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"Lets agree to agree"

A toolkit for commissioners and providers to agree the cost of residential and nursing care for older people in Wales

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OXFORD BROOKES UNIVERSITY

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1 Introduction

This document offers a toolkit for commissioners and providers of residential and nursing care for older people to assist with the complex process of seeking agreement on the cost of care in their local area. The aim is to produce an approach that will assist all parties to provide a sustainable cost model for care homes in Wales.

The work to develop the toolkit has been undertaken for the Welsh Government by Professor John Bolton and colleagues at the Institute of Public Care at Oxford Brookes University (IPC). The development process has involved engagement with local authority and health board commissioners, providers of care and representatives of the wider care sector, in an effort to seek to find a toolkit which is acceptable to all parties. The toolkit does not, however, provide all the answers. It recognises that the process ultimately requires negotiation to secure the critical decisions on costs of care. In essence the toolkit offers best practice guidance to those parties who need to agree a local price for care. The view of the Welsh Government's Cost of Care Steering Group which oversaw the development of this toolkit was that this offered a "best practice guide". There is no compulsion on its use but failure to establish a local mechanism for agreeing a fair price for care could lead to judicial processes that cost valuable time and money to the stakeholders. We think that those places that do not wish to understand the costs of care are likely to experience a loss of provision and for the provision that remains to offer lower quality care.

Residential and nursing care for older people is a really important part of the care services that are available to older people. We want them to offer good quality care for older people at the end of their lives. This care is usually provided for those people who are most frail or experiencing memory loss or other challenges in later life. It is important that when the public services are buying this care on behalf of older people that the costs are understood and accepted by all parties. If the full costs are not being paid there is a higher risk that a care home might offer lower quality care which could eventually lead to closure.

The Older People's Commissioner for Wales' report on care homes says that the duty to commission social care and nursing care, and to ensure the quality of this, is a core responsibility of local authorities and health boards respectively. In exercising this function local authorities and health boards must ensure that the quality of care provided is good, meeting the needs, and delivering the wellbeing outcomes, of the people in receipt of this. This is particularly so in the case of older people who require

residential care, who will potentially have high and complex social care and nursing care needs[1]. As a result, it is important that in using this toolkit local authorities and health boards do not lose sight of the need to undertake outcome based commissioning of residential care for older people. This is to ensure the social care and nursing care delivered to residents is of a good quality and acceptable level in order to meet their needs and outcomes, and thereby meet their statutory responsibilities. Such outcomes and associated costs should be considered as part of the fee setting process.

In some quarters there is apprehension that undertaking the work to analyse and understand the costs of care may actually increase the costs to hard pressed local authorities and health boards. It is the aim of this toolkit to enable an open and transparent process to take place so that costs are fully understood. If this leads to an increase in what is expected to be paid, commissioners may feel that they should either pay the agreed costs; or agree a time frame in which they will pay these costs. Whatever decision is taken then the commissioners will also have a clear set of evidence to put to the Government on why additional funding may be necessary.

The toolkit and its application can be set in the context of a number of developments that are currently happening in Wales. Every commissioning body is expected to produce a Market Position Statement which should indicate the future of the care market in any given area. The information collected from the process described in this document will assist in providing valuable information for that statement. The Welsh Government is looking for Regional Partnership Boards to focus on the strategic direction for services across health and social care, and to establish pooled budgets for care homes, in each region of Wales. Again the information collected from this process should assist with the data required to set the approach to the commissioning of residential care.

1.1 The legal framework

Local authorities and health boards are responsible under section 14 of the Social Services and Well-being Act 2014 to jointly undertake an assessment of the needs for care and support, and the support needs of carers, in their area. This assessment must also identify:

- the extent to which those needs are not being met; and
- the range and level of services required to meet those needs.

Regulations provided for the seven Regional Partnership Boards to publish combined population assessment reports in April 2017. Regions must now produce joint area plans in response to these assessments, as required by section 14A of the 2014 Act.

Separately, section 56 of the Regulation and Inspection of Social Care Act 2016 (RISCA) inserted section 144B into the 2014 Act, requiring local authorities to produce a local market stability report. At the time of writing this provision is not in place but it should be enacted soon. The 2010 statutory guidance from the Welsh Government entitled "Fulfilled Lives, Supportive Communities, Commissioning Framework and

[1] Older People's Commissioner for Wales (2014). *A Place to call home? A Review into the Quality of Life and Care of Older People living in Care Homes in Wales.* Available at: http://www.olderpeoplewales.com/en/reviews/residential_care_review/ReviewReport.aspx

Guidance", stated that commissioners should have an understanding of the costs of directly provided and contracted social care services and to act in a way to promote service sustainability. This toolkit aims to assist with that task.

1.2 Commissioning and procurement

The toolkit has used the term 'commissioners' to describe the staff from the local authorities and the health boards who are involved in the process of agreeing a price for care. It is, however, worth noting that it is very rare for a residential care or nursing home to have been formally commissioned by a public sector body. In most (though not all) circumstances the decision to open a care home in a particular locality is a business decision made by the owners of the care home with little or no reference to the local authority or health board commissioners.

However, many of the residential and nursing care homes in Wales are well established and they are committed to the geographical area in which they are located. The home considers that it is serving their local populations for both older people who may be funding their own care and for those for whom the state has financial responsibility. This document focuses on ensuring that a fair price is paid from the public purse for the latter group. This process is better called 'procurement of care'. Commissioners might also be mindful of the future requirements for their area and how they are going to encourage the investment required for this.

1.3 Principles

There are a number of important principles to note which are needed to enable the process described in this toolkit to work.

First, is that an agreed price has to be negotiated as with any other contract. This requires both parties to come to a shared view on the price and the components that make up the price – neither party can or should impose a price on the other without this negotiation.

Second, is that the essence of the approach is one of transparency and openness from both parties. Commissioners must be able to demonstrate how they have come to their conclusions on price from the evidence available. A good proportion of the local providers will need to be prepared to share their day to day costs. If providers are unwilling to provide the required information the process will not work and should be abandoned with an explanation to all stakeholders. Decisions on the price to be paid may be made in private but both parties must understand why it is a fair price. Some providers will set their own price irrespective of this process. They of course have a right to do so and commissioners have a right to negotiate with them separately.

Third, is that neither party has to do business with the other and therefore it is possible that either a public body will not come to an agreement with a provider of care or vice versa (therefore no business takes place). There is rarely any legal obligation for an agreement to be made through local authorities and health boards may feel some pressure to agree a price as they will want to offer a reasonable choice for care.

Fourth, is that there can always be agreed exceptions to the stated price. These need to be clear and transparent. A home can be paid more than the agreed rate where special circumstances are demonstrable and clearly recorded. The toolkit should not operate on a 'one size fits all' basis. There is not a single price for the cost of care in Wales and there is not a single price that should operate in any given part of Wales.

