Literature Review

Stop Smoking Services

Mortality and morbidity

In England, over 8 million people smoke (DH, 2010). Tobacco use is the primary cause of preventable morbidity and premature death in the UK (Dunstan, 2011). Smoking is associated with numerous illnesses, such as many cancers, respiratory and circulatory diseases. Smoking while pregnant increases the risk for adverse pregnancy outcomes (US Department of Health and Human Services, 2004). Half of long-term smokers die of smoking-related diseases and a quarter die before reaching 70 years of age (Doll, et al., 1994). On average, cigarette smokers die about 10 years younger than non-smokers (Doll et al., 2004). Moreover, smoking is the most important cause of gender gap in mortality across Europe with men dying of smoking-related causes more often than women (McCartney et al., 2011). Each year, 5.4 million world-wide die prematurely as a result of smoking. If the current trends persist, this figure will rise to more than 8 million by 2030 (WHO, 2008).

Passive smoking, i.e. exposure to second-hand smoke, is also a significant health threat accounting for 1% of worldwide mortality (603,000 deaths) (Öberg et al., 2011). Globally, 40% of children, 33% of male non-smokers and 35% of female non-smokers were estimated to be exposed to second-hand smoke in 2004. Passive smoking was estimated to be the cause of 379,000 deaths from ischaemic heart disease, 165,000 deaths from lower respiratory infections, 36,900 deaths from asthma, and 21,400 deaths from lung cancer. The loss in disability-adjusted life-years (DALYs) attributable to passive smoking was 10.9m (0.7% of worldwide burden). Alarmingly 61% of DALYs were in children, largely caused by lower respiratory infections and asthma (Öberg et al., 2011). A recent study (Leonardi-Bee et al., 2011) estimated that pregnant women who are exposed to second-hand smoke are 23% more likely to experience stillbirth and 13% more likely give birth to a child with a congenital malformation.

In 2009, smoking contributed to over 81,400 deaths per year in England, accounting for 18% of all deaths of adults aged 35 or over (NHS Information Centre, 2010a) and killing more people each year than the other six main causes of preventable death put together (alcohol abuse, road accidents, other accidents and falls, preventable diabetes, suicide and drug use) (DH, 2011). A larger proportion of men (23%) than women (14%) died from smoking-related diseases which reflects the higher rates of smoking by men in the past (DH, 2010). Around 37,500 deaths were due to cancers, 22,000 deaths due to respiratory diseases, 20,600 deaths due to circulatory diseases and 1,300 of deaths due to diseases of the digestive system (NHS Information Centre, 2010a). Moreover, smoking is a significant cause of health inequalities in death rates between the poor and the rich due to higher smoking rates among those with lower income levels (DH, 2010; Vallejo-Torres & Morris, 2010).

In England in 2008/2009, around 5% (462,900) of all hospital admissions among adults aged
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35 and over were attributable to smoking (NHS Information Centre, 2010a). Of these admissions, 166,100 were cancer related, 140,800 were for circulatory diseases, 119,400 were for respiratory diseases and a further 17,600 were for diseases of the digestive system. However, these figures do not include the admissions due to illnesses caused by second-hand smoke (NHS Information Centre, 2010a). Each year in the UK, around 165,000 new cases of lower respiratory infection, middle ear disease, wheeze, asthma and meningitis in children are estimated to be caused by passive smoking. Furthermore, these diseases account for ca. 8,500 hospital admissions costing over £12m per annum. Passive smoking in children also accounts for a total of over 300,000 general practice consultations costing over £9m (The Royal College of Physicians, 2010).

The cost of smoking to the NHS in England was estimated to have been £2.7 billion in 2006, equalling to more than £50m per week (Callum et al., 2010). This sum accounts for 5% of adult hospital admission costs, 11% of GP consultation and 12% of GP prescription costs, 8% of practice nurse consultation and 4% of outpatient costs. Due to increased awareness of smoking-related harm, the smoking prevalence has declined during the past decades. Whilst estimating costs in 2006, smoking would have cost the NHS 13% (£388m) more had the prevalence levels remained the same as they were in 1996 (Callum et al., 2010). For comparison, almost £84 million (excluding prescribed pharmacotherapy) was spent on NHS Stop Smoking Services in England in 2009/10 (NHS Information Centre, 2010b).

