# Rutland County Council

# Care Home Cost of Care Exercise 2022-23

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Rutland County Council

ARCC

# Contents

# 1 Executive Summary

## 1.1 Context the Cost of Care Exercise

### 1.1.1 Fair Cost of Care & Market Sustainability

On the 16th December 2021 Department for Health and Social Care (DHSC) released its policy paper: 'Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023' wit further detailed guidance following on the 24th March 2022. The 2022-23 funding provided under this policy is designed to ensure local authorities can prepare their markets for reform (particularly the impact of section 18(3) and the right for self-funders to request that a local authority purchase care on their behalf at the 'usual council rate'.

As a condition of receiving future funding, local authorities will need to evidence the work they are doing to prepare their markets and submit the following to DHSC by 14 October 2022:

1. Analysis of cost of care exercises conducted for 65+ care homes and 18+ domiciliary care. This includes a cost of care report and completed cost of care data table as found in Annex A, Section 3.

2. A provisional market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market, with particular consideration given to the further commencement of Section 18(3) of the Care Act 2014. A final plan detailed plan will be required in February 2023; in the interim a 5-page provisional plan should be submitted utilising the Annex 3 template.

3. A spend report detailing how funding allocated for 2022 to 2023 is being spent in line with the fund's purpose. A full breakdown of how funding has been allocated to support 65+ care home and 18+ domiciliary care markets (including domiciliary care providers who operate in extra care settings). This must specify whether, and how much funding, has been used for implementation activities and how much funding has been allocated towards fee increases beyond pressures funded by the Local Government Finance Settlement 2022 to 2023.

### 1.1.2 Scope of this report

This report has been prepared on behalf of Rutland County Council [Rutland CC] in response to the first requirement and presents the analysis and findings from the cost of care exercise conducted within 65+ care homes (residential and nursing). This report covers the following:

- The overall cost of care analysis, including the approach to engagement and data capture, methodology utilised and the formulae to inform future uplifts
- An approach to sensitivity analysis; based on costs being covered on a given volume of hours delivered by Providers, in addition to whether costs change in relation to changes in volume
- Costs to consider when determining future fee rates, which includes the flexibility to accommodate a range of assumptions, for example: occupancy, inflationary pressures and other factors such as staffing levels.
- Key findings and recommendations during the engagement to support future commissioning models in Rutland.

## 1.2 Provider Engagement

This review of cost of care has been informed by 4 months' engagement and data analysis work, comprising the following elements:

a) Provider Survey & Cost Template: submitted to 11 providers within Rutland, to gather data on both the costs and the operational experience of delivering residential care services in the local market.

b) 1:1 deep-dive structured interviews: providers were invited to express interest for a 1:1 session, with 3 interviews taking place with the finance and/or operational leads for the respective organisations

c) Closed feedback/questions: conducted via e-mail to allow providers to consider additional questions and clarifications following receipt of data

Engagement focused on the following key aspects of the market as well as a detailed study of costs:

1. The current residential care market in Rutland (structure, demand and supply).
2. The experience of commissioning and contracting with Rutland CC.
3. Provider's business operating models, general market outlook, workforce, contract and quality monitoring, business costs, and future commissioning arrangements
4. Deep dive with providers to understand operating costs and sensitivities that would impact cost

Responses to the request for cost information were unfortunately low, with only partial information returns or cost information from the 2021-22 fee setting exercise provided (see **section 2.3**). Despite this partial response data was received from 6 providers (54.5% of the market or 55.2% of beds).

## 1.3 Local Cost of Care Results

### 1.3.1 2022-23 cost of care median analysis from provider returns

As per the DHSC requirement, the exercise was required to identify a median cost of care for the delivery of 65+ care home services in financial year 2022-23[1]. **Table 1** identifies the "median" rates across the 4 types of care. **Section 4** provides a more detailed breakdown of the analysis and subsequent modelling.

| | 65+ care home without nursing | 65+ care home without nursing, enhanced needs | 65+ care home with nursing | 65+ care home with nursing, enhanced needs |
|---|---|---|---|---|
| Total Care Home Staffing | £481.55 | £481.55 | £731.17 | £731.17 |
| Total Care Home Premises | £69.25 | £69.25 | £43.86 | £43.86 |
| Total Care Home Supplies & Services | £185.39 | £185.39 | £117.42 | £117.42 |
| Total Head Office | £39.88 | £39.88 | £25.15 | £25.15 |
| Total Return on Operations | £52.96 | £52.96 | £63.59 | £63.59 |
| Total Return on Capital | £53.77 | £53.77 | £60.10 | £60.10 |
| TOTAL | £882.80 | £882.80 | £1,041.28 | £1,041.28 |
| LA Framework Rate (incl. FNC) | £523 | £558 | £817.19 | n/a |
| Variance on Framework Price | 68.8% | 58.2% | 27.4% | n/a |

***Table 1:*** *summary of provider median costs and variance against RCC framework rates*

[1] This includes: standard residential care; residential care for enhanced needs; nursing care and nursing for enhanced needs.

The financial impact of this model is estimated to be £1,433,536 per annum on the basis of the variance between the existing base rate and the median, multiplied by an estimated number of placements as of April 2022.

### 1.3.2 Conclusions

The cost of care exercise was conducted during exceptionally challenging conditions for the sector nationally, not just in Rutland. Recruitment and retention pressures arising during the Covid-19 outbreak and most recently inflationary costs have put further pressures on the care workforce and providers alike.

ARCC identified several quality issues from the limited data sets made available from providers which potentially impact the accuracy and robustness of data within the original datasets submitted. This has likely resulted (in some instances) in significantly inflated unit costs compared to what would reasonably be expected, based subsequent clarification with providers, current published fee rates (non-LA) and nationally recognised datasets such as Laing and Buisson's care home market reports[2].

Data quality issues are discussed further in Section 4; however, at a high level these comprise of:

- Acquiring representative unit costs during COVID-19
- Impact of snapshot/actual or current occupancy vs. typical unit-cost based models
- Impact of additional grant funding
- Errors deduced via typical assessment of available income and expected profitability

No providers responded to clarifications, as such, whilst some qualitative identification of errors has been identified, it has not been updated by the provider, and where no response has been received, potential unknowns will remain. Despite any existing data quality issues, ARCC utilised much of the cost information to model unit costs at target occupancy and staffing ratios, which is explored further in Section 4. These are presented alongside the median values as required to be submitted within DHSC's Annex A report.

It is important to note when commissioning care services, that Councils are not responsible for setting individual budget or cost lines for providers. Whilst pay rates and other non-pay costs have been utilised for the purposes of constructing the median cost and scenario models, this does not in any way represent the absolute shape and size of each provider, rather they are guidelines for producing an overall "budget" unit cost per resident per week. For instance, setting a "base" pay rate does not mean providers are only able to pay workers at that rate. They are free to work within their budgets to pay whatever they are able to retain a sustainable workforce.

As such, any model (and subsequent breakdown of costs) should not be taken explicitly as the exact cost the business needs to, or should it be read that it is the absolute maximum limit of, what the provider's affordability will be for any and all costs incurred by their businesses. There are many other factors (such as the prevalence of self-funders and other customer types) that also affect independent care providers, and no exercise of this nature can take all of these into account. Indeed, the range of services providers offer differ considerably between the self-funder and mixed funding stream providers and therefore a like-for-like comparison is not necessarily appropriate.

[2] For comparison, where referenced, ARCC uses LaingBuisson, CARE HOMES FOR OLDER PEOPLE UK MARKET REPORT, Thirtieth Edition [2019]

Finally, it should be re-emphasised that any Council has a duty under Section 5 of the Care Act to ensure they have a "sufficient" market to buy services from, and it is not the duty of any local authority to pay any specific "rate" for care. Rather, local authorities will need to consider how readily they are able to service their population's needs via existing contracting and pay mechanisms they have with the market, taking into account the scale of customer waiting for and length of time taken to fulfil placements, the availability of services and coverage of the market at existing framework or negotiated rates and many other factors outside of simply cost.

