Appendix 1 - Older Adult Care Homes

Sheffield City Council is committed to ensuring that diverse, sustainable and quality social care is available to meet the needs of people in Sheffield. Older Adult Care Homes are a key part of social care provision in the city and we have taken on board feedback from the providers we contract with about the challenges they face and the support they need.

Care Home providers told us in 2016/17 that the cost of delivering care was a key issue for them. In response we have undertaken a Cost of Care exercise during 2017/18 supported by Care Home Providers and Sheffield University in order to identify a fair and reasonable fee rate for Care Homes in the city. The total uplift for 2018/19 financial year represents a significant increase on previous years and an investment of around £3m by the Council.

We are recommending a single fee rate for all residential, residential EMI and nursing of £463 per week (gross). For nursing care this rate excludes the FNC rate which is currently £155.05 per week. This single fee replaces the range of fees being paid at present. This is in recognition of increased levels of complexity within residential care particularly older and frailer people with multiple and complex physical needs and increased occupancy from older people with all stages of dementia

The proposed rate takes account of the feedback on the cost of care exercise and also the proposed single rate (described fully below) as set out in the table below:

Category	Current rate (environmental standard)	Current rate (environmental enhanced)	2018-19 rate	% increase
Residential - standard	£389	£391	**£463**	**18 -19%**
Residential – high dependency	£426	£430	**£463**	**8 - 9%**
Residential - EMI	£434	£438	**£463**	**6 - 7%**
Nursing – standard excluding FNC	£433	£440	**£463**	**5 - 7%**
Nursing enhanced excluding FNC	£447	£453	**£463**	**2 - 4%**

1.1. Assumptions behind our fee rate approach for 2018-19

The decision to undertake a cost of care exercise was informed by feedback from Care Home providers and the following observations about our existing fee rate and approach. Our 2017-18 fee rates are set out below.

Residential Care	Proportion Paid	Current Rate (low)	Current Rate (high)
Standard	16%	£389	£391
High Dependency	29%	£426	£430
EMI	55%	£434	£438
Weighted Average Payment			£426.18

Nursing Care	Proportion Paid	Current Rate (low)	Current Rate (high)
Standard	43%	£433	£440
Enhanced	57%	£447	£453
Weighted Average Payment			£440.92

NB Nursing rates exclude FNC rate at £155.05

Our current fee rate approach is bureaucratic and complicated.

- The distinction between the “low” and “high” rates for residential care is very small and does not provide significant incentive.
- The distinction between Standard, High Dependency and EMI rates is also not evidence-based. All residential care should involve supporting people with high dependency, and all should involve specialist skills either in relation to dementia care or comparable levels of need.
- The distinction between Standard and Enhanced Nursing rates is also not evidence-based.

Our starting assumption is that it makes sense to focus on one fee rate for residential and nursing that is sufficient to meet the Local Authority’s statutory obligations. Therefore our model has been focused on building evidence for these fee rates.

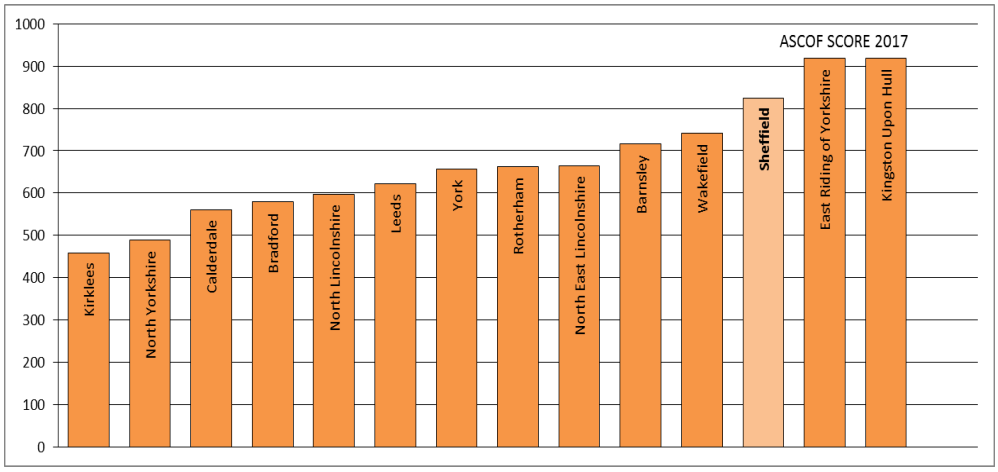
1.2. Acknowledging our comparative position: Costs

Sheffield City Council fee rates for residential and nursing care are low in comparison to regional neighbours. All areas will have different factors in relation to their local economy, so a one-size-fits-all approach cannot be assumed. However, Sheffield’s approach to fee rates for 2018-19 must be appropriately mindful of the approach taken by neighbours.

Average of local per group	£451.88	£480.62	£460.71	£504.04
Local Authority	Residential Min	Residential Complex EMI Min	Nursing Min	Nursing Complex Min
Doncaster	£465.36	£465.36	£465.36	£515.65
Hull	£429.20	£458.40		
Calderdale	£455.67	£515.39	£514.90	£536.84
Bradford	£430.98	£475.70	£348.45	
North Lincolnshire	£421.58	£451.00		
North East Lincolnshire	£430.50	£472.19	£430.50	£472.19
North Yorks	£515.76	£515.76	£507.43	£507.43
Barnsley	£416.56	£450.93	£416.56	£450.93
Rotherham	£432.00	£467.00	£436.00	£518.00
York	£490.64	£527.88	£519.14	£563.73
East Ridings of Yorkshire	£447.09	£506.59	£447.09	£506.59
Kirklees	£470.93	£490.53	£485.04	£505.04
Wakefield	£479.00	£479.00	£479.00	£479.00
Nottinghamshire CC	£441.00	£453.00	£479.00	£489.00

1.3. Acknowledging our comparative position: Number of care home placements

The graph below compares the number of care home placements (both residential and nursing) that Sheffield City Council made per 100,000 population in 2016-17 with other Councils in the Yorkshire and Humber region. Only two Councils made more. There is nothing to justify Sheffield's rate of care home placements being this high. The rate reduced in 2016-17 compared to 2015-16 but more can be done. More preventative work is being developed to ensure that a greater number of people can be supported at home. The Council remains committed however to ensuring that good quality care homes are available for those who need this type of support.



1.4. Care Homes in Sheffield for Older Adults

There are 78 independent care homes for older adults in the city providing 3209 beds in total. Of these, 22% (18) are voluntary/third sector homes. The 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. Approximately 32% of the current care homes in Sheffield are operated by large national organisations; however there are a growing number of more local organisations who have multiple care home ownership. Such a diverse range of ownership brings with it different business models: some providers operate with significant debts whereas others may have very little. National providers can cross-subsidise their homes to manage local variations in demand and profitability and are able to exploit economies of scale.

People living in care homes are often aged 85+ and are likely to be frailer and have greater care needs than in previous decades. Currently 13,300[1]people in Sheffield are over 85 and this is expected to rise steeply bringing the population of 85+ age group to over 19,000 by 2030. Although people are older and frailer when they enter a care home, their length of stay still varies but national evidence suggests it averages 2.5 years in residential and under 18 months in nursing. Many access care later in life after a spell in hospital or intermediate care hence their needs may be greater as a result.

The market in the city has remained relatively stable over the last 12 months however there continues to be a significant demand for places and the occupancy of care homes remains relatively high. If the demand increases there is a risk that there will be insufficient places at the right quality and price for the people who need them.

