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Article:

Benefits and Tensions in Delivering Public Health in Community Pharmacies – a Qualitative Study of Healthy Living Pharmacy Staff Champions.

Abstract:

Objective: Healthy Living Pharmacies (HLP) were introduced in the United Kingdom (UK) in a further attempt to deliver public health benefits in community pharmacy settings. Central to the initiative are staff trained as Healthy Living Champions (HLC) and this study sought to explore HLC perceptions of positive and negative aspect of their work and the wider scheme.

Methods: A qualitative study was undertaken with a purposive sample of HLCs working in pathfinder HCPs in the Sheffield area in 2014. Participants were recruited by email to either a focus group (n=7) held at a training event or later semi-structured one-to-one interviews in pharmacies (n=6). Four stages of interpretative phenomenological analysis were used to code and identify themes.

Key Findings: Four main themes emerged relating to the positive workforce development impact HLPs had upon HLCs themselves and on perceived customer and patient engagement and benefits. Tensions were identified with existing commercial business demands and negative views overall of the pharmacy setting with a perceived lack of not only integration with other services but also awareness amongst the public and healthcare staff. HLCs felt empowered and more confident in initiating conversation about health issues with patients, but identified barriers relating to workload, a lack of time to perform their role, isolation, tensions with non-HLC staff and logistical barriers such as poor internet access.

Conclusions: Delivering public health activities through the HLC role in UK pharmacies is associated with several perceived benefits for different stakeholders, but may be threatened by well recognised barriers in UK pharmacies related to the commercial setting.

Introduction

In recent years, community pharmacies in the United Kingdom (UK) and other countries have expanded from their traditional role of dispensing medicines to include the provision of additional health services. The community pharmacy setting has been recognised as having a unique role in allowing interacting with the public when they are '*in both good and poor health'* and possibly not in contact with any other health professional. [1] In particular, the contribution of pharmacies to public

health and wellbeing activities has been emphasised and there is evidence of the effectiveness of some community pharmacy based health promotion services such as coronary heart disease management and prevention and smoking cessation. [2, 3] Studies have suggested that pharmacists support engaging more with public health related roles, in the UK [1] and in countries such as Sudan [4] and Nigeria [5] although additional training needs have been identified. One relatively recent initiative has been the introduction of the Healthy Living Pharmacy (HLP) concept in the UK.[6] Following a successful pilot in 2009 in Portsmouth, the HLP concept was introduced in further pathfinder sites across England with aims of improving the health and wellbeing of local populations and reducing health inequalities.[6] The HLP initiative involves the accreditation of participating pharmacies through meeting standards relating to their workforce, environment, engagement and delivery of core and health promotion services based around identified areas of need (see table 1 for an example). [7]

Insert table 1 around here.

Unique to HLPs are requirements for pharmacists to undertake bespoke leadership training and for the pharmacy to have a trained and accredited member of staff - usually a sales assistant - who can provide health and wellbeing advice in a Healthy Living Champion (HLC) role. [8] Training is formalised through a mandatory Level 2 qualification in Understanding Health Improvement which is accredited by the Royal Society for Public Health (RSPH) [9] . This provides training via paper or electronic formats in health inequalities, communication, health promotion and behaviour change and can be completed in around 7 hours including an assessment. There are now more than 3000 trained HLCs in more than 800 pharmacies in the UK. [8]

Existing research has identified a number of emerging themes related to HLPs. The pilot evaluation in Portsmouth [10] revealed positive outcomes when comparing HLPs to those not participating and increased staff knowledge and job satisfaction. Similar benefits were also identified in another HLP site, although issues emerged about a lack of public awareness of the role. [11] Interviews with staff at a further HLP site identified mainly intangible benefits but also barriers relating to awareness, time and cost. [12] These studies offer important insights but due to HLPs' relative infancy, it is important to gain insights from different sites and perspectives. This study aimed to do so by exploring the perspectives of HLCs in a site not previously studied - in Sheffield - to understand the experiences of such staff and to identify their perceived positive and negative aspects of being involved in an HLP. The HLP scheme was introduced in Sheffield in 2011 after involving over 70 pharmacy staff in a launch event to decide if the city would be a suitable pathfinder site, based on existing pharmacy services and interest [7]. The local pharmaceutical committee and NHS Sheffield collaborated on a successful bid and subsequent initial recruitment of 11 pharmacies reflecting a range of independent and multiple owned and size of business [7].

