INSPECTORATE OF MENTAL HEALTH SERVICES

NATIONAL OVERVIEW OF EXECUTIVE CLINICAL DIRECTORS 2013

BACKGROUND

As well as formal inspection of 63 approved centres nationally, the Inspectorate of Mental Health Services seeks the views of clinicians on a regular basis. In 2012 the Inspectorate reported on the views of the disciplines of occupational therapy, clinical psychology and social work. In 2013 the Inspectorate met with the Executive Clinical Directors (ECDs) and Directors of Nursing.

On 26 November 2013, the Inspectorate met with the Executive Clinical Directors (ECD's) to elicit their views on a range of important issues in relation to the quality of mental health services.

Their views were sought in relation to 1) their experience as ECDs and 2) on how mental health service delivery might be improved. ECDs were asked to complete an online survey and were invited to participate in an open-forum discussion chaired by the Inspector of Mental Health Services.

METHOD

All 16 ECDs were notified about the survey and the national overview meeting via email. A total of 12 survey responses were received giving a response rate of 75%. Ten ECDs attended the national overview meeting on the 26 November 2013.

The online survey asked the following questions:

1. Which mental health service area do you work in?
2. How many consultant posts in your area?
3. How many consultant posts were filled by locums?
4. How many consultant vacancies were there in your area?
5. How many NCHD posts in total were there in your area?
6. How many NCHD posts were vacant?
7. To what extent were service users involved in governance in your area?
8. How embedded was the concept of governance in your area?
9. To what extent were services in your area community based?
10. What clinical outcome measures were used in your area?
11. In your opinion, what were the three most important aspects of a quality mental health service?

12. In your view, how well does the clinical governance structure work in your area?
13. How many sessions per week were dedicated to executive work?

RESULTS OF ONLINE SURVEY

Twelve ECDs responded to the survey out of a total of 16 ECDs. All respondents answered all questions.

Question 1: Which mental health service area do you work in?

There was a cross section of areas represented in the responses of the ECDs to the survey:

Area	Number
HSE Dublin Mid-Leinster	1
HSE Dublin North East	4
HSE South	4
HSE West	3

Questions 2-4

From questions 2-4 it was calculated that out of 203 consultant posts identified in the survey 14.7% of these were posts filled by locums.

Question 5-6

From questions 5 and 6 it was calculated that out of 274 non consultant hospital doctors (NCHD) posts identified in the survey 16.4% were vacant

Question 7: To what extent were service users involved in governance in your area?

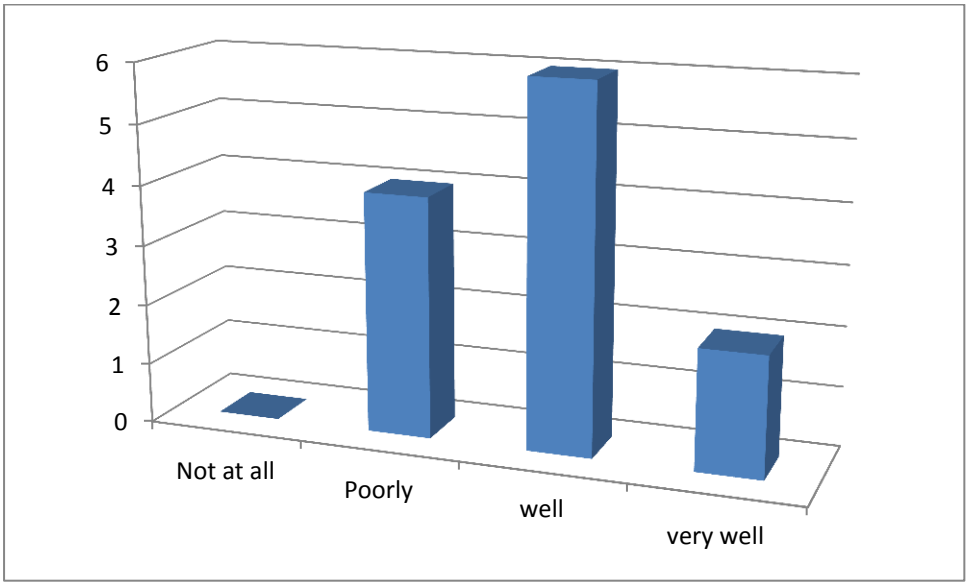

Chart 1

All 12 ECDs who took part in the survey responded to this question. In eight executive service areas service users were well or very well involved in governance. Comments included descriptions of how consumer panels were in place and that service users were on governance committees. The ECDs who responded that service users were poorly involved in governance commented that there were difficulties in service users being able to attend meetings.