## 1.4 Summary of recommendations

In concluding this exercise, we have noted the following recommendations, which take into consideration wider market sustainability and commissioning work locally (for further details, see section 5):

- Ensuring services are fit for the future. Work needs to be undertaken on the future specifications to ensure that services reflect the current needs of people and the strategic direction for commissioning of local services. Expectations such as acuity of need and dependency can be addressed through setting service level expectations such as support ratios or hotel + care bandings to reflect needs.

- Market management. Further work is required to understand the condition of the homes within the area, particularly the limited few who currently accept (close to) the framework rates, and whether they are physically fit-for-purpose. Depending upon the outcome of this review it may be that Rutland's strategy focuses on investment to develop existing settings as opposed to the formation of new build homes.

- Continued market dialogue and working towards the FCoC. Whilst a long-term intention, in line with this DHSC cost of exercise, may be to work towards the estimated median for care, DHSC guidance states that "fair means what is sustainable for the local market". The council should continue to monitor the pressure in the market (both staffing and business operating costs) through future fee exercises and make adjustment (% fee uplifts) to reflect changes to operating costs. ARCC advises further engagement to be completed with the market between October 2022 and February 2023 to present the costed scenarios back and discuss feasibility and co-develop a set of representative costs from across the market.

- Identifying ways to support the market beyond fees. Rutland CC's ability to meter towards the median cost will be governed by DHSC's future allocation of the Market Sustainability and Fair Cost of Care fund. However, there are actions that commissioners may be able to undertake which could support the local market to offset costs; for example, support for energy efficiency (e.g., green grants) and utilising group purchasing power.

# 2 Project Overview

## 2.1 Policy Landscape

On 7 September 2021, government set out its new plan for adult social care reform in England. This included a lifetime cap on the amount anyone in England will need to spend on their personal care, alongside revisions to the means-test for local authority financial support. From October 2023, the government will introduce a new £86,000 cap on the amount anyone in England will need to spend on their personal care over their lifetime. The charging reforms also propose to extend Section 18(3) of the 2014 Care Act which allows self-funders to request that their local authority commissions their care, in the same way as those who are supported by the means test. Whilst section 18(3) has been in place for domiciliary care for 7 years the uptake and financial impact remains unclear; however, in March 2022 the County Council's Network published an impact assessment on the implementation of section 18(3), which identified: "In its own impact assessment, the Government have not sought thus far to estimate the combined financial impact of Section 18(3) and FCC on care providers. But our analysis demonstrates that based on a 50% take up rate of Section 18(3) and current FCC funding levels for councils, providers across the country would experience significant financial challenges as a result of lost revenues amounting to £560m"[3].

The government is implementing wide-ranging and ambitious reform of adult social care. In December 2021 the DHSC published a white paper, People at the Heart of Care, that outlined a 10-year vision that puts personalised care and support at the heart of adult social care and supports the realisation of the funding reform. Implementation of the Market Sustainability and Fair Cost of Care Fund is one of the first foundational steps in the journey to achieving this vision.

On the 16th December 2021 DHSC released its policy paper: **'Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023'**. As a condition of receiving future funding[4], local authorities will need to evidence the work they are doing to prepare their markets and submit the analysis of cost of care exercises for 65+ care homes and 18+ domiciliary care. There is also a requirement to produce a provisional market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market. A final plan detailed plan will be required in February 2023; in the interim a 5-page provisional plan should be submitted utilising the Annex 3 template.

For the purpose of the policy and understanding of cost of care, DHSC have defined 'fair' as "*the median actual operating costs for providing care in the local area (following completion of a cost of care exercise) for a series of care categories….and is, on average, what local authorities are required to move towards paying providers. In the context of specific rates for care paid, fair means what is sustainable for the local market. For providers, this means they will be able to cover the cost of care delivery and be able to make a reasonable profit (including re-investment in their business), surplus or meet their charitable objectives. For local authorities, it recognises the responsibility they have in stewarding public money, including securing best value for the taxpayer*".[5]

A cost of care exercise is a process of engagement, data collection and analysis between local authorities, commissioners and providers with the purpose of arriving at a shared understanding of the local cost of providing care. The outcome of the cost of care exercise is not intended to be a replacement for the fee-

[3] Impact Assessment of the Implementation of Section 18(3) of The Care Act 2014 and Fair Cost of Care; The County Councils Network

[4] In total the fund amounts to £1.36 billion (of the £3.6 billion to deliver the charging reform programme). In 2022 to 2023, £162 million will be allocated. A further £600 million will be made available in each of 2023 to 2024 and 2024 to 2025. This funding profile allows for staged implementation that is deliverable, while also reflecting the timelines for charging reform.

[5] See detailed guidance 24th March 2022.

setting element of local authority commissioning processes or individual contract negotiation. Indeed, the Care Act 2014 states *'When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care… It should also allow retention of staff commensurate with delivering services to the agreed quality and encourage innovation and improvement. Local authorities should have regard to guidance on minimum fee levels necessary to provide this assurance, taking account of the local economic environment. This assurance should understand that reasonable fee levels allow for a reasonable rate of return by independent providers that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term.'*[6]

## 2.2 Project Scope

The scope of the project was determined by DHSC's Fair Cost of Care guidance and specifically focussed on care homes for older people (age 65+); although there was recognition that some residents in these homes may be aged under 65. The four types of care to be considered were: standard residential care; residential care for enhanced needs; nursing care; and nursing for enhanced needs. The following services were out of scope: local authority in-house services.

It is important to note that locally Rutland CC do not operate a framework rate for Nursing with enhanced needs; packages requiring this type of care are negotiated on a case-by-case basis based on the individually assessed needs. As a result, identification of a median cost was not possible.

## 2.3 Approach, Methods and Limitations

### 2.3.1 Project Governance

ARCC's approach was to encourage as much engagement as possible from the market. In order to monitor progress and mitigate project risks a project governance group was formed consisting of the Head of Commissioning, Senior Commissioner and ARCC. This group met fortnightly to discuss progress, risks and mitigations arising throughout the course of the project.

### 2.3.2 Engagement Activities and Timeline

Engagement activity was initially targeted to a cohort of 11 care home providers in the locality; this was reduced to 10 during the course of the engagement due to a care home closure. This cohort of 10 was engaged with throughout the process and offered multiple avenues with which to submit cost information, both via the national IESE web platform, and ARCC's own care homes cost survey (in the format of an MS Excel spreadsheet distributed via email). Engagement comprised the following key activities:

a) Provider Survey & Cost Template: Submitted to all 11 providers in the market, to gather data on both the costs and the operational experience of delivering homecare services in Rutland. The survey consisted of 3 parts:

*Part 1*: Commissioning Survey with thematic questions:

- Organisational details
- General business outlook and market growth
- Market insight and key challenges

[6] DHSC, section 4.31, Care and Support Statutory Guidance.

- Premises and occupancy information

*Part 2:* 2022 Organisation and Workforce:

- Current occupancy by funding stream and rate paid
- Workforce breakdown and payroll rates
- Staffing ratios
- Organisation workforce survey

*Part 3:* Historic costs 2021-22

- Historic revenue
- 2021-22 costs and % 2022 cost uplift/pressure

The team also accepted alternative returns such as the national iESE Fair Cost of Care Tool or alternative reports/accounts and the 2022-23 fee setting information questionnaire distributed by Rutland CC. In total, data (of varying levels of completeness) was received from **6 providers** – 3 submissions via the iESE Cost Toolkit and 3 Rutland fee setting templates. This represented **54.5% of the market and 55.2% of beds.** No responses were submitted utilising ARCC's cost survey (above).

b) **1:1 deep-dive structured interviews:** Interviews took place over 2 hours with senior finance and/or operational leads for provider organisations. All providers were invited to express interest for a 1:1 session and 3 providers took part in these.

c) **Closed feedback/questions:** these were conducted via e-mail and telephone to allow providers to consider additional questions and clarifications following receipt of the data.

