Medicines Optimisation Innovation Centre

SERVICE EVALUATION: Community Pharmacy Stop Smoking Service

Dr N Goodfellow, Dr G Fleming

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Acronym list

Acronym	Full term
BSO	Business Services Organisation
CO	Carbon monoxide
COPD	Chronic Obstructive Pulmonary Disease
CPNI	Community Pharmacy Northern Ireland
DH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety
GP	General Practitioner
HSC	Health and Social Care
MOIC	Medicines Optimisation Innovation Centre
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NICE	National Institute for Clinical Excellence
NICPLD	Northern Ireland Centre for Pharmacy Learning and Development
NRT	Nicotine Replacement Therapy
OTC	Over-the-counter
PHA	Public Health Agency
SPPG	Strategic Planning and Performance Group

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Executive summary

Smoking continues to represent a major public health challenge in Northern Ireland, contributing to approximately 2,200 preventable deaths annually and disproportionately affecting populations in deprived areas. The Community Pharmacy Stop Smoking Service plays a significant role in addressing this issue, offering a structured evidenced based 12-week programme combining behavioural support and nicotine replacement therapy (NRT) aligned with the National Institute for Clinical Excellence (NICE). This evaluation, commissioned by the Department of Health and undertaken by the Medicines Optimisation Innovation Centre (MOIC), assessed the current service model to inform its redesign from 2026 onwards.

A mixed-methods approach was used, including surveys of service providers (n=68), non-providers (n=4) and service users (n=5), alongside pharmacist interviews and quantitative data analysis. Findings indicate that the service is highly valued by both pharmacy staff and service users, with strong professional commitment from pharmacists and clear public health benefits. Community pharmacy settings were viewed as highly accessible, convenient and trusted environments, supporting engagement and delivery.

Service participation is primarily driven by pharmacists' commitment to improving public health rather than financial incentives. However, barriers to provision were identified among non-providers, notably the requirement for a private consultation area, perceived poor patient engagement and concerns regarding funding. Where the service is delivered, enrolment is largely dependent on service user motivation, often supported by the accessibility and cost-free nature of the service.

Despite these strengths, the evaluation identified several structural and operational limitations. The current service model is widely perceived as inflexible and not fully aligned with contemporary smoking behaviours. Key issues include rigid eligibility criteria, limited treatment scope (e.g. exclusion of vaping in the current service

specification and reduced support for complex quit attempts), weekly attendance requirements and lack of integration with other care pathways. There is no formal mechanism for transferring patients from hospital or GP settings into community pharmacy services, limiting continuity of care.

Operational challenges were consistently highlighted, particularly relating to workforce capacity and administrative burden. Delivery is heavily dependent on pharmacist time, creating pressure in busy or single-pharmacist settings. Administrative processes were described as cumbersome, involving duplication of paper and electronic records, lengthy forms and inefficient systems. These factors were viewed as disproportionate to the level of remuneration and acted as a barrier to both enrolment and sustained service delivery.

Training provision was generally regarded as high quality; however, accessibility and format were identified as areas for improvement. Respondents expressed a preference for shorter, flexible and predominantly online training modules, alongside expanded training for the wider pharmacy team. There was strong support for a more multidisciplinary approach, enabling appropriately trained staff to deliver aspects of the service under pharmacist supervision.

Quantitative data demonstrate that the service achieves strong short-term outcomes, with 55% of participants reporting abstinence at 4 weeks. However, long-term follow-up rates are low, limiting assessment of sustained impact. Variability in service uptake across pharmacies was also observed, with many sites enrolling fewer than 20 service users annually, indicating underutilisation of available capacity.

Overall, the evaluation concludes that while the Community Pharmacy Stop Smoking Service is clinically effective and highly valued, it is operationally outdated. To ensure sustainability and maximise impact, modernisation is required.

In order to operationalise the findings from this evaluation, the following service redesign recommendations were developed:

1. Digital transformation and process efficiency

Modernise administrative and IT infrastructure by streamlining systems and transitioning to a fully digital process that reduces burden and improves efficiency.

2. Service flexibility and responsiveness

Introduce greater flexibility in service design and delivery, including adaptable timelines, review of therapeutic interventions and eligibility criteria, to better meet diverse needs and improve accessibility.

3. Service scope expansion and innovation

Expand the scope of services to include emerging priorities such as vaping, support for individuals with complex quit journeys and pharmacist independent prescribing while ensuring interventions remain aligned with current evidence-based practice.

4. Integrated care and referral pathways

Develop and embed integrated referral pathways across primary and secondary care to ensure seamless patient journeys and improve continuity of care.

5. Workforce optimisation

Maximise utilisation of the wider pharmacy workforce by enabling skills mix, delegation and expanded roles to enhance capacity and service reach. Include consideration of the competencies that pharmacist independent prescribers will bring to the service.

6. Workforce development and training

Enhance accessibility, relevance and quality of training provision to ensure all pharmacy staff are equipped with the competencies needed for evolving service demands.

7. Sustainable funding and remuneration

Review and align remuneration structures to accurately reflect workload, complexity and resource requirements, supporting sustainability and workforce motivation.

8. Promotion and service uptake

Improve awareness of the service, particularly to priority groups, through a coordinated, multi-channel approach that builds on in-pharmacy engagement and staff advocacy. This should include the use of social media, digital screen messaging, targeted campaigns and empowering staff to actively promote the service.

Addressing these areas will support a more responsive, efficient and patient-centred service, better aligned with current public health needs and capable of delivering sustained reductions in smoking prevalence across Northern Ireland.

1. Introduction

1.1 Background

Smoking remains a significant public health challenge in Northern Ireland (NI). A recent report titled “Tackling the public health impacts of smoking and vaping” highlights the impact and prevalence of smoking among the NI population. There are approximately 2,200 preventable deaths each year which are attributable to smoking in NI. Significantly, smoking-related deaths per 100,000 population are 98% higher in most deprived compared to least deprived areas. Smoking also represents a significant drain on healthcare resource use coupled with associated economic inactivity due to 34,900 smoking-related hospital admissions recorded in annually in NI [1].

In Northern Ireland people who smoke or vape are more likely to live in urban, deprived areas [2]. Nearly 20% of current smokers use e-cigarettes or vaping devices and there is a growing prevalence of adults, particularly those aged 16-34, using these devices [2].

In order to address smoking prevalence and associated health inequalities there are over 600 free stop smoking services available across Northern Ireland in GP surgeries, community pharmacies, Health and Social Care Trust premises and community and voluntary organisations [3]. These services are commissioned by the PHA in Northern Ireland and community pharmacies are the largest provider of stop smoking services. The Regional Pharmacy Smoking Cessation Service was officially launched in Northern Ireland on 1st December 2006 ahead of the smoke free legislation which took effect on 30th April 2007. The Regional Pharmacy Smoking Cessation Service, now named the Community Pharmacy Stop Smoking Service, offers people who smoke a 12-week programme of behavioural support and provides the weekly supply of nicotine replacement therapy (NRT) if appropriate. The service was available in 463 out of 536 registered pharmacy premises in NI, accurate as of 31st December 2025 [4]. The current service model has remained largely unchanged since its introduction 20 years ago and helped to bring smoking prevalence rates in Northern Ireland down over the

last ten years from 23% in 2015/16 to 12% in 2024/25 [2], this represents an estimated 320,000 people [1].

