Aston University
Life & Health Sciences

An Evaluation: The Implementation and Impact of Healthy Living Pharmacies within the Heart of Birmingham

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ACKNOWLEDGEMENTS

disbanding of the Cluster resulted in the departure of John and Sajj to other NHS organisations. Although both John and Sajj continued to input to the Steering Group, the role of Chair of the HLP study Steering Group was subsequently taken-up by John Nicholls, and we offer our deepest thanks to John for being steadfast in his commitment to fulfil this, for which we are grateful.

We would also like to express our sincere thanks to Dipak Shah and Zahid Chishti both of whom kindly agreed to review the draft reports and provided valuable input to the final report.

FOREWORD

"Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and reduce health inequalities."

Department of Health (2010) **Healthy Lives, Healthy People: Our strategy for Public Health in England** [white paper] London: Stationery Office (Cm 7985)

"Pharmacies will become healthy living centres: promoting and supporting healthy living and health literacy; offering patients and the public healthy lifestyle advice, support on self-care and a range of pressing public health concerns; treating minor ailments and; supporting patients with long-term conditions."

Department of Health (2008) **Pharmacy in England: Building on strengths, delivering the future** [white paper] London: Stationery Office (Cm 7341)

The development of community pharmacies, as healthy living centres, has the potential to make a significant impact on optimising health gains and reducing health inequalities.

For many years pharmacies across the country have provided public health interventions at a local level, such as smoking cessation or sexual health services. Until now these services have mostly been delivered in isolation based on local needs and the relationships between local contractors and commissioners. The Healthy Living Pharmacy concept has the potential to pull these services together and change the public perception of pharmacy as a simple dispenser of medicines into a trusted Public Health provider.

John Morrison

Chief Pharmacist, **Worcestershire Health and Care Trust**

February 2014

EXECUTIVE SUMMARY

E.1.   Community pharmacy's traditional functions were focussed on the procurement, storage and compounding of medicines. Over the last three decades, the focus of activity of community pharmacy has shifted away from these technical aspects towards a patient-oriented focus on pharmaceutical care and the delivery of health-improving and harm-reducing services to the public.

E.2.   The 2008 pharmacy White Paper 'Pharmacy in England', proposed the concept of pharmacies as 'healthy living centres', which would see pharmacies become a primary and trusted source of advice for healthy living and health improvement within local communities.

E.3.   Since the publication of Pharmacy in England, the healthy living centres concept has been adopted by the professional leadership body for pharmacy (the Royal Pharmaceutical Society), numerous pharmacy contractor organisations (e.g. the National Pharmacy Association, the Company Chemists' Association) and community pharmacy's negotiating body in NHS matters (the Pharmaceutical Services Negotiating Committee), and has been rebranded as the 'Healthy Living Pharmacy' (HLP) concept.

E.4.   NHS Portsmouth (at the time, the organisation responsible for the provision of NHS primary care services to the residents of the city of Portsmouth) assumed some degree of leadership for the HLP concept by developing a model for HLPs which was launched in December 2009. The 'Portsmouth model' was characterised by an 'HLP framework' which formed the basis for accreditation frameworks across England in areas taking part in a national pathfinder programme.

E.5.   It was as part of this pathfinder programme that Heart of Birmingham teaching Primary Care Trust (HoBtPCT) began to accredit HLPs within its geographical boundaries. The HLP scheme in HoBtPCT was launched with a prospectus which was published in March 2011. This document highlighted the PCT's commitment to the HLP concept, detailed the PCT's vision of an HLP, outlined the PCT's approach to developing HLPs and invited local community pharmacies to participate in the programme.

E.6.   HoBtPCT provided healthcare services for approximately 300,000 people in the geographical centre of Birmingham. The area covered by the PCT incorporated Birmingham city centre and numerous 'inner-city' wards including Aston, Ladywood, Nechells and Sparkbrook. HoBtPCT planned and developed services with in excess of 170 General Practitioners (GPs) operating from approximately 75 practice premises.

E.7.   The community pharmacies of central Birmingham are located in some of the most deprived areas of England. Their location affords an opportunity to meet the health needs of those most in need of access to healthcare services but who find it most difficult to access such services.

E.8.   This report details the findings from a review of the implementation of HLPs within HoBtPCT. Data on service provision for four healthcare services (early pregnancy testing, emergency hormonal contraception, minor ailments scheme, and smoking cessation) were analysed, along with data from a series of interviews with service providers and from a service-user questionnaire deployed via touchscreen kiosks located within the ten HLPs included in this study.

E.9. Data on service provision presented in this report suggest that people accessing the services provided by the community pharmacies in central Birmingham are, unsurprisingly given their geographical location, predominantly from areas of high socioeconomic deprivation.

E.10. Analysis of the data from the smoking cessation scheme suggests that participants at HLPs are more likely to have been from sections of society commonly considered to be 'hard-to-reach' – men, people from black and minority ethnic groups, those who had never worked or were long-term unemployed and those from the most-deprived areas of central Birmingham. While this phenomenon was not observed universally across all four services analysed, smoking is the most important single behavioural cause of health inequalities making such observations notable.

E.11. Of particular note in relation to the analysis of the data from the minor ailments scheme was the large quantity of medicinal products which were supplied via the scheme but which are not supported by robust evidence to support their efficacy. Any continuation or extension of the minor ailments scheme should be accompanied by a review of the items which are available for supply so as to minimise any expenditure on potentially ineffective interventions.

E.12. This evaluation has revealed no evidence that HLP accreditation improves activity levels or outcomes in the services examined (early pregnancy testing, emergency hormonal contraception, minor ailments scheme, and smoking cessation). However, data from the minor ailments scheme suggests that HLP accreditation may influence how participants become aware of the services offered by pharmacy.

E.13. Results from the service-user questionnaire suggest that satisfaction with the services provided by HLPs is very high. Particularly notable are the high proportions of respondents who reported that they preferred to access the service they had used at the HLP rather than at their GP surgery.

E.14. Qualitative data suggest that a motive for contractor engagement with the HLP programme was a belief that accreditation of their pharmacies as HLPs would provide reassurance to commissioners that they were consistent deliverers of high quality services and that the accreditation would help to differentiate HLPs from non-HLPs with HLPs being favoured in future commissioning decisions. The NHS landscape has changed markedly since the data were collected and given such change, additional effort will need to be made if the initial momentum behind HLPs in central Birmingham is not to be lost.

E.15. The concern expressed by pharmacy contractors around remuneration for additional services should be noted. There was a belief that remuneration for such services was insufficient to divert activity away from the dispensing function towards patient-centred care. Whilst such considerations may be outside the scope of local pharmacy and health bodies, strategic level consideration should be given to how remuneration for pharmacies can be altered to support role extension and the HLP concept.

E.16. Of additional note were the observations by non-pharmacist staff (Health Trainers and Health Trainer Champions – HT/HTCs) that the depth of training in relation to the delivery of certain services was insufficient and that the awareness levels of the HLP scheme by general practitioners were low. Any development of the HLP model will need to ensure adequate training levels for pharmacy staff and an increase in the level of awareness within the local general practitioner population of the programme.

E.17. The study has made the following recommendations:

- **Recommendation 1** – Further research is recommended to identify whether the uptake of the stop smoking service in traditionally 'hard-to-reach' groups via Healthy Living Pharmacies can be replicated in other geographical areas.

- **Recommendation 2** – Further research is needed to establish whether the existence of pharmacy-based health services is more actively promoted in Healthy Living Pharmacies than in non-Healthy Living Pharmacies and whether more active promotion increases activity levels and improves the outcomes of such services.

- **Recommendation 3** – Any continuation or extension of the minor ailments scheme should be done in parallel with a review of the items provided via the scheme to ensure that any medicines included are supported by a robust evidence base so as to minimise any expenditure on potentially ineffective interventions.

- **Recommendation 4** – In any future commissioning of services through pharmacies, consideration needs to be given to the role pharmacies with Healthy Living Pharmacy accreditation, with their high level of service user acceptance, can offer in the effective delivery of health care services. Given the lack of randomisation in observational studies, a randomised study – perhaps in the form of a pragmatic cluster randomised controlled trial – should be conducted to establish whether HLPs achieve better outcomes than non-HLPs.

- **Recommendation 5** – In order for the number of Healthy Living Pharmacies to expand and for the number of services offered via Healthy Living Pharmacies to increase, further consideration needs to be given to the levels of training and support made available to pharmacy staff, especially at the Health Trainer/Health Trainer Champion level, and the level of awareness of the programme within the local general practitioner population.

- **Recommendation 6** – To ensure the success of any future roll-out of services via Healthy Living Pharmacies, consideration should be given at a strategic level as to how remuneration for pharmacies can be altered to support role extension and the Healthy Living Pharmacy concept, along with research conducted at the local level to examine the impact of Healthy Living Pharmacy accreditation on non-Healthy Living Pharmacies within an area.

GLOSSARY

For the purpose of this report and for ease of reporting, the following terms have been used:

Term	Refers to:
'Health programme'	Health services that requires a patient to attend a series of sessions over a period of time e.g. Smoking Cessation (SC) and Weight Management (WM).
'Health services'	Services such as Minor Ailments Scheme (MAS), Emergency Hormonal Contraception (EHC), Early Pregnancy Testing (EPT, diabetes/blood pressure tests,) etc.
'Health-service related role'	Health-service related responsibilities e.g. provision of advice/delivery of health services/signposting activities - undertaken by interviewees both prior to the HLP accreditation and after qualifying as a HTC or HT.
'HLP'	Healthy Living Pharmacy.
HoB	The Heart of Birmingham i.e. central areas of Birmingham.
HoBtPCT	Heart of Birmingham teaching Primary Care Trust.
'HT' role	Health Trainer i.e. an interviewee who has undertaken the *City & Guilds Certificate for Health Trainers at Level 3* qualification. (http://www.cityandguilds.com/Courses-and-Qualifications/health-and-social-care/health/7562-health-trainers)
'HTC' role	Health Trainer Champion i.e. an interviewee who has undertaken the *RSPH Level 2 Award in Understanding Health Improvement qualification.* (http://www.rsph.org.uk/en/qualifications/qualifications/qualifications.cfm/Level-2-Award-in-Understanding-Health-Improvement)
'Mr Pharm'	An animated character which enables users to navigate through online resources (on health related information) accessed via touchscreen screen kiosks-deployed in all HLPs.
MUR	Medicines Use Review.
'Non-HLP'	A Pharmacy that has not undertaken HLP accreditation.
'NPA'	National Pharmacy Association.
'Pharmaceutical-related role'	The supply and sale of medicines (under the supervision of the pharmacist) undertaken by HTs and HTCs.
'Patient'/'Customer'	Were used interchangeably by interviewees (depending on the context) to refer to an individual who accesses either a pharmaceutical service or a health related service. Therefore, for ease of reporting, the term 'patient' is used in Stage B of this report.
'PCT'	'Primary Care Trust', an abbreviated form to denote the Heart of Birmingham teaching Primary Care Trust (HoBtPCT), which later merged with other proximal PCTs to become the Birmingham and Solihull NHS Cluster. However, the interviews took place after the merger and therefore the majority of interviewees continued to refer to the 'Cluster' as the 'PCT'.
'PLT'	Protected Learning Time sessions for pharmacists and pharmacy teams– funded by the PCT.

BIOGRAPHIES OF AUTHORS

This study was undertaken by researchers from Aston Pharmacy School at Aston University in Birmingham. The research team comprised the following members:

Professor Christopher A Langley

Chris studied pharmacy at Aston University before undertaking his pre-registration training within hospital pharmacy, registering as a member of the Royal Pharmaceutical Society of Great Britain in 1997. Upon qualification, Chris returned to Aston to complete his PhD within the Medicinal Chemistry Research Group before moving over full-time to an academic position within the Pharmacy Practice group in 2000. Chris currently holds the post of Professor of Pharmacy Law and Practice and specialises in teaching the legal, ethical and practice components of the undergraduate degree course. In addition, he is currently the Associate Dean for Taught Programmes in the School of Life and Health Sciences.

His research interests centre on the role of the pharmacist in both primary and secondary care and work examining pharmacy educational policy. Chris has co-authored four academic textbooks, and numerous professional reports and academic papers within the area of pharmacy practice. Nationally, Chris is a member of the General Pharmaceutical Council's Pre-Registration Board of Assessors, Accreditation and Recognition Panel and the statutory Appeals Committee. He is also a non-executive director for Health Exchange, a member of the Royal Pharmaceutical Society's Education Expert Advisory Panel and a Principal Fellow of the Higher Education Academy.

Dr Joseph Bush

Joe studied pharmacy at Aston University, being awarded an MPharm in 2002. After undertaking a year of pre-registration training within a Birmingham-based independent pharmacy chain and passing the pre-registration examination, Joe registered as a pharmacist with the Royal Pharmaceutical Society of Great Britain in 2003. In October 2003, Joe began study towards a PhD in Pharmacy Practice at Aston University and, in 2008, accepted a full-time academic position as Lecturer in Pharmacy Practice with Aston Pharmacy School. He currently holds the position of Senior Lecturer in Pharmacy Practice and his teaching is focussed on public health, social pharmacy, health policy and evidence-based practice.

Joe's research interests lie in the role of the pharmacist and pharmacy in public health, organisational culture and its impact on community pharmacy and medicines adherence. He has authored a book chapter, a number of large reports for commissioned research projects and academic papers in the areas of pharmacy practice and pharmacy education. Joe has also acted as a consultant on research projects undertaken by external research consultancies and provided expert comment to the pharmacy press. He is a Fellow of the Higher Education Academy.

Alpa Patel

Alpa Patel is a Research Projects Coordinator and is responsible for the day-to-day management of projects undertaken by the Pharmacy Practice Research Group in addition to undertaking research-related responsibilities. Since joining the Aston Pharmacy Practice Research Group in 2008, Alpa has been involved in projects; examining pharmacy education in Ireland, evaluating Public Health programmes and exploring barriers and facilitators to medication adherence.

Alpa has a First in BA (Hons) Business and Marketing from Coventry University and holds an APM Introductory Certificate in Project Management.

Chapter 1 INTRODUCTION

This research, conducted in conjunction with Heart of Birmingham teaching Primary Care Trust (HoBtPCT) and funded by the Pharmaceutical Trust for Educational and Charitable Objects (PTECO) (which was subsequently merged with the Pharmacy Practice Research Trust (PPRT) to become Pharmacy Research UK), evaluates the impact of the Healthy Living Pharmacy (HLP) concept in the geographical area formerly covered by HoBtPCT. The research took place against a backdrop of organisational upheaval within the National Health Service (NHS) as a result of the Conservative-Liberal Democrat Coalition Government's programme of reforms. The Health and Social Care Act 2012 abolished PCTs on 31st March 2013.[1] In the time leading up to this date there was considerable flux within HoBtPCT including changes in personnel. These changes had no effect on the availability of data for this evaluation although it did complicate the data collection process somewhat as engagement with partner/successor organisations proved necessary.

1.1 THE HEALTHY LIVING PHARMACY CONCEPT

Community pharmacy's traditional functions were located in the procurement, storage and compounding of medicines. Over the last three decades, the focus of activity of community pharmacy has shifted away from these technical aspects towards a patient-oriented focus on pharmaceutical care and the delivery of health-improving and harm-reducing services to the public. This change of focus has been consistently supported by government policy amidst a narrative of community pharmacists being over-trained for their current functions and under-utilised in terms of their potential to improve the health of the public.[2–6] It was in this context that the 2008 pharmacy White Paper '*Pharmacy in England*', proposed the concept of pharmacies as 'healthy living centres'.[5] This would see pharmacies become a primary and trusted source of advice for healthy living and health improvement within local communities. It would also see increased pharmacy involvement in public health interventions such as smoking cessation services and weight management services. Pharmacy staff (i.e. non-pharmacist members of staff) would also be encouraged to become 'health trainers' so as to help pharmacy users to make informed choices about their health and lifestyle.

Since the publication of *Pharmacy in England*, the healthy living centres concept has been adopted by the professional leadership body for pharmacy (the Royal Pharmaceutical Society), numerous pharmacy contractor organisations (e.g. the National Pharmacy Association, the Company Chemists' Association) and community pharmacy's negotiating body in NHS matters (the Pharmaceutical Services Negotiating Committee), and has been rebranded as the 'Healthy Living Pharmacy' (HLP) concept.[7]

NHS Portsmouth (at the time, the organisation responsible for the provision of NHS primary care services to the residents of the city of Portsmouth) assumed some degree of leadership for the HLP concept by developing a model for HLPs which was launched in December 2009. Initially, pharmacies within Portsmouth could apply to be accredited as HLPs by NHS Portsmouth if they delivered active health promotion campaigns, targeted respiratory medicines use reviews (MURs), a stop smoking service and at least one other service from the 'Local Enhanced Services' level of the pharmacy contract[a].[8] The 'Portsmouth model' was characterised by an 'HLP framework' which formed the basis for accreditation frameworks across England in areas taking part in the pathfinder programme.[7]

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[a] The community pharmacy contract in England and Wales has three different levels of service – essential, advanced and enhanced (rebranded since the Health and Social Care Act 2012 as 'locally commissioned services'). Essential services are provided by all contractors. Advanced services can be provided by any contractor but both the pharmacy premises and the pharmacist delivering the service have to be accredited to provide the service. Enhanced services are commissioned from community pharmacies on the basis of local need.

It was as part of this pathfinder programme that Heart of Birmingham teaching Primary Care Trust (HoBtPCT) began to accredit HLPs within its geographical boundaries.

1.2 POPULATION CHARACTERISTICS OF HEART OF BIRMINGHAM TEACHING PRIMARY CARE TRUST

HoBtPCT provided healthcare services for approximately 300,000 people in the geographical centre of Birmingham. The area covered by the PCT incorporated Birmingham city centre and numerous 'inner-city' wards including Aston, Ladywood, Nechells and Sparkbrook. HoBtPCT planned and developed services with in excess of 170 General Practitioners (GPs) operating from approximately 75 practice premises.[9]

The population resident in the areas formerly served by HoBtPCT is disproportionately young with almost a third of the resident population aged under 19 years of age. Seventy per cent of people in the area are from Black and Minority Ethnic groups – the highest proportion of people from BME groups of any PCT in England.[10] According to the Indices of Multiple Deprivation 2010 (IMD 2010), HoBtPCT was the most socioeconomically deprived PCT in England with two thirds of the population living in neighbourhoods that are in the most deprived quintile of neighbourhoods in England.[9] Unemployment rates within the area formerly served by HoBtPCT, particularly for men, are high.

Religious belief plays an important part in the lives of a large number of residents in the area formerly served by HoBtPCT and there is considerable diversity in religious faith. According to 2001 Census data, amongst residents in the area, 44% identified themselves as Christian, 25% identified themselves as Muslim, 7% as Sikh and 4% as Hindu (Office for National Statistics, 2012).[11]

Migration has been a feature of Birmingham life for generations and it continues to be a prominent aspect of life within central Birmingham. Recently the area has witnessed an influx of immigrants from Eastern Europe and Sub-Saharan Africa, either as economic migrants or asylum seekers. This makes language a major barrier to accessing services, particularly to women.[10] A 'language barrier' does not present exclusively among 'recent' arrivals to the area however. One fifth of adults in the parliamentary constituencies which formerly constituted the area covered by HoBtPCT area can only read and write English to pre-GCSE level and approximately 64% of dependent children aged 0-15 are estimated to have 'language needs' (an indicator based on the likelihood that the first language spoken at home is not English).[10]

Life expectancy within the boundaries of HoBtPCT was shorter than the England average (76 years for men and 81 years for women versus 78 years and 82 years respectively (2006/8 figures)).[12] Diabetes is a major cause of ill health and shortened life expectancy in the local area and rates of heart disease, strokes and cancer are also higher than the England average. At least 20% of adults in the area formerly covered by HoBtPCT report a limiting long term illness which restricts their daily lives.[10] This has notable implications for the delivery of health services and expenditure on the management of long-term conditions.

1.3 HEALTHY LIVING PHARMACIES IN HoBtPCT

The HLP programme in HoBtPCT was launched with a prospectus which was published in March 2011.[13] This document highlighted the PCT's commitment to the HLP concept, detailed the PCT's vision of an HLP, outlined the PCT's approach to developing HLPs and invited local community pharmacies to participate in the programme. HoBtPCT also detailed the key features of their HLPs including the consistent provision of high quality services and a proactive approach to supporting and promoting health and wellbeing in order to become an accessible, valued and trusted healthcare resource which is engaged in the wider healthcare team and in the community they serve.

HoBtPCT developed a framework for an HLP, which detailed three different levels of service at which community pharmacies could be progressively accredited in a step-wise fashion (i.e. a community pharmacy would be accredited at level 1 before accreditation at level 2 and so on). Level 1 HLPs would be promoting health, wellbeing and self-care, level 2 HLPs would progress to optimising medicines interventions and level 3 HLPs would progress to the provision of treatment (see Figure 1).

In the first instance, HoBtPCT's approach was going to be to try and establish their pharmacies at level 1.[13] The service framework was supported by three foundations/enablers; workforce development, premises and engagement (see Figure 1).

Reflecting the aims of the 2008 pharmacy White Paper, HLPs in Birmingham would train staff – via accredited courses – to become 'health trainer champions' and/or 'health trainers' in order to engage members of the communities that the HLPs served.[5] Premises would have to be appropriate for the delivery of public health messages and health care services with consideration given to ensuring access to networked computers in consultation rooms, facilities for the disposal of clinical waste and facilities to promote patient comfort. The final foundation concerned engagement, with HLPs becoming engaged with primary care colleagues, the wider community, and then becoming a community leader as they moved through the levels of accreditation.[13]

The prospectus also detailed the many services, a number of which pharmacies within HoBtPCT were already delivering and were well-established, and the services that pharmacies could potentially deliver in order to obtain level 1 HLP accreditation (services required for level 1 HLP accreditation in HoBtPCT are highlighted in bold)[13]:

- **Smoking cessation.**
- Weight management.
- Chlamydia screening.
- **Early pregnancy testing (EPT).**
- **Emergency hormonal contraception (EHC).**
- Alcohol misuse services.
- **Minor ailments scheme (MAS).**
- Substance misuse and harm reduction.
  - o Needle exchange.
  - o Supervised administration of substitution therapy.
- Men's health.
- MURs for specific long-term conditions (e.g. asthma).

Figure 1: Service delivery framework for HLPs within HoBtPCT

Public Health Need	Essential Services	Level 1	Level 2	Level 3
Smoking	Promotion of health and wellbeing, support for self-care, signposting	Stop smoking NRT Proactive advice and signposting	PGD treatment, brief intervention	COPD risk assessment NHS Health Check
Obesity	Promotion of health and wellbeing, support for self-care, signposting	Weight management; Proactive advice and signposting	PGD Treatment, brief intervention	NHS Health Check
Sexual Health	Promotion of health and wellbeing, support for self-care, signposting	EHC PGD, Fast track pregnancy testing and referral, condom distribution	Chlamydia screening, PGD Treatment, brief intervention	Contraception service, HPV/HepB Vacc, screening
Alcohol	Promotion of health and wellbeing, support for self-care, signposting	Alcohol risk assessment, brief intervention and appropriate referral	Alcohol specific non-planned interventions	Structured care planned alcohol treatment
Minor Ailments	Promotion of health and wellbeing, support for self-care, OTC supply	Pharmacy First; assessment, advice and treatment with GSL and P meds	PGD Treatment	Pharmacist prescribing
Substance Misuse	Promotion of health and wellbeing, support for self-care, signposting	Supervised consumption	Harm reduction, screening, needle exchange	Client assessment and support. Hep B Vaccination
Men's Health	Promotion of health and wellbeing, support for self-care, signposting	Pro-active health promotion targeted at men; prostate and testicular cancer awareness	Early identification of some cancers/cancer treatment adherence support	NHS Health Check
Long-term conditions	Promotion of health and wellbeing, support for self-care, signposting.	Adherence support (MUR, MUR+, targeted MURs, First prescription service)	Condition parameter monitoring Appropriate referral	Chronic medication service, pharmaceutical care planning
Locally driven services (Maternal Health)	Promotion of health and wellbeing, support for self-care, signposting	Early Pregnancy Testing Healthy start	Maternal Smoking/weight interventions	Pregnancy and diabetes service inc PGD
Enabler	**Core**	**Level 1**	**Level 2**	**Level 3**
Workforce Development	Core Competencies	Health trainer Champion (Assess & Signpost) Clinical skills Leadership *Evaluation capability*	Accredited Health Trainer (Assess & Coach) Clinical skills Leadership *Audit Capability*	Advanced clinical/Public Health skills (PhwSI, prescribers)
Premises	Fit for Purpose consultation room (Drug Tariff)	Fit for purpose consultation room(s) DT/Enhanced Spec Health Screen	Fit for purpose consultation room(s) Enhanced Spec Health Screen	Fit for purpose consultation room(s) Enhanced Spec Health Screen
Engagement	Operational (RDS, EPS, collection and delivery services) Signposting and referral to other services	Primary Care	Community Engagement	Community Leader

1.4 EARLY EVIDENCE OF THE IMPACT OF HEALTHY LIVING PHARMACIES

Measuring the impact of HLP accreditation on the quality of services provided within community pharmacy is difficult and early evaluations have focussed largely on measuring the impact of HLP accreditation on levels of service activity. As HLPs are a comparatively new development, evidence of the effect of HLP accreditation on outcomes is sparse and the need for further research in this area is recognised.[7]

Evaluation of HLPs in Portsmouth revealed that HLPs delivered smoking cessation interventions and targeted respiratory Medicines Use Reviews (but not weight management interventions, alcohol awareness interventions or the provision of EHC via a patient group direction (PGD)[b]) to more people than non-HLPs.[14] This phenomenon was also observed in the national (England) evaluation of the pathfinder programme where increases in activity were observed in services including smoking cessation, the provision of EHC via a PGD, minor ailments schemes (MASs) and alcohol awareness programmes (although care should be taken when interpreting this data owing to the heterogeneity in reporting methods between different pathfinder areas and the absence of p-values to assess the significance of the reported differences).[7]

Data on the impact of HLP accreditation on the effectiveness of services is sparse. However, in Portsmouth, 4-week smoking quit rates were higher in non-HLPs than in HLPs.[14] Although smoking quit rates are reported in the pathfinder evaluation, owing to the reporting strategy, it is unclear whether quit rates increased or decreased after HLP accreditation. Similarly, a lack of aggregated data mean that it is not possible to determine whether quit rates were higher in HLPs or non-HLPs.[7]

Public satisfaction with the services provided by HLPs was high with 98% of 1,034 individuals saying that they would recommend the service they had used to others. Furthermore, 60% of the sample stated that, in the absence of the service they used, they would have consulted their GP instead, with an additional 21% stating that they would not have consulted anyone. The authors of the pathfinder evaluation suggest that this means that community pharmacy could help to reduce the workload burden of GPs.[7]

1.5 THE SERVICES PROVIDED BY HoBtPCT HLPs EVALUATED IN THIS REPORT

This section provides background information and an overview of previously published research on each of the four specific services provided by HLPs in HoBtPCT and evaluated in this report.

1.5.1 EARLY PREGNANCY TESTING

The Early Pregnancy Testing (EPT) local enhanced service aimed to reduce infant mortality within HoBtPCT by facilitating early antenatal appointment booking and providing folic acid (to reduce the incidence of neural tube defects) at the earliest possible opportunity.[15]

Provision of the service was advertised by participating pharmacies. Upon consultation by a woman wishing to access the service, and after consulting Fraser guidelines and assessing Gillick competency (where appropriate), addressing any safeguarding concerns and obtaining consent, an assessment of whether or not a pregnancy test was indicated was undertaken. Should a test be indicated then a test would be completed and the result would be communicated to the patient. In the event of a positive test result, folic acid tablets (400 mcg) would be supplied and the patient would be signposted to their GP to book a maternity/midwife appointment. In the event of a negative test, information would be provided on contraception and, should the patient express a desire to become

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[b] Patient Group Directions enable the supply of prescription-only medicines to specific patient groups without a prescription. Their use should be reserved for situations where provision via PGD improves patient care without compromising patient safety.

pregnant, the importance of folic acid pre-conceptually (and how to obtain it) would be discussed. Regardless of the result of the test, other relevant advice would be provided where appropriate (e.g. information on smoking in pregnancy, medicines and pregnancy etc.). Where a patient had diabetes, was on an anti-epileptic medication or already had an infant who had suffered a neural tube defect, the patient would be referred on to their GP for either high dose folic acid (if pregnant) or pre-conceptual advice and high dose folic acid (if not pregnant).[15]

While both the provision of pregnancy testing and the provision of advice relating to folic acid in pre-planned pregnancy via community pharmacy has been described before, a single service which combines both of these elements appears to be novel. There is insufficient evidence to suggest that such services are effective in improving outcomes or are delivered in a cost-effective manner via community pharmacy.[16]

1.5.2 EMERGENCY HORMONAL CONTRACEPTION

Emergency hormonal contraception (EHC) is used after unprotected penetrative vaginal intercourse, or after failure of a contraceptive method, to prevent a pregnancy. Levonorgestrel is the drug most commonly used as emergency contraception and, whilst it remains effective if used within 72 hours of unprotected intercourse, its efficacy decreases with time.[17] It is vital therefore, that women are able to access EHC promptly if unwanted pregnancies are to be avoided. Despite this fact, previously published research has suggested that many women found it difficult to access EHC within the 72 hours succeeding unprotected intercourse.[18]

In England, EHC was a prescription-only medicine (POM)[c] until 2001 when it was reclassified as a pharmacy-only (P) medicine. The reclassification of EHC did not lead to any increase in the overall use of EHC although it did lead to an increase in the proportion of women obtaining EHC from community pharmacies.[19] However, income is a barrier to purchasing EHC over the counter (OTC) via community pharmacy with higher income women being five times more likely to purchase EHC OTC than lower income women.[19] Prior to reclassification in 1999, EHC became available free-of-charge to patients from community pharmacies in two areas of England without a prescription via the use of PGDs. Supply of EHC via community pharmacy in this manner removes income as a barrier to access to EHC.

Reducing teenage conceptions and births was a key driver for reducing infant mortality within HoBtPCT and the HoBtPCT EHC scheme was one mechanism for furthering these aims.[13] The scheme was designed to provide access to EHC and associated advice (e.g. advice on regular contraception and sexually transmitted infections) to local residents aged under the age of 21-years-old, free at the point of use via a PGD.[20]

A 2006 structured review of the international literature on the community pharmacy supply of EHC found that pharmacy supply enabled most women to receive EHC within 24 hours of unprotected intercourse and that such services were highly rated by women.[21] In addition, evidence from a US randomised controlled trial (RCT) suggests that pharmacy supply of EHC does not influence rates of use of regular contraception or increase the incidence of risky sexual behaviour.[22]

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[c] Medicines for humans are divided into three classes under the Human Medicines Regulations 2012. Prescription-only medicines (POMs) are available from registered pharmacies upon the presentation of a prescription written by an appropriate prescriber (doctor, dentist, nurse independent prescriber, pharmacist independent prescriber, etc.). Pharmacy (P) medicines can be sold only from a registered pharmacy by a pharmacist or a person acting under the supervision of a pharmacist. General Sales List (GSL) medicines can be obtained in any retail outlet that can 'close so as to exclude the public'.

1.5.3   MINOR AILMENTS SCHEME

Minor ailments have been defined as "*conditions that require little or no medical intervention*".[23] Examples of such conditions currently listed on the NHS Choices website include[24]:

- Coughs and colds;
- Skin conditions such as mild eczema and mild acne;
- Constipation;
- Hay fever;
- Headaches;
- Indigestion; and,
- Vaginal thrush.

Treatment of, or relief from the symptoms of, these conditions is often provided by non-prescription medicines – that is P and GSL medicines. However, cost may act as a barrier that prevents some people from accessing these medicines (although it should be noted that robust evidence to support this assertion is not available) and influences how people decide to manage their condition(s).[25,26] It is estimated that 20% of total available general practitioner (GP) workload is dedicated to dealing with minor ailments, that 90% of consultations result in the issuing of a prescription and that the NHS spends £2 billion each year on the treatment of minor ailments by GPs.[27] Furthermore, it has been estimated that 8% of attendances at NHS Accident and Emergency (A&E) departments could be appropriately managed by community pharmacists.[28]

The theory underpinning the provision of bespoke, community pharmacy based minor ailments schemes (MASs) is that the financial burden placed on the NHS by minor ailments could be reduced by transferring patient flow away from higher cost GPs and A&E departments towards lower cost community pharmacists and by encouraging self-care.[2] It is hypothesised that such schemes would then create more time for GPs to deal with the management of more complex conditions and reduce pressures on A&E departments.[29]

Scotland and Northern Ireland introduced national MASs, delivered through all community pharmacies, in 2006 and 2009 respectively.[30,31] A national scheme for Wales was rolled out in pathfinder areas in October 2013.[32] In England, MASs are specified as a 'locally commissioned' (previously 'enhanced') service within the community pharmacy contract.[33] These services are commissioned by local NHS bodies (previously PCTs but now Clinical Commissioning Groups (CCGs) and/or NHS Area Teams) on the basis of need. In 2012-13, 3,440 community pharmacies in England (30% of all pharmacies in England) provided MASs.[34]

The HoBtPCT MAS was launched in 2005.[13] The scheme was targeted at patients who are entitled to free prescriptions[d] who would traditionally attend their GP for a consultation concerning a minor ailment, a phenomenon which was reflected in high GP prescribing rates for cough medicines, systemic decongestants and simple analgesics within HoBtPCT.[35] The aims of the service were to allow better access to medicines to treat common, self-limiting conditions and to improve GP capacity. The conditions which were eligible for treatment and the treatments available for each condition are detailed in Table 1 below.

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[d] There are a large range of exemption categories which entitle people to free prescriptions. These include exemptions based on age, pregnancy, exemptions for people claiming certain state benefits and exemptions for people with specific medical conditions. Further information on exemptions from the prescription charge can be found here: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx

Table 1: Conditions and accompanying treatments included in the HoBtPCT MAS

CONDITION	TREATMENT(S)/ADVICE AVAILABLE
Athlete's Foot	Terbinafine 1% cream
Cold Sores	Aciclovir 5% w/w cream
Constipation	Senna tabs
Contact Dermatitis	Clobetasone 0.05% cream
	Hydrocortisone 1% cream
Cough	Simple Linctus (SF)
	Simple Linctus Paediatric (SF)
Cystitis	Potassium Citrate Mixture 200ml
	Sodium Citrate 4g sachet
Diarrhoea	Advice only
Dry skin	Aqueous cream
Earwax	Sodium Bicarbonate 5% ear drops
Eczema	Aqueous cream*
	Clobetasone 0.05% cream^
	Hydrocortisone 1% cream^
Haemorrhoids	Anusol® cream
	Anusol® suppositories
Hay Fever	Beclometasone nasal spray
	Cetirizine 10 mg tabs
	Chlorphenamine 4 mg tabs
	Chlorphenamine syrup
	Sodium Cromoglycate 2% eye drops
Head Lice	Detection comb
Headache/earache/temperature	Ibuprofen 200 mg tablets
	Ibuprofen 100 mg/5 ml susp
	Paracetamol 500 mg tabs
	Paracetamol 120 mg/5 ml susp SF
	Paracetamol 250 mg/5 ml susp SF
Indigestion/heartburn/tummy upset	Gaviscon 250® tablets
	Magnesium Trisilicate Mixture
	Peptac® suspension
Migraine	Aspirin 300 mg tabs
	Aspirin 300 mg soluble tablets
	Ibuprofen 200 mg tablets
	Paracetamol 500 mg tabs
	Paracetamol 500 mg soluble tabs
Mild Sunburn	Aqueous cream
Minor Burns	Ibuprofen 200 mg tablets
	Paracetamol 500 mg tabs
Mouth Ulcers	Medijel® gel
Nappy Rash	Sudocrem® cream*
	Clotrimazole 1% cream^
Nasal Congestion	Menthol and Eucalyptus inhalation
	Sodium chloride nasal drops
	Xylometazoline 0.1% nasal spray
	Pseudoephedrine 60 mg tabs
	Pseudoephedrine 30 mg/5 ml linctus
Oral Thrush	Miconazole 20 mg/g oral gel
Period Pain	Ibuprofen 200 mg tablets
	Paracetamol 500 mg tabs
Scabies	Permethrin 5% dermal cream
Sore Throat	Aspirin 300 mg soluble tablets
	Paracetamol 500 mg tabs
	Paracetamol susp SF 120 mg/5 ml
	Paracetamol susp SF 250 mg/5 ml
	Tyrozets® Lozenges
Teething	Dentinox® teething gel
Threadworms	Mebendazole 100 mg tablet(s)
Vaginal Thrush	Clotrimazole 1% cream
	Clotrimazole 500 mg pessary

Verruca	Salatac® gel
Warts	Salatac® gel
*[f]first line treatment option	
^second line treatment option(s)	

A 2013 systematic review of 31 evaluations of pharmacy-based MASs reported that the total number of GP consultations and prescriptions for minor ailments often declined following the introduction of MASs.[36] Reconsultation (i.e. consultations with a GP after a MAS consultation) rates ranged from 2% to 23% and the proportion of patients reporting complete resolution of their symptoms after a MAS consultation ranged from 68% to 94%. MAS consultations (range £1.44-£15.90) were less expensive than GP consultations. The review highlighted that the extent to which MASs shifted demand away from higher cost settings was yet to be fully determined and that full economic evaluations of MASs were lacking.[36]

1.5.4 SMOKING CESSATION

Smoking is the single biggest cause of preventable morbidity and premature mortality in England and is the most important single behavioural cause of health inequalities.[37,38] It causes a wide range of diseases and conditions including cancers, respiratory diseases, circulatory diseases and impotence.[39] During pregnancy, smoking increases the risks of miscarriage, giving birth to a low birth weight baby, premature birth and still birth.[40] Second-hand smoke (i.e. smoke from a lit smoking object (e.g. a cigarette) or smoke exhaled by a smoker) also increases the risks of cancers and sudden infant death syndrome.[39] Decreasing the number of people who smoke has been a public health priority in government policy for a number of years.[6,41]

Community pharmacists have regular contact with people who are healthy as well as those who are sick, providing an opportunity for health promotion and disease prevention activities including activities directed at smokers. Nicotine Replacement Therapy (NRT) is commercially available over the counter via community pharmacies and has been demonstrated to increasing smoking cessation rates by between 50% and 70%.[42] More formalised, NHS-funded, pharmacy-based smoking cessation services typically consist of a brief intervention (advice, discussion, negotiation or encouragement and referral to more intensive treatment, where appropriate) accompanied by the supply of NRT.[38]

Stop smoking services are specified as enhanced services in the community pharmacy contract in England.[33] In 2012-13, 5,747 out of 11,495 (50%) contractors in England delivered a stop smoking service making this the most frequently delivered enhanced service in community pharmacies in England.[34] The HoBtPCT pharmacy stop smoking service has been established for over ten years and has become a major component of the city's stop smoking strategy, providing NRT to those wishing to stop smoking at no charge.[13]

A 2004 (updated 2008) Cochrane review examining randomised controlled trials of community pharmacy based interventions for smoking cessation suggested that community pharmacist delivery of services may have a positive effect on smoking cessation rates although the lack of strong evidence to support this assertion was highlighted.[43] A US-based RCT of a pharmacist-delivered smoking cessation programme demonstrated that pharmacists are effective providers of smoking cessation services, with the proportion of participants quitting in the treatment arm being larger than that in the standard care arm at all time points measured (from 1 day to 6 months).[44] An evaluation of a community pharmacy-based initiative delivered via community pharmacies in a rural area of Scotland reported that 45% of clients had quit smoking at four weeks.[45] Further research also suggests that community pharmacy delivery of smoking cessation services is cost-effective.[46,47]

1.6 CHAPTER SUMMARY

HLPs are a new concept that has been readily embraced by government, pharmacy contractor organisations and pharmacy's professional leadership body in England. Early evidence as to the

effect of the concept on outcomes has been described as 'positive' although the need for further evidence is pressing. It is hoped that this report helps to further the evidence base around the effectiveness of the HLP concept in driving activity and improving outcomes whilst also providing insights into the views of the public and participating pharmacy staff on the HLP concept.

1.7 HLP STUDY AIM AND OBJECTIVES

The aim of the present study is to evaluate the implementation and impact of HLPs in HoBtPCT. The study has the following objectives:

- To analyse the activity of HLPs using data obtained from compulsory returns to HoBtPCT from accredited HLPs.
- To compare the activity and services provided from HLPs with the activity and services provided by those pharmacies within the Primary Care Trust (PCT) not currently involved in the HLP scheme.
- To provide a quantitative estimate of the health gain generated by investments in HLPs.
- To elucidate and analyse the views of service providers from the HLPs on their;
  - motivation for becoming an HLP within HoBtPCT;
  - experiences at the start of their involvement with the HLP scheme within HoBtPCT;
  - current experiences of being an HoBtPCT HLP; and,
  - future plans in relation to the HLP scheme.
- To explore and evaluate the views of HLP service users.
- To make recommendations on the future direction and impact of HLPs within HoBtPCT.

1.8 ETHICAL APPROVALS

1.8.1 NHS ETHICAL APPROVAL

NHS ethical approval was not required, as the HLP study was classed as a 'service evaluation' by HoBtPCT.

1.8.2 ASTON UNIVERSITY ETHICAL APPROVAL

An application was submitted to the School of Life and Health Sciences (LHS) Ethics Committee at Aston University along with the following supporting documentation:

- A Letter to GPs informing them about the HLP study.
- A letter to pharmacists/HTCs/HTs introducing the HLP study.
- A participant information sheet, which provided an assurance of confidentiality and explained the interview process, what would be required etc.
- A poster (developed with assistance from the Cluster) to raise awareness of the service-user questionnaire.
- The service-user questionnaire.

Ethics approval was granted by the Aston University LHS Committee on 15th June 2012.

1.8.3 THE CLUSTER'S INFORMATION GOVERNANCE PROTOCOLS

The Aston research team worked in close collaboration with the Information Governance (IG) Team at the Cluster and complied with the recommendations made by the IG team; the following forms were completed and submitted to the IG team for approval:

1. Two Caldicott Guardian forms.
   a. The first, to obtain permission for access to SC/MAS data; Caldicott Guardian approval was granted on 27th July 2012.
   b. The second, to obtain permission for access to EHC/EPT data; Caldicott Guardian approval was on 10th August 2012.

2. A 'Cluster Data Sharing Protocol' form.

Both of the forms mentioned above required detailed accounts of processes and procedures implemented by the Aston research team to ensure:

- Safe and secure collection/transfer/storage/deletion of all original datasets.
- Confidentiality and anonymity of data used in all analyses and an assurance that the results of the data analyses would be aggregated to mitigate risk of identification.

Furthermore, since identifiable data (i.e. full and partial postcodes and date of birth (DoB)) were included within the SC, MAS, EHC and EPT datasets, it was necessary to include an assurance within the Caldicott form (#1a and #1b) that the:

3. Full postcodes would be converted into Lower Super Output Areas (as per the Index of Multiple Deprivation 2010).
4. DoBs would be converted into age.

The IG team were therefore notified in writing (via email) to confirm conversion of identifiable data to non-identifiable data and deletion of all identifiable data as outlined in #3 and #4.

1.9 STRUCTURE OF THE REPORT

In addition to this introductory chapter, the remainder of this report has been set out as follows. Chapters 2 to 4 provide an overview of the data collection methodology and a presentation of the results from the three core stages of the research. These stages were:

- Chapter 2: Stage A – An analysis of service activity data.
- Chapter 3: Stage B – Interviews with service deliverers.
- Chapter 4: Stage C – The views of the service users.

