National Audit Office

IMPROVING QUALITY AND SAFETY- PROGRESS IN IMPLEMENTING CLINICAL GOVERNANCE IN PRIMARY CARE

Community Pharmacy Clinical Governance Questionnaire Results

December 2005

Department of Health (DoH)/Clients/Department of Health/VFM Studies/PCT Governance/Reports/Publication/Improving Quality and Safety NAO Pharmacy final report

Contents

Methodology

Questionnaire
The questionnaire was designed in consultation with the Royal Pharmaceutical Society of Great Britain (RPSGB).

The questionnaire was initially advertised and distributed at the British Pharmaceutical Conference 10-12 September 2005.

The RSPGB made pharmacists aware of the questionnaire through circulating to LPC secretaries and asking them to pass it further down to their Board members and to other pharmacists within their localities.

The online questionnaire was also advertised in the Pharmacy Journal.

169 separate questionnaires were completed between 10/09/05 and 10/12/05. 42 of these were submitted on paper to the NAO. 127 were completed online.

East Devon PCT
The NAO received a single questionnaire from the PEC pharmacists in East Devon PCT, completed on behalf of 26 of the 27 pharmacists in East Devon, based on information obtained at visits to these pharmacists in July 2005.

The PCT had addressed most of the questions we were asking at this time. The response indicated how many of the 26 pharmacists had the processes we asked about in place. We decided not to combine these results into the results directly from our questionnaire for the following reasons:

- These results were from an audit done several months prior to our questionnaire going out. Some of the newer policies will have had even less time to become embedded.
- Not all of the questions we asked were asked by East Devon.
- Some of the results in East Devon are significantly different from the pattern nationwide. This suggests either they were asking a subtly different question or that East Devon is an unusual PCT. Either way it does not make sense to combine the results

However, we have still taken into account the results from the exercise undertaken by East Devon PCT to inform our overall findings on clinical governance in community pharmacy.

Discussion of preliminary findings
We identified 6 initial 'findings' from the questionnaire results up to October 19th. These were designed to prompt further discussion of the main emerging themes rather than to actually reveal our preliminary results.

The Royal Pharmaceutical Society then used these as threads on electronic discussion forums for clinical governance facilitators and prescribing advisors. The RPSBG forwarded the replies received on these forums to the NAO.

The NAO set up a website detailing these initial findings and allowing pharmacists to comment online on each. This website was advertised to those pharmacists who had completed the questionnaire. It was also advertised in the Pharmacy Journal.

23 pharmacists used this page to comment online on these issues, many going into significant detail.

Analysis of respondents

The 169 respondents appear to be from a reasonably representative geographical split. Roughly a third said they were from both the North and South categories. A quarter were from the Midlands and Eastern region and ten percent from London.

117 different PCTs were represented in the 169 responses. They seem to represent a good geographical spread.

The highest number of responses from one PCT was 5 (Bristol North PCT). Calderdale, Guildford and Waverley and Oxford PCT each offered 4 respondents. Some respondents listed more than one PCT.

Three-quarters of respondents said their main area of work was Community Pharmacy. 4 worked at a GP practice, the remainder being based within the PCT.

The majority (83%) of the respondents had been registered pharmacists for more than ten years.

Analysis of findings

Since the introduction of their new contract community pharmacists' terms of service have required them to participate in local clinical governance arrangements, however they were encouraged to do so prior to this

Two months after the publication of the *NHS Plan* the government published a related document *Pharmacy in the Future* in September 2000. This set out in more detail how community pharmacists would play a full part in delivering the new NHS. It acknowledged that there was more work to be done in ensuring that community pharmacy is fully included in local, multi-disciplinary clinical governance strategies. To help with this the Government promised to provide additional funding of up to £2m a year to HAs/PCTs specifically to support clinical governance in community pharmacy.

DoH Guidelines on clinical governance in community pharmacists published in December 2001 set out the initial action regarding clinical governance required by Primary Care Trusts by April 2002, as well as a development plan to integrate community pharmacy into wider clinical governance plans for past this date. By April 2002 PCTs were required to implement steps such as identifying a community pharmacy clinical governance facilitator at PCT or multi-PCT level.

The new NHS Community Pharmacy Contract was introduced from 1 April 2005. Community pharmacists had until 1 October 2005 to comply and then the PCT is able to assume a monitoring role. Its purpose was to ensure that community pharmacy is a fully integrated part of the healthcare team providing accessible, high quality, patient centred NHS services. The contract includes minimum standards and is intended to promote and reward high quality services, not just volume of prescriptions. The contract guarantees funding of £1,669m for seven specific 'Essential Services' in 2005/2006.

Clinical Governance is one of the Essential Services that all community pharmacists must provide under the contract. It is the largest element and embraces all of the other elements and services. The contract provides a Service Description for clinical governance, a four page document which clearly defines the clinical governance behaviours that community pharmacists must adhere to.

Most community pharmacies have basic clinical governance systems in place as prescribed by the new contract

Almost all community pharmacists have implemented the most simple systematic clinical governance requirements of the new contract. Most (86%) had an identifiable clinical governance lead at their pharmacy. Most (81%) have an up-to-date practice leaflet. Almost all (93%) had a complaints process in place. Almost all (87%) had arrangements to comply with the Disability Discrimination Act 1995. All have SOPs in place. Almost all (86%) gave appropriate induction on entering employment to all staff and locums, e.g. on confidentiality procedures, health and safety and security. Almost all (93%) say all staff undergo training appropriate to their role.

A significant minority of PCTs are failing to provide the support that community pharmacists consider that they need in implementing clinical governance

Most pharmacists surveyed (73%) knew that their PCT had a clinical governance facilitator for pharmacy in place. 13% thought that their PCT did not and 14% did not know. Often, separate pharmacists from the same PCT gave an opposing answer. This suggests that although some PCTs may have clinical governance facilitators in place they are not suitably active to have made all pharmacists in the region aware of their existence. If at least one pharmacist from a PCT knows of the existence of a facilitator then the likelihood is that one exists. However, the information given by the pharmacists themselves is perhaps more telling- it is more interesting to count the percentage of pharmacists who *know* of the existence of their PCT facilitator rather than the number of PCT facilitators known by at least one pharmacist.

PCTs were required to have had such a person in place by April 2002 so it is concerning that over three years later so many still did not (or at least had not made themselves aware to pharmacists) , especially since those without a facilitator in place can have had no or little support from their PCTs.

Indeed some pharmacists identified the lack of a clear lead from their PCT as a barrier to implementing clinical governance. This was the second most commonly identified barrier to implementing clinical governance by respondents (time was first). The second most frequently identified category of help required to implement clinical governance was more support from the PCT (again, time was first). This is a significant finding- little can be done to ease pressures on pharmacists' time but support from the PCT should always exist and be easily accessible.

Interestingly, a significant number of pharmacists identified that they needed help in clarifying the requirements of the clinical governance contract. Presumably this sort of help would best come from the PCT.

Some pharmacists identified the significant differences between levels of support between PCTs as an area of concern:

"Many PCTs have demonstrably NO interest in community pharmacy…it is simply the attitude of the PCT-in terms of support I can site a best-practice example locally: The PCT employed a facilitator and she put together a fantastic resource pack /tool kit covering both clinical governance and DDA. The LPC hosted a meeting at which she spoke, and made copies of the pack available to all contractors. The facilitator visited EACH pharmacy in the PCT to offer support and encouragement. ***By contrast in some neighbouring PCTs no action whatsoever has been taken****."*

Some pharmacists we asked were concerned that those facilitators in place did not have enough time to fulfil the requirements of a vital but demanding job, which is usually done as a sideline to working in a busy pharmacy. Indeed some facilitators were themselves concerned about the level of support they were able to offer:

"I am a PCT CG Facilitator, but am funded only for 2 hours a week. I would need two DAYS a week to make a significant impact."

Nearly three-quarters of community pharmacists (73%) were aware that their PCT has a strategy for implementing the clinical governance requirements of the new contract. (8% knew that there was not a strategy and 19% did not know either way). One would assume that all PCTs should have such a strategy and it is perhaps concerning that a significant minority had failed to produce one (or- just as bad- failed to cascade it to community pharmacists in their area).

Over two-thirds of our respondents (68%) knew that their PCT has a pharmacy representative on the PCT Professional Executive Committee. (Note that 10% knew that there was not a representative and 23% did not know). A survey done in 2003 put this figure at 47%. There is no requirement for the PEC to include dentists, pharmacists or optometrists, but the professional membership of the executive committee is expected to reflect the functions of the PCT. This suggests that although more PCTs are now incorporating pharmacists onto the PEC a significant proportion do not have a representative, which is perhaps indicative of the relative importance assigned to community pharmacy in these PCTs.

Pharmacists do not get protected time for training on clinical governance which means it may not be a priority compared to running the day-to-day business

Almost all pharmacists identify not having sufficient time, in particular to train themselves and their staff, as the main barrier to being able to implement further clinical governance measures. It was by far the most commonly identified barrier to implementing clinical governance. Due to the nature of community pharmacy it is not easy to remove people from the 'shop floor' during working hours.

If a pharmacist leaves practice to carry out training activities then either they must give long-term notice to the PCT in order to close the business or employ a locum, in which case their staff will often be unable to attend training. The business rather than the PCT usually fund this. Unless there are demonstrable benefits to the business, then pharmacists find it difficult financially to justify these measures. Many pharmacists feel it is unfair that GPs can close and have cover funded by PCTs for attending such training events.

More respondents identified help to overcome the lack of time and funding to carry out training than any other specific issue to help them develop clinical governance. In addition many identified lack of protected time in general as something that needs to be overcome. It is clear therefore that pharmacists consider this something that they need help to overcome; whether this help can viably come from the PCT is not clear. That the Service Description states that "*2.3.9- PCOs could request the attendance of one member of staff per pharmacy to attend local clinical governance training each year. The PCO would be liable for paying all training costs*" suggests that this should be overcome by the PCT.

"*…there is no backfill funding for locum cover. This also militates against multi-disciplinary training (potentially the most valuable training we could do) as most other healthcare professionals prefer daytime training. We dream of protected time for whole-team training and briefings! We pick up the pieces when irate patients demand to know why the doctor's is closed on a Thursday afternoon and how are they going to manage without their repeat medication...*"

"*Patients and customers are impatient and demanding. Training is easily put off to a later time because 'we're too busy at the moment.' There is rarely any NHS money for training pharmacy staff, and never any backfill funding so the pharmacy can continue to function properly. This is resented as other primary care contractors get 'protected time' and apparently ample NHS funding.*"

Burnley Case Study- Organisation of Training
Burnley Pendle and Rossendale PCT are organising clinical governance training during the day time in a venue to be funded by the PCT. This allows pharmacists to be free to attend accreditation training which takes place in the evening. However it is still incumbent on the pharmacists to release their staff for this time at their own cost.

Some areas of the new contract have not yet had time to become embedded and in some areas pharmacists are still awaiting advice from their PCT
Clinical Audit is one area where the requirements of the new contract have started to be implemented more slowly. Less than half (45%) of the pharmacists we surveyed said they had a clinical audit programme in place. Of those, only one third (36%) said that it included one multidisciplinary audit as agreed by the PCT. The Service Description says that pharmacists and their staff must participate in at least one practice based audit, and at least one PCT determined multidisciplinary audit each year.

The new contract has clearly not had time to fully embed itself, and clinical audit was not a guideline in place before the new contract. Many pharmacists report that they are still ignorant on this issue and are waiting for guidance from their PCT. Many pharmacists report that they feel isolated and some see that multidisciplinary audit in association with GPs will help this.

The contracted measures to ensure patient involvement in community pharmacy are at the embryonic stage, but pharmacists consider they have always valued patient involvement
Only one pharmacist we spoke to (out of 169) reported that they had had a visit from a Patient & Public Involvement Forum (PPIF). The new contact for pharmacists states that "*2.1.6- The pharmacy should cooperate with local Patient & Public Involvement Forum visits and give consideration to any report of such visits and identify and take appropriate action.*" It is incumbent upon the PPIF to decide their programme of visits, following leadership from the PCT.

Pharmacists reported that they were informed and ready for visits by the PCT, the slow uptake was perhaps due to the lack of resources at the PPIF. What the PCT can do about this is not clear.

"Our local PPIF has few members and a huge workload. They are involved in the QOF assessments and haven't had time to look at Community Pharmacy. I have asked our PPI Lead about this two or three times to ensure that they know that this is part of their remit. It is early days for pharmacists to get patients heavily involved, many are still trying to come to terms with the new requirements."

However, the very few pharmacists who reported visits from the PPIF praised the usefulness of their input. *"Locally the PPI forums have visited some pharmacies and have been pro-active in deciding what the criteria is needed for the consultation areas. This has been extremely rigorous and some shops are having to rethink screening ideas."*

The contract Service Description demands that pharmacists should encourage patient involvement through undertaking an annual patient satisfaction survey based on a national template. However, the Department has not finalised the fine detail of this template; an announcement is due to be made soon. However, 12% of pharmacists that we surveyed had still carried out a survey in the last year. Around three-quarters (71%) intended to carry out a survey in the forthcoming six months.

When the national template is finalised the pharmacy contractor will have the responsibility to ensure the survey is conducted and the data is processed. They will need to review the survey results and consider changes which could improve service provision. The pharmacy will share with their PCT the area where the survey identified the greatest potential for improvement and the action being taken to improve performance, along with the areas in which the pharmacy is performing strongly.

Despite the slowness of the introduction of these so called 'patient involvement' measures community pharmacists do not feel that they are failing to listen to their patients. Given their roles as independent businesses they consider it vital to maintain close links with their customers/patients, and always have done. Indeed, having a complaints process is an important aspect of patient involvement, and we found that almost all (92.5%) of pharmacists we questioned had a complaints process in place.

"Patient involvement is... extensive. We are a business where the patient has real choice; they can walk with their feet to another pharmacy. We are very close to our customers and very good at listening to their complaints and acting on them to improve our service. If a tick box exercise is required pharmacists can invite and PCTs organise such representation from the local Patient and Public Involvement Forum."

Some pharmacists are not emotionally committed to clinical governance and see it as a box ticking exercise which has no real influence on patient care

Many community pharmacy staff are part-time and some are temporary. Some pharmacists report it is difficult to motivate these staff to fulfil their clinical governance obligations, especially given the difficulty in finding time to train them. Difficulty in ensuring staff engagement in fulfilling their clinical governance duties was the third most commonly stated barrier to implementation. Many reported staff resistance to change and lack of motivation as issues.

The take up by pharmacists themselves is varied. Most take clinical governance very seriously and recognise its importance in an area where it can so obviously reduce risks to patients. However, some still doubt its usefulness. Many consider that pharmacists have done many aspects of clinical governance for a long time and formalising these procedures has only slowed down the speed with which they can serve patients. A significant number (15 pharmacists (9% of the sample)) identified cultural change within pharmacy as a barrier to implementation of clinical governance.

"The difficulty is that pharmacists do many aspects of CG, and have done for a long time, as part of good professional or business practice. Even now, they sometimes don't recognise it as CG at all. They rarely record it unless they have to. When they are required to do it and record it in formal ways this takes much longer, and is time they would rather not spend."

"Nothing is done by PCTs to follow up on the box ticking exercises and PCTs struggle to find resources to move this on. This type of attitude [CG is just box-ticking] is infectious."

Some pharmacists report changes in their systems and behaviour as a result of the impact of clinical governance risk based systems and processes

Over two-thirds (70%) of pharmacists have a risk management strategy in place. Nine out of ten (93%) of pharmacists reported having an incident reporting system in place. Almost all (93%) have a complaints process in place. Many of the pharmacists with whom we engaged reported that changes had taken place in their practices as a result of learning from mistakes identified by these processes.

"All the pharmacies I work in have changed practice following review of critical incidents, for example moving items on a shelf that are too similar in appearance, applying shelf-edge reminder stickers near high risk items, reviewing protocols and re-training to ensure addresses are checked when giving out medication, etc."

The challenge remains to spread the learning from these mistakes but some good work has been done to help achieve this:

Burnley PCT good practice example: Sharing of Error Logs

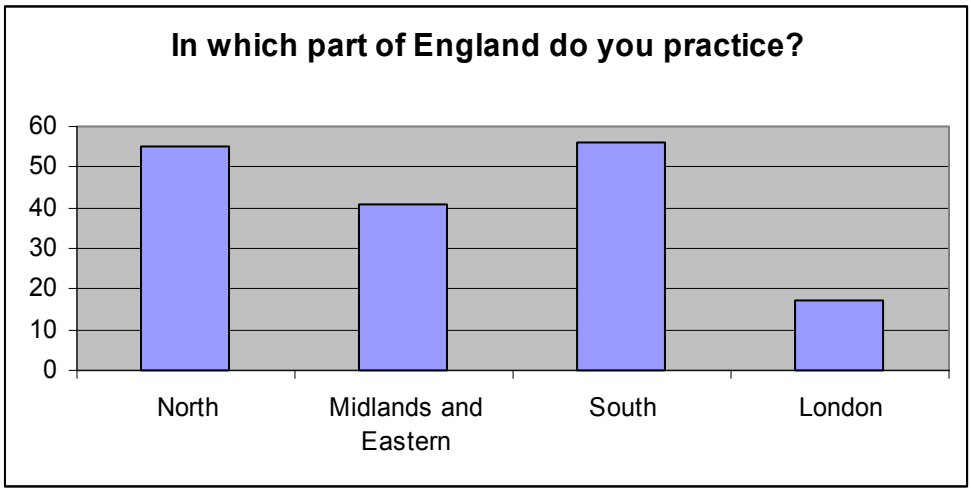
BPR PCT has initiated a scheme called *Good Areas of Practice for Sharing* (GAPS). Community pharmacists who make errors or near misses report these anonymously to the PCT who collate and present them on a glossy poster/leaflet which is distributed to all pharmacists in the PCT. They explain the dangers previously identified in 'one-liner' form, and ask 'could any of these happen in your pharmacy', and give advice to avoid them happening.