### Provider outreach to mitigate low levels of engagement

To give providers the best possible opportunity to engage with the exercise and to mitigate the low levels of engagement early in the process, the following steps were taken:

- Providers were invited to a launch session on the 18th May 2022, to introduce the project
- A minimum of 5 reminder emails were sent to each of the providers
- The team, supported by Rutland CC's Clinical Care Home Coordinator, conducted phone calls to providers to ensure the correct stakeholders within each organisation were informed of the exercise.
- Providers who had previously been in touch either via email or phone calls in response to the reminder emails (above), received additional personalised outreaches reminding them of the deadline and offering support to complete the template and ask any questions they may have, e.g., regarding engagement process, confidentiality, or expected impact of the exercise.
- To further encourage engagement, the submission deadline was extended by three weeks from 01/07/2022 to 22/07/2022 (giving providers 9 weeks in total) as well as individual later deadlines agreed with providers for supplementary information, which was not forthcoming.

# 3 The Care Home Market in Rutland

This section details the size and scale of the current homecare market in Rutland as well as observations in relation to commissioning, contracting, market structure and costs. In most economic markets, relative demand versus supply is key in determining prices.

## 3.1 Supply, Demand and Quality

### Demographics[7]

Latest estimates show the population of Rutland to be just over 41,000 (ONS 2021) an 9.7% increase since 2011 (a 37% increase in 80-84; 25% increase in 85-89 and 31% increase in 90+ year olds). Population projections for over 65s suggest an increase of 24% (**33% increase in 75+ and 52% increase in 80+**) in the next 10 years, compared to an overall population increase within Rutland of 8%, suggesting an ageing population and a **decreasing number of people of working age residents**, either through outward migration or falling birth rates, which is particularly important for in relation to recruitment and retention.

An ageing population suggests the number of people with a disability is likely to in increase substantially and projections published by Projecting Older People Population Information (POPPI) suggest a significant rise in the number of people with **dementia (up 24%)** and **mobility problems (29%)** in Rutland over the next 10 years.

Rutland is one of the most affluent counties in England as a result people often self-fund. Estimates of the self-funding population published by the ONS in May 2022[8]; projects **self-funder levels in local care homes to be 63.3%** (with a lower and upper confidence range of 41.0% to 85.6%; see **Table 3**). Correspondingly, state funded placements are estimated to be **36.7%** (confidence range of between 14.4% and 59.0%), which is significantly higher than the regional (35.6%) and national (34.9%) estimates.

| Region | Self-funded service users (%) | LCL (self-funded) | UCL (self-funded) | State-funded service users (%) | LCL (state-funded) | UCL (state-funded) |
|---|---|---|---|---|---|---|
| **Rutland** | **63.3** | **41.0** | **85.6** | **36.7** | **14.4** | **59.0** |
| East Midlands | 35.6 | 32.5 | 38.7 | 64.4 | 61.3 | 67.5 |
| England | 34.9 | 32.7 | 37.1 | 65.1 | 62.9 | 67.3 |

***Table 2:*** *ONS self-funder estimates 2022*

Unemployment rates in Rutland are extremely low (at 3%) in comparison to both regional (3.7%) and national averages (4.1%). Similarly economic inactivity due to retirement is significantly higher (27.5%) than the regional (15%) and national (13.6%) averages. Of those in employment just short of 60% are in professional occupations (Major Group 1-3[9]) which results in significantly higher weekly earnings at £710.4, compared to £573.4 (East Midlands) and £613.1 (national average).

### Supply and Demand

There are 10 care homes for older people within the geographic boundaries of Rutland (excluding the 25 bedded residential setting which closed in summer 2022 due to financial difficulties. Excluding the recent

[7] Information taken from Rutland's Older People's MPS (2021) and Rutland JSNA: Ageing Well (2018)
[8] Care homes and estimating the self-funding population, England: 2021 to 2022. ONS May 2022. Click here to access.
[9] Data taken from Rutland's Nomis Profile, available at: Labour Market Profile - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)

closure, there are 437 CQC-registered beds which equates to 1 bed per 11.4 people aged 75+ (ONS census 2021). Homes vary in size, the smaller homes tend to be registered for residential care and are sub 34 beds (5 homes), with the larger homes ranging from 46-82 beds offering mixed services (residential, residential EMI and nursing).

As of April 22, Rutland had 85 placements within local care homes distributed across a smaller share of the market, with only 3 providers having greater than 50% of the occupied beds funded through Rutland CC (see Figure 1). It is important to note that provider 7 has a significantly higher intake of local authority clients due to a block purchasing arrangement.

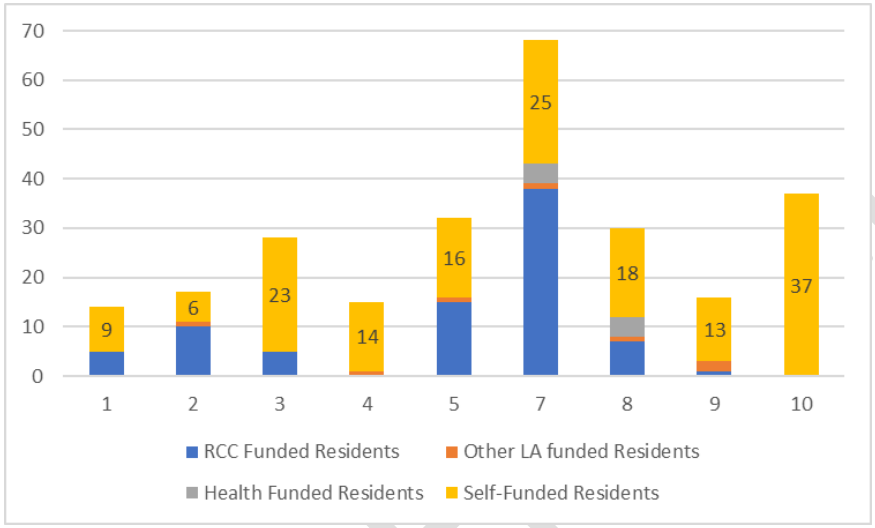


***Figure 1**:Occupied beds by funding source. April 2022 Rutland contract monitoring*

As of April, occupancy within the market was 59% (data for the new home which opened in October 2021 was not available); this reflects the increased capacity of 2 new homes which has distorted the market and resulted in approximately 250 vacant beds. Whilst there is an oversupply of beds locally, in reality there is a two-tier market, the self-funder market offering vastly different services which drive up cost; as can be seen by the following extract from a provider's website: *"…everything from our excellent personalised care, private meals in our fine dining rooms, use of special facilities (beauty salon, cinema and bar/bistro), limousine trips and telephone are all covered".* This presents a number of challenges in relation to the ability to purchase beds at the local authority specification and rate. New entrants who are actively targeting self-funders and deploying a strategy of low occupancy over several years are distorting the market capacity and also redirecting self-funders from existing providers which presents a risk to financial sustainability.

Fee rates for 2022-23 were set at £523 for Residential, £558 Residential EMI/Enhanced and Nursing £608 (excluding FNC). Rutland do not operate an enhanced Nursing rate as all placements that require this support are individually negotiated based on the needs of the individual. Historically, there have been only 3 providers which have accepted Rutland CC framework rates, restricting where it can place service users. In the last 6 months, predominately driven by the current economic pressures, these homes are refusing to accept framework rates which has resulted in some new placements being individually negotiated with providers at higher rates.

