Cabinet

Report of:	Joe Fowler – Director of Commissioning
Report to:	Cabinet
Date:	05/02/15
Subject:	Care Home Market and fees analysis 2015/16
Author of Report:	Steve Jakeman

Summary: This report:

- Describes the National Care home market and national demographics.
- Describes the local Care home market and Sheffield demographics
- Considers the impact of inflation and other cost pressures on care homes
- Considers the Council's financial position
- Makes recommendations on a the proposed level of Care home fee increase for 2015/16 given the above

Recommendation:

That there is a 2.33 % rise in Residential Care home fees and a 2.45% rise in Nursing home fees for 2015/16 acknowledging the general impact of inflation and the increase in staff costs on all Care homes, and the particular pressure of increased staffing costs on nursing homes

Summary

There has been a “freeze” in Care Home fees for the last two years. During this time we know that the cost of running a Care Home has increased.

This year the National Minimum Wage rose by 3% and inflation by 1.2%. Together these cost drivers create an estimated 2.33% cost pressure for care home providers.

In previous years, there has been sufficient confidence that the market would continue to develop and deliver modern, efficient accommodation to replace the capacity lost as less efficient care homes have closed. This confidence, coupled with the Council’s challenging financial position, meant that fees have not been increased for the last 2 years.

This year there has been further unplanned closures and there are a limited number of new care home developments at the planning stage. However, there *is* still capacity in care homes and providers tell us that they are benefiting from increased occupancy levels.

Our view is that the care home market is now in a stable position, with sufficient capacity for the short- to medium-term. However, we believe that given the cost pressures providers are under, there is a risk that a further fee freeze could de-stabilise the market and lead to unplanned closures. These closures would reduce choice for people in Sheffield needing to move into a care home, and increase the risks of capacity falling below demand.

Following consultation with providers, we have also acknowledged that staffing cost pressures for *nursing* homes are a particular challenge as staff costs inevitably form a greater proportion of overall costs in homes that have greater levels of staffing.

The recommendation this year is therefore for a rise of 2.33% in residential home care fees and an increase of 2.45% in the fee for nursing homes. These increases are based on a consistent calculation of increased costs given that inflation is at 1.2% and staff costs have risen by 3%.

It is recognised that the cost pressures discussed above relate to increases in the National Minimum Wage as opposed to the ‘Living Wage’. The introduction of the living wage across the care sector remains a key ambition for the Council. However, this *annual review of the fee level for just one component* of Sheffield’s health and care system is not in our view the vehicle for achieving this ambition.

We need to work with the full breadth of health and care providers to look at how the wider benefits of paying the living wage can be achieved within the context of the economic environment and the financial challenges faced by public services. This will be a key priority for the year ahead.

That the Cabinet lead:

- Note the conclusion of the market analysis.
- Confirm a 2.33% increase in Residential Care home fees for 2015/16
- Confirm a 2.45% increase in Nursing Home fees for 2015/16

Background Papers: Report attached

Category of Report: OPEN

Statutory and Council Policy Checklist

Financial Implications
YES Cleared by: Richard Jones
Legal Implications
YES Cleared by: Steve Eccleston
Equality of Opportunity Implications
YES Cleared by: Phil Reid
Tackling Health Inequalities Implications
NO
Human rights Implications
NO:
Environmental and Sustainability implications
NO
Economic impact
NO
Community safety implications
NO
Human resources implications
NO
Property implications
NO
Area(s) affected
Relevant Cabinet Portfolio Leader
Mary Lea
Relevant Scrutiny Committee if decision called in
Healthier Communities & Adult Social Care
Is the item a matter which is reserved for approval by the City Council?
NO
Press release
YES/NO

Fees and Market Analysis: Care homes 2015-16

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Report to Cabinet

1. Management Summary

1.1 This report

- Describes the National Care home market and national demographics.
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2. What does this mean for the people of Sheffield?

2.1 The City's Health and Wellbeing Strategy aims to support people to live at home for as long as possible. This strategy appears to be working as people in Sheffield are entering care homes later in their life.

2.2 The Council will continue to offer support to help people to live independently, safely and well in their own homes. The Council will also continue to support the development of homes that help people with support needs to live more independent lives.

2.3 However, some people do need the care that care homes provide, and the Council has a responsibility to ensure that the city has a sufficient choice of good quality provision. In recent years, the Council has taken robust action, with local and national partners, to drive improvement in care homes that do not provide the quality of care that Sheffield people deserve.

2.4 The city currently offers a good choice of good quality care homes. However, with recent unplanned closures and limited development of new homes, we are concerned that a third consecutive fee freeze (following a year in which fees were reduced) could lead to closures, which will start to restrict choice and potentially impact on the quality of service provided to the people of Sheffield.

2.5 We believe that the fee increases recommended in this report will enable providers to continue to deliver the current level of provision and quality of care. We will continue to work with providers to ensure that is the case.

3. Outcome and Sustainability

3.1 As discussed above, the city's Health and Wellbeing Strategy aims to support more people to live independently at home for as long as

possible. This outcome is being achieved as more people are entering care homes later in their lives. Sheffield also has a relatively low rate of admission into residential and nursing care.

3.2 However, local demographics indicate that the number of older people in Sheffield will continue to grow and, as a city, we will be reliant on care homes to provide good quality care accommodation for the foreseeable future. There is therefore a clear need for a healthy care home market in the city and this requires the Council, as the dominant 'buyer' of care home places, to pay a fee level that supports a healthy market.

4. Background and Context

Market size and make-up

4.1 Over the last 18 months capacity in the care home market nationally rose by 3,600 beds to an estimated 487,800 residential places nationally. However, demand over the same period rose by 10,000 to an estimated 432,000 occupied places.

4.2 Average fee levels are approximately 4.8% down in real terms over the last 3 years. However, home closures were historically low in 2012, with smaller homes continuing to survive despite financial pressures.

4.3 Local Authority run care homes across the UK are in decline, falling by 11% over the last year. Sheffield Council no longer runs any care homes.

4.4 The big four national care providers account for 18.4% of the national market and in localized areas this can be more than 25% of the market. This could eventually lead to an increase in the abuse of "supplier" power, but currently there is no evidence of this happening.

4.5 Care homes are generally increasing in size with the average number of beds per home going up from 24 to 50 over the last 25 years.

4.6 **In Sheffield**, providers range from small, long established operators with a single care home in a converted property, to large national organisations that run many purpose-built care homes – typically focused on areas of the city where land costs are lower.

4.7 Providers operate a range of different business models. Some operate with significant debts whereas others may have very little. National providers will cross-subsidise across their homes to manage local variations in demand and profitability. Larger providers can also exploit economies of scale.

4.8 The current market share of residential and nursing care home provision in Sheffield is dominated by the private sector with a 79%

share of the market. The voluntary sector has a 16% share and the NHS 5%.

4.9 There are currently 83 private Care homes in Sheffield providing 3804 beds (see table below).

Care Type	Number of homes 2014	Number of beds 2012	Number of beds 2013	Number of beds 2014
Care homes with nursing	44	2,007	2,447	2,313
Residential Care homes	39	1,887	1,542	1,491
Total Private Care homes in Sheffield	83	3,894	3,989	3,804

4.10 In addition to these 83 homes there are 6 homes that are registered with CQC as 'Caring for adults over 65 years' but provide a predominantly specialist service for Learning Disabilities and therefore have not been further included within this report.

4.11 Approximately 200 beds in the independent sector were booked out by health services over the last year for people leaving hospital with continuing short-term health needs. This impacted on capacity in nursing homes.

4.12 The last year has seen five care home closures, two of these were planned closures at Norbury and Bolehill View, but the other three were unplanned. This market re-sizing has reduced care home beds in the city by 185.

4.13 This was anticipated to a degree in last year's fee report and to an extent is the market re-sizing itself as the strategy of supporting people at home reduces demand. The closures this year have cancelled out increases from the previous three years.

Year	2011/12	2012/13	2013/14	2014/15
New Care homes	2	1	2	0
Unplanned closures	0	1	1	3

4.14 To contribute to this report, all residential and nursing homes were invited to submit their actual levels of occupancy over the last year. Just over a third of Homes provided data.

4.15 Average occupancy data shows overall that care homes in Sheffield remain broadly comparable with other regions. The overall trend is up from 2013/14 but there remain variations within homes across the city. Some care homes have consistently high levels of occupancy whilst others are experiencing significant problems filling places.

	Nursing	Residential
	% Occupancy	% Occupancy
Sheffield 2014/15	**87.53%**	**88.57%**
Sheffield 2013/14	**83.00%**	**86.70%**
Sheffield 2012/13	**90.10%**	**88.30%**
North East	84%	85%
Yorkshire & The Humber	87%	87%
North West	91%	89%
West Midlands	89%	94%
East Midlands	89%	88%
East of England	88%	91%
Greater London	87%	89%
Southern Home Counties	87%	90%
South West	87%	91%
England 2012	89.8%	90.4%
England 2013	88%	90%

4.16 In the consultation with providers it was noted that the impact of low occupancy is experienced differently by different sized homes.

4.17 Smaller homes need consistently high levels of occupancy to survive and therefore the risk of reducing demand levels can be greater.