The aims of this service are stated in the Pharmacist's Guide for the service [5] as being:

- to support smokers who are assessed as motivated to quit
- provide behavioural support and supply NRT, where suitable, to smokers weekly for up to 12 weeks
- complete DHSSPS monitoring forms to enable evaluation and monitoring of the service

The Public Health Agency, in partnership with the Strategic Planning and Performance Group (SPPG) and Community Pharmacy NI (CPNI) are currently revising and updating the service specification and associated contract for all pharmacy-based Stop Smoking Services in Northern Ireland. This refresh of the Stop Smoking Service Specification and updated Contract for Community Pharmacists is especially timely given the introduction of the Tobacco and Vapes Act 2026, the current regional update to stop smoking service provision in secondary care, changes in smoking behaviours and widening health inequalities.

1.2 Community Pharmacy Stop Smoking Service Evaluation

The Medicines Optimisation Innovation Centre (MOIC) was engaged by the Department of Health (DH) to support the evaluation of the current Community Pharmacy Stop Smoking Service in NI. This is the first review of the service since its introduction in 2006.

The aims of the evaluation were to:

- Feedback on the delivery of the contracted 12-week Stop Smoking Service and the pharmacy stop smoking specialist experience - including challenges, barriers, suggested improvements, key factors for service success and any factors which hinder delivery of this service in the pharmacy setting.

- Report on service user experience of using the Stop Smoking Service available through pharmacies – including feedback on challenges, barriers, suggested improvements, key factors for client success, awareness of services.

It is intended that the findings of this evaluation will provide insights into the current model, which will be used to support the refresh of the Stop Smoking Service Specification and updated Contract for Community Pharmacies for 2026 onwards. Engagement of service users in this evaluation will be used to support co-design and co-production of an updated service model and ensure service users have a say in how services can be improved to better meet their needs.

2. Evaluation methodology

The views of three key stakeholder groups were sought to facilitate evaluation of the service: community pharmacy staff providing the service; community pharmacy staff who do not currently provide the service; and service users who have used the service. A mixed methods approach was employed consisting of online surveys, in-depth interviews with pharmacists and quantitative data provided by the Public Health Agency (PHA) from interrogation of the Elite Monitoring System.

An online survey was developed for each stakeholder group and published on Microsoft Forms (Appendix 1-3). The surveys for pharmacy staff providers and non-providers of the service were circulated via email in January 2026. Links to the surveys were also hosted on a Business Services Organisation (BSO) website. CPNI provided a number of reminders and prompts via email to complete the surveys which closed to responses on 31st March 2026. The survey for service users was also developed on Microsoft Forms and was promoted to service users from February-March inclusive via printed posters displayed in community pharmacies, QR codes on leaflets distributed to community pharmacies and via social media posts (Appendix 4). All survey responses were exported to Excel for analysis. Responses to all free text questions were reviewed, coded and thematically analysed.

All pharmacy staff who completed a survey were invited to participate in an in-depth interview to provide further feedback. Each interview was hosted by a Programme Manager from MOIC to encourage open discussion. The interviews were conducted with an interview guide (Appendix 5) to ensure consistency and provide a framework for discussion. The discussions were audio recorded and transcribed in full using Microsoft Teams. All directly identifiable information were removed from the transcripts and they were verified by a Programme Manager in MOIC. Once the transcripts were verified, the audio recordings were deleted. Each transcript was coded and key themes from each interview were identified and grouped. Illustrative quotes are highlighted below, these are not directly attributable to individual participants.

Microsoft Copilot was used to compare AI thematic coding against programme manager coding of open questions in the surveys and coding of the interviews and to assist with thematic comparison of the interviews.

Quantitative data was provided by the PHA in order to inform interview sampling, however, due to the low number of interview acceptances all willing interviewees were interviewed. The data from the PHA is presented in section 3.6 below and provides additional context around the service specifically with regards to pharmacy deprivation index, service user enrolment and quit rates. The data points received included the following:

a) List of all contracted pharmacies
b) List of non-participating pharmacies
c) List of pharmacies which are located within/ close to areas of higher deprivation and provide services to these communities and individuals
d) Pharmacies separated into categories including; areas with low deprivation, areas with high deprivation, pharmacies with high quit rates and pharmacies with low quit rates, pharmacies with high client numbers and those with low client numbers
e) Definition of high / low quit rates and definition of high/ low deprivation and clarification on PHA target groups

f) The number of clients enrolled in specialist service, quit rates at weeks 4 & 52, numbers or % lost to follow-up at week 52, CO monitoring rates.

3. Evaluation results

3.1 Survey respondent characteristics

Anonymous, written survey responses were received from service providers (n=68), service non-providers (n=4) and service users (n=5).

Out of the 68 service provider responses, 67 were received from pharmacists and 1 from a dispensary assistant/technician. Thirty of these responses were from pharmacy contractors. When asked about their role in service delivery, pharmacists described all the different aspects of service provision and the dispensary assistant/technician described carrying out carbon monoxide (CO) monitoring, providing product advice and behaviour change support. Fourteen of these survey participants indicated a willingness to be contacted for an interview. Subsequently, three people took part in one-to-one interviews conducted via Microsoft Teams. All three participants were highly experienced community pharmacists who had delivered the stop smoking service for many years.

Out of the 4 respondents who indicated that they did not currently provide the Stop Smoking Service, 3 were contractors and 2 had previously provided the service.

Despite the low number of responses (n=5) received from service users who had used the Community Pharmacy Stop Smoking Service, the feedback provided gave a useful indication of patient experience, particularly around accessibility and perceived value.

3.2 Engagement with the service

Service provider's motivation to provide the service

Respondents overwhelmingly (n=41) described their motivation to provide the service as wanting to help people stop smoking in order to improve public health outcomes. Participation in the service was also in many cases due to the fact that it was already established in the pharmacy and a contractual obligation. A small number of participants cited public demand and the service being rewarding and fulfilling to provide as their motivation for service provision. Financial incentives may have played a role in the past but it was noted that remuneration has not kept pace with workload or inflation and income generated was not a main driver for service participation.

> "...it just it seems crazy that it's been at the same rate for almost 30 years..."
> Pharmacist interviewee 003

All three pharmacists interviewed described a commitment to public health as their motivation to provide the service and an opportunity to demonstrate pharmacists' clinical value outside of dispensing medication. They also described it as a service very well suited to community pharmacy and each had a long-standing involvement in service provision. This reflects strong professional buy-in and the differentiation of community pharmacy service provision since the Stop Smoking Service started.

