

# FIRST STEPS IN CLINICAL GOVERNANCE

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*In this article the authors describe a series of surveys, conducted in the East Riding and Hull Health Authority, of factors relevant to clinical governance in community pharmacy. The aim of these surveys was to initiate the clinical governance process*

Clinical governance was introduced as a concept in "A first class service: quality in the new NHS".<sup>1</sup> More detailed guidance on the implementation of clinical governance was given in "Clinical governance in the new NHS".<sup>2</sup> In the latter document the health authority was identified as being responsible for supporting and facilitating the development of clinical governance among those contractor professions not encompassed by primary care groups.

This group of contractor professions includes pharmacy. Development of clinical governance culture in community pharmacy presents some unique challenges not faced by other contractor professions. These include:

- 1 The role of multiples in implementing clinical governance
- 1 The widespread use of locums to manage pharmacies on a full-time basis
- 1 The professional isolation of community pharmacists
- 1 The competition between pharmacies leading to a culture of secrecy, not of sharing

Some of these difficult problems were recognised in the framework for clinical governance in pharmacy published by the Royal Pharmaceutical Society.<sup>3</sup> The framework set out in the document seemed to many to be idealistic. It does not tackle the major problems of different types of organisation or the lack of familiarity of community pharmacists with the survey/problem identification/training/resurvey cycle used in many parts of the directly managed NHS.

Pharmacists in the East Riding recognised the valuable contribution that clinical governance could make to improve the quality of community pharmacy practice. The health authority set up a "clinical governance in community pharmacy group" comprising PCG pharmaceutical advisers, local pharmaceutical committee representatives and pharmacy development group representatives. The group accepted that the development plans set out in "Clinical governance in the new NHS"<sup>2</sup> for the managed service are too ambitious for the pharmacy contractor service at this time. There are no direct incentives to persuade pharmacists to become involved in the process and no obvious rewards for participation. However there is a professional desire to embrace the new way of working.

Taking these factors into account the group agreed to move forward cautiously. We built on the experience of the South Humber Health Authority which had developed a number of surveys of pharmacy practice. The group planned and executed a

series of self-surveys as a way of initiating the clinical governance process.

Four surveys of pharmacy practice were developed.

- 1 Survey one: health and safety in the workplace
- 1 Survey two: the use of health promotion materials
- 1 Survey three: availability of information sources
- 1 Survey four: participation in continuing professional development

The surveys were approved by the community pharmacy clinical governance committee of the health authority and by the East Riding and Hull Local Pharmaceutical Committee. It was agreed that the health authority would pay a fee of £10 for each completed survey.

The survey forms were sent out in pairs. Surveys one and two were posted in spring 2000, surveys three and four in autumn 2000. Surveys one and two were repeated in spring 2001. They were posted to all community pharmacy premises in the East Riding and Hull Health Authority, a total of 116 pharmacies. A letter asking the pharmacist to complete the survey and return the form to their PCG pharmaceutical adviser accompanied the survey forms.

The replies for each PCG were collated by the pharmaceutical adviser and a summary of responses forwarded to the health authority. This preserved the anonymity of response.

The collated results for surveys one to four were presented to the clinical governance group and the LPC. A summary of the results was included in the newsletter and the results were sent to all pharmacies. Surveys one and two were then repeated in early spring 2001.

The response rate for survey one in spring 2000 was 46 per cent. The response rate varied between the four PCGs from 39 per cent to 62 per cent.

The first part of the survey dealt with health and safety issues. Several pharmacies

did not display health and safety information (11 per cent) or give a copy of the health and safety policy to their employees (13 per cent). Not all staff were trained in health and safety and 19 per cent of pharmacies had not carried out a health and safety assessment in the past 18 months. Fire precautions received a lower response rate than other sections. Only 46 per cent of those responding completed this section. Of these 31 per cent claimed not to have a fire certificate and 37 per cent had not received training in fire safety in the last 12 months.

The majority of pharmacies (78 per cent) had current Control of Substances Hazardous to Health assessments and a correct first aid kit (56 per cent). Just over half the pharmacies had an employee who was a qualified first aider. The survey asked about maintenance of balances: 52 per cent had not had their balance checked within the last six months.

The second survey dealt with the use of health promotion materials. Nearly all pharmacies (98 per cent) had the recommended list of leaflets available, prominent and in an accessible position. Most pharmacists (57 per cent) used the leaflets on a regular basis and considered the leaflets to be "quite relevant" (85 per cent). All pharmacies kept at least eight out of the 10 required health promotion leaflets, 72 per cent displayed additional leaflets and 65 per cent displayed their practice leaflet.

Availability of the set of reference books recommended for preregistration training pharmacies was the subject of the third survey. There was a 51 per cent response to this survey and this is summarised in Table 1. Several responses gave the edition in use of Martindale; this varied from the current edition (32nd) to the 28th edition.

The fourth survey asked pharmacists to identify which continuing professional development provision they had used in the last year. Most of the responders (62 per cent) spent more than 30 hours each year on CPD with a small number (7 per cent) spending less than 10 hours. Of the responders 22 per cent used the Royal Pharmaceutical Society's log book to record their CPD participation (Table 2).