In 2005, 17% of all mothers continued to smoke throughout the pregnancy. Younger women (45% of those aged 20 or under) were more likely to continue to smoke than older women (9% of those aged 35 or over) (NHS Information Centre, 2008). Costs to the NHS related to maternal outcomes of women that smoke during pregnancy (including e.g. increased risk of spontaneous abortion, placental abnormalities, preterm premature rupture of membranes) are estimated to be up to £64 million annually (Godfrey et al., 2010). Costs related to infant outcomes (including increased risk of preterm delivery, low birth weight, sudden infant death syndrome, perinatal mortality, asthma, otitis media, and upper and lower respiratory infections) are estimated to cost the NHS up to £23.5 million per year (Godfrey et al., 2010). It was also estimated that spending between £13.60-£37 per pregnant smoker would yield one-year positive cost savings for the NHS. These figures are conservative, as they are restricted to first year of life and do not include long-term health effects on the mother or the child (Godfrey at al., 2010).

Substantial health benefits could be gained by extensive public health and clinical interventions to reduce passive smoking (Öberg et al., 2011). International evidence shows that smoking bans have had clear health benefits in terms of reduced incidence of respiratory and cardiovascular conditions (e.g. Ayres et al., 2009; Barone-Adesi et al., 2011; Board on Population Health and Public Health Practice, Institute of Medicine, 2009; Meyers et al., 2009; Naiman et al., 2010). In
England, banning of smoking in enclosed public places from 1st July 2007 onwards has proven to be successful in terms of reduction of exposure to second-hand smoke; cotinine\(^1\) levels among non-smokers were reduced to about half of those before the ban (Craig et al., 2009). In Scotland, hospital admissions due to childhood asthma have declined by 15.1\% per year since the introduction of the smoking ban in 2006 (Mackay et al., 2010). Although exposure to second-hand smoke in private homes has reduced both prior (England: Jarvis et al., 2009) and post (Scotland: Akhtar, 2009) the bans, smoking in private places remains the main source of passive smoke exposure in the UK. In a Populus survey conducted in 2009, half of the children interviewed reported that their smoking parent(s) smoke indoors, and 35\% smoke in car while children are present (The Royal College of Physicians, 2010).

**Smoking prevalence**

Reducing prevalence of smoking is a key element in improving public health. The government has set a target of 18.5\% or less average prevalence in the adult population by the end of 2015 (DH, 2011). In England, smoking prevalence has significantly reduced since the 1970s. However, the decrease in smoking prevalence levelled off in the mid 1990s and although resumed, the decline has been slow since 2000 (Dunstan, 2011). The previous target of 21\% prevalence of all adult smokers set by the Department of Health in 2004 (DH, 2004) was reached by 2007, but the prevalence has been at around that level since then (Dunstan, 2011). The decrease has been less steep for women than for men. In 2009, the difference in prevalence levels was only 2\% the levels being 22\% for men and 20\% for women. In 1974, the figures were 51\% and 41\%, respectively (Dunstan, 2011).

Since the 1970s, the smoking prevalence has fallen more sharply for non-manual workers than manual workers, increasing health inequalities between the groups (Dunstan, 2011). In 2009, prevalence levels among routine and manual households was almost double the level in managerial and professional households (28\% compared to 15\%) (Dunstan, 2011). In terms of tar yield, the pattern is similar. In 2009, smokers in routine and manual households (18\%) were less likely to smoke low tar cigarettes (less than 8mg per cigarette) than smokers in managerial and professional households (36\%) (Dunstan, 2011).

Smoking prevalence is still high among some minor ethnic groups, e.g. 40\% for Bangladeshi men (Wardle, 2005). Socially very deprived people are very likely to smoke, and consequently highly likely to suffer from smoking-related ill health and death (Action on Smoking and Health, 2008). Moreover, in people with mental health conditions smoking prevalence can be two or three times the rate in general population (Hughes et al., 1986; Kelly & McCreadie, 2000).

In terms of health benefits, relief of financial burden and reduction of health inequalities, it is essential to implement appropriate actions to further reduce prevalence levels (Callum et al., 2010; Magnus, 2011).

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\(^1\) Cotinine is generally accepted as the best biochemical marker available for smoke intake used to discriminated smokers from non-smokers (Jarvis et al., 2008) or to assess the intake levels of smokers (Fidler et al., 2008)
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Smoker behaviour and willingness to quit

In the 2009 General Lifestyle Survey, 57% of smokers said it would be fairly or very difficult to go for a day without smoking (Dunstan, 2011). The perception of how easy it would be to go without smoking for a whole day and the time taken to the first cigarette of a day are measures used to determine the strength of dependency on cigarette smoking (Dunstan, 2011). Not surprisingly, heavy smokers are more likely to be dependent than light smokers (Lader, 2009; Dunstan, 2011). Between 1974 and 2009, the proportion of heavy smokers (20 or more cigarettes a day) fell considerably, from 26% to 7% for men and from 13% to 5% for women (Dunstan, 2011).

