'I expected just to walk in, get my tablets and then walk out': on framing new community pharmacy services in the English healthcare system

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Abstract   Reconfiguration of the healthcare division of labour is becoming increasingly attractive in the context of increased patient demand and resource constraints. One example is the introduction of extended roles for pharmacists to provide patients additional support to manage their medicines, while also reducing work pressures experienced by other health professionals. Understanding how such policies are framed by those delivering and receiving care has been under-theorised. Using Goffman's frame theory, we examine one newly introduced community pharmacy service (New Medicines Service (NMS)) to illustrate how a policy intended to support patient medicine-taking through the extended roles of pharmacists is framed and where this deviates from its proposed aims. Three themes emerged: (i) the spatial-material artefacts; (ii) existing discursive culture and practice around medicine-taking; and (iii) the NMS interactions that shape and govern framing and subsequent interpretation of the NMS. Our study offers an explanatory and dynamic view of the framing process with important lessons for reconfiguring medicine management policy and practice. As well as illustrating framing as being variegated, complementary or conflicting, it also shows how this plurality and fragility had consequences for patient engagement and sense-making. The consequences for engagement and recommendations for implementing future initiatives are discussed.

Keywords: Goffman, frame analysis, New Medicine Service (NMS), community pharmacy, patient, General practitioner

Introduction

The appropriate, effective and safe use of medicines has become global health policy priority, especially in the context of mounting concerns about anti-microbial resistance, the problems of polypharmacy for long-term conditions, and the spiralling costs associated with providing medicines in high to middle-income countries (Abbing 2016). Despite medicines prescribing being the most common patient-level healthcare intervention, patient adherence to medicines

prescribed for long-term conditions is variable (i.e. where patients take their medications as directed by their healthcare professional (Vrijens *et al.* 2012). It is estimated that approximately 50% of prescribed medicines are not taken as directed (Brown and Bussell 2011, Sabaté 2003), and non-adherence is linked to substantial worsening of disease, increased rates of hospitalisation and waste of scarce resource (Osterberg and Blaschke 2005). In light of the growing problem of adherence, the 'social life' of medicines and how they are perceived is of growing sociological interest. Attempts to understand medicines adherence has moved away from the traditional conceptualisation of adherence as a simple action of taking a medicine, towards a complex set of beliefs, attitudes and behaviours that can be affected by a range of influences including family and social context in which medicines are taken, and interaction with healthcare providers (Lutfey 2005, McCoy 2009, Whyte, Van der Geest and Hardon 2002).

Policymakers increasingly see the pharmacy profession, alongside other healthcare professionals, as especially well-placed to address this problem in the primary care setting, because community pharmacists are often more accessible than other professionals due to their extended opening hours and locations in the community (Todd *et al.* 2014). Government policies often see extended use of the pharmacy workforce as a means to reduce pressures on more expensive secondary or family practice services (Imison *et al.* 2014). The extended role of pharmacists in supporting medicines adherence also aligns with the contemporary 'professionalisation project' of moving pharmacy responsibilities away from retail and dispensing towards patient-centred services such as advice-giving and medicines optimisation (Mossialos *et al.* 2015). As a result, community pharmacy medicine management interventions are being introduced globally including Australia (Home Medication Review (HMR) (Pharmaceutical Society of Australia 2011), Canada (MedsCheck) (Ontario Ministry of Health and Long-Term Care 2011), New Zealand (Medicine Use Review) (Lee *et al.* 2009), Switzerland (Polymedication-Checks) (Niquille *et al.* 2010), the United States (Medication Therapy Management) (American Pharmacists Association and National Association of Chain Drug Stores Foundation 2008) and England (Medicine Use Review, New Medicine Service) (Pharmaceutical Services Negotiating Committee (PSNC) 2011).

The value and acceptance of community pharmacy interventions to the public is not always clear and pharmacists may underestimate the willingness of the public to take part in such services (Rodgers *et al.* 2016, Salter 2010). Although service users typically welcome pharmacists' advice when in line with expected core responsibilities (i.e. dispensing prescriptions/advice and treatment of minor ailments), advice is less readily accepted if extended beyond their perceived professional boundaries (Eades *et al.* 2011). Adoption of such services is also hindered by lack of patient awareness, insufficient integration into existing healthcare pathways, poor awareness among GPs (general practitioners), and pharmacist workplace barriers (Bradley *et al.* 2008). In addition, because community pharmacies in the UK are independent businesses, commercial incentives have influenced the way new services are introduced. This commercial-professional tension has been described as 'role strain' or 'role ambiguity' (Harding and Taylor 1997, Hibbert *et al.* 2002). A recent example of how organisational pressures impact on professional work can be seen in the 'target driven' delivery of the English MUR service (Bradley *et al.* 2008). Research also suggests policy-driven service innovations and workforce change can contribute to inter-professional competition, particularly where new roles extend the actual or perceived jurisdiction of pharmacy at the expense of other professionals, or for the benefit of corporate interests (McDonald *et al.* 2010).