1.5. What care home providers have told us about the issues that impact on the stability of the care home sector:

Providers have told us about the factors/pressures that impact on their ability to remain in the market and continue to provide good quality services. There is no indication that for 18/19 the issues have changed and this was confirmed in discussions with providers at:

- Care home owners meeting on 31May 2017, 3 August 2017, 17 November 2017, 14 December 2017 and 2 March 2018.
- Individual meetings with Council commissioners
- Consultation on the Cost of Care exercise via meetings (January 2018), email and telephone 1 and 2 January 2018
- An opportunity to view and comment on the final proposed rates (February 2018)

They identified the following key issues:

[1] POPPI

- The previous methodology for uplifting fees (based on CPI/National Living Wage(NLW)
- Fee Levels – the low fee base makes the impact of % increase minimal
- National Living Wage Increases
- Retention of Nursing Staff
- Increased costs associated with apprentices, registration/training and backfill for training
- Recruiting suitably qualified staff in leadership and management posts and paying an appropriate wage increase each year
- Third Party Contributions – providers feeling pressure to charge these
- Private fee payers – subsiding the low fees
- Cost of debt – high interest rates for debt
- Poor stock – the number of homes which need significant refurbishment
- The impact on quality of low fees

Rather than follow the traditional method of identifying the issues and looking at a % increase, the cost of care exercise enables us to work transparently with providers to understand the base costs for care. This would form a more realistic base fee on which a % increase could then be applied.

1.6. Background to the cost of care exercise

The Sheffield Cost of Care exercise commenced in April 2017 in response to feedback from Care Home providers during the fees consultation about 2017/18 fees. Sheffield City Council wanted to understand the cost of care in Sheffield based on Care Home providers volunteering their full set of accounts for analysis. We engaged with partners from Sheffield and Manchester Universities on the methodology used and the review of the expenditure information received from providers to ensure that these were as transparent and robust as possible. The initial analysis provided the basis for further consultation with providers.

1.7. Methodology and Engagement with Providers

The Cost of Care exercise was discussed with providers individually via email and in meetings during May and August 2017. In May 2017 the methodology was shared with Care Home providers and a question and answer session clarified a number of queries. The feedback from this session directly informed the final approach taken – for example it was agreed that full accounts should be submitted to ensure like for like comparisons.

1.8. Cost of Care Information Gathering

Care Home providers were positive about the Cost of Care model and supportive of the ‘open book’ approach to submitting full accounts to ensure transparency. However the level of returns was lower than expected:

- Of 12 providers who originally volunteered to provide financial information

- 9 of these providers submitted some information.
- 4 of these provided full accounts which were sufficient to undertake robust comparative analysis.

Where providers have care homes outside Sheffield we worked with them to identify costs for their Sheffield care homes and apportion centralised costs.

Subsequent reminders were issued by email and letter to those who had volunteered to participate and with those who had submitted partial information however no further information was received. Although the number of providers is relatively low they represent 48% of the residential care home beds purchased by the Council in Sheffield and reflect a range of different sized care homes from small, local and privately owned to large, national and voluntary sector run. The providers who submitted information were:

Ref	Provider Name	Type of Provider	Type of Care	Info supplied
1	Provider 1	Voluntary Local Large	Residential	Full detailed management accounts
2	Provider 2	North of England Large	Residential	Simple overview spreadsheet, no source accounts provided.
3	Provider 3	National Large	Residential & Nursing	Provided spreadsheet of income and costs from Council funded residents for nursing care. The method of allocation or the full source accounts not provided. For resi care provided costs per bed without supporting accounts.
4	Provider 4	Small Local Privately Owned	Residential	Statutory Accounts for the prior year with some additional analysis.
5	Provider 5	Large National	Residential	Detailed one page spreadsheet provided, but not full accounts.
6	Provider 7	Local Medium Sized	Nursing	Full detailed management accounts
7	Provider 8	Large National	Nursing	Template filled in but no source accounts provided
8	Provider 10	Voluntary Large National	Residential	Template filled in but no source accounts provided
9	Provider 12	Large National	Residential & Nursing	Provided detailed costings from accounting system

The template used to capture provider information was based on the model set out in CIPFA's 2017 guide for commissioners and providers: *"Working with care providers to understand the costs"*. Where necessary we worked with care homes and their finance departments to disaggregate costs under the agreed headings.

1.9. The Analysis

The overall model for the residential rate is broken down into the following cost headings:

1. Care running costs
2. Non-care running costs
3. Rental / mortgage costs
4. Corporate overheads
5. Approach to inflation
6. Return on investment

The current working position based on the analysis of the residential providers is set out under the cost headings below:

Staffing: Average care running costs including care assistant, management, admin, reception staff, catering, cleaning and laundry staff, training, registration fees and recruitment:

Total	**£321**

(Comprises the average of three residential providers that submitted full accounts)

Non Staffing: Average non-care running costs including food, utilities, catering, cleaning, laundry, handy person, gardening, insurance, non-food supplies, repairs and maintenance:

Total	**£75**

(Comprises the average of three residential providers that submitted full accounts)

Premises: Rental / Mortgage / Premises costs

Total	**£9**

(Comprises the average of three residential providers that submitted full accounts)

Corporate overheads

The amount paid on corporate overheads has been moderated to 7.5% of the sum of 1-3 above. This reflects the need to manage efficiently in a context of considerable public sector constraint. Corporate overheads of homes in the above sample range from 2.27% in a large local voluntary sector provider to 12.24% in a large national private sector provider:

Total	**£30**

(Comprises the average of three residential providers that submitted full accounts)

1.10 Return on investment

It is reasonable that there should be a return on investment within the model. The proxy chosen relates to national measures in relation to the cost of borrowing, with an allowance for commercial risk in this field, therefore this is base rate plus 2%. This has been calculated on business activity and capital expenditure.

Total	**£11**

1.11 Approach to inflation

To understand the increased cost pressures on care homes, consideration has been given to the Consumer Price Index (CPI) of 3.1% based on September 2017 and the increase to the National Living Wage from April 2018. This follows a similar process to that used in the previous 4 years however the Cost of Care exercise has enabled a more precise ratio for the application of these indices.

Care and nursing homes are subject to the same financial pressures in terms of food, energy and maintenance as any domestic home and therefore the CPI is a useful determinant of increasing non staff pressures. The September increase is also used by the DWP for determining pension increases.

The cost of care assistant staff and others on minimum wage should be inflated by the percentage increase published for the National Living Wage. We appreciate that this has implications for differentials in wage structures. Nursing homes receive funding nursing care which is determined nationally by the Department of Health.

Our approach is based on the ratios between detailed cost headings established by the cost of care exercise and the following indices:

Cost Heading	**% of Total Cost***	**Inflationary rate and rationale**
Care Staffing Costs	48%	4.4% based on National Living Wage Increase
Non Care Staffing Costs	33%	2% based on public sector wage increase
Non Staffing Costs	19%	3.1% based on CPI in September 2017

(*based on average of three residential providers that submitted full accounts and breakdown of staffing spend)

Total Inflationary Uplift	**£17**

1.12. Summary of Cost of Care Base Rate and Inflationary Uplift

The Cost of Care exercise established a single base rate of £446 for residential care homes and an inflationary uplift on that for the financial year 2018/19 of 3.8% making a single fee rate of £463.

