharmacotherapies – NRT, bupropion and varenicline
- self help materials
- telephone counselling and quit lines.

NICE guidance recommends that all frontline healthcare staff are trained to offer brief advice on stopping smoking and to make referrals, where necessary and where possible, to NHS stop smoking services. Simple advice from a physician or nurse can have a small, but significant, effect on the likelihood of a person stopping smoking with a quit rate of about five per cent. It is reasonable to assume that this is transferable to other credible healthcare professionals including pharmacists.

All community pharmacies in England should be providing such opportunistic advice under the NHS contractual framework when smokers present a prescription for dispensing or buy a relevant medicine, and refer on or provide stop smoking support as appropriate. This is particularly important for smokers with co-existing health problems such as COPD, diabetes and coronary heart disease

The AAA (very brief advice) 30 seconds to save a life approach allows very brief confidence-boosting advice for all smokers.

<table>
<thead>
<tr>
<th>VERY BRIEF ADVICE (AAA)</th>
<th>– 30 seconds to save a life</th>
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<tbody>
<tr>
<td>1. ASK and record smoking status</td>
<td>Smoker – ex-smoker – non-smoker</td>
</tr>
<tr>
<td>2. ADVISE patient of health benefits</td>
<td>Stopping smoking is the best thing you can do for your health</td>
</tr>
<tr>
<td>3. ACT on patient’s response</td>
<td>Build confidence, give information, refer, prescribe</td>
</tr>
</tbody>
</table>

Pharmacotherapy

Motivated quitters should be given the optimum chance of success in any quit attempt. Combining behavioural support with pharmacotherapy increases a smoker’s chance of successfully stopping by up to four times.
NRT, bupropion (Zyban®) and varenicline (Champix®) are all recommended by NICE as extremely cost-effective.

<table>
<thead>
<tr>
<th>Four-week quit rates</th>
<th>No medication</th>
<th>NRT</th>
<th>Bupropion</th>
<th>Varenicline</th>
</tr>
</thead>
<tbody>
<tr>
<td>No support</td>
<td>16%</td>
<td>25%</td>
<td>28%</td>
<td>37%</td>
</tr>
<tr>
<td>Individual behavioural support</td>
<td>22%</td>
<td>37%</td>
<td>39%</td>
<td>52%</td>
</tr>
<tr>
<td>Group behavioural support</td>
<td>32%</td>
<td>50%</td>
<td>55%</td>
<td>74%</td>
</tr>
</tbody>
</table>

Source: NHS Stop Smoking Services. Service and monitoring guidance 2009/10

All pharmacotherapies should be available to patients simply and easily as part of first line intervention. Current statistics suggest that varenicline is the most successful smoking cessation aid, followed by bupropion and then NRT. The decision to use any pharmacotherapy must be based on patient preference, clinical history, past use and its cautions and contra-indications.

In a pharmacy setting, patient group directions (PGDs) could be used to facilitate the provision of varenicline and bupropion and are being used by a number of PCTs. PGDs are not necessary for the supply of NRT in most situations, as it can now be used by adolescents over the age of 12, pregnant women and people with cardiovascular disease without a prescription. Supply of medicines under a PGD can be commissioned as a local enhanced service from community pharmacies.
Commissioners and providers need to work together to achieve optimum outcomes using evidence-based interventions. PCTs and community pharmacies will need to focus jointly on increasing reach and access for smokers from target groups, through the use of the 3As approach and referral to NHS stop smoking services where appropriate, improving data quality and ensuring that resources are allocated appropriately. The commissioning of stop smoking services will be informed by the PCT’s strategic plan and reflected in the more detailed annual operating plan and ‘patient offer’.

PCTs will need to work with their local pharmaceutical committee (LPC) to ensure appropriate provision and commissioning of stop smoking services. PCTs and LPCs may find the pharmacy enhanced services pricing toolkit useful as it provides a checklist of cost elements to consider when costing an enhanced service such as pharmacy stop smoking services. When making comparisons between different or potential providers of stop smoking services, PCTs need to recognise that the cost base will be different for services provided in different settings.

