

NHS Greater Glasgow and Clyde
Nursing and Midwifery HSCP Health Services
Real Time Staffing and Risk Escalation
Blueprint Standard Operating Procedure

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Purpose

The purpose of this Standard Operating Procedure (SOP) is to create a local process for Real Time Staffing and Risk Escalation to ensure compliance with NHS Greater Glasgow and Clyde's overarching [NHSGGC-Real-Time-Staffing-and-Risk-Escalation-SOP.V1.4.pdf](#). The purpose of this operational SOP is to allow Health and Social Care Partnership job families to have a blueprint to develop consistent local SOPs

This SOP will also be used in conjunction with the NHSGGC Rostering Policy and Common Staffing Method SOP. [GGC - Nursing & Midwifery Health & Care Staffing - Home](#)

Scope

Health and Social Care Partnership Registered Nurses, Registered Midwives, Health Care Support Workers and operational management (Service Managers, Senior Nurse Managers, Heads of Service and Chief Officers) will adhere to this SOP.

It is acknowledged that Nursing and Midwifery job families are all unique and individual therefore there may be specific escalation procedures agreed for some teams and this SOP must not replace these and instead be adapted to reflect agreed current procedures. Consideration should be given by each job family in each HSPC to work collaboratively to align job family SOPs.

Education Training

These modules must be completed as a once only (or if significantly updated) and the post completion survey /questionnaire must be completed to ensure TURAS analytic completion data is captured.

Roles in Scope of the Act: [Learning resources : Informed level | Turas | Learn \(nhs.scot\)](#)

Leadership roles: [Learning resources : Skilled level | Turas | Learn \(nhs.scot\)](#)

Roles and Responsibilities

All staff

All staff in scope of this SOP are responsible for escalating identified staffing concerns to the identified person in charge of a shift to allow mitigation when possible or to escalate further.

Patients, families and Carers

A patient, family or carer can also raise a voiced staffing concern which staff will be escalated to the identified person in charge of a shift to allow mitigation when possible or to escalate further.

All staff in scope must follow their agreed escalation process, please find an example in **Appendix 1** and Safe to Start in **Appendix 2**. Clinical Leaders must ensure staff have the relevant contact/page numbers visible for all staff in the team.

Real Time Staffing Assessment, escalations and mitigations

NHSGGCs agreed escalation process (**Example Appendix 1**) must be followed alongside NHSGGC Safe to Start method (**Appendix 2**)

Site Safety Meeting/Staffing Meeting Census Period

Health and Social Care services will have at least one site safety meeting /staff meeting each day or equivalent. Prior to and during each site safety/staff meeting period all staff in scope must follow the agreed escalation process (**Example Appendix 1**) and NHSGGCs Safe to Start method (**Appendix 2**)

Site Safety Meeting/Staffing Templates

Site safety/staff meeting template must include the minimum recording requirements which include:

- National RAGG Status (before and after recommended)
- Escalations
- Mitigations (Clinical advice provided)
- Staff notification
- Disagreements

Red Flags

Red Flag events can occur out with a site safety/staff meeting period. NHSGGCs Safe to Start method (**Appendix 2**) and the agreed escalation process (**Example Appendix 1**) must be followed. Red Flags may occur due to:

- Reviewing rosters – the shift ahead/medium /long term staffing concerns
- Immediate staffing concerns

Red flag events that occur outside the site safety/staff meeting period must be recorded and addressed appropriately. It should be logged on to the local site safety/staff meeting template and carried forward to the next site safety/staff meeting for a period for discussion and formal acknowledgement and record keeping, even if it has already been mitigated.

What is appropriate Clinical advice

The staff identified in **Example Appendix 1** who are involved in staffing mitigations may require to seek clinical advice if

- They are not a clinician
 - They are assessing risk, or making a decision, in relation to a clinical workforce for which they are not professionally responsible
- and/or**
- They are making a decision in a specialty/setting in which they are not an expert and/or do not normally work.

In the above situations clinical advice must be provided by a person with clinical expertise in the relevant clinical area who has responsibility for the clinical workforce engaged in the staffing concern. This person will be:

- In hours Team - Team Leader, Senior Nurse Managers (consider dual role service manager) and Professional Nurse Leads.
- Out of Hours - Nurse identified in charge / on call service manager (if registered Nurse), NHS 24 Out of hours General Practitioner.

