Psychiatric Bulletin (1990), **14**, 561–566

Correspondence

Implementation of Griffiths

DEAR SIRS

Many agencies have tried to advise on the government's implementation proposals for the Griffiths report. One might have hoped that the consistency of views expressed would influence decisions made. Opinions available to the author are astonishingly consistent, but do not seem to have been heeded. The Royal College of Psychiatrists, MIND, SAMH and the individual service responses all advocate effective and heeded consultation, at least transitional real extra money, an organised move towards new arrangements and a minister for community care, while endorsing many of the basic and manifest concepts behind the community care bill.

We now require a strategy for coping with the implementation of what is ultimately decided. The Scottish Psychiatric Rehabilitation Interest Group (SPRIG), a multidisciplinary forum, has had two debates on the topic. The author left these stimulated by the need to debate these topics widely, rather than by the quality of the debates witnessed. It is too easy for each discipline to say it does its job, too easy to get into interprofessional jealousies, too easy to suspect this government's motives, and above all else, far too easy to do nothing about it. SPRIG proposes a working group to examine implementation of community care and this letter is partly intended to be a contribution to that forum. It is suggested that the following might contribute to a strategy for coping with implementation.

(a) There is a need to grasp the new era and situation clearly. We should develop a clear view of what the plans for community care should be. If possible these should be prepared with the widest local consultation. If parts of the services are inaccessible to the planning process at this time, they should be developed and communicated anyway. The proposals should be based on demonstrable needs as far as possible, NHS and Social Work Managers should be made aware of the views as they develop. They should as far as possible include consumer opinion.

(b) Implementation of such plans or the lack of it, should be recorded and reported regularly. At times going to the press should be considered.

(c) In our practice excellence should be targeted. The new code of practice for the Mental Health Act and the Royal College discharge code of practice and the Tom Clarke bill should be implemented and in particular the vulnerable should be monitored indefinitely.

(d) It must be possible to protect and advance our service by using monitoring and audit of our practice. Both the Mental Health Act Code and the Royal College discharge procedures provide clear cue lists about what ought to happen, who ought to be invited in decisions. A picture will emerge in considering patients and their needs in the light of these two codes of what the facilities ought to be. If we recorded:
   (i) lack of contribution to the plan by a discipline
   (ii) ways in which the plan fell down
   (iii) what resources would be needed to do the job properly
   (iv) difficulties with services as they arise; (this would include indecision, delay, injustices and discrepancies)

   then we at least would have clarity about what the problems were.

(e) Such collected information could be made accessible to an independent monitoring body. In Scotland the obvious candidate for this would be the Mental Health Commission.

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Clinical audit in psychiatry

DEAR SIRS

According to Charles Shaw (1990), the planning and development of audit is divided into distinct phases.

Judging from recent communications in the *Psychiatric Bulletin* we are at present trapped somewhere between the philosophical, organisational and practical stages of audit. The organisational phase concerns resource implications and who should audit, the practical phase the subject matter and the method of audit. Dr Halstead has drawn attention to the College recommendation of one session per week per consultant and raises questions about the cost effectiveness of such a time commitment, an organisational issue. Dr Gath replied on behalf of the College emphasising the nature of audit as distinct from mere data collection, and the need for focusing

on the "feedback loop", in the practical phase (*Psychiatric Bulletin*, May 1990, **14**, 309–310). Although these phases are inextricably linked, by being able to clarify the process of audit into stages, some of the confusion may be lessened and the subsequent anxiety alleviated. The philosophical stage has yet to be negotiated, as I suspect that, although many psychiatrists accept that audit is going to happen whether they (we) like or not, hearts and minds have yet to be won.

While discussing the philosophical stage we urgently need to focus on the practical issues and set up robust and workable systems of audit which are simple and effective.

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Reference

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Management training

DEAR SIRS

The report of the CTC Working Party on Management Training (*Psychiatric Bulletin*, June 1990, **14**, 373–377) arrives at a time when the need for management training for clinicians is clearer than ever.

It has certainly been my experience that many junior doctors and a considerable number of consultants have very little knowledge of the organisation in which they work; some are unable even to identify correctly who pays them each month! Similarly, their management skills have been obtained more by luck than design and are consequently of variable quality.

I would strongly support the recommendations made by the working party but would like to point out that there is, in fact, a branch of medicine which is strongly involved with management training: public health (previously community) medicine. Indeed, throughout the country departments of public health medicine are actively training their registrars and senior registrars in both the theory and practice of management.

Additionally, trainees in public health medicine gain experience in the use of epidemiology and statistics, research methodology, health promotion and the application of medical sociology in their everyday work. They are closely involved in the development of audit and evaluation and the use of computers and information technology. They are in contact with managers at all levels in the NHS but also with general practitioners, community health councils, local authorities (including social services and education) and the myriad of other groups so closely involved in planning and implementing services. Such skills and experience would be at least desirable assets for clinicians to possess.

As we move into a new environment of purchasers and providers, it has been made clear that, in future services should be evaluated on the basis of "public health impact". The Annual Report of the Director of Public Health will form the basis upon which the new health authorities will write their planning strategies. It is, I believe, vitally important that clinicians are not only skilled in management but also possess a good knowledge of the public health approach to planning, if only to argue their case for more resources. For provider units, be they trusts or directly managed units, there will be a clear need to do good "market research" if they are to "sell" their services to districts; epidemiology is the market research tool of health care.

I would therefore suggest that an additional method of gaining experience in management would be to be attached to a Department of Public Health Medicine for a period of three to six months. This would give time to produce at least one piece of work with recommendations for implementation, and possibly present it to the necessary committees and health authority. Perhaps better would be a longer, part-time attachment engaged in a larger research project. Not only would the trainees gain useful management experience but also a grounding in the other areas mentioned above.

Such attachments are not new to public health medicine as many departments, including my own, already regularly have GP trainees working with them. An additional benefit is the knowledge and skills which these trainees bring to public health; too often our departments are both geographically and ideologically distant from our clinical colleagues. The development of closer collaboration and understanding between public health and psychiatry would be greatly enhanced by such attachments.

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Research experience in psychiatry

DEAR SIRS

When Dr Double (*Psychiatric Bulletin*, June 1990, **14**, 364) expresses his doubts concerning the desirability of all psychiatrists being required to do research, he speaks for many trainees. It seems reasonable, however, to expect all trainees to acquire a special interest or skill, and there are many modern possibilities available. More psychotherapies are now taught than in the past, management training is increasingly encouraged, computing is almost a