

Review of the Community
Pharmacy Public Health Service
for Smoking Cessation and
Emergency Hormonal
Contraception

**REVIEW OF THE COMMUNITY PHARMACY PUBLIC
HEALTH SERVICE FOR SMOKING CESSATION AND
EMERGENCY HORMONAL CONTRACEPTION**

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Scottish Government Social Research
2011

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Table of Contents

1	EXECUTIVE SUMMARY	1
2	INTRODUCTION	9
	Aims and Objectives of Evidence Gathering Exercise	9
	Background	9
	PHS Smoking Cessation Service	11
	PHS Emergency Hormonal Contraceptive Service (EHC)	13
3	METHOD	14
	Review of Literature	14
	Analysis of Routine Data	14
	On-line Survey of Community Pharmacists and NHS Boards	15
	Interviews with Smoking Cessation Service Users	18
4	FINDINGS - PHS SMOKING CESSATION SERVICE: RESULTS FROM ANALYSIS OF ROUTINE DATA	20
	Introduction	20
	Smoking Rates and Services in Scotland	20
	Characteristics of Users of the PHS Smoking Cessation Service	20
	Claims for Smoking Related Items	21
	Self Reported Quit Outcomes	24
5	FINDINGS - THE VIEWS OF COMMUNITY PHARMACISTS AND NHS BOARD STAFF ON THE PHS SMOKING CESSATION SERVICE	27
	Introduction	27
	The Smoking Cessation Service	27
	Effectiveness of the PHS Smoking Cessation Service	30
	Strengths of the PHS Smoking Cessation Service	33
	Areas where service works better	34
	Continuing to offer the service	34
	Links with other Local Smoking Cessation Services	35
	Data Collection	37
	The Scottish Government PHS Smoking Cessation Specification	37
	Training and Support	40
	Governance and Quality Assurance Arrangements	42
	Improving the PHS Smoking Cessation Service	44
	Summary	47
6	FINDINGS: USERS' VIEWS OF SMOKING CESSATION SERVICES PROVIDED IN COMMUNITY PHARMACIES	48
	Introduction	48
	Accessibility of the Service	48
	Satisfaction with the Service	48
	Effectiveness of the Service	49
	Recommendations for Service Development	49
	Summary	50
7	FINDINGS - PHS EMERGENCY HORMONAL CONTRACEPTIVE SERVICE (EHC): RESULTS FROM ANALYSIS OF ROUTINE DATA	51
	Introduction	51
	Number of EHC Items Dispensed	51
	Number of EHC Claims	51
	Patient characteristics	54
	Evidence on service users' experiences of community pharmacy EHC services	54

8	THE VIEWS OF NHS BOARD AND COMMUNITY PHARMACY STAFF ON THE PHS EMERGENCY HORMONAL CONTRACEPTION (EHC) SERVICE	55
	Introduction	55
	The EHC Service	55
	Effectiveness of the PHS EHC Service	57
	Support and training	58
	The Scottish Government PHS EHC Service Specification	60
	Integration and Links with Other Services	61
	EHC Data Collection	62
	Governance and Quality Assurance Arrangements	63
	Improving the EHC Service	64
	Summary	65
9	DISCUSSION AND CONCLUSIONS	66
	Introduction	66
	Limitations of data	66
	Smoking Cessation	66
	Emergency Hormonal Contraception (EHC)	72
	Conclusions	76
	APPENDIX A SURVEY QUESTIONS	79

ACKNOWLEDGEMENTS

We would like to thank our ISD colleagues for supplying the information on the number of items and claims for the services and for the information from the minimum data set for information on the users of the smoking cessation service.

Our thanks also go to all those community pharmacy and Health Board staff who responded to the online survey and the users of the smoking cessation service who gave their views on the service.

1 EXECUTIVE SUMMARY

- 1.1 This report summarises findings of an evidence review which was carried out to inform a review of the community pharmacy services provided under the Public Health Service (PHS)¹ element of the Community Pharmacy Contract introduced in August 2008. There are two patient-focussed services provided under PHS by Community Pharmacies:
- A smoking cessation service to help those who wish to stop smoking by providing a course of up to 12 weeks nicotine replacement therapy (NRT) and advice; and
 - A sexual health service which provides free access to Emergency Hormonal Contraception (EHC).
- 1.2 These public health services have been developed following the publication of *The Right Medicine: A Strategy for Pharmaceutical Care in Scotland* (Scottish Government 2002) where a commitment was made to further develop the public health role of community pharmacy contractors and their staff. The Public Health Service was initiated in July 2006 and is one of four core services which are provided as part of the new community pharmacy contract. The other three are: a Minor Ailment Service (MAS); an Acute Medication Service (AMS); and a Chronic Medication Service (CMS).
- 1.3 In 2008/9 national PHS specifications were adopted for smoking cessation and a sexual health service for emergency hormonal contraception. Given that these services have been in existence for over three years, it was agreed to review their operation to ensure that any future provision best meets the needs of users in Scotland.
- 1.4 To assist with the review, Health Analytical Services Division of the Scottish Government undertook a review of the evidence on the operation of the smoking cessation and sexual health services. The work included: a small scale review of the literature on the role of community pharmacists in delivering public health services for background information; analysis of routine PHS service data; surveys of community pharmacy and NHS Board staff; and interviews with smoking cessation services users which was carried out by IPSOS MORI.
- 1.5 A summary of the findings is detailed below.

Background

- 1.6 Over the last ten years there has been considerable international interest and activity in the development of the role of the pharmacist in the promotion of healthy lifestyles. This has led to the development of a range of specialised, extended or enhanced pharmacy services relating to health care and promotion other than routine provision of prescribed and non-prescribed medicines.

¹ In operation as part of the community pharmacy contract since August 2008

- 1.7 Examples of the types of public health roles for pharmacists have been documented in a range of literature include: self care; advice to young mothers; support to develop effective parenting skills; health promotion campaigns; drug misuse awareness; needle exchange schemes; AIDS awareness; sexual health support; unplanned teenage pregnancy support; support for patients with chronic illness; advice on how medicines work; out of hours services; collection and delivery services; domiciliary visits; disposal of waste medicines (Bush et al 2009).
- 1.8 Since the move to the provision of enhanced pharmacy services, research has been carried out looking at the operation and implementation of such services. Some studies have explored the facilitators and barriers to provision of enhanced services. For example one Australian study found that facilitators to providing enhanced services were: dedicated study time; accreditation; closed counselling areas; and access to patient notes. Barriers tended to be: a lack of time, space and skills; shortage of pharmacists; no extra remuneration; and lack of opportunities for meeting with local GP and health workers (Berbatis, et al., 2007). One Scottish study found that those who supported the provision of 'extended services' were more likely to be younger and have a postgraduate qualification (Inch, et al., 2005). However this study was conducted a while ago, not long after the introduction of the Right Medicine in 2001.
- 1.9 Studies have also examined public perceptions and experience of using enhanced services. Although the research suggests that pharmacists tend to be seen as 'drug experts' advising on medicines rather than illness and health, actual users of community pharmacy based health development initiatives express a high level of satisfaction with such services.
- 1.10 Much of the evidence on patient experience of using enhanced service suggests that both emergency hormonal contraception (EHC) and smoking cessation services are well received.

Response

- 1.11 There were 121 responses to the community pharmacists' survey from across 13 of the 14 health boards in Scotland. This is a small proportion of approximately 2500 registered community pharmacists in Scotland (although not all these will be providing services) and therefore the findings should be treated with caution. A total of 61 responses were received from NHS Board staff. Almost half (48%) of these respondents had a responsibility or interest in the PHS smoking cessation service only, over a third (36%) had a responsibility or interest in both services and 15% had an interest in the EHC service only.

The PHS Smoking Cessation Service

Analysis of routine smoking cessation data

- 1.12 Analysis of routine data collected on the number of smoking related items (NRT) dispensed through the PHS smoking cessation service suggests that

the PHS service can be seen to have contributed to an increase in the number of people attempting to quit smoking using NRT across Scotland to the levels experienced around the smoking ban in 2006. The total number of smoking items dispensed by all smoking cessation services across Scotland rose from 162,000 items in 2007/8 to over 330,000 items in 2010/11.

- 1.13 Community pharmacies can claim a fee for each month of the three months a client is receiving the service. The figures suggest that there are large falls in the number of items claimed between month 1 and month 3 for PHS smoking cessation service: in the period July 2010 to June 2011, over 88,000 claims were for clients receiving the service in month one, almost 36,000 were for clients in month two and just over 21,000 were for clients in month three. It is clear that a large number of clients leave the service without completing the 12 week course but it is difficult to say whether they have left the service having quit or whether they have given up the attempt to quit.
- 1.14 Analysis of patient characteristics – age, gender and deprivation decile, was undertaken using the smoking cessation minimum dataset. This data shows that the majority of people making a quit attempt with the PHS smoking cessation were female (59%), that most were in the middle age groups 35-59, (53%) and most were from the most deprived areas in Scotland (41% in SIMD 1-2 and 23% in SIMD 23%). This is not dissimilar from the client characteristics of other smoking cessation services overall but a greater proportion of people using the community pharmacy smoking cessation service tend to be younger and from more deprived areas than those using non-pharmacy services.
- 1.15 Information on quit outcomes is recorded at 1, 3, and 12 month 'follow up' of PHS clients. Analysis of this data suggests that while a large number of clients express a willingness to quit smoking using the PHS service, many do not in the end quit via the service. Thirty two per cent of those people who had set a quit date when they first visited the pharmacy, self-reported that they had quit smoking at 1 month compared to 52% of those using non-pharmacy services.² At three month follow-up, 11% of those setting a quit date reported that they were not smoking compared to 23% of those using non-pharmacy services.³
- 1.16 It appears that fewer quit attempts were successful via the community pharmacy PHS service than other non-pharmacy smoking cessation services in Scotland. Caution should be taken when reviewing these results as some users of the service are lost to follow-up and their quit status is unknown. More users of the PHS pharmacy service were lost to follow-up than users of non-pharmacy services, 55%:25%.

² Quit status and quit dates are not recorded for all smoking cessation patients.

³ Based on ISD figures which are based on total 'quit attempts', rather than total number of 'clients' with a quit attempt, so could include repeat quit attempts for the same client.

Views of Community Pharmacists and NHS Board Staff

- 1.17 The views of the community pharmacy staff on the smoking cessation service were in the main positive. Many felt that that the smoking cessation service offered a valuable way for people to attempt to quit smoking. Providing the PHS smoking cessation service led to real job satisfaction for some community pharmacy staff. However a small number felt that the service would be better provided by others.
- 1.18 The main concerns about the service were the paper work, workload and the support needed to provide the service. Many of community pharmacy staff felt that the scope of the service should be extended in terms of the products that were available. Some also felt that there were issues with clients who were not motivated to quit accessing the service and a small number suggested that a small charge might avoid this problem.
- 1.19 Views were also expressed by a small number of respondents that support should be offered to help reduce smoking not just to quit, and that the length of time support is offered should be more flexible to assist those who were making progress but needed further support.
- 1.20 Overall NHS Board staff had mixed opinions about the PHS smoking cessation service. Some staff felt that the smoking cessation service allowed more people to access NRT and that locally the service successfully complemented other more intensive smoking cessation services. Others felt that pharmacies did not have the time or skill to offer the support needed to help people quit smoking and there was not enough evidence around quit rates from the service to be seen to be successful. Many Board staff recognised that the paperwork that pharmacies had to complete was over complicated but also that it was poorly or not completed by community pharmacies. There was a widely held view that completion of data forms should be linked to payment.

Views of Service Users

- 1.21 The findings from the IPSOS MORI study, suggested that participants were very positive about the smoking cessation service provided by community pharmacies. Satisfaction was high among almost all service users who participated in the research, even those who were unsuccessful in their quit attempt. This suggests that many aspects of the service appear to work well and should be continued, particularly the accessibility and flexibility of the service, the interaction with pharmacy staff and the provision of free NRT. However, there are some aspects of the service which could be improved or developed further, these include:
- Advertising of the key aspects of the service.
 - Ensuring a relationship with the staff providing the service is built up and there is continuity of care.
 - Providing additional support after 12 weeks.
 - Allowing those who fail in their attempt to continue to try and quit or return to the service earlier.

- Helping users access other support options during their quit attempt e.g. to Smokeline.
- Providing further information, advice and tips to users to help them in their quit attempt.
- Ensuring private rooms or areas out of earshot of other customers are used for consultations.
- Ensuring that CO testing is available and machines are working.

1.22 Further details of this study can be found at:
www.scotland.gov.uk/PHSsmokingcessationusersviews

Emergency Hormonal Contraception Service (EHC)

Analysis of routine EHC data

- 1.23 Since its introduction in 2008, the PHS EHC service has increased in size and in 2009/10 it dispensed just over 82,000 items. The quantity dispensed in 2010/11 reduced slightly to just over 81,000 items. The number of items being dispensed monthly over the 2009/10 – 2010/11 remaining relatively constant at 7,000 items per month. The service can be seen to have increased access to EHC and to complement the service provided at other sexual health services where EHC is given out without prescription.
- 1.24 Between July 2010 and June 2011 there were just over 70,000 claims recorded for the PHS EHC service. Although the period for patient claims data is different from the period for the data on the number of dispensed items, the data suggest that there is a discrepancy between the number of claims made and the number of items dispensed. This discrepancy is being examined.

Views of Community Pharmacists and NHS Board Staff

- 1.25 Overall the PHS EHC seems to be working extremely well from the point of view of NHS Board and community pharmacy staff who responded to the on-line survey. In particular the community pharmacy staff felt that the EHC service was a valuable community service which needed very little adjustment. It was also clear from the analysis that respondents felt that for remote and rural locations, the PHS EHC was the only easily accessible service available and it therefore fulfilled a crucial role.
- 1.26 There were however some areas for improvement suggested. These included: the expansion of the service to include pregnancy testing; longer term contraception; and new drugs which can be prescribed up to 5 days; removal of religious exemptions; using pharmacy technicians in providing the service; integration with other services; more data to be collected about the service; and governance and quality assurance of the service.

Views of Service Users

- 1.27 It was felt that interviewing users of the service would not be appropriate due to the issues around keeping client confidentiality and the sensitivities around the service.

Discussion

- 1.28 Responses from both NHS board and community pharmacy staff and users of the smoking cessation services were in the main positive about both services. The following highlights the possible policy and delivery implications of the findings.

Smoking cessation

- 1.29 Although the figures from this research show that uptake of the smoking cessation service had increased the findings suggest that consideration should be given to improving promotion of the service via; other professionals such as GPs; providing promotional materials outlining the flexibility of the service; the support offered by staff and the availability of NRT.
- 1.30 Interactions with community pharmacy staff were an important feature in the effectiveness of the service and consideration should be given to ways that community pharmacies can provide continuity of service provision while maintaining flexibility for service users. It is also important to ensure that pharmacy staff delivering the service are competent in the necessary skills and knowledge and have access to appropriate training.
- 1.31 The research revealed that many service users do not return for subsequent visits. Ways of reducing the number of failed quit attempts needs to be considered as well as ways of continuing support to those who require this beyond the initial 12 weeks of the service. Widening the scope of the service to include other treatment options also needs to be considered.
- 1.32 The research suggests that links between the different smoking cessation service providers need to be encouraged so that users have access to the most appropriate package of support.
- 1.33 Service users found CO monitors a valuable tool in encouraging and motivating them to quit. Consideration should therefore be given to ensuring availability of CO monitors as part of the service and providing support to maintain the monitors.
- 1.34 A key theme emerging from this research was the complexity and duplication of the paperwork associated with the service. In addition, NHS board respondents were keen to see payment linked with data collection. Consideration should be given to simplifying the paperwork and the potential for merging and integrating data and payment systems explored.
- 1.35 Although a number of NHS boards had developed quality improvement programmes for the service others highlighted difficulties in providing local

quality assurance believing there was insufficient recognition of this in the service specification. In the light of this it is suggested that the PHS Directions and service specification should be reviewed taking into account quality assurance aspects. Sharing best practice at NHS Board and community pharmacy level could also be encouraged.

EHC service

- 1.36 Overall it was felt that the EHC service offered a valuable service across the country, particularly in rural areas and that it required little adjustment.
- 1.37 Over the last year (2010/2011) the number of EHC items dispensed has remained relatively stable. Some respondents suggested that there was a need for better promotion of the service including highlighting one of its key features – confidentiality. Consideration should also be given to ensuring that promotional materials include information on the benefits and convenience of the service.
- 1.38 The majority of community pharmacy staff had received training and 97% felt it was very useful or useful. Most respondents also felt supported by their NHS board but a significant minority (18%) did not and cited a lack of communication with NHS board and poor communications. On the back of this, consideration should be given to:
- increasing access to training and support for community staff ensuring they have good knowledge and understanding of the service and
 - making use of community pharmacy champions for example in supporting newly qualified pharmacists and those new to an area.
- 1.39 The EHC service was generally felt to be effective. However, there were various suggestions as to how it could be improved for users. These included extending the provision of services to include other forms of contraception and pregnancy testing, direct referral to other specialist sexual health services and using other pharmacy staff such as technicians to provide the service.
- 1.40 As with the smoking cessation findings many NHS boards reported the development of local quality assurance programmes including regular visits to the pharmacies, provision of toolkits and provision of performance data. It is suggested that the PHS Directions and service specification should be reviewed taking into account quality assurance aspects. Sharing best practice at NHS Board and community pharmacy level could also be encouraged.
- 1.41 Previous discrepancies between the number of claims made and the number of items dispensed for the EHC service are being resolved. Once this has been addressed consideration should be given to improving systems to record EHC dispensed and claimed e.g. by underpinning the service with IT support through the ePharmacy Programme which would allow community pharmacists to print and electronically claim EHC prescriptions.

- 1.42 Consideration should also be given to collecting more information on patient characteristics such as age range and post code area again using standardised pro formas underpinned electronically through the ePharmacy Programme.

Conclusions

- 1.43 The findings from this review suggest that both the PHS smoking cessation and EHC services are considered valuable services by both community pharmacy and NHS Board staff and in the case of the smoking cessation service, by the users as well.
- 1.44 However there are a number of suggestions as to how the smoking cessation service in particular could be improved with respect to increasing quit rates and enhancing the service such as follow up of users, extending the range of products available, training, further integration with other local smoking cessation services and linking completion of paperwork with payment.
- 1.45 Similarly improvements suggested with respect to the EHC service included; enhancement of the service e.g. community pharmacists providing other contraception and support, the use of pharmacy technicians, better links and referrals to other sexual health services, improving governance and quality assurance and improving data collection.

2 INTRODUCTION

2.1 This report summarises findings of an evidence review which was carried out to inform a review the community pharmacy services provided under the Public Health Service (PHS)⁴ element of the Community Pharmacy Contract. The review, which focuses on the smoking cessation service and emergency hormonal contraception (EHC), part of the sexual health services, was commissioned by the Scottish Government Primary Care Division of the Primary and Community Care directorate.

