REPOSITIONING INDEPENDENT COMMUNITY PHARMACY
IN THE
NATIONAL HEALTH SERVICE
PRIMARY CARE SECTOR

A thesis submitted by
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ABSTRACT

In 1994 the author of this thesis proposed a new role of medicines management (MM) for dispensing community pharmacists, requiring systematic collaboration with GPs. In 1998 the Minister for Health approved the proposal and commissioned pilot trials which are currently proceeding.

This thesis explores cultural, inter-professional and operational factors which may impede or facilitate service roll-out nationally. A review of management literature explored two areas, marketing and change management theory, which could be applied to a community pharmacy context. This review revealed innovative ways of presenting new services to target audiences and novel means of engineering organisational change. 'Culture'; 'leadership'; ‘motivation'; ‘communications'; and, ‘competitive force’ were studied alongside the psychology of ‘attitudes'; ‘needs'; and, ‘wants’. The Burke-Litwin change model was selected as the most applicable to pharmacy service change.

Triangulated field research has revealed forces which impede and facilitate change. A series of key informant interviews and focus groups helped identify crucial issues which informed the content and structure of national postal surveys to GPs (1000) and pharmacists (750). Key ‘attitudes'; ‘needs'; and, ‘wants’ of both professions were revealed:

i. 75% of GPs and 81% of pharmacists wish to engage in MM;

ii. 36% of GPs already receive pharmacist assistance at varying levels;

iii. 58% and 48% of GPs respectively, do not support pharmacist involvement with medication selection or identification of sub-therapeutic dosage; and,

iv. 89% of pharmacists do not have the ability and 81% do not have time to do MM.
The literature research findings were theoretically applied to these issues and suggestions made for managing the proposed transformation of pharmacy service.

This thesis recommends cultural support of the GP by styling and branding the MM service accordingly with the GP as the lead figure, directing the programme of work. It further recommends urgent action by pharmacy leadership, to provide the framework for dispensing pharmacists to acquire the knowledge and time to undertake this transformational service.
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<td>AIDA</td>
<td>Attention, Interest, Desire, Action</td>
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<td>AR</td>
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<td>ADR</td>
<td>Adverse Drug Reaction</td>
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<td>Autonomous Working Group</td>
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‘O mihi praeteritos referat si Iuppiter annos’

Virgil
GENERAL INTRODUCTION
TO THE THESIS

In the words of 'The New NHS – Modern Dependable'

'... in a changing world no organisation, however great, can stand still. The NHS needs to modernise to meet the demands of today's public...'

(White Paper Foreword – Tony Blair)

It is in this context that this thesis is undertaken, seeking an entirely new approach to moving the primary care pharmaceutical profession – specifically independents – from its traditional dispensing role, into one of patient-focused cognitive care.

To this end, a unique approach to effecting change in community pharmacy is investigated and developed through a detailed study of the relatively modern disciplines of marketing and change management. The bodies of literature in both fields are researched, to reveal those proven principles, techniques and processes, which have achieved successful change in other major fields. By re-applying such approaches in pharmacy, it is hoped that a systematic means of transforming the dispensing service and role of pharmacy can be devised.

To the best of the author’s knowledge, no such approach has hitherto been attempted. In one notable scheme for change (the Royal Pharmaceutical Society of Great Britain, with its ‘Pharmacy In A New Age’ initiative – PLANA) the final phase was designated as:

'... over to you.'

meaning the responsibility for moving into new service was passed to individual community pharmacists. Whilst such exhortation may encourage a number of individual pharmacists to pursue some new services, it is not clear, to the investigator, how effective movement of the whole profession was going to be engineered on a national scale without:
• Continued and 'expressed' vision, leadership, motivation and management of the change process;

• Studied design and presentation of the new service to the purchasing stakeholders;

• Detailed consideration of the target markets and their views on the new service offering; and,

• Setting out and facilitating, for contractors, acquisition of the required resources by which to engage the new role, e.g. knowledge, administrative systems, physical space, human resources and time.

The RPSGB initiative at that time lacked an operational plan and an underlying detailed study of the stakeholder impact of any new pharmacy service. The transformational nature of the change contemplated, will specifically impact upon one other major professional stakeholder in patient health care, the doctor.

General medical practitioners (GPs) are traditionally the head arbiter of routine patient treatment in primary care and any significant change in their role, triggered by another health profession, could be resisted or entirely blocked by them. Indeed, the history of medicine and pharmacy, as well as some modern developments (competition for dispensing rights in specified areas) may indicate some divergence of cultural interests.

Such effects, by definition, revolve around the deeply held values, beliefs and underlying assumptions of any cohesive group. In turn, these affect the group or individual attitudes, needs and aspirations, as expressed through their social, or in this case, professional context. Such powerful motivators therefore require careful study, in contemplating the operational and conceptual change required in primary care pharmacy and medical practice.
This thesis addresses these complex issues and is set out in nine detailed chapters as listed below:

**Chapter 1**
Describing relevant historic and cultural influences which may effect: the medico-pharmaceutical interface today; the changing modern environment; and, the competitive nature of today’s market place and its relevance.

**Chapter 2**
Setting out the overall thesis aim, specific objectives and strategic importance of the study.

**Chapter 3**
Setting out the research method.

**Chapter 4**
Comprehensively investigating the marketing function; necessarily addressing in detail the motivational, communications and cultural issues; and, the *attitudes, needs* and *wants* of people so as to enable effective design of the new pharmacy service offering and introduction to the market, the medical profession.

**Chapter 5**
Investigating in detail the theory and practice of organisational development and change, specifically 12 potential models as templates of change activity, to enable selection of the most appropriate for effecting change in pharmacy.

The detail of Chapters 4 and 5 is considered essential by the author to enable a thorough consideration of the cognitive and operational issues involved in the change of both pharmaceutical and medical practice. Without the detailed investigation of the twelve change models, confident selection of an appropriate model of change would not realistically be possible. At this stage of planning new service content for pharmacy in England and Wales, it is of the utmost importance to use the right template for targeted change effort.

**Chapter 6**
Setting out the field research results of phase 1 and relating these to the theoretical research in Chapters 4 and 5.
Chapter 7  Setting out the field research results of phase 2 and relating these also to Chapters 4 and 5.

Chapter 8  Summarising the whole work and discussing some major implications.

Chapter 9  Offering conclusions and recommendations for further research.

By this scheme and content of work, the problem of change on a national scale is addressed for the primary care independent segment of the pharmacy profession (but with relevance to all dispensing contractor pharmacy) as well as the primary care medical profession as affected by pharmacy role change. The operationalisation of strategic intent then becomes a realistic possibility and outcome from this work.

Within pharmacy, although the target of research is the independent sector, some of the work may also be useful in the publicly quoted multiple segment. In the latter also, resides the profession of pharmacy operated by pharmacists who may well have similar needs and wants to those in the independent sector. Especially will this be so if the multiples continue to expand by acquiring independent pharmacies.

It is recognised, however, that expansion of the multiple sector, could possibly take place through some future modification of the control of entry regulations.
DECLARATION

The research undertaken in this thesis is the original work of the author, carried out between January 1999 and May 2003 in the Pharmacy Practice Division, University of Portsmouth. The programme of study was directed by Professor Ian Jones, Professor of Pharmacy Practice.

The author’s publications associated with this research are:

   *The Pharmaceutical Journal*, (Vol. 252), pp. 507-508;

   *Chemist and Druggist*, 2 May, 1998;


   *The Pharmaceutical Journal*, (Vol. 266) p.248;

   *The Pharmaceutical Journal*, (Vol. 268) p.146; and,

CHAPTER 1
BACKGROUND AND HISTORIC INFLUENCES

This chapter is set out in six sections as follows:

1.1 Introduction;
1.2 Ancient History – Outline;
1.3 The Changing Environment;
1.4 Latest Developments;
1.5 Competition, Marketing and Stakeholder; and,
1.6 Chapter Summary

1.1 INTRODUCTION

This introductory chapter sets out the background, historic and current, which may have a major effect on the task of moving community pharmacy into a new order of service within the National Health Service (NHS) of England and Wales. Historic cultural traditions as well as some of the health professions own perceptions of their relative importance in the health care ‘hierarchy’ may have profound effects upon pharmacy’s aspirations for its own future. Key issues are explored in this chapter.

In 1927, La Wall (1927 : V), writing his treatise on the history of pharmacy, commented:

‘...the primary function of pharmacy is to prepare medicines for those who require them...’

Today, however, seventy five years later, the world has dramatically changed. The early bi-plane has been replaced by the swept wing, jet engine aircraft of inter-continental capability and advanced rocket projectiles are now able to probe the solar system. Likewise, medical remedies, derived from plants and animals and compounded by the skills and knowledge of the nineteenth century ‘chemist and druggist’, have been
progressively replaced by sophisticated formulations and delivery systems, manufactured by the pharmaceutical industry.

The role of the community pharmacist has thus, due to a number of influences, of which technology is one, (PEST analysis : Appendix 1, page 413) progressively shifted from compounding and supply, to counting, pouring and supply with some service elements attached.

These influences, or change drivers, may be summarised as follows:

- **New technological processes**, leading to new dosage forms (e.g. spansules and sustained release formulations);

- **Replacement of plant derived medicines** with modern synthetic compounds e.g. Reserpine replaced with methyldopa in hypertension and with the benzodiazepines in anxiety states;

- **New therapeutic approaches to illness management** e.g. Kaolin mixtures for diarrhoea replaced with replacement electrolyte therapy;

- **Peer pressure** on community pharmacy to form new models of service has been influenced by successful hospital pharmacy development into clinical services; and,

- **Political initiatives** have brought increasing focus upon the role of community pharmacy and a need to develop its role:

  i. The Nuffield Enquiry 1984 – 86;  
  v. White Paper – *Choice & Opportunity*, *Primary Care – The Future* 1996 (Nov);  
  vi. White Paper – *Primary Care – Delivering*
Documents v to xi all emphasise the pharmacist’s core expertise as *medicine's knowledge* and from 1997 progressively indicate the need for *collaboration* between the professionals in Primary Care. This view is expressed in its highest terms as *partnership*, in ‘*The New NHS: Modern Dependable,*’ (1997: 40).

However, operational developments to date have failed to transform the traditional supply service into one of in-depth patient care and pharmacy is still perceived as the dispensing service of the nation. Arguably, pharmacy remains essentially what it was two centuries ago, without the medicines compounding requirements of that time.

It is now recognised by the leadership in pharmacy that the modern competitive environment of the NHS provides opportunities, as well as threats. If pharmacy wishes to expand its responsibilities and play a bigger part in *primary health care*, then changes in operations and inter-professional relationships will almost certainly be required. In marketing parlance, pharmacy will, in fact require repositioning in the primary health care process.

Such repositioning may be affected by issues such as:

- The patient’s perception of the value of the pharmacist’s service;

- The priority given to pharmacy expertise in the primary health care process by government and the medical profession;

- The process sequence in which each of the health care professions makes its contribution to the patient’s medicines prescription; and,
• The relative contribution made by each health care professional in the chain of care, involving doctor, pharmacist and sometimes nurse, as perceived by government, health professions, patients and patient representative organisations.

The medical profession, arguably at the top of the health care pyramid, may well perceive expanded roles of other health care professions as a threat to some of their own responsibilities.

1.2 ANCIENT HISTORY

1.2.1 The Medical and Pharmaceutical Professions

The relationship between pharmacy and medicine has been forged in the crucible of history and certainly since the emergence of the modern professions within the NHS, underpinned with an element of competition and unease. (Competition, that is, in rural areas, where both professions vie in some instances for dispensing rights and unease on those occasions when a pharmacist must query some aspect of a patient’s prescription, which is medically suspect). There may be also, some adversely disposed GP attitudes to any proposed expansion of the pharmacist’s role as indicated in research by Spencer and Edwards, (1992: 1671) and Sutters and Nathan, (1993: 70 – 84). Spencer and Edwards report GPs’ opposition to pharmacist supervision of repeat prescriptions, (64%) and about half of the 744 respondents expressed the view that doctors should dispense. Approximately 33% of respondents thought pharmacists ‘should stick to dispensing’. Sutters and Nathan reported that overall, GPs disagreed that pharmacists should ‘become more involved in the selection of prescribed medicines.’

1.2.2 Early Relationships

Early origins of both pharmaceutical and medical professions are discernible in the realm of ancient Egyptian mysticism and religion, evidence of which lies in the hieratic
writings and in particular, the *Ebers Papyrus*, now residing in the Department of Egyptology of the Metropolitan Museum of New York, USA, (La Wall, 1927: 3). Certain other ancient prescriptions, preserved in the British Museum are said to date from Cheops, circa 3700 BC, (La Wall, 1927: 3).

Although there was no real equivalent of the apothecary or pharmacist at that time, Hunting, (1998: 11) records that the

> "...activities of Pa-heri-pedjet, during the reign of Ramses II, (1279 – 1213 BC) might qualify him for the title of the first recorded pharmacist."

The early efforts of the Egyptians were superseded by the influence of the Greeks and Hippocrates and Galen are enduring names of note. Dioscorides compiled *De Materia Medica*, containing some six hundred remedies, which were still used in sixteenth century London, (Hunting, 1998: 11).

La Wall (1927: 11 – 12) lists seven papyri as being important to our knowledge of the early origins of drug application and these are set out in Table 1 together with an additional papyrus listed by Kremers and Urdang,* (1976: 498).

### Table 1  IMPORTANT PAPYRI – HISTORY OF PHARMACY

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>The Kahon Papyrus 2000 BC, dealing with gynaecology and veterinary medicine;</td>
</tr>
<tr>
<td>ii</td>
<td>The Edwin Smith Papyrus 1600 BC, dealing with surgery and internal medicine;</td>
</tr>
<tr>
<td>iii</td>
<td>The Hearst Medical Papyrus 1600 BC, similar content to the Ebers Papyrus;</td>
</tr>
<tr>
<td>iv</td>
<td>The Lesser Berlin Papyrus, same period as the latter and also dealing with sorcery;</td>
</tr>
<tr>
<td>v</td>
<td>The Ebers Papyrus circa 1552 BC, detailing much polypharmacy in prescriptions with up to thirty five ingredients and in all, some seven hundred prescriptions;</td>
</tr>
<tr>
<td>vi</td>
<td>The Berlin Papyrus circa 1350 BC, comprising some twenty three pages with similar content to the Ebers Papyrus;</td>
</tr>
<tr>
<td>vii</td>
<td>The Chester Beatty Papyrus* circa 1200 BC, a formulary for anal diseases; and,</td>
</tr>
<tr>
<td>viii</td>
<td>The London Medical Papyrus circa 1000 BC, concerning medicines and magic.</td>
</tr>
</tbody>
</table>

Whilst it is accepted that some early evidence of Chinese medicines exists, little appears to be known of their remedies or prescriptions, which pre-date the Christian era, but
these are said to be based more upon mysticism than medicine. However, as Kremers and Urdang, (1976: 498) point out, regarding pharmacy's origins:

'Various opinions about pharmacy's origin continue to be put forward because speculation is tempered by logic and analogy, when there is not much real evidence.'

Nevertheless, it is evident that there have existed, even from earliest times, separate strands of medicine and pharmacy, (Jonckheere 1955: 160 – 161). European pharmacy is thought to be credited to the works of Mesue Marinate who studied at Baghdad. The Grabadian Medicinarum Particularum, prepared by him, was used for about five hundred years as an apothecaries' manual, according to La Wall, (1927: 105). Another Persian, Ibn Sina or Avicenna, was a physician and philosopher of the tenth century and is credited with founding the Graeco Arabic School of medicine and his writings were used in Europe until about 1650 AD, in both medicine and pharmacy.

However, emergence of a clear separate identity of the two professions was given momentum by the German Emperor Frederick II (1224), in his edict affecting that part of his realm known as the Kingdom of the Two Sicilies, (Osler 1923: 69). Pharmacy and medicine were thus separated and medicines were required to have uniform presentation and to be made to regular standards. Both professions, unfortunately, transgressed the lines of demarcation, records Kremers, (1976: 99) and dual education in Germany for both professions created conflicts of practice and interest, (Adlung and Urdang, 1935: 190 – 192).

In England, spicers from overseas, notably France, it is conjectured, began to take over the drug trade (pepperers as wholesalers and spicers as retailers). The spicers became increasingly involved in compounding medicines and by the beginning of the fourteenth century were known interchangeably as spicers or apothecaries. The pepperers became grocers, whilst the apothecaries became more specialised, until in the sixteenth century, they became referred to as assistants to the physician. As well as independent preparers and dispensers of drugs, they not infrequently took a hand in medical practice (Thompson, 1929: 86 – 100). Some competition, or conflict of interest, was thus evident between the physician and the apothecary.
In 1511, the professions in London became regulated by Act of Parliament and medicine could not be practiced unless the applicant was examined by the Bishop of London or Dean of St. Paul's, assisted by four doctors. In 1518, Henry VIII incorporated the College of Physicians. The provinces too later came under this system. In 1540 the College of Physicians was empowered to ‘...search, view and see the apothecary’s wares, drugs and stuff... ’ following continental tradition, (La Wall, 1927 : 208).

In 1540 the College of Physicians was empowered to ‘...search, view and see the apothecary’s wares, drugs and stuff... ’ following continental tradition, (La Wall, 1927 : 208).

In 1617, King James I granted the apothecaries independence in a new charter and so founded the City Guild of the Society of the Art and Mystery of the Apothecaries of the City of London, (Copeman, 1967: 16). The powers of the College of Physicians were strengthened in 1618 and extended to examining the stocks of apothecaries, druggists, distillers and sellers of waters and oils, as well as all preparers of chemical medicines. Thus, it may be conjectured that, the opportunity for conflict between physicians and apothecaries was perpetuated.

The ethos of protected territory and extension of authority, of one profession over another, may have begun a cultural mindset, pre-conditioned for later years, to encourage similar attitudes in the emergent strands of the apothecaries’ guild.

For two further centuries, some confusion and conflict of roles existed between physicians and apothecaries and some physicians were opening dispensaries, thus perpetuating the rivalry. The other strands of the apothecaries’ ranks were ‘druggists and chemists’, who in turn were challenging the pharmaceutical function of the apothecary, creating further confusion and antagonism. The ‘Rose Case’, 1703, (Hunt, 2001 : 191 – 195) illustrates the point. Rose, a compounding and dispensing apothecary, treated a butcher, one William Seale, who subsequently claimed to have been overcharged for a failed treatment. Seale enlisted the support of the College of Physicians, who then brought a case against the Apothecary, in the Court of the Queen’s Bench, under Lord Chief Justice Holt. The basis was that Rose had performed his duties ‘...without licence from the College, without the direction of a physician and without taking or demanding any fee for his advice.’
The College won its case in law, even though previous custom and practice supported Rose. However, the Lords subsequently overturned the judgement, holding that it had been contrary to custom and not in the public interest. This is one example, albeit notable, of the feuding relationship between the early Apothecary and the Physicians, who in their day were more akin to today’s general practitioner. The general Apothecary was subsequently allowed to prescribe and compound the medicines used for treatment.

In 1815 the Apothecaries achieved a Parliamentary Act giving them powers over medical education and standards in England and Wales. This had to be amended, through contest and pressure from ‘chemists and druggists’, giving these the control rights to the supply of pharmaceutical services, in other words the buying, compounding and dispensing of drugs and medicinal compounds.

The separation of the two disciplines in England, medicine and pharmacy, was thus confirmed in law and the evolution of the apothecary into the medical practitioner, was given added momentum. In 1841, amidst opposition from the Apothecaries Society, the *Pharmaceutical Society of Great Britain* was formed, bringing together chemists and druggists in one society. A Royal Charter was granted to them in 1843, followed by the first Pharmacy Act in 1852. Thus, the medical and pharmaceutical practitioners were individually identified by royal statute and law, as was the College of Physicians.

The first British Pharmacopoeia appeared in 1864 and La Wall interestingly records that one of the earliest factors to bring about change in the practice of pharmacy ‘...*was the introduction of the large scale pill machine...*’ which replaced much extemporaneous preparations, (La Wall, 1927 : 504). Even in those days, technology was driving change.

Figure 1 (Trease, 1964 : 32) summarises the progress of the professions between the twelfth and nineteenth centuries. This gives a snapshot of the major milestones in pharmacy development, as well as indicating an abbreviated route of development of today’s medical practitioner.
Figure 1  THE DEVELOPMENT OF PHARMACY AND MEDICINE IN ENGLAND 12th – 19th CENTURIES

12th C.  PEPPERER  SPICER

13th C.  Pepperer  Spicer  Apothecary

14th C.  Pepperer  Spicer  Fraternity of St. Anthony 1345

15th C.  GROCERS COMPANY

16th C.  GROCERS COMPANY  DRUGGISTS – ALCHEMISTS – APOTHECARIES

17th C.  ALCHEMISTS  APOTHECARIES

18th C.  G. PRACTITIONERS

19th C.  Now exists as historic livery company only

20th C.  Queen Victoria granted a Royal Charter

Examinations & Certificates of Registration

Qualifications & Registration Compulsory

(1518 Henry VIII formed College of Physicians)

(1617 James I granted the Apothecaries a Charter)

1815 ACT OF PARLIAMENT

(Power of Educational Standards for Medical Profession)

(Amended by pressure of Chemists & Druggists)

RIGHT OF CHEMISTS & DRUGGISTS TO BUY & COMPOUND & DISPENSE DRUGS

PHARMACISTS PHARM.SOC. FOUNDED 1841

ROYAL CHARTER 1843

PHARMACY ACT 1852

PHARMACY ACT 1868
1.2.3 Summary and Implications of History

The history of both professions, particularly in the last century and a half, is one of some sensitivity and jealously guarded professional rights. In like manner, but different setting, responsibilities are contested today in both rural and fringe urban areas, where medicine and pharmacy compete for dispensing rights. Both professions have been, to some extent, conditioned by history in their values, beliefs, attitudes and forms of tradition, from which cultural change may now be difficult to achieve. This could, nevertheless, be necessary in securing a new role for pharmacy, as contemplated by the RPSGB and PSNC, in seeking to transform pharmacy’s place in primary health care through a focus on ‘...specialised medicines knowledge and management...’, rather than simple medicines supply, (PSNC 1998: 10).

As Malinowski, (1945: 28) termed it, the ‘...living history of a long established organisation may dominate its ideology...’ Pettigrew, (1985: 117) also argues that culture change rests very much on the ability to ‘...think the unthinkable and say the unsayable...’

1.3 THE CHANGING ENVIRONMENT

1.3.1 Outline Developments – 20th Century

The first half of the twentieth century witnessed the transition from private dispensing by chemists, to a government funded insurance scheme (1911), giving contractors a per capita payment of one shilling and sixpence. The doctor received seven shillings, whilst six pence floated between the two professionals based upon actuarial calculations of prescription costs.

The system was replaced for pharmacists by a reimbursement of the cost price of drugs (1916), plus a payment for pharmacist services and overheads. Since that time, variations of the theme have been implemented, based upon drug cost reimbursement, professional fees, practice allowances and at one stage, an on-cost on pharmacy drug
acquisition costs. This latter was, however, ultimately held by the DH to be an adverse upward force on the pressure of drug costs, because the higher the price, the higher the on-cost for the pharmacist. Also, because of high drug cost inflation, the on-cost helped to exceed the "global sum" (remuneration) allocated by the government at the beginning of each fiscal year and became a cash flow benefit to pharmacists.

Currently, NHS contractor pharmacists are paid by a fee structure and practice allowance derived from a global sum, fixed by government, with reference to the previous year's allocated sum. Costs are no longer taken into account in negotiations. The so called cost-plus contract was unilaterally terminated by the government in 1989. (PSNC minutes, November 1989).

Nevertheless, the DH has consistently encouraged the pharmacy profession to develop its service and indeed look to a new role in the light of the redundant manipulative skills, rendered so by the pharmaceutical industry.

Government has, particularly within the last two decades, invited pharmacy to revise its raison d'etre and design for itself a new role. Gerard Vaughan is usually credited with starting this process and on September 19th 1981 said, when Minister of State for Social Services (Vaughan, 1981: 300)

"...the thrust for change and extension of role had to come clearly from pharmacists themselves. It was for pharmacists to work out their destiny and then for government to tell them whether it was legally, parliamentarily and financially possible..."

The author of this thesis would contend that pharmacy's leadership did not pick up the challenge, perpetuated the status quo and let matters rest by simply continuing with the drug supply function, as specified by the doctor on an FP10 (NHS prescription form).

That pharmacy failed to respond positively to the ministerial invitation is underlined by the number of subsequent government initiatives, that attempted to pursue the same objective:

- The Nuffield Enquiry 1984 – 86;
The Department of Health Working Party 1991 – 93; and,

All recommended an expanded role in primary health care for community pharmacy and sought to realign the pharmaceutical service with new societal demands.

There was no immediate address of the possibilities of expanded responsibility in the cognitive opportunities related to pharmacist / patient interaction, in other words, compliance advice, address of side effects, drug interactions, adverse medicines effects and therapeutic substitution. Nor was there consideration of a more formalised relationship with the medical profession to address, for example, formulary development and better drug economics.

More recent government policy has also facilitated new opportunities for pharmacy, as enshrined in the following White Papers / Resource Documents:

**WHITE PAPERS**

- Choice and Opportunity, Primary Care – The Future (medication review) Nov. 1996;
- Primary Care: Delivering the Future (as above) Dec. 1996;
- The New NHS: Modern, Dependable (New equal partnerships between professionals) Dec. 1997; and,

**NHSE RESOURCE DOCUMENTS**

- GP Prescribing Support (medication review) Sept 1998;
- Pharmacy in the Future Sept 2000; and,
These government initiatives may be regarded, in the terminology of modern management, as *external change drivers or triggers*. However, *internal change drivers* have also played their part in encouraging pharmacy to seek a much higher stake in primary health care. Individuals of vision, at all levels and in all sectors of the profession, have seen the necessity of becoming more patient focused, rather than prescription focused, in the delivery of pharmaceutical care.

Moreover, since the publication of the 1996 Conservative Government White Paper, *Choice and Opportunity* and the creation of the *competitive market place*, the professions have no longer had absolute security of tenure in their own domains, other than for their core functions. Nurses are creating new opportunities for their profession and encroaching upon some of the doctors’ traditional territory. Nurse practitioners are now running clinics for patients and in some areas, becoming the first port of call for patient treatment within the NHS.

Conceptually, the *competitive internal market* of the NHS, created by the Conservative Government, has now been removed by the new Labour Government White Paper, *The New NHS: Modern Dependable*, (1997 : 2). The *competitive internal market* was constructed primarily to create competition between hospitals for GP funds and therefore, hopefully drive efficiency and quality upwards and cost downwards in the secondary care sector. Secondly, by giving GP practices their own funds to manage, with incentives to make savings, it was hoped by government that GPs themselves would become more financially efficient prescribers.

However, in reality the Labour Government’s formation of Primary Care Groups and Trusts, of which all GPs are members, (New NHS : Modern Dependable, 1997 : 19, 65) has, in the author’s view, rather cleverly perpetuated competition by benchmarking performance. Improved clinical excellence and quality are now driven by the new National Institute for Clinical Excellence and the new organs of the restructured NHS. Every GP is thus now a member of a fund holding group, (a PCT). Entirely new services, unless already proscribed by law, are thus the domain of whichever profession is able to lay claim to them.
In the drive by all health care professions to achieve new responsibilities and perhaps additional rewards in primary care, new pharmacy aspirations may easily be threatened by competing professions. If sensitively handled, however, the medical profession in particular, could conceivably become a facilitating force rather than a competitor in the development of the pharmaceutical profession. This may be possible, for example, by presenting any new pharmaceutical service as a work-reducer for GPs, an extension of their authority in directing an extended team and a route to better practice budgetary control. Such issues may well be culturally related to preserving the status of the GP as the lead health care professional and indicating that the GP's lead position in primary health care is to be sustained and even strengthened. These issues will be explored in the research for this study.

If a new pharmaceutical service is presented in a threatening way, then doctors could easily oppose it. If pharmacists were to overtly press for increased clinical authority, in selecting patient medication for new practice formularies, or an increased role in managing patient medication, doctors may oppose any proposition which could be perceived as diminishing their own role or status. A carefully orchestrated marketing approach, using sensitively worded communications, may become both desirable and necessary. These latter two processes will be examined more fully in Chapter Four.

1.4 LATEST DEVELOPMENTS 1992 – 2002

Having observed a general lack of response to government overtures to the profession to re-examine their role, in 1996 a small sub-group of the PSNC, organised and chaired by the author of this thesis, developed a structured approach to a proposed new community pharmacy role of medicines management. A mission statement for community pharmacy was developed, together with an overall working definition of this new role. The work was completed in August 1998 and it is hoped that this new cognitive role will transform community pharmacy into a new order of service, medicines based and patient focused, giving the profession a much higher stake in primary care and a new position in the health delivery chain. The mission statement and definition of medicines
management, as agreed by the sub-group and confirmed by PSNC are set out in Tables 2 and 3.

Table 2 MISSION STATEMENT – COMMUNITY PHARMACY IN THE CONTEXT OF MEDICINES MANAGEMENT SERVICES

<table>
<thead>
<tr>
<th>Community pharmacy will develop its resources and services in such a way as to deliver:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health gain for the patient;</td>
</tr>
<tr>
<td>• New partnerships with other health professionals in quality driven care;</td>
</tr>
<tr>
<td>• More effective use of medicines through expert knowledge of the pharmaceutical sciences and unique relationship with the public; and,</td>
</tr>
<tr>
<td>• A major contribution to public health.</td>
</tr>
</tbody>
</table>

Health gain as described in Table 2 means improving longevity and/or quality of life. (Drummond and Maynard, 1993: 138).

Table 3 MEDICINES MANAGEMENT IN COMMUNITY PHARMACY - A DEFINITION

<table>
<thead>
<tr>
<th>Medicines management is maximising benefit and minimising risk for patients from all medicines, by ensuring on an ongoing basis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The safe and appropriate choice of medicines and therapeutic regimens;</td>
</tr>
<tr>
<td>• Structured discussion with the patient on specified aspects of their medicines;</td>
</tr>
<tr>
<td>• Systematic collaboration with the prescriber and other members of the primary health care team in addressing patient needs; and,</td>
</tr>
<tr>
<td>• Record and report maintenance for GPs in agreed format.</td>
</tr>
</tbody>
</table>

A more current definition by Jones and Tweedie (2001: 248) is:

'The systematic provision of medicines therapy through a partnership of effort between patients and professionals to deliver best patient outcome at minimised cost.'
Currently, community pharmacy is making progress towards this transformed role, as evidenced by approval from the Secretary of State for Health for pilot trials of a new service, that began in 2000. This will, in effect, treat the traditional NHS prescription as a *contract of patient care*, managing the progressive medication of the chronically ill, as their conditions and responses change over time. It will manage multiple regimens for the chronically ill and integrate acute illness treatments for them, when necessary.

For the historically aware, in the medical profession, this could, conceptually, represent a return to the blurred responsibilities of the strands of the Society of Apothecaries in the seventeenth century, a threat to medical autonomy and consequently, a threat to pharmaceutical progress in the current environment of health care reform generally.

1.4.1 *New Role – Core Detail*

The core detail of this proposed new community pharmacy service is set out in Tables 4 and 5 (See also Appendix 10, page 433, Phases of Medicines Management).

**Table 4**

**NEW CORE ROLE FOR COMMUNITY PHARMACY MEDICINES MANAGEMENT - PHASE 1**

<table>
<thead>
<tr>
<th>Structured discussion with the patient at regular intervals to identify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• counselling needs for patient compliance and commitment to therapy;</td>
</tr>
<tr>
<td>• drug side effects and toxicity;</td>
</tr>
<tr>
<td>• ineffective drugs;</td>
</tr>
<tr>
<td>• drug interactions;</td>
</tr>
<tr>
<td>• adverse reactions;</td>
</tr>
<tr>
<td>• patient acceptability of dosage form (liquid-v-tablet-v-capsule etc.);</td>
</tr>
<tr>
<td>• perceived acceptability of drug (e.g. taste, dose frequency, tablet size);</td>
</tr>
<tr>
<td>• potential NHS – OTC drug interactions;</td>
</tr>
<tr>
<td>• potential food – drug interactions;</td>
</tr>
<tr>
<td>• general feeling of well-being, or otherwise;</td>
</tr>
<tr>
<td>• family support problems; and,</td>
</tr>
<tr>
<td>• referral back to the doctor (Appendix 2, page 419).</td>
</tr>
</tbody>
</table>
Involvement of the patient will need their approval and collaboration. Assistance in this respect may well come from patient associations, who wish to be seen acting on behalf of improved patient care.

Table 5  NEW CORE ROLE FOR COMMUNITY PHARMACY  
MEDICINES MANAGEMENT - PHASE 2

<table>
<thead>
<tr>
<th>Structured discussion with the doctor at regular intervals for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• drug interaction removal;</td>
</tr>
<tr>
<td>• replacement of patent expired brands with generics;</td>
</tr>
<tr>
<td>• reduced side effects;</td>
</tr>
<tr>
<td>• therapeutic interchange / substitution;</td>
</tr>
<tr>
<td>• reduction of polymedicine;</td>
</tr>
<tr>
<td>• more economic prescribed quantities;</td>
</tr>
<tr>
<td>• more effective drug regimens;</td>
</tr>
<tr>
<td>• reduction of combination products and replacements by generics or individual branded components; and,</td>
</tr>
<tr>
<td>• tactics to increase patient compliance.</td>
</tr>
</tbody>
</table>

Patient review is likely to take place at three to six month intervals, or as indicated in the pilot trials and discussion with the GP as locally agreed.

The role outlined above is not traditional territory for pharmacy and no such formally recognised, structured intervention exists at present, in either community medicine or pharmacy. A search in the database *Healthstar* in January 2000, for example, indicated some eighty five ad hoc projects between pharmacists and doctors, involving one or two elements of the above. There is no example of a comprehensive address of patient care, which is multi component, structured, routine and a recognised pharmacist intervention, as part of a national contract.
1.4.2 Progress up to January 2003

Since publishing this initiative in the *Pharmaceutical Journal*, (1998, May 2 : 616), an outline operational plan, developed by the author of this thesis (Appendix 3, page 420) has been adopted by the new leadership group, comprising senior personnel in the representational organisations of pharmacy. Unity is important to signal to government the profession’s commitment to change. Mixed messages could weaken government will to support this far reaching restructuring of the pharmacist/patient/physician relationship. The author’s concept of the new relationships, are summarised in the diagram in Figure 2 showing also the political initiative underpinning change.

The heavy large black triangle represents the new connection between the community pharmacist and GP, driven by performance criteria, in raising the quality of primary care through a partnership in medicines management between physician and pharmacist. The light grey large triangle represents the political initiative of the White Paper, (*The New NHS – Modern, Dependable, 1997*) newly bringing together ‘primary health care’ and ‘public health’ in patient support. The small triangle, created by the overlap of the two former triangles represents strengthened patient care, being supported in the new political initiative and structural links between ‘public health’ supporting ‘primary health care’.

Following DH agreement to commission pilot trials in medicines management, another initiative heralded by the government document, *Pharmacy in the Future*, has commenced. This is the medicines management so called ‘collaborative’, managed by the National Prescribing Centre in Liverpool. Its approach to medicines management is in the development of systems and processes which will facilitate the beneficial delivery of medication to the patient from the health care professionals. By developing such systems, a partnership between health care professionals is facilitated.

The composition (of the leadership group) is shown in Table 6 and is chaired by the writer, who brought the group together because of the need to deliver a unified approach and strategy for the community pharmacists.
Figure 2  WHITE PAPER RELATIONSHIPS IN THE NEW HEALTH CARE STRUCTURE – PHYSICIAN, POLITICIAN, PATIENT & PHARMACIST

Performance

Political Initiative

Primary Care

Public Health

Patient Care

Physician  Community Pharmacist

Note: Author’s schematic representation of the new partnerships in patient care as outlined in the government white paper, 'The New NHS – Modern, Dependable', driven by the political agenda benchmarking performance.
Table 6  LEADERSHIP GROUP – COMPOSITION

<table>
<thead>
<tr>
<th>LEAD BODY</th>
<th>REPRESENTATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal Pharmaceutical Society GB</td>
<td>President; Registrar</td>
</tr>
<tr>
<td>The Pharmaceutical Services Negotiating Committee</td>
<td>Chairman; General Secretary</td>
</tr>
<tr>
<td>The National Pharmaceutical Association</td>
<td>Chairman; Director</td>
</tr>
<tr>
<td>The Company Chemists’ Association</td>
<td>Superintendent Pharmacist, Boots; Director of Pharmacy Services, Unichem</td>
</tr>
<tr>
<td>The Co-operative Pharmacy Technical Panel</td>
<td>Chief Executive; Head of Planning</td>
</tr>
</tbody>
</table>

CHAIR – A.M. TWEEDIE, PSNC

Note: The ‘Leadership Group’, comprises the senior figures in the major pharmacy representative bodies of community pharmacy contractors, plus the RPSGB and is responsible for leading the community dispensing contractor into cognitive service.

The leadership of the profession is a compound structure, (Figure 3) and can, on occasions, pursue overlapping, or even conflicting agendas, as evidenced by the NPA proposition to graft the medicines management initiative on to their repeat dispensing project and the Royal Pharmaceutical Society wishing to present it as an element of their PIANA initiative, Pharmacy in a New Age (‘Over to You’ phase RPSGB Doc., Sept. 1998).

Since this time, the repeat dispensing project has failed and PIANA has quietly disappeared into a phase which supposedly handed over the process to pharmacists in the community, who do not have the resources or authority to make progress in a systematic way.

This phase of the PIANA initiative, designated as ‘...Over to you...’ has seemed, to a number of people in the Northern Region canvassed on the subject during LPC meetings, (Gateshead; Sunderland; Newcastle March – May 2001) to be an abdication of further RPSGB involvement in the initiative. This ‘...Over to you...’ phase (RPSGB Doc., Sept. 1998) may also be an indication of the Royal Pharmaceutical Society’s lack of knowledge and expertise in creating and managing an operational programme of activity, leading to a transformation in pharmaceutical care within the NHS primary care team.
Figure 3 LEADERSHIP BODIES COMMUNITY PHARMACY STRUCTURE AND CULTURE

Note: The above diagram is the author's representation of the official leadership bodies in community pharmacy, together with the sectors of the operational profession.

CCA Company Chemists Association
CPTP Co-operative Pharmacy Technical Panel
NPA National Pharmaceutical Association
PSNC Pharmaceutical Services Negotiating Committee

Key: Structural variants of pharmacy in the health care market (NHS)
Profession & Trade Associations influencing the community pharmacy domain
Visions and aspirations may be relatively easy to create and conceptualise, but it is, of course, quite another matter to be able to design and operationalise a change management programme. Such a programme would need to be able to effectively re-engineer, not only the practice of community pharmacy, but a new relationship between pharmacy and medicine, which would more closely resemble a partnership on equal terms with each profession contributing its own expertise.

Although it could be said that the first major panoramic vision created for pharmacy was developed by the Royal Pharmaceutical Society in 1997, (PLAN A), the origin of the medicines management initiative pre-dates it by some three years, through another paper written by the author of this thesis, proposing this new role and published in the Pharmaceutical Journal, (1994, vol. 252 : 507). Both initiatives have encouraged pharmacists to look to the future in health care and see the possibilities for the profession’s development. However, the RPSGB vision was never transposed into an operational plan, without which, systematic progress towards meeting its objectives could not be fulfilled. The PSNC has closed that gap with its medicines management programme and commenced what is calculated to be a transformation and repositioning of the community professional service.

In pursuit of this objective, the writer, as Chairman of the leadership group, created five integrated sub-groups to develop the elements of medicines management roll-out and hold the leadership programme together, giving a unified approach with support from the lead organisations in pharmacy. The sub-groups were:

<table>
<thead>
<tr>
<th>Sub-group</th>
<th>Lead Organisation</th>
<th>Appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education / training</td>
<td>RPSGB</td>
<td>(4)</td>
</tr>
<tr>
<td>Communications</td>
<td>PSNC</td>
<td>(5)</td>
</tr>
<tr>
<td>Practice Research</td>
<td>RPSGB</td>
<td>(6)</td>
</tr>
<tr>
<td>Repeat Dispensing Development</td>
<td>NPA</td>
<td>(7)</td>
</tr>
<tr>
<td>Premises Function / Image Change</td>
<td>CCA / CPTP</td>
<td>(8)</td>
</tr>
</tbody>
</table>

Abbreviated general guidelines for all these groups are set out at Appendix 9. Each of these sub-groups has a membership of two representatives of each of the lead bodies listed above, supporting the nature of an integrated change effort.
Meetings were then arranged with the Minister of State for Health and subsequently representatives of the General Practice Committee (GPC) to discuss proposals. On both occasions reception was very positive and follow up review meetings were agreed to set up pilot studies and evaluate the proposals.

However, other agendas are being pursued by the nursing profession and indeed, elements of the medical profession, through new training and IT schemes for GPs in medicines’ review, e.g. MIQUEST, (NHSE, 1997 : E5273) and PRODIGY, (DH, 2000) targeted upon specific disease groups. Currently these ideas are in their infancy, but could develop more widely. *NHS Direct*, staffed by nurses, is already offered to the public and is referring patients to locations other than pharmacy. Competition for new services is thus a real issue.

What of competition generally? Who could conceptually offer a similar service to the pharmacy profession, as described above? These questions will be addressed in the following section.

1.5 **COMPETITION, MARKETING AND STAKEHOLDERS**

1.5.1 **Introduction**

As already indicated, competition within the NHS is a real issue and is briefly examined in the following section.

Kotler and Clarke, two eminent researchers and authorities in the field of marketing, argue that just as *marketing* was not an accepted concept in health care until the early 1980s in America, neither was the term *competition*, in spite of the fact that the USA private health care sector, by its very nature, must compete for its own private following of patients. As they point out, it was perceived by a conference of hospital administrators, (Kotler and Clarke, 1987 : 24) in the following terms:

*’Hospitals don’t compete. There is a sisterhood of hospitals. Hospitals help each other.’*
In the UK, Shaeff (1995 : 1) similarly points out:

'Marketing is reaching the NHS. Few organisations yet practice marketing consciously, but many of its ingredients are already familiar to them.'

He goes on to cite the first Griffiths Report, (1979 : 9) and the White Paper, Working for Patients, (1989 : 24) as containing major elements of marketing. These he argues, signalled the introduction of new thinking for the NHS, in terms of placing patients in the role of customers, in having consumer needs and expectations of a quality product. In pursuit of the latter, medical audit and the internal competitive market are cited by Shaeff, (1995 : 1) as driving towards this aim. In seeking to improve service, Griffiths, (1979 : 12) sets out one of the objectives of the NHS as being to provide a service ‘...responsive to local needs...’, which is a similar marketing principle to addressing the needs and wants of the consumer, in general markets.

The internal market which followed Griffiths, placed marketing and competition on the health administration agenda. This report was quite possibly the forerunner of the 1990 Act. The 1997 White Paper, The New NHS: Modern Dependable, (1997 : 5) purported to remove the internal market, some of its structures and competitive tendering, and create integrated care:

'This White Paper marks a turning point for the NHS. It replaces the internal market with integrated care... based on partnership and driven by performance.'

A framework of national standards and excellence will be guaranteed to patients, so that they can have confidence in the quality of the services they receive. The White Paper further recognises that people (not patients) expect more in terms of speed of service and range of treatment. Both these concepts of speed and range of choice are derived from marketing and modern management. Finally, in evidence of the new consumer focused trend in health care, it is reported that a new survey of patient and user experience will be carried out each year, (The New NHS, 1997 : 66) with the intention of assessing the quality of service and identifying potential improvements. This survey
will be conducted by a government agency and is similar, in principle, to market research surveys of customer views, in consumer marketing.

The 1997 White Paper also encourages dialogue between government and the health care professions, to suggest how they may best develop their contributions to the new NHS. This is clearly an opportunity for pharmacy development, especially in the new primary care structures, Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). It is conceptually also a threat, as other professions may wish to encroach upon the traditional pharmacy domain. New services, which are currently not the traditional tenure of a particular profession, may clearly be competed for, by any health care professional, for example patient counselling, medicines advice and review.

The latest strategy of pharmacy, to become the manager of patient medicines therapy, (PSNC report 1998), could, for example, be delivered by other health professionals. The nursing profession, in particular, is active in promoting its own professional services and the 'round the clock' nurses help line in NHS Direct, is already giving advice in this respect. It is not difficult to conceptualise a position where they could extend this to a follow up system, where patients are referred on, to their own medical practices to see a resident nurse practitioner. The medicines management circle is then complete, without pharmacist involvement and resident in the doctor's surgery, where the doctor may feel more satisfied that matters then are totally under medical control. The history of the medical profession indicates that, in extending their sphere of influence, they could again be successful in exploiting current opportunities.

Pharmacy is thus operating in a well supplied market place of competitive professional resources, which in terms of the new services contemplated, is not impeded by constraining laws, as is the core role of dispensing. Even the latter is not as secure as previously because technology has rendered complex compounding of medicines redundant and a simple supply function is easier to manage. Information technology also facilitates access to drug knowledge.

Patient packs containing the correct number of days' treatment for a suitable course, have made dispensing even more mechanical and consequently, easier. Somewhat more threatening is a consultation circular from the Medicines Control Agency (MLX260 :
13\textsuperscript{th} March, 2000) indicating that modification of the group dispensing and supply regulations, giving wider dispensing rights to other health professionals, is under consideration.

Whatever else this means, the indications overall, within health care, are that competitive forces are potentially increasing. There is, conceptually, no apparent absolute reason why the DH or any other health authority would want to automatically select community pharmacy for a new medicines management role.

Generically expressed, the five competitive forces (threats) of any ‘market’ as originally conceptualised by Professor Porter of the Harvard Business School, (1980 : 4) help to expose community pharmacy’s position with respect to its proposed new role.

Porter conceptualised new arrivals in the market place simply as ‘entrants’ rather than ‘new entrants’. The rationale is that old entrants become part of the established domain and therefore any new company entering the market for the first time is adequately described as an ‘entrant’.

The ‘market’ may be described as that part of any target population, specifically availing itself of a distributed product or service. The ‘competitive forces’ are created by the interplay of the market, its suppliers and new approaches to market exploitation. The effects are summarised in Figure 4 and dealt with in more detail under separate headings following.

This analysis is the author’s conceptualisation of the potential competitive elements which may face community pharmacy dispensing contractors as new services are developed in primary care.
PORTER'S FIVE COMPETING FORCES OF THE MARKET PLACE APPLIED TO NEW PHARMACY MEDICINES MANAGEMENT

THREAT OF ENTRANTS

- Hospital pharmacists
- Peripatetic pharmacists
- PCT extended board with pharmaceutical team
- SHA operational unit headed by pharmacist advisers

THREAT OF BUYER POWER - (STRONG)

- NHSE
- SHAs
- PCTs
- Patient Organisations (ascending)

PHARMACY COMPETITION IN THE DOMAIN

- Independents
- Multiples
- Co-operatives
- Supermarkets

THREAT OF SUPPLIER POWER - (WEAKER)

- IT Packages - Medicines management
- Pharm. Industry. Disease prognosis packages; meds. Information packs; clinics
- Community pharmacy employee pharmacists
- Wholesale IT packages & vertically integrated retail specialists peripatetic teams in MM

THREAT OF SUBSTITUTES

- Nursing profession with IT
- Medical profession with IT (GPs)
- IT review packages via healthy living centres
- PCTs with extended nurse practitioner teams
- Pharm. Industry (managed care)
- SHAs with doctor incentive packages for good prescribing

Note: The detailed bullet points under each of the five major headings, (threats) are the author's view of where the increased competition could arise.

Abbreviations

GP    General Practitioner
IT    Information Technology
MM    Medicines Management
NHSE  National Health Service Executive
PCT   Primary Care Trust
SHA   Strategic Health Authority
1.5.2 Competitive Advantage

If competition is to be encountered in attempting to deliver a new service to the NHS, as potentially indicated in the Porter's competitive forces analysis, then the notion of competitive advantage becomes important. Why should government choose one particular profession, or segment of a profession, to discharge a particular new role? Much could depend upon the advantages offered by each alternative, not necessarily based upon the cost of the unit of service. According to Lambin, (1993: 242), competitive advantage equates to the superiority of a particular protagonist over the next best placed competitor in the market place. It is not the net superiority over all other competitors. He goes on to argue that competitive advantage may be external or internal. It is external when based upon some distinctive qualities of the total product offering, attractive to the buyer or user. It is internal when the organisation making the offer has superior cost control, administrative and product management. The ability to exploit a competitive advantage depends, according to Porter, (1980: 22) not only upon the competition but the role played by the balance of the competitive five forces of the market place at a period in time. One simple example of this would be as in the nineteenth century situation, where the medical / apothecary blurring of activity was somewhat chaotic and perhaps, made it easier for chemists and druggists to proceed with their own agenda. An orderly structured proposition, in a generally complex and uncontrolled situation, can be an attractive option to the problem holder. The elements of Porter's five forces are described briefly in the following paragraphs.

1.5.3 Threat of Entrants (Figure 4)

This is conceptualised by Porter simply as more of the same service entering the market place, creating more internal competition. Within pharmacy, for example, Lloyds arrived in an established, stable market and built a chain of retail outlets. The chain then became vertically integrated and thus a new multiple entrant to compete with Boots and other national pharmacy organisations, but offering the same service. This situation can lead to price depression and pressure upon profit margins in a retail setting, although not in medicines supplies through the NHS.
1.5.4 Threat of Substitute (Figure 4)

A threat of substitute is more difficult for an organisation to anticipate, unless it has a corporate strategy, continually observing and analysing the business environment. Who could have seen that the fax machine would compete with the postal service, or indeed that e-mail would then compete with the fax. Neither comprised a new postal service, as understood at the time, but the new products powerfully compete with the older means of delivering communications.

Within pharmacy, the emergence of the electronic prescription means that postal dispensing becomes a nearer possibility. Similarly medicines reviews could be performed in healthy living centres, staffed by nurse practitioners, IT-linked to GPs. Indeed, the pharmaceutical industry, with vertically integrated new community outreach centres for patients, could do likewise. This is, of course, to think the unthinkable, but certainly not the impossible.

Threat of substitute is much more dangerous than threat of entrant because it represents a wholly new approach, which is much harder to compete against by the traditional suppliers. It is about total replacement and redundancy of a whole product / service in the traditional market, which is unlikely to be regained by the obsolete product / service. The total replacement of typewriters with word processors and then computers, further epitomises the effect and no amount of engineering refinement of the typewriter could conceivably displace the word processor or computer. If pharmacy were to be replaced by nursing, in medicines management, it would have a much more serious effect than community pharmacy being replaced by, for example, hospital pharmacists or peripatetic pharmacists. These latter are independent pharmacists self-employed, working exclusively in GP surgeries. If community pharmacy were to be manoeuvred out of this new role by doctors themselves undertaking the responsibility, this could well be an irretrievable position. The way in which pharmacy presents and pursues its new aspirations could be crucial to its success. Threat of substitute probably poses the most serious threat to pharmacy’s new future potential in primary health care. Independent community pharmacists would be less well placed to compete with nursing than the multiple who can employ pharmacists to specifically work in the GP surgery along with other health care staff.
1.5.5 Threat of Buyer Power (Figure 4)

The threat here lies with the potential to compete for profit in the value chain and to exploit competition to drive prices downward for the product or service itself. With the NHSE and indeed, PCTs being in a monopoly position for buying NHS services, this, in turn, could threaten ability of contractor pharmacists to provide the service if funding (profit) is inadequate. More dangerously, this could open the door for competing services which are cheaper, or have a smaller cost base than pharmacy contractors, for example: nurses; peripatetic pharmacists; pharmaceutical advisers. The threat of substitute is thus potentially magnified.

The strength of potential threat of the powerful NHS buyer to squeeze the price for a new quality product (and quality is a central tenet of the 1997 White Paper), may vary according to internally competing demands. For example, what is the value to the NHS of freeing up hospital beds occupied by patients suffering iatrogenic reactions and the effects of non compliance with medication? The Audit Commission Report (1994: 23) suggests that some 5% of hospital beds are so occupied. Col et al, (1990 : 15) suggest that as many as 11.4% of hospital admissions are caused by poor compliance. What is the value to the Gross Domestic Product in reducing iatrogenic illness, thus creating more man years of production per calendar year by healthier people?

From yet another perspective, 363,000 man years per year are reported as lost by industry due to stress related illness, with a cost to employers of between £1-2 billion each year, (Jenkins and Coney 1992 : 25). Could this be mitigated by, firstly, better selection of drugs, to assist the sufferer; secondly by medicines related patient counselling and encouragement by the pharmacist; thirdly by an effective system of onward referral by the pharmacist to other health professionals, providing extra social support and advice. A higher cost but higher value pharmaceutical service, carefully constructed and marketed to the key stakeholders already appears to be a prerequisite of success in reducing the threat of buyer power, which could create a barrier to the new role for the NHS pharmacy contractor service.

Threat of Buyer Power has important implications for negotiating pharmacy remuneration and could act as a positive force in stimulating new more effective
approaches. Such cost benefit equations have never been conducted on community pharmacy's behalf, with respect to a quality medicines management pharmacist intervention.

1.5.6 Threat of Supplier Power (Figure 4)

With regard to pharmacy's traditional role of dispensing, this market force is by no means simple and illustrates the effects of competitive advantage, for example, within the pharmaceutical manufacturing industry. The suppliers of branded and patented drugs, at manufacturing level, create their own unique product advantage by new research and development, as well as by market perceptions of the product through image, pharmacology and the marketing profile of the medicine itself. Generic manufacturers do not have such power, being deficient in either brand image or demonstrable pharmacological advantage over the same competing medicines. Indeed, branding of generics may become a ploy by generic manufacturers in order to improve product profit margins, provided they can find a suitable marketing platform to justify the branding. Potentially, a generic manufacturer of a calcium channel blocker, for example, by branding the product, could offer the doctor a means of prescribing a cheaper product of consistent bio-availability. The BNF (British National Formulary) recommends that such products are prescribed by brand name to guarantee such consistency. The generic manufacturer, having branded the generic, could then match the drug tariff price for the generic product, creating the cheapest brand on the market, in other words, best quality at best price.

Likewise, the wholesaling sector finds itself competing in a market place of near identical services, in quality and delivery. Thus, supplier power in the past has been generally mixed and not powerful. With the prospect of the new medicines management service, the suppliers of the new product will be the employee pharmacists themselves and single practice proprietors. This could, in turn, create a major shift in the focus of the pharmaceutical industry, which will then need to influence pharmacists as part of the drug selection chain. However, the other potential suppliers of this new medicines management service are likely to lie in the realm of IT and software suppliers, with packages of algorithmic diagnosis and review programmes. These, in
turn, may well constitute a threat, perhaps through offering such expertise to professions other than pharmacy.

The potential emergence of supplier power for the future could merit careful analysis by those strategists now working on behalf of the profession to design new medicines management services for pharmacist contractors. Strategic alliances between traditional pharmaceutical manufacturers and community pharmacist contractors could well form a powerful new partnership in delivering patient care.

1.5.7 Stakeholders

It could be argued that alongside a consideration of the competitive forces of the market place, as set out by Porter, lies the concept of stakeholders and their potential influence in affecting the future of an organisation. Whilst not necessarily falling into a category of competitive influence, stakeholders may drive or impede change in any organisational programme of effort. They can thus affect competitive effectiveness positively or negatively. They are important as a consideration in this section because at least one key stakeholder, (the GP) could easily turn out to be a competitor in pharmacy's new aspirations.

Early economic theory took account of the priority of shareholders in decision making. The assumption was, according to Thompson, (1993 : 129) that in the beginning of the formalised business organisation, owners (shareholders) were seen as synonymous with managers and so, were the major source of power.

The author would also agree with other writers that in the third millennium, organisational decision making is much more complex and must take account of the major external, as well as internal, agencies which can affect the interests of the organisation, (Newbould and Luffman, 1979 : 127). Freeman, (1984 : 62) defines such stakeholders as "any individual or group who can affect, or is affected by, the performance of the organisation." Their relative power is, of course, different and may even vary with the passage of time. Cyert and March, (1963 : 151) proposed that the
goals of any organisation are a compromise between the aspirations of those stakeholders with sufficient power to affect the course of the organisation's progress.

This may be particularly true of pharmacy and its new service development within the NHS and where the two professions of pharmacy and medicine are so closely connected in the daily transactions of dispensing and communicating on various aspects of prescribed medicines. Their agendas may be different, as may be the corporate aspirations of the different companies / chains, delivering the present dispensing service.

With respect to pharmacy and its proposed new service, Figure 5 summarises the author's concept of the stakeholder power / interest position. Considered together with the competitive market forces and an analysis of the political, economic, sociological and technical forces in the business environment, it forms a basis which may assist forward strategy formulation and exposes some potential barriers as well as opportunities for progress.

Whilst the DH is arguably the most important of the major stakeholders, they are not regarded in this thesis as a potential barrier to change since Government has approved the new MM philosophy.

More latterly, the DH has approved and funded pilot trials for the service and encouraged the pharmacy profession to move into this new role via the Department of Health Medicines Management Advisory Committee, of which the author is a member.

On the other hand, the medical profession is a very powerful social and political entity and could impede, or completely block, pharmacy progress toward its new role. It could do this, for example, by engaging nurse practitioners as practice employees to undertake medicines management duties. Alternatively, it could engage secondary care pharmacists on a sessional basis, to undertake similar duties and 'gate-out' the dispensing pharmacist. It is for this reason that, of the major stakeholders, the medical profession has been selected for study.
Figure 5

STAKEHOLDER POWER / INFLUENCE MATRIX
- PHARMACY AND PRIMARY CARE
AUTHOR'S CONCEPT OF MAJOR PLAYERS

<table>
<thead>
<tr>
<th>Minimal effort</th>
<th>Keep Satisfied</th>
<th>Keep Informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Keep Satisfied</td>
<td>Key Players</td>
</tr>
<tr>
<td>- CHCs</td>
<td>- LMCs</td>
<td>- PSNC / RPSGB</td>
</tr>
<tr>
<td>- Financial Markets</td>
<td>- HAZs</td>
<td>- DH / Government</td>
</tr>
<tr>
<td>- Local Authority SSDs</td>
<td>- LRCs</td>
<td>- BMA / GPC</td>
</tr>
<tr>
<td>- Hospital Trusts</td>
<td>- NHSE, SHAs</td>
<td>- GPs / PCTs</td>
</tr>
<tr>
<td></td>
<td>- Nursing Profession</td>
<td>- Community Pharmacists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- PAs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patients</td>
</tr>
</tbody>
</table>

POWER IN TIME

Low ── IN TIME ── High

Note: Author's interpretation of the relevant stakeholders in pharmacy role change; their respective power and influence position at the time of writing (2002)

Some of the above stakeholders will require careful address in any marketing and communications programme, calculated to influence and facilitate the way forward for pharmacy.

1.6 CHAPTER SUMMARY

Pharmacy's history, with its close connections and interwoven strands of development with the medical profession, can be seen to be either a hindrance, or a help, in taking
matters forward. Cultural prejudices may exist, borne of past custom and practice, which could form barriers to progress, as could both professions' perceptions of their traditional territorial rights. Other stakeholders may also have an influence on future possibilities. Groups such as patient organisations, consumer representatives, competing professions and government itself with its new organs of administration are likely to play important roles.

A brief consideration of the modern primary health care market place within the NHS and with respect to new pharmacy contractor services, particularly medicines management, shows a potentially more complex situation than previously experienced in this country. Structures within the new NHS, in the form of PCTs, Health Action Zones and new strategic Health Authorities, are likely to facilitate competition for the provision of new services. This creates, for pharmacy, the need to carefully prepare its own case, delivering and showing competitive advantage to the NHS in using the profession as a strategic resource for the development of a new primary care intervention. Other professions which can target the efficient use of prescribed drugs to deliver quality patient care, especially for the chronically ill, are already well placed to plan a similar intervention.

New techniques of case construction and presentation to the DH are likely to be required of the pharmacy profession, in, for example, computing the cost efficiency ratio of the proposed new service. The term cost efficiency has been created by the author of this thesis, to encompass recognised economic ratios, (such as cost-benefit) together with other health improvement measures, which may be suggested from the implications of this study. The health economist, with the expertise of analysing cost benefit and cost utility outcomes is one promising option for re-evaluating the pharmacy input into primary patient care and constructing a more robust case to present to the DH.

The following two chapters set out the objectives and scheme of research, and Chapters 4 and 5 explore modern management approaches to introducing new concepts into a market place and effecting change. In the context of this thesis, the change desired is in the concept and practice of primary health care, within the doctor / pharmacist relationship as it impacts upon patient care.
CHAPTER 2
OBJECTIVES OF THE THESIS

This chapter is set out in seven sections as follows:

2.1 The Thesis
2.2 Motivation
2.3 Strategic Importance
2.4 The Overall Aim
2.5 The Research Problem
2.6 Specific Objectives
2.7 Summary

2.1 THE THESIS

The thesis of this study is that there are cultural, professional and operational barriers to repositioning community pharmacy in the primary health care delivery chain, through a new role of medicines management, resident within the medical and pharmaceutical professions; and that these can be systematically addressed by original research and a novel application of modern management techniques.

In this context:

' Cultural' means collective mindset based upon historical customs, traditions, values and beliefs;

' Professional' means the professions' abilities to discharge their allocated tasks; and,

' Operational' means the communication channels, systems, policies and procedures linking the two professions.

(Note: In this context, 'the health care delivery chain' means the usual order in which patients encounter the NHS primary health care service, i.e. firstly the treatment specifying professional, then the medicines delivering professional - the pharmacist.)
2.2 MOTIVATION

The author has spent forty five years in the pharmaceutical profession, twenty of which have been partially occupied with work for the national negotiating body, the Pharmaceutical Services Negotiating Committee.

As chairman of various sub-committees and latterly, the Strategy Group of the PSNC, it has been possible to guide the main committee toward a consideration of an expanded role for community pharmacy within the NHS. Such a role was first written up by the author of this work in the Pharmaceutical Journal, (Tweedie, 1994 : 507 – 508) and developed, amidst initial resistance, to the stage when, in 1998, the proposition was presented to the Minister of State for Health (Mr. Alan Milburn) with full committee backing. Subsequently (April 2000), funding was allocated by the DH for national trials of a new medicines management package.

The subject of this thesis represents the culmination of seven years work in seeking to reposition the whole community pharmacy profession within the primary care sector of the National Health Service. Such repositioning will require careful analysis of cross professional cultural issues; polished internal communications within the pharmacy profession to lead, persuade and motivate the membership into a new order of service; and systematic management of medical stakeholder interest to engage collaboration at all stages of change.

2.3 STRATEGIC IMPORTANCE

Strategy, by its nature and definition, implies consideration of future trends, competitor activity and other influences. The importance of this work, therefore, is to provide a structured approach to the repositioning of community pharmacy in primary care. To achieve such repositioning, implies movement from the present state of the service to a different state, which offers new approaches to patient care, using pharmaceutical expertise and knowledge of medicines. Repositioning must also achieve benefit for the profession and ideally, ongoing security of tenure for current, developing and new
professional services. This implies a dynamic attitude to change, so that a theoretical ideal state is not pursued for its own sake, but rather to create a culture of ongoing change and improvement in all areas of current and potential service, as well as revision of objectives as new opportunities arise.

Strategically, therefore, this study should hopefully signpost a route to a new predetermined future for the pharmaceutical profession, as well as suggesting a new philosophy of ongoing change, within what is an increasingly dynamic health service environment.

2.4 THE OVERALL AIM

The overall aim of this thesis is to firstly expose those key issues which may impede or facilitate the development of a new operational partnership, between doctor and pharmacist. It seeks to do this by determining key 'attitudes', 'needs' and 'wants' of both professions in collaborative management of patient medication. Secondly, the aim is to investigate marketing and management expertise as a means of engineering change at the medico-pharmaceutical interface and within the community pharmacy profession itself.

2.5 THE RESEARCH PROBLEM

The research problem is therefore to devise a method whereby samples of GPs and pharmacy dispensing contractors in primary care can be investigated, so as to determine those 'attitudes', 'needs' and 'wants' and enable generalisation of results to their respective populations in England and Wales.

2.6 SPECIFIC OBJECTIVES

The specific objectives of the study are to:
i. Identify barriers to pharmacy change, within the medical and pharmaceutical professions, together with any facilitating factors which may assist change;

ii. Identify some of the key attitudes, needs and wants of medical and pharmacy stakeholders in the new pharmacy role;

iii. Develop suitable marketing approaches which may address the medical stakeholders’ key attitudes, needs and wants;

iv. Evaluate the role of *leadership* in repositioning the profession in primary care; and,

v. Inform a communications strategy to both professions, in initiating and delivering change, for pharmacy.

### 2.7 SUMMARY

The objectives of this thesis address the problem of moving the community pharmacy profession from its present medicines supply function, into patient focused cognitive service in collaboration with the medical profession.

In doing so, modern management and marketing techniques and original research will be examined and theoretically applied to determine means of introducing the new pharmacy driven concepts of medicines management to the medical and pharmaceutical professions.

Edict and directive to change is unlikely to work alone in the medico-pharmaceutical cultures and so persuasive means appear at this stage, to afford the best route forward.

The following chapter on research methods sets out the selected means of achieving the aim and objectives of this thesis and approaching the research problem.
CHAPTER 3
RESEARCH METHOD

This chapter is set out in six sections as follows:

3.1 Introduction;
3.2 Research Rationale;
3.3 Design of Research;
3.4 Methods and Techniques – Field Research;
3.5 Key Informant: GP Postal Surveys, and,
3.6 Chapter Summary.

3.1 INTRODUCTION

As part of the research for this thesis, two fields of literature are studied, and although not part of the field research itself, are mentioned here, for the sake of completeness.

3.1.1. The Literature Research

The literature research is directed toward the exploration of two subjects:

- Marketing expertise and techniques; and,
- Change management principles and systems.

The body of literature which deals with marketing and also change management is researched to determine those techniques and particular areas of expertise, which may assist the process of repositioning community pharmacy within the NHS from a supply function to a patient centred cognitive role. Marketing has much to say about product or service presentation, as well as productive communication of the service message. Change management is a field of complexity requiring careful address.
3.1.2 The Field Research

The field research in this thesis is targeted at revealing GPs' and pharmacists' attitudes, needs and wants, with respect to a new service offered by community pharmacy contractors. This is of strategic importance to the pharmacy profession in achieving a larger stake in the health care market within the NHS. It is also likely to strengthen pharmacists' influence in primary health care provision and more effectively enable the introduction of further new pharmaceutical services by virtue of a more structured pharmacy involvement with the patient and GP.

Collaborative practice between GPs and pharmacists involves participative clinical decisions and medicines selection for the patient. This research deals with doctors' and pharmacists' attitudes to working together. By focusing upon this relatively narrow area, it is hoped that lessons of practice and principle can be exposed and applied in this study, to engineering a co-operative partnership between doctors and pharmacists.

It is also directed toward exposing any contentious issues which are culturally, professionally or operationally related, so that again, properly targeted change effort in community pharmacy can be applied in attempting to resolve areas of potential conflict between the medical and pharmaceutical professions. It is the pharmacist who will be involved in major role change, but the doctor, in turn will experience consequential changes to practice, which could become an impediment to progress if the GP feels threatened or overloaded with additional work and no added benefit. On the other hand, issues which may be productive, in delivering collaboration between the two professions, may also be revealed and beneficially inform the subject of this work.

The attitudes, needs and wants of pharmacists, as the role change profession, are of key importance in bringing together two groups of professionals, in a symbiotic, structured collaboration, for the benefit of patients. There may be apprehensions and antipathies toward the changing NHS environment. There may be a lack of appreciation of operational matters, such as revised systems and management of the time resource, which could form barriers to change. Research will be undertaken seeking to reveal such factors which, in turn, will help inform change management activity directed toward the repositioning of the community pharmacy profession within primary care.
3.2 RESEARCH RATIONALE

3.2.1 The Hypotheses

The hypotheses under investigation are:

(i) The attitudes of GPs are such that they will resent incursion into their traditional area of responsibility for patient medication and constitute a barrier to change; and,

(ii) The attitudes of independent dispensing pharmacists are such that they will wish to remain in the traditional dispensing role.

3.2.2 The Purpose

The purpose of the method selected for investigating these hypotheses is to:

• Improve the validity of results;

• Enable the collection of a large volume of data;

• Enable generalisation of results;

• Reduce any prejudice induced by respondent pharmacists' knowledge of the role of the author, in seeking to move the profession into a new order of service;

• Explore some attitudinal issues of a representative sample of pharmacists, with regard to the new pharmacy role in primary health care; and,

• Explore some attitudinal issues of a representative sample of GPs with regard to the new pharmacy role in primary health care.
3.3 DESIGN OF RESEARCH

Having determined the core purpose of the method, the design of research selected for this study is a triangulation of three approaches, which comprise:

- A series of key informant interviews;
- The use of focus groups; and,
- Surveys of a larger number of individual units of research (doctors and pharmacists) suitably piloted.

Key informant interviews were undertaken for the doctors’ research but not the pharmacists, as previous unpublished work undertaken by the author had clarified the key issues involved, from the profession’s point of view.

Using this design, it is hoped that consistency of themes may emerge, or indeed disparate perspectives, which will expose both barriers to change, or facilitating issues. These may then be used in designing a change process and programme of effort, in seeking to build an effective collaborative partnership in patient care.
3.4 FIELD RESEARCH METHODS AND TECHNIQUES

The methods and techniques chosen to support the design of the research are summarised in Table 7 and discussed in detail below.

Table 7 METHODS AND TECHNIQUES OF THIS RESEARCH

<table>
<thead>
<tr>
<th>METHODS</th>
<th>TECHNIQUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Key Informant Interviews</td>
<td>Semi-structured interviews: Open and Closed questions; flexible order of</td>
</tr>
<tr>
<td>(Taped and / or notes as permitted)</td>
<td>topics to allow interview to develop a theme; notes taken.</td>
</tr>
<tr>
<td>2. Focus Groups</td>
<td>Schedule of Topics in the form of questions; Prompts by facilitator at ad</td>
</tr>
<tr>
<td>National Level (Notes by Secretariat)</td>
<td>hoc stages of discussion; Free story responses encouraged.</td>
</tr>
<tr>
<td>3. Pilot Surveys</td>
<td>A postal survey of 150 randomly selected GPs.</td>
</tr>
<tr>
<td>1. Doctor Respondent (GPs)</td>
<td>A purposive group of 14 pharmacists.</td>
</tr>
<tr>
<td>2. Pharmacist Respondent</td>
<td>Postal distribution: 4 sections – Attitude; Attribute; Behaviour; Belief.</td>
</tr>
<tr>
<td>4. National Surveys</td>
<td>Structured to enable comparisons between the sections. 1000 GPs and 750</td>
</tr>
<tr>
<td>1. Doctors (GPs)</td>
<td>pharmacists.</td>
</tr>
<tr>
<td>2. Pharmacists</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations:

<table>
<thead>
<tr>
<th>Abbreviations:</th>
<th>GP : General Medical Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LMC : Local Medical Committee</td>
</tr>
<tr>
<td></td>
<td>LPC : Local Pharmaceutical Committee</td>
</tr>
</tbody>
</table>

Note: The above table summarises a triangulation of approach to the field research methods together with the corresponding techniques for each method.

3.4.1 Key Informant Interviews (Appendices 11A, 11B, 11C, pages 434 – 445)

The use of key informants in this study is occasioned by a need to gain special insights and interpretations of some of the underlying issues in doctor attitudes to pharmacist collaboration; some answers to the who, why, what and how issues of the research aim. (Crabtree and Miller, 1992 : 78). Spradley, (1979 : 52) emphasises the usefulness of this approach, in informing the formulation of questions to a wider audience where planned. This view is supported by De Vaus, (1996 : 53) and Jancowicz, (1995 : 212).

Oppenheim (2001 : 51) also records that ‘...talks with key informants...’ can be exploratory in the earliest stages of pilot work. The informants for the medical interviews were selected in consultation with one pharmacist and one GP colleague. The basis of selection, was an agreed preference of achieving views from several sectors
of the medical profession, those who were opinion formers and those who were as described by Johnson (1990: 30) as:

'...trustworthy, observant, reflective, articulate and good story tellers...'  

Each was telephoned, seeking an interview, after explaining the purpose of this research. The sectors selected were:

- A professional body;
- A university;
- General practice medicine;
- A political representative body;
- A health authority; and,
- A government organisation.

The informants are listed in Appendix 11A (page 434) See also page 270.

3.4.2 Interview Format (Appendix 11B, page 435)

Each interview was conducted face to face, as a semi-structured discussion in a relaxed format, wording questions in such a manner as to avoid prejudicing the replies, or presupposing a particular attitude. For example, the following type of question format was used:

'...What are your views of current relationships between general medical practitioners and community pharmacists?...'  

rather than:

'...Do you have any concerns regarding current relationships between general medical practitioners and community pharmacists?...'

3.4.3 The Order of Questions

The order of questions was flexible, allowing the respondent to stray into other aspects of the discussion which may appear later in the question sequence. Confidentiality was
also guaranteed, together with anonymity, because of the potential sensitivity of both question and answer and the position of the informant, as suggested by Babbie, (1994 : 450). As recommended by Oppenheim (2001 : 66) the interviewer involvement in conversation was minimised to reduce bias in the interviewee responses.

*The subject of the research* was introduced by referring to latest developments in primary care, as described in Government White Papers, for example; *The New NHS: Modern, Dependable, (1997 : 40)*

Further reasons explained were:

- The need to investigate the views of a wider GP audience and the important issues to raise with them;

- The medical professions’ widespread agreement that modern medicines are complex entities producing complex effects; and,

- Government policy of encouraging inter-professional partnerships.

The emphasis for the researcher was upon listening, as also recommended by Dobbert, (1982 : 118):

‘...the question is not, how do you talk to an informant, but how do you listen...’

Miller, (1991 : 161) and De Vaus, (1996 : 113) were consulted on the advantages and disadvantages of personal interviews (Table 8) and these aspects together with an emphasis on listening, borne in mind in conducting the interviews and analysing the results. All interview times were kept below one hour.

Notes were taken during the interview question responses, interjecting occasionally to clarify or pursue a particular point. At the end of the question sequence, the interviewee was asked if there were any other comments they would like to make, which they felt were relevant to the subject under discussion. After the close of each interview, the author retired for coffee to a local hotel to reflect and abstract the dominant issues relating to each question.
Table 8  ADVANTAGES AND DISADVANTAGES OF THE PERSONAL INTERVIEW

<table>
<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fuller explanation of questions can be given;</td>
<td>• Time costliness;</td>
</tr>
<tr>
<td>• Supplementary information can be obtained;</td>
<td>• Number of interviewees possible to reach is limited;</td>
</tr>
<tr>
<td>• Return visits to clarify and expand issues are possible;</td>
<td>• Data inaccuracy potential, if questions are not adhered to by both participants;</td>
</tr>
<tr>
<td>• More spontaneous answers can be achieved;</td>
<td>• Difficult to arrange if busy people are involved;</td>
</tr>
<tr>
<td>• Time can be more controlled;</td>
<td>• Human interaction may distort the responses;</td>
</tr>
<tr>
<td>• Sensitive issues can be more easily and delicately handled;</td>
<td>• Access to key informants is sometimes difficult; and,</td>
</tr>
<tr>
<td>• More empathy can be created between interviewer and interviewee; and,</td>
<td>• Semi structuring may be too flexible – a garrulous interviewee can distort the response.</td>
</tr>
<tr>
<td>• Interviewee can seek clarification of issue from interviewer.</td>
<td></td>
</tr>
</tbody>
</table>

Note: Abstracts from Miller (1991 : 161); De Vaus (1996 : 113) contextualising the effectiveness of the personal interview in gathering social research data.

3.4.4 Analysis of Interviews (Appendix 11C, page 438)

Content analysis of each interview notes was employed to derive key issues and presented as a descriptive variable by case matrix, ‘...displaying reduced data in a systematic way’ (Miles and Huberman, 1994: 239) to identify common disparate/themes. These were, in turn, used to inform construction of the national survey questionnaire to GPs as well as interpretation of some results from both of the returned surveys. Data obtained through key informant interviews, are ‘...well suited to content analysis...’ argues Jancowicz, (1995 : 213). The validity of such interviews and analysis is subject to bias in the interviewer and interviewee but alongside other methods, is still useful in comparing emergent themes. Content analysis as further recorded by Babbie, (1994: 307) ‘...may be applied to any form of communication...’ and its applicability to the key informant interviews seems particularly appropriate to the abstraction of key themes and a consequent comparison of such across the informant cohort. Rather than analysis by pre prepared template, a post interview matrix layout of key responses is used in this work and common themes exposed (Crabtree, B.F. and Miller, W.L., 1992 : 18, 19).
3.4.5 **Focus Groups** (Appendices 12A, 12B, 12C : 13A, 13B, 13C, 13D pages 446 – 484)

**Purpose**

i. To elicit data relating to *attitudes, beliefs, needs* of the medical and pharmaceutical professions, as perceived by their leaders, in forming a collaborative partnership in patient care;

ii. To expose leadership views on the practical issues of operating such a partnership in the community;

iii. To elicit leadership areas of agreement which could form the basis of operational progress in building that partnership; and,

iv. To elicit statements indicating commitment to progress; and factors upon which these may depend, if leadership was to support the initiative.

3.4.5.1 **Number and Size of Groups & Organisation of Content**

According to Jancowicz, (1995 : 216) exploratory, structured work usually requires 1 to 4 groups. In this study, because of the levels and bipartite nature of the partnership proposed, it was considered appropriate to establish two groups with national responsibilities within their professions, through which to study the issues outlined under ‘purpose,’ above. By ‘leading’ or ‘moderating’ topic headings, the interchange was kept on target and relevant to the heads under review (Krueger and Casey, 2000 : 131).

The questions which were open ended were kept down to ten or fewer in number and the predetermined sequence maintained; (proceeding from the general to the particular). All views were legitimised by the author of this work as moderator, to encourage the development of a thought train and also to prevent domination of the discussion by strong personalities.
Two sets of focus groups were held:

i. Pharmacy Medicines Management Leadership Focus Group (Appendices 12A, 12B, 12C, pages 446 – 465)
   Consisting of representatives from leadership institutions in pharmacy, plus one HA medical director, to test some of the discussion from a medical perspective.
   Composition:
   Royal Pharmaceutical Society (RPSGB) - Two members
   Pharmaceutical Services Negotiating Committee (PSNC) - Two members
   National Pharmaceutical Assoc. (NPA) - Two members
   Leading Pharmacy Practitioners - Two members
   HA Medical Director - One member
   HA Pharmaceutical Adviser - One member
   Facilitator (notes taken) - A.M. Tweedie
   Secretary (notes of meeting) - PSNC

   This was held at the RPSGB in Lambeth and members invited by telephone, confirmed by letter. The date of session was 4th June 1999.

ii Medico-Pharmaceutical Leadership Focus Group (Appendices 13A, 13B, 13C, 13D, pages 466 – 484)
   (Ex BMA / GPC)
   British Medical Association
   General Practice Committee - Three members
   Pharmaceutical Services Negotiating Committee - Three members
   Facilitator (notes taken) - A.M. Tweedie
   Secretariat (notes of meeting) - PSNC + GPC: Two

   This was held at BMA headquarters, Tavistock House, London and members invited by telephone, confirmed by letter. The date of session was 14th January 1999. Six members in total were chosen, based upon their key decision-making authority in their respective organisations.
The participants of these two groups (1 and 2) contained elected members from the two professions respectively. They were all practising professionals in particular roles responsible for different aspects of their professions in terms of services rendered within their NHS responsibilities. They are people who are committed to thinking on behalf of their professions and weighing up propositions and consequences. Hence their selection as groups with special knowledge, who politically represent their professions and would have an input as opinion leaders for any new service proposition.

3.4.5.2 Analysis of Group Results

Note based results (Krueger and Casey, 2000: 131) were jointly taken by the moderator and secretariat, (assistant moderators) using a narrative approach and recording specific individual comment. These were compared and common themes identified, by taking each point raised by each member and extracted. Important points picked up individually only, were listed in a final transcript, which set out the major themes. Content analysis was then employed, accompanied by a matrix presentation and interpretative comment (Miles, B.M. and Huberman, A.M., 1994: 178 - 179). These views and results were compared with the key informant interviews, again looking for similarities and differences. A consistent style of transcribing was employed (Krueger and Casey, 2000: 142).

3.4.6 The Postal Questionnaires (Appendices 16, 17, 18 & 19, pages 487 – 504)

In this study, the postal questionnaire is the third and final element of triangulation in the research, to determine attitudes, needs and wants of general medical practitioners and community pharmacist contractors, relative to the proposed new partnership in medicines management. The sampling frame used for doctors was the medical practices lists for England and Wales, which comprise the geographical area of study in this thesis. Scotland and Northern Ireland operate independently and were excluded, whereas Wales was included as it still collaborates closely with England. Both medical and pharmaceutical service contract negotiation strategies for both countries are largely decided in England by the GPC and PSNC respectively.
A simple random sample of GP practices was selected using the *In-time* computer and its comprehensive data base and address labels run off. *In-time* is a respected commercial organisation operating in the health care research field for such organisations as those in the pharmaceutical industry and the Royal College of General Practitioners Research Network, from whence the recommendation came. The list was run off twice to accommodate a follow up mailing so as to achieve hopefully a bigger sample return. The physical mailing was collated and despatched by the University of Portsmouth, after coding to allow follow up. Pre-paid envelopes were supplied. One thousand targets were selected to hopefully produce sufficient responses to enable generalisation of results. The expectation of approximately a 50% response rate was derived from the author's previous work in the pilot study.

A random sample of independent pharmacy contractors (dispensing) was abstracted from a ready made sampling frame, the Statutory Register of Premises, compiled by the Royal Pharmaceutical Society of Great Britain. One in ten addresses were selected with a random starting point and where the tenth name was a multiple it was excluded and the next independent name used. (To follow the custom of the DH Statistical Bulletin, a multiple was classed as a group with more than five branches). The count stopped at 750 names forming a 15% sample of independent pharmacies. This number was selected so as to theoretically give a sufficient return on which to base some comment about the full population of 5026 independents (Statistical Bulletin: 2000 – 2001). A return of between 50 and 60% was expected, based upon past research (Jones, I.F. and Booth, T.G. 1975 : 150 – 153; Smith, A.J., 1994 : 5 - 7; Thomas, K. and Jones, I.F., 1996 : 855).

### 3.4.6.1 Purpose

The purpose of the postal surveys is to obtain a large number of GPs' views and pharmacists' views, which may, at best, be generalisable, so as to realistically estimate the views of the total populations. At worst, a larger number of views than those previously obtained, will better inform change management activity and marketing approaches to introducing the new *product* to the medical profession. Some of the advantages and disadvantages of postal surveys are listed in Table 9, (Babbie, 1994 :
273 – 274 and Oppenheim, 2001: 102), to assist informed interpretation and contextualisation of survey results.

Table 9 ADVANTAGES AND DISADVANTAGES OF POSTAL SURVEYS

<table>
<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low relative costs</td>
<td>Response rates are not guaranteed. (Only a sample of a sample may be achieved)</td>
</tr>
<tr>
<td>Reaches large sample</td>
<td>Respondent cannot seek any elucidation of question</td>
</tr>
<tr>
<td>Characteristics of population can be predicted</td>
<td>Non respondents may distort the statistical validity</td>
</tr>
<tr>
<td>Question sequence is controlled systematically (easy to difficult)</td>
<td>Question response categories may be misinterpreted</td>
</tr>
<tr>
<td>Categorised answers enable statistical treatment</td>
<td>Non respondent bias is not understood</td>
</tr>
<tr>
<td>No prejudice from interviewer presence</td>
<td>Length of questionnaire may deter responses</td>
</tr>
<tr>
<td>No question distortion by interviewer emphasis</td>
<td>The non respondents cannot be assessed and their sample view effects cannot be taken into account</td>
</tr>
<tr>
<td>Gives respondents privacy, freedom to state their true views</td>
<td></td>
</tr>
</tbody>
</table>

Note: Abstracts from Babbie, (1995: 273 - 274); Miller, (1991: 141) and Oppenheim, (2001: 102) to assist balanced interpretation of the postal survey results later in the work

3.4.6.2 Structure

Each survey is a computer generated simple random sample (1000 to GPs, 750 to pharmacists) abstracted from the general medical list and the contractor pharmacy list. The pharmacist survey is lower in number because of some difficulty in identifying true ‘independents’ at the time, as these are progressively being bought up by the multiples. The postal surveys consist of a mixture of questions, formulated to produce data on different aspects of respondents’ views, in categories described by De Vaus, (1996: 82):

- Attitudes;
- Attributes;
- Behavioural issues; and,
- Beliefs.

The content and sequence of questions were determined in advance as was the form and degree of the answers, making this a fully structured quantitative approach, as distinct from the previous two elements of triangulation, i.e. key informants; focus groups.
However, a degree of flexibility was created by including some open ended questions in... 'other, please specify'... categories. In this way, a more numerate and statistically based assessment is possible, both for analysis and generalisation.

3.4.6.3 Question Categories

*Attitude* questions are those which relate to what the respondents think is *desirable*.

*Belief* questions relate to what the respondents believe actually is the case.

*Behavioural* questions attempt to ascertain what the respondents *do*, in certain circumstances.

*Attribute* questions seek to establish certain characteristics of the respondents, especially those which may have a bearing on responses in other categories of question, for example, some attitudes may be related to age (an attribute).

Questions in each category were grouped on the survey form and led from easier to more difficult issues. The general principles upon which the survey questionnaire structure was based are set out in Table 10 and derived from Miller, (1991 : 143); Bell, (1996 : 82); De Vaus, (1996 : 83) and Oppenheim, (2001 : 104 – 105).

**Table 10**  
**PRINCIPLES OF QUESTIONNAIRE DESIGN**

- Language tailored appropriately to the audience (doctors, pharmacists);
- Contingency questions advisable;
- Questions kept as short as possible;
- Ambiguity avoided;
- Negative questions avoided;
- Prestige bias avoided;
- Objectionable connotations avoided;
- Respondent ego protected;
- Provide good instructions for each section;
- Replies set up for coding; and,
- Questions and sheets well spaced out.

*Note:* The above principles were researched to inform the structure and content of the postal surveys as well as 'cultural fit' so as not to offend respondents and thus avoid prejudiced replies.
3.4.7 Survey Pilots (Appendices 14, 15, pages 485 – 486)

Pilot surveys were conducted to test the clarity of questions and response categories for each profession. One group of 14 pharmacists was used in the form of an LPC (Appendix 15, page 486).

The questionnaire was applied individually, but in group session and in relative silence, precluding any supplementary questions from the group until after completion. An LPC was chosen as the group, as wider postal survey results from other unpublished research had already given an indication of question format and response categories.

Each question was then rehearsed again, asking for comment, to allow for amendments to the survey questionnaire, if necessary. It is acknowledged that this was not a random sample of respondents, but the LPC chosen was politically representative of NHS contractors, having similar operational problems and professional perceptions.

The GPs’ survey pilot (Appendix 14, page 485) was a sample of doctors (150) selected at random, once again by the ‘In time’ computer and distributed by post. Responses and comments were taken into account in preparing the finished survey for mailing to 1000 GPs in England and Wales and two questions added after considering the responses. A number of response categories were amended to give better clarity.

3.5 KEY INFORMANT: GP POSTAL SURVEY LINKS

As already stated (page 44) the purpose of the key informant interviews is to inform the formulation of questions to a wider audience (accessed by the postal survey). Table 11 sets out the specific links between selected key informant and postal survey questionnaires.
### Table 11
**THE LINKS BETWEEN SELECTED KEY INFORMANT QUESTIONS AND QUESTIONS IN THE GP POSTAL SURVEY**

<table>
<thead>
<tr>
<th>KEY INFORMANT QUESTION</th>
<th>POSTAL SURVEY LINKED QUESTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Q11 Governments seem to be encouraging pharmacist/GP collaboration on aspects of medication review. Do you agree with this approach? (The detail is in the next question)</td>
</tr>
<tr>
<td>Q2</td>
<td>Q12 (A selection of 10 options were listed)</td>
</tr>
<tr>
<td>Q3</td>
<td>Q13 As above</td>
</tr>
<tr>
<td>Q4</td>
<td>Q14 If you answered 'never' to Question 6, would you like a pharmacist to work for you in the future?</td>
</tr>
<tr>
<td>Q5</td>
<td>Q15 Do you feel the pharmacist should become a formal part of the doctor's team, addressing selected items agreed by you?</td>
</tr>
<tr>
<td>Q6</td>
<td>Q16 Patient perception of your overall service could be enhanced by a pharmacist medicines management review service directed by you. Do you agree?</td>
</tr>
<tr>
<td>Q7</td>
<td>Q17 Please tick the age groups you all come within.</td>
</tr>
<tr>
<td>Q8</td>
<td>Q18 As above</td>
</tr>
<tr>
<td>Q9</td>
<td>Q19 If a pharmacist worked with you to undertake a patient review of those medication issues agreed by you, how frequently should this be done for those on long term medication?</td>
</tr>
<tr>
<td>Q10</td>
<td>Q20 Quality of care and clinical excellence are recurrent themes in the White Papers. What is your perception of patient expectations of health care over recent years?</td>
</tr>
<tr>
<td>Q11</td>
<td>Q21 Patient perception of quality of care may be a factor in their commitment to the therapy. Do you agree?</td>
</tr>
<tr>
<td>Q12</td>
<td>Q22 As above</td>
</tr>
</tbody>
</table>

### 3.6 CHAPTER SUMMARY

The methods and techniques of research used in this study have been constructed to attempt to reduce the error factor of the final research by using triangulation. Key informant groups, focus groups, and wider postal surveys, are used in an attempt to gain...
the clearest picture of doctor and pharmacist attitudes to the new proposition of inter-professional partnership in medicines management.

