Briefing

The Pharmacy Practice Research Trust

INNOVATION IN COMMUNITY PHARMACY:

Accelerating the spread of change

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Introduction

Community pharmacy is on the verge of the most fundamental changes for decades. The introduction of a new NHS contract, removal of some restrictions on the award of NHS contracts and the implementation of the new General Medical Services contract will all be happening during 2004-5. This briefing paper, utilising new research into innovation in community pharmacy, is for policy and decision makers concerned with implementing change in community pharmacy services. It sets out the current structure and organisation of community pharmacy, key policies that are leading to change, and how evidence from research can inform change management. In this document the results of the research are discussed in relation to the health service system in England for clarity, however the principles of innovation and how it can be applied are unlikely to differ across different health care systems in the UK.

The Pharmacy Practice Research Trust was established in July 1999 as an independent research charity, with core funding provided by the Royal Pharmaceutical Society of Great Britain. The Trust's overall aim is to support and promote the development of high quality practice research in pharmacy and its contribution to informing health policy and practice.

There is wide agreement that community pharmacies could make a greater contribution to patient care but there are well acknowledged barriers to achieving this, including an NHS contract designed decades ago. A number of policies are now converging to bring about major change in community pharmacy (see Figure 1) and for this to be of maximum benefit to all stakeholders, the implementation of change will need to be optimised.

Although community pharmacy has a well-documented history of pilots for a number of innovations, roll-out in the past has been episodic, resulting in insufficient patient benefit and the sub-optimal use of resources.

This Briefing Paper sets recent research into innovation in community pharmacy (Tann and Blenkinsopp 2002; 2003) in the context of these changes, utilising the themes identified in a recent major literature review (Bond et al 2003), and concludes by suggesting how innovation could be more effectively implemented in the sector in future.

Innovation in community pharmacy – a definition

Innovation is an outcome (e.g. service or product) as well as the process of innovating and the term innovator is used to describe:

- the initiator of a new product or service (which may be intrinsically new or new in its geographical area) – e.g. NHS supply of Emergency Hormonal Contraception; medicines management services
- the adopter of a new service or new way of doing things – e.g. initiating organisational change

We use an inclusive definition, namely that innovation is:

"an idea, practice or object that is perceived as new by an individual, or other unit of adoption" (Rogers, 1995), which includes organisational innovation (frequently termed organisational change). The separation of innovation from the notion of originality is important. The key points for PCTs are that the product, service or technology is new to the initiating or adopting organisation and that its uptake leads to intended (and sometimes unintended) practical outcomes.

This briefing paper is divided into the following three sections:

Community Pharmacy - the current situation?

The market environment and the structure of community pharmacy

NHS policy has, since the publication of the NHS Plan in 1999, set a direction of change for community pharmacy. A new contract is under development that aims to shift the basis of payment away from numbers of prescriptions dispensed and towards quality of services provided.

Changes will also occur in the regulations that govern how and when NHS contracts for pharmaceutical services can be obtained. Since 1987 new NHS contracts for pharmacy services could only be obtained where a 'necessary and desirable' requirement was met. Whilst large pharmacy multiples have sometimes opened premises initially without a dispensary (a 'non-contract' pharmacy) this regulation has essentially restricted the opening of new pharmacies. The situation is likely to change with the implementation of a 'balanced package of measures' to reform the control of entry rules following the 2003 OFT Report which called for the deregulation of pharmacy contracts.

The new General Medical Services contract also has implications for community pharmacy. Chronic disease management services could be more effectively delivered if community pharmacies were involved; while the redistribution of GP workload, particularly transfer of the management of minor ailments, has been widely promoted.

Figure 1 - Key Policy Changes affecting Community Pharmacy

Policy	Implications for PCTs	Key timescales
New NHS Community Pharmacy Contract	Increased opportunity to tailor services to local needs; capacity required for needs assessment and service commissioning	Contractor vote 2004
Office of Fair Trading (OFT) 2003 report on community pharmacy	Opening of new pharmacies; PCTs will have less control on pharmacy numbers or distribution	Final DH regulations for changes to control of entry (expected later in 2004)
DH Vision for Pharmacy 2003	Development of public health role and pharmacist prescribing	Public Health Strategy by 2005
Pharmacy in the Future 1999	Implementation of repeat dispensing. Identification of medicines management needs for commissioning	*Repeat dispensing national roll-out target 2004 * PCTs to commission medicines management services from pharmacists by 2004.
New GMS contract	Out of hours services; Medicines management; Aspects of chronic disease management; Management of minor ailments	Implementation starting 2004-5
Choice, Equity and Responsiveness	Consideration of minor ailments schemes targeted in disadvantaged areas; transfer from general practices of some monitoring of chronic disease.	Implementation starting 2004

England has approximately 11,500 community pharmacies owned by individuals, small and large companies. The structure and context of community pharmacy are summarised in Figure 2. The 'average' PCT in England thus has around 40 pharmacies. Most pharmacies are located in high street shopping areas or local shopping parades. Some are near GP surgeries and a few are located within health centres.