Fifth, is that both parties are committed to delivering a sustainable care market. The generality of the care market is that the provision of good quality care will mostly come from investment from private monies (there are some developments from public monies but these are less common). The care market must attract the right type of investor. Investors will be looking for a reasonable return on their investment because they would expect a similar return if they chose to invest their money elsewhere. There may be additional returns that a provider who is operating a care home will require to assist them in managing the various risks associated with the running of the home. These might include: changes in occupancy (as lengths of stay are reducing), changes in regulatory requirements (or requirements following an inspection); upgrading and improving the home etc. This return on investment, which is explored in more detail later in the toolkit, is of fundamental importance for the future of the care market in Wales.

The basis of this toolkit is that commissioners in the public sector should expect to pay a fair and reasonable price for care. It should not be the case that those who are funding their own care are expected to subsidise those who are paid for from the public purse. In this period of financial austerity for the public purse there will always be a tension between paying for minimum standards and looking to deliver good quality outcomes.

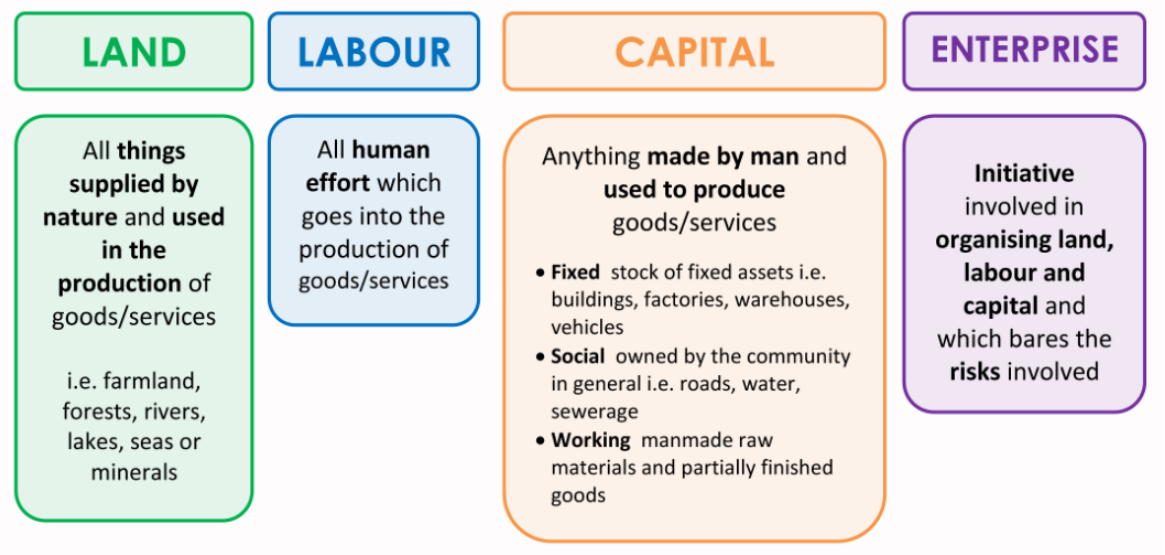
For those who want additional services or a higher standard of accommodation a top-up payment may be required that the public purse would not expect to fund. This view has certainly been reinforced from the various comments made by the Competition and Markets Authority in its review of aspects of the residential care market[2]. Requirements under the Social Services and Well-being Act 2014 ensure that, where a person's placement is funded by their local authority, they must be able to express choice for a particular care home as long as specific conditions are met. Only in instances where the care home is more expensive than an authority's usual rate to meet a person's needs in full, or where the person requests an additional service or facility that does not form part of their assessed need, can an additional cost payment (a top-up) be requested. Such arrangements can only be entered into with a third party (such as a family member).

Finally, the basis of developing a sustainable cost model has to be built through trust between commissioners and providers. There has to be both the openness described above but also a trust that working in partnership will produce the sustainable market that commissioners require and a sound business model that providers need.

[2] Competition and Markets Authority (2017) Care homes market study: final report. Available at: https://www.gov.uk/cma-cases/care-homes-market-study#final-report

2 The Elements That Make Up The Cost of Care

The following four elements are used in basic economics to show the costs of any product. Residential care costs are no different and should be understood in this way.



For residential care these four elements contribute to the costs of a care home. These all need consideration when understanding the price of care:

- Land: the land on which a home is built, whether owned by the operator or a third party.
- Labour: the carers, kitchen staff, cleaners, maintenance, managers and head office staff (where relevant).
- Capital: anything fixed that is needed to provide the service, such as vehicle costs, uniforms, food and buildings (see full list below). This either needs to be bought and paid for by the operator or leased from the owner. Either way, there is an annual cost. If the operator owns it, it will be the annual cost of depreciation to replace this fixed item at the end of its useful life (e.g. staff uniforms 1-3 years, the building 20-30 years). If the operator rents it, then there will be the cost of annual renting it (rent to the landlord).
- Enterprise: the operators return for organising the above three. It is worth noting that even the not for profit organisations are seeking to generate a 'surplus'.

It is for each of these four elements that providers and commissioners must first understand how they work and then come to an agreement on the best way of treating each part.

The initial work undertaken by the Institute of Public Care for the Welsh Government to inform this toolkit described six key areas where it was considered more complex to reach agreement on the price. These included:

- Establishing the right level of staffing for a care home (there is no common agreed formula to establish the numbers of care staff required to run a care home effectively).
- Establishing a fair price for overheads and management costs.
- Establishing a fair price for running the care home.
- Agreeing how to fund the value of the land and the building within the fair cost tool.
- Agreeing what is a reasonable operating profit for a provider.
- Agreeing a figure to ensure an operator can manage any risks arising from running the business e.g. changes in regulation

We hope that the toolkit provides a framework in which the discussion can take place between commissioners and providers to reach agreement and to determine a fair price for care.

Glossary

We have used the following definitions to underpin the terms we use in the toolkit:

- *Commissioner* - the staff from the local authority or the health board who have responsibility for ensuring that the right range and type of residential care is available for older people in their area.
- *Provider* - the owner of a care home or care homes (or their nominated representative) in a given area
- *Types of care homes* - There are four descriptions which have previously been used in Wales for the different types of care homes for older people:
  - Standard Residential Care
  - Standard Nursing Care
  - Care for the elderly with mental ill health (EMI Residential)
  - Nursing Care for the elderly with mental ill-health (EMI Nursing)

  These terms ceased to apply when the regulations changed from April 1st 2018. Now the nature of the care home is established through an understanding of the needs of the residents who are placed in a specific home.
- *Ownership of care home* - there are a range of different arrangements in place to run and operate care homes in Wales. The following may cover the various arrangements in place within Wales.
  - Local Authority run homes
  - Registered Social Landlord - Housing Ownership
  - Private Individual Ownership
  - Not-for-Profit Company Ownership
  - Voluntary Sector Ownership
  - Company Ownership with shareholders
  - Mutual Ownership
  - Postcode Group Homes – separate individual ownership but company registered at same address as another home
  - Small Group Provider

There are two important sources that have been used in creating this toolkit as well as drawing on the positive experiences that already exist in Wales:

LaingBuisson are a highly reputable and long established company who produce regular reports on care markets and have developed their own toolkits for the cost of care. Their web site can be a fount of knowledge. The references to their work in this document come from their reports on the state of the care markets which are reproduced annually.

