

Racks of make-up and no spanners

An action research project into men's use of pharmacy to improve their health

Dr Gillian Granville on behalf of The Men's Health Forum



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Dr Gillian Granville

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Introducing the report

The Men's Health Forum (MHF) is a charity whose mission is to be an independent and authoritative advocate for male health and to tackle the inequalities affecting the health and wellbeing of boys and men in England and Wales.

In March 2007 the MHF received funding from the Department of Health, the National Pharmacy Association, and Pfizer Ltd to carry out a 15-month action research project into men's use of community pharmacy services to improve their health and wellbeing. The Royal Pharmaceutical Society of Great Britain funded the production of an information booklet on Men and Pharmacy. The project's aim was to add to the knowledge base of 'what works' and 'why' in order to encourage men to make better use of community pharmacies and to identify the potential barriers. A workplace intervention was used to test the effectiveness of this setting for engaging with men about their health. The project would also contribute to our understanding of why men do not make use of mainstream health services generally for improving their health and wellbeing and what needs to happen to enable them to do so.

Project outcomes

- ▶ A review of the current literature and policy context on issues concerning men's health, workplace health and pharmacy services
- ▶ Primary evidence on the topic from focus group research with men and pharmacists
- ▶ Learning from a four-week feasibility study carried out in partnership with a large employer to encourage men to use pharmacy services
- ▶ Practical knowledge to drive forward policy implementation in NHS pharmacy (including education and training), workplace health and gender inequalities in health.

Project outputs

- ▶ **July to November 2007** – Policy and literature review.
- ▶ **November 2007 to March 2008** – two reports from the focus group activity with men and with pharmacists and their teams, using a thematic analysis.
- ▶ **May to July 2008** – description and evaluation of a four-week work based feasibility study in mid-Yorkshire.
- ▶ Twenty recommendations for policy makers, researchers and practitioners in the fields of pharmacy, workplace health and public health

These four outputs have been brought together in this final report.

This report is intended as a resource that captures the whole project.

Chapter one

The first chapter sets the scene for the project. It begins with a discussion on the rationale behind the project, its aims and the approach that was adopted. It includes a description of the partnerships that were developed and the involvement of a range of key stakeholders.

The chapter then considers secondary evidence from the literature on men's health, their use of services and what we know about their access to community pharmacists and pharmacies. It includes some examples from practice.

A description of the policy context in which the project was operating can be found in Appendix 2. In particular, it considers policies relevant to public health and health inequalities, workplace health and the developing role of pharmacy in promoting health. It illustrates the rapidly shifting policy agenda during the twelve months (July 2007 to July 2008) of the project, including the publication of the pharmacy white paper in April 2008.

Chapter two

The second chapter presents primary evidence obtained from four focus groups. Two of the groups were with men from mixed socio-economic backgrounds working with a large employer. The other two groups were with pharmacists and their teams. The chapter presents a thematic analysis of the data, and a summary of key findings.

Chapter three

Chapter three presents the feasibility study carried out in the workplace with a large employer, including the details of the design, the results and the follow-up internal evaluation. The response by men to the intervention was low, but a comprehensive follow-up evaluation gives very valuable insights and learning into why men did not access the pharmacy. An in-depth analysis of the evaluation identified five themes: private and public spaces, trusting relationships, men and healthy living, communications and relationships with men, and accessibility. The chapter ends with learning points from carrying out the study.

Chapter four

The final chapter brings together twenty recommendations from across the project. These recommendations are drawn from a synthesis of the three areas of the project, that is the literature and policy review, focus group material and the evaluation carried out as part of the feasibility study. These recommendations are grouped under three areas: Informing gender inequalities in health, informing 'Workplace Health' policy and practice and informing pharmacy. Each section includes recommendations for policy implementation, practice development and further research.

Chapter One: Setting the scene

The first chapter sets the scene for the project. It begins with a discussion on the rationale behind the project, its aims and the approach that was adopted. It includes a description of the partnerships that were developed and the involvement of a range of key stakeholders.

It then moves on to present a review of the literature on community pharmacy and the public health role, what we know about men's health and access to services and men's use of pharmacy. It concludes with examples from practice of men's use of pharmacy.



About the men and pharmacy project

Rationale

In 2004, the Men's Health Forum (MHF) published 'Getting it Sorted: A Policy Programme for Men's Health' (MHF 2004), which sets out the Forum's view on the policy changes needed to improve the unacceptable poor state of male health in England and Wales. The paper makes the case for why it is necessary to consider gender as a determinant of health, and although, in 1998, the inquiry into inequalities in health (Acheson 1998) cites gender, along with social class and ethnic origins, as a key factor in determining health status, gender continues to be viewed as a peripheral factor or not recognised at all.

This lack of awareness, the Forum argues, is due to the mistaken belief that differences in health status between the sexes are mostly the result of biology and therefore inevitable. This has led to health services being developed that do not understand or take account of male attitudes and behaviours towards their health, and what is required are services designed to take account of gender difference.

The report highlighted that community pharmacies are under-developed in their potential to offer health information, advice and guidance for self-care, as well as being significantly underused by men. This is in spite of them having many of the characteristics that men look for in a service, such as accessibility, flexibility and informality.

The MHF made these points in greater detail in its response to the Department of Health's consultation in 2003 on the future of pharmacy services (DH 2003a). Several of MHF's policy proposals were reflected in the subsequent Choosing Health through Pharmacy report (DH 2005a), which highlighted the potential role for pharmacy in reaching men.

Subsequently the MHF sought funding for a project to test out some of these assumptions of men's use of pharmacy.

Aim of the project

The aim of the project was to add to the knowledge base of what works and why in order to encourage men to use pharmacies and to identify the potential barriers. The workplace was used as a setting to facilitate this. The project would also contribute to our understanding of why men do not make use of mainstream health services in general for improving their health and wellbeing and what needs to happen to encourage them to do so.

Project approach

The approach the project adopted was a combination of bringing together what we knew already from the literature and examples of practice, the generation of new evidence through focus group work, and testing our hypothesis by carrying out a feasibility study in the workplace of a large employer. The evidence from the literature and focus groups was used to inform the design of the feasibility study.

The project was committed to working with a subset of men, in this case manual workers in an area with a significantly worse male life expectancy than the English average, and from mixed ethnic backgrounds. This was in order to understand more clearly the effects of gender on these other strands of health inequalities, and to identify any particular differences in approach to health improvement from these groups.

An action research approach was adopted in an attempt to achieve improvements by pursuing action and research outcomes at the same time (Bowling 2001, Pawson 2006). Action research seeks to bring together action and reflection, theory and practice in participation with others, in the pursuit of practical solutions. It uses mostly qualitative methods, such as focus groups.

The project was committed to being inclusive, involving a range of partners and stakeholders from the outset, in order to generate interest in any learning that emerged (Bates et al, 2004). The MHF website was used as a key

dissemination route for early findings and outputs from the project. An advisory group was convened involving partners from pharmacy, public health and employers (appendix 1); this met three times during the project.

A review of the literature

Community pharmacy and a public health role

This section reviews community pharmacy's role in public health, looking in particular at its place in local communities, the way it straddles the private and public sectors, conflict arising with other health professionals and education and training needs to carry out a health promotion and public health function.

A Social Pharmacy Approach

Pharmacists have everyday contact with both the healthy and the sick, which gives them a unique role in early diagnosis and identification of disease. Public use of community pharmacies is almost universal, and although use is currently low for general health advice, it is higher among women, respondents with young children and lower socio-economic groups (Blenkinsopp, et al 2003).

A report by the New Economics Foundation (NEF 2003) as part of its Ghost Town Britain initiative (NEF 2002), argued strongly against the proposed deregulation of community pharmacy because of the impact it would have on communities, and in particular, in communities which are economically deprived and have the worst access to NHS services. The report suggested that deregulation and the consequential takeover of the pharmacy market by major retailers would mean a loss of a vital lifeline for people in communities. This also has a 'knock-on effect' on the local economy, and "increases the stranglehold of supermarkets over an essential service" (NEF 2003). Deregulation has been partially implemented in England, with the current exemptions being large shopping centres, mail order and internet pharmacies and

pharmacies allowed to open for one hundred hours a week.

The motivation for a Social Pharmacy Approach emerged from the belief that health is influenced by socio-economic factors and that pharmacies can play a greater role in sustaining and developing local health networks. They are located at the heart of local communities, are accessible to local community members and crucially, are able to sustain and support equality of access for users (Anderson et al 2005). However, this approach raises concern for the Men and Pharmacy project if gender is not visible as an equality factor, and the possibility that 'equality of access' will mean 'equality of services' rather than equality of outcomes.

The most comprehensive evidence about the contribution that community pharmacy can make to improving health comes from a series of reports published by PharmacyHealthLink and the Royal Pharmaceutical Society of Great Britain (Armstrong et al 2005). 184 projects in the UK were surveyed, and 18 reported campaigns about mental health, parenting, men's health awareness and health promotion aimed at local ethnic minority groups. There was strong and good evidence of the pharmacy role in improving the incidence of coronary heart disease through smoking cessation services and weight management.

The authors concluded that although innovative projects in community pharmacies cover a range of health topics, they are highly concentrated in a small number of topic areas: smoking cessation, sexual health and drug use accounted for 75 per cent of the UK projects surveyed. The suggestion is that this may be related to the fact that these services were linked to medicinal merchandise such as nicotine replacement therapy, emergency hormonal contraception and supervised methadone administration (Armstrong et al 2005, Jesson and Bissell 2006). The authors also noted the limitations of evaluation studies into health initiatives, which makes it difficult to assess their contribution to public health.

A scoping review to explore the potential role of pharmacists in tackling health inequalities (Payne et al, 2005) found that on the limited evidence that existed, community pharmacists working in extended roles have had little impact on health inequalities, although this did not mean that there is no potential for them to make a contribution to this agenda. An article in the UKPHA Spring newsletter (Drucquer, 2008) offers the view that no government can be serious about addressing health inequalities without involving community pharmacies. However, Drucquer believes there are three important barriers to progress: the threat of the supermarket sector, misplaced faith in the new pharmacy contract as a mechanism for delivering outcomes that narrow the gap and the third is attitudinal barriers and capacity problems within the profession itself.

Straddling public and private sectors

Like GPs, dentists and optometrists, community pharmacists are independent NHS contractors. In other words, they all straddle both the public and private sectors (Armstrong et al 2005). Community pharmacists must also survive as small businesses in local communities, or as major retailers on the high street. Different pharmacy ownership models mean that competition is fierce between supermarket pharmacies, large independent chains and small independent pharmacies all looking for opportunities to take up healthy living models (Jesson and Wilson 2003). Conversely, this dual health and commercial role offers a unique position to pharmacy in targeting activities towards healthy people as well as sick (Armstrong et al 2005).

In the context of health improvement initiatives, consideration has to be given to the commercial/business environment and the extent of the financial risk to pharmacies in taking part. One of the strengths of pharmacies in offering open access also puts them at greater risk; the need to balance accessibility for casual advice against time spent on their paid dispensing role. Another consideration is the time and resources

required to train and support staff in new roles (Anderson et al 2005).

The availability of funding clearly influences the UK patterns of activity with fee-paying services an important motivation for participation. 60 per cent of projects surveyed in the PharmacyHealthLink/ RPSGB study received payment and these payments were far more likely to happen where national funding was available (Anderson et al 2005). In terms of the new Community Pharmacy Contract, this means that services are more likely to be provided if they are funded at local level as enhanced services. The authors recommended that if wider provision of services is to ensue, then funding needs to be available. At the time of the report (Armstrong et al 2005) it remained unclear how PCTs would use pharmacies to meet their health improvement targets, but the changes to the structure of the national pharmacy contracts to support the extended public health role was thought to help facilitate this (Anderson et al 2005).

Health promotion or public health?

There is still debate as to whether pharmacy will fully take on a public health role or whether it will remain at the level of a health information/ health education service with lifestyle interventions.

A critique of the proposals for the pharmacy profession to develop a public health strategy has been carried out (Jesson and Bissell 2006), providing a critical assessment of pharmacy's response to the public health agenda. To realise the full potential of pharmacy to improve people's health and reduce inequalities, its role in public health is intended to be more than just lifestyle interventions, but also directed at taking a broader population perspective of health needs. However, the authors found through a review of key pharmacy documents that the profession had not engaged with the new public health movement in the wider health community. They add:

“What they (core pharmacy policy documents) do not do is incorporate the core public health language of health divide, health inequalities, social disadvantage, social determinants of health, and upstream and downstream determinants of health (Jesson and Bissell 2006: 162)”.

On the wider debate of health inequalities and the health divide in particular, the pharmacy profession remains very medicine focused, and has not engaged in the wider public health debates. They conclude that:

“The contradictions of attempting to graft a public health mindset onto a commercial environment remain (at least to us). In particular, we draw attention to the increasing reluctance of pharmacy contractors to provide services unless there is a commercial incentive (Jesson and Bissell 2006: 167)”.

However, the authors go on to say they are not suggesting the business practices are necessarily incompatible with public health objectives, but that the NHS needs to keep it in mind when considering how to engage the pharmacy profession with the public health agenda.

If pharmacy remains outside the mainstream of public health, it will not be able to play its part in the identification of local community needs and the commissioning of local services, which it is well placed to provide. This is a paradox in many ways as they are in a unique position because of their commercial role to have sound knowledge of their customer base, in a way that has often in the past been missing in public health work.

A role for pharmacy in supporting long-term conditions has also been acknowledged. A report on meeting the future challenges of diabetes recognised the important part pharmacists can play in delivering care to people at risk of, or with, diabetes (Newbould and Taylor 2008). It recommends that community pharmacists should support lifestyle change, as well as helping individuals and families with

diabetes to use medicines more effectively. The report acknowledges that to tackle some of the twenty-first century demands for both new medicines and health behaviour changes, pharmacy can combine the delivery of both these vital ingredients for the prevention and treatment of diabetes.

Professional conflict

One of the other issues affecting an increased role for community pharmacy is the perceived or real conflict with other health professionals. One critique suggests that:

“Community pharmacy is developing strategies to enhance its professional status, it is not so much as an attempt at usurping general practitioners as a bid for survival (Edmunds and Calnan 2001)”.

One study explored the perceived professional barriers between GPs and community pharmacists (Hughes and McCann 2003). The shopkeeper image, as well as conflict between business and health care, emerged as the main barrier between the two professions. GPs were also largely unaware of the training and activities of community pharmacists, and similarly, pharmacists felt that GPs had no appreciation of their role in health care.

A recent report on the European public's perception of community pharmacy (Taylor, 2007) raised the issue of the introduction of financial incentives to encourage closer working between doctors and pharmacists in the community.