Aims and Objectives of Evidence Gathering Exercise

2.2 The objectives of this evidence gathering exercise were to:

- Explore successful approaches to providing smoking cessation and emergency hormonal contraception services through the community pharmacy;
- Examine uptake of the service, users of the services, drop-out levels (from smoking cessation) and overall effectiveness;
- Explore users' views on the accessibility of the current service (for smoking cessation only), their level of satisfaction with the service and what improvements could be made to provide a better service;
- Explore community pharmacists' views of delivering the service and their views on how the service could develop to better meet patients' needs;
- Explore the views of NHS Boards on the provision of the service at a local level, seeking views from Board managers of smoking cessation and sexual health services.

2.3 This report explores each of these objectives in turn, presenting and exploring the available evidence in order to assess the delivery and effectiveness of these elements of the PHS.

Background

2.4 Over the last ten years there has been considerable international interest and activity in the development of the role of the pharmacist in the promotion of healthy lifestyles. Internationally this has led to the development of a range of specialised, extended or enhanced pharmacy services relating to health care and promotion other than routine provision of prescribed and non-prescribed medicines. The promotion of healthy lifestyles is one of the five core pharmacist's roles defined by the Royal Pharmaceutical Society of Great Britain (1996).

2.5 The Scottish Government policy document 'The Right Medicine: A Strategy for Pharmaceutical Care in Scotland (Scottish Government 2002) focused on

⁴ In operation as part of the community pharmacy contract since August 2008

the extended healthcare roles for pharmacists in the future NHS Scotland. This strategy stemmed from commitments set out in *Our National Health: A plan for action, a plan for change* to improve healthcare in the NHS relating to several priorities: improving health; improving access; helping patients make better use of their medicines; service redesign; and partnership with staff (Scottish Executive 2000). Similar moves have taken place across the UK and new NHS community pharmacy contracts include a move away from technical supply to inclusion of a professional clinical role (Department of Health 2004, Scottish Executive 2004).

- 2.6 The new contract arrangements are part of a long-term strategy to move pharmacists (and their remuneration) away from a focus purely on the dispensing of prescriptions to the provision of patient-centred care as part of the wider primary care team. Together these services aim to play an important part in shifting the balance of care by:
- Improving access for the public as they do not need an appointment to see their pharmacist for a consultation;
 - Decreasing workload on GP and nursing colleagues therefore freeing up their time to see patients with more serious complaints;
 - Helping to address health inequalities; and
 - Making better use of the workforce by more fully utilising the skills of community pharmacists.
- 2.7 Examples of the types of public health roles for pharmacists have been documented in a range of literature include: self care; advice to young mothers; support to develop effective parenting skills; health promotion campaigns; drug misuse awareness; needle exchange schemes; AIDS awareness; sexual health support; unplanned teenage pregnancy support; support for patients with chronic illness; advice on how medicines work; out of hours services; collection and delivery services; domiciliary visits; disposal of waste medicines (Bush 2009).
- 2.8 There have been several studies on public perceptions, use and experience of extended services. A systematic international literature review on feedback from community pharmacy users on the contribution of community pharmacy to public health, found that consumer use of pharmacies is almost universal, especially for prescription supplies and over-the-counter medicines (Anderson et al 2004). Evidence from one study suggested that usage was low for general health advice and pharmacists were generally seen as 'drug experts' advising on medicines rather than illness and health (Hassell 1998 cited in Anderson et al 2004)
- 2.9 Some studies suggest that while many people believe that it is the community pharmacy role to provide public health services, in practice they hadn't used them themselves. For example, in one study (Anderson 1998) 40% agreed it was the community pharmacists 'usual job' but only 15% said that they ever sought such advice. A Scottish study of 600 customers of 30 community pharmacies found that there was a clear distinction in the proportion of people willing to seek advice on medicine related and non-medicine related topics (Coggans et al 1998 cited in Anderson 2004).

- 2.10 Some studies have looked at usage of such services within the population. For example, usage of general health advice tends to be higher among women, respondents with young children and C2DE groups⁵. This study suggests those more likely to take up services are generally people who already use the service for prescribed medicines. Harder to engage are those who may currently be healthy
- 2.11 Despite this perception among the public, evidence suggests that users of community pharmacy based health development initiatives express a high level of satisfaction with the services(e.g. see Blenkinsopp et al 2000 cited in Anderson et al 2004).
- 2.12 In Scotland, the contract includes the provision of four pharmaceutical care services: a Minor Ailment Service (MAS) which provides advice, treatment and referral of people who register with the service; an Acute Medication Service (AMS) which dispenses acute or 'one-off' prescriptions supported by the electronic transfer of prescription forms; and a Chronic Medication Service (CMS) which uses the professional skills of community pharmacists in the management of long- term conditions, in partnership with the patient and their GP, and the public health service. Within the PHS element, there are two patient focussed services provided by community pharmacies:
- A smoking cessation service to help those who wish to stop smoking by providing a course of up to 12 weeks nicotine replacement therapy (NRT) and advice; and
 - A sexual health service which provides free access to Emergency Hormonal Contraception.
- 2.13 There are approximately 1200 community pharmacies in Scotland providing the PHS service at any one time.

PHS Smoking Cessation Service

- 2.14 The aim of the smoking cessation service is to provide “extended access through the NHS to a smoking cessation support service, including the provision of advice and smoking cessation products, in order to help smokers successfully stop smoking as part of the Public Health Service (PHS) element of the community pharmacy contract” (Scottish Government 2008).
- 2.15 As part of the service, the pharmacist and support staff proactively seek out clients for the service, for example patients with cardiac or respiratory disease, people from disadvantaged neighbourhoods, pregnant women and young people. If clients want to quit, a quit date is discussed and an appointment is made for a return visit to see the pharmacist prior to the provisionally agreed quit date.

⁵C2 relates to skilled working class Skilled manual workers, D relates to working class Semi and unskilled manual workers and E to those at the lowest levels of subsistence.

- 2.16 At the first appointment, the pharmacist discusses treatment and, following an assessment, prescribes the most appropriate form of NRT⁶ including the option of dual therapy. At this stage some data is also collected about the patient, including their current smoking and previous quit attempts. The patient is usually given one week's supply of NRT and a prescription is written for four weeks worth of NRT. The patient collects either on a weekly or less frequent basis. The pharmacist must make the initial supply, however subsequent supplies can be made by a trained pharmacy support staff.
- 2.17 At four weeks, a follow up appointment is undertaken with the patient and they are asked if they have smoked in the last two weeks. If they report that they have smoked, no further NRT is supplied and the quit attempt is recorded as unsuccessful. The patient is informed that they can make another quit via the service after a period of time specified locally by the Board – which typically tends to be three months (six months in Greater Glasgow and Clyde)⁷. If the patient reports that they are not smoking, another prescription for NRT is provided.
- 2.18 At the 4 week follow up appointment, data is collected on how the quit attempt is progressing and a CO monitor⁸ may be used to confirm smoking status. The cycle of four week follow-up appointments and prescriptions then continues as part of the service for up to 12 weeks, when the course is completed. The pharmacist may refer the patient to other NHS board smoking cessation services according to an individual's needs and locally agreed patient pathways.
- 2.19 Each patient can therefore have up to 12 weeks supply of NRT and three follow up appointments as part of the PHS with NRT being prescribed on a weekly or less frequent basis. The pharmacy claims a payment of £25 for each patient for each month they are using the service by submitting a claim form to NHS National Services Scotland (NSS)⁹. The pharmacy is also required to submit a completed National Minimum Dataset Form¹⁰ to their Board for each patient for inclusion in the national monitoring of smoking cessation services.

⁶ NRT includes nicotine gum, patches, micro tabs, lozenges, nasal spray.

⁷ Current official guidance is that "If a smoker's attempt to quit is unsuccessful using NRT, Varenicline or bupropion, prescribers/specialist smoking cessation advisers should not offer a repeat prescription within six months (unless identified, specific circumstances have hampered the person's initial attempt to stop smoking, in which case it may be reasonable to try again sooner" (NHS Health Scotland & ASH Scotland, 'Guide to Smoking Cessation in Scotland 2010 – Planning & Providing Specialist Smoking Cessation Services' p.32).

⁸ A simple breath test using a CO monitor measured the level of carbon monoxide (CO) inhaled from tobacco smoke. CO monitors are used during smoking cessation programmes to give the smoker visible proof of the damaging CO levels and to help motivate by charting the progress during a quit attempt.

⁹ http://www.communitypharmacyscotland.org.uk/_resources/files/legislation/PHS%20Smoking%20Cessation%20SOP.pdf

¹⁰ The Minimum Dataset (MDS) is for recording the core data required for anonymous national monitoring of clients who access Scottish NHS Board specialist smoking cessation services, take part in a stop smoking intervention, and who set a quit date with the service during the course of the intervention. The data is analysed by NHS Boards and ISD.

- 2.20 The pharmacist or member of support staff should attempt to follow up the client if a client does not present as anticipated. The NHS Board undertakes follow up of clients at 12 weeks and 12 months after the agreed quit date unless it has been agreed that the pharmacist should do this. In this case, the data relating to the follow up should be sent to the NHS Board.
- 2.21 More information on the smoking cessation service can be found on Community Pharmacy Scotland website:
http://www.communitypharmacyscotland.org.uk/nhs_care_services/public_health_service/phs_smoking_specifications.asp

PHS Emergency Hormonal Contraceptive Service (EHC)

- 2.22 The EHC service is one of four elements of the PHS sexual health service. The other three elements are: testing for Chlamydia infection, treatment of Chlamydia infection, where clinically appropriate and referral to another health care practitioner.
- 2.23 This review focuses on the free provision of EHC service which aims to “provide, where clinically indicated, a free supply of emergency hormonal contraception (EHC) as specified within a Patient Group Direction (PGD).” (Scottish Government 2008).
- 2.24 The EHC service is available to any female client aged 13 years or over and must be provided by the pharmacist in person. The pharmacist takes a client history (including asking for information on medical history, current medication and the possibility of current pregnancy) to ensure that they have sufficient information to assess the appropriateness of the supply. If the client is under 16 years of age, the pharmacist follows local child protection (LCP) guidelines to ensure the scenario is managed appropriately. If the client is over 13 and under 16, following the LCP guidelines, EHC can be prescribed. If the client is aged under 13, EHC is not prescribed and they are referred to their GP. There is an ethical opt out which allows pharmacists to choose not to offer this service, but in such circumstances they must refer patients requesting the service to another pharmacy who provides it.
- 2.25 If a client is assessed as being eligible for the service, the pharmacist prescribes Levonorgestrel 1.5mg tablet and counsels the patient. The supply of EHC is recorded by the pharmacist who then claims a payment of £25 for each client by submitting a claim form to NHS National Services Scotland (NSS)¹¹.
- 2.26 More information on the EHC service can be found on Community Pharmacy Scotland website:

http://www.communitypharmacyscotland.org.uk/nhs_care_services/public_health_service/phs_sexual_health_specifications.asp

¹¹http://www.communitypharmacyscotland.org.uk/_resources/files/legislation/PHS%20Smoking%20Cessation%20SOP.pdf

3 METHOD

3.1 The evidence review comprised:

- a brief review of the literature on PHS;
- analysis of data collected routinely on the PHS e.g. data on number of claims, patient data;
- on-line surveys of community pharmacy and NHS Board staff;
- interviews with users of the smoking cessation service carried out by IPSOS MORI.

3.2 Please note that interviews were not carried out with EHC service users as it was felt that in doing so it may be perceived by users as compromising some of the important features of the EHC around quick and easy access, confidentiality etc. Instead we used information from the review of previous research to gain some insight to users' views on EHC services.

3.3 The methods used in each element of the review are described in more detail below.

Review of Literature

3.4 A brief review of the literature on pharmacy delivered public health services was undertaken to complement the analysis in this review and to provide further background.

Analysis of Routine Data

3.5 Practitioner Services Division, part of National Services Scotland¹² collects data on the PHS smoking cessation and EHC services in connection with their role in the payment of community pharmacies for delivering the services. Information on the number and type of patient claims and the pharmaceutical items provided as part of the services are collected. Information Services Division¹³ (ISD) analyse this data and regularly provide monitoring reports to policy officials. These reports are also publicly available. Data used in review covered both the pre and post introduction of the PHS patient services, from April 2006 to June 2011.

¹² National Services Scotland is a national is a non departmental public body, accountable to the Scottish Government, providing national strategic support services and expert advice to NHS Scotland.

¹³ISD delivers effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

- 3.6 Other data on the PHS service relating to patients comes from the Smoking Cessation Minimum dataset¹⁴ which community pharmacists should complete for each client, available via ISD at the time of this research for the period January to December 2010. This data includes information on smoking status, number of quit attempts, quit date for this attempt, intervention used, smoking status at follow up, CO readings, demographic data and consent for follow up and for anonymised data to be used in the national dataset.
- 3.7 It should be noted that data recorded for the minimum dataset has to date been less well completed than data recorded for claims for payment. Caution is therefore needed in the interpretation of data from these two sources about the patients who use the services.
- 3.8 For the purpose of the analysis, data relating to both claims and items dispensed has been analysed for the most recent (at the time of writing) full year's data, July 2010 to June 2011 has been provided by ISD and extracted from the Prescribing Information System. Data on national smoking cessation figures are provided for the calendar year 2010 from the National Minimum dataset provided by ISD. Smoking prevalence rates are available for 2009/10 from the Scottish Household Survey. Microsoft Excel was used to analyse the data and to provide summaries and basic descriptive statistics.

On-line Survey of Community Pharmacists and NHS Boards

- 3.9 Questback software was used to conduct online questionnaire surveys of community pharmacists in Scotland and NHS Board staff in each of the 14 territorial Boards who had an interest or responsibility for either the smoking cessation and/or EHC service. Whilst much was done to promote community pharmacist awareness of and participation in the online survey, the response was low. Almost all territorial Health Boards and all types of pharmacy (ranging from multiples to single outlets) were represented amongst the respondents, it is difficult to know how representative the views expressed in the survey are of community pharmacists more generally. The data provided in this report must therefore be treated with caution.
- 3.10 Similarly, responses from a wide range of Health Board staff were obtained but again it is difficult to know how representative these views are of all the staff that might have responded.

Survey of Community Pharmacy Staff

- 3.11 Community Pharmacy Scotland distributed the link to the community pharmacy survey to all its members. Directors of pharmacy at Health Boards were also asked to pass on the link to pharmacies in their area. The survey asked about which pharmacy staff were involved in the smoking cessation service; training they had received, details of the service offered; facilities for consultations; views on effectiveness of the service; and suggestions for improving the service.

¹⁴ Each NHS Board has adapted the national dataset form. This may lead to difficulties where a pharmacist has pharmacies in more than one Board area.

- 3.12 One hundred and twenty one community pharmacy staff from 13 out of the 14 NHS Boards in Scotland participated in the survey.
- 3.13 Over two thirds of respondents (68%) were pharmacists employed by the pharmacy, 24% were community pharmacy contractors, 7% were locum pharmacists and 2% were 'others' including practice managers and employee/shareholder.
- 3.14 Table 1 shows the type of pharmacy that respondents worked in. Over a third of respondents worked in a pharmacy which was part of a large multiple.

Table 1: Type of pharmacy

Type of pharmacy respondent works in	
	%
Multiple outlet (16+ pharmacies)	36
Medium outlet (6-15 pharmacies)	13
Small outlet (2-5 pharmacies)	26
Single outlet	24
N	121

- 3.15 The majority of respondents worked in pharmacies which did not open on Sundays or after six pm (Table 2). Of the 15 respondents (12%) who did open late in the evenings, the majority (between 13 and 14 respondents) opened late on a weekday evening; six opened late on a Saturday; and three opened late on a Sunday. Another respondent reported that they opened early in the morning.

Table 2 – Community pharmacy opening hours

Pharmacy open	Yes	Yes – but only on a rota	No
	%	%	%
On Sundays	10	5	85
After 6 pm	12	0	87

N = 121

- 3.16 The overwhelming majority of respondents (97%) worked in pharmacies providing both smoking cessation and EHC services, 2% only offered the smoking cessation service, and 1% provided neither service. The pharmacy which did not provide either service explained that the reason for this was that there was:

“No private area or consultation room to offer privacy and confidentiality to patients. Shop floor area measures 8 ft x 8 ft, cramped, scruffy, unprofessional and unfit for purpose.” [CP 67]

- 3.17 Of those pharmacies who did provide a PHS service (either smoking cessation or EHC) 90% provided it in a separate private consulting room, 5% provided it in a designated area of the pharmacy, and 5% provided it in another location such as a quiet area, a consultation room without a door,

temporarily over the counter, or different locations depending on which pharmacist was present.

3.18 The majority of those who provided one or both PHS services (92%) reported that there was no problem with providing suitable facilities - 8% did have problems providing facilities.

3.19 Problems listed by respondents included lack of space, the need to provide two consulting rooms for other services such as methadone supervision separately from the PHS service, lack of wheelchair access and consultation rooms having to double as staff rooms.

“One pharmacy I work in does not provide a consultation area therefore no privacy which is awkward for EHC - should be a requirement of EHC provision that there is a separate consultation area.” [CP 91]

3.20 A majority of respondents had been providing smoking cessation and EHC services prior to the introduction of PHS in Scotland. Over two thirds (68%) had been providing a smoking cessation service and 62% the emergency hormonal contraception service (Table 3)

Table 3 - Length of time providing a service before the introduction of PHS

	Smoking Cessation Service	Emergency Hormonal Contraception
	%	%
More than 2 years	40	44
Between 1- 2 years	18	7
Less than one year	10	11
Did not provide a service	31	38
N	116	111

Survey of NHS Board Staff

3.21 The survey of NHS Board staff was sent to Directors of Public Health; Directors of Pharmacy; Smoking Cessation Coordinators; Sexual Health Strategy Leads and Lead Clinicians. The survey asked respondents' views of the effectiveness of the services, support for training, how the PHS services linked with other services in the Board, governance and quality assurance arrangements.

3.22 Sixty one NHS Board staff from across 13 of the 14 NHS Boards in Scotland completed the NHS Board questionnaire on the PHS Service between 24 January and 28 February 2011.

3.23 Almost half of respondents (48%) had responsibility or interest in the PHS smoking cessations service only. Just over a third (36%) had an interest or involvement in both services (Table 4).

Table 4 – Respondents by type of PHS service

Respondent with interest/responsibility in:	%	N
Both services	36	22
Smoking cessation only	48	29
EHC only	15	9
Neither service	1	1

3.24 The roles of those completing the survey were wide ranging and included smoking cessation coordinators, stop smoking nurse specialists, tobacco health improvement leads, vascular nurses, sexual health nurses, sexual health/ GUM consultants, sexual health leads, data entry staff, health promotion specialists, community pharmacy advisors, community pharmacy business managers, public health pharmacists, consultants in pharmaceutical public health, directors of pharmacy, and directors of public health.

Interviews with Smoking Cessation Service Users

3.25 The views of a sample of people using the PHS smoking cessation service in October 2010 were sought by means of telephone interviews. Ipsos Mori was commissioned to undertake this work.

3.26 Services users were recruited using a three-stage sampling process. Initially a sample of community pharmacies offering the PHS smoking cessation service were identified across a range of NHS Board areas ensuring a spread of types of pharmacy; urban and rural locations, levels of deprivation and numbers of service users.

3.27 The selected pharmacies were provided with invitations to send to people who had used the service in October 2010. The invitation asked them to take part in a telephone interview on their experience of using the service. The invitations also contained demographic questions and questions on their current smoking status and previous attempts to quit. Using this data, a sample of 24 users was selected to be interviewed.