Service non-provider barriers to service provision

The most significant barrier to providing this service stated by pharmacists who did not provide the service was a lack of appropriate physical infrastructure within the community pharmacy setting. The service requirement to have a specific area in which a conversation can be conducted free of interruptions and without the possibility of being overheard [6] was preventing provision of the service even when there was willingness.

Another key barrier was poor perceived outcomes and service user engagement. One participant reported very poor retention with most participants dropping out within a month, this, coupled with a high time investment as viewed as professionally demoralising.

Funding was raised indirectly as a barrier with one participant highlighting uncertainty whether there is funding available to help support service set-up. Despite these barriers one respondent indicated that they were currently exploring ways to set-up the service and saw the potential benefit of improving community health.

The survey responses indicated the non-provision of the service is due to practical, structural and financial constraints and not opposition the service in principle.

Key barriers to service provision indicated by current service non-providers:
1. Requirement to have a private, sound-proof consultation area 2. Poor perceived outcomes and service user motivation to stop smoking 3. Funding challenges

Service user engagement

In terms of engagement, service users reported finding out about the service most commonly from the pharmacist or pharmacy staff. The most common reason for joining the service was intrinsic motivation (a clear desire to stop smoking) reinforced by practical incentives (free and accessible). This contrasts with pharmacy non-provider feedback, where lack of patient motivation was perceived as a barrier.

Pharmacy identification of potential service users

When asked about identification of potential service users, respondents predominantly stated that service users self-referred or initiated requests onto the service. A secondary theme was identification of suitable beneficiaries through over-the-counter

(OTC) consultations, particularly when potential service users who were unaware of the service enquired directly about NRT products. Another route of identification relied on the pharmacist identifying suitable service users opportunistically during routine pharmacy interactions. This could include; changes to prescriptions, when accessing other services (e.g. flu vaccination), new inhalers, recurrent antibiotics, chronic obstructive pulmonary disease (COPD) medication, or initiation of cardiovascular medication. Additionally, observations of breathlessness, persistent coughs, smell of smoke or colouration on hands and teeth were noted as prompts to provide information about the Stop Smoking Service. Another route into the service was referral from other healthcare providers, namely GP or hospital-led referral. Finally, there was frequent mention of in-pharmacy advertisement ranging from digital pharmacy TV screens, posters, leaflets and pharmacy social media pages.

Method of identification	Behaviour classification
Self-referral	Reactive
OTC consultations	Opportunistic
Pharmacist-led clinical interactions and observations	Opportunistic
GP/hospital referral	Reactive
Advertising and promotion	Passive

Similarly, the three interviewees described reactive and opportunistic methods of identifying suitable participants for the service. Notably, they each mentioned difficulties when service users were referred and expected immediate sign-up to the service. This is at odds to the pharmacist-preferred method of deferral for a few days in order to test motivation to quit and protect both pharmacist and service user time.

> "...persuading people that the guidance that we're now given is that we try and allow them a week of breaking habits before they start patches."
> Pharmacist Interviewee 001

Pharmacy-reported enrolment facilitators

Analysis of the responses identified three overarching themes that support enrolment onto the Stop Smoking Service. These reflected an interaction between individual readiness, structural enablers and service delivery. Enrolment was primarily facilitated by the service user's intrinsic motivation to stop smoking. This was stated as stemming from health-scares, worsening long-term conditions or a desire to improve health. This motivation to quit was frequently tested by pharmacists who often offered the potential service user an appointment to enrol onto the service at a later time point.

Extrinsic motivating factors also played a role in facilitating enrolment. These factors included GP or hospital referral, family pressure and the cost of NRT to purchase if not supplied through this service. Financial accessibility was frequently described as a key factor to encourage service enrolment.

Furthermore, the community pharmacy setting itself was viewed as a strong facilitator of enrolment. This was due to pharmacies being perceived as convenient, local, easily accessible without appointment and operating with extended opening hours. These factors alongside trusted relationships with well trained, empathetic pharmacy staff were seen as key to success in enrolment in the service.

The final theme that was noted to support enrolment was pharmacy-led promotion and awareness of the service. Methods of promotion included; word of mouth, social media, in-pharmacy digital screens, knowledgeable OTC staff who actively promote the service, stop smoking promotions and Living Well campaigns.

Pharmacy-reported enrolment barriers

Respondents frequently identified aspects of the service specification itself as a limiting factor for enrolment, particularly where the service was perceived as rigid, outdated or misaligned with current smoking behaviours, specifically:

- no hospital to community pharmacy transition pathway for entry onto the service for those who may have been given an initial supply of NRT in hospital. Those interviewed also highlighted the lack of formalised referral pathways to community pharmacy after both hospital and GP initiation;
- treatment options do not include varenicline, provision for service users who want to quit vaping or those who want to cut-down and not quit;
- exclusion of service users who have stopped smoking on their own but need additional support to remain abstinent;
- the inflexibility of attending the pharmacy weekly for advice and NRT provision;
- no central registration so pharmacists are unaware if there have been previous quit attempts;
- perceived inadequacy of 12 weeks' duration of the service;
- the mandatory waiting period of six months before re-enrolment following an unsuccessful quit attempt;
- perceived insufficient remuneration which impacts on the ability to release staff for training and contributes to the perceived undervaluation of community pharmacy.

The service was viewed as poorly accommodating to those service users who have more complex attempts to stop smoking and may require flexibility or longer-term support. The scope of the service was not viewed as inclusive to all people who express an intention to stop smoking or a smoking-related behaviour such as vaping. Vaping was framed as a looming public health risk and a growing unmet need by one pharmacist interviewee.

> "I think widen it to include people who are vaping would be helpful as well in terms of public health too. And I, I *{sic]* just think it's going to be a crisis coming down the line in the in, in [*sic*] years to come about vaping."
> Pharmacist interviewee 003

A common barrier to enrolment which is difficult to address is the intrinsic motivation of current smokers. Pharmacists described service users who; had a fear of failure or being judged, that didn't want to stop smoking, those who have accessed the service multiple times but have not completed the 12-week programme, unwillingness to have a full consultation or commit to a formal service, people who were apathetic and not ready to stop and those with competing priorities (work, family, life pressures).

Barriers to enrolment also exist due to pharmacy capacity which limits proactive enrolment. Key to this was that the service is pharmacist-delivered therefore anything that impacted on pharmacist time such as competing workload demands, lengthy form completion for on-boarding service users and insufficient staffing, particularly within single-pharmacist pharmacies, negatively affected capacity for proactive enrolment.

A less frequently stated barrier was low public awareness of the service and specifically how the service operates with an initial lengthy consultation and weekly attendance.

3.3 Delivery of the service

Who should deliver the service?

When service providers were asked "If you could change who delivers certain aspects of the service, what would you change and why?", twenty-two respondents stated that there should be no change to the current set-up with the pharmacist retaining responsibility for the service provision. This was largely due to the perception that pharmacists were best placed to assess smoking history and prior quit attempts, able to recommend the most appropriate NRT, build trust and rapport and ensure clinical safety. Concern was voiced about delegation potentially reducing service quality and there was a belief that patients were more honest and engaged when speaking to a pharmacist.