The Chartered Institute of Public Accountants (CIPFA) have produced their own guide to assist public bodies consider the true costs of care. Their guidance ought to be invaluable for commissioners of these services. Both of these organisations are referenced within this document.

3 The Toolkit

The key steps for agreeing a price for care are summarised in the table below and the following sections look at each step in turn:

Step 1: Agree what you need to agree, who needs to agree it, what information do you need and how will you agree?

A. Establish a standing committee of stakeholders to consider the issues arising from the cost of care. Ensure the process is transparent and open including recognition that there may be issues which are difficult to resolve.

B. Establish a group of providers who are willing to share their accounts with the standing committee (or include these providers on the standing committee).

C. Consider whether this might be best established on an area (council area), regional (local health board region) or other geographical basis. It is recommended that Regional Partnership Boards[3] oversee this work of the councils and local health boards in their areas of responsibility.

Step 2: Gather the data and intelligence

A. Establish a spread sheet that can collect the data from the care homes.

B. When required, collect additional information from all providers in the area through a questionnaire (contents agreed with the standing committee).

C. Populate the spread sheet and discuss the findings considering any outliers that should be removed from the average figures.

D. Consider if you need to distinguish between different sizes and types of care home e.g. those with fewer than 30 residents or more than 50 residents.

E. Calculate the average figures based on:

- *Staffing and management costs*
- *Other non-staffing costs*

[3] In April 2016, seven statutory regional partnerships came into being. Their purpose is to drive the strategic regional delivery of social services in close collaboration with health.

- *Care homes may be grouped in sub sets for this purpose according to size or other factors if they are worthy of consideration e.g. dementia care tends to cost more than other forms of care*

Step 3: Make a set of decisions!

A. Agree an approach to the following areas:

- *Profit and return on investment*
- *Occupancy levels*
- *Quality premiums*

B. Add together the decision made (as above) with the agreed average cost and arrive at a figure.

C. Consider any exceptions for specific care homes and / or high dependency residents.

D. Recognise that there may need to be compromises to reach a full agreement. Negotiate a final figure.

E. Recommend a figure for local authorities and health boards to consider within their own governance structures.

F. Ensure that if either a local authority or a health board is not going to pay the recommended rate that their reasons for doing so are understood by all parties.

4 Step 1: Agree what you need to agree, who needs to agree it, what information do you need and how will you agree?

4.1 Establish a standing committee

The important aspect of working collaboratively between commissioners and providers is to ensure that there is a transparent process to which both parties contribute. There are a range of different processes that have been operating within Wales, but this toolkit suggests the following approach (which may be adjusted or adapted to suit local circumstances).

A standing committee should be established between local authority commissioners, health board commissioners, local authority and health board procurement and finance staff and a set of providers who represent a cross-section of residential and nursing homes (including EMI homes) from a particular area. The standing committee should operate in a Regional Partnership Board area. There may be good reason why a local authority area is chosen to carry out the work because of the size of the area and the capacity of the key stakeholders. Even if the local authority area is chosen, their work should be reported to the Regional Partnership Board. For the most cost effective way of carrying out this work it is advised that undertaking the analysis of costs might be best completed at a regional level.

Consideration should be given to a good representation of the local care market within any committee. Where possible providers should reflect the size and different types of care homes operating within the area/region. These may include homes with: over 50 residents and under 30 residents/high levels of dementia care and nursing care and different types of ownership. Connections should also be made with local representative bodies.

Some authorities may want to consider whether other key stakeholders should be represented on the committee, but we suggest that the committee is limited to those directly involved in the commissioning/procurement of residential care and the providers. The reason for this is that there may be highly commercially sensitive or confidential information shared which would be very difficult if other parties were involved.

4.2 The role and tasks of the committee

This standing committee has a role in examining the data that is collected (see below) and ensuring that the evidence supports the decisions that will eventually be made on the agreed rates for the costs of care in a given area. Local authorities, health boards and providers who are engaged in the standing committee should agree to broadly accept the conclusions of the committee when agreeing to recommend prices to be paid for the different types of residential care. It is recognised though that it is local authority elected members or the health board members who will be making the final decision.

The standing committee will be responsible for asking care homes for data to be collected from care homes across their area in order to understand the costs from a range of different care homes (this may include the homes that the local authorities run themselves). The care home providers may decide that they are willing to directly contribute to the data from their own accounts. Some providers may be prepared to offer an 'open-book' to the commissioners so that their costs are clear and transparent.

In addition the standing committee may also want to collect additional data from other providers in their area/region (and this is recommended on a regular basis). This can be achieved by sending a questionnaire to all providers and seeking a full response on a voluntary basis (a copy of a questionnaire used in Carmarthenshire for this purpose is attached in appendix one).

The local authority and health board commissioners can check the authenticity of the data provided from providers by comparing the figures that emerge with those that the

care provider has published in their annual accounts. The detail of the data required is laid out in the sections below.

After all the data is collated there has to be a clear and transparent process where the figures can be understood and broadly accepted by all the stakeholders on the standing committee. It is important that this is an open process with room for discussion on key points. There are some difficult and complex issues which will require discussion and agreement. There will always need to be a balance between what is an acceptable price and is affordable to the public purse (the tax payer) and what prices are fair for providers in order that they can deliver a sustainable business.

The collection of the data does not alone provide the answers on the average costs of care. There will need to be an understanding of why there are variations between providers and how these have an impact on the care delivered. It might be that one provider looks to run a much more luxurious care home than another provider. As long as they meet the registration standards laid down by the Care Inspectorate Wales (CIW) then their costs should be included in the framework. The final analysis has to take a view on:

- The right level of staffing for a care home.
- A fair price for overheads and management costs.
- A fair price for running the care home.
- How to fund the value of the land and the building within the fair cost tool.
- What is a reasonable operating profit for a provider.
- A figure to ensure an operator can manage any risks arising from running the business e.g. changes in regulation.

It is how these are agreed and negotiated that concludes the final stage of the work. This is best done through the standing committee.

Example

In Carmarthenshire there is a standing committee set up between eight care home providers and the local authority finance and commissioning teams. They meet on a regular basis, but most importantly once a year they review all of the costs of the eight care homes that are represented on the committee. The standing committee is chaired and administered by the local authority.

The approach used in Carmarthenshire relies on the ability of commissioners and providers to work together to come to an agreement on average costs for running different types of care home.