3.28 A number of criteria were used to ensure a spread of participants. The criteria included type of pharmacy attended; length of treatment; age; gender; number of quit attempts; number of cigarettes smoked per day; mode of NRT/support; pregnancy; and geographical area.

3.29 Telephone interviews were conducted between February and March 2011. Participants were asked about their decision to quit smoking; previous attempts to stop, seeking help to quit smoking; and the smoking cessation service they received in their community pharmacy. A full report of the findings is available at:

www.scotland.gov.uk/PHSsmokingcessationusersviews

3.30 The next five chapters report on the findings from the data analysis and data gathering exercise. Findings relating to smoking cessation services are presented first, followed by findings on the EHC service. Chapter 9 presents a

discussion of the findings from the report. A copy of the questions used in the surveys can be found in Appendix A.

4 FINDINGS - PHS SMOKING CESSATION SERVICE: RESULTS FROM ANALYSIS OF ROUTINE DATA

Introduction

- 4.1 This chapter presents results on the PHS smoking cessation service and comprises analyses of routine data and of the surveys of pharmacists and NHS Board staff.

Smoking Rates and Services in Scotland

- 4.2 Data for 2009/10 from the Household Survey (Scottish Government, 2011) reveals that 24% of all adults aged 16 and over were current smokers in Scotland. Smoking rates were higher amongst men than women (men 26%, women 25%).
- 4.3 NHS Scotland offers a range of smoking cessation support to help smokers quit, this includes:
- Smokeline – the national telephone helpline service which gives advice on smoking cessation and signposts callers to appropriate support;
 - support from GP or other health professional;
 - support from a pharmacist through the PHS service; and
 - support from a local specialist smoking cessation service.
- 4.4 Data from the NHS Smoking Cessation Service Statistics (Scotland) show that during 2010 there were 79,672 quit attempts made with the help of NHS smoking cessation services in Scotland. This compares with 74,038 quit attempts in 2009 (revised 2009 figures), an increase of 5,634 (or 7.6%) (ISD, 2011). An estimated 7.4% of smokers in Scotland made a quit attempt with an NHS smoking cessation service during 2010 (6.9% in 2009). Pharmacy services accounted for 63% of quit attempts made (around 80% in some NHS Boards - Greater Glasgow and Clyde, Grampian and Ayrshire& Arran).

Characteristics of Users of the PHS Smoking Cessation Service

- 4.5 Table 5 shows the characteristics of people using the pharmacy PHS smoking service compared to those using other NHS smoking cessation services. For both services women are more likely than men to make a quit attempt. Also those in older age groups were more likely to attempt to quit than those in younger age groups. The pharmacy PHS smoking cessation service appears to be more attractive to younger people with the number of people making a quit attempt in the pharmacy PHS smoking cessation service in age groups under 25 to 44 higher than in the non-pharmacy services. However in the age group 45-59 and upwards, more people are making a quit attempt with non-pharmacy smoking cessation services. In contrast, the 2009/10 Scottish Household Survey, shows the highest smoking prevalence (at 29%) was in the 25-34s and 35-44s age groups.

Table 5 – Uses of smoking cessation services by age and sex - all NHS services and PHS service

	Users of PHS smoking cessation services	Users of non PHS smoking cessation services
Sex		
	%	%
Male	41	42
Female	59	58
Age group*		
Under 25	11	8
25-34	21	15
35-44	25	22
45-59	28	34
60+	15	21
Unknown age	<1	<1
SIMD*		
1-2	41	30
3-4	23	26
5-6	16	19
7-8	12	14
9-10	7	8
Unknown age	1	3
N =	49,928	29,744

* Percentages may not add up due to rounding.

Source: National Smoking Cessation System, ISD Scotland

- 4.6 Scottish Household Survey estimates (2009) reveal that the largest numbers of smokers in Scotland, and the highest smoking prevalence, to be in the most deprived areas. Analysis of quit attempts by SIMD¹⁵ show the largest number were made by people living in the 'most deprived' areas in Scotland (ISD, 2011). Those living in the most deprived communities (equivalent to SIMD 1-2) account for an estimated 31% of total smokers in Scotland and they account for 37% of quit attempts made in NHS cessation services in 2010.
- 4.7 Comparing the PHS smoking cessation service with other NHS smoking cessation services shows that the PHS service appears more attractive to those in the lower deprivation deciles. A higher proportion of quit attempts (41%) were made by those in the two most deprived deciles (SIMD 1-2) compared to 30% of quit attempts in non-PHS services.

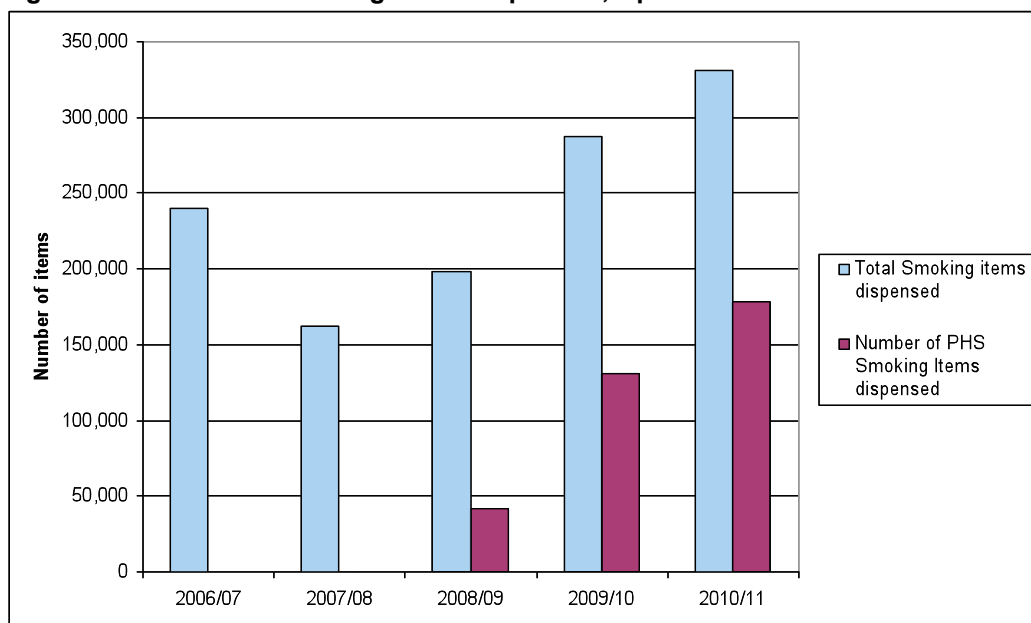
Claims for Smoking Related Items

- 4.8 Figure 1 shows the number of smoking items dispensed by all smoking cessation services and the number which were dispensed through the PHS

¹⁵SIMD is a relative measure of area deprivation. It combines deprivation information on income, employment, health and disability, education, skills and training, and geographical access to services. SIMD ranked wards are assigned to population weighted deprivation quintiles, and the most deprived wards containing 20 per cent of Scotland's population are assigned to deprivation quintile.

smoking cessation service in each year¹⁶. Since its introduction in August 2008, the number of smoking related items (NRT) dispensed through the PHS smoking cessation service has steadily increased to over 170,000 items in 2010/11. Over the same period there was an increase in the total number of smoking items dispensed by all smoking cessation services across Scotland from 162,000 items in 2007/8 to over 330,000 items in 2010/11. The take-up of smoking cessation services overall across Scotland was greater than the levels experienced around the time of the smoking ban in 2006 when over 284,000 items were dispensed. By 2010/11 the PHS service accounted for 54% of all smoking items dispensed (nicotine only) by all practitioners in Scotland.

Figure 1 – Number of smoking items dispensed, April 2006 – March 2011



Note: Data is based on Nicotine only.

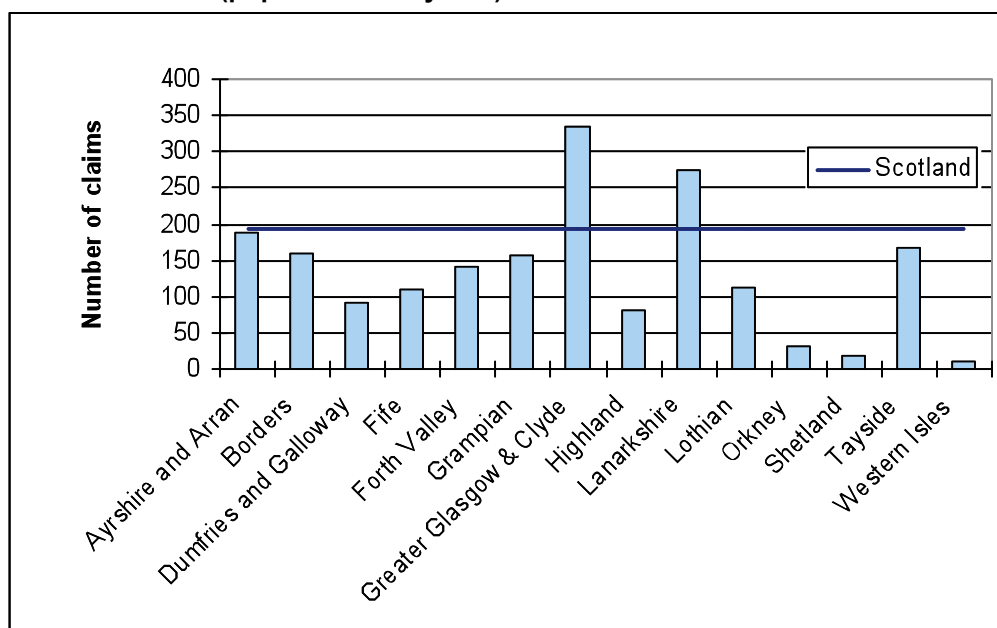
Excludes items not dispensed using a prescription e.g. in hospital.

Source: Prescribing information system, ISD Scotland.

4.9 Figure 2 looks at the breakdown of PHS smoking cessation items dispensed across all 14 NHS Boards by population (over the age of 12 years) and the average number of items dispensed across Scotland for the last year for which data is available. The rate of claims for was greatest in Greater Glasgow followed by Lanarkshire.

¹⁶Data is based on Nicotine only.

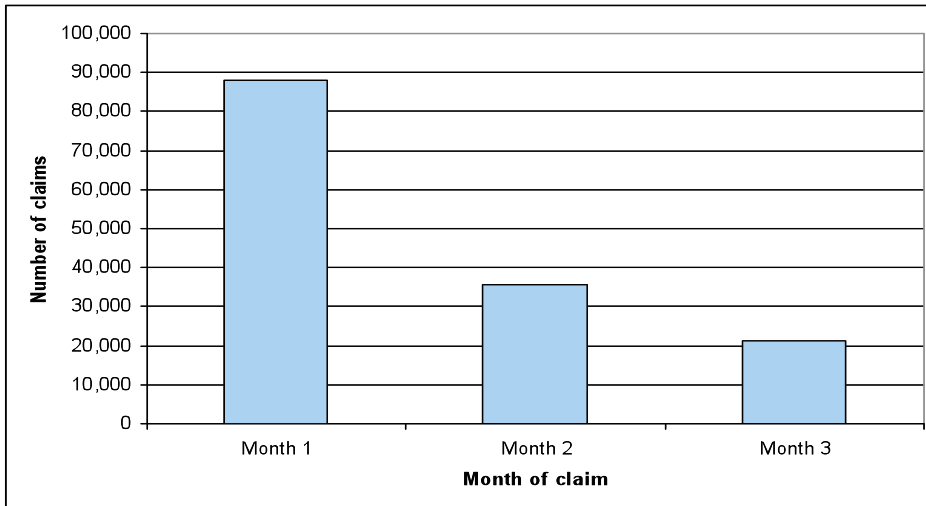
Figure 2 - Rate per 10,000 population of smoking cessation claims by NHS Board, July 2010 - June 2011 (population 12+ years)



Source: Based on data from Prescribing Information System, ISD Scotland.

- 4.10 The Island Boards have the lowest rate of claims for PHS smoking cessation. It is likely that this lower rate is linked to the number of dispensing GP practices in these NHS Boards and the lower number of community pharmacies.
- 4.11 Community pharmacies can claim a fee for each month a patient is receiving the service. In the period July 2010 to June 2011, just over 88,024 claims were for patients receiving the service in month one, almost 36,000 were for patients in month two and just over 21,000 were for patients in month three (see Figure 3). These claims are the total amount of claims at each month and do not track one patient's claims across the three months they participate in the service. However they indicate a reduction in the number of individuals remaining with the service at months two and three. Of the 88,024 people receiving a service at month one, 24% were still receiving the service at month three. It is clear that a large number of clients leave the service before the end of the 12 week course but it is difficult to say whether they have left having quit smoking or whether they have given up the attempt.

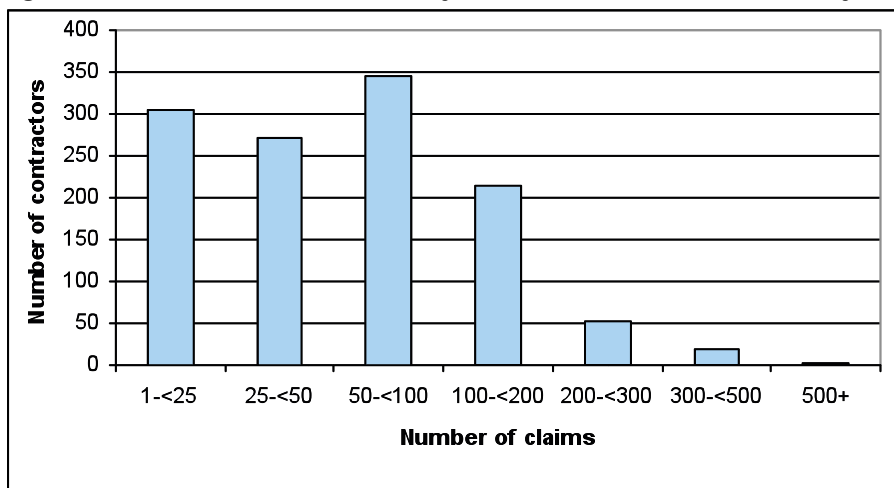
Figure 3 Number of smoking cessation claims – July 2010 – June 2011



Source: Prescribing Information System, ISD, Scotland

- 4.12 In 2009/10 there were 1,267 community pharmacy codes in operation in Scotland. Fifty eight of these did not have any claims against them for any items as part of the PHS smoking cessation service between July 2010 and June 2011.
- 4.13 Figure 4 shows the number of month one claims by contractor. A quarter of the community pharmacies (305) made less than 25 claims a year as part of the PHS smoking cessation service. Twenty nine per cent (345) made 50 to less than 100 claims. Eighteen contractors (1%) made between 300 - <500 claims and two contractors made over 500 month one claims.

Figure 4 – Number of contractors by number of month 1 claims July 2010 – June 2011



Source: Prescribing Information System, ISD, Scotland

Self Reported Quit Outcomes

- 4.14 At follow up appointments, clients of the PHS service are asked if they have smoked. At one month they are asked if they have smoked at all in the last two weeks (even a puff) and at three month follow up, whether they have

smoked since the one month follow-up. This is recorded on the minimum dataset form. Table 6 shows the outcome at one month for PHS smoking cessation services and non-pharmacy based services.

Table 6 – Self reported quit outcomes at one month follow-up for pharmacy and non-pharmacy based smoking cessation services

	PHS smoking cessation services	Non-pharmacy smoking cessation services
	%	%
At one month follow-up:		
Not smoking	32	52
Smoking	13	23
Lost to follow-up/smoking status unknown	55	25
N =	49,928	29,744

Source: National Smoking Cessation System, ISD Scotland.

- 4.15 Between January and December 2010, 16,029 (32%) people on the PHS service reported that they had quit smoking at one month. Over a half of clients (55%) were lost to follow-up or their smoking status was unknown at this stage (month 1). In contrast, in the non-pharmacy NHS smoking cessation services, 15,427 (52%) people reported that they were not smoking at the one month follow-up and 7,534 clients (25%) were lost to follow-up or unknown smoking status.
- 4.16 For the pharmacy based smoking cessation services, 11% of those setting a quit date at their first visit reported that they had not smoked at three months compared to 22% for those using non-pharmacy based services.
- 4.17 This would suggest that less people quit successfully via the PHS service than other smoking cessation services in Scotland where for example 19% of primary care smoking cessation patients had not smoked at 3 months and 21% of smoking cessation patients using services in a community venue had not smoked at three months, and the average across all services is 14% not having smoked at three months). However, caution should be taken when reviewing these results as not all patients on the PHS service self reported whether they had smoked since quitting, and over 54% of those who had self reported at 1 month that they had quit were lost to follow-up or their quit status was unknown at three months.

Summary

- 4.18 From the data on smoking items dispensed and claims, the PHS service can be seen to have contributed to an increase in the number of people attempting to quit smoking using NRT across Scotland to the levels experienced around the time of the introduction of the smoking ban in 2006. However, there are large falls in the number of items claimed between months one and three for PHS smoking cessation service. It is difficult to say whether they have left having quit smoking, given up the attempt or left the service for some other reason.

- 4.19 The analysis of the characteristics of services users shows that more females than males use the PHS service, are middle aged or older and are from the most deprived areas in Scotland.
- 4.20 In terms of self reported quit rates the data suggests that a large number of clients expressing a willingness to quit smoking using the PHS service are not successful in quitting. The data also indicates that less people quit successfully via the PHS service than through other smoking cessation services in Scotland. However caution should be taken when reviewing these results as many patients are lost to follow-up and their quit status is unknown.

5 FINDINGS - THE VIEWS OF COMMUNITY PHARMACISTS AND NHS BOARD STAFF ON THE PHS SMOKING CESSATION SERVICE

Introduction

- 5.1 This chapter of the report summarises the findings of the on line surveys of community pharmacists and NHS Board staff. The questions used in each survey can be found in Appendix A.
- 5.2 Community pharmacists were asked about how clients found out about the service; provision of the service; the therapies offered; facilities provided and the follow up of clients. They were also asked their views on the effectiveness of service; NHS Board support; links with other services; improvements they would like to see and data collection.
- 5.3 NHS Board staff were asked more specifically about the Scottish Government specification, training, governance and quality assurance.
- 5.4 A total of 120 community pharmacy staff (out of about 2,300 registered community pharmacists registered in Scotland) and 51 NHS Board staff responded to the two online questionnaires.

The Smoking Cessation Service

How clients find out about the smoking cessation service

- 5.5 Community pharmacists reported that most of their clients found out about the smoking cessation service they offered from pharmacy staff or material within the pharmacy promoting the service (Table 7). Health professionals were also an important source of referrals to the service. Clients also found out about the service from friends and family; TV, newspapers or radio; Smokeline; Facebook; local advertising; or NHS Board events.

Table 7- How clients found out about the smoking cessation service

	%
Pharmacy staff	83
Health promotion material in pharmacy	73
Referred to service by other health professionals	71
Other routes	28
Don't know	3
N	120

Staff involved in providing the service

- 5.6 Not surprisingly almost all pharmacists were involved in delivering the smoking cessation service (Table 8). Dispensing technicians and counter assistants were involved to a lesser extent. Others involved in delivering the service included pre-registration pharmacists, pharmacy students and dispensing assistants.

