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Clinical governance†

Six months of a functional programme in a forensic service

AIMS AND METHOD

To describe the introduction of a clinical governance programme within a regional forensic psychiatric service.

RESULTS

The established programme meets the objectives of clinical governance. It affords regular appraisal of model practice and dissemination of information among staff. It provides a forum for continuing professional development, assessment of users' views and input of its staff to service development.

CLINICAL IMPLICATIONS

A functional clinical governance programme is possible, and likely to produce considerable benefits, but requires substantial commitment from clinical, secretarial and managerial staff. To be sustainable in the long term it may require additional funding. It is still too early to seek to evaluate any long term changes produced in patient care by the process.

Following the change of Government in 1997, the White Paper, *The New NHS: Modern, Dependable* (Department of Health, 1997), and the subsequent publication of *A First Class Service: Quality in the New NHS* (Department of Health, 1998) made clear the Government's expectations in relation to clinical governance. All patients in the NHS are entitled to high-quality care, and clinical governance is the process by which the NHS will quality-assure its decisions.

The aim of clinical goverance is to ensure that all NHS organisations have in place proper processes for monitoring and constantly improving clinical quality. This new initiative emphasises the importance of the qualitative aspects of health care, in contrast to the past emphasis on collecting purely quantitative and financial data. The role of clinicians in assessing and monitoring quality and managing the processes that ensure it is therefore integral to the process of clinical governance.

There is now a legal duty of quality imposed on every NHS trust. Chief executives and trust boards are accountable for local policies. Continuing professional development (CPD) for all managerial and clinical groups in the workplace is fundamental. Ideas and innovations can be evaluated through clinical governance and progressively introduced into organisations.

The development of clinical governance is an evolutionary process. Organisations must be able to adapt to the demands of changing patterns of illness and new treatments as well as to the transformation in the needs and expectations of both patients and the wider community.

It has been argued that an unduly centralised approach may be unsatisfactory, as it is likely to produce undesirable passivity in clinicians. In counterargument, there is a risk that unnecessarily diverse approaches could cause fragmentation (Oyebode *et al*, 1999). To be effective, clinical governance must be owned by those who deliver care. It has been observed that clinical audit failed to change clinical practice in some parts of the NHS (Holden, 1999), but it is hoped that the integration of audit into a wider clinical governance agenda will change this (McErlain-Burns & Thomson, 1999). However, the chances of clinical governance achieving its objectives within the current organisational structures of the NHS has been rated by some as small (Jones, 1999). Exactly how clinical governance will change management structures within health provision is unclear. It has the potential to increase the control of clinicians (James, 1999), so a new style of partnership with managers will certainly be required; yet support from the very top of organisations is essential for its success (Weiner *et al*, 1997). Some elements of clinical governance will clearly remain at trust executive level (e.g. the management of poorly performing clinicians), but many key aspects should be devolved to local teams (Hopkinson, 1999). In view of this, a local clinical governance programme for a single site involving all professional staff groups appeared appropriate.

The Langdon programme

Langdon Hospital is a regional forensic psychiatric service covering Devon and Cornwall, based at a single site. There is a medium secure unit, an open unit for mild and borderline learning disabled offenders, a long-stay facility

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for severe and enduring mental illness and rehabilitation flats. Over the whole site there is a total of 81 beds.

The programme at Langdon hospital is based on the structure suggested by James (1999). A clinical governance committee has been established incorporating existing mechanisms for audit and quality assurance. The office of chairperson of this committee rotates on a yearly basis and is held by a specialist registrar in forensic psychiatry. The chairperson of the Langdon Clinical Governance Committee communicates local developments to the trust via the membership of the Mental Health Clinical Governance Committee. The chair of the latter (currently an occupational therapist) sits on the trust Clinical Governance Committee. The chair of the Langdon committee prepares a report every 6 months for the Mental Health Clinical Governance Committee, and the latter prepares an annual report for the trust's Clinical Governance Committee. The trust's medical director chairs its clinical governance committee. This is a post delegated within the trust by the chief executive. These relationships are represented in Fig. 1. Lines of responsibility and information flow are indicated by the arrows.