4.18 Medium sized Homes are proportionally more secure, however they may be managing low occupancy levels by cross-subsidy, drawing on capital, or re-scheduling debt.

4.19 Larger homes that are part of national organisations are often able to better manage reduced occupancy, through cross-subsidy or economies of scale.

4.20 The occupancy rate has risen slightly over the last year compared to previous year and this has been welcomed by providers. The figures below show that there is still sufficient capacity in the market to cope with any variations in demand. However any unplanned exits from the market could quickly change this situation.

	Number of beds	**Average occupancy**	**Vacancies 2014/15**	**Vacancies 2013/14**
Care homes with nursing	2313	87.53%	289	415
Residential Care homes	1491	88.57%	171	205

4.21 Another issue of note is that because residents are remaining in care for shorter periods of time, there is now increased turnover of rooms in care homes. It is hard to quantify this as a percentage as there are too many variables, but it is safe to say that at any given time not all of above 'vacancies' are actually available.

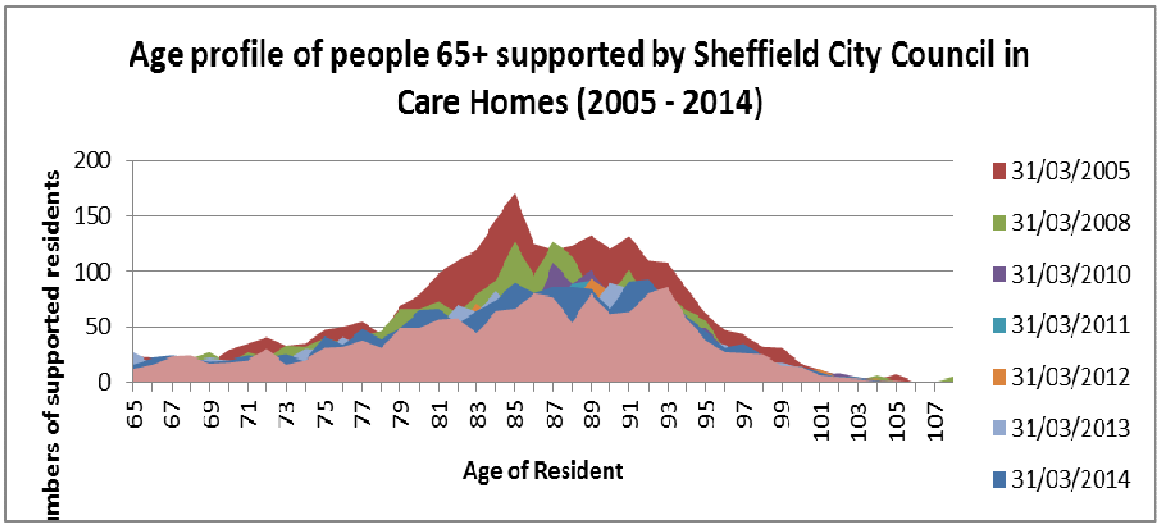
4.22 Some smaller homes are looking to diversify into taking residents with increased care needs. Whilst this may increase occupancy it may also increases staff costs. In the past this diversification has proven difficult for smaller homes to manage and sustain in the longer term.

4.23 The market for **adult mental health** care home accommodation is relatively small. There are around 80 beds registered for mental health only with some additional capacity added in 2014. Of these beds, 55% are provided by the independent sector and 45% by not for profit organisations (e.g. national mental health charities or housing associations).

4.24 However, there are a wider number of beds (300+) in homes registered to provide care across a range of needs including mental health, physical disability and learning disability. These are primarily in the independent sector. About 23% of people have high and complex needs requiring specialist packages of care including meeting physical as well as mental health needs. This includes people with a diagnosis of mental illness and Aspergers or other conditions on the autistic spectrum. (See Appendix B)

Market trends – history

4.25 Sheffield is mirroring the national demographic picture, with increased numbers of older people living for longer. In public health terms this is a huge success story with most people now able to anticipate increased life expectancy.

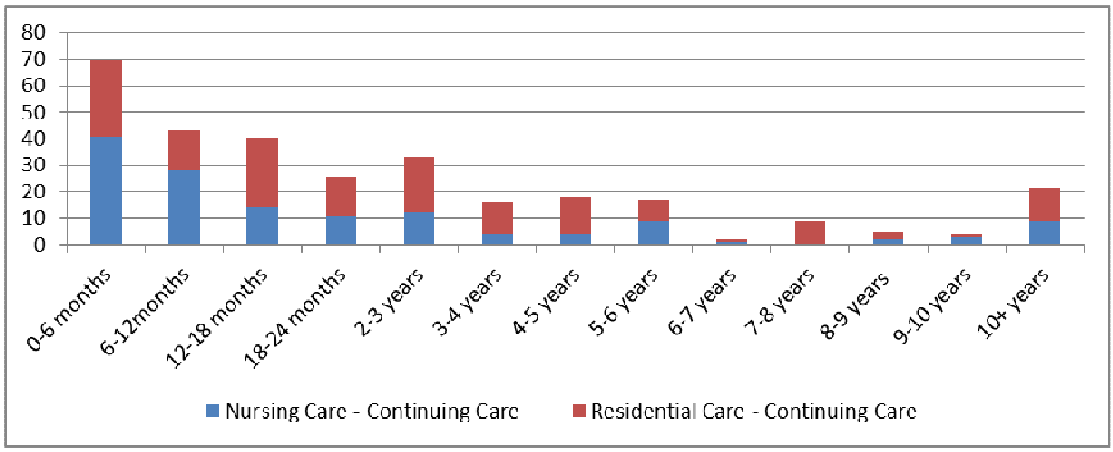


4.26 From this chart it can be seen that, 57% of the people living in residential Care are now aged 85 plus.

4.27 More people are entering residential care homes later in life 85+ when their care needs are likely to be greater. This increases pressure on care homes and also means that people's stay in care homes tends to be shorter. The graph below illustrates this – showing a gradual

decline in the average time spent in care (the 10+ years is historical data).

4.28 The overall strategy at national and local level is to support people to stay healthy and well in their own homes for as long as reasonably possible. This appears to be having an impact.



4.29 However, even if people enter care homes later in life, the changing demographics mean that there will still be an increasing need for residential and nursing care in Sheffield.

4.30 Typically, people entering residential care have increasingly high care needs and this can lead to higher costs for providers. Residents are also staying in care homes for a much shorter period of their lives. This needs acknowledging in our approach to residential care. Care homes can no longer be thought of as “old people’s homes” where residents live in relatively good health for many years.

4.31 Single or widowed women over 85 are most likely to become residents in a care home, the average length of stay is reducing; this is due to residents entering the Care home at a more advanced age.

Market trends – looking forward

4.32 In 2013 there were an estimated 89,900 people over the age of 65 living in Sheffield. By 2020 it is estimated that this group will increase to 96,000 with the over 85 age group showing a particularly pronounced increase.

4.33 In 2013, approximately 12% (9,000) of over 65s in the city received formal support from adult social care services.

4.34 Around 6,400 people aged 65 or over in Sheffield are living with some form of dementia. This number is expected to increase by 1,000 by 2020 and by 3,000 by 2030. We know the biggest increase is likely to be in the numbers of those aged over 85.

4.35 Almost a third of people living with dementia live in care homes with others living in the community (often supported by family carers). If the proportion of people with dementia living in care homes persists, then this will obviously put pressure on the capacity of care homes.

4.36 Although we know that older people live in many areas of the city, there are high numbers of older people living in Chapeltown, High Green, Burncross, Mosborough and the South West of the city.

4.37 We also know that as the city population diversifies so will the older population, therefore it will be important to ensure the market is ready to meet more diverse and differing needs.

4.38 In terms of **increased supply / capacity in the market,** there is currently a planning application for a 64 bed development in the city with a mix of extra care and residential care accommodation.

4.39 The Council is also working with a number of potential developers and providers of accommodation for people with care needs with an aim to bring in additional supply to a similar timescale.

4.40 Clearly, with increases in demand likely, ensuring a sufficient supply and choice of accommodation for people with care needs will be a challenge over the medium-term; particularly if Government funding to support schemes remains constrained.

Care home quality

4.41 The Council has robust quality assurance arrangements in place, which give an up to date position on standards in care homes. These arrangements include the use of Key Performance Indicators (KPI) (including data from a number of sources including the Care Quality Commission (CQC)).

4.42 As part of this monitoring process each home is visited by the team at least every two years. This is in addition to the CQC annual inspections and visits. A risk assessment tool is completed based on any evidence of risk and where a home requires some improvement, support is given and the visit frequency is increased.

4.43 The risk assessment tool, which is worked on in partnership with colleagues in health, enables us to determine the most effective interventions to improve quality.

4.44 The performance of each home is assessed alongside consideration of the commitment and ability of the home to improve. The Council escalates as appropriate from supportive actions to, if necessary, formal sanctions and termination of contract.

4.45 Currently very few care homes are assessed as being at any level of risk, suggesting that the quality of provision in the city is relatively high.

