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DATE: 19 November 2015

Dear Councillor

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE - THURSDAY, 26TH NOVEMBER, 2015

I am now able to enclose, for consideration at next Thursday, 26th November, 2015 meeting of the Health and Adult Social Care Overview and Scrutiny Committee, the following reports that were unavailable when the agenda was printed.

Agenda No Item 6

Adult Social Care Fee Rates (Pages 1 - 68)

To consider the report of the Director of Adult Social Care and Independent Living and consider comments to be submitted to Cabinet.

To advise the Director of Adult Social Care and Independent Living whether members of the Committee wish to be involved in the review of the delivery models of domiciliary care and residential care.

Yours sincerely

James Morley

Scrutiny Officer

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Agenda Item 6

Health and Adult Social Care Overview and Scrutiny Committee

Date of Meeting: **26 November 2015**

Report of: **The Director of Adult Social Care and Independent Living**

Subject/Title: **ADULT SOCIAL CARE FEE RATES**

1. Report Summary

1.1 The Council has operated with an Adult Social Care external providers' fee structure that it inherited from the County Council, which has remained at the same level since April 2009. The Council last reviewed its fee structure in 2013/14 with the support of RedQuadrant, where it was determined that the current fee level was reasonable and fair. During 2015/16 there have been an increasing number of queries and informal challenges from a variety of providers requesting a fee increase and a related increase in the number of providers unwilling/unable to provide care to the Council at the rates being offered. The Council commissioned an independent review of the adult social care fee structure, RedQuadrant were successful with their tender and began their work in May 2015.

1.2 The Care Act 2014 adds an additional requirement for Councils to formally consider the cost of care locally. This additional requirement in effect bolsters the previous more informal arrangement where Councils were required to evidence the fair price for care as it determines its local fee structure. Where Councils do not take into account the local costs of care they are more likely to be subject to formal challenge from providers. There have been a number of additional national recommendations that seek to sustain and improve the care market, including those from the UK Home Care Association and the Unison Ethical Care Charter, which encourage those commissioning care to develop and strengthen the local market for care.

1.3 This area of the Council's activity is probably one of the largest contracted services that the Council commissions in the external market, with the Council currently spending in excess of £80m on externally commissioned care which caters in a variety of forms for approximately 5,600 Adult Social Care residents. The local care market is vibrant and strong across Cheshire East, with approximately 67% commissioned privately and only approximately 33% commissioned by the Council. The commissioning structure adopted by the Council is vital to ensuring the continued vibrancy of this market, and the fee structure adopted by the Council is an important element of the commissioning approach and structure. In developing the care market locally the Council needs to pay due regard to the quality of care in addition to the price of that care.

1.3 The purpose of this report is to provide the Health and Adult Social Care Overview and Scrutiny Committee with an outline of the review undertaken by RedQuadrant, their recommendations, the impact of those recommendations both in care terms, economic terms, financial and budgetary terms, but also on the providers and their sustainability. It is important to note that during the review process the Chancellor of the Exchequer announced changes with regard to the National Living Wage, that required the Council, with Red Quadrant's support, to consider the impact in respect of the proposed fee structure. This has been a significant issue for the Council and will be for other Councils due to the nature of wage levels generally in the care market. The Council has committed to requiring its contracted suppliers to move towards paying the living wage and the fee structure assumed by RedQuadrant takes into account that commitment within their proposals.

2. Recommendation

2.1. That Scrutiny:

(a) Note the Care Home Fees and Home Care Fees reports produced for the Council by RedQuadrant attached to this report as appendix 1 and 2, and provide advice to the Cabinet

(b) Consider any advice that the Committee wishes to offer to Cabinet in respect of the recommendations being made

(c) Advise the Director of Adult Social Care and Independent Living if any members of Scrutiny wish to be involved in the review of the delivery models of domiciliary care and residential care going forwards

3. Reasons for Recommendations to Cabinet

3.1 The report to cabinet is to recommend:

That Cabinet:

(a) Endorse the Care Home Fees and Home Care Fees reports produced for the Council by RedQuadrant attached to this report as appendix 1 and 2.

(b) Endorse the increased fee rates proposed by RedQuadrant in full, with an estimated cost of £5.3m.

(c) Endorse the timeline proposed in this report which culminates in the implementation of the new rates beginning in January 2016.

(d) Commission and authorise the Director of Adult Social Care to explore with providers the impact of the fee structure remaining at its current levels until January 2016.

(e) Commission the Director of Adults Social Care to recommission the home care provision to the Council, seeking to co-produce a new arrangement between the customers and residents, providers, advocates and the Council.

3.2 The Council is required via the Care Act 2014 to assess the viability and sustainability of the fee structure locally, and to take account of the local fee structure when making its own recommendations about its future fee structure.

3.2 The Council has operated a fee structure for six years without an increase, which has seen the Council drop to a low fee structure when compared with our comparator Councils.

3.3 The impact of the Chancellor of the Exchequer's announcement in the summer regarding the National Living Wage has resulted in both the Council and providers recognising the need for action in respect of the fee structure. It will be necessary for all Councils to consider the impact of the National Living Wage on their local fee structure. It is clear locally that the impact of the National Living Wage, and the associated increase in the wage levels paid by other local employers, is impacting on care providers and the consequential impact has resulted in a more substantial recommended increase in the fee rates noted in this report.

3.4 The care market across the Council area has become established and vibrant with a flourishing private social care market. Providers have, through their discussions with RedQuadrant and the Council, stressed the difficulty the current fee structure is having on their businesses. RedQuadrant held a number of consultation sessions with providers in June 2015 where the providers stressed the importance of the care economy on the Cheshire East area and their desires to see this important area of the borough's economy enhanced and developed. In order to do this ist is recognised that this will include an on-going and developing fair price for care that will allow them to reward and recognise their workforce.

3.5 The model for care is changing both locally and nationally, with a number of initiatives combining to drive a requirement for a fundamental review of the commissioning approach to the whole care market. The home care fee review and the summer consultation highlighted a number of opportunities locally that need to be considered and developed. For example moving to an outcome based commissioning approach from the current more traditional time and cost model was something both the Council and a number of providers were keen to explore. Increasing integration of the social care market with that of the health care market is another important feature that will help to improve the overall care outcomes for our residents. Because of the nature and complexity of the market, the number of providers, the interactions between different agencies and providers, it is suggested that a fundamental review begins now but is allowed a period of time through to at least the middle of 2016/17 before proposals are finalised and brought before the Council. These proposals would be co-produced between the Council, the various agencies and partners, their advocates, providers and most importantly the residents and customers themselves.

4. Residential and Nursing Home Fee Levels

4.1 The report from RedQuadrant is attached as appendix 1, which details the approach taken in assessing the fee structure, the comparative information available and detailed feedback considered from a range of providers.

RedQuadrant highlight in their report that the final recommendations have changed substantially from the draft recommendations, as a result of the feedback from providers about the local cost of care. Taking account of the local costs of care is an important part of the Care Act 2014, the fact that the draft and final recommendations are different demonstrates the collaborative approach to the assessment of the local costs of care.

4.2 The attached appendix contains a variety of extracts of the legislation and case law which relates to the setting of care fees. Through the consultation, the feedback from the larger care providers has been to stress the importance of the Care Act 2014, which came into force on 1 April 2015, and the requirements upon the providers themselves and the Council to assess the local market. This has resulted in additional and valuable consideration and assessment by RedQuadrant, alongside the impacts of the National Living Wage.

4.3 In deriving a 'bottom up' cost of care RedQuadrant have taken into account the recent expert national advisers, Laing Buisson and their costing model for care homes, adapted for the factors affecting the local market. The various assumptions which have been modelled include:

- Average bed base for a home
- Occupancy
- Staffing levels
- Residential staffing levels
- Nursing staffing levels
- Management
- Other staffing levels
- Pay rate assumptions
- Other staffing assumptions
- Other non pay costs
- Maintenance
- Capital/Profit

4.4 During the consultation process a number of the assumptions in the draft report were challenged, along with the associated differential impact as not reflective of local conditions. In particular, the nursing pay levels quoted initially of £11.92 per hour were challenged as unrealistic. This has been increased to £13.30 per hour and a number of the other assumptions used were modified in the light of this feedback.

4.5 In making its recommendations RedQuadrant have advised the Council of a number of factors which it should consider as part of its deliberations. These include the fact that the current fee levels paid by the Council are low and becoming increasingly low compared to the bottom up calculations, the impact of the National Living Wage, the fact that the care market in the area is large and diverse with high utilisation levels and the Council is purchasing approximately 33% of the total market, that the Council is able to make placements at the current fee rates on most occasions and that there has been no increase since 2009, with a widespread disappointment amongst providers at the lack of an increase for 2014/15 when one was expected.

4.6 RedQuadrant have made a number of recommendations in respect of care home fees, with the following proposed fees (excluding the element paid by the NHS for Free Nursing Care):

Type of care	**2014/15**	**2015/16**	% inc	**2016/17**	**2017/18**
Residential Care	£376.74	£414.54	10.0	£431.13	£448.35
Residential Care (EMI)	£467.10	£490.28	5.0	£509.88	£535.36
Nursing Care	£433.07	£450.45	4.0	£468.44	£477.82
Nursing Care (EMI)	£467.10	£471.80	1.0	£483.63	£517.44

4.7 The estimated financial impact on these fee increases, based on current placement levels is £3.0m for 2016/17 and a further £1.5m in 2017/18.

4.8 The use of residential care as a service response is one which the Council is seeking to avoid unless this is the only appropriate option to meet needs. It is recognised that for most people receiving care and support in their own home is the preferred option. For some people the residential service option has been the service response to meet theor partcuklar n eeds in the absence of services available in the community. As new developments continue and more intensive response services in a crisis are made available it is expected that for some people the need for residential care will be removed. In developing new approaches to care, therefore, it is possible that reductions in residential and nursing care could be achieved. If a reduction of 12% in residential care and 6% for nursing care was achieved this could save an estimated £300,000. If those reductions could be increased to 20% and 10% respectively an estimated £470,000 could be saved from the overall levels of expenditure. The overall budgetary impact is considered in the financial section of this report.

4.9 One key are of work currently being planned is for commissioners across health and social care to work with all key partners to develop a strategy for care home services, both residential and nursing, based on a number of key principles including ensuring the commissioning of a model of service fit for the future with a clear focus on the outcomes for the resident.

5 Home Care Fee Levels

5.1 RedQuadrant have adopted a similar approach to the review of the home care fee structure, with the Care Act 2014 requirements applying to this market. The review included assessing the home care market, the direct payment system for individuals who wish to purchase their own care and the payment system for personal assistants. A similar approach to the review completed with the care home providers was undertaken, with workshops with providers, the sharing of a draft report, discussion with those providers who wished to provide additional information plus consideration of comparative information.

5.2 In addition to taking into account the implications of the Unison Ethical Care Charter, RedQuadrant utilised the research of the United Kingdom Homecare Association (UKHCA) in building the ‘bottom up’ costing of home care.

5.3 RedQuadrant compared the Council with fifteen other Councils, who are part of the Council's nearest statistical neighbours as identified by CIPFA, utilising the Personal Social Services Expenditure return (PSSEX) from 2013/14 which was the latest data available at the time the report was written. The principal finding was that activity was lower than the comparators and gross costs were also lower than the comparators, implying that fee levels were lower than the comparators.

5.4 In building the 'bottom up' costs, costs have been modelled utilising the National Living Wage, the impact of National Insurance levels quoted by the UKHCA, travel time and mileage costs along with time for training at 2.5 days per annum.

5.5 One of the major issues that has been explored as part of the review has been the indirect costs of the Home Care agencies and what is termed by the UKHCA as Staff Support Costs. The UKHCA have assessed these staff support costs at 27% until April 2016, reducing to 25.5% thereafter. This level of overhead includes a wide range of costs including for example, management, office costs, training (inductions etc.) and so forth. This was an area of contention during the period of consultation with providers arguing that their indirect costs had risen considerably having to incur additional expense meeting the requirement of the new national Care Certificate. In developing the bottom up cost RedQuadrant have allowed 22% plus 3% for the profit margin leaving 25% overall. This is an area that is likely to continue to receive scrutiny and discussion from the home care providers.

5.6 In later years the National Living Wage will continue to impact on the fee structure, requiring increases by the Council, this will also impact on the differential pay rates applied across the care market structure, which is an issue the Council has been considering with its own pay structure.

5.7 The home care fee structure has included three distinct elements, the payments direct to home care agencies, the allocated amounts for direct payments to the customer where they choose to purchase their own care and the allocation of payments to personal assistants where these are employed directly by the customer or someone on their behalf. The nature of the each of these service types provided is different and the proposed pay structure takes the different nature into account. Agencies recruit, train and employ care staff, require a level of infrastructure and require that the carers they employ have to travel from one customer to the next during their working day, which needs to be factored into the pay levels. Customers who employ personal assistants directly, typically via a direct payment, do not have the infrastructure or overheads, are not required to cover travel time etc. so do not need the same levels of pay to sustain the employment.

5.8 Within the home care fee review there are a number of additionalservice types, the first example being for a service called Shared Lives and the second for all the residents who receive care from the Extra Care facilities, with night sitting and care being a third. Separate discussions are in hand to resolve the increases required to allow the individual employees within these additional services to receive at least the National Living Wage. The service levels within these service areas are relatively small in comparison to the main home care services and the increases will be incorporated into the overall budget allocations detailed within this report.

5.9 The Council has taken a decision to cease the commissioning of 15 minute home care calls unless a resident specifically requests this. In order to manage the market in terms of capacity and quality, cases are being reviewed on a phased basis with 20% of the provision having already shifted away from a 15 minute call. In order to estimate the impact of the continued move away from 15 minute calls, it has been assumed that all 15 minute calls will be replaced by a 30 minute call. An estimate of the anticipated impact has been included below, assuming that initially the 20% movement increases to 50%.

5.10 The Council's current fee structure has a variety of elements, including a rate for the south of the Borough and another rate for the east area, plus a weighting for short periods of care (less than an hour). As personalised care is the priority for the customer and commissioning for outcomes is the direction of travel for the Council, it is intended that the future arrangements for home care commissioning will be to commission where possible a block number of hours per week and for the customer and the home care provider to agree how these will be delivered. The brief for RedQuadrant therefore requested one rate across the Borough with all elements being pro-rataed to the hour where this is required. The table below shows the impact of this.

Time	South	East	Blend	Proposed	% Difference
15 mins	£5.52	£5.77	£5.63	£3.83	(32%)
30 mins	£7.67	£8.03	£7.82	£7.66	(2%)
45 mins	£9.92	£11.41	£10.67	£11.49	8%
60 mins	£11.22	£12.55	£11.97	£15.32	28%

5.11 The financial impact of the above increases have been modelled on the current patterns of care that change from period to period but are reasonably constant to provide an indication for costing purposes. The above increase will cost an additional £2.3m in 2016/17 and a further £1.1m in 2017/18.

5.12 One key feature that was raised at the workshops in June 2015 was a desire from providers, residents and the commissioners to develop a new model of care based on outcomes for the resident. Following the implementation of this fee structure a new model of care will be co-produced between all the various interested parties. This should allow a more sustainable level of care to be developed and one that helps to demonstrate improved value for money overall.

6 Time Line and Consultation

6.1 The Council received the final reports from RedQuadrant on 19 October and is keen to achieve an approved fee structure at the earliest opportunity. The table below demonstrates the time line seeking approval, briefing both the providers and the residents/customer

Meeting	**Date**
Management Group Board	4th November 2015

Meeting	Date
Overview and Scrutiny Committee	26th November 2015
Cabinet Pre-Agenda Briefing	17th November 2015
Provider Forums	Late Nov/Early Dec 2015
Cabinet	8th December 2015
Customer Communications	8th January 2016
Implementation of revised fees and charges	6th February 2016

7 Financial Implications

7.1 The Council has not increased its Adult Social Care fees since it came into existence in 2009. Over the first six years of the Council many other Councils have increased their fees, particularly when the pension incomes have been increased by the Government. In benchmarking terms the Council has moved from near the top of the tables to near the bottom now.

