Nottinghamshire County Council

Adult Social Care and Health Committee

Monday, 04 February 2013 at 10:30

County Hall, **County Hall, West Bridgford, Nottingham NG2 7QP**

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Paul Davies (Tel. 0115 977 3299) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

Nottinghamshire County Council

minutes

Meeting	ADULT SOCIAL CARE AND HEALTH COMMITTEE
Date	7 January 2013 (commencing at 10.30 am)

Membership
Persons absent are marked with `A'

COUNCILLORS

Kevin Rostance (Chairman)
Stuart Wallace (Vice-Chairman)
Reg Adair
Ged Clarke
John Doddy
Rachel Madden
Geoff Merry
Alan Rhodes
Martin Suthers
Chris Winterton
Jason Zadrozny

Ex-officio (non-voting)
A Mrs Kay Cutts

OTHER COUNCILLORS IN ATTENDANCE

Councillor Mel Shepherd

OFFICERS IN ATTENDANCE

Caroline Baria, Service Director, Joint Commissioning, Quality and Business Change
Paul Davies, Democratic Services Officer
Sophie Edwards, National Graduate Trainee
Sarah Gyles, Committee Support Officer
David Hamilton, Service Director, Personal Care and Support (Older Adults)
Gail Holliday, Liberal Democrat Group Administration/Research Officer
Jennie Kennington, Senior Executive Officer
Paul McKay, Service Director, Promoting Independence and Public Protection
Amy Newbery, National Graduate Trainee
David Pearson, Corporate Director, Adult Social Care, Health and Public Protection
Lisa Swift, Committee Support Officer
Anna Vincent, Independent Group Administration/Research Officer
Peter Watson, UNISON Convenor, Adult Social Care, Health and Public Protection
Michelle Welsh, Labour Group Research Officer
Jon Wilson, Service Director, Personal Care and Support for Younger Adults

MINUTES

The minutes of the last meeting held on 26 November 2012 were confirmed and signed by the Chairman.

MATTER ARISING

In relation to the item on Quality in Care Services, Councillor Wallace asked for an update on the Havana and Silverdale Care Homes. David Hamilton informed the committee that Havana was likely to be closed by the end of January. The authority was working with residents and their families to find alternative care settings. He explained that the authority's contract with Silverdale had been suspended, and the authority was working with the home to improve standards and care planning. He and David Pearson responded to members' questions.

MEMBERSHIP

It was reported that Councillor Reg Adair had been appointed to the committee in place of Councillor Liz Yates.

DECLARATIONS OF INTEREST

There were no declarations of interest.

PERFORMANCE UPDATE OF ADULT SOCIAL CARE

RESOLVED: 2013/001

That the report be noted.

IMPROVING PERFORMANCE INFORMATION

RESOLVED: 2013/002

(1) That the Improving Performance Project in the Performance Improvement Team be extended;

(2) That 1 fte (37 hours) temporary Performance Data Analyst, Band A, scp 29-34 (£24,646-£28,636 per annum pro rata) be extended for a further nine months until 30 September 2013 and be based in the Performance Improvement Team at County Hall.

FUNDING FOR SUBSTANCE MISUSE SOCIAL WORKER POSTS

RESOLVED: 2013/003

(1) That £55,314 be committed as permanent funding to the 3 fte social work posts in Substance Misuse to maintain a countywide social work service in this specialist area.

(2) That the 3 fte (111 hours) Social Workers (Substance Misuse) be moved under the line management of the Team Manager for the Broxtowe and

Hucknall Community Mental Health Team with effect from the date of committee.

(3) That a period of consultation be approved on the proposal that from April 2013, the Council only funds the social care element of residential placements for substance misuse and that any therapeutic element of the placements is sought from the NHS, and that a further report be presented to committee on the outcome of the consultation.

ADULT CARE FINANCIAL SERVICES - BEDS IMPLEMENTATION RESOURCE

RESOLVED: 2013/004

That 1 fte (37 hours) temporary Finance Assistant, Grade 3, scp 14-18 (£15,725-£17,161 pro rata per annum) be extended for a further six months from 1 February 2013 to 31 July 2013 and be based in the Adult Care Financial Services Team at County Hall.

SOCIAL CARE WORKFORCE EFFICIENCY PROJECT

RESOLVED: 2013/005

(1) That social care students be engaged to undertake the further analysis and research of Social Worker activity under the supervision of the Research Officer.

(2) That the temporary post of Research Officer, Hay Band A (£24,646-£28,636) be extended for a period of six months from 31 January 2013 until 31 July 2013 and the post be allocated approved car user status.

(3) That a further report be brought to the next meeting on the outcome of negotiations about the project with the University of Nottingham.

REABLEMENT SERVICE UPDATE - LINGS BAR COMMUNITY HOSPITAL: ENHANCED COMMUNITY CARE SERVICE

RESOLVED: 2013/006

That the excellent progress made to date be noted.

SECONDMENT OF COMPLIANCE MANAGER FROM THE CARE QUALITY COMMISSION TO NOTTINGHAMSHIRE COUNTY COUNCIL

RESOLVED: 2013/007

(1) That the secondment of the Compliance Manager from the Care Quality Commission to the Adult Social Care, Health and Public Protection Department for a 12 month period from 14 January 2013 to 13 January 2014 be approved;

(2) That the use of departmental reserves to fund the salary and on-costs of the Compliance Manager for the 12 month secondment period be approved;

(3) That the secondment of one of the Department's Quality Development Officers for a 12 month period to the CQC to undertake the role of an Inspector be approved;

(4) That reports on the secondments be presented to committee after six and 12 months.

CARE AND SUPPORT CENTRE INDEPENDENT LIVING ACCOMMODATION

RESOLVED: 2013/008

(1) That the development of the two Independent Living apartments at Woods Court, Newark be approved;

(2) That the necessary capital funding be met from slippage from the planned expenditure from the NHS Support to Social Care from Health (s256) funding;

(3) That the apartments be evaluated after a six month period to assess their effectiveness as a model that could be used in other centres in the future.

LIVING AT HOME (FORMERLY AIMING FOR EXCELLENCE) EXTRA CARE HOUSING UPDATE REPORT

RESOLVED: 2013/009

(1) That approval be given to continued work on Options 1 and 2 described in the report;

(2) That subject to grant conditions being met, a submission be made to the Department of Health for funding from the Department of Health Specialist Housing Fund by 18 January 2013.

DAY SERVICES MODERNISATION PROGRAMME

RESOLVED: 2013/010

(1) That Day Services be authorised to set the period of the 2-week closure by local agreement with service users, carers and staff on an annual basis.

(2) That the following amendments to the day service staff restructure be approved:

a) 5 fte (185 hours) Team Managers, Pay Band D, scp 42-47 (£35,430 - £39,855 pro rata per annum) be extended from 1 April 2013 to 30 September 2013 and the post continue to be allocated approved car user status.

b) 3 fte (111 hours) Team Managers, Pay Band D, scp 42-47 (£35,430 - £39,855 pro rata per annum) are in post from 1 October 2013 and the post continue to be allocated approved car user status.

c) 2 fte (74 hours) temporary Business Support Assistant posts, Grade 3, scp 14-18 (£15,725 - £17,161 per annum pro rata) be extended from 1 April 2013 to 30 September 2013.

d) 1 fte (37 hours) temporary Service Manager (Day Services), Pay Band E, scp 47-52 (£39,855- £44,276 per annum pro rata) be extended from 1 April 2013 to 30 September 2013 and the post continue to be allocated approved car user status.

(3) The following temporary post in Business Change be extended as follows:

1 fte (37 hours) temporary Project Manager, Pay Band E, scp 47-52 (£39,855 - £44,276 per annum) be extended from 1 August 2013 until 31 August 2014 and the post continue to be allocated approved car user status

(4) That approval be given to consultation on the transfer of all day service catering staff and associated catering budgets to the Catering and Facilities Team.

COMMISSIONING OF SIGN LANGUAGE INTERPRETATION SERVICE FOR NOTTINGHAMSHIRE COUNTY COUNCIL

RESOLVED: 2013/011

That approval be given to the procurement of a new contract for a Sign Language Interpretation Service by competitive tender in partnership with Nottingham City Council, NHS Nottinghamshire County and NHS Nottingham City.

EXTENSION OF CONTRACT FOR SUPPORT WITH SECTOR-LED IMPROVEMENT IN ADULT SOCIAL CARE

RESOLVED: 2013/012

That the post of the temporary Programme Director, Sector-led Reform be extended on the basis of 2 days per week or equivalent until 31 March 2013.

WORK PROGRAMME

RESOLVED: 2013/013

That the work programme be noted, and reports be included to future meetings on the consultation on the funding of substance misuse residential placements, the Social Care Workforce Efficiency Project and the secondment of the CQC Compliance Manager.

The meeting closed at 12.20 pm.

CHAIRMAN

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

4th February 2013

Agenda Item:

REPORT OF SERVICE DIRECTOR FOR JOINT COMMISSIONING, QUALITY AND BUSINESS CHANGE

FAIR PRICE FOR CARE – EXECUTIVE SUMMARY

Purpose of the Report

1. To inform Members of the work undertaken to review the current local 'Fair Price for Care' framework and the associated fee levels for older persons' care homes in Nottinghamshire.

2. To propose new fee levels based on the work undertaken to ascertain the actual costs of providing older persons' residential and nursing care across Nottinghamshire.

Executive Summary

1 In 2008/09, the Council commenced implementation a local 'Fair Price for Care' framework. The framework was introduced in recognition of the following:

- the need to increase fee levels to reflect increasing costs faced by care home providers
- to provide incentives for care home providers to continuously improve the quality of the care services, with a particular focus on providing and developing good quality dementia care

2 The fee levels were set in consultation with older persons care home providers and their representative organisation the Nottinghamshire Care Association (NCA). However, due to financial constraints faced by the Council, the fee increases were phased in over a period of five years, with the final increases being applied during 2012/13. The application of annual inflationary increases to fees has been considered separately through the Council's normal annual budget setting processes. For the last two financial years, 2011/12 and 2012/13, inflation for externally provided services has been 0%.

3 At the start of the 2012/13 financial year, the total number of long term placements funded by the Council in older persons' care homes in Nottinghamshire was 2,284. The Council will also fund approximately 180 short term and respite care placements at any one time. Within the local fair price for care framework, and based on the total number of placements in independent sector older persons care

homes in mid-April 2012, the total estimated cost for 2012/13 for this provision is £57.8 million of which £53.2m is for long term placements and a further £4.6m for short term placements.

4 Over the past two and a half years, a number care home providers or their representative organisations have brought legal challenges against local authorities in relation to their fee levels and also for ways in which their fee levels have been determined and set. The successive court rulings have placed a requirement on councils to consider the 'actual costs' faced by their local care home providers. Councils have also been required to ensure that the fee levels will enable sufficient and sustainable capacity and choice of care home provision within the local market.

5 In order to set care home fees for 2013/14 and beyond, and in considering the legal context, the Council has completed a comprehensive review of its current fee levels. This has included undertaking a two-stage consultation process to determine actual costs of providing older persons' residential and nursing care in Nottinghamshire.

6 Stage 1 of the consultation process has entailed conducting a survey through the use of a questionnaire of local older persons' care home providers. The information and data provided by the care homes has been aggregated and analysed to establish the actual costs of care, including costs related to the provision of dementia services. This analysis has also included consideration of factors such as the size of the home and geographical locations in order to determine their impact on provider costs and capacity.

7 The information derived from the survey has been considered within the context of current and historic information about the local market position in relation to care homes and also the Council's wider strategic objectives and commissioning intentions in relation to health and social care services for older persons. This wide ranging information had been used to inform proposals for fee levels for 2013/14. The proposals have included consideration of allocating annual inflation related increases beyond 2013/14 as determined by an inflation formula which is relevant to social care services.

8 Stage 2 of the consultation process has entailed seeking the views of the care home providers in relation to future fee proposals including ascertaining the impact of the proposed fees in relation to capacity and sustainability within the local market.

9 Overall, the providers that responded to the consultation were supportive of the proposal to retain the local 'Fair Price for Care' framework and the five bandings, including the annual audit process, on the basis that the framework provides an incentive to continuously improve the quality of care. Provider also welcomed the proposal to apply an annual inflation related formula to fees as a means of ensuring the fees continue to reflect actual costs.

10 Providers who responded to the consultation challenged the Council's assumptions on two key factors on which the fee proposals had been based. These relate to:

- average occupancy levels
- assumptions about staffing levels.

11 The Council has given due consideration to all of the issues raised by providers, including the two key issues above, in order to ensure that future fee proposals continue to support a viable local market of provision to meet current and future needs. Consideration has also been given to ensuring that the fee levels and the fee model continues to enable providers to improve the quality of care.

12 The Council has also considered comparative data from other sources such as Laing and Buisson who are considered to be the industry leader on costs of care home provision following their development and implementation of the 'Fair Price for Care' costing toolkit.

13 As identified above, one of the key factors identified by local providers in their response to the consultation, and as identified by the recent Laing and Buisson research (2012), is the increased cost pressures arising from higher dependency and higher levels of needs of older people, which requires providers to have higher levels of staff.

14 The Council has revised its initial fee proposals, which formed the basis of its Stage 2 consultation, in recognition of the need for increased staffing levels as a result of higher dependency and higher levels of need of older people in care homes. As such, the revised fee proposals reflect the need for higher staffing levels.

15 The Council is proposing that fee levels are increased by an average of 11.8% across the five bands and the total estimated additional cost of the proposals is £6.8 million.

16 It is recommended that the proposed fees are implemented with effect from April 2013, with annual inflationary increases, as determined by the relevant index formula, being applied from April 2014. It is recommended that the framework is implemented over a five year period.

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

4th February 2013

Agenda Item: 4(b)

REPORT OF THE SERVICE DIRECTOR FOR JOINT COMMISSIONING, QUALITY AND BUSINESS CHANGE

LOCAL FAIR PRICE FOR CARE – OLDER PERSONS' CARE HOME FEES

Purpose of the Report

1. To inform ASCH Committee of the work undertaken to review the current local 'Fair Price for Care' framework and the associated fee levels for older persons' care homes in Nottinghamshire.

2. To inform ASCH Committee of proposals on future fee levels based on the work undertaken to ascertain the actual costs of providing older persons' residential and nursing care across Nottinghamshire.

3. To ask ASCH Committee to recommend the proposed changes to Policy Committee for approval.

Information and Advice

4. There are currently 169 older persons' independent sector care homes in Nottinghamshire. The Council funds approximately 34% of the total long term placements within these homes. In addition, the Council utilises some beds for short term placements or respite care. As well as placements funded by Nottinghamshire County Council, a number of placements are arranged and funded by the NHS in nursing care where the service users meet the NHS Continuing Health Care criteria, or by people who fund their own care, or which are arranged and funded by other Councils. It is important to note that not all the places are occupied all of the time and most, if not all care homes, will have vacancies at varying levels.

5. The Council, through the ASCH&PP department, has a statutory duty to undertake an assessment of need to determine the level of care and support required by service users and where relevant their carers. The assessment also includes completing a financial assessment to determine the service user's contribution to their care, based on their financial circumstances.

6. The Council also has a duty to undertake an annual review of each service user to ensure that the services continue to meet their needs. The reviews are

undertaken by social work staff based in the locality teams. These reviews provide staff with the opportunity to ensure that service users are receiving a good quality service.

7. Additionally, the Department of Health has issued guidance saying that fees setting must take into account the legitimate current and future costs faced by providers as well as the factors that affect those costs, and the potential for improved performance and more cost effective ways of working. Contract prices should not be set mechanically but should have regard to providers' costs and efficiencies, and planned outcomes for people using services.

Historical context of the local 'Fair Price for Care' framework and fee structure

8. Since 2008/09, the Council has been implementing a phased fee structure based on a 'Local Fair Price for Care' model which was developed with input from the Nottinghamshire Care Association (NCA) and an external consultancy, Pinders. The framework, through its bandings, sought to pay higher fees for high quality care provision as evidenced through an annual audit of each older person's care home. The aim of the fee framework was to improve the quality of care across the sector and to increase the amount of good quality dementia provision. Locally, there was recognition by the NCA that overall the quality of residential and nursing care needed to be improved.

9. The banding system has been recognised as a model of good practice by the CQC and by other local authorities. The advantages of the framework and the banding system are as follows:

- it rewards good quality as well as environmental conditions - since its implementation, there have been some overall improvements in the movement to a higher quality of care
- it provides an agreed system for quality audits across health and social care – both NHS Nottinghamshire County and NHS Bassetlaw have adopted the same framework and undertake joint audits, with the Council's quality development officers, of nursing homes across the county
- it provides a consistent means for assessing the quality of care in the sector on an annual basis
- it enables service users and carers to make informed choices based on the assessment of quality.

10. The banding system leads to an increase in costs as the number of homes in higher quality bands, and hence the number of placements made in higher quality bands, increases.

11. The annual quality audit that determines the banding of each home is undertaken by a team of Quality Development Officers. The audit comprises of two elements:

- an assessment of quality of care provision based on the outcomes of the Care Quality Commission's Essential Standards of Quality and Safety

- the home's accommodation and environmental standards.

12. The scores from these two assessments are combined in a ratio of 70% quality and 30% accommodation which gives an overall rating of each care home. A Quality Audit Framework tool is used to support the Quality Audit process. This tool is reviewed annually to ensure providers are demonstrating continuous improvement in the quality of the care they provide.

13. The audits are undertaken by Quality Development Officers (QDOs) and each audit takes approximately 2 days to complete with one day spent on the site visit and the equivalent of one day to gather supporting information and to write the report. A particularly strong feature of the approach in Nottinghamshire is that the quality audits are carried out by social care and health care staff working jointly.

14. Through the audit process, the QDOs seek to ensure that the providers are meeting the following objectives:

    - the health, well-being and safety of people using care services is maintained and promoted
    - service users are treated with dignity and respect
    - that service users and their carers' have choice and control over the services they receive
    - to ensure that care staff are appropriately trained to deliver the services.

15. Where the audit process identifies concerns about the quality of the care being provided then the QDO will make recommendations to the provider who will be required to develop and implement an action plan, within specified timeframes, to address the areas of concern. The concerns may range from poor recording such as that of service users' care plans, or care plans not being updated through to insufficient evidence of training of care staff, or high levels of staff turnover resulting in inconsistent and poor care management and practice. Where concerns have been raised through the audit process, the QDO will provide advice and support on how the service could be improved. The QDO will also undertake a follow up visit to ensure that the actions have been implemented.

16. As indicated in paragraph 11 above, the implementation of the Fair Price for Care framework has been phased over the past five years. The final year of implementation was initially intended to be 2011/12, however the final year's fee increase was not applied in full but spread across two financial years with 50% allocated in 2011/12 and the remaining 50% being allocated in 2012/13.

17. The application of annual inflationary increases to fees has been considered separately through the Council's normal annual budget setting processes. For

the last two financial years, 2011/12 and 2012/13, inflation for externally provided services has been 0%.

18. Fees for 2012/13, under the current Fair Price for Care framework are outlined in Table 1, below:

Table 1: Current Fee Levels

2012/13 Fee Levels					
	Band 1	**Band 2**	**Band 3**	**Band 4**	**Band 5**
Older People	£303/£348	£391	£417	£443	£469
OP Dementia	£359	£438	£464	£489	£515
Nursing	£376	£439	£465	£491	£516
Nursing Dementia	£386	£480	£506	£532	£558

19. At the start of the 2012/13 financial year, the total number of long term placements funded by the Council in older persons' care homes in Nottinghamshire was 2,284. In addition, the Council funds approximately 180 short term and respite care placements at any one time. Within the local fair price for care framework, and based on the total number of placements in independent sector older persons care homes in mid-April 2012, the total estimated cost for 2012/13 for this provision is £57.8 million of which £53.2m is for long term placements and a further £4.6m for short term placements.

Provision within the local market

20. The numbers of older persons' care homes and total numbers of care home places within Nottinghamshire have increased in recent years. There have been a number of care homes that have closed whilst at the same time new homes have opened.

Table 2: Total number of older persons' care homes, home closures and new homes opened

	2007/08	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Number of homes	166	166	165	163	170	169
Homes closed	0	3	2	2	3	2*
New homes Opened	0	2	1	0	4	2*
Council homes transferred to the Independent Sector	0	0	0	0	6	0

* As at 01/01/13

21. As outlined in paragraph 4 there are currently 169 older persons' independent sector care homes a further 6 Council owned care homes in Nottinghamshire. Overall, whilst the number of homes in Nottinghamshire in recent years has generally been level, the number of available beds in older persons' care homes has increased from 6,723 in 2007/08 to 7,033 in 2012/13 as outlined in Table 3 below.

Table 3: Total bed numbers and changes in bed numbers

	2007/8	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Independent Sector Beds	6076	6076	6167	6182	6162	6645
Changes in Year						
Beds Lost (Upgrades)	0	0	0	0	2	0*
Beds Lost (homes closed)	0	89	43	45	91	96*
Beds Gained (Upgrades)	0	19	18	25	43	126*
Beds Gained (New Homes)	0	161	40	0	202	118*
Beds Transferred (from the Council)	0	0	0	0	331	0
Independent Sector Beds	**6076**	**6167**	**6182**	**6162**	**6645**	**6793**
Council Beds	**647**	**647**	**593**	**571**	**240**	**240**
Total Beds	**6723**	**6814**	**6775**	**6733**	**6885**	**7033***

* As at 01/01/13

22. The decrease in the number of council owned beds in 2011/12 reflects the changes in ownership following the transfer of 6 homes from the Council to an independent sector provider who entered the Nottinghamshire market for the first time.

23. Table 3 also shows that as well as new providers entering the local market, existing providers are investing in upgrading or extending their care home provision. Over the past four years, a total of 52 homes have upgraded their premises and a further 14 homes have built extensions to their properties leading to improved environmental standards. Providers have commented that the improvements have been made to the fabric of their buildings as a direct result of the local Fair Price for Care initiative. The increase in the number of beds as a result of investments in new homes and of existing homes upgrading their provision is evidence that the sector is financially viable.

24. Table 4 below shows distribution of the older persons' care homes across the 5 quality bandings over the period of the fair price for care initiative. Band 5 is the highest quality band.

Table 4: Distribution of homes per band

	2008/09	2009/10	2010/11	2011/12	2012/13
Band 1	39	31	25	27	33*
Band 2	47	39	38	38	27*
Band 3	57	43	43	42	47*
Band 4	21	38	29	29	28*
Band 5	2	14	27	33	34*
Total Homes	166	165	162	169	169

* correct as of 01/01/13

Legal context

25. Over the past two and a half years, there have been a number of cases brought before the Courts by care home providers who have sought to challenge local authorities through Judicial Review both on the level of fees allocated and the way in which they have determined their fee levels.

26. In its decisions the Courts stressed the need for local authorities when setting fee levels to consider the actual cost to its private sector providers of providing care. Councils also need to ensure that its fee levels will allow for sufficient and sustainable capacity and choice of provision within the local market.

The Council's strategic commissioning intentions for health and social care services

27. The Council has set out its key strategic objectives in its 'One Council Strategic Plan, 2010 - 2014', and in accordance with Central gGovernment policy on personalisation, one of the Council's key objectives is to promote independence by enabling service users and carers to have more choice and control over the services they access including the ways in which the services are delivered.

28. One of the key priorities for the department is to help and support people to live independently in their own homes for as long as possible. In discussions with care home providers at Provider Forums, the Council has informed them of its intentions to support people to remain living independently in their own homes for as long as possible. To this end, the Council continues to develop and invest in care and support services which enable people to live safely within

their own home, and to prevent or to delay the need for residential or nursing care. As such, the Council has sought to increase people's independence, which may have the result of reducing the numbers of long term placements in care homes.

The review of the local Fair Price for Care framework and the fee levels

29. Given that the fee increases associated with the current local Fair Price for Care framework come to an end in 2012/13, and in light of the various Court rulings, the Council has completed a review of its fee levels and fee structure with a view to informing future fee proposals and the financial implications arising from these. In order to ensure that due processes were followed in determining fee levels beyond 2012/13, Browne Jacobson Solicitors have been engaged to advise the Council.

30. The Council also engaged KPMG to help complete the project to ascertain actual costs of older persons care home provision in Nottinghamshire.

31. In seeking to determine future fee levels and the fee model, the Council has taken in to account its strategic objectives and the legal and policy context, as follows:

    a meeting the legal requirement to take in to account the actual costs of care
    b setting a fee which allows a sustainable market
    c rewarding good quality, striking an appropriate balance which prioritises care quality issues over the environment but which recognises the importance of both
    d challenging inefficiencies at the same time as providing incentives for improvement in quality
    e enabling a more personalised approach to the delivery of care and ensuring that outcomes are achieved for residents through appropriately trained care staff
    f promoting good standards in the delivery of care and giving particular focus to dementia care and end of life care
    g creating a framework which can be applied over a period of years to ensure continuity in the market and clearer financial planning for the Council
    h ensuring the new/revised framework is simple to apply and to adjust over a given period of time and prior to any further review of the model in future years
    i ensuring that the Council considers and takes into account its financial resources when setting care home fees
    j ensuring the Council adheres to its duties under the Equalities Act.

32. The review of the framework and fee levels has included a comprehensive two stage consultation process with the care home providers, undertaken over a six month period from May to October 2012. Throughout this process, the Council has sought to work with the NCA and its executive members have broadly

supported the project scope and have provided feedback on the process which has helped to ensure that it is robust and comprehensive.

Consideration of Inflation

33. In determining future fee levels, consideration has also been given to future inflation related fee increases. Currently, in its contracts with external providers for social care services, the Council does not include a clause which ties it to a specific inflation formula. Instead, the Council has maintained that inflation related increases will be considered by Members as part of their annual budget setting processes.

34. In their discussions with the Council over the past 4-5 years, the NCA executive have requested that an inflation formula which takes in to account key elements of their costs, be agreed and included in their contracts. This has not been agreed by the Council to date.

35. The advantages of establishing and applying an inflation formula are:

- it provides a transparent way for updating the fee model annually
- it prevents the need for the Council to review the fees on an annual basis
- it minimises the risk of challenges, or threats of challenge, being brought on an annual basis
- it reduces the need for periodic and costly reviews to determine actual costs in order to inform future fee levels.

36. The disadvantages of applying an annual inflation formula are:

- it commits the Council to an increase which may prove to exceed the true inflation in actual cost experienced by providers.

Stage 1 – Provider Survey

37. Stage 1 of the consultation process entailed sending out a questionnaire to all of the older persons' care homes seeking information to establish their actual costs. Providers were given a four week period, between 8th May and 6th June 2012, to complete and return the questionnaire and support was made available during that time from KPMG and from officers within the Council to providers who had any queries or were experiencing difficulties in completing the form. This report refers to this as the 'provider survey'.

38. As well as considering the options for future fee levels, the survey has also sought feedback from providers about the current framework and the 5 bandings. This has entailed consideration of the following:

- whether fees should continue to be allocated on the basis of rewarding good quality

- whether the annual audit process needs to be changed to focus more time and resource on the lower band homes (Bands 1 and 2) in order to help improve quality of care

- whether environmental factors should continue to be taken in to account in the allocation of fees

- whether the Council, over an identified period of time, ceases to fund placements in Band 1 homes and if so, what the implications would be both in terms of future capacity and on finances

- whilst the current model includes an enhanced payment level for dementia provision, overall the quality of dementia provision has not improved as had been hoped. Consideration is being given to whether the Council should only allocate the enhanced dementia payment to those homes where the quality exceeds an agreed threshold.

39. The proposals align with the strategic objectives of continuing to develop and promote good quality care services and to focus particularly on improving the quality of dementia care. In particular, proposals have been made to award a higher level of payment for dementia services to those homes which are able to demonstrate high quality dementia care. The criteria for dementia placements is also being revised to focus on those people who have higher care and support needs as a result of their dementia. This initiative has yet to be devised and the Council is seeking to work with care home providers in its development. Implementation of the initiative would need to be phased over a period of time in order to prevent the destabilisation of current provision. It is anticipated that the transition period would take place over the next three years.

40. The Council also proposes that a limited number of care homes are awarded 'beacon status'. These homes would have a specific remit to promote best practice within their locality, including sharing their expertise and knowledge through a process of mentoring and providing support to those providers who historically who have not provided good quality care. It is proposed that a number of specific projects are considered and implemented to support lower banded homes to improve the quality of care. The Council will work with providers to develop this initiative.

41. A total of 70 completed questionnaires were returned, representing just over 41% of all of the older persons care homes in Nottinghamshire. There was a cross section of responses covering the different registration categories (residential and nursing) as well as a good geographical spread. The number of completed returns from Band 2 homes was lower than that of the other bands.

42. Once the questionnaires were returned, any queries were raised by officers with the relevant providers for clarification to ensure the data was robust, the information was aggregated and analysed and this has enabled the Council to determine the current costs to the market of providing residential care and nursing care.

43. Information from the survey on all of their costs including staff costs and non-staff costs across the different care types and quality bandings, and also their expectations on return on operations and return on capital, has been used to create an average cost of operating a care home in Nottinghamshire, as well as exploring costs associated with the provision of high quality dementia care. These costs have been segmented according to type of care home provision and the Council has relied on them when devising its fee proposals.

Comparison with other recent local cost models

44. It is important to note that in their rulings, the courts considered that while national factors may give an indication of costs, local factors should prevail when councils are setting their fee levels.

45. Accordingly the Council has ascertained the actual costs of local providers through the provider survey. The costs from the provider survey have been compared to the costs identified in other similar surveys. These comparator surveys are:

- a survey commissioned by a number of care associations in the East Midlands and the NHS East Midlands Resource Hub and undertaken by Laing and Buisson in 2010/11

- a survey commissioned by the Nottinghamshire Care Association and undertaken by Laing and Buisson in 2010/11

- a survey undertaken nationally by Laing and Buisson in 2008.

46. Given that the surveys were undertaken at different times, there are some likely to be some differences in the cost bases and there is some variation between the various cost elements. However, the overall costs and identified fee levels are broadly similar to each other (see **Appendix A**).

47. In addition to the above, consideration has also been given to the most recent survey undertaken by Laing and Buisson in 2012 and also to known fee levels across other neighbouring councils. Currently, Nottinghamshire's minimum fee levels are amongst the lowest within the comparable councils, whereas its higher band fee levels are the highest of the other councils.

Consideration of models for calculating inflation

48. Given the legal context and in order to reduce the need for periodic and costly reviews to determine actual costs to inform future fee levels, consideration has been given to incorporating an inflation formula which takes in to account key elements of costs, in to the future fee model. An inflation formula will provide a transparent way for updating the fee model annually.

49. Possible models for inflation range from applying a nominal flat rate percentage each year to complex models which recalculate individual elements of the costs

of homes each year to reflect specific impacts of inflation. In determining a model relevant considerations include the following factors:

- ease of understanding
- ease of calculation
- ease of application
- independence
- relevance to cost increases.

50. A number of proposals for increasing fees to reflect inflation have been developed and these are explained below. It should be noted that past changes in figures are not necessarily a guide as to how figures may change in the future.

a Flat rate increase of 2.5% per annum

b Retail Price Index (RPI) excluding mortgage payments in October of each year

c Consumer Price Index (CPI) in October of each year

d Index based on Average Weekly Earnings (AWE) in the Health and Social Care Sector for staffing costs (EARN03) and CPI for non-staffing running costs in October of each year. Finance costs are not inflated. In this model it is assumed that costs are made up as follows:-

Staffing	69%
Non-staffing running costs	26%
Finance costs	5%

(Figures based on data from the provider survey)

e Index based on Average Weekly Earnings in the Health and Social Care Sector for staffing costs and a range of indices for elements of non-staffing running costs. Finance costs are not inflated. In this model it is assumed that non-staffing running costs are made up as below. Index used for inflation is also shown. All indices are produced by the Office for National Statistics (ONS). Figures used are for the second quarter of each financial year.

		ONS Index
Repairs and maintenance	23%	04.3
Food	20%	01.1
Utilities	17%	04.5
Other running costs	40%	CPI

(Figures for split of non-staffing running costs based on data from the provider survey).

51. The model of a flat rate of 2.5%, (a) above, does not take in to account any established inflation indices and does not necessarily bear any relation to the general inflation levels in the economy or the specific factors relevant to the social care sector. The RPI and CPI (b) and (c) above, relate to general inflation but do not take in to account the specific cost pressures that make up the key elements of costs within the social care sector. Index based on Average Weekly Earnings (AWE) in the Health and Social Care Sector for staffing costs (EARN03) and CPI for non-staffing running costs, (d) above, takes into account staffing costs related to the sector but then non staffing costs are based on CPI. The AWE/Detailed indices, (e) above, takes in to account those factors that have a significant impact on all of the costs facing the social care market and as such, it is the most relevant to this provision and therefore is the preferred model for determining the level of inflation to be applied on an annual basis.

Outline of the fee proposals

52. The proposals for future Fair Price for Care framework and the future fee levels have been informed by the Council's commissioning intentions, as outlined in sections 27 and 28 above, and by the information gathered from the provider survey. Subsequently, consideration has also been given to more recent national survey undertaken by Laing and Buisson during 2012 (see paragraphs 94 – 96 below).

53. The future fee proposals are based on the current framework being maintained, with the differentials between the bands remaining the same. This would mean that the same cash uplift in fees is applied to each band.

54. The average quality banding of the 70 respondents to the survey was 3.2. The data from the survey shows that the actual costs identified by the homes do not correlate with the banding of the home. Various other factors, such as the size of the home, do however impact on actual costs. The consultation showed that providers are supportive of the banding structure as a means of improving quality through the allocation of higher fees as care homes move in to the higher bands. The fee proposals therefore are based on the continuation of the five bandings. The average cost of operating a care home in Nottinghamshire has therefore been re-calculated from the survey data, and then inserted at the mid-point of the banding. This reflects the fact that the cost data is an average and representative of all bands, and it represents an easily understood translation of the survey data into the fee level structure.

Assumptions on return on operation and capital

55. In their survey responses and in their feedback to the consultation process, providers expressed differing expectations on the level of return on their investment. Account has been taken of the national survey data and on the current economic climate, and on this basis, the proposal for future fee levels is based on an assumed return on operation of 18%. Whilst a number of providers responding to the consultation expected higher levels of return, other

providers acknowledged that an assumed return on operations of 18% was reasonable given the current economic climate.

56. The fee proposals are also based on a return on capital of 7%. The return on capital is a measure of the expected annual return (profit) generated by a provider when making a significant capital investment into the purchase, construction or refurbishment of a care home. The information from the provider survey was that a 7% return, on average, was expected. This matches other data sources such as the Laing and Buisson research which also applies a 7% return on capital.

Assumptions on occupancy levels

57. The data from the provider survey identified average occupancy levels of 83% in Nottinghamshire. When developing the initial Fair Price for Care framework, an average occupancy level of 90% was built in to the model as this was identified as the 'industry norm' from market analysis such as that undertaken by Laing and Buisson in 2008 and subsequently in their 2012 survey. Current fees assume 90% occupancy.

58. In the Stage 2 consultation process, the Council has proposed basing its fees for 2013/14 and beyond on average assumption levels of 92%. It is not considered reasonable to expect the Council to fund providers' overhead costs for empty beds at occupancy levels of 83% as identified by providers in their survey responses. This would mean that the Council would be funding costs which arise from inefficiencies in the market. Nonetheless, the Council recognises that providers will not be able to operate at average occupancy levels of 100% because of the following:

- turnover of residents – it is reasonable to expect that providers will not be able to fill vacancies as soon as they become available

- the Council's policy is to ensure that people do not have to share a room unless it is their expressed wish

Adjustments to staffing levels

59. The main element of cost for all care home provision is staffing costs. As a proportion of total operating costs, responses to the provider survey indicated that staffing accounts for 69% of costs across all care homes.

60. The provider survey reported a significantly higher average number of hours of staff time per resident in Nottinghamshire compared to the figures for 'industry norms' as reported by Laing and Buisson based on their 2008 analysis of care home providers nationally. For care homes (residential) the staffing levels reported in the provider survey were on average 15% above the Laing and Buisson industry norm, and the staffing levels for care homes with nursing were reported in the provider survey to be an average 14% higher than the industry norm.

61. The fee levels proposed in the Stage 2 consultation document were based on staffing levels which are above the Laing and Buisson industry norms data but below the staffing levels identified by providers in the survey. As such the fee proposals consulted on were based on staffing levels at a point between the two sets of data, enabling providers to have staffing costs in care homes which are 7.5% higher than the national average, rather than 15% higher as reported by providers in the survey, and for care homes with nursing, 4% higher than the national average, rather than 14% higher as reported in the survey response.

62. The staffing levels for care homes with nursing, in the fee proposals consulted on, were adjusted to a lower level than that identified from the survey because they took into account the staffing costs arising from health funded Continuing Health Care placements which at times will include the need for one to one staffing. Fees for Continuing Health Care placements are negotiated by health commissioners directly with the providers as part of their Any Qualified Provider accreditation process and this is agreed outside of the Council's fee structure.

Stage 2 – Consultation Report and Feedback from Providers

63. Stage 2 of the consultation process entailed sending out a report to all of the older persons' care home providers across Nottinghamshire as with the Stage 1 provider survey, to inform them of the findings of the Stage 1 process, and outlining the set of proposals on the future fee levels and fee structure based on the assumptions and adjustments identified in paragraphs 59 – 62 above. (See **Appendix B**).

64. Providers were asked to respond to 12 questions relating to the findings from the survey, the proposals on future fee levels and about the impact the proposed fees would have on their business. As well as inviting their comments in writing, two provider meetings were also held in early September, one in the north and one in the south of the county, giving providers the opportunity to raise questions about the fee proposals and to provide feedback on these.

65. The consultation was open for a six week period from 6th August to 17th September 2012. During this period, two consultation events were held, in order to give maximum opportunity for providers to respond to the proposals.

66. A total of 23 care home providers submitted a written response to the consultation document, representing 49 of care homes and a total of 33 providers attended the consultation events, representing 45 of older persons care homes. A written response was also received from the NCA who were also represented at both the consultation events. **Appendix C** outlines the full details of all the responses received and of the Council's comments relating to each of these.

67. Overall, the feedback from the consultation was that providers support the current Fair Price for Care model and framework and the proposal to continue with this in order to continue to reward good quality services. Providers also

welcomed the proposal to identify and apply an inflation formula for implementation on an annual basis.

68. In terms of the proposed fee levels, two main issues were identified from both the written responses and the verbal feedback received at the events. These related to:

- the assumptions about occupancy levels
- the adjustments relating to staffing levels.

Occupancy Levels

69. The majority of providers who responded to the Stage 2 consultation exercise stated that they are not able to achieve average levels of occupancy at 92%. The reasons they give are as follows:

- the Council's commissioning strategy of helping people to live independently in their own homes for as long as possible means that fewer people are being placed in care homes

- there has been an increase in the level of need of residents, with service users being admitted later than previously. This also shortens the average length of stay, increasing the turnover of residents which reduces providers' ability to sustain high occupancy levels

- the Council does not support placements in shared rooms unless explicitly requested by the residents. Therefore those homes that have shared rooms are usually not able to fill the second bed in a shared room.

70. Currently there is over-provision of older persons care home placements in Nottinghamshire and, in accordance with its commissioning intentions the Council is seeking to place fewer people in care homes. Accordingly, if there were to be a contraction in the market in line with the reduction in council funded placements, through the closure of less efficient homes with lower occupancy levels, that would not be a contravention of the council's duty to support a sustainable private sector market.

Staffing Levels

71. The majority of providers who responded to the Stage 2 consultation stated that their staffing levels are higher than those reported in the Laing and Buisson 2008 survey. The reasons they give are:

- service users have higher levels of dependency because of the Council's policy to support people in their own homes for as long as possible which means that when they are placed in care homes they have more complex social and health care needs, including managing challenging behaviour arising from dementia, or to provide end of life care, all of which require higher staffing levels

- the Laing & Buisson industry norms are not representative of the care home market as they reflect the costs of running a corporate, efficiently run 50 bed care home and this does not reflect the configuration of the average home in Nottinghamshire

- they would not be able to provide a good quality care which promotes and maintains service users' dignity if their staffing levels were at those identified in the Laing and Buisson industry norms data.

72. Following analysis of the feedback from the Stage 2 consultation process providers, further information and evidence was sought from providers. This was to enable account to be taken of the potential impact on providers of the Council's fee proposals specifically in relation to the assumed average occupancy and on staffing levels.

73. A total of 13 providers, representing 38 homes, responded to this further clarification process (see **Appendix D**). The providers re-iterated the same concerns that they had indicated in their initial written response or at the two consultation events and referred to their own staffing levels, as identified in the provider survey. The main points raised are:

Average occupancy levels:

- some providers commented that it is 'unfair' for the Council to set its fee levels on an assumed occupancy of 92% when the provider survey showed that in reality the average levels of occupancy are 83%

- some providers acknowledged that it would not be reasonable for the Council to fund inefficiencies that arise from high levels of voids but then stated that their occupancy levels were lower than they had been historically because the Council was not placing people in care homes

- these providers also commented that in placing people in care homes at a later stage, the average duration of a placement is shorter thereby resulting in a higher turnover of residents resulting in more frequent voids

- two providers commented that a significant number of the beds in their homes are used for 'respite' or 'interim' care resulting in a high level of turnover of residents and thereby an increased likelihood of vacancies

Adjustments to staffing levels:

- The majority of the respondents stated that their staffing levels are higher than the industry norm and that this reflects the increased dependency and higher levels of need of people who are now placed in care homes, and in particular they referred to the needs of people with dementia. Some of the providers referred to the report recently

published by Bupa, Bridging the Gap, 2012 which reports that nationally there has been a need to increase staffing levels in care homes due to greater dependency and higher level of need of residents

- providers stated that there would be a negative impact on the quality of care if they were required to reduce their staffing levels to the levels on which the fee proposals are based

- a number of the providers commented that they want to reward and invest in their staff so that they can maintain a stable and reliable workforce.