This is followed by Chapter 5, which summarises the results from the three stages of the project and discuss the key findings, before concluding and making recommendations for the future roll-out of HLPs and future research.

Chapter 2 STAGE A – AN ANALYSIS OF SERVICE ACTIVITY DATA

2.1 METHODOLOGY

2.1.1 DATA COLLECTION PERIODS

Data collection periods for all four services (Emergency Hormonal Contraception, Early Pregnancy Testing, Smoking Cessation and Minor Ailments Scheme) varied according to the date of accreditation of the individual HLPs. While the first HLP in HoBtPCT was accredited in January 2012, the final three HLPs (of the ten HLPs which form the basis of this study) were not accredited until July 2012. Details of the time periods used for analysis for each service can be found in the relevant section of the results.

2.1.2 METHODOLOGY FOR EHC AND EPT DATA EXTRACTION

The data collated for both EHC and EPT were as follows:

EHC	EPT
• Date of supply	• Date of test
• Age of service user at the time of treatment	• Age of service user at the time of treatment
• General Practitioner practice/name	• General Practitioner practice/name
• Reason for consultation[a]	• Result of test (positive or negative)
[a]As defined by PCT data collection paperwork: 'burst condom', 'unprotected penetrative sexual intercourse', 'missed pill' or 'other'.	

The data extraction process for the EHC and EPT data was complicated by a number of factors:

1. The EHC and EPT claims forms included information on both service users' demographic characteristics and the fee claimed by pharmacists for the supply of the EHC/EPT services.
2. The claims forms submitted to the Cluster (by pharmacists) were in paper format and the timing of submissions varied in that pharmacists submitted:
   a. EHC forms on a three-monthly basis.
   b. EPT forms on a monthly basis.
3. **The demographic data** were not available in electronic format i.e. the data remained in paper format. Furthermore, the Cluster's Information Governance protocols prohibited site to site (i.e. from the Cluster to a secure location at Aston University) transfer of the forms. Therefore, extraction of the demographic data required:
   a. Scanning of EHC/EPT Claims forms (at the Cluster) into an encrypted laptop, by members of the Aston research team.
   b. Manual entry of data from the scanned images (of the EHC and EPT Claims forms) into an Excel database and secure deletion of the scanned images thereafter.

Additionally, two elements of the data analysis necessitated a staggered approach to extraction of the demographic data i.e.:

   c. Comparison of each HLP's activity between two time periods, pre- and post-HLP accreditation, based on the date of accreditation of each HLP, which ranged from January 2012 to July 2012.
   d. Comparison of activity between each HLP and its equivalent non-HLP comparator across corresponding time spans (i.e. the pre- and post-accreditation dates as used in 3a.

Consequently, a data extraction plan was developed to ensure identification of the appropriate non-HLP comparators and to ensure that the staged collection of the demographic data (as explained in 3a and 3b) remained within the scope of the project timespan. The data extraction plan therefore entailed:

e. **Identification of ten comparator non-HLPs** (equivalent to HLPs) contracted to supply EHC and EPT services; the selection criteria included:

- Geographic proximity to the HLPs i.e. the nearest non-HLP to each HLP.
  - Where a non-HLP was the closest pharmacy to more than one HLP, the non-HLP was allocated to the HLP, which was furthest from the non-HLP so as to minimise the overall mean distance between HLPs and non-HLPs.
- Opening hours i.e. where a '100-hour' HLP was matched with its nearest 100-hour non-HLP.

f. **Establishing the pre and post time periods** (for data extraction) for:
  i. EHC data, i.e. three months pre/post the date of accreditation
  ii. EPT data i.e. one month pre/post the date of accreditation.

As an example, demographic data from EHC and EPT claims forms were extracted as follows for HLPs accredited in July 2012:

	FOR HLPs ACCREDITED IN JULY 2012, DATA WERE EXTRACTED FROM CLAIMS FORMS SUBMITTED BY HLPs AND COMPARATOR NON-HLPs, FOR THE MONTHS OF:	
	EHC	**EPT**
Pre-accreditation time period	April, May and June 2012	June 2012
Post-accreditation time period	August, September and October 2012	August 2012
Note: The data collection process for the EHC and EPT data did not conclude until December 2012.		

2.1.3 METHODOLOGY FOR SC AND MAS DATA EXTRACTION

As mentioned earlier, all data (EHC, EPT, SC and MAS) were collected in stages. However, whilst MAS data (managed by Webstar) was collated in real time i.e. instantaneous data collection upon user input, SC data (managed by the PCT) was collated and converted into electronic format by a third party. Consequently, the SC data for October 2012 was not available for collection until March 2013, which resulted in the extension of the project timeline. Therefore, data for the SC and MAS services were requested for the following time periods:

	DATA WERE REQUESTED FROM:
For all pharmacies (both HLP and non-HLP)	January 2012 to 31st October 2012 inclusive
For HLP accredited pharmacies	January 2010 to 31st October 2012 inclusive

The data categories requested for the SC service included:

DEMOGRAPHICS	MEASUREMENTS	PHARMACY DETAIL
• Age • Gender • Full postcode • Occupation • Ethnicity	• Carbon monoxide (CO) reading at recruitment. • CO reading at 4 weeks post-recruitment.	• pharmacy ID, • Pharmacy name • Full address with postcode

The data categories requested for the MAS service included:

DEMOGRAPHICS	OTHER INFORMATION	PHARMACY DETAILS
• Age at point of consultation • Gender • Full postcode	• How service users heard about the scheme • Would the patient have seen GP normally? • Symptoms presented by the service user (as categorised in Minor Ailments Scheme paperwork). • Product supplied • Criterion for acceptance on to scheme • Details from 'Declaration of Exemption (MAS1)'.	• Pharmacy ID, • Pharmacy name • Full address with postcode

2.1.4 DATA ANALYSIS

Descriptive statistics are presented for all pharmacies and by HLP status. Bivariate analyses were also undertaken to determine whether there were associations between variables. The following statistical tests were applied to the data during bivariate analyses:

- In the majority of cases, data were categorical and, where categorical data are detailed, the chi-squared test of association was used. Unless otherwise stated, the p-values provided are a result of a chi-squared test of association.
- When comparing the means of two samples, an unpaired- t-test was used unless the data could be paired (for example in comparing activity levels pre- and post-accreditation as an HLP), in which case a paired-t-test was used. Where an unpaired- or paired-t-test has been used, this is clearly stated in the relevant section of text, in the relevant table or immediately above the relevant figure.

2.2 RESULTS

2.2.1 SMOKING CESSATION ANALYSIS/RESULTS

2.2.1.1 Number of consultations per quarter

Data on service provision were obtained from all pharmacies (n=67) that provided the service in Heart of Birmingham Teaching Primary Care Trust (HoBtPCT) for consultations between 1st April 2011 and 31st October 2012. During this timeframe, 3608 consultations occurred, 477 (13.2%) of which were via HLPs. Some seasonal variability in the number of consultations was observed (see Figure 2). No association was observed between the number of consultations per quarter and HLP status (p=0.062).

Figure 2: Number of smoking cessation consultations per quarter (Q2 2011 – Q4 2012)
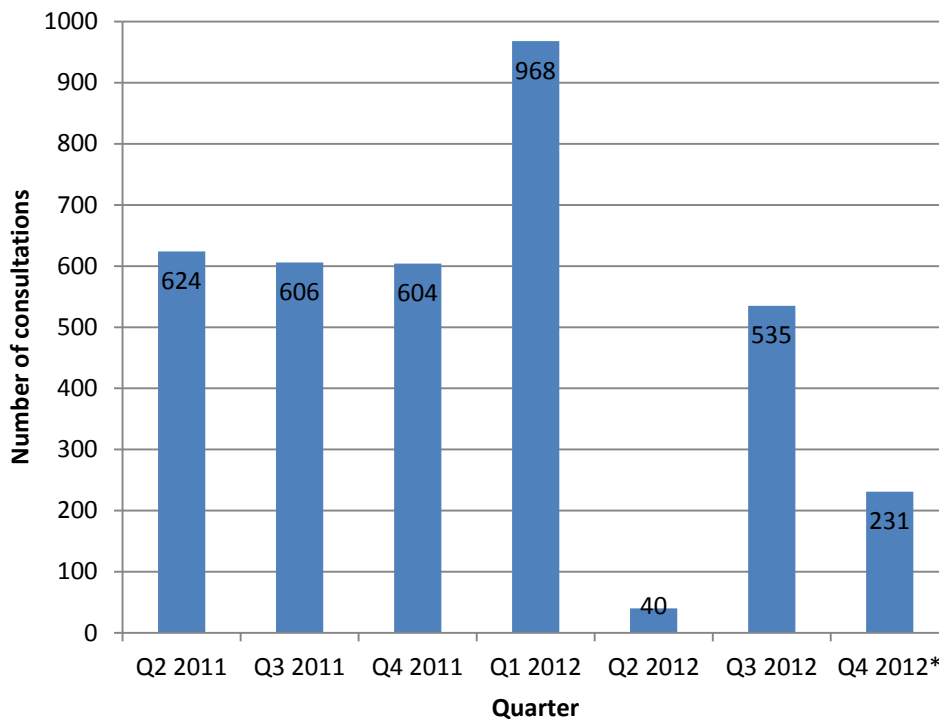
*Only data for October 2012 were available

2.2.1.2 Demographic characteristics of individuals taking part

Where an IMD 2010 score could be attached to a participant, 73.7% (n=2544/3454) of participants were from the most deprived quintile of LSOAs in England with only 1.0% (n=36/3454) of participants being from the least deprived quintile of LSOAs. The demographic characteristics of individuals accessing the smoking cessation scheme via HLPs and non-HLPs were heterogeneous. Participants in HLPs were older and were more likely to have been male, been from a black or minority ethnic group, have never worked or been long-term unemployed, and been from the most deprived areas of central Birmingham (see Table 2).

Table 2: Demographic characteristics of individuals taking part in the smoking cessation service

CHARACTERISTIC	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	**Non-HLP**	**Total**	
Age				
13-29	25 (5.3)	142 (4.6)	167 (4.7)	0.018
20-29	99 (20.9)	748 (24.1)	847 (23.7)	
30-39	113 (23.8)	889 (28.6)	1002 (28.0)	
40-49	110 (23.2)	664 (21.4)	774 (21.6)	
50-59	82 (17.3)	388 (12.5)	470 (13.1)	
≥60	45 (9.5)	276 (8.9)	321 (9.0)	
All	474 (100.0)	3107 (100.0)	3581 (100.0)	
Sex				
Female	165 (34.6)	1302 (41.6)	1467 (40.7)	0.004[b]
Male	312 (65.4)	1829 (58.4)	2141 (59.3)	
All	477 (100.0)	3131 (100.0)	3608 (100.0)	
Ethnicity				
Asian	208 (47.1)	846 (28.6)	1054 (31.0)	<0.001
Black	63 (14.3)	356 (12.0)	419 (12.3)	
Mixed	24 (5.4)	170 (5.8)	194 (5.7)	
Other	10 (2.3)	60 (2.0)	70 (2.1)	
White	137 (31.0)	1524 (51.6)	1661 (48.9)	
All	442 (100.0)	2956 (100.0)	3398 (100.0)	
Occupation[c]				
Full-time student	24 (6.7)	189 (7.2)	213 (7.1)	<0.001
Home carer	11 (3.1)	91 (3.5)	102 (3.4)	
Intermediate	22 (6.1)	182 (6.9)	204 (6.8)	
Managerial/professional	39 (10.8)	471 (17.9)	510 (17.0)	
Never worked/long-term unemployed	164 (45.6)	880 (33.4)	1044 (34.9)	
Retired	33 (9.2)	234 (8.9)	267 (8.9)	
Routine and manual	36 (10.0)	425 (16.1)	461 (15.4)	
Sick/disabled and unable to work	31 (8.6)	162 (6.2)	193 (6.4)	
All	360 (100.0)	2634 (100.0)	2994 (100.0)	
IMD quintile				
1 (least deprived)	25 (5.4)	666 (22.3)	691 (20.0)	<0.001
2	90 (19.4)	601 (20.1)	691 (20.0)	
3	109 (23.5)	581 (19.4)	690 (20.0)	
4	92 (19.8)	599 (20.0)	691 (20.0)	
5 (most deprived)	148 (31.9)	543 (18.2)	691 (20.0)	
All	464 (100.0)	2990 (100.0)	3454 (100.0)	

[a]Excludes missing values
[b]continuity correction applied
[c]Also excludes cases where response coded as 'in prison' (n=3)

2.2.1.3 Quit success

Quit status at 4 weeks showed seasonal variation (p<0.001) with a higher proportion of participants successfully quitting in the first two quarters of 2012 than in the other quarters for which data were available (see Figure 3).

Figure 3: Proportion of participants successfully quitting at 4 weeks per quarter (Q2 2011 – Q4 2012)

*Only data for October 2012 were available

Quit status at 4 weeks varied based on a number of demographic characteristics. Older participants, male participants and participants from higher occupational groups all had higher 'quit' rates than younger participants, female participants and participants from lower occupational groups respectively (see Table 3).

Table 3: Influence of demographic characteristics on quit status at 4 weeks

CHARACTERISTIC	NUMBER (%) OF CONSULTATIONS[a]				P-value
	Yes	**No**	**Lost to follow up**	**Total**	
Age					
13-29	55 (32.9)	38 (22.8)	74 (44.3)	167 (100.0)	<0.001
20-29	360 (42.6)	175 (20.7)	311 (36.8)	846 (100.0)	
30-39	477 (47.7)	202 (20.2)	320 (32.0)	999 (100.0)	
40-49	400 (51.9)	151 (19.6)	220 (28.5)	771 (100.0)	
50-59	226 (48.3)	111 (23.7)	131 (28.0)	468 (100.0)	
≥60	183 (57.2)	71 (22.2)	66 (20.6)	320 (100.0)	
All	1701 (47.6)	748 (20.9)	1122 (31.4)	3571 (100.0)	
Gender					
Female	657 (44.9)	353 (24.1)	452 (30.9)	1462 (100.0)	0.001
Male	1055 (49.4)	405 (19.0)	676 (31.6)	2136 (100.0)	
All	1712 (47.6)	758 (21.1)	1128 (31.4)	3598 (100.0)	
Ethnicity					
Asian	521 (49.6)	190 (18.1)	339 (32.3)	1050 (100.0)	0.150
Black	200 (47.8)	84 (20.1)	134 (32.1)	418 (100.0)	
Mixed	89 (45.9)	46 (23.7)	59 (30.4)	194 (100.0)	
Other	37 (52.9)	16 (22.9)	17 (24.3)	70 (100.0)	
White	766 (46.3)	381 (23.0)	509 (30.7)	1656 (100.0)	
All	1613 (47.6)	717 (21.2)	1058 (31.2)	3388 (100.0)	
Occupation[b]					
Full-time student	88 (41.5)	49 (23.1)	75 (35.4)	212 (100.0)	<0.001
Home carer	48 (47.1)	26 (25.5)	28 (27.5)	102 (100.0)	
Intermediate	110 (53.9)	39 (19.1)	55 (27.0)	204 (100.0)	
Managerial/professional	293 (57.7)	73 (14.4)	142 (28.0)	508 (100.0)	
Never worked/long-term unemployed	425 (40.8)	253 (24.3)	363 (34.9)	1041 (100.0)	
Retired	152 (57.1)	62 (23.3)	52 (19.5)	266 (100.0)	
Routine and manual	228 (49.5)	99 (21.5)	134 (29.1)	461 (100.0)	
Sick/disabled and unable to work	78 (40.6)	41 (21.4)	73 (38.0)	192 (100.0)	
All	1422 (47.6)	642 (21.5)	922 (30.9)	2986 (100.0)	
IMD quintile					
1 (least deprived)	354 (51.5)	141 (20.5)	193 (28.1)	688 (100.0)	0.055
2	332 (48.1)	148 (21.4)	210 (30.4)	690 (100.0)	
3	315 (45.8)	133 (19.3)	240 (34.9)	688 (100.0)	
4	344 (49.9)	144 (20.9)	201 (29.2)	689 (100.0)	
5 (most deprived)	306 (44.4)	167 (24.2)	216 (31.3)	689 (100.0)	
All	1651 (47.9)	733 (21.3)	1060 (30.8)	3444 (100.0)	

[a]Excludes missing values
[b]Also excludes cases where response coded as 'in prison' (n=3)

Where quit status at 4 weeks post-enrolment was recorded (3598 consultations), 47.6% (n=1712/3598) of participants had successfully stopped smoking. Quit rates at 4 weeks were slightly higher amongst participants attending non-HLPs than in participants attending HLPs although this difference was not statistically significant (see Table 4).

Table 4: Quit status at 4 weeks

QUIT STATUS	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	**Non-HLP**	**Total**	
Yes	222 (46.5)	1490 (47.7)	1712 (47.6)	0.154
No	116 (24.3)	642 (20.6)	758 (21.1)	
Lost to follow up	139 (29.1)	989 (31.7)	1128 (31.4)	
All	477 (100.0)	3121 (100.0)	3598 (100.0)	
[a]Excludes missing values				

2.2.1.4 Impact of HLP accreditation on quit status

To provide an indication of the impact of HLP accreditation on the effectiveness of the smoking cessation programme, quit status was compared between quarter 3 (July-September) 2011 and quarter 3 2012. Quarter 3 2012 was chosen as the period for post-accreditation analysis as this was the only quarter where the majority of pharmacies (n=7 – although data was missing for one HLP so only data from 6 HLPs were used for analysis) had been accredited as HLPs and data were available for a complete quarter. Quarter 3 2011 was selected as the pre-accreditation time period as an attempt to control for seasonal variations in both consultation rates and quit status at 4 weeks. There was no statistically significant difference in quit status at 4 weeks between HLPs before and after accreditation as an HLP. While there was a statistically significant difference in quit status at 4 weeks between quarter 3 2011 and quarter 3 2012 in non-HLPs, this was a result of an increase in the number of participants lost to follow up rather than any change in the proportion of participants successfully quitting smoking (see Table 5).

Table 5: Impact of HLP accreditation on quit status at 4 weeks

PHARMACY TYPE	QUIT STATUS	DATE		P-value
		Q3 2011	**Q3 2012**	
HLP[a]				
	Yes	36 (52.9)	30 (41.1)	0.369
	No	16 (23.5)	22 (30.1)	
	Lost to follow up	16 (23.5)	21 (28.8)	
	Total	68 (100.0)	73 (100.0)	
Non-HLP				
	Yes	259 (48.2)	222 (48.1)	0.029
	No	106 (19.7)	65 (14.1)	
	Lost to follow up	172 (32.0)	175 (37.9)	
	Total	537 (100.0)	462 (100.0)	
All				
	Yes	295 (48.8)	252 (47.1)	0.077
	No	122 (20.2)	87 (16.3)	
	Lost to follow up	188 (31.1)	196 (36.6)	
	Total	605 (100.0)	535 (100.0)	

[a]HLPs accredited before July 2012 (n=6; data missing from one HLP accredited before July 2012).

2.2.2 MINOR AILMENTS SCHEME ANALYSIS/RESULTS

This section presents an analysis of data collected during consultations provided as part of the minor ailments scheme (MAS). It is divided into two subsections; a comparison of provision between all HLPs and all non-HLPs providing the service and a comparison between provision before and after accreditation as an HLP for the ten HLPs.

2.2.2.1   Comparison between provision via HLPs and non-HLPs

Data on service provision were obtained from all pharmacies (n=71) that provided the service in Heart of Birmingham Teaching Primary Care Trust (HoBtPCT) for consultations between 1st January 2012 and 31st November 2012. During this timeframe, 194,315 consultations occurred, 23,579 (12.1%) of which were via HLPs (n=10). It is important to note that some patients may have presented with more than one minor ailment. In these instances, each ailment was recorded as a distinct consultation (i.e. one consultation does not equal one patient). Some seasonal variability in the number of consultations was observed. The mean number of consultations per HLP was 2358 compared to 2805 per non-HLP. There was an association between the mean number of consultations delivered per month and HLP status (p<0.001). In all of the eleven months for which data were available, the mean number of consultations delivered through non-HLPs exceeded the mean number of consultations delivered through HLPs (see Figure 4).

Figure 4: The mean number of MAS consultations delivered by HLPs, non-HLPs and all pharmacies per month (January 2012-November 2012)
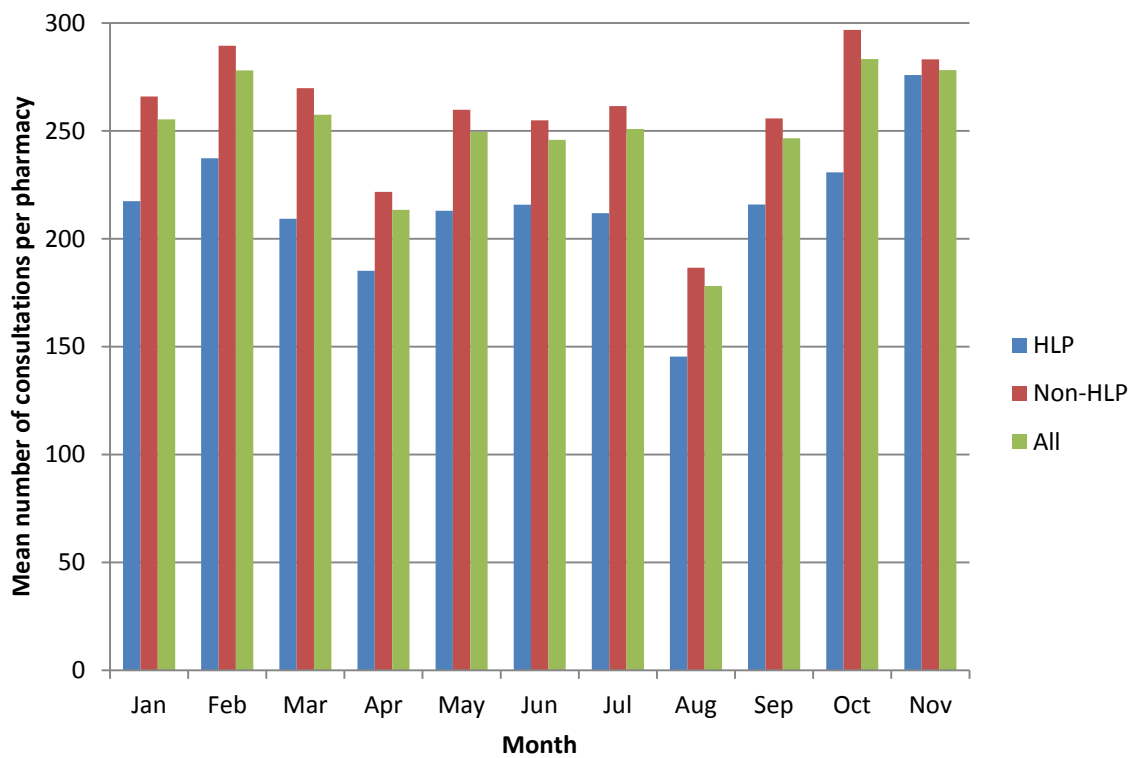
More than 9 out of 10 (91.3%; n=170791/187082) MAS consultations were with people residing in the most deprived quintile of LSOAs in England (where IMD 2010 score was known). The demographic characteristics of individuals accessing the MAS via HLPs and non-HLPs were somewhat heterogeneous. Statistically significant associations were observed for age, IMD quintile, exemption status and acceptance criteria between consultations in HLPs and consultations in non-HLPs. However, the differences in the characteristics of participants in HLPs and non-HLPs were usually minimal and the fact that such differences were 'statistically significant' is probably attributable to the large number of observations as opposed to any notable differences between the two groups. Arguably, the one exception to this rule is the differences observed based on IMD quintile where 41.7% of consultations delivered via non-HLPs involved a participant from the two most deprived quintiles within the cohort compared to 28.0% in consultations delivered via HLPs (see Table 6).

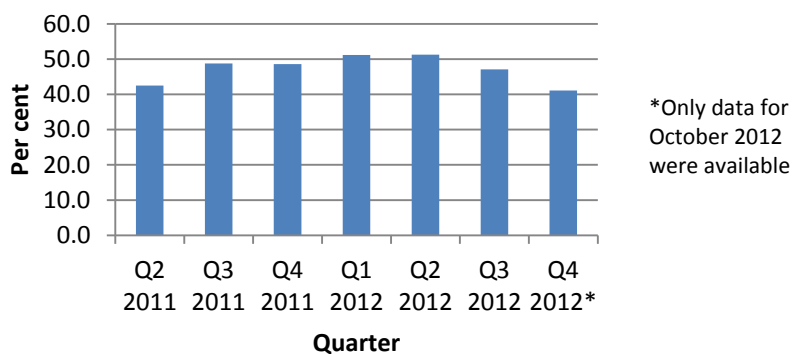**Table 6: Demographic characteristics of individuals taking part in the MAS**

CHARACTERISTIC	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	Non-HLP	Total	
Age				
0-1	2503 (10.6)	16889 (9.9)	19392 (10.0)	<0.001
2-3	2517 (10.7)	17606 (10.3)	20123 (10.4)	
4-5	2130 (9.0)	15390 (9.0)	17520 (9.0)	
6-7	1417 (6.0)	11173 (6.5)	12590 (6.5)	
8-9	1257 (5.3)	8767 (5.1)	10024 (5.2)	
10-11	1007 (4.3)	7027 (4.1)	8034 (4.1)	
12-14	939 (4.0)	7012 (4.1)	7951 (4.1)	
15-19	924 (3.9)	6411 (3.8)	7335 (3.8)	
20-29	1348 (5.7)	11106 (6.5)	12454 (6.4)	
30-39	2744 (11.6)	20300 (11.9)	23044 (11.9)	
40-49	2246 (9.5)	15604 (9.1)	17850 (9.2)	
50-59	1470 (6.2)	12681 (7.4)	14151 (7.3)	
60-69	1187 (5.0)	8423 (4.9)	9610 (4.9)	
70+	1890 (8.0)	12344 (7.2)	14234 (7.3)	
All	23579 (100.0)	170733 (100.0)	194312 (100.0)	
IMD quintile				
1 (least deprived)	5906 (25.8)	31510 (19.2)	37416 (20.0)	<0.001
2	5993 (26.2)	31424 (19.1)	37417 (20.0)	
3	4568 (20.0)	32848 (20.0)	37416 (20.0)	
4	2128 (9.3)	35289 (21.5)	37417 (20.0)	
5 (most deprived)	4282 (18.7)	33134 (20.2)	37416 (20.0)	
All	22877 (100.0)	164205 (100.0)	187082 (100.0)	
Exemption status				
Gets Income Support	2523 (10.7)	20127 (11.8)	22650 (11.7)	<0.001
Gets income-based Jobseekers' Allowance	1015 (4.3)	7551 (4.4)	8566 (4.4)	
Has a current Maternity Exemption Certificate	260 (1.1)	1496 (0.9)	1756 (0.9)	
Has a current Medical Exemption Certificate	936 (4.0)	4242 (2.5)	5178 (2.7)	
Has a current Prescription Pre-payment Certificate	85 (0.4)	829 (0.5)	914 (0.5)	
Has a partner who gets Minimum Income Guarantee	18 (0.1)	167 (0.1)	185 (0.1)	
Has a War Pension Exemption Certificate	3 (0.0)	40 (0.0)	43 (0.0)	
Is 16, 17 or 18 and in full-time education	537 (2.3)	4163 (2.4)	4700 (2.4)	
Is 60 years of age or older	2935 (12.5)	19284 (11.3)	22219 (11.4)	
Is entitled to, or named on a valid NHS Tax Credit Exemption Certificate	2978 (12.6)	26396 (15.5)	29374 (15.1)	
Is named on a current HC2 Charges Certificate	149 (0.6)	849 (0.5)	998 (0.5)	
Is under 16 years of age	12132 (51.5)	85555 (50.1)	97687 (50.3)	
All	23571 (100.0)	170699 (100.0)	194270 (100.0)	
Acceptance criteria				
Confirmation of Registration Document	1396 (5.9)	12118 (7.1)	13514 (7.0)	<0.001
From PMR/other pharmacy record	17270 (73.2)	121006 (70.9)	138276 (71.2)	
Medical card	4867 (20.6)	34103 (20.0)	38970 (20.1)	
Surgery Confirmed Registration	46 (0.2)	3505 (2.1)	3551 (1.8)	
All	23579 (100.0)	170732 (100.0)	194311 (100.0)	

[a]Excludes missing values

Over half (52.1%; n=101213/194315) of all MAS consultations during the study period concerned headache, earache or a raised temperature. The number of consultations for 'headache/earache/temperature' was over three times greater than the number of consultations for the next most commonly observed complaint 'cough' (16.0%; n=31065/194315). Fifteen separate conditions were the subject of less than one per cent of consultations (see Table 7).

Table 7: Number of MAS consultations for each listed condition between 1st January and 31st November 2012

CONDITION	NUMBER (%) OF CONSULTATIONS
Headache/earache/temperature	101213 (52.1)
Cough	31065 (16.0)
Hay fever	14018 (7.2)
Nasal congestion	8243 (4.3)
Indigestion/heartburn/tummy upset	7786 (4.0)
Sore throat	7601 (3.9)
Nappy rash	4215 (2.2)
Vaginal thrush	3747 (1.9)
Teething	2071 (1.1)
Mild sunburn	2015 (1.0)
Others[a]	12341 (6.4)
Missing	174 (0.1)
All	194315 (100.0)

[a]Athlete's foot, cold sores, constipation, contact dermatitis, cystitis, diarrhoea, earwax, head lice, haemorrhoids, migraine, mouth ulcers, oral thrush, scabies, threadworms and warts. All less than 1% of consultations.

A total of 44 different medicinal products were supplied to patients via the MAS at participating pharmacies. Unsurprisingly, the medication supplied during MAS consultations reflects the conditions on which consultations were focussed. Analgesics (paracetamol and ibuprofen) were supplied in over half (52.2%; n=101,213/194,315) of MAS consultations between 1st January and 31st November 2012. Simple linctus was supplied in 16.0% (n=31,065/194,315) of consultations and hay fever remedies (chlorphenamine, cetirizine and sodium cromoglycate) were supplied in 6.5% (n=12,732/194,315) of consultations (see Table 8).

Table 8: Medication (or advice) supplied via MAS between 1st January 2012 and 31st November 2012

MEDICATION SUPPLIED	NUMBER (%) OF CONSULTATIONS
Paracetamol[a]	88438 (45.6)
Simple linctus[b]	31065 (16.0)
Ibuprofen[c]	12775 (6.6)
Tyrozets™ lozenges	7476 (3.8)
Peptac™ liquid	5200 (2.7)
Chlorphenamine[d]	4892 (2.5)
Cetirizine 10 mg tablets	4369 (2.2)
Sudocrem	4215 (2.2)
Clotrimazole[e]	3927 (1.9)
Sodium cromoglycate eye drops	3471 (1.8)
Sodium chloride nasal drops	3245 (1.7)
Pseudoephedrine[f]	3219 (1.6)
Dentinox™ teething gel	2071 (1.1)
Aqueous cream	2015 (1.0)
Gaviscon™ 250 tablets	1910 (1.0)
Others[g]	15827 (8.1)
Advice only	26 (0.0)
Missing	174 (0.1)
All	194315 (100.0)

[a]500 mg tablets, 500 mg soluble tablets, 250 mg/5 ml sugar-free suspension and 120 mg/5 ml sugar free suspension
[b]Includes paediatric simple linctus
[c]200 mg tablets and 100 mg/5 ml sugar free suspension
[d]4 mg tablets and 2 mg/5 ml solution
[e]1% cream and 500 mg pessary
[f]60mg tablets and 30 mg/5 ml solution
[g]All less than 1% of consultations.

There were slight variations in medication supplied through HLPs and non-HLPs for the five most common conditions on which MAS consultations were focussed (see Table 9). While the differences observed achieved statistical significance in all five conditions, the differences were usually minimal and the fact that such differences were 'statistically significant' is probably attributable to the large number of observations as opposed to any notable differences between the two groups.

Table 9: Condition/medication supplied via MAS by HLPs and non-HLPs between 1st January 2012 and 31st November 2012

CONDITION AND MEDICATION SUPPLIED (PACK SIZE)	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	Non-HLP	Total	
Headache/earache/temperature				
Paracetamol 120mg/5ml susp SF (100ml)	4005 (32.9)	28945 (32.5)	32950 (32.6)	<0.001
Paracetamol 500mg tabs (32)	3517 (28.9)	26335 (29.6)	29852 (29.5)	
Paracetamol 250mg/5ml susp SF (100ml)	2094 (17.2)	15167 (17.0)	17261 (17.1)	
Paracetamol 500mg soluble tabs (24)	1206 (9.9)	7169 (8.1)	8375 (8.3)	
Ibuprofen 100mg/5ml susp SF (100ml)	894 (7.3)	6923 (7.8)	7817 (7.7)	
Ibuprofen tabs 200mg (24)	472 (3.9)	4486 (5.0)	4958 (4.9)	
Total	12188 (100.0)	89025 (100.0)	101213 (100.0)	
Cough				
Simple Linctus Paed SF (200ml)	2145 (49.7)	13923 (52.0)	16068 (51.7)	0.005[b]
Simple Linctus SF (200ml)	2169 (50.3)	12828 (48.0)	14997 (48.3)	
Total	4314 (100.0)	26751 (100.0)	31065 (100.0)	
Hayfever				
Cetirizine 10mg tabs (7)	485 (33.5)	3884 (30.9)	4369 (31.2)	0.014
Sod Crom 2% eye drops (5ml)	365 (25.2)	3106 (24.7)	3471 (24.8)	
Chlorphenamine 2mg/5ml Soln (150ml)	303 (20.9)	2817 (22.4)	3120 (22.3)	
Chlorphenamine 4mg tabs (30)	149 (10.3)	1623 (12.9)	1772 (12.6)	
Beclometasone 50mcg/dose nasal spr (100ml)	145 (10.0)	1141 (9.1)	1286 (9.2)	
All	1447 (100.0)	12571 (100.0)	14018 (100.0)	
Nasal congestion				
Menthol & Eucalyptus inhalation (100ml)	30 (2.7)	149 (2.1)	179 (2.2)	<0.001
Pseudoephedrine 60mg tabs (12)	127 (11.4)	1283 (18.0)	1410 (17.1)	
Pseudoephedrine 30mg/5ml liquid (100ml)	232 (20.8)	1577 (22.1)	1809 (21.9)	
Sodium Chloride nasal drops (10ml)	547 (49.0)	2698 (37.9)	3245 (39.4)	
Xylometazoline 0.1% nasal spray (10ml)	181 (16.2)	1419 (19.9)	1600 (19.4)	
All	1117 (100.0)	7126 (100.0)	8243 (100.0)	
Indigestion/heartburn/tummy upset				
Gaviscon 250 tabs (16)	76 (10.3)	1834 (26.0)	1910 (24.5)	<0.001
Magnesium Trisilicate mixture (200ml)	55 (7.5)	621 (8.8)	676 (8.7)	
Peptac liquid (500ml)	605 (82.2)	4595 (65.2)	5200 (66.8)	
All	736 (100.0)	7050 (100.0)	7786 (100.0)	
[a]Excludes missing values [b]continuity correction applied				

In almost four-fifths (79.8%; n=155,021/194,314) of consultations, patients reported being informed of the existence of the MAS by staff at their general practice surgery. In a further 19.9% (n=38,711/194,314) of consultations, patients reported learning about the service via posters and leaflets displayed in pharmacy premises. In the remaining 0.3% (n=582/194,314) of consultations, patients reported hearing about the service via other routes (there was one 'missing' value). There was an association between HLP status and how patients heard about the MAS with patients accessing the MAS via HLPs more likely to report having heard about the MAS through promotional materials (posters/leaflets) than at non-HLPs (see Table 10).

Table 10: How patients who had a MAS consultation between 1st January 2012 and 31st November 2012 heard about the existence of the MAS

HOW PATIENT HEARD ABOUT THE MAS	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	Non-HLP	Total	
Posters/leaflets	8748 (37.1)	29963 (17.5)	38711 (19.9)	<0.001
Surgery/receptionist	14814 (62.8)	140207 (82.1)	155021 (79.8)	
Other	17 (0.1)	565 (0.3)	582 (0.3)	
Total	23579 (100.0)	170735 (100.0)	194314 (100.0)	
[a]Excludes missing values				

Patients enrolled into the MAS were asked whether, in the absence of the service, they would have consulted their GP about their ailment. In almost every consultation (98.4%; n=191,235/194,315), the patient reported that they would have consulted their GP in the absence of the service. In the remaining consultations, patients reported that they wouldn't have seen their GP. There was one 'missing' value. A slightly higher proportion of patients accessing the MAS via HLPs reported that they would have seen the GP than in patients accessing the MAS via non-HLPs (see Table 11).

Table 11: Whether patients who had a MAS consultation between 1st January 2012 and 31st November 2012 would have consulted their GP in the absence of the MAS

IN ABSENCE OF MAS, WOULD PATIENT HAVE CONSULTED GP?	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	Non-HLP	Total	
Yes	23556 (99.9)	167679 (98.2)	191235 (98.4)	<0.001[b]
No	23 (0.1)	3056 (1.8)	3079 (1.6)	
Total	23579 (100.0)	170735 (100.0)	194314 (100.0)	
[a]Excludes missing values [b]Continuity correction applied				

Each month, pharmacies were remunerated £3 for each consultation, up to 150 consultations, and £1 per consultation thereafter. They were also remunerated for any medication provided on a 'cost + VAT' basis (data for drug costs were not available)[e]. During the period from 1st January 2012 to 30th November 2012, there were 194,315 Minor Ailments Scheme (MAS) consultations at a total cost of £355,965. This equates to a fee of £1.83 per consultation. Costs per consultation were higher in Healthy Living Pharmacies (HLPs) than in non-HLPs although this difference was not statistically significant (see Table 12).

Table 12: Costs of MAS consultations, excluding drug costs (1st January 2012 – 30th November 2012)

	HLP (n=10)	Non-HLP (n=60)	Total (n=70)	p-value[a]
Number of consultations	23,579	170,736	194,315	-
Number of consultations per pharmacy	2,358	2,846	2,776	0.472
Total cost (£) of consultations	50,127.00	305,838.00	355,965.00	-
Cost (£) per pharmacy	5,012.70	5,097.30	5,085.21	0.933
Cost (£) per consultation	2.13	1.79	1.83	0.892
[a]unpaired-*t*-test				

During each consultation, patients were asked if, in the absence of the MAS, they would have consulted their General Practitioner (GP). Using these data it is possible to provide an estimate of 'savings' attributable to patients consulting a pharmacist rather than their GP about their minor ailment(s). However, it should be noted that such estimates are based on a number of assumptions and that these assumptions may lack rigour (the assumptions are detailed in Table 13 below). Whilst every effort has been made to base these estimates on the best available data, they remain speculative and should be treated with a commensurate degree of caution. Furthermore, these estimates are based solely on consultation costs and do not include the costs of medicines (for which

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[e] The VAT was subsequently claimed back by the Primary Care Trust.

data were not available). For these reasons, the most conservative estimate (i.e. in the region of £2,000,000 per annum) should be given precedence.

Table 13: Estimates of potential 'savings' attributable to MAS consultations (1ˢᵗ January 2012 – 30ᵗʰ November 2012)

		HLP	Non-HLP	Total
	Number (%) of consultations where patient would have seen GP	23,556 (99.9)	167,679 (98.2)	191,235 (98.4)
a)	Costs (£) to NHS if patients who would have seen had actually seen GP for their minor ailment (11.7 minute consultation)[a]	1,012,908.00	7,210,197.00	8223105.00
b)	Costs (£) to NHS if patients who would have seen had actually seen GP for their minor ailment (3.19 minute consultation)[b]	276,168.90	1,965,857.00	2,242,026.00
c)	Costs (£) to NHS from MAS consultations where patient would have consulted GP	50,078.10	300,362.00	350,322.80
d)	Costs (£) to NHS from MAS consultations where patient would not have consulted GP	48.90	5475.98	5642.24
e)	Potential cost savings (£) to NHS attributable to MAS consultations (based on 11.7 minute GP consultations) (= a – c – d)	962,781.00	6,904,359.00	7,867,140.00
f)	Potential cost savings (£) to NHS attributable to MAS consultations (based on 3.19 minute GP consultations) (= b – c – d)	226,041.90	1,660,019.00	1,886,061.00
g)	Potential costs savings (£) per annum (based on 11.7 minute GP consultation) (= e * (12/11))	1,050,307.00	7,532,028.00	8,582,335.00
h)	Potential cost savings (£) per annum (based on 3.19 minute GP consultation) (= f * (12/11))	246,591.20	1,810,930.00	2,057,521.00
i)	Potential cost savings (£) per MAS consultation (based on 11.7 minute GP consultation)	40.83	40.44	40.49
j)	Potential cost savings (£) per MAS consultation (based on 3.19 minute GP consultation)	9.59	9.72	9.71

[a]Based on a figure of £43 per 11.7 minute surgery consultation.[48]
[b]Based on a figure of £43 per 11.7 minute consultation adjusted to reflect the mean MAS consultation time of 3.19 minutes reported by Whittington et al (2001) (quoted in Paudyal et al (2013)).[36,48]

2.2.2.2 Comparison of provision of the MAS via HLPs before and after accreditation as an HLP

Data were available for all MAS consultations taking place at HLPs from 1ˢᵗ January 2010 through to 31ˢᵗ November 2012 (HLPs were accredited as HLPs at various points of 2012). In total, 68,932 MAS consultations occurred in these pharmacies during this timeframe. There was marked seasonal variation in the number of consultations with activity peaking in November/December each year and dropping off to a minimum in August each year (see Figure 5).