The process

Multi-disciplinary steering groups based around the following five areas were formed: evidence-based practice; clinical audit; risk management; policy and procedure; and complaints and user issues (Fig. 1). These are chaired by a variety of professional staff (including managers), who recruit the multi-disciplinary members of these groups. The separation of the different aspects of clinical governance into these five steering groups enables focus to be maintained on each component. Clinical governance demands changes in our work culture that are still in their infancy, and to maintain the focus on the different components of changing practice the separation of the functions of clinical governance is, at present, a necessity. However, ultimately the components will need to be integrated. For example, user issues may be important for all aspects of clinical governance and it may be that in a fully mature system, user issues may be subsumed within one of the other components, thus ensuring that they have an impact at all stages and on all aspects of the clinical governance process. The need to integrate the components of clinical governance is best demonstrated by a topic-based approach. For example, users and a number of professional groups identified bullying as an issue of concern within the hospital. A multi-disciplinary group gave an evidence-based practice presentation on bullying at a Clinical Governance Afternoon (see below). Through discussion and feedback, it became clear that addressing bullying within all five components of the clinical governance mechanism was necessary to deal with the problem effectively.

The clinical governance programme is now an important component of the CPD of staff, but its prime function is to influence the way care is delivered

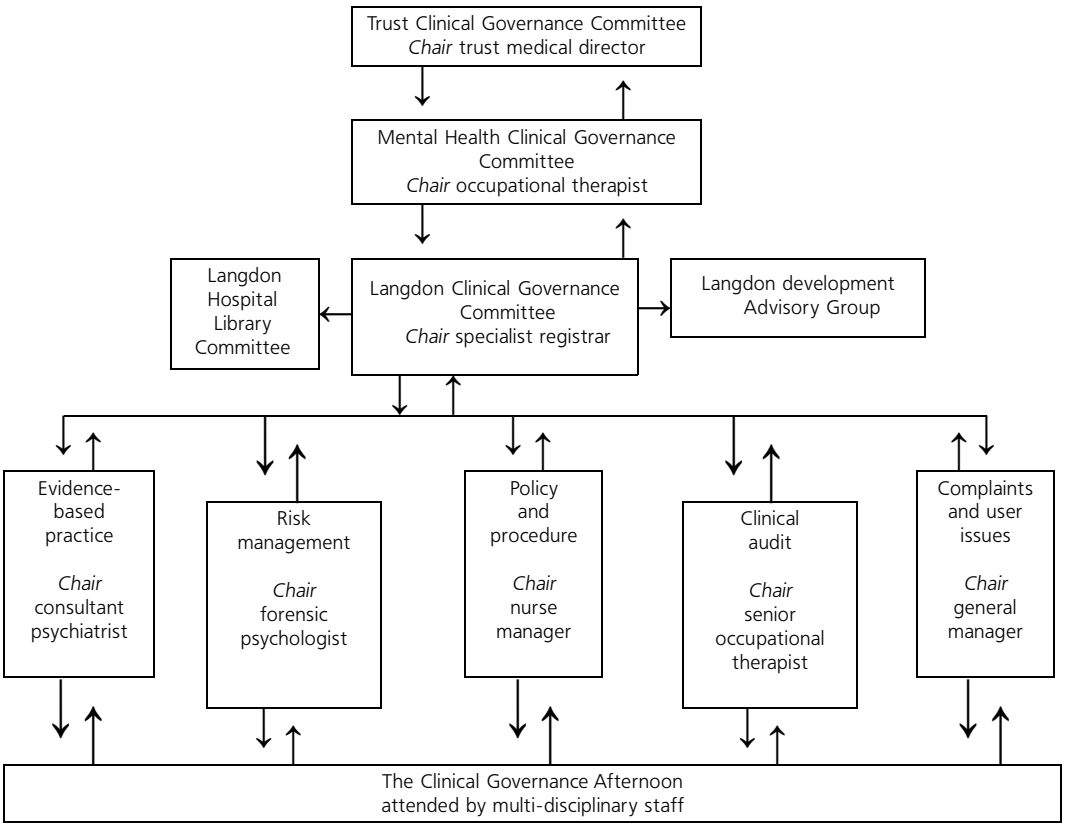

Fig. 1 Relationship between the devolved clinical governance arrangements at Langdon hospital and the trust-wide clinical governance programme

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to patients. It is the role of the steering groups to investigate practice and innovations that may be applied at the Langdon site. The steering groups report back to the Langdon Clinical Governance Committee and then arrange a rolling series of presentations at clinical governance afternoons, which began in May 1999. There are 10 meetings per year (excluding August and December). The programme runs from 12.30 to 4.00p.m. and staff from all professional groups are encouraged to attend. There is an evidence-based practice presentation at each meeting and the other groups alternate presentations (Fig. 2).