## Quality

Currently no services are assessed by CQC as 'outstanding', with the bulk of provision, 311 beds (71%) rated 'good'. 11% (c. 48 beds) are assessed as 'requires improvement' and the newly opened home is 'not yet inspected (78 beds/18%), see Figure 2.

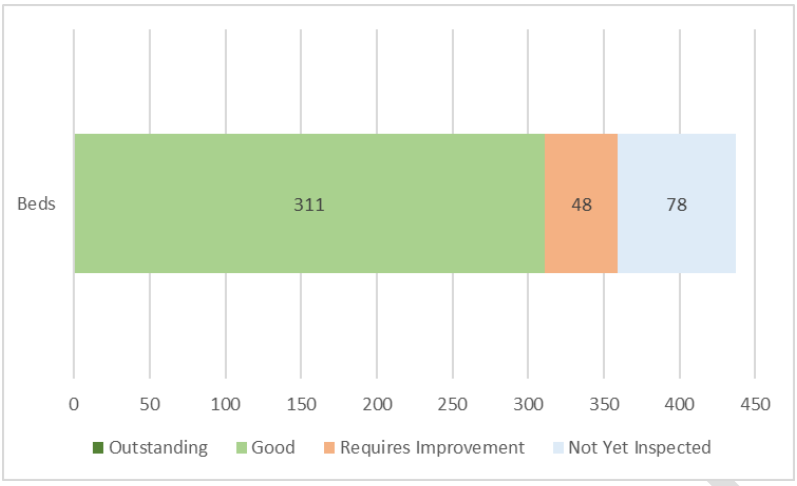


***Figure 2**: Number of beds by CQC inspection rating*

## 3.2 Stakeholder Feedback

Here we summarise relevant comments and observations arising from our engagement with stakeholders and a desktop review of contract documentation.

### 3.2.1 Internal Insight

- Most homes are now **refusing to accept the framework rate** with individual placements being subject to negotiation.
- Introduction of 2 new settings has **increased vacancy levels** and these new environments are likely to 'divert' self-funders from already established settings which could result in future sustainability issues.
- Whilst demand from Rutland CC is relatively small, 2-3 clients per month, the ambition locally is to **support people in the community** wherever possible. Implementation of this strategy is likely to have some impact in how Rutland CC purchase services, particularly on the handful of care homes which will accept RCC placements, although this number is diminishing and is likely to have minimal impact in the short-term given the self-funder strategy deployed by a number of providers.
- Workforce **recruitment and retention remains a significant concern** and cost pressure locally. The freedom to adjust rates within the self-funder market offers some providers greater flexibility in changing pay and T&C's, although challenges exist across the whole market due to labour market challenges alluded to above.

### 3.2.2 Provider Feedback

#### *3.4.2.1 General business outlook*

Engagement was limited to those providers who tended to deliver more business on behalf of Rutland CC; therefore, we have to accept a natural level of bias in this regard. Those providers who we spoke to were concerned regarding future sustainability; particularly, Local authority fees not being sufficient which necessitates the requirement to balance authority admissions with self-funders (up to 50%). However, the new entrants to the market are "suffocating" the market and re-directing self-funders as existing provision cannot compete with the capital investment of these new providers. Similarly, this additional occupancy is resulting unsustainable occupancy levels for some providers (85-90% was quoted as break-even).

It is important to note whilst providers stated it has never been the strategy for self-funders to top up local authority placements this unfortunately is the case, with anecdotal evidence that there may be a 30-40% differential in rates. Providers recognised the need to bridge the gap between self-funders and local authorities' clients due to the introduction of the social care charging reforms and the care cap in 2023. Examples were provided where a top-up or rate differential existed due to the occupant receiving a larger room or a garden view, but in these instances the additional charge was minimal. From discussions there was no evidence that self-funders materially receive a different service in mixed economy settings as opposed to those who cater exclusively for self-funders.

#### *3.4.2.1 Workforce*

Access to a stable and suitably experienced workforce remains a significant challenge locally, with providers having to compete to employ staff through competitive pay rates; the impact is starker with providers who have mixed funding streams as opposed to those exclusively targeting self-funders as the latter have greater flexibility to increase fees to increase rates of pay. As a consequence, some providers are reliant on significant levels of agency staff, nurse recruitment in particular has been reported by providers as extremely challenging with rates +50-100% above usual pay rates. Several factors exacerbating the current workforce challenges were identified:

- Demands on the workforce as care continues to be a growing service area both in volume and complexity, due to increasing frailty and acuity of service users.
- Staff 'burn out' post Covid and a sense that there are easier jobs for the same or more money.
- Terms & conditions are not as attractive as other sectors or types of health and social care provision.
- The continuing impact of Brexit on the potential availability of workers.

The impact of staff shortages is not only fiscal, but providers have also reported high than average staff turnover which affects the continuity of care and in turn may be impacting upon increased individual needs. New staff/entrants to the sector are more-likely in-experienced necessitating increased training and shadowing, which in turn can temporarily decrease capacity. Concerns were also raised in regard to the welfare of managers.

#### *3.4.2.2 Business Costs*

The impact of increasing utility costs has been partially mitigated in some instances by people entering fixed term deals, although some providers are reporting steep hikes in new deals with some extremes of a four-fold increase in energy costs; it is uncertain as to how recent announcements of an energy cap for business may change this position in the future. Similarly, providers reported that insurance premiums are rising as is the cost of finance and consumables, particularly food.

#### *3.4.2.3 Sufficiency and occupancy*

Providers were eager to point out that lower occupancy does not significantly reduce the costs of running services as providers are still required to pay premises costs and maintain safe staffing levels, regardless of the numbers. Indeed, staff cost as a % of income increases as turnover (occupancy) reduces. Whilst arguably it is not the responsibility of local authorities to maintain under-utilised capacity, there is a duty to ensure there is a sufficient capacity to meet current and future demand.

There was a perception that people are coming to service with higher level needs which cannot be met in the 'cost envelope' of framework rates; is likely to be driving challenges placing individuals or people 'stepping up the tariff'. Providers felt there is no incentive/support to take people with high dependency.

# 4 Cost Analysis and Scenario Modelling

## 4.1 Provider Cost Information & Data Quality

Following the four-month period of engagement with providers and commissioners from May to September 2022, the ARCC project team assessed a limited range of cost data from 6 providers. Due to the size of the market sample sizes across the care types were limited to 4 providers of residential and residential enhanced, and 2 providers of nursing care.

ARCC identified several quality issues from the limited data sets made available from providers (see section 2.3) which potentially impact the accuracy and robustness; these included:

- Absence of occupied bed data
- Absence of information on staffing establishment and care hours per resident
- Occupancy being attributed to one care type
- Unable to differentiate costs across care types, this was most common in residential and residential enhanced settings
- Data not provided, or separated by, return on operations and capital

No providers responded to clarifications, as such, whilst some qualitative identification of errors has been identified, it has not been updated by the provider, and where no response has been received, potential unknowns will remain. As a result of the above, the analysis of median cost has been derived from modelling the data available together with a series of assumptions (see Section 4.3).

## 4.2 Business Operating Model Observations

Below are some high-level observations on respondents' business operating models and costs.

### 4.2.1 Occupancy

Residential and residential enhance needs occupancy ranges from 60% to 91%, with an average of **74.8%.** The average number of beds within these 4 settings was 32 (ranging from 18 to 45 beds). Settings which provide nursing care had slightly higher occupancy at **83.4%** (average 64 beds).

### 4.2.2 Care hours per resident

Staff reported challenges at disaggregating care hours per resident per week, in part due to no recognisable requirement beyond ensuring safe staffing levels to meet resident dependency. We could infer from the limited data set average staffing ratio (staff to resident) of between 4:1 and 5:1 per day and 1:9 and 1:12 at evenings for residential settings. Nursing would of course require the addition of a 24/7 nurse, hence nursing settings are typically larger to offer greater scales of economy.

