Clinical governance in mental health services

2. The research and development director's perspective

Jake Lyne

Clinical audit has had a limited impact in the NHS because clinical outcomes and standards, while important to clinicians, have not received the investment required from NHS management which has been preoccupied with efficiency and customer satisfaction. With the advent of *A First Class Service* (Department of Health, 1998) the emphasis is changing and clinical audit committees and departments now have a central role.

As manager of the Clinical Effectiveness Department (this used to be called the Clinical Audit Department), I am grappling with the question of how to adapt clinical audit resources to the clinical governance agenda, this article outlines some of the steps that we have taken.

Clinical Standards Executive

Prior to the NHS White Paper (Department of Health, 1997), a medically-led audit committee, with representation from other professions and the Community Health Council, coordinated the work of the trust's small clinical audit department. A large proportion of the department's work supported junior doctors in conducting audits as part of their training. Occasionally this led to lasting change, but most audits could be described as 'interesting' – that is, they demonstrated how improvements in services could be made, but systematic change did not often follow.

The audit committee was under pressure to raise the quality and impact of clinical audit, but had great problems in doing this. Consequently, the health authority commissioned a countywide audit of audit departments, to establish whether the investment in clinical audit represented value for money. This created uncertainty and morale fell in the committee and audit department.

The advent of clinical governance and the need for trusts to work out what it meant, led to a renewed interest and debate. The clinical audit department and the audit committee were restructured, and became the Clinical Effectiveness Department and the Clinical Standards Executive (see p. 712, Fig. 1), respectively. The role of the department is to provide resources for carrying out tasks prioritised by the Clinical Standards Executive.

A consequence of these discussions is that the focus of audit has shifted from small-scale audit projects, to evidence-based, guideline-led service evaluation. These evaluations are the vehicle for planning changes in service delivery, and this brings with it the need for skills in implementing change.

Clinical audit of service effectiveness

The CASE programme

The National Centre for Reviews and Dissemination has produced a substantial number of Effective Health Care Bulletins (EHCBs), including several that have relevance for mental health services (Effective Health Care Bulletin, 1993*a*,*b*, 1997, 1998). These Bulletins summarise the literature for a particular health issue, and attempt to give an unbiased assessment of the implications for service delivery. They have met with mixed reactions depending on the topic. For example, as mentioned by Kennedy (1999, this issue), the report that suggested that the costs of selective serotonin re-uptake inhibitors outweighed the benefits was highly controversial. The report on deliberate self-harm is less controversial, but might be difficult to implement. There has been little assessment of how effective these reports are in influencing clinical behaviour, although it is known that guidelines have a greater chance of being implemented if they are developed locally with the participation of clinical staff (Effective Health Care Bulletin, 1994).

We are in the process of piloting methods of translating the recommendations of EHCBs into local clinical practice, and have developed the Clinical Audit of Service Effectiveness (CASE) programme. Because ours is a whole district trust we have had the advantage of initiating the programme in surgical specialities, where practice is relatively easy to audit and EHCB

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recommendations are well defined. We then moved on to management of colorectal cancer and lung cancer and management of stroke. The experience we have gained is relevant to the work that we are now supporting in mental health services.

Evaluating a service is intrinsically threatening and it was essential to gain trust. This was achieved by taking time, consulting at every stage and keeping drafts of each audit confidential until the clinical team owned them. Staff from the multi-disciplinary clinical teams provided information and commented on the recommendations. It was understood that the reports would not gloss over difficult issues, but the aim was to engender an atmosphere within which these could be addressed constructively. The outcome of these evaluations is a statement of what we do in the trust and how it measures up to the EHCB recommendations, together with recommendations for change that form the basis for action plans. The reports were disseminated widely.

For the cancer projects, we used a different approach. These became the topic of seminars, with speakers from the trust, the Centre for Reviews and Dissemination, and eminent specialists. Participants were all those who had a role to play in multi-disciplinary service provision. One of the seminars was particularly lively, because it was attended by a member of the audit department who had herself recently been a patient of the service (with good results). She combined an understanding of the research with forthright views based on her own experience. The afternoon of each seminar was used to develop a two-year implementation plan.