74. Providers reiterated that both the average occupancy levels and the assumed staffing levels should reflect the levels that were identified from the provider survey as they reflect the actual costs. It could also be reasonably assumed that the providers' costs will take account of an average occupancy level.

Consideration of Providers' Feedback on average Occupancy Levels of 92%

75. The Provider Survey revealed an average occupancy rate of 83%. The responses received throughout the consultation gave 3 systemic factors which reduce occupancy levels:

- Double rooms – out of the 169 number of independent sector older persons care homes, 109 homes have one or more double rooms. Of these, 53 homes have only one double room. Out of a total of 6,793 of rooms, there are 261 double rooms across the 169 care homes. If only one placement is made in each of these double rooms, the maximum level of occupancy achievable by the providers overall would be 96.3%.

- Time gap between successive occupancies - The Council has for many years implemented a policy of continuing to pay providers for two days following the death of the service user. This is in order to give family members sufficient time to collect the service user's belongings and ensures that respect and dignity is maintained both for the deceased service user and for their family. In making this payment, the Council is contributing to the costs of turnover of residents.

- High turnover rates due to placements being made at much later stages and subsequently for a shorter duration, and higher levels of short term or high levels of respite or interim care. The Council's data does not support this observation as it is evident from recent benchmarking data that the Council is continuing to place a higher number of people in care homes than that of comparator Councils and that the average length of stay in a care home is longer than that of comparator Councils.

76. The only other factor referred to by providers was a lack of demand, and particularly a lack of demand for local authority funded placements. That is not a systemic issue. It is also not something for which the council has any responsibility. The Council is not under any obligation to maintain its

placements at any particular level. Its obligation is to pay a fee for those placements which takes the provider's actual costs into account, and which supports a viable and sustainable market to meet the demand which exists at that time.

77. Over a number of years, the Council has given providers a clear indication of its commissioning intentions to reduce the number of people placed in care homes, with a view to supporting people to remain in their own homes for as long as possible. The Council continues to implement this strategy and therefore anticipates that there will be a reduction in the use of care home placements in the future. Currently there is an over provision of care home beds in Nottinghamshire. Also, the response from providers that occupancy levels are depressed by a decrease in demand for council funded placements shows there is overcapacity in the market.

78. Taking the three systemic factors into account, if there were sufficient demand, then care homes in Nottinghamshire should be able to operate at 92% occupancy or above. This is the figure the Council has used to calculate the future fee proposals.

79. The Council has taken into account the impact on residents where a home may need to close due to low occupancy. The Council has plans and processes in place to ensure that any home closure is managed sensitively, with support provided by social care staff, and with health care staff, to ensure suitable alternative placements are found within the local area and that residents are assisted to move with due consideration given to their specific health and social care needs.

Consideration of Providers' Feedback on Staffing Levels

80. The fee levels proposed in the Stage 2 consultation document were based on staffing levels which are above the 'industry norms' data from the Laing and Buisson 2008 survey but below the staffing levels identified in the provider survey. The proposed fees as set out in the consultation document would enable providers to have staffing costs in care homes which are 7.5% higher than the Laing and Buisson data, rather than 15% higher as reported by providers in the survey, and for care homes with nursing, 4% higher than the Laing and Buisson data, rather than 14% higher as reported in the provider survey.

81. The staffing adjustments for care homes with nursing, in the proposed fees, are greater to reflect staffing costs arising from health funded Continuing Health Care placements which at times will include the need for one to one staffing. Fees for Continuing Health Care placements are negotiated by health commissioners directly with the providers as part of their Any Qualified Provider accreditation process and this is agreed outside of the Council's fee structure.

82. As indicated above, the Council's policy is to support service users to maintain their independence and to remain in their own homes for as long as possible. This will mean that the Council delays the point at which a service user is

placed in a care home and the service user may well have higher levels of need as a result. However it is important to note that this policy is no different to that implemented by other local authorities as all will be striving to reduce the numbers of people placed in care homes.

83. There is no evidence to suggest that in Nottinghamshire, service users are placed in care homes at a much later stage than elsewhere. In fact, benchmarking data shows that the Council continues to place a higher number of people in care homes than other comparator local authorities and the length of stay is also longer in Nottinghamshire than in other comparator local authorities.

84. Some providers also commented that the Laing and Buisson industry norms are not representative of the care home market as they reflect the costs of running a corporate, efficiently run 50 bed care home and this does not reflect the configuration of the average home in Nottinghamshire.

85. It would be reasonable to expect care home providers in Nottinghamshire to run care homes as efficiently as possible and for their staffing levels to reflect this. However, consideration also needs to be given to the provision within the local market. Whilst the Laing and Buisson industry norm data is based on an efficiently run 50 bedded care home, the average sized home identified in the provider survey is a 39.7 bedded unit.

86. The Care Quality Commission (CQC) confirms that it does not use a methodology or tool to determine staffing levels and there are no specific staffing levels or ratios of staff to residents identified in the CQC's 'essential standards'. As part of the registration and inspection processes, the CQC places the emphasis on the provider to ensure they have a process for determining appropriate staffing levels based on the needs of the service users. Also, staffing levels in any one home will vary from time to time, depending on the numbers of residents and their levels of need. In recognition of the fluctuations in need of residents, the Regulator and the 'essential standards' that they use have moved away from a prescriptive and set formula of staff to resident ratios.

87. Feedback from providers to the consultation process shows that staffing levels in care homes in Nottinghamshire vary from provider to provider. However, on the whole, the majority of the providers indicated that they operate at higher staffing levels. During the consultation period many providers suggested that the Laing and Buisson industry norms data was outdated as staffing levels in the industry had increased considerably to reflect higher levels dependency of service users, including increasing numbers of people with dementia, in care homes.

Laing and Buisson 2012

88. Since undertaking the provider survey in May 2012 and consulting with providers on proposed fee levels for 2013/14 and beyond, Laing and Buisson

have issued an updated report and a revised toolkit for determining the cost of care home provision. The toolkit and report were published in October 2012.

89. The toolkit is based on cost benchmarks drawn from a survey of major care home groups, carried out during 2012. Findings from the survey show a significant increase in staffing levels in care homes which "reflect the rising dependency profile of care home residents, as evidenced by successive patient censuses carried out in Bupa care homes, covering about 16,000 residents on each occasion". Source: 'Laing and Buisson, Fair price for Care – A toolkit for care homes for older people and people with dementia', 2012.

90. Table 5 below shows the data on average staffing levels derived from the Laing and Buisson reports of 2008 and 2012 and from the provider survey undertaken in Nottinghamshire in May 2012. The table also shows the assumed staffing levels that were applied to the fee proposals on which the Stage 2 consultation was based.

Table 5: Comparative data on staffing levels

	Staffing hours per resident per week care homes (residential)	Staffing hours per resident per week care homes with nursing
Laing and Buisson 2008	24.5	34.0
Provider Survey 2012	28.7	39.6
Consultation Proposal	26.5	35.6
Laing and Buisson 2012	28.1	37.4

91. The Laing and Buisson 2012 report is based on the findings of the most recent and extensive survey of actual costs for older persons care home provision across the country and provides a reliable indicator of staffing levels. Both this national survey and the local provider survey show that staffing levels have increased in order to meet higher dependency and increasing levels of need of service users within care homes. In setting its fee levels, the Council has given due consideration to the increased costs to providers arising from higher dependency levels.

Fee Proposals for 2013/14 and beyond

92. Consideration has been given to the feedback from providers through the consultation process and to the latest national benchmarking data from Laing and Buisson in relation to the actual cost of care. Accordingly, the fee proposals are based on staffing levels identified in the Laing and Buisson 2012 national survey data. It is proposed that this new fee level is implemented for a five year period with inflation applied on an annual basis as of April 2014 in accordance with the formula identified in section 50 (e) above.

93. Table 6 shows fee levels based on the revised Laing and Buisson 2012 survey, and with an assumed occupancy level of 92%, compared to current fee levels.

Table 6: Proposed fee levels for 2013/14 compared to current fee levels

Proposed fees compared to current fees	Band 1	Band 2	Band 3	Band 4	Band 5
Older People					
Current	£348	£391	£417	£443	£469
Proposed	**£399**	**£442**	**£468**	**£494**	**£520**
OP Dementia					
Current:	£359	£438	£464	£489	£515
Proposed	**£410**	**£489**	**£515**	**£540**	**£566**
Nursing					
Current	£376	£439	£465	£491	£516
Proposed	**£433**	**£496**	**£522**	**£548**	**£573**
Nursing Dementia					
Current	£386	£480	£506	£532	£558
Proposed	**£443**	**£537**	**£563**	**£589**	**£615**

94. The total estimated additional cost of this proposal is £6.8 million with an increase in the overall cost and average fee paid of 11.8%. The above fee levels would be implemented as the baseline fees for 2013/14. An increase based on the proposed inflationary index would be added to the above base line fees on an annual basis commencing in April 2014.

95. The proposed fees outlined in Table 6 above are based on the comprehensive consultation exercise undertaken with providers during 2012/13. Feedback received from providers during the consultation process has been taken in to account and assumptions about staffing levels have been adjusted in light of the feedback and in consideration of the most recent survey of the sector undertaken by Laing and Buisson. The proposals are also based on average occupancy of 92% to reflect the need for providers to deliver efficient services.

96. As indicated in the table above, the Council is proposing to retain its bandings in order to continue to reward good quality care provision. It is proposed that the fee differentials between the bands should remain the same so that all the homes will get the same amount of increase in monetary terms. The Council is keen to reward good quality care provision but at the same time is seeking to provide an incentive for homes in the lower bands to improve and to move up to higher bands. The Council will seek to work with providers with the aspiration of phasing out Band 1 homes over a period of time. In accordance with the terms of its contract with care homes, the Council is able to terminate a contract on the grounds of poor quality provision where this places service users at significant risk of harm to their health and well-being. Where care homes have their contracts suspended on two or more occasions over a two year period, the Council will seriously consider terminating the contract with the provider.

97. In comparison to fee levels in other councils in the region, Nottinghamshire will continue to pay the highest fees in the region for those homes that are in bands

4 and 5. However, the fees will remain lower in Nottinghamshire for homes in Bands 1 and 2 compared to other councils in the region (see **Appendix E**). This reflects the wide range of fees paid by the Council through its five bandings. It is important to note that the fees set by other councils are likely to change as they will also be reviewing their fee levels in light of recent court rulings.

98. The revised proposed fee structure continues to support higher fees for the provision of high quality dementia care. However, currently, there are a number of care homes that, whilst providing services for people with dementia, are not able to demonstrate high quality dementia care. It is therefore proposed that a higher level of payment is made where providers are able to demonstrate and evidence high quality dementia care, including high level staff training. It is proposed that this will be implemented over a number of months with all new dementia care placements attracting the higher level payment where the providers have shown evidence of high quality dementia care. Those providers who are not able to demonstrate high quality dementia care will not be allocated the higher level of payment for new residents.

99. It is also proposed that the Council will continue to promote high quality care services by introducing a 'Beacon Status' award to a small number of providers who are delivering excellent care services. Providers awarded Beacon Status would be required to work with providers who in Bands 1 and 2 by providing mentoring, shared knowledge, information and access to training were relevant. The Council would want to work with providers in developing the 'Beacon Status' framework. Consideration will also need to be given to how the providers that are awarded the status may be rewarded for the work they undertake.

100. As part of the consultation process, providers were asked if there should be any grounds for changing the annual audit process in relation to the 70:30 weighting between quality indicators and environmental factors. Some providers suggested that the weighting should be changed with less emphasis being placed on environmental factors and more of a weighting on quality indicators. Other providers however, expressed a view that the current weightings are not changed. The Council has given due consideration to the feedback and it is proposed that the weightings are not changed.

Other Options Considered

101. With regards to the funding of care home provision, the Council has given due consideration to the actual costs of care and also of its responsibilities in ensuring there is a sustainable market of care provision to meet current and future demand. The fees proposed for implementation from April 2013 take in these into account whilst also reflecting wider and competing Council priorities.

102. As well as setting and implementing revised fees, the Council will continue to work with care home providers to focus on improving the quality of care services. This will include reviewing its internal processes, including its auditing

and monitoring activities to ensure that the quality of care services continues to improve.

Statutory and Policy Implications

103. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they have been described in the text of the report.

Implications for Service Users

104. The Council is proposing an increase in fees of £51 per person per week for people in care homes and £57 for people in care homes with nursing. In doing so, it is anticipated that care providers will be able to best meet the needs of people that live in care homes. The Council is also proposing to maintain its fee framework, thereby providing financial incentives to providers to continuously improve the services that they provide for service users.

105. The Council has completed an Equality Impact Assessment in order to consider whether the implementation of future fee levels and fee structure is likely to have any adverse impact on specific groups of people within Nottinghamshire and in doing so has considered the actions it will put in place to mitigate against these. As detailed in paragraph 104 above, the proposals are for an increase in payments to care home providers which should make care homes more viable and to enable the quality of care to be improved. Additionally, the proposals include applying annual index linked inflation to the fees reflect increasing costs and therefore financial viability of care homes.

Financial Implications

106. The Council currently spends an estimated £57.8 million per annum on both long-term and short-term care within its local fair price for care framework. The additional annual cost of the revised fee proposals set out in paragraph 89 is estimated at £6.8 million. The total annual cost from 2013/14 is therefore estimated at £64.6 million.

107. The County Council, like all local authorities, continues to face an extremely challenging financial future. The Council has to give due consideration to its key priorities in accordance with its Strategic Plan. The Council has a duty to effectively manage its finite resources whilst at the same time balancing its key strategic objectives which include the following:

- safeguarding children and vulnerable adults
- meeting increasing demand for children's social care
- meeting increased demand for essential adult social care services arising from demographic pressures, and within this helping people to live independently in their own homes for as long as possible

- promoting and enhancing economic growth and development including investing in roads, transport and infrastructure
- supporting the health and wellbeing of its citizens including through the provision of leisure and cultural services.

108. The Council's forecast financial position and initial budget proposals for the period 2013/14 to 2016/17 were set out in a report to Finance and Property Committee on 12th November 2012. The report detailed the financial pressures faced by the Council and identified a need to find further savings estimated at £106 million over the period 2013/14 to 2016/17. Since this report was considered the Government has announced the provisional financial settlement figures for local authorities for 2013/14 and also, in the Chancellors Autumn Statement, that local authorities will face additional budget reductions in 2014/15. A report updating the Council's financial position and setting out final budgets proposals and Medium Term Financial Strategy (MTFS) for the period 2013/14 to 2016/17 is to be presented to Policy Committee on 13th February 2013.

109. Additionally, the Government has stated its intention to undertake a spending review next year to determine spending allocations for 2015/16 and future years. The County Council will need to revisit its budget plans and MTFS following the publication of the results of this spending review. Given previous announcements from the Government regarding the difficulties being experienced in reducing the national budget deficit it is assumed that the County Council will be faced with an increasingly challenging financial position over the next few years.

110. The nature and scale of the financial challenges facing the Council are therefore clear. The proposals set out in this report to increase fees for residential and nursing care under the Council's fair price for care framework, and the consequent additional estimated cost of £6.8 million, need to be considered and balanced against the wider financial pressures faced by the Council.

RECOMMENDATION/S

It is recommended that the Adult Social Care and Health Committee:

1) note the findings of the local Fair Price for Care consultation process and the fee proposals arising from this

2) note the proposals to further support improvements in the quality of care provision through the development of initiatives for allocation of a higher level of payment for high quality dementia services and through the introduction and implementation of a 'Beacon Status' award

3) recommend the proposed changes to Policy Committee for approval.

CAROLINE BARIA
Service Director, Joint Commissioning, Quality and Business Change

For any queries regarding this report please contact:
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Service Director, Joint Commissioning, Quality and Business Change
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Constitutional Comments (KK 25/01/2013)

111. The proposals in this report are within the remit of the Adult Social Care and Health Committee.

Financial Comments (RWK 24/01/2013)

112. The additional cost of the fee proposals set out in the report is estimated to be £6.8 million. This additional financial pressure will need to be considered by Policy Committee and the County Council in determining the County Council's 2013/14 Budget and the County Council's Medium Term Financial Strategy (MTFS) for the period 2013/14 to 2016/17.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

a. East Midlands and the NHS East Midlands Resource Hub survey of care home costs, commissioned from Laing and Buisson, 2011

b. Nottinghamshire Care Association, survey of care home costs, commissioned from Laing and Buisson, 2011

c. 'Calculating a fair market price for care – A toolkit for residential and nursing homes' – William Laing for Joseph Rowntree Foundation, September 2008

d. 'Bridging the Gap – Ensuring local authority fee levels reflect the real costs of caring for older people' Bupa, 2012

e. 'Fair Price for Care – a toolkit for care homes for older people and older people with dementia' Laing and Buisson, October 2012.

Electoral Division(s) and Member(s) Affected

All.

ASCH100

Appendix A

Comparative Cost Models

	Nottinghamshire County Council Survey 2012		Laing and Buisson East Midlands 2010/11		Notts Care Association – Laing and Buisson East Midlands - Restated 2010/11		Laing and Buisson National 2010/11 Provincial Location	
	Residential	Nursing	Residential	Nursing	Residential	Nursing	Residential	Nursing
Occupancy Levels	92%	92%	90%	90%	90%	90%	90%	90%
	£	£	£	£	£	£	£	£
Staff Costs	246	390	234	366	287	425	242	371
Non-staff Costs	131	135	124	124	123	123	119	119
Capital and Financing costs, Return on capital	135	172	162	190	172	201	200	204

Nottinghamshire County Council

Consultation on Future Fee Levels for Older Persons Care Homes

Responses to this consultation should be sent to:

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Contents

1. Background Information and Context

Since 2008/09, the Council has been implementing a phased fee structure based on a 'Local Fair Price for Care' model. The framework, through its bandings, has sought to pay higher fees for high quality care provision as evidenced through an annual audit of each older person's care home as well as on environmental factors. The aim of the fee structure and framework has been to improve the quality of care across the sector and to increase the amount of good quality dementia provision.

Over the past few months, Nottinghamshire County Council has embarked upon a two stage process to review the local 'Fair Price for Care' framework and fee levels. Stage one of this review has included consideration of the Council's strategic objectives in relation to older people's services and more specifically the Council's commissioning intentions in relation to care homes. This has been considered within the context of the Council's financial position and requirements for savings and efficiencies. Part of the review has included completion of a Provider Survey to establish the 'actual costs' of care home provision including nursing and dementia care. The following key factors have been taken into consideration:

(a) meeting the legal requirement to take in to account the actual costs of care and to consult with care homes in the setting of fees;
(b) promoting a sustainable market of provision which meets the needs of service users across the whole County;
(c) ability of the Council to ensure that future fee levels are financially sustainable;
(d) rewarding good quality, striking an appropriate balance which prioritises care quality issues over the environment but which recognises the importance of both;
(e) challenging inefficiencies at the same time as providing incentives for improvement in quality;
(f) enabling a more personalised approach to the delivery of care and ensuring that outcomes are achieved for residents through appropriately trained care staff;
(g) promoting good standards in the delivery of care and giving particular focus to dementia care and end of life care;
(h) creating a framework which can be applied over a period of years to ensure continuity in the market and clearer financial planning for the Council;
(i) ensuring the new/revised framework is simple to apply and to adjust over a given period of time and prior to any further review of the model in future years

Within the context of the above there are a number of factors that point to the current funding arrangements promoting a sustainable market, including:

- A market with stable capacity: in recent years the Council has been aware of 8 homes closing in Nottinghamshire, 6 new homes opening, and 2 new homes currently under construction;
- A number of new entrants to the market in the last 2 years including one provider buying six homes from the County Council;
- Positive feedback from providers regarding their relationship with the Council as evidenced in outputs from the Provider Survey.

Savings and Efficiency Requirements

Given the current economic and financial climate all local authorities are being required to deliver significant savings and efficiencies across both directly provided and externally commissioned services.

The Council is currently undertaking a wide-ranging internal programme to identify and implement cost saving opportunities and efficiency improvements and also has an expectation that its providers and suppliers will seek ways to increase their operating efficiency, particularly where local data indicates that costs are higher than the national average.

Investing in Quality

Over the last 5 years, the Council has made significant financial investments to help increase the quality of care provided within older persons care homes. Staffing resources have also been increased in order to provide guidance and support to those homes that continue to be in the lower quality bands. The Council recognises that the continuation of support to lower quality homes is essential to help these homes improve their quality of care and subsequently receive higher fee levels to ensure continuous improvement.

It remains a priority of the Council to assess quality, and reward quality within the fee levels.

The second stage of the review is a consultation with the provider market based on the findings from stage one. This document outlines the findings of the review of the local 'Fair Price for Care' framework and fee levels, and sets out proposals for future fee levels. Before any decision is made about fee levels we want to gather the views of care providers on these proposals.

Detailed background to the Provider Survey– methodology, participation, calculation methodology and treatment of data – can be found in Appendix 1 & Appendix 2.

A Glossary of Terms is attached as Appendix 6.

2. Provider Survey Outputs

A key principle underpinning this data collection and analysis has been to summarise home costs as reported in the Fair Price for Care Provider Survey responses. Therefore outputs provided in this section are summaries of the actual costs reported by homes in their responses. All assumptions that are applied to enable a price per resident per week are clearly stated below.

Whilst some comparator benchmarks are referenced within this document, the output is representative of the costs reported in the Provider Survey, and does not include the application of external data.

A number of consistent assumptions have been applied to all elements of cost data as follows:

Occupancy Levels: 92%

To enable the calculation of a weekly cost per resident, it is critical that an assumption of occupancy is used. Data is available on care home sizes but to assume that care homes have 100% occupancy at all times is unrealistic and not representative of how costs are spread amongst residents in reality.

An occupancy level of **92%** has been assumed, applied to the average size care home in terms of numbers of beds. This level meets expectations of an efficient market, whilst retaining an appropriate level of bed capacity to mitigate against risks of unplanned demand increases. The average occupancy levels reported as a snapshot within the provider survey were 83%. Comparator Laing and Buisson data from March 2011 Care of Elderly Market Survey shows in the East Midlands averages of 88.8% Nursing occupancy and 86.1% Care home occupancy.

Return on Capital: 7%

The Return on Capital is a measure of the expected annual return (profit) generated by a Provider when making a significant capital investment into the purchase, construction or refurbishment of a care home.

The Provider Survey response, on average, was an expectation of 7%. This matches other data sources, for example Laing and Buisson research, which also applies a 7% return on capital.

To calculate this, 7% has been applied to the average value of a care home in Nottinghamshire, as reported in the responses.

Return on Operations: 18%

The Return on Operations is a measure of the expected return (profit) generated on day-to-day expenditure, i.e. the turnover of the care home.

The Provider Survey response, on average, was an expectation of 18%. Whilst the Council is aware that this is slightly lower than the assumption generally used by

Laing and Buisson, this figure does represent an up-to-date local view in challenging economic conditions.

To calculate this return, 18% has been applied to the average operational costs reported by the care homes (i.e. staff costs, overheads, non-staff costs, and finance).

Summary Cost Calculations

The sample group included Care Homes, Care Homes with Nursing, and Dual-Registered Homes. Therefore a number of summary cost calculations can be constructed according to these categories. As would be expected, Care Homes have the lowest overall cost per week per resident. The costs per week per resident in Dual-Registered Homes fall between those for Care Homes and Care Homes with Nursing, but are much closer to the Care Home cost. One reason for this is the inclusion of Continuing Health Care (CHC) funded resident costs in the Care Homes with Nursing data (see notes below).

Table 1: Summary of costs per resident per week[1]

	All Homes	Care-Only	Care with nursing	Dual
Average number of residents at 92% occupancy	*36.5*	*34.5*	*31.0*	*42.4*
Staff Wage Costs	216.03	182.93	292.00	214.26
Staff and Management Overheads and On-costs	74.93	64.66	99.47	74.95
Non Staff Costs	107.67	109.08	112.68	101.33
Finance Costs	22.24	22.24	22.24	22.24
Subtotal	**420.87**	**378.90**	**526.40**	**412.68**
Return on Capital (7%)	52.30	55.45	61.64	45.07
Return on Operations (18%)	75.76	68.20	94.75	74.28
Total Cost Per Resident Per Week (£)	**548.92**	**502.55**	**682.79**	**532.03**

Detailed cost structures for Care Homes, Care Homes with Nursing and Dual-Registered Homes are shown in Appendix 3.

Impact of Continuing Health Care

It was noted that the data contained costs associated with residents receiving NHS funded Continuing Health Care (CHC), including one to one care. This funding is already being provided by the NHS for the residents that meet CHC criteria. As should be expected, these costs are almost entirely within Care Homes with Nursing and significantly skew the average staffing costs of these particular homes in the sample.

- When the staffing costs of Care Homes with Nursing are recalculated to exclude homes with more than 40% CHC provision, this gives a revised average total cost per resident per week of £597.75 compared to £682.79 in the above table.

[1] This table and other total cost data throughout this document include calculated returns in addition to operating costs.

- This demonstrates that homes with a high proportion of NHS funded CHC (more than 40%) are inflating the total average cost of Care Homes with Nursing by £85.04 per resident per week (approximately 12.5%). This calculation does not take into account the impact of CHC care costs in homes which have less than 40% of their residents CHC funded.

Findings on Staffing Levels

The main element of cost for all care home provision is the staffing costs. As a proportion of total operating costs, the Provider Survey data indicates staffing accounts for 69% of costs across all homes. Therefore additional information is provided in this section to highlight the data received in relation to this key cost element.

The Provider Survey requested two measures of hours per week of staff time. Firstly, an average number of hours provided per person per week, over a given month (April 2012), the output from which follows in Table 2:

Table 2: Stated average number of hours of staff time provided per person per week

	Care-Only	Care with nursing	Care-Only with dementia	Nursing with dementia	Respite and short break
Care related Hours	23.7	27.3	26.9	36.1	25.8
Non-care related hours	10.3	10.9	9.1	13.6	9.1
Total	**34.0**	**38.1**	**36.1**	**49.7**	**34.9**

The second measure of hours per week of care provided was calculated from the staff rosters as stated by providers. Table 3 below shows the average rostered hours for each type of staff group in all the care homes. To calculate an average per person, the stated number of residents in the home at the time was used.

Table 3: Rostered average hours of staff time provided per person per week (Care Homes)

Staff Group (Care-Only Homes)	Mon-Fri		Saturdays		Sundays		Full Week
	Daytime	Night-time	Daytime	Night-time	Daytime	Night-time	Total
Care Assistants (No NVQ qualifications)	1.3	0.9	0.3	0.1	0.2	0.2	3.1
Care Assistants (NVQ 2)	4.0	1.8	0.7	0.4	0.8	0.3	8.0
Care Assistants (NVQ 3 or above)	2.2	1.2	0.6	0.3	0.5	0.3	5.0
Senior Carers	2.6	1.3	0.5	0.2	0.5	0.2	5.3
Nurses (RGN and RMN)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Care Hours per person per week	**10.2**	**5.3**	**2.0**	**1.0**	**2.0**	**1.0**	**21.4**
Administration/Reception Staff	1.2	0.0	0.1	0.0	0.0	0.0	1.3
Catering Staff	1.9	0.0	0.4	0.0	0.4	0.0	2.8
Cleaning Staff	0.0	0.3	0.0	0.3	0.0	0.8	1.5
Maintenance / handyman staff	0.8	0.0	0.0	0.0	0.0	0.0	0.8
Other staff	0.8	0.0	0.1	0.0	0.1	0.0	0.9
Non-Care hours per person per week	**4.7**	**0.3**	**0.5**	**0.3**	**0.5**	**0.8**	**7.2**
Total Hours per person per week	**14.9**	**5.6**	**2.5**	**1.4**	**2.5**	**1.8**	**28.7**

As a point of comparison, recent Laing & Buisson (L&B) figures[2] for "industry norms" are 18.5 hours of care and 6 hours of non-care per week for care only home (24.5 hours in total). In comparison, Nottinghamshire care homes report a higher than average number of hours of care, by approximately 15%[3].

This higher level of staffing is also reflected in the output of an East Midlands survey in 2011, but no explanation is provided for this localised variance from national averages.

The same summary is shown for Care Homes with Nursing, in Table 4 below. It should be noted that this data is an aggregated summary of care homes with nursing data, and not only those residents in receipt of nursing care. Therefore this data includes care provided to 8 care-only residents in care homes with nursing.

Table 4: Rostered average hours of staff time provided per person per week (Care Homes with Nursing)

Staff Group (Care with Nursing Homes)	Mon-Fri		Saturdays		Sundays		Full Week
	Daytime	Night-time	Daytime	Night-time	Daytime	Night-time	Total
Care Assistants (No NVQ qualifications)	3.3	1.6	0.5	0.4	0.7	0.3	6.9
Care Assistants (NVQ 2)	4.7	1.8	0.9	0.4	0.7	0.4	8.9
Care Assistants (NVQ 3 or above)	2.2	0.4	0.4	0.1	0.3	0.1	3.5
Senior Carers	2.9	0.1	0.6	0.0	0.6	0.0	4.3
Nurses (RGN and RMN)	3.0	1.9	0.5	0.4	0.5	0.4	6.6
Care Hours per person per week	**16.1**	**5.8**	**2.9**	**1.3**	**2.9**	**1.3**	**30.2**
Administration/Reception Staff	0.7	0.0	0.0	0.0	0.0	0.0	0.7
Catering Staff	2.4	0.1	0.4	0.0	0.5	0.0	3.4
Cleaning Staff	2.2	0.1	0.3	0.0	0.3	0.0	3.0
Maintenance / handyman staff	1.1	0.0	0.0	0.0	0.0	0.0	1.1
Other staff	1.0	0.0	0.1	0.0	0.1	0.0	1.1
Non-Care hours per person per week	**7.4**	**0.2**	**0.8**	**0.0**	**0.8**	**0.0**	**9.3**
Total Hours per person per week	**23.4**	**6.0**	**3.7**	**1.4**	**3.7**	**1.3**	**39.6**

For Care Homes with Nursing, the recent L&B figures for industry norms are 7.5 hours of nursing, 20.5 hours of care, and 6 hours of non-care per week for care only (34 hours in total).

Care Homes with Nursing in Nottinghamshire report a significantly higher than average number of hours of care, by 14%[4]. Again, specific reasons for this local variance cannot be established from the Provider Survey responses, but as per the commentary above, the data does include CHC provision.

The Costs Associated with Homes in different Quality Bands

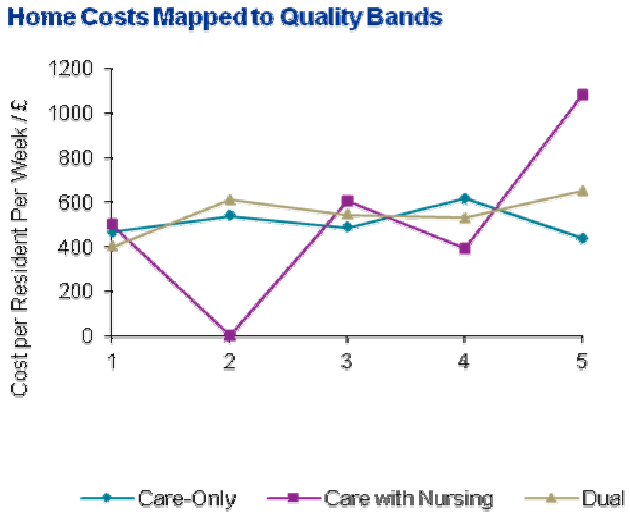
Table 5 and the graph below show the reported average cost of operating a care home in each of the quality bands. The information in this table is taken from the same dataset as table 1.

[2] L&B Report on FPC Parameters for East Midlands October 2010 - industry norms quoted for a "well-run corporate care home of 50 or more beds"
[3] (28.7-24.5) / 28.7
[4] (39.6 – 34.0) / 39.6

Table 5: Average Care Home Costs by Quality Band

Care Home Type	Quality Band / Average Cost					
	1	2	3	4	5	All
Care-Only	464	538	486	615	437	503
Care with Nursing	498	No data[5]	603	390	1079	683
Dual	399	611	543	529	650	532

The data does not show a clear link between the quality of a home and the cost of operating that home. This may be due to the relatively small sample sizes at this level. For example the band 5 Care Homes with Nursing costs are influenced by a very small number of homes reporting costs that are significantly higher than any other homes in the sample and are skewed by the inclusion of homes with a high proportion of NHS funded CHC.



[5] No Band 2 Care with Nursing homes responded to the survey

3. Proposals for Consultation

The Council has undertaken a review of the current fee model and the 5 quality bands. This has entailed consideration of the following:

- Whether fees should continue to be allocated on the basis of rewarding good quality;
- Whether the annual audit process needs to be changed to focus more time and resource on the lower band homes (Bands 1 and 2) in order to help improve quality of care;
- Whether environmental factors should continue to be taken in to account in the allocation of fees;
- Whether the Council, over an identified period of time, moves towards only commissioning care from Band 2 and above homes and if so, what the implications would be both in terms of future capacity and on finances;
- Whilst the current model includes an enhanced payment level for dementia provision, overall, the quality of dementia provision has not improved significantly in the past 4 years and in some cases remains poor despite the higher payment. Consideration is being given to whether the Council should only allocate the enhanced dementia payment to those homes where the quality exceeds an agreed threshold;

These considerations have informed a number of proposals, which are put forward in this section. These cover the following areas:

1. Fee Model
2. Fee Levels
3. Inflation

1. Fee Model

A number of changes to the proposed fee model, which take in to account the above considerations, are outlined in Appendix 4. The proposals align with the strategic objectives of continuing to develop and promote good quality care services and to focus particularly on improving the quality of dementia care overall.

In particular, whilst the majority of the existing Pinders model will be retained as is, it is proposed that the quality/environment weighting be changed from 70/30 to 80/20.

Proposals are made for the introduction of a two-stage process for the awarding of the enhanced dementia payment to those homes which have achieved the Council's dementia accreditation and the individual resident has reached the dementia criteria threshold.

It is also proposed that a small number of care homes be awarded 'beacon status', which would give them specific remit to support promote best practice within their locality.

It is acknowledged that the required changes would need to be implemented over a period of time in order to prevent the destabilisation of current market. It is

anticipated that the transition period would take place over the next three years. During this time, a number of specific projects would also be implemented, including, supporting lower banded homes to improve the quality of care and promoting the Council's vision for quality dementia care.

2. Fee Levels

The fee level proposal is informed by the outputs of the Provider Survey, using a number of key data elements as reported by the homes:

1. The total cost (on average) of operating care homes;
2. The total number of staff hours (on average) provided per person;
3. The difference in cost where homes have a high % of CHC funded residents.

This proposal recognises that the cost structures as outlined above in the Provider Survey Outputs section have been impacted by the high number of staff hours provided per person in Nottinghamshire, and also by the inclusion of CHC costs within the overall costs reported.

Therefore, two key adjustments have been made to the cost data, to reduce the impact of these two factors.

1. Staffing costs in the Care Homes have been adjusted downwards by 7.5%. The difference between the average staffing hours in Nottinghamshire against the Laing & Buisson (L&B) figures for industry norms, as stated previously, is 15%. The Council recognises that a number of local factors may contribute to this, for example, the number of smaller non-purpose built homes, plus the drive to increase the quality of service provision. However a greater level of efficiency is expected as compared with the industry norms, and therefore a mid-point 7.5% over the L&B figures has been applied to the costs instead of the 15% identified in the Provider Survey**.**

2. Staffing costs in Care Homes with Nursing have been adjusted downwards by 10% from the average identified from the Provider Survey. This takes into account a number of additional factors to those outlined for Care Homes above:

- The data includes an element of CHC funded residents which significantly impacts on the reported staffing costs. Whilst the Council does not dispute the additional costs associated with CHC provision, these costs are agreed and funded through a separate process to this fee setting exercise, and therefore should not inflate the costs as they apply to local authority funded placements.
- Twenty four Dual-Registered Homes responded to the Provider Survey. In total, 51% of the residents of these homes receive nursing care. The average staff wage costs of providing nursing care within these homes have been calculated as £244 per person per week. This provides a local comparator figure to the Care Homes with Nursing staff wage cost of £292.

With these two adjustments made to the data, the following cost summaries (Table 6) are used to inform the fee level setting:

Table 6: Summary of costs per resident per week with staffing adjustments

	Care-Only	Care with nursing
Average number of residents at 92% occupancy	*34.5*	*31.0*
Adjusted Staff Wage Costs	**169** (-7.5%)	**263** (-10%)
Staff and Management Overheads and On-costs[6]	62	91
Non Staff Costs	109	113
Finance Costs	22	22
Subtotal	**362**	**489**
Return on Capital (7%)	55	62
Return on Operations[7] (18%)	65	88
Total Cost Per Resident Per Week (£)	**482**	**639**

As per all cost summary data throughout this document, the following assumptions have been applied in the calculation of costs:

- *92% Occupancy*
- *7% Return on Capital*
- *18% Return on Operations*

The costs in the table above include dementia provision. The current fee structures include an uplift for dementia provision of £46 for Care Home Only fees, and £41 for Care Homes with Nursing fees. At this point these differentials from the current model are maintained, and therefore need to be taken into account when determining fees. This adjustment is based on current dementia placements being approximately 50% of total placements.

The nursing costs above represent the total cost to the home of providing the care. Part of this cost is funded by Health, via a Funded Nursing Care (FNC) contribution of £108.70. This needs to be taken into account when determining the Local Authority contribution to the fees.

Table 7 below applies both of these factors to the costs to determine the average cost of Care Homes and Care Homes with Nursing.

Table 7: Summary of costs per resident per week incorporating FNC and Dementia Premiums

Care Category	Care-Only Cost	Care with Nursing Cost
Cost per resident per week	482	639
Without FNC	(N/A)	530
Dementia Premium (+23 for care, +£20 for Nursing)	**505**	**550**
Non-Dementia (-£23 for care, -£21 for Nursing)	**459**	**509**

[6] The staffing on-costs are calculated as a % of staffing costs, and therefore is also impacted by a reduction in staffing costs

[7] Return on operation is applied as a % to operational costs, and therefore is also impacted by the reduction in staffing costs

Using this Cost data to inform Fee Levels

The average quality band from the 70 responses to the Provider Survey is 3.2. Therefore the cost data provided, on average, has been used to represent the costs of a notional band 3.2 care home. The model below applies these costs to a band 3 care home, and then re-calculates all fees from this point across all bands, using the current differences between fees.

For example, the cost of Care Home non–dementia care is £459. As this represents a band 3.2 care home, the fee below for Band 3 is calculated pro-rata at a slightly lower rate of £453, and other bands are applied from this point maintaining existing differences between the bands (i.e. band 4 is £26 more, band 2 is £26 less, as per current fee levels).

The same approach is taken to the Care Home with Nursing non dementia cost at band 3.2 of £509, which is therefore calculated pro-rata at £503 for band 3.

The fee levels, as informed by the re-calculated cost data are proposed as:

Table 8: Proposed Fee Level Baseline

Proposed Fee Level Baseline (% increase from 2012/13 fee levels in brackets)					
	Band 1	**Band 2**	**Band 3**	**Band 4**	**Band 5**
Older People	384 (10.3%)	427 (9.2%)	**453** (8.6%)	479 (8.1%)	505 (7.7%)
OP Dementia	395 (10.0%)	474 (8.2%)	500 (7.8%)	525 (7.4%)	551 (7.0%)
Nursing (exc. FNC)	414 (10.1%)	477 (8.7%)	**503** (8.2%)	529 (7.7%)	554 (7.4%)
Nursing Dementia (exc. FNC)	424 (9.8%)	518 (7.9%)	544 (7.5%)	570 (7.1%)	596 (6.8%)
Total increase in fees per band	**10.2%**	**8.5%**	**8.1%**	**7.7%**	**7.3%**

It should be noted that each Band is receiving a similar uplift in actual terms (£s). When this is calculated as a %, the lower bands will appear higher as the % is calculated on a lower base amount.

The Council considers that this is a fair way to allocate additional funding across all quality bands, and, in ensuring continued funding to the lower quality homes, this supports the Council's strategic intentions to drive improvements in the quality of care homes. In return, the Council will expect this additional funding to enable and support the movement of these homes into higher bands.

For the purpose of comparison Appendix 5 lists 2012/13 fee levels, as reported by Local Authorities nationally. It can be seen from this information that Nottinghamshire currently has maximum fee levels above regional comparators and minimum fee levels on a par in the region.

3. Inflation

In their discussions with the Council over the past 4 - 5 years regarding care home fees, the NCA executive have requested that an inflation formula which takes in to account key elements of their costs, be agreed and included in care home contracts.

The scope for determining an annual inflation increase is wide. Possible models range from applying a nominal flat rate percentage each year to complex models which recalculate individual elements of the costs of homes each year to reflect specific impacts of inflation. In determining a model relevant considerations include the following factors:-

(a) ease of understanding
(b) ease of calculation
(c) ease of application
(d) independence
(e) relevance to cost increases

The Council proposes the use of an index based on Average Weekly Earnings in the Health and Social Care Sector for staffing costs (EARN03 (Q) Not Seasonally Adjusted) and a range of indices for elements of non-staffing running costs. Finance costs would not be inflated. These indices are considered relevant and are known to have been used in previous models for calculating annual inflation in this market.