The clinical advice must be considered by the person who obtained it and when it conflicts, should use their professional judgement to decide to mitigate, escalate or accept the risk(s). For escalated risks, the person providing clinical advice may record disagreement with the decision and request a review from any decision-maker up to but not including members of the NHSGGC board.

Clinical Incident Reporting



Reporting on the Datix Incident Module does not replace escalation process (Example Appendix 1), The Safe to Start process (Appendix 2), the site Safety/staff meeting recording template and instead must be used as a retrospective recording tool.

Datix incidents must be submitted by the person in charge of a team if it is unable to be resolved. Despite this anyone in scope of this SOP can submit a Datix incident. The escalations and mitigations taken should be recorded within the incident report. Actions required to prevent a recurrence should be clearly noted against the incident by the reviewer. [Incident-management-policy-hs.pdf](#)

No Harm Incidents

All staffing incidents and voiced care concerns by patients, families or carers must be recorded on the Datix Incident Module in relation to potential or actual patient or staff safety risks, regardless of whether harm/injury occurred. In this circumstance CHI numbers should not be used.

Incidents with Harm

Current process must be followed for patient harm incidents. If staff feel that staffing is a contributory factor, they must include this in the description of the incident. The SCN/M/TL reviewing the incident will investigate to determine if staffing was a contributing factor, if it is a contributory factor they will formally record this in the contributory factors field.

An individual who provided clinical advice to a decision-maker can be listed in the “Investigators” field if they have a Datix account and will receive updates if this is done; and the original reporter can tick a box to receive feedback once a resolution is reached.

Datix incident reports must be created as soon as reasonably practical.

Severe and Recurrent Risk

To identify areas of severe and recurrent risk, Nursing and Midwifery Senior Managers shall review staffing Datix incident reports, SSTS (where appropriate) and locally held records monthly to identify severe and recurrent risks and whether there is a trend of incidents/near misses related to staffing within their area. Each HSCP may have a safe staffing risk within the Datix Risk Module. If a HSCP does not currently have this, please continue to use your current risk recording process.

This risk should be managed within the HSCP and reviewed monthly, ensuring that the Risk Score (Impact and Likelihood) reflects the events that have occurred within the area.

Each month the 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 due date.

The Risk Register Policy and Guidance for Managers must be used to systematically identify, analyse, evaluate and manage RTS risks consistently and at an appropriate level. Risks are assessed on impact and likelihood using a 5x5 impact matrix as noted in the Policy.

Normally risks would be escalated to another level where they require further management. However, the safe staffing risk should remain at HSCP level to provide visibility of staffing risks across each HSCP. Should any actions require to be taken to manage this risk further at a higher level, these actions should be discussed at Senior Management Team meetings as noted above and actions identified in the Action Management Section, with clear action owners and timescales.

To provide visibility of safe staffing Severe and Recurrent Risks across NHSGGC the safe staffing risks will be reviewed by the relevant members of the senior management and corporate team on a quarterly basis. Senior Management teams must provide a quarterly report on their staffing risk which

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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 HSPC Chief Officer would be escalated to corporate director.

Appendices

Appendix 1 Example NHSGGC Red Flag Escalation Flow Diagram

This flow diagram is for guidance purposes – each job family will have localised agreed processes, please update the diagram to reflect your process and ensure all staff are informed and understand localised processes.

