



editorials

Psychiatric Bulletin (2002), 26, 361–362

DAVID GOLDBERG

The benefits and costs of continuous inspections

At what point does patient care suffer?

Some of the first national inspections originated from within the profession, like Joint Committee for Higher Psychiatric Training (JCHPT) visits to accredit specialist registrar training, and the visits from the College to approve training of senior house officers (SHOs). Both of these require clinicians in each trust to stop their usual activities and spend some time preparing the preliminary documentation, and necessitate other clinicians taking time away from their usual work to act as inspectors. Yet few would doubt that the benefits, in terms of improvements in the training of both SHOs and specialist registrars, have more than justified the cost of time spent preparing the often voluminous documents to present to the visitors.

Other inspections have originated from the Department of Health, such as the Hospital Advisory Service, and from the Mental Health Act Commissioners, with the associated requirement to attend mental health tribunals. Here, the benefits have been less tangible but, in the case of the Mental Health Act Commissioners, the price seems well worth paying, in terms of the advantages to patients improperly detained under the Mental Health Act.

Then came the inspections where willing stooges in the medical profession carried out the whims of the Government, with whole departments deferring medical clinics and sitting around with one another for audit sessions, often to little effect. The insistence that managers ran the service necessitated many clinicians taking time to participate in meetings with local management. Sometimes there have been measurable benefits from such activities, but too often the benefit is not assessed, although the costs are always substantial.

A plethora of regulatory agencies were to follow: the National Institute for Clinical Excellence (NICE), the Commission for Health Improvement (CHI), the Modernisation Agency, the National Patient Safety Agency and the National Clinical Assessment Authority (Walshe, 2002).

More recently, there are plans for inspections by users and the Commission for Health Care Audit (CHCA). The remit of the Commission will be to scrutinise and account for the additional NHS resources announced in the Chancellor's 2002 budget.

The independent Commission for Healthcare Audit and Inspection (CHAI) will combine the roles of the existing Commission for Health Improvement (CHI) with the health care functions of the National Care Standards Commission (NCSC) and the Audit Commission's Value for Money studies in health. CHAI will be responsible for monitoring standards in both public and independent sector health care, improving accountability and providing an independent appeal body for complaints by patients.

Another new commission, the Commission for Social Care Inspection (CSCI), formed from the Social Services Inspectorate (SSI) and the social care functions of the NCSC, will be established to monitor processes in social services.

The benefits

The benefits of all these agencies are difficult to gauge, although we must assume that they give some comfort to harassed health ministers, who will no doubt feel that when things are going wrong the agency has not been doing its job. It is easy to see that the Treasury will need the reports furnished by CHCA, and NCSC may even produce better services for patients. None of the agencies described by Walshe (2002) has, so far, produced tangible benefits for patient care, although these are early days and in a few years there may be something to show. It may well be that CHI produces helpful reports on some failing trusts, or that clinicians will actually take some notice of the recommendations that NICE will produce over the next few years.

The costs

Walsh estimates that the five agencies described in his paper will cost the Treasury £114.8 million in running costs, but these are not the only costs involved. Clinicians and managers who volunteer to assist the commissions with their work will not be involved with patient care in their trusts, and the clinicians and managers who must spend time preparing the often lengthy reports from each trust represent, between them, a huge additional opportunity cost. Clinicians who, in response to public disquiet, need to re-qualify, presumably to avert the risks of another Dr Shipman or a case similar to that of the



Bristol heart surgeons, will also need to devote time to studying for their new examinations; and yet other clinicians will desert their responsibilities towards their own trusts in order to examine them. All this before the effects of continuing medical education have been fully assessed and despite the fact that the new examinations will provide no protection whatever against either of the risks mentioned above.

The requirements of clinical governance mean that clinicians must devote time to these activities as well, and there are also mental health tribunals and complaint procedures. This has been in addition to racial-awareness training, which is often attended only by the most racially aware members of staff. And now there is the necessity for a personal development plan and peer appraisals.

In addition to those invented by the Health Department, clinical academics have their own inspections: the Research Assessment Exercise and the Quality Assurance Agency for Higher Education. These are on top of an academic appraisal.

When will there be an end to these incursions upon the time that clinicians might have devoted to patient care and managers to administering their own services? When will some account be made of the extent of the benefits produced by the new regulatory agencies and some proper estimate of the costs in terms of the time no longer available to be devoted to patient care?

Some will say this point has long since passed.

Declaration of interest

None.

Reference

WALSHE, K. (2002) The rise of regulation in the NHS. *BMJ*, **324**, 967–970.

David Goldberg Professor Emeritus, Institute of Psychiatry, King's College London

Psychiatric Bulletin (2002), **26**, 362–363

ROY McCLELLAND, ALEX LEWIS AND MARTIN ELPHICK

Information and communication technology in mental health – opportunity or threat?

The purpose of this editorial is two-fold. First is to draw Members' attention to an important new learning agenda – clinical information management. Second, to alert Members to new opportunities for their trusts to invest in modern information technology systems and new opportunities for Members to obtain training in information technology (IT). For the majority of clinical professionals the very term 'information management', or its synonym 'health informatics', is at best a vague notion best left to computer buffs. For clinicians, the primary interest is to deliver effective, high-quality care to patients. However, consideration of two aspects of modern mental health services draw attention to the information challenge for clinicians.

The information challenge

The first challenge is the great variability in health care practice evident in diagnosis, treatment plans and management strategies. Recent research has shown that one of the major sources of such variability is a lack of readily accessible information on best practice. Although a tension can always be discerned between individual professional judgement and hard evidence, the lack of readily accessible reliable evidence at the point of clinical contact drives decision-making towards individual professional judgement and the inevitable individual variability within such judgements.

One of the major drivers within the present NHS strategy (England & Wales), *A First Class Service* (Department of Health, 1998), is to address variability in service quality and service effectiveness. Professional

efforts at clinical effectiveness and quality will now be informed by national service frameworks, clinical governance and frameworks for performance assessment. Information is a key element within all of these processes, the glue that holds the NHS Plan together.

A second information challenge is that care within current mental health services involves multiple contacts with many different professionals, often in different settings and across institutions. Effectiveness of clinical care depends on the collection, exchange and transfer of information, between clinicians, trusts and other agencies, in a flexible form at each and every point of patient contact. One of the most convincing strands of evidence is, sadly, the negative evidence – the great majority of claims by service users against hospitals and a recurring theme in incident enquiries concerns failed communication of information. The emerging premise is that optimal care and treatment of patients within a modern health environment is highly dependent upon:

- the availability, quality and accuracy of information
- the ability of professionals to access, use and manage information about individuals
- the use of information to enhance the effectiveness of professional practice.

This includes information on whether or not what we do actually makes a difference. However, present evidence indicates a substantial failure in the completeness of information of, and a lack of information flow within, health and social care and unsurprisingly poor analysis of information. This has been a key stimulus for the current NHS Information Strategy (NHS Executive, 1998).