Table 8 - Staff involved in providing the smoking cessation service

Staff groups	
	%
Pharmacists	99
Dispensing technicians	63
Counter assistants	43
Others	4
N	120

What the consultations covered

- 5.7 There was considerable uniformity in what community pharmacists included in smoking cessation consultations (Table 9). Almost all community pharmacists (93%) also reported that they recorded data for the minimum dataset and/or HEAT target at the consultation.

Table 9 -Content of consultations

	%
Discussion of previous quit attempts	99
Discussion of current tobacco use	99
Current smoking status	99
Quit date agreed	97
Information on different types of NRT	96
Motivations to quit	94
Provision of information on different methods of quitting	89
Use of CO monitor	85
Advice/signposting to clients about other smoking cessation services in the area	67
N	120

Nicotine therapy offered to clients

- 5.8 Eighty three per cent of all community pharmacy staff reported that clients were given a choice of which type of smoking cessation therapy they were given, 16% sometimes gave clients a choice of therapies and 1% never gave clients a choice.
- 5.9 A range of NRT and other products were offered to clients to help in their quit attempt. Ninety nine per cent of community pharmacists offered nicotine patches, 98% nicotine inhalers, 96% offered nicotine gum, and 89% offered nicotine lozenges. Only 62% offered nicotine nasal spray. A total of 15% of respondents reported that they offered other products including microtabs, mints and sublingual tablets. Several respondents were independent prescribers and reported that they prescribed varenicline¹⁷.

¹⁷ Currently varenicline is prescribed outwith the PHS service through a pharmacist led prescribing clinic or through a local arrangement with the Board

Arrangements for consultations and follow up

- 5.10 The majority of community pharmacists said that they saw smoking cessation clients on demand (Table 10). Just under a third (32%) of respondents said they offered an on demand and appointment service. A small number of community pharmacists saw clients on an appointment only basis. This was the case for both the first and follow-up visits.

Table 10 – Pattern of consultation arrangements

	First visit	Follow-up visits
	%	%
Clients seen on demand	60	69
Offered mixture of on demand and appointments	32	26
Clients seen by appointment only	8	5
N	120	120

- 5.11 Few community pharmacists estimated that more than 75% of clients returned for their second or third visit. There was a further drop off in the numbers returning for a third visit (Table 11).

Table 11 – Estimate of clients returning for a second and third visit

Estimate of clients returning for subsequent visits	Second Visit	Third visit
	%	%
More than 75%	10	2
Between 50-74%	39	18
Between 25-49%	30	33
Less than 25%	14	40
Could not give an estimate	7	7
N	120	120

- 5.12 Community pharmacists were asked to estimate what proportion of returning clients they thought had made a serious attempt to quit. Two thirds of community pharmacists estimated that more than 50% of clients had made a serious attempt by the time of their second visit (Table 12). In addition, 95% of those who responded saw clients who had made several quit attempts.

Table 12 – Estimate of serious quit attempts

Clients making serious attempt to quit	Second Visit
	%
More than 50%	66
Between 25-49%	20
Less than 25%	9
Can't say	5
N	118

- 5.13 As part of the PHS clients should be followed up by:

- the pharmacist or support staff if they do not present for an appointment
- the NHS Board at 12 weeks and 12 months after the quit date to assess progress with their quit attempt (for those who have attended all appointments)

and to ascertain their smoking status). If agreed locally, the pharmacist may carry out the 12 week follow-up and the results are sent to the NHS Board.

- 5.14 Both community pharmacy and NHS Board respondents were asked if there was any follow-up of clients who did not keep subsequent appointments. The majority of respondents in both groups reported that non-returners were followed-up (Table 13). A greater proportion of NHS Board staff than community pharmacy staff were aware that clients were followed up.

Table 13 – Awareness of follow-up of smoking cessation clients who did not return

	Community Pharmacy Staff	Health Board Staff
	%	%
Clients were followed-up	64	78
Clients were not followed-up	31	6
Did not know if clients were followed-up	5	16
N	120	50

- 5.15 Follow-up could take the form of telephone calls, texts, questionnaires, letters and sending stop smoking literature. In some cases NHS Boards contract out the follow-up service. Follow-up was seen as patchy by a few of the health board respondents due to the fact that some clients do not give consent to be contacted. In addition, resources were not always made available by Health Boards to follow-up clients.

“The worst part is going through the paperwork! Many clients have not given consent therefore are lost. Many clients have not completed course. Many clients have been followed up before their 4 week quit! The paperwork is so late being sent in that we are contacting clients who have already gone through other quit attempts and we have no idea which one they are on. If we cannot follow up clients by telephone we send them a letter.” HB 80

Effectiveness of the PHS Smoking Cessation Service

- 5.16 Both community pharmacy and NHS Board staff were asked how effective they thought the PHS service was in helping people to stop smoking. The majority of both groups felt the service was or ‘very effective’ or ‘quite effective’ (Table 14).

Table 14 – Effectiveness of PHS smoking cessation service

	Community pharmacy staff	NHS Board staff
	%	%
Very effective	27	20
Quite effective	62	61
Not very effective	10	12
Not at all effective	1	2
Can't say	0	6
N	120	51

- 5.17 There were a number of reasons as to why community pharmacy staff felt the service was effective. These are outlined below.

Ease of access

- 5.18 The ease of access to the service was the most frequent reason given for why community pharmacists felt the service was effective. A number of respondents mentioned that clients preferred the 'drop in' and 'on demand' nature of the service and that no appointment was needed.
- 5.19 The longer opening hours of pharmacies and pharmacies being open on Saturdays was also considered to be attractive to clients particularly those that worked or had other commitments and were unable to get to stop smoking clinics that were held at specific times.
- 5.20 Some respondents mentioned that clients were more likely to approach them for help to stop smoking than GPs as appointments were not necessary. Furthermore it was felt that some clients did not want to bother GPs but were happy to approach pharmacists for help.

"Personal and quick service which is adaptable to the patient's work and home life." [CP 38]

"They like the convenience of being able to come in at evenings and weekends." [CP 64]

"Very convenient for patient as a pharmacy easier to access than GP or specific stop smoking clinic." [CP 98]

Support

- 5.21 Some community pharmacy respondents mentioned that they were able to give more regular and face-to-face support (for up to 12 weeks) to clients than GPs.
- 5.22 The additional support from other pharmacy staff was also considered an important factor in helping people quit successfully. Some community pharmacists felt that some clients preferred this weekly individual support to group sessions. In some cases clients were encouraged to call in whenever they wanted and staff would give them encouragement and support which was particularly important when clients were having a 'bad day'. The rapport built up between client and staff was felt to be important in supporting quit attempts.

"Using motivational support by staff who are ex-smokers along with CO monitoring helps." [CP 38]

- 5.23 Some community pharmacy respondents felt they also offered a friendlier and less judgemental service than GPs and several commented that they had an

increasing number of clients who were referred to them by word of mouth and took this as evidence of a 'good/friendly/accessible' service.

- 5.24 It was also felt by some that quitting with a pharmacy enabled clients to have informal contact regarding progress with their quit attempt when they visited the pharmacy for other products or services:

"We encourage clients who have used the service to drop in to let us know, informally, how they are getting on. We get positive feedback from several people on a regular basis, and take the opportunity to reinforce how pleased we are with their success." [CP 113]

"Patients get regular individual support and are encouraged to return on a weekly basis. Previously they only saw the smoking cessation advisor once a month or received a prescription from the doctor for a month's supply." [CP 33]

Product/service features

- 5.25 Other features of the service offered by community pharmacists which respondents felt contributed to the effectiveness of the service were:

- the range of NRT products they were able to offer - one respondent felt that CPs had more up to date knowledge of the products available than GPs who tended to prescribe more traditional products.
- The service was low or no cost to patients.
- The use of CO monitors was a useful motivational tool.

Other comments on the effectiveness of the service

- 5.26 One respondent felt that most clients did quit even if they occasionally relapsed and others who did not quit were able to make 'a significant reduction in their smoking'.
- 5.27 Several community pharmacist respondents commented that other health professionals did not seem aware of the service or that community pharmacists can prescribe the NRT products under the Patient Group Directive (PGD).

Ineffectiveness of service

- 5.28 Lack of motivation by clients was the reason cited by many community pharmacy staff as the reason why they felt the service was not effective. They recognised that success in quitting smoking was almost entirely dependent on smokers' motivation to quit. There was a view held by some community pharmacy staff that some people did not want to use will power to stop smoking:

"A lot of people are not motivated enough they think that the medication is all they need to stop smoking" [CP121]

- 5.29 One respondent reported that the initial selection process focused on motivation to quit and they felt they had a 'good feel' as to whether an individual would be successful or not. If the motivation was questionable then the client was not enrolled in the service.
- 5.30 In the view of one respondent the provision of the service was 'very shaky' with large variations in the quality of provision between pharmacies. There was also concern expressed at the significant investment in the service despite the quit rates achieved.

Views of NHS Board staff on effectiveness of service

- 5.31 The reasons given by Board staff as to why they thought the service was effective were similar to those of community pharmacy staff i.e. the accessibility to clients and that it appealed to clients who did not want, or could not attend, stop smoking groups.

Strengths of the PHS Smoking Cessation Service

- 5.32 Many of the features of the service which community pharmacy staff and NHS Board staff felt worked well were very similar to the reasons given in the previous question as to why they felt the service was effective. These features included:

- Ease of access to the service
- Support from pharmacy staff
- One-to-one, flexible support
- Service free of charge to clients exempt from prescription charges and low cost to others and so avoiding high over the counter charges for products.

- 5.33 In addition to these strengths community pharmacy staff also reported that being able to supply more than one NRT product and being able to tailor these to people's needs was also a great advantage.

"Freedom to prescribe a wide variety of aids and the ability to combine if necessary more than one form of NRT." [CP 45]

"Multiple therapy has made a big difference to our ability to better manage patient's cravings and thus positively influence the outcome of quit attempts. [CP 56]

- 5.34 Other strengths of the service mentioned by pharmacy staff included:
- The recognition that remuneration gave to pharmacists for their work.
 - Improvement in the status of pharmacies within their communities and greater use of the abilities of pharmacists.
 - Staff satisfaction in helping someone to stop smoking.
 - Good training and good support from local Health Board.
 - Less rigidity in the regulations than when the service was introduced initially.
 - The weekly checklist to monitor progress or lack of progress.

- New, easy to follow MDS forms introduced (locally) in January 2011.
- Posters and cards advertising the service.

Areas where service works better

5.35 NHS Health Board staff were asked whether they thought the PHS smoking cessation service worked better in some areas rather than others for example in rural or urban areas. There was a mix of opinions. Many suggested that the motivation and skill of staff in providing the service was more important than the location.

“It works best where there are well trained and committed staff. Geography appears to have little to do with it.”[HB 33]

5.36 Others suggested that in smaller rural communities, pharmacy staff may be less busy and will be able to spend more time on face to face contact with potential quitters. However, several respondents said that uptake was more to do with volume of prescriptions i.e. uptake was higher in pharmacies with low prescription volumes and lower in pharmacies with high prescription volumes regardless of the location of the pharmacy.

5.37 The service was thought to be more important by some, in rural pharmacies where there was likely to be fewer smoking cessation services within easy reach and more problems with transport to travel to other services.

5.38 Some respondents felt that quit rates were better in more socially advantaged areas, although there was huge potential in more deprived areas where smoking rates were higher.

Continuing to offer the service

5.39 The majority of community pharmacy staff (88%), who responded, said that, given a choice, they would like to continue to offer the smoking cessation service, 4% would like to stop providing it and 8% were undecided.

5.40 Those who wanted to continue the service said this was because it was a valuable service appreciated by clients and easily accessible to them. Many respondents reported that they and the pharmacy staff involved found the work satisfying and professionally rewarding. However there was sometimes a downside to this when it was felt that clients did not attempt to quit. Several respondents also considered the service beneficial to the community and a good way to tackle a serious health issue. The service was also thought to be cost effective in comparison to other smoking cessation services.

“I enjoy offering the service and have had success with patients, who still come back to tell me how well they are doing which puts a smile on my face. One patient said I’d restored his faith in the NHS as the service was free (he was exempt from Rx charges)” [CP 20]

“Given the health implication for smokers and the prevalence of COPD in this area, smoking cessation is an essential service. I think the low quit rate is more to do with us having hard core smokers who have had a lifelong habit” [CP 120]

5.41 Workload was an issue for those who were undecided about continuing the service some felt there was little reward for all their hard work.

5.42 Those who said that did not want to continue to provide the service said this was because it did not seem to work, were uncertain if this was the best therapy and doubted whether people really did want to quit smoking. Others felt they were providing a service which GPs should be providing *‘for no reward or thanks whatsoever’*. One respondent wanted to end the service because:

“I feel that sometimes people need more support to help quit and maybe more interaction with other people attempting to quit.” [CP 28]

Links with other Local Smoking Cessation Services

5.43 Community pharmacists were asked a series of questions about how they worked with other smoking cessation services in their area. Just under half of the respondents (47%) reported that they had links with other smoking cessation providers in the area (Table 15). These included:

- links with other services using the pharmacy to provide specialist services
- links with independent prescribers who can prescribe varenicline
- links between different health professionals and the pharmacy service such as GPs, stop smoking nurses, midwives and the service
- sharing clients between pharmacies. Several respondents mentioned the role of coordinators to initiate these links.

Table 15 – Links and referrals to other smoking cessation services

Community pharmacists who	Yes	No	No other services in area	Not sure
	%	%	%	%
Link with providers in area*	47	42	2	10
Refer to other smoking cessation services**	71	25	0	3

Note: * N=120, **N=119

Referral to other smoking cessation services

5.44 The majority of community pharmacy respondents (71%) reported that they referred clients to other services (Table 15). The main reasons for referral were to provide group support for clients who needed this type of support, to provide additional prescribed medication not currently available via the

service, to provide treatment past the 12 week period, to refer people who did not meet the PHS service criteria, and to provide specialist support for complex cases. The services people were referred to included:

- GP services.
- Group therapies.
- One to one counselling.
- Specialist services for people with complex issues.
- Self help groups.

NHS Board staff views on integration of smoking cessation services

5.45 NHS Board respondents were asked more generally how well integrated were the smoking cessation services in their area. A majority of these respondents (61%) agreed that the PHS smoking cessation service integrated *very well*, *quite well* or *well* with other services while 29% did not agree. Ten per cent did not have a view on integration.

5.46 The reasons why it was felt the service integrated well were mainly to do with the commitment of NHS Boards and other organisations locally. For example:

“We have a referral mechanism into Fresh Airshire, our specialist service, for those requiring more intensive 1:1 or group support. This information is available to all pharmacies. Pharmacists also dispensed the vouchers used by Fresh Airshire for their clients, thus building up the local relationship. We also have a service in place to prescribe Varenicline (Champix) through a number of independent and supplementary pharmacist prescribers based in areas outlined by Fresh Airshire, usually deprived areas. We have had major success in quit rates from this service. Again it links the pharmacist and the specialist service. “[HB33]

5.47 The lack of referrals to other smoking cessation services was the main reason why some NHS Board staff felt that services were not well integrated. There were also some comments that pharmacists were not well represented at information evenings and training.

“Not many people say they come to the specialist service as a direct referral from a community pharmacy” [HB 6]

5.48 Other respondents reported that some pharmacies viewed the service as an income stream and did not want to refer people on as they would lose income. Other services were often seen as competitors rather than as providing a specialist service:

“Each service is paid separately Looking to maximise own income stream No incentive for joined up working” [HB 16]

5.49 One respondent, a smoking cessation specialist, felt very strongly that community pharmacists were presenting themselves as specialists but did not

have the training or knowledge required. They therefore did not know when it was appropriate to refer someone on to another service.

Data Collection

5.50 Community pharmacy staff are asked to collect a range of data as part of the smoking cessation service. A quarter of respondents (25%) said it was easy to collect and over half (55%) said it was quite easy to collect. These respondents reported that the forms used locally had recently been improved including improved layout. A fifth (20%) said data collection was difficult or very difficult. Suggested improvements to data collection included:

- Simplifying paperwork, reducing the number of forms to be completed and not duplicating information within and between forms.

“Is there a need to enter same date several times as referral date, initial appointment date, quit date, signing date are often the same in our situation.” [CP 76]

- Reducing the information required to be collected e.g. expiry dates of products, sensitive data such as social status and ethnicity.
- Collecting information electronically.
- Allowing pharmacists to keep the forms for 12 weeks so they can track patients rather than return them monthly.

5.51 Fifty six per cent of pharmacy staff who responded said the data collected was *quite useful* to them and 10% said it was *very useful*. A small number (14%) felt that the information could be made more useful to community pharmacies. Suggestions included:

- Providing feedback on our percentage quit rates and follow-up rates and comparing with regional and national averages.
- Adding more questions about lifestyle/health concerns/motivation.

The Scottish Government PHS Smoking Cessation Specification

5.52 Community pharmacy respondents were asked if they felt the smoking cessation specification was helpful. Of those who responded 29% felt it was *very helpful*, 56% said it was *quite helpful* and 4% had not read the specification.

5.53 Only 84% (42 respondents) of the NHS Board staff who responded to this question were familiar with the Scottish Government specification for the smoking cessation service.

5.54 Improvements to the specification included:

Data collection and payment

- Although a few community pharmacy respondents suggested linking pharmacy payment for providing the smoking cessation service to completion and return of minimum data set forms, this view was held more widely held amongst NHS Board staff.
- Respondents from both groups also suggested that electronic completion and return of forms would make the process easier and quicker.

The claims for payment and return of data need to be much more closely linked. This is vital for patient care and if Boards are to fully demonstrate their progress towards the HEAT target [HB 61]

Link the return of paperwork at week 4 to payment directly, rather than pharmacy claiming to Scot Govt and the MDS forms going for local compilation and inputting. Electronic completion and transmission of MDS would be a great help. [HB 19]

- There were also suggestions from NHS Board staff that payment should be linked to results for example that payments should be made for providing the service, for the number of clients receiving the service and the number of clients who remain quit after a year. Others suggested that there should be incentives to keep people engaged with the service for the full 12 weeks.
- One community pharmacy respondent suggested that clients should pay a small charge for the service as an indicator of their motivation to quit.

Changes to the service provided

- One respondent suggested introducing a week zero in which patients were given time to think about their quit attempt and could return a week later to sign up to the service. The respondent felt that this approach worked well in their pharmacy and did not deter those who were serious about quitting.
- There were several suggestions about people making another quit attempt. One respondent wanted to reduce the length of time clients have to wait before they try again. Another suggested an additional attempt could not be made until a certain time had elapsed. There was no suggestion as to what this length of time should be.
- There were several suggestions by community pharmacy respondents on ways that they could reduce their time commitment to providing the service, these included: more emphasis on pharmacy staff providing the service rather than the pharmacist; ancillary staff completing the administration for the service and health boards being responsible for follow up rather than community pharmacies.

- One NHS Board respondent suggested that the service should be available during all contracted hours.

Quality of the service

- Quality of service and training of staff delivering the smoking cessation service were a concern for several NHS Board respondents. There were concerns that staff had not undertaken the necessary professional development e.g. the NHS National Education for Scotland (NES) pharmacy training or PATH (ASHScotland) training. It was felt that the quality of the service should be specified with minimum quality standards incorporated into the specification, which should also include advice about training.