Results

A. ABOUT YOU

A1. In which part of England do you practice?

	Frequency	Percent	Valid Percent	Cumulative Percent
North	55	32.5	32.5	32.5
Midlands and Eastern	41	24.3	24.3	56.8
South	56	33.1	33.1	89.9
London	17	10.1	10.1	100
Total	169	100	100	



A2. In which Primary Care Trust?

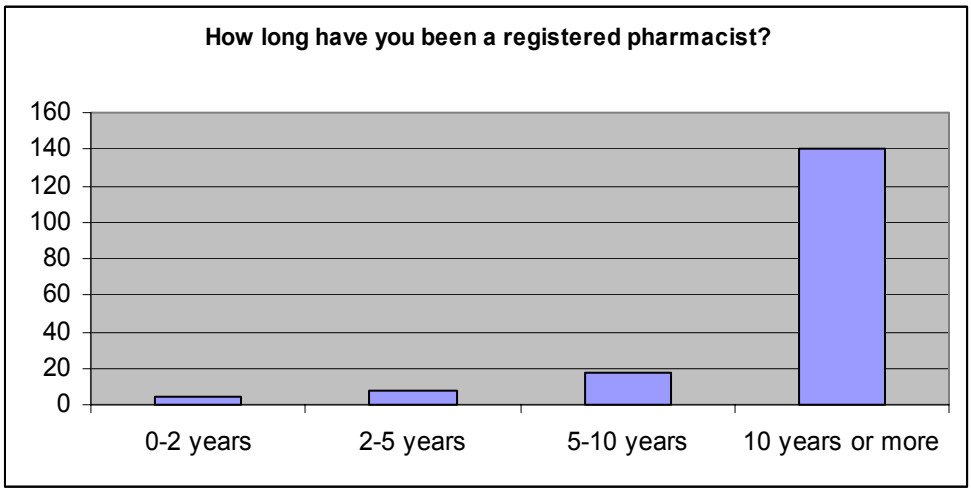
PCT	Total
Adur, Arun & Worthing	1
Airedale predominantly, Bradford South and West, Craven & Harrogate	1
B&NESKENNET	1
Barking & Dagenham	1
Bebington & West Wirral	1
Beds	1
Billericay, Brentwood and Wickford	1
Blackwater Valley & Hart and North Hampshire PCTs	1
Blank	4
Bradford South and West	2
Bristol North	5
Bristol S & W	1
Broadland	2
Bromley	1
Calderdale	4
Central Cornwall PCT	1
Central Suffolk	1
Cherwell Vale	2
Chesterfield	1
Chorley + South Ribble	2

Coventry	2
Darlington	1
Dartford Gravesend and Swanley PCT	1
Daventry and South Northants	1
Doncaster Central	1
Doncaster/Rotherham/Barnsley/Sheffield	1
Durham & CLS, Durham Dales, Sedgefield	1
Durham Dales	1
Easington	2
East Cambs and Fenland/ Suffolk West	1
East Hampshire	1
East Kent Coastal	1
Eastern Birmingham	1
Eastern Wakefield	2
Eden valley pct	1
EWPCT	1
Guildford and Waverley	4
Hambleton and Richmondshire	1
Hammersmith & Fulham PCY	1
Herefordshire PCT	1
Hertsmere	2
Horsham & Chanctonbury	2
Hounslow	1
Ipswich	1
Isle of Wight	1
Kennet and North Wilts	1
Kennet and North Wilts +West Wilts	1
Kensington & Chelsea	7
Kensington & Westminster	1
KPCT	1
Langbaurgh	1
Lincolnshire South West PCT	2
Maidstone Weald PCT	1
Maldon and South Chelmsford	2
Medway	1
Mendip	1
Middlesbrough	1
Mid-Hampshire	1
Mid-Hants	1
Milton Keynes	1
Morecambe Bay	1
N Herts & Stevenage PCT	1
New Forest	1
North Bristol	2
North Cumbria	2
North East Lincolnshire	2
North Kirklees	3
North Oxfordshire	1
North Tees	1
North Tyneside	3
North Warwickshire PCT	1
Northampton	1

Northumberland	3
Norwich	1
Oldham	1
Oldham Tamesdie and Glossop	1
Oxford	4
Oxfordshire	2
Portsmouth City Pct	1
Redditch & Bromsgrove	1
richmond and twickenham	1
Rochdale	1
S E OXON	1
Sedgefield	1
Sheffield south	1
Sheffield West	1
Shepway	1
Solihull	1
Somerset Coast	1
Somerset coast & North Somerset	1
South Birmingham	2
South Gloucestershire	1
South manchester	1
SOUTH STOKE	1
South Trafford	3
South West Oxfordshire	2
South wilts	1
Southampton	1
Southport and Formby	1
Southwark	1
Suffolk	2
suffolk coastal	1
Surrey Hearh and Woking and North Surrey	1
Sutton and Merton PCT	1
Swindon	1
Trafford North and South	3
Vale of aylesbury	1
Various	1
Walsall	3
West cumbria	1
West Hull, Eastern Hull, East Yorkshire, Yorkshire Wolds and Coast	1
West Norfolk	1
West Suffolk	1
West Wiltshire	1
Westminster	1
Wiltshire	1
Witham, Halstead & Braintree	1
Grand Total	*169*

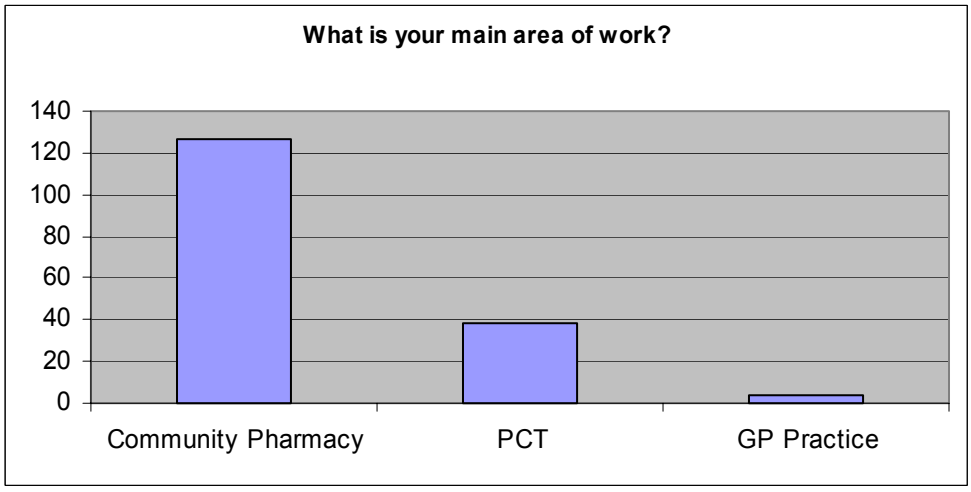
A3. How long have you been a registered pharmacist?

	Frequency	Percent	Valid Percent	Cumulative Percent
0-2 years	4	2.4	2.4	2.4
2-5 years	8	4.7	4.7	7.1
5-10 years	17	10.1	10.1	17.2
10 years or more	140	82.8	82.8	100
Total	169	100	100	



A4. What is your main area of work?

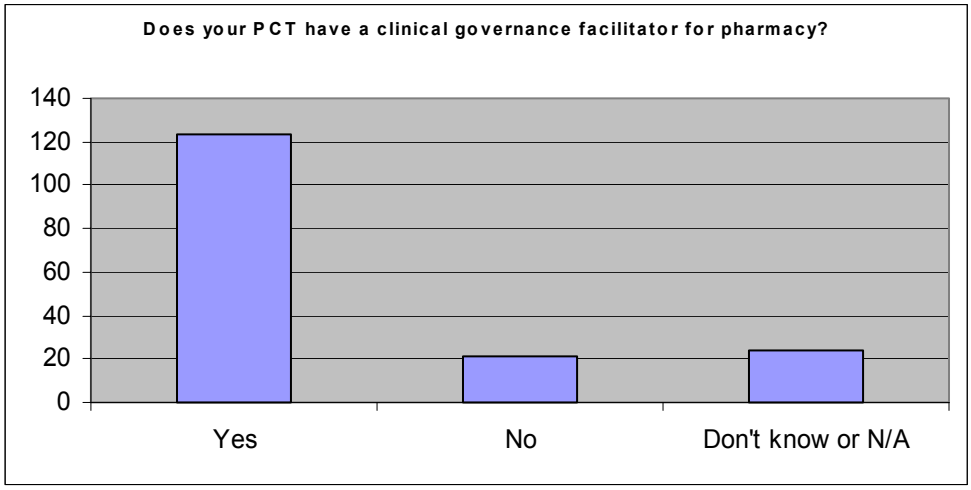
	Frequency	Percent	Valid Percent	Cumulative Percent
Community Pharmacy	127	75.1	75.1	75.1
PCT	38	22.5	22.5	97.6
GP Practice	4	2.4	2.4	100
Total	169	100	100	



B. ABOUT YOUR PRIMARY CARE TRUST

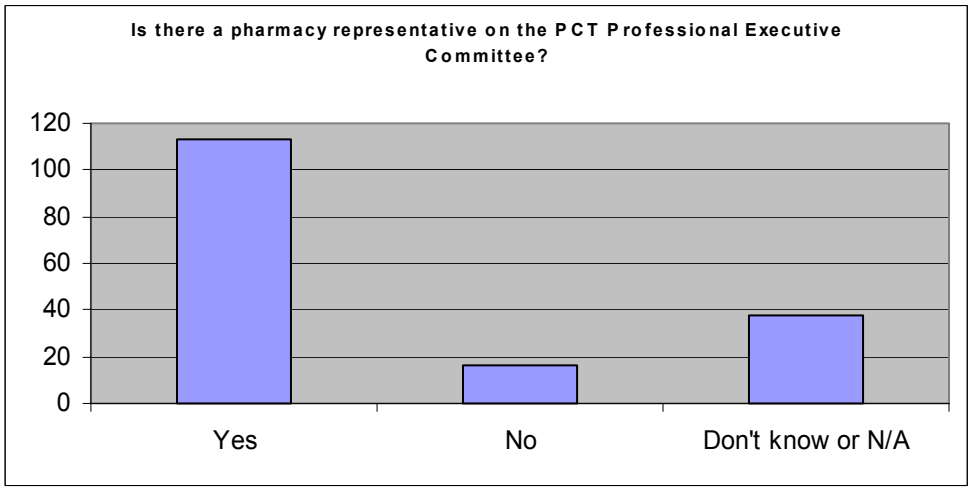
B1. Does your PCT have a clinical governance facilitator for pharmacy?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	123	72.8	73.2	73.2
No	21	12.4	12.5	85.7
Don't know or N/A	24	14.2	14.3	100
Total	168	99.4	100	
not answered	1	0.6		
	169	100		



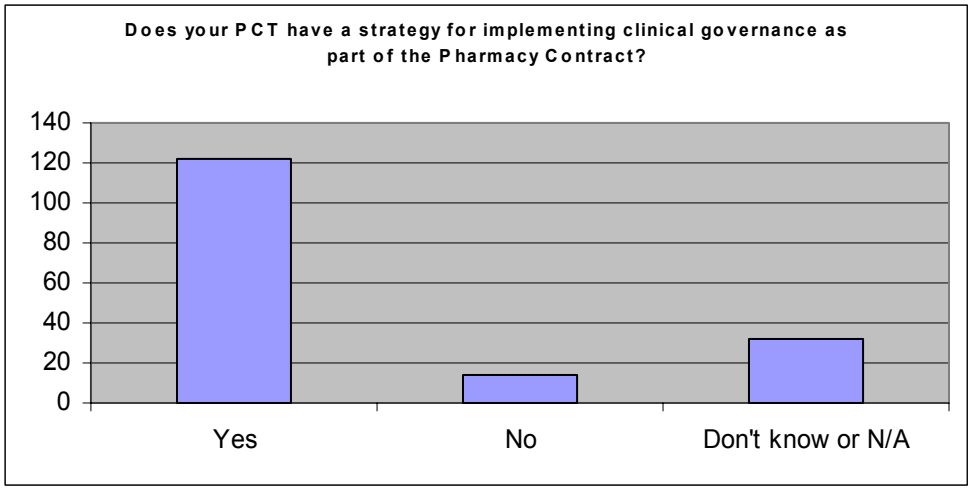
B2. Is there a pharmacy representative on the PCT Professional Executive Committee?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	113	66.9	67.7	67.7
No	16	9.5	9.6	77.2
Don't know or N/A	38	22.5	22.8	100
Total	167	98.8	100	
not answered	2	1.2		
	169	100		



B3. Does your PCT have a strategy for implementing clinical governance as part of the Pharmacy Contract?

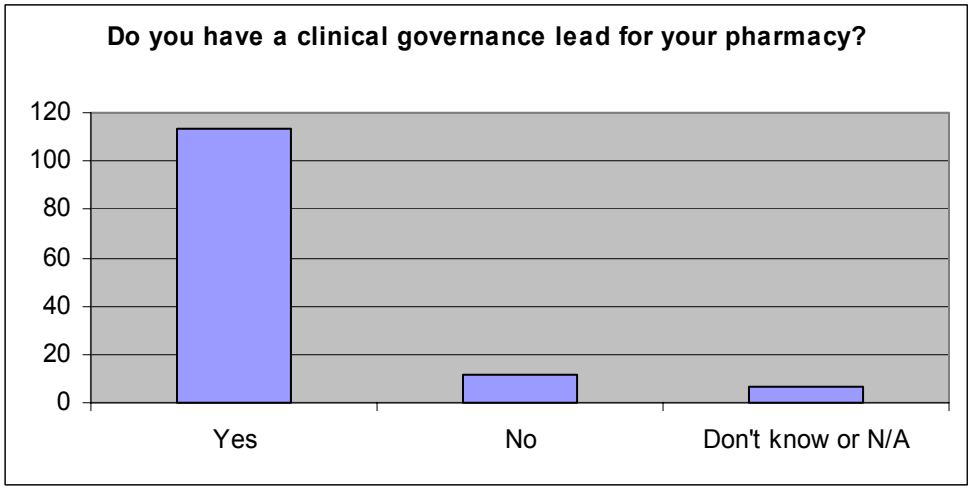
	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	122	72.2	72.6	72.6
No	14	8.3	8.3	81
Don't know or N/A	32	18.9	19	100
Total	168	99.4	100	
not answered	1	0.6		
	169	100		



C. IF WORKING IN COMMUNITY PHARMACY

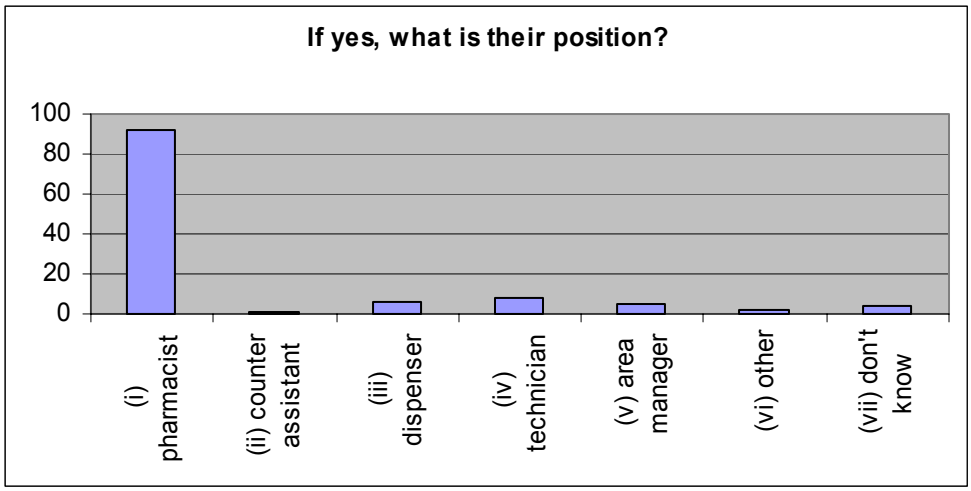
C4. Do you have a clinical governance lead for your pharmacy? (this might be a shared post)

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	113	66.9	85.6	85.6
No	12	7.1	9.1	94.7
Don't know or N/A	7	4.1	5.3	100
Total	132	78.1	100	
not answered	37	21.9		
	169	100		



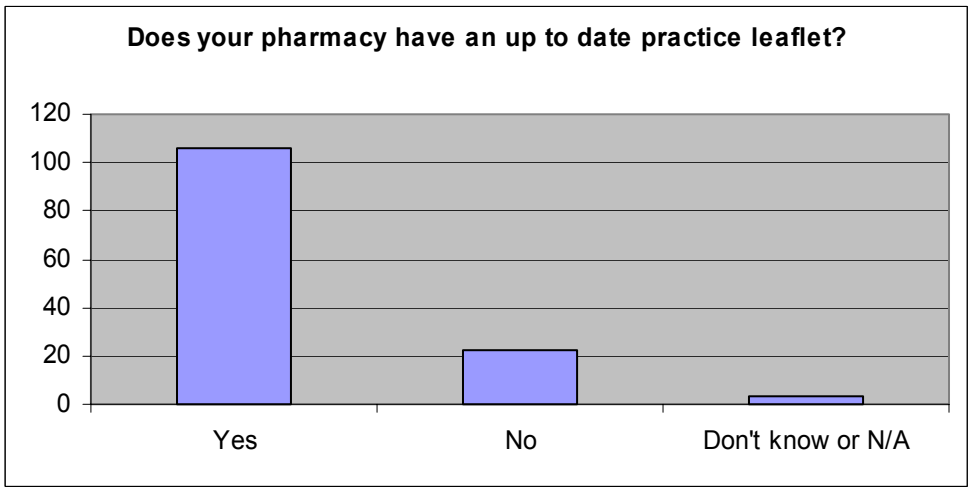
C5. If yes, what is their position?

