MANCHESTER CITY COUNCIL

# Annex B

# Fair Cost of Care Report

65+ Care Homes

**Executive Summary**

This report is Manchester City Council's submission for The Fair Cost of Care Exercise 2022/23. The contents comprise of an evaluation of Over 65's Registered Care Homes (Annex B) Submission for the Department of Health and Social Care, October 14th 2022.

The report is an evaluation and reflection of the summary findings as detailed within Annex A, giving insight and overview of the programme's methodology, processes, provider engagement, median cost lines and return on capital/operations percentage proposal.

The findings of the report based on provider feedback and the assumptions we have made (see section 5) are that in order to reach a fair cost of care for the City of Manchester for 65+ residential and nursing homes, that an additional funding envelope of between £8.7m - £10.8m would be required.

The ability to deliver this is therefore predicated on:

- The additional funding envelope provided through the Fair Cost of Care grant
- The ability to sustain these higher rates within our substantive budgets beyond 2024/25
- Further fee negotiation with providers in the residential and nursing market to target resources in the appropriate places and a review of the inflationary position for 2023/24

**Contents**

## 1. Overview of Adult Social Care Market – 65+ Care Homes

1.1 As of October 2022, Manchester City Council (MCC) commissions 41 registered 65+ care homes that were in scope of this exercise, covering 1,748 beds (981 residential and 767 nursing beds).

1.2 Adult Social Care in Manchester is deployed into Manchester Local Care Organisation (MLCO) which is an integrated partnership for the delivery of community health and care services. Currently MCC procures registered 65+ care home capacity as part of an integrated Health and Care system via MLCO. For hospital discharge this is operated through a centralised control room for Health and Care placements using the nationally recognised Discharge to Assess Pathway (D2A), NHS Continuing Healthcare framework as well as community referrals.

1.3 Manchester City Council and Manchester Local Care Organisation (MLCO) are currently engaged in delivering a large-scale transformation programme, Better Outcomes, Better Lives. The Better Outcomes Better Lives (BOBL) transformation programme is the ASC long-term programme of practice-led change centred on achieving better life outcomes for the citizens of Manchester by working in a strength-based way. The programme aims to enable less dependency on more formal care, whilst also helping us to build a more sustainable future for the people we support.

1.4. The BOBL programme commenced in January 2021 to an existing backdrop of rising demand for Social Care support among the adult population of Manchester, and growing pressures on Social Care funding. Since starting the programme, the unprecedented challenges of the COVID-19 health pandemic have continued to impact, and we are seeing more significant health challenges for our citizens, increases in unemployment, greater usage of food banks, and a rise in loneliness and mental health concerns.

1.5. Manchester's residents have been disproportionately adversely affected by the pandemic. Existing inequalities, particularly for our most deprived communities, ethnic minorities and those already living in poverty, have deepened, and we are seeing increasing numbers of new contacts from citizens in need of our support.

1.6. In this context, the BOBL programme has continued to focus on embedding a strengths-based approach alongside work to develop our short-term offer, work to enhance our operating model and social work practice, work on how and what we commission and embedding a performance approach across all of our services. Collectively these interventions have been intentionally designed to help our citizens achieve independence and better outcomes wherever possible, whilst preventing, reducing and delaying demand into adult social care services. We are seeing the positive impacts of the programme in reductions in demand for long-term care and improved outcomes.

1.7 Within the cohort of care providers referred to above, part of the bed base is contracted to deliver discharge activity via 60 D2A beds to support hospital flow as part of our Resilient Discharge Programme (RDP). The business case for this programme intends to increase this to 80 beds over the winter period in 2022/23.

1.8 The Manchester care market is a net importer of care home placements with the surrounding Greater Manchester authorities placing a much higher number of citizens in Manchester beds, than those which Manchester place out of area. This is

mostly due to the geography of the city within the Greater Manchester area and that beds in Manchester have historically been lower cost than those in most neighbouring authorities (particularly Stockport, Trafford and Cheshire East). Manchester also has the largest care home supply market in Greater Manchester.

