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Module: Clinical Governance

"DESCRIBE THE FRAMEWORK FOR CLINCAL GOVERNANCE IN THE UK, AND CRITICALLY ANALYSE HOW THIS COMPARES TO INDONESIA IN TERMS OF PHARMACY SERVICES OR HEALTHCARE DELIVERY"

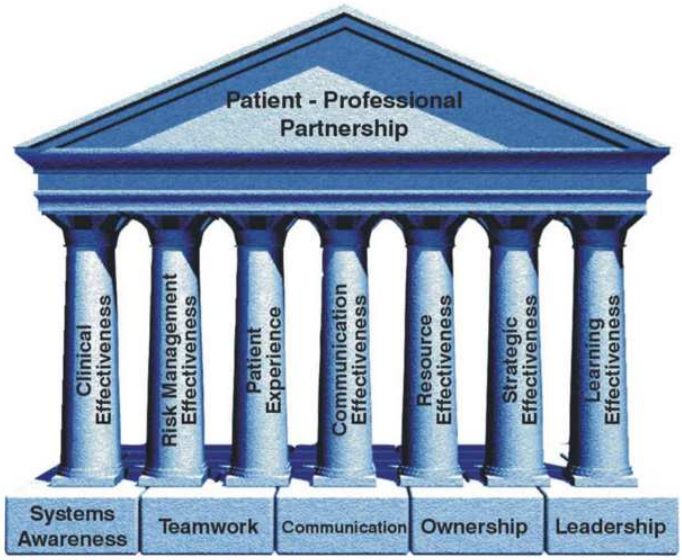
PREFACE

The good governance system in clinical domain was developed, pioneered by British National Health Service (NHS) in the 90s with the term of Clinical Governance (CG). The definition is stated in the document of A First Class Service: Quality in the New NHS, as: "A framework through which NHS organisations are accountable for continuously improving the quality of th eir services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson, 1998)

This definition has been interpretated in many ways among those who have a duty of care to patients and carer, based on the professional values an perceptions. And the core of the thought, CG is continous and long term improvement on quality, which is focusing and prioritising on patients, and this means ensuring patient safety under high standards.

The principles of CG apply to all those who provide or manage p atient care services in the NHS (A First Class Service – Quality in the New NHS, June 98). CG is for both clinical and non-clinical staff. It is cyclical and relates to all people who are involved in giving care to the patient, including treatment, care and contribution to the patient. CG involves effort, co-ordination and communication to commit excellent dedication in delivering services.

CLINICAL GOVERNANCE FRAMEWORK AND ITS IMPLEMENTATION IN THE UK



The CG parameters, known as "Seven Pillars" was devised by members of the NHS CG Support Team in 1999. In the Seven Pillars model, the pillars are supported by five foundation stones:

1. Systems Awareness

Systems awareness is about "What went wrong?" not "who went wrong?" It is important to pay attention on sytem failures, understanding the system flows and, understanding the system interconnections.

2. Teamwork

Properly developed, multidisciplinary teams will have t he potential to become prime levers for change; as teams grow and develop they will be able to both drive and deliver quality improvement initiatives.

3. Communication

Quality standard truly imply that healtcare service should have a well organized communi cation system to ensure that the service quality improvement concept has been well socialized to every staffs within the organization.

4. Ownership

Ownership is about real participation of staff in all developments. It is about creating a working environme nt where structures are in place to support individuals so that professionals and teams are empowered to own, and therefore to solve, problems.

5. Leadership

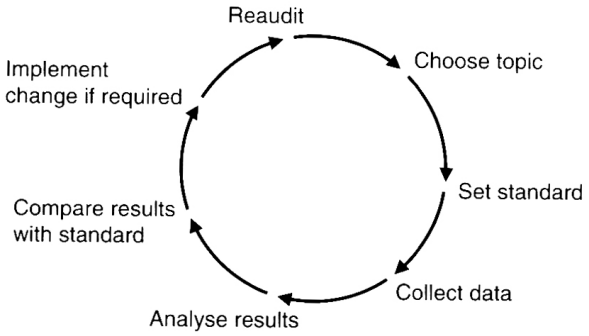
Leadership is the capability to create vision as well as create and maintain internal environment so that each and every staffs keep participating in achieving the target.