A spreadsheet has been established by the local authority which includes all of the costs submitted by the care homes. All parties can see the costs that are laid out in the spreadsheet. The committee then consider the costs and take a view as to which costs are appropriate and where there might be outliers that should not be included in any calculated averages of these costs. Homes are categorised as shown above and the costs for each type of care home are captured and put into the spreadsheet. In addition to the information provided voluntarily by these eight providers the local authority commissioners send a questionnaire annually to all providers in their area to

identify cost pressures that may be arising and to help verify that the figures used in the model are reasonable. Eventually, when the data has been collated averages are calculated which begin to inform the process of agreeing the costs.

The findings are openly shared and discussed. The standing committee in particular consider the most complex issues which have been identified above – staffing and management costs for different types and sizes of care homes; the return on investment that providers might realistically accept from the public purse; whether a vacancy or turnover rate should be included in the price and how that might be set; what other bonuses (if any) might be paid for good quality care; and how might overheads be apportioned and covered (particularly for larger providers)?[4].

It may be possible to conduct all of the above work without the necessity of establishing a standing committee. However the main advantage of this approach is to ensure the transparency of the process and to enable open discussions to take place on the more complex issues at any time. It may also be worth considering a change in the membership of the standing committee over time to encourage different providers to contribute to the discussions.

5 Step 2: Gather the data and intelligence

5.1 Creating average costs

The costs for a care home can be categorised in a number of ways. Often they are summarised under the following headings:

- Staffing (and local management).
- Repairs and maintenance.
- Non-staffing current costs e.g. provisions, materials etc.
- Occupancy premium.
- Capital costs, borrowing and return on investment.
- Profits.

An average cost for care is calculated following the methods identified in Step 1 to work with a representative group of providers in examining their accounts and asking other providers to complete a questionnaire covering their costs. The information collected can be placed into a spread sheet which can assist in understanding both the range of costs involved; the differences between care homes. It can assist in calculating the average costs for each type of care home.

[4] The policy adopted by Carmarthenshire County Council is attached as appendix two.

It is recognised that this is a time consuming exercise and requires significant input from providers. That is why it is suggested that a small representative group of providers be invited to contribute to this work. There are two immediate benefits for the providers who do contribute. First they will develop a good understanding of their own costs and can discover other cost effective ways of delivering good quality services from others. Second, they will be able to strongly influence the outcome of the negotiations on the price of care. It may only be necessary to undertake the wider questionnaire to providers once every three years as adjustments can be made year to year based on the information from the selected providers without necessitating a full exercise. Where there needs to be a greater understanding of the cost pressures in the sector then the questionnaire approach can be used to get the best possible understanding.

There may be some costs that emerge from the exercise that are outside of the normal price range – where they may be described as outliers. These can be excluded when considering the average costs. It is important that it is agreed by the committee which costs have been excluded.

5.2 Staffing costs

The staffing costs should be collected as they are presented by the provider. The staffing structure costs, irrespective of the management structure, are collated and recorded in the spread sheet. Though there are variations between different care homes the aim is to find an average figure which accurately reflects the costs of staff for each provider.

Staff *working in a care home* – there are a range of different staff who may be working within a care home:

- Managers (Person(s) responsible for the Care Home)
- Administrators/Reception Staff
- Senior Care Staff/ Shift Managers
- Level 2 qualified Care Staff
- Care Staff/Activity organisers
- Cleaners/Domestics
- Cooks/Chefs
- Nurses (for Nursing Homes)
- Auxiliary Nurses
- Maintenance and Repair Staff
- Gardeners

The staffing levels do vary according to the needs of the residents within a care home and the size and design of the care home. It is suggested that the average staffing levels are calculated in consideration of the following:

- Care homes with 30 or fewer residents (likely to require higher figures per person than the larger homes)
- Care homes with 31- 49 residents
- Care homes with 50 or more residents
- Care homes with more than half the residents with diagnosis of dementia (typically require more staff than any other type of care home).
- Care homes with a nurse on duty at all times (nursing homes from previous definitions).

It is worth noting and discussing that some of the larger providers that operate in Wales have pre-determined formulas that they use to determine the staffing levels in their care homes. If one or more of these providers operate in the area being examined these should be taken into consideration. They are usually larger care homes.

A specific issue that needs to be considered in some areas is the higher costs of agency staff. It is not ideal for any care home to rely on agency staff and some commissioners may be reluctant to fund the additional costs of agency staff. However, in some parts of the UK there have been challenges in recruiting staff to work in care settings. These might include the specific costs for nurses to work in care homes or for suitably trained and qualified managers as well as front line care staff. In an area where these difficulties have been identified the commissioner and providers will want to consider how to include the additional costs of employing agency staff are taken into account. Costs of pensions that are paid to staff (including managers/owners) should be included in the costs of staffing.

The final figures are usually shown as the average number of hours required per resident in the different care homes described above. The calculation is made by multiplying this figure with the average cost of a care worker for that care home. This should produce six different rates for an area (smaller and larger homes serving different populations of needs).

The average costs reflect the current rates of pay for all the grades of staff working in care homes in Wales at the time of the assessment. Some health boards and local authorities may wish to set minimum standards for the terms and conditions for staff in care homes. There are a number of arguments that might mean there are good grounds for doing this: the need to pay a higher rate for the valuable work undertaken; the need to reduce turnover in the workforce; the need to ensure a better trained workforce etc. If the standards require a higher rate than the current staffing costs then of course adjustments will have to be made to the overall calculation. It is expected that the workforce strategy for care staff in an area be one of the matters to be considered by the Regional Partnerships Boards.

Finally it is important to recognise the levels of need overall of those older people who are entering care homes. Their needs for the right level of staffing should be included within the average costs for all care homes. However, there are circumstances where a person in a care home requires significantly higher levels of support than the average cost model can fund. This is often for older people with dementia that include aspects of challenging behaviour or for specific requirements for palliative care but may include other agreed needs. There must be a local mechanism in place that can accept when a

person is admitted to a care home and additional staffing resources are required to meet their needs. The agreement to pay additional rates should be initially short-term and reviewed once a person has settled within the home. A provider should be able to seek an assessment of an older person's needs that can adjust the locally agreed rate because it is demonstrated that additional staffing are required to meet a person's needs. Local health boards and local authority staff should be able to work together to complete their assessments in a speedy manner to ensure there is no delay to a person's admission/care plan being in place.

There is a view that commissioners might want to move towards a model where the acuity and level of care needs of a resident is the determinant over what cost might be paid for their care. This approach is already being developed in Wales for aspects of patients who require nursing care. This may well offer a future approach to calculating the costs of care but there needs to be more research before it could be confidently established. In fact, until there is a good understanding on the current costs of care is very unlikely that a person centred cost model could operate. Commissioners might want to consider examining this once they have established their local cost base.

5.3 Non-staffing costs

There is a similar calculation to be made for the non-staffing costs for a care home. The standing committee will need to reach agreement about what these costs are (see the list below) but the process should allow for some discussion as to what may or may not be included.