To promote staff attendance, lunch and a 'lucky door' prize are offered, funded by the representatives of pharmaceutical companies. The steering groups have now formulated topics beyond November 2000. Members of the nursing staff are rostered specifically to attend the programme. An attendance register, records of the presentations and minutes of the post-presentation discussions are kept. It is important that CPD approval for the clinical governance afternoons be obtained prospectively from the relevant College representatives. Attendance has thus far been good and initial feedback very positive.

The future task

The Langdon Clinical Governance Committee has the task of monitoring the progress of the steering groups and keeping abreast of new developments both within the

	May	June	July	September	October	November
Evidence-based practice						
Title	'Alcohol-related treatment issues'	'Treatment-resistant schizophrenia'	'Complimentary medicine in psychiatry'	'Treatment of sex offenders'	'Observation levels'	'High-dose neuroleptic medication'
Presenter/s	Nurse tutor and consultant psychiatrist	Staff grade psychiatrist	Social worker	Forensic psychologist	Psychiatric nurse	Specialist registrar
Audit						
Title	'Violence in in-patient settings'		'Patient diet'		'Patient activity'	
Presenter/s	Specialist registrar and psychiatric nurse		Occupational therapist and psychiatric nurse		Nurse tutor	
Risk management						
Title	'Risk overview'		'Clinical risk instruments'		'The Langdon risk survey'	
Presenter/s	Forensic psychologist		Specialist registrar and forensic psychologist		Nurse manager	
Policy and procedure						
Title		'Modernising mental health services'		'Confidentiality'		'Seclusion'
Presenter/s		Nurse manager		Staff grade psychiatrist		Psychiatric nurse
Complaints and user issues						
Title		'Survey of user views of services (part 1)'		'Survey of user views of services (part 2)'		'Racism: the site response'
Presenter/s		General manager		General manager		General manager, Social worker and service user

Fig. 2 Clinical governance programme 1999

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trust and in the wider NHS. These will include the National Service Framework (Department of Health, 1999) and guidelines from the National Institute for Clinical Excellence that will affect local practice. The committee takes an overview of the process and can advise a steering group if an important area of practice has been overlooked. The local application of initiatives emerging from the presentations is fed into the Development Advisory Committee, a pre-existing structure examining overall site development and clinical activity. How this group will deal with the suggested innovations is awaiting evaluation. Involvement in the clinical governance programme may in the future form a component of the annual performance reviews of doctors and other health professionals. New acquisitions for the academic library may be suggested by the Clinical Governance Programme. This is another means by which clinical governance and the local components of continuous professional development can be woven into a coherent programme.

As yet there is no involvement from professionals in pharmacy and speech therapy owing to their part time presence at the Langdon site. It is hoped that members of these groups will join steering committees in the future. Unfortunately, Langdon receives no additional NHS funding for its clinical governance programme and it has relied on the goodwill of many staff, who invest time over and above their clinical, managerial and secretarial workload. In contrast, local health authorities have been able to appoint new staff specifically for the purpose of clinical governance, despite the fact that it is providers such as Langdon who will have to deliver it.

A functional clinical governance programme is possible and is likely to produce considerable benefits, but it requires substantial multi-disciplinary commitment. It is still too early to evaluate any long term changes in patient care resulting from the programme. To be sustainable in the long term it may need additional funding, especially for an administrator to coordinate the process. The creation of academic posts linked directly to clinical governance has also been suggested (James, 1999).

Conclusion

The Langdon initiative meets the objectives of clinical governance. It ensures a framework for the regular appraisal of new practice in a variety of areas and the dissemination of new information to as wide a staff group as possible. It also gives a forum for the professional development of all clinical personnel, including involvement in regular clinical audit and risk management, as well as a mechanism for incorporating the views of service users. It should allow all groups to play a role in the future direction of patient care at Langdon hospital. Although it is still too early to assess long term benefits to patient care, other mental health services might consider using this model.

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Patient or client? The opinions of people attending a psychiatric clinic†

AIMS AND METHOD

The use of the term 'client' has become increasingly popular among non-medical staff in psychiatric practice. We sought to describe the preferences and attitudes of people attending a psychiatric clinic to the terms patient and client. A questionnaire and case note review was employed.

RESULTS

147 people completed the questionnaire, of these 77% preferred the term patient. There was no subgroup that preferred the term client. Attitudes towards the two terms were significantly different, with a greater antipathy demonstrated towards the term client.

CLINICAL IMPLICATIONS

The majority of people attending a psychiatric clinic prefer the use of the term patient; the term client is disliked.

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