Support for adopting this approach has been culled from research methods literature, written up by the following authors: Babbie; Bell; De Vaus; Dobbert; Jancowicz; Johnson and Miller; Miles and Huberman; Krueger and Casey; and Oppenheim.

Analysis of results, in Chapter 7, should help expose common themes, problems and opportunities, which, in turn, will help inform managing change and marketing activity, if indeed progress is deemed possible. Figure 6 summarises the research programme.

Figure 6  SEQUENCE CHART OF FIELD RESEARCH ACTIVITY AND LITERATURE RESEARCH

HYPOTHESES
↓
KEY INFORMANT INTERVIEWS
(Eight)
↓
NATIONAL FOCUS GROUPS
(1) Pharmacy - 12 members
(2) Medical/pharmaceutical - 7 members
↓
SMALL PILOT SURVEYS
(1) Pharmacy - (14 members) Group Session
(2) Medical - Postal Survey - 150 GPs (Net 73)
↓
NATIONAL SURVEYS
(1) Pharmacy - random sample 750 pharmacists
(2) Medical - random sample 1000 doctors
↓
ANALYSIS OF SURVEYS
To determine potential barriers to change and facilitating issues, in effecting change at the medico pharmaceutical interface
↓
SUMMARY OF RESEARCH RESULTS
CONCLUSIONS AND RECOMMENDATIONS
↑
LITERATURE RESEARCH
↑
MARKETING LITERATURE
↑
CHANGE MANAGEMENT LITERATURE

56
The literature research in this thesis is focussed upon two areas:

i. Marketing Theory and Principles; and,

ii. Organisational Change and Management

These two fields have been chosen because they directly bear upon the subject of this thesis, i.e. 'barriers to change in repositioning community pharmacy in the primary health care chain...' and their 'systematic address.' Given that physical resources, such as finance and physical accommodation, can be made available, potential barriers to change lie in the realm of the needs, wants and attitudes of the key stakeholders, together with the motivation underlying these.

If there are barriers to change, as the thesis suggests, then because of Government intent to use pharmacy in a more cognitive way, they will need to be overcome if progress is to be made. Change will be required, not only in operating procedures within pharmacy, but also in attitudinal reorientation on the part of doctors and pharmacists, with respect to their traditional interrelationships.

Marketing according to Crozier, (1975 : 26) is the discipline which is tasked with:

'... identifying, anticipating and satisfying customers' requirements profitably...'

and argues Kotler, (1987 : 5) marketing designs an organisation's offering (services or products):

'...in terms of the target market's needs and desires
... using effective communications... to motivate and service the markets.'
The literature research explores relevant concepts, which are judged important to a consideration of introducing the new pharmacy role as a new service or product which can bring benefit to doctor as well as patient.

Equally the theory of organisational change and its management, is explored to inform appropriate means of addressing the particular issues which may be involved in transforming the pharmaceutical profession in primary care from a supply function, into one of cognitive service.

It is hoped, in exploring these two subjects, marketing and organisational change, a means may be found of integrating both in a concerted effort to achieve satisfactory change.

This literature research seeks to theoretically explore the potential role of marketing and change management in addressing the above issues, to bring about the required transformation in primary care pharmacy service. Both subjects are highly complex modern management processes, which deal with psychological aspects of individual reorientation, as well as structural and systems reorganisation in complex organisations.

A cursory study would not achieve the depth of consideration required for the task ahead, involving transformational change in pharmacy and some restructuring of the primary care doctor’s practice and administration. Considerable study and space is therefore dedicated in this thesis, to a thorough exploration of the issues involved in both disciplines of marketing and change management.

Chapters 4 and 5 respectively explore each and will be related to the field research findings when completed.
4.1 INTRODUCTION

The purpose of this chapter is to explore aspects of marketing, which is now a globally used discipline in modern economies, for conceptualising new products and services and bringing them to successful acceptance and usage by the target audience. This is not to say that all marketing campaigns are successful, but simply that the use of marketing philosophy and techniques is an accepted means of applying systematic and structured management approaches to introducing new, and sometimes re-introducing old concepts to the desired consumers. The old approach of pharmacy negotiators to government can be summed up on the basis of a comment by one member of Cumbria LPC:

'...we are a long established well known profession. everyone knows what we do and we have a right to expect
proper payment for our services to the NHS...’

The national negotiating body (PSNC) has historically, simply computed the cost of providing the service nationwide, added profit elements and tried to persuade the DH to agree the global sum of remuneration resultant therefrom. As explained in Chapter 1 the cost plus contract has gone and additionally, new services from pharmacy are required. Marketing offers a unique new perspective on both new product / service development and successful influence of key decision makers for NHS contracting services. Most importantly in this latter respect, ‘marketing’ will address, through a structured approach, the attitudes, needs and wants of the targets of change, GPs and dispensing pharmacists and inform the communications strategy as set out in the objectives of this thesis (Chapter 2 page 38). It is in pursuit of an entirely new approach to community pharmacy transformation, that marketing is being investigated in such detail. The key stakeholders, (the DH and medical profession) in these modern times of rigorous evaluation, need a refined and sophisticated approach to new service proposals.

This chapter explores in outline, the history of marketing to contextualise its use in society and its expertise in new product / service introduction.

4.2 MARKETING HISTORY

The progressive development of marketing practice, if not theory, arguably has a history as old as pharmacy. Davidson, (1987: 29 – 30) states of marketing origins:

‘...the practice of marketing is almost as old as civilisation...’

Baker, (1997: 4) writing a decade later, made a similar observation when he wrote:

‘...marketing came into being with the first barter exchange, when someone realised that exchanges add value for both parties to the exchange...’
Gilbert and Bailey, (1990 : 7 – 13) writing on historical approaches to the development of marketing, cite authors who propose that the smooth economic development of civilisation is causative of the emergent practices of marketing down the centuries, if not the theory.

However, writers such as Baudet and Van de Meulen, (1982); Fullerton, (1988); and Middleton, (1989) are recorded as contesting this view. Their objections are based upon challenging the historic basis of the account of economic development, which they argue was anything but smooth in the UK. Fullerton also challenges the precept that demand is reactive to product availability and claims that demand must be actively promoted. These authors basically view marketing practices as having pre-dated formal economic development, but recognise its influence.

Gilbert and Bailey themselves take the view that whilst elements of marketing practice existed from early times, modern integrated marketing techniques did not emerge until the beginning of the twentieth century, (1990 : 10).

Alderson and Cox, (1948 : 137 – 151) as long ago as the 1940s, were arguing the need for ongoing development of marketing theory and nominated various institutions from which this could come; the universities figuring prominently. Baumol, (1957 : 413 – 419) in reviewing this work, accepted their basic assumption, proposed in classical economics, that rational behaviour underlies individual choices; the concept being borrowed from behavioural theory in psychology and sociology. However, he does pose the question as to how far this theoretical concept can be assumed in practice, (Baumol, 1957 : 418).

Bartels, (1970) in his treatise on ‘...marketing theory and meta theory... ’ proposed that there was an ongoing need for the development of marketing theory, because of the developing knowledge of the psychology of people. His work also showed the increase in original thought given to marketing, in the period 1950 – 1990. It was during this period that the marketing mix concept was formulated and relationship marketing, received a resurgence in popularity. These two approaches, as shown later, could be used within the context of this thesis, in developing propositions for assisting in the repositioning of community pharmacy in primary care within the NHS.
In 1960 Robert Keith asserted, (1960: 35 - 38):

'... soon, it will be true that every activity of the corporation – from finance to sales to production – is aimed at satisfying the needs and desires of the consumer...'

This has been shown to be true of some organisations, but the number of journals continuing to exhort business enterprises to do this, right up to the present time, is an indication that the proposition is not yet universally accepted. Some professional institutions, such as the RPSGB may have little knowledge of the concept of marketing and problems may ensue in attempting to introduce such approaches to change.

Recorded definitions of marketing emerged during the development of the body of marketing theory and are in evidence from the 1950s. Crozier, (1975: 16 - 27) lists some forty seven versions in all. Particularly of note are those of the American Marketing Association and the British Chartered Institute of Marketing. These are set out in Table 12.

**Table 12 INSTITUTIONAL DEFINITIONS OF MARKETING**

<table>
<thead>
<tr>
<th>AMERICAN MARKETING ASSOCIATION</th>
<th>BRITISH CHARTERED INSTITUTE OF MARKETING</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The process of planning and executing the conception, pricing, promotion and distribution of ideas, goods and services, to create exchange and satisfy individual and organisational objectives.</td>
<td>• The management function which organises and directs all those business activities involved in assessing and converting customer purchasing power into effective demand for a specific product or service and moving the product/service to the final consumer, so as to achieve the profit target, or other objectives set out by the company.</td>
</tr>
<tr>
<td></td>
<td>• Later, this was amended and shortened to:</td>
</tr>
<tr>
<td></td>
<td>Marketing is the management process responsible for identifying, anticipating and satisfying customers' requirements, profitably.</td>
</tr>
</tbody>
</table>
For the purposes of this thesis a more comprehensive definition has been used which encompasses the whole essence of the marketing process and so marketing, as defined by Kotler, (1987 : 5), is:

'...the analysis, planning, implementation and control of carefully formulated programmes, designed to bring about exchanges of values, with target markets, for the purpose of achieving organisational objectives. It relies heavily on designing the organisation's offering, in terms of the target markets' needs and desires, and on using effective pricing, communications and distribution to inform, motivate and service the markets...'

Kotler's perspective is used as the definitive article, because of its comprehensive address of the marketing process, from initial market analysis to after-sales-service of the markets themselves; this latter factor being a crucial aspect of the new proposed pharmacy service to medical practitioners. Kotler's definition also accommodates the concept of relationship marketing, through its address of ...motivation and service of the markets.

This literature review and commentary, therefore, seeks to explore those aspects of marketing enshrined in Kotler's definition, which may inform potential approaches, in introducing the new pharmacy product to the medical profession and engaging their commitment to use it.

It further seeks to explore how marketing effort may be targeted to appropriate elements of a suitable model of organisational performance and change, in order to assist the repositioning of community pharmacy in primary care.
4.3 THE MARKETING MIX; RELATIONSHIP MARKETING; MARKETING AND HEALTH CARE

4.3.1 The Marketing Mix

The marketing mix was conceptualised as an integrated selection of activities, which a marketing programme would ideally embrace, to comprehensively address the marketing exchange process. That is, the activities set out in Kotler's definition relating to the transactional dealing of the exchange process. Introduced originally by Professor Borden of the Harvard Business School, (Borden, 1964: 2 - 7) it consisted of twelve elements within the control of the marketing company and four elements determined by the external factors of the business environment. At the time of introduction to general marketing theory, he did record that the original broad concept came from a colleague in the same business school, James Cullinton.

The long list of elements has since become attenuated to some four basic tenets, popularised by McCarthy, (1978: 35) and known as the 4Ps, to which other workers have added three items, (Booms & Bitner, 1981: 47 - 51). Tables 13 and 14 set out the related approaches:

Table 13  THE ORIGINAL MARKETING MIX  AS DESCRIBED BY BORDEN

| INTERNAL FACTORS | • Product policy | • Packaging | • Personal selling |
|                 | • Pricing       | • Display   | • Servicing       |
|                 | • Branding      | • Distribution channels | • Physical handling |
|                 | • Promotions    | • Advertising | • Fact finding + analysis |
| EXTERNAL FACTORS | • Customer buying behaviour | • Competitor behaviour / position |
|                 | • Trade behaviour | | |
|                 | • Government regulations | | |
Table 14  THE MARKETING MIX AS DESCRIBED BY McCARTHY
AND THE EXTENDED MIX FORMULATED BY BOOMS
AND BITNER

<table>
<thead>
<tr>
<th>McCARTHY – 4Ps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product -</td>
</tr>
<tr>
<td>Promotion -</td>
</tr>
<tr>
<td>Price -</td>
</tr>
<tr>
<td>Place -</td>
</tr>
<tr>
<td>Tailored to market needs / wants</td>
</tr>
<tr>
<td>Profile targeted at specific groups</td>
</tr>
<tr>
<td>Maximises profit and market acceptability</td>
</tr>
<tr>
<td>Located for best distribution</td>
</tr>
<tr>
<td>(McCarthy, 1978: 35)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BOOMS &amp; BITNER EXTENDED MIX – 7Ps (including above 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People -</td>
</tr>
<tr>
<td>Process -</td>
</tr>
<tr>
<td>Physical Evidence -</td>
</tr>
<tr>
<td>The parties involved in the transaction</td>
</tr>
<tr>
<td>The complexity of making it happen</td>
</tr>
<tr>
<td>Environment in which the product/service occurs</td>
</tr>
</tbody>
</table>

The ‘4Ps’ became the core approach of what is called the marketing management school of thought, which is simply to see marketing as management of a system of elements which are structured to each marketing situation and programmed to deliver the marketing objectives. This is viewed by critics of the school, (McKenna, 1991: 148; Webster, 1992: 1–17; Gronroos, 1993: 11–12) as manipulating the customer response by applying marketing techniques to them on behalf of the supplier, rather than operating primarily on a mutually beneficial basis, within a healthy commercial relationship. McKenna, (1991: 148) sees the marketeer as:

'...integrator, both internally – synthesising technological capability with market needs – and externally – bringing the customer into the company as a participant in the development and adaptation of goods and services...'

This concept is considered very important in this study, as it seems to make eminent good sense to bring doctors into the planning process of any new pharmaceutical offering which affects them.
Webster, (1992 : 14) argues for increased relationship management and for long term commitment from the firm (organisation), to maintaining that relationship, with quality service and innovation. He goes on to argue that repeated transactions over a period of time form the basis of a developing relationship. Within the context of this thesis, prescribing by doctors and dispensing of their prescriptions by pharmacists, comprises a multi-transactional relationship established over many years. Although these theories were not primarily written for community pharmacy services, clearly they concur with the spirit of the 1997 White Paper, *(The New NHS – Modern, Dependable)*. They have specific implications for the pharmacy initiative, in developing a new partnership with the medical profession. The White Paper emphasises the importance of relationships between the health care professions in a fully developed form, i.e. partnerships of patient care.

Webster, (1992 : 14) sees a continuum of marketing approaches as shown in Figure 7.

**Figure 7  MARKETING APPROACHES – A CONTINUUM**

![Marketing Approaches Continuum Diagram](image)

Pharmacy may be regarded as being positioned for stage ‘4’ in preparing to market the proposition in this thesis to the medical profession, which could easily form a barrier to change if they do not like the concept of close working relationships with pharmacists.

However, the *marketing management* approach, as distinct from partnership development, exemplified in the application of the 7Ps, is still widely practised. The elements of the mix still need consideration in relationship marketing, but with the emphasis on partnership collaboration. Such an integrated approach is practised in both profit and non-profit organisations such as charities and is effective across a wide variety of settings, (Belch & Belch, 1995 : 6).
Profession to profession marketing, as a routine formal practice, is relatively unusual, but in this study, and potentially for the future, it seems to be suited to a combination of both the 7Ps and relationship marketing. Before examining relationship marketing in more detail, the elements of the 7Ps will be addressed individually.

4.3.2 The Product

Kotler and Clarke, (1987 : 328) define a product as:

‘...anything that can be offered to a market to satisfy a need.
It includes physical objects, services, persons, places, organisations and ideas...’

They conceptualise the product offering as having three distinct components:

- The core product or service;
- The tangible product; and,
- The augmented product.

This is apparently a crucial consideration in preparing any product or service for its potential market, as each of the elements has appeal to different aspects of consumer perception.

Diagrammatically, this concept is represented in Figure 8. Its relationship to the new pharmacy service offering is set out in the paragraphs following and relates also to psychological effects of the new potential pharmacist relationship with the doctor.
THE THREE CONCEPTUAL LEVELS
OF PRODUCT OFFERING

AUGMENTED
PRODUCT

Installation of Product

TANGIBLE
PRODUCT

Styling

Features

Core Product

Packaging

Quality

Brand Name

After Sale Service

Delivery Credit

Warranty

(Kotler & Clarke, 1987: 331)

Note: The authors demonstrate that a product or service is not simply the article itself but a complex of factors which can be constructed to appeal to the target consumer at three different levels - the article itself; its presentation; its after effects or impact.
4.3.2.1 Core Product (Service)

The core service, which will help reposition pharmacy within primary care is as set out in tables 4 / 5, (Chapter 1) and is derived from recognised inadequacies in patient treatments involving medicines. Such defects span economic inefficiency, as well as pharmacological problems. These issues are documented in the USA as well as the UK:

i. The Audit Commission, (1994) reported that 3 – 5% of hospital beds were occupied by patients suffering from adverse drug reactions;

ii. Patient non-compliance with treatment accounts for 11% of hospital admissions, (Col et al, 1990 : 150);

iii. Average generic drugs dispensed in England and Wales is recorded as 52%, but best performance is 63%, (Statistical Bulletin 2001). Expired brand patents could further be replaced by cheaper generics, bringing generic dispensing up to the order of 80%, generating savings of up to £400m annually;

iv. Morrow et al, (1993 : 25 – 27) showed that patients were dissatisfied with the level of information they receive from doctors about their illness and medication; further that there is poor compliance with advice given; and,


Patients themselves may be unaware of the adverse effects of medicines and the complexity of their interactions, but the issues are now well known at professional level in pharmacy and medicine. Clearly however, for pharmacy to present a medicines management service in a way which is critical of the doctor could be seriously
unproductive, if not detrimental to progress in marketing the service. These issues will be addressed in due course.

The elements of the augmented product, for example, will thus need careful handling in the total ‘packaging’ of the concepts, so as not to imply a failure on the part of the doctor. Over-emphasis on the flawed elements of prescribing such as serious drug interactions and sub therapeutic dose levels, may produce resentment.

4.3.2.2 The Tangible and Augmented Product – Attributes

This is a somewhat more complex issue, in that it relates to the way in which the core product is presented and the messages it sends to the customer. The new product for pharmacy should also take account of competitors in the market place. The New NHS: Modern Dependable, (1997: 56, 70) promoted new partnerships in patient care and new care packages, which by implication, may well be presented by a number of professionals, such as nurse practitioners, doctors, peripatetic pharmacists and so on, (Chapter 1, Figure 4). The new core service, (Chapter 1, Tables 4, 5) could, in reality, be supplied by competing professionals. It is therefore sensible from a strategic point of view, to structure the Tangible and Augmented Product, in such a way as to create barriers to entry against other professional incursion.

Myers and Alpert, (1976 : 106 – 110) also make the very cogent point that common attributes among competitive products, whilst not being determinant in differentiation, probably become the expected norm of the specification in the given market. General upgrading of car quality and extras lists, in the consumer market, illustrates the point. Specifications below expectations are not likely to achieve a significant market take up and so, in the case of the present medicines management product, the basic specification should be as comprehensive as possible, whilst the tangible / augmented product, should create substantial determinant benefits / attributes, which may not be easily replicated by competitors. A number of routes of achieving this, are suggested through the work of researchers in the field of consumer behaviour and will be applied later to medicines management.
In researching the subject of product attractiveness, the core pharmacy product attributes will require testing for doctor acceptability along with the cultural implications they may represent. This will help avoid potentially threatening aspects to the GP’s cultural expectations.

4.3.2.3 Tangible and Augmented Product – Utilities

Lancaster and Massingham (1993: 79) propose that products should be distinguished by the perceptions that purchasers have of the product’s utilities, based on earlier work by Haley (1968: 30 – 35) on benefits segmentation, which related to the benefits conferred by the product as perceived by the purchaser. Such benefits may include status implications, resource savings (time and money), resolved problems and enhanced favourable opinions of others, i.e. patients. Benefits should be tailored to the value perceptions of the selected market (GPs) and how the selected market in turn, believes that others see them.

The product utilities explored by Lancaster and Massingham relate to the benefits conferred by the use to which the product may be put, or which it fulfils, such as ego protection. It seems appropriate, therefore, that research in this study is directed toward exploring doctors’ perceptions of the new service and exposing such needs and wants of the GP, that resultant appropriate utilities may be built into the tangible augmented product.

If the product (the medicines management service) could be designed taking such considerations into account, then in Levitt’s terms, (1980: 83 – 91) this would give the product distinctive features, (attributes) directly appealing to doctors’ needs.

4.3.2.4 Tangible and Augmented Product – Risk

Work by Bauer, (1960) indicates that buyers of products or services, (especially of a technical nature), try to reduce perceived risk in their purchases by developing strategies which protect them from ‘...the incalculable consequences of their decisions...’ (Bauer,
Whilst GPs are not directly the purchasers of the services within the present structure of the NHS, they are *specifiers* and in due course, as primary care groups achieve trust status, will perform the role of direct purchasers through the boards of these structures.

Bauer’s research has a direct bearing upon the present study, as the new pharmacy product offering may be perceived as having risk, as it could take on some of the present responsibilities of the doctor, in medicines selection, whilst still leaving the medical profession finally accountable for the activity. Clearly, the presentation of the product to doctors will benefit from, in Kotler’s terms, *warranty, quality of service and safety features*, such as regular audit and quality assurance.

Risk, however, not only applies to the shift in responsibility to another professional, but risk in more abstract terms, such as: perceived loss of prestige; loss, or diminished leadership in the health care team; and reduced status in the perception of the patient. Pinson and Malhotra, (1988 : 53 – 73) have observed that the perception of the buyer / customer is *selective* and will reject threatening or even disturbing information. If this is so of simple information, then a positive, challenging proposition, such as medicines management, may create even more disturbance in a long established culture such as the medical profession.

Doctor culture disturbance and consequent self protection, in the new pharmacy product situation (MM), could take the form of rejection of the service provider, the pharmacist, in favour of, say, the practice nurse, who is employed by the doctor. The nurse is in a clearly subordinate position in the primary care hierarchy and therefore is not a potential threat to GP authority. This is a real consideration, despite the fact that the nurse is not qualified to the same degree as the pharmacist.

Risk eradication, therefore, may be a consideration which could be addressed within Kotler’s perception of *packaging, styling and branding* elements of the tangible product.
4.3.2.5 Tangible and Augmented Product – Packaging; Styling; Branding

The packaging of the product, in this case conceptually rather than physically, could assume key importance in protecting the doctor's ego, status and visible headship of the primary care hierarchy. The dynamics of these issues will also be addressed under section 4.4.

The **styling and branding** of the product may change, according to its physical settings. The core product consists of two distinct parts or phases:

- The pharmacist-doctor interface; and,
- The pharmacist-patient interface.

The former phase is where the doctor will be directly confronted with another authoritative health care professional, the pharmacist, advising within the doctor's traditional domain. It may be beneficial, therefore, to brand and style the meeting as the **medical review group** rather than pharmacist medicines review. In this way the doctor chairs and retains the symbolism of medical leadership in primary health care.

In this model the doctor would set the agenda, schedule progress over the following three to six months and prioritise disease group focus. If quality outcomes are probable, then the doctor is heading up a quality drive with desirable effects for the NHS and his own team, of which he is visibly the head.

This leads to a brief review of Kotler's fifth element of the tangible product, *quality*.

4.3.2.6 Tangible and Augmented Product – Quality; After sale service; Warranty

If the GPs' needs, can be ascertained through research and the pharmacy product / service specifically tailored to meet those needs, it should follow that quality assurance will help reassure the doctor that there is safety, in technical terms, in engaging the service of the pharmacist.
Webster, (1988 : 36) states:

'...not only must the business be defined by customer needs...it must also define its distinctive competence in satisfying those needs...'  

Zeithaml et al, (1996 : 187) have also written extensively on the quality aspects of product differentiation and service delivery, emphasising its powerful influence on building reassurance and commitment in the perception of the customer.

Garvin, (1987 : 101 – 109) proposed eight dimensions of quality which are measurable and applicable to products generally and also relate to the product at the heart of this study. Kotler and Clarke's 'augmented product' (quality; after sale service and warranty), are also covered by the application of these dimensions as shown in Table 15. It can be seen that there is a progression from the tangible aspects of the service, to those more intangible, dependent upon the value judgement of the customer, such as perceived quality.

Garvin's approach has similar implications to the Sheth / Newman / Gross value theory, (Table 20, page 102) at the aesthetics and proprietary features levels in impacting upon the image and thus ego of the customer, here the medical practitioner. This is described later in the chapter. Any implied threats to the doctor image could be programmed out in the branding and styling of the product.
Table 15  
GARVIN'S DIMENSIONS OF QUALITY RELATED TO THE PROPOSED NEW PHARMACY PRODUCT AND THE CUSTOMER – THE DOCTOR

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>EXPLANATION</th>
<th>PHARMACY PRODUCT APPLICATION/RELEVANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance</td>
<td>Ability to deliver basic function</td>
<td>Qualifications / special training of community pharmacist + audit trail; outcomes measured</td>
</tr>
<tr>
<td>Proprietary Features</td>
<td>Range of additional benefits to basic function</td>
<td>GP Needs/Wants fulfilment; more satisfied patient; fewer doctor problems; GP/Pharmacist interface suitably styled – supports GP ego.</td>
</tr>
<tr>
<td>Conformance</td>
<td>To a level of excellence with small tolerances</td>
<td>Royal Pharmaceutical Society sets exacting standards – inspects (Warranty). Continuing training &amp; education.</td>
</tr>
<tr>
<td>Reliability</td>
<td>Constant performance over time</td>
<td>Constant inspection RPSGB; revision of protocols, constant positive results.</td>
</tr>
<tr>
<td>Durability</td>
<td>The product or service will not deteriorate</td>
<td>Updating/upgrading of knowledge by IT. New product information fed in. (After sales service)</td>
</tr>
<tr>
<td>Serviceability</td>
<td>Extent, speed and efficiency of service</td>
<td>Frequency of patient review set by doctor – continually audited. (Warranty)</td>
</tr>
<tr>
<td>Aesthetics</td>
<td>Design and appearance of the product service</td>
<td>Pharmacist image as doctor’s assistant and team member. Reporting system of patient review back to doctor reinforces this in patient perception. Doctor headship protected.</td>
</tr>
<tr>
<td>Perceived Quality</td>
<td>Image/reputation of the service</td>
<td>Resulting action x GP of Pharmacist recommendations recognisable x patient &amp; NHS.</td>
</tr>
</tbody>
</table>

**ABBREVIATIONS:**  
GP = General Practitioner;  
RPSGB = Royal Pharmaceutical Society, Great Britain

**Note:** Author's extrapolation of Garvin's 'dimensions of quality' related to the proposed New pharmacy service
Kotler and Clarke, (1987 : 333) set out three options for the way in which the issue of quality in health care can be dealt with over time and these are set out in Table 16.

Table 16 DEALING WITH QUALITY : THE OPTIONS

<table>
<thead>
<tr>
<th>ACTION</th>
<th>EXPECTED RESULT IN PHARMACY NEW ROLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Improve quality over time by training and rewarding employees and improvement in facilities.</td>
<td>Encourages ongoing quality performance. Improved market interest and response.</td>
</tr>
<tr>
<td>(ii) Maintain initial quality and emphasise other dimensions of the business.</td>
<td>Retains interest; develop competitive advantage by integrating OTC medication with NHS; improved outcome of NHS treatments.</td>
</tr>
<tr>
<td>(iii) Allow quality to decline over time.</td>
<td>Organisation decline; extinction in extreme cases. Community pharmacist becomes a technician.</td>
</tr>
</tbody>
</table>

A combination of option (i) and option (ii) may well indicate the correct route for pharmacy, as no other health care professional can integrate OTC and NHS treatments, in real time, to avoid incompatibilities and reduction of effectiveness of NHS doctor prescribed treatments. Currently, for example, cardiac disease patients, who are also taking co-codamol effervescent tablets for pain from other conditions, should be given alternative medication because of the high sodium content. However, patients can buy similar solpadeine tablets over the counter. This they may decide to do if co-codamol non-effervescent are prescribed by the GP to save cost and if they were previously on effervescent tablets. Vitamin B6, bought over the counter could negate the effect of NHS prescribed Levodopa. Currently, neither the doctor, nor the pharmacist would know of the conflicting therapy and the patient’s condition would not improve. Conceivably it could deteriorate and cost the NHS time and expenditure in trying to correct a patient lack of response. Such an integrated service, bringing concurrent knowledge of NHS/OTC treatment would reduce risk, create technical security, and bring some psychological comfort, for the GP and increase his prescribing effectiveness.

Groocock, (1986 : 27) summarises quality pursuit as follows:

'...conformance of all the relevant features and characteristics of the product (service) to all aspects of the customer’s needs...'
This is consistent with the dimensions of quality as set out by Garvin (Table 13), but implies ongoing review of how those needs manifest themselves in the customer’s (GP) changing wants (and / or patient condition) over time. Such change and its address, may well become another competitive advantage over time if pharmacy is made aware of it and creates a system whereby it is methodically addressed to deliver optimum outcomes tailored to the changes.

If pharmacy is successful in securing introduction of the new product / service and repositioning itself in primary care, then ongoing development of the service will not be totally visible to competitors and therefore, more difficult for them to replicate. The consultation process in both phases, (pharmacist / doctor; pharmacist / patient) is a relatively private affair. Threat of substitute and threat of entry, should reduce to an indeterminate level at this time.

A brief review of one element of the marketing mix, the product, has illustrated the complexity and opportunity inherent in good product (service) design. Its implications for the customer (doctor) have been visited in outline and further study of the customer and product implications will be dealt with later in the chapter. Kotler’s conceptualisation of the product offering, exposes potential ways of creating doctor appeal for medicines management especially at tangible and augmented product levels. Even if there were no barriers to product acceptence in the doctor’s mind, ego-supporting aspects of the MM package and clear benefits in practice, can help establish pharmacy as the preferred supplier for the GP. New product design also offers the opportunity to build barriers to entry for competing professionals — a real issue in pharmacy health care within the NHS and its competitive structures.

4.3.3 Promotion

This second element of the marketing mix addresses the process of:

- Informing;
- Persuading; and,
- Reinforcing.
This is achieved by appropriately worded communications, calculated to persuade the potential customer to use and continue to use the promoted product or service. The subject of communications will be dealt with in detail in a section of its own (4.6), as marketing communications has apparently become a specialist subject in its own right. The promotion strategy of an organisation is geared to achieving recognition of the product or service and improvement in the way that the service provider and product are perceived. The ultimate objective seeks to secure an increasing uptake of the commodity being promoted. The routes of promotion routinely used are:

- Advertising - Media channels;
- Sales Promotion - Temporary marketing techniques to make the product offering more attractive by providing benefit in cash or kind (free offers, vouchers, etc.);
- Public Relations - Publicity generated without payment due special interest of the media; and,
- Personal Selling - Face-to-face or person-to-person presentation of the product.

General promotion, through these routes, with the exception of specific sales promotion activity, (which has a more specialised meaning) may be appropriate at different stages of new product introduction to the medical profession. ‘Give aways’, in this intensely professional setting, could be construed as bribery, in the sensitive environment of the NHS and do not seem to be appropriate for profession-to-profession marketing. It is perhaps best omitted, as the other three channels, at this stage, appear to offer sufficient opportunities for publicising and engaging the initiative.

4.3.4 Price

Sufficient to comment at this stage, that the price of services to the NHS, whether it be negotiated centrally with the NHS, or locally with the HAs, or PCTs, will be constrained by budget limits on the one hand, and on the other, moderated perhaps by financial savings generated by the new service intervention. In theory, if such
intervention as described so far in this thesis, were to save £300m of taxpayers' money, then the theoretical budget for the new service may be flexed advantageously for pharmacy.

Such intervention effects may, at some point, need to be subjected to the rigour of health economics analyses by the sellers, (PSNC) if not government. Such analyses help to indicate potential new PSNC approaches to negotiations, by exposing new ways of presenting outcomes of an intervention by a health care professional. These options may also assist marketing approaches to the new pharmacy service. Drummond et al., (1999 : 2 – 3) have comprehensively described such analyses and these are outlined in Table 17.

Table 17 HEALTH ECONOMICS ANALYSES

<table>
<thead>
<tr>
<th>TYPE OF ANALYSIS</th>
<th>PURPOSE / BENEFIT</th>
</tr>
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<tbody>
<tr>
<td>Cost Minimisation</td>
<td>To seek the route of least cost</td>
</tr>
<tr>
<td>Cost Effectiveness</td>
<td>To establish the relative cost/effect ratio of alternatives</td>
</tr>
<tr>
<td>Cost Utility</td>
<td>The cost of the service compared to the extra utility it brings – sometimes expressed in quality adjusted life years (QALYs) compared with an alternative</td>
</tr>
<tr>
<td>Cost Benefit</td>
<td>The gold standard analysis – Total benefits measured against total cost of service compared with an alternative</td>
</tr>
</tbody>
</table>

A cost minimisation analysis would be used for example, in seeking a straightforward reduction in service costs, an appealing prospect for government. Cost effectiveness analysis is employed for straight comparison of two or more alternative interventions. The need to find specific pharmacist advantages may be crucial. Cost utility equations could be used, for example in computing the utility benefits in optimal prescribing, of keeping people out of hospital, improving the quality of their lives and delivering more man days of work to the economy. Cost benefit studies are engaged to comprehensively evaluate alternative interventions in terms of pounds sterling, not units of utility.
Price considerations, for a new pharmacy service therefore, are not the simple issue of computing the expense input, adding a gross / net profit margin and submitting the proposal to the DH. Even the present dispensing contract was originally based upon a more complex formula, as outlined in Chapter 1. If pharmacy wishes ultimately to proceed as a ‘value added’ service, rather than a ‘cost-plus’ supply function, then a value added case would need to be constructed and health economics analyses and computations will need to be part of the process.

Whilst in the economist’s perception of aggregate market dynamics, the price mechanism is generally seen as the major cause determining sales volumes. Demand in the case of the new medicines management services is, in reality, disease / patient led, but may be susceptible to some regulation by government. However this possibility remains to be seen. The service may then be described as *inelastic in the economist’s terms*, as the volume uptake is likely to be independent of price, at the consumer end. If the GP is regarded as the consumer, then the pharmacy profession may be faced with consideration of a competitor professional, such as the nurse.

The situation with respect to pharmacist uptake of the service is somewhat different, as the price finally offered by government may be well below the expectations of the profession. On the other hand, the competitive forces of the domain, (Chapter 1, Figure 4) may well lead the vertically integrated companies and multiples into implementing the service, after doing their own cost-benefit analysis, with increased consumer in-store footfall figuring importantly. This, in turn, may become an internal profession change driver, ultimately bringing a majority of the contracting pharmacists into the service, some against their natural inclination if the price reward is below expectation.

Clearly, price considerations have complex ramifications and are dependent upon many variables.

4.3.5 *Place, Physical Evidence, Process*

The final three elements of the marketing mix to be examined are grouped because of their close inter-relationship, especially with respect to pharmacy. Again, the
competitive forces of the market place, (Chapter 1, Figure 4) make these issues very important to the community pharmacist contractor.

Why should government conceptually regard the community pharmacy as the best location / setting in which to place the proposed new service? Why should the DH not visualise the whole scheme resident in the doctor’s surgery? After all, a physically close proximity of the professionals may be regarded as beneficial to inter-professional collaboration, partnership and patient convenience. It may also be cheaper.

The force militating against this, is of course, the exponential development of information technology, the tendency of which, in one aspect, is to encourage effective distance communication, ultimately by audio-visual. Beyond this, into the future perhaps, potential lies as far as holographic clinics, where a group of patients can network into a three dimensional T.V. clinic, gaining from each other’s experience and enjoying the experience of professional-led group dynamics.

For the present, design of the in-pharmacy facility for consultation and medicines review, could become one key determinant in both the doctor and patient perception of a thoroughly professionalised service. It feeds into the tangible and augmented product, as ‘quality’ and ‘warranty’. The two major stakeholders (patient and doctor) need to be confronted with an impressive visual impact, which sends a conscious message of professionalism. In other words, a comparable facility, to that of other primary care professionals in terms of privacy, relaxing environment and appropriate equipment.

The potential competitive advantage, (Chapter 1, section 5) for community pharmacy, may require concentrated thought by the leaders of the profession. It is suggested by the author (Figure 9) and is related to patient / pharmacist interaction within the community pharmacy, (place, physical evidence, process), as distinct from location in the doctor’s surgery. This could be a key issue in securing the MM service for the dispensing pharmacist contractor.
Figure 9  POTENTIAL COMPETITIVE ADVANTAGE – PHARMACIST / PATIENT INTERFACE IN COMMUNITY PHARMACY

PLACE  PHYSICAL EVIDENCE  PROCESS

Community Pharmacy – a non threatening; friendly environment – important for personal interaction & concordance issues  Physically defined consultation point; semi-private; greater professionalisation (patient must visit for FP10 dispensing anyway)  IT screen – Review Algorithm; review forms for joint patient pharmacist input – Partnership

Integrated review OTC + NHS Meds.  Ethical Livery Design and signing relating to OTC-NHS service; friendly surroundings  Pharmacist/patient interactive discussion; problems explored; reassurance /encouragement to patient; commitment to therapy

Routine OTC intervention of all customer requests for medication  Consultation bench; display surface for medicines identification and demonstration (inhales etc.); compliance aids discussion  Pharmacist recommendations owned by patient (side effects; adverse effects; lack of drug performance addressed)

Advice on OTC medicines, back related to NHS treatment  GP, IT – Link for immediate records access / doctor discussion. Relaxed environment of regular patient port of call  Pharmacist/patient ‘sign off’ the course of action; new review date set; distribute patient copy of review form; transmit to GP (or via IT)

SERVICE SCOPE – PRODUCT RANGE ADVANTAGE  ENVIRONMENT ADVANTAGE  COMPETITIVE ADVANTAGE

Note: The above figure is the author’s conceptualisation of delivering ‘competitive advantage to community pharmacy via three elements of the marketing mix and suggests the inter-relationship between each.
Such a scheme, fully developed through training in interpersonal skills, could create a productive pharmacist / patient consultation process and hopefully enhanced patient participation. This could be developed into an holistic patient partnership, in a friendly relaxed setting. Patients are rarely given bad news in a pharmacy and a specialised, enhanced pharmacist / patient consultation facility, in a comfortable ambience, could be a welcome change in surroundings from the doctor's surgery. If presented as taking weight off the doctor's workload, pressure off waiting room space and producing a satisfied patient, this could also enhance the doctor's view of the service.

If the doctor is abrupt, or too controlling of the doctor / patient encounter, patients can be inhibited from properly describing and discussing their health problem, (Street & Butler, 1987 : 234 - 253, Goleman, 1991 : Ch. 1, Ch. 8). Such patients, arriving at the pharmacy, may be stressed; good communication skills and reception could avert these problems, (Hays & Di-Matteo, 1984 : 1 - 20).

A further possibility may be that patients in the lower socio economic groups, (C2, D) are less able to cope with health problems, because of the likelihood of having little or no knowledge of their physiology and more difficult access to good information. Low self esteem may also play a part in their motivation to adhere to the regimen of therapy. Browne & Mankowski, (1993 : 421 - 430) showed that those who are already low in self esteem are especially vulnerable to negative moods. These may also prejudice patient interest and commitment to therapy on a short and long term basis. Greenberg et al, (1992 : 913 - 922) showed that positive feedback of information to individuals, in a test situation raised self esteem and Solomon et al, (1991 : 21 - 40) showed, in experimental circumstances, that raised self esteem reduces anxiety.

In a relaxed frame of mind, pleasant surroundings and supportive dialogue, the pharmacist may, therefore, be able to achieve patient commitment to therapy and patients' willingness to become more involved in their own health treatment. If stress is reduced, in the health / illness care continuum, the body's immune system is said to function more efficiently, (Stone et al, 1987 : 988 - 993). Cohen, et al., (1993 : 131 - 140) have shown that even susceptibility to the common cold is increased by negative events and perceived stress.
Clearly, the place of pharmacist / patient encounter, physical evidence and the process of interchange between the two, can be of crucial importance in delivering real patient benefit, involvement and commitment to a new professional service. Such extended professionalisation of the patient / pharmacist interface, may constitute some reassurance to the medical profession, if they need it, that a quality pharmacist consultation is on offer to the patient, in like-paradigm of their own physical amenities and doctor / patient interchange. Perhaps too, this may be seen as a threat in terms of the doctor image, prestige and traditional patient relationship in the health care hierarchy of the NHS.

The current pharmacy facility for patient consultation is usually not specifically designed for patient interview. In the experience of the author, attending LPC discussions and visiting pharmacies in the Northern NHS region over twenty years, a medicines counter-end, or part of a dispensary, is commonly used, but without any formally recognised system of interaction or content. Such amenities could be criticised for lack of confidentiality or formally recorded outcomes and in marketing terms, could be viewed as inadequate for creating confidence at doctor level and relaxed involvement in patient terms, for best interchange. Pharmacy facilities will need to be reviewed, with both patient and doctor consulted in the process. This leads to a consideration of relationship marketing.

4.3.5 Relationship Marketing

In the previous section, Figure 8 shows a theoretical continuum of marketing effort and focus of address, in the development of what some believe to be the heart of marketing. This has come to be known as relationship marketing. Gronroos (1999 : 11 – 12) defines it as:

'...the establishment, maintenance and enhancement of relationships with customers and other partners. This is achieved by a mutual exchange and fulfilment of promises...'

Building long term relationships in business, by development and management of the buyer / seller joint interests, argues Webster, (1992 : 12 – 14) can lead to sources of
competitive advantage that are knowledge based and difficult to copy. This is a particularly important concept, bearing in mind the potential professional competition facing pharmacy in the future (Figure 4, Porter’s Five Forces). Anderson and Narus (1990: 42 – 58) see the development of partnerships between customer and supplier, as being dependent upon long term commitments to maintain quality service and innovation. Consequently, they go on to argue, increased attention will need to be paid to relationship management. This, according to Connor, (1991: 121 – 154) will become a real cultural issue for customers’ suppliers and can create success and competitive advantage; the doctor is the pharmacist’s customer in the new role.

Cultural issues appear to become increasingly important to the subject of this study, involving two professional constituencies with a common interest and who may be mutually inter-dependent. This is not currently the case, with community medicine and community pharmacy simply collaborating on behalf of the patient, on the basis of ‘when needs must’. The real question is, could such a mutual dependence be developed through the proposed new pharmacy service? The present relationship is really through a third party, the patient, and it may be through this link that a true lasting relationship could be solidly established.

The health care field has now changed, primarily through a restructured NHS, into a more competitive and quality demanding environment, where professional boundaries are blurring. Nurses now prescribe and prescribing is also on the agenda for pharmacists, (Simpson, D., 1999: 267). Sale and supply of medicines under patient group directions, is also about to be changed, (DH circular, MLX260 : March 2000) which could mean other agencies supplying medicines. This is a serious development as is indicated in the consultation document, which sets out the various regulative instruments that would need to be changed, i.e.

- Section 55 (91) (b) Medicines Act 1968;
- The Prescriptions Only Medicines Order, 1997;
- The Medicine Order (Pharmacy and General Sales – Exemptions) 1980; and,
The circular limits this change to:

'...NHS bodies, or to NHS funded services provided through the private, charitable or voluntary sector...'

'Patient group directions' must be authorised, according to the circular, by the NHS Trust, Health Authority or Primary Care Trust. Whilst this is not a blanket order for universal dispensing of FP10s, it is a modification of supply, which further stretches the boundaries of community pharmacy’s majority rights of NHS dispensing in England and Wales. It is not beyond the bounds of credibility that the new walk-in health shops, staffed by nurses, could be given some dispensing rights.

A medical / pharmaceutical partnership, which could be viewed as a strategic alliance, may now be opportune between the professions to construct a new NHS ‘product’, in marketing terms, which also has major benefits for doctor and patient. The product is, of course, a partnership in medicines management.

*Relationship marketing* is not new, as evidenced by the statement made by Henry Ford (1922: 67)

'...when one of my cars breaks down, I know I am to blame...

*a manufacturer is not through with his customer when

*a sale is complete... the sale of the product is only the introduction...’

However, this form of marketing has experienced an upsurge in popularity in the 1980s when the automotive industry recognised the need to compete in new ways, (Womack, et al., 1991: 138 – 139). The underpinning theory is that old customers are a highly valuable commodity and retaining these by developing the relationship, whilst attracting new ones, enhances market share and profits. Sasser, (1978: 93) has shown in the commercial model, that retaining just 5% more customers than normal, can actually double profits.

*Relationship marketing* is thus the effort to build an enduring relationship by the supplier with each of its customers on a one-to-one basis. This it seems, is especially appropriate in the doctor / pharmacist relationship, within primary health care, where it
will be not so much a question of the pharmacist building a relationship with many customers, (doctors) but a small number, who are the source of patient flow and prescriptions, routinely dispensed by the pharmacy. However, on a pan-profession scale, leadership at various levels, will have responsibilities too, in building the inter-profession relationship. It must, argues Conner, (1981 : 122) and Fiol, (1991 : 191 – 211) become part of the organisation’s culture in co-ordinating mission and objectives towards the partnership goal.

From the foregoing discussion, it is apparent that relationship marketing and selected elements of the marketing management approach (7Ps), could have a function in applying marketing theory to the problem of change and the repositioning of pharmacy in primary care. A summary of the differences between the two approaches is shown in Table18. The importance of relationship marketing theory to the research in the thesis, is in its application to doctor attitudes, needs and wants related to the new service. These latter are discussed in Section 4. Table 18, (Gronroos, 1993 : 11 – 12; Adcock et al., 1998 : 187; Dibb et al., 1994 : 4) sets out a comparison between the marketing mix and relationship marketing.

Table 18  KEY DIFFERENCES BETWEEN EXCHANGE MARKETING AND RELATIONSHIP MARKETING

<table>
<thead>
<tr>
<th>EXCHANGE MARKETING</th>
<th>RELATIONSHIP MARKETING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEFINITIONS</strong></td>
<td></td>
</tr>
<tr>
<td>• The process of planning and executing the conception, pricing, promotion and distribution of ideas, goods and services, to create, exchange and satisfy individual and organisational objectives.</td>
<td>• To establish, maintain and enhance relationships with customers and other partners, at a profit, so that objectives of the parties are met.</td>
</tr>
<tr>
<td>• This is achieved by a mutual exchange and fulfilment of promises.</td>
<td></td>
</tr>
<tr>
<td><strong>CONTRAST</strong></td>
<td></td>
</tr>
<tr>
<td>• Importance of single sale</td>
<td>• Importance of customer retention</td>
</tr>
<tr>
<td>• Importance of product features</td>
<td>• Importance of customer benefits</td>
</tr>
<tr>
<td>• Short time scale</td>
<td>• Longer time scale</td>
</tr>
<tr>
<td>• Less emphasis on service</td>
<td>• High customer service</td>
</tr>
<tr>
<td>• Quality is concern of production</td>
<td>• Quality is concern of all</td>
</tr>
<tr>
<td>• Competitive commitment</td>
<td>• High customer commitment</td>
</tr>
<tr>
<td>• Persuasive communication</td>
<td>• Regular customer communication</td>
</tr>
</tbody>
</table>
4.3.7 Marketing and Health Care

The purpose of this section is to examine briefly the place of marketing in health care and specifically within the NHS. Whilst it is true to say that marketing has been used in the health industry, through drug promotion and advertising for many years, marketing practice within the NHS is a relatively recent phenomenon.

According to Schaeff, (1991 : 1 – 2) the origins of formalised marketing in the NHS are traceable to two major government sponsored reports, some twenty and ten years ago respectively:

- The Royal Commission on the National Health Service (1979); and,

Both promoted a locally responsive service, focusing upon patients' needs and emphasised individual services. The 1989 White Paper additionally recommended pleasant working facilities, clear patient orientated information and optional extras and amenities in hospitals.

The White Paper: The New NHS, Modern, Dependable, (1997 : 66) further guarantees an annual patient survey of users' views of the service, taking consumer orientation a stage further. This and supportive White and Green Papers, (Chapter 1) have developed the concepts of clinical excellence / governance, benchmarking, performance frameworks and new partnerships in patient care, (1997 : 40) to raise the quality of service and consumer participation.

Although the Competitive Internal Market is said to have been removed, (1997 : 2) the measures outlined above effectively retain competition rather more subtly and drive performance toward the best in the market place.

Primary Care Trust structures will be budget controlled, audited and given authority to commission new services. These will be based upon best quality / cost benefit and effectively places the other bidding professions in competition for new services, where alternative health qualifications are acceptable.
As has already been said, (Chapter 1, Figure 4) the traditional community pharmacist, therefore faces competition from other professions, as well as other sectors of its own profession, in other words hospital pharmacists, peripatetic pharmacists and Health Authority Trust pharmaceutical advisors through expanded staffing and responsibilities.

*Marketing* then, appears to offer a means whereby community pharmacy may strengthen its position within the NHS and by quality of service and comprehensive medicines knowledge, create barriers to entry for competing professions.

There are, however, prejudices to the use of what is seen in *marketing*, as an essential commercial activity. Some of these objections are set out in the following sections.

### 4.3.8 Specific Objections

#### 4.3.8.1 Economic Objections

Here, it is held that health care cannot be efficiently distributed by markets, nor consequently by marketing methods. Medical treatments and especially surgery, are often one-off events. Customers (patients) therefore, have reduced opportunity of learning about the product by experience and cannot easily exercise choice, a prerequisite of market dynamics, (Klein, 1983 : 153). Furthermore, the customer, it is held, cannot anticipate the need for specific health care. Consequently, price decisions cannot work exactly as proposed by economic theory, (Kotler and Clarke, 1987 : 369).

Capacity for informed and rational decision making is further prevented, or reduced, by the nature of the incidence of acute illness. Rational decision making may be impaired because of patient reluctance to antagonise the doctor, (Cartwright, 1967 : 22).

Finally, as an example of market distortion, it is seen that in economic terms the doctor is the product/service supplier *and* arbiter of patient needs. Supply and demand curves are, therefore, not independent and the market thus cannot act in a utility maximising way, (Culyer, 1987 : 21).
4.3.8.2 Ethical Objections

The core of the problem here, seems to be that marketing effort is directed toward the patient agent, (e.g. doctors) and decision making is thus removed from the ultimate consumer / patient, (Culyer 1976 : 180). It is also held by some critics that marketing techniques usually increase consumer demand, whilst in health service practice this may not be desirable, (Illitch 1977 : 22). It could be equally argued, of course, that de-marketing is a legitimate function of the marketing process and has the opposite effect, so that patients could be influenced toward more cost-effective services and medicines. Marketing pharmacy to the medical profession is different because the benefits are transparently patient orientated and DH backed.

Tolliday, (1978 : 25) raises the issue of clinical judgement and counter-prejudice, engendered by sales promotion / advertising, so that the clinician’s decision may not be based upon best practice. In a wider context, Daniels, (1981 : 153 – 158) argues that a market place in welfare generally can only function with equal opportunity of choice and so marketing, in this context, may well distort audience mix awareness. Those who are most needy, in the lower strata of society may not be in a position to hear of, let alone evaluate, health care information. Hammond and Jurkus, (1993 : 15) found that whilst marketing is generally held to be unethical by health care professionals, they themselves are of the view that ‘...marketing per se is not unethical...’ Further, that attention given to ethics by the stakeholders, would seem to be especially strong in health care, (Hammond and Jurkus, 1993 : 16).

4.3.9 General Objections

In the USA, the Council of Medical Speciality Services still publishes guidelines indicating classifications of fraudulent product advertising, which should be avoided. Widgery, (1979 : 88) two decades ago, cited the Federal Drug Administration (FDA) as having found that 60% of products it examined produced no evidence for the claims made. A decade ago, Kotler and Clarke, (1987 : 431) raised the same issue as an indication of the tendency of some ‘...less than ethical suppliers...’ to distort their case in promotional literature.
So far as the UK NHS is concerned, it is clearly essential, according to the Industry code of ethics, that all product propositions must be transparently blameless of prejudice and distortion. Similar standards must apply in the marketing of a new professional pharmaceutical service, which is likely to have a major impact upon primary care. In view of historical tensions between the medical and pharmaceutical professions, (Chapter 1) this concept will be crucial to reciprocal trust and empathy. Promotional communications should, therefore, ideally take account of this.

4.3.10 General Positive Considerations

Despite reservations and criticisms of marketing as applied in the health care context, the NHS does, as already indicated, employ some marketing practices with varying degrees of success, for example: meeting consumer illness needs and even convenience wants; health promotion initiatives; evaluation of care package outcomes in quality pursuit; and, consumer research. Social marketing in the pursuit of healthier living practices is well established through anti-smoking campaigns and better diet initiatives. Exercise encouragement is quite well developed, especially in the physiotherapy area of treatment, as well as in general health promotion.

Boonekamp, (1994 : 12) is of the view that network marketing and interdependence of the related parties, such as the provider, purchaser, patient and competitors, is of growing importance in the NHS. Together with a focus on solutions rather than product, this is, she feels, a distinct advantage to patients. Quality, she goes on to say ‘...is a paramount consideration in services and their delivery...’ (Boonekamp, 1994 : 22).

Berkowitz and Hillestead, (1991 : ix) are assured that marketing method fills the gap between master plans (of health care organisations) and tactical implementation. Hassan and Foltz, (1990 : 97) wrote at that time:

‘...Health care organisations are rising to the challenge of a dynamic environment and learning to market their services...'
Undoubtedly overload and inadequate resources with the NHS distort the ‘ideal’ marketing situation, but equally, the benefits of good marketing strategy may assist in changing patients’ perceptions of what should be expected and preferred. In this way, available resources may be maximised, inadequate resources relieved and priority needs given adequate attention.

4.3.11 Summary

It is clear that marketing as applied within the NHS is a somewhat controversial and relatively new practice, even though the pharmaceutical industry has successfully marketed to the health field, including the NHS, for some fifty years. Marketing strategy and application of the tools of marketing will need thoughtful and careful application in the market place, as a radically new pharmaceutical role is introduced into primary health care, requiring substantial change in medical routine. Relationship marketing, already begins to emerge as a key consideration in this thesis.

4.4 TARGET MARKET PERCEPTION; NEEDS / WANTS; MOTIVATION

4.4.1 Introduction

It is appropriate at this stage to state, as clearly as possible, the target market for the new community pharmacy service / product. It may be argued from Chapter 1 that all the stakeholders are elements of the potential market. Whilst this may be generally true, the original stakeholder analysis, (Chapter 1, Figure 5, page 34) indicated priority address of those interested parties, in the High / High quadrant of the matrix. These were the key players:

* PSNC / RPSGB
* DH / Government
* BMA / GPC
Those marked with an asterisk are known to be favourably disposed toward the new proposition, as indicated at conferences, Government White Papers, (Chapter 1, pages 2, 3), meetings attended by the author, (October 1998 to June 1999) and in correspondence, (Tweedie, 1999 - letters from GPC). Those marked with a cross have yet to be fully presented with the proposition (via LPCs and practising pharmacists) and form the key market for the service. Without the collaboration of doctors, (which could become active opposition) patients themselves could be dissuaded from accepting new pharmacist involvement in their medication. If a beneficial service is presented to patients by the doctor, it is unlikely that they would refuse and so doctor commitment to the proposed pharmacy intervention is judged to be of pivotal importance and comprises the target market of this thesis. Government directive, that a new service should be offered, would not necessarily make doctors select the pharmacist as the ‘professional of choice.’ The new proposition, therefore, needs careful introduction to the general body of GPs and the following sections explore some of the complex psychological issues underlying product or service selection by any consumer.

4.4.2 Target Market Perception

*Perception* has been defined by Harrel, (1986 : 66) as,

> '...the process by which an individual receives, selects, organises and interprets information, to create a meaningful picture of the world...’

Perception, in the context of this thesis, is about the way in which concepts are regarded, rather than just visual perception, upon which considerable research has been done. Visual perception does, however, raise some interesting related perspectives and in the 1950s and 1960s Bruner and his colleagues made certain observations from their
experiments on visual perception, (Bruner et al., 1964 : 1 – 15). Here, it became apparent that perception would be influenced by several factors, including:

- **Expectations** - which may be in the mind of the individual at the time;
- **Motivational states** - particular needs at the time;
- **Attitudes** - predisposed perspectives on the subject; and,
- **Cultural values** - the peer group perceptions.

Much earlier, Sandford, (1936 : 129 – 136) had shown that the motivation relating to specific *needs*, directly affected perception and in the 1950s, Gordon Allport, the notable psychologist had shown that prejudice could affect perception, (1954 : pp. 1 – 20). In the following decade, studies by Mundy-Castle, (1966 : 290 – 300) illustrated how radical culture, in this case racial could influence the interpretation of even visual perceptions. Gregory, (1973 : 23 – 31) argued that perception was not simply decoding of visual information but is a process of making inferences about the data being presented.

Harrell, (1986 : 66) in relationship to consumer behaviour, asserts that perception depends upon internal factors such as,

'...beliefs, experiences, needs, moods, expectations...'

Assael (1998 : 84, 205) also in relationship to consumers, states:

'...perception is the process of selection, organisation and interpretation of marketing and environmental stimuli into a coherent picture...'

and...

stimuli are more likely to be perceived when they:

i. Conform to consumers’ past experiences;

ii. Conform to consumers’ beliefs about the product;
iii. Are not too complex;
iv. Are believable;
v. Relate to a set of current needs; and,
vi. Do not produce excessive fears and anxieties.

Particularly important in the doctor's perception in this list may be items i, ii, v, vi, indicating a potential route into the doctor's psyche, avoiding threat; emphasising current patient needs; and, relating in some measure to the doctor's traditional experience in leading the health care team.

So far as the new pharmacy product is concerned, environmental stimuli, as mentioned in the definitions of perception may be increasing, in the form of political, sociological, economic and technological forces, as described in Appendix 1. A government driven (patient) culture change in the NHS, will be a powerful force for change in health care practice, even for doctors. If this can be used and portrayed by pharmacy as a general need in patient care enhancement, rather than being used as a threat, it may become an aid to new product introduction. The doctor's needs, therefore, in the new quality driven NHS with clinical practice focused on as never before, (The National Institute of Clinical Excellence NICE) may then revolve around a number of issues:

- The need for security of professional tenure and self esteem to be preserved in an increasingly critical environment;
- The need to perform well in practice; and,
- The need to be seen as an (if not the) authoritative health practitioner.

This leads to a consideration of needs, wants and motivation, which may be important avenues of successful presentation of the new pharmacy service to the individual doctor. The following sections explore this potential and inform the marketing process.

4.4.3 Needs/Wants; Motivation

This section is considered by the author as being necessary to gain new insights into how to influence doctors into accepting and feeling comfortable with the new pharmacy
service offering. In the experience of the author, committee decisions in the lead bodies of pharmacy relating to introducing the new service have concentrated on emphasising the pharmacist as the medicines expert. This assertion has not been linked to resultant benefits for the doctor but rather another general assertion that pharmacist involvement with the patient, in addressing medication needs, is bound to bring patients benefit, (Combined Leadership Group meeting, July 2001, Chapter 1, page 20). As a major stakeholder with blocking power, it seems sensible to spend time reflecting upon potential benefit to GPs as well as patients.

Wells and Prensky, (1996 : 227) assert that all consumer behaviour begins with motivation and motivation is, according to them:

'...the process whereby an individual recognises a need and begins to take action to satisfy it...'

They go on to define a need, as:

'...a discrepancy between an individual’s current state and some ideal state desired...'

Needs, drives and instincts have been described inter-changeably by some researchers as the precursors of motivation to act and in the early part of the twentieth century, were regarded as mainly instinctually based. Workers in psychology research, such as McDougall, (1932) investigated how instinct affected behaviour, using animals as the subjects. It was concluded that the presence of a drive or need could be inferred from the animal’s behaviour under conditions of the experiment. Following work by Morgan, (1943) a distinction was drawn between primary drives (basic needs within the organism) and secondary drives, which were learned. Morgan further classified primary drives as ‘physiological’ (thirst, hunger, etc.) and ‘general’ (fear, affection).

Theories of human needs followed and Maslow, in 1943 proposed a number of complex interacting needs, some more important than others at any point in time. He went further, suggesting that such needs were expressed and fulfilled in an hierarchical progression, so that when the more fundamental needs were satisfied (for example,
physiological), the individual then went on to satisfy other needs in a further priority order. In his construct, basic physiological needs were thus of prime importance, followed by safety needs and so on, up the hierarchy. He theorised that as each need was satisfied it therefore no longer acted as a motivator.

Whilst Maslow’s hypothesis is often categorised as having five elements, there were in reality seven, (Maslow, 1954 : 15 – 25). The five basic needs he proposed were physiological; safety; love; esteem and self actualisation. However, he also acknowledged the existence of cognitive needs, (to know and understand) and aesthetic needs, of order, beauty and symmetry. These latter may not be consciously recognised at any particular point in time. Figure 10 represents the hierarchical concept.
Interestingly, a few years earlier than Maslow, Murray, (1938 : 85 – 86) had set out what he considered were *states of need* in an individual relating to motivation, which could lead to positive action. These were:

- **Refractory** - in which no incentive will arouse it;
- **Inducible** - inactive, but can be aroused; and,
- **Active** - where need is determining behaviour.

A refractory state of need may illustratively be exemplified by the drug addict, who has no desire to change his/her state of existence. Rather there is a compulsion to perpetuate it and so, for some such addicts, no incentive will arouse the primacy of natural, physiological or safety needs. An *inducible state of need*, may in turn be illustrated by the present state of the medical profession, which has come under increasing pressure to improve the efficiency and cost effectiveness of prescribing and engage in clinical governance, (NHS Executive, 1998 : 1 – 3). In the author’s opinion, a societal need for better prescribing is there, (Chapter 4, page 69) but not necessarily widely accepted by GPs. Careful persuasive effort at medical leadership level may succeed in creating that conscious need and begin communicating it to the wider membership.

Continued pressure, through such avenues as NICE (p. 95) and the boards of PCTs, may further generate such an increasingly conscious need as to *become active* and start determining GP behaviour toward welcoming the proposed medicines management service. *Motivation*, in Murray’s terms, would then be actively directed to fulfilling the need and determining the GP behaviour.

McClelland, (1961) in his book ‘...The Achieving Society...’ expresses his belief that although motivation can be conceptualised as arising from needs, these would be likely to be social, such as, achievement; affiliation. Carl Rogers, a clinical psychologist, (1961 : 95) in his researches into personality, agreed that certainly two basic needs provide motivation, in other words, self actualisation and positive regard from others, (affection, love, respect). Some twenty years later, Harre, (1979) confirmed that social respect was possibly the most important motivator of all. Alongside this concept lies
the related subject of self image and Tajfel et al., (1971 : 149 – 178) from their *studies of social groups*, showed that group identity is an important part of self image.

In this present research, professional *group affiliation* of the doctors is likely to be strong and the medicines management service proposed by pharmacy should clearly take account of their needs, especially in relationship to the social and self actualising aspects of their position in health care. *Safety needs*, as described by Maslow and again, relating to the doctor's ultimate responsibility for the care of the patient, are also a real consideration.

In presentation of the new product to doctors, characterisation of the service could be constructed around:

- increased doctor authority and importance in directing an extended health care team;
- safety from increasing NHS clinical audit, (NICE) through engagement of another highly qualified professional (the pharmacist);
- self actualisation in performing the core clinical task of diagnosis and treatment, to an elevated level of quality and effectiveness; and,
- increased doctor esteem in the eyes of the patient, through improving medication and disease prognosis.

*Wants*, according to Kotler and Clarke, (1987 : 261) are exercised by people who see in a product the potential to satisfy various of their needs and therefore, attract them to the product or service. In this case, doctor satisfaction may come from a complex of factors, some of the most important of which may revolve around the doctor's culture, which is long established in history as the dominant figure in the treatment of illness.

Schein, (1986 : 6) persuasively argues that group culture is important in sustaining the values, customs and norms of that group and it seems sensible, therefore, to construct a
new product proposition, which ostensibly supports the medical culture, rather than challenges it. Cultural tolerance, argues Charles Handy, (1991 : 98) is required in organisational change, which is what the new medicines management partnership entails. Direct challenge to the core of any culture (the paradigm) is known to be very difficult in effecting change and more circumspect approaches may be indicated so as to avoid such head on challenge. As Clarke and Clegg (2000 : 11) have suggested:

'...being locked into a paradigm can... become a form of conceptual imprisonment...'

If the GP can be persuaded, by sensitive and supportive communications, to want the new pharmacy service, then further adjustment of the complete product design can be made during pilot trials, building in doctors' suggestions for improvement. In this way, as Barnes et al., (1998 : 140) put it,

'...satisfaction can be created by a fully developed product...'

4.4.4 Values and Needs

In design of the new product offering, (medicines management) as briefly discussed under The Marketing Mix, (pp. 61 – 89), it was clear that whilst the core product may satisfy the basic market need, other functions which provide other desirable features can also be built into it as the tangible and augmented product. A Ferrari sports car will certainly take its occupants from point A to point B but the style and charisma associated with Ferrari also provide features associated with image and wealth.

Emotional and symbolic values, thus become additional attributes of the product, satisfying multi-dimensional needs. Rokeach, (1973 : 28) identified eighteen cultural values of general society and categorises them as terminal or instrumental. The former relate to the end goals which people strive for, (in the case of GPs, perhaps status; professional satisfaction) and the latter relate to beliefs about desirable routes of achieving the end goals. Table 19 sets them out with relevant product attributes, (Rokeach, 1968 : 554; Vinson et al., 1977 : 47).
He went on to describe the following two functions of values which are important to the individual:

- They serve as standards by which to evaluate other items or propositions. (If the pharmacy offering and presentation is excellent, it could become a benchmark against which other similar services by other professionals are measured); and,

- They motivate behaviour so as to enable the individual to act in accordance with their attitude appropriate to the circumstance.

Although some psychologists regard values and attitudes as being the same thing, it appears that values are more deeply culturally embedded, whereas attitudes are developed in response to situations requiring some thought at the time, or over a period of time.
In the case of medicines management the route to achieving acceptance of the product, seems again to be partly through constructing the augmented product around increased doctor importance, in directing an extended team with enhanced results for a more satisfied patient. The medical culture appears to be increasingly important in a consideration of new service which can affect self perception.

Important work by Sheth et al., (1991 : 18 – 25) shows how values affect market choices. Table 20 sets out these researchers’ five categories of value and the related potential implication for the new pharmacy product in the view of the author of this thesis.

Table 20

<table>
<thead>
<tr>
<th>VALUE CATEGORY</th>
<th>EXPLANATION &amp; CHOICE FACTORS</th>
<th>SUGGESTED PHARMACY PRODUCT IMPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FUNCTIONAL VALUES</td>
<td>The utility of the product’s core; its physical purpose.</td>
<td>Improvement of patient health through illness alleviation. Esteem for doctor increased.</td>
</tr>
<tr>
<td>SOCIAL VALUES</td>
<td>The utility of the social grouping(s) within which the product is placed.</td>
<td>Specifically for the elderly/chronically ill on multi medicines – gives reduced drain on medical resources; Doctor effectiveness and performance increased.</td>
</tr>
<tr>
<td>EMOTIONAL VALUES</td>
<td>The utility acquired by the product through its ability to create emotional association of ideas.</td>
<td>Added care for the emotionally evocative segment of the illness market – elderly; needy; housebound – reduced workload in GP practice; caring image enhanced.</td>
</tr>
<tr>
<td>EPISTEMIC VALUES</td>
<td>The utility acquired through novelty, curiosity, or in satisfying a desire for knowledge.</td>
<td>New service addresses illness in a new way; delivers measurable benefit outcomes, economic/health gain. Doctor abilities and prestige increased.</td>
</tr>
<tr>
<td>CONDITIONAL VALUES</td>
<td>The utility of the product through the situation or context, faced by the choice maker – social or functional value is thus enhanced.</td>
<td>GP elevated to new, more important leadership of the widened primary care group in the new PCT; director of an extended team; seen as head of the pharmacist; ego protected.</td>
</tr>
</tbody>
</table>

ABBREVIATIONS: GP = General Practitioner  
PCTs = Primary Care Trusts

Note: The suggested pharmacy product implications are the author’s views of how Sheth’s value Categories would relate to the new pharmacy service.
These product value categories may prove useful in finalising product design for presentation to the medical profession's leadership and subsequently, if successful, the general membership. Furthermore, design of the medico-pharmaceutical interface, rather than just the product itself, may also be used to enhance the total perception of the new product/service. This would equate to Kotler's tangible product discussed earlier in the chapter.

In summary, the new pharmacy medicines management service could be influenced by a complex of the factors already discussed:

**Motivational Elements**
- Safety;
- Esteem;
- The professional/cultural values of the doctor; and,
- Self actualisation.

**Product Aspects**
- Quality of product;
- Quality of marketing; and,
- Design of the medico-pharmaceutical interface.

The way the doctor ultimately balances these issues in relationship to selecting from competing options, is similar to any consumer choice. In other words, it is through the totality of information, beliefs, cultural influence and values perceived by the individual. It is clearly a matter of the greatest importance that careful attention is paid to creating a product offering which sits comfortably and supportively with the doctor's perception of how it affects him/her in the totality of things. The perception of the product will, in part at least, determine also the doctor's attitude towards it.
From a consideration of needs, wants, motivation, values and perception in the previous sections, it is apparent that the construction of a final product offering by the pharmaceutical profession for GPs, will require very careful thought. The attitude of individuals in the medical profession is likely to be one determinant of acceptance, or otherwise.

In the nineteen thirties, Gordon Allport, (1935 : 798) defined attitude as:

'...a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related...

Rokeach, (1948 : 254 – 278) defined attitude in simpler terms as:

'...a learned orientation or disposition ... which provides a tendency to respond favourably or unfavourably to the object or situation...

More recent views regard attitudes as a composite construct that summarises a person's feelings toward the product / service, (Zajonc & Markus, 1982 : 123 – 131). Judd et al., (1991 : 366 – 379) express the definition of attitude as elevations of objects that are stored in memory and relate to any aspect of the social world; they are linked to other attitudes and stimulation of one of them may invoke response of another.

Allport went on to propose the following three components of the customer's choice process, in a buying situation:

- Brand beliefs - The cognitive effect;
- Brand elevation - The affective effect; and,
- Intention to buy - The conative effect.

Wilkie and Pessemier, (1973 : 428 – 441) view attitude formation as the process by which people form their opinions, which can be based upon:
- Learned knowledge - from experience;
- Evaluation of the product - based upon knowledge of it;
- Predisposition to act - based upon evaluation; and,
- Important criteria in the purchase decision - related to aspects of the product.

Attitudes are thus the result of motivation, perception and learning.

As attitudes are learned, they can be affected by new information, imparted or experienced even though some attitudes are very hard to change. For example, because of long cultural practices, the central values, assumptions, beliefs and traditions of the established professions, become accepted norms of practice which are regarded as axiomatic.

The question is, in the marketing situation: Can attitudes be influenced so as to deliver the required behaviour of the consumer, that is, the purchase of the service or product? Although some early researchers found little evidence to support the link, (Wickes, 1969 : 41 - 78) and studies by Newcombe et al., (1992 : 780 - 800) showed that specific attitudes, relating to particular subjects, rather than general attitudes, were good predictors of behaviour. Heightened self awareness, according to Hutton and Baumeister, (1992 : 68 - 75) increases the degree of consistency between specific attitudes and resultant behaviour. Self awareness, in this context, relates to the situation where the individual is focused for some reason upon their own attitude toward a particular issue, as might be the case in confronting the doctor with the new pharmacy product and the perceived effect upon his traditional position and role.

According to Fazio, (1989: 153 - 179) attitude accessibility plays a key role in the attitude-behaviour link, so that if attitudes can be easily stimulated or recalled, they influence perception of the proposition presented. Again, in the marketing situation, it would perhaps be helpful to look for past common GP / Pharmacist joint experiences which were good, such as in appropriate published collaborative practice and use these as a basis for presenting the new partnership service. The functions of attitudes are now briefly visited, together with their implications.
4.5.1 Functions of Attitudes

Smith et al., (1956: 22) were of the view that attitudes serve three functions:
- Object appraisal - a relatively quick assessment of new propositions;
- Social adjustment - helps affiliation with peer groups; and,
- Externalisation - help to externalise fears and rationalise internal dissonance.

Katz, (1960: 163 – 204) amongst his proposed four types of attitude function, lists ego defence and value expression as two of the most important, reinforcing earlier speculation in this work that cultural perspectives are key issues; (also see Sutters and Nathan, 1993 : 70 - 84). Katz’s four attitude functions in relation to product purchase are set out in Table 21, together with suggested implications for desirable product attributes of the new pharmacy service:

Table 21 ATTITUDE FUNCTION

<table>
<thead>
<tr>
<th>FUNCTION OF ATTITUDE</th>
<th>OBJECTIVE</th>
<th>IMPLICATION IN CURRENT STUDY – PRODUCT ATTRIBUTES DESIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Utilitarian</td>
<td>To assess core product functions in utilitarian terms; is the utility attractive?</td>
<td>New core product evaluated in scientific terms; scientifically sound? Should correct adverse effects and improve effectiveness?</td>
</tr>
<tr>
<td>• Value Expressive</td>
<td>To assess the product values in esoteric terms; personality, lifestyle (personal values of doctor, reflected).</td>
<td>Tangible product to reflect patient benefit – supports doctor values in quality of care of patient.</td>
</tr>
<tr>
<td>• Ego Defensive</td>
<td>To assess effect on self concept.</td>
<td>Must not reflect doctor inadequacy; rather a new doctor-driven enhancement of care; reflects concern; reflects lead position of GP.</td>
</tr>
<tr>
<td>• Knowledge</td>
<td>To evaluate product comparisons based upon hard facts; certainty in choice.</td>
<td>Pharmacy product more comprehensive; more knowledge driven than any competing profession.</td>
</tr>
</tbody>
</table>

Note: Column three is the author’s interpretation of the desirable attributes of the new pharmacy service.
To be attitude-friendly, therefore, the new pharmacy service needs to be constructed presentationally to support the doctor’s opinions on all four fronts. None of the above are mutually exclusive or necessarily dominate a hierarchy of functions, but there may well be one attitude function which predominates over the others for a particular person at a particular time; or in a product seller’s terms, one which is overridingly effective.

Wells and Prenskey, (1996 : 314) express the view that attitudes are important to marketing considerations because:

‘...a consumer with a positive attitude toward a product is more likely to buy it...’

One of the difficulties in divining customer attitudes, according to Eiser, (1971 : 1 – 10) is the discrepancy between attitudes expressed and tested behaviour relating to those attitudes. Fishbein, (1963 : 65 – 116) suggested that intentions, which attitudes help to form, are the important determinant of behaviour, rather than simply the attitude itself. In further work, a decade later, relating to attitude research, Fishbein and Ajzen, in assessing 109 studies, found that there were substantial differences in expressed attitudes and behaviour purporting to result from these attitudes, (Ajzen & Fishbein, 1977 : 888 – 918). The implications are that great care should be exercised in interpreting answers to research questions when attempting to correlate with predicted behaviour.

Within the context of the new medicines management proposals and the medical audience / market place, influencing attitudes, reinforcing some and changing others, is clearly of key importance in engaging the new service. Persuasion, through marketing communications, is geared up to influencing buyer behaviour, through their needs, attitudes and motivation (Rossiter & Percy, 1987 : 132). Marketing communications will be addressed later in the chapter.
4.5.2 Models of Attitude Components

Different views on attitude development and the components thereof have been offered as theoretical constructs, in order to understand better the motivation of consumers and their decision to buy, or not to buy. Allport, (1935 : 798) was an early proposer of the tri-component model, in other words:

'...the cognitive; affective and conative predisposition to act...'

Such models propose that behaviour involves knowledge, feeling and action and emphasise the affective element, which evaluates the depth to which a product will meet the customer’s needs. It is not at all certain, however, that there is a linear sequence in this process and in some instances of marketing, the initial sampling distribution of a product places the conative component first, hoping that this will provide the affective and cognitive beliefs necessary for further action. This revised sequence may be the most important of all, with respect to achieving a positive reception of the medicines management service by GPs. Such sampling would take the form of pilot trials to engage the service with a representative sample of doctors, building relationships, allaying fears and proving the quality. Success here would be powerful evidence and persuasion to extend the service to a wider sample of medical practitioners.

Multi-attribute models, consider the product or service’s multiple attributes and propose that the potential consumer’s attitude is due to evaluation of each one, leading to a summary net view. Fishbein, et al., (1963 : 223 – 240) suggested three components of this scheme:

- Product attributes, whereby the product / service is evaluated;

- Beliefs about the actual presence of the attribute, (is it there as advertised or not?); and,

- Evaluation of the relevance of each attribute to the individual’s perception of worth.
They further went on to distinguish two categories in this model, firstly:

The Theory of Reasoned Action Model

Here Fishbein et. al., (1967 : 477 – 492) conceptualise the customer as having beliefs and attitudes about the particular reason for the purchase, rather than about the purchased object itself. For example, it is the occasion such as a birthday, that drives perception of the need for the product, as well as the subjective norm for a particular product purchase that exists in a specific social context. Thus in a particular cultural group, there will be the commonly accepted expectations of what calibre and quality a birthday present should be. This influence might prevail, for example, in a gentleman’s club in London, where pin stripe dark suits and other customs are the norm. Bequests to the club would be expected to be of a particular quality and interest. The model is diagrammatically set out in Figure 11.

Figure 11    THEORY OF REASONED ACTION MODEL

Again, implications in a medical profession context, might include a requirement of pharmacy to designate its product as the medical (rather than medicines) review group service, giving the doctor the security and comfort of medical culture lead associations; the context and occasion would be medical rather than pharmaceutical.
The second category of Fishbein's multi-attribute model is:

**The Attitude Toward Object Model**

Here Fishbein, (1963 : 233 – 240) held that the customer's overall attitude to the product is the net effect of the sum total of the individual's beliefs about each product attribute and the evaluation of the importance of each attribute, in satisfying the consumer needs.

**Heider's Balance Theory – A Balance of Beliefs Theory**

Heider's Balance Theory proposes that people seek to achieve balance between their beliefs and actual evaluation of a product, situation, or service, (1958 : 20 – 39). The theory is based upon established behavioural principles, specifically cognitive consistency, implying that consumers seek harmony between beliefs and evaluations. If, it is argued, inconsistency occurs, attitudes will change to create harmony in the cognitive perception. Research by Sheth and Talarzyck, (1972 : 6 – 9); Lutz, (1977 : 197 – 208) and Bass and Wilkie, (1973 : 262 – 269) confirm this effect.

The implication for marketing the new pharmacy service to the medical profession, is that the service should ideally be constructed in such a way as to deliver satisfaction in clinical terms, support in cultural terms and a want, in terms of professional reinforcement. It should be a non-threatening conceptual partnership in enhanced patient care. In support of creating the right sort of medical beliefs about the new product (the other component of balance theory), work clearly needs to be done at leadership level, (GPC) to ensure positive messages to the medical profession in constructing a belief framework, for the proposition.

Before leaving this brief consideration of attitudes, in the context of market persuasion, one final element of the attitude formation process, which will be important during and following any pilot trials of the new pharmacy service, is experience of the product. Experiences during pilot trials can become positive or negative forces for development of the service and for the medical trialists, a potential determinant of their own future
attitude to pharmacist partnership. Strongly developed culture, such as in the medical profession, is one of the key influences in determining group attitudes and behaviour, (Stafford and Cocanougher, 1981: 329 – 343).

This leads to a consideration of communications about a product or service generally.

4.6 MARKETING COMMUNICATIONS, MODELS AND STRATEGIES

4.6.1 Introduction

Whatever processes and methods are eventually used in endeavouring to reposition community pharmacy within NHS primary health care, appropriate quality communications to the key stakeholders, GPs in particular, may be reasonably regarded as one pre-requisite of success. In this context, communications would need to be persuasive in nature, sensitive to inter-professional cultural issues and expressive of benefit to the consumer, the general medical practitioner and patient in this study.

Writing some four centuries ago Thomas Hobbes, (1651: 46 – 48) in his major work, 'Leviathan', dealing with the '...matter, form and power of the commonwealth, ecclesiastical and civil... ' declared that men are at best:

'...complicated automata, influenced by internal material perceptions of an external material world...'

Kotler, writing more than three centuries later, (1992: 161 – 164) characterised one model of customer behaviour as ‘...a black box of consumer characteristics and decision making processes...’ and went on to argue that this 'black box' is influenced by environmental inputs, such as political, economic, social, technological, cultural forces and marketing effort. This in turn, he suggested, could lead to attitudinal and behavioural change with respect to a promoted product. In this context the word
promoted, is used generally to mean, 'offered to the consumer with persuasive communication.'

Professional customers, evaluating propositions which affect their future operational practice, have the ability and knowledge to be analytical, critical, supportive or obstructive in dealing with any new proposal. The following section deals with some of the more important aspects of marketing communications generally and relating these to the target market for the new pharmacy service where appropriate. These theoretical considerations are to be used alongside the results of field research, in helping to construct a suggested way forward in establishing the new pharmacy service.

It is interesting to note, that in studying communications between animals, Slater, (1983: 10) defined the term as:

'...the transmission of a signal from one animal to another, such that the sender benefits, on average, from the response of the recipient...'

The 'on average' qualification, apparently, takes account of those occasions, (such as birdsong) where there appears to be no tangible benefit from recipient to sender. Krebs and Davies, commenting upon the same subject, suggest that the benefit to the sender arises from the ability to manipulate the receiver's behaviour in some way, (Krebs & Davies, 1978: 22). Marler, (1982: 87 – 94) proposed the view that both animal receiver and sender receive benefit, in that both are concerned with what is going on and it is this aspect, in human communications, that interests the marketing practitioner. In the latter context, Schram, (1955: 23) defined communications as:

'...the process of establishing a commonness or oneness of thought, between sender and receiver...'

Rossiter and Percy, (1987: 34) express the view, based upon their studies in marketing, that persuasion of potential customers to acquire products must take account of:

'...needs, wants; attitudes; and motivation...’
and these were discussed in outline in the last section. The following discussion seeks to explore the key issues in persuasive communications, as they apply in a situation requiring a message sender to persuade a target market to engage in a new model of buying preference. In this study context, medical approval of a new service, pharmacist partnership, in the management of patient medication comprises the potential buying preference with which the doctor is faced in possible competition with other suppliers of similar services. The section content will again be linked with field research results, to inform the way forward in introducing the new pharmacist role.

4.6.2 Models of Persuasive Communications

As early as 1925, researchers such as Strong, (1925 : 9) proposed that promotional communications should aim to secure from the target audience a hierarchy of effects:

- Attention - of the target individual;
- Interest - in the message content;
- Desire - to acquire the proposition; and,
- Action - to achieve possession.

(AIDA)

Almost forty years later, Lavidge and Steiner, (1961 : 59 – 62) postulated a hierarchy of effects, in attempting to describe the thought process through which a person might proceed, in deciding to acquire, or not to acquire, a product, after being exposed to a promotional communication. They suggested six stages: ‘...awareness; knowledge; liking; preference; conviction; and purchase, (or no purchase)...’

In 1962, work on customer response to innovation, in a product / service offering, led to what was termed the innovation – adoption model of customer response to promotional communications, (Rogers, 1962 : 79 – 86). This comprised the following elements: ‘...awareness; interest; evaluation; trial; and adoption...’
Almost two decades later, McGuire, (1978: 156 – 180) proposed a further sequence of consumer engagement as: ‘...presentation; attention; comprehension; yielding; retention; and, behaviour...’

Again, this appears to be similar to earlier models, with the additional idea that retention of information should be the outcome of successful marketing communications.

The above four examples of the hierarchical concept of customer response to promotional communications, are summarised in Figure 12, which also shows the elements of each, grouped into what became known as the cognitive, affective and conative phases of the sequence.

**Figure 12** MODELS OF CONSUMER RESPONSE TO PROMOTIONAL COMMUNICATIONS

<table>
<thead>
<tr>
<th>PHASES</th>
<th>MODELS</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDA</td>
<td>HIERARCHY OF EFFECTS</td>
</tr>
<tr>
<td>COGNITIVE</td>
<td>Attention</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>AFFECTIVE</td>
<td>Interest</td>
</tr>
<tr>
<td></td>
<td>Desire</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>CONATIVE</td>
<td>Action</td>
</tr>
</tbody>
</table>

**AIDA** = Attention, Interest, Desire, Action

All the hierarchical models set out above have become known as *high involvement* models of customer response because of the implied in-depth consideration by the consumer. They propose a sequence of orderly stages through which the individual’s thought process moves, in order to reach a decision to purchase, for the successful communication outcome. Like Maslow’s hierarchy of needs, there is an attractive natural logic about these proposals, but it seems, little hard evidence of a fixed hierarchy of stages.
Nevertheless, all models assume that marketing communications do not exist or operate in a vacuum, but through social interaction with others, (Berger & Luckman, 1991: 56 - 57). Other investigators in the communications field take the view that the arrival of the promotional message to the potential customer is all that may be achieved. Selective perception may screen out the central theme of the message, through certain 'cues', which are said to have an effect, such as group cultural values or existing consumer beliefs. These operate to make the task of handling the realities of a complex world, much easier for the recipient. Engel et al., (1993: 391 - 417) view consumers as information processors who combine cognitive learning with rational response, based upon a continuously updated view of the world, or society as more information is progressively gathered.

Another school of thought in the fields of sociology and marketing, rejects the concept of a hierarchy of elements in consumer persuasion, on the broad thesis that consumers receive information on a more passive basis without much ordered processing at all, (Palada, 1966: 13 - 24; Ray, 1973: 147 - 175; Smith & Swinyard, 1982: 81 - 93). According to Lastovicka, (1987: 174 - 179) such a passive process could be described as catching information rather than processing it. It is, according to Ray, (1973: 147 - 175) a 'low involvement' model of consumer response, as distinct from the above mentioned high involvement models (p. 114), which he saw as conceptually useful, where the consumer is highly involved, for some special reason, with the product.

Krugman, (1965: 353) did, in fact, suggest that personal involvement of the consumer was the key to success in advertising:

'...the number of conscious bridging experiences, connections or personal references that a person makes between his or her life and the stimulus received... is likely to be the deciding factor...'

Krugman later argued for the need of repeated exposure of the target consumer to the promotional message so as to '...build potential for the ability to see a product differently... What is next required...’ he went on to say ‘...to trigger the potential action, is behavioural opportunity, such as shopping routine...’
Therefore, it is considered that such models as described above have uses in setting out stages through which a consumer could be led, in reaching a purchase decision even though the message may require repetition. Equally, a consumer may well already be at one of the suggested stages of preparedness in the hierarchical sequence before active promotional communication begins. This may turn out to be the case with the medical consumer of pharmacy services, through some prior conditioning effected by new government policy on health, NICE guidelines and pressure on practice medicines’ budgets. This could be ascertained by research of the particular market and appropriate action taken by the communication sender, to move the customer on to a purchase decision. Conversely, the effectiveness of promotional communications could be tested at different points in a marketing programme, to see at what stage the customer is placed with regard to perception of the product being marketed.

As outlined above, the three phases of the high involvement hierarchies of effects with respect to market consumers are shown in Table 22 together with a proposed low involvement hierarchy. (Lastovica, 1987: 174 – 179)

Table 22   HIERARCHIES OF PROMOTIONAL MESSAGE EFFECTS IN CONSUMER DECISION MAKING

<table>
<thead>
<tr>
<th>PHASES OF THE HIERARCHY</th>
<th>TYPE OF HIERARCHY AND THEORETICAL ROUTES OF ENGAGEMENT BY CONSUMER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIGH INVOLVEMENT</td>
</tr>
<tr>
<td>'LEARN'</td>
<td></td>
</tr>
<tr>
<td>(Cognitive Phase)</td>
<td></td>
</tr>
<tr>
<td>Consumer is aware of and comprehends the product.</td>
<td>LEARN (Phase 1)</td>
</tr>
<tr>
<td></td>
<td>Active learning</td>
</tr>
<tr>
<td>'FEEL'</td>
<td></td>
</tr>
<tr>
<td>(Affective Phase)</td>
<td></td>
</tr>
<tr>
<td>Consumer has feelings and preferences toward the product.</td>
<td>FEEL (Phase 2)</td>
</tr>
<tr>
<td></td>
<td>Choice deliberation; favourable outcome</td>
</tr>
<tr>
<td>'DO'</td>
<td></td>
</tr>
<tr>
<td>(Conative Phase)</td>
<td></td>
</tr>
<tr>
<td>Consumer now evaluates, compares and buys / does not buy.</td>
<td>DO (Phase 3)</td>
</tr>
<tr>
<td></td>
<td>Purchase</td>
</tr>
<tr>
<td>A positive outcome theory</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: This table is the author’s tabular summary of the theoretical hierarchies of effects which consumers may go through, in response to promotional messages. The extreme left hand column outlines the phases proposed by the researchers listed in the foregoing paragraphs.
These hierarchies are, in some measure, derived from Krugman's *theory of passive learning*, (1965: 349 - 356) formulated after researching television advertising effects. His hypothesis was that TV advertising communication was *low involvement – low attention activity*, leading to *passive* learning. Such communication is, therefore, not linked to needs, wants or even brand beliefs, as they would be in high involvement purchase decision making.

