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Review of the Community Pharmacy Collaborative Lead (CPCL) roles

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Glossary

Acronym/Key word	Definition
CPCL	Community Pharmacy Collaborative Lead - role created to provide leadership and representation for pharmacies with other primary care professionals.
CPW	Community Pharmacy Wales – representative body of pharmacists in Wales.
HEIW	Health Education and Improvement Wales – Professional body responsible for commissioning, planning and development of education and training for the NHS Wales workforce.
IRP	Internal Research Programme
LHB	Local Health Boards
PCC	Primary Care Cluster – administrative health unit within a LHB which enables local co-ordination of health services. There are 60 PCCs across Wales.
UK GDPR	United Kingdom General Data Protection Regulation – the legislation that regulates the collection, storage and retention principles for personal and special category data in the UK.

1. Introduction

1.1 The Internal Research Programme (Knowledge and Analytical Services, Welsh Government) was commissioned by the Primary Care (Pharmacy and Prescribing) Branch to undertake a review of the Community Pharmacy Collaborative Lead (hereafter referred to as CPCL) roles (hereafter referred to as 'the leads' or 'the lead roles') across all Primary Care Clusters (PCCs) across Wales[1].

1.2 The CPCL roles were created in April 2021 with the aim of providing leadership and representation for pharmacies within each PCC. The integration and collaboration of community pharmacists within PCCs is vital to transforming the health and care system in Wales and to achieve the vision set out in A Healthier Wales[2]. The creation of the roles aimed to address the inconsistent approaches to community pharmacy representation within PCCs across Wales, to support collaborative working between different healthcare professions and to further integrate community pharmacy within PCCs.

1.3 The leads were responsible for representing the profession within their PCCs, which included GPs and other healthcare professionals. Their core responsibilities included; the promotion of the effective delivery of pharmacy service that were aligned to the priorities of each cluster; supporting the development of cluster-wide partnerships and facilitating improvement in access and quality of pharmaceutical services; developing effective communication with pharmacy teams and cluster teams; and providing professional leadership and representation for all community pharmacies within the cluster. Core tasks that comprised the role included meeting quarterly with representatives of all pharmacies within the cluster, meeting regularly with other professional leads, local health board community pharmacy leads[3], and primary care teams within the cluster, and attending meetings of the PCC and to provide feedback on the cluster plans, meetings and priorities to all pharmacies in the cluster. Depending on restrictions relating to the Covid 19 pandemic, these meetings took place either face-to-face or remotely.

[1] A map of all clusters within each health board is provided at Annex A.
[2] A healthier Wales: long term plan for health and social care | GOV.WALES
[3] Health board community pharmacy leads are health board employed and are responsible for commissioning and monitoring of community pharmacy services within their health board area.

1.4 Events promoting the roles and encouraging pharmacists in each cluster to volunteer for the role were held in late 2020, and those selected began in the role in April 2021. Support was provided by Welsh Government, Local Health Boards (LHBs), Health Education and Improvement Wales (HEIW) and Community Pharmacy Wales (CPW) in outlining the roles and responsibilities of the leads, and helping them settle into their role, providing access to training and responding to ad hoc queries.

1.5 A review was required after a year of the leads being in post, to understand the experiences of the leads in their first 12 months and assess the process of recruitment to the role. The IRP, an in-house research and evaluation unit, was approached to undertake this work. Working with colleagues in Pharmacy and Prescribing (Welsh Government), the following aims and objectives were agreed;

1.6 Aim: To review the CPCL role in the first 12 months of activity, and to understand whether the remits of the role and the funding provided to support it is a viable model that can be replicated in other primary care contexts, for example for equivalent lead roles in the optometry and dental professions. The review will explore;

- The process of recruitment of the leads within the role and understanding the purpose and remit of the role.
- Barriers and enablers to developing relationships with stakeholders within the PCC.
- Which aspects of the role and the support provided to the leads facilitated good relationships with other stakeholders within the PCC including community pharmacies.
- How the role developed over time e.g. what improved and what was not so effective.
- The process and effectiveness in forming relationships with other Pharmacy Leads and other key stakeholders.

- The outcomes of the first 12 months of the Pharmacy Lead posts, what potential outcomes should be considered for the roles and how outcomes may be measured using monitoring data.

1.7 Throughout this report, the work will be referred to as a review of the recruitment and implementation to date, as opposed to an evaluation. This is because the focus of the work is on this aspect of the roles only and is only seeking the views of those in the role regarding their experience in the first year with a view to adjusting certain aspects of the role based on feedback from the qualitative interviews conducted. A more comprehensive evaluation of the scheme, including more wide-ranging views on the implementation and its overall impact, as well as assessments of the applicability of the lead role for other professions, such as dentistry and optometry, will be undertaken when the scheme has been in operation for a longer period of time.

1.8 The outputs from this work were as follows:

1. **A logic model for the scheme** – this was conducted by IRP with internal staff and relevant external stakeholders retrospectively i.e. after the leads had been in post for a year. This helped researchers conducting interviews with the leads to map the programme and its expected outcomes fully. It also informed the creation of the topic guide for interviews with the leads.
2. **A qualitative dataset of interviews** with a sample of pharmacy leads, the findings from which informed the conclusions and a set of recommendations outlined in this report.

1.9 This report contains an outline of the methodological approach to the review in section two, including the theory of change workshop and the qualitative interviews. Section three outlines the findings from the qualitative interviews with leads and section four provides a set of conclusions and recommendations for improving the recruitment and overall experience of leads once in the role.

2. Methodology

2.1 This section sets out the methodological approach to the review, including a retrospective logic model and theory of change exercise and set of qualitative interviews with Pharmacy Leads. The theory of change, although to some extent retrospective i.e. following the start of the scheme, was of value for researchers in understanding the context and issues that the scheme was intended to address, and the intended outcomes of the lead role for internal and external stakeholders. The qualitative interviews aimed to provide an assessment of what aspects of the scheme were working well, and which aspects were causing issues for the leads. This would provide a set of recommendations for altering the programme as it continues. The theory of change will be of use for a future summative evaluation of the scheme, which will explore the impacts of the lead roles as well as the approach their set up. An impact evaluation is expected following the adoption of the lead roles by other primary care professions i.e. dental and optometry.

