Fee Review

Stage 2 Consultation Report

Appendix 2

Proposals and Provider Responses via the online questionnaire and consultation meetings

Proposal 1 – Older Adult Band Rates and Supplementary Needs Allowance.

C.co was commissioned by the Council to undertake an independent review of local care costs in Leicestershire. This exercise was undertaken using the cost data provided by local providers and other benchmarking data.

Based on the recommended options from C.co the Council proposes that for Older Adult Placements, the Residential band should be set at £561 per week (£576 for 2019/20). That the Residential Plus band is set at £619 per week (£635 for 2019/20), and that the Supplementary Needs Allowance (SNA) rate is set at £11.36 (£11.66 for 2019/20) per hour.

Questionnaire Responses

When asked to what extent do you agree or disagree that the Council has taken account of all the relevant factors, as set out in the C.co report and Stage 1 of the Consultation, in calculating the proposed band rates for Older Adult placements, 1 of the 7 respondents agreed, 2 neither agreed nor disagreed and 4 disagreed, of which 3 strongly disagreed.

Those that disagreed said that the contracts take hours away from the 'hands on' care needed. That good quality of care requires leadership, training and development, cover for holiday periods etc. Also, that it is not clear whether this takes account of those adults with complex needs, challenging behaviours and learning disabilities.

One provider commented that whilst they agree that the Council have taken feedback into consideration in relation to the calculation behind the band rates, it has also fed back that the way existing residents are allocated to the new bands will be all important in understanding if this model is sustainable.

One provider said that it appears that the wrong baseline has been used to evaluate the wage costs in care homes and the figures presented do not take account of the financing costs of a care home regarding wage costs. This provider explained that it has increased all staff wages by 4.3% in line with an increase in National Living Wage. It should not be assumed that such an increase only applies to Care Assistants, to maintain what are already very 'thin' differentials between staff for example care assistant and senior carers, all must be increased.

That provider continued, providers are subject (again) to an across the board 1% increase in pensions. Basing assumptions of wages increases in the service sector clearly does not reflect these issues. Further, providers cannot recruit staff on National Living Wage so again they are having to pay additional wage increases. It is difficult to believe that LCC, nor indeed many LA's, has taken any account of the fact that CQC's revised regulations and inspection regime which means that care homes have to employ more staff, For example, a few years ago a 25 bed home could be managed

with a good manager and part time administrator, now to meet regulations and handle paperwork an excellent manager is needed (paid over £40k whereas before £30-32k) and a great deputy earning £25k+.

The provider added, regarding financing costs, these are very significant, if you assume that a provider buys a home at a per bed price of £70k a bed, using bank finance (the vast majority of the sector do this), the bank will charge at least 4% interest on the loan (£2,800 per bed / year =£54 per bed per week interest charge) and expect the loan to be repaid over 15 years (£4666 / year or £90 / bed / week). Adding the two figures means financing costs are £54 + £90 = £144 / bed / week. There appears to be no explicit provision for these costs. For evidence of these costs refer to the most recent copy of Laing and Buisson report or talk to any reputable care sector valuation agent or any finance broker in the sector.

A different provider stated that this proposal is a positive move forward to acknowledge how important social care is and understand that it is approaching times of crisis. Another said that whilst this is an increase, it is not significant enough given the cost pressures faced by care home providers. One other provider stated; these rates do not cover the real cost of care and most care homes in Leicestershire charge more than the proposed rates.

When asked what additional costs, if any, should the Council consider when formulating how to uplift the Residential band to Residential Plus? What evidence can be provided to support these costs?

Two responses given cited, paperwork and admin time, training, holiday pay, leadership and management of staff and the quality assurance of service. Another pointed out that some residents will require a higher fee than the Residential Plus band as they have specialist care needs that need to be considered.

One provider argued that LCC needs to gather empirical data for the number of care hours used to meet the needs of residents with more complex needs. Also, that LCC need to consider that the management time overhead is significantly increased for such residents as there is a major step change in time taken to raise care plans, review monitoring charts / documentation, arranging for referrals and liaising with and accompanying health service professionals when they visit the home to see such residents.

