NHS Greater Glasgow and Clyde

Adequate Time given to Clinical Leaders (Time to Lead)

Standard Operating Procedure

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Background

Duty 12IH is about Lead Professionals having the time and resources to ensure appropriate staffing and sits alongside all the other professional duties and responsibilities they might have. This SOP will refer to this individual as a Clinical Leader.

Purpose

This Standard Operating Procedure (SOP) supports Health Care Teams within NHS Greater Glasow and Clyde (NHSGGC) to fulfill the requirements of the Health and Care Staffing (Scotland) Act 2019 (HCSSA).

Duty 12IH: The duty to ensure adequate time given to clinical leaders

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

- To supervise the meeting of 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

To meet the HCSSA requirements, NHSGGC must determine sufficient time and resources for each Lead Professional who is responsible for a team of staff.

This SOP must not replace Sector/Health and Social Care Partnerships (HSCPs) SOPs and should complement and provide guidance and consistency. All Sectors/HSCPs must review their SOPs to ensure they align with this SOP and the Act. If areas do not have SOPs in place they must be developed.

Scope

The duties in this SOP apply to Clinical Leaders who sit within a profession named within the HCSSA. This applies to both hospital and community-based colleagues employed by NHSGGC and associated HSCPs.

The named professional list can be found using the link below.

Roles in scope of the Act - Health and Care (Staffing) (Scotland) Act 2019: overview - gov.scot (www.gov.scot)

The list is regularly updated, and mainly includes colleagues who are regulated by a professional body (e.g. General Medical Council, Nursing and Midwifery Council, Health and Care Professions

Council, General Pharmaceutical Council, General Dental Council) though some healthcare support worker roles are also included.

Definition

The Act does not attempt to define which roles align with the Clinical Leader, rather it is left to NHSGGC and individual teams to define who a clinical leader is.

A Clinical Leader is the individual who has **lead clinical responsibility** for a group of staff. Duty 12IH applies specifically to these individuals. It is mandatory to refer to the HCSSA "leadership considerations list" **(Appendix 1)** when deciding who holds the Clinical Leader role.

The term "clinical" is used in its broadest sense and is applicable to all professions in scope including those without a directly patient facing role.

Appendix 2 contains examples of job titles that are likely to align with the Clinical Leader role. It is recognised that others not on this list may be appropriately designated as a Clinical Leader if that is the best fit for the team.

Time and Resource Allocation

Once Clinical Leaders have been identified, the organisation has a duty to ensure they have adequate time to lead and resources to fulfill their duties. The adequacy of time to lead is not defined in the Act.

The HCSSA statutory guidance is to "use existing arrangements/governance to discuss with individual clinicians and decide what sufficient time and resources looks like for them".

Individuals may need support from other staff to carry out their clinical duties e.g. admin time, which should be a reasonable resource in line with the guiding principle of allocating staff efficiently and effectively.

In addition to having adequate training, skills and knowledge for a leadership role, the Clinical Leader requires a high-level understanding of the Act, for example from the TURAS knowledge and skills framework "Health and Care Staffing in Scotland" at the Skilled level. This module is linked below.

Learning resources : Skilled level | Turas | Learn (nhs.scot)

Appendix 3 has examples of professions with job roles and time allocation.

Protecting and Evidencing Time to Lead

Providing Clinical Leaders with time to lead is key to the successful implementation of the HCSSA.

There is a process underway to migrate all teams onto the SafeCare platform (Allocate RLDatix UK) for real-time staffing. In addition to its other functions, this meets the HCSSA requirements for recording time to lead.

In the short-term teams should evidence time to lead using existing processes. Nursing staff can access SSTS to record leadership time. Job planning (particularly e-job planning) can be used alongside personal work diaries, and Turas appraisal and these will be the main mechanisms for other colleagues in scope. Additional sources that may be appropriate include: iMatter surveys, and reflective practice. 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.

The organisational leadership must ensure that mitigations are in place to protect this time against clinical workload and operational management pressures.

If the Clinical Leader is unable to take their time to lead, teams should have a process whereby this is identified, recorded and escalated to a more senior manager who is obliged to consider further mitigations and/or further escalation. This process is detailed further in the RTS and Risk Escalation SOP. The Clinical Leader or any other team member is able to disagree with the actions taken and ask for this disagreement to be recorded. If the Datix Incident Module is used to track this, it is important to note that this is not a real time system, but rather records events for a review and final approval within 28 days.

