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Clinical standards and the wider quality agenda

There is an unprecedented level of interest among the general public, the media and politicians in the quality of treatment and care provided by the NHS. Traditional methods for upholding the quality of medical practice, through professional self-regulation, are under attack. The General Medical Council (GMC) has responded by voting to introduce a process of revalidation for medical practitioners. If this is not seen to succeed, the Government could take this responsibility away from the GMC, and the Medical Colleges and Faculties.

The selection of mental health as one of the first two National Service Frameworks will ensure that mental health services will remain in the spotlight for at least the next three years. This is a mixed blessing. Increased funding will follow, but there will be the expectation that mental health services demonstrate their effectiveness and conform to explicit performance criteria. Concern about the quality of mental health care is so great that the Government's public position is that community care of the mentally ill has failed.

What is driving the quality agenda?

Professional interest and concern about variation in practice

This variation is present across medical specialities and is apparent between clinicians working for the same trust, between trusts and between regions and countries. An example in psychiatry is the 12-fold difference in rates of administration of electroconvulsive therapy (ECT) between two districts in the same region (Pippard, 1992). Differences in case mix of patients probably only account for a part of such a variation. Some is likely to be explained by differences in the behaviour of clinicians and it is possible that some is due to practice which is less than ideal. This variation is one of the catalysts for the growth of interest in evidence-based medicine and the application of the principles of clinical effectiveness.

Public concern about the quality of medical practice

The deaths of children who had cardiac surgery in Bristol is just the most prominent of a recent spate of news stories whose focus has been the alleged under-performance of particular doctors. Although death rates from surgery might catch the headlines, practice and outcomes of psychiatric care will not be exempt from scrutiny.

Concern about perceived failures of self-regulation

Events in Bristol gave politicians an opportunity to issue a final ultimatum that if doctors do not regulate themselves effectively then others will. If the GMC is not seen to be acting decisively its powers are likely to be limited by the Government. However, the GMC will only ever be able to directly regulate extremes of bad practice. Self-regulation is essentially a local activity which should be mediated through peer-review, audit, continuing professional development and clinical governance. Medical Colleges and Faculties might be expected to play a central role in enabling and facilitating these activities.

Doctors' accountability

The process which started with the transfer of consultants' contracts from regions to districts moves one step further with the introduction of clinical governance. This places ultimate responsibility for clinical quality with the chief executive (who often does not have clinical training). The GMC investigation into cardiac surgery in Bristol and the recent inquiry into Ashworth Hospital (Fallon *et al*, 1999) highlight the responsibility of doctors in management positions to assure the quality of practice of their consultant colleagues. The net result of these developments has been erosion of the special status that doctors have enjoyed since the establishment of the NHS and an increased emphasis on the accountability of doctors to the local organisations which employ them.

A climate of blame

When a public service is associated with an adverse event involving a member of the public, individuals must be found to shoulder the blame. This is true whether the event is the failure to apprehend racist murderers, deaths of spectators at a football ground or a homicide committed by a person with a mental illness. Although inquiries often highlight failures of a system, they still 'name and shame' individuals. This inevitably creates a climate of blame and defensive practice which has been fuelled by a great increase in medical litigation in recent years.

A culture of inspection/accreditation and regulation

The past 15 years has seen the establishment of a number of quangos to regulate both privatised industries (such as electricity and water utilities) and public services (e.g. schools and residential homes). It was a logical

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development for the Government to extend this approach to health care.

Patients as customers

The above developments have either influenced, or are manifestations of, increased expectations among the public of what health care services should deliver. People see themselves as 'consumers' with 'consumer rights'. Increasingly, the public views health care as a product which should be delivered in a timely way, in a polite and respectful manner and to a high and consistent level of quality. When standards fall short of expectations, patients are now more likely to complain and, if adverse consequences result, seek redress. People are also more informed about health and health care and expect to be given fuller information about diagnosis, treatment, care and services. Pressure groups and lobby groups are increasingly influential in determining policy, resource allocation (including decisions about priorities and rationing), local service planning and in triggering investigations into perceived failures of practice.