	Frequency	Percent	Valid Percent	Cumulative Percent
(i) pharmacist	92	54.4	78	78
(ii) counter assistant	1	0.6	0.8	78.8
(iii) dispenser	6	3.6	5.1	83.9
(iv) technician	8	4.7	6.8	90.7
(v) area manager	5	3	4.2	94.9
(vi) other	2	1.2	1.7	96.6
(vii) don't know	4	2.4	3.4	100
Total	118	69.8	100	
NA	12	7.1		
not answered	39	23.1		
Total	51	30.2		
	169	100		



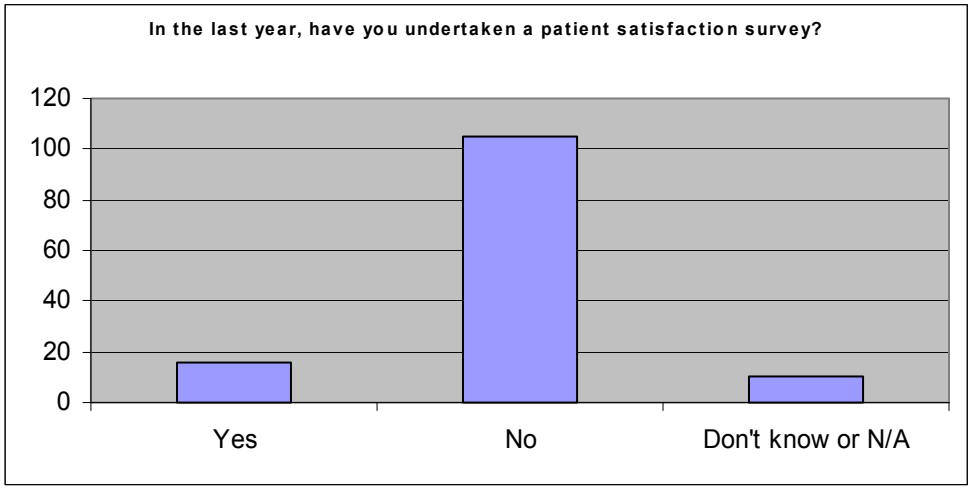
C6. Does your pharmacy have an up to date practice leaflet?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	106	62.7	80.9	80.9
No	22	13	16.8	97.7
Don't know or N/A	3	1.8	2.3	100
Total	131	77.5	100	
not answered	38	22.5		
	169	100		



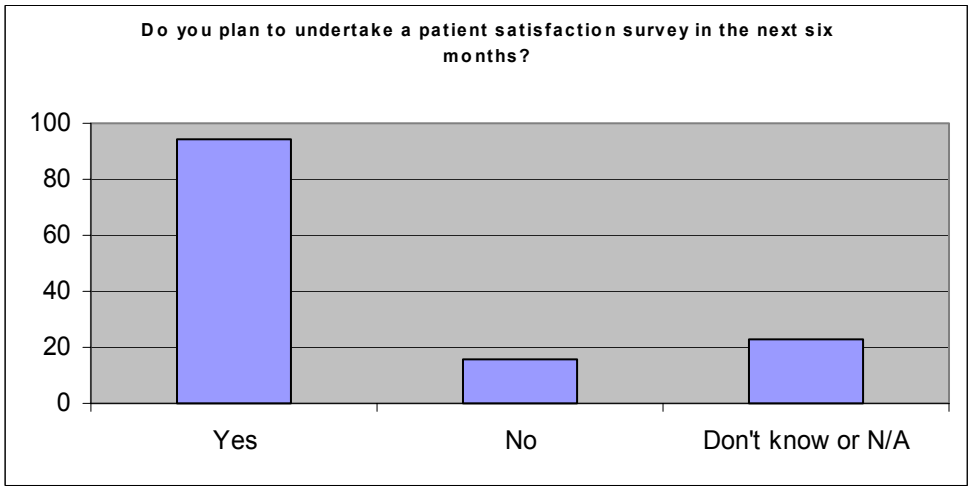
C7. In the last year, have you undertaken a patient satisfaction survey?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	16	9.5	12.2	12.2
No	105	62.1	80.2	92.4
Don't know or N/A	10	5.9	7.6	100
Total	131	77.5	100	
not answered	38	22.5		
	169	100		



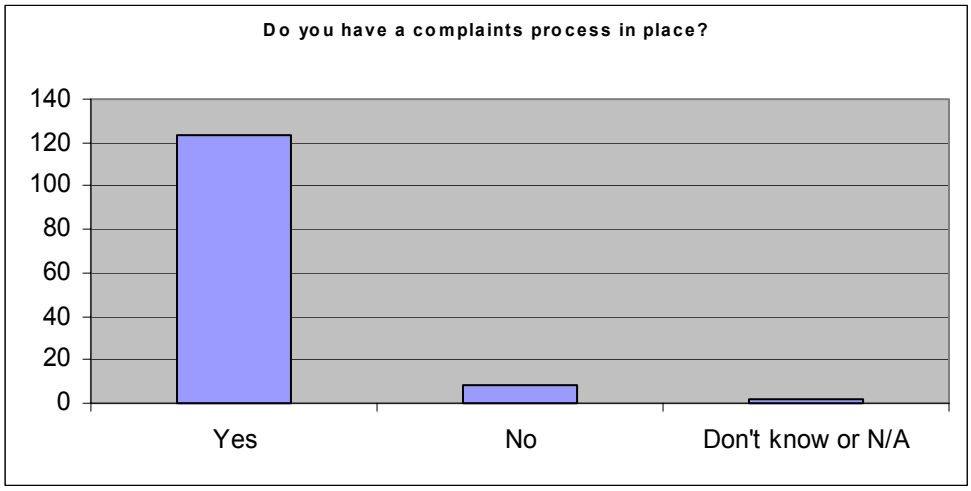
C8. Do you plan to undertake a patient satisfaction survey in the next six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	94	55.6	70.7	70.7
No	16	9.5	12	82.7
Don't know or N/A	23	13.6	17.3	100
Total	133	78.7	100	
not answered	36	21.3		
	169	100		



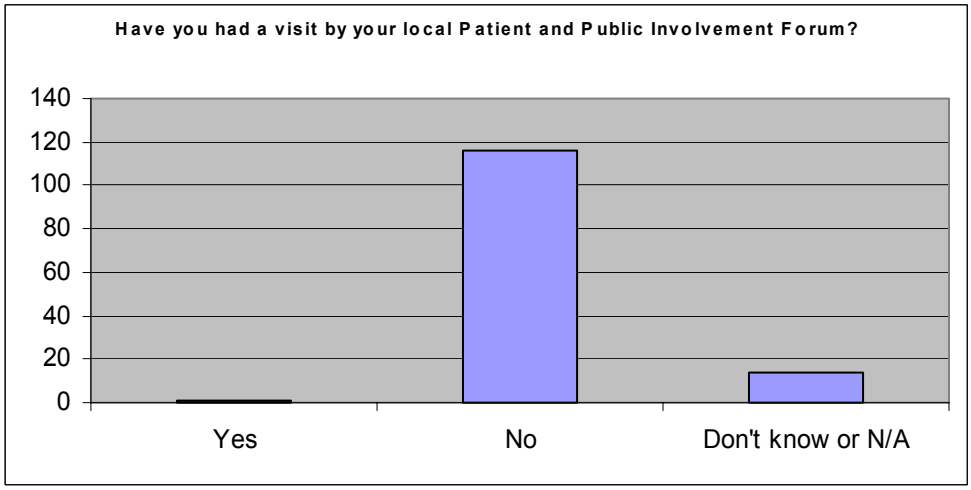
C9. Do you have a complaints process in place?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	123	72.8	92.5	92.5
No	8	4.7	6	98.5
Don't know or N/A	2	1.2	1.5	100
Total	133	78.7	100	
not answered	36	21.3		
	169	100		



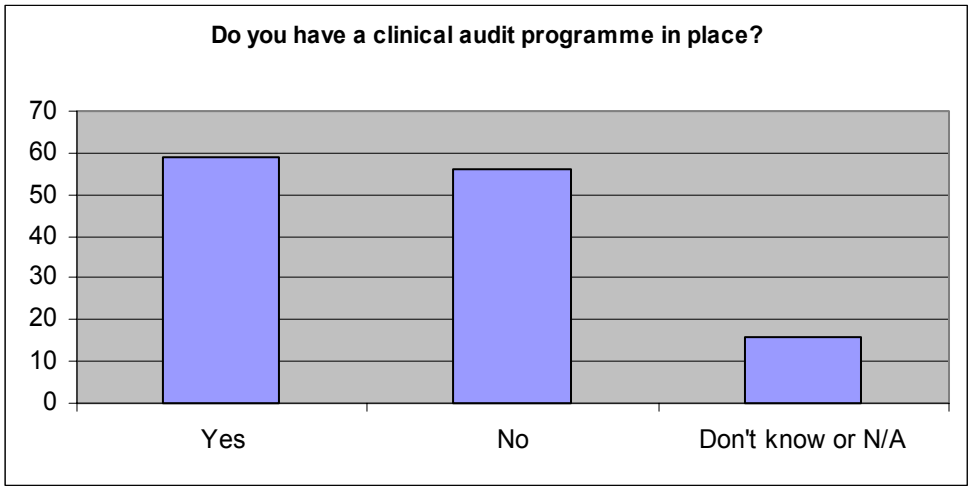
C10. Have you had a visit by your local Patient and Public Involvement Forum?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	1	0.6	0.8	0.8
No	116	68.6	88.5	89.3
Don't know or N/A	14	8.3	10.7	100
Total	131	77.5	100	
not answered	38	22.5		
	169	100		



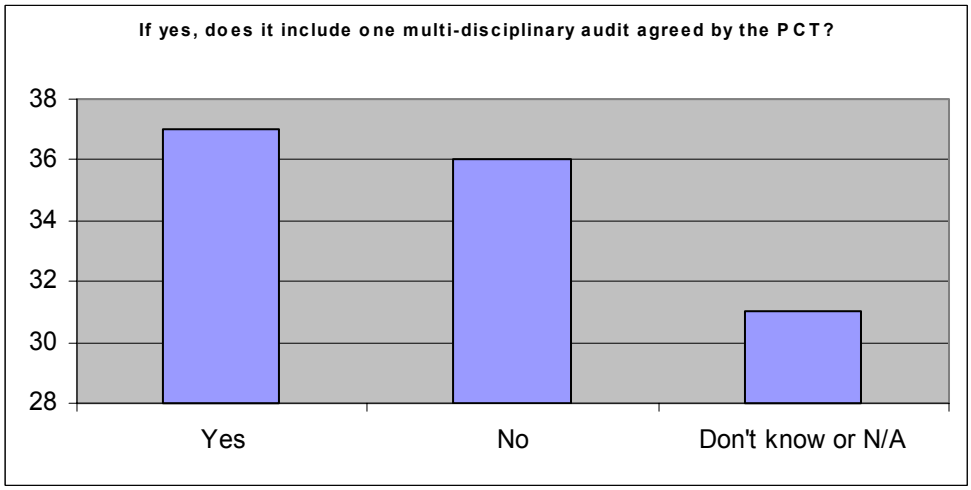
C11. Do you have a clinical audit programme in place?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	59	34.9	45	45
No	56	33.1	42.7	87.8
Don't know or N/A	16	9.5	12.2	100
Total	131	77.5	100	
not answered	38	22.5		
	169	100		



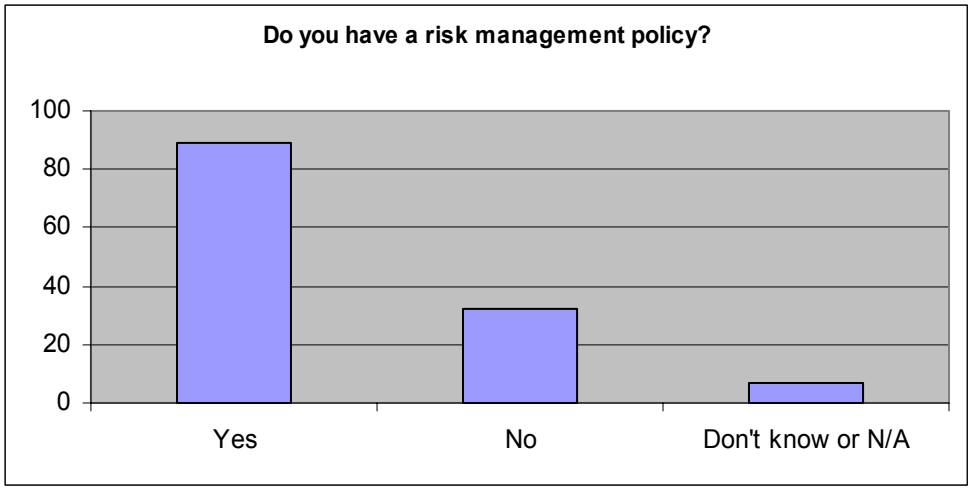
C12. If yes, does it include one multi-disciplinary audit agreed by the PCT?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	37	21.9	35.6	35.6
No	36	21.3	34.6	70.2
Don't know or N/A	31	18.3	29.8	100
Total	104	61.5	100	
NA	26	15.4		
not answered	39	23.1		
Total	65	38.5		
	169	100		



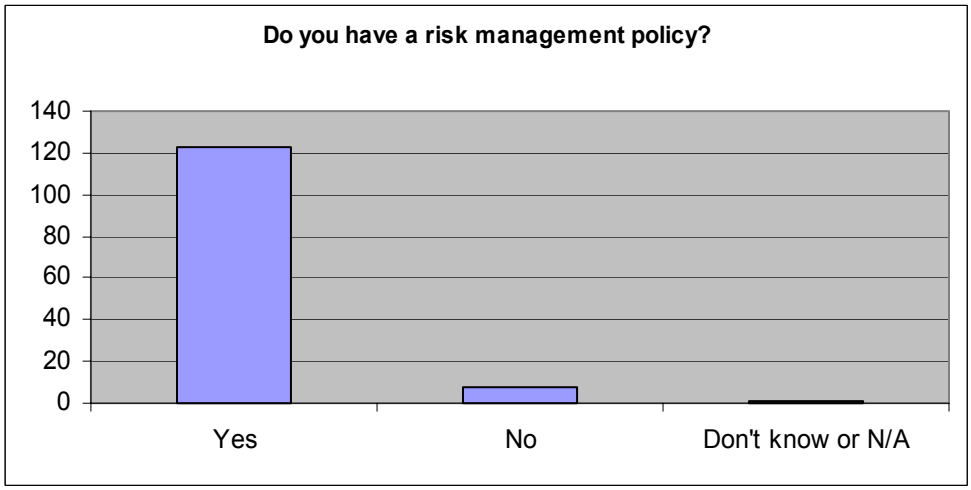
C13. Do you have a risk management policy?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	89	52.7	69.5	69.5
No	32	18.9	25	94.5
Don't know or N/A	7	4.1	5.5	100
Total	128	75.7	100	
not answered	41	24.3		
	169	100		