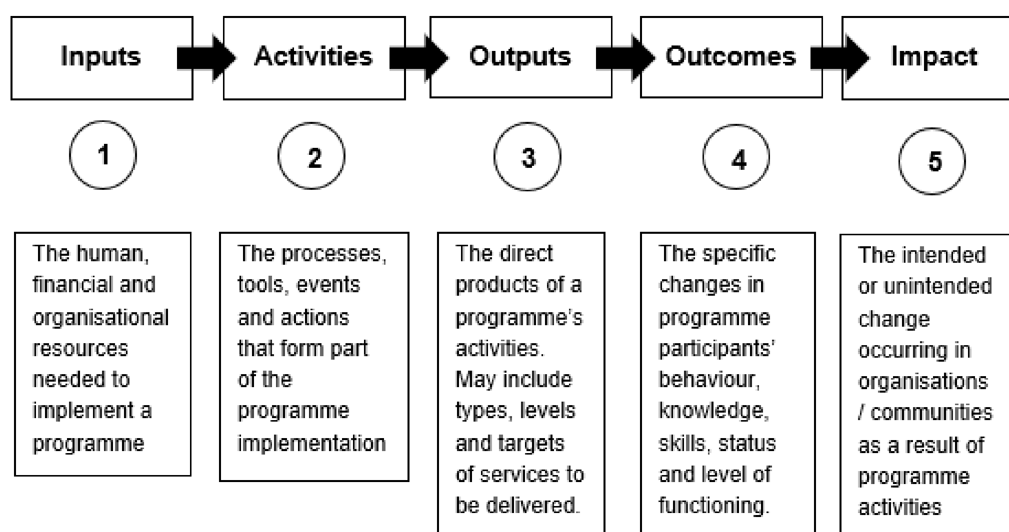
Theory of Change Workshop

2.2 Constructing a theory of change for the Pharmacy Leads scheme was suggested by researchers to the policy team as a beneficial preparatory step in developing the topic guides for the qualitative interviews. A theory of change is an evaluation approach employed to clearly articulate the intervention logic of a policy or programme. It is most beneficial when undertaken at the policy development stage and can help both those responsible for policy development and the analysts supporting them to set out why the intervention is needed, how it will work and what outcomes are desired to define the policy or programme as effective (UNICEF, 2014: 1). This enables the foundation of an evaluation approach to be determined and data collection and monitoring to be carried out which will help demonstrate impact.

2.3 The primary output of a theory of change is a logic model. A logic model firstly outlines the current **context** or issue that needs to be addressed, then details all the **inputs** relating to the intervention; for example, grant funding, staff resources and expertise, the **activities** that the inputs contribute to; for example a specific policy or

initiative, the **outputs** that are expected from these activities, the **outcomes** that are expected, and finally the long-term outcomes, or impacts that ultimately result.

Fig 2.1: Components of a logic model



Source: Kellogg Foundation, 2004

2.4 The logic model can also help uncover the assumptions underpinning the intervention logic, and potential risks that may occur along the causal chain. If completed early, mitigation measures can be put in place to address these risks. The logic model can also help identify sources of data that can be collected to evidence success of the intervention as part of a post-implementation evaluation.

2.5 Internal Welsh Government officials in Pharmacy and Prescribing and external stakeholders were invited to discuss the theory of change in April 2022. The workshop took place remotely via Microsoft Teams. It was attended by two Welsh Government officials from the policy team, two representatives from CPW, and was facilitated by three researchers. Participants were issued with a UK GDPR compliant privacy notice with their Teams invite, as well as a participant information form outlining the purpose of the session and the key questions they would be discussing, which were as follows;

1. What was the scheme trying to achieve at its inception?

2. What activities were undertaken to achieve these outcomes?
3. What barriers and risks to achieving these outcomes have been experienced in the first year of the scheme?

2.6 The topic guide for the session, a detailed outline of the running order for the workshop and a full list of all the follow-up questions, is provided at Annex B.

2.7 Two researchers facilitated the 90-minute session, with a third researcher using sticky notes to illustrate key points on Microsoft Whiteboard. This was visible to participants during the session and served as a reminder to all about what had been covered, as well as to ensure validity of the data by giving them an opportunity to check and clarify points recorded on the sticky notes. The data from this workshop was used to construct a first iteration of the logic model, which provided a starting point for researchers to construct the topic guides for the qualitative interviews, but also a tool to use in the future, should a summative evaluation of the scheme's impact be undertaken. The logic model should be considered a tool that can be revisited and altered over time to reflect changes to the scheme. The complete logic model can be found at Annex C.

Qualitative Interviews with Pharmacy Leads

2.8 The next phase of the review involved undertaking a set of qualitative interviews with a sample of those currently in the pharmacy leads role. The interviews were semi-structured, which allows for broad areas and key questions to be covered, whilst allowing for deviations into particular topics relevant to the interviewee. Topic guides for the discussion were developed and agreed with colleagues based in policy. The interview topic guide can be found at Annex D. The topic guide covered the following broad areas:

- Recruitment to the role
- Developing relationships within the PCC
- Developing cross-cluster relationships
- Training and development in the role
- Developing the role into the future

2.9 The policy team provided researchers with a full list of pharmacy leads, as recorded at the initiation of the scheme in April 2021. There was a total of 59 leads listed, and included their email addresses, the PCC in which they worked, and whether they were still in post as of April 2022. Three leads were excluded from the recruitment, as they were no longer in post, leaving 56 pharmacy leads who were contacted to take part in the study. The invitation to participate was issued via email and contained a UK GDPR compliant privacy notice and a participant information sheet. This stated the legal basis for collecting the data (public task) and made clear how the data would be stored and analysed, as well as for how long personal data would be retained following publication. Participants were asked to reply to take part in the study, stating their language preference. One of two researchers would then contact those who had expressed an interest to set up an interview slot, lasting no longer than an hour, to undertake the interview via Teams. Consent was sought to record the interviews, and the interviews were automatically transcribed by Teams. The transcripts were then checked and edited before the analysis stage.

2.10 In total, 12 leads were interviewed for the review and all interviews were conducted in English. Interview recordings and transcripts were saved on a secure filing system, with access limited to the researchers working on the project. The research team aimed to gain an even spread of leads across all local health board (LHB) areas. The following table shows the final numbers of interviews from each LHB.

Table 3.1: Breakdown of numbers of interviews by LHB area

Local Health Board	Number of Interviews Completed with Leads
Swansea Bay LHB	0
Aneurin Bevan LHB	2
Betsi Cadwaladr University LHB	5
Cardiff and Vale University LHB	3
Cwm Taf Morgannwg LHB	1
Hywel Dda LHB	0
Powys LHB	1

2.11 Despite targeted recruitment efforts, and with support from CPW and LHBs to encourage participation across all LHB areas, no leads were interviewed from Swansea Bay, and there is less representation from Cwm Taf, Hywel Dda and Powys LHBs when compared to other health boards.