Subsequently, Krugman argued that there was little opportunity for matching up needs with product benefits in this communicating situation, (Krugman, 1966: 584 - 585). Grass and Wallace, (1974: 19 - 23) confirmed Krugman's findings relating to *passive* and *active* learning with regard to television and press advertising respectively; the latter because press reading was found to be a high involvement activity.

In any proposed pharmaceutico-medical verbal seminar and workshop communications programme, for an agreed change project, the high involvement, hierarchical sequence of persuasion could be employed. Quality promotional articles in respected medical journals could also be a powerful means of communicating and reinforcing messages to the target GP audience, because of the high involvement nature of journal reading and theoretically improved response.

According to Petty et al., (1981: 847 - 855) the degree of individual high involvement processing of marketing communications depends upon motivation, (needs dependent) which, in turn, is highly correlated with involvement in the message.

Doctors experiencing increasing demands for quality and cost efficient prescribing, could be encouraged to become involved with messages conveying non-threatening solutions to their needs. Marketing communications strategies, based upon Ray and Petty's work have been suggested by Vaughn, (1980: 27 - 33) of the advertising agency, Foote, Cone and Belding and are summarised in the following Figure 13.
Communication strategies, would, in this scheme, link variants of the alternative response hierarchies with variants of the do-feel-learn process as GPs would be in pilot trials of the new pharmacy service. The cognitive information processing concepts proposed in all the above models assumes that external messages and information generally are absorbed to one degree or another by the individual and converted to
organised data. This systematically arranged information (conscious or not) is then used to evaluate other information received and construct an attitudinal response by the recipient. Decisions to buy or not to buy are then said to be based on economic utility, (Hirshman & Holbrook, 1982: 92 – 101). The degree of involvement of the consumer with the message, is linked in this matrix with the four types of learning response and potential implications for promotional strategies are set out under each alternative. Vaughn’s strategies are not, however, held to be mutually exclusive. The four promotional variants are provided as a thinking matrix, rather than a guaranteed solutions route and are amplified as follows:

<table>
<thead>
<tr>
<th>i. Informative Strategy</th>
<th>- For highly involving services / products, where careful thought and economic considerations are relevant, e.g. Medicines Management – the learn-feel-do sequence;</th>
</tr>
</thead>
<tbody>
<tr>
<td>ii. Affective Strategy</td>
<td>- For highly involving / feeling purchases; psychological and emotional motives should be emphasised; self esteem and image enhancement – the feel-learn-do sequence;</td>
</tr>
<tr>
<td>iii. Habitual Strategy</td>
<td>- For low involvement / thinking products in the routines of life; learning may come from trial i.e. learning by doing (do-feel-learn); and,</td>
</tr>
<tr>
<td>iv. Self Satisfaction Strategy</td>
<td>- For low involvement / feeling products; sensory pleasure and social motives are key issues; do-feel-learn sequence is operating.</td>
</tr>
</tbody>
</table>

In this way, appropriate communications strategies can be developed after researching the target consumers’ perceptions of the proposed product, in the aspects of involvement and thinking and feeling about the associated issues. This is likely to be a very important consideration in the selected approaches to GPs where culture and position in primary care needs to be considered. According to Sheth, (1979 : 47) consumers receive information provided, combine it with other experiences and their existing store of knowledge and use this to make judgements. McCracken, (1981 : 32) comments:
...each culture establishes its own special vision of the world; this incorporates understanding and rules that have particular significance for its members...

Finally, a model providing a further perspective on the way high and low involvement consumer audiences process persuasive messages is proposed by Petty and Cacioppo, (1983: 3–23). In this model the researchers are attempting to explain the internal cognitive process by which consumer attitudes are influenced and lead to positive decisions, for or against the product. This so called elaboration likelihood model (ELM) parallels Krugman’s theory of passive learning, except that he was studying message exposure and consumer response, whilst the ELM perspective is related to how the consumer actually processes the information.

The model suggests that elaborate processing of information takes place in the mind of the potential customer when they are highly involved with the proposition. This elaborate, high involvement position sits at one end of a continuum of potential customer response with low elaboration/low involvement at the other.

Schumann et al., (1990: 192–203) also found that less involved consumers are influenced more by presentational variations in the message, (picture; colour; layout etc.) and highly involved consumers, by message content, in terms of product benefits and attributes.

The elaboration likelihood model is set out diagrammatically in Figure 14 and depicts elaboration likelihood as being dependent upon:

- motivation related to individual needs and relevance; and,
- ability to process the message intellect and opportunity to think about the message.

Involvement of the medical profession leadership in joint promotional approaches to selling the new service to GPs may be positively influenced by, perhaps, linking the service to providing doctor solutions to cost effective prescribing and improved patient
compliance, under the new NHS quality demands, (NICE). In this way, highly involved doctor audiences (with the medicines management rationale) could be managed to ponder and elaborate their own thoughts on the proposition whilst being encouraged to reach the desired conclusion.

The elaboration likelihood model (ELM) may thus be engaged. (Figure 14)

**Figure 14**  
THE ELABORATION LIKELIHOOD MODEL OF PERSUASION

![Diagram of ELM model]

- **High Elaboration (Highly involved customers)**
  - Careful processing of information
  - Degree of attitude change depends upon quality of message, message cues important: **content and rationality**
  - Action - Positive or Negative

- **Low Elaboration (Uninvolved customers)**
  - Little cognitive effort
  - Degree of attitude change is apparently automatic if it occurs at all; depends upon persuasion cues relating to source credibility/prestige/likeability; (peripheral cues) style and form of message
  - Action or No Action

(Petty, Cacioppo & Schumann, 1982 : 143)
Persuasion message cues, (for example, quality of patient benefits) as used in the involved customer situation could help largely with doctor selection from a number of alternatives, whereas uninvolved customers are more likely to notice advertising messages by form, colour and character cues involved with the message delivery, (Gardener et al., 1990: 192 – 203).

In addition to a consideration of conceptual perspectives on communications models, there are other elements in the message chain which are important to the process of persuading target consumers to acquire the product or service. These are considered in the following paragraphs.

4.7 MESSAGE CHAIN

The phases of the message communications chain are sequentially set out as follows, as conceptualised by Barnes et al., (1997: 336) and show that messages are transmitted through factors which can affect the clarity and impact of the communication generally. Basically, five elements are shown as being present in the process, which also allows for message modification, through the feedback facility, in the light of experienced response:

- Sender;
- Message;
- Channel;
- Receiver; and,
- Feedback.

Figure 15 diagrammatically sets out the Barnes proposal.
Figure 15 A DEVELOPED MODEL OF THE MARKETING COMMUNICATION PROCESS

(Barnes et al., 1997: 336)

Note: Noise in this context, includes subjective issues which are socially, culturally or perceptually based and environmental factors, such as competitor communications or pre-occupation with general news items.

The sender will be discussed in detail under source and opinion leadership, but it is noted for the present as being a crucial factor in the whole process.

The message itself, it seems must take account of intellectual ability and the language culture of the audience; its expressions, implications, shorthand references and jargon. In using message jargon, the communication is then said to be 'encoded' and must be capable of being easily decoded by the recipient.

Selection of the channel is also a key issue. Some journals are read in detail because of special interest and others are skimmed for items that catch the attention, similar to passive television advertising impact. Some journals are lightweight and some are respected, such as ‘The Lancet’ and ‘The British Medical Journal’ and so the channel...
can greatly assist the impact of the message. Personal interaction between source and receiver, through verbal interchange with both parties present, is judged to be one of the most effective means of persuasion. Because of higher receiver involvement and ability to seek answers to queries, problems and apprehensions can be resolved and benefits emphasised, (Cash & Crissy, 1965: 56 – 75).

Kotler and Clarke, (1987: 436) list four main groups of channel tools, or routes by which the promotional message can be transmitted. These are shown in Table 23, together with some suggested applications to communicate the new product to GPs.

Table 23 PROMOTIONAL TOOLS – PURPOSE AND APPLICATION IN THE NEW PHARMACY PRODUCT OFFERING

<table>
<thead>
<tr>
<th>TOOLS</th>
<th>PURPOSE</th>
<th>APPLICATION FOR NEW PRODUCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADVERTISING</td>
<td>Non personal mass communication</td>
<td>Professional Journals; LMC Bulletins: HA Letters</td>
</tr>
<tr>
<td>SALES PROMOTION</td>
<td>Short term incentives to encourage the purchase/sale/or use of the product</td>
<td>Research grants for pilot work, practice expenses, facilities for locums</td>
</tr>
<tr>
<td>PERSONAL SELLING</td>
<td>Oral presentation to prospective purchasers to gain uptake of the product offering</td>
<td>National, Regional, Local Seminars / Focus Groups / Workshops. LMC / LPC Joint meetings</td>
</tr>
<tr>
<td>PUBLICITY</td>
<td>Creation of demand for the product-offering, through unpaid publicised media interest</td>
<td>Press conferences with the professional journals – Launch – progress – review – initiatives</td>
</tr>
</tbody>
</table>

Note: The Kotler proposed tools and purposes have been extended by the author to suggest specific applications in the medical context.

Finally, there is the approach of the message content and its linkage with the prescribing problems, which have given rise to the proposed new pharmacy service offering. Should the marketing communication focus upon the serious effects of poor prescribing and risk creating doctor dissonance, that may be resolved in an unfavourable way by the medical profession? Alternatively, should the message portray an opportunity, based upon the growing complexity of modern drugs and the emergent
need for doctor leadership, in addressing and directing a new beneficial intervention in primary care?

Festinger's *theory of cognitive dissonance*, (1957) indicates that when a conflict between attitude and behaviour arises, or when a strongly held belief is challenged, psychological dissonance arises. Usually this is resolved by screening out the offending stimuli (avoidance), or rationalising the stimuli to suit a preferred belief.

It is suggested in this work that dissonant messages should be avoided in communications and positive focus is directed toward GP-led joint professional management of the complexity of modern drugs.

The communications requirement is clearly a sensitive issue and guidance in this section has been sought from the literature on its application to some of the behavioural aspects of marketing.

The receivers, their needs, aspirations, culture and situational factors need to be studied carefully and messages tailored accordingly.

*Feedback* is essential to establish validity, or otherwise, of the message and to further refine the approach. Persuasive communication has been identified ideally as a two-way process, with benefit to both parties. Feedback exposes *attitudes, needs and wants*, which when properly addressed facilitate persuasion.

Schramm, (1995 : 22) indicates that four conditions need to be fulfilled if the message is to be effective:

i. The message must be attention getting;

ii. It must employ common receiver experience and reference terms, to properly convey intended meaning;
iii. It must cause awareness of recipient needs and suggest the means of fulfilment, e.g. for doctors; product benefits and solutions delivered; needs satisfied; and,

iv. The means of fulfilment should be appropriate to the recipient’s peer group.

The latter conditions, again point to cultural issues and relate, amongst other considerations, to the application of Maslow’s Hierarchy of Needs, as also indicated in point iii above. Gilliland and Johnstone, (1997: 21) propose that contextual involvement is a strong influence on buyer behaviour and is linked to the buyer’s personal sources of relevance, which are judged to be important, (such as peer group, respected sources of relevant information) as well as his or her own values and ego. Message source is thus an important consideration in promoting any new idea, especially in such a market as GPs, with customs, traditions and peer group values and norms of practice within primary care. Message source requires some detailed consideration.

4.7.1 Message Source and Opinion Leadership

Hovland and Weiss, (1951: 635 – 650) in their early formative work on this subject, have shown that consumers in general, interpret promotional messages in the context of source credibility. Later workers in the field have found likewise, (Homer & Kahle, 1990: 30 – 39; Goldberg & Hartwick, 1990: 172 – 179). Wilson and Sherrell, (1993: 101 – 112) have also confirmed this effect in their meta-analysis of effect size in various studies.

Kelman, (1961: 57 – 58) argued three basic characteristics of source effectiveness;

i. Credibility - Relevant knowledge, expertise, authority;
ii. Attractiveness - Similarity, likeability; and,
iii. Power - Authority to give reward or penalty.
It is reasonable to postulate in the context of this thesis, that authoritative medical sponsorship, perhaps combined with National Health Service Executive (NHSE) medical division support, for example, may well fulfil characteristics i and ii.

However, source credibility has been shown by some researchers to not be an absolute guarantee of message acceptance. Work by Sigall and Helmreigh, (1969: 70 - 78) also showed that where the message was threatening the credibility of the source did not increase message acceptance. This effect was observed in the early anti-AIDS advertising, which subsequently had to be changed. Where the consumer is more reliant upon past experiences, relating to a similar product or service, this becomes a precedent consideration, (Dholakia and Sternthal, 1997: 223 - 232). Where the message appears to be against the consumer’s best interest, this also overrides source credibility, (Eagly and Chaiken, 1975: 136 - 144). This suggests that if medicines management as a service is perceived as threatening to doctor status then it could fail. This in turn indicates a need for careful and sensitively worded promotional communications.

These issues are clearly key considerations in marketing the new pharmacy service to doctors, both in formulating message content and for example, the use of medical leaders in supporting their proposition.

General research into source attractiveness may also have a bearing upon the consideration of selecting a medical authority as a source, or supporter, of the agreed presentational message to doctors about the new pharmacy package. Research by McGuire, (1985: 233 - 346) showed that source attractiveness does increase message acceptance and additionally a greater likelihood of message empathy is achieved when the recipients see the source as similar to themselves, (Woodside and Davenport, 1974: 198 - 202).

The concept of opinion leadership is closely allied to source credibility and attractiveness, and in the general market place personal influence appears to be used for a specific product or closely allied article only, (King and Summers, 1970: 43 - 50). It would seem reasonable to suppose that this effect might actually be even more important in medicine where there are many specialities and different leaders in various fields. Additionally, featuring the opinion leader in public relations releases, or printed
articles, appears to add impact to the message, (Burroughs & Feinberg, 1987: 295 – 299) given that person’s authority, relevance and knowledge of the specialist subject.

The implication of the medico-pharmaceutical context may be that, for example, well known professors of general medical practice, rather than medical secondary care specialists, could be a suitable choice of message source. Especially might this be so if they are perceived as defenders of general practitioner services, rather than critics. Interestingly, studies by Eagley and Chaiken, (1975: 136 – 144) indicate that both high and low credibility sources (for example, doctors and film stars) operating as message purveyors, are equally effective when arguing for a position against their own best interest. For example, the film star may convey an effective message in health, relating to, say, warning against certain plastic surgery operations when they have had such an operation themselves. This would apparently have equal weight with a doctor arguing the same theme.

4.7.2 Summary

The issue of persuasive communication in a marketing context is a complex process, involving the needs, wants, motivation and attitude of the target consumer. Models of conceptual consumer response to persuasive messages have been proposed by researchers, as have various concepts of cognitive processing in the mind of the target consumer. Audience involvement with the message, because of its content and relevance, as may be the case with general practitioners and the subject of medicines management, is a key component of effective communication and requires careful consideration in the context of this study.

The values and common group practices of strong cultures, such as the medical profession, can also affect the response to messages which attempt to engineer change in long-held customs. However, because there is a framework of reference to all these considerations, the communicator can at least take a systematic and structured approach to the task and review progress and feedback during any communications programme.
Each element of the message chain, source, message content, receiver and competing messages, all require careful address in constructing the communication strategy.

Perhaps most noteworthy is the fact, proposed in the Barnes developed model of communications, that promotional messages are a two-way process, taking note of market feedback and adjusting message content accordingly. As Cearnal records, (1992 : 23 - 32):

'... as audiences become more sophisticated, they demand a higher level of information before making a decision. solid, data based information, prioritised and integrated, is required to ensure cost effective communication...'

4.8 CHAPTER SUMMARY

This chapter has been devoted to exploring aspects of marketing which may be applied to the problem of:

• Gaining acceptance of the new pharmacy medicines management service by the primary care medical profession; and,

• Effecting change in primary care pharmaceutical service from supply to cognitive service, in conjunction with recognised organisational change techniques.

4.8.1 The Medical Profession

The new pharmacy service (or product) has the potential to be a perceived threat to doctor autonomy in prescribing and managing patient care. It also has the potential to increase doctor effectiveness in medicine treatment and enhance doctor image in both the patients' eyes and in the doctors' self perception, if properly handled.
Maslow's hierarchy of needs, although flawed in its hierarchical concept, is nevertheless recognised as being an appropriate tool, in describing common inherent human needs. Of these, the individual elements of Maslow's model which could be issues of address, are:

- Safety needs;
- Esteem needs; and,
- Self actualisation needs.

This is to say, safety from negative image effects and safety in committing some responsibilities to the pharmacist (Table 14). Esteem needs, to the doctor, imply self esteem and esteem from others, notably the patient and the pharmacist. The potential threat of negative image and loss of safety effects, as interpreted above, should if possible, be programmed out of all communications and implications of the proposed medicines management service. The route to achievement of these criteria could lie in promoting 'self actualisation' of the doctor, in directing the efforts of an extended health care team by the addition of a pharmacist and increased safety in having a new professional partnership participating in medicines management. All marketing communications therefore could benefit from promoting the medicines management service via this aim, be doctor ego-supportive and sustain the cultural values of the medical profession, as generically described in Table 19.

The tangible and augmented product, as illustrated in Figure 8, could also be tailored to promote this approach and appeal to medical conditional values, such as those set out in Table 19, Column 3. It follows that copywriting should be of a very high order, as should person-to-person promotion, consistent in this theme of 'doctor culture support' and presenting the new service or product as a doctor's extended team effort, which of course is consistent with the definition of medicines management (Jones and Tweedie, 2001: 248)

'The systematic provision of medicines therapy through a partnership of effort between patients and professionals to deliver best patient outcome at minimised cost.'
Copy should be attention drawing, have real interest issues for the doctor sufficient ideally to create a desire to engage the service and act, in coming together with the pharmacist, in collaborative medicines management (Figure 12).

Opinion leadership could be helpful through engaging, for example, recognised doctor leadership in promoting the service, as well as highly regarded medical practitioners, possibly professors of general practice medicine, who are seen as being ‘at the coal face’. Medical journal articles, collaborative pilot work between pharmacists and doctors, local seminars for medical and pharmaceutical practitioners are all potential routes of promotion for the new medicines management service. One crucial element of an ongoing campaign, which the new service will require until full national implementation is achieved, is meaningful feedback from the target market (general practitioners) on its response to the marketing of this product so that refinement can be introduced, aberrant messages programmed out and increasingly positive messages planned in. The ultimate aim is the construction of a partnership between pharmacy and medicine through relationship marketing (Table 17), perhaps even into a formalised strategic alliance between doctors and pharmacists. In this concept, doctors and pharmacists would jointly plan the future development of collaborative service and be a powerful influence on Government, as well as an alliance for patient benefit.

This all indicates that the supportive marketing programme needs careful thought, careful monitoring, nurturing and developing and the personal relationships with key medical people, nurturing and developing. Such a sample programme is diagrammatically represented in Appendix 3, page 420.

4.8.2 Marketing in Pharmacist Role Change Management

The problem here is slightly different in concept and in practice. Here, the pharmacy profession is not overtly threatened by another profession encroaching upon its traditional territory, at least as a formal strategy. Covertly, it may be so via practitioner nurses, but certainly not as a government driven policy. By natural development from government strategy real opportunities exist for other professions to take up new potential pharmacy roles, including medicines management.
Pharmacy therefore is well advised to have a systematic programme of change for its members if it is to reach its goals of transformation ahead of potential competition and secure the new role. Unlike the medical situation, where new opportunities have not been formally offered for major role change, pharmacy which has received formal government encouragement to change, needs to be engaged in actively pursuing this advantage to fulfil its potential.

The role of marketing here is to communicate motivational messages about the benefits of change and to give assurance that the wherewithal, in terms of knowledge and physical premises facilities will be made available. It is also to provide a framework of selected activity, whereby the techniques and methods of marketing can effectively assist progress and help create a positive forward view. Some market research is advisable to ascertain the concerns, if any, of community pharmacists in pursuing the new role. In this way any barriers to progress may be addressed, offering solutions and guidance on their pursuit. This research will assist in exploring such barriers by the fieldwork to follow.

Additionally, because change of a transformational order requires careful structuring through well researched and tried methods, change models need selecting and at least some of their components targeting with effort, in this approach, by marketing techniques. Communications, to pharmacists once again, need to be sensitive and take into account cultural predispositions following traditional approaches anchored in outdated concepts, such as those relating to supervision.

Again Maslow's concept of innate needs is important for pharmacists and in this case similar to those of the GP:

- **Safety needs**
  - Safe in moving to a new order of service
  - Safe in moving some responsibilities to technicians;

- **Esteem needs**
  - Higher order of service; greater recognition
  - Recognition by patients from more involvement in their illness care; and,

- **Self actualisation needs**
  - Full use of the pharmacy degree; full contribution to patient health; fulfilment
Promotion of the need for partnership with medicine is a central consideration, as is construction of the new pharmacist / patient interface.

Marketing communications based upon benefits delivered by MM, some of which are indicated by the *Sheth-Newman-Gross* theory of value categories, will again be important (Table 20).

### 4.8.3 Marketing Approach Summary

The potential marketing approaches indicated at this stage are illustrated in outline in the following schema, (Tables 24, 25, 26) and will be related, in due course, to the process of change management and its elements of intervention in effecting change.

Table 24 indicates in the author's view where the elements of marketing can be targeted at the behavioural and cognitive perceptions of the GP to reinforce his / her status and build a collaborative relationship with the customer, the doctor.

Table 25 sets out elements of the marketing mix and how these can be used to promote the new service to doctors through selected channels with consonant messages.

Table 26 is also the author's suggested promotional approach, to target pharmacists with the right relationship messages for GP collaboration and also encouraging pharmacists themselves to engage the service. Tables 25 and 26 also tie in the principles of the motivational aspects based upon 'Lewin' and 'Maslow'.
Table 24  THE MARKETING MIX: BEHAVIOURAL IMPLICATIONS
AND RELATIONSHIP MARKETING RELATING TO
GENERAL PRACTITIONERS

<table>
<thead>
<tr>
<th>MARKETING MIX ELEMENTS</th>
<th>BEHAVIOURAL CONNECTIONS (MASLOW) - FOR DOCTORS &amp; PHARMACISTS</th>
<th>RELATIONSHIP MARKETING IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product (MM)</strong></td>
<td>Core Tangible Augmented Branding Attributes Benefits Values Utilities Quality</td>
<td>Self actualisation Self esteem Safety: Attitudes and beliefs of GPs dictate route &amp; presentational theme MOTIVATION</td>
</tr>
<tr>
<td><strong>Promotion</strong></td>
<td>Consonant messages; evidence based; leader sponsored at national and local levels. Targeted at GP structures – PCTs, LMCs, Practices</td>
<td>Utility of patient satisfaction &amp; doctor enhanced image. Doctor ego protected. Self actualisation carefully emphasised</td>
</tr>
<tr>
<td><strong>People</strong></td>
<td>Skills training &amp; audit of pharmacy input assured</td>
<td>Ongoing pharmacist training now essential; quality assurance measures are necessary. Clinical expertise essential</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td>Structural processes; systematic programmes &amp; pharmacist input; structured meetings; consistent recording &amp; reports. GP led &amp; chaired in joint meetings</td>
<td>Supportive of doctor lead &amp; self esteem; also helps guarantee safety in clinical terms</td>
</tr>
<tr>
<td><strong>Place</strong></td>
<td>Surgery for all decisions in principle, prioritisation of focus, by disease group &amp; programme content for each period GP - led</td>
<td>Doctor image as health care lead is supported</td>
</tr>
</tbody>
</table>

**Consonant Communications**

Note: Author’s concept of where the elements of the ‘marketing mix’ can be applied to behavioural needs of doctors and pharmacists and the linkages with relationship marketing, leading to potential motivation of the GP to engage in the new pharmacy service.

**ABBREVIATIONS:**
- GP: General Practitioner
- LMC: Local Medical Committee
- MM: Medicines Management
- PCT: Primary Care Trust
Table 25  SCHEMA OF MARKETING ACTIVITY IN A PROGRAMME OF INFLUENCE TO GPs IN ENGAGING IN MEDICINES MANAGEMENT

<table>
<thead>
<tr>
<th>MARKETING ELEMENT</th>
<th>ELEMENT COMPONENTS</th>
<th>PROPOSED CHANNEL OF APPLICATION</th>
<th>FUNCTION OF THE APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Product</strong> (or service)</td>
<td>Core As tables 4 &amp; 4a Message is patient benefit</td>
<td>GPC &amp; medical journals series of PR articles</td>
<td>Leader sponsorship and opinion forming</td>
</tr>
<tr>
<td></td>
<td>Tangible Branded as ‘GP Review Group’. Quality assured GP Chair – GP prioritisation of work</td>
<td>Agree with GPC, LMCs, PCTs Use LPC locally. Individualise for each practice.</td>
<td>Disseminates message at all levels for top – down and bottom – up change</td>
</tr>
<tr>
<td></td>
<td>Augmented (Fig. 8) Delivery at agreed intervals; simplified paperwork; Installed at surgery for the prescribing review, audited by the group</td>
<td>DH agreed; Use internal GPC letters to members. Series of med journal articles jointly authored by docs &amp; pharms.</td>
<td></td>
</tr>
<tr>
<td><strong>Promotion – Via</strong></td>
<td>National &amp; local pilot workshops; industry sponsored compliance seminars; PCT disease targeted initiatives; social services – elderly initiatives. Portray as GP support in bust NHS.</td>
<td>Via social services (SSDs) for elderly / disadvantaged. Patient Associations, e.g. Diabetes UK, Heart Foundation etc. SHAs Channel of message via direct mail and personal LPC visits</td>
<td>Engages government policy of local authority and NHS collaboration, with patients’ involvement.</td>
</tr>
<tr>
<td><strong>Place</strong></td>
<td>GP surgery for planning &amp; Reviewing pharmacist recommendations. GP chaired and led.</td>
<td>Promoted through GPC, PCT and SHAs.</td>
<td>Supports GP control &amp; avoids any loss of face / self esteem</td>
</tr>
<tr>
<td><strong>Psychology</strong></td>
<td>GP benefits clearly defined; patient benefits characterised as good reflection on GP. MM characterised as GP support – complementary not competitive GP self esteem promoted &amp; Self actualisation as directing an expanded team</td>
<td>To theme all communications in all channels at a psychologically consonant level i.e. Messages to be consonant &amp; supportive of GP cultural perspectives of their place in primary health care</td>
<td>Supports medical culture of lead health care professional &amp; image with major stakeholders</td>
</tr>
</tbody>
</table>

Note: Application of marketing principles / elements discussed in the chapter as conceived by the author, for an outline promotional programme.

ABBREVIATIONS:

- GPC: General Practitioner Committee
- GPs: General Practitioners
- LMC: Local Medical Committee
- LPC: Local Pharmaceutical Committee
- PA: Patient Association
- PCT: Primary Care Trusts
- SHA: Strategic Health Authority
- SSD: Social Services Departments

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### Table 26 SCHEMA OF MARKETING ACTIVITY IN COMMUNITY PHARMACY CHANGE PROGRAMME

<table>
<thead>
<tr>
<th>MARKETING ELEMENT</th>
<th>ELEMENT COMPONENTS</th>
<th>PROPOSED CHANNEL OF APPLICATION</th>
<th>FUNCTION OF THE APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Product</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core</td>
<td>As tables 4, 4a; message is: full use of pharmacist expertise</td>
<td>Leadership bodies in pharmacy. Pharm. Journals &amp; trade journals &amp; internal information supplements</td>
<td>Creates strong lead and pressure for change – universally visible indicates universal momentum</td>
</tr>
<tr>
<td>Tangible</td>
<td>Styling; branding; quality assured; reduced GP workload; new patient Relationship</td>
<td>Internal NPA, PSNC, RPSGB news letter. CCA organisational communications. Psychology strategy for GP - Approaches by internal news letters only</td>
<td>Internal communications strategy for themed approach to doctors avoids GP feeling of being patronised or manipulated</td>
</tr>
<tr>
<td>Augmented</td>
<td>Constant support for GP. Audited results - assurance for GP. Patient review at pharmacy – space &amp; time saving for doctor</td>
<td>An organised programme of local promotion via LPCs &amp; regional conferences + structured presentations to PCTs &amp; SHAs</td>
<td>Evidence base will be provided by national pilots: but local GP / Pharm. relationship building is of key importance in generating GP comfort zone. Dissonant messages re-present service – non-satisfying work / rewards (Lewin’s disconfirming technique)</td>
</tr>
</tbody>
</table>

| **Promotion – via** | National pilots; selected elements built into new contract – incremental introduction of components LPC / LMC collaboration; industry sponsored seminars. Local monitoring schemes. SSD link ups. New professional fulfilment. | Promoted via patient organisations, local SSDis, LMC & PCT presentations. Message of professionalisation of premises and image New physical amenities | Pharmacy is a non-threatening environment. Additional effort to create relaxed surroundings will help pharmacist / patient interface. Present service / environment inadequate in NEW NHS |

| **Place** | Pharmacy for patient review; patient – friendly; facilities for patient + partner + 1 other + pharmacist – relaxed environment. Surgery for treatments review generally | Targeted at a psychological approach through Maslow’s needs principles + progressively unsatisfactory contract of service (1989 loss of cost +) PSNC letters + LPC seminars Journal / Trade press | Will encourage pharmacists to see rewards in: Personal fulfilment Financial return Visible importance in primary care Stronger customer allegiance? |

| **Psychology** | Pharmacist benefits defined: Enhanced role in primary care patient & doctor partnership engages whole participative team effort. Professional fulfilment; Cognitive v. technician-like role at present. Self esteem + self actualisation promoted |              |                          |

**Note:** Author’s outline of communications content / programme for community pharmacists.

**ABBREVIATIONS:**

- CCA: Company Chemists Association
- GP: General Practitioner
- LMC: Local Medical Committee
- LPC: Local Pharmaceutical Committee
- NPA: National Pharmaceutical Association
- PCT: Primary Care Trust
- PSNC: Pharmaceutical Services Negotiating Committee
- RPSGB: Royal Pharmaceutical Society – Great Britain
- SSD: Social Services Department
CHAPTER 5
LITERATURE RESEARCH AND COMMENTARY

PART II
ORGANISATIONAL CHANGE AND ITS MANAGEMENT

This chapter is set out in eight sections, as follows:

5.1 Introduction;
5.2 Outline History of Organisational Development;
5.3 The Change Drivers and Strategic Capability;
5.4 Theory of Organisational Development;
5.5 Culture; Climate and Organisational Development;
5.6 Leadership and Management – Roles;
5.7 Motivation; and,
5.8 Summary

5.1 INTRODUCTION

Organisational development and the change it demands, involves a complex of issues, some of which are not self-evident and do not emerge until after detailed analysis of the organisation’s situation internally and in relation to its environment. Where management directive and the issue of suitable new rules would perhaps have succeeded in effecting successful change in earlier decades, consultation and consensus have now become the order of the day in modern society. Particularly, this is so in the context of this thesis, where independent pharmacists and doctors are required to substantially change the way in which they operate and interrelate. As will be seen later in the chapter, understanding of the term organisational change, cannot be taken for granted and the views of one local pharmaceutical committee on this subject are illuminating. Expressions such as 'leadership', 'strategic intent', 'motivation' and 'culture' were never mentioned by the LPC members in that discussion.
These crucial aspects of change will be explored in the following pages, together with an outline of the history of organisational development, which gives insights into the elements of the process and why they are important. The notes of the discussion at the LPC meeting are not offered as structured research, but simply a glimpse of the spontaneous views expressed by grass roots pharmacists about 'organisational change'. This chapter is important in identifying important change models and clarifying key elements of a wide ranging change process which may be suitable for community pharmacy in its potential role change. To the best of the author's knowledge, this is the first time such a comprehensive review has taken place of such models.

5.2 OUTLINE HISTORY OF ORGANISATIONAL DEVELOPMENT

Early examples of organisational practice, if not theory, can be traced back several thousand years from such diverse sources as The Bible and the writings of Xenophon, in ancient Greece. Exodus, circa 1490 BC, (Ch. 18, v. 13 – 26) records Moses as having delegated authority for judging people, to ‘...rulers of thousands’... ‘hundreds’... ‘fifties’... ‘and tens.’ Structure, function, management and delegation were thus recognised as essential in dealing with an organisational problem involving considerable magnitude and complexity.

Likewise, Xenophon, circa 370 BC, (Xenophon; trans., 1869 : 430 – 433) recorded a conversation between Socrates and Nicomachedes, discoursing upon the abilities of 'Leaders', in the context of army organisation. Socrates is held to have said:

'...over whatever a man may preside, he will, if he knows what he needs and is able to provide it, be a good president, whether he have the direction of a chorus, a family, a city, or an army...'

Perhaps, at the time, Socrates was simply illustrating a principle rather than expressing an absolute assertion. It is not necessarily true that individuals can scale up their abilities and competence in the way Socrates suggested. Other considerations enter the equation, such as personal courage, ability to lead very large groups of people, mass
communication skills and the strength of psychological constitution to cope with ever increasing responsibility, to name but a few.

However, if such a point had been put to him, his proviso may well have been emphasised:

'...if he knows what he needs and is able to provide it...'

Therein lies the essence of the problem for pharmacy. The centrality of the issue, the quality of human resource in leadership, is well recognised in modern management and will be discussed later in the chapter.

Notwithstanding ancient recognition of organisational problems, systematic study of organisational behaviour, in a more modern context, is usually attributed to the time of the Industrial Revolution. In the late eighteenth century Adam Smith, (1776 : Chapter 1) wrote comprehensively about the organisation of factory work and the relationship between equipment, labour and the economics of production.

Some fifty years later, Babbage, a mathematician and scientist studying the organisation of work, concluded that there were fundamental underlying principles and systems applicable in a wide range of manufacturing activities, (Babbage, 1832 : 121 – 140).

Other researchers and writers, (McCallum, 1856; Metcalfe, 1885; Towne, 1886) pursued this line of thinking, the systematic arrangement of work procedures, and began to develop the principles of methodical arrangement of the job components and the labour resource in factories. Such workers in the field comprised the forerunners of what became known as the 'Classical or Scientific School of Management.'

Foremost in the latter field were Frederick Winslow Taylor, (1911), Gilbreth (1908), Gantt, (1919) and Fayol, (1949). Fayol took Taylor's systems of arranging the individual's working efficiency and applied them to whole companies and organisations. Whilst technically efficient, these rigid systems of labour activity, created psychological and social problems in the work place and were open to exploitation by management, (Gantt, 1919). Nevertheless, large corporations such as the Ford Motor Company, adopted the *scientific management* system on its production
lines and many of the principles still operate today in some vehicle manufacturing companies.

Amidst the increasing complexity of the new manufacturing systems of the time and the effect on labour, other researchers were looking at alternative methods of addressing labour organisation and activity related to product output. They were particularly interested in 'people behaviour' rather than just behavioural efficiency.

Such theorists became known as the 'Human Relations' school of thought led by such workers as Barnard (1938), Roethlisberger and Dickson (1939) and Elton Mayo (1933–1949), the latter becoming famous for his studies at the Hawthorne Works of the Western Electric Company, USA. Here, the effect of worker participation in the experiments actually increased their efficiency in the work process, creating an enhanced effect, which would not have been the norm on the ordinary production line. This became known as the 'Hawthorne effect' in social research projects.

The general approach of the 'human relations' school was to regard organisation of work forces as human co-operative systems, where interpersonal relationships were recognised as important and could be used to improve work efficiency. In due course, combined approaches using both scientific principles of efficiency and human resource relationships were brought together in a further group of theories, known as 'socio-technical' approaches.

Trist and Bamforth, (1951: 3–38) performed a series of studies in the coal mines of Yorkshire where the technology of new coal cutting machines was forcing reorganisation of the labour force. Management imposed a three shift system allocating separate tasks to each shift. The system failed and the miners got together themselves to sort matters out, forming what became known as the autonomous working group (AWG). Instead of differentiating separate distinct tasks to different shifts, all tasks were performed on each shift by the group on that shift. Thus production was continuous and each group (not individual workers) possessed, in total, the task abilities for each shift. The AWG became self-regulating, freeing management time for longer-term planning. Production rose from 78% of theoretical maximum to 95%. The
concept spread world wide in the industrial economies and is still being used today in such companies as Volvo and Atlas-Copco.

Prior to his studies on workforce organisation in the mines, Trist, based at the Tavistock Institute, London, had been working on individual and group behavioural problems and therapy. The purpose was the resolution of socio-psychological problems in the family setting.

Bowlby, a medical doctor, also at the Tavistock Institute was simultaneously working on family group therapy in the context of mental illness, where he reasoned that family understanding and support could materially improve the patient’s condition. Even at this early stage, (1945) Bowlby is recorded as having expressed the view that the next logical focus for his work was in organisational development, (Salter, 1992: 668).

At about the same period in the USA at the Massachusetts Institute of Technology, Festinger, Radke and Lippett were also working on group dynamics, with the purpose of changing behaviour patterns in the discordant family situation. These groups eventually developed into training research workshops, involving what became termed *action research feedback*, (Marrow, 1969: 210 – 214; Benne et al., 1969: 100 – 102). This required a skilled group leader, or trainer, working with a group of people in their interactive discussion topic and an observer assistant. The observer fed back results to the trainer after the group session for analysis. Suitable adjustments were made for the next session, where the group in turn responded to the feedback from the trainer and observer.

This procedure then developed into group members listening in at the original trainer / observer feedback session and correcting misinterpretations. The double feedback mechanism became very effective in effecting behaviour change of the group, (Coan, 1991: 11 – 15).

This group behaviour change system was gradually trans-located into the commercial / industrial situation, with the intent of effecting organisational change in the workplace. The change of context was not successful to begin with, but refinements introduced by workers in their specialised field such as McGregor, became effective, (Beckhard et al.,
1967 : 2). This researcher worked with an industrial relations executive at Union Carbide, forming an internal consulting group and delivered the required change for the company. He named the group the 'organisation development group', (Burke, 1965 : 147 – 149).

This work merged well with earlier research by Tannenbaum in the 1950s, directed toward team building, (Tannenbaum et al., 1954 : 3). The sessions dealt with interpersonal relationships, communications and socio-metrics, policies, procedures and inter-departmental relations, (Kallejian et al., 1955 : 55 – 64). A modern definition of the word 'team' by Katzenbach and Smith, (1993 : 112) is:

'...a small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approach, for which they hold themselves mutually accountable...'

and such team effort is used today in effecting change in the workplace. It will be a relevant consideration in perhaps reconstructing regionally based teams of trained pharmacists as change agents, in effecting introduction of pharmacy’s new role of medicines management.

Parker, (1990 : 30) researching into successful teams, has set out the characteristics found in all such groups,

'CLEAR purpose; good participation; agreeable disagreement;
consensus decision making; clear roles for each member;
shared leadership; self assessment.'

Such factors will be useful in considering change techniques in the movement of the pharmacy profession from supply services to cognitive service. Druker records, (1981 : 24) that the capacity of individuals to handle change is limited and vested interest groups can also be major barriers to change, as was shown in Pettigrew’s studies at ICI with Sir John Harvey Jones, (Pettigrew, 1985). These issues may also need specific address within pharmacy.
Finally, in this brief outline of the history of general organisational development, three other modern approaches are worthy of mention:

i. Total Quality Management (TQM);

ii. Business Process Re-engineering (BPR); and,

iii. Macro Systems business change.

5.2.1 Total Quality Management

Dale and Cooper, (1992: 12) define TQM as:

'...an organisation-wide effort to improve quality, through changes in structure, practices, systems and attitudes...'

This approach to developing, or changing, the structure and culture of an organisation has been used very successfully by Japanese corporations in the last two decades. Perhaps as a consequence of the global growth of Japanese enterprise, TQM has been thought of by some as a Japanese innovation.

According to Clarke and Clegg, (2000: 217) however, TQM originated in the USA in the 1950s but was adopted most effectively by the Japanese soon after its publication as a concept. Its birth is credited to Deming, an American business consultant, (Wild, 1995: 582) and rests upon a number of key principles set out in Table 27, together with the author's view of suggested implications / corresponding measures within the NHS.

Table 27, also contains references from the Government White Paper... 'The New NHS: Modern, Dependable’, indicating that some thinking at least, about reorganisation of the NHS, closely mirrors the principles of TQM.
### Table 27 PRINCIPLES OF TOTAL QUALITY MANAGEMENT AND MODERN NHS EQUIVALENTS

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary emphasis on outcomes</td>
<td>Patient health improvement; Commission for Health Improvement (pp. 4, 28, 49)</td>
</tr>
<tr>
<td>Organisational Departments are each other’s customers</td>
<td>‘Interdependence’ not ‘Independence’ (p.12)</td>
</tr>
<tr>
<td>Measurement of Processes and results</td>
<td>Clinical Governance and Audit, Quality Assurance (pp. 47, 56, 58)</td>
</tr>
<tr>
<td>Competitive Benchmarking against the best in the world</td>
<td>Benchmarking; Performance Frameworks (pp. 49, 60, 65)</td>
</tr>
<tr>
<td>Continuous Search for defects and their elimination (Japanese = ‘Kaizen’)</td>
<td>‘NICE’ Patient Surveys; Professional Self Regulation (pp. 29, 58, 59, 66)</td>
</tr>
<tr>
<td>Participative Management emphasis on teams / teamwork</td>
<td>Partnership ‘of users, carers and staff’: ‘Everyone in NHS should take responsibility to improve quality’; Development and improvement of staff (pp. 10, 17, 51, 52, 66, 77)</td>
</tr>
<tr>
<td>Continuous Training of Employees</td>
<td>Human Resource development (p.51)</td>
</tr>
<tr>
<td>Top Management commitment to the philosophy of Total Quality Management</td>
<td>Three Government White Papers promoting quality; PM, Secretary of State for Health; leadership promoted (pp. 56, 60 – 61)</td>
</tr>
</tbody>
</table>

**Note:** This table seeks to expose similarities between TQM principles and some of the underlying themes of the Government White Paper. The right hand column is the author’s view of the elements of link-up.

The same White Paper also underlines the importance of forward thinking and strategy as well as a new vision, (p.3). The Prime Minister, (Tony Blair) says:

‘...we can again create an NHS that is truly a beacon in the world...’

This strategic approach is again emphasised by Steele, (1993 : 425 – 441) who asserts that for TQM to have full impact in an organisation, it is essential that there is clear ‘strategic direction’ and undoubtedly this will be crucially important for pharmacy as the way forward is planned, within the new NHS environment. The whole culture of the organisation, which is based upon TQM, argues Sashkin, (1992 : 4 – 5) needs to be anchored in teamwork, the generation of valid data (regarding change effects, processes
and progress) and continuous learning. These issues will be alluded to in examining the change programme later in the thesis.

5.2.2 Business Process Re-engineering (BPR)

This approach to the redesign of business processes was pioneered by Michael Hammer and first published in the Harvard Business Review, August 1990. The concept was further developed by Hammer and Champy, (1993 : 32) and defined as:

'*the fundamental thinking and radical redesign of business processes, to achieve dramatic improvements in critical contemporary measures of performance, such as cost, quality, services and speed.'*

They saw this process as one which made 'quantum leaps in performance,' not incremental change. Interestingly, they view this as a top-down process, arguing that people lower down in the organisation do not have the knowledge or conceptual mindset to visualise the change that is needed throughout, (Hammer and Champy, 1993 : 206 - 208). However, other workers in the field of BPR argue that everyone in the organisation can partake in the thought and action process, (Janson, 1992 / 93 : 45 - 53). The author of this thesis takes a similar view to Janson, based upon the study and work completed as a member of PSNC in community pharmacy, with regard to medicines management prior to the current research.

In BPR, each process within the company is reviewed and radical redesign undertaken. Talwar, (1994 : 43 - 45) sets out a spectrum of re-engineering intervention as:

- **Process improvement** - parts of the process only;
- **Process re-engineering** - redesign of the whole process;
- **Business re-engineering** - redesign of the entire business architecture and all processes;
- **Transformation** - re-invention of the business, i.e. what
business are we in? - Re-think the whole purpose and philosophy of the organisation; and,

- **On-going renewal** - constant review and improvement.

So far as pharmacy is concerned, within the avalanche of change in the 'New NHS', it is the view of this thesis that stages four and five in the above list need special consideration in moving community pharmacy into a new order of service, through medicines management and interpersonal relationships with the patient and doctor.

In the latter part of the twentieth century (1980s) interest turned to a different order of change, as large corporations such as British Airways, saw the need for company turnaround. Such wide scale change has been called *transformational* or *second order* change and is defined by Levy and Merry, (1986: 5) as:

'...a multi-dimensional, multi-level, qualitative, discontinuous, radical organisational change, involving a paradigmic shift...'

Culture change will be dealt with in detail later in this chapter.

### 5.2.3 Macro Systems Business Change

The nature of the business is re-conceptualised and change effected through multiple *organisational development* techniques. Internal leadership training is required at board level and lower group levels. Normally a long period of time is involved and this is likely to be the case in community pharmacy. This is based upon experience of the past seven years to reach its present stage from the first UK published paper on the subject of a proposed new nationally recognised role for community pharmacists, managing patient therapy, (Tweedie, 1994: 507 – 508).
Organisational structure and change has been recorded and practised for thousands of years in general society and especially in the development of battle forces and religious orders. Formal business organisation study and development has evolved through a number of strands, which have been classified into broad approaches:

- The nineteenth century, early pre-scientific approaches to work organisation;

- The emergence of the scientific school of thought in the early twentieth century;

- The human relations school, recognising the need to take account of socially interacting forces in the workplace;

- The socio-technical amalgam of principles which integrated systematic working, with sociological considerations and group behaviour; and,

- Recent developments based upon quality pursuit, greater efficiency of business processes and transformational techniques for whole organisations, redefining the business they are in.

The address of change in community pharmacy may well involve elements of all the above approaches in attempting to re-position the profession in the health care delivery chain. The mechanistic processes of dispensing, checking, supervision and pharmacist time apportionment, as well as knowledge development, will need to be addressed. A new patient focus, doctor focus and interaction between primary health care professionals, is likely to require a 'major paradigmic shift'. This is defined by Levy and Merry, (1986 : 5) in culture, from fulfilling the FP10, as a medicines order, to conceptual cognitive address of the psychology and motivation of patient, physician and pharmacist in addressing medicines usage, in a new collaborative effort.
5.3 THE CHANGE DRIVERS AND STRATEGIC CAPABILITY

It is generally accepted in the modern business management literature that the major change drivers in industry and commerce as a whole originate through the interplay of the following external influences in society, (Table 28) i.e. Politico-legal; Economic; Socio-cultural; Technological (P.E.S.T. analysis).

Table 28 GENERIC P.E.S.T. ANALYSIS

<table>
<thead>
<tr>
<th>SOCIETAL CHANGE DRIVER</th>
<th>EXAMPLE ELEMENTS OF IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politico-Legal</td>
<td>Government policy and legislation on Health, Education, Taxation policy, Employment law, EU Trading arrangements</td>
</tr>
<tr>
<td>Economic</td>
<td>‘The Trade Cycle’ – recession/recovery; inflation/deflation; employment levels; import/export balance (X - M); investment/borrowing rates; stock market movements; ‘Global economy’.</td>
</tr>
<tr>
<td>Socio-Cultural</td>
<td>Demographics – age movement in population; redistribution trends in income; education availability, i.e. fee or free; emphasis on leisure, lifelong learning; consumer power and knowledge trends – quality expectations; media power.</td>
</tr>
<tr>
<td>Technological</td>
<td>Exponential developments in IT systems; growth of automation in industry; global communications speed; internet access by growing segment of population and thus knowledge availability.</td>
</tr>
</tbody>
</table>

Note: The left hand column, societal change drivers, impact upon the pharmacy domain directly and with speed. Information technology and government policy have had far reaching effects in recent years.

A suggested analysis of these effects, with respect to community pharmacy, is set out at Appendix 1, (page 413) but in addition to the above forces, there are the ‘domain’ or sector-of-industry forces, generating competition. These have been summarised generically by Porter, (Chapter 1 : 27, Figure 4) and comprise on the one hand competition for profit (as down the supply chain in community pharmacy) and competition for market share on the other.

Supplementary to these overall forces within the business and societal environments another effective force for change lies within the organisation itself, the human
resource. Individuals with vision, who can see opportunity and room for improvement in overall organisational performance are also responsible for radical change in culture, structure, custom and practice.

Such has been the case in community pharmacy where a dedicated group of individuals has designed and developed the medicines management proposal. However, it is also true to say that this same group was undoubtedly aware of the generic environmental change drivers as described above, impacting upon community pharmacy at the time. Table 28 summarises key issues arising from the P.E.S.T. analysis, (Appendix 1, page 413) together with suggested implications for primary health care pharmacy.
### Table 29  KEY ISSUES – PSNC AND COMMUNITY PHARMACY

<table>
<thead>
<tr>
<th>CHANGE DRIVER</th>
<th>FOCUS OF IMPACT</th>
<th>IMPLICATIONS – PSNC</th>
<th>IMPLICATIONS COMMUNITY PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POLITICAL</strong></td>
<td>* NHS Policy and structure change; new pharmacy strategy; new emphasis on aged patients; NICE; competition for new services opened up. (LPS) Collaboration of health professionals, an objective of Government. (The New NHS: Modern, dependable)</td>
<td>New case presentation for new funds; evidence based proposals to Government; anti-competitor strategy required; understanding of health economics; understanding of market research; application of both the last two to case presentation at Government level.</td>
<td>New expertise in clinical pharmacology required; new relationship with other health care professionals needed – interpersonals skills development for patient relationships; practice audit. New premises facilities for patient privacy / consultation. Build relationships with PCTs.</td>
</tr>
<tr>
<td><strong>SOCIO-CULTURAL</strong></td>
<td>Patient empowerment; growing knowledge / awareness of health issues; healthy living = health promotion; healthy eating; self treatment for minor illnesses encouraged.</td>
<td>Strategic alliances with patient organisations (e.g. Heart Foundation) recommended; research of patient needs and wants by disease group and by age group.</td>
<td>Liaison with local GPs on OTC treatment protocols and referral information where necessary. System for harmonising OTC / NHS treatments increasingly important as more potent medicines transferred from POM to P.</td>
</tr>
<tr>
<td><strong>TECHNOLOGICAL</strong></td>
<td>Electronic prescriptions; ‘supervision’ by remote control; computer assisted medicines review. NHS net to be developed, onus for information exchange between GPs and pharmacists.</td>
<td>Assessment of skill-mix implication; development of review software and diagnostic aids; patient concordance / motivation technique development.</td>
<td>FP10 volume will be redistributed by electronic access to GP surgery and ease of pharmacy supply to local populations. Greater pull of local patients to local pharmacy for medication review and OTC prescribing. Loss to GP proximal pharmacies?</td>
</tr>
<tr>
<td><strong>SET UP STRATEGIC GROUP – NATIONAL BODIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EVALUATION &amp; CASE CONSTRUCTION FOR VALUE ADDED REWARDS</strong></td>
<td></td>
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<tr>
<td><strong>RE-INVENT PHARMACY PRACTICE &amp; ADAPT TO NEW WORLD, 21st Century</strong></td>
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</tbody>
</table>

*Ref: New NHS, Modern: Dependable

**Note:** The above table is the author’s view of the ‘PEST’ impact, in the market place of 2001 and the required activity of PSNC and community pharmacists to take advantage.

**ABBREVIATIONS**

- **FP10** National Health Service Prescription
- **GP** General Practitioner
- **LPC** Local Pharmaceutical Committee
- **LPS** Local Pharmaceutical Services
- **NICE** National Institute for Clinical Excellence
- **OTC** Over the counter medicine
- **POM** Prescription only medicine
- **PSNC** Pharmaceutical Services Negotiating Committee
- **P** Pharmacy only medicine
- **Ps** P Primary Care Trust

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5.3.1 Strategic Capability

Although it is an accepted corporate practice to systematically address environmental influences in attempting to formulate forward strategy, some workers in the field of management have argued that excessive focus has been directed toward this approach, in other words, from the outside looking into the organisation. Such workers have proposed that an equally effective approach is through the analysis of internal resources and expertise together with new potential market opportunities, (Wernerfelt, 1984 : 171 - 178; Collis, 1991 : 49 - 68). The core competencies of the organisation (internal resources) and its 'end products', according to Prahalad and Hammel, (1991 : 281) comprise the whole core product of the organisation. Assessment of the potential of these core competencies in planning strategy has, according to these authors, been under-utilised.

This may also be true of community pharmacy and its current internal resources. In brief, these are its professionally qualified people, together with their physical premises' amenities. The current core role of community pharmacy is undoubtedly dispensing but is this its core expertise or competence? Surely not; surely its core expertise is its specialist knowledge base of medicines' actions and interactions, which is what the concept of medicines management is based upon. With respect to the importance of core knowledge, Druker, (1993 : 22) more specifically has said:

'...the productivity of knowledge is going to be the determining factor in the competitive position of a company, an industry, an entire country...'

This has particular relevance to community pharmacy, where in the 'New NHS', new roles are not the prerogative of any one profession. Several may compete for any new service and even some traditional services. For example, doctors, pharmacists and nurses may compete to deliver medicines management. Dispensing pharmacy contractors may, additionally find themselves in competition with peripatetic pharmacists, offering cognitive services only, or hospital pharmacists offering the same, (Figure 4, Chapter 1).
The strategic capability of the organisation, in this case the collective primary care dispensing pharmacy network, needs assessing, in terms of its current and desired resources in order to position itself for any increased role in cognitive service. This is a task for the representative leadership body for pharmacy within the NHS contract, the PSNC.

In turn, this implies a need for PSNC to examine its own internal resources and fitness to adopt such a leadership role. As part of the work for this thesis, the author set out a proposed new committee structure (since adopted) to equip PSNC for this work. The new titles and outline purposes of each sub-committee are set out below and amplified in Appendices 4 to 9.

The sub-committee structure has been completely transformed to focus upon creative strategic planning, marketing and resource development, instead of a largely administrative and bureaucratic processing of information based upon past routines and custom. The comparisons are shown in Table 30 on the next page. It can be seen from this that Wernerfelt's approach, (1984 : 171 - 178) to formulating strategy by examining internal resources / expertise has been employed, within the limitations imposed by the PSNC organisation and constraints, i.e:

- Inexpert internal resources (committee members) well qualified in pharmacy, but not management specialities;

- Inadequate time input from individual committee members who meet only eight times a year;

- Small back-up office resource, again with few executives and none with speciality business management experience or qualifications; and,

- Consequently no previous structured and systematic address of the market environment, i.e. the NHS.
Table 30  COMPARISON OF PSNC SUB-COMMITTEE STRUCTURE
PRE AND POST 14th JUNE 2000

<table>
<thead>
<tr>
<th>PRE JUNE 2000 SUB COMMITTEE</th>
<th>POST JUNE 2000 SUB COMMITTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE:</strong> Finance &amp; General Purposes</td>
<td>Resource Development &amp; Finance</td>
</tr>
<tr>
<td><strong>ROLE:</strong> Administration of PSNC finances</td>
<td>Development of human; financial; systems resources of PSNC to facilitate achievement of strategic objectives.</td>
</tr>
<tr>
<td><strong>TITLE:</strong> AUDIT</td>
<td>Review and Audit</td>
</tr>
<tr>
<td><strong>ROLE:</strong> Annual audit of finances</td>
<td>Quarterly review of PSNC resources, activities and results; review of progress toward objectives; recommendations for improvement where necessary; corporate governance, quality assurance.</td>
</tr>
<tr>
<td><strong>TITLE:</strong> Contract &amp; Policy</td>
<td>Contract Planning</td>
</tr>
<tr>
<td><strong>ROLE:</strong> Process communications between PSNC and DH. React to DH initiatives; create PSNC policy on address of aspects of the dispensing contract.</td>
<td>Develop new approaches to DH policy; proactively take initiatives to DH; develop new contract proposals at national and local levels.</td>
</tr>
<tr>
<td><strong>TITLE:</strong> Strategy</td>
<td>Strategic Planning and Policy</td>
</tr>
<tr>
<td><strong>ROLE:</strong> Envision futures and construct strategies for address; identify strategic objectives, prioritise and pursue.</td>
<td>As before, but with systematic structured approach to the NHS / business environment, plus economic analysis of the environment.</td>
</tr>
<tr>
<td><strong>TITLE:</strong> Public Affairs</td>
<td>Marketing and Public Affairs</td>
</tr>
<tr>
<td><strong>ROLE:</strong> Conference planning; administration of communication with LPCs; liaison with MPs when necessary and special communications to Ministers.</td>
<td>Development of new services and income potentials; promote to DH, GPC, Patient organisations and LPCs. Analysis of health markets; market research; creation and promotion of issues to Inter-Parliamentary Group of MPs to a regular programme; create marketing plans for new roles; create training packages for presentational skills.</td>
</tr>
</tbody>
</table>

Note: Author’s reconstruction of the PSNC structure and functions to address the ‘New NHS’; implemented June 2000.

**ABBREVIATIONS**

- **DH:** Department of Health
- **GPC:** General Practice Committee of British Medical Association
- **LPC:** Local Pharmaceutical Committees
- **MPs:** Members of Parliament
- **NHS:** National Health Service
- **PSNC:** Pharmaceutical Services Negotiating Committee
The strategic capability of the PSNC is thus assisted by the new sub-committee objectives which impose disciplined consideration of relevant future issues by the sub-committee remits. However, it is impeded by the competency level of individual office and committee members in the relevant management disciplines.

The exceptions to this analysis are, of course, the members who represent the vertically integrated companies. Even so, the author’s discussions with these indicate that their individuals’ experience is based almost solely in their own companies. They have no recognised qualifications in sophisticated management and marketing theory, economics or market research. Perhaps their head office resources possess such expertise, but do not share it with the PSNC.

A further external impediment to strategic effectiveness is the limited global sum by which pharmacy contractors are paid. This has delivered diminishing profit returns since 1989, as shown in Table 30 and leaves little scope for additional new services / products, for marketing and financial return.

However, discussion is underway (as at April 2002) to deliver a new contract, which may give scope for new services and new money, some of which may be accessed through local budgets.

The strategic capability of PSNC, even if made effective internally, does need to find a route to relaxing the external constraints of funding and this may well be through local budgets via the Primary Care Trusts. This may, in turn, require central regulations to ring fence enhanced budgets for local medicines management needs at PCT level.
Table 31  COMMUNITY PHARMACY DISPENSING CONTRACT
SHIFT IN GROSS PROFIT % 1989 – 2001

<table>
<thead>
<tr>
<th>YEAR</th>
<th>GLOBAL SUM £M</th>
<th>% GROSS PROFIT (CORE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988/89</td>
<td>504.7</td>
<td>22.1</td>
</tr>
<tr>
<td>1989/90</td>
<td>502.8</td>
<td>20.3</td>
</tr>
<tr>
<td>1990/91</td>
<td>553.2</td>
<td>20.6</td>
</tr>
<tr>
<td>1991/92</td>
<td>601.4</td>
<td>20.0</td>
</tr>
<tr>
<td>1992/93</td>
<td>631.1</td>
<td>18.9</td>
</tr>
<tr>
<td>1993/94</td>
<td>640.6</td>
<td>17.5</td>
</tr>
<tr>
<td>1994/95</td>
<td>655.3</td>
<td>17.3</td>
</tr>
<tr>
<td>1995/96</td>
<td>671.7</td>
<td>16.6</td>
</tr>
<tr>
<td>1996/97</td>
<td>692.7</td>
<td>15.9</td>
</tr>
<tr>
<td>1997/98</td>
<td>709.3</td>
<td>15.2</td>
</tr>
<tr>
<td>1998/99</td>
<td>732.4</td>
<td>14.8</td>
</tr>
<tr>
<td>1999/00</td>
<td>755.1</td>
<td>13.8</td>
</tr>
<tr>
<td>2000/01</td>
<td>777.8</td>
<td>13.1</td>
</tr>
<tr>
<td>2001/02</td>
<td>806.6</td>
<td>13.0</td>
</tr>
</tbody>
</table>

Note: 'Core' in column 3 means the core dispensing service excluding 'oxygen'.

Although it has been argued by Prahalad and Hammel, (1991 : 281) that core competencies are a key factor in determining strategic capability, and by the author, that the core competence of pharmacy is its medicines knowledge, the latter remains to be established. It is a claim frequently rehearsed by the profession and part of the research in this work is geared to investigating this supposition, in other words that pharmacy contractors' clinical expertise is up to the task of medicines management.

The opportunities for cognitive service development and the core competencies of the organisation, in this case community pharmacy, need to be congruent, or to be made so, by adequate training, appropriate physical premises and equipment resources. If community pharmacy is not clinically competent, then this is a major barrier to entry into the new service. Other strengths and weaknesses need to be assessed.
The SWOT analysis, below, begins to expose the tactical position with respect to PSNC's and the profession's strengths and weaknesses as seen through the perception of the LPCs in Gateshead and South Tyne, as well as Sunderland. The opportunities and threats were also investigated. Here sessions were conducted by the author, amongst these politically aware, locally elected groups of people, who are all practising dispensing pharmacists, to gain their views upon the current situation of pharmacy in primary health care.

The views cannot be generalised from these small purposive samples (n = 27) but nonetheless, constitute a qualitative 'taste' of what may, or may not, turn out to be a general view held by a wider audience. It was also mentioned to the LPCs that their views should be set against the background of planning the profession's move into medicines management. These groups are politically representative of the various factions in the community pharmacy service, in other words, 'multiples'; 'independents'; and 'co-operatives' who have a more detailed awareness of the changing effects of the new NHS upon pharmacy than an ordinary contractor, hence their selection, as a useful reference group. The LPCs possess this knowledge through the volume of correspondence and communication with the PSNC.

The strengths and weaknesses are what could be described as perceived matters of fact, whilst the opportunities and threats may be more speculative, because they are dependent upon LPC knowledge of the 'external' economic world outside pharmacy, which may not be comprehensive. Indeed, it could be argued that establishing the opportunities and threats for any organisation is an expert task requiring specialist informed views of external forces. Figures 16 and 17 summarise the LPC assessments. As the matrices are dynamic, the issues noted inside the quadrants can change position over time and in accordance with changes in the business / NHS environment. This exercise was conducted at Sunderland LPC on 12th March 2002 (12 present) and Gateshead / South Tyne LPC (15 present) on 19th March 2002 and amalgamated on 22nd March 2002 by the author. Flip charts were used to list the SWOT elements and then pre-prepared matrices explained, for inserting the appropriate prioritisation.

Figures 16 and 17 set out strengths / weaknesses, opportunities / threats respectively in dynamic matrices for prioritisation purposes.
Figure 16 DYNAMIC SWOT ANALYSIS – PSNC & COMMUNITY PHARMACY – STRENGTHS / WEAKNESSES

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSNC</strong></td>
<td><strong>CP</strong></td>
</tr>
<tr>
<td>In depth knowledge of drug pricing mechanisms</td>
<td>Wide range of OTC products Relaxed relationship with patients</td>
</tr>
<tr>
<td>No knowledge of ‘value’ pricing systems No direct regular communications with contractors</td>
<td>No formal presentation skills to approach new NHS structures Culture anchored in the past</td>
</tr>
<tr>
<td>Good relationship with PPA Good relationship with NPC Good relationship with RCN</td>
<td>Potential to influence health promotion Friendly relationship with public</td>
</tr>
<tr>
<td>No line authority with LPCs No line authority with contractors</td>
<td>Mixed range of retailer / professional No formal structure of communication with other health care professions No formal requirement for updating of skills / knowledge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSNC</strong></td>
<td><strong>CP</strong></td>
</tr>
<tr>
<td>Regular access to high level Government and Civil Service Excellent relationships with GPC / BMA Patients' representative organisations</td>
<td>Easy access via LPCs to HAs/PCTs/HAZs; Social Services Strong patient / customer allegiance Widely distributed throughout the community</td>
</tr>
<tr>
<td>Experience spans all sectors of community Pharmacy (CCA; CPTP; NPA; RPSGB) Determination to modernise</td>
<td>Good relationships with GPs Willing to extend role</td>
</tr>
<tr>
<td>Has to represent disparate agendas Minimal modern management resource or understanding Under resourced – manpower - new management expertise absent at executive level Little influence on funding</td>
<td>Clinical expertise inadequate Premises not currently suited to patient consultation Workload distribution not conducive to MM</td>
</tr>
<tr>
<td>Good relationship with PPA Good relationship with NPC Good relationship with RCN</td>
<td>Potential to influence health promotion Friendly relationship with public</td>
</tr>
<tr>
<td>Only one of five representative bodies talking to government Known by DH to have divided interests Not a statutory body</td>
<td>High proportion of non-professional products in pharmacies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAGNITUDE OF STRENGTH/WEAKNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ABBREVIATIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMA</td>
</tr>
<tr>
<td>CCA</td>
</tr>
<tr>
<td>CP</td>
</tr>
<tr>
<td>CPTP</td>
</tr>
<tr>
<td>GPC</td>
</tr>
<tr>
<td>HAZ</td>
</tr>
<tr>
<td>MM</td>
</tr>
<tr>
<td>NPA</td>
</tr>
<tr>
<td>NFC</td>
</tr>
<tr>
<td>PPA</td>
</tr>
<tr>
<td>PSNC</td>
</tr>
<tr>
<td>RCN</td>
</tr>
<tr>
<td>RPSGB</td>
</tr>
</tbody>
</table>
### Dynamic SWOT Analysis – PSNC & Community Pharmacy – Opportunities / Threats

#### Opportunities

<table>
<thead>
<tr>
<th>PSNC</th>
<th>CP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opportunities</strong></td>
<td><strong>Opportunities</strong></td>
</tr>
<tr>
<td>Collaborative links (formal) – with universities</td>
<td>Expanded patient involvement</td>
</tr>
<tr>
<td>Greater liaison / collaboration with other pharmaceutical lead bodies; Structured links with pharmaceutical industry</td>
<td>Greater pedestrian traffic flow – higher OTC sales as POM moves to P; Support with local initiatives when developed</td>
</tr>
<tr>
<td>Multiples pressure to increase seats on PSNC</td>
<td>Contract remuneration redistribution? Flow from independent to multiple</td>
</tr>
</tbody>
</table>

#### Threats

<table>
<thead>
<tr>
<th>PSNC</th>
<th>CP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Threats</strong></td>
<td><strong>Threats</strong></td>
</tr>
<tr>
<td>Multiples growing influence through acquisition policy</td>
<td>LPS may weaken national contract; Rise in technician importance to take over dispensing contract</td>
</tr>
<tr>
<td>PSNC</td>
<td>CP</td>
</tr>
<tr>
<td>New position in primary care; New partnerships with doctors locally – new local money potential; Higher stake in primary care – bigger image</td>
<td>Reduced income; more local control of funding</td>
</tr>
</tbody>
</table>

#### Likelihood

<table>
<thead>
<tr>
<th><strong>Abbreviations:</strong></th>
<th><strong>Likelihood</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>BMA</td>
<td>General Practitioner Committee (GPC)</td>
</tr>
<tr>
<td>CCA</td>
<td>Medicines Management (MM)</td>
</tr>
<tr>
<td>CP</td>
<td>Prescription only medicine (POM)</td>
</tr>
<tr>
<td>PSNC</td>
<td>National Pharmacists’ Association (NPA)</td>
</tr>
<tr>
<td>NPC</td>
<td>Prescription Pricing Authority (PPA)</td>
</tr>
<tr>
<td>CPPE</td>
<td>National Prescribing Centre (NPC)</td>
</tr>
</tbody>
</table>

158
It may be significant that both groups expressed the view that a weakness of the community profession was its clinical expertise. On questioning by the author, on both occasions, each LPC volunteered similar reasons for their perceived assessment, e.g.

• "We have been commercially based for so long, the clinical skills have disappeared."  
  (Sunderland)

• "Commercial interests and the need to keep maximising NHS profit has blocked the development of clinical services."  
  (Gateshead & South Tyne)

Whilst the author would not necessarily agree with the chosen positioning of all the issues within the matrices the situation is dynamic and each element could change its position over a period of time. Emergent from this SWOT analysis is effectively an implied resource audit and opportunity options. The resource audit is commonly analysed under four headings:

1. **Human Resource**: Skills; adaptability; gaps between present and desired states;
2. **Intangible Resources**: Image; stakeholder relationships; goodwill;
3. **Physical Resources**: Extent of distribution; equipment; amenities in dispensaries and retail units; and,
4. **Financial Resources**: Source of funding; cash flows; relevant finance institutions; market stability.

Table 32 links the exposed community pharmacy resource strengths / weaknesses, with opportunities, giving key address issues in repositioning pharmacy within primary care. Table 33, a so called ‘TOWS’ analysis, outlines strategies / activities to manage the strengths and weaknesses, opportunities and threats inter-relationships. The TOWS analysis matrix, designed by the Harvard Business School, provides a devise for briefly summarising link-up strategies to address the strength and weakness / opportunity and threat components of the SWOT analysis.
Table 32 RESOURCE AUDIT: OPPORTUNITY LINKS  
KEY ISSUES OF ADDRESS

<table>
<thead>
<tr>
<th>RESOURCE: STRENGTHS &amp; WEAKNESSES</th>
<th>OPPORTUNITY</th>
<th>KEY ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HUMAN</strong> – Qualified pharmacist degree upgraded (M. Pharm). Clinical skills of present workforce questioned. Close gap with new skills and training packages from universities and CPPE.</td>
<td>Conversion from supply based service to cognitive role in MM. Greater professional satisfaction and financial reward?</td>
<td>Address of clinical / pharmacology knowledge – tailored training courses to suit market needs and time constraints. Options in training route are important.</td>
</tr>
<tr>
<td><strong>INTANGIBLE</strong> – Image with public held to be good; strong patient allegiance; friendly atmosphere of pharmacy; good GP relationships.</td>
<td>More in-depth friendly service to patients (MM) – patient collaboration, in new support service made easier / encouraged.</td>
<td>Polish the image; create more professional atmosphere with ‘qualified’ back up staff; improve interpersonal and presentational skills.</td>
</tr>
<tr>
<td><strong>PHYSICAL</strong> – Premises not geared to consultation with patients; are set up for merchandising; re-allocation of priorities is necessary, but geared to finance availability.</td>
<td>Transform service into recognisable primary health care professionalism; shadow the doctor amenities; create right image in perception of GPs and patients.</td>
<td>Create in-store privacy / confidentiality facility; professional visual aids and IT amenity; consultation facility to accommodate 3 people – pharmacist, patient, one patient helper.</td>
</tr>
<tr>
<td><strong>FINANCIAL</strong> – From DH for NHS contract; dependable, secure, but inadequate for new roles. New money required.</td>
<td>Create new value-added services worthy of attracting new money in DH perception.</td>
<td>Create new presentational expertise; case construction; new experts at PSNC level; new approaches at local PCT level via new training packages.</td>
</tr>
</tbody>
</table>

Note: The above table is the author’s extrapolation of the major SWOT analysis elements to clarify key issues of address in moving pharmacy into the new service.

**ABBREVIATIONS:**

- **CPPE** Centre for Pharmacy Post Graduate Education
- **DH** Department of Health
- **GPs** General Practitioners
- **MM** Medicines Management
- **NHS** National Health Service
- **PCT** Primary Care Trust
- **PSNC** Pharmaceutical Services Negotiating Committee
### Table 33

**TOWS ANALYSIS - COMMUNITY PHARMACY PROFESSION STRATEGIES / ACTIVITIES TO MANAGE SWOT ANALYSIS**

<table>
<thead>
<tr>
<th>ABBREVIATIONS</th>
<th>STRENGTHS (S)</th>
<th>WEAKNESSES (W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DH</td>
<td>1. Strong patient allegiance; liked by public</td>
<td>1. Clinical expertise inadequate*</td>
</tr>
<tr>
<td>GPs</td>
<td>2. Wide range of OTC medicines</td>
<td>2. Premises not suited to patient confidentiality*</td>
</tr>
<tr>
<td>IT</td>
<td>3. Good relationship with GPs</td>
<td>3. Current workload precludes extra cognitive roles*</td>
</tr>
<tr>
<td>LPS</td>
<td>4. Willingness to widen role in primary care</td>
<td>4. Inadequate presentational / interpersonal skills*</td>
</tr>
<tr>
<td>MM</td>
<td>5. OTC service reduces pressure on NHS</td>
<td>5. Mixed image – retailer / profession</td>
</tr>
<tr>
<td>NSF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OFT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RPSGB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABBREVIATIONS</td>
<td>1. Construct integrated OTC/NHS medicines service for patients – prevent interactions</td>
<td>1. Emphasise to DH patient / professional relationship and pharmacists growing importance. Closures and openings create instability and fragmented relationships</td>
</tr>
<tr>
<td>OPPORTUNITIES (O)</td>
<td>2. Target medicines management on disease groups with NSF's – collaborate with GPs</td>
<td>2. Install confidentiality facility in each pharmacy; with IT links and space for 3 people*</td>
</tr>
<tr>
<td></td>
<td>3. Attempt to add LPS to national contract not substitute. Present case for national benchmarking of national contract; tailor additional LPS to local needs</td>
<td>3. Move more mechanical work to technicians – ensure universal technician 'qualification'*</td>
</tr>
<tr>
<td></td>
<td>4. New position in primary care</td>
<td>4. Train pharmacists in interpersonal / presentational skills for patients and PCTs*</td>
</tr>
<tr>
<td></td>
<td>5. New partnership with social services – new money</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. New funding for LPS?</td>
<td></td>
</tr>
<tr>
<td>THREATS (T)</td>
<td>1. De-limitation of contract – reduced income</td>
<td>1. Present case to OFT for new pharmacist / patient relationship – similar to doctor – delimitation militates against improvement with quality services</td>
</tr>
<tr>
<td></td>
<td>2. Competitors, take up new role opportunities</td>
<td>2. Proceed with pharmacist training / skills upgrading – keep ahead of competition</td>
</tr>
<tr>
<td></td>
<td>3. Decreasing profit in dispensing contract</td>
<td>3. Encourage technician training and bring under umbrella of RPSGB authority – Pharmacist control of situation</td>
</tr>
<tr>
<td></td>
<td>4. LPS may weaken national contract</td>
<td>4. Proceed with new contract case</td>
</tr>
<tr>
<td></td>
<td>5. Rise of technician power – ‘take over’ dispensing*</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Author's extrapolation of the SWOT analyses from Sunderland and Gateshead LPCs into outline strategies of address. The key issues are marked thus, *
5.3.2 Section Summary

The change drivers affecting community pharmacy, as with all organisations, arise from the political, economic, sociological and technological influences of society, as well as the competitive forces of the domain. Especially is this so for pharmacy as it is part of primary care and subject to political drive and intervention. Additionally, there are the internal drivers of change arising from those members of the profession who have studied the strengths, weaknesses, opportunities and threats relating to the profession's future.

Strategic capability (fitness for the future) may be determined to some extent at least, by addressing the above factors and making appropriate responses, such as those outlined in Tables 29, 32 and 33. The PEST, SWOT, RESOURCE AUDIT and TOWS analyses all point toward similar key issues of address, which will be considered again later in this thesis.

It has not been the practice of the profession to routinely think in a structured way about its future. The RPSGB did so as a particular exercise in 1998 (Pharmacy in a New Age), but without a structured operationalisation programme to implement their strategy.

As far as the PSNC is concerned it remains to be seen whether it is capable, after its own comprehensive restructuring of engaging in a programme of effort to achieve its aims. The connection between strategy and effective change activity is now crucial to achieving transformation of the pharmaceutical service in primary care to achieve primary resource / environment fit for the future.

In seeking to reposition the profession in primary care, strategic capability is of the most fundamental importance; at PSNC level as well as the profession generally. The issue of the PSNC will again be addressed under 'leadership and management roles' later in this chapter.
5.4 THEORY OF ORGANISATIONAL DEVELOPMENT (OD)

In organisational terms, the primary care pharmaceutical profession is comprised of single independent contractors, independent vertically integrated multiples, co-operatives, independent and publicly quoted multiples. In structural / cultural terms, these equate to power cultures (independents and independent multiples) with the remaining list of companies being role cultures. The ‘profession’ of pharmacy, however, is conducted by individual pharmacists working within these commercial structures.

OD is directed at effecting beneficial change through people and, in turn, has an impact upon organisational structures and systems, dependent upon the nature of the change desired. The history of the general development of organisations has been described in the introduction to this chapter but the specialist term organisational development has a more specific meaning, derived from the early work of researchers in the 1940s, centred upon ‘group’ dynamics and individual behaviour change. A number of specific definitions which have evolved over time help clarify the concept, whilst showing slight variations in emphasis. Organisational development is:

i. (Bennis, 1969 : 2): ‘...a response to change; a complex educational strategy intended to change the beliefs, attitudes, values and structure of organisations, so that they can better adapt to new techniques, markets and challenges, and the dizzying rate of change itself’;

ii. (Margulies & Raia, 1972 : 24): ‘...a value based process of self assessment and planned change, involving specific strategies and technology, aimed at improving the overall effectiveness of an organisational system’;

iii. (Beer, 1980 : 10): ‘...enhancing congruence between organisational structure, processes, strategy, people and culture; developing new and creative organisational solutions and developing the organisation’s self renewing capacity’;
iv. (Burke, 1994: 12): ‘...planned process of change in an organisation's culture, through the utilisation of behavioural science, technologies, research and theory’;

v. (Porras & Robertson, 1992: 272): ‘...a set of behavioural-science based theories, values, strategies and techniques, aimed at the planned change of the organisational work setting, for the purpose of enhancing individual development and improving organisational performance, through the alteration of organisational members' on-the-job behaviours’; and,

vi. (Cummings & Worley, 1993: 2): ‘...a system-wide application of behavioural science knowledge, to the planned development and reinforcement of organisational strategies, structures and processes for improving an organisation's effectiveness.’

The author of this thesis contributes the following definition:

‘...enhancement of part or all of the organisation’s structure, systems, resources and culture to better equip it for improving its performance.’

There are other definitions in the literature but all ultimately relate to the behavioural change of people who, in turn, effect beneficial modifications of organisational behaviour in some way. Even when people are not mentioned as such (ii, iii and vi), they are there by implication through such terms as ‘beliefs’, ‘strategies’, (people) or ‘culture,’ which is a ‘people phenomenon’. Whilst there are clear differences in focus of definition, i.e. on technology (ii and iii); on externalities (i); and, internal efficiency (iv and v), the whole overall thrust, by implication, is toward creating greater effectiveness of the organisation's business in its domain and wider environment. In pharmacy and to a lesser extent in medicine, behavioural change will be essential in moving pharmacy into cognitive medicines service. New inter-professional relationships need developing, attended by new responsibilities for doctors and pharmacists. Some role ‘exchange’ will also be involved in transferring patient
medicines review from GP to pharmacist. This could signal inter-professional rivalry and must be avoided to achieve a smooth transition.

It is apparent that there are two main approaches to implementing change within an organisation:

- The planned approach; and,
- The emergent approach.

OD falls within the former approach and is a highly structured intervention to deliver beneficial change. The latter school of thought, views change as adaptive to the environment and is reactive to various influences when they arise on an iterative basis. Some writers go further; Pettigrew, for example, (1987 : 649 - 670) argues that prescriptive models of change do not equate to the reality of the workplace situation, which is ‘politically’ driven, either for or against change. Change efforts are thus messy and anything but systematic and continuous. The theories of change thus have not, according to Sashkin and Burke, (1987 : 401) reached an agreed synthesis.

Having said this, it seems to the author that those writers who adopt the ‘emergent’ approach and argue that issues of change can only be tackled when they arise, leave themselves to the mercy of the environment in a much more dangerous way, than those who try to plan ahead. The approach in this thesis is that having analysed in some detail future prospects for pharmacy in primary health care, there is a need for planned, systematic approach to change in pursuit of clearly identified objectives,

- repositioning pharmacy in primary health care, from the end of the supply chain to a co-authorship of medicines selection with the GP; and,

- effecting role change from simple drug supply, to full medicines management in support of patients and doctors.

In this situation, the NHS environment with its present universal restructuring and quality drive, the magnitude of change facing pharmacy is transformational, as illustrated in Figure 18. Because of the political initiatives driving change and a
specific White Paper for pharmacy, 'Pharmacy in the Future' it is the author's belief that a structured approach to change is preferred and is pursued in this thesis on the basis that future directions have been clearly signposted for the profession.

Many organisations do not have the benefit of such clear possibilities as options for the future.

**Figure 18 ORDER OF CHANGE FACING PHARMACY**

- PRIMARY HEALTH CARE

<table>
<thead>
<tr>
<th>Strategic</th>
<th>Tactical</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCOPE OF CHANGE</td>
<td>SCOPE OF CHANGE</td>
</tr>
<tr>
<td>TURNAROUND</td>
<td>REJUVENATION</td>
</tr>
<tr>
<td>TRANSFORMATION</td>
<td>ADAPTING</td>
</tr>
</tbody>
</table>

**Pharmacy in Primary Health Care**

**Note:** The above four commonly accepted categories of change show the author's perception of the order of change facing pharmacy. The transformation equates to a new order of service engaging in new doctor/patient relationships and role change for pharmacist and technician.

Diagnosis or investigation of organisational behaviour appears from the management literature to rest upon a number of precepts which have been researched or developed over time. Since the 1940s and Lewin and Trist’s work on group and individual behaviour, much modern thinking seems to derive from their research. Diagnosis of an organisation’s position in its operating environment usually forms one phase of corporate strategic decision making, even when the decision process is not highly structured, (Mintzberg et al., 1976 : 246 – 275). Deciding ‘futures’ for a ‘present’ organisation involves a review of current resources, strengths and weaknesses, to enable the planning of progress and this has been done for pharmacy, in outline, earlier in the Chapter, pp. 157, 158, 160.
Models of organisational diagnosis and intervention have been developed to focus on certain organisational features, which are held to be key areas in determining the success of the enterprise. In using models in this way, managers, consultants and researchers are assisted in guiding specific activity which is calculated to result in beneficial change. Harrison and Shirom, (1999; 11) argue that:

'...Models can contribute more directly to diagnosis than can whole bodies of theory... because models are generally simpler, less determined and less fully specified...’

Additionally, models appear to serve as frameworks for organising data for feedback and communicating it to participants in the research (via surveys), (Lundberg, 1989: 61-82; Schein, 1993: 653-661). The complexity of pharmacy’s position does require a ‘model’ approach to ensure capture and address of key relevant issues.

Surveys also, form a routine part of organisational development activity in obtaining data from individuals for analysis and feedback.

Two other perspectives, or frames of reference in organisational analysis are worthy of note. Firstly, the conceptualisation of organisations as ‘open systems’ in active exchange with their surrounding environments – external or internal, (Von Bertalanffy, 1956: 23-28). Secondly, they can be seen as political domains, where sub-surface dealing is conducted outwith recognised structures and machinery, (Bennis, 1969: 80-84; Pettigrew 1975: 191-208). Politics in organisational settings have been defined by Moyes and Allen, (1977: 672-678) as:

'...the use of power, to modify or protect an organisation’s exchange structure...’

A ‘system’ in organisation development is defined by Bertalanffy (1956: 1-10) as:

'...a set of elements standing in interaction...’
and by Hannah, (1990 : 12) as:

'...an arrangement of inter-related parts... 'arrangement'
and 'inter-related' describe inter-dependent elements forming an
entity that is the 'system'...

A system is recognised as having inputs, throughputs and outputs, each of which must be in balance with the other for efficiency and each of which has a boundary which defines it. Much of the basic theory of organisational systems comes from Trist's work in the 1950s at the Tavistock Institute, London, in his socio-technical systems research. This concept was extended in the 1960s into open systems planning, a technique for addressing the interface between the system and its environment, (Hannah, 1990 : 12). Systems theory is thus a basic tenet of OD, theory and practice and is involved in managing organisational change at some point in any change process. Systems mapping is, therefore, a useful tool to expose the key systems within any organisation and, in consequence, potential targets of change effort.

The planned approach to organisational change consequently addresses systems diagnosis by modelling the inter-related elements of the organisation. The change effort uses survey and interview work, with organisational members to provide the data. Models, consequently, serve a number of purposes; they:

- categorise data within specific organisational systems and make handling easier;
- help interpret data;
- map out trouble areas by category and give relativity to problems;
- therefore assist problem diagnosis and identify routes of change;
- provide a common shorthand language for handling complex concepts; and,
- assist understanding of the context and nature of the problem.

For this reason, a study of some of the better known models of organisational diagnosis and change is necessary to give insight and direction to the course of pharmacy change being explored in this thesis. It is also essential to the process of selecting, if possible,
an appropriate model of change on which to base change effort in moving community pharmacy from its present to future desired position with medicines management in primary health care.

Such choice, however, should not preclude the use of elements of other models if deemed necessary, as most, in any case, are rooted in Lewin's research of the 1940s in effecting behavioural change in individuals and groups.

The following section, therefore, describes and comments upon notable models of change which have been used in practice to effect change in the organisational setting. This study is essential to arrive at a conclusion as to which model is best suited to the change required for community pharmacy.

5.4.1 Models of Organisational Diagnosis and Change

The models investigated in this section of the work are:

5.4.1.1 Kurt Lewin's Model and Schein's development thereof;
5.4.1.2 Tichy's Strategic Rope Model & Tichy's framework;
5.4.1.3 The Nadler-Tushman Congruence Model;
5.4.1.4 The Berger-Sikora Change Model;
5.4.1.5 HAY Organisational Diagnosis / Change Intervention Model;
5.4.1.6 The McKinsey 7 S's;
5.4.1.7 Silverweig and Allen's Model;
5.4.1.8 Bunker & Alban – Whole Systems Change Approach;
5.4.1.9 Action Research Model;
5.4.1.10 Multi-Source Feedback;
5.4.1.11 Burke-Litwin Model of Change; and,
5.4.1.12 Weisbord's Six Box Model.
5.4.1.1 Kurt Lewin's Model of Change

As previously mentioned, Lewin was an early researcher into group dynamics and behavioural change at individual level. Whilst he viewed change as an ongoing process, he conceptualised it as taking place in three stages, (Lewin, 1951) i.e.: unfreezing the old behaviour, shifting to new behaviour, and re-freezing the new behaviour.

Lewin’s concept was later built upon by Schein, (1964; 199 - 213), Trice and Beyer, (1984 : 653 - 669) and Isabella, (1990 : 7 – 41). The phases of Lewin’s original concept were elaborated by Schein and are described below.

Unfreezing of the undesired behaviour was achieved by creating the evidence of failure of the current position and thus evoking disconfirmation that the situation as it stands is acceptable. This required, according to Schein, three different processes to motivate the individual to change. Thus *unfreezing* involves:

i. Sufficient disconfirming data to cause serious discomfort and disequilibrium in the present state;

ii. Connection of the disconfirming data to important goals, which cannot be achieved without moving – so causing anxiety and guilt; and,

iii. Sufficient psychological comfort / safety in terms of resolving the problem and changing behaviour without loss of identity or integrity; thus allowing the discomforted party (parties) to admit and accept the disconfirming data, rather than defensively deny or reject it.

This tripartite unfreezing stage related to pharmacy, may include emphasis on the progressively dwindling monetary / satisfaction position within the present national contract, together with the potential threat of strong competition for new funding from new roles. However, if the new goals for change are perceived to be so far away from current practice, even disconfirming data may be denied or rationalised and explained away, (Henderson & Clark, 1990 : 30). This could possibly be the case for pharmacy, *‘we know dispensing remuneration is going down, but we covertly make extra profit on*...
reimbursement... and new role payment may be sourced from the present global sum' (comment from Sunderland LPC).

Once unfreezing of the old perspectives has been achieved then, what Schein calls cognitive restructuring must take place to achieve the new goals. In pharmacy's case, this is complete role change from overall mechanistic dispensing processes into cognitive service with the patient and doctor. New core perspectives must then be constructed in the organisational culture; new values, beliefs and assumptions. The approach in community pharmacy may also lie in reinforcing beliefs that the pharmacist's expert knowledge can be profitably and more satisfyingly employed by applying it in a new way, in other words, through medicines management.

Such new beliefs and perspectives may then, according to the Lewin / Schein process be re-frozen by issuing confirming information. For pharmacy this may be, for example, evidence of new role acceptance by the NHS together with suitable NHS rewards and stakeholder support. This could be effected through successful pilot trials, showing real benefit to government and consequently, DH commitment to fair additional funding for pharmacists.