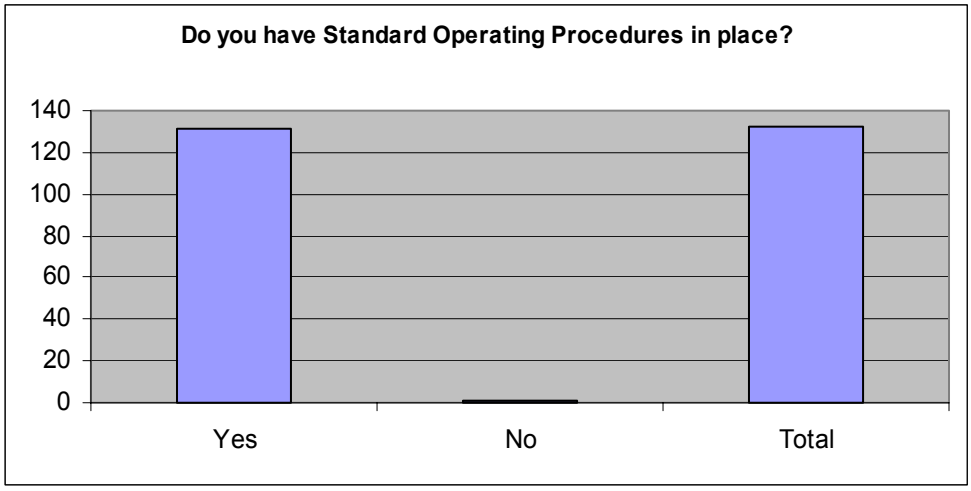
C14. Do you have an incident reporting system in place?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	123	72.8	93.2	93.2
No	8	4.7	6.1	99.2
Don't know or N/A	1	0.6	0.8	100
Total	132	78.1	100	
not answered	37	21.9		
	169	100		



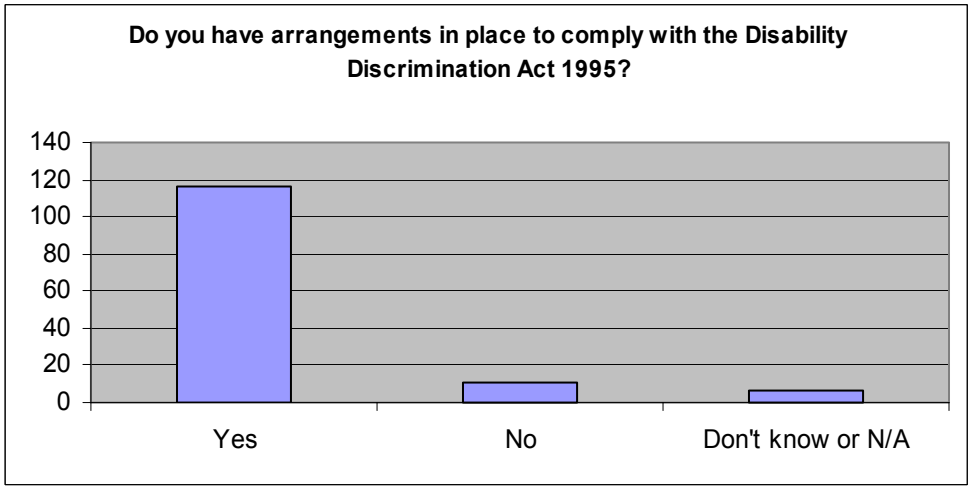
C15. Do you have Standard Operating Procedures in place?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	131	77.5	99.2	99.2
No	1	0.6	0.8	100
Total	132	78.1	100	
not answered	37	21.9		
	169	100		



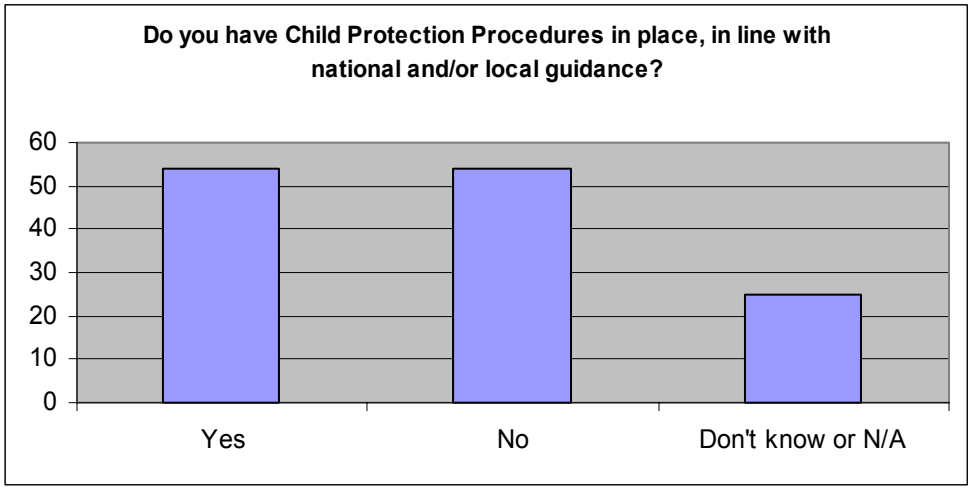
C16. Do you have arrangements in place to comply with the Disability Discrimination Act 1995?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	116	68.6	87.2	87.2
No	11	6.5	8.3	95.5
Don't know or N/A	6	3.6	4.5	100
Total	133	78.7	100	
not answered	36	21.3		
	169	100		



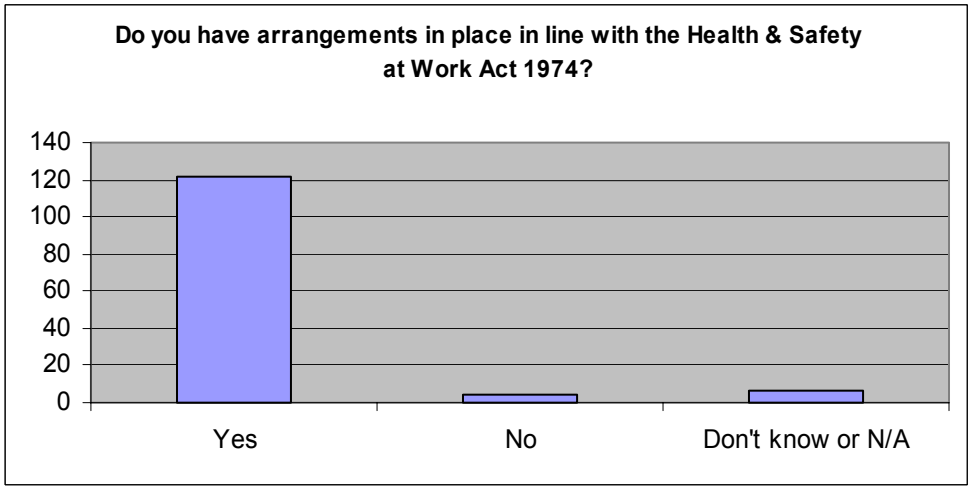
C17. Do you have Child Protection Procedures in place, in line with national and/or local guidance?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	54	32	40.6	40.6
No	54	32	40.6	81.2
Don't know or N/A	25	14.8	18.8	100
Total	133	78.7	100	
not answered	36	21.3		
	169	100		



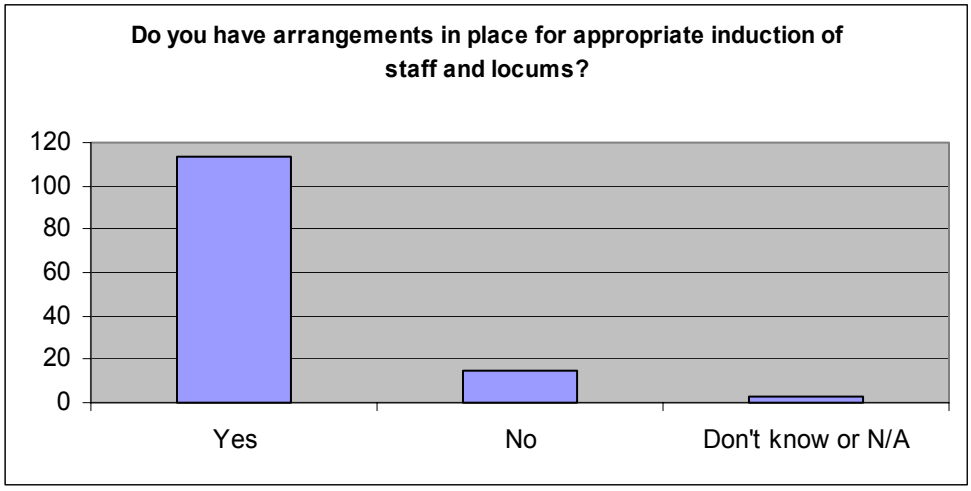
C18. Do you have arrangements in place in line with the Health & Safety at Work Act 1974?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	122	72.2	91.7	91.7
No	4	2.4	3	94.7
Don't know or N/A	7	4.1	5.3	100
Total	133	78.7	100	
not answered	36	21.3		
	169	100		



C19. Do you have arrangements in place for appropriate induction of staff and locums?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	114	67.5	86.4	86.4
No	15	8.9	11.4	97.7
Don't know or N/A	3	1.8	2.3	100
Total	132	78.1	100	
not answered	37	21.9		
	169	100		

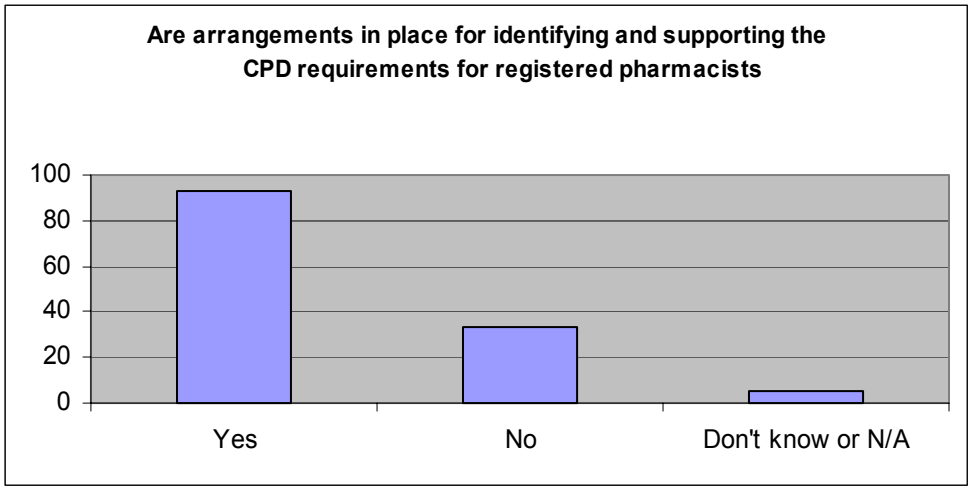


C20. Do you have appropriate training in place for all staff in respect of the roles they are asked to perform?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	121	71.6	93.1	93.1
No	7	4.1	5.4	98.5
Don't know or N/A	2	1.2	1.5	100
Total	130	76.9	100	
not answered	39	23.1		
	169	100		

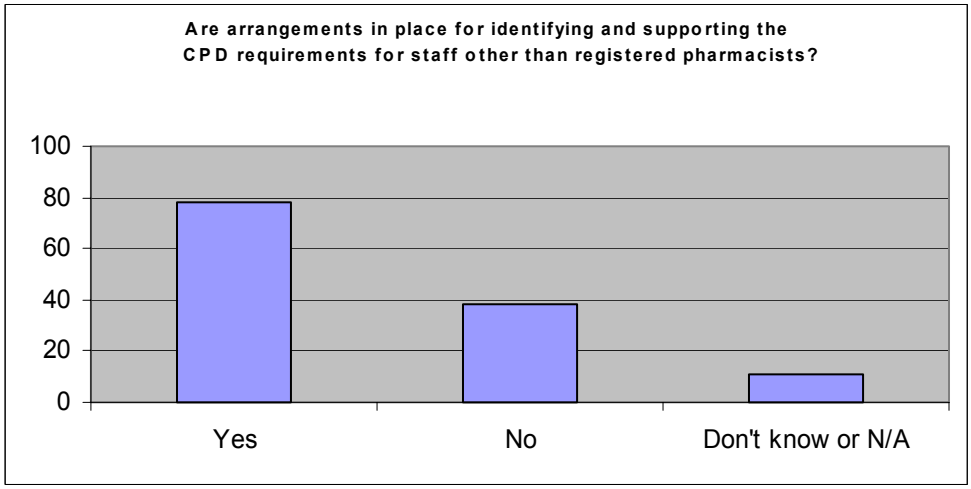
C21a. Are arrangements in place for identifying and supporting the CPD requirements for (i) registered pharmacists

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	93	55	71	71
No	33	19.5	25.2	96.2
Don't know or N/A	5	3	3.8	100
Total	131	77.5	100	
not answered	38	22.5		
	169	100		



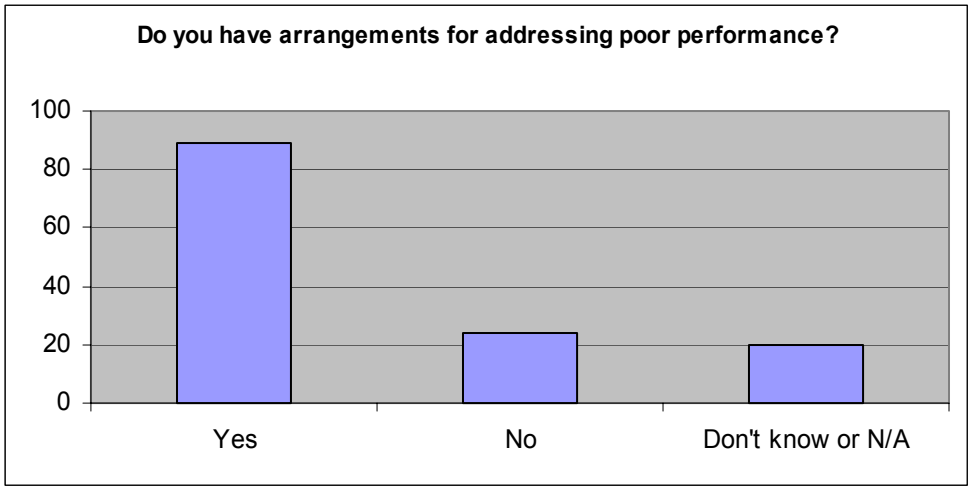
C21b. Are arrangements in place for identifying and supporting the CPD requirements for (ii) any other staff?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	78	46.2	61.4	61.4
No	38	22.5	29.9	91.3
Don't know or N/A	11	6.5	8.7	100
Total	127	75.1	100	
not answered	42	24.9		
	169	100		



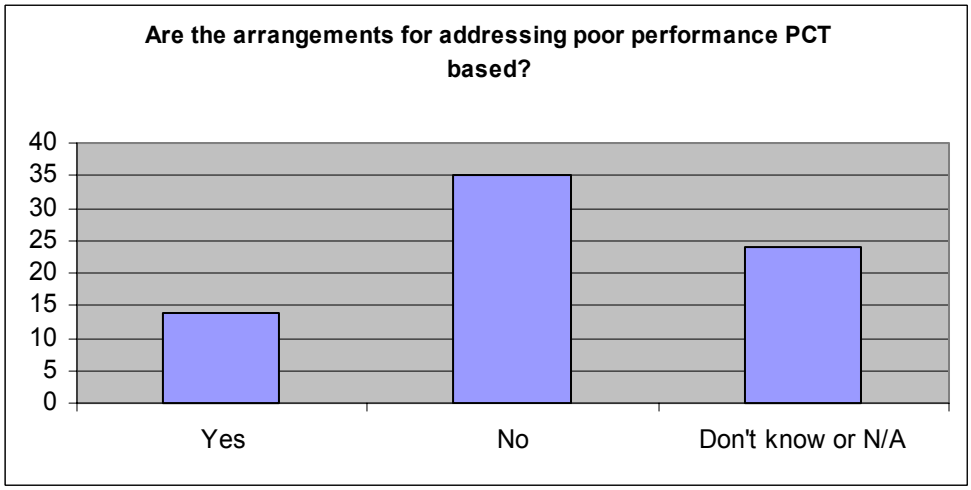
C22. Do you have arrangements for addressing poor performance?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	89	52.7	66.9	66.9
No	24	14.2	18	85
Don't know or N/A	20	11.8	15	100
Total	133	78.7	100	
not answered	36	21.3		
	169	100		



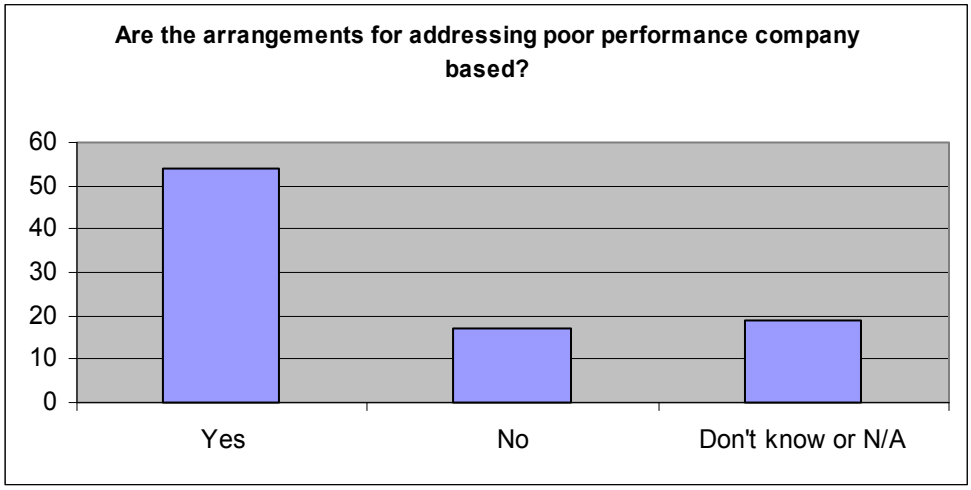
C23a. If you have arrangements for addressing poor performance are these PCT based?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	14	8.3	19.2	19.2
No	35	20.7	47.9	67.1
Don't know or N/A	24	14.2	32.9	100
Total	73	43.2	100	
NA	26	15.4		
not answered	70	41.4		
Total	96	56.8		
	169	100		