The above methodology was also used to model a single rate for nursing. However, the sample size for the nursing cohort was extremely small and the modelled cost from this sample was significantly lower than the residential model of £463. Implementing this rate would have resulted in a decrease in funding for nursing homes which in view of benchmarked rates of comparator authorities and the pressures on this market would have been irresponsible. Therefore the proposal is to use the modelled residential rate across both residential and nursing care.

1.13. Consultation on the Cost of Care Base Rate and Uplift

The outcome of the cost of care exercise was shared with providers at a meeting in December 2017. A report summarising the outcome of the exercise for consultation was sent to all care home providers in early January 2018. Opportunities to feedback were provided via face to face meetings, phone slots and email. 13 responses were received from providers of residential and nursing care. In addition 1 response was received from an independent consultancy (Kingsbury Hill Fox) on behalf of a provider who shared this with the network. 5 of the 13 respondents also supported the report undertaken by the consultancy (see end of report). The 13 providers who responded represent:-

- 40% of care homes in the city - 17 residential and 12 nursing (some who also have residential beds)

- 24% of organisations/providers in the city who run care homes

Providers were asked to respond to some specific questions about the cost of care exercise and give any general feedback – the number of responses is in brackets following the statements below. Clear themes arose from the consultation including:-

- The Information – limited data, concern re interpretation of the information, no rationale for conclusions and lack of independent scrutiny
- The Methodology – no account of dependency, additional staffing costs including pensions, additional nursing costs, quality and an evidence based methodology for identifying rate of return and approach to inflation
- Sustainability – lack of a long term plan for fees and the single rate which may reduce the supply of higher dependency and dementia beds
- Providers also responded to the individual questions posed as follows

Overall

- 5 providers agreed with the report submitted by Kingsbury Hill Fox Ltd
- Commend the Council on basing the fee rate offer on the cost of care and not simply an increment on a previous offer. Started in good time. Done as good a job as the Council can but too much involved and too close to it (KHF)
- More work is needed on the figures or the exercise should be repeated by an independent body (7)
- Sample size is too small to make a judgement and not representative based on 17/18 fees report (6)
- Would like an independent review undertaken by mutually appointed and independent intermediary (3)
- Market has usually been 40% self-funded but this is reducing as a result of new luxury homes and more providers moving to this market (4), one home is considering relocating to reduce reliance on Council fees.
- Supply maybe affected by occupancy levels and availability of self-funders (5)
- Needs a fee structure that is not negotiated each year but which gives guarantees for future years and supports longer term sustainability (5)
- Expected care package needs clarifying (3)
- Accept that work has taken place to so this and support the premise but it has been unsuccessful in understanding costs (6)
- Significant risk to nursing supply due to insufficiency of FNC
- Consultation is a farce

The method the Council has used to understand the cost of care

- Other authorities have used an independent organisation to review provider figures which provided greater confidence
- Inflation – NLW is fine. Nursing cost is higher than £155 however. We subsidise the nursing.

- No consideration of Capex costs, replacement equipment decoration etc. needs including poor stock with refurbishment needs. Low environmental standards don't attract self- funders with higher rates (2)
- Doesn't consider quality, homes who submitted info may require improvement
- Insufficient
- Presumes the 17/18 rate was well funded (3)
- Need to work on a typical users needs not rely on market data (1)
- No justification for use of CPI as opposed to RPI, healthcare historically runs above this (2)
- Comment on NLW is naïve, all staff will need to be increased by this amount, nursing wage inflation is running at least the same level as NLW
- Read as if Sheffield City Council are telling providers what they should do about 3rd party payments (2)
- Weighting should have been based on number of beds of those submitting information (5)
- Not taken account of dependency levels or asked for a breakdown of this (5)
- Suggest Sheffield compares its placement rate in age band and/or against recognised family of local authorities
- Referencing the rates of other authorities does not mean the rate is right or not, it should be based on the ability of the home to sustain the person
- Some providers have shown a '0' against some cost areas in the model and these have been included in calculating averages. This makes the average lower than if they were discounted.
- Did some providers provide '0' against costs in error?

The way the Council have interpreted feedback from care home providers

- Accounts used were an exceptional year of trading with high occupancy (95% not 92% as an average) resulting in a low cost per bed occupied not reflecting seasonal changes. Occupancy has reduced into 80% makes it loss making as some costs are fixed regardless
- Last year was not a good year in terms of the market (a number of failures)
- Since providing the figures circumstances have changed, more debt due to purchasing additional property
- The care costs look low in the model while domestic costs look high
- Pension contributions for TUPE staff have increased
- Numbers in the report are different to those submitted
- Residential figures have/may have been used in the nursing calculation, therefore the nursing figure is not reflective (5)
- Some nursing costs were submitted per resident and there is a mixture of nursing/residential skewing figures
- FNC has been applied to residential numbers

- Numbers weighted against no of homes not beds
- “0” figures were not classed as anomalies and may have affected the data quality (5)
- Training and registration costs not included although they were provided
- Data did not include comments made by providers when supplying it
- Figures have not been included even when supplied (BK)
- Doesn’t reflect costs, one provider estimated blended rate of 733.25 based on 50% nursing/residential and 94% occupancy and another £785 for residential and £1040 based on current costs
- Cost per week of care staff not clear and doesn’t reflect actuals
- Management costs of 2% are not realistic, these are increasing
- Increases should not be based on public sector (3)
- Some info not included labour shortage, wage inflation above NMW, agency costs, management costs and how these impact (2)
- Report was confusing and could be miss-interpreted
- Not clear how many homes were represented by the people who submitted accounts (5) or numbers of beds as a proportion of the total (5)
- Not clear if the accounts considered included homes outside the Sheffield area (5)
- Not clear on level of follow up to those submitting information (5)
- Difference in nursing costs provided, maybe as some may have reported costs which exceed FNC
- Have we ensured that the model does not allow FNC nursing fee to subsidise the cost of the social care in nursing provision?
- You should work on the basis of £155 FNC spent on staffing and then subtracted from staffing
- Why are the nursing costs in the cost of care modelling below £155?
- Have you artificially depressed the figure for the residential element of the nursing home?
- You asked providers for gross costs for nursing care and must ensure you haven’t assumed that every person is nursing.
- My organisation has provided new figures including staffing for nursing. Have these been reflected in the cost of care modelling? (PR)
- Corporate overheads, not clear how this figure has been arrived at
- Incorrect analysis of nursing costs
- Doesn’t include some capital repayments
- Evidence form one provider
- Higher dependency of residents equates to 1.6% additional costs
- Nursing costs are too low and cannot be under £155 per week closer to £250 per week

The approach to inflation

- Brexit should be considered, food costs up 10% more than CPI inflation
- Doesn't take account of increased pension costs or apprentice levy costs, training backfill costs and NEST (2)
- Doesn't take account of other staff on NLW e.g. domestic
- Does not take account of shortage in nursing staff and therefore why providers may need to pay increased wages (5)
- Managers costs have increased with responsibility and lack of appropriate applicants, perhaps by 5% per year (5)
- 3% increase for nurses would be acceptable
- Food and energy costs are on the low side
- CPI is a reasonable approach for 28% of the costs
- Council has not accounted for 1% increase in pension contributions from April
- Council has not accounted for apprenticeship levy that is not included in costs

The rate of return

- Should reflect rate of borrowing
- Too low, needs further clarification, L&B suggest 12%
- Too low (3)
- Return on capital - Rent and mortgage – payment should be independent of the circumstances of the provider e.g. whether they have a mortgage. We would base it on the capital tied up not just what they owe money on. E.g. through re-financing. Would therefore base it on cost of the room rent. We look at the selling values of homes
- No rationale for arriving at this figure – would not be a worthwhile investment based on this (2)
- Mistake in this if related to BoEE it's a capital measure but it's been used as a revenue one
- Entirely wrong, base rate does not effect on margin, cannot use last year's cost for this
- Rate of return should be independent of the capital structure, the degree of mortgage indebtness should not affect the cost of providing care (5)
- Should include a return on business activity (5), annual percentage varies but is higher than 2.5% (recognises there are some reasons why commissioners lower this) (5)
- Return on capital, profits and overheads need to be separated, , profit between 3-5% and cost of capital should be 6%
- Estimate that wages for managers have gone up by 5% per annum for many years now. 2% not enough.

