

THEME 4

**LEADERSHIP, GOVERNANCE
AND MANAGEMENT**

Theme 4

Leadership, Governance and Management

Aim 1

The mental health service has clear accountability arrangements in place to achieve the delivery of high quality, safe and reliable services.

Indicator 1.1

The mental health service identifies clear lines of accountability, responsibility and authority to oversee quality and safety.

These are the features that you need to have in place to meet this indicator:

1. There is an organisational chart in place, which demonstrates accountability arrangements at all levels of the mental health service.
2. The mental health service identifies clear lines of accountability, responsibility and authority to oversee quality and safety within the service.
3. Staff at all levels have a clear understanding of their accountability, responsibility and authority for quality and safety.
4. The persons identified have such responsibilities, authority and accountability identified in their job descriptions.
5. The persons who have responsibility authority and accountability for quality and safety demonstrate their awareness of their responsibilities for quality and safety.
6. Job descriptions outline responsibilities and accountabilities of all staff regarding the delivery of high quality, safe and reliable mental health service.
7. Staff are aware of their roles and responsibilities regarding quality and safety.



Aim 2

The mental health service has formalised governance arrangements for assuring the planning and delivery of high quality, recovery oriented, safe and reliable services.

Indicator 2.1

There are integrated corporate and clinical governance arrangements, throughout the service for assuring quality, risk and safety. These reflect the CHO operational plan, the national service plan and the mental health division operational plan.

These are the features that you need to have in place to meet this indicator:

1. The Community Health Organisation operational plan reflects the national service and mental health division operational plan, where applicable.
2. The CHO operational Plan reflects Department of Health and Health Service Executive policies and strategic directions.
3. There is consultation between managers and clinicians in the development of the CHO operational plan in a timely manner.
4. Managers and staff are aware of the CHO operational plan.
5. There is a clear management structure which includes corporate and clinical governance responsibilities and reporting relationships.
6. There is a local quality and safety committee in place, in line with the HSE (2016) Quality and Safety Committee Guidance and Resource document. This committee reports to the local management team and the service quality and safety committee, which in turn reports to the CHO quality and safety committee.
7. Quality and safety is an agenda item on every relevant meeting at all levels of the service
8. Minutes of meetings at all levels of the service show that discussion on quality, risk and safety taken place.
9. The minutes of all quality and safety committees' meetings demonstrate effective working of the committee and implementation of agreed actions, from meeting to meeting.
10. There are reports produced and circulated to the management team on quality, risk and safety indicators and outcomes.
11. This HSE Best Practice Guidance for Mental Health Services is actively implemented.
12. There is an escalation policy and system to ensure that quality and safety issues are escalated and dealt with at the appropriate level.

13. Quality and safety is considered in matters concerning finance. This is illustrated in the minutes of various management meetings.
14. The interests of service users and results of audits are taken into consideration when decisions are made about the planning, design and delivery of services.
15. The impact on service user safety and quality of care is a high priority in business decision-making. This is demonstrated within the minutes of management meetings.
16. A mechanism exists to support the constitution of committees and groups in the service, this includes, sponsorship, terms of reference, agendas and minutes for all meetings in the service. These are reviewed annually.
17. Management team meeting minutes are present and demonstrate consideration of progress against operational plan objectives and targets.

Indicator 2.2

An Integrated system to govern the development, dissemination, approval, implementation, monitoring and review of policies, is set, in accordance with regulations and best practice requirements.

Please read this indicator in conjunction with Theme 2- effective care and support, indicator 1.1.

These are the features that you need to have in place to meet this indicator:

1. There are policies in place to meet statutory and best available practice requirements.
2. All healthcare staff, service users, family and carers and other stakeholders are involved, as appropriate, in the development of Policies.
3. All operational policies and procedures are reviewed at least every three years or earlier if required from a legislative/service perspective, having regard to any recommendations made by the Mental Health Commission and in accordance with the *Mental Health Act 2001 (Approved Centres) Regulation 29 Regulations 2006, Operating Policies and Procedures*.
4. There are policies and procedures which sets out the development, dissemination, approval, implementation, monitoring and review, in accordance with the HSE national framework for developing policies, procedures and guidelines, (2016) and the Mental Health Act 2001 (Approved Centres) Regulation 29, Regulations 2006 Operating Policies and Procedures.

5. At a minimum, this policy includes:

- The roles and responsibilities for the development, management and review of operating policies and procedures.
- The processes for the development of the operating policies and procedures required by the Regulations.
- The processes for the approval of operating policies and procedures the process for dissemination operating policies and procedures either in an electronic or hard copy.
- The process for, reviewing and updating of policies and procedures at least every three years
- The processes for making obsolete and retaining previous versions of policies and procedures.
- The processes for training of staff including training following the release of a new or updated policy and procedure.
- The processes for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.
- The standard operating policy and procedure template and layout used by the service.