7.2 The impact of the Living Wage on the Adult Social Care market will be significant, requiring all Councils, in line with their Care 2014 requirements, to increase their fee structures and levels. It is the view of RedQuadrant that once Councils assess their local requirements they will need to increase their fees, with a substantial national impact across the country.

7.3 In assessing the impact of the proposed fee structure locally the finance team have used information from the social care systems. The units of commissioned care (e.g. volume of hours; number of care packages) can vary from period to period, so whilst the information included within this report is as accurate as possible, the full impact does change, including the impact on individual providers, who will have a different mix of residents that they are caring for from period to period.

7.4 The budget setting for 2016/17 (Pre Budget Report) includes a proposed allocation of allocation of £5.1m for fee increases. The initial assessment by the finance team is that the increased fee structure will cost the Council £5.3m in 2016/17 with a further increase due to the Living Wage of £2.6m in 2017/18.

7.5 Taking all relevant factors into account at this stage it is anticipated that the fee structure will be achievable within the overall budget envelope (subject to Council approval in February 2016).

7.6 During 2015/16 it is proposed that the fee structure will come into operation in January 2016, which will leave four 4 weekly periods remaining for the year. Assuming a constant level of care this will cost the Council an additional £1.6m during 2015/16. This has been factored into the outturn forecasts for the Adult Social Care Directorate.

7.7 It is proposed to recommission home care during the remainder of 2015/16 and into 2016/17, where the aim is to redesign the home care offer working with residents, partners and the providers. The newly designed offer will seek to improve the outcomes of our residents focussing on an outcome based model of

care. This review will incorporate a review of the differences between agency provided care with that provided by personal assistants.

8 Legal Implications

8.1 The Care Act 2014 requires Councils to consider the fee structure applicable to their local area, taking into account the circumstances of the local market, its viability, sustainability and ability to provide sufficient appropriate care provision to the Council's residents. The approach taken by RedQuadrant, particularly the period of consultation, feedback and reflective increases, have enabled the Council to comply with the requirements of the Act.

8.2 The Council requested that RedQuadrant include within their consultation draft report, that should the Council determine to adopt the RedQuadrant proposals in full, the Council will rely upon the period of consultation undertaken by RedQuadrant. This report recommends that the Council accepts the RedQuadrant recommendations in full. Whilst this approach is legitimate it should be noted that this does bring an increased level of risk because the final proposals from RedQuadrant are substantially different from their initial proposals shared with the market (it is acknowledged that this is a low risk as the changes have all been increases). It is also noted that the Council intends to share the final report with providers and discuss the reports with them via face to face provider forum meetings.

9 Access to Information

9.1 The background papers relating to this report can be inspected by contacting the report writer:

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APPENDIX 1

Care home fees: report for Cheshire East Council

29th October 2015

Frank Curran frank.curran@redquadrant.com 075 1587 5381

APPENDIX 1

APPENDIX 1

Brief for project

RedQuadrant was commissioned by Cheshire East Council in May to make recommendations for future care home fee levels. Specifically we were asked:

1. To carry out an independent review of fair price for care for Residential and Nursing Home services within the Borough of Cheshire East and to review fee sustainability in residential and nursing home care generally (to include Learning Disability and Mental health provisions). This includes:

    a. Establishing and updating information on the elements that makes up the unique standard cost of care, during the term of a new Care Home agreement.

    b. Reviewing fee sustainability in residential and nursing home care (including establishing and updating information on the elements that make up the unique standard cost of care) during the term of a new care home agreement including a analysis of Fair Price for Care requirements

    c. Options to influence the market established fee levels above the council fee levels

Purpose of this report

We have undertaken the following activities in relation to this project

- Interviewed a range of stakeholders from the Council, CCG and others
- Reviewed performance data, policy papers and other documentation
- Undertaken two workshops with local care home providers (see Appendix one)
- Prepared draft recommendations on which we have consulted with providers
- Reviewed feedback from providers (eight providers gave feedback - BUPA, CLS, HC-One, Maria Mallaband, Sharston House, Woodeaves, Porthaven and Care UK)

This report is our final report which summarises our findings and makes recommendations for future fee levels. The revised recommendations are now somewhat different from the draft recommendations as we have taken account of the feedback received about the local cost of care

Context

When setting fees for care home providers the Council is required to follow legislation and to take account of relevant guidance and case law. Below there is an extract from an article in *Local Government Lawyer*[1] written in February 2013 which summarises, in simplified form, the legal requirements:

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1 http://www.localgovernmentlawyer.co.uk/index.php?option=com_content&view=article&id=13115%3Aon-taking-care-cautionary-tales-and-lessons-to-be-learnt&catid=52&Itemid=20

APPENDIX 1

“The law is based upon statute, directions, statutory guidance and non-statutory guidance…together with a significant injection of case law.

1. S. 21 National Assistance Act 1948 enables councils to make provisions for residential accommodation for persons who by reason of age, illness of disability are in need of care;
2. S. 47 National Health Service and Community Care Act 1990 requires assessments of needs, when appropriate, and the provision of care;
3. The National Assistance Act 1948 (Choice of Accommodation) Directions 1992 sets out the core obligation: where a council has assessed that a person needs residential care then it shall make arrangements for that accommodation. But the cost will not be more than the council would "usually expect to pay" i.e. the council will pay the "usual cost";
4. The Local Authority Circular (2004) 20 (i.e. statutory guidance) states: In setting and reviewing the usual cost , councils should have due regard to the actual costs and to other local circumstances (Hint: read this requirement twice);
5. *Building Capacity and Partnership in Care* (DoH 2001) (i.e. non statutory guidance): "Providers have become concerned that..[fees are held down, or driven down].. to a level that recognises neither the costs ..not the inevitable reduction in the quality of service provision. This may put individuals at risk .and destabilise the system. ..Contract prices should not be set mechanistically", there should be "clear systems for consultation with all (and potential) providers", but NB providers should ensure that they are "able to provide a full breakdown of the costs of the services";
6. s. 149 Equalities Act 2010 imposes a general duty for a council to have due regard to the need to (a) eliminate discrimination, (b) advance equality of opportunity and (c) foster good relations etc. It is an onerous duty and must be exercised with rigour and an open mind;
7. *Pembrokeshire* [2010] 3514: Para 28 - "Following guidance is not mandatory: but an authority can only depart from it for good reason"; Para 29 "..the more the proposed deviation from guidance, the more compelling must be the grounds"; Para 79 it is "important that the authority makes a rational and reasoned decision to use a particular criterion in the context of the model it has adopted, and is able and willing to share that reasoning with interested persons, including providers";
8. *Sefton* [2011] 2676: Para 70 - "In my view the statutory [and non-statutory] guidance do not contemplate that there will be any significant imbalance between the usual cost of care and the actual cost";
9. *Newcastle* [2011] 2655; Para 49 - "Where the local authority has asked itself the right question, has used an evidence-based system to ascertain the actual cost of care and has then made a difficult decision about the allocation of resources the court will support it";
10. *Redcar and Cleveland* [2013] 4: Para 57 " Whilst benchmarking is likely to provide useful information to a local authority wishing to ascertain the actual costs of care it will need to be combined with some information which relates specifically to its own area before it can be said to have reliably established what the actual costs of providing care are likely to be".

The critical phrase here is that used in point 4: when setting fees Councils should have “due regard to the actual costs [of providing care] and to other local circumstances”. In the *Northumberland* judgement, published after the summary above, Judge Supperstone stated:

APPENDIX 1

> "As such it [i.e. the requirement to have due regard to the actual costs of providing care] means no more than that, when determining what they are usually prepared to pay for residential care, authorities should bear in mind, amongst other matters, the providers' need to recover their costs.
>
> Usual fee rates should not be set by authorities without any consideration being had to the question of whether it is viable to provide care at those rates. However, even if 'having due regard to the actual costs of providing care' should be understood as requiring a more specific consideration of actual costs, the circular does not require authorities to calculate or ascertain the actual cost of care.[2]"

The *South Tyneside* judgement in July 2013 qualifies this point. The judgement is summarised by Belinda Schwehr of Care and Health Law as follows:

> "The judgment in South Tyneside establishes that the actual cost of care must be conscientiously considered by reference to evidence – if it is not to be done arithmetically, then the state of the actual market, vacancy rates, and numbers of homes in agreement are an alternative basis. But if it is to be done by reference to a tool, that tool must be a sensible tool; and this case says that one that leaves out return on capital/equity, is not rationally able to be defended."

After looking at other recent cases in this field, the judge found as follows, as a matter of law:

> 'In my Judgment return on capital is a real cost for care homes and, therefore, is a cost which the Council must have due regard to, under Paragraph 2.5.4 of the Building Capacity Circular. …[t]he Birmingham case makes it clear that return on capital is an actual cost and that the real debate is how much that cost is. Whilst there may be cases where the local authority can properly conclude on the facts that capital cost is properly met by capital growth, that question of capital cost must be considered and due regard paid to it.'"[3]

Thus there is clearly an expectation that Councils are expected to consult with providers but Councils have discretion over how this is done. Judge Supperstone in *Northumberland* stated the following:

> "As regards consultation, he said the council was not required to quantify costs in the way contended for by the claimants. "That being so, the absence of a quantification of costs could not invalidate the consultation process," Mr Justice Supperstone said, adding that the claimants could have requested a quantification of actual costs, but they did not do so.[4]"

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[2] http://www.localgovernmentlawyer.co.uk/index.php?option=com_content&view=article&id=13231%253Acounty-council-in-rare-high-court-win-against-care-home-providers&catid=52&Itemid=20

[3] http://www.nationalcareforum.org.uk/viewNews.asp?news_ID=572&sector_id=12

[4] http://www.localgovernmentlawyer.co.uk/index.php?option=com_content&view=article&id=13231%253Acounty-council-in-rare-high-court-win-against-care-home-providers&catid=52&Itemid=20

APPENDIX 1

The *Torbay* judgement in late 2014 clarifies two further points:

- "the intensity and nature of the inquiry which is required of the local authority is primarily a matter for the decision maker" i.e. the Council has some discretion over how it determines the actual cost of care; and
- "the decision was unreasonable as the model considered top-up fees paid by privately paying "residents which were not relevant. This took into account costs in an unlawful manner and was contrary to Government guidance"[5].

The following points were made by David Collins Solicitors on behalf of Maria Mallaband Group LTd as part of the consultation process:

"Financial obligations on providers;
Under the Health & Social Care Act 2008, care homes are required to register with the Care Quality Commission. Pertinent to the funding issues in dispute:

(1) Regulation 13 of the Care Quality Commission (Registration) Regulations 2009 requires care home operators to take all reasonable steps to ensure the financially viability of their care home operation for the purposes of meeting all of their legal obligations pertaining to their service.

(2) Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 requires care home providers to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are deployed to meet the needs of the residents within the care home. In the case of a care home providing nursing services, this will include the need to ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced nurses on duty at all times.

Care Act 2014:
2. Prior to 1 April 2015, the source of a local authority's duty to provide care and accommodation was contained within section 21 of the National Assistance Act 1948 and directions made under it in Department of Health Circulars LAC (93)10 and 2004(20). By virtue of those provisions, local authorities had a duty to make arrangements for providing "residential accommodation for persons aged eighteen or over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them". By virtue of section 26 of the 1948 Act, local authorities had the power to fulfil this duty by making arrangements with the private sector.

3. LAC 2004(20) required local authorities when setting care home fee rates (referred to therein as the 'usual costs'), to have "due regard to the actual costs of providing care and other local factors" and to requiring them "to be sufficient to meet the

[5] http://www.localgovernmentlawyer.co.uk/index.php?option=com_content&view=article&id=21249%3Acare-home-providers-win-high-court-battle-with-council-over-payments

APPENDIX 1

assessed care needs of supported residents in residential accommodation" (paragraph 2.5.4).

4. As from 1 April 2015, there is now a new statutory regime governing the provision of care by local authorities. A local authority's obligations are now set out primarily in the Care Act 2014 (**'the 2014 Act'**). Those statutory obligations are considerably more onerous than the previous and more limited obligation to pay due regard to the actual costs of care when setting care home fees within the confines of LAC 2004(20).

5. The 2014 Act is supported by the Department of Health's Guidance: 'Care and Support Statutory Guidance' (October 2014) (**'the Guidance'**).

6. Attention is drawn to the following sections of the 2014 Act:

Section 1 of the 2014 Act places a general duty on local authorities (when exercising their functions under the Act) to promote an individual's well-being. This includes the promotion of the suitability of living accommodation. The Guidance refers to this duty as 'the well-being principle' (see Chapter 1 of the Guidance).

6.2. Section 5(1) of the 2014 Act places an obligation on local authorities to:
"(1) ...promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market –
(a) has a variety of providers to choose from who (taken together) provide a variety of services;
(b) has a variety of high quality services to choose from;
(c) has sufficient information to make an informed decision about how to meet the needs in question."

6.3. In performing its duty under section 5(1), section 5(2) of the 2014 Act requires a local authority to have regard to a number of matters, including:

"(b) the need to ensure that it is aware of current and likely future demand for such services and to consider how providers might meet that demand;
...
(d) *the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not);"*

6.4. Section 5(3) of the 2014 Act provides that:

"(3) In having regard to the matters mentioned in subsection (2)(b), a local authority must also have regard to the need to ensure that sufficient services are available for meeting the needs for care and support of adults in its area and the needs for support of carers in its area."

APPENDIX 1

6.5. Section 18 of the 2014 Act places an obligation on local authorities to meet any eligible adult's needs for care and support. Section 8 of the 2014 Act sets out examples of how a local authority may meet those needs, which includes the arranging of the adult's accommodation, care and support within a care home.