That provider went on, ‘for example, consider the time that is taken to change someone's diet if they are losing weight due to a suspected swallowing problem, all the steps from initial call to GP, through to obtaining a referral, getting the SALT team to visit, chasing for recommendations, planning menus, liaising with kitchen, training care staff etc.’ There is considerable time input and there are many other examples that could be cited. Referring to the distinction between Residential and Residential Plus, this provider continued, one way the increase on care hours for someone who requires two staff for the provision of personal care, could entail each element in the incremental service definition between the two bands being carefully broken down, a few homes getting together would readily agree on the number of additional hours that each incremental element, such as that above, would use.

A different provider said that resident's needs, the use of additional equipment, additional observations of the resident to keep them safe, special dietary needs were all putting pressure on costs. Another highlighted staff cost including pensions, NI, costs of recruiting and retaining staff are all pushing up costs. It was also stated by one provider in their response that the Council should not have two rates; it should pay the full cost of the care home

When asked to what extent do you agree or disagree that the Older Adult residential market is sustainable at the proposed band rates, 1 provider agreed that it was sustainable, and 4 providers disagreed saying that it was not sustainable, 1 didn't know and 1 neither agreed nor disagreed.

The cost pressures highlighted by the 4 providers that responded to this question were increases in National Living Wage, pension contributions and insurance costs. One provider went on to say that, to provide a high-quality service then the ability to pay a wage to reward the support staff would be ideal, put simply providers lose material amounts of money on each Local Authority funded resident. They can only continue to operate due to the effective 'subsidy' from self-funded residents. Whilst, it can be appreciated that LCC's fee increases have been above those of many LA's, the fact remains that costs have over past 9 or 10 years increased faster than fee increases.

One provider commented that the market will be sustainable if the transition is managed correctly and the band allocation to existing residents is fair and equitable. They strongly suggest that this is done as a one-off exercise, the results backdated to April 1st, 2019, and that all existing top-ups remain in place. That would then ensure sustainability and mean that going forward, the new rates could apply to all new admissions without a top-up for most of council funded residents.

That provider continued, CQC's constantly increasing requirements can only be met by using more care hours so that drives up staff costs, also, as LCC keep people in their own homes for longer, the level of dependency when people do eventually come into care is overall much higher than it used to be and is constantly increasing. Staff costs per resident are much higher than they used to be, yet fee increases have been well below 5% on average. Fees must be reflective of the actual cost of care.

Another stated that care homes are asking for top-ups and very few service users can get good quality of care without them. That provider claimed, 'this means that the cost of good quality care costs more than the Council is paying. Some homes may still be taking service users at LCC basic rates, but they are generally poor-quality homes with poor quality of life for service users. These homes will eventually be shut down by CQC or they will go bankrupt trying to raise standards. No good care home can manage on LCC rates'.

When asked to what extent do you agree or disagree that the nursing care market is sustainable at the proposed band rates, no provider agreed that the market is sustainable; 2 providers disagreed, 4 did not know and 1 neither agreed nor disagreed.

In response, 2 providers cited the reasons given earlier and, in addition, highlighted the difficulty of recruiting and training increasingly expensive RGNs, some of whom are now paid more than some managers. One reiterated that the Residential / Residential Plus split is critical and that, clearly providers need to understand what is proposed for CHC rates to make this judgment.

When asked to what extent do you agree or disagree with the assumption that the average of 19 individual care hours for residents on the Residential band and 24 hours for those on the Residential Plus band are correct, none of the 7 respondents agreed and 4 providers disagreed, 1 didn't know and two neither agreed nor disagreed.

One provider said that the daily banded rate equates to £66 per person per day. This must cover heating, food accommodation, staffing, insurance, environment and activities and it is not possible that the 19 hours are individually there to provide care.

One provider agreed the hours were correct for some residents but that it's hard to generalise and there are a lot of special cases that require additional hours and 2:1 support.

Another stated, this does not account for staff entitlement to breaks, change-overs, information exchange and holiday cover. It also doesn't take account of the additional costs associated with the leadership and management of staff.

One other provider stated that because it measures the number of care hours for existing residents it can say (a) that it uses more than 19 hours per resident now and (b) that the gap between the low/medium needs residents and someone with high/complex needs is much more than 25% (that is, 19 hours compared with 24 hours).

The point was re-iterated by one provider that residents' needs are more severe and increasing, compared with previous years.