Figure 5: Number of MAS consultations per month in pharmacies accredited as HLPs in 2012
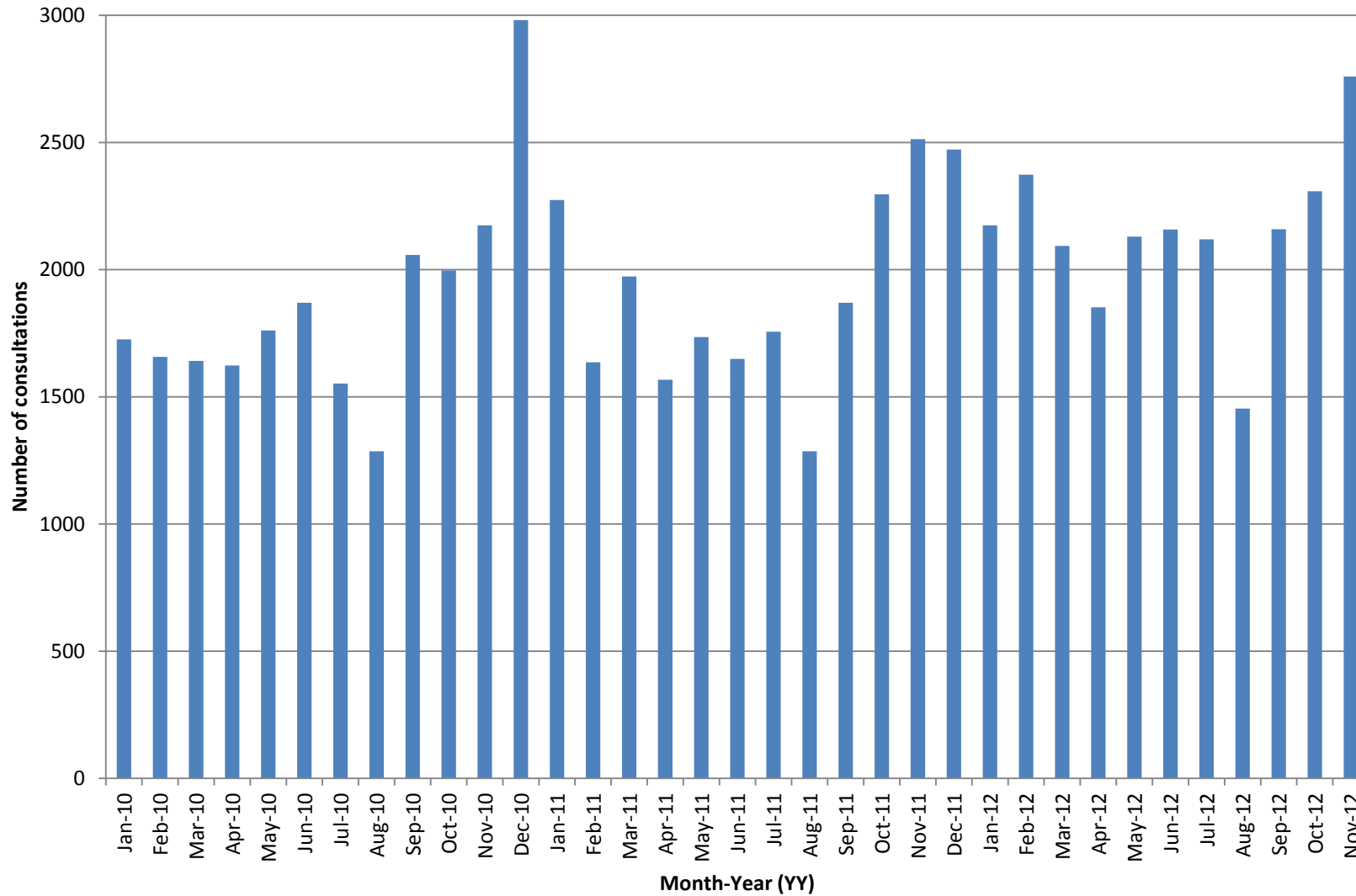
Analysis of the mean number of consultations per HLP demonstrated an increasing trend in the amount of MAS activity from year to year. As data for December 2012 were not available, data from January to November for each year were utilised. There was a 6.3% increase in the mean number of consultations per HLP between Jan-Nov 2010 and Jan-Nov 2011 although this change was not statistically significant. Between Jan-Nov 2011 and Jan-Nov 2012 there was a statistically significant 14.7% increase in the mean number of consultations per HLP (see Table 14).

Table 14: Mean number of MAS consultations per HLP from January 2010 to November 2012 (values for December excluded)

MONTH	MEAN (95% CI) NUMBER OF CONSULTATIONS PER HLP			CHANGE (%)		
	Year					
	2010	2011	2012	2010-11[a]	2011-12[b]	2010-12[c]
Jan	172.6 (±77.8)	227.4 (±97.8)	217.4 (±98.4)	31.7	-4.4	26.0
Feb	165.7 (±77.5)	163.6 (±70.4)	237.3 (±96.5)	-1.3	45.0	43.2
Mar	164.1 (±57.2)	197.3 (±86.2)	209.3 (±95.5)	20.2	6.1	27.5
Apr	162.3 (±110.9)	156.7 (±72.7)	185.2 (±83.1)	-3.5	18.2	14.1
May	176.1 (±74.7)	173.5 (±72.0)	213.0 (±84.7)	-1.5	22.8	21.0
Jun	187.0 (±91.5)	164.9 (±84.8)	215.8 (±98.7)	-11.8	30.9	15.4
Jul	155.2 (±67.7)	175.6 (±82.0)	211.9 (±94.7)	13.1	20.7	36.5
Aug	128.6 (±56.8)	128.6 (±60.0)	145.4 (±79.1)	0.0	13.1	13.1
Sep	205.8 (±97.6)	187.0 (±84.2)	215.9 (±103.5)	-9.1	15.5	4.9
Oct	199.7 (±85.2)	229.6 (±98.9)	230.8 (±108.9)	15.0	0.5	15.6
Nov	217.4 (±100.5)	251.3 (±117.3)	275.9 (±114.1)	15.6	9.8	26.9
Jan-Nov	175.9 (±79.2)	186.9 (±80.8)	214.4 (±93.0)	6.3	14.7	21.9
[a]Change not statistically significant (paired-t-test, p=0.171)						
[b]Change statistically significant (paired-t-test, p=0.003)						
[c]Change statistically significant (paired-t-test, p<0.001)						

The numbers of consultations before and after accreditation as an HLP were compared for all ten individual HLPs. The time period for data analysis varied from HLP to HLP depending on the month in 2012 in which the HLP was accredited so as to minimise the impact of seasonal variations in potentially confounding the observations. An increase in the mean number of consultations per month was observed in the post-accreditation period in 8 of the 10 HLPs. However, this increase was only statistically significant in three pharmacies and activity decreased in two HLPs in the post-accreditation period. When aggregating the data for all HLPs and comparing provision in the period August-November 2011 with August-November 2012, there was a slight increase in activity but this increase was not statistically significant (see Table 15).

Table 15: Mean number of consultations per pharmacy pre- and post-accreditation as an HLP

PHARMACY NUMBER[a]	ACCREDITATION DATE	TIME PERIODS ANALYSED		MEAN (95% CI) NUMBER OF CONSULTATIONS PER MONTH		P-value[b]
		Pre-accreditation	Post-accreditation	Pre-accreditation	Post-accreditation	
1	Jan 2012	Feb-Nov 2011	Feb-Nov 2012	167.9 (±12.7)	218.2 (±18.9)	<0.001
2	Feb 2012	Mar-Nov 2011	Mar-Nov 2012	472.7 (±65.7)	540.0 (±42.5)	0.003
3	Apr 2012	May-Nov 2011	May-Nov 2012	170.7 (±37.5)	179.4 (±31.4)	0.585
4	Apr 2012	May-Nov 2011	May-Nov 2012	209.1 (±42.9)	326.4 (±65.3)	0.002
5	Apr 2012	May-Nov 2011	May-Nov 2012	194.0 (±67.4)	281.0 (±56.2)	0.155
6	Apr 2012	May-Nov 2011	May-Nov 2012	298.1 (±54.3)	223.7 (±71.0)	0.059
7	Jun 2012	Jul-Nov 2011	Jul-Nov 2012	128.4 (±32.4)	143.8 (±37.1)	0.176
8	Jul 2012	Aug-Nov 2011	Aug-Nov 2012	5 (±5.7)	6.5 (±11.5)	0.764
9	Jul 2012	Aug-Nov 2011	Aug-Nov 2012	196.5 (±73.7)	199.3 (±64.3)	0.909
10	Jul 2012	Aug-Nov 2011	Aug-Nov 2012	34.3 (±17.3)	31.0 (±6.8)	0.633
All	Jan-Jul 2012	Aug-Nov 2011	Aug-Nov 2012	199 (±89.3)	217 (±98.4)	0.391
[a]Pharmacies numbered in the order in which they were accredited (earliest =1)						
[b]paired-t-test						

As all 10 HLPs had been accredited by July 2012, data from August-November 2012 were used as the post-accreditation data and data from August-November 2011 were used as the pre-accreditation data to conduct further analyses of the impact of HLP accreditation on service delivery. The proportion of patients reporting that they had heard about the existence of the MAS through promotional materials (posters and leaflets) was higher in the post-accreditation period than in the pre-accreditation period with a commensurate decrease in the proportion of patients reporting that they had heard about the service via their GP surgery in the post-accreditation period (see Table 16).

Table 16: How patients who had a MAS consultation at an HLP heard about the existence of the MAS in a period prior to accreditation and a period post-accreditation as an HLP

HOW PATIENT HEARD ABOUT THE MAS	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	Pre-accreditation (Aug-Nov 2011)	Post accreditation (Aug-Nov 2012)	Total	
Posters/leaflets	2486 (31.2)	3233 (37.2)	5719 (34.4)	<0.001
Surgery/receptionist	5473 (68.7)	5433 (62.6)	10906 (65.5)	
Other	5 (0.1)	14 (0.2)	19 (0.1)	
Total	7964 (100.0)	8680 (100.0)	16644 (100.0)	
[a]Excludes missing values				

Utilising the same pre- and post-accreditation timeframes, an association was observed (p=0.005, continuity correction applied) between patients' reports of whether they would have consulted their GP in the absence of the MAS and date with patients in the post-accreditation period being slightly less likely (99.9%; n=8,667/8,680) to report that they would have consulted their GP than patients during the pre-accreditation period (100.0%; n=7,963/7,964). However, as per previous analyses in this section, the statistical significance observed here is unlikely to be in any way meaningful when the absolute difference between the two groups was so small.

2.2.3 EMERGENCY HORMONAL CONTRACEPTION ANALYSIS/RESULTS

Data extraction yielded a total of 79 consultations, 61 in HLPs and 18 in non-HLPs. A total of 37 of these consultations took place in the periods prior to accreditation of the HLPs and 42 after accreditation. In addition to comparisons of demographic data collected during consultations between HLPs and comparator non-HLPs, the number of consultations before and after accreditation as an HLP was compared for all ten individual HLPs. The time period for data analysis varied from HLP to HLP depending on the month in 2012 in which the HLP was accredited (see Table 17).

Table 17: Accreditation dates and pre- and post-accreditation time periods analysed for EHC data

PHARMACY NUMBER[a]	ACCREDITATION DATE	TIME PERIODS ANALYSED	
		Pre-accreditation	Post-accreditation
1	Jan 2012	Oct-Dec 2011	Feb-Apr 2012
2	Feb 2012	Nov 2011 - Jan 2012	Mar-May 2012
3	April 2012	Jan-Mar 2012	May-Jul 2012
4	April 2012	Jan-Mar 2012	May-Jul 2012
5	April 2012	Jan-Mar 2012	May-Jul 2012
6	April 2012	Jan-Mar 2012	May-Jul 2012
7	June 2012	Mar-May 2012	Jul-Sep 2012
8	July 2012	Apr-Jun 2012	Aug-Oct 2012
9	July 2012	Apr-Jun 2012	Aug-Oct 2012
10	July 2012	Apr-Jun 2012	Aug-Oct 2012
[a]Pharmacies numbered in the order in which they were accredited (earliest =1)			

Where the IMD 2010 score corresponding to the home address of participants was known, all participants were from the two most deprived quintiles of LSOAs in England (quintile 1 (most deprived) 76.9%; n=60/78, quintile 2 23.1%; n=18/78). Table 18 shows the demographic characteristics of people accessing EHC via PGD at HLPs and at the comparator non-HLPs. While there did not appear to be any association between age and HLP status, over half (55.6%; n=10/18) of individuals accessing the service at non-HLPs were from the most deprived quintile within the cohort compared to only one-in-ten (10%; n=6/60) individuals accessing the service via HLPs. However, owing to the small number of consultations examined, the conditions of the test statistic were not met for either comparison as greater than 20% of expected values were less than 5.

Table 18: Demographic characteristics of people accessing EHC via PGD at HLPs and at comparator non-HLPs

CHARACTERISTIC	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	Non-HLP	Total	
Age				
≤18	17 (27.9)	1 (5.6)	18 (22.8)	0.203[b]
19	20 (32.8)	6 (33.3)	26 (32.9)	
20	12 (19.7)	6 (33.3)	18 (22.8)	
21	12 (19.7)	5 (27.8)	17 (21.5)	
All	61 (100.0)	18 (100.0)	79 (100.0)	
IMD quintile				
1 (least deprived)	12 (20.0)	4 (22.2)	16 (20.5)	<0.001[b]
2	13 (21.7)	2 (11.1)	15 (19.2)	
3	16 (26.7)	0 (0.0)	16 (20.5)	
4	13 (21.7)	2 (11.1)	15 (19.2)	
5 (most deprived)	6 (10.0)	10 (55.6)	16 (20.5)	
All	60 (100.0)	18 (100.0)	78 (100.0)	
[a]Excludes missing values				
[b]Greater than 20% of expected values less than 5				

Unprotected penetrative sexual intercourse was the reason given for the service user accessing EHC in 50 of the 79 consultations (63.3%). A burst condom was provided as the reason for the consultation in 14 of the 79 (17.7%) consultations with an 'other' reason being provided on 5 occasions (6.3%). There were 10 (12.7%) 'missing' reasons.

The majority (53.2%; n=42/79) of consultations examined were conducted in the post-accreditation periods. Accreditation as an HLP did not appear to have any significant effect on activity with only one additional consultation taking place in the post-accreditation periods compared to the periods prior to accreditation (see Table 19).

Table 19: The number of EHC consultations conducted in HLPs and comparator non-HLPs in the periods before and after accreditation as an HLP

PRE/POST-ACCREDITATION	NUMBER (COLUMN %) OF CONSULTATIONS			P-value
	HLP	**Non-HLP**	**Total**	
Pre-accreditation	30 (49.2)	7 (38.9)	37 (46.8)	0.617[a]
Post-accreditation	31 (50.8)	11 (61.1)	42 (53.2)	
All	61 (100.0)	18 (100.0)	79 (100.0)	
[a]Continuity correction applied				

2.2.4 EARLY PREGNANCY TESTING ANALYSIS/RESULTS

Data were collected for a total of 505 consultations. A total of 220 (43.6%) of these took place in HLPs and 285 (56.4%) in comparator non-HLPs. In the pre-accreditation period, there were 262 (51.8%) consultations and in the post-accreditation period, there were 242 (47.9%) consultations (there was one 'missing' value). In addition to comparisons of demographic data collected during consultations between HLPs and comparator non-HLPs, the numbers of consultations before and after accreditation as an HLP were compared for all ten individual HLPs. The time period for data analysis varied from HLP to HLP depending on the month in 2012 in which the HLP was accredited (see Table 20).

Table 20: Accreditation dates and pre- and post-accreditation time periods analysed for EPT data

PHARMACY NUMBER[a]	ACCREDITATION DATE	TIME PERIODS ANALYSED	
		Pre-accreditation	**Post-accreditation**
1	Jan 2012	Dec 2011	Feb 2012
2	Feb 2012	Jan 2012	Mar 2012
3	April 2012	Mar 2012	May 2012
4	April 2012	Mar 2012	May 2012
5	April 2012	Mar 2012	May 2012
6	April 2012	Mar 2012	May 2012
7	June 2012	Mar 2012	Jul 2012
8	July 2012	Jun 2012	Aug 2012
9	July 2012	Jun 2012	Aug 2012
10	July 2012	Jun 2012	Aug 2012
[a]Pharmacies numbered in the order in which they were accredited (earliest =1)			

Over 9-in-10 (91.3%; n=438/480) EPT consultations were with women from the most deprived quintile of LSOAs in England (where IMD 2010 score was known). There was an association between IMD quintile and HLP status with almost half (47.7%; n=128/270) of individuals accessing the service at non-HLPs coming from the two most deprived quintiles within the cohort compared to 30.4% (n=64/210) at HLPs (see Table 21). There was no association between the age of service users and HLP status.

Table 21: Demographic characteristics of people accessing the EPT service at HLPs and at comparator non-HLPs

CHARACTERISTIC	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	**Non-HLP**	**Total**	
Age				
Under 25	49 (22.3)	60 (21.6)	109 (21.9)	0.764
25-27	41 (18.6)	58 (20.9)	99 (19.9)	
28-30	42 (19.1)	57 (20.5)	99 (19.9)	
31-35	46 (20.9)	46 (16.5)	92 (18.5)	
36 and over	42 (19.1)	57 (20.5)	99 (19.9)	
All	220 (100.0)	278 (100.0)	498 (100.0)	
IMD quintile				
1 (least deprived)	50 (23.8)	46 (17.0)	96 (20.0)	<0.001
2	53 (25.2)	43 (15.9)	96 (20.0)	
3	43 (20.5)	53 (19.6)	96 (20.0)	
4	40 (19.0)	56 (20.7)	96 (20.0)	
5 (most deprived)	24 (11.4)	72 (26.7)	96 (20.0)	
All	210 (100.0)	270 (100.0)	480 (100.0)	
[a]Excludes missing values				

Sixty per cent (n=303/505) of consultations resulted in a 'negative' test result (i.e. the participant was not pregnant). The remaining tests (39.8%; n=201/505) provided a 'positive' result (there was one 'missing' value).

There was an overall trend of fewer consultations taking place in the post-accreditation periods than in the pre-accreditation periods. This trend was most pronounced in HLPs where 42.3% (n=93/220) of consultations took place post-accreditation, in marked contrast to non-HLPs where provision increased in the post-accreditation periods (52.5% (n=149/284); see Table 22).

Table 22: The number of EPT consultations conducted in HLPs and comparator non-HLPs in the periods before and after accreditation as an HLP

PRE/POST-ACCREDITATION	NUMBER (COLUMN %) OF CONSULTATIONS[a]			P-value
	HLP	**Non-HLP**	**Total**	
Pre-accreditation	127 (57.7)	135 (47.5)	262 (52.0)	0.029[b]
Post-accreditation	93 (42.3)	149 (52.5)	242 (48.0)	
All	220 (100.0)	284 (100.0)	504 (100.0)	
[a]Excludes missing values				
[b]Continuity correction applied				

Chapter 3 STAGE B – INTERVIEWS WITH SERVICE DELIVERERS

3.1 METHODOLOGY

3.1.1 HLP PHARMACIST AND STAFF INTERVIEWS METHODOLOGY

The following section describes the processes related to the:

- interview process i.e. development of the 'Pharmacist' and 'HT/HTC' interview guides, participant recruitment and sample, and,
- limitations of the chosen methodology.

3.1.1.1 Development of two interview guides

Two semi-structured interview guides ('Pharmacist' and 'HT/HTC') were developed by members of the Aston team based on three broad themes, to gain an understanding of participants':

- Motivation to engage in the HLP programme (from the pharmacists' perspective)
- Experience of the HLP accreditation process
- Barriers and facilitators to service delivery and service uptake

Both guides were refined internally through an iterative process prior to submission to the Steering Group for comment and review. Both interview guides were finalised thereafter. However, further adjustments were made to the Pharmacist guide, following completion of the first few interviews with HLP pharmacists (see Appendix 1 and Appendix 2).

The table below provides top-level outlines of the topics covered in both interview guides (see Table 23)

Table 23: Outline of topics covered in the 'Pharmacist' and 'HT/HTC' interview guide

'PHARMACIST' INTERVIEW GUIDE	'HT/HTC' INTERVIEW GUIDE
- HLP concept and objectives. - Demographic profile of local communities and prevalent conditions. - HLP accreditation process/criteria and motivation to participate in the HLP programme and benefits noticed. - HT/HTC recruitment and training. - Resources provided by the PCT. - Health services provided and advice process. - Reasons why members of the public access services via pharmacies. - Public awareness of HLPs and services offered by HLPs. - Recommendations for the future.	- Demographic profile of local communities and prevalent conditions. - HT/HTC motivation to undertake the HT/HTC role. - HT/HTC roles and responsibilities and - Health services provided and advice process. - Reasons why members of the public access services via pharmacies. - Public awareness of HLPs and services offered by HLPs. - Training undertaken to date. - Internal and external support mechanisms. - Public awareness of HLPs, HTs/HTCs and the reasons why members of the public access services via pharmacies. - Recommendations for the future.

3.1.1.2 Recruitment process

In mid-July 2012, all pharmacists (and their staff) who had accomplished HLP Level 1 accreditation were invited to attend an 'HLP Evaluation' event organised by the PCT. This event provided an opportunity for two members of the Aston team to disseminate information on the Aston HLP study and explain the interview process. All HLP pharmacists were also contacted by telephone/email to personally inform them about the study.

3.1.1.3 Recruitment sample

The interview sample included the lead pharmacist (involved in the accreditation process) and one HT/HTC, from each of the ten pharmacies awarded HLP Level 1 status by end July 2012.

Table 24 below shows the total number of pharmacies awarded HLP Level 1 status at various intervals from January to end July 2012.

Table 24: Timeline of HLP awards

MONTH (IN 2012) HLP LEVEL 1 STATUS WAS AWARDED	TOTAL NUMBER OF PHARMACIES AWARDED HLP LEVEL 1 STATUS
January	1
February	1
April	4
June	1
July	3

3.1.1.4 Interview process

Interviewees were initially provided with the following set of documents:

- An '**Invitation to Participate' letter** which provided a brief overview of the study's aim and objectives as well as informing participants that the interview would focus on four of the five mandatory services commissioned by the PCT i.e. MAS, SC, EPT and EHC (see Appendix 3).
- A '**Participant Information' sheet**, which detailed information about the study and the interview process - in a 'Frequently Asked Questions' format (see Appendix 4).
- A '**Consent' form**, which enabled the participant to indicate a date/time/location of the interview and mode of interview i.e. telephone or face to face at the pharmacy (see Appendix 4).

Following receipt of a signed 'Consent' form (by a member of the Aston team), interviews were scheduled with individual participants at a time/day, location and mode as indicated on the 'Consent' form.

All interviews ('pharmacist' and 'HT/HTC') were conducted between August 2012 and September 2012, by a member of the research team (JH) who, on occasion, was accompanied by the Research Projects Coordinator (AP).

The majority of interviews were conducted face-to-face (onsite – pharmacy location) with a small number conducted by telephone.

Prior to commencing interviews:

- Permission to audio record interviews was obtained from interviewees.
- Participants were assured that their views and opinions would remain confidential and any comments later referred to in the report would be anonymised.

In total, twenty interviews were conducted; two interviews per HLP (n=10):

- one interview with the lead pharmacist,
- one interview with an HT or HTC.

3.1.1.5 Limitations

At the time of the interviews, given the stepwise nature of the accreditation process employed by HoBtPCT, a small number of HLPs had only recently been accredited. Therefore, whilst the majority of pharmacists were able to describe their recent experiences of the HLP accreditation process with relative ease, insufficient time had elapsed to enable some interviewees to base their responses to questions concerning the benefits of acquiring HLP status, on actual experience.

The duration of the interviews ranged from half an hour to over an hour. In a small number of interviews, the quality of both the 'Pharmacist' and 'HT/HTC' interviews may have been compromised by a combination of factors:

- Despite all interviews being scheduled at a time and date specified by the interviewee, pharmacy workload may have resulted in some interviewees being unable to provide comprehensive answers. Additionally, the interviewer's awareness of interviewees' time constraints may have precluded probing for deeper understanding.
- Interviews held within a pharmacy setting predominantly took place in a room that was in close proximity to the dispensing area. Consequently, in some cases interviews were interrupted (by pharmacy staff needing to speak with the pharmacist on dispensing matters), which may have disrupted the flow of the interview.

3.1.2 QUALITATIVE DATA ANALYSIS METHODOLOGY

The 'Pharmacist' and 'HT/HTC' datasets were analysed separately because although both interview schedules were very similar, pharmacists provided responses that encompassed all aspects associated with the HLP experience, whereas HTCs and HTs provided candid views based on their job role and interactions with clientele.

The purpose of this stage of the study was to gain an understanding of each individual's perception, views, opinions, etc. and to discover commonalities between the interviewee data sets with a view to explaining the phenomena within the data sets. Data were analysed for emerging themes via constant comparison. Therefore, analysis of the qualitative data:

- First began during the data collection process from field notes taken at interviews, which prompted a series of further questions and aided the initial identification of potential themes.
- Included:
  - Immersion in the data and constant comparison of data through iterative examination of the datasets to enable development of a data coding structure as patterns emerged.
  - Categorisation of data (as relationships emerged between codes) to draw-out emergent themes.
- Was not entirely pre-determined by the format of the semi-structured guide or the existing literature.

3.1.2.1 Data analysis process

All interviews were transcribed verbatim. The initial read through (whilst listening to the recording of the relevant interview at the same time), enabled familiarisation with the data, and facilitated a general awareness of interviewees' experiences and opinions. This aided development of a broad list of primary codes i.e. all points of interest arising from the transcripts.

Nvivo9[f] (a qualitative software tool) was used to assign text to the relevant primary codes. The texts contained within each primary code were re-read, to explore the data for recurring patterns i.e. commonalities or differences in opinions/experiences/issues. This iterative process led to the progressive understanding of the significance of emerging themes, whether recurring or deviant, and aided understanding of the relationships between themes.

The emergence of themes and awareness of the relationships between themes enabled the texts within the primary codes to be broken down according to categories (themes). A hierarchical coding structure comprising of discriminate codes (themes) and sub-codes to which texts were assigned

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[f] NVivo qualitative data analysis software, QSR International Pty Ltd. Version 10, 2012

was developed. The emerging themes were summarised into a coding framework and presented to all other members of the Aston research team for review and discussion.

Texts within each code were then fully analysed further to gain a deeper understanding of the meanings contained within each code and sub-code.

3.1.3 REPORTING STRUCTURE

The findings from both the 'Pharmacist' and 'HT/HTC' datasets have been reported and summarised under two main sections entitled:

- Findings from 'pharmacist' interviews

- Findings from 'HT/HTC' interviews

3.1.3.1 Interviewee transcript referencing structure

All direct quotations within this report have been italicised and affixed with the interviewee reference identification number. The referencing structure is as follows:

- **'Pharmacist' interviews**

   Due to the small sample size, the referencing structure excludes identifiable elements such as gender, location, ownership status, etc., since assigning these characteristics to the coding structure may have compromised anonymity. Therefore, all comments made by pharmacists have been coded with a 'PH' and a numeric participant identifier (ranging from 1 to 10), based on the order in which the interviews were conducted.

- **'HT/HTC interviews**

   Every effort has been made to ensure interviewee anonymity. All comments referred to in this report have been coded with an 'HT' or 'HTC', followed by a numeric identifier (ranging from 1 to 10) which has been assigned on a random basis. The numeric identifiers do not correspond to the reference numbers allocated to comments made by pharmacist interviewees. The reason for using two distinct referencing sequences for both sets of interviewees (the HTCs/HTs and pharmacists) is to enable disassociation of the links between comments made by both sets, in order to prevent linking of HT/HTC comments to their respective employers and vice versa

3.1.4 BACKGROUND INFORMATION ON HLPs

3.1.4.1 Ownership status

The study sample of ten HLPs comprised of nine independent pharmacist-owned pharmacies and one pharmacy, which was part of a multiple-outlet pharmacy company.

3.1.4.2 Location of HLPs

The majority of HLPs were located on busy roads or high streets in central Birmingham; three of which were located on the same road whilst another two were located on the same high street within close proximity of one another. One pharmacy was situated in a quiet shopping precinct.

One HLP located close to the centre of Birmingham, benefited from both regular customers, as well as passing trade.

3.2 RESULTS FROM THE PHARMACIST INTERVIEWS

3.2.1 AWARENESS OF THE DEMOGRAPHIC PROFILE OF LOCAL COMMUNITIES SERVED BY HLPs

All interviews commenced with preliminary questions to ease interviewees into the interview process and to gain an understanding of their awareness of the health needs of the local community

they served. This section therefore details interviewees' perspectives on the demographic profile of the local population, the level of deprivation locally and the disease burden of the local population.

3.2.1.1 Ethnicity

All pharmacists mentioned having a highly ethnically diverse clientele base, with the majority of their patients being drawn from black and minority ethnic groups. A number of longer serving pharmacists stated having observed a change in the ethnic composition of the local populations from being predominantly White (English/Irish) to being predominantly Asian/Afro-Caribbean, with comparatively recent increases in people from Eastern European and Somalia.

> "Before it used to be a majority, English, Irish but now it is mainly Pakistani, Somalis, and Arabs but there is still white Irish, English, West Indians." **PH4**

> " [the community] ... is made up of mainly ethnic minorities, quite a high percentage of Asian, Afro Caribbean, also, in the last ten years, quite a few of the East Europeans have moved in as well, so quite a diverse culture." **PH6**

> " ... the community we serve is almost exclusively ethnic minority. Minority is the wrong word here because there is a majority here. It's a very diverse ethnic mix, we've got quite a lot of the Somali community here, Pakistani, Indians, the remnants of the West Indians, and Irish so that's the make-up of it. There's a fair amount of Arab and Yemeni decent people. It's a real mixture, it's difficult to distinguish between some of the Iraqis and Kurdish people." **PH1**

One pharmacist reported to having maintained the custom of patients '*from English backgrounds*' who although having moved out of the area had chosen to retain their General Practitioner (GP) – whose practice was in close proximity this HLP.

> "It is a predominantly Asian area but historically we have patients from English backgrounds as well who still come to the local doctor's surgery because they used to live here but it's a mix, we have some people from white backgrounds but mainly Asian which is mainly Pakistani and Bangladeshi and South Indian. We have a small amount of Polish community and a small amount from African, Somali community." **PH3**

3.2.1.2 Languages spoken

Interviewees reported that a large number of languages were spoken in the local area. This, combined with low levels of literacy and poor fluency in English, resulted in some pharmacists employing staff members who were conversant in the dominant languages spoken in the HoB to overcome barriers to communication.

> " ... there can be quite a few language problems because you're dealing with people from so many backgrounds but we tried to capitalise on that, making sure that the staff we have can speak the languages of those people. We do have difficulties with the East Europeans because we don't have staff from those countries." **PH6**

> " ... a large proportion of them [members of the community] are unable to read and write and come from a background where you know health has never been given priority ... " **PH5**

Note: Barriers to communication are explored further in this report.

3.2.1.3 Deprivation

There was a consensus of opinion that local communities experienced high levels of deprivation and high rates of unemployment.

> "It's quite a deprived area ... " **PH7**

> *"Mostly unemployed or long term unemployed in this area, most of our prescriptions - 97% of them would be unpaid certainly lower than the national average which gives you an indication of the deprivation in the area."* **PH1**

3.2.1.4   Prevalent health conditions

Pharmacists identified a range of prevalent conditions within the communities they served. The following diseases/health issues were reported by:

- Alcohol addiction
- Asthma, chronic obstructive airways disease
- Cardiovascular/Coronary heart disease
- Diabetes
- Drug addiction
- Eczema
- Obesity (including childhood obesity)
- Vitamin D deficiency

3.2.2   PERCEPTIONS OF THE MAIN OBJECTIVES AN HLP

When asked to consider the main objectives of an HLP, the responses were focussed on the role of HLPs in improving the health outcomes of the communities local to the pharmacy and the proactive supply of readily accessible health services and information.

> *"To promote health awareness to the local community, the services that are available for them to use, the advice on medical health issues and generally this makes my staff more proactive in giving information of the services and the health issues, and obviously the Health Exchange monitors* [the touch-screen kiosks] *are excellent."* **PH2**

> *"Again it's just looking at health needs of a local population and making sure we can improve their physical, mental, and even social health, bring down mortalities, hospital admissions."* **PH7**

> *"I think the main objective is to improve health of the community and accessibility and information ... "* **PH9**

3.2.3   METHODS IMPLEMENTED BY THE PCT TO DISSEMINATE INFORMATION ON THE HLP PROGRAMME

In March 2011, (prior to becoming part of the Birmingham and Solihull NHS Cluster), the PCT distributed the 'Healthy Living Pharmacy Prospectus' to pharmacies located within the geographical area covered by HoBtPCT.

However, the two main forms of information dissemination recalled by pharmacists included; Protected Learning Time (PLT) meetings at which the HLP concept was gradually introduced over a period of time and an HLP programme launch event.

3.2.3.1   PLT meetings

The monthly PLT meetings (organised by the PCT) appeared to be the primary mode for knowledge transfer and information dissemination on new developments within community pharmacy locally. These meetings also provided pharmacists with learning opportunities and an opportunity to network with their professional colleagues.

It was at the PLT meetings that the majority of pharmacists initially became aware of the HLP concept and the programme itself. A few pharmacists also mentioned acquiring knowledge of the HLP concept via PLT Newsletters, journals, literature on the Portsmouth HLP pilot and via the Local Pharmacy Committee (LPC).

"We have a very close relationship with the PCT, in particular the Medicines Management group. They are very supportive of pharmacists and through them we had monthly meetings which we've had for many years, again just looking at specific issues, whether it was developing services, negotiating new services and planning services in and it was out of that that this [the HLP concept] *arrived. Initially it was muted there were national programmes and national talk about that* [the HLP concept] *but it was taken on by one of the champions- I think John Morrison at the PCT - and so it was presented at the PLT to all Heart of Birmingham pharmacists. It was also presented at the Local Pharmacy Committee to give a vision ... "* **PH1**

"We go to all the PLT [meetings] *and they've been talking about it* [the HLP concept] *for a while and it's been in the journal* [Pharmaceutical Journal (PJ)] *so I've known about it for a long time."* **PH3**

"Well I've been reading all about it [the HLP programme]*, how good it's been in Portsmouth and then they started here ... Yes PLT meetings and a newsletter and also when you talk to your colleagues you hear things what's happening but the PLT meetings yes."* **PH4**

3.2.3.2   HLP programme launch event

Following the distribution of the HLP prospectus in March 2011, the PCT launched the HLP programme at a PLT event. All those interested in submitting an 'Expression of Interest' with regards to participation in the HLP programme, were required to attend the HLP launch event.

"Well we had to go to a meeting first which went through all the criteria and what you would have to do to be accredited so that was quite simple enough." **PH7**

3.2.4   VIEWS ON THE MODE AND CONTENT OF THE INFORMATION DISSEMINATED ON THE HLP PROGRAMME

One pharmacist reflected that there was a lack of firm affirmation, from the PCT, regarding the benefits (of undertaking HLP accreditation) to the pharmacist, which was attributed to the embryonic state of the HLP programme.

" ... Because it [the HLP concept] *is a new area it is very difficult to be specific about it so yes there was very good communication in terms of 'this is what we would like to do', 'this is what the plan is' but it was still very amorphous in that to get the exact tangible benefits was difficult. In many respects, it was good that there was a lot of engagement, a lot of communication ... it was still very amorphous in that to get the exact tangible benefits was difficult."* **PH1**

The view stated above was shared by another pharmacist, who also questioned the effectiveness of the mode of information dissemination, which was likened to a 'lecture', and considered to impede full discussion.

"I think the information given was a little bit, not very clear ... they [the PCT] *need more experience and in the meetings they need to give the forms and say 'if you have any questions to come back to us'. I suppose it is similar to lectures, you give a lecture, you have a workshop ... the workshop is where we sit down and digest what went on in the lecture. With the PCT, they give a lecture, you walk away, half of them* [attendees] *still didn't understand what is going on here. I explained some of the points, so it wasn't explained for people to understand, the pharmacists need more help in their understanding."* **PH9**

3.2.5 MOTIVATION TO PARTICIPATE IN THE HLP PROGRAMME

Pharmacists' motivations to participate in the HLP programme were based on a combination of factors; logical progression to enable development of a competitive advantage through differentiation from other pharmacies in the locality, and a genuine desire to improve health outcomes of the communities they served.

3.2.5.1 Extrinsic motivation: natural progression

As mentioned above, prior to engagement in the HLP programme, all pharmacies were already fulfilling a number of the HLP accreditation criteria e.g. most had a consultation room with IT facilities and provided some of the health services required for Level 1 accreditation. Therefore, engagement with the HLP programme was partially seen as a 'natural progression'.

> *"For us we were doing a lot of these things ... there was a list of criteria and we matched most of them and there was only a small amount of things to meet the criteria."* **PH8**

> *"I found that we'd done everything required for qualification so I thought 'Why should I not register myself for the programme?"* **PH10**

> *"It was natural, we've always participated in the sorts of activities that you need to be doing to be accredited to be an HLP. So it was a natural progression, we've been offering stop smoking for twelve years or more, we applied to take part in the weight management programme, the needle exchange, we've been doing those things anyway for many years, whenever they've come up ... "* **PH3**

3.2.5.2 Extrinsic motivation: the desire to gain a competitive advantage

Participating pharmacists also expressed strong levels of extrinsic motivation to secure long-term financial sustainability of their pharmacies in view of external factors that were cause for concern and potentially threatened the future viability of their pharmacies i.e.:

- Instability within the NHS caused by the NHS reforms; pharmacists reported to being bewildered about how services would be commissioned following the introduction of the Health and Social Care Act 2012.
- An anticipated tightening of healthcare budgets, which was expected to have a substantial impact on future revenues from dispensing.
- Operating within a hypercompetitive environment; many HLPs were located in high street locations within walking distance from other pharmacies.
- Demanding consumers, with high expectations for good standards of service and convenience.

In view of these external threats, pharmacists were cognisant of the need to develop a competitive advantage to enable differentiation from non-HLPs. Therefore, the HLP programme provided pharmacists with an opportunity to enhance the skill sets of their pharmacy team and drive a cultural shift that embraced development of a health service-orientated pharmacy model, whilst still maintaining the core pharmaceutical services.

> *"At the end of 2010 to January 2011, the White Paper had already come out and in that one there was a mention of how the community pharmacy can get involved. I got information from Portsmouth because they were the first ones and I took an interest, because there is a lot of competition in the area. I said I need to be something different from everybody else, so how can I be a different person, how can my pharmacy be different from other pharmacies and then these things came out."* **PH2**

"If some of the competition didn't provide all the services we might see some added benefit but due to competition we've got to keep our standards really high, have some differentiating aspects that discriminate us from other pharmacies ... it's only a matter of time. One of the pharmacies in the area has already obtained HLP accreditation, another one is on its way and the other two ... It's due to competition you're going to have to get accreditation achieved ... they [non-HLPs] *don't realise that the money that has been coming into pharmacy over the last few years has severely decreased and we've got to look at other revenues of other avenues of income. The way they see it is, 'I'm still getting paid each month' and they're* [non-HLPs] *not looking to the future as well, like what the government might do, the profession is heavily dependent on the NHS and that if we don't promote the profession, we don't get behind what the government want to achieve then there might not be a profession here in five to ten years."* **PH7**

"That's the good message for the public that when it's a Healthy Living Pharmacy they know that all the services are there, they don't have to go to one chemist for the prescription, they go to our chemist for minor ailments, they go to another for stop smoking (we do have stop smoking here) so it's very confusing for them. If they know there is an HLP they have a Champion who can explain to them about healthy living they, we have an information kiosk, they have all the services so they have one stop rather than three or four." **PH9**

Whilst pharmaceutical services continued to be the core activities, some pharmacists were acutely aware of the importance of 'quality' in terms of customer service, as a means of differentiation. Furthermore, since most pharmacies had an ethos of continuous development of their staff, the HLP programme served to reinforce the value of workforce development and the benefits of having qualified staff in terms of reducing the burden on the pharmacist and improving customer satisfaction.

"It was good [the training provided by the PCT] *but it's all about time, having the time to provide that level of service and that is where pharmacy now is perhaps struggling and you see other retail stores as well, when you go into M&S or Tesco's and want some help there's never really anyone there to help you, you can see it on the shop floor when you go shopping, the number of employees has decreased over the years and I think customer service is not as good as it used to be but the biggest problem I think pharmacy is facing now is not just with remuneration but if we want to provide that level of service we have to have highly trained staff ... "* **PH7**

"I have always tried to develop myself, by continuing professional development and I've always tried to do that with my staff because I think if we've got good staff and good customer service, if you've got good customer service you've got repeat business and the business will thrive. If we don't, there's no reason why someone should choose me over another pharmacy. We need to have a competitive advantage so that is the difference between us and the guy down the road ... the draw for them [customers] *is that she knows she's going to get a good level of service, it's a quality service she can rely on, the information she is given is accurate ... and even if there's situations when we can't help them we can sign post them all or offer them something constructive to take away with them so it's a good experience. The last thing someone wants to see is a sour face or chewing gum or having a chat with their friends, what you need to be is be attentive."* **PH1**

"I put one of my staff there [through the HTC training course] *because I thought it would be good because it gives you that extra prestige, if you have an HTC, you tell the customers we've got a HTC who can give good advice and they listen more."* **PH3**

Additionally, central to the goal of achieving differentiation from competitor pharmacies, was the need to build upon the trust between pharmacist and patient that had grown over a period of time (occasionally decades). By reinforcing the reputation of pharmacists and pharmacy staff as credible providers of a portfolio of health services/advice and information, it was hoped that repeat custom and customer loyalty would be generated and that this would help to secure future survival of the pharmacy as a business. Therefore, the HLP programme was a catalyst for change in that it was an impetus to maximise existing strengths to the best of their advantage.

"I suppose the main thing is that it is a chance to connect with your customers/patients and it's an opportunity to not just talk to them about their medication but also it's a lifestyle and other things that they can do to improve their health. So when you have that connection with the customers they are more loyal to you which helps the business as well, the sustainability of the pharmacy. So for two reasons, one it's a way to increase our standing in the local community, increase our profile and improve people's health for example if somebody quit smoking or somebody loses weight and then the other thing the off-shoot of that is that we would become busier and then we become more sustainable as a pharmacy." **PH3**

"Well it promotes the pharmacy brand, it promotes pharmacy as a profession ... , it does improve turnover and profitability as well ... it improves your reputation." **PH7**

However, pharmacist **PH7** highlighted the increasing pressure on pharmacists to maintain high standards with regards to pharmaceutical services, as well as health services. This combined with resource constraints (experienced by most community pharmacies) gave rise to the view that in the long-term, community pharmacists' may struggle to maintain a focus on 'quality' in terms of health services.

"We were ok because we are quite experienced in delivering services and maintaining standards but I think like a lot of pharmacies ... will struggle, trying to get their standards to what is expected by the society. A lot of pharmacists are finding it very, very difficult training staff so they can provide the professional services and the prescriptions at the same time as well ... " **PH7**

3.2.5.3   Intrinsic motivation

The high prevalence of life-threatening diseases within the local communities was of significant concern to a number of pharmacists. These pharmacists were intrinsically motivated to tackle health issues and, in the absence of NHS funding for the delivery of certain services, decided to provide non-commissioned health services, free-of-charge to patients or at a nominal charge.

"They [the PCT] *need to be a lot faster, a lot faster in responding to the problems and sorting out the problems ... also more services, like I'm asking for cardio vascular, this community really, really needs that. I am worried about the cardio vascular in this area. ... cardio vascular risk needs to be done. I asked the PCT to allow me to do this, and do blood pressure free and cholesterol - because if it is free, they will go for it. To be honest, I waited and waited to be offered the free service but I started offering the free service blood pressure and everything because I thought that they will benefit if at least I can do a cardio vascular risk assessment for them. - Oh my God it is dangerous! I can't just ignore it now ... I charge very low for diabetes because some of them are very uneducated and don't know how to use the machine so sometimes it is best for me to check it ... "* **PH9**

" ... We do free blood pressure testing, it's not an official service but we offer to measure peoples' blood pressure for free." **PH3**

*"I do blood pressure monitoring on my own but I charge two pounds for the charity box. I do it free, then anybody walks in but if I say 'give £2 put it in the box', only genuine people come for it ... I'm going to advertise as well with charges for diabetes checking and put the money into the charity box, so it is worthwhile rather than just doing it for free." **PH4***

Personal satisfaction from being able to provide a good level of customer service and a broad range of services with a genuine desire to improve health outcomes of local communities were also motivational factors for some pharmacists.