4.46 The Council and Clinical Commissioning Group (CCG) also provide direct support to care homes to help them deliver quality care. These include:

- additional payments (£6 per week for nursing care and £4 per week for residential care providers) based on a higher standard of physical environment (room size, availability of ensuite facilities, absence of shared rooms)
- Sheffield City council offer some training to Care home staff, mostly free of charge to the provider. The SCC current offer includes training to meet the Common Induction Standards and from April 2015 will offer training to support the Care Certificate. The training is seen by providers as relevant and of high value and is reported to save costs on training required by CQC. Evaluation suggests that it is well received by attendees.
- Sheffield CCG invest in a GP Locally Commissioned Service (LCS) which begun as a pilot in 2006 and extended to all Care homes in 2010. Under the scheme, which costs around £800,000, each Care home is aligned to one GP practice which accepts all residents who choose to register. A service agreement is set up between home and practice. One or two named GPs provide proactive care to all residents in the home. An annual medical review is arranged, leading to a medical care plan organised between residents and carers, to anticipate and plan for exacerbations and crisis, including end of life.[1]

4.47 A new initiative "Adopt a Care home" has also commenced, which is a collaboration between local Schools and nearby care homes. This aims to improve students understanding of old age and give the School greater reach into the community. If the current pilot proves successful this initiative will be rolled out city-wide

Who pays for home care in Sheffield?

4.48 There are three main purchasers of care home places in Sheffield:

- Sheffield City Council – about 48% of all places
- Self-funders (people who fund their own care) – estimated at about 32%
- NHS Sheffield – about 20% of all places

4.49 **Sheffield City Council** is the dominant buyer in the market. The Council contracts with care homes through an *individual placement agreement*, the content of this is currently under review. The agreement requires care homes to adhere to:

- Care Quality Commission (CQC) standards

[1] '*Sheffield - Integrated care and supporting care homes'* - Tom Thorpe, British Geriatrics Society March 2012

- Standards set out in *'A Better Home Life'*[2] *(under review)*
- Requirements in the individual resident's support plan

4.50 Each placement is an individual or spot contract at the usual fee level.

4.51 Sheffield City Council no longer managers residential or nursing homes having closed its last care home in September 2012.

4.52 Many people have the means to purchase their own care and choose to do so. As home ownership and property values increase across the population, the proportion of '**self-funders**' is likely to increase.

4.53 The estimated figure of 32% of self-funders in Sheffield is broadly in line with authorities with similar economies and demographics. However, it is lower than the national average of 43%.

4.54 **Self-funders** (and their relatives) generally have higher expectations of care and often exercise greater levels of choice. This generally benefits newer or refurbished care homes at the expense of smaller older homes, even though the care may be excellent in either alternative.

4.55 Generally, people who fund their own care tend to live in the south, west and south west of Sheffield. This reflects the higher level of income and home ownership in those parts of the city. The distribution of self-funders in care homes reflects this with some homes having a higher proportion of self-funders to others.

4.56 The **NHS** will assess if an individuals need for a care home placement is *primarily* related to their health needs using a nationally defined set of criteria. Unlike care funded by the local authority, health funding is not means tested and residents do not pay an assessed charge.

4.57 NHS Funded Nursing Care is provided to clients residing in a registered nursing home only. The local authority cannot provide clinical services because the NHS is responsible for any care provided by a registered nurse. The amount paid by the NHS for clinical services is set annually by central government and is currently £110.89 pw.

4.58 Younger adults in residential or nursing care are much less likely to be self-funding.

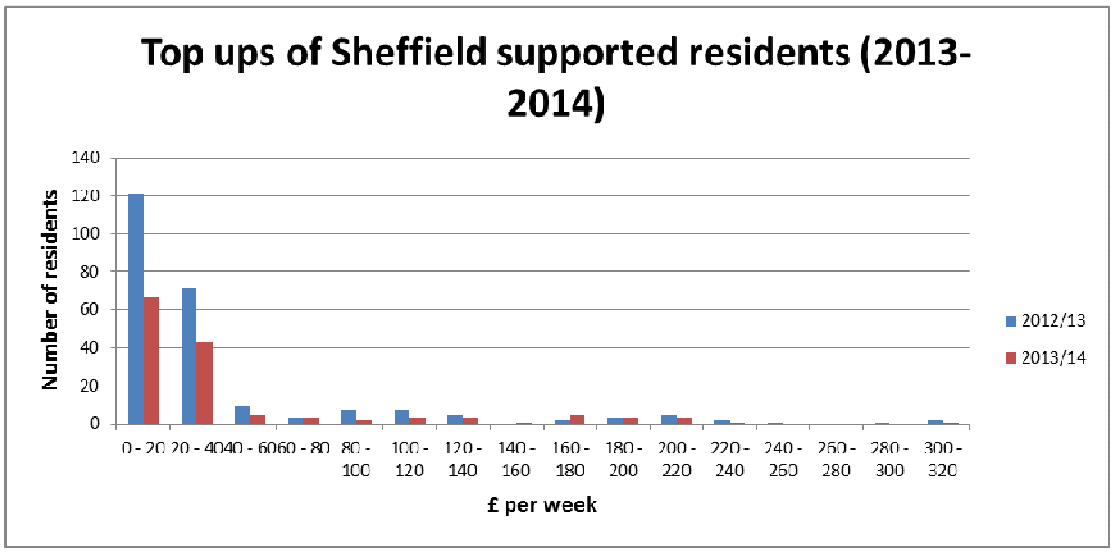
4.59 A "**top up**" is the difference between what the local authority would usually expect to pay (depending on that particular person's care needs) and the extra cost of a specific care home.

4.60 The number of top ups and their average cost are good indicators of the market response to local authority fee levels and to supply and demand in the market.

4.61 Over the last year the overall number of people paying "top ups" has decreased significantly, but the number of Care homes charging a top-up has gone up from 44 to 46 and the amount of the average top up has increased from £39.94 (2102/13) to £44.40 (2013/14)

No. of people paying top-ups	Average 2011/12	Average 2012/13	Average 2013/14
Total	201	237	139

4.62 The fact that more homes are choosing to charge an increased price indicates that some homes may have had to pass on the effect of the zero increase in fees last year to residents and their families. The average value of a top up has increased by 11% over the last year.



4.63 Many Care homes charge different rates for Council placements and self-funders with the latter price being dependent on market conditions at the time – e.g. local demand, occupancy rates, and the care home's business plan.

Residential care	Lowest Fee	Highest fee	Average Fee
Self-funders	£420.00	£785.00	£586.00

4.64 Providers in less well-off areas of the City have very small numbers of self-funders. This means they are highly dependent on the Council's fee level.

4.65 The implications of the cost of top-ups and self-funded care are a potential threat to the cost of care for the local authority. The

Directives on Choice notes that if insufficient supply is available at the contract fee level then the local authority may be obliged to fund care at the next level – potentially the third party level or self-funder price. The Council not only has an obligation as the dominant buyer in the market to ensure that it pays a fair price, but a direct financial incentive to ensure there is sufficient capacity at the fee level in the market.

Market profitability and cost pressures

4.66 Because of the wide variation of care home size and business models it is difficult to ascertain whether individual Care Homes are generally profitable or not.

4.67 What we can consider is the cost pressures on care homes and how, when compared with wider market intelligence, any changes to fee levels might impact on the market overall (in terms of capacity, quality, sustainability etc).

4.68 Care and nursing homes are basically subject to the same financial increases in terms of food, energy and maintenance as any domestic home. The difference between care homes and a domestic home is of course that there are staff costs associated with the running of the homes.

4.69 Therefore, a simple way to look at the increased financial pressures on care and nursing homes is to focus on two main areas:

- Staff costs
- Non-staff costs

4.70 Examining the inflationary impacts of these areas will give a good *indication* of the increased operating costs required to maintain the status quo. This can then be considered alongside other information such as market quality, demand, and capacity to inform recommendations on fee levels.

4.71 **Staff Costs** are predictably the biggest single factor in the running of care and nursing homes. Because of the nature of the work, the ratio of staff to residents also has a significant impact on the quality of care that can be provided.

4.72 Wage inflation in the UK is currently running at 1.1%. However a great many of the staff who work within care and nursing homes are working at the national minimum wage level - and the salary structures in care homes are often held relative to the national minimum wage (e.g. a supervisor will be paid a given amount more per hour than the minimum wage).

4.73 The national minimum wage level has increased each year since inception and care home employers are required to increase staff pay

accordingly. They have no choice but to absorb this cost unless they reduce staffing levels or find other efficiencies, which can *potentially* lead to compromises on quality.

4.74 The Sheffield contract fee increase in the last 14 years compared to minimum wage uplifts are set out below:

Year	% Fee Increase	Minimum Wage % Increase
2000	1.73	2.8
2001	3.39	10.8
2002	2.85	2.4
2003	7.35	7.1
2004	6.56	7.7
2005	4.47	4.1
2006	3.97	5.9
2007	3.14	3.2
2008	2.75	3.8
2009	2.39	1.2
2010	1	2.2
2011	-1	2.5
2012	3	2
2013	0	1.9
2014	0	3
Overall: ***last 5 years***	*3*	11.6

4.75 As most of the care homes consulted use the national minimum wage increase to inform wage increases for other staff the national minimum wage is a better measure than general wage inflation for estimating increases in care home staff costs.

