**Real Time Staffing and Risk Escalation SOP-Psychology**

This is a companion SOP to the high-level NHS GG&C RTS and Risk Escalation SOP. This SOP relates to 12IC Duty to have real-time staffing assessment in place; 12ID Duty to have risk escalation process in place; 12IE Duty to have arrangements to address severe and recurrent risks; and 12IF Duty to Seek Clinical Advice on Staffing. These duties are to ensure appropriate staffing for the health, wellbeing and safety of the people in our services, the provision of safe and high-quality health care and, in so far as it affects either of these matters, the wellbeing of staff.

All staff have access to education and training to inform them about the Act

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

Education and training is in place for staff with leadership roles in the Act

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

Management teams must identify the Lead Professional(s) (LPs) in the teams/settings

**Duties 12IC and 12ID require people with Lead Professional responsibility (clinical or non-clinical) to have specific responsibilities for the mitigation and escalation of staffing risks identified by members of staff or patient/family/carers. A Lead Professional is someone with a leadership role in a particular setting in relation to staffing (clinical or non-clinical).**

*Example 1. The Consultant Psychologist in the service is the Team Lead and operationally manages a range of Applied Psychologists, Psychological Therapists and admin staff. They are identified as the Lead Professional for the service. Any member of staff, or patient/family/carer, can raise a concern about staffing to the Lead Professional. For instance, concern is raised that a member of Psychology staff has had a short term (considered up to one month) absence from work for two weeks and no contingency plans have been enacted to review or reallocate their caseload. The Lead Professional is responsible for acknowledging any concern expressed and considering any steps required to mitigate the issue or escalation required. At this stage, the Lead Professional is satisfied that all patient appointments have been cancelled and plans to wait and see if the member of staff returns to work in the coming week and before they have been absent for 1 month.*

*Example 2. The Consultant Psychologist manages a small team of Psychology staff and is responsible for the Psychology provision in a large multi-disciplinary team. They are identified as the Lead Professional for the Psychology service within the multi-disciplinary team.*

*Example 3. The Lead Professional for a small multi-disciplinary team is the Nurse Team Lead. The sole qualified Psychologist in the team has no responsibility for staffing in this team.*

The LP in the setting carried out a 'staffing meeting' a minimum of once per day

**'Staffing meetings' must occur a minimum of once per day. They can be in many forms, including for instance a huddle or an email exchange. In very small Psychology Teams, the LP's general awareness of staffing on the day is likely to be sufficient.**

Each service's vulnerability to staffing risk will vary based on a range of factors, such as the substantive resource for the service (a service staffed by one individual postholder versus a staff group of eight postholders has less resilience during unplanned leave), services funded on non-recurring funds, demand-capacity, type of service delivery e.g., inpatient/outpatient, integrated team working service model, and local/specialty context.

*Example1. The Consultant Psychologist/LP has oversight of all Psychology staff expected to be working on any given day. When a member of staff calls in sick, they note this and take the necessary actions to cancel appointments and other diary commitments. When this occurs when the Consultant Psychologist/LP is absent from work, admin staff take a message and pass this to their deputy at the earliest opportunity. Admin staff update SSTS of the absence.*

*Example 2. A member of Psychology staff calls in sick. In their team, the Lead Professional is the Nurse Team Leader, therefore they report their absence to the Nurse Team Leader.*

*Example 3. The sole qualified Psychologist in the team reports their unplanned absence to the Team Lead. The Team Lead is the identified Lead Professional with a leadership role for staffing in the team. The Team Lead takes the necessary steps to record the absence, cancel patient appointments and consider any required mitigations associated with the absen*ce. *The Lead Professional is aware that they are assessing risk, or making a decision, in relation to a clinical workforce for which they are not professionally responsible and making a decision in a specialty in which they are not an expert, therefore they seeks clinical advice from the local Psychology Professional Lead regarding the risks associated with the staff absence.*

Where the LP is unable to mitigate the staffing issue which is causing a risk, the LP escalates staffing risks to a 'more senior decision-maker'

The parameters of what constitutes 'safe staffing', and subsequent risk categorisation, in a service must be compiled by the clinical service lead in collaboration with their staff group and operational

managers, based on the existing service model. These must be approved by the NHS GG&C Professional Lead for Psychology, amongst other key stakeholders. Variation between services is expected. Service models in Psychology Services are usually such that daily staffing may not be a significant concern when unplanned absence occurs due to short term sick leave and it would not have a major impact on service provision; however, if a service has a pre-existing high number of vacancies, even a single unplanned absence may adversely impact. Due to the nature of psychological interventions, therapeutic alliance and relational aspects of many interventions, reallocation to another Psychologist or Psychological Therapist would not usually occur during periods of planned leave, or during short-term periods of unplanned leave (for instance, up to one month). This difference in service model, compared to parts of service that provide access to acute treatment, means that the mitigation of unplanned leave involving the use of Bank staff would rarely occur.