Question 8: How embedded was the concept of recovery in your area?

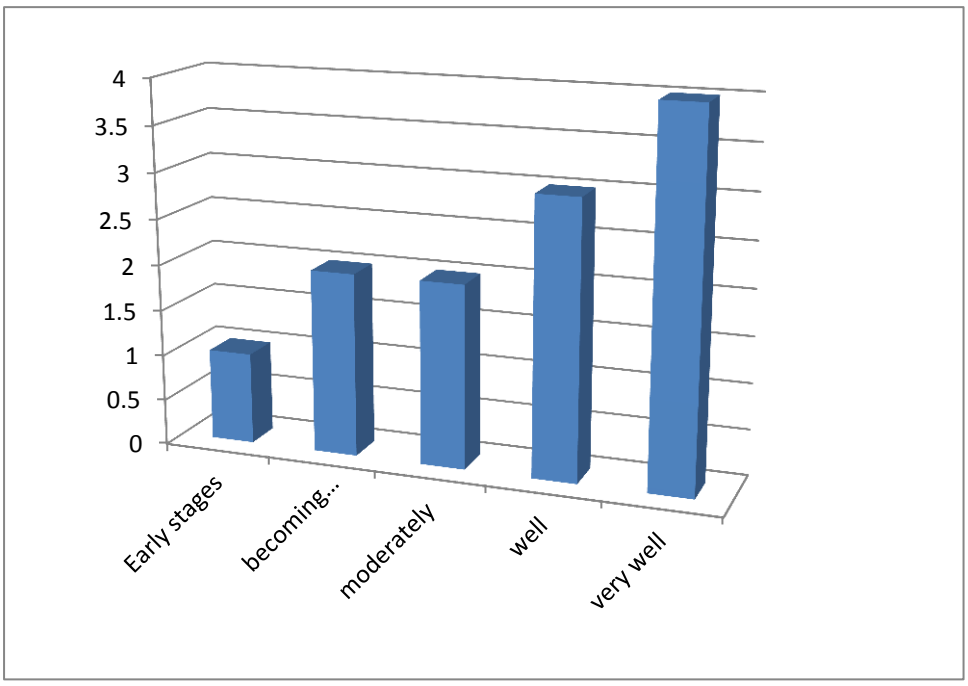

Chart 2

The responses to this question showed a wide variation in the extent that recovery was embedded in mental health services. All showed that recovery was embedded to some extent with 58% of respondents saying that recovery was well or very well embedded.

Question 9: To what extent were services in your area community based?

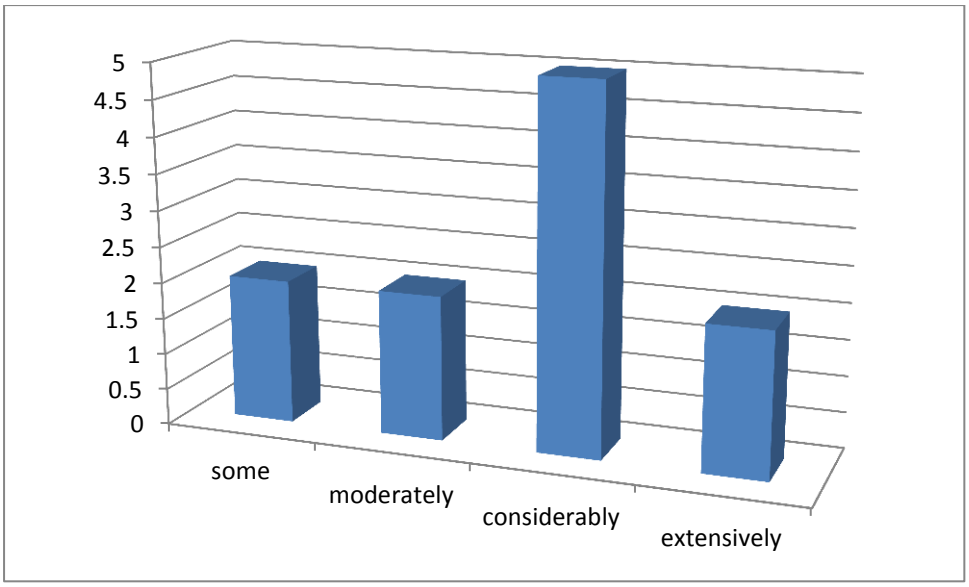

Chart 3

All service areas had at least some community services with seven considerably or extensively community based.