As Schein (1992 : 303) puts it:

'Once confirming data from important environmental sources, external stakeholders, or internal sources are produced, the new assumptions gradually stabilise...'

Research by Isabella (1990 : 7 – 41) led to re-conceptualisation, by her, of the 'unfreezing', 'moving' and 're-freezing' phases of Lewin's change model as 'anticipation', 'confirmation' and 'aftermath', as seen from the point of view of those managers having to undergo an organisational change process. Isabella relates the two approaches (Lewin's and her own) diagrammatically as follows in Figure 19, (Isabella, 1990 : 32).
Trigger events are those emergent incidents and events that signal change and may be self-evident to those within the organisation or deliberate announcements by senior management that they must change. Such triggers are said by Isabella, to be interpreted by individuals through personalisation of implications and then sense made by their interpretation. In the aftermath of change a final retrospective interpretation takes place confirming, rationalising and accepting the change through evaluation of its effects. Thus, the research offers a different interpretation of resistance to change, i.e. it can be viewed as ‘...elements of the cognitive transition of individuals occurring during change...’ Rather than trying to overcome resistance then, this model suggests using these deeper level elements to assist people through the transition stage, in other words by acknowledging concerns and helping people to interpret prospective change in a positive way by suggesting balanced perspectives. Trigger events in pharmacy can be considered to be all government initiatives to encourage change in pharmacy (the White and Green Papers, Chapter 1 : 12) since Gerrard Vaughn in 1981.
The theory of the Lewin and Schein / Isabella elaboration models has an attractive natural logic and contextualised in community pharmacy appears to have a sound basis for application. The present political and economic climate with the NHS would seem to provide powerful 'unfreezing forces' for the engagement of these models. In this overall model, individual cultural perceptions, behaviours and trigger events are of key importance.

5.4.1.2 **Tichy's Framework Model & Strategic Rope**

*Tichy's Strategic Framework*

In this concept, Tichy set out, (1983: 72) nine organisational 'levers' for change, illustrated in Figure 20.

**Figure 20**  **TICHY'S FRAMEWORK**

![Tichy's Framework Model](image)
Superimposed on this model of change, through his nine change levers, he uniquely overlays three further influences or systems, which he called a 'strategic rope':

- **Technical** - Production methods; management systems; structural design: resources. (In pharmacy, the system of dispensing process; ordering drugs; stocktaking; stock rotation; quality assurance; equipment.);

- **Political** - Power; leadership; decision making; staff relations; and,

- **Cultural** - Tradition; professional protocols; assumptions of ethics; hierarchy of staff; rights in law.

**Strategic Rope**

The 'strategic rope' concept derives from the degree of integration of the above three components, or indeed the lack of co-ordination of all three influences. The concept is illustrated in Figure 21, (Tichy, 1983 : 12):

**Figure 21  TICHY'S STRATEGIC ROPE MODEL**
To analyse the organisational situation before using the model and to expose key alignments, he used a matrix, with the ‘rope’ on the Y axis and his ‘framework’ as the X axis, in Table 34:

**Table 34  TICHY’S TECHNICAL POLITICAL CULTURAL MATRIX OF ALIGNMENT**

<table>
<thead>
<tr>
<th>MISSION STRATEGY</th>
<th>TASKS</th>
<th>PRESCRIBED NETWORK</th>
<th>PEOPLE</th>
<th>PROCESSES</th>
<th>EMERGENT NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Rope</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Amount of component change required

The matrix is simple in concept, but because of the strands of each variable requires thorough analysis of the organisational situation in each component as described above. Culture is a major issue, for the medical and pharmaceutical professions, with long embedded traditions and concepts which each may have of their respective places in health care.

Lacking in this model is, of course, address of attitude change at individual behavioural level and this is acknowledged in Tichy’s book (1983) as a certain skimming over of the psychological issues.

5.4.1.3 The Nadler and Tushman Congruence Model for Organisation Analysis

The key issue of address here is ‘congruence’, or the degree to which needs, goals, demands, objectives and structure, ‘fit’ with the same elements of other systems defined by the model (Nadler & Tushman, 1992 : 39 – 59), for example the systems of inputs
and systems of outputs. The relationship of the constructs and elements is shown in Figure 22.

**Figure 22**  \textbf{THE NADLER AND TUSHMAN CONGRUENCE MODEL OF ORGANISATION PERFORMANCE}

Nadler and Tushman view the organisation firstly as being the processor of inputs from the environment that is; resources, threats and opportunities and the effects of its own history (programmed / traditional attitudes). Secondly, it deals with these through its people, structures and systems and produces outputs at the three levels; individual; group; and, organisation, to give ideally, effective consideration of the business environment, thus meeting the organisational goals.

In analysing the degree of organisational effectiveness, the internal \textit{transformation process} is the target of address. According to Nadler and Tushman, this comprises four principal components:

i. Task of the organisation - its key resource and objectives;
The balanced relationship of these four with each other and therefore, the degree of suitable congruence is held to be essential to organisational efficiency. If, for example, the 'task' of the operation is not matched by the competence of the individuals, then there is no 'fit' or hope of achieving the output objectives. A fairly obvious conclusion to draw, but current staff competencies which match the current task, may actually not be adequate for strategic transformation into a future different task. In pharmacy, this may equate to current pharmacist/technician competence being conceivably inadequate for the new role of medicines management. The technician competence of the future will at least lie in the ability to deliver accurate dispensing plus a competent checking ability for quality assurance. Pharmacist competence revolves around knowledge of clinical pharmacology and interpersonal skills for patient dialogue. Cultural mindsets in pharmacy will affect the ease or difficulty of change in technician responsibility.

5.4.1.4 Berger-Sikora Culture Change Road Map

This model was developed by the Lance A. Berger and Associates Inc., Consultancy in the U.S.A. As previous Chief Executive of the HAY Group, Berger's clients have included Du Pont, GTE International and Pepsi Cola. The evidence for the validity of this model is the success enjoyed in transforming organisational cultures through using it as a 'road map' to encouraging change. Their template rests on the proposition that successful organisational change results from alteration of systems, skills and structure, which, according to them, affect organisational culture. Skills in this sense equates to competencies. This model is diagrammatically set out in Figure 23 and relates to pharmacy's position in primary care with its present skills and current systems for
liaising with the medical profession. Is community pharmacy clinically qualified for MM? Are its systems adequate for coping with this new intervention? Is the structure of pharmacy and medicine congruent with the new demands of MM?

Figure 23 THE CULTURE CHANGE ROAD MAP

Note: Critical success factors are determined by assessing what is required to achieve the vision and the structure, skills and systems altered accordingly. Behavioural change is thus encouraged.

Structure, skills and systems are described as levers of change in the process of changing individual's behaviour to give improved performance. Berger and Sikora cite Kotter and Heskett, (1992: 11) in '...their empirical study of the impact of culture on organisational performance', as having found that there are '...adaptive cultures and performance degrading cultures...’ that improve or diminish respectively the financial performance of the company. Whatever the future vision for a company or organisation, mechanisms to deliver the vision must be put in place for successful change to be delivered; it will not just happen, (Berger & Sikora, 1994: 320). These mechanisms will include appropriate systems, structures and skills that govern individual behaviour, (1994: 320).

The critical success factors (CSFs) in the above scheme are, according to Irwin and Michaels, (1989 : 4 – 19) what the organisation must address to deliver its strategy. Similar concepts have been confirmed by Stalk et al., (1992 : 57 – 69) but calling them capabilities.
Lasting culture change, argue Berger and Sikora, requires a strong link from CSFs to individual, as well as organisation level behaviours, in other words, systems, skills and structures. Schein’s disconfirmation strategy is again an important means of helping to create this link (1992: 303).

Pharmacy’s clinical abilities are again exposed as an issue in the role change in considering the critical success factors of the dispensing pharmacy service in new medicines management. Will these devolve around professional abilities, premises facilities, inter-professional relationships and support staff or simply new systems and procedures, or both? The full research will help clarify these issues.

5.4.1.5 HAY Organisation Diagnosis Model

This model encompasses the Nadler-Tushman principles, as well as the elements of the Berger-Sikora Road Map. It also describes the detailed inputs and outputs of the Nadler-Tushman model and by implication the levers of the Berger Sikora Road Map, through its elements of people, structure and processes.

Strategy and culture are again major issues of address in this construct, as with the former two models. The diagrammatic representation is set out in Figure 24 and comprehensively addresses all elements so far described in the foregoing models. It is partly derived from the Burke-Litwin model described later and more detailed discussion will be set out under that model.
Figure 24  THE ORGANISATION DIAGNOSIS MODEL - HAY

NOW  TRANSFORMATION PROCESS  FUTURE

THE CHALLENGE
- The Market
- Competitors
- Suppliers
- Media
- Public
- Government
- Stockholders

RESOURCES
- Base Operations
- Technology
- People
- Budget

CULTURE
- Values
- Norms
- Symbols
- History

PURPOSE
- Reason for Being:
  - Existence

STRUCTURE
- Division of Labour
- Distribution of Power
- Co-ordination
- Specialisation
- Integration

TECHNOLOGY
- Tools / Equipment
- Machinery
- Electronic Media
- Knowledge & Data

TASKS
- Diversity
- Difficulty
- Variability

LEADERSHIP
- Vision
- Awareness
- Attention
- Assumptions
- Visibility

PROCESSES
- Decision Making
- Information Channel
- Management Systems
- Methods & Practices

PEOPLE
- Training
- Selection
- Recruiting
- Transfer
- Development
- Location
- Environment

REWARDS
- Compensation
- Promotion
- Job Design
- Evaluation
- Inherent Reward

PRODUCT/SERVICE
- Quality
- Customer Satisfaction
- Profitability

ORGANISATIONAL
- Goal Attainment
- Resource Utilisation
- Adaptability
- Service to Community
- Shared Sense of Purpose

GROUP/UNIT
- Productiveness
- Readiness
- Cohesiveness

INDIVIDUAL
- Task Performance
- Job Satisfaction
- Health
- Quality of Work Life
- Loyalty

FEEDBACK
5.4.1.6  *McKinsey 7S’s Model of Change*

This model was used in the modernisation of British Telecom, West London District, a sub-unit of BT, with a staff of circa 6,000 and a multi-million pound turnover, (Price & Murphy, 1987 : 45 – 48). Following individual group interviews and postal survey questionnaires, the Board met to discuss and answer the questions:

- Where are we now?; and,
- Where do we want to be?

and then agree how change could be effected. The 'fish bone' chart (Figure 25) was used to assist the process.

*Figure 25  FISHBONE CHART SHOWING STRATEGY FOR CHANGE*

![Fishbone Chart]

It was after encountering difficulty in setting objectives en route to change, that the McKinsey 7S’s were used to help identify the key issues of address. The McKinsey framework focuses attention on seven inter-dependencies that are prime determinants of organisational success, (Peters & Waterman, 1982 : 71). These are:

- a clear organisational corporate strategy;
• skills of the organisation as a whole;
• the systems used by the organisation;
• the organisational structure;
• the staff quality / competencies;
• shared values of members toward collaboration / innovation; and,
• style of management, i.e. autocratic or democratic.

These are diagrammatically represented in Figure 26.

Figure 26  McKinsey 7S’s Model of Change

This is similar to, but less detailed than, the HAY model shown in Figure 24.

When an organisation is viewed as a network of interdependent parts as in this model, then major and sometimes minor changes in one sector affect all the others in some degree. This is also the case with resistance in one area, leading to blocking of change in another.

In task changes, the duties of individuals are changed; in staff changes, individual knowledge, skills and attitudes are modified in some way; systems changes focus on procedures, work flows and use of technology (for example, I.T.); and, structural alterations change the grouping of staff procedures used to guide personnel interactions / work relationships. Like other models, culture, (through shared values), is crucial to working collaboratively to the same strategy. The McKinsey consultancy has used this
model extensively, with such worldwide corporations as General Electric, General Motors and the Pepsi Cola company. The relevance to pharmacy is in the task change and staff skills change, together with inter-professional systems changes, which all must be addressed.

5.4.1.7 The Normative Systems Model

This model was constructed by Silverweig and Allen, (1976: 33 – 49) and is a four stage process, geared to changing what they describe as the 'norms' of the organisation, as perceived by the employers and leaders. Although comprehensive in its address of the levels of organisation structure, in other words, individual, group and leadership, it appears to have narrowly defined culture. They perceived this as being a set of 'norms' of the organisation as generally accepted by all employees, rather than also taking account of the more deeply held assumptions, beliefs and values of the paradigm, which would more correctly be regarded as the core of culture. The stages are shown in Figure 27.

Figure 27 NORMATIVE SYSTEMS MODEL

The stages they propose are summarised in Table 35:
## Table 35: STAGES AND ELEMENTS OF ORGANISATIONAL CHANGE THROUGH CULTURE MOVEMENT

<table>
<thead>
<tr>
<th>PHASE</th>
<th>DETAIL</th>
<th>IMPLEMENTATION</th>
</tr>
</thead>
</table>
| Stage 1: Analyse existing culture; establish 'norm' gap between existing and desired culture - 8 influences:  
  - Leadership - modelling behaviour  
  - Work team culture  
  - Organisational policies and procedures  
  - Training facilities  
  - Information and communications systems  
  - 1st line supervisor performance  
  - Performance/reward system  
  - Results orientations  |  
  - Words; actions; envisioning futures; changing emphases - exercises influence on employees  
  - Work teams develop own norms and ways of doing things - implement change here  
  - Can change organisation priorities and emphasis  
  - Develop competencies  
  - Persuasive; inspirational; leader sponsorship - role modelling  
  - The bridge between management and staff. Influence applied here is important  
  - That which is appraised or rewarded influences behaviours; helps drive cultural change  
  - Agreed measurable objectives at outset of change programme; enables directional drive and demonstrates satisfaction | Through worker discussion groups; opinion makers; leaders; individual, group, discussions and interviews; organisation wide surveys; publish results with objectives and 'necessity rationale' |
| Stage 2: Experiencing the desired culture: systems introduction - 5 influences  
  - Arrange discussion which identifies preferred culture  
  - Rehearse frustrations with present culture  
  - Construct new 'norms' and practice in selected work groups  
  - Experience the benefits and satisfaction  
  - Commit to new objectives which drive forward | All members of workplace are given opportunities to participate and experience a better way of working |
| Stage 3: Modify existing culture by systems installation  
  - Focus on culture influences identified in Phase 1  
  - Recategorise all junior levels of leadership  
  - Create action/study terms  
  - All teams meet regularly to modify their culture | Retrain line managers/supervisors by mentors who have on-the-job success record - strengthen and enact leader behaviours  
  Brief to identify problems and propose solutions in each of the 8 original influence areas  
  Discuss critical issues and problems | Construct involvement workshops to give impactful experiences which will be enjoyed and remembered. Measure change in general workplace compared to these |
| Stage 4: Maintain desired culture; ongoing evaluation and renewal  
  - Involve all employees  
  - Emphasis on results  
  - A total systems approach  
  - Build win-win solutions | Publish and celebrate success. Programme continuing appraisal and adjustment  
  Measure; notify participants; evaluate  
  Review policies and behaviours in all work systems for weaknesses and beneficial change opportunity | Build on previous strengths and introduce new techniques for greater success  
  Train team leaders - enables development of work groups as necessary  
  In-house bulletins; letters; house magazine  
  Regular written and verbal communications  
  Use work groups - study/action teams to implement and evaluate |

Note: This table exemplifies the Silverweig and Allen stages of culture change, through altering the 'norms' of the organisation. (Silverweig & Allen, 1976: 33 - 49)
Although this model, according to some researchers, is deficient because it does not address the deeper cultural issues, (Ogbonna, 1993: 42–54) such as personal/group values and beliefs, it nevertheless is a route to engineering change in working practice. This involves the whole organisation membership from leaders to operatives. It has themes of Lewin's original concepts of unfreezing, shifting and re-freezing culture, as he saw it. It may be applicable to pharmacy in seeking to avoid the complex work of culture change in depth and simply pursue behaviour change to deliver the new role and services.

5.4.1.8 The Whole Systems Change Approach

This is a highly complex organisation-wide intervention at all levels of the organisation and where necessary, on a global scale for international companies. It also enables organisation development practitioners to work in parallel with environmental stakeholder interests, which are crucial in effecting change of this scale. The process relies upon individual interviews and written survey feedback. The full range of employees is involved.

This approach aligns the internal organisational environment and its systems with the external environment and is applicable where, according to C. and W.A. Adams, (1999: 141):

- the present service offering is inadequate;
- there is an urgent need to change – driven by environmental forces;
- opportunity for creating new approaches to the 'domain' will add substantial value; and,
- competitive forces are showing real threat of blocking future development and marginalising the current service/product offering.

All systems in the organisation are reviewed, modified or recreated in alignment with each other and integrated in terms of operational workflow and objectives. Bunker and Alban, (1997: 31, 97, 157) set out three classifications of large scale intervention, each with four routes of accomplishment, which have emerged in the last decade or so from
different researchers. These are shown in, Tables 36, 37 and 38. Classification is by desired outcome, in other words, creating a future; (Table 36) work redesign; (Table 37) and problem solving, (Table 38) all of which are applicable to pharmacy but perhaps too complex for use in the pharmacy context.

Table 36  LARGE GROUP METHODS FOR CREATING THE FUTURE

<table>
<thead>
<tr>
<th>THE SEARCH CONFERENCE</th>
<th>FUTURE SEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong> To Create a Future Vision</td>
<td><strong>Purpose:</strong> To Create a Future Vision</td>
</tr>
<tr>
<td>Merrelyn and Fred Emery</td>
<td>Weisbord and Janoff</td>
</tr>
</tbody>
</table>

- Set Format: Environmental Scan
- Criteria for Participants: Within System Boundary
- Theory: Participative Democracy
- Search for Common Ground
- Rationalise Conflict
- No Experts
- Total Community Discussion
- 35 to 40+ Participants
- 1/3 Total Time is Action Planning

- Stakeholder Participation, No Experts
- Minimises Differences
- Search for Common Ground
- Self Managed Small Groups
- 18 Hours over 3 Days
- 40 to 80+ Participants
- Larger Groups = Multisearch Conference

<table>
<thead>
<tr>
<th>REAL TIME STRATEGIC CHANGE</th>
<th>ICA STRATEGIC PLANNING PROCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong> To Create a Preferred Future with System-Wide Action Planning</td>
<td><strong>Purpose:</strong> Strategic Planning</td>
</tr>
<tr>
<td>Dannemiller and Jacobs</td>
<td></td>
</tr>
</tbody>
</table>

- Format Custom-Designed to Issue
- Highly Structured and Organised
- Theory: Beckhard Change Model
- Common Data Base
- 2 to 3 Days + Follow-up Events
- Use of Outside Experts as Appropriate
- Use of Small Groups and Total Community
- Self Managed Small Groups
- 100 to 2,400 Participants
- Logistics Competence Critical
- Daily Participant Feedback
- Planning Committee and Consultants Design Events

- Focus Question
- Implementation Time Line
- Strategic Actions
- Underlying Contradictions
- Strategic Directions

- Stakeholder Participation
- 2 to 7 Days
- 50 to 200 Participants
- Planning Committee and Consultants Design Events

(Bunker & Alban, 1997: 31)
Table 37 LARGE GROUP METHODS FOR WORK REDESIGN

<table>
<thead>
<tr>
<th>THE CONFERENCE MODEL</th>
<th>FAST CYCLE FULL PARTICIPATION WORK DESIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dick and Emily Axelrod</td>
<td>Pasmore, Fitz and Frank</td>
</tr>
<tr>
<td>- System Wide Pre-conference Education</td>
<td>- Orientation Events Educate and Include Everyone</td>
</tr>
<tr>
<td>- Design Process in Five Conferences</td>
<td>- Five Meetings</td>
</tr>
<tr>
<td>- Vision</td>
<td>- Future Search (2 Days)</td>
</tr>
<tr>
<td>- Customer</td>
<td>- Meeting External Expectations (1 Day)</td>
</tr>
<tr>
<td>- Technical</td>
<td>- Work Systems Analysis (2 to 3 Days)</td>
</tr>
<tr>
<td>- Design</td>
<td>- Work Life Analysis (1 Day)</td>
</tr>
<tr>
<td>- Implementation</td>
<td>- New Design and Implementation (4+ Days)</td>
</tr>
<tr>
<td>- Three Weeks Between Conferences</td>
<td>- Up to 120 Attend Meetings</td>
</tr>
<tr>
<td>- 2+ Days for Each Conference</td>
<td>- Parallel Design of Support Process Changes</td>
</tr>
<tr>
<td>- Data Assist Teams Work Between Meetings to Involve Larger Organisation</td>
<td>- 1/3 of System Participation Goal</td>
</tr>
<tr>
<td>- 80+ Participants, Parallel Conferences for Larger Groups</td>
<td>- Design Ratification Events Include Everyone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REAL TIME WORK DESIGN</th>
<th>PARTICIPATIVE DESIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dannemiller and Tolchinsky</td>
<td>Fred and Merrelyn Emery</td>
</tr>
<tr>
<td>- Whole System Present at Launch and Implementation</td>
<td>- Bottom-up Process</td>
</tr>
<tr>
<td>- 50 to 2,400 Participants</td>
<td>- Company –Wide Education is First Step</td>
</tr>
<tr>
<td>- 1-Day Conferences on Key Administrative Support Issues</td>
<td>- Basic Principle: Each Level Co-ordinates and Controls Its Own Work</td>
</tr>
<tr>
<td>- Design Team Manages Process and Does Micro-Work</td>
<td>- Each Unit Designs Its Own Work</td>
</tr>
<tr>
<td>- Implementation Team Oversees Mini-Conferences</td>
<td>- Six Design Principles Used to Redesign Work</td>
</tr>
<tr>
<td></td>
<td>- Multiskilling is the Norm</td>
</tr>
</tbody>
</table>

(Bunker & Alban, 1997: 97)
### Table 38  WHOLE SYSTEM PARTICIPATIVE WORK – PROBLEM SOLVING

<table>
<thead>
<tr>
<th>SIMU-REAL</th>
<th>WORK-OUT (GENERAL ELECTRIC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose: Real-Time Work on Current Issues, Test Future Designs, Learn About System <em>Donald and Alan Klein</em></td>
<td>Purpose: Problem Identification and Process Improvement</td>
</tr>
<tr>
<td>- Organisation Selects Issue for Work</td>
<td>- Improvement Target Selected</td>
</tr>
<tr>
<td>- Room Arrangement Reflects Organisation's Structure</td>
<td>- Employee Cross-Functional Meeting</td>
</tr>
<tr>
<td>- People Act Their Organisational Role</td>
<td>- Process: Discuss and Recommend</td>
</tr>
<tr>
<td>- Decision Process Agreed to in Advance</td>
<td>- Senior Management Responds Immediately</td>
</tr>
<tr>
<td>- 1 Day</td>
<td>- Champions and Sponsors Follow Through to Implementation</td>
</tr>
<tr>
<td>- 50 to 150 People</td>
<td>- Follow-up as Needed</td>
</tr>
<tr>
<td>- Facilitator Needs Expertise to Process Consultation</td>
<td>- 1 to 2 Days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LARGE SCALE INTERACTIVE EVENTS</th>
<th>OPEN SPACE TECHNOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose: Problem Solving <em>Dannemiller and Jacobs</em></td>
<td>Purpose: Discussion and Exploration of Systems Issues <em>Harrison Owen</em></td>
</tr>
<tr>
<td>Uses Same Methodology as Real Time Strategic Change</td>
<td>- Least Structured of Large Group Technologies</td>
</tr>
<tr>
<td>See Description in Table 36</td>
<td>- Divergent Process</td>
</tr>
<tr>
<td>- Many Different Uses</td>
<td>- Large Group Creates Agenda Topics</td>
</tr>
<tr>
<td></td>
<td>- Interest Groups Forum Around Topics</td>
</tr>
<tr>
<td></td>
<td>- Periodic Town Meetings for Sharing Information Across Interest Groups</td>
</tr>
<tr>
<td></td>
<td>- One Facilitator Lays Out Format, Ground Rules, 'Holds the Space'</td>
</tr>
<tr>
<td></td>
<td>- Requires an Understanding of Large Group Dynamics</td>
</tr>
<tr>
<td></td>
<td>- 1 to 3 Days</td>
</tr>
</tbody>
</table>

(Bunker & Alban, 1997 : 157)
The large scale interventions approach is geared to become an inherent part of the business operation and thence, sustainable change. Holman and Devane, (1999: 153) set out three recommendations for sustaining the results of large scale interventions:

1. Ensure that 'running' the business is consistent with 'changing' the business, in other words, if large group participation is used to change the business, then use this to run the business;
2. Build organisational self reliance through reinforcing new behaviours and systems, building the core competence of self reliance; and,
3. Sustain resource capacity by giving the same focus on resources as was given in changing the business.

The whole system performance management model can be diagrammatically represented as follows in Figure 28. This connects leadership; teaming; morale; emotions; personal characteristics; critical customer behaviour; and, organisation _climate_. (Cady, 1995 : 43 – 56; Church, 1995 : 25 – 31; Church & Waclawski, 2002 : 131).

![Figure 28 THE WHOLE 'SYSTEM' PERFORMANCE MANAGEMENT MODEL](image)

Note: 'Climate' in organisational context means, employee perceptions of organisational elements such as norms of work, leadership style and control, decision making, personnel relationships, (derived from: Harrison & Shirom, 1999 : 213).
The model is designed to show the inter-relationship between personal behaviours and performances at various levels of the organisation and identify appropriate interventions. The steps in the intervention process, according to these researchers are:

1. Evaluate the existing practices and understand relationships – implicit and explicit;

2. Enhance existing model and measures of performance; clarify understanding of the system;

3. Implement data collection model and benchmark performance;

4. Diagram the predictive (customised model); and,

5. Action: facilitate group discussions to deliver appropriate action for change.

At first sight the scale of the ‘whole systems’ intervention may look attractive for application to the large scale of primary care pharmacy, but unfortunately, the latter is comprised of many small sub-organisations with their own cultures and some common systems. Parts of the large scale intervention, on the other hand, could be useful, such as the ‘survey feedback’ and confirming methods of communication. This will be explored as action research, as follows.

5.4.1.9 Action Research Model (AR)

Action research as originally conceived by Kurt Lewin, (1946 : 34 – 46) was defined as:

'...A spiral of steps, each of which is composed of a circle of planning, action and fact finding about the results of the action.'
In the 1990s, action research as an ongoing practice was defined by French and Bell, (1995 : 138) as:

'...A process of systematically collecting research data about an ongoing system, relative to some objective, goal or need of that system; feeding this data back into the system; taking action by altering selected variables within the system, based on both the data and hypotheses and evaluating the results of actions by collecting more data...' 

However, French and Bell (1995 : 140) go on to point out that action research can also be used as an approach to problem solving and therefore, is an intervention model in organisational improvement. Thus used, they define it as:

'...the application of the scientific method of fact finding and experimentation to practical problems requiring action solutions and involving the collaboration and co-operation of scientists, practitioners and lay persons...' 

Rollinson (2002 : 669) defines AR more succinctly as:

'...a participative method of effecting change in human behaviour that involves stages of data collection, problem diagnosis, action planning, action and re-evaluation...' 

Although identified in the literature as a distinct model of change in organisation development, it could be regarded as an underpinning methodology of many OD interventions, in terms of its survey research and feedback process.

Chein, Cook and Harding, (1948 : 43 – 50) set out four varieties of action research:

i. diagnostic - a problem situation that needs diagnosing and remedial action taken;

ii. participant - here, the people who are ultimately to take action,
are involved in the research from the beginning and 'own' the process;

iii. empirical - here the person who has to undergo change keeps a comprehensive record of the action taken and the effects it had. Clinical data from this activity may be flawed, because of the layman's approach; and,

iv. experimental - this is controlled research on the relative effectiveness of various action techniques, to find the best way of effecting change.

The foregoing authors are of the view that the experimental variety may make the most useful contribution to scientific knowledge. Argyris, (1983 : 115) argued that, action research, should be characterised by six elements:

i. It should be problem driven;
ii. It should be client centred;
iii. It should challenge the status quo;
iv. produce empirically disconfirmable propositions;
v. propositions could be inter-related into a theory; and,
vi. be useable in every day life (of the person or organisation).

He called this approach action science and expressed the view that this is similar to participative action research, (Argyris & Schon, 1989 : 612 - 623). Weisbord, (1987 : 196 - 252) devised a new approach to action research, which starts not with the problem, but the strengths of the situation and the potential and desired future. Through his review of a series of action research projects, he discerned that the most successful were not what the organisational development consultant wanted to do, but what the organisational members wanted, having understood the need for change.

Action research, like Lewin's original group work, seems to be an essential generic process in diagnosing and correcting organisational deficiencies. Through surveys researching employee views, followed by iterative action / feedback, action research is
used in many of the models so far discussed. It may be diagrammatically represented in Figure 29. (Rollinson, 2002: 670)

Figure 29  THE ACTION RESEARCH INTERVENTION

Church et al., (2002: 27) view action research as 'one of three fundamental dimensions' of organisational development, that is:

i. action research itself;

ii. understanding the organisation as a number of related systems; and,

iii. a normative values-based framework in which individual, as well as organisational improvement is effected.

They go on to say:

'...Collecting behaviourally based data about how individuals, groups, teams or an entire management population act on a day to day basis, is central to understanding, diagnosing, energising (through feedback) and ultimately improving that organisational system.'
As matters progress with pilot trials of medicines management, action research may become an important feature of service development in pharmacy. This leads to consideration of the next model, described as multi source feedback.

5.4.1.10 Multi-Source Feedback Process for Change

This process consists of collecting information on individuals from their peers, clients, customers and suppliers; amalgamating the information into a structured report and feeding back to the individual of focus. This may be a facilitated process, or relatively informal but using the information to drive behaviour change. This method gained popularity in the 1990s, (Bracken, 1994: 44 – 45).

It is based upon the psychology that any individual will feel a strong need to reduce discrepancy between their self view and the discordant view (if any) of others in the peer group. Self regulatory response in this way enhances self reflection and corrective action. At the feedback point, three issues are important to ensure the best effect of the feedback information:

1. Confidence that the process and technique of data collection was fair and appropriate;

2. The outcome (the data information) is perceived as positive, even when negative issues emerge; and,

3. Delivery of the outcome data is perceived as positive help and constructively administered (i.e. not destructive criticism).

As Brockner and Wisenfeld, (1996 : 189 – 208) have argued, matters of procedural justice and fairness in this context are crucial. Process and outcome treatment are key issues.

It can be seen that multi-source feedback is time costly and a complex process to be handled by competent practitioners. The process is administered at individual, group,
team and whole division levels. In these cases, perceptions of the whole entity are sought from related stakeholders, related divisions, suppliers and customers.

The principles involved are as Lewin’s original work on group feedback, of how people interact and perceive one another. Organisational strengths and weaknesses relating to key competencies can be revealed in this way and change effort directed to specific developmental programmes.

Multi-source feedback, interestingly, was used to effect organisational change and amalgamation in the Smith Kline Beecham merger, to communicate the new ‘core values’ to employees, (Burke & Jackson, 1991: 65 – 87).

In the large scale data analysis for the feedback sessions, cultural trends can be detected from such issues that are more highly ranked / rated on the formalised survey sheets. This can be of key importance in understanding the inter-relationships of the group(ings) and so help management in directing appropriate effort for change.

However, according to Church, (1999: 7 – 8) exploring relationships and cultural trends in this way is not widespread. Multi-source feedback is thus a potent tool for engineering behavioural change at individual level as well as diagnosing areas for development across the organisation.

In the view of the author of this thesis, this is a less practical route to engineering change in community pharmacy with its multitude of outlets and restricted resources within independent pharmacy. Other models at this stage appear more realistic.

The model is summed up in Figure 30.
Figure 30  MULTISOURCE FEEDBACK PROCESS FOR BEHAVIOURAL CHANGE

(Church & Wadowski, 1998 : 82)

Abbreviations:

OD  Organisational Development
I/O  Industrial/Organisational Psychology Techniques
HRD  Human Resource Development

Note: The sources of information to the left of the model provide information on the individual, group, or division of the organisation and feedback for self-assessment and change behaviour. Facilitation may be used.
Original work underlying this model was researched by Litwin and Stringer, (1968) and Tagiuri and Litwin, (1968) whilst investigating motivation and organisational climate. The latter, they argued, was created by such effects as employer / employee behaviour and relationships, as perceived by both, along with group norms and values. Climate is thus associated with the daily transactional issues of the work groups, whilst culture is concerned with processes of human transformation, relating to deeply held values, assumptions and beliefs in the work place. The literature indicates that the distinguishing features of transformational and transactional concepts have been influenced by the formative work of J.M. Burns, (1978 : 3) relating to leadership studies, as well as other researchers such as Zaleznik, (1977 : 67 – 78) and Bass, (1997 : 130 – 139). Burns classified transactional political leaders as ‘bargainers’, or ‘bureaucrats’, ‘legislators’ and ‘executors’. Transformational leaders he categorised as ‘...intellectuals, leaders of reform or revolution and heroes of ideologies’, (1978 : 3).

Robbins, (1989 : 329) a decade later defined transactional leaders as those who:

‘...guide or motivate their followers in the direction of established goals by clarifying role and task requirements...’

and transformational leaders as those who:

‘...inspire followers to transcend their own self interest for the good of the organisation and who are capable of having a profound and extraordinary effect on their followers...’

Burke developed his model during major redevelopment work at British Airways in the 1980s. The point is that Burke and Litwin see OD interventions, which are directed at ‘leadership’, ‘mission’, ‘strategy’ and ‘culture’ as transformational. Those which are directed at structural change, management practices and systems are seen as transactional and affect organisation climate, not culture. Reichers and Schneider, (1990 : 5 – 39) however, believe there is overlap between the two concepts and Burke himself, (1993 : 17) regards the two issues as similar but with important differences.
Climate, it seems, is the manifestation of culture. The relationship of culture to climate can be compared to that between individual personality and behaviour. Targeting climate change, therefore, through managerial behaviour change, is a practical route which may, in turn, help to begin culture change. This may be the simpler route for pharmacy.

The two parts of the Burke-Litwin model are shown in Figures 31 and 32 and integrated on the next page in Figure 33:

**Figure 31**  BURKE-LITWIN MODEL OF CHANGE TRANSFORMATIONAL FACTORS

**Figure 32**  BURKE-LITWIN MODEL OF CHANGE TRANSACTIONAL FACTORS
Organisation Levers
Levers which are relevant for achieving change through people

- **EXTERNAL ENVIRONMENT**: Any outside condition or situation that influences the performance of the organisation.

- **STRATEGIC INTENT**
  - (MISSION STRATEGY)
  - a) What top management declares it to be!
  - b) What employees believe is the central purpose of the organisation.

- **LEADERSHIP**: Executives providing overall direction and serving as behavioural role models for employees.

- **CULTURE**: The way we do things around here. The collection of overt and covert rules, values and principles that ensures and guides organisational behaviour.

- **BUSINESS PROCESS & STRUCTURE**: Arrangement of workflow, functions and people into specific areas and levels of responsibility, decision making, authority.

- **MANAGEMENT PRACTICES AND STYLE**: What they do in the normal course of events to use the human and material resources to carry out the strategy.

- **SYSTEMS POLICIES & STRUCTURES**: The standard policies and mechanisms that facilitate work, (e.g. HR systems and also accounting systems) IT systems and the impact these have.

- **WORK GROUP CLIMATE**: The collective current impressions, feelings and expectations that members have, that affect the relationship with boss, each other and non members.

- **TASK & INDIVIDUAL CAPABILITY**: Work processes and role requirements; the required skills, knowledge and behaviour to accomplish assigned work and responsibilities.

- **INDIVIDUAL NEEDS AND VALUES**: The enduring thoughts and feelings employees apply to determine the worth and satisfaction of their work. Also Remuneration and development.

- **MOTIVATION**: The behavioural tendencies to move towards goals, take needed action and persist until satisfaction is attained.

- **FEEDBACK LOOP**: The relationship with boss, each other and non members.

*Burke & Litwin, 1989: 277*
This model does not emphasise 'congruence' of internal systems or 'alignment', as does the Nadler-Tushman model, but does imply environmental 'fit' with 'leadership', 'mission and strategy' and 'culture'. It is a complex model, dealing comprehensively with the human and systems aspects of organisations and the input of the environment. The model should, according to Burke, be represented holographically, not two dimensionally, as in all systems theory, changing one factor will affect the others at some stage.

It could be represented in a similar way to the Nadler-Tushman model, in other words, with inputs (environment) on the left and outputs (individual and organisational performance) on the right, with all the other elements in between as throughputs. Information for addressing the various components is obtained by individual interview and surveys, (very like action research). A change agent, helping organisations to change would interview up to 30 representative individuals to gather indicative information. From the findings, which would be checked with another sample and dependent upon a requirement for transformation, or simply transaction adjustments, a suitable change programme is constructed. The original British Airways privatisation was an instance where the whole model was used (Goodstein & Burke, 1991: 5 – 17).

It may be particularly suitable for application to the current situation facing community pharmacy in the NHS. It appears at this stage to have a suitable mix of the relevant issues with which pharmacy is faced at present, both strategic, in terms of leadership, mission / strategy, culture and transactional in terms of task requirements / individual skills / abilities, motivation, individual needs and values, systems, policies, procedures and management practices. All these elements are likely to be affected in the role change of both pharmacist and technician as well as new pharmacist / doctor communications. The transactional elements are relatively easy to implement.

5.4.1.12 Weisbord's 6 – Box Model

Developed in the early 1970s, Weisbord conceptualises his model as a radar screen, which will from time-to-time exhibit 'blips' that inform the observer about key variables, good and bad. He identifies six crucial areas of organisation, where activity
must be right for organisational success. The model outline is shown in Figure 34 (Weisbord, 1976: 430 – 447).

**Figure 34** WEISBORD'S 6 - BOX MODEL OF CHANGE

Each box is diagnosed and analysed for both its formal and informal systems. Key to his rationale is the gap, if any, between the formal systems of the organisation and its informal arrangements. The larger the gap, the more ineffective the organisation. Key diagnostic questions attach to each box to enable the gaps to be exposed.

The issue of 'leadership' (at all levels) is central in his view to organisational health and efficiency. His formalised route to establishing the current status of organisational health is via a diagnostic matrix, which specifies the elements of address most significant to each box. These questions expose the formal and informal systems, which are operating simultaneously in each of the 6 dimensions of the model and discern the internal dissatisfaction with outcomes or outputs of the organisation. The matrix is shown in Table 39.
Table 39  WEISBORD’S MATRIX OF DIAGNOSIS FOR SURVEY DESIGN AND DATA ANALYSIS

<table>
<thead>
<tr>
<th>MODEL BOX</th>
<th>FORMAL SYSTEM</th>
<th>INFORMAL SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>• Goal clarity stated.</td>
<td>• Goal agreement.</td>
</tr>
<tr>
<td>Structure</td>
<td>• Functional Programme set out.</td>
<td>• How is work actually done?</td>
</tr>
<tr>
<td>Relationships</td>
<td>• Who deals with who; on what; which technology should be used? Role descriptions.</td>
<td>• How well do they do it in reality?</td>
</tr>
<tr>
<td>Rewards/Incentives</td>
<td>• Explicit system. What is it?</td>
<td>• Implicit psychological rewards. What do people feel about pay-offs?</td>
</tr>
<tr>
<td>Helpful Mechanisms</td>
<td>• Budget system. Management information systems. Planning and control systems.</td>
<td>• What are they actually used for? How do they function? How are the systems subverted?</td>
</tr>
</tbody>
</table>

When diagnosis of an organisational problem(s) is a matter of urgency, this model is, according to Burke, (1982 : 173) a model of choice. It would also apply in certain instances where the participants have no knowledge of open systems concepts. The sort of gaps looked for in the analysis are:

- What exists now?  What ought to be;
- What is done now?  What managers say they do;
- Gaps between layers of the hierarchy or units of operation (e.g. production; marketing)
- What rewards are given?  What are expected; and,
- Where does leadership strategy say we go?  Where are we actually going.
The weakness of the model appears to be its simplistic approach through six concepts of address, when in reality organisations are often more complex than the six issues of the model. Criticisms of this model include:

- its lack of address of culture; lack of detailed attention to the environment; and,
- lack of systematic route from expressed dissatisfaction, to the causes of such.

This model would not easily align with the pharmacy situation because of the transactional detailed address required.

As stated in the chapter introduction to this section, (p.169) elements of other models should not be precluded from use, if relevant and not already included in the chosen model of change. For example, Lewin’s approach of ‘unfreezing’ the old behaviour, before shifting to new behaviour, is relevant in dis confirming for dispensing pharmacists their present situation in primary care. The other models discussed also make important statements about particular aspects of change and their co-ordination. Currently, community dispensing pharmacy is very much a transactional operation which must be developed to a cognitive level, to effect transformation of the role and position of the independent pharmacist in primary health care. Only the Burke-Litwin model deals with all the crucial elements affecting change, as envisaged in this study, i.e.

**Transformational:** External environment; Leadership; Culture; Mission & Strategy; Individual, team and organisation performance.

**Transactional:** Motivation; Systems, policies, procedures; Task and Individual Capability; Individual needs and values; Business processes and structure.

It is also the model which integrates both transactional and transformational levels of change. The Burke-Litwin model offers a practical route into culture change – a notoriously difficult area to tackle, in organisational terms – through relatively simple adjustment of the factors comprising organisational climate, (Figure 36, pp. 216 – 217).
More importantly, the transactional elements of this model will be easily understood by the wider independent pharmacy profession, who may not be concerned with the more sophisticated concepts of strategy or environmental analysis. This model will also keep leadership focused on the health care environment of competitors and stakeholders, as well as inwardly to the profession itself. The former may be a critical aspect of pharmacy transformation if competitive forces increase.

5.4.2 Summary

An outline of organisational theory has been explored through twelve models of organisational performance and diagnosis. These are calculated to inform certain areas to be addressed in effecting organisational change, but at the same time express some different emphases of focus. None appear to cover the whole spectrum of possibilities in change management but in such a complex area this may be expected. However, they have all been employed in major corporations within sophisticated societies and markets. All depend, at the end of the day, on the willingness of the leadership and employees to view them positively and actively participate in the techniques and methods required to deliver change.

The chosen model for any organisational setting and pharmacy in particular, should be sufficiently comprehensive to address all major problem areas and as easy as possible to work with. All models testify to the fact that a systematic approach to effecting change is both popular and effective. From an examination of twelve models of organisational change, the Burke-Litwin model is recommended by the author for use in the role change of community pharmacy. Pharmacy is a ‘transactional’ operation at present, but in future will build upon the patient prescription for delivering cognitive service and increase transactional activity in doctor liaison. Equally with leadership responsibility in directing change, this model provides a template for so doing and through change in ‘work climate’ may effect the required culture change in due course.

Table 40 summarises the similarities and difference of the change models studied in this section.
Table 40

<table>
<thead>
<tr>
<th>MODEL NAME and APPROX. ORIGIN DATE</th>
<th>FEATURES</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LEWIN-SCHEIN (1946)</td>
<td>Specified focus on individual behaviour change i.e. unfreeze existing behaviour, move to new behaviour: refreeze. (P)</td>
<td>Based on premise that all change comes from individual people. Systems and structures adjust in consequence.</td>
</tr>
<tr>
<td>2. TICHTH (1980s)</td>
<td>Systems based – overlaid with political; cultural; technical influences. Internal organisation congruence pursued.</td>
<td>Lack of focus at individual behavioural level. Depends on systems leverage points to alter people. Seeks to align internal systems with each other. Includes environmental influences, mission and strategy.</td>
</tr>
<tr>
<td>3. NADLER-TUSHMAN (1980)</td>
<td>Advocates internal systems congruence. Like Tichy 6 pairs of systems routinely examined.</td>
<td>Comparing people construct &amp; work construct exposes how people needs are met by work tasks content. Also seeks fit between tasks and people skills / abilities.</td>
</tr>
<tr>
<td>4. BERGER SIKORA (1994)</td>
<td>Change systems, structures and skills (all 3 are adjusted); used to change culture of the organisation and effect behaviour change. (P)</td>
<td>Before changing the 3Ss, the critical success factors are identified by analysing the organisational strategy and current culture.</td>
</tr>
<tr>
<td>6. McKinsey 7S's (1981)</td>
<td>Systems based – key interdependencies stressed. Congruences also crucial e.g. staff abilities and shared values. No external environment or performance elements.</td>
<td>Strategy must be congruent with organisation skills and expertise. If strategy changes because of markets, skills and expertise must change etc. etc.</td>
</tr>
<tr>
<td>7. SILVERWEIG &amp; ALLEN (1976)</td>
<td>For cultural change; address only through the behaviours and norms of the people in the organisation. Installs 3 systems: reorientation of leadership; action study teams; organisational work teams.</td>
<td>Does not address more deeply held values, assumptions, beliefs of culture. Looks at 'norm gaps' between present and future desired states.</td>
</tr>
<tr>
<td>8. BUNKER &amp; ALBAN (1970s)</td>
<td>Large systems intervention; large event driven – intervenes at all levels of organisational operations. Survey/ feedback collated from whole system.</td>
<td>Rooted in Klein’s work (1992 : 566 – 578) and Owen in the 1980s addressing large groups of people at one time (up to 2,000). Gained greater use in the 1990s.</td>
</tr>
<tr>
<td>9. ACTION RESEARCH (1940s)</td>
<td>Data driven – people based. Four varieties practised; surveys used for diagnosis of problems; through data collection. (P)</td>
<td>Originated by Kurt Lewin (1940s). Developed in remainder of 20th century. Widely used in America. Iterative process until change achieved.</td>
</tr>
<tr>
<td>10. MULTI-SOURCE FEEDBACK (1980s)</td>
<td>People based; data from multiple sources collected on key individuals and fed back to encourage change of individual behaviour. (P)</td>
<td>Creates psychological dissonance in the target individuals who then feel strong need to change.</td>
</tr>
<tr>
<td>11. BURKE-LITWIN (1992)</td>
<td>'Transactional' and transformational aspects of the whole organisation targeted for diagnosis and selected for change effort. Originated from 1960s research. Survey based and environmentally interactive leadership key issue. Comprehensive approach. (SELECTED)</td>
<td>No emphasis on system congruence or alignment. Wide analysis, focused change effort on systems and people. Inter-relationships of model’s components emphasised. Does not account for organisation's technical position.</td>
</tr>
<tr>
<td>12. WEISBORD 6-BOX (1976)</td>
<td>Personal interviews and surveys, people and systems. Leadership central to maintaining balance of the 6 boxes. Most straightforward easy to use model of all.</td>
<td>Environment does interact with this model. Formal and informal arrangements within each system. Fit between purpose and internal structures essential. Similar to McKinsey 7S’s.</td>
</tr>
</tbody>
</table>

Note: Author’s summary of models examined and commentary against each. A bold (P) in column 2 signifies that some element thereof, is mentioned as applicable to pharmacy.
5.5 CULTURE, CLIMATE AND ORGANISATIONAL DEVELOPMENT

5.5.1 INTRODUCTION

The importance of corporate culture in the context of organisational development appears to be generally acknowledged, if to some degree controversial. Organisational climate on the other hand has been formally studied for somewhat longer and has more conscious manifestations which are it seems, easier to alter in management terms and so be susceptible to organisational change efforts. Nevertheless, culture has been taken seriously by the corporate world, as an influence on efficiency and excellence. Pharmacia of Sweden, for example, in the early 1980s set up a Personnel and Business Department to address this potential area of improvement (Alvesson & Berg, 1992: 11). Likewise, in 1988 Ciba-Geigy, a Swiss based world wide pharmaceutical company, discerning a rift between their organisational culture and the aspirations of stakeholders, decided to develop a new vision (Vision 2000) and set out upon a massive programme of change. ‘Leadership’ and ‘teamwork’ were to contribute to a new corporate culture (Kennedy, 1993: 18 – 27) ‘...and give employees a sense of identification with the company’s goals...’ These are only two examples amongst many whose culture is clearly an important issue requiring careful change where necessary.

Consideration of group culture (in this case a profession’s culture) is important for the purpose of avoiding cultural conflict with the medical profession, in the process of persuading them to support role change in pharmacy. Arguably the roots of group culture, and probably whole organisation culture study, date back to Lewin and Trist’s work (1940 – 1950) in group behaviour change. Later, workers in the field of culture, in an organisational context, such as Elliot Jaques, (1953: 3 – 24) who studied the concept on the basis of ‘acquired customs and traditions’, began to investigate the subject. He argued:

‘...life in a company is an uninterrupted interaction between structure, culture and personality...’
It seems to be much later, however, (1970s) that corporate culture as a specific subject began to be investigated and written about (Harrison, 1972: 119). Pettigrew, (1979: 579) writing in Administrative Science Quarterly, defined culture as:

'...the system of generally and collectively accepted meanings which operate for a certain group on a certain occasion.'

Schein, (1997: 12) defined culture as:

'...a pattern of shared basic assumptions that a group learns as it solves its problems of external adaptation and internal integration...'

In a large organisation, Schein (1997: 14) goes on to explain that culture variation in sub groups of the same organisation is substantial.


'Probably never before in organisational studies, has an innovative area been given so much attention so rapidly...'

Smircich (1983: 57) identified two streams of research that linked the concepts of culture and organisation in somewhat different ways:

i. The 'Application School':

Regarded culture as a ‘system’ and like the systems views of organisational functioning, regarded culture as a necessary means of maintaining organisational balance with its environment; and,

ii. The ‘Root Metaphor’ School:

Viewed culture as something an organisation is – not has, or does.
The first school of thought has prompted theorists and researchers to look for a correlation between culture and organisational success, (Peters & Waterman, 1982; Kanter, 1995).

Culture research in the latter school has consequently been devoted to investigating its nature, in organisational context, rather than its effect upon corporate performance.

The following are further definitions of culture as seen by other theorists in the field:

1. A pattern of beliefs and expectations shared by the organisation's members. These beliefs and expectations produce norms that powerfully shape individual and group behaviour in the organisation. (Schwarz & Davies, 1981: 33);

2. The common philosophies, ideologies, values, assumptions, perceptions, expectations, attitudes and norms which bind a group together. (Kilman et al., 1975: 5); and,

3. Another means of creating organised activity; by influencing the language, norms, folklore, ceremonies and other social practices, that communicate the key ideologies, values and beliefs, guiding action. (Morgan, 1986: 135).

However, Alvesson and Berg, (1992: 48) express a wider perspective:

'...culture is as rich as life itself and simply reducing it to a rigid framework or precise and absolute definitions, would seriously reduce its inborn complexity.'

In their book, Corporate Culture and Organisational Symbolism (1992: 50), they are critical of cultural research and theory as it was up to that time, because of what they considered to be an absence of empirical research. Nevertheless, these authors cite some 2,550 references to culture, in papers and publications, which indicate that the culture concept has become well established in organisational development theory and
practice. Culture certainly figures prominently in respected organisational change models from the 1980s onward.

A working construct of culture provided by Schein, (1997 : 17) is represented diagrammatically in Figure 35. It is perhaps in level 3 that pharmacy initially can commence change through the rites of practice in the dispensary, shifting more responsibility to technicians, then freeing time for the new ritual between pharmacist and doctor, placing and maintaining the GP as the lead primary care professional. In this way, doctor culture is not challenged and the new pharmacist role is made more harmonious with GP self image expectations.

The underlying explanation is set out by Schein as follows:

1. **Deeply held basic assumptions**
   The taken for granted subconscious basis on which behaviour is enacted and decision making happens; authority is accepted; the organisation’s raison d’être; automatic relationships in the work place;

2. **Values, Beliefs and Attitudes**
   Values as moral / ethical issues; expectations of what should be in terms of integrity; beliefs are perceptions of what people think is or is not the reality, i.e. ‘pay levels effect quality of product.’ Attitudes connect beliefs and values with feelings – a learned predisposition to respond to a stimulus; and,

3. **Artefacts**
   Stories, myths, rites, rituals, ceremonies, symbols, which characterise the organisation; the most visible aspects of culture; symbolisation of the organisation’s values.
SCHEIN'S LAYERED CONCEPT OF CULTURE

(Schein, 1997: 17)

Note: Schein's diagrammatic representation of corporate culture, 'basic assumptions' and 'taken for granted beliefs being at the heart of employees' perceptions about the way things are done. The deeply held basic assumptions and beliefs which are axiomatic in the individual's psyche are portrayed by Schein as being at the very core of individual and group culture. Next influential are the values, beliefs and attitudes of what people perceive to be their situation in relation to the expectations of the organisation. Finally, the visible manifestations of how work culture is expressed. These contribute to the 'climate' of the organisation.
The deeper layers of culture, basic assumptions; values and beliefs, are cognitive elements which, according to Sackman, (1992: 140 – 161) take four different forms, which he characterises as follows:

**Dictionary Knowledge**
Assumptions about the ‘what’ of organisational situations, i.e. what is a source of status; what constitutes job satisfaction; and what are managerial expectations;

**Directory Knowledge**
Assumptions about the causes of departmental / organisational success; about influence processes and about how common processes work. They shape the way in which people deal with problems;

**Recipe Knowledge**
Accepted prescriptions of how to improve processes at all levels – these can express norms and values; includes lessons from the past; and,

**Axiomatic Knowledge**
The most basic assumptions about the nature of things and why they occur; assumptions about the nature of people in the workplace.

Dictionary and directory knowledge are held to manifest in the organisation’s cultural artefacts, (Larwood, 1992: 149 – 154). Cognitions that have become widely accepted have been described as ‘theories in use’, ‘frames’, (Daft & Weik, 1984: 284 – 295) or cognitive maps, (Huff & Schwenk, 1990: 89 – 109). To effect change at these levels of culture would seem at a glance almost impossible in large compound organisations such as pharmacy, as the effort at individual level in all 10,000+ settings would be colossal. This is perhaps a pointer to seeking change mechanisms at a simpler level.

Schein (1997: 14) goes on to suggest that ‘culture’, in organisation, should not simply be read as a uniform set of behaviours and perceptions held by everyone in the workplace. Sub groups and departments may well have entirely different sub-cultures. Other researchers support this view, (Sackman, 1992: 140 – 161; Trice & Beyer,
The accounts and production departments in manufacturing organisations, for example, may well have different cultures; born of different backgrounds, professional education and the associated cultures of adjacent environmental contacts.

The culture factor has, not surprisingly, become associated with organisational performance, but Chatman and Jehn, (1994: 522 - 553) argue that it is only safe to associate 'strong' culture with success, if one of the culture's strengths is the ability to cope with the changing forces of the environment. Luthans, (1993: 12 - 13) believes that cultural 'strength' is a function of two factors:

i. The extent to which all organisation members have the same set of values; and,

ii. The intensity with which the values are held and the resultant degree of commitment.

However, the issue of strong culture being positively related to successful performance appears to be unresolved as Kotter and Heskett, (1992: 34) have shown that strong culture can also be associated with failure and some weak cultures, in their study, were actually successful organisations. In an attempt to shed some light upon the idea of 'strong' culture being a contributor to success, Christensen and Gordon, (1999 : 397 - 422) suggest the relationship is to some extent dependent upon the 'environmental fit' of the culture and its consequent ability to address the market context, in other words, the culture should be strategically appropriate. Kotter and Heskett go on to demonstrate that additional factors which may help the correlation between appropriate culture and success:

• the culture in external effect must be one that values and supports the legitimate interests of the large stakeholders; and,

• the culture internally must value excellent leadership from managers at all levels in the organisation.

Their studies showed that over an eleven year period, companies with culture which embraced the above perspectives increased revenues by an average of 682% compared
with a 166% increase from those which did not. In addition share prices rose by 901% compared with 74% respectively; an impressive comparison.

Goffee and Jones (1998: 127) argue in their book, *The Character of an Organisation*, that there is no such thing as one right or best culture for all organisations, but one which is synchronous with its environment. Thus culture change and culture management become important considerations. The pointer here is suggestive that pharmacy, with a culture evolved from history and perhaps entrenched in certain beliefs, for example about *supervision*, needs to develop an adaptive culture to address the modern rapidly changing environment.

Ogbona, (1993: 42 – 53) points out that culture change efforts are unlikely to materially affect deeper cultural assumptions and values in the psyche of the individual, but that some behavioural change does actually result from culture change interventions. This in fact may be all that is needed to reposition the pharmacy profession in primary care, with a new role of medicines management. Gilmore et al., (1997: 174 – 189) in a study of 530 American companies found that positive culture change effort can improve competency, quality, service levels and productivity. They go on to say that *climate* can decline considerably. *Climate*, in this context, is the manifestation of culture through work atmosphere, understanding, perception of work experience and organisational context, (Reichers & Schneider, 1990: 42).

Berk’s approach to cultural change is via changed managerial behaviour and thence the climate of the organisation, which because of its intimate relationship with culture, eventually effects change at a cultural level. Many culture change models appear to be derived from Silversweig and Allen’s early four stage change process (1975: 33 – 49):

1. **Analysis of existing culture**
   Surveys of all members to acquire comprehensive data;

2. **‘Experiencing’ the culture**
   Group participation workshops examine existing culture and future desired change;
3. System installation
Starts the change process – participation workshops – leaders involved –
modelling of new culture and processes; and,

4. Ongoing evaluation
Reviews and checks for 'drift'; reinforces change strategies.

Involving people at all stages seems to be essential to ensure thorough understanding of
the change need and its objectives. Hope and Hendry, (1995: 61 – 73) pose a relevant
question, asking if attempts should really be made to change the heart of culture at its
deep levels, or should more obvious factors be tackled (i.e. structures, systems, policies
and procedures, work climate, artefacts) and then allow the effects to pervade the true
cultural paradigm on an incremental basis?

Again, the question arises, with change contemplated for pharmacy, should this latter
approach be used to deliver the new service and allow culture change from 'supply' to
service to gradually change over time? This remains to be seen after the field research
in this study, but would it be a relatively straight forward means of operationally
engaging in pharmacy practice change?

5.5.2 Climate
Climate has already been mentioned in the context of culture as both are intimately
related and both concepts, in rudimentary origin, can be traced back to research and
practice in group work, in the 1940s, (Lewin; Trist 1951). Climate, according to
Tagiuri, (1968: 23) can be defined as:

'...a relatively enduring quality of an organisation that is experienced
by employees and influences their behaviour...'

As Jones and James, (1979 : 201 – 250) have commented ‘...it is the way people
subjectively describe an organisation to themselves and interpret what they find’. 
Schein, (1997 : 9) expresses it as:
The term 'relatively enduring', indicates the possibilities of climate change in certain circumstances. If climate influences behaviour, then behaviour change becomes a possibility through altering organisational climate in some way. Although an organisation-wide phenomenon, climate clearly operates in the psyche of the individual and is, therefore, according to Glick, (1985: 601 – 616) a multi-level phenomenon and is frequently evaluated in this way through 'climate questionnaires', (Litwin and Stringer, 1968) and the Business Organisation Climate Survey (BOCS); (Payne & Phesey, 1971: 77 – 98). Climate surveys probe perceptions of organisational members in issues such as the following:

- Relationship of employees with leadership at all levels;
- Organisational receptivity to new ideas;
- Authority relationships or how power is used;
- Reward systems;
- Social amenity of the work place; and,
- Effect of human resource management policies.

Warner Burke, (1994: 71 – 72) in describing the Burke Litwin Model of organisational performance and change, makes the point that both 'climate' and 'culture' should be viewed in terms of their interactions with each other, as well as other organisation variables. (See Burke Litwin Model, Section 5.4.11). He argues that some organisational variables are affected by culture, (transformational issues) and some by climate, (transactional issues). Reichers and Schneider, (1990: 5 – 39) in an examination of the literature on climate and culture see '...considerable overlap between the two concepts'. Burke, (1994: 71 – 72) is of the view that culture should not be changed by direct effort, but through managerial behaviour, which affects climate. Persistent effort in this way will incrementally change culture he argues. Denison, (1996 : 619 – 654) likewise supports the view that climate and culture are parts of the
same phenomenon and that speculative differentiation of the two has been something of a self-fulfilling prophecy.

Harrison and Shirom, (1994: 264) are of the view that despite overlap in the two concepts, there are important differences, which provide the opportunity for influencing the deeper issues of culture, through the more superficial aspects, some of which merge with ‘climate’ effects. They see top managers as the creators of climate and the employees have perceptions of it, through the factors cited above. Clearly, work related perceptions and attitudes are important to organisational performance and indeed strategic aspirations.


Those who wish for no change appear not, as yet, to have computed the short, medium or long term effects on new pharmacist role adoption in medicines management. This problem is quite possibly a mixture of cultural and climate effects. ‘Culture’, bound in tradition and history, as to how things have always been and ‘climate’ in the sense of perhaps poor organisational receptivity to new ideas, inadequate relationship between members and leaders and lack of leadership harmony and strong guidance.

Rollinson and Broadfield (2002: 601) set out the following scheme of climate antecedents and outcomes; together with interactions (Figure 36). Climate, they argue, is a result of the organisational structure, work group reporting procedures, tasks, rewards and recognition systems, role descriptions and environmental context. These, in turn, affect individual motivation, needs, goals and activities. The relevance to community pharmacy is plain to see in the changing roles of dispensing staff, procedure and task changes and systems adjustment for delivering medicines management. The political environment is driving change.
Figure 36 ORIGINS AND OUTCOMES OF ORGANISATIONAL CLIMATE

Note: Author's adaptation of a schema by Rollinson & Broadfield, (2002 : 601). Origins of 'climate' arise both internally and as an effect of the environment in which the organisation operates. Hence the two way arrows between the work group situation (organisation, context and individual) and the PEST factors of the environment.
5.5.3 Summary

Organisational climate then, is conceptualisation by its members of ways in which they interact with themselves, their surroundings, managers and leaders. It thus affects attitudes and is a basis for at least some of their behaviours, (Schneider, 1983: 53). It is further argued by Litwin and Stringer, (1968) that levels of motivation and morale are also affected by 'climate'.

Because of the more superficial nature of climate, as compared with culture, Zohar (1980: 96 – 102) for example, is of the view that sub-climates, at group or team level exist and are more pervasive than sub-cultures, because of the potential speed of change at relatively superficial levels in certain circumstances.

If climate, then, is a cognitive effect as Kozlowski and Doherty, (1989: 546 – 553) argue, then this could be a means of starting to affect individual mental perspectives on behavioural issues, relating to deeper cultural issues, for example, changing a value or assumption system to change outlook on customer / patient service.

So far as the primary care pharmaceutical service is concerned, deeply embedded attitudes, assumptions and beliefs, with regard to pharmacy’s role are even now surfacing, (PJ, Anon., 2002: 515). Letters and articles to the Pharmaceutical Journal show a mixture of support for modification to the legal requirements on supervision and strong resistance to modification of the interpretation of supervision in any way.

Similar dissent has been observed by the author, on the PSNC committee and also the NPA group within PSNC. History, tradition and some fear, appear to be exerting a strong influence in certain quarters and if reflected in large numbers nationally, will require effort directed at a culture shift, rather than simply trying to enforce change by directive and edict. An approach to culture change, by tackling the simpler issues contributing to organisational climate, may well afford the most practical and effective way of changing culture in the long term. Operational change in pharmacy, is after all, the most urgent issue.
Consideration will now be given to some systematic approaches to leadership effort in affecting change, dating from the 1940s when such approaches began to emerge. These systems attempt to draw together related aspects of leadership focus (of which culture is one) and form a blueprint for addressing organisational problems and a framework of addressing change in selected aspects. Most of the developed models date from the 1970s but use principles established much earlier.

5.6 LEADERSHIP AND MANAGEMENT THEORY: ROLE IN ORGANISATIONAL CHANGE

5.6.1 Introduction

In the change models discussed in Chapter 5, 5.5, ‘leadership’ figures prominently in those which comprehensively address the organisational systems, structure and infrastructure and totality of the organisation, in inter-relationship with its environment. Leadership, although a concept rooted in early history, has become a subject of increasing interest in modern management and ‘leaders’ are recognised as of key importance in the performance of their organisations. Levinson, (1994 : 41) has gone so far as to say:

‘All organisations are the lengthened shadows of their leaders.
Sometimes that shadow lasts for generations...’

Leaders have a marked effect upon corporate strategy, (Smith & White, 1987 : 263 – 280) and in operational terms, can make the difference in an organisation’s performance between, in extreme terms, success and failure. A continuum of effects between these extremes is the ultimate responsibility of the chief executive officer, (Thomas, 1988 : 388 – 400). The world’s leading business corporations have made use of the research on leadership in order to more successfully appoint individuals who will deliver impressive organisational performance, (Hadijian, 1995 : 95 – 97).
Leadership exists within pharmacy, in the hierarchical sense of having chief officers and lead responsibilities in the representative organisations. However, this is not to say that leadership, as defined in the following conceptualisations, has been a recognisable feature of pharmacy's official leaders in the past few decades. An exception fairly recently may be through the RPSGB ‘PIANA’ document, which unfortunately lacked an operational plan and programme of change. The following pages help to expose leadership targets of address and methods of role change for the pharmacists in the primary health care pharmaceutical service.

‘Leadership’, in a modern organisational context has been variously defined as follows:

i. (Yukl, 1989: 23): ‘...the process through which one member of a group influences other group members toward the attainment of specific group goals...’;

ii. (Jacques & Clement, 1991: 4): ‘...that process in which one person sets the purpose or direction for one or more other persons and gets them to move along together with him or her and with each other, in that direction with competence and full commitment...’;

iii. (Campbell, 1991: 3): ‘...actions which focus resources to create desirable opportunities...’; and,

iv. (Kotter, 1990: 4): ‘...the process of creating a vision for others and having the power to translate it into reality and sustain it...’

Leadership, by implication, argues Kotter, (1990: 4) does not produce consistency and order, it produces movement through at least three such processes:

i. **It establishes direction, developing a vision for the future and a means of getting there:**

ii. **It aligns key people, harmonising effort towards the objectives;** and,
iii. It motivates followers to achieve the goals of strategy and movement.

Leadership then, is regarded as a process, but does not indicate the nature or attributes of a leader and in this section of study, both will be addressed, but with greater attention to leadership. A definition of leadership offered by the author of this thesis is as follows:

‘Leadership is the ability to create a vision for a group of any size, together with the motivation, plan and activity to realise it.’

Leadership and the role of leaders is being explored in this chapter to help inform the way forward in taking the community pharmacy profession into a new position of service and responsibility in primary health care. It is studied on the basis of recognising that there are designated leaders and leadership bodies within the profession, with current roles and responsibilities in governing, negotiating and providing legal, commercial and political advice to members and contractors. These traditional roles and activities may however, be inadequate to lead and plan the way through change into a new order of service.

In the magnitude of change contemplated for community pharmacy, transformational, within a health care environment, which is itself undergoing considerable structural and motivational change, the profession’s leadership will have far reaching responsibility. This means responsibility to lead change by both elected leaders at the head of the profession and emergent leaders at all levels as the initiative develops.

The RPSGB will have the pivotal role of change agent, in terms of the legal interpretation and reform of ‘supervision’ relating to dispensary and OTC medicines, together with skill mix re-design. The PSNC will need to construct new models of remuneration and the NPA will be, by its business systems orientation, responsible for re-design of premises amenities for the medicines management cognitive service. The Company Chemists’ Association will be looking at new role implications for their members and taking an overall view on policies to be adopted.
The multiples and vertically integrated multiples may be drawn into the role of change agents, or indeed change barriers. The gross profit margins on cognitive service are dictated by high cost pharmacist involvement and thus, much lower than the margin on high volume drug purchasing. The new service will remove their competitive advantage of purchasing power. Because of this complexity in the internal domain, the author arranged a meeting in June 1998 to consider the formation of a ‘leadership group’ to, firstly, achieve ‘critical mass’ alignment, in commitment to role change and, secondly, to harmonise, if possible, aspirations of the various groups. A group was formed in July 1998 consisting of the following lead bodies:

- **Royal Pharmaceutical Society** - President; Registrar
- **Pharmaceutical Services Negotiating Committee** - Chairman; Chief Executive
- **National Pharmaceutical Association** - Chairman; Director
- **Company Chemists’ Association** - General Secretary; Director
- **Co-operative Pharmacy Technical Panel** - Director; Secretary

Since that time, the group has steered the introduction of a nation wide pilot of the new MM service. The structure is as follows:

**Pilot Structure**

- 9 locations in 3 regions (North; Midlands; South);
- 1 Research Fellow per region;
- 3 local co-ordinators per region;
- 43 GP practices;
- 76 GPs – approximately 3,000 patients;
- 71 community pharmacies;
- 91 community pharmacists;
- Universities: Aberdeen; Keele; Nottingham; and,
- Patients – 2/3 of cohort study group; 1/3 cohort as the control group.
The pilot is due to complete in 2003. However successful this may be, it will not guarantee the general introduction of the new service. The following issues also need to be addressed by the leadership of the profession:

- Training and education for community pharmacists in the new service;
- Shift of mechanical dispensing workload from pharmacist to technician;
- Better qualified staff at medicines counter level;
- Time impact management of MM, upon GPs and their staff; and,
- Partnership building between pharmacist / patient and pharmacist / GP.

The following section, therefore, seeks to study the relevance and activities of leadership and leaders in helping to direct and facilitate the change from current to future service in primary care pharmacy. It also seeks to identify means of connecting the leadership function and responsibilities in this change situation to the grass roots profession, in an appropriate manner.

5.6.2 Leadership – Development of the Concept

The concept of leadership and existence of leaders has been evident from early history. 'Headmanship' or 'chieftanship' in tribal settings and 'command leadership' in warfare, or battle situations is a fact of history. So the natural emergence of leadership, or lead people, down the centuries has been, it could be said, a natural phenomenon of social evolution, situational need and group interaction. Homer's *Odyssey* (Book iii, line 297), for example, mentions the subject and advises leaders to maintain social distance between themselves and subordinates:

'...the leader, mingling with the vulgar host, is in the common mass of matter, lost...'

Whether this could be realistically asserted in modern society is debatable.
Much later, in the sixteenth century, Machiavelli in his work 'The Prince', teaches leadership practices and tactics for the ruler of a Principality and refers to exemplars in Kingdoms and Empires. He himself served in Government from 1498 to 1512 and learned, it is supposed, the wiles and rules of effective leadership. The book prescribes a degree of ruthlessness, manipulation and strong discipline, in precedence over collaborative friendly dealing with people, based on strict moral principles (Machiavelli, 1513 / 1999 : 17):

'...There is no surer way of keeping possession (of a conquered city) than by devastation. Whoever becomes the Master of a city accustomed to freedom, and does not destroy it, may expect to be destroyed himself; because when there is rebellion, such a city justifies itself by calling on the name of liberty and its ancient institutions never forgotten, despite the passing of time and benefits received from the new ruler...'

However, he expressed more moderate views on interpersonal competencies relating to leadership and examples he gave, have it seems, been the precursors of certain modern approaches to leadership. Christie and Geiss, (1970) for example, actually constructed a leadership traits scale, in units they called 'Machs', to measure a person's potential in leadership ability. The higher the score on this scale, the closer the conformity to Machiavellian principles of resisting social influences and emotional concerns for others, to gain compliance to the leader's wishes and focus on the task in hand. Conversely, low scores are rated as being susceptible to social and personal relationship issues in leadership style and effort (Epstein, 1969 : 38 – 41).

The idea that personal traits of a different order could be observed in leaders gained some popularity in the early part of the twentieth century and led to a Traits school of thought. However, whilst recognising that leaders in certain situations, did exhibit such characteristics as strength of character, initiative, sensitivity, it was found that identification of a variety of traits found in leaders was not necessarily a predictor of successful leadership ability or performance. Other factors were also discovered to play a big part, such as situation and particular environmental circumstances. Research eventually moved to these latter aspects of determinant leadership effectiveness.
Some twenty years earlier than the work of Christie and Geiss, Fleishman, (1953: 153 – 158) constructed a two factor theory of leadership behaviour, derived from questionnaire results, prior to the main research in the notable Ohio State Leadership Studies. He analysed the questionnaire responses of the research and found two primary factors, describing group leader approaches, both of which were practised independently of each other:

1. ‘Consideration’
The extent to which some leaders expressed concern for group members’ welfare. Considerate leaders expressed appreciation for good work; strengthened member self-esteem; put member work suggestions into operation; sought group approval before going ahead; and,

2. Initiation of Structure
The extent to which the leader initiates and structures the work; standards and deadlines are imposed. Task orientation rather than people, is the focus; the leader does not consult the group but acts on own assessment of job requirements.

This approach to leadership analysis, through identification of leader style, became known as the ‘style theory of leadership’ and was pursued by other researchers investigating the same phenomenon.

The above ideas on leadership style were further addressed by Blake, et al., (1962: 12 – 15) who took a somewhat different view, that the two approaches were not necessarily independent of each other, but could be observed (and practised) in the one leadership behaviour. They constructed a scaled grid to assess people’s leadership ‘style / approach mix’, with two axes labelled:

- ‘Concern for people’ - maximum score 9; and,
- ‘Concern for production’ - maximum score 9;

Leaders, they argued could engage both styles of behaviour and with a highest ideal score on each axis of the grid (9.9) would show high concern for people as well as
production. Thirty years later, Blake and McCanse, (1991 : 29) refined the grid, which is shown in Figure 37.

This approach has been criticised by other researchers, (Larson et al., 1976 : 628 – 641) on the basis that no scientific rigour has been applied to successfully evaluate it and that, for example, other influences such as group environment have not been taken into account, i.e. situations can change leader behaviour, (Tracey, 1987 : 21 – 33).

Figure 37  BLAKE AND MOUTON LEADERSHIP GRID

Note: The grid shows the scores on two dimensions and examples of scoring for particular types of manager.
The above researchers worked at company department level, well below corporate board and the work is also important to revealing that leadership can take place at lower organisational levels not normally thought of in leadership terms.

Similar work at about the same time as Fleishman’s early work and still dealing with the style theory of leadership, had recognised the flaw in looking at only two dimensions of style and Tannenbaum and Schmidt, (1958 : 95 – 102) proposed a continuum of styles, based upon the leader being job centred at one extreme, (boss centred as they described it) and employee (follower) centred at the other. The Tannenbaum and Schmidt model is shown in Figure 38. (Tannenbaum and Schmidt, 1958 : 47)

**Figure 38**  TANNENBAUM AND SCHMIDT LEADERSHIP

**STYLE CONTINUUM**

<table>
<thead>
<tr>
<th>Boss centred leadership</th>
<th>Follower centred leadership</th>
</tr>
</thead>
</table>

Use of authority by leader

Area of freedom for followers

**TELLS**
Leader makes decision

**SELLS**
Leader sells decision

**SUGGESTS**
Leader presents tentative decision subject to change

**CONSULTS**
Leader presents problem; gets suggestions; makes decision

**JOINS**
Leader defines limits; asks group to make decision with leader as equal member

**DELEGATES**
Leader allows followers to function within limits defined by leader

Note: The oblique line of the inner rectangle indicates increasing transition from one style of leadership to another, through the stages shown below the rectangle.

From such early ideas, based initially upon personal traits of the leader and then styles of leadership, other theories began to emerge which have been called contingency approaches. These were apparently so named because the theorists perceived leadership
activity as being contingent upon the contextual circumstance of the operational group as well as the style of its leader.

The first notable of these was that of Fiedler, (1966: 237 – 264) who proposed that leadership effectiveness was contingent upon the task structure, leader-member relations, leader style and context of the group. His proposition is diagrammatically represented as in Figure 39.

Figure 39  FIEDLER'S CONTINGENCY THEORY OF LEADERSHIP VARIABLES

If leader-member relations are good, leadership is facilitated and there are overtones here of the ‘concern for people’ axis of Blake and Mouton’s grid. Fiedler’s measure of leadership style was scaled and measured, from the way in which the leader relates to the least preferred co-worker, (LPCW) within the group being led, so that:

(i) Leaders with high LPCW score, means a positive attitude to the LPCW and a social relations orientation to leading the group; and,

(ii) Leaders with a low LPCW score, points to a negative attitude to the LPCW and indicates a task orientated approach by the leader.

According to Fiedler, leaders in category (i) do best in situations which are not extreme, whilst category (ii) do best in extreme situations of favourableness or unfavourableness.
This leadership rating is thus a result of personality, which is usually regarded as a permanent quality of people and therefore, leader/group incompatibility may also be permanent, if personality fit is not present. Fiedler and Mahan, (1976: 247–254) went on to suggest that in such circumstances the group composition and context could be changed if the leader was not to be removed. Fiedler and Garcia, (1987: 49–93) further suggested how this might be achieved and Table 41 summarises their suggestions.

Table 41 LEADER ACTION TO CHANGE CONTINGENCY VARIABLES

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leader-member relations</td>
<td>- Spend informal time with group</td>
</tr>
<tr>
<td></td>
<td>- Draft in new members</td>
</tr>
<tr>
<td></td>
<td>- Offer help with aberrancy</td>
</tr>
<tr>
<td></td>
<td>- Engineer new routes of satisfaction</td>
</tr>
<tr>
<td>2. Task structure</td>
<td>a). To increase: add detail to the processes and create a tighter system</td>
</tr>
<tr>
<td></td>
<td>b). To decrease: increase leader-member joint working, reduce detail and</td>
</tr>
<tr>
<td></td>
<td>systems constraints</td>
</tr>
<tr>
<td>3. Leader position / power</td>
<td>Enhance by raising appearance of being in charge – formalise instructions; become sole channel of communications.</td>
</tr>
<tr>
<td></td>
<td>Diminish by sharing decision making and giving more autonomy.</td>
</tr>
</tbody>
</table>

The approach suggested by 1 and 2(a) may have application at both local and national levels in pharmacy when the time comes to engage the wider profession in role change. Small local study workshops may be a facilitating means, led by selected local pharmacists. Leaders at national level cannot easily be changed and some contingency variables and their application may be useful tools of facilitation for them to use, such as defining clearly new task structures relating to supervision and skill mix, to signal the commitment to change. However, Peters et al., (1985: 274–285) point out that the
above three variables in Table 41 are not the only ones contributing to leader effectiveness. Goals of the groups and relationships with other groups, for example, could also have a real influence. The goals in pharmacy are enhanced clinical knowledge, pharmacist / doctor partnership, a common new role and transformation of the profession’s place in primary care. A prime goal, involving external groups could be the new relationship with GPs and its means of construction.

At management and supervisory level, these issues appear to be relatively obvious, but at strategic level, may be more difficult to apply as autonomy usually increases at higher organisational levels and influencing powerful autonomous people may not be easy. Especially, this is also the case in autonomously run independent pharmacies and leadership bodies. Further, high level roles in the multiples are not usually task orientated, but deal with policies and futures.

However, a number of Fiedler’s ideas, such as leader / member relations, may be relevant at pharmacy leadership level for planning co-ordinated communications to members. Several autonomous leadership bodies are involved and a task orientated approach to leading such a group may not be appropriate, although allocating them responsibilities for selected task change ‘down the line’ may be of interest to them. Task orientation in this context would be, for example, getting into the detail of the programmes for which each individual body would become responsible, then dealing with the leader positions and integrating messages to members from each of the lead bodies on the following basis shown in Table 42.

Table 42 MESSAGE SUBJECTS

<table>
<thead>
<tr>
<th>BODY</th>
<th>MESSAGE SUBJECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPSGB</td>
<td>Education; ethics; law; professional governance</td>
</tr>
<tr>
<td>PSNC</td>
<td>NHS remuneration; service development; contractor support</td>
</tr>
<tr>
<td>NPA</td>
<td>Business services; legal defence; premises layout</td>
</tr>
<tr>
<td>CCA</td>
<td>The political and marketing interests of the members</td>
</tr>
<tr>
<td>CPTP</td>
<td>The internal interests of its units relating to the NHS</td>
</tr>
</tbody>
</table>
A more 'social' approach using Fiedler's 'context' issues, (i.e. for pharmacy the inevitability of change in the NHS) could be emphasising collaboration and integration of effort. Collaboration on looking to the future requirements of service roll out, may be advisable, then engaging in a dialogue for change with the members, rather than by edict and directive.

Other research, however, does not appear to support Fiedler's theory of leadership effectiveness and Isenberg, (1981: 119 - 134) for example, found no correlation between Fiedler's model predictions and the actuality of leadership effectiveness within the groups in his own communications studies. In other work Rice, (1981: 1 - 25) also could not find the predicted relationship between performance and leader type (as measured by the LPCW rating) in the expected conditions of Fiedler's model. Schriesheim and Hosking, (1978: 496 - 505) further concluded, after a review of certain studies which had used the Fiedler model, that 'it really has little empirical support... ' (Schriesheim and Hosking, 1978: 500).

On the other side of the argument, Strube and Garcia, (1981: 307 - 321) in a meta analysis of the model, concluded that the model was in fact valid.

Shortly after Fiedler's work commenced, House, (1971: 321 - 338) proposed that leaders are in fact flexible, unlike Fiedler's concept of fixed style and change their approaches to suit circumstance. This idea, first considered by Georgopolous et al., (1957: 345 - 353) has been progressively modified through practical experience and is described as 'path-goal theory'. It is based upon a leader's ability to improve the follower's motivation and satisfaction through creating perceived value of the group goals and facilitating the path of achievement, (House, 1971: 324). Fiedler also came to a similar revision of his own views and with House regarded supervisory leadership as comprising the setting of clear tasks and roles, support and concern for the followers' needs, and agreeable relationships in the work situation, (Fiedler and House, 1988: 25 - 42).

Appropriate leader behaviour (style) is apparently contingent upon two factors in path-goal theory' (of which Fiedler and House were protagonists):
• subordinate characteristics; and,
• environmental factors.

Diagrammatically these are represented in Figure 40.

**Figure 40**  THE PATH-GOAL INTER-RELATIONSHIP
AS PROPOSED BY HOUSE

1. LEADER STYLE OPTIONS
   - Participative
   - Directive
   - Supportive
   - Achievement Oriented

2. FOLLOWER (SUBORDINATE) CHARACTERISTICS
   - Task abilities
   - Experience
   - Need for achievement
   - Locus of control
   - Clarity need

3. ENVIRONMENTAL FACTORS
   - External influences
   - Character of work
   - Organisation of group
   - Authority system

Note: Three sets of variable factors, according to House, can lead to motivation of followers, if each is managed to best advantage.

With regard to pharmacy, the lead bodies within their own specialities may well be advised to adopt a mix of styles as described in box 1 of the model, in other words, directive, supportive and achievement orientated. The RPSGB, with responsibility for supervision and skill mix issues, will eventually be engaged in directives, as a legal responsibility, but with other lead bodies, can focus upon the rewards of achievement through change and support of the transition with training, premises aids and financial reward, through negotiation with the DH.
Some researchers have found support for the above model, (Szialgi and Sims, 1974: 622–634; Indvik's meta-analysis, 1986: 189–192). Others, although not having found substantial evidence against the model validity, found that in some studies, not all the elements were entirely supported, (Downey et al., 1976: 156–176). In interpeople relationships this is not surprising.

Vroom and Yetton, researchers in the field of management and motivation (1973: 12–15), constructed another model of leader effectiveness based on a much narrower focus of decision making in leadership. The model originally devised by Vroom and Yetton was later modified by Vroom, Yetton and Jago (1978: 151–162) by adding another option to the ‘direction’ – ‘participation’ choices of leaders in group involvement. The options continuum is reminiscent of that devised by Tannenbaum and Schmidt (Figure 37) and sets out the choices which the leader may assess to be most desirable in involving the subordinates in the decision process in a given situation. The authors argue that situations change the desirability of subordinate involvement. The criteria by which the leader may decide on the degree of involvement, is regarded by them as twofold:

i. Does the subject to be decided, affect the whole group or one individual; and,

ii. Does the leader give priority to the speed of decision making?

The four decision trees, which are part of the Vroom model, introduce great complexity and time involvement, but generally it seems that the model is well accepted scientifically when applied within its narrow focus.

Another model of leader behaviour in the contingency approach is that designed by Hersey and Blanchard, (1974: 23, 26–34) based upon subordinates’ readiness to perform the allotted task(s). ‘Readiness’ is related to experience, willingness and abilities to do the job. Leaders should, they argue, adjust their style according to the group’s readiness to take responsibility for the task in hand and this may well be necessary for community pharmacy, which the field research may hopefully inform.
They define four degrees of readiness:

**R1—Low**  
Followers with low psychological readiness and low task related ability.

**R2—Low/Moderate**  
Willing but unable, low task related readiness with some psychological readiness.

**R3—Moderate/High**  
Unwilling but able, high task readiness, low psychological readiness.

**R4—High**  
Willing and able, high in task and psychological readiness.

Along with the above follower characterisations they use four leadership styles to interrelate with R1 to R4 and so indicate an appropriate leadership style. The four chosen leadership styles are:

**S1—Telling**  
Leadership is high on task orientation, low on relationship emphasis.

**S2—Selling**  
Leader is high on task and relationship emphasis.

**S3—Participating**  
Leader is low on task orientation (followers decide the ‘how’ of things) and high on relationship emphasis.

**S4—Delegating**  
Low task and relationship emphases, followers relatively autonomous.

The contingent factor in this model is the degree of follower readiness and therefore the leader requires the ability to accurately discern the circumstances of the followers, vary his or her style and cultivate appropriate attributes in the follower group.

Diagrammatically, the model is represented in Figure 41.
There is some research which is supportive of the model, (Jacobsen, 1984: 45 and Vecchio, 1987: 444 – 451). However other research did not show a positive correlation with the predictions of the model, (York & Hastings, 1986: 37 – 47).

It seems once again that whilst the model has an innate feel of good sense about it and contributes to an understanding of leader-follower relationships, it cannot be regarded as a reliable predictor of leader style in the given situations. It can be a useful guide only.

5.6.3 Transactional and Transformational Leadership

These two approaches to leadership were initially expressed by Burns, (1978) comparing successful leadership in two sets of circumstances, i.e. stable situations and changing circumstances. In a stable situation it is argued that where the leader can discern the expectations and wants of subordinates, he or she can then arrange the context of work so that these requirements can be satisfied. Subordinates can then satisfactorily engage in transaction with the leader. The leader skill is in determining the needs of subordinates and engaging in the appropriate style of leadership.
This transactional perspective of leadership appears to depend upon three assumptions (Downton, 1973: 23):

i. Human behaviour is goal directed and individuals act rationally to achieve those goals;

ii. Behaviours that pay off, will persist; and,

iii. Norms of reciprocity govern the exchange relationship.

As Burns put it, (Burns, 1978: 3)

'... transactional leaders approach followers with an eye to exchanging one thing for another...'

In Section 4, page 227, on organisational change models in this thesis, the Burke Litwin model showed the transactional elements which give rise to the climate of the organisation, amongst which are, individual needs and values; individual performance; individual skills and motivation; management practices; and, systems, policies and procedures. These are the aspects of the workplace where transactional leadership can direct its efforts. Here is where change will be experienced and enacted in pharmacy practices, countrywide in engaging the new MM service. Here is where profitable effort may be directed in the pharmacy context. The author would argue that this style of leadership is required in the role change for pharmacy.

Transformational leadership, according to Burns' initial work, (1978) involved four elements:

- charismatic leadership - resulting in complete faith in the leader;
- inspirational leadership - communicating high expectations;
- intellectual stimulation - addressing old problems in new ways; and,
- individualised attention - recognising individuals, not an amorphous mass.

This construct of transformational leadership was also revealed in clinical work by Zaleznik, (1977: 67 – 80) whose research showed leaders attracting strong feelings of identity and respect (charisma), sending clear messages of organisational purpose and
mission (inspirational leading) and cultivating intensive one-on-one relationships. They were more interested in ideas than systems and procedures.


'...if you, as a leader, can make an appealing dream seem like tomorrow's reality, your subordinates will freely choose to follow you.'

House et al., (1991: 243 – 269) in their book on Personality and Charisma in the US Presidency, argue that transformational leaders have high levels of self confidence and a high degree of internal strength of character, convinced of their own ideals and beliefs. On a purely subjective level, the pharmaceutical profession may well be the sort of culture that now needs to generate such leaders. Strong belief in future health and importance of the profession in primary health care and a determination to get there would seem to be important qualities in leaders who are committed to moving the profession on.

Having looked briefly at transformational and transactional perspectives on leadership, it again seems to the writer, that perhaps too much of a distinction may have been made between the two in the legitimate interests of theory and research. In practice, it seems reasonable to suppose that both types of leadership can be practised by some individuals and indeed perhaps need to be, in the present circumstance of the change required of pharmacy.

It may be advantageous, in trying to steer the leadership bodies of pharmacy into integrated change effort, to place emphasis on the transactional issues already mentioned, as the need for change here is almost self evident and in some respects may be best treated in the usual style of a professional bureaucracy, i.e. the issue of edicts and protocols. Physical amenities processes and systems are relatively easily
understood and changed as a matter of professional necessity. The transformation of mind-set from supply to cognitive service culture may be the difficult process.