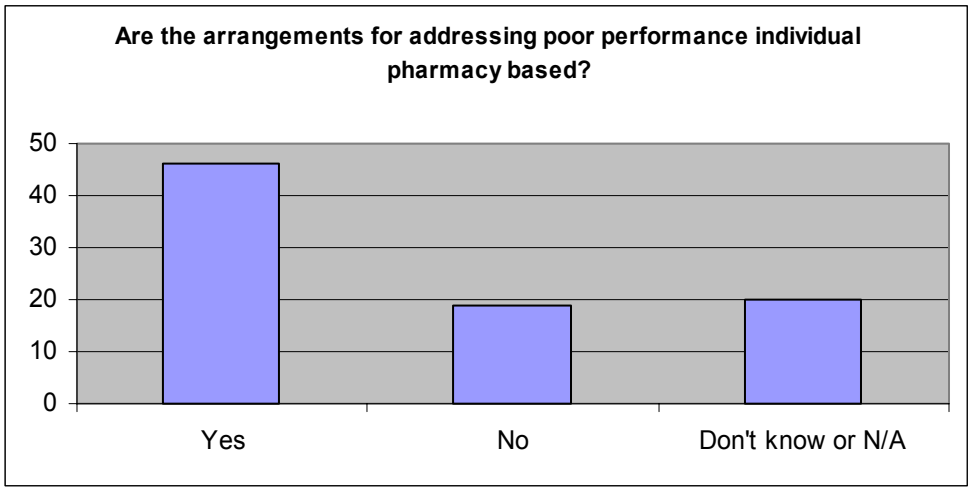
C23b. If you have arrangements for addressing poor performance are these company based?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	54	32	60	60
No	17	10.1	18.9	78.9
Don't know or N/A	19	11.2	21.1	100
Total	90	53.3	100	
NA	26	15.4		
not answered	53	31.4		
Total	79	46.7		
	169	100		



C23c. If you have arrangements for addressing poor performance are these individual pharmacy based?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	46	27.2	54.1	54.1
No	19	11.2	22.4	76.5
Don't know or N/A	20	11.8	23.5	100
Total	85	50.3	100	
NA	25	14.8		
not answered	58	34.3		
System	1	0.6		
Total	84	49.7		
	169	100		



D. YOUR COMMENTS

For each of the written questions analysed, similar responses have been grouped into code frames. The three separate responses for each question have been considered together (the questions asked for "*three main issues/barriers etc…*"), with no extra importance attached to the first responses.

This paper presents both the summary of the analysed responses and, in an Appendix, all of the verbatim responses (including the code frame to which each was assigned).

D24. What have been the three main clinical governance issues you have faced in your pharmacy? Analysed Responses:

NB. This question seems to have been interpreted in two different ways. Some responded with 'issues' that need to be overcome to implement clinical governance. Others simply named elements of clinical governance which they have come across in their pharmacy. This mixed interpretation reduces the usefulness of responses to this question.

Count of ISSUES	
Code frame	**Total**
Other	72
Reporting errors & near misses	45
SOPs	39
Training/CPD/Education	32
Audit	21
Record Keeping	13
Confidential information	11
Dispensing procedures/ repeat dispensing	8
Time	7
Culture	6
Complaints procedures	4
Paperwork	4
Support PCT	4
Understanding clinical governance	4
Disability Discrimination Act	3
Owings	3
Risk management	3
Similarity of packaging	3
Grand Total	282

D25. What are the main barriers to implementing clinical governance in your pharmacy? Analysed Responses:

Count of BARRIERS	
Code frame	**Total**
Time	98
Other	31
PCT support	22
Staff Engagement	21
Staff Level	16
Culture	15
Training	11
Unsuitable premises/facilities	11
Paperwork	10
Locums	9
Money	9
Support non-PCT	7
Communication	6
Understanding clinical governance	8
Grand Total	274

D26. What help do you require in developing clinical governance in your pharmacy? Analysed Responses:

Count of Help	
Code frame	**Total**
Other	44
Training (time and funding)	30
Support- PCT	28
Time/Protected time	18
Clarification	17
Lack of staff	15
Support- Misc	17
Money	8
Information	19
Facilities	7
Grand Total	203

D27. Best Practice Examples (verbatim reponses)
Lone worker policy introduced, to support and protect staff who are working alone.
Putting patients not paper first
We started to record the slightest near-misses, no matter how trivial, to encourage critical analysis of our own actions - only started this week but the results are astounding. People, when faced with a written record, seem to be able to absorb their blind-spots almost without thinking.
Ongoing problem of patient identification at prescription reception and supply Strict protocols developed and used
My specialist field is substance misuse management, and I attend many meetings and conferences on this, and I share my knowledge of the meeting on my return. Also I circulate any journal articles, or other information with the professionals working in my area. My activities were taken by the PCT as an example of "Good Practice"
At least one of my reported errors and my response to it have now made the company pharmacy audit - in a perverse way it's pleasing to see others learning from my mistake.NB also disappointing that no action has been taken with regard to similarity of packaging.
I think it forces you to analyse and communicate within your pharmacy. You can't implement CG without looking at what you do, discussing with staff and then implementing.
Starting MUR for patients at end of repeat prescribing period, and arranging for relevant blood tests before patient sees GP for next batch
Local Accreditation Scheme - developed by a colleague. It has 50 standards that are assessed in local pharmacies. 104 out of 116 pharmacies locally across 4 PCTs completed the process.

The] clinical governance lead did exceptional work in ensuring all the pharmacies in the area were up to date and well informed @ CG. This included workshop evenings and a support pack, help with baseline assessment, satisfaction survey, an assessment visit by her to ensure locum packs, PCT info, incident recording, signposting, health promotion etc were all in place in the locality.
Meeting with GPs to discuss CG issues and procedures to aid better patient service
Double checking of the dispensed items before they are handed out to patients
Collection of item from another branch by a patient with a copy of rxso pharmacist can double check
The PCT have produced a clinical governance support pack for community pharmacies.
Much of the work to do we have already covered in Investors in People that we completed 2 years ago. That was extremely valuable and helpful on the staff side. The value was in inviting input from all levels of staff. The SOPs have made us look at our procedures and improve many aspects of these. The errors makes everyone look at the type of errors and whilst they increase in the start this then brings benefit as staff get more confident they are just being used as a tool to improve the accuracy odour work.
Complete PMR's on computer, hence if Pt or GP's etc... needed to access medication history a complete record existed.
I try to use a card index file system to drive audit/issue enquiry and simultaneous recording. Since it is dynamic (partitions represent months which progress towards the front of the box) and the idea is to bring the next cyclical thing to the fore, cards can be more flexible than computers and A4 questionnaires.
A record book of Significant Events with many entries over 3 years +is available
Use of baskets for dispensing
1. Missing items on prescriptions. Requesting on the patient's behalf to acquire new prescription to cover supply 2. Provide an unofficial INR monitoring for a patient unable to access Warfarin clinic at the Hospital.

While training my dispensers, I used the Near miss reporting forms as an aid to education. Anything that I found dispensed or labelled incorrectly before it reached the patient would involve in a near miss form being completed by the individual. We do work in a no blame culture but this was more about identifying the mistake and ensuring that it would not reoccur by tackling and highlighting as to why it may of happened, what the influencing factors were which led to the mistake, and what we can do to prevent happening next time. This ultimately led to my dispensers being more careful and attentive to their work providing us with less dispensing errors, improved customer satisfaction and increase in job wellbeing.
Keeping a significant event register has helped increase awareness of need of interventions and improved self esteem of pharmacy staff
As a result of clinical governance the method of dispensing has been clearly defined to allow a separate check. A prescription collection scheme has been successfully developed to weed out as many large repeat prescriptions and collect and dispense during quiet times rather than come during peak surgery output times. This smoothes out the work load and reduces some of the pressure for acute prescriptions.
All incidents are reported to Pharmacy Superintendent, who shares them via our company news letter. Significant events are shared with the PCT Clinical Governance Leads.
Regular liaison with local surgeries under pct led project enables prescribing practice changes to be implemented quickly
Medical intervention forms and patient request forms
It is called Review Box - an 8" x 5" card based system. Cheap and practical. Not dependent on computers, but could be presented as a computer 'front end' to labelling and PMR systems. Brings the next thing to look at to the fore and is dynamic but not time critical. Helps audit and recording in a cyclical way. User friendly. Dates from 1994 as a general approach to audit that is not regarded as research based.
I have developed a portfolio of evidence around CG and the new contract. It is divided into sections headed with the service arrangement and evidence put in under these headings. We also do regular near miss audit as I have two technicians training to be accuracy checking techs.

D29. Other comments about clinical governance.

Other Comments
These comments relate to the pharmacy I locum for most regularly.
It is essential to have CG systems in place to ensure good quality of services are being provided. The problem is that it will take time to get set up and it's a change in culture for many pharmacists.
It's viewed as a standalone, not part of professional practice by most community pharmacists.
At present working in PCT there appears to be complete absence of CG with regards to my work as supplementary prescriber
[My] PCTs have endeavoured to support Clinical Gov. community pharmacy over the last 2/3 years. My experience as C.P clinical governance facilitator has been one of an uphill struggle. Whilst many multiple companies have personnel at their head offices writing SOPs, risk management strategies, complaints procedures etc the transfer of this work results in little change within the pharmacies, as the documents rarely reflect reality. It would almost appear to be a box ticking exercise from these companies. However, those few remaining conscientious independent pharmacies have embraced the new culture and made significant improvements in their working practices. There are also the poor performing independent pharmacies whose practices remain substandard irrespective of new contract guidelines or PCT support. The RPSGB inspectorate seems to have little or no power to demand improvements. To these pharmacists clinical governance is a reference term that has no meaning.
The concept is excellent and valuable, pharmacy needs a stable environment to allow it to be fully implemented
It is always a work in progress - regular reviews and changes are necessary as we take on new roles, or find that maybe an SOP is not entirely appropriate. It is also hard work - this is a complete change to the way we have worked. We have always done good work, but now we have to have the evidence to prove it. This can be difficult to find the time for - and don't let your CG lead tell you otherwise!
Our PCT should have a FULL TIME CG co-ordinator - our current one does a great job, but is in only on Mondays, and a visit from him or contacting him is remote, as he has so many other pharmacies to visit. If the Government is really keen to improve patient care via CG, then there should be more money put into it to fund a full time post.
Recording clinical interventions - concerned that if busy there's a pressure not to make the intervention because of the further time needed to record the intervention. That blindly following of SOP's, while safe, does not always work in the best interests of the individual patient.
Often confused with 'Standards for better practice' within the NHS. I personally do not like the term 'Clinical Governance'. A better title would communicate directly exactly what it was, perhaps 'professional standards' or 'quality assurance' in community pharmacy.
England could learn from the good aspects of the Scottish system. Pharmacists need to be jointly supported and trained @ meetings all in own silos. CG is a broad issue specific priorities need be themed in Quality Improvement Strategies rolling programme.
I am employed by the PCT as Community Pharmacy Clinical Governance Facilitator.
I am the Clinical Governance facilitator for Community Pharmacy for my PCT. I also work as a locum and have worked in at least 9 or 10 of my local pharmacies in that capacity over the last 12 months so I understand the problems of implementing all the aspects of clinical governance from both sides. I see the barriers as resistance to change, TIME remains the major factor for independent pharmacists- time for evening training and/or staff meetings. Improvements in teamwork and skill mix are a hurdle and will take time. I see the barriers as more of a problem for older pharmacists and independents as it is a new culture and there is so much to take in at the present time. Therefore, without spoon feeding people, the majority want simple paperwork for e.g. Audits and guidance to get going with audit, patient questionnaires and record keeping. Despite all the preparation up to now, some pharmacists are 'scared' about monitoring while at the same time the PCTs do not have the resources to implementation

As an LPC Secretary I have contact with four PCTs. It is my impression that CG for community pharmacy has had little or no priority with any of them. I am aware that in all of the organisations a vast amount of time has been spent in setting up structures in General Practice most of which would be more than adequate to cover Community Pharmacy. The mentality that Community Pharmacy is not part of Primary Care seems to lead to an automatic exclusion from these processes. We do have a pharmacist on the local CG committee, but there is no communication with contractors.
Why does our StHA have no pharmacy input? The PCT is so far behind others. They have declared that they will not develop any support systems for audit or another other services due to lack of money. Where is the corporate governance systems?
To be quite honest - still a little unsure what clinical governance is and how far it stretches
Still unsure about what is meant by the term
Although one strives to provide an excellent service, it seems that the communication between community pharmacy and PCOs could be much improved.
As a locum this questionnaire is not entirely relevant although I have used the pharmacy I am most knowledgeable about. There does not seem to be national guidance for locums and although individual pharmacies may take part in PCT enhanced services with appropriate training there are potential problems with locums out of area. The local pharmacy development group helps pharmacy managers/owners network and support each other but although open to locums few attend. They are at risk of not complying with many CG initiatives
I have a group of six pharmacies spread across three PCTs. The differences between them in terms of the level of interest and support for pharmacy is totally unacceptable. We are building inequities into the system in a way that is totally unfair for practitioner and patient alike
Mostly, pharmacists are prepared to help with clinical governance, but usual barriers as mentioned above mean it doesn't always happen. That doesn't mean that we don't see the opportunities. As noted, understanding by support staff, other professionals involved in patient care, and the patients themselves about the roles pharmacists can play is key issue.
The road to h*** is paved with good intentions.
One of the biggest culture changes to get to grips with in the new contract
Need more time to think about it – Most pharmacies are just too busy making sure that prescriptions are ready when patients come in for them. Patient's just won't allow enough time between requesting a prescription and expecting it to be ready. Staff waste huge amounts of time looking for prescriptions when they're not even due to be ready. Electronic transmission of prescriptions should help. Need better systems to ensure that prescriptions end up in correct place – problems when patient's tick wrong box or none ticked on repeat.
Clinical governance is controlled by the company for which I work I don't think it would be appropriate for me to answer some of your questions as I am not the manager
More admin to stop us helping patients! The list of items could be reduced giving more time to work on the important patient issues. I have many patients that prefer to see me that than GP and many that get medication at and the pharmacy and come to see us about their medication.
How to go about recording clinical governance is still fuggy. Improvements in practice are continually made- but records are not kept as don't know what records are required or wanted!
I find most community pharmacists are using the principles of clinical governance within their practice but do not associate their actions with the term clinical governance. Despite repeated approaches, I find the pharmacists difficult to engage regarding clinical governance, I think principally because of their lack of understanding of what clinical governance is.
Clinical governance must be done, key to being a professional, but not enough staff for safe working as now more recording being done, less time for patient care with same staff.
Clinical governance is important but must not become overly cumbersome to administer as community pharmacy will be faced with unnecessary additional costs of staff time. The danger is to produce a lot of unhelpful information that is recorded for the sake of it.

We desperately need more support from the PCT
If people do not like you they go elsewhere [no patient satisfaction survey planned or undertaken]
Clinical Gov Facilitator very useful role, Clinical Gov is mainstay of pharmacy, is a very important tool that has to be built into all of our professional services. People need to become accountable for maintaining and monitoring high standards of care in order to ensure excellence in clinical care will flourish. Need to ensure mind set changed in form of understanding via organisational behaviour strategy, why people are resistant to change and how different personalities can be targeted and influenced in different ways. Good Clinical Gov will emerge under a good leader, however it is not all about having fabulous CG audit groups, committees or meetings but is about education and the people who ultimately operate them, the culture people are immersed in and their receptiveness to new ideas.
To implement all clinical governance issues takes time and a gradual introduction would be better. CPD updates in the journal periodically to allow everyone to get to the required standard would help. Clinical governance needs to be explained more clearly in a more practical format than just theoretical.
I believe the increase/change in clinical governance is a positive step for pharmacy; I also believe that, subsequently, a pharmacist should have more support so he/she is able to concentrate on their varied roles.
Clinical governance is excellent news for pharmacy. I feel it is making us into better pharmacists (i.e. by recording advice given to patients and interventions made). We are thinking about what we have done and can reflect back on it. By monitoring near misses we are constantly making ourselves and our staff aware of mistakes, which allows us to think of ways to avoid making them again. Pharmacies are HAVING to provide a better customer service to patients. Risk management makes us aware of health and safety issues, CPS makes us think/plan what work we already do. Standards are set higher which will improve the quality of pharmacists.
Whilst every effort can and will be made to satisfy customers we seem to have a small number of people who are not satisfied for a suitable service .
I only work in the PCT so am unable to comment on some of these issues. I believe we are working well on the majority of CG issues, and the county facilitator and the PCT Clinical Governance manager work well together.
We all already use most elements of clinical governance in everyday work, but do not record it formally due to lack of time, space etc. Eventually by introducing guidelines good quality may be assured across the board, but the severe staff shortages in pharmacy are going to get much worse as many are leaving the profession due to extra burden of CPD recording, and constant changes in practice.
The DIY system of developing CG has put a heavy burden on independents and some pharmacists working for multiples. Once in place, we can also expect further changes which will again not be resourced!
There is not enough time in the timescale suggested to implement everything, and not enough pharmacists to locum.
We were promised training by our local PCT but so far NOTHING
The pharmacy company supplies all branches with appropriate policies. We also have an area CG lead to help branches working with locum pharmacists. Training is readily available.
I'm PCT Head of Medicines Management and our needs assessment for the community pharmacy contract identified that community pharmacists would it find challenging to implement the clinical governance service element. We are arranging some evening workshops to support elements of CG e.g. on clinical audit. It is frustrating that the PCT has not supported community pharmacy representation on the PEC or other strategic group. Barriers between GPs and CPs on professional support for the patient need to be overcome. Statements from high level GP (BMA) and CP reps about the benefits of a joint approach would be a good start. I'll continue to do what I can at the 'coalface'.

