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Title	Qualitative exploration of the views of healthy living champions from pharmacies in England.
Type	Article
URL	https://clok.uclan.ac.uk/14205/
DOI	https://doi.org/10.1007/s11096-014-0055-2
Date	2015
Citation	Rutter, Paul and Vryaparj, G (2015) Qualitative exploration of the views of healthy living champions from pharmacies in England. International Journal of Clinical Pharmacy, 37 (1). pp. 27-30. ISSN 2210-7703
Creators	Rutter, Paul and Vryaparj, G

It is advisable to refer to the publisher's version if you intend to cite from the work. https://doi.org/10.1007/s11096-014-0055-2

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Qualitative exploration of the views of Healthy Living Champions from Pharmacies in England

Introduction

Self-care is an important element of patient care and has become prominent in global health policy, [1-3] with community pharmacists identified as an accessible professional group that can facilitate patient self-care - combining traditional medicine supply with greater involvement in providing public health services. [4-6]

In 2009, a UK based initiative, known as Healthy Living Pharmacies (HLP) was piloted in Portsmouth (on the south coast of England). Its remit was to deliver population-wide interventions to maximise patient self-care. A HLP framework was designed and developed around a tiered commissioning framework delivering health and wellbeing services tailored to local requirements. The framework built on the nationally commissioned community pharmacy contract by providing three levels of increasing sophistication of service provision from level one to three, underpinned by a set of three 'enablers' to effect sustainable change, one of which was workforce development. This included providing additional training to any member of existing staff, other than the pharmacist, to become a healthy living champion (HLC). Once qualified the HLC takes a lead role in delivering HLP services such as smoking cessation, alcohol intervention and weight management. Ideally, the HLC should live in the community that they work in.

Preliminary findings from the Portsmouth study were positive and the Department of Health cascaded the model nationally in 20 locations across England. [7] The final findings from Portsmouth supported early findings but highlighted success was dependent on achieving the right staff skill mix, including the need for HLCs. [8]

Aim

The aim of the study was to understand the HLCs' perspective of their role and to explore the barriers and facilitators to their performance.

Ethical Approval

This study was assessed by The School of Applied Sciences Ethics Committee at Wolverhampton University and approved (BSEC 12/12/12).

Method

At the time of the study, thirty pharmacies (from 67) had been accredited as HLPs in the health boundary of NHS Dudley. Each pharmacy had one trained HLC. Every HLC (n=30) was written to and asked to take part in a semi-structured face-to-face interview. Interviews were performed by GV at the HLCs place of work. The interview schedule was developed by GV in conjunction with the community pharmacy development officer (MD). Questions were open-ended with additional prompts that explored HLCs reasons for taking on this new role, their experiences so far and the facilitators or barriers in fulfilling their duties. The interview schedule was piloted on two qualified HLCs working from pharmacies that had still to gain accreditation as functioning HLPs. The pilot showed that minor changes to wording were required to aid clarity and facilitated an interview of approximately 20 minutes' duration. These pilot data were not included in the results. Interviews took place between February and March 2013. Interviews were audio recorded and transcribed *verbatim*. Nvivo software (QSR International Pty Ltd, UK) was used to manage the data and content analysis was used to establish any emergent themes; these were validated for context and understanding by a second member of the research team (PR). With regard to researcher bias and reflexivity, the interviewer (GV) was not employed by NHS Dudley and had no relationship to any of the pharmacies or staff where interviews were conducted. GV also kept a research diary through the process to raise awareness of influences on data interpretation.

75 ## Results

76

77 Fourteen interviews took place; one person had relinquished their role, six
78 were either on holiday, sick or maternity leave. The remainder declined the
79 opportunity to be interviewed**.** All HLCs were women and had been an HLC
80 between six and twelve months. Coding produced three meta-themes; job
81 role, training and public awareness. Job role was constructed from the sub-
82 ordinate themes of: roles and responsibilities; motivation; satisfaction and
83 personal benefit. HLCs spoke about personal betterment being a key driver
84 for them to take on the role. Interviewees spoke of '*greater opportunities'*, and
85 the ability to do '*different things'.* All HLCs spoke with enthusiasm about their
86 new role and gaining personal satisfaction from helping patients, which was
87 reinforced through positive patient feedback. Below comments typify this:

88

89 "*I do like it when you can help someone and they really appreciate it, that is a*
90 *fantastic feeling."* (HLC 1)

91

92 "*I feel like I can make a difference to somebody and help to prevent them*
93 *going into hospital in the first place…it makes me feel good about myself that I*
94 *can actively help someone.*" (HLC 8)

