Navigating the challenge of practice change: lived experience of community pharmacists in England

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

In England, the community pharmacy profession is changing. With mounting pressures on the NHS to meet the needs of 21st century healthcare, community pharmacists are perceived as an untapped resource to relieve these stressors. Despite these calls to action, evidence suggests that change within the community pharmacy profession has been enacted slowly and inconsistently. Whilst existing research into practice change exists, a critical voice, the voice of community pharmacists themselves is seldom centred. Exploring their experiences is critical to fully understand the challenges of change in the context of practice.

This study utilised a phenomenological methodology to explore the lived experiences of practice change for community pharmacists in England. In-depth, semi-structured interviews with ten community pharmacists at two time points was intended to centralise and give voice to the lived experience of the participants. Reflecting the complex contexts in which community pharmacists work, Rogoff's Planes of Analysis framework was adapted and used to underpin the data analysis and view change through three separate, but interlinked 'planes':

Micro level: the personal experience

Meso level: the socio-cultural context of practice

Macro level: the wider profession and policy.

The experience of the individual was foregrounded, and situated within the context of the organisation and the wider profession.

The findings of this study illustrate the challenge of practice change for community pharmacists, whose role as change 'translators' takes place in complex systems driven by external policy, organisational demands, and personal agendas, which are frequently at odds. Findings were presented under four themes that illustrated key experiences of change: agency in the change process, role tensions, networks of support, and psychological safety. This study proposes that aligning community pharmacists' psychological and socio-cultural needs with external drivers of change is critical to meet the external demands for practice change, whilst nurturing a professionally fulfilled workforce.

Words: 299

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Abbreviations

ACT	Accuracy checking technician
CP	Community pharmacy/pharmacist
CPCF	Community Pharmacy Contractual Framework
CPCS	Community Pharmacist Consultation Service
CPPE	Centre for Pharmacy Postgraduate Education
GPhC	General Pharmaceutical Council
LPC	Local Pharmaceutical Committee
MUR	Medicines Use Review
NHS	National Health Service
NMS	New Medicines Service
OTC	Over the counter
PT	Pharmacy technician
RP	Responsible pharmacist
RPS	Royal Pharmaceutical Society

Chapter 1: Introduction

"There is nothing permanent, except change"

Heraclitus

This thesis is an opportunity to explore practice change for community pharmacy in England. In doing so, it takes a phenomenological perspective on practice change as it is currently enacted and experienced by community pharmacists themselves. This phenomenological perspective provides unique insight into the lived experiences of community pharmacists at a time of significant change within the profession. The study employs a sociocultural "Planes of Analysis" framework through which to consider the relationship between the individual community pharmacists and the wider context of practice. Finally, this thesis makes recommendations for education and policy in community pharmacy.

1.1 Why explore practice change for community pharmacy?

The National Health Service (NHS) is changing dramatically to meet the health challenges of patient care in the 21st century. There is a transfer of service delivery from hospital to community settings, an ageing population that increasingly suffer from multiple morbidities, and a growing focus on shifting from treatment to preventative medicine. These demands have prompted the NHS to explore how to use healthcare staff and resources more efficiently to meet these challenges (NHS England, 2017). In England, community pharmacy has been identified as having "significant unexploited potential" (Gerada and Riley, 2012) and community pharmacists themselves are increasingly recognised as clinically trained healthcare professionals, whose skills and knowledge could be more effectively used to benefit the healthcare service. In order to reach this potential, community pharmacists have been tasked with expanding their role beyond the preparation and supply of medicines, to take on new responsibilities including independent prescribing, administration of vaccines, management of long-term conditions and public health services (Mossialos et al., 2015; Agomo, 2012; PSNC, 2016; NHS England, 2017). As a result, the capacity of community pharmacists to be aware of, and responsive to, change has become critical. There are high expectations of community pharmacy to rise to the challenge of being the "first port of call" in community healthcare (Hassell et al., 1997 p 498).

Despite new community pharmacy contractual frameworks, and pressure on community pharmacists to adapt to a new paradigm of practice, evidence suggests

that change has been enacted slowly and inconsistently. This variability in how pharmacists implement change has created a “growing schism within the profession” (Rosenthal et al., 2010 p. 40). The Nuffield Trust undertook an independent review of community pharmacy in the UK and concluded that there had been ‘disappointingly little progress’ in shifting pharmacy away from dispensing towards the provision of direct patient-centred services (Smith et al., 2014 p. 2). Following this, a review by the King’s Fund determined that community pharmacy services remained underdeveloped and the public were not fully benefiting from the range of skills that community pharmacists offered (Murray, 2016). The same review argued that pharmacy has been unable to optimise the opportunities presented to it, and so has found itself as “an outsider” in community healthcare provision (p.11).

However, the requirement for community pharmacists to adapt and change continues to grow. Calls for expanded roles for community pharmacy are now found throughout national policy. The recent policy document “The NHS Long Term Plan” and the subsequent Community Pharmacy Contractual Framework (CPCF), both issued in 2019, are continuing to drive a practice change agenda, presenting new roles and responsibilities that represent new paradigms of practice for community pharmacists (NHS England, 2019a; NHS England, 2019b). Matt Hancock, Secretary of State for Health and Social Care said of the CPCF:

> *“I am now delighted to set out this landmark 5-year settlement for the community pharmacy contractual framework which… will expand and transform the role of community pharmacies and embed them as the first port of call for minor illness and health advice in England.* (NHS England, 2019a p.3)

Within this ongoing demand for practice change, a significant voice, that of community pharmacists themselves, has largely been absent. This voice is critical to understanding how members of the profession are reacting to this policy-driven change, and how practice change is holistically experienced, enacted and embedded within the context of organisations. This insight is crucial to effectively engage and support community pharmacists to respond to the changes envisioned and mandated by policy and the profession.

Within pharmacy, Rosenthal and colleagues (2016b) described these as “complex issues” worthy of further investigation to provide a better understanding of change (p.318). Existing literature in this field tends to focus on the barriers and facilitators of practice change. For example, practical barriers such as inadequate resources, time constraints, lack of managerial support, staffing and skill-mix, unsuitable

premises, lack of access to equipment and technology (Doucette and Koch, 2000; Roberts et al., 2008; Shoemaker et al., 2017; McCaig et al., 2011). Alternatively, they have taken a narrow perspective, for example by focusing on the individual pharmacists' traits as barriers to change, without considering the contextual factors that may be of relevance (Rosenthal et al., 2015a, Luetsch, 2017). In addition, quantitative, positivist approaches are common in the existing practice change literature (Varas-Doval et al., 2021; Weir et al., 2019; Bates et al., 2020) along with discussion and opinion pieces (Rosenthal et al., 2010; Rosenthal et al., 2016b; Forsyth and Rushworth, 2021). Overall, existing research seeks to identify why community pharmacy has failed to enact change, rather than what change has meant for the working lives of community pharmacists themselves. There is a lack of research into the influence of change on community pharmacists, in the situated context of the practice setting.

1.2 A Shift in Focus

This thesis is intended to encourage the profession to reflect upon what practice change means for community pharmacists themselves. The empirical research is embedded within the participant experiences viewed through the lens of the individual and set within the sociocultural context of their organisation and the broader profession. Practice change is presented as an opportunity for the profession to improve patient care and meet the needs of the NHS, with policy and guidance driving this endeavour, but what this means for the day-to-day working lives of community pharmacists is seldom considered. This study initially set out with the intent to explore self-directed change, purposefully selecting participants who were attempting to implement a change in their practice through participation in a leadership programme. However, throughout the research process it became evident that drivers of change are complex and multifaceted in community pharmacy. In engaging with the voice of community pharmacy participants, it was apparent that immediate surroundings and the broader contexts in which pharmacists operate, are central to the experience of practice change for community pharmacy. As a result, this study shifted focus. Instead of exploring self-directed change, the intention moved to a more integrated perspective of practice change that centralised the individual experience of the community pharmacist.

1.3 A Sociocultural Framework

In order to situate the individual experience of practice change within the wider context of community pharmacy practice, this study uses Barbara Rogoff's Planes of Analysis framework (1995). This seminal work was initially developed as a means to examine human development. As a sociocultural theory, it posits that individuals exist within the construct of multiple, dynamic contexts, or "planes", that are interconnected. These planes influence the individual experience through a bi-directional relationship between a person and their environment. These planes consist of:

Micro level: the personal, or individual experience

Meso level: interpersonal relationships

Macro level: the wider community (Rogoff, 1995).

The value of this model is in the interrelatedness of the three levels, which are considered mutually connected. As Rogoff (1998) explains:

"Using the personal, interpersonal and community/institutional planes of analysis involves focusing on one plane, but still using the background information from the other planes, as if with different lenses" (p.688)

Therefore, these planes of sociocultural analysis are interrelated and illustrate the participants' involvement in the context of practice. In this study, Planes of Analysis offers a way to understand how a community pharmacist interacts with the context of their environment and how they experience change as a result of this interaction. It allows an exploration of how specific features of the setting, for example, demands of the business or expectations of others, may contribute to the experience of practice change. To understand the influences of these systems on the individual, the micro level experience is foregrounded, and situated within the context of the organisation, social interactions and relationships, and policy and the wider profession.

Theorists working in the sociocultural paradigm have suggested that phenomenology provides a suitable methodology through which to understand how the environment influences a person, and how that influence is perceived by the person experiencing the phenomenon (Bronfenbrenner, 1979). This combined approach utilises the Planes of Analysis framework to analyse findings, which enables an in-depth understanding of community pharmacists' experience of

change. This requires exploration of thoughts, feelings, perceptions and reflections to provide insight into how community pharmacists are making sense of their experiences of changing practice. To surface this insight, the study uses an interpretative phenomenological analysis (IPA) methodology both to explore the lived experiences and give voice to community pharmacists whose situated experiences of change are currently not fully understood.

1.4 An Interpretative Phenomenological Analysis (IPA) Approach

It is essential to make clear the methodological framework that underpins this research. The empirical work of this thesis takes an interpretivist and subjectivist approach in which each study subject creates their own "subjective meaning" of their change experience (Eatough, 2008 p.98) acknowledging that there is no "single identifiable reality" or "single truth" (Lincoln et al., 2011 p.102). This is in contrast with much of the existing research in community pharmacy that takes a positivist and objectivist research approach. Instead, this research takes an inductive path, seeking to gain rich insight into the experiences of community pharmacists. This was achieved by utilising interpretative phenomenological analysis (IPA) (Smith et al., 2009). Phenomenology is defined as a methodology that seeks to describe a phenomenon through exploring it from the perspective of those who have experienced it. It offers a way for us to "look at what we normally look through" (Sokolowski, 2000 p.50). The goal of phenomenology is to describe the meaning of experience, both in terms of what was experienced and how it was experienced (Teherani et al., 2015). As Shaw (2001) explains:

> *" [Phenomenology] is particularly suitable for research where the focus is on the uniqueness of a person's experience, how experiences are made meaningful, and how these meanings manifest themselves within the context of the person both as an individual and in their many roles.*" (p.48)

Phenomenology is therefore well situated to provide a methodological approach through which to explore the pressing issues that community pharmacists face during the process of practice change. By examining an experience as it is subjectively lived, we can develop new meanings and appreciations that inform, or re-orientate, how we understand that experience (Laverty, 2003). A qualitative method using semi-structured interviews with community pharmacists at two time points was intended to explore progress in changing practice. Notably, the findings of this study are not intended to be generalisable (Smith et al., 2009), but instead offer in-depth insight into a small number of community pharmacists. It hopes to engage the profession in thinking more deeply into what it means for individual

community pharmacists to change their practice, and conceptualise how we might better support the profession to achieve professional fulfilment through practice change.

1.5 Thesis Aims

The primary aim of this research is to enhance our understanding of community pharmacists' unique experiences of practice change. To achieve this, the research was originally driven by the questions: How do community pharmacists enact practice change? What barriers and facilitating factors are important to community pharmacists in attempting to implement change? What are the implications of this for policy and the education of community pharmacists?

The focus of the research shifted from exploring self-directed change to a more holistic perspective of practice change for community pharmacists, highlighting the iterative and inductive nature of this study. As a result, this study intended to answer a single phenomenological question:

How do community pharmacists experience practice change?

This research question is underpinned by the following research aims, which drove the analysis and discussion of findings in this thesis:

- To describe the phenomenon of practice change for community pharmacists.
- To situate the experience of community pharmacists within the change process.
- To identify factors at the macro, meso and micro levels that influence the experience of change.
- To identify what community pharmacists need to support them in practice change.

1.6 Thesis Structure

This thesis is presented in a series of chapters. Chapter two presents background literature to situate this study within the recent history of policy that has driven practice change in England.

Chapter three critically discuss the existing literature on community pharmacy practice change at individual and contextual levels, and how these perspectives provide a starting point for this study. It illustrates what is already known about

practice change and where gaps in knowledge exist. This chapter concludes by making a case for Rogoff's Planes of Analysis framework through which to explore practice change in community pharmacy.

Chapter four provides the methodological perspective and highlights how phenomenology came to be realised throughout this study. It sets out the methodological approach to the study, describes the methods used and provides detail on the data analysis process.

Chapter five presents the empirical work on which this thesis is focussed. This chapter starts with a presentation of each participant, to ground the data in their lived experience as community pharmacists. It presents key themes derived from the convergence and divergence of participant experiences.

Chapter six returns to the research question and aims to provide a summary of the findings, along with the strengths and limitations of the research, implications of findings and recommendations for future research. It presents the core contributions of the thesis, including an overall summary of the experience of practice change for community pharmacists.

Chapter 2: Background to the Study

This study considers education as situated within the context of practice. Community pharmacists are required to engage in continuing professional development activities. However, from my perspective as an educator working with pharmacists in a postgraduate setting, it is apparent that community pharmacists are not consistently able to apply learning in the context of their practice. This highlighted the importance of the socio-cultural context in which pharmacists work for their ability to translate learning to practice. This study therefore focuses on community pharmacists' experience of practice change in England, which is firmly situated within the context of their everyday working lives and the wider pharmacy profession.

To understand change in relation to community pharmacy, it is vital to understand the overall direction of the profession, along with significant areas of professional and governmental policy that have contributed to shaping current practice and setting the vision for the direction for community pharmacy practice change. This chapter lays out relevant historical context, government policy and professional direction for community pharmacy as it relates to changing practice for the profession.

2.1 Current Community Pharmacy Practice

Community pharmacists are traditionally, and arguably, most well recognised as dispensers and retailers of medicines. With a professional body, originally the Pharmaceutical Society (now the Royal Pharmaceutical Society) dating back to 1841, and "pharmacist" a restricted title since 1868, the profession has a long history firmly grounded in medicines expertise and supply.

At the last census in 2021, there were 27,000 community pharmacists working in the community pharmacy sector, making up approximately 70 percent of the total pharmacy workforce in England (HEE, 2022). Like general practitioners (GPs), community pharmacies operate as privately owned businesses that are contracted and commissioned by the NHS to provide pharmaceutical services for local populations (Bush et al., 2009). Consequently, they are established private sector providers of public services. These community pharmacies take a number of organisational forms under different types of ownership, from independently owned pharmacies, to small- and medium-sized chains, through to large national chains or "multiples" and supermarkets.

Traditionally, community pharmacies were independently owned and operated. In recent years, there has been a shift to a large-chain model, with approximately 60 percent of pharmacies operated by contractors with six or more pharmacies, and the remainder by pharmacy contractors with five or fewer pharmacies (NHSBSA, 2020). Community pharmacists may either work for themselves, be salaried employees, or work as self-employed locums.

In England, the terms and scope of the services provided by community pharmacy are set out by the Community Pharmacy Contractual Framework (CPCF). The most recent contract renewal, released in July 2019, presented a five-year deal for community pharmacy (PSNC, 2019a; PSNC, 2019; NHS England, 2019a; PSNC, 2019b). Table 2.1 outlines the services community pharmacy can currently offer through this new contract. The implications of this for community pharmacy will be discussed in more detail in the next section.

Somewhat unusually within healthcare, alongside the contracted services, community pharmacy also offers a range of products and services for customer purchase, such as cosmetics and grocery items.

Table 2.1: Services offered through the Community Pharmacy Contractual Framework (adapted from PSNC, 2019)

Essential services and clinical governance	Advanced services	Locally commissioned services
Dispensing medicines Dispensing appliances Discharge Medicines Service Clinical governance Repeat dispensing Public health (promotion of healthy lifestyle) Disposal of unwanted medicines Support for self-care Signposting	Medicine Use Review (MUR)[1] New Medicine Service (NMS) Appliance Use Review (AUR) Community Pharmacist Consultation Service (CPCS) Flu Vaccination Service Hepatitis C Testing Service	Wide range of services that can be commissioned by a number of different routes including local authorities, Clinical Commissioning Groups (CCGs) and local NHS England teams

[1] The Medicine Use Review (MUR) service was decommissioned on 31st March 2021. At the time of this study community pharmacists were still able to provide MUR services under the CPCF at the time.

	Hypertension Case-Finding Service Stoma Application Customisation (SAC)	

Approximately 1.6 million people visit a community pharmacy in England every day (PSNC, 2021), with claims that 90% of the UK population is seen by community pharmacy each year (Anderson, 2000). This situates community pharmacists as "the most accessible healthcare profession" (Bates et al., 2016 p.2).

2.2. Policy and Practice Change

Since the 1950s there have been ongoing discussions about the direction of change for the pharmacy profession, from having a primary focus on the technical aspect of medicines supply, to having a more expansive role, where medicines expertise can be more widely utilised for patient care. This has been described as the "extended role" for community pharmacy (Edmunds and Calnan, 2001 p.953). To propel this change forward, numerous government health policy and pharmacy professional policy publications have proposed new recommendations regarding pharmacists' work and roles. Although the direction of change has not been linear and, for a profession whose role has been described as "ambiguous" (Cooper, 2020 p.205), there has been an ongoing challenge for pharmacy to find a professional niche among other healthcare professionals and create a defined role for themselves.

One of the first key drivers for change in community pharmacy came in the first half of the twentieth century, as the responsibility for medicines manufacture shifted to the pharmaceutical industry. This significantly reduced the compounding role for community pharmacists and repositioned the focus toward dispensing and labelling manufactured products. In the 1980s, new paradigms for pharmacy practice emerged, driven by both academics and professional organizations that described the future of pharmacist roles as patient-centred rather than medicines-centred (Miller, 1981). The Nuffield Report (Turner, 1986), the first policy review of the entire pharmacy profession, provided an early reference to "extended" roles for pharmacists, although details on the scope of these roles was unclear (Turner, 1986 p.1032). At a similar time, within the US, Hepler and Strand's seminal paper recognised pharmacy was at a critical point, and saw an opportunity to set a new direction for the profession toward a vision of "pharmaceutical care" (1990). They proposed:

> *"Pharmacy has shed the apothecary role but has not yet been restored to its erstwhile importance in medical care. It is not enough to dispense the correct drug or to provide sophisticated pharmaceutical services; nor will it be sufficient to devise new technical functions. Pharmacists and their institutions must stop looking inward and start redirecting their energies to the greater social good…. Pharmacy's reprofessionalisation will be completed only when all pharmacists accept their social mandate to ensure the safe and effective drug therapy of the individual patient."* (Hepler and Strand, 1990 p.533)

Their work underpinned the importance of the shift in pharmacy practice from a product focus to a patient focus. In the US and UK, this model of "pharmaceutical care" subsequently became a central concept for the development of the pharmacy profession (Wiedenmayer, 2006). In the UK, the bid to move pharmacists away from more traditional technical functions towards a new healthcare focused paradigm have manifested under many names, not just "pharmaceutical care" but also "medicines management", "role extension", "medicines optimisation", "public health pharmacy" and "advanced practice". These terms highlight the change to the role of the pharmacist, moving towards supporting patients in ways that enhance health outcomes.

Over the years, there has been significant debate regarding the direction of travel that the evolving pharmacy profession should take. For example, Harding and Taylor (1997) strongly argued that pharmacists should consolidate their knowledge to concentrate on medicines as the "social object of pharmacists' activities", and risked de-professionalisation if medicines were no longer the "focal point" of the profession (p.547). In contrast, Edmunds and Calnan (2001) argued that the journey to "re-professionalisation" required embracing more clinical skills and roles. Anderson (2002) offered a further perspective, suggesting that public health promotion should be the foundation of new roles for pharmacists. This dispute over the most appropriate direction for the profession highlights the lack of clarity over the pharmacist's role, which may be reflected at a practice level for community pharmacists.

At this time, a plethora of reports from the UK government and other agencies highlighted the need for pharmacy to embrace change, starting with *The NHS Plan: A plan for investment. A plan for reform* which set the vision for the NHS in the 21st century (DoH 2000a). They announced a challenging programme of reforms for the NHS, that included staff across the NHS having a "greater opportunity to extend their roles" (p.6). Leveraging this for pharmacy, the subsequent, *Pharmacy in the Future: implementing the NHS Plan* (DoH 2000b) published later the same year, set

out the government's plans to make the most of community pharmacy, by acknowledging that:

> *"Pharmacists are highly qualified professionals, whose skills the NHS has been under-utilising for too long"* (DoH, 2000b, p.9).

Community pharmacists' "under-utilised" expertise became a theme that endured across subsequent NHS and pharmacy policies. For example, in 2001 the Audit Commission published *A Spoonful of Sugar*, which argued the perception of community pharmacy needed to change, so that community pharmacy services could be considered a "*core clinical function not a technical support service*" (p. 44). In 2003 *A Vision for Pharmacy in the New NHS* (DoH, 2003) similarly stated that *"Pharmacists are probably the biggest untapped resource for health improvement"* (DoH, 2003, p. 7) and that the *"value of their role within the NHS cannot be overestimated"* (DoH, 2003, p. 23). This document set out a more specific vision for the pharmacists' role in public health, including promoting public health initiatives, tackling health inequalities and supporting patients with self-care. The following year the Government set out their plans to tackle public health issues of obesity, mental health, smoking and alcohol in the 2004 White paper, *Choosing Health: Making healthy choices easier* (DoH, 2004). However, disappointingly for the pharmacy profession, community pharmacists were largely absent from this document and their role in tackling this agenda was not made clear.

In 2005, the Pharmaceutical Services Negotiating Committee (PSNC) launched a new national contractual framework (PSNC, 2004) that sought to accelerate the changing role of the profession, with the provision of reimbursement for the delivery of services within community pharmacy. This contract attempted to create a remuneration model that would rely less on prescription volume. For the first time, pharmacists would be paid for delivering patient-centred services in addition to dispensing. An important introduction in the new framework were the nationally "advanced" services, the first of which was the Medicines Use Review (MUR). This was seen as a pivotal opportunity for pharmacy to redefine its professional status (Cipolle et al., 2012). Not everyone agreed with the direction of travel for the profession, with critics highlighting a focusing on "microlevel activities such as health promotion, medicines management and prescribing advice, rather than on wider public health issues such as health inequalities" (Anderson, 2007 p.844). Nevertheless, the profession widely adopted the MUR service, although individual pharmacists and pharmacies had differing views on the value of this initiative, and a significant number of pharmacists did not fully embrace the implementation of this

service in practice (Blenkinsopp et al., 2007). Overall, the MUR service had a turbulent time, prompting mixed reviews from the profession and the literature, with critics highlighting a prioritisation of profit over patients, an undermining of the quality of service, and limited evidence of improved patient outcomes (Blenkinsopp et al., 2007; Latif, 2018; McDonald et al., 2010; Latif and Boardman, 2008). During the same time period, prescription volumes were rising (The NHS Information Centre, 2011) and therefore, despite this significant policy revision and funding restructure, dispensing workload pressures meant community pharmacists continued to focus their attention on medicines supply (Lea et al., 2012; Hassell et al., 2011). The MUR service was subsequently withdrawn in 2021 as part of the revised CPCF (PSNC, 2019).

Also worthy of note, at this time legislation was introduced that allowed pharmacists to become independent prescribers (DoH 2005). Previously, pharmacists were only able to prescribe as part of a supplementary partnership with a doctor. This change intended to create paths of opportunity for pharmacists to further their practice and embrace new prescribing roles. In reality, uptake of prescribing qualifications in community pharmacy have been low, and a General Pharmaceutical Council survey in 2019 identified this was predominantly due to a perceived lack of opportunity to utilise this skill in practice (GPhC, 2019).

In 2008, a White Paper (DoH 2008) proposed landmark new roles for pharmacy to move fully beyond dispensing and supply, toward delivery of extended services to patients. At the same time, Responsible Pharmacist regulations were introduced to allow certain activities, such as supplying General Sales List medicines, to be conducted without the pharmacist's direct supervision. This was intended to free up pharmacist's time to engage in more patient-facing services. The RPS consolidated this move toward patient services by arguing for pharmacists to provide more direct patient care, and become integral to the management of long-term conditions and the triage of common urgent care complaints (Smith et al., 2013). The same report set a wide-reaching agenda that argued:

> *"Pharmacists have the capacity to take on this broader role, and in particular in relation to the care of people with long-term conditions, the management of medicines for people taking multiple drugs, the provision of advice for minor ailments, and the delivery of public health services such as weight management, sexual health, and smoking cessation"* (p.19).

Further publications from the Department of Health, General Pharmaceutical Council and Royal Pharmaceutical Society (General Pharmaceutical Council, 2015; Department of Health, 2014; RPS/GPhC, 2014) solidified the extension of the

community pharmacists' role primarily to relieve pressures on the healthcare service. Policy at this time was responding to challenges across the health system: an aging population, people with multiple morbidities and multiple medicines. This created unprecedented pressure across all primary care services as demand grew. In particular, general practice was struggling to manage the demand for healthcare in the community (NHS England, 2016). Between 2006 and 2008, consultations by general practitioners (GPs) grew by approximately 11%. During this time, funding to the NHS and particularly to general practice declined. In the face of these challenges, the Royal College of General Practitioners (RCGP) indicated that: "There remains a significant unexploited potential for pharmaceutical care provided in community settings to alleviate GP workloads and improve health outcomes and service user satisfaction" (Gerada and Riley, 2012).

More recently, in January 2019, the *NHS Long Term Plan* set the vision for a future NHS that would respond to the current challenges in healthcare (NHS England, 2019b). It set out a vision for a "world-class healthcare service" aiming to give people the best start in life and support them to age well (p.2). Notably, this document mentions pharmacists or pharmacy a total of 40 times. The most attention paid to pharmacy in a core NHS document. In response to this, a new community pharmacy contract framework came into effect later that year in October 2019. This new framework sets the direction for community pharmacy as an increasingly clinically focused profession, with less emphasis on dispensing and more on providing direct support for patients (PSNC, 2019b). It remains to be seen whether this contract can finally instigate widespread change for the profession. An overview of key NHS policy and pharmacy-specific policy over the past 20 years is outlined in table 2.2.

Table 2.2: Recent key policy documents for community pharmacy

Year	NHS policy	Pharmacy-Specific Policy
2000	The NHS Plan: A plan for investment. A plan for reform.	Pharmacy in the Future: implementing the NHS Plan. A programme for pharmacy in the NHS
2002	Delivering the NHS Plan. Next steps on Investment, Next steps on reform.	Pharmacy Workforce in the New NHS: Making the best use of staff to deliver the NHS Pharmacy Programme
2003	Building On the Best: Choice, responsiveness and equity in the NHS Tackling Health Inequalities: A Programme for Action Tacking Health Inequalities	A Vision for Pharmacy in the new NHS
2004	The NHS Improvement Plan: Putting people at the heart of public services;	

	National Standards, Local Action: Health and Social Care Standards and Planning Framework 2205/06 – 2007/08	
2005	Self Care – A Real Choice. Self Care Support – A Practical Option Supporting People with Long Term Conditions. An NHS and Social Care Model to support local innovation and integration	New Pharmacy Contractual Framework; Choosing health through pharmacy. A programme for pharmaceutical public health 2005-2015; Making the best use of the pharmacy workforce: Consultation outcome
2006	Supporting people with long term conditions to self care. A guide to developing local strategies and good practice	WHO and FIP endorse pharmaceutical care; Our Health Our Care Our Say; Implementing care closer to home – providing convenient quality care for patients: A national framework for Pharmacists with Special Interests
2007	Our Health, Our Care, Our Say: a new direction for community services	APPG Inquiry into Future of Pharmacy; RPSGB commissions Clarke Inquiry;
2008		Pharmacy in England: building on strengths delivering the future; First PwSI accredited
2009	QIPP Agenda	Responsible pharmacists legislation implemented
2010	Equity and Excellence: Liberating the NHS	Pharmacy Order; GPhC begins taking responsibility for regulation of pharmacists
2012	Health and Social Care Act Caring for our future: reforming care and support	
2013		Now or Never: Shaping Pharmacy for the Future
2014	NHS Five Year Forward View	
2015		
2016	New care models: Vanguards-developing a blueprint for the future of NHS and care services	Community Pharmacy Clinical Services Review Community Pharmacy Contractual Framework for 2016-18
2017	Next Steps On the NHS Five Year Forward View	Pharmacy: A Way Forward for Public Health
2019	The NHS Long Term Plan	The Community Pharmacy Contractual Framework for 2019/20 to 2023/24 supporting delivery for the NHS Long Term Plan Advanced Service Specification NHS community Pharmacy Consultation Service
2020		The Future of Pharmacy in a Sustainable NHS: Key principles for transformation and growth
2021	Integration and Innovation: working together to improve health and social care for all	

2.3 Progress in Changing Pharmacy Practice

The narrative presented in this chapter illustrates how, since the turn of the 21st century, policy, funding and professional bodies have placed emphasis on the

changing role of community pharmacists. Over the last 20 years, reports and research has suggested that pharmacy change is being implemented slowly and inconsistently in the UK and beyond. This has meant that a universal shift to roles beyond medicines dispensing has not been fully realised (Al Hamarneh et al., 2015; Yamada et al., 2005; Noble et al., 2014; De Oliveira and Shoemaker, 2006; Smith et al., 2014). Twenty years after his original influential work that presented a vision for the future of community pharmacy in pharmaceutical care, Hepler (2010) voiced his disappointment in the lack of progress toward this vision:

> *"Our biggest dream is to become a fully clinical profession… I dream that providing pharmaceutical care will become the central function, purpose, and responsibility of our entire profession… Universal clinical pharmacy is surely pharmacy's dream deferred"* (p. 1319)

Today, community pharmacy practice in the UK is characterised by variation between individual pharmacies and pharmacists on many levels, including the degree to which practice change has been enacted. Evidence has grown in recent years that supports the contribution of community pharmacists to a wide range of patient care agendas, including preventing hospitalisation, and providing care to patients with chronic diseases, and public health interventions (Ingram et al., 2018; Wright et al., 2014; Twigg et al., 2015). This has resulted in some pharmacists successfully implementing advanced practice, undertaking roles such as prescribing, physical examination and management of urgent care patients. However, the pace and extent of change varies greatly between pharmacies and pharmacists, with the majority continuing to focus on medicines supply and related activities (Hassell et al., 2011). In the UK, the policy head for the Pharmacist Defence Association (PDA), reported that a "lack of overarching vision and direction" had limited this good practice to isolated pockets, but still a universal and sustained uptake of extended roles has not been realised (Robinson, 2017 p.1). This variability has created a "growing schism within the profession" (Rosenthal et al., 2010 p.40).

Concern regarding a lack of progress toward a new role prompted a number of inquiries into the profession in the UK. In 2007, the All Party Pharmacy Group (APPG) launched an inquiry that concluded "…across the country, community pharmacy is not being utilised as effectively as it could be as a primary care resource" (p.4). Seven years later, the Nuffield Trust subsequently undertook an independent review of community pharmacy and concluded that there had been "disappointingly little progress over the last year in shifting the balance away from the dispensing and supply of medicines" toward a more expansive role that

included the provision of direct patient-centred services (Smith et al., 2014 p.2). Empirical work at the time reflected this, with a work-sampling study of community pharmacies in London finding that pharmacists spent 40 per cent of their time on prescription-related matters, including assembling and labelling products, and only 3 per cent on patient services such as MURs (Davies et al., 2014). The authors concluded that the majority of pharmacists' time continues to be spent on technical aspects of dispensing as opposed to cognitive tasks. Two years later, a review by the King's Fund determined that despite changes to policy, community pharmacy services were underdeveloped and the general public were not benefiting fully from the skills that community pharmacists possess (Murray, 2016). The same review argued that pharmacy had not grasped the opportunities presented to it and as a result found itself as "an outsider" within community healthcare provision (p.11). Although not explicit, this report inferred that pharmacists themselves were responsible for not maximizing the opportunities presented to enact change. This was preventing the profession from realising its full potential (Blenkinsopp et al., 2007; Bond et al., 2008).

This is surprising, as evidence has found pharmacists in traditional roles remain dissatisfied with their professional environment, lack of career progression, and under-utilisation of knowledge and skills (Hassell et al., 2011; Lea et al., 2012; Mak et al., 2013; McCann et al., 2009). In particular, time spent on dispensing duties was found to negatively correlate to job satisfaction, and community pharmacists reported lower satisfaction levels than pharmacists working in other sectors (Liu and White, 2011; Seston et al., 2009). In contrast, pharmacists in extended roles report high levels of job satisfaction (Joyner et al., 2009; Lapane and Hughes, 2006; Lapane and Hughes, 2004). A further challenge for community pharmacy is presented by new patient-focused roles that have been created in general practice in recent years. Dissatisfied community pharmacists have identified these roles as an opportunity to develop their practice and more effectively utilise their clinical knowledge and skills (Savickas et al., 2020). This has resulted in concerns of an impending pharmacist shortage within community pharmacy (Burns, 2021).

2.4 Summary

The narrative presented here illustrates how successive policy has sought to direct the way that community pharmacists have attempted to "re-professionalise". This has not been a clear, well-articulated or linear path for community pharmacy. NHS England and the profession have issued a significant number of documents that

attempt to embrace a new professional paradigm, but arguably have failed to direct the profession down a single path.

From this section, it is evident that over the course of the past 20 years, community pharmacy has faced contract changes, the introduction of new services, discontinuation of services, and an ongoing demand for pharmacy professionals to be doing more in their role to meet healthcare demands. Policy literature is often ambiguous, verbose and challenging to navigate. So whilst these policies and regulations are directed at the community pharmacy profession as a whole, the diverse practice contexts of community pharmacists make it challenging to understand how policy is understood and enacted at a local level. This study intends to explore this by examining community pharmacist's individual experience of change in the context of practice. The following chapter will outline literature on community pharmacy practice change.

Chapter 3: Review of the Literature

3.1 Introduction

The previous chapter set the scene for change within community pharmacy by presenting a relevant history of the profession outlining key changes in policy and practice in recent years. This chapter aims to critically review relevant literature surrounding the area of practice change for community pharmacy. Rather than presenting a broad overview of the literature, the intent here is to “draw upon the literature selectively and appropriately as needed in the telling of [this] story” (Wolcott, 1990 p.17). This chapter will present evidence of the challenges community pharmacist’s face when enacting change, which serves as a critical driver for this research. I review what is currently known about community pharmacist’s experience of practice change and highlight the areas that need further scrutiny. This identifies the gap in the literature addressed by this study. Finally, I look outside the profession to the wider sociocultural literature and provide a rationale for the application of the Planes of Analysis framework (Rogoff, 1995) to explore practice change.

3.1.1 The Purpose of a Literature Review: Inductive Research

Before reviewing the literature, it is helpful to confirm the intent of a literature review in an inductive study such as this one. There has been significant debate regarding the place of an in-depth literature review in inductive research (Holloway & Wheeler, 2010). Researchers have proposed that in qualitative research, and particularly in phenomenological studies, conducting an extensive literature review may lead to unhelpful preconceptions about the phenomena under investigation (Todres and Holloway, 2004). These preconceived ideas may create bias, as researchers look to confirm existing findings in the literature through their own study (Smith et al., 2009). In contrast, other scholars have argued for the importance of a literature review in identifying gaps in knowledge and illustrating the contribution a study will make to the existing literature (Holloway, 2013).

In an attempt to manage this friction, I conducted the literature review in two phases. I conducted a preliminary review of the literature (Polit and Beck, 2004) at the outset of the study to establish the background and identify theories to shape the conceptualisation of this research. The second phase was completed after data collection and analysis, in keeping with the reflexive approach of phenomenology (Shaw, 2010; Finlay, 2008). This approach conferred an openness to new ideas. As

a result, the initial theoretical and conceptual frameworks I considered relevant to this study at the outset, became less relevant as the process of data collection and data analysis revealed new insights into how community pharmacists experience change. To provide a sense of this journey, the second part of this literature review will highlight theories of relevance to this study that were considered and dismissed, and presents the framework that was subsequently recognised as valuable in exploring community pharmacy practice change from a sociocultural perspective. Presenting theories of past and present relevance highlights the evolving nature of this study and it is hoped, will allow the reader insight into the research process.

The literature review presented here is intended primarily to outline what is currently known about community pharmacy change and, where relevant, situate this literature within the wider organisational change literature. This intends to highlight where gaps exist that this study looked to explore. This section starts by attempting to define practice change for community pharmacy.

3.1.2 Defining Practice Change

Whilst research into practice change is constantly expanding, defining practice change for community pharmacy is challenging, as there is currently no broadly agreed definition in the literature. “Change” has several synonyms: alter, adapt, transform, modify, convert. These words create the impression of movement and a shift from one way of being to another.

Evolving over time, the organisational change literature has taken on the challenging task of creating a common language that creates a shared understanding of change (Cady and Hardalupas, 1999). These efforts have been helpful in cognitive understandings of change and creating categories of change and change processes. As a result of this work, change in organisations is generally understood in the following terms:

- incremental or transformative (Nadler, 1999)
- first-order or second order (Bartunek and Moch, 1987)
- episodic or continuous (Weick and Quinn, 1999).

First-order change or incremental change, refers to progressive, minor changes that occur in response to predominantly predictable events. The impact of these changes does not affect the function, structure or culture of a system. In contrast, second-order change aims to be transformational, and reframes structures, resources, rules, relationships and culture. These categories of change are not

binary, and other authors have created scales that provide a finer level of detail. For example, Reger and colleagues (1994) use the term “mid-range” to describe change that is more significant than incremental but not as significant as transformational.

Since change can take many forms (Corrigan and Boyle, 2003; Weick and Quinn, 1999) it is helpful to consider the specific characteristics of practice change for community pharmacy. These change efforts may include continuing professional development, developing and implementing services, using new tools, or employing new measures or care models. The community pharmacy literature primarily focuses on change in relation to implementing a new interventions, services, programmes, and practices. These changes are largely intended to directly or indirectly improve patient care through community pharmacy. Overall, there seems to be a broad understanding that this change in the profession is a “shift in focus to the patient who is taking the medication and away from the distributive aspects of preparing and delivering the medication” (De Oliveira and Shoemaker, 2006 p.56) thereby “extend[ing] the pharmacists’ role beyond dispensing and information-giving” (Latif et al., 2019 p.3) and toward the “human dimensions” (Talley, 1996 p. 517) of “patient-centred service delivery” (Roberts et al., 2008 p.861). Therefore, this study considered practice change to involve a shift away from the technical role of dispensing and toward more cognitive, patient-centred role for community pharmacists.