The public perception of General Practitioners is that GPs are more important than pharmacists (Community Pharmacy Research Consortium 1999) in the professional hierarchy. The community valued the pharmacist's role less highly, and used pharmacists when they considered the GP's time was too valuable to waste. However, in a Reader's Digest online survey (2007) of the most trusted professionals in the UK, pharmacists came out higher than doctor's (96 per cent as against 91 per cent).

A quantitative and qualitative market research report on use of community pharmacy (COI 2008) was recently carried out to inform the Pharmacy White Paper (DH 2008c). It supported the fact that people trusted the pharmacist to provide information that would be reliable and of good quality, and that they would quickly refer onto a doctor if they were not sure of their facts. Only some older men were less accepting of getting help from the pharmacist and they were most likely to be the group who saw visiting their doctor as their right.

Education and Training

The provision of training positively increases the level of involvement of pharmacists in health promotion interventions, as well as resulting in greater uptake of services for clients (Armstrong et al 2005). Specific health promotion areas where training was particularly successful were identified as:

- ▶ Producing behavioural change in pharmacists to a more holistic approach and understanding of health.
- ▶ Increasing the length of consultation with the clients.
- ▶ Increasing the effectiveness of interventions.
- ▶ Increasing local multi-agency working.
- ▶ Increasing the likelihood of pharmacists becoming more proactive in giving health information and advice.
- ▶ Increasing the likelihood of pharmacists discussing general health issues and prevention, rather than focusing on medicine.
- ▶ Increasing clients' satisfaction with the consultation.
- ▶ Increasing the likelihood of clients feeling able to ask questions.

It is also recommended that core pharmacy practitioner and specialist public health competencies need to be developed, based around the Faculty of Public Health's ten key areas for public health practice. Underpinning these competencies must be a comprehensive training and education programme (Armstrong et al 2005). It is also recommended at both undergraduate and postgraduate level that

joint training would go some way to improving mutual understanding, trust and communication between the professions (Hughes and McCann 2003).

The Centre for Pharmacy and Postgraduate Education (CPPE) University of Manchester has a public health learning programme that supports the public health agenda. The programme, based on the 'Choosing Health through Pharmacy' strategy (2005a) produced by PharmacyHealthLink, includes stop smoking, diet and nutrition, substance use and misuse, emergency hormonal contraception and sexual health. They also hold a variety of workshops to support the development of public health related skills across a range of lifestyle topics, practical approaches to health promotion, a public health framework for practitioners, and an understanding of the public health needs assessment process.

Public health resources

There are a number of other resources to support pharmacy service developments that have been produced. These include information on stop smoking, sexual health services and a forthcoming one on weight management by the CPPE/ NPA .

PharmacyHealthLink also produces a range of public health resources, training events and training resources to support public health development in pharmacy. A practical guide for community pharmacists was produced in July 2004 by the Royal Pharmaceutical Society, PharmacyHealthLink, the National Pharmacy Association and the Pharmaceutical Services Negotiating Committee.

Men's health and access to health services

This section reviews the literature on men's health and its relation to health inequalities, including access to health services, workplace settings and health information. This is followed by what we know about men's use of pharmacy for general health advice.

Men's health and health inequalities

The poor health profile of men is now well documented , but it is worth repeating for the purpose of this paper. Average male life expectancy at birth in the UK is 76.6 years compared to 81.0 years for women. These figures mask large variations across the nations, regions, local authorities and wards. Scotland is the country with the lowest rate at 74.2, and Manchester has the lowest average male life expectancy at local authority level in England at 72.5 years. Even these statistics mask the difference across local authorities, with some areas, such as Glasgow, reporting a male life expectancy of 54 in one of its wards (CSDH, 2008). The Health Secretary Alan Johnson, in a speech on health inequalities (House of Commons 2007), announced that data on life expectancy will in the future be collected at ward level rather than across local authorities, so that the worst pockets of health outcomes can be clearly identified.

Men are more likely than women to be overweight . Women and men are currently equally likely to be obese; however, there is good evidence that, by 2015, 36 per cent of men are likely to be obese compared with 28 per cent of women. In 2025, only 13 per cent of men will have a healthy body mass index (BMI) compared with around a quarter of women (McPherson et al, 2007). In 2004/5, 26 per cent of men smoked compared to 23 per cent of women, but even these figures do not demonstrate the differences between men, with those in lower socioeconomic groups being more likely to smoke.

Access to health services

The Government has highlighted the strong connection between access to appropriate services and health inequalities, and it has pledged that improvement to accessing primary care services would be one of its priorities. The Department of Health's progress report on health inequalities (DH 2008) has a focus on improving services to make them more accessible and responsive to the needs of the people they serve.

Men are much less likely than women to use primary health care services. Overall, men in Great Britain visit their GP four times a year compared to six times for women. The difference in usage is most marked for the 16-44 age group – women of this age are twice as likely to use the service as men. According to National Statistics analysis, the higher consultation rates by females is evident in all age groups except preschool children and is distributed across a wide range of illnesses in addition to the obvious needs of women to consult for contraceptive and pregnancy care. There is a similar pattern for dental check-ups: women are much more likely than men to seek regular dental check-ups and younger men are one of the groups least likely to seek regular check-ups.

People who were economically inactive were more likely to consult their GP than those who were working, with 19 per cent of men in this group having consulted their GP in the last 2 weeks compared with 8 per cent of those in employment. This supports the evidence that men's work can prevent them accessing the GP, and reinforces the need for more flexible and varied services, some of which should be near, or in, the workplace (White and Cash 2003, CBI 2007, Granville and Evandrou 2008).

There are important variations in these access figures in black and minority ethnic communities. Black Caribbean men had a higher consultation rate, and Bangladeshi men were twice as likely to have contact with a GP than men in the general population. This increased

with age, with the highest consultation rate at 7 per year found in Bangladeshi men over 75 years. (Source above ONS 2006)

There are implications for pharmacies in these variations, with pharmacies potentially having good access to men from ethnic minority communities. 76 per cent of men aged between 65 and 79 use prescribed medication, with Bangladeshi men, after taking age into account, taking twice as many prescribed drugs as men in the general population.

The workplace setting

The importance of the workplace and working with employers to improve health and reduce inequalities has been rising up the policy agenda (DH 2004, DWP 2005, Black 2008). The public health challenges to this approach are not to be underestimated (Wilkinson 1999, Allender et al, 2006), although the possibilities of accessing men through the workplace have been acknowledged (Granville and Evandrou 2008, MHF 2008). The advantage of workplace initiatives is that they are delivered where people are, although a recent commentary (Adshead and Thorpe 2008) warned that creative thinking is required about what is meant by the workplace, and how it is possible to reach different groups of male workers. The point is also made that through working with employers and their immediate workforce, there is huge potential to influence the community at large (Adshead and Thorpe 2008).

Health information

Men do not access health information for general awareness of their overall state of health; when they do use information it is driven purely by their immediate need or concern (Conrad and White 2007). Recent findings by the American Psychological Society (unpublished) found that even on the internet, men are less likely than women to look for health-related information, either for themselves or others. In a study of four internet usage surveys, 75 per cent of men said they searched the web for health related issues, compared with

82 per cent of women. This was an increase from 46 percent of men in 2000, indicating that men were increasing their use of web based health information, but still not as much as women. There was no breakdown with age and socio-economic status. The researchers concluded that the results were consistent with women's role as the health gatekeepers in most families. Women are also more likely to belong to online medical support groups, although men are more likely to go online for sensitive health information that may be difficult to talk about. This supports men's need to have confidential advice.

Men's use of pharmacy

General health advice

There is very little robust evidence on men's use of pharmacy, particularly in relation to general health and lifestyle advice. Evidence on pharmacy use is rarely gender-sensitive, and survey data that has a gender breakdown is not always comparable in purpose and methodology, giving a lack of clarity to the overall picture and making interpretation difficult at times.

A nationwide survey (Developing Patient Partnerships DPP 2004), carried out as part of a campaign to encourage men to make greater use of pharmacies in order to better manage their general health and minor ailments, found that 58 per cent of men (in a sample of 470) had visited the pharmacist in the past 3 months, although when asked to choose from a list of what they had most used their local pharmacy for, only 3 per cent said general health. This was spread across all social groups. General health advice came behind toiletries at 8 per cent, with prescription collection topping the list at 58 per cent.

A survey jointly commissioned by the Proprietary Association of Great Britain and Reader's Digest in May 2005 (PAGB and Reader's Digest 2005), had the overall objective of assessing how the general public view and manage their everyday health, how much they experience and respond

to a range of specific common health conditions, and how they use alternative sources of health information and advice available regarding their everyday health. 721 men and 779 women were asked the number of times they had ever been to the pharmacist to discuss general health: 48.7 per cent of men had done so, compared with 60.3 per cent of women. The number of men who said they had discussed general health with their GP at any visit was higher at 65.2 per cent.

In the same survey, when asked a different question as to whether they would use the pharmacist to get information on their health, 41.1 per cent of men, compared with 58.2 per cent of women, said they would never use a pharmacist for this. Similarly, 51 per cent of men would not go for healthcare leaflets compared with 34.7 per cent of women.

Another study in the West Midlands (Boardman et al 2005) found that only 12 per cent of people had asked the pharmacist for advice, with women being more likely than men to have obtained medicines or asked for advice. Men use pharmacies infrequently, particularly those in fulltime employment and those aged 16-24 (Community Pharmacy Research Consortium 1999). Ethnic status receives less attention in the literature, although data corroborates that pharmacies are used more by people in lower socio economic groups.

A study which explored men's awareness of indigestion (MHF/ PAGB 2005) found that pharmacists have the potential to offer health and lifestyle advice to men when they are seeking OTC remedies for indigestion, but this may not be an opportunity that pharmacists currently exploit. The study also concluded that it was necessary to raise the profile of pharmacists as someone who can be asked about health and lifestyle issues.

Engaging men

Although the survey data does not give us an exact picture of men's use of pharmacy for health advice, what is clear is that they use it less than women, in spite of pharmacies having

many of the characteristics that in other settings encourage men to use health services. These include:

- ▶ Ease of access with no appointments required
- ▶ Friendly, relaxed approachable service where pharmacy staff can spend more time with customers,
- ▶ The pharmacist's profile as a drug expert, advising on medicines (Community Pharmacies Research Consortium 1999).

We also know that men would be encouraged to make more use of a pharmacy if there was a confidential consulting area (DPP 2004, Armstrong et al 2005), followed by better signage and more male staff.

A US study to determine whether community pharmacists using a risk assessment tool could encourage men who were overdue for physical examinations (Boyle et al, 2004) to attend found that community pharmacists had a significant impact on motivating men to attend their doctor for follow up care once a potential health risk was identified. The tool and the pharmacists recommendation were the motivating factors rather than follow-up telephone interventions by the pharmacist.

A study, which evaluated a Well Men Services project in Scotland offering health assessments to men, found that services needed to be tailored to address the needs of different groups of men and depended on topic, setting and circumstances (Douglas et al, 2008). It also suggested that primary care staff should develop a gender-sensitive health improvement ethos to encourage men to raise health and lifestyle concerns with them.

The review now looks in detail at some practical examples in the UK of pharmacy services that support men's health and wellbeing.

Examples from practice

'Pop down your local' Campaign

The campaign that followed the survey by DPP (referred to above) was called 'Pop Down Your Local' (The Pharmaceutical Journal 24th April 2004). It was designed to raise awareness among men about the range of pharmacy services available and to encourage greater use of pharmacy services. During the campaign 834,403 leaflets and 16,632 posters were distributed, and a follow-up survey of DPP members found that 100 per cent believed the campaign would make men more aware of what the service would offer.

Men's Health Checks in Knowsley

An evaluation was carried out (Pennington 2006) of a project in Knowsley, piloting the use of community pharmacists to deliver health checks to men aged 50 to 65 years between January to March 2006. The evaluation aimed to assess the impact on clients and pharmacists of men's health checks in the pharmacy setting. The evaluation was particularly helpful in understanding what works as it covered a number of aspects: an exit survey of men attending the checks, a follow-up survey in 4 weeks to see if there was any behavioural changes, a non-user survey with men who did not attend, and finally a report on the pharmacists' opinions of the pilot.

The findings were very encouraging: 64 per cent of the 103 respondents had not been to a pharmacy for health advice before, and all but one of the respondents was likely to recommend the checks in pharmacies to other men. However, the report warns against complacency here, because there was an indication in the study that clients who are not likely to attend a health check at their GP surgery are also unlikely to look for information at the pharmacy.

The men went away with a record of their blood pressure, cholesterol and blood sugar levels, placing some of them in a position to consider making lifestyle changes. Four weeks

later, a follow up study showed that of most of those that responded (96 per cent, n=54) made lifestyle changes as a result of attending the life check. These included alteration to diet resulting in less fatty foods, snacks and salt and increasing fruit and vegetables; one client gave up smoking and another reduced their cigarettes, and some were taking more exercise. We could speculate that those who responded were those who had made change, but this was still approximately half of the men who had the checks.

Success was also achieved in signposting clients to other services: one contacted a smoking cessation service, one to alcohol services and 13 contacted their doctors (approximately 10 per cent of the total health checks).

There was some interesting learning from the non-user survey that was also carried out doing the pilot stage, when awareness was heightened. 180 interviews were carried out, although 38 per cent were outside the target age. 19 per cent did not feel that a health check would be useful as they felt well, and there was clearly a misunderstanding that these were lifestyle checks, rather than 'illness' checks. Other useful information emerged for anyone wishing to adopt this approach, including the value of vouchers for raising awareness.

The health checks in community pharmacies in Knowsley was built on the PITSTOP project - a PCT initiative to improve health inequalities by encouraging men, through a community development approach, to take a free health check. As a result of the findings from the pharmacy pilot project, Knowsley PCT is funding the health checks as an enhanced community pharmacy service. However, the focus has moved away from 'men only' to include women, and people aged between 40 to 75 years old. This was because of pressure from the community to make the checks more widely available, and has necessitated a change in the publicity to attract both women and men.

Birmingham Heart MOT pilot

The aim of the Birmingham Heart MOT pilot was to improve male life expectancy and close the gap across the city by targeting some of the most deprived communities or those areas with the poorest male life expectancy. The 'Heart MOT' pilot was developed as a partnership between Birmingham Health and Wellbeing Partnership (BHWP), Lloydspharmacy, Birmingham NHS PCTs, and 10 independent pharmacies, making a total of 24 pharmacies. The pilot began in September 2006 and finished in March 2008, and the evaluation is due in the Autumn 2008.

Community Pharmacists in areas of reduced male life expectancy in Birmingham aim to identify 'new' patients between 40 to 70 years old, who are not currently receiving NHS treatment, and offer them a Heart MOT. The patients are screened by the pharmacist, or their trained staff, for cholesterol, blood glucose, blood pressure and lifestyle information. Patients receive immediate printed results and advice showing their risk of cardio-vascular disease and whether they need to see their GP to be considered for treatment. Those at low risk are referred to health trainers for support to improve their lifestyle.

