AGENDA ITEM

HOPSC/xx/19

Committee Health Overview Policy and Scrutiny

Date 22 May 2019

Report from: **Essex County Council Adult Social Care**

Report Sponsors:

Peter Fairley, Director for Strategy and Integration

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?	ECC plays a role as both a provider and a commissioner. For example, we employ social workers to undertake Care Act assessments, and we also commission care placements for vulnerable adults. For the provider market, a commissioned service will be staffed by the provider dependent on the needs of the services that are to be delivered. Our contracts and service specifications include requirements around appropriate staffing levels in terms of skills and capacity. We do not specify the exact number of people that a provider needs to employ. For ECC, we establish our staffing requirement by reflecting a range of assumptions and data. For example, we factor in current and projected service user demand; assumptions around

KLOE	Response
	numbers of cases per worker, and reviews per week; and factor in a vacancy rate. We also make assumptions about the split between qualified workers and unqualified workers.
To what extent are commissioning decisions (and thereby staffing allocated for those services) determined solely by financial and budgetary considerations?	Finance plays a part, but the ability of a provider to meet assessed needs is key and service user choice is also an important factor. The prices we pay providers reflect an assessment of the cost of care, based around assumptions of skills and capacity of the workforce to meet care and support needs, as well as affordability for the council. Through our framework agreements for Live at Home services, the council sets out the prices that providers will access if we make placements off the framework agreement. These prices vary by area. Providers select a price for the area(s) they work in which will reflect their own cost base and profit margins.
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?	For ECC, we monitor several KPIs including assessments completed within 28 days, timeliness of reviews, DTOCs, and safeguards. We also factor in quality of staff morale, engagement survey, and manageable workloads. Any legislative requirements for the provider, will also influence staffing models, as do their obligation to meet Care Quality Commission (CQC) regulations.
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?	ECC is extremely supportive of the Joint Health and Wellbeing 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 agenda for adult social care that we enable people to live independently and to live well. Our strategy is about early intervention and prevention and we have set up teams in each locality with this focus. We also consider where we need to do things differently to make progress. One recent decision we have taken is to bring back in-house Approved Mental Health Practitioners to

KLOE	Response
	carry out assessments under the Mental Health Act 1983. This is dedicated team of 10 social workers.
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 are factored in. For example, both population size and demand forecasts influence our staffing model. This means for example that West Essex has fewer staff than North because demand is higher in North. It is also 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.
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?	Our specifications prepared to meet commissioning plans clearly identify the types of requirements from a staffing resource to meet the contract. In understanding our financial commitments to this, we work closely with colleagues from procurement and finance to model the costs associated with the specification. This reflects quality standards, safe practices and meeting any legislative requirements. This work produces an overall cost to inform the budget requirements for the contract, and in the specification, this informs the allocation of staffing from the provider. As an example under the Care Act 2014 we have several duties: 1) to ensure eligible need is met; 2) to prevent or reduce need where possible; 3) to ensure vulnerable people are safe; and 4) to ensure a diverse and sustainable care market. We also have duties in the event of provider failure. There is also other national policy that we expect to be adhered to e.g national living wage, health and safety policies etc. Our work with providers directly, in particular with the Essex Care Association, is a mechanism to understand specific challenges providers are facing workforce issues, including recruitment and retention. These factors are also used to inform each budgetary planning cycle.

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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?	This is a matter for the provider.
Can certain posts be left vacant (if unable to recruit) and not impact on patient safety or quality of service?	For ECC, all posts are required in the structure but there is flexibility of turnover and vacancy rates. We use agency to fill gaps. Obviously front line roles are deemed higher priority than non-front line For providers, they will assess safe levels. There are occasions where packages of care are returned to ECC to re-commission when a provider does not have enough staff to support them. Providers will also, as will ECC, make use of the temporary/interim market to manage vacancies and staff requirements to ensure safety of people who use their services; together with deliver a quality service to meet CQC and ECC requirements.
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?	N/A.