4.76 The national minimum wage (over 21 years) rose in October this year from £6.31 to £6.50, a percentage increase of 3%

4.77 **Non-staff costs** associated with the running of a care or nursing home are subject to the same inflationary pressures as the rest of society. These costs are published each month as the Consumer Price Index (CPI). It seems logical to use CPI as the benchmark for calculating increased staff costs.

4.78 CPI is a measure of the average change over time of prices paid by consumers for a market “basket” of consumer goods. The indices making up CPI total around 200, covering:

- Electric and Gas
- Food
- Mortgage

- Medicines
- Repairs & Maintenance
- Consumer white goods

4.79 Because of the wide ranging nature of the indices they do cover items such as tobacco and alcoholic drink that would not be appropriate to the running of a Care home.

4.80 However each item is “weighted”, with the items listed above carrying much greater weightings than Tobacco or alcohol. This means the inclusion of these items makes very little difference to the overall CPI rate.

4.81 For our purposes then, CPI is a good indicator of the rate at which non-staff costs are increasing.

4.82 CPI is calculated monthly on a twelve month cycle and therefore can fluctuate each month. The September CPI rate is the month used for the calculation of the increase in the State Pension. It seems sensible to use this same month for our calculation.

4.83 In September 2014, the CPI rate was 1.2%.

4.84 Providers tell us that the ratio of staff to non-staff costs varies across different care homes, e.g.

- Smaller homes (e.g. 30 beds) tend to have higher staff to non-staff ratios, with 70:30 being commonly quoted
- Nursing homes also consider 70:30 a reasonable ratio as they are more staff intensive
- Larger homes quote 55:45 as a reasonable ratio
- Laing & Buisson quote a 57:43 national ratio

4.85 This range of ratios makes it difficult to come up with an accurate estimate of the costs pressures for the local market as a whole. However, agreeing a sensible ratio for Sheffield is an intrinsic element of recommending a fee level.

4.86 For residential care, we have therefore put forward a mean figure of 63.37 staff to 36.63 non-staff. This is the same ratio used in the 2012/13 and 2013/14 market analyses and has been confirmed as a reasonable ratio during provider feedback this year.

4.87 Additionally, following this year’s engagement events with providers, a 70:30 ratio has been estimated for nursing homes. This slightly different ratio is why the recommended fee increase for nursing homes is slightly higher than for residential homes.

4.88 The **state pension** is taken into account as a contribution towards the cost of care when someone is placed in residential care and it is worth noting here that the Government’s commitment to a “triple-lock” on

the state pension means that the state pension rise will be 2.5% or £2.85 per week.

4.89 The assumptions above enable us to estimate the cost pressures on residential and nursing homes. The workings for residential care homes are shown in the table below to illustrate.

2013/14 Sheffield Care fee	Staff Cost ratio @63%	Non-Staff cost ratio @37%	Staff cost increase 3% (Min Wage)	Non-staff increase @ 1.2% (CPI)	Projected 2014/15 Sheffield Care home fee
£391.00	£246.00	£145.00	£253.37	£146.74	£400.11

4.90 Based on these assumptions (alone) the Sheffield maximum residential care fee for 2014/15 would need to rise to £400.11. This represents a 2.33% increase. For the Nursing Home fee the slightly different staff to non-staff ratio (of 70:30) results in a 2.45% increase in the fee.

Comparing care home fees with other towns and cities

4.91 The table below shows that Sheffield's standard nursing care and standard residential care are second lowest amongst neighbouring authorities. However for dementia care we are the lowest.

Authority	**Reg.**	**Elderly £/wk**		**Dementia £/wk**	
		min	**max**	**min**	**max**
Sheffield	Nursing	£391.00	£397.00	£403.00	£409.00
	Residential	£353.00	£391.00	£395.00	£399.00
Doncaster	Nursing	£434.67	£434.67	£486.41	£486.41
	Residential	£414.71	£414.71	£431.48	£431.48
Rotherham	Nursing	£411.00	£411.00	£508.00	£508.00
	Residential	£393.00	£393.00	£442.00	£442.00
Barnsley	Nursing	n/a	£369.39	n/a	£409.60
	Residential	n/a	£369.39	n/a	£399.86
Wakefield	Nursing		£416.00		£416.00
	Residential	n/a	£416.00	n/a	£416.00

4.92 The figures above all exclude Funded Nursing care at £110.89

4.93 The comparable figures for core cities are shown below. This shows that our residential fees are relatively low whilst our nursing figures appear relatively high. Note however that the primary cost driver in nursing homes is likely to be staffing costs, so comparison of costs with neighbouring areas, with shared labour markets, are most relevant.

Authority	Reg.	Elderly £/wk		Dementia £/wk	
		min	max	Min	max
Sheffield	Nursing	501.89	507.89	513.89	519.89
	Residential	353.00	391.00	395.00	399.00
Liverpool	Nursing	480.54	563.22	471.26	552.50
	Residential	366.82	449.51	366.82	449.51
Manchester	Nursing	402.62	443.48	402.62	443.48
	Residential	375.88	415.42	395.88	435.42
Newcastle	Nursing	447.98	492.35	467.46	511.82
	Residential	447.95	492.32	467.43	511.79
Leeds	Nursing	569.89	589.89	573.89	594.89
	Residential	429.00	446.00	442.00	464.00
Birmingham	Nursing	461.00	461.00	461.00	461.00
	Residential	405.00	405.00	405.00	405.00

N.B. These figures include the funded Nursing care fee and are taken from the Laing & Buisson 2013/14 report

Feedback from care home providers

4.94 In order to understand the issues from the perspective of providers, a range of engagement methods were used. This included:

- Consultation with three separate providers to gather learning points from last year's fee setting exercise
- An online questionnaire (resulting in 43 replies)
- Presentation and Q&A session at the October care home managers meeting
- Mail shot to all care home operators offering individual visits (only one provider took up this offer but detailed information was obtained)
- Four consultation events in December for care home providers to discuss cost pressures, fee levels, SCC financial pressures, and any other issues raised by providers
- Opportunity offered to all Care home operators to feedback via the SCC website

4.95 The key issues identified by providers during this engagement were as follows:

- The market for most operators remains difficult, with increased staff costs and price inflation, especially gas and electricity. There was no fee increase over the last two years
- The increase in minimum wage drives wage rises generally as it is seen to be important to preserve pay differentials across care home staff structures
- Nursing costs are rising and it is difficult to retain nursing staff. This can lead to an over-reliance on expensive nursing agencies
- Occupancy is rising slightly overall, but this does disguise a number of variables. Some homes say they are only managing by cross-subsiding different parts of their business, re-capitalising debt, or drawing on cash reserves
- Speed of payment by SCC is seen as a major issue by homes of all sizes. Waiting times for payment can stretch into months and this has an impact both on cash flow and administration time (chasing payments)
- Multiple inspections of the same premises by different organisations with different and sometimes inconsistent requirements also drew criticism

4.96 This feedback allows us to understand the real issues in the local Care home market and has genuinely informed the recommendation of the fee level. The feedback has been summarised in more detail in Appendix A of this report.

5. Financial Implications

5.1 The recommended 2.33% and 2.45% rise to fee levels for residential and nursing care homes respectively would have the following impact on fee levels.

Elderly	Min 2014/15	Max 2014/15	Min 2015/16	Max 2015/16
Residential	£353.00	£391.00	£361.22	£400.11
Nursing	£501.89	£507.89	£511.47	£517.62

Dementia	Min 2014/15	Max 2014/15	Min 2015/16	Max 2015/16
Residential	£395.00	£399.00	£404.20	£408.30
Nursing	£513.89	£519.89	£523.76	£529.91

5.2 Nursing fees figures in the tables above include the Funded Nursing Care element which is currently £110.89 per week. This element has not been uplifted by 2.45%.

5.3 The estimated impact on the Council's budget as a result of these increases would be as follows. These increases are in the context of significant reductions in other Council budgets. Note that the increase cannot be predicted exactly as levels of demand for care home places will vary over the year.

	Total £	Increase	Impact £
Residential	25.9m	2.33%	603k
Nursing	15.0m	2.45%	369k
Gross Total	**40.9m**		**972k**

6. Equalities Implications

6.1 Under the Equality Act (Public Sector Equality Duty) local authorities have to pay due regard to: "Eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations"). A key element of the Equality Act is that of 'no delegation' – public bodies are responsible for ensuring that any third parties which exercise functions on their behalf are capable of complying with the Equality Duty, are required to comply with it, and that they do so in practice. It is a Duty that cannot be delegated. This means that when we are commissioning and contract monitoring services, equality and diversity will form a key part of the criteria used to do this.

6.2 The EIA identifies that if fees are frozen or a rise is set too low, there would be a high risk of negative impact as quality of care to residents could be adversely impacted upon. As there was a reduction in fees in 2012/13 and zero increases in fees for 2013/14 and 2014/15, the cumulative effect of a further year could also mean that some providers would be unable to operate, which would cause disturbance to residents before, during and after the transition period.

The reverse logic of this would be that the proposed increase in fees, supports Care home viability, therefore reducing the risk of health inequalities and of potential disturbance to residents from unplanned closures.

