10

Clinical Governance

10.1 Overview

Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver (HIQA 2012). Service providers are accountable for continually improving the quality of their clinical practice and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes. This includes mechanisms for monitoring clinical quality and safety through structured programmes; for example, clinical audit (HIQA, 2019). Clinical governance helps ensure that people receive the care they need in a safe, nurturing, open and just environment, arising from corporate accountability for clinical performance. The benefit of clinical governance rests in improved patient experiences and better health outcomes in terms of quality and safety (HIQA, 2012). Healthcare providers must have formalised governance structures with clear accountability and responsibility arrangements (HIQA, 2019). Governance also ensures the establishment of learning systems so that all experience within a service is shared and used to improve patient/service user care. Good governance supports strong relationships between frontline staff, patients and senior leaders in an organisation (HSE, 2016a).

The Model of Care for the NCPSH adopts the clinical governance standards set out in the following documents:

- Quality Framework for Mental Health Services in Ireland (Mental Health Commission 2007)
- Achieving Excellence in Clinical Governance: Towards a Culture of Accountability (HSE 2012)
- The Code of Governance Framework for the Corporate and Financial Governance of the HSE (HSE 2015)
- Checklist for Quality and Safety Governance, HSE Clinical Strategy Programme Division (CSPD) and the Quality and Patient Safety Division (QPSD 2014)
- Framework for Improving Quality in our Health Service (HSE 2016)
- HSE Best Practice Guidelines for Mental Health Services (HSE 2017c)
- HSE (2019) Date Protection Policy

10.1.2 Legal and ethical considerations

There are statutory requirements of particular relevance for mental health service provision in Ireland. The NCPSH Model of Care will operate under the following legislation and frameworks so that it fulfils the legal and ethical obligations and ensures that the clinical needs, rights and safety of service users are respected by the National Clinical Programme.

- The Mental Health Act 2001 and associated Regulations, Rules and Codes of Practice
- The Data Protection Act (1998 and 2003)
- The Medical Practitioners Act 2007
- The Nurses and Midwives Act 2011
- The Assisted Decision Making (Capacity) Act (2015) (once commenced)
- The Children First Act (2015)
- European Convention on Human Rights
- UN Convention on the Rights of Persons with Disabilities
- European Union General Data Protection Regulations (GDPR) (2018)