- Return on capital investment is insufficient – would be better off putting the investment into a bond

The overall sufficiency of the rates

- Doesn't accurately reflect low rents in some case
- Nursing staff increases are too low and the fee proposal is unsustainable
- Nursing fee of most concern, for some this means an overall decrease across residential and nursing
- FNC doesn't cover the nursing elements, dependency levels have increased
- Those without self-funders are on the verge of collapse
- Nursing care is higher dependency and the difference between this and residential is insufficient
- Corporate overheads are made up of two components – those related to the home itself and then centralised costs of management for bigger groups.
- 4.1% would achieve status quo but more is required so providers don't have to subsidise rates
- Should be a further return on business activity to compensate for the time and to allow a charitable operator to reinvest. 2.5% rate of return on the overheads as described in the cost of care model is reasonable.
- The Council's approach to cost of care doesn't meet its duty to ensure a sustainable care home market
- Cross subsidy of self funders – how have you taken it into account in the cost of care?
- Can the Council look at how the customers' personal needs allowance might be used to pay for cost of activities in the home for choice benefits

Comments on the single rate

- Would think twice about admitting dementia and nursing people based on this (3)
- Would cease operating for nursing
- Would reduce number of dementia beds
- Agree current rate is complex but needs to be recognition of dementia and high dependency costs (2)
- Don't agree with this
- Doesn't recognise different dependency levels (5)
- Not achievable, suggest sliding scale for categories of care not based on environmental factors
- Understand one rate is simpler but may lead to "cherry picking" (5)

The following paragraphs address the feedback and how it has informed our final proposal:

Methodology and Data: The cost of care approach and template used to capture provider information was based on the model set out in CIPFA's 2017 guide for commissioners and providers: *"Working with care providers to understand the costs"*. The approach was supported by Professors from the University of Sheffield and Manchester as part of the 'Doing Care Differently' project. The approach was discussed and agreed with providers and the University representatives between May-August 2017 including the agreement that only full accounts should be taken into account to ensure transparency and that all costs including capital expenditure were included in the exercise.

Whilst we have worked with the University on designing the approach and reviewing the information submitted by providers, it is ultimately for the Council to propose an appropriate fee rate. We will continue to work closely however with the University on the 'Doing Care Differently' project to develop a longer term strategy for the funding of a sustainable and quality social care market in the city. We acknowledge the relatively low starting point for providers in undertaking this cost of care exercise and will continue to work closely with providers to monitor stability, quality and risk in the sector.

The consultancy report commissioned by a provider acknowledged the Council's approach to understanding the cost of care in a timely way rather than at the end of financial year. Concerns were raised about how representative the sample size was, however it represented 48% of residential care beds purchased by the Local Authority. We made repeated efforts to encourage more providers to submit information to increase the statistical base of the cost of care exercise including follow up emails to those who had initially shown interest and liaising with those who sent incomplete information e.g. budget headings. Ultimately it was up to providers to take part or choose not to. Where necessary we worked with care homes and their finance departments to disaggregate costs under the agreed headings and providers who also operate outside Sheffield were able to provide disaggregated data in order not to skew the exercise.

Independent Third Party Review: A number of providers fed back that they would like to see a mutually appointed consultancy undertake an independent cost of care exercise. This commissioning exercise would be at a cost, whether solely to the Council or jointly between the Council and the sector. The cost of purchasing the model would be coupled with the cost of officer time to interrogate it. However prcise the specification, outsourcing this work to a third party would build in extra costs and inefficiencies, and increase the risk of a model because of uncertainties around data quality. We have provided reassurances to all providers that the Council wll not compromise the cost modelling process by using information about individual care home providers for any purpose other than to contribute to a funding model that reflects the actual costs of care.

Accuracy: We have taken time since the consultation in January to review all the data used with our accounts team and in liaison with the providers who provided information. The detailed costs per provider are not provided here due to commercial sensitivity. A typo was identified in the report shared in January 2018 however we did not find any errors that affected the cost of care calculation or the way we

calculated our proposed fee level. There were challenges with identifying the cost of care in nursing net of FNC and CHC and taking into account feedback from one of the providers that their staffing costs were lower due to the use of a lower cost in house staffing agency. For this reason we are proposing a single rate for all based on the returns from residential care homes where there was greater consistency and confidence in the figures.

Occupancy Levels: The relatively high levels of occupancy during 17/18 across the providers who submitted full information meant that there was no significant impact of factoring occupancy into the cost model. We acknowledge that fluctuations in demand affect the business model for care homes. We expect that the single rate, which represents an increase of between 5-19% for most providers (only rates for enhanced nursing providers will increase by less) will enable providers to plan effectively to manage seasonable changes in demand.

Although occupancy levels have remained high over the 2017/18 period, the net loss of beds has been lower than in previous years (22 nursing beds and a net increase of 4 residential beds in 17/18) and there are also an anticipated 30 additional nursing beds coming into the market in July 2018.

Nursing Costs: The financial information originally received did not disaggregate nursing and non-nursing customers or costs (apart from nursing staff). The assumption was that the nursing homes were 100% nursing provision. Initially this meant that the cost for the residential element of the nursing provision was calculated as a lower rate. The FNC will be spent across a number of cost areas not just nursing staff. Therefore we would not expect the total nursing staff cost to be exactly £155 and believe that to assume this would overstate the costs of providing nursing. A nursing provider subsequently identified that their provision was mixed and that it was unreasonable to make a fee rate based on the assumption of 100% nursing. In order to address this we have therefore used the residential returns only to ensure an equitable rate for residential care and the residential element of nursing care. This is a reasonable approach that avoids overstating or depressing the rate because of the difficulty in extrapolating all aspects of nursing costs. The local authority is responsible for setting the fee rates for social care. Social care fees should not be used to subsidise the nursing element or vice versa. By basing the cost of care on residential only we have addressed this issue to reach a reasonable residential rate and are proposing to ensure equity with nursing by creating a single rate across all provision. The FNC rate for nursing is set by DoH nationally. We have taken on board the feedback that social care costs are not lower in nursing homes and therefore are proposing to increase the fee for nursing to align with the same single standard rate as non-nursing. We have shared the cost of care exercise with the CCG.

Amended Figures: One nursing provider submitted updated figures in February. These were put through the model and showed an increase in nursing costs and reduction in care assistant staffing and a slight increase in management costs. Overall there was a £1 difference in costs and once this was put through the model it had a negligible impact. The decision to establish a single residential rate based on the costs of residential only providers means that this minor variation does not impact on the offer.