In contrast, 32 respondents stated that suitably trained pharmacy members of staff could take the lead on certain aspects of the service with the pharmacist retaining oversight and NRT selection and supply. Trained pharmacy staff cited included; pharmacy technicians, dispensary assistants, counter staff and Foundation Training Year students. The suggestion to delegate aspects of the service provision included; administrative tasks and documentation, CO monitoring, routine follow-ups and initial questionnaires and information gathering. The primary drivers for this suggestion were to reduce pharmacist workload and reflect the fact that pharmacist time was considered poorly reimbursed for this service. Additionally, it was noted that pharmacy staff already have trusted relationships with service users and provide counselling on NRT products as part of their current job role.

Pharmacy-reported service delivery facilitators

Pharmacy resource consisting of adequate staffing and sufficient time were frequently cited as essential factors for service delivery. More explicitly respondents made reference to the need for more than one pharmacist on duty to enable protected time for consultations, the availability of well-trained staff who were engaged with the service, whole pharmacy team awareness with pro-active pharmacy staff identifying potential service users and consultation room availability.

Despite the constraints on pharmacy staff time the community pharmacy setting was highlighted as a facilitator of service delivery due to long opening hours, walk-in availability, being locally situated and having established good relationships with service users.

Service promotion was believed to improve service delivery and a request for more branding and marketing of the service was voiced with advertising material consisting of posters, social media and PHA campaigns.

In contrast to the more burdensome administration around enrolment, delivery of the service was perceived as straightforward in terms of easy-to-follow forms, quick service to administer.

Certain aspects of the service design were reported to actively facilitate delivery. This referred to the wide selection of NRT products included, the flexibility to change products during the programme, free-of-charge service, booklets supplied to help determine which strength products to start with and Living Well leaflets. Interestingly, while weekly engagement was highlighted as a barrier to enrolment it has was been highlighted as a facilitator to service delivery.

Pharmacy-reported service delivery barriers

Echoing the dominant theme of adequate pharmacy resource being a key facilitator to delivering the stop smoking service, the opposite, inadequate pharmacy resource was reported as being the main barrier to delivery of the service. The most consistently reported difficulty related to insufficient capacity due to high workload, competing demands for time, lone-pharmacist working, time required for initial enrolment and insufficient staff.

Certain aspects of administrating the service were described as barriers to service delivery. At present there is a requirement to complete some forms on paper only and store these in the pharmacy, other forms need to be completed on paper and either transcribed to be submitted electronically via the Elite Monitoring System or historically duplicated manually and submitted in hard copy, additionally the service user is provided with an Equality Monitoring Form to be returned via self-addressed envelope in the post. The dual record management of paper and online forms was disliked due to having to store paper forms, data duplication and the time requirement for double data entry. Additionally, the forms were perceived as unnecessarily lengthy. These administrative requirements were widely viewed as disproportionate to remuneration, reducing staff capacity to deliver the service.

Some elements of the service specification were reported to hinder effective delivery, these included:

- inflexibility was noted explicitly regarding the inability to set a quit date in the past for those who might have already stopped smoking in hospital or at home and then need additional support;
- the requirement to have completely stopped smoking in 4 weeks especially for service users who had dramatically cut down smoking;
- some people were unwilling to complete the CO testing;
- exclusion of vaping;
- fixed 12-week duration;
- weekly scheduled support often resulted in non-adherence and;
- the 52-week follow-up was viewed as too remote to their participation in the service.

The inflexibility of the service specification around 4-week cut off and 12-week duration were mirrored in the pharmacist interviews with a call for flexibility to accommodate set-backs such as bereavement, stress, illness or, uniquely, the suggestion of moving from a ’12 weeks’ time-bound service to an ‘up to 12 supplies’ model. An interviewee made the suggestion of completing baseline CO testing as a motivational tool, there was a clear desire for CO testing to be framed as motivational and not a pass/fail checkpoint. One pharmacist described a risk of misinterpretation of high CO perhaps due to passive smoking or occupational exposure (e.g. road tarmacking) if the context was not understood.

Maintaining consistent service user engagement and motivation was described as a recurrent challenge. Reasons behind this were stated as; peer pressure, family members who smoke, weight gain, cutting down rather than quitting, limited commitment once immediate financial need is met which can all result is poor weekly adherence or dropping out of the service prematurely.

Service user-reported assets and suggested improvements

The service users all reported positive experiences with the service and stated that the relationship with pharmacy staff was the strongest asset of the service. Pharmacy staff were reported as being friendly, knowledgeable and supportive. Additional positive attributes included: convenient access; free service; ability to talk face-to-face and; good quality products.

Dissatisfaction with the service stemmed from operational aspects including the weekly wait to access the service and a request for a slightly longer service duration. Suggested improvements to the service centred on: more flexible weekly NRT supply and advice; extension to service duration; provision of a leaflet or information pack on products available under the service, options to purchase outside the service and a directory of other support services; and an optional app or diary component to track symptoms, note coping strategies, record weight changes and money saved.

All service users reported that they had no difficulties using the service, indicating low barriers to using the service once enrolled.

Key factors for success as reported by service users:
1. Pharmacy staff were highlighted as being friendly, knowledgeable and supportive
2. Convenient access to the service (geographically proximal and walk-in access)
3. No cost to service user
4. In-person meetings
5. High quality NRT provided
Improvements suggested by service users:
1. Request for more flexibility around the timing of weekly advice and NRT supply
2. Extension to service duration over 12 weeks
3. Information requested to be provided on; products supplied under the service, options to purchase outside the service and signposting to other support services
4. Provision of a self-management tool

3.4 Training

There was a total of 81 reported instances of training completed by service providers, four people reported completing multiple types of training. The vast majority (n=41) were trained through the completion of the distance learning course provided by the Northern Ireland Centre for Pharmacy Learning and Development (NICPLD), 'A-Z of smoking cessation'. This course was initially a self-study book which was converted to an online course and was available as a training option prior to 2024/25. Smaller numbers had completed the full training provided by Cancer Focus NI (n=12) and the Cancer Focus NI update training (n=14). This full Specialist Smoking Cessation Training was originally delivered face-to-face over 2 consecutive days, during 2020, this training changed from face-to face delivery to online. A shorter (3.5 hour, half day) update course was also available to update knowledge every 3 years this changed to online delivery in 2017. The PHA is currently updating the training framework in NI. There were 10 reports of self-study, 2 in-house training and 2 who had completed the Scottish and Welsh equivalent training.

The responses regarding who should receive training showed a majority requesting broad, inclusive training rather than limiting this to pharmacists alone. There was a clear agreement that pharmacists should receive full, comprehensive training as they hold clinical responsibility and oversight. Nevertheless, there was a clear willingness for all pharmacy staff to receive some level of training. Many respondents explicitly stated that all pharmacy staff or anyone with direct service user interaction should be trained in the service, highlighting the importance of shared awareness and consistent messaging.