6.3 Any negative impact would be felt disproportionately by older and disabled people due to the demographic profile of the client group.

6.4 Approving the recommended 2.33% rise in fees, and following other actions identified in the EIA (e.g. fee levels to continue to differentiate between different levels of need; close management of provider viability), should provide effective mitigation for the identified risks.

6.5 A full list of our equality considerations, impacts and actions can be found in the Equality Impact Assessment at Appendix D.

7. Legal Implications

7.1 Under section 21 of the National Assistance Act 1948 (NAA 1948) and directions made under it in Department of Health Circulars LAC (93)10 and LAC (2004)20, local authorities have 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.

7.2 Sections 7 and 7A of the Local Authority Social Services Act 1970 (LASSA 1970) require local authorities to act under the general guidance and directions of the Secretary of State in the exercise of their social services functions.

7.3 The National Assistance Act 1948 (Choice of Accommodation) Directions 1992 (Directions 1992), which were made under section 7A of the LASSA1970, provide that where a local authority has decided that residential accommodation should be provided under section 21 of the NAA 1948 the local authority shall make arrangements for accommodation for that person at the place of his choice within the United Kingdom if:

- Having assessed an individual's needs, the preferred accommodation appears to the authority to be suitable in relation to his needs.
- The cost of making arrangements for an individual at his preferred accommodation would not require the authority to pay more than they would usually expect to pay having regard to his assessed needs (known as the “usual cost”, the basis on which local authorities set the fees they will normally be prepared to pay to care homes).
- The preferred accommodation is available.
- The persons in charge of the preferred accommodation provide it subject to the authority's terms and conditions.

7.4 Circular LAC (2004)20 (Circular) replaced the guidance that accompanied the Directions 1992 and is issued under section 7 of the LASSA 1970. The Circular sets out what an individual should be able to expect from the council that is funding his care, subject to the individual's means, when arranging a care home place. The relevant parts of the Circular for the purposes of this case are:

"*2.5.4 … [The usual cost] should be set by councils at the start of a financial or other planning period, or in response to significant changes in the cost of providing care, to be sufficient to meet the assessed care needs of supported residents in residential accommodation… In setting and reviewing their costs, councils should have due regard to the actual costs of providing care and other local factors. Councils should also have due regard to Best Value requirements under the Local Government Act 1999.*

3.3 When setting its usual cost(s) a council should be able to demonstrate that this cost is sufficient to allow it to meet assessed care needs and to provide residents with the level of care services that they could reasonably expect to receive if the possibility of resident and third party contributions did not exist".

7.5 The Care Act will come into force in April 2015. It sets out a range of measures, in order that local people can choose from a diverse range of high quality care services, to drive up the quality of care and put people's needs and outcomes centre-stage.

7.6 A new legal framework is planned which reinforces local authorities duty to promote a diverse, sustainable and high quality market of care and support services. Local authorities are required to ensure that there is a range of providers offering services that meet the needs of individuals, families and carers.

7.7 This duty requires local authorities to understand the level of risk and the quality support for Care home residents to assure itself that they:

- Meet the minimum standards as set out by the Care Quality Commission
- Is sustainable
- Have sound leadership and that all staff are appropriately trained
- Are focused on delivering quality care that is evidence based

7.8 The council should also consider a number of recent high court judgments made as a result of challenges by Care home providers following the cut in fees as local authorities try to meet the demands of the demographic changes and budget cuts.

7.9 In 2010 Sefton Council was ruled to have acted unlawfully by freezing Care home fees for 2011-12. Judge Raynor ruled that Sefton Council "failed adequately to investigate or address the actual costs of care with the claimants and other providers", which was contrary to relevant guidance. The judge said setting fee levels significantly below actual cost would inevitably lead to a reduction in the quality of service provision which "may put individuals at risk".

7.10 Also in 2010 Leicestershire County Council attempted to freeze the fees it paid to Care home providers for the year 2011-12 at the rate it paid for the year 2010-11. Judge Langon agreed with the findings in Sefton (above)

7.11 In 2011 SW Care v Devon Council. A group representing Care home providers challenged the council's decision taken not to increase the fees in 2011/2012 also citing that the council had also awarded no increase in fees for the previous financial year. The Council agreed not to award any fee increase but instead enter in to further discussions with providers to address individual concerns.

7.12 Concerns were expressed about the consultation process and the superficiality of the Equality Impact Assessment and the importance for local authorities to pay regard to their equality duty when setting fees.

7.13 On 18 October 2012 in Care North East Newcastle v Newcastle City Council the judge ruled that councils must have due regard to the actual costs of care, stating that, "In making the decision to set appropriate rates for Care homes the local authority is under an obligation to have due regard to the actual costs of providing care and other local factors".

7.14 He emphasised the need for local authorities to ask themselves the right questions when considering fees and the need for it to use an evidence-based system to ascertain the actual cost of care.

7.15 In March 2012 Northumberland County Council was involved in a dispute over the level of fees to care homes for older people under a new three-year contract starting in April 2012. The care home owners' trade association, Care North East – Northumberland (CNEN), would not accept the new terms offered by the Council, and advised their members to refuse to sign the contract. In June 2012 CNEN applied for judicial review of the Council's decision.

7.16 The detailed grounds of the claim changed between documents, but by the time of the court hearing, the claim alleged that the Council had:

- failed to consult adequately
- failed to ascertain the "actual cost of care" provided by care homes
- made irrational assumptions
- unlawfully refused to make placements with the claimant

7.17 The judgement which was published on 15 February 2013 dismissed all four of the grounds of claim. There was evidence of genuine consultation, that rational decisions had been made, and that Northumberland acted lawfully in making placements.

7.18 Most importantly, the judge rejected the claimants' argument that Government guidance required the Council to carry out research to set a figure for the "actual cost of care", and accepted the Council's view that it was reasonable to set fees based on what they knew about the Care home market – which was that there is substantial excess capacity, with many homes carrying large numbers of vacancies, and that new providers are still wanting to build Care homes.

7.19 In December 2014 in R (Torbay Quality Care Forum Limited) v Torbay Council [2014] The High Court upheld a challenge by a group of care home providers to a local authority's decision to set the rates it would pay for residential care. The court, in quashing the authority's decision, held that the mathematical formula on which the rate for establishing the usual cost of care was based was flawed in several respects, including that it took into account income the providers would receive from private clients. The judge reluctantly made the decision that he did, commenting that the council had been honest

and straightforward in its attempt to balance the competing needs of those requiring care against its duty to ensure that public funds were properly expended. However, he quashed the decision on the basis that the mathematical model that was used contained errors, had been interpreted erroneously and did not have regard to the guidance.

7.20 From April 2016 there will be changes to the amount of capital people can have before contributing to their personal care. There will also be a "cap" on the total amount care home residents will have to pay for their personal care during their lifetime. This will have implications for residents, Care providers and the local Authority in the future but not for the period covered by this report. A brief overview is included as Appendix D of this report

8. Alternative Options Considered

8.1 There were three options considered:

- Freeze the fee level for a third year
- Increase fees by 1.75% to partially off-set cost pressures on providers
- Increase fees by 2.33% and 2.45% for residential and nursing respectively based on estimated rises in provider costs

8.2 Consideration of the three options regarding fees 2015/16 was undertaken taking into account the following;

- Market factors as described in this report
- Costs of care as calculated in the report
- Provider feedback from engagement events & planned consultation
- The financial position of the Council.

8.3 Each option was risk assessed as summarised below. Detailed risk assessments are included on the following pages. The summary position is as follows:

Freeze the fee level for a third year

- Risk of unplanned exits from the Market and of legal challenge

Increase fees by 1.75% to partially off-set cost pressures on providers whilst recognising Council's financial position

- Reduces risk of further unplanned exits and legal challenge – but still a real terms reduction in fee at a time when the market is finely balanced

Increase fees by 2.33% and 2.45% for residential and nursing respectively based on estimated rises in provider costs

- Should stabilise market but increases risks on Council social care budgets.

The additional 0.18% (2.45%) reflected the additional staff costs faced by Nursing homes

Risk Assessment - The following risk assessment aims to inform this process.