Figure 2 - The Structure and Context of Community Pharmacy

- Community pharmacy services are provided by multiples, supermarket chains and independents
- The proportion of multiple-owned pharmacies is increasing – within 10 years it is estimated that independents will comprise only 25 % of all pharmacies
- Some of the multiples are part of large multi-national vertically integrated corporations which are publicly quoted on the stock exchange
- The national contract for core NHS service provision is held between the primary care organisation and the pharmacy contractor, which may be an individual, a partnership or a body corporate
- Decisions about service provision may thus be made by owner proprietors or by large corporate organisations
- PCTs are also purchasers of locally-determined community pharmacy services
- Local Pharmaceutical Committees (LPCs), elected from amongst local contractors, negotiate local service provision with PCTs on behalf of contractors
- PCTs appoint Pharmaceutical Advisers who often work in a change agent capacity with local pharmacists to promote the roll-out of service innovations

The question of how to manage the implementation of change within this contractor profession is therefore of great importance for the NHS.

Community pharmacy is a contractor service with both public and private sector funding. For most pharmacies the NHS is the main client, with 70% of income in the average pharmacy coming from its NHS contract.

Traditionally most NHS funding has been paid through the national pharmacy contract with relatively small amounts contracted locally for the provision of advice to care homes, oxygen services and out of hours rota services. New ventures may in the future be NHS-commissioned or introduced as part of a pharmacy's commercial plans for diversification within the wider context of primary and alternative healthcare.

Figure 3 - The Organisation of Community Pharmacy

- With the exception of the majority of health centre pharmacies, community pharmacies are retail establishments, which, besides providing NHS dispensing services, offer a range of health-related and other products for sale.
- Community pharmacy is not currently connected to the NHS net
- Community pharmacies are computerised and keep records of patients' prescribed medicines.
- Community pharmacy is regulated by the Royal Pharmaceutical Society of Great Britain, whose inspectors conduct regular visits to pharmacies
- Some pharmacies offer services such as blood pressure measurement, cholesterol testing and diabetes screening
- Some pharmacists co-operate with other health care providers such as chiropodists to provide an integrated service
- Some pharmacists offer complementary health services such as acupuncture and aromatherapy from their premises
- Pharmacists may belong to a local network such as a Pharmacy Development Group (established by the RPSGB) which provides a forum for the diffusion (roll-out) of innovations and best practice

In the future the balance between nationally (Essential and Advanced services, see Figure 4) and locally contracted (Supplementary) services will change, with the opportunity for more services to be commissioned locally by PCTs. The adoption profile necessary for implementation may range from fewer than 10% to 100% of pharmacies depending on the need for service. Unlike other parts of the NHS, community pharmacy's structure means that PCTs will be negotiating both with individuals and corporate groups.

Figure 4 - The New Community Pharmacy Contract

Service level	Nature of service	Pharmacy providers
Essential services	Includes one-off and repeat dispensing; Advice on minor illness	All pharmacies are required to provide
Advanced services	'Medicines Use Review'; Prescription Interventions (Pharmacy-based)	Accredited pharmacies will provide.
Supplementary Enhanced services	Eg: NHS Minor ailments scheme; 'Concordance services'	Some pharmacies will provide locally commissioned services

Community pharmacy operates in a competitive business environment and is therefore subject to market pressures. Its organisation is summarised in Figure 3. While community pharmacy is different from many NHS providers, the challenges it faces are not unusual in the world of business. Multiples and supermarkets may seek efficiencies through business scale-economies, while small chains and independents may compete in niches. Business, administrative and technological innovations, such as a policy for overall risk management, new ICT (Information and Communication Technology), an intranet between pharmacies in a small chain, new procurement arrangements, or premises re-design, are essential for overall business effectiveness and efficiency. In making a decision to introduce a service, technology, or management innovation, pharmacy owners need to undertake a feasibility assessment which includes the overheads of running the pharmacy, as well as the opportunity costs of innovating.

