Professional Briefing

Guidelines for Managing Vacant Caseloads

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Introduction

This document has been prepared as a guide for community practitioners when agreeing arrangements for covering workload vacancies in a planned and safe way with the support of their line manager.

These guidelines will provide community practitioners and their service managers with direction on the management of vacant caseloads. The overall aim of the document is to enable the provision of a prioritised health visiting and school or community nursing service targeted at those individuals or families identified as the most vulnerable. These guidelines should be used in conjunction with the local child protection caseload guidelines where applicable. Unite/CPHVA also produce a fact sheet on 'determining optimum caseload sizes' (CPHVA 2007) available from the website http://www.unite-cphva.org/docs/Fact%20Sheet%20-%20Determining%20optimum%20caseload%20sizes.doc.

Community practitioners are advised to inform their Local Unite/CPHVA Accredited Representative (LAR), of their situation and the progress made at each step and to call upon their assistance and advice when problems occur.

Firstly, a definition of vacant caseload should be agreed. For example, Unite/CPHVA defines a caseload as vacant "if there is no substantive health visitor or school nurse allocated because of staff turnover, maternity leave, planned sickness, planned annual leave, long term sickness, repeated sick leave or vacant post for secondment for a period of four weeks or more". In the situation of a corporate caseload or skill mix health visiting or school nursing team, a considered definition should be agreed on what a vacancy means.

The way that the vacant caseload is managed will be locally responsive and rely on good professional judgement and discretion. Once this has been agreed, this should be documented and signed *(Appendix 1).*

Planning

Before a caseload becomes vacant, wherever possible, there should be a plan for reviewing, and recruiting to the vacancy with estimated time scales determined locally. Once this has been agreed, a letter confirming responsibilities and actions should be shared with personnel/individuals involved *(Appendix 2).*

core standards and expectations of the covering practitioner

- negotiation between the manager and appropriate staff as to the scope for additional work to be taken on and time period until it is reviewed
- a planned handover of the workload with particular reference to caseload priorities the agreed plan should be documented and an identified person be made responsible for ensuring the agreed action is co-ordinated. If not possible in advance, the above should take place as a matter of priority
- a maximum review date of three months, agreed in writing with manager. Best practice would favour a more frequent review of the vacant post and responsibilities.

If it becomes apparent that the vacancy will be long term and not recruited to, it may be useful to seek clarification from the manager responsible for recruitment to the service *(Appendix 3).*

caseload priorities

Following negotiation with staff regarding priority areas, consideration of the following should be given as appropriate (These suggestions are not definitive or exhaustive. Negotiations should reflect local priorities.)

- new birth visits
- families with children on the Child Protection Register
- high concern families
- fixed commitments Ie, public health activities, such as clinics or group work
- time allocated for record keeping and data collection
- families, children and young people affected These will include those due for mental health and developmental assessments The numbers should be highlighted and agreed before agreeing priorities

Practitioner assessment of the workload is needed so that the number of clients likely to be affected is known

To reduce the additional stress on the covering practitioner, the allocation of the most vulnerable clients, although far from ideal, should be spread to practitioners across the locality rather than one practitioner assuming responsibility for all A proper and inclusive handover would also be expected

It is hoped that community practitioners are working on caseload priorities identified from their population health needs assessment

actions for vacant caseloads

The following is written to assist health visitors, school nurses and service managers to deliver an equitable service These steps will aid the practitioner to fulfil their accountability according to the Nursing & Midwifery Council Code of Professional Conduct (NMC, 2008) It is recognised that practice may vary in different clinical and geographic areas These actions should therefore be considered in the context of locally agreed practice and protocols

actions

1. A named health visitor or school nurse should be identified as being responsible to co-ordinate the services provided on the vacant caseload Specialist services involved with families or children identified as vulnerable on the caseload should be notified and increased support should be focused to provide an appropriate service as agreed by all providers

2. As a matter of course managers should inform social services of any long term reduction in the health visiting service that may impact on their provision Children on the Child Protection Register should be allocated a named health visitor and the clinical nurse specialist in child protection involved

