

# STRIVING FOR EXCELLENCE: THE DEVELOPMENT OF THE KENT PHARMACY ACCREDITATION SCHEME

*Kent pharmaceutical advisers Linda Dodds and Jackie Giltrow describe how community pharmacies in Kent are being integrated into local primary care clinical governance arrangements and suggest how clinical governance can be developed in the future*

In 1998 the White Paper "The new NHS: modern, dependable" set out the Government's vision of clinical governance as it applied to primary and secondary care. However, this vision did not specifically include professions allied to medicine working outside the direct scope of primary care groups and trusts, and it was not until December 2001 that "Clinical governance in community pharmacy: guidelines on good practice for the NHS" was published. This paper outlined the first steps for integrating community pharmacy into local primary care clinical governance arrangements, and proposed how clinical governance should be developed and embedded into professional practice.

In East Kent clinical governance has been robustly addressed by PCGs since their inception. A two-part clinical quality framework for GP practice has been implemented in East Kent since April 1998. The East Kent primary care clinical effectiveness programme sets clinical standards for GP practices in 14 disease areas and requires practices to demonstrate the achievement of these standards annually. This programme was aligned with an agreed set of organisational standards for primary care entitled "Goals 2000". In December 1999, quality standards for practice nurses were launched, shortly followed by the introduction of clinical supervision for practice nurses. All of these contributed to the PCG's overall clinical governance framework.

It was agreed that similar arrangements would be valuable for community pharmacy so discussions started in late 1999 with the local pharmaceutical committee. It was agreed the purpose of a clinical governance framework for community pharmacy would be to:

- Demonstrate the commitment of community pharmacy to the principles of clinical governance
- Integrate the community pharmacy's role into the primary care team
- Open discussions with PCGs on how to develop and use the framework
- Facilitate discussions with PCGs around developing and assuring the quality of future clinically effective pharmaceutical services

After scoping projects elsewhere in the UK, it was agreed that a system developed in Bromley Health Authority could best be

adopted to East Kent's needs, and discussions over several months with the LPC led to agreement for a framework which set standards in five areas of pharmaceutical services:

- 1 Premises
- 2 CPD for pharmacists
- 3 Training of medicines counter staff
- 4 Communication and complaints procedures
- 5 Health promotion

It was eventually agreed with the LPC that funding would not be made available for achieving the framework standards, which were acknowledged by all to represent good professional and business practice. Instead, linking the clinical governance framework with a process for accreditation enables accredited pharmacies to apply to participate in pharmaceutical services identified for funding and support by the PCTs.

In hindsight, the framework was able to be progressed for two main reasons. At the time of these discussions, a number of exciting new community pharmacy services were being developed in East Kent, such as provision of emergency hormonal contraception under patient group direction, smoking cessation services, together with pilot cardiovascular and repeat dispensing projects, all of which were being funded by the PCG/Ts. This helped demonstrate the commitment of PCGs to community pharmacy. In addition, we were fortunate to have a supportive LPC, which wanted to demonstrate the benefits of community pharmacy services to PCG/Ts and which was also committed to raising standards in community pharmacy, a commitment supported by the East Kent community pharmacists themselves who attended two consultation meetings on the framework held in November 2000.

## ROLL OUT OF THE FRAMEWORKS

The framework was rolled out in both East and West Kent, because the two health authorities were served by one LPC and were likely to merge in the future.

The LPC and one of us (LD) worked together to develop a package of information to support the framework, in consultation with relevant agencies such as the National Pharmaceutical Association and organisations providing packages for medicines counter staff training. The informa-

tion was collated into folders and distributed to all pharmacies in East Kent by the PCG pharmaceutical advisers in June 2001. In West Kent launch meetings were held in February 2002, followed by the distribution of the framework folders.

All the launch meetings were well attended and the concept was received with enthusiasm. Overall, contractors throughout Kent were positive about the framework. After contractors had had time to review the clinical governance framework and supporting documents they were asked, by mail and later by telephone, when they thought they might be ready for accreditation. In addition, those who believed that they were a long way from accreditation were asked what support they thought they might need, so that this could be provided. To add to this information, a baseline assessment was carried out across Kent to identify the relative strengths and weaknesses.

Some of the more controversial areas proved to be the following standards:

**Pharmacy premises** There was a requirement for written standard operating procedures (SOPs), including ones covering dispensing, arrangement of oiwings, responding to complaints, specific guidance to locums, dispensing private prescriptions and extemporaneous dispensing. In addition, there was a requirement for a private area for consultations to be identified within the pharmacy.

**Health promotion** There was a requirement for each pharmacist to complete the Centre for Pharmacy Postgraduate Education distance learning course "Improving the public's health through health promotion" and a requirement for the pharmacist manager to meet local surgery staff at least once a year to discuss areas of mutual interest.

As a result, it was agreed that one of us (JG) would be responsible for the preparation of written template SOPs for key areas of practice on behalf of the contractors. These SOPs were prepared and presented at four training meetings in East and West Kent. Again the level of attendance at the meetings (around 160 pharmacists overall) indicated that this support was valued and needed. Contractors who attended the meeting were provided with a paper and electronic version of the template SOPs, which they could use to tailor to the procedures operating within their own pharmacies.

## THE ACCREDITATION PROCESS

Although contractors were not enthusiastic about a formal accreditation procedure, this was believed to be a necessary part of the process and most agreed the best team to accredit a pharmacy was a pharmacist plus a non-pharmacist from the PCT who would see the pharmacy from the customer viewpoint.

In order to help demystify the accreditation process, a checklist of what the accreditors would be reviewing during their one-hour visit was drawn up and distributed to all community pharmacies.

