DERBY CITY COUNCIL

LEADER OF THE COUNCIL CABINET MEMBER MEETING
8 April 2011

ITEM 5

Report of the Strategic Director of Adults, Health and Housing

Independent sector fee rates for 2011-12

SUMMARY

1.1 For the last three years the fee rates for home care and care home providers on "standard" terms and conditions have been tiered in relation to the Care Quality Commission (CQC) rating of that provider. Providers with a Good or Excellent rating have received the top rate, Adequate providers have received the middle rate and Poor providers have received the bottom rate. CQC have now scrapped their rating system so the Council needs to consider how the fee rate system should be amended in accordance with this.

1.2 The Council also needs to consider its approach to setting fee rates for home care and care home providers in 2011-12. Issues for care home providers in particular need to be considered in view of the recent Pembrokeshire judgement.

1.3 The Council's fee rates for independent sector homes also need particular attention because of the relatively low dementia rate and the general lack of development of residential dementia care in Derby.

RECOMMENDATIONS

2.1 To inflate all care home and home care providers to the current highest tier of fee rates and use that as a starting point for 2011-12 fees.

2.2 To offer no further uplift to home care providers.

2.3 To offer a 1% further uplift to both residential and nursing care home providers.

2.4 To approve a new fee rate for dementia care in residential homes only, with a £404 per week rate that is obtainable only by care homes that have demonstrated they have met necessary criteria in terms of staffing and design.

REASONS FOR RECOMMENDATIONS

3.1 Maintaining a tiered fee rate system would require the Council to take over from the Care Quality Commission in determining how providers moved between ratings. This would require significant staffing capacity, from the ability to review all provision on a frequent and in-depth basis, to the requirement to deal fairly and promptly with the

inevitable challenges from providers. Above all there is no significant evidence that relatively small fee rate premiums actually incentivise better quality.

3.2 Four out of five providers in both the home care and care home sector are paid the top quality premium already. The remaining 20% of providers are at the middle quality rate. Inflating 20% of providers to the top rate is affordable for the Council and is the most pragmatic approach to moving away from the tiered system. Cutting the rates of the top 80% of providers would involve significant risks of challenge and of business continuity in the current legal and financial climate.

3.3 The home care provider market in Derby is in a position to absorb inflationary pressures. Current procurement lends itself to economies of scale and minimisation of travel costs by creating a strong link between "preferred providers" and specified localities. There is a strong supply of independent sector home care provision, minimising the impact of business continuity issues for individual providers. Derby's in-house home care service also provides a contingency should any individual providers struggle to provide a service in current market conditions.

3.4 The care home provider market in Derby has been stable for a considerable period of time and ought to be able to absorb at least some inflationary pressure. The current level of in-house residential care also provides a contingency for residential placements only. There is a demonstrable over-supply of nursing home places in the city with high vacancy levels at several homes. Nevertheless, there is a considerable risk that care home providers will seek to transfer their perceptions of inflationary pressures onto third parties (typically family members) who provide financial support to care home placements that are above the Council's published rates. Therefore it is advisable for the Council to seek to provide an inflationary payment to care home providers to minimise the risk to third parties.

3.5 Derby's top dementia rate for residential care is £352 per week, considerably lower than almost regional comparators. In reality most people with dementia are placed in residential care at the Very Dependent Elderly Rate of £369 per week. Even this is much lower than the rates most other East Midlands authorities are paying for good quality dementia care.

SUPPORTING INFORMATION

4.0 Summary of fee rate changes

4.1 The table below shows how rates are proposed to change for residential and nursing care.

Residential	April 2010 Basic*	April 2010 Standard**	April 2010 Premium***	April 2011 All
Elderly	318	323	328	331
Elderly Mentally Ill	342	347	352	356
Very Dependant Elderly	359	364	369	373
Physical / Sensory Imp	431	436	441	445
Learning Disabilities	381	386	391	395
Mental Ill Health	335	340	345	348
Drugs / Alcohol	335	340	345	348

Nursing	April 2010 Basic*	April 2010 Standard**	April 2010 Premium***	April 2011 All
Elderly	370	375	380	384
Physical / Sensory Imp	433	438	443	447
Learning Disabilities	382	387	393	396
Mental Ill Health	371	376	381	385
Drugs / Alcohol	371	376	381	385