What is unclear, is whether community pharmacy is undergoing a first-order or second-order change. In 1999, Morgall & Almarsdóttir argued that pharmacy would need to undergo a significant shift to “an entirely different paradigm: one that emphasizes a disease- and patient-oriented approach to pharmaceutical decision-making” (p. 1258). Whilst the profession itself continues to undergo practice change, it is unclear whether community pharmacists experience practice change as a seismic shift in their practice, or whether their day to day is experienced as more first-order - more progressive and planned than seismic. Transformational change involves greater perceived risks than incremental changes (Ahuja and Morris Lampert, 2001; Voss et al., 2008) and thus may more significantly influence the perception and experience of change.

Change can also be conceptualised by the instigator of the change. The literature traditionally proposes two primary categories that stem from whether internal or external factors are the impetus for change. Nadler and Tushman (1999) refer to

the former as “anticipatory change” and the latter “reactive change”. These categories differentiate between movement that stems from internal drivers and those that result from a need to adapt to or respond to changes driven by external environments or pressures. Based on these drivers, organisational research differentiates between individuals who generate change (“change agents”) and those who implement change (“change recipients”) (DeLeon and DeLeon, 2002; Matland, 1995). The change experience, and the support required to enact change, differs depending on the positionality of the individual in the change process (Oreg et al., 2011).

The following sections explore evidence relating to practice change, looking at the individual as part of this shifting landscape and cultural perspectives to exploring practice change. Concluding with framing the experience of practice change, which explores the theoretical model used in this study.

3.2 Evidence Relating to Practice Change in Community Pharmacy

This review will illustrate an emphasis in the literature on a single approach to understanding practice change, with an focus on resources and structural factors that influence the change process. It is possible that shifting the emphasis onto individual factors oversimplifies the complexity of change and creates a blame culture towards community pharmacists. It is also possible that a lack of integrated understanding of practice change gives way to quick fixes and one-size-fits-all approaches that do not consider the root cause of issues and are, therefore, not meeting the needs of the individual who is attempting to enact change. Researchers in community pharmacy have long identified the importance of adequate and appropriate resourcing to support change in practice (Jambulingam and Doucette, 1999; Doucette and Koch, 2000; Doucette et al., 2012) with an emphasis on the inadequate resourcing for the change process including: lack of time, lack of funding, lack of staffing, lack of support (Doucette and Koch, 2000; Roberts et al., 2010; Hopp et al., 2005; Doucette et al., 2012). These tangible factors, referred to by Lake and colleagues (2020) as “functional enablers” are often reported to be “lacking” in practice. If the challenge for pharmacy is a lack of resources, it is implied that adding these lacking items into the system will drive change. However, evidence suggests that this is not the case. For example, studies into MUR services found that despite remuneration for delivery, uptake was inconsistent (Bradley et al., 2008b). Whilst funding is critical to maintain a business model, evidence suggests that resources alone are not enough to drive change.

This indicates a need to move beyond “functional enablers” to consider whether the socio-cultural context in which pharmacist work is a critical factor in the change process.

3.3 Individual Perspectives in the Change Process

This section will consider the literature that centralises the community pharmacists themselves in the change process. This research mostly takes a psychological perspective in attempting to explore: attitudes toward change (Edmunds and Calnan, 2001; Luetsch, 2017; Bryant et al., 2017; Scott et al., 2007), personality traits and personal characteristics of community pharmacists (Rosenthal et al., 2015a; Rosenthal et al., 2016a; Rosenthal et al., 2016b; Van Rensburg et al., 2003), and, to a lesser extent, professional identity (Elvey et al., 2013).

3.3.1 Attitudes Towards Practice Change

Attitudes toward change is a commonly explored theme in the community pharmacy literature. Research in the broader context of organisational change indicates that attitudes and reactions towards change are critical to the successful implementation of new initiatives (Wanberg and Banas, 2000; Oreg, 2006; Maurer, 1996; Lines, 2005; Piderit, 2000). As Lines (2005) describes: “Attitude toward an organisational change is defined as a person’s overall evaluation of the change” (p.10). It is therefore a psychological evaluation of the positive and negative aspects of the proposed change (Eagly and Chaiken, 1998), determined by multiple factors including compatibility with one’s values, beliefs, emotional reactions, social interactions and role in the change process (Armenakis et al., 1993; Lines, 2005). As a result, responses to change can range from strongly positive attitudes to strongly negative attitudes (Piderit, 2000) and, unsurprisingly, negative perceptions of change can result in unwanted outcomes, such as resistance (Bordia et al., 2004; DiFonzo and Bordia, 1998). Understanding this link between attitudes and outcomes of change explains why community pharmacy researchers have been interested in exploring this field.

Several authors have explored community pharmacists’ attitudes toward practice change in Australia (Hermansyah et al., 2017), New Zealand (Bryant et al., 2009), and in Canada (Gregory et al., 2018). Within the UK, authors have consistently reported positive attitudes toward advanced roles (Edmunds and Calnan, 2001; Scott et al., 2007). Edmunds & Calnan (2001) conducted one of the most widely cited studies exploring attitudes to change in the UK. Researchers used a

purposive sampling strategy to recruit pharmacists working for independent pharmacies and multiple contractors, in rural and urban locations, and offering either repeat dispensing or medicines adherence schemes. Findings from semi-structured interviews suggested that pharmacists were enthusiastic and committed to providing more advanced pharmacy services to shift them away from being "over-qualified distributors of medicines" (p.948). A later study explored community pharmacists' attitudes specifically towards the MUR service (Latif and Boardman, 2008), which, as described in Chapter Two, was intended to catalyse a significant shift in the role of community pharmacists. Similarly, they found positive attitudes towards this change, with 86% of 167 surveyed pharmacists agreeing that the MUR services made better use of pharmacy skills. However, this study exemplified how attitude is not always correlated with action, as, despite positive attitudes, the surveyed pharmacists had performed low numbers of MURs and cited logistical hurdles, including lack of time and lack of staff as primary barriers. It is also possible that social desirability bias (Paulhus, 1984), that is, a desire to be seen as advocating for change and for the profession, may have impacted pharmacists' responses, and may account for the disconnect between reported attitudes and implementation of change.

Outside the UK, less positive attitudes have been reported towards clinically focused services. Empirical work in New Zealand found that community pharmacists were apathetic and lacked motivation to take on enhanced roles (Scahill et al., 2009b) and were less supportive of advanced services such as clinical drug monitoring and prescribing (Bryant et al., 2009). In Australia, research indicated that pharmacists felt tied to the dispensing role and were reluctant to transfer this responsibility to non-pharmacists (Mak et al., 2012). These conflicting attitudes could be attributed to differences in practice context between the UK and other settings. Alternatively, it could reflect a positive attitude towards roles that are more aligned with traditional roles of community pharmacists, such as providing medicines advice, and conversely, a level of discomfort with roles that require more patient contact and clinical responsibility, such as clinical examination and prescribing. Indeed, it has been suggested that pharmacists have a fear of new responsibilities, as Rosenthal and colleagues (2010) argue that "pharmacist's own psyche" (p.37) is the most fundamental barrier to practice change. They propose that pharmacists are afraid of taking on new roles, and intentionally "fly under the radar" within healthcare to avoid this perceived burden (Rosenthal et al., 2010 p.38). Authors suggest this arises from a lack of self-confidence (Bradley et al., 2006), evidenced by a tendency to underrate their own performance and report that

they are “inadequately prepared” for new tasks (Lau et al., 2007). This has resulted in claims that these characteristics stand in the way of pharmacists’ ability to respond effectively to change. It is worth noting that insecurity in the change process is widely reported in studies outside of pharmacy, and fear and uncertainty may not be confined to the community pharmacy experience. As Maurer (1996) states: “Resistance is an inevitable response to any major change. People naturally rush to defend the status quo if they feel their security or status are threatened.” (p. 56). This highlights the role insecurity plays in reactions to change, and perhaps suggests that pharmacists are not outliers when it comes to feeling uncertain and insecure with change.

3.3.2 Personality Traits and Characteristics

The proposal that pharmacists’ inherent characteristics influence change have resulted in personality traits receiving interest in the literature. Personality traits are interesting to explore in relation to practice change, as unlike attitudes, which fluctuate and are influenced by external factors, personality is considered to be a stable construct (Olver and Mooradian, 2003). Therefore, personalities are valuable in explaining and predicting attitudes and behaviours towards change, and could be relevant in the discussions of how pharmacists experience and respond to change. Empirical research into pharmacist personalities almost exclusively uses the ‘Big Five” personality traits framework (Rosenthal et al., 2015a; Rosenthal et al., 2016a; Van Rensburg et al., 2003). This framework uses a validated psychometric instrument to categorise tendency towards five generally accepted dimensions of personality: extraversion, agreeableness, conscientiousness, neuroticism and openness to experience (Barrick and Mount, 1991).

Rosenthal et al. (2016a) conducted a study in Canada to explore the correlation between advanced service provision and community pharmacist personality traits using the Big Five Inventory (BFI) framework. Through a survey method, participants ranked their agreement to statements that represented the BFI personality traits. This was correlated with data on advanced services delivered by participants. The study found that participants with BFI traits of extraversion, agreeableness and openness provided more advanced services. However, less than 50% of pharmacists identified with extraversion or innovation, which aligned with findings from other studies on pharmacist personality traits (Rosenthal et al., 2015a; Hall et al., 2013). From this work we could infer that pharmacist’s frequently have personalities at odds with new service delivery. In particular, a low affiliation

with openness to new experiences may create barriers to practice change. In contrast with these findings, Rosenthal et al (2015b) studied early adopters of prescribing authorisation in Canada, and found BFI traits similar to the general personality profile of pharmacists. The early adopters of change had a similarly low trait of openness when compared with the general population, and as such the authors reported no clear correlation between personality and practice change (Rosenthal et al., 2016). Outside the context of pharmacy, this was confirmed through a meta-analysis exploring the degree of openness with change performance, which similarly found no significant correlation between the two (Huang et al., 2014).

The use of models such as BFI was critiqued in the literature, most sternly from Buchanan (2003), who argues that typologies, such as the BFI, tend to be “post-hoc rationalisations, aprocessual and under-theorised, offering a static portrayal that may not reflect the dynamic reality [of change]” (Buchanan, 2003, p.666). It might appear that reducing the variance of complex socio-cognitive human behaviour to a small number of global factors is too simplistic a model to explain the complexity of change. The empirical findings discussed above, along with other research into personality traits and attributes of pharmacists, indicate that personality is unlikely to create significant barriers to practice change (Luetsch, 2017). As personality traits do not offer an explanation for pharmacist behaviours toward practice change, the experiences of pharmacists in positions of change remain relevant to explore, using methods that are better able to investigate the “dynamic reality” of the change process.

Although not a personality trait, other authors have theorised that pharmacists have a high degree of cautiousness and a dislike of uncertainty (Cordina and McElnay, 2001; Frankel and Austin, 2013; Droege and Assa-Eley, 2005). Frankel & Austin (2013) assert that anecdotal evidence suggests that pharmacists have a lack of confidence in their clinical decision-making skills and fail to take responsibility for patient care. The authors intended to explore why pharmacists lacked confidence in practice. This particular study used an interview method to collect data from pharmacists in Canada across sectors via written response, face-to-face contact or telephone. A clear theme to emerge from that data, by near unanimous response, was that pharmacists felt underprepared to take responsibility for patient care and did not feel their education had adequately prepared them for clinical decision-making in practice. Pharmacists are trained to practice with accuracy, which is emphasised as a key professional attribute of the profession (Harding & Taylor,

2007), with errors in checking prescriptions or dispensing medicines having potentially critical consequences. This emphasis on accuracy may create a rigid, risk averse mindset (Rosenthal et al., 2010) that is at odds with the uncertainty that is inherent in clinical decision-making and as a result pharmacists may struggle with ambiguity (Luetsch, 2017; Rosenthal et al., 2010; Harding and Taylor, 1997). These psychological factors may explain why pharmacists may be reluctant to enact practice change that results in increased responsibility for patient care and clinical decision-making skills.

3.3.3 Professional Identity

The construct of professional identity for community pharmacy has come to the fore in recent years. Although not always investigated in relation to practice change, the findings of studies focused on the identity of community pharmacists have provided a lens through which to consider professional roles and the implications this has for the profession. As pharmacists engage with new roles, they "have had to change identities and learn new ways of being" (De Oliveira and Shoemaker, 2006 p.57). A professional identity at odds with practice change may offer an explanation for the slow and inconsistent movement seen across the community pharmacy profession. How pharmacists conceptualise their role and how they see themselves is complex. Identity is formed through socialisation, which involves:

> *"The acquisition of attitudes and values, of skills and behaviour patterns making up social roles established in social structures"* (Merton, Reader, and Kendal, 1957, p.41).

As a result, professional identity is the social construct of how pharmacists perceive themselves in the context of the profession (Goffman, 1959). In Canada, Rosenthal et al (2011) conducted a cross-sectional qualitative study utilising brief telephone interviews and found that, despite their extended scope of practice, community pharmacists primarily self-identified their role as "dispensers of medication" rather than healthcare professionals. In contrast, a study in Northern Ireland sought to compare role identification in community pharmacists in Northern Ireland and Canada, and found pharmacists in Northern Ireland to be marginally more patient-centred (40%) than product-focused (39%) (Al Hamarneh et al., 2012). This was significantly different from pharmacists in Canada, who reported a product-focus (45%) more frequently than a patient focus (29%). There are many possible explanation for this, given the different context of practice between the two countries. However, in both instances, a product-focused attitude was widely prevalent.

In the UK, Elvey and colleagues (2013) considered pharmacist identity from multiple perspectives, exploring how pharmacists see themselves, how they believe they are seen by others and how they are actually seen by others. Elvey used a grounded-theory methodology, and through focus-group interviews and one-to-one interviews found that pharmacists have a total of nine identities: the medicines maker, the supplier, the scientist, the medicines advisor, the clinical practitioner, the minor medical practitioner, the unremarkable character, the business person and the manager. Having so many professional identities could potentially lead to role confusion and a lack of clear professional direction, which is particularly relevant to practice change. This study found the “scientist” identity to be articulated most strongly by participants. In his work analysing identity, Giddens (1991) argues that identities are grounded in “ontological security” or the cognitive and emotional certainty that enables individuals to develop a sense of “who they are”. This is based in shared values, routines and habits that provide a source of differentiation from others. Waring and Bishop (2011) developed these concepts to propose that identity is also strongly influenced by occupation, which serves as a source of social differentiation. Drawing on Gidden’s work, it is possible that transitions to new roles creates a dilemma for pharmacists’ identities that are anchored to traditional roles and values. Given the direction of change is a shift away from the “scientist” role, and toward a more “clinical practitioner” focus, this could create tension between community pharmacists' existing identities and expectations for change.

3.4 An Organisational Perspective

The second broad theme in the practice change literature takes an organisational perspective on change. In recent years, scholars have recognised the impact of the organisation and context of practice on community pharmacy change. Community pharmacists are situated within complex systems of healthcare and professional organisations that may influence how they experience and enact practice. When speaking about community pharmacy culture, it is crucial to consider it is not a single entity, but representative of a heterogeneous archipelago of interests.

Pharmacy research in this category explores organisational culture (Jacobs et al., 2011; Marques et al., 2018), professional relationships (Hindi et al., 2019a; Bradley et al., 2018) and leadership (Tekian et al., 2014; Tsuyuki, 2019).

3.4.1 Organisational Culture

Organisational culture is a vital concept that can act as a barrier for the provision of new services (Roberts et al., 2010; Scahill et al., 2009a; Tann et al., 1996). Schein's (2006) definition of culture is the most widely cited in healthcare as:

> *"…a pattern of share basic assumptions that was learned by a group as it solves its problems of external adaption and internal integration that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems"* (p.17)

This description highlights the social aspect of culture as a set of values and beliefs that are socially constructed to become *"the way we do things around here"* (Schein, 2006 p.13). Organisational culture in pharmacy has not been comprehensively studied (Jacobs et al., 2011) and its influence on the practice change experience has not been widely considered (Scahill et al., 2009a; Roberts et al., 2008).

Jacobs and colleagues (2011) conducted a narrative review of organisational culture in community pharmacy. Their review highlighted a lack of overall research into pharmacy culture, leading them to examine isolated variables of organisational culture. They found the most widely reported aspect of culture in community pharmacy to be the business vs healthcare orientation of the pharmacy. That is, the commercial nature of community pharmacy organisations creates tension between the professional aspect of the role and the need to generate profit. There is evidence that experiences of practice differ depending on organisation ownership, for example large chain, small chain or independent (Bradley et al., 2008b; Marques et al., 2018; Hann et al., 2017). For example, Hann and colleagues (2017) explored the factors that influenced the volume of services delivered by community pharmacies. They found that the type of organisation was the most important variable driving service volume, rather than local population need. This points to the possibility that in large chains and supermarkets, profit, rather than patient care, may be driving service provision. Further studies have found larger organisations put high levels of pressure on pharmacists to meet targets (Bradley et al., 2008b; McDonald et al., 2010). These organisational factors point to business values and culture that influence community pharmacists' practice.

Doucette and Koch (2000) suggest that practice change in pharmacy involves balancing dual opportunities, which are "to improve the use of medications in our society while at the same time developing new revenue streams for pharmacies"

(p.386). This highlights the need to consider both the professional and financial aspects of practice change initiatives. The remuneration arrangements through the CPCF provide funding streams for patient services, such as NMS, so it is important to note that concerns regarding tensions between these roles are not confined to financial viability, but extend more widely to how pharmacists are seen and how pharmacists see themselves. The literature indicates that pharmacists still widely regard a purpose of their role to be generating profit (Perepelkin and Dobson, 2009), and despite the profession embracing a “patient model” of practice, pharmacists primarily view their interactions with the public as taking places with “customers” rather than “patients” (Austin et al., 2006). The authors argue that the choice of terms used by pharmacists, such as patient, client, customer or consumer, illustrates pharmacists’ perceptions of their roles and responsibilities. This indicates their “ways of thinking and practicing” (Hounsell and Anderson, 2009) may be situated within a business paradigm.

In the research literature, culture may be studied through either an objective or subjective approach. An objective approach accepts that an organisation has a single shared culture that can be “measured”. Community pharmacy research has taken this approach to exploring culture through the development and implementation of tools and instruments that seek to measure cultural orientation (Clark and Mount, 2006; Marques et al., 2018) and identify cultural dimensions that benefit change (Scahill et al., 2011). In the US, Clark and Mount (2006) devised a validated scale, the Pharmacy Service Orientation (PSO), to explore the difference in culture between pharmacy organisations in the US. The tool captured respondents' perceptions of the pharmacy's culture on three scales: ‘Orientation’ (patient vs product), ‘Focus’ (quality vs quantity) and ‘Pharmacist's Work’ (professional vs technical). The higher the score, the more practice is aligned with a pharmaceutical care model rather than a technical model. Results of the survey indicated pharmacy ownership was the most important driver of culture, and independent pharmacies were more likely to have high scores, and large chains were overall lower. Studies into organisational culture often take an objectivist approach, with the majority of studies using survey questionnaires. Through this approach, culture is treated as a variable suggesting it can be measured through a framework, and presumably manipulated (Scahill et al., 2009a). This approach offers a starting point for understanding the differences that exist in culture, but the quantitative methods limit a more nuanced understanding of experience. Furthermore, frameworks assume a directionality, that culture influences performance, and not the other way around.

An alternative approach to exploring culture, is to take a subjective lens to the culture of the organisation, seeking to “describe” rather than “measure” (Scahill et al., 2009a). Muratovic (2013) suggests the first step toward creating a new culture is to explore the current culture within which change is situated. The study above suggests there may be significant variations in the local work-context of the community pharmacist. The diverse and diffuse nature of community pharmacy practice means that the individual context is likely to be nuanced. Bolon and Bolon (1994) argue that:

> *“The monolithic and integrative conceptualisation of organisational culture is not inherently wrong, but presents a rather limited and simplified version of the dynamics and attributes of culture.”* (p.22)

Therefore, even within a single organisation, culture may not be shared by all individuals and different perspectives and experiences of culture may exist. Investigating how community pharmacists experience practice change in the context of their environment is at the centre of this study.

3.4.2 Professional Relationships

Existing research into community pharmacist’s relationships has been mostly focused on associations with other healthcare professionals, with particular interest in the community pharmacist-general practitioner (GP) relationship (Hindi et al., 2019a; Bradley et al., 2018; Hall et al., 2018; Bradley et al., 2008a). With policy recognising the potential of community pharmacy to take on new responsibilities to reduce GP workload (NHS England, 2017), it is vital that collaborative relationships are built to establish seamless care pathways for patients. Pharmacy representative bodies, motivated by a need to ensure that contractual services are successful, have been vocal in calling for greater integration between these professional groups (RPS, 2020). However, despite these calls for more integrated working, it is largely the norm for these professions to work in isolation from one another “both physically and figuratively” (Bradley et al., 2018 p.426). This limited nature of interaction is often cited as a major barrier to the success of new services (Watson et al., 2020). Relationships with GPs have been frequently described as “strained” due to concerns regarding the financial motivation of pharmacy and perceived boundary encroachment (Bradley et al., 2012). Furthermore, GPs are potential “gatekeepers” to patient services in primary care (Willis, 2006), holding significant power in primary healthcare. This makes positive and constructive professional relationships critical for implementation of practice change (Murray, 2016).

Overall, GPs have reacted variably to the expansion of the community pharmacist's role. Lake et al. (2020) explored stakeholder perceptions of community pharmacists and their inclusion within the integrated delivery of healthcare services in Canada. They found that clinicians, decision makers, and pharmacists themselves expressed negative rhetoric towards community pharmacists, including concerns regarding a lack of knowledge and skill, as well as concerns regarding their motivation. The authors suggest that these negative perceptions could be a barrier to forming collaborative relationships with other healthcare professionals. In contrast with these findings, Hindi and colleagues (2019b) used focus groups in the UK to explore stakeholder expectations regarding community pharmacy integration in the primary care pathway. They found GPs considered community pharmacist skills to be under-utilised, were theoretically supportive of pharmacist's involvement in long-term condition management, and appeared willing to collaborate with community pharmacists . At the same time, GPs exhibited some negative attitudes towards pharmacy, indicating they believed pharmacists lacked the drive to take on additional responsibility. Furthermore, the GPs in this study reported having not referred any patients to pharmacy, citing that pharmacists were not promoting their services effectively. This finding was echoed by Latif and colleagues (2018), who explored the implementation of the NMS service and found that GPs were largely unaware of the services offered by pharmacists, leaving the authors to declare that pharmacy NMS services were being undertaken in "therapeutic silos" (Latif et al., 2018 p.1027).

Pharmacists themselves also feel this isolation from the wider multidisciplinary team. A study by Savage and colleagues (Savage et al., 2012) into the implementation of a community pharmacy-based cancer pain service, found that pharmacists described minimal contact with other health professionals, leaving them feeling isolated in practice. Most communication originated within the pharmacy and was related to prescribing or supply related issues, rather than a proactive attempt to build relationships with other healthcare professionals. This lack of interaction and integration is echoed elsewhere in the literature, with communication often initiated by pharmacists, and limited to serious issues (Qazi et al., 2021; Bradley et al., 2018).

Less well researched, is the professional isolation of community pharmacists from one another. In contrast with other sectors of pharmacy, such as hospital pharmacy, community pharmacists often work as independent practitioners and have little opportunity to collaborate with peers in the context of day-to-day practice

(Bradley et al., 2007). This is relevant to practice change, as organisational change theorists propose that social interaction has a key role in the transmission of cultural knowledge (Cole & Wertsh, 1996). In particular, peers play an important role in influencing social development and behaviours through ideas sharing, agreed actions and the development of common meanings (Argyris and Schon, 1978; Huber, 1991). As Gibbs (2013) suggests:

> "there has been increasing recognition of the limits on the extent to which [individuals] can change or improve in effective ways if their colleagues… do not, and on the difficulty of innovation and permanent change where the local culture and values are hostile to such change". (p.4)

This supports the argument that community pharmacists, despite being isolated in practice, gain their cultural perspective from interaction with others which is an important locus in developing ideas and ways of practicing pharmacy.

Critically, relationships may not necessarily promote change initiatives. The education literature proposes the concept of "organisational gravity" (Edström, 2017). This refers to the traits and values within an organisational culture that can "pull back" attempts to change practice. Within community pharmacy in Australia, this concept has been illustrated by the work of Noble et al. (2014), who found that as pharmacy students transitioned to practice, they were met with cultural barriers and an attitude of "that's not what we do" (p. 335). This was echoed in Canada, by Rosenthal et al (2016b) who described the experience of pharmacy graduates quickly losing their desire to take on advanced practice roles as they transition into the workplace culture. They found the practice environment and the expectations of others conflicted with their training, and found they did not have the time, support or energy to provide advanced services. Rather than expending energy on roles that were not supported by the organisation, they reoriented themselves toward other activities. This highlights the importance of social influence on practice behaviours.

3.4.3 Leadership

There is a consensus in the literature that effective leadership is required to navigate the complex issues associated with practice change and expanding pharmacist's scope of practice (Tekian et al., 2014; Osmani, 2013; Tsuyuki, 2019). A number of international authors have pointed to a "leadership crisis" within pharmacy creating a barrier to practice change (Tsuyuki, 2019; White and Enright, 2013; Scahill et al., 2011). In the UK, the NHS notes that "...a lack of leadership and clinical skills are a barrier to pharmacy investment", and despite the investment of a "significant amount of money" into leadership programmes, uptake among

pharmacists is poor (Wickware, 2019 p.1). Lofgren argues that “leadership is a rare quality in our profession, mostly because we learn from other pharmacy managers who were not trained to be leaders either” (Lofgren, 2015 p.1). Therefore, one of the keys to understanding the experience of practice change for the profession is the role of leadership in facilitating such change.

Leadership programs for UK community pharmacists, often assume individual community pharmacist are leaders of the change process, able to create conditions for change and facilitate individual and collective efforts to accomplish shared goals within the context of the organisation (Berson *et al.*, 2006). This influence has been suggested to be both direct and indirect, through leaders’ actions and communication with others, or through creating favourable conditions for implementing supporting activities and structures to facilitate change (Yukl and Lepsinger, 2004). The available research unfortunately offers little guidance on whether leadership programmes improve leadership capacity to enable and promote practice change. As a result, it is unclear whether community pharmacists perceive themselves as change leaders, or whether they look to their organisation or the profession for leadership in change.

The organisational change literature indicates that implementation efforts may fail if the strategy does not gain support and commitment by the majority of employees and middle management. This may be the case if they were not consulted during the development phase (Heracleous, 2000). If leadership is coming from the profession, this could be construed as “top-down” leadership. There is a significant body of literature in other fields, such as education, that highlights the difficulties in employing a top-down, policy-driven approach to change (Trowler et al., 2005). Whilst an authoritative “top down” approach increase chances of initial adoption of change, they make it less likely that change is implemented and becomes routine in practice (Rogers, 2010). Within pharmacy, Atkin (2021) argues that:

> “*Poorly evidenced top-down initiatives continue to be introduced with little involvement of those who deliver and receive them on whether the policy visions proposed for extending pharmacy are practical, desirable or meaningful to them*.” (p. 350)

Instead, authors in other sectors have argued that change should come from “within” an organisation, workgroup or department (Trowler et al., 2005). Spillane, Halverson, and Diamond (2004), refer to this approach as “distributed leadership”. At its core, distributed leadership posits that there should be multiple leaders within an organisation, and these leaders are included in decision-making processes to

deepen engagement. This creates a mechanism to create attitudes and behaviours that align with the needs of the organisation (Spillane et al., 2004). The community pharmacy profession is not an “organisation” as such, and yet the model of having decisions made at the “top” by the government and by the profession and then enacted by community pharmacists themselves within their organisations has parallels with this model. The focus on leadership training for community pharmacy, intends to build a culture of leadership across the profession. It is unclear whether the profession is also building both shared understanding and commitment to change, both of which are critical to changes in performance. The literature has not explored how pharmacists have experienced these changes, nor how the top-down nature of change is interpreted or operationalised by pharmacists at a local level.

3.5 An Integrated Approach to Exploring Practice Change

As discussed in the previous section, research into community pharmacy practice change is often explored through a single lens. Many focus on the individual practitioner, focusing on attitudes or personality types without due consideration of the context in which the individual is situated (Rosenthal et al., 2015a, Luetsch, 2017). Other studies have explored organisational and cultural factors in the process of change, but have failed to explore or explain the relationship between cultural aspects of practice and the individual experience (Feletto et al., 2011; Doucette et al., 2012; Rosenthal and Holmes, 2018). The issues involved in practice change should not be viewed as separate from one another, as individual experience influences, and is influenced by, the context in which the individual is situated.

Studies often explore the impact of change through a focus on service provision, rather than the influence that change has on the experience of community pharmacists in the workplace. In order to understand the support pharmacists need, it is important to consider how they experience change.

Quantitative approaches and frameworks are commonplace in the existing research literature. Attempts to measure culture using tools such as the Pharmacy Service Orientation, compare practice to predetermined factors of what constitutes culture. These approaches may lack nuance and limit the ability to interact with, and understand, the holistic, individual experience of change and the complex interaction between the individual and their environment.

3.6 Framing the Experience of Change

This section outlines the theoretical model which guided the analysis within this study, providing an integrated framework through which to explore community pharmacists' experience of change. Theoretical models are used in a number of ways in the literature, depending on the paradigm of the research. This study set out to be highly inductive in nature and, as such, required a theoretical framework that would focus findings without creating unhelpful boundaries to them. In this case, I was seeking a theoretical framework that was “conceptually appropriate and practically useful” (Aparasu, 2011 p.29).

This study is interested in exploring the lived experiences of community pharmacists in practice change. The focus on individual experience is at the centre of this study, however, experience is driven by a wide range of individual and external factors. The evidence presented and discussed in the previous chapter suggests that personal attributes and cultural factors may be contributing to community pharmacy practice change.

Through engagement with the findings in this study, it became apparent that pharmacists are embedded in complex systems that interact with each other and with the pharmacist themselves. In other words, there is a bi-directional influence between pharmacists and the sociocultural context of work, social interaction, policy and the profession, that contribute to the change experience. To consider the influences of these systems on the pharmacist experience of change, this study utilised an adaption of Rogoff’s Planes of Analysis (1995) to provide a holistic theoretical framework through which to explore practice change. In the context of this inductive study, the theoretical framework was used as a heuristic tool to guide analysis and provide sense-making of the results. To capture both individual experiences, whilst also recognising the context in which this experience is taking place, this study employs a sociocultural framework.

This section provides an overview and justification for the sociocultural focus and the Planes of Analysis framework (Rogoff, 1995) that underpinned the analysis of the findings in this study.

3.7 Sociocultural Theories

A conceptual model was needed that could centre community pharmacists within the wider context of their environment to explore the experience of change.

Sociocultural theory situates human development in the social and cultural world. This means that cognition is “situated” in specific contexts, and developed through engagement in cultural activities. Sociocultural approaches have their roots in the seminal work of Vygotsky (1978), who argued that human development can never be fully understood through a study of the individual in isolation. Indeed, exploring human development through any one lens is not enough to understand the complex and dynamic nature of this phenomenon. The same is true for practice change in community pharmacy - the exploration of which necessitates a comprehensive understanding of practice by conceiving the individual and environment as mutually interactive elements of a single system (Cole, 1985) Scholars have argued that when understanding human experience, context and culture do not remain static, but instead are continuously re-constructed through actions and interactions (Van Oers, 1998). This means that context is not the determinant of individual behaviour, but instead the relationship between the individual and their environment are fluid and influence one another (Abreu, 2000).

A number of sociocultural frameworks were considered for this study, in particular Bronfenbrenner’s Ecological Systems Model (1979) and Rogoff’s three Planes of Analysis (1995).

Bronfenbrenner’s Ecological Systems Model is an approach that was initially considered as a framework through which to explore change in community pharmacy as it considers individuals to be “inherently connected and susceptible to the world around them” (Kelly et al., 2000). Bronfenbrenner’s model was conceptualised to explain human development, by focusing on how individual’s live, behave and grow through interaction with their environment. Embedded in sociocultural theories, Bronfenbrenner took influences from many of the seminal scholars working in this paradigm, including Lewin (1951) and Vygotsky (1978). Bronfenbrenner took sociological theories and conceptualised them in a systematic way. As a result, the model focuses on the bi-directional interaction between an individual, the environment in which they are situated, and “the larger context in which the settings are embedded” (Bronfenbrenner, 1978, p.21). In other words, the qualities of both the individual and their wider environment interact with one another to influence individual development. Bronfenbrenner’s original model situates the individual as nested within multilevel systems that puts the individual at the innermost nested level and expands outward toward larger social systems of influence.

The Ecological Systems Model was initially thought to align well with this study, where the main focus was to investigate change through the lens of the individual and their lived experience of practice change. Other authors have highlighted the limitations of this theoretical framework (Vélez-Agosto et al., 2017), which became apparent through the application to this study. The main challenge in application was that Bronfenbrenner's model situated culture in the "macro" setting, removed from the individual. Within community pharmacy, it was apparent that culture exists at all levels of the system, not just as an overarching construct, but integrated at all levels. As a result, in its application, the Bronfenbrenner model created tensions between the framework and the participant data. This led to a reconsideration of the framework, and the identification of Rogoff's three Planes of Analysis as an alternative approach.

3.7.1 Rogoff's Three Planes of Analysis of Situated Cognition

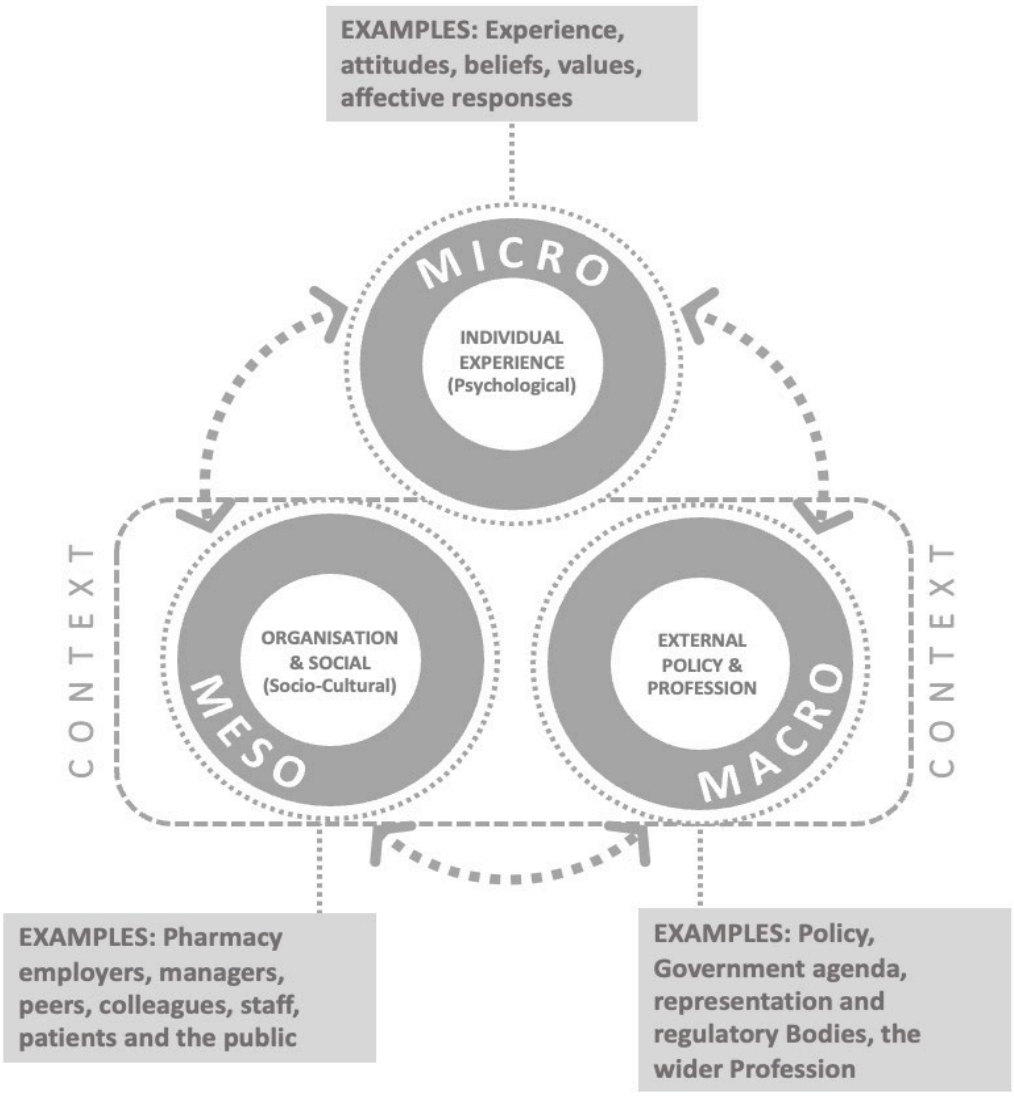
Based on a sociocultural perspective, Rogoff's Planes of Analysis (1995, 2003), based on the construct of "situated cognition", provided a more aligned theoretical framework for this study. Rogoff shares "Vygotsky's interest in the mutuality of the individual and the sociocultural environment" (1995, p.140) by emphasising that personal, interpersonal and cultural aspects of human activity are "mutually constituting" and learning and development take place through an individual's interaction with the real world (Rogoff, 2003, p.50).

Rogoff created "a three-fold analytic distinction between individual, group and community", called Planes of Analysis (1997, p. 267-268). The "individual", or micro level plane focuses on how an individual influences and is influenced by their environment. Rogoff argues for "participatory appropriation", which is how individuals are shaped by their engagement in activity, and this highlights the dynamic processes involved in participation (1995, p.139). The meso level or interpersonal plane focuses on how the individual changes through their involvement with the environment, through direct interaction, joint participation, and observation of others. The goal of the interaction may be explicit, implicit or emerging (Rogoff, 1995). The macro or community plane highlights the wider, cultural context of engagement. These aspects include the setting, structures and arrangements that are valued in the wider community.

When employing the model to explore community pharmacy practice change the micro level focuses on the individual practitioner, and reflects the attitudes, beliefs, values and experiences that are relevant to the experiences of community

pharmacists in enacting change. The meso level is used to refer to interactional settings that have been defined by other authors as the 'broader sociocultural milieu' (Wertsch et al., 1993 p.337). These are the social phenomenon and interaction that occur within the organisational systems in which they work, and the relationships they have within their organisation, including management, peers and patients. Finally, the macro level encompasses overarching systems such as the NHS, regulatory bodies, pharmacy policy and the wider pharmacy profession. See Figure 3.1 for Rogoff's adapted model.

Figure 3.1: Planes of Analysis framework for community pharmacy (adapted from Rogoff, 1995)



Exploring change requires a holistic lens through which to view situated experience of practice change, and Rogoff's Planes of Analysis provides a way to engage with

this complexity. A merit of the framework is that a single plane can be brought into focus, or is “foregrounded” while the others remain in the background. Attention is required at all levels to understand change in the situated context of practice, and importantly, the interaction between these levels and the individual. This study is interested in the micro level, in the context of the practitioner's day-to-day professional lives viewed from the perspective of the individual, but also aims to understand the experience, interaction and reaction to meso level culture and macro level culture that influence individuals experience of change.