<u>The parameter of the seven pillars are</u> :

1. Clinical audits

Clinical audit management, planning and monitoring, learning through research and audit. Clinical audit was introduced to NHS in 1993, it is defined as: “A quality improvement process that seeks to improve patient care and outcomes through systemic review of care against explicit criteria and the implementation of change” (Principles for Best Practice in Clinical Audit , NICE, 2002).

The Clinical Audit Cycle:



In the UK pharmacy practice, it includes peer review to validate the standards operating procedure, take effective action to minimise the problem identified, so better patient care can be achieved.

2. Education, Training and Continuous Development Program

Kennedy (2001) stated that “ a patient is entitled to be cared for by health care professionals with relevant and up to date skills and experience.” Education and training needs can be identified in various way s.

In the UK pharmacy practice, it can be applied an internal training once a week on schedule rotation, further training or seminar, books/journal/

magazines must be accessible and available, induce self-learning, develop and discuss evidence based practice.

For the junior pharmacist, there must be a induction week training besides to explore more on management such as conflict management, risk management, problem solving, etc, in addition of job training. Junior pharmacists should also be trained regularly about broad aspects of pharmaceutical work so they become more advance day by day.

Senior pharmacists must also be trained regularly for their life long learning and keep updated about new issues and evidence-based medicines, leadership and overall pharmacy management and new information technology, not only the pharmacy technical skills. There is no way, a pharmacist whether junior or senior may handle the area they are not fully trained, especially for the key and high risk medicines.

Besides individual training, members of team should go some training together to build the good communication, togetherness and motivate the team to achieve goal which is concentrated on patient safety and satisfaction.

3. Risk Management

A risk management system will enable an organisation and the people within it to identify, report and understand what goes wrong in patient care, learn from the experiences an take appropriate action to ensure that it does not happen again by sharing this knowledge. The Kennedy report (2001) discussed a “culture of safety” where errors should be analysed as a learning experience and that there should be a blame free culture where staff are encouraged to report errors and near ly misses (sentinel events).

Staff also need to work in an environment where they feel confident and safe in reporting incidents of unprofessional practice. The Whistleblowers Protection Act 1999 has been effective since July 1999 and encourages people to raise concerns about malpractice in the workplace. According to NHS data, every year 400 patients died or seriously injured by medical devices. The risk of problems with medicines must be reduce by identifying any issues and learn from it.

In the UK pharmacy practice, everything non clinical and clinical must be reported as in this case for further review. All information provided to the patient must be clear and accountable, and recorded as well as from the patient.There must be policies aimed at managing risk by improving area to work on. This can be done by holding regular meeting between the pharmacists. Every staff member must be informed and keep updated about patient safety. This will enable the pharmacy to eliminate the mistakes an errors so the patient safty can be ensured.

Head of Pharmacist and his senior team must be able to analyse the patterns of key medicines that often cause errors and must try to find way to minimise and reduce the risks. And then establish the system or risk assessment and make sure it meet regular standard, also develop the reporting system that can be used to reduce risk.

4. Staff Management

Staffing and staff management includes the recruitment and selection of staff, with their appraisal, personal and professional development, and welfare. It also includes effective methods of working and good working conditions.

In the UK pharmacy practice, there must be Guidance or SOP , in which must be implemented. In the SOP, job description of each staff must be clear and updated. This SOP should be introduced to all new staff member and for the senior staff member must be involved from time to time to do revision if necessary. During the recruitment, there must be sufficient induction to the SOP before the new staff may handle patients.

Hierarchy/ Structure organisation must be announced, so everyone know who to report to, and who is respective for what. Every staff member should be aware of their roles and responsibilities.

The superior must take care of his subordinate, identify area of training requirement and provide the on the job training. The head pharmacist must always have his subordinate ready to do any particular high risk expertise job. So, when a staff is on leave/sick, there is always another person ready to substitute the job.