When asked, do you have any concerns or see any potential risks for providers or service users, the following points were made in response.

One provider commented that, again, the implementation needs to be carefully managed and providers would need clarity on which existing residents would move to which band.

One provider commented that there are many risks with paying low wages, expectations of staff receiving minimum wage to provide high quality care are unrealistic. Good staff go over and above through dedication and commitment, this is unfair. One provider stated that, 'As a provider I feel ashamed to pay low wages and then expect high quality'.

It was also said by one that there are massive risks if no account is given to the need for services to be well led and staff well trained as per CQC regulations and standards for care. There is a national crisis in terms of the recruitment and retention of carers. Often services must be provided by agency workers for periods of time. Agencies charge more than the rates proposed; for the reasons already detailed relating to management, training etc., so it simply wouldn't be possible to put into operational practice the standards required.

When asked, do you have any concerns or see any potential risks for providers or service users, the following responses were given.

One respondent argued that the level of the fees determines how many staff are employed and the quality of staff. If there is insufficient money, then quality of care will suffer and its the service users who will be put at risk. LCC should be aware that the main high street banks who underpin the

majority of bank funding to the care sector are (a) no longer really lending to the sector and (b) are dramatically tightening the way they manage the banking covenants they have with their borrowers.

The respondent went on to say that providers who are not meeting their covenants (generally expressed as profitability) are coming under intense pressure from their bankers and in many instances forced to sell or to close because they are not making enough margin to meet their commitments to the banks.

LCC may say there is little evidence to support this in Leicestershire and that not that many homes close, but is LCC aware of the 'forced sales' etc. LCC should consider why is it that all four of the largest care home groups in the country are currently for sale? It is because they are not generating enough money to meet their financing costs. A property investment company will at some point buy them, re-finance, set up a 'Prop Co / Operating Co' structure and in 5 years, the situation will repeat.

Other respondents said that the general state of social care across the country is worrying, and that there were concerns for service users as unless they have a top up, a service user will get a poor quality of life. Poor homes will eventually disappear and that will mean a loss of beds.

Good homes will still be charging a top up and so some service users will not be able to have the care they need because they can't afford the cost of residential care. Good homes will not be able to expand to meet this new need because they will not have the money to invest.

When asked, is there any further evidence on the costs of providing care in Leicestershire that you wish to provide, to assist in establishing the costs of providing care in Leicestershire, if so, please provide details, one said, placing people into supported living to keep costs down runs a very high risk of expecting service users to adapt to taking responsibility without sufficient support.

An out of county respondent which provides residential care services to a young adult with complex needs associated with severe learning and autism and challenging behaviour. He requires a complex care plan to maintain his safety and wellbeing which cannot be provided by just having someone turn up for an allocated number of hours as a carer.

Another said that LCC should look at the Laing Buisson report and specifically the financial analyses of relevant providers in the appendices of that report.

Another stated, over half the income from service users goes on wage costs. The government keep increasing the living wage. Care homes cannot use the minimum wage for carers because the under 25 carers do the same work as the over 25 carers and to pay them less would be age discrimination. Due to the rise in the living wage, one provider gave an example at one home of saying that wage costs this year will go up by approximately £42,000, with 44 residents, that’s over £18 per resident per week. This respondent believes that next year’s costs will be similar and that the LCC basic rate and increases do not take these costs into account.

When asked for any other comments about this proposal, one provider said that the needs of the individual are not being considered, it is budget led not needs led. One provider was unclear whether the proposal is the same for those young adults where Leicestershire has commissioned an

independent provider to provide a service for a young adult. That provider's work is based on a fee structure as opposed to a set rate for hours of care.

Another provider said that, in summary, there should be a zero-based budget process that should engage all stakeholders that is a very different process than asking internally "what percentage increase can we afford"?

Consultation meetings

A reoccurring theme at the consultation meetings was that the proposed Supplementary Needs Allowance (SNA) rate of £11.36 per hour is too low. During the discussion that followed, an explanation of how the rate was derived was given.

One provider questioned the proposal to, where possible, reduce or eliminate Third Party Top Ups (TPTUs) when the fees increased. It was said that LAs should encourage TPTUs to enable care home places to be sustained and it was asked whether LCC's policy had changed? It was asked whether the Council is moving to a system where care homes collected the TPTU directly from the resident. It was explained that there had been no change in TPTU policy and that they would continue to be an important mechanism for residents to exercise choice and paid gross by the council.