*"I just liked the idea of being an HLP ... personal satisfaction from that - you can provide more services, quite a few little things that we do." **PH5***

*" ... it gives you a personal satisfaction more than anything else. I'm always keen on advancing, giving good quality service, we tend to chase prescriptions and that's how we get remunerated and the same with services, but what I like to do is get the best out of myself and my staff for the patients that we have here ... " **PH1***

*"To improve our services ... I want to give a good service to all the customers and we want to do the best that we can, this is one of the criteria that had to be met so I was willing to do that." **PH6***

3.2.6 DEMOTIVATING FACTORS LIKELY TO IMPEDE DEVELOPMENT OF THE HLP CONCEPT

Interviewees identified three possible obstacles that may have inhibited widespread participation in the HLP programme:

- Uncertainty about the potential benefits or return on investments of acquiring HLP status.

  *"I think where people struggled to engage was that they couldn't see the immediate benefit. They thought there was a lot of lag between them and would require a lot of effort before you see any benefits." **PH1***

- The risks and potential ramifications of 'fitness to practise' proceedings was considered to have placed substantial pressure on pharmacists to focus their attention on what they considered to be their primary role i.e. the safe dispensing of prescription only medicines.

  "I think that the problems are that a lot of people are under a lot of pressure from dispensing, there's also problems like if you do make a mistake, people, particularly the Society [sic; the General Pharmaceutical Council – the statutory regulator for pharmacy]*, fitness to practise they're coming down on you, people at the end of the day, there's not much work out there and people are looking to protect their jobs and ensure that they're doing their dispensing job properly and that's why they are really reluctant to start providing services. I think like fitness to practice is one, time to provide the services, support staff, they've got to go to the accreditation meetings from the PCT and sometimes they've got to do their CPPE course from the Pharmaceutical Society and even now a lot of pharmacists are like 'well why should I do it', I'm not getting anything out of it' ... " **PH7***

- Resource constraints (i.e. small team of staff) and an increased burden of processing larger dispensing volumes were considered to be inhibitive factors likely to dissuade non-HLPs from undergoing the accreditation process.

  *"I don't know, I think most will say time, staff but the thing is if you don't educate, your staff don't do these courses you can't really give good service ... " **PH4***

3.2.7 PHARMACISTS' EXPERIENCES OF THE ACCREDITATION

3.2.7.1 Process

To gain HLP Level 1 status, pharmacists were required to complete a form and work through an accreditation framework.

The majority of pharmacists praised the PCT for their support and guidance concerning the accreditation process.

> *"Oh I think so. They* [the PCT] *were very supportive. They supported all the leadership training for ourselves which wasn't cheap. They set up meetings for us and the staff and they paid for all of those. It's just a new area and it took time to do and in fact the support is still there now and they send people round to give that support. The support has been excellent."* **PH1**

> *"I think there were one or two other things that we had to find out about that we needed a bit of help with but the PCT was more than willing to guide us through that and give us support as we needed it ... they were more than willing to help at the beginning so that wasn't a problem."* **PH3**

3.2.7.2 'Paperwork'

Some pharmacists considered the volume of paperwork, related to the accreditation process, to be daunting and the questions (asked on the form) to be repetitive and/or ambiguous.

> *"To be honest it was quite overwhelming the actual paperwork that came with it, I think if you broke it down bit by bit and just worked through ... some of the things were a bit ambiguous on the accreditation, some of the things, for me anyway, when I was reading it, seemed to be asking the same things again and again. Some of the things were a bit vague, 'Like the pharmacy team is led by an effective leader to achieve an agreed vision' that seems a bit fluffy. I suppose as pharmacists we need it to be succinct, do this, do that."* **PH3**

Additionally, a number of pharmacists reported being uncertain about where and how to access credible sources of information in order to answer questions related to the prevalence of conditions and health needs within the communities they served.

> *"Some of the questions, I think the first question was 'do you know the setup of the area, what kind of medical conditions do they have', I didn't know about it so I said "you should put down where you should look for this information" when he* [a member of the PCT Medicines Management team] *came here, he told me to look at the Birmingham Health ... but otherwise everything else was fine, there was no issues there."* **PH2**

However, all pharmacists acknowledged and commended the level of support provided by the PCT with completion of the paperwork.

> *" ... if anything, the forms were very long winded- the application forms what have you and we did get good support from the PCT in that somebody came and helped go through the form."* **PH8**

> *" ... the forms were complicated so I had to keep phoning and asking and they were very helpful."* **PH9**

3.2.7.3 Accreditation criteria

Pharmacists provided insight into their experiences of working through a number of the HLP Level 1 accreditation criteria:

- Physical environment i.e. consultation room and availability of IT facilities within the consultation room
- Leadership training to be undertaken by pharmacists.
- Recruitment and training of a HT/HTC to enhance uptake of services and/or signpost patients to relevant services available within the community.
- Building relationships with other health professionals
- Recording interventions
- Pharmacy 'mystery shopper' audit (*optional*).
- Installation of a touchscreen screen health kiosk.

Note: The mandatory health services are discussed further into the report under 'Health Services'.

Most pharmacists had to some extent, fulfilled some of the HLP Level 1 accreditation criteria prior to engagement with the HLP programme, therefore, for these pharmacists the transition from non-HLP to HLP status was seamless.

3.2.7.3.1   *Consultation room and IT facilities*

The majority of HLPs were equipped with a consultation room with IT facilities. One pharmacist however was unconvinced about the need for committing financial resources to incorporate IT facilities within the consultation room, when IT facilities already existed in close proximity to the consultation room.

> *" ... Physically the pharmacy already has a consultation room ... we did have to get IT access into the consultation room which we didn't have before ... generally the pharmacy is fairly new in that respect so we've got the consultation room, we've got the private areas, we were delivering a lot of the services, we already thought ourselves as an HLP ... "* **PH1**

3.2.7.3.2   *Leadership training*

Pharmacists were required to undertake Leadership training organised by the PCT. Most pharmacists considered the leadership training to be useful in highlighting deficiencies in their current leadership skills and providing them with a better understanding of the difference between 'management' and 'leadership'. Consequently, in some cases the Leadership training prompted pharmacists to reflect on their own style of leadership, which instigated action to redress areas of weakness.

> *"The training was very good, we had training on leadership skills, on communication skills, customer service, a lot of the training we were doing anyway."* **PH7**

> *"First of all I was invited to do the leaders course. That course really tells you that we don't know much about our management skills. It really improved us and that was one of the conditions for us to be able to do the HLP programme ... I have had leadership training already, I have been a manager in different places so I have more experience than some other pharmacists but it opened my mind on how people do and it made me understand about myself. If you understand yourself, you can correct yourself and when you are doing something you can look how the people perceive it so it is that that the leadership gave me, which I think is useful."* **PH10**

> *"It was Leadership training and giving you training on how to deal with people, how to be a leader effectively, trying to get you to find out what kind of person you are and what you have to be, to become a leader. I think it is important because when you're providing a service like this, it's not just about managing people it's about being a leader of those people. Managing is one thing and leadership is a completely different thing. It has been quite useful.*

*I do go through the modules that we were given at that time and they are quite useful. I quite enjoyed that." **PH6***

*"I thought it was excellent, it was a real eye opener for me, especially the Leadership training that we did. It was Leadership and Communication Skills - those were the two ones that we did. There was an assessment in there where you assess yourself and you reflect on what kind of leader you are and you don't have to be the pharmacist, everybody can be a leader in their own right which was another important point to understand. I put myself down as one type of leader and then there was feedback from members of staff ... and I found out that what I thought I was, was something completely different to what the staff thought I was ... sometimes you just need to sit back and say 'how can I manage this situation in a different way to get the best out of the staff that I have or myself?" **PH1***

However, one pharmacist was sceptical about the value of the Leadership training which was considered to be 'full of jargon' and abstract in nature. This pharmacist stated a preference for a course that provided tangible solutions that could be easily transferred and implemented.

*"I found the leadership course not very useful. It was full of jargon about trying to work out which colour or which type of person you were and it was all very, very intellectual. He was going on and on about this particular philosopher and about different types of leadership and you had to try and work out which one you were. I'm quite a straightforward person. I found that not useful really. The Leadership training I honestly didn't find useful." **PH3***

3.2.7.3.3 Recruitment of HTCs/HTs

Most pharmacists alluded to having a small team of staff and in all cases recruitment of HTs/HTCs was from the existing pool of staff. Selection of an individual for the role of an HT/HTC was based either on staff seniority/experience or on an assessment of an individual's ability to undertake training/willingness to progress their training to the next level. The number of staff recruited to HT/HTC level ranged from one to two.

"To be honest we didn't really [choose]*, I suppose like with most pharmacies you don't have team of staff to choose, it will only literally be one person that might be able to attend the course or might do enough hours or who have enough experience and communication skills. For us it was, we had set people who were able to attend the training and who had enough experience and the skills to go on the course." **PH3***

*"Well we have a pool of staff here, we're not a large pharmacy so we've only got two or three staff so it wasn't hard to recruit but everybody wanted to do it ... I would still like the others to continue doing it, I would like to offer it to all of them but at that time it was practicalities of releasing one person at a time – I put my most senior member of staff in for it – that I thought most capable." **PH1***

3.2.7.3.4 HTC/HT training

Confusion regarding the differences between the HT/HTC training was evident from the responses given by interviewee's to a question referring to the number of staff recruited at HT/HTC level. The responses were often vague, requiring the interviewer to enquire about the duration of the training in order to determine whether their staff had attended an HT or an HTC course (the HT course was longer in duration than the HTC course). This may be partly attributed to:

- the absence of feedback from training providers, with regards to the HT/HTC course content and the attainable skills sets, and/or

- pharmacists not having received relevant communication from the PCT to explain the differences between both the HT/HTC training courses.

> *Interviewer: "How long have the courses been that your staff have been on?* **Interviewee:** *Two days* **Interviewer:** *I think that is the HTCs, I think the longer one is HT ...* **Interviewee:** *which is the higher accreditation?* **Interviewer:** *HT* **Interviewee:** *They haven't done the higher one, I thought the HTC was higher, that makes sense.* **Interviewer:** *"Did you just get a leaflet saying do your pharmacy staff want extra training, because a lot of people didn't really know the difference between the different roles.* **Interviewee**: *I don't either, that is why I was confused so yes we normally get a flier to say there's a training course going on this date, do you wish to put forward any names and I always do that."* **PH6**

> *"I'm not sure what the course entailed, whether there was any additional work for them to do or assessments or assignments that they had to do between days. I didn't get any feedback from staff on that ... it was almost like we were releasing them, they were doing some training but there was no feedback, we weren't closing the loop unless you asked."* **PH1**

> *"I'm working on memory because it was such a long time because they went last year, August, September 2011 which is nearly a year ago, it covered communication, I don't know what else it [HTC training] covered, you will have to ask [the staff member]."* **PH6**

Staff motivation to undertake training

Staff that had been identified for the role of HT/HTC, were asked (by the pharmacist) to undertake either the HT or HTC course, which was provided by the PCT. All pharmacists stated that their staff were enthusiastic and motivated to undertake the necessary training.

> *"We sent them on courses ... they were very excited to go on the courses."* **PH5**

> *"I asked them to go to the meetings and to do the test ... they are both very enthusiastic and I'm very lucky because I've got very enthusiastic staff ... "* **PH9**

Pharmacists' views on HT/HTCs ease of undertaking training

Some pharmacists were of the opinion that their staff did not experience difficulties with attending and completing the relevant courses on a day release basis, although others considered the courses to be onerous and an unwelcome addition to the already over-stretched workload of their staff.

> *"It wasn't a problem as long as, we obviously had to provide cover, give them adequate time to absorb information and to study but there was no problem."* **PH8**

> *"Well it should have been fairly straightforward we released them for that day, we paid them for that day so there was no added burden on them ... "* **PH1**

> *"it is very difficult, they do so many things in the pharmacy and then I tell them they have to do more, more requirements, they have to do more courses because they are involved in health and then on top of that they have to do extra courses for the CPD and they have to get involved in PCT courses."* **PH9**

> *"They offered two levels of training. The first one that we did was a bit too intense, too much, 16 weeks I think and they narrowed it down later to two days. I thought the 16 weeks one was a bit too intensive and it took far too long and the member of staff who did that felt exhausted by the end of it."* **PH8**

Furthermore, one pharmacist expressed frustration with having to contend with multiple training providers, which was believed to result in:

- Confusion as to which training staff were required (by the PCT) to undertake.
- Difficulties for the PCT in maintaining records of all training undertaken by each individual.

> *"What I don't like is that each company, each programme requires something different. If there was one company and they said this is what needs to be done and the education is controlled by one company ... before it used to be only CPD for example but now we have courses here, here and here and people are asking for updates ... we don't know which one we've done ... but at the moment they* [the PCT] *don't know, they* [the PCT] *say you're not coming to the meeting ... "* **PH9**

Issues with the HT/HTC training

Whilst the HT/HTC courses were paid for by the PCT, the staff members attending the course were paid their usual wage for the day by the pharmacy contractor. In the absence of their usual complement of staff, pharmacists had to contend with an increased workload during the day(s) staff were attending training sessions.

> *"You always miss a member of staff, especially with the HT course. I think the staff member had to go every Wednesday for so many months so you know, when that person is not there in the dispensary, it is difficult and obviously they didn't charge us to send the people on the course but I had to pay them, they did not go in their own free time, so obviously there's a cost, an outlay to the pharmacy."* **PH3**

> *" ... we have to give them the time [to attend training courses] as well and that's one of the issues, is time to do all that when there's other pressing things to do."* **PH7**

> *"I think with the training I do struggle with that a little bit because, even now, sending out two girls for two days has an impact on my business because I'm lacking two staff for two days. So if there could be some provision for that or maybe on a weekend that would be more useful. It's not the finance thing, it's just that we haven't got enough man power to do the services that we want to do. So, I think if they could do that at the weekend that would be useful. I know it's probably difficult for the providers as they don't work weekends but even the pharmacists it's not always easy to get the locums on the days that the training is, again if you do it at the weekend ... "* **PH6**

HT/HTC training considered to be useful

Most pharmacists were of the view that their staff benefitted from attending the HT/HTC training course(s), which were considered useful in reinforcing knowledge acquired from on-the-job training provided by pharmacists.

> *"Obviously the courses that the PCT do like the one day courses are more useful because I am there all the time with them, like sometimes what I say doesn't click whereas an outsider saying something clicks better, it's like when you tell your kids don't do it but somebody from outside tells them it makes a lot of difference."* **PH2**

> *" ... The health champion and the health trainer* [courses]*, they were very good, the staff benefited and they learnt some new things and it confirmed that the things that we were doing were right so that was good ... "* PH3

Furthermore, the HT/HTC training (organised by the PCT) for all pharmacy staff was considered to be valuable in motivating staff to proactively promote health services and in equipping them with effective communication and customer service skills to enable them to approach customers with confidence and provide opportunistic health advice.

[the training included]; *"how to be interactive, how to talk to patients, how to listen to them and it was like what you say and what you hear can be two different things ... I always say this to my staff, 'you must listen to what the patient is saying to you, not what you think you want to hear' so things like that."* **PH4**

"They [the PCT] *provided the training for the healthcare assistants and myself for services, improving communication skills."* **PH7**

Consequently, the perceived benefits of having trained staff were considered to be:

- Greater levels of customer satisfaction as a result of having trained, confident staff, able to interact with patients in a professional manner and provide health advice/services/signposting to other services within the community. Customer satisfaction with a service encounter was considered to be of vital importance in generating positive word of mouth and in so doing facilitate development of pharmacists reputations and of their staff, as trusted and credible sources of health services/information.

- Having appropriately trained staff, which also enabled pharmacists to readily delegate tasks to staff e.g. provision of services such as weight management, which helped to relieve pharmacists' work burden.

" ... Everyone wants a return on their investment, it doesn't have to be a financial return although that always helps, it can be a reward for training staff, they feel more empowered to give advice and stuff like that ... all of my staff are training to be technicians. I encouraged them to do that because staff are front of house. If you haven't got decent staff, if they're not trained and competent in what they're doing, people will walk out not happy with the services that you give so that was the real kudos, the real driving force for me, having trained knowledgeable staff – it simplifies it for me as well because I'm not being asked every five minutes about 'oh I need something for this cough'- a lot of them they will be able to deal with it themselves because they've had the training." **PH1**

" ... if you don't educate your staff, don't do these courses, you can't really give good service, they need to go through the motions even if they learn 50%, it is going to help you, you can delegate and the workload is increasing all the time and they [staff] can do things for me rather than I do it all the time, like smoking cessation, two of my staff are smoking advisors so we take it between the three of us." **PH4**

3.2.7.3.5 *Other training undertaken by pharmacy staff*

In addition to the HT/HTC related training, pharmacists also reported having developed a culture of continuous development whereby their staff had undertaken other training in order to become accredited to provide services such as weight management and smoking cessation for example:

" ... all my staff are taken on the understanding that any course that we have to go and attend is part of their job." **PH4**

"I'm putting the girls on smoking cessation courses which is one of the criteria as well but they haven't actually done that yet." **PH6**

"Any courses that have come our way they [staff] *have tried to attend, all my staff are taken on, on the understanding that any course that we have to go and attend is part of their job."* **PH4**

" ... all of my staff are training to be technicians and I encouraged them to do." **PH1**

*" ... they [staff] have to do the Medicines Management course then, we use NPA for the courses, accreditations." **PH2***

3.2.7.3.6   Building relationships with GPs

Some pharmacists were better able to build relationships with GPs in their local area whilst others struggled to do so. Pharmacists, who had strong relationships with GPs in their local area, were explicit in describing their relationship as being supportive and trusting, benefitting from open channels of communication. These pharmacists stated having regular contact via either telephone or face-to-face meetings with GPs in their area, over a period of time. Open channels of communication between pharmacist and GP benefitted both parties; pharmacists from referral of patients for minor ailments and GPs from reduced workload and more time to allocate to patients presenting serious health problems.

*"Well, the surgery across the road, we have an open channel of communication. I go over there and have lunches with their medical students and we have an opportunity to talk about a subject. They send medical students over here for an afternoon so we will give them the information and part of their presentation is to go back and tell them ... we talk to them all the time. They're [local GP practice] very supportive and I think when you get that support with the GP it really helps, that link really helps ... " **PH3***

*"I do go and talk to them. I make an appointment with the GPs and talk to them and say look this is what we provide. Tomorrow I'm going to this surgery and I'm going to say to them 'if there are any patients who want to stop smoking, please send them to us, it's free of charge, it's not going to cost you anything ... " **PH4***

*" ... We have a close working relationship with the GPs here anyway. We give them weekly/monthly updates of what is happening in the profession so yes, the GPs are happy, especially with minor ailments and blood pressure, it's the things they don't have to do." **PH7***

However, one pharmacist described his relationship with local GPs as 'working professional', whilst some pharmacists alluded to difficulties with forming relationships, which were attributed to the impracticality of maintaining regular contact with GPs, especially those based in multi-partner practices/health centres.

*"I think, I suppose it's how you define 'good'. We have a good working professional relationship, they're quite happy on the end of a phone call, we don't sit down and have meetings together which we perhaps ought to have but it's a good working relationship. If there's ever an issue on a script or if I have an issue about a patient or a product I'm usually on the phone and they will take the call or vice versa if they've got an issue they call me." **PH1***

*" ... we haven't met face to face or haven't attempted to, I wanted to talk to them once many years back but they haven't come to me ... the manager hasn't been able to contact me, although I have done the contact so these are difficulties, I think it is human relations rather than work." **PH10***

3.2.7.3.7   Recording interventions and signposting

This accreditation criterion entailed the recording of information related to interventions and signposting activities. However, pharmacists were generally unable to fulfil this criterion i.e. recording of activities was not commonplace and this was attributed to forgetfulness, time constraints and work-pressures experienced by pharmacists and their staff, especially for those pharmacies located on busy high streets.

"We do and I'll be honest, when I remember we try and put it on the PMR and I don't remember very often- on the PMR really, so I'll just go in there and log in on there that we sign posted or offered them a service." **PH3**

"You need time and time is not there, the amount of paperwork I have to go through every day, I need another twelve hours in a day I think to be able to record those things." **PH4**

One pharmacist had implemented a 'recording' system, which was considered to be beneficial in enabling a review of intervention/signposting activities. However, difficulties were experienced with embedding a data capturing orientation within a work culture that was characteristically orientated towards the performance of practical tasks.

" ... we've devised this template for the health trainer, where she records specifically and we have a debrief every week, what kind of issues were raised this week, what was the issue, who was it from, what did we do about it, was it resolved in house, did we have to get more information, did we signpost them elsewhere so then there's a record for us and then we share the learning with the other staff. We have also asked the other staff to input onto that template ... admittedly it's been a struggle because it's been a change of work practices as well, we're very much doers rather than recorders if you know what I mean, our work is practical ... " **PH1**

3.2.7.3.8   *Mystery shopper*

For all pharmacists, maintaining good standards of service was of prime importance and the mystery shopper feedback reports were generally considered valuable in highlighting potential areas of improvement.

"The PCT one [mystery shopper audit] *was some time ago. It was good but I always think things can be better ... there are pharmacies that came 100% and there are pharmacies that came 96% and I was in that category so ... my staff and I discussed it and asked what things are we missing and we started working on it ... "* **PH4**

"Yes we did [find the mystery shopper feedback report useful]. *There were a few things that we had to change, the way we answer the phone, a few bits and pieces but overall we got a positive feedback."* **PH5**

"We had to do a shop front audit, a customer service audit. I suppose [the audit was beneficial] *because I suppose you get a bit complacent because in the past we've won awards so you become complacent but you don't realise that you're lacking on things so it was good to have somebody else look at it."* **PH3**

3.2.7.3.9   *Health kiosk*

All HLPs (and a small number of non-HLPs) were fitted with a touchscreen health kiosk to facilitate ease of access to health related information (displayed on screen or in print format). However, whilst literate patients who were not fearful of using a computer, were able to access information independently, patients who were unfamiliar with computers or those with poor literacy skills required assistance from a member of the pharmacy team.

" ... we have the kiosk which is a good source of information ... if they can read and write then it is not a problem, I take them to the kiosk and I show them ... on the kiosk, they can read more and if they have any questions they come back, or print it or email it to themselves and so I think the kiosk really helped me to cut down me explaining ... I might explain everything but I might miss an important point whereas if they read, they can come back and

they can tell me what they didn't understand rather than me explaining the whole thing. It saves time." **PH9**

" ... I think one of the problems we've had, since that kiosk has gone up, a lot of the people who walk in, they see a computer and they get scared ... they think it's part of the shop and they're not supposed to touch it. Secondly when they try to access it it's not always easy, we have a lot of ethnic minorities here and their computer skills are not good so it always needs intervention by one of the girls here." **PH6**

Additionally, two pharmacists reported that technical issues resulted in kiosk malfunction on a regular basis.

" ... we had the Health Exchange screen already, before it was not working very well because of the signal but now they have put us a router and now it works very well so if any pharmacy has got a problem with the signal because the signal in this area is not very good so hence they put a router." **PH2**

"We had many problems with that [health kiosk] *right from day one, it just wasn't working."* **PH6**

3.2.7.4   Expected benefits of undertaking accreditation

Unsurprisingly, pharmacists expected:

- That commitment to the HLP programme would secure the position of HLPs as the PCT's preferred providers of future services commissioned through pharmacy.

"What would be really useful is if there were service elements attached to the Healthy Living Pharmacy from the outset so that if you managed to get this accreditation you would be entitled to provide X, Y and Z services or you would be the first port of call for these services, which is what we have been told already but clearly what they might have done is say that if you are going to invest this time and effort in terms of yourself and your staff, what you need to do is say OK there's elements involved with that that you need to do." **PH1**

"There's trust between us and the PCT because they know that we are working very hard. They reward you for it as well because, if the PCT see you are a leading pharmacy so therefore they will allow you to do these services so it's actually a good thing ... One of the reasons [for participating in the HLP programme] *was that we can provide more services and involve the PCT more, to increase more customers and increasing business, that's one point."* **PH9**

- A financial return on their investment (associated with the cost of meeting accreditation criteria such as installing computers, paid day-release of staff (to enable them to attend training sessions etc.) in the form of realisable benefits that would ensure that their pharmacy remained financially viable going into the future.

" ... Now we've done all the exercises, we've become accredited ... you do want to see some reward for that and it has to be in terms of services or financial gain to yourself because otherwise, you can do a lot of things to the nth degree but, at the end of the day, you've still got to pay the bills and the staff and yourself." **PH1**

" ... If we spend £2,000 on a computer or a laptop for the consultation room, if I pay a builder to knock through a toilet in our consultation room is it going to be worth it or it is just spending money hoping that you have a few more customers through the door? I suppose traditionally pharmacies and pharmacists do work for free whereas doctors and dentist and other professions wouldn't. Pharmacists have done a lot of things for free in the past." **PH3**

- That HLPs would continue to be supported and promoted by the PCT to increase awareness of the HLP logo and concept within the local population, to enable differentiation between an HLP and a non-HLP, which it was hoped would drive footfall into the premises.

" ... I would expect when services are offered, whether the PCT are there anymore I don't know but when services are offered, for us obviously to be considered and perhaps involved in pilots with the PCT where they can guarantee that the HLP, can hopefully guarantee a better uptake of a service as opposed to a non HLP pharmacy so that is the support I would expect ... For us, we were doing a lot of these things already but to have that title perhaps could be beneficial for us in the future to have services offered so for that reason - Obviously whether you're called HLP or not doesn't really make any difference to the service you give because you'd expect to be doing that anyway, that's the standard that I would expect anyway, however for future funding or support from the PCT for advertising that would come from the PCT if you are an HLP so that we stand better ground as opposed to a non HLP." **PH8**

3.2.8 REALISED BENEFITS OF UNDERTAKING HLP ACCREDITATION

Some pharmacists reported a number of benefits as a consequence of the accreditation process i.e.:

- a greater awareness of prevailing health issues,
- ability to attract 'new customers' *(PH9)* stemming from the training organised by the PCT for both pharmacists and HTs/HTCs, *and*
- improved staff motivation to deliver a high quality of service.

"Yes the benefits are that I have become more aware of the health issues. I tend to read up more, I get my staff to read up more and take interest in the services." **PH2**

"The customers are the same but the quality [of health advice provided] *has improved."* **PH5**

"We had to look at our leadership skills and communication skills, the staff makeup and how, again the communication skills for staff and the training for staff, and their understanding of the health environment so it was up-skilling staff really, those are the main changes." **PH1**

Consequently, an increase in custom was reported by a few pharmacists, although this may have been attributed to the one-off promotional activity organised by the PCT to launch newly accredited pharmacies.

"The benefit we have got in terms of the prescriptions have gone up because obviously they come for advice and then they bring their prescriptions, the services that we do have increased ... We're getting a lot of different types of customers coming about their health problems. The thing in this area is that if you are a good pharmacist or your staff are good and they give good advice the word goes round, it's a lot of word of mouth in this area, they say "you know what I went there and I got really good information, a printout of my diabetes problem in a language which I could understand" so then that passes round a lot and then it is beneficial." **PH2**

"It sounds better and also when we tell people we are an HLP they get impressed and we tell them what we can do and I have seen an increase in people coming through the door ... I think more people are coming in for advice then before, I've seen an increase, I'm spending more time in here [in the consulting room]. *I used to spend time before but now I think there's an increase and people will say "can I talk to you in there" whereas before they used to have a quick chat with me."* **PH4**

"Yes definitely I think the week we had the HLP up and we got advertising, people came in and started asking questions, we had a lot of new customers which showed that they had advertised our pharmacy and that was really, really good, it really increased the attention of the community." **PH9**

There were however, some pharmacists who had not noticed any significant, sustained improvement in terms of an increased uptake of health services or an increase in footfall as a result of having acquired HLP status. This was attributed to high levels of competition and patients being oblivious of any changes between pre and post accreditation periods since:

- Patients in HoB were accustomed to accessing health services via pharmacies - prior to the rollout of the HLP programme.

- The level of health service provision remained constant between pre and post accreditation periods.

  " ... I suppose that pharmacies that haven't traditionally done these things [HLP related activities] *and have just started doing them more recently to become accredited will have a bigger improvement than pharmacies like us that have done these services for years and have always pushed them, so maybe the increase that our pharmacy shows, might not be as great as somebody who has only just started doing the services ... "* **PH3**

  "I picked up on it before - is there a difference between the before and now, what's the difference? How do you see an increase in business? Is it an increase in foot fall or the number of referrals or the interventions, not necessarily, we're recording them a bit better now so there's not going to be a magic jump in the number of stop smoking people just because we are an HLP or the number of minor ailment schemes we're seeing because these were long established disciplines, so you're not going to see the quantitative increase. If you went into an area in south Birmingham where the services aren't available and you put a healthy living pharmacy and you promoted it in the way that HoB did here I think you would see a completely different picture because people aren't used to having those services there, whether it's a minor ailment scheme or stop smoking so that would be a completely new way of looking in those sorts of areas – you would see a big difference in those sort of areas ... but hopefully it's going to be a changing culture of people and customers will find that this is the first point of call for their health needs." **PH1**

  "As for the benefits I haven't really seen the benefits and to be quite honest I don't think we're going to see a massive increase in business because of the competition in the area but it's only because we've got standards and because we offer all the services we've been able to survive as a business because over the last three years we've seen like four new contracts, there's a lot of GP direction that goes on here and there's a lot of 100 hour contracts, HOB PCT have had the second highest number of 100 hour contracts in the whole of the country, second behind Westminster PCT so it's just about survival really." **PH7**

3.2.9 PERCEIVED DIFFERENCES BETWEEN HLPS AND NON-HLPS

Interviewees were asked what they perceived to be the differences between an HLP and a non-HLP to be. Some of these beliefs are highlighted below:

"The pharmacies that are HLP become more active and more conscientious of the health problems, health issues for the community because, initially, before we became an HLP, I had to do some research, strategic joint health problems in the area so from the survey of 2010 I

*got information and this year there was a high prevalence of certain kind of medical conditions in comparison to Birmingham City." **PH2***

*"I suppose the main thing would be the enthusiasm for promoting public health that would be a main difference. Maybe a pharmacy that is not an HLP will still offer some of the services but I think the HLP pharmacies have to demonstrate and have to provide those services more enthusiastically. I think that is the difference." **PH3***

*"It's basically health promotion, prevention is better than cure, providing services, trying to tailor individual health needs to each patient and being their local health authority." **PH7***

*"I think the staff are more highly trained, they can provide more advice better advice." **PH5***

*" ... We would be a base for people to be signposted to as well as us signpost from this pharmacy ... provide information [such as] whether it's 'I don't have a doctor', 'I need to find a doctor' or 'where is my local gum clinic' or 'what do I do about drugs' or 'I'm concerned I may have diabetes' – the whole range. We're an information zone or point that is the difference ... [HLPs] have that depth of knowledge from their staff who can then signpost other people to the appropriate areas of advice. I think that's what the difference is." **PH1***

3.2.10 HEALTH SERVICES

3.2.10.1   Mandatory health services

To achieve HLP Level 1 status, pharmacies were required to provide five 'core' health services and a minimum of one 'extra' health service. At the time of embarking upon HLP accreditation, most pharmacies were already delivering a wide range of health services including the mandatory services (listed in Table 25), with the exception of two pharmacies, which at the time the interviews were conducted, did not provide SC and EHC/EPT services.

*" ... we were doing the services anyway and the rest of it was just basically looking at the standards within your pharmacy, making sure you had proper standards so for us it was just basically filling out a form because we've been doing this for a number of years now**." PH7***

Table 25: List of 'core' and 'extra' services as defined in HoBtPCT's HLP Prospectus

CORE SERVICES (MANDATORY)	EXTRA SERVICES (MINIMUM OF ONE TO BE SUPPLIED)
• Smoking Cessation (SC)	• Weight Management
• Sexual Health	• Substance Misuse and Harm Reduction
o Emergency Hormonal Contraception (EHC) service	• Men's Health
o Chlamydia screening	• Alcohol Screen and Brief interventions
• Minor Ailments Scheme (MAS)	
• Long-term conditions	
• Early Pregnancy Testing (EPT) Local service	

3.2.10.2   Most accessed health service

Most pharmacists were of the view that the MAS was the most accessed service and according to some pharmacists, young mothers benefitted the most from convenience of access to expert advice.

"The minor ailment scheme because it's so convenient and a useful service. The demographic of our area is low income and a lot of unemployment so what they do have is time on their hands and they don't have money and also they don't have the self-knowledge or information for themselves to differentiate between something that is minor that they can

*treat themselves and something that is a bit more serious and they need to see a doctor, so they may visit a doctor for every eventuality so with the minor ailment scheme, that's been a tremendous thing for a cough or a cold and also get advice if it continues and they need to see a GP so that's been one of the most valuable ones I think." **PH1***

*"Minor ailment because it is free for the patient and they don't have to wait at the doctors, for the children they keep coming in for the paracetamol, nasal drops, they don't have to wait at the doctors. They love it, they think it is a good service." **PH4***

*"Most frequently, minor ailments is very popular, one reason- that's been running for a long while, since 2005 so people are used coming to the pharmacy instead of the GP so that's very popular." **PH6***

Success of the MAS was attributed to:

1. Convenience of access to professional health advice/treatments at a time, date, and location of choice, thereby bypassing the need to make GP appointments.
2. Access to free medicines – for patients exempt from prescription charges.
3. Good awareness of the service (locally), as MAS has been running in the Heart of Birmingham since 2005. Consequently, members of the public in HoB are accustomed to accessing this service (and other services) from pharmacies.

   *"Yes they trust, usually for minor ailments you find they have gone to the doctor and get possibly the same thing so we are only supplementing or cutting short so they don't go to the doctor again, it's not really new- what we do." **PH10***

3.2.10.3   Least accessed health services

There was general agreement that EHC and Chlamydia testing services were the least accessed, which was attributed to the stigma of accessing services for culturally sensitive health issues considered as 'taboo' topics within the Asian community. However, one pharmacist reported an improvement in the uptake of EHC.

> *"Because of the area, the morning after pill and the stigma that is associated with it, that is probably the least frequently accessed because of the stigma of someone coming to ask for the morning after pill and Asian communities and stuff like that." **PH5***

One pharmacist contended that EPT was the least accessed service and attributed this to availability of inexpensive testing kits that enabled patients to conduct the test in the comfort and privacy of the home environment.

> *"I think the least would be, I'm not sure if it's pregnancy testing or weight management, pregnancy testing is obviously supply and demand, whether somebody wants to come into a pharmacy and have it done or do it in the comfort of their own home, pregnancy tests are relatively cheap to purchase so that's probably the least really even though locals are aware of that, to buy a pregnancy test kit for £2 and then do it at their own convenience, and it waives the need for filling in forms and spending twenty minutes at the pharmacy." **PH8***

3.2.10.4   Difference in opinion regarding the popularity of Smoking Cessation

There were mixed views with regards to the popularity of the SC service. Some pharmacists reported a good uptake and attributed this to patients noticing the outcomes in a short period of time. However, one pharmacist noticed a decrease in comparison to the previous year's figures and attributed the drop in uptake to difficulties experienced with engaging male patients, whilst another highlighted that during Ramadan, uptake of the SC service was generally low.

> *" ... stop smoking - this is harder and harder to come by because it's become less prevalent in that respect but it's still high among the local community and especially the males, they're much harder to reach, to engage with."* **PH1**

3.2.11 MULTI-SKILLED PHARMACY TEAM

In some instances, pharmacists often delegated some tasks related to the provision of health services, such as smoking cessation, to appropriately trained members of staff.

> *"With the smoking and the weight checking and height checking and healthy life, they [pharmacy staff] are involved ... "* **PH5**

> *"They [pharmacy staff] are obviously involved in pregnancy testing, I get them to do the EHC as well to a point so they can go through the questionnaire, if they get stuck I obviously intervene, ... so that's how they are involved."* **PH6**

> *" ... [with regards to] smoking it will generally be me but I don't do all the mechanical stuff, so maybe I'll get one of the other staff members to measure the carbon monoxide and maybe fill in the form but I will run it ... if I'm running a scheme by myself I definitely delegate little bits of it to other people."* **PH3**

> *" ... if it's a minor ailment, the healthcare assistants will load all the information up onto the computer. For EHC, they'll fill out the forms and then I'll go in there and do the clinical bit."* **PH7**

3.2.12 BARRIERS TO HEALTH SERVICE DELIVERY: RESOURCE CONSTRAINTS

In addition to managing dispensing workloads, pharmacists also oversee the commercial aspects related to running a business.

> *"One of the things that I struggle with as an independent pharmacist, becoming an HLP is great, it looks fantastic, obviously we're carrying out lots of services, I think it becomes increasingly difficult for an independent person to cope with everything because don't forget we're still running the business, dispensing, giving advice over the counter and in addition to that, we're having to carry out these additional services as well, MURs, MAS, smoking cessation, EHC, pregnancy testing, weight management, chlamydia, there's a whole list of services that we have to provide as part of the criteria. I think for an independent to do that, because it's very difficult to time manage that, for one person to do that in one day's work, especially when you've got a very busy pharmacy, we are quite busy with prescriptions, we have a high number, I think to do this in addition is difficult to do"* **PH6**

Consequently, during peak periods, when dispensing workloads peaked, most pharmacists highlighted experiencing a strain on capacity (arising from the limited number of staff at any given point in time) necessitating prioritisation of the core pharmaceutical activities, which sustained the financial stability of the pharmacy.

> *"As I mentioned before I think HLP is a good idea but there is a lot of pressure on independent pharmacies. I think one of the drawbacks is going to be that we don't have the time to do these services. It's not that we don't want to do them, it's just that you don't have enough time in the day to do it and not enough manpower ... I think the only way to go forward is to increase your number of members working in the pharmacy, whether it's pharmacist or pharmacist technician or health trainers but we need some financial support from the PCT in order to provide those services, that's where I struggle and that's one of the reasons why the numbers may not stack up, when you come to independent pharmacy, the*

*number of new medicine services or MURs won't be as high as say someone like Lloyds or Boots, they have the additional members there so they have more financial powers." **PH6***

*"If you've got a couple of staff in the pharmacy then it's quite easy but on their own it's difficult. The problem in this area is that there is no such thing as a busy period and a quiet period, like this morning every day in the morning has been very quiet because of the fasting but today we were so busy in the morning, I just couldn't believe it that we had so many customers come through so there is no fixed time. The thing here is that when they come they want information quickly so we are always rushing so sometimes you have to step aside but normally we have two staff here so it's quite good that way but you definitely need two staff to do this service." **PH2***

3.2.13 BARRIERS TO HEALTH SERVICE UPTAKE

3.2.13.1 Challenges of serving a socioeconomically deprived clientele

Pharmacists identified a number of challenges associated with engaging and attracting specific groups within the community and described the challenges faced with serving socioeconomic deprived clientele.

3.2.13.1.1 *Patients averse to change*

One pharmacist highlighted the issues presented by elderly patients and those with learning difficulties who preferred to maintain the status quo with regards to lifestyle choices and were resolutely opposed to any suggestions that might require them to make changes. Consequently, pharmacists erred on the side of caution to avoid causing offence and the likely loss of custom as a consequence of providing unwelcome information.

*"People that are in a rush, people that are elderly and having learning difficulties, sometimes you see people who don't want to change their ways, they like smoking, they like eating, drinking and some of these people, because it's a poor area have few pleasures in life and they see it like you're taking the one thing that they do enjoy doing, and you've got to be careful, you should be providing health information and promoting health as well but you certainly don't want to lose patients over it so you have to balance that." **PH7***

3.2.13.1.2 *Patient apathy*

A number of pharmacists experienced difficulties with generating uptake of specific health services within the Asian community and particularly Asian males.

*" ... the males, they're much harder to reach, to engage with." **PH1***

*"I suppose young Asian lads, we find that they don't really come into the pharmacy that much and when they access services, predominantly the stop smoking we find them hard to keep them going on the service so we struggle with that group, young lads, they don't really engage with services very easily." **PH3***

One pharmacist, with in-depth knowledge of the local community also noted a propensity for Asian men to disregard health issues and wait until escalation of the symptoms before seeking advice.

*"The males don't look after themselves and I try to push them to see the doctor, their blood pressure is high but they're not interested and I am worried about the cardio vascular in this area ... I think mostly the problem is the males are not into looking after themselves so the Asian community always wait for them to be very old ... " **PH9***

3.2.13.1.3 *Language difficulties*

Although pharmacists employed multilingual staff (conversant in the dominant languages spoken in the local area), it was not feasible to cater for the diversity of languages spoken in central Birmingham. Consequently, difficulties were experienced with communication of information on prescriptions or encouraging uptake of services. This was especially the case with new migrant communities such as Eastern European and Somali communities.

> *" ... the ones who don't understand English at all, because I've got three staff who can speak different dialects and most of the time I understand what they are saying. For example, there is a Somali family, if he speaks anything, you don't understand what he is saying, he's got problems and he's got four or five kids and all of them have got incontinence problems, health problems and he came here and I took time out and I figured out what he was trying to say and I sorted out his problem, so now he comes here because nobody would get him the pads he wanted and because of my experience I knew what he was looking for and I sorted him out but you have to be patient and you try and figure out what he is trying to say but it is hard. If I am busy, I tend to say come back in 15 minutes and I will see him or I will tell him to come back in the afternoon."* **PH2**

> *" ... I think language is the biggest barrier. Like I said we tend to cover the majority of languages but we do struggle with the East European ones because they are fairly new and their grasp of the English language is not as good as other ethnic minorities. We do struggle a lot and it does cause a big problem because they do come in for prescriptions and you try to explain things to them, it's almost impossible ... "* **PH6**

3.2.13.2 Cultural norms

Pharmacist **PH9** provided an insight into cultural sensitivities within Islamic communities, which were considered to impede access to health services such as Alcohol Interventions since consumption of alcohol, is prohibited. Consequently, uptake of such a service would result in disclosure of engaging in activities considered to be taboo and the associated stigma.

> *"In this community drinking is taboo ... Alcohol is an issue because most people would not admit to drinking alcohol, so we can't give advice on alcohol and it's* [drinking alcohol] *very discreet. I worry about that because I know for a fact that there are people drinking but we cannot give advice at all, it's forbidden. It's very difficult and I think it is an issue with other communities as well. It is not possible to get involved with alcohol consumption. Even with weight management, it is very difficult. Usually I wait for people to say they have a problem and then I get involved. Those two issues are very difficult to talk about, the alcohol and weight management. Sexual health is also very difficult ... "* **PH9**

Furthermore, pharmacist **PH9** also highlighted that the stereotyping of gender roles within Asian communities:

- Results in reluctance by Asian males to seek health information from female members of the pharmacy team.

> *"I employed a male* [member of the team] *because some of them* [male patients] *are shy to come and talk to* [female members of staff] ... *"* **PH9**

- Impacts upon the health of Asian women in terms of diet control.

> *"The ladies have so many duties that they have to perform ... they are looking after the whole family and the in-laws ... There's a lot of young ladies in the Asian community having diabetes ... It's not controlled because when they cook they don't think 'I can't have sugary, I*

can't have this, I can't have that' because they have to sit and eat together. Diet control is the problem." **PH9**

3.2.14 PROMOTIONAL ACTIVITIES TO RAISE AWARENESS OF HLPs

3.2.14.1 PCT-led promotional activities

Interviewees were in agreement that the PCT had assured HLPs that they would undertake responsibility for raising awareness of the HLP concept and the HLP brand. Generally, pharmacists recalled a range of components of the marketing strategy implemented by the PCT to raise awareness of the HLP concept, which were as follows:

- Posters
- Leaflets
- Badges (for staff)
- T-shirts
- HLP signage

> *"Yes they've* [local residents] *been given lots of leaflets. We've got in store promotion material … a few badges for staff to wear. There's been quite a bit of support … "* **PH1**

> *"They started with giving us the posters in our shops, so people can't miss it … This is the best thing that has come out because we can give them leaflets and we can say this is what we do."* **PH2**

The majority of pharmacists were of the view that the leaflet-drops, which had been promised by the PCT, may not have materialised in some areas, although one pharmacist noticed an increase in uptake of health services and attributed this to leaflet-drops within the surrounding area.