An example of how this might work in practice is contained in **Appendix 4.**

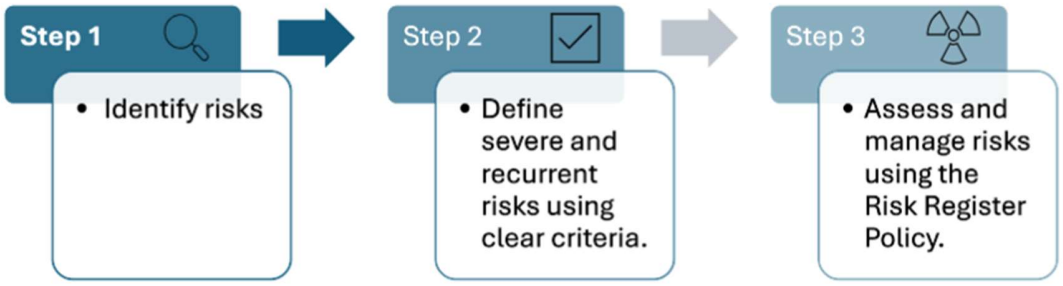
Severe and Recurrent Risks

Severe and recurrent risks are not defined within the Act; the definitions found within this SOP have been adopted by NHSGGC.

A risk is an uncertain event which can have an impact on an organisation's ability to achieve its objectives. To prevent the risk from occurring controls and mitigation actions are required to manage the risks.

An incident is any event or circumstance that led to unintended or unexpected harm, loss or damage. A near miss is as a result of chance or intervention; the outcome could have led to

harm but on this occasion it did not.



To identify areas of severe and recurrent risk, NHSGGC Senior Decision makers and Managers within each Directorate / Sector / HSCP shall review monthly:

- Staffing Datix incident reports
- Rosters SSTS or Optima eRoster (where appropriate)
- Locally held records, such as Site Safety 'Huddle' meeting templates or SafeCare (if utilised), should be reviewed for staffing-related incidents. This includes:
  - Assessment of National RAGG Status (both before and after mitigation)
  - Documentation of escalation processes and outcomes
  - Recording of mitigations, including any clinical advice provided
  - Noting and tracking any disagreements arising during staffing management

Senior Decision makers and Managers within each Directorate / Sector / HSCP are required to identify these risks by applying the agreed definitions outlined below.

Severe Risk

Red Flag (holding RAGG-unmitigated staffing concern)

Recurrent Risk

- Recurrent risks are captured through the frequency of RAGG status whereby Safe and Appropriate Care is potentially compromised (AMBER/RED) before and after mitigation (Professional Judgement actions)
- The frequency of RED flags (escalation) that identify a reduction in staff or patient experience, increase in concerns raised about service delivery and/or safety (i.e. Voiced Care Concerns, Business Continuity and staff wellbeing red flags)
- The frequency in which mitigations are detrimental to the delivery and quality of service (Professional Judgement Actions – cancelling clinical activity, non-clinical activity, Clinical Lead takes a workload, cancel training)

Each Directorate / Sector / HSCP is required to adhere to the Risk Register Policy and Guidance for Managers to identify, analyse, evaluate, and manage RTS and Escalation risks consistently.

Monthly reviews of severe and recurrent risks require to be conducted to ensure that Risk Scores accurately reflect current level of risk. Responsibilities for preventative actions should be assigned, with corresponding owners and deadlines. These risks are to be discussed at Senior Management Team meetings, with relevant actions identified, recorded, and reported through applicable governance structures and partnership forums.

Severe and recurrent risks are managed within the Datix Risk Module. If HSCPs use an alternative risk register or policy, the Excel Risk reporting spreadsheet, compliant with NHS GGC Risk Scoring, must be completed and submitted with quarterly HCSSA submissions.

The GGC Risk Management process has an escalation process in place for the management of risks, which would result in a risk being removed from the current Risk Register and escalated to a higher management level risk register. However, for Safe Staffing Risk there should be a staffing risk identified, as a minimum, at Directorate / Sector / HSCP level. These risks should be used to record the level of Safe Staffing Risk within each area, along with details of all controls currently in place and additional actions required. The current score for the risks should reflect the current risk score based upon the number of defined severe and recurrent risks that have occurred over the previous month. This enables a clear risk profile to be created across NHSGGC. To ensure this process is visible, the risks should be managed at Directorate / Sector / HSCP level and not escalated to a higher level (i.e. Acute Divisional). This to ensure that there is visibility across Directorates of the staff risk level and escalation of risks to Divisional would prevent this happening.

Instead of escalation a process has been developed by the Health and Care Staffing Oversight Programme to monitor the level of risk within each Directorate / Sector / HSCP. Severe and Recurrent Staffing Risks across NHSGGC undergo quarterly review by corporate team members. Each Directorate / Sector/ HSCP provides a quarterly report outlining current risk scores, any changes, and planned mitigation actions for both HCSSA quarterly and annual reporting purposes. This enables overall visibility of level of current risk across Directorates / Sectors / HSCPs, and clear identification of the areas of highest risks or where further action is required.