PCTs will also want to look at their commissioning of stop smoking services from community pharmacies in light of the level four world class commissioning competencies described in Improving pharmaceutical services.

Transparent use of performance information

Good comparative information on the quality of services provided enable PCTs to effectively manage performance, support quality improvement and provide information for patients and the public.

PCTs should seek an objective and rounded view on the performance of stop-smoking services that are commissioned from community pharmacy. In order to effectively monitor service provision, PCTs will need to ensure that the data they receive from community pharmacies is of high quality. Therefore community pharmacy providers should be required to adhere to nationally agreed definitions when deciding who to include in monitoring returns and the four-week quit status of a client. These are set out in the national service and monitoring guidance and should be a standard requirement of agreements.

A comprehensive approach to managing performance

The full and accurate completion of individual client data monitoring forms (whether in hard copy or electronic) and their timely submission, should be included in agreements for stop smoking services commissioned from community pharmacies. The performance cycle for NHS stop smoking services is set out in the Department of Health’s service and monitoring guidance. Formal data is collected quarterly via strategic health authorities (SHAs).

To encourage greater consistency in the data collected a gold standard monitoring form has been devised (see Appendix 3). In commissioning stop smoking services from pharmacies, PCTs will want to ensure that the data that pharmacies are required to submit, contains as a minimum...
Some PCTs have invested in web-based information systems for collecting data and the Department of Health is piloting a web-based data collection system with the national stop smoking helpline. Such systems can be of great benefit to commissioners and also reduce the amount of paperwork that needs to be completed by community pharmacies. They can prove to be a worthwhile investment, improving timeliness of reporting, data completeness and reducing duplication. Commercial systems are currently available that facilitate:

- prompt and accurate return of quarterly service data
- alignment with mandatory data requirements and the flexibility to update data fields as required
- effective management of client appointments
- detailed analysis of local performance.

As a commissioner, the PCT should be checking quit rates for intervention types and settings. Four-week quit rates are expected to fall between 35 and 70 per cent. If reported rates fall outside this range the PCT can consider the following:

- check that all definitions are being followed and if not, recalculate data
- undertake random checks of smokers treated by the pharmacy concerned, to verify the reliability of recorded quits
- if necessary, recheck all smokers treated. If results are still outside the expected range, assess the most likely causes.

If pharmacies repeatedly submit incorrect or incomplete data, refresher training should be provided on the approved definitions and procedures.

PCTs need to ensure that service level agreements specify that data is returned on all clients treated, not just those with a successful outcome, and that payments may be withheld where providers fail to return data within the required timescale. Although some PCTs have considered payment systems based on successful quitters, this may discourage pharmacies to participate or influence who they are willing to support.

Supporting performance and quality improvement

PCTs should outline what they are prepared to do to help pharmacies improve. PCTs can offer a range of support to pharmacies providing stop smoking services. This could include:

- sharing best practice examples from other providers
- establishing learning networks of pharmacies providing such services to share experience
- mentorship and supervision provided by the NHS stop smoking service.

Pharmacies will vary in the types of intervention they provide (brief advice, brief interventions,
pharmacotherapy offered etc) and in their approaches to delivery. However, the quality of services should remain consistent and be maintained in line with clear quality principles set out in the national service and monitoring guidance.

PCTs will need to be clear about the degree of support in terms of training and equipment, e.g. CO monitors, that they are prepared to provide to pharmacies. This needs to be set out in the service specification for stop smoking services.

**Information for patients and the public**

When commissioning stop smoking services from community pharmacy, PCTs are investing public money. Therefore, in principle, the information about available interventions and quit rates should be made available to the public. As well as providing an incentive for providers to match or outperform their peers, this information enables people to compare all providers and decide which they want to use. The PCT’s ‘patient offer’ should clearly set out the range of services available to patients and the PCT’s expectations around service quality, and patient experience for stop smoking services.