6. Each PPPG has a signature sheet which indicates that all staff have read and understand each operating policies, procedures, protocols and guidance.

7. Relevant staff can articulate the processes for the development and review of operating policies and procedures.

8. All policies and procedures are communicated and implemented.

9. Relevant staff have read and understood the policies and procedures on developing and reviewing operational policies, as set out in the policy. This is documented.

10. Obsolete versions of operating policies and procedures are retained but removed from possible access by staff.

11. The format of policies and procedures is standardised and is in accordance with the national framework for developing policies, procedures and guidelines, (PPPG 2016). This includes at a minimum:

- Title of the policy and procedure
- Reference number and revision of the policy and procedure
- Document owner
- Approvers
- Reviewers, where applicable
- Scope of the policy and procedure
- Date from which the policy will be implemented (effective from)
- The implementation plan
- The procedure (s)
- Scheduled review date - the document is re-dated after each review
- Total number of pages in the policy and procedure.
- Audit tool specific to the adoption of the PPPG in practice.

12. Any generic policies used are appropriate to the service and the service user' group profile
13. Where generic policies (e.g. dealing with complaints, recruitment of staff, etc.) are used, the service has a written statement, adopting the generic policy, which is reviewed at least every three years.
14. Each policy includes an audit tool to support audit of implementation.
15. There is an annual audit completed to determine compliance with policy and procedure review times. Analysis is completed to identify opportunities to improve the processes of developing and reviewing the policies.

Aim 3

Each mental health service/team maintains a publicly available Statement of Purpose that accurately describes the services provided, including how and where they are provided. The statement of purpose is communicated in an accessible format to all stakeholders, including service users.

Indicator 3.1

A Statement of Purpose is in place for each mental health service.

These are the features that you need to have in place to meet this indicator:

1. There is an up to date statement of purpose in place, which includes the:
 - Aims and objectives of the service including how resources are aligned to deliver these objectives.
 - Description of services provided.
 - Intended service-user population.
 - Inclusion/ exclusion criterion.
 - Models of service delivery and allocated resources.
 - Location or locations of service delivery.
2. The Statement of Purpose is signed off/approved by the CHO senior mental health management team in consultation with the mental health service team/local management team.
3. The service delivered reflects the approved statement of purpose.

4. The statement of purpose is communicated in an accessible format and is available publicly.
5. The statement of purpose is reviewed on an annual basis or sooner if there are any proposed service changes to ensure the statement of purpose reflects what will be delivered safely, sustainably and within available resources.
6. Notification of any changes is provided in a timely manner that allows stakeholders appropriate time to respond to proposed changes. Any necessary approval is sought before changes to the statement of purpose are made.

Aim 4

The mental health service has systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of mental health services, which are in compliance with relevant legislation, national standards, best practice, and any service level arrangements².

Indicator 4.1

There are systematic monitoring arrangements for identifying internal and external opportunities to improve quality and safety.

These are the features that you need to have in place to meet this indicator:

1. Data is collected from quality, risk and safety systems and used to measure and improve the service (e.g. audits, analysis, trending, complaints, risk register, safety notices, incidents, HSE nursing and midwifery metrics).
2. Information is used and shared as appropriate within and between services/agencies to inform continuous improvement and the provision of safe services; (e.g. quality and safety committees, and other areas including notice boards, journal clubs, suggestion box, survey, focus groups, sharing learning days, newsletter and conferences).
3. There are proactive measures and mechanisms in place to elicit and respond to feedback from service users, families and carers.
4. Opportunities are sought for local and national benchmarking and sharing good practice initiatives.

2. Section 38 Health Act, 2004 (as amended); Section 39 Health Act, 2004 (as amended)

Indicator 4.2

The quality and safety of mental health services provided on behalf of healthcare service providers are monitored through formalised agreements, (Applicable only to services that have service level arrangements / agreements³ with the funding body (HSE) or with external recruitment agencies⁴ / contractors).

These are the features that you need to have in place to meet this indicator:

1. A formalised, signed service level agreement is in place and is available in accordance with the national template.
2. The service level agreement specifies:
 - Scope of service provided.
 - Required standards.
 - Resources required.
 - Quality assurance, monitoring and governance arrangements for the quality and safety of services delivered, including compliance with relevant standards.
3. There is written evidence of monitoring of the agreement, in accordance with the requirements set out in the service level agreement.
4. Any non-compliance with the service level agreement are acted on and appropriate action is taken to address the non-compliances.