10.2 Clinical governance structure for the NCPSH

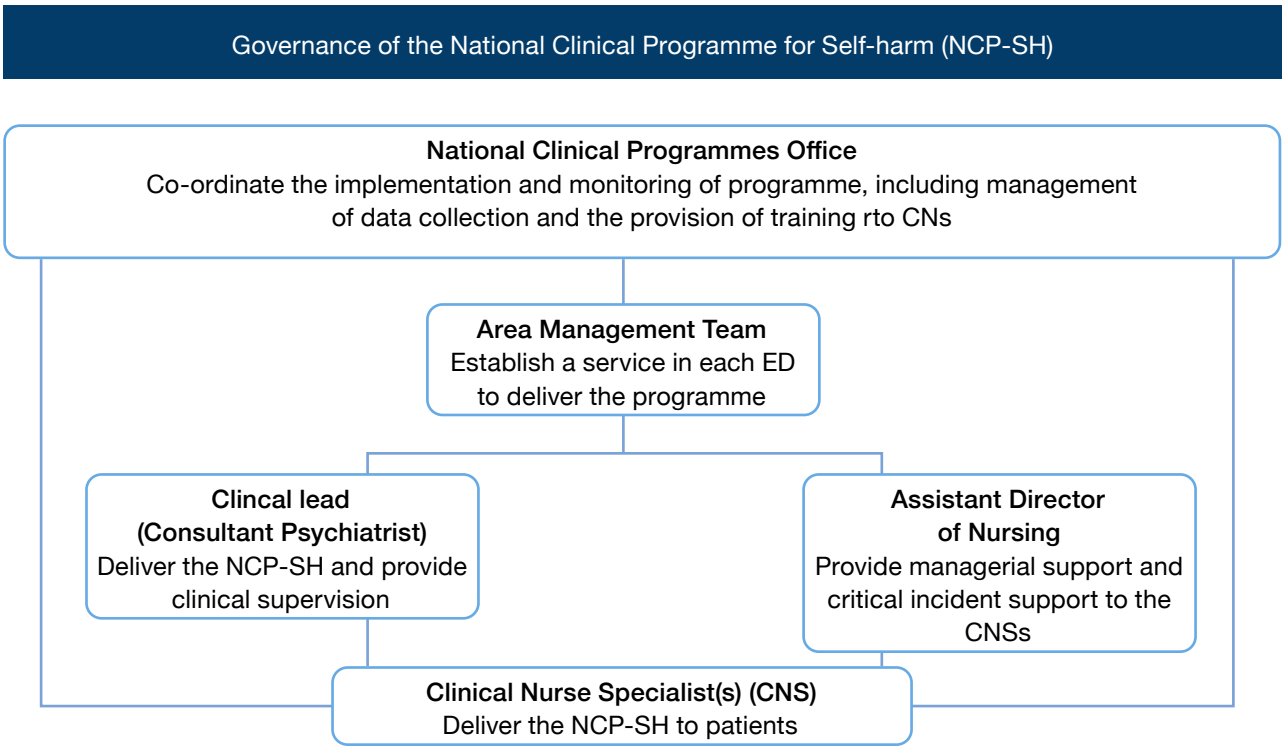
10.2.1 Summary

The National Clinical Programme (NCP) includes a number of measures to ensure that the key pillars of clinical governance facilitating quality, safety and effective service provision are developed and maintained. The HSE National Clinical Programme Office and HSE National Mental Health Service will monitor the services on a regular basis to support and review progress towards the identified standards, identify issues of concern and lead out on future developments. The full implementation of the NCPSH is also a key priority for Connecting with Life (NOSP 2020) and for Sharing the Vision (DoH 2020).

TABLE 10.1 SUMMARY OF NCPSH GOVERNANCE COMPONENTS TO ACHIEVE QUALITY AND SAFETY

Knowledge and Skills	Management teams ensure they have the knowledge and skills for driving quality care.
Leadership and Accountability	At all levels, activities and services are measured and management teams drive quality and safety.
Information	Information is used to measure, monitor and oversee quality and safety of care.
Culture	A learning environment focused on improving quality of care is promoted. Use of clinicians, service users and family members in driving this learning is supported.
Relationships	The NCPSH supports strong relationships that partner with service users, family members and staff in primary care and secondary care and with voluntary and community agencies.
Quality Improvement	A quality improvement plan is in place, based on the Model of Care and learning from clinicians, managers, service users and family members.

FIG. 10.1 SUMMARY OF NCPSH GOVERNANCE (GRIFFIN ET AL 2021)



10.3 Management structure and responsibilities

To support the clinical governance, a project management structure has been developed at both national and Community Healthcare Organisation (CHO) levels, with the following roles and responsibilities.

10.3.1 National Clinical Programme Office

The office of the National Clinical Advisor and Group Lead (NCAGL) has oversight over the development, implementation and monitoring of the clinical NCPSH. Within this, the NCPSH office requires a programme manager, a clinical lead, a lead nurse and a data manager. As the programme expands, hours of work for these key personnel will increase and should be reviewed annually.
Overall the team will have responsibility for:

- Oversight and governance of the implementation of the NCPSH nationally
- Supporting services to deliver on NCPSH objectives
- Supporting and implementing national training plans in accordance with the Model of Care (MOC)
- Managing, reviewing and reporting on data collected monthly at each site nationally
- Working with an Implementation Advisory Group of clinicians, managers, individuals and family members with lived experience of self-harm to review, evaluate and update the MOC
- Collaborating with and reporting to the National Office of Suicide Prevention in delivering Connecting for Life
- Collaborating with the National Suicide Research Foundation in improving the quality of data collected and in evaluating the MOC
- Working with relevant stakeholders in the HSE in embedding the NCPSH into day-to-day operations
- Collaborating with clinicians, people with lived experience, researchers, universities, professionals and training colleges in delivering training and in conducting research and audit in the NCPSH

10.3.2 CHO Area Management Team responsibility

The CHO Area Management Team have responsibility for:

- Recognising the importance of this programme in improving service provision for the CHO population, and providing leadership and support to ensure implementation
- Identifying a clinical lead to implement the programme in the ED
- Appointing a clinical lead to implement the SCAN service – funding for 0.2.WTE Consultant Psychiatrists per 300,000 population is provided through the NCPSH
- Appointing a CNS or suitably qualified mental health professional to deliver the NCPSH – funding for 1 CNS per 200 ED presentations of self-harm per annum one SCAN practitioner per 75,000 population and 0.2 WTE Consultant Psychiatrist per 300,000 is provided through the NCPSH
- Designing, setting up, recruiting, managing and overall governance of the NCPSH services in their region
- Ensuring that all line managers are aware of the requirements of the NCPSH for their staff
- Having systems in place locally for accurate, comprehensive and timely data collection to facilitate audit and evaluation locally and nationally
- Allocating resources to provide supervision and training requirements
- Facilitate staff in the area to receive supervision and training as required
- Collating and feeding back to the National Clinical Programme Office on key performance indicators
- Working with the National Clinical Programme office in implementing the Clinical Programme
- Establishing a Clinical Forum to ensure that the Clinical Programme activities are well integrated with other activities of the mental health service
- Ensuring that all line managers for clinicians have a working knowledge of the NCPSH, and that line managers support the full implementation of the NCPSH

» Ensuring that local CHO Connecting for Life plans include the NCPSH

10.3.3 Clinical leads, Advanced Nurse Practitioners, Clinical Nurse Specialists, Social Workers

Clinical leads, ANPs, CNSs and Social Workers:

» Deliver the NCPSH in accordance with the NCP

» Deliver awareness training on suicide and self-harm to ED staff and GPs as appropriate

» Attend supervision and training as identified in the Education and Training Plan

» Record and submit monthly data on time in accordance with NCPSH requirements, using the agreed format

» Provide leadership, education and training in issues related to self-harm

» Monitor and ensure best practice in their area of expertise through audit and research

» Maintain a database of staff trained in particular interventions

10.4 Professional reporting relationship

To implement the Clinical Programme, CNSs and other suitably trained mental health practitioners will be appointed to work in the EDs or with GPs to provide mental health input for patients who present following self-harm or with suicidal ideation.

» The professional reporting relationship for CNSs, whether working in EDs or in the SCAN service is to the HSE Area Director of Nursing or designated Assistant Director of Nursing, Mental Health Services.

» The professional reporting relationship of ANPs is to the HSE Area Director of Nursing, Mental Health Services.

» The professional reporting relationship for other mental health professionals is through their professional line management structure.

» The professional reporting relationship of the NCHD is to their educational supervisor.

» The professional reporting relationship of the Consultant is to the Executive Clinical Director.

10.5 Clinical reporting relationships

It is the responsibility of the Clinical Director of each service to ensure that the NCPSH is implemented.

10.5.1 Clinical reporting relationship for staff delivering the NCPSH in the ED

There are a number of variants of governance arrangements, as outlined below. They are based on the principle of a CNS or mental health professional of equivalent skill and training working within the ED, reporting on clinical matters to a named consultant psychiatrist.

a. **CNS or other mental health professional (MHP) working in a HSE service with a Consultant Psychiatrist-led liaison service.** The CNS or MHP work as members of the liaison psychiatry team and report on clinical matters to the Consultant Psychiatrist on that team.

b. **CNS or MHP working in a non-HSE hospital where there is a Consultant Psychiatrist-led Liaison service.** The CNS or MHP is part of the liaison psychiatry team and reports on clinical matters to the Consultant Psychiatrist on that team. In this situation there must be a close working relationship between the Area DON of Mental Health and the DON of the acute hospital to ensure a smooth professional working relationship for the CNS or MHP.

c. **Acute Model 3 or Model 4 hospital with no consultant-led liaison service.** This should only be an interim situation, as the Model of Care recommends that all Model 3 and Model 4 hospitals have access to a Consultant Psychiatrist-led Liaison service. There should be a named and funded HSE consultant in adult psychiatry to whom the CNS or MHP report on clinical matters. The introduction of an ANP would reduce the required clinical commitment from the Consultant Psychiatrist; it would allow the CNS to report to the ANP while the ANP would report to the Consultant Psychiatrist, as required.

d. **Acute hospitals with injury units and medical assessment units.** These hospitals have low numbers presenting; people who present following self-harm or with suicidal ideation should receive all four

components of the NCPSH, with a biopsychosocial assessment by the on-call non-consultant hospital doctor in psychiatry, and clinical supervision from the on-call Consultant Psychiatrist.