One provider asked whether the Council was taking account of increases in pension costs and a question was asked whether the Council was taking account of increases in training costs. It was explained that these costs had been included in the work undertaken by C.Co.

Use of the 93% occupancy rate was questioned, it was said that this was too high and that a figure of 85% would be more realistic. It was explained that this reflected the last survey undertaken by the Council and there was discussion about estimates used by Laing Buisson and others.

One provider asked a question as to whether the Council was taking account of differing costs of care in different parts of the county. It was stated that recruitment cost varied significantly from locality to locality. It was explained that the Council would operate on a county-wide basis only.

A provider asked whether LCC were short of residential beds or had difficulties making placements. The answer given was that in general, no, the council could make placements at banded rates but that there were a small number of people with complex needs that are more difficult to accommodate.

Whilst the two-band approach was welcomed the point was made that the higher band should be greater than currently proposed. The offer of information and data was made to support this proposition.

A question relating to supporting cultural needs was raised and whether these will be met through the bands. It was explained that most were expected to me be met via the bands, but that an SNA could also be used in certain circumstances.

Clarification was requested about nursing placements. It was explained that such cases would be allocated to either Residential or Residential Plus, according to the social care element of their need.

It was asked whether this new approach would give more flexibility in making placements. It was explained that the significantly higher bands are expected to give operational staff more flexibility in making placements. Linked to this, a question was raised whether the proposed rates would be acceptable to Providers and the response given was that in most of cases the Council expected them to be.

A reoccurring theme related to the allocation of Service Users to the Residential & Residential Plus rates as this would have a significant financial impact. It was acknowledged that this is a critical issue and providers were advised to review the proposed band definitions and comment on them.

A question was asked about the nursing band going forward, as mentioned earlier, it was explained that there will be no nursing band or rate as such under the proposed arrangements, but that SUs would be allocated to Residential or Residential Plus according to their social care needs.

A question was asked whether third party top ups (TPTUs) would reduce as the banding rates are been increased. The Council does expect to see a reduction and as part of the transition expects to reduce and remove several TPTUs

It was asked will the Council continue to collect TPTUs and it was confirmed that it would.

A question was asked would the Supplementary Needs Allowance (SNA) be reduced as the banding rate was increasing. It was explained that the proposal was to do this during the implementation.

Proposal 2 Working Age Adult Band Rate

Following the options developed by C.co, the Council proposes that for Working Age Adult (WAA) Placements, the proposed WAA Residential band is £705 per week (£724 for 2019/20). The Care Funding Calculator will be used, as it currently is, to calculate the individual cost of care for WAAs with needs greater than those that can be met at the WAA Residential band.

Questionnaire Responses

When asked to what extent do you agree or disagree that the Council has taken account of all the relevant factors in calculating the proposed band costs for Working Age Adult placements, of the 6 responses, 1 provider agreed, and 1 provider disagreed, 1 neither agreed nor disagreed and 3 did not know.

The point was made by one provider that whilst it is appreciated the CFC is a recognised costing tool across the sector, it is not reflective of actual costs within the service. The provider referred to the Department of Health's guidance Building Capacity and Partnership in Care Agreement (BCPCA) published in October 2001, saying that paragraph 6.2 states:

"…Fee setting must take into account the legitimate current and future costs faced by providers as well as factors that affect those costs...". In respect of a rigid reliance on financial models for calculating fees, BCPCA, adds: "…Contract price should not be set mechanistically but should have regard to providers' costs and efficiencies, and planned outcomes for people using services, including patients…".

The CFC is a universal tool which does not allow for actual costs per service to be presented. This provider's costings are based on specific running costs in the service (such as heat/light/water bills) and can be evidenced accordingly.

The provider stated that It is more prudent to present the true financial cost to a Commissioner, rather than using a lower figure calculated by a CFC, which in time may make the service financially unsustainable which would inevitably lead to closure.

When asked to what extent do you agree or disagree that the Working Age Adult residential market is sustainable at the proposed band cost, 1 provider agreed, and 1 provider strongly disagreed, the other 4 did not know. It was said by one provider that while this doesn't apply in their case, each residential service should be funded in line with true cost of care, as opposed to rigid cost model with assumptions.

