

Achieving excellence in pharmacy through clinical governance

Royal Pharmaceutical Society of
Great Britain's policy on clinical governance

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Introduction

The Royal Pharmaceutical Society of Great Britain (RPSGB) welcomes the introduction of Clinical Governance in the NHS. Although clinical governance is a new term, many of the principles behind clinical governance are not new and have been used in other quality initiatives such as TQM and CQI. There are four main components of clinical governance.

1. Clear lines of responsibility and accountability for the overall quality of clinical care.
2. A comprehensive programme of quality improvement activities.
3. Clear policies aimed at managing risks.
4. Procedures for all professional groups to identify and remedy poor performance.

A comprehensive programme of quality improvement activities is further defined as including:

- Clinical Audit
- Continuing Professional Development
- Clinical guidelines/Evidence based practice
- Research and development
- Effective monitoring of clinical care

The coming together of these different components into a cohesive programme offers significant opportunities.

Pharmacy has a long history of innovation and quality improvement and brings many strengths to clinical governance. In the *Pharmacy in a New Age* (PIANA) strategy, we have stated pharmacy's aspirations and quality is at the heart of this strategy. The PIANA strategy is wholly compatible with clinical governance. The Society's strategic aims for standards of practice; clinical audit; Pharmacists' education and training; evidence base and information all reflect the principles of clinical governance. Our strategic aims for remuneration and workforce; the improvement of premises and commitment to progress are also relevant.

In developing a framework for clinical governance in pharmacy we have built on pharmacy's unique strengths and highlighted areas that require further development. It is important to realise that there are two separate aspects to this framework. Pharmacy needs a mechanism to implement clinical governance within its uni-professional activities but it also must feed into an overall structure that deals with the care of the patient by all healthcare professionals. This second aspect is easier in secondary care where pharmacy can more easily integrate into the structures for clinical governance in a Trust. In primary care, pharmacy will have to develop new mechanisms in order to integrate into the primary care clinical governance structures. We would look to pharmacists to establish better links with the rest of primary care, but also to Health Authorities to facilitate and require this to happen.

1. Clear lines of responsibility and accountability for the overall quality of clinical care.

- 1.1 Community pharmacy already has clear lines of responsibility for quality. The superintendent/proprietor pharmacist is responsible for the quality of the clinical care provided by the pharmacy. The superintendent/proprietor pharmacist is held accountable by the professional body for breaches of the RPSGB's Code of Ethics and Standards. This is unique to pharmacy and is a great strength of pharmacy. Local Pharmaceutical Committees have often involved themselves in the development of quality e.g. accreditation schemes, audit, etc.
- 1.2 The superintendent/proprietor pharmacist must retain professional responsibility for the quality of his/her pharmacies. In addition however, there needs to be some commonality in the arrangements for clinical governance for community pharmacy and arrangements for other professions. PCGs/Local Health Groups and Health Authorities will be looking for a lead pharmacist or body to liaise with. They will not want to liaise with many different pharmacists, especially if they are located outside the local area.
- 1.3 In the hospital sector, the Chief Pharmacist of a Trust will usually have responsibility for the quality of clinical care provided by the pharmacy department and the safe and secure handling of medicines in the hospital as a whole. There will usually be a line management relationship with either a Director or directly with the Chief Executive of the Trust.
- 1.4 In some NHS Trusts, pharmacists may be managerially accountable to the Directorate that they serve rather than the Chief Pharmacist. The Chief Pharmacist usually retains professional responsibility for all pharmacists employed in the Trust, but may not be managerially responsible for them.
- 1.5 A variety of job titles are used in hospital pharmacy to signify the most senior pharmacist of which Chief Pharmacist is probably the most common. The term "Chief Pharmacist" is not defined in either law or the RPSGB Code of Ethics.
- 1.6 The question of accountability for community pharmacy is complex and is different in England and Wales.

