

Achieving excellence in pharmacy through clinical governance

Royal Pharmaceutical Society in Scotland's
policy on clinical governance



**Royal
Pharmaceutical
Society**
of Great Britain

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Introduction

The Royal Pharmaceutical Society is a self-regulating professional body and is responsible for all professional standards of practising pharmacists. The Society not only has a code of ethics but a statutory responsibility for the maintenance of quality of standards within the profession. The Society welcomes the introduction of Clinical Governance in the National Health Service in Scotland (NHSiS).

Clinical governance has been described as the “vital ingredient, which will enable us to achieve a Health Service in which the quality of health care is paramount”. It has been defined as “corporate accountability for clinical performance”. The draft guidance on clinical governance produced by the Scottish Office Department of Health in 1998 stated that clinical governance would not replace professional self-regulation. The Royal Pharmaceutical Society in Scotland agrees with this.

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

Clinical governance must operate in all patient services within the NHS whilst recognising that the environments within primary, secondary and tertiary care are different. Pharmacy as a whole continually addresses the defining and implementation of professional standards for pharmacists within all areas of the NHSiS, through the Royal Pharmaceutical Society.

Summary

The Royal Pharmaceutical Society in Scotland welcomes the introduction of clinical governance into the National Health Service in Scotland. This paper addresses the main components of clinical governance and makes specific recommendations relevant to the practice of pharmacy.

Responsibility and accountability for the overall quality of clinical care

There are clear lines of responsibility for the quality of clinical care in both community and hospital pharmacy practice. The Society recommends that in each Health Board area the Specialist in Pharmaceutical Public Health should have responsibility for formulating a strategy for clinical governance as part of a multi-disciplinary approach. It is essential that community pharmacy is recognised as a key player within the health care team in order to develop and progress the multidisciplinary approach within PCTs and LHCCs. Ideally, a local community pharmacist should be nominated as the clinical governance lead for community pharmacy. The time and resources required will necessitate funding by the Health Boards. PCTs and LHCCs must consider appointing a local community pharmacist to their clinical governance committee.

Quality improvement activities

The Society has been supporting clinical audit for several years. It is a formal requirement of NHSiS contractor services and the profession has contributed to its development by the Clinical Resource and Audit Group (CRAG). The Society will continue to support pharmacists developing clinical audit. Health Boards and NHS Trusts should ensure that pharmacists have access to clinical audit expertise at a local level with appropriate funding.

The Society will continue to develop and implement its approach to continuing professional development (CPD). However, it has concerns about funding for CPD. The government should provide funding to ensure full participation in CPD in both community and hospital pharmacy.

Pharmacy contributes to the development of clinical guidelines at both a national and local level. However, local adaptation of national guidelines is often conducted without pharmaceutical input and clinical guidelines are not routinely distributed to community pharmacists. Clinical guideline producers at both national and local levels should ensure that they obtain appropriate pharmaceutical expertise. The Society anticipates significant participation from pharmacy with the Scottish Health Technology Centre (SHTAC) and the Clinical Standards Board for Scotland (CSBS).

The generation of research-based data is recognised as underpinning and supporting clinical governance. The Royal Pharmaceutical Society commissions and publishes rigorous health services research throughout the whole of Great Britain. The Society's Research Fellow in Scotland is currently preparing a paper on pharmacy practice research in Scotland.

The Society will facilitate the implementation of the CRAG reports, “Clinical pharmacy in the hospital pharmacy service: a framework for practice” and “Clinical pharmacy practice in primary care”. However, 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 Scottish Executive Department of Health should ensure that the ability to exchange clinical information is incorporated into its programme to develop Electronic Data Interchange (EDI).

Managing Risks

The profession is well aware of the risks attached to its work. Pharmacists must ensure that they have robust, regularly reviewed procedures in place to manage risk. CPD providers should ensure that risk management is included in their training programmes. Health Boards and NHS Trusts should ensure that pharmacists have access to training and advice about risk assessment and risk management.

Procedures to identify and remedy poor performance

The Royal Pharmaceutical Society’s Inspectorate should remain the profession’s principal means of identifying poor performance and encouraging improvement in community pharmacy practice. The Society has the power to reprimand poor performers or refer them to its Statutory Committee, which has the power to order the removal of a pharmacist’s name from the register. However, the Society has no intermediate disciplinary measures and needs the power to fine or otherwise take action against pharmacists with poor standards. Monitoring procedures within hospital pharmacy should detect poor performance at an early stage. The CRAG reports, “Clinical pharmacy in the hospital pharmacy service: a framework for practice” and “Clinical pharmacy practice in primary care” should be used as a starting point for establishing appropriate standards of clinical pharmacy practice.