5. Information Management

The NHS and the people within it collect a huge amount of data. It is essential that this data isa mada available as useful information. This can be used for clinical audit, planning and commissioning services to improve patient care. Staff should have have knowledge on how to access and use emails and internets.

In the UK pharmacy practice, the information system in the hospital is pretty much advanced and in some big chain pharmacies have also been well developed. Automatic information on personalised patient records are designed to deliver service according to the health condition of individual patient.

This benefit of data management should then be used to promote public health on more advanced programmes, such as smoking cessation, healthy lifestyle promotion, fighting obesity, prevent cardiovascular disease, health screening, etc. However, the disadvantage is confidentiality issue. To tackle this, it is applicable to layer accessibility with password.

6. Patient and Public Involvement (PPI)

This pillar aims to improve patient care through regular review of care against public and patient expectations and patient experience, therefore can be used as a learning mechanism within Staff Management.

PPI can reveal where changes need to be made to improve patient safety, for example through feedback from complaints which includes implications for staff training. This means putting patients, carers, relatives and members of the public at the centre of all that we do in the health service.

In the UK pharmacy practise, it has been applied some quantitative and qualitative methods, ie: Surveys: postal, face-to-face interviews, by

telephone, semi-structured interviews, focus groups,structured consultation, community development, health needs assessment by local people, observation, community groups and individuals, health impact assessment , etc.

The result and feedback gained by PPI, will then be utilise for monitoring and evaluation, which is important to improve healthcare services.

7. Research and Development (R&D)

Clinical Research establishes what is the most effective way to treat patients. Research and development are needed to establish the most effective way to treat patients.

In the UK pharmacy practice, the scientific work in the field of health ser vices research has contributed some important new initiatives. The pharmacy research genda to enter the research strategies of the large R&D funders.

Concerns and Barriers of CG Implementation in the UK

Generally, problems encountered have included:

1. Shortage of time, resources and skills necessary for the new tasks .
2. Use of new managerial language and ideas – perceived shifting of power from doctors to managers.
3. Perceived as threatening – failure to engage some individuals .
4. Perceived distance between la nguage and reality of process, i.e. CG often does not affect how patients are treated .
5. Implies culture change

In the UK pharmacy practice, some common pratical problems during implementation can be described as below:

1. Clinical audit: Not enough staff to do peer review/audit
2. Training, Education and CPD: No budget to do it, No e xtra hour work
3. Risk management: Feeling insecure to share problems
4. Staff management: Lack of leadership or managerial skills
5. Information management: No budget to purchase a system, n o system analist staff to help, Lack of computing skills
6. PPI: Lack of follow up, no futher evalution and monitoring
7. R&D: No budget to conduct R&D, no expertise

COMPARING AND CONTRASTING PHARMACY SERVICES AND HEALTHCARE DELIVERIES IN INDONESIA USING CLI NICAL GOVERNANCE APPROACH

Current Pharmacy Practice in Indonesia

In 2005, statistic data showed that out of the 8,93 2 registered pharmacists in Indonesia, 34% in community pharmacy, 8% in hospitals and 27% in industry. The remainder were employed in aca demia and in the government bodies or

other fields. With a population of well over 220 million people, this means over 20,000 people are served by one pharmacist. This ratio is far beyond UK . Lack of pharmacists and low pay within community pharmacies and hospitals, urge the pharmacists to do double job. It is rarely to find a pharmacist in the community pharmacy. In hospitals, only offer a very basic pharmacy service and usually only one pharmacist handle the whole hospital. In industry, the strength of In donesian pharmacists is in their pharmaceutics and pharmacognosy knowledge.

In Indonesia there is still no official record about pharmacies or hospitals which have implemented CG concept, or if there is any, still not known of how the implementation takes place. However, it is known that some big chain retail pharmacies and hospitals has implemented ISO 9000 quality management, namely Kimia Farma with 365 outlets and Century Healthcare with 268 outlets. The other multinational retail pharmacies, namely Gu ardian Pharmacy, Medicine Shoppe, Watsons, are known not implementing CG yet, but they have a very advance SOP and systems in running the pharmacies.