### 4.2.3 Use of Agency Staff

Agency staffing levels varied considerably across respondents to April 2022's contract monitoring. Hours per occupied bed ranged from 0 to 24.5. Agency cost is often considerably more expensive than direct employment (41-64% uplift was quoted) and are often exacerbated due to unrecoverable VAT.

As an alternative to agency usage, providers are looking towards overseas recruitment which is an equally cost prohibitive approach to mitigating recruitment and retention issues. On provider gave an example of £2,790 per staff member.

### 4.2.4 Operational Costs

Table 4 identifies the cost range (min and max) and median for key operational cost lines expressed as per resident per week across all 6 settings.

| | Min | Median | Max |
|---|---|---|---|
| **Food / Catering** | £20.55 | **£45.73** | £49.98 |
| **Utilities** (Gas, Electricity, Water, TV License) | £18.92 | **£41.64** | £63.87 |
| **Medical Supplies** (incl. equip rental) | £0.00 | **£3.13** | £9.49 |
| **PPE & other consumables** | £1.39 | **£6.77** | £18.00 |
| **Domestic & Cleaning Supplies incl. Laundry** | £9.65 | **£12.34** | £19.17 |
| **Trade and Clinical Waste** | £2.12 | **£7.74** | £9.14 |
| **Uniforms** | £0.00 | **£0.00** | £0.63 |
| **Registration Fees** | £3.77 | **£4.72** | £5.26 |
| **Telephone / Mobiles** | £1.15 | **£1.79** | £8.81 |
| **Marketing** | £0.00 | **£0.64** | £4.61 |
| **Client Transport** (vehicle lease etc.) | £0.00 | **£0.80** | £6.17 |
| **Entertainment** (outings & expenses) | £0.00 | **£0.07** | £4.74 |
| **Insurance & Other** | £3.14 | **£7.19** | £27.65 |

***Table 3:*** *operational cost range and median per resident per week*

## 4.3 "Median" Provider Cost Analysis

ARCC compiled a set of average unit costs across each cost line from all 6 homes (4 residential; 2 nursing) and used this as the basis for modelling costs.

An average was chosen in preference to using the median due to the small sample size and the lack of complete information from each home. This however results in there being "£0" costs for some cost lines where costs are in reality occurred. For example, some homes submitted "£0" for management costs, as they have been rolled into total staff costs; however, for the purposes of arriving at a representative total unit cost, an average was used across each of these lines to smooth out the effect of where data was not present. Similarly, the median cost for staffing was derived from grouping settings by care type, i.e., 4 settings within residential and 2 nursing. All other costs lines, such as non-staffing and premises were grouped (6 settings) to provide a larger sample size.

To ensure that costs were representative of the typical size and make-up of the homes in each care type, the average home size across the respondents was also utilised to break down total expenditure into cost per resident per week. This was necessary due to only partial submissions on IESE, and other information gathered through 1:1 interviews and Rutland CC's fee survey template.

Return on Capital (RoC) and Return on Operations (RoO) were highly variable across responses, and ARCC were unable to verify the accuracy of these figures without conducting forensic analysis with provider's actual accounts to hand. ARCC used the information presented by the market, alongside our own experience across homes in similar authorities and nationally published data (Laing and Buisson) to apply ROC/ROO figures. These were each set at 6% of total expenditure respectively for the purposes of the median unit cost across all care types.

Finally, the median costs are also informed by occupancy, to arrive at a representative cost per resident per week figure. The figures used in the median unit costs are as follows:

- For residential & enhanced residential care, an average home size of 38 beds at 80% occupancy (30.4 occupied beds)
- For nursing and nursing enhanced care, an average home size of 60 beds at 80% occupancy (48 occupied beds)

It is important to note that there is no variable in the base provider cost analysis for enhanced provision in either residential or nursing, due to the lack of information present in the market. ARCC have instead utilised information regarding recommended staffing ratios to inform the variation in cost in section 4.4.

Table 5 presents a "median" cost per resident per week for all care types utilising the average unit costs derived from the provider submissions in Rutland (a more detailed breakdown can be found in Annex A).

| | 65+ care home without nursing | 65+ care home without nursing, enhanced needs | 65+ care home with nursing | 65+ care home with nursing, enhanced needs |
|---|---|---|---|---|
| Total Care Home Staffing | £481.55 | £481.55 | £731.17 | £731.17 |
| Total Care Home Premises | £69.25 | £69.25 | £43.86 | £43.86 |
| Total Care Home Supplies & Services | £185.39 | £185.39 | £117.42 | £117.42 |
| Total Head Office | £39.88 | £39.88 | £25.15 | £25.15 |
| Total Return on Operations | £52.96 | £52.96 | £63.59 | £63.59 |
| Total Return on Capital | £53.77 | £53.77 | £60.10 | £60.10 |
| TOTAL | £882.80 | £882.80 | £1,041.28 | £1,041.28 |

***Table 4:*** *summary of provider median costs*

It is important to note the inherent and practical limitations of such an exercise and reflect particularly on what the outputs to any cost modelling exercise aims to achieve. Any single cost median or model will not reflect the diversity within a whole market due to the number of variables to take into consideration, in addition meaning that any attempt to include all variables would result in an unusably large range of outputs in any practical sense. Thus, the modelling of a median cost can only be a simplified version of reality, indeed, as we have alluded to above, providers were unable to differentiate costs across care types; this was most acutely seen in the cost for enhanced needs staffing, which is a variable we would expect to shift based on need, being a mirror of the none enhanced care type. It is for this reason that we have also developed cost models which consider variance by care type staffing establishment and variances in occupancy.

The model can then help to highlight different costs and cost drivers and this in turn can promote a greater level of understanding, particularly for commissioners, when the commissioners come to consider future pricing. This analysis, and subsequent modelling, should be considered as the start of a dialogue with the market in relation to a sustainable rate for care.

## 4.4 Cost Modelling

The cost model was built utilising cost data extracted from the 6 provider returns alongside recognised industry standards. As Figure 3 identifies, our treatment of modelling is based on settings having 3 key components within their costs; these are:

a) **Staffing:** provider data returns did not identify any variance in the staffing establishment and hence costs remained the same. However, ratios of 1:6 as a minimum to maintain a safe and effective service are recognised within the industry and LaingBuisson[10] market analysis: *"Staffing intensity benchmarks ('on shift' staff hours per resident per week)….for nursing care for older people and dementia is 39.8 hours per resident per week, for residential care of frail older people it is 28 hours per week and for residential care of older people with dementia it is 32.2 hours per resident per week".* Adjustments for each of the staffing ratios were made to differentiate levels of support and whilst the rates of pay remained the same (£10.23 carer and £10.50 senior), for each of scenarios the number of staff assumed to be on shift, at any one time, to derive the staffing ratio/care hours per resident per week.

b) **Operations:** as with the treatment of the "median" cost we utilised the sample data from all 6 settings to inform the cost base. We have assumed that operating costs, such as food, utilities etc. will remain broadly similar regardless of the care type. Whilst there may be some nuances, we believe these to be relatively small.

c) **RoO/RoC:** was treated in a similar way to the above; however, from the calculation of the "median" a ITDARM expectation of c.£147 per bed was identified and has been applied to each of the occupancy scenarios. As a result, the corresponding % decreases slightly as we adjust the staffing establishment and number of occupied beds, see 4.4.1 to 4.43.