In some larger pharmacies, the quitter may not see the same stop smoking adviser each time they attend for support, which may make comparative information overall less relevant to the individual quitter’s experience. Community pharmacy needs to be treated consistently with other providers of stop smoking services in publicising quit rates.

In order to maximise the opportunities available for smokers wanting to quit, PCTs need to make sure that stop smoking services are promoted locally. This needs to sit alongside social marketing campaigns, using ideas and techniques from the commercial sector and applying them to improve the health and well-being of individuals.

Although the Commissioning for Quality and Innovation (CQUIN) and publication of quality accounts start with acute trusts, these will extend to other providers of NHS services over time and PCTs will need to bear this in mind when commissioning stop smoking services.

**Assuring minimum standards**

**Training standards**

The success of NHS stop smoking services depends on highly trained and skilled advisers to provide advice to smokers who are motivated to quit. It is important to recognise that pharmacy-based stop smoking services are provided by pharmacy staff as well as pharmacists. All stop smoking advisers need to have specific training for the role. The Health Development Agency smoking cessation training standard was developed to improve the effectiveness of smoking cessation services by raising the quality of the training provided to advisers. The standard covers three ‘levels’ of smoking cessation advice:

- brief interventions
- intensive one-to-one support and advice
group interventions.

Pharmacists and pharmacy staff who provide stop smoking services should undertake tailored training on stop smoking interventions that meet the national training standards and should be able to demonstrate appropriate competencies. This may be provided in-house by PCTs or there should be a requirement in the service specification that the provider is responsible for ensuring that staff are appropriately trained.

As part of the Government’s commitment to modernise and improve treatment for smokers who wish to stop, a new NHS Centre for Smoking Cessation and Training will be set up in 2009/10. This will provide a number of key products and services including ‘gold standard’ nationally accredited training programmes, competencies and best practice delivery models, based on the latest research evidence.

This will help to overcome the variations in accreditation requirements across PCTs, which cause problems for staff moving between PCTs. In some areas, for example the North West, work is already underway to achieve standard PCT accreditation requirements and reciprocal accreditation between PCTs. The Harmonisation of Accreditation Group (HAG) is planning to review the competencies and training frameworks for stop smoking services during 2009/10.

Premises

Pharmacies wishing to provide locally commissioned stop smoking services should, as a minimum, be expected to meet the premises requirements needed for the provision of advanced services within the community pharmacy contractual framework. Depending on the detail of the service being commissioned, PCTs may wish to include other premises requirements in their specification.

Developing the market

PCTs will want to analyse the capacity and capability of pharmacy-based stop smoking services and the extent to which they match patient needs. When looking at requirements for developing pharmaceutical services more generally, PCTs will want to consider specific requirements for additional stop smoking services, such as the need to target particular communities.

Commissioning additional capacity

Where a needs assessment indicates a requirement to increase the capacity of pharmacy-based stop smoking services, either across the PCT or in particular communities, or where performance management reveals that an existing provider is continually underperforming and a service has been decommissioned, a PCT might decide to commission additional capacity.

In the future, subject to parliamentary approval of the Health Bill 2009, market entry arrangements for community pharmacy are expected to be based on a PCT’s statement of pharmaceutical needs (i.e. PNA). It is important that this adequately reflects needs relating to pharmacy-based stop smoking services.
Practice based commissioning

The full potential of practice based commissioning (PBC) will only be achieved by bringing together a range of community clinicians and GPs to develop multi-professional PBC groups. Through reviewing patient pathways, releasing resources for reinvestment and helping shape wider commissioning decisions, practice-based commissioners have a key role in shifting care into more local settings that provide convenient and integrated care for patients. PCTs should encourage their practice-based commissioners to involve pharmacists in identifying priorities and commissioning redesigned services as part of their business plan.