The application of inflationary indices to specific elements of care home costs is shown below in Table 9. The breakdown of costs has been based on the Provider Survey response. The index proposed for inflation is also shown. All indices are produced by Office for National Statistics (ONS) and are available on their website http://www.ons.gov.uk/ons/index.html.

The respective indices are titled:

01.1 Food
04.3 Maintenance and repair of the dwelling
04.5 Electricity, gas and other fuels

and form part of a whole set of detailed indices available within ONS.

Table 9: Cost Elements and Proposed Inflationary Indices

Cost Element	Proportion of Total	Index Proposed
Staffing	69%	AWE EARN03 (Q)
Finance	5%	Not inflated
Non-Staff Costs	*26%*	*As per below:*
Repairs and maintenance	24% of Non-Staff Costs	ONS detail 04.3
Food	19% of Non-Staff Costs	ONS detail 01.1
Utilities	17% of Non-Staff Costs	ONS detail 04.5
Other running costs	40% of Non-Staff Costs	CPI

The indices used to calculate the inflation rate will be those for the month of October or Q2 in the year preceding the April in which fees are to be increased. For example, fees increases in April 2014 will be based on the indices for October 2013.

The proposed calculation follows:

Annual Inflation (%) =
0.69 x (EARN03 (Q - Oct Preceding Year)
+ 0.24 x 0.26 x (ONS 04.3 - Q2 Preceding Year)
+ 0.19 x 0.26 x (ONS 01.1 – Q2 Preceding Year)
+ 0.17 x 0.26 x (ONS 04.5 – Q2 Preceding Year)
+ 0.40 x 0.26 x (CPI – Oct Preceding Year)

The inflation rate produced by this formula would be applied to each existing fee level (20 in total) to determine new fees. It is not proposed that there would be separate calculations for each of the 20 fees to determine revised fee levels.

4. Consultation Questions

Questions 1 & 2

The proposed fee levels take in to account the actual costs, as reported in the Provider Survey, of operating care homes within Nottinghamshire, with a proposed annual inflationary uplift.

Please explain how the proposals would affect your returns on capital / operations?

_____
_____
_____
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_____

Please explain what effect, if any, the proposals would have on your staffing levels, and on any other aspect of your business which has a direct impact on the quality of your care provision.

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Question 3

The Provider Survey responses show that on average Providers expectation on rates of return are 18% on Operations, and 7% on Capital.

What level of return is needed to make a care home business viable?

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Question 4

In the creation of the fee level proposal, the data from the questionnaire has been used. The main assumption in all cost-per-resident calculations is an occupancy rate of 92%.

Do you consider the Provider Survey response and treatment of this data to be a reasonable basis for calculating the costs of operating care homes in Nottinghamshire?

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Question 5

Whilst all fees are proposed to be increased, the current £ differences between each quality band have been maintained in the proposal.

If the proposals either increase or decrease the incentive for you to improve the quality of your care provision, please explain this.

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Question 6

The average number of hours of staff time per resident in Nottinghamshire is significantly higher than the figures for industry norms as reported by Laing and Buisson. The proposed fees have been set to reflect the cost of operating with staffing levels between these two comparators.

Why are staffing levels in Nottinghamshire homes higher than the national average?

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Question 7

The Provider Survey data does not indicate a clear correlation between the quality band and the cost of operating a home. However to encourage higher quality provision the Council will continue to pay higher fees for higher quality homes.

How will the continuation of the Council's strategy to directly reward quality by the payment of additional fees help you increase the quality of your home?

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Question 8 & 9

To ensure longer term sustainability of the care home market, the Council is proposing an annual inflationary mechanism which uses indices relevant to the specific costs incurred by care homes.

Does the proposal to apply annual inflation to the fee levels provide additional financial security to your business, and therefore give you the incentive to continue investing in increasing quality of care provision?

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Do you agree that the proposed inflation indices are appropriate ones to use? If not, which others would you suggest, and why?

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Question 10

Consideration of the physical environment currently accounts for up to 30% of the total 'score' available in determining service quality. This model is somewhat biased towards purpose built properties and is subjective in some elements. It is proposed that the subjective environmental elements be removed, the overall environmental audit be simplified and that the new 'scoring' methodology be based on an 80/20 quality/environmental split, rather than the current 70/30 one. Your views on this approach would be welcome.

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Question 11

To ensure the needs of residents with dementia are met the Council is considering both developing specific placement criteria and a care home accreditation process.

Do you think that this will a) help people to choose care homes more suitable for their needs and b) help care homes to promote specialist dementia care services?

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Question 12

In its commitment to the further promotion of high quality dementia services, Nottinghamshire County Council is considering the option of creating 'Beacon Status' for a small number of care homes, i.e. with the expectation that those homes would share examples of excellence, innovation etc and promote good practice both within, and outside of, Nottinghamshire.

Do you support this proposal and what criteria do you think the Council should be setting for the creation of 'Beacon' status homes and what, if any, rewards should be considered?

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Appendix 1: Provider Survey Methodology and Participation

The 2012 Fair Price for Care Provider Survey:

The Council embarked upon this data gathering process with the objective of understanding the current actual local costs of operating a care home in Nottinghamshire, to inform the setting of future fee levels.

The Council engaged KPMG to provide independent support to this process. KPMG created a bespoke questionnaire in partnership with representatives from the Council's Adult Social Care, Health and Public Protection Department, using evidence from a number of sources to identify key cost areas incurred in operating an older person's care home. These included:

- Knowledge from previous KPMG Local Authority projects which have included collecting care home cost data;
- Knowledge from KPMG's team that works on care home portfolio sales and acquisitions;
- Comparative review against other models such as Laing and Buisson, the 'Care Funding Calculator', and the previous Pinders model used in Nottinghamshire.

The draft questionnaire was piloted with 5 providers prior to finalisation. This involved working through each question with each of the providers to check their understanding and perceived ability to respond. It also included identification of any areas of cost that may have been omitted. The draft questionnaire was also provided to the NCA executive for comment, and their feedback was incorporated where possible into the questionnaire.

Questionnaire Distribution

During May and June 2012, the Council forwarded the Provider Survey questionnaire to all of the 170 older person's care homes within the county requesting that the Provider Survey be completed in order to enable a cost analysis to be undertaken. Homes were asked for a mixture of quantitative cost information and for qualitative contextual comments.

Care Homes were invited to email, fax, or post their responses back to the Council. The Council made initial calls to the care homes to confirm that the Provider Survey had been received and subsequently re-sent a number of questionnaires to different email addresses.

Provision of Support during Response Period

Providers were requested to complete the questionnaire within a four-week period. During the pilot phase, four of the providers stated that a four week period was adequate to complete and return the Provider Survey and the one of the providers stated that the timeframes were 'challenging but not impossible'. A small number of responses were received and added to the database during week 5.

During the 4 week response period, a number of activities were undertaken to support providers including:

- Providing direct contact details for expert support from a dedicated officer from the Council and/or a KPMG representative;
- The Council held a provider forum during week 2, attended by approximately 60 care home providers or their representatives. The purpose was to discuss the Provider Survey process and respond to specific questions raised;
- A FAQ sheet was created from initial feedback, answering questions and offering guidance on completing the questionnaire;
- The NCA held a number of workshops to support their members in completing the questionnaire;
- The Council project team contacted every care home that the Provider Survey was sent to and were able to speak to over 90% of managers or owners to offer or provide support directly;
- Reminder and support emails were regularly sent by the Council and the NCA to emphasise the importance of responding to the questionnaire and re-iterating the support that was available.

Data Validation

Completed questionnaires were posted or sent to a unique secure email address, created for this purpose. Detailed checks were undertaken on each, and each data point validated, following a set process:

1) Initial review to identify gaps in the data, inconsistencies, or commonly recognised misinterpretation of questions. This included a detailed check of the response to every question, identifying incomplete responses and clear outliers.
2) Emails and calls with providers to discuss and validate their response or to amend the responses where relevant based on clarifications. If the questionnaire was updated directly by the Council team member during the call or following email advice, a copy of the amended document was sent back to the care home.
3) Technical review of each home's final response, looking for any data issues which may impact the import into the aggregation tool.

Making the Data Anonymous

The questionnaire asked for the home name and contact details. This was important for the purposes of clarifying the response directly with the person that had completed the form. Once all responses had been entered into the database, several activities were undertaken to ensure the data was made anonymous:

- all email and electronic files containing the responses were deleted, both from the email inbox, and from backup systems;
- all electronic responses were deleted from the folder where they had been stored during the validation process;
- all hard-copy files were destroyed securely;
- the database was built to be able to delete several data points i.e. the name of the home, the contact details, and the second part of the postcode.

Once these actions had been undertaken, an email was sent to all homes confirming this. As a result it is not possible for the Council to link data to any specific home.

During July, the data collected was analysed, and a number of cost summaries produced, for different types of home (care/nursing/dual). Details of these can be found elsewhere in this document.

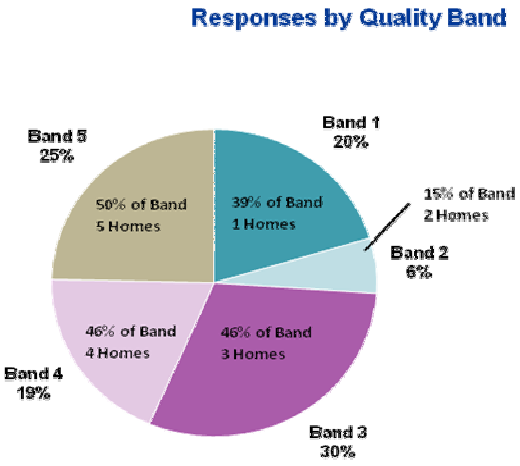
Provider Survey Participation

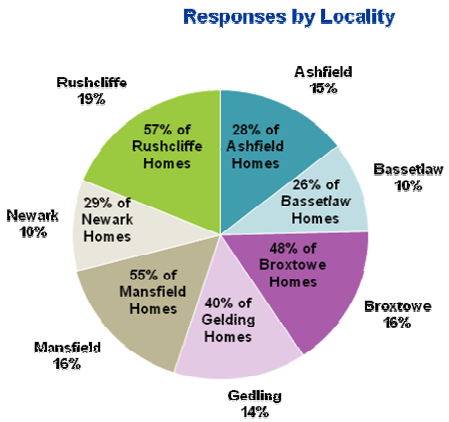
41% of homes contacted sent a response to the questionnaire. This is considered to be a large enough sample size to enable the Council to use data collected to inform decisions.

Table 10: Provider Survey Participation Details

	Total number of Homes	Total Bed Capacity
Nottinghamshire Total Contacted	170	6564
Response Sample	70	2809
Representative %	**41%**	**43%**

The responses include representation from all quality bands. The chart to the right shows the proportion of the responses in each band, and also the number of responses as a % of the total homes within that band in Nottinghamshire. As can be seen from the chart, the response sample group is slightly weighted towards the higher quality bands, with 26% of responses in bands 1 and 2, and 44% of responses in bands 4 and 5. Band 2 homes provided the lowest response rate to the Provider Survey. The average band of home that responded to the Provider Survey was 3.2.





The responses are also geographically dispersed across Nottinghamshire, with representation from each of the localities, as per the chart to the left. There are very high levels of representation from homes in Rushcliffe and homes in Mansfield.

Responses were received from all home registration categories, and across a wide variation of home sizes. The average home size, by bed number across the responses is

shown below. The number of responses from care with nursing homes is low, which leads to any individual variation in cost within this group having a disproportionate impact on the average.

Table 11: Registration category of responding homes

Registration Type	Number of Respondent Homes	Average size of respondent home (beds)	Average size of total Nottingham County Population (beds)
All Homes	**70**	**39.7**	**38.8**
Care-only	33	37.5	33.4
Care with nursing	13	33.7	47.3
Dual Registered	24	46.1	

The 70 homes are of variable size and provide a broad mix of large and small, with a slight weighting towards larger homes than the total Nottinghamshire average, as per Table 12 below.

Table 12: Size of responding homes (number of beds)

Number of Beds	Respondent Sample Size	Sample %	Total Nottinghamshire Population Contacted	Total %
0-20	9	13%	26	15%
21-40	25	36%	83	49%
41-60	25	36%	44	26%
Over 60	11	16%	17	10%
	70		**170**	

As noted above, the average quality band of the responding homes was 3.2. The spread across the quality bands and home types is shown in table 13 below.

Table 13: Quality Banding by Care Home type in responding homes

Number of responses by band						
Care Home Type	**Band 1**	**Band 2**	**Band 3**	**Band 4**	**Band 5**	**Total**
Care	4	3	5	9	12	**33**
Nursing	6	0	3	1	3	**13**
Dual	4	1	13	3	3	**24**
Total	**14**	**4**	**21**	**13**	**18**	**70**

The number of beds funded by the Council within each of the homes at the time the questionnaire was completed has also been analysed. Again, this evidences a spread of responses, ranging from homes where all beds are funded by the Council, through to homes with self funders making up the majority of residents.

Analysis Methodology

The Provider Survey requested data on a range of cost areas, which were designed to comprehensively cover the costs of operating a typical care-only or care with nursing home. Opportunities were provided within the questionnaire to detail 'other' costs that were not explicitly stated.

The questionnaire also contained a series of qualitative, open-ended questions, to enable homes to provide a context and background to the cost data. (e.g. what is impacting costs currently).

The Provider Survey responses were grouped into a number of key cost areas as follows:

- Staff Costs (from rostered hours)
- Staff On-Costs (e.g. national insurance)
- Management Costs (e.g. manager's salary)
- Non-Staff Costs (e.g. food)
- Finance Costs (as stated in responses)
- Returns (split by operational and capital)

Homes were asked to complete as much of the Provider Survey as possible, however no questions were mandatory. Therefore, incomplete returns have been included in the data. This makes it possible to include all of the data provided by homes to inform the analysis.

To be able to create robust averages, costs are therefore taken at a cost-line level, and averaged across all homes, for example, where homes have provided a cost of Waste Collection and Disposal, the average of these costs from these homes have been taken to create a group average. For the majority of costs, a '0' or a blank response is not included in this calculation of the average.

More detailed information on the way averages have been calculated is included in Appendix 2.

During the validation process a number of inconsistencies and 'outliers' were identified and checked with the homes that submitted the response. However, several outliers were identified after the data had been made anonymous and additional analysis undertaken. These had to be removed from the data. They are listed below:

- 3 homes (2 care homes and 1 care home with nursing) where weekly staffing costs per person were over double the average. On closer inspection it was found that with stated staffing numbers it was extremely unlikely that the rostered hours stated could be correct for example in one response, staff would need to be consistently working 80 hours per week each. For these homes, only the staffing costs were excluded.
- 2 homes (1 care home and 1 dual registered home) where staffing levels were very low, that is approximately £60 per person per week. Again, it was considered extremely unlikely that these numbers were correct. For these homes only the staffing costs were excluded.

All other costs in all homes and all cost categories were included in the analysis.

Appendix 2: Summary of Calculation Methodology

General calculation principles

Homes were asked to complete as much of the Provider Survey as possible, however no questions were mandatory. Therefore, incomplete returns have been included in the data.

To create robust averages, costs are taken at a cost-line level (e.g. Cleaning Supplies), and averaged across all homes. These averages are calculated in slightly different ways, according to whether a home has omitted the cost due to being unable to provide the information, or whether the home has actively submitted a '0' response. Where there was any doubt, this was checked with the home prior to anonymisation of the data.

Decisions have been made for each of the cost types as to whether all homes must incur that cost, whether they have responded or not. For example food, and national insurance - where homes have submitted a '0' for such costs, this has been excluded from the calculation, because we know that care homes must incur these costs.

A summary of the approach taken to the calculations of averages is shown in table 14 below:

Table 14: Detail of calculations of averages

STAFF COSTS	**Treatment of '0's in Averages**
Care Assistants (No NVQ)	0's included where stated, null returns excluded from average
Care Assistants (NVQ 2)	0's included where stated, null returns excluded from average
Care Assistants (NVQ 3 or above)	0's included where stated, null returns excluded from average
Senior Carers	0's included where stated, null returns excluded from average
Nurses (RGN and RMN)	0's included where stated, null returns excluded from average
Administration/Reception Staff	0's included where stated, null returns excluded from average
Catering Staff	0's included where stated, null returns excluded from average
Cleaning Staff	0's included where stated, null returns excluded from average
Maintenance / handyman staff	0's included where stated, null returns excluded from average
Other staff	0's included where stated, null returns excluded from average
STAFF ON-COSTS	
Avg Training Days	0s excluded from average
Avg Holidays	0s excluded from average
Employer's National Insurance	0s excluded from average
Sick Pay	0s included in average where stated
Additional (maternity, pension etc)	0s included in average where stated
Total %age on-cost	***For reference only***
MANAGEMENT COSTS	
Average Manager Salary (weekly)	0's included in average where stated
Management Duties on shift	0's included in average where stated
NON STAFF COSTS	
Repairs & Maintenance	0s excluded from average

Renewals of furnishings and equipment	0s excluded from average
Leasing costs of equipment	0s excluded from average
Food	0s excluded from average, (variable cost)
Utilities (energy, water, telephone)	0s excluded from average
Maintenance / Handyman, Gardener	0s excluded from average
Professional Services	0s excluded from average
Medical supplies	0s excluded from average, (variable cost)
Cleaning supplies	0s excluded from average
Waste collection and disposal	0s excluded from average
Registration fees	0s excluded from average
Recruitment and Training	0s excluded from average
Transport and activities	0s excluded from average, (variable cost)
Any other non-staff expenses	0s excluded from average, (variable cost)
Centralised costs	0s included in average where stated

FINANCE COSTS	
Average Annual Financing Costs	0's included in average where stated

RETURN ON CAPITAL	Calculated
Average value of home	0s excluded from average

RETURN ON OPERATIONS	Calculated

Treatment of Staffing Costs

Weekly staff costs are calculated using the hourly rate (£) as stated, multiplied by the number of hours rostered per week for the sample month. This is calculated for each staff group in each home, and then aggregate averages for each group of staff are calculated from the sample.

Initial views of the data showed that the proportions of care staff with different qualification levels (e.g. No NVQ / NVQ2 etc) vary across the sample population. For example some homes have a majority of NVQ3+ staff, and other homes have a high percentage of unqualified staff.

It was also notable that some homes employ non-care staff (e.g. handyman), but not all homes employed all categories – for example some homes use an external handyman service.

The cost calculation therefore does not assume that a typical home will directly employ a full complement of each of these staffing types.

Therefore, where a home has provided answers against some staff categories e.g. NVQ2, and either stated a ‘0’ for others or left blank, the averages will include this response across all categories as reported by the provider.

Where no staffing costs at all are provided in the home’s response, this has been identified and staffing costs for that home are excluded from calculations as a ‘null’ response.

Treatment of Staffing On-Costs

The staff costs, as calculated above, will only include the basic hourly rate paid to staff. There are a number of additional costs associated with staffing a home, and these have all been included within Staffing 'On-Costs'. This data provides an uplift % to the basic hourly rate, as reported by the respondents, which includes:

- National Insurance, an average % uplift was requested for nursing staff and non-nursing staff.
- Sickness cost (where paid), again, an average % uplift that is experienced or budgeted for was requested.
- The number of paid training days was requested for each staff group. The responses were averaged, and calculated as a % uplift to staff costs.
- 'Other' costs, for example maternity pay, where stated, were also averaged, including '0's where stated.

Treatment of Management Costs

Two key weekly costs have been calculated. Firstly, the average cost of a managers salary, as reported across the sample group. In this case, '0's are included in the average, where stated, as not all homes pay a manager a separate salary from the owner's earnings.

Secondly, the costs associated with staff members taking on temporary additional management duties whilst on shift. Again, '0's are included in the average, where stated, as not all homes incur this cost.

Treatment of Non-Staff Costs

Almost all of the categories within this cost area are considered to be costs incurred by all homes. Therefore, where '0's have been returned by the homes, these are excluded from the calculation of averages. For example, if a home has returned a '0' or not responded to Food costs, this home is excluded from the calculation, as it is not possible for the home to avoid this cost.

The one exemption to this rule is the 'Centralised costs allocated to the home if part of a group' question. Not all homes incur these costs, and therefore where a '0' has been given, this is included as part of the calculation of the average.

Most non-staff costs are considered as 'fixed' and therefore slight changes in occupancy levels will not have an immediate impact on these costs (for example, waste collection). As occupancy levels change, there is minimal gradual corresponding increase or reduction in these costs, although there are likely to be 'step' changes upwards or downwards at certain occupancy levels.

Four costs are identified as 'variable' (see table above) as these costs are directly incurred by each resident in the home. These are Food, Medical Supplies, Transport & Activities, and 'Other'. The average cost per resident will stay constant for these costs, and therefore at a resident level they are not impacted by occupancy levels in the calculation.

Treatment of Finance Costs

Annual finance costs were requested in the Provider Survey. Due to the very variable nature of this cost between homes, dependent on their particular financial circumstances and decisions, an average annual value has been calculated from all responses, including '0's. This cost (£22.24 per resident per week) is then treated as a constant across all home types and sizes, as can be seen in the cost summary tables in the main document.

Treatment of Returns (Capital and Operations)

In the cost summaries given in this document, Return on Capital has been calculated using a constant 7%, against the average home value (land and buildings) in Nottinghamshire as returned in the Provider Survey. The base average home value as identified from the Provider Survey (£1.42m) is treated as a constant across all home types and sizes, as it becomes very variable at lower levels of granularity. The calculation excludes '0' and incomplete responses for home value. The actual return per resident value varies according to average home size in the sample groupings.

In the cost summaries given in this document, the Return on Operations has been calculated using the average across all homes that responded to this question. This excludes '0' and incomplete responses. This average as reported is 18% across the entire sample group. Again, it becomes very variable at lower levels of granularity so the overall average is used across all home types. This level of return is applied to the operational costs as detailed by the homes (staff, staff on-costs, non-staff, management, and finance).

Appendix 3: Average Cost Structures of Nottinghamshire Care Homes

1. Care Homes (average)

This cost calculation represents care-only homes. It is based on a sample size of 33, with an average home size of 37.5 beds.

The costs below include care for residents with and without dementia, and encompass all quality bands. Calculations are based on assumptions of:

Return on Capital: 7%
Return on Operations: 18%
Occupancy: 92% (34.5 beds[8])

AVERAGE TOTAL WEEKLY COST PER RESIDENT	£502.55

STAFF COSTS	£182.93
Care Assistants (No NVQ qualifications)	£18.03
Care Assistants (NVQ 2)	£49.89
Care Assistants (NVQ 3 or above)	£26.00
Senior Carers	£33.95
Nurses (RGN and RMN)	£0.00
Administration/Reception Staff	£10.53
Catering Staff	£17.39
Cleaning Staff	£16.59
Maintenance / handyman staff (where directly employed by the home)	£5.60
Other staff (where directly employed by the home). E.g. Activity Co-ordinator	£4.95

STAFF ON-COSTS	£43.83
Avg Training Days	**2%**
Avg Holidays	**11%**
Employer's National Insurance on-cost, additional % uplift per hour	**8%**
Sick Pay on-cost, additional % uplift per hour	**2%**
Additional (maternity, pension etc)	**1%**
Total %age on-cost	***24%***

MANAGEMENT COSTS	£20.83
Average Manager Salary (weekly)	£14.96
Management Duties on shift	£5.87

NON STAFF COSTS	£109.08
Repairs & Maintenance of equipment and property	£17.00
Renewals of furnishings and equipment (e.g. furniture replacement)	£9.18
Leasing costs of equipment (e.g. laundry equipment)	£3.03
Food	£21.22

[8] 37.5 x 0.92.

Utilities (energy, water, telephone)	£17.42
Maintenance / Handyman, Gardener (where externally sourced)	£3.45
Professional Services: Insurance, Legal Advice, Marketing/Advertising the home	£7.92
Medical supplies (including medical equipment rental)	£1.99
Cleaning supplies	£6.27
Waste collection and disposal	£1.82
Registration fees (including CQC registration, CRB checks)	£2.77
Recruitment and Training, where external fees need to be paid (e.g. for facilities hire, travel, and external trainer fees).	£2.95
Transport and activities (where a cost is incurred that is not self-funded by residents)	£2.84
Any other non-staff expenses (please provide detail)	£7.53
Centralised costs allocated to the home if part of a group	£3.68

FINANCE COSTS	**£22.24**
Average Annual Financing Costs per resident per week	£22.24

RETURN ON CAPITAL	**£55.45**
Average value of home (000's)	£1,419

RETURN ON OPERATIONS	**£68.20**

2. Care Homes with Nursing (average)

This cost calculation represents only care homes with nursing. It is based on a sample size of 13, with an average home size of 33.7 beds.

The costs below include care for residents with continuing healthcare needs and dementia, and encompass all quality bands. Calculations are based on assumptions of:

Return on Capital: 7%
Return on Operations: 18%
Occupancy: 92% (31 beds[9])

AVERAGE TOTAL WEEKLY COST OF SAMPLE PER RESIDENT	**£682.79**

STAFF COSTS	**£292.00**
Care Assistants (No NVQ qualifications)	£43.47
Care Assistants (NVQ 2)	£54.06
Care Assistants (NVQ 3 or above)	£27.28
Senior Carers	£25.87
Nurses (RGN and RMN)	£73.50
Administration/Reception Staff	£6.28
Catering Staff	£26.15

[9] 33.7 x 0.92.

Cleaning Staff	£19.94
Maintenance / handyman staff (where directly employed by the home)	£7.66
Other staff (where directly employed by the home). E.g. Activity Co-ordinator	£7.79

STAFF ON-COSTS	**£78.64**
Avg Training Days	**2%**
Avg Holidays	**11%**
Employer's National Insurance on-cost, additional % uplift per hour	**8%**
Sick Pay on-cost, additional % uplift per hour	**2%**
Additional (maternity, pension etc)	**4%**
Total %age on-cost	***27%***

MANAGEMENT COSTS	**£20.83**
Average Manager Salary (weekly)	£14.96
Management Duties on shift	£5.87

NON STAFF COSTS	**£112.68**
Repairs & Maintenance of equipment and property	£12.81
Renewals of furnishings and equipment (e.g. furniture replacement)	£11.05
Leasing costs of equipment (e.g. laundry equipment)	£2.13
Food	£22.97
Utilities (energy, water, telephone)	£19.79
Maintenance / Handyman, Gardener (where externally sourced)	£1.41
Professional Services: Insurance, Legal Advice, Marketing/Advertising the home	£6.67
Medical supplies (including medical equipment rental)	£7.55
Cleaning supplies	£7.37
Waste collection and disposal	£2.44
Registration fees (including CQC registration, CRB checks)	£2.84
Recruitment and Training, where external fees need to be paid (e.g. for facilities hire, travel, and external trainer fees).	£6.46
Transport and activities (where a cost is incurred that is not self-funded by residents)	£2.19
Any other non-staff expenses (please provide detail)	£7.00
Centralised costs allocated to the home if part of a group	£0.00

FINANCE COSTS	**£22.24**
Average Annual Financing Costs per resident per week	£22.24

RETURN ON CAPITAL	**£61.64**
Average value of home (000's)	£1,419

RETURN ON OPERATIONS	**£94.75**

3. Dual-Registered Homes (average)

This cost calculation represents dual-registered homes. It is based on a sample size of 24, with an average home size of 46.1 beds.

The costs below include care for residents with and without dementia, and encompass all quality bands, plus care and nursing provision. Calculations are based on assumptions of:

Return on Capital: 7%
Return on Operations: 18%
Occupancy: 92% (42.4 beds[10])

AVERAGE TOTAL WEEKLY COST OF SAMPLE PER RESIDENT	£532.03

STAFF COSTS	£214.16
Care Assistants (No NVQ qualifications)	£42.30
Care Assistants (NVQ 2)	£36.38
Care Assistants (NVQ 3 or above)	£14.20
Senior Carers	£19.53
Nurses (RGN and RMN)	£48.08
Administration/Reception Staff	£5.29
Catering Staff	£18.29
Cleaning Staff	£16.99
Maintenance / handyman staff (where directly employed by the home)	£6.53
Other staff (where directly employed by the home). E.g. Activity Co-ordinator	£6.56

STAFF ON-COSTS	£54.13
Avg Training Days	**2%**
Avg Holidays	**11%**
Employer's National Insurance on-cost, additional % uplift per hour	**11%**
Sick Pay on-cost, additional % uplift per hour	**1%**
Additional (maternity, pension etc)	**1%**
Total %age on-cost	***25%***

MANAGEMENT COSTS	£20.83
Average Manager Salary (weekly)	£14.96
Management Duties on shift	£5.87

NON STAFF COSTS	£101.33
Repairs & Maintenance of equipment and property	£15.21
Renewals of furnishings and equipment (e.g. furniture replacement)	£11.07
Leasing costs of equipment (e.g. laundry equipment)	£1.12
Food	£17.78
Utilities (energy, water, telephone)	£19.27

[10] 46.1 x 0.92.

Maintenance / Handyman, Gardener (where externally sourced)	£1.33
Professional Services: Insurance, Legal Advice, Marketing/Advertising the home	£3.55
Medical supplies (including medical equipment rental)	£2.97
Cleaning supplies	£6.45
Waste collection and disposal	£3.18
Registration fees (including CQC registration, CRB checks)	£3.13
Recruitment and Training, where external fees need to be paid (e.g. for facilities hire, travel, and external trainer fees).	£1.90
Transport and activities (where a cost is incurred that is not self-funded by residents)	£1.16
Any other non-staff expenses (please provide detail)	£4.63
Centralised costs allocated to the home if part of a group	£8.59

FINANCE COSTS	**£22.24**
Average Annual Financing Costs per resident per week	£22.24

RETURN ON CAPITAL	**£45.07**
Average value of home (000's)	£1,419

RETURN ON OPERATIONS	**£74.28**

Appendix 4: Consideration of new Fee Models

1. Overall System

Further to the work undertaken to determine the appropriate fee levels for the current 5 band system, the commissioning strategies need to be considered to ensure the fee model is appropriate to the future needs of the Older Persons' care homes. In particular, there is an increasing need for the development and promotion of good quality dementia and end of life care.

1.1 Care Categories

Feedback from care providers indicates that the current 5 band system is well received and generally understood. However, it is noted that care homes in Band 1 have not had sufficient incentives to encourage movement towards and the attainment of the higher bands. To enable further work to be undertaken with homes that are at Band 1, it is proposed that the 5 band system is retained.

It is proposed that a project be initiated to provide specific focus on Band 1 care homes to improve their quality as the Council moves towards only commissioning care from Band 2 and above homes. This project would need to include targeted financial assistance and focused interventions by the Joint Commissioning Unit and the Nottinghamshire Partnership for Social Care Workforce Development.

Work is currently ongoing to ensure the objectives can be realised without destabilising the existing countywide provision.

1.2 Care Categories

The current care categories of Older Persons Residential Very Dependent Needs (VDN), Older Persons Residential Dementia (DE), Older Persons Nursing and Older Persons Nursing DE are understood and integrated into the Local Authority's systems. The legacy category of 'OP' currently remains, but since the inception of the Pinders model no additional residents have been placed in this category.

It is proposed that all remaining 'OP' care category residents (total of 3) be transferred to the VDN care category and 'OP' care category is removed.

It is proposed that the remaining 4 care categories are retained. However, further guidance on the application of the dementia care categories is required; addressed under section 2.

1.3 Environmental Factors

The Pinders model included consideration of the care home's physical environment. This assessment considered the space and facilities available to residents, and represents 30% of the overall quality score. Feedback indicates that some care homes that deliver high quality care cannot achieve Band 5 due to their environmental factors. Equally, some lower quality homes are inappropriately achieving higher fee bands for the same reason. Whilst the environment of the care

home has some impact on the quality of care, the current model is biased towards new and purpose built properties.

It is proposed that the environmental element be simplified and reduced to account for 20% of the overall quality score.

2. Dementia and Service Quality

Data collected since the implementation of the Pinders model indicates that, while some improvement has been noted, a large amount of dementia care is still provided by lower banded care homes. As Nottinghamshire is striving to ensure the provision of high quality dementia services, a number of proposals need to be given further consideration, as follow below.

2.1 Care Home Accreditation

To support and recognise the development and implementation of good quality dementia care it is proposed that a Care Home Accreditation Process is developed that will take account of:

o Environmental factors to support people with dementia
o Staffing, e.g. specialist training
o Application and thorough understanding of staff training
o Detailed outcomes for service users etc.
o Clear evidence of a person-centred approach which ensures safety, wellbeing and dignity of the residents
o End of Life Care for people with dementia

It is proposed that this accreditation process be introduced over a two to three year period. This time-span will allow for providers and home managers to be fully informed of the process and to make the required adjustments to working practices.

It is proposed that the fees paid to those care homes that either choose not to take part in or fail the accreditation process be maintained for existing residents but be restricted to the non-dementia rates for new placements.

It is proposed that the accreditation process be opened annually for existing homes and new entrants into the market. All relevant homes would need to be re-accredited on a rolling three yearly basis, with the specific outcome of retaining or losing their accreditation.

It is proposed that the Council work closely with the NCA to identify and deliver any additional support required to support the transition to accredited dementia services and, that this is supported by a robust action/project plan.

2.2 Dementia Placement Criteria

In addition to the Care Home Dementia Accreditation scheme, which will acknowledge and reward good quality dementia care as a general standard, it is also recognised that some residents with dementia, although not all, require additional

levels of support. This support is over and above that which can be provided under the VDN fee rate. These residents may require, for example, additional resources, staff contact time and/or staff with enhanced skills. It is for this group of people that the dementia enhanced payments would be paid, and not for all residents with dementia, as is the current situation.

It is proposed that a Dementia Placement Criteria is developed which will be used to determine individual's need for the enhanced payment. This Dementia Placement Criteria would take account of the Decision Support Tool used for determining eligibility for NHS Continuing Healthcare.

It is proposed that assessment staff, i.e. Social Workers, Community Care Officers, Reviewing Officers, are fully trained in the application of the Dementia Placement Criteria.

2.4 Beacon Homes

Consideration needs to be given to the proposal to create a 'Beacon Status' to a selection of homes where they are able to evidence the provision of the highest possible standards of care.

A limited number of 'Beacon' homes would be invited to demonstrate successes against a number of specific criteria. A Beacon Dementia home, for example, would need to be at Band 5, be accredited to provide dementia care and hold recognised national standards in the provision of dementia care. Upon accreditation, these homes would be expected to work in partnership with the Council to promote and support the delivery of best practice within the other care homes in their geographical location. The homes with 'Beacon Status' will be expected to share their achieved excellence in key areas, for example, dementia care and/or End of Life care.

An annual payment could be awarded to these homes to reward them for their work. It is proposed that specific criteria and reward programme be developed for the accrediting of a limited number of 'Beacon Status' homes.

Appendix 5: National and regional fee comparator data

Table 15: Care-Only (without dementia) Fee Levels, 2012, as reported by Laing and Buisson

	Res Elderly £/wk		Res Elderly £/wk
Authority	**MIN**	**Authority**	**MAX**
Islington	£748.70	Essex	£1,082.00
Southwark	£488.64	Richmond upon Thames	£936.00
Camden	£480.00	Lewisham	£868.82
City of London	£480.00	Windsor & Maidenhead	£800.00
Hounslow	£460.00	Bath & North East Somerset	£800.00
Wandsworth	£450.00	Wokingham	£685.00
Hackney	£449.82	Islington	£623.54
Luton	£449.00	Wandsworth	£588.00
Havering	£448.80	Croydon	£569.06
Wokingham	£447.43	City of London	£520.00
Central Bedfordshire	£438.64	Hackney	£515.10
Bexley	£434.86	Bromley	£515.00
Bedford	£429.87	Buckinghamshire	£509.78
Bath & North East Somerset	£425.00	**Nottinghamshire Proposed**	**£505.00**
Merton	£423.10	Southwark	£500.44
Northumberland Care Trust	£419.08	Suffolk	£497.00
Middlesbrough	£417.00	Somerset	£495.65
Hertfordshire	£416.71	Central Bedfordshire	£480.00
Lambeth	£414.00	Camden	£480.00
Wakefield	£402.00	North Somerset	£477.88
Greenwich	£400.00	Dorset	£476.00
North Somerset	£398.08	Bournemouth	£474.00
Sunderland	£394.80	Bedford	£470.40
Doncaster	£394.66	**Nottinghamshire Current**	**£469.00**
Southend on Sea	£387.24	Redcar & Cleveland	£468.00
Redcar & Cleveland	£385.00	Bracknell Forest	£466.15
Hartlepool	£384.00	Northumberland Care Trust	£466.14
Nottinghamshire Proposed	**£384.00**	Hammersmith & Fulham	£466.00
Devon	£381.00	Westminster	£466.00
Derbyshire	£380.73	Ealing	£466.00
Lewisham	£380.51	Harrow	£466.00
North Tyneside	£379.62	Hounslow	£466.00
Cheshire East	£376.73	Hillingdon	£464.95
Knowsley	£375.34	Barking & Dagenham	£463.00
Salford	£373.52	Brighton & Hove	£460.00
Trafford	£373.30	Middlesbrough	£457.00
Swindon	£372.74	Sunderland	£456.10
Herefordshire	£372.70	Newham	£454.50
Coventry	£371.00	Havering	£453.20
Dudley	£371.00	Merton	£453.10
North Yorkshire	£365.61	Brent	£451.00
Calderdale	£361.92	Greenwich	£450.00
Norfolk	£361.58	West Berkshire	£450.00
Bury	£360.89	Luton	£449.00
Wolverhampton	£360.87	Hertfordshire	£447.86
Stockton on Tees	£360.00	North Tyneside	£446.77
Solihull Care Trust	£360.00	Stockport	£446.00

Suffolk	£359.00
Barnsley	£358.55
Rutland	£357.00
Darlington	£356.00
Cumbria	£354.00
Sheffield	£353.00
Gloucestershire	£351.80
Liverpool	£350.40
Windsor & Maidenhead	£349.47
Nottinghamshire Current	**£348.00**
Dorset	£347.00
Cambridgeshire	£345.00
Blackburn with Darwen	£344.00
Stockport	£340.00
Warrington	£340.00
Nottingham City	£339.00
Somerset	£334.46
Kent	£333.59
Birmingham	£333.22
Lancashire	£312.00
Leicestershire	£311.00
Essex	£311.00
Brighton & Hove	£302.40
Kingston upon Hull	£298.50
Southampton	£285.11
Wigan	£283.23
Shropshire	£275.15
Bournemouth	£275.00
West Sussex	£274.89
Richmond upon Thames	£274.00

Darlington	£443.00
Gloucestershire	£442.60
Hartlepool	£442.00
Leicestershire	£437.00
Nottingham City	£433.00
Southend on Sea	£430.43
West Sussex	£430.02
South	£429.00
Milton Keynes	£424.20
Stockton on Tees	£424.00
Poole	£422.00
Lancashire	£420.50
Sutton	£415.00
Devon	£415.00
Southampton	£414.12
Blackburn with Darwen	£410.50
Derby	£407.58
Trafford	£406.44
Cumbria	£406.00
Bury	£403.01
Wakefield	£402.00
Derbyshire	£401.73
Doncaster	£401.21
Herefordshire	£400.00
Coventry	£396.00
Swindon	£393.14
Sheffield	£391.00
Bristol	£390.00
Cornwall	£390.00
Dudley	£389.00
Barnsley	£388.13
Peterborough PCT	£387.03
Knowsley	£385.14
Bradford	£384.09
Warrington	£384.00
Salford	£382.86
Lambeth	£382.50
Rutland	£382.00
Worcestershire	£382.00
Rotherham	£381.00
Calderdale	£380.22
Rochdale	£380.00
Shropshire	£373.81
Norfolk	£373.70
Wigan	£373.17
Wolverhampton	£372.09
Solihull Care Trust	£372.00
Northamptonshire	£367.70
Oldham	£367.50
Birmingham	£367.18
Medway	£367.13
Cambridgeshire	£366.00
North Yorkshire	£365.61
Walsall	£362.47

Portsmouth	£356.72
Liverpool	£350.40
Kent	£348.01
Kingston upon Hull	£330.50

Table 16: Care with Nursing (without dementia) Fee Levels, 2012, as reported by Laing and Buisson

Authority	Nursing With FNC - Min	Authority	Nursing With FNC - Max
City of London	£858.15	Windsor & Maidenhead	£1,750.00
Wandsworth	£723.70	Bath & North East Somerset	£1,308.70
Bexley	£694.06	Essex	£1,299.40
Luton	£680.40	Richmond upon Thames	£1,024.70
Merton	£664.16	Lewisham	£946.65
Cheshire East	£650.47	Croydon	£900.81
Bath & North East Somerset	£644.70	Wokingham	£900.00
Lewisham	£636.63	City of London	£898.15
Northumberland Care Trust	£636.48	Newham	£824.40
Trafford	£631.86	Wandsworth	£823.70
Southampton	£631.52	Bromley	£808.70
Knowsley	£629.71	Hillingdon	£735.02
Hackney	£624.03	Ealing	£724.70
Southwark	£612.33	Harrow	£724.70
North Yorkshire	£611.22	Bexley	£717.51
Wokingham	£606.00	Brent	£716.70
Southend on Sea	£604.64	Suffolk	£714.40
Hartlepool	£601.40	Hackney	£699.28
Suffolk	£600.40	Merton	£694.16
Coventry	£597.70	Barking & Dagenham	£693.70
Salford	£590.92	Dorset	£693.40
Blackburn with Darwen	£590.70	Bournemouth	£691.40
North Somerset	£588.18	Poole	£685.40
Bury	£578.29	Sutton	£684.40
Darlington	£573.40	Northumberland Care Trust	£683.54
Central Bedfordshire	£565.46	Luton	£680.40
Hounslow	£565.00	Southampton	£680.24
Bedford	£556.32	Middlesbrough	£679.40
Camden	£550.00	Herefordshire	£668.70
Greenwich	£550.00	**Nottinghamshire Proposed**	**£662.70**
Devon	£543.70	Blackburn with Darwen	£661.70
Doncaster	£543.37	Darlington	£660.40
Essex	£539.40	Hartlepool	£659.40
Kent	£533.71	Doncaster	£658.01
Solihull Care Trust	£532.70	Portsmouth	£656.94
Gloucestershire	£531.80	Southend on Sea	£647.83
Hertfordshire	£530.03	Knowsley	£641.12
Brighton & Hove	£529.62	Trafford	£636.86
Windsor & Maidenhead	£528.37	North Somerset	£634.77
Middlesbrough	£525.70	Coventry	£626.70
Nottinghamshire Proposed	**£522.70**	Cornwall	£625.40
Herefordshire	£522.00	**Nottinghamshire Current**	**£624.70**

Lambeth	£513.00
Wakefield	£510.70
Stockport	£508.70
Sunderland	£503.50
Derbyshire	£501.33
North Tyneside	£500.59
Sheffield	£499.70
Warrington	£495.70
Richmond upon Thames	£485.70
Calderdale	£484.84
Swindon	£484.79
Nottinghamshire Current	**£484.70**
Norfolk	£484.22
Cambridgeshire	£484.00
Dudley	£480.00
Havering	£478.38
Birmingham	£472.70
Lancashire	£472.50
Stockton on Tees	£468.70
Barnsley	£467.25
Islington	£465.89
Wolverhampton	£459.45
Liverpool	£459.10
Nottingham City	£447.70
Wigan	£431.37
Shropshire	£425.62
Kingston upon Hull	£407.20
Redcar & Cleveland	£385.00

Southwark	£624.13
Bury	£620.41
Hammersmith & Fulham	£616.00
Westminster	£616.00
Hounslow	£616.00
Brighton & Hove	£614.56
Northamptonshire	£614.07
Buckinghamshire	£612.50
North Yorkshire	£611.22
Central Bedfordshire	£608.70
Bracknell Forest	£601.64
Salford	£600.26
Camden	£600.00
Greenwich	£600.00
West Berkshire	£600.00
Bedford	£598.70
Rochdale	£597.40
Havering	£591.77
Oldham	£584.90
Stockport	£584.70
Kent	£584.17
Redcar & Cleveland	£576.70
Nottingham City	£573.70
Hertfordshire	£572.52
North Tyneside	£571.45
Milton Keynes	£569.46
Sunderland	£564.80
West Sussex	£564.62
Medway	£562.16
Bradford	£559.09
Devon	£558.70
South	£551.70
Somerset	£550.54
Lancashire	£550.00
Solihull Care Trust	£545.70
Swindon	£542.13
Gloucestershire	£539.75
Cumbria	£539.70
Cambridgeshire	£538.00
Warrington	£536.70
Lambeth	£535.50
Stockton on Tees	£532.70
Bristol	£527.70
Derby	£527.28
Rutland	£523.70
Derbyshire	£522.33
Sheffield	£517.70
Peterborough PCT	£516.39
Shropshire	£515.84
Wakefield	£510.70
Barnsley	£508.15
Dudley	£508.00
Worcestershire	£506.70
Rotherham	£505.70

Birmingham	£504.53
Calderdale	£504.18
Norfolk	£495.63
Leicestershire	£490.70
Wigan	£482.22
Walsall	£479.51
Wolverhampton	£471.65
Liverpool	£459.10
Kingston upon Hull	£439.20
Islington	£356.81

Appendix 6: Glossary of Terms

Care Homes: (Also referred to as Care-Only) Care Homes providing personal care only to older people including those, where admitted, with dementia.