Extension of the service provision of community pharmacy

At the heart of the new contract is the extension of service provision in community pharmacy to encompass a more active role in monitoring and reviewing medicines in greater contact with patients. Some PCTs are known to be commissioning additional services from community pharmacy, with a range from 0 to 14 services by PCT (Celino et al 2003) and the innovators studied in the current research routinely provided additional services. The scale and extent of such service provision is unknown although a survey conducted by the King's Fund found that many pharmacies provide services beyond those remunerated in their current NHS contract and that provision was variable (Lewis 2003). Research also showed that while the majority of community pharmacists believed the future lay in clinical practice and direct patient care, there were key barriers to progress (Taylor and Carter 2003). Some of the new services that have been piloted locally and are currently under development for wider implementation, such as 'Medicines Use Review', have implications for premises (provision of private areas), training and deployment of skill mix.

Composition of the community pharmacy workforce

Key aspects concerning the workforce are summarised in Figure 5. The majority operate, at any one time, with a single pharmacist supported by ancillary staff, including self-employed locums. Larger multiples and supermarkets tend to employ a number of part-time pharmacists and locums on a shift basis in order to cover the longer opening hours. Pharmacy staff typically comprise pharmacist(s), dispensing technician(s), medicines counter assistants and other counter assistants.

Figure 5 - The Community Pharmacy Workforce

- Major changes in the composition of the pharmacist workforce have occurred in recent years.
- In particular, more pharmacists are working part-time or as self-employed locums and fewer appear to aspire to the traditional model of being a 'pharmacist-in-charge' on a full-time basis.
- There is a national shortfall of pharmacists in the community pharmacy workforce.
- Continuing professional development will become compulsory for pharmacists in 2005.
- Training has been compulsory for medicines counter assistants since 1996 and will become compulsory for all dispensing staff by 2007.
- The work of dispensing technicians must be subsequently checked by a pharmacist or, for specifically qualified staff, a checking technician.
- Where technician-dispensed prescriptions are authorised by another technician, opportunities are provided for the pharmacist to engage in other patient care activities.

Partnership-based approach to service delivery

Inter-pharmacy collaboration and the development of inter-professional partnerships between community pharmacists and other health care professionals were identified as central issues in the literature review (Bond 2003). The review also identified the *"substantial managerial challenges associated with the development and maintenance of these organisational forms"*. It is clear that better integration of community pharmacy into the wider primary care team is needed if community pharmacy is to make a greater contribution to patient care. Examples include local plans for integrated out of hours services, as well as emergency care networks.

Changing nature of the pharmacist-consumer interface

The wider NHS is moving towards greater patient and public involvement in service design and development and increased attempts are being made to offer services that meet users' different needs. Research has shown that patients would like to receive more information about treatment and to be more involved in decision making about treatment (Building on the Best 2003). To date, patient and public involvement in planning and development of community pharmacy services has been limited (Celino et al 2003).

Learning from the Research

Supporting Change and Evolution; the innovation process

The research on innovation in community pharmacy confirmed findings in the literature that the spread of innovation depends on three factors:

a) Characteristics of the innovation
b) Adopter categories
c) Innovation roles in the management of innovation

a) Characteristics of the innovation

The research findings supported Roger's (1995) categories of innovation characteristics which enhance adoption rates: relative advantage, compatibility, complexity, trialability and observability. Three innovations were analysed for their fit with these characteristics: an asthma management programme, supervised methadone administration and supply of emergency hormonal contraception. In each case the relative advantage was clear to patients, GPs and pharmacists; there was a degree of compatibility with existing services and systems and also, importantly, with the pharmacist's values; levels of complexity were perceived to vary but, as we have shown above, early adopters tended to perceive levels of complexity to be lower. Each of the three could be trialled, and pharmacists were able to withdraw from the scheme; while observability was high to PCTs and to service users.

We identified six categories of innovation outcomes in community pharmacy: improved patient care; increased external collaborative working with other health professionals; greater business efficiency and effectiveness; improved inter-pharmacy relationships; improved intra-pharmacy relationships; increased professional esteem and recognition. Different parties will have different priorities and are likely to accord different levels of importance to specific outcomes. Where innovation characteristics are related to potential outcomes there is greater potential for 'fit' between patient needs and service provision.

b) Adopter categories – pharmacist adopters

In the adoption of any innovation there are earlier and later adopters. Rogers showed that the adoption of an innovation, when plotted on a frequency basis over time, follows a normally-distributed bell-shaped curve. We are not suggesting that innovation proceeds in a simple linear way but Rogers' adopter categories are very relevant in understanding behaviour and spread. The first 2.5% are 'innovators' who identify and try out new ideas. Innovators are not necessarily engaged in networks and may be more interested in moving on to the next area of interest than in spreading the previous one more widely.