Many reported that the current training content is excellent, satisfactory or fit for purpose with little or nothing to change. Despite the training content being widely viewed as positive there were a number of clear, consistent suggestions for improvement.

- The training is time heavy and could be condensed. This would improve uptake and feasibility.

- Clear guidance on vaping is needed and information included on how to support people to quit vaping.
- Respondents asked for training to include more real-world examples, including success stories, coping strategies, conversation prompts and role play videos.
- Role-appropriate content with clear separation between clinical training for pharmacists and brief-intervention or awareness training for other members of staff.
- Clearer information on NRT products available and calculating the correct dose.

> "…it is very long compared to essential training for other services."
> Pharmacist service provider

When asked about access to training, responses varied depending on what iteration of training they had completed. Some felt access was already adequate however the majority expressed the view that training would be more achievable if it was shorter, online, flexible, locally supported and backed by protected time and funding. In terms of format, the preference was for fully online to facilitate easy access at a convenient time however it was noted that a significant proportion valued face-to-face components to enable discussion and ask questions. Additionally, a modular training approach was favoured when compared to the 2-day training course. Protected time during working hours, employer support and funding/backfill to allow staff to attend training were significant issues. Localised training days or evening events were suggested to reduce travel and staffing disruption.

The requirement to update training every 3 years was not explicitly questioned in the survey, however from a number of responses it was clear that this had not been achieved. When asked about how they would improve the training content, one respondent explicitly stated, "forgotten as we have completed 10 plus years ago". Others indirectly indicated that their training was completed prior to the Cancer Focus

training moving online (approx. 2020) by requesting an online course or referring to the practicalities around attending a face-to-face 2-day training course.

An interviewee singled out gaps in understanding the service specification, accurately completing paperwork and conducting CO monitoring at the correct timepoints among locums and less engaged members of staff.

3.5 Administration of the service

Pharmacy respondents were highly consistent with administrative improvements they would like to see. The feedback focused on reducing the perceived excessive administrative burden by simplifying, modernising and streamlining administration. The main point was to move to a fully online system, this would reduce the need for physical storage space in pharmacy premises and reduce duplication of data entry. Related to this point was the request for a single point of entry onto the service and allow for patient registration and tracking to enable the pharmacist to see previous quit attempts and identify service use across different pharmacies to reduce perceived misuse of the service. Regarding the data collection, the forms were viewed as too long and overly detailed. Specifically, there were requests to remove irrelevant questions such as those relating to Zyban which is no longer available under the service, reduce equality and monitoring requirements, improve sequencing of questions and use larger text (on paper forms). Suggested improvements to the online platform centred around making it more user friendly with fewer screens, faster navigation and integration with pharmacy medication record systems. In terms of the claim process there were calls to adopt the Pharmacy First or EHC claims process with claims completed via a single product code/fee code or automatic, electronic claim generation. There was also a recommendation to change the timeframe of review and claims. Many suggested changing the current 4- and 52-week follow-ups with 4- and 12-week follow-ups. This was largely due to the view that the 52-week contact was stated as difficult to manage, clinically less meaningful and time consuming if people have changed address or telephone number. Similarly, requests were made to have a payment at sign-up or at 12 weeks only. Email reminders to the

pharmacy were requested to facilitate pharmacy compliance with the follow-ups.

The pharmacists interviewed unanimously reiterated the excessive paperwork, duplication of data entry (paper and online), dislike of intrusive questions (employment status and previous quit attempts) and a desire for streamlined e-forms.

> ...I find it a bit embarrassing asking those questions, you know, or they may be unemployed or you know, and you don't want to be sounding judgmental...
> Pharmacist interview 003

3.6 Quantitative data presentation

To provide context for the service the PHA provided quantitative data on pharmacy service provision in 2024-25, including pharmacy post code deprivation index (1 representing pharmacies in the most deprived post code areas and 5 representing least deprived areas), numbers of service users enrolled and quit rates (%). The data described two specific subsets:

i) pharmacies separated into areas with low deprivation and areas with high deprivation
ii) pharmacies with high client numbers and those with low client numbers

A key limitation to interpretation of these data were that typically urban areas have larger numbers of population, pharmacies and more deprivation. Additionally, the deprivation index associated with the pharmacy post code is a proxy to service user post code and therefore implied deprivation index to the population served by the pharmacy. However, on average service users live within 0.9 miles of their nearest pharmacy [7].

In February 2026 there were 462 pharmacies contracted to provide the service and 45 pharmacies that did not provide the service. Figures show that 6857 people set a quit date in 2024/25 using this service. At four weeks 3802 people (55%) had self-reported

reported as having successfully quit smoking and this was validated in 67% (2536) using CO testing. The remainder had either reported not quitting (1174) or were lost to follow-up (1881). In the previous year 2023/24, 6671 people had set a quit date using this service and when contacted 1 year after their stated quit date 1326 (20%) self-reported that they had remained abstinent however the proportion lost to follow up was much higher 4495 (67%) and 850 (13%) had self-reported not quitting.

In terms of those pharmacies at both ends of the deprivation scale it was most common to see low service user numbers, <20 people enrolled per pharmacy. In the most deprived areas there were a small number of pharmacies with high numbers of service user enrolment as shown in Figure 1

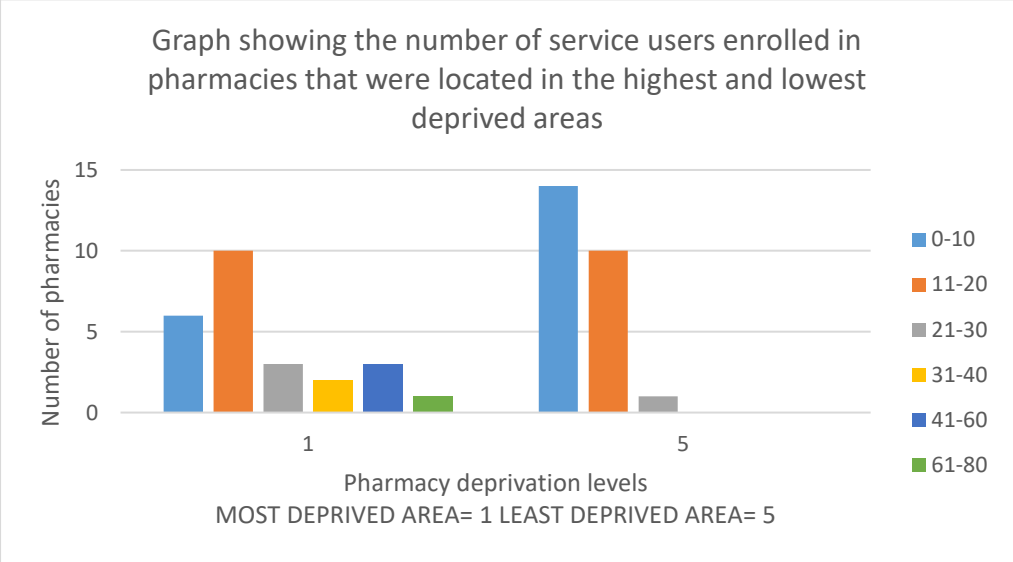

Figure 1. Graph showing the number of service users enrolled in pharmacies that were located in the highest and lowest deprived areas in Northern Ireland

When looking at the quit rates at both ends of the deprivation spectrum the reported quit rates were, again, very similar with the majority reporting quite rates of 50% or higher regardless of deprivation index as shown in Figure 2.