Action	Risk	Risk Impact	Risk Probability	EIA Risk	Overall risk	Costs/Benefit	Notes/Mitigation
Decision taken to freeze fee level for a third year.	Service User –Risk of top up fees increasing.	Medium	High	High	High		
	Provider risk – Homes could be forced out of business	Medium	High	low	High		Real terms cut to fee level
	Financial - Risk of litigation	High	Medium	n/a	High		Provider legal challenge risk high – resulting in legal fees for Council
	Financial risk to SCC budget	Low	n/a		Low	**Cost neutral**	Although cost neutral a fee freeze plus uplift to the State pension would result in financial benefit to the Council of approx **£200K**..
	Reputational risk – risk to quality within care homes	High	Medium	low	High		

Action		Risk Impact	Risk Probability	EIA Risk	Overall risk	Costs/Benefit	Notes/Mitigation
Decision taken to increase fees by 1.75%	Service User –Risk of top up fees increasing.	Medium	Medium	Medium	Medium		
	Provider risk – Homes could be forced out of business	Medium	Low	Low	Low		Additional 1.75% compared to 2.33% increase in staff/non staff costs would still be a real terms decrease in fee for Care Homes.
	Financial - Risk of litigation	Medium	Low	n/a	Low		
	Financial risk to SCC budget	Low	n/a	n/a	Low	**£716k increase to budget required**	Increase will **£716k** for SCC off-set by approx. £200k
	Reputational risk – risk to quality within care homes	Low	Low	Low	Low		

Action	Risk	Risk Impact	Risk Probability	EIA Risk	Overall Risk	Costs/Benefit	**Actual Cost**	Notes/Mitigation
Decision taken to increase Care home fees for 2015/16 by 2.33% & 2.45%	Service User –Risk of top up fees increasing.	Medium	Medium	low	low			
	Provider risk – Homes could be forced out of business	Medium	Low	Low	Low			Additional 2.33% compared to 2.33% increase in staff/non staff costs would equate to a zero increase in real income for Care Homes. Additional 0.18% (2.45%) reflects higher staff costs for Nursing Care providers.
	Financial - Risk of litigation	Medium	Medium	n/a	Medium			Early provider feedback on draft recommendation indicates legal action may be possible. Legal services aware of this possibility
	Financial risk to SCC budget	medium	medium	low	low	**£972K increase on budget**		Increase will **£972k** for SCC off-set by approx. £200k
	Reputational risk – risk to quality within care homes	Low	Low	Low	Low			

9. Recommendations

- That the market analysis is noted
- That a 2.33% increase in Residential Care home fees for 2015/16 is confirmed
- That a 2.45% increase in Nursing Home fees for 2015/16 is confirmed

10. Reasons for Recommendation

10.1 There has been a “freeze” in Care Home fees for the last two years. During this time we know that the cost of running a Care Home has increased.

10.2 This year the National Minimum Wage rose by 3% and inflation by 1.2%. Together these cost drivers create an estimated 2.33% cost pressure for care home providers.

10.3 In previous years, there has been sufficient confidence that the market would continue to develop and deliver modern, efficient accommodation to replace the capacity lost as less efficient care homes have closed. This confidence, coupled with the Council’s challenging financial position, meant that fees have not been increased for the last 2 years.

10.4 This year there has been further unplanned closures and there are a limited number of new care home developments at the planning stage. However, there *is* still capacity in care homes and providers tell us that they are benefiting from increased occupancy levels.

10.5 Our view is that the care home market is now in a stable position, with sufficient capacity for the short- to medium-term. However, we believe that given the cost pressures providers are under, there is a risk that a further fee freeze could de-stabilise the market and lead to unplanned closures. These closures would reduce choice for people in Sheffield needing to move into a care home, and increase the risks of capacity falling below demand.

10.6 Following consultation with providers, we have also acknowledged that staffing cost pressures for *nursing* homes are a particular challenge as staff costs inevitably form a greater proportion of overall costs in homes that have greater levels of staffing.

10.7 The recommendation this year is therefore for a rise of 2.33% in residential home care fees and an increase of 2.45% in the fee for nursing homes. These increases are based on a consistent calculation of increased costs given that inflation is at 1.2% and staff costs have risen by 3%.

Appendix A

Care Home Engagement – Summary of Feedback

Introduction

As part of the review of Care Home fees for 2015/16, a number of different Care Home engagement sessions were held:

Feedback on last year' process – 3 x individual meetings
On-line questionnaire – 43 responses
Care Home Manager's Forum x 2
Individual Meetings with Providers x
Evening and daytime engagement sessions x 4

The aim of these sessions was to find out what the pressures were on Care Home providers, both regarding the fee level and any others. It became clear that there were a number of "themes" developing that were of concern to Care Home providers.

This paper summarises this feedback but detailed notes from each event are available if required.

Key Points

Nursing Costs

It is becoming increasingly difficult for Nursing Homes to recruit and retain nursing staff, largely due to recruitment by the NHS and competition from other neighbouring authorities. This was leading to a reliance on agency nurses which was pushing up costs. Nursing homes reported staffing was now approximately 70% of their costs.

Fees level

Fees were obviously important and providers made the point that Sheffield's fee levels were lower than other local towns and cities. The point was also made that the Local Authority had in fact gained from last two years fee freeze as State Pension levels had risen but this rise had not been passed on to the providers.

National Minimum wage (NMW) rise

The National minimum wage rise is a key contributor the Care Home costs; this is because the rise for those employees on minimum wage has a knock on effect on all employee salaries to preserve differentials between grades. This year the NMW is rising by 3%, much higher than in previous years.

Pension Costs

Many Care homes are already paying the compulsory pension to their employees, over the next two years all Care homes will have to offer this to their employees. This has to be paid to all employees who can then “opt out” if they wish. It was thought that the majority of lower paid workers would opt out of this pension; however this has not proved to be the case and is another additional cost for Care homes.

Speed of payment

The length of time taken between assessments of an individual until the provider actually received the payment was consistently raised at all events. Averages varied but 6-8 weeks was not unusual and in cases providers were waiting many months before payment arrived.

Whilst waiting for payment, the providers had to manage the care needs of the resident at their own cost. The delayed payment had a detrimental impact on business cashflow.

This issue was the subject of a recommendation last year, improvements have been made but staff reduced at the same time. Providers are therefore still experiencing the same problem of an average 8 weeks to receive payment.

A further complication is that it is no longer unusual for a resident to have passed away before payment is received. This leaves care home providers with the unenviable task of trying to agree back-dated payments with recently bereaved families.

Occupancy

Whilst overall occupancy is up, many homes were experiencing reduced occupancy as a consequence of the strategic direction of the Local Authority which was to support people to stay in their own homes as long as possible. Care home providers were supportive of this strategy, but felt in many cases people were remaining in their own home when actually 24/7 residential care might be more appropriate.

Age and frailty of residents

People were entering residential care much later in their lives, typically 80-85 and frequently their care needs tended to be higher. This had an impact on the skill levels of Care home staff and on the number of staff required. This is of particular concern in Nursing homes where providers are reliant on agency nurses that tend to be paid above the rate of in-house staff.

Downtime

Because of the age and frailty issue outlined above, residents tend to be in Care homes for much shorter periods before they die or move to a Nursing home... The person’s room cannot simply be re-filled overnight and the

increasing turnover of shorter term residents is leading to Care homes having to build in significant periods of “downtime” i.e. rooms standing vacant , into their Business planning

Other Issues

Quality premium – This premium payment is considered unfair as it is based on size of room rather than actual quality of the environment and of the service delivered.

Inspection regimes

Multiple inspections of the same premises, by different organisations with different and sometimes opposing requirements also drew criticism.

Summary of Provider feedback - Internet

Introduction

Following engagement session with Care Home providers the following draft recommendation was made and placed on the SCC internet (05/02/15) for comment.

Recommendation:

That there is a 2.33 % rise in Residential Care home fees and a 2.45% rise in Nursing home fees for 2015/16 acknowledging the general impact of inflation and the increase in staff costs on all Care homes, and the particular pressure of increased staffing costs on nursing homes.

No. of responses received

There were 14 responses received covering 39 Homes

Main points of feedback

Fee Level

The recommended level of fee increase was not generally well received with only one provider writing in its favour. Providers cited the fact that Sheffield's fees were now among the lowest in the country and that this had been the situation for some years.

Providers felt that the fees were at a level that would make either further unplanned closures or a decline in quality inevitable. Several providers had used the Laing & Buisson cost of care model to evidence the fact that the fee levels were too low. Rotherham Council was mentioned by two providers as a benchmark of the true cost of care regionally. Leeds was mentioned similarly by a different provider. Opinion on the size of the gap varied from 3.1% to 49%.

Two Providers backed up their assertions above with a detailed breakdown of costs and in one case with an extract from their management accounts.

Providers recognised the impact of budget cuts on the Council but felt that the cumulative impact of low fee rises over the last 10 years on their businesses was not recognised by the Local authority.

One Provider made the point that a yearly review was not the most appropriate way of dealing with fees and that a longer term view of where we want to move fees to should be taken.

Staff costs

Staff costs were an issue for Providers. The minimum wage is expected to rise sharply again this October and this tends to drive all wage differentials up in the sector.

.Three Providers specifically mentioned that they were committed to the principle of the "living wage" but conceded that achieving this would be unlikely with inflation only fee increases.

Other costs
Other significant costs mentioned were the cost of insurance, higher utility costs, loans and higher maintenance costs.
The new Pension arrangements were mentioned by three Providers who felt that although we had acknowledged this additional cost it had not been factored into the proposed fee rise. By 2018 these costs could be 3% of payroll.

Training costs were a mentioned as a factor, even when training is free there is a cost of cover and travel.
Regulation and inspection were seen as costs both in terms of subscription increases (CQC) and indirect cost impact on management and staff time.

Recruitment and retention
Nursing staff was a particular problem, staff were being “poached” by better pay in the NHS or moving to other local authorities whose Care Homes were able to pay better rates. One Provider. was trying to fill this gap by recruiting nurses from Eastern Europe, but this presented a different set of problems in terms working practices and additional payments to recruitment agencies.