As with many areas, there are aspects that are 'second nature' in a good, well run pharmacy. It is the recording of such things and the 'being seen to be done' that tends to grate.
The National Audit Office is usually relied upon to give a balanced view and even unpalatable news to politicians. This exercise sets out to justify a political programme that has had no thought put into the practicalities. That is bad for your image.
I feel a lot more confident re the quality of my services now and better able to deal with issues that arise from my practise
I am not convinced CG will improve my practice. Perhaps this is very conceited. I would like you to prove it is effective in improving practice. I see it as a tool to ensure recording of any event which may lead to a claim by a member of the public against a pharmacist. I do not see it as being 'cost-effective'. I am convinced that my time is better spent 'talking to patients'! PS Excuse any spelling or typographical errors.

Appendix 1 - Verbatim Responses

D24. What have been the three main clinical governance issues you have faced in your pharmacy? Verbatim Responses:

ISSUES	Code frame
A lack of information coming out from the PCT with regard to Clinical Governance Structures	Support PCT
A massive increase in paper work i.e. writing SOP's, patient satisfaction surveys etc and the extra work involved in learning about dispensing repeat prescriptions and carrying out MUR's.	SOPs
Above adequate training opportunities necessary to fully implement the new contract	Training/CPD/Education
Accepting the need to document things in order to 'cover our backs' in this age of 'someone is responsible'	Culture
Access to PT medical records- data protection/ confidentiality	Confidential information
Accreditation of locums	Other
All the paperwork necessary for the shop.	Paperwork
Animosity from local surgery over EHC	Other
Appointing a clinical governance lead	Other
Audit	Audit
Audit	Audit
Audit - there is no clear evidence that government understands that outcomes depend on structure and process (which are not cost neutral).There is no guidance, few examples to follow, only a promise of reduced funding! Multidisciplinary audit stands no chance when GP and PCT priorities exclude it.	Audit
Auditing	Audit
Auditing near misses	Reporting errors & near misses
Audits	Audit
Audits	Audit
Audits	Audit
Audits both within the independent pharmacy and in conjunction with the PCT (clinical)	Audit
Awareness and clarity of requirements	Understanding clinical governance
CD storage and returns	Other

Changing the behaviour of staff, to ensure we document what we do	Culture
Changing the procedures of working in the pharmacy to facilitate second check. Locums and pharmacist still hand out unchecked work especially on a Saturday when there is one person in the dispensary.	Culture
Clinical Audit	Audit
Clinical Audit	Audit
Clinical Audit	Audit
Clinical Audit - collecting data- no proper guidance we haven't had visit as promised from the Clinical Governance lead from the PCT	Audit
Clinical audit and the effect of feeding that back to the local practice	Audit
Clinical Intervention with regard to Prescriptions	Other
Collecting reports of errors. The Clinical governance Pharmacist at the PCT has not arranged to receive these reports and act on them	Reporting errors & near misses
Complaints are too few and hence insignificant in changing practice. What is wrong with a constant review of business practice? S.O.P.s follow practice, they don't lead practice. Usually practice changes in line with circumstance. Staff can't remember the detail and have neither the time nor the patience to read them. Over-rated ideal.	Complaints procedures
Complaints procedure	Complaints procedures
Complaints procedures	Complaints procedures
Completing the paperwork whilst working- computers not capable of doing work.	Paperwork
Complying with the requirements for a satisfactory consultation area.	Other
Complying with the requirements for an updated computer system which will support ETP.	Other
Confidential information	Confidential information
Confidential Waste disposal	Confidential information
Confidentiality	Confidential information
Confidentiality	Confidential information
Confidentiality for new services	Confidential information
Confusion over how reporting systems operate - do we report to NPSA or PCT	Reporting errors & near misses
Coping with increased work load at the same time more rx	Other
CPD	Training/CPD/Education
CPD	Training/CPD/Education
CPD	Training/CPD/Education
CPD - time for	Training/CPD/Education
Cpd for staff along with new contract	Training/CPD/Education
Critical Analysis of near-misses	Reporting errors & near misses
Crosses not done for opened boxes of medicines dispensed.	Other
Customer satisfaction audit	Audit
DDA	Disability Discrimination Act
DDD	Disability Discrimination Act
Dealing with errors and near misses	Reporting errors & near misses
Delivery services	Other
Destruction of confidential waste	Confidential information

Developing a significant incident reporting scheme, and knowing how to deal with the data collected	Reporting errors & near misses
Developing and using appraisal systems	Other
Developing appropriate, workable SOP's	SOPs
Development and completion of local community pharmacy accreditation scheme	Other
Development of SOPs as we are small team within the pharmacy with differing skill levels to incorporate these within workable SOP	SOPs
Development of SOPs for all Essential services in new contract	SOPs
Disability Discrimination Act	Disability Discrimination Act
Disagreements with PCT re repeat prescription collection and delivery on behalf of patients -- their requirements are different to my ideas for what an ethical and legal service should be	Other
Dispensing Errors	Reporting errors & near misses
Dispensing errors	Reporting errors & near misses
Dispensing errors	Reporting errors & near misses
Dispensing errors	Reporting errors & near misses
Dispensing errors/incidents	Reporting errors & near misses
Dispensing 'near miss' and error recording and reporting Getting everyone (dispensers and locums) to record near misses	Reporting errors & near misses
Dispensing procedures	Dispensing procedures/ repeat dispensing
Doing audits	Audit
Educating and training the staff about the new contract and implementing the new procedures.	Training/CPD/Education
Education	Other
Ensure continuity of services as I work just three days a week	Other
Ensuring staff training is up to date and of a good standard.	Training/CPD/Education
Error reporting	Reporting errors & near misses
Error reporting	Reporting errors & near misses
Error reporting	Reporting errors & near misses
Error reporting	Reporting errors & near misses
Error reporting	Reporting errors & near misses
Error reporting not done, no internet connection to NPSA site No N3 connection Paper based system now in operation	Reporting errors & near misses
Errors between prescribed and supplied quantities	Reporting errors & near misses
Errors in prescribing changes between hospital or consultant recommendations and GP prescribing – lack of clear communication, or lack of understanding of appropriate medication changes by patients.	Reporting errors & near misses
Errors/near misses	Reporting errors & near misses
Even the PCT cannot answer questions without reference to national orgs so what chance have I?	Support PCT
Feedback	Other
Feeding back dispensing error to the PCT in order that the "community" can learn from these events.	Reporting errors & near misses

Finding the time for all additional requirements in an already busy store	Time
Finding the time for form filling and feedback	Time
Finding the time to carry it out	Time
Finding time for recording CPD	Training/CPD/Education
Finding time to annotate the things we do in order to satisfy the clinical governance requirements	Time
Finding time to do the CPD, meetings with staff and all extra stress with no extra money to find cover whilst doing the work.	Training/CPD/Education
Following standard operating procedures (i.e.) having time to read through them all and staff to do that and then follow them exactly.	Training/CPD/Education
Forming relationship with survey to reduce their errors	Reporting errors & near misses
Fridge temperatures	Other
Funding a dispensary refit and inclusion of consultation room to the highest spec possible without really knowing what is to be expected of us	Other
Gaviscon/Flomax change over	Other
Getting all signed up to and actually reporting errors and other incidents	Reporting errors & near misses
Getting my staff to sign up to CG -- e.g. reporting incidents and putting issues in writing	Reporting errors & near misses
Getting paperwork done	Paperwork
Getting SOP's in place instead of a procedures manual, and ensuring staff understand and comply with them	SOPs
Getting to grips with new contract	Other
Getting used to completing intervention records	Record Keeping
GPs sending scripts as promised	Other
Handling confidential information	Confidential information
Handling of waste	Other
Health and Safety, risk analysis, child protection training or lack of all of it – no courses or help anywhere.	Training/CPD/Education
High turn over of store staff leading to poor continuity and therefore poor professional service	Other
Identifying a suitable clinical audit to carry out	Audit
Implementation	Other
Implementation of Repeat Dispensing	Dispensing procedures/ repeat dispensing
Implementing and CPD of Pathfinder repeat dispensing prescriptions.	Training/CPD/Education
Implementing clinical governance	Other
Implementing SOP	SOPs
Implementing SOPs	SOPs
Implementing SOPs	SOPs
Implementing staff training	Training/CPD/Education
Implementing the new contract, including all the essential services and CPD associated with it for all members of staff.	Training/CPD/Education
Implementation of SOP's	SOPs
Importance not seen as high by staff	Culture

Inability of manufacturers to supply products, now that the "just in time" approach to reduce stock-holdings has cut safety stocks available to cover interruptions to manufacturing	Other
Incident reporting	Reporting errors & near misses
Incident reporting	Reporting errors & near misses
Incident reporting & near miss reporting	Reporting errors & near misses
Increased record keeping and documentation	Record Keeping
Interventions recording	Reporting errors & near misses
Interventions to aid better prescribing to improve patient outcomes(things like changes of formulation, timing of doses, quantities prescribed, repeat processes.	Reporting errors & near misses
Introducing clinical governance! All staff new / never heard of it. Became pharmacy manager here 1 yr ago, nothing in place then at all, slowly getting them to implement SOP's etc	SOPs
Introduction and adherence of SOP's by staff	SOPs
Introduction of intervention recording - ensuring all members of the department recording, including locums	Record Keeping
Introduction of SOP`s	SOPs
Job Descriptions - another long and arduous process - worth it, but the effort required has far outweighed any benefit we might have gained in the new contract	Other
Keeping records of interventions/ significant events	Reporting errors & near misses
Keeping the CG facilitator happy!! and sticking to our development plan time-table	Other
Knowing which clinical governance issues to address.	Other
Lack of concordance – GP thinks patients are taking meds or using them in a particular way, particular dose, etc, but patient is either not using correctly, or not using at all.	Other
Lack of funds allocated for reference sources	Other
Lack of training time for counter/dispensing staff	Training/CPD/Education
Lack of understanding	Understanding clinical governance
Local Drs lack of willing to a/c [or d/c?] prescribing outside licenses	Other
Locums not signing both dispensed and checked boxes	Dispensing procedures/ repeat dispensing
Logging of complaints and redress of such.	Complaints procedures
Looking at the level of owings	Owings
Looking at the whole dispensing process to make it more efficient and safe.	Dispensing procedures/ repeat dispensing
Luckily the PCT and LPC has identified and agreed the multi-disciplinary clinical audit -- for controlled drugs which we are signed up to. However, we have now to consider the planning and content of the other practice based audit ourselves	Audit
Making time for clinical governance while running a pharmacy	Time
Management of supermarket not understand	Other
Mistake reports	Reporting errors & near misses
Motivation	Culture
MUR	Other
My own CPD	Training/CPD/Education

Near Miss and error reporting - trying to get over to the staff the importance of recording and using records as a tool for learning not punitively.	Reporting errors & near misses
Near miss reporting	Reporting errors & near misses
Near misses	Reporting errors & near misses
Needle exchange and it's confidentiality c.f. advice from the RPSGB regarding needle exchange clients who are also undergoing treatment for addiction.	Confidential information
New contract	Other
No lead from P.C.T. AT ALL	Support PCT
Non threatening error reporting	Reporting errors & near misses
Not recording near misses	Reporting errors & near misses
NPSA reporting is statistical and ludicrous. Aviation is used as an example of blame free reporting, but at least it is interesting, diverse and diverting - pilots are still prosecuted for transgressions. Not many people will bother reporting once they have learnt from their mistakes.	Reporting errors & near misses
Owings	Owings
Owings	Owings
Owings and audit trail on these	Audit
Patient & public involvement	Other
Patient confidentiality	Confidential information
Patient confusion caused by changes to generic brand / parallel import	Other
Patient identification issues	Other
Patient information	Other
Patient satisfaction	Other
Patients closettes	Other
PCT audit	Audit
Poor prescribing practice by GPs	Other
Poor standard of locums	Other
Practice leaflets	Other
Preparation of SOP's for essential services	SOPs
Preparing and implementing SOP's	SOPs
Pressures of work with increased script volumes	Other
Procedures (SOPs) for other areas than dispensing	SOPs
Process mapping each of the pharmacy's activities by all staff and then writing the SOPs for each activity	SOPs
Professional image	Other
Promoting healthy lifestyle in accordance to contract	Other
Realising that often what we do automatically as good practice actually fulfils the clinical governance requirements	Other
Record keeping	Record Keeping
Record keeping- IT limitations	Record Keeping
Recording advice/interventions	Record Keeping
Recording errors and doing near miss audit.	Reporting errors & near misses
Recording everything we do or say, lack of time to make records, and space to store them.	Record Keeping
Recording Interventions	Record Keeping
Recording of incidents	Record Keeping

Recording on paper or computer every last, damned piece of information that is required - it can be extremely difficult to find the time!	Record Keeping
Recording systems, within the constraints imposed by the slow introduction of IT systems	Training/CPD/Education
Recording, reporting and learning from adverse incidents. risk management	Reporting errors & near misses
Records (Pt)	Record Keeping
Reduction of dispensing errors	Reporting errors & near misses
Repeat Dispensing	Dispensing procedures/ repeat dispensing
Repeat dispensing	Dispensing procedures/ repeat dispensing
Repeat dispensing	Dispensing procedures/ repeat dispensing
Reporting errors	Reporting errors & near misses
Risk management	Risk management
Risk management	Risk management
Risk management	Risk management
Risk Management - Near Miss reporting	Reporting errors & near misses
Robust system for assessing MUR's supplied from pharmacies	Other
Satisfaction survey for substance misuse patients	Other
Setting up the protected time to ensure training takes place	Training/CPD/Education
Shortage of dispenser hours to release pharmacists to concentrate on clinical issues	Time
Significant Event recoding	Reporting errors & near misses
Signposting	Other
Similarity between product names leading to wrong product being supplied	Similarity of packaging
Similarity of packaging of generics within a manufacturer's branding	Similarity of packaging
Similarity of patient packs leading to the wrong product or strength being supplied	Similarity of packaging
Skill mix- training time	Training/CPD/Education
SOP	SOPs
SOP	SOPs
SOP's	SOPs
SOPs	SOPs
SOPs	SOPs
SOPs	SOPs
SOPS	SOPs
SOPS	SOPs
SOPs	SOPs
SOPs - time for	SOPs
SOPs for ALL areas of practice	SOPs
Staff and their understanding and agreement to of Confidentiality and Data Protection	Confidential information
Staff development / training	Training/CPD/Education
Staff following protocol	Other
Staff induction and appraisals	Other
Staff levels	Other

Staff training	Training/CPD/Education
Staff training	Training/CPD/Education
Staff training	Training/CPD/Education
Staff training	Training/CPD/Education
Staff training	Training/CPD/Education
Staff training and staff performance	Training/CPD/Education
Staff Training, as most of our staff members had not previously worked in pharmacy	Training/CPD/Education
Staff training/development	Training/CPD/Education
Staffing	Other
Standard operating procedures	SOPs
Standard operating procedures	SOPs
Standard Operating Procedures - not that is necessarily a bad thing but it has been time consuming although a very positive outcome at the end	SOPs
Standard operating procedures- writing and developing	SOPs
Standard Operating Procedures	SOPs
Standard Operating Procedures - they keep expanding to cover more of the work	SOPs
Stating to do MURs	Other
Stating to do Repeat Dispensing	Dispensing procedures/ repeat dispensing
Stock control	Other
Stock control / owings	Other
The acceptance of waste - and the new rules relating to it	Other
The need to sort everything out with no help from the PCT. The LPC has supported us a lot in [our county].	Other
The PCT has not conducted a local needs analysis to support the pharmacy contract	Support PCT
The prescribing advisor is the PEC member.	Other
These questions hardly apply to locums such as myself - I have answered for the pharmacy in which I do the most of my work.	Other
Time	Time
Time to record	Record Keeping
To get all staff engaged in this process	Culture
To get all the paper work ready and tidy for the process	Paperwork
To report errors in a no blame culture	Reporting errors & near misses
To write the sops	SOPs
Too many aspects to consider	Other
Too many records required	Record Keeping
Total lack of engagement by the PCT - I have an identified lead with no access to training or CG networks	Training/CPD/Education
Training	Training/CPD/Education
Training of staff	Training/CPD/Education
Trying to embrace the staff development program	Other
Unable to get past receptionist to address clinical issues with prescriber	Other
Unclear and unhelpful information about waste disposal due to changes in regulations in August	Other
Understanding audit	Audit

