Clinical governance in mental health services

1. A chief executive's perspective

Peter Kennedy

This is one of three articles describing how one National Health Service (NHS) trust is tackling clinical governance. The first is by the trust chief executive, the 'accountable officer' in the White Paper *The New NHS* (Department of Health, 1997). The second is by the trust's director of research and development whose responsibilities include assisting clinical directorates to carry out an annual programme of improvements in clinical effectiveness. The third paper is by the mental health 'lead clinician' for clinical governance.

The NHS trust in question is a large, whole district trust, serving a mixed rural–urban population of about 350 000, with 5000 staff. It comprises a district general hospital, hospital and community mental health services and a range of other community services. Figure 1 shows the structure within which clinical governance is managed. There is, in addition, a clinical board that is crucial for taking soundings on cross-directorate problems and projects as well as resolving priorities competing for resources.

Clinical governance is a new term but it is not a new concept. It simply identifies that high quality service cannot be delivered without collaboration and collective responsibility of health professionals and managers working together. What else have we been doing over the last decade or more in developing clinical directorates, multidisciplinary clinical audit programmes and clinical boards to engage everyone in taking collective responsibility for the quality of patient services? Before setting up new structures and processes for clinical governance, it is suggested that existing ones are reviewed: they may be perfectly adequate and more bureaucratic structures best avoided.

The really new emphasis in the White Paper and in ministerial speeches ever since its publication, is to be on information systems monitoring and comparing clinical performance with benchmarks and league tables, and external checks that national guidelines and protocols have been implemented.

So, where do we go from here? As a chief executive, I think my first task is to work out with consultants and other clinicians in the trust what short- and medium-term priorities are feasible for progressing clinical governance and quality assurance. Tardiness in taking initiatives could bring the considerable disadvantages of the 'top-down' approach to clinical quality (telling clinicians what to do) dominating the 'bottom-up approach' (clinicians setting standards).

Top-down or bottom-up?

Mental health services have had more than their share of top-down guidance and advice, as a result of high profile serious incident enquiries. 'Naming and blaming' may have led to guidance being implemented a little too rigorously and rigidly, without the necessary adaptation and interpretation to local circumstances that it undoubtedly needs if it is to work. There is no doubt from experience of managed care in the USA that when the drive for quality is mainly top-down it undermines professional self-confidence and is much less successful than when the lead comes from professionals themselves.

However, we must all be aware that the government and the public have been shocked by the failure of some trusts and their professionals to address known serious problems, culminating in the General Medical Council investigation into a Paediatric Cardiac Surgery Department in Bristol. Unless we can restore confidence from the bottom-up there will be a strong inclination for government, with public support, to invest in heavy external monitoring, inspection and accreditation.

Where to begin

The first questions I raised with every clinician and member of staff in my trust were:

> If it dawns on you one day that there is a colleague or team who you would advise any

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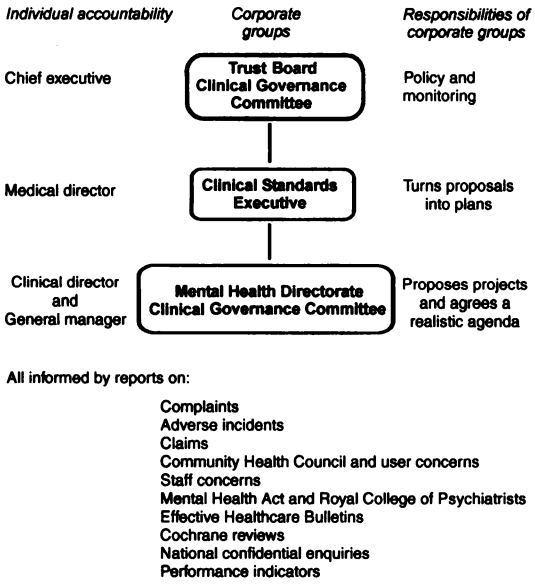

Fig. 1. Clinical governance: roles and responsibilities

friend or relative of yours to avoid should they ever need treatment:

(a) Would you feel able to raise your concern so that action can be taken in the interest of all patients?
(b) Would you feel confident that effective action would then be taken?
(c) Would you feel confident that the colleague and anyone else involved would be dealt with sensitively and fairly?