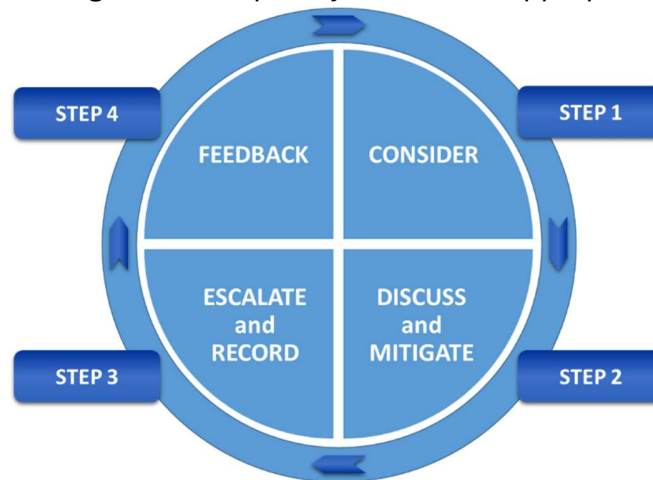


Provide feedback to staff who escalated and involved in trying to mitigate, and or who provided clinical advice, consider and record disagreements. If unable to resolve disagreements continue to the next step in the escalation process

Appendix 2 NHSGGC HSCP Safe to Start

Safe to Start

- Improving standards and outcomes for service users
- Taking account of the particular needs, abilities, characteristics and circumstances of different service users
- Respecting the dignity and rights of service users
- Taking account of the views of staff and service users
- Ensuring the wellbeing of staff
- Being open with staff and service users about decisions on staffing
- Allocating staff efficiently and effectively
- Promoting multi-disciplinary services as appropriate



- Step 1:** Proactive considerations at local team level, led by the frontline clinical leader (safety brief/huddle)
- Step 2:** Discussion between frontline clinical leader and Lead Nurse/Midwife (LN/M) or Team Lead
- Step 3:** HSCPC site or Service level consideration of clinical activity, safety, risk and staffing (safety huddle)
- Step 4:** Feedback at local level between LN/M or Team Lead and frontline clinical leader and local team

Safe to Start Guidance Health and Social Care Partnerships

Step 1:

Considering all of the following factors (using knowledge, experience, situational awareness, professional judgement and the ability to deliver quality care):

- appropriate staffing, considering skill mix and familiarity with clinical environment
- the nature of the particular kind of health care provision
- the local context in which it is being provided
- the number of patients being provided care
- the needs of patients being provided care
- appropriate clinical advice

Identification of Red, Amber, Grey or Green (RAGG) status (see below and [page 3](#)) through discussion across the team, led by the 'Nurse/Midwife in Charge' of the team during safety huddle and as required. Consider any local ward level mitigations to reach safe to start, e.g. reorganise planned but not time critical activity.

RED	=	ACTUAL patient or staff safety risks requiring mitigation; Review resources to consider what actions can be taken to support.
AMBER	=	POTENTIAL patient or staff safety risks requiring mitigation; Monitor situation, adapt & support as needed.
GREY	=	Safe and appropriate staffing – NO immediate patient or staff safety risks identified; no mitigations currently required.
GREEN	=	Safe and appropriate staffing – there are excess staffing hours and potential to support with appropriate priorities.

Step 2:

Senior Nurse / Service Manager / Lead Nurse/Midwife (LN/M), or identified person out of hours, informed of RAGG status at local departmental huddle and a review process of each teams staffing should be conducted with each Team Leader / SCN/M or RN/M in charge to determine if the ward / community team is 'Safe to Start.' Any immediate mitigations ([see page 3](#)) should be actioned and documented.

How RAGG status is applied:

There is a natural and inevitable layer of subjectivity to the process of determining RAGG rating; however, this guidance should be used with informed and experienced clinical judgement to apply as uniform interpretation as possible when determining if an area is 'Safe to Start'. The LN/M will provide clinical advice and support to develop the confidence and competency of staff in assessing the safety of their ward/area.

Any staff member identifying any risk relating to patient or staff safety, irrespective of RAGG status, should escalate concerns in real time and record this by completing a DATIX Incident Form.

Step 3:

Site huddle/staffing meeting including Senior Nurse / Service Manager for community informed of RAGG status and any further mitigations ([see page 3](#)) actioned and documented. When risks cannot be fully mitigated, the escalation response must also be documented.

Step 4:

Senior Nurse / Service Manager / LN/M / Team Lead / Nurse/Midwife in Charge feeds back to local team with current status of their clinical environment, the department and the hospital / community team. Local team encouraged to review actions and mitigations on [page 3](#) and share their views of status and actions taken. Where staff are not in agreement with any mitigations, they should be given the opportunity to request a re-review with feedback.