Question 10: What outcome measures were used in your area?

Two responses indicated that clinical outcome measures were not used or were poorly developed. Ten responses stated that Key Performance Indicators were used and two stated that they also used Health Research Board statistics. Two responses indicated that other clinical outcomes were used. These included the Recovery Star, Functional Analysis of Care Environments (FACE), Beck Depression Inventory, the Hamilton Anxiety and Depression Scale (HADS), Scale for Assessment of Positive Symptoms (SAPS) and Scale for Assessment of Negative Symptoms (SANS)

Question 11: What were the three most important aspects of a quality mental health service?

Accessibility and responsiveness to the service user were the most frequently cited important aspects of a quality mental health services. Skilled workforce, standardised evidence based practice and recovery model were also deemed important by respondents.

Aspects of a Quality Mental Health Service	Number of ECD responses
Accessibility	5
Responsiveness to individual	5
Skilled workforce	3
Evidence based practice	3
Recovery model	3

Other responses included the following as important aspects of a quality mental health service:

- MDT working
- Care Planning
- Community service
- Recovery model
- Early intervention
- Safety
- Variety of therapeutic options
- Sufficient capacity and capability
- Outcome focussed
- Strong research and educational ethos
- Excellence of treatment

Question 12: How well does clinical governance work in your area?

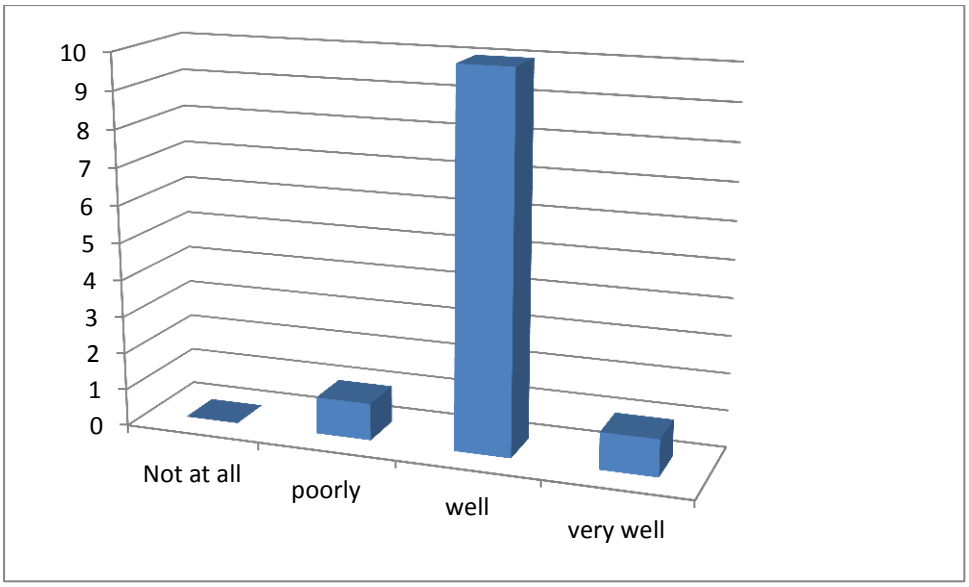

Chart 4

All ECDs except one stated that clinical governance worked well or very well in their area. Comments indicated that difficulty arose where there was interdisciplinary tension, different management structures for disciplines, imposed changes due to national policy, inability at local level to provide infrastructure, confusion regarding lines of reporting and non engagement of some consultant psychiatrists.

Question 13: How many sessions per week were dedicated to executive work?

