Editorial

After the standards . . . a gaping cavity filled by Clinical Governance?

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The National Minimum Standards (NMS) for General Adult Services in Psychiatric Intensive Care Units (PICUs) and Low Secure Environments were published by the Department of Health in April 2002 (DOH, 2002). As a Policy Implementation Guide, the document provides each unit with a tool for benchmarking their own service and gives any stakeholder or staff member associated with PICUs/Low Secure Services something to take from it.

However, within an individual organisation, PICUs are only a small part and, within a climate of ever increasing policy documentation and guidelines, the standards face the possibility of becoming yet another thing that must be done at some point but will not contribute to ratings or "must do" tasks. Understandably this has meant they run the risk of being placed at the back of the minds of Trust Chief Executives, leaving every unit to lobby their own organisation in the same manner that they used to. In order that impetus was not lost, an implementation measure of the standards needed to occur.

Since publication, a number of units have requested individuals and organisations to perform service reviews and continual monitoring with respect to the NMS. This supplies specific units with a measure of their own service (on which to base improvements and future developments), however it is only of benefit to individual units and proves a labour intensive exercise for reviewers (most of whom did this in addition to full time clinical employment). Furthermore, the process runs the risk of becoming yet another review of services (in addition to CHI/Healthcare Commission, HAS, HQS etc). Additional recent developments within secure services eg publication of the Bennett report (Norfolk, Suffolk and Cambridgeshire SHA, 2003) and the Government response (DOH, 2005), the manslaughter of a nurse colleague by a patient within a PICU in June 2003 and the publication of the NICE guidance on management of disturbed behaviour (NICE, 2005), continued to highlight the need for a more systematic approach to governance within PICUs.

This has been achieved to some extent by the discussion forum on The National Association of Psychiatric Intensive Care Units (NAPICU's) website (www.napicu.org.uk) within which a dedicated section on the NMS has been developed and constructive debate occurs. Also, the development of a Team of the Year award has encouraged units to show others what improvements have been made and how these have been achieved. NAPICU quarterly meetings have expanded in size and give the hosting service an opportunity to showcase their practice. All these are to be commended but make limited impact on overall improvements in delivery of quality care.

In the implementation section of the NMS, mention is made of the development of a PICU/

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Low Secure Practice Development Network being a way forward to monitor implementation of the standards. To this end, in partnership with the National Institute for Mental Health in England (NIMHE), money was secured for one year (2004/2005) to pilot and develop a system in which individual service improvements could be shared and implemented by psychiatric intensive care services on a wider basis. This was developed into a Governance Network that focused on 8 units from around England. The idea of using networks to support in developing services is not new and has been implemented in other spheres of medicine. The Cancer Services Collaborative was established in 1999 (one of the first collaboratives to be launched in the NHS) and has now entered its fifth year. It has evolved from a pilot phase to one of implementation of real change for patients with suspected or diagnosed cancer. Within UK psychiatry local networks have established that have made positive changes to the delivery of services in different parts of the country. The idea of a PICU specific network focussing on governance seemed an appropriate venture with different PICUs working in a collaborative fashion that enables them to share experiences, difficulties and plan improvements drawing upon expertise from both within and outside the network.

The pilot of this network concentrates on four specific themes: multidisciplinary working, diversity, service user/carer involvement and responding to emergencies (psychiatric and physical) using the NMS as a benchmark. Through project working it enables positive change in services for patients to occur with demonstrable benefits via a system of audit and review. The PICU clinical governance project team specifically chose the themes as they embrace a number of topical wider issues within the health service, including modern ways of working. They also give an opportunity to make significant differences to a service over the lifespan of the network (and beyond) by improving practice.

The PICUs involved were nominated by NIMHE Regional Development Centres and selected by the Network Coordinators in conjunction with NIMHE. This ensured that there was a spread of units from different types of areas that were experiencing different challenges with service provision.

Initially, each PICU was visited for a day and the four specific aspects of the service were assessed (in relation to the National Minimum Standards) using a semi structured interview technique and observation. Overarching themes were objective measurement and training. The units subsequently received a report outlining the assessors' initial findings and units then committed to attending eight, one day, learning sets on a monthly basis. Each involved PICU was represented by the same team of individuals at the meetings to enable consistency and continuity. These individuals were: Unit Manager, Unit Consultant, Service User and Service Operational Manager. The composition of delegate teams was decided specifically with both the ability to produce change and to influence local areas in mind (the consultant psychiatrist can feed back to medical Trust members, the service user representative to service users, the operational manager to Trust Management and Ward Manager to other wards and also to staff within the PICU).

Common themes and difficulties were addressed at the first network learning set meeting and following this, each unit focused on a particular area and, using a project-management approach, aimed for specific and measurable improvements to service provision. A sustainable improvement is more likely to occur as a result of a practice improvement that staff delivering care can see benefiting patients. Each specific intervention has patient care and service improvement at the forefront of its agenda and feedback is received in an objective manner (eg in the form of increased positive formal patient feedback, decreased length of stay, decrease in the level of untoward incidents or restraint episodes, decrease in the need for additional psychotropic medication etc). The particular measurement and the specific instrument tools used were discussed and decided upon within the Network forum and within local Trusts' governance forums.

All units present updates and progress reports at meetings and any common difficulties are worked through using the expertise within the network. The unit delegate team has ownership of their specific project at the outset thus ensuring commitment for change.

The learning set days are based upon the RAID (Review, Agree, Implement and Demonstrate) model of change (Cullen *et al*, 2000) and each one is themed:

- Introduction and Aims
- Sustaining Change
- Multidisciplinary Working
- Emergencies
- Training
- User & Carer Involvement
- Diversity
- Dissemination of Good Practice, Conclusion & The Way Forward

The days are interactive and geared to helping units make a difference to patient care. During intervals between learning days, delegate teams are expected to undertake specific activities and present results at the following learning day. This forms the basis of the clinical governance implementation programme that is led by the delegate team.

The coordinators liaise with and visit units between monthly meetings to give support surrounding the particular projects, to identify themes that may be hindering development and provide additional assistance (eg workshops, information, training etc) as necessary. Having coordinators who are clinicians and are likely to drive the Network forward ensures its sustainability for the project period. The project team meet at regular intervals to plan and review various issues that emerge as well as troubleshoot difficult issues within the Trusts concerned.

Successful spread of interventions used by units occurs in three ways: locally within organisations to other services (if appropriate) via mechanisms of clinical governance, locally within psychiatric intensive care services (by utilising regional contacts and regional development centres) and nationally by utilising organisations such as NAPICU to demonstrate benefits. It is also hoped that successful projects will be illustrated in further issues of this journal and presented at the 10th Annual NAPICU Conference 2005.

By individual units demonstrating successful and sustainable improvements to patient care and being able to share these with other units in a similar position, introduction of the Governance Network has helped in not only monitoring standards but also disseminating positive change occurring as a result of their development. It therefore provides a welcome measure to help fill a potential void following publication of the standards. Further intake years to continue the Network are currently being planned

References

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