Methods

A qualitative research design involving a focus group and semi-structured interviews was undertaken with two purposive samples of HLCs in the Sheffield pathfinder site in mid-2014 An email invitation was sent to all the accredited HLPs that had been included in Sheffield – 21 at the time of the study - to participate in a questionnaire (not reported in this paper) and with a further request to participate in a focus group and individual interviews. From expressions of interest a purposive sample was used to ensure representation from different types of pharmacies (multiple or independently owned, located in affluent, deprived, urban and rural setting) and HLC gender (although of note was that there was only one male HLC in the Sheffield HCP scheme and they were included in the final sample). Seven HLCs were selected and written informed consent obtained for the focus group, which used a semi-structured approach with questions aimed at exploring HLCs' experiences and views about positive and negative aspects of their role and HLPs more generally and perceived barriers and facilitators to these. The focus group was digitally audio recorded and transcribed verbatim and was undertaken at a training event for HLP staff to encourage participation. An interpretive phenomenological analysis (IPA) [13] was used to code and explore the focus group data, giving an emphasis to participants' experiences in relation to the HLC role and how they made sense of those experiences. One researcher (JT) undertook the four stages of IPA analysis which involved reading and re-reading the transcript and cataloguing emerging preliminary codes and making notes, iteratively looking for patterns in order to identify main themes and sub-themes, which were then tabulated. [8] A further six semi-structured interviews were undertaken following consent with another purposive sample of HLCs not involved in the focus group to explore in greater detail emerging themes from the focus group. This was comprised of staff from three multiple ownership companies and three independent pharmacies in different locations to ensure that potentially different barriers and facilitators could be captured based on different employer, premises and customer profiles. An interview schedule was adapted from that used in the focus group with additional questions relating to the emerging themes being incorporated with an emphasis on exploring the impact of the HLP on the individual, the pharmacy and patients. Interviews were undertaken in pharmacy consultation rooms and recorded digitally and transcribed verbatim. IPA was used to inform the analysis which followed the same process as the focus group, although with greater emphasis on a cyclical process of comparing transcripts. [8] Ethical approval was obtained from a University of Sheffield Research Ethics Committee.

Results

The focus group with seven staff lasted 46 minutes and the subsequent six individual interviews ranged in duration from 15 to 40 minutes with an average length of 26 minutes. Participants were all female with the exception of one male individual interview. Four key themes emerged relating to the

personal impact that the HLC role had for staff, perceptions of the impact on patients, pharmacy business tensions, and setting and awareness. These reflected positive views in the case of benefits for HLCs and patients but more negative perceptions overall in relation to the other two themes. Within these further sub-themes were also identified which will be presented in turn.

Personal Impact of Healthy Living Champion Role

All participants reported the view that becoming a HLC had been a benefit to them personally, giving them greater knowledge and confidence to interact with patients about health and well-being issues. HLCs felt empowered in undertaking more formal continuing professional development, and experienced greater job satisfaction. Participants described an increased knowledge of public health and specifically noted health information and resources to support patients and other staff, and communication skills which had been viewed positively:

> "[…] if somebody comes in and a circumst*ance arises, then you've got that confidence to talk* to somebody and you know a little more*…I can now speak to a person whereas before you thought, well I don't really know, I'll just go and ask the pharmacist".* (HLC 3)

Learning was described as an iterative process requiring ongoing activity and several examples of undertaking further training and qualifications were cited. The role had empowered staff who described experimenting with different ways of imparting information and also broaching and handling more sensitive topics such as alcohol consumption. A key emerging sub-theme was the increased job satisfaction HLC experienced in their roles based on the positives they described:

> "So, I feel like you're fulfilling your role a little bit more rather t*han just coming to work and counting tablets and dishing them out".* (HLC 9)

Impact on Patients

Patients were a recurrent theme across all the interviews and this related to perceptions of patient awareness and their interaction with HLCs and the HLP model, what made a successful patient intervention, how to reach more patients and the impact of patient characteristics. Participants made reference to the importance of the other themes in relation to the success of HLP for patients. There was a perception that patients had responded positively to their roles overall through using appropriate communication to empower them to take further action:

> "It's nice to be able to explain it in a way that makes them understand […*to*] know how to take it *further rather than just being told something".* (HLC 13)

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It was also recognised that such patient interaction could vary in relation to the amount of information and also the focus and it was apparent that the HLC role was a continual activity with opportunities in every interaction with patients:

> *"Everybody I speak to I like to think that I do give healthy living advice. I*t can be something *really minor…you know, a little hint, a little tip, pointing them in the right direction."* (HLC 11)

Participants felt they were not only offering reactive advice about issues such as medicines but also making a more significant holistic impact on behaviour change for example. Despite this positivity, a recurring theme concerned the need to continue to raise aware of the HLP scheme and HLCs within this, through visual and other media. It was noted that word-of-mouth and positive patient experiences may have led to more patients actively approaching pharmacy staff for advice and support.