> *" … . Leaflet drops although I haven't seen the fruition of that … "* **PH1**

> *" … . The other thing is the leaflet that I gave, they were going to do a door-to-door drop but I'm not sure if they've done it or not."* **PH2**

> *" … They* [the PCT] *said that they would do a leaflet drop, which hasn't happened yet."* **PH3**

> *"I've spoken to* [a member of the PCT Medicines Management team] *about this as well about giving out A5 leaflets which they said would be distributed around all the houses in* [the locality]*. They did say it would happen within two weeks but there hasn't been any distribution yet. That was about four months. So I'm disappointed about that … "* **PH6**

3.2.14.2 Publications relations (PR) activities

The PCT held a one-day launch event for each newly accredited HLP. Pharmacists mentioned that this PR activity featured:

- A large inflatable 'Mr Pharm' (a virtual pharmacist icon used to convey health related information to patients via touchscreen health kiosks) positioned outside their HLPs to attract local attention,
- Employees of a local radio station handing out cards to passers-by,
- A mobile HLP billboard in the form of an ad-van, which paraded up and down the High Street/road or within the vicinity of newly, accredited HLPs.

> *" … .there was a lot of promotion with Mr Pharm … "* **PH1**

> *"The only thing they have done was on the day that I was accredited. I'm not sure if you are aware of this but they had people giving out cards and big blown up Mr Pharm. So they made a lot of noise on the day for three or four hours and they had a van driving up and*

down Soho Road, even around the area. ... Only a certain number of people will have seen that on the day ... " **PH6**

" ... we did have a promotional day when we had our launch day, about three weeks ago, when. they handed out leaflets and told people about the services that they could obtain from [name excised] pharmacy which you probably couldn't get from anyway else ... " **PH7**

3.2.14.3   Perceptions of the effectiveness of the PCT's marketing/PR strategy

There was a consensus of opinion that the PCT-led marketing/PR strategy was of insufficient length and intensity to effectively promote the HLP concept (at a local level) and unsuccessful in engendering; public recognition of the HLP brand and understanding of the differences between an HLP and a non-HLP.

"I don't think they [members of the public] *really understand it* [the HLP concept] *to tell you the truth."* **PH5**

"I don't think the public itself are aware of the fact of what an HLP is and what that actually means so they don't know what the difference is between a normal pharmacy and an HLP. I think it needs to be marketed more, either by the PCT or by ourselves, so I think there needs to be awareness that we provide more services as a result of accreditation whereas a non HLP wouldn't. I think marketing is required at the moment ... nobody has come in and said they've seen us on the website or seen our sign to say we're an HLP or come in as a result. So at the moment there's no statistic to show there's an increase in number of people using the services. The services that we do are the same ... " **PH6**

" ... The promotion around the HLP kudos is critical ... It can't just be a snap shot of when you get accredited, it needs to be on-going and then you need to establish the difference between an HLP, where you can go for x, y and z services or information, and a pharmacy that is not accredited ... " **PH1**

"I think the actual branding hasn't really caught anybody's imagination publicly yet so our customers don't really understand the HLP banner and I don't know if those badges or T-shirts and signage have helped. They [the PCT] *were saying that they will start doing radio adverts, newspaper, magazines and leaflet drops. Once that starts maybe people will recognise the branding 'oh this is a Healthy Living Pharmacy, this particular pharmacy must do this, this and this because it is a Healthy Living Pharmacy', but that hasn't really happened as yet."* **PH3**

"As an HLP, we've actually promoted ourselves. They [the PCT] *did bring the HLP banner but the advertisement is still missing. I think they're not fast moving, I guess they have a huge amount of work -that could be the reason."* **PH9**

"I'm not sure how much of the community realise we are an HLP because a lot of the community round here is illiterate ... The problem is a lot of the area is Asian and elderly West Indian people as well so I don't think they understand the concept of HLP." **PH7**

" ... they [members of the public] *wouldn't have a clue* [about the HLP concept]. *I don't think anyone would. I don't think many pharmacists know. It's* [HLP] *not really an official title, it's something that has been loosely, used in PCT language."* **PH8**

A few pharmacists also highlighted that printed promotional materials were not designed to meet the need of audiences with poor literacy skills or for those for whom English is not their first language.

" ... a lot of the patients are illiterate and it's difficult for them to read pamphlets ... " **PH7**

One pharmacist was of the view that information in print format required simplification to initiate interest and suggested that communiqué only include just the top-level, brief outlines of the key messages rather than providing in-depth explanations. Once the interest has been initiated, the pharmacist would then be able to provide additional information as required.

" ... There's too much reading, a few points that's enough ... if you give them more information then they will read and forget about it but if you give them some points then they will come back and you can you give me more information ... If you get a leaflet at home, half of the time you don't read it ... the best thing is a one sided [leaflet] *to highlight something ... and then they might take interest in it."* **PH2**

3.2.15 HLP-LED PROMOTIONAL ACTIVITIES

3.2.15.1   To raise patients' awareness of the <u>health services</u> offered by HLPs

Promotion of health services, (including provision of opportunistic health advice and signposting) to raise patients' awareness of the health services offered by HLPs, seemed to be considered the responsibility primarily of HTs and HTCs.

Most HLPs employed in-house promotion to raise awareness of the services on offer and about the HLP concept by, for example:

- Talking to customers and informing them of their HLP status.
- Displaying posters/stickers in pharmacy windows and surgeries.
- Displaying posters on 'A' boards.
- Displaying leaflets within the pharmacy
- Proactive promotion of services to individual patients by pharmacy staff

    " ... . As a team we all promote the service but I suppose with the HT and HTC they are more focussed on it, so they would do their day-to-day duties, which is dispensary assistant but then make sure that they promote the services when they need to so." **PH3**

    " ... We've got A boards that you put outside when you want to advertise something in particular. So when smoking cessation have a new campaign, we'll put that out so people can be aware. I would say that everyone knows about it but if it's in your face you're more likely to take it up and you're reminded of it. We also do bag stuffers telling them what we do. The staff are encouraged to, with tact, if they feel that somebody would benefit from a service, to mention a service we offer ... " **PH8**

    "We try and print leaflets ourselves. So, for the minor ailment, we always only use our own leaflets, so we've got a flyer that we hand out so say somebody who has joined the surgery or moved into the area and who is exempt from prescription charges and whose GP is in the Heart of Birmingham, so they can access the minor ailment scheme. The weight management, again the Your Choice posters are a little bit vague; they didn't seem to capture anybody's imagination. So again, we made our own and they were quite straight forward and they worked, so we make our own when we can. Sometimes when you do your own in black and white they sort of catch people's eyes, whereas posh posters seem to blend in with the other posh posters." **PH3**

    "When they [patients*] come here, the staff will mention services to them, if they ask for cough mixtures or they take some medications for the asthma. They* [staff] *will ask if they* [patients] *smoke and if patients have ever thought about giving up - so we promote it that way ... The pregnancy testing is* [promoted] *if they* [patients] *ask for folic acid tablets, so*

staff ask if the patient is expecting or trying to conceive. We advise patients that they can have a test [pregnancy] *done anytime provided they bring their medical card ... weight management we do if somebody comes here and asks for weight loss tablets, which will prompt staff to suggest alternatives-so that's how we promote it."* **PH2**

"I suppose like they've [pharmacy staff] *always have done* [promoted services] *because in terms of promoting, we promote our services quite a lot. Whenever anyone comes in, a member of staff will be responsible to tell them about a service, whether it's a minor ailment, about the Healthy Start vitamins, ... So whoever hands out a prescription or whoever is working on the front, I've always said 'try and leave them with one bit of information, don't bombard them'. So we've always done that ... we just promote it when we have the opportunity ... "* **PH3**

"Again you have to individualise that [promotion of a health service] *to the patient who is in front of you. Maybe visually look at them, see if they smoke, see if they drink, see what medication they are on, maybe do a MUR, see if they're having any problems with their tablets, see if you can help them. We do asthma review as well. If they are asthmatic, see if they know the difference between the inhalers, how to prevent side effects of the inhalers and give them a patient care plan and also give them non-pharmacological advice as well about allergies, house dust mites so it's all tailored to individual needs of the patients ... "* **PH7**

3.2.15.2   To raise GPs' awareness of the health services offered by HLPs

Generally, most interviewees reported having contacted GPs based in neighbouring health centres or GP practices to inform them of their HLP status and in some cases invited key members of the local surgery staff to the launch event.

" ... I've told all the managers and the GPs ... When the launch was there I invited the GP managers [to the HLP launch event]*. They came and took these cards and gave them to all the GPs ... We were getting in touch with surgeries and things like that and going to their meetings but we were doing that anyway. In fact the surgeries were inviting us to meetings so we didn't have to make an effort."* **PH4**

However, one pharmacist highlighted the difficulty experienced with disseminating information to GPs attached to multi-partner practices, since time constraints prevented the pharmacist from informing each GP on an individual basis.

"I mean I can deal with one GP but there's five or six GPs in the health centre across the road. I will speak to one but it's very difficult to speak to each one because it takes time." **PH6**

3.2.15.3   Word of mouth promotion to raise awareness of the health services offered by HLPs

Customer satisfaction and trust were believed to generate positive 'word of mouth' recommendations by patients. However, pharmacists were equally wary of customer dissatisfaction that could give rise to negative 'word of mouth', which, within the tight-knit communities they served, had the potential for widespread and rapid dissemination.

" ... Once someone has accessed it [a health service]*, then word of mouth - that is a big factor in this area. If you are a bad pharmacist the word will go round."* **PH2**

"[We promote services] *through word of mouth, we can probably put up posters in the GP's surgery in the waiting areas but besides that through word of mouth plus the posters in the windows here."* **PH6**

" ... Word of mouth is very important so if you give good advice to one person more will come and it is working. I give advice and I've seen more people come because of that." **PH4**

" ... We find that word of mouth is the best ... " **PH3**

" ... A lot of it is word of mouth is because of staff telling patients [about the services being offered etc.] *who then tell others that could benefit from it* [health service]*."* **PH8**

3.2.16 THE EXTENDED ROLE PHARMACISTS AS HEALTHCARE PROVIDERS

3.2.16.1 Extent of <u>patients'</u> awareness of the extended role of pharmacists

Pharmacists interviewed believed that awareness within the local population of pharmacists and pharmacy staff as providers of health services and healthcare advisors was high. This was attributed mainly to pharmacists having established reputations (that spanned decades) and having built relationships with members of the local community and also to having been involved in the provision of such services for several years. A reputation for reliable delivery of high quality services had also led to GP referral into such services.

" ... From 2005 we've been providing all the services that are done in the area by the PCT. We took part in them so we were all ready to provide all these services ... Awareness for our pharmacy I would say about 80%, the general public who go to any pharmacy I would say 30 to 40%, in this area there is a lot of awareness because a lot of services have been going on for quite a few years. In south Birmingham there isn't much awareness because the PCT did nothing because they did everything for the GPs and never took interest in the pharmacy, we never had meetings for two or three years, there was nothing proactive at all." **PH2**

"I think it's fairly high [awareness of the extended role of the pharmacist]*, they don't always know everything you can do which is down to us to market the terms in general. I'm talking about specific services, in terms of general advice. I think most of our patients are aware that, we're a community pharmacy. We've been established for some time and I myself am quite established, so I think the pharmacist also makes a difference. So if I've got locums or somebody who is changing all the time, the patients, even though the locum will still have the same title, they* [patients] *may not feel that they can relate to a locum in the same way, locums won't understand the problems they* [patients] *had four years ago. I think most of ours* [patients] *because it is a community pharmacy in the heart of this community I think it's fairly well known the pharmacist's role in terms of health advice."* **PH8**

"The other services, because they've been running for a long time they might be signposted from GPs or friends but we have been doing them for a long time. A lot of them are signposted from GPs, particularly EHC, early pregnancy testing, diabetes testing, blood pressure testing and minor ailments." **PH7**

Furthermore, some pharmacists held the view that patients in HoB were inclined to make pharmacies the first port of call for certain conditions, rather than a visit to the GP.

" ... Initially they all used to go to their GP and slowly they've learnt that for certain conditions they could come here and for other conditions they would have to go to the GP ... . and over a period of time, they are changing their way of thinking ... they need to know they can come to a pharmacy instead of going to the GP and that's happened over the last seven years ... " **PH1**

"They will come to me first and then they will go to the GP and tell them my advice and they will also ask me what questions they can ask the GP, so they can get the best possible advice. Most times I talk to them, 'this is your problem, these are the questions you must ask' ... . If

there is some advice I have given and they have been to the GP they will come back to me and they'll say 'what do you think about this, about the medication prescribed etc." **PH4**

3.2.16.2   Extent of GPs awareness of the extended role of pharmacists

There was a mixed picture in terms of perceived levels of awareness of the HLP concept and the delivery of services via community pharmacy amongst GPs. A number of pharmacists reported that GPs in their local area were kept well informed of health services supplied by pharmacists and those pharmacies benefitted from GP referrals to such services.

However, a small number of pharmacists were of the view that the GPs they had spoken to were unfamiliar with the HLP concept and had little knowledge of the health services provided by pharmacies. These pharmacists expected the PCT to promote HLPs within the GP population in their local area and heighten awareness of services being offered by HLPs.

> *"Yes they* [GPs] *know that we are an HLP but I don't think it's really taken off because the GPs don't really understand what we are here for … I think the PCT could write to them and say what we do in the area and that we can provide them with this, this this and this; that would help."* **PH5**

> *" … in HoB there's a whole bunch of GPs in the area who should all know what's going on … That's one of the things that always comes out of the PLTs, GPs do not know what's happening in pharmacies, they think that the pharmacy is still just a place where you pick up your medication, that's it, nothing else. Even with the minor ailment scheme, they* [GPs] *did not do very well with that. The PCT did not tell GPs, maybe that's not correct, I think they did tell GPs that we do a minor ailment scheme but the GPs and the receptionists were not aware exactly of which conditions were covered. So they* [GPs] *were saying 'go to the pharmacy' whereas certain conditions are not covered, so they should have the knowledge as to what they can refer the patients for. They* [GPs] *were referring patients for conditions that are not covered at all, so yet again, a lack of knowledge and it is wasting the patient's time because they go to the GP and then they come to the pharmacy and find out that they can't actually have something for that particular condition, so they go back to the GP again, it's time wasting. What I'm trying to say is that GPs need to know a bit more about what a pharmacy does."* **PH6**

3.2.16.3   Benefits of the extended role of pharmacists

All pharmacists were cognisant of their contribution towards improving access to health services and they believed that this improved health outcomes within the local population as a result of:

- Trusting relationships established over many years, which enabled continuity care.

- Extended opening hours facilitating convenience of access to a range of free health services (eligibility criteria dependent), mostly provided on a walk-in basis by trained members of the pharmacy team.

- A friendly welcoming atmosphere.

> *" … If you deliver, then people will trust you, the GPs will send them* [patients] *here because once every two or three months I send them a newsletter and remind them of the things that we do … "* **PH2**

> *"They trust me, I've been here twenty-seven years and I'm part of the furniture so they know anything I say will be for their benefit … "* **PH4**

" ... Access is really important to people who are working or not working, different shifts on the High Street as opposed to fixed appointment times. ... access is key, we tend to be open for six days a week and open late hours as well." **PH1**

"It's convenient, it's free and they don't have to go to the doctors ... blood pressure testing and diabetes testing, again it's free, it's convenient and if people have got concerns about their health, not only do we tell them what their blood pressure is and whether they might be diabetic or not but they also get health promotion advice as well." **PH7**

"Just walk straight in, it's just so convenient to walk in, to be able to see somebody straight away, to not be pressurised for time, to have friendly faces as opposed to sometimes a receptionist and not having to go through two or three people to book in [GP appointment]*, and sit there* [in the surgery]*. It's very convenient to walk into a pharmacy, have a person on the front, you may have to wait a minute, to be brought into a room. The accessibility and the ease for patients is second to none I believe."* **PH8**

A number of interviewees were of the view that GP referral of patients to pharmacies for health services has facilitated a reduction in the number of GP consultations for minor ailments and enabled GPs to concentrate on more serious conditions. Furthermore, a number of pharmacists mentioned that GPs are able to score Quality of Framework (QoF[g]) points as a result of positive patient outcomes from health services (e.g. SC) provided by pharmacies.

"It's saving doctors' time and all the hassle for the patient ... The public have started to know that pharmacists give advice on most of the problems and we can identify whether they need to go to the doctors, whether they can wait till tomorrow to see the doctor or whether they need to go to hospital. First point of contact, information free, no waiting etc." **PH9**

"Because it's a poor area, people make appointments to see GPs for paracetamol, Calpol suspension, so the GPs, particularly with minor ailments, they like that service ... " **PH7**

" ... they [local GPs] *were quite happy* [to hear about PH4's HLP status]*. Anything to decrease their workload, they are happy as long as I don't take the money off them. It is a very big balancing act because they want to meet their QoF and they want to earn their money."* **PH4**

"It's a brilliant service [minor ailments scheme]*, it's really good, it takes the pressure off the GP for minor things. Hopefully the doctors will be noticing that their, patients are coming in less for things like simple coughs and colds, hopefully the GP will be noticing that. Then they'll obviously have more appointments available for more serious conditions where the GP does need to get involved such as heart conditions, asthma these kind of things, so the doctor can concentrate on those patients that he needs to deal with and less on the minor things ... They can see if one of their patients has gone in and quit it helps them and they get QoF points."* **PH3**

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[g] "QoF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF gives an indication of the overall achievement of a practice through a points system. Practices aim to deliver high quality care across a range of areas, for which they score points. Put simply, the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take account of the practice list size and prevalence." [*http://www.nice.org.uk/aboutnice/qof/*]

One pharmacist also expressed the belief that the PCT benefitted from being able to optimise available resources in order to generate maximum benefit for patients in the Heart of Birmingham.

> *"I'm sure they'll [PCT] will be getting the results, they must be saving lots of GP appointments with the minor ailments scheme. In terms of the stop smoking, I know from talking to the Stop Smoking team that they get massive of numbers of quits from pharmacies. I know that it's worth it but I hope that they can see that and keep these services going."* **PH3**

3.2.16.4 Pharmacists' perceptions of the value placed by <u>patients</u> on the extended role of pharmacists

Interviewees believed that positive patient feedback and patient initiated referrals (via word of mouth) were indicative of patients' appreciation of the value of the services provided by pharmacists. It was mentioned that patients were especially appreciative of services when advised about the financial savings patients could make by accessing treatments such as Nicotine Replacement Therapy (NRT) via the SC scheme as opposed to purchasing NRT directly over the counter.

> *"When somebody comes and says this person said go to this pharmacy because they gave good advice it makes you feel happy ... "* **PH4**

> *"All the services that we provide, they* [patients] *are quite happy with. We've had no negative feedback from anyone so I think it goes down quite well especially as we never used to do this before ... "* **PH6**

> *"With the services they [patients] do appreciate it because sometimes with the smoking cessation they come in if they want to buy something and they only pay one price for the whole* [treatment] *whereas each of the patch is £22 or £15 or £18, yet* [patients] *only pay £60 for the whole eight weeks ... Minor ailments again ... it's helping them to see the costs and they* [patients] *actually don't have to pay ... they* [patients] *appreciate it."* **PH9**

3.2.16.5 Pharmacists' perceptions of the value placed by <u>GPs</u> on the extended role of pharmacists

Pharmacists expressed mixed views on whether GPs valued the contributions made by pharmacists as health service providers. The variation in opinions appeared to be routed in the apparent absence of formal recognition, from the PCT or GPs, with regards to the contributions made by pharmacists in improving health outcomes of local communities within HoB. One pharmacist attributed this lack of recognition to the absence of quantifiable proof i.e. '*we will be valued if we* [HLPs] *succeed*' **PH10**.

> *"Yes they* [GPs] *value it, the receptionists value it because when somebody stumps up at half five because little Johnny has got a cough, well 'why don't you go across the road because there's no appointments left' ... If they've just gone in and sat for an hour to see the doctor for a bottle of paracetamol the doctor can say 'next time you can just go in and see the pharmacist and they can give it for free' ... "* **PH3**

> *" ... In fact only the day before yesterday a lady brought a letter from the GP and saying they* [GP] *want me to do the smoking cessation with this lady. So we had a thorough discussion, I said 'see the GP, see what they want and then come back and we will put you through the smoking cessation'."* **PH4**

> *"It's difficult to say, we don't have any joint meetings* [between pharmacists and GPs] *as such. There's always room for improvement and knowledge of other professionals i.e. the services we do do, what we can offer and having a level playing field with them ... "* **PH1**

"I couldn't say. I think they've [GPs] got used to the idea like pregnancy testing and minor ailments and any additional services like new medicines services and MURs. I really don't think they value that at all. The number of times you see it in the press that they think it's a waste of time because they say they do it anyway. So what's the point? They just see it [communications sent to GPs by the pharmacist] as additional paperwork coming from the pharmacy; it goes straight in the bin." **PH6**

3.2.16.6 Pharmacists' perceptions of the value placed by the PCT on the extended role of pharmacists

In a similar fashion, most pharmacists were uncertain as to whether the PCT valued the contributions made by pharmacists in helping to improve health outcomes of the local communities they served.

"Certainly the PCT value us, the current incumbents from the Heart of Birmingham, which is now the Cluster, they've always been supportive and they value the services that's why they have promoted a lot of the services through us and we've delivered those services quite well so I think they are valued in that respect … " **PH1**

"I don't know. They [the PCT] don't tell me anything like that but I am sure they value it because I think they value us highly. That's why they made us the first HLP. I think it's the trust." **PH2**

"I don't know about PCT, … I'd probably say not- I'd say semi valued in terms of helping us getting along to this position but the proof is what they do now to show the value. The support they've given us yes, that was valuable but to date I don't feel any difference to six months ago." **PH8**

"I should hope so yes, the results will tell, I should think they will want to have some sort of feedback from me after six months or something to see what we've been doing since we've been accredited, so we will find out then." **PH6**

3.2.17 GOING FORWARD

3.2.17.1 Services pharmacists would like to supply

Some pharmacists praised the PCT for being pro-active with the commissioning of health services and most were keen to supply additional services that would be of benefit to the local community to enable targeted provision of services.

" … This PCT is very active compared to some PCTs around the country are not offering half the services that Birmingham and Solihull are providing and a lot of them are now cutting back on services as well." **PH7**

Services pharmacists would like to provide in the future included:

*" … **Flu vaccination** or **travel vaccination** is a really key one in the area. So I'd like to offer those kinds of services as well and become accredited to offer that. **Travel advice**, with the ethnicity, there's a lot of international travel occurring and the health needs and the potential risks of travelling abroad without proper cover are quite considerable."* **PH1**

*"We would like to provide **blood pressure monitoring** if we could and **diabetes** obviously but because that is to do with blood, how we can do it may be difficult but blood pressure monitoring would be useful in this area."* **PH2**

*" … Maybe cholesterol, I've got everything here but someone has to say 'go ahead, here is the machine for **checking the cholesterol**'."* **PH4**

*"There's a **weight management** service out there that I would like to get on to but I've heard that it's been stopped … I think that would be a good service to have."* **PH5**

*" … Maybe **running a warfarin clinic** but I think for the time being we do quite a few services and I'm not sure we want to add to anymore."* **PH7**

*"Cardio vascular is definitely needed in this community … I think the services need to increase, the **cardio vascular risk** has to be one of the services I think, most communities need that for definite."* **PH9**

3.2.17.2   Threat to role extension

3.2.17.2.1 *Due to insufficient funding*

The pharmacists interviewed were confident about the ability of HLPs to improve health outcomes given their local presence and in-depth knowledge of the local communities whom they served and with whom they had developed trusting relationships. However, many raised their concerns that pharmacists were increasingly coerced into increasing their workloads without fair remuneration for the additional services provided. Therefore, a number of interviewees questioned the financial viability of continued expansion of services in view of current levels of reimbursement for the services provided by pharmacists which were considered to be insufficient to maintain current standards for the provision of health services. Consequently, most interviewed pharmacists stated a need for financial support to enable expansion of their workforce, the need for remuneration for services provided in a timely manner, and incentives to encourage patient-facing staff to take on additional HT/HTC responsibilities.

Furthermore, the discrepancy in funding available to GPs as opposed to pharmacists and the greatly enhanced ability of multiple pharmacy chains to absorb the costs of such services when compared to independent pharmacies was keenly felt.

"It's whether the PCT see the cost to benefit ratio. I would like to offer as much as possible because I think we've performed where we can … " **PH10**

"I think the way the PCT can help us is to have two pharmacists, so if there can be some additional support, financial support from the PCT, like the GPs have; GPs get funded for 70% of their staff, they get funded for the computers, they get funded for electric, gas, council tax, … we don't get funded for anything at all and at the same time the PCT wants us to do the services that the GPs have traditionally been providing. So they want us to do it through our own resources … but the fact is that we need the money initially to invest in to our premises in order to carry the services so unless they can change that I think it's going to be very difficult. … A lot of people come in for blood pressure, diabetes, cholesterol, I would like to provide that but we've got no funding. The bigger boys like Lloyds and Boots do it free of charge because they've got the finance behind them but unfortunately we're not in a position to do that, so that is something I would like to see." **PH6**

"I'd like to be able to offer services where we get fair remuneration, I'm sure everyone says the same thing because at the end of the day you can't do something for nothing, it takes time, pharmacist, a member of staff, everything has to be paid for, we've all had cutbacks, staff, the cost of living is greater, you've got to increase people's salaries but from your side you're not getting any more money so it's a difficult one but in reality will you ever get that- I don't know but fair remuneration for some of the services." **PH8**

3.2.17.2.2 *Due to instability within the NHS*

A number of pharmacists raised their concerns about the perceived turmoil within the NHS. Although there was awareness of the impending (at the time of the interviews) disbanding of PCTs, there appeared to a lack of comprehensive information on the impact of the changes taking place within the NHS. Consequently, there was a high degree of uncertainty as to which of the nascent organisations (Clinical Commissioning Groups, Health and Wellbeing Boards, Local Area Teams etc.) would assume the responsibility for the future commissioning of services from community pharmacy. Therefore, a number of pharmacists were reticent about committing any further resources into developing their HLPs further in view of the uncertainty about the impact of the structural changes within the NHS on the viability of HLPs.

> *"I suppose the other thing is just the money situation, we're being ask to invest in extra services and then we keep hearing that there might be cuts, so do you invest loads of money in training a member of staff, hiring extra people, possibly thinking that next year there's no PCTs, that this is all going to shut? We read it in the C+D* [Chemist and Druggist] *that the PCT somewhere has to cut their services so that's difficult. W*e're not being paid to be an HLP and that's something you work out straight away**.***" PH3*

> *"I think it's quite political, it* [further development of service provision] *all depends on what happens with politics. I try not to think too far ahead ... I have my thoughts but I tend not to dwell too much on them because of things that are out of your control. It depends on who is in parliament, and what is happening with PCTs, GP commissioning, the whole structure. Everything is changing ... It's difficult because I'm aware of the economic climate, I'm also aware of the fact that PCTs are finished and you've got your Health and Wellbeing Boards being brought in and nobody really knows what is going to happen in the future."* **PH8**

> *"We would hope that the PCTs, while we've got them, or whoever is going to take over that particular role will support because it needs to be supported with new services; commissioning new services and protecting the existing ones ... I know that for certain services, in terms of public health, it's going over to the Public Health Commissioning Boards which is more aligned with the council. At the moment it's sort of under the health umbrella but it's going to be going over to the commissioning but I'm not very clear on the specifics of it. There's a lot of jargon. I think that at the last PLT we went to, even some of the presenters were not clear about what is happening, who is going to be doing what; that's my perception ... It would be nice to know that it is going to be carried on and who is going to be well not in charge but looking after this HLP project ... I know that one of the reasons for the PCT to get involved in this project* [piloting the HLP programme] *was to safeguard some of the services through pharmacy because they thought if they could start this HLP concept, it would protect services once the PCT had gone ... "* **PH3**

However, one pharmacist was "optimistic" that the Government would support further development of HLPs.

> *"The PCT is not going to be there ... it is my hope and this is my own personal opinion, it will be one of the things that the Government will say that all pharmacies must provide these services and I think it will come. I am very optimistic about it. I think it is a good thing for pharmacy."* **PH4**

3.2.17.3 Motivation to progress to HLP Level 2/Level3

Most pharmacists stated a desire to undertake HLP Level 2/Level 3 accreditation and motivation to do so appears to stem from the need to maintain a competitive advantage in view of the changing

focus of community pharmacies from being primarily focused on supply of pharmaceutical services to one that embraced the supply of clinical services, health advice, and signposting.

*"I don't like to get left behind so if there is one, we will go for it." **PH4***

*"Yes I would love to be involved, I think it's going to be the way forward. I think pharmacy isn't just there to provide medicine, I think it's there to provide help and advice." **PH5***

*"I'd like to be able to do everything, a mini hospital here, my drive is service and this is how I see pharmacy in the future." **PH5***

It is noteworthy however, that some interviewees expressed reservations about rapidly progressing onto subsequent levels of HLP accreditation:

"I don't know, I am a bit reluctant [to move onto Level 2/Level 3 accreditation] *because I want to stabilise myself for a year or two years because I find that when you start jumping too quickly you tend to fall and then you lose interest. I always find that when I do things I like to do it properly, take my time, make sure that everyone is comfortable and I know there are some people who like to see quick results but I don't believe in quick results, in health it is different." **PH2***

"Ideally what we need to do is, there needs to be a ground swell on the idea of a healthy living pharmacy as a [quality] *kite mark, which is important. Then going onto the higher levels, to prove that you've got the infrastructure in the business and that you're promoting those services. That's always been my way of working ... " **PH1***

*"Pharmacy has to wear a number of hats unfortunately, which is quite frustrating and lack of manpower - the only big hurdle in terms of the growth of the HLPs. If you can increase that I think we can basically carry out most services, whatever is required through level one, level two and level three. So I think we can do well but we need more manpower." **PH6***

3.2.18 PHARMACISTS' RECOMMENDATIONS

3.2.18.1 Training: HLP course for pharmacy staff

Two pharmacists highlighted the need for a course specifically designed to improve pharmacy staff's knowledge and understanding of the HLP concept, perhaps delivered via PLT sessions to facilitate exchange of ideas.

"I think they [staff] *need more training, even the HLP model, they* [staff] *need more knowledge about that. I can do a training course for them about what an HLP means but I don't think they know as much as they should do and I think the PCT should recognise that fact and do another training course based on HLP and the criteria of an HLP just to increase their knowledge." **PH6***

"The PLT evenings are very informative, they come and give us a lecture which is fairly good but they are short and concise. So I suppose if there are any courses to do with the HLP. Rather than having one hour have a bigger discussion. There are, ten of us now, if all ten [HLPs] *are there we can exchange ideas about something." **PH4***

3.2.18.2 Involve pharmacists in health promotion outside of the pharmacy

Two pharmacists iterated a belief that pharmacists, as trusted members of the local community, can play an effective role in health promotion in venues outside of the pharmacy premises. Potential venues suggested included schools and homes:

"In future if the adults are not changing what they eat it's going to be a problem for the youngsters. I'm trying to get involved in homes and schools, to try and teach healthy eating

*from the beginning in order to change behaviour, by telling them they have to cook more healthily. Maybe, in the future that will change some of the health problems in this community." **PH9***

*" ... There are a lot of young boys and girls smoking around school. I know this community, I have lived here for twenty years and I notice them hanging round the church and other places and smoking. They're hiding from their elders ... I see them because I know them, I know the families and the families don't know that they are smoking ... So I'm trying to get involved ... and tell them the dangers of smoking, of cancer and to get them to see what the danger is and to avoid new people smoking ... The problem with the smoking cessation is you're not allowed to give to under sixteen ... I think it should start from primary school, it shouldn't be secondary school because in primary school they have the message that smoking is really bad but in secondary school they are drawn to these things and the problem is, there is no help for the youngsters and they are ignored ... " **PH9***

"The community know that I am a pharmacist, we have to get involved by organising meetings for Asian ladies for example, to encourage them to provide healthy eating for the family or something like that. If you get information into one family it can change everything in a generation; one family, one mother decides I have to do this then the attitudes are automatically changing and you are protecting them for the future ... if one family changes or two families changes, they are in competition with each other, slowly the community will change. They [PCT] *need to find a place where we can make big changes in families and if we get pharmacy involved with the community then I think it is a good thing. The PCT themselves should advertise in the community, lectures for mums or for the men to look after themselves." **PH9***

"I think every community has a website which they list their problems so we look at that and we have to sit down and see what we target. The idea of going into a school and talk is one, the idea of people coming to talk about their illness is another. I don't know if I'll stand out there [outside the pharmacy] *and tell them* [passers-by] *to come into* [the pharmacy] *to talk about something. What I will do is go to a specific group people and talk about a small subject, which has nothing to do with pharmacy but may be of help; like if you tell children about the dangers of smoking, I think that is worth talking about ... " **PH10***

3.2.18.3   Potential improvements to facilitate development of the HLP programme

3.2.18.3.1 *Continuous promotion via TV, radio, leaflet drops etc.*

Most interviewees were in agreement that the PCT-led marketing of HLPs needed to have been an on-going stream of a variety of PR and marketing (e.g. radio, TV, posters in GP surgeries, leaflets) activities to highlight the differences between HLPs and non-HLPs.

" ... I think it's a case of plugging away because there's not a huge differential between them [HLPs and non-HLPs] *in terms of the service we offer but hopefully when they* [the public] *engage with our services, word of mouth should get out and they'll say 'well actually go to that pharmacy they'll be able to help you with x y or z', so you need to establish that ... and that would come through bits of radio, leaflets, promotion, little and often all the while because that's how you make the differential, because then people engage and say 'when I went in there I was able to do this, this and this." **PH1***

*"You have to go back to education, educating people, maybe improve the adverts on the TV or on the radio." **PH5***

*"To do the leaflet distribution first, that's the most important thing maybe have something in surgeries, a poster in the surgery to say who is an accredited pharmacy." **PH6***

3.2.18.3.2 *HLP Brand development*

Some pharmacists highlighted the need for a concerted effort to develop the HLP brand to enable further development of HLPs.

*"I suppose it's a banner, it's a heading to build on and I suppose it's a branding that hopefully the PCTs while they are around can use that branding to build on more services and to promote the existing services more so we're hoping that it will grow, this is just the start." **PH3***

*"I suppose like the brand I hope they grow that brand, I know that the PCT have invested heavily but we have as well, we've invested in our time and our staff and we want to hope that we don't waste that investment and we want to expand any HLP role within the pharmacy we would be actively looking to do that." **PH3***

*"One word Healthy Living Pharmacy automatically gives you so much behind it for example if somebody says is this halal, it's very difficult, but actually you know what halal food is, it's one word explaining so much behind it and I think it's a very good idea because if they keep advertising HLP automatically if people will start knowing what an HLP is, one word explains all the processes. We do smoking cessation, we do weight management but if it is called HLP it automatically clicks in every head, ok we've got everything that I need." **PH9***

3.3 RESULTS FROM THE HT/HTC INTERVIEWS

3.3.1 BACKGROUND INFORMATION ON HT/HTC QUALIFICATIONS

The Level 2 HTC qualification precedes the Level 3 HT qualification within the National Qualification Framework and according to the NPA guidelines; both roles are distinct in terms of their remit, in that the HTC role is limited in its remit as a supportive role compared to the HT. The role descriptor for an HTC according to NPA guidelines is:

'[the HTC role] facilitates the uptake of Health Trainer services and other interventions, as appropriate. This is often referred to as 'signposting and improving access to services achieved by peer support and information giving ... Health Trainer Champions (sometimes called Level 2 Health Trainers, Associate Health Trainers or Health Champions) do not provide one-to-one behaviour change programmes.'[49]

3.3.2 AWARENESS OF THE DEMOGRAPHIC PROFILE OF LOCAL COMMUNITIES SERVED BY HLPs

As with the 'pharmacist' interviews, all HTC and HT interviews commenced with preliminary questions to ease interviewees into the interview process and to gain an understanding of their awareness of the prevalent conditions, socio-economic and demographic profiles of the local population. The majority of interviewees demonstrated good awareness of the prevalent conditions and demographic profiles and responses to these questions, were generally in alignment with statements made by pharmacists on the respective topics.

However, most interviewees differed in their view with regards to the most predominant communities within the locality, which may be reflective of the geographical location of the HLP at which participants were employed. That is, whilst HTC10, HTC1 and HTC3 shared the view that communities within the vicinity of their HLPs, were 'mainly Asian', HT9 and HTC8 maintained that the local community comprised of 'mainly Somalian people'. Additionally, both HT7 and HTC8 had observed migration of the original communities and inflow of new communities i.e. Somali and Arabic, which HT7 believed to transient.

"To be quite honest there's quite a lot of different people round here. Over a period of time, the community has changed from what it was, to what it is now. Whereas before you had a lot of Asians, Pakistani, Indian, Bangladeshis and English, now you've got Somalians and Arabics ... most of them are from out of town, but come to visit. When they come in [to the HLP] obviously you talk to them and ask where they're from because they're not faces that you see all the time, so when you talk to them they say they've come from London ... " **HT7**

"It's mostly a mixed community. Here, the local area is Asian, Bengali, Pakistani, Indian, African but because of the surgery we are next to, we get a lot of British white citizens as well, we've got a good mixture of customers ... " **HTC4**

3.3.3 PERCEPTIONS OF THE MAIN OBJECTIVE OF AN HLP

Interviewees' comments indicated an understanding of the general purpose of an HLP i.e. the proactive promotion of healthy living and the provision of a range of easily accessible services designed to prevent ill health or promote good health.

" ... We're going to be promoting healthy living, that is what our accreditation is, so that patients can walk in here and benefit. They can't always get to their doctors can they? They need to make an appointment or for whatever reason they haven't got the time and there are these pharmacies that are available that will benefit the patient. We are there to try and provide some of the services, that is what I understand of it [objectives of an HLP].*"* **HTC3**

"Just to make sure of the health and wellbeing of the local community, try and find things that could be happening with a particular group of people before it actually gets any worse- identify problems at the beginning." **HTC8**

However, **HTC3** further explained that the desired outcome of an HLP was to encourage the local community to make HLPs the 'first port of call', to reduce the burden on the GP's time. **HT7** also agreed and was optimistic that in time, the public would come to view HLPs as an alternative source of health-related services.

" ... Their first port of call does not have to be their GP basically, they can come into a pharmacy and discuss with either the pharmacist or the health care trainers and depending on their requirements if we can help them we should be able to do so then that eliminates the GP having to intervene and he can concentrate on other matters which are more important." **HTC3**

"I think they could be quite vital in the long run, they could save the NHS a lot of money and I think it's good because people can know that they can go to a pharmacy for this this and this but it's going to take a little while, because people are so used to doctors ... most of the people who come here are through the doctors ... the first port of call is the doctor's so once that trust between them and us grows then it will help quite a lot ... " **HT7**

3.3.3.1.1 *Health improvement*

When asked to identify which patient groups would gain most benefit from the HLP programme, many interviewees referred to patient groups such as the elderly, children/teenagers, the overweight/obese, people with diabetes and those with poor levels of English literacy.

Interviewee: *"I think elderly people, to make them understand and to improve their health.* **Interviewer**: *Do you have many elderly people?* **Interviewee**: *Yes, we do, we have plenty of elderly, we've got children as well and their parents will come and ask for advice and stuff but mainly it's elderly people."* **HTC10**

"Like I think with children and the elderly, some people think there's nowhere to go or they don't know where to get help from or anything like that so a lot of people don't look for help, don't ask for help, it's like an initial start for them to try and sort out their problems ... " **HTC8**

"We've signposted many people that have come in, who are not diabetic but who come in for a glucose test. We signpost them to the doctor if it is showing very high for a certain period. Blood pressure is the same, if they've come in and they've got low or high blood pressure we signpost them to the GP." **HTC1**

"I can speak for the weight loss programme because there's a lot of little things in there like the Health Exchange organise walks at different surgeries and things like that. What I do is help them find an activity that they want to do or if they want to do something in groups, we've got a little leaflet that we've got for them to refer to." **HTC4**

"I would say that it's beneficial for the customers, people that are not aware of the services that are there for them, especially with the elderly or those who are not very well educated or can't speak the language. If we tell them that there are these services available to them and are free, they would be happy with us." **HTC1**

3.3.4 DIFFERENCE BETWEEN HLPS AND NON-HLPS

When interviewees were asked to define the differences between HLPs and non-HLPs, **HTC3**, focussed on comparing the range of health services provided before and after accreditation, contending that the HLP accreditation had not resulted in any noticeable change.

"I've personally not noticed any change in the services that we are providing now [post-accreditation] *or to what we were providing before that* [pre-accreditation]*."* **HTC3**

However, the majority of interviewees were of the view that HLPs provided a broader range of health services and were more proactive in the promotion of those services than non-HLPs.

"HLPs do more services don't they, that's the only difference." **HT6**

"We've also got the schemes like stop smoking targeted to the younger generation ... We offer a wide range of different activities, like we offer bowel cancer screening, Chlamydia, pregnancy tests, all sorts." **H*T*C1**

"The main difference is that the HLP can offer a lot more services. We can give more advice on healthy living and smoking to the community because a lot of the community round here need our support with their medication, with healthy living, with their lifestyle." **HTC2**

" ... Now, as an HLP we have to advertise, that if they needed help they could come to us for advice that we can give or signpost people ... " **HT9**

"As an HLP we're able to advise the patient because, for example, we can give leaflets to the patients, explain to them that there are gyms available if they are overweight, diets to follow so the diabetes stays in place ... before we only had patients coming in for medication, they'd bring their prescriptions in and then they would go, they wouldn't ask for any help on stop smoking or any schemes that they can join ... Whereas now because we've got more posters up and we actually speak to the customer. We do actually ask them 'do you need help with stop smoking?', 'Do you need help with diabetes plan?' We didn't have that before." **HTC1**

HT9 also reflected that since becoming an HT, s/he was proactively signposting patients i.e. referral of patients (whenever the need arose) to the pharmacist or external organisations.

"Before we became an HLP we didn't have an HT. Now I'm a HT, if anybody came up to me and said I need help with this, if I could help them I would, but if it was beyond my

competence, I would refer them but before we became an HLP, if somebody had come up to me, and I didn't know anything about it, I would say sorry we don't do it. Now if somebody comes to ask me for help, I would them refer them to a pharmacist, otherwise I will signpost them to where they can get more help from ... " **HT9**

Furthermore, **HTC10** and **HT7** shared the view that the difference between HLPs and non-HLPs was that HLP staff were knowledgeable and able to provide credible advice, which **HT7** considered important to ensure a professional approach when dealing with patient enquiries.

"I would say advice, the knowledge, because we are an HLP I've been to the meetings so I've got the knowledge of how to use health exchange site and stuff." **HTC10**

" ... making sure that first of all the advice you give to people is right so you have to be always up to date with what's going on because when you get people coming in with random questions ... you can't start Googling it, they're going to say, 'oh forget it he doesn't know what he is talking about, even I could do that at home'. So you have to know what you're talking about." **HT7**

HT7 also contended that, whilst the aim of HLPs was to be patient focussed, non-HLPs were likely to adopt a transactional orientation. However, upon further reflection, HT7 was of the view that the development of a patient-centred culture within a pharmacy was ultimately dependent on the pharmacist's predisposition to be either commercially orientated and/or embrace a patient-focussed outlook.