The next 13.5% are characterised as 'early adopters' who see the big picture, are venturesome and willing to accept setbacks. In practice it is not always possible (or necessary) to distinguish 'innovators' (in Rogers' terms) from early adopters, although Rogers suggests that later adopters more readily follow early adopters whom they perceive to be more reliable and with whom they can more readily identify.

By contrast, later adopters have been described (Rogers, 1995) as being more dogmatic, less able to deal with abstract concepts, less able to cope with uncertainty and risk, and less highly connected through personal networks, including having less contact with change agents.

Almost all pharmacists in the research were innovators or early adopters of new practices, which had been initiated or sponsored by PCTs (sometimes by wholesalers), in response to an identified need. Pharmacists located in PCTs in which there were area and network innovations were clearly identified as early or later adopters, or non-adopters, by their noticeably different behaviours. Figure 6 summarises these behaviours.

Figure 6 - Adopter Categories in Community Pharmacy

Innovators/ Early Adopters

- Volunteer for pilots
- Motivated by desire to respond to patient and customer needs
- Likely to be 'continuous improvers'
- Motivated by the prospect of integrated working with other health professionals
- Not afraid to experiment – risk-takers
- Money an enabler, not a show-stopper

Early and Late Majority (later adopters)

- Likely to be more risk averse
- More likely to identify complexities and potential difficulties
- More likely to need to see incremental steps to change
- Money likely to be viewed as more important

Innovator and early adopter pharmacists were characterised by their focus on the needs of their pharmacy users. Examples include design of the premises, with the creation of a 'medicines management' area where the pharmacist could undertake medication reviews with patients; the installation of a computer for patient internet access to health information; allowing the use of the pharmacy as a classroom for patient education sessions; and ensuring that patient information leaflets were available in a variety of languages in areas with

higher numbers of people from different ethnic backgrounds. Innovators and early adopters were more likely to be seen talking with patients and customers in the pharmacy (management by walking about) and, in areas of relatively stable population, ensuring that they and their team knew most patients by name.

c) Innovation roles in the management of community pharmacy innovation

The roll-out of innovation was found to be consistently more effective within a network or a delineated area (for example, a Pharmacy Development Group area or a Health Action Zone in which a change agent worked as a catalyst with identified innovators and early adopters who, in turn, acted as role models for potential later adopters). This endorses Rogers' (1995) observation that later adopters are more likely to be persuaded by the demonstration effect of earlier adopters. Change agents, thus, have a key role in a) identifying early adopters and b) resourcing and affirming them in a networking role.

One wholesaler-owned organisation in the study developed a series of extended services in community pharmacy. The Company implicitly acknowledged the segmentation of populations of adopters, tailoring its approach to the characteristics and behaviours of pharmacists within different time-related adoption segments. Their asthma programme illustrates this point. An early adopter was proactive and in touch with local GPs, recruiting patients and referring them if not satisfied with the patient's response to treatment. By contrast a later adopter became a non-adopter, complaining that the scheme was too complex, that asthma was too difficult to handle and so withdrew from the scheme.

Change agents are key to the diffusion (roll-out) of innovations in community pharmacy. They are likely to be external to the independent community pharmacy sector (for example, employed as a Pharmaceutical Adviser in a PCT) and internal to multiples and supermarkets, where corporate structures for pharmacy include professional development staff. They are characterised by vision and energy and an ability to see the 'big picture', as well as being politically sensitive, not seeking the credit for successful innovation but achieving job satisfaction from their contribution to making it happen. For example, one multiple in the research nominated change agents as Professional Service Managers who were responsible for mapping NHS opportunities at a local level and identifying and facilitating information exchange in different parts of the UK. For spread to occur early adopters who not only believe in the new idea, but also have status within the profession and are able to influence thinking are important (Fitzgerald et al 2003). The credibility of this small group of people is essential for change and for an innovation to be adopted, which can then signal the start of wider spread. Without these respected members of the profession, who occupy a central position in professional networks, an innovation will not diffuse.

An important consideration in community pharmacy innovation is the extent of spread that is needed. For some innovations it may be sufficient to engage only early adopters, taking into account the location of pharmacies to enable optimum access for patients. For other innovations, a more complete roll-out to include later adopters will be needed if a widespread and equitable service availability is required. Besides the importance of fit between innovation characteristics and perceived needs, innovation requires effective leadership and management. Innovating pharmacists studied in the research involved pharmacy staff in the introduction of innovations, and in so doing developed the pharmacy team. They were also prepared to consult widely with others through formal and informal networks.

