NHS Greater Glasgow and Clyde

FAQ - Medical

	Question	Answer
Q1	**Does the Act prescribe minimum staffing levels?**	No. It is up to the Health Board to consider and provide processes to ensure appropriate staffing, for the needs of the patients within each clinical area. Sometimes this can be multi-disciplinary / professional.
Q2	**Does this mean there is more funding for staffing?**	No. The Act does not come with specific or extra funding but should allow senior decision makers to have a better knowledge of any staffing issues in each area.
Q3	**What are my responsibilities?**	As a doctor at any level, you already have a professional duty to ensure your patients get the best care. If there is a staffing issue impacting on patient care, and it is within your control to fix it, you have a duty to do so. If you are not able to fix it, you have a duty to escalate higher up the management chain. You must ensure that you know the local process for doing this. As a 'Clinical Leader' you will have a real time view of staffing requirements and some authority to mitigate and escalate problems and communicate with staff. As a senior doctor in a management role, you are responsible for mitigating or escalating as appropriate and communicating decisions with staff. Senior management are responsible for decision making on accepting risk if no mitigation is possible. The Act requires that you have a system to record and report this, for example Datix.
Q4	**Who is the 'Clinical Leader'?**	This will vary with service, but will be someone with a responsibility for rotas, duty allocations etc and who has authority to redistribute staff or place extra staff. Additionally, they will have time in their job plan for this role and are responsible for ensuring staff are familiar with the Act and more broadly are suitably trained for their roles. The responsibilities of the clinical leader may be shared by different team members, eg the duty rota may be administered by a registrar and the Clinical Director may have the authority to ensure staff training and to authorise agency use.
Q5	**What do we mean by mitigation?**	Once a staffing issue is identified, the first step is to try and mitigate the impacts, so that patient care is not affected, so if a doctor phones in sick, the clinical leader might for example move another doctor from another well-staffed area, cancel non-essential work to move a doctor to cover emergency work, bring in bank staff, use other members of the MDT etc.

Q6	**What If I don't agree with the mitigation plans?**	If you are involved in the staffing issue, the Act puts a duty on the clinical leader to discuss and communicate the mitigation actions to you. If in your opinion the mitigation is not appropriate, the Act requires that there is a mechanism for your objections to be recorded and the mitigation reassessed. How this will be recorded is being developed.
Q7	**Why are bank/agency costs supposed to be restricted to 150%?**	One of the aims of the Act is to reduce the use of high-cost agency and use this type of resource in a more cost-efficient way. Normally extra hours/bank/agency use should not exceed 150% of the cost of an equivalent employee's normal hourly rate. This is not however an absolute. The service can exceed this cost, but every time this happens, it must be recorded along with an explanation of the circumstances and included in the routine reports to Scottish Government.
Q8	**What if my unit is always short staffed?**	You have a duty, as above, to mitigate and / or escalate as appropriate. Senior decision makers have a duty to review Datix and other information to identify areas of recurring and severe risk. This then puts a responsibility on the Health Board to consider mitigations to reduce that risk, this could include service re-design.
Q9	**Can non-clinical managers make staffing decisions?**	The Act specifies a duty to seek clinical advice for any staffing interventions, so no decisions can be made without appropriate clinical input.