Complex needs
It was acknowledged by a number of providers that generally people were entering care with more complex needs requiring more costly care arrangements or additional trained staff.
One Provider made the point that people were entering care later in life with more complex needs and were therefore staying in care for less time before dying. This was impacting on occupancy when one resident dies or goes into hospital and a new resident arrives.

F3 process
Only one Provider specifically referenced this process, they believe that although the payment process has improved the F3 process is still delayed due to incorrect or delayed completion by social workers.

Care Act
One Provider expressed the view that the current level of fees could have an adverse impact on the ability of the Local Authority to meet the requirements of the Care Act

Meeting
Five providers indicated that they would welcome the opportunity to discuss points raised in their feedback with the appropriate councillors or SCC Officers.

Appendix B – Adult Mental Health

Registered care (residential and nursing home) provision for adult mental health in Sheffield is relatively small but continues to play a vital part in the spectrum of provision.

40+ different providers currently support 150-160 adults of working age with mental health problems with funding support from SCC at any one time. Not all providers are in Sheffield. There are currently approximately 80 beds in Sheffield across residential and nursing care registered to provide care only to people with mental health problems, but a further 300+ beds available with providers registered to provide care across a range of needs including mental health, physical disability and learning disability.

The numbers of placements supported by SCC for residential and nursing care has fluctuated over recent years. However, there has been a noticeable increase in the last two years corresponding with NHS Continuing Health Care transfers and a greater identification of people with complex needs on the Autistic spectrum including Asbergers. See Table 1

Table 1

Year	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Average Number of Residential Care Placements	99	90	96.75	115.5	136	138
Average Number of Nursing Care Placements	26.5	19.25	18.25	28.25	29.5	29
Total	125.5	109.25	115	143.75	165.5	167
% subject to S117	57.8%	61.8%	61.1%	63.1%	66.1%	73%

There are a small but significant number of high cost placements funded by SCC mental health care purchasing: at November 2014 there were 23% greater than £600 per week; 16% greater than £850 per week and 8% over £1000 per week. These are primarily with independent sector providers offering support for people with complex needs. This is where a person's mental health problems present risky and challenging situations that need to be managed and/or there are additional needs due to e.g. Asperger's, learning disability, Huntingdon's Disease. Some high cost placements have been inherited from CHC funded placements including programmes to bring people from secure rehabilitation facilities back to Sheffield. The demand for this range of placements has been increasing.

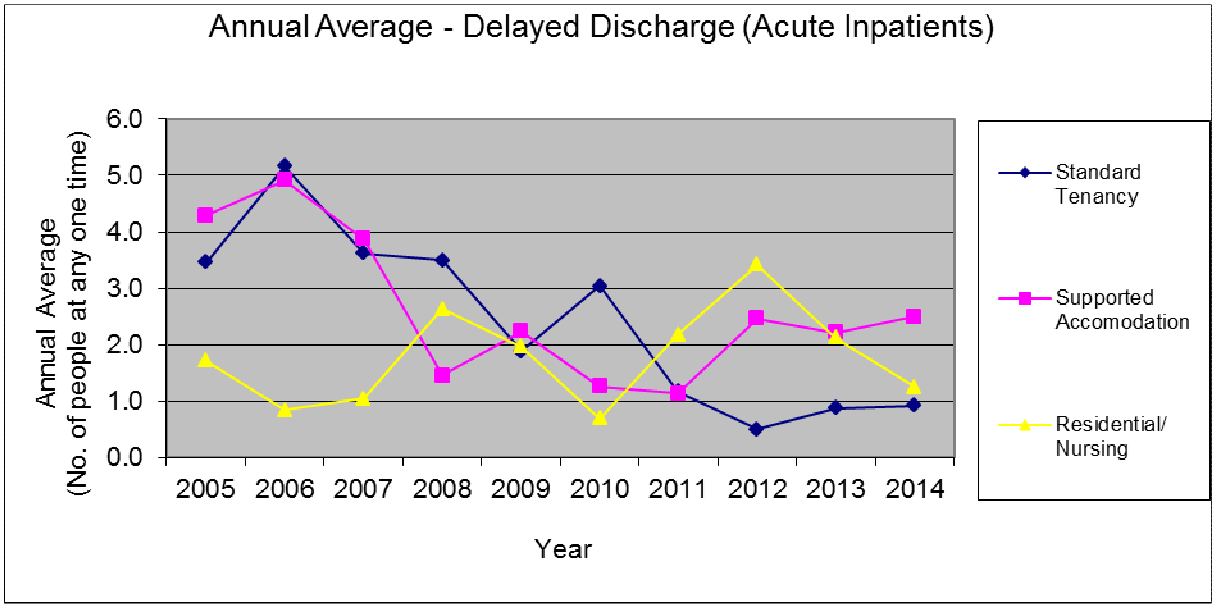
S117 of the Mental Health Act places a duty on local health and social care authorities to provide after-care following discharge from particular sections of the Act. Under S117 charges for care cannot be levied by local authorities. This applies to a significant number of the placements (see table 1).

There is an aging profile within nursing and residential care. Some services remain the home of people placed in the community following closure of the

long stay psychiatric hospital (Middlewood). Over 78% (70% in 2006) 45 plus years old; 66% men. (2010)

Delayed Discharge

The following table indicates a reduction in the number of people on acute psychiatric inpatient wards whose discharge is dependent on a place in residential/nursing care, indicating there is reasonable availability, although new services have set to enter the market at high fee levels.



Appendix C – Implications of the Care Act

From April 2016 there will be changes to the amount of capital people can have before contributing to their personal care. There will also be a “cap” on the total amount care home residents will have to pay for their personal care during their lifetime. This will have implications for both residents and for the local Authority in the future but not for the period covered by this report.

New Capital allowance

The Capital allowance will increase from £23.5k to £118k
(This amount includes any property owned by the individual)

New Personal care allowance “cap”

The cap on lifetime personal cost of care will be £72K.

Hotel costs

The Care act also introduces the idea of ‘hotel’ costs whereby residents have to pay towards their accommodation costs such as food / utility bills etc. The hotel costs are likely to be set at £12,000 per annum for the UK. Approximately £230 per week.

The implications of this are:

Current fee paying care home residents.

The new capital allowance will not be introduced retrospectively but self-funders in residential care will be re-assessed so that any eligible needs and corresponding funding starts to accrue against the personal care cap.
The £72k cap will start to apply to personal care of the resident and will not be backdated. It is estimated then that it will be approximately 7 years before people reach the £72k threshold and the Council has to start picking up additional care costs. Since the average stay in residential or nursing care is only around three years, this may not be a major issue.

Future fee paying care home residents. (Assessed post April 2016)

The capital allowance will have an impact on people assessed after April. The higher capital allowance will mean fewer people having to contribute to the cost of their own care with the Council contribution rising to meet the shortfall. Initial work on this suggests the Council contribution will rise by £2.6m in 2016/17.

Implications for Care home providers.

New Capital allowance.

Increasing the upper limit for funding means that current privately funded service users, those with assets above 23k, but below 118k will be eligible for funding and require assessments from us, they may need support from homes on how to access this.

The Personal care cap

Care providers will have to separate what is a hotel cost, and what is a care cost so that the Local authority can count the residents contribution towards the 72k cap. Some homes may not have the facility to do this.

If we take the current bed price of £395 per week, and residents pay 12k PA towards the “hotel” costs, then this is a weekly amount of £230 meaning they would only be paying £165 per week towards their personal care. This may cause some homes to re-negotiate rates, or increase the cost of meeting care needs, pushing up the weekly bed price.

If someone falls into arrears and makes a split payment do they pay the care costs first, or the accommodation costs, - the home would probably want the hotel costs as they are higher, but the individual may want the care costs so they contribute towards the cap.

APPENDIX D: Equality Impact Assessment

Portfolio: Communities

Name of policy/project/decision: 2015/16 Fees for Care Homes
Status of policy/project/decision: New

Name of person(s) writing EIA *Steve Jakeman*

What are the brief aims of the policy/project/decision?

- To consider the appropriate fee level for care home fees as part of the budget setting process
- This is achieved by:
  - A market analysis which considers demand, supply, quality and care home viability
  - Calculating the actual cost of care
  - Consultation with providers
  -

Recommendation

That there is a 2.33 % rise in Residential Care home fees and a 2.45% rise in Nursing home fees for 2015/16 acknowledging the general impact of inflation and the National Minimum wage rise on all Care homes and the particular pressure of staffing costs on Nursing homes

This recommendation recognises the impact of inflation and the National minimum wage on Providers.

Fee levels to continue to differentiate between different levels of need, to continue to meet the needs of those with more complex needs.

Provider feedback

Extensive engagement has taken place with residential care home and nursing Home providers, the key issues for them are as follows:

- Increases in staff costs created by rise in the National minimum wage and by increased reliance on agency nurses.
- Occupancy levels

- Speed of payment

Providers are concerned that without a fee rise quality of care to residents could be adversely impacted upon.
It is important to note that this is not the case at present and that quality of care remains high.