3. Section 38 Health Act, 2004 (as amended); Part 2 of Service Arrangements with non-statutory agencies funded under Section 38 Health Act, 2004, Section 39 Health Act, 2004, Section 10 Child Care Act, 1991, and Commercial / For Profit

4. Public Service Management Recruitment and Appointments Act 2004 (as amended)

Indicator 4.3

An up-to-date register⁵ (Approved Centre only) is established and maintained in relation to every service user as required by legislation. The certificate of registration is managed in accordance with Mental Health Act 2001 (Approved Centres) Regulation 34

These are the features that you need to have in place to meet this indicator:

1. The register of service users is in a format determined by the Mental Health Commission and the service makes available such information to the Mental Health Commission as and when requested by the Commission.
2. A documented register (electronic or hard copy) of all service users admitted to the Approved Centre is available, with accurate and current information. The register of service users contains at a minimum the following information in accordance to the *Mental Health Act 2001 (Approved Centres) Regulations 2006*, 28, Schedule 1.

- A. Full name.
- B. Address.
- C. Gender.
- D. Date of birth.
- E. Country of birth.
- F. Ethnic or cultural background.

White

- Irish.
- Irish Traveller.
- Roma.
- Any other white background.

Black or Black Irish

- African.
- Any other Black background.

Asian or Asian Irish.

- Chinese.
- Any other Asian background.

Other, including mixed background

Other, write in description

- G. Next of Kin/Representative(s).
- H. Admission date.
- I. Discharge date.
- J. Diagnosis on admission (or provisional diagnosis where diagnosis is not available).
- K. Diagnosis on discharge
- L. Patient Status, i.e. voluntary or involuntary

5. Regulation 28 Mental Health Act 2001 (Approved Centres) Regulations 2006

3. The register of service users is up to date.
4. There is a process in place to support the following, in relation to the register of service users in the approved centre:
 - The roles and responsibilities for the maintenance and access to the register.
 - A standard and agreed practice to be applied in updating and maintaining the register (to include informing relevant staff of the process for updating and maintaining the register).
 - The method to maintain the register in the format determined by the Mental Health Commission.
5. Relevant staff are informed of the processes relating to the updating and maintenance of the register.
6. The registered proprietor is responsible for ensuring that the register of service users contains up-to-date and accurate information (certification of registrations)
7. The current approved centres certificate of registration issued pursuant to section 64(3) (c) of the Act⁶, including any conditions of registration, is displayed in a prominent position in the approved centre, in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 34, Certificate of Registration.
8. Where changes have arisen in relation to the information detailed within the certificate of registration, this has been communicated to the Mental Health Commission.
9. Defined processes are available to support the following in relation to the certificate of registration.
 - The roles and responsibilities in relation to the management and display of the certificate of registration.
 - The process to review the certificate of registration and communicate with the Mental Health Commission should a change be required to the content (e.g. the number of registered beds).
10. Relevant staff are aware of the processes relating to the approved centre's certificate of registration.
11. The registered proprietor monitors the approved centre's certificate of registration.

6. Section 64 Mental Health Act 2001 (as amended)

Aim 5

The mental health service has effective management arrangements to support and promote the delivery of high quality, safe, reliable and recovery oriented services.

Indicator 5.1

Management arrangements are in place to effectively and efficiently achieve planned objectives.

These are the features that you need to have in place to meet this indicator:

1. The mental health service reviews management arrangements and identifies gaps and acts to address these gaps.
2. Effective and efficient management arrangements include the use and review of the following structures, processes and systems:

A. Workforce management

- Workforce planning is based on a documented process, in line with the assessed needs of service users, projected and actual service demand and the resources available.
- Processes for addressing issues with rosters / staff deficits.
- Attendance and absence records, policy and processes.
- Records of back to work interviews.
- Employee assistance system.
- System of agreement on annual leave and records of planned annual leave.
- Records of allocations of staff.
- System for professional development planning and review.
- System for the use and review of agency and contracted staff.
- Appropriate means of measuring demand based on acuity and activity.
- System for managing changes in demand (resource allocation, contingency plans, gate keeping policies).
- Robust Information system which facilitates workforce management.
- Exit interviews for staff.

B. Communication Management

- Terms of reference, agendas and minutes of all meetings.
- Minutes available to all relevant stakeholders.
- Clinical Handover records.
- Communication fora to improve communication (e. g. huddles, information share, broadcast, safety pause, memos).
- ICT infrastructure to support communications.
- Media management systems, Health Service Executive (HSE Land).
Detailed terms of reference for project groups, to include how they are commissioned, established, operated and terminated.