It is open to men and women, although the marketing is aimed at men, and women are encouraged to bring their male partners. The latest analysis (June 2008) showed that over 50 per cent of attendees were men. Approximately half the men have been referred to the GP for treatment.

The BHWP commissioned the service as an enhanced pharmacy service, and the participating pharmacies receive training and accreditation for carrying out the checks. The service has subsequently expanded to include the three PCTs in Birmingham, and it is a Birmingham wide initiative. The age range has now increased to 74 to bring it in line with the proposed government vascular checks. The final evaluation report will give important data on which men used the service and whether it was

able to reach men with the greatest need. So far, the results appear very promising.

Weight management service

A local pilot project was carried out by a community pharmacy in Redcar, with support from Langbaugh Primary Care Trust, to offer a weight management service (White and Pettifer, 2007). The service was delivered by a pharmacy assistant with a particular interest in weight management, and supported with professional backup from the pharmacist. The service was built around lifestyle modification, looking at eating habits, levels of exercise and psychological barriers for change. No conscious effort was made to target either gender.

After seven months of activity, only 15 per cent who attended were men. The project concluded that this was due to men's different attitudes to weight management, and that obesity and diet have been seen as feminine issues. They felt that it would be more effective to combine weight management with, for example, blood pressure monitoring and cholesterol testing, therefore removing the emphasis on weight control. Also running clinics and sessions in the pharmacy dedicated to men's health would help men to realise that this is not a problem individual men suffer alone.

It is clear that a lot of learning emerged from this project. However, currently, the service is not developing because of a lack of funding from the local PCT.

The Men and Chlamydia Project: 2002-2004, Men's Health Forum

The Men and Chlamydia project carried out by the Men's Health Forum, sought to increase men's awareness of chlamydia, promote safer sexual practices and encourage men to seek screening and treatment where appropriate. The first phase was a research phase involving a series of group discussions with young men aged 18 to 25. This was followed by an implementation phase in 2004, involving a partnership between the MHF and Telford

and Wrekin Primary Care Trust (T&WPCT). Six local workplaces, employing between them 4000 men, agreed to endorse and circulate health promotion materials, and specifically-designed free kits were made available to allow young men to self-test for chlamydia infection. Those who tested positive were offered the opportunity to go to a pharmacy for treatment without the necessity of a prescription from their GP or local GUM clinic. This was made possible by the PCT instituting a Patient Group Direction to enable a named group of pharmacists, who received specific training, to issue treatment 'over-the-counter'.

During the project only 2 of the 10 positive testers actively chose not to seek treatment at the pharmacy, and although the figures are small, the option of obtaining treatment at the local pharmacy was the most popular by a considerable margin. Availability of treatment at pharmacies was considered one of four key elements that have the potential to increase male inclusion in chlamydia screening programmes.

Chlamydia Screening

In November 2005 the Department of Health launched a two-year pilot scheme to deliver a free-to-user chlamydia screening service through community pharmacies to 16-24 year men and women within the M25. The pilot scheme was made available to both men and women although there was limited gender-specific promotion. Boots The Chemist Ltd was commissioned to provide screening and treatment, and Boots pharmacies across 31 London PCTs made the kits available (DH 2006b).

The pilot scheme in pharmacies has been independently evaluated and the final report (TNS Health Care, 2007) shows that male users of the pharmacy service comprised 21 per cent, which exceeded the national rate in the National Chlamydia Screening Programme of 18.6 per cent (2005/6 Annual report). A higher proportion of men (5 per cent) from non-white ethnic backgrounds used the service

than females from similar backgrounds: 69 per cent of female users were white compared with 64 per cent of white male users. The evaluation report suggests that all users liked the convenience of accessing this service through pharmacies due to the high street location, as well as the extended opening hours and anonymity. A key barrier was embarrassment and feeling nervous about approaching staff.

Boots also have a private chlamydia screening scheme and they claim that this is attracting a higher proportion of men, 36 per cent, although they think the higher age limit and availability of kits online are contributory factors.

Regarding other services to the public through their pharmacies, Boots do not collect central data that breaks down gender usage, although they do run two programmes specifically for men, one on hair retention and one on erectile dysfunction.

Summary

The literature demonstrates a critique of the public health role of pharmacy of which some issues remain to be resolved. It is also frustrating to find the extent to which studies remain 'gender blind', even when they are seeking to address health inequalities. Regarding men's use of pharmacy for health and lifestyle advice, there appears to be a lack of evidence of what works to encourage men to make better use of pharmacy. There is a pattern of short, 'go-stop' projects which do not receive mainstream funding, therefore making it difficult to establish a robust evidence base. Similarly, there is not a sufficiently strong evidence base to understand what works, for whom, in what circumstances and why, which makes spread and adoption of research findings in complex community-based initiatives difficult.

Chapter Two: Collecting primary evidence

Chapter two introduces new evidence. This was obtained from a series of four focus groups – two groups with men working in a large organisation, and two groups with pharmacists and their teams.

The data from the four focus groups was analysed through a thematic approach. Three broad themes emerge from the men's groups. These are: men's health and wellbeing including the meaning of health, conflicting advice and information and the role of family and friends; men's use of pharmacy covers purchasing products, accessibility and convenience, understanding the pharmacy space and having 'something to do'; the third theme is medicines management or health promotion and includes fear of commercial pressure, confidence in the doctor, who to trust in the pharmacy and men have to ask.

Five themes emerge from the focus groups with pharmacists and their teams. These are: accessing pharmacy services; finding the right hooks for men; building trusting relationships; fit for purpose; gaining awareness of the health promoting function; and the role in the wider health economy through rewards and incentives.



Findings from the two focus groups with men

Two focus groups of men, employed at Royal Mail in the mid Yorkshire area, took place in November 2007 (Appendix 3). Group 1 consisted of 10 men of mixed age groups, all were white British and their jobs ranged across frontline postal workers to middle managers. Group 2 consisted of 5 men, with a range of ages and occupations. 4 men were white British and 1 Asian. A thematic approach was used to analyse the data and the emerging themes were grouped under the following broad framework headings:

- ▶ Men's health and wellbeing
- ▶ Men's use of pharmacy
- ▶ Medicine management or health promotion

Quotation marks and italics are used for direct quotes.

Summary of key findings

- ▶ The understanding of health differed across age groups with younger men being more concerned about fitness and health, and older men being more concerned about freedom from illness
- ▶ Men find information about health and wellbeing from a variety of sources, although they often find the information conflicting and biased
- ▶ In general, they would not go to the doctor for advice on staying healthy
- ▶ However, there was a consensus that if they did decide to seek health advice they would prefer to go to a doctor. This was partly attributed to a lack of knowledge of the pharmacist and the team's role and training
- ▶ Some of the older men shared health information with their sons
- ▶ Men used the pharmacy for prescriptions, over-the-counter medicines and information on holiday health, contraceptives and family health
- ▶ Choice of pharmacy depended on a variety of issues such as convenience, parking, loyalty

cards, facilities for children, buying lunch when at work, and time

- ▶ Men thought the public nature of the pharmacy space was more suited to the way that women communicate, whereas men are more private and reluctant to share concerns with others about their health
- ▶ Most had seen the private consulting rooms but were unaware of their function. They did not fit with men's expectations of the public nature of pharmacy interactions
- ▶ Men felt there was nothing for them to do in a pharmacy if they had to wait. They preferred to go in for a task, rather than browse
- ▶ Concern was expressed that they might be charged for health advice or they would be asked to purchase products
- ▶ However, if men were more aware of the role of pharmacies they may consider using them more
- ▶ Men need a legitimate reason to go and ask for advice on preventative health care issues (either pharmacists or doctors), and would welcome an invitation/ appointment to attend so they would not feel that they were wasting a health professional's time

Men's Health and Wellbeing

The Meaning of Health

The word health to the majority of the men, meant being able to "do what you want to do", whether that was being active, going on holiday, or doing a job of work. It also meant feeling well, having a general feeling of wellbeing, as well as knowing your body, being of the correct weight and not getting out of breath.

However, the meaning of health differed across the age span. The younger men were concerned about fitness and looking healthy (watching their diet, being active) and on the whole did not think about being ill - whilst the older men were more concerned about freedom from illness, and being able to carry out the functions of their daily lives. One older man spoke of health as being able to have your working life

and your private life "free from pain and drugs", and another as having no aches and pains.

Another man spoke of "being as fit as I used to be in my youth".

Conflicting Advice and Information

It was no surprise that the men got their information about keeping healthy from a variety of sources, although they often found it conflicting and biased. There was "something different every day saying this was bad or good for you". One young man used humour to illustrate this:

"You are told dark chocolate is good for you, so I eat as much as I can. Kit Kat do dark chocolate now, so that's great"

They spoke about being subconsciously 'force fed' information, and if they scratched below the surface of information sources, they could identify the producers of the information. This particularly applied to information picked up in supermarkets.

They got information from the media, information leaflets, the internet, health professionals and families, with no obvious age differences in the selected method. The older men "browsed the internet" or "just sat on the internet", as much as the younger ones, using men's health websites and in particular the BBC site. Men's health magazines were also mentioned.

With regards to health professionals, for some of the men the practice nurse was a key source of advice on specific conditions. About half had used NHS Direct for advice on illness but not for general health. They did not go to the GP unless it was for a specific purpose, and did not go for advice on maintaining a healthy life. One man imitated going to the doctors:

"'Oh Doctor, I am eating this, is it good for me, or is this bad for me?' You can find out on the internet, not waste the doctor's time".

One young man, who wanted to give up smoking, had been advised by a friend to go to the GP for advice. The GP referred him to the NHS stop smoking service. The only problem was, when he made contact, the service was only available at 2pm on a Tuesday and he started work at 1pm. He was now waiting for something else to be sorted out for him.

The role of family and friends

Information from family members presented an interesting discussion. Two men had partners who were nurses, another's mother was a nurse, and they spoke of being aware of healthy lifestyles and seeking advice from these family members. Others said they discussed health issues with other people (family and friends) to get their point of view.

A few of the men demonstrated a responsibility to improving their family's health by examples of passing on advice and information. They spoke of having kept information during campaigns, which they put in a drawer and forgot about, such as testicular cancer. But now that their children were reaching those age groups, they share that information with them because: "you know lads, they don't bother".

Men's Use of Pharmacy

Purchasing products

Unsurprisingly, the men overwhelmingly said that they used the pharmacy for prescriptions. They also used it for over-the-counter medicines, information on holiday health and contraceptives. They appreciated the opportunity to have advice on particular products, such as pain-killers, and those to treat indigestion and coughs, especially if they had not been used before. However, if they knew what they wanted they could buy it off the shelf. The young fathers in the group found the pharmacist particularly helpful if they were concerned about their children's health, such as a cough:

"If you are not sure what you need, you can ask 'is this is the right stuff?' They can advise you on a better product to use".

They found it easier to "cut out the GP", because they felt that the pharmacist would send them to the GP if necessary. Others expressed annoyance at saving time by seeking advice from the pharmacy and then still being told to go and see the doctor.

Accessibility and convenience

The choice of pharmacy depended on a number of issues and varied depending on the reason for the visit. Nobody favoured just one style of pharmacy, that is small independents, large multiples or supermarkets, and most used all three at different times. They would use small independent pharmacies near their home if it was convenient, and for some with small children, the local one was often the easiest. One man spoke of the convenience of the pharmacy in the health centre as he now lived in a rural area. Some men spoke of their small independent pharmacies being very helpful, and that trust could be built up by seeing the same person.

However, availability of parking, loyalty cards, broader spectrum of products, competitive prices, facilities for children, buying lunch, time and other shopping commitments all had an influence. The men sought to distinguish between using the pharmacy for medicines advice and using it as a shop to buy other products.

"We are all strapped for time"

Time was a very significant factor in determining which pharmacy to use. They recognised that for a prescription, the wait on average was 20 minutes, and they did not want to wait around with nothing to do. In the supermarket, for example, it was possible to go and do other shopping and come back later.

Understanding the pharmacy space

The men said that the atmosphere in pharmacies was dull and quiet, no one speaks a word, and every one keeps themselves to themselves.

“I just hand the prescription over and rush out” or

“Drop off a prescription and go off for a ‘fag’ or do other shopping”.

They recognised that it was mainly women who used the pharmacy, although not because pharmacies sold more female products (which they do), but because the **environment** was more suited to the way women interact with each other. The public nature of the space, the way matters are discussed across the counter or in the open shop area, was more conducive to female customers. The men were clear that whilst women talk to each other about health issues and are more open about health, men stand around on their own in corners and don't discuss health because: “well, it's a macho thing”. One good example was given by an older man:

“If I went into the pharmacy and any of you guys were in the queue for prescriptions, I would talk to you about anything else than what you were there for – football, pies, internet – but not ‘what's wrong with you?’ But women would ask ‘what are you here for?’”

One man spoke of feeling embarrassed for a young man he had overheard asking for a methadone prescription.

The issue of the pharmacy space was also related to the men's expectations of how interactions with pharmacists take place. Most had seen the private consulting rooms but had no idea what they were for. From their own experience, they perceived space within the pharmacy to be wholly in the public arena unlike GP's surgeries, where people can expect to go into a private area and discuss concerns on a one-to-one basis. So they did not see a purpose

in the consulting rooms; it was all rather a mystery. One man expressed it as:

“it wouldn't be an option to go (to a pharmacist) for personal stuff, or ask to go into another room, you go to the GP for that”.

In summary, although the men recognised that pharmacies sold a great deal of products for women, this did not discourage them if they had a purpose, a specific reason, to visit. In fact many of them went to the pharmacy to buy women's products for their partners. The difficulty for them was discussing personal health issues in a public space.

Having something to do

One of the things that discouraged men from staying in a pharmacy was that there was nothing to do. They preferred to go in and deal with the task and were not keen to browse around the products. There was an acknowledgement that pharmacies appear to cater more for female customers:

“There are racks and racks of make-up, and there are no spanners”

They acknowledged that for this reason it made more commercial sense for pharmacies to target women for goods.

However, they were relieved when they were served. They spoke of there being no male or car magazines, or plasma screens to look at and they felt uncomfortable being surrounded by all the female products, which had no relevance for them. Hence they came in and out very quickly or sent in female partners.

Medicine Management or Health Promotion

This section explores the men's perception of the role of pharmacists and pharmacies. It was clear from the discussions that the men highly regarded and trusted pharmacists on the use of

medicines and medicine management. However, they did not recognise the public health role, and the opportunity pharmacies presented for getting advice on staying healthy and preventing illness. They spoke of not knowing what a pharmacist or pharmacy could do for them, and the need to make men more aware of their health promoting services. As one man put it “you wouldn’t go to the butchers for an apple”, and that it was important to know what is for sale.