It was also recognised that the HLC role could not reach all relevant patients and the issue of how to address this was raised, with sheltered or community housing locations being cited as examples where this was considered problematic:

> *"… part of our training is a lot of people that can't get to us. It's a shame they miss out on services. And we need to look at the bigger picture to go out to them to bring 'em to us in whatever way you can."* (HLC 11)

Participants again demonstrated considerable empowerment in exploring such patient groups and examples included whether blood pressure monitoring or diabetes testing could be offered away from pharmacies, although staff resource was recognised as a barrier. It was perceived to be easier to raise health and well-being conversations with some patients but not others, particularly in relation to socio-economic status. Focus group discussion in particular explored the perception that it was easier to initiate conversation in pharmacies in more deprived areas compared to more affluent areas. Furthermore, the topics were perceived to vary, with weight management and smoking cessation advice being considered less relevant in more affluent settings for example.

Business Tensions

Several aspects of pharmacies qua businesses were perceived to impact on the HLC and HLP and this theme was associated with the most tensions. These related to sub-themes of staffing, infrastructure, business priorities and income generation and were perceived to be barriers that could not be changed. However, it was noted that the HLC role could bring economic benefits in generating customer

loyalty and increased foot fall and uptake of commissioned services and some employers had been particularly supportive of the service. The commercial aspect of the community pharmacy setting led to challenges in creating a suitable area for health promotion activities for HLC. It was perceived that there was a tension between trying to create such spaces whilst also maintaining space for commercial stock display (such as toiletries). Participants argued that employers still prioritized shop space for selling stock but did recognise the need to maintain income from these, which could in turn help to fund their HLC roles.

Staff issues included managing multiple work roles and dispensing staff felt they were less visible and unable to initiate patient conversations, which counter assistant staff recognised was an advantage in their metonymic roles. Several pharmacies had trained more than one HLC and this was perceived to be advantageous in increasing capacity, bringing different skill sets and accommodating part-time work in a busy demanding environment. Some participants reported their selection for a HLC role and particularly time away from the pharmacy to train to have led to "resentment" (HLC 7) from other staff, with another reporting a colleague being dismissive of the role, and noting: *"it's a load of* rubbish – *who's going to listen to you?"* (HLC 3). However, it was thought that training more than one HLC would reduce such tensions between pharmacy staff and for expansion of the role to be important, to raise standards of advice and support overall:

> *"I do think everybody should be made to d*o it, giving them a bit of basic background *knowledge, so that what they're actually saying to patients is right, leading them in the right direction ... and that every member of staff is on the same wavelength."* (HLC 13)

Time emerged as a theme is several ways in relation to the business, workload and other staff. HLCs reported needing to manage their time carefully and adopted diaries and appointment systems in some cases to balance differing workloads. There was also a perception that HLC training was time-consuming and put pressure on participants and other staff whilst being undertaken. As noted earlier, HLCs reported enjoying imparting knowledge to other staff but experienced little time due to workload to do so. Several HLCs in multiple owned larger pharmacy companies noted that their employers had provided support for staff to be trained and to undertake their roles and this appeared to be an important facilitator to the success of the HLC role.

Setting, Isolation and Awareness

The final key cluster of themes related to participants' reflections on the place and status of HLC/HLP. Many participants commented on the relationship of community pharmacy with the wider community, other health and social care services, and in particular, a perceived relative lack of awareness amongst many groups. The community setting was considered positively in some respects

and one example related to the promotion of free NHS flu immunisations to eligible patients in the community and one HLC reported that the unique place of the pharmacy in the community led to a word-of-mouth effect and increased uptake of services. A further aspect of this community setting was that HLCs referred to continued conversations with patients and their families over a period of time allowing them to follow-up on advice and support given. The public health possibilities were expanded by this ongoing dialogue, allowing time for patients to consider possible lifestyle changes they might make.   Several participants reflected on the status of community pharmacies which emphasised the need to demonstrate community pharmacies offered more than was traditionally perceived to be the case in terms of a commercial business:

> *"We're kind of seen less as a shop and more as a place to go for not just ... your prescription* or to buy some shampoo – *we're also here to give you some advice and tell you what's around in the area".* (HLC 8)

The relationships and status of HLP/HLC externally were questioned with concerns emerging that these were not well recognised amongst wider NHS and social care services and were perceived to be negative at times. This was argued to be a barrier to successfully undertaking HLC roles such as signposting patients to services and support not offered by the pharmacy. This was exacerbated by the lack of information technology and particularly internet availability – particularly in some large sized companies - which was recognised as being important to support patients through offering appropriate advice.