Analysis

2.12 As the interviews were completed and transcripts checked and edited, the data were being uploaded onto MaxQDA, a qualitative data analysis software package. All researchers had access to the analysis file, and the analysis was divided between, the research lead, senior researcher and an apprentice. MaxQDA allows for researchers to code, or thematically group data to enable researchers to see the frequency at which codes occur in the data and analyse the content of the coded interview segments more easily. The research lead developed a basic coding framework before coding the first few interviews, and the coding framework was added to by other researchers as the data were analysed and relevant themes were

emerging from the data. All coding additions were discussed and agreed with the research team.

2.13 From the coding of most of the data, an emerging findings report was produced for the policy team in September 2022. This allowed for the key findings to be discussed with the researchers and the initial suggestions for recommendations arising from the findings to be made by the researchers. This enabled timely feedback to the policy team and allowed them to consider some changes to the running and administration of the scheme. A fuller analysis of the data is outlined in the following section of this report.

3. Findings

3.1 The section presents the findings from the individual interviews with the pharmacy leads. The following subheadings relate to the five broad areas for questioning from the topic guide (see Annex D).

Recruitment to the role

3.2 Most pharmacy leads heard about the opportunities for the role via emails asking pharmacists to provide expressions of interest. They also mentioned that the opportunities were publicised via their respective health boards or through CPW.

3.3 Their motivations for taking up the role included wanting an opportunity to improve the levels of communications between pharmacists to identify issues and solve problems. This included working with other healthcare professions, mainly GPs, within their PCC but also with other leads in other PCCs, to identify common problems and share best practice for addressing these issues. However, some noted that they took the role on due to lack of interest or availability from other pharmacists in their area. Some pharmacy leads described how they were approached or encouraged by colleagues to take on the role as they were considered to be the most appropriate candidate. Often, they were experienced pharmacists who could take on the role confidently, and several explained that they had relevant experience already, such as developing communications or managing. However, some experienced pharmacists felt that the role would be more suitable for early career pharmacists, for whom it could offer experience in networking and leadership. Most leads also recalled attending a virtual event that introduced the role.

3.4 By far the biggest challenge for leads in taking on the role was the time available to fulfil the requirements of the role. Every pharmacy lead said that time was a problem. The allocated funding provided to cover leads' attendance at meetings were universally felt to be too little to undertake the role competently, with insufficient time to organise, prepare for and attend meetings as well as complete paperwork. Leads often cited that it was a struggle to attend all meetings and keep up with the day-to-day requirements of their role, meaning they were spread thinly.

“I'd like to do more in my role, but I'm reluctant to do more only because I haven't got the time to do it.” (Pharmacy lead)

3.5 Most suggested an increase in allocated time and the corresponding funding would be beneficial to perform the role competently. Obtaining backfill to cover their time in meetings was also a problem as there were often few locums available to cover the time of the leads. This was exacerbated when cluster meetings were cancelled and backfill was required again. Leads often met resistance with their employers who were unwilling to fund this and be left out of pocket. Funding for backfill offered by the scheme was described as often not covering the local rates of a locum pharmacist or cover how often a locum is needed for leads to attend all meetings. As a solution to this issue, meetings have sometimes been scheduled in the evenings or during lunchbreaks which has required leads to undertake the requirements of the role in their own time.

“I did attend the meeting on my lunch break last week, but then you don't have a lunch, so it's, you know, you either attend the meeting and try and fulfil the role or you just, you know, don't. So it is, it is that I do find quite difficult.” (Pharmacy lead)

3.6 Most leads reported that COVID-19 had had a negative impact in terms of availability to obtain backfill to cover sickness and having less time to spend on the role. The move to remote working as a result of the pandemic had also had a somewhat negative impact in that it prevented them for forming relationships with others in the role due to the lack of interaction afforded in Teams meetings. This was largely attributed to the format of the meetings i.e. not being able to see the faces of others in the meeting.

“Face to face is just better. You get much better conversation than when everybody's hiding behind their cameras and their mutes and everything.” (Pharmacy lead)

3.7 However, some leads reported that having to use Teams for meetings was a positive outcome of the pandemic, as it meant that time was saved and that it was possible to have evening meetings that could be attended virtually from home.

"Travelling time, petrol time there, travelling home […] you've lost a whole evening whereas by doing it via teams meeting you've lost an hour and 10 minutes." (Pharmacy lead).

3.8 A final challenge that some leads identified was the lack of direction provided in the role. Whilst some felt that the independence to shape the role as they wanted was a positive, others were unsure whether decisions made were the right course of action. Some also felt that other stakeholders had different views on the key responsibilities of the lead roles, which further complicated their understanding of the role. These individuals identified a need for some direction in the role and to understand what the expectations are in terms of tangible outcomes that they could work towards.

3.9 When asked about their understanding of what the lead role aimed to achieve, the responses included;

- To improve multidisciplinary working
- To build relationships within their PCC
- To problem solve via building better communication across healthcare professions, particularly with GPs.
- To promote the services that pharmacists provide to other healthcare professionals, e.g. GPs, dentists
- Improving processes to facilitate problem solving and reduce duplication of effort
- Representing their cluster and advocating for the needs of healthcare providers within the PCC

3.10 These outcomes largely align with the outcomes stated by internal colleagues in the workshop undertaken earlier this year, although there is less mention of the professional development aspect of the role as a key outcome. This could indicate that this is less prominent in the minds of those in post and might be worth emphasising the professional development benefits of the role to future applicants.

3.11 In taking on the role, most participants felt well supported, citing the benefits of colleagues at CPW and staff in their respective health boards as being good sources of support.

3.12 Some areas where more support would be appreciated included how to chair online meetings effectively, support from line managers in the pharmacy to undertake the role, and clerical support to keep on top of the paperwork.

Developing Relationships within the PCC

3.13 The pharmacy leads described the main enablers and barriers to developing relationships within their PCC. Most leads stated that the ability to build links with other pharmacies and health professionals within their PCC was key to developing positive relationships, and it meant that they could act as sounding boards for each other to solve problems.

"Before this sort of role, I would never speak to anybody in another pharmacy. So it's good to know […] what's going on […] for their pharmacy and it's good from like a support perspective because if they've got certain problems or if you've got certain problems, it's a chance to actually talk about them." (Pharmacy Lead)

3.14 Leads that had developed good relationships with other professions, in particular GPs, described how important this was in meeting the expectations of the role, and ensuring other stakeholders understood the purpose and benefits of their role.

