editorials

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The inspector calls: the CHI comes to town

The news has got around. The Commission for Health Improvement (CHI) has reported on Northern Birmingham and in their clinical governance review, found it wanting (CHI, 2001*a*). There has been much amusement that the template for the soon to be thoroughly modernised mental health service (Department of Health, 2001) did not impress the avowedly impartial inspectors when they came to call. Northern Birmingham, a specialist mental health trust of undoubted national importance, was chosen as one of the earliest sites for a clinical governance review by the CHI. At the time of writing only one other governance review of a mental health service is available (all reviews are placed on the CHI website: http://www.chi.nhs.uk). This reported on the mental health directorate of Wrightington, Wigan and Leigh NHS Trust (CHI, 2001*b*), a service that presumably lies at the opposite end of the mental health fashion spectrum to Northern Birmingham. These reports provide the clearest picture yet of what is expected of us in terms of clinical governance and deserve a wide readership.

What CHI does

According to its website, the CHI "will raise standards [in the NHS] by: assessing every NHS organisation and making its findings public; investigating when there is a serious failure; checking that the NHS is following national guidance; [and] advising the NHS in best practice". Its earliest task was to investigate the North Lakelands NHS Trust following an inquiry by the Regional Office into the abuse of elderly patients by trust staff (CHI, 2000). Northern Birmingham is an example of an organisational assessment. This focuses largely on the structures in place to deliver 'clinical governance' rather than the actual service or the outcomes it delivers. The CHI is committed to publishing its review methodology, although the evaluative framework for mental health services was in development at the time of the Northern Birmingham review. The CHI proposes to review implementation of the mental health national service framework "separately later", which promises a double dose of future joy for mental health providers.

Clinical governance — a primer

'Clinical governance' is a neologism. It was introduced as a core element in the current round of NHS reforms as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (NHS Executive, 1999, p. 3).

NHS provider organisations now have a statutory duty for quality that parallels the longstanding duty of probity in financial governance. The policy aim is clear. There should be no more embarrassing failures of quality of care such as occurred in Bristol or, more realistically, when failures occur the chain of accountability will not be traced back to Government but will rest with the trust's chief executive. Even without the impetus of an external scandal, a negative CHI clinical governance review has already led to the precipitate departure of at least one chief executive.

Clinical governance is the central component of a broader quality agenda for the NHS (Department of Health, 1998). This envisages clear standards of service, provided by the National Institute for Clinical Excellence and an array of National Service Frameworks; care delivered dependably by local provider organisations; and monitoring by the CHI, a National Performance Framework and a National Patient and User Survey. The NHS modernisation agenda also places demands on local health and social care economies: in 2001 more than 700 quality and delivery targets were set and are being assertively performance-managed. Modernisation has a large and specific mental health component (Department of Health, 2001).

The CHI has an abstract model of clinical governance (CHI, 2001*a*, p. 47), which envisages an organisational culture based on learning, innovation and improvement, within which a 'strategic capacity' (direction from the top) maps onto 'resources and processes' for achieving quality improvement, both underpinned by 'use of information'. These lead to positive 'results' for patients. More concretely, the systems dictated by the CHI for monitoring and improving services include "consultation and patient involvement; clinical risk management; clinical audit; research and effectiveness; staff training and

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staff management; education, training and continuing professional development; [and] the use of information about patients' experiences, outcomes and processes" (CHI, 2001*a*, p.xii).

CHI and Northern Birmingham

A CHI report is a substantial document produced within a 24-week cycle. Fifteen weeks are devoted to pre-visit preparation, as the host site assembles masses of data for the CHI to digest, 1 week to the visit by the CHI review team and 8 weeks for production of the report. Only a proportion of the host organisation's services are scrutinised in any review. In the case of Northern Birmingham 12 of 13 functional teams serving two of six localities were assessed. The review team interviewed 25 service users (including 13 in-patients, representing 0.6% of the reported annual in-patient flows), 80+ front-line staff and senior managers (out of a total of 1256 trust staff) and a range of stakeholders.

The report presents some information on the trust, the catchment area and its now famous service model, although not in a way that allows ready comparison with other services. A substantial chapter is devoted to users' experience, derived partly from interviews and partly mediated through the impressions of the CHI team. Verbatim comments of users are supplied to a range of questions that demonstrate the CHI's expectations on services: "did anyone ask you what sort of treatment and support you would like?", "have you got a care plan?", "overall did you get as much information as you wanted or were there other things you would have liked to have been told?", "if you were unhappy with the treatment and support you received, do you know what to do in order to make a complaint?". The headline finding, however, was that the acute wards (which appear to be small free-standing units) serving the localities had high occupancy levels and were felt by the CHI team and users to be potentially unsafe.

Although information is seen by the CHI as crucial in underpinning clinical governance, the treatment of informatics within the report was cursory and reflected aspiration rather than achievement. Much more searching, perhaps because more thoroughly developed by the CHI, was the analysis of the trust's systems for quality improvement. Here the focus is again on 'service user involvement', which includes the disparate areas of user involvement in service planning and the planning and delivery of their own care, complaints and the provision of information. In tune with the times, arrangements for risk management were scrutinised, and roundly criticised because of the lack of a formal systematic risk assessment tool or training in risk assessment. Clinical audit systems were viewed positively and the trust research programme was commended (although outsiders await results of the evaluation of the model). There was surprisingly little scrutiny of clinical effectiveness work within the trust. The CHI took the trust to task for its human resources function, highlighting the importance of staff appraisal and supervision, which were seen as rather poorly developed.

'Strategic capacity' was neatly analysed by contrasting the trust's clinical governance structure with the separate and parallel management structure and identifying the gap between central rhetoric and locality activity. The report ended by identifying areas for action that have been responded to by an action plan posted on the CHI website. This includes no fewer than 90 actions to be undertaken by the management team, many of which are focused on risk assessment.

Lessons for mental health trusts

This clinical governance review probably tells us more about the CHI and its agenda than about Northern Birmingham and its services. In the absence of comparative data it would certainly be wrong to draw conclusions about the appropriateness, or otherwise, of the North Birmingham model or small isolated in-patient units, tempting though this might be. It is striking that the flagship was just as criticised as an unglamorous service struggling with poor resources (CHI, 2001*b*). Although CHI congratulates itself on both its transparency and commitment to evidence-based practice, both reports strike one as subjective and dominated by the fashionable rather than the empirically based.

We can begin to see what the CHI expects of us. Managers and clinical governance leads are likely to want to ensure that there are document-heavy systems of risk assessment and risk management in place. The rhetoric of user empowerment will be ostentatiously adopted. The troops on the ground will be expected to be singing from the same clinical governance hymn-sheet as those at the top of the organisation. Quite what these activities have to do with empowering staff to provide high quality and innovative care is not entirely clear.

The challenge for the CHI is to ensure that its activities do lead to more effective mental health services. Time will tell.

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