Looking at that the basic principle in implementing CG, by combining organizational management with clini cal management , then there is a chance that some pharmacies which has a comprehensive quality management, service quality enhancement, including clinical service , have been applying CG. However the term CG is unknown.

Implemention CG in Indonesia's cur rent practice

There's a policy and strategy document for improving the service quality in general, including clinical service quality improvement. The policy and strategy is relevant to the individual organisation's mission and target. Below is the common practice and standards that are set within some pharmacies and hospitals. The CG framework of 7 pillars is used to appraise the implementation of CG within pharmacy practice in Indonesia and how management system supports the implementation itself.

1. **Clinical audit**
   In some organisations, policy and procedure that support this pillar are: medical service standard compiling procedure which considers evidence - based service standard by professional organization, and clinical service quality target measurement procedure. But usually there's no procedure for clinical audit, medical record review, nor procedure for getting the most updated information such as medical protocol or clinical pathways.

2. **Training, Education and Continuous Professional Development**
   All clinical staffs, specialist doctor in particular, pharmacists, nurses and other healthcare professionlas area usually well informed with their profession's training and development, but usually the common professional training and development they can participate is about clinical knowledge and in common practice, budget are not supported by the organisation.

3. **Risk management**
   Mostly in the pharmacy services and healthcare deliveries, there's no policy and procedure concerned about clinical risk management such as: clinical incident report procedure, sentinel event and the analysis using root cause analysis or other work frame, and clinical risk identification procedure as well as analysis and further action.

4. **Staff Management**
   Both pharmacies provides determined resource to support clinical service quality improvement activity, but information system is still in development process so that not every related data about clinical service can be found. Management system plays the role in giving a more definite framework to determine the necessary resource.

5. **Information Management**
   In Indonesia, information system in still far behind. In some traditional pharmacies, they even do not use computer at all. Everything is done manually.

6. **Patients and Public Involvement**
   Some government policies and procedures has shown the implementation, among other are documentation procedure for patient's consent, patient's complaint management, and patient's questionnaire feedback compiling. But there's still no procedure for releasing the patient's information, revealing information to the patient and his family about serious clinical incident or sentinel events

7 **Research and Development**
   R&D is never been conducted within healthcare services organisations, due to lack of funding. Usually R&D is done by collaboration of foreign funder in academia and industry.

The Possibility of Implementing CG in Indonesia

In most healthcare organisations, vision of their service quality has evolved, from neglectable service quality to currently compact quality management. There also must be a balance between customer satisfaction with other relevant party, like owners, employers, suppliers, investor, public and government. Systematic approach for management system is a group of process, so there's a need for identification, comprehension, and system management from related process to achieve and improve organisation target.

The whole concepts to implement CG are; cultural transformation, staff's involvement, resource support and organisational awareness. It's also needed to build a non-blaming culture to support the CG implementation in order to improve clinical service quality. Beside that, conducting teamwork effectiveness, building an open culture and always inquire the truth, and making sure that all the things mentioned above being applied in daily activity in every clinical service.

Focus on the patient, healthcare professionals in Indonesia should understand how to use information and feedback input from patients for measuring and improving the service quality. Patient's participation will affect next step process to improve quality so that means every staffs should focus on the patient in everything they do. In hospitals, it starts from doctors who discussed therapy options to the patient, nurses who make sure that the patient aware of what the given treatments are for, up until pharmacy's managers who allocate their time in the ward to seeing first hand how the clinical service implementation was performed and listening to the patient's response.

The CG implementation plays the part in building staff's involvement in quality improvement, by materializing a policy in quality manual document that says every staffs have to participate in order to improve qualit y. Possible impact of the strategy on CG implementations are enhance patient safety, good practice, patient's confidence, improve pharmacy services and healthcare deliveries, employees job satisfaction and decrease medication errors.

Success Assurance

CG is essentially about the development of a culture that supports and promotes improvements both in practice and in patient care. It requires organisation wide commitment. Pharmacies and hospitals who want to actualize CG can start from something new or modified a specific services.

