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much greater extent than they have been before. Among other things, this has led to a much more substantial engagement of service users in monitoring and designing the services they receive. Perhaps all of these benefits have come about because the improvement measures reflect clinical priorities and user experience; the result appears to be that teams will work hard to try to achieve progress towards their targets. It could be argued that there are lessons in this for the way the NHS develops performance indicators.

## Conclusion

The problems facing many acute wards may seem utterly daunting, but there really does seem to be something in a systematic collaborative approach that can lead to rapid and significant improvements. It requires planning, enthusiasm and commitment, I know the solutions are out there, because I have seen them.

## Declaration of interest

None.

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# Clinical governance in the asylum

Clinical governance was introduced in 1998: 'a framework through which NHS organisations are accountable for constantly improving the quality of services and safeguarding standards of care by creating an environment in which excellence in clinical care can flourish'. (Department of Health, 1997)

The closure of Bexley Hospital, a Victorian asylum, in 2001 led to the rediscovery of the formal minutes of the Medical Staffing Committee, 1949–1961. This period of enormous political and social change and scientific advances encompassed the early development of the NHS, the introduction of imipramine and chlorpromazine, the 1959 Mental Health Act and the development of multi-disciplinary working and community care. This gave a unique opportunity to explore how new a concept clinical governance is. The minutes were examined for material relevant to some of the main components of clinical governance outlined in the NHS White Paper, *The New NHS. Modern, Dependable* (Department of Health, 1997). As we are so often reminded in the assessment of clinical risk, the best predictor of future behaviour is past behaviour.

## Risk

'Clinical risk systematically assessed with programmes in place to reduce risk.' (Department of Health, 1997)

Issues of clinical risk clearly preoccupied the Committee, although violence and suicide did not receive a single mention; perhaps they were regarded as inevitable. What

did matter was containing devastating outbreaks of dysentery and the spread of tuberculosis, obtaining supplies of fresh blood for transfusion at weekends and persuading local physicians and surgeons to make their expertise available. There are numerous references to outdated and inadequate equipment and the ongoing struggle to retain a functioning operating theatre.

The health risks associated with falls were acknowledged and it was suggested that 'as a start, non-skid floor polish should be experimented with in infirmary wards'. Clinical governance requires that professionals act only within the bounds of their competence and psychiatrists faced a dilemma about how much physical care they should provide. When the local radiologist insisted that all patients referred for a barium enema should undergo a sigmoidoscopy by their psychiatrist, most, but not all, refused to cooperate.

## Evidence-based medicine

'Evidence based practice is supported and applied routinely in everyday clinical practice.' (Department of Health, 1997)

Following lengthy discussions about the relative merits of many mixtures with similar compositions, a hospital formulary was finally agreed. The names of the mixtures tended to describe their purpose rather than their constituents, with each consultant having his/her own preferred concoctions. For example, Mist Comerfordii, a mixture of chloral and various bromides, was named after Dr Comerford, the chair of the Formulary

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Committee at the time. The hospital formulary was no sooner agreed than the first *British National Formulary (BNF)* was published in 1949. A taste of what was to come when guidance from the National Institute for Clinical Excellence (NICE) would supersede local protocols demanded by the National Service Framework for Mental Health (Department of Health, 1999) 2 years earlier. As now, the need to reduce drug costs was a priority, both locally and nationally. Cost pressures included insulin for coma therapy, reserpine, imipramine and chlorpromazine. The mean cost of drugs had reached 7 d (2.8p) per patient per week and this was felt to be excessive. Sub-committees were set up and numerous reports produced. This resulted in only consultants being allowed to prescribe the newer, more expensive drugs like chlorpromazine.

In another early example of gatekeeping, the admission of patients with psychopathic disorders who presented at the hospital gates late at night had to be agreed by a consultant.

The Committee discussed a draft protocol for the emergency treatment of poisoning. Not everyone liked the lack of flexibility. The programme of academic meetings was discussed frequently. No day seemed to be convenient for all, with many starts and stops.

Every learning organisation requires good library facilities. At Bexley Hospital, heated discussions took place about which journals and textbooks should be stocked despite the chaotic archiving arrangements, widespread pilfering of resources and the lack of electric lighting.

## Research and development and clinical audit

'Full participation by all doctors in audit programmes including speciality and subspeciality national external audit programmes endorsed by the Commission for Health Improvement.' 'Research – what's in it for consumers?' (Department of Health, 1997)

Bexley Hospital, with over 2000 patients, provided considerable scope for original research. The minutes contained reference to many requests from professors and centres of excellence to 'provide' patients with diverse conditions, for example asymptomatic jaundice, recurrent catatonia or Crohn's disease, for unspecified purposes. The hospital prided itself on public demonstrations of treatments such as insulin coma therapy and unmodified electroconvulsive therapy (ECT) using 'mental defectives' from Darenth Park Hospital.