Recent research suggests extended roles for pharmacists can transform the relationships, not only between health professionals, but also between professionals and patients (Edmunds and Calnan 2001; Harding and Taylor 1997). For example, advice-giving roles have been

interpreted as forms of 'pastoral' care with patients engaged in confessional and self-regulatory behaviour (Waring *et al*. 2016). However, the changing social relationship between patients and pharmacists in the context of these new services remains under-theorised. This paper examines the implementation of a new community pharmacy medicine management service called the 'New Medicine Service' (NMS), which aims to address the problems of non-adherence for people starting a new medicine for asthma/chronic obstructive pulmonary disease (COPD), type 2 diabetes, hypertension or antiplatelet/anticoagulant treatment (PSNC 2011). Using Goffman's framing perspective, we focus on the micro-realities in which this new policy is interpreted and cascaded by health professionals through their subsequent relational interactions. We focus in particular on pharmacists' interactions with patients and how this shapes and co-creates new sense-making that is context specific and situated according to circumstance. Framing not only demonstrates the dynamic nature of health policy implementation, but importantly the consequences of reconfiguring the division of labour, in particular, how framing by providers and service users is context-specific and influences outcomes.

The application of frame theory

According to frame theory, interacting individuals within in a given situation classify their experiences according to guiding 'frames of reference' that shape how they give meaning to the situation and their interactive roles within it. Goffman defines a 'frame' in the following way:

> I assume that definitions of a situation are built up in accordance with principles of organisation which govern events – at least social ones – and our subjective involvement in them; frame is the word I use to refer to such of these basic elements as I am able to identify. That is my definition of frame.   (Goffman 1974:10–11)

Frames enable individuals to organise and give meaning to their experiences through, for example, filtering and selecting relevant cues and providing a 'framework' for cognition, interpretation and to guide future action. Frames are the background meanings, cognitive structures and cultural frames of reference through which experiences are organised. It is argued that individuals organise the frames they create according to common understanding, and so enabling individuals, groups and society to function (Swingewood 2000). For Goffman, the core question to be asked when analysing such frames is to determine 'what is it that's going on here?' (Goffman 1974: 9). Far from being static, an individual's frame activity is embedded in their ongoing reality, in what Goffman calls 'organisational premises':

> Organisational premises . . . are something cognition somehow arrives at, not something cognition creates or generates. Given their understanding of what it is that is going on, individuals fit their actions to this understanding and ordinarily find that the ongoing world supports this fitting. These organizational premises – sustained in both the mind and in activity – I call the frame of activity.   (Goffman 1974: 247)

Framing has been used to explain how individuals condense manifold meanings to reduce the complexity of the world and so enabling them to interpret and make sense of what is happening (Moscovici 1984). In these cases, frames act as a filter so that people are only receptive to information that fits to the frame. An individuals' 'primary framework' helps render an otherwise meaningless aspect of a scene into something meaningful as it is experienced (Goffman, 1974). As well as creating social order, frames can be fragile, multifarious, malleable,

layered and often multidimensional (Manning 1992). The framing process is active and influenced by discursive and strategic processes (Benford and Snow 2000). This flexibility and multiplicity opens up possibilities for re-framing, frame misalignment and frame transformation. Goffman calls one kind of transformation 'keying' or staging, where new values, new meanings and understandings are transposed onto another framework. To illustrate this, he suggests a 'strip of activity' can be keyed by acts of framing, scripting, staging, and performing. However, keyed frames are likely to collapse when based on ambiguity, for instance when an actor is unsure of which frame to apply. One example Goffman provides to illustrate this is if someone suspects a bank is being robbed, but then only to realise that this was part of a filming of a bank robbery. A second type of frame transformation is where frames are manufactured or 'fabricated' intentionally by one or more individuals in an effort to 'manage activity so that a party of one or more others will be induced to have a false belief about what it is that is going on' (Goffman 1974: 83). These frames are liable to collapse when the deceiver is uncovered (e.g. someone realises they have been conned) leaving the actor disoriented and questioning the legitimacy of the activity.

Goffman's framing theory has been used and adapted by a multitude of social science disciplines (Fisher 1997), and has provided useful insights into health policy and systems research (Koon *et al.* 2016), including interpreting public health agendas (Driedger and Eyles 2003, Rothman and Salovey 1997) and patient-professional communication (Coupland *et al.* 1994). However, few studies explore service reconfiguration in light of the construction of multifarious stakeholder frames and consequential outcome for service providers and users (Koon *et al.* 2016). As such we use the NMS to:

1. Illustrate the dynamic nature of the framing process, in particular, how the NMS policy is interpreted, framed and enacted by professionals.
2. Understand how NMS interactions and associated contextual and spacio-material embodied artefacts shape lay-professional, relational and communicative exchanges and how these processes co-construct stakeholder frames and sense-making of the NMS.