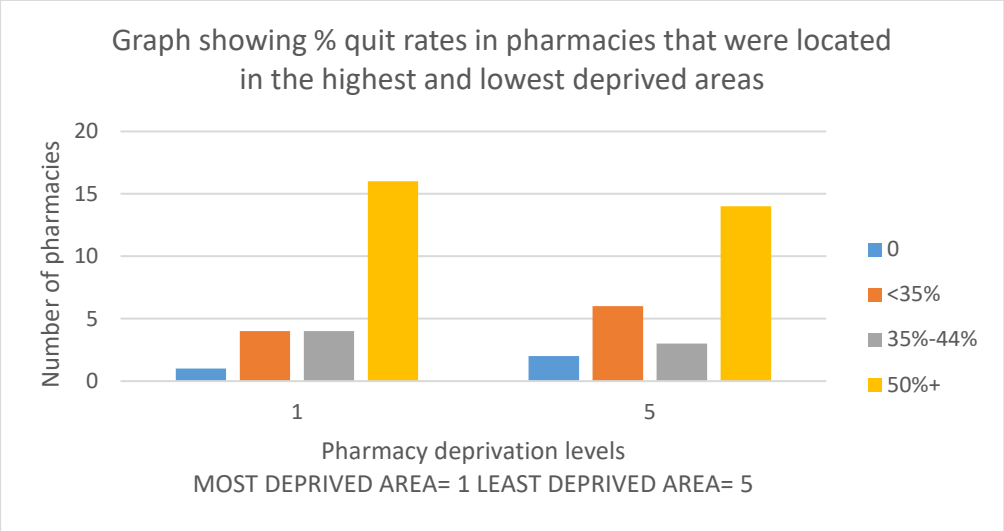

Figure 2. Graph showing the % quit rates in pharmacies that were located in the highest and lowest deprived areas

Whilst noting that the pharmacy post code is a proxy to service user post code and therefore an implied deprivation index, this data suggests that pharmacies are uniquely, locally placed to provide stop smoking services to the communities they serve across the spectrum of deprivation.

4. Discussion

The Community Pharmacy Stop Smoking Service is highly valued and has an important part to play in improving public health through supporting stopping smoking and, perhaps in the future, supporting people to stop vaping. This evaluation has highlighted parts of the service that could be updated to provide a modernised design addressing current smoking behaviours.

Despite being a widely provided and well utilised service, a low proportion of invited stakeholders provided feedback in the context of this evaluation and this should be noted as a key limitation. Nevertheless, the feedback that was provided was rich in qualitative detail and consistent in the messages relayed.

In terms of service initiation, the decision to provide the service is largely based in the pharmacist's motivation to improve public health. Importantly among the service-non

providers surveyed there was a willingness to provide the service if financial constraints and the requirement for a soundproof, private consultation area were removed.

The reactive, passive and opportunistic nature of identification of potential service participants share a reliance on external triggers or a perceived readiness to quit rather than being driven by proactive, planned interactions. While community pharmacy is well placed to target all people who smoke, the current Quality Standards [6] for the delivery of the service require service providers to focus on priority groups of people who smoke, specifically those that are: disadvantaged, routine and manual workers, pregnant women, children and young people. The rationale behind this is to target the disproportionate health inequalities and smoking prevalence in these specific groups. It should be further examined whether there is scope for community pharmacy to provide targeted interventions in these populations.

Enrolment into the service was predominantly facilitated by service user's motivation to quit. A potential method of harnessing this would be via public health messaging campaigns about the harms of smoking and promoting the Community Pharmacy Stop Smoking Service. The inflexible nature of weekly attendance for advice and NRT was particularly problematic as it does not allow any modifications for holidays or stressful life events. Allowing some level of flexibility in this regard has the potential to improve retention onto the service. Another barrier to enrolment was the inability to accept people onto the scheme who had already began a quit attempt in another setting (independently at home, GP initiated or secondary care initiated). If new pathways onto the service could be designed to include transitions from these settings into community pharmacy it would align with the Neighbourhood Model of Health and Wellbeing [8] to provide more integrated care to service users in their local community. The exclusion of those who would like to stop vaping was frequently highlighted as a shortcoming of the current service offering. It has been reported that vaping has overtaken current levels of smoking for the first time in Great Britain [9], and is growing in prevalence in Northern Ireland [2] therefore, it would seem prudent to include this in

any future service redesign. The barriers to enrolment identified by pharmacy staff have the potential to be addressed and accommodated within the scope of review of the service specification.

Delivery of the service is reported to be clinically manageable but operationally dependent on workforce capacity. This service is particularly vulnerable in pharmacies with single-pharmacist working and anything that was perceived as taking an additional time burden such as lengthy and duplicative administration reduced that capacity. Conversely, anything that streamlined the process such as weekly engagement, perhaps due to planning workflow in advance, was viewed as an enabler of the service. It would be welcomed to permit professional judgement being used to decide the number, timing and frequency of appointments offered to service users who had successfully stopped smoking and explicitly legitimising delayed entry onto the service. It may be relevant to consider that current smokers may represent a high proportion of complex cases and require more time, flexibility or a more personalised service to supporting them to quit successfully. It is also important to note the growing numbers of independent prescribers within community pharmacy in Northern Ireland and the potential scope to review and widen the therapeutic interventions offered. The key points are summarised in the table below:

Theme	Key Enablers	Key Barriers
Workforce & time	Adequate staffing, protected time	Lone pharmacist, workload pressure
Administration	Familiar systems, consultation rooms	Paperwork, duplication, follow-ups
User engagement	Trusting relationships, motivation	Drop-out, weekly attendance burden
Service design & funding	NRT flexibility, public health value	Rigid rules, poor remuneration

Some of these pharmacy-reported enablers (strong relationship with pharmacy staff) and barriers (no flexibility of timing of weekly support and support limited to 12 weeks) were echoed by service users. An interesting suggestion made by service users was

to employ online self-management tools. There is a growing market for tobacco-cessation apps worldwide, many of which include this type of digital support [10]. An additional benefit of employing a digital tool for service users is the potential to support outcome tracking and future evaluation and commissioning evidence for the service. The current follow-up at 52 weeks had low uptake which limited assessment of sustained impact.