Above all, for innovative services to be widely available and cost effective they must be sustainable. Resource is wasted where pilot projects are inappropriately placed with less innovative pharmacists, where they are not followed through, and where successful experiments are abandoned when funding ceases. The research suggests that innovators and early adopters do not seek financial reward for new service provision, but

that appropriate remuneration is required for mainstreaming an innovation through the majority and late adopter populations.

Many of the collaborative innovations studied had a central hub where a change agent had taken on the responsibility of persuading and facilitating individual pharmacists to adopt an innovation. In one example where a similar innovation was introduced in two areas, one on the 'hub' model and one where community pharmacists developed the innovation collaboratively as members of a network, it was the latter situation that proved to be more sustainable.

The collaborative innovations studied were those initiated by Pharmacy Development Groups, pharmaceutical wholesalers and primary care organisations; these were often led by change agents. Examples included prescription intervention schemes, the review of medicines for specific conditions (for example hypertension, asthma) and the supply of medicines for specific patient groups (for example, emergency hormonal contraception, supervised methadone). There was considerable variability in pharmacists' activity levels within PCTs, but this is not surprising in view of the differences in adoption rates within adopter populations. The highest variability in level of activity was where the pharmacist was required to be proactive, for example in contact with doctors. Innovations that required active recruitment of patients to a service were also subject to considerable variability in uptake.

Overcoming barriers to innovation

The importance of understanding barriers to change is highlighted by recent research (Fitzgerald et al 2003). Recent organisational literature tends to emphasise this aspect, arguing that overcoming barriers plays a more crucial role than stimulating innovators. The change agents in community pharmacy, studied in the research identified potential barriers and ways of overcoming them. Indeed tenacity and a relish for finding creative solutions were distinguishing features of these change agents. In one example the change agent identified early adopters to pilot a new service, arranged for them to visit colleagues in another area to discuss barriers and subsequently to work with later adopters as 'product leaders' and informal mentors. The shadowing and understanding gained enabled the early adopters to learn more quickly about perception and the reality of providing a service. In this way they were able to reassure other colleagues and share solutions.

Next steps for PCTs

During the next year PCTs have a challenging agenda to implement change in community pharmacy services. The NHS has published a specific series of requirements (Figure 7).

Figure 7 - PCTs are expected to:

- Review their existing range of pharmacy services to assess development needs.
- Appoint a lead in implementing the new community pharmacy contract who works at or reports to director level
- Include, as part of GMS implementation, consideration of the services that may be provided by community pharmacists
- Take account in the Local Delivery Plan of opportunities to develop community pharmacy services
- Identify sufficient resource to allow for implementation of the contract

www.natpact.nhs.uk/newcf/index.php?show=y&d=M&sd=11&&&c=1&s=2

In addition PCTs will need to consider pharmacy services in the context of general needs assessment and the requirement to provide services comprehensively across the PCT. The roll-out of the new pharmacy contract will be dependent on PCTs and on whether the PCT views this as an opportunity for change or simply as a different way to pay for usual pharmacy services.

The NHS needs to adopt a strategic approach to innovation in community pharmacy in order to optimise patient benefit and resource utilisation. Relevant innovations are identified alongside the major policy changes below (Figure 8):

Figure 8 - NHS Policy Changes and potential Innovations

Policy	Potential innovations
New NHS community pharmacy contract	- Distinctive pharmacy capabilities identified - Selectivity in service offerings, minimum standards adopted
OFT regulatory changes	- Service differentiation and specialisation - Collaboration - Organisational innovation - Supply chain alliances
Vision for Pharmacy	- Partnership with other health care professionals - Strategic alliances - More patient-centred services
Pharmacy in the Future	- Collaborative relationship with GPs - New models for medicines management
New NHS General Medical Services contract	- Collaborative relationship with GPs - Transfer or sharing of some existing GP-led services (e.g. transfer of minor ailments management to community pharmacy; pharmacist streamlining of repeat prescription services; development of new out of hours services) - Pharmacists entering partnerships with GP practices
Choice, Responsiveness and equity	- Transfer or sharing of some existing GP-led services - Greater use of community pharmacies as 'first contact' resources