1.9 Through this exercise, MCC has gauged enhanced insights into the business models of our registered care providers. Establishing a mechanism for MCLO to regulate the financial and business models as part of quality and contractual monitoring, is being explored further and will be described in Annex C: Market Sustainability Plan.

## 2.0 Programme Methodology

2.1 In order to properly manage the fair cost of care exercise, MCC undertook a programmatic approach to deliver a comprehensive planning and engagement programme in which to gather the required volume and quality of data to ensure a robust return to the Department of Health and Social Care (DHSC).

2.2 As part of this planning, MCC recruited a 0.8FTE Programme Manager from June 2022 as well as diverting internal resources from Commissioning and Finance. A formal programme plan was developed with close links to the wider charging reforms (Section 18(3)) through an aligned governance structure.

2.3 Across the Manchester system, colleagues from Adult Social Care (ASC) and Health were engaged within the governance structure to ensure a broad system view on both the inputs and impacts of the exercise were understood. These include the Executive Director of Adult Social Services (DASS), Deputy DASS, Deputy Chief Executive and City Treasurer (Section 151 Officer), Social Work Leads, Finance Leads (Health and Care), Clinical Leads, CHC leadership and ASC Commissioning.

2.4 The method utilised began with a local project initiation document which gave clear action to set out an approach and to create a project management plan, with a weekly highlight reporting mechanism and governance framework.

2.5 The chosen Cost of Care tool for this exercise was CareCubed (FCOC element). The tool was commissioned by CHIP (delivered by ADASS and the LGA) for use by Care Home Providers and Local Authorities in England to input, share and collate data for the DHSC 65+ Care Homes Cost of Care Exercise.

2.6 There were 5 key areas of focus; as drawn from the Project Initiation Document.

1) Provider Engagement
2) Data Collection
3) Data Analysis
4) Sensitivity Analysis
5) Report Production

2.7 A large scale engagement programme was planned and delivered to ensure that the widest range of providers were able to contribute to the exercise. This programme included:

- Main agenda items at two separate quarterly Manchester Commissioning Innovation Labs*
- Three specific cost of care exercise webinars

- Twice weekly drop-in sessions (online) over a six-week period for provider to discuss any concerns, issues or clarification to support accurate submission
- Clarification meetings with providers who submitted to the exercise to standardise data on cost lines, where possible and to address anomalies and outliers
- Direct contact by the FCoC Programme Manager to homes yet to submit by telephone call and email

2.8 Additional activity logs and evidence were collated, as part of the project planning methodology; to inform task analysis, report structure, risk and issue management and to give timescale for completion, including space for governance, advice, evaluation and reflection.

2.9 The care-cubed fair cost of care tool, was completed by our care homes with our finance team reviewing and analysing data-sets for analysis inclusive of explanations of those workings (Annex A).

2.10. A check and challenge element to commissioner / provider queries further improved the quality of the data and therefore the overall robustness of the submission.

## 3. Data Submissions

3.1 Of the 41 eligible care homes (1,748 beds), we received a submission from 16 Care Homes (39%).

3.2 The 16 submissions covered a total of 951 registered beds (54%). Of those, 475 beds were residential, and 476 beds were nursing.

3.3 As of 04 October 2022, bed occupancy across **all in-scope** 65+ Care Homes was **93.5%** (1,634/1,748 beds occupied).

3.4 Residential occupancy was **87.6%** (859/981 beds occupied).

3.5 Nursing Occupancy was **95.2%** (730/767 beds occupied).

## 4. Base Price Year & Future Uplifts

4.1 The base year costs provided are actual costs incurred in 2021/22 with an adjustment for 2022/23 made on projections in conjunction with providers. (See also 5.2).

4.2 The framework of contract rates in operation are informed by a cost of care exercise undertaken some years ago and which is acknowledged as being in need of further update, as we are now procuring off framework rate placements on an increasing basis and as such, the Fair Cost of Care work is timely. Since then, fee setting has been based on an annual percentage uplift of these rates in lieu of a full cost of care approach and is informed through a consultation exercise with providers to understand key pressures and issues, although input from providers has been relatively low. The response rate to the FCOC programme has seen an improvement. Annual inflationary increases have varied and have fully taken into account the movements in the National Living Wage. The market supply of beds has been

challenging at times but overall remained robust. The 2022/23 approach has provided for three key components:

1. Sector specific modelled staffing costs and an offer to providers to fund a pay structure reflective of the Real Living Wage (and know NLW/FLW increases);
2. Sector specific modelled non-staffing costs (blend of RPI and CPI); and
3. Exceptional inflationary items (for 2022/23 this includes energy, insurance and food using national indices and provider feedback and national insurance changes).