A number of observations follow from these exercises. First, we were not overawed by the recommendations of the EHCBs. In some cases, we believed they were open to question, and our reports explored the issues. Second, we found that recommendations from some EHCBs were not controversial because the Bulletins reflected widely held clinical opinion. In such cases clinical staff were likely to regard audit as no longer topical enough to be worth doing, although this does not guarantee that audit would be irrelevant. Predictably, we found that the seminar approach was a good way of involving people and gaining commitment to future audit and service change, whereas direct evaluation was more thorough. In future, we plan to combine the two approaches.

One of the by-products of the programme has been to engender discussion and facilitate standard setting. Another by-product can be to trigger strong emotions if people feel threatened. Therefore, it is necessary to take time to listen carefully to the issues. Deriving conclusions and recommendations is a process of negotiation, because there is little point in recommending action that is unlikely to be supported, but on the other hand there has to be a willingness to address the real issues that are raised by the audit. Each of the audits took at least a year to complete, and this is before the implementation phase, but the process of auditing itself led to some early changes, including development of better information leaflets for patients.

Implementing change

We are now entering the second phase with these projects, which is to implement the recommendations. The audits of service effectiveness were largely dependent on cooperation and support from clinical staff, but implementation will depend on managerial involvement, because there are resource and time issues, and clinicians are often too busy with clinical work to coordinate the process of change. We are setting up implementation groups for each audit, coordinated by a business/general manager, whose job is to facilitate agreed change, not to impose it. A member of the Clinical Effectiveness Department will support the implementation groups. It is too early to comment on how this part of the process will develop. We are unsure as to whether the managers responsible for implementation will have the wide range of clinical governance skills that will be necessary. One option we are considering is to bring them together to discuss their different projects so that we can solve common problems and meet training needs.

'Closing the loop'

Clinical audit has been criticised for the relatively small number of projects in which the audit loop, from evaluation, to implementation and then to evaluation of change, is completed. This will be the third phase of our projects. We will re-assess each service after the implementation of change and disseminate the results. Closing the loop is a necessary, but not sufficient, step in establishing the link between CASE projects and change. There is plenty of evidence that clinical practice continuously changes and evolves without external involvement or a detailed plan. However, this is not a research exercise designed to settle the question of what precisely determines change – but rather an attempt to engage in the complicated business of making the process of clinical change explicit and widely understood.

Making the CASE programme bottom-up

This year for the first time the trust's Clinical Standards Executive engaged in a process of

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consultation with the Community Health Council and NHS staff from all professions and sectors, in which we asked people to identify their concerns and suggest priorities for future work. The advantage of this is that for most projects we will be responding to a request, rather than encouraging participation in a top-down process. It has been rumoured that the National Institute for Clinical Excellence will produce up to 15 guidelines per annum for implementation in the NHS. It will be interesting to see how this will work. We suspect that one consequence of an imposed demand for guideline implementation and evaluation, is that it will tie up significant resources, given the time scales we have identified in completing the cycle from implementation to evaluation.

CASE projects in mental health

For our project work in mental health there are at least four EHCBs to choose from – mental health promotion, management of deliberate self-harm, treatment of depression in primary care, and brief treatments for alcohol problems. However, there are many other guidelines that could become the focus for a project, some of which are evidence-based (Royal College of Psychiatrists, 1999). Our experience suggests that the following summary will be useful in prioritising future CASE projects:

(a) Consultation on the topics that are of local concern and importance.
(b) Prioritising topics where there is a reasonable evidence base.
(c) Choosing hot topics, rather than audits which will simply confirm that good practice is being followed.
(d) Starting with a relatively simple topic (that will probably become more complicated and time consuming than was anticipated anyway).
(e) Ensuring that there are adequate resources to complete the project.
(f) Disseminating the results and evaluating progress.

Comment

The CASE programme is our approach to implementing the aspect of clinical governance that is concerned with clinical standards and guidelines. In the words of one of the trust's consultants, 'clinical governance has generated a whole lot more interest than clinical audit ever did.' We hope that by combining some of the principles of clinical audit with evidence-based service evaluation, clinical governance will be relevant and useful to clinical staff, and will lead to continuous improvements in the quality of health care provided for service users.

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Jake Lyne, *Director of Research and Development, York Health Services NHS Trust, Bootham Park, York YO30 7BY*

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