7. Chapter 4 of the Guidance is entitled 'Market shaping and commissioning of adult care and support'. It provides local authorities with guidance on their duties arising under section 5 of the 2014 Act. Chapter 4 is stated to cover the following principles underpinning market-shaping and commissioning activity:

- *focusing on outcomes and wellbeing;*
- *promoting quality services, including through workforce developments and remuneration and ensuring appropriately resourced care and support;*
- *supporting sustainability;*
- *ensuring choice;*
- *co-production with partners.*

8. Chapter 4 includes the provision of the following guidance:

- *"High-quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the local authority is critical to achieving this, both through the actions it takes to directly commission services to meet needs, and the broader understanding and interactions it facilitates with the wider market, for the benefit of all local people and communities."* (paragraph 4.1)

- *"Market shaping means the local authority collaborating closely with other relevant partners..."* (paragraph 4.6)

- *"Local authorities **must** facilitate markets that offer a diverse range of high-quality and appropriate services. In doing so, they must have regard to ensuring the continuous improvement of those services and encouraging a workforce which effectively underpins the market. The quality of services provided and the workforce providing them can have a significant effect on the wellbeing of people receiving care and support, and that of carers, and it is important to establish agreed understandable and clear criteria for quality and to ensure they are met."* (paragraph 4.21)

*"People working in the care sector play a central role in providing high quality services. Local authorities **must** consider how to help foster, enhance and appropriately incentivise this vital workforce to underpin effective, high quality services."* (paragraph 4.28)

"When commissioning services, local authorities should assure themselves and have evidence that service providers deliver services through staff remunerated so as to retain an effective workforce. Remuneration must be at least sufficient to comply with

APPENDIX 1

the national minimum wage legislation for hourly pay or equivalent salary." (paragraph 4.30)

"When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and ***fee levels*** *for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care. This should support and promote the wellbeing of people who receive care and support, and allow for the service provider ability to meet statutory obligations to pay at least the national minimum wage and provide effective training and development of staff. It should also allow retention of staff commensurate with delivering services to the agreed quality, and encourage innovation and improvement."* [Emphasis added] (paragraph 4.31)

"Local authorities should understand the business environment of the providers offering services in their area and seek to work with providers facing challenges and understand their risks." (paragraph 4.34)

"Local authorities ***must not*** *undertake any actions which may threaten the sustainability of the market as a whole, that is, the pool of providers able to deliver services of an appropriate quality – for example, by setting fee levels below an amount which is not sustainable for provider in the long-term."* (paragraph 4.35)

"5. Where a local authority is responsible for meeting a person's care and support needs and their needs have been assessed as requiring a particular type of accommodation in order to ensure that they are met, the person must have the right to choose between different providers of that type of accommodation provided that:

- *the accommodation is suitable in relation to the person's assessed needs;*
- *to do so would not cost the local authority more than the amount specified in the adult's personal budget for accommodation of that type;*
- *the accommodation is available; and*
- *the provider of the accommodation is willing to enter into a contract with the local authority to provide the care at the rate identified in the person's personal budget on the local authority's terms and conditions.*

6. This choice must not be limited to those settings or individual providers with which the local authority already contracts with or operates, or those that are within that local authority's geographical boundary. It must be a genuine choice across the appropriate provision." (Annex A: Choice of accommodation and additional payments, paragraphs 5 and 6)

"The personal budget is defined as the cost to the local authority of meeting the person's needs which the local authority chooses or it required to meet. However, the local authority should take into consideration cases or circumstances where this 'cost to

APPENDIX 1

the local authority' may need to be adjusted to ensure that needs are met. For example, a person may have specific dietary requirements that can only be me in specific settings. ***In all cases the local authority must have regard to the actual cost of good quality care*** *in deciding the personal budget to ensure that the amount is one that reflects local market conditions. This should also reflect other factors such as the person's circumstances and the availability of provision.* ***In addition, the local authority should not set arbitrary amounts or ceilings for particular types of accommodation that do not reflect a fair cost of care****. Guidance on market shaping and commissioning is set out in Chapter 4. Local authorities* ***must*** *also have regard to the guidance on personal budgets in Chapter 11, and in particular paragraph 11.23 on calculating the personal budget."* [Emphasis added] (Annex A: Choice of accommodation and additional payments, paragraph 11)

Equality Act 2010:

9. Further, local authorities are required to act in accordance with their obligations arising under the Equality Act 2010. Section 149(1) of the 2010 Act provides so far as is material:

"(1) A public authority must, in the exercise of its functions, have due regard to the need to- eliminate discrimination…,
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it."*

10. In R (South West Care Homes Ltd & Ors) v Devon CC [2012] EWHC 2967 (Admin), however, Judge Jarman QC accepted that a local authority's public sector equality duties arising under the 2010 Act applied to decisions on residential care home fees. In R (Members of the Committee of Care North East) v Northumberland County Council [2013] EWCA Civ 1740, the Court of Appeal accepted that there:

"… should be a structured attempt to focus upon the details of equality issues", see paragraph 61 of Bracking v Secretary of State for Work and Pensions [2013] EWCA Civ 1345 is readily understandable if the decision taker is having to demonstrate compliance with the statutory duty to have due regard to various factors as part of the public sector equality duty imposed by section 149 of the Equality Act 2010."

11. The Equality Act allows for a challenge to be brought by persons (real or legal) who have been treated less favourably because of their association with persons who are disabled (or have any particular disability).

Consultation Obligations:

12. In R v North East Devon Health Authority, ex parte Coughlan [2001] QB 213, paragraph 108, the Court stated:

"...whether or not consultation of interested parties and the public is a legal requirement, if it is embarked upon it must be carried out properly. To be proper,

APPENDIX 1

consultation must be undertaken at a time when proposals are still at a formative stage; it must include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response; adequate time must be given for this purpose; and the product of consultation must be conscientiously taken into account when the ultimate decision is taken."

13. The requirement to provide 'sufficient reasons' was considered by the Court of Appeal in R (Eisai) v National Institute for Health and Clinical Excellence [2008] EWCA Civ 438, a case concerning a decision of NICE not to authorise the use of a particular drug for cost-effectiveness reasons. The claimant in that case argued that NICE ought to have disclosed a fully-executable version of the model it had used to assess cost-effectiveness, rather than the read-only version they had been given. In accepting that argument, the court made it clear that the test is what fairness requires (see paragraph 27 of the judgment). In his judgment Richards LJ relied on the judgment of Lord Diplock in Bushell v Secretary of State for the Environment [1981] AC 75, at page 96, who held that '[f]airness … also requires that the objectors should be given sufficient information about the reasons relied on by the department as justifying the draft scheme to enable them to challenge the accuracy of any facts and the validity of any arguments upon which the departmental reasons are based'. The Court held that, in the circumstances of the case before it, it was necessary for NICE to disclose a fully-executable version of the model.

Key factors included: (i) the importance of the issue at hand, and (ii) the importance of the model to the decision (see paragraphs 34-36). At paragraph 66, Richards LJ held that:

"…procedural fairness does require release of the fully executable version of the model. It is true that there is already a remarkable degree of disclosure and of transparency in the consultation process; but that cuts both ways, because it also serves to underline the nature and importance of the exercise being carried out. The refusal to release the fully executable version of the model stands out as the one exception to the principle of openness and transparency that NICE has acknowledged as appropriate in this context. It does place consultees (or at least a sub-set of them, since it is mainly the pharmaceutical companies which are likely to be affected by this in practice) at a significant disadvantage in challenging the reliability of the model. In that respect it limits their ability to make an intelligent response on something that is central to the appraisal process.""

David Collins Solicitors argue that the approach taken in the consultation process does not meet the legal criteria stated above because, in their view, we have not taken account properly of the requirement to consider the actual cost of care

"By applying a confused and irrational approach to the costs of care within East Cheshire, [the Council (through the agency of RedQuadrant)] has misdirected itself as to the costs of

APPENDIX 1

> care within East Cheshire. The proposals contained within the Report are flawed and irrational. In doing so, as matters currently stand, the Council is not in a position whereby it can rationally make any decisions regarding its duties arising under section 5 of the Care Act. Accordingly, were the Council to adopt the proposals contained within the Report at the present time based upon the work undertaken to date by RedQuadrant and the approach taken within the Report, the Council will enter into public law error; thereby making any decision taken by the Council amenable to judicial review. "

"The Council must not proceed on the basis of the Report and the proposals contained within it"

We are not lawyers and thus not qualified to give legal advice. However our understanding of the requirements of the council in this area is that the Council is obliged to take account of the actual costs of care when setting fees, can do this in a number of ways but it cannot consider top-up fees in this process. The Care Act strengthens this duty by requiring the Council to ensuring that the level of fees set allows for a sustainable local market to exist. Furthermore the consultation process when setting fees should be fair and open

In this exercise we have considered occupancy levels, ease of placement by the Council and a calculation of reasonable costs using information on local costs of care to come to a view as to what fee levels should be. We have not undertaken a market wide cost of care exercise as this, in our view, is not required to comply with the legislation and has a number of defects as an approach; however we have shared outline calculations (and the assumptions and methodologies behind these calculations) with the provider market and have modified our approach when presented with reasonable evidence on local costs that differed from our original assumptions. We also propose that any provider who feels that the proposed fees are inadequate, are given the opportunity to present their actual costs of care on an open-book basis. This in our view complies with the requirements of the legislation

Cost of care in Cheshire East

As part of our review we have carried out a 'bottom up' costing exercise for both residential and nursing care. The purpose of this exercise is to consider the factors affecting the local costs of care within the local authority area. We have taken account of the most recent Laing Buisson (LB)[6] costing models for care homes as outlined below as well as information on local costs. Where we have not used LB assumptions we have explained why.

Where possible we have attempted to identify local, reasonable costs of residential and nursing home care using an evidence based approach which is discussed in further detail below. As the purpose of this project is to make recommendations for standard fees across a range of care homes we have used average costs wherever appropriate. It is also important to emphasise that we are not stipulating that homes should comply with the occupancy levels, salary levels, cover arrangements or any other parameter set out below: these are decisions for individual home providers to take.

[6] LaingBuisson provide a set of data on care costs that is gathered from providers and produces cost models derived from this data

APPENDIX 1

The assumptions which we have modelled are detailed below:

- Average Bed Base: The model works on the basis of average bed numbers across all Cheshire East care homes for older people. This was calculated to be 40 beds.

- Occupancy: Expected occupancy levels are assumed to be 96% for the purpose of the calculation. Although LB base their calculations on 90% occupancy they do state that nationally over 50% of care homes are running at over 95% occupancy, a target which we believe to be achievable. Indeed overall occupancy levels were 95% in a snapshot exercise across the Council in June 2015. Some providers argued that a 95% occupancy rate should be used as this does reflect actual local conditions: however, as clearly significant numbers of local providers re operating at higher levels of occupancy than this we feel it is not unreasonable to use the higher %

- Staffing Levels: Whilst the Care Quality Commission (CQC) regulates the care home industry they do not provide any prescriptive formulas regarding minimum safe staffing levels, nor does the Council prescribe staffing levels within homes. Additionally the regulatory body for the nursing profession, the Royal College of Nursing (RCN) does not offer their own guidance other than reference to the Irish 'Regulation and Quality Improvement Authority' (RQIA) for nursing care levels. Ultimately of course care home proprietors are responsible for ensuring a safe level of staffing in their homes and the Council is responsible for ensuring levels of funding to ensure a safe level of staffing. However different providers approach staffing in very different ways so it is not possible to define a standard safe staffing level across all services. Our approach is thus to use the RQIA model as a basis but modified in the light of feedback.

  Two providers (including David Collins Solicitors) criticised our use of the RQIA staffing model on the basis that these were Irish and thus not applicable locally. There clearly will be a wide range of staffing structures and rotas used locally and we have reflected these by modifying our model for all four types of care in the light of consultation on actual costs as follows:

  - inclusion of 10 minute handover time for each shift
  - modification of shift patterns from 6 to 7 hours for Early, 6 to 7 hours for Late and 12 to 10 hours for Night

  Two providers argued that Activity Co-ordinators should be included as a cost for each home, but, although there is a contractual requirement to ensure that an adequate range of activities is provided, there is no contractual requirement to employ an Activity Co-ordinator and, presumably, not all homes do so

  Residential Staffing Levels: The RQIA guidance states that any residential home with between 31-40 residents should have one person in charge with three to four care on duty during the day and two members of staff on duty at night with an additional member on call. We have assumed 10 minutes handover per worker at the end of each

APPENDIX 1

shift. The night guidance is however based on a high dependency unit, with no definitive guide for medium to low evening dependency. Taking this into account the model for nights has been reduced to allow for between two and three staff on duty and one on call. The staff to patient ratio used for this model is as follows:

Early 1 Care Worker for 10 Clients (7 hours)
Late 1 Care Worker for 10 Clients (7 hours)
Night 1 Care Worker for 17 Clients (10 hours)

This equates to 15.45 hours care per person per week, based on 96% occupancy. We have assumed that no registered Nurses work in Residential homes.

One provider observed that the LB model assumes 21.5 hours care per person per week in the north-west, somewhat more than we have calculated here.

- Residential Staffing Levels with Mental Health Needs: The baseline assumptions from above have been applied though staff to patient ratios have been amended to reflect the increased level of support required. We have assumed 10 minutes handover per worker at the end of each shift. We have assumed that between two and three additional care staff would be required to support the daily care of the residents in the home. At night a high dependency staffing level of three to four care staff has been applied with one on call staff member for during the night.

The staff to patient ratios used for this model are as follows:

Early 1 Care Worker for 6 Clients
Late 1 Care Worker for 6 Clients
Night 1 Care Worker for 12 Clients

This equates to 24.6 hours care per person per week, based on 96% occupancy. This is slightly higher than the figure of 24.5 modelled by LB in the north-west

- Nursing Staffing Levels: The RQIA also makes reference to the Rhys Hearne dependency models, which use the care requirement of the patient to determine the level of staffing required over a 24 hour period. A summary of the care levels is detailed below:

Care Group	Care Type	Estimated Direct Care Require Per Day
A	Self-Care	1
B	Average Care	2
C	Above Average Care	3
D	Maximum Nursing Care	4

APPENDIX 1

Taking into account the above model the following assumptions have been made in relation to the level of care required for each level:

Care Group A	0%
Care Group B	0%
Care Group C	50%
Care Group D	50%

These %s have been modified in the light of feedback from providers that our previous figures did not adequately reflect the reality of the level of need of people being referred by the Council

Based on this the following staff to patient ratios were determined:

Early	1 Nurse and/or Care Worker for 6 Clients
Late	1 Nurse and/or Care Worker for 6 Clients
Night	1 Nurse and/or Care Worker for 12 Clients

This equates to 25.17 hours care per person per week, based on 96% occupancy and 10 minutes handover per person at the end of each shift.

We have assumed that the ratio of registered nurses to care workers follows a 26:74 split, consistent with the LB model.

- Nursing Staffing Levels with Mental Health Needs: In order to assess the staffing model for those nursing homes with mental health needs the Rhys Hearne dependency model was again used. In this case we assumed that patients were split 80% to care group D and 20% to care group C. These %s have been modified in the light of feedback from providers that our previous figures did not adequately reflect the reality of the level of need of people being referred by the Council. This results in the below patient ratios:

Early	1 Nurse and/or Care Worker for 5 Clients
Late	1 Nurse and/or Care Worker for 6 Clients
Night	1 Nurse and/or Care Worker for 9 Clients

The above model equates to 27.02 nursing hours per patient per week, based on 96% occupancy and 10 minutes handover per person at the end of each shift.

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The same registered nurse split and pay scale assumptions have been applied as those within purely nursing homes.

- Management: Every care home regardless of status or occupancy has been assumed to have one Manager. No allowance has been made for any backfill cover due to annual leave, sickness, etc. Two providers argued for the need for a deputy manager and/or management cover for absences In the light of this and other provider feedback we

APPENDIX 1

have assumed one senior care worker on each shift where a manager or nurse is not available; as was pointed out this is consistent with the RQIA guidance.

- Other Staff Groups: The calculations for the roles of admin, domestics and catering staff were computed in line with the RQIA guidance. Only domestics and catering staff had an element of 'timeout cover' provided for within the calculations.

- Pay Rate Assumptions (2015/16): All salaries (except for nursing staff – see below) were calculated using the average figures for that staff group contained within the report National Minimum Dataset for Social Care (NMD-SC) within the Cheshire East and North West area. The quoted rates for care staff, catering and domestics are a little above the current minimum wage for people over 21 of £6.50 per hour and we have adjusted these to take account of the increase in minimum wage in October 2015. The website payscale.com was also referred to in order to ensure that rates of pay were consistent. The rates used are as follows:

Staff Group	Care Home Rate
Qualified Nursing (per hour)	£14.00
Care Staff (per hour)	£6.65
Senior Care Staff (per hour)	£7.65
Catering (per hour)	£6.65
Domestics (per hour)	£6.60
Admin (per hour)	£7.35
Residential Manager (per annum)	£26,280
Nursing Manager (per annum)	£30,034

One provider quoted LB composite rates for the North West in 2014/15 as being £12.61 for nursing, £6.90 for care staff, £7.39 for catering and £6.70 for domestic staff. However, NMD-SC figures are derived from local survey data and thus seem reasonable to use and more relevant to local costs. Similarly one provider quoted a rate of £9 per hour for catering costs, considerably in excess of the rate from NMD-SC data. As no other provider made this point we consider it reasonable to use the NMD-SC rates for catering staff

The main challenge in this area during the consultation was in in relation to pay for nursing staff where we used £11.92, a figure taken from NMD-SC. A number of responding providers reported that this rate was too low and that the market rate was somewhat higher – with figures of £12.61 (see above) - £14.00 being quoted. We have used £13.30 as this is the mid-point of the range of figures quoted.