5.6.4 Leadership Substitutes

In the discussion so far on leadership and some of the established theories, those situations encountered in practice, which apparently do not require leaders, have not been mentioned. Kerr and Jermier, (1978 : 375 – 403) argue that the circumstance of a group may well be enough to provide direction and motivation towards objectives. Influences such as those mentioned at the beginning of this thesis, i.e. political, economic, sociological and technological, may well be powerful and relevant enough to drive change in a particular direction. Other internal leadership substitutes are, (Kerr & Jermier, 1978. : 378):

- the presence within the group, of task knowledge;
- the group individuals' characteristics; and,
- the organisational culture and framework.

However, such influences need to be translated into operational dimensions to actually effect change and this requires the intervention of the internal organisational leaders. In such cases, Podsakoff et al., (1996 : 380 – 400) argue that the results are greater than conventional leadership. Such contextual circumstances, if positively orientated toward achieving objectives, productively engage employee attitudes, task performance and role involvement.

It is difficult to see, however, why such substitute leadership forces could succeed by themselves unless the organisational group is autonomous as in perhaps professional situations such as ‘accountancy’ and ‘law’, but even here, internal leadership is likely to occur even if it is simply opinion leadership. Nevertheless, the concept of leadership substitutes is useful in focussing upon the potential of circumstance to facilitate change.
Once again, this appears to be particularly appropriate to community pharmacy in the present circumstance of improving group professional task knowledge plus the external drivers of change, for example, government and the competitive forces of the domain.

The eventual outcomes of leadership substitutes at work in an organisation will, according to Tosi, (1982: 403 – 411) vary by organisational level, in any hierarchical structure. Modern management approaches using circumstance and task knowledge operate in a more social rather than a formally structured way. However, in the community pharmacy situation, use could be made of the drive to change the legal framework for supervision. The skill mix issues may be used to effectively lead change in pharmacy practice. Once again, opportunities for effecting change present themselves through this ‘substitute theory’ alongside other leadership effort.

5.6.5 Summary of Leadership Discussion

The approaches to leadership study were formalised around the beginning of the twentieth century and led to successive work on personal traits of the individual, style of leading, contingent and contextual effects, and more recently, organisational transactional and transformational mechanisms.

As with many aspects of human qualities and abilities, leadership is complex and it could almost be said, elusive. The question has been asked, “are leaders born or are they made?” (Kirkpatrick and Locke, 1991: 58) Or is circumstance and opportunity the progenitor of effectiveness in the leader role? Perhaps more importantly in this study, what is the place of leadership in the subject of this thesis, the transformation of community pharmacy?

Leadership, however it is defined, does exist within pharmacy as a level of authority but what action must it be involved in and initiate to lead pharmacy forward? The glimpse of some approaches and models of leadership orientation in this chapter help to cast light upon some potential methods of effecting change through leadership activity. These will be discussed in the next section together with an examination of the relationship between management and leadership.
Meanwhile the theories of leadership discussed are summarised in Table 43 together with an indication of relevance to pharmacy in the present study. This will help inform the following section on management.

The relevance to pharmacy role change, is suggested in the lower half of Table 43. Leadership in pharmacy, in the sense of having representational bodies which liaise with other authorities and make decisions for the profession, is compound, as illustrated in Chapter 1:21, Figure 3. The author's suggested 'relevance' of the models of leadership studied is based upon this fact.

The different bodies, professionally or commercially orientated, will need to take varied approaches because of the nature of their responsibilities. The RPSGB for example, being responsible for professional and associated legal matters, may be suited to the dual approach of the Blake and Mouton model, combining authority-compliance at the clinical governance and professional ethics levels, and also the team-management approach encouraging profession members to move forward into the new role. Such an approach may also help the RPSGB image, in terms of being supportive, as well as authoritative. Their grid score on this basis would be maximal.

On the other hand, the commercial organisations such as NPA and PSNC, may be better suited to adopting the Tannenbaum and Schmidt model, deciding with government the major issues of new NHS service for pharmacy and going through the process of selling the concepts. The members can be consulted and after feedback a 'route map' set out to deliver change. The task of facilitating link-up with the medical profession could be delegated to thoroughly briefed LPCs.

The author's recommended model is the Path-Goal approach (page 231, Figure 40 & page 241, Table 43, Column 5) for an integrated effort for all the leadership bodies. It combines approach options whilst addressing the needs of the members and the environmental influences.
### Table 43  THEORIES OF LEADERSHIP: CHARACTERISTICS & RELEVANCE TO PHARMACY

<table>
<thead>
<tr>
<th>THEORY TYPE &amp; BRAND</th>
<th>STYLE THEORIES</th>
<th>CONTINGENCY THEORIES</th>
<th>7. TRANSFORMATIONAL</th>
<th>8. TRANSAC-TIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAIN THEMES OF INTEREST</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEADERSHIP STYLE</td>
<td>Focus on people and job requirements</td>
<td>Continuum of varying styles</td>
<td>Leader/member relations; leader power; task structure favourableness of the situation</td>
<td>Style tailored to member readiness degree</td>
</tr>
<tr>
<td>CONTINGENCY ELEMENTS IN EACH THEORY, AFFECTING LEADERSHIP APPROACH</td>
<td>None</td>
<td>None</td>
<td>As above</td>
<td>Subordinates degree of readiness</td>
</tr>
<tr>
<td>CLASSIFICATION OF STYLE OF LEADERSHIP</td>
<td>Fixed in two dimensions</td>
<td>Fixed in one dimension</td>
<td>Varied style with circumstance</td>
<td>Variable with contingencies</td>
</tr>
<tr>
<td>RELEVANCE TO PHARMACY - ROLE CHANGE</td>
<td>People and job requirements will change in new pharmacy role. General focus here is relevant but limited.</td>
<td>Not applicable: project is too complex for one approach.</td>
<td>Appropriate to new pharmacy situation requiring different approaches at different times</td>
<td>Appropriate because of need to develop leader-member relations and task structure situation is favourable by government assent and support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These theories have relevance and should sit comfortably within an appropriate change model for implementation.

Note: The table summarises the key elements of the leadership theories studied, their authors (brand) and suggested relevance to the change proposed in pharmacy.
5.6.6 Leadership and Management

Much, it seems, has been written by researchers and consultants in the field of management studies, attempting to distinguish between leadership and management. Some twenty years ago, Dagirmanjian, (1981 : 1609) writing in the context of mental health service organisation, asserts that leaders serve as managers, by linking the organisation with their subordinates. In the same year, Bernhard and Walsh, (1981 : 22) wrote with regard to the professionalisation of nursing, that leadership involved co-ordinating activities in two groups, those who seek care and those who give it. It is fairly easy to see this latter point in context, as one group (patients) are led into the collaborative process of professional encounter. Guidance and at least some motivation are important factors in the degree of success achieved. Writing in a more general sense on strategy leadership Hosmer, (1982 : 47 – 57) comments that leaders manage and managers lead. Jaques and Clement (1991 : 21) take that assertion further and assert ‘...managership and leadership as being not different...’ However, Kotter in his book, ‘A Force for Change’, asserts that ‘...leadership and management are not the same thing...’ (Kotter, 1990 : 3).

Clearly, the debate is lively, with varying viewpoints, but what seems to be reasonable is that there is overlap in activity and responsibility between the two functions. Bernhard’s early identification of leadership functions as setting of objectives, directing means of achievement, co-ordinating effort and action planning could be seen as management functions also, but perhaps at a lower order. This is similar to Kotter’s approach (1990 : 5) when he views leadership as:

‘...creating a vision of the future, aligning the appropriate people with the objectives and motivating them to achievement by appealing to basic human needs, values and emotions.’

Management, however, he believes is concerned with:

- Planning and budgeting - Detailing the steps, timetable and resources;
- Organising and staffing - The detail of task organisation;
• Controlling & problem solving  -  Programming, auditing, problem address; and,

• Producing order system & structure - Detailing the framework and objective of the task.

(Kotter, 1990: 6)

The relationship of leadership and management is summarised by him, in the following matrix, as Figure 42.

**Figure 42  LEADERSHIP & MANAGEMENT IN THE CONTEXT OF CHANGE**

<table>
<thead>
<tr>
<th>REQUIRED CHANGE</th>
<th>LEADERSHIP</th>
<th>MANAGEMENT</th>
<th>LEADERSHIP</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Considerable</td>
<td>Considerable</td>
</tr>
<tr>
<td>HIGH</td>
<td>Considerable</td>
<td>Minimal</td>
<td>Considerable</td>
<td>Minimal</td>
</tr>
</tbody>
</table>

The point illustrated by him in this matrix is that the impact of leadership and management vary with both the complexity of the organisation and the degree of change required. Both functions therefore can vary at differing points and degrees of organisational transformation or change.
Warren Bennis, (1999: 63) wrote:

'...the manager administers; the leader innovates; the manager’s eye is on the bottom line, the leader’s on the horizon... The manager maintains; the leader develops. The manager asks ‘how’ and ‘when’; the leader asks ‘what’ and ‘why’...'

Capowski, (1994: 23) similarly views management as coming from the head and leadership from the heart and lists the qualities of both, as follows:

**The Manager**
- Rational, persistent, problem solving, analytical, structured, deliberate, stabilising, consulting; and,

**The Leader**
- Visionary, passionate, creative, flexible, inspiring, innovative, imaginative, experimental, change driving.

Bryman, (1986: 6) regards management as:

'...a preoccupation with the here and now and with goal attainment...'

and Naylor, (1999: 6) defines management as:

'...the process of achieving organisational objectives by balancing efficiency, effectiveness and equity... working with and through other people...'

In other words, management deals with operational efficiency and achievement and as such requires a degree of planning and programming the daily, weekly and monthly work flow and objectives.

Within the context of this study, the transformation of community pharmacy, good management will be an essential requisite of success and prioritisation of effort is one very important issue within the management of transition.
Such effort includes:

- Training of pharmacists and ancillary staff (TPAS);
- New quality assurance systems (NQAS);
- Medication four phase review process and structure (MRPS);
- Premises facility layout – consultation area (PFLC);
- Transmission / interchange of data (TID);
- Communication skills and motivational techniques (CSMT); and,
- Skill mix – supervision implications (SMSI).

The recommendation by Adair, (1998: 14) for handling this in a structured way, is by a simple matrix of priorities, such as set out in Figure 43.

**Figure 43**  
URGENCY – IMPORTANCE MATRIX FOR PRIORITISATION OF TASKS

<table>
<thead>
<tr>
<th>Most Important</th>
<th>Top Priority (1)</th>
<th>Medium Priority (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Important &amp; Urgent</td>
<td>Important &amp; Less Urgent</td>
</tr>
<tr>
<td>TPAS</td>
<td>CSMT</td>
<td></td>
</tr>
<tr>
<td>MRPS</td>
<td>PFLC</td>
<td></td>
</tr>
<tr>
<td>SMSI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medium Priority (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent but Less Important</td>
</tr>
<tr>
<td>NQAS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Priority (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Urgent &amp; Less Important</td>
</tr>
<tr>
<td>TID</td>
</tr>
</tbody>
</table>

**Note:** The prioritisation in the matrix is the author's assessment of the relative importance of the elements of effort described above.
Mintzberg, (1971: 97 - 110) in his comprehensive studies and research on management in the 1960s, identified the roles that managers regularly fulfil and placed these in three categories:

- Interpersonal;
- Informational; and,
- Decisional.

The categories and roles are set out in Table 44.

**Table 44** MANAGER CATEGORIES, ROLES AND DESCRIPTIONS

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROLE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal</td>
<td>Figurehead</td>
<td>Embodies authority &amp; formal duties (signing documents; receiving visitors; committing resources)</td>
</tr>
<tr>
<td></td>
<td>Leader</td>
<td>Motivates; sets targets; monitors progress; mentors; encourages; disciplines</td>
</tr>
<tr>
<td></td>
<td>Connector</td>
<td>Vertical and horizontal communications</td>
</tr>
<tr>
<td>Informational</td>
<td>Venue centre</td>
<td>Focal point for information - formal and informal; the matrix of the organisation</td>
</tr>
<tr>
<td></td>
<td>Disseminator</td>
<td>Communicates information to appropriate organisational targets</td>
</tr>
<tr>
<td></td>
<td>Speaker</td>
<td>Source and channel of information to appropriate external agencies</td>
</tr>
<tr>
<td>Decisional</td>
<td>Intrepreneur</td>
<td>An internal entrepreneur giving impetus to change and new developments</td>
</tr>
<tr>
<td></td>
<td>Disturbance Handlers</td>
<td>Intervenes to avoid or resolve difficulties and pursue harmony</td>
</tr>
<tr>
<td></td>
<td>Resource Allocator</td>
<td>Commits capital and personnel in assessed proportions</td>
</tr>
<tr>
<td></td>
<td>Negotiator</td>
<td>Internal personnel; external suppliers - costs and qualities / quantities</td>
</tr>
</tbody>
</table>
It is interesting to note, that in Mintzberg's observations, *leadership* is actually identified as one of a manager's interpersonal skills. This tends to support one of the earlier propositions in this section, that 'managers lead and leaders manage'. (Hosmer, 1982 : 48)

In practical terms, the role of both manager and leader do interrelate and overlap and perhaps the roles become more specific and separate the higher up the organisational tree the person is, as there is, in the author's experience, less hour-by-hour transactional activity there.

### 5.6.7 Summary

The roles of *leadership* and *management* are indispensable in an organisational setting and in theoretical terms, perform different functions. In practical terms there is overlap between both functions with differences perhaps becoming more obvious at the higher and lower levels of the corporate management tree. Management is concerned with operational goals which in turn feed into overall corporate strategy.

The leader and especially the ultimate leader (the chief executive officer) is concerned with strategic goals, providing creativity and driving change. Perhaps too much has been made of attempting to isolate differences between the two roles but on the other hand, it is important that both do perform the responsibilities peculiar to each, whilst discharging their amalgam of cross over functions.

Within the changing environment of the NHS and pharmacy's potential to fulfil a different role, there will be clear responsibilities for both management and leadership, in order to achieve the repositioning of pharmacy within the health care delivery chain. Inspiration and motivation from leaders, coupled with management programmes of change will be needed. Table 45 summaries some of the key responsibilities of both functions, culled by the author from the study so far.
### Table 45 A COMPARISON OF MANAGEMENT AND LEADERSHIP: KEY RESPONSIBILITIES

<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>MANAGEMENT ROLE ELEMENTS</th>
<th>LEADERSHIP ROLE ELEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning &amp; budgeting</td>
<td>To quality; on time; on budget; detailed steps and timetables</td>
<td>Envisioning; strategic alliances; establishes direction and change creating overall strategy to get there. Ultimate performance responsibility</td>
</tr>
<tr>
<td>Operational Performance</td>
<td>Systems &amp; policies creation; detailed planning and monthly budget control</td>
<td>Aligns key sub-groups &amp; external stakeholders</td>
</tr>
<tr>
<td>Controlling &amp; problem solving</td>
<td>Minimises deviations from plan. Monitors budgets &amp; results</td>
<td>Motivational activity toward the vision. Creates human resource policy; major resources provision</td>
</tr>
<tr>
<td>Creation of processes</td>
<td>Hands on management &amp; control / audit</td>
<td>Leadership processes in change management; corporate image change; culture change; climate change</td>
</tr>
<tr>
<td>Primary co-ordinating</td>
<td>Job descriptions; chain of command; task specifications</td>
<td>Role descriptions much less specified; informal networks and relationships</td>
</tr>
<tr>
<td>mechanisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Presentability and order</td>
<td>Change and adaptability</td>
</tr>
</tbody>
</table>

Note: The author’s summary of management and leadership roles in relation to major corporate functions.

It seems reasonable to suggest at this stage, that the pharmacy leadership bodies should concentrate on the issues in the last column of the Table 45, but at the same time giving guidance on the systems, operating procedures, processes and task mix for the body of the profession at the delivery face. Even the multiples and publicly quoted companies will be required to operate within professional guidelines, with quality assured processes. In a change programme of the magnitude contemplated, leadership and management responsibilities need careful co-ordination, so that the professionals at the primary care patient / doctor interface perform with efficiency, quality and consistency in line with Kotler’s core, tangible and augmented aspects of the product; the medicines management service.
5.7 MOTIVATION

5.7.1 Introduction

Although briefly discussed in Chapter 3, in the context of marketing the new pharmacy service to doctors (the target market), motivation, in this section, is discussed in relationship to the task of motivating pharmacists to move from a supply function to one of cognitive service. The subject has also been touched upon in section 5.6, as a function of leaders, in bringing their subordinates to a future desired position in company or organisational performance. Here, in the MM project, the pharmacist population will need assistance / encouragement to move into a different order of service.

It is important, therefore, to consider other approaches to motivation, alongside Maslow's early ideas. Motivation has been defined as follows, (Huczinski and Buchanan, 1991: 64):

'...a decision making process through which the individual chooses desired outcomes and sets in motion the behaviours for acquiring them...'

In every day parlance, people are spoken of, from time-to-time, as well motivated or sometimes de-motivated and in organisational theory, high motivation is perceived as being one important determinant of good performance, (Kanfer, 1990: 75 - 170). Hence organisations have sought ways of motivating work forces to deliver best quality; best output; and, best attendance, to name but a few organisational human resource objectives.

In addition to Maslow's early ideas, a number of other approaches have been developed by researchers and these are discussed in the following pages. If change can be facilitated for pharmacists through established motivational techniques, then the willing collaboration with the change process and objectives may be accomplished. If so, then
the involvement and commitment which results, could in turn, become a secondary change driver helping to increase the momentum of change.

5.7.2 Theories of Motivation and Comment

Motivation, it seems, is generally interpreted in two broad ways:

i. As the mental process which leads people to pursue certain objectives and the link they consciously make between the objectives and the behaviour which they decide will help to achieve them. In this context it has been defined as:

"The internal psychological drives of the individual, giving rise to activity which seeks to initiate, direct and terminate behaviour."

(Landy & Becker, 1987: 1 – 38); and,

ii. As the social processes that people use in seeking to change the behaviour of others, i.e. by the cultural norms of societal expectation and their valued perceptions, e.g. 'wealth is admired', 'social position is admired'; 'hard work should lead to success'; 'achievement is satisfying'. In this context it has been defined as:

"Managerial activity to encourage specified results from others in the organisational environment."

(Tosi, et. al., 2000: 127 – 129)

The common element in the above two concepts is the goal(s) or objective(s) that people consciously recognise as part of their existence. This is not to imply that all people then actively pursue such goals, but if it is recognised that general societal and work goals do exist, then it may be possible to show people a route and reward of achievement.
Briefly restating the potential in Maslow's theory in an organisational context for pharmacy:

**Esteem Needs**
May be partly fulfilled by positive work-results feedback, through patient satisfaction surveys, doctor satisfaction surveys and in cultural terms, moving up the health care delivery chain to greater profile and recognition; and,

**Self Actualisation Needs**
May be fulfilled by equipping pharmacists who've been in the dispensing contract for a long time, with new clinical knowledge / interpersonal skills to discharge the new role – achieves 'consultant' status in medicines management. Transforms pharmacy into a clinical service.

Maslow's approach is classified as a content theory, because it consists of a proposed package of inherent needs, to explaining motivation in a social context, rather than an organisational setting.

However, alternative approaches have been developed by other workers and researchers in the field of motivation. These appear to fall into two categories:

- Theories known as *process* theories, seeking to explain the routes by which people can be motivated by others to undertake some course of action; and,

- Theories known as *content* theories, seeking to explain the individual's internal psychological factors that initiate and sustain pursuit of certain objectives.

It seems to be recognised, however, that each group of theories contains elements of the other, as some human drives are learned by socialisation with peer groups which reinforce certain ideals and objectives of the particular culture. Examples of these two groups of theories are discussed in the following section.
5.7.3 Process Theories

Reinforcement Theory

Reinforcement theory, as discussed by Allyon & Azrin, (1965: 357 – 383) appears to have been used successfully in industry and depends upon the particular approach taken to sustain good effort, or to discourage undesirable practice in the work place. Positive reinforcement is found to increase the probability of repeated good practice, as is negative reinforcement.

An example of the latter, in relationship to the proposed new pharmacy role, might be the removal of certain barriers to change. One of these, for example, could be the present full work load of the pharmacist, leaving no time for additional responsibilities. This could be resolved by taking away the barrier through delegating some of the present pharmacist activities to technicians. Similarly, positive reinforcement could be by adding incentive, through designing and implementing a new more fulfilling and better remunerated contract. Other elements of reinforcement theory are:

- **Punishment** – which can deter bad practice but have unpredictable side effects, such as resentment in other staff, by implied peer group pressure (e.g. statutory committee judgements); and,

- **Extinction** – removal of benefits, if only average performance is delivered. In pharmacy, this could be, for example, removal of the ‘period-of-treatment-fee’, if pharmacist influence on excess doctor prescribing proves ineffectual.

Reluctance in moving into a new cognitive service by community pharmacists could result in reduction of dispensing fees and part of the ‘global sum’ removed to fund other suppliers of the medicines management service. Reinforcement approaches to change, if managed well, could be an effective lever of change into the new role.
Expectancy Theory

At about the same time as Maslow, another American psychologist, E.C. Tolman argued that human behaviour was determined by the goals people have (either emergent or actively decided) and the personal activity they perceived as being necessary to achieve them. (This is as indicated in item (i), page 249). Georgopoulos et. al., (1957: 345 – 353) applied this concept in the work situation, in what they described as a path goal approach, to work productivity. This latter activity was seen by them as a function of the individual’s goals (as delivered by management) and required behaviours (paths) to achieve them.

The benefits of being able to set goals and constructively help with the means of achieving them (for example, introduction of more efficient systems and procedures) made this theory attractive to management. In pharmacy the position will be similar as new systems are introduced and this could still tie in with Maslow’s approach, (self esteem / actualisation) in constructing the goals, which would additionally include doctor and patient satisfaction and improved clinical outcomes. As new contract proposals are a real possibility in 2003, this new service could be based, not upon global sums, which divide a fixed financial return, but item of service payments, which multiply individuals’ rewards. The Georgopoulos approach has become known as expectancy theory because of the expectations people develop from set objectives and routes of achievement. It is thus classified as a process theory.

In 1964 a researcher named Vroom, also developed such a theory, which he formalised on mathematical lines. This rested upon a number of assumptions (Vroom, 1964: 8 – 28):

- People pursue desirable outcomes;

- People place subjective values on these outcomes (called valence, V) and exercise preference;
• People have a view about the likelihood of achieving these outcomes by good performance. Expressed mathematically as a probability this can be between 0 and 1. This is known as instrumentality (I); and,

• People further have an expectation that effort will result in good performance. Expectancy (E) can also be measured in probability terms, i.e. from 0 (no possibility) to 1 (certainty).

Vroom further argued that behaviour can have a number of outcomes and so the alternatives have to be summed up if expressed mathematically:

\[ F \text{ (force of motivation)} = \Sigma (V \times I \times E) \]

Clearly, if one of the components on the right hand side of the equation is zero, then \( F = 0 \). This apparently is why the equation cannot be expressed in a summational way:

\[ F = \Sigma (V + I + E) \]

If the probability of becoming a world marathon champion is zero, it matters little that \( E \) or \( V \) is high; the outcome is still zero. The probability of arriving at the desired outcome of the medicines management pilot trials is, on experience and evidence so far, very good and the possibilities for Vroom's equation being fulfilled positively, are good as \( V \) is indicated by the DH as being positive. (Although not called \( V \) by them).

Vroom's ideas appear to be usable in the pharmacy context through leadership communications emphasising the value of medicines management outcomes through, for example, Maslow's concepts as well as financial rewards and also delivering a route map to achieving the outcome (Author's leadership definition, p. 220). Job design is involved, in this particular approach, because of the potential need to free up time for the pharmacist to perform new roles. In this respect, re-design of the pharmacist's job, which is what medicines management does, could be looked upon as job enrichment and emancipation from a routine and sometimes boring process of re-labelling medicines and mechanically processing an FP10.
The work experience of the dispensing process could certainly be enhanced by formally adding other elements of patient care to it, for example, identification of adverse drug reactions, drug interactions, side effects and issuing formalised reports to the doctor of such effects for eradication. This may give better job satisfaction, but would it reposition pharmacy within primary health care? In the view of the author it would not, simply because there is minimal patient involvement and adverse drug reactions could equally easily be identified by the doctor, health visitor, social worker or nurse.

However, such modest formalised additions to the dispensing process, could perhaps be regarded as preliminary incremental change to the standard dispensing process and therefore the beginning of general movement in the overall change process toward medicines management.

Goal Setting Theory

This is another 'process' approach to motivation based upon the proposition that necessary desirable goals are pursued by individuals if they are clearly set out. Such goals give or reinforce a person's workplace raison d'être. Locke et al., (1981 : 125 – 152) showed that specific goals set for a range of personnel (laboratory, production, marketing and students) achieved consistently higher performance than those simply 'trying to do their best'. In this context, information sharing and participation in setting goals is important, as is feedback on progress. Further, a sense of self confidence or competence related to which is self esteem (Maslow), is a strongly related factor. In further research into this route of motivation it was found that managers with high self esteem worked harder toward performance goals than those with low self esteem (Carroll & Tosi, 1973 : 235 – 237; Locke, 1997 : 375 – 412).

Goal setting in the proposed new community pharmacy service could revolve around clinical governance and patient outcomes measured by health gain and quality of life improvement.
Equity Theory

This relates to the perception of personnel, as they evaluate fairness of treatment. Adams, a social psychologist, (1963 : 422 - 436) proposed a ‘social’ approach to motivation, based upon interpersonal comparisons, such as mentioned above, which were made by people in the course of their work. This rests upon the proposition of perceived fairness and is known as equity theory. In essence this regards people as being aware of and concerned with, comparative treatment of themselves and related groups with similar jobs. They engage in comparisons based upon their own evaluation of what inputs were being made, to attract observed rewards. They are said to compare their own ratio of input to returns, with the same ratio in the comparator group or individual. When these ratios are about the same then treatment is judged to be fair.

Greenberg in 1989 / 90 conducted studies in the effects of perceived pay inequities in three different production plants of the same company during an economic down turn in trade, in two of them. (Greenberg and Stone, 1992 : 76)

<table>
<thead>
<tr>
<th>PLANT</th>
<th>BUSINESS SITUATION</th>
<th>EMPLOYER ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plant 1</td>
<td>poor economic results</td>
<td>pay was reduced by 15%</td>
</tr>
<tr>
<td>Plant 2</td>
<td>poor economic results</td>
<td>pay was reduced by 15%</td>
</tr>
<tr>
<td>Plant 3</td>
<td>stagnant economic conditions &amp; performance</td>
<td>pay kept static</td>
</tr>
<tr>
<td>Phase 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plant 1</td>
<td>employees given thorough explanation of the reasons and need to preserve employment; management showed sympathy and regrets</td>
<td>theft rates marginally increased (of tools and equipment)</td>
</tr>
<tr>
<td>Plant 2</td>
<td>employees given minimum explanation and no sympathy from management</td>
<td>theft rates dramatically increased (of tools and equipment)</td>
</tr>
<tr>
<td>Plant 3</td>
<td>employees given brief explanation of static conditions which meant no increase</td>
<td>theft rates unchanged (of tools and equipment)</td>
</tr>
</tbody>
</table>
The results were predicted by Greenberg with accuracy before implementation. After the recession the effects returned to normal when pay increases were re-instated. This and other studies, (e.g. Bretz & Thomas, 1992) have shown that perceptions of inequity produce de-motivation and negative consequences. Equity theory thus has a contribution to make to understanding motivation in the work situation and the consequences of negative contextual factors.

5.7.4 Content Theories

Maslow's theory has already been considered and other theories based upon 'needs' of the individual followed his proposals. The basic premise recognised by all such researchers was that people will generally respond to innate or perceived needs by trying to satisfy them.

Achievement Power Theory

Two decades after Maslow, McClelland (1965: 321 - 323) developed an 'achievement power' theory in which he described motives as:

'...affectively toned, associated networks arranged in a hierarchy of strength and importance peculiar to the individual...'

The three basic motives he described were:

- The need for achievement - the extent to which success is important;
- The need for power - the need to exercise influence over others; and,
- The need for affiliation - the need for recognition in connected groups.
This differs from Maslow's theory in that the 'hierarchy' varies from individual to individual and one of the above three aspects may be dominant for any one person.

All three elements could relate to pharmacy and be motivational inducements to promote change by:

i. Demonstrating the *achievement* potential via medicines management by elevating the pharmacist's importance in primary health care;

ii. Demonstrating the power potential in being a decision maker in patient medication selection and adjustment; and,

iii. Demonstrating the prestige affiliation with the prime decision maker (the GP) in patient medication, in a potentially competitive situation.

This theory could be used for background marketing communications 'theme-ing', in promotional literature and messages (conferences).

*Job Enrichment Theory*

This is founded upon the proposition that the nature of the work undertaken has an effect upon motivation. This approach has been studied by researchers, such as Herzberg, (1959), Lawler, (1973) and Macoby, (1988) and it is said that changing the design of a job can determine intrinsic and extrinsic rewards.

Intrinsic rewards are those valued outcomes which the individual pursues (self actualisation; esteem; achievement) and extrinsic are those contrived by others, (prestige titles; symbols; trappings of authority; bonuses linked to performance). A so called job 'characteristics model', generically describing methods of job enrichment, was constructed by Hackman et. al., (1975 : 62) and links the:

- Characteristics of jobs, with...
- The individual's experience of these characteristics, with...

- Resultant outcomes

Again, desire for personal growth and fulfilment and self actualisation present themselves as variants within each individual and motivation will consequently vary. Of special interest in the context of primary care pharmacy is the heart of the model which splits any job into five dimensions.

<table>
<thead>
<tr>
<th></th>
<th>Skill variety</th>
<th>Extent to which the job uses different skills and abilities;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Task identity</td>
<td>Extent to which the job encompasses a complete piece of work;</td>
</tr>
<tr>
<td>2.</td>
<td>Task significance</td>
<td>Extent to which the job affects other organisation members;</td>
</tr>
<tr>
<td>3.</td>
<td>Autonomy</td>
<td>Extent of individual freedom; and,</td>
</tr>
<tr>
<td>4.</td>
<td>Feedback</td>
<td>Extent to which performance excellence is related back to the individual.</td>
</tr>
</tbody>
</table>

The whole model is diagrammatically set out in Figure 44, on the next page, (Hackman et al., 1975 : 62).
Figure 44  JOB CHARACTERISTICS MODEL
(AN EXPECTANCY THEORY)

**Note:** The model shows how the elements under 'core job dimensions' are fed and enhanced by the implementation concepts to deliver enriched psychological states and better work outcomes.

**Pharmacy Implications**

The motivational possibilities in this model, so far as primary care pharmacy is concerned appear to revolve around:
Skill variety  Equip pharmacists with a comprehensive clinical and communication abilities.

Client relationships  Equip pharmacists with interpersonal skills for GP / patient interaction.

Autonomy  Build the actualisation potential in carefully structured communications to pharmacists from leadership. Support independence and authority to make decisions.

Personal & work outcomes  Resulting from confidence in knowledge, skills and ability in medicines management, patient feedback and influence with the doctor.

These factors again reference back to Maslow’s construct of innate needs together with marketing communications copy, which should theme around self esteem and self actualisation in the professional forum.

At about the same period as Hackman’s work, another researcher in the USA, (Herzberg, 1968 : 53 – 62) was investigating a different approach to organisational motivation encompassing not only motivating influences but also de-motivating circumstances which obstructed motivating factors from being fully effective.

The de-motivational influences he called hygiene factors and included such items as poor working environment, low pay, poor professional relationships and poor staff benefits. However, his research indicated that whilst such factors were an impediment to positive motivational activity, removal of them did not constitute a motivating force themselves. They simply allow other motivational effort to proceed unimpeded.

The task of leader or manager is therefore to see that both issues are properly addressed. Within community pharmacy the implications are likely to include an equitable remuneration reward system to justify the substantially increased effort required from community pharmacy in medicines management. Consistent comments to the author at seminars and conferences since the termination of the cost-plus contract, indicate dissatisfaction even with the present remuneration package for dispensing.
A comment from a seminar in Swansea (35 pharmacists) illustrates a common attitude:

‘... the way the DH has retained all its own advantages from the old cost-plus contract and removed all of ours, shows what they think of us...’

(Swansea: Medicines Management Seminar, 23.04.02)

The comment received murmurs of support in the group and no dissent.

The general working environment for pharmacists, is on the other hand, largely a matter of self selection in the independent sector and good in the multiples who have additional benefits for employee pharmacists, such as career development, pension schemes, bonus schemes and training packages. It could be argued that the multiples are driven to compete with each other on such benefits because of an adverse supply position for pharmacist labour. Their employment terms are therefore arguably at least what the market minimally expects. In the forty five years experience of the author within the profession, the independent sector dissatisfaction has focused around perceived inadequate reward from the NHS contract compared with other professionals and their respective contracts. It should be said, however, that little research appears to have been done, by the PSNC on comparative, measured responsibilities / rewards, with the other NHS health care professions. Career patterns within the multiples do, understandably, involve a different assessment process, which takes into account commercial management responsibilities as well as professional pharmacy qualifications and obligations.

Herzberg's motivational factors included:

- Interesting and meaningful work content;
- Sense of achievement;
- Recognition;
- Responsibility; and,
- Personal growth and advancement.
Herein is potential attractiveness in medicines management, which arguably has the potential to deliver all of the above desirable elements of motivation.

In practical terms, in the pharmacy work situation, such 'hygiene' factors as Herzberg conceptualised, could ensure:

- Adequate bench space for efficient systematic dispensing, ready for increased technician responsibility;
- Adequate consultation facility for the new pharmacist / patient interface;
- Non-stressful workload quotas for each member of staff;
- Adequately trained support staff; and,
- Pleasant pharmacy layout.

In a new demanding service, such as medicines management, the working conditions need to be right, properly rewarded and patient friendly in order to engage commitment and sustained dedication to the role. There are high expectations for beneficial outcomes to the DH, the tax payer, the patient, the pharmacist and the doctor, as indicated to the author in a conversation with the Chief Pharmacist DH, in May 2002. It follows, therefore, that the profession’s leadership have a duty to create the right motivational circumstances in discussion with the DH, to achieve the benefits for the major stakeholders.

5.7.5 A Content & Process Theory Combined

A more comprehensive model of motivation, borrowing elements of content and process theories and containing some of Maslow’s elements was constructed by Porter and Lawler (1968 : 165).
The elements of the model are set out below:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Intrinsic Rewards</th>
<th>Originating with the person or job itself (self esteem; actualisation; job interest / variety)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Extrinsic Rewards</td>
<td>Arising externally from third parties. (praise, recognition, promotion, pay, bonuses, etc.)</td>
</tr>
<tr>
<td>Factor 2</td>
<td>Perceived value of the rewards</td>
<td>Is value commensurate with job input &amp; value? Is it seen to be worth pursuing?</td>
</tr>
<tr>
<td>Factor 3</td>
<td>‘Performance - Reward’ probability is clear</td>
<td>The performance delivered has every chance of achieving the rewards</td>
</tr>
<tr>
<td>Factor 4</td>
<td>‘Effort - Performance’ probability is assured</td>
<td>Effort to performance relationship to be credible and achievable</td>
</tr>
<tr>
<td>Factor 5</td>
<td>Perception of role demands</td>
<td>Role to be credible and perceived as such</td>
</tr>
<tr>
<td>Factor 6</td>
<td>Task abilities required</td>
<td>Within the competence of the worker and perceived as such</td>
</tr>
<tr>
<td>Factor 7</td>
<td>Perceived equity rewards</td>
<td>Rewards stand up to comparison with similar reward systems</td>
</tr>
</tbody>
</table>

This model is diagrammatically summarised in Figure 45.
Figure 45  PORTER AND LAWLER MODEL OF MOTIVATION (After Porter – Lawler, 1968: 165)

- Perceived Value of Reward (Factor 2) (Reinforcement)
- Expectancy Vroom
- Perceived Effort – Performance Probability (Factor 4)
- Perceived Performance – Reward Probability (Factor 3) (Expectancy – Vroom)
- Task Ability – Confidence (Factor 6)
- Maslow Self Esteem
- Perception of Role Demands (Factor 5)
- Performance at required level
- Extrinsic Rewards (Factor 1)
- Intrinsic Rewards (Factor 1)
- Herzberg Motivators
- Herzberg Hygiene Factors
- Adams: Equity
- Perceived Equity of Rewards (Factor 7)
- Note: The factors' interplay, is shown together with the types of motivation theory at work and their authors.
- Satisfaction

Achievement reinforces probability

Mutually complimentary
5.7.6 Section Summary

The purpose of visiting the issue of motivation has been to explore some elements of potential address in moving community pharmacists from supply to cognitive service. Several issues emerge as potential areas of detailed consideration in encouraging pharmacists to shift into a new order of health care:

- A potential to take account of Maslow's concepts of self actualisation and esteem. Greater professional fulfilment should be experienced in cognitive service;

- The assurance of commensurate rewards based upon equity and comparative rewards in related professions;

- The professionals' belief that quality performance will deliver those rewards;

- Equipping the profession with task ability, to give confidence in role discharge and enjoyment of the new activity;

- Good communications from leadership in setting out a clear route by which role change can be achieved and enjoyed; and,

- Visible recognition and praise for those who systematically move into the new service - extrinsic rewards.

Motivation, on the evidence examined, appears to be a subject which will continue to unfold and new principles and techniques discovered, but there is enough solid foundation on which to build a programme of leadership effort for moving the profession forward. Much however, may depend upon the sincerity of the Department of Health in wanting to employ in greater depth, the qualifications and expertise of the pharmacist, whilst being committed to creating rewards perceived as equitable and achievable.
5.8 CHAPTER SUMMARY

Organisational development in a general sense, has been a feature of society since early history. Societal evolution, driven by environmental effects such as war, famine and survival needs, together with individual and group belief systems, such as religion and mysticism, have all played a part in developing more formal structures and cultures in all walks of life.

In the late nineteenth and twentieth centuries more specific attention was directed toward organisational development in the work place. Lewin and Trist's research into group behaviour in the first half of the twentieth century, heralded the emergence of formalised models of change, from further research and consultancy in the field of management.

Twelve such models have been examined here in the search for an appropriate model of effecting change in primary care pharmacy within its NHS responsibilities. The issues for pharmacy are complex but identifiable and thus capable of address. For this reason a change model has now been suggested by the author for application in pharmacy.

The Burke Litwin Model of Organisational Performance and Change has been chosen, because of its comprehensive address in principle and detail of the transformational and transactional aspects of the order of change required in pharmacy. An identified weakness of the model is its lack of specific address of the organisation's technical resources. However, this is not a weakness in the present application because it does deal with:

- 'task and individual capability'; and,
- 'individual needs and values'.

Herein lies the technical expertise within pharmacy, its professional knowledge base.

It contains all the elements requiring address in the proposed service change for pharmacy.
Motivation of the leadership bodies and pharmacists themselves remains of key importance in sustaining momentum for change and preventing strategic drift. Pharmacy currently has a unique opportunity for a bigger role in an expanding health care environment and failure to grasp it may result in a decline in role into that of a highly qualified technician, whilst other health professionals seize the option.

An outline examination of the motivational triggers and processes has indicated a number of potential ways of engaging the profession in commitment to change and the field research may give further clues on how these may be applied in the practical situation of community pharmacy.

Leadership targets and means of intervention have been explored and found to be useful in indicating both its role and relationship with the organisational management function. Leadership has a major role to play, which if mishandled, may well have to preside over a fragmented disorganised market situation. This would in turn send the wrong signals to the major stakeholders, who have so far supported the strategy of change; namely the doctors’ national General Practice Committee and the Department of Health.

Table 46 sets out the elements, or levers of change, in the Burke Litwin model and their suggested relevance to the present pharmacy position. The table also indicates potential marketing effort to be applied through each of the levers, in helping to initiate and sustain change. Marketing and change techniques are thus brought together by the author, illustrating how the two disciplines can be uniquely used to bring about change in the pharmacist’s role in primary care.

The following field research will help to steer the way forward and indicate where and how the theoretical research may be used. The results of this are set out in the following chapters.
Table 46  
BURKE-LITWIN CHANGE LEVERS: RELEVANCE TO PHARMACY: SUGGESTED MARKETING APPLICATION

<table>
<thead>
<tr>
<th>LEVER</th>
<th>RELEVANCE</th>
<th>MARKETING EFFORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LEADERSHIP</td>
<td>Compound disparate leadership requires constant effort to deliver congruent messages and integrate activity in leading pharmacist/pharmacy change.</td>
<td>PSNC MM group to plan programme of workshops to brief on change management and agree individual contributions. (Relationship/collaboration theme).</td>
</tr>
<tr>
<td>2. STRATEGIC INTENT</td>
<td>To reposition pharmacy in primary care and sustain competitive advantage.</td>
<td>Series of professional journal articles on necessity of change plus its benefits.</td>
</tr>
<tr>
<td>3. CULTURE</td>
<td>Historically programmed attitudes, some of which may impede progress. Culture shift required (Lewin &amp; Trist’s work).</td>
<td>Message content very important; disconfirm pasts interpretation of supervision; confirm safety of new proposition; have lead figures confirm. Journals and in-house letters and periodicals used for media campaign consistent and regular.</td>
</tr>
<tr>
<td>4. TASK AND INDIVIDUAL CAPABILITY</td>
<td>New skills and knowledge required for MM. Involves pharmacists, technicians, counter medicines staff. Key to a new pharmacy image and position in health care.</td>
<td>Publish in journals / periodicals the availability of training packages; menus of access and time / cost involvement of options.</td>
</tr>
<tr>
<td>5. INDIVIDUAL NEEDS AND VALUES</td>
<td>Self esteem; self actualisation; equity of rewards; belief that effort will deliver performance and the rewards.</td>
<td>A series of articles to a national programme, with local LPC collaboration and monitoring schemes.</td>
</tr>
<tr>
<td>6. SYSTEMS AND POLICIES/PROCEDURE</td>
<td>New IT links with GP and PPA. Exception reporting to minimise work.</td>
<td>Essence of message effectiveness is the right psychology and repetition. Benefits of MM to be specified and the utilities of those benefits (Ch. 5.2) clarified related to the needs and wants of pharmacist contractors (Ch. 4.4).</td>
</tr>
<tr>
<td>7. BUSINESS PROGRESS &amp; STRUCTURE</td>
<td>Re-engineer dispensing work process; greater technician responsibility and checking. Quality assured process and audit scheme.</td>
<td>Ideally a dedicated section in the Pharmaceutical Journal, until the profession move is finally under way.</td>
</tr>
<tr>
<td>8. MANAGEMENT PRACTICES/STYLE</td>
<td>Pharmacist / Doctor; Pharmacist / Patient interfaces to re-design; psychology very important to sustain cultural needs of both.</td>
<td>Consider similar uniforms and new livery for consultation area / dispensary – a major image change to be visible to public and DH. Again publicise in PJ, C + D, NPA internal supplement.</td>
</tr>
<tr>
<td>9. WORK GROUP CLIMATE</td>
<td>The group is pharmacist, technician and OTC medicines staff. A new collaborative atmosphere is required in integrating NHS + OTC medicines – part of MM.</td>
<td>All pharmacy media involved; web sites of PSNC, RPSGB, NPA and cross referenced in the professional press. Message content once again consistent with needs/wants of pharmacists and expressed as benefits.</td>
</tr>
<tr>
<td>10. MOTIVATION</td>
<td>Motivation engineered through the means explored in Ch. 5.7.</td>
<td></td>
</tr>
</tbody>
</table>

Note: The above table is the author’s view of where and what marketing effort can be applied in the context of the Burke-Litwin model of organisational performance and change.

ABBREVIATIONS:

<table>
<thead>
<tr>
<th>CD</th>
<th>Chemist &amp; Druggist</th>
<th>PJ</th>
<th>Pharmaceutical Journal</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM</td>
<td>Medicines Management</td>
<td>PPA</td>
<td>Prescription Pricing Authority</td>
</tr>
<tr>
<td>NIS</td>
<td>National Health Service</td>
<td>PSNC</td>
<td>Pharmaceutical Services Negotiating Committee</td>
</tr>
<tr>
<td>NPA</td>
<td>National Pharmaceutical Association</td>
<td>RPSGB</td>
<td>Royal Pharmaceutical Society</td>
</tr>
<tr>
<td>OTC</td>
<td>Over The Counter medicine</td>
<td></td>
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</tr>
</tbody>
</table>
CHAPTER 6

RESEARCH RESULTS ANALYSIS

PHASE 1

6.1 INTRODUCTION

The elements of research in this phase (Chapter 3 : 44 – 48) have been described in the method.

6.2 Key Informant Interviews; and,
6.3 National Focus Groups.

This chapter now brings together the results of phase 1 of the primary research and relates this to the previous chapters on marketing and change effort.

6.2 KEY INFORMANT INTERVIEWS
(Appendices 11a, 11b 11c, pages 434 – 438)

The content analysis, (Appendix 11c, page 438) is summarised in Table 47 abstracting the key issues from individual interviews. A commentary follows after the last sheet of Table 47. All interviews were cordial and constructive and have exposed a number of issues, which will be borne in mind when analysing the GP national focus group results and the results of the postal survey to GPs. Common themes will be abstracted from each and used to inform a change programme for repositioning community pharmacy within primary care, with reference to the key stakeholder, the GP.
<table>
<thead>
<tr>
<th>QUESTION</th>
<th>KEY INFORMANT</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Are there any aspects of patient treatment which may be suitable for new pharmacist involvement?</td>
<td>Compliance. ADR/Drug reporting or correction. Explain to the patient the medication.</td>
<td>Rationalise prescribing. Don’t add drugs to deal with side effects – change the basic drugs. Reduce costs by your price knowledge.</td>
<td>Pharmacists to deal with minor ailments. Biggest issue is patient compliance with treatment. Explain the medicine’s benefits.</td>
<td>Drug waste reduction. Patients to be encouraged to follow instructions. XS brand prescribing can be reduced.</td>
<td>Formalised advice to GPs on drug inter-relationships. Patient information on their medicine. Reduction in brand usage.</td>
<td>Patient understanding of drugs. Reduction in waste prescribing. Identify side effects. Harmonise treatment periods for each drug.</td>
<td>Clinics for such as asthma patients – how to maximise their drugs. Checks for ADRs. Motivate the patients to comply with treatments.</td>
<td>Monitoring drug response. Compliance clinics. Advice to GPs on minimising drugs interaction. Checking the response to a changed drug.</td>
<td></td>
</tr>
<tr>
<td>Q2 What do you anticipate will be GP reaction to a new structured relationship with community pharmacists?</td>
<td>Mixed; some will welcome; some will oppose. It needs selling – benefits shown.</td>
<td>Younger doctors will agree – older feel threatened. Some will employ pharms in GP practice.</td>
<td>New doctors will like it but older may give trouble. Overall it could reduce the doctor’s workload.</td>
<td>Mixed but Govt. pressure will help. They will groan about the work. Some will feel threatened.</td>
<td>OK in time, if their funds are not threatened. Some will be resistant but are under Govt. pressure for efficiency.</td>
<td>Older GPs have seen more and more people encroaching on their territory; may be resistant. Young doctors may be OK.</td>
<td>Will welcome if there is no increase in work and their fund is not threatened. OK if tasks agreed.</td>
<td>Good – if the elements are right. But it creates a lot of work. Suspicious if not well sold.</td>
<td></td>
</tr>
<tr>
<td>Q3 Do you foresee problems with such collaboration?</td>
<td>Yes, which pharmacies with which GPs. Reporting procedures. Quality markers.</td>
<td>Yes – a plan for introduction essential. Workload of GP. Patient confusion with who is responsible for what.</td>
<td>Yes, mainly the link up with information exchange and follow-up. GP time is a touchy subject.</td>
<td>Not if you plan well. A problem could be with the paperwork. Systems to be efficient. Keep things simple.</td>
<td>Handling the volume of work. Making your input effective. Doctor must act on your advice – how?</td>
<td>Matching the GP practices with the pharmacies. Patient continuity with same pharmacy confusion over which pharm sees which GP.</td>
<td>Keeping the paperwork down. Ensuring follow through of your input. Measuring the benefits you bring.</td>
<td>Persuading the GPs that it is worthwhile. Proving the benefits. Getting the organisation right.</td>
<td></td>
</tr>
<tr>
<td>Q4 How could such problems be addressed?</td>
<td>Focus group discussions with GP/Pharms. PCG could facilitate</td>
<td>Through discussion with GPs, LMC/LPC to collaborate.</td>
<td>Needs series of discussions. Benefits should be emphasised.</td>
<td>As I said – plan thoroughly. Discuss with GPs and PCGs.</td>
<td>Get Govt. research backing if possible. Design best systems to minimise volume.</td>
<td>You must work out a good system. Maybe HAPA could help.</td>
<td>Jointly with GPs; get joint solutions. Develop good IT systems.</td>
<td>A joint GP / Pharms study of the prospect. A number of pilots.</td>
<td></td>
</tr>
</tbody>
</table>

ADR = Adverse Drug Reaction  
CHC = Community Health Council  
DI = Drug Interaction  
FP10 = NHS Prescription Form  
GP = General Practitioner  
GPC = General Practitioner Committee  
HA = Health Authority  
HAPA = Health Authority Pharmaceutical Advisor  
IT = Information Technology  
LMC = Local Medical Committee  
LPC = Local Pharmaceutical Committee  
.Outer The Counter medicines  
PC = Patient Compliance  
PCG = Primary Care Group  
PCT = Primary Care Trust  
Pharm(s) = Pharmacist(s)  
RCGP = Royal College of General Practitioners  
XS = Excess
### Table 47 cont.

**KEY INFORMANT QUESTION / RESPONSE MATRIX : DISTILLATION OF COMMENTS**

<table>
<thead>
<tr>
<th>KEY INFORMANT</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q5</strong> What in your view, would be conducive to a new pharmacist involvement in patient care?</td>
<td>a) Confidentiality. Pharmacy premises not suitable; need better facilities. Pharmas running an efficient system.</td>
<td>a) GP confidence in the pharmacist. Your service presented as good support for doctor, not a replacement.</td>
<td>a) NPC support. RCGP support. Good liaison between the prof. Bodies for MEDICINE and PHARMACY. GP/Pharm, local good will.</td>
<td>a) HA support and coordination. LMC with major role in facilitation. Good GP/Pharm series of workshops.</td>
<td>a) A recognisably good training package for pharmacists in your complete new role proposition. A clear sign of teamwork.</td>
<td>a) Dr. to be assured of Pharm ability and report systems. Pharm support of all Dr. therapeutic decisions.</td>
<td>a) An LPC study of the GP and patient needs by LPC and a proposition put to LMC. Pharm. Ability to be assured.</td>
<td>a) Flexibility on location – GP surgery or pharmacy. Joint agreed routine for patient interview &amp; GP/Pharm meetings.</td>
</tr>
<tr>
<td>b) for patient?</td>
<td>b) Confidentiality. Simple non threatening approaches to patient. Encouragement for the patient on long term treatment.</td>
<td>b) Good pharmacy facilities. Good patient manner. Good follow through of decisions.</td>
<td>b) Good facility in pharmacy to give patients confidence. A good review routine. Patient knowledge that Dr. is directing affairs.</td>
<td>b) A clear procedure which shows the Dr/Pharm team effort. Professional facility in pharmacy.</td>
<td>b) A ritual which gives maximum patient understanding and support in helping compliance. Occasional Dr. &amp; Pharm meeting with patient.</td>
<td>b) A ritual that implies a joint initiative of GP and pharmacist. A familiar report form like a FP10. Relaxed atmosphere and some privacy.</td>
<td>b) User friendly format and minimise the questions; focus on main issues. Encourage relaxed procedure. Interviews at quiet times in pharmacy.</td>
<td></td>
</tr>
<tr>
<td><strong>Q6</strong> How could a more structured operation be developed between pharmacist and doctor?</td>
<td>HA, PCG, LMC, LPC need to agree a programme of effort. LPC should initiate Government support would be likely – would help to facilitate. PCG/PCT especially should be involved.</td>
<td>It should be 'top down' and assisted by 'bottom up' initiatives. Workshops to agree approach. Working groups to agree systems. Pilots to try out: LMC/LPC close liaison. Start by linking GPs with the closest pharmacies for trials.</td>
<td>Workshops to agree approach. Working groups to agree systems. HA can facilitate a series of focus groups to define the operational requirements. HA can give steer on patient 'needs' address. LMC/LPC to work closely.</td>
<td>Outside help may be needed – consultants. HA can assist with systems via PCGs / PCT and practices – a study should be conducted after requirements are defined.</td>
<td>A group of GPs &amp; Pharm should meet to discuss and define the intervention and tasks. Needs of GPs can be defined then build the system. Joint university Med &amp; Pharm schools could provide seminars &amp; workshops.</td>
<td>LMC/LPC should discuss and agree both protocols and role content. Then design paperwork to fit requirements. Consider exceptions only for drug change: exception reports are time efficient. GPs would welcome.</td>
<td>HA and LMC can assist redeveloping an admin system. Keep it simple and start thinking IT connections. Consider Dr./pharm team building initiative. Confidential IT exchange of key medicines records between Dr./pharm.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADR</th>
<th>Adverse Drug Reaction</th>
<th>HA</th>
<th>Health Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC</td>
<td>Community Health Council</td>
<td>HAPA</td>
<td>Health Authority Pharmaceutical Advisor</td>
</tr>
<tr>
<td>DI</td>
<td>Drug Interaction</td>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>FP10</td>
<td>NHS Prescription Form</td>
<td>LMC</td>
<td>Local Medical Committee</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
<td>LPC</td>
<td>Local Pharmaceutical Committee</td>
</tr>
<tr>
<td>GPC</td>
<td>General Practitioner Committee</td>
<td>OTC</td>
<td>Over The Counter medicines</td>
</tr>
</tbody>
</table>
### Table 47 cont.

#### KEY INFORMANT QUESTION / RESPONSE MATRIX: DISTILLATION OF COMMENTS

<table>
<thead>
<tr>
<th>KEY INFORMANT</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7 Where should a new pharmacist role be located?</td>
<td>The pharmacy. In some cases the surgery. Pharmacists may need a little more professionalisation.</td>
<td>Pharmacy – but will need flexibility for some elderly and housebound.</td>
<td>Pharmacy is best where the prescription is dispensed.</td>
<td>Leave choice to patient if necessary, but prefer pharmacy where OTC can be checked as it happens when patient is buying.</td>
<td>Pharmacy is only place where OTC/NHS conflict of treatment can be checked.</td>
<td>Pharmacy if IT link systems are good enough. Could be a need in some cases for locating in surgery – difficult family circumstances.</td>
<td>At surgery, but good IT may change my view. Surgery location keeps it a truly medical matter.</td>
<td>At pharmacy if patient registration can be arranged – gives good consistency. Patients could view other dosage forms here if necessary.</td>
</tr>
<tr>
<td>Q8 In a new pharmacist role along the lines we have discussed, are there any aspects you feel should be omitted?</td>
<td>Diagnostic issues – that is Dr’s job. But add official reporting of ADRs. Avoid at present, therapeutic substitution.</td>
<td>Don’t always shift from brand to generic. Sometimes the sustained release brands are better than old generics.</td>
<td>No, but develop effective measures for compliance. This is a major issue. Much drug wastage is created by non-compliance.</td>
<td>In developing cost savings don’t sacrifice quality. Keep prejudice out of drug selection.</td>
<td>No, but try to reduce drugs wastage by limiting the periods of supplied quantities.</td>
<td>Try to develop better compliance; motivation of patients is essential. Be careful with family problems.</td>
<td>Don’t major on therapeutic substitution. Brand to generic shifts OK most of the time.</td>
<td>No, but keep the process as simple as possible. Keep away from medicines selection in first instance.</td>
</tr>
<tr>
<td>Q9 Would you like to be involved in developing a new role for pharmacists in partnership with GPs?</td>
<td>Maybe issues I could help in – quality issues and the like. Keep me informed please.</td>
<td>Would be interested in pilot and development work.</td>
<td>I could give advice on some issues.</td>
<td>Depends upon HA view but I think yes.</td>
<td>I think HA would say yes and I certainly would.</td>
<td>Yes.</td>
<td>Yes.</td>
<td>Yes, it would be ideal here. We could work through it together.</td>
</tr>
<tr>
<td>Q10 Would you be willing to comment on some aspects of this research?</td>
<td>Unofficially yes. Politically sensitive. Must be confidential.</td>
<td>Yes.</td>
<td>Probably yes. Time is the factor.</td>
<td>Yes.</td>
<td>Yes, if confidential.</td>
<td>Yes.</td>
<td>If time permits.</td>
<td>Certainly. Let me know how you propose proceeding.</td>
</tr>
</tbody>
</table>

ADR: Adverse Drug Reaction  
CCHC: Community Health Council  
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PCG: Primary Care Group  
PCT: Primary Care Trust  
Pharm(s): Pharmacist(s)  
RCGP: Royal College of General Practitioners  
XS: Excess
6.2.1 SUMMARY AND BRIEF COMMENT
(KEY INFORMANTS' RESPONSES)

The main themes emerging from the eight key informants are:

• Patient non-compliance with medicines regimens is a major concern in these informants’ perceptions. It was raised specifically in responses to Questions 1, 5, 8 (and obliquely throughout discussions). (A, C, F, G, H)

• Doctor autonomy and lead role were also implied as important to the doctors. This theme recurred in responses to Questions 2, 5, 7 and 8. (A, B, C, D, F, G)

• Implications of the new pharmacist role being ‘threatening’ emerged from responses to Questions 2 and 5. (B, C, D, E, F, H)

• Message source and sponsorship may be important in helping avoid this. Respected sources, in persuading GPs to adopt the new practice, could be a key consideration in leading the GPs into change. GPs themselves, despite any reassurances given to them, may be apprehensive about deeper pharmacist involvement with their patients. Lead figures in their own profession, with positive encouragement messages, could be a key factor in the change process; Questions 4 and 6. (A, B, D, E, G, H)

• GP workload was cited by four informants as being a potential barrier to progress. If medicines management imposes a bigger workload on doctors, it could be slowed down, or rejected as a new service from pharmacists; Questions 2 and 3. (B, C, D, E, G, H)

• Joint development of the project (with GPs and pharmacists), was suggested and also the need for a team relationship. Good persuasive communications to doctors is clearly signalled, together with team workshops facilitated by the PCT. Questions 4, 5, 6. (A, B, C, D, E, F, G, H)
• Potential doctor age related barriers were raised by three informants; Question 2. (B, C, F)

• Pharmacy facilities need to be appropriate for patient confidentiality, confidence and recognition that the new pharmacist role is a joint structure; Questions 5a and 5b. (A, B, D, E, F, G)

A proper consideration of marketing philosophy and principles, its tools and channels of application, should take account of cultural sensitivities, particularly self esteem and doctor autonomy in the health professional hierarchy. Barriers to progress, such as perceived extra workload and age related resistance, will need address through the tangible product, (Chapter 4) and tailored communications process and content (Chapter 4). The overall positive views of the key informants may be because of their in-depth knowledge of the changing nature of the NHS and the desirability of each professional making a full contribution to patient care, as indicated in the Government White Papers on the 'New NHS'. None overtly voiced knowledge of prejudice among GPs, but some comment may imply an assumption that the GP should be seen as the lead professional in the new service, not least by the patient. These views relate to Garvin's dimensions of quality (Chapter 4: 75 – Table 15) in product design and the relationship is set out in the following table:

Table 48

<table>
<thead>
<tr>
<th>DIMENSION (Bold Type)</th>
<th>KEY THEME (Light type)</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance</td>
<td>Confidence in pharmacist</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Proprietary Practices</td>
<td>Confidentiality</td>
<td></td>
<td>X</td>
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<td></td>
<td>Premises adaptation</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td></td>
<td>Clear sign of team working</td>
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<tr>
<td>Durability</td>
<td>Run an efficient system</td>
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<td></td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Reliability</td>
<td>Good liaison inter-</td>
<td></td>
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<td></td>
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<td>X</td>
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<td></td>
<td>Professionally</td>
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<td>X</td>
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<tr>
<td>Aesthetic</td>
<td>Present as support for doctor</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>- not competition</td>
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<td></td>
<td></td>
<td>X</td>
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</tbody>
</table>

Note: The crosses indicate mention by the respective key informant, of issues caused by the 'DIMENSIONS'
6.2 NATIONAL FOCUS GROUP

6.3.1 MEDICO-PHARMACEUTICAL LEADERSHIP FOCUS GROUP
(Appendices 13A, 13B, 13C, 13D, pages 466 – 484)

The complete focus group discussion content analysis is set out in Appendix 13D and the key themes are summarised as follows:

- Non-compliance by the patient with the regimen, again emerges as a major issue. There was repeated return to this issue. (Questions 1, 2, 5, 8, 9 responses);

- Doctor self esteem and autonomy are important implications (responses to Questions 2, 8, 9, 10);

- Resistance to increased workload could be a major barrier if the medicines management product is not properly constructed. (Questions 2, 3, 5, 9, 10 responses); and,

- The desirability of doctor / pharmacist collaboration underpinned the doctor responses (Questions 1, 2, 3, 5, 6, 7);

6.3.2 SUMMARY – MEDICO-PHARMACEUTICAL LEADERSHIP FOCUS GROUP

There was clear indication, by body language and repeated return to compliance issues, at certain points in the discussion, that some responsibilities for patient care are considered by GP leaders as the preserve of the GP (as indicated in Questions 2 and 10) (Appendix 13D). Here is an opportunity to design the product offering accordingly, by retaining doctor leadership in the medicines management process. The **tangible** and **augmented** product features can be constructed to accommodate and enhance the appeal to doctor culture (Chapter 4), for example, locating clinical decision discussions at the GP surgery, chaired by the doctor and disease areas of address, prioritised by the doctor.
Overall, there was a high degree of similarity with the essential themes of the Key Informant responses to some questions (Table 49), even though the questions themselves were not identical; e.g. compliance is a major issue; workload; spirit of collaboration; and whilst no overt hint of being threatened emerged, Dr B (Question 8) wanted measurable results that both doctor and pharmacist would look at. The other GPs present, by nods of agreement, emphasised this point. The underlying cultural perspectives of the GP in the work situation may account for this. All medical members of the national focus group were practising GPs.

However, no mention was made by participants of the focus group about the possibility of age related GP resistance, or a need to sell the new pharmacy role to the medical profession. This may be due to the medical leadership knowledge of the need for cultural change in primary care, engineered by Government documents and White Papers, (1997- 2002) emphasising performance, clinical excellence, and 'partnership' between the health professions.

The comparative views of the GP key informants and focus groups, are set out in Table 49, together with the suggested marketing implications of both.

6.3.3 PHARMACY MEDICINES MANAGEMENT LEADERSHIP FOCUS GROUP
(Appendices 12A, 12B, 12C, pages 446 – 465)

The complete group content analysis is set out in Appendix 12C (page 465) and the key themes are as follows:

- Special training for MM will be required;
- Outcomes for beneficiaries (GPs & patients) very important;
- GP/pharmacist teamwork is essential – pilots advised; and,
- Pharmacy and medical leadership collaboration essential.
Columns 2, 3 and 4 of Table 50 show a positive response to the prospect of medicines management and recognition of the need for collaboration internally and externally at leadership levels. Piloting the service was considered essential, as was joint ownership of the whole introductory process. Allocation of specific responsibilities for each lead body in pharmacy was assumed from cues in the comments and collaboration in the group (Appendix 12B, items 5, 6). This turned out to be the case as evidenced by formation of the leadership group. A summary of key issues and areas of agreement is set out in Table 50 and the sub-committees are as set out in Appendices 4 to 9, (pages 421 – 432).

6.3.4 SUMMARY

Table 49 draws together the themes expressed by key informants and the medico-pharmaceutical focus group. The key marketing elements which could address these themes have been abstracted from the literature research on marketing, (Chapter 4: 64 – 84; 111 – 114; 122 – 127) and cross matched in the matrix, showing potential links. Marketing activity through the listed elements should be constructed around the cells marked with an asterisk under the column header. On this basis, the expertise of relationship marketing, emphasising for example, service quality, through consonant messages from opinion leaders supporting the doctor led health care position, would be applied to underpinning the existing GP support for medico-pharmaceutical collaboration. Similarly, design of the new service and its promotion (‘product design’) would use the tangible and augmented product aspect to portray the new service as doctor led, quality assured and guaranteed through clinical governance (Kotler & Clarke, Figure 8, page 68). Likewise the remaining themes at the head of the table are addressed using appropriate elements of the marketing process and marked in the table cells as the author’s concept of the appropriate link up.

Table 50 (page 281) summarises in matrix layout, the individual contributions of the pharmacy focus group under the main heads of discussion at the top of the table. It contains pointers to targets of change activity in moving to a new role. (Chapter 5: 199 – Figure 33) such as:
• Leadership activity importance;
• Tasks and individual capability;
• Individual, team & organisation performance; and,
• Strategic Intent.

This means that the profession's leaders have a grasp of the problems and commitment to engage in a formalised change process, requiring specified activity to start and maintain change momentum. If the pharmacy profession leadership is able to co-ordinate a sustained effort addressing the above issues, together with those revealed by the postal surveys, then at least some of the elements of the Burke-Litwin model of change can begin to be applied, i.e. Leadership role, Strategic Intent, Individual performance, (Chapter 5: 199) These three are transformational, which are most important in the context of the change order which is transformational. (Chapter 5: 198).
Table 49  MEDICO-PHARMACEUTICAL LEADERSHIP FOCUS GROUP / KEY INFORMANT RESPONSE COMPARISON SUMMARIES: KEY THEMES WITH ASSOCIATED MARKETING IMPLICATIONS

<table>
<thead>
<tr>
<th>ASSOCIATED MARKETING ISSUES</th>
<th>Support for med/pharm collaboration</th>
<th>Resistance to increased GP workload</th>
<th>Medicines compliance by patient</th>
<th>Implied doctor self esteem/autonomy</th>
<th>Pilot trials as suggested way forward</th>
<th>Sponsorship suggested to facilitate role</th>
<th>Pharmacist potential recognised</th>
<th>Age related GP resistance to change recognised</th>
<th>Need to sell proposition is recognised</th>
<th>Location of service in the pharmacy</th>
<th>Limit on items of pharmacist input to new role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship marketing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship management</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Service quality</td>
<td>*</td>
<td>*</td>
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<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Consonant message</td>
<td>*</td>
<td>*</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Communications</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
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<td>*</td>
<td></td>
<td></td>
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<tr>
<td>Process and content</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Opinion leadership</td>
<td>*</td>
<td>*</td>
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<td>*</td>
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<td>*</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Message source + sponsorship</td>
<td>*</td>
<td>*</td>
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<td>*</td>
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<td>*</td>
<td></td>
<td></td>
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<tr>
<td>Marketing mix</td>
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<td>Product design</td>
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<tr>
<td>- Core</td>
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<td>*</td>
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<tr>
<td>- Tangible</td>
<td>*</td>
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<tr>
<td>- Augmented</td>
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<td>*</td>
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<td>*</td>
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<tr>
<td>Promotion</td>
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<td>*</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>People</td>
<td>*</td>
<td>*</td>
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<td>*</td>
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<td>*</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Physical evidence</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Process</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key:**
- FG: Focus Group
- KI: Key Informant
- 0: No view given
- *: Suggested main marketing link
- #: Minor resistance
- Majority View

**Note:** The asterisks in the matrix denote the author's view of the relevant aspect of marketing applicable to the particular key response themes. The marketing issues in the far left column, discussed in Chapter 4, are the author's view of which elements of marketing are involved. The column headings are the subjects raised by key informants and the Medico-Pharmaceutical leadership focus group.
TABLE 50  MATRIX ABSTRACT OF THE PHARMACY MEDICINES MANAGEMENT LEADERSHIP FOCUS GROUP HELD AT RPSGB ON THURSDAY 4th JUNE 1999, 1.00 pm

KEY VIEWS: RPSGB, PSNC, NPA & OTHERS

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>Pharmacist Ability</th>
<th>Doctor &amp; Pharmacist Partnership</th>
<th>Introducing the Service into Practice</th>
<th>Communications to Stakeholders</th>
<th>Focus Group Collaboration &amp; Ownership</th>
<th>Critical Mass Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Training is required; in agreement with F's views</td>
<td>Pilots are the way forward. Consider outcomes for benefit</td>
<td>Meet with GP leaders soonest. Inform pharmacists as soon as possible</td>
<td></td>
<td>✓</td>
<td>✓ PSNC</td>
</tr>
<tr>
<td>B</td>
<td>Many could do this role. Some will never do it</td>
<td>Start early with schools of pharmacy in building good communication skills with doctors</td>
<td>Outcomes for doctors, patients and any other beneficiary are important</td>
<td>Agreed with A and F; asked about preparatory work</td>
<td>✓</td>
<td>✓ RPSGB</td>
</tr>
<tr>
<td>C</td>
<td>Pharmacists have good skills interpersonal; will adapt to MM very quickly</td>
<td>Pharmacists have good interpersonal skills. Inter-profession collaboration necessary</td>
<td>Team work is necessary; pharmacist and GP</td>
<td>Agreed with F</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>D</td>
<td>Impressed with H's point and referred to RPSGB courses</td>
<td>Agreed with H's comment RPSGB has skills courses. Produced a booklet</td>
<td>Connect the professions via the NHS net</td>
<td>Use joint research group as base for communication. Start within the pharmacy profession</td>
<td>✓</td>
<td>✓ RPSGB</td>
</tr>
<tr>
<td>E</td>
<td>MM requires life long learning. The place is the community pharmacy</td>
<td>Locums as well should be trained - response to H's point, i.e. GP + pharmacist partnership</td>
<td>Team work is essential</td>
<td>Agreed with F</td>
<td>✓</td>
<td>✓ RPSGB</td>
</tr>
<tr>
<td>F</td>
<td>Special training will be required - courses are available'</td>
<td>Do not have access to all medical information of patients - very important</td>
<td>Examples of pilot work given from Aberdeen</td>
<td>Inform GP leaders soonest. Use Crown Report as a possible basis</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>G</td>
<td>Experience in repeat script trials shows pharmacists can build abilities</td>
<td>Interpersonal skills are very important</td>
<td>Agreed with F</td>
<td></td>
<td>✓</td>
<td>✓ NPA</td>
</tr>
<tr>
<td>H</td>
<td>Impressed with skills already in this area now being used by pharmacists</td>
<td>Doctor and pharmacist collaboration/communication is urgent. Have we any plans?</td>
<td>Integrate the pharmacist into primary care team. Focus on the patient service</td>
<td>Should initiate at Chief Exec level, Health Authority. Also primary care directors</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Note: The above matrix summarises six major themes of the group discussion and the contributions of each member (A-H). The double ticks indicate both 'collaboration' and 'ownership' commitment by each contributor (body). Single ticks, final column mean the organisation named has committed and accepts responsibility for action in columns 1, 2, 3 or 4 as appropriate.

CODE
A = Baumber  B = Curry  C = Dutton  D = Ferguson  E = Hawksworth  F = Mackie  G = McCreedy  H = Spencer  MM = Medicines Management

RPSGB = Royal Pharmaceutical Society of Great Britain
7.1 INTRODUCTION

The field research postal surveys in this study (Chapter 3: 51) are geared to exposing GPs' and pharmacists' attitudes, needs and wants, with respect to the new role for community pharmacy, i.e. medicines management, in partnership with doctor and patient.

It has further attempted to reveal potential barriers to change within both professions and indicate targets for change effort through modern marketing and management techniques. From these studies and analyses, a communications strategy will be suggested for pharmacists and GPs and an outline change template set out for community pharmacy in moving both professions toward the new collaborative service, as stated above. The following sections examine the results of the field postal surveys and their relevance to this thesis, which is:

"... that there are barriers to repositioning community pharmacy in the primary health care chain, resident within the medical and pharmaceutical professions and that these can be systematically addressed by original research and a novel application of modern management techniques."

(Chapter 2: 37)

Results of the postal surveys will also be related to issues arising from the key informant and focus group work (Chapter 6: 270–277).
PHASE 2 FIELD RESEARCH

PART I

POSTAL SURVEY QUESTIONNAIRE ANALYSIS: GPs

7.2 SURVEY RETURNS

Of the 1000 surveys posted to randomly selected GP practices in England and Wales in November 2002, not all were returned:

- 4 were returned blank;
- 3 were unusable;
- 37 were not deliverable; and,
- 540 were useable.

Giving a 54% response rate.

This figure (540) in turn, represents a 5.79% sample of the total population of GP practices in England and Wales (Statistical Bulletin, 2000 – 2001: Table 10). The raw data has been set out in Appendix 18 (page 489) for reference and the interpreted data set out in the body of the thesis.

Unfortunately nothing is known of non-respondents, which if for example, lie mainly in one particular size of practice, would skew the result and reduce sample relevance to the whole population. However, a sample return of 540 gives useful information, which if interpreted with care, will give a useful indication of GP views on the subjects addressed by the survey.

The survey was mailed twice, the second time four weeks after the first mailing, in an attempt to maximise returns. Anecdotal views from three GPs in Newcastle serving on doctor representative committees, (Gateshead; Newcastle; and Sunderland) all regarded a 54% response rate as very good. Response rates quoted by them as being ‘normal’ were 10 to 15% for postal surveys from sources external to their own profession.

In this instance, there was a general practitioner as one signatory to the research and perhaps this has led to a higher response rate. The following charts and tables help interpret the survey returns, together with comment accompanying.
7.3 SURVEY RESULTS: ANALYSIS BY QUESTION

7.3.1 Analysis of Question 1a & 1b: Group Practice Sizes

'Please state the number of doctors in your practice. Of these, how many are partners?'

Purpose - To determine the difference in status, if any, of practice members and form a base which can be used for relating to other issues in the questionnaire.

Result - The sample response profile of practice group sizes approximates to that of the total population (DH: General and PMS Statistics, Table 10) (Figure 46)

Figure 46 BAR CHART SHOWING SAMPLE RETURNS FOR GROUP PRACTICE SIZES TOGETHER WITH CORRESPONDING POPULATION PERCENTAGES OF PRACTICE SIZE (n=536)

Comment - It is interesting to note that all practice sizes, grouped as above, show similar perception of patient health care expectations having increased over recent years, (Question 17) as shown in Table 51. The $X^2$ test on Table 51 gives a Chi square value of 4.006 and a p value of 0.261 i.e. > 0.05. A Somers Delta test gives a d value of -0.027 and a p value of 0.165. Both show no association between practice size and perception of patient expectations of health care.
Table 51 GROUP PRACTICE SIZES COMPARED WITH GP PERCEPTION OF PATIENT EXPECTATIONS OF HEALTH CARE OVER RECENT YEARS (n=539)

<table>
<thead>
<tr>
<th>PRACTICE SIZE (GPs)</th>
<th>GP PERCEPTION OF PATIENT EXPECTATIONS OF HEALTH CARE RELATED TO PRACTICE SIZE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Greatly Increased</td>
<td>Somewhat Increased</td>
</tr>
<tr>
<td>Single</td>
<td>36 (63.2%)</td>
<td>14 (24.6%)</td>
</tr>
<tr>
<td>2-4</td>
<td>136 (64.2%)</td>
<td>59 (27.8%)</td>
</tr>
<tr>
<td>5-7</td>
<td>125 (67.6%)</td>
<td>51 (27.6%)</td>
</tr>
<tr>
<td>8+</td>
<td>55 (67.9%)</td>
<td>20 (24.7%)</td>
</tr>
</tbody>
</table>

Markedly different is the group practice size related to the desirability of doctor / pharmacist collaboration, as set out in Question 11, 'Government seem to be encouraging pharmacist / GP collaboration on aspects of medication review. Do you agree with this approach?' This comparison is illustrated in the following table:

Table 52 GROUP PRACTICE SIZE COMPARED WITH DOCTOR VIEW OF 'GP – PHARMACIST COLLABORATION' (n=539)

<table>
<thead>
<tr>
<th>PRACTICE SIZE (GPs)</th>
<th>GP AGREEMENT WITH PHARMACIST – GP COLLABORATION ON MEDICINES MANAGEMENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree 2</td>
<td>Agree 3</td>
</tr>
<tr>
<td>Single</td>
<td>9 (16.1%)</td>
<td>20 (35.7%)</td>
</tr>
<tr>
<td>2-4</td>
<td>29 (13.6%)</td>
<td>132 (62.0%)</td>
</tr>
<tr>
<td>5-7</td>
<td>34 (18.4%)</td>
<td>109 (58.9%)</td>
</tr>
<tr>
<td>8+</td>
<td>18 (22.2%)</td>
<td>54 (66.7%)</td>
</tr>
</tbody>
</table>

Here, there is increasing general agreement to the proposition with increasing size of practice (column 4). Speculatively this may be associated with larger drugs budgeting responsibility in the larger practices and greater awareness of the difficulties of thoroughly managing medication review processes for large numbers of patients. Medicines management services are now a government requirement of all PCTs by April 2004 (Pharmacy in the Future, 2000 : 15). A Chi square test on Table 52 gives a $X^2$ value of 25.184 and a $p$ value of 0.005 showing an association between practice size and GP views of GP / pharmacist collaboration. A Somers Delta test gives a $d$ value of 0.124 and a $p$ value of 0.005 confirming the association.

Pharmacy should keep in mind that, if the population of single handed practices is of a similar view to this sample, it may require a more supportive and empathetic approach, when seeking to build a collaborative relationship with pharmacy.
7.3.2 Analysis of Question 2: Practice Dispensing Status

"Is your practice a dispensing practice?"

The null hypothesis for Question 2 comparisons with Questions 8, 11 and 19, is that there is no difference in the dispensing doctor (DD) and non-dispensing doctor (NDD) responses.

Purpose - Because of traditional competition between GP and pharmacist in rural / fringe urban areas, this question seeks to determine the views of dispensing doctor respondents. These can then be constructively related to dispensing doctors' responses in other parts of the questionnaire, to determine any barriers or prejudice.

Result - Response shows a 13.4% response from dispensing doctors. This approximates to that of the total population of dispensing doctors = 14.0% (DH: General and PMS Statistics, Table 5). The random sample is therefore encouragingly similar in dispensing doctor percentage compared with the population and other GP responses are a little high at 86.6%. (Figure 47)

Figure 47 BAR CHART SHOWING SAMPLE PROPORTION OF DISPENSING AND NON-DISPENSING PRACTICE RESPONSES (n=538)
Comment - This question was posed because of the potential sensitivity of the rural competition for dispensing rights between pharmacists and doctors, (Chapter 1: 11) which may require a different approach to collaboration building in medicines management. The following questions have been selected to investigate potential differences in response from dispensing doctors:

Q8 ‘... would you like a pharmacist to work with you in the future?’

Q11 ‘... do you agree with pharmacist / GP collaboration in medicines management?’

Q19 ‘... do you agree that patient perception of your service could be enhanced by a pharmacist medicines review service directed by you?’

and the results are illustrated in Table 53.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>GPs - Total Numbers &amp; Types</th>
<th>Response Category</th>
<th>Full Time</th>
<th>Regular Part Time</th>
<th>Periodically</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8 (n = 232)</td>
<td>36 DD</td>
<td></td>
<td>1 (2.8%)</td>
<td>4 (11.1%)</td>
<td>16 (44.4%)</td>
<td>15 (41.7%)</td>
</tr>
<tr>
<td></td>
<td>196 NDD</td>
<td></td>
<td>8 (4.1%)</td>
<td>58 (29.6%)</td>
<td>109 (55.6%)</td>
<td>21 (10.7%)</td>
</tr>
<tr>
<td>Q11 (n = 537)</td>
<td>Strongly Agree</td>
<td></td>
<td>3 (4.2%)</td>
<td>38 (53.5%)</td>
<td>24 (33.8%)</td>
<td>3 (4.2%)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td></td>
<td>2 (18.7%)</td>
<td>277 (59.4%)</td>
<td>85 (18.2%)</td>
<td>13 (2.8%)</td>
</tr>
<tr>
<td></td>
<td>Neither Agree nor Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q19 (n = 537)</td>
<td>71 DD</td>
<td></td>
<td>2 (2.8%)</td>
<td>31 (43.7%)</td>
<td>24 (33.8%)</td>
<td>12 (16.9%)</td>
</tr>
<tr>
<td></td>
<td>466 NDD</td>
<td></td>
<td>38 (8.2%)</td>
<td>269 (57.7%)</td>
<td>124 (26.6%)</td>
<td>31 (6.7%)</td>
</tr>
<tr>
<td>CODE: DD = Dispensing Doctors</td>
<td>NDD = Non Dispensing Doctors</td>
<td>GP = Doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 53 COMPARISON BETWEEN DISPENSING AND NON-DISPENSING GP RESPONSES TO Q8, Q11 & Q19
The three questions (Questions 8, 11, 19) are about GP attitude to future working together with pharmacists and the effect this may have upon improved patient perception of the collaborative partnership in medicines management. The percentage of affirmative responses in Questions 8, 11 and 19 is higher in all questions, from non-dispensing doctors, (combining columns 1 and 2 in Questions 11 and 19).

Chi square tests on all three comparisons show:
Question 2 cf. Question 8, $X^2 = 23.5; p < 0.005$
Question 2 cf. Question 11, $X^2 = 13.78; p < 0.005$
Question 2 cf. Question 19, $X^2 = 9.984; p < 0.002$
The null hypothesis is rejected in all three cases. There is thus an association between GP dispensing / non-dispensing status and their respective responses to these questions.

However, a substantial proportion of dispensing doctors (58.3%) do want a pharmacist to work with them in future, (columns 1, 2, 3 Question 8) which, if reflected in the whole population, is an encouraging base to work from in bringing the two professions together in rural and fringe urban areas. A similar percentage (57.7%) also agree that ‘collaboration’ is the right approach, (columns 1, 2 Question 11) but only 46.5% think that such collaboration would enhance patient perception of their service, (columns 1, 2 Question 19).

The sub-group responses for dispensing doctors are small but can be generalised. The total group of 71 dispensing GPs does give an indication of what might be expected in the wider population of this group and it would be judicious to plan an empathetic marketing communications programme in attempting to build collaboration between dispensing doctors and pharmacists.

**Potential Barriers to Change** - A proportion of dispensing doctors perhaps through competitive sensitivities for dispensing rights with pharmacists; also other uncommitted and antagonistic non dispensing respondents in Questions 8, 11 and 19.
7.3.3 Analysis of Question 3: Practice Size By Patient List

'Approximately how many patients are in your practice?'

Purpose - Confirmation of workload.

Result - Response shows similar percentages of respondents from the 2000 to 9,999 patient volume levels, with substantially different percentage responses below and above these levels. (Figure 48)

Comment - Distribution of practice size measured by patient number proportionately follows distribution of number of GPs per practice.

Potential Barriers to Change - The workload issue needs address in the communication and marketing programme to present medicines management as work reducing/shared, rather than increasing the administration.
7.3.4 Analysis of Question 4: Doctor Ages

'Please tick the age groups you all come within.'

The null hypothesis for Question 4 comparison with Question 11 is that there is no age related difference in willingness to collaborate with pharmacists.

**Purpose** - To investigate relationship of attitude with age and determine any resultant need for ‘approach change’ to building collaboration with GPs / pharmacists.

**Result** - The age spread of respondent returns approximates to a normal distribution. (Figure 49)

Figure 49 AGE GROUPS OF SAMPLE RESPONDENTS COMPARED WITH ‘AGREE’ CATEGORIES IN QUESTION 11 (n= 526 accounting for 1147 age categories)

![Graph showing age groups compared with 'agree' categories in Question 11](image)

*Note: The percentage of each group is calculated on the total number of ages reported, i.e. 1147*

**Question 11 Comparison**

‘Do you agree with GP / pharmacist collaboration on medicines management?’

**Comment** – The highest percentage agreement is in the youngest GP group (90%) and progressively reduces as age increases, but is still high percentage support in all age groups. All proportions of the groups agreeing with collaboration are good bases on
which to build a new partnership between GPs and pharmacists. However, when age groups are compared with one of the key elements of Question 12 (12.5 'choice of medicines') the percentage 'agreeing' more steeply declines with increasing age. (Table 54)

**Question 12 Comparison**

'Which of the following items do you think a pharmacist could assist you with?'

*Item 12.5 'Choice of medicines'*

Table 54 AGE BANDS COMPARED WITH GP RESPONSE TO QUESTION 12.5

<table>
<thead>
<tr>
<th>QUESTION 4 AGE BANDS</th>
<th>20 - 29</th>
<th>30 - 39</th>
<th>40 - 49</th>
<th>50 - 59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of GPs Responding (n = 503)</td>
<td>32</td>
<td>143</td>
<td>170</td>
<td>130</td>
<td>28</td>
</tr>
<tr>
<td>% Response Agreeing to 12.5</td>
<td>55.2%</td>
<td>48.8%</td>
<td>46.6%</td>
<td>43.6%</td>
<td>35.0%</td>
</tr>
</tbody>
</table>

Overall, Question 12.5 gets to the heart of the traditional GP role; selection of appropriate medicine for the patient's illness. This may be an indication of unwillingness to be challenged as the original selector of medication for the patient's condition. As the age increases, so does the resistance to allowing the pharmacist to become involved in the choice of medication. This may be as a result of older traditions being more firmly preserved by the older GPs (Chapter 1:11). The Chi square test on this comparison shows: $X^2 = 20.646; p < 0.005$. The null hypothesis is rejected and there is an association between GP age and willingness to collaborate with pharmacists.

**Potential Barriers to Change** - Cultural mindset, in older GPs, may see selection of suitable medication for the patient as the doctor's right and thus may be a barrier to change (Chapter 5, Section 5). The less positive percentages of respondents to Questions 11 and 12 which increase with age increase need careful consideration. Communications should be tailored to positive benefits and recognition of GP leading position.

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7.3.5 Analysis of Question 5: GP Contact with Pharmacist

'Broadly, how would you describe the frequency with which you contact a dispensing pharmacist?'

The null hypothesis for Question 5 comparison with Question 11 is that there is no difference in the GPs' willingness to collaborate with pharmacists related to their frequency of contact.

**Purpose** - A basis for comparison with other responses showing potential effect of contact on relationship, if any.

**Result** - A positively skewed distribution of responses with the majority of doctors having contact with a pharmacist. (Figure 50)

*Figure 50 GP FREQUENCY OF CONTACT WITH A DISPENSING PHARMACIST (n=538)*

**Comment** - At one extreme, a very small percentage of doctors never contact a pharmacist (1.3%) and 15.2% have rare contact. There is, however, 'very often' to 'periodic' contact in 83.3% of the sample, which again, if reflected in the whole population may be a good base on which to build a more structured and systematic
contact on a regular basis. There do not appear to be any major barriers to progress indicated here.

When this response is compared with the Question 11 responses on, the 'desirability of collaboration with pharmacists on medication reviews', the following picture emerges as shown in Table 55. For this comparison the 'strongly agree' and 'agree' categories have been combined as have the 'disagree' and 'strongly disagree' categories in Question 11. The full response to Question 11 is set out under Question 11 analysis.

**Question 11 Comparison with Question 5**

'Do you agree with pharmacist / GP collaboration in aspects of medication review?'

**Table 55 FREQUENCY OF GP CONTACT WITH A PHARMACIST COMPARED WITH DESIRE TO COLLABORATE ON MEDICATION REVIEW**

<table>
<thead>
<tr>
<th>GP Frequency of Contact with a Pharmacist (n = 538)</th>
<th>Q11 — Desire for Collaboration (n = 539)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree and Agree Combined</td>
</tr>
<tr>
<td>Very Often (52)</td>
<td>43 (82.7%)</td>
</tr>
<tr>
<td>Often (173)</td>
<td>145 (83.8%)</td>
</tr>
<tr>
<td>Periodically (224)</td>
<td>169 (75.4%)</td>
</tr>
<tr>
<td>Rarely (82)</td>
<td>46 (56.1%)</td>
</tr>
<tr>
<td>Never (7)</td>
<td>3 (42.9%)</td>
</tr>
</tbody>
</table>

Looking at the 'frequency of contact' (column 1) and 'desire for collaboration' (column 2), agreement with the Question 11 proposition of collaboration increases with increasing routine contact of the GP with the pharmacist. A positive relationship appears to be related to frequency of contact. The Chi square test on this comparison shows:

\[ X^2 = 28.613; p < 0.005 \]

The null hypothesis is rejected and there is an association between frequency of GP / pharmacist contact and willingness to collaborate.

**Potential Barriers to Change** — Continued lack of routine contact.
**Analysis of Question 6: Current GP / Pharmacist Collaboration**

'Do you have a pharmacist work for you in the practice?'

**Purpose** - To determine who currently has pharmacist support and by implication who is still to require support; thence the potential magnitude of the change programme, for those practices with rare or no pharmacist contact at present.

**Result** - The majority of OPs do not have regular work undertaken by a pharmacist. (Figure 51)

**Figure 51 CURRENT FREQUENCY OF GP / PHARMACIST WORKING TOGETHER (n=538)**

Comment - 36.7% of respondent practices have pharmacist help, on a full time or periodic basis, and 63% have rare or no contact. If applied to the population of GP practices in England and Wales (9,334) this means an opportunity for regular collaboration in at least 5,880 practices; a worthwhile objective. (NHS Statistics Bulletin 2000 – 2002)

The manpower requirements from pharmacists is substantial. The skill mix issue assumes greater importance. A marketing and change programme would in theory require targeting initially at those practices not receiving help (an open market) and at 294
least the same number of pharmacist dispensing contractors (at least one such pharmacy will be currently serving each GP practice in terms of the present dispensing service).

