What will we do without to get what we really want?

Peter J Connelly

Successful clinical governance can only occur if staff, managers and commissioners are prepared to accept that traditional solutions are not necessarily the most appropriate. Accurate assessment of clinical risk and the development of strong and effective clinical teams with clear leadership, multidisciplinary appraisal and clearly defined implementation plans will help to shape good practice.

In 1998, Sam Galbraith, Minister of Health for Scotland, said: 'The best definition that I have seen of clinical governance is simply that it means "corporate accountability for clinical performance".' The context of this interpretation of clinical governance should not be overlooked. Comparisons can be made with corporate governance and its financial focus. It is important that clinical governance is not simply the introduction of control mechanisms and quality assurance, but that a 'hearts and minds' change in the culture of delivering health services accompanies this accountability (British Association of Medical Managers, 1998).

A 'HEARTS AND MINDS' CHANGE

'That patient should never have absconded. Carry out an investigation of how it could possibly happen. Someone must be to blame — we are always putting extra resources into that ward. Discipline is required here.'

This scenario is likely to be all too familiar to a number of readers, but is it really clinical governance in action?

Why were extra resources required in the ward? Was this a permanent increase in staffing, multiple temporary moves, or an indication that something serious was wrong in the ward? If there are difficult patients, is there a pool of sufficiently trained nurses to carry out functions which are clearly over and above the workload involved in the day-to-day management of patients?

In the setting of low morale and under-staffing it is difficult to maintain a quality service. Have adequate steps been taken to identify the root of this perception and to resolve the problems? Is team building working optimally? The ward environment may not be conducive to the therapeutic management of patients. Has there been sufficient investment in the fabric of the ward to raise its therapeutic potential?

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CLINICAL GOVERNANCE: A NEW FRAMEWORK

An initial response to the challenges of clinical governance has often revolved around more accurate counting of data and the setting up of a committee to oversee the process primarily geared towards the need to 'target bad apples', including adequate sanctions for dealing with practitioners who are under-performing and emphasizing the rather reactive nature of risk management. In fact, this is an extreme oversimplification of the change in culture required to ensure successful governance.

In reality, most clinicians (of all disciplines) already deliver a high quality service under considerable pressure. An atmosphere of encouragement rather than criticism should drive clinical governance if people are to admit to poor quality and to learn from errors. Fundamental to successful implementation of clinical governance is that the culture of examining practice in the NHS changes with a change in ethos to concentrate on the questions 'Are we doing the right thing?', 'If so, are we doing it right?', and 'What will we do without to get what we really want?'. The desired outcomes are increased involvement, increased ownership, increased morale and increased expertise among NHS staff.

CLINICAL RISK ASSESSMENT AND MANAGEMENT

Fundamental to governance is the identification and reduction of clinical risk. Risk cannot be eliminated and indeed is inherent in psychiatry, where the patient's behaviour is modified by the

illness itself, and where poor peer support has contributed to adverse learning before coming into contact with the mental health services. Risk is dynamic and prone to change; with some patients this can be rapid. Intervention can increase as well as decrease risk. Accurate assessment of risk is crucially dependent upon the interaction between the clinician and the patient. Even after rigorous assessment outcomes can be unpredictable. Some people are liable to abscond, no matter what relationship they have with staff.

Assessment of risk will vary between specialities but in mental health, current mental state and social circumstances will be greater determinants of risk than previous history, even though the latter may include violence or suicidal behaviour.

In formulating the risk, questions should address the seriousness, the immediacy and the specific nature of the risk before formulating a management plan. Such management will encompass a range of professionals and information needs to be passed clearly between individuals.

Equity of assessment and response is required. Staff must not simply prioritize potential risks of patient violence or absconding in young people but must ensure that clinical risks are not underestimated in older people.

Managing risk is not a simple matter. A law of diminishing returns applies. Hypothetically, in a ward with 20 staff, six incidents of absconding might be expected per year; with 40 staff two incidents might be expected, but even with 80 staff an incident might occur. A balance is required but both management and staff must accept that some incidents will occur and that additional staff will not always be a solution. How should managers respond, however, if staff in the ward at the outset of this article demonstrate that incidents are 90% lower with six on a shift than with five?

To ensure that clinical risk management works well, ensure that people are working within their level of competence. Staff are unlikely to be complacent about absconding, but a culture of 'no blame' requires development where practical, with systems in place to deal with poor practice. This involves openness, monitoring, appraisal and re-training where required. Standards, guidelines and protocols require agreement and review with the concept of the Local Team Implementation Plan (LIP) being developed to ensure an integration of training, easier objective setting and appraisal.

Multidisciplinary clinical risk assessment

Consider the following conversation between a physiotherapist, nurse and occupational therapist in a dementia ward.

'There's no point in having that patient sitting in that chair — his posture is inappropriate and his mobility will deteriorate. He will be in hospital longer than necessary' says the physiotherapist.

'But his agitation is more severe if he is not in that chair and he is at risk of more falls and will be in hospital longer than necessary' says the nurse, 'Perhaps medication would help'.

'There's no point in giving him more medication', says the occupational therapist, 'I won't be able to work with him and he will be in hospital longer than necessary'.

How would such an apparent 'no-win' situation be resolved to the benefit of the patient? Within a LIP focused on improving rehabilitation of agitated patients at risk of falling, the mixture of mobilization, exercise and therapeutic input can be adjusted to allow the patient to gain the benefits of relaxing in a suitable chair without periods of prolonged inactivity or increase in medication.