This approach to understanding practice change from the perspective of the individual is critical for several reasons. Firstly, the responsibility for change lies with the community pharmacists themselves, they are the “ground level implementers of change” (Lau and LeMahieu, 1997 p.7). How the paradigms of the profession are interpreted, understood and acted upon are unique to each pharmacist. Secondly, significant meso level variations exist in different workplaces and local organisational contexts (Evetts, 2009). This is of particular relevance to community pharmacy, where the individual context of practice can make for different practice change experiences. Finally, whilst there has been much interest in the role of community pharmacists in enacting change, there is little existing research that focuses on how change is actually experienced by community pharmacists themselves at a micro level. Importantly, community pharmacy comprises many organisations, both large and small, and these may not share an organisational culture. However, they may share a professional culture.

3.7.2 Rationale for Planes of Analysis Framework

The reasons for selecting the Planes of Analysis framework for this study were:

1. Scholars have argued that organisational change occurs at three levels: the individual, the group and the organisation, meaning that attention is required at all levels to effectively explore change (Crossan et al., 1995).Planes of Analysis provides a framework through which to explore all three levels. Meaning that this study could delve deeper into the sociocultural influences of context of the pharmacist’s experience of change.
2. It views individual experience through “inseparable, mutually constituting planes” (Rogoff, 1995 p. 139) and provides the construct of “foregrounding and backgrounding”, where by one plane can be brought into focus whilst the others remain at a distance. Meaning in this study that the participant’s

micro level experience can be centralised, but the external influences on this experience are also explored.

3. Sociocultural theories can help to identify the “below the surface” elements that have the potential to advance change (Foster-Fishman, 2007, p.204). Meaning this offers a framework to go beyond the “functional enablers” of practice to consider the sociocultural aspects of change.
4. Sociocultural theorists have advocated for a phenomenological methodology (Bronfenbrenner, 1979), thereby highlighting the appropriate integration of phenomenology and Planes of Analysis in this research.

I have employed Rogoff’s Planes of Analysis here as an informative framework through which to consider the levels of culture that may be influencing change in the context of the practice of individual community pharmacists. The value of this model is in how it highlights different levels in relation to organisational change. This thesis explores practice change focusing on the experiences of community pharmacists and honing in on their experiences at the individual micro level. Their experiences may also reflect elements of culture at the meso level and the macro level. This is significant as pharmacists work as participants within wider organisations within a wider profession, and this approach allows us greater understanding of the broader healthcare environment. Essentially, all of these levels are explored through the micro level lens of the community pharmacists themselves and their lived experience.

3.8 Gaps in the Literature

It is evident that community pharmacy and community pharmacists’ roles continue to change. The desire to move the profession beyond a medicines supply role is ubiquitous in current policy. The external demands for change continues to grow to try to make the best use of pharmacists’ skills and expertise.

As a result, there is a growing body of literature interested in exploring change for community pharmacy, but many of these studies focus on a single factor in the change process, for example community pharmacists’ attitudes, personality types, or relationships with GPs. Therefore, there is an opportunity for a holistic approach that considers not only the individual or the organisation, but the complex interplay between the individual and the wider systems which they influence and are influenced by.

Rather than emphasising the discourse of policy and the profession, this study will centre the subjectivity of experience for the community pharmacists themselves, and attempt to move the discussion beyond change barriers and facilitators. I want to consider what practice change means for community pharmacists, how they are situated within the process of change, and what aspect of practice change engage and disengage individuals from the change process. The hope is to move away from siloed discussions of change factors, to a socio-cultural exploration of the practice change experience.

It is intended that the insights derived from this research and the resulting recommendations will assist thought leaders and educators in better meeting the needs of community pharmacists engaging in the change process. As a result, the overall aim is to contribute to the understanding of how community pharmacists experience practice change, with a focus at the individual level, to facilitate the practice change agenda for community pharmacy. Policy leaders working from the 'top down' can manipulate the macro environment, and the organisation can dictate the meso culture within which individual pharmacists operate. Ultimately, though, implementation relies on the practice habits of the individual pharmacists at the local level. An understanding of this subjective and situated experience is critical.

The significance of this study is that it offers a more in-depth, individualised understanding of the personal interpretations of the practice change experience, situated within the context of practice and viewed through the perspective of the community pharmacist themselves.

3.9 Summary

This chapter has provided an overview of the practice change literature within community pharmacy. It has proposed Rogoff's Planes of Analysis framework as a theoretical framework through which to explore the experience of practice change for community pharmacists. This is an opportunity to explore the integrated individual and contextual factors that underpin community pharmacists' change experience. The next chapter outlines the methodological approach employed in this study.

Chapter 4: Methodology

4.1 Introduction

This chapter addresses the methodological principles informing the design of this study. The purpose of this research was to gain an in-depth understanding of community pharmacists' subjective experience of change. This required the exploration of individual's thoughts, feelings, perceptions, and reflections to provide insight into how community pharmacists make sense of, and understand, their experiences in the situated context of practice. To enable this insight, this study was inductive and exploratory, based upon a subjectivist ontology, interpretivist epistemology, and a qualitative methodology.

The first section introduces the methodological underpinnings, including the epistemological and ontological positions. It then provides an overview of Interpretative Phenomenological Analysis (IPA), the rationale for selecting this approach and the limitations associated with it. The second section focuses on the study methods, and describes the research design in terms of sampling, data collection and analysis. Finally, this chapter concludes with a discussion on quality in qualitative research in the context of other work adopting IPA (Smith et al., 2009; Smith, 2011; Yardley, 2017).

4.2 Ontological Stance

Outlining my ontological and epistemological stance to the research is critical, as it reflects my worldview as a researcher which directly impacts the methodology for this study, which in turn justifies the methods employed (Carter and Little, 2007). Ontology is "the study of being" (Crotty, 2020 p.10) and "raises basic questions about the nature of reality and the nature of the human being in the world" (Lincoln et al, 2011, p. 183). Traditional positivist approaches to research have adopted an objectivist ontological perspective on the nature of reality. This position advocates for a single, objective, independent reality that can be uncovered through the rigorous application of research methodology (Willig, 2013). It believes that reality can exist independent of human consciousness and experience (Levers, 2013).

In contrast, a relativist ontological position assumes that an objective reality does not exist (Guba & Lincoln, 1982). From this perspective, universal "truths" or understandings instead become negotiated truths (Lincoln et al, 2011). Bray et al. (2000) suggest that one cannot take a passive perspective on knowledge, but must

instead take an active role in constructing meanings. As a result, the research intent from a relativist ontology is to explore the subjective experience of reality and uncover multiple possible truths. The purpose of this study was not to produce an objective or “true” account of community pharmacists’ experiences of change. People are embedded in the context of the world around them, and therefore participants will be interpreting the world from their perspective (Giorgi, 1997) As a result, the same phenomena may be understood in different ways depending on the individual’s unique perspective (Madill et al., 2000). In this study, the intention was to gain an understanding of individual experiences, along with the meanings and interpretation of practice change from this relative and subjective perspective (Willig, 2013).

4.3 Epistemological Stance

Epistemology has its roots in philosophy and is concerned with the theory of knowledge and how knowledge is constructed (Willig, 2013). As Crotty asserts, it is “a way of understanding and explaining how I know what I know” (Crotty, 1998, p. 3). Epistemological positions exist along a spectrum, with a realist perspective at one end and a radical constructionist perspective at the other (Madill et al., 2000). A realist perspective suggests that knowledge is pre-existing and the role of the researcher is to uncover this reality through objective investigation. In contrast, a radical constructionist perspective considers knowledge to be a social construct. Between these extremes lies a social constructionist perspective, a position that asserts that social realities are constructed through interaction, that is, from negotiations between individuals and their environments. This study attempted to explore individual perspectives and understandings, whilst recognising these are related to a particular person, in a particular context, at a particular time (Larkin et al., 2006).

As the researcher I must recognise my active role in the research process, as research findings are also dependent on the context in which the data is gathered and analysed (Madill et al., 2000). Social constructionism “emphasises the subjective interrelationship between researcher and participant” (Mills et al., 2006 p.26) and recognises that findings are influenced by the researcher and the researcher is influenced by the participant and the findings (Levers, 2013).

In summary, my ontological and epistemological position recognised there was no single truth, and therefore assumes that the phenomenon can only be understood

from the participant's perspective. Therefore, this study aims to explore the practice change experience for community pharmacists constructed at the micro level.

4.4 An Introduction to Phenomenology

In seeking a methodology that aligned with my epistemological and ontological perspectives, I identified Interpretative Phenomenological Analysis (IPA) as the methodological approach through which to explore the in-depth experiences of community pharmacists. This choice of methodology was driven by a determination to work with a methodology that sought to centre the experience of participants. In determining which phenomenological approach to use, it was important to first consider the "family of phenomenological approaches" (Smith et al. 2009 p.200). Whilst an in-depth review of each approach is not possible here, for the purposes of rationalising the choice of methodology this section will briefly attempt to "position IPA within the general conceptual map of phenomenological research" (Smith et al., 2000, p. 200).

Phenomenology refers to both a philosophical movement and a range of research methods (Finlay, 2008). While philosophers may differ in their conceptualisation of phenomenology, they align in their emphasis on focusing upon the "lived experience". In essence, phenomenology is a philosophical approach to studying human experience and "the way in which things are perceived as they appear to consciousness" (Langdridge, 2007, p.10).

Originally conceptualised by Husserl (1970), the philosophy of phenomenology is concerned with the study of conscious experience and a focus on the way the world appears to people (Langdridge, 2008). Frustrated by the objective focus of empirical science, Husserl argued that it was possible to set aside one's assumptions about everyday occurrences and get closer to the "essence" of human experience. Husserl argued that to fully understand any given phenomena "we must go back to the 'things themselves'" (1900; 70, p.252). He rationalised that we often experience the world through a "natural attitude", taking experiences for granted and perceive them with regard to our pre-existing expectations (Smith et al, 2009). According to Husserl, in order to be able to examine everyday experience it is necessary to step back from the "natural attitude" and he proposed a "phenomenological attitude", which involves employing methodical steps in a process of "phenomenological reduction" (Giorgi, 1997 p.239). Reduction in this context draws on the Latin verb *reducere* and signifies "a 'leading back' or redirection of thought away from its unreflective and unexamined immersion in

experience of the world to the way in which the world manifests itself to us" (Thompson and Zahavi, 2007 p.69).

Husserl argued that getting to the essence of an experience could be achieved by bracketing off or putting aside one's "natural attitude", a process referred to as "epoche" or "phenomenological reduction" (Giorgi, 1997, p.63). Later phenomenologists, most notably Heidegger (1962) and Gadamer (1975), provide critique of Husserl's work. Both scholars doubted it was possible to bracket one's worldview in the manner described by Husserl in order to view experience objectively as we cannot assume a "view from nowhere" (Nagel, 1989 p.70). For these reasons it is argued that people are unable to entirely suspend their prior assumptions (Langdridge, 2007) but can be alerted to them through a reflective and reflexive awareness (Smith et al, 2009). As a result of these critiques, interpretation of experience by the researcher became a more realistic expectation. This gave rise to the hermeneutic or interpretative strand of phenomenology. Heidegger, one of the main proponents of interpretative phenomenology, views the relationship between individuals and the world in which they live as reciprocal in which both exist and can be mutually understood. Therefore, new understandings come from exploring one's subjectivity in relation to a phenomenon of interest. Smith argues that at the heart of the phenomenological project is cognition that is "dynamic, multi-dimensional, affective, embodied, and intricately connected with our engagement with the world." (2009 p.191). This led to IPA as the research methodology for this study.

4.5 Interpretative Phenomenological Analysis (IPA)

IPA is "committed to the examination of how people make sense of their major life experiences" (Smith et al., 2009, p.1), and in doing so adopts an interpretative ontological stance. IPA does not view reality as objective and is therefore situated within the interpretivist paradigm of the ontological continuum. It does not attempt to define, nor seek, truth. At the heart of IPA is a desire to understand the person's own experience and the meaning they make of it. In this, it seeks to examine a topic, as far as is possible, in its own terms. Heidegger (1962) states that "an interpretation is never a presuppositionless apprehending of something presented to us" (pp. 191/192).

IPA was first introduced by Smith (1996) as a reaction to the over-emphasis placed on quantitative approaches in psychological research. Smith (1996) argued that a paradigm shift was needed in order to enhance the depth of knowledge within

psychology. Since its inception, it has broadened its reach and is now situated within a range of domains of inquiry, including healthcare, organisational studies, humanities and education. Across these diverse fields, IPA is committed to understanding phenomena of interest from a first-person perspective and believes in the value of subjective knowledge for psychological understanding (Eatough, 2008).

4.5.1 The Core Tenets of IPA: Phenomenology, Hermeneutics and Ideography

The foundations of IPA are based within philosophy and guided by three theoretical influences: phenomenology, hermeneutics and ideography. IPA draws on these theoretical approaches to inform both the epistemological framework and research methodology (Larkin et al., 2006; Smith, 2004; Shinebourne, 2011). In order to understand the focus and aims of IPA, and its relevance to exploring community pharmacists' experiences in this study, it is important to explore these theoretical approaches.

4.5.2 Phenomenology

Phenomenology is defined as a philosophical approach to the study of experience (Smith et al., 2009). Within IPA, phenomenology is an investigative commitment to "the study of human experience and the way in which things are perceived as they appear to consciousness" (Smith et al., 2009, p.11). To further this idea, Eatough and Smith (2008) argue that the researcher should investigate the lifeworld of the participants, which are unearthed through attention to participant's thoughts, feelings and memories (Noon, 2018). This focus takes IPA beyond the descriptive to create a more interpretative account of experience in the context of the individual. Smith & Osborn (2008) highlight that the focus of IPA is the in-depth exploration of personal experience and how people perceive, ascribe meaning to and make sense of their experiences. It assumes that people are actively engaged in the world and reflecting on their experiences to make sense of them (Smith et al, 2009). Researchers adopting IPA aim to listen intently to their participants so that they may obtain an insider's perspective of the phenomenon under study and attempt to interpret these accounts to understand what it means for those people in that particular context (Larkin et al., 2006).

4.5.3 Hermeneutics

The second major underpinning of IPA research design is derived from hermeneutics, or the "theory of interpretation" (Langdridge, 2007). Dallmayr (2009)

offers a more grounded definition as the “practice or art of interpretation” (p.23). Whilst hermeneutics is a different strand of methodology, it meets with phenomenology through the work of Heidegger. Heidegger (1927/62) coined the term “*dasein*” to describe how our “being-in-the-world” is always in relation to other people; situated and perspectival. As Starks and Trinidad assert:

“The truth of the event, as an abstract entity, is subjective and knowable only through embodied perception; we create meaning through the experience of moving through space and across time” (2007 p.1374)

As a result, IPA’s epistemological stance rests on the person’s subjective account of their experience, meaning that a researcher’s access to this world is “always through interpretation” (Smith et al., 2009, p.23). It is the interpreter’s analysis that unmasks hidden phenomena (Moustakas, 1994). The researcher is therefore responsible for making sense of the meaning the participant has made of their experience, a process referred to as double hermeneutic “whereby the researcher is trying to make sense of the participant trying to make sense of what is happening to them.” (Smith et al, 2009: 3). Here, the double hermeneutic points to how interpretation and understanding involves a synthesis, in this instance, of participants’ sense-making and my subsequent interpretation during the stages of analysis. This concept is central to IPA and results in the co-creation of participant’s meaning-making, where the attempt is to get “as close to the respondents view as possible” (Larkin et al., 2006).

4.5.4 Ideography

The third major influence of IPA is a commitment to ideography. An ideographic approach is concerned with the “particular”. Firstly, it is the understanding of how a phenomena is understood “by a particular person in a particular context” (Smith & Eatough, 2017, p.10), which aligns with my epistemological stance. Smith (2004) has critiqued “nomothetic" research for making unsubstantiated, generalisable claims concerning human behaviour. In contrast to these approaches, IPA has been described as “resolutely ideographic” (Breakwell et al., 2012). This represents a commitment to focusing on the personal perspective and experiences of the individuals (Smith, 2004), and moving to tentatively develop generalised claims. This is further reflected in the approach to analysis, where each individual’s account is central to the research and, as such, requires careful examination of each case individually and the use of a smaller, purposeful sample. The analytical process aims to reach some level of “*gestalt*”, which means “complete”, and must be done

for each participant first before moving onto wider group analysis to search for convergence and divergence across participant accounts (Smith, 2011).

4.5.5 Rationale for an IPA Approach to this Study

IPA focuses on lived experience. This study did not intend to make a predetermined claim regarding group behaviour or experience. Instead, its focus was exploring the experience of change for each individual. The purposive sampling of participants benefited the ideographic process by allowing exploration of similarities and differences and paid attention to the convergence and divergence of experience between participants (Smith et al., 2009 p. 202). As Breakwell and colleagues (2012) assert:

> *"it should be possible to learn something about both the important generic themes in the analysis but also something about the narrative lifeworld of the particular participants who have told their stories"* (p. 443).

This approach benefits from a small homogenous sample where the individual and shared experiences can be highlighted (Smith et al., 2012). In this study a sample of 10 allowed for in-depth analysis, and deep exploration of each case. Including transcript extracts for each individual provided a means of highlighting experiences individual to each participant. This retains a focus on the "particular" experience of practice change for the individuals in my study. The participants in this study were able to offer in-depth insight into their perception of the phenomenon they have experienced.

In terms of positionality, the interpretivist strand of phenomenology resonates best with my approach to this study. Like Heidegger, I do not believe that we are able to fully bracket off our prior knowledge, experience and preconceptions. Indeed, I am connected to the world of pharmacy in ways I am both aware and unaware of. I hold presuppositions that undoubtedly impacted this study on multiple levels, from how I designed the study, the research questions asked, the way I interviewed the participants and, perhaps most importantly, the way I interpreted the data. Bracketing remains an important concept in this study, not to assume "a view from nowhere", but to ensure my findings are grounded in the experience of my participants and not my own suppositions.

These biases may only become evident during the processes of engaging with the text. As a result, Gadamer (1975) notes a cyclical process is required when "bracketing" to ensure the presuppositions that were not apparent at the start of the process are revealed. This approach was essential so as not to impose my pre-

existing understanding of practice change onto the data (Crotty 1996, 1998: Polit & Beck 2004). It was necessary for me to employ a “double hermeneutic” stance at the analysis stage, and during interviewing. At both stages the hermeneutic cycle provided support for interpretation and sense-making.

This double hermeneutic approach has a second meaning in IPA. Conducting IPA research involves navigating between different layers of interpretation to engage deeply with texts of participant’s personal experience (Smith, 2004). Interpretative layers arise out of a dual interpretative engagement: a hermeneutics of empathy or affirmation and a hermeneutics of suspicion (Ricoeur, 1970). For Ricoeur, interpretation is “the work of thought which exists in deciphering the hidden meaning in the apparent meaning, in unfolding the levels of meaning implied in the literal meaning” (Ricoeur, 1974, cited in Kearney, 1994: p. 101). In interviewing participants, I assumed an empathic stance to put myself in the participants’ shoes and gain an inside perspective in order to understand the meaning of experience from a participant’s viewpoint (Smith et al, 2009). This involves engaging with the data and text to best understand the participant themselves (Willig, 2013).

At the same time, an approach driven by suspicion attempts to explore what may be hidden in the participant’s experience (Willig, 2013). Taking this stance, I probed for meaning in ways which participants might have been unable to do themselves. The empathic stance aims to produce rich experiential understandings of the phenomenon under investigation and remain close to the participant’s sense-making. Following Ricoeur involves putting aside what I had previously accepted at face value in order to develop a narrative of possible meanings. This ultimately results in being able to “stand in the shoes" of my participants but also “stand alongside” them to make sense of their experience (Smith et al., 2009, p.80).

The hermeneutic circle is central to IPA and emphasises the interactive relationship between the part and the whole (Smith, 2007). Therefore, the meaning of any part can only be understood in relation to the whole and the meaning of the whole can only be understood in relation to the parts (Smith et al, 2009). This relationship operates on several levels within the text and highlights that interpretation in IPA requires a circular process of engagement with the data (Smith, 2011).

A primary aim of this study was to give voice to the community pharmacists who are seldom centred in discussions of practice change, which are instead largely driven by policy and the profession. The purpose was to make participants visible and disrupt the narrative hierarchies, dominated by top-down discussions of practice

change, and provide an alternative to a dominant discourse. In undertaking this study, I wanted to ensure that the methodology took participants seriously and sought to “listen and understand” (Langdridge, 2008, p. 1126), thereby giving voice to the lived experience of pharmacists who were engaged with change at the practice level. Phenomenology is well situated to provide an understanding of the pressing issues that community pharmacists face in the change process.

4.6 Reflexivity

Reflexivity is a central part of IPA, and this importance warrants an explanation of both the concept and more specifically how a reflexive approach was employed throughout this study. Husserl (1970) has highlighted the importance of engaging in reflective and reflexive thinking whilst exploring experiences of others, as it is crucial to demonstrate integrity and sincerity of the research work (Tracy, 2010). Unlike “reflection”, reflexive research involves both reflection and interpretation of experience (Alvesson, 2003). In other words, reflexivity requires an approach that considers both how something is done and questioning the ways of doing it (Hibbert et al., 2010).

My role as a researcher in this study has not been passive but rather active and reflexive, co-constructing the research through data gathering and analysis. I brought to this study my identity as a pharmacist, educator, and researcher with a research question I was seeking to answer. There have been times when I have recognised my identity becoming entangled with my participants, both in terms of my background as a pharmacist, and in my own personal experiences of change. Griffiths (1998) proposes that “membership” to a community, in this case pharmacy, provides an “insider” researcher with familiarity with practices, values and strategies of the setting that an “outsider” may not understand. Others have argued that an insider perspective provides an opportunity to engage with the data on a deep level (Mercer, 2007). Ybema and colleagues suggest that the boundary between researcher and participants is more complex than insider or outsider, and could be better considered as spaces of mutual influence in which the relationship is critical and data construction is connected to both parties (Ybema et al., 2009). In this study I have aimed to identify and acknowledge factors that may influence my own construction of meaning. I have attempted to recognise where preconceptions have enabled understanding, and where they have created a barrier to the interpretation process as focus should be on allowing the object of concern to show itself, as it is (Smith et al, 2009). I have been sensitive to a range of interpretations and voices in

the data, and willing to critique and question my own interpretation and voice (Mason, 2002).

Engaging in reflexivity involves participating in thoughtful self-awareness (Finlay, 2002) and the ability to "think about thinking" (Haynes, 2012 p.87). It subjects my role in the process "to the same critical scrutiny as the rest of [the] data" (Mason, 2002 p.6). A reflexive approach was undertaken throughout the research process by adopting several strategies:

- Stepping back at each stage, maintaining reflexivity and questioning my biases. This approach has been core to my study methodology.
- Maintaining a research diary and keeping field-notes has allowed me to record and reflect upon biases I recognise.
- Discussing findings and reactions to findings with my supervisors and colleagues has been critical to evolving my thinking and challenging my assumptions about the data.

As previously described, the research question and the theoretical framework were adapted during this study, as my understandings and assumptions shifted throughout the research process. It is widely acknowledged that studying experience is complex and challenging, ultimately my aim throughout this process has been to create an account which is "experience close" and not "experience far" (Smith, 2011 p.10). Acknowledging my active participation contributes to the credibility of this work (Lincoln et al., 2011). The resultant knowledge does not claim to be a perfect or pure translation of experience, rather it is the meaning of experience for these specific community pharmacists at a particular point in time.

4.7 Rationale for the Research Method

As described above, the IPA methodology of this study focuses on experiences of change. It therefore required an approach that drew on participants' personal interpretations of their experiences, yet also sought to discover patterns that would explain their relationship to broader social phenomena. As a result, it required a research method which would be sensitive to my participants' interpretation of the topic and allow them to share their experiences openly and freely. Semi-structured interviews are a recognised method for generating data in qualitative research studies that offers an opportunity to acquire in-depth first person accounts of a participant's experience (Kvale, 2007). Specifically within IPA, interviews facilitate the elicitation of stories, thoughts and feelings about the study phenomenon. As

Smith and Osborn assert, at the heart of IPA is a desire to “analyse in detail how participants perceive and make sense of things which are happening to them” (Smith and Osborn 2007 p.57). As such, one-to-one interviews are often the data-collection instrument of choice in IPA and an overwhelmingly feature of IPA literature (Brocki and Wearden, 2006). There are different types of interview: structured, semi structured or unstructured. Initially I intended to use unstructured interviews, or as Lavrakas (2008 p.151) describes them, “conversational interviews”. These are open-ended with a broad overview of the purpose and focus of the interview, with no pre-established questions (Punch, 2014). These unstructured interviews are becoming increasingly popular in educational research, as they open up the opportunity for extremely rich data.

In the context of this study, the limitation of unstructured interviews was a risk that the conversation would become unfocused, losing the emphasis on the experience of change. An unstructured approach may have resulted in “a day in the life of” rather than data that spoke specifically to the experience of change. In contrast, a structured approach, that does not allow deviation from the interview schedule, would not have afforded the opportunity to engage in full or in-depth discussion and disclosure. The interview approach needed to allow the participants to engage in dialogue, and allow me to follow up and ask probing questions. At the intersection of a structured and unstructured approach are semi-structured interviews. These have the benefits of creating a framework of interview questions in advance to focus the interview discussion, and allow for deviation from the schedule to follow up topics of concern to participants themselves. For these reasons, semi-structured interviews were selected for this study.

4.8 Population and Sampling

This study was specifically interested in exploring the experiences of community pharmacists. Although pharmacy teams can be comprised of pharmacy technicians, ACTs, counter assistants and other staff members, this study focuses only on the pharmacist-level of the profession. Pharmacists were selected as they are often considered to be responsible for enacting change at a local level. I wished to access participants who were currently practicing community pharmacists and likely to be planning or implementing a change in practice. As a result, study participants were recruited from community pharmacist learners from a national pharmacy leadership programme. At the time of recruitment to this study, 150 participants

were completing this programme. This was the population that was approached to participate in the study. A total of 10 participants were recruited.

Purposive sampling was used to identify community pharmacists actively engaged in practice change. The initial rationale for this was to explore self-directed practice change and the practice change experience through individuals who were trying to implement a new initiative in practice. The intent was to gather a sample who shared a similar background and experience, were undertaking practice change and for whom the research question would be meaningful. This would allow the participants to provide an in-depth account of the phenomenon of practice change being explored. The participant sample for this study was therefore purposive and homogenous. Pharmacists had to work at least 20 hours/week in community pharmacy and be qualified for at least 5 years. The purpose of this was to recruit pharmacists who had sufficient experience of community pharmacy practice, both in terms of number of hours worked and length of time qualified. These individuals are more likely to be embedded in community pharmacy practice and therefore best able to answer the research question. Otherwise, there were no other demographic restrictions, enabling a diverse data set to condense the phenomena and highlight "common features of the lived experience" (Starks and Trinidad, 2007 p.1375). In the end, a pragmatic approach was taken to sampling, as "one's sample will in part be defined by who is prepared to be included in it!" (Smith and Osborn, 2007 p.56). Through coincidence, there was heterogeneity across the participants that came forward in terms of gender, type of role (locum, relief, pharmacy manager, superintendent), longevity in role (5 to 30 years), and type of pharmacy in which they worked (large chain, supermarket, small chain, independent). An overview of these participant features can be seen in table 4.1. All participants were assigned a pseudonym to maintain confidentiality.

Table 4.1: Participant Demographics

Participant pseudonym	**Gender**	**Length of time qualified**	**Role**	**Organisational setting**
Ellen	Female	20 years	Store pharmacist	Small chain pharmacy
Luna	Female	9 years (previously qualified overseas)	Locum pharmacist	Independent pharmacy
Sophie	Female	7 years	Store pharmacist	Medium chain pharmacy

Dev	Male	5 years (previously qualified overseas)	Pharmacy manager	Supermarket pharmacy
Kalpna	Female	30 years	Pharmacy manager	Medium chain pharmacy
Bashir	Male	9 years	Relief pharmacist	Large chain pharmacy
Oliver	Male	14 years	Superintendent & pharmacy manager	Independent pharmacy
Michael	Male	10 years	Pharmacy manager	Supermarket pharmacy
Timothy	Male	16 years	Superintendent, owner & pharmacy manager	Independent pharmacy
Zahid	Male	8 years	Pharmacy manager	Large chain pharmacy

In the first instance, participants were accessed through an existing relationship with the organisers of the pharmacy leadership programme. In order to avoid pressuring or coercing participants, the Director of the leadership programme was contacted by email to explain the purpose of the research and to seek access to programme participants. In this context, the Director acted as a gatekeeper to participants. Permission was granted to approach participants through the leadership programme workshop facilitators, who agreed to introduce the study to their cohort of learners and invite participation. I prepared a PowerPoint presentation outlining the main features of the study for facilitators to share in their workshop. Those interested in taking part in the research project were asked to contact me directly and then sent the Participant Information Sheet and Consent Form. If participants were happy to proceed, their offers were accepted in the order in which they were received.

It has been suggested that studies using IPA should aim for a small, homogenous sample of participants (Hefferon and Gil-Rodriguez, 2011), although there is no consensus on this and IPA studies have been published with samples of one, three, nine, fifteen and more (Smith et al., 2009). In recent years there has been a trend towards IPA studies conducted with small numbers of between one to three participants to enable a richer and more sensitive analysis (Smith, 2011). I considered this approach, but was concerned that only including three participants would not allow me to adequately capture the diversity of experiences in community pharmacy. In an attempt to try to balance breadth of experience with depth of analysis, I initially aimed for a sample of 12 participants. This number was selected

for several reasons. Firstly, although this study is underpinned by IPA and a desire to explore the in-depth engagement with the experiences of the individual, it also hoped to capture experiences that spoke to the diversity of the change experience for community pharmacists and the profession. This sample size allowed for detailed examination of similarity and difference, convergence and divergence between cases. Secondly, as my design involved follow-up, there was an expectation that some participants would drop-out between interview one and two. Aiming for 12 participants allowed for attrition between the initial and follow-up interview. A total of 10 participants completed the first interview, and 8 completed a follow-up interview. In retrospect, a smaller sample size would have allowed for a more in-depth analysis of each case. Some level of depth must be compromised to analyse across the breadth of 10 cases and 18 interviews. In hindsight, it is more apparent why Smith (2011) makes a case for a small cohort size.

4.9 Interview Schedule

Producing a schedule for the first interview was an iterative process conducted in conjunction with my supervisors. Initial questions were too explicit, and were reworked to become more open and less leading. The questions were piloted with two community pharmacists - one ex-colleague and one acquaintance of the researcher. This was an incredibly valuable process, allowing reworking of misinterpreted questions and recognising where prompts were needed. It also allowed an opportunity to practise interview technique in a low-stakes environment and gather feedback from participants on interview style. The final interview schedule for interview one consisted of 10 questions, along with several prompts, that were funnelled to ask about general experiences and perceptions of pharmacy change, and then more particularly the plans and experiences for implementing a change specific to the participant's practice. A second follow-up interview was conducted between 9 and 11 months after the first interview. Change is an ongoing phenomenon, and capturing experiences at two time points was intended to provide a sense of the dynamic nature of change. The first interview provided participants with a reference point from which to describe the pace and nature of change between the two time points. The schedule for the second interview was devised after reading each of the transcripts from the first interviews. This allowed questions to be developed taking into account the initial experiences of participants and identifying specific areas for follow up. Example interview schedules are included in Appendix B.

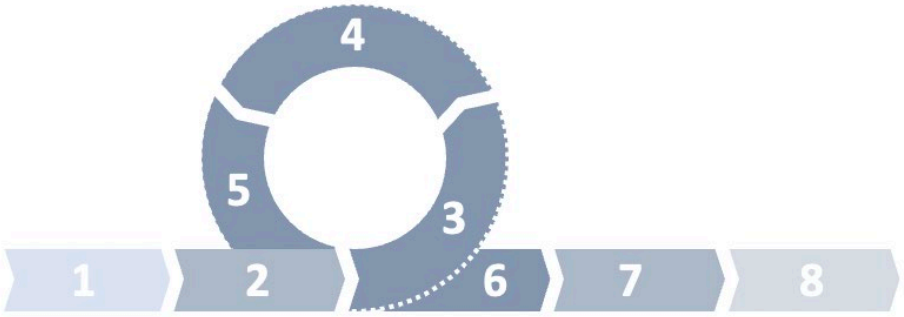
Interviews were conducted via Skype. This platform was used as participants were based at locations across England, so face-to-face meetings were not possible. Skype offers the ability to engage with participants via video. As an interviewer this allows for building rapport with the participant and observation of facial expression and body language, which greatly helps with interpretation of language and meaning. As described in the previous section, reflexivity was critical throughout the interview process (Coghlan and Brannick, 2014).

Interviews lasted between 55 and 86 minutes. Each interview was audio recorded with the participant's permission, using an application on a mobile phone device. Transcription was undertaken by the researcher. Interviews were transcribed verbatim. Basic reproduction of pauses, overlaps, and interpolations were included. Body language was not added to the transcript, as phenomenological studies focus on language use and content of speech (Langdridge, 2007). The process of transcription and repeated listening to the audio recording allowed me to recall the interview, familiarise myself with the transcript, and start the analysis process.

4.10 Data Analysis

As data analysis is a fundamental part of an IPA research project, this was undertaken rigorously and thoroughly. To achieve this, I found it valuable to employ an analysis method that brought structure to the process. The analytical process used was based on the Smith, Flowers and Larkin approach to thematic analysis in IPA (Smith et al., 2009). Although the authors clarify this is not a prescribed approach, they offer a comprehensive framework that outlines the steps and stages of data analysis in IPA. This approach was invaluable in providing a systematic and rigorous approach to a large volume of data. In the absence of guidance from Smith et al. on how to perform epoché (or bracketing), guidance from van Manen (2017) and Langdridge (2008) was followed to perform bracketing at all stages, including between each round of analysis and between each case. The stages of analysis are illustrated below in Figure 4.1.

Figure 4.1: Data analysis process based on Smith et al 2009 (adapted from Charlick, McKellar, Fielder, & Pincombe, 2015)



1 **Read and re-read**
Immersion in the original data (single case)

2 **Initial noting**
Free association, make initial notes to describe content

3 **Develop emergent themes**
Focus on chunks of transcript and analysis of notes to create themes

4 **Search for connections across themes**
Abstract and integrate themes

5 **Move to the next case**
Bracket previous theme to approach new case with an open mind

6 **Look for patterns across cases**
Find patterns of qualities across cases, noting convergence and divergence

7 **Integrate Rogoff's planes of analysis**
Deepen analysis by viewing data through theoretical framework

8 **Develop context charts**
Return analysis participants to ground findings in participant experience

The detailed case-by-case analysis of individual transcripts was a labour-intensive process that was necessary to meet the aim of the study, which was "to say something in detail about the perceptions and understandings of this particular group rather than prematurely make more general claims." (Smith, 2015 p.55). The analysis involved phenomenological reduction as follows. Starting with the first case, the initial approach was a full immersion in the participant's world by reading and rereading each case, frequently with audio accompaniment. Using a simple table in a Word document (table 4.2 below), I used the right-hand column to note anything that came to mind to provide notes and comments on the data. Some of the comments were summarising or paraphrasing the data, some were preliminary interpretations and others were perceptions of links or connections. Any interesting or meaningful use of language was noted, along with comment on language features such as pausing and laughing. The column to the left of this captured descriptive comments and more conceptual comments, intending to engage at a more interrogatory level. By asking questions and reflecting on meaning, the analysis moved away from the original text to provide a level of interpretation of the participant's experience.

Table 4.2: Thematic analysis format example

Emergent theme	Transcript text	Description	Comment
Externally imposed change *Professional identity conflict*	*Then they're talking about, oh, giving flu injections and I'm thinking, "I didn't want to be a nurse. I wanted to be a pharmacist. I don't want to do this [long pause]""*	*Forced into new role* *Associates vaccination with nursing role* *Protecting pharmacist identity (identified later as dispensing focused)* *Rejection of identity shift*	*Who is "they"? – reflective of others controlling practice* *"wanted to be a pharmacist" - reiterated later "it was always pharmacy'* *"I don't want to do this" – is "this" just giving injections? Or does it reflect a rejection of the new roles of practice more widely?*

The next stage was to assign emergent themes to each of the comments, and these were recorded in the left-hand column of the document. Themes were clustered and a superordinate descriptor assigned to capture the essence of the grouped themes. Themes were all considered of equal importance, in line with Langdridge's concept of horizontalisation, which steers researchers away from producing hierarchies of meaning, and instead treats all parts of a participant's experience as equally important (Langdridge 2007).

An ideographic approach was followed, beginning with particular examples and slowly working up to more general categorisation or claims. This description may suggest a linear approach, however, in reality the process was highly iterative, moving between commenting, interpreting and theming, and returning frequently to the transcript to ensure the themes remained firmly grounded in the data. This is critical to constantly check the researcher's understanding of the data with the data itself, so as not to impose external understanding of the experience on to the participant's understanding of the experience.

IPA studies are occasionally critiqued for lack of depth in their interpretation (Smith et al., 2009) so I completed several cycles of analysis to ensure an in-depth interpretative analysis of each individual case. Only once each case had been analysed individually were constituents of the phenomena then pulled together into an overall picture of themes and sub-themes shared across all participants. This

took the form of a summary table in Excel, where themes and subthemes for each participant was listed. Summary tables form a “descriptive matrix” (Miles et al., 2018 p.107), which is valuable to aid comparison between cases.

I frequently returned to the analysis throughout the research journey; both to the coding and the original participant data. As new understandings came to light, categories were refined to most accurately capture themes of interest grounded in participant experience.

At this stage, Rogoff’s Planes of Analysis (1995) framework was employed as a hermeneutic to extend the analysis. This categorised elements of experience that were influenced by the macro level of the profession, the meso level of the organisation, and the micro level of the individual. In doing so, each plane became the “current focus of attention” (Rogoff, 1997 p.269) but remained situated within the holistic experience of the individual. These planes are considered interdependent, and therefore provided an integrated understanding of how macro and meso level factors influenced the individual, micro level, experience of change and vice versa.

Finally, context charts were developed to return the analysis to the individual participant and their experience. A context chart is a visual display of the relevant aspects of data (Miles et al., 2018), intended to “show you the real richness of a person’s life setting” (Miles et al., 2018 p. 163), whilst simultaneously displaying information relevant to the research questions. This final step aimed to ground the general findings in the experiences of the individual, and illustrate the experience through the Planes of Analysis framework. Context charts are presented in Chapter 5, Figures 5.1 – 5.10.

4.11 Strategies for Trustworthiness

The issues of quality and validity are pertinent to all research. As a pharmacist previously working in the positivist paradigm, considering trustworthiness through the lens of qualitative research has been one of my personal challenges in this study. Pratt et al (2020) suggest that trustworthiness in qualitative research is:

> *“the degree to which the reader can assess whether the researchers have been honest in how the research is carried out and reasonable in the conclusions they make”* (p.2).