When asked, do you have any concerns or see any potential risks for providers or service users, the response from one was that if fees calculated by a CFC are lower than true cost of care, it may in time make the service financially unsustainable which would inevitably lead to closure and termination of the care package.

When asked is there any further evidence on the costs of providing care in Leicestershire that you wish to provide, to assist in establishing the costs of providing care in Leicestershire, if so, please provide details, none were provided.

When asked, do you have any other comments about this proposal, again clarity about what this means for those young adults with complex needs placed outside Leicestershire, by Leicestershire with independent providers was requested by one provider.

Consultation meetings

A provider asked a question about the distinction between Older Adults (OA) and Working Age Adults (WAA). It was explained that the basic cut-off was 65 years, but that there may be situations where a WAA is accommodated in an OA setting and funded at the OA band rate.

It was asked whether the WAAs included people with mental health issues, and it was confirmed that they were included.

The initial impression from one provider present was that the WAA band seems fair, but he intends to check his caseload in detail.

A question was asked about how allocation will be made. The Provider was referred to the WAA banding rate definition.

An observation was made that the WAA band was low in terms of the average spend on WAA placements. That was acknowledged, and it was explained that the Council understood that most WAA residents had more complex needs that would be funded via a CFC calculation and require an SNA in addition to a band payment.

A question was asked whether the fees could go down or up as they are based on the Care Funding Calculator (CFC). It was explained that the fee could go up or down as the person's needs changed,

but that with effect from April 2019, the CFC would be upgraded to use 2019/20 rates which would have the effect of increasing fees, if there was no change in the level of need.

Proposal 3 – Annual uplift

In line with the C.co options developed, the Council proposes that band rates are increased annually for the next 3 years to March 2022 using a blended rate based on Average Week Earning (AWE) services rate and the Consumer Price Index (CPI).

The Council proposes applying AWE to staffing costs only, with CPI being applied to the remaining elements, a 57/43 split. Using the latest rates published in December 2018, this would produce an increase of 2.68% for 2019/20.

Questionnaire Responses

When asked, to what extent do you agree or disagree with the proposed approach for annual increases in band rates, 2 providers of the 6 respondents to this question agreed with the approach and 2 disagreed, one strongly disagreed, the other 2 responded that they did not know.

It was said that by one provider that pay rates need to be based on market forces and the availability of suitable carers. If there is a shortage of carers a service can be sustainable only if wages will attract care workers.

Another said the Average Weekly Earning Services Rate does accurately reflect the staff cost increases seen in care. Provider cost structures are different to those seen by a domestic household and therefore headline CPI is a not a perfect indicator.

One other provider stated that it agreed with the basis of the calculation (CPI and increase to NLW), however C.co have used the percentage split of 57/43% which is more typical of Older Adults than Working Age Adults, which tends to be 70/30% split.

One provider commented that while it is acknowledged CPI can be utilised as an inflationary measure against non-staffing costs, they would urge caution in using (AWE) as the primary factor to calculate an increase in staffing costs (until it is reviewed alongside the increase in NMW & NLW), notwithstanding they would still want to consult on any proposed annual uplift against its calculated local fair price for care. As such, and currently the provider acknowledges the proposal but reserves the right to review and discuss the implementation on this proposed annual inflation mechanism.

When asked, do you have any concerns or see any potential risks for providers or service users, the point was made by one respondent that 'the most vulnerable adults in the country seem to be being fobbed off because of a cost cutting exercise where there will be increased risks to their safety and wellbeing. If staff are not suitably trained and managed, then this will lead to poor outcomes and poorer quality services without the necessary checks and balances'.

The question was posed, 'can providers continue to operate and provide a high quality of care if increases will not be in line with the actual cost increase sustained by providers. As care home fees rise faster than LCC increases the cost to poorer service users will become too much for them to pay'.

The point was also made that implementation of such a clause may widen the gap to the fair price for care and may not cover the appropriate annual increase in costs.

When asked, what are your proposals for seeking efficiencies and how could these lead to mutually beneficial outcomes for providers and the Council, both during and beyond the 3-year proposed uplift process, one provider said, the Council and providers should seek to develop more inclusive community-based programmes of support and provide the families of dependent adults with the early help they need to support the care of their own relative better for some of the time.