   The service manager should inform schools, local education authorities (LEA's) of any long term reductions in the school nursing service As with health visiting, children on the Child Protection Register should be allocated to a named school nurse and the clinical nurse specialist in child protection should be involved in the support provided to the practitioner

3. a) Children on the Child Protection Register, high concern families, families receiving active intervention, and families with special needs who are receiving a higher level of intervention should be allocated to named health visitors All of these clients should be informed of their

named health visitor and appropriate contact numbers should be provided. Handover summaries should be prepared by the current caseload holder and made available to colleagues for the planning process.

b) Although Unite/CPHVA advocate that all schools should have a school nurse, schools with a high level of need or vulnerable groups should, as a priority, be allocated to a named school nurse. In rural areas, or where school nurse resources are particularly low, routine activities should be reviewed across the service. As an absolute minimum, schools and young people/families should be provided with a telephone contact with the school nursing service.

A process should be set up to inform clients appropriately of the reduced service and what service is available. For example, informing clients how to contact the health visiting or school nursing service if they have any particular concerns when their child is due for a contact or how the service will respond to a client initiated contact.

5. In order to deal with day to day client queries regarding health visiting/school nursing services the possibility of increasing administration resources (reception and clerical support), should be considered. A rigorous system must be put in place to ensure messages from clients are communicated to an identified person in a timely way.

6. The service manager has a responsibility to inform those GPs who are directly affected by the vacancy and advise them of the arrangements that have been made and, wherever possible, before they are finalised. The service manager will be responsible for balancing the neighbourhood/locality needs with the individual practice needs. Any action plan impacting on services provided by GP surgeries should be agreed, and any additional support required from the GP practice should be identified and negotiated. Any child health clinics or public health commitments should be covered by an agreed system. For example, a rota shared by local health visiting/school nursing teams.

7. New clients falling within the vacant caseload e.g. transfers into the area should be contacted according to local policy and procedures so that their vulnerability can be assessed and any referrals or interventions can be identified and addressed in order to ensure that they are not disadvantaged by the reduced service.

8. These clients should be sent a standard letter informing them of the services available. Once the records have been reviewed an appropriate plan of contact will be decided upon by a designated health visitor. Due consideration should be given to the standard of information received from the previous case holder thus allowing a more comprehensive assessment to be made by the designated practitioner.

9. Antenatal clients will be sent a standard letter explaining services available and will be invited to make contact with a member of the health visiting team if any further advice or information is required. Best professional practice would ensure good written and verbal communication with midwifery team colleagues

10 Direct referrals from the A&E department must be assessed by an appropriate member of the health visiting or school nursing team to determine whether further action is appropriate. Where it is, contact should be made inviting the family to attend clinic or to arrange a home visit.

11. a) Client initiated contact. Wherever possible telephone advice should be given or alternatively the client should be invited to attend the local health centre. A visit should only be made when deemed necessary by the health visitor who should determine the most appropriate member of the health visiting team to make this visit.

    b) All schools within the vacant caseload should be contacted/visited at regular intervals to maintain communication with the school nursing service and address any immediate concerns.

12. There should be a system to identify the activities on the vacant caseload so that the incoming health visitor or school nurse is aware the work which has been generated while the caseload was vacant.

conclusion

It is hoped that in the majority of cases, the actions described will take place routinely demonstrating good practice

In some cases, difficulties may be experienced e g the workload is not fairly shared out across the health visiting/school nursing team or that the onus to cover the caseload and to continue to provide a comprehensive service to their identified caseload falls on one individual This may happen because of peer or management pressure to take on additional work Where appropriate, flexible ways of working should be considered but practitioners and their management should be aware of the potential increase in stress levels

The practitioner must report this concern to their line manager at the earliest opportunity stating clearly why their workload is excessive and practice, as a consequence, will become unsafe *(Appendix 4)*

Should the situation persist, the Unite/CPHVA LAR, who the health visitor/health visiting team or school nurse/school nursing team should have kept informed, may contact the line manager concerned for a meeting to address the situation *(Appendix 5)*