Making clinical governance work as a cohesive whole

Clinical governance is a multi-disciplinary activity. It attempts to bring together aspects of quality that have often operated as separate entities in the NHSiS. Pharmacists contribute to clinical governance in the overall care of patients in a variety of ways, most obviously through prescription monitoring as part of the dispensing process. However, pharmacists also have important roles in: medicines management, prescribing advice to GPs and hospital doctors, Drug and Therapeutics Committees, hospital prescription monitoring and intervention services, medication reviews in primary care, repeat supply, patient counselling, OTC supply of medicines, and pharmacy-led clinics (e.g. for warfarin, asthma, angina).

It is vital that these activities are integrated with the work of other healthcare professionals and their clinical governance arrangements. The Society will continue to develop links to facilitate this process, particularly with the Royal Colleges, other professional bodies, SHTAC and CSBS so that an integrated approach to quality may be developed.

Achieving excellence in pharmacy through clinical governance

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 Royal Pharmaceutical Society's Code of Ethics and Standards. This is unique to pharmacy and is one of the great strengths of the profession.
- 1.2 The superintendent/proprietor pharmacist must retain professional responsibility for the quality of his/her pharmacies. In addition there needs to be some commonality in the arrangements for clinical governance for community pharmacy and arrangements for other professions. Primary Care Trusts (PCTs), Local Health Care Co-operatives (LHCCs) and Health Boards 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 The question of accountability for community pharmacy is complex. PCTs encompass primary care and some elements of what were previously secondary care services, such as mental health, learning disabilities and care of the elderly. All PCTs should have a Trust Chief Pharmacist who has responsibility for developing clinical governance in the delivery of pharmaceutical care as part of the Trust's policy. LHCCs are currently developing clinical governance frameworks.
- 1.4 In the acute sector, the Chief Pharmacist of a Trust will 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.
- 1.5 In some NHS Trusts, pharmacists may be managerially accountable to the Directorate that they serve rather than the Chief Pharmacist. The Chief Pharmacist should retain professional responsibility for all pharmacists employed in the Trust, but may not be managerially responsible for them.
- 1.6 Trust Chief Executives, together with their Boards, have corporate responsibility for the delivery of clinical governance. It would therefore be inappropriate to delegate or share this responsibility beyond these bodies. The Royal Pharmaceutical Society believes that whatever internal management arrangements are put in place to monitor and assign responsibility for the quality of care should be multi-disciplinary and represent all healthcare professionals.

- 1.7 The Scottish Specialists in Pharmaceutical Public Health should provide support at Health Board level.

Recommendations

- 1.8 *The Royal Pharmaceutical Society in Scotland proposes a framework for local clinical governance accountability as follows:-*
- 1.8.1 *In each Health Board the Specialist in Pharmaceutical Public Health and Trust Chief Pharmacists should have a collective responsibility for formulating a strategy for clinical governance in pharmacy as part of a multi-disciplinary approach. Community pharmacists' status as independent contractors must be recognised. In order to progress and develop the multidisciplinary approach within PCTs and LHCCs it is essential that community pharmacy be recognised as a key player within the health care team. Ideally, a local community pharmacist should be nominated as clinical governance lead for community pharmacy. The Society recommends that the Area Pharmaceutical Committee involves the local Royal Pharmaceutical Society Inspector in the selection of an individual to perform this role. It is recognised that more than one person may be required in some of the larger Health Board areas to fulfil this role.*
- 1.8.2 *The clinical governance lead should consider all aspects of clinical governance and ensure close working of community, hospital, practice and academic pharmacists. Specific responsibilities of this position should include:*
- *Work with the local Health Board/PCT/LHCC 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 Board/PCT/LHCC on the quality of pharmaceutical services locally. The report should contain data collated from information supplied by the superintendent/proprietor pharmacist and the Royal Pharmaceutical Society Inspector.*
 - *Work with the APC and Royal Pharmaceutical Society Inspectors to identify and offer support to rectify poor performance.*
 - *Report to the Health Board/PCT/LHCC and Royal Pharmaceutical Society about persistent poor performance following clearly laid out procedures agreed at a national level with all relevant bodies.*
 - *Liaise with PCT and LHCC Clinical Governance leads over how pharmacy links into the overall clinical governance of patient care.*
 - *Liaise with and provide professional support to pharmacists serving on PCT/LHCC clinical governance sub-committees.*
- 1.8.3 *Financial support and resources will be required together with mechanisms to facilitate the independent (perhaps sole proprietor) contractor to release free time. The role of clinical governance lead for community pharmacy will require time and resources. It is anticipated that a minimum of one to two sessions per week will be necessary to fulfil this role. It will require adequate funding from the Health Board.*