For innovation in community pharmacy to become embedded and sustained it is essential for the innovation process to be effectively managed. This requires attention being paid to the characteristics of the innovation, the categories of adopters (and how full a roll-out is required), and the requisite innovation roles in the management of innovation. For example, PCTs will need to adopt a strategic perspective of the role of innovation in community pharmacy's contribution to patient care. They will need to identify which innovations are required to be adopted in response to different elements of the policy agenda and how fully the roll-out should be within the area (Figure 9). Although there are different models that PCTs might use we suggest that this requires the involvement of the CEO, leadership from the Professional Executive Committee and Primary Care Development Manager, with the Pharmaceutical Adviser (possibly in change agent role), a representative of the LPC, and one or two innovator/early adopter pharmacists, together with representatives of GP practices, to audit the present situation, envision a development plan for new pharmaceutical service provision, and identify and plan for what has to be put in place to achieve the strategy.

Within this overall strategy a number of separate innovations will be identified. These

will be more effectively rolled-out, once the size of the intended adopter population has been ascertained.

Change agents are key to the process of identifying which innovations and which potential adopters are to be targeted, besides acting as a catalyst in bringing individuals together and identifying the necessary resources, including skills. For this reason the identification of change agents needs to be undertaken with reference to the characteristics outlined above and possibly, also, employing an appropriate psychometric measure.
Recognition of the benefits of segmenting the adopter curve and applying it in practice will facilitate the identification of potential adopting pharmacists by making reference to the characteristic behaviours of innovators and early adopters, the early and late majority and laggard adopters. Change agents will be at their most effective in energising and working with early adopters who, in turn, can be involved to act as role models for later adopters. While early adopters are unlikely to seek compensation initially for innovation (since they gain job satisfaction), remuneration is a significant potential blocker to later adopters and it is important that this is recognised if a particular innovation is to be mainstreamed (Figure 9).

Figure 9 - Innovation Process in community pharmacy: Implications for PCTs

Innovation Process Implications	**Action required**
Holistic perspective on contribution of innovation in community pharmacy to patient care	Strategic plan for innovation
	Involvement of relevant parties
Recognition of need for change agents; job descriptions	Methodology for identifying change agents in PCTs, and multiples and local pharmacy groups
Recognition of benefit of segmenting adopter curve	Change agents involved in identifying pharmacists with different adopter characteristics and planning roll-out with reference to the adopter categories
	Change agents work with early adopters to empower them as role models in roll-out to pharmacists with later adopter characteristics
	Pharmacy Development Group or other network to facilitate adoption
Identification of the characteristics of innovations to be rolled-out to facilitate perception of benefits	Change agents work with identified local network and early adopters to identify characteristics and encourage ownership
Strategies for embedding and sustaining innovations	Targeted persuasion of later adopters to sustain innovation
	Commitment of resources for innovation

Conclusion

This paper has brought together policy and research findings to put forward actions that PCTs can take to increase the likelihood of success in implementing innovation in community pharmacy. Finally we suggest six 'next steps' for PCTs in Fig 10.

Figure 10 - Summary of next steps for PCT's:

1. Establish local team to review existing pharmacy services against local needs, led by the PEC
2. Review needs to consider community pharmacy roles in supporting nGMS and achieving PCT health objectives as well as the new pharmacy contract
3. Identify funding to support new community pharmacy services and/or extend existing services
4. Recognise that decisions about innovation are not always made locally and there may be a need to negotiate with national multiples and supermarkets
5. Identify change agents, innovator and early adopter pharmacists locally to support the spread of innovation
6. Engage and support local pharmacists in the process of roll-out

Glossary

GMS - General Medical Services
NatPaCT - National Primary and Community Care development Team
PCT - Primary Care Trust
RPSGB - Royal Pharmaceutical Society of Great Britain

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About the research

The research on which we draw in this briefing paper studied innovations, innovators and the innovation process in community pharmacy. A Delphi-type panel nominated individual pharmacist innovators, innovations and examples of areas and networks exemplifying innovation in community pharmacy. Panel members were asked, through repertory grid interviews and critical incidents, to identify key attributes of innovating pharmacists and examples involving innovation. Interviews were conducted with 68 individuals – community pharmacists and change agents ('shakers and movers') and stakeholders in Primary Care Organisations, community pharmacy companies, and the wider NHS. Visits were made to six case study sites (including one multiple and one wholesaler) to observe the practice of innovator pharmacists and to see new services in action. Case studies were included from England, Wales, Scotland and Northern Ireland. A sub-study of high and low performer pharmacies in innovative services was undertaken to better understand the critical success factors.

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