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Department of Health/National Health Service as monopolists, and many are concerned that the bullying style of the Medical Training Application Service may be an indication of worse to come.

To address these issues the psychiatric profession must speak with one voice. Differences with other medical colleagues should not be minimised but should be acknowledged. First and foremost we are doctors and the core function of doctoring is to care for our patients and their families. The doctor should also be an advocate for the patient, for social policy and for future generations of doctors. The psychiatric profession must continue to work with other interested organisations such as Mental Health Alliance to raise concerns. We need to take our patients and their carers with us, simply because it is their needs which must be met and they not the politicians are our paymasters. In order to return professionalism to the hands of professionals, we must stand up to any perceived bullying tactics. The medical profession in general, and psychiatry in particular, has to closely analyse the demands of the Department of Health and to provide alternatives.

At an institutional level, the Royal College of Psychiatrists has already taken the lead in seeking to establish networks for medical directors, postgraduate school leads and directors of medical education networks to ensure better communication. The College must have further discussions about New Ways of Working. Some suspect that many trusts are using New Ways of Working to get rid of doctors so that the same services can be provided more cheaply. Such suggestions must be examined and if proven exposed and resisted.

In conjunction with other medical Royal Colleges we need to respond robustly to consultation exercises such as those that surround proposals to reorder relicensing, revalidation and reaccreditation in order that the core values of professionalism endure. It is the duty of all individuals to be fully aware of policy changes at national level and implementation processes and problems at local levels. We must effectively communicate with each other so that we can learn where changes have been successful and where they have failed.

Psychiatry is one medical discipline which is able to deal with ambiguity, but the procedural changes that are being thrown at us all the time have the potential for a cumulative destructive effect on the medical profession. It is high time we took a step back to reflect and respond in a sensible pragmatic way to improve clinical services. As a first step, the Royal College of Psychiatrists is planning to hold a series of seminars later this year to discuss the definitions of professionalism in relation to psychiatry. These will take the shape of groups of individuals meeting to explore and discuss what professionalism means, how it can be achieved and how it is retained and developed.

Declaration of interest

N.B. is Associate Dean and D.B. is Dean of the Royal College of Psychiatrists.

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Governance, strategy and innovation in mental health

There is a contemporary move in the National Health Service (NHS) to adopt commercial-style governance for provider trusts. Clinical governance has been developing toward 'integrated healthcare governance', and there is now an intense focus on corporate responsibility for healthcare activity, especially in NHS foundation trusts.

Any form of governance requires systems to manage risk and to provide information on performance, which are surely essential tools for all senior healthcare staff. However, governance initiatives may fail if they are overly bureaucratic, and this may be a particular risk in the complex world of mental health. Good governance is therefore of great importance to psychiatry. Successful governance depends on innovation and integration at a strategic level. This should begin with the culture of the senior staff and directors, and a simple reporting system, such as the balanced scorecard. These must embody a clear vision of future success, based on 'what really matters' for patients.

Governance may sound a very dry concept, of limited relevance to psychiatrists. However, in order that large healthcare organisations deliver good services for patients, there must be good governance arrangements of some form. For organisations which are not well run, real innovation in governance is essential for effective clinical practice to develop and flourish. Understanding good governance is therefore crucial to all clinicians, including psychiatrists.

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Corporate and clinical governance

Corporate governance is about how commercial companies are run, and the integrity of relationships between company boards, staff, shareholders, customers and society. In practice governance often focuses on the control of company finances, and on board responsibility for corporate risks.

Governance has been developing in the NHS for some years, around finance audit and systems of controls assurance (Emslie, 2004). NHS foundation trusts are now set to have a code of governance (Monitor, 2005) which relates closely to the UK Combined Code on Corporate Governance (Financial Reporting Council, 2003). The Combined Code begins with a clear statement:

> 'Every company should be headed by an effective Board, which is collectively responsible for the success of the company'.

In recognition of the potential for improved governance in the NHS, clinical governance was introduced for local NHS trusts, a new concept 'built on the principles of corporate governance' (Department of Health, 1997). Scally & Donaldson (1998) gave one of the shorter definitions of clinical governance:

> 'A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.

There is some consensus that clinical governance has not been clear or effective in achieving excellence. Many have suggested different ways of working (see Degeling *et al*, 2004). Healthcare Commission reports on NHS services have found failings in clinical governance, especially in mental health (Oyebode *et al*, 2004). Clinical governance has resulted in a loss of clinical autonomy and influence for psychiatrists, at least in Australia (Callaly *et al*, 2005). This is consistent with a long-standing perception by senior NHS mental health professionals of a culture of mistrust and unrealistic management plans and directives (see Norman & Peck, 1999).

The fall-out from high-profile incident inquiries has also had a major impact on NHS psychiatrists and the services they work in (Salter, 2003). The NHS response is national risk management initiatives such as the National Confidential Inquiries, and newer bodies such as the National Patient Safety Agency and the NHS Security Management Service. How can a local NHS trust and its staff deliver good governance and clinical excellence in this climate?