It is recognised that how an activity is framed has significant consequences for its outcome. Importantly then, there is an opportunity to understand how new roles and relational interactions are constructed and framed according to pre-existing schema, cognitive structures, and values.

The study

The case of the New Medicine Service (NMS)

In line with many other countries, the UK government made significant changes in 2005 to the organisation and delivery of community pharmacy services to improve patient choice, reduce work pressures on GPs, and to encourage pharmacist involvement in chronic disease management (Department of Health 2008, Mossialos *et al.* 2015). The new community pharmacy contractual framework divided pharmacist work into three categories. 'Essential services' (dispensing of medicines, support for self-care, and health promotion etc.), and 'advanced service' (e.g. Medicines Use Review (MUR)) are remunerated at a national level, whereas 'enhanced services' (e.g. smoking cessation services) are commissioned locally according to the area's needs.

The NMS was based on research that showed that a significant proportion of patients starting a long-term medication quickly become non-adherent (Barber *et al.* 2004). Subsequently, a theoretically-informed (necessity-concerns framework) intervention was developed which

involved a pharmacist telephone consultation to follow-up patients prescribed a new medicine (Elliott *et al*. 2008). This intervention was found to be cost-effective in reducing non-adherence and was developed into the NMS, which was introduced as an advanced service in 2011. In practice, patients are initially invited to participate in the service (engagement) following a presentation of a prescription for a new medicine. The service comprises two semi-structured 'conversations', shaped to explore patients' understanding and use of their new medicines, especially to uncover non-adherence, from which individualised educational guidance and advice can be provided by the pharmacist to promote behaviour change. The consultations are undertaken (either face-to-face or via telephone) at 7–14 days and a further 14–21 days, after receiving the new medicine. To encourage pharmacist uptake, pharmacy contractors claim from the NHS between £20 and £28 per consultation depending on the number of patients who receive the service in any given month.

The NMS is framed in health policies as a way of helping patients manage newly prescribed medicines for a long-term condition. Critically, it becomes apparent that by proposing a 'one size fits all model' policymakers consider patients as a homogenous group with normative claims that they are somehow in need of professional support. On examining the service aims and intentions, the NMS arguably seeks to promote adherence through the identification of deviant behaviour in relation to patients' medicine or management of their long-term condition (Box 1) (PSNC 2011).

Data collection
This paper draws upon the findings of a qualitative study within a larger appraisal of the NMS in the English National Health Service (NHS), carried out between Spring 2012 and Autumn 2013. In the first instance, a detailed analysis of relevant health policies, training documentation and research evidence was undertaken to understand the development, implementation

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Box 1: NMS service aims and intended outcomes (PSNC 2011).

 1. Help patients and carers manage newly prescribed medicines for a Long-term condition (LTC) and make shared decisions about their LTC
 2. Recognise the important and expanding role of pharmacists in optimising the use of medicines
 3. Increase patient adherence to treatment and consequently reduce medicines wastage and contribute to the NHS Quality, Innovation, Productivity and Prevention (QIPP) agenda
 4. Supplement and reinforce information provided by the GP and practice staff to help patients make informed choices about their care
 5. Promote multidisciplinary working with the patient's GP practice
 6. Link the use of newly-prescribed medicines to lifestyle changes or other non-drug interventions to promote well-being and promote health in people with LTCs
 7. Promote and support self-management of LTCs, and increase access to advice to improve medicines adherence and knowledge of potential side effects
 8. Support integration with LTC services from other healthcare providers and provide appropriate signposting and referral to these services
 9. Improve pharmacovigilance
10. Through increased adherence to treatment, reduce medicines-related hospital admissions and improve quality of life for patients.

and policy framework of the NMS, especially the discursive expectations, policy aims and intentions through which the NMS was to be realised.

Following approval by the National Research Ethics Service (NRES), the study next investigated the implementation of the NMS within 23 community pharmacies located in three regions of the English NHS (London, Midlands, and Yorkshire). Pharmacies were purposively sampled to reflect recognised contextual factors, including pharmacy (ownership) type, geographical area and social deprivation (see Box 1). Following an ethnographic approach, non-participant observations were carried out for up to five days in each site to understand the social organisation of pharmacy services and day-to-day patient-pharmacist interactions. This provided detailed observations of how the NMS was organised and delivered as a routine intervention, including observation of how pharmacists provided information about the service, scheduled and undertook consultations, and managed patient information during and following the NMS consultation. A standardised profiling template was used to guide observations and developed from similar studies (Cornford *et al*. 2012) and from a review of the pharmacy literature.

Twenty patients were recruited to be 'tracked' or more closely observed as they experienced the NMS service. Twenty initial and sixteen follow-up consultations were observed and audio or video recorded (of the four patients who did not receive a follow up consultation, one patient withdrew from the study, one received a medicine change and two patients were referred back to the prescriber). Short (10 minutes) 'before and after' interviews were undertaken with both patient and pharmacist for each tracked NMS consultation to examine how patients and pharmacists interacted and influenced one another through the NMS, explore a priori and posteriori expectations, and how they framed consultations. All observations were written up in field journals and typed up as electronic summaries.

