NHS GG&C Adequate Time Given to Clinical Leaders

(Time to Lead)

Standard Operating Procedure (Psychiatry)

This is a companion SOP to the high level NHS GG&C SOP, and considers the requirements of the HCSSA Duty 12IH (the duty to ensure adequate time given to clinical leaders) in relation to the medical specilaity of psychiatry.

The Act defines, as a minimum, that three key leadership roles are considered:

- To supervise the meeting of the clinical needs of patients in their care
- To manage and support the development of the staff for whom they are responsible
- To lead the delivery of safe, high quality and person-centred care

It is mandatory to refer to the HCSSA "leadership considerations list" (Appendix 1) when deciding who holds the Clinical Leader role. In Psychiatry the Clinical Leader will be the Clinical Director who can devolve responsibility to Clinical Leads as per their staffing profile. The DMD should ensure the Clinical leads have adequate time to lead and resources to fulfil their duties.

There are 11 Clinical Directors across MHS in NHS GG&C. Each has responsibility as Clinical Lead for the medical staff employed in their sector. They can delegate responsibility to Lead Clinicians as per their staffing profile.

The Clinical Directors will advise the Chief of Medicine and Deputy Medical Director about any issues which require to be escalated from their individual sector.

Time and Resource Allocation to carry out leadership activities is guided by NHS GG&C job planning process using Allocate.

In this specific role, the time allocation in the postholder's job plan is contingent upon the number of medical staff they manage, their responsibilities for management of resident doctors and the number of Lead Clinician's working in their sector. This will be agreed at job planning.

In this specific role, there will be an allocation of administrative support provided through current administrative staff and input from the rota co-ordinator for those managing resident doctor rotas

In order to ensure a high level understanding of the HCSSA, the named Clinical Leader has completed the TURAS Skilled Level module on (date) _____

Protecting and Evidencing Time to Lead

Until such times as the SafeCare system is available for use, and can capture Time to Lead, existing systems to monitor Time to Lead should be utilised. These will be included in annual job planning exercise.

If the Clinical Leader is not able to take their Time to Lead and this time is, for instance, diverted to direct patient care or operational management pressures, this should be identified, recorded and escalated to the Chief of Medicine and the Deputy Medical Director

Severe and Recurrent Risks should be identified via a monthly review of the incidents of Time to Lead being unable to be protected as above, included as a recurring item at the monthly CD management meeting. DATIX should be used to record incidents of severe and recurrent risk to protecting Time to Lead. Each month the local Senior Management Team should review the incidents in the previous month and use this data to inform the likelihood and impact of the staffing risk occurring. The controls in place should be reviewed and actions identified to prevent a recurrence. Each action should have an owner and a due date. The Risks should be discussed at each monthly SMT meeting. When there are increased risk levels, discussion should be held to ensure appropriate actions have been identified. The Risk Register Policy and Guidance for Managers must be used to systematically identify, analyse, evaluate and manage risks consistently and at an appropriate level. Risks are assessed on impact and likelihood using a 5x5 impact matrix as noted in the Policy.

Assurance and Reporting will be carried out and provided in quarterly reporting commissioned by the Board on behalf of the Boards lead clinicians, which is made available to HIS. This will also contribute to assessment and the Board's annual submissions to Scottish Government

Appendix 1: Leadership considerations specified by the Act

This list must be consulted before defining who is a Clinical Leader:

Requirement Yes/No

1. Oversight of care delivery including enhancing patient experience

2. Clinical supervision and observation of clinical practice

3. Supporting improvement and promoting reflective practice

4. Inspiring patient confidence by setting and maintaining high standards of care

5. Visible leadership

6. Direct management of staff (including rostering, appraisals, PDP, recruitment etc)

7. Budget management (rostering, procurement, effective use of resources etc)

8. Investigation and management of adverse events, complaints and staff performance

9. Lead on quality improvement and change in a clinical service

10. Act as a role model for colleagues, and setting standards for care delivery

11. Promoting and maintaining psychological safety within the team

12. Using patient feedback to support improvement

13. Implementing real-time staffing assessment and risk escalation procedures

14. Running the common staffing method (where applicable)

15. Contributing to reporting compliance

This list is not exhaustive and should be considered in conjunction with the other duties of the Act particularly the duty to have real-time staffing assessment in place (Duty 12IC).