Care Homes with Nursing: Care Homes providing nursing care to older people including those, where admitted, with dementia.

CHC: Continuing Health Care. This is funded by the NHS to support residents assessed as having eligible health needs.

Dual-Registered Homes: Care homes providing both personal and nursing care to older people including those, where admitted, with dementia.

Environmental Factors: A quantitative assessment of the fabric of the care home, which includes consideration of the bedroom sizes and facilities, and the size of communal space available to each resident.

Finance Costs: The annual finance costs incurred by the care home - i.e. the cost of borrowing the money used to fund investment into the care home.

FNC: NHS Funded Nursing Care. The NHS contribution to cover the costs of providing nursing care, which is currently £108.70.

NCA: Nottinghamshire Care Association. NCA is a not-for-profit organisation that represents its membership of independent care homes throughout Nottinghamshire.

Occupancy: The percentage of the total number of beds that are in use at any one time.

Quality Bands: Nottinghamshire County Council currently assesses the quality of care homes and homes are placed into one of five quality 'bands', where '1' is the lowest quality, and '5' is the highest quality.

Return on capital: The Return on Capital is a measure of the expected annual return (profit) generated by an Operator when making a significant capital investment into the purchase, construction or refurbishment of a care home.

Return on Operations: The Return on Operations is a measure of the expected return (profit) generated on day-to-day expenditure, i.e. the turnover of the care home.

Staff On-Costs: Staffing Costs which are not included in the hourly wage rate. For example National Insurance, Sickness, Training, and 'other' costs such as maternity leave.

Appendix C

Local 'Fair Price for Care' Stage 2 Consultation Questions

Analysis and Comment on Provider Responses

Questions 1 and 2

The proposed fee levels take in to account the actual costs, as reported in the Provider Survey, of operating care homes within Nottinghamshire, with a proposed annual inflationary uplift.

1. Please explain how the proposals would affect your returns on capital / operations?

2. Please explain what effect, if any, the proposals would have on your staffing levels, and on any other aspect of your business which has a direct impact on the quality of your care provision.

Question 1

The responses received from providers are detailed in full, as follows:

- If we had to rely on NCC funded clients only at the proposed prices we would not be viable

- Increased fees as outlined in the proposal will do no more than enable us to keep up with rising costs. We do not anticipate returns on capital or operations to be greatly affected. We are however more concerned about the NCC policy of reducing placements into residential care and the subsequent reduction in occupancy levels. This would have a major negative affect on returns

- If the inflationary index happens this must be a great thing for all parties

- The proposals represent an increase of 7% and the additional income will enable further investment into the home

- Slightly improve, taking into account current levels of R&M, but excluding extraordinary costs

- The proposed fee levels are short of reasonable reflect of a return on capital employed. The proposed levels do not suitably reflect a return on an investment for the risk profile of running a nursing Home.
  The considerations of the local authority of forgotten many important factors when considering their pricing.
  The fee levels may result in non viable business model.

- Positively: a contractual inflationary uplift, on actual costs not RPI, will provide more certainty. The proposal also indicates an overall increase in fees which is positive. Negatively: the calculated price is still too low. We would still

require higher self funding fees and top ups to try to make up the difference, and since that is not always possible investment in the home does suffer.

- [Name of provider] welcomes the opportunity to comment on the proposal provided by Nottinghamshire County Council, which reflects a sensible and pragmatic approach to fee negotiations.
  However, based on the information provided, and from discussions at your recent provider forums, we have concerns about the basis of your calculations. In your proposal, you allow a return on capital, of 7%, which is derived from an understanding that the capital cost of investment is £35k per bed (£1.4m for 40 beds). This cost is not realistic, with industry standards, as reflected through Laing and Buisson, suggesting capital costs of at least £55k per bed, considerably (%) higher than your expected cost.
  A return on capital of closer to 10%, based on this cost of capital is required for operators to meet the cost of financing such an asset, as well as ensuring that sufficient profit is made to enable investment in the care home, to enable quality.

- The model assumes occupancy of 92% yet in March 2011 as stated occupancy was on average 88.8% in nursing homes and 86.1% in care homes. The proposal is based that on the East Midlands data from Laing and Buisson and not Nottinghamshire which begs the question why? And it's on March 2011 rather than 2012 data. This is Based on the information collated from the homes which took part in the 'fair price' exercise occupancy was on average 83%.

  Aside from the crux of their argument is that Nottinghamshire is above the industry norm in terms of the no. of payroll hours per resident per week. The proposal indicates an average for care home 15% above the norm so they will reduce the average costs provided by 7.5% and for a care home with nursing the reduction is 10% but the proposal does not show what % it is above the norm. We understand that the proposal is saying that CHC residents obviously are more dependent and thus skew the payroll. The overall effect would mean we will not meet the capital return on the homes

- The proposed fees would still be too low to provide an adequate return on capital/operations. Further details are given in the remaining questions

- Personally I don't feel the proposed fee level will provide the RoC to the extent that is claimed as an average of 92% occupancy seems unrealistic for non purpose built homes like mine. However it is definitely good progress on what is currently achievable

- Increased fee levels will help maintain returns as they will offset ongoing increases in staffing and other costs

- The proposed fee levels do not take into account actual costs. The occupancy levels of 92% is not from actual costs. The staffing hours have not been taken from the actual figures, in fact they have been substantially reduced. The capital costs of purchasing and setting up a care home has been inaccurately underestimated.

Your proposals drastically affect the return on capital and operation costs and hence puts my business at risk. Your proposal hugely underestimates the capital cost, in the current market Care Homes meeting national minimum standards are costing at £65,000 per bed. Banks base their funding levels on these figures and hence this could potentially destabilise a Care Home and ultimately destabilise the care home market. This destabilisation will affect the vulnerable elderly residents directly by affecting the quality of service they receive.
The base line fee has been calculated incorrectly with a lot of assumptions so ultimately the capital and operational costs will be a lot lower.

- [Name of provider] have significant financial commitments in TUPE costs, staff training and capital investment in improving and extending the homes. The proposals will ensure that we continue to meet these commitments.

- As discussed at the meeting on 11th September at Notts Forest Football Ground it was explained by Peter Barker KMPG that the staffing costs given in the Provider responses were collated and averaged to ascertain a fair cost, which was stated to represent 69% of operating costs for Care Homes. We were informed that Providers responses with higher staffing costs were not taken in to account in the calculations. The actual average costs for staffing collated from the Provider survey were reduced by a further 10 % to take in to account CHC funded residents and Dual Registered Homes data. It is unfair to reduce these figures by 10%, for the following reasons:

  The report stated that they have excluded data from Nursing Homes that had more than 40% CHC provision, as they took the view that this would have distorted the figures. Therefore, it appears that they included the remaining data provided by Nursing homes with less than 40% CHC residents. Therefore, as they have excluded the 40% CHC provision homes, it can not be justified that a further 10% reduction has been applied.

  At the meeting it was acknowledged by Caroline Baria that residents with Residential needs would continue to be supported in their own homes provided it was practical and safe to do so. Therefore, residents entering Care homes are by definition requiring a significant level of care. Furthermore, residents admitted to Dual Registered/Nursing homes, who may at the outset have been assessed as having Residential needs and are being funded on this basis, can quickly deteriorate and develop health care needs requiring a reassessment to Nursing. The Dual Registered/Nursing homes have to meet the needs of these residents whilst awaiting the reassessment process to be completed, this involves significant input from the home's own Registered Nurses in terms of monitoring/assessing/ and liaising with the District Nursing teams to ensure that the District Nurses are fully informed with regard to the nursing procedures required by them, monitoring the resident until the assessment process is completed. This process takes several weeks dependant on the workloads of Nursing Assessor's and then further time is expended before we receive the uprated Nursing fees. There is usually an exchange of views with regard to the backdating of payments to either the date of referral or the date of the assessment visit, which can vary from resident to resident. In addition, the assessment criteria for a review from Residential to Nursing status can frequently change and residents can still be

reviewed to remain as Residential but in fact require a significant amount of input from Registered Nurses in terms of monitoring/assessing etc which can not be undertaken by Care staff alone as it would be unsafe to do so. Therefore, it is unfair to disregard the staffing costs of Registered Nurses in the care of Residential residents in Dual Registered Homes.

It is unfair to totally disregard Care homes whose staffing costs are higher than the average figure taken from the Survey responses. Our own staffing costs are 12% above this average with 2% CHC residents. We regard that it is of paramount importance that the needs of residents are fully met in all aspects of their care and life in a Care home. Therefore, the staffing costs related to meeting these requirements by residents have to be addressed and maintained rather than not doing so in order to adhere to "industry norms".

- Broadly unchanged

- The first point to make is that 'actual' costs as reported in the survey do not tally up with mine – they are underestimated by a factor of about 20/25% because the 'actual' costs are underestimated and therefore the actual care shown is 'reduced' by real level of return is much lower than claimed in your document.

  The inflationary uplift is welcomed but again, if you start at the wrong point you will never get to the correct position again. From my discussions with other providers it also seems clear that the increase will be approx 1 year in arrears?

- The proposed fee structure does not fully cover our costs. Therefore we will continue to need to request a top up to meet costs. At the proposed social services fee level there will be no profit.
  The proposals do not reasonably take into account actual costs. Due to the cherry picking of numbers the proposal significantly, and dangerously, underestimates the full costs reported, and incurred by local Nottinghamshire homes both now and in the future, this will lead to a serious risk that the fee level proposed will not to cover resident's needs - putting residents, providers and staff at risk

- I find it hard to see how NCC has taken into account the actual costs when NCC has 'cherry picked' the figures it wants to use. In Oct 2012, the National Minimum Wage increases by 1.8% and from May 2014, my organisation will have to pay a minimum of 3% each employee's pay towards a pension fund- some larger organisations will be affected sooner i.e. Oct 2012. Your proposal does not appear have taken these factors into consideration.

  My organisation currently has staffing levels over the norm and certainly exceeding the old staffing levels. As wage costs are our highest expense we will have no alternative but to reduce staffing and suffer the consequence to quality of care provision.

  The Paper talks about challenging inefficiencies, but it fails to identify what these are. The paper talks about a new provider buying 6 local authority homes suggesting this indicates a stable market. These homes were not

bought at the normal market rate but at a much reduced rate to compensate the high wages paid by local authority to their staff.

The paper talks about significant financial and staffing investment being made by NCC to increase quality and to support lower banding homes. This may have been the case but where is this support and additional resource for 2012/13. Also the impact of this significant investment has been ineffective as still 76% of those people supported financially by NCC are in Bands 1 and 2 homes.

The use of occupancy level of 92% is unfair if the average amongst homes surveyed was 83% - is this NCC addressing inefficiencies?
Your paper suggests that Care homes with nursing taking in continuing care clients had higher figures because of the CHC. My home has CHC clients but I excluded their costs from my figures – still my figures remain high due to the number of people with nursing dementia needs and the high levels of staff required. The cost of our organisation providing nursing care (not CHC) in my home is £664 per week as opposed the NCC figure of £597.75. How did banding of home affect the costs? How did type of service provided affect cost? I am not confident NCC have explored or understood this i.e. bullet point at top of page 7.

If I reduce our staffing levels there will be an increase in safeguarding incidents, staff turnover will increase, the quality of our service will decrease.
My family have owned our care home for the past 23 years and all surplus/profit has always been ploughed back into the business. NCC's fee contribution has not increased in line with inflation for a number of years and the only way we have been able to maintain our high quality service has been by not taking any money (including Director's drawings) out of the business. In the last year we extended and refurbished the home – at a review by the Bank we were criticised for failing to achieve the Bank's expected return (profit). This was due to the high expenditure associated with providing quality care to our specific client group.

In addition to the above, the NCA provided a response to this question as follows -

- Some of the statements and questions you are consulting on are misleading. Question 1 states " The proposed fee level take into account the actual costs..." which most people would take as the actual cost not the actual costs reduced by:
  - artificially increasing occupancy levels so reducing costs
  - reducing the stated average number of hours by about 15 to 20% (table 2)
  - reducing the non care hours
  - artificially low capital costs

- Due to the cherry picking of numbers the proposal significantly, and dangerously, underestimates the full costs reported, and incurred by local Nottinghamshire homes both now and in the future, this will lead to a serious risk that the fee level proposed will not to cover residents needs - putting residents, providers and staff at risk.

Question 2

The responses received from providers are detailed in full, as follows:

- We would not change staffing levels but would reduce the number of NCC clients we could fund. We do not feel that a care home can meet the regulations on staffing by providing 20.5 hours of care staff and 6 hour of non-care staff per week. This a total of 26.5 hours and our comparative figure is 34 hours per week. The number of nursing hours per resident is about right.

- Staffing levels would remain static as we already maintain good levels. Quality of care would remain as-is, as we already provide good quality care. Any costs should not impact on Residents' quality of care.

- As outlined above. We do not envisage extra resources being generated by the proposals. [Name of provider] will continue to increase quality of care provision but not as a result of these proposals

- The proposals would have no effect on staffing levels or any aspect of the business which has a direct impact on the quality of care provision since we already invest in these areas. If due to increasing needs of the residents additional staff is needed, the additional income of 7% would assist fund this.

- None as we would not let anything effect the levels of care we aim always to provide.

- The staffing will certainly have to be scrutinised carefully as the fee levels are not sufficient to provide a return for the risk in involved in running a business.
  In addition where cost pressures will also become apparent will be the investment capital available to invest in training and development of staff.
  If restrictions of staff development are necessary this can only impact in poorer care standards.

- I cannot understand why you have cut the 'actual staffing costs' as reported by the homes. The Laing & Buisson is a model of a 50 bed 'efficient operator', not an industry norm. We all know what happened to this 'efficient operator' last year, when they couldn't keep up their rental payments.

  The reality is that there are very little efficiencies in respect of care and nurse staff in larger homes. You have essentially told the sector to reduce staffing by 7.5%. Since you can't reduce your wages (and many are still on minimum wage) that could only mean a reduction in actual staffing hours. However, that is not possible either as we have a duty to provide enough staff to maintain safe and dignified care.

  The fee does not allow for expansion or reinvestment. That would still have to be funded out of self funding clients and additional top ups.

- It is clear from discussion that your proposals expect providers to decrease current staffing levels, at a time when client groups, Care Quality Commission and our own internal observations require us to increase staffing levels.

From discussion, and review of the proposal, we understand that the proposal expects providers to reduce staffing levels by c 7.5%, from a level as stated in your proposal, which we believe is already inappropriate.

Table 2 within your proposal states that the average number of hours provided per person per week, in a "care home", is 34.0 – rising to 49.7 hours per week in a home with Nursing and Dementia residents. L&B have stated that for Care Homes with a nursing client group, 28 hours of Care / Nursing staff are required per resident, per week. From discussion, your proposal involves a 7.5% reduction to 21 hours per week of care per resident – which is in direct contrast to resident needs.

As a consequent, at this stage we do not expect the proposal to have a direct effect on staffing levels, as [name of provider] homes in the Nottinghamshire CC region are staffed to ratios expected by CQC, are in line with levels expected by those commissioning services from us and are arranged to support and protect our users.

- [Name of provider] work with safe staffing levels, care provision on the basis of needs of the residents in our care. The impact of the proposal may lead to a review of our current process of assessing non care roles within our homes. Our care practitioners provision will be always be needs led, any requirements of individual residents will be presented to local authorities at pre-admission assessment stage.

- As a charity providing elderly residential care, we always put the well being of our residents first and provide staffing levels in line with assessed care requirement of the individuals.

- Currently, under difficult economic conditions staff retention is somewhat easier as other employment options available to staff are reduced, however once this starts to change it becomes more difficult to retain good staff. The proposal will help retain a proportion of staff by increasing their salary to some extent and provide a few additional hours in care and entertainment.

- Retention of staff will be improved and continuity of care will maintain the necessary standards.

- The proposal underestimates significantly the staffing levels both care and non care. The proposed staffing levels are very much on the lower level and this could endanger my service users and put them at huge risk. The service users coming into care have higher needs then ever before and hence staffing levels have to reflect their needs.

  No provider puts on additional staff unnecessarily as this is the biggest cost that hits care home providers. I believe this proposal will put the service users at huge risk and without doubt will increase safeguarding cases in Nottinghamshire.

- We provide care for service users with varying dependency levels, these dependency levels are ever increasing with the increase in the populations age and increase in service users living with dementia. Staff levels are

reviewed periodically to ensure we continue to meet the needs of the service users in terms of both staffing levels and also staff skill sets. The proposed fee increases will enable the group to continue to invest in staff training and development to ensure they are properly skilled.

- The proposals would not cover staff costs, when staffing levels are determined by service users dependency levels

- Our staffing costs are 12% above the average figure identified from the Provider Survey. This includes 2% CHC funded residents. Therefore at the very minimum, the data for staffing costs provided from the responses should be included without the 10% reduction. These proposals will necessitate the requirement for a review of our staffing levels overall. However, I trust that the feedback provided from this exercise from Providers, will be well received and taken in to account.

- We believe that in order to attain high standards of care, maintaining the correct levels and skill mix of the staff is an absolute priority. If financial pressures are experienced they would always be absorbed in other areas, wage inflation in the sector is anticipated to increase above national averages as the private sector attempts to catch up with the public sector.

- There is an extremely serious risk that unless we can manage to get 'top-ups' from families the proposals would reduce the level of care provided - staff costs are such an important factor in these discussions – it is something the report should drive to get right and I do not think it is at the moment.

- At the hours proposed we would have to drastically reduce our staffing levels leading to residents not having their needs met. The proposed management costs are half of what is needed. Your proposal dangerously underestimates the level of care and on-care staffing hours required. If we follow your proposal this will lead to serious risk that residents will not have their needs met leading to poor care, safeguarding issues etc.

- As stated above when I completed the questionnaire I calculated costs by removing those with CHC funding and calculating their additional costs. To have fees as proposed by NCC would leave me no option to reduce staffing levels even though there would be a significant negative impact on the quality of care/service we could then offer. If I reduce our staffing levels there will be an increase in safeguarding incidents, staff turnover will increase, the quality of our service will decrease.

  Forthcoming additional costs e.g. National Minimum Wage and Pension contributions would exacerbate the need for me to reduce our staffing to reduce expenditure as staffing is our highest cost.

In addition to the above, the NCA provided a response to this question as follows -

- Your proposal dangerously underestimates the level of care staffing hours required. If providers follow your proposal this will lead to serious risk that residents will not have their needs met.

NCA propose that you use the information used to populate Table 2 to calculate a fair price, that the hours used are no less than in Table 2

Comparing to "L & B industry norms" is misleading and inaccurate. The figures you refer to are for large corporate homes, Southern Cross was a source of data!!. Cherry picking this number but ignoring the other higher costs that Corporate homes incur would mean that smaller non corporate homes will be under funded – leading to the risk that residents will not have their needs met.

Summary of Responses to Question 1 and 2:

Three providers indicated that the proposals would improve their returns on capital / operations. A further three providers said that returns would be broadly unchanged. One provider responded that the inflationary index would be a great thing. No response was provided by one provider.

Nine providers indicated that the proposals would have no impact on staffing levels, and or on any other aspect of your business which has a direct impact on the quality of care.

The Council's analysis and comments in relation to providers' responses to Questions 1 and 2:

Many of the responses received show that providers have a different view on the assumptions contained within the proposed fee model. It is important to note that the fee proposals are derived from the analysis of a wide range of data reflecting both what the market has stated in the provider survey and in relation to other local data on historic and current capacity and levels of provision within the market.

The use of averages means that the resulting proposals are based upon data reflecting a wide variety of providers and individual care homes across Nottinghamshire. The model upon which this is based and related assumptions (i.e. on occupancy, staffing levels and returns) should therefore not be taken as the recommended operating model for all care homes. In the management of their business, it is ultimately decision of each provider to balance risk and levels of return, taking in to account not just the Council's fee levels but also all other relevant factors specific to the home such as occupancy levels and competition from other providers locally, levels of borrowing, their management ethos, objectives, etc.

Specific comments to the responses are:

a The following evidence demonstrates that the current fee levels for 2012/13 are not a barrier or disincentive for new and existing providers to invest in older persons care homes in Nottinghamshire:
   - Over the past four years, a total of 52 homes have upgraded their premises and a further 14 homes have built extensions to their properties leading to improved environmental standards. Providers have commented that the improvements have been made to the fabric of their buildings as a direct result of the local Fair Price for Care initiative
   - There is also evidence that new providers are entering in to the local market, with 5 new homes opening in Nottinghamshire during 2011/12,

offering a total of 272 beds. A further 3 new homes are currently under construction and are due to open during 2013

- Additionally, in March 2012, the County Council completed the sale of six of its own older persons' care homes to a provider who entered the Nottinghamshire market for the first time. The provider has already undertaken building works to increase the bed capacity of three of the homes by a further 64 beds and work is underway to extend the number of bedrooms on a fourth home by a further 17
- Over the same four year period, 13 homes (a total of 263 beds) have closed. In the main. the reasons for closures have been poor quality of provision and low occupancy levels making the homes financially unviable
- Whilst the number of homes in Nottinghamshire in recent years has generally been level, the number of available beds in older persons' care homes has gradually increased.

b The Council has been clear with providers regarding its strategic intention to support a greater number of service users to live independently in their own homes for as long as possible thereby seeking to reduce the numbers of long term placements into residential care.

c With regard to return on capital, responses to the provider survey showed an expected average of 7%, which matches other data sources (e.g. the 7% return on accommodation applied by Laing & Buisson). The survey questionnaire also sough information on the home value, for which the average was £1.4m for Nottinghamshire homes in current condition. These figures are both averages of all Nottinghamshire homes responding to the survey and were used to derive the amount allocated for return on capital within the average cost structures used to inform the fee proposals. It should be noted that the average cost structures also contain a separate line for finance costs, in addition to a return on capital, and taken together these would equate to around a 10% return.

d Any changes to National Minimum Wage should be reflected in the proposed inflation index.

e Costs arising from future pension contributions increases are not reflected in the current model. It would be reasonable to expect providers to absorb these costs in line with many other businesses.

f The assumptions on staffing levels have been reviewed and higher levels of staffing taken in to account as a result of the feedback from providers and in consideration of the latest national data from Laing & Buisson in their 2012 survey. The proposed fee levels reflect a higher staffing levels than those identified in the consultation document.

Question 3

The Provider Survey responses show that on average Providers expectation on rates of return are 18% on Operations, and 7% on Capital.

What level of return is needed to make a care home business viable?

The responses received from providers are detailed in full, as follows:

- We would need 22% on your cost levels. We do not expect any more than 7% but 15% is required

- Improved Rate of Return would obviously be more beneficial. 20% - 8%

- If you define viable as possible 18% and 7% returns are appropriate. If you define viable as a worthwhile business investment you need 25% and 12% (in our opinion). We have concerns that the question asked for "expectation" rather than "needed to increase or maintain quality".

- A return of 18% on Operations (after rent/mortgage costs) is adequate to make a care home business viable, however the return before finance costs depends on how the home is financed. Homes operated on a leasehold model where rent is paid to the owner of the freehold generally have higher finance costs so require a higher return on operations. A care home business operated on a leasehold basis is generally only cash neutral at occupancy in excess of 90%.

- Don't know, as everyone's costs and expectations are different

- The question raised is a generic one. Each business will have its own unique cost of capital and also its own risk profile. Returns on capital can only be set based on the specific risk profile of the business. The higher the risk the greater requirement for a higher rate of return. We would expect a minimum rate of return of 10% for our risk profile.

- I believe L&B worked out that the market return is 21% and 7%, so you are slightly out of the market expectation. But that is not the only part of the equation. The Market Value is equally important and if you assume £34k per bed, then you do not allow for costs of new homes. Our homes are not new and I would expect the value to be over £40k per bed. We rent of these buildings and based £34 k per bed, the 7% is not enough to pay the rent. That means that the 18% operating profit is reduced as the rent will take some of this. Since our full head office costs at ca 5% of the fee is not covered either, the operating profit is further reduced.

- Like other providers we have had discussions with, we would have concern operating with a 7% return on Capital. We would expect to achieve a return on Operations, before the allocation of central costs, rent, or financing of c27%. After allocation of such costs, we would expect a net return of 15%. We understand that Laing and Buisson research indicates a return on Capital of 11%, for corporate groups, and 14% for independents, in addition to a

return on Operations, or Gross Profit Margin of c 25%. To ensure and retain capital expenditure programmes, which for 2012 in [name of provider] Care's case alone amounts to 7% of turnover, a return on capital in the region of 11% makes the business viable.

- 12% Capital; 25% Operations

- In theory the percentage figures are adequate to provide a return. However the base costs that you have applied the figures to are inadequate so the calculated fee is too low to support a viable business.

  The capital element is significantly understated. You have based it on a cost of £1.42m. Based on the average number of beds across all homes in the survey of 39.7 this is approximately £36k per bed. Build costs of care homes to meet current minimum standards would be in the region of £70-£80k per bed.

  Food costs are also too low. Laing & Buisson propose £26 per resident in their 2011 update of the Fair Price for Care report while you are quoting £21.22 for care only and £22.97 for nursing. This impacts the return on operations calculation.

- Laing & Buisson cost of capital per resident per week is £194 for care only (proposed in this model £120) and £198 for nursing (proposed £150). This would be a significant shortfall

- My calculation has always been 20% on operations and 10% on capital

- 7% on capital is insufficient given the risk levels involved. A level of 12% is more realistic. 18% return on operations should be in the region of 20-25%.

- It is important to get the capital cost per bed correct, your report suggests £35,000 per bed but the actual market is showing £65,000 plus per bed. It is important that you get these figures correct by obtaining advice from an independent valuation company. To make a care home viable the real cost of care has to be paid for individuals.

  Your proposal is misleading because the industry percentages from L & B have been used but because you are basing these on incorrect figures then these are not actual returns as stated above. This could potentially destabilise the care home market because care homes will be at risk of closure or financial unstability.

- [Name of provider] aim is to ensure that we provide care to the highest standards with high levels of occupancy. We ensure our business plan allows the group to continue to expand and develop whilst meeting the expectations of stakeholders. We would agree that the rates of return shown in the provider survey are consistent with a viable care home business.

- I am not professionally qualified to give information in this regard.

- As a general rule banking and financial institutions look for a minimum of 20% return (capital + operation) on existing business and a considerably higher figure for people coming fresh to the sector, the identified average therefore seems appropriate.

- Your proposal under estimates our capital costs and our operational cost. We would expect at least a 21% and 7% respectively: Based on our real costs. The proposal has set operational costs well below safe and actual levels thus reducing the return. We estimate that your capital cost estimate is about 60% of what it should be. Your estimate of operational costs is significantly below actual.

  We are aware that the NCA propose that you obtain independent valuations of the costs of replacing current providers buildings and plant. Because the return on operations is based on an artificially reduced level of care and overhead then the real return on operations is much lower than claimed in your document.

- I cannot answer the question as the real value of a business is acquired when the business is sold. I can state that with the current fees and our costs that we are not achieving the expected profits required by our Bank. In the last year we extended and refurbished the home – at a review by the Bank we were criticised for failing to achieve the Bank's expected return (profit). This was due to the high expenditure associated with providing quality care to our specific client group.

The NCA did not specifically respond to this question.

Summary of Responses

Two providers responded that the proposals were appropriate for a viable business. Another two providers indicated that the percentages were adequate / reflected industry norms but indicated that they felt that the base costs to which these were being applied were inadequate. Seven providers either did not respond or did not feel able to answer the question, some pointing out that every business will have its own unique costs and risk profile. A further provider suggested that expected return on finance would depend on how the home was financed but indicated that 18% was adequate for return on operations.

Nine providers responded with specific figures for expectations ranging from 20 to 27% (average 22.6%) for return on operations and from 7% to 15% (average 10.4%) for return on capital.

The Council's analysis and comments in relation to providers' responses to Question 3

As identified above, a range of responses were received with regard to the level of return needed to make a care home business viable. As the responses show, each business will have its own unique costs and risk profile. In order to remain viable each business will ultimately have to balance its own risk and the level of return it requires in order to operate a service which meets national minimum standards as

regulated by the Care Quality Commission and also which meet the County Council's requirements in terms of good quality care.

In their responses, providers' expectations was, on average, for a return on operations of 18% and on average a return on capital of 7%. Nine consultation responses indicated expectations in excess of these amounts.

With regards to the return on capital it should be noted that the average cost structures used to inform the fee proposals also contain a separate line for finance costs, in addition to a return on capital, and taken together these would equate to approximately 10% return.

With regard to the market value of care homes, this was sought as part of the provider survey which came back on average at £1.4m for Nottinghamshire homes in current condition.

Given the current economic climate, the County Council considers it to be reasonable for the care home operators to receive a return on operations of 18% and a return on capital of 7% and that providers would be able to operate a viable business on these percentage returns. It is evident that there is already a sufficient level of return on capital to enable new providers to enter the local market, and for a number of existing providers to invest in extending their provision, and it is believed that these returns will ensure there is more than sufficient care home provision within the local market.

Question 4
In the creation of the fee level proposal, the data from the questionnaire has been used. The main assumption in all cost-per-resident calculations is an occupancy rate of 92%.

Do you consider the Provider Survey response and treatment of this data to be a reasonable basis for calculating the costs of operating care homes in Nottinghamshire?

The responses received from providers are detailed in full, as follows:

- Although 92% is a reasonable assumption, 90% may be a more realistic figure.

- It is OK for us and I understand your argument

- I agree that setting the fee level proposal at the occupancy rate of 83% is unrealistic and inefficient so a higher occupancy rate is reasonable. However given the market average occupancy for East Midlands from Laing & Buisson in March 2011 was 88.8% Nursing occupancy and 86.1% Care home occupancy, and average occupancy has generally not increased since March 2011, using an average occupancy rate closer to the L&B data would be more reasonable, for example 89%.

- An average occupancy level of 92% is indicative of the upper quartile of care homes and therefore not a suitable yardstick for measurement of the sector as a whole. Latest figures for Four Seasons Health care shows their average occupancy is just short of 90%. Southern Cross obtained an average occupancy of 80% just before it was reconstituted. When using occupancy average figure for a pricing model this should certainly not be in excess of 90%

- No. The figures are worthless if you disregard the most influential data. We understand that the response was 83% occupancy. Given that poor quality Homes are underrepresented in the survey we would suggest that the true rate is even less than that. At [name of provider] - 27 beds - the difference between an occupancy of 92% and 83% is 2.43 beds, at 2012/13 NCC/PCT fee levels this would equate to a loss in income of £84 222.00 per year.

  Given NCC policy to reduce placements into residential care combined with new beds coming into the market occupancy levels in Nottinghamshire will fall below 83% (if they're not already). This is an opportunity for NCC to end placements in sub-standard Care Homes, drive up quality and help well performing Homes maintain high occupancy rates.

  Last year despite having a waiting list [name of provider] operated at 96% occupancy. We expect to "lose" 14-20 residents per year which results in inevitable empty beds while we prepare for the next admission. We doubt if 92% occupancy is achievable for the majority of Care Homes providing high dependency nursing care. Do not assume that 92% occupancy equates to 8% spare capacity in the market. We regard 96% as full.

- This is not reasonable. That means we could only have 2 vacancies on average, which is impossible considering the needs of the residents (some do not live for long unfortunately) . This is not industry norm when calculating a fair price for care. 90% is the norm (but for our small but popular home that would be difficult to maintain too). It is the council that drives down the occupancy as they are trying to keep people at home for longer, so to expect care homes to have a higher occupancy is rather perverse.

- We welcome Nottinghamshire's awareness of current occupancy levels, which per the consultation response are 88.1% in the East Midlands region, – however wish to note that in our 11 Care homes, average 82% at the current time, against a National Average (across 120 care homes in the West of England) of 86.5%.

  As you will be aware, care homes with an occupancy level of 80% struggle to retain quality and provide a return to investors – with profitability really only returned, across a wide portfolio of homes, where occupancy can get above 85% on a consistent basis. Whilst we understand the Councils strategy is not to pay for inefficiency of operation – hence the assumption of 92% - we believe that this is set too high, and should be closer to the realistic occupancy levels achieved by well managed homes in the county.

- The model assumes 92% occupancy based on 2011 data. The average occupancy in Nottinghamshire homes based on a survey by Candesic was 84.2% as at July 2012. Also our accounts to date show the actual occupancy to be 83%

- Laing & Buisson base their Fair Price for Care on an occupancy figure of 90% as their assumption for an efficiently run care home. Using 92% reduces the expected costs per resident and therefore the proposed fee.

- I don't feel an average of 92% occupancy is realistic, especially for a non-purpose built home. My feeling is such homes range between 70% to 80%.

- Your proposal hugely over estimates occupancy levels that is being and can be achieved for the average home in Nottinghamshire. It is clear from the report that average home in Nottinghamshire is showing occupancy of 83% and hence your occupancy assumptions further reduce the costs.

  In current times Care Homes are not able to achieve 92% occupancy levels. The occupancy levels of 92% is highly misleading because it has been calculated on per bed basis. There are quite a number of homes which have double rooms but the councils policy is to place in single rooms so hence the expected 92% will in fact be a lot higher for some homes. Example we are 38 bed home but we only have 36 rooms. I feel this is inconsistent and unfair approach. The low levels fees will affect the quality care of all the service users and hence put service users at risk.

- Yes we do consider 92% to be a reasonable basis for calculating the cost of operating care homes. However, with the cost of TUPE staff and capital

investment in the Nottingham homes we will be aiming to exceed occupancy of 92%.

- The meeting spoke of average 83% occupancy, though this has been recalculated to 92%. The 9% difference makes a huge difference on actual costs, and does not show a true reflection.

- At the meeting it was discussed at length that the occupancy rate used in the calculations was not fair and resulted in a reduction in fees overall by approx. 10%. The executive from Notts Care Association has made representation in this regard and have asked for this to be re-calculated.

- No, over the last ten years we have experienced an average of 83% occupancy over our 3 homes in the area. Given that the council is openly informing providers of their need to rationalise future placements and considering the increased dependencies of the admittances that are made (inevitably shortening client stays) 92% is an absurd and wholly unrealistic basis to base any calculation on.

- Although I do have 2 rooms available at the moment (out of 18) I would expect to be full most of the time – approx 98% would be reasonable – so your figs have underestimates. This is a very important issue to get right – 92% would be far too low for me.

- Your proposal under estimates the occupancy level that is being and can be achieved for the average Nottinghamshire home. As this calculation reduces the fee across all categories; staffing, non staffing and capital costs this will lead to serious risk that residents will not have their needs met. 92% is unachievable, If the average occupancy is 83% that is the real Nottinghamshire cost.

  It also ignores the effect of double rooms/ beds in your calculation of the average fee. We have provided 3 double rooms to provide for choice for couples (not 2 unrelated individuals) who wish to continue sharing a room. These rooms are rarely used as doubles. However they do provide an important need when used. The impact of this means that when we have all rooms used for single occupancy we appear to be 95% full where in fat we are 100% full. Because we have been provided you with open book figures, and from an understanding of how KPMG calculated the figures this will understate the real costs. To ensure the choice of couples is not restricted the calculations on occupancy should be rebased on room occupancy not bed occupancy.

- No. If the survey was telling you that occupancy rate was 83% on average, how can you pluck 92% without any justifiable reason other than efficiency saving. We all strive to be efficient but costs and occupancy are fact not fiction! By using 92% as opposed to 83% you are effectively reducing the fee to care homes. This will ultimately reduce the level of service each care home can and will be able to provide.

In addition to the above, the NCA response was as follows:

- Your proposal under estimates the occupancy level that is being and can be achieved for the average Nottinghamshire home. As this calculation reduces the fee across all categories; staffing, non staffing and capital costs this will lead to serious risk that residents will not have their needs met.

Summary of Response

Three providers agreed that an average occupancy rate of 92% was a reasonable basis for calculating the costs of operating care homes in Nottinghamshire. A further provider stated that "although 92% is a reasonable assumption, 90% may be a more realistic figure". One provider suggested that 92% was too low and suggested that approximately 98% would be reasonable. A total of 15 providers and the NCA disagreed with this proposal.

The Council's analysis and comments in relation to providers' responses to Question 4

The Council has taken in to account the over capacity of residential and nursing care within the local market. The Council has been clear with the care home market that its strategic commissioning intentions are focused on supporting people to live in their own homes for as long as possible and to reduce the numbers of older people placed in care homes. As such, the Council would want to see a reduction in the overall capacity and particularly in relation to those providers who are providing poor quality services and which have lower occupancy levels as a result.

It is not reasonable for the Council to fund the overhead costs of providers for the level of vacant beds identified by providers. The Council expects providers to operate their services efficiently by reducing their voids and maximising occupancy levels. It is believed that in requiring providers to operate at average occupancy levels of 92%, there will still be sufficient provision in the market to meet local needs, not only for people who require Council funding but also for people who are self-funders or who are funded by health partners or other local authorities.

The Council has undertaken detailed analysis of the numbers of double rooms in older persons' care homes. Out of the 169 number of independent sector older persons care homes, 109 homes have one or more double rooms. Out of a total of 6,793 of rooms, there are 261 double rooms across the 169 care homes. If only one placement is made in each of these double rooms, the maximum level of occupancy achievable by the providers overall would be 96.3%. In reality a number of such rooms are occupied by married couples or close friends. The proposed occupancy of 92% therefore allows for some capacity to be retained whilst seeking to increase the efficiency of the market.