Dependency Levels/Single rate: The move to create a single standard rate for residential and nursing care homes aims to address the challenges of managing a range of dependency levels. The proposal to move away from differentiated rates and to adopt a single higher rate reflects the fact that homes report more complex needs across all residents whether those are dementia related, health and nursing related or frailty and physical needs. We will continue to monitor the stability of the sector including any changes to the supply of dementia/EMI beds over the next 12 months.

Use of Zero Figures in calculating average costs: Some providers were concerned that when their figures were run through the cost of care model it produced a 0 against some costs headings. This occurred where the amount per annum was relatively low and, once split across the number of beds and 52 weeks it came to less than 50p. The model rounded up or down as appropriate and this resulted in some lines with the lowest costs showing as zero. As a principle, not using 0 returns in calculating the average cost across several providers would overstate the average because we have used *all operating costs provided to us* and therefore would assume that if a cost if not included under one heading, it is attributed to another.

Weighting: Weighting based on numbers of beds would have actually depressed the figures and we therefore made the decision not to weight the figures. The difference was marginal but not in favour of care home providers.

Quality and the 'care package': All homes who submitted full accounts and on which the base rate is therefore modelled are CQC rated adequate or above and are considered good quality providers. As such the costs provided can be assumed to be meeting users' needs in those homes and providing good quality care. As discussed at the forum in December 2017, we do not prescribe a 'care package' as we expect, as per CQC requirement, that each provider assesses the needs of the person and how they can meet that need appropriately in their specific setting. Individual homes and their managers are best placed to make decisions about the mix of dependency, the levels of care for each person and how they manage this safely.

Staffing Costs: A review of the cost of care exercise, commissioned by a care home provider, describes the inflation of care assistant and domestic staff wages as 'reasonable' and is unable to provide an 'objective figure' on a higher rate for nurse wage inflation. Where care home managers' salaries have risen by more than the 2% figure in recent years this will have been reflected in the cost of care exercise on top of which the 2% inflationary increase is based. We acknowledge the pressures on care homes and other social care providers including recruitment and retention, NLW, agency costs etc. and the cost of care approach provides an opportunity to take these into account fully in establishing a base rate for care homes. We encouraged providers at the meeting in December 2017 to forward any further information that might be relevant to setting the cost of care, some additional information was received from one provider however this did not affect the outcome of the model overall.

Our consultation with providers suggests that most care home staff are paid above the current National Living Wage. We know however that management staff are crucial in ensuring the stability of care home therefore we have proceeded on the basis of an uplift of 4.1% for front line staffing and 2% for management. The proposed uplift therefore enables providers to maintain salary differentials across their provision and attract and retain staff and reduce agency costs. We will continue to monitor recruitment and retention and agency spend in the sector over the next 12 months to identify any negative trends in these areas.

Rate of Return: It is reasonable that there should be a return on investment within the model that, as with the cost of care, should be based upon current economic conditions and reasonable precedents set elsewhere. There are a wide range of factors affecting return on capital investment that make it challenging to apply an approach public funding for return on a capital in a market with a diverse range of business and financing models. The proxy chosen needs to relate to national measures in relation to the cost of borrowing, with an allowance for commercial risk in this field. The proposal is therefore base rate plus 2%. Linking the rate of return to a variable nationally recognised indicator gives the Council a means of ensuring fees are annually updated to shadow borrowing costs.

Capital Expenditure: We acknowledge the wide range of costs that different providers state they incur but were not given evidence for this spectrum in the cost of care exercise. Therefore providers were asked for their suggestions and for evidence to inform a reasonable assumption in this area at the provider meeting in December 2017. We have encouraged providers to come forward to share their figures relating to premises and capital expenditure however no further information has been received. We will work with providers over the next year to monitor the impact of the fee rate increase on provider quality and sustainability.

CPI: We have used September's CPI for non-staffing costs for four years and this year it increased from 1% to 3.1%. In previous consultations providers have suggested that CPI is a reasonable index for 30% of total costs. Given the main non staffing costs of delivering care homes are similar to those of domestic households we feel this is a reasonable approach.

Third Party Contributions: Third party contributions are decided by individual providers based on their costs. The Council has tried to balance the interests of care home providers with those of third party contributors, often family members who face considerable financial pressures in the current climate. It is only right to ask care home porviders to be mindful of this when setting rates, and not to presume that extra funding from the Council should have no impact on the contributions being made by others. The Council is not trying to pay the full cost for every home and remove all third party contributions: some care homes will always seek to operate a higher fee rate than the Council sets and will seek to provide this service to invdividuals who can afford it. The Council has worked to model an appropriate level of inflation that reflects pressures on key areas of spend. We believe, as the Council underwrites these, that it is reasonable to expect that where providers are receiving a significant increase in fee rate (e.g. up to 19%), that this would be reflected in a reduction to any third party contributions charged.

Long Term Planning: We acknowledge the low start point for fees and therefore engaged in the cost of care exercise to address this. It is difficult to say at this point in time how our fee levels will compare with other authorities as most are still in the proposal stage. We will engage with other authorities who have a 3-5 year fees plan to identify learning for our approach in Sheffield. The cost of care exercise was one element of a wider reaching partnership project with Sheffield and Manchester Universities' Business Schools to look at the future of social care in the city and 'Doing Care Differently'. We will continue to work with academics on developing a longer term strategy that aligns to the Ethical Care Charter that the Council has already signed up to.

Consultation: The outcome of the cost of care exercise was shared with care home providers at a meeting on 14th December 2017 where we took comprehensive feedback. The minutes from this meeting plus additional information requested has been shared with providers. The cost of care report was circulated to all care homes in January 2018 and a range of feedback channels and opportunities were provided. The proposed fee rate following consultation was shared with providers on 9th February 18 to allow a further opportunity for providers to respond to the revised fee (aligning nursing with residential single rate). Further feedback was provided by 4 providers on 2nd March 2018 to officers and the Cabinet Member, Cllr Cate Macdonald.

1.14. Other Fees

In addition to standard fees for older adults there are some placements made out of city where it is in the best interest and choice of the individual and their family Although these are small in number a policy position is required so it is clear what fee will be paid. To ensure Sheffield is in line with its legal duties it is proposed that out of city placements will be paid at the host authority rate and this will be uplifted by the amount which the host local authority agree each financial year.

1.15. Additional support offered/to be offered to care homes

The Council and Clinical Commissioning Group (CCG) provide other support to care homes to help improve the quality of care. These include:

- Training to meet the Common Induction Standards.
- Owner and manager forums aimed at improving partnership working and quality.
- Working with the Department for Work and Pensions on recruitment initiatives
- A GP Locally Commissioned Service (LCS) scheme, which costs around £800,000. Under this scheme each Care home is aligned to one GP practice which accepts all residents who choose to register.
- Provision of the online care homes bed portal which is used to identify vacancies.
- However it is clear that there are other opportunities to collaborate with providers and potential ways of creating further efficiencies.

There is a commitment within social care to develop these initiatives which will include:

- Investigating the potential use of assistive technology in care homes which could improve efficiency
- Actively involving providers in the review of the quality and contract monitoring processes undertaken by the Council
- Providers working jointly with the Council on exploring gain share agreements and/or more efficient solutions to capital repayments and the cost of debt
- Ensuring a flexible and innovative approach to meeting the needs of the population both in terms of demographic changes and seasonable fluctuations such as winter pressures in the health service.