As a result, authors have suggested numerous means of determining quality and validity within the qualitative paradigm (Guba and Lincoln, 1982; Elliott et al., 1999;

Elliott and Timulak, 2005; Finlay, 2006). The principles behind the criteria are largely convergent (Cohen and Crabtree, 2008). Yardley's work broadly groups these criteria into four key dimensions: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance (Yardley, 2000, 2008). Within the context of "lively debate" on how best to evaluate IPA research specifically for validity and quality, these criteria have been further adapted and refined by Smith (Shaw, 2011; Smith, 2011). It is worth noting that Smith concludes that assessment of quality and validity will always be a matter of judgement (Smith, 2011a p.15). Vicary and colleagues, who work with IPA, have recommended that quality and validity be achieved through reflexivity, reflection and journaling (Vicary et al., 2017). It appears that Vicary and colleagues' suggested approaches may provide actionable mechanisms through which to enact Yardley's principles in a meaningful way. These measures were applied to this research study using the same original application as Smith and colleagues (Smith et al., 2009, p.180-84) and integrating the additional considerations from Vicary et al (2017).

4.11.1 Sensitivity to context

According to Yardley (2008, p.219), sensitivity to context in qualitative research includes recognising social and cultural settings, reflecting sound understandings of theory, accurately capturing the participant's perspective and considering ethical issues.

Findings are presented from the perspective of the participant but, as with all IPA studies, the interpretation of the researcher is also important. It is possible that findings may unintentionally support the desired outcome of the researcher, or information may be interpreted to confirm the pre-existing beliefs (Cohen et al., 2002), or to confirm the experiences of prior research participants (Smith et al., 2009). As a researcher, I worked to recognise my inherent biases and reflect upon these through journaling and ongoing discussion with my supervisors. For example, during an interview one of the participants refers to "being treated like a locum". My community pharmacy experience instantly made me perceive this with negative connotations, with these suppositions based on my own biases. Only through reflection was I able to recognise this assumption, and return to question the participant further on the meaning of this experience to them. Therefore, the aim was not to eliminate preconceptions completely, but to prompt further exploration that minimised the impact so as not to shift the data away from the lived experience of the participant.

Smith et al. (2009) contends that sensitivity is also shown during the interview process, through an awareness, and successful application, of empathy and putting the participant at ease (Smith et al., 2009 p.180). Completing two pilot interviews allowed me to practice these skills, obtain feedback from the pilot participants, and reflection upon areas for development. These skills were further explored in conversations with my supervisors. Smith et al. also suggest that a robust study will have a considerable number of verbatim extracts from the participants to support the arguments being made, thereby giving voice and allowing interpretations to be checked by the reader (Smith et al., 2009 p.180). In this thesis, interpretations are presented as such and general claims made cautiously. Last, as with most studies, relevant literature is used to help orient the study and it is argued that findings should be related to relevant literature in the discussion (Smith et al., 2009). Situating the findings to the context of the wider literature is presented in Chapter 5 in relation to each theme.

4.11.2 Commitment and rigour

The second criteria of commitment and rigour is described by Yardley (2008) as the in-depth engagement with the topic, and methodological competence. Methodological competence is demonstrated through the depth and breadth of data generation and analysis. According to Smith, this criterion is met through engagement with the participant during the data collection and the level of care and attention to detail in analysing each individual case (Smith et al., 2009). As previously described, each interview was audio recorded and transcribed verbatim. Data analysis for sections of the transcript was performed independently by my supervisors, allowing confirmation and triangulation of analysis. In addition, each theme is supported with quotes from a number of participants, thereby grounding the interpretation in the experiences of the individual.

4.11.3 Transparency and coherence

The third principle of transparency and coherence is, as Smith states, “what steps were used in analysis” (Smith et al., 2009 p.182) “so [the] reader can see what was done” (Smith, 2011 p.17). It is essentially an audit trail of the research process. For Yardley (2008) these principles refer to the clarity of argument presented, which is achieved through clearly articulated methods. Achieving transparency requires careful and in-depth attention to how knowledge is being constructed by the researcher (Malterud, 2001). Throughout this thesis, I have attempted to guide the

reader through the methods, data analysis, providing examples of work to substantiate the findings and conclusions presented in this study.

4.12 Ethical Considerations

Ethics approval was obtained from the University of Leeds prior to recruiting participants (see Appendix A). Ethical considerations in this study were intended to respect the dignity and maintain the wellbeing of research participants by minimising harm, gaining informed consent and maintaining privacy (Shaw, 2008). The main ethical issues considered in this project were:

- Providing participants with study information that included the purpose of the research, their right to withdraw their data, plans for maintaining confidentiality and contact details for the researcher
- Ensuring confidentiality by participating in Skype interviews from a private office space, and encouraging participants to do the same. In the transcription process all names were replaced with pseudonyms and other identifiable data removed.
- Considering the potential requirement for disclosure. As a registered pharmacist, the researcher would be required to raise concerns if a patient care issue was identified during interview. Participants were made aware of this as part of the recruitment process.

4.13 Summary

This chapter has described and justified the IPA methodology that underpins this study. It described the recruitment strategy, data collection methods, data analysis and ethical considerations. I have explained why I selected these approaches and my role within the process, and have provided an overview of the approaches taken to promote the quality and validity of this work. The following chapter will outline the key findings of this study.

Chapter 5: Findings

5.1 Introduction

This chapter will present the research findings of this study. The purpose of this study was to give voice to the lived experiences of community pharmacists undertaking practice change within the context of community pharmacy. As described in the previous chapter, the analysis was conducted based on the interpretation of the research, using the process outlined by Smith et al. (2009) for data analysis of IPA studies.

According to Creswell (2007), a phenomenological approach seeks to search for essentials, essences and the central underlying themes of experience. In order to provide context and insight into participants as individuals, this chapter will start with a short description of each participant's experience, along with a context chart for each. This is designed to provide general insight into the participant's background, context and the experience of change in their current professional role. It also adds a clear overview of each community pharmacist's unique perspective, providing space for their voices and experiences to be acknowledged in the context of their individual experience, as is intended in phenomenological work.

The chapter will go on to present emerging themes from the interpretative analysis that were shared across the experiences of community pharmacists. Throughout the narrative I have aimed to explore depth and breadth, whilst also highlighting shared and distinct experiences, capturing convergence and divergence between participants. Although themes have been separated during the analysis process, many of them are related, which is apparent throughout the narrative account. It is therefore important to consider each theme in relation to the holistic experience and the hermeneutic circle to avoid overly-simplistic or reductionist accounts of change.

Transcript extracts in the form of direct participant quotations are included to present the phenomenological core from which my interpretations were developed (Smith, 2011). I have aimed to sample quotes proportionally across participants.

Important note: Underlined text indicates that words, names and places have been replaced to ensure anonymity of participants throughout this section.

5.2 The Participants

The ideographic nature of this study made the particular experiences of the participant central to the research process (Smith et al., 2009). The following summaries are intended to provide background information about each of the participants to give a snapshot of their experiences, thereby providing insight into who they are as individual community pharmacists. Each participant description is followed by a context chart that illustrates experience through integration with the Planes of Analysis framework.

Participant 1: Ellen

Ellen is a community pharmacist working as a manager for a small chain of community pharmacies in a semi-rural part of England.

She qualified as a pharmacist approximately 20 years ago, and has worked for small chain, large chain and multiple community pharmacies over the course of her career. She has been with her current company for a number of years, which she describes as *"quite old-fashioned. We sell hot water bottles and hairnets. A quite old-fashioned high street pharmacy".* She is the only pharmacist working in this store, and has a pre-registration pharmacist, a dispenser, and three counter assistants. She takes on responsibility for the day-to-day running of the pharmacy, enacting a wide number of important and more menial roles *"Oh, and I check prescriptions, answer the phone, mop the floor (laughs), make the tea, and all that".*

There are a small number of branches of her pharmacy in the local area, and a head office. Decisions are made by head office and filter down to her within the store. There is little interaction between the individual stores as she explains *"there's not much interaction between each branch, but there's interaction between each branch and head office. So we get emails to and from head office, and then each branch just acts on those".*

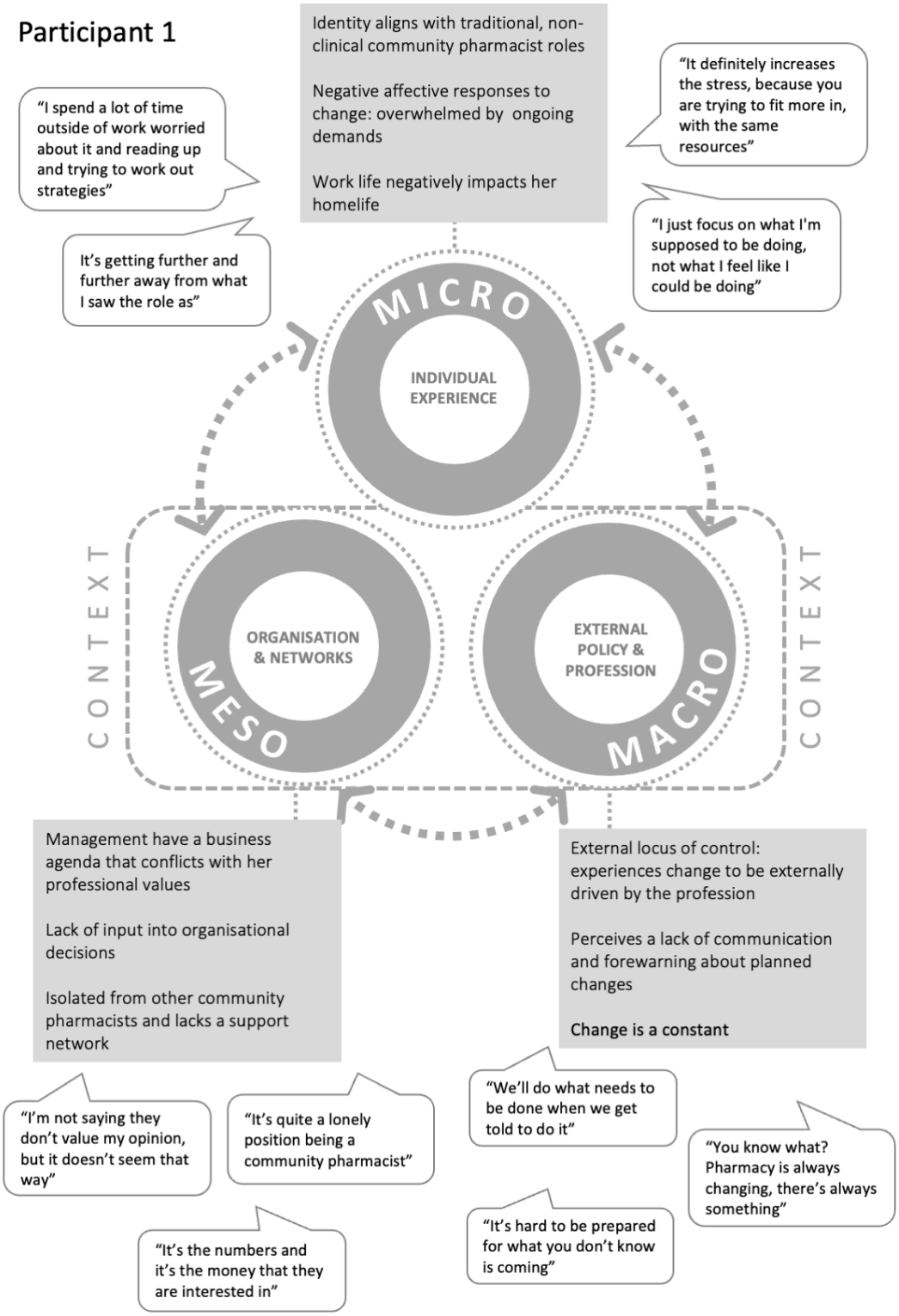
At interview one she identified her practice change focus was to reconfigure the dosette box dispensing service, whereby tablets and capsules are put into compartments labelled with time of day and day of the week, to assist patients in administering their own medicines. This change arose following a decision by head office to reduce the allocation of staff hours to the store which meant the staff member allocated to the dosette box service would no longer be funded. She describes the purpose of this change as "*trying to work out ways of doing twice the work with half the staff*". At follow up interview two she had not been able to find a way to make this work, and had withdrawn the service, a solution she wasn't entirely happy with, but felt she had no choice but to implement *"It just feels wrong because these people don't want me to stop providing service. But I can't carry on providing the service as it is".*

She describes significant stress within her role, which has caused her to suffer from both depression and anxiety. The stress stems from both her role as a CP generally and more specifically is in relation to the perceived pressures of practice change. She describes *"it is a stressful job because you're trying to please everyone all the time, and the phone is always ringing, and you are doing all that… and then things are always chang[ing] and I don't really have a break because I feel like I don't want*

to miss out or get behind on something". She has a strong sense of professional identity and a clear view of what a pharmacist "*should*" be doing, which is to supply medicines and provide advice. She is concerned that the profession is moving toward a role that conflicts with her identity, as "*I didn't want to be a nurse. I want to be a pharmacist*".

The 2019 Community Pharmacy Contractual Framework was announced in the preceding weeks before interview two. Ellen displayed conflicting emotions about this prospective change, ranging from interest in what the changes might mean for her, to resignation, to anxiety and apprehension. Her main source of concern was the unknown nature of the changes when *"you just don't know what they are planning",* and most critically, what the change would mean for her day to day practice which "*just keeps changing*". She perceives change to be out of her control and believes these decisions are made by the organisation and external drivers such as policy. As a result, her attitude toward change is resigned to *"just quietly do what I can do".*

Figure 5.1: Context Chart: Ellen



Participant 2: Luna

At interview one, Luna is a locum pharmacist who worked three to five days per week across four small independent pharmacies. She originally trained overseas, and has been qualified in the UK for approximately 10 years. As part of her conversion to UK pharmacy she did an elective in community pharmacy. It wasn't her first choice and she found herself in community pharmacy through accident rather than by design. *"I elected to go and do it in community and then started to have children and then I got stuck in community really. But I do enjoy it, it's not-- I'm not passionate about community pharmacy".*

She refers to her home life frequently, as she has four young children, and her husband works away, so she is often the primary caregiver. She struggles to balance the demands of her job with being there for her children, and experiences some guilt about the balance between home and work. "*If I work the late shift, I only get the mornings with them for three days in a row, which is kind of-- it's fine, and it works alright, but my youngest one does-- by the end of those three days, he goes, 'You're not there for me anymore'* ". This tension between her work life and home life has been an important factor in her decision making and can make work feel "*overwhelming at times*".

At interview one she identified the practice change that she wanted to pursue was to develop her clinical skills through a clinical diploma and then go onto complete a prescribing qualification. She was driven by a desire to keep current and relevant within the profession as without additional qualifications she felt that *"ultimately, I'd become a relic".* She sees the potential for patient care to be improved and thinks it's the "*right thing"* for her to do.

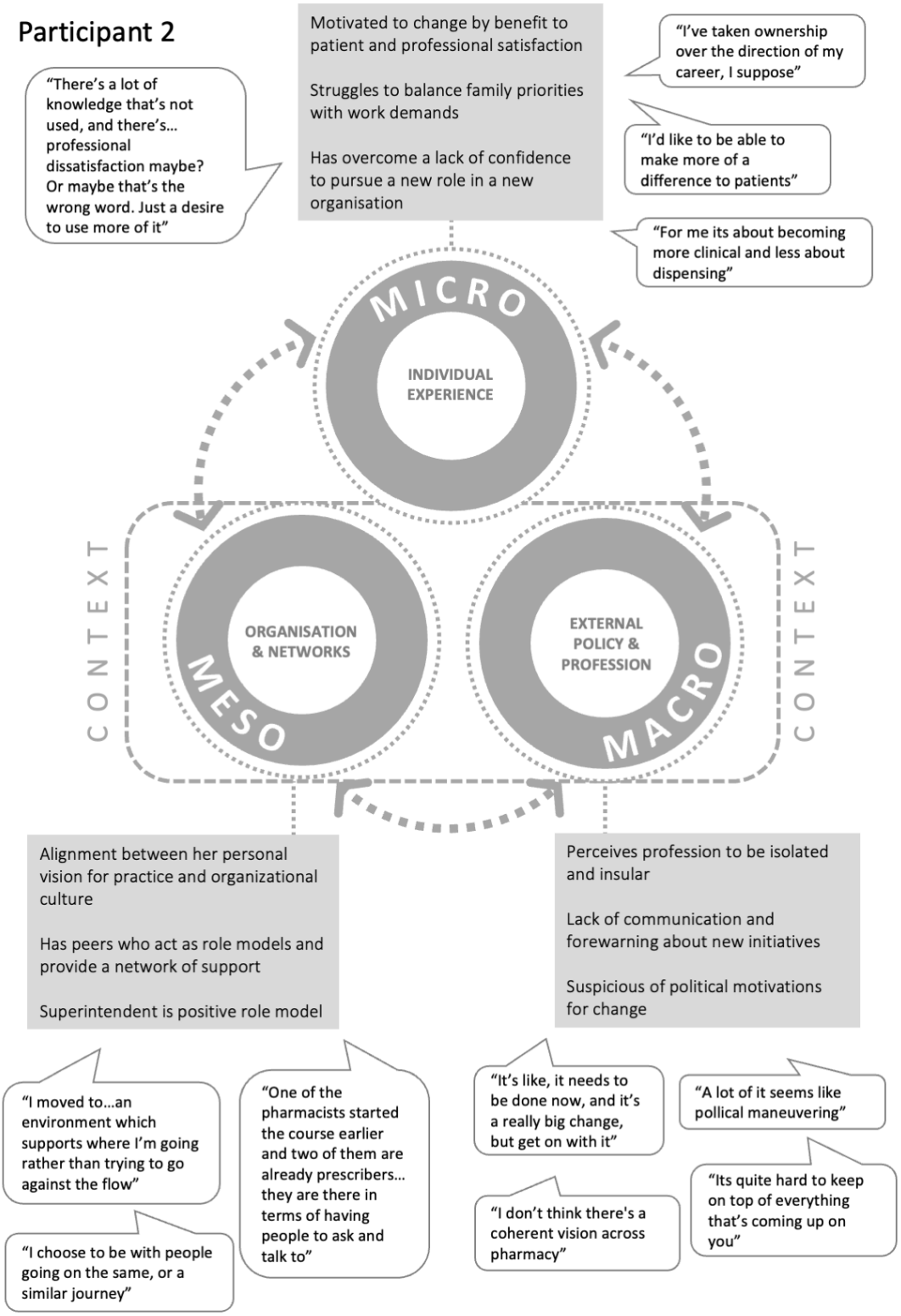
Between interview one and two she had made the decision to join a small chain as an employed pharmacist at part-time hours, and had also taken on a part-time role working in medicines management with a Clinical Commissioning Group (CCG). She intentionally sought out a community pharmacy organisation whose values and direction aligned with her own desire to be more clinical. *"The superintendent's really young and he's quite forward looking".* This decision to move roles seems to be driven by both push and pull, a desire to pursue a more clinical direction for herself, but also an opportunity to get away from some frustrations she experienced in her role as a locum, particularly a lack of continuity and feelings of isolation. She describes the culture and climate of this new organisation as having a profound impact on her ability to move into a clinical role. In this new role she works closely with two other pharmacists, in addition to accuracy checking technicians,

dispensers and counter assistants. She views these colleagues as "*going on the same or similar journey*", creating a community of support and role models for her future practice.

She describes letting a lack of confidence hold her back from pursuing change in the past, as she can find new things "*daunting*" and describes herself as "*my own worst enemy in life*". She credits her experience on the leadership programme as helping her reflect on what she wants from her job, which has highlighted a "*desire to use more"* of her skills and training.

At follow up the Community Pharmacy Contractual Framework is about to be implemented, and Luna is critical of the way policy and guidance are disseminated from the government and the profession. She feels pharmacy lacks a "*coherent vision*" of where it is moving, and that change feels "*fast paced*" and poorly communicated. She finds it difficult to *"keep on top of everything coming at you".*

Figure 5.2: Context Chart: Luna



Participant 3: Sophie

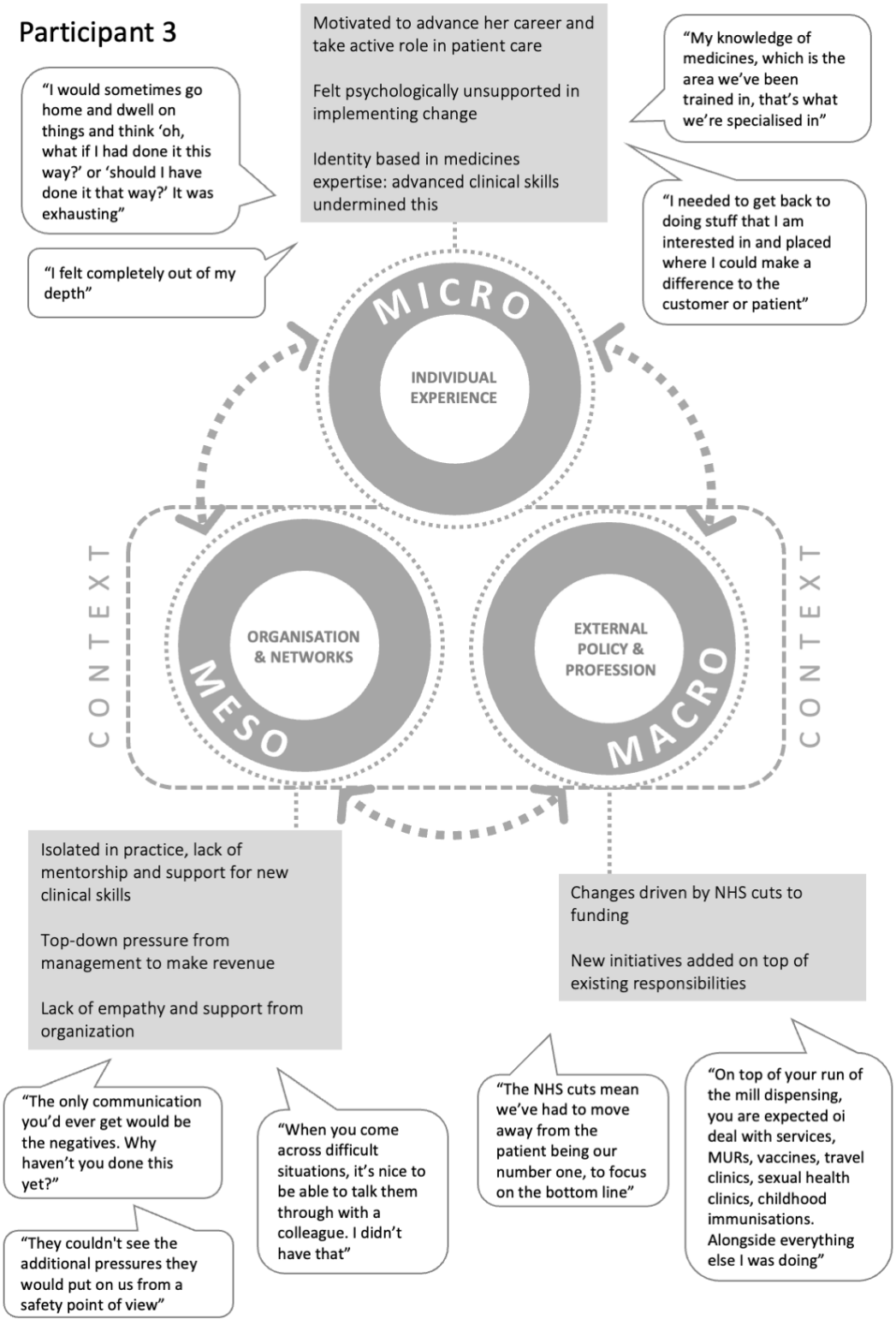
Sophie only participated in interview one, as she was in the process of transitioning out of community pharmacy to work in another pharmacy sector. She had been qualified for around seven years, and worked in a small, independent village community pharmacy with one dispenser and one counter assistant. The superintendent pharmacist is responsible for decision making, and approached her specifically to train to offer a range of additional services in the pharmacy, including travel health vaccines and sexual health services. She perceived her superintendent's motivation for changes as driven by organisational demands to make profit and to "*beat the cuts that were being made*" to dispensing fees at a national level.

She was initially excited to be offered opportunities to engage in practice change, specifically as she saw this as an opportunity to develop her skill set and add a *"string to her bow".* However, she hadn't anticipated being "*the only one in the whole company*" to be trained to offer these services. This resulted in a sense of professional isolation, as she "*didn't really have anybody*" to share experiences and concerns with. She articulates a need for a "*clinical supervision"* model, which she has seen in other sectors of pharmacy, and believes this would provide important support for extended roles for CPs.

Whilst practical training was provided for her new roles, this did not adequately meet her learning needs. She found herself unprepared for the more advanced interactions with patients, such as breaking bad news or offering psychological support to patients accessing the sexual health services. This required a skill set that she perceived to be beyond her level of training and contributed to her feeling "*out of her depth".* She also struggled with her professional identity moving into these new roles, highlighting how she saw her role as a medicines expert, yet the sexual health service had "*turned me into a phlebotomist".*

She describes changes to her role as being added "*on top of*" existing responsibilities and being expected "*alongside everything else I was doing*". Funding pressures resulted in low staffing levels, and she expressed concern about compromising patient safety due to lack of staff support. She found her superintendent to be unsupportive and unsympathetic to the pressures she was under. The tipping point for her leaving community pharmacy was being asked "*to do more and more with less and less*".

Figure 5.3: Context Chart: Sophie



Participant 4: Dev

Dev originally qualified as a pharmacist overseas and after relocating to the UK he registered as a pharmacist five years ago. At interview one he had recently started a new role as a pharmacy manager in a supermarket pharmacy. He previously worked for a large multiple pharmacy, and took this new role for the managerial responsibility that came with it. He works with a second pharmacist, an accuracy checking technician, a number of dispensers and counter assistants. He is trying to find his feet in his new role, get to know the staff, and is "*just trying to understand how the company works*". His transition into this new company highlights for him how practice is driven by local contexts as this new role feels like a "*totally a different company, different place, different everything*".

He expresses mixed attitudes towards taking on a more clinical role, articulating multiple times that it is "*hard to say*" how he feels. He is proud of the medicines-focused role of a pharmacist, and his identity is strongly linked to "*compounding and the medications… to me, that's the pharmacists main profession".* He articulates an enthusiasm for clinical roles as "*there is more than just dispensing medication that we can do"*, but behind this there is a sense of loss of identity and concern that he *"will lose the medication knowledge".* His perception is that pharmacy change is a direct result of "*the shortage of doctors and nurses*", and pharmacy is being expected to fill this gap.

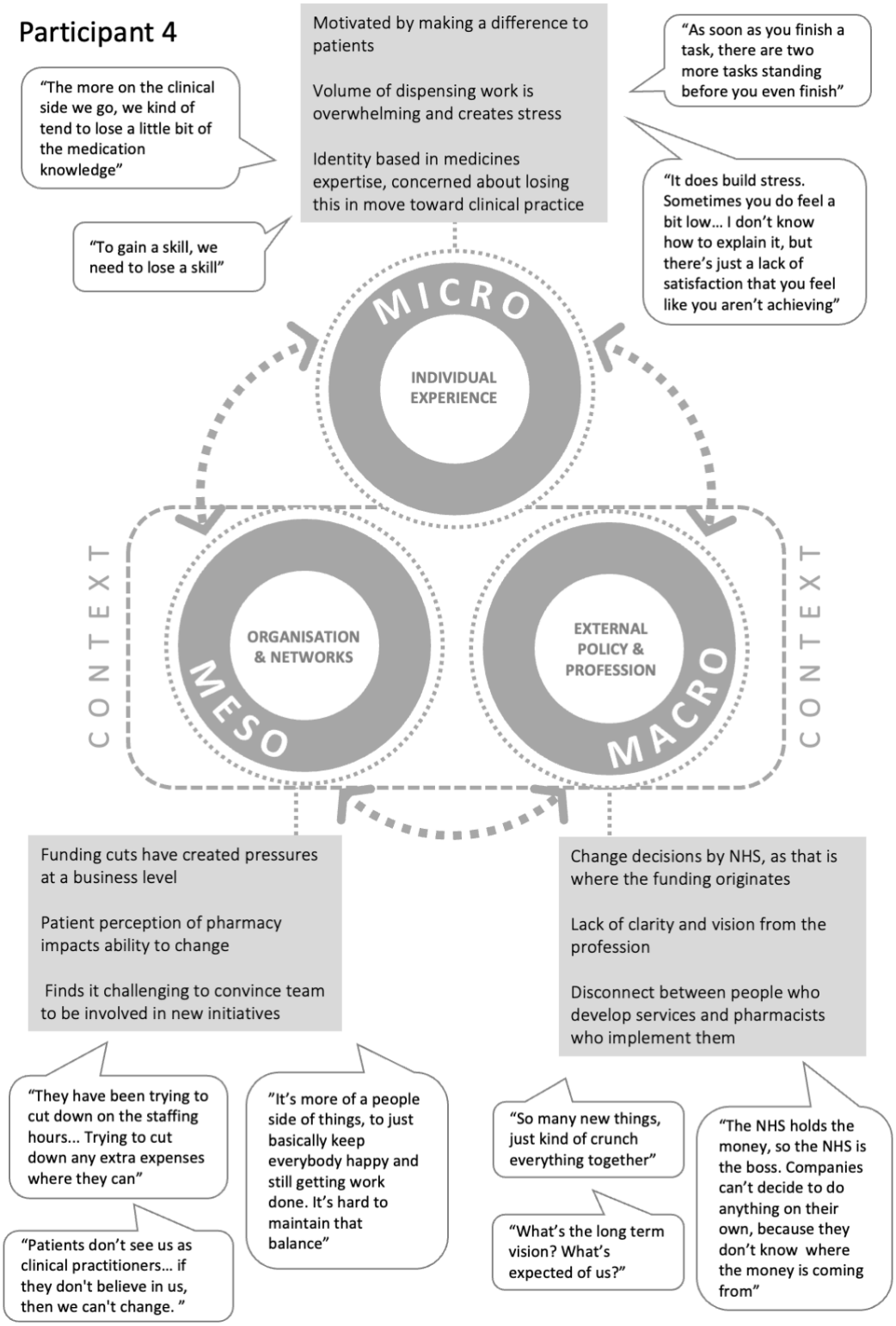
Dev identified his practice change focus as a personal learning need to develop skills required to lead his team, and rolling out a text message service to customers. At interview two he articulates that he has come to the realisation that "*managing people is quite difficult*" but has been successful in transitioning to his new role and rolling out the new service. His second pharmacist was able to cover clinical services, which allowed him to focus his energy more on managing the team and running the pharmacy. His experience was characterised by overwork, finding that *"whatever you do, no matter how much effort you put in, it's just never enough".* As a result, he reported a *"lack of satisfaction"* as the demand of the role were consistently more than the time he had available. He frequently mentions job satisfaction, which is important to his professional satisfaction. He is motivated by "*a happy patient, a happy customer*", but often feels he is not achieving this to his full potential.

His pharmacy is within a supermarket, and he describes an "independence" from the wider store. However, staffing decisions are made at an organisational level,

and cuts in staffing have had a negative impact on him ability to offer services. He blames the NHS funding cuts for creating staff issues that have directly increased his workload and his ability to implement change.

At the end of interview two, Dev volunteered a frustration about the lack of communication from the NHS, and a lack of vision or roadmap to help steer practitioners. This seemed to be related to the way the CPCF had been implemented in the preceding weeks. He found that change is "*just thrown our way*" and there is not enough consideration of timings or the impact this will have on pharmacists like him on the front line when they have existing responsibilities to maintain. This created a "*crunch*" on time and resources. He believes change ultimately comes from policy, as *"the NHS holds the money, so the NHS is the boss".*

Figure 5.4: Context Chart: Dev



Participant 5: Kalpna

Kalpna has been qualified as a pharmacist for over 30 years. She describes herself as a "*dinosaur of the profession*". She left her role as a pharmacy manager at a large multiple to retire, but then a few months later joined a small chain of "*family-orientated"* pharmacies, initially as a locum, then as a branch manager. She has been with the company for two years in total. She has four accuracy checking technicians, a second pharmacist who works part-time, and locum pharmacist who covers a couple of days per week. She strongly identifies with community pharmacy, referring to pharmacists as *"we*" throughout the interviews.

Kaplna had a clear goal for her practice change. The company she works for has closed a smaller branch, that mainly provided care home services, and decided to merge this smaller branch with the branch that Kalpna manages. Her role was to successfully facilitate a merger that involved integrating both staff and services, a task that was "*just thrust upon me"* by her organisation, and was a change that *"I had no choice in".* She focuses on her organisation as the driver of change in our discussions, but sees the NHS as controlling the direction of travel, particularly through remuneration decisions.

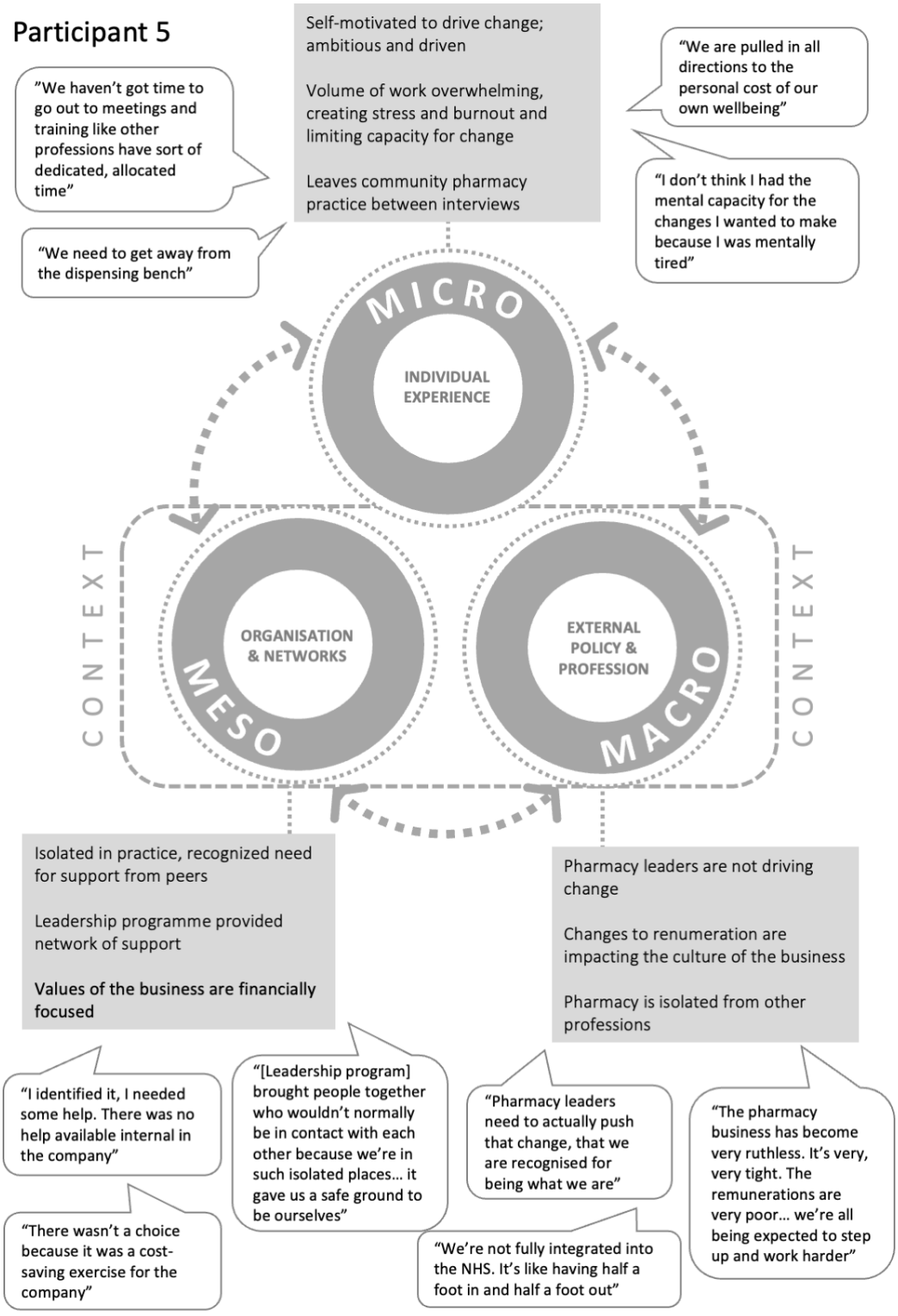
She is critical of the organisation she works for as they are "*holding onto family values*" and not stepping up to meet the challenges of current pharmacy practice, which she describes as "*ruthless*". Due to poor remuneration, staffing levels have been reduced, and more is expected from staff. She believes pharmacists could be doing an expanded role to relieve pressures on doctors, if they were not "*trapped behind the bench"* taking care of prescriptions and medicines supply. She describes the difficulty maintaining a dispensing service whilst also trying to deliver services and implement change. She reported the volume of work prevented her from being innovative and trying new things: "*I couldn't think of creative solutions… because it was the sheer volume. I couldn't deal with that".*

She describes a tendency to "*resolve problems myself*", but in order to be successful in implementing this change, she identified a need for support. She found this lacking within her company, making her feel like she "*was on her own*". This was her primary driver for signing up for the leadership programme, to gain external support for this process and "*to learn how to not lose it, basically, because the pressure was so much"*. She found this valuable in helping her to *"step back*" and gain perspective on the change, which was hard to do during the day-to-day

work. It also helped her to connect with like-minded peers with whom she could share the challenges of practice.