4.3 The approach to fee setting for 2023/24 will be informed by the outcome of the Fair Cost of Care research. The annual consultation with providers will also look to gain an understanding of the latest inflationary and other cost pressures. There will be a new offer to those Providers who did not accept the offer to move to Real Living Wage rates for their workforce last year. In setting the 2023/24 fees, the Council will also place due regard to the requirements of the Care Act and DHSC's 2022 policy, "Market Sustainability and the Fair Cost of Care Fund guidance". In line with the framework for this exercise there is an expectation we will 'move towards' a fair cost of care.

4.4 In 2018, Manchester City Council contracted a new homecare framework (by neighbourhood) which obligated all contracted providers to pay the Foundation Living Wage (FLW). During 2022/23 all other sector providers were offered the opportunity to pay FLW through a secondary inflationary increase to fees. For ***Residential and Nursing Homes*** 33/74 (45%) of externally commissioned homes (inc MH & LD) have now signed up to the FLW offer covering approximately 60% of placements. All new contractual frameworks will now mandate payment of Foundation Living Wage as a minimum.

4.5 Reflections on workforce challenges/strategies have featured during this work as a natural by-product. These are a feature of Annex C: Market Sustainability Plan.

4.6 Plans to further establish the financial stability of registered care homes and homecare are explored within the Market Sustainability Plan (Annex C). This will allow us to incorporate the findings from this exercise to give a stronger evidence base for future fee uplift projections.

## 5. Modelling Assumptions, Adjustments and Exclusions

5.1. The Manchester view of this exercise is that it is about providers real cost of care regardless of funding source, placing authority or perceived affordability for the local authority. Therefore, when analysing the data provided to us, we wanted to understand outliers, but only exclude those where services provided were fundamentally outside the scope of this exercise (e.g. hotel quality services / living arrangements). For this reason, we have not adjusted for FNC contributions or any other funding arrangement.

5.2. When reviewing the nursing rates within the providers returns, the median nursing rates are coming out lower than the residential rates once a FNC deduction is made. For this exercise, we have followed the format of Annex A and left all costs gross and made no adjustments in relation to nursing staff costs. We would want to complete

further work with the providers to review the differences as we do not feel this is correct.

5.3. Where a provider did not include inflationary costs for 2022/23 in their return, we have used our existing internal modelling (pay 11.1%, non pay 5%, food 15% and energy 100%) to make an appropriate adjustment. The approach to 2023/24 fee setting will review inflation factors as detailed above in line with the critical success factor of ensuring a sustainable yet competitive market. No other adjustments have been made to direct expenditure or costs submitted.

5.4. Our approach to return on operations has been to apply a 5% mark up on operations and head office costs, for both care homes and domiciliary care agencies. This reflects discussions across Greater Manchester and our knowledge of the local market and is our commissioning judgement of a reasonable rate to maintain a good supply market and that it may be considered reasonable for to calculate return on operations on a consistent basis across all providers, rather than using figures supplied by each provider

5.5. In respect to the return on capital, we are aware there is a diverse range of operating models in place including owner occupier, rental of premises and an offshore parent arrangement whereby an internal rent is charged. In determining our approach, it is clear that:

(i) Using the information returned creates a median skewed by the type of provider that responded; and
(ii) It has been important to strategically consider the market supply and future needs.

Based on the information available to inform a decision, the methodology for calculating return on capital has been normalised to use a valuation per bed of £70k, rate of 5% at 90% occupancy level. We have materially increased the valuation per bed (against the average value of returns) to allow for a reasonable additional tolerance to allow for diverse operating models and estate. The use of 5% is a judgement but informed by DHSC information and the consideration outlined at 5.3 with regard to being a reasonable basis for market comparison. It is understood that such returns are being squeezed downwards but Manchester has maintained a higher % reflective of the need to attract and maintain a good supply market. This approach is considered the most appropriate and transparent to reflect what is a highly complex issue of capital investment.