There also should be a quality element built in to the service. The variation in quit rates seems to suggest uneven service provision. There should be a requirement to attend training if the quality of service (i.e. quit rates) indicate such. HB 11

Make training for at least one member of a pharmacy team mandatory and ensure all people effectively signpost. Better still unless there is good evidence that it works- scrap the scheme- it would help local services and they are the experts in the field. HB 39

- A small number of NHS Board respondents felt that the PHS service was not a specialist Stop Smoking Service and should not be referred to as such. They also felt that unless PHS smoking cessation worked as well as other specialist services it should be scrapped and potential quitters referred to specialist services by pharmacies with a small referral fee as this would give them the best chance of quitting. Some suggested that referral criteria should be specified.

Widen the scope and flexibility in the service

- Three community pharmacy respondents wanted to be able to supply Champix or varenicline as part of the service and some NHS Board respondents suggested that pharmacotherapy beyond NRT should be included.
- Allowing leeway on the 12 week timeline for the supply of medication for those patients who had difficulties coming off treatment.
- Taking on patients who have already quit smoking at another service e.g. those who attended a group for 1 or 2 weeks but wish to continue their quit at a pharmacy.

Additional conditions of service such as:

- That the services will be available during all contracted hours.
- Making CO monitoring mandatory.

Training and Support

Support from NHS Boards

5.55 Community pharmacy staff was asked if they felt supported by their NHS Board in the delivery of the smoking cessation service. Of those who responded 86% felt supported while 14% did not. Support on offer from the NHS Boards included:

- Advising and helping with completion of forms
- Providing training, support materials and updates on changes to service.
- Service coordinators who were accessible and helpful.
- Setting up networks of support with specialist support.
- Visits to pharmacies to offer support.

5.56 A number of reasons were given as to why some community pharmacies did not feel supported by their NHS Board. For several respondents their complaints centred on a lack of communication, for example, local GP services being unaware of what pharmacies can offer while pharmacies are asked to publicise GP smoking cessation services.

5.57 Some felt there was poor understanding about pharmacists' workload and how the smoking cessation service fitted into their day.

5.58 It was also felt by some community pharmacists that the Health Board were only interested in the paper work and phoning the pharmacy if their success rate was not high enough.

5.59 Other issues raised were

- Lack of funds to maintain and support use of CO monitors.
- Problems with providing face-to-face training in remote and rural areas.
- Too many changes to forms.

Training

5.60 Community pharmacy staff were asked about what training they had undertaken to help them deliver smoking cessation advice. Almost three quarters had undertaken 'brief intervention' training provided by their local NHS Board and over a half had undertaken in-depth training from the same source (Table 16). Distance learning packs provided by NHS NES were used by over two thirds of respondents. Few had made use of the ASH Partnership Action on Tobacco and Health (PATH) training. One respondent having received the brief intervention training and none reported using the PATH/ASH in-depth training.

Table 16 – Training in smoking cessation

Training received	
	%
Local NHS Board training - brief intervention	73
NES distance learning pack	68
Local NHS Board training - in-depth advice training	53
NES local training course	31
Path/ASH Scotland training – ‘Raising the issue of smoking’	3
Path/ASH Scotland training – brief intervention	2
Other training	10
No training	1
N	120

- 5.61 Other training mentioned included pharmacy champion/ smoking co-ordinator training, training on specific groups such as young people. Some had attended manufacturers’ training events and others reported that they had read journals. One respondent had not received any training.
- 5.62 Fifty eight per cent found the training they had received very useful and a further 38% quite useful, the remainder, 4%, felt that the training they had received was not very useful.
- 5.63 Suggestions for revising or further training included:
- Adding more information on how to tailor support for different types of smoker and situations e.g. tips on dealing with difficult smoking cessation clients and ; chain smokers versus occasional smokers,
 - Providing training on specific methods e.g. Neural Linguistic Programming, aversion therapy, motivational training (to be mandatory) and brief interventions.
 - Training around the client journey and on patient experience.
 - Providing training jointly with frontline pharmacists.
 - NES training for pharmacy assistants and funding to allow staff to attend training.
 - More information being provided about paper work and claim process.
 - Providing training on new products and multiple therapy approaches.
 - Shorter more concise training.
 - Providing a national NHS Board helpline or contact person if there are any questions post training.

- 5.64 Board staff were asked what support they gave to community pharmacies to help them with training. Almost all provided training events and provided information on accessing specialist services (Table 17).
- 5.65 ‘Other’ forms of support for training included posters, newspapers, toolkits, websites including NES¹⁸ online training, use of pharmacy champions and pharmacy facilitators, visits to pharmacies, direct contact with pharmacists, and support with CO monitors.

Table 17 – Support offered by NHS Boards for training

Support offered	
	%
Training events	92
Information on accessing specialised services	82
Information leaflets	76
Other support	28
No support offered	6
N	50

- 5.66 Other comments from NHS Board staff around training included the need to: train counter assistants; provide refresher training; have training budgets; provide locum cover for pharmacists so they can attend training; and making training compulsory. Ongoing issues around training included: the difficulties of providing training across large areas of the country; the fact pharmacy staff don’t have much time to attend training; and the problems of high staff turn over in pharmacies making training difficult.
- 5.67 Other advice and support offered by NHS Boards to community pharmacies on smoking cessation included:
- Funding sessional pharmacists or public health facilitators to mentor those pharmacies that did not have a particularly high throughput.
 - Targeting pharmacies which were returning poor quality data or no data.
 - Provision of training within pharmacies for support staff.
 - Providing calibration or repair of CO monitors.
 - Incentive schemes for additional payments if targets are exceeded.
 - Offering access to training on the provision of varenicline to pharmacists as part of the PHS service.

Governance and Quality Assurance Arrangements

- 5.68 NHS Board staff were asked about what sort of governance arrangements were in place for the PHS smoking cessation service. Analysis of the minimum data set was the governance arrangement most likely to be in place followed by quality improvement programmes such as training and monitoring of the service (Table 18). Seven respondents did not know what governance

¹⁸ NHS Education Scotland.

arrangements there were and another 2 respondents thought governance arrangements should be in place at a national level, as it was a national programme. These respondents reported that they had not been aware that local governance was expected.

Table 18 – Governance of PHS smoking cessation

Arrangements in place	
	%
Analysis of minimum data set	84
Development of quality improvement programmes for service	65
Procedures to identify and remedy poor performance	55
Clear lines of responsibility and accountability	45
Processes for managing risk	27
Unaware local governance was expected	4
Don't know	14
N	49

5.69 NHS Board staff listed the following local quality assurance activities:

- Regular visits to pharmacies.
- Employment of sessional pharmacy mentors and pharmacy practitioner champions.
- Providing annual update sessions, pharmacy specific smoking cessation packs and guidance and local toolkits.
- Monitoring levels of unallocated CPUS forms, completion of NES Smoking Cessation training, use of CO monitors, complaints and concerns.
- Providing feedback to pharmacies on performance compared to others in the CHP.
- Monitoring return of minimum data set forms against payment and highlighting discrepancies to relevant pharmacies and offering them support.
- Monitoring quit rates and conducting three month follow up of clients

5.70 Several NHS Board staff highlighted difficulties with providing local quality assurance as this is not explored adequately within the service specification. For example:

“No quality assurance in place, its not about quality its about getting paid for a service, quality is not part of that service.” [HB 21]

“We try to ensure a quality service where possible by identifying poor performance but there is no potential course of action within the specification to allow serious action to be taken.” [HB 33]”

“The arrangements suggested in the contract are weak and it's not clear who can hold pharmacies to account.” [HB 12]

- 5.71 In terms of arrangements for dealing with problems or complaints many NHS Board staff reported that the NHS Complaints Procedure was used. Some had specialist routes for complaints through pharmacy leads or other pharmacy/ medicine teams or units. Some respondents mentioned that they were considering withholding payment to pharmacies who did not complete paperwork satisfactorily.

Improving the PHS Smoking Cessation Service

- 5.72 Both community pharmacy and NHS Board staff suggested a number of improvements which could be made to the smoking cessation service. Many of these have already been covered in previous sections on the specification and training. The main areas for improvement mentioned included:

Paperwork and administration

- 5.73 There was a widespread view amongst community pharmacists that there should be less and simpler paperwork associated with the service. Many also suggested that data should be collected electronically and that something similar to the electronic minor ailment prescription forms could be used.
- 5.74 Many NHS Board staff also felt there was too much paperwork associated with the service and that it was unnecessarily complicated – easier paperwork would allow more timely completion and better tracking of outcomes for individuals. However, many of this group also commented that the paperwork was poorly or not completed and would like to see payment linked to timely and better quality completion of the MDS form and in the view of a few, linked to success rates.

*“Paperwork is time consuming, cumbersome and is either not completed at all or completed and not submitted. Pharmacy staff not checking patient status each month - in-pharmacy processes poor
Confusion over Annex E claims leads to potential overpayments.”
[HB23]*

“The submission to minimum dataset forms requires to be linked to payment somehow for this work.” [HB 32]

- 5.75 There was a suggestion that more detail should be included in the service specification to allow NHS Boards to hold pharmacies to account. For example:

“Having payment claims detached from the return of patient information (MDS) has caused Boards endless problems. The specification also allows little recourse to address this situation. It is too vague.” [HB 33]

Changes to the service

- 5.76 Many community pharmacy respondents wanted to be able to provide a greater range of products as part of the service. Varenicline (Champix) in particular was mentioned and it was suggested this could be supplied through a PGD. There was also some support for this from Health Board staff with one suggesting this could be supplied to those who have failed to quit with NRT. One community pharmacy respondent wanted NRT products to be limited to patches.
- 5.77 There was a suggestion by a few community pharmacy respondents that clients should be charged for the service. It was felt that this would not be a deterrent to using the service if clients were motivated to quit.
- 5.78 One respondent wanted some flexibility in the period that patients could receive the service so that they could be 'weaned off' over a longer period if required while another respondent felt that patients should be weaned off the service by steadily reducing the frequency of visits. There was some support from Health Board staff for more flexibility in the service to '*facilitate the patient's journey*' as clients would otherwise end up going back to GPs for continuation of supply of NRT for example community pharmacists wanted some discretion in not having to ask clients to leave the scheme if they admit they have smoked or provide a high CO reading when their progress has been good.
- 5.79 In contrast, some community pharmacy respondents wanted there to be a minimum period of time between one attempt and the next one – it was felt allowing quit attempts in quick succession reduced people's motivation to quit.

Payment

- 5.80 Some community pharmacists suggested that funding should be made available to allow them to employ a second pharmacist to allow them to undertake all the tasks they are being asked to do in addition to '*the efficient and professional running of our pharmacies*'.

'Consultation time needs to be reimbursed at a better rate than the allowance given. Some follow-ups can be 20 minutes long'. [CP 35]

- 5.81 Some NHS Board respondents felt that there should be sufficient staff to effectively provide and deliver the smoking cessation service but they did not suggest additional payment for this. There was a suggestion by one NHS Board respondent that an appropriate payment should be given for the initial contact session which could take up to 45 minutes if explanations and motivational counselling were given.

Advertising and information

- 5.82 It was widely felt among community pharmacy respondents that continual advertising of the service at a national level and more information on what clients could expect from the service was required e.g. that clients sometimes can't be seen on demand if the pharmacy is busy.

Training, support and recognition for staff

- 5.83 Although some community pharmacy respondents felt more training was required e.g. motivational training, the view that more training was required was more prevalent amongst Board staff and much more strongly expressed:

There should be mandatory training to deliver smoking cessation support. [HB 57]

"Stop using staff with no stop smoking training" [HB 21]

- 5.84 Some respondents felt that there was a lack of knowledge of NRT, cessation support and little use of CO monitors by those providing the smoking cessation support. In addition, there was no requirement to take up Health Board offers of training and information.

Support for clients

- 5.85 There was a view that only those pharmacies that have the time and skills to provide the service should do so. Several NHS Board respondents felt that some pharmacies were too busy dispensing prescriptions to give the time needed to give a quality service to smoking cessation clients.

"Spend more time with clients. Clients often report that they just get their product and very little support within some pharmacies." [HB 38]]

Better signposting and referral

- 5.86 Greater integration with other smoking cessation services and signposting for clients to the most appropriate support, particularly if they have had several unsuccessful attempts with a pharmacy. One community pharmacist suggested giving pharmacists incentives for referring appropriate clients to specialist services. Another suggested providing the smoking cessation service in health centres.
- 5.87 However, there were mixed views amongst community pharmacists about the role of GPs and other health professionals. Some respondents felt GPs should be encouraged to refer patients to them but not, in the view of another respondent, before the clients were ready to quit. Another felt that clients should be referred to GP if they failed to quit after two attempts.

Summary

- 5.88 The views of the community pharmacy staff on the smoking cessation service were in the main positive. Many felt that that the smoking cessation service offered a valuable way for people to attempt to quit smoking and providing the PHS smoking cessation service led to real job satisfaction. However a small number of community pharmacy staff felt that the service would be better provided by others.
- 5.89 The main concerns about the service were the paper work, workload and support needed to provide the service. Many of community pharmacy staff felt that the scope of the service should be extended in terms of the products that are available, to offer support to help reduce smoking not just quit, and to provide support for longer than 12 weeks. Some also felt that there were issues with clients, who were not motivated to quit, accessing the service and that a small charge might avoid this problem.
- 5.90 Overall NHS Board staff had mixed opinions about the PHS smoking cessation service. Some staff felt that the smoking cessation service allowed more people to access NRT and that locally the service successfully complemented other more intensive smoking cessation services. Others felt that pharmacies did not have the time, training or skill to offer the support needed for supporting smoking cessation. Some commented that the paperwork for the service was onerous but many suggested that payment should be linked to the completion and return of paperwork. Several commented there was not enough evidence on successful quit rates for the service to be considered to be successful.

6 FINDINGS: USERS' VIEWS OF SMOKING CESSATION SERVICES PROVIDED IN COMMUNITY PHARMACIES

Introduction

- 6.1 This chapter presents the key findings from interviews with users of the PHS smoking cessation service undertaken by Ipsos Mori between February and April 2011. The sample was designed to obtain a range of views and experiences and was not intended to be representative of pharmacies and/or service users. The key findings from this work are presented here. The full report of this element of the study can be found at www.scotland.gov.uk/PHSsmokingcessationusersviews

Key findings

Accessibility of the Service

- 6.2 The most common way for participants to find out about the service was in the pharmacies themselves, either through advertising posters or discussion with pharmacy staff. Participants also became aware of the service through referrals by GPs and word of mouth.
- 6.3 The accessibility of the service was one of its key attractions for participants because of the flexibility and convenience it afforded them. They liked the fact that they could enrol in the service immediately and then 'pop in' each week at a time that suited them.
- 6.4 The availability of NRT products on prescription increased the appeal of the service because the cost of buying these had previously been a disincentive to using NRT for participants.

Satisfaction with the Service

- 6.5 Participants who took part in the research were overwhelmingly positive about the service and reported very high levels of satisfaction with almost all aspects. Service provision was broadly similar across most pharmacies, although there was some variation between those that were very busy and those that were less so.
- 6.6 Participants were particularly satisfied with the high levels of customer service provided to them by pharmacy staff. They described staff in very positive terms and particularly liked their friendly and informal approach.
- 6.7 Participants also expressed satisfaction with the confidentiality and privacy of the service. They were aware that pharmacies had a responsibility to ensure their details would be kept confidential. Where consultation rooms were used to hold discussions, participants tended to like the privacy this afforded them. However, not all pharmacies used consultation rooms, which made participants uncomfortable because other customers could potentially see that they were receiving the service or hear what was being discussed.

- 6.8 Satisfaction with the advice and information offered to participants was relatively high. However, there was some variation in the nature and extent of provision and some found the advice more useful than others. Few participants were given information about the health benefits of stopping smoking or the affect on their overall fitness. Others did not receive, or could not remember receiving, any information, advice or tips.
- 6.9 The choice of NRT products available and the ability to combine products was one of the main attractions of the service. Participants were given information about each of the products and decisions on which to use were made jointly between them and the pharmacist. This added to the flexibility and personalised nature of the service.
- 6.10 Participants were generally happy about the duration of the programme, although some felt that 12 weeks was not long enough to kick a lifelong habit. Regardless of whether or not they felt 12 weeks was long enough, participants said they would have liked the opportunity to attend a follow-up appointment or receive additional support if required.
- 6.11 Almost all participants said that they would recommend the service to other people who wanted to quit smoking and many had already done so.

Effectiveness of the Service

- 6.12 A number of aspects of the service appeared to have an impact on its effectiveness, including the interaction with staff, the personalised and flexible service offered, the availability of NRT products on prescription and carbon monoxide testing.
- 6.13 The interaction with pharmacy staff and their availability on visits was important because it allowed participants to build relationships with staff. This provided a great deal of motivation to participants because they did not want to let staff down, while the encouragement and genuine interest they received from staff helped to motivate them further.
- 6.14 The availability of NRT products on prescription allowed participants to access products they may not have considered before and also provided them with the opportunity to use more than one product at a time. The perceived high cost of buying NRT products had previously been a disincentive to using NRT for participants.
- 6.15 Carbon monoxide (CO) testing provided participants with additional motivation by allowing them to prove to pharmacy staff that they had not smoked. It also gave them a tangible measure of progress because they were able to see how much CO was leaving their system as a result of not smoking.

Recommendations for Service Development

- Many aspects of the service appear to be working well and should be continued. However, the research also identified some areas for improvement:

- Advertising of the service should be focused on the key aspects of the service to highlight the benefits. This should focus on the aspects that people do not expect from the service, such as its convenience and flexibility, the support, encouragement and advice provided by pharmacy staff and the provision of NRT on prescription.
- Pharmacies should try to ensure continuity in the member of staff users' are seen by, particularly in busier pharmacies. This would enable service users to build up relationships with staff, which would result in them feeling more supported and encouraged.
- At the end of the 12 weeks, pharmacies should develop a follow-up support plan with users to check their progress and to provide additional support if they need it. This would be tailored to suit the needs of the service user based on their past quit attempt experiences, their progress since enrolling in the pharmacy service and what they think might help them in the period after they finish.
- Users who fail in their quit attempt should be allowed to re-enrol in the service straightaway to allow them to continue in their quit attempt. However, pharmacists should retain some discretion to prevent abuse of the system.
- There should be increased link-up between smoking cessation services provided by pharmacies and other support services, such as *Smokeline* and specialist NHS services. Pharmacy staff should play a more active role in encouraging uptake of these services, which would help service users who are struggling with cravings or going through a particularly stressful period.
- In addition, pharmacy staff could provide more information to service users about specific health benefits of stopping smoking, such as reducing their risk of cancer and other diseases and the likely impact on their overall fitness. Staff could also provide advice on how to deal with side effects, such as weight gain.
- Any perceptions that the service lacks privacy may discourage some people from using the service or being open and honest about how they are progressing. Pharmacies should try to use consultation rooms where possible to ensure discussions are confidential.
- Pharmacies should also be encouraged to have CO testing machines available – and try to ensure that they are maintained and working at all times.