Appendix 2 – Home Care

2.1. Background to home care

The home care market has developed and stabilised over the past 12-18 months, partly aided by a significant uplift in fees in April 2017 and procurement activity, which has increased the number of contracted providers from 9 to over 40. The market requires careful monitoring to maintain the balance between supply and demand. More hours (28,472 per week) are now being commissioned for more people (2,774) than at this time last year, with the increasing demand created largely by people coming out of hospital sooner, avoiding care home admissions and requiring more support.

The new home care framework contracts started on October 2nd 2017. Six providers have one or more primary contract areas, and a further 35 providers are part of the Framework Agreement. Overall capacity, contingency arrangements and performance have improved. A further tender in November 2017 is likely to add several more providers to the framework.

2.2. Pressures on the home care market

As demand has continued to grow, the market has responded by recruiting more care workers although this remains a challenge for many providers and the most commonly cited barrier to increasing capacity. Wage levels have risen but there is still a staff churn of around 25% per year. Contracts officer and brokers have been working closely with home care providers, particularly the newer, smaller organisations to support them in growing their business in the city in a controlled and sustainable way.

2.3. The cost model

A ‘cost of care’ model approach to home care fees was implemented in April 2017. Based upon extensive consultation with providers, this model better reflected the true cost of delivering a home care service in Sheffield and took into account local disparities in travel time for care workers.

The new model resulted in an average 8% increase in hourly rates in April 2017. Sheffield rates became more competitive with comparable authorities and the private market. A tender exercise in May 2017 attracted over 50 applicants, including many organisations with no existing operation in Sheffield.

2.4. Additional support offered/to be offered to providers

The Council and Clinical Commissioning Group (CCG) provide other support to home care agencies to help improve the quality of care. These include:

- Regular provider forums with development opportunities

- Opportunities for providers to engage with piloting new approaches to increasing capacity and delivering care in the city
- Identifying training and development needs to inform training provision in the city

However it is clear that there are other opportunities to collaborate with providers and this should include:-

- Development of a recruitment and retention strategy for the city
- Collaborative approach to developing the monitoring arrangements

2.6. Proposal

Although there is no mandatory uplift clause in the contract, the Council has a duty to support a diverse and high quality market and will therefore take into account all relevant factors impacting upon delivery of services, including financial costs.

The split between wages and non-wages costs varies across different business models and between companies. Using widely accepted industry standards, an 85:15 ratio has been used to calculate the uplift. As not all staff would be subject to the NLW rise, the wages element was further broken down to reflect this.

Cost Area	2018/19 Inflationary Uplift
75%: front line staff at or close to NLW levels	4.4% increase (in line with National Living Wage)
10%: staff at higher pay levels	2% increase (in line with public sector pay increase)
15%: non-staffing costs	3.1% increase (in line with Consumer Price Index)

This produces an overall figure of 3.95%

2.7. Consultation:

This proposal was put to the market for comments; 38 providers were asked for comments and 7 responses were received. While most welcomed the increase, several commented that the increase in wage costs should be higher than the 4.1% NLW uplift because of factors such as increased pension contributions from April 2018. Some also commented that other staff needed to see differentials maintained and that the 2% increase for higher paid staff was therefore inadequate. One provider pointed out that the new rates were well below the UKHCA recommendation of £18.01. Our response is that these fee rates were set on the basis of local modelling, incorporating not only costs specific to Sheffield but also variations within Sheffield linked to travel time and our range of urban and more rural communities.

In order to maintain the relative stability of the market through 2018/19, it is recommended that a 3.95% increase in fees is implemented as this takes into

account inflationary and wage pressures, including the increase in the National Living Wage from April 2018. We will continue to work closely with providers via the Care Homes Forum and our contract monitoring relationships to continue monitoring the quality and sustainability of our providers. A full break down of the increased rates per framework contract area is provided below:

Area	**Current Framework Hourly Rate**	**Rate from April 2018**
A1	£15.02	£15.61
A2	£15.31	£15.91
A3	£15.55	£16.16
B1	£15.14	£15.74
B2	£15.20	£15.80
C1	£15.49	£16.10
C2	£15.20	£15.80
C3	£15.08	£15.68
D1	£14.78	£15.36
D2	£15.43	£16.04
D3	£14.78	£15.36
E1	£15.08	£15.68
E2	£15.14	£15.74
E3	£14.90	£15.49
F1	£15.85	£16.48
F2	£16.34	£16.99
F3	£16.40	£17.05
F4	£15.97	£16.60
G1	£16.03	£16.66
G2	£15.20	£15.80
G3	£15.14	£15.74

Appendix 3 - Supported Living

3.1. Background to supported living

The supported living market in Sheffield has had a period of relative stability over the past year, aided by procurement activity, which increased the number of contracted providers on our supported living framework, and the uplift in fees in October 2017. The new supported living framework started on October 2nd 2017 and 22 providers are now on the supported living framework.

Demand for supported living services has continued to grow over the last year. As supported living is a key model of support for adults with disabilities we expect demand to continue to increase in 2018/19. The Council's Commissioning service works closely with care managers and providers to ensure requests for supported living packages are responded to promptly, and that people requiring supported living have a choice of provider.

3.2. The cost model

In October 2017 we implemented a new approach to supported living fees, based on the home care fees 'cost of care' model. Based upon extensive consultation with home care providers, this model takes into account local disparities in travel time for support workers who need to travel between visits, alongside a discounted rate for supported living 'schemes' where travel time is not an issue. The framework also set a rate of £9.66 per hour for sleep-in nights, which reflects changes in payment regulations.

The new fee model resulted in an average 9.8% increase in hourly rates for supported living providers. These rates were published in the tender process for the new supported living framework for which over 40 organisations submitted bids, including many organisations with no existing operation in Sheffield.

3.3. Additional support for providers:

The Council and Clinical Commissioning Group (CCG) provide other support to home care agencies to help improve the quality of care. These include:

- Regular provider forums with development opportunities
- Opportunities for providers to engage with pilots in the city

However it is clear that there are other opportunities to collaborate with providers and this should include:-

- Development of a recruitment and retention plan
- Collaborative approach to developing the monitoring arrangements for supported living

3.4. Proposal

In order to maintain the current stability of the market, it is recommended that an increase in fees is offered which takes into account inflationary and wage pressures, including the increase in the National Living Wage from April 2018.

The split between wages and non-wages costs varies across different cost models and will also vary between companies. Using widely accepted industry standards and feedback from local providers, we used an 85:15 ratio of wage to non-wage costs to calculate the inflationary pressures then took into account that management staff will not be receiving the same uplift as staff at or near to National Living Wage levels. We therefore used the following formula to calculate an inflationary uplift to the base rate for each area:

Cost area	2018/19 Inflationary pressure
75% front line staff at or close to NLW levels	4.1% increase (in line with National Living Wage)
10% staff at higher pay levels	2% increase (in line with public sector pay increase)
15% non staffing costs	3% increase (in line with Consumer Price Index)

In summary we therefore proposed a 3.95% inflationary uplift to the hourly supported living rates for each area, for the discounted rate and for the sleep-in night rate. This proposal was shared with supported living providers on the framework in January 2018.

3.5. Consultation:

We received five responses from providers; four supported the proposed uplift and one was neutral.