The next question, Question 7, further indicates that 83.4% of the 344 GP sample receiving assistance currently, do so from other than dispensing pharmacists and so the ultimate potential market is larger than the 5,880 GP practices mentioned above if some of the other pharmacist help can be displaced.

Potential Barriers to Change - The rare and nil contact situation currently experienced by 63% of GP practices, where the reasons for little contact are not fully understood.
7.3.7 An Analysis of Question 7: Sources of Pharmacist Assistance to GPs

'What is the source of your pharmacist help?'

Purpose - To determine the competition to dispensing pharmacists and thus the nature of the barriers to entry into this segment of the market.

Result - The majority of pharmacist help is supplied by the PCTs which could constitute a real threat if the trend continues. This would be described in Porter's terms (Figure 4, page 37) as threat of new entrants into the MM market. (Figure 52)

Figure 52 SOURCES OF PHARMACIST HELP (n=344)

![Source of Help Bar Chart]

Categories of Response
Sources of Help

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>HA</td>
<td>Old Health Authority</td>
<td>238 (69%)</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
<td>57 (16.5%)</td>
</tr>
<tr>
<td>DP</td>
<td>Dispensing Pharmacist</td>
<td>9 (2.6%)</td>
</tr>
<tr>
<td>PP</td>
<td>Peripatetic Pharmacist</td>
<td>15 (4.4%)</td>
</tr>
<tr>
<td>PMS</td>
<td>Pharmacist Member of</td>
<td>5 (1.45%)</td>
</tr>
<tr>
<td>O</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Note: The apparent discrepancy between Q6 aggregate of pharmacists working for doctors (290) and "sources of help" in this question maybe the frequent changes in sources of help from time to time (several boxes ticked by some respondents, in Q7).

Comment - Dispensing pharmacists provide 16.6% of the GP current pharmaceutical assistance. This may serve a two-fold purpose:

i. To act as a mentoring group for other pharmacy contractors wishing to undertake medicines management.
ii. To form an experience base from which to cull useful information to facilitate change elsewhere.

Potential Barriers to Change - The competitor help being given to 83.4% of the proportion of the respondents to Question 6, who do receive pharmacist help, which if reflected in the population is a substantial segment of the market.
7.3.8 Analysis of Question 8: Intentions Of GPs Who Have No Current Pharmacist Help

'If you answered 'never' to Question 6, would you like a pharmacist to work for you in the future?' (Question 6 = 'Do you have a pharmacist work for you in the practice?')

Purpose - To ascertain the proportion of GPs who currently would like pharmacist assistance but do not have it and the desired frequency of such support.

Result - The majority of respondents not currently receiving help, would like to have this at various frequencies. (Figure 53)

Figure 53 PROPORTION OF GPs WITHOUT PHARMACIST ASSISTANCE (Q6) WHO WOULD LIKE THIS IN FUTURE (n=233)

Comment - Of the 248 respondents to Question 6 not currently receiving pharmacist help, only 233 answered this question (Question 8) and of those who answered 'never' in Question 6, 41.6% were dispensing doctors. This again points to the sensitivities exposed in Question 2 and emphasises the need for careful address of the dispensing doctor and dispensing pharmacist relationship. From an analysis of returned questionnaires the 'never' group above, are all dispensing doctors.
However, 84.5% of respondents do want pharmacist help. This has positive implications for medico-pharmaceutical collaboration in MM.

Potential Barriers to Change - The attitude that led to decline of the offer of pharmacist support, plus a dispensing doctor negative component. Further research needs undertaking on the dispensing doctor antipathy, to seek a more specific role of collaboration.
7.3.9 Question 9: Doctor Awareness Of Medication Problems

'Please indicate the frequency with which you encounter the following medicines problems with patients (8 items specified).'

Purpose - To ascertain awareness of medicines problems and to see if such awareness relates to other attitudinal responses to the questionnaire; to determine most popular items selected by GPs with a view to incorporating these in a core product of medicines management (Chapter 4 : 67, 68); to determine one aspect of potential pressure upon the GP to achieve better patient outcomes.

Result - All specified problems are encountered at various frequencies by all respondents. (Table 56)

Table 56 NUMBER AND SAMPLE FREQUENCY WITH WHICH DOCTORS ENCOUNTER MEDICINES PROBLEMS WITH PATIENTS (n = 539)

<table>
<thead>
<tr>
<th>MEDICINES PROBLEMS</th>
<th>Very Often</th>
<th>Often</th>
<th>Periodically</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Troublesome side effects</td>
<td>57</td>
<td>227</td>
<td>248</td>
<td>4</td>
</tr>
<tr>
<td>2. Drug interactions</td>
<td>13</td>
<td>108</td>
<td>402</td>
<td>15</td>
</tr>
<tr>
<td>3. Adverse drug reactions</td>
<td>12</td>
<td>57</td>
<td>455</td>
<td>15</td>
</tr>
<tr>
<td>4. Patient non-compliance</td>
<td>71</td>
<td>240</td>
<td>226</td>
<td>2</td>
</tr>
<tr>
<td>5. Poor response to treatment</td>
<td>36</td>
<td>201</td>
<td>298</td>
<td>4</td>
</tr>
<tr>
<td>6. Elderly patient confusion</td>
<td>69</td>
<td>208</td>
<td>255</td>
<td>7</td>
</tr>
<tr>
<td>7. Food and drug interactions</td>
<td>2</td>
<td>41</td>
<td>414</td>
<td>82</td>
</tr>
<tr>
<td>8. NHS &amp; OTC drug interactions</td>
<td>3</td>
<td>37</td>
<td>407</td>
<td>75</td>
</tr>
</tbody>
</table>

Comment - There was 100% multiple response to this question. Recognition of these effects is widespread. All but two specified problems are encountered, at some frequency by at least 97% of respondents. The two exceptions are NHS / OTC interactions and food / drug interactions. The latter two are recognised relatively rarely.
Perhaps this is because patients themselves are unaware of those interactions and so do not report them to the GP. The GPs may also be unaware of these problems.

Equally interesting is that the highest recognition of problems lies in the area of patient compliance (item 4, 57.7% very often / often; item 6, very often / often) and thus perhaps a non-threatening area for pharmacist intervention, from the doctor's viewpoint. This could become a major component of the new 'core product' – medicines management (Chapter 4 : 67, 68). Improved compliance would benefit the patient, the tax payer and the doctor, in improved health, reduced waste and better health outcome respectively.

Potential Barriers to Change - None apparent.
7.3.10 Analysis of Question 10: Doctor Awareness of Medication Problems in the 'Elderly'

'Please indicate what you believe to be the incidence of the following potential problems, elderly patients may have with medicines.'

**Purpose** - To reinforce the focus of the doctor's attention on medicines problems in the largest consumer group of NHS medication. To ascertain recognition of specified problems in this group; to determine areas that may be suitable for incorporating into the medicines management 'core and/or tangible product' (Chapter 4: 67, 68); to expose opportunities for non adversarial collaboration with the GP.

**Result** - The specified potential problems are recognised by high percentages of respondents. (Table 57)

**Table 57** FREQUENCY WITH WHICH DOCTORS ENCOUNTER MEDICINES PROBLEMS IN THE ELDERLY (n = 535)

<table>
<thead>
<tr>
<th>NUMBER &amp; FREQUENCY OF ENCOUNTER</th>
<th>Very Often</th>
<th>Often</th>
<th>Periodically</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICINES PROBLEMS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Capsule/tablet size</td>
<td>26</td>
<td>193</td>
<td>312</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99%</td>
</tr>
<tr>
<td>2. Calendar packs</td>
<td>21</td>
<td>135</td>
<td>336</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>92%</td>
</tr>
<tr>
<td>3. Frequency of dose</td>
<td>70</td>
<td>303</td>
<td>161</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99%</td>
</tr>
<tr>
<td>4. Multiplicity of drugs</td>
<td>214</td>
<td>270</td>
<td>51</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>5. Remembering to take the medication</td>
<td>153</td>
<td>290</td>
<td>92</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>6. Medication taste</td>
<td>11</td>
<td>70</td>
<td>385</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87%</td>
</tr>
<tr>
<td>7. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comment** - There is high recognition of all items as problems and in the *often / very often / periodically* categories, items 3, 4 and 5 figure most prominently. These are
again compliance issues confirming the result in Question 9. Once again a non doctor-threatening issue suitable for pharmacy support.

**Potential Barriers to Change** - None apparent but caution should be exercised in the approach to item 3 (frequency of dose) by the pharmacist and this issue not portrayed as a doctor inability to address.
7.3.11 Question 11: GP Attitudes to Government Policy on Collaboration

'Government seem to be encouraging pharmacist / GP collaboration on aspects of medication review. Do you agree with this approach?'

Purpose - To achieve a plain view of doctor attitudes to official collaboration with pharmacists; to relate the responses to other questionnaire items; to give a measure of the difficulty / ease of promoting the new GP / pharmacist partnership concept in medicines management.

Result - A high percentage of respondents agree with collaboration. (Figure 54)

Figure 54 GP VIEWS OF COLLABORATION WITH PHARMACISTS ON ASPECTS OF MEDICATION REVIEW (n=539)

Comment - An encouraging 75.5% strongly agree or agree the proposition. However effort will require targeting at the uncertain, disagree and strongly disagree groups, although the latter two are small (3% and 1.3% respectively).

Potential Barriers to Change - 24.3% of respondents who are uncommitted or against GP / pharmacist collaboration. 57.7% of dispensing doctor respondents (71) ‘strongly agreed’ or ‘agreed’ and 33.8% were uncertain. 8.4% ‘disagreed’ or ‘strongly disagreed’. (Table 52) Clearly a proportion of dispensing doctors favour collaboration
and it may be possible to build the MM service with like minded doctors in the population. If so, then these in turn could become role models or mentors for the reluctant or 'anti' members of the dispensing doctor sector.
7.3.12 Analysis of Question 12: GP Selection Of Suggested Items For Pharmacist Assistance

'If you ticked any box from 11.1 to 11.3, which of the following items do you think a pharmacist could assist you with? (Please tick all appropriate boxes).'

**Purpose** - To determine if any of the 'uncertain' respondents to question 11 would be prepared to speculatively give an opinion on potential help; to see if 12.5 and 12.10 were regarded less favourably than other items of help, as these could be regarded as direct challenges to the GP competence and threatening from a pharmacist intervention. These two items are part of established GP territory.

**Result** - A favourable response to all items but diminishing approval for 12.5 and 12.10. (Figure 55)

![Figure 55 ITEMS A PHARMACIST COULD ASSIST YOU WITH (n=536)](image-url)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.6</td>
<td>Advice on food &amp; drug interactions</td>
</tr>
<tr>
<td>12.7</td>
<td>NHS/OTC drug interactions</td>
</tr>
<tr>
<td>12.8</td>
<td>Drug interactions</td>
</tr>
<tr>
<td>12.9</td>
<td>Patient compliance</td>
</tr>
<tr>
<td>12.1</td>
<td>Comparison of equivalent medicines costs</td>
</tr>
<tr>
<td>12.2</td>
<td>Review of number of drugs taken</td>
</tr>
<tr>
<td>12.4</td>
<td>Replacing brands with generics</td>
</tr>
<tr>
<td>12.3</td>
<td>Optimum pack sizes</td>
</tr>
<tr>
<td>12.10</td>
<td>Sub therapeutic dose levels</td>
</tr>
<tr>
<td>12.5</td>
<td>Choice of medicines</td>
</tr>
</tbody>
</table>
Comment - The bar chart has been arranged to show in order, the ‘most’ to ‘least’ popular of these items with which pharmacists can help, as specified in the question. The three most popular items are non-threatening to the doctors’ position as decision maker in the health care hierarchy. The two least popular items could be seen as threatening to the doctor’s authority in drug selection for patients. However, 42.5% of respondents do wish assistance with these items. Again this may be a good base on which to build approaches to the other 57.5%.

Of the uncertain group in Question 11, all completed Question 12, with the same emphasis on top and bottom 2, ‘most’ and ‘least’ popular items nominated for pharmacist help. ‘Patient compliance’ again rates highly for pharmacist assistance.

Potential Barriers to Change - Implied from 12.5 and 12.10, doctor ego / culture threat, in being challenged on correct selection of medicines for the patient’s illness at the correct dose level (Chapter 1: 10).

As medicines management is very much about the selection of appropriate medicines and dosage levels, a suggested strategy for dealing with potential doctor sensitivity on these issues, is as follows:

i. Construct the first marketing package for MM, excluding the above two issues. Thus the introductory new inter-professional collaboration package, is GP culture protective and non-threatening.

ii. When the first package is agreed, (via the GPC and LMCs) it should be implemented and then effort put into building GP confidence in remaining the clinical lead in the team.

iii. When the relationship between GP and pharmacist is developed, (perhaps within one year) the pharmacist can then introduce the additional concept of contributing to selection of initial treatment and dosage. A diplomatic vehicle could be the need to observe the NICE guidelines for addressing disease treatment in a structured way. Achievement of the quality markers, which will form part of a new GP contract, thus receive the assistance of a
'friendly pharmacist' acting to the instructions of the GP. Furthermore, offering alternatives for initial treatment can be suggested in the guise of seeking cost minimisation and helping practice budgets.

The PCT advisers can be encouraged by the LPCs to continually emphasise with the PCT Boards the need to pursue the NICE guidelines, as well as use the dispensing pharmacists to support the GP in this drive.
7.3.13 Analysis of Question 13: Objections To Collaboration (Derived From Q 11.4; 11.5)

'If you ticked boxes 11.4 or 11.5 in Question 11 please outline your reason here.'

Question 11 'Government seem to be encouraging pharmacist / GP collaboration on aspects of medication review. Do you agree with this approach?'

**Purpose** - To attempt to determine reasons for opposition to Question 11 proposition; to thereby indicate a means of approach to these people.

**Results** – Increased workload and professional sensitivities are apparent in this result. (Table 58)

**Table 58** SPECIFIC REASONS FOR DISAGREEING OR STRONGLY DISAGREEING QUESTION 11 PROPOSITION OF COLLABORATION (n=18)

<table>
<thead>
<tr>
<th>AUTHOR CATEGORISATION OF RESPONSES</th>
<th>RESPONSE IN DETAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privacy &amp; Confidentiality</td>
<td>1. Lack of confidentiality of pharmacy; 2. pharmacist not clinically qualified; 3. pharmacy lacks privacy; 4. such collaboration will not reduce demand on GP</td>
</tr>
<tr>
<td>The Responsibility of the GP</td>
<td>5. Doctor can judge necessity of patient review; 6. patient problems should be taken straight back to surgery; 7. pharmacists are not doctors, &quot;I prescribe. I am responsible.&quot; 8. &quot;We monitor all the above issues and make the decisions ourselves.&quot; 9. &quot;I am an expert in general prescribing, working on behalf of my patient&quot;; 10. a collaborative approach may lead to uncertainty and confusion of the patient.</td>
</tr>
<tr>
<td>GPs See no Benefit</td>
<td>11. No need; 12. not convinced collaboration leads to better prescriptions for patients; 13. no knowledge of government encouragement to collaborate. 14. The bureaucracy would be stifling and feedback from patients would be deafening.</td>
</tr>
<tr>
<td>GPs See Themselves as Already Well Organised</td>
<td>15. Clinical application of drugs and theoretical knowledge are two different approaches. 16. &quot;We prescribe from limited formulary; we review prescribing with our nurse practitioner. 17. Pharmacist would have to be based in surgery to be of any use – easier to do ourselves. 18. Already enough interference by NICE and PCT prescribing advisers. Responsibility is simply duplicated.&quot;</td>
</tr>
</tbody>
</table>

**Comment** - These individual comments begin to expose some real and perceived objections by doctors to pharmacist involvement with their own traditional roles and must be taken into account in the marketing campaign to bring the professions together in collaboration on medicines management. Item little '14' is again a reflection of
views already exposed by key informants. Workload is a real issue and some of the views exposed here may well be held also by doctors who do want pharmacist help.

Potential Barriers to Change - Cultural mindsets on whose territory belongs to who; concern about pharmacy facilities inadequacy; pressures of time, bureaucracy and workload. All must be addressed in the final product design, the presentation of 'medicines management.'
7.3.14 Analysis of Question14: Desired Frequency of Pharmacist Involvement with Patient Review

'If a pharmacist worked with you to undertake a patient review of those medication issues agreed by you, how frequently should this be done for those on long term medication?'

**Purpose** - To obtain measures of doctor perception of desired frequency of review requirement; to obtain a proxy for doctor view of potential added workload and scarcity of time.

**Result** - The most favoured review periods are four monthly and six monthly. (Figure 56)

*Figure 56 GP PREFERRED PATIENT REVIEW FREQUENCY (n=513)*

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Specified Time Intervals</th>
<th>Codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Bi-monthly</td>
<td></td>
</tr>
<tr>
<td>Q</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>4 Monthly</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>6 Monthly</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

*Comment* - A small proportion of GPs (8.6%) want one or two-monthly reviews. This may be because they know that new patients are constantly going onto long term therapy which may need change early in treatment. Wastage of drugs could be reduced by issuing smaller initial quantities; this group may indicate a few astute cost-conscious doctors.

A much higher percentage would like quarterly review (31.7%) and 3.9% seek a four monthly period. Interestingly, a much higher percentage (55.7%) prefer a six or twelve
monthly programme. Whilst there may be a genuine clinical basis for this in the minds of these respondents, time pressures may also be a factor and again workload implications may be involved. The subject does require further research.

Potential Barriers to Change - Possible time constraints on GP; increased workload aversion and determination to minimise additional administration. Nevertheless reviews are an accepted proposition for 513 respondents, (100%) albeit for differing frequencies.
7.3.15 Analysis of Question 15: Formalisation Of GP/Pharmacist Collaboration

'Do you feel the pharmacist should become a formal part of the doctor's team addressing selected items agreed by you?'

**Purpose** - To ascertain from a direct question, the degree of GP commitment to formal collaboration between pharmacist and doctor. This question effectively links Questions 8 and 11 to the ultimate recognition of 'partnership.'

i.e. **Q8** 'Would you like a pharmacist to work with you in the future?'

**Q11** '... do you agree with pharmacist/GP collaboration?'

(Question 8 and Question 11 responses exposed as percentages only, for the purpose of comparison and using the 'yes' and 'no' categories only).

**Results** - More than half the respondents agree with formalising the GP / pharmacist team relationship. (Figure 57)

**Figure 57 GP RESPONSES TO PROPOSAL OF FORMALISING COLLABORATION WITH PHARMACISTS AND CORRESPONDING RESPONSE PERCENTAGES TO QUESTIONS 8 AND 11 (n=539)**
Comment - The results to Question 15 show lower commitment to formalising the levels of collaboration already agreed in Question 8 and the commitment expressed in Question 11. The percentages are the important figures. Similarly the anti-formalisation group in Question 15 is higher. (Question 8 ‘no’ category only refers to the balance of Question 6).

This question begins to get to the heart of the issue of ‘visible involvement’ and degree to which the GP is prepared to accept recognition of partnership with patient medication.

Potential Barriers to Change - Limited GP commitment to pharmacist formal membership of the doctor’s team in the patient care process through participation in joint medicines management.

It may be that doctor ego is involved and the esteem needs postulated by Maslow are being threatened, (Chapter 4 : 97, 98) by higher profile recognition of the pharmacist.
7.3.16 Analysis of Question 16: Doctor Views On Importance Of Patient Perception Of Quality

'The quality of patient care in general practice may be very good, even though the patient may not be aware of that quality. How important is the patient's own perception of that quality?'

Purpose - To determine GP awareness of importance of patient perception of quality of care by the GP; to explore potential in the responses for presenting the pharmacist as a complimentary element to the doctor's own quality of care, in Question 19.

To link with Questions 17 and 18, building up to Question 19, to again explore an opportunity for presenting the pharmacist as a complimentary addition to the doctor's own image in the eye of the patient and not a threat.

Result - There is wide recognition of the importance of patient perception of quality of care. (Figure 58)

Figure 58 GP PERCEPTIONS OF PATIENT AWARENESS OF QUALITY OF CARE (n=537)
Comment - 95% of respondents considered patient perception of quality of care to be important or relatively important. This is very useful to promoting pharmacist / GP collaboration if the links to quality can be made, with the additional pharmacist help role and presented as a non-threatening addition.

Potential Barriers to Change – None, other than potentially in a small percentage of GPs.
7.3.17 Analysis of Question 17: Doctor Views On Patient Expectations Of Health Care

'Quality of care and clinical excellence are recurrent themes in the White Papers. What is your perception of patient expectations of health care over recent years?'

Purpose - To determine GP awareness of any change in degree of patient expectations over recent years. To determine whether patient expectations could be used as a route to presenting once again, the pharmacist as relief pressure on GP performance, which may be increasing through patient knowledge of what to expect in terms of health care.

Result - A large majority of GPs recognise increased patient expectations of health care. (Figure 59)

Figure 59 DOCTOR VIEWS OF PATIENT PERCEPTIONS OF HEALTH CARE (n=539)

Comment - 92.7% of respondents recognise increased patient expectations of health care over recent years. This could therefore be a useful lever of proposed change, in marketing the new pharmacist collaboration in medicines management, i.e. present pharmacist involvement as a solution to potential increased pressure.

Potential Barriers to Change - None. Facilitating change through patient pressure may be a possibility.
7.3.18 Analysis of Question 18: Doctor Perspective on Patient Motivation

'Patient's perception of quality of care may be a factor in their commitment to the therapy. Do you agree?'

Purpose - Another build up to Question 19 and a possible lever of change in engaging pharmacist / GP collaboration. This may also strengthen the case for a pharmacist role in patient compliance. This question uses a non-threatening but important issue to explore again, the possibility of pharmacist involvement in patient medication problem solving.

Result - A large majority of GPs agree with the proposition. (Figure 60)

Figure 60 DOCTOR VIEWS ON IMPORTANCE OF PATIENTS' PERCEPTION OF QUALITY OF CARE (n=540)

Comment - 85.2% of respondents agree that patient perception of quality of care may be a factor in their commitment to therapy. Commitment to therapy is an important component of patient compliance which doctors see as an area for pharmacist intervention. This is potentially an indicator for the possibility of being able to construct an appropriate product offering welcomed by doctors as a non-threatening issue (Chapter 4 : 16).
Potential Barriers to Change - None substantive, but the 'undecided' require marketing address and some persuasive benefits outlining to them, for engaging patient commitment to comply with the doctor’s treatments. This could also be presented as a work reducing input from the pharmacist, through achieving better patient outcomes in patient compliance.
7.3.19 Analysis of Question 19: Doctor Opinions On Potential Pharmacist Impact On Their Image

'Patient perception of your overall service could be enhanced by a pharmacist medication review service, directed by you. Do you agree?'

Purpose - To get a straight forward answer to a key question having led the doctor respondents into focussing on related issues in Questions 17 and 18, which gives an indication of the value GPs place upon the new pharmacist intervention.

Result - A majority of GPs agree the position. (Figure 61)

Figure 61 DOCTOR OPINION ON ENHANCEMENT OF MEDICAL SERVICE BY A PHARMACIST (n=539)
Comment - The respondent component in agreement with this proposition is 63.4% which is somewhat higher than those who believe the pharmacist should become a formal part of the doctor’s team (54.5%). This is encouraging but there again appears to be some reluctance to recognise the potential beneficial impact of pharmacist involvement in the eyes of the patient. Is third party recognition of the pharmacist an ego threat? A counter view could be that there is only a small percentage of respondents, (9.1%) who disagree with the proposition. Is this the ego speaking and inferring that GP image could not be improved by pharmacist assistance? All respondents in this latter group are dispensing doctors.

Potential Barriers to Change - A threat to the doctor’s ego? Potential lack of recognition of the importance of the pharmacist in the health care delivery process; potential fear of rising importance of the pharmacist? Although the doctor is being asked for a patient view, it is in reality, partly at least, the doctor’s own view. A prime target for persuasion is the uncommitted group, through reassuring communications and dialogue.

The pharmacist should be presented as a supportive addition to the doctor’s team, enhancing the doctor’s own image of quality service in patient overall health care.
7.3.20 Analysis of Question 20: Practice Location

'Please indicate in which of the following locations your practice is based.'

Purpose - An approximate internal validation of the figure respondents gave to Question 2 with respect to dispensing doctor numbers. 'Is your practice a dispensing practice?'

A basis for further research, relating location of doctors to other question responses in the current research, i.e. Questions 8, 11, 15, 19.

Result – Rural GP respondents comprise 14.7% of respondents. (Figure 62)

Figure 62 LOCATION OF GP PRACTICES (n=526)

Comment - There is an approximate consistency between this result and that in Question 2 which gave dispensing practices as 71 out of sample of 528, (13.45%). This Question 20 sample response gives 89 rural practices out of 526 respondents which equals 16.7% and not all of these will be dispensing doctors; nor do all rural GPs dispense. Also some dispensing practices will be in fringe suburban areas.

Potential Barriers to Change - Potentially dispensing doctors. Other comment has been made on this potential problem under Question 2.
A summary of the GP survey returns (Table 59) and implications follows. After analysis of the pharmacy postal survey a consolidation (Table 63) of GP and pharmacist survey returns link-ups, brings the two surveys together.
### Table 59 DOCTOR POSTAL SURVEY RESPONSES SUMMARY – POTENTIAL BARRIERS TO CHANGE WITH ASSOCIATED MOTIVATIONAL & MARKETING IMPLICATIONS

<table>
<thead>
<tr>
<th>1. SURVEY QUESTION NO. &amp; CONTENT</th>
<th>2. EXPOSED BARRIERS</th>
<th>3. SUGGESTED MOTIVATIONAL IMPLICATIONS &amp; NEEDS FOR GPs</th>
<th>4. COMMUNICATIONS; MARKETING; IMPPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q1a:</strong> Please state the number of doctors in your practice; Of these, how many are partners?</td>
<td>Single handed practices less inclined to want collaboration with dispensing pharmacists. cf. Q 11</td>
<td>Possible fear of workload increasing or as a single practitioner, being in the hands of a pharmacist, without GP peer support. Need to preserve GP:</td>
<td>GPs who are less interested, or not interested in collaboration with pharmacists, need to be offered attractive benefits, framed in an ego &amp; culturally supportive package, i.e. via the Augmented &amp; Tangible Product (Ch. 4: 67) Face to face presentations by pharmacists. The Sheth/Newman/Gross theory of Value Categories are important here (Ch. 4:102, Table 13) especially the 'emotional', 'epistemic' and 'conditional values'. Promotional communications should be in persuasive message and structure (Ch. 4 :113) seeking to engage cognitive, effective and conative components of GP perception (Ch. 4: 114)</td>
</tr>
<tr>
<td><strong>Q2.</strong> Is your practice a dispensing practice? cf. Q8, Q11, Q19</td>
<td>Dispensing doctors less inclined to want to: a. Have a pharmacist work with them in future (Q8) b. Collaborate with pharmacists on MM (Q11) or to... c. See that a pharmacist could enhance patient perception of their service by working with them (Q19)</td>
<td>Self esteem; self actualisation; (Ch. 4 :95) &amp; promote GP cultural values</td>
<td></td>
</tr>
<tr>
<td><strong>Q3.</strong> How many patients are in your practice?</td>
<td>Single handed doctors need special address. (ref Q1) Workload?</td>
<td>Psychological safety needs also need supporting; design appropriate approach to service (product) introduction, which is ego defensive (Ch. 4 : 106, Table 19)</td>
<td></td>
</tr>
<tr>
<td><strong>Q4.</strong> Please tick age groups you all come within. cf. Q12</td>
<td>As age increases, so does unwillingness to see the pharmacist be party to choosing the patient’s medication (ref Q12)</td>
<td>Same comments as above</td>
<td>Q3. Communications copy: Portray the new MM services as time saving not time consuming – release GP time for important disease diagnosis/management/reviews</td>
</tr>
<tr>
<td><strong>Q5.</strong> Broadly, how would you describe the frequency with which you contact a dispensing pharmacist? (cf. Q11)</td>
<td>Infrequent contact with a pharmacist is related to lack of desire for collaboration (ref. Q11). Less current contact → less desire to collaborate.</td>
<td>Pharmacist contact with GP may be approached through satisfying doctor needs in the developing new NHS. These are partly likely to lie in the area of quality prescribing, driven by pressure from NICE. Certain payments to GPs depend upon hitting the PCT Quality Markers</td>
<td>Relationship marketing will be important in engaging those GPs who only have ‘periodic’ or ‘rare’ contact with dispensing pharmacists. Local workshops with GPs and pharmacists could become one means of developing a good inter-professional rapport by setting joint objectives in theoretical patient medication problems of a non-critical nature e.g. reduction of side effects in the elderly patient.</td>
</tr>
</tbody>
</table>

**Note:** Where the same or associated barrier was exposed in the Key Informant (KI) Focus Group (FG) research, this is shown in columns 2.1 & 2.2 by a tick (✓)

**Abbreviations:** MM = Medicines Management  
NICE = National Institute of Clinical Excellence  
PCT = Primary Care Trust

Further explanation of this table is on page 328, connection of Chapter 4 (theory) and survey results of doctor needs, wants.
<table>
<thead>
<tr>
<th>1. SURVEY QUESTION NO. &amp; CONTENT</th>
<th>2. EXPOSED BARRIERS POSTAL SURVEY</th>
<th>2.1 K1</th>
<th>2.2 FG</th>
<th>3. SUGGESTED MOTIVATIONAL IMPLICATIONS &amp; NEEDS FOR GPs</th>
<th>4. COMMUNICATIONS; MARKETING; IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q6. Do you have a pharmacist work for you in the practice?</td>
<td>Only 36.8% of GPs have a full time or periodic pharmacist working with them. Lack of relationship basis on which to build for 63.2% GPs</td>
<td></td>
<td></td>
<td>Create a GP 'want' from presenting the DH driven need for high quality GP prescribing and patient care; also the growing requirement for cost effective prescribing which the pharmacist can address for the GP.</td>
<td>Of the 36.8% (198) only 57 GPs receive such help from dispensing pharmacists ie. 10.6%. However, 197 would like help in the future (36.6%).</td>
</tr>
<tr>
<td>Q7. What is the source of your pharmacist help?</td>
<td>83.4% of doctors who do have pharmacist help acquire it from competing sources to dispensing pharmacists.</td>
<td></td>
<td></td>
<td>Negative reinforcement (Ch. 5 : 251)</td>
<td>Thoughtful construction of the product offering, focusing the core product upon non-contentious issues initially and demonstrating effectiveness in small pilot exercises by selected GP practices or PCTs - should provide encouragement to GPs to engage the service.</td>
</tr>
<tr>
<td>Q8. Would you like a pharmacist to work for you in the future?</td>
<td>The ‘NEVER’ group: all dispensing doctors (DDs)</td>
<td>✓</td>
<td></td>
<td>Present dispensing pharmacist as added value through real time interventions in OTC/NHS drug interactions &amp; food / drug interactions (Ch. 4 : 96). Positive reinforcement (Ch. 5 : 251)</td>
<td>As the outcomes are seen to be beneficial, confidence in the new collaborative relationship should build. This strengthening of partnership approach should in turn lead to other more sensitive issues (medicines selection &amp; sub-therapeutic dose levels – Q12) at least being discussed or more acceptably, naturally entering discussions at practice meetings.</td>
</tr>
<tr>
<td>Q9. Please indicate the frequency with which you encounter the following medicines problems with patients.</td>
<td>NONE: All specified problems were experienced by all respondents.</td>
<td></td>
<td></td>
<td>Resolution of those problems in whole or part can be achieved by pharmacist intervention. A sense of GP accomplishment as described by Rekeash &amp; Vinson et al (Ch. 4 : 101) may thus be achieved. Motivation through a more satisfied patient. (Self esteem, Maslow)</td>
<td>The Tangible &amp; Augmented Product (Ch. 4 : 67 – 72) should be addressed through its:</td>
</tr>
<tr>
<td>Q10. Please indicate what you believe to be the incidence of the following potential problems, elderly patients may have with medicines.</td>
<td>NONE: All respondents recognised incidence of the specified problems except in two categories.</td>
<td></td>
<td></td>
<td>Motivation through clarifying government policy for GPs re the partnerships in patient care, emphasising change necessity and shared benefit for GP / pharmacist.</td>
<td>• Utilities &amp; Benefits segmentation</td>
</tr>
<tr>
<td>Q11. Government seem to be encouraging pharmacist / GP collaboration on aspects of medication review. Do you agree with this approach?</td>
<td>24.3% of respondents who are uncertain or disagree.</td>
<td>✓ ✓</td>
<td></td>
<td>(Vroom – Expectancy theory) Major on non-sensitive areas in constructing benefits to GPs' package.</td>
<td>• Risk reduction</td>
</tr>
<tr>
<td>Q12. If you ticked any box from 11.1 to 11.3, which of the following items do you think a pharmacist could assist you with?</td>
<td>12.5 &amp; 12.10 indicate GPs feel threatened – culture / age related.</td>
<td>✓ ✓</td>
<td></td>
<td></td>
<td>• Packaging; styling; branding (to support doctor ego)</td>
</tr>
</tbody>
</table>

Note: Where the same or associated barrier was exposed in the Key Informant (KI) Focus Group (FG) research, this is shown in columns 2.1 & 2.2 by a tick ( ✓ )

Abbreviations: MM = Medicines Management NHIS = National Health Service (Drugs) OTC = Over the Counter (Drugs)

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Table 59 DOCTOR POSTAL SURVEY RESPONSES SUMMARY – POTENTIAL BARRIERS TO CHANGE WITH ASSOCIATED MOTIVATIONAL & MARKETING IMPLICATIONS

<table>
<thead>
<tr>
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<th>2.2</th>
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<th>4. COMMUNICATIONS; MARKETING; IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q13. If you ticked boxes 11.4 or 11.5 in Q11, please indicate your reason here.</td>
<td>Cultural mindset on which territory belongs to whom.</td>
<td>✓</td>
<td>✓</td>
<td>Design MM service around cultural values (Ch. 4: 101) and select value categories supportive of patient benefit - hence doctors satisfaction &amp; doctors benefit outcomes (Ch. 4: 102, Table 18). McClelland’s achievement-power motivational theory (Ch. 5: 256)</td>
<td>The reasons given indicate the need to build GP confidence in the pharmacist ability and non-threatening nature of the MM intervention. Kotler’s tangible product in particular (Ch. 4: 67) requires careful assembly to reinforce the “quality” of the pharmacist intervention.</td>
</tr>
<tr>
<td>Q14. If a pharmacist worked with you to undertake a patient review of those medication issues agreed by you, how frequently should this be done for those on long term medication?</td>
<td>Time constraints and increased workload.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q15. Do you feel the pharmacist should become a formal part of the doctor’s team, addressing selected items agreed by you?</td>
<td>Only 54.5% said yes. 45.5% may be reluctant to have pharmacy officially recognised. Ego issue?</td>
<td>✓</td>
<td>✓</td>
<td>Theory of reasoned action model (Ch. 4: 109, Fig 11) clearly defines the outcomes and values of the benefits. Establish by piloting the harmony between beliefs and actual experience (Ch. 4: 110).</td>
<td>This issue can be allowed to incrementally develop rather than through aggressive promotion. The soft sell approach built up as the GP/pharmacist relationship develops.</td>
</tr>
<tr>
<td>Q16. The quality of patient care for general practice may be very good, even though the patient may not be aware of that quality. How important is the patient’s own perception of that quality?</td>
<td>NONE</td>
<td>-</td>
<td>-</td>
<td>Maslow’s “safety” needs require address to reassure doctor as head of “team” – psychological comfort.</td>
<td>Q16, Q17 &amp; Q18 indicate GP awareness of patient importance, both for medication outcomes and patient expectations.</td>
</tr>
<tr>
<td>Q17. Quality of care and clinical excellence are recurrent themes in the White Papers. What is your perception of patient expectations of health care over recent years?</td>
<td>NONE</td>
<td>-</td>
<td>-</td>
<td>Reinforce these positive responses by use of the patient as the ultimate beneficiary and thus a route to achieving the quality markers’ targets of each PCT/GP practice.</td>
<td>Opinion message source and opinion leadership (Ch. 4: 126) may be built into marketing communications by enlisting the spokesman for patient organisations and their high profile medical advisers in reinforcing the message content that MM collaboration and partnership is crucial to improving primary care treatment for patients.</td>
</tr>
<tr>
<td>Q18. Patient’s perception of quality of care may be a factor in their commitment to therapy. Do you agree?</td>
<td>None substantive, but the undecided need address.</td>
<td>✓</td>
<td>✓</td>
<td>Emphasis on needs of GPs to be recognised by DH/NICE as quality prescribers.</td>
<td>Promotional channels (journals, direct mail &amp; in-house newspapers) should periodically carry articles in which external spokesmen figure prominently, in support of the new proposed relationship (partnership building) between pharmacists and GPs.</td>
</tr>
</tbody>
</table>

Note: Where the same or associated barrier was exposed in the Key Informant (KI) Focus Group (FG) research, this is shown in columns 2.1 & 2.2 by a tick (✓)

Abbreviations: MM = Medicines Management NICE = National Institute of Clinical Excellence PCT = Primary Care Trust

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Table 59 DOCTOR POSTAL SURVEY RESPONSES SUMMARY – POTENTIAL BARRIERS TO CHANGE WITH ASSOCIATED MOTIVATIONAL & MARKETING IMPLICATIONS

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<th>3. SUGGESTED MOTIVATIONAL IMPLICATIONS &amp; NEEDS FOR GPs</th>
<th>4. COMMUNICATIONS; MARKETING; IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q19. Patient perception of your overall service could be enhanced by a pharmacist medication review service directed by you. Do you agree?</td>
<td>36.6% undecided or 'anti'. Doctor ego barrier? cf. Q15</td>
<td>✓ ✓</td>
<td>Q12.5, Q15, Q19 reflect GP attitudes on important issues. 'Ego defence' (Ch. 4: 106, Table 19) is one explanation. All communications – face to face; written and published – would benefit from portraying to patients and the health professions, the new MM intervention, as GP led and directed.</td>
</tr>
<tr>
<td>Q20. Please indicate in which of the following locations your practice is based.</td>
<td>Potentially dispensing doctors. cf. Q2, Q11, Q8, Q19</td>
<td>— —</td>
<td>—</td>
</tr>
</tbody>
</table>

Note: Where the same or associated barrier was exposed in the Key Informant (KI) Focus Group (FG) research, this is shown in columns 2.1 & 2.2 by a tick (✓)

Abbreviations: MM = Medicines Management NICE = National Institute for Clinical Excellence PCT = Primary Care Trust
Table 59 is the summary of the postal survey results and exposed barriers to pharmacist role change from doctors and indicates alongside these the same, or similar issues, raised by key informants and focus group. Columns 3 and 4 summarise the author’s concept of the motivational implications for GPs, as well as the marketing approaches that would be best pursued to encourage doctor participation in the new partnership service of medicines management. This brings together the results of the literature research findings in Chapter 4, relating to the marketing and presentation of any product (service) through its core, tangible and augmented benefits, (Chapter 4 : 68) and field research results. The table also marks the place of relationship marketing, marketing communications, opinion message source and advertising channels.

The potential barriers to progress, in introducing medicines management, are in degree rather than absolute terms:

- Lack of GP time;
- Age related antipathy (as age increases);
- Lack of existing routine contact with pharmacists (58.1%);
- Current competitor entrenchment within the GP practice (36.8%);
- Those who do not wish to collaborate (15.5%); and,
- Cultural mindsets on territorial rights (47 - 57%) with respect to professional cultural sensitivities.

Facilitating issues, as discovered in the general analysis are:

- Respondents who do wish to collaborate (75%);
- Respondents who have identified eight issues for collaboration (61 – 75%);
- Very high percentage of respondents who see patient expectations of health care increasing (92.7%); and,
- High percentage of respondents who see the pharmacist as an enhancement to their service image (63.4%).

If the above barriers and facilitating factors are reflected in the whole population, the facilitating issues can be used to address the barriers by creating initial collaboration with the collaborative segment of GPs. These practices may then be used as role model / mentors for more reluctant colleagues.
PHASE 2 FIELD RESEARCH

PART II

POSTAL SURVEY QUESTIONNAIRE ANALYSIS
INDEPENDENT DISPENSING PHARMACISTS

7.5 SURVEY RETURNS

Of the 750 surveys posted to randomly selected independent pharmacies in England and Wales, in November 2002 not all were returned:

7 - were returned blank;
3 - were unusable;
14 - were not deliverable;
55 - materialised as multiples; and,
403 - were usable.

Giving a 53.7% response rate.

This figure (403) in turn represents a marginally lower percentage return than in the GP survey and 7.4% of independent pharmacies in England and Wales. (Statistical Bulletin, 2001 : 1)

Nothing is known of non respondents (46.3%) and therefore the results are interpreted with caution.

Nevertheless a return of 403 respondents constitutes a useful sample size and will give an indication of independent pharmacists’ views on the range of issues covered by the survey questions.

The survey was mailed twice, the second time four weeks after the first mailing, in an attempt to maximise returns. Other researchers have achieved similar percentage returns, (Jones, I.F. & Booth, T.G. 1975 : 150 – 153, Vol. 215 – 56%; Smith, A.J. 1994 – 53.5%; Brown et al., 1996 : 854 – 858, Vol. 257 – 61.4%). The response for this thesis was judged to be reasonably good and should give a useful view of general independent pharmacy opinion on the subject matter.
7.6 POSTAL SURVEY ANALYSIS BY QUESTION

7.6.1 Analysis of Questions 1 and 2; Gender And Position

*Question 1* - 'What gender are you?'
*Question 2* - 'What position do you hold?'

**Purpose** - These two questions are to ascertain the proportion of each sex responding to the survey and to use for comparison with later questions, if necessary, to investigate potential differences of views based upon male / female perspectives.

**Result** - A large majority of respondents were the owners of the pharmacy and 80% of all respondents were male. (Figure 63)

*Figure 63 NUMBER, STATUS AND SEX OF RESPONDENTS (n=397)*

<table>
<thead>
<tr>
<th>Status</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>45</td>
<td>4</td>
</tr>
<tr>
<td>Manager</td>
<td>46 (11.6%)</td>
<td>30 (7.8%)</td>
</tr>
<tr>
<td>Assistant Pharmacist</td>
<td>4 (1%)</td>
<td>5 (1.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>18 (4.5%)</td>
<td></td>
</tr>
</tbody>
</table>

**Comment** - The proportion of female respondents in all categories is small and renders generalisation inappropriate. It may, nevertheless, be interesting on a qualitative basis to see if any marked differences do exist with respect to certain issues. These will be dealt with under selected questions following. The ‘other’ category consisted solely of ‘partners’ and ‘superintendent pharmacists.’

**Potential Barriers to Change** – None apparent.
7.6.2 Analysis of Question 3: Size Of Organisation Represented

'How many pharmacies are in your group?'

**Purpose** - To ascertain the spread of independent pharmacist respondents in terms of organisational size, to discover whether size may affect possible approaches to change.

**Result** The majority response was from single pharmacies followed by groups of two to four. (Figure 64)

![Figure 64 SIZE OF RESPONDENT ORGANISATIONS (n = 395)](image)

**Comment** - Those respondents with more than one branch may need support on handling internal group change, one route of which may be the employment of extra pharmacist (s) to move around the groups' associated doctors and pharmacy bases. Groups may well initially be the best potential for introducing the service.

**Potential Barriers to Change** - Potential workload on single contractors.
7.6.3 Analysis of Question 4: Ages And Linkages

'What age group are you in?'

The null hypothesis for Question 4 comparison with Questions 11 and 19 is that there is no age related difference in responses to these questions.

**Purpose** - To act as potential basis for attitude difference, for example in Question 11 ‘...how satisfied... pharmacist skills being used in present contract?’ Question 19 ‘... desire to undertake Medicines Management (MM).

**Result** - Overall response pattern resembles a normal distribution across the age groups. The percentages of all age groups expressing dissatisfaction, varies between 37% and 71%. (Figure 65)

**Figure 65 AGE GROUPS COMPARED WITH PHARMACIST DISSATISFACTION WITH SKILL USE (n = 396)**

**Comment** - There does not seem to be a consistent dissatisfaction ratio with use of present skills, which is related to age. Lowest percentages dissatisfaction are expressed by the groups: 25 < 30 - 49% 35 < 40 - 43% 45 < 50 - 49% 55 < 60 - 43.4% 65+ - 37.5%

The Chi square test gave an $X^2$ value of 12.75 and a p value of 0.121 and this result is therefore not significant. The null hypothesis is sustained. A Somers Delta test gave d
as -0.039 and p as 0.244 confirming no association between age and dissatisfaction with skills use.

**Potential Barriers to Change** - With the five exceptions listed above, plus the four age groups with above 50% dissatisfied, there is still a large base on which to build dissatisfaction / disconfirmation of the present contracts (Lewin’s cultural shift Chapter 5: 171) preparatory to moving to a different contract and culture. The next chart compares age groups with desire to undertake medicines management.

**Figure 66 AGE GROUPS COMPARED WITH DESIRE TO UNDERTAKE MM (n = 394)**

![Chart showing age groups compared with desire to undertake medicines management](chart.png)

**Comment** - Again the sub groups are small but a high proportion of all age categories would like to undertake medicines management. The lower positive responses to medicines management are in age groups: 50 < 55 – 69% in favour, 60 < 65 – 75% in favour 65+ – 62% in favour. The 30 < 35 age group is again a highly positive group (as Question 11). Overall, the proportion is very positive (above 80%) in all other groups. A Somers delta test gave a d value of -0.54 and p value of 0.05 which is not less than 0.05. A Chi square test gave X² as 9.696 and p value of 0.287 confirming no association between age and desire to undertake MM. The Somers test, however, shows how close the result is to there being an association.

**Potential Barriers to Change** - The percentages uncommitted and against undertaking medicines management (see Questions 11 and 19 discussion).
7.6.4 Analysis of Question 5: Dispensing Activity

'On average, how many prescriptions are dispensed in your pharmacy each month?'

**Purpose** - To gain a picture of work load of respondents and possible relationship of work load to other issues in this questionnaire.

**Result** - Prescriptions dispensed range from less than 1,000 to 11,000 plus with 70% revealed as below 7,000 items per month. (Figure 67)

![Figure 67 PRESCRIPTION VOLUME DISPENSED IN RESPONDENTS' PHARMACIES EACH MONTH (n = 388)](image)

**Comment** - The majority response band are around the national average (5000 items per month: PSNC Internal Statistics, 2002).

**Potential Barriers to Change** - None at this stage.
7.6.5 Analysis of Question 6: NHS / OTC Balance of Business

'Approximately what percentage of your total turnover is generated by NHS receipts?'

Purpose - To gain a measure of dependency on NHS services and thus potential interest in expanding that aspect of the total business / health service.

Result - More than 95% of respondents have 50% to 90% dependency upon NHS receipts. (Figure 68)

**Figure 68  NHS RECEIPTS AS PERCENTAGE OF TOTAL TURNOVER FROM EACH RESPONDENT (n = 370)**

![Bar Chart](image)

Comment - Only 4.65% of the independent profession are not dependent upon NHS receipts for their turnover. The NHS contract is therefore of crucial importance to over 95% of contractors. Any improvement in service return is therefore likely to be of interest as may be the route to acquiring that increased return. Equally the cost and effort of achieving that increase will also be relevant to contractors. Construction of the medicines management product and its valuation is a key issue, together with its marketing.
Potential Barriers to Change - There may be an inverse relationship between workload in dispensing and take up of the new medicines management role so that the 4.65% have more time and desire to go for the extra work and compensation. Question 20 helps clarify the picture and will be related to Question 6 under Question 19 analysis.
7.6.6 Analysis of Question 7: Location of Respondents

'What is the location of your pharmacy?'

Purpose - To see whether, for example, rural pharmacies are different in attitude to the medicines management role from their city / town counterparts.

Result - All categories of response were returned, with the dominant number lying within suburban distances. (Figure 69)

Comment - The vast majority of respondents are suburban which reflects the national distribution as polled from PSNC statistics. (PSNC Internal Statistics, 2002)

Potential Barriers to Change - None at this stage.
7.6.7 Analysis of Question 8: Staffing Levels - Dispensing

‘How many dispensing assistants do you employ?’

**Purpose** - To determine support in human resource terms, for the dispensing function.

**Result** - Dispensing assistance varies between zero and five or more full or part time assistance. (Figure 70)

**Figure 70** NUMBERS OF PHARMACISTS EMPLOYING FULL TIME AND PART TIME DISPENSERS (n = 319)

![Graph showing the numbers of pharmacists employing full and part-time dispensers.]

**Comment** - To be read in conjunction with Question 5. All pharmacies with no dispensing assistance lie within the prescription bands below 2,000 items per month. All respondents employing one full or part time assistant lie in the 2,001 to 4,999 range.

**Potential Barriers to Change** - To be determined on cross tabulation with Question 5. A much more detailed analysis needs to be done on manpower and workload relationships for planning any expansion of cognitive service. This will be undertaken within the next twelve months.
7.6.8 Analysis of Question 9: Dispensing Assistants Qualifications

'How many of your dispensing assistants have a technician certificate?'

The null hypothesis for Question 9 is that the proportions of full time and part time technicians with a certificate in the population is the same.

**Purpose** - To determine the general level of competency in dispensing support staff; to thereby gain a view of the amount of work required to bring other staff up to an officially recognised level of competence and thereby assist in assessing whether dispensing work could be realistically delegated from pharmacist to support staff. Gives a measure of time resource, which may be released for pharmacist transfer of the role to cognitive service.

**Result** A large proportion of full time technicians are certificated (68%) but only 50% of part time dispensing assistants. (Figure 71)

![Figure 71: Percentages of Full and Part Time Dispensing Assistants with Technician Certificates](chart.png)

**Comment** - For the pharmacist to move from largely mechanistic dispensing into cognitive medicines management, dispensing staff will need to be formally trained, to
take more responsibility for the quality dispensing process. This will take time (2 years for NVQ 3; 1 year for NVQ 2). With several competing professionals for medicines management, this is a matter requiring urgent address. A time barrier, if protracted, could lose the medicines management role for dispensing contractors.

The Chi square test gave a p value of 0.005. The null hypothesis is therefore rejected and this result would occur by chance only 5 times in 10,000.

Some pharmacist respondents to this questionnaire (19%) are not convinced that even fully trained technicians would solve the problem of pharmacist time availability. This is illustrated by pharmacist responses to Question 24. Question 23 shows that 53.4% of respondents consider that currently they do not have time to undertake the MM Role. (Figure 72)

*Question 23 'Assuming your present workload remains the same, do you believe you currently have time to undertake the medicines management service?'*

Figure 72 TIME AVAILABILITY TO UNDERTAKE NEW ROLE
(n = 399)
Question 24 'If you answered 'no' or 'not sure' in Question 23 could some of your work load be delegated to other staff if they were fully trained?'

Figure 73 WORK DELEGATION TO TRAINED STAFF (n = 320)

19% of all respondents to Question 23, therefore are not convinced that better qualified support staff are the answer. If the same percentage is reflected in the total population, there are certain implications:

- This percentage of independent dispensing pharmacists may never take up the new role, even though many of them wish to (Question 19, 80%);

- It may be possible to persuade a proportion of them otherwise;

- Independent pharmacists in the same district may be amenable to joining forces and acquiring extra pharmacists to engage the new role for them on a rotational basis each month – or other alternating time periods. Thus the service would still be based in a community pharmacy;

- An effect of the latter strategy may be to encourage, in time, the original dispensing pharmacists to engage in the role themselves;

- If 19% of the independent dispensing contractors were to opt out of new service pick up, then the opportunity – even encouragement – would be there for the potential competitors identified in Chapter 1 to take up the role; and,
• This may in turn, prompt the DH to reallocate a portion of the present 'global sum' to the new service providers through the PCTs.

Lack of time resource is clearly a serious matter, requiring constructive address and this will be dealt with in the next chapter on conclusions and recommendations.

Potential Barriers to Change - Limited pharmacist time resource; pharmacist perception of 'trained staff' as not the solution.
7.6.9 Analysis of Question 10 and Question 11: Contractor Satisfaction – Extra Pharmacist Support And Skills Use

Question 10
'How many pharmacists regularly work with you in the pharmacy? (Not locums)'

Question 11
'How satisfied are you that the pharmacists' skills are being fully used in the present contract?'

Purpose - To assist with Question 12 in determining levels of satisfaction / dissatisfaction with the current status of community pharmacy NHS work and related factors for potential use in role change.

Results – Question 10 response rate was low at only 55.5% of all surveys returned. Lack of extra pharmacist help is apparent in 70% of those returns. (Figure 74)

Figure 74 HOW MANY PHARMACISTS REGULARLY WORK WITH YOU IN THE PHARMACY: FULL AND PART TIME (n = 300)
Comment - Question 10. Almost three quarters of respondents have neither full nor part time pharmacist help (71.7% and 70% respectively). Of the remainder 26.9% have one to three additional full time pharmacists in attendance and 30.4% have extra part time pharmacists. Figure 75 shows respondents' views on skills use, Question 11.

Figure 75 RESPONDENT SATISFACTION WITH SKILLS USE (n = 399)

When this response is compared with Question 10 breakdown of respondents who have full time pharmacist assistance the following picture emerges. (Table 60)

Table 60 PHARMACIES STAFFED WITH ONE OR MORE FULL TIME PHARMACISTS AND SATISFACTION WITH SKILLS USE
(Question 11 n = 295)
The sub groups are small at the 2 and 3 extra pharmacist levels and generalisation is not possible. However, the sample shows increasing satisfaction with skills use, as the number of pharmacists employed increases (column 3). It may be that the higher volumes of prescriptions dispensed, in generating increasingly high 'reimbursement profit' are partly, at least, responsible for that satisfaction. Conversely, the greatest dissatisfaction expressed, increases as pharmacist levels drop (again in the lower prescription volume pharmacies). Perhaps this is because low prescription volumes give low patient contact, low reimbursement profit and little opportunity under the present contract to enter cognitive service / gain remuneration.

**Potential Barriers to Change** - Time and pharmacist resource shortage at lower prescription volume levels; the apathy partly implied in column 4 from the neither satisfied nor dissatisfied.

A facilitating force for change may be the psychological 'dissatisfaction' levels, creating one of the suggested conditions assisting any change process, (Lewin, Schein, Chapter 5 : 172). This dissatisfaction level is again, strongly indicated by responses to the next question.
7.6.10 Analysis of Question 12: Contractor Satisfaction With Remuneration

'How satisfied are you with current remuneration levels in the NHS contract?'

**Purpose** - To investigate another element of satisfaction / dissatisfaction for potential use in effecting role change.

**Result** - There is a predominant dissatisfaction with remuneration. (Figure 76)

*Figure 76 SATISFACTION WITH REMUNERATION (n = 401)*

![Graph showing satisfaction levels](image)

**Comment** - Here again in Question 12, is confirmation of strong dissatisfaction with NHS remuneration; 84.2% being dissatisfied or very dissatisfied with their position in financial returns. There was no relationship with any particular size of pharmacy (in dispensing volume terms) in responses to the question. (In Dr Alan Smith's thesis, 1994, a postal survey to all categories of dispensing pharmacies – independent and multiples – returned 82 – 92% of the sample of 362 as being dissatisfied with remuneration).

**Potential Barriers to Change** - Perhaps, inferential dissatisfaction with the paymaster (the DH) and antipathy to collaboration with a perceived mean employer. Facilitating pressure to change may be a new role offering better remuneration prospects and satisfaction. (Lewin; Schein, Chapter 5 : 172)
7.6.11 Analysis of Question 13: Pharmacist / GP Relationship

'How do you rate your present relationship with GPs?'

Purpose - To indicate potential relationship barriers to collaboration in a new role.

Result - A high proportion of respondents believe their relationship with GPs to be positive. (Figure 77)

![Figure 77: Rating of Pharmacist/GP Relationship by Pharmacists (n = 394)](image)

**Codes:**
- **VS:** Very Satisfactory
- **S:** Satisfactory
- **NSNU:** Neither Satisfactory nor Unsatisfactory
- **U:** Unsatisfactory
- **VU:** Very Unsatisfactory

**Number of Respondents:**
- VS: 99 (25%)
- S: 193 (49%)
- NSNU: 62 (15.7%)
- U: 32 (8.3%)
- VU: 8 (2%)

**Comment** - From a pharmacist viewpoint, relationships with 74% of respondents and their GPs are 'very satisfactory' or 'satisfactory' and 10.3% 'very unsatisfactory' or 'unsatisfactory'. This is a good base on which to build collaboration around a closer GP relationship in cognitive service and therefore an important facilitating factor in a change process.

**Potential Barriers to Change** - Those unsatisfactory situations (10.3%), which if reflected in the total population of GPs / pharmacists, need specific address. Minorities, if useable, can be very effective influences – positive or negative.
7.6.12 Analysis of Question 14: Pharmacist Views On Patient Response To Greater Pharmacist Involvement With Their Medication

'What do you assess would be the view of patients on greater pharmacist involvement with management of their NHS medicines?'

**Purpose** - To determine potential pharmacist positive or negative attitude to the prospect of greater interpersonal relationship with the patient.

**Result** A very high positive response to this question from almost the whole survey return (98.5%). A large majority see patient response as positive. (Figure 78)

**Figure 78** PHARMACIST PERCEPTION OF PATIENTS' RESPONSE TO INCREASED PHARMACIST INVOLVEMENT (n = 397)
Comment - Again, this is a very positive response in terms of the pharmacist's perception of how a patient may respond to a different sort of relationship with the pharmacist. 88.6% see the patient view as likely to be welcome. New service design therefore, through medicines management is not likely to hold apprehension for the pharmacist on the basis of potential patient antipathy. Nevertheless, service design for the new role should take account of the possibility of patient apprehension and build the interpersonal skills of the pharmacist, ready to deal with any such patient sensitivity.

Potential Barriers to Change - Potentially mistaken pharmacist expectations of patient response; inadequate interpersonal skills to deal with this.
7.6.13 Analysis of Question 15: Pharmacist Perception Of Doctor Response To Greater Pharmacist Involvement With Medication Management

'What do you assess would be the attitude of your local doctors to greater pharmacist involvement with patient medication management?'

The null hypothesis for Question 15 is that there will be no difference in the categories of pharmacists' perceptions of doctor attitudes to pharmacist involvement in patient medication management.

Purpose - To determine potential apprehension and thus barrier, to closer pharmacist / GP collaboration on what could be regarded as a threatening issue for the doctor.

Result A much lower positive response than to Question 14. A majority still see doctor attitude as positive. (Figure 79)

Figure 79 PHARMACIST PERCEPTION OF GP VIEWS ON PHARMACIST ASSISTANCE WITH MEDICATION MANAGEMENT (n = 396)

Comment - Here there is a marked difference in the pharmacist's perception of how the doctor, as distinct from the patient, might view the proposition in the question. The
percentage of 'very welcome / welcome' has dropped from 95% in Question 14 to 61.3% or 352 down to 243 positive respondents – a reduction of 31%.

The Chi square test gave a p value of 0.005. The null hypothesis is therefore rejected and the sample result could only occur by chance 5 times in 1,000.

Likewise, the 'unwelcome / very unwelcome' responses have risen by 1,120%. Whilst the numbers are small, this still indicates a substantial difference in how pharmacists view patient and doctor possible responses to the proposition.

**Potential Barriers to Change** – Pharmacist relatively more uncertain of positive doctor response; consequently more negative mindset in approaching change.
7.6.14 Analysis of Question 16: Knowledge Of The New Role

'Are you aware of the Government backed PSNC medicines management proposals for community pharmacy?'

**Purpose** - To reveal how much information on community pharmacy's potential future has been absorbed by dispensing contractors.

**Result** - Detailed awareness of MM is almost non-existent. A high proportion of the sample returns (99.5%) gave responses to this question; these approximately follow the pattern of a normal distribution. (Figure 80)

![Figure 80 RESPONDENT AWARENESS OF PSNC PROPOSALS (n = 401)](image)

**Comment** - The responses show that there is little detailed knowledge of the PSNC medicines management proposals, which in principle have been accepted by the DH and are currently being piloted in England and Wales. This indicates a need for an effective communications programme to contractors, giving:

- Details of the 'core', 'tangible' and 'augmented' scheme;

- Its implications for relationships with primary care, doctors and other health workers;
• Details of human resource and facilities requirements;

• Details of knowledge and skills requirements for those who undertake the service; and,

• Routes of entry and means of partnership building with GPs.

On the positive side of the survey result, 77.6% of respondents have some knowledge of the 'medicines management' concept on which can be built the above communications programme. There is, however, a failure of leadership to properly inform the target market of change, the dispensing contractor, of the MM proposals.

Potential Barriers to Change - Complexity of information to be imparted and time to absorb.
7.6.15 Question 17: Perceptions of Doctor ‘Needs’ in Medicines Management Collaboration With Pharmacists

‘In this new professional relationship between doctor and pharmacist, how would you rate the potential importance of the following factors? Please circle each of your choices on a scale of ‘0-5’ (0 = not important; 5 = most important).

Note: The four phases of medicines management were outlined in the introduction section of the questionnaire together with its definition. (Appendix 10)

Purpose - To gain a measure of the level of pharmacist insight into the potential effect of medicines management, on the cultural and professional mindset of the doctor; to thereby assist the construction of a communications and marketing programme for introduction of the new service.

Result - A high response rate within the total returns showing recognition of GP needs. (Table 61)

Table 61 PHARMACIST RANKING OF SIX FACTORS, POTENTIALLY IMPORTANT TO DOCTORS’ CULTURAL / PROFESSIONAL NEEDS (n = 401)

<table>
<thead>
<tr>
<th>Factor of Need</th>
<th>Ranking by Likert Scale</th>
<th>Not Important</th>
<th>Most Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor’s need to feel non-threatened by pharmacist involvement</td>
<td>1</td>
<td>7</td>
<td>133 180</td>
</tr>
<tr>
<td>Doctor’s need to be recognised as the lead health care professional</td>
<td>2</td>
<td>9</td>
<td>134 151</td>
</tr>
<tr>
<td>Doctor’s need to be the final decision maker on medicines regimen</td>
<td>3</td>
<td>10</td>
<td>125 177</td>
</tr>
<tr>
<td>Doctor’s need to have confidence in the pharmacist’s abilities</td>
<td>4</td>
<td>1</td>
<td>103 280</td>
</tr>
<tr>
<td>Doctor’s need to be sure of confidentiality in all matters</td>
<td>5</td>
<td>3</td>
<td>103 256</td>
</tr>
<tr>
<td>Doctor’s need to have confidence in the pharmacy facilities for confidential consultation</td>
<td>6</td>
<td>3</td>
<td>131 179</td>
</tr>
</tbody>
</table>
Comment - More than 70% of all respondents have ranked the specific list of all doctor 'needs' at the 4-5 level, recognising the importance of these cultural and professional issues in the context of medicines management. This awareness of potential sensitivities, if reflected in the whole population is a sound basis from which to construct a culturally empathetic communications and marketing programme for the introduction of the full medicines management service. Pharmacists further recognise, by the largest majority, the importance of 'pharmacist abilities', (factor 4) as a potential requirement of the doctor 'need' in any such service. Linked with the responses to Question 19, which show 80% of pharmacists wishing to undertake the new role, this is also a key motivational basis for making progress in additional training commitment for medicines management via dispensing pharmacists.

'Confidentiality' is the next most highly ranked need element (89.5%) which includes information confidentiality as well as privacy of pharmacist / patient interchanges at consultations. Again, premises amenities need constructing for patient comfort, relaxed atmosphere and confidential discussion (Chapter 4 : 81; Figure 9).

Third most importantly ranked doctor need, is '...to feel non-threatened by pharmacist involvement' (78%). This element, relates back to Maslow's 'hierarchy of needs' (Chapter 4 : 98; Figure 10) 'esteem' and self actualisation' and again is a key consideration in marketing communications theming.

Potential Barriers to Change - None obvious. It is encouraging to find that in pharmacists' perceptions, the 'doctor need issues' presented to them, are recognised, highly ranked and form a sound basis on which to package the new service in an empathetic framework. This should help doctor collaboration and willingness to begin sharing responsibility for patient medication. Even if it transpired that doctors themselves were not overly sensitive about the issues, an empathetic approach to GPs, based upon address of these factors would still be recommended for the service package, (Schein, Chapter 4 : 10; Rokeach, Chapter 4 : 101 – 102) which underpin the overall service benefits.
7.6.16 Analysis of Question 18: Pharmacist Task Abilities

'How would you describe your present ability to undertake the medicines management (MM) role?'

**Purpose** - To measure the magnitude of training requirements to undertake medicines management and determine the population of respondents who are ready now; expose potential educational / training differences and barriers to progress.

**Result** - This shows a large majority of the respondents to be unable, at present, to undertake MM. (Figure 81)

**Figure 81** DEGREES OF DISPENSING PHARMACISTS ABILITY TO UNDERTAKE MEDICINES MANAGEMENT (n = 399)

<table>
<thead>
<tr>
<th>Degree of Ability to Undertake Medicine Management</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able Now</td>
<td>45 (11.3%)</td>
</tr>
<tr>
<td>Able with suitable training</td>
<td>287 (71.9%)</td>
</tr>
<tr>
<td>Not Sure</td>
<td>42 (10.5%)</td>
</tr>
<tr>
<td>Unable now</td>
<td>25 (6.3%)</td>
</tr>
</tbody>
</table>

**Comment** - The positive aspect of this result is that although only 11.3% of respondents consider themselves able to undertake the role now, 71.9% consider that they would be able to do so with suitable training. This represents an opportunity for the profession to design training packages with appropriate content, to facilitate uptake of the medicines management service (Ref. Questions 19, 21).
Potential Barriers to Change - The training required of such a large number of dispensing pharmacists, i.e. 88.7% if all are requested, in a new contract, to undertake the new service.
7.6.17 Analysis of Question 19: Desire To Undertake Medicines Management

'Would you personally wish to undertake the new medicines management service if remuneration is acceptable?'

Purpose - To determine the existing commitment to undertaking the new role, given the stated proviso; to link this response with those of Questions 17, 18, 20, 21, 22.

Result A high proportion of the sample wish to undertake MM. (Figure 82)

Figure 82 PHARMACIST COMMITMENT TO MEDICINES MANAGEMENT (n = 401)

Comment - Question 17 showed strong awareness of perceived doctor needs; Question 18 exposed requirement for training to be substantial. This question declares a large majority (80.8%) of respondents to be in favour of taking up the new role, with 16.2% still to be persuaded and only 3% against. There is thus, some understanding of the doctor's position (needs) in this new pharmacist role; acceptance of pharmacist training needs; and a firm declaration of desire to get into medicines management, given that remuneration is acceptable.

These positive indications that dispensing community pharmacists do want to extend their role into cognitive service.
Potential Barriers to Change - The nature and time commitment to training; those 'not sure' and 'no' who may fear erosion of their dispensing focus or for other reasons wish to stay with the present service. These, in percentage terms constitute 19.2% of respondents which approximates to 18.3% of respondents (Question 11) who are satisfied that the pharmacists' skills are currently being fully used anyway. Again, this represents an opportunity for invasion by threat of entrants, e.g. nurses; PCT pharmaceutical advisers.
Analysis of Question 20: Antipathy To Competing Professionals For Medicines Management

'In the following list (8 options) who do you feel should not take up the service? Please tick appropriate boxes.'

Purpose - A measure of the strength of feeling, as to who actually should be the deliverer of medicines management, in the context of Questions 18 and 19; another proxy for potential commitment and motivation; a measure of 'competitive intent'.

Result – There is a clear declaration of who should not undertake the MM role. 354 respondents made in total, 1149 choices. (Figure 83)

Comment - One interesting feature of this response is the 10.2% who do not wish dispensing contractors to undertake medicines management. This is three times the number who said 'no' to Question 19. These responses all come from those in the 'not sure' category of Question 19 and so appear to have firmed up a view after being focussed on alternatives in this question, to dispensing contractors.
Equally interesting is the 75.7% of respondents who do not feel that nurses should be involved. This is the highest 'anti' vote of all the alternatives, next to which is the doctor at 53.1%. Freelance pharmacists are almost as unpopular as the doctor. On querying why this could be, with Gateshead and South Tyneside LPC, the reason given was:

'...peripatetic pharmacists make changes doing deals with drug companies that disadvantage contractors...’

'...their prescribing advice and changes to approved practice formularies leave us with dead stock...’

These answers cannot be generalised, but perhaps give a hint as to the reasons for peripatetic unpopularity.

**Potential Barriers to Change** - The responses to this question indicate a facilitating force for change into cognitive service, pushing dispensing pharmacists towards engaging medicines management. The potential competitive entrants may thus constitute one of Lewin's disconfirmation factors (Lewin; Schein, Chapter 5 : 172) However, some of the competitive options are already providing some medication review services and with further development could become a growing barrier to dispensing pharmacist entry into the medicines management service (Chapter 1 : 29, Figure 4).
7.6.19 Analysis of Question 21: Training Preferences

'If you require training to undertake the new role, what subjects among the following list would you select? Please tick all appropriate boxes.'

**Purpose** - To obtain a measure of respondents perception of what is required for medicines management knowledge; to assist in formulation of training programmes.

**Result** - The response indicates awareness of weaknesses in respondent knowledge base required for MM. 390 respondents exercised in total 1,438 choices for training requirements. (Figure 84)

**Figure 84** RANGE OF SUBJECTS SELECTED FOR TRAINING BY DISPENSING PHARMACISTS TO ALLOW THEM TO PERFORM MM

(n = 390)

<table>
<thead>
<tr>
<th>Categories of Response Preferred Subjects</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pharmacology</td>
<td>328 (84.1%)</td>
</tr>
<tr>
<td>Drug Economics</td>
<td>199 (51%)</td>
</tr>
<tr>
<td>Pathology</td>
<td>237 (60.8%)</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>129 (33.1%)</td>
</tr>
<tr>
<td>Disease Management</td>
<td>321 (82.3%)</td>
</tr>
<tr>
<td>Techniques to Motivate Patients</td>
<td>224 (57.4%)</td>
</tr>
</tbody>
</table>

**Comment** - The two leading preferred subjects are 'clinical pharmacology' and 'disease management' which are not surprising choices. What is surprising is that the lowest popularity is attracted by 'interpersonal skills'. There may be a number of reasons for this, of which three possibles are:
Some pharmacists have no knowledge of it as a formalised subject and cannot make a judgement;

Pharmacists believe they already have sufficient skills; and,

Pharmacists don’t see medicines management as other than technical address of drugs and diseases (perhaps partly reflected in their two top choices of preferred subject learning).

The three top choices are technical subjects, well known in the treatment of disease field. The three bottom choices are subjects without in-depth pharmaceutical address in traditional training and education. Perhaps there is little knowledge of their application.

Potential Barriers to Change - Possible lack of knowledge of the importance of the three subjects least popular of the specified list; (interpersonal skills; drug economics; motivation techniques) the training / education hurdle of the three most popular choices - clinical pharmacology, disease management; patho-physiology.
7.6.20 Analysis of Question 22: Preferred Training Options

'In the following list of training (PD) options, which one would be your preferred training route?

Purpose - To establish preferences, so as to facilitate the move into further professional development for dispensing contractors.

Result - Clear views are expressed on all options on a very personal basis. 357 respondents exercised only 382 choices in total. (Figure 85)

![Figure 85 PREFERRED CHANNELS OF FURTHER PROFESSIONAL DEVELOPMENT (n = 357)](image)

Comment - Daytime lectures are preferred by 46.5% of respondents with the next most preferred route being distance learning (24.1%). The latter being further supported by those who would like seminars to supplement the distance learning (16%). Web based learning is not popular in either of the variants offered (5.6% and 1.7%). Evening lectures fair a little better at 13.2%. The above results are not surprising bearing in mind the detailed concentrated daily work of the dispensing pharmacist and its tiring effects. Nevertheless, all options have some support and training packages could be prepared accordingly.
Potential Barriers to Change – Time available to study. This would need very careful reflection to provide the right amenity in the most time and cost efficient way so as to maximise enthusiasm and uptake.
7.6.21 Analysis of Question 23: Workload Implications

'Assuming your present workload remains the same, do you believe you currently have time to undertake the medicines management course?'

Purpose - To establish respondents' views on time availability for additional cognitive service; to link with Questions 9 and 24, relating to technician qualifications (and hence ability to handle more responsibility); to consequently identify and change management action required.

Result - This shows lack of time to undertake MM by a large majority if the present workload remains the same. (Figure 86)

Figure 86 TIME AVAILABILITY TO UNDERTAKE MEDICINES MANAGEMENT (n = 399)

Comment - A relatively small percentage of respondents think they currently have time to undertake medicines management. This is a serious situation if reflected in the total population as there is:

- A community pharmacy shortage of pharmacists, not likely to be corrected for several years (PSNC projections: internal document January 2003);
• An active competitive range of professionals in the market place, already expanding their services (Chapter 1: 24, Figure 9); and,

• Lack of time resource to undertake the new role; shortage of pharmacist manpower in the short to medium term.

Question 17, elicited strong awareness of doctor needs (71.0%);
Question 18, exposed a large majority requiring training for MM (78.2%);
Question 19, showed a large majority wishing to undertake MM (80.8%);
Question 20, revealed widespread antipathy to other professionals undertaking MM (89.8%); and,
Question 23, shows a lack of belief that there is time to undertake MM (80.2%).

This shows dispensing pharmacists' desire to move into a new role; substantial barriers to progress; competitive force for change (antipathy to other professionals); and, appreciation of the potential for GP sensitivities (needs). All these issues require careful consideration in formulating a programme for change of role.

Potential Barriers to Change - These issues, together with the implications in Question 9 will be dealt with more fully under Question 24 following.
7.6.22 Analysis of Question 24: Potential Resolution Of The Problem Of The Scarcity Of Pharmacist Time, Blocking New Role Take Up

'If you answered 'no' or 'not sure' in the previous question, could some of your workload be delegated to other staff, if they were fully trained?'

Purpose - To establish whether a relatively simple solution would be acceptable to respondents; to determine by implication, respondent views on 'other staff' potential.

Result A majority of pharmacists believe delegation of work is the answer to the scarcity of time problem. (Figure 87)

Comment - On the positive side, 51.2% of respondents to this question (41.1% of respondents to original Question 23) do believe they can delegate some workload. The 'not sure' and 'no' groups (156) constitute 39% of the original responses to Question 23 (399) and are not convinced at this time, that they can delegate any present workload to other staff. If reflected by the total population, this is a seriously restrictive factor in gaining quick uptake of medicines management.

The implications of the answers, 'not sure' and 'no', raise a number of potential problems:
• This segment of the total population may never take up the new role even though many actually do wish to (Question 19 – 80%);

• This in turn may prompt the DH to remove money from the global sum for dispensing and reallocate to practitioners of medicines management; and,

• Other competitor professionals, will have an 'open' market to target for themselves, making later entry by dispensing pharmacists very difficult.

However, a positive approach to marketing the benefits of the new service and benefit of workload reallocation to trained dispensing technicians, may be able to convert a proportion of the 'not sure / no' group quite quickly and use the change momentum to encourage others to so do. Other possibilities could include:

• The LPCs (now LRCs) employing pharmacists to work for selected groups of local dispensing pharmacists on a rotational basis, e.g. 1 pharmacist per 6 pharmacies working 1 ½ days at each and repeating fortnightly.

(This would save the complexity of 'consortia' becoming an employer, with all the attendant corporate set up costs and some pharmacies wishing to drop out or alternatively have more time allocated to them).

• Groups of independent pharmacies actually going down the corporate consortia route and employing their own pharmacists – rather than those of the LRC.

In suggesting extra pharmacists employed as above does imply obtaining manpower from sources other than community pharmacy, e.g. the hospital service, which would in turn create greater shortages there.

Roles such as the above are effectively 'tied peripatetics' but would be different from the current group of peripatetics, as they would be based in pharmacies not surgeries.

**Potential Barriers to Change** - Antipathy to workload delegation; lack of pharmacist time resource. This is a serious matter requiring positive and creative address and will be dealt with in the next and final chapter on conclusions and recommendations.
7.6.23 Analysis of Question 25: Satisfaction With Current Contract

'Do you think it is time for an entirely new pharmacy contract?'

**Purpose** - To obtain a measure by proxy, of the potential willingness to change the current basis of the NHS dispensing contract toward more cognitive service.

**Result** - A clear majority say yes but a substantial minority say 'not sure' or 'no'. (Figure 88)

![Figure 88 RESPONDENT ATTITUDE TO CHANGE OF CONTRACT (n = 394)](image)

**Comment** - A high percentage (60.7%) do want a new contract; 11.4% definitely do not and 27.9% are not sure. The 11.4% who don't want a new contract are largely those who also do not want dispensing pharmacists to undertake medicines management (Question 20 - 10.2%).

The 'not sure's' are also largely those who do not believe they have the time for medicines management (Question 23 - 26.8%) and to a marginally lesser extent those who are 'not sure' about delegating to other staff (Question 24 - 25%).

It appears that there are two broad groups of dispensing pharmacist who are not fully committed to moving into medicines management:
1. Those who believe they have no time and cannot delegate workload; and,

2. Those who are set against moving out of the current dispensing contract. This group appear to be operating from an individual perspective of preference for the status quo and are not related to particular age or prescription volume categories. Nor is there a difference related to the numbers of technicians or extra pharmacists employed. It appears to be a particular attitude of mind opposed to change.

Potential Barriers to Change - The mind set that doesn’t want change; the undecided.

This is a strange result in view of the 80.8% response rate to Question 19 who do wish to undertake medicines management which will certainly require a different contractual framework than the simple dispensing contract of the present.

It may be that the term 'entirely new contract' used in the question has implications for some, that the very foundations of stability in the present contract will depart leaving them with the unknown. An unknown remuneration package for unknown new services may be one motivational force driving this result which would relate in some measure to the responses in Question 16 where 20.4% were not aware of the 'PSNC Government backed medicines management proposals' and 54.4% were only aware 'in outline'.

Perhaps linking responses to Question 16 and Question 24, the further barrier to change is lack of clarity in the future vision of the pharmacy service (Chapter 1: 21).

A summary of the pharmacist survey returns and implications follows, after which a consolidation table (Table 62) of GP and pharmacist survey returns link-ups, brings the two surveys together.
Table 62 PHARMACIST POSTAL SURVEY RESPONSES SUMMARY – POTENTIAL BARRIERS TO CHANGE WITH ASSOCIATED MOTIVATIONAL & MARKETING IMPLICATIONS

<table>
<thead>
<tr>
<th>1. SURVEY QUESTION NO. &amp; CONTENT</th>
<th>2. EXPOSED BARRIERS</th>
<th>3. SUGGESTED MOTIVATIONAL IMPLICATIONS &amp; NEEDS FOR PHARMACISTS</th>
<th>4. MARKETING; COMMUNICATIONS; IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. What gender are you?</td>
<td>None apparent</td>
<td>Subsequent analysis failed to expose response differences based on these 3 attributes. Different approaches not required at this time.</td>
<td>Uniform approach to promotion, irrespective of gender, position or group size. (In independent sector)</td>
</tr>
<tr>
<td>Q2. What position do you hold?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3. How many pharmacies are in your group?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4. What age group are you in? (cf. Q19 - who wishes to do MM?)</td>
<td>19.4% were unsure or did not want to do MM in the 50+ age groups.</td>
<td>Negative reinforcement (Ch 5 : 251) may come from change engaged by peer groups. Porter-Lawler model could be useful also – (Ch 5 : 262) elements 1 – 7.</td>
<td>Marketing 'copy' to reflect benefits using the Porter-Lawler factors as framework of major underpinning guides (factors 1, 2, 3, 5, 7)</td>
</tr>
<tr>
<td>Q5. On average, how many prescriptions are dispensed in your pharmacy each month?</td>
<td>Workload and time constraints</td>
<td>Herbert Two factor motivational approach. (Ch 5 : 260) Also negative reinforcement theory.</td>
<td>Professional journal articles, arguing need for urgent address of skill mix and training options for pharmacists. – Reinforce by guidance to LPCs on engaging their electorate.</td>
</tr>
<tr>
<td>Q6. Approx. what % of your total turnover is generated by NHS scripts? (cf. Q23... do you believe you actually have time to do MM?)</td>
<td>80.2% said ‘no’ or ‘not sure’</td>
<td>Facilitation required – approach to pharmacists/GPs based upon the Hackman et al., motivational model (client relationship aspects)</td>
<td>Present as complimentary benefits eradicating the previously competitive nature of relationship between rural GP and pharmacists. Patient is major beneficiary.</td>
</tr>
<tr>
<td>Q7. What is the location of your pharmacy?</td>
<td>Rural pharmacist/and dispensing doctor antipathy.</td>
<td>Subsequent analysis failed to expose response differences based on these 3 attributes. Different approaches not required at this time.</td>
<td></td>
</tr>
<tr>
<td>Q8. How many dispensing assistants do you employ?</td>
<td>32% FT dispensers have not - 50% PT dispensers have not Delegation restrictions.</td>
<td>As Q5 &amp; Q6</td>
<td>Supportive guidance literature on dispensing assistants' training courses to NVQ Levels 2 &amp; 3. Engage if possible, message sponsorship from DH.</td>
</tr>
<tr>
<td>Q9. How many of your dispensing assistants have a technician’s certificate? (cf. Q24 could some of your workload be delegated?)</td>
<td>70+% have no extra pharmacist. MM will require delegation of work. Workload and time constraints.</td>
<td>As Q5 &amp; Q6</td>
<td>As Q5. Marketing themes promoting skill mix.</td>
</tr>
<tr>
<td>Q10. How many pharmacists regularly work with you in the pharmacy?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Where the same or associated barrier was exposed in the Focus Group (FG) research, this is shown in column 2.1 by a tick (√)

Abbreviations: DH = Department of Health MM = Medicines Management
FG = Focus Group (Pharmacy) PT = Part Time
FT = Full Time
LPC = Local Pharmaceutical Committee
Table 62 PHARMACIST POSTAL SURVEY RESPONSES SUMMARY – POTENTIAL BARRIERS TO CHANGE WITH ASSOCIATED MOTIVATIONAL & MARKETING IMPLICATIONS

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<thead>
<tr>
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<th>2.1 FG</th>
<th>3. SUGGESTED MOTIVATIONAL IMPLICATIONS &amp; NEEDS FOR PHARMACISTS</th>
<th>4. MARKETING; COMMUNICATIONS; IMPLICATIONS</th>
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</thead>
<tbody>
<tr>
<td>Q11. How satisfied are you that the pharmacists' skills are being fully used in the present contract?</td>
<td>53% were dissatisfied. Only 18.3% were satisfied – a facilitating influence.</td>
<td>Levin's disconfirming technique for driving change can exploit this dissatisfaction (Ch 5: 171, 172; Fig 19; Hackman et al. Ch 5: 259)</td>
<td>Product benefits to pharmacists to be promoted (core, tangible, augmented) together with the benefits to GPs and patients. Message based upon new route into job fulfillment &amp; higher profile in primary care. Outline disadvantages of remaining with status quo. (Ch 4: 67)</td>
<td></td>
</tr>
<tr>
<td>Q12. How satisfied are you with current remuneration levels in the NHS contract?</td>
<td>84.2% were dissatisfied – a facilitating influence.</td>
<td>As above – but caution with possible Rebound component in form of resentment against DH paymaster.</td>
<td>Relationship Marketing – based upon mutual product benefit and self actualising outcomes. Service to be presented as supportive of GP lead position in health care &amp; confidence built so as not to threaten doctor culture (Ch 4: 84)</td>
<td></td>
</tr>
<tr>
<td>Q13. How do you rate your present relationship with GPs?</td>
<td>74% rated as very satisfactory or satisfactory – a facilitating measure; but 26% are unsure or have unsatisfactory relationship. The latter is a significant barrier if reflected nationally.</td>
<td>Relationship between a large proportion of GPs/pharmacists appear positive. For MM to engage, this firm base needs developing – a positive force for change (Schein/Isabella Ch 5: 172; Fig 19)</td>
<td>Engage opinion sponsorship and message leadership from patient organisations to reinforce what pharmacists instinctively believe (i.e. 88.6%) about patient relationships (Ch 4: 126)</td>
<td></td>
</tr>
<tr>
<td>Q14. What do you assess would be the view of patients on greater pharmacist involvement with management of their NHS medicines?</td>
<td>88.6% view it as likely to be welcome – a facilitating force. Potential barrier: pharmacists may be mistaken.</td>
<td>As above for Q 13</td>
<td>Cite beliefs of 61.3% of colleagues re. doctor response together with views of the GP National Focus Group. Cite survey views of GPs on elements of MM which they are agreeable to receiving assistance on (Third party evidence Ch 4: 127)</td>
<td></td>
</tr>
<tr>
<td>Q15. What do you assess could be the attitude of your local doctors to greater pharmacist involvement with patient medication management?</td>
<td>Lower percentage positive view here – 61.3%. Overall a good sign of positive thinking but 38.7% are more negative – a barrier to overcome.</td>
<td>Disconfirming information on present contract to be reinforced (Lewin / Schein) using Q11, Q12 responses &amp; consequent need to change to achieve satisfaction / rewards. Porter Lawler model useful in planning the motivational communications.</td>
<td></td>
<td></td>
</tr>
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Note: Where the same or associated barrier was exposed in the Focus Group (FG) research, this is shown in column 2.1 by a tick (✓)

Abbreviations: FG = Focus Group (Pharmacy) MM = Medicines Management
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<tr>
<td>Q16. Are you aware of the Government backed PSNC medicines management proposals for community pharmacy?</td>
<td>Little detailed knowledge (23.2%). Thus little grasp of the &quot;knowledge needs&quot;.</td>
<td>Promote staff actualisation and self esteem, delivered by new place in primary care through the new role (Maslow Ch 4 : 97; McClelland (Ch 5 : 256)</td>
<td>Marketing of the concept is a real requirement; communications need polishing and a programme for informing dispensing pharmacists needs constructing.</td>
</tr>
<tr>
<td>Q17. In the new professional relationship between doctor and pharmacist, how would you rate the potential importance of the following factors (6 given)?</td>
<td>No obvious barriers in the responses. A strong facilitating factor in change would be the strong grasp of the doctors' needs in a new role. Also pharmacists recognise the doctors' need to have confidence in the pharmacists' abilities and facilities.</td>
<td>Again, a good base for arguing the 'softly, softly' approach to engaging doctors and encouraging the pharmacist to proceed with confidence. Job enrichment theory; (Herzberg Ch 5 : 260)</td>
<td>The promotion of the MM concept to pharmacists, should emphasise the gains to be made by taking full account of the doctors' cultural practice of leading the primary health care team and having reciprocal confidence in the pharmacist. The psychology of the message is crucial (Ch 4 : 126)</td>
</tr>
<tr>
<td>Q18. How would you describe your present ability to undertake the MM role?</td>
<td>88.7% of respondents not yet able to undertake the new role at present.</td>
<td>Impart self-confidence &amp; esteem by good training package based upon response to Q21 &amp; Q22. Vroom / Yetton model (Ch 5 : 252). Use self actualisation; esteem; self image (Ch 4 : 98 - Harré, Tajfel et al.) Group identity; group culture (Schein : Ch 4 : 99). Emphasise 'need' for dispensing pharmacists to equip themselves for MM role without delay. (Ch 4 : 93 Wells &amp; Punsky definition) (Ch 5 : 251 reinforcement theory - elements 1 &amp; 2).</td>
<td>Communications: Provide clear routes of support through training &amp; mentoring schemes, derived from PSNC pilot trials; pursue possibility of day release and distance learning plus seminars. 'Reinforcement' copy, confirming the positive beliefs patient / GP / pharmacist, win/win/win benefits enumerated.</td>
</tr>
<tr>
<td>Q19. Would you personally wish to undertake this new MM service if remuneration is acceptable?</td>
<td>19.2% not sure or don't want to enter new role. However 80.8% do.</td>
<td>Firm views expressed: Anti nurse 75.7% Anti doctors 53.1%</td>
<td>As Q19 with addition of community pharmacist competitive advantage i.e. NHS / OTC interventions in real time.</td>
</tr>
<tr>
<td>Q20. Who do you feel should not be the deliverer of MM? Please tick all appropriate boxes.</td>
<td></td>
<td></td>
<td></td>
</tr>
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Note: Where the same or associated barrier was exposed in the Focus Group (FG) research, this is shown in column 2.1 by a tick (√)

Abbreviations: FG = Focus Group (Pharmacy) MM = Medicines Management
### Table 62 PHARMACIST POSTAL SURVEY RESPONSES SUMMARY – POTENTIAL BARRIERS TO CHANGE WITH ASSOCIATED MOTIVATIONAL & MARKETING IMPLICATIONS

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</thead>
<tbody>
<tr>
<td>Q21. If you require training to undertake the new role, what subjects among the following list, would you select?</td>
<td>Clear needs and, in this case, barriers to role uptake are: knowledge deficiency in a number of subjects principally: Clinical pharmacology (84.1%) and Disease management (82.3%)</td>
<td>As Q18. Equip with training packages – strengthen self confidence. Target the need for achievement and affiliation (McClelland Ch 4 : 98). Hackman et al. Job characteristics model (Ch 5 : 259)</td>
<td>As Q18 – communications providing solutions to concerns; via LPC, and direct to contractors by professional journals. Set out sources of training packages with alternatives. Copy to point out rewards in terms of self actualisation &amp; new important place in primary care.</td>
</tr>
<tr>
<td>Q22. In the following list of training options, which one would be your preferred training route?</td>
<td>The least popular option i.e. web based packages &amp; evening lectures.</td>
<td>Training packages to be offered in most popular routes i.e. daytime lectures and distance learning (70.6%) as Q21.</td>
<td>Copy to offer a range of options, at launch of desire to market the new service, but major on availability of the most popular, taking account of day release implications.</td>
</tr>
<tr>
<td>Q23. Assuming your present workload remains the same, do you believe you currently have time to undertake the medicines management service?</td>
<td>53.4% who said ‘no’ + 26.8% who said ‘not sure’ – lack of time resource (79.8% total 320)</td>
<td>Taking the Q19, 80.8% who do wish to do MM, the ‘path’ to this goal, should be prepared carefully and the route made as easy as possible (Ch 5 : 252 – Tolman; Geolgopoulos ‘Path-Goal Theory’)</td>
<td>Communications: As Q6 and disconfirm possibility of remaining with present contract. Emphasise new service benefits in pharmacist / GP / patient terms.</td>
</tr>
<tr>
<td>Q24. If you answered ‘no’ or ‘not sure’ in the previous question, could some of your workload be delegated to other staff, if they were fully trained?</td>
<td>48.8% of the 79.8% (156) said ‘no’ or ‘not sure’. This is 39% of all respondents to the questionnaire.</td>
<td>Job enrichment model of motivation, Hackman et al., combined staff skills realignment.</td>
<td>Promotional platform of the new service to portray benefits of greater competence of ancillary staff – easier workload for pharmacist; more efficient patient service – consequent greater attraction of patients to the pharmacy; patient/pharmacist relationships strengthened; allegiance strengthened.</td>
</tr>
<tr>
<td>Q25. Do you think it is time for an entirely new pharmacy contract?</td>
<td>60.7% said ‘yes’ but 11.4% said ‘no’ and 27.9% were not sure. The latter two groups are potential barriers to change.</td>
<td>New contract with underpinning principles from Maslow &amp; McClelland.</td>
<td>Benefits of change to be clearly set out in practical effects; higher value service attracts higher recognition or potential rewards.</td>
</tr>
</tbody>
</table>

Note: Where the same or associated barrier was exposed in the Focus Group (FG) research, this is shown in column 2.1 by a tick (✓)

Abbreviations: FG = Focus Group (Pharmacy)  
MM = Medicines Management
Pharmacist Postal Survey Summary

Table 62 summarises the postal survey results and exposes barriers to role change from pharmacists and indicates alongside these, the same or similar issues raised by the national focus group. Columns 3 and 4 set out the author’s concept of the *motivational* and *needs* implications for pharmacists, as well as suggested marketing approaches that would be best pursued to encourage pharmacists into the new service of medicines management.