5.6. It has been necessary to exclude 3 homes from the exercise. Two homes are significant outliers with costs over 50% higher than the other submissions and one home did not submit staffing information. We have approached this home to submit this information, but did not receive this information prior to the 14th October deadline.

5.7. During the course of undertaking the fair cost of care exercise, localities across Greater Manchester and North West Association of Directors Adult Social Services have engaged in collaborative discussions, to better inform our approaches to the treatment of certain cost items and interpretation of the guidance. It is anticipated that these discussions will continue as we work towards fee setting for 2023/24, so as to be cognisant of any potential impact, particularly on the market sustainability of neighbouring authorities..

## 6. Cost of Care Estimates

6.1 (NOT FOR PUBLICATION) Our existing median base prices for the types of care covered by this exercise for 2022/23 are as follows:

| **Designation** | **Existing Median Rate (per week)** |
|---|---|
| Residential | £563.53 |
| Residential (enhanced needs) | £613.33 |
| Nursing | £602.13 |
| Nursing (enhanced needs) | £639.36 |

6.2 The outputs from the Cost of Care Exercise for 65+ Care Homes are as follows:

| **Designation (CoC)** | **Lower Quartile Rate (per week)** | **Median Rate (per week)** | **Upper Quartile Rate (per week)** | |
|---|---|---|---|---|
| Residential | 756.94 | 838.71 | 979.67 | |
| Residential (with Dementia) | 773.98 | 831.25 | 916.41 | |
| Nursing | 869.48 | 985.52 | 1,126.58 | |
| Nursing (with dementia) | 916.36 | 991.42 | 1,096.88 | |

* The median rate from the exercise is slightly lower than residential only therefore we have adjusted the figure up to be the same as residential.

## 7. Challenges (Engagement, Uptake & Data Quality)

7.1 Engagement with providers proved to not be as effective as hoped, given the perceived opportunity to address what is believed to be underfunding of care homes nationally. Demonstrable pressures exist around recruitment and retention and a current attrition rate of over 30% of care staff is a major concern. The amount passported to providers and the links to this additionality being paid through to carers will have a level of impact that it is difficult to estimate in terms of real terms workforce increase and reduction in costs associated with turnover rates.

7.2 We know that price and quality are not inextricably linked and this exercise does not consider the art of the possible in terms of commissioning for outcomes and has been a missed opportunity to consider how added-value within services could lead to better outcomes and improved independence.

7.3 The quality and accuracy of the returns drew out anomalies between submissions which were broadly related to:

(i) Who within an organisation completed the return.

(ii) The challenges of understanding different operating models of medium and larger organisation and their relative access to cash.

(iii) The perception of the exercise within a provider.

(iv) Whether providers wanted to accurately attribute cost lines manually to submit to the tool from their own operational and financial reports.

(v) The volume of submissions that a provider needed to support regionally / nationally, leading to capacity challenges within providers.

7.4 The lack of clear national provider communication strategy, given the number of medium and larger enterprises that submitted to the exercise could be a consideration for future exercises.

7.5 The partnership and power dynamics between public sector commissioners and providers, particularly around cost has a history that requires consideration, with providers being suspicious of the purpose of the exercise, the deliverability of the outcomes and the understanding that Local Authorities were not the bodies that would ultimately provide the financial envelope for implementation. That said, it was appropriate that local authorities used their understanding of local markets and conditions to lead the work.

7.6 Providers do not necessarily produce either management or published accounts in the format used and this often took significant manual working to enable an accurate submission.

## 8. Cost of Implementation

8.1 Using current levels of activity for 65+, the cost to implement, after applying the modelling assumptions, adjustments and exclusions as per section 5, would be in the region £10.8m per annum. The cost is based on existing client levels and the increase in unit cost from the current median weekly rate (detailed at 6.1) to the new median weekly rate detailed at 6.2 (and built up in Annex A).