Integrated healthcare governance

Integrated healthcare governance is not easy to define concisely, but the Department of Health (2006) has recently tried:

> 'Systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations'.

Integrated healthcare governance has origins in US corporate and not-for-profit healthcare (Sugarman, 2005). A programme of integration promises to make healthcare services simpler to run, more effective for patients and more dynamic to work in. True integration of governance must create a non-bureaucratic culture of shared knowledge, teamwork and high achievement. Integration should bring together line management, clinical governance and risk management in finding solutions (Sugarman & Midgley, 2005).

Integrated governance has been particularly pursued by NHS trusts to meet regulatory requirements (Healthcare Commission, 2005; Department of Health, 2006). Many will recognise the strategic vision in integrated governance, but have doubts that complex governance initiatives in the NHS can lead to positive change.

Need for trust and good information

Integration at the top of the organisation is the right place to start on the path to good governance. The NHS Clinical Governance Support Team is championing the adoption by the NHS of crucial lessons learnt from industry (Bevington *et al*, 2005). A healthy balanced culture of trust and challenge must prevail for any team to perform effectively. If executive and non-executive board members dare not openly challenge each other, or have too cosy a relationship, then information about real service performance and risks will be neglected. Unless trust can be achieved, serious consequences for the care of patients will follow. The same observations apply to the relations between managers and clinicians, senior doctors and nurses, and others.

Team-building for directors and senior staff is therefore an important priority. It should also aim to clarify the strategic goals of the organisation. Once key groups achieve integrated teamwork, they naturally champion the true value of integrated working across the whole organisation. This brings into focus the challenge of transforming organisational culture towards easy sharing of information and good communication. Making a great start in converging the activity of various departments and bureaucracies soon becomes crucial.

The next step is the recognition by senior managers of the need for clear information about healthcare activities (Wells *et al*, 2006), an idea central to the concept of governance. Providing timely, meaningful data is a big challenge, especially in mental healthcare. New information flows, targeted on the organisation's refreshed strategic goals must be created. A successful project on this, which is properly resourced, reaps many rewards and doubles as the first ambitious move to kick start integrated working. Key senior managers and clinicians, working together on this fundamental project, develop new trusting relationships, enjoy their work more and ultimately provide better information for everyone. Familiar data flows that are not in line with key priorities are questioned, even scrapped, allowing improved time management.

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The NHS foundation trust regulator Monitor expects trust boards to be provided with clear strategic agendas (see Wells *et al*, 2006) and with monitoring information in the form of a 'dashboard'. The idea of key performance indicators as dials in a cockpit, necessary for navigation, is derived from the balanced scorecard (Kaplan & Norton, 1996). This business concept has been moving rapidly into healthcare internationally. However, it has been unhelpful that numerous NHS targets have been labelled as key performance indicators. A properly developed balanced scorecard system, including clinical key performance indicators, can be really effective in complex mental healthcare settings for managing resources and delivering healthcare priorities (see Sugarman & Watkins, 2004). This does not depend on integrated electronic systems, the starting point should be simple and non-technical. Indicators must measure not only operational performance but also highlight a more strategic agenda. This is key area where clinicians, who really understand healthcare delivery, must be at the forefront of innovation.

Strategic innovation

The strategic challenge in 'mental health governance' is integration in a diverse and complex sector. Happily, innovative thinking in governance is common in mental health services both in the NHS (see Bayney, 2005) and the voluntary sector (see Austin, 2004). For mental health providers looking to the future, perhaps as NHS foundation trusts, an innovative, strategic governance programme is essential.

Initial investment in the culture of the senior management team and in the development of an integrated reporting system is an excellent start. The content of the balanced scorecard and strategic agenda will test the ability to innovate successfully (see Fig. DS1 in the data supplement to the online version of this paper). Each organisation has to decide for itself what it wants to measure and why that really matters. In the future, trusts will want to protect patients by gathering real data on clinical standards and outcomes, and clinical risk management, and also focusing on strategic development, as well as financial performance and staff management. Clinical indicators must be built on explicit healthcare standards and measures, allowing the organisation to champion safe and effective healthcare. These standards must be the core content of all corporate and clinical policy, audit and training activity.

Once 'what really matters' is measured, programme and project management techniques can allow the organisation of diverse teams of clinicians and managers, whose tasks would be to deliver improvements. These processes will challenge assumptions about professional identity and management responsibility.

Conclusions

Mental healthcare providers, increasingly independent of central control, will be able to prioritise use of scarce human and financial resources. Cultural change in mental health services will require further deconstruction of traditional structures and thinking. Innovations in teamwork will be necessary for better use of resources and better patient outcomes. Clinicians should be at the forefront of this change.

New forms of governance must empower mental health service users, clinicians and managers to find innovative routes to recovery. The only successful strategy will be to create a culture of trust where diverse people truly work together on what really matters for patients.

Declaration of interest

None.

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