# Care home fees: report for Cheshire East Council

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## 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:

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

“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:

> "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

[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

the claimants could have requested a quantification of actual costs, but they did not do so.[4]"

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

[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
[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

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 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."*

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 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 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, 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 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

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

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.

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 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 |

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.
  .

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 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 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 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

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

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

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

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 | % difference |
|---|---|---|---|

| | | fees | |
|---|---|---|---|
| **Residential Care** | £432.22 | £376.73 | -12.8% |
| **Residential Care (EMI)** | £513.37 | £467.10 | -9.0% |
| **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 |
|---|---|---|---|
| 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;
- 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

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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 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;
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 | Current fees net | Diff current/ | Proposed Fee 15/16 net FNC | Diff current | Diff new fee/BUC |
|---|---|---|---|---|---|---|

| | net FNC | FNC | 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% |
| 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: 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

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.

- 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.

- 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.