A demand for 'value for money'

Public services have always had to account for their use of public money. Increasingly, there is a demand that this accounting includes explicit demonstration of what has been achieved with the funding in terms of benefits to those using services. School league tables are well established; children are regularly tested for attainment and targets have been set for literacy of young children. The Education Minister has offered to resign if the latter are not met.

Health is following this lead. The *Health of the Nation* initiative (Department of Health, 1992) set targets which were largely to do with the health of populations; *Our Healthier Nation* (Department of Health, 1998*a*) extends this. In future targets, or performance indicators, will be set which relate much more closely to the processes followed by, and outcomes achieved by individual clinicians. Allocation of the modernisation fund for mental health services will be performance managed by the NHS Executive which will only be able to persuade the Treasury to release successive tranches if there is clear evidence that the money is resulting in measurable improvements.

The escalating cost of health care stimulates a demand that the value of services and interventions be demonstrated. The development of explicit guidelines, monitoring of practice, increased accountability and knowledge among patients means that decisions about rationing will no longer be made covertly or implicitly. Ideally these decisions, now in the public and political domain, should be based on evidence, not just of what works, but of how well. In mental health, the public debate has focused mainly on newer, and more expensive drugs. It could just as easily be concerned with the unavailability of cognitive–behavioural therapy to people with depression, or of assertive outreach services to those with severe and disabling mental illness who, as a consequence, either receive no mental health care or spend an unnecessary amount of time in hospital.

A conceptual framework for standards in mental health care

Very often the quality of health care is influenced by factors which are not under the direct control of the individual clinician. This point is often tacitly acknowledged by inquiries into perceived failures of care which point to failures in the care system.

The Health Advisory Service (1999*a*,*b*,*c*) classifies standards according to 'levels' of the care system. This approach can be used to illustrate the breadth of issues which might be addressed by a set of service standards.

Level 0

'Clinical practice standards' describe the desired performance of an individual clinician working with patients; for example, prescribing the right drug, in the right dose to the right patient. Such standards are the domain of clinical practice guidelines and are usually monitored by clinical audit.

Level 1

'Service delivery standards' describe the responsibilities of clinicians in relation to the wider delivery of care, such as, involvement in assessment and care planning.

Level 2

'Standards about the organisation of care' describe the responsibilities and activities of managers which have a direct bearing on the quality of care delivery. Such managers might also have clinical responsibilities (e.g. as a clinical director or ward manager). Standards relating to access and waiting times would fall into this category.

Level 3

'Intra-organisational standards' describe the activities of managers which have only an indirect bearing on the quality of care. These activities create an environment which supports the organisation and delivery of care, for example, quality of training and supervision, staffing levels and skills mix, systems for quality assurance and audit, information management. At this level, the direct beneficiaries, or 'customers' of the activity are not patients but other workers within the organisation, often front-line clinical staff.

Level 4

'Standards for planning, integration and commissioning' describe principally the activities of senior provider managers and commissioners, for example, population needs assessment, resource allocation, joint planning.

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Performance at one level is often highly contingent on activities at others. For example, the correct prescribing of clozapine (Level 0) requires systems for assessment and identification of patients who would benefit (Level 1); the provision of a clozapine clinic (Level 2); a programme of training of staff in the recognition of adverse effects (Level 3) and a recognition of the benefits of the drug, and a willingness to fund it, by commissioners (Level 4).

National activity to develop and promote quality standards

Clinical standards

The term 'clinical effectiveness' encompasses a spectrum of activities. These include: the identification and costing of effective treatment and care interventions from the research evidence base; the placing of the messages derived in the context of 'real world' practice; the incorporation of messages into accessible and simple practice guidelines; dissemination of these messages; support for their implementation and the monitoring of the care processes and outcomes involved.