One provider argued that there is not a single area left where it can make any meaningful efficiency gains 'the fact that the question even gets asked is at best surprising because it infers a lack of understanding of provider cost structures', the main elements of which are:

1. Staff costs, 80% of all costs, is there a care home which can reduce wages and / or reduce its staffing hours? No one carries 'spare' staff.

2. Food and drink, this is all about quality of care and having analysed and tested every option the cheapest route with least wastage is to use retail supermarkets (bulk suppliers are much more expensive)

3. Heat Light & Power, is negotiated aggressively with suppliers and are below market average rates, could less energy be used? Yes, if there is capital to invest in better insulation but the Return on Capital there is greater than 7 years and there is not the spare cash

4. Maintenance / refurbishment - reducing that impacts directly on quality of care

There are other areas and this provider would welcome a detailed P&L analysis.

This provider went on, in respect of 'mutually beneficial outcomes' it is agreed that there must be, LCC and providers should sit down and discuss them, for example there is another LA which has a brokerage team of over 20 and is commissioning 1,500 beds, that seems an extremely high cost and there has to be scope for providers and the LA to work together to improve processes and reduce cost so some of that money could be used for funding care.

Another provider explained that it has introduced assisted technology into services where it possible to minimise payroll costs, however there is still a need for an adequate level of core care within the services that cannot be removed. It states that it does constantly review the staffing structures within our service to see if we can minimise payroll costs and we liaise with Social Workers where we think this is possible, for example the replacement of sleep-ins with a roving waking night. The same provider said it also regularly reviews supplier costs for services such as utilities to keep the reflective fees at the lowest rates possible.

Another stated that it already absorbs increases to the best of its ability. It seeks out cheap utilities and continually source good quality at the lowest prices. This is offset by the amount of wages paid. Good quality staff should be remunerated accordingly and any reduction in staff would impact negatively on the care provided to service users.

When asked, you have any other comments about this proposal, there were none.

Consultation Meetings

The use of changes in the Average Wage Earning (AWE) rather than National Living Wage (NLW) to drive annual increases was questioned repeatedly. Current difficulties with recruitment and retention were highlighted and it was said that sustainability would be undermined.

Clarification requested about how annual uplift would work and it was explained that, as with other contracts, the current proposal is that the annual increase in CPI and AWE would be measured in January each year (published rates for the preceding year to December) and applied to fee using the proposed blend with effect from April.

A question was raised as to the use of Average Week Earning (AWE) rather than National Living Wage (NLW) as a driver for the fee increases. The Provider concerned highlighted the fact that a large proportion of staff was on the cusp of National Living Wage and therefore had received the full 4.9% increase this year. Furthermore, differentials had been protected with all the senior staff who had therefore received similar increases.

A question was raised as to the labour / non-labour split 57:43 identified in the uplift mechanism and one provider pointed out that in the Working Age Adult context the split was 70% labour and 30% non-labour.

Proposal 4 – Contractual Changes

The proposed changes are to ensure the contract is reflective of the current legislation, best practice and guidance. The Council is also seeking to align its quality requirements with those of the Care Quality Commission (CQC). Wording has been updated to be more respectful to people who use the services and to consider changes in terminology. New clauses have been added to reflect changes in legislation such as Human Rights, Health and Safety, General Data Protection Regulations and Equalities. As part of the contractual changes, the Council will remove the voluntary QAF payments but work with providers, via Inspired to Care, to recognise and reward best practice and excellence in care.

Questionnaire Responses

When asked, to what extend do you agree or disagree with the proposed changes to the Core Contract, 4 of the 7 providers that responded to this question agreed with the proposed changes and 2 providers disagreed and 1 neither agreed nor disagreed.

One provider commented that excellence in care is extremely difficult for small individual providers, large providers have the means to carry additional costs.

One respondent acknowledged that the Council needs to meet its obligations when reviewing current legislation, best practice and guidance and that the contract will need updating to reflect these matters. Furthermore, they are happy to continue to work with the Council to agree a final specification and acknowledge the removal of the quality assurance framework will be part of this. However, they would appreciate it if the Council could give clarity on the existing QAF payments so that this is kept in mind when reviewing the new terms.