One example is whether the owner can legitimately purchase a car for their use through the company that runs the care home? In most cases the answer will be yes if they use the car to visit prospective residents; procure and transport goods; and offer transport to staff. Each of the expenses below must be agreed by the standing committee. The average costs are then calculated after inclusion in the spread-sheet. The non-staffing costs may be broken down further into the sub-sets as listed below:

	Non-Staffing Costs	
Food	Business rates	Gas
Oil	Electricity	Water
Tel/Broadband	B&C Insurance	Vehicle insurance
Trade	Bank	Fixtures and Fittings
Garden	Accountancy, Payroll	Training
Vehicle Cost	Recruitment	Adverts
Assistive Technology	Call Systems	IT
Waste collection	Fire Equipment	Stationery
General Maintenance	Licences and registrations	Repairs
Bedding and Linen	Patient Welfare/Activities	Clothing
Plant Hire	Laundry	Leasing Costs
Crockery etc	Travel/Accommodation	Medical Costs
Subscription	Private Health Insurance	
Marketing and Advertising		

This list is indicative of the areas where cost may be collected but can be adapted to suit local circumstances. This list should be developed locally to suit the way care homes operate and account for their costs in a particular area.

5.4 The overhead and management costs

There has been found to be significant variations between care homes for the overhead and management costs. There can be, for example, significant variation between those larger providers who are running a number of care homes and the smaller homes where the owner also runs the home day-to-day. The evidence can be used from the data collated to agree the respective cost for overheads and management. It is estimated that this is likely to be between 4%- 5% of the overall costs.

The methodology described above assists in creating an '*average overhead cost'* for care homes in an area. This can be established from the spread sheets which capture the returns from the providers. Individual providers can make a special case where necessary.

6 Step 3: Make a set of decisions!

Once the costs have been collected then an average cost has to be calculated. It is advised that any significant outliers (where costs are more or less than 15%) should be excluded from this calculation unless there is a good reason not to. These homes should be advised of their position to see if there either is a problem with their data or they may need assistance with their costs (or can contribute to others lowering their costs). The figure for the average costs of care for the different types and /or sizes of care homes can then be put into the spread sheet. There then needs to be discussion on the calculation of the following aspects of the costs which are laid out below.

6.1 Return on capital and investment

The return on capital investment is a concept that some commissioners have found difficult to grasp and they may need accountancy advice as to how best to deal with this. The Chartered Institute for Public Finance Accountants (CIPFA) has produced their helpful toolkit for commissioners (and finance officers) – *Working with care providers to understand costs (2017).* In Chapter 3 of their toolkit they clearly explain why providers of care (whether for profit or not-for-profit) will require both a return for their investment and make an expected profit on their business. Commissioners (and their accountants) might consider this guidance on these matters when considering how to proceed.

The concept is relatively straightforward but the calculation and the amount to be paid can be seen as controversial for commissioners (and elected members). For a number of reasons care home owners will need to keep investing in their business if they are going to both modernise their facilities as well as keep pace with changes in the requirements from regulators. Commissioners will want to ensure that their local care market is sustainable and is developing to meet local needs. LaingBuisson[5], argue that

"An adequate return on capital for care home operators is the key to achieving a stable sector of sufficient quality and size to meet the commissioning needs of councils and their NHS partners".

Return on Capital Employed (ROCE) is an essential part of care fees. It is necessary for the enterprise to remain viable and to continue to deliver the service. The income is required by the provider for several purposes:

- **Servicing the 'capital employed'** in other words the money tied up in the home that could otherwise be used for another purpose and providers may withdraw or not invest in renewing stock if the return is insufficient.
- **A return to the provider for running and managing the enterprise** in addition to the traditional management tasks always provided, such as appointing and overseeing the manager, managing the finances etc. New requirements introduced under RISCA from 2018 have been placed on the Responsible Individual – these will all need to be taken into account.
- **A provision for the risk related to the enterprise**, this is both the financial and reputational risk dependent on unknowns like future fees, changes in demand or commissioning policy. These will need to cover for example dips in occupancy, which cannot be made up by, for example, selling the same bed twice later in the year in the way that other businesses might.
- **A provision for upgrading and improvement of the facilities** both premises and services.

NB: The toolkit has separately dealt with day to day maintenance (capital and annual). This element provides for renewing or maintaining of existing facilities which is not included in the ROCE.

It is recognised that it is difficult to estimate these costs taking into account the different models of ownership even within one local authority area. The most extensive work in

[5] Laing and Buisson Market Report 2010. See the following website for most recent update https://www.laingbuisson.com/shop/care-homes-older-people/

this area has been undertaken by LaingBuisson who state in their annual review of the care market:

> *"Calculation of capital costs must be independent of capital structure, otherwise users of the model are faced with the impossible task of calculating capital costs for an infinite combination of mortgages, other loans, leases and the imputed cost of the proprietor's own capital, or, just as bad, choosing a single capital structure as a 'standard' for the purposes of calculating capital costs."*

LaingBuisson have looked at the rate of return required by the corporate providers, on the basis that they will represent the most efficient investors. You may want to consider the prevalence of corporate providers in your area and if it is not attractive to them why not and whether you wish to make it more so or would prefer a reward structure more appropriate to providers in your area to take into account the four factors above.

One approach where caution must be taken is in basing the return on capital on actual borrowing of individual homes. This could be seen as rewarding riskier enterprises with higher borrowing and incentivising higher borrowing and lower equity by providers to increase fees. Using borrowing costs as the primary consideration leads to an unstable ROCE calculation and usually understates the real required ROCE as it does not take account of all four bullet points listed above.

The difficulty is in arriving at an appropriate ROCE. This should be arrived at by applying an estimate for rate of return to the estimate of capital employed. Both parameters can be estimated from the market. Again as LaingBuisson state:

> *"Market behaviour is the best indicator of what investors' reasonable 'whole business' ROC expectations actually are, and by extension, a good indicator what the ROC benchmark should be for the purposes of the Care Cost Benchmark model"*

LaingBuisson arrive at the current ROCE of 11% by considering the rates prevalent in the market for modern efficient care homes. In the 2016/2017 version the rate had dropped from 12% to 11%. To explain how it is split their report has used readily available market data. For the efficient corporate provider the split of the return is made as follows:

- 1.5% for the cost of management of the home.
- 6.0% for the pure cost of property (bricks and mortar) without the operational part.
- This number has been arrived at by looking at the yield achieved by providers selling the property to a landlord and then the provider becoming the tenant. The commercial initial yield *(sale and leaseback)* in these transactions is around 6%. After the sale by the provider the landlord has no operational or management input, in effect they only collect rent on this property.
- 3.5% for the return to the operator to run the home.