*Example. A member of staff has been off sick for four weeks and no return to work date has been identified. All scheduled patient contacts have been cancelled by admin staff by telephone, or letter when there was sufficient time. The LP now writes to all patients on the staff member's caseload, to advise them of the individual's absence, apologise for any inconvenience and distress caused, reiterate how to make contact with the service should they require to whilst awaiting another appointment, and that they will be offered an appointment on their return to work. An example template letter is in Appendices.*

**A 'more senior decision-maker' receives risk escalations from Lead Professionals. Senior decision-makers can keep escalating to more senior levels up to the level of NHS GG&C Board.**

*Example. The Consultant Psychologist in the team (and the Lead Professional) is concerned that the member of staff has now been off work for more than one month and during the process of carrying out a desktop review of their caseload and contacting all patients by letter notes that several patients cannot safely wait and require reallocation to another Psychologist in the team. This will mean that no new patients can be picked up from the waiting list for the next number of months. They escalate this issue to their operational manager and professional lead (this may or may not be the same individual) to advise them of this issue and to seek advice regarding any access to peripatetic resource which may be available, any potential for staff to work additional hours/overtime or any staffing resource from elsewhere which could be pivoted to their team to assist whilst the member of staff remains off work. And to inform the more senior decision-maker that they have had to cancel another member of staff's forthcoming training and did not have their Time to Lead in the last two weeks due to carrying out additional clinical tasks in the staff member's absence. The CL also informs the more senior decision-maker(s) that the absent member of staff is the sole accredited practitioner of EMDR and is the supervisor for EMDR in the team. In their absence, the staff practicing EMDR do not have access to supervision.*

*The operational manager and the professional lead (this may or may not be the same individual) escalates this issue further to a 'more senior-decision maker', in this scenario the local Head of Service, to enquire about access to a budget to pay for additional hours/overtime and to enquire about access to EMDR supervision from another source.*

The LP and the more senior decision makers seek appropriate clinical advice to assist them to make a decision regarding appropriate mitigation measures. If a mitigation used is the redeployment of staff from one team to another, the borrow function in SSTS should be used to allow reporting.

LPs and more senior decision-makers reaching a decision on risk, must "seek and have regard to appropriate clinical advice". This is required when the LP or more senior decision-maker:

- Is not a clinician
- Is assessing risk or making a decision in relation to a clinical workforce for which they are not professionally responsible

and/or

- Is making a decision in a speciality/setting in which they are not an expert and/or do not normally work

**Who can provide appropriate clinical advice?**

Clinical advice is appropriate when it is relevant to the identified risk and is provided by a person with clinical expertise in the relevant clinical area and responsibility for the clinical workforce engaged in the risk. Clinical advice may need to be obtained from more than one person. The LP/more senior decision-maker must consider this advice and, when it conflicts, should use their professional judgement to decide to mitigate, escalate or accept the risk(s).

*Example. The staff member who is absent from work is the sole accredited EMDR practitioner in the team/locality and supervises the EMDR practice of the others in the team. The senior decision-maker is unsure of the relative risk associated with these circumstances and seeks clinical advice from the Psychology Professional Lead for the care group. The advice from the Psychology Professional Lead is that the clinicians should not be practicing in the absence of the appropriate supervision and governance and that unfortunately no alternative access to appropriate supervision and governance can be identified. They advise that the delivery of this specific therapy should cease until the member of staff/supervisor returns to work or an alternative supervisor can be identified. The senior decision maker believes that pausing delivery of the therapy will have an adverse impact on the patients and should continue, with additional oversight from a senior clinician but non-specialist in the field. The senior decision-maker has to weigh up the clinical advice and use their professional judgement to decide to mitigate, escalate or accept the risk(s). The senior decision-maker decides to accept the risk and allow the clinicians to continue to practice in the absence of the appropriate supervision.*