This table also brings together the results of the literature research findings in Chapter 4, relating to the marketing and presentation of a new product (service) through its core, tangible and augmented benefits, (Chapter 4 : 68) and field research results. Relationship marketing, opinion sponsorship and the psychology of tailored communications to members is emphasised. The potential barriers to progress are:

- Lack of pharmacist time for the additional work (80.2% of respondents);
- Age related antipathy (as age increases) (19.4% in 50+ age group);
- Reluctance to delegate present workload (39% of respondents);
- Rural pharmacist / dispensing doctor antipathy;
- High percentage of 'unqualified' technicians (50% part time, 32% full time); and,
- Inability to undertake medicines management (88.7% of respondents).

Facilitating issues, as discussed in the general analysis were:

- Good relationship with GPs (74% of respondents);
- Positive view of patient response to MM (88.6% of respondents);
- Positive view of GP response to MM (61.3% of respondents);
- Respondents do not wish various other professionals to undertake MM (89.8%);
- Respondents’ dissatisfaction with remuneration in present contract (84.2%); and,
- Respondents’ desire to undertake MM (80.8%).
If the above barriers and facilitating factors are reflected in the whole population, the facilitating issues can be used to address the barriers by creating disconfirmation of the current position and indicating better rewards for a new service using the Lewin-Schein theory, (Chapter 5 : 172, Figure 19). This leads to the final summary table (Table 63) showing barriers and link ups for the professions of medicine and pharmacy.
Table 63  SUMMARY – POSTAL SURVEYS DOCTORS & PHARMACISTS
BARRIERS AND FACILITATORS TO CHANGE:
KEY RESPONSE CROSS LINK-UPS

<table>
<thead>
<tr>
<th>DOCTOR SURVEY QUESTIONS &amp; RESPONSES</th>
<th>KEY RESPONSE LINK-UPS</th>
<th>PHARMACIST SURVEY QUESTIONS &amp; RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXPOSED BARRIERS &amp; FACILITATORS</strong></td>
<td><strong>FACILITATORS</strong></td>
<td><strong>BARRIERS</strong></td>
</tr>
<tr>
<td>Q1 Please state the number of doctors in your practice. Of these, how many are partners? Barriers: None Facilitators: None Comment: As practice size increases so does agreement with collaboration with pharmacists.</td>
<td>Link-up 1 GP Q2 High proportion of GPs favouring pharmacist / GP collaboration. P Q13 High proportion of pharmacists claim good relationship with GPs – even in rural areas. P Q15 High proportion of pharmacists believe GPs attitudes to collaboration would be positive. A good basic mutual empathy exists</td>
<td>Q1 What gender are you? Q2 What position do you hold? Barriers: None Facilitators: None Comment: Basic attributes which may have implications in relationship to other responses.</td>
</tr>
<tr>
<td>Q2 Is your practice a dispensing practice? Barriers: Dispensing doctors; Q8 Less desire to work with p'cists Q11 Less agreement with collaboration in medicines management Q19 Less agreement that pharmacists could improve patient perception of the GPs' service. Facilitators: The high proportions of GPs who gave positive responses to Q8, 11, 19 (see under those questions).</td>
<td>Link-up 2 GP Q3, 14 Scarcity of time resource P Q6, 23, 24 Scarcity of time resource</td>
<td>Q3 How many pharmacies are in your group? As Q1 &amp; Q2 note workload implications in single contractors (60.3%) of respondents.</td>
</tr>
<tr>
<td>Q3 Approximately how many patients are in your practice? Barriers: Potential workload needs address Facilitators: Workload reduction of GP by the pharmacist.</td>
<td>Link-up 3 GP Q4 Increased age shows greater reluctance to involve pharmacists with GP traditional roles. P Q4, 19 Higher age groups marginally more reluctant to undertake medicines management.</td>
<td>Q4 What age group are you in? Barriers: None specifically related to age. Facilitators: Dissatisfaction overall with remuneration of present contract – 84.2% (Q12)</td>
</tr>
<tr>
<td>Q4 Please tick the age groups you all come within. Barriers: With increasing age there is less willingness to have p'cists selecting initial patient medication &amp; less willingness to collaborate. Facilitators: Large % of GPs who do want collaboration.</td>
<td></td>
<td>Q5 On average, how many prescriptions are dispensed in your pharmacy each month? Barriers: Workload in high dispensing pharmacies with only one pharmacist and minimal technicians. Facilitators: Very low volume dispensing pharmacies (20%).</td>
</tr>
<tr>
<td>Q5 Broadly, how would you describe the frequency with which you contact a dispensing pharmacist? Barriers: Lack of routine contact (cf. Q11) Facilitators: Greater routine contact corresponds with greater desire for collaboration (Q11).</td>
<td></td>
<td>Q6 Approximately what % of your total turnover is generated by NHS receipts? Barriers: As Q5 Facilitators: As Q5</td>
</tr>
<tr>
<td>Q6 Do you have a pharmacist work for you in the practice? Barriers: Low incidence of pharmacist work in GP practice. Facilitators: 37% of respondents who have pharmacist help in the practice – potential mentors / role models.</td>
<td></td>
<td>Q7 What is the location of your pharmacy? 87.6% in town/city centre/suburban 18.5% rural Barriers: Rural pharmacist/dispensing doctor potential antipathy. Facilitators: Majority of pharmacists are where majority of doctors are.</td>
</tr>
<tr>
<td>Q7 How many dispensing assistants do you employ? Barriers: Facilitators:</td>
<td></td>
<td>Q8 How many of your dispensing assistants have a technician's certificate? Barriers: Limited pharmacist time resource with limited quality support. Facilitators: 68% respondents with qualified assistants (full time) &amp; part time.</td>
</tr>
<tr>
<td>Q9 How many of your dispensing assistants have a technician's certificate? Barriers: Limited pharmacist time resource with limited quality support. Facilitators: 68% respondents with qualified assistants (full time) &amp; part time.</td>
<td></td>
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</tbody>
</table>

Note: These are the author's representation of identified link-up issues where both GPs and pharmacists have similar problems or synergistic views on subjects raised in surveys.

**CODE:**

- GP = General Medical Practitioner
- MM = Medicines Management
- P = Pharmacist
- P'cist = Pharmacist
Table 63 cont. SUMMARY – POSTAL SURVEYS DOCTORS & PHARMACISTS
BARRIERS AND FACILITATORS TO CHANGE:
KEY RESPONSE CROSS LINK-UPS

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<td><strong>LINK-UPS</strong></td>
<td><strong>EXPOSED BARRIERS &amp; FACILITATORS</strong></td>
</tr>
<tr>
<td><strong>Q7 What is the source of your pharmacist help?</strong></td>
<td><strong>Link-up 4</strong></td>
<td><strong>Q10 How many pharmacists regularly work with you in the pharmacy?</strong></td>
</tr>
<tr>
<td><strong>Barrier: Competitor entrenchment in the new dispensing pharmacist role (medicines management elements).</strong></td>
<td><strong>GP Q7 Pharmacist/GP collaboration works.</strong></td>
<td><strong>Barrier: cf. Q5 present workload of p'cists not conducive to time intensive medicines management.</strong></td>
</tr>
<tr>
<td><strong>Facilitator: 16.6% dispensing pharmacists working with doctors i.e. role models; exemplars; mentors.</strong></td>
<td><strong>P Q18 Only 11.3% dispensing pharmacists able to do full medicines management.</strong></td>
<td><strong>Facilitator: 53% dissatisfied with use of pharmacist skills. 38.3% undecided – potential for marketing effort.</strong></td>
</tr>
<tr>
<td><strong>Q8 If you answered 'never' to Q6 would you like a pharmacist to work with you in the future?</strong></td>
<td><strong>P Q16 Only 19% know of MM scheme in detail.</strong></td>
<td><strong>Q12 How satisfied are you with current remuneration levels in the present contract?</strong></td>
</tr>
<tr>
<td><strong>Barrier: Dispensing &amp; other GP mindset (15.5%).</strong></td>
<td><strong>Facilitator: Recognition of patient problems relationship as unsatisfactory.</strong></td>
<td><strong>Barrier: None</strong></td>
</tr>
<tr>
<td><strong>Facilitator: Of those who said never in Q6 84.5% want pharmacist help in future (some dispensing GPs included).</strong></td>
<td><strong>Q13 How do you rate your present relationship with GPs?</strong></td>
<td><strong>Facilitator: 84.2% dissatisfaction with the present contract.</strong></td>
</tr>
<tr>
<td><strong>Q9 Please indicate frequency with which you encounter the following problems (8).</strong></td>
<td><strong>Barrier: None apparent.</strong></td>
<td><strong>Q14 What do you assess would be the view of patients on greater pharmacist involvement with management of their NHS medicines?</strong></td>
</tr>
<tr>
<td><strong>Barriers: None apparent.</strong></td>
<td><strong>Facilitator: Recognition of medication problems – focus for pharmacist solutions.</strong></td>
<td><strong>Barrier: If they are wrong.</strong></td>
</tr>
<tr>
<td><strong>Facilitator: Recognition of patient problems which are not effectively addressed.</strong></td>
<td><strong>Link-up 5</strong></td>
<td><strong>Q15 What do you assess would be the attitude of your local doctors to greater pharmacist involvement with patient medication management?</strong></td>
</tr>
<tr>
<td><strong>Q10 Please indicate what you believe to be the incidence of the following potential problems, elderly patients may have with medicines.</strong></td>
<td><strong>GP Q11 Collaboration with pharmacists welcome (75.5%).</strong></td>
<td><strong>Barrier: A much lower proportion of respondents who see doctor response as welcome (61.3%).</strong></td>
</tr>
<tr>
<td><strong>Barrier: None apparent.</strong></td>
<td><strong>P Q15 Pharmacist expectation of doctor views on collaboration is good (61.3%).</strong></td>
<td><strong>Facilitator: The 61.3% who positively view doctor response.</strong></td>
</tr>
<tr>
<td><strong>Facilitator: Recognition of medication problems – focus for pharmacist solutions.</strong></td>
<td><strong>P Q19 80.82% wish to do MM</strong></td>
<td><strong>Q16 Are you aware of the government backed PSNC medicines management proposals?</strong></td>
</tr>
<tr>
<td><strong>Q11 Government seem to be encouraging pharmacist/GP collaboration on aspects of medication review. Do you agree with this approach?</strong></td>
<td><strong>Facilitator: 75.5% agree – fertile market place.</strong></td>
<td><strong>Barrier: Not as such but not sufficiently well known. Publicity inadequate.</strong></td>
</tr>
<tr>
<td><strong>Barrier: None substantial.</strong></td>
<td><strong>Facilitator: 17.6% 'know it'.</strong></td>
<td><strong>Facilitator: 77.6% 'know of it'.</strong></td>
</tr>
<tr>
<td><strong>Facilitator: 75.5% agree – fertile market place.</strong></td>
<td><strong>Six other items, very well supported – could become core of new service offering.</strong></td>
<td><strong>Note: These are the author's representation of identified link-up issues where both GPs and pharmacists have similar problems or synergistic views on subjects raised in surveys.</strong></td>
</tr>
</tbody>
</table>

**CODE:**
- **GP** = General Medical Practitioner
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Table 63 cont. SUMMARY – POSTAL SURVEYS DOCTORS & PHARMACISTS

BARRIERS AND FACILITATORS TO CHANGE:
KEY RESPONSE CROSS LINK-UPS

<table>
<thead>
<tr>
<th>DOCTOR SURVEY QUESTIONS &amp; RESPONSES</th>
<th>KEY RESPONSE LINK-UPS</th>
<th>PHARMACIST SURVEY QUESTIONS &amp; RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXPOSED BARRIERS &amp; FACILITATORS</strong></td>
<td><strong>EXPOSED BARRIERS &amp; FACILITATORS</strong></td>
<td></td>
</tr>
<tr>
<td>Q13 If you ticked boxes 11.4 or 11.5 please outline your reason here.</td>
<td>Link-up 6</td>
<td>Q17 In this new professional relationship between doctor and pharmacist, how would you raise the potential importance of the following factors? (Six given)</td>
</tr>
<tr>
<td>Barriers:</td>
<td>GP Q14 Time scarcity.</td>
<td>Barriers: None obvious.</td>
</tr>
<tr>
<td>- Lack of privacy &amp; confidentiality</td>
<td>P Q23, 24 Lack of time.</td>
<td></td>
</tr>
<tr>
<td>- 'It is GP's responsibility'</td>
<td>Facilitators: 95% who are confident that they can do it with appropriate training.</td>
<td></td>
</tr>
<tr>
<td>- 'Bureaucracy would be stifling'</td>
<td>Barriers: 80.8% said yes. A positive attitude basis for change.</td>
<td></td>
</tr>
<tr>
<td>- 'Already enough interference from NICE'</td>
<td>Q20 In the following list (8 options) who do you feel should not take up the new service?</td>
<td></td>
</tr>
<tr>
<td>Facilitators: None.</td>
<td>Barriers: None.</td>
<td></td>
</tr>
<tr>
<td>Q14 If a pharmacist worked with you to undertake a patient review of those medication issues agreed by you, how frequently should this be done for those on long term medication? 55.7% preferred over six-monthly.</td>
<td>Link-up 7</td>
<td>Facilitators: Recognition of real competition to deprive pharmacists of a major new role (dispensing contractors).</td>
</tr>
<tr>
<td>Barriers: Scarcity of time.</td>
<td>GP Q15 Formal recognition of pharmacist agreed by 54.5%.</td>
<td></td>
</tr>
<tr>
<td>Facilitators: 44.2% said four monthly or less. Good base to work with but pharmacist reviews are acceptable.</td>
<td>P Q17 Pharmacists aware of doctors' needs of recognition as the lead in health care.</td>
<td></td>
</tr>
<tr>
<td>Q15 Do you feel the pharmacist should become a formal part of the doctor's team addressing selected items agreed by you?</td>
<td>P Q19 80.8% wish to do medicines management.</td>
<td></td>
</tr>
<tr>
<td>Barriers: 45.4% 'uncertain' or 'no'.</td>
<td>P Q20 Dispensing pharmacists feel others should not.</td>
<td></td>
</tr>
<tr>
<td>Facilitators: 54.5% said 'yes'.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q16 The quality of patient care in general practice may be very good even though the patient may not be aware of that quality. How important is the patient's own perception of that quality?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barriers: None.</td>
<td>Q21 If you require training to undertake the new role, what subjects among the following list, would you select?</td>
<td></td>
</tr>
<tr>
<td>Facilitators: 95% of respondents in the affirmative.</td>
<td>Barriers: None but the effort required and time commitment.</td>
<td></td>
</tr>
<tr>
<td>Q17 Quality of care and clinical excellence are recurrent themes in the White Papers. What is your perception of patient expectations of health care over recent years?</td>
<td>Facilitators: A thoughtful response and recognition of the main requirements.</td>
<td></td>
</tr>
<tr>
<td>Barriers: 92.7% respondents saw an increase. No barriers.</td>
<td>Q22 In the following list of training options which one would be your preferred training route?</td>
<td></td>
</tr>
<tr>
<td>Facilitators: This is a facilitating issue.</td>
<td>Barriers: Probably time at night. Day time lectures preferred.</td>
<td></td>
</tr>
<tr>
<td>Q18 Patients' perception of quality of care may be a factor in their commitment to the therapy. Do you agree?</td>
<td>Facilitators: Willingness to exercise choice.</td>
<td></td>
</tr>
<tr>
<td>Barriers: None.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitators: 85.2% who agree.</td>
<td></td>
<td></td>
</tr>
</tbody>
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Note: These are the author's representation of identified link-up issues where both GPs and pharmacists have similar problems or synergistic views on subjects raised in surveys.

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</tr>
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</table>
| Q19 Patient perception of your overall service could be enhanced by a pharmacist review service, directed by you... Do you agree? | Link-up 8  
GP Q19 Favourable GP view of pharmacist involvement – 63.4% respondents.  
P Q15 Pharmacists judge GPs to be favourable to pharmacist help (61.3%) | Q23 Assuming your present workload remains the same, do you believe you currently have time to undertake the medicines management service?  
Barriers: Lack of time (53.4% 'nos', 26.8% 'not sure'.  
Facilitators: Some willing to shed workload (51.2% - Q24). |
| Barriers: 36.6% disagree or are uncommitted – an age threat.  
Facilitators: 63.4% agree – positive indication for good relationship building. |  | Q24 If you answered 'no' / 'not sure' in Q23 could some of your workload be delegated?  
Barriers: 48.8% 'not sure' / 'no'.  
Facilitators: 51.2% 'yes'.  
Q25 Do you think it is time for an entirely new pharmacy contract?  
Barriers: 39.3% 'not sure' / 'no'.  
Facilitators: 60.7% who said 'yes' – fertile ground for persuasion to role change. |
| Q20 Please indicate in which of the following locations your practice is based.  
Barriers: Rural 14.7% cf. Q2 – 13.4% dispensing doctors.  
Facilitators: Not Applicable. |  |  |

Note: These are the author’s representation of identified link-up issues where both GPs and pharmacists have similar problems or synergistic views on subjects raised in surveys.

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This chart brings together the GP and pharmacist responses to the random postal surveys and indicates, in the central column, those issues which could be mutually beneficial or are mutually problematic.

Such factors can be used in an empathetic way to each profession by using them in marketing communications to show some of the benefits of collaboration. Reassurance that each profession has similar views or problems and indeed aspirations (e.g. GPQ19 : PQ15) would be positive reinforcement of ‘collaborative’ proposals, generating mutually beneficial working outcomes in the future.
CHAPTER 8
SUMMARY AND DISCUSSION

This final chapter is set out in eleven sections and sub-sections as follows:

8.1 Introduction
8.2 Literature Research
8.2.1 Part I, Marketing
8.2.2 Part 2, Organisational Change
8.3 Field Research
8.3.1 Key Informants
8.3.2 Focus Group: General Practitioners
8.3.3 Focus Group: Pharmacy
8.3.4 Postal Surveys – General
8.3.5 Postal Survey – General Practitioners
8.3.6 Postal Survey – Independent Dispensing Pharmacists

8.1 INTRODUCTION

This thesis, occasioned by the author’s interest and involvement in developing the dispensing pharmacist’s role, has created a unique approach to effecting change in primary care pharmacy, which necessitates some change in primary care medical practice.

Change necessity has been signalled to the pharmacy profession from official sources over a period of some twenty years, arguably starting with the Minister for Social Services in 1981, Dr Gerrard Vaughan, (Chapter 1: 11). Redundancy of traditional skills and radical redesign of the NHS, especially within the term of the present Government, now necessitates positive movement into a new cognitive service. To engage in the role change envisaged (partnership in medicines management) will of necessity impact upon the GP’s role, with which the pharmacist must interact.
This research summary and discussion deals with the results, implications and further suggestions for research arising from the work undertaken in this study.

8.2 LITERATURE RESEARCH

8.2.1 Part 1, Marketing

The history of ‘marketing’ was briefly outlined to contextualise its place and role in general society. Then, specific aspects of marketing practice were theoretically applied to the problem of effecting change in the working relationship between GPs and pharmacists in primary care, taking account of the doctor’s traditional lead in patient illness treatment.

A number of marketing authorities and practitioners were consulted through the literature in an investigation of, the marketing mix, relationship marketing and health care marketing. The nature of the target market’s needs, wants, attitudes and motivation was studied, together with product design, communications and message content (Chapter 4: 59 – 129).

Based upon these considerations a number of models were constructed by the author addressing the following problems:

- Creation of competitive advantage (Chapter 1: 29) for dispensing pharmacists against threat of entry and substitute (Chapter 4: 82, Figure 9);

- Harmonisation of the behavioural connections between pharmacists and doctors in primary care and integrating marketing activity (Chapter 4: 134, Table 23);

- Targeting of GPs with suitable marketing activity via selected routes, to assist acceptance of pharmacy’s new role of medicines management (Chapter 4: 135, Table 24); and,
• Design of appropriate marketing approaches to dispensing pharmacists, in encouraging role change into cognitive service and recommending the communicating channels (Chapter 4: 136, Table 25).

From a theoretical viewpoint, persuasive communications, in a marketing context, involves consideration of the target audience in terms of its potential involvement or passivity with the service/product promotional messages, (Chapter 4: 113-118, Figures 13 & 14) and achievement of audience response. Design of mechanisms to achieve feedback, as in action research, will be important here, (Chapter 4: 120, 122 & Figure 15) as is opinion leadership in reinforcing the message (Chapter 4: 126). These are key issues in communicating with both professions, in the change initiative, to achieve ownership of the new role and conceptual partnership between ‘medicine’ and ‘pharmacy’.

Marketing, its instruments of application, techniques and psychology have an important role to play in the presentation of the new proposition to the target audiences, i.e. medical and pharmaceutical practitioners in primary care. Careful formulation of the service/product, in its ‘core’, ‘tangible’ and ‘augmented’ aspects, is crucial to its potential attractiveness, (Chapter 4: 67 – 73, Figure 8) and success to both doctors and pharmacists. Garvin’s dimensions of quality, (Chapter 4: 75, Table 15) applied in the context of the new pharmacy service are likely to be appealing aspects of service to the doctor. The ‘product’ in essence should be designed from the doctor’s perspective, being culturally acceptable in values, (Chapter 5: 209) and offering desirable benefits fulfilling the ‘needs’ of the medical profession in primary care. Thus, according to Maslow’s content theory of motivation, doctors have reasons to welcome the new pharmacy service. They may also see it as complimentary rather than confrontational, in relationship to their currently perceived place in primary care and patient perception of who is responsible for what.

A legitimate question is,

“Could change be achieved without the application of marketing expertise and principles?”
If, as Baker maintains, (Chapter 4 : 60) ‘marketing came into being with the first barter exchange...’ then marketing processes can hardly be avoided and with normal discursive interchange, the process of role change could be taken forward. It is also likely, that sensible people at leadership level in medicine and pharmacy would speak in reasonable terms to each other, observing the normal courtesies and sensitivities, being as persuasive as possible.

However, it could be argued that a more planned, efficient and thorough approach to the medical profession, with better prospect of success, could only be achieved by an in-depth awareness of the formalised methods and techniques of persuasion. Marketing practice could certainly have existed in Baker’s concept of its origins, but formalised marketing theory, research and structured practice has arrived relatively recently (Chapter 4 : 61). It has undoubtedly therefore developed much more sophistication and learned a great deal more about the psychology of human behaviour in consumer mode. It is the author’s view therefore, that a systematic programmed approach to role change, has a far better prospect of success and in a given time frame, than simple well meaning approaches of a somewhat haphazard nature. This latter approach has happened in the past, with mediocre results (e.g. ‘PIANA’ – General Introduction, xiv).

Following the literature research on marketing, the problem of organisational change management was addressed.

8.2.2 Part 2, Organisational Change

Once again the approach was through a discussion, the history of ‘organisational development,’ which was summarised to identify important early research still used today in effecting change on an organisational scale. It is apparent that whilst organisational structures can be changed relatively easily, individual commitment to change and change of working culture is considerably more complex (Chapter 5 : 137 – 267)

A consideration of the general change drivers in society, from which organisational change is also derived, was undertaken alongside internal change forces. From this, a
matrix of ‘effects’ and ‘implications’ was constructed against the external P.E.S.T. change drivers, (Chapter 5 : 150, Table 28) to expose objectives and activity judged necessary by the author to effect change in community pharmacy.

The implications for PSNC and community pharmacy were:

- The professional input and reward relationships required reformulation and presented to the DH in new more effective ways, based upon market research;

- Strategic alliances with patient organisations were indicated for greater impact with government; accompanied by researched evidence of patient needs and wants; and,

- ‘People ability’ to be matched to tasks, is a necessity for;
  - effective negotiation (national and local);
  - delivery of new cognitive clinical service;
  - managing interpersonal GP/patient relationship with the pharmacist; and,
  - reallocation of NHS duties from pharmacist to technician to free up time resource.

The ‘strategic capability’ of the PSNC was examined, (Chapter 5 : 151 - 161), comparing its present (recently restructured by the author) capability with that prior to June 2000. The comparison shows (Chapter 5 : 153, Table 27) a more analytical address of the core functions of the PSNC and integrated effort toward the strategic objectives, instead of each sub-committee running an independent agenda. ‘Strategy’ is an important element of the Burke Litwin model of change. A resource audit was then speculatively undertaken by the author following a SWOT analysis completed by Gateshead / South Tyneside LPC and Sunderland LPC. Here the crucial issues of importance for community pharmacy were:

- Renewal of clinical knowledge to a new standard for MM;
- Renewal of image as a professional health care resource with ‘qualified’ staff;
• Renewal of pharmacy facilities to engage the new MM role; and,
• Renewal of negotiating skills and presentational structure at national and local levels.

The process of analysis was then completed in a further ‘solutions matrix’ (Chapter 5: 161, Table 30) to give an outline of strategies to be engaged in managing the ‘weaknesses’ and ‘strengths’ position together with the ‘opportunities’ and ‘threats’.

The change drivers, strategic capability and suggested appropriate action were thus addressed from a theoretical standpoint relating to overcoming barriers to role change in pharmacy.

Twelve specific models of change were then studied, to enable selection of an appropriate model, by which to guide change effort in community pharmacy. After summary and comparative analysis (Chapter 5: 204, Table 37) the ‘Burke-Litwin’ model was selected for application to community pharmacy change because of its ‘transactional’ and ‘transformational’ perspectives and focus on change of systems and people. It does not deal with ‘systems congruence’, which would be important in a large organisation containing many different systems. The independent community pharmacy sector comprises many ‘small’ units (pharmacies), which scale-wise rely much less on systems congruence. Although the technical resource of the organisation is not addressed in this model, ‘task and individual capability’ and ‘individual needs and values’ are. Herein lie the technical resources of the pharmacy, i.e. pharmacists and technicians equipped with new knowledge, supported by I.T. Overall, therefore, this model is recommended for use alongside suitable marketing techniques to engineer change.

A general consideration of organisational climate, the visible manifestation of culture, and culture itself, was undertaken and related to pharmacy in particular. This indicated that initially at least, attention may best be given to climate, being the simpler of the two issues to address. In doing so, cultural change from being largely a supply service, to a cognitive service with attendant changes in mind set can be encouraged.

Such changes could include:
• Premises adjustments, giving a more comprehensive consultation facility, accommodating three to four people, (one pharmacist plus patient and up to two relatives / carers);

• The livery presentation of the whole medicines / surgical area to reflect a more clinical image and professional service;

• The signage by which these areas are to be easily recognised; and,

• The ritual by which patients / customers are received into these areas.

In this way, the physical layout of premises sends messages to staff as well as patients, that a new approach has arrived. Thus, the simpler aspects of culture manifestation i.e. physical layout and the ‘way in which staff interact with each other and patients / customers’ (Schein, Chapter 5: 210) begin a change in outlook or attitude.

‘Climate’ is also a component of the Burke-Litwin change model. Accompanying such change may be a discreet notice in the window, outlining the consultation services available and ultimately, for example:

‘Full medicines review service, giving you the best results
from NHS & OTC treatments – FREE
ASK INSIDE’

The foregoing change imperative implies leadership involvement and this subject was studied in the context of organisational direction and change. A number of models of leadership were examined and value found in several to guide leadership activity, (Chapter 5 : 241, Table 41). Path-Goal theory seems particularly appropriate to pharmacy because of its flexibility in leader styles, which are likely to be advantageous in the complex organisational units of the community pharmacy sector (Chapter 5 : 231 – 232). In this respect, the goals for community pharmacy should be clearly articulated (full implementation of MM) through repeated messages in the pharmacy journals (Page 136, Table 26). Accompanying these messages should be a list of educational packages
and their sources, and the means of accessing them. It will be leadership’s job to also communicate with the LPCs who will in turn, co-ordinate local activity in the planning of premises’ amenities and act as a mentor for local pharmacists.

Differences and complimentary aspects of leadership and management were explored and compared, (Chapter 5: 248, Table 43) and both functions were found to be essential to the process of change management in community pharmacy (Chapter 5: 246). ‘Leadership’ and ‘management’ are once again elements of address in the ‘Burke-Litwin’ model of organisational performance and change. The complex leadership structure of pharmacy will need to allocate its own responsibilities to avoid confusion of messages and create complementary themes with common direction of change destination, i.e. cognitive medicines management service.

In seeking to lead community pharmacy into a new role, it was clear that some motivational effort would be required in creating a desire and commitment to move into a new order of service. To this end, a study of motivation theory was undertaken, to investigate different approaches to engaging certain human behaviours in an organisational setting.

Work dating from the 1940s in England and the USA was reviewed, together with a number of more recent models of motivational effort, all dependent to some extent, upon that early research. Promising avenues of motivational effort, are Hackman’s job characteristics model and that of Porter and Lawler, revolving around task abilities, meaningfulness of the work and perceived value of the rewards of undertaking that work, (Chapter 5: 260, 265, Figures 44, 45).

Consideration of marketing and change management principles, elements and methods, from a theoretical point of view, has revealed approaches from both disciplines, which can help facilitate change in the role of community pharmacy.

The elements or levers of organisational change, their relevance to this study and suggested avenues of marketing efforts, targeted toward engaging those levers, were brought together by the author in Table 46 (Chapter 6: 269) as a general schemat of the organisational development marketing interface. Specific issues, relating to ‘barriers’
and ‘facilitators’ of change, exposed by the field research are now considered in the following sections related to the theoretical research.

8.3 FIELD RESEARCH

8.3.1 Key Informants (Appendices 11A, 11B, 11C, pages 434 – 445)

The results of these semi-structured, purposive interviews conducted by the author and relating to the medical profession, were to ‘gain special insights and interpretations of some underlying issues in doctor attitudes to collaboration with pharmacists,’ (Chapter 3 : 44). From the results, abstracted and then charted out as a matrix, (Chapter 6 : 271 - 273, Table 47) a number of relevant themes emerged giving signposts as to what may:

- Be acceptable approaches to promoting GP / pharmacist collaboration (supporting doctor lead role);
- Be important to avoid inadvertently creating barriers to partnership (time consuming interventions);
- Give GPs’ confidence in the proposed new pharmacy service (clinical premises facilities);
- Encourage GPs’ interest (authoritative ‘message source’ and ‘opinion leadership’);
- Engage joint ownership of the proposal (joint pilot work); and,
- Be non-threatening to GPs’ own role (address of patient compliance).

(Chapter 6 : 273, Q8)
These important observations of highly qualified and experienced professionals in the health care field were recorded and compared with themes arising from the national focus group of leading GPs on the national representative body, the GPC.


From this group, a number of key themes also emerged, some of which coincided with those raised by the *key informants* (Chapter 6 : 280, Table 49).

These were:

- Patient non-compliance is a major concern and non-sensitive in terms of pharmacists potentially encroaching upon GP core cultural perception of their responsibilities;

- Doctor self esteem and autonomy are important;

- Increased workload is a disincentive to additional service; and,

- Doctor-pharmacist collaboration is supported at national level.

However, therapeutic and clinical decisions are held to be the preserve of the doctor, as in some of the key informant interviews (Q8, A & G, Chapter 6 : 273).

Both focus group and key informant analysis point to service design, in such a way as to be supportive of doctor culture and majoring on issues which are patient beneficial without implying doctor inadequacy.

The results of both key informants and focus group were consolidated in Table 49 (page 280). The comparison was then cross related to 'relationship marketing', 'the
marketing mix' and 'marketing communications', giving an indication of the type and target of effort required (Chapter 6: 280, Table 49).

8.3.3 National Focus Group – Pharmacy (Appendices 12A, 12B, 12C, pages 446 –465)

The group discussed the potential of medicines management, as a new role for pharmacy and as a means of repositioning the profession in primary care. Role change was agreed as necessary and the individual leadership bodies represented at the group agreed their own specific roles in taking the prospect forward.

Judged to be of key importance (Chapter 6: 281, Table 50) were:

- Suitable training for dispensing pharmacists;
- The support of the GP leaders is essential;
- Piloting of the new service is essential for testing the service itself and doctor / pharmacist working relationships;
- Pharmacist locums must be brought into the scheme;
- Interpersonal skills must be of good standard; and,
- Suitable communications with GPs in primary care must be developed.

The overall summary of these points is set out in Chapter 6: 281, Table 50, which informs certain change management activity, as summarised in the Burke-Litwin model of organisational performance and change, (Chapter 5: 199).
Communication to stakeholders was generally acknowledged to be of crucial importance and in this respect, marketing has a specialised role in managing message content, message source and sponsorship (Chapter 4: 113 – 118, 126) along with the media channels to be used. In the case of a health care profession, in this instance pharmacy, professional journals should be used for a series of informative articles, charting out the route into medicines management service, as well as the means of achieving a suitable professional standard of clinical ability to deliver the intervention. Trade publications can supplement this effort, as well as 'in-house' leadership body letters (Chapter 4: 136, Table 26). Other promotional activity is also summarised in this table.

8.3.4 Postal Surveys – General (Chapter 7: 282)

Some limitations of postal survey questionnaires have already been examined, (Chapter 3: 52, Table 9) and whilst response rates for both the doctor and pharmacist surveys achieved around the 50% level, non-respondents remain a problem. They could conceivably have introduced bias in pharmacy returns, for example through 'active disinterest', being so against changing the traditional comfort zone of dispensing, they may have set aside the questionnaire in irritation.

Equally, it is not known whether either doctor or pharmacist returns, contain a proportion of composite views, i.e. some questionnaires may have been completed by small groups of people, thereby embodying several different perspectives on one form. Conversely, it could be argued that those who do complete and return questionnaires, do so, simply because they enjoy the mental exercise, but without real commitment to the answers. They may also feel a pressure to say the 'right things', if the social context of the day is pushing toward a new 'correct' way of approaching, as in this study, public service, i.e. through partnerships of collaboration. This could conceivably be the case in the doctor survey, seeing that the signatories were a doctor and two pharmacists 'observing' their responses. This may conceptually equate to the Hawthorne effect mentioned earlier in the thesis, (Chapter 5: 140).
It perhaps should also be recognised that psychological thought patterns leading to decisions or attitude formation, are not usually expressed in either thought or word as, 'strongly agreeing', 'agreeing', 'neither agreeing nor disagreeing' and so on. Such categories, however, do impose a net expression of opinion or attitude and reduce interpretive bias in the researcher. Having said all this, much successful marketing involving billions of pounds worth of profitable product / service sales worldwide is launched from postal survey research encapsulated in such categorisation. Results and deductions from the surveys in this research are, therefore, interpreted with caution and used on the basis that if sample results are reflected in the total populations, then certain marketing and change activity is recommended, using the principles and techniques exposed in this research.

8.3.5 Postal Survey – General Practitioners (Chapter 7 : 283)

The survey returns of the random national sample of GPs have produced interesting results, exposing both barriers to change, in relationship to the new pharmacy role and also substantial facilitating issues.

The survey-exposed barriers, as partially indicated in the key informant and focus group work, were time constraints (Chapter 7 : 312, Q14), some age related antipathy toward certain potential pharmacist involvement, (Chapter 7 : 290, Q4), therapeutic choice and sub-therapeutic dose identification (Chapter 7 : 306, Figure 55 – 12.10 and 12.5) and workload (Chapter 7 : 289 Q3) Insensitive challenge of the doctors' own role is to be avoided and focus on non-confrontational issues in medication management should be pursued.

Few dispensing pharmacists work in the GP practices at present, (16.6%) and the more frequent the present routine contact between GP and pharmacist, the more positive is the GP over future collaboration. Introduction of the new role, (which involves closer collaboration between the two professions) is supported by 75.5% of GPs (Chapter 7 : 304 Q11) but only 54.5% think the pharmacist should become a formal part of the doctor's team, (Chapter 7 : 313 Q15). This may be an ego effect, as postulated in the discussion on Maslow's needs theory, (Chapter 4 : 97) and a perceived threat to doctor
autonomy and primacy in the health care hierarchy. Whether this is so or not, the medicines management service promotional presentation, should take account of this possibility and marketing communications copy should clearly recognise the GP as lead clinician and final decision maker.

Medication problems are recognised by all respondents (specifically those problems listed in the survey) and by implication, ideally need resolving. Doctors (77%) recognise that pharmacists could assist with this, especially in food / drug interactions, NHS / OTC drug interactions and patient compliance. Support for the general proposition declines specifically with those issues that challenge the doctor’s right to be the decision maker, in traditional GP responsibilities, i.e. choice of drug; choice of dose level; selection of brand versus generic, (Chapter 7 : 290 Q4). The percentage of GPs, who regard a pharmacist medication review service as an enhancement to their overall service, in the eyes of the patient, is 63.4%, (Chapter 7 : 320 Q19). This is a sound base upon which to build introduction of the new pharmacist role and by peer sponsorship, become an inducement to the remainder of their colleagues who are not yet convinced.

To assist this process, PCT seminars could be a route of sponsorship of this approach and the benefits measured throughout the PCT.

Special attention will need to be paid in promoting the new service to rural and suburban dispensing doctors, who may feel doubly challenged, as they compete for dispensing rights already and may feel uncomfortable in opening up their patient records to adjacent pharmacists. Support for collaboration with pharmacists, from dispensing doctors is 58% compared with 78% of non-dispensing doctors, (Chapter 7 : 287, Table 53). Nevertheless, 58% is a positive base upon which to build a new relationship with this sector of general medical practice and should not be approached in a negative way. The overall marketing approach has been discussed in the literature research and field research summary, (Chapter 4 : 82, 126, 134).

Because support for the MM proposition at the medico-pharmaceutical focus group was good, it may be possible for both bodies to endorse a programme of ‘collaborative facilitation’, bringing the professions together at grass roots, to address patient care
through medication management. Results from the national pilot trials on medicines management, should help clarify interpersonal issues between GP and pharmacist, and patient and pharmacist.

A mentoring scheme could be evolved from these pilot participants leading willing members of both professions into the new relationship.

The messages from the GP Key Informants, Focus Group and Postal Survey are complimentary and positive in overall acceptance of a new role for pharmacy, in helping manage the patient's medication. However, some dangerous barriers do exist, which if not effectively addressed could undergo metamorphosis into a complete block on dispensing pharmacist role development.

These are:

- The established pharmacist assistance to GPs is largely (83%) from other than dispensing pharmacists who have made better progress into cognitive service (Chapter 7: 296, Q7);

- Cultural challenges to the doctors' lead role in choice of patient medication, is resisted and increases as age of respondents increases (Chapter 7: 291, Q4 v Q12);

- Potential increased workload involved in medicines management (Chapter 6: 271, Q2, Q3; Chapter 7: 289) and lack of time (Chapter 7: 311. Q14);

- Current lack of contact between some GPs and pharmacists (Chapter 7: 292);

- Single handed GPs potentially short of time (8% nationally, 10% of sample) (Chapter 7: 284); and,

- Dispensing doctor antipathy (Chapter 7: 287, Q2).
For these reasons the programme of change in pharmacy's role, must, in its marketing approach to GPs, emphasise medicines management as time saving, (and construct the service to be so) and doctor supporting, (not challenging) using the 'more-satisfied-patient' as a work reducer and doctor image enhancer, (Chapter 7: 315 – 318, Q19 response especially).

Applied as a marketing strategy across the board, this pharmaceutical platform should accommodate those GPs who may be uncertain about the new pharmacy service, or those who feel threatened or apprehensive about increased workload. Presented well, the new service benefits should help to outweigh any temporary 'set-up' problems and encourage wider doctor acceptance.

Although barriers to progress do exist within the medical profession, there are strong facilitating messages which, if carefully managed, could overcome much resistance.

From the GP postal survey response, the factors which may facilitate progress of the new pharmacy role are substantial. All survey questions relating to future collaboration with pharmacists, (Q8, Q11, Q15, Q19) show that there is an encouraging percentage of respondents, positively disposed toward working with a pharmacist (84.5%; 75%; 54.5%; 63.4% respectively).

The external pressures upon the primary care medical profession are also facilitating forces for change, (Government White and Green Papers, Chapter 1: 12) and will in turn help a medical role transition from sole decision maker in patient medication to one of collaborative effort with the pharmacist. This makes it even more important for pharmacy to engage in empathetic discourse and communications with doctors, recognising cultural sensitivities relating to a traditional medical lead and authority in patient care (Chapter 4: 125, 126).

Carefully constructed marketing plans with the right presentation of the product, (Chapter 4: 67) careful address of doctor needs and wants, (Chapter 4: 95) and persuasive communications, (Chapter 4: 113) are clearly prerequisites of smooth, time efficient transition of the pharmacists' role together with committed doctor support. The problems within pharmacy will now be examined in the light of the field research.
The respondents to this survey have expressed very interesting attitudes, needs and wants. There are substantial barriers to change within the pharmacy profession, arguably more so than in the medical profession. The nature of the problems are, however, somewhat different, although one outstandingly, is identical; the lack of time in which to discharge substantial additional responsibilities. Only 19.8% of respondents claimed to have time to undertake the new role and 53.4% said they definitely had not; 26.8% were not sure (Chapter 7: 366, Q23). Moreover, only 51.2% of those who did not have time argued that some of their current workload could be delegated to other staff (Chapter 7: 368, Q24). Extrapolated to the full population of independent dispensing pharmacists this would equate to 27% of independent contractors in England and Wales. Further research into this group is advised to determine the nature of the workload problem and at least one proposed solution, which might be a shared pharmacist with similar contractors, proportionately paid for by the participants.

However, other major barriers also exist:

1. The majority of contractors cannot currently provide the service due to lack of knowledge. Training is required for 88.7% of respondents which would be a major task for such a proportion of the total population (Chapter 7: 356, Q18).

2. Only 68% of full time and 50% of part time dispensing assistants have formal qualifications. Workload delegation, such as prescription accuracy checking, could not easily be actioned at this stage (Chapter 7: 339, Q9).

The basic motivation for independent pharmacists to engage in the new role, is likely to be a net balance of forces for and against. If the skill mix / manpower situation is not managed to deliver extra time, then no amount of incentive will be able to help the movement into medicines management. Applying Vroom’s equation, (Chapter 5: 253) then:

$$F \text{ (force of motivation)} = \Sigma (V \times I \times E)$$
If 'I' (the perceived likelihood of achieving outcomes) is in this instance, zero, without the time or manpower, then Vroom would predict that motivation would be absent. Real address of these issues must be undertaken to have any success of transforming the profession’s role.

There may however, be an interim stage. It may be possible to construct as a first step, a simplified additional process to the present dispensing operation, which would lead ultimately to full medicines management. It would require formal acceptance by the DH and medical stakeholders (Chapter 1: 34, Figure 5) and a proper system of implementation, which would by agreement be acted upon.

Such an incremental but definite move could be delivered by undertaking for the chronically ill, within specified disease categories to begin with, the following services:

- Dose rationalisation;
- Dose alignment;
- Pre-agreed brand to generic shift;
- Reduction of 'prn' quantities by half; and,
- Maintenance dose correction for specified diseases (e.g. proton pump inhibitors to reduce levels of non required additional medication or ACE inhibitors increased from the starter dose to maintenance level.

Such a scheme would be managed by pre-printed forms, with ‘tick boxes’ to indicate the task completed or to be reviewed by the medical practice.

This could be agreed as part of a new national contract, for an enhanced fee structure and full medicines management, incrementally introduced as locally commissioned services by those who could provide them. A period could then be set during which the majority of the profession would complete training and skill mix re-distribution, after
which full medicines management could become part of a second stage national contract; i.e. Phase 1 national contract attracts one fee structure; Phase 2 national contract attracts an extra fee structure.

Alternatively, a second phase could be specified by a ‘NICE’ agreed package, so that postal code variation in service availability is minimised and then PCTs commission this locally, funded through the PCT budget, as pharmacists become ready to engage the service. Target service take up, could for example, be set at 65% of the dispensing profession in full service, (Phases I and II) within three years and a further 20% within another two years.

Such interim stages would:

- Send a positive message to the major stakeholders, especially the DH and medical profession, that pharmacy’s change in role is a commitment with a timetable;

- Allow time for training in the full medicines management service;

- Provide a comfort zone for pharmacists and doctors, in engaging in formalised collaboration, without confrontational issues creating barriers to change; and,

- Build the pharmaco-medical relationship and with it, GP confidence that their position in health care is secure.

More complex issues such as choice of therapeutic route and/or substitution, may thus be allowed to filter into the joint approach to patient medicines management, when a secure relationship has been established.

Once again, on the positive side of things, there are a number of major forces exposed by the research, potentially assisting the proposed transition from relatively simple dispensing supply, to cognitive service. These are:
• Government pressure to change the pharmacist contribution to primary care (Chapter 1: 2);

• The desire of respondents to undertake medicines management (80.8% - Chapter 7: 358);

• The desire of respondents, that alternative professionals to themselves should not undertake this service (Chapter 7: 360);

• A large majority think it is time for a new contract (60.7% - Chapter 7: 370);

• A large majority recognise doctors' psychological needs in having a non-confrontational relationship with the pharmacist (Chapter 7: 370); and,

• A majority believe that the GP will welcome the new pharmacist role proposed (Chapter 7: 350).

Given that the profession's leadership are able to:

• Provide the training courses to bring dispensing contractors up to the required level of knowledge and ability;

• Resolve the skill mix issues around the dispensing process and release pharmacist time; and,

• Construct a new framework of systematic collaboration between GPs and pharmacists,

Then the barriers to progress can be overcome and a new order of pharmaceutical service programmed in, over a planned timescale. Those contractors who may be reluctant to move out of their traditional comfort zone, will in all likelihood, be pulled by a majority of those who do wish to change into the new service.
CHAPTER 9
CONCLUSIONS AND FURTHER RESEARCH

9.1 INTRODUCTION

The thesis of this work is that:

'...There are cultural, professional and operational barriers to repositioning the community pharmacy dispensing service in the primary health care delivery chain – through a new role of medicines management – resident within the medical and pharmaceutical professions; and that these can be systematically addressed by original research and a novel application of modern management techniques.'

(Chapter 2 : 36)

This thesis is sustained by the findings of the field research and by the management issues exposed in the literature research.

The hypotheses under investigation are:

i. The attitudes of general medical practitioners are such that they will resent invasion into their traditional area of responsibility for patient medication and constitute a barrier to change (Chapter 3 : 42); and,

ii. The attitudes of independent dispensing pharmacists are such that they will wish to remain in the traditional dispensing role.

Both hypotheses are not sustained. Both professions are willing to move into a synergistic role in managing patient medication, but there are substantial barriers to achieving the role change. Now that this research has been completed the following facts are revealed.
The barriers are of a cultural, professional and operational nature, which according to the research findings can be systematically addressed, by the application of modern marketing and change management principles, processes and techniques of application. The main research findings from the respondent information sources and postal surveys are set out below:

9.2.1 Doctors

i. General medical practitioners, by a large majority (75%), support collaboration with pharmacists on patient medication; a professional attitude;

ii. A large proportion, (92.7%) recognise increased patient expectations in health care; a professional assessment;

iii. A large proportion, (63.4%) see a pharmacist medication review service as a potential enhancement to their overall service; a cultural perspective; and,

iv. A large proportion of GPs, (84.5%) who do not have a pharmacist working for them currently would like such help in future; an operational need.

These are powerful facilitating factors in moving the dispensing pharmacist into new cognitive service. However:

v. 83.4% of GPs currently receiving pharmacist assistance do so from sources other than dispensing pharmacists; an operational barrier potentially growing;

vi. 45% of GPs do not yet see the pharmacist becoming a formal part of the doctor’s team; a cultural effect with possible operational considerations;
vii. Traditional core doctor responsibilities for choice of patient medication and dosage level are seen by fewer GPs, (42.55 and 52%) as issues for pharmacist involvement; a cultural effect which increases with increased doctor age;

viii. Adverse time and workload consequences of the new service are disincentives to GP involvement; an operational effect; and,

ix. Only 57.7% of dispensing doctor respondents support collaboration, a much lower percentage than non-dispensing GPs and thus a potentially more difficult sector to engage in change.

The overall message from these responses is that the new proposed pharmacy service is welcome, given that it does not overtly threaten the culturally perceived rights of the doctor to be the arbiter of patient medication regimens. Within the primary care dispensing pharmacist profession the following information was revealed from the respondent postal survey.

9.2.2 Pharmacists

i. A large majority of respondents (80.8%) wish to undertake medicines management if remuneration is acceptable; a professional consideration;

ii. A large majority believe doctors and patients would view this service favourably (61.3% and 88.6% respectively); a cultural perspective;

iii. A large majority believe they have a good relationship with GPs (74%); an operational perspective;

iv. A collective large majority do not wish various other professionals to undertake medicines management (89.8%); an operational and cultural effect; and,
v. A large majority are dissatisfied with remuneration for the present contract (84.2%); a professional attitude.

These are all potentially facilitating issues, encouraging a move into a more satisfactory service and reward system.

However:

vi. 80.2% of respondents believed there was not time to undertake the new medicines management role; an operational consideration;

vii. 88.7% require further training to undertake the new role; a professional requirement;

viii. Delegation of present workload is not supported by 39% of respondents; a cultural view; and,

ix. Of the numbers of technicians employed by respondents, 50% of part time staff had no technician certificate; 32% of full time staff had no certificate; an operational requirement for the future.

9.2.3 Aims and Objectives of the Thesis

The overall aim was to expose those issues which may impede or facilitate the development of a new operational partnership between doctor and pharmacist, in managing patient medication and to examine the potential of marketing as a means of effecting change at the medico-pharmaceutical interface in primary care.

This has been done in the field and literature research and the specific objectives have been fulfilled:
i. Identification of barriers to pharmacy change within the medical and pharmaceutical professions, together with any facilitating factors which may assist change;

ii. Identification of some of the key attitudes, needs and wants of medical and pharmacy stakeholders in the new pharmacy role;

iii. Development of suitable marketing approaches which may address the medical stakeholders' key attitudes, needs and wants;

iv. Evaluation of the role of *leadership* in repositioning the profession in primary care; and,

v. Inform a communications strategy to both professions, in initiating and delivering change for pharmacy.

Although barriers have been exposed in both practical and conceptual dimensions within the medical profession (e.g. increased workload; cultural threat) these are counterbalanced with positive GP perceptions of their potential use of community pharmacy in a new role. Suggested elements of medicines management were well received, but challenge to the doctor's right of therapeutic selection and dose choice were much less so. The majority of respondents welcomed pharmacist / GP collaboration in specified issues, but time consuming systems should be minimised or avoided altogether. Dispensing doctors need special address to downplay competitive outcomes, whilst still building a collaborative relationship, which from the research, appears to be a real possibility.

Provided the potential barriers to collaboration are sensitively and constructively managed, the facilitating issues emerging from the research give pharmacy a major opportunity to move into a new partnership of patient care with the GP.

The barriers to repositioning community pharmacy, existing within pharmacy itself, are more substantial in practical terms. Conceptually a large majority of respondents wish to engage in medicines management. They see both patient and doctor prospective
responses to the new pharmacy service very positively and do not wish competitor professionals to take up this role. However, lack of time is a major impediment to installing the new service, as is current ability to deliver the clinical expertise. Provided these barriers can be overcome then pharmacy also is able to move forward. These matters require urgent address, if competitors are to be prevented from blocking the expansion of the potential cognitive resource within the present dispensing service.

Leadership has a responsibility in providing the means and motivation to achieve the vision of a new role and place in primary care for dispensing contractors.

9.3 NEXT STEPS

From a consideration of the literature and field research, an outline programme of change, leading to engagement of the new MM role by independent primary care dispensing pharmacists, is suggested in Table 64. It encompasses:

- Leadership activity;
- Key external stakeholder management;
- Internal stakeholder preparation;
- The Burke-Litwin change levers;
- New Service configuration; and,
- A suggested timetable.

The suggested timetable is geared to the negotiation, currently underway, for a new community pharmacy contract initially discussed with the Minister of State for Health at the presentation of the new MM service in 1998. The author's discussions with the DH, in July 2003, indicate that the new contract is likely to contain some basic elements of MM, as suggested by the author in this thesis, with a later phase to include full medicines management. This would create some time in which to train pharmacists, but would not prevent competitor professionals (e.g. from PCTs) from continuing to enter the new service.
It is therefore very important that a programme of role change is implemented without delay. Although this suggested plan is for independents, pharmacists employed by the 'multiples' could benefit from all or parts of it. The multiples also have a choice to make, i.e. stay with the current service or move into cognitive MM-based patient care, which the DH is now offering to pharmacy. Table 64 outlines the change programme elements.
TABLE 64 OUTLINE PROGRAMME OF CHANGE FOR INDEPENDENT PRIMARY CARE DISPENSING PHARMACISTS

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>ACTIONED BY; AND ROUTE</th>
<th>BURKE-LITWIN LEVER OF CHANGE</th>
<th>PURPOSE</th>
<th>TARGET DATE</th>
</tr>
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<tbody>
<tr>
<td>1. Leadership Role:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Create phased service specification and configuration;</td>
<td>RPSGB; PSNC</td>
<td>LEADERSHIP. BUSINESS PROCESSES / STRUCTURE. CULTURE.</td>
<td>To define the new service; create barriers to entry for competitors; to support GP culture.</td>
<td>December 2003</td>
</tr>
<tr>
<td>• Promote the need for role change; its benefits; avoidance of delay;</td>
<td>Liaise with DH.</td>
<td>STRATEGIC INTENT; MOTIVATION.</td>
<td>To create movement of minds; disconfirm present situation and create desire to change.</td>
<td>Ongoing from October 2003</td>
</tr>
<tr>
<td>• Timetable the process;</td>
<td>Spoken and written word; journals, seminars and conferences by region.</td>
<td>STRATEGIC INTENT. INDIVIDUAL TEAM AND ORGANISATIONAL PERFORMANCE.</td>
<td>To govern change by milestone objectives.</td>
<td>By October 2003</td>
</tr>
<tr>
<td>• Ensure availability of training courses and alternative routes. (Pharmacists and Technicians);</td>
<td></td>
<td>TASK AND INDIVIDUAL CAPABILITY.</td>
<td>To equip pharmacists with knowledge and skills to deliver the new service; to create the time resource for pharmacists; to reassure GPs that patient care is safe in pharmacists’ hands.</td>
<td>By January 2004</td>
</tr>
<tr>
<td>• Set out new protocols of supervision and skill-mix guidelines; and,</td>
<td></td>
<td>EXTERNAL ENVIRONMENT.</td>
<td>To build support for the new MM role and establish dispensing pharmacists as preferred source of supply.</td>
<td>By April 2004</td>
</tr>
<tr>
<td>• Initiate and maintain dialogue with key stakeholders and with pre-determined objectives.</td>
<td></td>
<td></td>
<td></td>
<td>Started January 2003 – continues</td>
</tr>
<tr>
<td>2. Key External Stakeholder Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• GPC and DH to be regularly briefed by face-to-face meetings and pre-arranged agendas;</td>
<td>RPSGB; PSNC</td>
<td>EXTERNAL ENVIRONMENT.</td>
<td>To establish opinion leadership and message sponsorship, assisting motivation of pharmacists and GPs.</td>
<td>Started August 2002 – continues</td>
</tr>
<tr>
<td>• Joint interim supportive announcements to be made in the pharmaceutical media; and,</td>
<td>GPC; DH; PSNC; RPSGB.</td>
<td>MOTIVATION OF RESPECTIVE CONSTITUENCIES.</td>
<td>DO.</td>
<td>January 2004</td>
</tr>
<tr>
<td>• Patient organisations to be regularly briefed.</td>
<td>PSNC; Face-to-face meetings.</td>
<td>STRATEGIC INTENT. EXTERNAL ENVIRONMENT.</td>
<td>DO.</td>
<td>Started January 2002 – continues</td>
</tr>
</tbody>
</table>

Abbreviations: DH = Department of Health
DO = Ditto
GPC = General Practice Committee
NPA = National Pharmaceutical Association
PMRs = Patient Medication Records
PSNC = Pharmaceutical Services Negotiating Committee
RPSGB = Royal Pharmaceutical Society Great Britain
WWW = World Wide Web

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<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>ACTIONED BY; AND ROUTE</th>
<th>BURKE-LITWIN LEVER OF CHANGE</th>
<th>PURPOSE</th>
<th>TARGET DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Internal Stakeholder Preparation</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>• Dispensing pharmacists to regularly receive information on new contract elements and phasing;</td>
<td>RPSGB; PSNC</td>
<td>MANAGEMENT PRACTICES AND STYLE.</td>
<td>To perpetuate motivation, emphasise professional benefits.</td>
<td>Start January 2004</td>
</tr>
<tr>
<td>• To be informed of training packages, sources and costs;</td>
<td>PSNC letters to LPCs and on WWW to contractors; LPCs to be given templates of support for contractors by PSNC; NPA to propose premises/facilities plans; and,</td>
<td>TASK AND INDIVIDUAL CAPABILITY; INDIVIDUAL NEEDS AND VALUES.</td>
<td>To generate confidence, remove psychological barriers and give purpose for new role.</td>
<td>Start January 2004</td>
</tr>
<tr>
<td>• To be given blueprints for new premises facilities and work processing systems (new skill mix responsibilities and patient interview protocols); and,</td>
<td>PSNC to provide guidance packages on how to support contractors.</td>
<td>SYSTEMS POLICIES AND STRUCTURES; BUSINESS PROCESSES AND STRUCTURE.</td>
<td>To provide the organisational knowledge and time resource for new role implementation.</td>
<td>October 2003</td>
</tr>
<tr>
<td>• To have available mentoring schemes and LPC support.</td>
<td>PSNC; RPSGB</td>
<td>MANAGEMENT PRACTICES AND STYLE.</td>
<td>To provide security and confidence to enter new service, with back up help.</td>
<td>May 2004</td>
</tr>
<tr>
<td></td>
<td>Journal articles and RPSGB branch seminars; PSNC/LPC seminars. Joint IT committee NPA, PSNC, RPSGB; RPSGB; PSNC Mailed to community pharmacies.</td>
<td>CULTURE; BUSINESS PROCESS AND STRUCTURE.</td>
<td>To minimise patient apprehension, maximise patient comfort and ensure universal quality of service.</td>
<td>May 2004</td>
</tr>
<tr>
<td><strong>4. New Service Configuration</strong></td>
<td></td>
<td>SYSTEMS POLICIES AND STRUCTURES.</td>
<td>To facilitate recording, reduce time involvement and guide patient as well as pharmacist, for repeat encounters.</td>
<td>July 2004</td>
</tr>
<tr>
<td>• The patient-pharmacist interface to be protocol driven with possible algorithmic guidance;</td>
<td>PSNC, RPSGB</td>
<td>CULTURE.</td>
<td>To support GP culture; use the pharmacists’ understanding of GP needs; and,</td>
<td>January 2004</td>
</tr>
<tr>
<td>• Paper driven to commence, then IT linked to PMRs; and,</td>
<td>Professional journals and internal letters.</td>
<td></td>
<td>To encourage doctors to participate.</td>
<td></td>
</tr>
<tr>
<td>• Systematic review process with pre-determined elements.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• The GP-pharmacist interface to be styled as doctor led with collaborative pharmacist assistance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Suitable articles prepared for medical and pharmaceutical communications.</td>
<td></td>
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</tbody>
</table>

**Abbreviations:**

- DH = Department of Health
- DO = Ditto
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- RPSGB = Royal Pharmaceutical Society Great Britain
- WWW = World Wide Web

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The outline programme of change set out in Table 64 now needs to be considered in
detail and work apportioned between the leadership bodies. It will be presented by the
author in the next leadership group meeting in early October 2003, for this purpose and
if possible a timetable agreed.

From the research conducted in this thesis, it is apparent that a realistic opportunity
exists for the independent sector of primary care dispensing pharmacy to transform its
role. It remains to be seen whether adequate progress can be made in time to prevent
competing professionals from supplanting this role.

The thesis and its contents are the original work of the author, researched from the
recognised bodies of literature and using standard methods of field research, applied to
an original plan of work.

9.4 FURTHER RESEARCH

Suggested areas of further research arising from this work are:

1. Research into building the collaborative partnership between dispensing doctors
   and rural pharmacists;

2. Research into patient motivation to comply with treatment; and the pharmacist
   / doctor link in that process;

3. Research into the patient consultation amenity provided by dispensing
   pharmacists, for future development of the service – the IT aid; algorithms; inter
   communication psychology;

4. Research into GP / pharmacist relationship development and reapportionment of
   responsibilities as medicines management develops (toward a point where, for
   example, doctor diagnoses, pharmacist prescribes); and,

5. The issue of obstruction to delegation of pharmacist workload to other staff.
Such studies will generally assist continuous development of primary care service to patients and specifically pharmacists' continual development of professional contribution to that health care process.
APPENDIX 1
(Ref. Chapter 1 : Page 2)

PEST ANALYSIS – COMMUNITY PHARMACY

POLITICO – LEGAL ISSUES

• Government legislation on limitation of contract has increased the equity value of individual and group community pharmacy business.

• Government perception of community pharmacy contribution to health care, as mainly counting and pouring, has limited government views of the value of the profession’s service.

• Government restructuring of the National Health Service into Primary Care Groups / Primary Care Trusts, has placed all doctors in a cost conscious environment. Pharmacist expertise being welcomed by GPs to assist in control of prescribing costs (Hansard : Nov 23, 1999 : 468). Inter-professional partnerships encouraged.

• Requirement in Law of pharmacist supervision of medicines sales, restricts pharmacist domicillary work.

• Pharmacist requirement to supervise dispensing activity gives similar effect.

• Creation of benchmarking performance and clinical audit of GPs (‘NICE’) by 1999 White Paper drives quality improvement in primary health care – potential for pharmacist input in medicines management.


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• Government edict has effectively devolved budgets for primary care expenditure to Health Action Zones and Primary Care Trusts when they form. (Not dispensing remuneration)

• Possibility of pharmacists prescribing, signalled by Secretary of State for Health in 1999.

• Government sponsored ‘Walk in Centres’ created by Government in 1999 – staffed by nurses – potential competition for pharmacists in health advice and possibly medicines supply.

• *NHS Direct*, introduced by Government (staffed by nurses) in 1999; more competition for health education from the nursing profession; but potential for pharmacy as the *fourth disposition*.

• Continued encouragement by Health Minister for pharmacist role in medicines management. Pilot trials agreed May 2000.

**ECONOMIC INFLUENCES**

• EU devolvement of health care spending to member states gives UK Government flexibility in allocating resource.

• Global sum remuneration for community pharmacy restricted to inflation increase only, year on year, since 1993. (Inflation is measured by RPI). True inflation for pharmacy is consistently ahead of the retail price index, because of the additional rise in drug costs.

• Global sum for pharmacy has, therefore, diminished in real terms. Profit surplus for reinvestment in pharmaceutical service is either non-existent or much diminished at independent pharmacy sector level, dependent upon size of pharmacy dispensary.
Foreign competition entering the UK market (Phoenix and GEHE) have pushed other vertically integrated UK indigenous companies into re-entering another expansion phase to block the competition. The independent sector is thus diminishing, down from 70.4% in 1990 to 55% in 2000 (PPA Statistics Bulletin, 1998 and RPSGB Register, 1999) and still declining.

This movement in pharmacy ownership must restructure the national representative committees in favour of the multiples being in a majority, in due course. This, in turn, means real risk of contract limitation terminating, (possibly within three to five years) as the multiples, e.g. Superdrug, have never been comfortable with restricted expansion. Pharmacy equity values will then drop.

Resale price maintenance on medicines is now removed despite a new pharmacy group (CIPAG) being formed to fight the prospect, now instigated by the Office of Fair Trading (1998). CIPAG failed in it mission during 2001.

In the current phase of the economic trade cycle (recovery) the pressure for competition in all markets is the order of the day and is further encouraged by anti-monopoly EU legislation. (The competition laws).

A new pharmacy price negotiation scheme for branded drug suppliers, introduced in 1999 and price regulation for generics introduced in 2000, now means reduced profit margins for independents and multiples alike, further pressure upon the viability of the independent and increased propensity to sell out to multiples. Equity values may begin to fall.

SOCIO CULTURAL EFFECTS

Stress related illness is increasing, (Statistics Bulletin, 1999) – increased pressure on drugs budget NHS by increased prescribing of tranquilizers.
• Government emphasis in society on health promotion; increased number of leisure centres / gymnasia; Government sponsored initiatives in dietary importance and healthy lifestyles. Health promotion role for pharmacy is increasingly important.

• Public involvement in health service quality, annual patient survey proposed (Government White Paper: 'The New NHS – Modern, Dependable : 1997); may be an opportunity for pharmacists to form strategic alliances with patient organisations to build new cases for extra services to special groups, i.e. CHD, diabetic patients, etc.

• Illicit drug abuse still increasing; methadone scheme development? Other approaches?

• NHS medicines compliance still a problem (RPSGB / MSD Joint Project 1996 : 3 – 12) and related to drug waste on a grand scale; a major element of medicines management?

• Public awareness of quality of care issues through television current affairs programmes and DH constant publicity on the subject. Further pressure upon stretched resources of independent community pharmacy through clinical governance. Aid or barrier to medicines management?

• Connection of whole population to world wide web a real possibility through touch screen television; future communications with patients in their own homes greatly facilitated. Who will staff terminals at the GP end of the line? - Practice nurses? Further potential for pharmacy terminals and patient compliance / communication issues?

• Nation wide drive to life-long learning – may have beneficial effect upon public’s attitudes to medicines over a period of time.
TECHNOLOGY EFFECTS

- ‘IT’ installed in every pharmacy in UK and every medical practice – facilitates collaboration inter-professionally, when ‘IT’ links developed.

- Potential for rapid communication in patient medication information, between pharmacists and GPs.

- The virtual prescription is a reality and electronic prescriptions only a few years away (by 2005) – strong potential for redistribution of prescription volume and renewed viability of all pharmacies – may be resisted by multiples as script volume is lost.

- Potential for more sophisticated compliance aids and containers at reasonable cost for large scale use – especially the chronically ill. Perhaps increased potential for compliance assistance through television linked to the internet, triggered by pharmacy input for registered patients (signal transmission).

- Potential for nation wide on-screen system and structure for review of patient medication in the pharmacy by pharmacists; more than an algorithm. It could also a training aid and upgrade of review system, with latest drug information and evidence based advice.

- Doctor / pharmacist conferencing a future possibility (1 GP practice + several pharmacists) in consolidating the periodic review of medication for each group of patients (e.g. CHD, asthma, etc.).

- Potential to extend the last concept to Internet patient compliance clinics, for specific disease groups, at regular pre-agreed intervals, when all individuals (pharmacist / doctor / patients) hold a ‘virtual’ get together to discuss the disease and its prognosis and medication review. Patients would assemble in a room with a facilitator and television screen, receiving selected advice (live) from consultants,
pharmacists, doctors, in different locations, joining the clinics at pre-determined times.

- PRODIGY or MIQUEST IT systems to place more expertise in the hands of doctors? Is this a threat to pharmacy or an opportunity to add the medicines management initiative at pharmacy level with the patient?

SUMMARY

The above analysis, conducted under four main headings, gives an indication of dynamic environmental forces which pose threat and opportunity for community pharmacy, in its present form and structure. These issues will be used in the body of this thesis to illustrate and indicate ways of using the market environment to take the profession forward into a new order of service.
Dear Dr

The current review of this patient's medication prompts the following observations:

Pharmacist management on an ongoing basis helps to maximise the benefit and minimise the risk from prescribed medicines by ensuring:
- full understanding by the patient of the way in which the medicine is to be used, and the need for concordance with the recommended treatment; the safe and appropriate choice and combination of medicines, and structured collaboration with the prescriber.

BLANKSHIRE H.A.
N.E. Pharmacist P6414
The Pharmacy
Well Street
Blanktown
Tel: 01476 592020

I consent to the information and advice contained on this form being made available to other members of the health care team:

Signature of Patient (or representative) Date: / /
APPENDIX 3
(Ref. Chapter 1 : Page 18)
OUTLINE NETWORK ANALYSIS OF ACTIVITY REQUIRED TO
CHANGE COMMUNITY PHARMACY FROM SUPPLY ROLE TO
COGNITIVE SERVICE IN MEDICINES MANAGEMENT.
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APPENDIX 4
(Ref. Chapter 1 : Page 22)

GROUP 1

CHAIR: RPSGB              EDUCATION / TRAINING / ETHICAL

Objective:  

To ensure that pharmacists have the knowledge and ability to apply that knowledge to help people gain maximum therapeutic benefit and encounter minimum untoward side effects from medication which is appropriate for their treatment, in the pursuit of self-regulation and lifelong learning.

Comments:

* Knowledge, skills and culture are developed to enable community pharmacists to discharge effectively the role of managing medicinal therapy.

* Skills in the learning methods can be applied according to the principles specified by the working group and establish best practice by giving learning providers a specification for desired outcomes.

* Key events and systems for a suitable change process are identified, to be certain that the learning (attitude, knowledge and skills) is achieved, and to build in ways of reviewing that learning and monitoring progress.
* Account is also taken of the need to work with and / or influence the learning of other professions.

* The approach reinforces, and helps pharmacists to meet their requirements of the code of ethics and professional standards.

* Aspects of clinical governance relevant to medicines management will also be part of this group's remit.
APPENDIX 5  
(Ref. Chapter 1 : Page 22)

GROUP 2

CHAIR : PSNC

COMMUNICATION / MEDICO-PHARMACEUTICAL TEAM BUILDING

Objective: Using the outline stakeholder analysis in the PSNC document this committee will identify and engage the major stakeholders of the new role, by appropriate communication techniques, and enlist their support in delivering a successful new role for pharmacy.

Comment: * In conducting its work this committee will make best use of existing resources such as PR consultants, political consultants and other organisations as deemed necessary for the different target ‘publics’.

* The committee will develop an outline communications programme for each target group setting out: the selection of media / means of promoting successful ownership of the new role implementation and suggested frequency of contact.

* The group will take account of the internal resources of each member constituency such as the major professional journals, regular organisational mailings (NPA Supplement, PSNC News, etc.) and such bodies as the RPSGB branches, LPCs and NPA branches.
GROUP 3

CHAIR: PHARMACY PRACTICE RESEARCH GROUP: COMMISSIONING PROJECTS

**Mission:** This committee will develop and present to the leadership group for approval satisfactory model(s) of service for the medicines management role. The models will use 'Action Research', as the developmental process in pilot style, so that by the end of the chosen period, a developed intervention is ready for a larger scale roll out.

**Comment:**

* In conducting its work for this project, the group will engage internal resources and external expertise in defining and structuring the interventions and suggesting a tight time scale.

* Funding will be sought in collaboration with the leadership group for several pilots on a regional basis, taking account of new HAZ and PCG structures. Careful work with these bodies will facilitate adoption of the new service within the revised structure of the New NIIS.

* This committee will also make recommendations to the leadership group on best approach to the overall intervention, i.e. should the pilots all be similar, or...
differentiated for example by disease group? The leadership group currently favours a generalist approach.

* Performance measures will also be developed, as well as statistically valid processes for generalisation, at completion.

* This group will liaise closely with the communications group in engaging the team building component of each medico-pharmaceutical collaborative project.

* It will also be the responsibility of this group to suggest methods of project funding and to collaborate with the leadership group in approaching suitable sources.

* Proposed models of service and pilot locations together with performance measures will be submitted to the leadership group prior to action.
APPENDIX 7
(Ref. Chapter 1 : Page 22)

GROUP 4

CHAIR: NPA REPEAT DISPENSING DEVELOPMENT

Objective: *To develop an action plan including: key tasks, time scales and funding to roll out repeat dispensing across the whole of England and Wales in line with the time scale dictated by negotiations with the NHS Executive. To submit this action plan to the Medication Management Group for approval. To manage and monitor the implementation of the approved action plan.*

Comments: *To ensure that the platform created by repeat dispensing is a suitable base from which medicines management can be developed.*

*Establishment of the ‘FP10’ as a central document in medicines management is a crucial factor in securing the new role for community pharmacists already in contract to the NHS. This document, instead of simply being an order for medicines, becomes a contract for patient care, triggering for the chronically ill, a medication review.*

*Developing pharmacist familiarity with increased responsibility is judged by the leadership group to be an
important prelude to the transformation of the pharmacist's place in primary care.

* Progressing acceptance and roll out of repeat dispensing services, may also be used as a relatively user friendly way of engaging the medical profession in a collaborative exercise and building confidence between the two professions.

* Continued excellence in extending this service will make a big contribution to the successful introduction of medicines management.

* Liaison between this group and the PPRG will establish means of collaboration in the commissioning project roll out.
APPENDIX 8
(Ref. Chapter 1 : Page 22)

GROUP 5

CHAIR: CCA / CPTP PREMISES / IMAGE CHANGE

Objective: This group will develop concepts for in-pharmacy transformation of facilities and image, in such a way as to:

- encourage patient participation in the new service

- facilitate and encourage pharmacist engagement in the new role

- generate confidence in the medical profession through a thoroughly professional new intervention in primary care by the pharmacist.

Comments: * Successful transformation of the professional side of pharmacy, through its image with the public is one of the most powerful influences in successful modern relationship marketing and will build public confidence in the community profession.
* Information technology as well as consultation facilities will be a key consideration in this work, both for records and intercommunication with the medical profession.

* The area where the medicines management activity occurs should be within the pharmacy counter / dispensary area (i.e. where there is immediate access to the pharmacist).

* The area should be uncluttered, clean, warm, welcoming, professional and with no barriers to entry.

* The area should be quiet and information in the form of leaflets and / or videos and books should be available.

* There should be ready availability of trained support staff, easy access to the pharmacist and easy access to the area itself. There is no need for separate consulting rooms, at this stage.

* Only pharmacy merchandise should be available in the pharmacy counter / dispensary area and in the consulting area itself. Little, if any, merchandise should be promoted. It is recommended that health promotion / health education information should be available, together with compliance aids and equipment to support, for example, the demonstration of inhalers, etc., together with appropriate diagnostic equipment necessary for patient monitoring, e.g. peak flow meters, cholesterol testing and blood pressure monitoring.

* There is a need to provide seating, particularly for elderly patients and there should be some worktop provision.
* Cash taking facilities within the consultation / quiet area can detract from the professional image. It is, however, recognised that it is not possible to remove these facilities in all small pharmacies.

* The area itself needs to be within the pharmacy counter / dispensary area so that the pharmacist will still be able to be in control of activities within the professional area, and the area needs to be discreetly located and obviously apart from the main customer traffic flows so that patients / customers cannot inadvertently walk into it.

* The area should be able to accommodate more than just two people, particularly when children will require to be accompanied by a parent and possibly a minimum of 40 square feet will be required.

* It is recognised that it will be necessary to generate sufficient income from this space to cover the potential lost sales opportunity.

* There should be appropriate signage outside the pharmacy, within the pharmacy and also at / over the consultation area.

* Consideration will be given to the appropriate location of IT equipment within the pharmacy / counter dispensary area.
WORKING GROUP GUIDELINES

1. GENERAL – EACH GROUP WILL:

1.1 Construct an outline programme of proposed work with milestone objectives and submit to the leadership group for approval / amendment. Each working group will progressively agree a timetable of delivery of objectives with the leadership group. Working groups should also set out a reporting programme indicating how the work of the group will be reviewed and monitored, taking into account quality objectives, a time plan and milestones.

1.2 Meeting frequency is at the discretion of each working group.

1.3 Adopt the partnerships of patient care as the overall guide document.

1.4 Submit minutes of their meetings to leadership group one week or thereabouts after the meeting. Members of the working groups will be kept appraised of the progress of other groups by the Leadership Group. Minutes of the working groups will be considered by the Leadership Group to ensure that the working group’s activity is co-ordinated and there is no overlap.

1.5 Refer items of all proposed expenditure for operational proposals to leadership group for approval.

1.6 A verbal report on each working group will be made at the Leadership Group meeting by the appropriate lead organisation.

1.7 The chairman and secretary of the leadership group may be ex officio members of the sub-committees and will attend on an infrequent ad hoc basis.
1.8 Each constituent membership of the groups will be responsible for its own expenses and meeting facilities.

1.9 It will accomplish this with a timetable progressively agreed within the leadership group.

NB. Progress of each group will be reviewed by the leadership group and matters for joint collaboration and interests relayed on to other sub groups for action.
APPENDIX 10

(Ref. Chapter 1 : Page 16)

MEDICINES MANAGEMENT – PHASES

Note: The medicines management process, has hitherto been conceptualised as a cyclical four phase process, i.e.

- Review of the patient's prescription;
- Consultation with the patient;
- Recommendations to the patient's GP; and,
- Implementation and review.

The phases of medicines management, in an operational setting have been regarded as falling into four distinct procedures as outlined in the note above. However, with experience of operating a scheme in Gateshead on Tyne, it has become clear that a fifth process is desirable as a formalised part of the complete service.

This is a pre-phase, to the review of the patient’s prescription, in a fully developed partnership of care, between patient, doctor and pharmacist. That phase is a review of the patient’s illness / condition as being currently treated. This is to contextualise the medication, so that accurate recommendations can be made, i.e. it should be known for example, what a particular diuretic is being used for; is it simple diuresis, congestive heart failure or hypertension? The full cyclical phases of developed medicines management would thus be:

- Review of current patient medical condition;
- Review of current medication;
- Patient consultation with pharmacist;
- Pharmacist recommendations to GP; and,
- Agreed implementation and cyclical review.
APPENDIX 11A
(Ref. Chapter 3 : Page 45)

KEY INFORMANTS – CODES

CODE

Professor Sir Michael Rawlins BSc MD FRCP (Ed.) FRCP (Lond.) FFPM A
Chairman: National Institute of Clinical Excellence

Professor Colin Bradshaw MB ChB FRCP FRCGP B
Visiting Professor of Health & Social Science & Education
University of Northumbria & General Practitioner, South Tyneside

Dr. G. Rae MB BS C
Chairman, North Tyne Medical Committee and General Practitioner

Dr. K. Megson BA MB BS MRCGP DRCOG D
Secretary, South Tyne Medical Committee and General Practitioner

Dr. B. Posner MB BS E
Secretary, Sunderland Medical Committee and General Practitioner (Retd.)

Dr. M. Stewart BSc MBA PhD F
Director of Professional Services, Durham Health Authority

Dr. I. Spencer MB BS G
Director of Primary Care, Newcastle & North Tyne Health Authority

Dr. D.M. Fleming OBE, MB ChB PhD FRCGP H
Royal College of General Practitioners and General Practitioner, Birmingham

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APPENDIX 11B
(Ref. Chapter 3 : Page 45)

FRAMEWORK OF INTERVIEWS – KEY INFORMANTS

Technique : flexible, semi-structured

Introduction : brief and based upon Government White Papers

Thank you for helping with my research. The purpose of this work is to explore some issues which may be involved with closer medical / pharmaceutical collaboration in primary care. As you know, recent Government White Papers are supportive of the primary health care professionals working closely together and this discussion simply seeks to obtain your views on these matters.

Question 1

Are there any aspects of patient treatment which may be suitable for a new pharmacist involvement?

Question 2

What do you feel will be the general reaction of GPs to a new structured relationship with community pharmacists?
**Question 3**

Do you see any particular problems arising with a proposition to bring the medical and pharmaceutical professions more closely together?

**Question 4** (for those who see problems)

How, in your view, may these problems be addressed?

**Question 5**

What, in your view, would be conducive to a new pharmacy involvement with patient care:

(a) For the patient?
(b) For the doctor?

**Question 6**

How could a more structured operation be developed between the doctor and pharmacist?

**Question 7**

Where should a new pharmacist role be located?
Question 8

If a new role for pharmacists along the lines we have discussed was proposed, are there any aspects you feel should be omitted from such a proposition, i.e. which may be regarded as unattractive?

Question 9

Would you like to be involved in developing a new role for pharmacists in a new ‘partnership’ with GPs?

Question 10

May I refer back to you for comment when this research nears completion?

Many thanks for your help in the consideration of the way forward for pharmacy. I will refer back to you with some results, for any comment you wish to make.
APPENDIX 11C
(Ref. Chapter 3 :Page 47)

RESEARCH RESULTS ANALYSIS

KEY INFORMANTS

KEY INFORMANT INTERVIEWS

CONTENT ANALYSIS

ABBREVIATIONS

<table>
<thead>
<tr>
<th>ADR</th>
<th>Adverse Drug Reactions</th>
<th>LMC</th>
<th>Local Medical Committee</th>
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<tbody>
<tr>
<td>CHC</td>
<td>Community Health Council</td>
<td>LPC</td>
<td>Local Pharmaceutical Committee</td>
</tr>
<tr>
<td>DI</td>
<td>Drug Interaction</td>
<td>OTC</td>
<td>Over the Counter medicines</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
<td>PC</td>
<td>Patient Compliance</td>
</tr>
<tr>
<td>GPC</td>
<td>General Practitioner Committee</td>
<td>PCG</td>
<td>Primary Care Group</td>
</tr>
<tr>
<td>HA</td>
<td>Health Authority</td>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>HAPA</td>
<td>Health Authority / Pharmaceutical Adviser</td>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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<tr>
<td>IT</td>
<td>Information Technology</td>
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Introduction

The Key Informant interviews are discussed under each of the questions asked in the semi-structured interviews. The dominant themes have thus been extracted and exceptions reported where they are considered significant. Additionally, where responses under particular questions also relate to responses under other questions, these are mentioned to help establish consistency / inconsistency in attitudes and beliefs of the respondents.
Questions

Question 1 Are there any aspects of patient treatments which you feel may be suitable for a new involvement by the pharmacist?

The interesting overall aspect of the responses here is the unanimity of assent, that there were tasks, which these highly qualified doctors perceived as the domain of the pharmacist. No respondent stated, or implied, that such issues were the sole realm of the doctor. As to why this is, could be pursued in further question and comment, in final feedback of results to the key informants.

Equally interestingly, the suggestions from all were medicines based and of these five (62%) related to patient compliance with the medicines regimens. As respondent C put it:

'...I have done some research on patient compliance... and figures collected by me vary, between 34% and 60% of patients not taking their medicines regularly or correctly...'

A similar number of respondents emphasised rationalisation of prescribing within the practice (5 = 62%) as suitable for pharmacist involvement. The implication, according to respondent A, was that doctors are conscious of inconsistencies of prescribing practice.

Three respondents mentioned drug cost reduction and shifting branded drugs to generics, which are related issues, (Q8 : D, E confirm this issue).

Only one informant, at this stage (respondent A) mentioned premises deficiencies in pharmacies. This translates in his terms, into lack of confidentiality for patients and could form a major consideration in the total product offering.
Key Themes - Recognition of pharmacist potential
- Patient compliance problems

Exception - Could reduce doctor workload

Question 2 *What do you anticipate will be GP reaction to a new structured relationship with community pharmacists?*

Six respondents, (75%) felt sure that reaction would be mixed and three, (37%) judged age difference, (young v old doctors) to be a significant factor.

Respondent A was keenly aware that the new pharmacist proposition would need selling... and benefits shown. This is a clear indication of the need to consider not only the new product, but the presentation (packaging) and communication issues involved in the target market needs and motivation.

Key Themes - Age related doctor resistance (self esteem?)
- Potential workload barrier to change

Exception - Need to sell the new proposal

Question 3 *Do you see any particular problems with a proposition to bring the medical and pharmaceutical professions more closely together?*

The problems mentioned, developed mainly around the operational difficulties in sustaining a formalised relationship. The systems and paperwork implications were mentioned by six of the eight informants, (75%) and five, (62%) mentioned the volume, time and paperwork involved – all matters of resource. The total product offering needs to address these issues effectively, because even if the product could be
successfully introduced without such consideration, in practice these aspects may become serious disincentives to continue the scheme. The product could thus fail, post market introduction. It is significant that respondent D felt that problems could be avoided by ...planning well. This is one of the first elements in Kotler’s definition of marketing, (Chapter 4).

**Key Themes** - Potential workload and organisational barriers to change

**Exception** - Need to sell the idea

**Question 4**  *How, in your view, may these problems be addressed?*

Six, (75%) of the eight informants favoured a joint GP / Pharmacist approach by preparatory discussions, (the beginning of relationship building) and five, (62%) suggested facilitation by one or more of the NHS bodies, (PCG / HA / LMC / LPC). This, in effect, is sponsorship in communications, (Chapter 4) and will be used at the appropriate stage.

**Key Themes** - Collaboration inter-professionally

- Official sponsorship: Government bodies

**Exception** - Need to sell benefits

**Question 5**  *What, in your view, would be conducive to a new pharmacy involvement with patient care?*

(a)  *For the doctor?*

(b)  *For the patient?*
For the doctor a number of requirements emerged, some of which reflect or relate to Garvin’s dimensions of quality in product design, (Table 13, page 64). These included premises facilities, teamwork, doctor support by pharmacist and official leadership.

The doctor's perception of the factors which may assist patient participation in the new pharmacist role, were confidentiality of encounter with the pharmacist in the pharmacy and reflection of the joint doctor / pharmacist nature of the new service to the patient, (75% of respondents C, D, E, F, G). There is a hint here of the needs of the doctor to be satisfied, in terms of esteem and actualisation (Chapter 4).

**Key Themes**
- Confidentiality of service
- Official sponsorship: Government bodies
- Doctor self esteem

**Question 6** *How could a more structured operation be developed between doctor and pharmacist?*

The unanimous theme here was that of sponsorship / opinion leadership through the structure of the NHS, (PCGs, HAs, LMC / LPCs) and lead organisations of the professions (GPC / PSNC). Top down, bottom up effort was suggested by respondent B. The leadership level, of the Burke-Litwin change model, is assuming importance as a target of marketing effort, in encouraging change, as discussed in Chapter 5. Workshops, focus groups and systems development are indicated by six respondents, (75%).

**Key Themes**
- Official sponsorship / leadership
- Collaboration inter-professionally
**Question 7**  Where should a new pharmacist role be located?

Seven respondents were firmly in favour of the pharmacy, (87%), but one said the surgery, unless IT links were good enough to allow a pharmacy based service. Interestingly, respondent A indicated in his reply that ‘...a little more professionalisation may be required in all pharmacies...’ When questioned further, this turned out to mean a premises confidential facility and an agreed protocol for interfacing with the patient. This supports the overall response in *Question 5*, to factors which may be conducive to the new pharmacy service.