Outside of meetings, most leads described how the immediacy of the Pharmacy Lead's WhatsApp group was really useful for advice and problem solving.

"We have a WhatsApp group with all of us in […] so any stock issues, any services that people need access to and don't know who's offering at a certain time […] It's generally daily communications going between us now and so it's been really, really good to kind of start working together as a network more than be competitors, which we have traditionally been." (Pharmacy Lead)

3.15 The main barriers to developing relationships within PCCs was identified as the dominance of GPs within the cluster meetings sometimes meaning that the voices of the leads were marginalised. This was sometimes accompanied by resistance to or objection to the pharmacy approach from GPs. This was reported by one lead but

they also said that this occurred early on and had improved with relationship-building with GPs whilst in the role. Others reported that there was often not parity of the pharmacists with other healthcare professions.

“A lot of the time that the cluster meetings that have gone on have been very much driven by the GPs for the GPs. So [they haven’t been of] so much relevance to me. [W]hen I was sitting there really as the lone pharmacist amongst mostly GP’s practice managers and then a few other sort of healthcare professionals as well, my engagement was really quite minimal, if I'm honest and so as a result of that […] I didn't take a great deal away from those then to take back to my cluster pharmacist.” (Pharmacy lead)

“It is a constant uphill struggle to try and you know get across to the GP that we're not here to steal. You know, we're here to help and assist and you know that I think that really is the main barrier.” (Pharmacy lead)

3.16 Whereas some leads that had formed relationships with GPs in their cluster (typically prior to taking on the lead role) did not report these issues. Instead, these leads described how the role had led them to build on their relationship with GPs and be successful in promoting their services to them and keeping each other informed of any issues arising in their cluster.

3.17 A small number of leads stated that distance between pharmacies or having a large number of pharmacies made developing communication more difficult. Others stated that they had struggled to get other healthcare professionals involved (e.g. dentists, mental health workers) which meant that meetings tended to mainly consist of pharmacists. One lead suggested that the Welsh Government could provide more information about the leads role to other healthcare professionals to promote attendance at the cluster meetings.

3.18 Another barrier to developing relationships was that the use of Teams was reported as being more challenging than if the meeting were held face to face. This was because often people left their cameras off and this made interaction difficult. Many leads felt it was important to have at least some networking events in-person in order to build effective relationships with others in the PCC. In addition, some leads stated it was often difficult to commit to everything falling under the remit of the role

due to staff shortages as a result of COVID-19 and the general lack of time available. It’s important to note that not all felt that there were barriers, with about half the respondents reporting they did not experience these issues.

Developing Cross-Cluster Relationships

3.19 The leads consistently reported that the quality of communication and support from CPW was very good, particularly the meetings they facilitated, which were cited as a good opportunity to network. The leads felt that CPW staff were always available to provide guidance and assistance. Access to and the opportunities available on the online leadership platform was also felt to be very beneficial. A number of leads cited that the WhatsApp group created by CPW for all the leads was a good source for asking questions and sharing ideas for approaches to issues encountered in the role. Most leads also reported that they had constructive relationships with key contacts in their health board, and that they met regularly and were a good source of support.

“We've got [the] WhatsApp group as well and all the cluster leads are in that group, and so if you, if you have any questions or if you’ve got any concerns, there's always somebody that's very accessible and always willing to help.” (Pharmacy lead)

3.20 Although a small number of interviewees reported that they didn’t have much contact with other leads, most did have contact through the meetings set up by CPW and via the WhatsApp group. Some felt that it would be more beneficial to have more regular contact with leads who worked in PCCs which were geographically close, or who operated within the same health board. This was felt to be useful for understanding whether they were experiencing the same issues as nearby PCCs and whether they could work together to produce a solution beneficial for all.

3.21 Barriers identified in developing cross cluster relationships included difficulties in getting to know others e.g. leads and individuals who could provide support. The lack of face-to-face meetings, as has been cited as an issue in many other aspects of the role, was felt to be a barrier to building effective working relationships and to network, which is one of the main benefits of the role.

With COVID going on, we've had very few sort of face to face meetings and maybe in future that would be a good thing to do is to actually get together somewhere with the other cluster leads. I'd sort of value that perhaps more so than trying to do that online and because I think online tends to be more of a, of a presentation and we're all there as opposed to a meeting where we all meet […] one of the drawbacks of things like online and teams is you don't kind of mingle in the same way. (Pharmacy lead).

3.22 Again, as with other aspects of undertaking the role, the lack of time available and staffing constraints meant that leads were not able to devote as much time as they liked to building professional links outside of their PCC. One lead also mentioned the large size of the nearby clusters as being a barrier to effective communication.

We [Pharmacy leads] don't have the time to do that [share information]. Like for the funding that's available and the time you have to take out when you're attending five pharmacist cluster meetings and five GP cluster meetings, plus all the chasing around sending emails, doing minutes for meetings, and all the […] various claiming and paperwork and other CPW LHB meetings." (Pharmacy lead)

Personal Development

3.23 Participants were asked about their experience of being offered and undertaking professional development opportunities in the pharmacy lead role. Those who had undertaken training reported that it had been helpful. When questioned about the Teams training specifically, those who had attended all stated it had been helpful, with several leads explaining that they had not previously used Teams before taking on the role. The leads were aware of the HEIW online leadership platform, but most had not accessed it due to time constraints. The small number of leads that had accessed this training thought it had been useful.

"There's just lots of resources that you're made aware [are] available that [..] I wouldn't that have known about had I not been in the role, and then it just helps build your confidence, helps you develop those skills that are important for, you know, being able to take partake in these meetings and you know, holding your

ground or, you know, just making yourself more, more noticeable and present." (Pharmacy lead)

3.24 However, those more experienced pharmacists thought all the training opportunities provided would be more suited to pharmacists earlier in their career, as more experienced pharmacists felt they had gained the skills required earlier in their careers and did not feel that the current training and development offer provided anything new in terms of skills or knowledge.

3.25 The barriers to undertaking training and development were attributed again to lack of time; some leads highlighted that they would have benefitted from protected time to devote to learning and development to prevent it being an activity that was side-lined in favour of other tasks.

"We need the headspace to be able to do that training as well and […] it is four days in 12 months that we get, […] it just doesn't marry up the potential demands and the benefits that we could produce to what the days that we've been renumerated for." (Pharmacy lead).