Fear of commercial pressure

Some of the men had seen notices in pharmacies for cholesterol and blood pressure testing, and some had seen ‘stop smoking’ services advertised. However, none had been sure what this was about, mainly because their perception of pharmacists is not in this health-promoting role:

“Never really picked up that pharmacies may offer those sorts of things”.

On top of this was a very real concern that they might be charged for these services and also may be required to buy products. The issue of being ‘sold something’ was particularly strong. Their view was that if health-promoting services were free then that should be clearly stated.

Confidence in the doctor

The consensus was that if they were seeking health advice on staying healthy from a health professional, they would prefer to go to a doctor. The reasons are complex. Some were around perception and expectation of the pharmacist’s role, and a general lack of awareness that pharmacists may be trained to carry out that type of advice. One man told a story about cholesterol testing, which had made him lose confidence in the pharmacy for this type of service:

“A couple of years back, (large pharmacy chain) were doing free cholesterol tests. I had had everything else checked out so I made an appointment and they checked it and it was scarily high, but I have learnt

since (from friends) that if you go to the doctors for a test you have to starve, whilst at this, you just call in. So have a nice fry up at lunchtime and then go for your cholesterol test and the fat levels were quite high. So, I thought I don’t like this idea, do they really know what they are on about.....that was a load of tosh, and it discredited what I had had done”.

Although this illustrates an example of misinformation about types of cholesterol tests, it also shows how perceptions can lead to loss of trust.

Another reason for preferring to go to a doctor for health advice was, as discussed above, the public space in the pharmacy: “I don’t feel I could talk across a counter”, and this may trigger deeper worries about confidentiality.

There was an issue of confidence too, drawn from a belief that doctors could be trusted to give personal advice on health. Reference was made to the fact that doctors “know your history”, “know you personally”, “the receptionist knows you”, in a different way than pharmacists and their teams do.

Some had seen the machines for recording health status, although generally the men felt that they would rather assessments were done by a person and to speak with someone who knew what they were doing:

“How do you know it (the machine) is going to be accurate and right, and you want to know what you can do about it (if something is wrong) and not panic”.

Who to trust in the pharmacy

The men’s understanding of who to ask in the pharmacy for advice is based on their experience of medicine management and over the counter remedies. So, for example, if they sought advice on their children’s health, it was not given by the person at the counter, but by the pharmacist who was at the back. Some assumed that counter staff had training in following protocols and asking certain questions, and then would

ask the pharmacist, because “they are not trained to answer everything”. A few of the men thought that counter staff had no training at all. Due to the low level of awareness of pharmacies role in health promotion, it was probable that the men assumed pharmacy staff were untrained in these matters too. Supermarket pharmacies in particular were assumed by the men to be staffed by shop assistants in white coats serving behind a medicines counter.

Some men believed that doctors were the experts on medical matters, and therefore for advice “you go to a doctor, not a shop assistant”.

Men have to ask: making health advice a legitimate activity

In spite of this issue of confidence and trust, there was evidence in the discussions that if men were aware of the health promoting services pharmacies could offer, they would consider using them. There was a difference expressed between ‘having something checked’, for example blood pressure, and ‘having it treated’ if something was wrong.

The men felt they lacked a legitimate reason to go and ask (pharmacies or doctors) for check-ups on their health. They wanted targeted information so they would know when it was appropriate to seek that advice, eg at what ages were things likely to need checking. They also wanted permission to go and ask for check-ups through being recipients of targeted marketing and specific invitations. A specific invitation also made them feel more comfortable about ‘bothering’ a busy health professional, and not feeling they were wasting a professional’s time. They would feel uncomfortable and selfish asking for a private word in the consulting room if the pharmacist looked busy with prescriptions. This particularly applied to a general health issue rather than a very specific problem.

They discussed the national screening programmes for women, how they receive invitations to attend for health screening, and said how they would welcome that approach for

men, as at the moment “men have to ask”. The majority, both younger and older men, said that if invited, they would attend for a health check at the pharmacy, particularly if the invitation gave no specific time and they could work it around their life:

“You could leave it (the invitation) where you can see it, and when you wake up, you can still see it, and you keep looking at it, and one day you go”.

The invitation would need to be specific and basic, for example: “come for a check up at such and such time and place”, and that it should be on NHS paper in order to instill confidence.

This acknowledgment of their interest in having a check-up on their health fitted with men’s approach to having a clear purpose in order to use a service. They considered that a health check/ advice would be a good way of passing the time if they were waiting for their prescription. It would also be useful if they could go out at lunchtime, or on the way home from work. The opening hours were an important factor, as well as the location.

Findings from two focus groups with pharmacists and pharmacy teams

Two focus groups were held in December 07 and March 08 with pharmacists and pharmacy teams to capture their views on men’s use of pharmacy to improve their health and wellbeing. The first group was with eight pharmacists, 6 men and 2 women, who were members of the Hertfordshire Local Pharmaceutical Committee. The pharmacists came from 5 independent, and 3 multiple (Boots, Lloyds and Co-op) pharmacies. The second group was held in Leeds with 9 members of pharmacy teams made up of one pharmacy assistant, one supervisor, one dispensing technician, one dispensing assistant, 4 pharmacists and a community pharmacist services facilitator. There were 7 women and two men and they came from independent, multiple and supermarket pharmacies.

Members of the two pharmacy focus groups

	Independent	Multiples	Supermarkets
Pharmacists	Mx5, Fx1	Mx2, Fx3	Fx1
Pharmacy assistant		Fx1	
Supervisor		Fx1	
Dispensing Technician	Mx1		
Dispensing assistant			Fx1
Community (F) Pharmacist Services Facilitator			

M = male, F - female

The meetings were recorded and transcribed by the researcher. Five key themes emerged from a thematic analysis of the data. These themes are:

- ▶ Accessing pharmacy services- finding the right hooks for men
- ▶ Building trusting relationships
- ▶ Fit for purpose
- ▶ Raising awareness of the health promoting function
- ▶ Role in the wider health economy – rewards and incentives

Quotation marks and italics are used for direct quotes.

- ▶ Pharmacists cannot always see people immediately without affecting other parts of their service
- ▶ Pharmacists and their teams feel able to build up trusting relationships with their male customers
- ▶ Health promotion has always been part of the pharmacists role, although there is now a greater emphasis on it
- ▶ The majority felt that more pre and post training in health promotion and communicating with men would be useful
- ▶ There needed to be more awareness of the role of the pharmacist and their teams in promoting health and some suggested a national campaign should be launched
- ▶ Pharmacists could be encouraged to have a wider role by going out to where men were, such as workplaces, community venues and schools
- ▶ Incentives need to be in place to enable pharmacists to balance their commercial role and their professional role to improve health and well being
- ▶ Many pharmacists found it difficult to be involved in the commissioning processes in their local health community

Summary of findings

- ▶ Men purchasing products can offer an ideal opportunity to engage them in wider discussions about their health
- ▶ Medicine Use Reviews can offer a holistic approach to health, particularly among older men, if time is allowed
- ▶ Pharmacies are a feminised environment although it is unclear whether female staff enhance this or not
- ▶ Good communication skills which are gender specific are essential to make men feel comfortable when visiting pharmacies
- ▶ Men have less time to visit pharmacies, and when they do they are very clear on the purpose of their visit

Accessing Pharmacy services – finding the right hooks for men

'Women's world'

It was generally agreed that pharmacies were 'women's shops' with nothing to particularly draw men in. Men's products, such as razors, were even bought by women for men, often as Christmas presents, and women often collect prescriptions for men and take away information. It was thought that women take responsibility for the family's health and that the way to reach men was through women. Some of the group felt that because the majority of counter staff and, increasingly, pharmacists were women, this could be a barrier to men accessing pharmacy services and increased the feminisation of the environment. However, others in the groups thought it was more about the communication and relationship between the staff and the male customer.

Specific Hooks

The group acknowledged that purchasing products was an ideal opportunity to raise issues about general health and wellbeing with men and that selling products was seen as an opportunity to offer support services. It allowed conversations to develop and many thought they needed to make more use of these opportunities to reach men, particularly young men who are less easy to engage: "They just rush off with huge bags of condoms".

When men come into the pharmacy they are usually clear about why they have come in, and often it is to buy products, such as for backache, toothache and so on. Travel advice was another reason why men come in for specific advice about products, and examples were given of men, after doing some internet research, wishing to discuss various options with the pharmacist. Some thought the purchase of acne and body-building products by young men was an ideal opportunity to discuss health issues more broadly.

One specific hook identified was when men wished to purchase nicotine replacement therapy. This opened up the opportunity to offer smoking cessation support, which many pharmacies now offer as an enhanced service and is well-used by men. Smoking cessation was also considered a route into discussing alcohol issues.

The pharmacists and their teams observed that many young men were now more supportive of the women in their relationships and would often come to the pharmacy with their partner. It was no longer unusual for young couples to come in together for pregnancy testing and to wait for the result. Also, there were examples of men coming in for the morning after pill for their girlfriend without realising that the woman needed to come in herself. Young fathers also made good use of the pharmacy, initially for their child, but this offered opportunities to also engage in the father's own health:

"It was the baby that introduced him to the pharmacy. He would come in for advice on the baby's health. Now he also asks for advice and information on his own health".

The Medicine Use Review (MUR), which many pharmacists now offer as an advanced service is seen as another way of engaging with men and which could offer a holistic approach to health improvement. Most of the men that attend are older men and it would be possible to proactively discuss issues that are relevant for this age group such as prostate awareness. The increasing use of Patient Group Directions was another way to bring in more men and widen out conversations to include general health information.

Time

Men have less time to visit the pharmacy because of work commitments and therefore they appear to always be in a hurry. There was often a 'lunchtime rush' with a lot of men of all ages coming in, but lunchtimes only allow limited time and it was not always appropriate to start longer conversations.

Weekends did not seem the right time either. Men had other commitments at the weekends and only seem to use the pharmacy for advice on acute problems.

There was also an issue here for independent community pharmacists in particular as many now close at weekends and at times during the week in line with GP surgeries, because it is not commercially viable to stay open: "There is nothing to support us being open". This cut down the options for men who worked full time to use their local independent pharmacy, and has implications for the increasing dominance of the multiples and supermarkets in the high street who could stay open longer.

Time was also an issue for availability of pharmacists as sometimes they are busy and have to ask people to either wait or come back later. If a pharmacist does a health check or MUR which can take 30 minutes, this has an effect on other parts of the service. Similarly, customers do not always want to wait.

Building Trusting Relationships

The theme of building trust was very strong across both focus groups. The pharmacists were clear that people's relationship with pharmacists and their teams were very different to people's relationship with their doctors. The pharmacy relationships built up through regular opportunistic contact with the counter staff, who were there every day, and were able to build longer term relationships with customers. They thought word of mouth was particularly important for attracting men. One pharmacy assistant had experience of men being told by others: "They are nice they are. Go and ask them".

The majority of men that pharmacists see are retired, and the more they visited the pharmacy the more the relationship built up. Counter staff and pharmacists spoke of customers coming back regularly, which enabled trust to develop between the men and staff. One team member

gave an example of a man asking whether chocolate would affect his sexual performance and he was offered reassurance on that issue: "*If you are helpful with one thing, they come back again*".

The style and nature of the work enabled some community pharmacists and their staff to get to know whole families and their family histories. This information could be used proactively to make other family members aware of potential problems. One example given was that if an older man with heart disease was being seen regularly for medication, prevention advice could be directed towards younger men in the family. In a similar way, there was recognition that pharmacy services could be more tailored to the needs of their local communities.

However, the issue was raised about temporary counter staff at weekends and the increasing use of locums as potential barriers to relationship building.

Communication skills

Communication skills and style were seen as very important for engaging men in more holistic conversations about their health. One person said that a way to make men feel comfortable in the pharmacy was to be actively interested in what they are saying, especially if they did not use the pharmacy very often. It was important to help people feel relaxed and create a non-threatening atmosphere: "we are approachable and make people feel at home".

Some pharmacists and staff felt that their skills could be enhanced, in particular when wishing to engage with men.

Location, location, location – continuity or anonymity

There were important differences acknowledged between pharmacies located in small communities and those in city centres. Some felt that it was useful to have the continuity offered by small pharmacies in order to build trusting relationships whilst others disagreed and felt that relationships can also be built up with

customers in big city centre stores.

In supermarket pharmacies there were less regular customers; men and women called at the pharmacy counter because they were already out shopping. This differed from local community pharmacies that have a local, regular customer base. However, the point was made that on some occasions men may prefer to go to a pharmacist who does not know them or their family, for reasons of embarrassment and anonymity.

Fit for Purpose

Many of the pharmacists said that health promotion has always been part of their role, but it was just labeled differently now. They have always given health advice to customers and 'signposted' people to other services. One example was giving advice on healthy eating following a cholesterol test.

The group did acknowledge that health checks are a more recent service, and that health 'MOTs' were becoming very fashionable, although some doubted the value if they became a tick box exercise. Others feared that health checks would be seen by men as interfering with the role of the doctor, although some of the group thought it was an appropriate extended role for pharmacists.

There was not a clear consensus on whether pharmacists and their teams currently had the skills to carry out a full health-promoting role. Some thought they had the skills but just need more opportunities to carry out the role.

However, a number of members of the focus groups acknowledged that more training at pre and post registration was required in men's health and public health, as well as regular updating on current issues, in order to fully deliver a public health service. Pharmacists could undertake accredited training, both for themselves and their staff. There were already opportunities to take up training on specific topics such as smoking cessation and blood

pressure measurements. One technician talked about being trained in delivering smoking cessation services that involved a lot of men, and how men, once engaged were more successful at quitting because they were very focused.

Counter staff recognised that further training could develop their skills and confidence to be proactive about engaging men on certain health topics. Some staff said they felt more comfortable discussing lifestyle health if they had health promotion resources to hand. One concern raised was that often counter staff on Saturdays were temporary staff who may not have the same level of confidence as regular staff to engage men in discussions about their health.

Many felt that all the team could be trained in health promotion activities, and someone from a large multiple pharmacy said that, for example in cholesterol testing, this was carried out by other members of the team and not the pharmacist. The staff already had clear roles and responsibilities in the team and they were aware of the times they needed to involve the pharmacist.

Consulting rooms

The groups acknowledged that the private consulting room was a new phenomenon and that on the whole the public was unaware of its existence and purpose. There was a perception among the public that conversations with pharmacists took place 'over-the-counter', not in private rooms. However, the teams found that when people were aware of them it was seen as a 'pleasant surprise' and served to reinforce the message that the consultation was not a 'quick in and out' and that the pharmacist had time to listen and discuss health issues.

Raising Awareness of the Role

There was general agreement that there was a lack of awareness among the public of the full professional role of the pharmacist and the training that the support staff received. A sustained national campaign that advertised their service would be extremely useful. There was a lot of discussion on how men could be encouraged to use the pharmacy more, and it was acknowledged that pharmacists and their teams had a responsibility to advertise their services. It was felt that a campaign that focused on men's health would be useful, and should include information on depression, heart problems, blood pressure readings and prostate symptoms. One suggestion was a campaign that used a male role model to promote pharmacy services.