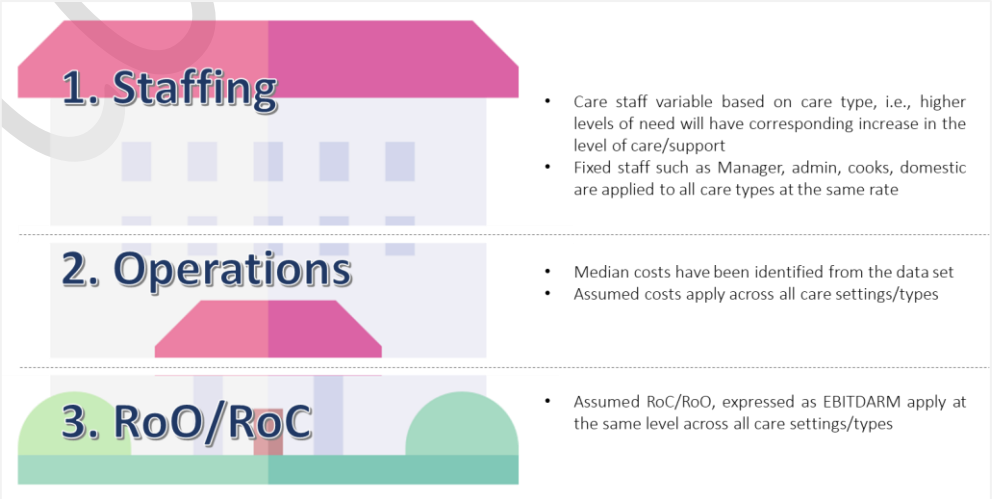


***Figure 3:** approach to modelling care home costs*

[10] LaingBuisson market analysis (30th edition, 2019)

Overall, through adopting a modelling approach to disaggregate costs across care types we see an increase on the residential enhanced care cost per week; however, there is a corresponding reduction in the cost of residential (see Table 6) which reflects, as expected, the difference in the cost based on levels of need.

| | 65+ care home without nursing | 65+ care home without nursing, enhanced needs | 65+ care home with nursing | 65+ care home with nursing, enhanced needs |
|---|---|---|---|---|
| COST MODEL @ 85% OCCUPANCY | £863 | £925 | £1,136 | n/a |
| Variance on Framework Price | 65.0% | 65.7% | 39.0% | n/a |
| COST MODEL @ 90% OCCUPANCY | £823 | £881 | £1,080 | n/a |
| Variance on Framework Price | 57.3% | 58.2% | 32.2% | n/a |

***Table 6**: impact of cost model rates against framework*

### 4.4.1 Residential

Figure 4 presents a summary table for residential care. A staffing establishment of 5 care staff and 1 senior to service the occupied beds during the day and 2 carers and 1 senior at night.

The assumption within the model is costs are set at the base rate (£882.80) with adjustment to set the staffing establishment. The corresponding models (1A to 1C) reflect changes in occupancy, set at 80, 85 and 90%. As the occupancy increases the apportionment of the staff to resident slightly decreases from 27.5 hours per resident to 24.4 to reflect the additional resident support within the staffing establishment. Correspondingly, there is a slight reduction in the operating costs as these too are apportioned across more residents; assuming that they remain constant and do not increase with additional head count. The rate differential from model 1A (80% occupancy) to 1C (90% occupancy) is -£85 per week.

| **Residential** | | **Model:** | | |
|---|---|---|---|---|
| **Occupancy Scenarios** | **Base** | **Model 1A** | **Model 1B** | **Model 1C** |
| Total Bed Capacity | 38 | 38 | 38 | 38 |
| Annualised Occupancy (no. beds) | 30 | 30.4 | 32.3 | 34.2 |
| Occupancy % | **80%** | **80.0%** | **85.0%** | **90.0%** |
| Direct Hours per Resident per Week | Custom | 27.5 | 25.9 | 24.4 |
| Carer:Resident Ratio (Day) | | 1 to 5.07 | 1 to 5.38 | 1 to 5.7 |
| Carer:Resident Ratio (Night) | | 1 to 10.13 | 1 to 10.77 | 1 to 11.4 |
| Direct staffing pay cost per Bed (£) | £320 | £375 | £353 | £333 |
| Indirect staffing pay cost per Bed (£) | £161 | £133 | £125 | £118 |
| Weekly pay cost per Bed (£) **(a + b)** | **£482** | **£507** | **£477** | **£451** |
| Weekly non-pay cost per Bed (£) | **£255** | **£255** | **£245** | **£237** |
| Weekly EBITDARM per Bed (£) | **£147** | **£147** | **£141** | **£135** |
| Weekly EBITDARM per Bed (%) | **16.6%** | **16.1%** | **16.3%** | **16.5%** |
| Total Weekly cost per Bed (£) | **£883** | **£908** | **£863** | **£823** |
| **Care / Non-care / EBITDA Split** | | | | |
| Care related cost/bed (£) | **£504** | **£530** | **£500** | **£473** |
| Non-care **(daily living)** cost/bed (£) | **£378** | **£378** | **£364** | **£351** |
| of which (c) EBITDA per Bed (£) | **£54** | **£54** | **£51** | **£48** |
| Weekly EBITDA per Bed (%) | **6.1%** | **5.9%** | **5.9%** | **5.8%** |

***Figure 4:** Residential modelled scenario at 80,85 and 90% occupancy*

### 4.4.2 Enhanced Residential

Figure 5 presents a summary table for residential enhanced needs. A staffing establishment of 6.5 care staff and 1 senior to service the occupied beds during the day and 2 carers and 1 senior at night.

The assumption within the model is costs are set at the base rate (£882.80) with adjustment to set the staffing establishment, reflecting the expectation that care staff input will be greater than residential due to resident needs. The corresponding models (1A to 1C) reflect changes in occupancy, set at 80, 85 and 90%. As the occupancy increases the apportionment of the staff to resident slightly decreases from 32.3 hours per resident to 28.7 to reflect the additional resident support within the staffing establishment. They do however remain within the carer to resident ratio of 1:4. Correspondingly, there is a slight reduction in the operating costs as these too are apportioned across more residents; assuming that they remain constant and do not increase with additional head count. The rate differential from model 1A (80% occupancy) to 1C (90% occupancy) is -£102 per week.

| **Residential EMI** | | **Model:** | | |
|---|---|---|---|---|
| **Occupancy Scenarios** | **Base** | **Model 2A** | **Model 2B** | **Model 2C** |
| Total Bed Capacity | 38 | 38 | 38 | 38 |
| Annualised Occupancy (no. beds) | 30 | 30.4 | 32.3 | 34.2 |
| Occupancy % | **80%** | **80.0%** | **85.0%** | **90.0%** |
| Direct Hours per Resident per Week | Custom | 32.3 | 30.4 | 28.7 |
| Carer:Resident Ratio (Day) | | 1 to 4.05 | 1 to 4.31 | 1 to 4.56 |
| Carer:Resident Ratio (Night) | | 1 to 10.13 | 1 to 10.77 | 1 to 11.4 |
| Direct staffing pay cost per Bed (£) | £320 | £440 | £414 | £391 |
| Indirect staffing pay cost per Bed (£) | £161 | £133 | £125 | £118 |
| Weekly pay cost per Bed (£) **(a + b)** | £482 | £573 | £539 | £509 |
| Weekly non-pay cost per Bed (£) | £255 | £255 | £245 | £237 |
| Weekly EBITDARM per Bed (£) | £147 | £147 | £141 | £135 |
| Weekly EBITDARM per Bed (%) | **16.6%** | **15.1%** | **15.2%** | **15.4%** |
| Total Weekly cost per Bed (£) | **£883** | **£974** | **£925** | **£881** |
| **Care / Non-care / EBITDA Split** | | | | |
| Care related cost/bed (£) | £504 | £595 | £561 | £531 |
| Non-care **(daily living)** cost/bed (£) | £378 | £378 | £364 | £351 |
| of which (c) EBITDA per Bed (£) | £54 | £54 | £51 | £48 |
| Weekly EBITDA per Bed (%) | **6.1%** | **5.5%** | **5.5%** | **5.4%** |

***Figure 5:*** *Residential enhanced needs modelled scenario at 80,85 and 90% occupancy*

### 4.4.3 Nursing and Enhanced Nursing

Figure 6 presents a summary table for residential enhanced needs. A staffing establishment comprising of 10 care staff, 3 seniors and 2 nurses has been set to service the occupied beds during the day and 4 carers, 1 senior and 1 nurse at night. The significant increase in the number of staff is due to the increased size of nursing settings in comparison to residential.