In terms of the high turnover of residents and the subsequent time gap between successive occupancies, the Council has for many years implemented a policy of continuing to pay providers for two days following the death of the service user. This is in order to give family members sufficient time to collect the service user's belongings and ensures that respect and dignity is maintained both for the deceased service user and for their family. In making this payment, the Council is contributing to the costs of turnover of residents.

Consideration has also been given to providers' comments that there is a high turnover rates due to placements being made at much later stages and subsequently for a shorter duration, and because of higher levels of short term or respite care. The Council's data does not support this observation as it is evident from recent benchmarking data that the Council is continuing to place a higher number of people in care homes than that of comparator Councils and that the average length of stay in a care home is longer than that of comparator Councils.

The only other factor referred to by providers was a lack of demand, and particularly a lack of demand for local authority funded placements. However, the Council is not under any obligation to maintain its placements at any particular level. Its obligation is to pay a fee for those placements which takes the provider's actual costs into account, and which supports a viable and sustainable market to meet the demand which exists at that time.

The Council has received no compelling evidence of there being a structural reason why care homes in Nottinghamshire cannot operate at 92% occupancy.

Question 5

Whilst all fees are proposed to be increased, the current £ differences between each quality band have been maintained in the proposal.

If the proposals either increase or decrease the incentive for you to improve the quality of your care provision, please explain this.

The responses received from providers are detailed in full, as follows:

- Operators will just pocket additional fees. Incentive fees must be linked to achieving higher standards and as a reward for achieving

- Neither. Cost factors should not affect quality of care.

- Decrease. You are proposing to increase Band 1 homes 2.9% more than Band 5 homes

- We believe the incentives should clearly be weighted towards the quality providers

- I disagree with this proposal. A monetary increase across all quality bands at the same level does not incentivise the operators on lower quality bandings to improve quality.

- Generally homes with better care provision will already benefit from higher occupancy and stable staffing. Therefore a significant differential should not be instigated. However a reasonable differential to reflect reward of high standards is not unreasonable.

- One can argue both sides of the coin. Probably best keeping status quo.

- A fundamental corporate and regional goal is to continually improve the quality of care provision in our homes. Against a background of continually rising costs and economic uncertainly, the proposal to increase fees paid by Nottinghamshire, which incorporates maintenance of fee rate differentials continues to support our corporate goals, which not only include continued quality improvements, but continued investment in our infrastructure and our resources.

  The incentive to improve quality could be further enhanced if Nottinghamshire was able to review the quality and banding of its lower banded homes on a more regular basis, thus enabling homes to achieve enhanced rates, and allow homes that proactively improve their quality to benefit from premium fees, rather than have to wait considerable time for assessment.

- Banding 3 and above should increase; Band 1 should have no increase; Band 2 nominal fee increase. The rationale would be that is not acceptable to still have homes in band 1 when homes have worked in partnership with Nottinghamshire Local Authority to achieve compliance with the Nottinghamshire Local Authority.

- We provide the appropriate care and resources that are required to meet the assessed care requirement for the residents in the homes and would not compromise this standard of care. We would not accept costs that would have a detrimental effect on our ability to deliver quality and the care needs of our residents

- I am happy with this

- It is important to maintain the incentive but the proposals haven't increased or decreased them materially.

- The proposal fees do not meet actual costs and hence decisions will have to made where 25% reduction in costs need to be made. It is absolutely clear that this will have a direct impact on the quality of service that we will provide, particularly the low levels of staffing levels that are suggested. It is suffice to say that it is highly impossible to make improvements based on the proposed fees.

- The [name of provider] Nottingham homes are already operating in band 5, so the proposals do not increase incentive for improvement, however we are continually stiffing to improve our quality to ensure we remain at band 5, therefore a difference in fees between the bands should remain.

- I understand from what was discussed at the meeting that there are 20% of Care Homes that are in Quality Band One and have been so for many years.

  I understand that Homes that fall into Quality Band One have not been successful in demonstrating to Notts County Council that their accommodation/service meets the minimum standards required.

  It was discussed that placing service users in to Care Homes in Quality Band One was questionable given the vulnerability and dependency levels of residents generally and there could be potential risks to residents which can attract adverse media publicity for the Care Sector in general.

  No doubt these homes have received support/advice from Notts County Council to assist them in improving their service to higher quality bands, but this has not been achieved.

  It could be concluded therefore, that these homes are content to remain in Band One and be financially supported by Notts County Council. Any Care Home Provider with a genuine commitment to providing at the very least a good service, would make significant efforts/investments both financially and in terms of time input to improve from Band One to higher bands. Therefore it appears that there is no current incentive for these homes to move to higher bands.

  It was discussed at the meeting that Notts County Council are looking towards addressing this issue. Several points were made that these providers may say that are unable to improve as they are being funded at Band One rates. However, Providers should fund improvements to their services themselves

and by doing so, achieve higher quality banding which results in enhanced fee levels paid.

It is of paramount importance that the Quality Banding system remains and we were informed that Notts County Council will continue to support this model. It is important to maintain the differential between the different bandings as this gives incentive to maintain standards and improve where necessary.

However, it was discussed that the proposed increase of 10.2% to homes in Quality Band One was questionable and was significantly greater than the proposed % increases to the other quality bandings.

It is my view that this would give them further disincentive to move out of Band One. It was discussed that Notts County Council are proposing to communicate with them on the most strictest of terms, to make it clear that improvements to services must be made and strict timescales be given to achieve this. It was discussed that Care Homes who do not comply will be informed that Notts County Council will have no choice but to not make any future new placements.

I fully support this proposal, as without some kind of firm action plan, the situation may carry on for years to come with little prospect of it being resolved.

Providers in higher quality bands work very hard to achieve and maintain these standards and it is of genuine concern to us that Homes in Band One remain in Band One and there is great potential for adverse media interest who may regard this standard of service to be the norm in the Care Sector.

Furthermore, it was discussed that these Homes should receive a much lower % increase and the subsequent cost saving to the Council could be redistributed to the other homes in higher bandings who have worked very hard to achieve and maintain their quality banding level year in year out.

- Increases should be considered an incentive to develop and promote good quality care. The current strategy of applying a single across the bands increase proportionately rewards the lower quality homes better than the higher band ones such a mechanism would seem counter intuitive and potentially counterproductive if continued into the future.

- We are constantly being ‘pressured’ into providing the best possible level of care – and quite right too – but excellence should be rewarded. It is seemingly more difficult to get LA funded residents the higher your banding – so a) the differentials should be bigger and b) you should not be penalised for being a 4/5 home.

- The proposed fees overall do not fully reflect the costs. In order to encourage and reward better quality you need to provide a viable carrot to improve. The 5 quality bands provide a good structure but the fees need to be higher to reward the higher costs of good and high quality.

- I believe the fee to Band 1 and 2 is totally inadequate to sustain any sort of quality provision. I do not believe NCC is practising robust commissioning by purchasing a service from poor quality care homes. I have no preference as to how NCC increases each band as long as it is equitable. I do believe NCC should seek to change the way it supports homes to improve in quality as clearly NCC's attempts over recent years have had no significant impact.

The NCA did not specifically respond to this question.

The Council's analysis and comments in relation to providers' responses to Question 5

The local 'Fair Price for Care' framework with its five bandings and associated fee levels was designed to incentivise providers to continuously improve the quality of their care in order to attract higher fee levels. Each home is audited annually following a revision to the Audit Tool, and this determines the banding and the fee level allocated to the home for the following financial year.

As indicated in the providers' responses, overall there is support for the Fair Price for Care framework and the 5 bandings to be retained. On the whole, providers did not indicate that the differentials between the bandings should be altered. The Council is therefore not proposing to change the framework or the current £ differences between each quality band.

The Council continues to work directly with providers where they are consistently rated as Band 1 with a view to supporting them to improve the quality of care. The Council recognises that the same cost pressures affect all care homes, whichever band they are in. Therefore fee increases need to reflect these cost pressures and homes in the lower bands also need incentives to enable them to improve the quality of care that they provide.

In relation to the fee proposals, whilst the percentage increases proposed for the lower bands are greater because the base is lower, the actual cash increases in fees will broadly be the same. This is considered to be reasonable given the analysis of the survey responses which indicates that the costs of operating homes in different bands are broadly similar and as such, the cost pressures will have increased at similar levels for the lower band homes as that of the homes in the higher bands.

Question 6

The average number of hours of staff time per resident in Nottinghamshire is significantly higher than the figures for industry norms as reported by Laing and Buisson. The proposed fees have been set to reflect the cost of operating with staffing levels between these two comparators.

Why are staffing levels in Nottinghamshire homes higher than the national average?

The responses received from providers are detailed in full, as follows:

- They may be above Laing and Buisson calculated average levels but we believe they seriously understate the safe levels required

- I have no comparison for other areas. However, I pay national rates but would 'presume' that the only factor skewing the figures may be 'more time off due to sickness' with the resultant sick-pay.

- We don't know. However we feel it is dangerous to disregard the data you have received without robust contradicting evidence

- I don't have the answer but our staffing hours are significantly higher

- The staffing levels in the home we operate in Nottinghamshire are comparable with the staffing levels in our homes in other areas of the UK.

- We cannot comment on other Homes staffing. Ours falls within Laing and Buisson norms and is supported with reference to the residential forum staffing tool and resident need.

- L&B did not report a national average. They reported on a 50 bed 'efficient operator' – e.g. Southern Cross. This is not the norm at all. That exercise was also done a number of years ago and they have kept the figure the same since. We all know that residents needs have increased substantially as people come into care homes in later stages, where they have already had several falls or their dementia have developed to the point where they can no longer live at home safely with a care package. IN our homes we have increased staffing levels significantly and they have also had to have a lot more training to cope with the higher needs.

  Care homes are already operating as efficiently as they can following the pressure on costs and fees over the last few years. To expect care homes to cut staffing hours is irresponsible and could lead to a safeguarding case.

- We have concern that the comparator statistics are based on inaccurate or out of date data. For instance, Southern Cross data, when it was the largest operator, contributed significantly to the models operated by Laing and Buisson.

  We are aware that Southern Cross staffed its homes at levels that we believe are inadequate. To add to this, dependency levels across Nottinghamshire

are higher than we mostly experience elsewhere, leading to a higher staffing requirement in the County, than in other areas of the country. To compensate for these, a higher than "normal" level of staffing is required.

- Our actual current occupancy is 83.1% this is reflective of the national average. Our homes work assess needs prior to admission, the staffing. The current placements within our homes are people who need 2 people for majority of their interventions.

  The Laing & Buisson information is not based on a sufficient sample of providers, approximately 10%, to confidently calculate industry norms and does not include feedback from larger providers. Consequently it should not be considered a fair sample. Based on our internal data the cost of running our homes in Nottinghamshire is no more than homes in other areas of the country and thus we would contest that Nottinghamshire staffing levels are significantly higher than the national average.

- The staffing levels in Nottinghamshire homes are not significantly higher than the figures for industry norms as reported by Laing and Buisson (L&B). There is an error in the survey assumptions.

  For care only homes L&B quote 18.5 hours of care and 6 hours of non-care per week (24.5 hours in total). The 6 hours non care is only to cover chefs, cooks, domestic assistants, kitchen assistants and laundry assistants. The cost of administration, reception, maintenance and management are added into the L&B calculation separately as a cost per week. When Table 3 (Rostered average hours of staff time provided per person per week (Care Homes)) has Administration/Reception, Maintenance/handyman and other staff hours excluded the hours are 25.7 compared to L&B's 24.5 (4.9% higher rather than 15%) and for nursing the comparable hours are 36.7 compared to L&B's 34 (7.9% higher rather than 14%).

  This seriously undermines the proposal to reduce the staffing cost element of the proposed fee by 7.5% which you took as the mid point between L&B and average Nottinghamshire staffing hours. [Name of provider] suggests that the staffing cost element is not reduced in the fee calculation

- It is difficult to recruit care staff for my particular home and going forward this is going to be more difficult as the next generation carers will be put off by the stigma associated with caring for the elderly. It has always been seen as a job which does not reward good carers what they are worth and the promise of future wage increases is no longer effective to attract those coming into the care industry. The minimum wage has created a culture in which the salary between a good member of staff and poor one is often negligible which can cause disputes, lengthy sickness absence and a lack of long term commitment.

- The higher proportion of private sector beds requires the homes to maintain high occupancy levels and maintain standards.
- The national averages are based on big corporate homes such as Southern Cross homes and we all know what happened to those homes. The proposed

staffing levels will not be acceptable to Care Quality Commission and there is a potential risk of them closing down services.

The service users admitted to care homes are of high needs and that is the reason why staffing levels are higher. I do feel that Nottinghamshire care homes generally provide quality care and this is evident from the quality banding as majority of homes are in band 3 and higher.

As a company we would have to look at whether we could provide the level of care to Notts Social Services funded clients particularly with the low levels of staffing.

- [Name of provider] are new operators in Nottingham and as such do not have sufficient local data and knowledge to answer this question.

- Staffing levels are determined by the dependency levels of service users. Those service users moving into the home subsidised by the local authority are significantly more frail than those paying for their own care.

- As discussed at the meeting Caroline Baria confirmed that residents would continue to be supported in their own homes provided their needs could be met. By definition the residents that are being placed in to Care Homes have much higher dependency levels and in addition, for Care Homes with Nursing, more complex health care needs. There are increasing levels of residents with all levels of dementia needs as these residents would be unsafe to be cared for at home without 24 hour support, which would be too expensive. Therefore, it is of paramount importance that staff give time to the individual residents they are caring for and in fact there is great emphasis, from our Regulatory Authorities that listening to what residents say and supporting them as much as is required is essential to their well-being. Therefore adherence to industry norms for staff time is not really appropriate.

  Care home providers with a genuine commitment to providing a safe environment with staffing levels that are matched to the needs of the residents, will make a financial investment in funding the costs of the staffing in their homes and this may well mean costs being higher than industry norms.

  Providers are responsible and accountable for ensuring that the residents that are cared for them in their homes have their needs fully met and not put residents at risk by not providing sufficient staffing levels and staff time for residents. This factor is far more important that adhering to industry norms. In the event of an incident in a Care Home which was attributable to insufficient staffing levels etc, then the Provider would be unable to state that they were adhering to “industry norms”.

  Providers are constantly being told that Notts County Council support the concept of Quality care in Care Homes and a huge part of this is ensuring staffing levels meet residents needs in all aspects of their care. Therefore, I find it confusing that we are being compared to “industry norms”.

- Staffing is a key factor in attaining a high quality of care and it is one that has to be appropriate to the individual residents needs as they are placed. Local variations in industry and lifestyle are inevitably reflected in those dependencies and conditions of the residents that populate our homes. Equally council strategy is often aimed at rationalising the numbers of residents placed into care, effectively holding residents at home till dependency reaches a critical level. This has a twofold effect in that the lack of round the clock care at an early stage often accelerates the deterioration of the individuals abilities (particularly in relation to their mental state) but also that when the placement is eventually agreed the individual enters the Home at a higher dependency.

- I cannot answer this except to say – this is good – it shows that general staffing levels are good in Notts

- Over the years the dependency levels of those social services funded resident have increased, meaning that more care and non care hours are essential to meet those demands. Equally those social services funded residents with lower needs are not now being funded, resulting in the average hours per social services resident increasing significantly.

  Comparing to "L & B industry norms" is misleading and inaccurate. The figures you refer to are for large corporate homes, Southern Cross was a source of data and date back some years!! Following your proposal will lead to the risk that residents will not have their needs met. For example the most recent L & B report in 2010 reported on average 30.5hours of care per residential resident per week in Nottinghamshire.

- Laing and Buisson figures are not a national average! Laing and Buisson figures are based upon costs of an efficient large (50 beds +) corporate care home. The majority of care homes in Nottinghamshire are small converted houses and so costs are going to be higher than the efficiencies found in large corporate organisations.

In addition, the response from the NCA response was as follows:

- Question 6 does not make it clear by how much you are reducing staffing hours. In previous correspondence and discussions you agreed to send us the brief KPMG were working to and the anonymised data set, we still await them.

<u>Summary of Responses</u>

Four providers responded that they did not know why staffing levels in Nottinghamshire homes were higher than the national average and a further provider did not respond to this question. One provider indicated that the staffing levels for their home fell within the Laing & Buisson "norms" and two providers responded that their staffing levels were comparable with those operated in homes operated elsewhere in the UK.

Several providers challenged the use of Laing & Buisson calculated averages on the basis that they relate to 50 bed 'efficient' operators. They also stated that the data is

out of date and do not reflect increasing levels of dependency in Nottinghamshire homes.

A number of providers responded with specific suggestions regarding why staffing levels in Nottinghamshire homes were higher. The main reason mentioned by four providers relates to increasing levels of dependency for NCC placements.

The Council's analysis and comments in relation to providers' responses to Question 6

The Council has taken into consideration the findings of the survey questionnaire in relation to staffing levels in homes in Nottinghamshire and of the feedback received from providers as part of the consultation process.

In addition, consideration has been given to the Laing and Bussion's 2012 survey data. The Laing and Buisson 2012 report is based on the findings from the most recent and extensive survey of actual costs for older persons care home provision across the country and it provides a reliable indicator of staffing levels. On the basis of this information, the Council has revised and increased its fee proposals to reflect the need for higher levels of staffing arising from higher levels of need of residents.

Question 7

The Provider Survey data does not indicate a clear correlation between the quality band and the cost of operating a home. However to encourage higher quality provision the Council will continue to pay higher fees for higher quality homes.

How will the continuation of the Council's strategy to directly reward quality by the payment of additional fees help you increase the quality of your home?

The responses received from providers are detailed in full, as follows:

- The Pinders element reflects the incentive. Delivery must come before reward

- We already maintain high quality. However, additional fees would give us more to spend on quality

- Additional fees will provide some of the incentive to increase quality.

- I believe we have all got to keep working to keep the quality levels up and as such you need the funds to achieve this goal.

- I agree with the approach by the Council to directly reward quality by the payment of additional fees. Homes operating at the lower fee bandings have an incentive to improve quality and homes operating at higher bands can continue to reinvest in maintaining the higher quality of care through the fee premium received.

  However the quality audit process adopted by the Council needs to be reviewed. There is inconsistency between the approach of individual members of the Council's team completing the quality audits and homes can be penalised based on unreasonable views/conclusions made by some individuals.

- A higher fee only acts as reward.

- I don't think homes have always been treated in a fair and balanced way. I understand that this is difficult to achieve but we have ourselves experienced a huge difference in approach from individual inspectors. Costs and quality is very likely to have a correlation but it does not necessarily mean that the quality banding and costs have a correlation.

- We have concerns that the current pressures on the LA are resulting in some placements being diverted to lower banded homes as a means of controlling expenditure.

  As demonstrated by lower banded homes within our organisation, homes in bands 1 & 2 require an increased level of funding to support them achieve higher standards. There is clearly an issue that the reduce funding not only becomes punitive it also prevents development.

As part of Central Government strategy, the base line criteria for admission to residential and nursing care has been increased creating much higher dependency levels this is evidenced through the joint assessments with the social work discharge teams. This also reduces the options available to services users which ultimately will result in high numbers of emergency admissions and admissions into hospital through rapid response. This can be clearly evidenced by the homes on the county boundary with Lincolnshire.

- No two homes are the same the number of factors which impact on the service are internal and external factors, which include layout of building. Registration mix of a care home also impacts on one service verses another uses a higher ratio of staffing. Fee strategy helps management teams maintain the focus on compliance of the Nottinghamshire framework with an outcome of improved quality of life for people in our care.

- [Name of provider] continually looks to improve the quality of care in its homes and maintain high quality and good value services for residents as we are a not for profit organisation providing valued person centred care.

- I am happy with this proposal and feel it incentivises every home to continue improving which will only help the industry over the long term.

- A higher rate will promote the maintenance of higher standards trough care home improvements and the affordability of higher quality staff and staff numbers.
- I think the quality banding system is a very good system to encourage providers to continuously improve and strive to improve their services. The higher level of fees will give us the opportunity to re invest funds into the home and the staff to improve the quality of service that is provided. However the true costs of care must be paid in the first instance.

- Incentive for improvement is also driven by the desire to ensure our occupancy levels are maximised, increased investment in quality leads to increased service user experience and ultimately the homes local reputation.

- It is of paramount importance that the Quality Banding system remains with fair remuneration for each of the Quality Bandings. Providers can therefore continue to commit time and financial investment to not only maintain their quality banding but also to progress on to the next banding level if possible to do so.

- Quality care is often the result of good management and planning, it has benefits in both how the care is delivered and in the relative efficiency of the home's operation. The funding levels are the reward that provides the incentive to aim for, and maintain, the highest standards of care, it is also the foundation for ensuring that as care needs change and become individualised the home can develop and adapt quickly.

- It will as long as the 4/5 band homes get the fair amount of placements from LA. If we don't then it does not matter what the funding level is. Assuming we get the referrals/placements it does of course encourage the provision of

better care – but as mentioned earlier I do think the model has underestimated our costs quite considerably.

- The table of average cost by quality band required further understanding as appears illogical that nursing care and care-only costs are so similar. We would suggest that this requires further work to understand.

- Firstly fees must increase to address the lack of inflation and to remember the last payment towards the Fair Price for Care relates to Pinder's fees for 2007/8. 4 years later fees need to increase. This year Nottinghamshire Care Homes has seen the loss of Workforce Development Grant, the loss of the Balance (Nutritional Team), reduced number of quality development officers, no dignity conferences for 18 months, an invisible workforce planning team (other than Claire Poole and Halima Wilson). As a result training events are provided by the Nottinghamshire Partnership for Workforce Development. Within a year we will see that few homes have achieved to maintain the mandatory training required to ensure safe practices and as a result of this quality of care and services will fall. A fee increase will enable homes to continue to invest in developing their staff and to invest in the overall service too.

The NCA did not comment on this question.

Summary of responses

The majority of providers who responded to the survey supported the view that the payment of additional fees does provide an incentive to increase the quality of care. A number of providers stated that higher rates would promote higher standards through care home improvements and the affordability of higher quality staff and staff numbers with a further response indicating that increased fees would enable homes to continue to invest in developing their staff.

The general view was that providers were able to invest in their services to improve the quality to the benefit of service users which in turn then leads to an improvement in the care homes' local reputation, which in turn helps maximise occupancy levels and ultimately levels of return.

Some providers noted that lower banded homes needed an increased level of funding to support them achieve higher standards but there was also one view that reducing funding becomes punitive and prevents development.

The Council's comments in relation to providers' responses to Question 7

The consultation has identified that the current fee banding system, with the payment of higher fees for higher quality homes is, on the whole, supported by providers. The Council is committed to seeking continuous improvements in the quality of care provided in older persons' care homes and proposes to continue to implement its Quality Audit framework and to maintain the banding system currently in place. The Quality Audit process is continually reviewed to ensure that it is consistently applied. The Council is keen to support increased numbers of higher banded care homes and therefore proposes that all homes, including those that are in the lower bands, would receive fee increases which take in to account costs pressures.

Questions 8&9
To ensure longer term sustainability of the care home market, the Council is proposing an annual inflationary mechanism which uses indices relevant to the specific costs incurred by care homes.

8. Does the proposal to apply annual inflation to the fee levels provide additional financial security to your business, and therefore give you the incentive to continue investing in increasing quality of care provision?

9. Do you agree that the proposed inflation indices are appropriate ones to use? If not, which others would you suggest, and why?

The responses received from providers in relation to Question 8 are detailed in full, as follows:

- Inflation increases are welcomed but if NCC is to climb out of being a low fee council it should grant above inflation increases to prevent homes closing

  Additional comment: ….we think your estimates are broadly in line as a derived percentage with the level that would cover cost increases. We do however assume that it will fully cover the on-going costs of minimum wage, the new statutory pension contributions, working time directives and other proposed or muted changes. If we have a concern, it is the LA funded residents will be destined to receive care of a lower quality and in lower quality establishments as price increases reflect inflation but not the market driven level of average fees.

- Yes, as long as the figure is inclusive of staff costs.

- Yes – It is an excellent idea and would be a great help to manage the business

- The proposal to apply annual inflation levels does provide additional financial security. For several years the gap between the true cost of care and the fees Council's pay has widened and whilst there is still a gap, the proposal should minimise the risk of it widening further. It has been difficult to decide whether or not to invest further into the care provision in the past few years knowing that costs will increase combined with the unknown of Council fees. Having a contracted calculation for annual inflation gives operators some stability.

- The proposal to have an annual inflationary award is only suitable if the indices it is calculated in reference to are appropriate. Assuming they are, there is no major objection to this, however we do not know what indices you are proposing using.

- If the inflationary uplift is based on real costs (i.e. food CPI index, utility CPI index, minimum wage increase, actual CQC registration costs, etc) than this will undoubtedly give us more certainty. For the inflationary uplift to be effective it must of course be based on a true fair price for care, otherwise the gap to real costs will increase every year. All in all a very good move

- We would welcome a proposal that uses and inflationary index to secure future fee increases. Such a proposal would enable commitment to further improvements and investments in our homes in the region. Whilst the proposal offers such an indexation, it should be recognised that the cost increases will also include rents and financing

- costs – which are not necessarily reflected in the current proposal.

- Yes. Does the inflationary increase take account of statutory increases in payroll costs (i.e. pension auto-enrolment & increase to the national minimum wage).

- The inflation mechanism is welcomed but there are concerns around it. If the starting point of costs (see other answers) is incorrect the inflation mechanism will not cover the real increase in costs leading to an ongoing shortfall which will grow over time. If any of the individual indices are negative in a particular year will they be treated as zero inflation? Any possibility that this mechanism could result in a drop in fees year on year would seriously undermine your efforts to provide additional financial security.

  [Name of provider] provides high quality and good value services for residents as we are a not for profit organisation providing valued person centred care. Therefore the fees need to recognise the services provided and we would not allow the quality of care and services to be compromised.

- I am happy with this proposal and feel it incentivises every home to continue improving which will only help the industry over the long term.

- Providing there is a direct correlation with RPI inflation and wage Inflation (in particular minimum wage levels).

- The annual inflationary mechanism is an excellent system because it will allow us to plan for future years and hence able to produce more accurate annual development plans such as workforce development and budgets. I think it will prove to be cost effective for councils in the long run in terms of time in put and forward planning.

- Yes, provided the inflationary mechanism is clear and defined.

- It is of paramount importance that an annual inflationary mechanism is incorporated in to the fee structures. However, in calculating this figure, it is essential that the correct baseline figures are fair and correct and the inflationary element be applied.

  Care homes are faced with increased operating costs the majority of which are out of our control. The main cost is the annual increase in the National Minimum Wage and working Time Directive, which are continually driving up staffing costs. The NMW has increased annually at a significant rate since its introduction and these increases have not been supported by corresponding increases in funding generally. Further increased staffing costs are in the pipeline with regard to pension contributions, working time directives etc We have also seen significant increases in utilities and consumables, the

increased costs levied on to suppliers are then passed on to their customers, with no room for negotiation with regard to pricing.

- An annual inflationary mechanism is essential to ensure standards aren't compromised and ensure stability for residents in the area.

- Yes it does but only to a certain level. Again is the base level set right. Are all inflationary factors taken into account. Some of our larger costs (fuel) have gone up way over the general level of inflation. What about the new pensions we all have to provide etc etc

- Yes – as long as the figures used are fair and truly mirror our costs.

In addition to the above, the response from the NCA was as follows:-

- The inflation indexing mechanism is welcomed but there are concerns:

  Because the base costs (reduced staffing, occupancy, training, admin etc) omits certain costs then the increase each year will not cover the real increases in cost so will lead over time to an increasing serious risk that residents will not have their needs met.

  The indexing calculation performed in April each year will be based on the previous Octobers in inflation (6 months in arrears at the start of the year and 18 months at the end of the year), so over the year the inflation will be on average one year behind the actual costs. Historically care home inflation has run at levels up to 4 or 5% a year. Therefore using the proposed method of calculation will lead to a fee level that has serious risks that residents will not have their needs met.

  We are not clear whether the AWE accurately reflects the wage pressures on providers where the majority of staff are on the National Minimum wage which has historically increased at a faster rate than wages generally. This will need further discussions to fully understand the proposed mechanism.

  In future there will be incremental costs increases, eg statutory pension contributions, working time legislation changes, statutory tax changes and others yet unknown that the proposed mechanism will not cover. Unless the mechanism includes these factors will lead over time to an increasing serious risk that residents will not have their needs met.

Question 9 Do you agree that the proposed inflation indices are appropriate ones to use? If not, which others would you suggest, and why?

The responses received from providers in relation to Question 9 are detailed in full, as follows:

- Yes, as long as the figure is inclusive of staff costs.

- I agree with the indices.

- I do not know which indices you propose using.

- The wages index needs to be split up between managers/admin/nurses/maintenance and care/domestic/kitchen.

  The average wage index should apply to the former. The latter should either have the average wage index OR the minimum wage applied depending on which is higher. For instance, if the average wage index is 2% but minimum wage is 5%, then homes are forced to increase wages for most staff at 5% but will only get 2%.

  Finance should also have an index, which should be the average inflation (e.g. CPI). If not , the profit in the model will remain the same even though inflation is going up (or down). If inflation is going up the profit will decrease in value (e.g. £100 is worth less if inflation goes up 5%) All other indices are fine.

- We would welcome a proposal that uses and inflationary index to secure future fee increases. Such a proposal would enable commitment to further improvements and investments in our homes in the region. Whilst the proposal offers such an indexation, it should be recognised that the cost increases will also include rents and financing costs – which are not necessarily reflected in the current proposal.

- Clarification requested of the type of models to be used for comparison to confirm the best one to use.

- It is not clear whether the AWE will adequately reflect any increases in the National Minimum wage which in the past has increased more than general wage inflation. There should be an ability to factor in specific incremental and one off increases eg statutory pension contributions, tax changes etc to ensure the model costs do not get out of step with reality.
- I am happy with this proposal and feel it incentivises every home to continue improving which will only help the industry over the long term.

- They would seem fair.

- Generally the indices seem correct but my concern is that the base fee proposed is not correct then the annual increase will not cover the real increases in costs.

  I think the current proposal needs re looking at in terms of the inflationary mechanism which will always be 12 months behind the real figure. The other aspect is the fact that does the wage indices actually reflect national wage increase or general wage increases as the care home sector generally is on the national minimum wage levels. The national minimum wage increases have always been higher then national wage increases. Again if the annual increases do not reflect the actual increases faced by the sector then again this will have a serious impact on the quality of care provided. In future there will be incremental cost increases such as pension contributions, working time legislation and others. Will the proposed mechanism be robust enough to incorporate those increases.

- Yes the proposed indices seem appropriate. We note that no account is taken in finance costs, we would like to see this linked to movements in either bank base rate or LIBOR.

- I am not qualified to give feedback on inflation indices but give the Notts Care Association my full support in their feedback to these proposals as they communicate with independent professionals in this regard.

- The suggested indices are a positive step forward but the rapidly changing economic climate and the equally rapidly escalation in requirements in terms of equipment provision and staff training do require regular review in addition.

- General levels for us are about 5/6%

- As I stated in question 1. NMW increase this year by 1.8% and pension contributions are coming into force. Any inflationary mechanism must take into account such costs which will significantly impact of financial viability of Care Homes.

The NCA did not specifically respond to this question separate to their comments on question 8.

Summary of responses

Providers are generally supportive of both the principle of developing and applying an annual inflationary increase to fees based on a locally-determined, composite index, and the proposed formula and indices to be used to calculate such an index. A number of concerns relating to the detail of calculating an annual inflation index were raised. These are detailed below.

The NCA raised a concern that the index applied to fees from each April would be based on inflation indices from the previous September/October.

A number of providers highlighted that the chosen indices in the formula should be relevant and appropriate. Specifically, some concerns were raised regarding the appropriateness of using AWE to reflect increases in staffing costs and whether a set of indices reflecting the different types of staffing in care homes would be more appropriate, and whether AWE will adequately reflect increases in other staffing costs such as increases in employers' national insurance and pensions contributions or the impact of legislative changes in terms and conditions.

One provider sought further clarification on how negative values for chosen inflation indices will be applied and whether these will be treated as zero rather than negative values.

A couple of providers also noted that finance element of costs is not directly included in the proposed inflation index formula and also note that finance costs are also subject to change.

Additionally, some general comments were made about specific inflation experienced by care homes over a period of time being different to the calculated inflation index

due to elements of costs increasing at a greater rate or due to additional costs arising for the sector.

The Council's analysis and comments in relation to providers' responses to Questions 8 and 9

Providers are supportive of the principle and detailed proposals to develop a mechanism for uprating fees annually for inflation and view this as a positive development. Comments in relation to concerns regarding some of the details are set out below.

Given that future inflation levels cannot be known, it is inevitable that an element of estimation of future inflation will be necessary when setting fees prior to April for the forthcoming year. However, in order to minimise this, it is proposed that inflation for the financial year ahead would be calculated using the relevant indices from Sept/Oct of the previous year – this would mean that there isn't a significant time lag between the relevant inflationary pressures being identified and the time that they are implemented.

The proposal to use specific indices directly related to major areas of care home costs rather than general indices such as RPI and CPI is generally supported. The AWE chosen (EARN 03) relates specifically to 'Health and Social Work' and is therefore considered to be an appropriate index.

It is accepted that alternative, more detailed calculations reflecting different staff groups employed within care homes could be used but this would require the use of both a number of different indices and require a more detailed breakdown of the proportionate costs of differing staff groups. This would result in a significantly more detailed and complex set of calculations and a more complicated process to apply different indices to different fees levels. It is not felt that this more detailed and complex calculation would result in significantly enhance inflation related fee increases. Therefore it is reasonable to propose that a simple formula which is both easy-to-understand and to apply is a used to determine the level of inflation to be applied for the following financial year.

Whilst AWE calculates increase in earnings the fee includes allowances for employers contributions so increase in fees based on AWE will include increase for total staffing costs to providers. It is acknowledged that the proposed formula may not automatically pick-up changes to employers' staffing costs arising from legislative changes to employers' contributions or resulting in changes in terms and conditions. Such changes will need to be incorporated through periodic revalidation/reviews of the model used to calculate the base fee.

Negative values for indices will be treated as negative values and not as zero. Negative figures for indices would indicate that costs have fallen. Inflation index needs to reflect both increases and decreases. Application of indices needs to be consistent and cannot only include increases. The likelihood of negative values for individual indices is however considered to be small, and the likelihood of overall calculated index being negative resulting in reducing fees, is considered negligible.

Finance costs comprise around 5% of overall costs. The inflation index formula does not include an element to pick-up inflation on finance costs as these are not directly

related to inflation but are linked to home capital and interest rates. However as finance costs are included in the base fee calculation and the intention is to apply the inflation figure calculated by the formula to the whole of the fee, the finance element of costs will be inflated annually in line with the calculated inflation figure. This proposal is considered sufficient to reflect changing finance costs in the short term. Over the longer term changes in care home capital values and interest rates would be incorporated through a process of periodic revaluation/review of the model used to calculate the base fee.

In order to ensure that over the longer term fee levels remain appropriate the model would be reviewed in the lead up to and/or during the final year of the proposed five year period of implementation of the proposed model.

Question 10

Consideration of the physical environment currently accounts for up to 30% of the total 'score' available in determining service quality. This model is somewhat biased towards purpose built properties and is subjective in some elements. It is proposed that the subjective environmental elements be removed, the overall environmental audit be simplified and that the new 'scoring' methodology be based on an 80/20 quality/environmental split, rather than the current 70/30 one. Your views on this approach would be welcome

The responses received from providers are detailed in full, as follows:

- The council will be seen as not recognising that purpose built comes at a price, without them there is nothing to replace ageing and not fit for purpose care homes

  Additional comment: We think your estimates (related to capital cost of a care home) are in line with current built costs. We question however your thinking on how poorer quality operators should be incentivised to improve their quality. Those operators you refer to are normally operating in homes which have been built at least 8 years if not 10 years before when the cost of the build and the cost of the funding was lower or has been depreciated. The thought that you will use your pricing mechanism to encourage them to improve their quality gives them a double benefit, the savings they already make on being able to provide care at a lower cost and my experience indicates they simply pocket the extra cash and not invest it in the business.

- What is successful is if you use the Pinders evaluation to set targets for instance, that operators will get an extra £20 per week if they provide an en-suite and another £30 if they provide en-suite showers. That provides operators with the incentive to introduce them and the revenue to pay for the cost.

- It would certainly be fairer towards the non -purpose built home

- We are in support of this proposal.

- I am happy with the current 70/30 but I have no problem with the proposed 80/20

- I agree with this approach, to improve the quality of care provision the score should be based on a higher quality element. However the 'subjective' elements of the quality score also need to be removed to stop care homes being penalised based on inconsistent views of those completing the quality audits

- I would support this proposal as what one person may find as suitable may not be suitable to another. The main criteria for any fee should be the care and happiness of residents, not what wallpaper is used.

- I think an 80/ 20 model would be better and fairer. The residents are looking for good quality care, not necessarily a shower ensuite. More expensive facilities should be recognised but is not as important as the care.

- As experienced in 2 of our 11 homes in the County, [name of home] and [name of home], are currently on band 4, but have been told that they are unable to achieve band 5 due to the current Pinder Score system, and the link to provision of en-suite accommodation – however both homes are considered in there local communities as the home of choice. So it would depend on what tool was used to assess the environment. As such we support the proposed 80/20 methodology

- We agree it is fair and reasonable to all providers

- We continually look at improving the environment that are residents are cared for, as this is an integral part of the well being for all residents - appropriate care provision and environment.

- I think the current ratio is quite comprehensive and reflects the actual demand of service users requirements. Potential service users and their families still prefer to have ensuite rooms and have very high expectations in terms of the fabrication of the building and the facilities offered.

  I think the ensuites reduces the potential of cross contamination and service users can receive personal care in the privacy of their bedrooms which enhances the quality of care provided.

  The size of the bedrooms is very important in making the service users comfortable and homely because they can host family and friends in their bedrooms and this has direct impact on their privacy, dignity and self esteem.
  I think the current ratio split is just right and is also in line with the current Care Quality Commission standards.

- [Name of provider] believe that the physical environment has a large impact on the service quality provided, and as such spend a lot of time, energy and money to ensure our homes environments are as good as possible. After staff costs this is the biggest area of spend for the group. Sufficient recognition should be made of this in determining the quality score, therefore we do not support a reduction from 30%.

- I do not agree that the physical environment split be changed to 80/20 from 70/30, for the following reasons:

  i We have been Providers for the last 20 years and therefore have seen many changes in the requirements of our Regulatory Authorities. We have made a genuine commitment to be compliant with these in terms of the standard of accommodation provided and this has meant significant personal financial investment to enable improvements to be made on a rolling basis over many years. It is reasonable that Providers with a genuine commitment to provide and maintain good quality services/accommodation be remunerated to take these factors in to account by maintaining the 70/30 split.

ii In recent years we have found that families seeking placements for their relatives expect to see at least a good standard of accommodation, with single bedrooms of a good size (some insist on an en-suite facility) and spacious, light communal areas. Therefore we have had to make financial investments in meeting these requirements. This has meant converting our existing double bedrooms in to single occupancy very large rooms, with capacity for en-suite facilities and as a result loosing overall bed space numbers in the building. Fortunately, we were able to extend the building to make up the majority of the loss in the bed spaces.

iii Care homes that continue to have double bedrooms and need to improve their general environment, must endeavour to do so in order to keep abreast of consumer demand and changes in requirements.

iv It is unfair to change the split to 80/20 as this would penalise the vast majority of Care Homes that have made significant financial investments to update/improve their environment. In order to move forward as a Care Sector which is fit for the future, it is essential that Provider services keep up to date with requirements for both Regulatory Authorities and consumer demand/expectation.

- A good quality environment benefits everyone involved in the care process, the efficiency, safety and hygiene of care provision can be greatly enhanced or at least eased as a result of the environment it exists within. It would be dangerously counterproductive to undervalue this element further than the existing bias (already heavily skewed to diminish the environments influence). The 30% factor should not be reduced in our opinion.

- 80/20 is far better. I have always said the care is paramount. What is the use of a great environment if the care is rubbish/dangerous. Many new homes have wonderful facilities, far better than residents would have at home – but it is sterile/hospital type environment with very high staff turnover rates. I think this is a fantastic move.

- To encourage investment in care which takes many years to recoup - it is important that the fee structure remains transparent, stable over years and fair. Significant changes mean that existing providers will not be able to get the backing of banks etc who will see the income stream as unreliable.

- The aspects of the physical environment that do impact on resident care should remain and be sufficiently reflected in the fee. So decoration, size of room, lifts etc should be included. Showers in each room could be excluded.

- I welcome it. Prior to our extension our building was totally inadequate and the highest banding we could achieve was Band 4 unless we scored 100% in the quality care audit.

The NCA have not responded to this question.

Summary of responses

There were mixed responses from providers about the proposal to change the audit process to reflect the 80% for quality and 20% for environmental factors, with some providers indicating that this would be seen as being fairer for the older, non-purpose built homes, whilst others commenting that this would not recognise the capital investment made by some providers who have upgraded their facilities and would not sufficiently provide incentives to other providers to improve their care home's environment in the future.

The Council's analysis and comments in relation to providers' responses to Question 10

As indicated by some providers in their feedback, service users and carers have higher expectations about the quality of the environment in terms of the fabrication of the building, the facilities offered and prefer single, larger rooms with en-suite facilities. It is recognised that these factors help maintain standards of efficiency, safety and hygiene. The Council would also want to continue providing sufficient incentive for care home providers to invest in the environmental aspects of their provision as well as the quality of care. It is proposed that the current model will continue with the quality/environmental split of 70/30 being retained.