[The difference between HLPs and non-HLPs] *"is probably the services that you provide and the time you take out. Say, a pharmacy that is an HLP and a pharmacy that is not, is doing smoking, the time they spend with a patient is obviously much more than a non HLP because with an HLP you're dedicated to doing it, that's your aim to help the people. Whereas that one* [a non-HLP] *is more of a money basis, a service which you offer to get money out. An HLP is more about helping people and giving them more support. With a non HLP, I think it depends on the pharmacist as well, on what their beliefs are and how they run the pharmacy, you get some pharmacists who want people in and out, all money orientated whereas you've got other pharmacists who always want the best for the patients. It just depends on the pharmacist working."* **HT7**

3.3.5   METHOD OF HT/HTC RECRUITMENT

As part of the Level 1 accreditation criteria, pharmacists were required to recruit a HT/HTC. All interviewees were selected for the role of HT/HTC from the existing pharmacy teams.

According to some interviewees, the selection criteria for the HT/HTC role were generally based on interviewees' experience of delivering health services and working hours.

"I don't know why he chose me except for the fact that I'm here all the time ... " **HT6**

"I was just chosen, [the Pharmacist] *just chose me to do it because I was doing smoking anyway ... "***HTC5**

3.3.6   REASON FOR UNDERTAKING HT/HTC TRAINING

3.3.6.1   Prompted by pharmacist

All interviewees were prompted by the pharmacist/manager to undertake the relevant HT/HTC training.

"Just through being offered to go on the course [HTC]*, I think that's what it was."* **HTC8**

*"The pharmacist told me that we needed a HT and a health champion so there were two of us who went for the Health Champion and after that I went for the HT, it was good, I enjoyed it ... "***HT9**

*"Because my boss told me to, we got the training manuals sent to us from the PCT and my boss looked into it and obviously he wanted one of us to become a HT at that point ... "***HT6**

3.3.6.2 Acquire knowledge

Interviewees also valued the opportunity to acquire knowledge through training, which provided scope for personal development. Additionally, interviewees also shared a keen sense of purpose and a genuine desire to contribute towards addressing health issues within the local community.

"There's nothing to lose. There's more to gain, so I just gained more knowledge." **HTC10**

"I think anything that is offered it's just better to go ... " **HTC8**

*"I just wanted to experience a bit more really. I was working in the pharmacy before I became a HTC and I was giving out advice, we were offering top tips to patients. I just wanted to be more helpful, being able to advice people on healthy diets, going to gyms, activities that we do here for them like the stop smoking- being able to help the patient more***."* **HTC1**

*"Because I thought it would help our community. Our community comes and asks for advice on health and there's a lot of people in our community who need help with child health and there are a lot of children around our area that are becoming obese, so I thought it would help***."* **HTC2**

3.3.7 COMPARISON BETWEEN THE PHARMACEUTICAL−RELATED ROLE AND HT/HTC QUALIFICATION UNDERTAKEN

A comparison between the pharmaceutical-related role and the HT/HTC qualification undertaken shows that the category of the pharmaceutical-related role i.e. 'Counter Sales', 'Healthcare Assistant' or 'Dispenser' was not a deciding factor in determining the level of qualification (HTC or HT) undertaken. Even within the same category, there was a variance as illustrated in Table 26, which shows that of the four interviewees who described their pharmaceutical role as 'Counter Sales', three undertook the HTC qualification whilst one undertook the HT qualification.

Table 26: A comparison between the pharmaceutical-related role and the HT/HTC qualification undertaken

INTERVIEWEE SAMPLE N=10	CATEGORY OF PHARMACEUTICAL-RELATED ROLE (AS DESCRIBED BY INTERVIEWEES)	HT/HTC QUALIFICATION UNDERTAKEN BY INTERVIEWEE
n=1	Not specified	HT
n=1	'Counter sales'/ 'dispensary'	HT (qualification completed prior to HLP set-up) and HTC
n=1	'Counter Sales'	HT
n=3	'Counter Sales'	HTC
n=1	'Healthcare assistant'	HTC
n=2	'Dispenser'	HTC
n=1	Not specified	HTC

3.3.8 TRAINING RESOURCES

Two sources of training were mentioned by interviewees:

- PCT-funded formal HT/HTC training courses (delivered by external training providers) leading to the award of the respective qualification.
- PCT-led PLT sessions for pharmacists and pharmacy staff, which were a source of information and informal training.

3.3.8.1   HTC and HT courses

Usefulness of the HTC and HT courses in enhancing healthcare-specific knowledge

The majority of interviewees asserted to having experience of fulfilling health-service related responsibilities prior to undertaking either the HTC or HT training. Therefore, there was an expectation that the training would cover aspects related to the provision of healthcare services. However, this was not the case with the HTC course.

> *"It* [referring to the HTC course content] *was nothing new to myself. As an individual and being a healthcare trainer, it doesn't change my job role. I'm still continuing to do what I used to do … "* **HTC3**

> *"The training was very brief because it was only two days and it went very quickly. It was like an introduction to the level three and we were reminded of that on the day that briefly we're going through everything. So I think it was a bit quick. If there was a future training course, there should be a bit more in depth of what is going on."* **HTC4**

> *"It covered quite a bit about the communities and how to help the community but there wasn't enough information. It was on people's health but it wasn't about obesity because in our community there are a lot of people suffering with obesity."* **HTC2**

> *"We get a lot of customers coming in with really dry skin … so if they* [training providers] *talked about different skin conditions and then actually show us, we can actually understand so that we can get that knowledge on what you should use on this skin condition … I would have liked more information I think."* **HTC10**

In contrast, those who undertook the HT training generally considered the course to be useful in terms of enhancing their healthcare specific knowledge.

> *"I've got more knowledge then I had because when we were doing the course we had loads of course work to do … "* **HT6**

> *"The HT* [course] *did more or less everything, so it did blood pressure, diabetes, smoking, weight management. The main things that you need in an HLP, you did them. You have paperwork to do, you have activities like blood pressure checking and smoking, cleanliness, like keeping on top of what you normally do, making sure there's no germs spreading, if people come in and they smoke, always change the mouth piece to stop spreading contamination and also confidentiality, the protocols and all that … Whereas in the HTC one you didn't do much on them to be honest … "* **HT7**

Benefits of the HTC and HT courses

When asked which elements of the respective courses interviewees found useful, a number of interviewees highlighted the benefits of the 'communication skills' module, which they believed equipped them with practical skills and knowledge on how to effectively engage with patients in order to identify potential opportunities for the provision of opportunistic health advice.

> [The HTC course covered] *"How to communicate and how you would work with the customers, basically to give them advice, there are different ways … It was useful … It just tells you how to approach the customers without scaring them or without them feeling uncomfortable so they are quite useful."* **HTC10**

> *"It* [referring to the HTC course] *gave us a summary of what we should be targeting, just taught us about advice that we should be giving to patients as they're coming in."* **HTC1**

"It [referring to the HT course] *wasn't all a waste of time I wouldn't say because a few weeks ago when I was working with one of my customers, before I went to the training I wouldn't have been able to talk to her but after the training I knew what sort of questions to ask her, I knew what I had to do and I did that, it has helped me, I'm more confident now ... It was like if somebody was to come up to you, how we would talk to them, what sort of questions to ask, open questions, closed questions, how we would communicate so they are open with you so they tell you everything that you need to know." **HT9***

Three interviewees, also spoke positively about the benefits of other elements of the HTC course which:

- Enhanced their knowledge on demographic profiles and levels of deprivation faced by communities in HoB, which enhanced their understanding of the hardships faced by local communities.

    "It [HTC course] *was more an insight into people's way of life. I didn't realise how they have to live. I didn't realise until this course how other people have to live ...* [The HTC course enabled] *Looking at people in a different light, you know what I mean? I suppose it's like judging people, first impressions. You should never judge people by first impressions until you know a bit more about them. I think that's opened my eyes ... and getting the insight really ... just to be open and welcoming to people." **HTC5***

    "It covered quite a bit about the communities and how to help the community ... " **HTC2**

    For **HTC5**, this knowledge was instrumental in breaking down personal embedded views and raised awareness of the need to keep an open mind when dealing with patients.

- Highlighted the need to infer meaning from conversations with patients.

    "I think they made us more aware of noticing, reading between the lines, with what people say, that there could be underlying issues ... " **HTC8**

HT/HTC course unsuccessful in clarifying the HT/HTC role and responsibilities

Some interviewees appeared to be somewhat confused as to their designated role and their actual role was deduced from the duration of the course undertaken; the HT course being longer in duration than the HTC course.

Interviewee: *"Initially it* [the training] *was eight weeks but it rolled onto about sixteen weeks, it was two days a week going to Gee House.* **Interviewer:** *That sounds like a HT. Are you the HT? That's the long course?* **Interviewee:** *No the HTC is, or is it? I went on the long course, there's now a two day course which is at Gee House as well." **HT6***

*"I'm a health trainer ... I had the two day training in the Gee business centre." **HTC10***

3.3.8.2   PLT sessions

A number of interviewees highlighted the usefulness of PCT organised PLT sessions for pharmacy staff in terms of aiding the development of knowledge on various topics and the dissemination of information on any changes to programmes currently being delivered:

" ... Counter staff have been on training for it [pregnancy testing]. *Training is once a year and then I think you have updates so that's staff based. They're all trained by PCT training events, on the PLT evenings. There has been one when we first started to do the scheme alongside Healthy Vitamins, there was training based on both of those two. The PLT training* [sessions] *are more than enough really. I have heard that they might be stopping them, so that's*

probably not a good thing because that's the only training that we get. I know when you work for Boots, you get training events and that kind of stuff but in an independent you don't get it. Yes, the PLTs are when we get most of our training." **HT6**

"I mean if there's any changes made to a scheme put out for us to do, we're aware of that, if they've changed any spreadsheet, any information, how we should be running the scheme. It does teach us what is new and this is what needs to be done." **HTC1**

"Yes they [PLT sessions] *are very useful, they help me a lot. Some of them are to do with the pharmacist but there are quite a lot which are for pharmacy staff as well. So I find all of them useful … "* **HTC2**

3.3.9 SIMILARITIES IN THE HEALTH-SERVICE RELATED RESPONSIBILITIES UNDERTAKEN BY INTERVIEWEES ACROSS HLPS

Prior to the HLP pilot, most interviewees had undertaken relevant health service/programme training (e.g. SC and WM) and fulfilled health-service related responsibilities which included signposting members of the public to other healthcare providers, the delivery of health services/programmes and providing health-related advice. Indeed, one interviewee repeatedly highlighted that there was little change in terms of the health-service related responsibilities fulfilled prior to and post accreditation or after having completed the HT/HTC training.

" … I keep saying this I don't feel like I am doing anything different to what I was doing before [accreditation]*, like I've always provided, like we've always done the pregnancy testing, the minor ailments and EHC and in terms of bringing the patient into the consultation room, and advice we can help them with, myself personally, I've been giving that, if you need the pharmacist to intervene then obviously I call the pharmacist but I've not seen any change in the role that I've been providing for many, many years … "* **HTC3**

Therefore there was a degree of similarity in the responsibilities undertaken by most interviewees irrespective of their designation. Table 27 below shows the responsibilities mentioned by interviewees.

Table 27: Responsibilities undertaken by interviewees

DESIGNATION	RESPONSIBILITIES MENTIONED BY INTERVIEWEES
HTCs	
HTC1	• Trained to deliver the WM programme
HTC2	• Trained to deliver the SC programme
HTC4	• Provide advice and treatments on minor ailments • Deliver the EPT service • Trained to deliver the SC and WM programmes
HTC5	• Carry out blood glucose tests (diabetes test) • Trained to deliver the SC and WM programmes
HTC8	• Provide advice and treatments on minor ailments • Carry out blood glucose tests (diabetes test) • Deliver the EPT service • Signpost patients
HTC10	• Provide advice and treatments on minor ailments • Deliver the EPT service • Trained to deliver the SC and WM programmes
HTs	
HT6	• Deliver the EPT service • Responsible for the completion of MAS forms • Trained to deliver the SC and WM programmes
HT9	• Provide advice and treatments on minor ailments • Carry out blood glucose tests (diabetes test) • List of local community services to enable efficient signposting

3.3.10 BENEFIT OF UNDERTAKING THE HEALTH-SERVICE RELATED ROLE

The majority of interviewees when asked to define the benefits of undertaking the HTC or HT role, based their responses upon their general experience of fulfilling health-service related activities (as per Table 27), as opposed to the responsibilities associated with HT/HTC roles as defined by the NPA.

Interviewees spoke of various aspects of the health service role that were considered to be rewarding for example opportunities for interaction with patients enriched their roles and job satisfaction was derived from a belief that their interventions had a positive impact on the health of the patients they interacted with:

> *"See in my job role, I help a lot of customers and I enjoy that, knowing that you're helping someone. You see it's not always about working and doing things, when someone comes in and says 'thank you for doing that' or 'it's helped me', you feel good, you feel much better and when people give you praise, you feel good about yourself, that you've helped someone. It's much better than me standing behind the counter and talking to the customers for two seconds and then having to run back to do prescriptions ... "* **HT7**

> *" ... I really like doing it* [delivering SC programme] *because it helps people and I've actually helped a lot of people stop smoking. It makes you feel like you help the community achieve something."* **HTC2**

> *"I think it's the relationship that you build with the customers because when you're dispensing and you're in the back, they don't really know what's going on in the back because they'll just see you when you go out to give the medicines, whereas when you're running a programme, you're interacting more with them and you start to build up this relationship or trust with them. So I guess that's the best thing out of it."* **HTC4**

> *" ... I do enjoy it* [HT role] *because now when people come to me I can help them a bit more, before I couldn't do that much so it has made a difference."* **HT9**

> *" ... I can help them depending on what their requirements are- to see the patient walk out of here a happy person and* [they] *thank you for the information that I have been able tell them. Just makes me happy that I've done something and made someone aware of something that they didn't know ... If I'm providing a service and it has actually benefitted somebody it, gives you a sense of reward- that is your job satisfaction, that you're actually doing something that is benefitting somebody. It's a wonderful feeling that you can't explain. When I did the weight management programme, this one person, she actually lost a considerable amount of weight and it was so nice to see her happy that she had benefited from a service that we were providing."* **HTC3**

3.3.11 STAFF SUPPORT AND GUIDANCE

The pharmacist/manager was the primary source of information, support and guidance for the majority of interviewees.

3.3.11.1 Staff meetings

Most interviewees felt supported in their health-service related role and benefitted from regular team meetings with the pharmacist, which were reported to take place on a weekly, a monthly or on an informal ad-hoc basis as and when required.

Team meetings whether they took place on a formal or informal basis provided an opportunity to discuss and resolve issues (both personal and pharmacy related) with the pharmacist and other members of the team and instilled a sense of a team spirit.

*Interviewee: "We have regular informal meetings, nothing formal. **Interviewer:** Do you find it useful? **Interviewee:** Yes, because you can convey any issue or problems rather than letting them build up then forgetting about them. I find it quite helpful." **HT6***

*"Yes we have staff a meeting every week or every other day, whenever you feel that there is something going wrong or you need help on something or just generally all of us just sit down and you talk to each other and address the issues, how we can solve them and how things have been going the last week and stuff like that. We do that every week between us and the pharmacist ... It's all about team work because if you don't have team work you can't do the HLP." **HT7***

"We don't have a set day for meetings but he is always available for me to ask any questions it's not a problem or if I need any advice. [Scheduled team meetings] *could help but because we're small pharmacy, I don't think it's a problem for us to communicate or to get advice from each other." **HTC4***

*"Yes we do, we had a meeting yesterday, we have a meeting every month ... which includes everything about the pharmacy, how we should improve the services. The meeting that we recently had was about Healthy Living and the pharmacist advised us that we should start telling people a bit more about our Healthy Living and asking them to fill out the survey while they are waiting for a prescription." **HTC2***

However, one interviewee reported an absence of meetings with the pharmacist owing to the busy nature of work at his/her pharmacy:

"It's not easy to speak to the pharmacist, he's too busy. We don't have hardly any meetings, one or two in the whole year. No we don't have regular meetings [to discuss] *how to progress and what else can we do to better the service or are we making any mistakes. It's always a good thing to sit down, the longest you should leave it is probably three months, you need to sit down as a group and discuss 'are there any things we could do better' in a general meeting but this doesn't happen at all. Where can we point out our concerns? You can't even go back and say 'I had this patient in or I don't know if I've done the right thing'. I then speak* [to health professionals within the family] *... because there is not the time here to be able to discuss something or be told 'yes you've done the right thing'. It's too busy its prescriptions, prescriptions, prescriptions." **HTC3***

3.3.11.2 Opportunity to network

The majority of interviewees stated that they had not had an opportunity to network with their peers. When interviewees were asked if they would find networking meetings useful, there was a consensus of opinion that formal peer networking meetings would be beneficial in aiding transference of knowledge, exchange of ideas/experiences and the sharing of best practice across the HT/HTC community.

"It would be [useful] *because you'd get to see how they do their work and how they give advice out." **HTC1***

"No that is one thing [network meeting] *that I think would be good, having a meeting with all other HTCs, in that way we will know their views because that is one thing that would help other pharmacy staff, talking to people and knowing people and how other pharmacies are doing, it would actually help out ... You can learn a lot by talking to individuals, in the way they operate and in the way we do, we should be able to do that and then decide 'they're doing it like that perhaps we should try, it might work better for us'." **HT9***

*"Everybody could all discuss what the things that have been going on in their shops, see if other people have similar problems or if the same things crop up ... " **HTC8***

3.3.12 FEELING VALUED BY THE PHARMACIST

When interviewees were asked if they felt valued by the pharmacist and other members of the team, the majority of interviewees reported that they did feel valued.

*"Yes, I think so, I think we all are really, because we all work as a team here. I suppose everybody else does but I personally think we've got a good team here." **HTC5***

*"Yes I do, we work as a team here, no one feels undervalued or anything like that." **HTC4***

The exception to this was **HTC3**, who expressed his/her dismay at being subjected to disparaging comments (made by the pharmacist) for being conscientious in fulfilling a role that was assigned to the interviewee.

" ... Even if you're sitting in the consultation room, you know that you're being timed basically and you have to get out of here [consultation room] *as soon as possible and if you do take a length of time, you get comments sent to you ... for example, I might be in here doing a pregnancy test and then you get a comment sent to you saying, 'what took you so long, were you delivering the baby?' I don't like these things said to me and I find that happens a lot. 'What were you doing?' and remarks like that being said to you* [by the pharmacist]. *It makes me question how I do my job basically, you're* [referring to the pharmacist] *asking me to provide a service so I'm trying to do it to the best of my ability but yet you're* [referring to the pharmacist] *still not happy, you're throwing these comments. How do you draw the line?" **HTC3***

3.3.13 HEALTH SERVICE ADVICE/DELIVERY PROCESS

All interviewees were involved in the provision of a range of health services. However, at the time of the interview, one HLP was in the process of training a member of staff to enable provision of the SC service, whilst another HLP was awaiting authorisation for the provision of two services; EPT and EHC.

3.3.13.1 Recording of data

General recording of HT/HTC activity did not appear to be commonplace unless there was a requirement to complete forms to enable delivery of a health service/programme. However, **HTC8** was informed (by the pharmacist) of the need to do so in the future.

"No but he [the pharmacist] *did say we've got to start doing ... " **HTC8***

*"No we just deliver the services." **HT6***

3.3.13.2 Paperwork' completed for certain health services

Data capture activity was predominantly associated with EPT, MAS, WM and SC, which required the completion of 'paperwork' i.e. a form. These forms therefore guided service deliverers through a step-by-step process which included assessment of symptoms, evaluation of a patient's eligibility for free treatments (particularly for the EPT, MAS and SC programme) etc.

Interviewee: *"That's the paperwork* [interviewee shows the paper to the interviewer] *that we get given for minor ailments so we just have to keep them filed ... So we've got all the patient's details, their GP address that we have to double check to see if their GP is on the scheme then we can give the products out, if they're not, then we can't because obviously we don't get paid for that so any symptoms that they're presenting, that's like a prescription the pharmacist signs and they put their exemption and stuff on the back and we give the*

products accordingly. **Interviewer:** *So the pharmacist fills that bit in then?* **Interviewee:** *Well we fill that part in for the patient and take down what symptoms they've got, sore throat and stuff like that, staff will get the drugs out and then the pharmacist double checks everything, makes sure that there's no interactions with medication and then signs it off and we give it out.* **HT6**

"We have records, for weight management we have their cards that we write every data on them so we have different folders for different things ... " **HTC10**

3.3.13.3   Monitoring of patient progress

Both the SC and WM programmes required patients to attend a series of weekly sessions over a period ranging from six to twelve weeks, during which time various measurements such as carbon monoxide levels (for SC service), blood pressure, weight, etc., would be taken and recorded onto a form. The collection and recording of clinical data, enabled staff to monitor progress and discuss with the patients concerns or issues that could result in patients not meeting their target goals.

"That's the smoking paperwork that we have and say on week one we will go through all the patient details plus their smoking history and then that's where we put in when the patient comes in for their appointments, that's where we put the dates and the products that we have given and anything that we have discussed or any problems ... " **HT6**

" ... With the smoking it's a twelve week course and they have to attend the clinic every week for twelve weeks and what we do is, obviously we give them the free patches and everything but we have a CO [carbon monoxide] *reading every time they come in and obviously if their CO reading isn't coming down there's obviously an underlying problem that they're smoking, lying to me and then I have to say something has got to be done ... "* **HTC5**

3.3.14   MULTI-SKILLED WORKFORCE FACILITATED PROVISION OF HEALTH SERVICES ON A WALK-IN BASIS

The multi-skilled capabilities of pharmacy staff facilitated provision of health services on a walk-in basis and generally ensured continuity of health service provision even during peak hours.

"If someone came in for a service, we've got counter staff and a pharmacist and a dispenser here. So if they came in for a service we would help them straight away, we wouldn't make them wait because we don't like our patients waiting, we like our service to be perfect, so if someone came in for advice and needed help on emergency contraception the pharmacist would be there straight away because here, there's a dispenser who dispenses everything so the pharmacist is free to leave but the pharmacist will do the final check. There's always someone to help out." **HTC2**

"If we are free, you can have a talk because there will always be someone available to talk because there's either me or the pharmacist or the other members of staff who can take the query down ... " **HT7**

Interviewee: *"For smoking cessation we have an appointment system ... If a patient can't come back we will see the patient then, we won't just turn round and say you have to come back for your appointment, we will do it. On the smoking cessation scheme you have to be accredited to do it, so we've got four or five people here accredited, so someone will always be able to see the patient.* **Interviewer:** *What happens if a member of staff that provides the service is busy or isn't here?* **Interviewee:** *There's three pharmacists who can do it so depending which pharmacist is in on that day, my boss is also smoking accredited and I am, so someone will always be here who is free."* **HT6**

3.3.15 CHALLENGES TO SERVICE DELIVERY

3.3.15.1 Cultural sensitivities/religious factors

HTC8 highlighted a minimal uptake of the SC service owing to religious and/or cultural factors.

> " ... we haven't got that many people who come for the smoking [smoking cessation programme] ... like I said, we have got a lot of Muslims in the area. I think the smoking in the area has been cut by quite a lot because Muslim ladies don't really smoke that much- I'm not saying that none of them do." **HTC8**

HT6 reflected that elderly patients considered male pharmacists to be more experienced and an authoritative figure in comparison to female pharmacists or younger members of the pharmacy team. Consequently, elderly patients were reticent about consulting with younger members of the pharmacy team on health issues and were more inclined to request a consultation with a male pharmacist. On such occasions, when possible, staff would endeavour to accommodate patients' requests or they would be asked to come back at another time.

> " ... Sometimes, especially our elderly patients, they like to speak to a male, older male, like we'll tell them and they'll want confirmation from the boss, sometimes when we have a female pharmacist, they like to speak to a guy, the man gives them more authority or something. Generally it's ok but sometimes you get patients who specifically say 'you look too young or too little' or 'can I speak to the pharmacist' ... if they want to speak to a male, my boss, he's in the office, if not, we do have male members of staff, so they'll speak to them. Failing that they'll speak to whoever or like if someone wanted to speak to a male pharmacist today, I've got a male pharmacist who is in tomorrow so I would have to tell them to come back tomorrow if my boss wasn't here." **HT6**

However, for the EHC and EPT services, patients' preferred to consult with a female pharmacist.

> **Interviewer:** "Do you ever get people asking for a female? **Interviewee:** Yes especially for EHC and pregnancy testing, a lot of patients want to speak to a female ... " **HT6**

3.3.15.2 Language barriers

The majority of interviewees stated being multi-lingual and or being supported by other members of the team conversant in a range of languages. The breadth of languages spoken within local communities caused pronounced communication difficulties in certain circumstances:

> "Myself, I can speak Mirpuri and Urdu and Punjabi so I'm quite valuable like that. Our pharmacist is only English but we've got a pre-reg student who is Bengali, so we're quite alright like that." **HTC4**

> "We speak Punjabi, Urdu, English, we've got a man who speaks Arabic, Farsi, Bengali, Mirpuri. We've got quite a range." **HTC2**

> "I speak a bit of Urdu but mainly I speak English, I can work around my Urdu and make them understand about the medicines they use and the health conditions and stuff." **HTC10**

> "We have staff speaking all the different languages, the Somalian girl who works here is only part time and our community is a Somalian community, so when people come in, we find that with some people, you couldn't understand them. It's really hard to communicate with them, they don't know a single word of English, so what I have to do is go out onto the street and find somebody and they have to translate for us, that's the best that we can do." **HT9**

> " ... To be honest with you, the way that people come across [referring to health professionals' communication skills] is quite confusing for a lot of people who don't

*understand English and people who don't understand big words and stuff like that. They don't even know what half the stuff means so that's what I think. For example, they don't know what the morning after is ... it's confusing for the people who don't understand what things mean. It's like you going to the optician or the dentist and they're in there talking about things, you have no idea of what is going on but people who work there know exactly what is being talked about. It's the same when you're explaining things to patients, speak to them on their level so they understand and they feel more comfortable talking to you. If you speak to them and you say you're a HT and you're someone big or a pharmacist or a doctor and you start speaking posh and fancy words, they won't have a clue what you're talking about and they will walk out." **HT7***

3.3.15.3 Familiarity with pharmacy staff

A further possible obstacle to service uptake, which was highlighted by two interviewees, was the familiarity that potential service users had with pharmacy staff. It was suggested that this had the potential to cause embarrassment and precluded uptake of certain services:

[Regarding] *"Weight Management, I think a lot of people don't want to come in and start talking about their weight to people they see every day. It's like when you go to the doctor's, you can go in and it's between you and the doctor. Whereas if they come here, it's still between you and the HT but it's like when you see them, (the doctors they live in the posh areas you don't really see them), so if you see normal people like us who walk around after lunchtime and you probably see them and then it's like, I don't know if this is even true but it's like embarrassing for them to look at someone outside of the place, especially if you see them in a takeaway or something and they're doing Weight Management they're stuck."* **HT7**

"I think it's the community we live in ... if somebody from this area wanted a chlamydia test they wouldn't come to the local pharmacy because we would know that they are from here and they would get embarrassed that we know them. I think they would go to a far pharmacy to get that service." **HT9**

3.3.15.4 Difficulty with balancing dual roles (i.e. health service and pharmaceutical-related roles) during peak periods

A number of interviewees highlighted tension between their involvement in HT/HTC-related activity and their more traditional, pharmaceutical-related focus. Given the workload of those interviewees, it was common for the pharmaceutical-related activities to be given primacy over the health-service related activities:

"The amount of work you have to do, because HT is like a part time, like on the side, whereas you've got your daily job routine which is prescriptions and serving customers and bringing in business but this [HT role] on the other hand is just like part-time. If someone comes in and I have to do this [provide HT service] but then when I finish here I have to go back to the work that I have to do but obviously that's the only downfall." **HT7**

"My original job [pharmaceutical-related] *that is what I mainly do. If somebody is waiting for their medicine or prescription when the pharmacist is getting it ready, I will probably have a word with them and say 'are you interested, what do you think about your health'. I will explain my job role ... "* **HT9**

The pressure to prioritise pharmaceutical-related activities was deeply frustrating for HTC3, who felt unable to fulfil his/her HTC role satisfactorily due to the constant interruptions, whilst in consultation with a patient and felt pressurised (by the pharmacist) into completing consultations

quickly. Consequently, this gave rise to both personal and professional conflict within the HTC, who questioned why s/he had been asked to undertake the health-service related role.

> *"Actually patient advice suffers sometimes because sometimes I'm sat in the consultation room and the door is constantly being knocked to say you need to get out of there. I don't really like that at all because it takes time to talk to a patient and we're not given this time at all but on the other hand they say we need to provide these services but the time is just not there ... I feel I am a counter assistant, I am not a dispenser but I feel that I am pulled into there, there is still a requirement for myself to have to sort out prescriptions ... I'm being drawn away from everything [and] into the dispensary [therefore], not being able to provide these services- I don't think there's the time at all." **HTC3***

3.3.15.5   Time to fulfil HT/HTC responsibilities

HTC1 and **HTC3** both spoke of the lack of time to fulfil their health-service related duties due to the need to prioritise the primary pharmaceutical-related role. HTC3 recommended increasing staffing levels to enable provision of a good standard of service.

> *"If we had more time we would target every single customer that comes in but it's hard to do that, in a day we would maybe give advice to five or six patients." **HTC1***

> *"The barriers are time, you know when they say that pharmacies are not all about prescriptions, I personally feel that when it comes to providing a service, the assistants are not given the time that they require and I think that is a big barrier within itself. I've mentioned to you about patients asking if we do diabetes, 'do you do blood pressure', I would personally like to provide these services but I don't think that we would have the availability of time because I don't think we've got sufficient staff, our pharmacy concentrates more so on prescription side ... I think he* [the pharmacist] *needs to take on more staff and there's the staff that work strictly in the dispensary and deal with that side and then there should be the staff who are able to be at the forefront, give the customers the best service we possibly can for their requirements." **HTC3***

However, interviewees that did not find the dual aspect of their job role challenging were either/or;

- Able to exercise control over how they managed their time i.e. diarise tasks on a daily basis and prioritise them in order of importance (based on in-depth understanding of the requirements of both the pharmacy and health-service related roles).
- Supported by other members of the team.
- able to refer patients' health-service related enquires to another member of the team.
- Responsible for the delivery of either the WM or SC programmes which were delivered on an appointment basis and as such enabled effective management of time.

> *"Well we have a patient who comes in and I can't fit them in, let's say I'm overloaded with work that day, either I will refer them onto the pharmacist or I book an appointment and tell them to come in later." **HT6***

> *" ... we have a diary of what needs to be done and then you work out what needs to be done. I've been working here for a while so you know what are the important things and what are not so important and the things that could be done the next day if needs be but to be honest with you, we're here for eight/nine hours a day and there's a lot of drugs." **HT7***

> *" ... dispensing it is myself and another member of staff as well and we've got the pre-reg student, so I get help on that side as well but the weight loss programme is all appointment*

based, so I know when I have an appointment, so I have to free myself for that time so we've just really managed it so far." HTC4

3.3.16 FACILITATORS TO HEALTH SERVICE UPTAKE

This section outlines interviewees views on why patients choose to access health services/treatments and/or advice via pharmacies.

3.3.16.1   Convenient access to health services/treatments and advice

Interviewees believed that the extended opening hours (in comparison to GP surgery opening hours) facilitated convenient access to an alternative source of credible health advice and a broad range of health services, especially MAS. Consequently, convenience was considered to be the principal reason for patients' inclination to access a health service via a pharmacy and especially useful to individuals unable to take time off work to attend GP appointments.

> *"I think with the GP you have to make an appointment, with the pharmacy they can pop in at any time so I think that's the reason. It's more convenient … " HT9*

> *"For minor things really like headaches, coughs, something that they can actually purchase over the counter instead of waiting for a doctor's appointment." HTC1*

> *"The people who work, it's a big benefit for them because most of them buy medication over the counter. They're the people who usually work, they're the ones who are always on the go, they have no time to go to the doctor and sit there and have a discussion. It's like they are always running around doing things … If you've go to the doctor they'll say the appointment is at this time, you haven't got the freedom of choosing." HT7*

> *"Because they've got someone else to speak to other than a doctor whereas the doctor, if you're ill you have to get up a certain time and ring and try and get an appointment before fifty other people and it's like a race, to be the first one to get through and get an appointment, whereas if you're poorly and you're working you don't finish until five, six, seven and by then you can't book an appointment, you can't see a doctor. So if they can just see the HLP pharmacy … you've got that comfort of having someone there who knows what they're talking about and they won't give you a rubbish answer or you can just purchase something until you can actually see a doctor or you might not even have to, it depends on what the problem is." HT7*

> *"They're [HLPs] probably better for our community because you get more access to them, with the doctor's surgery they are only open certain hours and the doctor is not always there, whereas we're open 9-7 six days six days a week. So I think it's better for the patients, it's more access, they can speak to the pharmacist, they can speak to myself, they can speak to the other HT that we've got … " HT6*

3.3.16.2   Trusting relationships

A number of interviewees commented on their HLP benefitting from a regular client base, which over a period of time had enabled development of trusting relationships between the pharmacist and regular patients. Trust was considered to be pivotal in patients' feeling at ease to consult with the pharmacist and in some cases, to corroborate GPs' diagnosis.

> *"I think it's more of the relationship that they build with the pharmacy, they see us day in and day out as they are coming in and it's probably easier for them to approach us … They'll go to the doctor and they'll come here, often they'll say to the pharmacist, because of the relationship they have with him, often they will say 'you know he [GP] said this to me and I'm*

not sure' and the pharmacist will be there for fifteen/twenty minutes reassuring them what the doctor has said because they have that trust in him ... " **HTC4**

"A lot of them, ... they've just come in and ask the pharmacist for his advice to see what he recommends. They're very trust worthy with the pharmacist so if the pharmacist has asked them to do this or change their diet plan they are willing to have a go." **HTC1**

"I think it's because it's local [the HLP]*, especially around this area, as you can see there's quite a lot of pharmacies, it's local and they trust us like we've had a lot of customers more than thirty years so obviously the trust has been on the pharmacist for a very long time. So they just come for advice, it's like a walk-in, you need no appointments so it's easy to come and ask for advice."* **HTC10**

3.3.17 PATIENTS' UNDERSTANDING OF 'HLP' AND 'HT' TERMINOLOGY

There was general agreement that understanding of the term 'HLP' at a local level was considered to be very poor. This was attributed to low levels literacy in English resulting in each word within the term being interpreted separately. Consequently, the meaning of the term 'Healthy Living Pharmacy' was misinterpreted as, the pharmacy team living healthily.

"They think we've become healthy living so they don't really understand, because a lot of people round here don't speak English and they don't understand English. You have to explain what HLP means. What they look at, is each single word so 'healthy' then 'living' then 'pharmacy' but they don't put it altogether, so you have to explain and say 'we help you in your general life' and then that's when they get happy and think 'oh ok, I need this, can you do this for me ... " **HT7**

The term 'Health Trainer' was also misinterpreted as being synonymous to the role of a fitness instructor.

" ... A lot of them, you know when we were doing the HT thing and they were like HT so you're going to give me gym advice, so that kind of Health Trainer! Not like healthy lifestyle advice trainer. I think 'HT' seems to bring this gym thing and it's quite funny ... " **HT6**

3.3.18 LEVEL OF LOCAL AWARENESS OF THE HLP CONCEPT AND HEALTH SERVICES PROVIDED

There was general agreement that awareness of the HLP concept amongst the local population was low.

"Since we've been accredited ... we've not had anyone walk in and notice that we are an HLP. Nobody has come in and questioned or noticed this. I personally haven't had anyone come in and pick up on this [HLP status] *... "* **HTC3**

" ... People aren't aware of it [HLP concept]*, nobody comes in here and says you're one of those Healthy Living Pharmacies, people don't know about it."* **HTC8**

"There are a lot of people who are unsure about it [HLP concept] *at the moment, they still don't know that we run this scheme but we advertise as much as we can when they come in ... "* **HTC1**

"Well they [people who walk into the pharmacy] *wouldn't know anything* [about the HLP concept] *until I explained it to them."* **HTC5**

However, **HTC4** and **HTC2** were both of the view that proactive promotion of the HLP had improved awareness of the HLP concept and generated patient enquiries regarding healthy living lifestyles. This view was also shared by a number of interviewees, who stated having noticed an increase in the number of patients enquiring about health services being offered, following HLP accreditation.

"Since we've been advertising HLP, we have got a lot of people come through here to ask for our advice and ask for information on healthy living and how we can help them or if we can't we signpost them." **HTC2**

"I think they're getting more aware of it now because we are promoting it, but before, they weren't that aware of it, because for us we were running most of the services before and now we've just got that title and it's something extra to work on and hopefully go on and do more services so they do understand ... so it's just really we've been promoting it so they are more aware of it now." **HTC4**

"More busy and people actually coming for advice; if they pass and see the HLP kite mark they will actually come in and ask." **HTC10**

"The things that have changed are that we do get a lot more people coming in asking for more so instead of your regular patients you get a few other people coming in saying we want to do this or that so you've got to go out and talk to more people than you used to ... " **HT7**

Furthermore, some interviewees highlighted the role of the GP in aiding local awareness of the health services available via pharmacies, through patient referral.

"Yes, we do a lot of the weight management - the doctor's recommending now, so we will get patients coming from doctors' surgeries." **HTC10**

"I think the GPs, they do help us out. The surgery from across the road they refer to us, if someone has phoned in for a cough or something minor and the receptionist normally does say to them 'you can have an appointment for this day but you know across the road they run the minor ailment scheme' so they've also recommended us because of the relationship we have with them and I've noticed even with the pregnancy testing, other local surgeries do refer their patients to us for the pregnancy test so that helps as well." **HTC4**

3.3.19 PROMOTIONAL ACTIVITIES UNDERTAKEN TO RAISE AWARENESS OF THE HLP CONCEPT

HLP-led promotional activities to raise awareness of the HLP concept were undertaken by most interviewees, and generally included interviewees talking to clients to inform them about the HLP concept.

"When they walk into the pharmacy ... the staff that are in the pharmacy tell patients or customers about what is an HLP and what services we provide and how it benefits them. Every pharmacy is trying to do that at the moment. It's trying to advertise and making people aware that they can get stuff without going to the GP and making people aware of the help." **HTC2**

"Basically we bring it into the conversation because when we're running the services, we'll say to them 'we're an HLP now' so then they're more aware of it - just by telling them really." **HTC4**

Promotional materials such as posters, HLP leaflets, HLP banner etc. were also used to improve awareness of the HLP concept. Some interviewees reported having informed local GPs of the accreditation of the pharmacy as an HLP and one interviewee suggested that a mobile phone app had played a role in promoting HLP:

"We are planning on getting some posters up and we've got an HLP signboard up there before we never had that, so when people see that they ask what it is about so you tell them all about that." **HT9**

"Yes we have, we have been to a couple of surgeries and given out letters as well to our nearby surgeries that these are the services that we are providing if anyone is interested." **HTC10**

"We're on the map more, I'm not sure how it works but someone phones them and then they get a message or a text saying 'this is your nearest pharmacy' so you can go there, more people are coming in, they are more aware of. I think we've been promoted more since that." **HTC4**

3.3.20 PROMOTIONAL ACTIVITIES UNDERTAKEN TO RAISE AWARENESS OF THE HEALTH SERVICES OFFERED BY HLPS

Proactive promotion of health services was undertaken by all interviewees. The promotional materials used included posters (listing services being provided) displayed in the pharmacy window, leaflets and generating word of mouth.

"We've got quite a few of these [leaflets] and we put them in people's bags." **HT7**

"We advertise, we've got leaflets ... " **HTC2**

"Word of mouth, letting patients know when they come in if they question 'do you provide this service', we've got posters in the window saying what services we are providing, it does clearly state in the window what services we are providing, so anybody who notices that comes in and we take it from there." **HTC3**

Targeted promotion of health services and proactive recruitment of patients into services was commonplace through the provision of opportunistic health advice based on various prompts or as a result of identifying health needs during interactions with patients.

"You've got to be careful not to offend anyone but you mostly go off a question that they've asked and that's how you start the conversation and by their medication they normally do mention something and then you go on from their question and then you offer them the service that is available ... We also talk to our customers, even by having a normal conversation, they'll mention something, maybe about quitting and we'll say we run a Stop Smoking clinic ... " **HTC4**

3.3.21 PROMPTS WHICH INSTIGATED PROACTIVE PROMOTION OF HEALTH SERVICES

- General observation

"I remember once somebody came in and I was talking to them and I could smell that they smoke, so I was talking to them about the stop smoking services that we do ... Now he's on the smoking cessation programme, which is really good." **HT9**

- Awareness of presenting health issues

"When prescriptions come in, we look through the prescriptions like the asthmatics, we'll ask them if they smoke or not or if they know how to use the inhaler because some of the patients do not know how to use inhaler, then we'll refer them to the pharmacist and then the pharmacist himself will take them to a consulting room and talk them through how to use the inhaler ... In a general we would just ask, we would say these are the services we provide, if you are interested, if anyone else is interested then you can come in, book an appointment to see myself." **HTC10**

- Medicines listed on prescriptions or over the counter purchases

*"Like for example if they are asthmatic and they've got a prescription for an inhaler and they've also wanted to purchase something over the counter for a chesty cough but more of a smokers cough we would advise them 'would you like to try the stop smoking scheme or the reducing scheme' and see if they want to join that because someone here is always trained to do the paperwork, to give them advice, even if they don't want to join we do still give them advice and they can go back and think about it and they always come back. We get loads of patients bringing their scripts in for like heart medication, blood pressure, diabetes, overweight, whilst they're waiting for medication, we give them leaflets to read through, if they're unsure about anything then we can translate to them or give them advice ... " **HTC1***

- New medication prompted the New Medication Service or Medicines Use Reviews

*Also when they come in we do MURs and NMS so whenever the pharmacist comes in and they are on new medication or they go through a medication, he can always say to them' you need to do this or that and this is what we offer' and stuff like that." **HT7***

3.3.22 VALUE PLACED ON THE HEALTH SERVICES PROVIDED BY HLPs

This section provides an understanding of interviewees' perceptions of the value placed by patients, health professionals and the PCT on the health services provided by HLPs.

3.3.22.1   Patients

Some interviewees were of the view that patients were appreciative of the health advice provided by HLP staff and welcomed being made aware of the range of services on offer.

*"It's a positive response because everyone round here is friendly and caring so they would take your advice. Because they're not too aware of all the schemes that are running they would be happy to hear that we provide it and they don't have to see the doctor for it." **HTC1***

*"We see a lot of patients coming in and they want to know a bit more about healthy living and about other things that we can provide for them and it is helping. Even with the healthy living, it is helping with our other services like smoking and it's helping with our healthy life scheme, so healthy living is a good point ... " **HTC2***

HT6 and HTC2 also viewed repeat custom as an indication of customer satisfaction and value of the services provided by HLPs*.*

*"Yes because they're the ones who are using us so it's like the better service you provide they will come back to you, whether it be with prescriptions or they're using your other services, you're doing it for them." **HT6***

*"Yes they do, our patients are really good and they are really happy with our services- that is why they come back ... " **HTC2***

3.3.22.2   Health professionals

Referral of patients for pregnancy, blood pressure and diabetes tests was considered to be an indication of the value placed by local GPs on the services provided by HLPs. There was uncertainty as to whether this was a reflection of the value placed on the concept by GPs themselves or the value placed on HLPs by the staff of the practice more generally:

*"Our local GP, any pregnancy test he will send them to here to do the pregnancy test and blood pressure and glucose testing." **HT9***

"Definitely by the receptionists and stuff, I don't know with doctors and stuff because I don't really speak to them but with the receptionists definitely yes." **HT6**

3.3.23 RECOMMENDATIONS

3.3.23.1 Further training required to enable service improvement

Two interviewees stated a desire for additional or refresher training to enhance their knowledge on health services to facilitate improvements to service delivery.