Another way to raise awareness of the pharmacy was through the use of the media, such as men's magazines, which could carry more information about the pharmacist's role. However, one group expressed disappointment at the way the media sometimes portrayed their profession, such as recent media reports on the 'morning after pill' and the encouragement of promiscuity.

With regards to men's health, window displays were important for attracting men into the pharmacy, although some staff thought they needed to be more specific than 'men's health', and instead should focus on a particular topic of relevance to men.

One group wanted to encourage a wider role for pharmacists, and thought they should be more encouraged to go out to factories and other workplaces to raise awareness of the role. Schools were also mentioned.

Rewards and Incentives

A thread running through both focus groups was the concerns of pharmacists in balancing their professional role in serving the public against remaining an economically

viable business. It was a particular issue for independent pharmacies but did apply to other types of community pharmacy as well. There was disquiet expressed at the lack of recognition of their public health role and the need for this to be sufficiently rewarded. Some services were commissioned by PCTs as enhanced services, such as smoking cessation, or advanced services such as Medicine Use Reviews, but currently (December 2007) there was little incentive to carry out health checks for example, for which there was no extra remuneration.

Pharmacists and their teams did 'naturally' give advice if it was required, because that was their role, but time constraints made that difficult at times. There was no evidence in the discussion that pharmacists tried to sell products when they gave lifestyle advice.

Many pharmacists found it difficult to be involved in the local processes for commissioning services, and often they were unaware of the opportunities that were available.

Chapter Summary

The findings from the literature review and the four focus groups were used to inform the next stage of the project which was to carry out a feasibility study in a defined geographical area. In particular, the findings contributed to the design of the information booklet and the invitation for men to visit a pharmacy for health information and advice.

A model was to be tested that involved working with a large employer to encourage its male employees to access community pharmacy services in order to improve their health and wellbeing. A description of the intervention, the results and the follow-up evaluation are the subject of the next chapter.

Chapter Three: Testing the Hypothesis

The Feasibility Study

1. Introduction

This chapter sets out the details of the feasibility study and includes the design of the four-week workplace intervention, the results and the follow-up internal evaluation. It describes the assumptions that went into the intervention design, the process undertaken and the findings. The chapter then goes on to describe the evaluation approach and methodology and presents a thematic analysis of the data. It concludes with a discussion and learning points that have emerged from this style of intervention.



The Workplace Intervention

2. Aims of the workplace intervention

To design, develop and test a workplace intervention that attracted men in manual work to access local community pharmacies for health information and advice:

- ▶ To assess the effectiveness of a health information 'mini manual' and voucher scheme in encouraging men to use pharmacy services
- ▶ To work with a major employer in a defined geographical area, with a mixed socio-economic population, to stimulate uptake of mainstream health services through a workplace setting
- ▶ To engage a range of pharmacies in providing health advice and information to men

3. Assumptions based on evidence and practice experience – 'our hypothesis'

- ▶ The workplace is a good setting for taking health messages to men as they are often reluctant to use health services
- ▶ The workplace setting facilitates more general dialogue amongst men about health issues
- ▶ Endorsement from an employer encourages male employees to use health services
- ▶ Internal workplace mechanisms will tell men what they need to do to take part
- ▶ Encouragement from the employer and workplace colleagues means they are more likely to take up a service
- ▶ Men need advice on their health through the use of male specific information
- ▶ Men will see and recognise the purpose of the tear-off slip in the manual
- ▶ At least 10 per cent of the men will go to one of the pharmacies taking part in the intervention
- ▶ Pharmacists will be able to carry out a health promotion role

Design of the four-week intervention

The intention was to work with a large employer who had a majority of male workers from manual backgrounds, in order to set up a four-week workplace based intervention in a local area. Meetings were held with a large national organisation and the partnership was agreed.

4.1 Engaging a large employer and identifying the 'patch'

A partnership was created with Royal Mail as a large employer of men from working class backgrounds and Leeds and Bradford was chosen as the area to carry out the four-week intervention. It was chosen because there were a large number of workplace sites in a clearly defined geographical area and it addressed the issue of health inequalities through a mix of poor health status, race and ethnicity. For example, both Leeds and Bradford have a significantly worse male life expectancy than the English average. Another factor was that the area manager and other senior staff were very keen to take part.

A small project team of senior managers was set up in the area. It met four times between November 2007 and May 2008.

4.2 Engaging a range of local partners

A mapping exercise was carried out to identify a range of pharmacies across the geographical patch, which was accessible to the male employees either through work, home or key shopping centres. We then worked with our national partners, the National Pharmacy Association (NPA) and the Company Chemists' Association (CCA) and in partnership with the Local Pharmaceutical Committees (LPC) in Leeds and Bradford, to identify possible pharmacies to take part.

The area managers of the large multiples (Lloyds, Boots and Superdrug) and the supermarkets (Sainsbury's and Asda) nominated stores to take part in the intervention. The independent

pharmacies were contacted directly by the project manager. Seventeen pharmacies were finally recruited which included a mix of independents, big multiples and supermarkets. They also varied in size from small shops to large stores.

Each participating pharmacy was visited by the project manager and given a face-to-face briefing and information pack. There was regular support from the MHF project manager throughout the 4-week period through visits and telephone calls. The information pack prepared for each pharmacy contained details of the project, a range of male specific information booklets, PharmacyHealthLink resource packs on brief interventions for healthy lifestyles and details of the data collection process for the follow-on evaluation.

4.3 Producing materials

A mini-manual booklet, 'Men and Pharmacy, Haynes Owners Workshop Manual' (Appendix 4) was designed by the MHF specifically for the project in order to inform men about pharmacy services, and to offer advice and information on staying healthy. A tear-off voucher was designed and secured at the back of the manual, which was intended to provide men with an invitation to tear out and take along to the pharmacy. It consisted of a series of tick boxes of common male health issues with the intention of giving the men the opportunity to consider in advance what they might wish to discuss with the pharmacist.

One week before the intervention was to take place, the mini manual was posted to the home addresses of all the organisation's male employees (n=3322) in the Leeds and Bradford area with an accompanying letter (appendix 5) explaining what was taking place.

4.4 Workplace/ employer support

During the four-week period a number of activities took place within the organisation to raise awareness of the initiative and encourage attendance at the pharmacies. These included a poster campaign in all the work sites (appendix 6).

The communication plan was as follows:

Communication mechanism	Numbers
Posters	65 in 31 sites
Work Time Listening and learning Sessions – briefings produced	4 planned at each site
'Huddles' and briefings	Opportunistic
Email reminders to DOMs from RM project team	5 in total
Email briefings to RM project team from MHF project lead	4

A key communication mechanism for the project was to brief the Royal Mail Delivery Office Managers (DOMs) who hold weekly Work Time Listening and Learning Events (WTLLs) with their staff in each work site. These meetings are a mechanism for the exchange of information between the work teams. Briefings were prepared for the managers, and four sessions were planned at each site during the intervention period. The intention was for the managers to discuss the booklet and invitation with the men in their teams and to explain the nature of the intervention.

Briefings on the project were also prepared for the 'huddles'. Huddles take place between operational managers and front line staff when small groups are brought together for informal briefings in the workplace area. Regular email reminders were also sent from a member of the Senior Management Team to the operational managers during the four-week period.

The MHF project manager sent regular updates to a member of the senior management team about the progress of the project, as well as any other information that would stimulate uptake.

The results

5. Quantitative findings

3322 booklets and invitation letters were posted to all the male employees in the study site, making up approximately 85 per cent of the workforce. Eight men went to receive health information and advice and five made enquiries at the pharmacy but did not take the voucher so their data was lost. However, of the eight whose visits were recorded, it is worth noting that even with the small numbers, they all requested blood pressure checks; seven out of eight requested waist measurements and three wanted to discuss mental health issues.

No Asian men or men from other Black and Minority Ethnic (BME) populations used the service in spite of there being approximately five per cent Asian employees included in the study.

There were 17 participating pharmacies, six of which were visited, one had three visits and 11 had none. There seemed to be no clear reasons why some pharmacies were used and not others. It may be worth noting though that the six Boots pharmacies did not offer blood pressure checks, and all eight men who returned the slips had requested these.

5.1 Results

- ▶ 7 slips were completed, and 1 man attended for a health check without a slip (the pharmacist provided verbal feedback to the evaluator)
- ▶ 5 other enquiries were made but forms not completed because:
 - ▷ One man came with his mother, and the pharmacist was unable to respond at the time. He did not come back.
 - ▷ Three men had no slips but receive general lifestyle advice
 - ▷ One pharmacist did not have the time and although an appointment was made, the man did not attend

Therefore, the following results are based on data from 8 participants

- ▶ All male (n=8/3322)
- ▶ Aged 46-65, n = 6/8, 26-45, n = 2/8
- ▶ White British, n = 7/8, white Irish, n = 1/8
- ▶ Five enquiries were all white British

Reasons for Attendance

Health issue listed	Number
Waist measurement and BMI	7
Blood pressure check	8
Information on diabetes	3
Advice on being more physically active	1
Common sense advice on reducing alcohol consumption	1
What to do about tiredness, mood swings, disturbed sleep	3
What to do about unexplained cough	1
Information on testicular examinations	1
Advice on difficulties with passing urine	1
Information on bowel problems	1
What to do about feeling bloated and having a lot of wind	1
A review of your medicines	1
Other: Muscular leg pains	1

- ▶ Referral to GP or other health professional, n = 3/8
- ▶ Where they received the manual = at work (n=1/8), through post (n=2/8), work at RM (n=2/8), no reply (n=4/8)
- ▶ Reasons given for choosing the particular pharmacy were varied and inconclusive. Reasons included the nearest (unknown if this was near to work or home), local knowledge, on route when shopping, on the way to work, biggest pharmacy on the list, pass on the way to work

6. A Case study

Mr S works as a postman based at a delivery office on the edge of the city. He is a white British man aged in his mid forties. He received his booklet and invitation letter to attend one of the participating pharmacies, and after looking through the booklet he decided he would attend: "I thought it was a good idea as you could go in your own time". He chose a national chain pharmacy that was not his nearest to home but one that he was passing at the time. He filled in the tear off slip from the booklet asking for waist measurement, BMI and a blood pressure reading and handed the slip in at the pharmacy counter.

His blood pressure reading was very high and the pharmacist referred him to his GP. He was unaware that his blood pressure was high and was feeling healthy before he attended for the pharmacy. He saw his GP and had further tests for cholesterol and diabetes and now is on medication for high blood pressure and high cholesterol:

"I felt great on the outside, but you don't know what's going on inside, owt could be going on, so hopefully now, nowt will happen".

He is also overweight and has taken advice on how to eat more healthily. He was very proud that, although he gets great pleasure from eating, he is now making small healthy changes to his diet:

“In the morning I used to have a sausage sandwich and now I have replaced it with a ham or chicken sandwich. It's not a lot, but it's my way of doing it”

Mr S had not discussed his visit to the pharmacy with any of his work colleagues, and had not heard about the project through the Work Time Listening and Learning sessions. He had not seen any posters advertising the initiative or attended any huddles run by the operational managers, but he liked receiving the booklet privately at home as he described himself as a private individual. However, now he is on treatment, Mr S is happy to share his experience with other colleagues at work.

Follow up evaluation

The final section in this chapter considers the follow-up internal evaluation of the workplace intervention. It describes the evaluation approach and limitations, key evaluation questions and the methodology used. Five themes that emerged from the analysis are then described and the chapter concludes with a discussion and learning points from carrying out this type of intervention.

7. Aim of the Evaluation

The aim of the evaluation was to assess the outcome and draw out key learning points of a feasibility study designed to attract men in manual work to access local community pharmacies for health information and advice, through a workplace intervention.

8. Evaluation questions

- ▶ What are the implications in working through a workplace of a major employer? How does that influence the design? What works well? What are the barriers?
- ▶ Did the intervention encourage more men to use community pharmacies?
- ▶ Does the booklet work in providing men with health information and advice? Does

the booklet increase men's knowledge of pharmacy and its services?

- ▶ Does the voucher give men 'permission' to use the pharmacy for health advice?
- ▶ Is the intervention replicable?
- ▶ What are the unexpected outcomes?

9. Evaluation approach

The evaluation approach was both formative (process) and summative (outcome). This allowed an understanding of why the outcomes may have occurred and to draw out key learning points for replication of the study.

A pragmatic decision was made about the design of the evaluation, which led to the project manager taking on an additional task of evaluating the project to carry out an internal evaluation. She was supported through the process by the appointment of an external critical reviewer. The role of a critical reviewer is to provide critical and objective feedback on the methodology and analysis employed during the project and to support the project manager in the delivery of the evaluation.

The evaluation approach included using a range of methods (see below) to capture the diversity of the study and the relevant stakeholder interests. In view of the fact that such a very small number (8) had attended the pharmacy, it was important to learn why this was the case. In total, 70 men were interviewed, including one who attended the pharmacy. An analysis of the qualitative data was through a thematic approach.

An ethical framework was developed for the evaluation, which included a project information sheet for all participants in the evaluation and a consent form. The data collected through interviews, focus groups and questionnaires was anonymised and held by the project manager/evaluator in secure files.

10. Methodology

A triangulation of research methods was used to capture the data, which included both

qualitative and quantitative sources. This allows different perspectives to be brought together in the analysis.

The methods used were:

Method	Numbers
Tear-off vouchers collected by pharmacist	n=8/3322
Face-to-face interview with participant – case study	n=1/8
Three focus groups with front line postal workers in Leeds and Bradford (at WTLLs)	42
Two focus groups with Delivery Office Managers (DOMs) – one face-to-face, one teleconference <i>Appendix 7</i>	27
E- questionnaire with Royal Mail Senior Management Project team	n=4/6
Telephone interviews with participating pharmacists	n=16/17

Therefore 70 men who had received the booklet took part in five focus groups. It had been originally planned to survey the whole sample of 3322 men through sending out a postal questionnaire. However, due to the low response to the initiative, it was decided that this was too much of a risk. Instead the resources available were used to carry out in-depth focus group work with a sample of the 3322 men.

The one-to-one interview, three focus groups and one DOM's meeting were recorded on a digital recorder. These were transcribed by the evaluator who used an approach called critical listening . Notes were made from the teleconference immediately after it was carried out. Analysis of the qualitative data was through a thematic approach.

11. Limitations of the evaluation

There were some limitations to the evaluation design that were identified:

11.1 – The decision to appoint the project manager as also the internal evaluator meant that the evaluator played an integral role to

the project outcome. The limitation was that it was difficult to separate the role of design from evaluation and sometimes objectivity was lost. However, this was minimalised by the appointment of an external critical reviewer.