3.26 A small number of leads stated that some of the available training online was difficult to navigate and didn't seem to be suitable for their role or seemed less important than pharmacy specific training. Some said that they were not aware of the different training opportunities and their benefits at the point it was offered and would have appreciated more information on the objectives and benefits at the time.

3.27 One lead explained their view that feedback was important for personal development and suggested that feedback forms were handed out to find out if colleagues think that this new role has been beneficial for the cluster and the pharmacies. Another lead suggested that short training videos or talks could be useful because it wasn't always possible to sit down and commit to the time needed to complete a course, but there were more opportunities where you might have time to just listen.

3.28 In terms of informal support, leads highlighted the benefits of networking when they had had the opportunity to undertake it. Health board staff and the assistance they provided was particularly well received. CPW were again praised by all leads as

being adept at solving issues and being quick to respond to queries. Others cited the importance of GPs as helping to solve issues in surgeries, with that then having a positive knock-on effect in pharmacies. Professional leads, based in pharmacies were also useful for providing updates on what the company position was on certain issues that leads were dealing with.

Development of the Role into the Future

3.29 The following themes emerged from discussions about how the role could be developed and improved in the future.

Improving links with others in the PCC

3.30 Although most leads felt that a positive start had been made, there were a few areas they felt could be built on. A number expressed the wish to build better links with other pharmacists in their PCC so as to better understand the main issues they faced and whether there is commonality in the issues faced. This may provide an opportunity to address problems more efficiently as a collective. This sentiment was extended to GPs and other healthcare providers. One lead suggested that it would be useful to have an independent person or mediator chair the cluster meetings, to make sure that everyone from each profession felt included and were given an opportunity to speak.

Improving processes

3.31 A number of leads identified a number of current practices that could be improved. Some had identified the possibility of taking some responsibility from GPs, as some of their work fell within the pharmacy remit. This would reduce burden on GPs e.g. on smoking cessation. The wider promotion of Choose Pharmacy by leads to other healthcare professionals, so that they could identify any responsibilities they could transfer to pharmacy would also be a general solution to this issue.

Better ICT

3.32 Leads often reported that there was a lot of security in the NHS IT systems which often posed a barrier to communicating effectively. Some reported technical issues related to security when giving presentations to external audiences, despite having

tested the platform beforehand. Resolution of these issues would make meetings more efficient.

“NHS teams is quite restrictive in terms of […] sharing documents and being able to download documents that don't come from directly from the NHS, and […] in terms of hardware […] you're either trying to use your work computers which aren't maybe adapted for a Teams meeting because they […] have no camera or that we're not able to download […] the Teams app or whatever because of our own security restrictions. (Pharmacy lead)

Time available

3.33 When asked about potential changes to improve the scheme, the most frequent response was more time allocated to perform the requirements of the role, including time devoted to learning and development. The leads referred to the amount of work that had to be conducted in their own time for them to carry out the role effectively. One lead suggested the need for a secretariat function to reduce the admin burden on leads.

Funding

3.34 Increasing funding was another suggested improvement, specifically more funding available to cover the cost of backfill that reflects the price of locums currently. In addition, some leads mentioned throughout their interviews that they thought that branches receiving the funding for the role, rather than the individual leads themselves, had caused some difficulties, for example having to request funding for backfill for locums. One lead suggested that the role could be improved by funding going directly to the pharmacists, as this then gives them more flexibility to choose whether backfill or working in their own time is more appropriate. Some leads also suggested that if the role was perceived as a paid role (i.e. leads were paid for the work they did in their own time) then they thought the role would be more attractive to other pharmacists.

“Everything I do is out of goodwill [..] which is fine because I'm quite happy to carry on and, but I think if it's a paid role one day a week […] that would make it more attractive to somebody.” (Pharmacy lead).

Getting feedback

3.35 Some leads explained they would like to get feedback from CPW on whether the approach being taken by leads is what is required. This may be facilitated through more regular informal knowledge sharing sessions, which would provide an opportunity for this. Leads also said they would benefit from information about what the role entails and the long-term goals of the posts when they take up their positions.

3.36 Other suggestions included setting up forums for leads in the same health board as a way of sharing common problems and collaborating on solutions, as well as improvements in technology. Some leads thought that removing some of the unnecessary security restrictions on ICT systems would make their roles easier and providing laptops would enable leads to perform role more easily.

3.37 The majority of interviewees would recommend the role to others, with one saying they would not, due to the resource constraints and the lack of funding to cover backfill.

4. Conclusions

4.1 This section sets out the conclusions of this review based on the analysis of data from interviews with pharmacy leads.

4.2 This research aimed to review the CPCL role in the first 12 months of activity, to explore the experiences of the pharmacy leads and whether the expected outcomes of the role are being realised, as well as determining if the funding and time allocated are appropriate. The purpose of this research was to support policy officials in making decisions to improve the scheme, and whether it can form a viable model that could be replicated in other professions (e.g. optometry and dental).

4.3 This review involved conducting 12 semi-structured interviews with pharmacy leads, who were asked questions based on five main topics of interest:

- Recruitment to the role
- Developing relationships within the PCC
- Developing cross-cluster relationships
- Personal development
- Development of the role into the future

4.4 The findings section explored each of these topics in turn and drew out the emerging themes. To meet the purpose of this research, this section draws together the findings to set out perceived strengths of the lead roles, and areas of improvement for each theme, to identify key recommendations for the Welsh Government.

Communication within and across clusters

Perceived strengths

4.5 Pharmacy leads consistently explained how communication within clusters had improved as a result of the role. For some pharmacy leads, there had been a significant change, with them meeting and frequently communicating with pharmacists and health care professionals that they had previously had little to no

contact with. Whereas for others, the roles provided greater opportunities to meet and develop relationships that had already been forged but had often previously been more informal and ad hoc in nature. Most pharmacy leads described frequent communication with professionals in their cluster, often mentioning using Whatsapp as a sounding board or to problem solve. Most pharmacy leads also described improved communication across clusters, but to a lesser extent in terms of the frequency of meetings and amount of communication.

Perceived areas to improve

4.6 Some pharmacy leads described how a lack of inclusivity in cluster meetings had meant that their voices were not being heard. Often these leads referred to the dominance of GPs in their meetings, and a small number of leads described a resistance or objection to the pharmacy approach, which impeded their ability to work with the cluster as a whole to improve services for the community.

4.7 A small number of leads explained that the distance between pharmacies or having a large number of pharmacies made within and across cluster communications more difficult.