Unless the answer to all three questions is in the affirmative, and the trust has a well understood procedure in which people have confidence for handling such concerns, then I suggest it is about the first thing to be addressed. Because such concerns were raised about someone in my trust some years ago, we have a well-established procedure that has been used and improved. It needs to be regularly reviewed by the clinical board to be sure that the culture is really changing away from the traditional diffidence that allowed known problems to persist.

For me, the next logical step was to promote discussion on whether we have a culture that regards failures and adverse incidents as normal. The NHS needs a culture in which staff feel able to be open about such events and to participate in monitoring and reviews to avoid repetition of the same failures. Are we still hampered by a medical ethos of self-sufficiency where failures are not shared. If failures are shared, are they seen as individual failures with connotations of blame and professional inadequacy. Experience shows that most clinical failures are failures of the system that can only be avoided in the future if there is a collective review by everyone involved.

We are now considering whether 'audit half-days' should devote more time to sensitive explorations of incidents where patients have been let down (e.g. a medication mishap, a communication failure, missed clinical signs, lost contact). Greater benefit for patients might be obtained than from audits of patient cohorts in an NHS with lamentably poor clinical information systems. It might also benefit staff; too many suffer from fear of making mistakes, isolation and self-blame, with a propensity for self-medication and alcohol to contain anxiety (Firth-Cozens, 1993). Only a simple data system is required to collate incidents and 'near misses' to identify clusters and repetitions. The public will thank us more for getting this part right, before pursuing elaborate clinical information systems to monitor quality of clinical care.

The big picture

Figure 2 was produced by the Chief Medical Officer and is a useful representation of what the NHS is trying to achieve through clinical governance. It assumes that most clinical practice is satisfactory. To the left of the Gaussian curve is the tail of problematic practice that should not be allowed to persist in a culture where there is a commitment to identify failures and avoid their repetition. At the right of the curve is the tail of exemplary, most cost-effective best practice.

The aim is to spread best practice quickly throughout the service rather than continue to have the usual time lag of many years before the service catches up with best evidence-based practice. Thus we must expect guidance and direction from the National Institute for Clinical Excellence (NICE), and monitoring to see that guidance has been implemented properly – a principle responsibility of the Commission for Health Improvement (CHI).

Handling clinical guidelines

It is important to get balance and sense into the way clinical guidelines are to be handled in a trust. Figure 3 represents the extent to which national guidelines are likely to impact on the service. Only a small part of clinical practice is likely to be standardised by central direction. No doubt the College will advise NICE on these matters and any sensible chief executive will welcome an audit carried out by the College from time to time to confirm that standards are being

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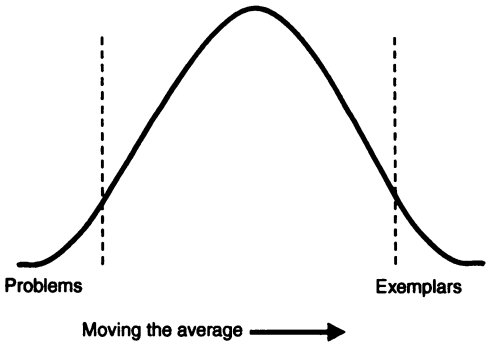

Fig. 2. Focus on the best and the worst

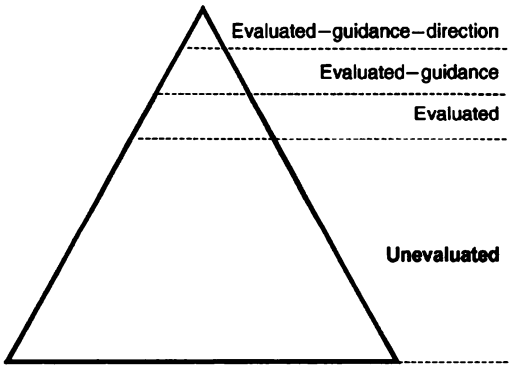

Fig. 3. Only a small part of practice can be standardised

observed. But I hope clinicians in my trust will always be ahead of NICE and CHI in having identified what areas of practice need guidelines, like electroconvulsive therapy, use of high-dose neuroleptics and indications for expensive new drugs. Then national guidelines will feel like a useful double-check rather than telling us where we have got it wrong.