Question 11

To ensure the needs of residents with dementia are met the Council is considering both developing specific placement criteria and a care home accreditation process.

Do you think that this will a) help people to choose care homes more suitable for their needs and b) help care homes to promote specialist dementia care services?

The responses received from providers are detailed in full, as follows:

- We support in principal but do not see why there is discrimination in favour of one care group. The same criteria should apply to all placements

- 'Should do.

- As long as the accreditation process is fair & not biased to new, purpose built homes

- More information required

- We are specialist dementia care providers, and as such do believe it is critical that staff have the correct training – this is a massive area and it could go on and on

- I agree with this approach. In developing the accreditation process consideration should be given to any endorsements/partnerships care homes have with external bodies such as the Alzheimer's Society. The process should also consider specific dementia training provided to staff to ensure that staff are skilled to deliver care more suitable to individual needs.

- Our Home already went through a detailed registration process with CQC to obtain a dementia registration. I am not sure what additional benefit a further accreditation will achieve other than an additional cost burden.

- I think more details are need on this before we could respond further.

- I do not agree fully with this. There is not a 'one fits all' solution for people with dementia and to impose criteria could leave very good homes out. Some homes do not have purpose built homes with circular paths etc, but can offer a much personalised service which is more important and which is difficult to measure with criteria. I would expect staff to have dementia care training and a plan in place as to how people are looked after, but to be more specific can be dangerous. If the council wishes to promote good dementia care services then I think they need to look at providing a more supportive role instead, e.g. training, sharing experiences amongst providers etc.

- [Name of home] have been addressing the quality of dementia provision within the industry for a number of years, including by the creation of an internal accreditation process. This has been hugely successful in developing the services we offer. in a number of regions throughout the country and which will

be rolled out to the homes providing care for people living with dementia within Nottinghamshire on a phased programme. We believe that such an accreditation, when managed properly does indeed give people greater understanding of the suitability of a home to support their own, individual needs, and does promote specialist dementia care.

- [Name of provider] are currently working towards creating an accreditation for Dementia services and this includes consideration on the following aspects:
    - Activities of daily living
    - Environment
    - Carer/qualified learning & development
    - Leaders trained as skilled Dementia Care Mappers
    - Specific care planning documentation to support residents needs more effectively

  To achieve all of this a significant investment is required from [name of provider] to provide the additional skills and the improved level of interaction. Residents with Dementia do require a higher level of staffing ratio to provide additional services and this needs to be reflected within the bandings.

- Care homes providing dementia services offer the appropriate environment and increased staffing levels. This also includes specifically trained staff in dementia awareness and interventions. The ratio of staff to residents is significantly higher in dementia care homes compared to general residential. 1:5 & 1:8 respectively

- I feel the accreditation process will only continue to create unnecessary expense to the tax payer. The CQC report, Quality Audit and visit of the home should be sufficient for any potential service user.

- Yes, provided the specialist services are given an appropriately Increased fee to reflect the specialist care.

- I think this approach is excellent and this will lead to enhancing dementia care in Nottinghamshire. Obviously I would be keen to see the details of the proposals to make a final judgement.

- A care home accreditation process is essential if people living with dementia are to receive the appropriate standard of care, but must utilise the Alzheimer's Society Standards and cover other areas such as training, the use of anti-psychotic medication and clear evidence of leadership in dementia care at the highest level.

- At present residents supported by Notts County Council with Dementia needs receive an additional £10.00 per week in the funding. This equates to £0.05 per hour, which can only be deemed a token contribution towards the care provided. Therefore, there needs to be put in place a more realistic remuneration for caring for residents with dementia needs.

  It was discussed at the meeting that increased funding in this regard was being considered in conjunction with a new process. Care Homes are already overburdened with Regulations, Audits, Inspections, reviews, etc and

therefore any new proposed layer of assessment criteria/accreditation process needs to be very carefully put together, so as not to add even further significant workloads for management staff.

The proposed system may well be useful in the respect that it may more clearly define/assess residents who have specific behavioural issues that can not be met safely in a Care Home or Care Home with Nursing, as these residents would need placements in Care homes that specialise in this area. This would help people choose care homes more suited to residents with this high level of need.

It is essential that any new system be transparent and made as simple as possible to minimise unnecessary extra work required from our already very busy staff. It is our experience that criteria's within systems are often changed, making it difficult to achieve a satisfactory outcome: for example getting residents assessed from Residential status to Nursing status.

The Notts Care Association must be involved in formulation any proposed new system

- The quality banding system already implies achievement/attainment of certain standards, further accreditation systems would seem to be unnecessary and potentially confusing.

- Yes – I do – on both counts. I am fully behind accreditation route

- I would need to see the specifics in more detail to usefully comment. But CQC already accredit care homes, does there need to be a duplicate process.

- Can the Council do this legally if CQC have registered a home to deliver dementia care? I doubt it will make any difference. People choose Band 1 and 2 homes irrespective of the quality of care provided

The NCA have not commented on this question.

<u>Summary of Response</u>

Feedback from the consultation shows that approximately half of the providers support the introduction of an accreditation process which, when properly managed, gives people a greater understanding of the suitability of a care home to support individual needs and helps promote good quality specialist dementia care. Providers also noted that consideration should be given to the Alzheimer's Society standards, covering areas such as training, usage of anti-psychotic medication and leadership in dementia care at the highest level. There was also a view noted that any accreditation process should not, in itself, be biased towards new or purpose built care homes and that specialist services needed to be appropriately remunerated to reflect the specialist care. Individual providers did offer the Council the opportunity to view their own dementia accreditation programmes.

Approximately a quarter of responses did not support the proposals with providers stating that the current banding system already implies attainment of standards or that the CQC registration process should suffice.

The Council's analysis and comments in relation to providers' responses to Question 11

The Council has clearly indicated to providers that one of its priorities in relation to this service is to support providers to improve the quality of dementia care. The current fee structure means that all providers who deliver dementia care services are awarded a dementia payment. However, currently, there are a number of care homes that, whilst providing services for people with dementia, are not able to demonstrate high quality dementia care.

The Council proposes to award a higher level of payment to those providers that are able to demonstrate and evidence high quality dementia care, including high level staff training. Those providers who are not able to demonstrate high quality dementia care will not be allocated the higher level of payment for new residents.

The Council has not yet developed the details of this initiative and proposes to work together with providers to consider different options and agree the best means of determining how and to which care homes the higher level payment would be allocated. The Council will seek the expertise of some providers who already deliver excellent dementia care services in the development and the implementation of the initiative. It is proposed that this will be implemented over a number of months with all new dementia care placements attracting the higher level payment where the providers have shown evidence of high quality dementia care.

Question 12

In its commitment to the further promotion of high quality dementia services, Nottinghamshire County Council is considering the option of creating 'Beacon Status' for a small number of care homes, i.e. with the expectation that those homes would share examples of excellence, innovation etc and promote good practice both within, and outside of, Nottinghamshire.

Do you support this proposal and what criteria do you think the Council should be setting for the creation of 'Beacon' status homes and what, if any, rewards should be considered?

The responses received from providers are detailed in full, as follows:

- This is supported in principle but with an appropriate fee level. We have our own dementia programme and any operator who would deserve the accreditation should also have a system the incentive needs to be worthwhile and be geared to delivery of defined outcomes.

- Yes, in principle. The rewards, if any, should, possibly, be a % of income paid by the council.

- [Name of provider] supports this proposal. The criteria should be excellence in care. The prestige of being a Beacon Home would be reward enough.

- Yes, I really support your proposal and would be delighted to have the opportunity to be a 'Beacon' status home and assure you we would work flat out to help you achieve your goals

- I partly agree with this proposal since sharing good practice with homes with lower quality rating will improve the quality of service provision across Nottinghamshire. However there is a competitive disadvantage of 'excellent' homes assisting 'poorer quality' homes to improve. Given the area has excess capacity this approach may lead to an erosion of occupancy in the better homes.

- Further details of this scheme are needed before a detailed comment can be made

- I agree with the idea of sharing examples of excellence, but I don't really see what a 'beacon' status will do and if it will be fair. Can anybody achieve the beacon status or is it limited to a certain number? And who would give them the status and on what basis?

- We support this proposal, which we expect would enable improvements in quality across the county; a proposal which we, as a responsible and well-resourced corporate provider would be happy to take a lead role in. We would welcome the opportunity to meet with the local authority to discuss our accreditation process which is highly regarded within the industry.

- We support the proposal of the expectation that those homes would share examples of excellence, innovation etc and promote good practice both within,

and outside of, Nottinghamshire. The Beacon Status would need to be a home that has sustained level 4/5 banding and has evidence of internal quality monitoring processes which demonstrate positive outcomes for residents in their care.

- In principle we would embrace the concept, as an organisation we strive for continuous improvement in all areas of our homes.
- It would be important that should a home become a Beacon status home that they are not burdened with additional reviews or audits that impact the delivery of the services to the residents.

- Would like more information on this before I comment.

- To safeguard the 'beacon' status they will probably be only awarded to 5 star homes which is discriminatory to other homes and surely disadvantageous

- I welcome this approach and I think the long term benefits will become evident. Beacon homes must be selected on the basis those that achieving band 5 consistently. In current climate financial reward will be the most useful to these homes.

- Beacon Status Homes will recognise true innovation and commitment to caring for those living with dementia. Beacon status must include evidence that homes are providing training that makes a difference and that can be evidenced. This must be structured and shown career progression opportunities, with leadership training.

  Focus on engagement and interaction not entertainment.

  There is clear understanding about the needs of older people living with dementia and their families and that this is measurable. Life history work must be seen to happen with homes creating care based on individuals and their life experience and remaining strengths.

  The physical environment should reflect the need for space to walk and be orientated with themed areas and social meeting places such as cafes.

  Staff must feel confident and empowered to act as advocates for those living with dementia and the beacon homes should have Dementia Champions.

  Antipsychotic medication should be used as a last resort and this should determine part of a beacon homes status.

  Rewards should be in the form of an enhanced payment and priority placements for beacon homes. This could save the authority considerable amounts of money if people were not inappropriately placed in nursing care at great cost.

- It was discussed at the meeting the proposal for some Care Homes in Quality Band Five to be accredited with Beacon Status, to assist other Providers.
  I am unsure whether this could be achieved effectively as Providers historically are so busy running their own homes, that it may conflict with the time/effort expended in assisting others. The financial remuneration proposed to support this scheme would need to be fully compensatory for the time/input that would need to be expended to achieve satisfactory results.

- As per Q11 It is possible additional accreditation/status beyond the five quality bands could undermine the clarity and transparency of the existing system, funding could be better aimed to encourage Band 5 homes to expand their role to function as models for other homes could learn from, however there are likely issues re competition and investment that need to be resolved in order to achieve this.

- There should definitely be some reward – Not sure what the criteria should be

- The Beacon status should be open to all classifications of homes. Status should be for homes scoring highly on the care portion of the audit. The reward must be sufficiently large to more than cover all the Beacons homes additional costs and provide a significant financial incentive.

- Knowing we would achieve Beacon Status I welcome this. However Beacon Homes should contribute to supporting the development and improvement of other homes. In order for Homes to do this they would have to be rewarded financially otherwise why do it. Beacon Homes should participate in research to improve practice and performance. Beacon Homes should have a recognised kite mark.

The NCA did not specifically respond to this question.

<u>Summary of Response</u>

The majority of responses (three-quarters) supported the proposals although a number raised issues relating to whether the scheme would need to be financially incentivised.

4 providers fully supported the proposals and felt that the prestige of being a home with Beacon Status would be sufficient reward with a further provider supporting the proposals in principle but commenting that it was important that homes should not be overburdened with additional reviews/audits

A further 5 providers supported the proposals in principle but felt that they should be financially incentivised with a further provider simply stating that there definitely should be some reward but not specifically saying whether they supported the proposals or not

The Council's analysis and comments in relation to providers' responses to Question 12

The support indicated by providers in their consultation feedback in relation to this proposal is welcomed. The Council is of the view that, as well as providing help and support to providers to improve the quality of care, it is reasonable to also expect providers to support one another and their industry to achieve continuous improvement in the quality of care that they provide.

It is important to acknowledge that some providers in Nottinghamshire who provide excellent care services have already recognised and acknowledged the need for providers to help improve the standards of care across the care sector. Also, some of these providers have already expressed a keen interest in being actively involved in helping poorer quality care homes to improve their quality of care, through the use of mentoring schemes, sharing of knowledge, providing information on best practice etc.

The Council is keen to support and promote this approach and in doing so would also wish to reward excellent quality care providers through the award of Beacon Status.

The details of the initiative are yet to be determined and the Council will seek to work with providers at the developmental stages, ensuring that the excellent practice in existing dementia care homes is drawn up and used to help and inform the process. Consideration will also be given as to whether any remuneration will be given to those providers who are awarded beacon status in recognition of any additional costs they may incur in fulfilling the responsibilities aligned to the status.

Appendix D

Stage 2 Consultation: Further Clarification from Providers

Providers who responded to the Stage 2 consultation exercise were asked to provide further clarification and supporting evidence in relation to two specific issues identified in the fee proposals:

- assumption of 92% occupancy
- adjustment to staffing levels

The questions and responses received to each are detailed below.

1 On the basis of its commissioning intentions as described in the Stage 2 consultation document, the Council is proposing to base its fees on average occupancy levels at 92%.

What is your view on this proposal? If you think this is not reasonable, please can you explain why and on what evidence you base your views?

- I run a 30 bed home & if I average my typical occupancy level of 27 that equates to 90%. Clearly, however, larger homes may stand higher shortfalls yet could (possibly) be able to achieve an average closer to the proposed 92%.

- Whilst we welcome the Authority's awareness of current occupancy levels, which per the consultation response are 88.1% in the East Midlands region we would again wish to note that in our 10 care homes within Nottinghamshire itself the average occupancy is currently at 82% well below the proposed bar. As you will be aware, care homes with an occupancy level of 80% struggle to retain quality with profitability only really returned where occupancy can sustain above 85%. Whilst we understand the Council's strategy not to pay for inefficiency of operation – hence the assumption of 92% - we believe this is set too high and should be set nearer to the realistic occupancy levels achieved by well managed homes in the county.

- I do not feel 92% occupancy is realistic in the current market. Over the last 3 years the residential market has changed completely, we now have more respite service users coming into the home than at any time in our history. These service users over periods of several months come in and leave every few weeks creating a significant amount of administrative work as well as a continual rehabilitation for the carers to enable the service user to settle and relax in their surroundings. This coupled with a huge reduction in referrals, increased dependency of every service user coming into the home and in effect a drastically reduced life expectancy once a service user becomes permanent the effective occupancy rate for my home is more in the region of 75-80%.

- The management have indicated that they believe your proposals are fair and reasonable.

- Whilst our opinion is that occupancy levels of 92% are achievable given cooperation by all parties to ensure that any vacancies are filled in a timely manner, we raise the point that the national occupancy average occupancy is around 88% (as recently reported in the Knight Frank research document). Coupled with the fact that four of the six homes we operate in Nottinghamshire have significant number of interim beds which naturally have a high turnover of residents leading to more vacant periods we would recommend a reduction in the 92% assumption.

- Your consultation document (page 5 of 42) stated “to assume that Care Homes have 100% occupancy at all times is unrealistic.” You further acknowledged “the average occupancy levels reported within the provider survey was 83%.” You will therefore not be surprised that to come up with an assumption that Occupancy Levels are 92% is unrealistic and does NCC no credit at all. It makes a mockery of the term “Fair Price for Care Programme.” In our view if you stick to this fabrication your credibility falls at the first hurdle.

  We have attached the Yearly average occupancy for our three Nottinghamshire Homes from 2002 to 2012. You will see that overall we were very close to the survey average of 83% being slightly better probably because the care home 1 average has been helped by the block booking of 10-12 beds, while care home 2 has benefitted from a slightly higher number of private clients. Without those two advantages we have no reason to think we would not be very close to 83%.

  Currently, due to NCC making very few placements, our occupancy over all three Homes is only 80%. You must surely realise that when NCC restrict placements, occupancy levels decline; this affects our efficiency and has a knock on effect on our profitability. That means that in an area like Sutton-in-Ashfield where very few private clients exist, and the few that do quickly use up their savings, we need higher fees to sustain our fixed overheads especially with ever increasing power costs and wage bills. To achieve an average occupancy of 92% you would really need to take the brakes off of placements. If you know that is not likely to happen, as seems certain in the current climate of austerity then we will be hard pressed to average 80% occupancy going forwards. The National Audit Social Care Intelligence Service has recently confirmed that the number of people receiving care services in 2011-12 was down 7% from 2010-11 and down 17% from 2006-07. We have never known a time when fewer placements are being made and would certainly support our Association in challenging your assumption of a 92% occupancy which is clearly a device to reduce the fee. You cannot possibly be said to be “meeting the legal requirement to take into account the actual costs of care” if you persist with this figure.

  Having worked out an average of 83% occupancy we would like to know how this varied across the banding levels.

- Our own experience of occupancy levels is somewhat different to your proposed expectations. At no point in this calendar year have we achieved an occupancy of 92% or higher. BUPA confirmed in March of this year their average occupancy

across its 302 homes was 87.3%. Knight Frank released details of its study into care homes in August this year. Its study revealed average occupancy rates of 87.8% for the UK as a whole. This was however skewed somewhat because occupancies in London, Northern Ireland, South East & Scotland were higher than the average. Four Seasons Healthcare average occupancy was less than 90% in 2011. We are at a loss to identify how you perceive 92% occupancy to be a good yard stick when setting fees. It is not a figure we recognise or any of the sources noted above. I would recommend occupancy of 88% is more realistic.

- I am a member of the South Notts Care Forum and of course all these subjects get raised at our meetings. My response to your questions reflects the actualities of the general market rather than my specific care home – mainly because we are a family run organisation, which is a different beast entirely. The 92% occupancy rate is definitely not being hit by most providers – it is more like low/mid 80's. There are some providers who maintain a very high level of occupancy but because the fair price for care model is aimed "at the market" it is very dangerous to cherry pick a number that is unobtainable (and will remain so) for most. Given that providers have such high fixed costs – which by definition are there regardless of the occupancy rate – in the model these costs should be spread across the actual occupancy rates not an inflated figure. If these costs are not reflected fairly in the model the only way for providers to go is to try and cut other costs – training, food, heating, repairs etc.

- Your proposal under estimates the occupancy level that is being and can be achieved for the average Nottinghamshire home. We have seen a clear move by social services towards respite and shorter term care that inevitably leads to more "voids" and lower overall occupancy. The evidence from your report is that the average occupancy across the County is 83%. As your proposed unrealistic occupancy level of 92% reduces the fee across all categories; staffing, non-staffing and capital costs this will lead to serious risk that residents will not have their needs met. Care homes operate with very high fixed costs. These costs have to be spread across all their residents. If those overheads are not covered then the only way independent care homes have to cover them is by reducing other costs, such as care hours, food and maintenance etc. So using artificially high occupancy rates will result in insufficient funding. Thereby resulting in the danger that the needs of the residents cannot be fully met.

- It is my belief that under this present climate (i.e. heightened eligibility criteria and home care preference) it would be difficult for Care Homes to achieve an annual occupancy level of 92%. The eligibility criteria being set high means the average residential duration has fallen and will continue to do so, therefore a greater number of time laps days between the previous resident and a new resident adding to the number of unoccupied beds thus reducing occupancy levels and adding cost to the Care Home in the form of room refurbishment, Home viewings, assessments of potential resident which may include hospital or home visits and associated paperwork). The result of the (KPMG) survey showing occupancy of 83% is historically low, but taking into account the changed circumstances of the care sector as stated above which gives a truer reflection of the situation. Clearly the possibility of achieving an annual occupancy level of 92% is in my opinion unobtainable. The above views are based on the last twenty four months of trade.

- We, using an independent consultant, Casendic, carried out detailed research on local competition. The findings of this research were that Nottinghamshire care homes have an average occupancy of 82%. This was based on a survey of the closest competitors to each of our homes. We therefore propose that this would be a fair occupancy calculation.

- I feel that basing fees on an average (assumed) occupancy level of 92% is unfair, and it does not reflect the actual average occupancy levels in Care Homes in this consultation. The evidence given by Care homes who submitted their responses to the Stage 1 Consultation reported an average occupancy level of 83% and this figure was included in the subsequent report of the data gathered.

  It was confirmed at the consultation event that Nottinghamshire County Council would continue to support people who wished to be cared for at home, provided it was safe to do so and their needs could be met in full. Therefore, by definition, new residents being admitted to Care homes have significant care needs and higher dependency levels, which cannot be met in the home environment. In addition, residents with health care needs who are admitted to Care homes with Nursing, have increased dependency levels and complex health care needs that cannot be met in the home environment and it would be unsafe to do so.

  The eligibility criteria for Nottinghamshire County Council funded residents for admission to Care Homes has been increasing over the last few years and it appears that this has led to fewer residents being admitted to Care Homes, which has led to a significant decrease in bed occupancy levels. We have experienced fewer enquiries and placements over the last eighteen months as, we understand, there has been greater emphasis on people being cared for at home with the support of external services i.e. carers/district nurses. Our own occupancy levels have averaged in the region of between 78% to 85%.

  As stated in points 1 and 2, using artificially high occupancy rates will result in insufficient funding to Care Homes. The very high fixed operating costs that Providers have to meet to ensure that resident's needs are fully and the environment is maintained to at the very least a good standard has to be supported by sufficient funding. If operating costs are not covered, there is a risk of Providers reducing costs such as staffing, consumables and the maintenance of the building/equipment. There would be a serious risk of resident's needs not being met and the environment not being safe. Therefore, as 92% occupancy does not accurately reflect the actual average occupancy levels given by Care Homes in the Consultation Stage 1, it not fair and unreasonable to use that figure. A figure nearer to 83% is therefore fairer to use.

2 Based on the responses received from providers to the Stage 1 Survey Questionnaire in relation to staffing levels, the Council is proposing to set fees

which assume staffing levels above the industry norm by 7.5% for care homes and 4% for care homes with nursing.

What is your view on this proposal? If you think this not reasonable, please can you explain why and on what evidence you base your views?

- Although 7.5 % is to be welcomed, Incremental increases in food, Utility, Wage, maintenance & mandatory training costs make the proposal rather 'tight'.

- There is little we can add to the responses we made to the Consultation Questions regarding occupancy and staffing levels other than to point out that Laing & Buisson's latest revision to the Fair Price for Care toolkit has shown that dependency levels of care home and nursing home residents have risen faster than expected. These findings match our own experiences. This may go some way to explain the discrepancies in expected staffing levels and actual staffing levels.

- We referred in the introductory paragraph that we now have a considerable number of dementia clients who require higher staffing levels and we appreciate the fact that NCC have understood that and pay a higher rate for dementia clients. However, as NCC have restricted placements by increasing eligibility needs to gain a supported place in a Care Home we are finding even our basic elderly clients are requiring more care not less. It therefore does not come as a great surprise to us that many Homes in Nottinghamshire are above Laing & Buisson National averages. As in 1 above this is an effect caused by the Council's placement strategy. We feel it is essential that the assumptions made in calculating fees should be consistent with the assumptions in the Council's placement strategy.

  Looking at the hours presented in Table 2 on p7 of your report we seem to be slightly under the average for Care Hours but very close to the average for none-care hours. We are trying to recruit more Care staff at present but find this quite difficult at current wage rates. One of the main reasons we need higher fees is to enable us to compete in the labour market.

  From the above one might expect our wage costs would be considerably under the amount calculated in Table 1 which is not the case. Is this because you have not put a high enough value on the hours worked by our staff or is it to do, as I suspect it is, with the 92% occupancy?

  Our conclusion is therefore that we could probably cope with your proposals on hours worked at present were it not for the unrealistic occupancy assumption.

- There is little we can add to the responses we made to the Consultation Questions regarding occupancy and staffing levels other than to point out that Laing & Buisson's latest revision to the Fair Price for Care toolkit has shown that dependency levels of care home and nursing home residents have risen faster than expected. These findings match our own experiences. This may go some way to explain the discrepancies in expected staffing levels and actual staffing levels.

- We are not aware of the criteria used of Lang and Buisson and therefore cannot comment on the suitability of the proposal. We would however be interested in

what average pay rates you are assuming when using the varied Lang and Buisson staffing ratios as this is just as important.

- At a time when resident dependencies are increasingly high and where client groups, Care Quality Commission and our own internal observations require us to increase staffing levels we would view any reduction in staffing levels as having a negative impact on direct delivery of care. Any such proposal would seem to be in direct contrast to resident needs and the fundamental principles of delivering high quality individualised packages of care. The impact of reduced staffing levels is a direct causative factor in the majority of safe guarding referrals and areas of non-compliance and poor practice. As a responsible provider we will continue to staff our homes as necessary to support and protect our users and to ratios expected by those commissioning services from us.

- With regard to staffing, the annual increase in minimum wage and the demands placed on carers and support staff by the higher dependency of service users and respite placements leads me to suggest a staffing level above the industry norm of 10% for care homes.

- The management have indicated that they believe your proposals are fair and reasonable.

- In view of the fact that the six homes operated by us in Nottinghamshire include related TUPE costs, and little time has passed for these costs to be brought into line with industry norms we argue that, for us, staff costs are far higher than industry norms plus 7.5%, and would therefore seek for this to be recognised.

- I am a member of the South Notts Care Forum and of course all these subjects get raised at our meetings. My response to your questions reflects the actualities of the general market rather than my specific care home – mainly because we are a family run organisation, which is a different beast entirely. The hours of care that the model assumes are not the figure being reported to me at our forum and elsewhere – it seems homes are providing more hours than this. I was at the consultation event and although I cannot remember the exact figures quoted (I think it was 15% higher for care homes) all attendees said the figure in the model was too low for Nottinghamshire and the care provided at the level shown in the model would be dangerous and lead to the needs of residents not being fully met.

- Your proposal dangerously underestimates the level of care staffing hours required. The evidence is mostly in your own report, tables 2 and 4, page 7 gives a good baseline starting point. The fee should be based on no less than these and, in light of the following comments, actually be at a higher level. The residential care we provide for funded clients is significantly higher. Your calculations for nursing care (FNC) are equally very concerning. We provide significantly more hours of care than you are proposing and is evidenced in Tables 2 and 4 of your report. If we were to follow your proposal this will lead to serious risk that residents will not have their needs met. We have also noted that the eligibility criteria for council funded admission to care homes have been steadily increasing over the last few years. On admission, council funded residents generally require higher levels of support than privately funded residents. Therefore just using the “average care

hours" for Nottingham will result in too few hours being funded for the council funded clients.

I am also concerned that many of your other costs are not in line with the market costs, in particular finance costs, food and management costs. Other detrimental effects have been the reductions in grant funding, increase in regulation and statutory guidance. In the future the effects of increases in the National Minimum Wage, compulsory pension contributions etc. will have a major impact which will be even greater if the correct cost structure is not identified now.

- I find it inconceivable that either of our homes could reduce staff levels without the consequence of a reduced level of service and therefore a heightened possibility of risk to residents. The annual Quality assessment survey was introduced by Nottinghamshire County Council to improve the standards in the County Homes and year on year since its introduction standards have indeed improved, however to achieve these improving results it has been necessary to increase staffing levels and I fear that unless realistic fees are forthcoming the quality of service will fall leading to additional costs to the services provided by you the Local Authority and the NHS services. The above views are based on the last twenty four months of trade.

- As the occupancy percentage used in the 'Fair Price for Care Programme' differs greatly to our survey findings it is reasonable to assume that the same will apply to the calculation of the 'industry norm staffing levels'. As greater efficiencies are possible at higher occupancy levels, the use of an inflated occupancy % will result in a distorted payroll calculation per resident. Thus on this basis we believe that there may be a risk that this could result in the Council being in breach of its legal obligation to pay a basic fee at a rate that covers the fair cost of care.

- Providers have given their data for care hours/staffing costs for the services that they are providing (Tables 1 and 2). The report states that for Care Homes with Nursing, Industry norms are stated to be 14% lower for care hours compared to the Provider data. The Council's proposal above indicates using the Industry Norms data plus 4% for Care with Nursing. This proposal is unfair as it is still lower than the data given by Providers in this Consultation. Our own staffing costs are 12% above the average staffing costs identified from the Provider survey. Therefore, I feel that the data contained in Tables 1 and 2 should be used. It seems fairer to me to use the data given by Providers in this Consultation with regard to their actual operating costs, rather than Industry norms which are not representative of the real costs.

  With regard to increasing dependency levels and complex health care needs. As there is continued support to enable people to be cared for in their own homes, residents being admitted to Care Homes with Nursing require significant input from both Senior Management/Registered Nurses and carers with regard to all aspects of their care and daily life. In order to fully meet the needs of residents, it is of paramount importance that there is sufficient funding to support the operating costs of the employment of staff at all levels to deliver the services to residents.

As stated above our staffing costs are 12% above the average staffing costs identified from the Provider survey with 2% CHC provision. We greatly value our staffing team and consider it to be of paramount importance to provide a stable, reliable, hardworking workforce, which in turn provides reassurance and stability to our residents. Our Matron/Deputy Matron and Registered Nurses have worked with us for many years and have a genuine commitment to providing the best of services to residents. Management staff ensure that staff are supported in their roles and as a consequence we have a very low turnover of staff and the majority have worked with us for many years. In order to maintain this level of professionalism and commitment to providing a good standard of service to residents, our staffing costs are higher as we regard the remuneration of staff to be of paramount importance and staffing levels must be commensurate with the dependency levels of residents.

Appendix E

Comparative Data – Other Local Authority Fee Levels

2012-2013 Fee levels in neighbouring authorities (for all care types/quality bands in neighbouring authorities)

Authority	OP Residential £ - range	EMI Residential (Elderly Mentally Infirm) £ - range	OP Nursing £ - range	EMI Nursing (Elderly Mentally Infirm) £ - range
Nottinghamshire (for reference)	348 min	359 min	376 min	386 min
	469 max	515 max	516 max	558 max
Derbyshire	380.73 min		501.33 min	-
	401.73 max		522.33 max	-
Leicestershire	288 min	341 min	525.40 min	568.00 min
	404 max	404 max	525.40 max	582.40 max
Lincolnshire	391.00 min	391.00 min	416.00 min	416.00 min
	432.00 max	432.00 max	416.00 max	416.00 max
Northamptonshire	367.70 min	405.02 min	505.37 min	533.88 min
	367.70 max	405.02 max	505.37 max	533.88 max
Nottingham City	343.30 min	-	452.00 min	-
	433.00 max	-	573.70 max	-

Source: Nottinghamshire County Council research

Note: the nursing rates do not include the £108.70 Free Nursing Care (FNC)Contribution

Nottinghamshire County Council

Report to Adult Social Care and Health Committee

4th February 2013

Agenda Item: 5

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION

NATIONAL POLICY DEVELOPMENTS ON MONITORING AND REGULATING CARE STANDARDS

Purpose of the Report

1. To provide an update and overview of recent national policy developments relating to the monitoring and regulation of care standards, and to request support for a Council response to the consultation on market oversight of adult social care.

Information and Advice

The State of health care and adult social care in England in 2011/12

2. In November 2012 the Care Quality Commission (CQC) published their report to Parliament on **The state of health care and adult social care in England in 2011/12.** This draws on evidence from the CQC's register of care providers, inspections, experiences of people who use services and national statistics. It also includes findings from the CQC's themed inspections which in 2011/12 included dignity and nutrition for older people in acute hospitals, and services for people with learning disabilities.

3. In summary, the CQC found that the 'increasing complexity of conditions and greater co-morbidities[1] experienced by people are impacting on the ability of care providers to deliver person-centred care that meets individual's needs'.

4. The report highlights the nature of the current population and how this impacts on the shape of the health and social care sector. Figures show that by mid-2011 England's population was at its highest ever level, at an estimated 53.1 million. Within this, 8.7million people were aged 65 or over and 1.2 million were 85 or over. As the population ages, there is a rise in health conditions for which age is a major risk factor, such as dementia. There are now 800,000 people living with dementia across the UK. It is forecast that one in three people over 65 will develop dementia, which means providers will have to develop increasingly specialised skills to care for people. In addition, there are more and more people living with long-term conditions such as diabetes, heart disease and respiratory diseases as well as cancer. One in four people will experience mental health problems at some point in their lifetime.

[1] Two or more coexisting medical conditions.

5. The report also identifies changes within the health and social care landscape, which include increased NHS day treatment, people spending less time in hospital and more recuperation at home, and provision of NHS services through independent sector providers.

6. In the adult social care sector there has been a decline in residential care services, and new types of support and provision have been developed that enable more people to live at home for longer. There has been an increase in extra care housing, and short-term nursing care in homes replacing extended stays in hospital. Reablement services have been extended, and are now a mainstream part of the support offered by many local authorities. The provision of home care rose significantly in the year: there were 6,830 domiciliary care agencies registered with the CQC; an increase of 16% on 2010/11. At the same time, the number of residential care homes registered with the CQC decreased by 2.5%. The report also recognised the increasing number of people who are now funding their own care, and the number receiving self directed support – a rise of 40% on the previous year, leading to a growth in more personalised care services.

Healthcare

7. In the NHS the themed inspection programme looked at dignity and nutrition for older people in hospitals and found that 90% met the required standards. Where poor care was identified three things were found to underpin this:

    - cultures in which unacceptable care becomes the norm
    - an attitude to care that is 'task-based', not person-centred
    - managing with high vacancy rates or poorly deployed staff.

8. The CQC identified significant problems within independent services providing longer term care for people with mental health problems and learning disabilities, and these services performed badly in comparison with the NHS. They found that many people were in assessment and treatment services for disproportionate periods of time, with no clear plans for discharge and too many people were in services away from their families and home.

9. The CQC also took a particular look at discharge arrangements and found that patients discharged over the weekend are at significantly higher risk of being readmitted as an emergency. This illustrates the different levels of service provision over the weekend, either in the hospital setting or the available social care services.

Social Care

10. The CQC report notes that the increased complexity of people's social care needs seems to be having a direct impact on the quality of care they are finding through social care inspections. The poor performance in respect of medicines management continued across all types of social care setting, but was most evident in nursing homes, which proportionately have to deal with the more complex health needs. Worryingly, the same picture emerges when looking at the respect and dignity of people in social care settings - while residential care homes and domiciliary care agencies performed relatively well on providing respectful and dignified care, with 93% and 95% of services meeting the standard in 2011/12, the performance of nursing homes was less positive at 85%.

11. Information from the CQC's inspections shows that those services that maintain people's dignity and treat them with respect all have a number of things in common: they recognise the individuality of each person in their care, and help them to retain their sense of identity and self-worth; take time to listen to what people say; are alert to people's emotional needs as much as their physical needs; and give them more control over their care and the environment around them.

12. In the CQC's themed review of learning disability services, only 63% of the 32 care homes inspected as part of the review met the general standard on care and welfare and only 59% met the standard on safeguarding. In the review, the CQC saw some very positive examples of people being involved in their care and being given control over their care plans. Where there were problems, the most common issue was a lack of person-centred planning - with little information about people's individual preferences and likes and dislikes about how care is delivered.

13. Ensuring that people in care homes are helped with the food and drink they need is central to respectful and dignified care. There were some concerns about this in nursing homes and residential care homes. Inspections found that 80% of nursing homes and 89% of residential care homes inspected met this standard in 2011/12. Given that this is so vital to good care - particularly for older people - this is a real concern for the CQC, and will be the focus of a targeted inspection programme of 500 care homes in 2012/13. Findings will be reported in early 2013.

14. The increased co-morbidity and complex care needs of people requiring social care – for example managing people with dementia and cancer in the same setting – has a direct impact on staffing levels and in particular the increasingly specialist skills, training and support that care staff need. The CQC found that a number of services across the social care sector were not able to support staff with proper training, supervision, appraisals and development opportunities in line with the national standards. Of those inspected in 2011/12, 76% of nursing homes, 84% of residential care homes and 85% of domiciliary care agencies met the relevant standard.

15. As set out in its document - **The Next Phase** - published in September 2012, the CQC's intention is to make more use of its unique sources of information, and the information held by others, to drive improvement in how services are provided and to promote best practice. It intends to do this by being clear about good care and poor care; and reporting on the state of the different sectors, identifying problems and challenges in how services are provided and commissioned and recommending action.

16. The State of Care report for 2012/13 and future Market Reports will incorporate and synthesise the CQC's findings from the following pieces of work that will be published in the coming months:

    - The themed inspection programme examining the care given to people in their own homes by 250 domiciliary care providers
    - The themed inspections of dignity and nutrition in 500 care homes and nursing homes
    - The follow-up inspection programme looking at issues of dignity and nutrition in 50 NHS hospitals
    - Reviews of information and data on three topic areas:

- dementia care during admissions to hospital
- the experiences of people waiting for NHS treatment
- the physical health needs of people with a learning disability.

17. In addition, the CQC intends to include the findings of some of the first inspections it carries out in GP surgeries and practices.

Market Oversight in Adult Social Care

18. In the Care and Support White Paper **Caring for our Future: Transforming Care and Support**, the Government was clear it is not acceptable for people to be left without the care and support they need if a provider fails and goes out of business. Under current legislation no-one would be left without the care and support they need should a provider fail. The Government is now considering to what extent further measures are necessary to manage provider distress and failure to support a smooth transition for people who depend on care services.

19. The Government has published a consultation document, **Market Oversight in Adult Social Care.** Responses are required by 1st March 2013 and will be made available before or alongside any further action in this area, such as possible legislation.

20. The Government believes that there is a need for greater reassurance to people receiving services which are likely to close or transfer to new ownership. The primary motivation for any change is to minimise the risk of a negative effect on the health and wellbeing of care users in the event of a provider failing financially and ceasing to provide services.

21. Recent events have highlighted the need to review whether or not current mechanisms to oversee the social care market are sufficient, and whether additional measures are necessary to protect service continuity for care users. The difficulties faced by Southern Cross Healthcare in 2011 demonstrated that there are specific challenges associated with monitoring and managing transition and continuity of service if a provider that is operating across England with highly complex financial structures fails. The National Audit Office (NAO) recommended that the Department of Health should determine where current oversight was insufficient and where more central oversight is necessary.

22. The Government intends to provide a new legislative provision to apply specifically in the case of provider failure. It will impose a duty on local authorities to meet the needs for temporary care and support of any person whether self-funded and whether in receipt of residential or non-residential care if they have urgent unmet needs as a result of provider failure. Such a provision will extend and strengthen existing powers and duties to provide care and support and provide clarity for people who are receiving care at the time their care provider fails.

23. The Government believes that there is a case for additional oversight of those care and support providers that are above a risk threshold because of concern about their ability to ensure continuity of care, due to the factors listed below:

- size and scale of the organisation
- regional or sub-regional geographical concentrations (market-share) or
- highly specialist services with a wide catchment area of dependency.

24. The favoured proposal is to have stronger requirements on such providers to disclose relevant information to a regulator, and for them to have robust plans in place in case they fall into distress. This would require an effective regulator to oversee and enforce this process, whilst ensuring that in the event of exit from the market there is co-ordination and information sharing between all parties, supporting the work of local authorities. It is likely that the regulator would be the Care Quality Commission or Monitor[2].

25. Providers meeting a certain risk threshold would be required to provide financial information and other key metrics which would be similar to information required by investors, lenders and boards. The precise nature of the information required would be determined by the regulator in line with the Department of Health. Possible metrics may include: occupancy rates, capital investment in facilities, numbers of homes embargoed by local authorities, turnover of registered managers and compliance with the CQC's essential standards of quality and safety.

26. The regulator would analyse the data and perform a further risk assessment. Where a high risk to service continuity was identified the providers would be required to:

- prepare scenario-based contingency plans for the regulator to approve
- take action, or demonstrate what action would be taken, to protect continuity of quality services during any period of distress and transition, and
- submit information to support continuity of service in distress, e.g. regarding business structure and operating costs.

27. Adult Social Care, Health and Public Protection is planning to submit a response to the consultation document. Because the response is required by the 1st March 2013, it is not possible to bring the draft response to this Committee. It is therefore, proposed to delegate the response to the Corporate Director for Adult Social Care, Health and Public Protection in consultation with the Chairman and Vice-Chairman of the Adult Social Care and Health Committee. To help preparations of the response, it is proposed to set up a meeting involving Committee Members from all parties. The final consultation response will be shared with all Committee Members.

Other Options Considered

28. This is not applicable as the report is for information only.

Statutory and Policy Implications

29. This report has been compiled after consideration of implications in respect of finance, the public sector equality duty, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

[2] **Monitor** authorises and regulates **NHS** foundation trusts and supports their development, ensuring they are well-governed and financially robust.

Implications for Service Users

30. The proposals for increased market oversight are intended to provide greater protection and to help ensure continuity of care for people in residential and nursing home care and receiving community-based care.

Human Rights Implications

31. As already identified, the proposals for market oversight are intended to ensure and protect the human rights of people in residential and nursing home care.

Human Resources and Finance Implications

32. The proposed new legislative provision to apply specifically in the case of provider failure will impose a duty on local authorities to meet the needs for temporary care and support of any person whether self-funded and whether in receipt of residential or non-residential care if they have urgent unmet needs as a result of provider failure. This may have some human resources and financial implications for the local authority.

RECOMMENDATION/S

It is recommended that the Committee:

1) notes the content of the report.