Another said, the concerns already expressed related to care quality are reinforced here and that 'the Council may want to reward best practice and excellence in care but how will you know where this exists and how can it be promoted if you have devalued the cost of quality through your proposals and not taken account of the need for services to be led and staff trained'.

LCC have advised they will realign to CQC regulations, one provider advised that it upholds and regulates its own policies & procedures which go above and beyond those set by CQC. The contract must be workable, flexible and tangible, this change appears to support this.

When asked, to what extend do you agree or disagree with the proposed changes to the Specification, 2 respondents agreed with the proposed changes and 3 providers disagreed, one did not know and one neither agreed nor disagreed. One provider pointed out that it was not detailed enough in right areas.

When asked, to what extend do you agree or disagree with the proposed changes to the Individual Placement Agreement, 5 providers said they agreed with the changes, none disagreed, one neither agreed nor disagreed and 2 didn't know.

When asked, do you have any concerns or see any potential risks for providers or service users, one provider highlighted the risks for continuity of care and quality of care for service users. Another said that it had no issues in the Council tightening signatory requirements when the resident does not have capacity to sign.

When asked, do you have any other comments about this proposal, one respondent requested information about how the process works with working age adults where it has been determined that their placements should be funded wholly by a Continuing Healthcare budget.

Consultation meetings

A concern that had been raised previously during the 1st stage of the consultation around the proposal to remove QAF payments, it was reiterated that it may result in a loss of focus on quality, motivational aspect and income. The underlying rationale for the proposal was explained, which includes low take up of the scheme and the desire to align quality standards with those of the CQC.

The issue of the contract changes was raised. It was asked whether QAF payment would be stopped immediately or whether they would be run down over time as the population of the care home changed. It was explained that no decisions had been taken and no proposals formulated on that point.

It was asked whether the Leicestershire would continue to pay Leicester City rates to care homes based in the city. It was explained that based on the response to stage 1 the Council now proposed to continue to pay the host LA rates for out of county providers.

Proposal 5 – Implementation Approach

The Council wishes to make the implementation of the new fee rates as seamless as possible for all involved. To this aim the intention is to automatically transfer as many cases as possible to the new appropriate band. To enable this the council will begin assessing the eligibility of individuals against

the proposed new banding definitions from April 2019 onwards. Although new placements will be made on the existing banding definition the information will be used by the authority to support an automatic transfer to new rates.

The same approach will also be carried out for reviews undertaken between April and the start of formal implementation. It is the intention of the council to automatically transfer current Service Users with a Band only placement, and where possible those with SNAs and Third Party Top Ups onto the proposed Residential band.

More complex placements will be reviewed to determine the eligibility of the individual within the new Band Definitions. To expedite the implementation, the Council intends to establish a proportionate review process to support this implementation.

Questionnaire Responses

When asked, to what extend do you agree or disagree with the proposed implementation approach, 2 providers agreed, and 4 providers disagreed, 1 didn't know.

One respondent stated that eligibility for the bands should only be needs led and not a budget led exercise, that would be unfair to the individuals concerned.

Another provider repeated a point made earlier that the proposed rates would not provide adequately for the working aged adult from Leicestershire in its care, and the contract is for an agreed fee which covers all the young person's residential needs not just the care element. Clarity is required about what this will mean for the young adult in an out of area placement in the independent sector.

The comment was also made that care homes will be financially disadvantaged by implementation until issues are ironed out and given the sheer numbers, this will take time. Also, with residents on a Band 5 who need to be on Residential Plus, LCC don't know enough to make the transition without input from the home, LCC should ask each home to give input by identifying, with evidence, why each LCC funded resident should be on which band.

One provider has recently had social workers review all in county placements and fees agreed in January 2019 following this review. As such, it would expect this agreement is upheld and the annual uplift applied to the agreed fees. It is hoped that implementation will be a quick process and is not dragged out. Service users may become anxious if they are subject to questioning or delayed action especially if the new rate is lower than what they are receiving at present.

One provider re-iterated that as said earlier, and verbally advised, they would be interested in a smooth and timely transfer from the old to the new bandings, but this would need to be completed carefully (accurately) so that it is fair and to ensure a sustainable model moving forward. This provider worked with LCC to screen, to assess whether they should transfer to the Residential or Residential Plus during the consultation.