Staff are notified of the decision and the reasons for it. **Does the person providing the clinical advice agree with the decision reached?** If no, they record their disagreement (in DATIX) and request a review from a more senior decision-maker up to, but not including, members of the NHS GG&C board

*Example. The Psychology Professional Lead expresses their disagreement with the decision reached, believing that their advice should have been weighted more heavily because they are "responsible for*

*the clinical workforce engaged in the risk". They request a review of the decision from a more senior decision-maker. They record their disagreement and request for review.*

'Recording' should be via DATIX. Additionally it can be by email correspondence or on an excel spreadsheet

Please remember that it is the responsibility of all registered Practitioner Psychologists to work within the required standards as set out by HCPC.

**What are severe and recurrent risks?**

**Severe and recurrent risks are not defined in the Act. The following definition has been adopted by NHS GG&C.**

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

*Example. Demand outstrips capacity for Psychological Therapy in the team and demand fluctuates throughout the year. This creates a risk of staff burnout and patient needs not being effectively met. This risk is managed by the operation of waiting lists for Psychological Therapy in the team and by job plans for the Psychology staff. Also, long waits are experienced by service users as difficult and can contribute to worsening mental health, deterioration in functioning and poorer clinical outcomes when treatment eventually commences. Mitigating actions are measures to attempt to improve the waiting experience.*

*Example. The Clinical Leader in the team has had to pivot their Time to Lead to direct delivery of psychological therapies for the last 4 weeks due to the sickness absence of the Principal Clinical Psychologist in the team. This is the mitigation which has been agreed in the current staffing situation. This should be recorded in DATIX.*

**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.**

The DATIX incident reporting module should be used to report near misses or incidents in relation to staffing concerns, including both No Harm Incidents and Incidents with Harm

*Example. A patient has not been able to be contacted by admin staff to cancel their appointment when the member of staff is off sick. The patient attends the resource centre to see the Psychologist, and has taken an overdose on the way to the appointment and plans to disclose and help-seek during*

*their appointment. They become distressed when told by reception staff that the Psychologist is off sick and their appointment is cancelled. Reception staff are concerned about the level of distress being expressed and ask the clinician on Duty to see the patient. The patient discloses the overdose and is sent to A&E in an ambulance from the Resource Centre for emergency medical assessment and treatment. A DATIX is completed to record this incident.*

**A severe and recurrent risk is defined as a situation in an area where there is a trend in number of incidents (impact severity level of 3-5 as defined in the NHS GG&C Risk Management Policy) or near misses that have occurred that directly relate to staffing. These near-miss events without the intervention of management could have resulted in a risk of harm to patients and staff.**

*Example. There is an unfilled Psychology admin vacancy and the telephone is regularly going to the answer machine, with regular delays before messages are heard and passed on. The vacancy is also leading to delays in sending appointment letters to patients and lapses in appointments being cancelled in a timely fashion when staff have unplanned absences. These circumstances have contributed to disruption to service delivery and an increase in complaints from service users and referrers. This is a marked change from service functioning when the admin post was occupied. Several DATIXs have been completed to record specific incidents. The severe and recurrent risk associated with this staffing gap is recorded in the Risk Register as per NHS GG&C Risk Management Policy.*

**SOPs should make reference to the National RAGG classification**

RED Over-utilisation, safe and appropriate staffing is compromised. Potential of missed care and/or high risk to service delivery. Cannot assist with shortages and action is required.

AMBER Over-utilisation, potential for safe and appropriate staffing to be compromised. Potential of missed care and/or moderate risk to service delivery.

GREY Acceptable utilisation, safe and appropriate staffing. Are working within recommended parameters and do not need any additional staffing hours. Potential to be able to assist with shortages.

GREEN Under-utilisation. Safe and appropriate staffing. There are excess staffing hours and the potential to assist with staff shortages.

Senior Management Teams will 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 mitigating actions to inform the quarterly board report.

Are there severe and recurrent risks? Local Senior Management Team review DATIX reporting and local records on a monthly basis. Risks discussed at monthly SMT meetings. Where there are increased risks, the Risk Register should be used. Safe Staffing risks should remain at the Sector/HSCP level to provide visibility at Sector/HSCP level. Safe Staffing risks will be reviewed by the senior management and corporate team on a quarterly basis

**Appendix 1: Definitions and mitigations**

The **Lead Professional** can be clinical or non-clinical and is the identified person in the service/team with responsibility for staffing.