Quality of support

Perceived strengths

4.8 In the interviews, pharmacy leads universally praised the support they had been provided with while in the lead roles. This support had often come from CPW, as well as from staff in their respective health boards.

Perceived areas to improve

4.9 A small number of pharmacy leads stated that they felt they needed more direction in the role, were unclear what the key responsibilities of the role were, and what they were expected to achieve. Some leads felt that the amount of administration work (e.g. arranging and setting up meetings) was too great, and one lead suggested clerical support would be beneficial.

Professional development

Perceived strengths

4.10 Leads were aware that there were different training opportunities available to them, and those that had undertaken training said it had been helpful. One lead described how the training had helped to build up their confidence in meetings and getting their voice heard. Those who had attended the Teams training said it had been helpful, with some leads noting that they had had no previous experience of using Teams.

Perceived areas to improve

4.11 More experienced pharmacists thought that the training seemed to be more suited to pharmacists earlier in their career. Time to carry out training was the reason most leads gave for not accessing the training available to them. Some leads suggested that protected time to carry out training would be beneficial. A small number of leads reported that they found the online training difficult to navigate.

Time and funding allocated to the role

Perceived areas to improve

4.12 All pharmacy leads reported that time was a barrier in their ability to carry out the role effectively. Although a small number of leads explained that they were happy to work in their own time, it is nevertheless the case that all leads stated they had worked over the number of hours covered by the funding provided. Leads often reported having meetings in the evenings as they didn't have sufficient time in the day. Time also emerged as a barrier to training opportunities, with most leads stating that a lack of time was the main reason they hadn't taken up any of the training offered by CPW or through the HEIW leadership platform.

4.13 Most leads reported that the amount of funding or how it was distributed was a problem. Some leads that were able to hire locums to backfill their roles, stated that the funding was insufficient to cover the costs of the locum, or that their meetings were too frequent to be able to hire locums to cover them all. A small number of leads explained that the funding was held by their branch to cover locums, which meant that the funding could not be used to cover them working in their own time

when it was not feasible or possible to hire locums due to a lack of availability. A small number of leads stated that they were effectively working for free when carrying out the duties of the role.

Use of technology/ IT

Perceived strengths

4.14 Some leads described how learning how to use Teams had a been a new useful skill for them. A small number of leads thought that having to use Teams had been a positive outcome of the pandemic, as it had meant that meetings could be carried out more easily and took less time, and it was possible to have them in the evenings.

Perceived areas to improve

4.15 Some leads reported that using Teams was a barrier to developing relationships, as most participants had their cameras off and this made social interaction more difficult. A small number of leads cited difficulties with using Teams itself. For example, work computers not allowing Teams to be downloaded, not having cameras on their computers or NHS security restrictions meaning that documents shared could not be opened. Other leads stated that the ‘lite’ version of Teams they had been provided with was causing unnecessary complications with organising and arranging meetings, as meeting series could not be set up and other functions such as meeting recordings or transcripts were not available.

6. Recommendations

6.1 This section sets out the recommendations for the Welsh Government to consider when making decisions about the pharmacy lead (PCCPL) roles.

6.2 **Recommendation 1:** Welsh Government should consider reviewing the allocated time and funding for the pharmacy lead roles. An option could be surveying the leads to get a clear understanding of the time spent on the role and adjusting time and funding expectations accordingly. Relatedly, the communications around the relationship between the funding provided and what this covers should be reviewed to clarify the view of many leads of the funding equating to a certain number of hours.

6.3 **Recommendation 2:** Welsh Government should consider exploring whether providing funding for the role to the individual leads themselves rather than to the pharmacy would allow for greater flexibility in how the roles are conducted.

6.4 **Recommendation 3:** The quality of support provided for the role has been a strength of the scheme. This support could be developed to include a clear consistent set of objectives for all leads, and to provide an opportunity for leads and their clusters to feedback more formally on the roles.

6.5 **Recommendation 4:** Welsh Government should consider building in protected time for specific development needs of the individual taking up the role. This should include regular signposting to specific training courses and their learning outcomes, to facilitate the navigation of the large number of training opportunities provided.

6.6 **Recommendation 5:** Those supporting pharmacists in the CPCL role should provide some guidance on the capability of the technology used to carry out the role and explore the feasibility of digital support. For example, varying security measures implemented by some employers of pharmacists makes accessing Microsoft Teams and other functionality more challenging. Making leads aware of this in advance, as well as methods for overcoming these issues would make meetings and other duties run more smoothly.

6.7 **Recommendation 6:** Welsh Government should consider what support the leads need to enable them to have more inclusive meetings with healthcare professionals

in their cluster. Increasing the awareness and understanding of the expected benefits of the lead roles amongst other healthcare professionals could help to raise the profile of the leads in their clusters.

6.8 **Recommendation 7:** Welsh Government should take steps to implement an evaluation framework to provide a structure for assessing the implementation and impact of this scheme and equivalent schemes for the optometry and dental professions, expected to roll-out in 2023 and 2024 respectively. The logic model produced as part of this review can be used as a starting point for doing so. It is also suggested that the leads from optometry and dental are involved in the evaluation planning from the outset, as are Welsh Government colleagues in Knowledge and Analytical Services.

Reference section

HM Treasury (2020) The Magenta Book. London: HM Treasury: HMT_Magenta_Book.pdf (publishing.service.gov.uk)