As well as observational data, this study draws on 35 patient interviews exploring different aspects of pharmacy service and the NMS, and 58 health professional interviews. NMS observations and the short 'before and after' interviews provided the foundation for subsequent semi-structured qualitative interviews with nineteen patients receiving the NMS (one patient withdrawal; ten male, nine female). These interviews explored patient reflections on the NMS in light of their previous experiences and interaction with the pharmacist and role of community pharmacy services. To facilitate comparison, thirteen patients who initially had agreed to receive the NMS at the 'engagement' stage, but had been randomly allocated to receive 'usual' care as part of the wider appraisal were interviewed about their experience of pharmacy interactions and how they were managing taking their new medicine. Usual care was the normal supply and advice associated with presentation of a prescription for a new medicine for a long-term condition. In broad terms this was dispensing the medicine(s) and providing advice at the point of handover to ensure the safe and effective use of the medicine. Three patients who had declined the invitation to participate in the NMS, were also invited to an interview (15 minutes) to further understand their reasons for declining to participate in the service.

Professional experiences and perceptions of the NMS were examined from semi-structured interviews with 47 community pharmacists and 11 GPs. Pharmacists were recruited through their involvement in the study's RCT. GPs whose patients were recruited to the study were also invited take part and offered an inconvenience allowance of £40. Due to the low numbers recruited (n = 5), a further six GPs were recruited through the Primary Care Research Network (PCRN). Full details of sampling and recruitment are reported elsewhere (Elliott *et al*. 2014).

Analytical approach
Qualitative data analysis started with the initial stages of data collection and proceeded iteratively so that emergent findings were incorporated into subsequent qualitative data collection,

including the revision of data collection methods. All data were transcribed and imported into qualitative analysis package NVivo (Version 11, QSR International, Brisbane) for the purpose of coding through constant comparison, with all authors sharing and comparing interpretations to clarify the internal consistency of codes and identify conceptual relationships. The coded data were systematically related back to understanding participant frames, how these were formed, realised and aligned in relation to other stakeholder groups and policy. We considered how issues of non-adherence had been framed, the dynamics of how the proposed solution (NMS) was represented within policy documents, which actors were addressed, and how the solution (using the community pharmacy) was portrayed. Our analytical approach therefore sought to understand NMS policy framing, stakeholder interpretation and framing of this policy, and how these were co-constructed alongside existing norms and expectations. Three themes that influenced this process emerged: (i) the spatial-material artefacts that shape and govern framing and subsequent interpretation of the NMS through this framework; (ii) how existing discursive culture and practice around medicine-taking influence NMS frame structures as well as beliefs; and (iii) NMS interactions and the local situated context in which the NMS was delivered.

Findings

Pharmacy environment and NMS engagement

Our first theme considers the spatial and material artefacts of the community pharmacy as the primary site for framing the NMS. The most prominent professional activities were for dispensing of prescription medicines and the sale of over-the-counter medicines. Each of the participating pharmacies used posters, displays and leaflets to promote a range of services, i.e. influenza vaccinations, smoking cessation. Not all pharmacies displayed information about the NMS, and where information was displayed, it was alongside other retail, promotional and educational materials, allowing limited scope for patients to differentiate new from existing services. As such, the 'spatial-material' embodied artefacts did not clearly covey a new image or pharmacy function where private, seated consultations about a newly prescribed medicine could be held.

This interpretation was supported when we observed pharmacists inviting patients to participate in the NMS. With the exception of one patient (who worked in a pharmacy), none of the patients who accepted the invitation were actually aware of the NMS or the extended role of the pharmacist into medicine review. Rather, they appeared to frame pharmacy activities predominantly as a means to fill prescriptions, obtain advice on minor ailments and to purchase over-the-counter medicines. The frame itself was based on a 'pharmacist as supplier' framework through which these activities were understood. This led to some patients being surprised when they were offered the NMS as they were unable to reframe the pharmacist invitation from their well-established or usual frame for which they were accustomed to:

Researcher: Did you expect the service to be offered when you first entered the pharmacy?
Patient: No, no I expected just to walk in, get my tablets and then walk out (laugh) [Patient_NMS_10-1]

Findings from patients who declined the initial offer, further suggested that these patients did not feel a need to receive the NMS. Patients revealed a lack of awareness of the purpose of the NMS, a lack of perceived necessity and relevance. With the service being offered with no existing frame or awareness of ambitions to extend the pharmacists' role, the offer for an NMS caught them 'off-guard':

I was taken by surprise when it was offered to me at [name of pharmacy] so I had no inkling about such a service beforehand.   [Patient_Decline_NMS_2]