Assurance and Reporting

Senior Management teams must provide a quarterly report on their Staffing Risk which includes the current risk score and changes over the last quarter. This should include details of the mitigating actions planned to inform the quarterly board report. The GGC Risk Management Strategy details the Risk Hierarchy in place for the escalation of Risks. For example, Risks escalated from Sector Director would be escalated to corporate director. A high level summary is then provided as part of the quarterly assurance reporting.

Job Descriptions

It is anticipated that any adjustments to working arrangements will be accommodated through existing job planning processes. Where appropriate, this may require advice and support following the Job Evaluation process.

Job Evaluation - NHSGGC

New appointments, job adverts and job descriptions (for those who will have a Clinical Leader function) should incorporate the language of the HCSSA. Teams can take guidance from the NHS Scotland NHS job templates and NHSGGC's Job hub.

NHS Scotland | Jobs | Search here for your perfect career - Jobs Page

Appendices

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).

Appendix 2: Job roles that are most likely to align to the Clinical Leader definition by profession.

Profession	Best fit job role	Comments
Medical and Dental	Clinical director OR Lead Clinician/associate Clinical director	For larger teams, subspecialty groups may have a lead clinician structure whereas smaller ones may only have a CD
Nursing and Midwifery	Senior Charge Nurse (SCN)/Midwife (SCM) OR Charge Nurse/Midwife OR Team Leader	The SCN/SCM role is likely to align best for the majority of teams, but where the structure is such that the Team Leader has a largely operational role, the Clinical Leader could be at the Professional Nurse Lead/Chief Nurse/Chief Midwife level.
Pharmacy	Band 8 Advanced Pharmacist (and above)	
Pharmacy Technician	Band 6 (and above)	
Health Care Scientists	Professional Lead OR Team Lead	There are multiple different professional structures within this group
AHP	Professional Lead OR Team Leader	This group covers a variety of professionals and team structures
Psychology	Professional Leads for Psychology OR Consultant Clinical/Counselling Psychologists OR Principal Clinical/Counselling Psychologists	Psychologists are often embedded within a multi-disciplinary structure. Depending on their specific role, they can be the Clinical Lead for psychology staff or MDTs providing Psychological Therapies and Interventions.

Appendix 3: Examples of time allocations, team sizes and numbers

Profession	Time allocations	Team sizes	Numbers	Comments
Medicine Clinical Director	4 to 8hrs per week	Variable	Approximately 40 in Acute	Time allocation is by individual negotiation and can be evidenced by e-job planning.
Nursing and Midwifery Senior Charge Nurse/Midwife	15hrs per week	Variable	Variable	This can be evidenced by job plans and SSTS.

Appendix 4: Example of time to lead process within a team

The Clinical Leader of a team has protected leadership time on a Monday. They have planned to supervise and train a less experienced team member performing a procedure on a patient. However, due to unplanned absence the team is short of staff. The Clinical Leader uses the area's real-time staffing SOP (see NHSGGC Health and Care Staffing (Scotland) 2019 Real-time staffing SOP) to address this. The Clinical Leader (or a more senior decision maker) mitigates the staffing issue by converting protected leadership time to clinical /case holder time. The staffing for the unit is now appropriate to provide the safe and high-quality care required by the Act, but this is at the expense of a staff member not getting the planned training. The SafeCare (or equivalent) system would record loss of time to lead as the staffing mitigation. Anyone involved, including the Clinical Leader (if the decision has been made at a higher level) has the right to disagree with this plan and ask that it is reviewed and the disagreement recorded. It would normally be the Clinical Leader's responsibility to do so.

This may be all that is required if this is an isolated incident. However, if something similar is happening to the Clinical Leader's leadership time every Monday there is a cumulative negative effect on team performance, potentially meaning the Clinical Leader cannot do staff appraisals or there is a delay in accessing the appropriate training. In the language of the HCSSA this has the potential of becoming a "severe and recurrent risk".

The Clinical Leader should record incidences where time to lead is not protected using a system such as the Datix Incident Reporting module and/or local recording e.g. huddle templates.

Senior decision makers responsible for the team will review the output of these systems to identify that time to lead is not being protected and are obliged to put in place mitigations to protect this time in the future.

So it may be that staffing within the team is changed to have an additional member of staff available or skill mix is reviewed to include more senior members of staff on a Monday to allow the Clinical Leader to undertake their leadership duties on a reliable basis.