Capability to measure provided service quality is an important issue in implementing CG, such as waiting time measurement, tests that has to be retake, and strategic indicator such as innovation amount, innovation effectiveness etc.. CG plays a role in determining quality target including clinical service quality target, performance target, periodically appraisal, analysis and further actions and contingency improvement.

Other integrated part is management process to appraise h ow the design can be evaluate and improving the performance. To design a good pharmacy services and healthcare deliveries, it is important to see and reevaluate the clinical service process that has been provided.

SUMMARY

Key strategies for effective CG involves effective teamwork, leadership, ownership, openness and, most importantly, communication. The additional recurring theme is that the public and patients need to be involved in all aspects of the planning, organisation and environment of care.

CG implementation needs a cultural transformation and organizational structure along with the healthcare professionals, and also needs resources to support the involved practitioners in quality improvement activity that's not just using traditionally quality improvement approach but also using the approach which enforce organizational awareness and experience sharing.

REFERENCES

1. Scally G. & Donaldson L. (1998) CG and the Drive for Quality Improvement in the new NHS in England, *BMJ,* 61-65, retrieved at 26 April 2008 from: http://bmj.bmjjournals.com/cgi/content/full/317/7150/61

2. Donalson H (2001) Implementing Clinical Governance: Turning Vision into Reality, *BMJ,* Vol.322,1413-1417.

3. A First Class Service – Quality in the New NHS (1998), retrieved at 26 April 2008 from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902

4. Seven Pillars (1999), retrieved at 26 April 2008 from: http://www.cgsupport.nhs.uk/downloads/Seven_Pillars.doc

5. NICE (2002), Principles for Best Practice in Clinical Audit, retrieved at 26 April 2008 from: http://www.nice.org.uk/niceMedia/pdf/BestPracticeClinicalAudit.pdf

6. Kennedy I. (2001) The Bristol Royal Infirmary Enquiry London: Her Majesty's Press, retrieved at 26 April 2008 from: http://www.bristol-inquiry.org.uk/index.htm

7. The Kennedy Report (2001), retrieved at 26 April 2008 from: http://www.library.nhs.uk/HealthManagement/ViewResource.aspx?resID=26885

8. Badan Pusat Statistik (2006), Data Pelayanan Kesehatan 2005, Litbang Kesehatan, Jakarta, Indonesia.

9. Integrated Governance (2004), retrieved at 26 April 2008, from: http://www.cgsupport.nhs.uk/downloads/Board/integrated_governance_paper.pdf

10. Standard for better care (2004), retrieved a t 26 April 2008, from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665

11. Essence of Care (2001), retrieved at 26 April 2008, from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/Pu blicationsPolicyAndGuidance/DH_4005475

12. Healthcare commision (2005), retrieved at 26 April 2008, from: http://www.healthcarecommission.org.uk/homepage.cfm

13. National Standards, Local Action: Health and Social Care Standards and Planning Framework (2005/06-2007/08), retrieved at 26 April 2008, from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086057

14. Clinical governance for community pharmacists: e-learning programme (2006), retrieved at 26 April 2008, from: http://www.cg4cp.org.uk/

15. Guidance on recording interventions(2004), retrieved at 26 April 2008, from: http://www.rpsgb.org.uk/pdfs/recinterventionsguid.pdf

16. Clinical governance, standards for better health and the new community pharmacy contract (England and Wales) (2005), retrieved at 26 April 2008, from: http://www.rpsgb.org.uk/pdfs/cpcontracthealthmap.pdf

17. Beyond the baseline: The role of clinical governance facilitators working within community pharmacists (2006), retrieved a t 26 April 2008, from: http://www.rpsgb.org.uk/pdfs/beyondbaselinerept.pdf

18. Achieving Excellence in Pharmacy Through Clinical Governance (2005) retrieved at 26 April 2008, from: http://www.rpsgb.org.uk/pdfs/achieve.pdf

19. Community Pharmacy Clinical Governance Assessment (2004), retrieved at 26 April 2008, from:
http://www.rpsgb.org.uk/pdfs/assessment.pdf

20. The Whistleblowers Protection Act 1999, retrieved at 26 April 2008, from:
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/W/WhistleblowA94. pdf