The 6% represents servicing the capital employed i.e. the second bullet point above, with the other three bullet points split across the 1.5% plus 3.5%. This is the split for the

large corporate provider. The split will be different for other providers and the data *(usually from business transfer agents)* is usually scant. However, it is a reasonable assumption for the commissioner to estimate the rate of return using large corporate provider data as this tends to be lower than other providers who do not have the scale or efficiency. In effect the large providers' rate underpins the ROCE estimate. However, as noted earlier commissioners may wish to consider how their provision differs.

This percentage will then need to be applied to the cost of land and beds and LaingBuisson currently also includes a start-up cost. Recent LaingBuisson cost estimates in England would give £99,000 per bed, however we would except that given lower land values in Wales, somewhere in excess of £80,000 per bed would be more realistic. Commissioners will also need to consider whether they pay a premium in this area for provision that meets the RISCA requirements for new builds and extensions.

In summation, there are various approaches to estimate the capital employed. The capital employed should be the best estimate of the enterprise value. The replacement value of the care home is one way of arriving at this. LaingBuisson estimates this by looking at the new build cost and then discounting this to allow for the lower quality of the older care homes. Some commissioners have tried to estimate this from the balance sheet of the care home, but these are unreliable as they usually represent historic costs and do not resemble the current costs. This usually understates the capital employed.

Care Forum Wales advise that they use an inflation factor developed by the Royal Institute of Chartered Surveyors (RICS) for their members which includes both the value of the rooms in the home (including areas such as corridors, laundries and kitchens) as well as the value of the land. It is suggested that an independent process is established to achieve these values.

There are some care homes where the provider does not own the building or the land but they lease the premises from a third party (a leasing company). Charges will be made by the leasing company of the provider to cover costs. These payments are likely to be at similar levels to those which other providers may have to make if repaying interest rates (though some are higher). For another set of providers they may be funded by an investment where a group of individuals or a pension fund (or similar investment body) have put forward the money to purchase the care home and expect a high return for their investment.

Whatever method has been used to fund the land and the buildings for a care home there will need to be a local way developed to determine the costs to the provider. This can either be achieved individually with each care home or an average locally agreed figure may be included. It is important that commissioners include this figure in their cost of care calculation. This figure does not include the additional calculation for care home owners in relation to their operational risks (see below).

6.2 Taking a collective decision about how these matters will be handled

For care home owners this is a really important issue. From their viewpoint unless there is a proper return on capital there will not be a healthy sector encouraging much-needed investment (and a market permitting existing providers to exit the market in a proper and fair fashion). Nor will it enable providers and commissioners to discharge their statutory

responsibilities to run/foster sustainable businesses and so to secure the future viability of the sector.

LaingBuisson calculate on an annual basis what the return might be and this does vary from year to year. They consider the level of interest rates and the attractiveness of the care home market for current and future investors and the profit margins that might be expected. A recent factor where private equity and venture capital companies have started to invest in the care market might add to the expectations from providers (or their investors) for a larger return. In 2018 they are advising that the combined rate for the property value and the risks to be borne by the provider are in the region of 11%[6].

There may be some ways of funding care homes that come at such a high cost that no public body will want to procure care from these places. However, for every care home there does need to be included in their costs a sum for repayment of interest rates and the management of risks for the care market.

The key issue here is that commissioners and providers should jointly agree a process for how the value of the property and the land is going to be calculated and agreed as well as a reasonable figure for the management of risk in the care market to arrive at a figure for the return on capital investment. There are different ways of doing this but it should be locally agreed.

The CIPFA paper refers to the need to consider the accounts of care homes using EBITDARM (earnings before interest, taxation, depreciation, amortisation, rent and management fees). It is important that commissioners use those with accountancy knowledge and skills to assist in considering the appropriate compensation to care home providers while also bearing in mind the CIPFA paper was written based on English legislation and regulatory requirements.

This is one of the most important parts of the local negotiation and needs to be handled with proper care by both providers and commissioners respecting each other's different pressures.

6.3 Occupancy levels in care homes

Many care homes operate from time to time with bed vacancies. Obviously, if all the beds are not filled then the homes will not be receiving the anticipated income.

Typically, care homes cover loss of revenue by asking the person paying for the bed to meet the costs for a short period after the bed is vacated. It is reported that this may be

[6] Laing and Buisson Market Report 2010. See the following website for most recent update https://www.laingbuisson.com/shop/care-homes-older-people/

between 3 – 7 days extra. However, providers report that even where they have a waiting list of potentially new residents looking to move in to an unoccupied bed, it can often take a couple of weeks to make the necessary arrangements (this can be longer if the room requires redecoration after occupation). The Care Inspectorate Wales (CIW) reports an average of a 90% occupancy rate for care homes in Wales.

It is possible to use the results from the open-book accounting exercise with providers and from the questionnaire to get a sense of the average levels of vacancies within care homes in a particular area. It is important that this matter is discussed and a view taken as to what level of occupancy might be considered within the agreed cost of care and to what extend an additional payment is agreed to cover vacancy rates. Many providers argue this should be set at the Welsh average (of 90%) – the toolkit implies that this should be considered and looked at in the light of local circumstances. It also needs to be borne in mind that a bed that is vacant cannot be 'sold' twice the following week and thus calculations here are different from many other businesses. This is a matter for local negotiation.

6.4 Quality premiums

It is argued by some commissioners and providers that there could be some financial reward for those care homes which offer a consistently higher level of care quality. Any figure agreed should be over and above the agreed local price for care. Others have stated that all care homes should be of a good enough quality to offer residents a good and positive experience with quality care. Payments should not be reduced because a home is performing badly or offering poor quality. Providers who are struggling should be helped to improve their care but financial penalties should not be imposed as they are only likely to exacerbate the situation.

Agreeing any additional 'quality payment'" is a matter for local negotiation. LaingBuisson propose that the best way to achieve this is through an acceptance of the grade offered to the residential home by CIW (the regulator). Hence the decision about any quality payments needs to take into account the current CIW inspection arrangements under RISCA. It is suggested that where there is a local agreement to pay a quality premium that this does not exceed 3% of the value of the contract.

Some have suggested that quality has two quite different aspects – the overall quality of care and the outcomes achieved for residents and separately the quality of the physical environment. The toolkit suggests that the former is a matter of necessity for all registered care homes in Wales and that the physical environment is addressed in the section on return on capital. There is a particular issue that new provision and extensions under RISCA require higher physical standards than pre-existing accommodation. This is a matter to be determined locally though the workshops that assisted with the development of this toolkit did not recommend additional quality payments were made.

6.5 Profits

Any person running a business expects to receive some reward for the trouble of taking the risks and developing the services (in addition to the matters raised above with regard to return on investment). Owners of care homes are taking such risks when they enter the care market. This should be recognised within the price a commissioner may

want to set. How the owners of care homes use any profit margin has to be their choice – some (particularly the not-for-profit sector) may use the amount to invest further in the care sector (to the overall benefit of the sector), others may choose to take a dividend payment from the business as a personal reward, whereas in the not for profit sector they would be paid a salary. How the monies are used is not the business of commissioners but they should recognise the importance of building a reasonable profit into the price as a means of sustaining the local market. Risk factors as identified in this toolkit also need to be taken into account as well as the return to the provider for running the enterprise.