There was generally high satisfaction with training course content with the main concern being the length of training and requests to include training on vaping. It should be noted that this feedback is mainly based on the NICPLD course 'A-Z of smoking cessation' as this was the training method that the majority of respondents had completed. There was considerable support for a hybrid training model to be initiated with awareness/support role training for other members of the pharmacy team while the pharmacist retained clinical oversight. Anecdotally, a number of respondents made reference to having completed their training many years ago, this should be given due consideration when revisiting the Quality Standards. The current requirement states that update training should be completed every 3 years [6], if this were to be enforced it may negatively impact the ability to provide the service.

Updates on administration of the service should focus on streamlining data collection, improving user friendliness of the online system, consider changing the data entry time points and to enable patient registration tracking across the whole service.

5. Service redesign recommendations

In order to operationalise the findings from this evaluation, the following service redesign recommendations were developed:

1. Digital transformation and process efficiency

Modernise administrative and IT infrastructure by streamlining systems and transitioning to a fully digital process that reduces burden and improves efficiency.

2. Service flexibility and responsiveness

Introduce greater flexibility in service design and delivery, including adaptable timelines, review of therapeutic interventions and eligibility criteria, to better meet diverse needs and improve accessibility.

3. Service scope expansion and innovation

Expand the scope of services to include emerging priorities such as vaping, support for individuals with complex quit journeys and pharmacist independent prescribing while ensuring interventions remain aligned with current evidence-based practice.

4. Integrated care and referral pathways

Develop and embed integrated referral pathways across primary and secondary care to ensure seamless patient journeys and improve continuity of care.

5. Workforce optimisation

Maximise utilisation of the wider pharmacy workforce by enabling skills mix, delegation and expanded roles to enhance capacity and service reach. Include consideration of the competencies that pharmacist independent prescribers will bring to the service.

6. Workforce development and training

Enhance accessibility, relevance and quality of training provision to ensure all pharmacy staff are equipped with the competencies needed for evolving service demands.

7. Sustainable funding and remuneration

Review and align remuneration structures to accurately reflect workload, complexity and resource requirements, supporting sustainability and workforce motivation.

8. Promotion and service uptake

Improve awareness of the service, particularly to priority groups, through a coordinated, multi-channel approach that builds on in-pharmacy engagement and staff advocacy. This should include the use of social media, digital screen messaging, targeted campaigns and empowering staff to actively promote the service.

6. Conclusion

This evaluation clearly demonstrated that staff and service users alike valued the Community Pharmacy Stop Smoking Service and pharmacists had a high level of professional commitment to the service. However, while the service was deemed clinically strong it was described as operationally outdated. Community pharmacy is a highly appropriate delivery setting, nevertheless, sustainable implementation requires protecting time, streamlining processes and better aligning service expectations with real-world pharmacy environments and service user behaviour.

This evaluation presents the current enablers and barriers in service design alongside suggestions made to update and improve service engagement and delivery. This feedback should contribute to service redesign and modernisation to ensure continued relevancy and engagement in the stop smoking service in community pharmacy and a continued reduction in the number of people smoking in Northern Ireland.

7. References

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[8] Health and Social Care NI Reset Plan. Department of Health, 9th July 2025. Available online at: Health and Social Care Reset plan | Department of Health (accessed 20/05/2026).

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Appendices

Appendix 1: Community Pharmacy Stop Smoking Service Evaluation – Service Users survey

Community Pharmacy Stop Smoking Service Evaluation- Service Users

If you have used pharmacy services to help stop smoking we would like to hear your views.

- This survey is part of a service evaluation of the pharmacy based stop smoking service.
- One of the goals of this evaluation is to gather service user feedback on the service.
- The Medicines Optimisation Innovation Centre (MOIC) will collect and review all responses to the survey. All responses will be stored securely and confidentially. Data will be analysed and presented when combined, individual responses will not be shared.
- A written summary of the evaluation will be made available on MOIC's website [https://themoic.hscni.net/] once completed. Results, including direct quotations may be published in a report to the funding body, journals, publications and conferences. Any quotes used will be anonymous.
- By completing this survey, you confirm that you voluntarily consent to participate in this evaluation and that you also grant consent to the processing of your responses for the purpose of evaluation and dissemination of the pharmacy based stop smoking service.

Please do not provide any identifiable information in your responses below.

All responses are anonymous.

If you would like any further information on the evaluation please contact

Nicola.Goodfellow@northerntrust.hscni.net

Thank you for your participation.

1.Have you used the Community Pharmacy Stop Smoking Service?

Yes

No

2.How did you find out about this service?

Pharmacist

Other pharmacy staff

GP

Word of mouth

Social media

Website

Other

3.Why did you decide to join the pharmacy stop smoking service?

Enter your answer

4.What did you like about the service?

Enter your answer

5.What did you not like about the service?

Enter your answer

6.How could the service work better?

Enter your answer

7.Tell us about any difficulties you had using the service?

Enter your answer

8.If there is anything else you would like to tell us about the service please write this below.

Enter your answer

Appendix 2: Community Pharmacy Stop Smoking Service Evaluation – Service non-providers survey

Community Pharmacy Stop Smoking Service Evaluation- service non-providers

We would like to hear your views

- This survey is part of a service evaluation of the pharmacy based stop smoking service.
- One of the goals of this evaluation is to gather feedback on the service.
- The Medicines Optimisation Innovation Centre is conducting the evaluation and will receive and review all survey responses from both providers and those who have chosen not to deliver the service. All responses will be stored securely and confidentially. Data will be analysed and presented when combined, individual responses will not be shared.
- A written summary of the evaluation will be made available on MOIC's website [https://themoic.hscni.net/] once completed. This evaluation report will be made available to SPPG, PHA and CPNI once completed. Results, including direct quotations may be published in this report and in journals, publications and conferences. Any quotes used will be anonymous.
- By completing this survey, **you confirm that you voluntarily consent to participate** in this evaluation and that you also grant consent to the processing of your responses for the purpose of evaluation and dissemination of the pharmacy based stop smoking service.

Additionally, there is the opportunity to be contacted to take part in a brief follow-up interview to gather more detailed information. If you would like to participate in this one-to-one interview please provide your contact details below where indicated.

If you would like any further information on the evaluation please contact

Nicola.Goodfellow@northerntrust.hscni.net

Thank you for your participation.

1.This survey is only to be completed by pharmacies who **do not** provide the Community Pharmacy Stop Smoking Service. Please confirm that you do not provide this service.

My pharmacy **does not** provide the Community Pharmacy Stop Smoking Service

2.Are you a pharmacy contractor?

Yes

No

3.Did you previously provide the Community Pharmacy Stop Smoking Service?

Yes

No

4.Why have you chosen not to provide the stop smoking service in your community pharmacy?

Enter your answer

5.What changes to the service would be required for you to offer the stop smoking service?

Enter your answer

6.If there is anything else you would like to tell us about the service please write this below.

Enter your answer

7.If you would like to be contacted for a brief interview to provide any further feedback on the service **please leave your email address and/or phone number below.** All feedback provided will be confidential.