In England, the current Department of Health guidance states that :-
The Health Authority has a responsibility of "Supporting and facilitating the development of clinical governance amongst all local NHS organisations, but particularly in Primary Care Groups (PCGs) and amongst those contractor professionals (who are not encompassed by PCG arrangements)." It further says that PCGs and PCTs must "Make sure that clinical governance principles are applied to services delivered by other providers on their behalf through Long Term Service Agreements and through contracts with non-NHS providers."

In England, community pharmacy will therefore have to give account to the Health Authority over its arrangements for clinical governance for all aspects of its contracted service and to the PCG over services provided under

separate contract to the PCG/PCT. Community pharmacy will also be able to assist the PCG/PCT fulfil its multi-professional clinical governance obligations. Many PCGs are already inviting local community pharmacists to sit on the PCG clinical governance sub-committee.

These arrangements are not straight forward and there is confusion amongst some Health Authorities and PCGs. We would welcome further guidance from the Department of Health to clarify the position for all concerned.

In Wales, the guidance suggests that all the above functions can be devolved down to Local Health Group. This is because Local Health Groups have the more general role of "Supporting clinical governance in primary care settings". A community pharmacist is also a member of the Board of each Local Health Group.

Recommendations

- 1.7 The RPSGB proposes a framework for local clinical governance accountability as follows:-
- 1.7.1 In each Health Authority area, the Local Pharmaceutical Committee (LPC) should nominate a local community pharmacist as clinical governance lead for community pharmacy. In Wales, this appointment may be at a Local Health Group level. We would recommend that the LPC involve the local RPSGB Inspector in the selection of an individual to perform this role.
- 1.7.2 The role of the clinical governance lead for community pharmacy will be to:
- Work with the local Health Authority/Local Health Group to ensure that suitable mechanisms are in place to support community pharmacists developing and implementing a comprehensive programme of quality improvement activities.
 - Report to the Health Authority/Local Health Group on the quality of pharmaceutical services locally. The report should contain data collated from information supplied by the Superintendent/proprietor pharmacist and the RPSGB Inspector.
 - Work with the Local Pharmaceutical Committee and RPSGB Inspectors to identify and offer support to rectify poor performance.
 - Report to the Health Authority/Local Health Group and RPSGB about persistent poor performance following clearly laid out procedures agreed at a national level with all relevant stakeholders
 - Liaise with Primary Care Group, Local Health Group or Primary Care Trust Clinical Governance leads over how

community pharmacy links into the overall clinical governance of patient care.

- Liase with, and provide professional support to, community pharmacists serving on PCG/PCT/LHG clinical governance sub-committees.

1.7.3 The role of clinical governance lead for community pharmacy will require time and resources. We would expect such a role to require a minimum of one to two sessions per week. It will require adequate funding from the Health Authority/Local Health Group.

1.8 In hospital pharmacy, the Chief Pharmacist should take professional responsibility for all pharmacists and pharmacy staff in the NHS Trust and liase with the clinical governance lead in the Trust. The Chief Pharmacist should sit on the clinical governance committee of the Trust. A formal definition of the term “Chief Pharmacist” may need to be developed.

1.9 In order to develop meaningful comparisons between pharmacies and pharmacists, the RPSGB will develop a small number of quality indicators for both community and hospital pharmacy. It is likely that suitable indicators would deal with participation in CPD and clinical audit; record keeping (patient medication records); presence of procedures; critical incidents such as complaints; additional services such as Health Screening (e.g. Cholesterol testing) and some hospital pharmacy specific indicators regarding clinical pharmacy.

1.10 PCGs/PCTs and LHGs should consider appointing a local community pharmacist to their clinical governance sub-committee.

2. A comprehensive programme of quality improvement activities.

2.1 Clinical Audit

2.1.1 The RPSGB has been supporting the development of clinical audit for several years. We have published examples of clinical audits on the RPSGB web site and these can be freely downloaded. The Society’s Audit Development Fellow provides training and support to pharmacists wishing to undertake clinical audit in England. In Wales, training and support is provided through the WCPPE.

2.1.2 Clinical audit is taught at undergraduate level, is a component of most postgraduate diploma courses and is being incorporated into several continuing education courses.