PCTs will need to encourage practice-based commissioners to think about pharmacy as a provider of redesigned services, including health improvement initiatives such as stop smoking services. This is particularly the case when trying to target hard-to-reach groups who do not routinely engage with other health services and otherwise “well” people.
### Checklist for commissioners

#### Mapping the baseline
- Does your JSNA / PNA include local prevalence and activity data on smoking populations? Does this include high-risk groups such as those in prison or with mental health problems, as well as priority populations such as BME and pregnant women?  
- Have you established the composition of your local routine and manual population and their service needs?  
- Are you clear about the scale of the challenge locally to meet 2010 targets and is the stop smoking service take-up by routine and manual smokers proportional to your local smoking populations?

#### Developing the vision
- Does your pharmacy-based stop smoking service offer the optimum balance of high-efficacy treatment, reach and accessibility?  
- Does your stop smoking budget include adequate provision for the supply and maintenance of required equipment (CO monitors, tubes, calibration kits etc)? How is this built into your agreements with pharmacy-based stop smoking service providers?  
- Are all NICE approved stop smoking medicines available first-line for smokers wanting to quit? Are PGDs etc in place to facilitate supply through community pharmacies? If not, what action do you need to take to address this?

#### Making it happen
- Do pharmacy-based services achieve CO validation at the recommended minimum of 85 per cent of reported quits? If not, what action do you need to take to address this?  
- Does your pharmacy-based stop smoking service provide high-efficacy, evidence-based interventions? Do you have the data to measure this? Is this data routinely fed back to providers? If not, what action do you need to take to address this?  
- Do services benefit from a robust, integrated IT system that provides:  
  - Systems for prompt and accurate return of quarterly data?  
  - Concordance with mandatory data requirements and the flexibility to update data fields when necessary?  
  - The facility to manage client appointments efficiently and conduct detailed analyses of local performance?
• Do you have a robust and routine clinical governance system to monitor service quality and facilitate independent audit of the service provided by community pharmacy?

• Are community pharmacy employees supported to attend local, regional or national training events? Are your agreements clear about where responsibility lies for training to the required standard?

• Is service development informed by local intelligence, community engagement and customer evaluation involving different populations?

• Is the core NHS stop smoking service fully aware of all arrangements for pharmacy-based services? Are pharmacy based services aware how they fit into the wider NHS stop smoking services locally? (i.e. are locally commissioned services fully integrated?)
Appendix 1: the evidence base for community pharmacy stop-smoking services

Earlier reports, including the references, can be downloaded from PharmacyHealthLink: www.pharmacyhealthlink.org.uk

The contribution of community pharmacy to improving the public’s health: Summary report of the literature review 1990–2007

General overview

Thirty-six papers were reviewed. The evidence shows the following.

- Community pharmacists trained in behaviour-change methods are effective in helping clients stop smoking.
- Community pharmacy-based stop smoking services are cost effective.
- Abstinence rates from one-to-one treatment services provided by community pharmacists and primary care nurses are similar. Rates are lower for specialist one-to-one advice than group interventions with specialist behavioural support.
- Training increases knowledge, self-confidence and positive attitude of pharmacists and their staff in relation to smoking cessation.
- Involving pharmacy support staff may increase the provision of brief advice and recording of smoking status in patient medication records.

Community pharmacy-based stop smoking services, run by trained pharmacy staff are effective and cost-effective. Abstinence rates at one year in two UK randomised controlled trials (RCTs) of community pharmacy-based stop smoking services, were 14.3 per cent (Maguire et al. 2001) and 12 per cent (Sinclair et al. 1998). A large UK study using a quasi-experimental design with 1,500 participants and validated abstinence found similar abstinence rates at four weeks (19 per cent) for people receiving the service on a one-to-one basis from community pharmacists and primary care nurses compared with 30 per cent for those receiving a group treatment service from ‘behaviour change experts’ (McEwen et al. 2006). The authors commented that the difference may be due to the additional behavioural support given by the latter.