Interviews with pharmacists also supported the view that patients had poor awareness and often declined participation. The most common reasons given for patients declining the service included being short of time, not seeing the relevance, or being confused about what the service entailed. Another significant barrier was the perceived disconnect between the GP and the pharmacist, and a perceived 'duplication' of work resulting in pharmacists struggling to justify why patients should engage in the NMS:

A barrier to the service to be honest is mainly when the doctor and nurse or someone is going to see the patient in the next 2 weeks. Because then patients say well do I need to come here as well?   [Pharmacist_175]

With patient frames aligned strongly with pharmacy's dispensing function, many pharmacists accepted that communicating the aims of the NMS was challenging. As a consequence, they adapted their approach, framing the NMS in ways they thought would 'convince' patients to accept the offer. They accomplished this by reassuring patients that the NMS was not a lengthy activity and by informing them that this was nothing threatening (i.e. not a policing / reporting activity). To facilitate engagement they offered the NMS as a phone consultation that was presented as a convenient alternative to a face-to-face encounter:

Sometimes if you go through everything it kind of just scares people away from it, and they are 'Oh I'm not signing up for it', when all you are doing is calling them up and asking for a quick chat, which is very informal.   [Pharmacist_63_1]

The new medicine

Our second theme unpacks the challenges of engaging patients with the NMS and how existing patient experiences and beliefs shape understanding. When asked about their new medicine, most patients reported being content with the level of information received at the time of prescribing and reported few problems. A minority reported adherence issues. Rather than returning to the GP, or speaking to the pharmacist, these patients adopted their own strategies to overcome medicine problems. These ranged from tolerating the medicine (where the problem was a side-effect), experimenting with the medicine (i.e. changing their prescribed dose) through to stopping the medicine altogether where they deemed this was necessary:

When I first took it [metformin] I was taking it with cholesterol tablets and for a couple of days I felt dizzy. So I separated the two tablets ... I've stopped taking the cholesterol to see if it was the metformin and that dizziness never came back ... Just for a couple of days because I wanted to like eradicate which one was making me dizzy. [Patient_No_NMS_120]

Pharmacists and GPs reported that significant numbers of patients experienced problems with medicines. They attributed this to patients fearing side effects, general unwillingness to take medicines, reports of negative media stories and problems associated with polypharmacy. Despite the mandate given to support adherence, some pharmacists were sceptical over the extent to which they could fully uncover or influence patient medicine-taking behaviour:

At the end of the day you can talk to them for half an hour, they'll do exactly what they want when they get back home . . . nothing you can say will change their mind.   [Pharmacist_04-1]

Despite GPs expressing frustration over the lack of time during the medical consultation, and recognition that medicine adherence was a problem, some GPs were open to the idea that pharmacists with their expertise in medicines, could help support patient adherence to medicines

It feels to me as though the pharmacist probably has got more time . . . we can't do it in 10 minutes, you're scratching the surface really. So somebody else spending a bit more time going through it is really important.   [GP_07]

However, there was little evidence to suggest the NMS policy had any impact on their practice or that the NMS policy frame had been effectively constructed as a potential 'medicine non-adherence' solution. One reason for this was that their contact with pharmacists varied but typically remained minimal, intermittent or ad hoc; the nature of the contact predominantly being about problems relating to prescription queries, minor errors, supply issues or drug interactions. With the NMS being undertaken in 'therapeutic silos' and with a lack of existing pharmacist-GP interaction, pharmacists reported seeing little difference in their relationships with GPs. Others have commented on the professional isolation that accompanies community pharmacy solitary working arrangements (Cooper *et al.*, 2009). As a result, GPs framing of the NMS was constrained by the lack of information about its aims or personal experience of how the service benefited their patients:

They [patients] would just say 'It's a conversation I've had with my pharmacist'. 'Was that useful?' Some will go 'Yes, I talked it through' and others will go 'Well not really, they just, you know, told me to carry on'.   [GP_03]

GPs' lack of understanding of the NMS, limited collaborative involvement and absence of clear NMS outcomes inhibited effective framing of the NMS as a means to support patient adherence. Being outside their circle of influence, the NMS frame itself was construed as being a 'pharmacist pretence'. This led to GPs not valuing the potential benefits, being disinterested or at times even being suspicious of the pharmacist intentions. Even pharmacist acknowledged the NMS potentially encroached on professional boundaries:

I think there's a lot of suspicion about amongst GPs about what this is about, you know that we're trying to do part of their job . . . there needs to be an open and transparent discussion about what this service is and what it isn't.   [Pharmacist_112]

The consequence of this was that GP referral to the NMS or even feedback when patients had been referred was limited. Most GPs made little effort to engage patients in the service at the time of prescribing, with some viewing the NMS as an unnecessary intervention with no clear benefit and questioning their cost-effectiveness:

I don't know how much the government are spending on NMS but it must be a phenomenal amount of money and I'm sure there are better ways of spending that money to do the same job.   [GP_10]