C. Information management

- Information Governance policy.
- ICT systems
- Data Protection and Freedom of Information policy.
- Safe storage of data in line with policy.
- Consent policy.
- Confidentiality agreements included in employment contracts.
- Audit of records.
- Systems to integrate service user information.
- System to actively manage information (record retention policy, healthcare records management).
- Data protection breaches reported investigated and communicated in line with policy.

D. Environment and physical infrastructure management

- Records indicating management of estates / infrastructure and environment; Compliance with Regulation 22, Mental Health Act 2001, (Approved Centres) Regulation 2006.
- Maintenance records.
- Health and Safety statement.
- Minutes of health and safety committee and infection control meetings.
- Maintenance records of portable appliance testing.
- Records of equipment testing and servicing.
- Records of environmental assessment and relevant tests (e.g. legionella testing).
- Fire register / fire safety records.
- Records of assessing, adaptation and customising the environment to meet service user's needs (e.g. safety considerations, ligature points, accessibility needs, compartmentation).
- Quality improvement and audit results being implemented.

E. Financial and resource management

- Financial and resource management system in accordance with HSE National financial regulations.
- Financial control regulation processes complied with (E.G staff above grade eight sign annual declaration)
- Committee meeting records (including audit and finance sub-committees where in place).
- Policy, system and safeguards on service user finance are aligned to national financial regulations.
- Agreed budgetary allocation in place.
- Agreed budget is appropriated managed to deliver operational plan.
- Service level arrangement and records of monitoring and compliance with these.
- Internal and external audit records.
- Evidence of implementation of actions from audits.
- Records of theft and fraud preventative measures.

F. Regulatory management

- System of notification to Regulatory Authorities and other agencies.
- Analysis of the system of notifications.
- Nominated person allocated responsibility for
 - 1) Notification of Incidents in accordance with MHC and other regulatory requirements and
 - 2) Maintenance of records in accordance with HSE Standards and recommended practices for Healthcare records management 2011.
- Compliance with Mental Health Commission Codes of Practice and Guidance & Rules and Regulations.
- Clear tracking of regulatory activity and responses taken to address breaches/conditions/recommendations/immediate action notices.
- Professional registration requirements adhered to.

Indicator 5.2

The mental health service is adequately insured⁷ against accidents and injury to service users, staff, relevant others and to the service itself.

These are the features that you need to have in place to meet this indicator:

1. The service insurance is comprehensive and covers accidents or injury to service users, staff and others, loss or damage to the assets of the service user, any services provided and the building and its contents.

2. There are defined policies and procedures in place regarding insurance and they include:

- The roles and responsibilities in relation to the sourcing, scope and payment of insurance.
- Process for ensuring insurance is in place and up to date.
- The process for required approval to renew the insurance annually, or as appropriate.
- The process for the provision of evidence of insurance to relevant individuals or bodies, including the Mental Health Commission.
- The process to be applied in the event of a claim being submitted by a service user, visitor or staff member

3. The policies and procedures are implemented

4. The policies and procedures cover the following:

- Public liability;
- Employers' liability;
- Clinical indemnity; and
- Property

5. Relevant staff are aware of the processes relating to the approved centre's insurance cover.

6. There is a process for an annual claims review with the insurance provider.

7. Insurance is in place for the number of service users in the service / centre and on the capacity of the service.

8. The Insurance certificates are available and up to date.

9. There is a review of the scope of insurance cover in accordance with any increase in the risk of injury to service users, staff, visitors or others.

10. An audit is completed of the notification to the state claims agency and to insurers for potential claims.

11. There is an indemnity scheme statement available for inspection or on request by the Mental Health Commission as provided by the HSE insurers.

12. Confirmation of insurance is available in documentary form and in date on inspection and on request by the Mental Health Commission.

7. Regulation 33 Mental Health Act 2001 (Approved Centres) Regulations 2006

Aim 6

Managers at all levels in the mental health service promote and strengthen a culture of quality and safety throughout the service.

Indicator 6.1

Managers at all levels demonstrate a clear commitment to promote and strengthen a culture of quality and safety.

These are the features that you need to have in place to meet this indicator:

1. The HSE mission statement, are in place and displayed.
2. The Health Service Executive Code of Governance (October 2015) is adhered to and includes the code of conduct and management of conflict of interest. Management staff are aware of this code.
3. Resources are allocated and training is provided to promote quality and safety.
4. Quality and safety processes are developed and evaluated.
5. The HSE open disclosure policy is implemented.
6. The Managers promote and facilitate service user feedback.
7. There is external input to improve the quality and safety of services.
8. There are management and training opportunities for staff to support quality and safety.
9. Management walkabouts and visibility of leadership occur.
10. Quality and safety issues are prioritised and included as an agenda item in all meetings.
11. There is senior management presence on quality committees and initiatives.
12. Managers sponsor specific quality initiatives.