2) supports the intention to produce a response to the consultation on market oversight of adult social care

3) delegates the response to the Corporate Director for Adult Social Care, Health and Public Protection in consultation with the Chairman and Vice-Chairman of the Adult Social Care and Health Committee

4) supports a meeting involving Committee Members representatives from all parties to help inform the response to the consultation.

DAVID PEARSON
Corporate Director, Adult Social Care, Health and Public Protection

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Constitutional Comments (LMc 09/01/2013)

33. The Adult Social Care and Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (CLK 23/01/2013)

34. The financial implications are contained within the body of the report.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

ASCH92

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

4th February 2013

Agenda Item: 6

REPORT OF THE SERVICE DIRECTOR, PERSONAL CARE AND SUPPORT (YOUNGER ADULTS)

TRANSFORMING CARE – NOTTINGHAMSHIRE'S RESPONSE TO WINTERBOURNE VIEW HOSPITAL, GLOUCESTERSHIRE

Purpose of the Report

1. To inform Members about the local action being taken to respond to the national concerns rising from the abuse perpetrated at the Winterbourne View Hospital in Gloucestershire.

Information and Advice

2. Winterbourne View hospital was part of an independent health care organisation and as such was commissioned by NHS commissioners. The County Council is not responsible for commissioning or funding care within hospital or healthcare settings.

3. In response to the BBC Panorama programme of May 2011, the Government established an inquiry to consider the abuse that occurred at Winterbourne View Hospital and make recommendations to prevent similar abuse from occurring in any other establishment.

4. In addition, the Care Quality Commission (CQC) undertook a national programme of inspections which included visits to 150 learning disability hospitals and registered care homes.

5. The CQC report found that:

   a. too many people were in hospital and they stayed there too long
   b. there was insufficient care planning and person centered approaches to care
   c. people did not have access to care and support locally, close to their families and friends.

6. The Government also considered the Mansell report which asserted that commissioners needed to take responsibility for ensuring that services were meeting the needs of people; that services should focus on personalised care and preventative social care; that services should be provided locally and that services should specifically meet the needs of people who have complex or challenging needs.

7. The Government published their findings in December 2012 in a report entitled, 'Transforming Care: A National Response to Winterbourne View Hospital'.

8. The review found that people placed at Winterbourne View were:

   - Often placed far from their homes and families
   - Stayed far too long in Hospital with average stays of 19 months
   - Experienced a very high number of physical interventions
   - Experienced poor quality physical healthcare
   - Did not have their concerns picked up by other agencies such as local authorities, Police and Hospitals
   - Often did not have access to families and other visitors.

9. The report sets out a programme of 63 actions to be carried out by Central Government, the NHS, the CQC, local government and various other statutory bodies.

10. The Governments mandate to the NHS Commissioning Board says;

    "The NHS Commissioning Boards objective is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities, and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on in patient care for these groups of people".

11. In summary the main measures which the Government have determined are:

    - **An end to all inappropriate placements by 2014.** To this end, all specialist hospital placements of people with a learning disability or autism must be reviewed by June 2013, and if people would be better supported in the community they must be moved out of hospital by 1st June 2014.

    - **There should be stronger accountability and responsibility for owners and directors of private hospitals and care homes.** The Government will set out how Boards of Directors and organisations can be held to account later this year.

    - **There must be tighter regulation and inspection of providers.** The CQC will undertake more inspections and unannounced inspections of providers and will be more vigorous in holding organisations to account for poor quality care.

    - **There should be improved quality through staff training and better leadership.** A new code of ethics will be published in 2013 with guidance on training standards and commissioning practices. Local authorities responsibilities in relation to safeguarding will be strengthened through the Care and Support Bill and Government will work with providers to reduce the amount of physical restraint used in care settings.

    - **There should be better local planning with national support.** Local authorities and the NHS will be expected to work more closely on joint plans with pooled budgets to ensure people get the support they need. A new national joint NHS and local government led joint improvement team is to be established to provide support to local planning teams.

- **There will be greater transparency and monitoring.** Government will publish a range of key performance measures to help local councils assess the standard of care in their areas and the Learning Disability Programme Board, chaired by the Minister for Care and Support will monitor progress against milestones.

12. In Nottinghamshire the Strategic Commissioning Group for Mental Health, Learning Disability and Autism (which reports to the Shadow Health and Wellbeing Board) are overseeing the development of an action plan to address the key findings and actions required. It is proposed to establish a joint Project Board to oversee the implementation of the action plan over the next 15 months.

13. The NHS in Nottinghamshire currently commission around 50 placements for people in specialist hospitals and other accommodations. Some of these people will be appropriately placed in hospital, either as an alternative to prison (e.g. some of those in high secure at Rampton) or receiving treatment or rehabilitation services. However, for others they are only in hospital because of a lack of alternatives. It is these individuals who the authority will be looking to ensure move out of hospital into more appropriate settings for people to live.

14. In addition the local authority and health have around 100 people placed out of the county in residential and nursing home placements. All of these individuals are being reviewed to see who could return to Nottinghamshire.

15. In many cases people have lived out of county for many years and the original reason for them moving is unclear. However, the reason for the initial placement in over 50% of cases was 'no suitable local service available'. Other reasons included family choice e.g. where an individual had gone to residential school out of area and the family wanted that provider to continue to deliver services, this may be due to lack of confidence in local services or unwillingness to face change. In other cases there was a genuine reason for living out of area, for example because family had moved or because the service was just over the boarder but nearer to the individual's family and community than an in county service. In these cases the authority would not be seeking to bring someone back to Nottinghamshire.

16. Overall the kinds of issues which arise from Out of Area placements include:

- Difficulty for patient's family/friends to visit
- Lack of input/contact from staff in home authority
- Problems with communication and coordination across authorities and with settings and families
- Increased cost for authority of dealing with reviews/problem that may arise/safeguarding issues
- Difficulty of monitoring the quality of provision from a distance
- The cost of the placement at the setting. Out of area placements are on average higher cost than those in area - however, account should be taken of the fact that many out of area placements were made due to the complexity of the care needs of the individual which could not be met by local providers and therefore moving individuals back into area may not reduce the cost of a care package. It does, however, mean that the local authority will have a clearer idea of what it is paying for and the quality of the service which makes it easier to prevent over commissioning.
- Lack of identification and engagement between the service user and with the new local community.

17. Locally, the joint project board with Health colleagues will ensure that the deadlines set by the Department of Health are met which will include:

- All individuals currently living out of county or in hospital settings will have a person centred review by June 2013, which will consider the reasons they are living out of county or in hospital and whether they would benefit from moving back into the authority or whether the hospital setting is no longer appropriate.

- Where appropriate people will be moved to more independent living arrangements by June 2014. In all cases, Supported Living or Shared Lives (where an individual lives with a family who are paid to support them) will be considered above residential care as it is considered that these settings best promote independence and the engagement of an individual within their community. Residential care, will, however be used in circumstances where it is felt the individual is not yet ready for more independent living or where there would be a long delay in finding the right accommodation and support.

- Where an individual is admitted to (or remains in) hospital, a clear plan will be in place to review their progress and ensure they are moved back into the community as soon as is possible.

- The development of a variety of alternative services including intermediate care and 'step down' accommodation intended to be temporary rather than a home for life which helps people get used to the idea of living back in the community, as well as supported living, self-contained accommodation developed to allow people to live as independently as possible but because the accommodation is together (e.g. flats in a house or small block) the right levels of staffing can be put in to ensure people are properly supported.

18. As a **Statement of general principle**, only where there are clear benefits for the individual to remain in an out of area placement, or where it can be evidenced that there is a genuine reason why the individual needs to remain in hospital plans will not be put in place to enable that person to move. These benefits will be documented and reviewed annually to ensure they remain relevant reasons for an individual continuing to live outside of Nottinghamshire or within a hospital setting.

19. Excepting for personal circumstances where an out of county placement has been deemed appropriate (e.g. to be near family who have moved away, or because that individual is at risk if they remain in Nottinghamshire) new out of area placements will only be made where there is no viable alternative. However, a plan will be put in place to develop an appropriate local service, which will allow the individual to return to Nottinghamshire within an agreed timeframe.

20. The exception to this is where the needs of the individual are only able to be met by a specialist service and there are not sufficient other people with similar needs to make the development of a local very specialist service viable. In these circumstances, wherever possible, work will be undertaken with neighbouring authorities to develop a service regionally to keep people as close to home as is feasible. Individuals within hospital settings will have a joint health and social care formal face-to-face review every year, but contact will

be made at least every 6 months by a case manager from Health and the 'annual' joint review brought forward if appropriate.

21. Funding responsibility for the project delivery is being negotiated between the local authority and NHS partners. The initial project delivery costs and transformational funding associated with individual reviews and service development is likely to be funded by the NHS. This cost is estimated to be in the region of £800,000 – £900,000.

22. As the assessments of people in hospital placements needs to be completed by 1st June 2013 there is an immediate need to establish temporary capacity to undertake these assessments, and in the medium term to commission services for any people found to be inappropriately placed. The following temporary posts are, therefore, required with immediate effect for a period of 18 months:

    a. 0.5 fte Team Manager post at Pay Band D
    b. 2 fte Care Manager posts at Pay Band B
    c. 1 fte Occupational Therapy post at Pay Band B
    d. 0.5 fte Business Support post at Grade 3.

    The costs of these posts will be met by S.256 transfer of funding from the NHS to the authority (NHS Fund for Social Care).

23. However, the ongoing care management and support package costs will be a shared responsibility between the NHS and the local authority. Whilst the current expenditure on people placed in inpatient care is held by the NHS, as people move into independent living environments, the local authority will become responsible to meet their needs either wholly or partly in conjunction with NHS continuing care requirements.

24. It is not possible to accurately estimate the ongoing revenue implications until the initial reviews have taken place to assess the level of support required by people currently placed inappropriately. However, the current average expenditure of the NHS on individual placements is £2,500 per week per person. It is unlikely that these costs will reduce significantly on discharge, and therefore if the local authority were to become responsible for 50% of the future cost of provision for people requiring new placements (estimated at half the current cohort) the additional costs placed on the authority would amount to £1.6m per annum.

25. As the additional cost of providing this care results from a national policy shift which transfers responsibility from the NHS to local authorities, discussions are currently taking place with local NHS colleagues to agree how these costs should be met in the longer term.

Reason/s for Recommendations

26. This report details the actions required to ensure the County Council is compliant with national policy guidance.

Statutory and Policy Implications

27. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of

children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Human Resource Implications

28. The report recommends the temporary posts for a period of 18 months as follows: :

    a. ½ x FTE Team Manager post at Pay Band D
    b. 2 x FTE Care Manager posts at Pay Band B
    c. 1 x FTE OT post at Pay Band B
    d. ½ x FT E Business Support post at Grade 3.

29. These posts will be allocated authorised car user status (except for the Business Support post). It is anticipated that existing staff on temporary contracts within the New Lifestyles Team will be offered extensions to their contracts whilst additional temporary staff will be recruited in the short-term.

30. The Trade Unions have been consulted and UNISON welcomes the implementation of a review of out of area placements following the enquiry in abuse of residents at Winterbourne View Hospital, and the recruitment of staff to implement this. We are in favour of local placements if it meets the needs of residents and we assume that it will mean a better monitoring process.

Financial Implications

31. The full financial implications arising out of this report are to be determined once all individual assessments have been completed in June 2013. However it is estimated that the full financial impact on the authority could be in the region of £1.6m recurrently. Negotiations are underway with NHS colleagues to determine the appropriate financial responsibility for meeting these costs.

32. In addition there is an amount of non-recurrent start-up funding required to meet the initial cost of assessment and care management over the course of the next 18 months. These costs will be met by S.256 transfer from the NHS (NHS Funding for Social Care).

RECOMMENDATION/S

It is recommended that the Committee

1) notes the content of the report and agrees to the local actions proposed to meet the requirements set out in the **Transforming care: A national response to Winterbourne View Hospital** ***Department of Health Review: Final Report*** document; and specifically:

    a. The assessment of all people placed out of the local area in hospital settings and care home environments
    b. The resettlement of any persons assessed as being placed inappropriately
    c. The development of local intermediate care services to prevent future inappropriate placements and reduce the length of hospital stays

d. The commissioning and provision of locally based accommodation and care for people placed out of the local area.

2) Approves the establishment of the following temporary posts with effect from 5th February 2013 for a period of 18 months until 4th August 2014:

a. 0.5 fte (18.5 hours) Team Manager post, Pay Band D, scp 42-47 (£35,430 - £39,855 pro rata per annum) and the post be allocated authorised car user status

b. 2 fte (74 hours) Care Manager posts, Pay Band B, scp 34-39 (£28,636 - £32,800 pro rata per annum) and the post be allocated authorised car user status

c. 1 fte (37 hours) Occupational Therapy post, Pay Band B, scp 34-39 (£28,636 - £32,800 pro rata per annum) and the post be allocated authorised car user status

d. 0.5 fte (18.5 hours) Business Support Administrator post, Grade 3, scp 14-18 (£15,725 - £17,161 pro rata per annum).

3) receives a progress report in six month.

JON WILSON
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Constitutional Comments (LMc 17/01/2013)

33. The Adult Social Care and Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (KAS 22/01/2013)

34. The financial implications are set out in paragraphs 31 and 32 of the report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972:

a. Raising our sights: services for adults with profound intellectual and multiple disabilities - A report by Professor Jim Mansell - March 2012.

b. Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report - December 2012.

Electoral Division(s) and Member(s) Affected

All.

ASCH95

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

4th February 2013

Agenda Item: 7

REPORT OF THE SERVICE DIRECTOR FOR PERSONAL CARE AND SUPPORT – OLDER ADULTS

UPDATE OF POLICY AND STAFF GUIDANCE: REVIEWING PERSONAL BUDGETS

Purpose of the Report

1. To summarise key changes within the new staff guidance for reviewing personal budgets.

Information and Advice

2. Every local authority has a legal obligation to review all existing community care packages, personal budget arrangements and care home placements. Department of Health (DOH) guidance *advises* such reviews should take place annually. Given the significant range of support provided by Nottinghamshire County Council, from single simple inexpensive care packages to others that are both complex and costly, the Department of Health also advises reviews should be 'proportionate'.

3. Historically, most local authorities have found the task of reviewing all existing care packages very challenging because of the high volume of cases involved. Hitherto Nottinghamshire County Council was able to complete a large number of reviews by issuing a review form for completion by independent care providers. Whilst this was an effective and low cost way of administering reviews, it did not provide a truly 'independent' review of the care provided. Furthermore, Department of Health guidance is clear; reviews should be carried out by staff other than those providing the service. For these reasons, the reviewing policy needed updating. Unfortunately, with more complex assessment processes in place, the challenge of completing all the required scheduled reviews remains, particularly if staffing costs are not to rise significantly.

4. To tackle this challenge, new Adult Social Care, Health and Public Protection guidance provides a framework whereby the most vulnerable services users can be identified to receive 'face-to-face' reviews, whilst other review 'types' can be used for more simple situations thus ensuring a 'proportionate' approach.

5. Before describing briefly the different review 'types', it is important to note, a service user or relative can ask for a review at *any time*. In addition, the majority of reviews completed within the department are not annual scheduled reviews but rather unscheduled reviews, whereby a service user requests reassessment because needs have changed.

6. The new guidance introduces *some* new arrangements whilst consolidating existing practice.

7. Below is a brief summary of the key changes:

- Minor amendments can be made more quickly and easily to existing care packages as these no longer require a face-to-face visit. Often changes can be agreed over the telephone, making it easier for staff but more importantly, more convenient for service users and relatives (section 2.1 page 3 of guidance).

- The guidance clarifies which cases should always have a 'face-to-face' review (section 8.1 page 15), describing key factors of vulnerability i.e. where service users' lacks capacity, where there has been a history of abuse and or the care support arrangements are complex and costly.

- In other situations, where the service user to be reviewed, has both simple and a single service of support, other approaches are available such as 'telephone reviews' and or review by 'correspondence' (section 8.2 page 16).

- In residential/nursing care homes, staff are advised to carry out 'surgeries' thereby undertaking a number of reviews of residents within the same care home setting.

- The guidance also emphasises the importance of reviewing carers' needs (section 3.7 page 8).

- Whilst different types of reviews are described, if during a 'telephone' review it becomes clear a 'face-to-face' review is needed, then the review types can be immediately changed.

- The guidance also outlines what is expected of staff when completing a review and an easy checklist has been made available for staff to use as an aide memoire.

Statutory and Policy Implications

8. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Human Resources Implications

9. The Human Resources implications have been considered and it is not thought that there will be any impact on the current staffing establishment.

Financial Implications

10. None anticipated as a result of the introduction of this new policy and guidance.

Equal Opportunities Implications

11. The policy applies to all service user groups.

RECOMMENDATION/S

It is recommended that:

1) Subject to approval by the Adult Social Care and Health Committee the Reviewing Policy for Personal Budgets and staff guidance be approved and recommended for adoption by the Policy Committee at its next meeting.

DAVE HAMILTON
Service Director for Personal Care and Support - Older Adults

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Constitutional Comments (SLB 17/01/2013)

12. The Adult Social Care and Health Committee may approve the recommendations in the report and recommend to the Policy Committee that the policy be approved and adopted.

Financial Comments (CLK 23/01/2013)

13. There are no financial implications in this report.

Background Papers Available for Inspection

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

(a) See previous Departmental Review Policy documents.

Electoral Division(s) and Member(s) Affected

All.

ASCH 90

Nottinghamshire County Council

Policy Library Pro Forma

This information will be used to add a policy, procedure, guidance or strategy to the Policy Library.

Title: Reviewing Personal Budgets Policy

Aim / Summary: To set out the Council's commitment to reviewing personal budgets; to ensure that public money is being spent properly, and to ensure that service users and carers are in receipt of the support outlined in their support plan and that they are satisfied with the support they receive.

Document type (please choose one)			
Policy	x	Guidance	
Strategy		Procedure	

Approved by:	**Version number:1**
Date approved:	**Proposed review date:**

Subject Areas (choose all relevant)			
About the Council		Older people	x
Births, Deaths, Marriages		Parking	
Business		Recycling and Waste	
Children and Families		Roads	
Countryside & Environment		Schools	
History and Heritage		Social Care	x
Jobs		Staff	
Leisure		Travel and Transport	
libraries			

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Please include any supporting documents	
1.Reviewing Personal Budgets Guidance	
2.	
3.	
Review date	**Amendments**

Nottinghamshire County Council

Context

1. The County Council is committed to ensuring that:

- Local people are enabled to live as independently as possible throughout their lives.

- Where people need social care support they are enabled to have as much choice and control as possible over how it is provided.

- All services are good quality and provide value for money.

2. This policy sets out the Council's commitment to reviewing personal budgets to ensure that public money is being spent properly and that service users and carers are satisfied with the support they receive.

Scope of this policy

3. This policy covers the review of personal budgets for people living in the community and those living in a care home.

4. The legal framework governing reviews for social care support is set out in'Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care – Guidance on Eligibility Criteria for Adult Social Care, England 2010.

5. This policy is consistent with the requirements of this legal framework, which states that:

- The frequency of reviews should be proportionate to the circumstances of the individual, but there should be an initial review within three months of help first being provided or major changes made to current support plans. After that reviews should be scheduled at least annually, depending on circumstances such as mental capacity (which requires more regular reviews) and requests for a review by the service user or other persons connected with the service user.

- The process of review should be simple and avoid duplication or unnecessary amounts of paperwork or visits.

- Particular attention should be paid to the need for more frequent monitoring of adults who lack capacity. It highlights the need, specified in the Mental Capacity Act Code of Practice, to involve Independent Mental Capacity Advocates in reviews, 'where the person concerned has no-one else to be consulted'.

Principles and Commitments

6. The Council is committed to enabling service users and carers to play an active part in the review of their personal budget to make sure that the outcomes they anticipated from their support are being achieved.

7. The number of reviews for the same service user will be reduced in order to help manage the high volume of reviews and to improve efficiency. Other related reviews, for example, for continuing health care and for carers will be done at the same time as the personal budget review, where possible.

8. Reviews will be "proportionate" to the situation. This means that reviews can be completed in different ways: face to face; by correspondence or telephone; by using a surgery approach in care home and some day care settings. The type of review will be determined by the reviewing officer and agreed by their team manager.

9. Priority for face to face reviews will be given to service users whose needs are defined as "complex" or who are assessed as particularly vulnerable or at high risk. All service users with a personal assistant, and where a relative is employed, will have a face to face review.

10. In defined circumstances an adjustment to a support package can be made without the need for a formal review.

11. The review will include detailed attention to the finances of any direct payment made to the service user or "suitable person", to ensure that public money is being properly spent.

Key actions to meet the commitments set out in the policy

12. The Council will undertake the following key actions to meet the commitments set out in this policy:

- Maintain up to date guidance for staff to ensure that this policy is applied consistently across all service users and carers, including those living in residential care and in receipt of aids and adaptations.

- Take appropriate action if the findings of the review suggest that public money is being used inappropriately or inefficiently.

- Monitor the outcome of reviews in order to respond to any quality assurance issues raised about the social care support provided or arranged by the Council.

Nottinghamshire County Council

Policy Library Pro Forma

This information will be used to add a policy, procedure, guidance or strategy to the Policy Library.

Title: Reviewing Personal Budgets Guidance	
Aim / Summary: To set out the Council's commitment to reviewing personal budgets; to ensure that public money is being spent properly, and to ensure that service users and carers are in receipt of the support outlined in their community care assessment and support plan and that they are satisfied with the support they receive.	
Document type (please choose one)	

Policy		Guidance	x
Strategy		Procedure	

Approved by:	Version number: 8
Date approved:	Proposed review date:

Subject Areas (choose all relevant)

About the Council		Older people	x
Births, Deaths, Marriages		Parking	
Business		Recycling and Waste	
Children and Families		Roads	
Countryside & Environment		Schools	
History and Heritage		Social Care	x
Jobs		Staff	
Leisure		Travel and Transport	
libraries			

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Please include any supporting documents	
1. Reviewing Personal Budgets Policy	

Nottinghamshire County Council

REVIEWING PERSONAL BUDGETS GUIDANCE

Contents:

1. INTRODUCTION

The purpose of this guidance is to:

- Ensure that the County Council's policy on reviewing personal budgets is consistently applied.
- Ensure that people currently having a managed service are offered a direct payment, so that they have the opportunity to have as much choice and control as possible over the support they receive.
- Help staff to make judgements about where service users should have 'face to face' reviews and where the other options can be applied.
- Ensure that service users with existing packages of care have a review of their support and that new "contacts" are not created for them on Framework.
- Clarify the role of reviewing officers and officers from Adult Care Financial Services (ACFS).
- Clarify when a minor amendment to a care package can be made without the need for a formal review.
- Clarify the position regarding reviews for carers.

Please note: Reviews can be undertaken by any appropriate social care worker from the Council. The term reviewing officer is used in this guidance to cover all possible roles.

1.1. Local policy and guidance

This staff guidance is based on the County Council's Reviewing Personal Budgets Policy.

For details of:

- The current eligibility threshold, see the staff guidance on Eligibility and Fair Access to Care Services.
- Assessment, support planning and reviews, see Assessment, Support Planning and Personal Budgets (staff guidance).

Staff must take account of the following when conducting reviews:

- Fairer contributions policy
- Use of Warnings in Social Care Records

Staff should also be aware of the guidance from the Care Quality Commission, "Key Lines of Regulatory Assessment" (KLORA) when conducting reviews of care home placements.

2. MINOR AMENDMENTS TO SUPPORT WITHOUT A REVIEW

2.1. Criteria

Minor amendments to a person's support can be made without a full review if the case meets any of the following criteria:

- The requested amendment to the existing support costs does not result in an increase to the overall personal budget of more than £75 per week

- The person's circumstances have changed, rather than their individual needs.
- The requested amendment is to previously identified and agreed support arrangements in the support plan or is temporary in nature.
- This could include the temporary unavailability of unpaid support.
- The person has had a face to face review within the last 12 months
- Information from adult care staff/provider suggests that the support package needs to increase to fulfil health and safety requirements.
- A predicted increase in needs has already been identified in the assessment

Before making an amendment workers must:

- Consider the criteria above using the last completed assessment and support plan or review to decide whether the request for an amendment meets the criteria or whether a review is needed.

- Ensure that service users/carers are aware of the proposed amendments and agree to them being made. Where there is no agreement, a review needs to be completed to resolve these issues.

If an Adult Access Team worker decides that a review is needed, he/she should send an update message to the appropriate district team to request this.

If the case is open to a district team and the worker has decided that it is not appropriate to make a minor amendment, the scheduled review can be brought forward and commenced, following discussion with the manager.

2.2. Procedure for making amendments

If the amendment does meet the criteria, workers must:

- Commence a new episode (from the New Episode list), called **Request Care Package Amendment.** This episode contains a form to outline the reason for the amendment and summarise the changes that are required. A commissioning outcome can then be sent to the worker who will be making those changes, which in most cases will be the reviewing officer themselves. The outcome will lead to a commissioning episode that will allow changes to be made to the care package, and contains tasks that allow the worker to ask other workers or teams make changes to the care package as appropriate. For example, a task can be sent to a service organiser team in the case of managed home care packages for physical disability and older adults' cases.

- Ensure that, where required, all amendments to existing packages are authorised by a an appropriate manager, unless the total value of the personal budget remains below £75 per week, in which case it can be authorised by the worker making the amendment.

- Choose the relevant outcome to ensure that a copy of the amended commissioned services is sent to ACFS (following team manager or self-authorisation). This will allow ACFS to amend the service user's contribution where necessary.

- Ensure that there is an appropriate review episode pending for the service user. It is not anticipated that making an amendment will necessitate bringing a scheduled review date forward, unless the amendment has been made on health and safety grounds or there has been a predicted increase in a service user's needs.

3. CONDUCTING A REVIEW FOR COMMUNITY SUPPORT

3.1. Checklist for use by staff (community reviews)

A checklist for staff to use when preparing for and conducting reviews for community support is included in appendix 1 of this guidance. Please use it.

3.2. The initial review

An initial review must be completed up to three months from the date of support being delivered. The purpose of the initial review is to check that the support provided is meeting the outcomes agreed in, and to make any amendments to, the original support plan. Subsequent reviews must take place at least annually.

Initial reviews are normally the responsibility of the original assessor. However, the central reviewing teams will complete initial reviews where:

- Home based support is in place with a provider, either as a managed personal budget or direct payment.
- The support being provided is **not** subject to complications, for example, a safeguarding investigation.

Currently the reviewing teams will complete all the initial reviews of support plans completed by assessors linked to START and this could apply more widely to all hospital and community based cases.

3.3. The annual or scheduled review

Send out standard letter, Appointment Letter Review. Annual reviews should be co-ordinated so the service user receives one review and enables workers to share information. Where a review is planned by an internal provider, the review should be co-ordinated with other workers involved with the person. The review will need to consider ***all*** the support or activities within the support

plan including services previously provided to the carer, not only their service area. This includes:

- Transport
- TV Licences
- Telephone Rental payments
- Day services
- Talking books

A community care review and support plan must be completed.

Following the organisational redesign and the restructuring of the teams in the Department, responsibility for annual or scheduled reviews will fall to teams responsible for assessing service users for their personal budgets. The only exception to this will be the reviewing of older adults in care home settings, which will remain the responsibility of the centralised reviewing team until March 2013

3.4. Unscheduled reviews

Although reviews are typically scheduled on an annual basis both carers and service users needs are subject to constant change. Often service users will request changes to their support as their needs change.These reviews are known as unscheduled reviews and are usually the responsibility of the team responsible for assessing service users. However, the central reviewing team will pick up straightforward cases from the service organisers or the Adult Access Team.

Please note: An unscheduled review should be commenced by identifying the scheduled review outcome, assigning this to yourself and starting work on it. After completing an unscheduled review **ALWAYS** remember to schedule the next annual review, which will typically be 12 months from the time the unscheduled review was completed. This will help to avoid duplication of effort within teams and keep the scheduled review list up to date.

If there is no scheduled review outcome, the Adult Access Team must create a review of community based services and send it to the apporpriate team or district. The only outcome available is to the team reviewing box. Therefore to avoid missing an urgent unscheduled review, the Adult Access Team should also send an updated message to the relevant team, which will act as an alert in the main team ‘in box’.

3.5. Reviewing Continuing Healthcare

The NHS has a mandatory responsibility to review all people who receive fully funded continuing health care or funding for nursing care at three months and then annually. This is referred to in the new "National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care", see point 8 of the executive summary or, for more detail, the section entitled Review.

Reviews of people receiving fully funded continuing healthcare or funding for nursing care should be linked to the reviews undertaken by colleagues in the NHS, where possible. Annual social care reviews should be done at the same time. This reduces the need for the service user to have multiple reviews and enables workers to share any relevant information. It also enables social care staff to consider the quality of the nursing care within a care home from the perspective of a qualified health professional.

A copy of the completed National Framework Decision Support Tool should be scanned into Framework after the review as part of the service user's record.

Where continuing healthcare funding is Fast Track (end of life) the service user will not be reviewed by adult care staff as they will no longer be receiving funding from Nottinghamshire County Council.

3.6. Reviewing Direct payments

Whilst guidance about reviewing direct payments is provided in section 13 of Direct Payments for Adults, including to a "Suitable Person", attention is drawn below to the different roles of Adult Care Financial Services and reviewing officers. This particularly applies to the responsibilities of reviewing officers in reviewing the finances of any direct payment arrangement.

The role of reviewing officers is to:

- Check bank statements etc at the annual review to see if the direct payment is not being used, if there is a high surplus in the accounts, if money is being mis-spent, or the service user's contribution is not being paid into account.
- Take action if there is a high surplus in the direct payment account. For further information, see section 12.2 of the staff guidance, Direct Payments for Adults, including to a Suitable Person.
- Investigate if evidence is found of the direct payment being mis-spent. This will include consideration of whether payments should be stopped and whether a safeguarding investigation is required.

The role of Adult Care Financial Services workers is to take the following action as a result of a review:

- Provide feedback to workers if any concerns have been raised during the audit process, for example: forms not returned; money not being used; high surplus in accounts; money being mis-spent; service user's contribution not being paid into the account.
- Request return of surplus/unspent money (over 6 weeks)
- Assist with cases of mis-spent funds
- Calculate and review the personal budget contribution

3.7. Reviewing carers' support

Whenever possible, a service user's personal budget review and a carer's review should be completed at the same time. This provides the clearest picture of the eligible need of the service user, the impact of caring on the carer and the support required for both. The carer's review may need to be held away from the person that is being cared for, to allow the carer to freely discuss their own level of need.

It is essential that main carers and people cared for are linked on Framework so that the services provided to both can be clearly identified. In the case of a disabled parent with a young carer, it is also essential that the service user is linked to the child record and set up as having parenting responsibilities.

See for following for more information:

- Carers: Completing an assessment of need-staff guidance
- Carers Personal Budgets – staff guidance
- Disabled Parents and Young Carers (supporting)
- Disabled Parents and Young Carers (additional funding)

3.8. Mental Capacity Act 2005

Staff must refer to the "Multi-Agency Joint Policy and Procedure on the Mental Capacity Act 2005" when conducting reviews with people who may lack the capacity to make decisions about matters that the review relates to. If there are doubts about the person's capacity and they are without friends or family to support them, they can be referred to an Independent Mental Capacity Advocate (IMCA) in certain circumstances. Details of the IMCA service in Nottinghamshire can be found in the Policy for Independent Advocacy.

The appropriate forms can be found in Framework if an assessment of capacity is needed:

1 Test of Capacity. This is contained in the 'Mental Capacity' episode (available from the new episode menu). Alternatively, if concerns regarding capacity arise during an assessment or review, the form is also available in those episodes - 'Community Care Assessment and Support Plan', 'Review – Community Based Services',' Review – Long Term Care'.
2. Best Interests Checklist. If the test of capacity results in the need for a Best Interests decision then the episode in which the capacity form is completed includes the outcome 'Person lacks capacity – Best Interests decision needed'. This leads to the 'Best Interests Checklist' episode that contains the Best Interests Checklist form.

Even if the person clearly has capacity to make the decision/s, it is good practice to cover the following points in all community care reviews:

- Does the person have a Lasting Power of Attorney?
- Does the person have a Court of Protection Appointed Deputy?
- Has the person made an Advance Decision to Refuse Treatment?

If the answer is yes to any of these questions, it is useful to briefly give or update details on Framework, where necessary.

3.9. Outcome of the review for community support

There are five possible outcomes from the review of community support. The expected response to each of these is set out below.

3.9.1. Needs can be met within existing personal budget

Where a service user's needs are being met with their existing personal budget, the budget must remain the same or it can be lowered if the person's outcomes can be met more cost effectively. Staff must always consider the options for meeting needs at a cost lower than the current support package, for example, daily living equipment or Telecare. Any changes to services must be reflected in the appropriate sections of the community care review and support plan.

Use standard letter, Post review – eligible, and choose appropriate option.

3.9.2. Unmet eligible needs identified

Where the review identifies unmet eligible needs workers must explore all options to meet needs and outcomes in the most cost effective way before the personal budget is increased. Consider a period of reablement if needs have changed.

Remember: Just because the review indicates that a person's eligible needs have increased **does not** necessarily mean their needs cannot be met at a cost *lower* than their current support.

Any changes to services must be reflected in the appropriate sections of the community care review and support plan.

Use standard letter, Post review – eligible, and choose appropriate option..

3.9.3. Needs can be met with a lower personal budget

The local authority has an obligation to meet a service user's needs in the most cost-effective way. If an individual can meet their needs with a lower personal budget, the service user should be moved to new arrangements as soon as is reasonable (and if it is possible to do so once pre-existing contractual arrangements have been taken into account). If the service user is not in agreement 4 weeks notice of the change will be given in writing.

Use standard letter, Post review – eligible, and choose appropriate option..

There will be cases where professional judgement is required to consider the need for a longer transitional period so that a change in support arrangements can be gradually introduced (perhaps with staggered reductions in the personal budget over a number of months). The plan should aim to ease the transition, ensure that the person can cope with their new settlement and allow for the careful monitoring of whether the new arrangements adequately meet eligible needs. Plans should include specific timescales in order to help planning and ensure that there is an agreement about the pace of the transition. This will require a team manager's approval and should only be considered where there are good reasons, for example where a service user has attended a day service for a number of years and this provides respite for the carer.

Funding should not be withdrawn until a viable alternative is identified. If no viable alternative can be found then existing levels of support and funding should be maintained until such time as a more cost-effective alternative has been brokered. Professional judgement is paramount.

Any changes to services must be reflected in the appropriate sections of the community care review and support plan.

3.9.4. Support to be withdrawn or reduced

If a service user is no longer eligible for all or part of their personal budget following review, four weeks notice must be given to withdraw or cease support. Managers have the discretion to extend this where appropriate (see above) and use their professional judgement.

If the review indicates that a person has a moderate risk in one of the domains in the assessment, the person may no longer be eligible for support in this area and the their personal budget may be reduced. This will leave people with needs that pose a substantial or critical risk to their independence receiving a personal budget. However, the guidance on eligibility, "Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care", states that councils should exercise caution when considering the withdrawal or reduction of support. The process below must be followed in these cases.

Where a person is no longer eligible for support in all or some areas, you must:

- Consider whether the service user's situation will get worse and their needs increase in the foreseeable future because of lack of support.
- Consider whether the support of any unpaid carers could break down in the future because of the lack of help.
- Ensure that the decision to cease or reduce support is scrutinised by the Group Manager before the final decision is made.
- Give information on the reasons for the withdrawal or reduction verbally and in writing, and offer an opportunity to comment on or make representations about the proposal, so that these can be taken into account before the decision is made.

- Confirm the eligibility decision in writing if a decision to cease the service is made. Use standard letter, Post review – ineligible service ended..
- Offer advice and guidance on other sources of help, including ways of purchasing comparable support where appropriate.
- Give a 4 week period of notice that the support is going to end.
- Offer information about the Council's complaints procedure.

If one or more services will continue to be provided, any changes to the care package must be reflected in the appropriate sections of the community care review and support plan.

For further information see the policy on Eligibility and Fair Access to Care Services

3.9.5. Service user has to meet the full cost of their support

Where a person continues to be eligible for support, but has to meet the full cost following a financial assessment, you must:

- Send out standard letter, Post review – self funders continue **or**
- If the person decides to make their own arrangements, send out standard letter, Post review – self funders ceased.

4. REVIEWS OF RESIDENTS IN CARE HOMES

Placements in care homes are not considered to be permanent until after the 6 to 8 week initial review. If the resident does not return home after eight weeks, but the potential for rehabilitation has been identified in the support plan, regular reviews of progress should be undertaken. This applies to placements both in the County and out of the County.

See, Charging for social care support – residential, for information about charges on a person's property.

4.1. Checklist for use by staff (residential reviews)

Reviewing officers should organise their reviews using the care home review checklist (SDS/CHRC). This can also be used to take notes during the review. The completed checklist should be used to complete relevant episodes in Framework. It can then be shredded.

4.2. Responsibility for undertaking reviews

Responsibility for reviews in care homes is as follows:

- Commissioning teams are responsible for the 6 to 8 week initial review of care home placements they have made.

- Currently the review of all long term placements for older adults without a personal budget will be the responsibility of the central reviewing team.

As soon as these service users are transferred onto a personal budget and a review scheduled, responsibility will transfer to the mainstream assessor teams after April 2013.

- Nursing home reviews ideally should be completed jointly with NHS colleagues. Where a social care review raises concerns in relation to the health needs of the resident then consideration should be given to completing a continuing care checklist and appropriate referrals made to GP or district nurse. A continuing care checklist should always be considered when reviewing people in residential or funded nursing care. NHS colleagues should be consulted for all nursing care reviews and, ideally, care programme approach reviews should also feed into the social care review; where possible both reviews should happen at the same time.

- Reviews of out of county placements remain the responsibility of Nottinghamshire County Council, but may be undertaken, if agreed, by the local social services department on Nottinghamshire's behalf. There will often be a fee, or reciprocal arrangements can be made. When Nottinghamshire staff undertake the review, they should see the resident face to face to assess the quality of care and to make sure that the resident is satisfied with the arrangements. Where the review is undertaken on behalf of Nottinghamshire it is the responsibility of the person requesting the review to upload this review onto Framework.

- Reviews of care home placements made locally by other authorities are the responsibility of the placing authority. If agreed by the team manager the review may be undertaken by Nottinghamshire's staff. The Department will charge a fee of £65 an hour up to a maximum charge of £165 for these reviews or reciprocal arrangements can be made where appropriate. The exception to this is where the review is requested on the basis of safeguarding concerns when Nottinghamshire will pass its review findings on to the relevant funding local authority without charge. See the staff guidance on safeguarding.

When considering an out of county review the team manager will decide if the distance to be travelled and time required prohibits a face to face review by Nottinghamshire.

4.3. The purpose of reviewing care home placements

The purpose of reviewing a care home placement is to consider whether it is the most appropriate way of meeting the long term needs of the service user. The reviewing officer needs to detemine whether the placement meets the outcomes in the support plan and offers choice and flexibility for the service user. The review should include the service user and any relatives they wish to be present, a representative of the home and any other appropriate person, for example, an independent advocate. The review should include consideration of:

- The existing support plan and outcomes
- Whether the resident's care plan clearly reflects the outcomes identified in the support plan.
- Whether care is provided at an appropriate level for the resident's needs
- Whether the resident has the mental capacity to make the decision in question. For example, does the resident have the capacity to participate in the review, or to agree to the placement?
- Whether there is an authorised Deprivation of Liberty safeguard in place. If so, the reviewing officer needs to check to see there is an allocated worker in a district team. If there is no allocated worker, the reviewing officer needs to take into account any conditions attached to the Deprivation of Liberty as part of the review.
- Whether the care home manager has taken appropriate action regarding any deprivation of liberty concerns arising from a resident's lack of capacity.
- Consideration should also be given to reviewing the entitlement of residents under section 117 of the Mental Health Act 1983. Where a resident is in receipt of section 117 aftercare and is exempt from contributions because of this, staff should review their entitlement to make sure that they are still eligible.

4.4. Before the review

In preparation for the review the preparation for review form (SDS/CHPR) can be sent to the resident along with standard letter SDS/CHRLETSU. Standard letter (SDS/CHLET) should be sent to any relatives or friends who are involved with the resident's care.

Reports should also be obtained from providers and other professionals.

4.5. Outcome of the review

Following the review a copy of the community care Review and support plan and letter SDS/CHRLETR must be sent to the service user.

If the service user is funding their own care, reviewing officers should ensure that they are given information about Paying for Care.

4.6. Quality assurance reviews

Quality assurance reviews are undertaken by a range of staff, including quality monitoring officers. Quality assurance audits are completed for each service provider annually. This work is led by quality monitoring officers and by the Market Development and Care Standards Team.

Reviewing officers should complete form CH/QMF – Care Homes following reviews at a care home if they identify any areas of concern during the review relating to generic care issues or to highlight good practice. The completed form must be sent to the Market Development and Care Standards Team (pmm@nottscc.gov.uk) where it will be forwarded onto the relevant quality monitoring officer. All fieldwork staff who visit care homes must also use this form if they have any general concerns about the quality of care or want to highlight any areas of good practice. This will help quality monitoring officers to pull together information relating to particular care homes, about possible problems and about good practice. Please note that quality monitoring officers cannot respond to concerns about care relating to individual service users, only to generic issues within the home.

The information from quality assurance reviews should form part of a service user's review.