There is some evidence of effectiveness of the involvement of pharmacists in smoking cessation in hospital pharmacy and prison settings, and of the feasibility of using a computer programme as the basis for a community pharmacy-based smoking cessation service. A pharmacist-led smoking cessation service initiated from a hospital pharmacy and continued at outpatient visits, or in a community pharmacy, was assessed using a RCT design (Vial et al. 2002). The 12-month abstinence rates were 38 per cent in the hospital group and 24 per cent in the community group. A computer-based service (Pro-Change) was tested in a community pharmacy setting with the aims of improving local access to services and to engage low income and unemployed smokers in quit attempts (Anderson & Mair 2002). Access was improved compared with a general practice-based service and programme users included a large proportion of people on low incomes or without work.

A US study tested the feasibility of a protocol to target specific people for questioning and giving
brief interventions' (akin to giving ‘brief advice’ in the UK) about smoking in two community pharmacies (Purcell et al. 2006). The smoking status of 57 per cent and 29 per cent of eligible people was recorded in the two pharmacies.

**Quality**

Quality criteria developed in two studies could be used further to develop frameworks for UK services.

A quality criteria assessment framework developed in a Scottish study included 13 elements: cessation rates of 30 per cent (one month); 28 per cent (three months); 14.3 per cent (one year); and in those not abstaining, to achieve a reduction in smoking levels; improve access to smoking cessation services; client groups from areas of inequality; client satisfied with the service; successful use of the ‘stages of change’ model; ensure ongoing written material is available; subjective estimate of reduced workload in general practice; avoid increasing time pressure on pharmacists; pharmacists satisfied with service; achieve a cost of £300 per quitter (Cramp et al. 2007).

Six of the 13 criteria were achieved: improved access; clients satisfied with service; successful use of ‘stages of change’ model; one month 30 per cent success rate; three months 28 per cent success rate; and, in those not abstaining, achieve a reduction in smoking levels.

A quality framework for advice during sales of over-the-counter nicotine replacement therapy (NRT) developed in Norway had 12 criteria (six relating to customer service and six on content of pharmaceutical advice) (Granas et al. 2004). A mystery shopper study found a mean score of 17.3 (of a possible 45) on a first visit and 16.2 on the second visit, highlighting there were areas for improvement.

**Costs and cost-effectiveness**

In a Scottish study, the cost per quitter was £525 compared with the quality criterion of £300 in that programme (Cramp et al. 2007). In other studies costs were £300 or £83 per life-year saved (Sinclair et al. 1999) and cost per life-year saved ranged from £197 to £351 for men and £181 to £722 for women (Crealey et al. 1998). A study modelling cost-effectiveness of a US community pharmacy-based service (Tran et al. 2002) found that, depending on the smoker’s age at the time of cessation, the incremental discounted cost-effectiveness was US$720–1,418 per life-year saved (the equivalent cost was US$290–1,155 in the Crealey study based on the 1997 exchange rate).

**Skill mix and training**

Training, especially in behaviour change methods, was found to be essential to the success of pharmacy stop smoking services. Without training, pharmacists are more likely to just respond to smokers’ requests for advice rather than to proactively initiate conversations about smoking (Sinclair et al. 1998).

In a US study, the pharmacy which involved its dispensing technicians in implementing a protocol
for offering brief interventions (brief advice in the UK) and recording smoking status, had recording rates and numbers of interventions roughly double those in the pharmacy that did not use technicians (Purcell et al. 2006).

There is potential benefit to be gained from a whole staff approach in community pharmacy, although there is no comparative data for when pharmacists alone have provided the service.

**Attitudes and practice**

There is consistent evidence across the review period that pharmacists are apprehensive about proactively raising smoking with their customers but after training, pharmacists’ practice becomes more proactive.

Two surveys of US community pharmacists provided further evidence of the tendency among most pharmacists to adopt a reactive approach towards smoking cessation (Kotecki & Hillery 2002; Aquilino et al. 2003). When asked whether it was important to know if a patient smoked, the vast majority of pharmacists agreed that it was. However, only one in ten had any systematic method of obtaining this information and recording it in a way that made it easily accessible when the patient next presented a prescription.