Are there any potential Council staffing implications, include workforce diversity? No

Entered on Qtier: -Select- **Action plan needed**: Yes

Approved (Lead Manager) (Commissioning) **Date:** 12/11/14

Approved (EIA Lead person for Portfolio): **Date:**

Does the proposal/ decision impact on or relate to specialist provision: *Yes*

Risk rating: High

Under the Public Sector Equality Duty, we have to pay due regard to: "Eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations." More information is available on the council website

Areas of possible impact	Impact	Impact level	Explanation and evidence (Details of data, reports, feedback or consultations. This should be proportionate to the impact.)
Age	Negative	H	A high proportion of care home residents are older people. (50% are aged over 80 and 31% aged over 85 years old.) They tend to have high dependency levels. To stay in line with minimum wage rises and cost of living rises (CPI) the fees would need to rise by 2.33%. Potentially then any decision to set fee levels below this level could negatively

			affect the quality of life of residents should Care home providers choose to cut costs affecting the quality of the environment or the amount of staff care available. Existing supported residents are entirely dependent on the fee level set by the Local Authority as they have no income of their own.
Disability	Negative	H	People of all ages with physical or mental health disabilities are residents of care homes. Any change in the ability of providers to deliver care at a reasonable level would have a disproportionate impact on the most frail or disabled residents. People are entering residential care much later in life, and an increasing number have some form of disability. Local figures are unavailable but national statistics suggest 69% will suffer from incontinence, 40-45% with dementia and 20% will have suffered a stroke. This means that they require more support from Care home staff. If fee levels did not properly differentiate between different levels of need, those with more complex needs may find these are not able to be met.
Pregnancy/maternity			No disproportionate impacts are anticipated.
Race	Neutral		Our Market analysis tells us that BME residents are under-represented in Care homes. This may be for many reasons but we do not believe that there is any disproportionate impact from the setting of the fees level itself.
Religion/belief	Neutral		No disproportionate impacts are anticipated.

Sex	Negative	L	There are more women than men in older people care homes - 73% to 27%. Any change in the ability of providers to deliver care at a reasonable level would have a disproportionate impact on women
Sexual orientation	Negative	L	We expect providers who are under contract to the Council to provide care and support which is personalised to the individual, including recognising and respecting their sexual orientation but we are conscious that national research suggests that there is some way to go in achieving acceptable outcomes for LGB people in residential care. Notwithstanding we do not anticipate any disproportionate impacts from the proposals on fees for LGBT residents
Transgender	Neutral		No disproportionate impacts are anticipated.
Financial inclusion, poverty, social justice, cohesion or carers	Negative	L	A fee level below inflation may increase affect the fee levels providers charge self-funders as there is evidence that care homes cross-subsidise council fees with higher fees for those who fund their own care. A recent judicial review in Sefton highlighted the responsibility of the local to carefully consider the impact of the level of fees set on the quality of care provided to people supported by a local authority. There is a risk that a fee level below inflation may also adversely affect the lives of people funded by the local authority as it maybe below the level that they may reasonably expect good quality care to be provided. However we have found no evidence of this happening anywhere at present in Sheffield.

Voluntary, community & faith sector			No disproportionate impacts are anticipated.
Other/additional **Closure of Care Homes – impact on age/disability**	Negative	H	Fee levels have been frozen for the last two years and the cumulative effect of a further year could mean that some providers will be unable to operate. Whilst here is sufficient capacity within the market at present to re-house residents if necessary, five homes have closed this year and the situation needs careful management. It is recognised that Care Homes closures can cause disturbance to elderly/disabled residents before, during and after the transition period. Whilst the local authority is not obliged to remove the risk by supporting inefficient providers it needs to demonstrate that it has mechanisms in place to anticipate this and mitigate the impact on existing care home residents whether funded by Sheffield CC or not. Sheffield CC has carefully considered the steps necessary to mitigate that risk further. Those steps are discussed in detail in the impact assessment. In summary they are: (i) Be alert to, and respond to, indicators of a risk of a home closure such as: low occupancy; high dependence on council placements; low number of registered beds. (ii) Improve the 'early warning

			system' for homes that are in difficulty to encourage discussion with the council or with an independent advisor to examine options other than closure. (iii) Develop a reasonable offer of support to failing homes where the council considers that there is a need for that home to remain open, which may avert closure and/or minimise impact on affected residents. (iv) In the event of an anticipated or actual closure, Sheffield adheres to the principles of the Association of Directors of Adult Social Services national guidance: 'Achieving Closure – Good Practice in supporting older people during residential care closures' (http://www.adass.org.uk/images/stories /Publications/Miscellaneous/Achieving_Closure.pdf In summary Sheffield takes care to: • Put in place well organised, dedicated and skilled assessment teams. Involve all relevant parties (especially older people and their families themselves) in decisions about future services. • Get to know people well and carry out holistic assessments of their needs. Support older people, families and care staff through potentially distressing and unsettling

			changes. • Work at the pace of the individual and give as much time and space to explore future arrangements as possible. • Help residents and key members of care staff to stay together if possible. Ensure independent advocacy is available. • Plan the practicalities of any moves and ensure as much continuity as possible after the move has taken place. • Stay in touch with people and assess the longer-term impact of resettlement. Work in partnership with a range of external agencies and key stakeholders, managing information and communication well. • Follow the above principles even in an emergency closure so far as possible. These are, of course, general principles which are adapted to the needs of specific cases. Although home closures are rare in Sheffield, where there has been a closure in the past 12 months a combined health and social care team oversaw the work surrounding the closures being prioritised to support affected residents. This in turn was monitored by Head of Service Adult Social Care Commissioning. Sheffield is satisfied that it follows best practice which enables the most appropriate mitigation of the risk.

Carers and Families	Negative	H	There was a reduction in fees in 2012/13 and zero increases in fees for 2013/14 and 2014/15 We have seen a slight decrease in the number of people paying a top up fee, however the amount of the average top-up has increased by 6.7% in 2012/13 and by a further 11% over the last year with more than 50% of care homes now charging top up fees. Any further freeze will potentially impact the financial burden on carers and families as Care homes increase Top up fees to balance their books.

Date**:* ***Service: *Adult Social Care Commissioning*

Overall summary of possible impact (to be used on EMT, cabinet reports etc):

The EIA identifies that if fees are frozen or a rise is set too low, there would be a high risk of negative impact as quality of care to residents could be adversely impacted upon. As there was a reduction in fees in 2012/13 and zero increases in fees for 2013/14 and 2014/15, the cumulative effect of a further year could also mean that some providers would be unable to operate, which would cause disturbance to residents before, during and after the transition period.

The negative impact would be felt disproportionately by older and disabled people due to the demographic profile of the client group.

Approving the recommended 2.33% rise in fees,(2.45% in Nursing homes)and following other actions identified in the EIA (e.g. fee levels to continue to differentiate between different levels of need; close management of provider viability), should provide effective mitigation for the identified risks.

Action plan

Area of impact	Action and mitigation	Lead, timescale and how it will be monitored/reviewed
If fees were not sufficient to cover costs of care, then individuals' needs arising from age or disability might not be properly addressed.	Sheffield has carried out an extensive market analysis of a number of years and has also developed a good understanding of the issues facing care home providers. We believe that the fee level applied in recent years has ensured that there is an adequate supply of care home places for all care types. The evidence for this is the low level of market failures in the past 5 years and the fact that new care homes have opened in Sheffield and they do not require residents to 'top-up' the Council's contract fee. Analysis of the top up fees generally has shown that the numbers have not increased significantly. Occupancy levels in general are comparable with the national average. Sheffield has a policy of spot purchasing care from a range of providers rather than single providers on block contracts. This allows providers to meet diverse needs, in particular because of the potential for smaller providers to cater for specific cultural needs of (for example) minority ethnic and religious communities	Annual Fees and Market Analysis Reports compiled by Adult Social Care Commissioning
There is a risk that some inefficient providers will be unable to operate if fee levels are not increased.	Whilst the local authority is not obliged to remove the risk by supporting inefficient providers it needs to demonstrate that it has mechanisms in place to anticipate this and mitigate the impact on existing care home residents whether funded by SCC or not.	The Monthly multi-agency KPI led by SCC Contracts team

Area of impact	Action and mitigation	Lead, timescale and how it will be monitored/reviewed
	SCC has a duty to ensure that the citizens of Sheffield receive value for money for the residential services but it recognises the need to protect those people who are residents in care homes that become non-viable because the provider is inefficient. As demonstrated in the section of the Fees and Market Analysis report titled 'Reducing Risk and Raising Quality' Sheffield has in place a comprehensive multi-agency monitoring process. This allows SCC to identify providers that are struggling to meet appropriate standards. It further allows them to offer support where appropriate or take direct action to safeguard residents. Currently there is still some over supply of Care Home places in the Sheffield market but this year has seen some Care home closures and it is important that this happens in a managed fashion. As part of the 2014/15 review the Local Authority committed to reviewing and speeding up the assessment and payment processes to improve cash flow for Care Homes. This has not been as successful as we believed and a further review will be a recommendation of this year's report. The Local Authority has also committed to align its Quality requirements more closely with those of the CQC to avoid duplication of	

Area of impact	Action and mitigation	Lead, timescale and how it will be monitored/reviewed
	work and inconsistency of advice for care homes. This will save staff time and associated costs.	

Approved (Lead Manager): Joe Fowler Date:

Approved (EIA Lead Officer for Portfolio): Phil Reid Date:

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