- Other Staffing Assumptions: The National Insurance (NI) rate has been applied at 7% across the board as there will be variations of full and part time staff which will impact on differing levels of NI payable. A pension contribution of 1% has been applied to

APPENDIX 1

account for the current minimum employer contribution. We have not applied a higher pension % for managers as some providers have argued for as there is no evidence from NMD-SC or payscale.com that this is routinely offered. For nursing/care staff a 20% pay enhancement has been built in for Sunday enhancements, and a 25% pay allowance has been used to account for any on call arrangements. The on call applies to night cover, whereby one staff member may be required to be on call at home, should the need arise to provide additional cover. As it is assumed unlikely that staff will need to be called out frequently, a cost equivalent to 25% of a night shift payment has been applied to the fees.

As agency staff may be required in exceptional circumstances an agency premium has been applied to nursing. This represents 2.5% of qualified staff and 1.5% of care workers, and is applied as a 100% cost increase.

A 'timeout' allowance has been applied to all of the staffing levels, other than Management posts and admin. This comprises of 28 days annual leave, 5 days sickness and 3 training days, with annual leave in line with statutory requirements.

- Other Non-Pay Costs: The non-pay costs have been calculated on the basis of the LB care calculation model 2014 plus one year of CPI and include the following categories

    - Food;
    - Utilities;
    - Handyman and Gardening;
    - Insurance;
    - Medical Supplies;
    - Domestics & Cleaning Supplies;
    - Trade & Clinical Waste;
    - Registration Fees;
    - Recruitment;
    - Direct Training Expenses;
    - Other Non-Staff Current Expenses.

We initially used 95% of the LB figures on the basis that their data reflects national averages and it would be reasonable to expect some of these costs to be a little cheaper in Cheshire East than in, say, the south-east or London. We modified this to 100% in the light of feedback from providers

We have not included a figure for corporate overheads, despite this being a parameter included in the LB cost model. Indeed as LB state

> "Previous reports on the model published in 2002, 2004 and 2008 had argued that those costs which relate to the administration of a care home group, and which would not be incurred by a standalone care home operator, should be ignored for the purposes of estimating what fee rates councils should pay, since

APPENDIX 1

> such overheads are best regarded as portfolio management costs which corporate investors are prepared to absorb within their gross rate of return"[7]

This argument seems strong to us particularly as many homes are run by small scale operators. We have however included £5000 per home to cover audit and other requirements of running a business. This was argued as inadequate by one provider – however, the reality is that real costs in this area will vary considerably depending on the type of provider.

- Maintenance/Services: These are split to maintenance capital expenditure, repairs and maintenance and contract maintenance of equipment. For this we have applied the fair price toolkit values from LB adding one year of CPI inflation. The argument has been made that we should use a higher value for maintenance based on our assumptions about the age of properties – however the LB values are derived from survey returns which (presumably) reflect maintenance costs over homes of a range of ages

- Capital/operator profit: The LB model has again been used as a basis for this calculation. Using the required occupancy rate alongside floor space benchmarks, turnkey build costs and land allowances (assuming 0.75 acres required to build a care home), the capital figure has been determined, applying inflation where necessary. We have based land values on current local land prices and the figure of £601k per acre derived from this is consistent with the LB model which states £605k per acre for the North West. Though the LB model assumes a return on capital investment of 7%, we have reduced this to 5% reflecting the current very low rate of inflation. The LB Cost of Care Model assumes a maximum 70% capital cost adjustment factor which is applied only to those homes failing to meet up to new building standards. This adjustment is applied only to the building costs element. As many of the residential homes are older properties, we have, following discussions with commissioners, assumed that 50% do not comply with the 2002 National Minimum Standards and thus have applied a capital adjustment of 35%. Nursing homes however offer a more modern selection of properties: we have assumed that 25% of nursing homes do not comply and thus have applied 17.5% reduction factor.

  One provider argued that "the building cost allowed for in the cost of capital calculation should increase by more than CPI - the BCIS's Building Cost Indices indicate a rise of 9.8% for the period from December 2014 to March 2016." However we would argue that this level of precision would require unpicking the whole model used and, in effect, setting individual prices based on the individual cost of capital in each home and, in particular its current age and physical condition. This would make calculation an average impossible

[7] *Fair Price for Care for: a toolkit for care homes for older people and people with dementia* LaingBuisson 2014 p40

APPENDIX 1

We have not included a separate calculation for operator profit which clearly providers expect to achieve. The LB model assumes a further 5% on top of cost of capital of 7%: whilst providers expect to make a profit we think it is reasonable to argue that this should not be included in a cost of care calculation, as it is not a direct cost of care (although the case law is clear that cost of capital is a legitimate cost of care). However if providers are unable to make profits then this could threaten the sustainability of the local market, and thus leave the Council in breach of its' duties in relation to the Care Act (see below for suggested approach in this area)

Other information on cost of care: a number of providers supplied information on their cost of care calculations. We have summarised these below:

- Craegmoor: requested 2% uplift for 2015/16
- Care Tech: wanted "inflationary uplift" for 2015/16
- MHC: requested 2.9% increase for 2015/16
- Huntercombe: requested 2.5% increase for 2015/16
- Delam: requested 2% uplift for 2015/16
- Care UK: requested 2.4% uplift for 2015/16
- BUPA: requested 3.46% uplift for 2015/16 to cover "part of the funding gap"

The table below gives cost of care calculations supplied by providers

	Proposed rates 15/16 inc FNC	Care UK	BUPA	HC-One	CLS
Residential Care	£415		£684	£509	£462
Residential Care (EMI)	£491	£626		£537	£565
Nursing Care	£562		£781	£607	
Nursing Care (EMI)	£584	£747		£640	

There are a number of features of this table

- There is widespread variation in cost between providers indicating that any consideration of the actual cost of care needs to make a judgement on what is a reasonable cost and what is not;
- Notwithstanding this all quoted figures by providers are considerably in excess both of current rates and proposed rates;
- Part of the difference will be due to different assumptions on utilisation with, for example, BUPA modelling costs on 90% occupancy;
- A further substantial part of the difference will be assumptions on depreciation, central office and profit costs with, for example, CareUK assuming 20-25% of costs in these categories compared to 12-14% in our model
- This is not the whole story however as some providers (eg CareUK) are clearly providing staffing at levels well above what we have modelled as reasonable

APPENDIX 1

Conclusion: Our calculation indicates that the fees currently paid by Cheshire East for 2015/16 are somewhat less than our estimated cost of running a care home based on the above set of assumptions, with an average difference of -4.4% across the four categories

	Bottom up costs net of FNC	Current Cheshire East fees	% difference
Residential Care	£415.94	£376.73	-9.4%
Residential Care (EMI)	£490.90	£467.10	-4.8%
Nursing Care	£446.50	£433.07	-3.0%
Nursing Care (EMI)	£462.32	£467.10	1.0%

2016/17 costs: From April 2016 the national living wage (NLW) of £7.20 must be paid by care homes for staff over the age of 25. For 2016/17 we have therefore remodelled our calculations, assuming that all staff are paid NLW as a minimum. We modified our approach following consultation with providers: previously we had modelled costs based on only 75% of staff being over 25 and thus entitled to NLW but this was felt to be invidious, impossible to implement in practice and inconsistent with the Council's own approach to employees. We also increased salaries for all other staff by 3% to partially maintain differentials, a rate proposed by one provider,

Inflation, based on the OBR's estimate of CPI (1.8%) has also been applied to other costs. In the consultation version we had applied a 0.75% efficiency factor but we have removed this following feedback from providers: although we do not think assuming an efficiency factor is inherently unreasonable given that all parts of the public sector have to find such savings one provider did make the point that insurance premiums were likely to go up by more than inflation as these were often linked to salaries; the same provider also pointed out that CQC registration costs had also gone up buy more than inflation in recent years. Another provider argued that food inflation was likely to be greater in future years. Taking all of this into account we consider an uplift linked to CPI to be reasonable

The breakdown of the resulting costs is as follows:

	Bottom up costs net of FNC	Current Cheshire East fees	% difference
Residential Care	£432.22	£376.73	-12.8%
Residential Care (EMI)	£513.37	£467.10	-9.0%

APPENDIX 1

Nursing Care	£465.68	£433.07	-7.0%
Nursing Care (EMI)	£482.81	£467.10	-3.3%

2017/18 costs: For 2017/18 we have assumed a NLW rate of £7.65 per hour. This is a little less than the figure we used in the consultation version: it is slightly unclear how the 2017/18 NLW will be set but it appears that the ambition is £9.00 per hour by 2020 and we have assumed £0.45 increments a year towards this target. We have also applied CPI at 1.7% (OBR estimate), increased other salaries by 3% and taken into account mandatory pension increases of 1% from October 2017. The breakdown of the resulting costs is as follows:

	Bottom up costs net of FNC	**Current Cheshire East fees**	**% difference**
Residential Care	£448.54	£376.73	-16.0%
Residential Care (EMI)	£534.77	£467.10	-12.7%
Nursing Care	£481.69	£433.07	-10.1%
Nursing Care (EMI)	£519.83	£467.10	-10.1%

There is clearly a significant difference between these calculated costs of care and current fees which will need a response from the Council

Care Home Additional Hourly Rates**:** At times some clients will require additional one-to-one care over and above the base fee levels. For this reason we recommend that a standard hourly rate be applied where care is required above the base rate. The proposed fees have been calculated using a bottom-up approach with the same pay rate assumptions detailed in the earlier section (i.e. hourly rate plus NI, pension, timeout allowance). From 2016/17 we have assumed that care staff will move onto the living wage. We have made the same assumptions as earlier with the workforce rate of pay split due to age. In addition an allowance has been made for the following non pay areas (some based on the LB model):

- Registration Checks
- Recruitment
- Direct Training Expenses
- Other Management Costs
- Margin @ 5%

The calculated hourly rates are as follows:

	2015/16	**2016/17**	**2017/18**

APPENDIX 1

Care Worker	£10.08	£10.87	£11.51
Registered nurse	£20.50	£21.10	£21.71

No comments were received from providers on the methodology for calculating these rates. We have modified these rates from those on which we consulted to take account of the change in approach to NLW and the increase in the nursing hourly rate

Sustainability of local market

Cheshire East has approximately 100 care homes with approximately 4030 registered care beds for older people. The Council commissions about one-third of the available beds in the area, and CCGs, self-funders or other councils commission the balance. We understand that the following facts are true;

- Occupancy levels within local care homes are high, with the snapshot figure of 95% well in excess of the national averages quoted by LB (typically 87-90% occupancy levels are quoted in national surveys);
- There is considerable interest in developing new care homes in Cheshire East to the point where over-saturation of the market has become a policy concern of the Council;
- The Council rarely has difficulty in making placements

Thus there is no evidence of market failure or lack of a sustainable local market despite the widespread provider view that rates paid by the Council are too low. This could of course change rapidly, particularly if the Council succeeds in its ambition of reducing the number of placements it makes in the medium term but there is simply no evidence that the current market is anything other than effective and sustainable

Workshops with Residential and Nursing Care Home Providers

Residential and nursing care home provider feedback from the workshops

We held two workshops with residential and nursing home care providers. They were attended by 17 representatives from 10 provider organisations. These were: MHA, CLS, Tunnicliffe House, Highfield House, BUPA, Porthaven Care Homes, HC-One, The Laurels, Four Seasons Health Care, and Care UK (see Appendix 1 for detailed feedback).

Workshop One was attended by MHA, CLS Care Services, Tunnicliffe House, Highfield House and BUPA. The key issues raised by members of the workshop were:

- The cost pressures they are experiencing, and increasing costs despite a reduction in the headline rate of inflation;
- Recruitment and retention of nurses and care workers as a result of low pay levels and high local employment levels;

APPENDIX 1

- Concern that private funders are charged more than Council funded service users, which will be highlighted by the introduction of care accounts under the Care Act;
- Concern that people entering residential care for an assessment under the Care Act, are being placed at the Council rate even though they are self-funding and could pay the full self-funding rate. Social workers are saying that when a service user goes into residential care under the 12 week disregard, they must be charged the Council rate, even though they will be a self-funder and would otherwise be paying the higher self-funding rate. This threatens provider's existence because they use self-funders to subsidise the lower Council rates;
- Their fear that a shortage of Council staff to do assessments as required by the Care Act will result in delays in referrals to their homes, and subsequent vacancies. This will threaten their financial viability because of the high occupancy assumption included in the fee setting;
- The amount of return on capital included in the calculations of the fee levels; and
- They would like block contracts because it would give them increased financial security and allow them to plan ahead and flex their costs.

Workshop Two was attended by Porthaven Care Homes, Bupa, HC-One, The Laurels, Four Seasons Health Care, and Care UK. The key issues raised by members of the workshop were:

- Their increasing costs and the financial pressure they are experiencing;
- They need to charge top-ups but social workers are opposed to this, and this puts them in a difficult position;
- Recruitment and retention of nurses and care workers as a result of them being unable to compete with other employers;
- The need for a balance of self-funders and Council funded service users in a home to make it financially viable, but the Care Act will make the difference between the two levels more obvious;
- The shortage of bed spaces for reablement for people needing step up or step down provision; and
- The potential to block purchase one to three beds in a home for respite care.

Conclusions from workshops

The discussions in the two workshops covered similar issues. Both workshops included discussion about the cost pressures providers were experiencing as a result of the increasing cost of living; the difficulty in recruiting and retaining staff when they could obtain higher paid work elsewhere; and the need for a balance of self-funders and Council funded service users in the homes

.

Both workshops raised the potential implications of the Care Act, in particular the way in which the introduction of care accounts will highlight the difference in the fee levels paid by self-funders and the Council. They were also concerned that a shortage of Council staff to do assessments as required by the Care Act will result in delays in referrals to their homes, subsequent vacancies, and threaten their financial viability because of the high occupancy assumption included in the fee setting. Both workshops took place prior to the announcement

APPENDIX 1

that the implementation of care accounts would be delayed until 2020, thus mitigating many of the points raised

Both workshops expressed interest in the use of block contracts. Block purchasing offers guaranteed placements and financial stability to providers, but there is a risk that it results in higher costs for the Council, as it pays for voids, and for voids arising as a result of delays in Council processes in placing service users in the homes. Workshop One discussed it in relation to residential and nursing care home places, as opposed to spot contracts. Workshop Two discussed it in relation to respite care. They also discussed the need for more reablement with step up and step down beds.

