AGENDA ITEM

HOPSC/xx/19

Committee Health Overview Policy and Scrutiny

Date 22 May 2019

Report from: mid and south Essex; and Suffolk and north east Essex CCGs

Report Sponsors:

Caroline Rassell – Accountable Officer, Mid Essex CCG

Tricia D'Orsi – Chief Nurse, Castle Point & Rochford CCG and Southend CCG

Ed Garrett – Accountable Officer, Suffolk and North East Essex CCGs

Lisa Llewelyn – Director of Nursing and Clinical Quality , North East Essex CCG

Key Lines of Enquiry

To understand where and how staffing levels are determined, including identifying the contribution of key performance indicators, financial and budgetary pressures, and commissioning strategies to those levels:

KLOE	Response
What are the differing roles and influence of commissioners and providers in determining workforce levels?	A commissioned service will be staffed by the provider dependent on the needs of the services that are to be delivered. Service specifications are negotiated and will include appropriate agreed staffing levels. It should be noted that ultimate responsibility of workforce skill-mix will be dependent on the ability of the provider to provide a quality service measured through national and local quality outcomes and measures. The move towards outcome-

KLOE	Response
	based contracts will mean less focus on prescriptive staffing numbers, enabling a focus on measurable outcomes provided by a multi-disciplinary team.
To what extent are commissioning decisions (and thereby staffing allocated for those services) determined solely by financial and budgetary considerations?	Although value for money is an important aspect of commissioning decisions this can never be to the detriment of quality of care provision. All commissioning cases are underpinned by quality frameworks informed by Quality Impact Assessments with a focus on many factors including appropriateness of staff to provide safe services.
What part do nationally (or locally) defined KPIs have in influencing the staffing resource allocated to a service? Are there any other quality considerations that influence staffing levels?	Nationally, there are quality metrics that inform local commissioning. ***Extract from the National NHS Standard Contract:*** National Quality Requirements and Local Quality Requirements 36.27 Subject to SC36.28, if the Provider breaches any of the thresholds in respect of the Operational Standards, the National Quality Requirements or the Local Quality Requirements the Provider must repay to the relevant Commissioner or the relevant Commissioner must deduct from payments due to the Provider (as appropriate), the relevant sums as determined in accordance with Schedule 4A (Operational Standards and National Quality Requirements) and/or Schedule 4C (Local Quality Requirements). The sums repaid or deducted under this SC36.27 in respect of any Quarter will not in any event exceed 2.5% of the Actual Quarterly Value. All NHS STANDARD CONTRACT 2019/20 SERVICE CONDITIONS (Shorter Form) SERVICE CONDITIONS 2019/20 NHS STANDARD CONTRACT (Shorter Form) 16 36.28 If the Provider has been granted access to the general element of the Provider Sustainability Fund, and has, as a condition of access: 36.28.1 agreed with the national teams of NHS Improvement and NHS England an overall financial control total and other associated conditions for the Contract Year 1 April 2019 to 31 March 2020; and 36.28.2 (where required by those bodies): 36.28.2.1 agreed with those bodies and with the Commissioners specific performance trajectories to be achieved during the Contract Year 1 April 2019 to 31 March 2020 (as set out in an SDIP contained or referred to in Schedule 2G (Other Local Agreements, Policies and Procedures));and/or

KLOE	Response
	36.28.2.2 submitted to those bodies assurance statements setting out commitments on performance against specific Operational Standards and National Quality Requirements to be achieved during the Contract Year 1 April 2019 to 31 March 2020 which have been accepted by those bodies (as set out in an SDIP contained or referred to in Schedule 2G (Other Local Agreements, Policies and Procedures)), no repayment will be required to be made, nor any deduction made, in relation to any breach of any threshold which occurs during that Contract Year for which such financial control totals and specific performance trajectories have been agreed and/or such assurance statements have been submitted and accepted in respect of any Operational Standard shown in bold italics in Schedule 4A (Operational Standards and National Quality Requirements). Methodologies such as Care Hours and Safer Staffing levels inform providers as to the required workforce mixes that should be operating within their services. This work is led by the Chief Nurse in NHSI.
To what extent does the Essex Health and Wellbeing Strategy determine local priorities and resources allocated to specific services or are there other overriding considerations?	CCGs are responsible for commissioning healthcare including mental health services, urgent and emergency care, elective hospital services, and community care. There is a balance between nationally set priorities (eg as set out in the NHS Constitution and the NHS Mandate), and local priorities. All members of the health and wellbeing board own the health and wellbeing strategy and as members of the Board, CCGs are extremely supportive of the strategy. Its central aims of improving mental health and wellbeing, addressing obesity, reducing health inequalities and supporting those with long-term conditions are core to the services we commission.
To what extent do differing local health needs and health inequalities determine the staffing resource? E.g. does an area of deprivation have more staffing resource dedicated to it - more community and district nurses?	The needs of a population will drive the commissioning position and providers will staff services accordingly. However, it is worth noting that many deprived areas find it difficult to recruit and retain staff as there is a perception that the demands of caseloads and client groups may make roles much more difficult to recruit to. All providers have a rolling programme of recruitment to fill workforce gaps to negate this risk

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When a commissioner draws up commissioning plans as part of each budgetary planning cycle what are the factors that influence staffing allocated by the provider?	A commissioned service will be staffed by the provider dependent on the needs of the services that are to be delivered. Service specifications are negotiated and will include appropriate agreed staffing levels. It should be noted that ultimate responsibility of workforce skill-mix will be dependent on the ability of the provider to provide a quality service measured through national and local quality outcomes and measures. The move towards outcome-based contracts will mean less focus on prescriptive staffing numbers, enabling a focus on measurable outcomes provided by a multi-disciplinary team.
To what extent does the provider have to agree the staffing resource allocated for a service with commissioners or is it entirely left with the provider to determine?	It is part of a negotiated position before the commissioning case can progress, however, the provider will manage the staffing resource on a day-to-day basis.
Can certain posts be left vacant (if unable to recruit) and not impact on patient safety or quality of service?	A risk assessment would be undertaken and reasonable adjustments would be made with locum and agency staff to provide necessary cover. Regular assessment of caseloads and acuity are taken during the working day and staffing adjusted accordingly by the provider. If posts are to be removed this would be part of a consultation process led by the provider with its staff.
With the development of STPs, to what extent are resourcing decisions for Essex based services being taken across the border? [Particularly applicable to the STP footprints with Hertfordshire and Suffolk]. To what extent are they staying with CCGs?	Suffolk and North East Essex STP is made up of 3 CCGs, each commissioning services on behalf of their respective populations. CCGs have an obligation under the NHS Act 2006 to exercise their functions effectively, efficiently and economically. We ensure that the three CCGs are meeting this obligation by reviewing current working arrangements and identifying opportunities to collaborate. We are also working with local authorities to consider what opportunities there may be for joint commissioning in the future. While the NEE Health and Wellbeing Alliance work collaboratively with partners to meet the needs of our population, where it is appropriate we also commission collaboratively and share best practice with STP colleagues to better meet the needs of our population. e.g. pathology services; ambulance services.