"The health training is just like one thing, you should have a day where you can just go back in and they refresh your thoughts and things like that and then if there's any more that can be added they can add things in." **HTC10**

"More training to train yourself more that would help to get more information, be able to deliver better advice to the customers." **HTC4**

3.3.23.2 Further training required to enable provision of blood pressure and diabetes tests

A number of interviewees highlighted that both blood pressure and diabetes tests were often requested by patients. It was believed that this was a reflection of the high burden of cardiovascular disease and diabetes in the local community. Interviewees highlighted the need for additional training to enable delivery of these services.

Interviewee: "Probably a bit more training. Interviewer: What specifically on? Interviewee: The diabetes stuff that we don't do, the blood pressure that we kind of do but not officially, these services that we do, we already get quite a lot of training for those. It's the services that might come in the future, definitely we'll need training for those, more so because we don't know, like I wouldn't know how to do a diabetes check or anything like that and even if I did, I wouldn't know what the results mean, like blood pressure test, to check the results, then we refer them to the pharmacist. I don't know what is normal blood pressure, that kind of stuff." **HT6**

Blood pressure because I get a lot of patients coming in and asking if we take blood pressure in here and the other one is diabetes checking, so I think if we were able to provide those services as well it would benefit the community that we are working in because there are a lot of people that are diabetic and a lot of people that are on blood pressure medication, definitely two aspects that are worth looking into as well for us to be able to provide those services. Obviously we would have to be trained up and I think, I don't know if training costs money or if there is anybody available to give us that training, I have mentioned a couple of times to the pharmacist that it would be nice if we could provide these additional services as well but nothing is ever done about it so I don't know really. If somebody was able to provide us this training we've already got the place, the consultation room then we could provide these services with no problems. I'm always for doing anything that would benefit the patient but unfortunately we don't have the training, we can only do what we've been trained up to do really." **HTC3**

" ... We need more practical stuff, like I said before with the glucose one was practical, we could see how to do it properly, some of the other PCT training (after work, we work 9-7) we went to, we just talked about it. You don't take much information in, some of them weren't that helpful but if you do something practically, it sticks in your head." **HT9**

3.3.23.3 Improve the HTC course

A number of interviewees suggested that the HTC course could be improved by the inclusion of content on the topics listed below:

- Asthma techniques
- Skin conditions; it was believed that information on different skin conditions would enable pharmacy staff to better understand the needs of the many patients presenting with skin conditions, thereby enabling pharmacy staff to make knowledge-based recommendations.
- Obesity; this was considered to be a prevailing health issue within the local community and that training would have been pertinent given that it is a sensitive issue for patients.

3.3.23.4　Improve awareness of HLPs

Two interviewees suggested that it was necessary for more pharmacies to become HLPs in order for the idea to become embedded in the public consciousness**:**

> *"To be honest I think it's a good idea and if more pharmacies were to become it* [HLP] *then I think more people would know about it* [HLP] *because you've got a few pharmacies, one here and one on that side and one there so you've got odd pharmacies and not everyone uses them ... If I didn't work here I wouldn't have a clue what an HLP is." **HT7***

> *"I think you need to advertise it [HLPs] a bit more and make people more aware that the service is here. Like an open day sort of thing, like a counter, something more eye catching, leaflets, a coffee morning, let them drop in." **HTC8***

Chapter 4 STAGE C – THE VIEWS OF THE SERVICE USERS

4.1 METHODOLOGY

The service user questionnaire (see Appendix 5) was developed by the Aston research team to gain an understanding of service user experience of one of four health services (being reviewed i.e. SC, MAS, EHC and EPT) accessed via an HLP. A draft questionnaire was reviewed by the Steering Group, and following amendment, piloted amongst pharmacists from the Aston University Pharmacy Practice staff (who were not directly involved in the project).

The final version of the questionnaire (see Appendix 5) was deployed electronically via the touch-screen health-kiosks located in the ten HLPs included in the study. In addition to patients being signposted to the questionnaire by pharmacy staff, a poster was also displayed within each HLP highlighting the questionnaire and study (see Appendix 6).

At the time of the study, the kiosks were owned by the Cluster; however, responsibility for the maintenance and management of the kiosks, including the online content (i.e. health-related information), was undertaken by *Health Exchange*[h] *CIC,* a social enterprise.

The Aston research team worked in close collaboration with Health Exchange to develop an effective method of deploying the questionnaire via the kiosks, whilst maintaining data security and confidentiality. The deployment plan entailed development of:

1. Ten unique URLs (web-addresses) for the ten HLPs.
   o Ten distinct URLs were required to ensure that the questionnaire was *only* accessible via kiosks located in HLPs and *not* via kiosks located in non-HLPs.
2. A distinctive touch-button on the display screen which, when clicked, navigated the service-user directly to the questionnaire (ease of access to the questionnaire was considered important in encouraging participation).
3. Data security measures to safeguard respondent data. This was achieved by firstly hosting the questionnaire on a secure Aston University server i.e. the electronic questionnaire files were saved in a secure folder on an Aston University server. The URL (link) to the folder containing the questionnaire files was then forwarded to Health Exchange for upload onto the touch screen system of the kiosks located in the ten HLPs included in the study.
   o This method of deployment ensured electronic transmission of encrypted data (from each completed questionnaire), directly to a member of the Aston research team, via an email.
   o The encrypted respondent data contained within the email was decrypted upon importing the email into the SNAP Surveys[i] software.

Following the initial deployment of the questionnaire, two members of the Aston Research team, visited all HLPs to check if the questionnaire had been deployed successfully and to demonstrate the questionnaire to pharmacy staff. Technical issues related to the kiosks were evident and the questionnaire was not initially available for access at all the ten HLPs. The issues were resolved by Health Exchange and the questionnaire was subsequently launched on 15th August 2012 and closed on 15th February 2013. Kiosk malfunctions were reported intermittently by a small number of pharmacists throughout the duration but any problems were swiftly rectified and did not significantly impinge on data collection.

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[h] Further information on Health Exchange CIC can be accessed via http://www.healthexchange.org.uk/about/.
[i] See http://www.snapsurveys.com/.

All HLPs were kept informed (via weekly emails) of the number of questionnaires submitted per HLP for each of the four health services (SC, MAS, EHC, EPT).

Note: The launch of the Aston HLP Study touch screen Service-User questionnaire coincided with the Royal Pharmaceutical Society's paper-based questionnaire, which was prioritised by HLP pharmacists at the request of the Cluster.[j]

4.2 RESULTS

Descriptive statistics are presented for all returns received from the participating HLPs. A number of bivariate analyses were undertaken to determine whether there were associations between variables. Data were categorical in nature and where p-values are stated, they are a result of a chi-squared test of association.

4.2.1 NUMBER OF RETURNS

In total, 445 service-users completed questionnaires via the touchscreen kiosk (aided, if appropriate, by a member of the pharmacy team). The returns received by the research team, split by individual pharmacy are as follows (see Table 28).

Table 28: Questionnaire returns by pharmacy

PHARMACY[k]	NUMBER OF RETURNS (PERCENTAGE OF TOTAL RETURNS)
Pharmacy A	40 (9.0%)
Pharmacy B	17 (3.8%)
Pharmacy C	19 (4.3%)
Pharmacy D	36 (8.1%)
Pharmacy E	27 (6.1%)
Pharmacy F	5 (1.1%)
Pharmacy G	78 (17.5%)
Pharmacy H	151 (33.9%)
Pharmacy I	17 (3.8%)
Pharmacy J	55 (12.4%)
TOTAL	445 (100.0%)

Of the total number of respondents, 85.8% of questionnaire respondents (n=364/424) indicated that the HLP at which the questionnaire was completed was their regular pharmacy, with 14.2% (n=60/424) indicating that it wasn't. A total number of n=21 respondents did not answer this question.

4.2.2 NHS HEALTH SERVICE – CURRENT AND PAST ACCESS

All respondents were then asked which of the four NHS health services within the study they had used at the pharmacy. Patients were only signposted to the study on the touchscreen kiosk if they had accessed one of the four services within the study; however, it was possible for respondents to complete the questionnaire without staff referral and therefore a proportion of respondents will not have accessed one of the four services in the study.

This split between the four services is detailed in Table 29. By far the greatest number of respondents (41.3%; n=184/445) had accessed the pharmacy for the minor ailments service. Respondents answering "other" to this question were removed from the remainder of the data collection (n=68), leaving a remaining study total of n=377).

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[j] The Aston University service-user questionnaire started on 15th August 2012 and completed on 15th February 2013.
[k] The pharmacies have been randomly assigned a letter to preserve anonymity.

Table 29: Frequency of use of the different NHS health services

NHS HEALTH SERVICE	PERCENTAGE (n=445)
Minor Ailments	41.3% (n=184)
Early Pregnancy Testing	18.9% (n=84)
Stop Smoking	17.3% (n=77)
Other	15.3% (n=68)
Emergency Hormonal Contraception	7.2% (n=32)

Cross-tabulation of these data with responses to the question as to whether this pharmacy was their regular pharmacy did not show any statistically significant differences (Chi, n=424, p=0.136)[I].

The remaining respondents (n=377) were asked if this was the first time they had used the service that they had indicated in the previous question. Just over one third (37.8%, n=128/339) indicated it was with the remainder (62.2%, n=211) indicating it wasn't. A total of n=38 individuals didn't answer this question. Cross-tabulation of these data with responses to the question as to whether this pharmacy was their regular pharmacy indicated statistically significant differences with respondents answering from their regular pharmacy more likely to have used the service before (see Table 30) (p=0.002).

Table 30: Results of the cross-tabulation between whether a respondent had used a particular NHS service before and whether they were responding from their regular pharmacy

IS THIS YOUR REGULAR PHARMACY? (n=326)	IS THIS THE FIRST TIME YOU HAVE USED ONE OF THESE NHS SERVICES?	
	Yes (n=120)	No (n=206)
Yes (n=280)	33.2% (n=93)	66.8% (n=187)
No (n=46)	58.7% (n=27)	41.3% (n=19)

Further cross-tabulation with the responses related to the NHS health service accessed also indicated statistically significant differences (see Table 31) (p=0.001), with Minor Ailments service users much more likely to be repeat services users, followed by Stop smoking, Emergency Hormonal Contraception and finally Early Pregnancy Testing service users (see Table 31).

Table 31: Results of the cross-tabulation between whether a respondent had used a particular NHS service before and the type of service accessed

TYPE OF SERVICE (n=339)	IS THIS THE FIRST TIME YOU HAVE USED ONE OF THESE NHS SERVICES?	
	Yes (n=128)	No (n=211)
Minor ailments (n=161)	27.3% (n=44)	72.7% (n=117)
Stop Smoking (n=70)	40.0% (n=28)	60.0% (n=42)
Emergency Hormonal Contraception (n=30)	46.7% (n=14)	53.3% (n=16)
Early Pregnancy Testing (n=78)	53.8% (n=42)	46.2% (n=36)

Respondents who indicated that this wasn't their first time of accessing one of these NHS health services (n=211) (or didn't provide an answer to that question, n=38) were asked how long ago they last accessed one (n=249). The results are detailed in Table 32 (n=7 individuals didn't answer this question).

[I] One cell indicated an expected frequency of less than 5. With the removal of all responses relating to "Emergency Hormonal Contraception" (n=31), the results of the cross-tabulation remained statistically insignificant (Chi, n=393, p=0.093).

Table 32: Time since repeat users last accessed any of the NHS health services

TIME OF LAST ACCESS	PERCENTAGE (n=242)
Last week	18.6% (n=45)
1-4 weeks ago	28.9% (n=70)
1-3 months ago	26.9% (n=65)
3-6 months ago	11.6% (n=28)
More than 6 months ago	7.4% (n=18)
Can't remember	6.6% (n=16)

4.2.3 PHARMACY STAFF

Respondents (n=377) were asked which staff member they spoke to during their current visit. The results split as follows (see Table 33). A total of n=10 individuals didn't answer this question.

Table 33: Summary of the staff the respondents spoke to during their current visit

STAFF MEMBER	PERCENTAGE (n=367)
Pharmacist	51.2% (n=188)
Other staff	28.1% (n=103)
Health Trainer	9.5% (n=35)
Health Trainer Champion	6.3% (n=23)
Not sure	4.9% (n=18)

Respondents (n=377) were then asked who they would most have liked to have spoken to during their current visit. The results showed that a majority of respondents (49.2%; n=175/356) didn't mind, and where respondents did have a preference, the pharmacists was the overwhelming choice (43.0%; n=153/356). The full results split as follows (see Table 34). A total of n=21 respondents didn't answer this question.

Table 34: Summary of the staff member the respondents would most like to have seen during their current visit

STAFF MEMBER	PERCENTAGE (n=356)
I don't mind	49.2% (n=175)
Pharmacist	43.0% (n=153)
Health Trainer	5.6% (n=20)
Health Trainer Champion	2.2% (n=8)

Respondents were then asked a series of questions about the staff member who provided advice on their current visit. Results are detailed in Table 35. A total number of n=9, n=20 and n=24 respondents respectively didn't answer these questions.

Table 35: Respondents' responses to a series of statements relating to the staff member who provided advice on their current visit

	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
The person I spoke to today, had enough time to deal with my enquiry (n=368).	71.2% (n=262)	26.9% (n=99)	1.1% (n=4)	0.5% (n=2)	0.3% (n=1)
I felt comfortable talking about my health with the person I spoke to today (n=357).	65.5% (n=234)	31.9% (n=114)	1.7% (n=6)	0.6% (n=2)	0.3% (n=1)
I would like to be seen by the same person every time (n=353).	56.1% (n=198)	26.9% (n=95)	15.3% (n=54)	1.4% (n=5)	0.3% (n=1)

Overall, respondents either Strongly Agreed or Agreed with all statements, indicating that they were generally satisfied with the staff member they saw during their visit and would want to deal with the same staff member again.

4.2.4 THE HEALTH ADVICE

Respondents were then asked a series of questions about the health advice they received on their current visit. Results are detailed in Table 36. A total of n=16, n=25 and n=30 respondents respectively didn't answer these questions. As with responses to the questions about the staff member the respondents saw, respondents were also happy with the advice provided during their visit with a majority of respondents who either Strongly Agreed or Agreed that the advice was easy to understand, that they trusted the advice and that they were satisfied with the advice provided.

Table 36: Respondents' responses to a series of statements relating to the health advice they received on their current visit

	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
The health advice I was given was easy to understand (n=361).	70.1% (n=253)	28.3% (n=102)	1.4% (n=5)	0.0% (n=0)	0.3% (n=1)
I trust the health advice given to me (n=352).	69.0% (n=243)	28.1% (n=99)	2.3% (n=8)	0.3% (n=1)	0.3% (n=1)
I am satisfied with the health advice provided (n=347).	68.0% (n=236)	29.7% (n=103)	2.0% (n=7)	0.0% (n=0)	0.3% (n=1)

Respondents were then asked a further series of questions regarding the health advice they accessed at the pharmacy during their current visit. Results are detailed in Table 37. A total of n=11, n=23, n=20 and n=21 respondents respectively didn't answer these questions.

Table 37: Respondents' responses to a further series of statements relating to the health advice they received on their current visit

	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
I preferred to go to a pharmacy to get health advice rather than going to my GP (doctor) (n=366).	56.6% (n=207)	30.1% (n=110)	10.7% (n=39)	2.5% (n=9)	0.3% (n=1)
Pharmacy opening times are more convenient than GP (doctor) opening times (n=354).	63.8% (n=226)	33.3% (n=118)	2.3% (n=8)	0.3% (n=1)	0.3% (n=1)
Getting health advice at {this pharmacy} when I need it, has helped me to take better care of myself (n=357).	58.0% (n=207)	37.8% (n=135)	3.9% (n=14)	0.0% (n=0)	0.3% (n=1)
I would recommend the NHS health service I have used at {this pharmacy} to friends or family (n=356).	68.5% (n=244)	30.1% (n=107)	1.1% (n=4)	0.0% (n=0)	0.3% (n=1)

With responses to these questions, as with others, a majority of respondents either Strongly Agreed or Agreed that they preferred to go to the pharmacy than their GP for health advice and that the opening times were more convenient than the opening times of their GP surgery. In addition, a majority of respondents either Strongly Agreed or Agreed that the advice helped them take better care of themselves and that they would recommend the health service they accessed to friends or family.

4.2.5 LOCATION OF CONSULTATION

Respondents were asked if the consultation which formed part of their last visit took place in a private room. Nearly three-quarters of respondents (70.2%, n=214/305) stated it did, with 29.8%

(n=91) stating it did not (72 respondents didn't answer this question). Cross-tabulation of these data with whether the respondent was in their regular pharmacy did not show any statistically significant difference (p=0.276). However, further cross-tabulation with the health services accessed did show a statistically significant difference (see Table 38; p=<0.0001), with over three-quarters of consultations for all services except Minor Ailments taking place in a private room.

Table 38: Results of the cross-tabulation between whether a respondent's consultation took place in a private room and the type of service used

TYPE OF SERVICE (n=305)	DID THE CONSULTATION TAKE PLACE IN A PRIVATE ROOM?	
	Yes (n=214)	No (n=91)
Stop Smoking (n=64)	95.3% (n=61)	4.7% (n=3)
Early Pregnancy Testing (71)	88.7% (n=63)	11.3% (n=8)
Emergency Hormonal Contraception (n=21)	76.2% (n=16)	23.8% (n=5)
Minor Ailments (n=149)	49.7% (n=74)	50.3% (n=75)

Further cross-tabulation with whether this was the first time the respondent had accessed one of these NHS services also showed a statistically significant difference (see Table 39; p=0.013) with respondents more likely to be taken into a private room if this was the first time they had accessed a particular service.

Table 39: Results of the cross-tabulation between whether a respondent's consultation took place in a private room and whether this was the first time the respondent had accessed one of these NHS services

IS THIS THE FIRST TIME YOU HAVE USED ONE OF THESE NHS SERVICES? (n=278)	DID THE CONSULTATION TAKE PLACE IN A PRIVATE ROOM?	
	Yes (n=196)	No (n=82)
Yes (n=104)	79.8% (n=83)	20.2% (n=21)
No (n=174)	64.9% (n=113)	35.1% (n=61)

Further analysis by the member of staff who provided advice also indicated statistically significant differences (see Table 40; p<0.0001)[m] with services delivered by pharmacists being more likely to take place in a private room than services delivered by other staff members.

Table 40: Results of the cross-tabulation between whether a respondent's consultation took place in a private room and the member of staff who provided the advice

STAFF MEMBER (n=299)	DID THE CONSULTATION TAKE PLACE IN A PRIVATE ROOM?	
	Yes (n=210)	No (n=89)
Pharmacist (n=151)	82.8% (n=125)	17.2% (n=26)
Health Trainer Champion (n=20)	75.0% (n=15)	25.0% (n=5)
Not sure (n=15)	66.7% (n=10)	33.3% (n=5)
Health Trainer (n=33)	63.6% (n=21)	36.4% (n=12)
Other staff (n=80)	48.8% (n=39)	51.2% (n=41)

Owing to the fact that a majority of respondents either Strongly Agreed or Agreed with the range of statements relating to the pharmacy staff (see above), full cross-tabular analysis was statistically invalid. However cross-tabular analysis on the agreement level options for the statement relating to whether the staff member had sufficient time did indicate differences whereby respondents were more likely to strongly agree to the statement if they had not undertaken a consultation within a private room (see Table 41; p=0.022).

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[m] One cell indicated an expected frequency of less than 5. With the removal of all responses relating to "Not sure" (n=15), the results of the cross-tabulation remained statistically significant (p<0.0001).

Table 41: Results of the cross-tabulation with the agreement level from respondents for the statement relating to whether the staff member had sufficient time and whether a respondent's consultation took place within a private room

THE PERSON I SPOKE TO TODAY, HAD ENOUGH TIME TO DEAL WITH MY ENQUIRY (n=294)[n]	DID THE CONSULTATION TAKE PLACE IN A PRIVATE ROOM?	
	Yes (n=206)	No (n=88)
Strongly Agree (n=212)	68.0% (n=140)	81.8% (n=72)
Agree (n=82)	32.0% (n=66)	18.2% (n=16)

When asked about the importance of talking in private about their health, over ninety present either strongly agreed (59.6%, n=218/366) or agreed (31.1% (n=114) with this statement (Neither agree nor disagree, 7.9%, n=29); Disagree, 1.1%, n=4; Strongly Disagree, 0.3%, n=1).

4.2.6   AWARENESS OF HEALTHY LIVING PHARMACIES

Respondents were asked if they had heard about Healthy Living Pharmacies, with 68.1% (n=252/370) indicating that they had (with 31.9% (n=118) indicating that they hadn't). A total n=7 respondents did not answer this question. Cross-tabulation of these results with whether the pharmacy was the respondent's regular pharmacy indicated that respondents answering from their regular pharmacy were much more likely to have heard of Healthy Living Pharmacies (see Table 42; p<0.0001).

Table 42: Results of the cross-tabulation between whether respondents had heard of Healthy Living Pharmacies and whether they were responding from their regular pharmacy

IS THIS YOUR REGULAR PHARMACY (n=354)	HAVE YOU HEARD ABOUT HEALTHY LIVING PHARMACIES?	
	Yes (n=240)	No (n=114)
Yes (n=306)	71.6% (n=219)	28.4% (n=87)
No (n=48)	43.8% (n=21)	56.2% (n=27)

Respondents were also asked if they were aware that the pharmacy they were in was a Healthy Living Pharmacy. A similar percentage (68.7%, n=252/367) responded that they were aware (with 31.3% (n=115) indicating that they were not aware). A total of n=10 respondents did not answer this question. As before, respondents who were answering from their regular pharmacy were more likely to be aware that the pharmacy was a Healthy Living Pharmacy (see Table 43; p<0.0001).

Table 43: Results of the cross-tabulation between whether respondents were aware that the pharmacy they were in was a Healthy Living Pharmacy and whether they were responding from their regular pharmacy

IS THIS YOUR REGULAR PHARMACY (n=351)	DID YOU KNOW THAT THIS PHARMACY IS A HEALTHY LIVING PHARMACY?	
	Yes (n=242)	No (n=109)
Yes (n=303)	72.6% (n=220)	27.4% (n=83)
No (n=48)	45.8% (n=22)	54.2% (n=26)

Owing to the fact that a majority of respondents either Strongly Agreed or Agreed with the range of statements relating to the health advice (see above), full cross-tabular analysis was statistically invalid. However cross-tabular analysis on the agreement level options for the statement relating to whether the respondent trusted the advice given to them did indicate differences whereby respondents were more likely to strongly agree to the statement if they knew the pharmacy was a Healthy Living Pharmacy (see Table 44; p=0.020).

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[n] Cross-tabulation was only undertaken for respondents who answered "Strongly agree" or "agree" to this question as numbers of respondents who answered "Neither agree nor disagree", "Disagree" or "Strongly disagree" were minimal making any statistical comparisons invalid.

Table 44: Results of the cross-tabulation between whether respondents were aware that the pharmacy they were in was a Healthy Living Pharmacy and whether they trusted the health advice given

I TRUST THE HEALTH ADVICE GIVEN TO ME (n=334)[o]	DID YOU KNOW THAT THIS PHARMACY IS A HEALTHY LIVING PHARMACY?	
	Yes (n=234)	No (n=100)
Strongly Agree (n=235)	74.4% (n=174)	61.0% (n=61)
Agree (n=99)	25.6% (n=60)	39.0% (n=39)

Next, respondents were asked how they became aware of the NHS Health Service they used during their current visit. The results are summarised in Table 45 (respondents could select more than one option) with awareness via pharmacy staff (44.7%, n=180/377) being the most frequent response.

Table 45: How respondents became aware of the NHS Health Service they used

METHOD	NUMBER OF RESPONSES (PERCENTAGE OF VALID RESPONDENTS)
Pharmacy staff	180 (47.7%)
Friends/family	95 (25.2%)
Word of mouth	87 (23.1%)
Advertisement	58 (15.4%)
GP	46 (12.2%)
Other	7 (1.9%)

Furthermore, respondents were asked where they had seen any advertisements relating to Healthy Living Pharmacies. The results are summarised in Table 46 (respondents could select more than one option) with advertisements in pharmacies (70.3%, n=265/377) being the most frequent response.

Table 46: Where respondents had seen any advertisements relating to Healthy Living Pharmacies

METHOD	NUMBER OF RESPONSES (PERCENTAGE OF VALID RESPONDENTS)
In a pharmacy	265 (70.3%)
Don't remember seeing any	55 (14.6%)
On the local NHS website	46 (12.2%)
At an NHS roadshow	21 (5.6%)
Other	20 (5.3%)

Finally, in this section, respondents were asked if they had seen any of the Healthy Living Pharmacy logos. The results are summarised in Table 47 (respondents could both logos).

Table 47: Healthy Living Pharmacy logos seen by respondents

LOGO	NUMBER OF RESPONSES (PERCENTAGE OF VALID RESPONDENTS)
HLP Kitemark	255 (67.6%)
"First Stop Pharmacy"	194 (51.5%)
Have not seen either	53 (14.1%)

4.2.7 DEMOGRAPHICS OF RESPONDENTS

The gender of respondents was provided as follows (see Table 48; 51 respondents did not answer this question), with female respondents making up the greater proportion 70.6%, n=230/326).

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[o] Cross-tabulation was only undertaken for respondents who answered "Strongly agree" or "agree" to this question as numbers of respondents who answered "Neither agree nor disagree", "Disagree" or "Strongly disagree" were minimal making any statistical comparisons invalid.

Table 48: Gender of respondents

GENDER	PERCENTAGE (n=326)
Female	70.6% (n=230)
Male	27.3% (n=89)
Do not want to say	2.1% (n=7)

The age of respondents was provided as follows (see Table 49; 5 respondents did not answer this question).

Table 49: Age of respondents

AGE RANGE	PERCENTAGE (n=372)
Under 18	4.0% (n=15)
18-19	3.5% (n=13)
20-29	28.0% (n=104)
30-39	34.7% (n=129)
40-49	15.9% (n=59)
50-59	5.1% (n=19)
60-69	6.2% (n=23)
70-79	1.3% (n=5)
80 and over	0.0% (n=0)
Do not want to say	1.3% (n=5)

The ethnic group of respondents was provided as follows (see Table 50; 2 respondents did not answer this question).

Table 50: Ethnic group of respondents

ETHNIC GROUP	PERCENTAGE (n=375)
Pakistani	40.3% (n=151)
Bangladeshi	11.7% (n=44)
Indian	10.1% (n=38)
English/Welsh/Scottish/Northern Irish/British	9.9% (n=37)
Caribbean	6.1% (n=23)
Arab	3.5% (n=13)
Do not want to say	3.5% (n=13)
African	3.2% (n=12)
White and Asian	3.2% (n=12)
White and Black Caribbean	2.1% (n=8)
Any other Black/African/Caribbean background	1.9% (n=7)
Irish	1.3% (n=5)
Any other Asian background	0.8% (n=3)
Any other ethnic group	0.8% (n=3)
White and Black African	0.8% (n=3)
Any other Mixed/Multiple ethnic Background	0.5% (n=2)
Any other white background	0.3% (n=1)
Gypsy or Irish Traveller	0.0% (n=0)

Chapter 5 Discussion and Conclusions

5.1 SUMMARY OF PROJECT FINDINGS FROM STAGE A

5.1.1 SMOKING CESSATION

Almost three-quarters of participants accessing the smoking cessation scheme via community pharmacies between 1st April 2011 and 31st October 2013 were from the most deprived quintile of Lower Super Output Areas (LSOAs) in England. Participants accessing the smoking cessation scheme via community pharmacies were more likely to be female than participants accessing NHS Stop Smoking services (i.e. NHS funded smoking cessation services provided across all settings including GPs and pharmacies) in HoBtPCT between April 2012 and March 2013 (41% of all participants and 35% of all participants respectively).[50] The age profile of participants accessing the smoking cessation scheme via community pharmacies was broadly similar to that of those accessing wider NHS Stop Smoking services in HoBtPCT.[50] Data on the ethnicity and occupational status of participants accessing NHS Stop Smoking Services in HoBtPCT were not available for comparison.

Almost half (48%) of all participants enrolled onto the smoking cessation programme between 1st April 2011 and 31st October 2013 had successfully stopped smoking four weeks post-enrolment. This is slightly lower than the comparable figure for people accessing NHS Stop Smoking services in England between April 2012 and March 2013 (52%) but identical to the comparable figure for people accessing NHS Stop Smoking services in HoBtPCT between April 2012 and March 2013 (48%).[50] When examining quit rates at four weeks in pharmacy-specific smoking cessation programmes, the quit rate reported in the present study is similar to that reported in pharmacy-based programmes in Sheffield, Hereford and North Yorkshire.[51]

Older participants and male participants had higher quit rates than younger participants and female participants. This reflects patterns observed across both HoBtPCT and England.[50] Participants from higher occupational groups were also more likely to successfully quit than those from lower occupational groups. While data from NHS Stop Smoking services concerning differential quit rates dependent on occupational status is not available, previous research has also suggested that those from higher socioeconomic groups are more likely to successfully quit than those from lower socioeconomic groups.[52–54]

Participants in HLPs were older and were more likely to have been male, been from a black or minority ethnic group, have never worked or been long-term unemployed, and been from the most deprived areas of central Birmingham than participants at non-HLPs. While quit rates were slightly higher in non-HLPs than in HLPs, this difference was not statistically significant. Given the associations observed between quit rates and demographic characteristics, when comparing outcomes data between HLPs and non-HLPs, this heterogeneity in demographics should be considered.

To examine the effects of HLP accreditation on the provision of the smoking cessation programme, data covering quarter 3 (July-September) 2011 were compared with data from a period after which 6 HLPs had received their accreditation (quarter 3 (July-September) 2012). Data from the same quarter of each year were selected to minimise the impact of seasonal variations in both activity and quit success rates.

Activity rates in the post-accreditation period were 12% lower than in the pre-accreditation period. A 12% reduction in activity was also seen between quarter 3 2011 and quarter 3 2012 nationally.[50] Whilst the number of consultations in non-HLPs was 14% lower in the post-accreditation period than in the pre-accreditation period, the number of consultations in HLPs was 7% higher post-accreditation than in the pre-accreditation period. An increase in smoking cessation activity was also

observed in the post-accreditation period in the evaluation of the national HLP pathfinder programme although, in both that evaluation and in the present one, any increase in activity cannot be claimed to be as a result of HLP accreditation.[7]

Overall, participants with a 4 week quit date in quarter 3 of 2012 were slightly less likely to have successfully quit smoking than participants who had set a quit date in quarter 3 of 2011 although this difference was not statistically significant. The decrease in the proportion of participants successfully quitting at four weeks between the pre-accreditation and post-accreditation period was more pronounced in HLPs (53% pre-accreditation versus 41% post-accreditation) than in non-HLPs (48% versus 48%). Data from the pathfinder evaluation are inconclusive as to the effect of HLP accreditation on quit rates with increases in quit rates recorded in some areas and decreases in others.[7] There was no evidence to suggest that HLP accreditation in HoBtPCT improved quit rates in smoking cessation services.

5.1.2 MINOR AILMENTS SCHEME

In the period from 1st January 2012 to 31st November 2012, there were a total of 194,315 MAS consultations. Where Indices of Multiple Deprivation (IMD) 2010 scores could be matched to participants' postcodes, over 90% of these consultations were with individuals resident in the most deprived quintile of LSOAs in England. The mean number of consultations per pharmacy per month was higher in non-HLPs than in HLPs in all eleven months studied. The mean number of consultations per HLP increased post-accreditation but this increase was not statistically significant and was in line with the year-on-year increase in the number of MAS consultations between 2011 and 2012. An increase in the mean number of consultations per HLP in the period post-accreditation was also observed in the small number of pharmacies in the three areas examined in the evaluation of the HLP pathfinder programme (although no indication is provided in the evaluation report as to whether these increases were statistically significant).[7] Costs per consultation (excluding drug costs) were higher in HLPs (£2.13 per consultation) than in non-HLPs (£1.79 per consultation) although this difference was not statistically significant.

Headache/earache/temperature was the subject of over half of all MAS consultations. Given this, it is unsurprising that analgesics (paracetamol or ibuprofen) were also supplied in an identical proportion of consultations. One aspect of the medicines supplied via the MAS which may be a focus for rationalisation in the future is the provision of medicines which are not supported by a robust evidence base. For example, there were 16,068 supplies of Simple Linctus Paediatric (200 ml), 14,997 supplies of Simple Linctus (200 ml) and 2071 supplies of Dentinox Teething Gel (15 g). Using data from the November 2012 Drug Tariff and the Boots website (for Dentinox Teething Gel as no figure for this product is provided in the Drug Tariff), the total spend on these products was £32,779.64.[55,56]

In almost every consultation the patient reported that they would have consulted their GP in the absence of the service (99.9% HLP, 98.2% non-HLP, 98.4% overall). This proportion is higher than the proportion reported in other evaluations of MASs (47-92%).[36] Based on the proportion of participants reporting that they would have consulted their GP in the absence of the service, the cost per consultation and figures for GP costs from the widely used Unit Costs of Health and Social Care, the 'savings' to the NHS produced by diversion of participants from GPs to participating pharmacies for minor ailments consultations are estimated to be around £2,000,000 per annum.[48] Whilst the HoBtPCT MAS may reduce demand amongst GPs for minor ailment consultations the extent to which MASs shift demand away from higher to lower cost settings is yet to be established and there is no evidence to suggest that the MAS reduces overall demand for GP time.[36]

Patients accessing the MAS via HLPs were more likely to report having heard about the MAS through promotional material than patients at non-HLPs. Furthermore, the proportion of patients accessing the MAS via HLPs who reported that they had heard about the scheme via promotional materials was higher in the post-accreditation period than in the pre-accreditation period. This may be a reflection on the emphasis placed on proactive health promotion and accessibility as part of the HLP programme in HoBtPCT.

5.1.3 EMERGENCY HORMONAL CONTRACEPTION

Data collection yielded very few observations relating to provision of EHC via PGD in HLPs. Observations from comparator non-HLPs were even scarcer. However, the data retrieved highlight that over three-quarters of individuals accessing the scheme were normally resident in the most deprived quintile of LSOAs in England. In addition, the data suggest that accreditation as an HLP did not appear to have any significant effect on activity.

5.1.4 EARLY PREGNANCY TESTING

Nine out of every ten people accessing the EPT programme were from the most deprived quintile of LSOAs in England. People who accessed EPT via non-HLPs were more likely to be from the two most deprived quintiles within the cohort accessing EPT. There was an overall trend of fewer consultations taking place in the post-accreditation periods than in the pre-accreditation periods. This trend was most pronounced in HLPs where 42% of consultations took place post-accreditation. This is in marked contrast to provision in non-HLPs where provision increased in the post-accreditation periods (53%). Neither of these observations can be attributed to accreditation as an HLP.

5.1.5 LIMITATIONS OF THE APPROACH ADOPTED FOR STAGE A

The approach utilised for the analysis of services data can broadly be described as a non-randomised, retrospective, observational comparison of provision of the stated services in HLPs and non-HLPs. The lack of randomisation of service users to either an intervention (i.e. HLP) group or a control (i.e. non-HLP) group led to heterogeneity between some comparator groups and means that any associations between HLP status and service activity and/or quality levels cannot be causally attributed to HLP accreditation status (they may, for example, be a result of bias introduced by the heterogeneity between groups).

Wherever possible, data were collected from as many non-HLPs as possible (i.e. for the SC and MAS analyses) so as to avoid the introduction of any selection bias which may have resulted from the selection of specific non-HLP comparator pharmacies. However, when considering the results of the EHC and EPT services – where, owing to the nature of the available data, and the time and financial constraints of the project, specific comparator pharmacies were identified – selection bias may have been introduced. Some heterogeneity between HLP and non-HLPs was observed in these small cohorts and is reported in the relevant results sections.

5.2 SUMMARY OF PROJECT FINDINGS FROM STAGE B

5.2.1 MOTIVES FOR ENGAGEMENT WITH THE HLP PROGRAMME

The majority of interviewees reported that they were undaunted by the HLP accreditation criteria as they were already meeting most of the accreditation criteria prior to engaging in the HLP programme.

The most commonly reported motivation for engagement with the HLP programme was that accreditation as an HLP would differentiate the pharmacy from other, competitor pharmacies. It was believed that HLP accreditation would identify the pharmacy as being one which could be relied upon, by both patients and NHS commissioners, to provide consistently high quality services.

Pharmacists believed that pharmacies with HLP accreditation would come to be seen as 'preferred providers' of future locally commissioned services therefore securing their pharmacies a competitive advantage over non-HLPs and helping to ensure the financial sustainability of their businesses in the short- to medium-term. Similar views were expressed by interviewees in an evaluation of the HLP programme in Portsmouth.[14]

The other prime motive for engagement in the HLP programme was an altruistic desire on the part of pharmacists to improve the health of the communities which they serve. Pharmacists expressed a desire to combat the preeminent health problems in their localities with many pharmacists also describing their proactive approaches to providing health-improving services, including the provision of an isolated number of interventions without any NHS funding. An intrinsic motivation to improve the health of their local population was also identified as an important driver for HLP engagement in Portsmouth.[14]

5.2.2 CHALLENGES TO IMPLEMENTATION OF THE HLP PROGRAMME

While Interviewees were positive about the opportunities offered by HLP accreditation, a number of challenges to the successful implementation of the HLP programme were identified. These included:

- Role extension placing ever greater pressures on pharmacist workload particularly in the context of year-on-year increases in the volumes of prescriptions to be dispensed.
- Remuneration for extended services being insufficient to cover recruitment of extra staff to accommodate for an increasing workload.
- In the light of the above, precedence being given to the dispensing of prescriptions amidst fear of regulatory action being taken against the pharmacist in the event of a dispensing error.
- Poor recognition of the HLP brand as a quality kite mark by members of the public primarily as a failure of the PCT-led marketing and promotional activities.
- A difficulty in persuading clients of the differences in daily operations before and after accreditation as the local populations were accustomed to accessing health services via pharmacies for several years before the introduction of HLPs.
- Some interviewees did not consider that the HT/HTC training had been of benefit in altering and developing their practice.
- A lack of clarity amongst pharmacists as to the differences in the defined roles of HTs/HTCs.

Workload pressures and inadequate levels of remuneration were also highlighted as particular challenges to successful implementation of HLPs by pharmacy staff interviewed as part of an evaluation of HLPs in Portsmouth.[14]

5.2.3 EFFECTS OF HLP ACCREDITATION ON PHARMACY STAFF

The majority of HTs/HTCs felt:

- Able to consult pharmacists readily about any issues they had regarding their working practice.
- Supported by their employer in their 'new' role, a role which had become more 'client-centred' and this had led to HTs/HTCs feeling 'valued' by their employer.

Echoing the results from qualitative interviews undertaken with pharmacy staff in Portsmouth HLPs, HTs and HTCs were highly motivated to support the HLP objectives and this was inextricably linked to job satisfaction.[14] The majority of HTs/HTCs felt a sense of achievement and pride in fulfilling a health-service related role and were of the view that patients valued and appreciated the advice/health service provided.

However, HTs/HTCs reported that peer support was virtually non-existent. There was no communications amongst HTs/HTCs working in different pharmacies and there was a belief that

peer networking would be valuable in enabling transfer of knowledge and sharing of best practice amongst HTs and HTCs to facilitate continued improvement of service delivery in HLPs. The experience of HTs/HTCs in Birmingham is in marked contrast to their colleagues in Portsmouth who reported that a "*pharmacy community*" had been created by the HLP programme with pharmacies working together in an attempt to improve outcomes.[14]

To summarise the views of the pharmacy staff interviewed in the study, a SWOT analysis was undertaken and the findings are summarised in Figure 6.

Figure 6: SWOT analysis of the internal and external challenges faced by pharmacy staff interviewed in the study

STRENGTHS	WEAKNESS
• All pharmacies in the sample group had several years of experience of delivering Health services prior to the roll-out of the HLP programme. Consequently, there was good awareness (at a local level) of the availability of health services via community pharmacies. • The majority of pharmacists who undertook HLP accreditation were already meeting most of the HLP accreditation criteria prior to embarking upon HLP accreditation. • Extended opening hours; providing convenient access to health/pharmaceutical services. • Pharmacists' reputations established over many years resulting in the development of trusting relationships with local communities. • Pharmacists' familiarity with their clientele and with successive generations; enabling continuity of care. • A culture of continuous training (of the pharmacy team) resulting in the development of a multi-skilled workforce, enabling pharmacists to delegate certain health-service related tasks to appropriately trained staff, thereby reducing pharmacists' work burden. • Multi-lingual pharmacy teams conversant in the dominant languages spoken in HoB facilitated communication with clientele not fluent in English. • Pharmacists with good relationships with the local GP(s) benefitted from GP referrals.	• Barriers to communication experienced with newly established communities i.e. Eastern European and Somali. • Difficulties experienced with establishing relationships with multi-partner GP practices. • Perception that GPs were generally unaware of the extended role of pharmacists.
OPPORTUNITIES	**THREATS**
• The HLP programme; as a means of differentiation to gain a competitive advantage.	• Uncertainty about the future financial sustainability in a highly competitive arena. • Demanding consumer expectations resulting in the need to maintain reputations. • Fear of negative word of mouth. • Uncertainty of the impact of the NHS reforms on commissioned services.

5.3 SUMMARY OF PROJECT FINDINGS FROM STAGE C

5.3.1 KEY FINDINGS

The collated returns from the service user questionnaire provided a useful snapshot of the views of service users who accessed HLPs for all four services within the study (Early Pregnancy Testing, Emergency Hormonal Contraception, Minor Ailments and Stop Smoking). The majority of respondents were female and most were between 20-49 years of age. By far the greatest number of responses was received from respondents who classified themselves as being from the Pakistani ethnic grouping.

Variability was seen from the responses in the number of consultations for the different services, with a majority of responses from service users who had accessed the HLP for the Minor Ailments service. However, consideration should be given to the fact that the proportion of services users who may complete a questionnaire would be expected to vary by service type (with, for example, service users accessing a sexual health-related service potentially being less likely to complete a questionnaire). A majority of respondents were in their regular pharmacy and around two thirds were accessing the service for the first time. Respondents accessing the Minor Ailments service were also more likely to be repeat service users than respondents from the other three service areas.

Overall, there was strong support for the staff member who provided the service, with a majority of respondents stating that they were seen by the pharmacist (as opposed to any other pharmacy staff member), but with slightly fewer stating that they would prefer the pharmacist over other staff members (with either the pharmacist or no particular preference being the core choices). There was strong agreement with a series of statements relating to the staff member the respondent interacted with, indicating that they were happy with the amount of time the staff member had to deal with the enquiry, how comfortable they felt dealing with that member of staff and indicating a wish to be seen by the same staff member again.