Discussion and recommendations for fee levels

The Council is obliged to take account of the cost of care when setting fees. However there are a range of fees that the Council could set that would meet this criteria. There are a number of factors to consider:

1. The calculation above models the actual cost of care based on our understanding of reasonable local costs. It indicates that current fees do not fully cover current average costs and this will become more acute from 2016/17 onwards. The fee levels for residential care homes in particular are low both in relation to comparison with the bottom-up calculation
2. The local care home market is large and diverse. Utilisation across the care home sector is high (reported to be 95% in June 2015) and the Council only purchases 33% of beds, indicating that there are plentiful alternative funders for care beds (including CHC, other authorities and self-funders). Thus there is no current evidence of market failure or collapse
3. The Council is currently able to place people within the Borough at current fee rates on most occasions
4. There has been no fee increase since 2009 although costs have obviously increased since then. There was widespread disappointment amongst providers at the lack of a fee increase in 2014/15 when one had been expected

We recommend the following:

1. For 2014/15 the Council should not give an uplift partly because of point 2 above and the level of proposed increase in 2015/16 but also because of the considerable bureaucratic complexity this would involve, including re-assessing all client contributions (this point was disputed by one provider who felt that there should be a backdated increase applied from 1st April 2014);
2. For 2015/16, we recommend an increase of 10% for residential care homes, 5% for residential with EMI, 4% for nursing and 1% for nursing with EMI. These increases are significantly in excess of the rates recommended to Cabinet in 2015 for two years and in excess of the rates requested by providers for 2015/16;
3. For 2016/17 we recommend an uplift of a further 4% for residential care, residential EMI and nursing provision;

APPENDIX 1

4. For 2017/18 we recommend an uplift of a further 4% for residential care, 5% for residential EMI, 2% for nursing and 7% nursing with EMI;

We recommended the following rates for additional one-to-one care:

	2015/16	2016/17	2017/18
Care Worker	£10.08	£10.87	£11.51
Registered nurse	£20.50	£21.10	£21.71

5. Given the difficulty of recalculating all fees and client contributions since April we recommend that the 2015/16 increase be applied on a pro rata basis after the 2015/16 fee levels have been agreed ie we propose that increases are not backdated to 1st April but applied from the date of agreement, allowing providers to discuss the impact of their increased costs during 2015/16 prior to the agreed date of implementation (an alternative approach would be to increase the fees on a *pro rata* basis from the data of agreement);
6. These fees are proposed as average fees designed to cover a range of circumstances: if providers are genuinely struggling to cover reasonable costs on these fee levels they need to be given the opportunity to request fee uplifts over and above these levels by showing their costs on an open book basis. The Council should assess these requests reasonably
7. These fees are predicated on the premise that the current market is vibrant and sustainable. The Council needs to continue to monitor this situation and be prepared to alter its' approach if the situation changes

In summary the proposed fees are thus:

	2014/15	2015/16	2016/17	2017/18
Residential Care	£376.73	£414.52	£431.11	£448.35
Residential Care (EMI)	£467.10	£490.26	£509.87	£535.36
Nursing Care	£433.07	£450.39	£468.41	£477.78
Nursing Care (EMI)	£467.10	£471.77	£483.57	£517.42

The impact of this recommendation is as follows for 2015/16:

	Bottom-up costs net FNC	Current fees net FNC	Diff current/ BUC	Proposed Fee 15/16 net FNC	Diff current	Diff new fee/BUC
Residential Care	£415.94	£376.73	-9.4%	£414.52	10.0%	-0.3%
Residential Care (EMI)	£490.90	£467.10	-4.8%	£490.26	5.0%	-0.1%

APPENDIX 1

Nursing Care	£446.50	£433.07	-3.0%	£450.39	4.0%	0.9%
Nursing Care (EMI)	£462.32	£467.10	1.0%	£471.77	1.0%	2.0%

The impact of this recommendation is as follows for 2016/17:

	Bottom-up costs net FNC 16/17	**Proposed fees 16/17 net FNC**	**% difference 16/17 fees -15/16 fees**	**% difference 16/17 fees – BUC**	**% difference 16/17- 14/15 fees**
Residential Care	£432.22	£431.11	4%	-0.3%	14.4%
Residential Care (EMI)	£513.37	£509.87	4%	-0.7%	9.2%
Nursing Care	£465.68	£468.41	4%	0.6%	8.2%
Nursing Care (EMI)	£482.81	£483.57	0%	0.2%	3.5%

The impact of this recommendation is as follows for 2017/18

	Bottom up costs net FNC 17/18	**Proposed fees 17/18 net FNC**	**% difference 17/18 fees to 16/17 fees**	**% difference 17/18 fees - BUC**	**% difference 17/18-14/15 fees**
Residential Care	£448.54	£448.35	4%	0.0%	19.0%
Residential Care (EMI)	£534.77	£535.36	5%	0.1%	14.6%
Nursing Care	£481.69	£477.78	2%	-0.8%	10.3%
Nursing Care (EMI)	£519.83	£517.42	7%	-0.5%	10.8%

APPENDIX 1

Appendix 1: Feedback from consultation with the Council's residential and nursing care home providers on 22nd and 23rd June 2015

Workshop 1

It was attended by seven residential and nursing care home providers:

- Toby Simon, MHA, Woodlands, Poynton
- Sheila Wood-Townend, CLS Care Services
- Cassandra Shreeve, Tunnicliffe House, Macclesfield
- Denise Moss, Highfield House
- Tracey Stakes, CLS Belong Villages
- Zara Carter, BUPA
- One other attendee who did not sign in.

They made the following comments:

- A lot of service users cannot pay top ups and the Council does not pay enough.
- They rely on top ups from self-funders to pay for Council service users. This issue has been there for years.
- One charity has put private fees up by £20-25/week so the Council's fee is even less by comparison.
- If people come into residential care for an assessment under the Care Act because that is their right, and the Council says they must be placed at the Council rate even though are a self-funder and could pay the self-funding rate, providers will not be able to continue to exist, because they use self-funders to cross subsidise the Council rates. SWs are saying that when a service user goes into residential care under the 12 week disregard, they must be charged the Council rate, even though they will be a self-funder. This will result in a big problem. They should still be coming in under a private contract because they can self-fund.
- Self-funders are choosing cheaper places.
- People are pushing harder to get CHC funding than in the past.
- They get a lot of requests to see service user's notes.
- People are more aware of their rights.
- CHC affects residential care as well as nursing care because service users do not necessarily go into a nursing home if they have dementia.
- There is a £200 difference between the Council and private rate / week. So the private person is paying £100 towards the Council rate and they all know that.
- Situation deteriorating rapidly.
- Provider's fear that a lack of staff in Council's to do assessments as required by the Care Act will result in vacancies. They don't need many to make a home unviable because they are operating on the margins of profitability. But Councils do not know how many people will want assessments. Delays in referrals and assessments could affect viability.
- Hospital discharge – not big issue.
- Recruitment and retention is a problem as they come out of recession. Nurse recruitment is particularly difficult. Recruiting at the minimum wage is hard when others

APPENDIX 1

pay more. Staff go to the agencies because they get paid more, and homes go to agencies if they can't recruit.

- Nursing staff – there is a general shortage. They pay £13/hour and they can get £18/hour elsewhere.
- Care workers are paid at or around the minimum wage. They are competing with supermarkets, etc.
- They have the minimum number of nurses on duty. The Council doesn't stipulate the number in their contracts nor does CQC. They have 1 on all the time, and another if necessary.
- Good practice is 1 to 4 care staff to service users during the day for dementia care, but they don't do it because it costs too much.
- They use staffing levels which have been generally accepted for many years (agreed 28 years ago in 1 home), but service user needs have increased. Self-funder payments cross subsidise what they pay for.
- If the Council sets the staffing levels then they would have to pay extra for it; but they don't set the levels.
- The Council quality assures the care, and they think some of the requirements are unnecessary.
- No management time allowed in the contract for dealing with inspections; there is a long list of people inspecting – Healthwatch, fire, CQC, environmental health, infection control, the Council contracts monitoring team. Bureaucracy is an increasing burden because of the number of inspections.
- Food costs have gone up despite them going down nationally because they were already getting the discounts. Insurance costs have increased. They are putting the prices up because of previous claims. CQC costs have gone up. Energy prices have gone up.
- CQC inspections cost them more because they are checking more areas. This requires more management time. They need to complete information before CQC arrive.
- Occupancy was unrealistic in RedQuadrant's last report: 95-96%, when LaingBuisson put it at 90%.
- If they had block contracts they would like it. Block contracts would need to be for 75%+ beds to make it work for providers.
- Top up fees for additional 1:1 care involve paying in effect a domiciliary care worker to do it.
- Some disagreed with the break-down of costs in RedQuadrant's last report.
- They want the return on capital to reflect risk and reward, because their risks have increased as the complexity of cases has increased. LaingBuisson recommended 7% + 5% for profit. RedQuadrant disagreed with this amount.
- The service user's contribution has increased but it has not been passed to the homes.
- Service users go into a home for 6 weeks, and then there should be a review when they decide whether it should be a permanent placement. Usually it is. But an increasing number remain on extended short stay placements. Sometime it is the service user's choice.
- If the Council has less money it has to pay less placements.

APPENDIX 1

- Most service users are too dependent for re-ablement. Some may be able to go home if it is adapted, with care, but it takes a long time to arrange. Most have exhausted the other options before they got there. They may need 24 hour domiciliary care which is expensive. Also it is stressful for service users to go into residential care and then home.
- Delayed discharges are not an issue for people going into residential care. It is an issue for people requiring aids and adaptations on their own homes.
- If they linked quality assurance to payment to increase the amount paid for a service, it would require Council resources to set up, maintain, etc.
- When they have LA inspections they have 4 people do it. The number could be reduced to save money.
- The Council could just pay the service user their assessed fee without a set price.
- Wigan Council has a spot contract which is short.
- Paying net – providers participated in a net payment pilot but customers and providers didn't like it.
- Payment in advance could only be done on a block contract, but it is not a particular benefit to providers.
- Providers can't reclaim VAT on the welfare elements of the service they provide but if they set up a separate company for Council service users which the Council paid they could reclaim VAT. Would need to change the contract to do this.

Workshop 2

It was attended by ten residential and nursing care home providers:

- Lance Tipper, Porthaven Care Homes, LLP
- Julie Lowndes, Porthaven Care Homes, LLP
- Irene Pointon, Bupa Greengables Nursing Centre
- Linda Brooks, Bupa Newton Court Nursing and Residential Home
- Gill Bratt, HC-One
- Chris J. Thomas, The Laurels
- Philip Middleton, The Laurels
- Karen Cullen, Four Seasons Health Care
- Paula Gresham, Care UK, Station House
- Neil Kerry, Care UK, Station House

They made the following comments:

- Increasing costs from cost of living increases means they have got to charge top ups, but SWs oppose it and that puts them in a difficult position.
- Fees don't meet actual care costs.
- Cost pressures: salaries – they have to pay more to recruit staff. Competition from the NHS for nurses means they have to offer an increased salary for nurses. They can't compete with agencies.
- General shortage of nurses.
- Care staff earn more with the Council or NHS – they pay £9.
- Trying to upskill staff so they can then pay them more, but they leave.

APPENDIX 1

- BUPA give staff bonuses and incentives (physio, access to BUPA fit if they are ill).
- Aldi pay £9/hr.
- It is about seeing care work as a career progression as well as the money.
- Use a dependency tool to assess needs. Flex the rota according to the dependency levels. Try to use own staff rather than agency staff. Flex the rota on vacant beds.
- Non staff costs have increased.
- CQC has changed how they look at things, so providers need to make sure they reach their targets and have the right staff in, and there is a greater risk of enforcement resulting in a fine, so they have to include that in their costs, but it is not a big issue.
- Have joint visits from the Council and DCLG.
- All have a mix of Council and private funded service users.
- Average occupancy in one last year was 92%, and in another it was 91%.
- It is a balance between private funders and Council funded to keep homes sustainable.
- Fewer private funders than in the past at the moment but it depends where they are situated. There are a lot of care homes in Cheshire East so there is a wide choice.
- Service users want to stay in their own area.
- Are asking the Council for top ups because it causes resentment in the home if they charge different rates.
- The Care Act makes the price differential more obvious.
- Shortage of bed spaces for reablement for step up/down.
- City Care in Nottingham provides a service to provide short term care to reable people rather than provide a home. It is spot purchased for people coming out of hospital. They need a staff team equipped to reable rather than maintain dependency.
- Service users are so ill by the time they get into residential care they can't be reabled.
- Could block purchase 1-3 beds reserved for respite but homes prefer a long term person. For respite to work they need to reserve the bed all year.
- Provider forum – not attended them. It is more important for them to build their own relationship with the local Council team.
- Packages of care – takes time to get changes sorted – it depends whether they have got a SW or not as to how quick it is.

APPENDIX 2

Home care fees: consultation and analysis for Cheshire East Council

19th October 2015

Draft FINAL version v0.05

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APPENDIX 2

Contents

APPENDIX 2

Brief for project

RedQuadrant was commissioned by Cheshire East Council in May to make recommendations for future fee levels. Specifically we were asked

1. To carry out an independent review of fair price for care Domiciliary Care within the borough of Cheshire East and comparator authorities from Cheshire East's CIPFA family group- the "market analysis". This includes:

    a. Analysis of out of borough services for ad hoc commissioning.

    b. Review of fee sustainability in the Domiciliary Care sector during the likely term of the new agreement including an analysis of Fair Price for Care requirements and the implications of implementing the Unison Ethical Care Charter

2. To develop for consideration by the Council appropriate and fair prices for care and support fees that take account of the principles of the Care and Support and Aftercare (Choice of Accommodation) Regulations 2014 whether or not they are expressly applicable and which has regard to the Council's financial position so far as is reasonable, based on the work undertaken with care home and domiciliary care service providers and the intelligence gained during the market analysis.

3. To offer suggestions as to how to sustainably grow the market in areas where there is a current shortage of choice and provision.

4. To offer market analysis, position statement, review of fee levels and advice on the following areas:

    - Direct Payments (taking account of new pension responsibilities from April 2015)
    - Fee structures for Extra Care, Respite, other supplementary commissioned services including Shared Lives and Rapid Response Domiciliary Care
    - Setting Rates for Individual Personal Budgets for full-cost payers who wish to access a Care Account
    - Telecare banded service costs – to include a review of the free community alarm service for those aged over 85
    - A review of the impact of mandating payment of the Living Wage and the payment of travel time on fee levels and it's consequence on capacity and sustainability in the market

Purpose of this report

We have undertaken the following activities in relation to this project

- Interviewed a range of stakeholders from the Council, CCG and others
- Reviewed performance data, policy papers and other documentation
- Undertaken two workshops with local care home providers (see Appendix one)
- Prepared draft recommendations on which we have consulted with providers

APPENDIX 2

- Reviewed feedback from providers (nine providers gave feedback – Rossendale, Alternative Futures, AbleWell Care, Intercare, Archangel, Eden Care, HCSS, Sure Care, Tracey Ault)

This report is our final report which summarises our findings and makes recommendations for future fee levels. The revised recommendations are now somewhat different from the draft recommendations as we have taken account of the feedback received about the local cost of care

Context

When setting fees for care home providers the Council is required to follow legislation and to take account of relevant guidance and case law. The requirements in relation to other types of care have, traditionally been far less prescriptive. However the Care Act 2014 strengthens the general duties on local authorities when setting fees. Relevant features of the Act include:

- Section 1 of the 2014 Act places a general duty on local authorities (when exercising their functions under the Act) to promote an individual's well-being. This includes the promotion of the suitability of living accommodation. The Guidance refers to this duty as 'the well-being principle' (see Chapter 1 of the Statutory Guidance).

- Section 5(1) of the 2014 Act places an obligation on local authorities to:
  "(1) ...promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market –
  (a) has a variety of providers to choose from who (taken together) provide a variety of services;
  (b) has a variety of high quality services to choose from;
  (c) has sufficient information to make an informed decision about how to meet the needs in question."

- In performing its duty under section 5(1), section 5(2) of the 2014 Act requires a local authority to have regard to a number of matters, including:

  "(b) the need to ensure that it is aware of current and likely future demand for such services and to consider how providers might meet that demand;
  ...
  (d) *the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not);"*

- Section 5(3) of the 2014 Act provides that:

  "(3) In having regard to the matters mentioned in subsection (2)(b), a local authority must also have regard to the need to ensure that sufficient services are available for meeting the needs for care and support of adults in its area and the needs for support of carers in its area."