However, it was recognised that local support had been available from the (now obsolete) Primary Care Trusts and (later) Clinical Commissioning Group sponsors of the service who were viewed positively through offering training, guidance and resources. Off-setting this though was a sense of isolation and desire to know what other local and national public health campaigns involved.

The final emerging sub-theme related to concerns that the public - and particularly patients and other health care professionals - might not be as aware as they could be of HLCs and HLP service and the benefits they offered, limiting them performing their role. It was felt that marketing of HLP and HLCs could be undertaken more effectively and particularly externally through 'advertising' of services in local GP surgeries or newspapers. Where promotion had occurred there was a perception that patients responded positively with positive examples being given of patients commenting on HLC staff photos being displayed in the pharmacy and the HLP logo had generated patient interaction and an opportunity to explain how the HLC might help them. Several noted that the term 'champion' might have particular resonance with patients and give them confidence to engage with HLCs. The perception that other health professionals and the public continued to view pharmacies as a shop

rather than part of the public health delivery of the NHS re-emerged as a theme. One participant described an occasion where they had attempted to refer a patient to a third sector provider for support with a specific health need and had been met with some resistance in accepting the referral from an HLC.

Discussion

This qualitative study has identified four broad themes relating to the experiences and perceptions of HLCs in a further HLP pathfinder area. Several benefits to the role were perceived to be important, primarily around empowering HLCs and further supporting patients. Concerns emerged in relation to tensions with ongoing business demands and workload in community pharmacy and a perception that the HLC role and HLPs more generally are relatively isolated in relation to other services and are not widely recognised by others.

Strengths of the study are the use of two qualitative methods to elicit rich in-depth data from those most directly involved in a further HLP area, in this relatively under-studied and emerging area of community pharmacy in the UK. The use of an IPA method was also particularly suited to answering the research question in this area of health. [13] Limitations of the study were that sampling involved only one case study area, and due to the scale of the study, only HLC views were included and the views of the public for example were not represented. Although sampling was purposive but some HLCs did not respond and potentially may have held different views. The sample size was relatively small and theoretical saturation was not used, but this was consistent with IPA and the focus on intense analysis of up to ten interviews. [14]

This study emphasises the important contribution that pharmacy assistant staff can make to public health related activities. It provides an important insight into their views and working practices and complements other pharmacy assistant health promotion studies in Australia [15] and Scotland [16] in suggesting such staff have a valuable role. Such views have arguably been under-represented and there has been a tendency to focus on pharmacist perspectives in the public health pharmacy literature [1] [4] [5] and wider workforce literature. [17] [18] This study consolidates several themes from other studies and adds to evidence that there is a perceived need to raise awareness of HLC and HLP much more amongst key stakeholders.[11] The use of media campaigns at local and national level has been suggested [8] [12] and staff in this study reported such concerns. Similar barriers emerged in this study as have been identified in other research, such as time and workload. However, this study highlights in particular the view that the fundamental commercial nature of community pharmacy can conflict with public health related and arguably more altruistic activities and this has been a recurrent theme in

community pharmacy.[19] Indeed, several barriers identified in this study reflect wider and enduring concerns in community pharmacy which go beyond the scope of HLP such as the relative isolation of community pharmacy to other healthcare providers.[20] The literature does suggest possible solutions to some barriers and, for example, the finding in this study that HLCs felt unaware of what others were doing, may be addressed by the introduction of HLC networks. [21] In addition, some of the suggested improvements identified in this study, such as the need for better information technology and internet access, highlight increasing recognition that these tools and services are becoming a routine part of community pharmacy practice. [22] This was particularly apparent in larger, multiple ownership companies, reflecting the influence of the type of pharmacy employer as a barrier, but arguably also as a facilitator as such companies also appeared to be more likely to offer training. The key implications for future practice involve ensuring that there is a consistently good environment across the different types of pharmacies that are being considered as HLPs and ensuring that commercial interests do not impinge upon public health related activities.

Conclusion

This study has identified perceived benefits in the role of HLCs in delivering public health in community pharmacies in another geographical setting in the UK. However, of concern was the identification of a tension between providing such services and meeting existing commercial demands in other aspects of community pharmacy activities and a perception that these latter demands and others contribute towards a lack of awareness amongst the public and health care professionals of HLCs' activities.

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