NHS GG&C Adequate Time Given to Clinical Leaders

(Time to Lead)

Standard Operating Procedure

Orthotics

This is a companion SOP to the NHS GGC Board Time to Lead SOP, and considers the requirements of the Health and Care (Scotland) Staffing Act (HCSSA) Duty 12IH (the duty to ensure adequate time given to clinical leaders) in relation to the profession of Orthotics, which is a named profession within HCSSA.

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. Once Clinical Leaders have been identified, the organisation has a duty to ensure they have adequate time to lead and resources to fulfil their duties.

The specific service area being considered in this document is Orthotics

The clinical leaders in this service area are considered to be:

- Orthotic Clinical Lead/Manager
- Orthotic Clinical Team Lead/ Deputy Manager
- Orthotic Assistants Team Lead

Time and Resource Allocation to carry out leadership activities is guided by NHS GGC Orthotic job planning and yearly PDP&R via TURAS appraisal.

In order to ensure a high level understanding of the HCSSA, all Leads will complete the TURAS Skilled Level modules.

Protecting and Evidencing Time to Lead

Where the Clinical Leader is responsible for staff appraisals or job plan reviews, the annual completion rate is a quantitative measure of one aspect of leadership.

Systems for evidencing Time to lead in Orthotics:

- Orthotics utilise 'SafeCare' to capture Time to Lead mitigation required.

- MS shifts for rota planning and communication.
- TURAS appraisal is used to capture development activities and takes place a minimum of once a year.
- Job planning takes place for staff the Clinical Leader is responsible for, and is captured on a standard template linked to Job descriptions.
- Findings from imatter surveys to evidence staff wellbeing and satisfaction.

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 a manager (who is responsible for consideration of mitigations and/or further escalation as per the Orthotics Real Time Staffing SOP. This escalation takes place using red flags within 'Safecare'.

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, carried out by the Orthotic Clinical Team Lead/ Deputy Manager and the Orthotic Assistants Team Lead and the Orthotic Clinical Lead/Manager.

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:

No.	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).