The NMS interaction

Our final theme focuses on the NMS interaction and the impact context has on the framing process. Analysis of observed NMS consultations revealed these to be typically polite and friendly encounters with discussions centred on the new medicine. Pharmacists would usually begin the conversation either by enquiring about the patient's general wellbeing, e.g. 'how are you' or asking how they were 'getting on' with the medicine. In about half of the consultations the pharmacist iterated the purpose of the consultation framing the activity as a 'check on how you are getting on with the new tablets' or whether they were 'okay' with the new medicine. Pharmacists then predominantly reinforced the prescribers' instructions, routinely enquiring about side effects and offering reassurance where these were considered transient or minor. With few opportunities to set their own agenda, most patients took a passive role within the consultation:

Pharmacist:	Have you been taking it?
Patient:	I've been taking it, I had a word with the pharmacist, and somebody rang me from your chemist and I told them I'm getting indigestion when I'm having this tablet. Now she said it will settle down in a couple of weeks. It's feeling a lot better now.
Pharmacist:	Oh good excellent, well that's quite normal, it can, upset your stomach to a certain extent but it's usually just a passing thing, it will improve after . . .
Patient:	So I used to take it when I'm having breakfast, I'm starting after the breakfast now.
Pharmacist:	Well that's fine, whichever way suits you. Are you still just taking the one a day?
Patient:	Yeah one a day.
Pharmacist:	Have you been taking that every day, have you missed any doses at all?
Patient:	No I haven't missed any days. [Extract_Consultation_130]

The NMS was generally portrayed by patients as a form of governance because of the enquiry into the new medicine and about how they were coping. However, with the pharmacist inviting and spending time with them, they also interpreted the interaction as an opportunity to talk with someone with expertise and to ask questions. They perceived the encounter as a caring and thoughtful gesture. The NMS was therefore framed as being 'above and beyond':

It's the first time I've been asked to give my opinion, get a chance to talk to somebody. Because before I never had this opportunity of doing things like that.   [Patient_NMS_112]

To sum it up, you actually felt cared for and that's important isn't it, that people aren't just being dished out medication and that actually there's a caring service. I would say you felt somebody is taking an interest in you.   [Patient_NMS_102]

When asked to reflect on whether the NMS was personally relevant or necessary for them a range of views emerged. Importantly, patients' understanding of the NMS was not found to be dependent upon existing notions or policy intentions of what the NMS was designated to do, but rather their understand appeared to be framed by what transpired during their interaction with the pharmacist. For instance, where there were few concerns with medicines or health, patients did not perceive the NMS to be personally relevant and their poor awareness of what the NMS could offer led some to find it challenging to articulate, or at times even remember, details of what had been discussed during their consultations:

Researcher: Do you remember anything of the consultations at all?
Patient: To be quite honest I don't, no. There was certainly nothing intrusive about it, there was no problems.   [Patient_NMS_169-2]

I think she asked me if, no to be honest I can't remember and I don't want to put words into her mouth that she might not have said.   [Patient_NMS_101]

Occasionally patients seized the opportunity to discuss extraneous issues that were unrelated to the new medicine, such as other ailments or diet. Pharmacist response to, and flexibility to accommodate, such issues affected patient framing and subsequent interpretation of the NMS, reinforcing the proposition that what occurred during the consultation significantly impacted on the way the NMS was framed:

I think its [NMS] been very helpful to me because it gave me the opportunity to talk about the other issues ... like the water infection I had, and then [name of pharmacist] made some suggestions about that as well. So on the wider issues I would say it was invaluable.   [Patient_NMS_102]

In contrast, experience and reporting of problematic side-effects allowed patients to construct frames that were amenable with NMS policy intentions. In cases where the patient themselves felt it was necessary to stop the medicine, the pharmacist's intervention provided legitimacy for this action. The interaction effectively offered patients 'permission' to return to the GP about the matter:

Pharmacist: So I just wanted to see how you're doing with that one [aspirin].
Patient: The problem is I'm not going to be able to continue taking them ... Because they're giving me a really bad stomach ... I've already had seven days in hospital with quite a large stomach bleed that needed five units of blood.
Pharmacist: And when was that?
Patient: That was in 1989 ... as soon as I started taking the aspirin. I started to get sore quite quickly and then it lasted for about 16 hours before my stomach seemed to settle down and then I took the next one again with my tea and it got even worse ... So I don't know really what my options are.
Pharmacist: No that's fine. What we are going to do we are going to refer you back to the doctors ... I can send a letter back to the doctors saying what side effects you are experiencing and I would advise you not to take the tablets any more ...   [Extract_Consultation_169-1]

The uncertainty that patients felt taking the decision to stop medicines was made easier when supported by the pharmacist:

It was well worthwhile having a second opinion on whether I'd either done the right thing ... I think even if the pharmacist had said yeah you'll have to persevere with it, I don't think I could have done, but that isn't what he said, so no it was a valuable second opinion to me.   [Patient_NMS_169-1]