The assumption within the model is costs are set at the base rate (£1041.28) with adjustment to set the staffing establishment, reflecting the expectation that care staff input will be greater than residential due to resident needs. The corresponding models (1A to 1C) reflect changes in occupancy, set at 80, 85 and

90%. As the occupancy increases the apportionment of the staff to resident slightly decreases from 40.2 hours per resident to 35.7 to reflect the additional resident support within the staffing establishment. They do however remain within the carer to resident ratio of 1:3.

Correspondingly, there is a slight reduction in the operating costs as these too are apportioned across more residents; assuming that they remain constant and do not increase with additional head count. The rate differential from model 1A (80% occupancy) to 1C (90% occupancy) is -£119 per week.

| **Nursing** | | **Model:** | | |
|---|---|---|---|---|
| **Occupancy Scenarios** | **Base** | **Model 3A** | **Model 3B** | **Model 3C** |
| Total Bed Capacity | 60 | 60 | 60 | 60 |
| Annualised Occupancy (no. beds) | 48 | 48 | 51 | 54 |
| Occupancy % | **80%** | **80.0%** | **85.0%** | **90.0%** |
| Direct Hours per Resident per Week | Custom | 40.2 | 37.8 | 35.7 |
| Carer:Resident Ratio (Day) | | 1 to 3.2 | 1 to 3.4 | 1 to 3.6 |
| Carer:Resident Ratio (Night) | | 1 to 8 | 1 to 8.5 | 1 to 9 |
| Direct staffing pay cost per Bed (£) | £520 | £669 | £629 | £594 |
| Indirect staffing pay cost per Bed (£) | £212 | £221 | £208 | £196 |
| Weekly pay cost per Bed (£) **(a + b)** | **£731** | **£889** | **£837** | **£790** |
| Weekly non-pay cost per Bed (£) | **£161** | **£161** | **£155** | **£150** |
| Weekly EBITDARM per Bed (£) | **£149** | **£149** | **£144** | **£139** |
| Weekly EBITDARM per Bed (%) | **14.3%** | **12.4%** | **12.6%** | **12.9%** |
| Total Weekly cost per Bed (£) | **£1,041** | **£1,199** | **£1,136** | **£1,080** |
| **Care / Non-care / EBITDA Split** | | | | |
| Care related cost/bed (£) | **£746** | **£904** | **£851** | **£804** |
| Non-care **(daily living)** cost/bed (£) | **£296** | **£296** | **£285** | **£275** |
| of which (c) EBITDA per Bed (£) | **£60** | **£60** | **£57** | **£53** |
| Weekly EBITDA per Bed (%) | **5.8%** | **5.0%** | **5.0%** | **4.9%** |

***Figure 6:*** *Nursing and nursing enhanced modelled scenario at 80,85 and 90% occupancy*

## 4.5 Factors that affect the median cost of care

It should be noted that the median cost of care the exercise may not match any particular fee rate – nor might it be expected to. The exercise is aimed at understanding the unit cost and ***not aimed at*** disaggregating different levels of income or price points paid for care. Whilst both "sources of funding" and "expenditure" should ideally match in order to assure the validity of any set of costs; exploring income and profit in detail is ***not the purpose of the exercise*** and therefore checks and balances must always be applied. It is not uncommon however for any typical observer to want to understand why this variance exists, and so it is important for ARCC to offer context in this report as to how the outputs results can be impacted by real-life business operations.

- **Not all provision is equal:** as alluded to above, services differ greatly across local provision. Some settings offered what could be considered as 'traditional' care, whilst the new homes which are actively targeting the self-funder market offer additional amenities and services such as cinema rooms, a la carte dining and a more luxurious 'hotel' experience.

- **Impact of costs during the pandemic:** Reviewing actual costs in 2021-22 is a helpful comparator when married alongside the DHSC requirement to model "expected" cost as of April 2022, which inevitably requires some form of forecasting and cannot always be guaranteed to be accurate. However, we must be cognisant that the last two years have also been exceptional and therefore may not represent the most ideal situation in which to assess future costs. This is made more complex by the exceptional amount of grant funding applied to the sector to cover extraordinary costs in this year, and whilst some providers may make effort to disaggregate any expenditure via these routes, it can never be guaranteed that all costs are considered "normal" costs and so may be affected by additional non-typical costs during the pandemic years.

- **Changes to UK fiscal policy:** It is worth noting that this undertaking cannot forecast with any certainty the costs that providers will ultimately experience over the next 2-3 years, against the market's current estimates. Whilst the current economic situation remains uncertain; recent announcement will also have an impact on the entire analysis within this report:
  - The reversal of the additional 1.25% on employer's NI payments will reduce provider costs; whilst the levy was initially intended to fund health and social care the UK government has also said this will not impact on the availability of funding to the sector
  - The business energy bill relief scheme will no doubt curb future energy costs, and is indeed difficult to predict due to the nature of variable tariffs in the market as well as fixed term contracts many providers will have secured over a period of time
  - Cancellation of the planned rise in corporation tax will also continue to support provider's bottom-line profit/surplus

  As detail of these changes are still being released by Government and have been introduced late in the process, it is not possible to measure the impact of these policy changes other than to hypothesise that the combined impact is likely to reduce the increased cost impact presented in this report.

## 4.6 Summary Budget Impact

Table 7 identifies the impact of the median cost against the current weekly fees paid by Rutland CC. If the median cost of care was to be paid this would require an additional £1,433,536 per annum.

| | 65+ care home without nursing | 65+ care home without nursing, enhanced needs | 65+ care home with nursing | 65+ care home with nursing, enhanced needs |
|---|---|---|---|---|
| 2022/23 Fee (£) | £523 | £558 | £817.19 | n/a |
| Cost of Care Median (£) | £882.80 | £882.80 | £1,041.28 | n/a |
| Variance (%) | 68.8% | 58.2% | 27.4% | n/a |
| Est no. placements | 19 | 59 | 7 | n/a |
| Est. impact per annum (£) | £355,482 | £996,486 | £81,568 | n/a |

***Table 7:*** *Estimated budgetary impact*

The intention of an analysis of this nature is never to arrive at a *specific cost to each provider business. The cost model merely aggregates different provider data to provide an indicative set of figures for consideration.* It is the role of commissioners to assure themselves that the rate paid is commensurate with a 'cost envelope' which supports a sustainable, diverse and quality market as per the Care Act.

## 4.7 Future Fee Uplifts and Sensitivity Analysis

Whilst future year cost impact is not yet fully known, providers were asked during the course of the engagement what they considered was the most accurate and transparent method for future years fee uplifts. Broadly the consensus was:

- Pay costs reflecting changes to factors such as NLW, National Insurance increases and changes to employment legislation. Analysis of the data made available suggests that approximately 55% (residential) and 70% (nursing) of costs relate to this component of the unit cost; and
- Non-pay, i.e., business costs being adjusted to reflect CPI; analysis suggests that approximately 45% (residential) and 30% (nursing) of costs relate to this component of the unit cost.

Whilst in principle, the above is common practice, there are some important considerations which can have both a positive and negative impact on provider sustainability:

- Establishing a more realistic picture of market occupancy levels, currently set at 80%, which includes the historic trend alongside the impact covid has and continues to have on the market through temporary suspensions in line with government and local guidance, continues to impact occupancy levels.
- Staff ratios and the level of care per resident per week.

