

Using clinical governance can not only improve drug misuse treatment – it can drive an exciting opportunity to change services' culture. Grab the chance to be part of it, says **Dr Susi Harris**.

Vehicle for change



Clinical governance is a system for delivering – and demonstrating the quality and safety of – high standard services. It is a framework encompassing a wide range of established mechanisms, such as clinical audit, education and training, research and development, and risk management, but also requires a culture of openness between professionals and with the general public.

For most drug treatment services, implementation of clinical governance is already a statutory or contractual obligation. But there is now a new emphasis on the ability of clinical governance to improve drug treatment. This is because it is an effective mechanism for improving clinical practice in line with recent clinical guidance (*Drug Misuse and Dependence: UK Guidelines for Clinical Management* and the suite of NICE drug misuse guidance).

Clinical governance can be complex in the drug treatment sector, which crosses health, social care and criminal justice, and organisational boundaries. And, although it is well-established in much of the NHS and in other sectors, the National Treatment Agency and National Audit Office research found that it was sometimes inconsistently implemented, especially in drug treatment and in primary care. There is also evidence that primary care trusts are not always aware of their clinical governance responsibilities when acting as purchasers of drug treatment from the independent sector.

Clinical governance can bring a whole new culture to a caring organisation. It can promote the development of a 'learning organisation' – one that sees untoward events as spurs to necessary improvements. But it goes one step further, giving rise to the proactive 'self-regulating organisation' – one that systematically reviews all its people and processes, seeking out potential areas for improvement, before untoward events have a chance to occur. The whole ethos of clinical governance is about quality. Quality means safety and effectiveness:

making sure that our clients, staff and communities are safe, and that we responsibly allocate finite resources towards evidence-based treatment that we know will make a difference. It's basically about making sure we do the caring that we all try to do in our jobs every day, as well as we possibly can.

But don't just take my word for it. The NTA published draft guidance on clinical governance in February (www.nta.nhs.uk/areas/clinical_guidance/clinical_governance) and the following quotes are adapted from the guidance:

'The more people grasp it the more they want to be involved. This is exciting – as chair of a big committee, it is akin to conducting an orchestra of accomplished players... The cardinal benefit has been the ability to form a culture that feels good. Staff [from all involved services] know that they belong to this Directorate. It has... allowed for the expression of local need as well as local qualities.'

Camden and North West London Mental Health Trust (William Shanahan, medical director and chair, Clinical Governance Committee)

'Now that staff are engaging with the process, teams will automatically come up with service improvement initiatives rather than these being imposed by managers... A massive vehicle for change, very exciting.'

Cygnit Healthcare (Malcolm Carr, director of clinical services)

'Benefits to the organisation include... involvement of all staff, which is empowering to more junior staff... allows a bottom-up approach.'

Addaction

Consultation on the draft guidance, which will end shortly, is your opportunity to shape and influence guidance that will ultimately affect you as a professional with a remit for drug misuse treatment,

whether delivering health or social care, and whether independent or public sector. The principles of clinical governance – of systematic quality assurance and quality improvement – apply whether or not you consider your drug treatment interventions to be 'clinical'.

The consultation draft seeks responses in a number of key areas. Firstly, clinical governance has been around in the NHS for a few years now but, because drug misuse services are so widely distributed among different sectors, it is important to know if the briefing adequately covers primary and secondary care, non-statutory and criminal justice sectors (including prisons).

Secondly, how do we manage clinical governance interfaces, for example, between the clinical governance lead in a Trust and the clinical lead in a drug service, or between a local authority and its young people's drug and alcohol services?

Thirdly, what do you want to see in the guidance to ensure it is of practical benefit? Would you like more detail on how clinical governance can be made to be valued and to work in real situations? Should it tackle more practical aspects of implementation – almost making it a 'how to' manual? And should it go into detail on topics that are covered within clinical governance but important in their own right and perhaps needing greater guidance, such as clinical supervision?

The consultation closes on 14 May so – assuming you are reading this soon after DDN's publication – there is still an opportunity for you to contribute. A diverse response from a wide range of those in the drug treatment sector will help ensure that the final guidance is a genuinely useful document that can support us all in getting the positive benefits of clinical governance embedded in our work, for the good of our clients.

Dr Susi Harris is clinical lead in substance misuse (Calderdale) and formerly NTA Clinical Team GP.