IMPROVING PRACTICE

Clinical guidelines

There are many definitions of guidelines, of which the Evidence-based Medicine Working Group (Hayward et al, 1995) is probably the most pragmatic. The problems for which guidelines are most needed are complex trade-offs between competing benefits, harm and costs, usually under conditions of uncertainty. While there has been resistance to the introduction of guidelines, which are perceived by some as inhibiting clinical practice, most conditions in psychiatry fulfil the criteria for which guidelines are most needed.

Guidelines provide a focus for two mechanisms closely associated with clinical governance: clinical audit and integrated care pathways (ICPs).

Clinical audit

Suspicions about the motivation behind developing guidelines and the motivation of commissioners in seeking audit has led to an inconsistent approach to the topic throughout the country, which must change.

CRAG, in its paper *The Interface between Audit and Management* (Clinical Resource and Audit Group, 1993), highlights some very useful conditions for audit. Ideally, audit should involve issues which are common problems, a significant or serious condition, relevant to the team's or individual's practice or need for development. Potential directions for change should be identi-

fied which are likely to bring benefits to patients or greater effectiveness in the delivery of care. There should be a realistic potential for improvement in the service and the end result should justify the time and effort in the process.

Integrated care pathways

Guidelines and audit based around them can combine to ensure standards are met and allow the development of appropriate protocols.

ICPs require the development of common practices which should enhance the communication between members of an effective clinical team. They can be an effective alternative to multiple unidisciplinary care plans and allow common milestones in the treatment of patients to be identified thus allowing exceptions to be recorded making audit, critical incident review and targeted training easier to conduct.

Clear lines of accountability are required which may well be a potent issue in a multidisciplinary, multi-agency approach such as that commonly seen in psychiatry. Each member of the team must be aware of the need for exception reporting, and be committed to using that information to drive clinical audit and to make clinical risk management more effective.

Critical incident analysis

Even the most successful guidelines, protocols, ICPs, audit and risk management procedures will be unable to prevent all incidents occurring. An effective clinical team will be aware of the need to investigate critical incidents:

- Speedily — memory is fresh
- Sensitively — people are feeling vulnerable
- Scrupulously — to identify issues which may affect future patient care
- Supportively — ensuring a culture of openness and lack of apportioning blame is at the heart of team-working.

Effective clinical team

Crucial to clinical governance is the ability to develop strong and effective clinical teams with clear leadership. The rewards are better multidisciplinary integration, better joint planning and better integration with other agencies. Effective teams cannot function without committed, supportive management, without time to be properly professional with patients and without resources to make self regulation work well.

Managing poor performance

Inevitably some critical incidents will be a result of poor performance, although this will not be the only manifestation of a poorly performing individual or team. A clear structure must be in place to identify and manage performance including transparent disciplinary measures if required. However, an effective clinical team will benefit from the use of internal and external appraisal of performance.

APPRAISAL

A system of appraisal is required to identify opportunities for improving performance, marrying personal development, service development and overall management of service resources. This combination of approach ensures that service innovations become common practice and that training is tailored to improving performance. As an example, widening the consultant job plan to include issues which affect performance, including non-clinical aspects of a consultant's job, is an ideal vehicle on which to base a system of appraisal, in which use of service resources, development of staff, targeted continuing professional development and monitoring of involvement outwith normal clinical remit can be discussed openly (BMA Central Consultants and Specialists Committee, 1998).

An agreed balance between existing tasks and the incorporation of new tasks is required reflecting the needs of the trust and the development of individual consultants. Prioritization requires a key question — 'What must we do without to get what we really want?'

BARRIERS TO GOVERNANCE

External barriers to successful governance exist. These include a poor fabric of building in which to deliver inpatient services, too few alternatives to admission, too few treatment options and too little integration of multidisciplinary follow-up.

Conditions which can lead to errors happening include high workload, too much complacency or exhaustion, inadequate knowledge, ability or experience to manage conditions, poor design, inadequate supervision or instruction, a stressful environment and too much or too little change!

These factors affect commissioners who again must ask 'What will we do without to get what we really want?'

IMPLEMENTATION PLANS

The development of Service Implementation Plans and LIPs will enhance the implementation of governance in areas in which multidisciplinary and multiagency work is common, such as mental health, with agreed training and targeted areas for improvement of care, allowing exploration of relationships within departments as well.

SUCCESSFUL GOVERNANCE

In summary, to change from existing practices to a new form of successful clinical governance in mental health services, the development of LIPs, focusing on the questions 'Are we doing the right thing?', 'If so, are we doing it right?', and 'What will we do without to get what we really want?' provide a sound basis for improvement.

The keys to success are a willingness to pursue a hearts and minds change, a mature approach to clinical risk assessment and management, developing appropriate clinical guidelines, audit and ICPs without stifling innovation, learning from critical incident analysis, developing team-focused objectives and appraisal, managing poor performance and removing barriers to governance; something which involves not only service providers but commissioners too. **HM**

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KEY POINTS

- Good clinical governance requires an atmosphere of encouragement rather than criticism if people are to admit to poor quality and learn from errors.
- Key questions are 'Are we doing the right thing?', 'If so, are we doing it right?' and 'What will we do without to get what we really want?'.
- Fundamental to clinical governance is the multidisciplinary identification and reduction of clinical risk.
- Risk is dynamic and prone to change.
- Developing a Local Team Implementation Plan ensures integration of training, easier objective setting and appraisal.
- Guidelines, care pathways and audit form a natural progression which underpins clinical governance.
- Strong and effective clinical teams with clear evidence of leadership are crucial to the whole ethos of clinical governance.
- A clear structure must be in place to identify and manage performance including transparent disciplinary measures if these are required.
- External barriers to governance must be dealt with to improve implementation.
- Governance involves not only service providers but commissioners too.