At interview two, following successful completion of the merger, she has decided to retire from community pharmacy to look after her grandchildren full time. She explains *“I just couldn't do it anymore. It was just getting so busy*”. Leaving the job had given her some perspective to reflect back, and she recognises the overwork and stress related to the job, which had “*taken a lot of toll on my physical health”.* She is looking for a new pharmacy-related role, and is considering a role in primary care rather than community pharmacy. She clearly states “*I don’t want to go back into a factory again”.*

Figure 5.5: Context Chart: Kalpna



Participant 6: Bashir

Bashir is a multi-sector pharmacist, working part-time across community pharmacy, general practice and university settings. He qualified as a pharmacist a little over 10 years ago and works two days per week as a relief pharmacist for a large multiple chain. He is often sent to different stores and lacks continuity, which he finds frustrating. He describes his attitude to work as *"simply turn up, do the best I can for that day and then I tend to sort of leave".*

He has not particularly engaged in delivering new services, and has a role primarily based in dispensing and *"supply, supply, supply".* He has a negative attitude toward services, believing that they are primarily driven by a business agenda and don't make the most use of the pharmacist's skillset. His experience with MURs is particularly negative, as the organisation management were pushing him to conduct MURs to meet revenue targets, and so *"MURs became a byword for just pressure".*

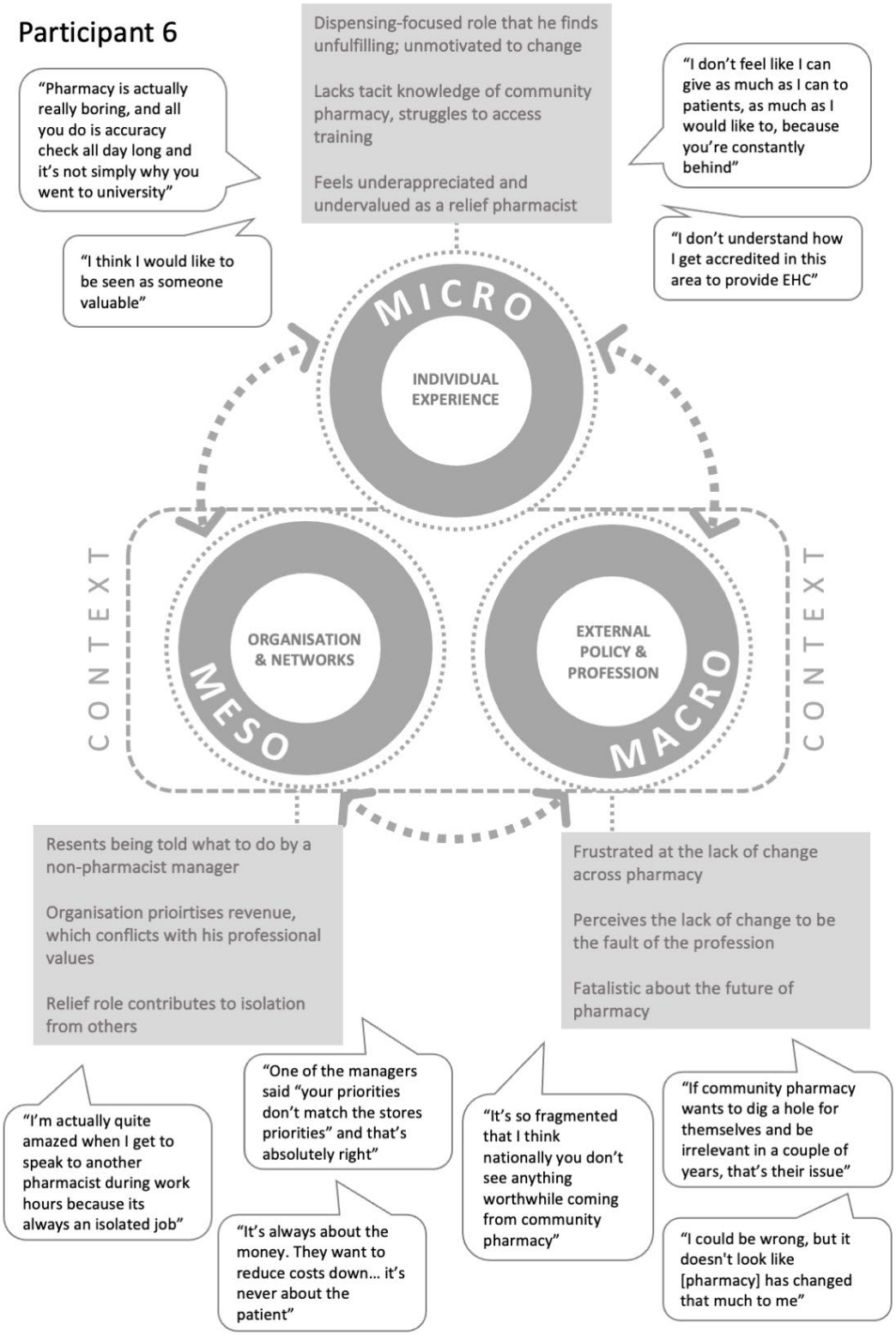
Much of the discussion focused on his relationship with his organisation, and the influence this had on his motivation to engage in practice change. He described the organisations priorities as "*a race to the numbers*" and believes revenue is prioritised over patient care. His relationship with his manager is tense, and he is particularly aggrieved at having his professional decisions "*second guessed"* by a non-pharmacist. He does not feel appreciated or valued in his role, and this undermines his sense of security in his current position as he feels he is *"just another pharmacist and could be replaced easily".* Part of his decision to be a multi-sector pharmacists is grounded in hedging bets professionally so *"I don't need to be a community pharmacist, I can work elsewhere"*.

He believes he misses out on development opportunities offered to full-time staff due to the part-time, relief nature of this role. He has become disengaged as "*I've got zero training from [the company] ever*" and believes the organisation does not value him. Although he has been able to access centrally-funded education, this does not compensate for the lack of investment in him from his organisation. Perhaps as a result of his multi-sector role, coupled with this relationship with the organisation, he appears to lack a sense of belonging to community pharmacy and struggles to navigate some of the tacit aspects of community pharmacy. For example, he doesn't know how to access training, or how to get accredited to offer particular services. He states that *"I don't really know who to send my information to get a smartcard… understanding the services is quite difficult".*

At interview one he reported the focus of his practice change was to upskill himself to offer services, specifically the influenza vaccine service. At interview two he reported he had received a negative performance review from his manager, and was told he was not meeting professional expectations, which had left him *"pretty naffed off".* This negatively impacted his desire to enact change, which he perceived to be more benefit to his employers than himself, and instead he refused to undertake new responsibilities. This appeared to be in retaliation for a perceived lack of support and concern regarding a blame culture. He asks the rhetorical question *"why would I do an extra service on top of my basic? Which I'm apparently having problems with".*

At a wider level, he doesn't think pharmacy has "*changed that much*" and experiences practice as dispensing-focused. He believes the direction of travel is externally driven, and change will not happen unless "*someone starts thinking proactively about community pharmacy and what it can do".*

Figure 5.6: Context Chart: Bashir



Participant 7: Oliver

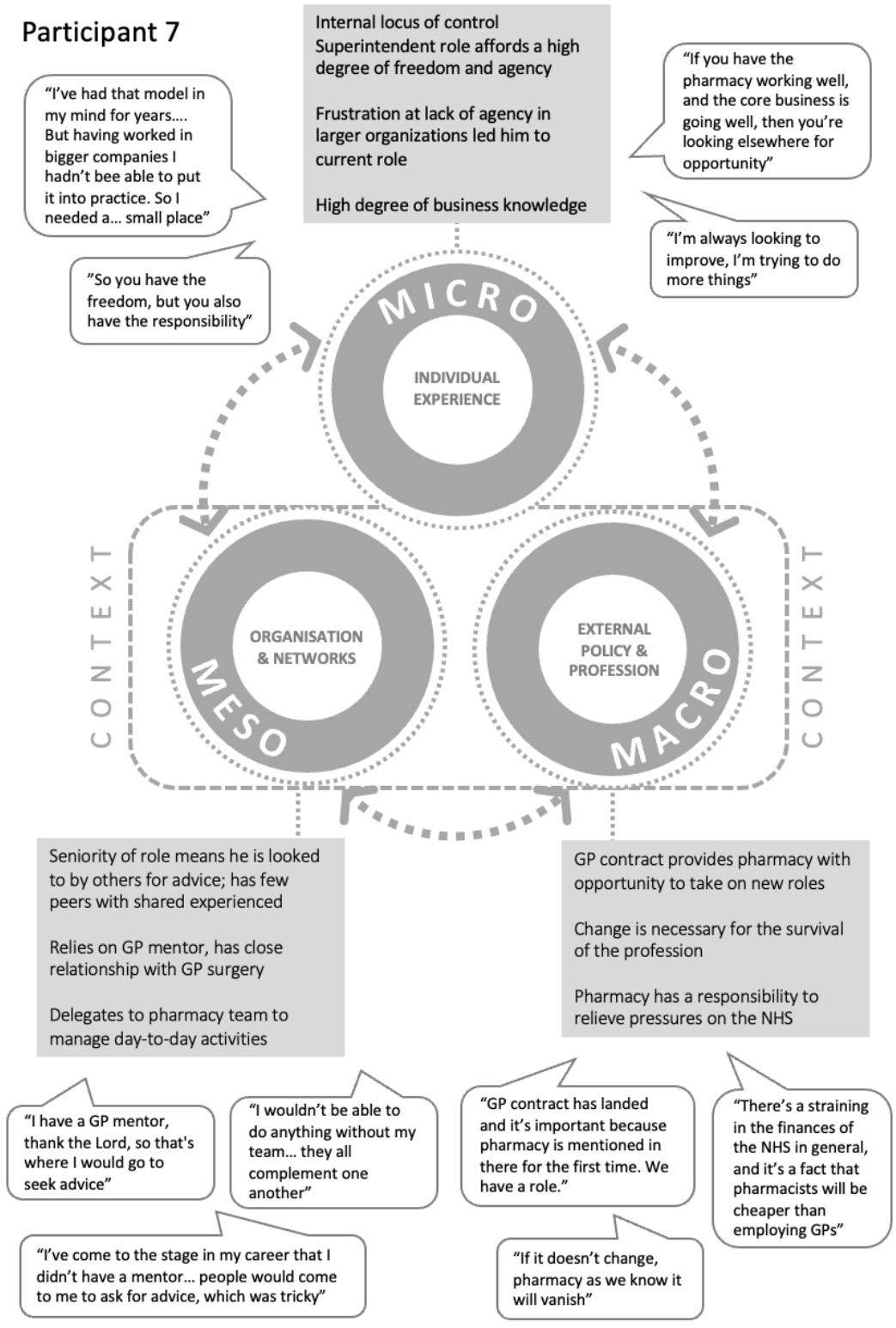
Oliver participated in interview one, but could not be reached for a second follow up interview. He is a superintendent pharmacy manager for an independent pharmacy. He works part-time in his community pharmacy role, and part-time as a care home pharmacist with responsibility for medicines management. He is currently completing an independent prescribing qualification. At his pharmacy there are three pharmacists, one ACT, two dispensers, two delivery drivers, and occasional locum pharmacists. He previously worked for larger pharmacy organisations, but became frustrated that his ideas for change were often not implemented as *"everything has to be checked by lawyers and everything was talked about for so long and nothing was happening".* This left him feeling "*a bit disengaged*".

The move to his current organisation provided more freedom, agency and "*a white canvas"* for him to realise his ideas for practice change. In his role as a superintendent he is accountable to a board of shareholders but otherwise is responsible for setting the budget, and the day-to-day running and decision making within the company which affords him *"a great degree of freedom".* He describes himself as business savvy and enjoys "*finding effective ways of using the money".* He has a high degree of self-efficacy and motivation, and reports that he is *"always looking to improve"*. He relies heavily on his team to keep the pharmacy "*working well"* as this provides him with time and energy to focus on new projects and ideas.

His pharmacy is within a GP surgery, and he has worked to build a close working relationship with his local GPs and the surgery staff. He describes this as based on "*trust*" and *"kind of proving that we can deliver*". He has a GP mentor for his prescribing qualification, and greatly values this relationship as a source of support and advice. He also has a network for pharmacy colleagues who he's met though previous jobs, keeping touch with those who he "*respect[s] better*" because "*they know more than others, or you like their way of thinking"* but there are not many pharmacists he would go to for advice.

His identified practice change is to conduct annual medication reviews for the local GP surgery, gaining access to their patient medical records, and being paid by the local GP surgery to deliver this service in order to "*free up some time from them*". He identified this change by recognising a common agenda with GPs and asking "*what would you like us to do?"* He sees services like this as the "*only way forward"* for the pharmacy profession, which is at risk of disappearing unless it can move beyond dispensing, because "*anyone can do that".*

Figure 5.7: Context Chart: Oliver



Participant 8: Michael

Michael works for a supermarket pharmacy in a busy town. He has been qualified for a little over 10 years, spending his first year after qualification in a large multiple before making the move to this supermarket because he wanted to develop managerial skills and this particular store "*sounded like a fun challenge"*. He has two dispensers and a part-time accuracy checking technician. He is an active member of his local LPC and describes his attitude towards change as "*not really necessarily the frontier, but certainly maybe second back from the front line in terms of change".* As a "*young pharmacist"* he sees his role as services-based and "*not counting tablets".*

His organisation has a complex management structure, *"you've got managers all over the place. You've got line manager, you've got store manager, you've got regional manager, you've got superintendent".* He reports positive relationships with most managers, understanding their priorities and trying to speak their language in terms of the business aspect of pharmacy, the "*process and sales"*. However, he is not always transparent and open with management, and can take advantage of their lack of pharmacy knowledge in order to make decisions that are "*above his paygrade"*. He believes he is trusted to make decisions because he has "*run a very successful pharmacy"* in terms of revenue generation.

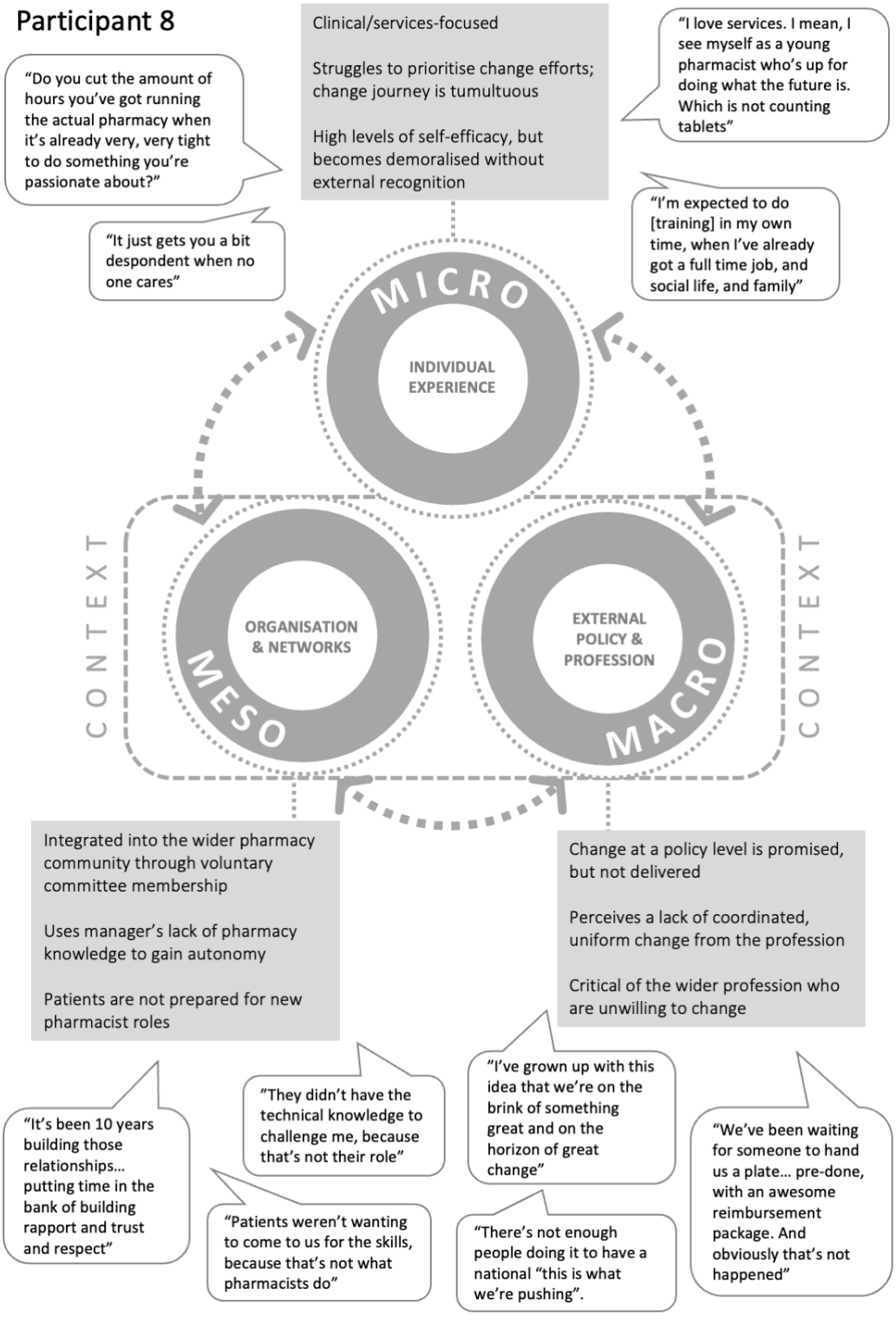
Michael's change journey between interview one and two was torturous. At interview one he identified that he wanted to expand a health check service that his pharmacy was running. At interview two he had instead started a travel vaccine service, a change that was made at the request of his organisation. However, the new community pharmacy contract was implemented around the same time, and after putting a lot of time and effort into the vaccine service, including reading *"about 55-odd PGDs*", head office ultimately decided not to implement this service to instead focus on the changes brought by the new contract, something he describes as "*their loss*". He refocused his efforts again on withdrawing a prescription collection service, a decision that he made in order to *"free up staff time".* He describes this as "*the most autonomous thing I've done*", and has found the change effective in reducing the "*bunch of stress*" he reported at the first interview.

He often volunteers himself to be involved in new projects, and enjoys doing "*a bit more than the day job*", including work on several committees. Much of this additional work has to be done "*on my days off*" He finds it demotivating when others do not recognise his efforts as *"it just gets you a bit despondent when no one*

cares". He has a specific example of learning how to use an otoscope on a clinical skills training course, and trying to implement this in practice but there was "*no active support for the skills"* from his organisation because these were not revenue generating. He also found that patients were not receptive to these new roles.

He exhibits frustration toward the wider pharmacy community and other pharmacists in particular who he perceives are often "*stragglers that aren't interested… and don't want to do stuff".* He has a wide network of peers from his work on various committees which makes him feel like less of a *"lone wolf"* but reports there is only one colleague that he trusts when it comes to seeking professional advice and support.

Figure 5.8: Context Chart: Michael



Participant 9: Timothy

Timothy has been qualified for approximately 16 years. He is a superintendent pharmacist for a small group of four pharmacies and manages one of the branches. He is an independent prescriber and plays an active role in the pharmacy profession, holding a number of roles at a national level. Although these roles take up significant amounts of time, he believes "*the balance is good*". He has a close-knit team of six people, including dispensers and accuracy checkers, and explains that "*each of the individuals are, in themselves, a key to this [success]*". He is interested in innovative practice and has *"pioneered some different ways of working. So doing cardiovascular assessments in pubs and social prescribing and mental health support."* These are novel services within community pharmacy.

He is passionate about patient care and is driven by a desire to meet the needs of his local community. The vision for his pharmacy is to be a "*local healthcare and wellbeing hub*" that offers a range of services to the local community. He refers to patients are "*our patients*" and "*our community*", stating that as a community pharmacist him and his team are a "*part of their lives"*. Funding cuts have taken their toll on his some of his ambitions, and a lack of funding means he has had to put some of this new changes on hold to instead "*look after its survival"* by "*trying to protect and hold onto what you have".* For him, there is tension between his aspirations and *"the practical need to have a business that's going to survive*", which means focusing his attention on finance-generating services such as dispensing and the services in the contract.

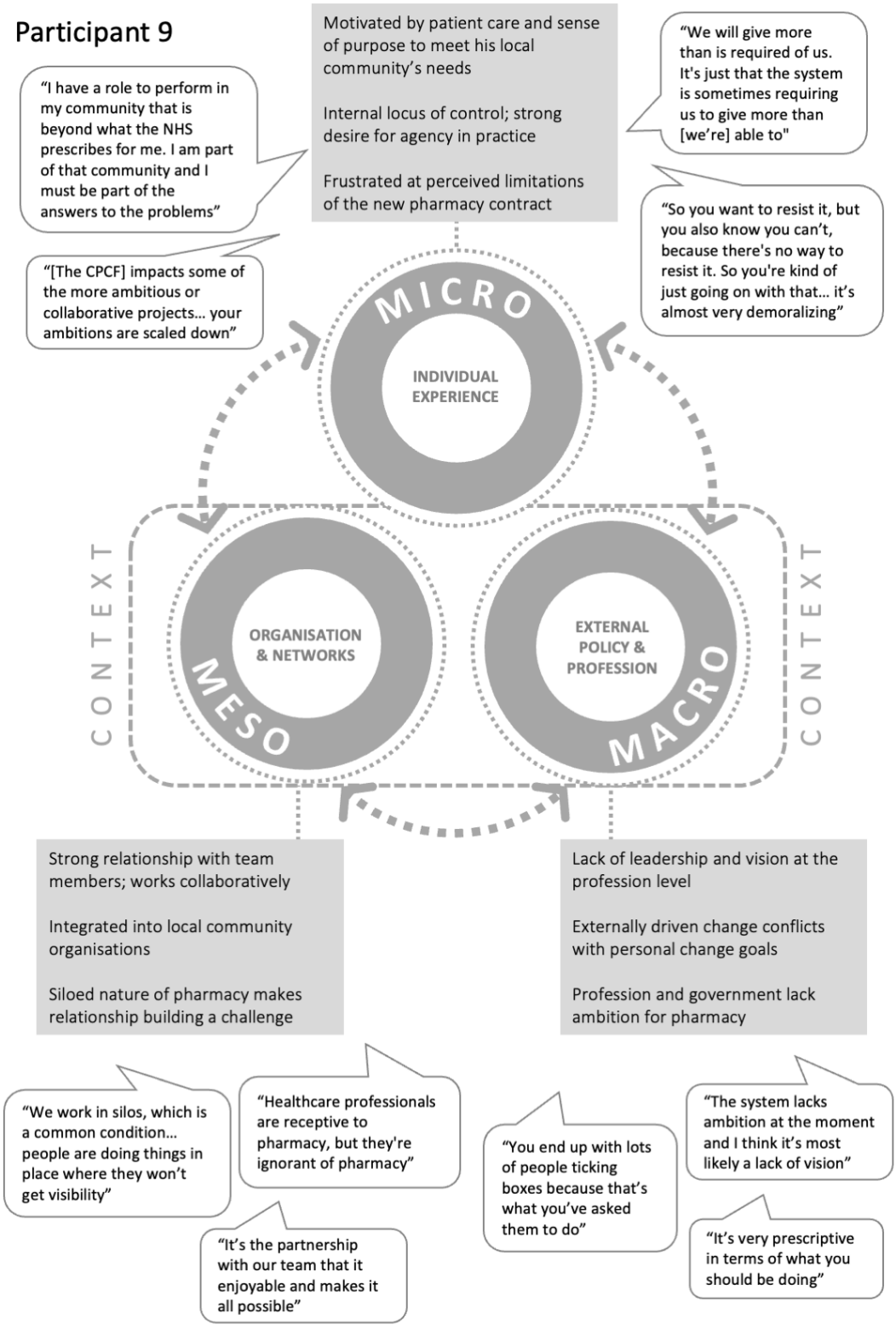
He reports that he often goes above and beyond for his patients and is willing to offer services and care for free. However, the funding cuts have made him question his ability to do this, and "*the goodwill that used to exist and was taken for granted*" may not be there anymore. From a patient perspective, he felt that the removal of funding for services *"undermines how people see pharmacy"* and undermines the trust the general public have in him.

At interview one he identified that he would like to implement a mental health check service in his pharmacy, where patients could be prompted by staff to share any mental health concerns. At interview two he was disappointed at the lack of progress with this change, reporting that his "*wider ambitions haven't come to much fruition yet*". He attributed this to a disruption caused by the new pharmacy contract. Timothy did not believe the contract aligned with his own vision for practice change, nor the direction that his pharmacy was moving as it *"doesn't give*

us a role in terms of mental health at all". This resulted in a "*very big shift*" in his focus, and made the work he had put into implementing this mental health service "*redundant".* It also makes him question whether the "*system*" values him and his innovative approach. He reports a lack of an overarching vision from the profession for community pharmacy change, and a lack of leadership, which has limited his ability to align his practice with the wider ambitions of the NHS.

The impact of the new contract on Timothy and his practice was considerable. As a pharmacy owner, he usually has a high level of autonomy in his practice, which was stifled by the "*prescriptive"* nature of the contract which "*lacks ambition".* He feels disengaged from the change, and felt the profession "*could have bothered to ask us how to do more*". He also perceives a threatening undertone to the contract, of "*do what we say or you won't be around*". For him, it is "*a frightening time*". He is disappointed that the focus on the new contract changes will take away from the "*pioneering care that happens, just in terms of responding to local needs".*

Figure 5.9: Context Chart: Timothy



Participant 10: Zahid

Zahid is a resident pharmacist at a large chain pharmacy, close to a GP practice in a busy town centre. He has been qualified for around eight years, and previously worked as a store manager at a busy high street branch of the same chain. At interview one he had recently moved to this branch in anticipation of the current manager moving locations, and with a plan for him to take on a manager role. He has a trainee accuracy checking technician, a technician and two dispensers who have been with the company for many years and have "*local knowledge of the area*". He offers a wide range of services in his pharmacy, including "*travel clinics, meningitis B vaccine, HPV vaccines… I do them all*". He is enthusiastic and motivated about offering services, describing these as an opportunity to "*speak my knowledge*". He feels strongly that the future of pharmacy is clinical, and speaks at length throughout both interviews about pharmacy's need to "*step up*". Despite this, he notes that *"most of our time, 90% of our time, is taken up by dispensing".*

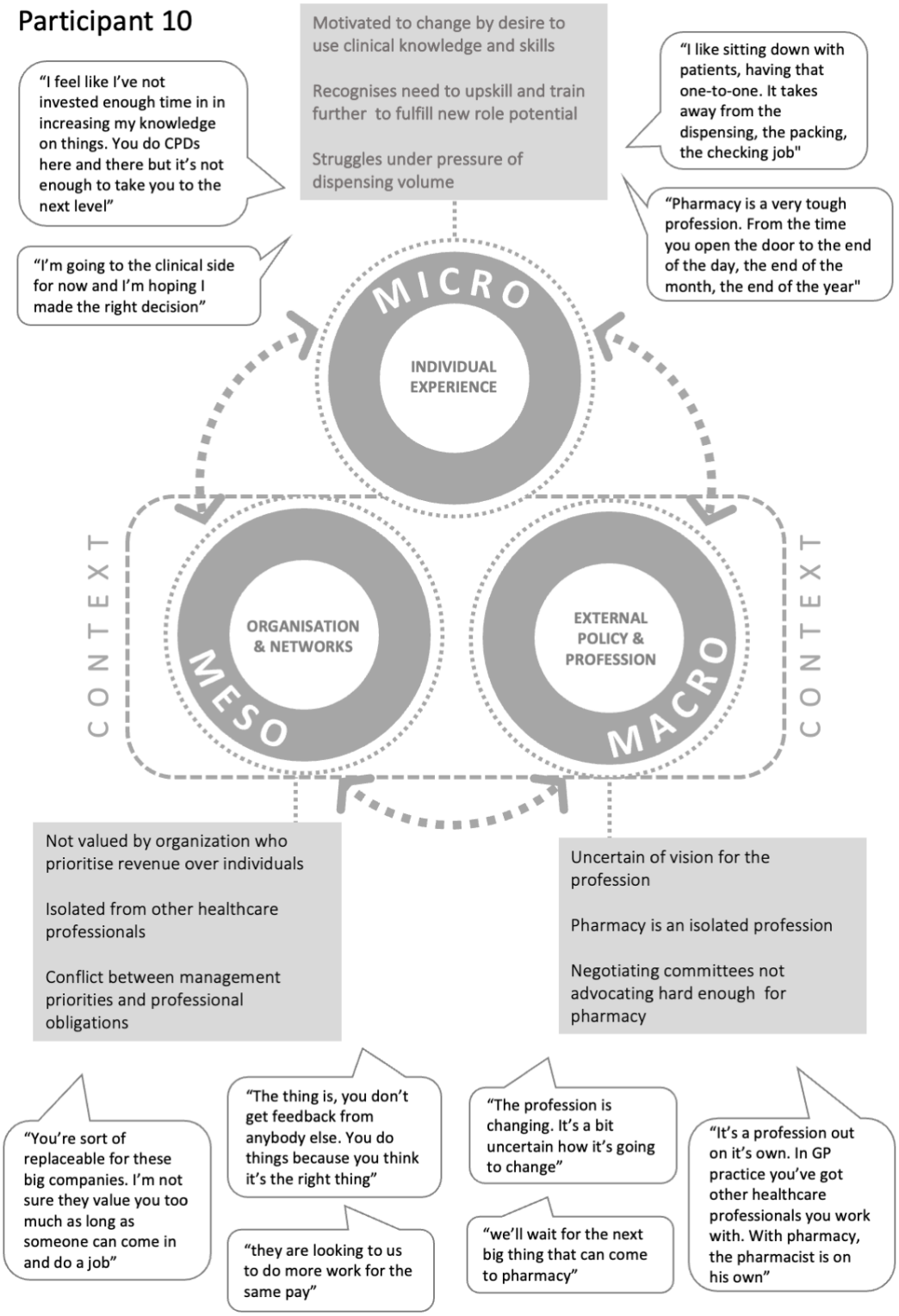
He understands the business pressures that the company is faced with, as *"they have to make profits, they have to pay bills, they have to pay employees*". This results in pressures on him from managers to meet targets of numbers of services delivered. This drive for profit can occasionally clash with his professional judgement, and so "*as a professional, you just have to draw the line*".

At interview one he identifies a desire to expand his clinical knowledge more formally by completing a diploma or advanced clinical programme, and subsequently wants to complete an independent prescribing qualification. He is unsure if this is the right thing to do, and highlights a lack of overarching vision from the profession as a cause of this uncertainty. The move to a pharmacy that was near a GP practice was a deliberate choice "*so I can start creating some links with the local doctors*" and progress his independent prescribing ambitions. His motivation for this is "*for my future because I see pharmacy changing and moving into clinical roles*". This was also a factor in his decision to move to a pharmacy in close proximity to a GP surgery, hoping he could build relationships with local GPs. At interview two, he had started an advanced practitioner programme, but ended up leaving as he "*didn't find that it was taking me to a next level*". At interview two he hadn't managed to establish any relationships with GPs, as "*it's just over time you build those relationships, really*". He has not pursued a diploma, as he is not in a financial position to fund this himself. He has not completed a prescribing qualification, as he is unsure how he will use this in his current practice, and has not

interacted with role models for this practice. He states "*I've not heard many inspiring stories out there*". He is also frustrated by a lack of investment in training by the company, as "*we're just told to deliver the services and train ourselves".* This often involves using his own time outside of work to engage in training. These discussions are timely, as the new CPCF had been implemented between interview 1 and 2, and he is considering how to upskill to deliver the new services. He feels strongly about the withdrawal of the MUR service, describing its withdrawal as a *"stain on the profession".*

He has a small network of other pharmacists that he interacts with, including fellow pharmacists on the leadership programme. He describes these individuals as *"his first port of contact*" but reports infrequent contact due to workload pressures. At a wider level, he describes the future of pharmacy as "*uncertain*" and is unsure of the direction of travel for the profession. He notes that pharmacy is a "*profession out on its own*" and that to realise the potential of the profession, it will need to be better integrated with other healthcare professions. However, he sees this as a wider issue for others to manage, and states that at a local level "*we'll wait to see what is coming our way next*".

Figure 5.10: Context Chart: Zahid



5.3 Presentation of Findings

Within phenomenology there are competing perspectives on whether participant narratives should be presented ideographically or assembled into themes common across more than one participant (Gillespie et al., 2018). Given that the purpose of this research is to make recommendations to the wider community pharmacy profession about practice change, it seemed appropriate to synthesise interpretations from across the wider dataset. As described by Moules and colleagues, the goal of this study was: “not to describe participants fully, nor to conserve their stories and experiences intact, but rather to… expand understanding of the phenomenon we [are] attending to” (2015, p112). With this in mind, shared themes are presented below, that “stand enriched beyond the initial horizons of either the researcher or the participant” (Moules et al., 2015, p. 198).

5.3.1 Introduction to Themes

Analysis of the data and its subsequent theme development yielded four overarching key themes of relevance to the research questions and the areas of focus within this study. These were:

agency in the change process,

role tensions,

networks of support,

psychological safety.

The following sections are organised somatically, with each presenting an overarching theme which then breaks down into the subordinate themes capturing the participants’ experience. Rogoff’s three Planes of Analysis (1995) have been used to organise the findings within each theme (see Appendix C for an overview of themes). This highlights the factors of importance to participants in the wider professional context (macro level), the socio-cultural context of practice (meso level) and their individual experience (micro level). Within each theme these levels are interlinked, but each plane will provide the “current focus of attention” (Rogoff, 1997), whilst maintaining the completeness of the theme and illustrating the interdependence of the levels.

The following presents a detailed description of the thematic findings as determined through an in-depth analysis of the participant interviews. Data from interviews one and two have been combined so themes contain data from both. Where possible, the words of the participants themselves are integrated into theme descriptions,

before going on to present extended quotes from the interview data. These direct quotes have been selected to ground themes in the lived experiences of the individual participants.

5.4 Theme 1: Agency in the Change Process

This first theme considers the agency, that is, the level of control that participants experienced in the practice change process. As noted in section 1 the original intent of this study was to explore self-directed practice change. Pharmacy literature often emphasises the role of the community pharmacist in driving change, or more commonly, as barriers to change (Rosenthal et al., 2010). The interviews undertaken for the study were intended to explore a self-identified practice change, identified by participants themselves at interview one. Interview two was to focus on the experience of implementation. In reality, the interviews at time point two revealed that many of the pharmacists were unable to implement their identified change in their practice in the way they intended. This did not mean change had not occurred. In fact, many participants reported a period of rapid and ongoing change between time points. Through the analysis process, it became apparent that this was frequently the result of directives and drivers external to the community pharmacist themselves. This resulted in an emerging construct that highlighted the role of agency in the change process, which, for most of the participants, was largely perceived to be driven by factors outside the community pharmacist's control. This section discusses this theme under the headings outlined in table 5.1.

Table 5.1: Agency theme: sub-categories

Plane of Analysis	Subcategories
Macro	Top-down change
	Unclear vision and direction
Meso	Managerial control
Micro	Passivity
	Taking control

5.4.1 Macro Level: Top-down Change

Community pharmacists in this study largely perceived change to be driven by forces outside their control. This finding problematised the original aim of this study, which had intended to explore self-driven practice change. Instead, for the majority of participants, change was driven at the macro level and was therefore result of "*a landscape dictated by things outside of the [community pharmacy] service*" (Luna). At the macro level, these changes were perceived to be driven by a wider agenda for change. Participants tended to be vague when describing who was responsible

for change, using phrases such as *"the system"* (Timothy), "*the profession*" (Dev), "*the NHS*" (Kalpna), "*the government*" (Luna). It was often unclear to community pharmacists exactly who was driving the change agenda. These external entities were viewed with suspicion, as were their motives for pushing the pharmacy change agenda. Based on her experiences, Luna indicates a cynicism that community pharmacy change is driven by a political agenda that may not have community pharmacy's best interests in mind:

> *"I've seen four major re-organisations of how the NHS is structured in terms of commissioning bodies and strategic health authorities, PCTs, commissioning groups. And a lot of it seems like political manoeuvring, which has huge costs financially and bureaucratically, and in terms of time, and knock-on effects all the way down to the front line. But it doesn't seem to achieve anything. I don't see very many gains because often what happens is four years later, somebody else gets into power and it all gets changed again." (Luna)*

Her description indicates how a myriad of agencies are involved in the change process, but ultimately, pharmacy and pharmacists themselves are not benefitting from these transient changes. Ellen echoes this, by describing how, *"the next minute, there's a new person in change at the Department of Health… suddenly everything changes".* These shared experiences highlight how pharmacy, and healthcare more widely, has been politicised. Rather than pharmacists, or even the pharmacy profession, driving change, there was instead a sense that decisions were driven externally *"by [political] ideology rather than evidence*" (Timothy). This created a sense of perceived pointlessness to the implementation of change, as it was likely to "*just all change again*" (Ellen). Additionally, there is hierarchy implied in Luna's example, that a wider agenda controls change, and pharmacists "*all the way down*" on the "*front line*" are the recipients of a "top-down" approach to change.

The nature of this externally driven change was largely perceived as forced onto community pharmacists, who used phrases like "*thrust upon*" (Kaplna) and "*imposed*" (Luna) to describe practice change. Kalpna highlighted that often, pharmacists had "*no choice in the matter*" when it came to deciding what was to be implemented in practice. This created a sense that pharmacists were implementers of change, responsible for taking policy directives and translating them into practice. However, there was a perceived disconnect between those who developed services, and the reality of implementation in practice. As Bashir states, *"the people commissioning the services don't really understand community pharmacy"* and was echoed closely by Luna who suggests. "*I often think the people who make these decisions about new services… don't actually know how community pharmacy*

operates". As an illustration of this disconnect, Michael shares his experience of the NHS Urgent Medicines Supply Advanced Service (NUMSAS)[2], a service where patients can be referred from NHS 111 to receive an emergency supply of existing prescription medicines:

> *"NUMSAS is a great service. It's actually a terrible service. But it varies a bit, it's not very well organised service. But in principle, it's an awesome service because all those expensive out of hours, consultations, and prescriptions that we're removing... It's just unwieldy. Why do you have to be referred in from 111? Why can't I help the patient stood in front of me?... I had a patient last week… she came in saying, "What can I buy to get rid of these symptoms?" I said, "What symptoms?" Well, turned out they're withdrawal symptoms because she's run out of her antipsychotic meds and she's feeling really bad because of these symptoms from these quite potent drugs that she's meant to be on... I couldn't have even referred her to 111, and that would have been against the rules."* (Michael)

His enthusiasm for the service in principle is undermined by the challenging implementation in practice and the fact he is unable to use his own professional judgement to identify patients for the service. He goes onto describe how the constraints of the service are "*hamstringing us",* because of a "*lack of trust*" in pharmacy, which undermines his agency in how to implement this service. This creates the conflict between the "top-down" vision of the service, and how it is then implemented in practice at a "ground level". Although the NUMSAS was a pilot service, and some challenges were perhaps to be expected, the flaws in the proposed service became amplified in a practice setting. Luna highlights her own challenges with the same service:

> *"They set up pharmacy mailboxes for NHS, but the way it works, you can have one shared mailbox which was accessed through three or two personal mailboxes, but a pharmacy could only have three personal mailboxes and then a shared one. So it didn't really-- I don't know who thought up that process, but for me to provide NUMSAS as a locum, and it is largely locums that work out of hours, it meant somebody in the pharmacy giving you access to their personal NHS email address in order to access the shared mailbox. So some places weren't really keen for that to happen, which is understandable, but it also means you can't provide the service" (Luna).*

This example was provided by Luna to show how it was specifically difficult to engage in change as a locum, as she had no ability to access the necessary resources. So although Luna expressed enthusiasm for delivering this service "*a*

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[2] The NUMSAS service was superseded by the Community Pharmacy Consultation Service in 2019

lack of joined up thinking" hindered the implementation of this service and prevented participants from being able to offer the service as intended, if at all.