10.5.2 Clinical reporting relationship for SCAN service

SCAN provides a consultation service to general practice/ general practitioners. Within the service, the CNS reports to an ANP or consultant psychiatrist. The ANP reports to a Consultant Psychiatrist.

a. Within the SCAN service, all patients remain in Primary Care.

b. The CNS should discuss cases with the GP and also receive clinical supervision from a registered ANP (RANP) or Consultant Psychiatrist, depending on individual service need.

c. The mental health professional should discuss cases with the GP and receive clinical supervision from a Consultant Psychiatrist.

d. The RANP should receive clinical supervision from a General Adult Consultant Psychiatrist.

e. Where the supervision is provided by an ANP, that ANP should be allocated time to provide weekly face-to-face supervision, time to establish the service with GPs and, when required, provide input on individual cases.

f. Where the supervision is provided by a General Adult Consultant Psychiatrist, that Consultant Psychiatrist should be allocated time to provide weekly face-to-face supervision and time to develop the service with the local GPs. This will require 0.2 WTE consultants per 300,000 population.

10.6 Roles and responsibilities of staff in relation to the NCPSH

10.6.1 Role of the clinical lead in the ED

The clinical lead has overall responsibility for ensuring all patients who present to the Emergency Department will receive all 4 components of the Clinical Programme. The clinical lead is a Consultant Psychiatrist who has one dedicated session a week to provide clinical supervision to the Clinical Nurse Specialist (CNS) and/ or mental health professional appointed through the Clinical Programme.

10.6.1.1 Where the clinical lead is a Consultant Liaison Psychiatrist (CLP), the CNS/mental health professional will be part of the liaison team.

- The Consultant will provide clinical cover and supervision for the CNS/ mental health professional appointed to the programme.
- The clinical lead and CNS/mental health professional will ensure that the programme is at all times implemented; provide education and training for NCHDs and ED staff, and record and collate data as required by the NCPSH office.
- The clinical lead will support the CNS/mental health professional in ensuring they receive support and training to implement the programme.
- The clinical lead will provide support to the area management team in developing local policies and procedures for the programme.
- Particular attention needs to be paid to the need for the clinical lead to have time for personal reflection, supervision and scheduled work. In some services, this may require that general adult psychiatrists provide clinical cover for one day a week.

10.6.1.2 Where there is no Consultant Liaison Psychiatrist (CLP), the clinical lead will be a named Consultant Psychiatrist in general adult psychiatry. The service should ensure that the consultant has time dedicated to implementing the clinical programme and to providing clinical supervision for the CNS/ mental health professional. In these circumstances:

- The day-to-day clinical cover will be provided by the consultant on call or the sector area consultant.
- The clinical lead will meet with the CNS/mental health professional for at least one-hour face-to-face supervision once a week. This supervision time will be used to support the CNS/mental health professional in implementing the programme, to review the week's work, to problem-solve and to ensure that training needs are met.

- The CNS/mental health professional and clinical lead will record and collate data as requested by the NCPSH office.
- The clinical lead and local management team are responsible for ensuring that local policies are developed to implement the programme. The clinical lead is advised to link with a regional liaison consultant who can provide direction and guidance on developing these policies.

10.6.1.3 Where the clinical lead is a Consultant Liaison Psychiatrist or a General Adult Psychiatrist the following applies:

- The clinical lead should work with the clinical director in ensuring that NCHDs in psychiatry receive appropriate training in assessing and managing those who present following self-harm, or with suicidal ideation. They should also ensure that NCHDs are familiar with the clinical programme and that there be good communication between the CNS/mental health professional and the NCHDs.
- Where the programme is delivered in the ED, the clinical lead and CNS/mental health professional are responsible for providing education to the ED staff.
- Good governance requires regular (e.g. quarterly) ED-mental health service meetings to optimise communication and risk management. These meetings should include representatives from Liaison Psychiatry, General Adult Psychiatry and Management.
- The clinical lead can work with the clinical director in ensuring that there is good collaboration between the staff working in the ED and other mental health staff. This will facilitate integrating this clinical programme with the day-to-day practice of all mental health teams.
- It is the responsibility of the ECD to ensure that the clinical lead is resourced to provide time to deliver the NCPSH. The CNS/mental health professional and clinical lead are invited to the national training days organised by the NCPSH office.