Individuals who start smoking at an early age are more likely than other smokers to smoke for a long period of time and more likely to die from a smoking-related disease (DH, 1998). Most (66%) of current and ex-smokers who had been regular smokers started smoking before they were aged 18 (NHS Information Centre, 2010a). Of current heavy smokers, 52% started before the age of 16, compared to 39% of light smokers (fewer than 10 cigarettes a day) (Dunstan, 2011).

In 2009, 6% of school children aged 11 to 15 were regular smokers and the third had tried smoking at least once (NHS Information Centre, 2010c). Children whose parents or siblings smoke are 90% more likely to start smoking themselves compared to those from non-smoking homes. About 17% of smoking uptake of those up to 15 yrs (~23,000 new smokers) is attributable to exposure to smoking at home (The Royal College of Physicians, 2010). Therefore, helping adult smokers to quit is vital in reducing smoking initiation and so achieving a long-term decline in smoking prevalence (Action on Smoking and Health, 2008).

In the National Statistics Opinions Survey 2008/2009 (Lader, 2009), 63% of smokers said they would like to quit smoking and 75% said they had tried to quit in the past. Some kind of advice or help for stopping smoking had been sought by 43% of smokers in the last year. 55% had received advice from a medical professional in the past five years. A fifth (22%) had given up for a week, 49% had given up for more than a week but less than six months, 29% had been abstinent for six months or more, but only 8% managed to quit for more than two years (Lader, 2009).

Most (83%) of those willing to quit stated at least one health-related reason for their motivation to stop smoking (Lader, 2009). People were well aware of the health risks of second-hand smoke to adults and children, as over 80% of respondents named passive smoking as a risk factor for certain conditions. However, fewer people (44%) thought that smoking was responsible for the most premature deaths (deaths before the age of 65) in the UK (Lader, 2009).

Improvements in life expectancy and prevention of disease are the most obvious benefits of smoking cessation (Parrot & Godfray, 2004). Smokers also tend to have a lower self-rated health status than non-smokers and thus, cessation can improve individuals’ quality of life. Furthermore, reductions in the health effects of passive
smoking, savings to the NHS and employers give rise to wider economic benefits to individuals and society (Parrot & Godfray, 2004). Smoking cessation has beneficial long-term effects at any age, although the earlier you stop the greater the benefit in terms of life expectancy (Doll et al., 2004).

Stop smoking services

Although some smokers manage to quit unassisted, success rate is higher for those trying to stop smoking with assistance (e.g. Hatsukami et al., 2006; Stead et al., 2008; West, 2006; West et al., 2010; West & Fidler, 2011; West & Zhou, 2007). Nicotine replacement therapy (NRT) and individual counselling are among the most effective interventions for smoking cessation among adults (Valery et al., 2008). Interventions to assist smoking cessation are found to be cost-effective (Bauld et al., 2011; Boyd & Briggs, 2009; Flack et al., 2007; Godfrey et al., 2005; Parrott & Godfrey, 2004); to have potential to reduce health inequalities (Bauld et al., 2007; Chesterman et al., 2005); to have potential to reduce subsequent mortality (Anthonisen et al., 2005); and to significantly increase quit rates in pregnant women (Godfrey et al., 2010).

The comprehensive tobacco control strategy, Smoking Kills (DH, 1998), has been highly successful in reaching its goals and has established the UK among the world leaders in tobacco control (Action on Smoking and Health, 2008). An important component of a comprehensive programme for tobacco control is the provision of treatment that targets several aspects of tobacco addiction (Hatsukami et al., 2008). Undeniably, one of the many achievements of the strategy (DH, 1998) is the founding of NHS Stop Smoking Services (Action on Smoking and Health, 2008). Globally, the UK is unique in having a comprehensive and free national stop smoking service (Bauld et al. 2009a; Gibson et al. 2010).

Currently, NHS Stop Smoking Services (NHS SSS) aim to offer a range of support options in order to provide clients with the possibility of choosing the type of intervention(s) they prefer to use during a quit attempt. However, all interventions involve behavioural support in multiple sessions and the offer of approved pharmacotherapy (Crogan, 2011). In the International Tobacco Control Four Country Survey (Gibson et al., 2010), smokers in the UK reported fewer quit attempts but were more likely to use pharmacotherapy and/or support when quitting and to achieve short-term abstinence than smokers in the United States, Canada, and Australia where less support is provided.