5.4.2 Macro Level: Unclear Vision and Direction

Having determined that change is driven in a top-down manner, participants were then largely frustrated at how change was communicated to them by these external entities. Participants shared the perception that there was a lack of overarching vision for the future of pharmacy. Participants wanted to know "*What's the long-term vision? What's expected of us?"* (Dev), but consistently bemoaned that there was "*no clear vision*" (Timothy) for practice change to guide practitioners. This was discussed repeatedly as creating uncertainty at a local level:

> *"The profession is changing. It's a bit uncertain how it's going to change in the next two to five years. I mean, I have taken a plunge on the clinical side. I'm investing time for now to improve my clinical knowledge. Don't know if it's a bright move to make now, but I don't see any other options to go at. And that's what I'm doing. I'm trying to prepare myself for the future, next two to five years. Maybe it's medium term. It's not long term. But yeah, for me, I'm just investing myself, because I do see something has to change in the next five years. There would be some sort of change in pharmacy and the role that we play in the NHS. I could be wrong altogether. But yeah. I think there's definitely some sort of change in pharmacy, and for me, I'm going to clinical side for now and I hope I've made the right decision."* (Zahid)

The lack of certainty over the future of the profession was clear in Zahid's description. Considering his experience more closely, it become apparent that he is second guessing the decisions he has made about his own practice. His reference to having "*taken a plunge*" indicates a blind leap of faith rather than a calculated and aligned decision. This lack of ability to plan was reflected in the pace of change, which was described as rapid and unexpected. The perception of abruptness perhaps related to a lack of clear communication with pharmacists, who appeared to be unprepared for the changes being presented to them, as "*it's hard to be prepared for what you don't know*" (Ellen). Both Luna and Dev describe their experiences and responses to how change is being implemented through the new CPCF:

> *"They just come up and one or two months before, they say, 'Oh, we are starting this new service CPCS. This is what you need to do. This is what—' So we have got everything going on. We've got flu season going on, and, suddenly, you're like, 'Oh, I need to read this. I need to read that. That's another CPD. I need to increase this skill set.' So it becomes kind of too much at that minute." (Dev)*

> *"I think that's been a bit of a shock because it's, kind of, come very suddenly. Like it needs to be done now, and it's a big change, but get on with it. It kind of feels quite up in the air. Like nobody really knows how they*

> *do, what they're doing, how they're doing, how it's supposed to happen and that's not just-- locally to our group of pharmacies. It's like, kind of, nobody really knows." (Luna)*

The same expression, "*up in the air"* is used here by Luna and echoed elsewhere by Ellen, to describe the implementation of the contract. Rather than feel grounded in the change with solid plans for implementation, this suggests change is floating and intangible. This reflects the uncertainty about implementation at a practice level that results from a lack of communication. Luna uses the phrase "*get on with it*" emphasising that power is held by those driving change and not with her as the implementer. In addition, participants referred to the constant nature of change in the profession. This was noted in both interview one and two. Several of the CPs described how they experience change as *"continual"* (Ellen) and *"ongoing"* (Dev), and resulted in "*having to transition again*" (Timothy). This was particularly expressed by Timothy, Ellen, Kalpna and Luna, who had all been in the profession for a significant amount of time. Ellen describes how pharmacy has continually changed in her experience:

> *"Having that sort of 20 years of reflection thing, I thought, "You know what? Pharmacy is always changing." There's always something. There's always someone's leaving, or somebody's starting, or there's been a change in the law. There's been a change in procedure or something like that… There's always something with this new contract that's come in. I did get very anxious to begin with about it. And I started thinking, "Ugh, it's just business as usual" ... But that's just life. That's just pharmacy. The job is so different when I started that actually change is almost part of it in some ways." (Ellen)*

For Ellen, her perspective of the profession has become synonymous with change. Rather than this being motivating or teaching pharmacists how to effectively respond to change, the continuous nature of change in CP appeared to have the opposite effect. Some participants appear to have grown fatigued by change, and are left wondering *"is it worth it?"* (Sophie) and "*where does this stop?"*(Ellen).

5.4.3 Meso Level: Managerial control

The experience of agency manifested differently depending on the context of the local organisation, highlighting the different cultures of practice. Issues of agency at the organisational-level were most widely discussed by participants who worked as employees in small or large chains, where there was a hierarchical structure that included organisational commercial retail managers who were not part of the pharmacy team. Corporate rules and regulations created a sense that participants had "*no input"* (Ellen) and instead "*you've got managers all over the place telling you what to do*" (Michael) and there is "*not a lot of room for manoeuvre*" (Sophie). Oliver specifically described the struggle of trying to implement change in a

corporate organisation, which was a primary reason he relocated to a new role in an independent pharmacy:

> *"Oliver: There were ideas that I would like to have supported, and they weren't supported, and things that I could see—so I put [in] a valid business case… and I mean, I've been told [by] people in finance, you're a pharmacist, you should just focus on your pharmacy job, don't bother with all that. And why are you doing business plans for another service? And I said, "Well, I think it's worth presenting a case as intended."*
> *Interviewer: And how did that response make you feel?*
> *Oliver: Well, I mean, leaves you feeling a bit estranged from the organization and demotivates, I guess, and you kind of think, "Well, it's not really worth putting the effort to do something, to go the extra mile"*

Managerial control was described on a smaller scale in the day-to-day practices of participants. Pharmacists reported being accountable to managers for their business performance, which diminished their agency through labour control. These interactions were expressed in largely negative terms:

> *"The only communication you'd ever get would be the negatives. Why haven't you done this yet? When actually you needed their help."* (Sophie)

> *"They're on your back about "why haven't you done this?" and "why haven't you done that?"* (Ellen)

These descriptions reflect the power dynamic of the relationship with managers, who were responsible for business performance and placed demands on pharmacists. There was a widely held perception that managers were "outsiders" who were responsible for ensuring targets were met, tracking performance, and answering to business owners. They were seen as not understanding patient care or the professional obligations of the pharmacists. In particular, the distinction between being a professional and being a manager was a source of tension. As Bashir explains *"I don't think as a healthcare professional you should be second guessed by someone who isn't".* Zahid and Michael echoed these sentiments:

> *"[Managers] don't have a professional obligation to anything… they wouldn't know the clinical need of doing certain services or what my thoughts are on a service provision. Or what my pressures are on a daily basis. They would just be looking at a spreadsheet… It makes you feel that somebody is monitoring you, but you are the expert."* (Zahid)

> *"They didn't have the technical knowledge to challenge me because that's not their role."* (Michael)

Despite this, the day-to-day workflow of the pharmacy was largely described as being within the pharmacist's remit, as "*the store manager doesn't know much about the pharmacy. He's dealing with the rest of the store that's more retail*" (Dev). This created a sense of agency over some pharmacy decisions, although there

were limitations and boundaries to this control. Michael provides an example of going outside his usual sphere of influence to withdraw a pharmacy service:

> *"So for me, it was a tough decision, but it was one that I knew the head office would not take. You email head office and say, 'Can I make a decision that's going to lose 10% of our business?' They're going to say, 'no' aren't they? But I didn't ask that question. So the decision needed making and someone needed to make it. It's just that there was no one else willing to make it."* (Michael)

He goes onto say that the leadership programme taught him to "*not have the fear of, 'oo well I'm not sure I've got the authority to do that'*". He credits the positive relationship he has with management and the established relationships of trust that allow him to push these limits. As he describes: *"I didn't ask as much as inform and- - I suppose it came down to trust"* (Michael). Michael sounds confident in this excerpt, but goes onto be a lot less sure of the authority of this decision, describing it as "*a bit reckless*". This uncertainty perhaps reflects an overstepping of an authority boundary.

Oliver and Timothy have formal leadership positions within their independent pharmacies; Oliver is a superintendent pharmacist and Timothy is an owner-operator. In contrast, to the participants in this study who were employees, these participant had a high level of autonomy at the meso level. Oliver was given a budget and the autonomy to allocate this as he deemed appropriate:

> *"When I first started the job I said, 'okay, what do you expect from me?' And essentially, they said 'we'll give you a budget and you manage it. That's our expectation'." (Oliver)*

He goes onto describe the influence this has had on his agency *"It gives a great degree of freedom, and it gives a lot of creativity, that sort of model, it certainly has with me".* Along with this freedom came a greater sense of responsibility for "*economics"* and "*cost analysis*", a role he greatly enjoyed, but skills that are much more aligned with the business side of pharmacy rather than the clinical side. However, having this control over the business aspect, provided the autonomy needed to develop more clinical services.

5.4.4 Micro Level: Passivity

At the micro level, these external drivers of change influenced participant's reactions to change. Participants exhibited frustration at being "*dictated to*" (Bashir) and presented a number of examples that highlighted the sense of powerlessness working in a community pharmacy environment:

> "*It just seems to take all the enjoyment out of the job because it just became about doing what you were asked to do."* (Luna)

This idea of "*doing what you were asked to do*" describes an external loci of control, whereby participants did not feel empowered to direct change in their own practice, but instead were directed by others. This was echoed by both Timothy and Dev who describe being the passive recipients of change specifically from policy directives, whereby initiatives get "*thrown our way*" (Dev):

> *"Things just get thrown our way. Or, 'This is what you've got to do by next month,' or 'This is what you're going to do in the next six months'… So we are just kind of are walking and just something gets thrown our way." (Dev)*

> *"They say, 'Well, we can do this'. So, of course, we can do that… I think we've got a list of things that they want us to do, which we will do. But, you know, I guess after that finishes then we'll go onto the next list of things to do. So it becomes not the best model for sustainability because we just keep doing things then but we're not actually building anything." (Timothy)*

Both participants highlight the lack of engagement in the change process, as they "*just keep doing things*" that they are asked to do, rather than exhibiting any level of situated control. This lack of agency frequently resulted in an observed passivity, whereby participants indicated they would "*wait to see what'll happen*" (Zahid). Ellen explains how this lack of control over the course of her professional career has left her fatigued and inclined to resign herself to change:

> *"I think maybe, as a teenager, you feel like, if you shout loud enough, you can change the world. And when you get to 42, you think, "I can't, and I can't be bothered to keep shouting, so I'll just quietly do what I can do, influence what I can influence, and make things better where I can." Yeah. Maybe that's it. It's an old-person thing [laughter] or a giving-up kind of thing - I don't know - but it's certainly a lot less stressful, sort of realising what you can and can't do." (Ellen)*

Ellen's example of trying to "*shout loud enough*" suggests a lack of authority in the change process, that leads her to relinquish control for the most significant aspects of change, allowing her to focus on influence her practice on a small scale. She sees a limit to the power and influence she has within her organisation. Another participant reacted to the external driver of change by seeing change as a problem for the profession to deal with:

> *"I personally think community pharmacy's going to be completely sidelined… And if they want to continue. I mean, it sounds like I don't work in community pharmacy when I say this, but they want to just keep on doing the same old- - dispense. You know? Although I'm a community pharmacist, I can't change anything about that. So community pharmacy wants to dig a hole for themselves. That's really their problem." (Bashir)*

Bashir exhibits dissociation from the profession here and elsewhere in his interview. He described being dissatisfied with a dispensing role, yet perceives he has no influence to change his practice. The lack of change is attributed to others and viewed as "*their problem*". This reflects an external loci of control.

5.4.5 Micro Level: Taking control

Several participants in this study described examples of ways that they were able to take control of their practice. Some of these examples supported practice change and others worked against it.

Luna provided the clearest example of taking control of her practice. Formerly a locum pharmacist, Luna experienced low levels of control over her practice, which she found "*frustrating*". She transitioned to a new role between interview one and two, into an organisation that provides significantly more support for training and clinical development. She has started a clinical diploma that will lead into a prescribing course. Reflecting on her experience after interview one she explains that "*I've taken ownership of the direction of my career, I suppose".* She explains why she made this decision:

> *"I'm doing it now--it's more towards the voluntary… I also feel like if you don't do these kinds of things, in 10 years' time we won't really be able to practice in a very full, rounded way and be quite limited, so it's important to do and I'd rather do it now while I get to decide"* (Luna)

The description Luna provides highlights the decision that was intrinsic motivation and driven by a desire for agency, in what is "voluntary" and within her control. This was an empowering experience for her, as she had previously reported a lack of confidence in her own ability, and highlighted that she was often "*swept along*" when it came to her career. Bashir also exhibited an example of control in his practice, although, in contrast, this agency inhibited practice change. Having been asked by his manager to train to offer the influenza vaccination, he responds to this request negatively:

> *"I refuse to do the flu jab. But because the way I see it, if they see that there is development problems or development needs for myself, the priority should be doing the basic first. And I've received no support. So they've said I'm crumbling under pressure. Well, what support have I received? I've received zero. So why would I do an extra service on top of my basic, which I'm having problems with? So I refuse to do the flu jab…They just assumed that I would do it… But it's my decision at the end of the day" (Bashir)*

In this example, Bashir takes control over his organisation by refusing to do something that management have requested. Whilst training to administer the flu vaccine would advance his practice, the frustration felt toward his organisation is

the overriding influence here. Michael and Timothy shared a sense of undermined control, as they sought to direct their practice but were instead subject to external forces that overrode personal objective. These participants described these as personal "*passions*" (Michael) and "*desires*" (Timothy) that were not always aligned with policy or funding streams. This created a conflict between activities that were funded and personal professional goals. As a result, Timothy had to "*scale down*" his ambitions in order to focus on the externally driven priorities. The 2019 CPCF was launched between interview one and interview two, and came to illustrate how change was implemented in a way that community pharmacists felt failed to engage them in the process. Timothy provides an example of implementing a mental health service in his pharmacy prior to the launch of the CPCF. The new CPCF does not provide any funding for this, and limited capacity means it is not possible to keep the mental health service running and respond to the CPCF simultaneously. This macro level change was perceived to undermine his agency:

> *"[The new community pharmacist contract] is a big-- for us it's a very big shift. It means that some of the training that we've put into the team to look at maybe getting into being better able to support long term care and to be able to facilitate some of the conversations… has become a bit redundant because the NHS is shifting what they want the focus of community pharmacies to be-- you know, away from the long term to the minor, lower acuity presentation." (Timothy)*

Although holding a leadership role in an independent pharmacy provided a level of autonomy, the overarching top-down approach to change meant that decisions were not fully *"in your trust"* and Timothy found himself having to *"look at changing our focus".* The NHS, and more specifically the funding the NHS could provide, was ultimately what drove the direction of change in this instance. As a result, he expresses concern about making autonomous decisions in the future, that may ultimately not align with professional funding. This has stifled innovation and "*kills that sense of aspiration*". As a result, he has adopted a more cautious attitude toward innovations he does not want investment in new initiatives as "*you don't want to get yourself in trouble*". Michael highlights a similar tension, asking the rhetorical question, *"Do you cut the number of hours you've got for running to actual pharmacy… to do something you're passionate about?".*

5.5 Theme 2: Role Tensions

This theme focuses on the tensions community pharmacists experience in the change process. The existing literature has clearly articulated a long-standing role-tension for community pharmacists, specifically as it relates to the dichotomy of the community pharmacist as both business person and healthcare professional (Scahill et al., 2018; Jacobs et al., 2011).

Other areas of conflict with existing roles were apparent as community pharmacists attempt to embrace new roles. In particular, the role of dispensing and medicines supply was a significant factor when it came to implementing practice change. For the most part, participants in this study had a core role in medicines supply, with new roles and practice changes added into these existing responsibilities. At the meso level, and it became apparent that the commercial demands of the business were often perceived to be in conflict with the paradigm of new roles. At a micro level pharmacists navigated these tensions in the context of practice change by prioritising responsibilities and drawing on their professional values. This section discusses this theme under the headings outlined in table 5.2.

Table 5.2: Role tensions theme: sub-categories

Plane of analysis	Sub-categories
Macro	Cumulative roles
Meso	Heathcare-Business Conflict
Micro	Forced to prioritise
	Professional values

5.5.1 Macro Level: Cumulative Roles

Almost all participants described the conflict between trying to implement something new in their practice and maintaining dispensing services. The safe provision of medicines through dispensing remains in policy an “important” and “essential” role of community pharmacy ((Department of Health, 2008). Despite ongoing discussion that accuracy checkers and pharmacy technicians can take over responsibility for the dispensing role, this was not reflected in the experiences of these participants. Although the interview schedule did not ask specific questions about the process of dispensing or existing tasks, most pharmacists discussed the need to maintain a medicines supply service as a core function of their role, and considered medicines supply to be “*the day job*” (Michael). Participants widely

reported they had experienced rising prescription numbers, along with pressures to keep on top of this provision:

> *"The money comes from the clinical services we do, but we're actually having to do even more dispensing than ever. We are sort of definitely seeing more prescriptions than ever. But the other stuff is on top. So it just feels like you're just working harder than ever" (*Ellen)

> *"The prescription volumes are not dropping. They seem to be going higher and higher."* (Zahid)

Overall, there was a sense that dispensing was *"repetitive"* (Luna) and "*really boring*" (Bashir). As a result, discussions about dispensing and medicine supply work were largely negative:

> *"The dispensing stress needs to be taken away. Some robots need to be implemented so this day-to-day, simple, packing medicines job is somehow to be taken away."* (Zahid)

> *"There is such a phenomenal amount we could do, but our basic workload, doing the prescriptions… hasn't really been taken off us.*" (Kalpna)

Participants refer to the "*basic*" (Kalpna) and "*simple*" (Zahid) job of medicines supply, indicating a perceived lack of skill required to fulfill this role. All but one participant expressed an eagerness to move beyond this supply role, to make better use of the training and skills and offering a more exciting prospect for community pharmacists. For Bashir, the fact that dispensing was still a key role for pharmacy symbolised the lack of change within their own practice and in the profession more widely:

> *"But what, what has actually happened? What change has there been? Because I still think we're in the pharmacy, sorry, we're still in the dispensary. So what has changed from that, because I can't see anything?" (Bashir)*

Bashir goes onto suggest that "*I'd love to spend more time with patients, but I can't because there're a backlog of dispensing to do*". High dispensing volumes were largely attributed as being the reason pharmacists were held back from new roles. As a result, the participants perceived that they were "*doing all the new things, but you're still doing what you always did*" (Ellen). Rather than change being a transition, participants reported new responsibilities and priorities being added on top of existing job roles. Sophie provides an example of the cumulative nature of changes:

> *"On top of your general run-of-the-mill prescription dispensing, you are expected to deal with services, MURs, a few vaccinations. I also ran travel*

> *advice clinics, sexual health clinics, and childhood immunisation clinics alongside everything else that I was doing… [it] was getting totally impractical."* (Sophie)

This perception of work overload was shared by others, who, like Sophie, provided long lists of tasks and responsibilities.

5.5.2 Meso Level: Healthcare-Business Conflict

The dichotomous role of the community pharmacy as both a business and a healthcare provider was seen at the meso level. All ten participants raised the business nature of pharmacy as relevant to their change experience. This was seen as the way community pharmacy was commercially viable, and was considered a "*necessary evil*" (Kalpna). For the majority of participants, this was seen as conflicting with their vision for change, that was largely situated within a paradigm of increased patient care and time spent with patients, however "*they don't go together, the commercial aspect and healthcare*" (Bashir). Pharmacists who were employees of organisations, all emphasised a focus from their organisational management on "*profit*", "*revenue*", "*numbers*" and *"targets*", which characterized the ethos and values of the community pharmacy sector. This was linked to the commercial priorities of the organisation:

> *"It's the numbers and it's the money that [management] are interested in." (Ellen)*

> *"It was very much just a numbers game… with MURs because like, say you had a day and only patients came in that already had an MUR previously recently done. Well, of course the MURs numbers are going to be down. So then you have to justify to a manager, 'Why haven't you done any MURs?' 'Well, there was no one eligible'." (Bashir)*

> *"They have to get their full allowance of MUR, that's where the bread and butter is, they're not getting enough from the item cost, so MURs and NMS is the focus for the companies. So it's a big climb towards it, but we have to do it." (Zahid)*

The "*numbers game*" refers to both revenue and the number of prescriptions or services that can be offered. Bashir and Luna perceived that services that were originally implemented to support the move of pharmacists toward a more patient-centered practice, had been hijacked by the corporations as a way of increasing profit. Bashir suggests that "*it wasn't a service that was helping patients, it was more about pressure on pharmacists*" and Luna describes a focus on "*how many services you've done. How many MURs, NMSs. Not about the patient*". This

undermined the value these pharmacists saw in these services, as they became "*a byword for pressure*" (Bashir).

The perception that community pharmacy organisations were overly concerned with profit created a disconnect for pharmacists trying to implement patient-focused change. This focus on profit meant that management was perceived to be indifferent to the professional nature of pharmacist's work, and did not value pharmacy services and pharmacist roles that did not generate income. Michael provides an example of trying to utilise newly acquired clinical examination skills in practice:

> *"I bought an otoscope… My line manager didn't see the point because they'd either end up being sold the same product or referred to the doctor with no charge. Head office, had-- they had no-- not that they were against it but there was no active support for the skills because it didn't make money… At least if you can say to the boss at the end of the day, 'I've done two MURs,' they're happy. If you say I looked in 10 people's ear and done some-- listened to some chest percussions, then 'Right, what did that earn you?' 'Well nothing but—', 'Well, don't do it again' [laughs]. So nobody really was interested."* (Michael)

It was also common for community pharmacists working in pharmacy chains to describe a conflict between their organisation's values, which they perceived to be rooted in business, and their own values, which they predominantly described as being rooted in patient care. Organisations were concerned with profit, which, for a number of participants, this conflicted with their personal values. Participants drew on professional codes of conduct to justify non-compliance with requests from management that were not aligned with their values:

> *"When I said I wouldn't do that MUR, one of the managers said, 'Your priorities don't match the store's priorities'. And that's absolutely right. You've said it pretty much as it should be. My priorities are not the same as [the organisation's] priorities. They go on about saying, 'Oh. We're patient focused, blah, blah, blah.' I mean, it's clear. They're not. It's day and night. They're not."* (Bashir)

> *"They've got their own pressures to deal with, and you can understand that. But as a professional, you just have to draw the line."* (Zahid)

In contrast to the other pharmacists in the study, Oliver was able to position his work in relation to a business-focused ethos, by aligning the business aspect of pharmacy with his vision for change. For this participant, the emphasis on profit and business did not undermine his healthcare profession status, but instead he suggested "*you have to be able to do it all"*. His role as superintendent created a

vested interest in running a business that was profitable. He described an interest in learning to be business-savvy:

> *"You need to find effective ways of using the money and you do a lot of cost analysis, so that enhanced a lot of my understanding of economics and how to make the best use of money."* (Oliver)

5.5.3 Micro Level: Forced to Prioritise

At the micro level, it was apparent that the participants could not "*fit it all in*" (Kalpna), as participants experienced a sense of work overload. They responded to the addition of new responsibilities onto existing work in different ways. Several participants reported trying to "*balance"* (Michael) or "*juggle*" (Kalpna, Dev) the tasks they had, to try and meet patient needs:

> *"I can feel kind of too overwhelmed with it. Yeah, but the majority of the things, I think from one of the things was to just kind of juggle everything in it around-- juggle everything around and just kind of fit everything just to make sure everything is everything is done in time."* (Dev)

> "*In a course of a day, I have to juggle, say, like 10 baskets awaiting patients or to go and do a UTI. So you do it. You don't turn people away. That is something that's ingrained within us. I suppose we're old-fashioned in that way. We don't turn people away. We will try and manage in between. So we do them."* (Kalpna)

Two participants specifically use the term "juggle" to explain how they are trying to manage both the dispensing of prescriptions and the extra roles of pharmacy. This reflected the precarious situation individuals found themselves in as they tried to take on responsibility for new roles whilst maintaining existing responsibilities. When juggling was not possible, participants found they were unable to complete all the responsibilities and instead had to "*limit and focus on the essentials"* (Zahid) and "*pass on the things I couldn't do*" (Kalpna), and therefore had to limit the number of activities they could complete:

> *"It's just basically trying to keep the balance-- trying to keep the balance as well. You can't provide the clinical services, but then sometimes the rest of the work is too much time. So, 'Okay, I can't do it this time, but we'll do it next time'. It does happen in terms of like-- not everything, but in terms of the MURs. So it's like-- and also, they've reduced the number of it. So then we basically-- if there is anything we need to do and it's not the right time, it's just basically we've got a big queue, and then I tend to say just have-- okay, if it's not urgent then we say, 'Okay, we'll do it next time'." (Dev)*

Through probing, it became apparent that the *"rest of the work"* was largely situated in medicines supply. When forced to prioritise, the dispensing function consistently took priority over newer roles, such as services. Dispensing was prioritised as a time-sensitive task due to the unpredictable nature of walk-in patients. Participants

reported having to be reactive to this patient demand, which resulted in behaviour driven by the expectations of others:

> *"There's going to be one patient who's getting annoyed because the pharmacist is too busy with another patient and you come back and you'll get loads of, like, awful comments. I mean, I still get the odd comment just because I've got my lunch that's for 30 minutes, no prescriptions can be checked or given out and I just think that there's that aspect."* (Bashir)

Both Michael and Ellen provided examples of change that related to withdrawing a service, rather than implementing something new in their practice. Ellen withdrew a dossette service and Michael withdrew a prescription collection service. Zahid also expressed that he was "*thinking of withdrawing from the NUMSAS service… because I was getting behind on other work*". These individuals made their decisions for similar reasons; to maintain dispensing and the provision of other income-based services that were a considered higher priority.

A lack of time is a common theme in the practice change literature (Saramunee et al., 2014; Duckett, 2015), and this was referenced here, but more in relation to the prioritisation decisions community pharmacists had to make about where their time and energy would be spent. A widely held concern by participants was that change was being undertaken in an unsupported way without adequate staffing resources and would lead to an increased risk of errors. Patient safety is a critical component of the pharmacist role, and the volume of work, perceived to be created by change, was concerning to participants "*from a safety point of view"* (Sophie). Adding new responsibilities on top of existing workload created concerns for community pharmacists about their ability to cope effectively without making a potentially serious patient error:

> *"You feel like mistakes are going to happen. I mean, mistakes happen anyway because we're human but it just feels like that's a way-- a mistake waiting to happen-- if you don't have those kinds of support levels. If you're taking on too much." (Luna)*

> *"... I've just got to get on with it and, again, hope I don't make any mistakes. I guess it's a safety thing and I don't think either the patients or my employers probably take the safety side of it as seriously as me. Because I know that the responsibility would land on my shoulders at the end of the day rather than anyone else's. So I'm thinking, always, from a, 'How is this possible to do this without making mistakes, and how can I do this the safest way I can?'" (Ellen)*

Ellen describes the responsibility of patient safety that would "*land on my shoulders"*, a visual metaphor that suggests the physical weight and burden of responsibility she feels for managing medicines safety. This not only reflected a concern about patient safety, but also concern that she would be blamed and face

repercussions from her employer or the professional body should an error occur. Several participants highlighted specifically "*deferring"* (Kalpna) or "*refusing"* (Bashir) to provide services as it was perceived to be unsafe. In addition, several participants expressed a conscientiousness to *"deliver a standard"* (Luna) that they did not want to compromise by being overstretched. Safe medicines supply requires commitment and attention to task, which is conflicted in situations where attention needs to be diverted to many tasks simultaneously.

Even with prioritisation, the volume of work on a day-to-day level was "*hectic" (Sophie)*, "*ridiculous*" (Bashir) and "*overwhelming*" (Ellen). For Dev and Kalpna, this work overload meant they did not have the mental capacity to engage with higher-level cognitive functions, such as innovation, change, and implementing new services:

> *"From the point you walk into the pharmacy and then at the end of the day when you walk out. There's not even a second that your mind is free."* (Dev)
>
> *"I couldn't think of creative solutions or creative management because it was just the sheer volume. I couldn't deal with that." (Kalpna)*

These experiences highlight the impact of overload on the ability to think about and effectively engage with tasks other than those in front of you. Without the cognitive space to think about new initiatives, participants took a reactive, rather than proactive approach to their workload. Oliver had a significantly different experience. As he was able to delegate the day-to-day running of the pharmacy and medicines supply to employees, he was able to redirect his attention to other initiatives that were more innovative:

> *"If you have the pharmacy working well, and the core business is doing well, then you're looking elsewhere. So you have to have an ability first. You have to have the basics covered… this pharmacy is working well, it's not creating any problems for me in the background, so I can focus and do my novelty stuff."* (Oliver)

Oliver was supported by other pharmacists, an ACT, and dispensers, who were able to take responsibility for the "*basics*". This provided Oliver with the mental capacity to focus on areas of interest and implement change. This is not to say the issues of overwork were not apparent in Oliver's pharmacy, but that he was not directly involved in the supply function to the same extent as other participants in this study. The role of staff members is explored more fully in Theme 3.

5.5.4 Micro Level: Professional Values

The demands of the organisation prompted participants to reflect upon what drove them and what was important to them in practice. Several participants reflected on what had led them toward a career in pharmacy in the first place, to make a "*positive difference*" (Zahid) and to *"look after [patients] the best way that we can*" (Timothy), "*make that difference to patient's lives*" (Kalpna) and "*to help people… not because you want to make money.*" (Ellen). A conflict arose when the expectations of the business did not align with these values:

> *"If somebody was buying sunglasses, make sure you got them to buy some sun cream as well. And if somebody was buying tablets, find out what the pain was so you can get them to buy a muscle rub or heat pads to go alongside it. And I think personally, that's not the reason I came into pharmacy. We haven't trained in trying to force people into doing what we want but that's through advice and guidance in doing what they need to do for themselves." (Sophie)*

Sophie's example described how for her the business element undermined the healthcare role and conflicted with her values and beliefs about the pharmacist's role. She describes this as sitting "*awkwardly*" for her, and was one of several reasons for leaving her community pharmacy role.

Furthermore, participants were particularly concerned that a commitment to revenue reduced the amount of time pharmacists were able to spend on patient care activities, instead creating a culture that focused on *"supply, supply, supply"* (Bashir). Several concerns were raised by participants, including prioritising quantity over quality of services and limiting the amount of time pharmacists had available to spend in contact with patients and customers:

> *"I'd like to spend more time with patients but I cannot do it because nothing will get done in the pharmacy and it's just again, it's supply, it's just supply, supply and supply. Nothing about quality, nothing about really having patient-centred care. I think because you want to have a chat with them but then you're kind of thinking, 'Can you leave now?' When you're in the consultation room because you want to spend time with them but then you also think there's going to be like piles of work left over."* (Bashir)

> *"It was manic, and you half-wished people wouldn't ask for clinical services because you just didn't have a minute to be able to go and do anything, and that saddens me that there's something that we could and we can't do it because we are trapped behind the bench."* (Kalpna)

The description of being "*trapped behind the bench*" is a phrase specific to the pharmacy profession. The "bench" is where dispensing happens, and has clear connections with traditional, technical roles of the profession. This was echoed by Zahid, who described dispensing as being "*stuck behind a wall somewhere"* and

Luna who was *"stuck at the back of the dispensary".* These descriptions indicate how pharmacists perceive dispensing to be holding them back, both physically and figuratively, from patients and from new roles.

Also of note, Kalpna's description of wishing "*people wouldn't ask*" is reflected in Bashir's example of moving patients on to get back to prescription checking to deal with the "*piles of work*". Note his repetition of the word "*supply*", emphasised as a key responsibility, one that overrides all other tasks. It is interesting that despite being guided by a professional desire to make a difference to patients, the majority of participants continued to focus on dispensing as a core priority.

5.6 Theme 3: Networks of Support

This theme is about the relationships with others that were central to the change process, both within the organisation at a meso level and outside the organisation at a macro level. During the analysis it became apparent that community pharmacists lack robust networks of support. This was largely the result of being lone practitioners, working in isolation with small teams of support staff. The extensive references to the lack of relationships and networks made it worth unpacking where support does come from, where the gaps are, and how this influences the change experience. This section discusses this theme under the headings outlined in table 5.3.

Table 5.3: Networks and relationships theme: sub-categories

Plane of Analysis	Subcategories
Macro	An insular profession
Meso	Engagement of the pharmacy team
	Peer isolation
Micro	Professional development

5.6.1 Macro Level: An Insular Profession

Several participants highlighted how, on a macro level, community pharmacy was an outsider in the NHS and lacked a voice in the wider healthcare landscape. They described how the profession itself had been "*left out of lots of loops*" (Luna), "*out on its own*" (Zahid) and "*so fragmented*" (Bashir). So when it came to moving healthcare forward, there were "*missed opportunities*" (Timothy) for change across the whole of community pharmacy. As a result, participants suggested that other professions and the public *"don't see anything worthwhile coming from community pharmacy"* (Bashir).

Luna, who has taken on a part-time role with the CCG, describes how she came to realise through her first-hand experience that community pharmacy is left out of the wider healthcare conversation:

> *"... it's showed me some ways where there are communication gaps with community pharmacy, still left out of lots of loops, like-- oh there's been so many supply shortages, and there's a lot of information around managing those and even just around what's available when, which the CCG has access to and does distribute, but not to community pharmacy as a whole.*

> *It's quite ad hoc, see, whether or not your community pharmacist gets that information or not. So that's kind of been an eye-opener."* (Luna)

This "*ad hoc*" distribution of information to community pharmacy suggests that pharmacy is not integrated or centralised within the wider network of healthcare. Participants thought that as a result, community pharmacy "*missed out on opportunities*" (Zahid) that were afforded to other healthcare professionals.

Participants often reported "good" relationships with GPs, but when this was unpacked, they were often unable to give clear examples. Experiences of interaction were largely with reception staff or practice managers, and as a result relationships with other healthcare professionals were largely absent, as *"we work in silos… I think the problem with that is a lot of the time we are doing things is places where they won't be able to get visibility"* (Timothy). As a result, there was a perception that GPs were "*ignorant about pharmacy*" (Dev) as "*we don't have much point of interaction with them*" (Timothy) and the "*professional contact is not there"* (Zahid). There was a sense that GPs were not aware of the changing role of pharmacists:

> *"I think not many doctors value that [MUR] service. They probably don't even think that pharmacies do that kind of thing."* (Dev)

> *"Working in a high street pharmacy, it's very difficult to build contact and have a relationship with a GP."* (Zahid)

In contrast, Oliver was implementing a service in practice that relied upon the support of a GP to implement. In this instances, the GP relationship was central to the experience and this relationship was actively maintained on a professional level:

> *"So I went to prescribing lead and the chief partner, and said, 'Okay, here is something we can do as a community pharmacy to help you'. So we started talking about various things. So we do all these services and they signpost people to us... So I think it all started with having good communications, so I started off by sending them like a newsletter every so often saying, 'That's what we offer. We've got a new service. If you want to signpost patients to us, this is what we cover', and all that. Also we ensured that the service was robust and it was consistent… So I think we've kind of proven that we can deliver any service. And then take it forward and said, 'Okay, what's next then? We've done this. We've done that. What's important to you? What would help you? What would free up your time?' And essentially they said, 'Well, if you could do the medication reviews, the annual medication reviews, that would be brilliant*.'" (Oliver)

In this example, Oliver is proactive in approaching the GP to build this relationship. His description of "*proving*" the value in the service, suggests that trust needs to be earned in the GP-pharmacists relationship. Oliver goes onto describe how GPs

"*control the game*", indicating the power-dynamic in the relationship and the need to engage GPs to advance practice. This experience of the GP-pharmacist relationship was not reflected in the experiences of the other participants, where relationships with GPs were notably absent.

5.6.2 Meso level: Engagement of the pharmacy team

Staffing was mentioned by a number of participants as being critical in the change process. It was so critical, that when participants in interview referred to "support", this was often a synonym for staff. Competent and well-trained staff members allowed pharmacists to concentrate on other aspects of the role. In particular, Timothy reported a strong relationship with his team that made the job not only "*enjoyable*" but "*possible*". He describes this in terms of overcoming the limitations of his own abilities and lack of time:

> *"And I think for me, I also realized that-- my own limitations. And I think one of those was the fact it's impossible for me to meet the needs of my community especially when you have such seemingly insurmountable challenges in the community and also in your own business as well. So you then think okay, if I can partner with the team, we have the fair chance and I think that's what it's really being, is just really creating the partnership environment for the team and making sure everybody knows that they take order in what we're doing and that they are valued and actually that they are indispensable in what we have."* (Timothy)

This was echoed by Sophie who equally found the support of staff to be essential to allow her to offer advanced services, saying "*you just can't do it if you've not got the support from your staff*" (Sophie). In contrast, other participants report the struggles of having staff that could not be trusted to take on responsibility. This was reported as a considerable source of stress as *"the pressure comes straight back onto the pharmacist"* (Kalpna). Ellen provides an example of a staff member who was unable to provide effective support:

> *"I ended up taking on all the stuff that she couldn't do, because she actually, I think, sort of-- not intelligently, but she just couldn't manage it. She doesn't have a logical personality. That sounds awful, but she couldn't manage all the different factors, all the ordering, all the preparing. So I ended up working extra hours… because I just thought that it just needs to be done*." (Ellen)

This experience contributes to the sense of overwork explored in Theme 2. A more pressing issue for many of the participants was *"a decrease in staffing levels*" (Sophie) and "*staff shortages"* (Kalpna) that were primarily attributed to funding cuts. This left participants to "*try to cope on your own*" (Bashir).

Timothy highlighted how many of the current education opportunities were offered to pharmacists and pharmacy technicians, but not other members of the pharmacy team:

> *"I think also, maybe, there is a lack of a training opportunity sometimes for the whole team. So maybe, for the pharmacist and the technician, they have some of their training available that can been facilitated for them. But I think there is the-- I think we need to fully grasp how to train the whole team, that is the whole community pharmacy team."* (Timothy)

Without wider opportunities for staff training, the responsibility for upskilling staff then often fell to the pharmacist. Dev describes this as a challenge "*because of the busy environment it's difficult to train staff members*" (Dev). This meant staff training added another responsibility to pharmacists who were already overloaded.

5.6.3 Meso Level: Peer Isolation

The nature of community pharmacy practice provides few opportunities for day-to-day interaction with others. Community pharmacists reported being physically isolated from one another, often working as the only pharmacist in a community pharmacy or with a very small number of colleagues. This physical separation resulted in being "*isolated*" (Timothy), "*lonely*" (Ellen) and "*disconnected*" (Luna), with community pharmacists lacking interaction and support from peers and colleagues. As Bashir states "*I'm actually quite amazed when I get to talk to another pharmacist during working hours because it's always such an isolated job"*. As a result, the majority of participants described the apparent impact this had on the ability to advance their practice, explaining there were few opportunities to discuss issues with peers or other healthcare professionals. Participants expressed a desire for more connectivity and saw the importance of this to their experience of change:

> *"For example, for GP practice you've got other healthcare professionals you work with. You work with a doctor, a nurse, you've got three or four professionals working alongside. With pharmacy, [the] pharmacist is on his own, as a top professional in the area, has got no other profession to sort of be around with, to bounce any ideas, or solve problems together. It's always met by you being the answer to everything. You have to be an answer to all solutions and you have to answer queries, solve problems, plan activities… the answer comes from you. You just don't have that professional angle from somebody else."* (Zahid)

> *"I think if I'd got colleagues on hand that I could discuss things with-- I think that would have helped. Because you've got somebody, then, who understands what you've actually been through and what you've done. When you've got nobody else in the company, nobody else, locally, doing the same as you-- when you come across the difficult situations, it's sometimes nice to be able to talk them through with a colleague, and I didn't*

> *have that… clinical supervision [is] non-existent in community pharmacy… And there was no opportunity for anything like that."* (Sophie)

There is pressure involved in "*being the answer to everything*" and both Zahid and Sophie describe a reassurance that would come from sharing challenges with others and problem solving collaboratively. Although many of the participants worked with pharmacy technicians, dispensers and/or ACTs, these was not perceived to be the same as connecting with someone who has the same background as you. In particular, pharmacists wanted to connect with participants who had similar professional experiences to themselves and who could understand and empathise with their experiences of changing practice:

> *"It's quite a lonely position being a community pharmacist because you're in charge of so much on a day-to-day. But everybody that you're working with has not got the same background as you. They haven't been to university and they haven't ever had to run a shop or been a responsible pharmacist. So they don't really understand your worries and concerns, necessarily. And the only other pharmacists you'd be dealing with is probably your boss. Who again, hasn't got the same priorities and worries as you. So yeah. So other pharmacists that are in the same sort of position and know the same sort of things and have been in the same sort of situations. Yeah. It's really, really important."* (Ellen)

In addition, participants were selective about which peers they engaged with. This was because individual pharmacies have different ways of working, which could inhibit the understanding of individual contexts and as a result may not get valuable advice from outside sources.