APPENDIX 2

- Chapter 4 of the Guidance states:

  "High-quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the local authority is critical to achieving this, both through the actions it takes to directly commission services to meet needs, and the broader understanding and interactions it facilitates with the wider market, for the benefit of all local people and communities." (paragraph 4.1)

  "Market shaping means the local authority collaborating closely with other relevant partners..." (paragraph 4.6)

  *"Local authorities **must** facilitate markets that offer a diverse range of high-quality and appropriate services. In doing so, they must have regard to ensuring the continuous improvement of those services and encouraging a workforce which effectively underpins the market. The quality of services provided and the workforce providing them can have a significant effect on the wellbeing of people receiving care and support, and that of carers, and it is important to establish agreed understandable and clear criteria for quality and to ensure they are met."* (paragraph 4.21)

  *"People working in the care sector play a central role in providing high quality services. Local authorities **must** consider how to help foster, enhance and appropriately incentivise this vital workforce to underpin effective, high quality services."* (paragraph 4.28)

  "When commissioning services, local authorities should assure themselves and have evidence that service providers deliver services through staff remunerated so as to retain an effective workforce. Remuneration must be at least sufficient to comply with the national minimum wage legislation for hourly pay or equivalent salary." (paragraph 4.30)

  *"When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and **fee levels** for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care. This should support and promote the wellbeing of people who receive care and support, and allow for the service provider ability to meet statutory obligations to pay at least the national minimum wage and provide effective training and development of staff. It should also allow retention of staff commensurate with delivering services to the agreed quality, and encourage innovation and improvement."* [Emphasis added] (paragraph 4.31)

  "Local authorities should understand the business environment of the providers offering services in their area and seek to work with providers facing challenges and understand their risks." (paragraph 4.34)

  *"Local authorities **must not** undertake any actions which may threaten the sustainability of the market as a whole, that is, the pool of providers able to deliver services of an*

APPENDIX 2

> *appropriate quality – for example, by setting fee levels below an amount which is not sustainable for provider in the long-term."* (paragraph 4.35)
>
> *"The personal budget is defined as the cost to the local authority of meeting the person's needs which the local authority chooses or it required to meet. However, the local authority should take into consideration cases or circumstances where this 'cost to the local authority' may need to be adjusted to ensure that needs are met. For example, a person may have specific dietary requirements that can only be me in specific settings.* ***In all cases the local authority must have regard to the actual cost of good quality care*** *in deciding the personal budget to ensure that the amount is one that reflects local market conditions. This should also reflect other factors such as the person's circumstances and the availability of provision."* [Emphasis added] (Annex A: Choice of accommodation and additional payments, paragraph 11)

Thus there is an expectation that fees set by councils for all types of care should take account both of the actual cost of good quality care and the need to ensure a diverse array of local provision. Furthermore, it is clear from the brief for this project that the expectation of the Council is that fees need to be set at such a level as to allow providers to recover reasonable costs. We have focused on understanding costs and the broader market in our approach below

Benchmarking and Comparisons

CIPFA Nearest Neighbours Comparator Group

The benchmarking exercise has been performed against the local authorities defined by CIPFA as the closest socio-economic group, taking into account such factors as population, age, unemployment and council tax bandings. The group of fifteen comparator authorities is defined as follows:

1. Cheshire West and Chester
2. Wiltshire
3. Shropshire
4. Bath and North East Somerset
5. Herefordshire
6. Solihull
7. Central Bedfordshire
8. Stockport
9. North Somerset
10. East Riding of Yorkshire
11. York
12. Bedford
13. Poole
14. Warrington
15. South Gloucestershire

Demographics

As population is one of the key drivers behind the number of people receiving social care, the population of each of the authorities was taken into account when undertaking all analysis. Using the most recent detailed data (mid 2013 estimates) from the Office of National Statistics (ONS) all data could be expressed in terms of cost or activity per population. Cheshire East is estimated to have a population of 372,707 including 219,742 adults (18-64 age bracket) and 78,035 older people (65 and over).

APPENDIX 2

PSSEX Benchmarking Outcomes

Using 2013/14 PSSEX data from the Health and Social Care Information Centre (HSCIC) we were able to benchmark key data for Cheshire East against their nearest neighbour authorities, as defined by the CIPFA nearest neighbours model. The outcomes of this analysis should not be used in isolation as average figures could be significantly impacted upon should an authority have submitted inaccurate data. Additionally, the data is already over one year out of date, and therefore authorities may have very different data for the last twelve months.

The information below analyses the information at a weekly and aggregate package of care level, it is not possible from the PSSEX information to extract the comparative hourly rates. Utilising the benchmarked average unit costs, weekly average packages of care and the averages per head of population it is possible to determine the shape of the Councils care levels. All data was based on the gross cost and activity.

Home Care

1. Home care average weekly costs for older people were 13% above peers, though with activity 41.2% lower; gross costs were also 32.1% lower than expected.
2. Due to higher than average activity (26.5%) and higher than average weekly costs (38.3%), gross costs for learning disabilities were 111.7% higher than peer group.
3. Though activity was only marginally below average for mental health clients, average weekly costs were at £526.61, 138.3% higher than peers, thus increasing gross costs by 144.2%.
4. As with all home care client groups, physical disabilities had a higher than average weekly cost by 21.6%. Activity was, at 57.5%, just over half that of the comparator group.

Direct Payments

- Direct payments for older people were 53.8% higher in terms of weekly cost. Activity was also higher by 14.5%, resulting in gross costs 99.9% higher than peers.
- Learning disabilities activity was only 12.1% higher than comparator group though the weekly costs were also higher by 18.1% giving rise to gross costs 35.9% higher than the group.
- Average weekly costs of £92.21 were 24.4% lower than the comparator group for mental health, though as activity was 43.6% higher, gross costs were 98.6% higher than comparator group.
- Physical disabilities had lower than average activity (26.8%) as well as weekly costs (12.3%), thus resulting in gross costs being 34.6% lower than expected for the population size.

(Note the above analysis utilises the weekly packages of care, they do not determine or indicate comparative information about the individual unit (hourly) rates paid by the Council).

APPENDIX 2

Bottom Up costing

Home care costs

As part of our review we have again carried out a 'bottom up' costing exercise for domiciliary care fees. We have used assumptions from within the UKHCA[1] model as a basis for some of the support costs methodology as outlined below. In addition we have relied on our professional judgement and experience, and wherever possible, used regional benchmarking data to enable us to the set costs at an appropriate level.

- Unison Ethical Care Charter: the Unison Ethical Care Charter[2] was launched in 2013 and is an attempt "to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which a) do not routinely short-change clients and b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels."

  There are a number of components to the Charter including

  - The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients
  - The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients. Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones
  - Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time
  - Those homecare workers who are eligible must be paid statutory sick pay
  - Zero hour contracts will not be used in place of permanent contracts
  - All homecare workers will be paid at least the UK Living Wage
  - All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients.

  We have followed these assumptions in our calculations below, unless otherwise stated

- Staff Salary Costs: NMDS-SC indicates that domiciliary care staff are paid an average of £7.18, compared to currently vacancies within the Cheshire East area which indicated hourly rates of between £6.70 and £7.90. It is not however known what level of experience will fall into this level of pay. We have therefore modelled the rates based on £7.20 per hour as this lies near the midpoint of current advertised roles and equates to the new national living wage (NLW)[3] of £7.20 per hour from April 2016. We have also modelled costs in relation to

[1] 'United Kingdom Homecare Association Limited – A Minimum Price for Homecare' version 3.0, July 2015
[2] https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf
[3] 2015 budget announced new national living wage with effect from April 2016.

APPENDIX 2

the current UK Living Wage (UKLW)(£7.85 per hour in 2015/16), assumed to be uplifted by 1% in April 2016 and 2% in April 2017

- Other Staffing Assumptions: The National Insurance (NI) rate has been applied at 9.5% across the board as there will be variations between full time and part time staff which will impact on the differing levels of NI payable. In the consultation version of this report we used 7% but after provider feedback have uplifted this to the figure used in the UKHCA report

A pension contribution of 1% has been applied to account for the current minimum employer contribution, which is consistent with UKHCA recommendations. National minimum employer pension contributions will increase in future years to 2% from October 2016 and 3% from October 2017, and this is taken account of in the proposed rates for 2016/17 and 2017/18.

A 'timeout' allowance of 13.6% has been applied which comprises of 28 days annual leave, 5 days sickness and 2.5 training days. This is virtually identical (0.2% lower) than the UKHCA recommendation. We have not priced an occupational sickness scheme as this is not included in the UKHCA recommendations

- Mileage Costs: An allowance of 2 miles per hour of contracted time has been allocated to the hourly fee, which is consistent with the assumptions made in a similar exercise in 2012 but less than the UKHCA assumption of 4 miles per hour of contracted time. Several providers challenged us on this point, pointing out that some journeys undertaken by carers take much longer than this: however our rationale for this is that we have been asked to set one rate to cover both rural and urban locations and this must imply an average weighting to each area of cost

- Travel Time: There will be an element of non-productive time due to staff members travelling between clients. We have used the UKHCA recommendation of 11.4 minutes for every hour which is consistent with the assumptions made in a similar exercise in 2012 (7.5 for urban locations and 15 minutes for rural locations) and assumed that this will be paid for. Our rationale for this is that we have been asked to set one rate to cover both rural and urban locations.

- Staff Support Costs: The UKHCA model assumes staff support costs totalling 27% of the total price until April 2016 and 25.5% thereafter. This budget line is assumed to include the following costs:

    - Branch staff: Registered manager, supervisors, coordinators, finance and admin staff, quality assurance costs;
    - Office costs: Rent, rates, maintenance, water, lighting and heating, insurance, cleaning and equipment hire;
    - Training etc: Induction training, external training and qualifications;

APPENDIX 2

- Recruitment: Recruitment advertising, criminal record disclosures;
- IT equipment: Computer systems, telephones, electronic call monitoring; Marketing: Advertising and marketing;
- Consumables: Uniforms, personal protective equipment;
- Finance: Bank charges, interest, depreciation.
- Print and postage: Printing, postage, stationery;
- Business travel: Fuel, tax, insurance, vehicle leasing, repairs, mileage, accommodation and subsistence;
- Legal/professional: Legal, professional accountancy, registration fees;
- General: Donations, subscriptions, translation services, general expense

The UKHCA figures seem extremely high in our view. We initially applied a rate of 17%, which we believe to be more realistic for costs across all client groups: this was based on our previous experience of commissioning care services and the views expressed by commissioners of what margin they would expect to see in tendering exercises.

This area was one of the main subjects of contention in the consultation process. Many providers argued that costs in these areas had gone up considerably since the last fee increase and there were increased requirements in this area (eg the Care Certificate) that resulted in higher costs. There does seem little doubt that there are genuine cost pressures in this area. Indeed one provider quoted a KPMG cost of care exercise in Birmingham that, apparently, showed:

- "The average business costs for supported living are 31%, the median is higher.
- The average business costs for dom care is 27% - bang on the UKHCA recommendations!"

We have applied a rate of 22% in our revised model. Together with a profit margin of 3% this results in 25% of the proposed fee being paid in indirect costs. although there is evidence that actual costs are about this proportion we still consider this rate to be uncomfortably high. We suggest that an open tendering exercise would produce a lower rate in this area

- Profit Margin: A margin of 3% has been applied which is suggested by the UKHCA.

- Bottom up home care costs 15/16: The figures above result in a bottom-up cost of home care of £15.28 per hour (=25.5p per minute) for 2015/16. The impact of paying UKLW is to increase this cost to £16.57 per hour

- Bottom up home care costs 16/17: As the 15/16 figure is based on a £7.20 hourly pay rate for home care and this is the level at which the NLW for 2016/17 is set we have used this figure as the basis for the 16/17 costs also. With the impact of pension increases we calculate £15.32 as the cost for 16/17. The impact of paying UKLW is to increase this cost to £16.80 per hour

APPENDIX 2

- Bottom up home care costs 17/18: we estimate that the NLW will increase to £7.65 in 2017/18; previously we had modelled costs based on only 75% of staff being over 25 and thus entitled to NLW but this was felt to be invidious, impossible to implement in practice and inconsistent with the Council's own approach to employees. Using NLW for all employees leads to a fee rate of £16.38 for 2017/18. The impact of paying UKLW is to increase this cost to £17.27 for 2017/18

- Impact of bottom-up costs: At present Cheshire East are using a 15 minute fee structure for all domiciliary care. There are also two sets of fees for the east and south of the Borough. For the future the authority intends to use a standard hourly rate which will be pro- rataed to reflect the time of the appointment. Current rates are set out below as is the impact of setting fees using the bottom-up costs and one standard rate

Appointment time	South Rate per call	East Rate per call	Blended E/W Rate per Call	Bottom-up calculation	Diff bottom-up/blended	Diff bottom-up/East	Diff bottom-up/South
15 minutes	£5.52	£5.77	£5.63	£3.83	-32%	-34%	-31%
30 minutes	£7.67	£8.03	£7.82	£7.66	-2%	-5%	0%
45 minutes	£9.92	£11.41	£10.67	£11.49	8%	1%	16%
60 minutes	£11.22	£12.55	£11.97	£15.32	28%	22%	37%

- 2015/16 costs and fees: The bottom-up figures above are based on one rate being set across the Borough with no differential rates for 15, 30, 45 and 60 minute calls. This approach will bring greater clarity both for providers and commissioners. However, in practice implementing this rate would require considerable changes to current arrangements and it is unlikely that these changes can be implemented this financial year. Thus there is a question as to whether any increase should be offered for this financial year. The table above shows that bottom-up costs are significantly less than the rates paid for 15 minute calls, slightly less than the rates paid for 30 minute calls in the south and considerably more than the rate for 45 minute calls in the south and all 60 minute calls. The decision on whether an increase should be offered thus depends on the ratio of 15, 30, 45 and 60 minute calls amongst providers: this will vary considerably amongst providers thus meaning that a fair overall increase is impossible to calculate. However as there has been a decision to no longer commission 15 minute calls this discrepancy should disappear over time as presumably these are then re-provided as 30 minute calls. The impact of this change on the fees paid to providers for 15 and 30 minute calls was greater in the consultation version of this proposal and attracted negative comment from providers but the figures above, effectively show a very modest impact on one call category and considerable increases in other categories

Direct Payments

We have calculated Direct Payment costs in two different ways:

APPENDIX 2

1. We have used the same methods for building up costs as detailed above for domiciliary care. However we have not included travel time and mileage costs – arguably these should not be considered in the DP calculation. Furthermore where Direct Payments are used to purchase personal assistants there should be less need for support cost overheads so we have reduced these to 5% to cover insurance. There should also be no need for profit margin when employing Pas. Where Direct Payments are used to purchase care via an agency it is reasonable for the agency to expect a similar contribution towards overhead costs and margin – we have modelled this at 25% as with commissioned home care
2. We have done the same calculation as in 1 but we have based the pay costs on the UKLW of £7.93 per hour (£7.85 plus 1%) for 16/17 and £8.09 (plus 2%) for 17/18

The impact of these two different methods is shown below

Method 1	2015/16	2016/17	2017/18
DP agency rate	£12.05	£12.11	£12.98
DP PA rate	£9.82	£9.87	£10.58
Method 2			
DP agency rate	£13.14	£13.33	£13.72
DP PA rate	£10.37	£10.53	£11.19

Both methods can be defended: method two has the advantage of allowing care workers to be paid more than NLW.