2.1.3 Clinical audit in hospital pharmacy is well developed with pharmacists participating in uni-professional and multi-professional clinical audit. There are several regional or speciality audit schemes within hospital pharmacy. In some areas, this has extended into benchmarking clubs. In addition, most hospital pharmacies conduct drug use reviews. These usually fulfil all the criteria for good clinical audit, but often fail to be reported to the Trust as clinical audit.

- 2.1.4 In the community pharmacy sector, clinical audit has been slower to develop. This has been mainly due to difficulties accessing local audit expertise and support. MAAGs and their equivalents have been reluctant or unable to offer support to community pharmacists. A few Health Authorities have offered audit support but this has mostly been for one-off projects.
- 2.1.5 Despite these difficulties, there have been significant developments in clinical audit in community pharmacy. The Society has worked with groups of pharmacists across England supporting their local work. Many multiples have developed in-house clinical audit structures and audit is a component of the majority of Health Authority accreditation schemes.

Recommendations

- 2.1.6 The Society will publish further examples of both uni-professional and multi-professional clinical audits in pharmacy and continue to offer support to pharmacists wishing to develop clinical audit.
- 2.1.7 Health Authorities and NHS Trusts should ensure that pharmacists have access to clinical audit expertise and support at the local level.
- 2.1.8 Drug use reviews should be re-classified as clinical audit and reported to the clinical governance committee.

2.2 Continuing Professional Development

- 2.2.1 The national continuing education centres (CPPE, SCPPE and WCPPE) are a major strength for pharmacy. They produce and disseminate nationally produced evidence based training to pharmacists. A mixture of national and local topics allows some local targeting of training.
- 2.2.2 Hospital pharmacists can access training in work time. There are several good quality in-house training schemes linked with the Clinical Pharmacy Diploma courses. Hospital Pharmacists are encouraged to obtain further qualifications, especially clinical diplomas. Some regions have regional training pharmacists with responsibility for training and development.
- 2.2.3 The RPSGB is piloting a new approach to CPD based on the Society's existing CPD advice. It involves reflecting on current and future CPD needs, making appropriate development plans and then putting the plan into action. This would all be recorded in a CPD portfolio. The pilot will end in September 1999 with the results of the pilot available early in 2000.
- 2.2.4 The Society has concerns about the funding for CPD in pharmacy and has urged the government to provide adequate funding to ensure full participation in CPD in both community and hospital pharmacy.

Recommendations

- 2.2.5 The RPSGB will continue to develop its new approach to CPD and will roll it out depending on the results of the pilot.

- 2.2.6 Employers should use staff appraisal as an opportunity to help pharmacists identify their training needs.
- 2.2.7 The government should ensure that adequate funds are made available to ensure full participation in CPD in pharmacy.

2.3 Clinical guidelines/evidence based practice

- 2.3.1 There is often national input by pharmacy into the development of clinical guidelines. This is likely to be improved by the presence of a pharmacist on the Partners Council of the National Institute for Clinical Excellence (NICE) and the liaison between the Audit Development Fellow and NICE.
- 2.3.2 However, clinical guidelines usually do not identify the pharmacist's role in implementation of guidelines. Local adaptation of clinical guidelines is often conducted without pharmaceutical input, especially in primary care. We have also found that local clinical guidelines are not routinely circulated to community pharmacists.
- 2.3.3 The Society has recently conducted research into getting research into pharmacy practice. This has recently been published by the Society together with a series of recommendations for improving the generation, dissemination and use of research evidence in pharmacy.

Recommendations

- 2.3.4 The Society will implement the recommendations about getting research into pharmacy practice.
- 2.3.5 Health Authorities and Trusts should ensure that pharmacists have proper access to sources of evidence based research literature – both paper based and electronic media.
- 2.3.6 Clinical guideline producers at both the national and local level should ensure that they obtain appropriate pharmaceutical expertise, preferably from those working in the sector that the guideline is aimed at.