> *"A lot of pharmacies don't do nursing homes so it's quite a different. There's quite a lot of things that are done slightly differently or issues that come up that aren't ones you encounter in ordinary patients. In residential care patients, there's different problems that arise that you won't necessarily come across… other people in community wouldn't necessarily know what I was talking about" (Luna)*

> *"I know that asking someone from another company what they think isn't going to change my bosses mind.*" (Dev)

This highlighted the differences in the context of practice and the varied responsibilities of individual pharmacists. As a result, several community pharmacists in this study were stumped by the question of who was involved in helping them to implement change or who they turned to for help and advice during practice change:

> *"Interviewer: Who supports you during this process?*
> *Dev: Um, I don't know really. I guess not really anyone."*

> *"That's a really hard question. As a locum, because you don't necessarily have those networks... I think as a locum you're often on the outside.*"
> (Luna)

Where peer networks were discussed, these were often described as consisting of a single individual or a small group of individuals who could be contacted to answer specific questions. These relationships tended to be informal and mostly existed remotely, due to the geographically isolated nature of pharmacy:

> *"We [are] people that's met and got on well at a conference, similar interests and that, and it sort of grew as word spread to most of the stores in our region...But we do share things that we've learned, things that have gone wrong [laughter]. Little things like 'where is the button for this training?' 'Why is that not working?' 'Who do you call for this?' and that sort of thing… we all have different skills that we're sharing."* (Michael)

Trust and perceiving the individual to be competent and experienced were key components of these relationships:

> *"I've got three people that I can possibly ring and be confident in and probably trust them better. Because I've seen them a bit more experienced than me, and probably they've got an added 20 years to my practice, so they'll have seen everything. So they'll have seen it all. So I think I would probably reach out to those kind of people who've been pharmacists for a long time. They've managed big teams, different teams. They were at a different level. They've got depth in the service. They've done everything they possibly can."* (Zahid)

> *"But if it's something more practical and personal than that, I'll almost certainly ask Brian, who's my friend from LPC... If I'm not sure, Brian will know and if Brian doesn't know, it doesn't matter. That's my opinion of Brian, anyway."* (Michael)

At both interviews, community pharmacists discussed the relationships they had established with other pharmacy professionals through participation in a national leadership programme. This was not prompted through the interview schedule, but was mentioned most consistently as the primary benefit of participating in the learning programme. The leadership programme provided a *"camaraderie"* (Kalpna) of people who were "*in the same boat*" (Zahid) where "*you felt safe*" (Kalpna). This experience was critical in making community pharmacists feel connected to a "*network of likeminded people*" (Luna). More than this, the leadership programme allowed participants to meet colleagues they would not have come across in their practice and this "*diversity*" (Zahid) of participants in terms of professional background created connections that *"stretch your horizons"* (Kalpna):

> *"The network that I've had has always just been a small network people that I've known in the area. And once you're in a corporate chain way of life, you're kind of locked in. You just know what they communicate and what's important to them and everything becomes about their circle. Once you step outside of the circle, you get different perspective. You get different view to things. At the leadership program, the people I've met there, they are from all different walks. Different experiences, different skills, they work for different companies. They have worked for multiples in the past, they have*

> *left the multiples for a number of reasons. So, yeah. I think that was quite important. Because again, it just gave me different network to tap into which I've never had."* (Zahid)

In terms of role-modelling practice, having someone who had already implemented a change in their practice was important, as this created a path to follow and a reassurance that the change was possible. Role models were important so participants could see what practice could look like. Luna had started a clinical diploma, and explained how knowing people who have already done the course was reassuring and gave her confidence at the outset to pursue something new:

> *"I know a few people have done the course, and talking to them has also made it seem less daunting because I feel like I can do it then [laughter], if they can do it. And their experiences have been quite positive and quite-- yeah, exciting. So it makes you anticipate it more and think, 'Yes. That is something I want to do', whereas when it's more of an unknown you think, 'Oh. Could I? I could!' So I think that's helped."* (Luna)

In contrast, Zahid explains one reason he has not yet completed a prescribing course is due to a lack of role models:

> *"If I saw a bit more of other pharmacists who are prescribers and positively using that somehow, that could be something of an encouragement. I've not heard many inspiring stories out there to be honest.*" (Zahid)

Not having a positive example of others who were successful in this role created a hesitancy and reluctance to undertake this new role.

5.6.4 Micro Level: Professional Development

There was notable discussion about the professional development needed to take on new roles. Limitations of training workshops were discussed by several participants, who instead perceived value in mentorship and opportunities for feedback on performance. Participants noted that training was often available at a regional level through the CPPE or the LPC, but it wasn't always conveniently located and was often expected that "*I have to do in my own time, at home"* (Dev).

Bashir and Zahid both highlighted a lack of training from their organisations, as Bashir stated *"I got zero training from them ever",* which was echoed by Zahid who suggested: "*We're just told to deliver the service and train ourselves".* This created tensions and frustrations, where CPs felt that their organisations should financially invest in them by providing training time:

> *"I'm currently looking into some of the comments on a forum that I'm on, the company forum about actually—'there's no resources, where's the training?'*

> *I'm not coming across it. It's all expected just you're already trained up on an aspect and you just do it in your own time. So I always find that actually you're spending your own time doing this work and you're not getting paid for it but then you just sort of expected to do it."* (Bashir)

> *"So, yeah, you just have to manage work. And, yeah, you can just see there's no investment. You can see there's no training, actually. There was no central training provided by companies for the new services that came. We were just told to train ourselves. So, yeah, there was no investment in them creating a day's event. And that'll take out all the pharmacists in the business to train for such a new service. Even though the service is there to stay for many years, there's no training available. So you just have to, as a professional, take your responsibility towards it and just train yourself, which is fair enough."* (Zahid)

Although Zahid concluded this example with "*fair enough*", this did not reflect the overall sentiment as both examples highlight an expectation for training that has not been met. Oliver and Sophie highlighted similar disconnects between the training offered and the application of this training in practice. Oliver explains how the leadership course he is currently completing is the only one he has been able to apply in practice. He attributes this to his formal leadership role in his current practice:

> *"I've done many leadership courses in the past… but this I could actually put into practice because I have the experience that I was able to use the tools we were taught… In other roles I couldn't"* (Oliver)

Similarly, Sophie describes how the training she was provided to offer a sexual health service focused on the practical aspects of the service, but neglected to provide training on the softer skills that were required:

> *"We were given the training on how to perform the process, how to fill the pipette with blood sample how to add it into the cast, what order to add solutions in, how long to wait, all of that was done very regimented. Did it help how you then passed on the information to the patient if it's not good news? Not at all."* (Sophie)

She goes onto describe how the role mostly about being *"a counsellor, you are supporting them through difficult times",* and the training provided was not as relevant to practice and did not address her specific learning needs. Zahid shared a more general perspective about the limitations of training, that *"you do CPD here and there but it's not enough to take you to the next level".* The "next level" indicates the anticipated demands of future roles are perceived as a significant step up from current skill levels.

Zahid, Luna and Sophie proactively suggested education support that they would find value in the change process. The examples that emerged from data analysis

were linked to mentorship and the opportunity for guidance and feedback from others. An absence of feedback was specifically highlighted:

> *"The thing is, you don't get feedback from anybody else. You just do things because you think it's the right thing to do. You know you're going to aim to include the asthma control over long term. You don't get any feedback from doctors or nurses. They get your letters, they get people in for reviews, treatment get changed, but you don't hear anything back." (Zahid)*

Without mentors or supervisors to provide feedback, this led to uncertainty during the change process. Sophie describes being the first person in her company to undertake a sexual health service, something that is fairly novel within community pharmacy. She describes how *"being the only one in the company running the service, I think I was feeling particularly isolated with some of the challenges I was coming across"* (Sophie). As a result, she felt she didn't have anyone to support her through this process and this lack of guidance became a cause of stress:

> *"When you're in situations where you are working essentially on your own. Not knowing if you're doing the right thing all the time, it's challenging. And you want to do your best for the patient. At least I hope all pharmacists want to do their best for their patients. And I sometimes would go home and dwell on things and think, 'Oh, if I had done it this way', or, 'Should I have done it this way?' It was-- [long pause] it was exhausting."* (Sophie)

Sophie's example highlights how she is second guessing the decisions she has made, as a result of being the sole person responsible for decision making. Luna echoes this, describing there are "limited options" for support in the practice environment and highlighting that whilst you may have "*colleagues that you can ring… it's not really the same as all being in one working environment".* She compares this to a hospital environment, where support and feedback were frequently prevalent.

5.7 Theme 4: Psychological Safety

This final theme that emerged from the analysis, focuses on a perceived sense of safety and belonging throughout the change process. It is important to note that "safety" here does not refer to patient safety, but safety for the community pharmacists themselves, to feel secure in their role during periods of change. Whilst never asked directly about or referred to overtly in the discussions, the stories told by the participants and their experiences spoke of a desire for stability. In some cases, there is a search for an organisation and a culture that aligned with aspirations for change. This created a sense of security that was not found in organizations where support was lacking.

This theme also deals with the emotional responses to change that came to the fore during interview. Theme 1 noted the stress responses that were a direct result of a lack of autonomy and control of the change process. The interviews generated considerable discussion of the impact of change on the individual wellbeing of the participants. This appeared in relation to physical and psychological wellbeing, work-life balance, and their feelings towards their role.

This section discusses this theme under the headings outlined in table 5.4.

Table 5.4: Psychological Safety Theme: sub-categories

Planes of Analysis	Sub-categories
Macro	Instability of the profession
Meso	Recognition and appreciation
Micro	Professional identity
	Stress and burnout

5.7.1 Macro Level: Instability of the Profession

At the macro level, many of the participants raised concerns about the future viability of the profession. Two key changes fed into these concerns: the cuts to funding in community pharmacy which resulted in "*our belts just tighten all the time*" (Zahid) and the removal of the MUR service in the latest CPCF, which was perceived to be indicative of a "*failure*" (Bashir) of the profession to provide this service successfully.

Funding cuts were a particular sources of concern, as "*funding cuts are just getting worse and worse and worse"* (Bashir), which was important as "*it's all going back to the financial bit. It always comes back to that"* (Oliver). Funding cuts had several

implications for pharmacists at the meso level: it put a "strain" (Dev) on pharmacies in terms of operations, it "*reduced our staffing levels*" (Ellen) and limited "*training and investment in staff*" (Timothy). At the macro level it also sent a negative message about how pharmacy was valued within the healthcare sector. As Timothy states *"I think that [it] really undermines how people perceive community pharmacy"*. Zahid explains his perceptions of the MUR service withdrawal:

> *"In a way, that [MUR] service going away showed that pharmacists did those services really badly. Why could they not just improve the service and leave it with pharmacy. The service is gone forever. Never to be seen again… So it's sort of a stain on the profession in a way, that we couldn't do medicines management, we couldn't do medicines optimisation in a good way"* (Zahid)

> *"The NHS are definitely asking questions. Do we need this service? And that's why I think they cut the funding. They don't see value" (Bashir)*

Participants frequently discussed the future of community pharmacy, and discussions were characterised by two different attitudes: participants who were fatalistic about the future of pharmacy, and those who saw potential in a changing landscape following the launch of the new CPCF. Michael and Bashir were both cynical about the current state of pharmacy practice and concerned for the future:

> *"I've grown up as it were with the-- with this idea of we're the brink of something great and on the horizon of great change and we'll be doing hub and spoke[3] and they can do everything. We're going to stop doing prescriptions and start doing our services. And I've heard those headlines, you know, a white paper's come out that's going to say how great pharmacy is going to be and the NHS really recognised our value. That headline has been there my entire life. So how well are we doing? We're doing terribly."* (Michael)

> *"Because essentially, the dispensing process could even be done by robots and have distribution centres and people that are used to technology as they are nowadays, why would they give them-- in a pharmacy, they can collect it from a drop-off point or have it delivered to their doorstep. So actually, for me, it's a matter of survival of the pharmacy profession altogether, we need to be doing more than just dispensing. Because anyone can do that."* (Oliver)

Oliver's mention of the "*survival"* of the profession was frequently mentioned throughout participant experiences. This reflected concern about the viability of the profession in the future in pharmacists could not take on new roles. He goes onto state that unless the profession can adapt "*pharmacy as we know it will vanish*".

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[3] A "hub and spoke" dispensing model refers to the assembly of prescriptions in a large scale automated "hub", which are then sent to "spoke" pharmacies for distribution

Whilst all participants shared concerns about the future of the profession, Kalpna and Timothy offered more positive perspectives:

> *"A pharmacy graduate standing at this precise moment has got so much potential. It really is good. I think there are a lot of people out there who are very negative, but to be honest, I think the options and the career of options and the amount that we can do has exponentially improved. And it's actually quite exciting to be a pharmacist."* (Kalpna)

These positive perspectives were at odds with current experiences, which were grounded in stress and frustration, but there was "light at the end of the tunnel" seen in the future of the profession by some. This was characterised by a perceived opportunity to do more with the pharmacist's skillset.

5.7.2 Meso Level: Recognition and Appreciation

Participants wanted to feel recognised and appreciated for their practice, particularly when trying to implement change. They wanted others to "*recognise our value*" (Michael). For pharmacists working as employees, there was a widely reported a lack of recognition and appreciated for their change efforts by their organisations:

> *"You're sort of replaceable for these big companies. I'm not sure they value you too much as long as somebody can come and do a job, I think everybody's replaceable for these big companies."* (Zahid)

> *"I remember showing them all my certificates at interview and it just didn't seem that important. It was like, you've got a pharmacy degree, right? Okay, cool" (Bashir)*

> *"I used to do tons of CPPE courses and after the ATAMUC, I did none for several years because I thought, "Well, who cares?" Who is fussed if I spend my own time learning about this, that and the other? I might be able to give a better MURs, I might be able to give better advice on the counter but I don't get any recognition at work, I don't get any pay for it, I don't get service for it. I get bugged by staff on Christmas because I'm spending more time than another pharmacist would, trying to give better care. But again, with nothing, no recompense. There was just no appetite for a great pharmacist. The appetite was only for a body to stand at the front and open the shop and check prescriptions."* (Michael)

He goes onto say "*It just gets you a bit despondent when nobody cares".* The lack of appreciation from others reduced the aspirations of participants in enacting change. Both Michael and Timothy used the phrase "*good not great*" to describe what others expected of community pharmacists.

Patient expectation and appreciation of the pharmacist role was also mentioned by participants. There were mixed perspectives on whether patient's appreciated the extended role of the pharmacist. Dev states "*patients don't see us as clinical*

practitioners" and a clinical role was seen by patients as "*not what pharmacists do*" (Michael). Michael provides as example of completing a clinical examination course, and returning to practice to use his skills:

> *"I bought an otoscope and I remember the first patient I used it on was-- he looked at me with horror as I cleaned it as if I was doing something way out of my depth"* (Michael)

This response, combined with a lack of appreciation from his organisation, resulted in Michael declaring that "*the batteries eventually ran out*". This expression reflected the reality for the equipment, and was an analogy for Michael's fading enthusiasm for this role.

In contrast, Sophie described how, over time, expectations of her patients shifted as they became accustomed to new roles and ways of working in the pharmacy:

> *"They were very used to having a very quick turnaround time at my pharmacy. Never keep your patient waiting more than 10 minutes at an absolute push. But they saw all the benefits that it was bringing to their community pharmacy. As a village setting, to be able to access a lot more than they previously had and the flu vaccine being an absolute key wonder. The first year we did about 15, and by the end, we were doing over 100 in a flu season. The fact that they knew these things would mean a time they would be waiting for longer, and they were just really supportive of having these options available to them."* (Sophie)

Sophie's example indicated how new services were accepted by patients as they saw value in the services offered. She goes onto describe having a good "*rapport*" with her patients, as the village setting of her pharmacy meant the majority of her patients were "*regular clientele*". These personal relationships allowed patients to more readily accept change.

5.7.3 Micro Level: Professional Identity

Identity played an important role in the experience of change for participants interviewed, as they had role expectations and a professional identity that may or may not align with the direction of change. The conceptualisation of a professional identity was interestingly not shared across the participants and this was an area where experiences diverged. Some participants were connected with the idea of a clinical future, as a way of using "*the knowledge that you've spent years gaining"* (Michael), whilst others rejected a clinical remit at odds with the role identity of a pharmacist. For example Ellen states *"I never wanted to be a doctor. Never wanted to be a nurse".* These pharmacists saw safe and efficient medicines supply as the primary focus of their role.

Ellen and Dev were passionate about their role as scientists, embedded as a dispenser of medicines, considered to be a more traditional roles for the profession. This led to a perceived conflict with change and new roles that moved them away from this established identity into something that was more clinical. Ellen makes the case for a medicines-based identity most strongly:

> *'I was always good at science, and I enjoyed science, and I enjoyed sort of the logical sort of scientific you're right or you're wrong, and so I liked the sort of the working sort of lab-based thought or feel of a dispensary...I didn't want to just be stuck in a lab, so having customers coming in and everything just felt like actually, that's the best of both, isn't it? I get to do* everything *I enjoy. Chat to people, work in a shop, do a bit of sciency stuff....my technicians now, I look at them and I think, 'Oh, you're doing what I joined pharmacy to do and I feel like I'm doing a much more clinical role than I wanted'... So it is sort of getting further away from what I enjoy." (Ellen)*

Ellen sees the role of a pharmacist moving away from what she enjoys and the reason she came into the profession. In this respect the dynamic and evolving role of a pharmacist has not moved in a direction that works for her personal and professional motivations, as "*it does seem a bit sort of further and further away from what it was when I started" (Ellen)*. As a result, she appears to reject other roles/responsibilities that conflict with this embedded identity. She highlights the centrality of the dispensing role to be critical to her experience of being a pharmacist, and expressed a strong desire to maintain a medicines supply role:

> *"Interviewer: How would you feel if there was a machine or someone else took over the dispensing element of the job?*
> *Ellen: I think I'd probably feel like actually the point of-- I think that really would be the end of me being a pharmacist because that doesn't feel like being a pharmacist anymore. That feels like being, I don't know, a health advisor or a doctor. You're not physically supplying medicines anymore if someone else is doing that for you… I think I would probably want to give up my job and become a technician."*

A more clinical role appears to be unappealing. She specifically highlights the task of administering injections as being linked to the role of a nurse. For Ellen, the pharmacist role is more aligned with that of an expert technician (Rapport et al., 2009) as she asserts "*I'm happy sticking labels on boxes".*

In contrast, other participants had identities more strongly linked to clinical practice and were positive about their role as "*becoming more clinical and less about dispensing*" (Luna). For these interviewees the changes that move the profession towards a more hands-on clinical role aligned with their identity vision.

Sophie and Michael are clear that they perceive themselves first and foremost as healthcare professionals, describing roles that involved providing services and optimising medicines and rejecting the identity of dispenser:

> *"I love services... It's delivering patient care at the point where it's most needed, and be the, I think, services are the way you use the knowledge that you've spent years gaining...I never pictured myself just stuck behind a counter, counting tablets for 40 years. I can't think of anything worse."* (Michael)

Many public health and clinical roles are not unique to community pharmacy, and are being provided in other healthcare settings by other providers. Participants attempted to create clear boundaries and make the distinction between the pharmacist's role and that of other healthcare professionals:

> *"So actually giving injections felt to me a bit-- that's a nursing role rather than a pharmacist's role." (Ellen)*

> *"It turned me into a phlebotomist… that's not my expertise"* (Sophie)

Despite this apparent conflict between the identities of these participants, there was general agreement that pharmacists' main expertise and unique contribution to healthcare was their expertise in medicines. As Sophie describes: *"my knowledge of medicines is the area we're trained in, that we're specialised in."* Holding onto this medicines-focused aspect of the role was important for many of the participants, as it was the differentiating factor between pharmacists and other healthcare professionals. As Dev describes "*it's what makes us different".* The concern was that this unique skill could be lost in the move toward a new practice paradigm:

> *"The more on the clinical side we go, we kind of lose a little bit of the medication knowledge"* (Dev)

Perceptions of age also appeared to play a role in how pharmacists identified. Kalpna described herself as a "*dinosaur of the profession*", Luna was concerned about "*becoming a relic*" and Ellen described her perspective as "*an old-person thing" (Ellen).*In contrast, Michael says "[I] *see myself as a young pharmacist*" and was eager to identify himself with the newer generation of the profession. Ellen and Luna, who has been in the profession for some time, expressed concern that they would be replaced by a "*younger generation*" who had learned the skills needed for a new paradigm of practice. For pharmacists who were more recently qualified, there was a conscious effort to disassociate themselves from the "*old*" pharmacists who "*don't want to do anything, just stagnate*" (Michael). This created the perception of a divide between the young and old, the former who were perceived to embrace change and the latter who were perceived to resist. Attitudes towards change in this study were mixed and did not necessarily align with age or duration in practice, but this perception was widely held.

At the meso level, having a sense of identity that aligned with the organisation created a sense of belonging that supported change. The pharmacy owners and superintendent pharmacist clearly demonstrated a commitment and a sense of belonging to the pharmacies that they ran. Timothy described this as a local culture, and the value of being in a small organisation where you can dictate your culture more effectively:

> *"I think also, it's much more easier to influence culture. Because the culture that exists, which is got the positive and I guess the negative, because I'm also conscious that if you're working with the "'n our' environment, or you're working 'in my team', the culture that's created in this team is not one that necessarily exists in every team. So you may find, 'Wow, this is how everybody does things', and then you have a reality check when you come across other ways of doing things that's not really there. So there is also sometimes the fact that in the independent pharmacy there's usually small teams that the leadership structures are very small. Or sometimes, there is no structure, there's just the one person. And that one person is the secret to the whole culture, the whole agenda, the whole-- well, everything, there."* (Timothy)

Similarly, working within an organisation that has the same priorities as you can be a powerful driver of change. Luna, who moved into a new job to pursue a clinical diploma, describes actively seeking out a culture that represented her personal vision for her future self in order to support her in change. She sought out an organisation whose "*vision aligned quite well with where I wanted to go*": She describes this as an important facilitator for changing her practice:

> *"I think the biggest reason why I'm acting on it [the change] is because I made a move to somewhere which, that's the way they're going, so that's the way I'm going too… I think having an environment which supports it, it does definitely make it a whole lot easier. For a start there are external prompts to do it...I think having an external environment, firstly it facilitates doing it. There's more support and [long pause] um, it definitely makes it easier... So for me I found it easier because maybe I'm just lazy [laughs] and I wouldn't want to take on the extra pressure of trying to do it in my old environment because that would've been quite difficult." (Luna)*

5.7.4 Micro Level: Stress and Burnout

As a result of the challenges that have been presented throughout these themes, pharmacists in this study reported the emotional and mental efforts required in current changing practice. Participants described how role overload and the pressures of practice resulted in individual stress at the micro level. Participants described this in multiple ways including "stress", "exhaustion", "worry" and "drain". The volume of work combined with reduced levels of funding, and concerns about safety, and worry about the future created the overarching pressures felt in trying to manage change in community pharmacy practice:

> *"The company wasn't giving me the support, staffing, ACT-wise, pharmacist-wise. It wasn't being provided and me personally couldn't take it, do it any further. I think I'd, unless I just worked there I think, what, 18 hours a day, you could not have completed the work. It wouldn't have been ethically clinically safe to do that volume of work, so I knew that I'd reached capacity, and I think health starts to suffer… I felt let down that they couldn't recognise what needs to be supported. I felt I was on my own. I didn't really have a voice to say anything further because the answers were always that everybody's short. There isn't any more support."* (Kalpna)

> *"I think I've almost burned myself out because I'm like, 'I want to do some knitting. I want to do some reading. I want to spend more time with my family' but I have to also work full-time and walk the dog, and all the rest of it. So I think it's just part of my personality. I feel like I have to do everything. And yeah. That isn't a very good way of managing my life." (Ellen)*

Ellen's example highlights the impact of workload on her personal life. It impinges on time spent with her family and opportunities for hobbies and personal interests. She feels like she "*has to do everything*", indicating a high level of responsibility she feels to her pharmacy role. This is echoed by Luna, who also described the compromises she had made in her personal life in order to meet the demands of her job:

> *"October's been difficult because there's been a lot of extra evening meetings on top of working days. And the two days that I'm not working in the pharmacy because I'm doing surgery work. But I do keep that limited to school hours, so I'm still available before and after school, which again is partly the reason I took that job is because it had that flexibility, and it means I can still be there. One thing I find quite hard is that I used to help with the schoolwork. I can't do that anymore."* (Luna)

Both Sophie and Ellen reported taking the mental strain of work home with them. Ellen described how she would *"spend a lot of time outside work worrying about it"* and likewise Sophie indicated how she *"would go home and dwell on things".*

These psychological responses reported were associated with a lack of job satisfaction and reports of intention to leave. Dev describes how he lacks a sense of achievement working as a community pharmacist:

> *"Well, it does build on stress. Yes, it is. Sometimes you do feel a bit low, but then-- I don't know how to explain it, but there's just lack of satisfaction that you feel that you aren't achieving much. You're just in a continuous race. It's just basically if you're running, you run when you've got the strength. When you start then you keep running. Then after a while you run mile two, mile three, mile-- you just can't run forever. There's a point then you've got to stop, and that doesn't happen in the pharmacy, community pharmacy. You're always running after something. You can never stop."* (Dev)

Dev describes a sense of feeling that no matter how much he does, it is not enough as there is always more work to be done. Participants frequently described being

"*mentally tired*" (Kalpna), "*exhausted*" (Dev) and "*burnt out*" (Sophie). Most seriously, Kalpna described how the stress of the workload had "*taken a lot of toll on my physical health"* and Ellen reported a deterioration of her mental health as a result of work-based pressures to do it all:

> *"I mean the fact that I've had to go and have my antidepressant dose upped recently. I was like, 'Yeah. I know. I know I do too much'. But then I think, 'Well, it is a stressful job because you're trying to please everyone all the time, and the phone is always ringing, and you are doing all that'. So having this break and having a proper break. I mean usually if I've got time off, I'm just at home, and I'm doing CPPE, or I'm popping into work [laughter]. Yeah. So I don't really have a break because I feel like I don't want to miss out or get behind on something." (Ellen)*

Trying to implement change against the backdrop of overwork and pre-existing stress created extreme tensions. Despite a widespread acknowledgement that change is ongoing in pharmacy, Timothy describes the funding cuts as "*unchartered territory*" which has created a "*very frightening time*". He jokes that:

> *"for what is usually quite a boring-- [laughter] you know. One of the things that you kind of used to say about community pharmacy, that—'It's fairly repetitive' is a phrase that used to come in. And now the repetition, you know, that could be welcome."* (Timothy)

There is a desire for some stability within the constantly shifting landscape of practice. Zahid described how these stressors influence the ability to engage in change:

> *"Pharmacy is a very tough profession. From the time you open the door to the end of the day, the end of the month to the end of the year, so it's a very tough business to work in and sometimes you just forget yourself because you're in sort of an operator mode, you just turn up, do the thing, save the day, and make sure everything's all right. But you forget about yourself and your thinking processes." (Zahid)*

There are many factors that go into planning new initiatives and implementing change. The intensity of the pharmacist's workload creates a lack of cognitive space with which to consider these changes. Instead, Zahid describes "*operator mode*", which involves covering the basics of the role, but with little opportunity go beyond this.

5.8 Summary of findings

Analysis of the data focused on participant experience of practice change and found four key themes to be central to the change experience for community pharmacists. Each of these themes has been presented through the Planes of

Analysis framework and grounded in the narrative of the participants. It is acknowledged that there is overlap between the contents of these themes, which illustrates the inter-related nature of the factors involved. These themes have been intentionally separated to facilitate understanding and bring focus to areas identified by community pharmacists themselves as being of importance. It is also acknowledged that the separation of these themes is somewhat artificial and that the change experience as a whole is more than the sum of its parts. These themes have offered insight into the experiences of community pharmacist that is both interesting and valuable for policy and practice.

The following chapter collectively discusses the findings presented in this chapter and returns to the research question to bring together key findings, reflects on the methods used and finally makes recommendations for practice and further research.

Chapter 6: Discussion and Conclusions

6.1 Research questions and Main Findings

As a profession we are interested in moving practice forward, and as a result the existing literature has focused on the barriers and facilitators to implementing practice change. Pharmacists themselves have been conceptualised as the ultimate barrier to change (Rosenthal et al., 2016b). What has not been explored thoroughly in the current literature is the impact that change has on the individual pharmacist. A deeper insight into their experiences may shed light on what practice change means for them and thereby enable us to better support community pharmacists through the practice change process. The primary aim of this thesis was to centre community pharmacist experience in the change process. Their experience was considered through three separate, but interlinked, perspectives:

Micro level: the personal experience

Meso level: the socio-cultural context of practice

Macro level: the wider profession and policy.

The micro experience of the individual was foregrounded, but situated within the context of organisational and professional culture, and viewed through the lens of the individual.

This study revealed several key features related to the experience of practice change for community pharmacists, which are discussed below. Although the type of change and the complex interplay of factors at the three levels were unique to each community pharmacist, some shared experiences provide insight into the complex combination of factors that contribute to the experience of change for these members of the profession.

6.2 The Phenomenon of Change

Change was experienced as “top-down” (DeLeon & DeLeon, 2002, p.13) and resulted from both planned and unplanned change. Unplanned change, particularly externally driven change, often took precedence over planned change. The majority of change experiences resulted from “reactive” rather than proactive change (Nadler and Tushman, 1999).The changes described by community pharmacists were predominantly incremental in nature, and practice did not appear to have changed dramatically in the nine months between interviews. An important finding in this study was that change felt ongoing for community pharmacists and, at

second interview, several described how “everything” was different since the first interview. Perhaps this perceived significance of change was that the number of small changes appeared greater than the sum of their parts. This study found that community pharmacy is continuously changing in both small and more significant ways, and community pharmacists are being asked to adapt and meet these expectations on an ongoing basis. The speed at which new policy was implemented provided little time for participants to evaluate the change and consider how best to implement it in the context of their practice. Demands from the profession, from the organisation, and their own internal personal and professional goals often result in competing pressures that make change a challenging concept.

This study also identified that pharmacist’s response to change was more nuanced than previous literature had indicated. Behavioural responses to change are often considered as a dichotomy of acceptance and resistance (Weir et al., 2019). In community pharmacy, literature has focused more on how we might measure and mitigate this (Roberts et al., 2005; Harding and Taylor, 1997). The findings from this study indicate that community pharmacists are continuously wrestling with what can and cannot be done with the resources they have available to them and are implementing new initiatives and withdrawing others on a constant basis. Buchanan and Dawson (2007) argue that change is often “multi-authored” and we see this here with these participants, as each adapts policy and organisational expectations based on their own circumstances and capabilities at a particular point in time. As a result, practice context for each community pharmacist in this study looked slightly different, despite a shared professional agenda. This was often the result of meso context of practice and the micro level interests of the individual. The complexity of factors at an organisational level means macro level change needs to “fit” with local meso level context and what the pharmacist believes can be achieved at the micro level.

The section below discusses the change experience as presented through four overarching and interconnected themes of agency, role tensions, networks of support, and psychological safety. Each theme highlights factors at the macro and meso levels that influence attitudes, beliefs and behaviours at the micro level. This reveals how community pharmacists have experienced a changing landscape and a move toward a new paradigm for the profession that promotes more clinically and patient focused practice.

6.2.1 Agency in the Change Process

This first theme highlights the lack of agency community pharmacists have in the change process. This study was initially designed to explore self-driven change and yet perhaps the most surprising finding of the study is the extent to which the issue of agency was raised in the change experience. The organisational change literature emphasises the importance of inclusion and engagement in the change process (Kotter, 1995) and highlights that one of the primary reasons for resistance to change is a reluctance to lose control. As Oreg states: “Individuals may resist changes because they feel that control over their life situation is taken away from them with changes that are imposed on them rather than being self-initiated” (2003 p.680).

Greenberger and Strasser (1986) define personal control as “an individual's beliefs, at a given point in time, in his or her ability to effect a change, in a desired direction” (p. 165). This aligns with the construct of “locus of control”. An internal locus of control is an individual’s perception that their behaviour impacts events, in this case community pharmacists believe that they have control over their own environment and personal success. In contrast, an external locus of control is the perception that events are the result of external forces (Rotter, 1966). This suggests that it is not the objective level of control that is important, but the subjective perception of control by an individual. Although participants may objectively have some agency over their practice, a widely held experience was that change was controlled by external macro and meso level factors.

Pharmacists who had an internal locus of control, such as Oliver, believed they had the influence to make change happen and direct their practice in a direction they had chosen. More commonly, participants had an external locus of control, believing that NHS policy, the profession or commercial pressures drove change in their practice.

The involuntary nature of change, reported by participants, resulted in little opportunity for control, and greater uncertainty around change and what this meant for their future. Although the issue of agency, more usually described as “autonomy” arises in the existing community pharmacy change literature (Perepelkin and Dobson, 2009; Marques et al., 2018) the impact of this on the individual is not well explored. For example, Marques and colleagues (2018) identified autonomy as a theme that described “one’s ability to plan one’s own workload” (p.181). What this means for the pharmacist themselves or for the change process was not well articulated in their findings. The corporatisation of

community pharmacy has been a topic of interest for some time (Rosenthal et al., 2010; Bush et al., 2009). Bush and colleagues (2009) highlight ‘control’ as a core dimension of corporations, whereby control is “exerted by minimizing the skilled activities of the workforce” (p.307). Through this data, we have insight into the lack of control felt by pharmacist employees of corporations. This lack of control appears to hamper their ability to take ownership of their own practice, as it relates to practice change. For those working in corporate organisations, there were corporate managers at the meso level that challenged agency. This was particularly jarring for participants who perceived corporate managers as not understanding professional practice. This seemed to challenge a hierarchy, whereby pharmacists felt as professionals they merited a level of agency in their practice. Where community pharmacists were able to more directly influence change through the culture of the organisation, this was primarily linked to holding position of formal leadership within their organisation. It was therefore seen in organisations where the participant was an owner or superintendent.

Other researchers have identified that pharmacists working in independent pharmacies have more autonomy than those working in large chain corporate environments (Duckett, 2015). The findings of this study highlighted that agency and power dynamics in the experience of change was relevant to the majority of participants, although they manifested differently. Owners and superintendents reported a greater sense of control over their own practice and the direction of travel for them and their teams. However, they were not immune to external drivers, although these were more likely to be experienced from the macro level, where policy and funding streams dictated the demands of the service. This created frustration and a sense that valuable time and energy was spent on a developing an initiative that was at odds with external priorities for change. This also illustrated how personal ambitions did not always align with the requirements of the community pharmacy contractual framework.

It was apparent that participants perceived that at a macro level there was a lack of communication of a clear goal for the profession and a roadmap for change. Communication during a change process has been widely researched, and organisational change literature is clear on the importance of a clear communication strategy about every aspect of the change, from explaining the need, to articulating objectives, to generating support and buy-in (Cawsey and Deszca, 2007; Kotter, 1995; Armenakis et al., 1993). Evidence suggests that effective and well-executed communication alleviates uncertainty and enhances morale (Campbell et al., 2015)

A study by Oreg et al. (2011), found that active involvement in the change process, with participants experiencing high levels of participation, resulted in reports of higher readiness and acceptance of change and assessed change as less stressful. The data from this study highlights how a lack of timely and clear communication negatively influences how community pharmacists experience change. Participants did not understand the consequences of change on their roles and professional status, which left them feeling ill-equipped to manage externally driven change.

This study has provided insight into not only how external systems influence the individual, but also how the individual responds and reacts to these influences at the micro level. Participants perceived agency to be linked with professionalism, and sought minor or limited ways of taking control. This could either work toward a change outcome or against it. For others, externally dictated goals caused individuals to lose interest in their day-to-day efforts. This resulted in the adoption of a passive attitude toward change. As Foster-Fishman (2007, p.209) articulates, top-down models of decision making “reinforce a climate of dependency” on others to make decisions and drive change, and removes self-efficacy. Without agency and an ability to influence change, learned passivity can become the norm.

Analysis of these findings highlighted the complex role of community pharmacists in enacting and reacting to practice change. Although not explicitly stated in the literature, the emphasis of practice change discussion often centralises community pharmacists themselves as change agents. That is, individuals who are responsible for driving and delegating change in an organisation. We see the assumption that community pharmacists are responsible for change through questions such as “are pharmacists the ultimate barrier to pharmacy practice change?” (Rosenthal et al., 2010 p.37). The inductive approach adopted in this study provided a nuanced understanding that the role of community pharmacists in the change process, which is complex, multidimensional, and dynamic. This study identified that many community pharmacists view themselves as change recipients (Oreg et al., 2011). The role of a change recipient is to enact change that is primarily driven by priorities outside the community pharmacists’ control. However, community pharmacists are not passive recipients of change. The experiences of the community pharmacists in this study show how they bring their own personal and professional attitudes, values, experiences and identities to the change process. This means they are central, active participants, often with complex affective responses to the pressures that change brought to their working lives (Oreg et al., 2018).

This study has shown that many of the community pharmacist participants are not situated as change agents, but instead they operate as a complex combination of change agent and change recipient. They are change agents in that they are seeking to implement new initiatives in their practice, but this is problematised by external factors at both policy and organisational levels that require them to assume the role of change agent. Importantly, the priorities of change agent and change recipient do not always align, and tensions arise between these roles. The policy implementation literature describes the role of change "translators", who are the "ground level" workers responsible for translating national agendas into local contexts (Lau and LeMahieu, 1997 p.7). Translation refers to the adaptation of an external change by an individual, to enhance fit with the local context (Ansari et al., 2010). This study identified how community pharmacists wait to find out what is required of them by policy, and then how they adapt this into their practice is, to varying degrees, based on the pressure from their organisations, their interpretation of the importance of this to themselves, the fit with their identity and values, and the practical challenges of implementation. They also assess the level of stress on themselves and their teams, and the impact on the customers or patients in their community. Change translators treat policy directives as a starting point (Campbell, 2012), which are then implemented differently in the different contexts of practice.

6.2.2 Role Tensions

Participants often experienced practice change as a challenging addition to existing community pharmacist roles and responsibilities. These were interpreted as role tensions. The challenge of integrating new initiatives into the existing workload of community pharmacy is highlighted in the existing literature (Jacobs et al., 2018; Hassell et al., 2011). It appears that despite ongoing calls for reallocation of dispensing responsibilities to non-pharmacists, this is yet to be resolved, as it was clear from the study data that community pharmacists are largely still undertaking dispensing and medicine supply work. The focus of most participants' day-to-day role remained centred on medicines supply, with a reported lack of other staff available to fulfil supporting roles. Funding cuts to dispensing were arguably intended to push pharmacy towards new roles. However, there appears to be an absence of a plan for who would then be responsible for this work. Patients continue to rely on pharmacy to supply their medicines, and organisations continue to look to pharmacists to lead medicines supply. Without a plan for how dispensing is dealt with, community pharmacists will continue to prioritise dispensing, meaning they will not have the time nor capacity to embrace new roles. Dispensing is a task that holds them back from change, but also, in some instances, something they are

psychologically tied to in the form of a “medicines supplier” and “medicines maker” identities (Elvey et al., 2013 p.322). This appeared to be driven by patient expectations at the meso level, and the demand that medicines be supplied in a timely manner. It also appeared to be driven internally by a level of familiarity and security with the medicines supply and dispensing process. Analysis revealed that the continued focus on dispensing was both a practical and psychological barrier to changing community pharmacy practice.