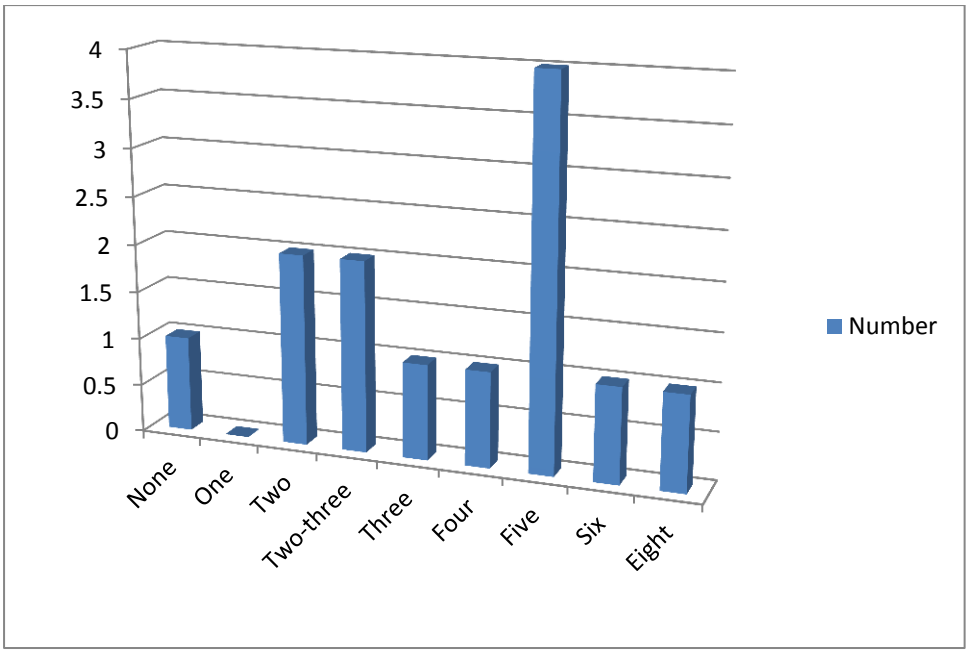

Chart 5

One ECD had no dedicated time to perform executive work. There was a wide variation in the number of sessions allowed to ECDs to carry out their executive function with one ECD having eight sessions while five ECDs had less than three sessions.

NATIONAL OVERVIEW MEETING WITH EXECUTIVE CLINICAL DIRECTORS

ECDs were invited to meet and discuss issues arising from the survey, their perspective on current mental health services and any improvements that they felt could be made in the mental health services. Ten ECDs attended this meeting. Their views are summarised as follows.

OUTCOME MEASURES

Key Performance Indicators (KPIs) were collected in all areas as were health research board statistics. However, other outcome measures were used only in pockets of the mental health service. Very often the data was not analysed by the teams who were collecting the data although some services did analyse data, for example in North Dublin. The importance of collecting measures such as diagnosis and caseloads was highlighted. The National Forensic Service collected data using the Global Assessment of Functioning and the Dundrum Toolkit which gives a series of outcome and recovery measures for a forensic setting.

Recently the National Director of Mental Health Services had surveyed ECDs regarding the use of KPIs and requested that they identify useful KPIs to monitor activity. A road show was currently underway to increase the awareness and use of KPIs by the services.

The difficulty with definitions used in KPIs was highlighted and how definitions can have different interpretations. Examples included referrals, re-referrals and waiting times.

A further number of difficulties with KPIs were outlined. All data collected was quantitative and no qualitative data was collected. Population data was not always included. KPIs were medical-activity based and did not reflect multidisciplinary team (MDT) activity. It was felt that KPIs might therefore under-represent what activities were taking place.

Current activity data is focussed on timely access to both general adult and psychiatry of old age community mental health teams. Since all referrals to each service are assessed by medical staff this data collects medical activity only. The National KPI Group are piloting intra team referrals in Dublin North City to ensure the activity of all members of each community mental health team is collected. This will demonstrate service users have access to a range of therapeutic inputs. ECDs have been very active in supporting this process.

Each service had their own system of collecting data and the ECDs felt that one system should be in use. A small number of services such as the Mid-West area had an IT system to aid in data collection. The absence of a national IT system was

highlighted and it was stated that that a national IT system would be in place within 3-5 years.

COMPLIANCE WITH REGULATIONS

Three different ways of improving a service were outlined: (1) compliance with Rules and Regulations (2) quality improvement (3) Activity Monitoring. There was debate as to whether compliance with Regulations necessarily equalled a quality service.

The suggestion was made that ECDs and Directors of Nursing accompany the inspectors on inspection in order to gain greater insight into compliance requirements with the Rules and Regulations.

Some areas had appointed a compliance officer in order to increase compliance. However this impinged on that staff member's clinical time. Also it was stated that compliance officers did not change practice and that a better service was obtained through cycles of audit. It was felt that compliance officers should have a clinical background.

INDIVIDUAL CARE PLANS

The fact that according to the Mental Health Act 2001 (Approved Centres) Regulations 2006, S.I. No. 551 of 2006 the absence of even one care plan gave rise to a non-compliant rating was seen as a difficulty. It was felt that the Inspectorate would deem a service non compliant if the care plans were not completed according to the definition[1] in the Regulations and without comment on the substance of the care plan. ECDs agreed that they have an important governance role with responsibility for ensuring the completion of individual care plans.