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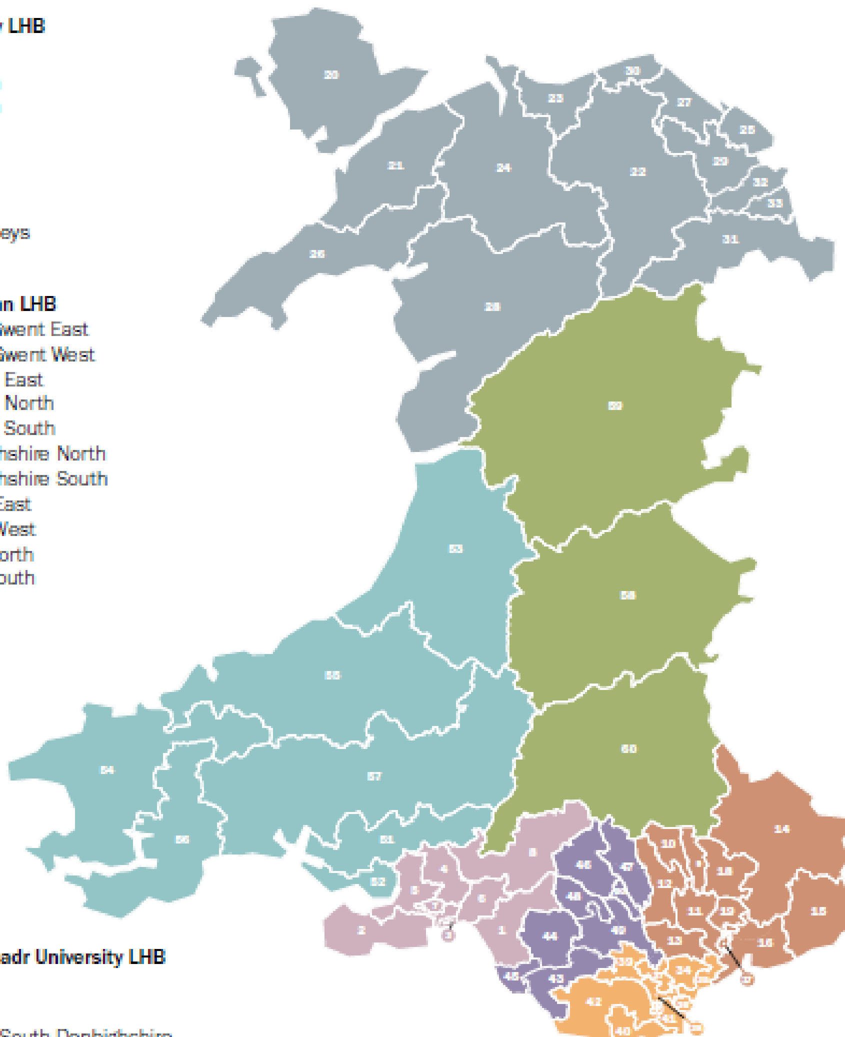
Annex A

Map Showing the Primary Care Cluster groups within each LHB

Primary Care Clusters

Swansea Bay LHB
1 Afan
2 BayHealth
3 CityHealth
4 Cwmtawe
5 Llwchwr
6 Neath
7 Penderi
8 Upper Valleys

Aneurin Bevan LHB
9 Blaenau Gwent East
10 Blaenau Gwent West
11 Caerphilly East
12 Caerphilly North
13 Caerphilly South
14 Monmouthshire North
15 Monmouthshire South
16 Newport East
17 Newport West
18 Torfaen North
19 Torfaen South



Betsi Cadwaladr University LHB
20 Anglesey
21 Arfon
22 Central & South Denbighshire
23 Conwy East
24 Conwy West
25 North East Flintshire
26 Dwyfor
27 North West Flintshire
28 Meirionnydd
29 South Flintshire
30 North Denbighshire
31 South Wrexham
32 North West Wrexham
33 Central Wrexham

Cardiff and Vale University LHB
34 Cardiff East
35 Cardiff South East
36 City & Cardiff South
37 Cardiff North
38 Cardiff South West
39 Cardiff West
40 Central Vale
41 Eastern Vale
42 Western Vale

Cwm Taf Morgannwg LHB
43 Bridgend East
44 Bridgend North
45 Bridgend West
46 North Cynon
47 Merthyr Tydfil
48 Rhondda
49 Taf Ely
50 South Cynon

Hywel Dda LHB
51 Amman Gwendraeth
52 Llanelli
53 North Ceredigion
54 North Pembrokeshire
55 South Ceredigion
56 South Pembrokeshire
57 Tywi Taf

Powys Teaching LHB
58 Mid Powys
59 North Powys
60 South Powys

Annex B: Theory of Change Workshop Topic Guide

Section	Questions / Issues to cover
1. Introduction (15 mins)	
2. Impacts and Outcomes (20 mins)	SHARE WHITEBOARD We will use the Whiteboard to record key points KEY QUESTION: What was the scheme trying to achieve at its inception? • Are these impacts clear enough? • What do you think about the wording of [each impact]? Do these terms need adjusting? • What alternative concepts / definitions would you use? • What tangible outcomes from the pilot are needed to deliver the impacts you have suggested? • How could we evidence these outcomes in the short term i.e. in the first year? PROMPTS • Developing effective cluster-wide partnerships • Facilitating improvement in access to and the quality of pharmaceutical services • Developing effective communication methods with pharmacy teams and cluster teams; Providing professional leadership and representation for all community pharmacies within the cluster.

<table>
<tr><td>3. Activities and resources (20 mins)</td><td>KEY QUESTION: What activities were undertaken to achieve these outcomes?

PROMPTS
• What resources will be required? E.g. funding, staff, expertise, stakeholder resource? Access to technology (i.e all leads have been give office 365 and teams)

• Who was responsible for delivering these activities?

• Is any monitoring data currently collected? What could be collected? In general-how can we/could we measure if the scheme is successful? Doesn’t have to be quantitative- e.g. are you looking for examples of the pharmacies working together?
•</td></tr>
<tr><td>4. Barriers and Risks (20 mins)</td><td>KEY QUESTION: What barriers and risks to achieving these outcomes have been experienced in the first year of the scheme?

