

# Role of commissioners in promoting clinical effectiveness in everyday psychiatric practice

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In a nutshell, commissioners (i.e. health authorities) have a statutory responsibility to buy the best health care for a defined population with a defined amount of money. They also have a broader, but less well-defined, responsibility for health, as opposed to health care. There is no doubt that health care has a relatively small influence on health compared with deprivation, housing and unemployment, but in reality the majority of effort of commissioners focuses on health care.

Clinical effectiveness is clearly an important determinant to achieve value for money and as such is of legitimate interest to commissioners (NHS Executive, 1995). Indeed, promoting clinical effectiveness, and therefore increasing the accountability of clinicians was one of the key objectives of radical changes introduced in the early 1990s (Secretaries of State for Health, Wales, Northern Ireland and Scotland, 1989) and the creation of 'purchasers'.

## Balance of power

The configuration of services in London confirm that service developments over the past few hundred years have not been based on an assessment of what interventions would benefit local residents (i.e. are effective), and it is certainly not the most efficient way of providing services.

The current configuration and balance of services reflects the relative power of certain professional groups (doctors) and institutions. This has resulted in a plethora of acute units and an imbalance between the acute sector and the so called 'priority' or, more accurately, the cinderella services and services which meet the needs of professional aspirations rather than those of the patients.

However, recent challenges to the traditional balance of power is not without its own problems and there is a danger that rather than support clinical effectiveness clinicians become entrenched in their legitimate claims for clinical freedom because of the insensitivity of the purchasers (Hargreaves, 1996).

The new purchasers (health authorities) soon wanted to be referred to as commissioners as they realised their job was more complex than simply buying services from providers (trusts). It was clear that the success of health authorities depended upon the success of the local trust and that the notion that health authorities could shop around many trusts was ill conceived. The 1996/97 *Priorities and Planning Guidance for the NHS* (NHS Executive, 1995) directed health authorities to use evidence of outcomes and the results of clinical audit to influence change in services. How they can do this is less clear. It is quite simple to include specific quality clauses within contracts between commissioners and providers but that alone will not bring about change.

That improvements are possible in many areas of clinical practice is beyond doubt. It is quite simple for a director of public health (a commissioner) to read, for example, the *British Medical Journal* ABC of mental health and insist through the contract that all patients on high doses of antipsychotics have regular electrocardiograms. This will not result in a change of practice for many reasons, not least that this approach is based on the premise that sub-optimal practice results from a lack of knowledge. This is rarely the case. Furthermore, how would the commissioners know if the trusts were complying and what would they do if they were not? Our understanding of the clinical processes determining whether change will be achieved is still limited. None the less there are sufficient pointers for commissioners and clinicians to take steps in the right direction (Grol, 1997). The main source of power for commissioners comes from their access to money and their, often overstated, ability to switch contracts among providers and their discretion to fund developments.

## What to do?

The role of the commissioner is to encourage appropriate systems rather than dictate practice. There is a huge body of evidence that practice of

evidence-based medicine is far more to do with attitudes and 'systems' rather than knowledge (Aveyard, 1997).

Mental health services are, in my view, the most complex services and thus achieving the systems for supporting clinicians in evidence-based practice the most difficult. This is compounded by a relative lack of evidence which renders the service more susceptible to the vagaries of working in a public service in a democracy (i.e. politicians) so that clinicians find themselves working within policies that they have not contributed to and often oppose.

The recent increase in expectations and demands of the public and patients, usually not evidence-based, poses a further challenge to clinicians who could be forgiven for feeling under siege as if they actually go to work to do harm.

On the other hand, psychiatrists may have to be challenged, often about entrenched views in support of a 'medical model' based on beds and doctors rather than a multi-disciplinary approach based on teams of professionals for whom acute beds are only part of the picture. Commissioners are often well placed to provide this challenge, not least because they can be seen as a common enemy and the reluctance of psychiatrists (and all doctors) to challenge each other constructively.

### Leadership

Improvement and change requires action by leaders (Berwick, 1992). Leadership in the National Health Service is rarely through a formal chain of command, particularly in psychiatry where although it is probably politically incorrect to say so, psychiatrists must provide leadership to a wide range of disciplines. Commissioners can support individuals in a leadership role or, occasionally and for a short time, provide leadership themselves. This can be through financial support of audit or developments or offering advice in areas in which few psychiatrists have received training (e.g. needs assessment, administration and number crunching).

Whatever new developments bring, it is a reasonable assumption that patients will still be seeing psychiatrists for many years to come and therefore any systems must encourage young doctors into psychiatry and keep senior psychiatrists motivated. Commissioners must support clinical effectiveness by erecting and mainstreaming systems and methods for the involvement of psychiatrists who in turn must make their commitment to clinical effectiveness visible.

As clinical effectiveness is a value, and therefore subject to judgement like all values, assess-

ing whether services are clinically effective is difficult, particularly in the mental health field. What is essential is that there is agreement between all parties about the aims and objectives. The separation of purchasers and providers can be used to clarify objectives.

### Role of the commissioner

The role of the commissioner is to provide money, support and occasionally provide leadership, and be an 'honest broker' when there is disagreement within trusts and between trusts and other organisations. To achieve anything there must be strong partnership between commissioners and clinicians. We should actively seek cooperative relationships between purchasers and providers, between public health departments and psychiatrists, in pursuing our joint aspirations for high-quality care (Thompson, 1994). The challenge is to introduce quality monitoring and its associated controls so that they become part of an organisation rather than a foreign irritant to be neutralised or repudiated (Donabedian, 1988).

Commissioners must ensure that as much money as possible is available for patients. A recent article in the *Health Service Journal* (Dixon & Klein, 1997) contends that "variations in the capacity of authorities to deal with problems may be as important as variations in the nature of the problems themselves". What is the role of psychiatrists in promoting value for money in everyday health authority business?

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