# 5 Future Commissioning Considerations

This report has focused predominantly on the method of engagement and subsequent analysis to establish an indication of the current costs of care in line with the DHSC's requirements. This was the prime purpose of the project; however, ARCC also recognise that informing the future price point for care home placements is only part of a good sustainable commissioning model. This section presents our main conclusions which we believe commissioners should consider for the future, drawn from local engagement and ARCC's experience of good commissioning practice locally and elsewhere.

## 5.1 Ensuring Services are Fit for the Future

As previously alluded to, competition for staff is driving up pay costs and resulting increasing usage of agency staff. The impact of this staff shortage is not only fiscal, but this may also be affecting continuity of care, which in turn may be impacting upon increased individual needs. Stability and experience of staff will have a contributing factor on the ability to support people with more complex needs.

The ability to meet high dependency and acuity will be dictated by the ability to staff homes (numbers and experience) which is in turn somewhat governed by the 'cost envelope'. Whilst there is no clear mandate on the staff to resident ratio requirement from either CQC or Rutland CC, other than to operate a staff dependency tool. Further dialogue with the market to understand how staffing establishments are set and impacted upon by needs, both acuity (hence enhanced needs) and dependency (due to increased frailty) would be advisable as this represents the largest proportion of the 'cost envelope'.

Despite this potential change in the profile of needs, the cost envelope for staffing on core remains the same (+CPI and pay legislation adjustments) which will have a 'knock-on' effect on how beds are utilised as the staff that can be deployed by homes is regulated by the fees and any additional monies that can be levered such as top up or FNC. Given the earlier point about higher levels of presenting needs, homes will be cautious of accepting residents who have needs beyond shared care hours, i.e. requiring more focused 1:1 or 2:1 personal care as the resource may simply not stretch this far despite the needs not being acute enough for more 'higher acuity' beds. The result is that these clients become 'difficult to place' and may end up occupying a more acute bed than is necessary due to the rate differential.

Work needs to be undertaken on the future specifications to ensure that services reflect the current needs of people and the strategic direction for commissioning of local services. Expectations such as acuity of need and dependency can be addressed through setting service level expectations such as support ratios or hotel + care bandings to reflect needs.

## 5.2 Market Management

Further work is required to understand the condition of the homes within the area, particularly the limited few which currently accept close the framework rates, and whether they are physically fit-for-purpose. Depending upon the outcome of this review it may be that Rutland's strategy focuses on investment to develop existing settings as opposed to the formation of new build homes.

## 5.3 Continued Market Dialogue & Working Towards the FCoC

Whilst a long-term intention, in line with this DHSC cost of exercise, may be to work towards the estimated median for care, DHSC guidance states that *"fair means what is sustainable for the local market"*. The council should continue to monitor the pressure in the market (both staffing and business operating costs)

through future fee exercises, and as was the case for this financial years' 6.7% uplift, make adjustment (% fee uplifts) to reflect changes to operating costs.

ARCC advises further engagement to be completed with the market between October 2022 and February 2023 to present the costed scenarios back and discuss feasibility and co-develop a set of representative costs from across the market. Similarly, the charging reforms proposal of a notional £200 per week daily living cost is unlikely to be sufficient to meet local needs; therefore, further detailed work in relation to top up charges will need to be undertaken once the charging reforms are fully implemented.

## 5.4 Identifying ways to support the market beyond fees

Rutland CC's ability to meter towards the median cost will be governed by DHSC's future allocation of the Market Sustainability and Fair Cost of Care fund. However, there are actions that commissioners may be able to undertake which could support the local market to offset costs; these included:

- Support for energy efficiency, utilising any green grants or incentives to support the generation of green energy such as solar panel installation.
- Utilising group purchasing power for consumables which may assist in reducing unit costs when purchasing significantly higher volumes.
- Screening the development of new homes and cultivating existing business relationships, including supporting capital refurbishment programmes.
- Assistive technology to offset staff capacity issues, for example Vitalerter bed sensors.
- Explore what support commissioners can provide to support current workforce challenges, for example: recruitment campaigns and increasing uptake of free training offers.

# Appendices

## A. Reference Table: "median" breakdown by care type

| | 65+ care home places without nursing | 65+ care home places without nursing, enhanced needs | 65+ care home places with nursing | 65+ care home places with nursing, enhanced needs |
|---|---|---|---|---|
| **Total Care Home Staffing** | **£481.55** | **£481.55** | **£731.17** | **£731.17** |
| Nursing Staff | - | - | £112.35 | £112.35 |
| Care Staff | £320.16 | £320.16 | £407.26 | £407.26 |
| Therapy Staff (Occupational & Physio) | - | - | - | - |
| Activity Coordinators | - | - | - | - |
| Service Management (RM/Deputy) | £30.40 | £30.40 | £52.11 | £52.11 |
| Reception & Admin staff at the home | £11.22 | £11.22 | £23.60 | £23.60 |
| Chefs / Cooks | £27.72 | £27.72 | £23.67 | £23.67 |
| Domestic staff (cleaning, laundry & kitchen) | £22.74 | £22.74 | £50.65 | £50.65 |
| Maintenance & Gardening | £8.26 | £8.26 | £24.19 | £24.19 |
| Other care home staffing | £61.05 | £61.05 | £37.35 | £37.35 |
| **Total Care Home Premises** | **£69.25** | **£69.25** | **£43.86** | **£43.86** |
| Fixtures & fittings | £0.00 | £0.00 | £0.00 | £0.00 |
| Repairs and maintenance | £40.01 | £40.01 | £25.34 | £25.34 |
| Furniture, furnishings and equipment | £0.00 | £0.00 | £0.00 | £0.00 |
| Other care home premises costs | £29.24 | £29.24 | £18.52 | £18.52 |
| **Total Care Home Supplies and Services** | **£185.39** | **£185.39** | **£117.42** | **£117.42** |
| Food supplies | £49.65 | £49.65 | £31.44 | £31.44 |
| Domestic and cleaning supplies | £13.60 | £13.60 | £8.61 | £8.61 |
| Medical supplies (excluding PPE) | £5.87 | £5.87 | £3.72 | £3.72 |
| PPE | £7.52 | £7.52 | £4.76 | £4.76 |
| Office supplies (home specific) | £0.00 | £0.00 | £0.00 | £0.00 |
| Insurance (all risks) | £11.12 | £11.12 | £7.04 | £7.04 |
| Registration fees | £0.00 | £0.00 | £0.00 | £0.00 |
| Telephone & internet | £5.69 | £5.69 | £3.60 | £3.60 |
| Council tax / rates | £1.30 | £1.30 | £0.82 | £0.82 |
| Electricity, Gas & Water | £53.02 | £53.02 | £33.58 | £33.58 |
| Trade and clinical waste | £8.08 | £8.08 | £5.12 | £5.12 |
| Transport & Activities | £1.39 | £1.39 | £0.88 | £0.88 |
| Other care home supplies and services costs | £28.18 | £28.18 | £17.84 | £17.84 |
| **Total Head Office** | **£39.88** | **£39.88** | **£25.15** | **£25.15** |
| Central / Regional Management | £8.17 | £8.17 | £5.18 | £5.18 |
| Support Services (finance/HR/legal etc.) | £15.69 | £15.69 | £9.94 | £9.94 |
| Recruitment, Training & Vetting (incl. DBS) | £13.04 | £13.04 | £8.26 | £8.26 |
| Other head office costs (please specify) | £2.98 | £2.98 | £1.78 | £1.78 |
| **Total Return on Operations** | **£52.96** | **£52.96** | **£63.59** | **£63.59** |
| **Total Return on Capital** | **£53.77** | **£53.77** | **£60.10** | **£60.10** |
| **TOTAL** | **£882.80** | **£882.80** | **£1,041.28** | **£1,041.28** |

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Rutland County Council