10.6.2 Role of the clinical lead for the SCAN service

The clinical lead is a General Adult Psychiatrist who has two dedicated sessions a week (0.2 WTE) to provide clinical supervision to SCAN professionals and provide overall leadership for the development of the programme. The clinical lead has overall responsibility for ensuring the full implementation of the SCAN service.

The clinical lead and local area management team are responsible for ensuring the programme is implemented, including ensuring a Consultant Psychiatrist or other senior clinical decision-maker is available to provide clinical support to the SCAN professional.

The clinical lead and SCAN professional will provide education and training on SCAN for local GPs.

10.6.3 CNS working in self-harm in the ED

The Clinical Nurse Specialist in Self-Harm postholder is professionally and operationally accountable to the Area Director of Nursing or designated Assistant Director of Nursing, Mental Health Services.
On day-to-day clinical matters the CNS will report to the local named clinical lead for the Clinical Programme. They will liaise and consult with the relevant Consultant Psychiatrist pertaining to clinical matters, as required.

10.6.4 Role of the SCAN or mental health professional (MHP) working in SCAN service

This could be a CNS or other suitably qualified MHP.
The SCAN postholder is professionally and operationally accountable to the Area Director of Nursing or designated Assistant Director of Nursing, Mental Health Services/Head of Discipline, respectively.

On day-to-day clinical matters, the SCAN postholder will report to the local named clinical lead for the Clinical Programme. They will liaise and consult with the relevant Consultant Psychiatrist about clinical matters, as required.

They will report to the GP about clinical matters as required.

10.6.5 Registered ANP (RANP) working in general practice

The RANP in self-harm postholder is professionally and operationally accountable to the Area Director of Nursing, Mental Health Services.

The RANP will report to a named clinical lead in the mental

health services. They will liaise and consult with the relevant Consultant Psychiatrist about clinical matters, as required.

10.6.6 Role of the non-consultant hospital doctor (NCHD) in psychiatry

The Model of Care advises that, where possible, mental health services should ensure there is at least one CNS or equally qualified MHP available to provide assessments in the ED from 8am to 8pm, seven days a week. This may not be possible in all hospitals. When a CNS/MHP is not available, the assessments are provided by the NCHD in psychiatry, usually the on-call NCHD.

It is the responsibility of the clinical director to ensure the following:

- The NCHD in psychiatry has a working knowledge of the National Clinical Programme.
- Each patient assessed by the NCHD should be discussed with a Consultant, the Sector Consultant and Consultant on call or the Liaison Consultant. The timing of this discussion depends on the skill and experience of the NCHD. For NCHDs in their first six months working in psychiatry, all presentations should be discussed with a consultant before the person is discharged from the ED.
- All services should ensure there is immediate telephone access to a Consultant Psychiatrist for all NCHDs, both during working hours and out of hours.
- The workload of the NCHD should allow them to attend in a timely manner to each person who has self-harmed or presents with suicide-related ideation.
- Their knowledge and workload should ensure that each patient receives a comprehensive biopsychosocial assessment, that family or supportive adult input is obtained and that a written collaborative emergency care plan is developed with the patient.
- The NCHD is aware of the responsibility to inform the patient's GP of the outcome of the presentation. Information should be sent to the GP by secure elink such as Healthlink or by telephone within 24 hours of the patient's discharge.
- The NCHD is aware of the responsibility to inform the CNS the following day of all patients who presented out of hours. The CNS will provide a follow-up phone call where this is clinically appropriate. All other follow-up arrangements should be made by the NCHD, such as ensuring that information is sent to the CMHT and the GP.

10.7 Facilities and administrative support

In each ED, facilities must be available for the safe and therapeutic assessment of all patients. Standards should follow those recommended by the College of Psychiatrists of Ireland (see Chapter 3.)

Each CNS/mental health practitioner will require suitable office facilities, located close to the ED.

Each SCAN will require suitable office facilities, ideally alongside a CMHT. Assessments should be carried out in general practice if space is available. It is the responsibility of the HSE to ensure that facilities in primary care are available for use in situations where accommodation is not available in general practice.

Each CNS/MHP will require the administrative support of 0.2 WTE secretarial supports.

Each CNS/MHP will need access to a computer/laptop to submit data on each patient and to access online training opportunities.