Understanding clinical governance mainly by the staff	Understanding clinical governance
Understanding correctly what we need to do	Understanding clinical governance
Unsupportive GP practice to provide Medicines Use review	Other
Updating SOPS in line with new pharmacy contract	SOPs
Waste disposal	Other
We have carried out a full clinical audit on owings. This has taken a lot of time and effort but hopefully will contribute to patient satisfaction.	Audit
When the pharmacy systems come under pressure from the volume of dispensing to adhere to the standard operating procedures with all the checks and not to take short cuts.	SOPs
Whether a prescription will kill a patient or not.	Other
Who to have as a lead	Other
Why are DRs misprescribing unlisted medicines?	Other
Why have DRs prescribed 10 months supply in 10 weeks!	Other
Writing and implementing SOPs	SOPs
Writing so many SOPs and finding the time for this and all other new requirements whilst also trying to do my normal day to day work	SOPs
Writing SOPS	SOPs

D25. What are the main barriers to implementing clinical governance in your pharmacy? Verbatim Responses:

BARRIERS	Code frame
A change in culture	Culture
A clear set of questions that we can address as to "what good looks like" that is relevant to daily work life, and applicable for all patients	Other
Access to appropriate training resources	Training
Additional bureaucratic workload	Culture
Admin	Other
Age of premises	Unsuitable premises/facilities
As a locum, can be in a difficult position to recommend changes	Other
Attitude	Staff Engagement
Available support from the PCT	PCT support
Availability of trained staff	Staff Level
Being new process --getting staff on board	Staff Engagement
Blame culture	Culture
Boring!	Culture
Bureaucratic systems being introduced like the new Repeat Dispensing scheme are horrendously complicated and potentially time consuming, yet our existing mechanisms are well organised and work like a charm without effort	Time
Change of culture within Pharmacy to report incidents	Culture
Changes in staff	Staff Engagement
Communication	Communication
Conflicting & vague "advice"	Communication
Conflicts between SOPs and common sense. The inability to accept waste sharps unless its part of needle exchange. A returned sharps container is a returned sharps container.	Other

Cost - Clinical governance is unproductive and costly but unfunded and totally out of control. A4 questionnaires - and tabled analyses - meaningless, impenetrable and demotivating.	Culture
Difficult to keep protected time when other staff are off ill - does working with a reduced staff increase the risk of error?	Time
Difficult to know if locums are up to speed	Locums
Difficulties in communication between GPs and community pharmacies	Communication
Direction from PCT	PCT support
Drowning in too much paperwork and administration and less time for patients	Paperwork
Electronic connection to various institutions to forward reporting forms	Unsuitable premises/facilities
Encompassing a new role without any training	Training
Engaging staff	Staff Engagement
Excessive change of processes and system in a short time	Unsuitable premises/facilities
Extra staff required but no extra money in the contract.	Staff Level
Facilities	Unsuitable premises/facilities
Fear of blame when and if errors made are reported to the PCT now instead of the NPA as previously. Increased indemnity insurance premiums if sudden rise in errors reported=made!	Culture
Financial cost	Money
Financial-manpower	Staff Level
Finding the time to carry out paperwork whilst carrying out daily duties	Time
Funding	Money
Getting agreement with the pct facilitator on different interpretations of the requirements	PCT support
Getting all members of staff signed up to the changes	Other
Getting help from the PCT. I am okay to implement CG as I am CG facilitator in another PCT so bring ideas to my pharmacy but I can imagine the difficulty of other pharmacies	PCT support
Getting info from PCT	PCT support
Government pursuit of minimum payment for the contract = generic +parallel import supplies (see D1/2)	Other
Guidance from PCT can not comply with their guidance if they don't give	PCT support
Having all staff available at set time for meetings	Time
Having info supplied to us later than expected in such of waiting for official national guidelines on DDA toolkits and Child Protection etc	PCT support
Implementing paper work on top of normally dispensing	Paperwork
Implementing strict procedures and making sure all staff adhere to them, non compliance not being an option	Staff Engagement
Increased workload	Other
Increased workload in general both for the pharmacist and staff alike	Staff Engagement
Inertia, although in the practice in which I work the standard is very high.	Culture
Information overload- new contract!	Other
Informing staff (all part-timers)	Staff Engagement

Initially, disclosures of dispensing errors and reporting of near miss incidents as a change of approach needed to be adopted. This has now ceased to be a problem as personnel have accepted that it is beneficial to use these occurrences as learning opportunities.	Culture
Insufficient clear information	PCT support
Insufficient staff resources	Staff Level
Interprofessional communications	Communication
It's all new, with so many new things starting at the same time- new contract procedures	Time
Jargon	Understanding clinical governance
Know how	Understanding clinical governance
Knowledge	Understanding clinical governance
Lack of an practical help or advice from the Pharmaceutical Society.	Support non-PCT
Lack of any funding to reward good governance (unlike GP's)	Money
Lack of communication.	Communication
Lack of engagement in PCT policy	PCT support
Lack of engagement of Locums	Staff Engagement
Lack of feedback from pct about procedure details	PCT support
Lack of financial resources	Money
Lack of funding	Money
Lack of funding for new equipment, features, IT etc	Money
Lack of GP liaison / team working / communication	Communication
Lack of info	Support non-PCT
Lack of info from PCT currently	PCT support
Lack of interest or understanding from company hierarchy, IT suppliers, other professionals	Staff Engagement
Lack of IT links - to NPSA NRLS	Unsuitable premises/facilities
Lack of IT links to electronic reference sources	Unsuitable premises/facilities
Lack of knowledge	Understanding clinical governance
Lack of manpower	Staff Level
Lack of money	Money
Lack of money	Money
Lack of motivation when stores run on different locum each day for weeks on end	Locums
Lack of protected learning time	Time
Lack of provision of suitable waste disposal system for confidential waste and CD waste by employer/PCT	PCT support
Lack of resources	Staff Level
Lack of spare time for pharmacist to implement ideas and review procedures etc	Time
Lack of staff	Staff Level
Lack of Staff Training and the issue with high staff turnover	Training
Lack of time	Time
Lack of time	Time
Lack of time	Time
Lack of time due to staff shortages	Time

Lack of time for staff training about new implementation procedures	Training
Locums and SOPs - how we ensure compliance	Locums
Locums doing their own thing	Locums
Locums in for half of opening hours	Locums
Locums – making sure they follow the rules and standard of my pharmacy	Locums
Managing change in the workplace, work loads and resistance to changes in traditional roles	Culture
Managing change of habit	Culture
Manpower & expertise	Staff Level
Many locums working in pharmacy	Locums
Many meetings to discuss such matters with other contractors are by necessity after work, when many of us have other things to do	Other
Mind set to change, Negative attitude in some older staff	Staff Engagement
Money	Money
More company involvement	Support non-PCT
More time	Time
Most staff are part time & lack of conviction or do not like taking responsibility	Time
Motivation of the staff	Staff Engagement
Need more facilitation	Support non-PCT
No clear lead from pct or head office	PCT support
No internet connection	Unsuitable premises/facilities
No lead from local PCT , it does not seem to have a chief Pharmacist at all	PCT support
No permanent manager and now, with change of company areas, use of a variety of 'stray' locums who do not know the systems in place, thus only half do the job.	Locums
No time to keep all records required	Time
None	Other
Not enough examples of good practice	Other
Not enough time to read all the documents and sort out what is relevant to my own work place	Time
Not knowing exactly what the PCT recommendations are or whom to get in touch with to discuss issues regarding pharmacy	PCT support
Not one I am a locum	Other
Other people's (other healthcare proffs) perception of my CG responsibilities e.g. under the DDA -- compared to my own!!	Other
Other skilled staff to help	Staff Engagement
Otherwise I do not foresee any barriers.	Other
Out Time - despite increasing the staffing levels, pharmacy employs mainly female counter assistants who, by their family commitments, appreciate the flexibility that pharmacy working gives them in terms of part-time work. This means that it has proved impossible to disseminate information and gain views in a consistent manner as you can't get them all together in one place at one time - more work is needed on this!	Time
Outside agency inputs, PCT RPSGB DOH impenetrable terminology &jargon	PCT support
Paperwork	Paperwork
Paperwork	Paperwork

Paperwork cumbersome	Paperwork
Patient demand on time	Time
Personalities	Staff Engagement
Pharmacist time	Time
Pharmacists are not interested	Culture
Physical limitations, e.g. storage space	Unsuitable premises/facilities
PMR not very good for recording anything outside script details	Other
Poor working conditions, high work load, minimal working space, minimal storage space no/negligible breaks	Time
Problems with conflicts in legislation, e.g. waste regulation contradicting new pharmacy contract	Other
Realising importance	Culture
Reluctance of GPs for repeat dispensing process	Other
Reluctance to interfere with GP /patient relationship	Other
Resentment - I resent the imposition of reams of paper exhorting recording and justification for what we do. For 30 years we have lead development, invented new products, provided services at no cost to patients without NHS recognition or funding and definitely without clinical governance.	Paperwork
Resistance to change	Culture
Resistance to change	Culture
Resistance to change by staff	Staff Engagement
Resource- falling PPA payments vs. rising cost of implications of new contract	Other
Same as above	Other
Severe time pressures- both pharmacists and staff	Time
Shortage of good locums to allow time to deal with all the paperwork	Locums
Shortage of staff hours	Staff Level
Shortage of time - any errors are dealt with as a priority but paperwork is sometimes not completed after the event	Time
Shortage of time - company has provided SOPs for main areas of practice, store specific SOPs need to be done for specific local practices(e.g. supervised consumption)	Time
Shortage of time - difficult to get quality time with new staff to address training issues, difficult for staff to be freed from duties to do any training during working hours.	Time
Sign up by all staff	Staff Engagement
Six months to implement what we should have been doing for the last five years? Thank you PCTs and StHAs - whilst stepping from the backwaters of Primary Care into the mainstream is exciting, the difficulty that pharmacies have encountered in implementing Clin Gov is not solely of their own making. The complete disregard of this essential part of care provision has been ignored by our NHS task-masters and now we are paying the price. Thankfully, many of us have taken the bit between our teeth but would hope that PCTs recognise some of their culpability in all this and do not expect miracles in six months from all of us...	Other
Skill mix restrictions caused by delays to legislative change that have occurred in the last ten years	Other
Some training issues to resolve, although forthcoming PCT training should address this!	Training
SP	Other

Space for all the resources and paperwork required	Paperwork
Space to carry out training (no stock/staffroom in shop)	Training
Staff	Staff Level
Staff & systems management	Staff Engagement
Staff attitude and apathy	Staff Engagement
Staff expectations	Staff Engagement
Staff leaving and time needed to be spent retraining new staff	Time
Staff levels	Staff Level
Staff motivation	Staff Engagement
Staff resistance	Staff Engagement
Staff shortage	Staff Level
Staff to be fully engaged	Staff Engagement
Staff turnover	Staff Level
Staff understanding	Understanding clinical governance
Storage of paper work	Paperwork
Sufficient qualified staff	Staff Level
Sufficient staff	Staff Level
Support	Support non-PCT
Support	Support non-PCT
Support from company for CPD.	Support non-PCT
Support from local PCT	PCT support
Support from PCT - what are their expectations / base line?	PCT support
Support from store management (supermarket) wrt training, staffing levels	Training
The apparent need for more time to do things	Time
The Department of Health have frequently changed the requirements within the pharmacy contract, or have issued information late. For example the Regulations were only issued on the date when the contract was introduced, and there has only been a six month transition period.	Other
The fact that I am the sole pharmacist, and have only one assistant. Any work I have to do in CG has to be done in my own time	Time
The increasing number of manufacturers who cannot supply like carduraxl 4mg and 8mg make regular supply of medication with a seamless service very difficult; for elderly patient who are stable on their medication this would seem an added encumbrance. Do manufacturers not have an obligation to provide a continuing supply?	Other
The PCT	PCT support
The public expectation of obtaining their medicine quickly, we are explaining how many people or items are in front of them to quantify why there is a time wait. This still can cause exasperation in some people.	Time
The whole thing is unnecessarily time and paper consuming. The workload is phenomenal, unanticipated and unremunerated. We have developed services and advanced community pharmacy very well without it for decades. We are also busy trying to run a pharmacy, a hospice charity, get deeply involved with pharmacy politics and have a home life. Clinical governance runs a poor fifth.	Time
There are only two of us working there. Formalising everything with written SOP's seems somewhat pointless at times.	Time

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Time - extremely busy pharmacy - trying to arrange weekly staff meeting time	Time
Time - Providing high quality services, minimising risk and liability, coping all day with high dispensing volumes in response to unremitting demand, spending evenings on meetings, home visits, tray checking, staff training and personal CPD leaves no time for family life. Clinical governance comes last in priority when motivation is non-existent.	Time
Time - very busy pharmacy with a number of part time staff. CG requires time out of the dispensary with staff	Time
Time & effort	Time
Time and IT not keeping up with demands.	Time

Time and paperwork	Time
Time and pressure of day to day work	Time
Time constraint	Time
Time constraint	Time
Time constraint	Time
Time constraints - other more immediate priorities - and excessive boredom with the process.	Time
Time constraints, availability of clear guidelines	Time
Time- especially "profited time"	Time
Time in a busy pharmacy with no extra staff	Time
Time issues	Time
Time management and workload demands are always a pressure. The DH has also introduced an unprecedented amount of change in the health arena; but to whose benefit. Apparently not the patients or the staff.	Time
Time pressures	Time
Time protection	Time
Time to do all paperwork	Time
Time to document CPD	Time
Time to record on the pc	Time
Time to train al members of staff	Time
Time.	Time
Time. Who pays?	Time
Too busy	Time
Too many SOPs for too many of the standard everyday functions we carry out so naturally that they are virtually automatic -- but need to be SOP'd for evidence that PCT wants	Other
Too much paper work, lack of time	Time
Too much paperwork	Paperwork
Training	Training
Training	Training
Training	Training
Training lay staff in the concept of clinical governance, my experience is that it can be complex even for professional staff (including GPs, nurses etc). It is very demanding for medicines counter assistants.	Training
Trying to record so much more which takes so much time	Time
Uncertainty in the contract	Other
Uncertainty of future of PCTs within 'Fitness for Purpose'	PCT support
Uncertainty with respect to relocation of local surgery and implications for essential refit	Unsuitable premises/facilities
Uncertainty within the PCT about their own future	PCT support
Understanding of clinical audit	Understanding clinical governance
Understanding of required procedures	Understanding clinical governance
Understanding the meaning of CG and how it applies to day to day working a pharmacy	Understanding clinical governance
Unsuitable premises	Unsuitable premises/facilities
Village pharmacy in old building therefore difficulties with space and DDA compliance	Unsuitable premises/facilities

Volume of prescriptions 5,500 per month together with staffing levels and gluts of work load pressure when dr surgeries are in full swing. It is tempting to check dispense and hand out prescriptions as fast as possible whilst checking dispenser generated prescriptions too. This keeps the waiting time down and the complaints too.	Staff Level
We are already busy up to 12 hours a day trying to be exacting in dispensing, providing care through managing elderly patients medication(not MURs), daily liaison and collection from nursing centres and surgeries, delivery of medicines direct to patients and providing medication trays to domiciliary confused, elderly, disabled and housebound patients. None of these is properly recognised or remunerated.	Other
We do not want service to the patient to suffer because of the burdens of paperwork.	Paperwork
We have not received enough support from the PCT, e.g. the nationally agreed patient satisfaction forms have not come.	PCT support
Window dressing i.e. If that is all it is then I have patients to deal with	Other
Working practices built up over many years	Other
Working single handed there is no time for 'extras'.	Time
Workload	Time

D26. What help do you require in developing clinical governance in your pharmacy? Verbatim Responses:

Help	Code frame
30 hours in every day!	Other
A Clinical Governance lead to come to the pharmacy and guide us.	Support- PCT
A forum to exchange ideas and see how others are implementing CG	Support- Miss
A lead from the PCT	Support- PCT
A second pharmacist and higher staffing levels , this is not feasible due to the cost.	Lack of staff
A single site where I can find documents relating to clinical governance issues in community pharmacy, or an email system like NELM to alert me to such documents	Information
Access to suitable CPD resources for staff	Information
Additional staffing- 2nd pharmacist	Lack of staff
Admin support	Support- Misc
Advice about procedures	Support- Misc
Advice regarding priorities of Clinical Governance Issues needing tube resolved	Support- Misc
Agreement by PCT to accept change in shop opening hours to allow a 1hour per week staff meeting time - for training purposes.	Training (time and funding)
Allocated time for staff training	Training (time and funding)
An extra member of staff	Lack of staff
Another pair of hands	Lack of staff
appropriate staff training	Training (time and funding)
Audit design	Other
Audit support	Support- Misc
Awareness of extra workload being created for pharmacists and KEEP ITSIMPLE!	Other
Back fill funding for staff training	Training (time and funding)