11.2 –The project was ambitious and worked to very tight timescales. This meant there was insufficient time to build up a high level of trust with the participants and, consequently, they may have been more reluctant to express their views.

11.3 – The evaluator worked with the senior management team in the organisation to gain access to participants. This may have raised issues of trust and confidentiality between the participants and the evaluator. In the focus groups, a small proportion of participants did not give consent to be recorded and did not speak during the recordings.

11.4 – Due to the tight timescales and low resources available for follow up evaluation in the study, the data that was obtained through focus groups had to be fitted into existing, pre-scheduled organisational work meetings. This meant that time allowed for the discussion was limited, sometimes rushed and the conditions were not ideal for gathering information. However, this was a pragmatic decision, making the most of what was possible, which did allow interesting information to be collected.

12. Thematic analysis

As described in the methodology (section 10) a triangulation approach was used to collect a range of different data sources. A thematic analysis was then carried out and five themes emerged:

- ▶ Public and private spaces
- ▶ Trusting relationships
- ▶ Men and healthy living
- ▶ Communications and relationships with men
- ▶ Accessibility

12.1 Private and public spaces

A strong theme that emerged in the evaluation was the value that men placed on privacy in matters that concerned their health. One of the assumptions of the study was that, as it was sent to men employed by the same organisation, they would discuss it at work and perhaps go in groups to visit a pharmacy near the workplace. This did not happen and none of the men interviewed had discussed the possibility of visiting the pharmacists with work colleagues. One comment was that you would not come into work and say: "I have been to the chemist today – that's a difficult step to take, it's embarrassing". Others had not discussed it with friends or family "Ooooooh, I don't think so!" One of the on-site managers involved in promoting the study admitted that: "Men don't want to talk".

However, the large organisation has a Health Bus, which visits several work sites. This is well attended by men, who book appointments for health checks well in advance. Comments about the use of the health bus included: "It's just not an issue, you see colleagues using it and you just join in", "its 10 minutes off work" and "we are all together". One of the reasons given by a workplace manager for his staff not taking the opportunity of visiting a pharmacy was that the Health Bus had recently been to their site.

The reasons for the difference in usage between a workplace based health initiative (the Health Bus) and one endorsed by the employer through correspondence sent to the employee's home (the booklet and invitation) are not clear, although researchers have highlighted the problem of an employee's working life encroaching on their private life (Allender et al 2006). Perhaps it was the private nature of receiving it individually as against the collective nature of workplace activities. It may be that sending information home separated the private sphere of home from the public place of work. Other inferences may include an opportunity to use work time to have a health check, or it is easier to use facilities that come to the workplace, rather than go to mainstream

services in the High Street. However, the man interviewed who had attended the pharmacy said he had not discussed it with any work colleagues because: "you don't go around broadcasting it, I am a private individual, that was the best thing about sending it home, you don't know who's done it".

The men were also aware of the public nature of pharmacies, as shown in the focus groups (in chapter two), and felt embarrassed about discussing health issues 'over-the-counter'. In the feasibility study the men, although aware of the private consulting rooms, did not understand their function in relation to pharmacy services.

A related issue that emerged was that this concern for privacy extended to making appointments at GP surgeries; the men did not like being asked over the phone or at reception why they wanted to see the doctor and this deterred them from making appointments.

12.2 Trusting relationships

The second theme that came out strongly in this particular study was the importance of trust, both in relation to the employer and with the pharmacist.

The employing organisation

In the workplace, approximately two thirds of men interviewed (total 70) in this study were suspicious of the company's motivation in promoting the health and wellbeing of their staff, the so-called 'image enhancer' for the modern organisation (Wilkinson 1999). This was in spite of the many successful health promotion programmes that are run in the organisation, and in particular the annual commitment to National Men's Health week. Although the company concerned was just coming out of some difficult industrial action with their workforce, it is important to acknowledge that conflict is an almost inevitable feature of organisations where there are issues of resources, promotion and power (Wilkinson 1999).

Also, it may be the case that the traditional image of employers as 'paternalistic' carers of their employees wellbeing is an outdated concept and no longer applicable to current working practice (Allender et al 2006). It is recognised that motivating participation of employees is problematic (Stead and Angus 2007) and an approach where the employer's business case for investing in their employee's health and wellbeing is made more explicit may be a more effective way of engaging staff. More detailed interviewing of workers would offer the opportunity to test this hypothesis.

The trade unions were aware of the study and fully supported the messages that were going out. However, the union representatives were not involved in delivering any of the messages themselves or in undertaking any of their own communications.

At least two thirds of the men involved in this evaluation (total 70) doubted the lasting commitment of the employer to their long-term health and wellbeing. They saw it as a "tick box exercise" which made the company appear caring, but then it quickly moved on to another initiative: "Right, we have covered that (men's health), so let's move on". The decision to use the operational managers to communicate the messages may have compounded this scepticism. Conversely, it is possible that the Health Bus was seen in terms of a free 'gift' from the employer because it came on site.

This distrust of the company was particularly expressed in terms of health and safety. Examples were given where the men felt that safety concerns and adverse working conditions were not being addressed. This led to the majority of those interviewed being unreceptive to initiatives from management that appeared to promote their health and wellbeing: "Why are they sending this (the booklet) through?"

The pharmacy profession

There was a lack of trust shown by the men in the pharmacist's ability to improve the health of individuals, and the majority said they would

prefer to go to their doctor. Many of the men were unaware that pharmacists and their teams received training to perform a health promoting role. Comments included: "How would they (the pharmacist) know if there is anything wrong with me?", "Why would you go to a shop keeper about your health?", "Surely if you have a problem that you couldn't see your doctor about, surely you wouldn't see the pharmacist either?" There was a particular reluctance to discuss sensitive matters with pharmacists ("prostate and stuff"), and many said they would feel embarrassed talking to young female counter staff.

There was a further issue of trust expressed around familiarity with the pharmacist. In many ways the informal approach and easy accessibility of the pharmacy may in itself disguise the professionalism of the pharmacist and the team. There was speculation by some of the men that if a sensitive issue was discussed with the pharmacist in the daytime and they met the pharmacist later in the village pub then: "The whole place would go quiet and then everyone is laughing". The same issue did not apply to meeting the doctor, although concern was expressed about receptionists.

12.3 Men and healthy living

A strand running through the study has been men's attitudes and behaviour towards their own health and wellbeing. For many of the men, receiving health information was a question of timeliness; if they were not feeling unwell then they did not see the point in going for a check up. "When you are healthy, you don't look at things (the mini manual) like that". There were several comments about how men take life for granted, "it's a Man thing", and the literature on men's health and masculinity (White, 2006) would endorse this finding .

When this is considered in light of the good attendance at the Health Bus, perhaps men were not given the right 'permission' to go to the pharmacy. The design of the tear-off slip and the accompanying letter may not have been seen as an invitation to attend for advice and

information. In fact, many of the men could not recall even seeing the tear off slip or the letter.

It clearly was not a priority to go for health advice if they did not have any symptoms. However, it is possible that those men who kept the booklet may refer to it and go to the pharmacist in the future if they thought something was wrong. Also, some may have gone to their GP without the project team's knowledge. One surprising factor was that although the sample attending was small, nearly 50 per cent of them (n=3/8) asked for advice on mental health issues.

Another factor to consider in this analysis of men's attitudes to their health is the differences between men, and how relevant this approach of sending out health information is to the lives of particular groups of manual workers who may be at different stages within their life course. Moreover, no Asian men attended the pharmacies and this suggests that the information and the approach of the study may not have been culturally sensitive to the needs of this group.

It is also useful to note that the majority of the men who attended for health advice, and who said they had kept the booklet to refer to at a later date, were in the older age group. This was not an unexpected finding as the focus groups held earlier in the project showed how different age groups viewed health and well being differently; for older men it was about freedom from illness, whilst for younger men it was about keeping fit.

12.4 Communications and relationships with men

A key strand of the study was to test a range of communication channels in the workplace as a means of encouraging men to use a mainstream health service (community pharmacy). These included sixty-five posters (appendix 6) in the thirty-one different work sites around the area, as well as the individual invitation letters sent to each male member of the workplace in that area. The majority of the men interviewed

(n=70/3322) had not seen the posters and it was probable that in many of the sites they were not displayed. The issue of communicating with the men through individual letters sent to their homes (as discussed above) appears to have been unsuccessful in engaging men in this particular initiative.

Front line managers

The key channel to communicate the intentions of the feasibility study was through the frontline managers in each workplace site. This was chosen because Weekly Listening and Learning sessions (WTLLs) are held between the managers and their teams, and this was considered a useful forum to encourage men to take part in the study. Also, the company is taking a proactive approach to offering their employees access to information on health and well being, and this project created an ideal opportunity to involve front line managers in "selling" the company's wellbeing message.

There was a general consensus among the managers that they had had enough information to discuss the project with their staff. The managers also agreed in principle that it was within their role to promote the project, although their priorities were to deal with the day-to-day issues of the business, to ensure that targets were met and staffing levels managed.

It was clear that some of the managers had discussed the project in more detail at the Listening and Learning sessions than others, and that a large proportion had not discussed it at all. Reasons given were lack of time, other business responsibilities and how comfortable they felt about discussing health matters. Comments included: "I went through the booklet but only very delicately, there is a line you can't cross", "It was quite a busy session, I thought everyone was busy listening, there was humour as well".

Briefings were sent regularly to the managers from the organisation's senior project team throughout the 4 weeks of the study, and although most of the managers remembered

seeing them, they had not acted on them. None of the managers interviewed had held 'huddles' (bringing a few men together on the shop floor for a brief discussion about an issue) on the project.

It would appear that as a communication channel, the use of frontline managers was ineffective in encouraging men to use the pharmacy. Reasons for this can be gleaned from the focus group discussions such as role conflict with other organisational priorities, the trust of the frontline staff in their managers and having the necessary skills to deliver health messages. It may also been more effective if the managers had been involved in the original design of the study, and therefore felt more commitment to ownership of the objectives.

Helpful suggestions came from the managers and front line staff on how the project could have been communicated more effectively. There was a strong view that if a pharmacist had attended the learning sessions, the project may have been better understood and the uptake improved. Also, they thought the pharmacist could have come to the workplace to deliver health advice and information rather than the men going to a pharmacy: "If the pharmacist had come to them, rather than us go to them, like the Health Bus proves", "(The pharmacist) could have set up a stall in the office, and more people would just wander in for a chat", "Turn it on its head".

Pharmacists and pharmacies

An interesting finding from the study was the significant difference in expectations between what the participating pharmacies thought would happen and what did happen. The pharmacies thought the four-week study was well set-up with plenty of information and activities happening and that this would encourage the men to attend. Many felt they already had good relationships with their male customers, but in this study it did appear that the information given in the booklet may not have sufficiently conveyed the message about the role of community pharmacy as a

credible source of preventive health advice and information.

12.5 Accessibility

The final theme that runs through this analysis is that of accessibility. Even though the pharmacies were selected in various locations near workplaces, in health centres, high streets and shopping centres many of the men said they did not go because there was not a participating pharmacy near them. One of these comments was made by a man at a site where the participating pharmacy could be seen from the window. However, it is probable that the limitations of the study meant that in some areas this was an issue.

Time to access the pharmacy was a second concern and often linked to working life. There were comments such as "things like this have to be put to one side as the job is changing" and "there's that much going on with the job". Others talked about meaning to go but "kept putting it off", and a few commented that they are not even allowed time off to visit the doctor so why would they go to a pharmacist.

Time was also a factor for the pharmacist and in three cases the pharmacist asked the man to come back as he was busy. Only in one case did a man return, and he was already known to the staff because he was their regular postman.

It would appear, through the good uptake of the Health Bus, and the suggestions about the pharmacist coming to the workplace, that the men may well have accessed the pharmacy services if the services had come to them. One pharmacist working in a particularly deprived area felt that his customers would not take up offers of health information and advice because they had challenges around poverty and housing to consider before they could think of giving up smoking and having their blood pressure checked.

13 Discussion and learning points

This feasibility study was designed to test out a model of using the workplace and working through employers to encourage men to access mainstream health services for health information and advice. This was seen as an alternative approach to taking health services to men at work. Although there may have been too many variables to attribute the reason to a specific cause, the analysis offers useful insights into why the men did not take up the opportunity.

Another factor is that although this was a time limited, one-off study when the men using a designated range of pharmacies were counted, it is unknown how many men may use the booklet and the services of the community pharmacy at a later date. It is also possible that the information in the booklet may encourage them to seek advice from their GP, and this has not been captured. It would have been interesting to survey the sample of men again to see how many had used health services at a later date.

Although many of the men sampled for the evaluation (n=70) admitted throwing the booklet away or losing it, and many were sceptical about the involvement of their employer in their health and welfare, the case study of the man interviewed who had taken up the invitation demonstrated that if we can get the communication right, the potential for improving men's health could be considerable.

The men that did attend all requested blood pressure measurements, and there was feedback through the pharmacists that some also wanted cholesterol tests which were not offered in this study. It is possible that specific tests may attract men into pharmacy, and could be a mechanism for implementing the Government's systematic programme of vascular risk assessment and management for those aged between 40 and 74 .

13.1 Learning points from the feasibility study for future work:

The final section focuses on learning points from carrying out and evaluating the feasibility study. Wider recommendations are included in the final chapter of the report.

- 1 This type of workplace health initiative, which used the workplace as a channel to encourage men to take up mainstream health services to improve their health, needs to engage the intended beneficiaries (the men on the shop floor) and the main communication channels (the operational managers) in the design process. This would have allowed commitment and ownership to develop and may more closely have met the needs of the participants.
- 2 The case study shows that for a small number of men (n8/3322) the intervention was successful, but it illustrated that men are not an homogenous group and that a range of approaches are required to reach further.
- 3 The needs of Asian men were not met in this study and specific work is required to understand from them the types of interventions that would have encouraged them to use community pharmacy.
- 4 The methods of communication used in this study needed to consider the boundaries between the private sphere of home, which is separated from the workplace, and the public communal environment of the workplace, and the impact this may have had on engaging men through work.
- 5 The study would have benefited from closer involvement with the two Local Pharmaceutical Committees and the two Primary Care Trusts in the study site. It would have allowed more local intelligence to be gathered, meaningful relationships between key partners to develop and the channels to be opened to receive the learning from the study. More time was needed to build these partnerships more effectively.

- 6 The pharmacist and the pharmacy team needed to be involved in promoting the initiative in the workplace, and in some instances could deliver health information and advice in the workplace. This would enable trust to be built up between the pharmacist and the male employees, the breaking down of barriers and a greater understanding of the role. This in turn may lead to a greater use of the pharmacy outside the workplace.
- 7 Pharmacists would also benefit by understanding more closely the barriers that prevent men using their services, and listening to what could make a difference. This may require them to work in non-traditional ways and outside existing structures.
- 8 A study of this nature would benefit from a longitudinal approach that followed up the study sample at regular intervals. A longer term study would allow such questions as "Was the booklet used on a future occasion?", "What triggers its usage?", "Was there a greater understanding of the pharmacists role?" to be answered.