A breakdown of how this would impact on the current rates is set out below

Area	Current Framework Hourly Rate	Rate from April 2018
A1	£15.02	£15.61
A2	£15.31	£15.91
A3	£15.55	£16.16
B1	£15.14	£15.74
B2	£15.20	£15.80
C1	£15.49	£16.10
C2	£15.20	£15.80
C3	£15.08	£15.68
D1	£14.78	£15.36
D2	£15.43	£16.04

D3	£14.78	£15.36
E1	£15.08	£15.68
E2	£15.14	£15.74
E3	£14.90	£15.49
F1	£15.85	£16.48
F2	£16.34	£16.99
F3	£16.40	£17.05
F4	£15.97	£16.60
G1	£16.03	£16.66
G2	£15.20	£15.80
G3	£15.14	£15.74
Discounted scheme rate	£14.50	£15.07
Sleeping night rate	£9.66	£10.04

Appendix 4 - Extra Care Housing

4.1. Background to Extra Care

There are 9 extra care/assisted living schemes in Sheffield, they range both in size and the facilities they offer, however most cater for the older age group. The Council fund 5 of the schemes, 2 through contracting arrangements and 1 through a Health and Wellbeing Grant. The remaining 4 schemes were privately developed to accommodate people funding their own care. The majority of the contracted schemes were built during the first half of 2000 as part of an extra care strategy set up to run alongside the care home strategy which involved the closure of a number of Council run care homes.

The landlords of each scheme tend to be registered social landlords who operate on a not for profit basis and the care and support providers are traditionally home care providers. Whilst the operation of the scheme is registered by CQC as home care, it has more similarities with the supported living schemes where providers are registered as domiciliary care providers but their work is focused around a building or house and therefore travel time is minimal.

The current care and support contracts were tendered for and involve 3 providers who also provide some home care, either Council funded or privately. The contracts were let in 2015 when the care and support elements were combined (previously supporting people funding along with housing benefit) and are due to expire in 2019, although there is the option to extend these.

Providers have therefore remained at the same funding level for almost 3 years, the care element is paid based on actual service delivered as it fluctuates based on need, the support element is paid at the same rate each week as it has an overarching aim to engage all of the tenants in activities/support that enables them to remain independent and without care for as long as possible.

It is clear at the point of tender that the providers would not have been able to factor into their fee the National Living Wage (NLW) as this was announced by Government after the tender. It is also clear they would not have been able to accurately predict how the support element would work as the housing benefit rules were changing at the time and it was unclear what elements of support the landlord would deliver as opposed to the care provider. What this has led to is a need to review the support element of the contract to ensure it is value for money; this has already commenced and will form part of the new tender arrangements.

Providers have remained relatively stable however two have raised concerns about the fee rates for care and support during recent consultation. This is due in part to the relatively low care hours being provided in the schemes (in contrast to supported living schemes). A recent revision and relaunch of the nominations policy will

address this in the longer term however the turnover in extra care is slow and redressing the balance of care hours will take a longer period of time.

4.2. Pressures on the Market

The pressures on extra care are similar to those experienced by other social care providers, for example increases in cost of rent, registration, training and DBS checks. It is also well reported that there are ongoing issues in the recruitment and retention of staff in the social care industry, although this is less of an issue in extra care housing than in home care. In November 2017 extra care providers were asked about pressures in their market and other than those which are already stated there were no additional areas we were asked to consider.

There are specific pressures relating to the extra care providers and these are:

- The current extra care providers have not received any increase in fees since the contract began in 2015 therefore with the introduction of the living wage and other costs such as registration and training costs the pressure is increasing
- There is recognition about the similarities between extra care and supported living but because there was a recent tender for supported living and as there has been no uplift for extra care providers the difference in hourly rates between them is significant and growing
- The major pressure over the past year has been the implementation of the National Living Wage (NLW) to cover night time support, with HMRC investigating providers where they appear to be non-compliant with legislation. (Extra care providers need to provide emergency cover over night). The new Supported Living Framework covers the cost of this; however there has been no recognition of this in the hourly rate paid to extra care providers.

4.3. The cost model

The ‘cost of care’ model was implemented in April 2017 and better reflects the real cost of delivering a home care service, while taking into account local disparities in travel time for care workers. The 2017 home care and supported living framework established an approach that treated home care and supported living consistently whilst recognising key differences. Extra care was not part of this framework even though it has a number of similarities with the discounted supported living schemes and therefore the base rate for extra care remains significantly lower. There is a need to adopt a consistent approach and therefore the extra care providers were offered a similar uplift to the supported living schemes.

4.4. Proposal

In the interim it is proposed to align the extra care, care hours only with that proposed supported living. Therefore we have applied the following inflationary uplifts to these cost areas:

75% front line staff at or close to NLW levels	4.4% increase (in line with National Living Wage)
10% staff at higher pay levels	2% increase (in line with public sector pay increase)
15% non-staffing costs	3% increase (in line with Consumer Price Index)

This results in an increase of 3.95% to the hourly rate for care from April 2018.

4.5. Consultation feedback

2 providers responded to the proposal (although 1 was received 3 weeks after the consultation closing date) saying overall they were pleased with the fact that an increase had been recommended which would go "some way in providing market stability during a difficult time for staff recruitment". However significant concern was raised about the viability of the contracts for the next 12 months. Providers asked for further consideration of the following points (extracted from their communication with us):

- The real cost of NLW on employers of 5.3% (including an extra 20% for employment costs, i.e. holiday pay and employer's NIC). We will also see annual increases to younger employee's hourly rates for apprentices and those up to 24 years.
- Employer's contributions to workplace pensions will double from 1% to 2% in Gross Pay.
- Annual inflation currently running at 4%
- With effect from April 2018 auto-enrolment pension contributions for employers will increase by 1%.
- The NLW uplift should apply to all staff, not only front-line workers. Its important to maintain the wage differential in order to attract/retain office staff.
- Identifying these financial pressures, UKHCA recently carried out a calculated study which identified that from April '18 to March '19, local authorities should be paying a minimum price of £18.01 per hour for homecare services. Typically, this would include values for care worker pay, travel time, NI and Pensions, holiday, training and SSP. We are mindful that fixed address care services such as our own Extra Care courts should not include care worker travel time at £1.48ph within the sum, so a more realistic £16.53ph for care looks far more reasonable.
- Staff turnover show it is currently averaging 24.9% and there is a need to increase staff retention

Following this feedback and further consideration it was agreed that the extra care hourly rate for care should be increased to match that supported living schemes rate

for geographically based support of £15.07 per hour for care with no increase to the support costs.

Appendix 5 - Non Standard Fees

5.1 Background.

A significant proportion of local adult care and support services do not have standard fee rates. This includes 'non-standard fee' care homes, community-based services, Personal Assistants, Money Management services, Direct Payments and other individualised support arrangements.

This Appendix sets out the Council's proposals for fee uplift requests for non-standard fee care and support services.

5.2 Residential and Nursing Fees with non-standard fees

5.2.1 The local market

The local care home market includes a number of residential and nursing care services where placement costs exceed Sheffield's standard rates – 'non-standard' fees. The majority of care homes at 'non-standard' fee rates support working age adults with learning disabilities, physical disabilities or mental health problems. Some support adults from two or more of these customer groups.

There are 35 care homes for adults with learning disabilities, physical disabilities or mental health problems in Sheffield. Most provide continuing care with a small number specialising in residential respite/short breaks services.

The market in in 'non-standard' fee care homes has been relatively stable this year. There have been two exits, both on quality and safeguarding grounds. This capacity has been more than compensated for by new supported living schemes offering high quality accommodation with support from providers on our supported living framework.

Quality in care homes for adults with learning disabilities, physical disabilities or mental health problems is largely good as measured by CQC ratings. One care home is currently rated outstanding, 29 good and five as requiring improvement.