The discourse during these NMS interactions appeared to have developed the patient's frame of the NMS and extended the frame of the pharmacists' role. This was towards a concordant frame where patient-pharmacist decision-making was being shared. This frame enable

patients to more fully recognise the pharmacists' expertise and the support they could potentially provide. There was evidence to suggest changes to patients' behaviour had occurred:

> I do ask more advice of the pharmacy now than I used to ... I went in the other day about some tablets and they said take this ... Before I wouldn't have done that, I'd have just gone in the shop, took a box off the shelf, paid for it and walked out.
>
> [Patient_NMS_112]

The shift in how the patient-pharmacist interaction enabled and shaped the framed the NMS was clearest when comparisons were made between those who had been randomised to receive the NMS and those who did not. For those who had not received the NMS, patient frames remained static, being fixed on the supply and retail functions of pharmacy. When hearing about the NMS for the first time, their pre-conceived frames constrained their understanding resulting in them raising questions about whether pharmacists could spare time to undertake such activities and even whether the pharmacist had the jurisdiction to intervene:

> It would be well worth it. Whether they've [pharmacists] got time to do it I don't know. It is time consuming after all.   [Patient_No_NMS_114]

> If my GP has prescribed something, my GP is the one who needs to know what's going off with it, not the pharmacist ... The pharmacist issues it. If I get an ice cream from an ice cream van, I don't go to the corner shop and say I don't like this ice cream.   [Patient_No_NMS_103 3]

Interestingly where a patient had reported a medicine problem, such as a side-effect, their frames appeared more malleable allowing the possibility for them to understand how pharmacists' greater involvement, even when they had not experienced the NMS, could be helpful, suggesting patients were capable of re-framing and better contextualising the extended role if they appreciated, or personally experienced, the context in which the service could be valued:

> He'd [pharmacist] would have the opportunity to say to me, 'I think you should see a doctor', or maybe he could say 'well don't worry about that because that's normal for that sort of drug, but if it's really worrying you I advise you to go see a doctor'.
>
> [Patient_No_NMS_167]

Pharmacist interviews provided insights into the way they re-framed, interpreted and then cascaded the aims of the service. This was found to be not always aligned with the NMS policy aims and intentions. Overall, the framing of the NMS acted as a means to improve their relationship and sought to govern medicine use. With increasing realisation that patients experienced problems with medicines, the NMS was interpreted as a support encounter. The NMS was often perceived as a way to 'check' how patients were coping with taking the new medicine, to offer help managing side effects, answering questions and providing information. However, NMS encounters in practice often did not identify significant problems with the patients' medicines or matters of adherence:

> I would say the majority of NMS that I have done, people are taking medicine regularly ... about 15% of patients have either not been taking the medicine or having problems

with the device ... And we were able to, for the majority of them, turn them around with advice to give them the opportunity to make an informed choice about taking the medicine or not.   [Pharmacist_113]

Although it was clear community pharmacies combined retail business alongside professional clinical services, there was little evidence that the sale of medicines created role strain. However, pharmacists' interpretation of the NMS policy frame was influenced by organisational views that the NMS was an income stream. Several commented that the NMS had come about to offset income loss associated with recent reductions in government dispensing budgets. For employee pharmacists, their interpretation of the NMS policy frame and subsequent motivation to engage with the service appeared to be more influenced by organisational pressure rather than an aspiration to improve patient medicine use. Several pharmacists felt uneasy where their professional responsibilities towards the patient's welfare conflicted with commercial interests. The NMS was being framed to patients in one way but some had a different views about it 'backstage'. This resulted in them expressing disquiet about their own motivations for carrying out the service:

I think, if only this patient knows that the reason why you are ringing at that time is because you need to make sure you get paid.   [Pharamcist_102]

If the target is not there then you can choose people you think that are really going to benefit ... so when the money is involved, we have to recruit everybody.   [Pharmacist_169]

Discussion

Through investigating the introduction of the NMS within the English NHS, this work extends understanding of the lay-professional framing process, how it is influenced by spatial-material artefacts, discourse and situated within professional structures and practices. Despite criticisms of framing theory, including methodological imperfections (Manning 1992), lack of definitional consensus (Scheff 2006) and divergent views on how framing influences thinking (Vliegenthart and Van Zoonen 2011), frame analysis has allowed for an exploration of how the NMS policy frame becomes manifest in pharmacists day-to-day delivery of the NMS, and how perception and understanding is generated and organised within everyday reality.