Chapter Four: Recommendations

The Men and Pharmacy project was set-up to test whether, by working through the workplace of a large employer, men could be encouraged to use community pharmacy for improving their health and wellbeing. The purpose was to contribute to our understanding of why men do not use mainstream health services and what needs to happen to encourage them to do so. The findings from this project have opened-up this complex debate for consideration by a number of stakeholders, in particular those concerned with workplace health, pharmacy services and reducing inequalities in health.

This chapter brings together a series of recommendations from across the work of the project. They are based on evidence from the literature review and a description of the policy agenda, the focus group findings with men and with pharmacists, as well as learning from the four-week feasibility study. The recommendations are grouped under three areas:

- ▶ Informing gender inequalities in health
- ▶ Informing 'Workplace Health' policy and practice
- ▶ Informing pharmacy

Each section includes recommendations for policy implementation, practice development and further research.



Informing gender inequalities in health

- 1 This report should contribute to the Health Inequalities Progress Review in particular in the area of impact of equality (DH2008b), and the effect this has on widening inequalities in health. This project emphasises the need to design gender sensitive services so both men and women receive appropriate access to health improvement initiatives.
- 2 Lord Darzi's final report on the NHS Next Stage Review (DH 2008a) stresses the new focus of the NHS in promoting good health and preventing ill health, including services for people at work. It requires a greater responsibility on local commissioners to commission for health outcomes. The findings in this report show that if this is to be achieved for all, the NHS will need to engage a wider group of providers such as community pharmacists, and ensure adequate funding is made available.
- 3 The findings of this report demonstrate the potential of pharmacy to support healthy living and better care, although more work is required to put the necessary mechanisms in place. The health trainer programme, life checks and the proposed vascular checks are all means to support behavioural change and would all be suitable for delivery in pharmacy, although this requires a gender-sensitive approach to both delivery and outcomes.
- 4 Commissioners of health improvement services and those charged with delivering improved health inequality outcomes through Local Area Agreements will find this report useful in informing possibilities for programmes with employers, initiatives in the workplace setting and services with community pharmacists and in pharmacies.
- 5 There is also a need to further understand how to communicate effectively with men that takes account of the diversity of and difference between men. An evaluation

of the current approach used by the Men's Health Forum in their Mini Manual publications would provide valuable insights into this important issue.

Informing 'Workplace Health' policy and practice

- 6 Workplace health improvement initiatives need to be part of an ongoing programme in order to build trust and understand the motivation of male employees. Measurements, which demonstrate the behavioural change of employees over time, are required and longitudinal research, rather than short-term projects, are necessary to understand better 'what works'.
- 7 Workplace interventions that are intended to improve the health and wellbeing of male employees through supporting them to use health services located outside the workplace may benefit from an improved understanding of the motivations of employees and front-line managers to participate. Interventions are likely to be more effective if they are designed in partnership with the beneficiaries, as then they may more closely reflect their needs.
- 8 Employers, including senior managers, should make the business case for improving the health of their employees clear to the workforce, health professionals and the wider public, and these should be used as drivers of performance within business. The Corporate Citizen agenda is an ideal vehicle for conveying these messages.
- 9 The differences between health and wellbeing lifestyle improvement and the safety needs of employees need to be explicitly articulated throughout organisations. Initiatives, such as this study, that seek to improve the health and wellbeing of employees, are different to initiatives that are concerned with improving the safety of employees at work and in the workplace.
- 10 Occupational health has a key role to play

here through linking with the wider health community, including building relationships with a range of partners, such as community pharmacies. In smaller organisations, without access to occupational health services, the proposals in Dame Carol Black's report (Black 2008) for the development of a health and wellbeing consultancy service would be invaluable.

- 11 The Men and Pharmacy project demonstrated the need to be more mindful of the distinction between work and home, and for employers to be aware of encroaching into the home lives of male employees. This project, whilst workplace-based, sought to encourage employees to use their own time to adopt healthier lifestyles, thus blurring the boundaries between work and home life. However, if health at work is to become a reality, the workplace will be important in building awareness and encouraging engagement with health services.

Informing pharmacy

- 12 The findings from this report should be used to inform the work of the Department of Health Public Health Leadership group and the implementation of the Pharmacy White Paper (DH 2008c)
- 13 In particular it should inform the Communication Programme being developed by the Department of Health to highlight the role that pharmacies play in promoting healthy living and better care in their communities, either through the workplace or in the wider community.
- 14 The report supports the view that undergraduate education and post-graduate pharmacy training courses should cover the issue of communicating with men. This should embrace social marketing principles, which through segmentation acknowledge that men are not a homogenous group; interventions need to be understood in the context of individual lives and aspirations.

- 15 This report offers insights into how pharmacists and their teams can be more effective in communicating with men through:
- ▷ Providing male-specific information
 - ▷ Exploring 'hooks' to engage men in improving their health
 - ▷ Training staff in communication skills
 - ▷ Taking the pharmacists skills and knowledge out of the pharmacy and to where the public are
- 16 There are already examples of 'peer support' models which could be further developed in pharmacy, and which take advantage of life transition points, such as fatherhood. These models seek to communicate, engage and support groups in the community, such as men, that do not use health services effectively for a variety of reasons. The models include NHS health trainers and expert patients, and an emerging concept of 'expert parents'.
- 17 The report shows the potential of community pharmacies to be commissioned to carry out the proposed Department of Health Vascular Checks (DH 2008d). The plan to introduce a systematic and integrated programme of vascular risk assessment and management, for those aged between 40 and 74, was announced in April 2008. The purpose is to identify an individual's risk of coronary heart disease, stroke, diabetes and kidney disease. The pharmacy white paper (DH 2008c) recognises this role for pharmacy, although there will need to be robust design and monitoring systems set up so all participating pharmacies can offer the core services.
- 18 Pharmacy should be more proactive in developing partnerships with occupational health services and linking into existing initiatives. It could become part of a network of services that is used by employers to support their employees to improve their lifestyles.
- 19 Pharmacy owners and store managers need

to explore their own responsibilities as an employer in improving the health of their employees, through Corporate Citizenship programmes

- 20 More robust evaluation and research is required to understand what interventions are effective in pharmacies to support individual behavioural change and address inequalities in health. Evaluation of complex interventions need to challenge assumptions and answer the questions 'what works', 'for whom', 'in what circumstances' and 'why'. This is required in order to scale up what works and address inequalities at a population level.

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Appendix 1

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Appendix 2

The Policy Context

1. Improving health and wellbeing through the NHS

NHS Next Stage Review

The recently published NHS Next Stage Review carried out by Lord Darzi (DH 2008a) sets out the future vision for the NHS, following on from the NHS Plan (DH 2000) developed eight years ago. In particular the report places a greater emphasis on the NHS helping people stay healthy as well as treating them when they are ill. There is acknowledgement that more support is needed to help people stay healthy and particularly to improve the health of those most in need. The report identifies some immediate steps that are required to take this forward. Those of particular relevance to this project include: Primary Care Trusts to commission comprehensive wellbeing and prevention services, in partnership with

local authorities, private and third sector organisations; support for people to stay healthy at work and encouraging companies to invest more in the health of their workforce and raised awareness of vascular risk assessment through the role out of a national programme of vascular risk assessment for people aged 40 to 74 years.

The Review places great emphasis on tackling variations in quality of care and giving people more information and choice. It stresses the importance of high quality services and the key mechanisms will be through developing strong clinical leadership and world class commissioning of services.

World Class Commissioning

The world class commissioning programme (DH 2008) is expected to transform the way health and care services are commissioned. It will deliver a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. There are four key elements to the programme; a vision for world class commissioning, a set of world class commissioning competencies, an assurance system and a support and development framework.

The Commissioning Framework for Health and Wellbeing and Practice Based Commissioning are two mechanisms in place to support the commissioning function and are relevant to commissioning pharmacy services.

Commissioning Framework for Health and Wellbeing (DH 2007a)

Commissioning for Health and Wellbeing provides new mechanisms for how the NHS will spend its money locally. It is focused on the whole health economy producing local health outcomes.

The key mechanism for commissioning will be through the Joint Strategic Needs Assessment (JSNA) in which Primary Care Trusts (PCTs) and local authorities will be required to describe the future health, care and wellbeing needs

of local populations, with a new duty for PCTs and local authorities to co-operate. JSNAs also require local health economies to take account of data and information on inequalities between different and overlapping communities, and support the meeting of statutory requirements in relation to equality audits.

Practice Based Commissioning

Practice Based Commissioning (PBC) was introduced in 2005 to devolve power even closer to the local level. It is believed that GP practices are in the best position to understand the needs of their local populations and it is expected that all PCT areas will encourage their practices to take part in PBC.

A recent report by the CBI (CBI 2007) on the need for a thorough overhaul of family doctor services, recommended an increase in practice based commissioning, enabling GPs to match more closely the services they offer with patient needs. The report also recommended that more primary care services should be made available from qualified pharmacists, nurses and walk-in centres. As the demand for NHS services is increasing, the areas with the greatest health needs have fewer GPs, and although the population is more likely to have coronary heart disease, they are less likely to receive preventive care (Office for National Statistics 2006).

Clearly the pharmacy profession has recognised the importance of PBC for community pharmacy. Pharmacy PBC week was held in September 2007 to encourage pharmacy engagement with PBC. The week was designed to raise awareness of this new method of commissioning and to enable pharmacists to engage more readily in the process. A bulletin produced by the NHS Primary Care Contracting (PCC 2007) provides PCTs, practice based commissioners and pharmacy stakeholders with an opportunity to take stock of local clinical engagement between practice based commissioners and pharmacy and suggests ways in which practice

based commissioners could benefit from closer working with pharmacy. It recommended that

“Practice based commissioners and PCTs should invite community pharmacy representatives to discuss commissioning plans and to identify complementary pharmacy activities” (PCC 2007:2)

The report also makes it clear that PBC provides a mechanism to mainstream pharmacy's contribution to reducing hospital admissions, addressing health inequalities, bringing care closer to home and building capacity in primary care. However, this requires active and effective local engagement and communication between stakeholders if community pharmacy is to support PBC.

Resources are also being produced to facilitate pharmacist's role in PBC. The National Pharmacy Association (NPA) has developed a suite of PBC business case templates for its members, in order to support community pharmacists in preparing service proposals. The templates can be used in different ways, either to structure ideas early in the PBC commissioning cycle about the pharmacy contribution to modernising service patterns, or later in the process, for submitting a 'provider business case'.

2. Improving health and wellbeing and reducing health inequalities

Choosing Health: Making Healthier Choices Easier

In November 2004, the influential public health white paper was published by the Department of Health (DH 2004) following an extensive consultation process. Choosing Health showed a fundamental shift away from the perception of the National Health Service (NHS) as a sickness service rather than a health service, and reinforced the founding principle that the NHS should improve health and prevent disease, not just provide treatment for those who are ill. The white paper is intended to make a difference to the health of people in England, as well as reduce enduring health inequalities. It recognises

that a 'one size fits all' approach to services will not meet people's needs.

Choosing Health is built on three key principles:

- 1 Creating the right environment to support people in making healthy choices. The smoke free legislation introduced by the Government in July 2007 is an example.
- 2 Personalisation of support, which means building information, support and services around people's lives to enable them to make changes in their behaviour. NHS Health trainers and Life Checks are an example.
- 3 Working in partnership to make health everyone's business. This recognises the influences of local government, advertisers, retailers, industry, employers and communities on people's opportunities to improve their health.

Choosing Health was a response to the landmark report of Derek Wanless (HM Treasury 2002), which stated that traditional methods for improving health and reducing health inequalities were becoming outdated: new approaches and new action was needed to secure progress. The report is considered further in the next section.

Securing Good Health for the Whole Population

The report *Securing Our Future Health: Taking a Long-Term view* (HM Treasury 2002) was commissioned by the Treasury, to examine future health trends and identify the factors determining the long-term financial and resource needs of the NHS until 2022. It captured three scenarios – "slow uptake", "solid progress" and "fully engaged", of which "fully engaged" made the most efficient use of resources. As a result of this first report, Gordon Brown, then Chancellor of the Exchequer, announced the largest ever sustained investment in the health service and allocated record levels of funding until 2008.

In 2004, a further review was published

(Wanless 2004), which focused particularly on prevention and the wider determinants of health. It called for a comprehensive public health strategy to enable people to become fully engaged in their own health. 'Choosing Health' was the response to that report.

In 2007 (Wanless et al 2007) the Kings Fund published a further report assessing progress over the last 5 years, which showed that more needed to be done to tackle the key determinants of ill health. The report examined whether health care expenditure increased in line with the recommendations from the 2002 review, where the extra money was spent, if the additional resources were being used effectively, and if not, why not, and what lessons could be learnt for the future. The review found that funding had more or less matched the recommended amounts, but would need to increase by 4.4 per cent a year to maintain progress; the majority of the funding had been used in fund pay increases through three new contracts – Agenda for Change, hospital doctors and general practitioners but there was little robust evidence to demonstrate significant benefits from these pay increases. Most significantly, health inequalities between socio-economic groups had increased, and the authors found that low priority was given to public health, with the number of public health consultants decreasing in the same period that non-public health medical staff had increased by 60 per cent. They concluded that the raiding of public health projects during the NHS financial difficulties was short sighted, and that we were a long way short of the fully engaged scenario.

Health inequalities: progress and next steps

In June 2008 the Department of Health published its review of the health inequalities targets and its plans for the future (DH 2008b). The report acknowledged that whilst life expectancy had increased year-on-year over the past decade, the health of the most disadvantaged had not improved as quickly as that of the better off. Life expectancy for men in disadvantaged areas had increased by over two-and-half years in the period since 1995-1997,

and by over one-and-half years for women.

It reinforced the Government's commitment to develop new ambitions to reduce health inequalities, and the Department of Health is to scale up what has been shown to work to reduce inequalities through tackling wider inequalities. It emphasised four areas in particular where progress needs to be made: in primary care, commissioning services in partnership with other organisations, creating services which reach out to individuals, groups and communities and using NHS services actively to promote equality.

Gender mainstreaming

Gender mainstreaming is the term used to describe a fully integrating approach to male and female health needs, both strategically and operationally throughout an organisation. Whilst the health inequalities debate has failed to consider gender as an issue in comparison to socio-economic status and to an extent race and ethnicity, the Equality Act of 2006 brought in a new Gender Equality Duty on public bodies. The new duty, which came into force on 6 April 2007, requires primary care trusts and other NHS and public bodies to promote equality of opportunity between men and women when planning and delivering services in order to produce equal outcomes. The government has made it clear that this means bringing about measurable improvements in the lives of men and women, where one sex has previously fared less well than the other.