The **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 3) 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.

**Planned Leave** refers to all types of leave, including annual leave, which have been requested and approved with some degree of notice to allow patients contacts to be re-scheduled, out of office messages to be added to email and the Electronic Patient Record (EPR) system and MDT colleagues to have been informed of the planned absence.

**Unplanned Leave**

Unplanned leave occurs when the clinical service lead has not had notice of leave in advance. This includes special leave and sick leave. In the event of unplanned leave the process should include:

1.1 If a staff member is calling in sick – request the staff member puts an out of office response on email, redirecting incoming queries to a manned telephone number within the service, and on the EPR.

1.2 Receiver of sick leave notification advises the person responsible for updating SSTS and/or the Real Time Staffing Tool.

1.3 Line manager should ascertain duration of sick leave to determine any action required.

Mitigations could include:

1.4 Review of clinics planned that require cancelling, patients contacted by admin staff by telephone on the day of appointment, or letter if sufficient time advising another appointment will be sent on the clinician's return (template in Appendices). Inform/advise the relevant MDT also involved in patient care with a priority focus on patients considered higher risk. Informing all teams the member of staff works with, is essential.

1.5 Action for longer term absence (>4 weeks) could include reviewing case management records to identify any 'at risk' patients and assessment of the prioritisation of clinical need by the service lead or clinical supervisor. Inform/advise the relevant MDT also involved in patient care with a priority focus on patients considered higher risk. Informing all teams the member of staff works with, is essential.

1.6 Patients should be advised to contact the service should they require assistance from the service in the time-period awaiting a re-appointment via standard letter.

1.7 If sick leave is longer than 4 weeks, and no return-to-work date is proposed, formal contact with the staff member's caseload should occur to assess whether re-distribution of case should be considered at this time. This should be managed with oversight of the service lead.

1.8 Should unplanned absence modify any existing risk to be escalated from Minor to Moderate (or above) on the RTSA the mitigation requirements should be put in place, recorded, and escalated as defined below.

**Appendix 2: Template letters (please note that these letters can be amended as required, for instance, to reduce the reading age)**

1) ***Cancellation of appointment during unplanned absence (when there is sufficient time to letter the individual)***

Dear [Name]

I write to advise that regrettably [name] is absent from work and your upcoming appointment with them planned for [date] is cancelled. You will receive another appointment with [name] at the earliest opportunity on their return to work. Please accept our apologies for any inconvenience or distress caused by this.

Should you require to make contact with services whilst you wait for another appointment to be arranged, please be aware of the contact numbers below.

[insert contact numbers]

Yours sincerely

[Name]

2) ***Contact with all on caseload when absence is 4 weeks or longer***

Dear [Name]

I write to advise that regrettably [name] remains off work and I do not yet have a date when they are expected to return to work. Please accept our sincerest apologies for any inconvenience or distress caused by this. You will be issued with an appointment with [name] on their return to work.

However, if you do not feel that you are in a position to await their return and would like to request re-allocation to another clinician, please do not hesitate to contact us at the number at the top of this letter to advise us of this. We will do our best to accommodate this request in a timely way.

Should you require to make contact with services whilst you wait for another appointment to be arranged, please be aware of the contact numbers below.

[insert contact numbers]

Yours sincerely

[Name]

### *3) Contact with all on caseload to offer option of re-allocation or waiting when absence is longer term (e.g. two months or longer)*

Dear [Name]

I write to keep you informed about [name's] ongoing absence from work. Regrettably [name] remains off work and I do not yet have a date when they are expected to return to work. Please accept our sincerest apologies for any inconvenience or distress caused by this lengthy disruption to your treatment.

Given the length of time [name] has been absent from work, we would like to offer you the option of either continuing to wait for another appointment with [name] on their return to work or to be re-allocated to a different clinician at the earliest available opportunity.

**I'd be most grateful if you would respond by calling the number at the top of the letter to advise of your preference.**

Should you require to make contact with services whilst you wait for another appointment to be arranged, please be aware of the contact numbers below.

[insert contact numbers]

Yours sincerely

[Name]

**Appendix 3: 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).*