2.4 Research and Development

- 2.4.1 The generation of reliable, robust research-based data is recognised as underpinning and supporting clinical governance. Results from research commissioned as part of the NHS R&D Programme, together with relevant outputs from the Research Councils and Medical Charities, forms the basis of much of clinical audit and guidelines. The progress made by the Society in commissioning and publishing rigorous scientific work in the field of health services research has gone some way to strengthening our claim to be involved and to contribute to these wider initiatives. Other work to identify and prioritise the research agenda in pharmacy is beginning to reap rewards as pharmacy related work steadily enters the research strategies of the large R&D funders.

- 2.4.2 However, the Society's contributions to wider NHS debates on the development the R&D workforce capacity and changing professional behaviour through the dissemination and uptake of research results have placed pharmacy at the forefront of thinking in these complex areas.

Recommendations

- 2.4.3 The recommendations of the Society are contained in the various papers about practice research published by the Society:

RPSGB. A new age for pharmacy practice research : Promoting evidence-based practice in pharmacy. London: RPSGB, 1999

RPSGB. Medicines, pharmacy and the NHS : Getting it right for patients and prescribers. London: RPSGB 1999

RPSGB. Drug therapy and pharmacy : Setting the research agenda. London : RPSGB 1999

RPSGB. Self care and pharmacy : Setting the research agenda. London : RPSGB 1998

2.5 Effective monitoring of clinical care with high quality systems for clinical record keeping and the collection of relevant information

- 2.5.1 The Society sees this as an essential component of clinical governance. Clinical care cannot be effectively monitored unless healthcare professionals have access to appropriate information and record relevant information.
- 2.5.2 Most community pharmacies have computerised Patient Medication Records that record the patient's prescription dispensing history from that pharmacy. They generally have the option to record some clinical information about the patient.
- 2.5.3 Hospital Pharmacy generally keeps good records. E.g. Dispensing, production, drug information, drug use review, aseptic dispensing, distribution, quality control. In addition, hospital pharmacists have free access to patient's hospital medical records.
- 2.5.4 However, community pharmacists do not have access to patient's clinical notes. Neither do they routinely record interventions made on prescriptions or advice given to other healthcare professionals. This is a weakness of community pharmacy and one that will need national solutions.
- 2.5.5 Although hospital pharmacists keep more comprehensive records than their community colleagues do, there are no nationally agreed standards for the recording of pharmacist's interventions and contributions to individual patient care. Some Trusts undertake intermittent recording of interventions while others record continuously. There are discrepancies between what is recorded with junior pharmacists tending to record all interventions while senior pharmacists tend to only record the more interesting interventions. Even the definition of what is an intervention varies between hospitals. This leads to an inability to compare practice across Trusts.

- 2.5.6 The majority of hospital pharmacists do not record their contribution in patients' notes. There are historical reasons for this, but pharmacy is still one of the few professions not to routinely contribute to the patient's notes. This can lead to clinicians being unable to identify the reasons for changes in medication when reviewing a patient's history.

Recommendations

- 2.5.7 The RPSGB will develop national solutions to assist community pharmacists to record their contributions to clinical care.
- 2.5.8 A common data set needs to be developed for clinical pharmacy services in hospital. This would allow comparison of the clinical pharmacy services between hospital pharmacies and the identification of where improvements can be made. The RPSGB will facilitate a meeting to start this process.
- 2.5.9 Pharmacists need access to relevant patient clinical data and to record their contributions in a way that allows other healthcare professionals to access the information. The development of the electronic patient record may help this situation providing that community pharmacists are given access and allowed to contribute more than just dispensing data.
- 2.5.10 Hospital pharmacists need not wait for the electronic patient record before recording their contributions in patient's records. This is something that could be negotiated locally and should be the norm rather than the exception.