- 1.9 *In hospital pharmacy, the Chief Pharmacist should take professional responsibility for all pharmacists and pharmacy staff in the NHS Trust and liaise with the clinical governance lead in the Trust. The Chief Pharmacist should sit on the clinical governance committee of the Trust or its operational sub-committee.*
- 1.10 *Local implementation of the CRAG (Clinical Resource and Audit Group) guidelines “Clinical pharmacy in the hospital pharmacy service: a framework for practice” and “Clinical pharmacy practice in primary care” should be used to make meaningful comparisons in the quality of care to different sectors of service and to individual patients. (See also Section 4.)*
- 1.11 *PCTs and LHCCs must consider appointing a local community pharmacist to their clinical governance committee.*

2. A comprehensive programme of quality improvement activities

2.1 Clinical audit

- 2.1.1 The Royal Pharmaceutical Society has been supporting the development of clinical audit for several years. Examples of clinical audit have been published on the Royal Pharmaceutical Society's web site and these can be freely downloaded at www.rspgb.org.uk/audhome. The Society has a Scottish Clinical Audit Fellow who is funded by a grant from the Scottish Executive Department of Health.
- 2.1.2 There is national input by pharmacy to the development of clinical audit through participation in the Clinical Resource and Audit Group (CRAG). In this particular context there have been CRAG guidelines on "Counselling and advice on medicines and appliances in community pharmacy practice", "Clinical pharmacy in the hospital pharmacy service: a framework for practice" and "Clinical pharmacy practice in primary care".
- 2.1.3 Training and support for clinical audit to both community and hospital pharmacists is provided by the Scottish Centre for Post-qualification Pharmaceutical Education (SCPPE) as well as by Health Boards and Trusts. Clinical audit is taught at undergraduate level, is a component of most postgraduate diploma courses and is being incorporated into several continuing education courses.
- 2.1.4 Clinical audit in hospital pharmacy is well developed with pharmacists participating in uni-professional and multi-professional clinical audit. There are several regional or specialty audit schemes within hospital pharmacy. 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.
- 2.1.5 Audit is a formal requirement of NHSiS contractor services as defined in the Scottish Drug Tariff (Part I Section 20). However, clinical audit has been slower to develop in the community pharmacy sector. This has been mainly due to difficulties accessing local audit expertise and support. Support from Health Boards, when it has been available has been beneficial. Greater Glasgow, for example, with an Audit Specialist Pharmacist and a network of Audit Facilitators has ensured a high level of participation amongst community pharmacists.
- 2.1.6 Despite these difficulties, there have been significant developments in clinical audit in community pharmacy. Many community pharmacy chains have developed in-house clinical audit structures and pharmacists working with general medical practices also undertake clinical audit.

Recommendations

- 2.1.7 *The Society will publish further examples of both uni-professional and multi-professional clinical audits in pharmacy and continue to promote and offer support to pharmacists wishing to develop clinical audit.*
- 2.1.8 *Health Boards and NHS Trusts should ensure that pharmacists have access to clinical audit expertise and support at the local level.*
- 2.1.9 *Drug use reviews should be considered in the context of clinical audit and conducted accordingly. Results should be routinely made available to the clinical governance committee.*