10.8 Personal and clinical supervision

10.8.1 Personal supervision

The role of the consultant, CNS, NCHD and other mental health professionals working in the ED can be stressful. It is important they have access to both clinical and managerial supervision and support. This minimises the risk of burnout or of developing compassion fatigue, both of which have been associated with poorer clinical outcomes (Hunsaker et al 2015).

In delivering the Clinical Programme, CNSs benefit from daily clinical input from a Consultant Psychiatrist, and also from discussing all cases with a Consultant Psychiatrist. The

timing of this discussion depends on the experience and expertise of the practitioner.

Each CNS or MHP should have access to monthly formal face-to-face meetings with their administrative supervisor, i.e. ADON or senior MHP respectively. Along with reviewing clinical work, the ADON should ensure that all data is submitted and that the CNS is attending required training sessions. It is up to the immediate supervisor to identify if the CNS/MHP requires any further psychotherapeutic supervision.

Twice a year, when public health permits, the NCPSH office arranges a two-day training meeting. This provides important training and also allows networking between CNSs.

Supervision of staff leads to improved management and care planning. Supervision will be informed by trauma-informed approaches.

Trauma-informed supervision involves a facilitated reflective group that recognises the impact of secondary traumatic stress (Applegate and Shapiro 2005). Etherington (2000) suggests that the specially trained supervisor should be alert to:

- changes in workers' behaviour with and reactions to clients
- intrusions of client stories in workers' lives
- signs of burnout and feelings of being overwhelmed
- signs of withdrawal in either relationships with clients or in the supervisory relationship
- signs of stress and an inability to engage in self-care

Sommer and Cox (2005) reported that trauma-sensitive supervision should include time for talking about the effects of the work and related personal feelings; directly address vicarious traumatisation, and use a collaborative, strengths-based approach.

Cultivating the practice of reflecting on one's own emotional responses to a client is an integral aspect to trauma-informed supervision. Negative reactions to suicidal individuals in 'counter-transference' are well documented (Maltsberger and Buie 1996). The reactions of clinicians towards patients may result in feelings of incompetence, hopelessness, demoralisation, hostility and/or withdrawal from emotional involvement with the client (Hunter 2015). Balint groups are named after the psychoanalyst Michael Balint; in the late 1950s Michael and his wife began holding psychological training seminars for GPs in London. The group met on a weekly basis, encouraged doctors to discuss cases, and in a safe and supportive environment others are invited to respond to what they have heard. Since the publication of the work (Balint 1957), the Balint approach has flourished and has encouraged the development of reflective practice among GPs and psychiatrists.

Another approach, which is used in cognitive behavioural psychotherapy (CBT), is the process of self-practice/self-reflection (SP/SR), a form of personal practice for CBT that continues a long tradition of experiential group work for psychotherapists (Freeston et al 2019). SP/SR, originally proposed by James Bennett-Levy (2001), involves trainee cognitive behaviour therapists applying the CBT model to themselves and then reflecting on what they have learned by doing this. The reflections involve reflections on the content, the process and how the theory relates to their experience.

The experiential nature of this approach provides insights that are unlikely to be gained from other training methods. SP/SR outcome studies indicate that the benefits to therapists include greater empathy (Davis et al 2015), enhanced conceptual skills (Haarhoff et al 2011) and improved confidence (Spendelow and Butler 2016). This approach could also be used for clinicians delivering the NCPSH in self-harm, giving them direct lived experience of, for example, developing their own safety plan so they can develop further understanding and empathise when working with service users who experience self-harm.
There is scope to develop SP/SR groups nationally. Training should be developed and delivered to clinicians to facilitate SP/SR groups supported by the NCPSH.

10.9 Summary and recommendations

- Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver.
- The office of the NCAGL is responsible for the development, coordination, and oversight and monitoring of the implementation of the NCPSH.
- The NCPSH identifies the Model of Care and training required for practitioners delivering the NCPSH.
- The Local Area Management Team is responsible for the implementation of the NCPSH in each area.
- Staff implementing the NCPSH are employed by the mental health services and report professionally to their line manager in that service.
- Staff implementing the NCPSH work under the clinical guidance of a Consultant Psychiatrist.
- The role of the consultant, CNS, NCHD and other mental health professionals working in the ED can be stressful. It is important that they have access to both clinical and managerial supervision and support.