3. Clear policies aimed at managing risks.

- 3.1 Pharmacy is a profession that is well aware of the risks attached to their work. Dispensing errors have the potential to cause catastrophic harm to patients. Poor advice to either doctors or patients carries risks to patients and pharmacists should be similarly aware of the potential dangers. In order to manage these risks and others associated with pharmacy; pharmacists have developed a range of procedures and protocols.
- 3.2 Pharmacists also have a significant role to play in the risk management of other professions. Pharmacists check the prescribing of doctors and identify errors and omissions in therapy. This role is more complete where pharmacists have access to clinical information about the patient.
- 3.3 Formal risk assessment and risk management has not featured in many pharmacy training courses, although some pharmacists will have received risk management advice and training in Trusts.

Recommendations

- 3.4 Pharmacists should ensure that they have robust, regularly reviewed procedures in place, especially for activities that carry the most risk.
- 3.5 Continuing professional development providers should include risk management in their training programme.

- 3.6 Health Authorities and NHS Trusts should ensure that pharmacists can access training and advice about risk assessment and risk management.

4. Procedures for all professional groups to identify and remedy poor performance

- 4.1 Community pharmacy is subject to external inspection by the RPSGB Inspectorate. The RPSGB inspectorate is a major strength for identifying poor performance. Employers have a role in monitoring the performance of employee pharmacists.
- 4.2 The monitoring procedures within hospital pharmacy should detect poor performance at an early stage in most aspects of the work of a hospital pharmacy. Staff are reviewed annually as part of the Individual Performance Review (IPR) system. Additionally, quality control departments monitor aspects of the work of the hospital pharmacy and the Medicines Control Agency inspect hospital pharmacy production units and have an enforcement role in unregistered hospital pharmacies following a failure in quality or a complaint.
- 4.3 At present, the Society only has the power to reprimand poor performers or refer them to the statutory committee. The statutory committee has the power to order the removal of a pharmacist's name from the register. There are no intermediate disciplinary measures that can be taken or enforced against pharmacists with poor standards.
- 4.4 It is difficult to detect poor clinical pharmacy performance. Reviewing interventions is used by some hospital pharmacies, as are accompanied visits. However, this remains a difficult area.
- 4.5 We may need to consider re-validation as a means of identifying and dealing with sector specific competency to practice.

Recommendations

- 4.6 The inspectorate should remain as our main means of identifying poor performance and encouraging improvement. However, the Society needs the power to fine or otherwise take action against pharmacists with poor standards.
- 4.7 The Society is seeking reforms to its present disciplinary structures, which will give it the ability to deal more effectively with poor performance.

5. Making clinical governance work as a cohesive whole

- 5.1 A strength of clinical governance is that it is attempting to bring together aspects of quality that have often operated as separate entities in the NHS. The Society is playing its part in linking the elements of a comprehensive programme of quality improvement activities together with accountability and the management of poor performance. We have made strong links between clinical audit, CPD, research and development; clinical guidelines and evidence based practice. E.g. many of the continuing education

courses developed by the national continuing education centres have included aspects of audit; training on clinical audit has made use of both clinical guidelines and CPD; etc.

5.2 Pharmacists contribute to the clinical governance of the overall care of patients in a variety of ways. The most obvious way is through the prescription monitoring before dispensing. However, there are a number of other activities that are relevant, including:

- Medicines management
- Prescribing advice to GPs and Hospital doctors
- Drug and Therapeutic Committees
- Hospital prescription monitoring and intervention services
- Medication reviews in primary care
- Patient counselling

5.3 It is vital that these activities are integrated with the work of other healthcare professionals and their clinical governance arrangements. This must occur at both a local level and a national level.

Recommendations

5.4 The Society will continue to forge links between the different aspects of a comprehensive programme of quality improvement.

5.5 The Society will maintain and develop its links with NICE and the Royal Colleges and professional bodies so that an integrated approach to quality may be developed.

5.6 Clinical governance leads for community pharmacy should work with the clinical governance leads for PCGs/Local Health Groups and Health Authorities to develop an integrated approach to quality locally.