Care plans needed to be relevant to practice and be appropriate for the patient group. If a care plan was clinically relevant and meaningful then multidisciplinary staff would engage with it.

Some ECDs were of the view that service users did not always want to be part of their care planning process. However it was important to engage with patients about their care plans and to record this.

It was suggested that a checklist may be useful in ensuring compliance with individual care plans.

[1] Definition of "Individual Care Plan" means a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation.

Reference was made to the Mental Health Commission's Guidance Document on Individual Care Planning which contained a sample template and an audit tool.

SERVICE USER INVOLVEMENT

How to establish a Consumer Panel was discussed. Some areas had difficulties in ensuring the attendance of service users and advocates on management teams. The importance of training and support was highlighted. Two service users should be involved in such meetings.

INTEGRATED SERVICE AREA REVIEW

Difficulties were expressed with regard to the Integrated Service Areas (ISA) as these were in a process of change. An ISA review had almost been completed. There was concern that this change could undo good work such as the amalgamation of Waterford and Wexford. It was the understanding that ECDs will map onto the new Integrated Service Areas.

DIFFICULTIES

ECD's were asked the main difficulties facing them within the mental health services. The responses were as follows:

Beds: There were difficulties in accessing accommodation for patients who did not have a place to go. There were a large number of patients who were long stay in acute mental health care who were difficult to place in accommodation. North Dublin had a particular difficulty in acute beds with a ratio of 13.5 beds per 100,000 (*A Vision for Change* recommends 17 per 100,000) (50 per 300,000).

Funding and cutbacks: Funding issues and cutbacks were a particular difficulty in large geographical areas. Mileage had been cutback by 25% and community staff had run out of travel allowance and could not carry out their role.

Staffing: The loss of staff had resulted in loss of expertise and some staff were being replaced by basic grade staff with little experience. Also there were vacant consultant posts and agency staff were filling these posts.

Change: There was a difficulty in trying to plan when the services were subject to change. For example it was difficult to plan services in Louth/Meath as this area may soon be changed either to Cavan/Monaghan/Louth/Meath or Cavan/ Monaghan/Louth.

ECD Job description: A uniform practical interpretation of the role of ECDs needed to be articulated.

Homelessness: The National Forensic Service had a particular problem with the discharge of patients back to prison and the difficulty in monitoring these patients. People leaving prison had a difficulty in re-engaging with catchment areas.

Unions and change: On occasion industrial relations issues around change made progress difficult. It was also noted that morale could be low especially in areas where there was change occurring.

Dedicated time for ECDs: One ECD had no dedicated time for executive work. A uniform allocation should be identified.

Medical manpower Medical recruitment was in difficulty and the quality of NCHDs was not always consistent. There was difficulty in recruitment in a location where there was no university. Retention of staff was also difficult.

CONCLUSIONS

There were 16 ECDs working in the mental health services in Ireland in 2013. Twelve completed the on-line survey and ten attended the overview meeting.

Medical manpower was an issue of concern for all ECDs. The survey showed that out of 203 consultant posts identified in the survey 14.7% of these were posts filled by locums and that out of 274 non consultant hospital doctor (NCHD) posts identified in the survey 16.4% were vacant.

Most ECDs stated that governance worked well or very well in their area. However the dedicated time for executive work varied between no dedicated time and eight sessions. There was also no job description for ECDs. Sixty-six per cent of ECDs said that service users were well or very well involved in governance.

There were difficulties in obtaining meaningful outcome measures. While all services collected KPIs, other outcome measures were only collected in some areas. Different methods of collection and definitions used in KPIs added to the difficulty. Quantitative data was collected while qualitative data was not. The KPIs collected medical data rather than data from the multidisciplinary team. The lack of a computerised system nationally was highlighted.

ECDs were concerned about compliance with Regulations and the provision of a quality service. This was particularly relevant in the case of individual care plans. There was agreement that care plans should be meaningful and relevant. ECDs agreed that they had a responsibility to ensure that care planning was operational but that it was also the responsibility of the multidisciplinary team.

Most services were community based and recovery was in the process of becoming embedded in each area. Accessibility and responsiveness to the service user were seen as important aspects of a quality mental health service as were having a skilled work force, a recovery model and evidence based practice.