**Key Themes** - Location of product in the pharmacy

**Exception** - At GP surgery: doctor self esteem

**Question 8**  In a new pharmacist role along the lines we have discussed, are there any aspects you feel should be omitted?

Two elements of the responses seem to be particularly significant. Informants A and C suggested that therapeutic substitution of drugs is an issue for later, (as opposed to a launch topic). They indicated that the decision to change the patient’s drugs must lie with the doctor, even when current medication is failing. Further questioning exposed the view, that pharmacist involvement here would be likely to be perceived by GPs as a threat to their core role. The rationale underlying *Maslow's Hierarchy of Needs* again emerges as a concept to be considered carefully, with regard to self actualisation and esteem. Otherwise, respondents did not raise any major items to be omitted. A system to ensure reduction in wastage was mentioned twice.

**Key Themes** - Avoid therapeutic substitution

- Doctor autonomy: self esteem
- Reduction of drug wastage
- Patient compliance
**Question 9**  *Would you like to be involved in developing a new role for pharmacists in partnership with GPs?*

All respondents were interested in becoming involved, given that certain *political sensitivities* would need to be recognised and addressed.

**Key Themes** - Unanimous assent, given time and sensitivity

**Question 10**  *Would you be willing to comment upon some aspects of this research?*

Again, all respondents were positive, but two again emphasised the *politically sensitive* nature of their positions.

**Key Themes** - Unanimous assent, given confidentiality / sensitivity

The potential sensitivities mentioned in response to questions 9 and 10 may be in themselves, some indication of tensions between the two professions.

**Summary**

The overall result of the key informant interviews was positive and constructive, with respondents recognising certain appropriate tasks for the pharmacist. All these elements are present in the core product offering.

Prominent, was patient compliance and workload considerations, the latter of which were perceived to be a potential barrier to GP acceptance, as was the *older GP*. The scheme would *need selling*, in the view of two respondents.

Collaboration and the usefulness of sponsorship emerged as suggestions for taking the process forward.
An indication of underlying doctor self esteem emerged in questions 5, 7 and 8 and it will therefore be advisable to ensure that product packaging and the communications message, support this possibility in consonant copy.
MEDICINES MANAGEMENT FOCUS GROUP : STEERING CUES

SEMI STRUCTURED FORMAT – FREE RANGING DISCUSSION

Chair : A.M. Tweedie
Secretariat : PSNC General Secretary

Introduction Content

Medicines management as a new role for community pharmacy; repositioning community pharmacy in primary care; communications with stakeholders; education / training; interprofessional relationships; the way forward.

Rationale and Objectives

The leadership of the pharmaceutical profession is complex with several autonomous bodies with nominally different responsibilities. Political drivers create overlap and sometimes disparate views and conflict. The overall purposes of this group were:

• To begin to generate joint ownership of changing the profession’s future;
• To encourage the ‘leaders’ to begin to relax in joint efforts and discussion;
• To allow mind sets to begin to see clear individual responsibilities in taking the medicines management issue forward and avoid duplication; and,
• To achieve ‘critical mass’ of commitment at leadership level;
The specific overt objectives were:

- To gain group views of current dispensing pharmacist abilities to undertake medicines management;
- To ascertain group views on any educational and training requirements for dispensing pharmacists;
- To gain, if possible, unanimity on ways of taking the initiative and the profession forward;
- To achieve an agreed group view on communications to the stakeholders; and,
- To agree, if possible, on immediate next steps (to avoid loss of momentum), if group agreement and approval of the initiative was achieved.

Meeting Flow

The meeting was conducted on informal lines to encourage open debate and expression of views. Straying conversation was permitted, if the stray subject was relevant to the topic in hand. Intervention by the chairman was minimised to encourage the nature of freely expressed group discussion. It is sometimes the case that the most important issues arise and underlying views emerge, tangentially, to what is perceived to be the central issue of the main agenda.

Summary

The report of the group is by abstract and matrix of group member contributions showing the response of the group members and indicating the effect upon group collaboration and future potential.
APPENDIX 12B
(Ref. Chapter 3 : Page 48)

REPORT OF THE PHARMACY MEDICINES MANAGEMENT
LEADERSHIP FOCUS GROUP HELD AT THE RPSGB ON
THURSDAY 4th JUNE 1999 AT 1.00 pm

Present:

Mr. N. Baumber  ) PSNC Medicine Management Group
Mr. S. Williams

Mr. P. Curphy  ) RPSGB
Mr. J. Ferguson

Ms. C. McCready  ) NPA
Dr. I. Spencer  ) NHSE

CHAIR: Mr. A.M. Tweedie

NHSE National Health Service Executive
NPA National Pharmaceutical Association
PSNC Pharmaceutical Services Negotiating Committee
RPSGB Royal Pharmaceutical Society of Great Britain

1. INTRODUCTION

The Chairman introduced the purpose of the meeting, which was to discuss in an open and relaxed way, the future potential of medicines management, as a new role for community pharmacy and a means of repositioning the profession in primary care. It was hoped that the group would also explore some of the issues associated with the proposition and express views on such topics as communications within and external to the profession, education and training and inter-professional relationships. He further
explained that his role was simply to steer the group and clarify, where necessary, any subjects where guidance was needed at times, during discussion. All members had been pre-supplied with the new medicines management booklet which had been prepared by a working group, chaired by the Chairman of this focus group. The session was conducted on informal conversational lines.

Steering cues for the group were:

i. Community pharmacists' ability to undertake the new role and any educational / training requirements / facilities.

ii. The way forward.

iii. Outcomes beneficial to stakeholders.

iv. Communications.

Recording of comment was undertaken by the secretariat and abstracted, with the Chairman's help, as a written account, with specific quotations where felt to be helpful.

2. PHARMACISTS' ABILITY TO UNDERTAKE THE NEW ROLE – EDUCATION / TRAINING

CHAIR:

"This section of our discussion relates to dispensing pharmacists' present ability to operate a medicines management scheme. Can we discuss this subject and flag up those issues we feel are important?"
Mr. Ferguson asked:

'Have any apprehensions been expressed within the survey which has been carried out in the north east of England, about the ability of community pharmacists to carry out the role of medicines management.'

The Chairman replied that the apprehensions expressed mainly related to their professional ability regarding clinical knowledge and their ability to influence general practitioners. However, a majority of respondents had indicated willingness to undertake the medicines management role, given that they would receive training.

Professor Mackie:

'I'm sure that special training will be required for many pharmacists. The course at Aberdeen University... and from other universities, would equip pharmacists to undertake the new clinical role involved in medicines management.'

On being questioned by Mr. Baumber, she responded that those taking part already in such courses did not come from any particular age group, but covered a fairly wide spectrum of experience. She indicated that, in her view, the Aberdeen course was more rigorous than many of the courses available.

The main characteristics of the Aberdeen course summarised by Professor Mackie were:

- Distance learning
- Modular format of 15 hours per module
- Six modules in total for community pharmacy
- A period of placement within GP practices
- Cost of the order of £2,000

In addition to the cost of the course, participants need to provide for attendance at Aberdeen for three weeks.
The course could then be converted to an MSc at a cost of a further £500.

Professor Mackie agreed to send details of the course to the Chairman.

Mr. Curphy asked:

'Does medicine management start from the assumption that there is to be a massive amount of training and that every pharmacist will provide the medicine management service?'

His feeling was that currently many pharmacists could undertake the role, but others would never be able to provide the role due to lack of expertise. He asked whether these points would be covered in pilot trials. Mr Tweedie replied that research conducted in the northern NHS region (his MBA dissertation 1997) indicated that all pharmacists could undertake the role, given adequate training. This was irrespective of age groups. However, as the project rolled out, interest should help stimulate commitment amongst all contractors, who may not wish to be left behind.

Ms. McCreedy referred to the experience of the National Pharmaceutical Association with pilot trials of some of the elements of medicines management and indicated that other basic experience was being built at local level. She suggested that in devising pilots, an examination should take place of what is currently known, to avoid the necessity of:

'...reinventing the wheel. It is important to work upon specific skills, including those of an inter-personal nature.'

Ms. Dutton indicated that health authorities were working on some aspects of medicines management, such as prescribing advice, and that her experience, and that of other pharmaceutical advisers, was that general practitioners are very keen to use pharmacists. She also said:

'In my experience, pharmacists have good inter-personal skills, and will quickly adapt to medicines management.'
She noted that the PSNC working party report had made very sparse mention of other professions – in particular, nurses and hospital pharmacists. She felt that there was a need to make use of all local expertise, in appropriate ways.

Mr. Ferguson referred to the government health improvement programme:

'I'm pretty sure the new NHS structure will produce a huge demand for prescribing support... when Primary Care Groups begin to operate... there'll be a 'demand pull' for pharmacist expertise.'

Professor Mackie indicated that she disagreed with much of the implication of what had been said with regard to community pharmacists' lack of clinical ability:

'... many pharmacists are already providing some clinical service, as far as they can, but they feel they don't have sufficient access to the information required, as well as facilities, to provide a complete service.'

In this respect, she criticised the definition of 'dispensing' set down by the Royal Pharmaceutical Society of Great Britain, saying:

'The profession has to start from the assumption that community pharmacists are clinical pharmacists; that clinical practice should take place across the whole of the spectrum of pharmacy activity.'

Unfortunately, in her experience:

'Some pharmacists provide services at only one end of that spectrum.'

(She did not relate the RPSGB definition of 'dispensing'.)

She also disagreed with what had been said within the profession, in the past, about the core skill being 'dispensing'. She considered the core expertise to be the clinical skills, rather than the mechanical or commercial skills, of a retail pharmacy operation. Pharmacy, she said, was concerned with applied therapeutics.
Dr. Hawksworth welcomed the PSNC working party report produced under Mr Tweedie's chairmanship.

'It sets out the way that pharmacy practice should be undertaken... this is the way it operates in my pharmacy... I am interested in patient care; not just dispensing.'

'One can't just provide a training course and expect a pharmacist to be immediately allowed to practice. Other support systems need to be in place... medicines management requires a life-long learning process.'

She also stressed the importance of the service being provided within the community and from the community pharmacy, rather than peripatetics.

Dr. Spencer, (HA Medical Director, Newcastle and North Tyne) during his time working for the NHSE, had learned what pharmacy could offer in terms of a range of skills which could be provided from the site where services are available to patients. He said:

'As far as health authorities are concerned, it's not so much a cost argument, as one of getting the maximum value for money.'

He felt that one of the main barriers was that of communication between doctors and pharmacists, brought about by the lack of recognition of the community pharmacist as an integral member of the Primary Health Care Team. He said:

'This should be addressed as a matter of some urgency... do you have plans to address this problem?'

Mr. Curphy:

'We need to start a dialogue with heads of schools of pharmacy for a built in baseline, with regard to the need to encourage undergraduates well ahead of the need to communicate with GPs. Discussions should
also take place with the Education Division of the RPSGB, to encourage practising pharmacists to make an effort to build good rapport with the local GP.'

Mr. Ferguson regarding Dr. Spencer's point about 'skills', referred to the range of courses available through the RPSGB and passed across a booklet on this to the Chairman.

Dr. Hawksworth was firmly of the view that the medicines management service should be encouraged, without pharmacists being put off by either major cost, or major examinations. She also pointed to the problems that exist where a medicines management service would be provided in a pharmacy and the pharmacist owner was absent. She felt, therefore:

'locum pharmacists must also be targeted for the provision of the service, and given some training.'

SUMMARY

The Chairman summarised this part of the discussion by saying that there appeared to be general agreement that there was a need for a structured programme of education and training for community pharmacists, as defined at present, and that this was a major issue on which the RPSGB would undoubtedly be able to give guidance and oversee / co-ordinate the various options.

'Clearly, the operating relationship between doctors and pharmacists needs careful priority address, as suggested by Dr. Spencer. This can either be a major facilitation of the proposed new service, or indeed a major barrier to progress.'
3. THE WAY FORWARD

CHAIR:

'We have looked at some of the issues involved in preparing the profession for this role. What do you feel is the best way of taking things forward?'

The meeting then turned to a general discussion relating to bringing pharmacists and doctors together.

Mr. Curphy opened the discussion by asking:

'How far are we prepared to go with the detail of any pilot work? For example, are we talking about taking blood pressure readings or samples? If so, what action should the pharmacist be prepared to take – to refer to the GP, or to be more proactive in changing dosages?'

Ms. Dutton expanded on this point by asking:

'Will the pharmacist take full charge or responsibility for the care of the patient?'

CHAIR:

'That is not what is envisaged at present. We need to bear in mind the role of the doctor.'

Professor Mackie took up the issue saying:

'It is easy to 'cherry-pick' the simpler items of medicines management and devise protocols for them. The danger of this is that others could also do it, such as nurses; blood pressure monitoring is a very good
example. However, if blood pressure monitoring leads to the changing of drug regimens, this would be a task which the pharmacist alone would be properly fitted for... but it's not taking full charge of the patient.'

She envisaged a movement to self-management by patients, together with the pharmacist’s support, as the pharmacist had an advantage over all other health professionals, due to the knowledge of the interactions of drugs, both NHS and OTC, and multiple disease states.

Dr. Hawksworth considered that the management of medicine should be linked to an ongoing monitoring process within the pharmacy. Dr. Spencer pointed to the importance of the service being patient-focused. He made the point:

'A Primary Care Group is an administrative group, but the pharmacist should be an integral part of the Primary Health Care Team. It is important to distinguish between Primary Care Groups, on the one hand, and the service provided through the Primary Health Care Team, on the other.'

Ms. McCreedy raised the issue of the definition of 'Medicines Management' by saying that the PSNC definition clearly included prescribing support, whereas the NPA felt that the definition within the PSNC's document was more akin to pharmaceutical care. The Chairman indicated that this was an issue that would need to be examined again by the Group and agreement reached on a universally acceptable definition. He asked:

'Is it your view that on this issue, in particular, the profession should speak with one voice?'

A discussion then took place with regard to terminology, in particular:

- medicine management
- compliance
- pharmaceutical care
Different members favoured different expressions and the matter was left for further discussion.

Mr. Curphy stated:

'Terminology will be a matter to be resolved through the Joint Steering Group when it meets.'

4. OUTCOMES BENEFICIAL TO STAKEHOLDERS

CHAIR:

'Perhaps we could now move on to another important issue; what outcomes of medicines management do you feel are important to the stakeholders?'

(No guidance was given on who the stakeholders may be; views were left to emerge)

The meeting then turned to the discussion of outcomes. Mr. Curphy felt that these were key to the whole process and that, ultimately, the payment to pharmacy contractors would solely depend on outcomes:

'We should be looking at outcomes for patients, doctors and any other beneficiary we can think of.'

(The indication here was that a range of stakeholders needed to be identified)

Ms. Dutton asked how these outcomes might be defined and suggested that it would be necessary to have appropriate 'proxies'. The following suggestions were made:

• the impact of services on drugs budget (Mr. Baumber)
• reduced admissions to secondary care (Mr. Ferguson)
• patient and users' views, such as doctors and nurses (Dr. Hawksworth)
• surrogate markets (Ms. Dutton)

As regards the patient / user views, Ms. Dutton said:

'It's very important that this should include satisfied professions, satisfied users and a good financial outcome. Important stakeholders would be, for example:

• Pharmacists themselves
• Patients and Patient's Organisations
• Doctors
• The Department
• Health Authorities.

Professor Mackie referred to the importance of clinical outcomes for the patients and mentioned 'bandolier'. She went on to outline this research project which had been undertaken within her University, where the NHS drug and OTC treatment of patients was examined and, where appropriate, reference was made to the patient's GP. In this particular study, follow-ups were made a year later to confirm the clinical outcome. The project had involved a control group, which was also documented.

Patients within the project were on four or more drugs and the referral rate was 84% on clinical grounds. The GP rejection rate of pharmacist recommendations was only 3%. On average three problems per patient were noted. Professor Mackie indicated that they would shortly be publishing the research, which had been put to the Scottish Office and had been well received. She undertook to let the Chairman have the detailed information.

Some discussion, triggered by Mr. Ferguson, then took place with regard to the cost of pilots. Professor Mackie outlined the cost of the pilot carried out in conjunction with the Scottish Office.
In brief:

- 30 community pharmacists had been trained at a cost of £46,000;
- the training involved 40 hours clinical pharmacy (problem based);
- private study time commitment was 30 hours over 10 weeks;
- the protocol included time within a GP practice over a period of 3 – 6 months; and,
- £20,000 was being made available to progress this project.

She cited an important point that had come out of this project, was the need for full relevant patient information being made available to the pharmacist and the value of an IT link was also identified for the future.

Mr. Curphy asked:

'Will it be possible to undertake medicines management without the full patient information?'

A discussion then took place where various views were expressed:

- formulary advice could be given without specific patient input (Ms. Dutton);

- prescribing advice could also be given without patient records being involved (Mr. Ferguson);

- review of patient medication cannot be realistically undertaken without patient illness history and / or full medication record (Mr. Baumber); and,

- Mr. Williams, likewise, confirmed that concordance issues and identification of side effects could not be identified without patient collaboration.

Dr. Hawksworth felt, however, that it was a prerequisite for an effective system, that teamwork should operate, there should be a full patient profile and ideally, an IT link.
Ms. Dutton referred to teamwork being very relevant to health improvement programmes, which might provide an opportunity to expand upon medicines management and to encompass health promotion.

Mr. Ferguson said:

'This again emphasises the importance of pharmacists being connected to the NHS net, through which a more comprehensive approach can be made.'

Dr. Hawksworth expressed some reservations, based on time involvement of both pharmacist and staff.

Mr. Curphy agreed, saying:

'Technician responsibilities will undoubtedly be on the agenda again, won't they? The onerous supervision requirements of the pharmacist need to be examined.'

CHAIR:

'Ian (Dr. Spencer) what is your view of the role of the health authority in the new pharmacy initiative?'

Dr. Spencer:

'I think health authorities will be very positive in trying to move towards your new role, but currently the situation is in a state of flux for funding. Most of the available finance comes to the health authority through the general medical services budget and some health authorities have facilitators in this area. Funding opportunities will arise if PCGs are organised and accordingly, provided that those doctors at 'grass roots' are convinced of the need of the service and the benefits it brings.'
(In his Authority that benefit was already being used and recognised.)

'It is really a matter for good promotion of the service by your profession.'

Professor Mackie referred to the needs assessment of patients and that this should be proactive by the GP transmitting relevant information to the pharmacist through an IT system. This process, she felt, should be based upon specific groups of patients and conditions, which would automatically qualify for the new intervention. This would be a 'first stage' in the overall process and assist in producing the best outcome.

Turning to the selection of those who might be included in the trials, Mr Curphy suggested that the service may have to grow by starting with those who currently provided elements of medicines management. There would thus be a 'cascade' roll out programme which would also be in line with the uptake of new educational programmes for the service.

Dr. Hawksworth referred to the need for service in all areas, including those where there is, perhaps, only a single pharmacist and a single OP. It was generally agreed that flexibility was necessary in the selection of trialists for any pilot research:

'... I think this should be a country-wide service with all pharmacists able to take part...'  

5. COMMUNICATIONS

CHAIR:

'We have talked through some of the issues in engaging the profession in a new medicines management service. Who should we talk to about this, to progress the initiative and keep the stakeholders informed.'
Dr. Spencer:

'It is important that communication should be initiated at Chief Executive level with the HAs.'

He pointed out that arrangements apply at regional level for meetings between Chief Executives. Meetings with Directors of Primary Care and Directors of Public Health would also be important, to explain the initiative and enlist their support.

There could also be follow up meetings, where the detailed issues need to be picked up and structures laid down. This would involve groups with specialist input.

Mr. Ferguson referred to the relevance of the Society's Steering Group on Research, of which the Chairman of the Medicines Management Working Group is a member. The Chairman agreed that this group could have a pivotal role in co-ordinating pilot work, as all the major pharmaceutical bodies were represented on it. This would form a strong integrated link in a unified effort throughout the profession:

'However, promotion of this self initiative itself would need to come from additional sources. Who might these be?'

Professor Mackie raised the issue of the possibility of a suggestion being made in the Crown Report relating to review of prescribing, which would be very relevant to medicines management and Mr Ferguson said that this would be extremely helpful.

If the communication process is to be effective, it was generally agreed by everyone that GP leaders would need to be informed as soon as possible of the profession's views and enlisted in promoting the service.

Mr. Baumber reported that steps had already been taken by the PSNC in this respect and were of a preliminary nature, through a brief discussion with the GMSC. However, a full focus group meeting with the GMSC was in the process of being arranged by the Chairman, when a thorough discussion would be conducted.
6. NEXT STAGES

CHAIR:

'Is there anything else we should do?'

Mr. Baumber responded by saying that:

'Our own members (community pharmacists) should be brought into the picture as soon as possible and kept informed of progress. In this way, interest can be generated at an early stage and people encouraged to prepare their knowledge base, through training courses and local initiatives in elements of medicines management, such as prescribing advice.'

Mr. Curphy agreed and asked if any preparatory work had been done to look at a communications programme.

CHAIR:

'Some work on a communications programme has been done by the medicines management working group. What are your views on the formalisation of a programme. What do you all feel?'

There was general agreement that a proper programme should be organised and Mr. King suggested a special booklet be prepared for circulation to some of the stakeholders:

'... we need something that describes the process of medicines management as well as its purpose... a small booklet of some sort...'

The Chairman thanked the members for committing their time and interest in attending the Focus Group and for the comments which had all been very constructive and
helpful. He said the next stage was to set up a steering group for the project and that this should be arranged following a meeting between representatives of the PSNC, the RPSGB and the NPA.

The Chairman invited all participants to write in with any further comments or suggestions, following reflective thought on the discussions which had taken place.

The group was closed at 4.15 p.m.
### APPENDIX 12C
(Ref. Chapter 3 : Page 48)

**MATRIX ABSTRACT OF NATIONAL PHARMACY MEDICINES MANAGEMENT LEADERSHIP FOCUS GROUP HELD AT RPSGB ON THURSDAY 4th JUNE 1999, 1.00 PM**

**KEY VIEWS : RPSGB, PSNC, NPA & OTHERS**

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>INFORMANT</th>
<th>Pharmacist Ability</th>
<th>Doctor &amp; Pharmacist Partnership</th>
<th>Introducing the Service into Practice</th>
<th>Communications to Stakeholders</th>
<th>Focus Group Collaboration &amp; Ownership</th>
<th>Critical Mass Achieved</th>
</tr>
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<tbody>
<tr>
<td>A</td>
<td>Training is required; in agreement with F’s views</td>
<td>Pilots are the way forward. Consider outcomes for benefit</td>
<td>Meet with GP leaders soonest. Inform pharmacists as soon as possible</td>
<td>√ √</td>
<td></td>
<td>PSNC</td>
<td></td>
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<tr>
<td>B</td>
<td>Many could do this role. Some will never do it</td>
<td>Start early with schools of pharmacy in building good communication skills with doctors</td>
<td>Agreed with A and F; asked about preparatory work</td>
<td>√ √</td>
<td></td>
<td>RPSGB</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Pharmacists have good skills interpersonal: will adapt to MM very quickly</td>
<td>Pharmacists have good interpersonal skills. Interprofession collaboration necessary</td>
<td>Team work is necessary; pharmacist and G.P.</td>
<td>Agreed with F</td>
<td>√ Not applicable but committed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Impressed with H’s point and referred to RPSGB courses</td>
<td>Agreed with H’s comment RPSGB has skills courses. Produced a booklet</td>
<td>Connect the professions via the NHS net</td>
<td>Use joint research group as base for communication. Start within the pharmacy profession</td>
<td>√ √</td>
<td>RPSGB</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>MM requires life long learning. The place is the community pharmacy</td>
<td>Locums as well should be trained – response to H’s point, i.e., GP + pharmacy partnership</td>
<td>Team work is essential</td>
<td>Agreed with F</td>
<td>√ √ RPSGB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Special training will be required – courses are available</td>
<td>Do not have access to all medical information of patients – very important</td>
<td>Examples of pilot work given from Aberdeen</td>
<td>Inform GP leaders soonest. Use Crown Report as a possible basis</td>
<td>√ √</td>
<td>Not essential to critical mass but important</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Experience in repeat script trials shows pharmacists can build abilities</td>
<td>Interpersonal skills are very important</td>
<td>Agreed with F</td>
<td></td>
<td>√ √ NPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Impressed with skills already in this area now being used by pharmacists</td>
<td>Doctor and pharmacist collaboration / communication is urgent. Have wearing plans?</td>
<td>Integrate the pharmacist into primary care team. Focus on the patient service</td>
<td>Should initiate at Chief Exec level, Health Authority. Also primary care directors</td>
<td>Ownership committed at local level</td>
<td>Not applicable but committed</td>
<td></td>
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</table>

**CODE**

A = Baumber  
B = Curphy  
C = Dutton  
D = Ferguson  
E = Hawksworth  
F = Mackie  
G = McCreedy  
H = Spencer  
MM = Medicines Management

RPSGB = Royal Pharmaceutical Society of Great Britain

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APPENDIX 13A
(Ref. Chapter 3 : Page 48)

FOCUS GROUP – CODES
(Medico-Pharmaceutical)

MEDICAL

Dr. George Rae
(Chairman Practice Sub-Committee) A

Dr. John Chisholm
(Chairman GPC) B

Dr. Hamish Meldrum
(Chairman Rural Sub-Committee) C

PHARMACEUTICAL

Mr. R. Carrington
(Chairman Co-op Pharmacy Technical Panel) D

Mr. A.M. Tweedie
(Chairman PSNC Strategy Sub-Committee) -

Mr. S.R. Axon
(Secretary) E

Mr. W. Dove
(Chairman PSNC) F
APPENDIX 13B
(Ref. Chapter 3: Page 48)

MEDICO-PHARMACEUTICAL LEADERSHIP FOCUS GROUP
14th January 1999 at 4.00 p.m.

MEMBERSHIP

Medical
Dr. John Chisholm (Chairman GPC) B
Dr. George Rae (Chairman Practice Sub-Committee) A
Dr. Hamish Meldrum (Chairman Rural Sub-Committee) C

Pharmaceutical
Mr. W. Dove (Chairman PSNC) F
Mr. R. Carrington (Chairman Co-op Pharmacy Technical Panel) D
Mr. A.M. Tweedie (Chairman PSNC Strategy Sub-Committee) -
Mr. S.R. Axon (Secretary) E

FORMAT – SEMI-STRUCTURED

Background delivered by A.M. Tweedie: Origins of Proposed Pharmacy New Role

• Minister of State for Social Services 1981 (Dr. Vaughn)
• The growing complexity of medicines
• The new M. Pharm. degree for entry to Pharmacy
• White Paper 1997 emphasising partnerships in primary care
• Widespread collaboration already on ad hoc projects locally
• Elements of core service handed around on sheets
Question 1

What is our general view of the sort of service doctors may see pharmacists fulfilling in the near future, bearing in mind recent Government policy on health care?

Question 2

What inter-professional relationship issues, do we see as being important in new collaborative work between our two professions?

Question 3

What do we feel are the resource implications for future collaborative work such as described in our introduction?

Question 4

If doctors and pharmacists do engage in a new service together, what do we see as the main issues to be addressed, not already mentioned?

Question 5

How do we feel progress could be made toward such joint goals as may be agreed?

Question 6

Do we feel that, if a joint proposition could be achieved, then a proposal could be taken to the Secretary of State for Health:
a) separately?
b) jointly?

**Question 7**

What may be the difficulties for Government in:

a) a separate approach?
b) a joint approach?

**Question 8**

Do we see any education / training issues inherent in such a proposition for joint working of the two professions?

**Question 9**

If a new role for pharmacy was agreed, what outcomes would our medical colleagues see as being crucial?

**Question 10**

How may we progress matters from here?
APPENDIX 13C
(Ref. Chapter 3 : Page 48)

MEDICO-PHARMACEUTICAL LEADERSHIP FOCUS GROUP
14th January 1999 at 4.00 p.m.

ABSTRACTED

Abbreviations

<table>
<thead>
<tr>
<th>GP</th>
<th>General Practitioner (Medical)</th>
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<tr>
<td>PCG</td>
<td>Primary Care Group</td>
</tr>
<tr>
<td>GPC</td>
<td>General Practitioner Committee</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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</table>

MEMBERSHIP

Medical

Dr. John Chisholm (Chairman GPC) B
Dr. George Rae (Chairman Practice Sub-Committee) A
Dr. Hamish Meldrum (Chairman Rural Sub-Committee) C

Pharmaceutical

Mr. W. Dove (Chairman PSNC) F
Mr. R. Carrington (Chairman Co-op Pharmacy Technical Panel) D
Mr. A.M. Tweedie (Chairman PSNC Strategy Sub-Committee) -
Mr. S.R. Axon (Secretary) E

FORMAT – SEMI STRUCTURED : NOTES

Background delivered by A.M. Tweedie: Origins of Proposed Pharmacy New Role

- Minister of State for Social Services 1981 (Dr. Vaughn)
• The growing complexity of medicines
• The new M. Pharm. degree for entry to Pharmacy
• White Paper 1997 emphasising partnerships in primary care
• Widespread collaboration already on ad hoc projects locally
• Elements of core service handed around on sheets

Purpose of Meeting:
To explore views on future collaboration based on the proposed core service.

The following questions were asked by Mr. A.M. Tweedie

**Question 1**  *What is our general view of the sort of service doctors may see pharmacists fulfilling in the near future, bearing in mind recent Government policy on health care?*

Dr. B: I think there is an awful lot of collaboration out there already with all sorts of schemes. I think usually that we receive help on formulary work and general advice on generics usage. What do you think George?

Dr. A: I think that’s right John and in my practice my local pharmacist does quite a bit of work on compliance... but unofficially, I believe. We don’t have a system of formal collaboration.

Mr. D: Do you come across such issues as adverse drug effects or iatrogenic reactions?

Dr. B: All the time, I’m afraid the pharmacist usually rings me and keeps me right.
Dr. C: I think I’m mainly concerned with compliance issues, but we don’t seem to have any systematic way of looking at this. Perhaps what is needed really is a more formal system to record problem areas.

Mr. Tweedie: Looking at the collaboration which already exists, do you feel that there is now a case to perhaps formalise some of this into a systematic review of medicines effects, particularly say, for the chronically ill whose prognosis often changes?

Dr. B: I think that must be right, certainly the way health care is now going with a more structured approach. The PCGs certainly need advice right now on all sorts of issues, ranging from economic drug usage, to perhaps a more formal approach to specific disease treatment... after all, we in general practice are going to be required to collaborate with other members of our profession in adjacent practices... that needs bringing together somehow.

**Question 2** What inter-professional relationship issues, do we see as being important in new collaborative work between our two professions?

Dr. A: I think one of the main issues here is proper agreement about the way any new collaborative effort will work. How would reporting be organised between doctor and pharmacist? And who would set the agenda?

Dr. B: Yes, we would need to look carefully at the issues involved... what we don’t want is a lot of extra paperwork to clog up the system. I think the main point really is agreeing what your new proposals would involve and then prioritising them for each practice. Each practice will have its own view on priority diseases and care needs to be exercised not to try to impose some sort of rigid view...
Dr. C: Yes, it would be important to get agreement from each practice on what the priorities are. A different focus may need to be taken at different times of the year.

Mr. E: Do you mean by that, reviewing a range of diseases in sequence?
Dr. A: Yes, I think so. It would also depend, I suppose, on the government’s priorities. They have targeted a number of diseases to be addressed to bring better results. There’d probably need to be a core service tweaked for local needs.

Dr. C: We would need to sit down together to look at the troublesome issues involved in all medication. You know the sort of thing...side effects, drug reactions, and, of course, the old issue of compliance. How would you do all this anyway? It sounds like a lot of time and effort.

Mr. E: *(Question 3)* This really leads us into the problem of resources doesn’t it? I was going to ask what you felt might be the resources involved at your end, for a collaborative project such as the one we described at the beginning of the meeting?

Dr. A: Yes, I agree with Hamish. We don’t all want to be buried in paper that never gets looked at. How would you see this being handled?

Mr. F: I think what we had in mind was interviewing patients individually and only recording the problems rather than the norm. We could consolidate such reports and deal with special patients at a practice meeting... what do you think?

Dr. B: It’s obviously something we need to think about... that is, if we could get through the Committee. We all realise the need for good prescribing... and drugs are becoming more complex... and the alternatives keep increasing. I think we would want to see probably a fully worked proposal for trying some of the ideas out and see if we could get something going. *(Question 4)* We probably need a proper trial with
some idea of the paperwork and some means of review so that we all made best use of time. As we have said, surgeries are getting busier and the workload increases.... How many practices are you thinking about? (Question 5)

Mr. Tweedie: We think that for this to be meaningful we should look at a spread of practices across the country, perhaps picking samples of urban and rural practice and also maybe specialised health centres as well as inner cities. Could this be arranged, say through the RCGP?

Dr. B: That’s quite a good idea... and certainly there will be people within the network who already work with pharmacists from time to time... should we do that or would you?

Mr. Tweedie: Perhaps we could do that together and in preparation I could visit the RCGP to explore some possibilities and outline the service we have in mind.

Dr. A: I have one or two contacts there, Allen and I can have a chat with you back north... maybe you could give me a ring and we could meet. As a matter of fact, I wrote a short paper on pharmacist / GP collaboration and I could let you have that as well...

Question 6  Do we feel that, if a joint proposition could be achieved, then a proposal could be taken to the Secretary of State for Health:

a) Separately?
b) Jointly?

Dr. C: We’d need to give that some thought. There are a few things on the general health agenda right now and if we’re not careful some confusion may arise. Perhaps this is a subject we could discuss when we are a little further forward with our discussions on some joint collaboration?
Yes, the ‘round table’ meeting called by the Secretary of State last September, suggested that pharmacist prescribing is also on the agenda. Where does your proposal fit in with this? The GPC is not likely to be entirely negative about this, but I cannot predict the outcome of the Crown Report which will enlarge this debate. I think we have a positive feeling overall with what you are saying today – there are many constructive examples of collaboration in practice already and the Glaxo Innovation Award comes to mind, when we submitted joint examples of collaboration to them.

Mr. Tweedie: Thank you. That gives us a steer of what may lie ahead and I wonder if you perhaps see any difficulties for Government at this stage in going for a separate or joint approach to them? (Question 7)

I think we could probably jointly see the Department on the project you have in mind, but as far as remuneration goes, I think we would need to keep that separate.

Dr. A: The new sort of formal link up with the two professions you’re proposing will certainly need some briefing and training in getting GP practices to work with community pharmacists... but I think educational requirements will be minimal on our side. You people will know what sort of extra educational training you require and as long as we are assured that you are fully able to the new job, that’s all we need.

Dr. B: We need to be careful to do things in close collaboration if such a service becomes a real proposition nationally. I think the local medical committees and pharmaceutical committees need to work much closer together.
Mr. Tweedie: Yes, I agree. When we get into the nitty gritty of medicines management as we see it, I think we would expect the doctors to set out appropriate protocols and parameters to link the two professions on an ongoing basis. There shouldn't be any problems here at all. The way we see it, the doctor will become director of a new service which will give him much greater support in medicines selection and review, and, of course, the patient will get greater benefit out of their treatments.

Dr. A: There's no question about it... the sort of stuff you are talking about... if it can be targeted at compliance issues, as well as side effects and the like, will make a big contribution to patient response. I reckon between 30 – 50% of patients don't take their medicine correctly. I can see, however, that access to medical records may be a problem. Maybe more than education and training, we need things like relationship building and trust...

Mr. Tweedie: Thank you and if we could perhaps pick up that theme of relationship and trust in this question...

**Question 9** If a new role for pharmacy was agreed, what outcomes would our medical colleagues see as being crucial?

Dr. B: I think fairly obviously we would want to see measurable results... on the items we would both agree to look at. This could be at this level and local issues agreed with the PCGs.

Dr. C: We need to look at how to get the patient to take the right medicine in the right way, without increasing problems for the patient or increasing bureaucracy in the system.

Mr. Tweedie: Do you feel that practice meetings would help in jointly developing the outcome measures on a practice basis?
Dr. B: This would certainly ease our workload and cut the paperwork down... I suppose, though, we would need some national measures which could apply across the board... practice level, of course, is where the effort is needed to make things work for the patient.

Dr. C: There are, I'm sure you know, pharmacist advisors already in health authorities, but advice from a commercial background would be useful from a drug budgeting point of view... but we would expect savings in drug bills to be ploughed back into patient care...

Dr. B: The pharmaceutical advisor's role could overlap with the one you are proposing at practice meetings for your people... but, of course, the role you propose with the patient is a different matter altogether... you are certainly best placed for that.

Dr. A: I think overall we'd want to be able to see that patients were taking their medicines properly and keeping the drug cost under control. Patients do respond differently over a period of time on long term medication and we could look at that... for adjustments and updating... we could also look at health gain measures if we keep it simple. Do you have anything of a more specific nature in your proposal?

Mr. Tweedie: We are currently producing a booklet which outlines the whole service and perhaps we could let you have a final draft of this to look at and you might even wish to add a few paragraphs of your own, if your committee feels it can take these proposals forward on the lines we have discussed.

Dr. B: That's a nice idea... if you could let us have that within two weeks we can put it to our practice committee... if we miss that date, then the next slot is in five weeks time.

Mr. Tweedie: We'll do our best to get that to you within the two week time frame.
**Question 10  How may we progress matters from here?**

Dr. B: We’ll discuss your proposals at our next committee meeting, but I think we can say (looking to left and right) that we’re pretty well sold on the idea.

Dr. A: Yes, the pharmacist will be taking on new responsibilities, but the GP will not be devolving overall responsibility for the patient. To some extent we’ll all have to manage our time a bit better, but we are getting busier and busier and it would be very helpful if the pharmacist could provide the sort of information we’ve talked about to the patient. It’s not so much a transference of a role, from us to you, but a question of plugging the gaps. I’m disappointed that the pharmacist is not included automatically in the primary care groups, but it’s not critical.

Dr. C: I would just like to confirm that there would not be commercial involvement of drug companies?

Mr. D: The only involvement we see, at present, is that the industry may be useful for sponsoring joint meetings at local level... they will not have any part in the process of medicines selection or prioritisation for disease groups.

Dr. B: I’m glad to hear that... it’s a sensitive issue you know... I think we’ve had a very positive meeting and I look forward to receiving your document in due course.

Mr. Tweedie: Thank you for the time you have all spent in discussing this most important issue. We, for our part, look forward to progressing the proposals with you and perhaps we could meet again after I’ve seen the RCGP.
Summary

The focus group can only be described as positive, in atmosphere and approach by the medical members. Collaboration was a central theme of the doctors overall attitude, together with a tacit assumption of doctor lead in the new process. Doctor autonomy, or in Maslow’s terms of self actualisation and esteem, were clear implications in some of the question responses.

Clearly, care must be taken to preserve the doctors’ perception of the lead role in patient care and to ensure that pharmacist initiatives are, at the very lest, joint endeavours contextualised as support service rather than an independent intervention. A potential barrier to change in the GP network could well be increased paperwork and workload. A product design, (Chapter 4) should now take account of this, making the new prospect user friendly.

This holds promise for the future and perhaps even the possibility of engaging the three prominent members of the GPC, as sponsors and leaders of the change process. Message source and opinion leadership, (Chapter 4) may be pursued with the GMC at a later stage.

The Chairman of the GPC specifically requested total confidentiality in view of the sensitive nature of the discussions and the need to consult further with his committee. This guarantee was given.

Meeting closed 5.28 pm.
APPENDIX 13D
(Ref. Chapter 3 : Page 48)

MEDICO-PHARMACEUTICAL LEADERSHIP FOCUS GROUP
CONTENT ANALYSIS

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>GPC</td>
<td>General Practitioner Committee</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>PCG</td>
<td>Primary Care Group</td>
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Introduction

Key themes have been extracted from the discussion recorded in Appendix 13C - completed, and are set out below under the respective questions 1 – 10. There was, overall a collaborative spirit from the members of the GPC group, tempered with caution. No particular barriers to progress were apparent, but there were a number of issues which, on analysis, are judged to be important to maintaining the co-operative stance.

The following analysis is set out in abbreviated summary form, covering the main points and reinforced by quotation where this is deemed to be helpful.

A summary of the meeting draws the main points together at the end of the analysis.

Analysis

**Question 1**  What is our general view of the sort of service doctors may see pharmacists fulfilling in the near future, bearing in mind recent Government policy on Health Care?
Key Themes - GP recognition of present level of inter-professional collaboration
- Importance of compliance issues
- Formulary and drug effects tasks

**Question 2** What inter-professional relationship issues do we see as being important in new collaborative work between our two professions?

Key Themes - Inter-professional collaboration
- Doctor dislike of added paperwork / workload
- Strong hints of doctor autonomy

Dr. A... *Proper agreement about the way... collaborative effort will work.*

Dr. B... *Each practice will have its own view on priority diseases and care needs.*

Dr. C... *important to get agreement from each practice.*

**Question 3** What do we feel are the resource implications for future collaborative work such as described in our introduction?

Key Themes - Dislike of *paperwork* and *workload* (trial suggested by Dr. B).
- Interprofessional collaboration
- Agreement reached to approach RCGP for trialists

**Question 4** If doctors and pharmacists do engage in a new service together, what do we see as the main issues to be addressed, not already mentioned?

**Question 5** How do we feel progress could be made toward such joint goals as may be agreed?
The above two questions were subsumed by Question 3 and were not pressed individually having received firm indication of the way forward.

**Question 6**  Do we feel that if a joint proposition could be achieved, then a proposal could be taken to the Secretary of State for Health:

a) Separately?
b) Jointly?

d) Jointly?

Key Themes - Overall response was hesitant – the issue was portrayed as too far ahead. It was, therefore, not pursued.

Collaboration still pursued.

**Question 7**  What may be the difficulties for Government in:

a) A separate approach?
b) A joint approach?

Again response was understandably brief and related to Question 6. However, Dr. B. briefly replied:

... I think we could probably see the Department jointly on the project you have in mind, but as far as remuneration goes, I think we would need to keep that separate.

Key Themes - Collaboration accepted.

**Question 8**  Do we see any education / training issues inherent in such a proposition for joint working of the two professions?

Key Themes - Doctor autonomy (self esteem)
Dr. A...educational requirements will be minimal on our side... you people will know what extra educational training you require... as long as we are assured you are fully able to do the job...

- Collaboration between the two professions.
- Relationship building.

(Dr. A. further responded by again citing patient compliance as a major issue and in passing also mentioned relationship building and trust as matters to be considered.)

**Question 9** If a new role for pharmacy was agreed, what outcomes would our medical colleagues see as being crucial?

**Key Themes** - Interprofessional collaboration; joint medical / pharmaceutical approach.

- Doctor autonomy.
- Workload / paperwork apprehension.

**Question 10** How may we progress matters from here?

**Key Themes** - Referral to BMA main committee.

- Dr. A. stressed that the GP would not be devolving responsibility for patient care. The proposed new pharmacy intervention would be...plugging the gaps... in present service.

- Doctor leading role / autonomy (self esteem)
- Doctor workload increasing.
Summary

The doctor element of the focus group, positively and collaboratively viewed the subject as a practical dynamic, rather than a static intellectual discussion. As leaders of their profession, the doctors concerned were happy to suggest ways forward through piloting the scheme and engaging a joint intervention, rather than regarding the new proposition as a solely pharmacist initiative.

Doctor autonomy underpinned the GPC approach as exemplified in the responses to questions 2, 8 and 10 which lay at the beginning and end of the focus group.

Patient compliance again emerged as a substantial issue which was also reflected by the key informants and clearly represents a comfortable area for the doctor where the pharmacist could play a part. Also like the key informants, the focus group perceived the issues of drug interactions and adverse reactions as potential pharmacist responsibilities. Likewise, formulary development and drug economies, but therapeutic decisions clearly are perceived as the domain of the doctor. This supports the research by Sutters and Nathan, (Chapter 3 : 23).

It was also interesting that there seemed to be a willingness to jointly approach the DH in discussing the principle of the proposition, but not unreasonably the doctors did not see discussion progressing to matters of remuneration.

A potential product deficiency emerged in discussions... increased paperwork and workload. The product design, (Chapter 3 : 35) must take account of this and in doing so perhaps become a determinant product benefit, (Chapter 3 : 33, 35). Otherwise it may become a significant barrier to change.

As leaders of the medical profession, the doctors partaking in the focus group could subsequently become a key message source and leaders in opinion forming and, indeed, sponsors of the new proposition. This will be borne in mind when relating the whole study to the marketing discussion in Chapter 3.
PILOT SURVEYS

Purpose: To expose any anomalies in question phrasing, questionnaire instructions and receive feedback for any suggested amendments to these, as well as response categories.

General Practitioner Survey (Appendix 14)

For GPs, an initial sample of 150 was randomly selected by the computer and posted to GPs on 19th February 1999. As this was a pilot, no follow up mailing was sent out. Of 79 responses, notes on the introductory letter indicated:

- One GP had died
- Two GPs had retired
- One GP declined to partake
- Two GPs had moved into hospital work from general practice

The resulting 73 respondents' returns, were analysed for comment, regarding the issues listed in purpose above. From this, the following amendments were made and the final survey (1000 GPs) adjusted accordingly:

Response categories were tightened up e.g. Question 16 pilot ‘... how important is the patient's perception of that quality?’

Pilot: ‘very important’; ‘quite important’; ‘hardly important’; ‘not important’
Changed to: ‘important’; ‘relatively important’; neither ‘important’ nor ‘unimportant’; ‘relatively unimportant’; ‘unimportant’.
An addition was made to the list of problem elderly patients may well have with medicines:

'remembering to take the medication'

Two questions were added:

Question 7 'What is the source of your pharmacist help?'

Question 15 'Do you feel the pharmacist should become a formal part of the doctor's team, addressing selected items, agreed by you?'

Community Pharmacy Survey (Appendix 15)

The same procedure was adopted for Newcastle Local Pharmaceutical Committee (14 members), also by prior arrangement with the secretary. On this occasion, the author introduced the draft questionnaire before handing it out, as:

'... a random survey to be posted to 850 independent community pharmacists in England and Wales, seeking their views on aspects of the new medicines management role proposed for community pharmacy...'

The LPC are likewise politically representative of community pharmacists but also represent 'company chemists' and co-operatives.
APPENDIX 16
(Ref. Chapter 3 : Page 50)

RANDOM SAMPLE OF GPs ENGLAND AND WALES
POSTAL SURVEY : Letter and Form
(1,000 GPs)
Dear Doctor

RECENT GOVERNMENT WHITE PAPERS -
DOCTOR & PHARMACIST COLLABORATION
SURVEY OF GP'S: ENGLAND & WALES

You will be aware of recent Government White Papers and documents, which set out possibilities of new collaboration between the health care professions. With the advent of the new PCTs, the potential for collaboration between doctors and pharmacists is substantial.

Your views are being sought on potential elements of such services and some of the implications. Could you please spend a few minutes completing the enclosed questionnaire and return this in the business reply envelope.

The questionnaire is strictly confidential and there is no need to record your name or address. You have been selected at random as one of 1,000 doctors chosen for this research.

We appreciate that there are many demands on your time these days, but your assistance here will greatly help in addressing the future. Your answers will make an important contribution to this research, the general results of which will be published early next year in the medical and pharmaceutical press.

Thank you for your time and help.

Yours sincerely

Dr Ken Megson BSc (Hons) MB BS MRCGP DRCOG DCH DMJ
Secretary – General Practitioners Committee, Northumberland/Tyne & Wear

Allen Tweedie MA MBA FRPharmS FCIM FRSH
Chairman – Medicines Management Leadership Group

Ian F. Jones
Professor of Pharmacy Practice, University of Portsmouth

www.port.ac.uk
Dear Doctor

DOCTOR & PHARMACIST COLLABORATION
SURVEY OF GPs ENGLAND & WALES

This is a ‘follow up’ letter intended for those doctors who have not yet replied to the first circulation of this survey sent three weeks ago.

For serious research in this field it is standard practice to send a second copy to encourage those who have not responded to do so now. The initial response has been very encouraging and if publication of our results in the medical press next year is to be seriously meaningful a high response to this survey is both important and necessary.

We believe that your collective views can make a valuable contribution to the future development of NHS medical and pharmaceutical services.

Please find time to complete and return this survey.

To those who have already completed and returned our survey – many thanks – and please discard this second circulation.

Thank you for your time.

Yours sincerely

Dr Ken Megson BA (Hons) MB BS MRCGP DRCOG DCH DMJ
Secretary – General Practitioners Committee, Northumberland/Tyne & Wear

Allen Tweedie MA MBA FRPharmS FCIM FRSH
Chairman – Medicines Management Leadership Group

Professor Ian Jones
Professor of Pharmacy Practice, University of Portsmouth
NEW PARTNERSHIPS IN PRIMARY CARE?

SURVEY OF GPs

Conducted by: Allen Tweedie, Ken Megson & Ian Jones
(University of Portsmouth)

Note: This questionnaire is designed to assist us obtain information which will help steer the way forward into new collaboration between doctors and pharmacists in managing aspects of patient's medication. Please tick the appropriate boxes, unless otherwise indicated.

SECTION A

This section consists of some brief questions of detail about your practice and some pharmacist and patient issues.

Question 1 Please state the number of doctors in your practice ........................................

1.1

Of these, how many are partners? .................................................................

1.2

Question 2 Is your practice a dispensing practice?  Yes  No

2.1 2.2

Question 3 Approximately how many patients are in your practice? ..........................

Question 4 Please tick the age groups you all come within

20-under30  30-under40  40-under50  50-under60  60+

4.1 4.2 4.3 4.4 4.5

Question 5 Broadly, how would you describe the frequency with which you contact a dispensing pharmacist?

Very often  Often  Periodically  Rarely  Never

5.1 5.2 5.3 5.4 5.5

Question 6 Do you have a pharmacist work for you in the practice?

Full Time  Regular  Periodically  Rarely  Never

6.1 6.2 6.3 6.4 6.5

If you answered 'Never', please go to question 8.
Question 7  What is the source of your pharmacist help?

Health Authority  PCT  Dispensing Pharmacist

7.1  7.2  7.3

Peripatetic Pharmacist  Pharmacist member of your own staff  Other – Please specify

Question 8  If you answered ‘Never’ to question 6, would you like a pharmacist to work with you in the future?

Full Time  Regular Part Time  Periodically  Never

8.1  8.2  8.3  8.4

Question 9  Please indicate the frequency with which you encounter the following medicines problems with patients.

Troublesome Side Effects  Very Often  Often  Periodically  Never

9.1  9.2  9.3  9.4

Drug Interactions

9.5  9.6  9.7  9.8

Adverse Drug Reactions

9.9  9.10  9.11  9.12

Patient non-compliance


Poor response to treatment


Elderly patient confusion


Food & Drug interactions

9.25  9.26  9.27  9.28

NHS drugs & pharmacy medicines interactions

9.29  9.30  9.31  9.32
Question 10  Please indicate what you believe to be the incidence of the following the potential problems elderly patients may have with medicines

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<thead>
<tr>
<th></th>
<th>Very Often</th>
<th>Often</th>
<th>Periodically</th>
<th>Never</th>
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</thead>
<tbody>
<tr>
<td>Capsule/Tablet Size</td>
<td></td>
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<td>10.1</td>
<td>10.2</td>
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<td>10.4</td>
</tr>
<tr>
<td>Calendar packs</td>
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<tr>
<td></td>
<td>10.5</td>
<td>10.6</td>
<td>10.7</td>
<td>10.8</td>
</tr>
<tr>
<td>Frequency of dose</td>
<td></td>
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<td></td>
<td>10.9</td>
<td>10.10</td>
<td>10.11</td>
<td>10.12</td>
</tr>
<tr>
<td>Multiplicity of drugs</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>10.13</td>
<td>10.14</td>
<td>10.15</td>
<td>10.16</td>
</tr>
<tr>
<td>Remembering to take the Medication</td>
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<td></td>
<td>10.17</td>
<td>10.18</td>
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<tr>
<td>Taste of Medication</td>
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<td></td>
<td>10.21</td>
<td>10.22</td>
<td>10.23</td>
<td>10.24</td>
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<tr>
<td>Other: Please state briefly</td>
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SECTION B

This section contains questions relating to Government policy in the ‘New NHS’ and an enhanced doctor/pharmacist working relationship. Please tick the box that most closely reflects your views.

Question 11  Government seem to be encouraging pharmacist/GP collaboration on aspects of medication review. Do you agree with this approach? (The detail is in the next question.)

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
<td>11.4</td>
<td>11.5</td>
</tr>
</tbody>
</table>

If you ticked box 11.4 or 11.5, please go to question 13.
Question 12. If you ticked any box from 11.1 to 11.3, which of the following items do you think a pharmacist could assist you with? (Please tick all appropriate boxes)

12.1 Comparisons of equivalent medicines’ costs
12.2 Patient compliance
12.3 Drug interactions
12.4 Replacing brands with generics
12.5 Choice of medicines
12.6 Advice to patients on food and drug interactions
12.7 Advice to patients on pharmacy medicines & NHS drug interactions
12.8 Optimum pack sizes
12.9 Review of number of drugs taken
12.10 Help with identifying sub-therapeutic dose levels

Question 13. If you ticked boxes 11.4 or 11.5 in question 11, please outline your reason here.

................................................................................................................................................
................................................................................................................................................

Question 14. If a pharmacist worked with you to undertake a patient review of those medication issues agreed by you, how frequently should this be done for those on long term medication?

Monthly □ Bi-monthly □ Quarterly □
14.1 14.1 14.3

Four Monthly □ Six monthly □ Other: Please specify □
14.4 14.5 14.6

Question 15. Do you feel the pharmacist should become a formal part of the doctor’s team, addressing selected items agreed by you?

Yes □ Uncertain □ No □
15.1 15.2 15.3
SECTION C

This section contains questions relating to some health care issues arising from Government White Papers in recent years. Please tick the box that most closely reflects your view.

Question 16 The quality of patient care in general practice may be very good, even though the patient may not be aware of that quality. How important is the patient’s own perception of that quality?

Important    Relatively important    Neither important nor unimportant    Relatively unimportant    Unimportant
☐           ☐                  ☐                              ☐                           ☐

Question 17 Quality of care and clinical excellence are recurrent themes in the White Papers. What is your perception of patient expectations of health care over recent years?

Greatly Increased    Somewhat Increased    No change    Somewhat Decreased    Greatly Decreased
☐                   ☐                           ☐                  ☐                           ☐

Question 18 Patient’s perception of quality of care may be a factor in their commitment to the therapy. Do you agree?

Strongly Agree    Agree    Neither agree nor Disagree    Disagree    Strongly disagree
☐                  ☐                  ☐                           ☐                           ☐

Question 19 Patient perception of your overall service could be enhanced by a pharmacist medicines review service, directed by you. Do you agree?

Strongly Agree    Agree    Neither agree nor Disagree    Disagree    Strongly Disagree
☐                  ☐                  ☐                           ☐                           ☐

Question 20 Please indicate in which of the following locations your practice is based.

City Centre    Town Centre    Suburban    Rural
☐                  ☐                  ☐                           ☐

Thank you for taking the time to help with this important survey of issues. The information will be treated in strict confidence and used only for general statistical purposes.
If you have any further information that you think might be useful to the aims of this research please use the space below to explain.
APPENDIX 17
(Ref. Chapter 3 : Page 50)
RANDOM SAMPLE OF PROPRIETOR PHARMACISTS
ENGLAND AND WALES POSTAL SURVEY : Letter and Form
(750 Pharmacists)
Dear Colleague

DOCTOR & PHARMACIST COLLABORATION
SURVEY OF INDEPENDENT PHARMACY
PROPRIETERS: ENGLAND & WALES

You will be aware of government publications that set out possibilities of new collaboration between the health care professions. As part of an ongoing research programme at this School of Pharmacy your views are sought on potential elements of such collaboration and some of the implications. Your pharmacy is one of approximately 800 independently owned pharmacies selected from the RPSGB Register of Pharmacy Premises.

Could you please spend a few minutes completing the enclosed questionnaire and then return it in the business reply envelope. The survey is strictly confidential and there is no record of your name or address. Your answers will be used for general statistical purposes only and the results will be published in the medical and pharmaceutical press early next year.

We appreciate that there are many demands on your time these days but your assistance will greatly help in addressing the future – particularly for the independent pharmacy proprietor. Your answers will make an important contribution to this research.

Thank you for your time and help.

Yours sincerely

Allen Tweedie MA., MBA., FRPharmS
Chairman: Medicines Management Leadership Group

Dr Paul Rutter, B.Pharm., Ph.D., M.R.Pharm.S.
Pharmacy Practice Division, University of Portsmouth

Ian F. Jones
Professor of Pharmacy Practice, University of Portsmouth
20 November 2002

Dear Colleague

DOCTOR & PHARMACIST COLLABORATION
SURVEY OF INDEPENDENT PHARMACY
PROPRIETORS : ENGLAND & WALES

This is a ‘follow up’ letter intended for those proprietors who have not yet replied to the first circulation of this survey sent three weeks ago.

For serious research in this field it is standard practice to send a second copy to encourage those who have not responded to do so now. The initial response has been very encouraging and if publication of our results in the medical/pharmaceutical press next year is to be seriously meaningful a high response to this survey is both important and necessary.

We believe that your collective views can make a valuable contribution to current thinking on the development of your role in providing future NHS pharmaceutical services.

Please find time to complete and return this survey.

To those who have already cooperated – many thanks – and please discard this reminder.

Thank you for your time.

Yours sincerely

Allen Tweedie MA., MBA., FRPharmS
Chairman: Medicines Management Leadership Group

Dr Paul Rutter, B.Pharm., PhD., M.R.PharmS
Pharmacy Practice Division, University of Portsmouth

Professor Ian Jones
Professor of Pharmacy Practice, University of Portsmouth
SURVEY OF INDEPENDENT NHS PHARMACY CONTRACTORS ON NEW PHARMACIST RULES

Conducted by Allen Tweedie, Ian Jones and Paul Rutter
Pharmacy Practice Division, University of Portsmouth

Note: This questionnaire is designed to assist us obtain information which will help steer the way forward into new responsibilities within the 'New NHS' for pharmacy contractors.

If the pharmacist completing the questionnaire is not the proprietor, please obtain his/her permission before continuing.

SECTION A

This section seeks some basic facts about you and the pharmacy you own or work in. Please tick the appropriate box unless otherwise directed.

**Question 1** - What gender are you?  
Female ☐  
Male ☐

**Question 2** - What position do you hold?  
- Owner ☐  
- Manager ☐  
- Assistant Pharmacist ☐  
- Other (Please State) ☐

**Question 3** - How many pharmacies are in your group?  
☐ (Please place number in the box)

**Question 4** - What age group are you in?  
- Under 25 yrs ☐  
- 25-Under 30 ☐  
- 30-Under 35 yrs ☐  
- 35-Under 40 yrs. ☐

- 40-Under 45 yrs ☐  
- 45-Under 50 yrs. ☐  
- 50-Under 55 yrs ☐  
- 55-Under 60 yrs. ☐

- 60-Under 65 yrs. ☐  
- 65yrs. and over ☐
Question 5 - On average, how many prescription items are dispensed in your pharmacy each month? (The one you work in.)

<table>
<thead>
<tr>
<th>Range</th>
<th>Under 1,000</th>
<th>1,000-1,999</th>
<th>2,000-2,999</th>
<th>3,000-3,999</th>
<th>4,000-4,999</th>
<th>5,000-5,999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1,000</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,000-1,999</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2,000-2,999</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3,000-3,999</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4,000-4,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5,000-5,999</td>
<td></td>
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<td></td>
<td>✓</td>
</tr>
<tr>
<td>6,000-6,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>7,000-7,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>8,000-8,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>9,000-9,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>10,000-10,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>11,000 Plus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Question 6 - Approximately, what percentage of your total turnover is generated by NHS receipts?

<table>
<thead>
<tr>
<th>Percentage Range</th>
<th>Under 10%</th>
<th>10-19%</th>
<th>20-29%</th>
<th>20-39%</th>
<th>40-49%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 10%</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-19%</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29%</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-39%</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>40-49%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>50-59%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>60-69%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>70-79%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>80-89%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>90% and over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Question 7 - What is the location of your pharmacy?

<table>
<thead>
<tr>
<th>City/Town Centre</th>
<th>Suburban</th>
<th>Rural (controlled locality)</th>
<th>Other (Please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Question 8 - How many dispensing assistants do you employ? Please place number(s) in appropriate boxes.

<table>
<thead>
<tr>
<th>Full Time (5 full working days)</th>
<th>Part Time (less than 5 full working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Question 9 - How many of your dispensing assistants have a technician's certificate? Please place number(s) in boxes.

<table>
<thead>
<tr>
<th>Full Time (5 full working days)</th>
<th>Part Time (less than 5 full working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Question 10 - How many pharmacists regularly work with you in the pharmacy? (Not locums). Please place number(s) in boxes.

Full Time (5 full working days)  Part Time (less than 5 full working days)

10.1

SECTION B

This section seeks your views about certain aspects of your role in the NHS. Please tick the appropriate box unless otherwise directed.

Question 11 - How satisfied are you that the pharmacist’s skills are being fully used in the present contract?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Very dissatisfied

11.1 11.2 11.3 11.4 11.5

Question 12 - How satisfied are you with current remuneration levels in your NHS contract?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Very dissatisfied

12.1 12.2 12.3 12.4 12.5

Question 13 - How do you rate your present working relationship with the local GPs?

- Very satisfactory
- Satisfactory
- Neither satisfactory nor unsatisfactory
- Unsatisfactory
- Very unsatisfactory

13.1 13.2 13.3 13.4 13.5

Question 14 - What do you assess would be the view of patients on greater pharmacist involvement with management of their NHS medicines?

- Very welcome
- Welcome
- Neither welcome nor unwelcome
- Unwelcome
- Very unwelcome

14.1 14.2 14.3 14.4 14.5

Question 15 - What do you assess would be the attitude of your local doctors to greater pharmacist involvement with patient medication management?

- Very welcome
- Welcome
- Neither welcome nor unwelcome
- Unwelcome
- Very unwelcome

15.1 15.2 15.3 15.4 15.5
Question 16 - Are you aware of the Government-backed PSNC 'medicines management' proposals for community pharmacy?

<table>
<thead>
<tr>
<th>In detail</th>
<th>In some detail</th>
<th>In outline</th>
<th>Not sure</th>
<th>Definitely not</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 16.1</td>
<td>☐ 16.2</td>
<td>☐ 16.3</td>
<td>☐ 16.4</td>
<td>☐ 16.5</td>
</tr>
</tbody>
</table>

SECTION C

This section seeks your views about some possibilities for community pharmacists in the near future, relating to a role in medicines management. Please tick the appropriate box or circle the appropriate numbers in Question 17.

First, a brief refresher on the medicines management initiative.

Note: 'Medicines Management’ is defined for this research as:

"The systematic provision of medicines therapy, through a partnership of effort between patients and professionals, to deliver best patient outcome at minimised cost".

In outline, the medicines management process has four phases for the pharmacist:

i. Review of patient's drug regimen (from PMRs before interviewing the patient) for optimisation of pharmacology and cost.

ii. Interview with patient by a predetermined process to discuss important issues.

iii. Communication of results of i) and ii) to GP, with recommendations (tick box form).

iv. Implementation of agreed changes/action.

Repeat the above cycle at agreed intervals.

Note: In answering the following questions, please assume that full training in medicines management will be given to those who engage in the new role.

Question 17 - In this new professional relationship between doctor and pharmacist, how would you rate the potential importance of each of the following factors? Please circle each of your choices on a scale of 0-5. (0 = not important; 5 = most important)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Doctor's need to feel non-threatened by pharmacist involvement</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>The Doctor's need to be recognised as the lead health care professional</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>The Doctor's need to be the final decision maker on medicines regimen</td>
<td>0 1 2 3 4 5</td>
</tr>
</tbody>
</table>
17.4 *The Doctor’s need* to have confidence in the pharmacist’s abilities

17.5 *The Doctor’s need* to be sure of confidentiality in all matters

17.6 *The Doctor’s need* to have confidence in the pharmacy facilities for confidential consultation

**Question 18** - How would you describe your **present** ability to undertake the medicines management (MM) role?

<table>
<thead>
<tr>
<th>Able now</th>
<th>Able with suitable training</th>
<th>Not Sure</th>
<th>Unable Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.1</td>
<td>18.2</td>
<td>18.3</td>
<td>18.4</td>
</tr>
</tbody>
</table>

**Question 19** - Would you personally wish to undertake this new MM service if remuneration is acceptable?

Yes  Not Sure  No

| 19.1 | 19.2 | 19.3 |

**Question 20** - In the following list, who do you feel **should not** take up the new service? Please tick all appropriate boxes.

- Hospital pharmacists  20.1
- Pharmacists employed by GPs  20.2
- Freelance pharmacists  20.3
- Doctors themselves  20.4
- Nurses  20.5
- Pharmacists employed by the LPC  20.6
- Pharmacists employed by PCTs  20.7
- Pharmacy contractors (ie. like you!)  20.8

Please add any brief comment .................................................................

.................................................................
Question 21 - If you require training to undertake the new role, what subjects among the following list would you select? Please tick all appropriate boxes.

- Clinical pharmacology
- Drug economics
- Patho-physiology
- Interpersonal skills
- Disease management
- Techniques to motivate patients to comply

Other (please specify)

Question 22 - In the following list of training (CPD) options, which one would be your preferred route?

- Daytime lectures (locum funded)
- Evening lectures
- Distance learning packages
- Distance learning plus seminars
- Web based computer assisted learning
- Web based packages plus seminars

Other (please specify)

Question 23 - Assuming your present workload remains the same, do you believe you currently have time to undertake the medicines management service?

- Yes
- Not Sure
- No

Question 24 - If you answered 'No' or 'Not Sure' in the previous question, could some of your workload be delegated to other staff, if they were fully trained?

- Yes
- Not Sure
- No
Question 25 - Do you think it is time for an entirely new pharmacy contract?

Yes ☐ Not Sure ☐ No ☐

25.1 25.2 25.3

Thank you for your time and commitment in addressing the important issues set out in this survey. Your responses will be used to help plan the way forward for community pharmacy.

If you have any information you think would be useful to the aims of this research please use the space below to explain.
APPENDIX 18
(Ref. Chapter 3 : Page 50)

NEW PARTNERSHIPS IN PRIMARY CARE
SURVEY QUESTIONNAIRE

Conducted by: The University of Portsmouth

Note: This questionnaire is designed to assist us obtain information which will help steer the way forward into new collaboration between doctors and pharmacists in managing aspects of the patient's medication. Please tick the appropriate boxes, unless otherwise indicated.

SECTION A

This section consists of some brief questions of detail about your practice and some pharmacist and patient issues.

Question 1 (n=536) 1 2-4 5-7 8+
Please state the number of doctors in your practice 57 248 185 46

(n=536) 1.1
Of these, how many are partners? 56 213 179 46

1.2

Question 2
Is your practice a dispensing practice? Yes No

(n=538) □ □
2.1 2.2
71 467

Question 3
Approximately how many patients are there in your practice? (n=527)

under 2000 2000-3999 4000-5999 6000-7999 8000-9999
21 97 86 93 81

10,000+ 49

Question 4
Please tick the age groups you all come within (n=526)

20-under 30 30-under 40 40-under 50 50-under 60 60+
□ □ □ □ □
4.1 4.2 4.3 4.4 4.5
58 305 385 314 84
Question 5
Broadly, how would you describe the frequency with which you contact a dispensing pharmacist? (n=538)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Very often</th>
<th>Often</th>
<th>Periodically</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>5.2</td>
<td></td>
<td>5.3</td>
<td>5.4</td>
<td>5.5</td>
</tr>
<tr>
<td>52</td>
<td>173</td>
<td>224</td>
<td>82</td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>

Question 6
Do you have a pharmacist work for you in the practice? (n=538)

<table>
<thead>
<tr>
<th>Availability</th>
<th>Full Time</th>
<th>Regular Part Time</th>
<th>Periodically</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2</td>
<td>78</td>
<td>108</td>
<td>92</td>
<td>248</td>
<td></td>
</tr>
</tbody>
</table>

If you answered ‘Never’, please go to Question 8.

Question 7
What is the source of your pharmacist help? (n=344)

<table>
<thead>
<tr>
<th>Source</th>
<th>Health Authority</th>
<th>PCT</th>
<th>Dispensing Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>20</td>
<td>238</td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td>7.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>Peripatetic Pharmacist</th>
<th>Pharmacist member of your own staff</th>
<th>Other – Please specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.4</td>
<td>7.5</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>15</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Question 8
If you answered ‘Never’ to Question 6, would you like a pharmacist to work for you in the future? (n=233)

<table>
<thead>
<tr>
<th>Availability</th>
<th>Full Time</th>
<th>Regular Part Time</th>
<th>Periodically</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>8.2</td>
<td>8.3</td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>62</td>
<td>126</td>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>
Question 9
Please indicate the frequency with which you encounter the following medicines problems with patients. (n=539)

<table>
<thead>
<tr>
<th></th>
<th>Very often</th>
<th>Often</th>
<th>Periodically</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Troublesome side effects</td>
<td>9.1</td>
<td>9.2</td>
<td>9.3</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td>57</td>
<td>227</td>
<td>248</td>
<td>4</td>
</tr>
<tr>
<td>Drug interactions</td>
<td>9.5</td>
<td>9.6</td>
<td>9.7</td>
<td>9.8</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>108</td>
<td>402</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>57</td>
<td>455</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>71</td>
<td>240</td>
<td>226</td>
<td>2</td>
</tr>
<tr>
<td>Poor response to treatment</td>
<td>9.17</td>
<td>9.18</td>
<td>9.19</td>
<td>9.20</td>
</tr>
<tr>
<td></td>
<td>36</td>
<td>201</td>
<td>298</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>69</td>
<td>208</td>
<td>255</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>41</td>
<td>414</td>
<td>82</td>
</tr>
<tr>
<td>NHS drugs &amp; pharmacy medicines</td>
<td>9.29</td>
<td>9.30</td>
<td>9.31</td>
<td>9.32</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>37</td>
<td>407</td>
<td>75</td>
</tr>
</tbody>
</table>
**Question 10**

Please indicate what you believe to be the incidence of the following potential problems elderly patients may have with medicines. (n=535)

<table>
<thead>
<tr>
<th></th>
<th>Very often</th>
<th>Often</th>
<th>Periodically</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capsule/tablet size</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10.1</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>193</td>
<td>312</td>
<td>4</td>
</tr>
<tr>
<td>Calendar packs</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10.5</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td>135</td>
<td>336</td>
<td>43</td>
</tr>
<tr>
<td>Frequency of dose</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10.9</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>70</td>
<td></td>
<td>303</td>
<td>161</td>
<td>2</td>
</tr>
<tr>
<td>Multiplicity of drugs</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10.13</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>214</td>
<td></td>
<td>270</td>
<td>51</td>
<td>1</td>
</tr>
<tr>
<td>Remembering to take</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>the medication</td>
<td>10.17</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>153</td>
<td></td>
<td>290</td>
<td>92</td>
<td>0</td>
</tr>
<tr>
<td>Taste of medication</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10.21</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>70</td>
<td>385</td>
<td>70</td>
</tr>
</tbody>
</table>

Other: Please state briefly

........................................................................................................................................................................

........................................................................................................................................................................

**SECTION B**

This section contains questions relating to Government policy in the 'New NHS' and an enhanced doctor / pharmacist working relationship. Please tick the box that most closely reflects your views.

**Question 11**

Government seem to be encouraging pharmacist / GP collaboration on aspects of medication review. Do you agree with this approach? (The detail is in the next question.) (n=539)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
<td>11.4</td>
<td>11.5</td>
</tr>
<tr>
<td>90</td>
<td>317</td>
<td>109</td>
<td>16</td>
<td>7</td>
</tr>
</tbody>
</table>

*If you ticked box 11.4 or 11.5, please go to Question 13.*
Question 12
If you ticked any box from 11.1 to 11.3, which of the following items do you think a pharmacist could assist you with? (Please tick all appropriate boxes) (n=536)

12.1 Comparisons of equivalent medicines’ costs □ 375
12.2 Patient compliance □ 391
12.3 Drug interactions □ 399
12.4 Replacing brands with generics □ 339
12.5 Choice of medicines □ 228
12.6 Advice to patients on food and drug interactions □ 414
12.7 Advice to patients on pharmacy medicines & NHS drug interactions □ 403
12.8 Optimum pack sizes □ 332
12.9 Review of number of drugs taken □ 366
12.10 Help with identifying sub therapeutic dose levels □ 280

Question 13
If you ticked boxes 11.4 or 11.5 in Question 11, please outline your reason here.

.............................................................................................................................................

Question 14
If a pharmacist worked with you to undertake a patient review of those medication issues agreed by you, how frequently should this be done for those on long term medication? (n=513)

<table>
<thead>
<tr>
<th>Monthly</th>
<th>Bi-monthly</th>
<th>Quarterly</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 14.1</td>
<td>□ 14.2</td>
<td>□ 14.3</td>
</tr>
<tr>
<td>24</td>
<td>20</td>
<td>163</td>
</tr>
<tr>
<td>Four monthly</td>
<td>Six monthly</td>
<td>Other: Please specify</td>
</tr>
<tr>
<td>□ 14.4</td>
<td>□ 14.5</td>
<td>□ 14.6</td>
</tr>
<tr>
<td>20</td>
<td>250</td>
<td>36</td>
</tr>
</tbody>
</table>
Question 15
Do you feel the pharmacist should become a formal part of the doctor’s team addressing selected items agreed by you? (n=539)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Uncertain</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.1</td>
<td></td>
<td>15.2</td>
<td>15.3</td>
</tr>
<tr>
<td>294</td>
<td></td>
<td>185</td>
<td>60</td>
</tr>
</tbody>
</table>

SECTION C

This section contains questions relating to some health care issues arising from Government White Papers in recent years. Please tick the box which most closely reflects your view.

Question 16
The quality of patient care in general practice may be very good, even though the patient may not be aware of that quality. How important is the patient’s own perception of that quality? (n=539)

<table>
<thead>
<tr>
<th>Important</th>
<th>Relatively important</th>
<th>Neither important nor unimportant</th>
<th>Relatively unimportant</th>
<th>Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.1</td>
<td></td>
<td>16.3</td>
<td>16.4</td>
<td>16.5</td>
</tr>
<tr>
<td>260</td>
<td>16.2</td>
<td>15</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

Question 17
Quality of care and clinical excellence are recurrent themes in the White Papers. What is your perception of patient expectations of health care over recent years? (n=539)

<table>
<thead>
<tr>
<th>Greatly decreased</th>
<th>Somewhat increased</th>
<th>No change</th>
<th>Somewhat decreased</th>
<th>Greatly decreased</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.1</td>
<td></td>
<td>17.3</td>
<td>17.4</td>
<td>17.5</td>
</tr>
<tr>
<td>356</td>
<td>17.2</td>
<td>22</td>
<td>12</td>
<td>5</td>
</tr>
</tbody>
</table>

Question 18
Patient’s perception of quality of care may be a factor in their commitment to the therapy. Do you agree? (n=540)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.1</td>
<td>18.2</td>
<td>18.3</td>
<td>18.4</td>
<td>18.5</td>
</tr>
<tr>
<td>106</td>
<td>354</td>
<td>57</td>
<td>23</td>
<td>0</td>
</tr>
</tbody>
</table>
**Question 19**
Patient perception of your overall service could be enhanced by a pharmacist medicines review service, directed by you. Do you agree? (n=539)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.1</td>
<td>19.2</td>
<td>19.3</td>
<td>19.4</td>
<td>19.5</td>
</tr>
<tr>
<td>40</td>
<td>302</td>
<td>148</td>
<td>43</td>
<td>6</td>
</tr>
</tbody>
</table>

**Question 20**
Please indicate in which of the following locations your practice is based. (n=526)

<table>
<thead>
<tr>
<th>City centre</th>
<th>Town centre</th>
<th>Suburban</th>
<th>Rural (controlled locality)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.1</td>
<td>20.2</td>
<td>20.3</td>
<td>20.4</td>
</tr>
<tr>
<td>62</td>
<td>145</td>
<td>238</td>
<td>89</td>
</tr>
</tbody>
</table>

Thank you for taking time to help with this important survey of issues. The information will be treated in strict confidence and used only to explore the possibility of closer doctor/pharmacist collaboration.
APPENDIX 19
(Ref. Chapter 3 : Page 50)

SURVEY OF INDEPENDENT NHS PHARMACY CONTRACTORS ON NEW PHARMACIST ROLES

Conducted by: Allen Tweedie, Ian Jones and Paul Rutter
Pharmacy Practice Division, University of Portsmouth

Note: This questionnaire is designed to assist us obtain information which will help steer the way forward into new responsibilities within the 'New NHS' for pharmacy contractors.

If the pharmacist completing the questionnaire is not the proprietor, please obtain his / her permission before continuing.

SECTION A

This section seeks some basic facts about you and the pharmacy you own or work in. Please tick the appropriate boxes unless otherwise directed. (n=397)

Question 1
What gender are you? Female □ Male □
1.1 80
1.2 317

Question 2
What position do you hold? (n=397)
Owner □ Manager □ Assistant Pharmacist □ Other □
(Please state)
2.1 2.2 2.3
294 76 9
2.4
18

Question 3
How many pharmacies are in your group? □ (Please place number in the box)
3.1
1 2-4 5-7 8+
238 103 19 35
**Question 4**
What age group are you in? (n=396)

<table>
<thead>
<tr>
<th>Under 25</th>
<th>25-under 30</th>
<th>30-under 35</th>
<th>35-under 40</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4.1</td>
<td>4.2</td>
<td>4.3</td>
<td>4.4</td>
</tr>
<tr>
<td>0</td>
<td>18</td>
<td>40</td>
<td>49</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>40-under 45</th>
<th>45-under 50</th>
<th>50-under 55</th>
<th>55-under 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4.5</td>
<td>4.6</td>
<td>4.7</td>
<td>4.8</td>
</tr>
<tr>
<td>97</td>
<td>84</td>
<td>58</td>
<td>28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>60-under 65</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4.9</td>
<td>4.10</td>
</tr>
<tr>
<td>16</td>
<td>8</td>
</tr>
</tbody>
</table>

**Question 5**
On average, how many prescription items are dispensed in your pharmacy each month? (The one you work in.) (n=388)

<table>
<thead>
<tr>
<th>Under 1,000</th>
<th>1,000-1,999</th>
<th>2,000-2,999</th>
<th>3,000-3,999</th>
<th>4,000-4,999</th>
<th>5,000-5,999</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5.1</td>
<td>5.2</td>
<td>5.3</td>
<td>5.4</td>
<td>5.5</td>
<td>5.6</td>
</tr>
<tr>
<td>5</td>
<td>12</td>
<td>66</td>
<td>67</td>
<td>72</td>
<td>50</td>
</tr>
<tr>
<td>6,000-6,999</td>
<td>7,000-7,999</td>
<td>8,000-8,999</td>
<td>9,000-9,999</td>
<td>10,000-10,999</td>
<td>11,000+</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5.7</td>
<td>5.8</td>
<td>5.9</td>
<td>5.19</td>
<td>5.11</td>
<td>5.12</td>
</tr>
<tr>
<td>42</td>
<td>15</td>
<td>28</td>
<td>12</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

**Question 6**
Approximately, what percentage of your total turnover is generated by NHS receipts? (n=370)

<table>
<thead>
<tr>
<th>Under 10%</th>
<th>10-19%</th>
<th>20-29%</th>
<th>20-39%</th>
<th>40-49%</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6.1</td>
<td>6.2</td>
<td>6.3</td>
<td>6.4</td>
<td>6.5</td>
</tr>
<tr>
<td>0</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>50-59%</td>
<td>60-69%</td>
<td>70-79%</td>
<td>80-89%</td>
<td>90%+</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6.6</td>
<td>6.7</td>
<td>6.8</td>
<td>6.9</td>
<td>6.10</td>
</tr>
<tr>
<td>16</td>
<td>58</td>
<td>102</td>
<td>128</td>
<td>50</td>
</tr>
</tbody>
</table>
**Question 7**
What is the location of your pharmacy? (n=392)

<table>
<thead>
<tr>
<th>City/town centre</th>
<th>Suburban</th>
<th>Rural (controlled locality)</th>
<th>Other (Please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

7.1 7.2 7.3 7.4
71 237 70 14

**Question 8**
How many dispensing assistants do you employ? Please place number(s) in appropriate boxes. (n=319)

<table>
<thead>
<tr>
<th>Full time (5 full working days)</th>
<th>Part time (less than 5 full working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8.1</td>
<td>8.2</td>
</tr>
<tr>
<td>341</td>
<td>501</td>
</tr>
</tbody>
</table>

**Question 9**
How many of your dispensing assistants have a technician’s certificate? Please place number(s) in boxes. (n=319)

<table>
<thead>
<tr>
<th>Full time (5 full working days)</th>
<th>Part time (less than 5 full working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9.1</td>
<td>9.2</td>
</tr>
<tr>
<td>278</td>
<td>285</td>
</tr>
</tbody>
</table>

**Question 10**
How many pharmacists regularly work with you in the pharmacy (Not locums). Please place number(s) in boxes. (n=300)

<table>
<thead>
<tr>
<th>Full time (5 full working days)</th>
<th>Part time (less than 5 full working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10.1</td>
<td>10.2</td>
</tr>
<tr>
<td>90</td>
<td>126</td>
</tr>
</tbody>
</table>
SECTION B

This section seeks your views about certain aspects of your role in the NHS. Please tick the appropriate box unless otherwise directed.

**Question 11**
How satisfied are you that the pharmacist’s skills are being fully used in the present contract? \( (n=399) \)

<table>
<thead>
<tr>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
<td>11.4</td>
<td>11.5</td>
</tr>
<tr>
<td>9</td>
<td>64</td>
<td>115</td>
<td>175</td>
<td>36</td>
</tr>
</tbody>
</table>

**Question 12**
How satisfied are you with current remuneration levels in your NHS contract?

<table>
<thead>
<tr>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>12.1</td>
<td>12.2</td>
<td>12.3</td>
<td>12.4</td>
<td>12.5</td>
</tr>
<tr>
<td>0</td>
<td>17</td>
<td>46</td>
<td>176</td>
<td>162</td>
</tr>
</tbody>
</table>

**Question 13**
How do you rate your present working relationship with the local GPs? \( (n=394) \)

<table>
<thead>
<tr>
<th>Very Satisfactory</th>
<th>Satisfactory</th>
<th>Neither satisfied nor unsatisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>13.1</td>
<td>13.2</td>
<td>13.3</td>
<td>13.4</td>
</tr>
<tr>
<td>99</td>
<td>193</td>
<td>62</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Very unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
</tr>
<tr>
<td>13.5</td>
</tr>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

**Question 14**
What do you assess would be the view of patients on greater pharmacist involvement with management of their NHS medicines? \( (n=397) \)

<table>
<thead>
<tr>
<th>Very welcome</th>
<th>Welcome</th>
<th>Neither welcome nor unwelcome</th>
<th>Unwelcome</th>
<th>Very unwelcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>14.1</td>
<td>14.2</td>
<td>14.3</td>
<td>14.4</td>
<td>14.5</td>
</tr>
<tr>
<td>124</td>
<td>228</td>
<td>40</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>
**Question 15**

What do you assess would be the attitude of your local doctors to greater pharmacist involvement with patient medication management? (n=396)

<table>
<thead>
<tr>
<th>Very welcome</th>
<th>Welcome</th>
<th>Neither welcome nor unwelcome</th>
<th>Unwelcome</th>
<th>Very unwelcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>15.1</td>
<td>15.2</td>
<td>15.3</td>
<td>15.4</td>
<td>15.5</td>
</tr>
<tr>
<td>54</td>
<td>189</td>
<td>97</td>
<td>49</td>
<td>7</td>
</tr>
</tbody>
</table>

**Question 16**

Are you aware of the Government backed PSNC 'medicines management' proposals for community pharmacy? (n=401)

<table>
<thead>
<tr>
<th>In detail</th>
<th>In some detail</th>
<th>In outline</th>
<th>Not sure</th>
<th>Definitely not</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>16.1</td>
<td>16.2</td>
<td>16.3</td>
<td>16.4</td>
<td>16.5</td>
</tr>
<tr>
<td>15</td>
<td>78</td>
<td>276</td>
<td>96</td>
<td>5</td>
</tr>
</tbody>
</table>

**SECTION C**

This section seeks your views about some possibilities for community pharmacists in the near future, relating to a role in medicines management. Please tick the appropriate box or circle the appropriate numbers in Question 17.

First, a brief refresher on the medicines management initiative.

**Note:** ‘Medicines Management’ is defined for this research as:

‘The systematic provision of medicines therapy, through a partnership of effort between patients and professionals, to deliver best patient outcome at minimised cost.’

In outline, the medicines management process has four phases for the pharmacist:

i. Review of patient's drug regimen (from PMRs before interviewing the patient) for optimisation of pharmacology and cost.

ii. Interview with patient by a predetermined process to discuss important issues.

iii. Communication of results of i. and ii. to GP, with recommendations (tick box form).

iv. Implementation of agreed changes / action.

Repeat the above cycle at agreed intervals.
Note: In answering the following questions, please assume that full training in medicines management will be given to those who engage in the new role.

Question 17
In this new professional relationship between doctor and pharmacist, how would you rate the potential importance of each of the following factors? Please circle each of your choices on a scale of 0-5. (0 = not important; 5 = most important) (n=401)

17.1 The doctor’s need to feel non-threatened by pharmacist involvement
7 0 8 1 23 2 50 3 133 4 180 5

17.2 The doctor’s need to be recognised as the lead health care professional
9 0 8 1 26 2 73 3 134 4 151 5

17.3 The doctor’s need to be the final decision maker on medicines regimen
10 0 7 1 27 2 54 3 125 4 177 5

17.4 The doctor’s need to have confidence in the pharmacist’s abilities
1 0 2 1 1 2 14 3 103 4 280 5

17.5 The doctor’s need to be sure of confidentiality in all matters
3 0 4 1 4 2 31 3 103 4 256 5

17.6 The doctor’s need to have confidence in the pharmacy facilities for confidential consultation
3 0 3 1 9 2 75 3 131 4 179 5

Question 18
How would you describe your present ability to undertake the medicines management (MM) role? (n=399)

Able now Able with suitable training Not sure Unable now
☐ ☐ ☐ ☐
18.1 18.2 18.3 18.4
45 287 42 25

Question 19
Would you personally wish to undertake this new MM service if remuneration is acceptable? (n=401)

Yes Not sure No
☐ ☐ ☐
19.1 19.2 19.3
324 65 12
Question 20
In the following list, who do you feel should not take up the new service? Please tick all appropriate boxes. (n=354)

Hospital pharmacists
Pharmacists employed by GPs
Freelance pharmacists
Doctors themselves
Nurses
Pharmacists employed by the LPC
Pharmacists employed by PCTs
Pharmacy contractors (i.e. like you!)

Please add any brief comment.

Question 21
If you require training to undertake the new role, what subjects among the following list would you select? Please tick all appropriate boxes. (n=390)

Clinical pharmacology
Drug economics
Patho-physiology
Interpersonal skills
Disease management
Techniques to motivate patients to comply
Other (please specify)

Please add any brief comment.
Question 22
In the following list of training (CPD) options, which one would be your preferred route? (n=359)

Daytime lectures (locum funded)  
☐  22.1  166

Evening lectures  
☐  22.2  47

Distance learning packages  
☐  22.3  86

Distance learning plus seminars  
☐  22.4  57

Web based computer assisted learning  
☐  22.5  20

Web based packages plus seminars  
☐  22.6  6

Question 23
Assuming your present workload remains the same, do you believe you currently have time to undertake the medicines management service? (n=399)

<table>
<thead>
<tr>
<th>Yes</th>
<th>Not sure</th>
<th>No</th>
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<td>23.1</td>
<td>23.2</td>
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</tr>
<tr>
<td>79</td>
<td>107</td>
<td>213</td>
</tr>
</tbody>
</table>

Question 24
If you answered 'No' or 'Not sure' in the previous question, could some of your workload be delegated to other staff, if they were fully trained? (n=320)

<table>
<thead>
<tr>
<th>Yes</th>
<th>Not sure</th>
<th>No</th>
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<tr>
<td>24.1</td>
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<tr>
<td>164</td>
<td>80</td>
<td>76</td>
</tr>
</tbody>
</table>

Question 25
Do you think it is time for an entirely new pharmacy contract? (n=394)

<table>
<thead>
<tr>
<th>Yes</th>
<th>Not sure</th>
<th>No</th>
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<td>25.1</td>
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<tr>
<td>231</td>
<td>110</td>
<td>45</td>
</tr>
</tbody>
</table>
Thank you for your time and commitment in addressing the important issues set out in this survey. Your responses will be used to help plan the way forward for community pharmacy.

If you have any information you think would be useful to the aims of this research please use the space below to explain.
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