Appendix one - Summary of Recommendations

The Society

1. Clear lines of responsibility and accountability for the overall quality of clinical care.

In order to develop meaningful comparisons between pharmacies and pharmacists, the RPSGB will develop a small number of quality indicators for both community and hospital pharmacy. It is likely that suitable indicators would deal with participation in CPD and clinical audit; record keeping (patient medication records); presence of procedures; critical incidents such as complaints; additional services such as Health Screening (e.g. Cholesterol testing) and some hospital pharmacy specific indicators regarding clinical pharmacy.. (*para 1.9*)

2.1 Clinical Audit

The Society will publish further examples of both uni-professional and multi-professional clinical audits in pharmacy and continue to offer support to pharmacists wishing to develop clinical audit. (*para 2.1.6*)

2.2 Continuing Professional Development

The RPSGB will continue to develop its new approach to CPD and will roll it out depending on the results of the pilot. (*para 2.2.5*)

2.3 Clinical guidelines/evidence based practice

The Society will implement the recommendations about getting research into pharmacy practice. (*para 2.3.4*)

2.4 Research and Development

The recommendations of the Society are contained in the various papers about practice research published by the Society. (*para 2.4.3*)

2.5 Effective monitoring of clinical care with high quality systems for clinical record keeping and the collection of relevant information

The Society will develop national solutions to assist community pharmacists to record their contributions to clinical care. (*para 2.5.7*)

A common data set needs to be developed for clinical pharmacy services in hospital. This would allow comparison of the clinical pharmacy services between hospital pharmacies and the identification of where improvements can be made. The Society will facilitate a meeting to start this process. (*para 2.5.8*)

3. Clear policies aimed at managing risks.

Continuing professional development providers should include risk management in their training programme. (*para 3.5*)

4. Procedures for all professional groups to identify and remedy poor performance

The inspectorate should remain as our main means of identifying poor performance and encouraging improvement. However, the Society needs the power to fine or otherwise take action against pharmacists with poor standards. (*para 4.6*)

The Society is seeking reforms to its present disciplinary structures, which will give it the ability to deal more effectively with poor performance. (*para 4.7*)

5. Making clinical governance work as a cohesive whole

The Society will continue to forge links between the different aspects of a comprehensive programme of quality improvement. (*para 5.4*)

The Society will maintain and develop its links with NICE and the Royal Colleges and professional bodies so that an integrated approach to quality may be developed. (*para 5.5*)

Community Pharmacists

The RPSGB proposes a framework for local clinical governance accountability as follows:-

In each Health Authority area, the Local Pharmaceutical Committee (LPC) should nominate a local community pharmacist as clinical governance lead for community pharmacy. In Wales, this appointment may be at a Local Health Group level. We would recommend that the LPC involve the local RPSGB Inspector in the selection of an individual to perform this role.

The role of the clinical governance lead for community pharmacy will be to:

- Work with the local Health Authority/Local Health Group to ensure that suitable mechanisms are in place to support community pharmacists developing and implementing a comprehensive programme of quality improvement activities.
- Report to the Health Authority/Local Health Group on the quality of pharmaceutical services locally. The report should contain data collated from information supplied by the Superintendent/proprietor pharmacist and the RPSGB Inspector.
- Work with the Local Pharmaceutical Committee and RPSGB Inspectors to identify and offer support to rectify poor performance.
- Report to the Health Authority/Local Health Group and RPSGB about persistent poor performance following clearly laid out procedures agreed at a national level with all relevant stakeholders

- Liase with Primary Care Group, Local Health Group or Primary Care Trust Clinical Governance leads over how community pharmacy links into the overall clinical governance of patient care.