Actions and Mitigations (HSCP)

GREEN	<p>Safe and appropriate staffing – there are excess staffing hours and potential to support with appropriate priorities.</p>
	<p>All staff are jointly committed to:</p> <ul style="list-style-type: none"> • Working as a team: with respect, professionalism and trust, working with other colleagues across all disciplines to assess risk and share responsibility. • Staff health and wellbeing is paramount: To care for others, we must care for ourselves and those we work with. • Delivery of safe, effective and person-centred care: Patients and their families are at the centre of what we do. • Adhere to the professional codes of conduct. • Visible clinical leadership: Team Leader / Senior Charge Nurse/Midwife (SCN/M) and/or Register Nurse/Midwife (RN/M) in Charge will be a visible presence to ensure effective communication, clear direction, advice, support and reassurance; Senior Nurse / Service Manager / Lead Nurse/Midwife (LN/M) available and contactable for support and guidance. • Regular clear and effective multidisciplinary huddles: Demonstrating openness about decisions about staffing and taking account of the views of staff. • Support with excess hours to areas of risk (red and amber) or other appropriate duties e.g. quality assurance
GREY	<p>Safe and appropriate staffing – NO immediate patient or staff safety risks identified; no mitigations currently required.</p>
	<p>All staff are jointly committed to:</p> <ul style="list-style-type: none"> • Working as a team: with respect, professionalism and trust, working with other colleagues across all disciplines to assess risk and share responsibility. • Staff health and wellbeing is paramount: To care for others, we must care for ourselves and those we work with. • Delivery of safe, effective and person-centred care: Patients and their families are at the centre of what we do. • Adhere to the professional codes of conduct. • Visible clinical leadership: Team Leader / Senior Charge Nurse/Midwife (SCN/M) and/or Register Nurse/Midwife (RN/M) in Charge will be a visible presence to ensure effective communication, clear direction, advice, support and reassurance; Senior Nurse / Service Manager / Lead Nurse/Midwife (LN/M) available and contactable for support and guidance. • Regular clear and effective multidisciplinary huddles: Demonstrating openness about decisions about staffing and taking account of the views of staff.
AMBER	<p>POTENTIAL patient or staff safety risks requiring mitigation; monitor situation, adapt & support as needed.</p>
	<p>All considerations of the Grey status; <i>and</i> consider mitigating actions, such as:</p> <ul style="list-style-type: none"> • Provide an increased visibility of clinical leadership; • Assess need and capacity to provide wellbeing support to staff; • Explore options to offer changes to rostered shift, considering hybrid shifts where appropriate; • Review staffing, including skill mix and familiarity with the area, and consider staff movement where support is required – including potential redeployment of non-case-holding staff (focus on matching skill mix deployment and quality interventions to workload rather than staff numbers exclusively); • SN/SM / LN/M to consider TL/ SCN/M 'Time to Lead' across the HSCP and redeploy as appropriate/required; • Consider supplementary hours, such as additional hours or support via Staff Bank; • Community Nursing – refer to business continuity plans, HV service consider implementation of baseline cover guidance
RED	<p>ACTUAL patient or staff safety risks requiring mitigation; review resources to consider what actions can be taken to support.</p>
	<p>All considerations of the Grey and Amber statuses, <i>and</i>:</p> <ul style="list-style-type: none"> • Continued increased visibility of clinical leadership and direct escalation to the Chief Nurse/Director of Midwifery and wider Senior Management Team (SMT)*; • Initiate short-term deployment of support staff, e.g., Clinical Nurse Specialists and Practice Educators • Redeploy RN/M/HCSW staff from other areas (local, site, Sector/Directorate, across Acute and Board-wide) with consideration of clinical/staff safety; • Consult with LN/M and N/M in Charge for potential escalation to Standard Rate Agency; • Provide continuous clinical review of care whilst assessing for risk, in discussion with and through escalation to the SCN/M, LN//M, N/M in Charge and SMT; • SMT to consider <i>extremis</i> actions. <p>*NB: 'Senior Management Team' includes Chief Officer, Chief of Medicine, Chief Nurse, Chief AHP, Service Managers, General Managers and Clinical Directors.</p>