Summary

- 6.16 Overall, smoking cessation services provided by community pharmacies were viewed very positively by service users. The accessibility and flexibility of the service, the personalised service provided by pharmacy staff and the provision of NRT products on prescription were found to be particularly important in shaping user satisfaction.

7 FINDINGS - PHS EMERGENCY HORMONAL CONTRACEPTIVE SERVICE (EHC): RESULTS FROM ANALYSIS OF ROUTINE DATA

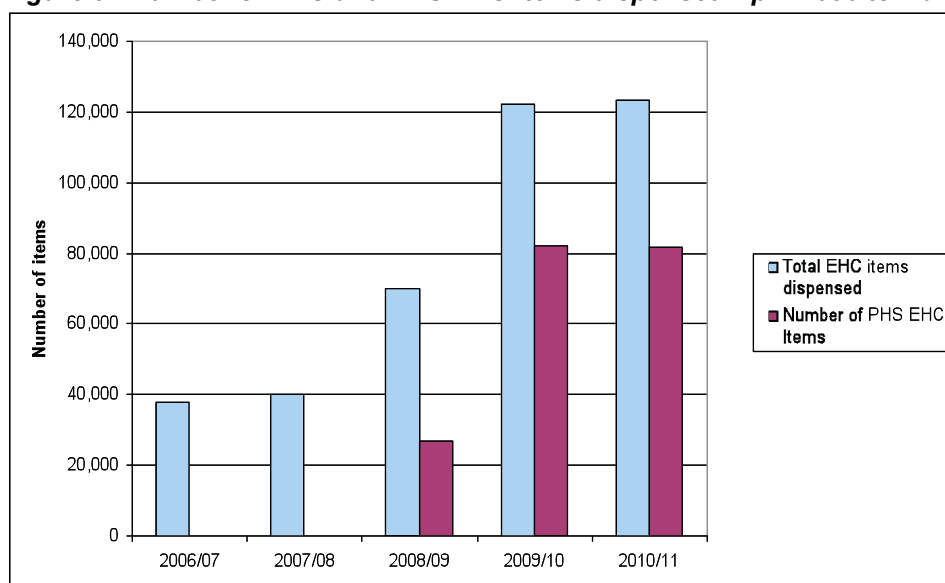
Introduction

7.1 The chapter present results around the PHS Emergency Hormonal Contraception Service (EHC), first for routine data and then for the results of the surveys of pharmacists and NHS Board staff.

Number of EHC Items Dispensed

7.2 By 2010/11 the PHS EHC service was dispensing just over 81,000 items in a year (see Fig 5), this was 66% of the emergency hormonal contraception items dispensed in Scotland using a prescription. As this graph does not include EHC given out at sexual health clinics it is not possible to ascertain whether the service has increased the amount of EHC accessed in Scotland, or whether there has been a transfer of clients to the PHS service from other parts of the NHS. Since 2009/10 however, the amount of EHC dispensed by the PHS EHC service has remained relative constant at about 7,000 items per month. The PHS service can therefore be seen as improving access to EHC and complementing the service provided by sexual health services in Scotland who also provide EHC but without a prescription.

Figure 5 - Number of EHC and PHS EHC items dispensed April 2006 to March 2011



Source: Prescribing Information System, ISD Scotland.

Note: Includes all items dispensed using a prescription pad but excludes items given out by sexual health services without a prescription. Data for 2008/09 is for the 8 months that the service was operating.

Number of EHC Claims

7.3 Within the PHS EHC service, there were just over 70,000 patient claims recorded between July 2010 and June 2011. Although the period for this patient claims data is different from the period for the data on the number of

dispensed items, the data would suggest that there is a discrepancy between the number of items dispensed and the number of claims being made. ISD investigated the discrepancy for 2009/10 using a small number of contractors in the Western Isles. This area was chosen as it has the smallest number of pharmacies participating in the PHS and therefore made the investigation manageable. Caution should however be applied and more work is needed on this discrepancy to check if other areas of Scotland are experiencing similar issues. The investigation revealed that:

- On occasion a claim for a patient has been made when there is no corresponding prescription; and
- On multiple occasions a prescription has been dispensed, but no claim for a patient.

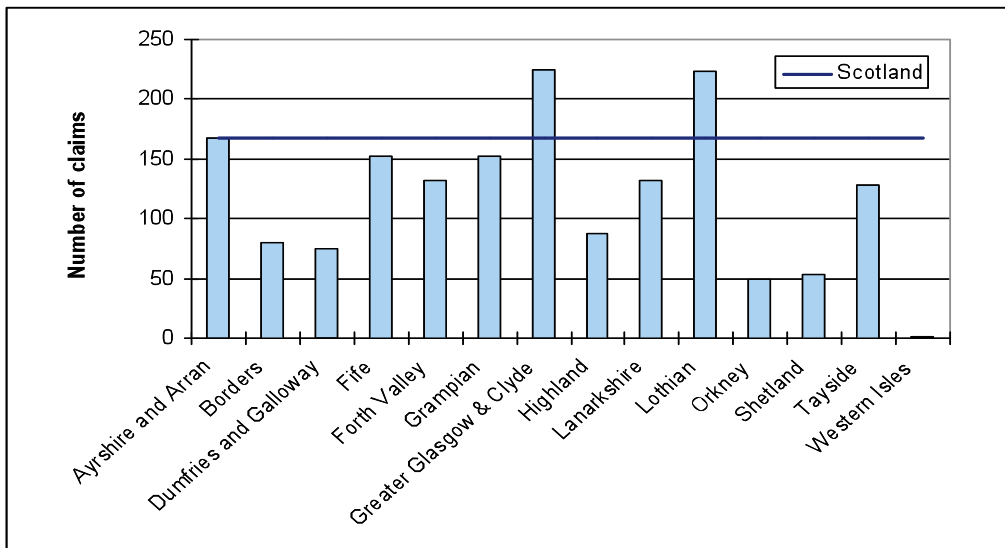
Other potential reasons, for the discrepancy, might be:

- Late submissions of the prescriptions, but the patients are claimed within the correct month.
- Pharmacies completing paperwork incorrectly.
- Issues around the central scanning of forms and their reconciliation. In particular where the serial numbers of prescription forms are not recorded leading to discrepancies in the data e.g. where the data shows one patient and four EHC items but there have actually been four individual patients.

7.4 Some of these problems are currently being addressed e.g. the issue around central scanning and reconciliation, others would need to be further explored and rectified in light of the findings in this report.

7.5 Figure 6 shows the rate of patient claims recorded across Scotland for the PHS EHC service, between July 2010 and June 2011. The rate of claims was much higher in the largely urban areas of NHS Lothian and NHS Greater Glasgow and Clyde.

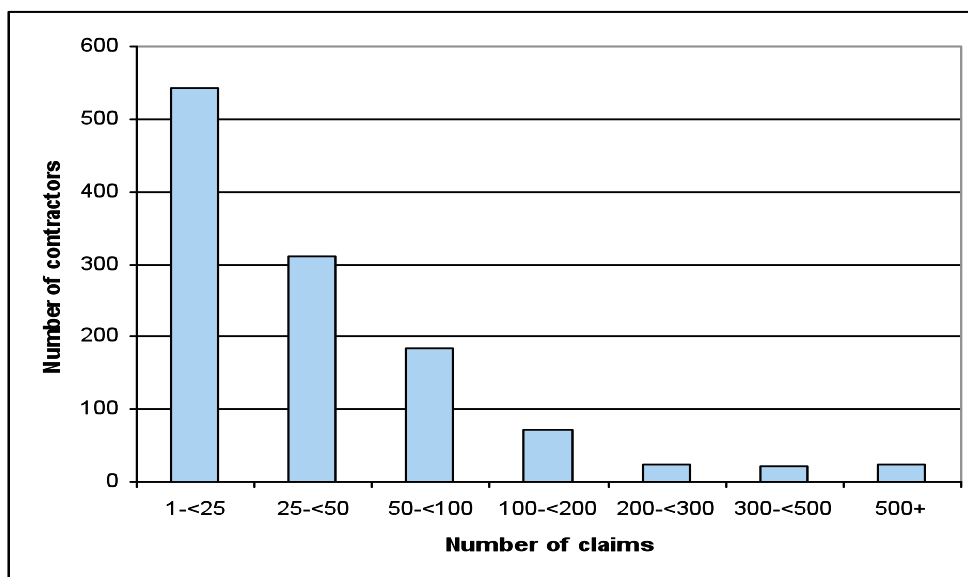
Figure 6 – Rate of EHC patient claims per 10,000 population by NHS Board July 2010 – June 2011



Source: Based on data from Prescribing Information System, ISD Scotland.

7.6 In 2010/11 there were 1,267 community pharmacies codes in operation in Scotland, 89 of which did not make claims as part of the EHC service between and July 2010 and June 2011. Almost a half of contractors had less than 25 EHC claims, as part of the PHS EHC service. A further 26% submitted between 25 and 50 claims for the year (see Figure 7). Two businesses, who made claims for over 500 items for the year were in NHS Ayrshire and Arran (660 claims) and NHS Fife (835 claims)

Figure 7- Number of contractors by number of EHC patient claims, July 2010 – June 2011



Source: Prescribing Information System, ISD Scotland.

Patient characteristics

- 7.7 Unlike the PHS smoking cessation service, data on the characteristics of women who use the EHC service is not routinely collected due to the sensitive and confidential nature of the service. Therefore an analysis cannot be undertaken of who uses the service from ISD data sources.

Evidence on service users' experiences of community pharmacy EHC services

- 7.8 Unlike the PHS smoking cessation review, the EHC review did not include research with service users. It was felt that interviewing users of the service would not be appropriate due to the issues around keeping client identity confidential and the sensitivities around the service for women. However there have been a number of published studies exploring the use and experience of community pharmacy-based EHC services.
- 7.9 In a systematic review of studies of users of Community Pharmacy PHS Services, Anderson 2004 suggested that EHC schemes have generally been well received (Anderson 2004). One EHC study found high levels of satisfaction among women using EHC service in south London (Lambeth, Lewisham and Southwark Health Action Zone 2002 cited in Anderson 2004). In a national survey of women receiving treatment on prescription, community pharmacies were rated highly as a place to obtain and discuss EHC (Pharmacy Alliance 2002 cited in Anderson C 2004). Reasons cited included the desire for anonymity.
- 7.10 Concerns of people using EHC services in the literature included: the open pharmacy environment; confidentiality; and what records would be kept afterwards on the supply of EHC (Anderson 1998). However Anderson's 2004 systematic review suggested that pharmacies are perceived by women to be suitable places to obtain and discuss EHC. The review concluded that many women find it acceptable to discuss this sensitive subject in community pharmacies.

8 THE VIEWS OF NHS BOARD AND COMMUNITY PHARMACY STAFF ON THE PHS EMERGENCY HORMONAL CONTRACEPTION (EHC) SERVICE

Introduction

- 8.1 Thirty one NHS Board staff and 118 community pharmacy staff (from 13 NHS Boards) gave their views on the PHS EHC service via two separate online questionnaires. The questions used in the survey can be found in Appendix A.
- 8.2 This section of the report summarises the findings of these two surveys. Community pharmacy staff were asked how clients found out about the service; returning clients; what consultations covered; who was involved in providing the service; effectiveness; possible improvements; data collection; support; links with other services; the Scottish Government specification; training; governance; and quality assurance.
- 8.3 NHS Board staff were asked whether they thought the service was effective about the support they offered community pharmacies in delivering the service, whether the service integrated with other services providing contraception services, what data was used to monitor the service, what governance and quality assurance measures were in place.

The EHC Service

How clients find out about the EHC service

- 8.4 People were more likely to find out about the EHC from 'other health professionals' (Table 19). The 'other ways' mentioned as to how clients found out about the service included, NHS 24, friends and family, school or college, TV and press advertising.

Table 19 - How clients find out about the PHS EHC service

	%
From other health professionals working in the area	64
From health promotion materials in the pharmacy e.g. posters or leaflets	54
From pharmacy staff	53
Other ways	22
Don't know	13
N	118

Returning clients

- 8.5 Community pharmacists were asked whether they saw the same people returning for the service. Ten per cent said they did see the same people returning for the service and over half (53%) said they sometimes saw the same people returning for the service (Table 20). Note: pharmacists were only asked whether in their view the same people returned for the service, not how often they returned.

Table 20 – Clients returning to the EHC service

Do you see the same clients returning:	
	%
Yes, see the same people returning	10
Sometimes	53
Rarely	31
Never	4
Can't say	2
N	118

- 8.6 When people did return, 98% of the community pharmacy staff (107 respondents) offered further support at least sometimes in relation to contraception. Only 3 respondents said they did not offer any further support.
- 8.7 The type of support given included: suggesting or referring for an appointment to see their GP or family planning clinic about contraception; discussion on sexually transmitted infections; giving them information on pharmacy contraception; liaising with district nursing; providing leaflets on contraception options and services not available at the pharmacy; or offering free condoms where this service is provided. Additional support was seen as particularly important for young people who were still learning about contraception methods.
- 8.8 Those who did not offer further support for returning clients felt it was not their place to do this. In some cases returners had drug addiction issues and in others the person had experienced a contraception failure e.g. a split condom and further support was not needed.

What the service and consultations covered

- 8.9 Ninety three per cent of the community pharmacy staff who responded said the consultation included advice on other contraception services in the area, 86% said that the service included information on different methods of contraception, and 77% said it covered advice on longer acting reversible contraception (LARC).

Who was involved in providing the service?

- 8.10 All the community pharmacy staff who responded (100%) said that pharmacists were involved in delivering the EHC service. Pharmacy technicians (4%), counter staff (3%) and pre-registration pharmacists (3%) were also involved in providing the service under supervision.

Offering the service

- 8.11 Ninety seven per cent of community pharmacy staff who responded wanted to continue to offer the service, 1% did not want to continue and 2% were undecided.
- 8.12 The reasons given for wanting to provide the service included:

- that it was a valuable service, particularly out of GP hours and was appreciated by clients;
 - it prevented unwanted pregnancies, particularly in young girls;
 - it allowed people to access the service at no cost;
 - it provided an opportunity to discuss contraception in a relaxed atmosphere;
 - it improved pharmacies' status in their local communities and enabled pharmacists to use a wider range of their skills;
 - the financial incentive
 - the service was cost effective.
- 8.13 Those who did not want to continue or were undecided about continuing to provide the service, said this was because the service was time consuming or was not appropriate.
- 8.14 Two respondents who did provide the service reported that they did not like providing it particularly to 'minors' as they felt they may be encouraging under age sex.

Effectiveness of the PHS EHC Service

- 8.15 The majority of NHS Board staff (81%) who responded thought the PHS EHC service was either '*very effective*' or '*effective*'. None of the respondents felt the service was '*not effective*' but 19% could not say if it was effective or not.
- 8.16 In general there was considerable agreement between community pharmacy staff and NHS Board staff in what they considered worked well regarding the service. The main reasons cited by both groups as to the reasons the PHS EHC service was effective were that:
- The service was available on the high street, easy to access with no appointment necessary and available in the evenings and at weekends.
 - It enabled women to get access to EHC and avoided the necessity of GP appointments.
 - It reduced the number of women falling outside the 72 hour window for treatment.
 - The service was free to clients.
- "The ability to use the PGD to supply Levonelle free of charge - cost would put some patients off."* [CP 87]
- The service was supportive, non judgemental, confidential and discrete and the visit was not recorded on their GP notes.

- Information on other forms of contraception and local services was available.
- Paperwork was easy to complete.
- The guidelines were helpful and clear.

8.17 These factors were summarised by two respondents:

“Accessibility beats all other services hands down. Much more attractive location for service user as more anonymous e.g. patients attend pharmacy for a wide range of reasons so no stigma. Privacy and confidentiality maintained. Patients are usually very honest with their information. Very professional service and surgeries refer patients as we will see them right away so improved treatment efficacy. The longer the patient waits to be seen, this increases the chance of treatment failure.” [HB 68]

“This service is free to women and we have enhanced it by also offering free condoms when they access EHC. Pharmacies offering this service do so in a supportive and non judgmental manner and offer them advice on more reliable contraception.” [HB 5]

Support and training

8.18 Information on accessing specialist advice or services, providing training events, and providing information leaflets were the most frequently mentioned ways that Health Board staff offered support to community pharmacies (Table 21). Other support offered included: PGD support; provision of condoms; child protection and support in determining capacity to consent; NES distance learning packs; and one to one support/ mentoring.

Table 21 – Support offered to pharmacies on EHC

Support offered:	
	%
Provision of information on accessing specialist advice or services	87
Provision of training events	81
Provision of information leaflets	77
Other support	23
No support offered	3
N	50

8.19 Comments on the support provided include:

“We developed a pharmacy support pack that covered sexual health initiatives including the EHC, some child protection issues and the provision of condoms. Pharmacies were given training on the application of this pack.” [HB 5]

“We run support sessions once or twice a year with specialists from the sexual health services updating on new developments and providing an opportunity for pharmacists to share best practice and discuss ethical dilemmas.” [HB 32]

8.20 Suggestions made by NHS Board staff on support included:

- A new governance framework for the service should be developed in consultation with NHS Boards.
- It should be made clear that it was the contractors’ responsibility to keep their staff up-to-date around training and the service, this was seen as particularly important where there was high staff turnover.
- Helpful to integrate pharmacy services with specialist sexual health services.

8.21 Some (40%) NHS Board staff also offered additional support. This additional support was mainly provided by telephone or email and covered issues such as child protection and PGD’s.

8.22 In the view of community pharmacy staff, over four fifths (82%) felt supported by their NHS Board in delivering the EHC service. Respondents felt supported through the training they had received, the clear guidelines NHS Board’s provided, the support given by family planning and NHS Board Pharmacists and Medicines units, the ease of referral, the support given around child protection and help received with filling in forms. In some cases, NHS Boards provided help via the telephone.

8.23 Those who did not feel supported (18%), said this was because of poor communication, the wrong forms being sent to them, lack of leaflets, lack of an EHC coordinator, and some had had no contact with the NHS Board.

“There doesn’t seem to be a co-ordinator as in the Smoking Cessation service, whom you can access freely if you encounter an issue.” [CP 46]

8.24 Some respondents did not feel they needed any support and others said they were not aware of any support offered by their Health Board. One respondent commented:

Don’t think they ever asked the question if pharmacists were happy to supply EHC to under 16s. [CP 90]

Training

8.25 The majority of respondents had received local NHS Board training (75%), or had used the NES distance learning training pack (72%). Over a half (52%) had received child protection training (Table 22). Other training mentioned included manufacturer’s training, family planning training or in house training by another pharmacist.

Table 22 – Source of training undertaken

Training source:	%
Local NHS Board training	75
NES distance learning training pack	72
Child protection training	52
NES training course	30
Other training	9
No training	1
N	118

8.26 More than two thirds (68%) said the training was *very useful* and 29% that it was *quite useful* while 3% said it was *not very useful*. The only improvements to the training suggested was to: include technicians and pre registration pharmacists in the training; provide annual refresher training; provide more on child protection and under 16's; update the NES training pack; do more around the PGD; and to include information on what to do about difficult client situations.

8.27 Other support community pharmacy respondents wanted following the training included:

- Providing a guide for pharmacies to keep in the pharmacy as a reference.
- Providing the opportunity for role play.
- Further support around child protection.