All meetings should be followed up with a letter *(Appendix 2)* confirming agreements and actions

In discussions it should be raised that inappropriate use of skill mix is not the answer either in the short or long term and will ultimately undermine the quantity of service provision and the status of public health nursing

Eventually, with advice and support from the LAR, the practitioner may refuse to take on any additional responsibilities in order to avoid acting in contravention of the NMC Code of Professional Conduct

References

CPHVA (2007) Fact Sheet Determining Optimum Caseload Sizes London, CPHVA www.unitetheunion.org/cphva

Nursing & Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives , NMC www.nmc-uk.org

Appendix 1:

Standard letter confirming the outcome of a meeting

Date: ______________________________

Name: ______________________________

Address: ______________________________

____

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Telephone: ______________________________

Email: ______________________________

Dear (Manager) ______________________________

Issue: ______________________________

I write to confirm the outcome of the *(status)* meeting held on *(date)* to discuss *(issues)*.

At that meeting the following points were agreed *(identify what was agreed, who was to implement it, when by, what matters of contention were clarified and whether there is to be a further meeting)-*

1)
2)
3)

Unless I hear to the contrary within a week/ month, I assume that you accept the above summary.

Yours sincerely

(Name)
(Position)

cc Unite/CPHVA LAR
Unite/CPHVA professional officer (where appropriate)

Appendix 2:

Workload priority plan example (vacant caseload)

Smith Street Public Health Nurses

This caseload has been defined as vacant. The action taken to address this is as follows:

- If a permanent vacancy, the recruitment plan is timetabled as ______________________________

____

- If a short term vacancy (more than four weeks and less than eight weeks), interim planned cover will take effect.
- If a medium or long term vacancy (more than eight weeks and less than six months), additional locum cover should be provided.

Agreed plan regarding cover on a caseload while vacant. The health visitor/school nurse with responsibility for co-ordinating the service is ______________________ During this period, no routine visits will be made.

Priority areas	Action by	Rota/ allocation	Review Date/ update
New birth visits	A Name	Rota	
Families with children on Child Protection Register	A Name	Allocated	
High concern families	A Name	Allocated	
Crisis calls and follow-up	A Name	Rota	
Transfer in visits	A Name	Allocated	
Time allocated for record keeping, notification to child health	All	Ongoing	
Other priorities (italics state)	Names	Allocated	

Continued….
Known high concern families

Family	Allocated to	Review Date
A	A Name	
B	A Name	
C	A Name	
D	A Name	
E	A Name	
F	A Name	

Known families with children on the Child Protection Register

Family	Allocated to	Review Date
A	A Name	
B	A Name	
C	A Name	
D	A Name	
E	A Name	
F	A Name	

Signed by: (case load holder)

_________________________ **(case load holder)** _________________________ **(Manager)**

Appendix 3:

Standard letter to management re-changes in staffing levels

Date:________________________________

Name:________________________________

Address:________________________________

Telephone:________________________________

Email:________________________________

Dear (Manager) ________________________________

Issue:________________________________

I write to you on behalf of ____________________ to seek clarification of the recently announced *(vacancy freeze).*

Would you please let me know the following:

a) why this was introduced?
b) what implications you believe this *(vacancy freeze)* will have on service delivery and professional accountability.
c) its intended duration, and
d) a breakdown of the current trust funded establishment and outstanding vacancies by department, as of *(actual date).*

I would be grateful if you could also let me know what plans exist formally to consult with the Unite/CPHVA on these issues.

An immediate response would be appreciated.

Yours sincerely

(Name)
(Position)

cc Other managers (where relevant)
Unite/CPHVA LAR
Unite/CPHVA professional officer (where appropriate)

Appendix 4:

Standard letter for registered nurse managers regarding unsafe practice and excessive workload

Date:____

Name:____

Address:____

____

____

Telephone:____

Email:____

____

Dear (Manager) ____

Issue:____

My reason for writing to you is that I believe you to be the appropriate authority to notify that I am experiencing clinical difficulties that are preventing me from providing a high standard of practice and care. This will prevent me from acting within the prescribed professional standards of The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC, 2008)

I write in confirmation of our recent discussion(s) when I drew your attention to various issues as they affect the environment of care and the interest of clients in the community Included in these discussions were the professional, staffing and financial resource issues facing your local NHS Primary Care Services

Due to the magnitude of the present service problems, which I identified on (date), my practice is compromised for the reasons listed below (list reasons).