5.2.2 Non-standard residential and nursing care fees

The fee setting process for non-standard fees is different from standard fees. Non-standard fees are set individually by the provider or negotiated on an individual basis, and not on the basis of a standard fee level fixed by the Council.

Non-standard fees range from less than £450 per week to over £3,000 per week. As an example, Table 1 below sets out the range of non-standard care home fees for adults with learning disabilities.

Table 1: Non-standard residential and nursing care rates for adults with learning disabilities.

Price range	No. of placements
£450 to £999	68
£1,000 to £1,499	58
£1,500 to £1,999	31
£2,000 to £2,999	18
£3,000 and over	2

The wide variation in non-standard fees reflects the wide variation in the nature and level people's support needs and the diversity of services that can meet these needs. Different care homes have significantly different cost structures and specific budget pressures can impact on them in ways specific to their business.

5.2.3 Staffing and non-staffing/accommodation costs.

In our consultation with standard fee residential care home providers in 2016, feedback indicated a ratio of approximately 70% staff costs and 30% non-staff costs. It also showed a range in accommodation costs between £85 and £244 per person per week. In contrast, in 'non-standard fee' residential and nursing care staffing ratios can vary widely, with some homes providing one to one support, at times even higher.

Accommodation costs in many non-standard fee care homes vary significantly, and in some cases are significantly higher than in standard fee rate homes. In some high cost packages, accommodation and non-staff costs exceed £1,000 per person per week. This results in a lower ratio of staff costs compared with standard fee care homes despite the higher staffing ratios. As an illustration, in recent costings from one non-standard fee high cost care home provider (over £2,000 per person per week), staff costs accounted for only 47% of the total cost.

5.2.4 Inflationary pressures on non-standard fee care homes

The Council recognises that individually negotiated non-standard fees will have similar market pressures as other social care providers including

- National Living Wage Increases
- Retention of Nursing Staff
- Increased costs associated with apprentices, registration/training and backfill for training
- Recruiting suitably qualified staff in leadership and management posts and paying an appropriate wage increase each year
- High interest rates for debt

5.2.5 Proposal for non-standard fee care homes

Inflationary pressures affecting staff /non-staff costs are different. As staff /non-staff costs ratios vary significantly in non-standard fees care homes, it is

inappropriate to apply a standard percentage uplift based on assumptions of standard staff /non-staff cost ratios.

Proposal. We therefore propose not to apply an automatic inflation uplift, but to respond to requests on an individual basis taking into account individual needs, individual provider costs and value for money considerations. We propose an 'open book' approach, using a transparent breakdown of costs and income.

- If the fee for any the Council placed resident is not sufficient to meet that person's care the provider will notify the Council and be asked to provide details of their expenditure and income on a standard template.
- Each request will be considered on an individual basis.
- If there are no requests for an uplift then no automatic uplift will be applied.

The above is also the position that Sheffield NHS Clinical Commissioning Group (SCCG) has agreed for jointly funded CCG/Council placements during 2017-18. They will be writing separately to Care Homes/other providers with whom they contract directly, to explain the position on those fees for 2018-19.

5.3 Direct Payments

Over 2,500 people in Sheffield have a Direct Payment. These are individually negotiated arrangements between the person with support and support providers. Direct Payments are used for a wide range of support – including personal assistants, home care, supported living, community and day activities, short breaks, and transport. In some situations Direct Payments may be used to pay relatives to provide support. Many people use part of their Direct Payment to pay Money Management organisations to help with the financial and administrative arrangements of their Direct Payment.

5.3.1 Personal Assistants.

There is no standard rate in Sheffield for a Personal Assistant. The Council expects Personal Assistants to be paid at least the National Living Wage, and that the Direct Payment recipient as the employer makes the relevant payments towards the Personal Assistant's Pension and National Insurance. Rates for Personal Assistants range from the National Living Wage to over £20 per hour, reflecting the range and nature of people's individual support needs.

Proposal. Any need for an increase in Personal Assistant fees is therefore likely to vary between individual Direct Payment recipients. It is therefore proposed that requests will be responded to on an individual basis.

5.3.2 Direct payments for community-based support.

Many people use Direct Payments for support in the community, including day activities, transport, short breaks and other personalised support. These community-based services have a wide range of costs, again reflecting the diversity of individual need and choice, and the diversity of community-based

support in the city. Some people also use Direct Payments to fund mainstream community activities (including membership fees) and other personalised ways of meeting their support needs, again with a wide variety of costs.

Many community-based organisations support a number of Direct Payment recipients at the same fee rate (for instance a day activities provider with a standard daily rate).

Proposal.

Any need for an increase in community-based support fees is likely to vary between individual Direct Payment recipients. It is therefore proposed that requests will be responded to on an individual basis.

Requests from community-based support providers funded through Direct Payments for an increase in their fees is likely to vary between individual providers. It is therefore proposed that requests will be responded to on an individual provider basis using an 'open book' approach similar to that proposed for non-standard fee residential and nursing care homes.

5.3.3 Money management

Around 60% of Direct Payment recipients use a third party account company (sometimes called Money Management) to help with the administration of payments to care and support providers. These companies levy a charge for their service which is negotiated privately between the provider and the individual. The Council has no influence or input into this negotiation. Similarly for provision of payroll services; charges are made but these are outside the remit of any fee setting processes overseen by SCC.

Proposal. Any need for an increase in fees for these aspects of people's arrangements is likely to vary between individual Direct Payment recipients. It is therefore proposed that these will be responded to on an individual basis.

5.3.4 Direct Payments for Home Care and Supported Living – the 'guide price' principle

Many people use a Direct Payment to purchase Home Care or Supported Living services. The Council has a framework for Home Care and Supported Living services with a range of fixed hourly rate prices depending on the type and location of the service regardless of the organisation providing the service. These rates will be uplifted in 2018/19 (see Appendix 3).

Proposal. Where Direct Payments are being used for Home Care and Supported Living it is proposed that the Council's standard approach will be to apply the 'guide price' principle, where the Supported Living framework hourly rate is the maximum the Council will expect to pay. Where providers are charging Direct Payment recipients higher rates, the individual would normally be expected to meet the difference through their own funds. Where this creates specific difficulties, or where there are specific support requirements that create higher

costs for providers, the Council would review each situation on an individual basis.

5.4 Council arranged community-based support

The Council directly arranges and funds a small number of community-based care and support services, including community and day activities. Costs range from under £30 to over £150 per person per day again reflecting the wide variation in the nature and level people's support needs and the diversity of community-based support services and activities that can meet these needs. Inflationary pressures will vary between different providers.

Proposal. The need for a fee increase for community-based support providers is likely to vary between individual providers. It is therefore proposed that requests will be responded to on an individual provider basis using an 'open book' approach similar to that proposed for non-standard fee residential and nursing care homes.

The above is also the position that Sheffield NHS Clinical Commissioning Group (SCCG) has agreed for jointly funded CCG/Council placements during 2017-18. They will be writing separately to Care Homes/other providers with whom they contract directly, to explain the position on those fees for 2018-19.

Appendix 6 – Report commissioned by Kingsbury Hill Fox Limited on behalf of a Care Home Provider

Please see separate attachment. This appendix has been commissioned by a Care Home Provider and not by the Council. It is included as consultation feedback because it describes an alternative approach to fee setting from the one the Council has employed. The reasons for the Council pursuing its model rather than the approach set out by Kingsbury Hill Fox Limited are set out in these papers.

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