NHS Stop Smoking Services significantly contributed to the decrease of 25% in smoking rates in England during the last decade. They provide effective support for smokers who want to quit (Bauld et al, 2009a; DH, 2010). Since NHS Stop Smoking Services were set up in England, over 4 million people have set a quit date, with over 2 million of these having stopped smoking at 4 week follow-up (DH, 2010). From April 2009 to March 2010, over 757,000 people set a quit date through the service and after 4 weeks, 49% of them reported to have quit smoking (NHS Information Centre, 2010b). Between April and December in 2010, 511,697 people had set a quit date and 245,664 of them (48%)
were successful at 4 week follow-up (NHS Information centre, 2011).

At present, around 2% of all smokers are treated by NHS Stop Smoking Services, and less than 9% of those attempting to quit use the services (West & Findler, 2011). NICE (2008) recommends that commissioners should aim to treat at least 5% of the estimated population of local tobacco users with the target of 35% CO-validated successful quitters at a 4-week follow-up. They should also make sure that minority ethnic and socioeconomically disadvantaged communities, as well as people with mental health problems, are taken into account (McNally & Ratschen, 2010; NICE, 2008). In order to assist smokers to access the most effective stop smoking support options available, healthcare professionals should systematically identify smokers at every opportunity and deliver brief advice on smoking cessation (Croghan, 2011). To facilitate long-term success, the stop smoking service should be provided for a minimum of 12 weeks. However, pharmacotherapy should remain available to the client for at least the duration recommended by the product specification (Croghan, 2011).

According to the national evaluation of the smoking cessation services conducted in 2001-2003, 53% of clients trying to quit were carbon monoxide (CO) validated quitters at four weeks (Judge et al., 2005), and 14.6% at one year (Ferguson et al., 2005). Some subpopulations, such as younger, pregnant and more deprived smokers, as well as females, have lower quit rates (Bauld et al., 2009a; Hiscock et al., 2010). Group interventions appeared to be more effective than one-to-one interventions, although many clients prefer one-to-one treatment (Bauld et al., 2005). To date, an adequate evidence base has not yet been accumulated on the effectiveness of different NHS SSS intervention types or the cessation rates of different subpopulations (Bauld et al., 2009a; NICE, 2008; Murray et al., 2009).

Nicotine can be highly addictive. Tobacco addiction has physical, psychological and social dimensions that are shown differently in different people. In general, long-term quit rates are low and relapse rates high (DH, 2010; DH, 2011). Over the past 40 years in England, the background long-term cessation rates are estimated to have been between 1 to 2 % (West, 2006). Most quitters who relapse do so at the beginning of a cessation attempt, and the rate of relapse decreases over time (Hughes, et al., 2004; Herd, et al., 2009). In a study of routine NHS services conducted in 2002-2003, three quarters of 4-week quitters relapsed back to smoking within the first year and most of them relapsed within the first six months following the treatment (Ferguson et al., 2005). In the International Tobacco Control Four Country Survey, 17% of quitters who had been abstinent over one year still relapsed, but only 5% of those who managed to go without smoking over 2 years relapsed (Herd et al., 2009). A study using data from the British Household Panel Survey (Hawkins et al., 2010) estimated that 37.1% of former smokers who have been abstinent for a year will relapse within 10 years. The authors

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2 abstinence assumes a CO reading of 10 parts per million (p.p.m.) or less (used by Judge et al., 2005, Bauld et al., 2009a & Bauld et al. 2009b)
(Hawkings et al., 2010) call for better long term support to those who quit smoking and especially to those most likely to relapse who are identifiable through socioeconomic and health variables.

Consequently, nicotine addiction should be viewed as a chronic disorder which might require long-term treatment (Hatsukami et al., 2008). Relapse prevention interventions implemented after the currently used abstinence target of 4-weeks might be cost-effective and could increase long-term abstinence rates, although evidence on the effectiveness of most relapse interventions is still scarce (Coleman et al., 2010; Hajek et al., 2009). However, there is some indication that extending pharmacotherapy from current 3 month period could increase 52-week quit rates by between 10 to 20 % (Coleman et al., 2010). Currently, there is a relapse intervention pilot for routine and manual workers ongoing in London (Croghan, 2011).