1)
2)
3)

In my professional opinion, there are significant risks arising from such a situation I am not working in accordance with The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC, 2008) I am not in a position to account for a standard of service delivery on a wide scale.

I am only able to account for a prioritised system which safeguards the interests of individual patients and clients if they fall into the priority category, but which excludes all other patients/clients, despite the fact that appropriate needs have been identified.

Continued….

My prime objectives are now as follows

1) To enable staff and managers to identify the appropriate patient/client priorities and to reallocate work as necessary, in order to maintain a safe service.

2) To make a case for an improvement in the funded level of staff such that the number of staff in post equates to the workload and that all staff are working within their Code of professional conduct. If this objective is unrealistic in the present climate, I need a clear direction from the authority so that the service can be contracted on a planned basis, and so that expectations of colleagues, other agencies and the public can be focused on the reality of the situation, and not on hopes or perceived needs

3) To improve morale so that staff and managers feel valued

4) To assist managers in carrying out their duties effectively and efficiently, and to determine management priorities to meet the needs of the crisis situation.

5) To avoid worsening service problems

I attach a breakdown of the current shortfall of staff and resources, and the impact on the service

Yours sincerely

(Name)
(Position)

cc Chief Executive
Director of Children's Services
Director of Human Resources
Director of Clinical Governance
Unite/CPHVA LAR
Unite/CPHVA professional officer(s) *(where appropriate)*

Appendix 5:

Standard letter regarding unsafe practice and excessive workload

Date: ____________________

Name: ____________________

Address: ____________________

____

____

Telephone: ____________________

Email: ____________________

Dear (Manager) ____________________

Issue: ____________________

I write to draw attention to *(situation/incident which has occurred)* affecting my/my colleague's professional practice as a *(school nurse/nurse manager/health visitor/community practice teacher),* which affects the environment of care and the interests of clients in the community

My reason for writing to you is that I believe you to be the appropriate authority to notify that I am experiencing clinical difficulties that are preventing me from providing a high standard of practice and care. This will prevent me from acting within the prescribed professional standards of The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC, 2008)

The issue/s which gives rise to concerns are as follows (state details with relation to The Code: Standards of conduct, performance and ethics for nurses and midwives)

1)
2)
3)

In my professional opinion, the implications/nsks/consequences arising from such a situation are/are likely to be *(state the grounds for professional concern, what is unsafe about it, why the workload you are asked to undertake is excessive and an abuse of a practitioner, how the environment of care or safety of practice is adversely affected)*

I recognise the difficulties of meeting health care needs from limited resources, but find that in the current position the professional practice requirements placed on me/my colleague/s cannot be adequately met *(within current workload allocations/without additional support and/or resources)*

Continued...

I therefore seek an urgent meeting with you as my/their line manager/senior manager to discuss how this situation may be resolved I would ask you to note that I/they *(do not feel able to continue to cover any additional work/wish to be relieved of some of the excess workload at the earliest opportunity)*
As my/their line manager, I believe that you have responsibility for the appropriate allocation of workloads and I will provide you with details of my/her/their current responsibilities at our meeting

I hope that this situation can be rectified without delay, and assure you of my commitment to provide the best possible service to clients and the community, while at the same time maintaining professional standards in the delivery of care and the development of services to the community

I hope to hear from you soon regarding arrangements for a joint meeting, for what I trust will be constructive discussion.

Yours sincerely

(Name)
(Position)

cc Unite/CPHVA LAR
Unite/CPHVA professional officer (where appropriate)

(Where appropriate, details of the workload and caseload profiles of the staff concerned should be copied and attached to this letter).

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