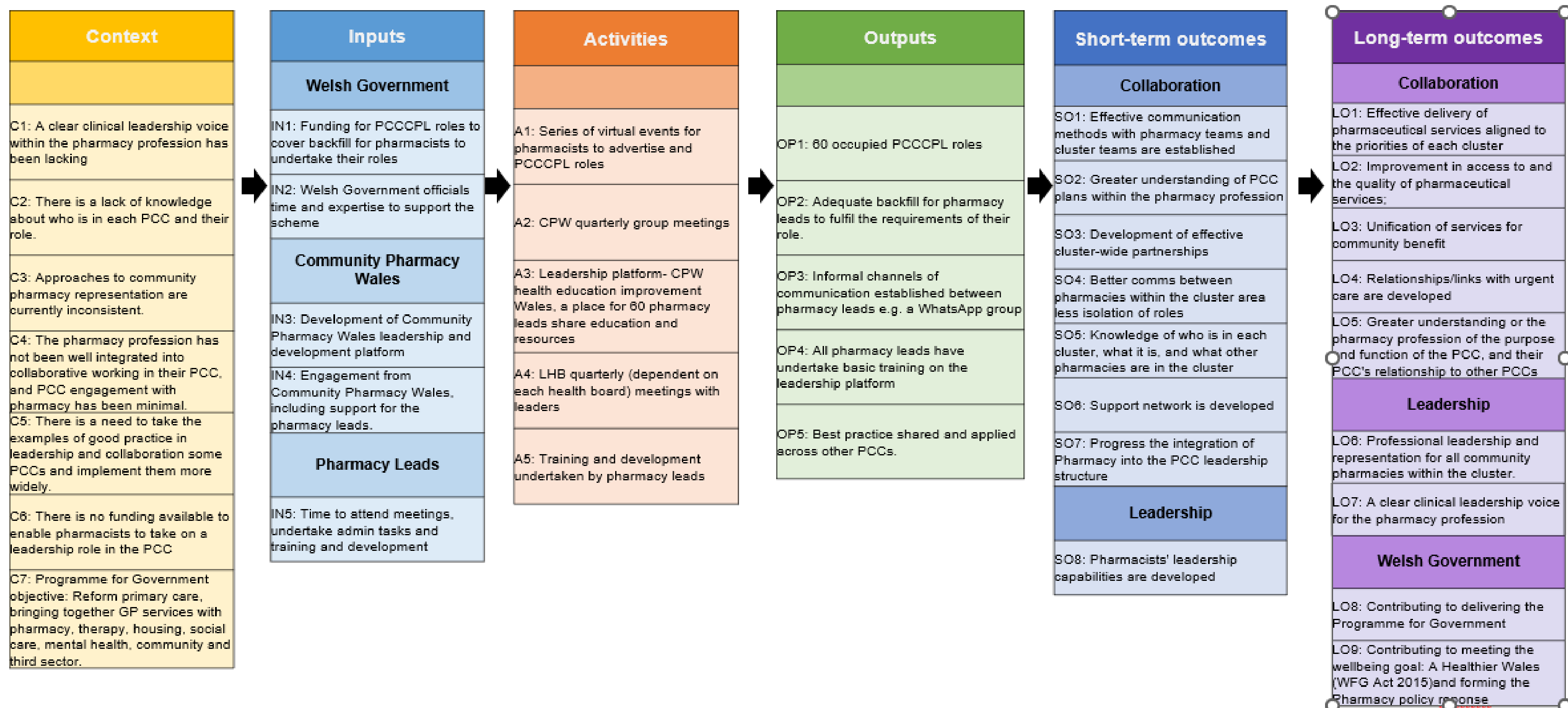
PROMPTS
Specifically around;
• Accessing resources (is the funding sufficient?)
• Delivering activities
• Evidencing that impact has been achieved

• What would need to change to minimise or remove these risks and by whom?

SPECIFIC PROMPTS</td></tr>
</table>

	• Issues with paying locums to cover the pharmacy (backfilling a few hours is awkward, need to pay a locum for full day) • Potential further training needs to enable the leads to use teams to communicate with other pharmacies • Pharmacies in the same cluster may be in direct competition with each other (making communication and working together difficult to manage/encourage) • Issues in who becomes the lead?
5. Summing up and next steps (Jo, 10 mins)	• Thanks all for attendance and contributions. • Content of the discussion will be used to construct a logic model mapping the scheme, providing us with background information and to inform the questions we ask Pharmacy Leads in interviews. • We welcome additional contributions after the workshop if there is anything you'd like to add. We will circulate the notes from this session as a record of the discussion if you would like. • This will be published as part of the full evaluation report, alongside suggestions around data monitoring. This will be published on the WG website. Questions?

Annex C: Logic Model



Identified Risks

(i) Staffing and Capacity

- The regular movement of pharmacy staff means that you will always need someone to put themselves forward to perform the lead role. This may be a challenge due to workforce pressures.
- Pharmacy staff may have problems securing backfill to attend daytime cluster meetings.
- Absences due to Covid-19 mean engagement in the role is lower, either because staff are off themselves or are covering other staff who are absent.
- The leadership capabilities of the leads are unknown at the point at which they take on the role.
- Leads will be at different points in their career and will have different training needs. There needs to be a discussion about how these varying needs can be addressed.
- It is unknown whether the financial remuneration is sufficient to enable the leads to discharge their duties in the role adequately.
- It is unknown whether the support provided to leads by CPW is sufficient and of the right kind.

(ii) Governance

- Clashes in governance arrangements e.g. independent vs non-independent operations
- There is no equivalent to these roles and therefore no set outcomes for what they can and will achieve.
- The variation in the management of pharmacies within clusters may lead to varying experiences in the leads role for pharmacists.
- There are varying needs of LHBs of PCCs and this places different burden's on professionals between each cluster.

Annex D: Pharmacy Leads Interview Topic Guide

Recruitment to the Role

1. How did you hear about the CPL roles and what was the process of recruitment to the role?
   FOLLOW-UP: Did you attend the virtual events before the application process and what was your experience of this session?

2. Were there any challenges to entering into the role and what were they?
   PROMPT: Backfill for your pharmacist or pharmacy technician role; the level of funding to cover your time, workforce pressures, COVID-19.

3. Are the key responsibilities of your role in line with your expectations when taking it on?
   FOLLOW-UP: If no, what are the key differences?

4. What did you understand to be the outcomes of the initiative and your role in achieving them?

Developing relationships within your PCC

5. Can you tell me about the various stakeholders you engage with within your primary care cluster and how these relationships have developed over time?

   PROMPT: Did the quarterly meetings with the pharmacies in your cluster help facilitate this and if so, in what way?
   Did attendance at the primary care cluster meeting help facilitate this and if so, in what way?

6. How have the opportunities to develop relationships with others enabled you to achieve the objectives of your role, or posed a barrier to doing so?

7. How has the support provided in the role enabled or posed a barrier to building relationships with stakeholders?

PROMPT: How community pharmacies engage with the cluster; support provided by Health Education Improvement Wales (HEIW) and Community Pharmacy Wales (CPW).

Developing cross-cluster relationships

8. How does the role offer opportunities to form working relationships with other Community Pharmacy Leads?

9. What were the enablers and barriers to developing effective cluster-wide partnerships?

PROMPT: Peer networks; time commitment, workforce pressures, COVID-19.

Personal Development

10. What training and development opportunities have you been (i) offered and (ii) taken up as part of your role?

PROMPT: Did you use the online leadership platform provided by HEIW, and what was your experience of using it? Did your health board provide any support? Did you have support from CPW?

11. To what extent has the training and development offer helped you in the role?

12. Have there been any barriers to taking up training opportunities?

PROMPT: time commitments, funding, workforce pressures, COVID-19

13. Have other forms of support have been provided to you and to what extent have they helped you undertake the role effectively?

Development of the role into the future

14. What was the most rewarding aspect of the role?

15. What is the most important change to the initiative that needs to be made to make it a more positive experience?

16. Would you recommend this role to a colleague? Why / why not?