6.6 Annual uplifts

Once the above process has been completed the standing committee will have to take a view on how this needs to be repeated. One option is to invite providers to make representation on an annual basis on specific cost pressures that they have experienced in the previous year. There are always likely to be changes to the minimum wage and national living wage, to pension contributions as well as to the cost of living index. These can be considered in turn and the standing committee can take a view as to whether this requires further investigation through the examination of accounts or a further survey for providers or can be accepted as a pressure and included within any agreed calculations for the following year.

Many commissioners might start their annual negotiations by applying an indexation based on the retail price index (RPI) to the different sectors of supplies and services, from the base figure. There has in recent years been an offer of uplift for the wages rates to the level of the national living wage or 1% whichever is the higher. This of course can be applied to the spread sheet which has already been established. There should be a locally agreed figure to be used as the index for inflation to be added annually.

It is suggested that a fuller analysis of the costs in the care market take place once every three to four years or if particular pressures are identified by the standing committee where the impact on costs are not fully understood.

6.7 Austerity and the public sector

After the final calculations have been made it is possible that local authorities and local health boards consider that they do not have sufficient resources within their budgets to fund the cost of care that their local calculations have produced. If this occurs, (though in most circumstances if there is to be a sustainable care market the costs agreed should be funded) there should be a local plan developed as to the period of time in which the public bodies will strive to find the resources to fund the care at the appropriate level. Commissioners should be aware that failure to meet the accepted costs of care (by all parties) are likely to lead to a break in confidence from the providers and could well lead back to legal action which should be avoided. On the other hand, it is absolutely recognised that the issues raised within the toolkit are both complex and require skilful negotiation to get it right for both parties. Many of the key decisions require joint agreement and maybe some compromise on both sides.

7 Some Other Issues to Consider

7.1 Retainers

There should be a clear local policy in place to establish the price that will be paid for an older person who is absent from the care home for a period of more than one week e.g. a period in hospital. The costs of keeping the bed available for the person should be recognised whilst some costs such as food or other provision may allow for a small discount (though this is negligible within the overall costs of retaining the bed for the resident).

It should be noted that staffing is likely to be maintained and Welsh Government discourages the use of casual contracts in the care sector which would enable staffing hours to be reduced more flexibly. Providers also prefer to have a reliable and consistent workforce.

7.2 Intermediate and short term care

It is expected that in the near future there will be more requests from commissioners for short-term or intermediate care beds that are focused on supporting older people in recovery from hospital or other significant events. The main aim of these beds is to help people to recover, recuperate or rehabilitate following a physical or an emotional event.

There will be a high expectation that residents live in the home for no more than six weeks whilst their recovery is supported. To support the recovery needs to be therapeutic help (occupational or physiotherapy); for some will require nursing or other medical help (e.g. managing and monitoring medicines) and support staff who understand the principles of reablement /rehabilitation.

In some places these beds are procured at a higher cost (allowing for better qualified staff; in-house medical support; and a high turn-over of residents). In addition some commissioners will pay an additional reward for those providers who are successful in helping older people return home (often a figure of 75% people returning home will trigger a financial reward). If any resident is placed permanently in the care home following their short-term admission they should revert to the agreed price for care.

These services require an additional negotiation to agree price and the terms of the contract (e.g. payment for outcomes).

7.3 Cost of nursing care

This approach can capture the average cost of nursing care. The model allows the rate to be calculated and then discussed between the local health boards and the providers. Nursing care can be treated as a separate line for staffing on the spread sheet. The

costs of this can be separated out from other costs and the evidence provided as to what are the average current costs. This will not necessarily equate to the rate at which the NHS will pay for that care and this is being reviewed separately. Of course medical equipment and other associated costs for nursing care need to be included too. Because nursing and Continuing Health Care rates are set by the health boards in Wales it will be their decision as to whether nursing care costs are included within the toolkit or not. The advice is that there should be a move from health boards to ensure that they are meeting the costs of nursing care to avoid the legal debates and challenges around the Funded Nursing Care rates in the last few years.

8 Making Final Calculations

The agreed recommended costs for running care homes in an area/region are then calculated by adding together the sum of the matters discussed from above:

- The average costs of staffing (depending on type and size of home)
- The average costs of the agreed items of expenditure (not staffing) but including all reasonable running costs
- The agreed return on capital
- The agreed occupancy premium
- The agreed profit line for providers
- The agreed quality payment (though not recommended)

A total amount can then be recommended by the standing committee. Their recommendations will then have to be accepted (or otherwise) by each of the local authorities or health boards that participated in the process. If a local authority or a health board were determined not to adopt the regionally (locally) recommended price then they should both explain this to the standing committee with their reasons and propose a way in which they might be prepared to pay the recommended price over a period of time.

9 Conclusion

There are some quite complex and difficult questions that need to be answered if commissioners and providers are going to come to agreement on the cost of care. There are no scientific answers to the questions posed. What is needed is a process where openness, trust and flexibility are the established culture. *No one party should impose a solution on the other.* Both parties should accept that there will need to be a compromise. The most challenging areas include agreeing the right level of staffing for the needs of the residents; agreeing whether a vacancy rate should be included in the calculation; agreeing a reasonable return on investment and understanding the possible impact of borrowing on the care homes (interest rates). It may be accepted that there may need to be a premium to reward quality care providers.

It is unlikely that agreement is straight forward. Both parties will need to accept some degree of compromise. It is ultimately important that local people have good quality care available for them that is sustainable for the longer term.

In relation to introducing this approach it is advised that any current negotiations should continue to reach a conclusion before this approach is trialled. If the current approach in a particular area is satisfactory for both commissioners and providers and it works to obtain a fair price then that should continue.

10 Acknowledgements

The toolkit has been based on work that has already been developed across Wales. In particular the toolkit has heavily relied on work Carmarthenshire County Council has undertaken, which has addressed many of the key questions raised. A particular note of thanks goes to colleagues from their Finance and Commissioning Teams who have been extremely helpful in finalising this toolkit.

Since 2006, COSLA (Convention of Scottish Local Authorities) and Scottish Care/Coalition of Care and Support Providers in Scotland (acting on behalf of providers) have negotiated and agreed a common contract (known as the National Care Home Contract) for all care homes across Scotland. This is negotiated at a national level and accepted by most authorities and providers. The annual negotiation sets a price to be paid for nursing and residential care and amends any contract terms. There have been helpful exchanges between staff in Scotland who have worked on this contract and this work in Wales. The Scottish model has also influenced this toolkit. The spread sheet approach that is proposed in this toolkit has also been developed by Excel Scotland (a national procurement hub) on behalf of their local authorities. However, negotiations in Scotland on the findings from the spread sheets have not concluded to the point where there is agreement on the way forward.