Identifying the evidence

The Cochrane Centre is the main engine for the systematic search for, and review of, randomised-controlled trials (RCTs) of clinical interventions. Thanks to the energy of mental health academics, psychiatry is well represented. The Cochrane Schizophrenia Group is one of the most prominent. Groups also exist for dementia and cognitive impairment; depression, anxiety and neurosis; developmental, psychosocial and learning problems and drugs and alcohol. As in all medical specialities, only a minority of published studies involve RCTs. A growing number of broader based, systematic reviews are being conducted and published, funded by a variety of sources including national and regional NHS research and development.

Making evidence-based messages available

Over the past decade, a number of new journals have been published which carry messages derived from systematic reviews. These are both generic (e.g. *Quality in Healthcare, Bandolier*) and mental health specific (e.g. *Journal of Evidence-Based Mental Health* and *Advances in Psychiatric Treatment*). Another example of the packaging of such messages are the *Evidence-Base Briefings* (EBB) produced by the Royal College of Psychiatrists' Research Unit. EBBs have been developed on the use of stimulants in children with attention–deficit hyperactivity disorder (Joughin & Zwi, 1999) and for dementia (Palmer, 1999). An EBB on conduct disorder is under development.

The development of clinical practice guidelines (CPGs) are a further way of packaging evidence-based messages. The better ones put the messages into context by considering the real-life 'modulating factors' that affect the acceptability of, or practicalities of, implementing the messages. One problem facing those developing guidelines is the patchiness of the evidence base. Often, RCTs address issues which are not of central importance to practising clinicians (e.g. whether yet another new antidepressant is as effective as standard treatment). Issues which are a priority raise questions which cannot easily be addressed by RCTs (e.g. questions of risk assessment and management). Practice guidelines are, therefore, often based on a broad base of evidence ranging from RCTs through consensus opinion to the views of an individual. The College Research Unit (CRU) has compiled a bibliography of more than 600 CPGs, and related documents, relevant to mental health (College Research Unit, 1999). The quality of the methods by which these CPGs have been developed is very varied; few meet NHS Executive criteria.

Support for dissemination

The National Institute for Clinical Excellence (NICE) was established as a Special Health Authority in Spring 1999. Its Chair is Professor Sir Michael Rawlins, whose background is in clinical pharmacology, its Chief Executive (Andrew Dillon) is a health service manager. The purpose of NICE is to "give new coherence and prominence to information about clinical and cost-effectiveness" (Department of Health, 1997, 1998*b*). It will produce and disseminate clinical guidelines, clinical audit methodologies and information on good practice. It is intended that NICE will be funded from current resources by the Department of Health. A major source of this funding will be the money previously allocated to professional organisations for guidelines and audit. This top-sliced funding to professional bodies has been considerably reduced in the past few years.

Two mental health topics appear in NICE's programme of 11 guidelines to be developed in its first year – the early pharmacological management of schizophrenia and depressive illness in the community.

Effective dissemination is about ensuring that the right messages reach the right people at the right time in the right place (Palmer & Fenner, 1999). It therefore depends on good information management. This is acknowledged in the new NHS information strategy, *Information for Health* (NHS Executive, 1998). In particular, a National Electronic Library, will make guidelines, and other evidence-based messages, more accessible. There will be a specific emphasis on the development of a strategy for mental health information.

The national confidential inquiries, including that into suicide and homicide by people with mental illness, are now under the umbrella of NICE. The future of other multi-centre audits (like those coordinated by the CRU into ECT, prescribing of antipsychotic medication, the

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Care Programme Approach and the management of violence) is less certain.