2.2 Continuing professional development

- 2.2.1 Continuing professional development (CPD) is a cyclical process of reflection, planning, action and evaluation. It includes everything that a pharmacist learns which makes him or her better able to do his or her job. CPD should be distinguished from continuing education which is used to refer to traditional methods of learning such as attending courses, following diploma or distance-learning courses, or structured reading. Pharmacists have a personal commitment to participate in at least 30 hours of continuing education *per annum*.
- 2.2.2 The national continuing education centre (SCPPE) is a major strength for pharmacy. It produces and disseminates nationally evidence-based training to both community and hospital pharmacists. A mixture of national and local topics allows some local targeting of training, often in a multi-disciplinary context.
- 2.2.3 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. The Association of Scottish Trust Chief Pharmacists (ASTCP) has developed a vocational training scheme for hospital pharmacists in conjunction with the College of Pharmacy Practice. The ASTCP is also developing a training scheme for hospital pharmacy leaders.
- 2.2.4 Performance appraisal and development systems already in place not only include objective setting but also incorporate a personal development plan. These should be introduced where they are not already practiced.
- 2.2.5 The Royal Pharmaceutical Society 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.

- 2.2.6 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 all areas of pharmacy practice. The acute sector attracts funding in support of its training and development programme. The community sector fails to attract similar levels of funding and this should be remedied.

Recommendations

- 2.2.7 *The Royal Pharmaceutical Society will continue to develop its approach to CPD and will roll it out depending on the results of the pilot.*
- 2.2.8 *Employers should use staff appraisal as an opportunity to help pharmacists and their support staff identify their training needs, which should then be incorporated into a personal development programme.*
- 2.2.9 *Trust Chief Pharmacists should develop an education strategy as part of the overall planning strategy.*
- 2.2.10 *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 Pharmacy has national and local input into the development of clinical guidelines. A representative nominated by the Society's Scottish executive is a member of the Scottish Intercollegiate Guideline Network (SIGN). The Society anticipates significant pharmacy participation with the Scottish Health Technology Assessment Centre (SHTAC) and the Clinical Standards Board for Scotland (CSBS).
- 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. The Society has also found that local clinical guidelines are not routinely circulated to community pharmacists.
- 2.3.3 The Society has 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 (see also paragraph 2.4.3).
- 2.3.4 The Scottish Executive Department of Health is keen to develop a learning organisation culture across organisations within the NHSiS. A learning organisation is one where: the importance of individual learning is recognised; team learning is promoted; experimentation is encouraged and failure tolerated; and responsibility is devolved in supportive environment (in a way that allows individuals to develop and grow). Pharmacy's emphasis and record on evidence-based practice and audit are clear demonstrations of the profession's commitment to such a culture.

Recommendations

- 2.3.5 *The Society will implement its recommendations on getting research into pharmacy practice.*
- 2.3.6 *Health Boards and Trusts should ensure that pharmacists have appropriate access to sources of evidence based research literature – both paper based and electronic media. The Trust pharmaceutical department should be proactive in supporting evidence-based practice by the preparation and dissemination of appropriate guidelines.*
- 2.3.7 *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.*

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 (in England and Wales), 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 throughout the whole of Great Britain 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. Specifically, the Royal Pharmaceutical Society has a Research Fellow in Scotland.
- 2.4.2 However, the Society's contributions to wider health service debates on the development of 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 Royal Pharmaceutical Society has published the following papers about practice research:*
- *A new age for pharmacy practice research: Promoting evidence-based practice in pharmacy. London: RPSGB, 1999*
 - *Medicines, pharmacy and the NHS: Getting it right for patients and prescribers. London: RPSGB 1999*
 - *Drug therapy and pharmacy: Setting the research agenda. London: RPSGB 1999*
 - *Self-care and pharmacy: Setting the research agenda. London: RPSGB 1998*
- The Society's Research Fellow in Scotland is currently preparing a paper on pharmacy practice research in Scotland.*

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 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 However, community pharmacists do not have access to patients' 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 multidisciplinary solutions.
- 2.5.4 Hospital pharmacy generally keeps good records, for example, dispensing, production, drug information, drug use review, aseptic dispensing, distribution and quality control. In addition, hospital pharmacists have free access to patient's hospital medical records. These hospital records need to be integrated within a hospital pharmacy system that includes an electronic prescription and administration cardex and is linked to the electronic patient record. An electronic cardex is essential in the hospital service to facilitate effective clinical governance.
- 2.5.5 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 contribute routinely to patients' notes: this can lead to clinicians being unable to identify the reasons for changes in medication when reviewing a patient's history and should be remedied.
- 2.5.6 The CRAG guidelines "Clinical pharmacy in the hospital pharmacy service: a framework for practice" and "Clinical pharmacy practice in primary care" have been implemented to varying degrees in Trusts across Scotland. This means that currently there is an inability to compare practice effectively across Trusts.