Being expected to attend the training in the 3 PCTs. Need more coordinated working.	Training (time and funding)
Being in a very small chain, the boss is supportive of us doing whatever we feel necessary, without imposing inappropriate procedures onus	Other
Better systems (? prepare for eTP)	Facilities
Better understanding	Other
Central training opportunities for support staff	Training (time and funding)
Clarification of certain areas of the new contract	Clarification
Clear frameworks	Clarification
Clear guidance from pct	Support- PCT
Clear guidelines availability	Clarification
Clear guidelines on PRACTICAL (not time-consuming) work to do.	Clarification
Clear indication of how to implement each aspect of clinical governance	Clarification
Clear 'nuts and bolts' guidelines on what contractors need to achieve and what PCT monitoring will involve.	Clarification
Clear standards by RPSGB	Clarification
Clear templates	Clarification
Clinical governance facilitator	Support- PCT
Communication and guidance from head office and the PCT.	Support- PCT
Consultation room	Facilities
CPD	Other
Create more time or provide protected time for this	Time/Protected time
Critical appraisal and advice of a constructive and practical nature from someone who has implemented the procedures and faces day to day problems of running a pharmacy i.e. not from idealists or pen- pushers.	Support- Misc
Currently, any help needed is provided by the PCT clinical governance facilitator	Support- PCT
Dedicated time to train all staff in new protocols, and more time to get used to them.	Training (time and funding)
DH need to issue less 'woolly' ideas, without proper consultation, stop changing goalposts, re-organising the PCT areas, and let us get on with our jobs.	Other
Direction from pct on topics	Support- PCT
Direction from PSNC	Support- Misc
DO NOT need more evening meetings.	Other
Electronic recording systems	Facilities
Evidence of existing good practice	Information
Financial support for staff training	Training (time and funding)
For the company to recognise the above, not just the qualification but for the person so actually to be able to do the employed job efficiently and effectively.	Other
Funded protected time every 3-6 months for pharmacies to run group sessions with staff about CG issues such as critical incidents, audit, Patient Satisfaction etc.	Training (time and funding)
Funding for electronic Links	Facilities
Funding to allow daytime multiprofessional training	Training (time and funding)
Funding to employ staff to have the time to complete reports and do risk analysis as well as dispense 600 items	Money
Funding to reward good governance as carrot rather than the stick approach responding to poor performance.	Money

Funding within the contract- GPs have monies for premises and learning time- why are pharmacists different?	Money
Get staff to stay in position long enough to realise benefits from training -- retention of staff	Training (time and funding)
Give PCTs more guidance so they all are approaching this in the same way and there is not too much variation	Support- PCT
Good quality training on staff development programmes, including induction, appraisal etc	Training (time and funding)
Guidance	Information
Guidance from PCT - support material - what do they want in place	Support- PCT
Guidance to GPs and district nurses and PCTs on what they can reasonably expect from community pharmacies under support for the disabled	Information
Guidelines better written and better disseminated	Information
Having a local advisor who can be readily contacted	Support- PCT
Help from pct	Support- PCT
Help in changing roles	Support- Misc
Help with audit	Support- Misc
Higher skilled level counter assistants again more cost.	Other
How to go about it	Information
Improved links with all GPs	Other
Increase skill mix	Other
Increase staff levels	Lack of staff
Increased hours available	Time/Protected time
Increased support staff, properly trained	Training (time and funding)
Increased templates - guidance at national level	Information
Information from PCT on audit	Support- PCT
Information on local self help groups	Other
It is wrong to regard the concept of audit as being 'clinical'. People don't understand Prof Abedis Donabedian's principle that Structure, Process and Outcome are interlinked and involve all aspects of the business we run. 'Clinical' means to do with medicines use (to pharmacists) not 'clinic' as in Michel Foucault's writings where the term changes its meaning in medical practice. Overall we have not been able to transfer practice and advice from medical MAAGs into useful or applicable roles in community pharmacy. There is a lack of definition and general understanding. We also don't have time, staff, patient records or incentive payment targets that exist in medical practice.	Other
IT links to NPSA and NHS Net	Facilities
IT suppliers who are not fixated with ETP, and who listen to what we need	Other
It's led from outside the pharmacy and imposed upon it. There's little sense of ownership - more a sense of jumping through hoops.	Other
It's still a piecemeal process - one step at a time - need to bring it'll together	Other
Just time to get used to the new ways of working.	Other
Keep it simple if it is to work	Clarification
Knowing what guidance the PCT offers and where to access the information, who is responsible etc	Support- PCT
Less advice	Other
Less errors and queries and careless quantities and doses on prescriptions. A dedicated person per surgery who takes on board a query and returns the solution ASAP. Hospital prescription written for community too i.e. quantities and generic.	Other
Level of support from PCT and employer	Support- PCT

Line management agreement	Other
Local facilitator	Support- PCT
Local pharmacy forum meetings, or clinical governance meetings to beheld during working hours with funding to replace the staff/pharmacist hours involved. There is no such thing as protected time in a community pharmacy setting so closing the pharmacy is not a realistic option, as business will simply be lost to a competitor who remains open. Such meetings would help us all to identify and share best practice.	Training (time and funding)
Locum allowance so that the regular pharmacist can spend about half a day per week to cover clinical governance issues.	Other
Lots	Other
Main current issue is around training in child protection.	Training (time and funding)
Making it simple enough to delegate (and interesting)	Other
Meeting with other local pharmacists to discuss how they are dealing with this area	Other
Meetings about tried and best practice	Information
Money	Money
Money for locum fees to free some time to do the work	Money
Money to implement necessary changes to premises	Money
More "easy to digest" information for me AND MY STAFF	Lack of staff
More consistency and more guidance e.g. to the above	Information
More control of Locums who think this doesn't include them!!	Other
More courses for pharmacists that are compulsory - too often our PCT organises courses that are poorly attended, and the message of CG is diluted somewhat - too many pharmacists are practising at sub-standard levels of care to the patient	Support- PCT
More definitive guidance on what we should be doing. There seem to be many lists and monitoring tools, and it is hard to know which one we should be using.	Clarification
More details of what is to be recorded and how	Information
More dispensing staff	Lack of staff
More financial resources to employ staff to carry out duties	Lack of staff
More help and feedback from the PCT	Support- PCT
More indication (specific) of what is required.	Clarification
More money	Money
More realism and practicality injected into PCT CG staff	Lack of staff
More specific time allocated for it which is funded -- locum cover is very expensive!!	Time/Protected time
More staff	Lack of staff
More staff	Lack of staff
More staff / time	Lack of staff
More staff dedicated to the job.	Lack of staff
More support from PCT	Support- PCT
More support from PCT	Support- PCT
More templates	Information
More time	Time/Protected time
More time	Time/Protected time
More time to undertake the tasks required	Time/Protected time
Multidisciplinary audit suffers from prejudice and GPs' focus on income and GMS priorities.	Other
Nationwide standards	Information
Networking and publication of best practice information from other PCTs	Support- PCT
None	Other

None - there's more than enough support for the process.	Other
None for us. We can manage fine through our own networking amongst our own colleagues and sharing our resources	Other
Non-threatening error reporting	Other
Locums need more information to understand how important CG is	Other
NPSA recording	Other
Office space	Facilities
Or time when shut	Time/Protected time
Paid time to learn more	Time/Protected time
Patient understanding that pharmacists can help and may have some better ideas about therapy or treatment of their condition than other health professionals and almost certainly a better idea than the newspaper, media or their friends and family.	Other
Payment would be nice. At the moment we are remunerated for prescription volume. Commercial success has to sustain a pharmacy since there is very little recognition of what our cognitive contribution is to patient care.	Money
PCT lead initiatives	Support- PCT
PCT run training on community pharmacy orientated clinical audit.	Training (time and funding)
PCT support	Support- PCT
Pharmacist led courses, instead of the CG director, so that best practice can be shared	Support- Misc
Practical help / suggestions	Information
Priority change - Government needs to get an idea of workload and real costs but the practitioners of government are disingenuous and avoid paying for what they get, so they don't really want to recognise either burden. Parliamentary draftsmen have walked away from Disability Discrimination. Collection and delivery systems are ubiquitous and easy to maintain unlike the horrendous Repeat Dispensing scheme. ETP is going to be a nightmare and the PCTs will once again fund practices not community pharmacy. Our real strength is in managing the medicines of the confused and elderly at home in trays and through weekly visits - again ignored by central funding. The New contract has pushed more money into volume dispensing and the largest contractors and ignored the value of cognitive functions.	Other
Protected Time	Time/Protected time
Protected time	Time/Protected time
PROTECTED TIME	Time/Protected time
Protected time to tackle a range of issues, NPSA reporting etc	Time/Protected time
Reduce the number of factors	Clarification
Refit, make dispensing process more efficient	Facilities
Regular updates from National organisations	Support- Misc
Repeat dispensing should reduce amount of time spent chasing prescriptions	Time/Protected time
Simple nationally agreed template/guidelines	Clarification
Simplification of concepts	Clarification
Simplify the recording	Clarification
Some clear guidance from PCT	Support- PCT
Some help is provided by company I work for and by PCT	Other
Some ways of reprieving pharmacist from burdens	Other
Someone to find more hours in the day!	Time/Protected time
Spare pharmacist	Lack of staff

Specific guidelines	Clarification
Stable staff	Lack of staff
Staff appraisal support, and other HR resort (as an independent pharmacy)	Support- Misc
Staff training programme	Training (time and funding)
Standard package to buy off shelf would be good	Other
Strategy for achieving new contract standards	Information
Structure for record keeping	Information
SUPPORT	Support- Misc
Support	Support- Misc
Support from company and PCT (i.e. regular advice/visits)	Support- PCT
Support from national bodies in developing and implementing SOPs	Support- Misc
Support from NHS / other professions / other Pharmacists	Support- PCT
Support from pct	Support- PCT
Support from PCT, Company, RPSGB	Support- PCT
Survey templates	Information
Tell us what is required	Clarification
There has been a lot of excellent material produced (CPPE, NPA, PSNC and others) - the main challenge now is in funding protected time to develop this.	Time/Protected time
There is a shortage of practical tools and examples. No spin-off from the MAAG exercise. A CD-ROM from the PCT ignores the fact that we haven neither the time nor the inclination to use its resources.	Support- Misc
Time allocated specifically to developing clinical governance	Time/Protected time
Time- patients want to see me not anyone else!	Time/Protected time
Time required – e.g. use support staff to cover while pharmacist makes the intervention, discusses meds and conditions with patient etc.	Time/Protected time
Time to train staff	Training (time and funding)
To have regular meetings with other area pharmacists	Other
Tools to do it	Other
Training	Training (time and funding)
Training	Training (time and funding)
Training (on the job)	Training (time and funding)
Training and engagement with the PCT for CG lead	Training (time and funding)
Training for all staff	Training (time and funding)
Training for staff and managers	Training (time and funding)
Training for staff and pharmacists	Training (time and funding)
Training from the PCT to cover all aspects of CG	Training (time and funding)
Training of staff and pharmacists by the PCT	Training (time and funding)
Training of support staff to understand that sometimes an intervention should be made, even though it is against the GP instructions, or might upset the patient.	Training (time and funding)
Training, as mentioned above. PCT has arranged this already.	Training (time and funding)
Try not to reinvent the wheel - if a Company already has a system in place that address a topic - accept that and do not double report	Other

Turning theory into practice	Other
Understanding what the local PCT need	Support- PCT
Visits from clinical governance authorities	Support- Misc
We get all the help we need from the PCTs clinical governance facilitator	Other
We have a good, available CG lead here so help is available	Other
Workable template for patient satisfaction survey	Information
Written information/protocol	Information
Yes. Paid training time with PCT facilitators - NOT after hours	Training (time and funding)

Appendix 2 - Questionnaire

NAO STUDY: IMPROVING QUALITY AND SAFETY – PROGRESS IN IMPLEMENTING CLINICAL GOVERNANCE IN PRIMARY CARE

National Audit Office

Questionnaire for pharmacists in primary care and community pharmacy

The National Audit Office is currently conducting a study of clinical governance in primary care in England. The main objective is to examine whether Primary Care Trusts (PCTs) are achieving improvements in patient care through better clinical governance. The output of our work will be a report to Parliament. We are keen to include as part of our study the experience of pharmacists and would be very grateful if you would spend a few minutes completing this questionnaire.

The majority of questions only apply to community pharmacy. All responses will be anonymised and no information disclosed other than to present an analysis nationally.

The findings from this questionnaire will also be used to prompt an electronic discussion forum facilitated by the Royal Pharmaceutical Society during October 2005 to further inform the NAO study.

If you prefer to complete this questionnaire electronically, please go to http://www.nao.org.uk/survey/pharmacy/index.htm

For further details of the study see the Work in Progress section of our website at http://www.nao.org.uk/publications/workinprogress/primary_care.htm

PLEASE RETURN YOUR COMPLETED QUESTIONNAIRES TO NATIONAL AUDIT OFFICE BOX AT THE ROYAL PHARMACEUTICAL SOCIETY STAND AT THE CONFERENCE

(If you would prefer, please post to the NAO at: Clinical Governance Study Team, Room A579, 157-197 Buckingham Palace Road, London, SW1W 9SP)

Thank you very much for your assistance.

A. ABOUT YOU

	North	Midlands and Eastern	South	London
A1. In which part of England do you practice?	❑	❑	❑	❑

A2. In which Primary Care Trust? _____

	0-2 years	2-5 years	5-10 years	10 years or more
A3. How long have you been a registered pharmacist?	❑	❑	❑	❑

	Community Pharmacy	PCT	GP Practice
A4. Area of work	❑	❑	❑

B. ABOUT YOUR PRIMARY CARE TRUST

	Yes	No	Don't Know or N/A
1. Does your PCT have a clinical governance facilitator for pharmacy?	❑	❑	❑
2. Is there a pharmacy representative on the PCT Professional Executive Committee?	❑	❑	❑
3. Does your PCT have a strategy for implementing clinical governance as part of the Pharmacy Contract?	❑	❑	❑

C. IF WORKING IN COMMUNITY PHARMACY

		Yes	No	Don't Know or N/A
4. Do you have a clinical governance lead for your pharmacy? (this might be a shared post)		❑	❑	❑
5. If yes, what is their position?	(I) pharmacist	❑		
	(ii) counter assistant	❑		
	(iii) dispenser	❑		
	(iv) technician	❑		
	(v) area manager	❑		
	(vi) other /don't know	❑		❑
6. Does your pharmacy have an up to date practice leaflet?		❑	❑	❑
7. In the last year, have you undertaken a patient satisfaction survey?		❑	❑	❑
8. Do you plan to undertake a patient satisfaction survey in the next six months?		❑	❑	❑
9. Do you have a complaints process in place?		❑	❑	❑
10. Have you had a visit by your local Patient and Public Involvement Forum?		❑	❑	❑
11. Do you have a clinical audit programme in place?		❑	❑	❑
12. If yes, does it include one multi-disciplinary audit agreed by the PCT?		❑	❑	❑
13. Do you have a risk management policy?		❑	❑	❑
14. Do you have an incident reporting system in place?		❑	❑	❑
15. Do you have Standard Operating Procedures in place?		❑	❑	❑
16. Do you have arrangements in place to comply with the Disability Discrimination Act 1995?		❑	❑	❑
17. Do you have Child Protection Procedures in place, in line with national and/or local guidance?		❑	❑	❑

	Yes	No	Don't Know or N/A
18. Do you have arrangements in place in line with the Health & Safety at Work Act 1974?	❑	❑	❑
19. Do you have arrangements in place for appropriate induction of staff and locums?	❑	❑	❑
20. Do you have appropriate training in place for all staff in respect of the roles they are asked to perform?	❑	❑	❑
21. Are arrangements in place for identifying and supporting the			
CPD requirements for (I) registered pharmacists	❑	❑	❑
(ii) any other staff	❑	❑	❑
22. Do you have arrangements for addressing poor performance?	❑	❑	❑
23. Are these (I) PCT based	❑	❑	❑
(ii) company based	❑	❑	❑
(iii) individual pharmacy based	❑	❑	❑

D. YOUR COMMENTS

24. What have been the three main clinical governance issues you have faced in your pharmacy?

1……..

2……

3……

25. What are the main barriers to implementing clinical governance in your pharmacy?

1……..

2……

3……

26. What help do you require in developing clinical governance in your pharmacy?

1……

2……

3……

please turn over

27. We are also hoping to identify examples of **good practice** illustrating how clinical governance has made a difference. If you have an example of good practice you would be willing for us to contact you about please tick here ❑ and provide contact details below

Please tell us briefly about your example of good practice here

28. If you would be willing to be contacted by the NAO about the comments you have made please tick here ❑

Name **……**

e-mail address**……**

telephone **……..**

29. If you have any other comments you would like to make about clinical governance in pharmacy then please use the remainder of this page.

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(If you would prefer, please post to the NAO at: Clinical Governance Study Team, Room A579, 157-197 Buckingham Palace Road, London, SW1W 9SP)

Thank you for completing this questionnaire and the information you have provided.