The toolkit has also drawn on the work of LaingBuisson who have established themselves as one of the main bodies who examine the fair price of care of behalf of the providers in the UK. The toolkit does not always come up with the same answers as LaingBuisson but has looked closely at and where appropriate followed the methodology they have already established to answer some of the more contentious issues that require resolution. Reference is also made to the CIPFA document *Working with providers to understand costs* that is a useful guide for commissioners, and to the work of Mazars on the costs of nursing care in England.

Professor John Bolton
Institute of Public Care
August 2018

Appendix One

Questionnaire used by Carmarthenshire

CARE HOME COST RETURN

Name of Home	

Name of contact person for queries	
Contact telephone number	
E-mail address	
Statement of accounts provided for year ending - specify date	

Please complete the following from information relating to the year of account provided bearing in mind that these are no longer registration categories		
	No of beds	Occupancy %
Residential		
Residential EMI		
Nursing		
Nursing EMI		
Total Number of beds		
Average Occupancy for the home %		

Please provide the gross annual pay excluding employers' NI, employers' pension contribution for the year of account provided	£ per annum
Care staff	
Catering staff	
Domestic staff	
Gardener handyman	
Care Home Manager	
Care Home Assistant Manager	
Clerical staff	
Nurse - level 1	
Nurse - Level 2	
Payments to Directors	
Payments to staff not included above	
Total employers NI cost	
Total employers pension contribution	
Total Pay (should equate to P&L figure(s))	

Please provide the following hourly rates which applied during the year of account provided			
	As at <u>first</u> day of year of account	As at <u>last</u> day of year of account	Date on which change occurred
Hourly rate £ - carer non NVQ			
Hourly rate £ - carer NVQ2			
Hourly rate £ - Senior carer			
Hourly rate £ - chef/cook			
Hourly rate £ - catering assistant			
Hourly rate £ - domestic			
Hourly rate £ - Gardener handyman			
Hourly rate £ - Nurse 1			
Hourly rate £ - Nurse 2			
Usual date when hourly pay rates are reviewed/changed			
Anticipated date of next increase			

Please state the contract hours per week during the year of account provided for the following	Contract hours/per week
Manager	
Assistant Manager (s)	
Clerical staff	

Please state the employers percentage pension contribution for each of the following	%
Carer non NVQ	
Carer NVQ2	
Senior carer	
Chef/cook	
Catering assistant	
Domestic	
Gardener handyman	
Hourly rate £ - Nurse 1	
Hourly rate £ - Nurse 2	

For one sample week during the year of account provided please give total hrs for the following	Rostered Hours	Hours needed to be delivered (based on occupancy)	Actual Hours delivered
Carer non NVQ			
Carer NVQ2			
Senior carer			
Chef/cook			
Catering assistant			
Domestic			
Gardener handyman			
Nurse - level 1			
Nurse - level 2			
Other staff (not included elsewhere in this return)			
Date of week that information relates to			
In that week what was the % occupancy of the home			

If the care home was fully occupied (100%) please give the total weekly hours that would be rostered	Weekly hours
Carer non NVQ	
Carer NVQ2	
Senior carer	
Chef/cook	
Catering assistant	
Domestic	
Gardener handyman	
Nurse - level 1	
Nurse - level 2	

From the profit and loss part of the set of accounts provided please show the following annual amounts	£ per annum
Food	
Business rates	
Heat and light	
Telephone	
Water rates	
Insurance - buildings and contents	
Insurance - vehicles	
Insurance - public liability, third party etc	
Insurance - other	
Medical supplies	

Trade/clinical waste	
Bank charges	
Interest payments	
Repairs and maintenance including servicing and testing	
Major repairs (please give description)	
Replacement of non-capital items	
Training costs	
IT costs	
Advertising costs	
Vehicle running costs	
Office supplies	
Other costs	

For each loan that the business had during the year of account provided please give the following information	
Loan 1	
Purpose of loan	
Year taken out	
Original value of loan	£
Outstanding amount at end of year of set of accounts provided	£
Amount of interest paid during year of account	£
Interest rate payable on loan at end of year of account	%
Loan 2	
Purpose of loan	
Year taken out	
Original value of loan	£
Outstanding amount at end of year of set of accounts provided	£
Amount of interest paid during year of account	£
Interest rate payable on loan at end of year of account	%
Loan 3	
Purpose of loan	
Year taken out	
Original value of loan	£
Outstanding amount at end of year of set of accounts provided	£
Amount of interest paid during year of account	£
Interest rate payable on loan at end of year of account	%

Appendix Two

Policy for Carmarthenshire County Council

The purpose of this policy and procedure is to explain the process by which the Council sets a fee level for residential and nursing care home providers for older people that is appropriate, fair and justifiable recognising that the Council must at all times balance its fiduciary duty to its tax payers so as not to waste their money against the statutory duties required of it.

Policy Context
Carmarthenshire County Council as the Social Services Authority for Carmarthenshire has an obligation under Section 21 of the National Assistance Act 1948 to provide Residential Accommodation to those in its area who by reason of age, are in need of care and attention not otherwise available to them

(1)Subject to and in accordance with the provisions of this Part of this Act, a local authority may with the approval of the Secretary of State. And to such extent as he may direct shall, make arrangements for providing –

(a) Residential accommodation for persons aged eighteen or over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them

The Welsh Government Fulfilled Lives, Supportive Communities:

Commissioning Framework Guidance and Good Practice Standard 10 states:

"Commissioners have understood the costs of directly provided and contracted social care services and have acted in a way to promote service sustainability"

"Local authorities need to have mechanisms in place to discuss costs and performance with providers. Fee setting must take into account the legitimate current and future costs faced by providers as well as the factors that affect those costs."

The Council is required to have robust and effective commissioning arrangements.

This should include:

Obligations

The Council will:

- Invite care providers to submit their costs in October of each financial year using a standard template prepared by the Council.
- Meet with representatives of the care home sector on a six-monthly basis to review the costing framework prepared by the Council, taking account of all influencing factors that may affect the fee level.

Additionally, the Council will seek to communicate its strategic vision and commissioning intentions via relevant methods e.g. Annual Meeting between Director

and Executive Board Member with representatives of the Care Home Sector, Older Person Provider Forum, Community News, Publicity Events, Council Website.

The Council will develop and maintain a methodology in the assessment of the costs of care home providers. This will include

- Develop an annual market position statement in assisting its evaluation of the care home sector.
- Ensure an open and transparent decision making process is followed that is recorded and open to scrutiny.

The report will be submitted to the Social Care, Health and Housing Strategic Leadership Team for consideration and approval. The decision will be recorded.

The report will be submitted to the Council Corporate Management Team for consideration and approval. The decision will be recorded.

Exceptions to this process will take place where the Director of Social Care, Health and Housing determines an alternative and preferred method of decision making is required.