Reduction of smoking before quitting has been suggested as a resolution for smokers finding it hard to suddenly stop smoking, as reduction has been found to produce similar quit rates to abrupt cessation (Lindson et al., 2010). Self-help materials or behavioural support with or without pharmacotherapy could be provided, although research on relative effectiveness of different intervention types and identification of target groups that would benefit the most from different interventions are still to be carried out (Lindson et al., 2010).

The government’s recent tobacco control plan (DH, 2011) calls for tailored local Stop Smoking Services that reach out to people in high prevalence groups (in order to reduce health inequalities between poor and rich), provide more service options (including reduction or long-term use of NRT) and maximise value of money. The plan also requires that data is collated on service outcomes and evaluation of cost-effectiveness is enabled (DH, 2011).

**Community pharmacies’ contribution to smoking cessation**

The recent Department of Health Guidance on Local Stop Smoking Services (Croghan, 2011) acknowledges the potential of pharmacies as a provider of smoking cessation services. The guidance states that “Community pharmacies are easily accessible: 99% of the population, even those living in the most deprived areas, can get to a pharmacy within 20 minutes by walking or using public transport. Some 84% of adults visit a pharmacy at least once a year. An estimated 1.6 million visits take place daily, of which 1.2 million are for health-related reasons. This ready access makes community pharmacies an ideal location to provide opportunistic and brief advice”.

Moreover, NICE (2008) notes that “Community pharmacies serve local communities and have the potential to reach and treat large numbers of people who use tobacco. They are able to meet the needs of minority ethnic and disadvantaged groups and those who may have difficulty accessing other community services. Community pharmacies … also have an important role to play in local education and communication campaigns”.

The NHS Community Pharmacy Contractual Framework is made up of three different levels, Essential, Advanced and Enhanced (PSNC 2005). Within the Essential services, all pharmacies in England are required to provide opportunistic and prescription-linked healthy lifestyle advice to patients presenting prescriptions for diabetes, those who may be at risk of heart disease, those who smoke and those who are overweight. In addition, pharmacies are required to participate in six public health campaigns each year, organised by the primary care trust (PCT).

NHS SSS are provided by community pharmacies as Enhanced services commissioned locally in response to the needs of the local population. A nationally negotiated Enhanced service specification (EN4 Stop Smoking), produced to assist commissioners, includes one to one support and advice to the service user with referral to specialist services if necessary. Within this Enhanced service, the pharmacy will also help to facilitate access to, and where appropriate supply, suitable stop smoking drugs and aids. (PSNC 2005). On 31st March 2010, 5612 community pharmacies were providing NHS SSS in England (NHS Information Centre, 2010d).

Community pharmacies can successfully deliver stop smoking interventions (Blenkinsopp et al. 2009; Dent et al., 2007; Murray et al., 2009; Sinclair et al., 2008). According to a review (Blenkinsopp et al. 2009), stop smoking services based in community pharmacies and run by trained pharmacy staff are effective and cost-effective. Findings of another review (Murray et al., 2009) also indicate that due to their high accessibility community pharmacies have the potential to reach large number of smokers including the more disadvantaged. An US review (Dent et al., 2007) concluded that the evidence strongly suggests that pharmacists can effectively help smokers to quit.

A US study compared two different interventions provided by pharmacists; a face-to-face group program and a brief session over the telephone (Dent et al., 2009). Patients in both intervention groups (in total, 101 patients) were offered free pharmacotherapy. Six months after the quit date, 28% of patients within the group intervention and 11.8% of those receiving the telephone session were still abstinent. The authors concluded that pharmacists are effective providers of stop smoking interventions. They suggest that if pharmacists were utilised more in tobacco cessation efforts, it could have a significant impact on smoking rates, prevention of tobacco-related diseases, and overall improvement in public health (Dent et al., 2009).

An observational study (Bauld et al., 2011) followed the quit rates of patients attending group-based support (with the duration of 7 weeks) and one-to-one counselling provided by pharmacists (12 weeks) for one year in Glasgow. Clients in both treatment groups were offered nicotine replacement therapy. The combined proportion of CO-validated quitters was 22.5% at 4-week follow-up but fell to 3.6% of continuous abstinence at 52 weeks (Bauld et al., 2011). At four weeks, 18.6% of clients using the pharmacy service...
and 35.5% of those using the group-based service were CO-validated quitters, although pharmacies were treating more patients (Bauld et al., 2009b). The group-based intervention achieved a higher quit rate (6.3%) at 52 weeks than the pharmacy service (2.8%)(Bauld et al., 2011).