The basic principles about handling guidelines need to be widely discussed. First, no trust can afford to deal with more than a few each year – because their implementation requires a lot of time and effort. Second, no guideline, whatever its provenance, should be implemented without local interpretation. A chief executive must persuade the board that there may be very good reasons why some guidelines are modified or not applied at all. That places an obligation on clinicians to make their reasons clear and open, and demonstrably in the interests of patients, if what seems important guidance has to be modified to make it applicable locally.

Then what does a chief executive do if a clinician or a group of clinicians decline to interpret or implement an important guideline or to explain why? The chief executive would have to intervene but it is far better if these possibilities are discussed widely in the trust beforehand and conventions agreed about how this would be handled. I am pleased to say that in my trust the clinical board decided that anyone who declined to take part would be asked to account for themselves to the clinical board as well as to the chief executive.

The learning organisation

The greater part of the potential benefits to patients from clinical governance should come from within the trust itself. Never mind the small percentage of clinical practice that might be subject to nationally agreed protocols, what about the 97% that could be improving continuously if the culture in a trust is outward looking, searching for exemplary practices elsewhere, and using research reviews to inform all decisions about practice and service development. Such organisations will put high value on thinking time and will be action-oriented not paralysed by analysis.

Clinicians should expect the chief executive to ensure that all clinical staff have access to library databases; Cochrane reviews, for example. Trusts will need to identify resources and designate staff with responsibility for assessing the evidence base to inform plans and decisions, or simply to inform clinicians whose area of work may benefit.

A subsequent paper in this series will develop ideas on what supporting structure may be needed to help clinical directors and their teams take the lead in clinical governance. But such investment will only be justified in organisations where clinicians and managers are open to new ideas and have shown commitment to continuous learning and review.

Realisation of the new emphasis on information to monitor clinical outcomes and compare clinical performance is some way off. Clinical information systems in the NHS have suffered from low investment. The new NHS information strategy promises only £6 billion for the whole NHS over the next five years, and most of that will go into the primary care-based electronic patient health records. Chief executives would be wise to temper the expectations of their trust boards and health authorities for elaborate reports on clinical performance in every area for which the board is responsible. In my view, the worst thing that could happen to clinical governance is that it becomes a pre-occupation with information on comparative performance in the early years, before the NHS has the

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capability to produce it and we have the culture and experience to use it. If information is used to judge clinicians and trusts rather than for continuous learning, it will be regarded as dangerous with all the effort going into damning the quality and rebutting interpretation.

Priorities

The priorities we decided for developing clinical governance in York Mental Health Services are summarised below. I will be responsible for ensuring that there are adequate resources and management support to clinicians taking the lead. But even more important than resources, success depends on getting the right culture supported by effective conventions and procedures. Bristol was a watershed in the NHS following which all services and clinical staff will be held accountable for the quality of service that they provide for patients. Catching up with most cost-effective practice cannot be left entirely to the discretion of individuals and local services.

Priorities for clinical governance in York

(a) Is everyone clear about the government and public concerns, and the principal objectives of clinical governance?

(b) Has a procedure been agreed for dealing with concerns about the clinical performance of a colleague?

(c) Are adverse incidents/near misses being reviewed to avoid repetition?

(d) Have existing structures for collective responsibility of clinical performance been reviewed?

(e) Have conventions for handling clinical guidelines been agreed?

(f) Is there access to national clinical databases (e.g. Cochrane reviews) for all clinicians?

(g) Is the management infrastructure adequate to assist clinicians in identifying and carrying out an annual programme of clinical effectiveness projects?

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