The Scottish Government PHS EHC Service Specification

8.28 Ninety four per cent of the Health Board staff were aware of the Scottish Government Service Specification for the EHC service, 6% were not. A total of 88% thought it was very or quite helpful (Table 23)

Table 23 – Usefulness of PHS service specification

The specification was considered:	%
Very helpful	35
Quite helpful	53
Not helpful	7
Not helpful at all	0
Haven't read the specification	5
N	116

8.29 Most respondents were happy with the specification and did not suggest any changes. Some respondents from both NHS Boards and community pharmacies however felt there was some room for improvement and suggested that:

- The religious exemption should be removed to avoid people in rural and remote areas having to drive long distances to access the service.
- All pharmacies should offer the service to under 16's.
- The service could be extended to include free condoms, other forms of contraception and pregnancy testing.
- That products that can be used for up to 5 days should be available (if alternatives such as IUD or ulipristal are not an option) e.g. ellaOne.

“Bring it into keeping with national guidance that Levonelle be given out until 120 hours as causes an inequity ... and also further delay” [HB 28].

- Pharmacy technicians should be able to provide some of the service where appropriate.
- Training should be specified more clearly in the specification.
- Clearer guidelines on audit should be included

Integration and Links with Other Services

8.30 NHS Board staff was asked how well they thought the PHS EHC service integrated with other services locally. Seventy three per cent of those who responded felt that the service integrated very well, quite well or well, 13% felt it did not integrate well and 13% could not comment.

8.31 Examples of good integration from the point of view of NHS Board staff included links with wider contraception services and free condom schemes. Several areas reported that local services referred to each other effectively and shared information materials. For example:

“See community pharmacy as a key element of how young people can access pregnancy testing, chlamydia testing and free condoms”. [HB 42]

8.32 Aspects where integration did not work so well from the point of view of NHS Board staff included difficulties in areas with dispensing GP practices and no easy access to pharmacies, integration with sexual health services, and linking with Chlamydia testing. For example:

“...tried to tie this into chlamydia testing, but that aspect of it wasn't welcome by the women”. [HB 5]

“Most of the activity generated for EHC is from a small number of city centre pharmacies. Very few clients are referred to specialist services for LARC or for STI screening”. [HB 53]

8.33 There was a suggestion by NHS Board staff that it would be helpful if appointments to family planning could be made by the pharmacy as part of

the EHC service. This was seen as particularly important for young people. However, where pharmacies had tried to help people access family planning there was some suggestion that it was difficult getting through on the phone/ contacting the appropriate services.

- 8.34 Community pharmacy staff were asked about their links with other local contraception services. Over a third of respondents (35%) had links with other services but the majority (54%) did not (Table 24). There was little further information as to the nature of these links.

Table 24 – Links and referrals to other services offering help with contraception

Community pharmacists who	Yes	No	No other services in area	Not sure
	%	%	%	%
Link with providers in area*	35	54	1	10
Refer to other services**	94	3	2	1

*N= 117

**N= 117

- 8.35 The vast majority of respondents reported that they referred clients to other services (Table 24). Clients were referred to GPs; family planning clinics; Genito-Urinary Medicine (GUM); minor injury clinics; Brook and the Caledonian Youth Service (providing support and advice on sexual health to young people); Wellwoman services; Sandyford (Sexual Health Services in NHS Greater Glasgow and Clyde) and Contraception and Sexual Health Clinics (CaSH). The reasons for referring were to provide long term support to clients around sexual health or contraception, for people who fall outside the service specification e.g. need an IUD or has had multiple use of Levonelle in cycle and for young people who need specialised help or advice.

EHC Data Collection

- 8.36 NHS Board staff were asked what data they used to monitor the uptake and costs of the EHC service. Some respondents received data from local data sources and others used centrally administered data such as PRISMs¹⁹. For example:

“Pharmacies provide us with uptake data, ages of women and payment requests. This gives us some usable data in terms of trends.”
[HB 5]

- 8.37 Suggestions for how data could be improved included:
- Collecting additional data such as age range, post code area and data on repeat requests
 - Providing trend data by day of the week, time of the day and across the year.

¹⁹Prescribing Information System for Scotland (PRISMS) — It is a web-based application, giving access to prescribing information for all prescriptions dispensed in the community for the past five years

- Enabling comparison of services e.g. national, CHPs, localities and pharmacies.
 - Recording information on cases where EHC was not dispensed.
- 8.38 Suggestions for how this data could be made available centred on more information being provided via PRISMs, using CHI etc, and using NASH.³⁴ There was a suggestion that if more data was available there would be scope for an annual audit which is needed for the PGD⁵ and a sexual health clinical indicator.

Governance and Quality Assurance Arrangements

- 8.39 The majority of NHS Board staff indicated that they had a variety of governance arrangements in place (Table 25). Most of those who said they had other governance arrangements in place, explained that they did not know much about them as these were not their responsibility e.g. they were the responsibility of the CHP.

Table 25– Governance arrangements for the PHS EHC service

Arrangement	%
Clear lines of accountability	66
Quality improvement programmes	62
Procedures in place to manage risk	45
Procedures in place to identify and remedy poor performance	35
Other governance arrangements in place	21
No arrangements in place	3
<i>N</i>	29

- 8.40 Some NHS Board staff who responded were not aware of any quality assurance arrangements being in place for the EHC service. Others however explained that pharmacies worked to a PGD which offered some quality assurance and that information on the use of the PGD was reported to Boards overseeing the service and in annual reports. About a quarter of respondents were planning audits, used mystery shoppers to check quality, looked at complaints data, identified poor performance from the available data, and where needed, offered support to poorly performing community pharmacies.
- 8.41 When it came to problems or complaints about the PHS EHC service most NHS Board respondents explained that complaints were dealt with through the NHS Complaints procedure. Some said that complaints would be flagged up to the pharmacy advisor or team. A small number said that complaints were dealt with locally by the pharmacy team. Several respondents reported that they had never had a complaint.

Improving the EHC Service

8.42 There were a wide range of suggestions for improving the EHC service. Some of these have already been mentioned in earlier sections of this chapter. Improvements suggested by NHS Board and community pharmacy staff included:

Staffing

- All pharmacies should provide the service and the religious exemption should be removed.
- Ensuring all locums should provide the service.
- Including provision for double cover in pharmacies with high numbers of requests for the service.

Extension of the service

- Consideration of off-label use for up to 5 days alternative such as ellaOne²⁰ within the service if an IUD²¹ or ulipristal are not an option.
- Provision of free condoms as part of the service.
- Including the option to provide regular contraception as part of the service.
- Provision of pregnancy testing and long term contraception follow-up appointments as part of the service.
- Access to the emergency care summary.
- Enabling direct referral to sexual health services particularly for multiple users with a small referral fee for pharmacists.

Guidance and support

- Improving the PGD.
- Developing better guidance and a detailed protocol around child protection.
- Providing regular refresher training or set protocols.
- Providing guidance on what to do if a client is registered with an English GP.
- More information should be given on issues around age of clients

²⁰ ellaOne is new form of emergency contraception which can be taken up to five days after sex. Before ellaOne was introduced in 2009, morning after pills only allowed women to prevent pregnancy within three days of having unprotected sex.

²¹ Intrauterine device which is a form of contraception which prevents a fertilised egg implanting.

Information and advertising

- Providing a larger range of contraception and service leaflets.
- Better advertising of the service and what it can offer and highlighting the confidential nature of the service.

Data collection

- Moving to electronic data collection like eMAS. This included giving community pharmacists access to the IT "Nash"²² to provide a more integrated recording of information.
- Undertaking better evaluation of the service, including mystery shopping.

8.43 Other comments made by community pharmacy staff included: that the NES training pack was quite old and could be refreshed; that community pharmacists would need different support and funding if the number of services they provided increased in the future; and that there might be a need to document more around the service to justify a particular decision if required.

Summary

8.44 Overall the PHS EHC seemed to be working well from the point of view of NHS Board and community pharmacy staff. In particular the community pharmacy staff who responded to the survey felt that the EHC service was a really valuable community service which needed very little adjustment. It was also clear that particularly in remote and rural locations the PHS EHC was the only easily accessible service available and fulfilled a crucial role.

8.45 There were however, some suggestions for improvement including the expansion of the service to include pregnancy testing, longer term contraception and new drugs which can be prescribed up to 5 days; removal of religious exemptions; the use of pharmacy technicians; integration with other services; data collection; and governance and quality assurance of the service.

²²NaSH – the NHSScotland National Sexual Health IT system project aims to provide a common IT system to support specialist sexual health services across NHSScotland

9 DISCUSSION AND CONCLUSIONS

Introduction

9.1 Over the last ten years there has been considerable interest and activity in the development of the role of the pharmacist in the promotion of healthy lifestyles. Internationally this has led to the development of a range of specialised, extended or enhanced pharmacy services relating to health care and promotion other than routine provision of prescribed and non-prescribed medicines. In Scotland a range of policy initiatives have been implemented to develop and promote extended health care roles for pharmacists in Scotland in line with developments across the UK. Against this backdrop, the Scottish Government and partners are currently reviewing the services provided under the PHS element of the community pharmacy contract. To inform the work, this evidence review was carried out to explore the operation of the smoking cessation and emergency hormonal contraception services. This chapter discusses some of the key findings to emerge from the review and highlights possible policy and delivery implications arising from findings.

Limitations of data

- 9.2 Whilst much was done to promote community pharmacist awareness of and participation in the online survey, the response was low. Although almost all territorial Health Boards and all types of pharmacy (ranging from multiples to single outlets) were represented amongst the respondents, it is difficult to know how representative the views expressed in the survey are of community pharmacists more generally. The data provided in this report must therefore be treated with caution.
- 9.3 Similarly, responses from a wide range of Health Board staff were obtained but again it is difficult to know how representative these views are of all the staff that might have responded.
- 9.4 However, having acknowledged the limitations of the surveys they do provide insights into the views of community pharmacy and health board staff with regard to these two PHS services. The analysis suggests that there are common themes to emerge from responses while in some cases clear differences in the views of the two groups.

Smoking Cessation

9.5 The evidence review found that overall the service appears to be working well. Service users who participated in the research were very positive about the service provided by community pharmacists; even those who were unsuccessful in their quit attempt were positive about the service. Responses from both NHS board and community pharmacy staff were in the main positive. However there were some elements of the service that were identified by both service users, community pharmacy and NHS board staff as requiring improvement or further development.

Access to and promotion of the service

- 9.6 The findings from the routine data collected on the number of smoking related items dispensed suggest that there has been an increase in the number of people using the smoking cessation service offered by pharmacists. While these figures suggested increased take-up of the service, the research with users highlighted some problems in promotion of the service.
- 9.7 Users of the service tended to 'stumble across' it if they happened to be visiting a pharmacy or they were recommended by family or friends. Many felt that the service was poorly advertised generally. Furthermore, referral by GPs was the 'exception rather than the rule'; in some cases GPs had provided a prescription for NRT products but had not mentioned the pharmacy service which as well as providing NRT products also included regular (normally weekly) face-to-face support. Participants in the research also suggested that the advertising should reflect some of the highly valued features of the service, including benefits of the service, the convenience and flexibility, support from staff and the availability of NRT on prescription.
- 9.8 The view that the service should be better promoted was also shared by some community pharmacists and NHS boards respondents to the survey. For example, some community pharmacists suggested there was a lack of support from boards to promote the service in the board area. There was also a suggestion that the service should be promoted at a national level.
- 9.9 Taken together these findings on access and advertising suggest consideration should be given to:
- Doing more to ensure that the community pharmacy smoking cessation service is promoted via other professionals including encouraging GP referrals;
 - Developing strategies for promoting the pharmacy smoking cessation service more widely e.g. on a national and or regional basis including specific action where appropriate aimed at target groups of smokers; and
 - Providing promotional materials which include information on the benefits, convenience and flexibility of the service, support from staff and the availability of NRT on prescription.
 - Exploring appropriate opportunities to link the availability of pharmacy smoking cessation services to other pharmacy and primary care promotional activity and marketing campaigns, e.g. in relation to long-term conditions, screening etc.

Continuity of staff

- 9.10 The research with users as well as with community pharmacies and NHS boards suggested that staff interaction is seen as an important feature in the effectiveness of the service. In particular the users found it helpful if there was a degree of continuity in the staff member who they saw on a weekly

basis as it enabled them to build up a relationship with staff and as a result feel more supported and encouraged.

- 9.11 The research with service users concluded that community pharmacies should try to find ways to:
- provide continuity whilst allowing for flexibility for service users to access the service when they like;
 - ensure pharmacists and support staff are offered access to training;
 - ensure smokers are supported to quit by staff with appropriate skills and knowledge.

Follow-up of those lost to the service and access for those who fail first time round

9.12 Community pharmacists responding to the survey suggested that many initial users of the service are lost to follow-up. The estimated proportions of users returning for second and third visits were around half for the second visit and one fifth for the third visit. There was some suggestion that more could be done to follow-up on users who had not completed the course.

9.13 For those who fail in their first quit attempt or in cases where service users have smoked while using the service, there appears to be variation in practices between NHS boards around whether users can continue to use the service. For example while some users who had failed in their first quit were allowed to continue the service, others were told they had to wait for six months before trying with the service again.

- 9.14 Consideration should therefore be given to:
- ways of reducing the number of failed quit attempts;
 - providing clarity and consistency on the evidence-base for whether service users can continue to use the service if they fail in their first quit attempt or if they have smoked during the course of the service ; and
 - agreeing a length of time before a service user can use the service again after an unsuccessful quit attempt in keeping with evidence-based good practice and efficient use of scarce resources.

Additional support beyond 12 weeks

9.15 A key improvement suggested by users of the service was the provision of follow-up beyond the 12 weeks to assist service users in their quitting journey. This view was shared by a number of NHS board and community pharmacy staff. A variety of suggestions were provided by users such as: being able to visit the pharmacy weeks or months after finishing the service; speaking to the pharmacist face-to-face or over the phone; being able to collect a one-off prescription; and a proactive call from the pharmacist.

- 9.16 Building on this finding, the report on service users recommended that ‘pharmacists help service users develop an exit plan or follow-up support plan on their last appointment’. Within the plan itself there were some suggestions for what should be included such as: information on seeking further support and help from the pharmacy; a follow-up appointment at a specific point e.g. four weeks; and information about other forms of support such as Smokeline and local smoking cessation support groups.
- 9.17 The responses suggest therefore that consideration be given to:
- the provision of follow-up support (both contact and NRT) beyond the 12 week period;
 - evidence-based guidance on the flexibility to extend the 12 week period where appropriate including guidance on the maximum length and other parameters of such an arrangement; and
 - the development of an exit/follow up support plan to help service users in their on going effort to stay smoke-free.

Links with other services

- 9.18 The research with users and the survey of NHS boards and community pharmacists indicated that links with other smoking cessation services could be improved. There was a view from other smoking cessation service providers that there was a need to ensure that those trying to quit can take advantage of other services especially if they are struggling or need additional support once they finish using the pharmacy service. Users reported being only provided with “*basic information about the availability of other services.*” In the survey of community pharmacists while over two thirds suggested that they referred people to other smoking cessation services, only around half suggested that they had links with other smoking cessation providers in their area which may explain why users felt that they lacked awareness about other forms of support available to them.
- 9.19 This review therefore points to the need to:
- do more to improve the links between community pharmacy and other smoking cessation;
 - encourage referral between GPs, community pharmacy and specialist smoking cessation service providers including incentives for joined-up working; and
 - ensure that community pharmacy is linked in effectively to Health Promoting Health Service objectives on creating effective person-centre smoking cessation pathways in both directions between secondary care and community settings

Advice given to service users

9.20 The advice on quitting provided to service users appeared to vary. While some users suggested that they received helpful advice and tips, other received little or none at all. Suggestions were provided by users about the types of advice which would be useful such as: dealing with cravings, stress and the side effects of quitting such as weight gain.

9.21 Consideration should therefore be given to:

- providing support materials to pharmacists which include information and advice to assist them in their quit attempt; and
- including more information on the services user's experiences.

Use of CO testing machines

9.22 Research with users suggested that where CO testing machines were used, these were found to be a valuable tool to encourage and motivate quitters as they demonstrated tangible evidence of the reducing levels of CO in the body. Users also reported that their use was an incentive not to smoke as they would be 'found out'. The research reported that some users were disappointed when CO testing equipment did not work. The use of the CO monitors was seen as valuable by some community pharmacy and NHS board respondents. However there was a suggestion by some that there was a lack of funds to maintain and support the use of CO monitors.

9.23 The responses suggest therefore that consideration be given to:

- the use of CO monitors as part of the service; and
- ways to maintain the CO monitors.

Training and support for staff

9.24 The majority of community pharmacy staff who responded to the survey had attended or undertaken some form of smoking cessation training. Over half found the training to be very useful. Some suggestions were given to improving training for community pharmacists which ranged from training on multiple therapies and dealing with clients who lapse to role play and motivational training.

9.25 On the back of some of these suggestions, consideration should be given to:

- ensuring staff providing the service (pharmacists and pharmacy staff) are competent in the necessary knowledge and skills including the completion of associated paperwork;
- undertaking a modest review of the training available to support the service involving some community pharmacists, NHS Health Scotland, Partnership Action on Tobacco and Health, NHS board representatives and NHS Education for Scotland (NES);

- providing regular updates on service enhancements and guidelines; and
- making better use of community pharmacy champions to support community pharmacies.

Pharmacy Premises

9.26 Almost all community pharmacies providing the service claimed to do so using a separate consultation room or counselling area within the pharmacy. However a small number of pharmacies reported problems such as availability of the room, space, lack of wheel chair access or no suitable room or space being available. Service users also shared some concerns about the availability and use of a private room; where pharmacies used a room service users tended to like the privacy afforded to them as they did not like others customers in the pharmacy being able to see or hear what was being discussed. On the other hand a couple of service users were uncomfortable about using a room which was also used for methadone clinics. In pharmacies where this may be a problem consideration should be given to advertising the smoking cessation service on the door of the room.

9.27 In view of these comments, consideration should be given to:

- providing community pharmacies with advice about service users' preference to receive the service in a consultation room or counselling area; and
- encouraging community pharmacies to ensure their pharmacy premises have appropriate facilities such as a consultation room or discrete counselling areas available to deliver the service to service users at times when it is needed and provide adequate levels of privacy.

PHS Service Specification

9.28 The research with community pharmacists and NHS boards demonstrated that there was widespread awareness of the smoking cessation specification and many community pharmacists found it to be helpful. Nevertheless there were a large number of suggestions put forward about how the specification could be improved. These centred around a range of areas, including: payments associated with the service; widening the scope to include dual therapy and other products such as varenicline; increasing the flexibility of the service; the role of pharmacy support staff in providing the service; reviewing the terms of condition for the service; clearer guidance; and simplifying the paperwork associated with the service.

9.29 In view of some of these suggestions consideration should be given to a review of the PHS smoking cessation service specification.

Data collection and paper work associated with the service

9.30 NHS boards and community staff made a number of other suggestions to improve the service. A key theme that arose was the paperwork associated with the service, for example the requirement to send three forms to three different places. There was a suggestion that the paperwork associated with

the service should be simplified, minimising the duplication between data collection forms, and consideration be given to providing electronic means to document records. Community pharmacies also requested the ability to electronically generate the prescription forms for NRT. This may also improve CHI capture which is currently very low. There was also a widespread view amongst Health Board respondents that data collection should be linked to payment.