The Darzi Report (DH 2008a) refers to the focus on prevention, improved quality and innovation in the NHS as an excellent opportunity to pursue the duties of the Equality and Human Rights Act. However, when the Men's Health Forum carried out a survey in July 2007 of gender equality schemes (GES) in primary care trusts three months after the deadline, it found that over one-third of the 152 PCTs in England had failed to publish a GES at all. Of those that did, most failed to comply with the majority of requirements for a GES, as specified in the official code of practice. The emphasis of

most GESs was also on internal administration and process, not on how to achieve equitable outcomes between men and women, demonstrating a failure to follow guidance from the Department of Health, the Equal Opportunities Commission or the Men's Health.

The Equality and Human Rights Commission (EHRC) responded to the MHF's findings by conducting its own enquiry into compliance by PCTs. The EHRC found, that by early March 2008, 27 PCTs were non-compliant in that they had not published a GES; it also concurred with the MHF's view that the vast majority of published schemes were inadequate in many key respects.

Later this year a report, commissioned by the Department of Health and carried out by the Men's Health Forum and the School for Policy Studies at the University of Bristol, looking at gender difference in access to services is to be published.

The Role of Local Government in promoting health and wellbeing

The Local Government White Paper (Department for Communities and Local Government 2006) confirmed the importance of local authorities in promoting health and wellbeing. It identified how more systematic partnerships between local agencies could be brought in through joint appointments, pooled budgets and joint commissioning.

A report by the Audit Commission (Audit Commission 2007) reviewed 77 corporate assessments of individual local authorities, 3 national studies and local audits of action to tackle health inequalities, particularly in North West England. They emphasised the critical role local authorities have in tackling health inequalities and promoting health and wellbeing, because many of the factors affecting health are influenced by local authority action. The report suggests that improving health and wellbeing is likely to be a high priority for many Local Strategic Partnerships (LSPs) and therefore a focus for the new Comprehensive

Area Assessments . However, they did find that a systematic strategic approach was the exception rather than the rule, and that health and wellbeing could be better integrated with other activities. They also found that evaluation was very weak, leaving little scope for the assessment of the impact and effectiveness of interventions. They concluded that if we are to reach Wanless' 'fully engaged scenario' local authorities will be required to make sizable shifts in approach and have greater rigour.

Local Area Agreements are another mechanism used to bring partners together to achieve particular local outcome.

3. Improving health and wellbeing and tackling health inequalities through work

The public health White Paper Choosing Health (DH 2004) highlights the central part that work plays in health and wellbeing, and in determining inequalities in health throughout the life course. It set out a number of actions that need to be taken: reducing barriers to work to improve health and reduce inequalities through employment; improving working conditions to reduce the causes of ill health related to work, and promoting the work environment as a source of better health.

In response, the strategy for Improving Health and Well-being of Working Age People was produced, a joint document between the Department of Health, Department for Work and Pensions and the Health and Safety Executive (Department for Work and Pensions, 2005). This strategy aimed to co-ordinate the Government's approach to improving health and tackling inequalities through the workplace, and to identify gaps where further work was needed. In 2006, the Government's commitment to improving the health of the working age population was further strengthened by the appointment of Dame Carol Black as the first National Director for Health and Work, and in March 2008, Dame Carol produced a review of the health of the working age population (Black 2008).

The review made a compelling case to improve the health of the working age population through a number of measures. It stressed the need for employers and their representative bodies, such as the CBI (Confederation of British Industry), to invest in the health and wellbeing of their employees. The Government is due to issue its response to Dame Carol's review in the autumn (2008) but there is growing recognition that the work and health agenda is gathering momentum and that it will become an important focus for improving health and reducing health inequalities in the future.

4. Improving health and wellbeing and tackling health inequalities through pharmacy

One of the commitments in Choosing Health (DH 2004) was to publish a strategy for pharmaceutical public health in 2005, which would expand the contribution that pharmacists, their staff and the premises in which they work could make to improving health and reducing health inequalities. This focus was further enhanced in 2008 by the publication of the Pharmacy White Paper (DH 2008c).

Choosing Health through Pharmacy 2005 to 2015

Choosing Health through Pharmacy (DH 2005a) set out the pharmaceutical public health strategy and the contribution that community pharmacy could make in the local health economy to delivering the commitments in Choosing Health. At a similar time, the new contractual framework for community pharmacy was agreed for England and Wales (see below), which sought to make public health more integral to the pharmacy role. Several key features were identified in Choosing Health through Pharmacy that could be developed over the next decade. These include:

- ▶ Building the evidence base for pharmaceutical public health.
- ▶ Tackling health inequalities by investing in health improvement services in areas with the

worst health indicators.

- ▶ Providing information and advice to the public on health improvement and signposting to services.
- ▶ Putting people in touch with health trainers, identify people who might become health trainers and provide a setting in which health trainers can work.
- ▶ Developing pharmacy's contribution to tackling obesity.
- ▶ Providing sexual health services.
- ▶ Becoming a major provider of NHS stop-smoking services.
- ▶ Identifying individuals with risk factors for disease and offer them lifestyle assessments.
- ▶ Making pharmacies more accessible and inviting to men, offering information, advice and support for self care. Men do want more health information and are more likely to use diagnostic tests if offered in a male friendly environment.
- ▶ Developing the pharmacy workforce, in the three main groups identified by the Chief Medical Officer – the wider public health workforce, public health practitioners and specialists.
- ▶ Strengthening the undergraduate pharmacy curriculum and training support staff to better encompass public health.

Community Pharmacy Contractual Framework, April 2005

The potential opportunity for pharmacy to play a role in public health was also demonstrated in the new pharmacy contract, which came into operation in April 2005 (DH 2005c).

The contract makes the expectation of the Government clear that community pharmacy has a part to play in improving the health of the population and tackling health inequalities. The three tiers of service identified in the contract are essential and advanced services, which are nationally set, and enhanced services commissioned locally by the PCT.

Essential services provided within the NHS contract include the promotion of healthy lifestyles through prescription-linked interventions and up to six public health

campaigns a year, as well as signposting and support for self-care. Advanced services can only be undertaken if all the criteria of all essential services are made and both pharmacist and pharmacy premises must be audited, and the first advanced service offered was the Medicines Use Review (MUR). Examples of enhanced services, commissioned locally by PCTs in response to local need, would be smoking cessation services (Pharmaceutical Services Negotiating Committee PSNC). The Knowsley health checks (described in chapter two) are an example of a local enhanced service.

Pharmacy in England: building on strengths-delivering the future

In April 2008, the Department of Health published a Pharmacy White paper (DH 2008c), which sets out the vision for pharmacy over the coming years. It includes the Government's response to the review of the NHS pharmaceutical arrangements, commissioned by the Government in 2007, and the views put forward by the All-Party Group report 'The Future of Pharmacy' in 2007.

There is a strong focus within the paper on the community pharmacy's role in addressing health inequalities and securing improved health and wellbeing for all. In particular, it sees pharmacies as centres promoting and supporting healthy living through offering people healthy life style advice and support to self-care. The Government also wants pharmacies to offer new services such as routine monitoring of people with long-term conditions, and offer screening for those at risk of vascular disease.

The white paper also stresses the need for raising awareness and understanding of the varied services that pharmacies and pharmacists offer. A communications programme is to be developed to support the delivery of key messages to patients, the public, the NHS and others. In addition, a working group is to be set up to promote closer working between GPs and pharmacists through a shared understanding of how their respective clinical roles can help deliver more personalised and effective care to patients.

Summary

It is clear from this brief review of current health policies that the policy context offers a number of levers to support the case to encourage men, through a workplace setting, to use community pharmacies in order to improve their health and wellbeing and reduce health inequalities between men. The key themes to emerge are:

- ▶ There are mechanisms in place to support a more holistic approach to commissioning through partnerships
- ▶ A focus on outcomes rather than inputs
- ▶ An emphasis on prevention and improving health, and an increased drive to reduce inequalities in health
- ▶ A specific policy commitment to use pharmacy to improve men's health
- ▶ New service models encouraged to deliver health improvement and health care services
- ▶ The 'Wanless' agenda which encompasses the 'fully engaged scenario'
- ▶ An understanding of a more tailored approach to service delivery, using social marketing principles, rather than a 'one size fits all' model,
- ▶ Better approaches to self-care and managing long term conditions
- ▶ Implementation of the Gender Equality Duty

Appendix 3

Men's Focus Group Discussion Guide – Final

Two focus groups of 8 to 10 men to be held with blue-collar men working at Royal Mail in the mid Yorkshire area.

Approximate time 1 hour

The groups will be moderated at a medium level to allow discussion and interactions to occur within the group

Introduction and welcome:

- ▶ My name, thanks etc
- ▶ Reminder about tape recorder and photos (consent should already be signed) BRING EXTRA COPIES
- ▶ Confidentiality of data in and outside the group
- ▶ Everyone's view important – helps if we try to speak one at a time
- ▶ Timings of group

Why have we asked you to be here?

- ▶ About the project – DH funded, improve men's health, etc
- ▶ Should already have received project information sheet, but reiterate key points
- ▶ To talk about how you may use a pharmacy to get information and advice on keeping healthy.
- ▶ Their views will inform the practical pilot which they will have the opportunity to take part in

Starter discussion question

Everyone to answer individually, name and:

1. "What does 'being healthy' mean to you?"

Prompts: Does it mean different things to different men?

Guiding Discussion Questions

2. Where would you go to find information and advice on staying healthy?

Prompts: Informal advice v formal GP, nurse, health trainer, NHS walk in Centre, super market, pharmacies
Media, TV and magazines, pharmacies
Wife, partner, each other, mother

3. Can anyone give any examples of how they have used a pharmacy?

Prompt: Present prescriptions, Over the Counter

Medicines (OTC), Medicine Use review, other well being products eg, tonics, vitamins etc.

Neurphen, panadol, gaviscon, Rennie,
- painkillers, medicines for indigestion, coughs

Other health care products – toothpaste, sun lotion

Do they only buy these at the pharmacy?
Supermarket, garage.....

4. If yes – which type of pharmacy do you normally use?

Prompt: near work, home, GP.
Is it supermarket, big chain, independent, type of ownership, physical size?

What do you like/ dislike about each?

4. How do you feel when you go into a pharmacy?

Welcomed, comfortable, in a hurry

5. What's the experience like?

Who speaks to you and about what?

Is there a difference in supermarkets, big chains, or local independent groups?

6

“One of the things we are particularly interested in is whether the local pharmacy is somewhere you could or would go to get information and advice on keeping healthy”

What would encourage you to use the pharmacy to get help on having a healthy life?

Prompt: who in the pharmacy? Confidentiality and consulting rooms?

Appointments or drop in? During the working day? Technical machines? Is it different for different groups of men – age, ethnicity, disability?

7. What may make it less easy for you to use the pharmacy for health information and advice?

Prompt: barriers? Too busy? ? Is it different for different groups of men – age, ethnicity, disability?

Final summary question

8. What services would you like to see in the future to help you keep fit and healthy?

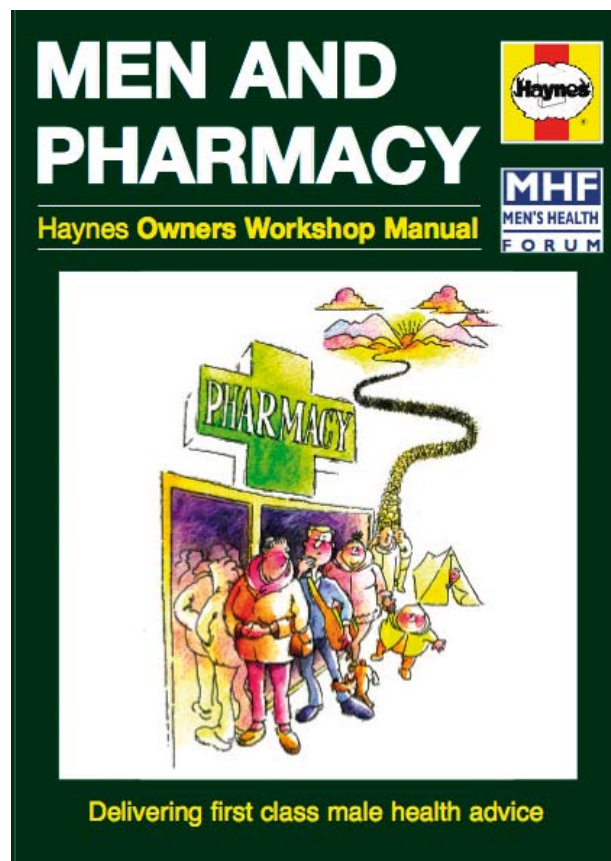
In conclusion

Anything else to add? Give my contact details for follow up.

Reminder of what happens to the information they have given.....

Thanks etc

Appendix 4



Appendix 5



Appendix 6



Appendix 7

Delivery Office Managers (DOMs) post intervention focus group – discussion guide V2

Two focus groups of 8 to 10 Delivery Office Managers – one face to face in Leeds at a DOMs meeting, the other a teleconference with Bradford staff.

Approximately 30 minutes.

Introductions and welcome

- ▶ Introduce myself, MHF, project and the reason I am there
- ▶ Seek consent to record discussion (give out consent forms)
- ▶ Record demographic characteristics of group
- ▶ Discuss confidentiality – no names will be used
- ▶ Ground rules for the group
- ▶ Show mini manual and tear off slip

Why we have asked to talk to DOMs?

- ▶ Played a part in setting up the project
- ▶ Hear their views

Starter Questions

Individual responses

1. How long have you worked in Royal Mail and can you please describe your role?

How do you carry out your duties? How often do you hold WTLLs?

Discussion questions

2. What did you think the 'Men and Pharmacy' project was trying to achieve?

3. Can you please explain your role in the men and pharmacy project?

Is it usual for you to raise health issues with the staff? Can you give any other examples?

4. Can you please describe what you were asked to do?

5. Did you have enough support to carry out your role?

How useful was the information sheet about the huddles? Did you discuss the project at the WTLLs? How did you feel about the email prompts from Paul? Were they useful?

“One of the things we are particularly interested in is whether it is possible to encourage men to look after their health by working with their employers?”

6. What do you think are the advantages of working with employers on improving health? What are the disadvantages?

Do people use the Health bus? Is it useful to focus on men’s health? It is a good idea to have projects that are different for men and women?

7. What was the response from the men?

Did they take extra mini manuals from the workplace? Did they go to a pharmacy? Did they find it useful?

8. What are your own views on the project?

Have you looked at the mini manual? Have you visited the pharmacy? Did any partners, family members or friends look at the information? Where is it now?

Final Questions

9. Have you learnt anything new about the health services (GP/ Practice nurses/ pharmacies?) for improving your health and wellbeing?

10. In what circumstances would you use them in the future for health information and advice?



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