For more information about the management of quality assurrance issues please refer to the Home Care Quality Monitoring Framework.

5. REVIEWING PROFESSIONAL SUPPORT

This staff guidance should be applied where professional support is the only service or part of a package of support. For a definition of professional support see, the guidance on Assessment, Support Planning and Personal Budgets, (Appendix 1: Guidance for staff on counting and monitoring professional support within Framework).

6. REVIEWING THE OUTCOME OF OT SPECIALIST ASSESSMENTS

See: Occupational Therapy – guidelines for assessment.

7. RECORDING THE REVIEW

Reviews must be recorded in Framework using the Review – Community Based Services episode for service users whose care is delivered in the community, or Review – Long Term Care for service users in long term care. This is regardless of review type, and includes telephone reviews and reviews by surgery or correspondence.

Within the review episodes is the mandatory review form:

- Community Care Review and Support Pan (mandatory)

The following optional forms are for use when setting up a Direct Payment:

- Direct Payment Agreement and Setup
- Pre-Payment Card Terms and Conditions

The episodes also contain a number of forms that can be used to request a variety of services, including:

- Home Care Request
- Day Service Support Needs Matrix
- Supported Living Referral Form
- Telecare Request
- Transport Eligibility Assessment

There are a number of other optional forms available within the review episodes to assist with other aspects of the service user's care, including risk management and finances.

Following review eligible service users will need a future review scheduling, typically after 12 months (following any initial review that may take place). However, workers will need to ensure that multiple reviews are not created. If a review already exists, then it either has to be closed down or re-scheduled (contact your Business Systems Support Officer for support on how to do this) or there is no need to add another one.

Attention must be paid to the quality of the case recording – see the Case Recording Policy. It is particularly important that the evidence recorded in the review relates to the decision about eligibility.

8. SCHEDULING FUTURE REVIEWS

Reviews should be 'proportionate' to the situation and reflect Departmental priorities in targeting staff resources at the most vulnerable. Priority for reviews, including for people living in residential care, has been established as follows.

8.1. Annual face to face reviews

Priority for face to face reviews must be given to service users whose needs are defined as "complex" or who are assessed as particularly vulnerable or at high risk. As all service users who are eligible for and in receipt of social care support are likely to be vulnerable in some way, the following factors should be taken into account:

- A high cost personal budget is likely to indicate a degree of complexity.
- Previous safeguarding alerts and investigations. An annual, or more frequent, review of the personal budget must be undertaken if the service user is likely to stay in contact with people or situations that have already resulted in safeguarding alerts and investigations. Additional reviews may also be required if indicated in the safeguarding plan.

- Multiple teams or agencies are involved with the service user. This indicates that co-ordination of support may be required and this may be best done through a face to face meeting; unless the service user is subject to, for example, the Care Programme Approach or Deprivation of Liberty safeguards where reviews are already mandatory.
- Other income strands may also indicate a degree of complexity, for example payment from the Independent Living Fund or continuing healthcare funding.
- The service user lacks mental capacity and has no friends or family to act in their best interests.
- Where a service user is not regularly seen by professional carers or other professionals and appears to avoid contact with caring and statutory agencies
- Where a service user has a personal assistant who is a family member.
- The assessor/team manager considers that a face to face review is needed for any other reason, for example, complex health/social issues.

8.2. Reviews by telephone, letter or surgery

The following circumstances may indicate that a telephone review/letter or review at a surgery can be undertaken:

- **Single service** - where a service user only has one managed service, such as day care or a homecare package. The review can be completed by telephone if other sources of information are readily available to the reviewer, for example, current information from the homecare agency, which is consistent with the information from the service user and/or carer. If the service user attends a day service, consideration can be given to holding a reviewing surgery in that location to undertake a number of reviews at the same time. This can also be considered for people living in residential care.
- **Long standing personal budgets** - where a service user has had the same personal budget either as a managed service or as a direct payment for more than one year with no changes anticipated to eligibility or support. This would apply where several services are in place or the support package is relatively high cost.
- **Residential placements** – where none of the indicators for a face to face review exist; the placement is considered to be stable and well supported; a face to face or surgery review has taken place the previous year; a trusted relative is available to consult. In this situation the reviewing officer MUST contact the relevant local authority to ask about the quality of the care home.

During a surgery the reviewing officer will undertake a number of reviews at a designated home, which will include meeting the resident and looking at their care plan.

8.3. Making a decision about level/type of future review

The decision about the frequency and type of future review can only be made on the evidence available at the time. Practitioners must make an informed and reasonable professional judgement on a case by case basis and provide evidence to support their recommendation. Where there are doubts about the best type of future review the practitioner must consult with their manager. The proposed type of next review and the reaons for this decision must be recorded in the "Agreement of support plan (signatures)" section of the community care review and support plan.

Methods of review other than face to face should be considered for the majority of situations where support arrangements are assessed as stable and safe.

Consideration must be given to undertaking a face to face review every other year with service users who meet the criteria for a telephone/clinic review.

The future review must be scheduled in Framework.

9. APPENDIX 1 - CHECKLIST FOR REVIEWING PERSONAL BUDGETS, DIRECT PAYMENTS AND CARERS SUPPORT

Personal Budgets
✓ Check Framework to see if another worker is involved in the case
✓ Send out standard letter "SDS Introduction to review" to service user.
✓ Demonstrate a partnership approach across agencies, with the service user and their family and friends, if they choose to involve them
✓ Complete/update the Community Care Review and Support Plan
✓ Check the eligibility banding and change if necessary
✓ Check the schedule and cost of all existing support/activity, including: regular breaks that the carer received previously and sitting services or day services for the service user
✓ Check to see if any minor amendments have been made to the support package in the last 12 months without a review. Ensure the support plan accurately reflects the current package of care by adding any new costs and removing any that have ceased.
✓ Find out the cost of support to the service user using the Social Care Directory (if new support) or by looking at the package details on the front screen of Framework and record in the support plan
✓ Ensure the support plan is cost effective, within budget and authorised by a team manager or panel
✓ Complete a referral for a financial assessment in Framework to ensure a correct invoice for the personal budget

✓ Establish whether the outcomes identified in the support plan are being met through current arrangements
✓ Support people to review their personal goals and consider what changes, if any, should be made to the support plan.
✓ Ensure that the risk assessment recorded in the support plan is up to date and identify any further action that needs to be taken to address issues relating to risk
✓ Support people to strengthen their informal support networks by the provision of appropriate information and advice on available community resources
✓ Check data quality on Framework and update information if necessary
✓ Schedule a future review date on Framework
Direct Payments
✓ **Always** review the Direct Payment Agreement andf Set Up document (ACM/39)
Carers
✓ Check whether a carers' assessment is in place and if a carers' review has been scheduled. If so, bring forward the carer's review to coincide with the service user's review. If not, complete Part A of the assessment and, if the carer is providing regular and substantial care, Part B
✓ Complete a young carers' assessment if an unpaid carer under 18 is identified within a review. An outcome of the review should be to provide support to the parent (or grandparent) so that the young person is not conducting care that is inappropriate for their age.

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

Agenda Item: 8

REPORT OF THE SERVICE DIRECTOR FOR JOINT COMMISSIONING, QUALITY AND BUSINESS CHANGE

CHANGES IN RELATION TO LOCAL AUTHORITY RESPONSIBILITIES FOR DEPRIVATION OF LIBERTY SAFEGUARDS

Purpose of the Report

1. This report provides an update on current practice in relation to Deprivation of Liberty Safeguards, and an overview of the implications arising from national changes to Supervisory Body responsibilities from 1st April 2013 through the Health and Social Care Act[1].

2. The report seeks approval from members to:

   - establish an additional full-time Senior Practitioner post in the Safeguarding Adults Practice Team to meet the requirements of the changes in Supervisory Body responsibilities

   - assume responsibility for the Primary Care Trusts (PCTs') contribution towards administrative support posts for the Safeguarding Adults Practice team

   - ensure that funding is available for annual refresher training of Mental Health Assessors.

Information and Advice

Deprivation of Liberty Safeguards

3. The Mental Capacity Act (2005) (MCA)[2] came into force in October 2007. It provides a statutory framework to enable people to make decisions for themselves and, where they cannot, to enable others to make decisions on their behalf.

4. The Act was amended in 2009 and introduced the Deprivation of Liberty Safeguards (DOLS) to protect those people in hospitals and care homes who may not be able to make decisions for themselves about their care and treatment.

[1] Health & Social Care Act Schedule 5 Para.134 -136 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[2] The Mental Capacity Act (2005) http://www.legislation.gov.uk/ukpga/2005/9/contents

5. Managers of care homes or hospitals must ask for permission from a supervisory body to provide care or treatment in a way that deprives the resident or patient of their liberty. The supervisory bodies (currently the Local Authorities and PCTs) must then arrange for an assessment.

6. Staff who undertake these assessments are called Best Interests Assessors and are specially trained and qualified in this work.

7. Local authorities are responsible for undertaking assessments in independent sector care homes and PCTs are responsible for assessments in hospitals. The legislation does not allow local authorities to complete the assessments within their own care homes because of potential conflicts of interest.

Current practice in Nottinghamshire

8. Within Nottinghamshire, there are currently three Supervisory Bodies: Nottinghamshire County Council, NHS Nottinghamshire County PCT and NHS Bassetlaw PCT. The Safeguarding Adults Practice Team co-ordinates all the DOLS referrals and acts as the administrative centre for processing these on behalf of each of the Supervisory Bodies.

Table 1: Referral rates for the three Supervisory Bodies

	Nottinghamshire County Council	NHS Nottinghamshire County PCT	NHS Bassetlaw PCT
2009/10	158	28	3
2010/11	192	45	5
2011/12	178	34	8

9. In addition to the above, there are a small number of referrals for assessments to be completed on behalf of other local authorities whose service users live within Nottinghamshire. These amounted to a total 20 assessments between 2009 and 2012.

10. NHS Nottinghamshire PCT and NHS Bassetlaw PCT make a combined contribution of £21,657 per annum. This covers the costs for business support staff in the Safeguarding Adults Practice Team to support the co-ordination of all the referrals for Best Interests Assessors to undertake assessments in hospital settings.

11. Currently, the Safeguarding Adults Practice Team hosts one Best Interest Assessor post. The post holder is employed by NHS Nottinghamshire County PCT.

Supervisory Body changes from 1st April 2013 and impact for the Local Authority

12. From 1st April 2013 the Supervisory Body responsibilities for Deprivation of Liberty Safeguards in hospitals will be transferred from PCTs to local authorities. As such, local authorities will be the only organisations assessing and authorising deprivations of liberty outside the Court of Protection.

13. From this time NHS Nottinghamshire County PCT will cease funding the Best Interests Assessor post within the Safeguarding Adults Team. The £21,657 per annum funding for administrative support will also cease.

14. At the same time as the reduction in staffing, the number of Deprivation of Liberty assessments will increase as the Council assumes responsibility for the assessments required in hospital settings.

15. Group Managers within the Adult Social Care, Health and Public Protection Department will be required to take on signatory responsibility for hospital assessments, amounting to just under one additional assessment per week, and given that the largest number of assessments relates to older people, this will impact mainly on Older Adults' Group Managers.

16. Additionally from 1st April 2013, the Council will have to assume responsibility for continuous professional development (CPD) training of the 15 Mental Health Assessors that are employed by Nottinghamshire Healthcare Trust.

Preparation for the changes

17. A programme of work is underway to enable implementation of the changes. These changes will be informed by the guidance document provided by SCIE and the Department of Health in November 2012[3], "Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare commissioners".

18. As indicated in section 7 above, the Council is not able to undertake the assessments within its own care homes. Previously these assessments were undertaken by the Health funded Best Interest Assessor within the Safeguarding Adults Practice Team. In anticipation of the changes, the Council is currently in the processes of agreeing reciprocal arrangements with Nottingham City Council for completion of these assessments with as from 1st April 2013.

19. In order to undertake the additional DOLS, it is proposed that a permanent full time equivalent Senior Practitioner is established to be based within the Safeguarding Adults Practice Team commencing in April 2013.

Financial Implications

20. The PCTs' contribution of £21,657 p.a. (towards administrative support costs) will cease at the end of March 2013. NHS Nottinghamshire PCT will also cease funding the Best interest Assessor post at the end of March 2013.

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3 "Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare commissioners" http://www.scie.org.uk/publications/reports/report62.asp

21. The Department of Health will provide additional funding to local authorities for this transfer of responsibilities. In 2013/14, additional national funding to the value of £4.55m will be available from the Department of Health to local authorities to help them to undertaken the Supervisory Body function in hospital settings in 2013/14.

22. This funding will be included in the Learning Disabilities and Health Reform Grant. The grant allocation for Nottinghamshire for 2013/14 is £65,759, which is in addition to the usual local authority funding for the Mental Capacity Act role and the supervisory body role in relation to care homes, both of which will continue.

23. It is anticipated that the total funding of £65,759 will be recurrent. However, the grant will no longer be ring-fenced. The Council will be required to demonstrate that it has a robust system for the Deprivation of Liberty Safeguards which is legally compliant.

Reason/s for recommendations

24. Establishment of an additional Senior Practitioner (Best Interest Assessor) post and the retention of the business support post will enable the Council to continue to provide a comprehensive and effective service which takes in to account its additional mandatory responsibilities.

25. The Council will seek to progress the option of transferring of the current post holder from NHS Nottinghamshire County PCT to the employment of the County Council to ensure continuity of service. The Safeguarding Adults Practice Team will continue to benefit from the current post-holder's expertise in undertaking DOLS assessments in hospital and their role in providing training to staff within the department.

26. It is a legal requirement for Mental Health Assessors to undertake annual refresher training and provision of this will be the local authority's responsibility from April 2013.

Statutory and Policy Implications

27. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Implications for Service Users

28. Nottinghamshire already has in place joint arrangements for the receipt and management of DOLS referrals which means that in practice there should not be any impact of the changes to service users.

Human Rights Implications

29. Continued best practice in assessment of mental capacity and deprivation of liberty safeguards contributes towards the protection of the European Convention on Human Rights for the citizens of Nottinghamshire.

Human Resources Implications

30. A permanent full-time equivalent Senior Practitioner post will need to be established, commencing from 1st April 2013.

31. The business support staff post will be continued.

RECOMMENDATION/S

It is recommended that:

1) 1 fte (37 hours) Senior Practitioner post, Pay Band C, scp 39-44 (£41,434-£47,106 per annum) be established within the Safeguarding Adults Practice team, with an authorised car user allowance at a cost of £1,350 p.a. with effect from 1st April 2013

2) Funding of £19,768 to be allocated from the Learning Disabilities and Health Reform Grant for the continuation of current business support arrangements.

3) Funding of £2,000 to be allocated from the Learning Disabilities and Health Reform Grant for the annual legal training of Mental Health Assessors.

4) The shortfall in the Learning Disabilities and Health Reform Grant compared to existing provision from the PCT's be met from within existing service budget.

CAROLINE BARIA
Service Director for Joint Commissioning, Quality and Business Change

For any enquiries about this report please contact:
Claire Bearder
Group Manager, Safeguarding Adults
Email: Claire.bearder@nottscc.gov.uk

Constitutional Comments (LMc 24/12/2013)

32. The Adult Social Care and Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (CLK 25/01/2013)

33. The financial are contained in the body of the report.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

ASCH101

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

4th February 2013

Agenda Item: 9

REPORT OF THE SERVICE DIRECTOR FOR JOINT COMMISSIONING, QUALITY AND BUSINESS CHANGE

OVERVIEW OF ADULT SOCIAL CARE AND HEALTH SAVINGS AND EFFICIENCIES PROGRAMME

Purpose of the Report

1. This report is for information purposes and updates on the progress of the Adult Social Care, Health and Public Protection (ASCH&PP) Department's four year Savings and Efficiencies Programme (2011/12 to 2014/15) based on project information as at the end of December 2012. It compares the department's actual savings achieved for the year to date against its savings target.

2. The information outlined in this report covers projects delivered under the remit of the Adult Social Care and Health Committee only. A separate update is being provided to the Community Safety Committee on those projects coming under the remit of Public Protection.

Information and Advice

3. The budget approved by the County Council on 24th February 2011 required the ASCH&PP department to make savings and efficiencies totalling £63.827 million for the period 2011/12 to 2014/15. Over £27 million of these were to be delivered in the 2011/12 financial year, through delivery of projects spanning across both the Adult Social Care and Health and the Community Safety committees.

4. At the 23rd February 2012 County Council budget meeting the total savings target for the department was increased to £65 million over the four years of the programme, with the delivery of a further 8 projects.

5. There are currently 42 savings and efficiency projects being delivered by the department; 39 that fall within the remit of ASC&H committee.

6. As previously reported at the 26th November 2012 Committee, the department achieved £24.241 million of its £25.929 million savings target for Year 1 (2011/12), which represented 93% of the target across all of the ASC&H projects (i.e. excluding Public Protection targets).

7. Based on project information as at the end of December 2012, the department has already achieved £21.450 million (93%) of its Year 2 (2012/13) savings target of £23.164 million (once again, excluding Public Protection figures), although £1.1m of the savings achieved so far this financial year covers delivery of savings that slipped from 2011/12 into 2012/13.

8. The strong performance to date is due to a number of factors, including:

   a. A number of projects delivering some of their Year 2 (2012/13) savings ahead of schedule during 2011/12.

   b. The full year effect of savings where activity started to generate savings part way through 2011/12.

   c. Similarly, some of the projects completed all of their implementation activity during 2011/12, putting in place mechanisms ready for achieving savings during 2012/13.

Current Position Against the 2012/13 Savings Target

9. Of the 42 current projects, there are:

   a. Eleven high governance projects (i.e. projects with total savings values of more than £1 million and / or high risk / high complexity), all within ASC&H.

   b. Thirty-one low governance projects (i.e. projects with total savings values of less than £1 million and / or low risk / low complexity). Of these, 28 come under the remit of ASC&H and 3 under the remit of Public Protection.

10. A summary of progress in the 11 high governance projects achieving their 2012/13 savings targets is provided below:

    a. Three projects (*Day Services Modernisation, Supporting People* and *Review Expenditure on Learning Disability & Mental Health Community Care*) are currently on target to achieve or exceed their Year 2 (2012/13) savings targets.

    b. Three projects have already been fully completed (*Sale of Residential Care Homes, Reablement and Homecare,* and *Review of Fair Access to Care Services Eligibility and Support Packages*) and achieved all target savings.

    c. One project (*Organisational Redesign*) is shortly due to end, and is on target to achieve its total target savings. However, due to a delay in instigating the new staffing structure within the department (a delay from April to September 2012), £256,000 of its 2012/13 savings target will not be achieved this financial year, but will instead be achieved in 2013/14.

    d. One (*Living at Home*) is currently undertaking re-scoping work, which will inform a revised savings profile for the programme.

    e. Three (*Redesign of Home Based Services, Sherwood Industries*, *and Managing ASCH Income*) have no savings targets assigned to them for 2012/13.

11. These projects will continue to be scrutinised monthly by the Department's Transformation Board (formerly the Business Improvement Board), chaired by the Corporate Director for ASCH&PP. In addition, they are also managed via monthly project boards, established to oversee delivery of each of the high governance projects.

12. Of the 28 low governance projects falling within ASC&H:

a. Fourteen have already been completed, either fully or tasks / savings for 2012/13 have been delivered.

b. Six are currently 'on target' to achieve their Year 2 (2012/13) savings targets.

c. One has no savings target assigned for this year.

d. Four are currently anticipating achieving some of their 2012/13 savings in 2013/14 instead:

i. A*dult Care Financial Services:* anticipates achieving £21,000 of its 2012/13 savings target in 2013/14, due to a delay in instigating staff changes.

ii. *Charging based on Ordinary Residence of Service Users:* anticipates achieving £83,000 of its 2012/13 savings target in 2013/14.

iii. *Budget Reductions within Learning Disability Teams:* anticipates achieving £55,000 of its 2012/13 savings target in 2013/14, due to a delay in re-locating staff into different premises.

iv. *County Horticulture & Work Training / Brooke Farm:* the project's savings target of £100,000 this financial year was predicated on a reduction in staffing costs from the implementation of a revised staff structure. Taking into account contractual notice periods and redeployment processes, it was not possible to implement the revised staff structure from the beginning of the financial year. Therefore, only £76,000 of the savings will be delivered in 2012/13, with the remaining £24,000 being realised in 2013/14.

e. Three are currently reporting difficulties in achieving all of their 2012/13 savings targets, for the following reasons:

i. *Redesign of Sensory Impairment Service:* as the service's budget was at an overspend position at the beginning of the financial year, although this project has achieved savings this year, when offset by the start of year position, as at the end of November 2012 a subsequent shortfall of £65,000 is anticipated by year end.

ii. *Increased Income:* at the beginning of the financial year, it was anticipated that the department would continue to see an increase in the amount of income it received during 2012/13. However, based on income already received this year, the forecast now is for there to be a reduction in the total amount of income received by the end of March 2013. There are various reasons for this, including a reduction in the number of full cost payees receiving a service in the community, and the property market is also impacting on the ability to sell former homes where debt is accruing. As a result, it is now anticipated that £1.04m of the savings target assigned to this project will not be achieved.

iii. *Adult Access Team:* due to other budget commitments, this service is also currently anticipating a shortfall against its target savings of £40,000.

13. Low Governance projects will continue to be scrutinised monthly by the Savings & Efficiency Board, established to oversee delivery of all ASCH&PP projects, chaired by the Service Director responsible for delivery of the department's savings and efficiencies programme. Any exceptions will continue to be reported to the department's Transformation Board.

Current Position Against the 2013/14 Savings Target

14. Looking ahead, there is currently anticipated slippage of up to £4.435m savings from 2013/14 into 2014/15, i.e. a delay in when the savings will be achieved. This is made up as follows:

    a. *Supporting People:* due to a delay in one of its scheduled tendering exercises, it is anticipated that up to £1.53m of its 2013/14 savings target will instead be achieved in 2014/15.

    b. *Living at Home:* as already referenced, the programme is currently being re-scoped and re-profiled, which will inform any changes required to its existing savings profile (£3.108m over four years, of which £1.152m is scheduled to be achieved during 2013/14).

    c. *Redesign of Home Based Services:* similarly, a delay to one of this project's scheduled tendering exercise of up to 12 months will lead to slippage of up to £865,000 savings from 2013/14 into 2014/15.

    d. *Shared Lives:* the savings profile set out in the 2012/13 Budget Book did not anticipate delays in implementing several aspects of the project, outside of operational control. As a result, slippage of up to £152,000 savings is anticipated from 2013/14 into 2014/15.

    e. *Day Services Modernisation:* the approval at the 29th October 2012 ASCH Committee to defer implementation of market-testing and potential externalisation of some Council-run day service provision until 2013/14 will lead to slippage of an anticipated £590,000 savings into 2014/15.

    f. *Sherwood Industries:* as there are still some staff who have not yet been successfully re-deployed into another job within the authority, the project is anticipating that up to £146,000 of its savings target for 2013/14 will not be made in 2013 and a reviewing is taking place on the level of savings that can be achieved.

15. Provision for most of this slippage has already been approved in the report on initial 2013/14 budget proposals taken to the 12th November 2012 Finance and Property Committee meeting, and hence taken into account as part of the Medium Term Financial Strategy. Further refinement of the budget proposals will be recommended in the final 2013/14 budget report, to accommodate the updated position regarding anticipated slippage from 2013/14 into 2014/15.

16. As referenced in Section 12eii above, it is now forecasted that the amount of income received by the ASCH&PP Department this financial year will be less than originally anticipated. The

reduced forecast also applies to 2013/14, and so it is anticipated that the current savings target of £526,000 additional income next year will not be achieved. This revised forecast for next year will also be reflected in the final 2013/14 budget report.

Other Options Considered

17. Since the completion of the service reviews in 2010/11 across the Council, and during the implementation of its savings and efficiencies programme over 2011/12 and 2012/13, the department, through its Transformation Board, has continued to scrutinise the way in which services are arranged and delivered, with a view to identifying further opportunities for achieving efficiencies and improving services.

Reason/s for Recommendation/s

18. This report is for information purposes only and there are no recommendations stemming from it. A separate update on progress against those savings and efficiency projects coming under Public Protection will be provided to the Community Safety Committee.

Statutory and Policy Implications

19. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) It is recommended that the report be noted.

CAROLINE BARIA
Service Director for Joint Commissioning, Quality and Business Change

For any enquiries about this report please contact:
Ellie Davies, Project Manager – Improvement Programme
Email: ellie.davies@nottscc.gov.uk

Constitutional Comments

20. Because this report is for noting only, no Constitutional Comments are required.

Financial Comments (CLK 25/01/2013)

21. The financial implications are contained within the body of this report

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- 24th February 2011 County Council – Budget meeting: 11-12 Budget Report

- 23rd February 2012 County Council – Budget meeting: 12-13 Budget Report

Electoral Division(s) and Member(s) Affected

All.

HWB 98

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

4th February 2013

Agenda Item: 10

REPORT OF THE SERVICE DIRECTOR, PERSONAL CARE AND SUPPORT (YOUNGER ADULTS)

TRANSFER OF THE INDEPENDENT LIVING FUND TO LOCAL AUTHORITIES

Purpose of the Report

1. To provide Members with information about the transfer of the Independent Living Fund to local authorities from 1st April 2015.

Information and Advice

2. The Independent Living Fund (ILF) was established in 1988, originally intended to run for 5 years, to enable disabled people to choose to live in their communities rather than in residential care. The fund provides discretionary cash payments directly to disabled people so they can purchase care from an agency or pay the wages of a privately employed Personal Assistant (PA).

3. When the original Fund closed in 1993, two new Funds were created. The Extension Fund was created to administer the payments of people who applied between 1988 and March 1993 and who continued to receive awards under the old rules. The new 1993 Fund was created with slightly different rules - mainly, the condition that Social Services should provide a weekly financial contribution - to take on new applications.

4. By 2006, there were over 18,000 people using the ILF across the country and the two Funds were united as of 1st October 2007. The ILF continues to fund its existing users, but closed to new applications in 2010.

5. Nottinghamshire County Council has encouraged disabled people to apply for funding through the ILF over the course of the last 20 years and, as a county, has a high number of ILF recipients. There are currently 208 people in receipt of ILF within Nottinghamshire, 39 of whom have no existing local authority funding and 8 people are not known to the local authority.

6. The total value of all ILF payments to individuals within the County is £3.6 million per annum.

7. In October 2012, the Government completed a consultation on the future of the ILF which proposed to close the fund in 2015 and devolve the current funding to local authorities.

8. The consultation[1] received around 2000 responses nationally including a response from Nottinghamshire County Council. The outcome of the consultation is that the government will transfer funding to local authorities in April 2015 based on the pattern of expenditure in 2014/15.

9. The Council is working closely with the ILF to ensure a smooth transition for service users and to ensure all service users in receipt of ILF payments receive a full review of the care requirements before the transfer date.

10. The ILF will commence a communication programme with recipients next month to ensure appropriate engagement with current recipients.

11. From April 2013, the ILF will undertake joint reviews of all recipients with the County Council to enable a smooth transfer of responsibility in 2015.

12. It is anticipated that the transfer of funding will take place from April 2015, and be based upon the actual payments to recipients in the financial year 2014/15.

13. The financial implications of the transfer are that there will be no further availability of the fund past 2015 and therefore in future years, costs which would have been met by the ILF will need to be met by the authority. Based on the number of people accessing the fund previously (circa 15 people per year) at an average payment of £328 per week, this would equate to a budget pressure of around £ 256,000 per annum

14. However, the fund was closed to new applicants in December 2010, therefore no new applications have been accepted over the last two years during which time the authority has picked up this pressure through existing budget setting processes. This will need to be considered in the authorities medium term financial planning processes.

15. In addition, there is a risk that some recipients may have their payments stopped or reduced prior to the transfer date as their payments are reviewed by the ILF officers. Should this happen the local authority would be required to meet any Fair Access to Care services eligible needs that may be identified. However, this risk is no different to the current situation as all ILF recipients have their payments reviewed every two years currently.

16. The expectation is that the funding will be fixed at the point of transfer to the authority, however, thereafter the funding is likely to become part of the authorities' base budget allocation and will therefore be subject to any variation in the County Council's overall allocation.

Reason/s for Recommendations

17. This report provides information for Members and asks that Members note the transfer of funding responsibility as determined through national government consultation.

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[1] Consultation on the future of the Independent Living Fund – December 2012

Statutory and Policy Implications

18. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) It is recommended that the Committee notes the content of the report.

JON WILSON
Service Director for Personal Care and Support -Younger Adults

For any enquiries about this report please contact:

Jon Wilson
Tel: (0115) 977 3985
Email: jon.wilson@nottscc.gov.uk

Constitutional Comments

19. Because the report is for noting only, no constitutional comments are required.

Financial Comments (KAS 23/01/2013)

20. The financial implications are set out in paragraph 13 of the report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972:

a. Consultation on the future of the Independent Living Fund – December 2012.

Electoral Division(s) and Member(s) Affected

All.

ASCH94

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

4th February 2013

Agenda Item: 11

REPORT OF THE SERVICE DIRECTOR FOR PROMOTING INDEPENDENCE AND PUBLIC PROTECTION

BENEFITS, TRAINING AND ADVICE SERVICE – PERMANENT ESTABLISHMENT OF A SENIOR BENEFITS ADVISER POST

Purpose of the Report

1. The purpose of the report is to seek approval to establish on a permanent basis 1 fte Senior Benefits Adviser post in the Adult Access team at the Customer Service Centre.

Information and Advice

2. In October 2011, the Benefits Training and Advice Team was established with a Senior Benefit Adviser post on a temporary basis until 31st March 2013, subject to review.

3. The Benefits Training and Advice Team offers specialist telephone advice, training and information on benefits on behalf of the Council. The team provide the following services:

    a. Production of web information relating to welfare benefits, tax credits and advice provision.

    b. Undertake promotional campaigns to inform residents in Nottinghamshire and relevant Nottinghamshire County Council staff of welfare benefit related issues.

    c. Provide guidance to Customer Service Centre staff on welfare benefit matters.

    d. Develop and deliver a training programme for staff on welfare benefit matters.

    e. Provide telephone benefit advice to customers where Customer Service Centre staff establish specialist advice is appropriate.

4. The Senior Benefits Adviser post is responsible for the day-to-day operations of the service. The post offers professional support and supervision to the three Benefit Advisers within the team and advice to the Finance Officers employed by the County Adoption Service. The Senior Benefits Adviser post also represents the Council on the executive board of Nottinghamshire Advice Network, the Local Government Association advisers Forum, Department for Work and Pensions Local liaison meetings and the County Housing Benefit / Council Tax Benefit managers meetings. This post reports to the team manager of the Adult

Access Team, who manages a service comprising of 21 fte posts plus a project of 7 fte posts.

5. The Welfare Reform Act 2012 will introduce the most far reaching change to the benefits system for twenty-five years with wide ranging implications for the Council. The main changes to the welfare as a result of the act include; the introduction of Universal Credit, changes to Housing and Council Tax Benefit, the replacement of Disability Living Allowance with Personal Independence Payment, the abolition of the Social Fund, and the Act enables the Government to put a cap on the total benefits a person is entitled to. The Senior Benefits Adviser post will support the changes to the welfare system through providing up-to-date information and training to the Council and liaising with District Councils.

6. From April 2013, the Council will be responsible for distribution of funds to alleviate hardship to the citizens of Nottinghamshire abolition of the Department for Work and Pension administered Community Care Grants and Crisis Loans. The Senior Benefits Adviser post will play a key role in supporting the implementation of the discretionary Nottinghamshire Local Welfare Assistance Scheme which will locally replace Community Care Grants and Crisis Loans. The model for delivery of the Nottinghamshire Local Welfare Assistance Scheme would be a third party organisation in the first year and the Senior Benefits Adviser post would oversee the delivery of this service. Learning from the first year would enable a review and development of the provision in year two with consultation with key stakeholders such as the voluntary and community organisations and District Councils. The Senior Benefits Adviser post would be responsible for the review and implementing recommendations on future delivery beyond year two.

Other Options Considered

7. The implications of the Welfare Reform Act necessitate this post and the work could not be absorbed by other existing posts or would there be the necessary professional expertise in the area of benefits.

Reason/s for Recommendation/s

8. It is recommended that the Senior Benefits Adviser post in the Adult Access team at the Customer Service Centre is established on a permanent basis. The post is required to:

    a. Deliver day-to-day operations of the service
    b. supervise three Benefit Advisers
    c. represent the Council at a strategic level on Welfare Benefit forums
    d. support and provide professional expertise on the implementation of the capital Nottinghamshire Local Welfare Assistance Scheme
    e. oversee the delivery of the scheme
    f. review and develop future options.

Statutory and Policy Implications

9. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder and users. Where such implications are material, they have been brought out in the text of the report. Attention is, however, drawn to specifics as follows:

Human Resources Implications

10. The human resources implications are contained within the body of the report.

11. The Trade Unions have been consulted. Unison supports the appointment of a Senior Benefits Adviser post and welcomes the development of the welfare benefits team which can give real help to vulnerable adults in Nottinghamshire. Unison have consistently supported having this service and vigorously opposed the closing of the Welfare Rights team some two years ago.

Financial Implications

12. The cost of 1 fte (37 hours) Senior Benefits Adviser, Pay Band B, scp 34-39 per annum (full year costs) from April 1st 2013:

		£
1 fte Senior BTIA scale point 39		41,640
casual car user		800
Training		300
TOTAL		**42,740**

13. Funding for the post has been identified within the base budget.

Equal Opportunities Implications

14. These proposals will help empower the most vulnerable members of society by enabling them to access welfare benefit information and advice.

Implications for Service Users

15. These proposals will enhance the provision of advice on benefits for residents of Nottinghamshire.

RECOMMENDATION/S

It is recommended that following the outcome of the review that the following post be established on a permanent basis:

1) 1 fte (37 hours) Senior Benefits Adviser post, Pay Band B, scp 34-39 (£28,636 - £32,800 per annum) in the Adult Access team at the Customer Service Centre and the post continue to be allocated casual car user status.

PAUL MCKAY
Service Director for Promoting Independence and Public Protection

For any enquiries about this report please contact:
Jane North
Group Manager, Customer Access Social Care
Email: jane.north@notttscc.gov.uk

Constitutional Comments (KK 18/01/2013)

16. The proposals in this report are within the remit of the Adult Social Care and Health Committee.

Financial Comments (KAS 22/01/2013)

17. The financial implications are set out in paragraphs 12 and 13 of the report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

a. Delegated decision Record - Disestablish the Welfare Rights Team and establish the Benefits Training and Advice Team.

b. The Welfare Reform Act 2012.

c. Social Fund Guide – Department for Work and Pensions – May 2012.

d. Government Response Local Support to replace Community Care Grant and Crisis Loans for Living Expenses in England – June 2011.

Electoral Division(s) and Member(s) Affected

All.

ASCH91

Nottinghamshire County Council

Report to Adult Social Care and Health Committee

4 February 2013

Agenda Item: 12

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

1. To consider the Committee's work programme for 2012/13.

Information and Advice

2. The County Council requires each committee to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the committee's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and committee meeting. Any member of the committee is able to suggest items for possible inclusion.

3. The attached work programme has been drafted in consultation with the Chairman and Vice-Chairman, and includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified.

4. As part of the transparency introduced by the new committee arrangements, committees are expected to review day to day operational decisions made by officers using their delegated powers. It is anticipated that the committee will wish to commission periodic reports on such decisions. The committee is therefore requested to identify activities on which it would like to receive reports for inclusion in the work programme. It may be that the presentations about activities in the committee's remit will help to inform this.

5. The work programme already includes a number of reports on items suggested by the committee.

Other Options Considered

6. None.

Reason/s for Recommendation/s

7. To assist the committee in preparing its work programme.

Statutory and Policy Implications

8. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the committee's work programme be noted, and consideration be given to any changes which the committee wishes to make.

Jayne Francis-Ward
Corporate Director, Policy, Planning and Corporate Services

For any enquiries about this report please contact: Paul Davies, x 73299

Constitutional Comments (HD)

1. The Committee has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (PS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to Committee on operational activities and officer working groups, will contain relevant financial information and comments.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

ADULT SOCIAL CARE & HEALTH COMMITTEE - WORK PROGRAMME

Report Title	Brief summary of agenda item	Lead Officer	Report Author
4 March 2013			
Progress update on 2 of ASCH high governance projects	Update on biggest projects currently in progress within ASCH (Alternatives to residential care – including extra care developments)	Relevant Service Directors	
Proposals for redesign of community based services	Update on redesign of community based care services.	Service Director – Joint Commissioning, Quality and Business Change	Kate Revell
Personalisation and Promoting Independence – progress report	To provide an update on progress on personalisation and promoting independence.	Service Director for Promoting Independence and Public Protection	Jane North/ Nicola Peace
Update on homeless prevention services	Overview and update on services provided to people who are homeless.	Service Director – Joint Commissioning, Quality and Business Change	Beth Cundy
Progress update on Day Services Modernisation Programme	To provide an update on the progress made to date with the modernisation of day services.	Service Director for Personal Care and Support – Younger Adults	Wendy Lippmann
Reablement for Younger Adults	Update on the Reablement services being provided to younger adults.	Service Director for Personal Care and Support – Younger Adults	Jon Wilson
Nottinghamshire County Council's Response to Equalities and Human Rights Commission Survey on Older People's Home Care and Human Rights	To report back on the response to the survey	David Pearson, Corporate Director, for Adult Social Care, Health and Public Protection	Jennie Kennington
25th March 2013			
Contract Extension for HPAS	To seek approval to extend the contract for the HPAS Service	Service Director – Joint Commissioning, Quality and Business Change	Jane Cashmore / Jane Zdanowska

Report Title	Brief summary of agenda item	Lead Officer	Report Author
Welfare Reform Act - Update	To provide an update on the Welfare Reform Act	Service Director for Promoting Independence and Public Protection	Paul McKay
Electronic Roster and Monitoring System	To seek approval for funding for an Electronic Roster and Monitoring System	Service Director for Promoting Independence and Public Protection	Karen Peters/ Nicola Peace
Young Carers Strategy	To present the Young Carers Strategy	Service Director for Personal Care and Support – Younger Adults	Sue Foster
Proposed Reconfiguration of the staffing establishment within Physical Disability Teams	To proposed a revised staffing structure for Physical Disability Teams	Service Director for Personal Care and Support – Younger Adults	Ellie Davies
22nd April 2013			
Update on ASCH performance	Overview of current performance in ASC including key performance indicators, and including review of quality dashboard.	Service Director – Joint Commissioning, Quality and Business Change	Anne Morgan
Think Local, Act Personal – Expenditure Plan for 2013/14	To seek approval for of the Think Local, Act Personal expenditure plan for 2013/14	Service Director for Promoting Independence and Public Protection	Jane North
Services to Support Young People in Transitions - Update	Update on the work taking place on the transition from Children's to Adult Services.	Service Director for Personal Care and Support – Younger Adults	Jon Wilson
May 2013			
June 2013			
Project to develop the Nottinghamshire partnership for social care workforce development training function to shape the independent social care workforce	Update on progress of the Social Care Workforce Development	Service Director for Personal Care and Support – Older Adults	Anita Astle/Richard Burke

Report Title	Brief summary of agenda item	Lead Officer	Report Author
Supporting People Deaf Floating Support Service Commissioning Update	To provide an update on progress made with commissioning the deaf floating support service	Service Director – Joint Commissioning, Quality and Business Change	Beth Cundy
Day Service Modernisation Programme – Outcome of consultation on the transfer of all day services catering services	To report on the outcome of the consultation on the transfer of all day service catering staff and associated catering budgets to the Catering and Facilities Team	Service Director for Personal Care and Support – Younger Adults	Wendy Lippmann
Living at Home – Extra Care – Care and Support Specialist Housing Fund Bid	To report on the outcome of the bid for funding to the Department of Health and the Home s and Communities Agency's Care and Support Specialised Housing Fund.	Service Director for Personal Care and Support – Older Adults	Cherry Dunk/ Paul Boyd
July 2013			
Shared Lives Policy	To report back to Committee on the implementation of the Shared Lives Policy	Service Director for Personal Care and Support – Younger Adults	Cath Cameron Jones
Care Quality Commission – Secondment of an Officer – progress report	To report on the progress of the Secondments.	Service Director – Joint Commissioning, Quality and Business Change	Caroline Baria
Funding For Substance Misuse Social Worker Posts	To report back on the outcome of the consultation period regarding the social care element of residential placements for substance misuse and that any therapeutic element of the placements is sought from the NHS.	Service Director for Personal Care and Support – Younger Adults	Tessa Diment
September 2013			
Update on the progress of assistive technology use in maintaining the independence of vulnerable people	Update on the progress on the Assistive Technology (see report of the 29th October 2012)	Service Director for Personal Care and Support – Older Adults	Mark Douglas
Transforming Care – Nottinghamshire's	To provide an update on the local action being taken to respond to the national concerns.	Service Director for Personal Care and Support – Younger Adults	Jon Wilson

Report Title	Brief summary of agenda item	Lead Officer	Report Author
Response to Winterbourne View Hospital			
October 2013			
NHS Support for Social Care	To report back to Members as stated in the report on the 29th October 2012	Service Director for Personal Care and Support – Older Adults	Jane Cashmore
November 2013			
December 2013			
January 2014			
Care Quality Commission – Secondment of an Officer – final report	To report on the conclusions of the Secondments.	Service Director – Joint Commissioning, Quality and Business Change	Caroline Baria

ASCH 93