Implementation of evidence-based messages is a local issue

Although national bodies can enable and facilitate local services to take up guidelines, their introduction ultimately depends on the interest of local services and individual practitioners (Palmer & Fenner, 1999). The Government's mechanism for promoting this is clinical governance under which "chief executives will be accountable on behalf of NHS trust boards, for assuring the quality of NHS trust services . . . for the first time, the NHS will be required to adopt a structured and coherent approach to clinical quality" (Department of Health, 1998*b*). Clinical governance requires: full participation by all hospital doctors in audit programmes; evidence-based practice to be supported and applied routinely in everyday practice; effective monitoring of clinical care; processes for assuring the quality of clinical care; effective professional performance procedures and support for staff who report concerns about colleagues' professional conduct and performance. It also places great emphasis on the importance of continuing professional development.

The GMC and Colleges and Faculties are expected to respond to this new agenda and clearly define their role in relation to the setting and monitoring of clinical standards, professional self-regulation and continuing professional development.

The CRU has established a "Clinical Governance Support Service" (CGSS) which aims to create a network for mental health services to support the implementation of clinical governance. It will also act as a conduit by which information can flow from the centre to local services and a recruiting ground for multi-centre audits and large-scale research. By December 1999, nearly 100 NHS trusts had subscribed to the CGSS.

Service standards

The development of standards

Over the past decade, a number of attempts have been made to develop and apply standards for the organisation of mental health services and delivery of care. This is not confined to this country; sets of standards exist relating to mental health services in Australia (Commonwealth Department of Health and Family Services, 1996), New Zealand (Ministry of Health, 1997) and the USA (Joint Commission on Accreditation of Healthcare Organisations, 1997). In the UK, standards have been developed by a number of bodies including King's Fund Organisational Audit (1997) and the Health Advisory Service (1999*a*,*b*,*c*).

National Service Frameworks

The Mental Health National Service Framework contains statements and performance indicators relating both to individual practice and to service organisation and care delivery. The framework for mental health, relates to services for people of working age (including mentally disordered offenders); the framework for older people, due to be published in spring 2000, will include mental health services for older people.

National Performance Framework

A National Performance Framework will underpin performance management of trusts and health authorities and NHS Executive regional offices (NHS Executive, 1999). The Performance Framework contains 41 indicators which cover health improvement, access, effective delivery of appropriate health care, patient and carer experience, health care outcomes and efficiency. Only a few of these relate to mental health, including emergency psychiatric readmissions and suicide rates. The intention is to collate, publish and monitor performance against these for every NHS trust in the country. A separate set of outcome indicators for severe mental illness with a more clinical orientation has been developed separately by a Department of Health Working Group (Charlwood *et al*, 1999).

Commission for Health Improvement

The Commission for Health Improvement is a new statutory body. Its establishment required primary legislation which was included in the Health Bill published in January 1999. The Chair and Director report to the Secretary of State.

The purpose of the Commission is to "support and oversee NHS activity to assure and improve clinical quality" (NHS Executive, 1998). As well as overseeing the implementation of clinical governance, it is intended that the Commission will "conduct a rolling programme of reviews, visiting every NHS Trust and Primary Care Trust provider over a period of around 3–4 years". The Commission will target services which are the subject of National Service Frameworks with a programme of systematic service reviews. If these are carried through, they will apply to mental health services between 2001 and 2003. Early in its life the Commission will be centrally funded. As it develops, it is likely that it will charge trusts for its services.

Although the Commission is supposed to "concentrate on clinical issues", it is difficult to see how, given the breadth of its remit, it can do this in any depth. In practice it will probably focus more on its remit to "become involved in management issues where these lie behind clinical problems". The Commission has the power to recommend the removal of a trust board "if there has been a serious default in meeting statutory duties". It has already been likened to OFSTED by at least one minister.

Comment

Clinical standards cannot be separated from the political policy and service management agenda for the NHS. For patients with mental illness, the way in which services are organised is probably as important a determinant of quality of care as the quality of clinical practice. Furthermore, in recent years there has been an increasing

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demand for accountability, both of health service organisations and of individual clinicians. The latter applies to doctors in particular. The setting, application and monitoring of explicit standards will be an unavoidable part of this process.

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