One study from Canada (Brewster et al. 2005) and another from Australia (Edward et al. 2006) explored pharmacists’ attitudes, and a further study from the US (Purcell et al. 2006) investigated actual practice in relation to unsolicited questioning and advice about smoking. Most pharmacists did not routinely ask about, or record, the smoking status of their customers. Pharmacists in the Canadian and Australian studies were apprehensive about raising the topic of smoking cessation and expressed concerns about alienating their customers.
An integrated stop smoking system

This is about ensuring a systems approach is developed that makes it straightforward as possible for local smokers to get help to quit. This involves widespread messages from a range of stakeholders that quitting is not only desirable but achievable by providing quality brief advice to quit and supplying a range of evidence based support for those that require it. The approach recommends tackling key populations through primary care, secondary care, pharmacy, mental health and maternity and family services, whilst taking account of the cross-cutting priority of routine and manual workers (R&M). By ensuring that such an approach is informed by market intelligence and appropriately commissioned, local areas can offer the best chance for smokers to quit.

Core functions of an integrated NHS stop smoking system

The core functions shown in the diagram are those recommended for inclusion within an effective local NHS stop smoking system. These functions can be carried out by a combination of individuals across the local commissioning and delivery landscape, all of whom have a role to play in influencing and supporting successful delivery. Within the system it is helpful to have an individual with responsibility develop and communicate the vision and lead on overall
co-ordination.

Who leads on the individual functions may differ according to local NHS context but in a typical system might comprise:

- commissioning
- procurement and contract management
- service provider/s
- clinicians
- medicines management
- public health team, including intelligence
- marketing and communications.

This information has been supplied by the Department of Health’s National Support Team for Tobacco Control. Further information is available on the Department’s website at www.dh.gov.uk

- *Excellence in tobacco control: 10 high impact changes to achieve tobacco control*
- *NHS Stop Smoking Services and Monitoring Guidance 2009/10*
- *Tackling health inequalities: targeting routine and manual smokers in support of the Public Service Agreement smoking prevalence and health inequality targets*
Appendix 3: Gold standard monitoring form

You can download a version of this form that you can complete, on the Smoke Free Resource website:

V. ANNEX B: GOLD STANDARD MONITORING FORM
(INSET SERVICE NAME & ADDRESS) STOP SMOKING SERVICE
Note: All patient data will be kept securely and in accordance with Caldicott guidelines. Information can only be passed to another healthcare professional if this contributes to the provision of effective care.

**ADVISER DETAILS:**
- Department/Unit
- Location/Setting
- Name
- Venue
- Contact Tel. No.
- Adviser code/Ref.

**CLIENT DETAILS:**
- Surname
- First Name
- Mr/Mrs/Ms/Other
- Address
- Postcode
- Daytime tel no.
- Mobile no.
- Alternative contact number (friend/family)

**Date of Birth**
- Exempt from prescription charge: Y/N
- Pregnant: Y/N
- Breastfeeding: Y/N

**Occupation code**
- Full-time student: Y/N
- Never worked/long term unemployed: Y/N
- Home carer: Y/N
- Sick/disabled and unable to work: Y/N
- Retired: Y/N
- Managerial/professional: Y/N
- Routine & manual: Y/N
- Unable to code: Y/N

**ETHNIC GROUP:**
(a) White
(b) African
(c) Asian or Asian British
(d) Other ethnic groups
(e) Other

**HOW CLIENT HEARD ABOUT THE SERVICE:**
- GP
- Friend/family
- Other

**TYPE OF INTERVENTION DELIVERED:**
- Closed group
- Open (rolling) group
- One to one support
- Telephone support
- Other

**TYPE OF PHARMACOLOGICAL SUPPORT USED:**
- NRT – Lozenge
- NRT – Nicorab
- NRT – Inhalator
- NRT – Spray
- NRT – Patch
- NRT – Gingko

**TREATMENT OUTCOME:**
- Quit Co verified
- Quit self report
- Not Quit
- Lost to follow up

**Adviser signature**

Client signature (indicating consent to treatment and follow-up and pass on of outcome data to GP)
Notes:

1. A client is classified as long term unemployed if they have currently been unemployed for one year or more. If unemployed for less than a year last known occupation should be used for classification.