It could, however also be argued that the DP agency rate should be set at the rate for commissioned home care as otherwise there is no incentive for providers to provide care in this way

Supported living

At present the same rates are used for home care (which we are defining here as episodic care being provided to people living in their own home, usually to older people and typically non-intensive) and supported living (which we are defining here as continuous/near continuous care being provided to people living in supported living arrangements, usually to adults with learning disabilities and typically intensive). Using the same cost-bases for both types of service cannot be defended when the home care rate is set as above, because the home care costs includes a substantial component of cost for travel time and mileage which obviously do not apply in supported living settings. Effectively the supported living and DP rates thus should be the same on this argument. One provider argued that

“Your report has not taken into account that Customers requiring round the clock support are more complex and therefore more likely to require the intervention of Senior Branch Staff. These staff will be in addition to the rostered staff member/s already supporting the Customer, and are an extra cost with no additional revenue available for the intervention they provide.”

The point of course does not take account of the areas where indirect costs might be lower eg the rostering and co-ordination of peripatetic home care workers is more complex than for workers in supported living. The same provider reported the KPMG cost of care exercise in Birmingham as showing 31% of costs in complex placements were indirect, implying that 34% of the fee should go on indirect costs. We think (based on our experience of commissioning supported living in a variety

APPENDIX 2

of settings) that this is a very high ratio of indirect costs, that a tendered pricing exercise would result in providers quoting at below this rate and thus to expect the Council to pay this level is not reasonable. Thus we recommend continuing to price supported living based on a 25% indirect costs ratio

Sleep-ins

The council currently pays £45.44 per night for sleep-ins, equivalent to £5.05 per hour assuming a 9 hour shift.

There were two legal cases in relation to sleep-ins in 2014 which changed practice in this area. Their impact was summarised by PinsentMasons as follows:

> "…the legal position [now]seems fairly settled – for a sleep-in shift of this type, the entire shift will count as working time for NMW [National Minimum Wage] purposes.
>
> How does this fit with the practice of paying a fixed fee for sleep-in shifts? The simple answer is that it doesn't (subject to the point set out below). It therefore remains to be seen whether employers in the care sector continue to flout the law and hope for the best, or whether they will start to pay in line with NMW. If the latter, the big question is this: who will dare to jump first? It is worth stressing that the above cases do not necessarily mean that employers will have to pay sleep-in shifts at NMW rate. What they mean is that the time spent on a sleep-in shift will count as working time for the purposes of the NMW calculation"[4]

Thus a set rate for sleep-ins that is below the minimum wage is only applicable if the workers undertaking the sleep-in are earning enough above the minimum wage to take their total income to above minimum wage for the payment period

It seems likely that many people undertaking sleep-ins will be paid at or near minimum wage , particularly from April 2016: thus the seems little alternative to increasing sleep-in rates to NMW/NLW levels in this scenario (plus associated NI and leave costs), although the rate could be maintained at the present level for people doing sleep-ins who earn more than this

Comparison of fee levels with other authorities

We have attempted to compare current fees paid by Cheshire East with those paid by others. All of the comparator authorities in the CIPFA comparator group were contacted in order to establish their current fees. In addition to this three further local authorities – Flintshire, Denbighshire and Wrexham - were also included to ensure that the comparison size included neighbouring authorities. To date we have gained the fees from nine of the eighteen identified authorities. Where authorities had a range of rates for one particular area, an average rate has been used in the analysis. In some cases there are no fees noted as they may vary between clients/providers. The results are discussed below by client group.

[4] http://www.pinsentmasons.com/ELP/The%20rising%20costs%20of%20a%20quiet%20'sleep-in'.pdf

APPENDIX 2

Domiciliary Care

The table below shows the costs paid for domiciliary care by comparator authorities:

Council	Older People	Learning Disabilities	Physical Disabilities	Mental Health
Cheshire East	£11.97 - 60 min £10.52 - 45 min £7.82 - 30 min £5.63 - 15 min			
Wiltshire	Commission outcomes not hours	£13.00 to £23.78	£13.00 to £23.78 per hour	£15.00
Poole	£14.28	£14.00	£14.28	£14.28
Warrington	£11.37 - 60 min £11.68 – 45 min £12.18 – 30 min £19.76 – 15 min			
Herefordshire	£13.98			
Flintshire	£14.78 - 60 min £11.09 - 45 min £9.82 - 30 min			
East Riding	Average £14.28 (provider prices used), with an additional cost of £0 - £10 per hour for rural locations			
Bedford Borough	£14.70 (average) for home care			
South Gloucestershire	Home care varies according to provider from £14.16 to £21.04 per hour. If a domiciliary care package is particularly hard to place, we may offer an enhanced hourly rate. Sleep ins vary according to provider.			
Central Bedfordshire	Home care varies according to provider from £11.75 to £19.00 per hour.			

Cheshire East are not the only authority to be currently paying fees on 15 minute blocks, with Warrington and Flintshire also doing so. Compared to those authorities who pay on an hourly rate the Cheshire East fee is lower than its peers, with the closest hourly rate being £13.00, which is 8.6% higher than Cheshire East. The majority of respondents have hourly rates within the range of £14-£15.

Direct Payments

Council	Direct Payments Hourly Rate			
	Older People	Learning Disabilities	Physical Disabilities	Mental Health
Cheshire East	£12.55	£12.55	£12.55	£12.55
Wiltshire	Range from £15.32-£17.22	£16.06 per hour	£16.06 per hour	£16.06 per hour

APPENDIX 2

Poole	£14.28	£14.28	£14.28	£14.28
Warrington	£10.61			
Herefordshire	If Direct Payment for Domiciliary Care then based on standard rate, otherwise on need.			
Flintshire	Variable by negotiation			
East Riding	The usual rate for 2014/15 was £11.00 per hour but this is increased high needs.			
Bedford	Between £10.13 and £12.53 per hour.			
South Gloucestershire	£17.80	£17.80	£17.80	£17.80
Central Bedfordshire	£14.10	£14.10	£14.10	£14.10

Personal Assistants

Council	Personal Assistants			
	Older People	Learning Disabilities	Physical Disabilities	Mental Health
Cheshire East	£12.55	£12.55	£12.55	£12.55
Wiltshire	£11.84 - £13.65	£11.84 - £13.65	£11.84 - £13.65	£11.84 - £13.65
Poole	n/a			
Warrington	n/a			
Herefordshire	n/a			
Flintshire	FCC provides £10.56 per hour for people to employ PA's. Includes employment on costs.			
East Riding	n/a			
Bedford	£7.50 per hour (payable to the PA)			
South Gloucestershire	£11	£11	£11	£11
Central Bedfordshire	£7.89 ph (payable to the PA)			

Outcome based commissioning

Outcome-based commissioning is widely regarded as an important aspect of the personalisation agenda (see Appendix 2 for more information). Commissioning on the basis of individual outcomes, rather than placements, shifts the emphasis away from systems and processes, and onto the quality of the service and the impact on the SU. It focuses on reducing the care needs of SUs, improving their quality of life and maximising their independence.

With growing pressure on adult social care resources, the goal of promoting efficient, outcome-focused services has never been more important. As the Care Act introduces market shaping and commissioning responsibilities, and a greater focus on outcomes within assessments, the use of outcomes based commissioning has considerable merit.

APPENDIX 2

Benefits of an outcome based commissioning model

The benefits of an outcome based commissioning model are:

1. It is person-centred and focuses on the outcomes that service users (SUs) say matter most to them.
2. It maximises SUs capabilities, delaying or reducing the need for services, and promoting their independence.
3. It empowers SUs to have choice and control in their lives and over their care and support.
4. It minimises costs by reducing the long term needs of SUs.
5. It reduces waste and helps to improve the financial efficiency of the service.
6. It holds providers directly to account for the service they provide.
7. It maximises SUs support within their communities from family, friends and community and voluntary sector providers.
8. It incentivises providers:
   - to look at the most efficient and effective way of delivering what the SU needs, which may include community and voluntary sector providers or other services;
   - not to create dependency; and
   - to invest in their staff who will need support and training to work in a way in which they enable SUs to achieve the outcomes they have identified that they want to achieve.
9. It supports providers to pay care workers (CWs) at least the UKLW and guaranteed hours contracts because they have agreed volumes of work in a geographical area.
10. Providers have a geographical area in which they provide services to all the SUs so they can make economies of scale, and reduce CWs travelling time between SUs. This makes the work more attractive to CWs.
11. It supports collaborative working and sharing between providers, because they are not in competition with each other for SUs or for CWs.
12. Having one provider for both re-ablement support and home care services would improve the continuity of care for SUs and reduce administrative costs and information sharing issues.
13. It is consistent with the increased focus on outcomes and payment by results/use of tariffs within the NHS.
14. It is consistent with the national policy drive towards payment by results as seen in a number of major policy areas (e.g. substance misuse treatment, offender rehabilitation, employment services).

Consultation with Domiciliary Care Providers

The Council has 90 domiciliary care providers on its list of providers, and commissions 70 to provide domiciliary care for approximately 1,150 people.

Domiciliary care provider feedback from the workshops

We held two workshops with domiciliary care providers. They were attended by 27 representatives from 21 domiciliary care provider organisations. These were: Care Connect, SureCare Cheshire East, Intercare Services, Valleywood Care, You Like Your Way, Alice Chilton In-Home Care Services Ltd,

APPENDIX 2

Care Needs Ltd, Kare Plus, Cheshire and Staffordshire Homecare Ltd, Quality Care (Staffordshire) Ltd, Lantern Care Services Crewe, AR1 Homecare, Insafehands, Lady Verdin Trust, Evolving Care Ltd, Embrace Group, Homecare4u, Salopian Care, Spiritual Inspiration Ltd, SOS Homecare Ltd and Lantern Care Services (see Appendix 2 for detailed feedback).

Workshop One was attended by representatives from Care Connect, SureCare Cheshire East, Intercare Services, Valleywood Care, You Like Your Way, Alice Chilton In-Home Care Services Ltd, Care Needs Ltd, and Kare Plus.
The key issues raised by members of the workshop were:

- Recruitment and retention is very difficult, because of the salary levels they pay to domiciliary care workers. This is compounded when they do not pay travel time between calls;
- Providers risk having to hand work back to the Council because they cannot recruit staff to do it;
- They have cost pressures;
- Provider forums are not held regularly and are poorly attended; they suggested that they could be improved by allowing providers to put forward agenda items, and having senior Council staff attend;
- They are paid two different rates, depending on the geographical area, which they disagree with;
- It is difficult to get a package of care changed when a service user's needs change;
- Allowing service user's to choose their provider makes it difficult for providers to make economies of scale by caring for a number of service users living near to each other;
- Social workers specifying what time a service user should have, for example, breakfast, makes it difficult for providers to meet the demand at that time – they need to be able to negotiate this with the service user;
- The Council has stopped commissioning 15 minute calls, but these are needed for some tasks, for example, giving eye drops, so it should be the service user's decision;
- There was some interest in outcome based commissioning as a way of dealing with these issues, but some scepticism that it would make any difference; and
- Better crisis management, and planning for the end of reablement would reduce the number of requests for providers to deliver emergency domiciliary care.

Workshop Two was attended by representatives from Cheshire and Staffordshire Homecare Ltd, Quality Care (Staffordshire) Ltd, Lantern Care Services Crewe, AR1 Homecare, Insafehands, Lady Verdin Trust, Evolving Care Ltd, Embrace Group, Homecare4u, Salopian Care, Spiritual Inspiration Ltd, SOS Homecare Ltd and Lantern Care Services.

The key issues raised by members of the workshop were:

- Recruitment and retention – this is not necessarily improved by offering travel time and a higher hourly rate;
- Providers are unable to take work because they cannot recruit the staff to do it;
- It is particularly hard to recruit in rural areas because care staff want to work where they live, and this is not necessarily where the service user is;
- It is hard to recruit staff for palliative care because they are only required for a short period of time for a service user;

APPENDIX 2

- Providers are experiencing cost pressures as a result of the increasing cost of living;
- There has been an increase in the amount of administration involved in running a domiciliary care agency;
- It is difficult to get a package of care changed when a service user's needs change;
- A fixed allowance of time per day does not give providers the flexibility to deal with people whose needs are fluctuating on a daily basis;
- They were positive about outcome based commissioning as a way to deal with the issues they are experiencing, and some had had experience of this in other areas;
- They were concerned that outcome based commissioning may result in the use of fewer domiciliary care providers, but service users who do not want to use the provider delivering domiciliary care in their area can commission their own care from another provider using Direct Payments; and
- The Council pays them promptly which is good.

Conclusions

The issues raised in the two workshops were very similar, with both of them highlighting the difficulty in recruiting and retaining staff when they could obtain higher paid work elsewhere; the cost pressures providers were experiencing as a result of the increasing cost of living; the difficulties involved in getting a package of care changed; and the issues associated with providing a service across a geographical area that is flexible enough to meet service user needs, at a competitive price. Workshop Two included people who had experience of using outcome based commissioning elsewhere and were positive about it. However, Workshop One did not have anyone with any experience of it and was a bit sceptical that a change to outcome based commissioning would help to address the issues they were experiencing. (See Appendix 3 for more information on outcome based commissioning).

Discussion and recommendations for fee levels

Home care, supported living and Direct Payments

The Council needs to take account both of the actual cost of care and the need to retain market diversity when setting home care fees. There are a number of factors to consider

1. Home care average weekly costs for older people are significantly above comparators; this seems to be due to greater commissioning of hours as rates are not out-of-kilter with comparator authorities
2. Direct Payment average weekly costs and activity are both greater than comparators; again this seems to be due to greater commissioning of hours as rates are not out-of-kilter with comparator authorities
3. The current rates are overall probably a little below average compared to comparator authorities although like-for-like comparisons are hard to make
4. There are geographic pockets within the Borough where placements are increasingly difficult to make

APPENDIX 2

5. Providers are claiming a high proportion of cost relating to indirect costs. We believe these costs to be largely genuine but we strongly query a model of provision of care where a third to a quarter of all costs are in back-office and indirect functions rather than directly associated with carer costs
6. the current practice of the Council setting fees based on actual costs of care, combined with the current time and task approach to commissioning care will lead to greatly increased costs in this area in the future: provider costs will continue to increase and there are few incentives currently in the system to reduce the number of hours commissioned

We recommend the following in relation to fees:

1. The Council moves to paying a single rate for home care across the Borough with no east/south split in pricing and no differential rates for 15, 30 and 45 minute packages
2. This will be quite a complex process to implement: we therefore recommend that new arrangements for home care should be introduced from 1st April 2016 and the rate of £15.32 per hour set until 31st March 2017
3. There should be separates rates for personal assistants at £10.53 and other Direct Payments at £13.33 for 2016/17
4. The rates for 2017/18 should be £16.38 for home care, £11.19 for personal assistants and £13.72 for Direct Payments respectively
5. Providers should be allowed the option of proposing higher rates for Direct Payment clients on a case by case basis provided they can give a clear rationale for this and with a ceiling of the home care rate
6. Supported living rates should be £13.33 for 2106/17 and £13.72 for 2017/18; these should be set as ceilings
7. The Council should not increase fees for 2014/15 but should be prepared to listen to arguments from individual providers for fee increases, provided that provider costs are shown on an open-book basis
8. The Council should develop its plans to introduced outcome-based commissioning of home care and include providers in this process
9. The sleep-in rate should be calculated as the NLW hourly rate (plus NI and leave on-costs) multiplied by 9 hours where workers are being paid at NLW levels; the rate should remain the same as at present otherwise

We recommend the following in relation to commissioning:

10. The Council should move towards developing an outcome-based approach to commissioning of home care as soon as possible. The current time and task approach to commissioning will prove very expensive if allowed to continue
11. as part of this approach the Council should tender for a much smaller number of providers to provide home care (with the tender evaluation partly based on price), perhaps on a cost and volume basis as in Wiltshire and perhaps within geographically based localities as is Wiltshire and Cheshire West and Chester
12. Alongside this the Council should strongly promote the use of DPs and. in particular, PAs as an alternative way of meeting care needs. PAs in particular can offer better outcomes

APPENDIX 2

at lower cost and with more money going to the carer; this will require some investment in infrastructure to support PAs and a review of current assessment and placement practices

13. Supported living packages should be retendered on an outcome-focused basis with the aim of reducing the number of commissioned hours where safe and appropriate to do so and with part of the tender evaluation being based on price

APPENDIX 2

Appendix 1: Feedback from consultation with domiciliary care providers

Workshop 1

It was attended by ten domiciliary care providers:

- Richard Wyatt, Littleton Hall Ltd, Care Connect
- Sue Ritchie, SureCare Cheshire East
- Paul Brandrick, SureCare Cheshire East
- Mike Doherty, Intercare Services
- Stuart Coxon, Valleywood Care
- Grace Moffitt, You Like Your Way
- Karen Perry, Alice Chilton In-Home Care Services Ltd
- Andy Wardle, Care Needs Ltd
- Lesley Crowe, Kare Plus
- Jamie Hickson, Kare Plus.