Enter your answer

Appendix 3: Community Pharmacy Stop Smoking Service Evaluation – Service providers survey

Community Pharmacy Stop Smoking Service Evaluation- service providers

If you have helped to provide pharmacy stop smoking service we would like to hear your views.

- This survey is part of a service evaluation of the pharmacy based stop smoking service.
- One of the goals of this evaluation is to gather feedback on the service.
- The Medicines Optimisation Innovation Centre is conducting the evaluation and will receive and review all survey responses from both providers and those who have chosen not to deliver the service. All responses will be stored securely and confidentially. Data will be analysed and presented when combined, individual responses will not be shared.
- A written summary of the evaluation will be made available on MOIC's website [https://themoic.hscni.net/] once completed. This evaluation report will be made available to SPPG, PHA and CPNI once completed. Results, including direct quotations may be published in this report and in journals, publications and conferences. Any quotes used will be anonymous.
- By completing this survey, you confirm that you voluntarily consent to participate in this evaluation and that you also grant consent to the processing of your responses for the purpose of evaluation and dissemination of the pharmacy based stop smoking service.

Additionally, there is the opportunity to be contacted to take part in a brief follow-up interview to gather more detailed information. If you would like to participate in this one-to-one interview please provide your contact details below where indicated.

If you would like any further information on the evaluation please contact

Nicola.Goodfellow@northerntrust.hscni.net

Thank you for your participation.

1.This questionnaire is only to be completed by pharmacies that **do** provide the Community Pharmacy Stop Smoking Service. Please confirm that you provide this service.

My pharmacy **does** provide the Stop Smoking Service

2.Please indicate your primary job role.

Pharmacist

Locum pharmacist

FTY trainee pharmacist

Medicines counter assistant

Dispensary assistant/technician

Other

3.Are you a pharmacy contractor?

Yes

No

4.What is your **role** in delivering the stop smoking service as it is now?

Enter your answer

5.If you could change who delivers certain aspects of the service, what would you change and why?

Enter your answer

6.How do you **identify** suitable service users to approach about the service?

Enter your answer

7.What factors help encourage **enrolment** in the service?

Enter your answer

8.What factors act as barriers to **enrolment** in the service?

Enter your answer

9.What factors facilitate **delivery** of the service?

Enter your answer

10.Tell us about any difficulties you experience **delivering** the service?

Enter your answer

11.What **training** have you completed?

Cancer Focus stop smoking specialist training programme (2 days)

Cancer Focus stop smoking specialist UPDATE training

NICPLD 'A-Z of smoking cessation'

In-house training

Self-study/personal study

Other

12.**Who** should receive training on the service?

Enter your answer

13.How would you improve the **content** of the training you received?

Enter your answer

14.How would you improve **access** to the training? Multi Line Text.

Enter your answer

15.Why did you choose to provide the service?

Enter your answer

16.How could administrating the service (data entry and claim form) be improved?

Enter your answer

17.If there is anything else you would like to tell us about the service please write this below.

Enter your answer

18.If you would like to be contacted for a brief interview to provide any further feedback on the service **please leave your email address and/or phone number** below. All feedback provided will be confidential.

Enter your answer

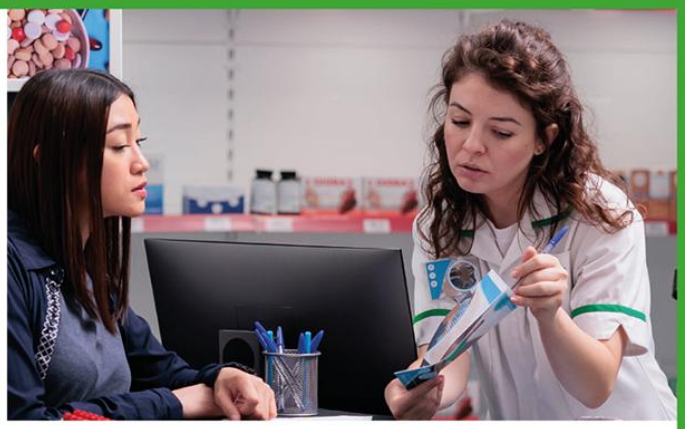
19.In order for us to link deprivation data and smoking cessation rates to increase our understanding of service delivery please provide the **name** and **postcode** of the pharmacy to which your responses relate.

Enter your answer

Appendix 4: Community Pharmacy poster, leaflet and digital media

Stop Smoking Service in community pharmacies

If you have used the **Stop Smoking Service** in a community pharmacy we would like to hear your views.



Please scan the QR code or visit https://forms.office.com/e/HZN1gAYhCj to complete the survey.

The survey:

- takes less than five minutes to complete
- is completely confidential
- will provide valuable feedback for service improvement

Thank you for taking time to complete the survey.

HSC Public Health Agency

moic Medicines Optimisation Innovation Centre

Stop Smoking Service helping you to quit

Produced by the Public Health Agency. Tel: 0300 555 0114 (local rate).

Appendix 5: Interview guide

Medicines Optimisation Innovation Centre

MOIC STAFF INTERVIEW GUIDE

STUDY TITLE: Community Pharmacy Stop Smoking Service Evaluation

DATE: _____

INTERVIEWER NAME: _____

The aim of this interview is to inform a service evaluation of the Community Pharmacy Stop Smoking Service by gathering feedback on the delivery of the contracted 12-week Stop Smoking Programme.

The interview will cover the broad themes below and example questions are provided to guide the discussion.

*Reminder -There are no right or wrong answers, we are interested in your honest thoughts and opinions.

PLEASE AUDIO RECORD (TURN OFF CAMERA) AND USE THE MS TEAMS MEETING LINKS PROVIDED

Enable transcription

Interview questions

Focus of questions	Example interview questions
Engagement	-What motivated you to provide this service? / Why did you make the decision not to provide this service? / Did you previously deliver the service? -What factors affect enrolment of service users? -How do you identify potential users for the service? -What opportunities for improvement are there for service users transitioning from a stop smoking service in hospital to community services?
Challenges	-What factors are a barrier to delivering this service? -How were these barriers overcome? -What do you dislike about the service? -What do you think that service users dislike about the service?
Facilitators	-What are the key factors for service success? -What do you think service users like most about this service?
Monitoring	-How often should service users be contacted once they join the 12 week programme? By who? -What do you think about the length of the current 12 week programme? -What challenges are there around CO monitoring?

	-What are your thoughts on the 6 month time period required before re-registering for a second quit attempt? -How do you find completing consultation form (green form), are there any forms/questions within the consultation form that you are uncomfortable asking service users? -How do you find using the Elite monitoring system?
Training	-How confident do you feel delivering the service? - selection of NRT - do the range of treatment options available meet the needs of service users? - delivering the behavioural support aspect. -What training needs do you have that haven't been met? -How would you improve the training available?
Improvements	-Thinking about the service as a whole what could be improved? -What additional support would be helpful?
	Is there anything else you would like to add?

THANK YOU!!