2. Home carer - i.e. looking after children, family or home.

3. If a client is self-employed please use the flowchart below to determine classification.

4. Managerial and professional occupations, examples include: accountant, artist, civil/mechanical engineer, medical practitioner, musician, nurse, police officer (sergeant or above), physiotherapist, scientist, social worker, software engineer, solicitor, teacher, welfare officer. Those usually responsible for planning, organising and co-ordinating work for finance.

5. Intermediate occupations, examples include: call centre agent, clerical worker, nursery auxiliary, office clerk, secretary.

6. Routine and Manual occupations, examples include: electrician, fitter, gardener, inspector, plumber, printer, train driver, tool maker, bar staff, caretaker, catering assistant, cleaner, farm worker, HGV driver, labourer, machine operative, messenger, packer, porter, postal worker, receptionist, sales assistant, security guard, sewing machinist, van driver, waiter/waitress.

For further assistance in determining socio-economic classifications please see the flowchart below. If you are still unable to establish this, please record as unable to code.

![Flowchart](image-url)
Appendix 4: Good practice examples

NHS Bradford and Airedale

NHS Bradford and Airedale in collaboration with Bradford Local Pharmaceutical Committee established a local enhanced service (LES) for level 2 (one-to-one) stop smoking support within community pharmacy in Bradford, in January 2008.

The service targeted areas with the greatest health inequalities and, to meet the requirements for availability, continuity and sustainability, had to:

• be available to ‘walk-in’ clients
• rigorously maintain an appointment system for patient follow-up
• be available regardless of pharmacist workload and locum cover.

Evidence from unsuccessful services suggested that a major barrier had been the lack of availability of the pharmacist due to workload, leave or staff turnover, so it was decided to develop a pharmacy technician-led service. Pharmacy support staff are usually drawn from the local community and communicate in local languages – this was seen as a major advantage in addressing health inequalities and accessing otherwise ‘hard to access’ patients.

The LES specifies that two days of training, provided by the Bradford Stop Smoking Service, is a requirement for accreditation and training conforms to the standards set out by the Health Development Agency. It is also a requirement that the service should complement, and work in partnership with, the NHS stop smoking service. Where a client is deemed to need specialist support which is outside the capacity of the pharmacy stop smoking advisor, the LES specifies that the client should be referred to the specialist stop smoking service and examples of such clients and a referral pathway are included in the documentation.

Pharmacy staff are required to offer structured follow-up sessions of behavioural support and offer weekly support for at least four weeks following the client’s quit date. Total client contact must be at least 1.5 hours and the specification includes guidelines on structuring appointments during that period. CO validation of quits should be attempted in at least 85 per cent of cases and a definition for a four-week quit is included.

Payment is conditional on providing fully completed Department of Health minimum data sets on a monthly basis and on time. The completion of user satisfaction questionnaires also form part of the performance management of the service. Evaluation has shown that across the 16 participating pharmacies a 45 per cent four-week quit rate was achieved which was verified by CO testing in 81 per cent of cases.

NHS East Sussex Downs & Weald and NHS Hastings & Rother

NHS East Sussex Downs & Weald and NHS Hastings & Rother have a LES specification for level 2 stop smoking services which is delivered within both pharmacies and GP surgeries.

It forms the middle layer of a three tier approach to stop smoking services across the area. A separate LES covers tier 1 services provided by GP practices and tier 3 is provided by the specialist
smoking cessation team.

