opinion & debate

Psychiatric Bulletin (2000), **24**, 442–443

FEMI OYEBODE

Devolution of clinical governance mechanisms to units and teams†

The subject matter of Gralton *et al*'s paper (2000, this issue) is quite important: the devolution of clinical governance arrangements to a forensic psychiatry unit, which is part of a larger trust. The arrangements described are also unique, in that they involve a large number of members of the multi-disciplinary clinical team. While it is clear that there is a need for clinical governance mechanisms to be devolved in this way as far down the structures of organisations as possible, very few trusts have gone beyond establishing the managerial structures for clinical governance and identifying the clinical leads.

Clinical governance is a central plank in the Government's wish to open up the working of the NHS to scrutiny, that is, to make both clinicians and managers more accountable for the quality of clinical care. It is obvious that this objective cannot be achieved merely by establishing clinical governance committees and identifying clinical leads for the process. There is recognition that clinical governance is an evolving concept that is very much in gradual change. The guidance on the implementation of clinical governance sets modest targets and has a vision of a 5-year development programme. The earliest targets, which should have been accomplished by all trusts by the end of March 2000, included establishing leadership, carrying out baseline assessments and formulating and agreeing a development programme with regional offices. This paper from the Langdon unit demonstrates what is possible when enthusiastic clinicians with a desire to implement clinical governance at a local level facilitate the process.

The authors present both structures and processes for clinical governance, which move beyond the static and grand committee structures that to date have been described. The problem that clinical governance faces is how to translate a potentially powerful tool from a theoretical concept into a vigorous mechanism with relevance for practitioners. At present, many trusts will have in place committee structures that are restricted to monthly meetings. The dilemma is how to transform such symbolic but ineffectual systems. One method is to encourage the development of clinical governance committees at all levels of the trust, including the clinical team, ward team and self-standing unit. It may make sense for such committees to reflect the composition of the higher, trust-level committee. By this I mean that the membership, agenda and organisational arrangements should be similar to those of the trust-wide committee. The reporting arrangements between these committees and the parent committee should be explicit. However, it is self-evident that a system such as this is likely to be resource intensive and expensive. Gralton *et al* do not comment on whether the relationship between the Langdon clinical governance committee and the trust's committee is dynamic in nature, with information flows between both committees and with representation of the Langdon unit on the trust committee. The purpose of a devolved system is to involve as many people as possible in clinical governance or, to put it in another way, to find modes of turning the principles of clinical governance into part of the culture of all practitioners. In this way clinical governance could conceivably become part of our professional framework, as is a ward round, a journal club or a case conference. This is a long term goal.

The aim of clinical governance is to integrate apparently discrete and independent domains of activity into a unified whole. These domains include evidence-based practice, audit, risk management, complaints and life-long learning. There is a temptation for clinical governance committees to deal with these domains in isolation from one another; taking each in turn and discussing whatever is of interest. This approach will only perpetuate the compartmentalisation of these domains and is unlikely to lead to an integration of the clinical governance agenda. It is, of course, difficult to integrate these items, but a start has to be made. For example, it is clear that an audit of violence in in-patient settings, as described by Gralton *et al*, could be allied to an evidence-based session on the management of violence in in-patient settings. In this way the discussions link the separate domains into a thematic unity. Creating and managing an agenda in this way is a major administrative task, but in the end is more likely to turn the clinical governance process into something that is tightly knitted and meaningfully integrated.

The achievement of the Langdon unit is that it is inclusive in its membership, and the way in which the contributions to the agenda are truly multi-disciplinary is admirable. The challenge for clinical governance

†See pp. 444–447, this issue.

opinion & debate

committees is to ensure that they are not medically dominated to the exclusion of other professional groups. It is important that other professionals are not restricted to being merely members of committees, but that they should also be active participants. At the Langdon unit it is impressive that social workers, nurses, psychologists, doctors and managers are actively involved in presenting and taking the lead on specified topics. We all have something to learn from this approach.

It is unclear how the topics for discussion at the Langdon unit are arrived at. It is likely that, as in other trusts, these topics have not been chosen in any systematic way. It is important that an underlying rationale exists for the creation of agenda items. Indeed, particularly with respect to audit programmes, there should be a rolling programme of routine audits that regularly inform practitioners about their clinical performance along parameters jointly agreed by all parties and that accurately reflect the clinical care of patients. What is clear from the programme of activities at Langdon is that clinical governance is a time consuming activity. Although there is no empirical evidence that it can deliver continuous improvements in quality of care, it is mandatory for NHS trusts to have systems in place to deliver clinical governance. It could be argued that it is an act of faith that clinical governance will produce improved quality of clinical care for patients. What is unquestionable is that most clinicians would want to support much of the rhetoric of clinical governance, even in the absence of evidence that it will improve clinical care. This description of clinical governance activities at Langdon at the very least encourages clinicians at team and unit level to grapple positively with clinical governance. This is surely the only way to underscore the importance of the role of clinicians in the whole process.

Reference

GRALTON, E., JAMES, A. & OXBORROW, S. (2000) Clinical governance. Six months of a functional programme in a forensic service. *Psychiatric Bulletin*, **24**, 444–447.

Femi Oyebode Professor of Psychiatry, Queen Elizabeth Psychiatric Hospital, Mindelsohn Way, Edgbaston, Birmingham B15 2QZ