In terms of audit, it was noted that 'little was known about the long-term outcomes of leucotomy' and 'patients were kept on drug treatment without very much in the way of supervision'.

## Information technology

'To ensure patients can be confident that NHS professionals have reliable and rapid access 24 hours a day to the relevant information necessary to support their care.' (Department of Health, 1997)

On the top left-hand corner of every patient's record was a portrait and profile photograph to ensure they were correctly identified. This was considered a high priority and care was taken to allocate the task to an interested male nurse.

Temperature, pulse and respiration charts, prescription cards and admission pro forma were designed and redesigned by sub-committees. It was decided that saving old medical records from destruction was a priority.

Rapid access to doctors within the hospital was considered a high priority and the Committee pre-varicated over the most desirable 'staff location system'. The discussion proved fruitless as financial constraints ruled out any purchases and the duty doctors were urged instead to 'let the telephonists know where they are'. The ultimate responsibility was delegated to the gatekeeper. Similarly, the Committee was informed that updating parts of the hospital telephone system to allow it to cope with two-way conversations had been deferred again in view of a further round of 'economy cuts'.

## Workforce planning

'Workforce planning and development (recruitment and retention of appropriately trained workforce) is fully integrated within the NHS Trusts service planning.' (Department of Health, 1997)

In 1958, the Committee was informed of the work of the South-East London and Metropolitan Regional Consultants and Specialists Committee, which was inquiring into the medical staffing needs of all hospitals in the region. There was no mention of staffing requirements for the other professions.

## Multi-disciplinary working prior to Care Programme Approach

Fifty years ago, the multi-disciplinary approach to care was evolving. Preliminary discussions were held with health visitors and general practitioners (GPs) and basic training in psychiatry was provided. The consultants found the new psychologist, Dr Bannister, a considerable threat. He was allowed to assess patients but was told 'therapy was very much a medical matter'.

After frequent appearances before the Committee to explain his intentions, Dr Bannister was allowed to purchase an electronic calculating machine. Such was the humble beginnings of personal construct theory and repertory grids.

Other disciplines made less impact and posed less of a threat. It was noted that there was a lack of clarity about the role of the social workers. The pharmacist was under considerable pressure, compounding large quantities of mixtures of questionable benefit and reporting on their cost. Sympathy was extended to the occupational therapists, who were overwhelmed on non-ECT days. Consultants provided support by encouraging duty doctors to make sure that patients were escorted to the weekly dance. Junior doctors were also encouraged to



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talk regularly to nurses about clinical problems; a new initiative.

## User and carer involvement

This would appear not to have been a contemporary issue. On one occasion, a relative's letter was read to the committee and 'points were discussed'. Suggestion boxes were placed in the wards but it is not clear if patients' views were actively sought. Consultants complained about the 'number of redundant and unnecessary telephonic communications' from patients' relatives.

## Governing governance

'Processes for ensuring the quality of clinical care are in place and integrated with the quality programme for the organisation as a whole.' (Department of Health, 1997)

The minutes contain numerous references to reorganisations of services, boundary changes, requests for information about the prevalence of 'defectives' and of the availability of secure services as well as circulars about drug costs, medical records and comparative costs that arrived to 'benchmark' services.

Such documents generate enormous anxiety today and require teams of support staff to move a trust from red to amber status and to allay fears about the job security of senior managers. The response was more considered 50 years ago, and at times dilatory, for example 'after the chairman had read out the relevant sections from the Ministry of Health memorandum, no discussion arose'. A preliminary meeting was held in 1960 to consider the implications of the 1959 Mental Health Act. It was decided to defer any action until these became clear.

The most passionate debates centred around matters much closer to home. The pay and conditions of medical staff, the loss of the tennis court and the size of the car park were all the subject of disgruntled memoranda to the relevant authorities. As early as 1954, senior medical staff unanimously requested the purchase of a television set for the doctor's mess. To be fair, consultants

were also passionately concerned about the welfare of their patients, including the state of the toilets on T block, hygiene in the kitchen and the availability of pocket money for those who were too disabled by illness to contribute towards the hospital community.

## Conclusion

The asylum has gone, to be replaced by a limited number of acute beds on district general hospital sites and numerous statutory and private community placements in the community and elsewhere, often spot purchased – a so called 'virtual mental hospital' (F. Holloway, personal communication, 2002).

With the exception of clozapine, the efficacy of drug treatments has not significantly improved since 1956, although there is more choice. Therapy is no longer considered 'exclusively a medical matter'. Doctors have moved from a position of too much power with little regard for any authority other than their own, to having limited power while being accountable for almost everything.

The Medical Staff Committee was preoccupied with process. Who should chair the Committee, what sub-committees should be formed and who should chair them, what should the terms of reference be and what relationships should there be between committees? Some things change, but many stay the same.

## Declaration of interest

P.W., C.P. and P.J. are employed by Oxleas NHS Trust, which managed Bexley Hospital until its closure in 2001.

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