Participating pharmacists are required to complete the Centre for Pharmacy Postgraduate Education Stop Smoking CD-Rom open learning programme and a two day in-house course.

Providers are expected to maintain a minimum data set and make monthly reports to the trust. The Gold Standard monitoring form is the required proforma for data collection.

Pharmacists are required to offer one-to-one and on-going help sessions for at least four weeks following the client’s quit date. Total client contact is expected to be a maximum of one hour 40 minutes per client and the specification includes guidelines on structuring appointments during that period. Where a client has made two unsuccessful quit attempts, the pharmacist is required to refer them to the specialist stop smoking service.

Derbyshire County PCT

Derbyshire County PCT has recently commissioned a LES to enable primary care contractors to compliment the Derbyshire County Stop Smoking Service.

A separate LES specification has been developed for a service solely for the supply of nicotine replacement therapy to support other accredited advisor services.

Providers are required to ensure that staff delivering the service are trained and accredited by the PCT stop smoking service. The specification indicates the activities to be undertaken at the initial assessment and consultation. Where the provider is a pharmacy, clients are able to obtain NRT from that pharmacy. The service includes documentation for requesting varenicline and bupropion to be prescribed by the client’s GP. A four-week quit should be confirmed by CO validation.

NHS East Lancashire

NHS East Lancashire’s community pharmacy stop smoking service is targeted at areas of high deprivation and is expected to work alongside the trust’s specialist stop smoking service to widen access and the availability of treatment.

Although the scheme is open to all smokers over the age of 16, specific emphasis is placed on disadvantaged groups and smokers from BME groups. One of the stated service objectives is that the scheme will work with the trust’s stop smoking service to achieve an integrated service. Participants must have attended in-house training provided by the specialist stop smoking service, which then provides mentorship and supervision of pharmacy advisors.

The service specification is supported by a standard operational procedure which defines the activities to be undertaken at initial and follow up consultations, and a flowchart for referring those clients who meet the referral criteria to the specialist stop smoking service.
References

8. NICE guidance: *Brief interventions and referral for smoking cessation: guidance 2006 (PH1), Workplace health promotion: how to help employees to stop smoking 2007 (PH05), Varenicline for smoking cessation 2007 (TA123) and Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. 2008 (PH10)*.
10. *Occupational classification within the National Statistics Socio-economic Classification (NS-SEC) system*.


22. *Smoke Free Resource Centre policy guidance*.


24. NHS North West Community Pharmacy Enhanced Services Harmonisation of Accreditation. NHS Primary Care Commissioning website.

Acknowledgments

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Association of Independent Multiple Pharmacies  
Centre for Pharmacy Postgraduate Education  
College of Pharmacy Practice  
Company Chemists’ Association  
Croydon Local Pharmaceutical Committee  
Devon Local Pharmaceutical Committee  
Dispensing Doctors’ Association  
Department of Health  
English Pharmacy Board  
Guild of Healthcare Pharmacists  
Independent Pharmacy Federation  
National Pharmacy Association  
National Prescribing Centre  
Pharmaceutical Services Negotiating Committee  
Royal Pharmaceutical Society of Great Britain  
Warwickshire Local Pharmaceutical Committee
3As – (very brief advice) 30 seconds to save a life approach
BME – black and minority ethnic
CO – carbon monoxide
COPD – chronic obstructive pulmonary disease
CQUIN – commission for quality and innovation
FSR – financial stability review
HAG – harmonisation of accreditation group
JSNA – joint strategic needs assessment
LAA – local area agreement
LES – local enhanced service
LPC – local pharmaceutical committee
LSOA – layer super output area
NICE – National Institute for Clinical Excellence
NRT – nicotine replacement therapy
ONS – office for national statistics
PBC – practice based commissioning
PCT – primary care trust
PGD – patient group directions
PNA – pharmaceutical needs assessment
PSA – public service agreement
QOF – quality and outcomes framework
RCT – randomised controlled trial
SHA – strategic health authority
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