The group intervention was more intensive and required greater overhead costs than the pharmacy-based service (Bauld et al., 2011). The life-time cost-effectiveness analysis resulted in an incremental cost per QALY of £4,800 for the group support and £2,600 for pharmacy counselling (Bauld et al., 2011) and both services were considered to be highly cost-effective (Bauld et al., 2011; Boyd & Briggs, 2009). Additional information about relative costs, models of service delivery and comparative client characteristics are required to allow more comprehensive assessment of the relative success of pharmacy service outcomes (Bauld et al., 2009c). Boyd & Briggs (2009) conclude that ‘...the results indicate that these two cost-effective services coexist to provide a comprehensive smoking cessation service across Glasgow. They offer good value for money and meet the varying needs of different smokers, providing a choice of cessation therapies in order to maximize smoking cessation attempts and quits in Glasgow’.

In recent years, there has been a dramatic increase in the proportion of NHS smoking cessation treatment delivered in healthcare settings such as primary care and pharmacies with a sharp rise in the proportion of one-to-one interventions and a corresponding decline in the provision of closed group treatment (Chambers, 2009).

The Local Stop Smoking Services Guidance for 2011/12 (Croghan, 2011) points out that although smoking cessation interventions delivered by advisers, such as pharmacy staff, are in general less effective than interventions delivered by staff working exclusively in smoking cessation, such settings remain a valuable resource. They often provide clients with greater choice and flexibility, as they are more easily reached and open at times when specialist provision may not be available. The previous guidance (Chambers, 2009) stated that pharmacies have a good track record of providing stop smoking services to the general public. Pharmacies also provide a readily available network of trusted health professionals at the heart of the community and are ideally located to provide credible and reliable information and promote health and well-being.

Commissioners and service leads should be encouraged to commission services from pharmacies and should continue to work in partnership with them to develop high-quality stop smoking services that the general public can access easily (Chambers, 2009). Guidance produced by NHS Employers (2009) aims to help strengthen the contractual arrangements so that pharmacy-based stop smoking services show clear evidence of close partnership with local NHS Stop Smoking Services (Chambers, 2009).

The quit rate of a NHS Stop Smoking Service should fall between 35-70 % at 4-week follow-up (NICE, 2008). During April to September
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2010, 57,156 people set quit date at pharmacies in England and 44% of them were successful in their quit attempt\(^3\). The average success rate for all settings was 48% (NHS Information Centre, 2011).

- Under the Sheffield Stop Smoking Service, community pharmacies provide one-to-one support to quitters. In 2008/2009, the quit rate was 55% for pharmacies and 42% for GPs.

- In Hereford, the average quit rates (2004-2010) at 4-week follow-up were 47.5% for pharmacies, 42.7% for GP practices and 44.2 % for specialist services. The number for patients attending the services since 2004 was 2950, 4174 and 2679, respectively.

- Within NHS North Yorkshire in 2009/2010, 721 clients set a quit date to stop smoking with a pharmacy and 348 (48%) had quit successfully at 4-week follow-up. The success rate varied from 37% for those using no pharmacotherapy (7% of all clients) to 73% for those using Varenicline (Champix)(16% of all clients). About half (51%) of the clients chose combination NRT, reaching success rate of 45%. For comparison, the success rate of GP surgeries was 46% and specialist services 52%.

- In an evaluation of North Wales smoking cessation service based at community pharmacies (Allgeier & Tinkler, 2009), on average 36.5% (1558/4273) of clients who had set a quit date were CO-validated successful quitters at the 4-week follow-up.

- Healthy Living Pharmacies concept was piloted in Portsmouth in 2010. At HLP pharmacies with an accredited Health Trainer Champion, 78% of smokers expressing some interest in smoking cessation set a quit date with a 62% quit rate at 4-week follow-up (Bowhill et al., 2010).

Between April 2009 and April 2010, 559 people had stopped smoking which is 23% of the total PCT target and shows an increase of 36% in comparison to the previous year. Moreover, from April 2010 to September 2010, there have been 339 quitters, an increase of 102% compared to the same period in 2009, and by December 2010 pharmacy had met their annual quit target.

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\(^3\) At present, pharmacy-based service often includes referral to local stop smoking services. These clients are not included in quit rates at pharmacy settings. However, recent guidance calls for establishment of formal referral systems and recommends that the referrers should be informed on treatment outcomes (Croghan, 2011).

References

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