The NMS policy originated from evidence suggesting that pharmacists could extend their professional role in supporting patients' medicines adherence (Barber *et al.* 2004). It was evident from our data that both patient and professional accounts suggest patients experience problems with medicines indicating a common shared or 'aligned' frame. However, framing of the potential solution (in our case the NMS) was in practice found be more complex and variegated being dependent on the perceived need or value, the context of who and where this support was offered. The NMS policy frame in many instances remained unrealised and professional inconsistencies developed particularly when patients' frames were found to be misaligned resulting in low engagement and even resistance to the service. One proposed reason for this misalignment was that pharmacists are expected to realise the aims of the NMS within an established and embedded role that is located within conventional and largely unadjusted institutional practices and discourse. The impact of these well-established frames was that even patients who received the NMS appeared to have frames that were 'misaligned'

having constructed these based on strips of activity of what actually had occurred during the NMS rather than what should have occurred. This may explain findings from other studies suggesting patients' motivation to engage in similar pharmacy medicine review services are driven by a tendency to politeness and cooperation rather than self-interest or the prospect of personal benefit (Latif *et al.* 2013). In extreme cases, patient frames appeared to have collapsed where there was ambiguity or poor prior understanding of the NMS. Furthermore, the absence of materials issues during the NMS hindered opportunities for frames to be constructed and sense-making to happen.

The NMS policy frame appears to have been successfully constructed when patients, in Goffman's terms, were able to form new 'keyed' frames that extended or replaced their existing primary frame of reference. The crucial difference in these cases was that patient keying originated mainly from personal experience of a particular issue related to a new medicine for which they perceived support could be offered. The new interactions and routines offered through the NMS could more easily be embedded by patients to enable an alternative story to be construed that helped them form and replace existing frames (Jarratt and Mahaffie 2009). In effect, overt realisation of the NMS policy aims and intentions became manifest through enactment or in what Goffman (1974) would portray as it being necessary for the individual to understand the actual outcome or end-product of activities of others during the interaction. Our findings support the idea that interventions should be targeted to people that require them and that a service can only be influential to the extent that they are relevant or applicable to the users' pre-existing predispositions and perceptions (Nisbet and Scheufele 2009). Significantly, this study challenges policy and professional assumptions that reorganisation of services can be proposed without significant promotion, support, and review of current patient care pathways. Consideration of the existing division of labour and patient and professional frames are needed to allow any new service to be more readily accepted and adopted.

At a societal level, lessons can be drawn from social movement theorists with particular attention to the process by which 'ordinary people make sense of public issues' often with regards to challenging established orthodoxies (Benford 1994: 1103). Mass movements are said to be successful when the frames projected align with the frames of actors to produce what is known as frame resonance between parties. 'Collective action frames' are important for establishing both a common understanding of a social issue and the route through which the issue should be challenged. This frame alignment is key to the process of a group transitioning from one frame to another. Relating this to the NMS, if similar policy-lay-professional frame resonance is to occur, effective vignettes or other novel strategies are needed to educate and inform patients about how and when the NMS could be valuable, what happens during the process and what outcomes can be expected. With current NMS and other pharmacy medicine review promotional materials being found wanting (Van Den Berg and Donyai 2010), a review of promotional and public campaigns are needed in order to generate emotional engagement among segments of the public who may be indifferent, medically under-served or unacquainted with newer pharmacy services (Nisbet and Scheufele 2009, Latif *et al.* 2016, 2018).

Our study indicates that greater service traction may be possible if frame alignment (mainly with prescribers) is achieved. In order to improve awareness of the potential value to doctors and to patients, greater integration of the NMS with other health services is needed. For example, in Australia physicians are responsible for the referrals of patients to the HMR service (Pharmaceutical Society of Australia 2011). Moreover, responsibility also rests with policymakers and employers to ensure organisational targets and target-linked remuneration for undertaking the NMS do not lead to perverse incentives, as found in other healthcare settings (Mears 2014). Our study suggests that some pharmacists might have interpreted the NMS primarily as a means of securing income, over and above a health promotion intervention.

Although these are not necessarily mutually exclusive, the motivation of pharmacists could have implications for their consequent framing of the NMS with patients, including what might be interpreted as 'fabricated' frames, where underlying financial motives are overlaid with a health promotion frame.

In conclusion, our study offers an explanatory view of the NMS framing process that has important lessons beyond medicine management policy to potentially any reconfigured service. Our case illustrates framing as being dynamic, variegated, complementary or conflicting, and how this plurality and fragility had consequences for patient engagement and sense-making. In light of these findings, policy and professional assumptions that suggest patients can be categorised and treated as a homogenous group requires reconsideration and service innovation so that a more personalised care approach can be introduced. Recent work indicates the NMS increases patient adherence to a new medicine by about 10% when compared with normal practice and increases health gain at reduced overall cost (Elliott *et al*. 2017). This paper offers recommendations so service improvements can be made to ensure the service realises its full potential. Whereas the findings are embedded within the analysis of agency, the analysis did not seek to include the 'interaction of the powerful' (Giddens 1987: 134) or circumstances in which 'power' is exercised as this has been explored elsewhere (Waring *et al*. 2016). Further work may be needed to understand how professional power and influence affect framing and the consequences for patient care.

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Acknowlegements

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