Recommendations

- 2.5.7 *The Royal Pharmaceutical Society will facilitate the implementation of the CRAG reports "Clinical Pharmacy Practice In Secondary Care" and "Clinical Pharmacy Practice In Primary Care".*
- 2.5.8 *The Royal Pharmaceutical Society will develop solutions to assist community pharmacists to record their contributions to clinical care.*

- 2.5.9 *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 Royal Pharmaceutical Society will facilitate a Great Britain-wide meeting to start this process.*
- 2.5.10 *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 Scottish Executive Department of Health should ensure that the ability to exchange clinical information is incorporated into its programme to develop Electronic Data Interchange (EDI).*
- 2.5.11 *Hospital pharmacists need not wait for the electronic patient record before recording their contributions in patients' 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 its 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 are similarly aware of the potential dangers. Pharmacists have developed a range of procedures and protocols in order to manage these risks and others associated with the practice of pharmacy.
- 3.2 Pharmacists also have a significant role to play in the risk management of other professions. Pharmacists assess prescriptions and identify errors and omissions in therapy. This role is more complete where pharmacists have access to clinical information about the patient.
- 3.3 There is also a financial risk in medicines usage. There is a need to ensure that medicinal treatment is effective, that medicines are used correctly, that pharmacists encourage concordance and that waste is kept to a minimum.
- 3.4 Currently, formal risk assessment and risk management do not featured in many pharmacy training courses, although some pharmacists will have received risk management advice and training in Trusts.

Recommendations

- 3.5 *Pharmacists should ensure that they have robust, regularly reviewed written procedures in place, especially for activities that carry the most risk.*
- 3.6 *Risk management training should be available, preferably on a multi-disciplinary basis. This will ensure that professionals recognise the risks within colleagues' practice and work collectively to reduce these risks.*
- 3.7 *Health Boards and NHS Trusts should ensure that pharmacists have access to 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 Royal Pharmaceutical Society's Inspectorate. The Inspectorate is a major strength for identifying poor performance. Also, employers have a role in monitoring the performance of employee pharmacists.
- 4.2 There are hospital pharmacy procedures in place that are continuously reviewed and updated. Application of these should ensure a high standard of performance and dispensary procedure. Members of staff are appraised on an on-going basis as part of the Individual Performance Review (IPR) system. Additionally, quality control departments monitor technical 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 its 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 by the Society.
- 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 The Society 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 the profession's principal means of identifying poor performance and encouraging improvement in community pharmacy practice. However, the Society needs the power to fine or otherwise take action against pharmacists with poor standards.*
- 4.7 *At present, the Society only has the power to reprimand poor performers or refer them to its Statutory Committee. The Society needs reforms to its present disciplinary structures to give it the ability to deal more effectively with poor performance.*
- 4.8 *Standards for clinical pharmacy practice are essential. The CRAG reports "Clinical pharmacy in the hospital pharmacy service: a framework for practice" and "Clinical pharmacy practice in primary care" should be used to develop and establish appropriate standards of practice.*

5. Making clinical governance work as a cohesive whole

- 5.1 A strength of clinical governance is that it attempts to bring together aspects of quality that have often operated as separate entities in the NHSiS. 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, evidence-based practice and risk management.
- 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 prescription monitoring as part of the dispensing process. However, there are a number of other activities that are relevant and should be taken into account, 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
 - repeat supply
 - patient counselling
 - OTC sale of medicines
 - pharmacy-led clinics (e.g. for warfarin, asthma, angina)
- 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 and national level.
- 5.4 Pharmacists are uniquely placed to involve patients and other members of the public. This is considered essential to effective clinical governance.

Recommendations

- 5.5 *The Society will continue to forge links between the different aspects of a comprehensive programme of quality improvement.*
- 5.6 *The Society will maintain and develop its links with the Royal Colleges, professional bodies, SHTAC and CSBS so that an integrated approach to quality may be developed.*
- 5.7 *Clinical governance leads for community pharmacy must work with the clinical governance leads for PCTs, LHCCs and Health Boards to develop an integrated approach to quality locally.*

Scottish Department
Royal Pharmaceutical Society of Great Britain
36 York Place
Edinburgh
EH1 3HU

Telephone: 0131-556-4386
Facsimile: 0131-558-8850
E-mail: 101561.2226@compuserve.com