The response rate to the repeat of surveys one and two in spring 2001 was 58 per cent. The responses given in these surveys are compared with those of the first surveys in Table 3. There was a significant increase in the proportion of responders answering "yes" to four questions (chi squared  $P < 0.1$ ). These were the questions relating to display of health and safety policy and information, possession of a fire certificate, checks on clearance of fire exits and fire extinguishers. However because the questionnaires were anonymous it was not

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**TABLE 1: SUMMARY OF RESPONSES TO SURVEY OF REFERENCE BOOKS IN PHARMACIES**

	% of pharmacies with book available
Martindale	98
British National Formulary	100
Medicine Ethics and Practice	88
Pharmacy Law and Ethics or Pharmacy Law and Practice	38
Patient Care in community pharmacy	24
Datasheet compendium	95
Minor Illness or Major Disease etc	31
Nutrition and dietary advice or Centre for Pharmacy Postgraduate Education course on nutrition	41
Catalogue of pharmaceutical products-updated	45
Diluent Directory	86
Drug Tariff	95
Medical dictionary	71
Handbook of Health Education or Health Promotion for Pharmacists	45
Electronic sources of information	41

possible to compare changes in individual pharmacies. There was no major change in the proportion of responders to other questions.

The response rates to the survey were not as high as expected in view of the payment offered. There could be several factors contributing to this, for example the prevalence of locums in the East Riding and Hull Health Authority. However, there is not a culture of voluntary participation in surveys of practice in community pharmacy and therefore response rates may improve with familiarity and a realisation that anonymity was intended and preserved. The health authority did not know the origin of individual responses and could not use them for follow up of replies which indicated a low level of service.

The responses indicated that the survey had been answered honestly. It would have been simple to answer "yes" to all questions if the responder was intending to impress since it was clear that "yes" was the expected answer for the majority of questions in the surveys.

The results do give cause for concern in that some basic systems and facilities do not appear to be in place in this sample of pharmacies. The results of the survey were distributed to all pharmacies with an accompanying letter explaining that one of the principles of clinical governance was to use such information to improve practice and the safety of patients.

The clinical governance group has used the survey to identify training needs for community pharmacists. The priority areas identified were health and safety at work, preparation of standard operating procedures and preparation of personal development plans. As yet the group has not commissioned the training identified because of the problems surrounding release of pharmacists during the normal working day.

**TABLE 2: SUMMARY OF RESPONSES TO PARTICIPATION IN CONTINUING PROFESSIONAL DEVELOPMENT**

	% of pharmacists participating in continuing professional development
Centre for Pharmacy Postgraduate Education workshops	55
CPPE distance learning systems	71
<i>The Pharmaceutical Journal</i> credit for distance learning	36
Other distance learning programmes	31
College of Pharmacy Practice distance learning/study days	14
Royal Pharmaceutical Society branch meetings	48
Local pharmaceutical committee meetings	22
Pharmacy development group	34
British Pharmaceutical Conference	3
Royal Pharmaceutical Society audio/visual loan	7
United Kingdom Clinical Pharmacy Association	3
National Association of Women Pharmacists meetings	0
Liaison meetings with health authority	29
Conferences organised by health authority	28
National Pharmaceutical Association conferences/training activities	16
Company conferences/training	64

This has been a tentative first step to introducing community pharmacists to clinical governance. It should have helped pharmacists identify problem areas in their current practice, which they should then be able to remedy. The exercise has raised many questions. Not least of these is the relationship of multiples, with their own in-house approach to clinical governance, to that of independent pharmacies. The multiples do have excellent systems in place. However, the use of locums to staff some pharmacies might mean that there is a lack of ownership of the systems.

The results of the repeat of surveys one and two were disappointing in that there was little improvement in those areas where there was scope for improvement. There were five questions where the "yes" response was less than 60 per cent on the first survey. There was an increase in the proportion of "yes" responders in four of these questions.

No educational or training events dealing with health and safety were held between the first and second surveys. The expectation was that pharmacists would realise that a "yes" answer was the correct one and set about remedial action. This appears not to have taken place, although the responders to the second survey could be a different population from those responding to the first survey.

Comparison of all responses does suggest an overall small improvement. There are still deficiencies in some pharmacies. The clinical governance group now plans to provide appropriate training following each

**TABLE 3: SUMMARY OF RESPONSES TO SURVEYS ONE AND TWO**

	% of pharmacists answering "yes"	
	First survey	Repeat survey
Health and safety policy displayed	85	96
Health and safety information displayed	89	97
Poster displayed or copy to employees	87	91
All staff trained in safety instructions	81	91
First aid notice displayed	72	78
Health and safety assessment performed	81	90
Control of Substances Hazardous to Health assessment current	78	85
First aid kit correct	56	79
Access to disposable gloves	98	99
Any employee a qualified first aider	52	54
Correct selection of weights	96	96
Accuracy checked in past six months	48	44
Do you have a fire certificate	69	79
All fire extinguishers checked in past 12 months	41	96
All staff received fire training in past 12 months	63	69
All fire exits clear	67	93
Leaflets prominent and accessible	98	99
Leaflets used regularly by pharmacists	57	60
How relevant are the leaflets to practice?		
very	7	13
quite	85	76
not	6	10

survey. This will enable benchmarks to be set and allow the repeat survey to be classed as an audit.

The more challenging aspects of clinical governance lie ahead, the application of evidence-based choice to over-the-counter medicines and validation of consistency of advice to patients are two such areas. It remains to be seen whether the self-audit approach coupled with additional training to meet identified needs is a sufficiently robust method to apply clinical governance to these issues.

## REFERENCES

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3. Royal Pharmaceutical Society. Achieving excellence in pharmacy through clinical governance. London: The Society; 1999.