- Liase with, and provide professional support to, community pharmacists serving on PCG/PCT/LHG clinical governance sub-committees. *(para 1.7)*

Employers should use staff appraisal as an opportunity to help pharmacists identify their training needs. *(para 2.2.6)*

Pharmacists should ensure that they have robust procedures in place, especially for activities that carry the most risk. *(para 3.4)*

Clinical governance leads for community pharmacy should work with the clinical governance leads for PCGs/Local Health Groups and Health Authorities to develop an integrated approach to quality locally. *(para 5.6)*

Hospital Pharmacists

The Chief Pharmacist should take professional responsibility for all pharmacists and pharmacy staff in the NHS Trust and liase with the clinical governance lead in the Trust. The Chief Pharmacist should sit on the clinical governance committee of the Trust. A formal definition of the term "Chief Pharmacist" may need to be developed. *(para 1.7)*

Drug use reviews should be re-classified as clinical audit and reported to the clinical governance committee. *(para 2.1.8)*

Staff appraisal should be used as an opportunity to help pharmacists identify their training needs. *(para 2.2.6)*

Hospital pharmacists need not wait for the electronic patient record before recording their contributions in patient's records. This is something that could be negotiated locally and should be the norm rather than the exception. *(para 2.5.10)*

Pharmacists should ensure that they have robust procedures in place, especially for activities that carry the most risk. *(para 3.4)*

Health Authorities/PCGs/Local Health Groups/NHS Trusts

The RPSGB proposes a framework for local clinical governance accountability as follows:-

In each Health Authority area, the Local Pharmaceutical Committee (LPC) should nominate a local community pharmacist as clinical governance lead for community pharmacy. In Wales, this appointment may be at a Local Health Group level. We would recommend that the LPC involve the local RPSGB Inspector in the selection of an individual to perform this role.

The role of the clinical governance lead for community pharmacy will be to:

- Work with the local Health Authority/Local Health Group to ensure that suitable mechanisms are in place to support community pharmacists developing and implementing a comprehensive programme of quality improvement activities.

- Report to the Health Authority/Local health Group on the quality of pharmaceutical services locally. The report should contain data collated from

information supplied by the Superintendent/proprietor pharmacist and the RPSGB Inspector.

- Work with the Local Pharmaceutical Committee and RPSGB Inspectors to identify and offer support to rectify poor performance.
- Report to the Health Authority/Local Health Group and RPSGB about persistent poor performance following clearly laid out procedures agreed at a national level with all relevant stakeholders
- Liase with Primary Care Group, Local Health Group or Primary Care Trust Clinical Governance leads over how community pharmacy links into the overall clinical governance of patient care.
- Liase with, and provide professional support to, community pharmacists serving on PCG/PCT/LHG clinical governance sub-committees.

The role of clinical governance lead for community pharmacy will require time and resources. We would expect such a role to require a minimum of one to two sessions per week. It will require adequate funding from the Health Authority/Local Health Group. *(para 1.7)*

PCGs/PCTs and LHGs should consider appointing a local community pharmacist to their clinical governance sub-committee. *(para 1.10)*

Health Authorities and NHS Trusts should ensure that pharmacists have access to clinical audit expertise and support at the local level. *(para 2.1.7)*

Health Authorities and NHS Trusts should ensure that pharmacists have proper access to sources of evidence based research literature – both paper based and electronic media. *(para 2.3.5)*

Clinical guideline producers at both the national and local level should ensure that they obtain appropriate pharmaceutical expertise, preferably from those working in the sector that the guideline is aimed at. *(para 2.3.6)*

Health Authorities and Trusts should ensure that pharmacists can access training and advice about risk assessment and risk management. *(para 3.6)*

Clinical governance leads for community pharmacy should work with the clinical governance leads for PCGs/Local Health Groups and Health Authorities to develop an integrated approach to quality locally. *(para 5.6)*

Department of Health/National Assembly for Wales

The government should ensure that adequate funds are made available to ensure full participation in CPD in pharmacy. *(para 2.2.7)*

Clinical guideline producers at both the national and local level should ensure that they obtain appropriate pharmaceutical expertise, preferably from those working in the sector that the guideline is aimed at. *(para 2.3.6)*

Pharmacists need access to relevant patient clinical data and to record their contributions in a way that allows other healthcare professionals to access the information. The development of the electronic patient record may help this situation providing that community pharmacists are given access and allowed to contribute more than just dispensing data. *(para 2.5.9)*

The Society is seeking to establish a Standards Tribunal, which will give it the ability to deal more effectively with poor performance. *(para 4.7)*