9.31 The review suggests therefore that consideration is given to:

- ways to simplify the paper work associated with the service;
- underpinning the service with IT support through the ePharmacy Programme to support data collection, four week follow up and printing and electronic claiming of NRT prescriptions;
- ensuring pharmacists complete the paperwork timeously; and
- exploring the potential to merge or integrate the data collection and payment systems.

Governance and Quality Assurance

9.32 Many NHS boards reported having developed quality improvement programmes for the service. These include regular visits to pharmacies, use of pharmacy champions / mentors, provision of toolkits and updates, monitoring poor performance, providing performance data and sharing three month quit rates for service users. Some NHS board respondents highlighted difficulties in providing local quality assurance believing there was insufficient recognition of this in the service specification.

9.33 The responses suggest therefore that consideration be given to:

- reviewing the PHS Directions and service specification to take into account quality assurance aspects; and
- sharing best practice in quality improvement programmes, including feedback on performance, between NHS boards.

Emergency Hormonal Contraception (EHC)

9.34 The findings from the review of pharmacy EHC services are based on the analysis of routine data, the survey of NHS boards and community pharmacists. No research was carried out with users of the service due to the sensitivities and confidential nature of the service. Nevertheless the work carried out provided some useful reflections from the perspective of community pharmacists and NHS board staff on how the service is operating in practice.

9.35 Overall it was felt that the community pharmacy EHC provision offered a valuable community service across the country, particularly in rural areas. The service was viewed as working well with little adjustment required from the

point of view of community pharmacy and NHS board staff. Over 90% of community pharmacy staff felt that it should be continued to be offered and over 80% of NHS Board staff felt that the service was effective. However a number of suggestions for improving the service were made and these are discussed below.

Access to and the promotion of the EHC service

- 9.36 From the analysis of the routine EHC dispensing data, the PHS Emergency Hormonal Contraception (EHC) Service, since its introduction in 2008, has enabled increased access to EHC and complements the service provided at specialist sexual health services and GPs where EHC is given out without prescription and GP practices where EHC is available on prescription. Over the last year (2010/11), the number of items EHC items dispensed in community pharmacies has remained relatively stable.
- 9.37 No information was collected from users about their views on promotional information as already explained. However, according to community pharmacists who participated in the survey, the main ways users found out about the service was through community pharmacy staff, other health professionals and local health promotion materials. A number of respondents suggested that there is need for better promotion of the service which could include service key features, for example that the service is confidential.
- 9.38 Taken together these findings suggest that consideration should be given to:
- Continuing to ensure that the community pharmacy EHC is promoted, for example via other health professionals such as school nurses; and
 - Ensuring that promotional materials include information on the benefits and convenience of and support offered by the service.

Training and support for community pharmacists in delivering the EHC service

- 9.39 The vast majority of community pharmacy staff who responded said they received training and 97% felt it was either very useful or useful. There were a number of suggestions for improvements around training which centred on widening access to training to other staff, dealing with difficult clients, information on under 16s and child protection issues and the option of refresher training including eLearning options.
- 9.40 In the main community pharmacy staff said that they felt supported by their NHS board in delivering EHC services due to the training and support provided as well as NHS board guidelines and contact with other sexual health services. However there was a significant minority (18%) who did not feel supported and cited lack of contact with NHS board and poor communications.
- 9.41 Taken together these findings on training and support for community pharmacists suggest that consideration be given to:

- ensuring staff providing the service (pharmacists and pharmacy staff) are competent in the necessary knowledge and skills including the completion of associated paperwork;
- undertaking a modest review of the training available to support the service involving some community pharmacists, NHS board representatives and NHS Education for Scotland (NES);
- providing regular updates on service enhancements and guidelines;
- making better use of community pharmacy champions to support community pharmacies for example in providing training and support to newly qualified pharmacists and those new to the area who may not be aware of local networks; and
- ensuring links to local specialist services

Improvements to the EHC Service Specification

9.42 As with the smoking cessation findings, research with community pharmacists and NHS boards demonstrated that there was widespread awareness of the EHC specification and many community pharmacists found it helpful. Nevertheless there were a number of suggestions put forward on how the specification could be improved. These included: removing the religious exemption; the role of other pharmacy staff in the service such as technicians; specifying training and better guidance around the use of Levonelle. However, as already stated, the response to this survey was not high so it is difficult to say how representative these findings are and therefore they should be treated with caution.

Improvements to the EHC Service

9.43 The EHC service was generally felt to be effective. However there were various suggestions as to how the service could be improved for users. These suggestions included better advertising; extending provision of services across all pharmacies; extending provision to include other contraception and pregnancy testing; direct referral to specialist sexual health services; ensuring locums provide service; use of other pharmacy staff such as technicians; improving the links with other services; and better monitoring and evaluation of the services.

9.44 On the back of some of these suggestions consideration should be given to:

- Reviewing those involved in providing advice and the service at community pharmacist
- Considering of extending the service to provide other contraceptive advice and support; provision of contraception and pregnancy testing
- Direct referrals to other services such as specialist sexual health services.

- Engaging with users of the service to explore how the service could be improved.

Governance and Quality Assurance

- 9.45 As with the smoking cessation findings, many NHS Boards reported having developed quality assurance programmes for the service. These include: regular visits to pharmacies; use of pharmacy champions / mentors; provision of toolkits and updates; monitoring poor performance; providing performance data. This good practice could be usefully shared across NHS Boards in Scotland. Some NHS Board respondents, however, highlighted difficulties in providing local quality assurance data because they believed that there was insufficient recognition in the service specification to address this.
- 9.46 Similar to the smoking cessation findings, the responses suggest therefore that consideration should be given to:
- reviewing the PHS Directions and service specification to take into account quality assurance aspects; and
 - sharing best practice in quality improvement programmes, including feedback on performance, between NHS Boards.

Data collection and paperwork associated with the EHC Service

- 9.47 The analysis of the routine data for EHC items dispensed as part of this review revealed discrepancies between the number of claims made and number of items dispensed. Further investigation identified that this was likely due to changes in the way that Practitioner Services Division (PSD) now capture prescription data. The findings suggest that consideration should be given to:
- ensuring this discrepancy has been addressed going forward; and
 - improving the systems to record EHC items dispensed and claimed e.g. by underpinning the service with IT support through ePharmacy Programme which would allow community pharmacists to print and electronically claim EHC prescriptions.
- 9.48 Various suggestions were made on how to improve data recorded on the community pharmacy EHC service which would be useful at local and national levels. Based on these suggestions consideration should be given to:
- collecting more information on patient characteristics such as age range and post code area by using a standardised pro formas underpinned electronically through the ePharmacy Programme; and
 - better information on individual pharmacy, CHP, NHS board prescribing activity (for NHS boards, and nationally)

Conclusions

- 9.49 The findings from this review suggest that both the PHS Smoking Cessation and Emergency Hormonal Contraception (EHC) Services are considered valuable by both community pharmacy and NHS Board staff and in the case of the smoking cessation service, by the users as well.
- 9.50 However there are a number of suggestions as to how the services could be improved to ensure that the services are as effective and efficient as possible.
- 9.51 However, there are a number of suggestions as to how the smoking cessation service in particular could be improved with respect to increasing quit rates and enhancing the service such as: follow up of users, extending the range of products available, training, further integration with other local smoking cessation services and linking completion of paperwork with payment.
- 9.52 Similarly improvements suggested with respect to the EHC service included; enhancement of the service e.g. community pharmacists providing other contraception and support, the use of pharmacy technicians, better links and referrals to other sexual health services, improving governance and quality assurance and improving data collection.

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APPENDIX A SURVEY QUESTIONS

Community pharmacists' survey questions

These first questions are about the pharmacy in which you work and the PHS services you offer?

1. Can you say what your role is in the pharmacy?
2. Do you work for a: *multiple outlet (16+ pharmacies); medium outlet (6-15 pharmacies); small pharmacies (2-5 outlets); single pharmacy.*
3. Does your pharmacy open late in the evening (after 6 pm)?
If yes: On which days is your pharmacy open late in the evening?
4. Is your pharmacy open on Sundays?
5. In which health board area is your pharmacy located?
6. Does your pharmacy provide? both the PHS *smoking cessation and emergency contraception services*; PHS *smoking cessation service only*, PHS *emergency contraception service only*; *neither*.

For those that do not provide either service:

7. Can you say why you do not provide either of these services? **>end of survey**

For those providing one or both services:

8. What particular facilities do you provide for PHS consultations?
Designated area in the pharmacy; Separate, private consultation room; no particular provision – just over the counter; other.
9. Are there any problems with providing suitable facilities within your premises to carry out these ...
- Can you comment further?

This next series of questions is about the smoking cessation service you provide.

10. How do clients usually find out about the smoking cessation services offered at your pharmacy? *Pharmacy staff; Health promotion material in pharmacy; Referred to service by other health professionals; Other routes; Don't know*
11. Which of the following do you include in your smoking cessation consultations? (Tick all that apply) *Discussion of previous quit attempts; Discussion of current tobacco use; Current smoking status; Quit date agreed; Information on different types of NRT; Motivations to quit; Provision of information on different methods of quitting; Use of CO monitor; Advice/signposting to clients about other smoking cessation services in the area.*
12. Are clients given a choice as to which type of smoking cessation therapy they try? *Yes; No; Sometimes.*

13. Which of the following nicotine replacement therapies are offered? (Tick all that apply.) *Nicotine gum; nicotine inhaler; nicotine lozenge; nicotine nasal spray; nicotine patch; other.*
14. Which staff are involved in delivering the PHS smoking cessation service? (Tick all that apply.) *Pharmacists; Dispensing technicians; Pharmacy counter assistants; Other.*
15. Before the start of the PHS patient services in August 2008, how long had you been delivering a smoking cessation service? *Less than 12 months; between 12 and less than 24 months; more than 24 months, didn't provide this service.*
16. For smoking cessation services - what arrangements are in place to see clients?
 - **For first visit:** *Clients see on demand but may have to wait or return later if the pharmacist is busy; clients seen by appointment only; mixture of 'on demand' and appointment.*
 - **For follow up visits** *Clients see on demand but may have to wait or return later if the pharmacist is busy; clients seen by appointment only; mixture of 'on demand' and appointment.*

These next few questions are about your views on the effectiveness of the PHS smoking cessation services

17. What proportion of clients would you say, return for a second visit at 2 months? Please estimate:
More than 75%; between 50 and 75%; between 25 and 49%; less than 25%; can't say.
- and what proportion, would you say, return for a final visit at 3 months?
. More than 75%; between 50 and 75%; between 25 and 49%; less than 25%; can't say.
18. Of those that return for subsequent visits what proportion would you say have made a serious attempt to quit?..
. More than 75%; between 50 and 75%; between 25 and 49%; less than 25%; can't say.
19. Is there any follow up of clients who do not return for subsequent appointments? Yes; No; Don't know.
 - Is this follow up carried out by: *pharmacy; health board*
 - Can you say more about this?

20. Do you see some people returning to the service and making several attempts to quit? *Yes, No, sometimes.*
21. In your view, how effective do you think the smoking cessation service is in helping people to stop smoking? *Very effective, quite effective; not very effective; to not at all effective; not sure.*
 Can you please say why you think this?
22. In your view, what has worked well in the PHS smoking cessation service?

23. What changes/improvements would you like to see to the smoking cessation services you offer?
24. If, offered a choice, would you continue to offer the smoking cessation service?
 - Can you say more about this?

Training and support

25. What training have you had in delivering smoking cessation advice? (Tick all that apply.)
Local NHS Board training - brief intervention; Local NHS Board training - in-depth advice training; Path/ASH Scotland training – ‘raising the issue of smoking’; Path/ASH Scotland training – brief intervention; Path/ASH Scotland training in-depth advice training; NES local training course; NES distance learning pack; other training; no training.
26. How useful was the training in enabling you to deliver the smoking cessation service? *Very useful; quite useful; not very useful; not at all useful.*
27. What additional assistance, if any, do you feel you need following this training?
28. If you were asked to revise this training what would you change?
29. Do you feel supported by your Health Board and/or others in delivering the smoking cessation service?...
 - Why do you say that?
30. How useful has the PHS service specification been in helping you deliver the smoking cessation service? *Very useful; quite useful; not very useful; not at all useful.*
31. What additions/changes do you think should be made to the specification?
32. Do you refer clients to other smoking cessation services in your area?
 Can you say which services?
33. Can you say a bit more about this?

Links with other smoking cessation providers

34. Do you have any links with other providers of smoking cessation services in the area?
 Can you say a bit more about this?

Data collection

These next few questions are about your views on the data you are required to collect and maintain...

35. Is the data you are required to collect and maintain for the smoking cessation service easy to collect? *Very easy; quite easy; quite difficult; very difficult.*
36. How could this be improved?
37. Is the data useful to you?

38. Could the data be made more useful to you?
If yes, how could it be made more useful?

Emergency hormonal contraception services

The next questions are about the Emergency Hormonal Contraception service you provide

39. How do clients usually find out about the EHC services offered at your pharmacy? *Health promotion material in pharmacy; Pharmacy staff; Recommended by other health professionals working in your area; Other; Don't know*
40. The EHC service offered at our pharmacy includes: (tick all that apply)
Provision of information on different methods of contraception; advice/signposting to other contraception services in the area; advice on long term contraception.
41. Before the start of the PHS in August 2008, how long had you been delivering an EHC service? *Less than 12 months; between 12 and less than 24 months; more than 24 months, didn't provide this service.*
42. Which staff are involved in delivering the PHS emergency hormonal contraception service? (Tick all that apply) *Pharmacists; Dispensing technicians; Pharmacy counter assistants; Other.*
- ...
43. Do you see the same people returning for this service? *Yes, see the same people returning; Sometimes; Rarely; Never; Can't say.*
44. In these cases do you offer further advice and support in relation to contraception? *Yes; sometimes; No.*
Can you say a bit more about this?

These next few questions are about your views on the effectiveness of the PHS EHC services you offer.

45. In your view, what has worked well in the PHS EHC service you provide?
46. What changes/improvements would you like to see to the EHC services you offer?
Can you say more about this?
47. If, offered a choice, would you continue to offer the EHC service? *Yes; No; Undecided.*
Can you say more about this?

Training and support

48. What training have you had in delivering emergency hormonal contraception? *Local NHS Board training; Child protection training; NES local training course/s; NES distance learning pack/s; none; other.*

49. How useful was the training in enabling you to deliver the EHC service? *Very useful; quite useful; not very useful; not at all useful.*
50. If you were asked to revise this training what would you change?
51. What additional assistance, if any do you feel you need following this training?
52. Do you feel supported by your Health Board and/or others in delivering the EHC service? *Yes; No.*
Why do you say that?
53. How useful has the PHS service specification been in helping you deliver your EHC service. *Very helpful; quite helpful; not helpful; not helpful at all; haven't read the specification.*
54. What additions/changes would you like to see to the specification?
55. Do you refer clients to other services in your area that can offer help with contraception? *Yes, No, not sure, no other services in the area.*
Can you say which services?
Can you say a bit more about this?
56. Do you have any links with other providers of EHC services in the area?
Yes; No, not sure, no other services in the area.
Can you say a bit more about this?
57. Do you have any other comments on any aspect of the PHS smoking cessation and/or EHC services?
58. Do you have any other comments on any aspect of the PHS smoking cessation services?

Health Board Survey questions

This survey aims to explore the views of Health Board staff on the Community Pharmacy Public Health Services.

These first questions are about your role in the Health Board and the Public Health Service patient services.

1. What is your role in the health board?
2. Can you describe your role/interest in the PHS?
3. What is the name of your health board
4. Do you have an interest/responsibility in: *the PHS smoking cessation service only; the PHS emergency hormonal contraception service only; both services; neither.*

For those with an interest in the PHS smoking cessation service

5. How effective do you think the PHS smoking cessation service is in terms of helping people to quit? *Very effective; quite effective; not effective; not at all effective; can't say.*
6. What do you think are the best things about the PHS smoking cessation service?
7. What could be improved?
8. Do you think the PHS smoking cessation service works better in certain areas than others e.g. rural or urban areas?
9. Is there any follow up of PHS smoking cessation users?
10. Who carries out this follow up of users of the service? *The health board; the pharmacy?*
11. What does the follow up involve?
12. What information and support is given to pharmacies in terms of referral to other smoking cessation services in the area?
13. How well do you think the PHS smoking cessation service integrates with other smoking cessation services locally? *Very well; quite well; well; not well; don't know.*
Why do you say that?
14. What support do you offer to pharmacies in terms of training for smoking cessation? *Information leaflets; training events; information on accessing specialist advice or services; none, other.*
Any further comments on support for training?
15. Do you offer any other advice/support to community pharmacies for the PHS smoking cessation service? *Yes/no/don't know*
Can you say a bit more about this?
16. Are you familiar with the Scottish Government's specification on the PHS smoking cessation service? *Yes; no.*
17. Can you suggest what changes could be made to improve the specification?
18. What data do you use to assess uptake and cost of PHS smoking cessation services locally?
19. How could this data be improved?
20. What governance arrangements are in place in the Board for the PHS smoking cessation services? (Tick all that apply). *Clear lines of responsibility*

and accountability; development of quality improvement programmes e.g. training, monitoring of service; analysis of minimum data set; management of risk; procedures to identify and remedy poor performance; none; other; don't know.

21. Can you say what Quality Assurance measures are undertaken locally regarding the PHS smoking cessation service?
22. What arrangements does the Board have in place to deal with problems or complaints about the PHS smoking cessation service?

These next questions are about the PHS emergency hormonal contraception service

23. How effective do you think the PHS emergency hormonal contraception service is? *Very effective, quite effective, not effective, not at all effective; can't say.*
24. What do you think are the best things about the PHS emergency hormonal contraception service?
25. What could be improved?
26. What support do you offer to community pharmacies in terms of training for the emergency hormonal contraception service? *Information leaflets; training events; information on accessing specialist advice or services; none; other, please specify.*
Can you say anymore about this?
27. Do you offer any other advice/support for the emergency hormonal service?
Can you say a bit more about this?
28. Are you familiar with the Scottish Government's specification on the PHS emergency hormonal contraception service? *Yes; no.*
29. Can you suggest what changes could be made to improve the specification?
30. How well do you think the PHS emergency hormonal service integrates with other similar services locally? *Very well; quite well; well; not well; don't know.*
Can you say a bit more about this?
31. What data do you use to assess uptake and cost of PHS emergency hormonal contraception services locally?
32. How could this data be improved?
33. What governance arrangements are in place in the Board for the PHS emergency hormonal contraception service?
34. Can you say what Quality Assurance measures are undertaken locally regarding the emergency hormonal contraception service?...
35. What arrangements does the Board have in place to deal with problems or complaints about the PHS emergency hormonal contraception service?
36. Do you have any other comments on either the PHS smoking cessation smoking or emergency hormonal contraception service?
37. Do you have any comments on the PHS smoking cessation or emergency hormonal service?

Social Research series

ISSN 2045-6964

ISBN 978-1-78045-517-4

web only publication

www.scotland.gov.uk/socialresearch

APS Group Scotland
DPPAS12298 (11/11)