95

96 "*I do enjoy helping them and the most part I enjoy is when they come back*
97 *and thank me…makes me feel I have helped somebody in my role as I am*
98 *supposed to.*" (HLC 4)

99

100 With regard to training, sub themes of confidence and support were
101 identified. It was clear from interviewees that the role had allowed them to
102 gain new knowledge, with HLCs being much more confident in their own
103 ability:
104
105 *"I have more confidence to deliver the service and talk to patients about stuff*
106 *you wouldn't have…I have been taught ways to communicate more*
107 *confidently."* (HLC 9)
108
109 *'I feel more confident as a person as people can approach me and ask me*
110 *questions…I feel like I have more knowledge that I can add to all my counter*
111 *and dispensing training…feel like I have something extra to offer.'* (HLC 2)
112
113 Despite HLCs identifying that their confidence had improved as a result of the
114 training, they still had reservations over delivering services such as alcohol
115 and obesity services. HLCs were keen to receive further training and on-going
116 support as there was a general feeling that they wanted to keep up-to-date
117 and ensure new skills did not '*lapse*'.
118
119 HLCs voiced concern about the public's general low level of awareness HLPs
120 and the services on offer despite acknowledgment that NHS Dudley had
121 promoted the HLP concept and HLPs had displays and signage to advertise
122 this. Typical comments illustrating this point were:
123
124

"I still don't think the local community know that we are an HLP." (HLC 14)

"*Patients do not know about HLPs…it needs to be put out across in a wider scale about what healthy living pharmacies are because that may encourage people to seek us. "* (HLC 1)

150 Discussion

151

152 The HLP concept is an attempt to embed public health services alongside
153 traditional pharmacy functions and represents a new model of care delivery.
154 Evidence shows that adoption and delivery of innovative new community
155 pharmacy services is highly dependent on motivated individuals and teams [9-
156 10] This study therefore sought to understand the views of HLCs and explore
157 the barriers and facilitators to their performance – as the HLP concept
158 acknowledges that HLCs are central to effect sustainable change the delivery
159 of public health services. Our findings highlight HLCs held very positive views
160 toward their new role and were motivated through a sense of personal
161 development and a desire to want to help people; a sense of personal reward
162 being evident rather than financial gain. The change of status appeared to be
163 welcomed by HLCs, and helped them to talk with patients in a way that they
164 probably would have not done so before. This enabled HLCs to gain greater
165 job satisfaction through helping patients. These findings echo those seen in
166 the Portsmouth data [8]. However, unlike the Portsmouth data, it was
167 apparent from HLCs in Dudley that they had grown in confidence, which was
168 underpinned by the training and support received. Training undertaken clearly
169 facilitated their transition to an HLC yet when delivering certain services
170 (alcohol awareness and obesity), they found it challenging to engage with
171 patients and identified that further training and on-going support was required.
172 Further work on the mechanism of support to HLCs is needed to firstly
173 maintain competency and secondly to improve skills and confidence to allow
174 all (and potentially future) services to be delivered.

175 A major barrier to the success of HLPs appears to be public engagement.
176 HLCs reported low public awareness of HLP services and is consistent with
177 pilot and pathfinder findings. [7, 11] Recent research suggests that community
178 pharmacy has the potential to deliver public health services, although the
179 impact on public health may be limited due to negative public (and health
180 provider) perceptions toward community pharmacy. [12]
181
182 The HLP model has does offer a way in which community pharmacy can
183 contribute to patient care in a formally recognised and remunerated way.
184 Evaluation to date has been generally positive both from a provider and user
185 perspective. Such a model could be used by other countries with similar
186 health policy and primary care networks. However, sustainability has yet to be
187 demonstrated in the HLP model and this work suggests that HLCs will be key
188 to long-term success. Support networks between HLCs need to be put in
189 place that are self-monitoring but require additional formal in put to maintain
190 and improve skills in delivering services.
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Limitations

Only 14 of the 29 currently employed HLCs were interviewed and it is unknown if those unwilling to be interviewed would have given the same viewpoints; self-selection bias is therefore possible. Within the 14 interviews conducted, data saturation could not be guaranteed as new themes were still coming to light in the latter interviews, although these were infrequent and all major themes had been identified by interview eight. In addition, this work was conducted in just one of the 20 sites in England and therefore data must be seen in this context and not necessarily representative of other areas. Despite these limitations findings do highlight that staff can be trained to delivery public health services to local communities and results in a motivated workforce.

Conclusion

HLCs in NHS Dudley were motivated, enthusiastic and derived job satisfaction from helping people to improve their health. Training provided facilitated the transition to HLC but on-going training and support is needed to ensure HLCs are able to continue in this role.

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