PCTs were each asked to nominate a non-pharmacist representative who would take part in the accreditation process for pharmacies within their PCT. Most nominated a primary care service development manager. A half-day training programme was drawn up which covered background issues such as what happened in a working day in a community pharmacy, and what procedures and practices would be reviewed during the accreditation visit, and why they were important. A session also covered the differences between an inspection by the Royal Pharmaceutical Society and the Kent accreditation process. The training left the PCT accreditors with a much better understanding of the work of community pharmacies and an enthusiasm to be involved in the process.

## LIAISON WITH PCTs

In addition to the work with named PCT representatives around accreditation, the PCTs in East Kent have been kept fully informed of all developments in this process through the East Kent Clinical Governance Forum, where all PCT and trust clinical governance representatives meet quarterly to discuss clinical governance issues across the health economy.

In West Kent, PCTs have been kept informed through correspondence with chief executives and clinical governance leads. The proposals have similarly been met with enthusiasm and support. PCT chief executives, clinical governance leads and pharmaceutical advisers are now being informed each time a pharmacy becomes accredited.

## THE EXPERIENCE SO FAR

To date, the accreditation team has visited 30 pharmacies. To help define and evaluate the process, the first few visits were carried out by the two pharmacists involved in developing it, plus the PCT representative. Now, only two people (one pharmacist and one PCT representative) visit. The visit takes approximately one hour, with tasks divided between the assessors. The PCT representative views mainly the shop area and staff-customer interaction and carries out a survey on a minimum of three customers visiting the pharmacy. The pharmacist assessors concentrate on the professional issues, such as SOPs, staff CPD and training etc. At the end of the

visit the pharmacy is informed that it will hear from the team within 28 days. The assessors then review their findings in private and agree on the way forward. Each lead pharmacist is left with an evaluation form to provide the accreditors with feedback on the accreditation process. The forms have been a useful tool to assess how the pharmacists judge the accreditation procedure. Comments have been positive and have allowed procedures to be improved for subsequent visits.

Of the 30 pharmacies visited, 23 have obtained accreditation. Three have been refused accreditation because the SOPs were not tailored to the individual pharmacy, two because of failure to undertake a surgery visit, and two for a variety of reasons. Many more visits will be taking place over the next few months. Each accredited pharmacy is provided with a certificate signed by the chief executives of the strategic health authority and of the PCT, which they are encouraged to display.

## FEEDBACK ON THE PROCESS

All the pharmacists visited thought that the accreditation process was a positive experience. Some of those pharmacists who have had their pharmacies accredited have indicated that by looking at the best practice SOPs provided to them they have been encouraged to change their own practice to achieve a higher standard rather than to downgrade an SOP to match their current practice. In this way a rise in standards at those pharmacies has been seen which is extremely encouraging. This is also reflected in the feedback from participating pharmacists. Comments from pharmacists have included "The accreditation visit was a real catalyst to take things forward rather than think about it" and "I obtained feedback on my business without it costing me".

The PCT accreditors have also reported that they have found the visits interesting and rewarding, and believe that they have gained insight into the contributions the pharmacist can make to the primary care team. This will undoubtedly help the PCT pharmaceutical advisers develop community pharmacy services.

Throughout the whole process, the importance of keeping the LPC well informed was recognised. LPC feedback about the accreditation process has been encouraging and supportive.

As with all new developments it has not all been plain sailing. The success of the clinical governance accreditation scheme has been the result of a lot of hard work by those involved with its development and many late nights trying to "sell" the concept of clinical governance to pharmacy contractors. To effect a culture change in the way that community pharmacists work has not been easy. Inevitably resistance has been met, and continues to be met, from a minority of pharmacists in the area. By offering practical support and assistance to contractors, it is hoped that the vast majority will see the benefits both to themselves

and their patients of having a quality agenda set within community pharmacy. Of course, there are things that would be done differently if we were starting again. Certainly, work on the SOPs would have started earlier if we had realised that this would be such a big sticking point for pharmacists. Even now with the template SOPs, pharmacists have said that the time commitment needed for the preparation of SOPs tailored to their own pharmacies is a rate limiting factor to coming forward for accreditation. Overall, however, we have found that communication really is the key to most things.

## THE WAY FORWARD

The accreditation process has continued with minor adjustments. Approximately 50 pharmacies across Kent and Medway have indicated that they will be ready for accreditation in the next couple of months. PCTs and pharmacists are regularly updated by newsletter that informs them of progress and lists accredited pharmacies. We have managed to obtain publicity in the local press for some pharmacies as well as in papers produced by the local health economy aimed at patients and staff.

The additional funding allocated in 2002/03 for clinical governance in community pharmacy will continue to be used to support pharmacies working towards accreditation and also to help develop the clinical governance framework further. Clinical governance describes a continuous system of quality improvement and it is vital that accredited pharmacies are encouraged to develop and continuously review the systems that are covered in the framework through audit.

For those who have achieved accreditation, opportunities for both the provision of new services and greater integration into the local health economy has been sought and promoted, for example through funding closer working relationships with surgery staff, or clinical governance groups in the PCT. We have now started on clinical governance development work. However, funding for the project work is only available for accredited pharmacies. We are also working to ensure that clinical governance arrangements are incorporated into all additional services contracted with community pharmacies from April 2003. There is no doubt that the money recently sent down from central government for the purpose of clinical governance will be put to good use to further the Kent clinical governance quality agenda.

In conclusion, in Kent we are proud of the commitment and support of community pharmacists to clinical governance and look forward to working with them in the future to develop this agenda, which we believe will be an extremely strong plank to the development of new community pharmacy services within PCTs.

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