Turning to the advice provided, again there was strong support for all aspects of the advice, with respondents stating that it was easy to understand, that they trusted the advice and that they were satisfied with the advice. When examining the service provided compared to what the respondents could obtain from their general practitioner, again there was strong support for the services provided through the HLP with respondents agreeing (87% 'Strongly agree' or 'Agree') that they preferred to go to the pharmacy for this type of health advice, that the pharmacy's opening times were more convenient than the GPs' opening hours (97%) and that the advice they have received has helped them keep better care of themselves (96%). Respondents were also happy to recommend the services they had accessed to friends or family (99%). These high levels of satisfaction were also seen in the national evaluation of the pathfinder HLP programme where 81% of service users rated the service they had used as 'excellent' and 98% stated that they would recommend the service to others.[7]

Variability was seen in whether the consultation took place in a private consultation room by the type of service accessed. Stop Smoking service consultations almost always took place in private compared to only half of minor ailment services and consultations involving pharmacists being more likely to take place in a private room than with other staff members. Owing to the variability in the services provided and the likelihood that the pharmacist, rather than any other staff member, dealt with the more complex or personal enquiries, this level of variability was to be expected.

Just over two-thirds of respondents indicated that they had heard of HLPs.[7] This is more than twice the proportion of respondents who reported that they had heard of HLPs in the national pathfinder evaluation, perhaps indicating that awareness of the HLP concept amongst pharmacy users was

growing as time progressed.[7] Similarly, over two-thirds of respondents reported that they were aware the pharmacy they were in was an HLP, with respondents being more likely to indicate both that they had heard of HLPs and that they aware that the pharmacy they were in was an HLP if they were answering from their regular pharmacy. Almost half of respondents were aware of the NHS service they used through the pharmacy staff, rather than through other external sources (via their general practice surgery, for example). This echoes the findings of the national pathfinder evaluation where 44% of respondents to a questionnaire reported that they were made aware of the NHS service they used by a member of the pharmacy's staff.[7] A majority of respondents who had seen any advertisements for HLPs had done so in a pharmacy and the HLP 'Kitemark' was the more commonly recognised HLP logo.

Overall, the views of the service users indicated high levels of support for all the services provided and a reassurance that the respondents were happy with the service provided and the staff members who provide the service. Respondents stated that they would prefer to access these services via their local HLP, rather than general practice surgery, and would recommend the services they accessed to friends and family.

5.3.2 LIMITATIONS

The service user questionnaire stage of the study has a number of limitations which needs to be taken into consideration when interpreting the results. These are as follows:

- The completion of the service user questionnaire was variable across the ten HLP pharmacies within the study and so analysis by individual HLP was not possible. In addition, although a good number of responses were received, the number of respondents for certain questions meant that full cross-tabular analysis was not possible in some cases.

- The questionnaire was in English and so it may not have been easy for some service users to engage with the study owing to language barriers, especially taking into consideration the ethnic diversity found within the centre of Birmingham. Although it was possible for the staff members to assist service users in completing the study questionnaire where language may have caused a problem, it was unknown how many times this took place.

- In addition, it is accepted that response levels may have varied between the different services included in the study as respondents may have felt less inclined to complete the study instrument for services relating to, for example, early pregnancy testing and emergency hormonal contraception compared to stop smoking and minor ailments.

- Finally, it should be noted that the questionnaire was only administered to service users (and so the views of the non-service users were not captured). In addition, owing to the need to protect anonymity, the data collection method chosen meant that there was no way to identify the proportion of service users over the study period who completed a questionnaire and therefore, how representative the views from the respondents are to the general service user population.

5.4 CONCLUSIONS AND RECOMMENDATIONS

5.4.1 CONCLUSIONS

The community pharmacies of central Birmingham are located in some of the most deprived areas of England. Their location affords an opportunity to counter the inverse care law whereby those most in need of access to healthcare services are paradoxically those who find it most difficult to access such services.[57] Data on service provision presented in this report suggests that people accessing the services provided by the community pharmacies in central Birmingham are, unsurprisingly given

their geographical location, predominantly from areas of high socioeconomic deprivation. While logic suggests that community pharmacies located in areas of socioeconomic deprivation improve access to health services in areas of great need, further research is encouraged to establish whether community pharmacies enable access to health services amongst the people who find it most difficult to access such services.

Data from the smoking cessation scheme suggest that participants at HLPs are more likely to have been from sections of society commonly considered to be 'hard-to-reach' – men, people from black and minority ethnic groups, those who had never worked or were long-term unemployed and those from the most-deprived areas of central Birmingham. While this phenomenon was not observed universally across all four services analysed, smoking is the most important single behavioural cause of health inequalities making such observations notable.[37]

Of particular note in relation to the analysis of the data from the MAS was the large number of items which were supplied via the scheme but which are not supported by a robust evidence base. Any continuation or extension of the MAS should be accompanied by a review of the items which are available for supply to ensure that resources are not being devoted to ineffective interventions.

All of the services examined were already being provided across the pharmacy network in HoBtPCT prior to the introduction of HLPs locally. In the case of SC and MAS, these services were well established, widely available and well used by the local population. Given this context, it is perhaps unsurprising that this evaluation has revealed no evidence that HLP accreditation improves activity levels or outcomes in the services examined.

However, data from the MAS suggests that HLP accreditation may influence how participants become aware of the services offered by pharmacy with participants at HLPs being much more likely to report that they had heard about the existence of the scheme via promotional material than participants in non-HLPs. This phenomenon was also observed in the service-user questionnaire where a large proportion of respondents reported hearing about the existence of the NHS services provided from a member of pharmacy staff. Further research is needed to establish whether the existence of pharmacy-based health services is more actively promoted in HLPs than in non-HLPs and whether more active promotion increases activity levels and improves the outcomes of such services.

Results from the service-user questionnaire suggest that satisfaction with the services provided by HLPs is very high. Particularly notable are the high proportions of respondents who reported that they preferred to access the service they had used at the HLP rather than at their GP surgery and the very high proportion of respondents who would recommend the service they had used to their friends and family. Over two-thirds of respondents to the questionnaire indicated that they had heard about HLPs, with the HLP 'Kitemark' also being widely recognised. The views of service users on the visibility of HLPs were in contrast with those expressed by the pharmacy staff who were interviewed as part of this evaluation who believed that awareness of the HLP concept amongst their local populations was low – principally as a result of a perception of a failure of the PCT's publicity drive. Whilst these divergences in perception between service providers and service providers may need to be addressed, and taking into consideration that the views of the public were limited to those actively accessing the services on offer, such public approval provides an excellent foundation on which to develop the HLP programme.

A motive for pharmacist engagement with the HLP programme was a belief that accreditation of their pharmacies as HLPs would provide reassurance to commissioners that they were consistent deliverers of high quality services and that the accreditation would help to differentiate HLPs from non-HLPs with HLPs being favoured in future commissioning decisions. The NHS landscape had

changed markedly since the data were collected with the PCTs that pharmacists were referring to as commissioning organisations being abolished and the commissioning of pharmacy services being fragmented between Clinical Commissioning Groups (CCGs), Local Authorities (LAs) and NHS Area Teams. Furthermore, after the abolition of PCTs, the responsibility for accrediting HLPs has been assumed by Local Pharmaceutical Committees (LPCs – the local representative bodies for pharmacy contractors). While there is no evidence that this has altered the mechanics of the accreditation process or decreased the degree of oversight of HLPs, there is a potential risk that accreditation of HLPs by a contractor body may be viewed as partial by commissioning bodies. Given such upheaval, additional effort will need to be made to ensure that faith in the accreditation process for HLPs is maintained and that the initial momentum behind HLPs in central Birmingham is not lost.

Amidst discussion of the commissioning landscape, the concern of pharmacy contractors around remuneration for additional services should be noted. There was a belief that remuneration for such services was insufficient to divert activity away from the dispensing function towards patient-centred care. Whilst such considerations may be outside the scope of local pharmacy and health bodies, strategic level consideration should be given to how remuneration for pharmacies can be altered to support role extension and the HLP concept. Furthermore, issues around the level of training provided (especially for HT/HTCs) and the awareness of the HLP scheme by local general practitioners were also highlighted as potential barriers to future HLP development and should be considered in any development of the HLP scheme.

5.4.2 RECOMMENDATIONS

The review of the implementation of Healthy Living Pharmacies within the area formerly covered by the Heart of Birmingham teaching Primary Care Trust described in this report has produced a number of recommendations.

Although no evidence of an increase in the levels of services provided for the four services examined from HLPs, when compared to non-HLPs, within HoBtPCT was seen, the analysis did indicate that service users accessing the stop smoking service from HLPs, rather than non-HLPs were from traditionally 'hard-to-reach' groups. Further work is warranted to examine the potential benefit of HLPs in relation to the provision of stop smoking services in other geographical areas of the country to see if this observation can be replicated.

- **Recommendation 1** – Further research is recommended to identify whether the uptake of the stop smoking service in traditionally 'hard-to-reach' groups via Healthy Living Pharmacies can be replicated in other geographical areas.

The present study has revealed no evidence that HLP accreditation improves activity levels or outcomes in the services examined within this one geographical area. However, data from the minor ailments scheme has suggested that HLP accreditation may influence how participants become aware of the services offered by pharmacy with participants at HLPs being much more likely to report that they had heard about the existence of the scheme via promotional material than participants in non-HLPs. This phenomenon was also observed in the service-user questionnaire where a large proportion of respondents reported hearing about the existence of the NHS services provided from a member of pharmacy staff.

- **Recommendation 2** – Further research is needed to establish whether the existence of pharmacy-based health services is more actively promoted in Healthy Living Pharmacies than in non-Healthy Living Pharmacies and whether more active promotion increases activity levels and improves the outcomes of such services.

Analysis of the items provided via the minor ailments scheme indicated that a large number of items were supplied via the scheme which were not supported by a robust evidence base. Any continuation or extension of the minor ailments scheme should be accompanied by a review of the items which are available for supply.

- **Recommendation 3** – Any continuation or extension of the minor ailments scheme should be done in parallel with a review of the items provided via the scheme to ensure that any medicines included are supported by a robust evidence base so as to minimise any expenditure on potentially ineffective interventions.

One reason for the initial motivation of pharmacists to engage with the HLP programme was in relation to the belief that they would be seen my commissioners as consistent deliverers of high quality services. It was understood that the accreditation would help to differentiate HLPs from non-HLPs with HLPs being favoured in future commissioning decisions. It is important that this momentum is not lost so as to facilitate the continuation and development of future services.

Results from the present study have shown high levels of motivation within the HLP staff group (pharmacists and HT/HTCs) and very high levels of acceptance by service users of the services covered by this study. Particularly notable are the high proportions of respondents who reported that they preferred to access the service they had used at the HLP rather than at their GP surgery. To obtain a more complete picture of the opportunities for service delivery through community pharmacy, it would be beneficial to conduct future research in non-HLPs providing these services to examine if satisfaction in non-HLPs is as high as it is in HLPs.

However, it was also noted that some pharmacy staff (HT/HTCs especially) stated that the depth of training in relation to the delivery of certain services was insufficient and that the awareness levels of the HLP scheme by general practitioners were low. Furthermore, the remuneration for certain activity was highlighted as an issue and future roll-out should ensure adequate levels of remuneration along with research conducted at the local level to examine the impact of HLP accreditation on non-HLPs within an area.

- **Recommendation 4** – In any future commissioning of services through pharmacies, consideration needs to be given to the role pharmacies with Healthy Living Pharmacy accreditation, with their high level of service user acceptance, can offer in the effective delivery of health care services. Given the lack of randomisation in observational studies, a randomised study – perhaps in the form of a pragmatic cluster randomised controlled trial – should be conducted to establish whether HLPs achieve better outcomes than non-HLPs.

- **Recommendation 5** – In order for the number of Healthy Living Pharmacies to expand and for the number of services offered via Healthy Living Pharmacies to increase, further consideration needs to be given to the levels of training and support made available to pharmacy staff, especially at the Health Trainer/Health Trainer Champion level, and the level of awareness of the programme within the local general practitioner population.

- **Recommendation 6** – To ensure the success of any future roll-out of services via Healthy Living Pharmacies, consideration should be given at a strategic level as to how remuneration for pharmacies can be altered to support role extension and the Healthy Living Pharmacy concept, along with research conducted at the local level to examine the impact of Healthy Living Pharmacy accreditation on non-Healthy Living Pharmacies within an area.

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APPENDICES

Appendix 1 - HLP Pharmacist Structured Interview Schedule

Preamble *– If calling on the phone:*

Good **morning/afternoon**. My name is [insert name] from the Pharmacy School at Aston University. Further to our previous conversations, I am calling to carry out a telephone interview about your views and opinions of your experience of participating in the Healthy Living Pharmacy or HLP Programme.

As you will now be aware, the Pharmacy Practice Research Group at Aston University has been asked by the PCT to carry out an independent evaluation of the HLP programme and this short interview will only take around 45 minutes to complete.

Just to let you know that I will record the next part of this telephone conversation so I can go over the answers I receive to the questions; however, anything you say during the call will remain anonymous and no-one can be identified from their responses.

Preamble *– If face to face:*

- Introductions.
- Purpose of the interview.
- 45 minutes to complete.
- I will record the interview so I can go over the answers.
- Your responses may be used in the report but you will not be identified.

General Awareness of Health Issues in the Local Community and Understanding of the HLP Concept

1. Before we begin with the interview, please can you describe the make-up of the community your pharmacy serves e.g. ethnicities, languages spoken, age profiles etc.
2. What would you consider to be the differences between an HLP and a pharmacy that is not an HLP?
3. What would you consider to be the main objectives of an HLP?

Motivation to participate

4. Please can you tell me when your pharmacy became HLP accredited?
5. Why did your pharmacy decide to participate in the HLP Programme?
6. What in your opinion are the benefits to the pharmacy of becoming an HLP?
   6.1. Have you experienced any of these benefits yet?

Programme set-up

7. Were you involved in the set-up of the HLP programme at your pharmacy?
8. How did you find out about the HLP programme?
9. How was information about the HLP programme disseminated by the PCT?
   9.1. How well did you understand what you had to do to become an HLP?
10. Could you please tell me what you had to do in order to become HLP Level 1 accredited?
    10.1. What changes did you have to implement in order to achieve HLP Level 1 accreditation?
    10.2. Please can you tell us about your experiences of working through the accreditation criteria that you had to meet in order to gain Level 1 status?
    10.3. How easy/difficult was the process of becoming a Level 1 HLP?

10.3.1. If difficult, what issues/difficulties did you experience as you worked through the criteria?

10.3.2. What would have helped make the process easier?

11. Did you undertake mystery shopper and premises audit?

    11.1. If yes, was this useful? Did you implement any changes owing to this?

12. Do you feel that there was a sufficient level of support from the PCT to help you through the accreditation process?

    12.1 At the start of the programme?

        12.1.1 If yes, please can you explain what type of support was provided?

            12.1.1.1 How important was the support you have just mentioned (in achieving accreditation)?

        12.1.2 If no, what type/level of support did you hope for at the start?

    12.2 Going forward, what level of support do you hope to receive from the PCT, post accreditation?

HT/HTC Recruitment/Training

13. How many Health Trainer/Health Trainer Champions (HT/HTCs) do you currently have?
14. How did you recruit them to become HT/HTCs?
15. What training have they undertaken for the role e.g. (college/PCT/on the job)?
16. How easy was if for staff to undertake the training in relation to their other duties?
17. Do you think the training you mentioned earlier (recall response to Q15) provided them with adequate skills and knowledge required to provide this advice?

    17.1. If not, why not?

18. What activities have your HT/HTCs been involved with up until now?
19. What other duties do your HT/HTCs have aside from the HT/HTC roles?
20. How do HTs/HTCs balance their various roles i.e. how do they prioritise HT/HTC duties with other work-related commitments?
21. What factors do you think affect how effective an HT/HTC is within their role?

Information/Resources/Training provided by the PCT

22. Were you offered training sessions by the PCT?

    22.1. If yes, what was provided?

        22.1.1. Who attended the training sessions? (not just leadership training, MUR training, monthly meetings etc.)

            22.1.1.1. What was covered in the training sessions?

            22.1.1.2. How useful were the training sessions?

    22.2. If no, what training would you have liked to have been made available?

23. Were you offered any resources by the PCT?

    23.1. If resources, what resources were provided?

            23.1.1.1. How useful were they?

            23.1.1.2. What additional resources would be useful?

Services Provided

24. Which HLP health services do you currently provide?
25. Which HLP service(s) would you say are most frequently requested in your pharmacy?

    25.1. Why do you think that might be?

26. Which HLP service(s) would you say are least frequently requested in your pharmacy?
    26.1. Why do you think that might be?
27. Are there any HLP services that you would like to provide but are unable to at present?
    27.1.   If yes, please can you tell us about this/these service(s) is/are?
        27.1.1. What is preventing you from providing this/these service(s)?
28. How do you promote services to members of the public?

Health Advice Process

29. Please can you talk me through the health advice process i.e. please imagine a member of the public has just walked in and asks about a service, what would happen next?
30. Do you have an appointment system for certain services?
    30.1.   If yes, for which services do you have an appointment system?
        30.1.1. Would 'regular' patients have an opportunity to see the same person each time they visit?
31. How do you monitor a patient's progress if patients have to return to the pharmacy to complete a programme?
    ➢ Probe for various data collection tools, method of collating information (paper/electronic) etc.
32. What evidence do you collect with regards to the interventions you make and their outcomes?
33. How do you pro-actively provide health advice?
34. Are patients/members of the public signposted to other resources available within the community?
35. Does the pharmacy have standard operating procedures for the four main services?
    35.1.   If yes, where do they come from and are there any aspects of the SOPs that are carried out by HT/HTCs?
    35.2.   What training has the HT/HTC received in order to deliver this aspect?

Patients' registered or not registered with a GP

36. At any stage during the consultation process, are you able to find out whether the patient is registered with a GP?
    35.1   If yes, when might the opportunity arise?
        ➢ Probe find out if information is captured on an ad hoc basis, or captured routinely

Patients' reasons for accessing health services via a pharmacy

37. What would you say are the main reasons why members of the public choose to access health services via pharmacies rather than going to a GP?
38. In your experience, would you say that when advised, patients do consult their GP after having sought advice from yourself?
    38.1.   If yes, please could explain how you know and why you think this might be the case?

Public's awareness of HLPs and health services being offered

39. In your opinion, how well understood is the term 'Healthy Living Pharmacy' by people who walk into the pharmacy?
    39.1. What level of understanding would you say people who walk into the pharmacy have about your role as healthcare advisor?
        39.1.1. If low, how do you think this could be improved?
40. What level of awareness would you say members of the public have about the range of health services offered by HLPs?
    40.1.   If low, how do you think this could be improved?

41. In general, how do the patients accessing your services originally hear about the service?
    - ➢ HT/HTC actively promotes the services by attending local community group meetings.
    - ➢ Word of mouth
    - ➢ PCT promotional events/posters/media
    - ➢ Signposted by an HTC or other member of staff
    - ➢ GP/hospital referrals
    - 41.1. If in-house publicity: How did you publicise the HLP programme?
    - 41.2. If PCT publicity: Please can you explain what the PCT did to raise awareness of HLPs within your local community?
        - 41.2.1. How effective were the publicity campaigns,
        - 41.2.2. Are there any aspects of the publicity campaigns which you thought worked particularly well?
42. What contact have you had with your local GP practice?

    Prompts: To promote services, to develop the relationship, to formalise protocols etc.

    - 42.1. Did you feel this was beneficial?
43. What contact have you had with other healthcare professionals?
    - 43.1. Did you feel this was beneficial?

44. Are there any particular groups of patients that you find hard to engage with?
    - 44.1. If yes, please tell us a little more about these groups.
    - 44.2. What issues have you experienced?

45. Do you think the service you provide as an HLP is valued by:
    - 45.1. The Primary Care Trust? Why?
    - 45.2. Other Healthcare Professionals? Why?
    - 45.3. Patients? Why?

Recommendations and Future Plans

46. Do you intend to progress to Level 2 and Level 3 accredited HLP?
    - 46.1. How do you see the role of HLPs developing with regards to the services they could provide?
47. What changes would you recommend to improve the provision of health services via HLPs?
48. *Are there any other points about the HLP programme you would like to make?*

Thank you for your time in participating in this interview.

Appendix 2 – HT/HTC Structured Interview Schedule

***Preamble** – If calling on the phone:*

Good **morning/afternoon**. My name is [insert name] from the Pharmacy School at Aston University. Further to our previous conversations, I am calling to carry out a telephone interview about your views and opinions of your experience of participating in the Healthy Living Pharmacy or HLP Programme.

As you will now be aware, the Pharmacy Practice Research Group at Aston University has been asked by the PCT to carry out an independent evaluation of the HLP programme and this short interview will only take around 45 minutes to complete.

Just to let you know that I will record the next part of this telephone conversation so I can go over the answers I receive to the questions; however, anything you say during the call will remain anonymous and no-one can be identified from their responses.

***Preamble** – If face to face cover the following points:*

- Introductions.
- Purpose of the interview.
- 45 minutes to complete.
- I will record the interview so I can go over the answers.
- Your responses may be used in the report but you will not be identified.

HT/HTC's General Awareness of Health Issues in the Local Community and Understanding of the HLP Concept

1. Before we begin with the interview, please can you:
    1.1. Tell me when your pharmacy became an HLP?
    1.2. Describe the make-up of the community your pharmacy serves e.g. ethnicities, languages spoken, age profiles etc.
2. What do you think are the main differences between an HLP and one that is not an HLP?
3. How do you think HLPs can help improve the health of local communities?
    3.1. Probe – who do you think would most benefit from the health services provided by HLPs?

Motivation to become an HT/HTC

4. To get a little background information about your role as a Health Trainer/Health Trainer Champion, please could you tell me how long you have been an HT/HTC?
    4.1. Are you an HT or an HTC?
    4.2. How did you become an HT/HTC?
    4.3. Are you the only HT/HTC in your pharmacy?
5. What prompted you to take on the HT/HTC role?
6. Would you say you have personally benefited from taking on the role of HT/HTC?
    6.1. If no, why is that?
    6.2. If yes, please can you tell me more?
        ➢ Probe; Job satisfaction, Job enrichment, personal development, financial
7. What do you find most rewarding/enjoyable about being an HT/HTC?
8. What aspects of your HT/HTC role do you find challenging/frustrating?
9. In addition to being an HT/HTC what other roles do you perform as part of your original job?
10. How do you balance the roles of HT/HTC with your original job roles?

HT/HTC Roles and Responsibilities

11. Were you involved in the HLP accreditation process?

    11.1.   If yes, how did you find it?

12. Could you describe the HT/HTC activities you undertake on a weekly/monthly basis (e.g. admin, promoting the NHS health services etc.)?

    12.1.   How do you record your activities as an HT/HTC?

13. What would you consider to be important aspects of your HT/HTC role?

14. Have you noticed any changes since your pharmacy became an HLP

    14.1. If yes, please can you tell me more?

15. Do you feel valued by the pharmacist or other members of the team?

Services Provided

16. Which services do you offer at your pharmacy?

    16.1.   Which services do you yourself deliver and which do you pass on to other members of staff?

17. Which service(s) would you say are most frequently requested in your pharmacy?

    17.1.   Why do you think that might be?

18. Which service (s) would your say are least frequently requested in your pharmacy?

    18.1.   Why do you think that might be?

19. How do you promote services to members of the public?

Health Advice process

20. Please can you talk me through the health advice process i.e. please imagine a member of the public has just walked in and asks about a service, what would happen next?

    20.1. What would happen if the member of staff that normally provides the service was busy or was not at work that day?

21. Do you have an appointment system for certain services?

    21.1.   If yes, for which services do you have an appointment system?

        21.1.1. Would 'regular' patients have an opportunity to see the same person each time they visit?

22. How do you monitor a patient's progress if patients have to return to the pharmacy to complete a programme?

    ➢ Probe; Data collection tools, method of collating information (paper/electronic) etc.

23. What is the general response that you receive when offering health advice?

24. How do you target people for health advice?

    ➢ Probe; Publicity Campaigns, individual advice

25. Are patients/members of the public signposted to other resources available within the community?

26. Does the pharmacy have standard operating procedures for the four main services?

    26.1.   If yes, where do they come from and are there any aspects of the SOPs that are carried out by HT/HTCs?

    26.2.   What training has the HT/HTC received in order to deliver this aspect?

Patients' registered or not registered with a GP

27. At any stage during the consultation process, are you able to find out whether the patient is registered with a GP?

    27.1.   If yes, when might the opportunity arise?

➢ Probe find out if information is captured on an ad hoc basis, or captured routinely

Patients' reasons for accessing health services via a pharmacy

28. What would you say are the main reasons why members of the public choose to access health services via pharmacies rather than going to a GP?

29. In your experience, would you say that when advised, patients do consult their GP after having sought advice from yourself?

    29.1.   If yes, please could explain how you know and why you think this might be the case?

Training, Skills and Knowledge

30. What **training** have you had to help you carry out your role as an HT/HTC?
        (HT/HTC should have completed their respective college courses).

    30.1.   If none, why is that?

    30.2.   Regarding training on the job/college:
        30.2.1. Was the training completed in your own time or were you given study leave?
        30.2.2. How did you find the training?
        30.2.3. What did the training cover?
        30.2.4. Did the training provide sufficient knowledge to enable you to confidently carry out the HT/HTC role?
        30.2.5. Did you find any of the training irrelevant?
        30.2.6. Is there anything you would have liked to have been included in the training provided to enable you to provide a better health advice service?

    30.3.   Regarding training by the PCT,
        30.3.1. How did you find the training?
        30.3.2. What did the training cover?
        30.3.3. Did the training provide sufficient knowledge to enable you to confidently carry out the HT/HTC role?
        30.3.4. Is there anything you would have liked to have been included in the training provided by the PCT to enable you to provide a better health advice service?
    30.4.   What particular **skills/knowledge** do you have which you feel have been useful in helping you carry out your role as an HT/HTC?

Internal Support Mechanisms

31. Which member of staff at your pharmacy would you speak to for guidance or support in your role as an HT/HTC?

32. Do you have regular meetings with [the person stated in Q31] to discuss issues arising?
    32.1. If yes, are the meetings with [the person stated in Q31] scheduled on a regular basis or do you catch-up as and when you can?
        32.1.1. How helpful have you found these meetings?
    32.2. If no, do you think you would find it useful to have regular meetings?

External Support Mechanisms

33. Have you had opportunities to attend network meetings with HTs/HTCs from other pharmacies, other health professionals or community groups?
    33.1. If yes, please can you tell me more?
        33.1.1. How often do meetings take place?
        33.1.2. What is discussed?

     33.1.3. How useful are networking meetings and how have the meetings helped you carry out your role?

  33.2. If no, would you find it helpful to attend networking meetings?

     33.2.1. If yes, please can you explain?

Service-user awareness of HLPs and HTs/HTCs

34. In your opinion, how well understood is the term 'Healthy Living Pharmacy' by people who walk into the pharmacy?

  34.1. What level of understanding would you say people who walk into the pharmacy have about your role as an HT/HTC?

     34.1.1. If low, how do you think this could be improved?

35. In general, how do the patients accessing your services originally hear about the service?

  ➢ HT/HTC actively promotes the services by attending local community group meetings.

  ➢ GP/hospital referrals.

  ➢ Word of mouth.

  ➢ PCT promotional events/posters/media.

  ➢ Signposted by an HTC or other member of staff.

  35.1. What level of awareness would you say members of the public have about the services offered by HLPs?

     35.1.1. If low, how do you think this could be improved?

36. Are there any particular groups of patients that you find hard to engage with?

  36.1. If yes, please tell us a little more about these groups.

  36.2. What issues have you experienced?

37. Do you think the service you provide as an HLP is valued by:

  37.1.   The Primary Care Trust? Why?

  37.2.   Other Healthcare Professionals? Why?

  37.3.   Patients? Why?

Recommendations and Future Plans

38. What aspects of your HT/HTC role would you change to enable you to provide a better quality of service to patients?

  38.1. Why would you make these changes?

39. How do you see the role of HLPs developing with regards to the services they could provide?

40. What changes would you recommend to improve the provision of health services via HLPs?

Thank you for your time in participating in this interview.

Appendix 3 – Letters of invitation

Name & Address

Date

Dear [member of pharmacy staff]

Aston University Healthy Living Pharmacy (HLP) Study

Evaluation of the implementation and impact of Healthy Living Pharmacies (HLPs) in the Heart of Birmingham (HoB)

In collaboration with the
Heart of Birmingham teaching Primary Care Trust (HoBtPCT)

Brief overview

You will already be aware that the Pharmacy Practice Research team at **Aston University** has been commissioned by HoBtPCT to conduct an independent evaluation of the effectiveness of Level 1 Healthy Living Pharmacies (HLPs) in helping to improve access to health services in the communities they serve (in the Heart of Birmingham), and the health gains generated. The study itself is independently funded by The Pharmaceutical Trust for Educational and Charitable Objects (PTECO).

For the purpose of this study, three services will be evaluated; Smoking Cessation, Sexual Health (incorporating the provision of emergency hormonal contraception (EHC) via a patient group Direction (PGD) and Early Pregnancy Testing) and the Minor Ailments Scheme. Approval for the HLP programme had been granted by the previous HoBtPCT Professional Executive Committee (PEC) and John Morrison, Associate Director for Medicines Management, Birmingham & Solihull NHS Cluster, has approved the evaluation of the HLP programme by the Pharmacy Practice Research Group at Aston University. We will also obtain approval from the Aston University Ethics committee before the study starts. NHS Research Ethics Committee approval will not be required as the project has been classified as a service evaluation.

The evaluation comprises of three stages:

1. Stage A; analysis and comparison of HLP and non-HLP monthly activity data submitted to HoBtPCT.
2. Stage B; interviews with HLP pharmacy staff (responsible for the provision of the HLP services) to determine motivation for involvement in the HLP programme. We hope to conduct two interviews per HLP i.e. with:
   a. A Pharmacist, and
   b. A Health Trainer (HT) or Health Trainer Champion (HTC).
3. Stage C; a short service-user questionnaire will be deployed via touchscreen health kiosks (located in pharmacies) to determine service-user views and satisfaction with the service.

Invitation to participate

It is with reference to Stage B, which we write to invite pharmacists and HTs/HTCs who have been involved in the HLP programme at [INSERT PHARMACY NAME], to participate in a short research interview. The purpose of interviews is to gain health service providers' perspectives on and

motivations for involvement in the HLP programme, the facilitators and barriers to delivery of the programme, opinions on the benefits the programme provides to the local community, recommendations for future improvement, etc.

The interviews are expected to take between fifteen minutes to half an hour to complete and we hope to schedule interviews between mid-July and August 2012. However prior to this, a member of research team will contact all Level 1 HLPs (in HoB) with a view to arranging mutually convenient dates and times to conduct the interviews. Ideally, we would like to conduct face-to-face interviews, at the pharmacy for your convenience, however, if you prefer, we would be happy to accommodate telephone interviews.

Your cooperation and participation in the Stage B interviews would be appreciated. Enclosed with this letter is a Participant Information Sheet (PIS), which provides further information, a portion of which is the Consent Form. We would be grateful if you could please complete the Consent Form and post it to Aston University in the pre-paid envelope provided.

Please be assured that any views and opinions later referred to in the study report will be anonymised and it will not be possible to link responses back any individual interviewee. If you have any concerns about participating please feel free to contact a member of research team at Aston University or Sajj Raja, Community Pharmacy Development Manager, HoBtPCT; please see below for contact details.

Further information

If you would like any further information about the study contact details are as follows:

- the Project Manager (Alpa Patel) on a.patel10@aston.ac.uk, or
- the Research Pharmacist (Jane Haworth) on j.e.haworth@aston.ac.uk, or
- the Community Pharmacy Development Manager (Sajj Raja) on sajjad.raja@nhs.net.

Yours sincerely

Professor Chris Langley
Deputy Head of Pharmacy
Professor of Pharmacy Law and Practice

Enc.

Appendix 4 – Participant Information Sheet and consent form

Aston University Healthy Living Pharmacy (HLP) Study

Evaluation of the implementation and impact of Healthy Living Pharmacies (HLPs) in the Heart of Birmingham (HoB)

**In collaboration with the
Heart of Birmingham teaching Primary Care Trust (HoBtPCT)**

> **Participant Information Sheet**

What is the study about?

The overall aim of the study is to evaluate the implementation and impact of Level 1 accredited HLPs within HoBtPCT.

What will I have to do?

We are inviting all HLP staff in the Heart of Birmingham who have been involved in the HLP programme, to participate in a short research interview.

A member of the Aston University research team will contact you to schedule a mutually convenient time to conduct an interview. We can conduct either a face-to-face interview at the pharmacy or a telephone interview, whichever is easiest for you. The researcher will ask you questions about your motivations for involvement in the HLP programme, the facilitators and barriers to delivery of the programme and uptake of health services, your opinions on the benefits of the programme, recommendations for future improvement, etc. We will not ask any personal or intrusive questions.

Do I have to take part?

Participation is voluntary, therefore the decision to take part is entirely yours. You can decide not to take part in the study. If you do decide to take part, you will still be able to withdraw from the interview at any point in time.

What are the risks in taking part?

You will not be put at any risk. If you feel uncomfortable with the questions being asked, you can exit the interview at any time.

What are the advantages of taking part?

One of the PCT's missions is to firmly establish community pharmacies as an integral component of the NHS healthcare system; playing a key role in helping to reduce health inequalities and improving the general health and wellbeing of the local communities pharmacies serve. Your perspective of the issues (arising at grass roots level), the benefits associated with becoming an HLP, practices implemented in your HLP that have worked well, your views/opinions on how uptake of health services (via community pharmacies) could be improved etc., will form an essential element of this study.

What will you do with the results of the interviews?

The information (data) collected from the interviews, will be analysed and the knowledge acquired will be assimilated into a report along with the analyses of Service-User questionnaire and

pharmacy returns data. The report will initially be made available to the study Steering Group and thereafter information will be disseminated via publications and conferences.

Will the information provided be kept confidential?

Yes. The interviews will be audio recorded (with your consent) and stored securely. The data will only be accessible to members of the Aston University research team; the recordings will not be accessible by the Medicines Management team at the PCT.

Any views and opinions that you share with the research team will be considered as confidential data and comments later referred to in the study report will be anonymised, therefore, it will not be possible to identify individuals by the comments made.

The data will be kept for three years post study and thereafter deleted.

Who is funding the study?

The study is being funded by The Pharmaceutical Trust for Educational and Charitable Objects and the research is conducted by the Pharmacy Practice Research Team at Aston University, in close collaboration with the Medicines Management team at HoBtPCT.

Who has reviewed the study?

Ethical permissions for this study have been sought from the Aston University Ethics Committee.

Whom can I contact if I have concerns about the study?

If you have any concerns or questions, please contact a member of the Aston University research team and we will do our best to address your queries. Our contact details are:

- the Project Manager (Alpa Patel); a.patel10@aston.ac.uk, 0121 204 4963

- the Research Pharmacist (Jane Haworth); j.e.haworth@aston.ac.uk, 0121 204 4967

If you wish to make a formal complaint, please contact please contact the Secretary of the Aston University Ethics Committee on j.g.walter@aston.ac.uk or telephone 0121 204 4665.

What do I have to do if I want to take part?

If you would like to take part, please complete the enclosed Contact Details and Consent Form and post it back to us in the reply paid envelope provided.

Aston University Healthy Living Pharmacy (HLP) Study

Please complete and return in the reply paid envelope provided

CONTACT DETAILS	
Your name:	
Pharmacy name:	
Telephone:	
Email Address:	
Please indicate below your preference for an interview at the pharmacy or a telephone interview:	
Interview at pharmacy ☐ Telephone interview ☐	
Days of the week you would be available for interview:	
Best time for interview:	

CONSENT FORM	
I agree to take part in the Aston University Healthy Living Pharmacy (HLP) study. **I have read and understood the information provided in the Participant Information Sheet.** **I understand that agreeing to take part means that I am happy to:**	**Please initial both boxes below** ⇩
1. Participate in an interview in which I will be asked questions by a member of the research team at Aston University about my views and opinions of delivering health services and my motivations for involvement in the Healthy Living Pharmacy programme.	
2. I have had the chance to think about the information and ask questions. Any questions I have had have been answered.	

During the study:
- We (the research team) will not pass on your details to anyone else.
- We will keep any information you give us confidential.

After the study has finished:
- We will delete any computer folders where we have stored interview data.
- We might refer to comments and opinions shared in the study report but all data used will be anonymised.

_____ _____ _____
Name of volunteer   Date   Signature

_____ _____ _____
Researcher   Date   Signature

Appendix 5 – Service User Questionnaire

This appendix contains a copy of the questionnaire which was deployed on the touchscreen healthkiosks in the HLPs participating in the study.

HEALTHY LIVING PHARMACY SURVEY
To take part ...

1 **Please touch the purple box below to show that you have understood the previous information.**

❑   I agree to take part and understand that all data are anonymous and my individual responses will be kept confidential.

Thinking about the pharmacy you are visiting today ...
Please SELECT ONE only

2 **Please tell us which pharmacy you are visiting today.**

❑ Advance Pharmacy   ❑ Health Plus Pharmacy   ❑ Hustans Pharmacy
❑ Ladywood Pharmacy   ❑ Lloyds Pharmacy   ❑ Pauls Pharmacy
❑ Saydon Pharmacy   ❑ Shah Pharmacy   ❑ Soho Pharmacy
❑ Sparkbrook Pharmacy   ❑ Other

3 **Is {Q2} your regular pharmacy?**

❑ Yes   ❑ No

Thinking about the NHS health service you have used at {Q2} today ...
Please SELECT ONE only

4 **Which ONE of the following NHS health services have you used at {Q2} today?**
[*Minor Ailments includes: coughs, constipation, diarrhoea, hayfever, headache, headlice, heartburn, earache, indigestion, nasal congestion, sore throat, tummy upset, temperature, thrush*]

Emergency Hormonal Contraception (EHC) **e.g**. morning after pill	Stop Smoking	Minor Ailments	Early Pregnancy Testing	Other
❑	❑	❑	❑	❑

Thinking about the NHS health service you have used at {Q2} today ...
For each question, please SELECT ONE only

5 **Is this the first time you have used one of the NHS health services listed below at this pharmacy?**
[*Emergency Hormonal Contraception (EHC), Stop Smoking Service, Minor Ailments, Early Pregnancy Testing*]

❑ Yes   ❑ No

6 **When did you last use one of the NHS health services listed below at this pharmacy?**
[*Emergency Hormonal Contraception (EHC), Stop Smoking Service, Minor Ailments, Early Pregnancy Testing*]

Last week	1 - 4 weeks ago	1 - 3 months ago	3 - 6 months ago	More than 6 months ago	Can't remember
❑	❑	❑	❑	❑	❑

Thinking about the <u>pharmacy staff</u> who gave you health advice at {Q2} <u>today</u> ...
For each question, please SELECT <u>ONE</u> only

7 Who did you speak to for health advice today?

Health Trainer	Health Trainer Champion	Pharmacist	Other staff	Not sure
❑	❑	❑	❑	❑

8 Who would you <u>most like</u> to have spoken to for health advice today?

Health Trainer	Health Trainer Champion	Pharmacist	I don't mind
❑	❑	❑	❑

Thinking about the <u>pharmacy staff</u> who gave you health advice at {Q2} <u>today</u> ...
For <u>each statement</u> please SELECT <u>ONE</u> from each line

9 How strongly do you agree or disagree with the following statements?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The person I spoke to today, had enough time to deal with my enquiry.	❑	❑	❑	❑	❑
I felt comfortable talking about my health with the person I spoke to today.	❑	❑	❑	❑	❑
I would like to be seen by the same person every time.	❑	❑	❑	❑	❑

Thinking about the <u>health advice</u> provided <u>today</u> at {Q2} ...
For <u>each statement</u>, please SELECT <u>ONE</u> from each line

10 How strongly would you agree or disagree with the following statements?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The health advice I was given was easy to understand.	❑	❑	❑	❑	❑
I trust the health advice given to me.	❑	❑	❑	❑	❑
I am satisfied with the health advice provided.	❑	❑	❑	❑	❑

Thinking about the <u>reason</u> for getting health advice at {Q2} <u>today</u> ...
For <u>each statement</u>, please SELECT <u>ONE</u> from each line

11 How strongly would you agree or disagree with the following statements?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I preferred to go to a pharmacy to get health advice rather than going to my GP (doctor).	❑	❑	❑	❑	❑
Pharmacy opening times are more convenient than GP (doctor) opening times.	❑	❑	❑	❑	❑
Getting health advice at {Q2} when I need it, has helped me to take better care of myself.	❑	❑	❑	❑	❑
I would recommend the NHS health service I have used at {Q2} to friends or family.	❑	❑	❑	❑	❑

Thinking about the <u>facilities</u> at {Q2} ...
For each question, please SELECT <u>ONE</u> only

12 Did your consultation with pharmacy staff at {Q2} take place in a private room?

❏Yes   ❏No

13 How strongly would you agree or disagree with the following statement?

	Strongly Agree	*Agree*	*Neither agree nor disagree*	*Disagree*	*Strongly disagree*
Talking about my health in private is important to me.	❏	❏	❏	❏	❏

Do you know about <u>Healthy Living Pharmacies</u>?
For each question, please SELECT <u>ONE</u> only

14 Have you heard about Healthy Living Pharmacies?
❏Yes   ❏No

15 Did you know that {Q2} is a Healthy Living Pharmacy?
❏Yes   ❏No

Nearly there, please tell us ...
Please SELECT <u>ALL THAT APPLY</u>

16. How did you find out about the NHS health service you used today?

Advertisements	Pharmacy staff told me about them	Word of mouth	Heard about them from friends / family	GP told me about them	Other
❏	❏	❏	❏	❏	❏

17. Have you seen NHS Healthy Living Pharmacy advertisements?

On the local NHS website?	In a pharmacy?	At an NHS roadshow?	Do not remember seeing any	Other
❏	❏	❏	❏	❏

18. Touch the logo(s) you have seen before your visit to {Q2} today?

		Have not seen these logos before
❏	❏	❏

About yourself
Please SELECT ONE only

19. Are you male or female?

Male	Female	Do not want to say
❑	❑	❑

20. How old are you?

Under 18	18-19	20-29	30-39	40-49	50-59	60-69	70-79	80 and over	Do not want to say
❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

21. Which Ethnic Group do you belong to?

❑ English/ Welsh/Scottish/ Northern Irish/British   ❑ Irish   ❑ Gypsy or Irish Traveller   ❑ Any other white background

❑ Indian   ❑ Pakistani   ❑ Bangladeshi   ❑ Any other Asian background

❑ African   ❑ Caribbean   ❑ Any other Black / African / Caribbean background   ❑ Arab

❑ White and Black Caribbean   ❑ White and Black African   ❑ White and Asian   ❑ Any other Mixed / Multiple ethnic background

❑ Any other ethnic group   ❑ Do not want to say

To finish please touch the blue <u>Submit</u> button

Thank you for taking the time to complete this survey

Appendix 6 – Copy of service poster

Tell us what you think about the NHS services you have used at this pharmacy

This survey will only take about five minutes. The questions are about the NHS services you may have used at this pharmacy.

To select an answer just touch the button on the screen. We won't ask your name and all responses will be kept confidential.

Please talk to a member of the pharmacy staff if you need help with this survey.

For more information please call:

0121 204 4963 or **0121 204 4967**

Emergency contraception

Stop smoking

Use the touch screen to tell us what you think

Minor ailments

Early pregnancy testing