The tensions between existing responsibilities and the addition of change appeared to represent an important area of discontinuity in the change process. Rather than presenting an insoluble dilemma, many community pharmacists attempted to “juggle” and “balance” their responsibilities to integrate new roles and responsibilities into their practice. The challenge came when they became overwhelmed by the number of tasks, tending to revert to dispensing as the primary function. Existing research has described this as an unwillingness to leave the “comfort zone” of the dispensary (Bush et al., 2019, p.312), although reasons for this are not fully understood (Yong et al., 2020). The experiences of participants in this study highlight less of an unwillingness, and more a complex interplay of reasons, grounded in juggling an unpredictable workload, maintaining safety and meeting patient expectations. Many participants found this frustrating, and appeared to be ready to move beyond the limitations of “the bench”, although one pharmacist strongly felt that dispensing was a core function of the pharmacist’s role.

For pharmacists who wish to maintain their connection to the traditional role of dispensing, this reflects a core part of their job and something they recognise as key to being a pharmacist. Harding and Taylor argue that the tangible nature of medicines creates a “solid” role for pharmacists (2007). For other pharmacists, the fact they were still dispensing reflected a lack of progress and a lack of change at the micro and macro levels. Dispensing was viewed here as a waste of community pharmacist skills as participants wished to implement change that maximised the use of their skills to improve the health of patients. The “under-utilisation” of pharmacists is widely reflected in the policy literature and was echoed here by participants. Community pharmacists train for five years before qualifying, and there appears to be a gap between the expectations of the role and the reality in practice. This confirms findings from other studies reporting newly qualified pharmacists found practice did not align with their expectations (Eden et al., 2009; Noble et al., 2014). The community pharmacists in this study who considered dispensing to be unfulfilling work that failed to make full use of their skills, were frustrated by these responsibilities which they perceived as hindering their ability to change.

It was also apparent from this data that community pharmacists perceived change to be constant and cumulative within their roles, as new changes and tasks were added onto existing tasks. Many aspects of the change experience created practical and psychological instability for the individual pharmacist. At the macro level, the volume of policy, the ongoing nature of change, and the political nature of changes created a sense of perpetual motion that could feel pointless. Authors in other healthcare sectors have described how continuous, incremental movement towards change could be interpreted as "a torturous path to the inevitable" and "unnecessarily frustrating" (Corrigan & Boyle, 2003, p.383). Herold et al. (2007) describe this type of change as "turbulence" and states:

"The preponderance of changes going on in the organisation at the same time as the focal change – changes that represent additional distractions and adaptation demands and thus form an important part of the context for individuals' reaction to the focal change" (p.944).

That is, individuals find it difficult to enact a single change if it is embedded in the context of other ongoing changes (Herold et al., 2007). The data from this study suggests that, for pharmacists, multiple ongoing changes created a source of stress and even though pharmacists often supported the idea of change, their ability to enact that change became difficult in the face of turbulence. The literature on practice change uses words like "transition" and "transformation" (Holland and Nimmo, 1999; Nimmo and Holland, 1999), implying that through the process of change something is given up or relinquished in order for new endeavours to be undertaken. These findings have revealed that this is not the case for community pharmacy. Instead, change is mainly experienced as the addition of new roles to existing ones, leading to time pressures and experiences of overwork.

The multiple, overlapping and continuous nature of change placed demands on community pharmacists who had limited physical and psychological resources to cope with the ongoing nature of change. It has been recognised that:

> *"The benefit to the public of pharmacists services…is dependent on the proportion of time that is devoted to pharmaceutical tasks"* (Fisher et al., 1991 p.2)

The logic follows that pharmacists must be available to direct attention towards new roles if these are to be implemented effectively. It is important to note that pharmacists in the study were overall enthusiastic to embrace new roles, however, the burden of change was high. It was challenging to balance new roles with existing responsibilities, resulting in overwork. Other studies in community

pharmacy have recognised that increased workloads are associated with increased levels of stress, decreased levels of well-being and reduced job satisfaction (Jacobs et al., 2020). This was confirmed by my study, which not only highlighted examples of stress and burnout, but also pointed to volume of work affecting pharmacist's mental health and intention to leave current roles. Participants also reported not having the cognitive space to engage effectively with new initiatives.

At the meso level, the expectations of the organisation play a vital role in the change experience. Priorities for the organisation were frequently described by participants as business-focused and target-driven. These conflicts between business and healthcare roles of community pharmacists are frequently reported in the literature as a source of tension (Scahill et al., 2018; Jacobs et al., 2011; Hughes and McCann, 2003; Bryant et al., 2009) and the *Now or Never* report previously called for the conflict between the priorities of large chain pharmacies and their pharmacists to be addressed (Smith et al., 2013). In practice, these tensions were also identified in this study, confirming this is an ongoing issue experienced by many participants. Participants with non-pharmacist managers felt these individuals could not relate to the challenges or obligations of the profession. Their motivations seemed to be financially driven, sometimes at the expense of professional responsibilities and patient care. The commercial nature of community pharmacy has been a source of discussion in the literature for some time (Hughes and McCann, 2003) and there is a traditional understanding that business and professional values are a source of conflict (Quinney, 1963) and these dual roles are at odds with one another (Smith et al., 1985). In relation to practice change, the struggle between business and profession was frequently discussed by participants in this study, who found a disparity between the community pharmacist's vision for change and the expectations and motivations of their managers. Organisations needed to be financially viable, and the demand for revenue meant that organisations pushed pharmacists to complete MURs and NMSs to meet targets. There was a sense that targets drove quantity over quality, and this undermined the value of these services for the participants. Importantly, this conflict challenged many participants' morals, values and ideals. Participants frequently returned to discussing professional ethics and their priorities grounded in patient care and keeping the patient safe.

Historically, community pharmacists were owners and managers who ran their own pharmacies. One such participant was able to align their healthcare and business identity through embracing the business aspect of practice, as a means to propel new services forward. This was a single experience, but illustrated the potential for

independent pharmacies to align these apparent dichotomies. However, this required a high level of autonomy that came from managing the business aspect of the pharmacy. This was not the reality for the majority of participants in this study.

6.2.3 Networks of Support

The process of change was an isolated experience for many participants, which reflected the siloed nature of community pharmacy practice. At the macro level, pharmacy was perceived to be poorly networked with other professions and the wider NHS. This aligns with existing reports, that describe pharmacy as “an insular profession, busy with its own concerns on debates and decisions in other health and social care organisations”(Smith et al., 2014 p.14).

At the meso level, pharmacy staff were seen as critical to the change process, in freeing up participant time to engage in other roles. This echoes findings from existing research, which found staffing and skill mix to be the most important factors in practice change (Jacobs et al., 2018). Participants with competent, trustworthy members of staff were able to be less actively involved in medicines supply, and have more opportunity to pursue new initiatives. Conversely, staff who were perceived to be less competent were a burden, and participants felt it was challenging to find time to train staff in an already overworked context. The most significant issue, however, was a widely reported lack of available staff to provide support. There are ongoing discussions about restructuring the current supervision requirements to allow pharmacy technicians to take delegated responsibility for the sale and supply of medicines. This reportedly could free up pharmacists' time to engage in newer roles (Bradley et al., 2016). However, low staffing levels were highlighted in this study as a critical issue that would undermine the success of any such approach.

Participants experienced loneliness and isolation in the change process, and expressed a need for pharmacist colleagues with whom they could share problems, concerns and challenges. Pharmacists did not feel integrated into a community or supported by peers or mentors. At the micro level, pharmacists in the study reported feeling isolated, despite many having teams of dispensers, technicians, and other staff members. These colleagues were not recognised as peers with similar professional experiences and challenges. Existing literature focuses on the isolation of community pharmacy from other healthcare professionals and organisations, particularly GPs (Bradley et al., 2008a). This was also reflected in this study, but more specifically, there was a more profound sense of isolation from other pharmacists. Considering this isolation from a situated learning perspective

(Lave and Wenger, 1991) isolation results in other members of the community having minimal influence on the development of the skills and knowledge needed in the context of practice for practice change. Interpersonal relationships are known to be important in the process of change as they enable knowledge sharing through social interaction. Within organisational psychology, knowledge sharing is considered to be a necessary precursor to change (Seitz and Misra, 2020). Pharmacists were also quite specific about the type of support they wanted. They were clear they wanted to connect with colleagues with experience in the same or similar roles. This appears to reflect the local cultures and contexts of practice, and a perception that there are pharmacists who will not understand the specific challenges faced. Even more specifically, some pharmacists spoke of how they wanted someone within their own organisation to connect with, who would understand their specific organisational challenges.

When it came to developing clinical skills, there was a sense that without feedback or the support of somebody with more clinical experience, for example a mentor in a practice setting, it would be difficult to self-evaluate performance. Experts in other fields have highlighted the pivotal role of senior peers in promoting self-assessment of performance and identifying areas for development (Kruger and Dunning, 1999). As a result, participants highlighted a need for connections with individuals with whom they could problem solve and who could offer feedback about roles, akin to clinical supervision and mentorship. A study into advancing pharmacy practice in hospitals in Canada identified that mentorship was a positive predictor of confidence post-graduation, as it increased decision-making abilities and willingness to take on new responsibilities (Frankel and Austin, 2013). Yet there is little research or understanding of the role that ongoing mentorship may have on the ability and experience of enacting change for practicing community pharmacists. This study has found that community pharmacists feel unsupported in the change process and seek some of the informal, practice based learning that a mentor could provide: feedback, opportunity for problem solving, and continued learning.

This shed light on the current models of training offered to community pharmacists. Participants recognised that current training is delivered at the macro level, requiring them to use their own evenings and weekends in order to engage in professional development that was removed from the meso setting of practice. This was criticised by a number of pharmacists in this study as not meeting their needs and adding burden to an already heavy workload. Existing research suggested that training is of high importance to pharmacists to prepare for service delivery (Moullin

et al., 2016). The findings of this study have highlighted that the type of learning experience, tailored to the specific learning needs of the participant, was critical to develop new skills. Therefore, an experiential model of learning that integrates with meso level practice may provide a more effective education practice for pharmacy.

For new graduates, pharmacist foundation training happens under the supervision of a qualified pharmacist (acting as a supervisor and mentor). At the end of this year, following successful completion of a pre-registration exam, pharmacists are able to practice “independently”. Within hospital pharmacy, the team nature of the role means that practice is not truly independent, as pharmacists continue to have mentorship and support from more experienced pharmacists. In community, the pharmacist role often becomes genuinely independent. For some participants in this study, the act of reaching out to others for help and support made participants feel like a burden, or was experienced as undermining their self-efficacy. This leaves us to question whether a model of “independence” is right for a pharmacy profession of the future. Magola and colleagues (2018) used a nominal group technique (NGT) to explore novice pharmacist’s transitions into practice, and found that isolation and lack of support resulted in “isostrain”, where the workplace became a “noxious” environment (p.849). Crucially, the absence of support limited the ability of newly qualitied pharmacists to manage stressors and cope with challenges. It appears that more experienced community pharmacists may also struggle as they move into roles that are new for them, and with a similar lack of support.

This finding is timely as, in January 2021, the GPhC announced the pre-registration training year was to be replaced with a “GPhC Foundation Training Year” (GPhC, 2021). Interestingly, new learning outcomes have been devised for pharmacists to meet throughout their degree and their training year. These include “work collaboratively with other members of the multidisciplinary team” and “make use of the knowledge of other members of the multidisciplinary team”. However, there is no learning outcome or emphasis on the role of peer networks. Multidisciplinary teamwork is indeed important but, as we have seen in this study, there is also a need for peer support for and from pharmacists who understand the unique challenges faced in community pharmacy. Indeed, the GPhC standards highlight the unique role of pharmacists as “experts in medicines”; a role that requires others to understand the specificity of these responsibilities.

The value of a peer network was seen through the connections made on the leadership programme, which provided participants with different perspectives and different ways of envisioning practice. This programme created an opportunity to

establish peer relationships, which were evidently unusual for these participants. These provided support networks whilst on the programme, but were not often maintained after the course ended and the pharmacists returned to practice. The reasons for this were not clear, but could be related to Edstrom's (2017) concept of "organisational gravity", in which returning to practice settings participants were "pulled back" into their established ways of working. This brings into focus the gap between education and practice in a continuing education setting. Others have explored this in students transitioning into practice (Noble et al., 2014), but this study specifically highlighted the challenge of learning translation for qualified pharmacists. It has highlighted the conflict between expectations and goals of a corporate organisation and the expectations and goals of an individual. These challenges have implications for the training of new pharmacists, as new graduates with more advanced professional judgement, clinical decision making, diagnostic skills are likely to meet the same challenges current pharmacists have in enacting change within established organisational cultures.

6.2.4 Psychological safety

Participants expressed a need for psychological safety and security during the change process. Evidence suggests that individuals need to feel secure in their role in order to challenge or change existing ways of working (Jaaron and Backhouse, 2017). Radical change involves greater perceived risks than incremental changes (Ahuja and Morris Lampert, 2001; Voss et al., 2008) and thus may more significantly influence the perception and experience of change. External forces such as funding cuts, concerns about errors, and conflict with management, challenged a sense of security in one's role. This created an instability in practice that may have undermined an ability to take risks and try new things when it came to practice change. As professionals who hold a responsibility for the safety of patients, this burden is significant. Adding change to a vulnerable psychological foundation creates an unstable situation for community pharmacists.

Existing research highlighted that pharmacists are cautious and dislike uncertainty (Cordina and McElnay, 2001; Frankel and Austin, 2013; Droege and Assa-Eley, 2005). The findings from this study have highlighted the lack of stability and high levels of uncertainty that exist within the profession currently. At the macro level, the perceived risk of technological advances in taking over the dispensing role created a threat to pharmacists' perceptions of job security. Several pharmacists highlighted the danger to them on an individual level and the threat to pharmacy as a profession. Whilst these concerns, on some level, act as motivators to engage in

change to maintain the viability of the profession, they also act as the destabilising factors, making pharmacists concerned for their futures.

At a macro level community pharmacists believed they were not being recognised for the contributions they made to healthcare. In particular, funding cuts, which had created strain and pressures at the meso and micro levels, were interpreted as diminishing the contribution community pharmacy made to patient care. At the meso level, these funding cuts were used by organisations to justify cuts to staffing, increasing the struggle for individual pharmacists to fulfil old roles and new roles simultaneously. At the meso level, pharmacists did not feel appreciated for any additional skills they brought to their role beyond medicines supply. This lack of recognition was particularly prevalent when activities were not revenue generating. Without external appreciation, recognition, and acknowledgment pharmacists often became demotivated and disengaged. In addition, pharmacists perceived that patients were not prepared for them to be offering clinically-focused services, and were more interested in obtaining their medicines in a timely manner. This confirms findings from other studies, which highlight that patients often do not recognise the pharmacists' role in self-care (Elvey et al., 2013) and would rather seek care from a GP who is perceived as a more qualified healthcare provider (Latif, 2018).

It is important to note that participants believe that they offer significant value to the community and make an important contribution to community healthcare. They also believe they are highly trained professionals who are not being used to the best of their ability. This study illustrates a willingness from community pharmacists to play a greater, more integrated, role in healthcare. This is consistent with other findings in the literature that suggest pharmacists see potential for their role as primary care providers and healthcare hubs (McMillan et al., 2013) to maximise the use of their skills (Edmunds and Calnan, 2001). However, intrinsic motivation is not enough, and this enthusiasm to see a more expanded role was tempered with the challenges that exist in practice. These challenges create a complex dynamic of tensions that ultimately influence community pharmacist's psychosocial wellbeing.

Community pharmacists found change psychologically challenging, and a source of stress and anxiety. Participants frequently exhibited and described the key dimensions of burnout: emotional exhaustion, cynicism and a decreased sense of personal accomplishment (Freudenberger, 1974). This resonates with existing literature, where it has been well documented that community pharmacy professionals are overworked, and increasing levels of stress are reportedly common across the profession (Murray, 2016; Hassell et al., 2011). A 2021

Workforce Wellbeing Study identified that almost 90% of the profession were at high risk of burnout (RPS, 2021). A combination of factors are likely to be influencing these psychological responses including high levels of responsibility (McCann et al., 2009), high workloads (Lea et al., 2012; Hassell et al., 2011) and reduced staffing levels or inadequately trained staff (McCann et al., 2009). The findings of this study have highlighted the additional pressures of trying to take on new responsibilities against a backdrop of these existing sources of stress.

A review of the UK literature found a correlation between increased workload and pharmacist feelings of stress, with higher workloads being correlated with lower levels of job satisfaction and higher levels of stress (Lea et al., 2012). Jacobs et al. (2014) reported evidence of stress levels in community pharmacy that were significantly higher than other healthcare workers. The same study reported a link between stress from work overload and dispensing errors. The possibility of making a dispensing error was also of concern for community pharmacists in this study, and seemed to contribute as a source of stress and creating a barrier to engaging with new initiatives. This has contributed to pharmacists struggling to take on new responsibilities, in addition to their pre-existing workload.

Not dealing adequately with these issues has resulted in what Oreg (2006) calls “withdrawal behaviours”. Intention to leave a workplace is a withdrawal behaviour that is often seen when individuals perceive a situation is unlikely to improve. Two participants in this study left community pharmacy between the two interview time points, and others discussed the possibility of leaving in the future to pursue other career options.

Psychological health and wellbeing have been less commonly studied in the change literature (Oreg et al., 2011). However, these outcomes should be considered as important factors, since they might affect an individual’s ability to succeed in change and be successful in their role. Perceptions about organisational change, change self-efficacy, and perceived stress relative to a major organisational change have been found to be linked to psychological wellbeing (Martin et al., 2005). Greater uncertainty in one’s role has been linked to a more severe decline in psychological wellbeing (Pollard, 2011). In particular, role ambiguity has been related to a decline in psychological wellbeing and job satisfaction (Jimmieson et al., 2004).

Considering the professional identity of pharmacists, the literature suggests that pharmacists have multiple identities (Elvey et al., 2013). The findings of this study also found examples of different identities that influence how pharmacists

understand their roles. Although this study did not set out to explore identity, discussions on how change aligned with or conflicted with the pharmacists' understanding of their own identities were frequently apparent. This influenced how community pharmacists felt about particular changes. Ellen spoke with nostalgia about her role as a scientist, lamenting the loss of more technical aspects of the pharmacist's role, such as compounding medicines. She is clear that she does not perceive herself as a clinician, and therefore rejects roles that conflict with her identity. Schermerhorn and colleagues (2002) argue that when people resist change, they do so to "defend something important" that they perceive is being threatened by the change. Professional boundaries between pharmacists and other healthcare professionals have previously been described as "blurred" (Elvey et al., 2013 p.322). Participants in this study were eager to differentiate themselves among other healthcare professionals and maintain a defined identity related to the "medicine". However, there was apparent role ambiguity and role conflict in attempts to take on a new identity. Where participants identified with roles that were more clinical or service-related, their organisations and patients were not necessarily keeping pace with this identity transition. Research on organisational commitment has typically focused on employees' identification and feeling of attachment to the organization as a whole (Vakola and Nikolaou, 2005). Organisational commitment is one of the most commonly studied outcome variables in change research (Oreg et al., 2011), and is related to many key organisational outcomes, including job performance, absenteeism, and turnover intentions (Martin et al., 2005; Fedor et al., 2006).

The study has found that the experience of pharmacists is influenced by a complex interrelated system of sociocultural and systemic factors that influence practice change at an individual level. The "complexity" comes from the way that factors across the macro, meso and micro level interact. This experience is situated within a complex system comprising the environment and the organisation in which the individual works. Bronfenbrenner argues that a key factor is how people perceive environments as opposed to how the environments exist in a perceived objective reality (Bronfenbrenner, 1979, p.4). If we hope to move pharmacy practice change forward, understanding community pharmacists experience of change will be critical to its success.

6.3 Recommendations

The study has explored the experiences of community pharmacists in the context of practice change and has highlighted the personal impact of change on participants, driven by the challenge of change at multiple levels. In building a comprehensive system of support, we should acknowledge the role of the profession, the organisation, and the individual. Considering factors across the Planes of Analysis, provides a holistic perspective to consider these multiple influencing levels. Attempting to coordinate change interventions across planes has been recognised as challenging and complex (Noonan et al., 2008). Much of the difficulty in community pharmacy comes from the individual nature of practice and the diverse cultures of organisations in which community pharmacist work. This restricts communication within and between organisations and isolates individual pharmacists.

6.3.1 Leadership

At a macro level an enhanced communication strategy is required, that articulates a clear vision for the profession and for pharmacists as individuals. Change in healthcare is not slowing down, and the COVID-19 pandemic has highlighted that desirable outcomes of change may need to be moving targets. However, it is the job of leadership to create clear vision and direction for practitioners on the front line. Pharmacists in the study engaged with the idea of change, but needed to be inspired by a broader sense of purpose and clearly articulated achievable goals. With the rate of change unlikely to slow, more careful consideration could be given to the volume of policy documents and professional communications that pharmacists are required to engage with. Clarity of message and a clear vision for the profession is needed. Streamlining communication is not a radical strategy, but given the fragmented nature of community pharmacy it is critical to get right. At a meso level, the challenge of management, organisation, and a requirement to maintain a business, is undoubtedly a struggle for community pharmacists. It is important within the structure of the organisations that community pharmacies feel engaged, valued and have agency within their scope of practice.

6.3.2 Support Networks

Networks of support at macro and meso levels are critical. Within organisations, re-negotiations of the role of pharmacists needs to take place. Organisational values at odds with professional values creates role tensions. Autonomy for decisions, and

role specialisations could create more opportunity for personal and professional goals to align. Otherwise, role tensions will continue to hamper change.

6.3.3 Educating for new roles

Community pharmacists should be provided with protected, funded time to engage in the education and training required to take on new roles. Funding from the NHS, via Health Education England, would provide the capacity for pharmacists to be released to develop the skills required for a new paradigm of practice. Training needs to be brought from the macro level into the meso level, where exposure to situated, experiential learning for pharmacy teams and organisations can promote learning and problem solving in practice. Furthermore, community pharmacists need hands-on support and mentorship, with mechanisms for feedback in the practice environment. The benefit of experiential learning is widely recognised in healthcare, along with the role of practice-based mentorship and support. Professional competence should be assessed through observation in a practice setting.

Taking on new clinical skills, in particular, is a significant shift in community pharmacy roles and should be supported in a similar way to a newly qualified pharmacist taking on a transition into practice.

6.3.4 Professional Fulfilment

Community pharmacists, like any professional, should be provided with the opportunity to experience professional satisfaction or to “flourish”. Of course, this needs to be balanced with the needs of the NHS, but currently the external demands are dampening job satisfaction and creating a disengaged workforce. The reality is that there are many ways for community practice to look, which have been evidenced by the experiences of these individuals, and these pharmacists have the potential to meet the needs of the NHS in different ways. Indeed, pigeon holing everyone into the same paradigm of practice may ultimately stifle innovation and the ability to meet the needs of a local community. The NHS needs pharmacists to take on more clinical roles, but it also needs patients to receive safe and effective medicines supply. At the moment pharmacists are being asked to do it all. An alternative approach may be to create distinct specialist roles for community pharmacists. The profession might argue that community pharmacists are free to tailor their practice to the communities and pursue practice initiatives that interest them, and are frequently encouraged to be more proactive, seek out opportunities to get involved in PCNs and build relationships with GPs, but the realities of balancing the business and medicines supply demands make these expectations

unrealistic for many. Ultimately, should the purpose of practice change be solely about achieving efficiency and effectiveness? Or should it also seek to integrate improving the working lives of community pharmacists to allow professional fulfilment? I would argue that these two aims must co-exist, and significantly more attention is needed in this area.

6.4 Contributions of the Methodological Approach

The combined use of Rogoff's (1995) Planes of Analysis framework and IPA, provided a novel perspective on both the influence of change on community pharmacists and their experience of the process. The integration of Rogoff's model at the analysis stage provided insight into the inter-related factors that influenced the change experience at micro, meso and macro levels of practice. It has highlighted that community pharmacist experiences of change do not occur in isolation, but are influenced by the interactions in practice with the meso and macro levels of pharmacy. The application of a phenomenological approach allowed this insight to be gained through the lived experiences of the community pharmacist themselves. It has given voice to community pharmacists who have often felt their voices were missing from decisions made by the NHS and pharmacy's professional bodies. Situating the study in the day-to-day lives of the community pharmacist has provided a unique perspective on practice change. Although practice change is not a novel application of Rogoff's model (Hermansyeh et al., 2018), the study has foregrounded the micro experience of the community pharmacists in a novel way, and has specifically highlighted the relationship between external levels and individual experience. It is the first time it has been used to situate the experience of community pharmacist within the context of their practice in England.

Importantly, this approach illustrates that community pharmacists are largely positive toward the prospect of extended and enhanced roles for themselves, if these can be aligned with existing work. This study highlights the tensions between aspirations at the micro level and the many meso and macro environmental factors at play. The dynamic context in which pharmacists work creates pressures at multiple levels, which often do not align with the intended change. Instigators of practice change in pharmacy need to think critically about what pharmacists are being asked to do, especially the other complex factors that interplay in a practice setting, where the direction for practice change may be at odds with management priorities, the overall organisational culture, and the expectations of patients and other healthcare professionals.

6.5 Strengths and Limitations of Study

A key strength of this study is that it presents a rare example of an integrated model of interpretative phenomenological analysis and Rogoff's Planes of Analysis (1995). This enabled me to illustrate the multidimensional and interrelated factors involved in the practice change experience, highlighting its tensions, complexities and contradictions. In particular, phenomenology has highlighted the socially constructed nature of practice change as a lived experience. This approach has provided an alternative to both the "barriers and facilitators" model or the "single variable" approach to exploring practice change. It centralises the community pharmacist as the subject of interest.

There are several limitations of this study. Firstly, phenomenology cannot, and does not, aim to produce generalisable results. Instead, it is interested in the potential transferability of findings from one group or context to another (Hefferon and Gil-Rodriguez, 2011). This "theoretical generalisability" encourages the reader to take an active role by drawing on their existing knowledge and experience, with the purpose of judging the applicability of the findings and possible implications for practice (Smith et al, 2009). Although the experiences presented are specific to the community pharmacists is this study, it is hoped the insights drawn from them increase our understanding of the experience of practice change and add to existing knowledge. My research question acknowledges that we do not know how community pharmacists experience practice change, and only community pharmacists themselves can provide this knowledge.

Secondly, as a researcher, I am inextricably linked with the findings in this study. Another researcher may have engaged differently with the participants and with the data, and may therefore have reached different conclusions. As previously discussed, the claims made in this study are not, and cannot, be objective claims to knowledge. I have discussed the trustworthiness of these findings in depth in Chapter 4. The trustworthiness approaches described were central to building rigour and confidence in the findings presented.

Thirdly, selection bias may be associated with the recruitment of participants. Volunteers were recruited from a leadership programme, and therefore represent a narrow band of pharmacists who were proactive in seeking training for organisational change. Therefore, participants may have an intrinsic motivation to engage in practice change that may not be representative of the wider population of community pharmacists. The ideographic nature of this study makes this less

important, as the findings are not intended to be generalisable to the wider population of community pharmacy.

The final limitation to this study is the point in time in which it was conducted. Data was gathered before the unanticipated and unprecedented COVID-19 pandemic, which heavily impacted all of healthcare, including communtiy pharmacy. Recent literature indicates that wellbeing and burnout resulted from this (Langran et al., 2022; Johnston et al., 2021). My research findings may provide a benchmark from which to explore the impact of COVID-19 on community pharmacists' practice change experience.

6.6 Contributions to the Field

Practice change is, and continues to be, an ongoing challenge for community pharmacists. This research study is timely, as a significant period of change has followed the undertaking of this study. Indeed, the COVID-19 pandemic has imposed unprecedented change across healthcare, and highlighted how external influences drive change for the community pharmacy profession. It has also illustrated how the future cannot be predicted. With there being no end in sight for community pharmacy practice change, now, more than ever, pharmacists are expected to step forward and take on more responsibilities.

Whilst research and discussion on pharmacy practice change has been ongoing for many years, I hope this study challenges the profession to think about the more human side of practice change. Organisational change models are powerful tools, but arguably only address part of the challenge that the profession faces. No two community pharmacists had the same experience of change, so I hope this has highlighted the differing perspectives and variance in individual experiences. While further research is needed, this study has extended our understanding of the contextual factors at meso and macro level that influence the change process for community pharmacy. I hope this thesis has allowed us to stand in the shoes of these community pharmacists to consider what practice change asks of the "ground level implementers of change" (Lau and LeMahieu, 1997 p.7). Finally, I hope this study has illuminated the levels of conflict that exist in the change experience for community pharmacists.

As a profession, more credence needs to be given to how we might better support pharmacists to manage the psychological aspects of the change process. This is likely to be better received following the COVID-19 pandemic, which has made clear the need for a more intentional approach to fostering professional wellbeing.

This study refocuses the attention on community pharmacists themselves and gives voice to community pharmacist experiences, providing insight into the demanding nature of practice change.

The study makes a contribution by presenting a less-common approach to practice change research, using an IPA methodology to explore the experience of change through community pharmacist's lived experience of the change process. This has illustrated the value of interpretive qualitative research in understanding the factors at play as community pharmacists attempt to change their practice. This inductive approach has allowed for unexpected findings, including the complex role of community pharmacists, as both change agents and change recipients, participants' perceived lack of autonomy in the change process and change as a source of psychological stress and burnout within the profession.

This study has made recommendations to get the community pharmacy profession thinking about how it approaches practice change. It is hoped, through dissemination and publication, that other practitioners, academics and scholars will offer their perspectives on how best to support community pharmacists through the experience of change.

With changes to the education and training of pharmacists, a new type of pharmacist is being created, one whose identity and expectations may not align with the current context of practice. Other studies have suggested the context of practice has an important influence on the experience of graduates (Noble et al., 2014). Unless we tackle our existing practice and established practitioners, graduates will move into a workplace context that continues to conflict with the vision for change and undermine progress toward a new paradigm for pharmacy practice.

Educators have a responsibility to create a learning environment that meets pharmacists where they are, and supports them to create a pathway for where they wish to go. As a governing body and professional body the GPhC and RPS have a responsibility to create and articulate the vision for change, in the short term, medium term and long term. Creating a roadmap and a vision for change is central to making community pharmacists feel a sense of belonging, feel engaged, and understand how their personal priorities, goals and values might influence the change process. Strong, charismatic leadership has been shown to increase belongingness when leaders are able to "articulate an attractive vision" that "inspire followers to transcend their own self-interest for the sake of the collective" (Den Hartog et al., 2007 p. 1132). In addition, harnessing the desires of community

pharmacists may help to drive change, rather than create friction with personal priorities.

The literature on organisational change often considers organisations as single entities and consequently recommendations are made with a single chain of command in mind. More recently, organisations have come to be understood as multiple cultures and contexts within the same company. Community pharmacy offers a somewhat unique context in which to explore organisational change given the distributed organisations, and different cultures. Yet, there were shared experiences and challenges in attempting to implement policy in practice.

6.7 Areas for Future Research

This study sought to gain an in-depth understanding of how practice change is experienced by community pharmacists. The exploratory nature of this study has illuminated areas for additional research that that could further extend our understanding of practice change for community pharmacy. Key areas of research are outlined below.

This study recruited a small number of homogenous participants in order to focus on depth of experience rather than breadth. This study could be widened to explore whether themes identified in this study resonate with community pharmacists more widely. This work also identified contextual factors that were relevant to the change experience for community pharmacists. However, community pharmacists are part of a wider team dealing with practice change. Another possible way to extend the study would be to explore the experiences of other staff within the organisation, such as technicians, dispensers, managers, superintendents and patients. This could create a multi-faceted understanding of the micro, meso and macro levels of change, and highlight areas of convergence and divergence between individuals with the context of practice.

Another unanticipated finding was a lack of psychological safety in the change process and the emotional strain that a continuously changing environment puts on the individual. Stress and burnout have recently begun to receive attention in the community pharmacy literature, but not specifically in the context of dealing with and managing change. This is an essential aspect of creating a workforce who are supported and psychologically enabled to deal with change. This finding came strongly into focus during synthesis of the analysis. Had it been known earlier, the job demands-resources (JD-R) model (Bakker et al., 2003) could have offered a theoretical framework to explore the particular aspects of the community

pharmacist's role that contribute to burnout. This model was originally developed to explain adverse outcomes from work, for example, emotional exhaustion, burnout, cynicism. These characteristics have been identified in the pharmacists in this study, and the application of this model would allow an exploration of the specific demands being placed on community pharmacists, and the resources they have available to counteract those demands. Such a research project would have particular resonance in the wake of the COVID-19 pandemic.

6.8 Final Summary

Community pharmacy practice change is not new, and yet, much of the existing research has focused on individual level factors that influence the ability of pharmacy to change, with community pharmacist themselves considered moderating variables in the change process. Until now, the impact of practice change on the experiences of individual pharmacists has not been a priority in discussions of change. Instead, they are often criticised for not doing enough to drive change forward.

This research has illustrated the complexity of change, and the dynamic interplay of policy organisation and relationships on community pharmacist's change experience. The Planes of Analysis framework, combined with a phenomenological approach, has highlighted the critical influence of external factors on the community pharmacist in the change process, and has illustrated the role of community pharmacists as actors operating as "change translators" within a wider dynamic system.

The influence of external demands has resulted in tensions between the expectations of policy, the profession and the organisation, and the reality of practice. For each pharmacist in this study, change was a challenge in one way or another.

Community pharmacists experienced the most tension in relation to control of their practice, work overload and the cumulative nature of change, feeling valued by the organisation, the profession and wider society, and integration with their peers and other practitioners. This resulted in instability and psychological stressors that hindered development. This study identified that community pharmacists recognise the agenda for change and the opportunities it will provide for them, their patients and the profession. Therefore, attempts need to be made to address the challenges of change to better support pharmacists to realise their potential.

Several recommendations have been made at each level that highlight the need for clarity of vision, and leadership at macro and meso level to make pharmacists feel connected, appreciated, and in control of how practice change plays out for them as individuals, and mechanisms through which pharmacists can be made to feel psychologically safe, secure and appreciated.

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Appendix A: Ethics Approval

The Secretariat
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UNIVERSITY OF LEEDS

Layla Fattah

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Leeds, LS2 9JT

ESSL, Environment and LUBS (AREA) Faculty Research Ethics Committee

University of Leeds

28 August 2018

Dear Layla

Title of study:	**Exploring community pharmacy practice change through the lived experience of community pharmacists: an interpretive phenomenological analysis (IPA)**
Ethics reference:	**AREA 17-165**

I am pleased to inform you that the above research application has been reviewed by the ESSL, Environment and LUBS (AREA) Faculty Research Ethics Committee and following receipt of your response to the Committee's initial comments, I can confirm a favourable ethical opinion as of the date of this letter. The following documentation was considered:

Document	Version	Date
AREA 17-165 EthicalReviewForm_LF_23.07.2018_V2.docx	2	23/07/18
AREA 17-165 ParticipantAccessPermissionEmail_LF_27.06.2018.pdf	1	27/06/18
AREA 17-165 ParticipantInvitationEmail_LF_27.06.2018.docx	1	27/06/18
AREA 17-165 ParticipantRecruitmentPresentation_LF_27.06.2018.pptx	1	27/06/18
AREA 17-165 StudyInformationSheet_LF_27.06.2018.docx	1	27/06/18

AREA 17-165 ParticipantConsentForm_LF_27.06.2018.docx	1	27/06/18
AREA 17-165 InterviewQuestions_LF_27.06.2018.docx	1	27/06/18
AREA 17-165 FieldworkRiskAssessment_LF_27.06.2018.docx	1	27/06/18

Please notify the committee if you intend to make any amendments to the information in your ethics application as submitted at date of this approval as all changes must receive ethical approval prior to implementation. The amendment form is available at http://ris.leeds.ac.uk/EthicsAmendment.

Please note: You are expected to keep a record of all your approved documentation and other documents relating to the study, including any risk assessments. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited. There is a checklist listing examples of documents to be kept which is available at http://ris.leeds.ac.uk/EthicsAudits.

We welcome feedback on your experience of the ethical review process and suggestions for improvement. Please email any comments to ResearchEthics@leeds.ac.uk.

Yours sincerely

Jennifer Blaikie

Senior Research Ethics Administrator, the Secretariat

On behalf of Dr Kahryn Hughes, Chair, AREA Faculty Research Ethics Committee

CC: Student's supervisor(s)

Appendix B: Interview Schedules

Schedule Interview 1:

Introduction: Recap the purpose of the research
Reassert ethical considerations

Main body:
Main Q: Can you tell me about your role at the moment?
Probes: What is your current job title? How long have you been doing this job?
What type of community pharmacy do you work for?
How would you describe your current role?

Main Q: Can you tell me what you understand by the term practice change in relation to community pharmacy?

Main Q: Can you tell me about that change to your practice that you are trying to implement?

Main Q: Can you explain the personal qualities or skills you think you are using to implement this change?
Probes: What are your learning needs? How will you address these?

Main Q: What do you hope the outcome will be?
Probes: What do you want your practice to look like after the change?

Main Q: What do you think will happen to your practice if you don't attempt this change?

Main Q: Who is involved in this change?
Probes:

Main Q: How do you feel about this change?
Probes:

Concluding Points: Is there anything else you would like to discuss?
Thank participant for sharing in the interview.
Explain plan for follow up interview.

Schedule Interview 2:

Introduction: Thank participant for agreeing to speak again.
Recap the details of practice change discussed at the first interview

Main Body:
Main Q: Tell me what has happened with this change since we last spoke?

Main Q: What has gone well?

Main Q: What do you think has contributed to this success? How?
Prompts: How have other people helped you?
Last time you mentioned your peer relationships - have you involved these people in this change?
How has you organization been involved?
What resources have you drawn on?

Main Q What barriers did you face?
Prompts: How did you overcome these?

Main Q: Was this process easier or harder than you expected? Tell me why?

Main Q: What role did education or professional development play in your ability to implement change?

Main Q: How has this experience made you feel?
Prompts: How has this affected you personally? For example, your work/ life balance?

Concluding Points: Is there anything else you would like to discuss?
Thank participant for sharing in the interview.
Explain dissemination of findings

Appendix C: Planes of Analysis Themes

	THEME 1: AGENCY IN CHANGE PROCESS	THEME 2: ROLE TENSIONS	THEME 3: NETWORKS OF SUPPORT	THEME 4: PSYCHOLOGICAL SAFETY
MACRO LEVEL	Top-down change Unclear vision & direction	Cumulative roles	An insular profession	Instability of the profession
MESO LEVEL	Managerial control	Healthcare-Business Conflict	Engagement of the Pharmacy Team Peer Isolation	Recognition and appreciation
MICRO LEVEL	Passivity Taking control	Forced to prioritise Professional values	Professional development	Professional identity Stress and Burnout