When asked, do you have any concerns or see any potential risks for providers or service users, one provider commented that cutting the additional needs allowance will have dire consequences

for the individuals supported. This provider can envisage situations arising where providers will be forced to say they cannot meet a resident's needs within the available funding.

One provider highlighted the administrative disruption and additional workload generated by the implementation as a significant risk.

One re-iterated that it would like to see a fair and appropriate transition, thus ensuring Residents are allocated the correct banding and new fee as quickly as possible and the provider would be happy to continue to work with the Council to finalise this matter.

When asked, do you have any other comments about this proposal, one provider said that 'small providers will be forced to close if fees are cut'.

Consultation meetings

A question was asked about implementation of the new arrangements and when the new rates would become effective. It was explained that though completion of the review was not due until June 2019, the increases would be backdated to 8 April 2019.

A question was asked as to whether there was sufficient review staff given that for many WAAs the uplift would be driven by review. It was acknowledged that this could be a challenge and explained that plans are in progress to recruit additional staff, automate the transfer to the new system where possible and implement the increases using a desktop or telephone review where possible.

A question was asked about payments made by residents that are self-funding via a Deferred Payment Arrangement (DPA). It was explained that the Council had contacted that group of people directly to explain the changes.

An observation was made that using the Cost Effective Care Guidance, some people that currently might move into Residential Care may continue to be supported at home. It was acknowledged that this may be the case and that this fits with the Council's aim to support people in their own home for as long as possible.

General points and other issues

Questionnaire

When asked to what extent do you agree or disagree that the Council has properly consulted providers in developing the proposed band rates, 2 of the six providers that responded agreed that the Council had consulted properly, and 3 providers said that Council had not, 1 neither agreed nor disagreed.

The point was made by one provider that small providers don't have the support of legal departments and advisors to assist.

Another reiterated that, as stated previously, the Council should have used zero-based budget analysis and involved the providers at an early stage. Also, the whole thesis that the real cost of care is different in Leicestershire to, for example, Warwickshire or Worcestershire is, given the cost structures of care homes, complete nonsense. Staff wages are the same, food costs the same etc. so

employing an expensive consultant to do this work is wrong. The core data exists in multiple reports by Laing Buisson, all 3 of the valuation agencies and some academic analyses.

One provider commented that it had have been involved in the consultation process and all feedback provided has been acknowledged and responded to by LCC. The Council's intentions appear to be good but the lack of response from providers made its job difficult. However, whoever worked out the cost of care got their sums badly wrong. As said previously if care homes could give good quality care on LCC rates alone that would be an indication that the rate was high enough. It isn't high enough because service users are being asked for top ups. The provider challenges the Council to find one home in Leicestershire that makes a profit and gives good quality care at those rates.

One other provider said that it welcomed the Council's consultation process and are content with the process to date.

When asked do you have any comments in relation to the first stage consultation proposals themselves, or how they interact with the proposals in this stage of the consultation, none were made.

When asked, do you have any suggestions about the ways in which the Council could recognise excellence in care in Leicestershire, one suggestion related to recognition in respect of length of service. The comment was also made that the rates LCC pay and the CQC quality standards are not compatible. Excellence cannot be produced at the rates you are proposing to pay. LCC has also stopped the QAF payments which were an incentive for some homes to try harder. These payments were not classed as a luxury, they plus a top up were still needed to meet the standard of care expected by the CQC.

When asked, is there anything else the Council should do to recognise and celebrate high quality provision and best practice in Residential and Nursing care, one respondent highlighted a provider of a small home for 26 years, with a group of individuals that reside as a family, should be recognised as its residents have been together over 20 years. Another provider commented that the Council should pay more and watch quality improve.

When asked, are there any other comments you wish to make or is there anything else the Council should consider regarding the fee review, the only comment was that there should be consistency in expectations from health, the Council and the CQC.

Consultation meetings

The question was asked to whether decisions had already been taken despite the consultation process. It was explained that no decisions had been taken.

It was asked whether Cabinet had seen the proposals and it was explained that both Cabinet and the Scrutiny Committee had seen the proposal and would be consulted before any final decisions are taken by Cabinet.

A question was asked whether this was a cost cutting exercise, it was confirmed that it was not and that there was capacity for growth in this area set out in the MTFS.

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