They made the following comments:

- Recruitment is their biggest problem. They risk having to hand work back to the Council because they can't get the staff, because they go to other jobs where they can be paid more. It is especially an issue when they do not pay travel time. It is more of an issue in Crewe, but not in Bury.
- Retention is also a big issue.
- Recruitment and retention are both harder now than 6 yrs ago, even when they pay travel time.
- Current position is unsustainable because providers can't pay staff enough because the Council doesn't give them enough money;
- Some can't bid for work because they have not got staff to do it.
- The skill level drops because good staff leave.
- No collective feedback from the Council from the previous consultation 3 years ago, and they have been unable to get feedback when they have approached the Council individually.
- They don't do whole hours of care they do parts of an hour.
- The length of calls has reduced.
- 1 provider does 1 hour calls only so it doesn't pick up LA work.
- Provider forums not well attended so one provider said they didn't go because it was not well represented by the market.
- Provider forums supposed to be quarterly but they are not held quarterly, and not attended by senior Council people. Providers should be allowed to put forward agenda items.
- Their relationships with care arrangers are ok.
- It is difficult if they need to increase the package of care (POC). They have to contact the duty team because SWs have closed the case. This takes longer and the duty team don't know the case.
- When they get the package increased it is often not reflected in the contract, so they have to push for the money to be backdated.
- They have to wait 3 weeks before an increase will be considered. SWs say they don't increase the POC until they contact them with a decision, but the extra is required earlier.

APPENDIX 2

- This also works the other way when they need to reduce the POC; they email SWs to say need to reduce the POC.
- Short calls are a false economy. 1 provider had done an analysis of it and had wanted to discuss it with the Council but the Council was not interested.
- Paid more in Congleton than Crewe /hr and they don't think it is right.
- SWs define what time they want the call, which makes it hard to provide the call at that time.
- Block contracts assume that the service user is willing to accept the provider /carer on offer. But choice of where to go destroys the provider's ability to manage geographical areas.
- Cheshire West & Cheshire pay the minimum wage + travel time.
- They all need to look at things differently.
- Crisis management, re-ablement and planning for when it ends, and better care would help avoid requests for emergency domiciliary care.
- Council staff changes lead to inconsistent ways of doing things.
- Some cynicism about outcome based commissioning (OBC) – 'is another way to pay them less'.
- Insulting to staff to pay them to do the work and not pay travel time. They need to pay carers more /hour.

Workshop 2

It was attended by 17 domiciliary care providers:

- Clair Scott, Cheshire and Staffordshire Homecare Ltd
- John Mussell, Cheshire and Staffordshire Homecare Ltd
- Paul Ravenscroft, Quality Care (Staffordshire) Ltd
- Kirsty Burns, Lantern Care Services Crewe
- Irene Merricks, AR1 Homecare
- Rachel Wright, Insafehands
- Charlotte Parton, Insafehands
- Chris Yearsley, Lady Verdin Trust
- Carol Vickers, Evolving Care Ltd
- Jenny Payne, Embrace Group
- Ryan Brummitt, Embrace Group
- Stephanie Roberts, Homecare4u
- Heather Haley, Salopian Care
- Tracy Ault, Spiritual Inspiration Ltd
- Richard Jackson, SOS Homecare Ltd
- Chris Atherton, SOS Homecare Ltd
- Moira Mccumskey, Lantern Care Services.

They made the following comments:

- They have recruitment issues. It is not just about salary. They have tried offering £12.00 / hour and still only got four applicants – normally they pay £8.30 / hour.
- Zero based contracts are an issue for some people but others don't want contracts.

APPENDIX 2

- People are not applying for jobs. Low unemployment locally so there is a limited pool of people. All potential staff have been round all the agencies and decided where they want to work.
- Petrol price is an issue, so that people don't want to go out of their own area.
- Providers can't take on more hours because they can't recruit staff.
- In Staffordshire the Council offered better terms and conditions and one provider lost 4 staff to the Council. Providers can't compete with this but it has not happened in Cheshire East.
- There are people on a Council list that they can't provide care for.
- All service users want breakfast at the same time, and providers can't do it.
- Increasing numbers of domiciliary care providers.
- Travel time is an issue.
- For palliative care, and end of life the Council will pay whatever the domiciliary care providers ask for the last 2-3 weeks of life.
- Providers can do as much palliative care as they want – a list of people needing it goes out every day, but staff don't want to go out to rural areas, and staff are only required for short period of time, so it is hard to recruit them.
- Self-funders come from word of mouth.
- Providers charge the same rate for Council funded service users and self-funders. The self-funders ring the Council to check the price before they ring the domiciliary care agency and ask for the same rate.
- Cost pressures – 1 provider pays double time on bank holidays to keep staff but they don't get the money from the Council.
- One said they had spoken to their company solicitor who had said they will be breaking the law if they don't pay travel time.
- When new care agencies open they are using the same group of carers – it is someone deciding to set up on own, whilst others close.
- Schools had stopped doing health and social care courses so young people have not been doing care, and older workers are retiring so there is a staff shortage; colleges /schools have now started to do them again this year.
- Low status of carers – you only hear about nurses pay in the media and not social care pay.
- Perception that care is an easy thing to go into, but when the young people start and see the training and NVQ they have to do when they are people who have already failed academically, it puts them off.
- CQC now use key lines of enquiry (KLOEs) – this has increased workload for providers.
- Care Certificate – it must be obtained within a specified number of weeks, so their practice has to be observed.
- Extra documentation is required for CQC.
- Fees have to cover staff in the office to meet the regulations as well as provide care. The mount of administration has increased significantly.
- The Council has stopped commissioning 15 min calls, but it is needed for some calls, e.g. giving eye drops. Thinks the Council should not take a blanket approach – it should be at the service user's request.
- 15 min calls should be paid proportionally more because of travel time involved, and because two 15 min calls is double the admin of a 30 min call.

APPENDIX 2

- Outcome based commissioning (OBC) would be better because people's needs fluctuate.
- Unless they have pods of carers in different places, it takes longer to travel to rural areas.
- Don't want rural 15 min calls because of travel time and admin costs involved.
- Pay enhanced sleep in rate which is higher than the Council pays – other councils recognise this following legal challenge.
- Travel time has to be counted as part of the minimum wage – HMRC has said so and they are blitzing care companies, asking them to do it.
- One provider had experience of OBC in South Wales – 'it is brilliant': the provider meets the assessor to write the POC, and then the provider can change it, and so long as they deliver the agreed number of hours/week they are all happy. The provider talks to the service user to talk about how they should deliver the hours. The SW is not there, but provisionally accepts it, depending on the discussions with the service user about times, etc.
- Under current arrangements, when the provider meets the service user to talk about delivering the care, and family wants breakfast at a different time to what the service user has agreed with the SW, the provider has to go back to the SW to agree the change. OBC would cut out all that to'ing and fro'ing.
- Once the POC has been in place for 6 weeks, the SW closes the case and the provider has to go back through the duty team if there are any problems or the package needs changing; this takes extra time. They have to wait 2 weeks before get a response. It is difficult to get an assessor. They get paid when the case is assessed and agreed by the SW manager even though they are already providing the extra care. Some others are done within the same day. So the time it takes is variable. If it needs reducing they get an immediate response.
- Current way of being given times to call on the service users is not sensible because their needs vary on a daily basis.
- In Newcastle they are looking at swopping service users into geographical areas, so e.g. if 4 domiciliary care agencies are going to 1 block, they would swop service users so they all go into one.
- Staffordshire say that all the work has to go on the framework first – it can't just be swopped form 1 domiciliary care agency to another.
- In another area they have put proximity to another service user as a criterion for winning the tender.
- With OBC - how would the Council assess whether the outcome has been achieved – in South Wales it is: 'is the SU happy?'
- OBC is better for the service user than task based commissioning and better for the agency – there was no opposition in the room to it.
- There are a lot of providers here so reducing them to approx. six for OBC would mean that a lot will go out of business.
- There is a risk of the price going down to the lowest and company folding.
- Paying in advance would remove the uncertainty about when providers are paid; some LA's pay weekly, monthly, some 3 months in arrears; all were happy with the Council's approach.
- It would need to be transparent and monitored for OBC to work properly.
- It is harder to develop outcomes for older people, easier for LD and MH.
- OBC is good for people with dementia because the care is flexible to meet their need; the flexibility if they are bed bound and need a hoist is not an issue.

APPENDIX 2

- Positive about OBC.
- If a service user doesn't want the provider under OBC they can take a DP; this allows other agencies to exist.
- The Council's rate is low, but they pay promptly which is good.
- For some service users providers wait for payment whilst the SW puts it on the portal.
- The Council can pay a salary enhancement for reablement, etc, which they provide in house and which providers cannot compete with. But the Council has to pay inherited terms and conditions, and also the Council is the provider of last choice for service users who cannot be placed with any other provider.

APPENDIX 2

Appendix 2 Outcome Based Commissioning

Outcomes Based Accountability

Outcomes Based Accountability (OBA) is an approach to planning services and assessing their performance that focuses attention on the results – or outcomes – that the services are intended to achieve. It was developed by Mark Friedman and described in his book, 'Trying Hard Is Not Good Enough', in 2009. OBA is the basis for Outcomes Based Commissioning. The OBA model has been used in the USA and several countries worldwide as a way of structuring planning to improve outcomes for whole populations and for improving services. It is seen as more than a tool for planning effective services. It can become a way of securing strategic and cultural change: moving organisations away from a focus on 'efficiency' and 'process' as the arbiters of value in their services, and towards making better outcomes as the primary purpose of their organisation and its employees.

Key features of OBA include:

- population accountability, which is about improving outcomes for a particular population within a defined geographical area; and
- performance accountability, which is about the performance of a service and improving outcomes for a defined group of service users.

The approach involves:

- The use of simple and clear language;
- The collection and use of relevant data;
- The involvement of stakeholders, including service users and the wider community, in achieving better outcomes; and
- The distinction between accountability for performance of services or programmes on the one hand, and accountability for outcomes among a particular population on the other.

What are Outcomes?

An outcome is 'an impact on quality of life conditions for people or communities'. There are three types of performance measure in OBA:

1. How much did we do? (our traditional pre-occupation)
2. How well did we do it? (important, but not as important as…)
3. Is anyone better off/what difference did we make?

Answering the third question has driven recent work on outcome based commissioning within Adult Social Care (ASC), most notably in Wiltshire Council with its Help to Live at Home Service.

There are two types of outcomes in OBA:

1. Individual outcomes; and
2. Broader community or service level outcomes, in which providers are paid to reduce the number of SUs going into residential care in a year.

Outcomes Based Commissioning

APPENDIX 2

The use of outcomes in local government is developed by Richard Selwyn, in his book, 'Outcomes & Efficiency: Leadership Handbook', 2012. This describes how to implement a new outcomes and efficiency model to build a resilient government organisation that is able to radically and quickly transform. It includes designing the system of services, partners and citizens; implementing a full commissioning model to manage the system; and realising the benefits through dynamic change management.

Outcome-based commissioning is widely regarded as an important aspect of the personalisation agenda. Commissioning on the basis of individual outcomes, rather than outputs, shifts the emphasis away from systems and processes, and onto the quality of the service and the impact on the SU.

Most outcomes have value, both 'soft' (improved SU well-being) and 'hard' (financial). Therefore, investing in them may initially increase expenditure in the short term but deliver subsequent and sustainable larger saving in the medium term. Most outcomes can be realised in the short or at least medium term – often within a year and potentially in time for the next regular care review. If this is implemented well, then the net cost in one budget year should be similar to earlier commissioning budgets. In subsequent years, savings will accumulate and deliver against Council expenditure targets and/or in part, fund more invest to save initiatives in social care, in concert with health partners.

Outcomes Based Commissioning and Payment by Results

The process of paying providers on the basis of the outcomes they achieve is less widely used than outcomes based commissioning. Payment by Results (PbR) can be introduced into new outcomes based frameworks in pre-declared phases, initially monitored and reported in shadow format ("if PbR were already live this would have been your payment"), and ultimately as a major component of payment, allowing a modest guaranteed element to cover basic staff costs. This approach to payment was introduced in Wiltshire in 2012 in the Help to Live at Home Project.

The Care Act: Market Shaping and Commissioning

The Care Act introduces new duties on local authorities to facilitate a vibrant, diverse and sustainable market for high quality care and support in their area, for the benefit of their whole local population, regardless of how the services are funded. The Council's commissioning and procurement practices must take account of these wider 'market shaping' duties. These relate to the market shaping and commissioning section of the regulations and guidance for implementation of part one of the Care Act in 2015/16.

To support these developments, Birmingham University has published, 'Commissioning for Better Outcomes – a Route Map'. This was commissioned by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). The standards are designed to drive improvement, and provide a framework for councils to self-assess their progress against best practice in commissioning and enable them to identify areas for further improvement. It is being piloted by a small number of local authorities and will be rolled out in January 2015.

APPENDIX 2

With the Care Act requiring a greater focus on outcomes within assessments the use of outcomes based commissioning has considerable merit. Many councils are introducing it. However, it requires considerable change to ASC assessment and care planning arrangements, supporting systems, the providers' approaches to delivering care, the expectations of SUs and carers, and the expectations of community and voluntary sector organisations.

Benefits of an Outcomes Based Commissioning Model

The benefits of an outcome based commissioning model are:

1. It is person-centred and focuses on the outcomes that SUs say matter most to them.
2. It maximises SUs capabilities, delaying or reducing the need for services, and promoting their independence.
3. It empowers SUs to have choice and control in their lives and over their care and support.
4. It minimises costs by reducing the long term needs of SUs.
5. It reduces waste, and helps to improve the financial efficiency of the service.
6. It holds providers directly to account for the service they provide.
7. It maximises SUs support within their communities from family, friends and community and voluntary sector providers.
8. It incentivises providers to:
   - look at the most efficient and effective way of delivering what the SU needs - which may include community and voluntary sector providers or other services;
   - not to create dependency; and
   - to invest in their staff who will need support and training to work in a way in which they enable SUs to achieve the outcomes they have identified that they want to achieve.
9. The Council aims to ensure an integrated approach to commissioning health and social care services; this is a fundamental part of the council's vision to become a commissioning authority. A key focus is on achieving positive agreed outcomes with service users that increase their independence and wellbeing.
10. It is consistent with the national policy drive towards payment by results as seen in a number of major policy areas (e.g. substance misuse treatment, offender rehabilitation, employment services).