4.2 The table below shows how rates are proposed to change for home care.

	2010-11			2011-12
	Basic*	Standard**	Premium***	All
Day Time Care				
Per Hour	£11.00	£11.11	£11.31	£11.31
Per ¾ Hour	£8.24	£8.33	£8.48	£8.48
Per ½ Hour	£5.50	£5.55	£5.66	£5.66
Per ¼ Hour	£3.72	£3.76	£3.84	£3.84
Night Time Care				
Per Hour	£12.20	£12.30	£12.50	£12.50
Per ¾ Hour	£10.18	£10.25	£10.40	£10.40
Per ½ Hour	£8.24	£8.28	£8.38	£8.38
Per ¼ Hour	£5.58	£5.66	£5.74	£5.74
Weekend Care				
Per Hour	£12.20	£12.30	£12.50	£12.50
Per ¾ Hour	£10.18	£10.25	£10.40	£10.40
Per ½ Hour	£8.24	£8.28	£8.38	£8.38
Per ¼ Hour	£5.58	£5.66	£5.74	£5.74
Sleep-in Care	£5.55	£5.66	£5.86	£5.86
Live in Care	£926.00	£938.00	£949.40	£949.40

* All providers rated as “Poor” by Care Quality Commission (CQC)
** All providers rated as “Adequate” *** All providers rated as "Good" or "Excellent"

5.0 Changing the tiered fee rate system

5.1 In practice 82% of care homes and 81% of home care providers are on the Premium rate already because they have secured Good or Excellent CQC ratings. This reflects the steady progress in recent years that providers have made in securing higher CQC quality ratings.

- 5 Nursing Homes and 3 Residential Homes are paid on the Standard rate, while 20 Nursing Homes and 16 Residential Homes are paid at the Premium rate.
- 4 domiciliary providers are paid at the Standard rate and 17 are paid at the Premium rate.
- No providers, either care home or domiciliary, are paid at the Basic rate because there are no providers rated as "poor" by the CQC in Derby.

5.2 This relatively small amount of activity at the Standard Rate means that the financial pressure from making the change would be just below £46K per year.

5.3 The pattern of CQC ratings et out in 5.1 also reflects the fact that the CQC system had become a blunt instrument in determining quality. The Council has other more effective ways of incentivising quality than via small increments on fee rates. For home care:

- The Preferred Provider system means that providers are assessed on an annual basis about their quality and sustainability before being in a position to pick up regular work from the Council
- Quality monitoring is developing via the Brokerage Team and will be linked to better public information to help deliver personalisation
- The Council will also need to move away from a fixed price system over time, so that people with Personal Budgets can make decisions on the basis of both quality and cost.

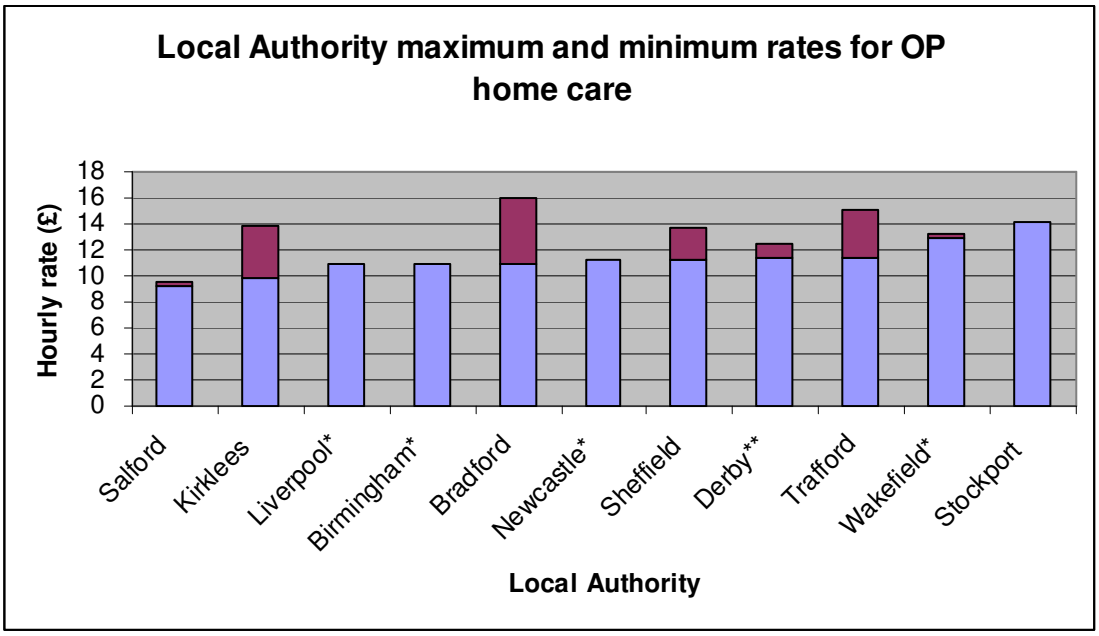
For care homes:

- The Council and the NHS are working in partnership with LINk to publicise the outcomes of their visits to care homes
- Improved Council quality monitoring capacity will also help this: see below.

6.0 Benchmarking domiciliary rates

6.1 Derby's current rate is £11.31 for weekday care, and £12.50 for evening and weekend care. Previous comparison with other East Midlands authorities has seen Derby come out as the lowest payer in the region. However, county coverage is inherently more expensive because of travel costs. The chart overleaf was compiled from data collected by another council to compare home care rates of Midlands / Northern urban local authorities. Caution should be exercised when comparing rates because some include travel and some do not. Derby's rate is inclusive of travel: the inclusive rates of Liverpool, Birmingham and Bradford might well elevate them above Derby in this chart.

6.2



* These authorities also pay travel rates in addition to their basic rate.
**Only premium rates are used for Derby in the chart. Using the lowest rates will distort the picture presuming recommendations 2.1 and 2.2 are accepted.

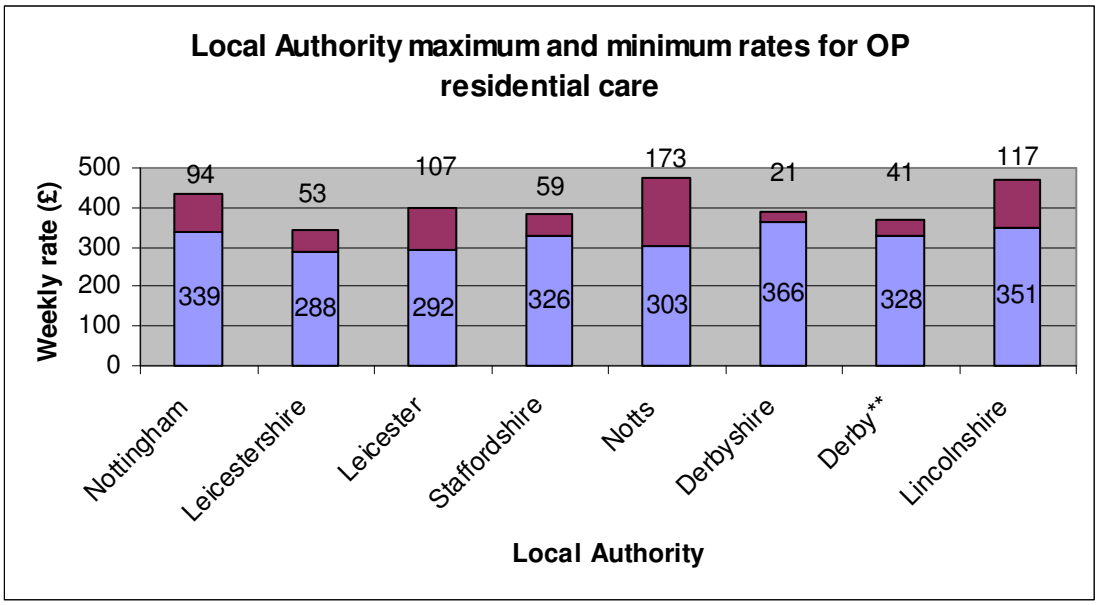
6.3 Although there are risks in relation to sustaining quality, not inflating the Derby domiciliary rate for 2011-12 is supported by the following arguments:

- Almost all new business is given to eight Preferred Providers who are therefore in a position to benefit from economies of scale
- The Council's in-house service is large enough to manage any business continuity risks if necessary
- The Council is providing significant workforce development funding to benefit home care providers

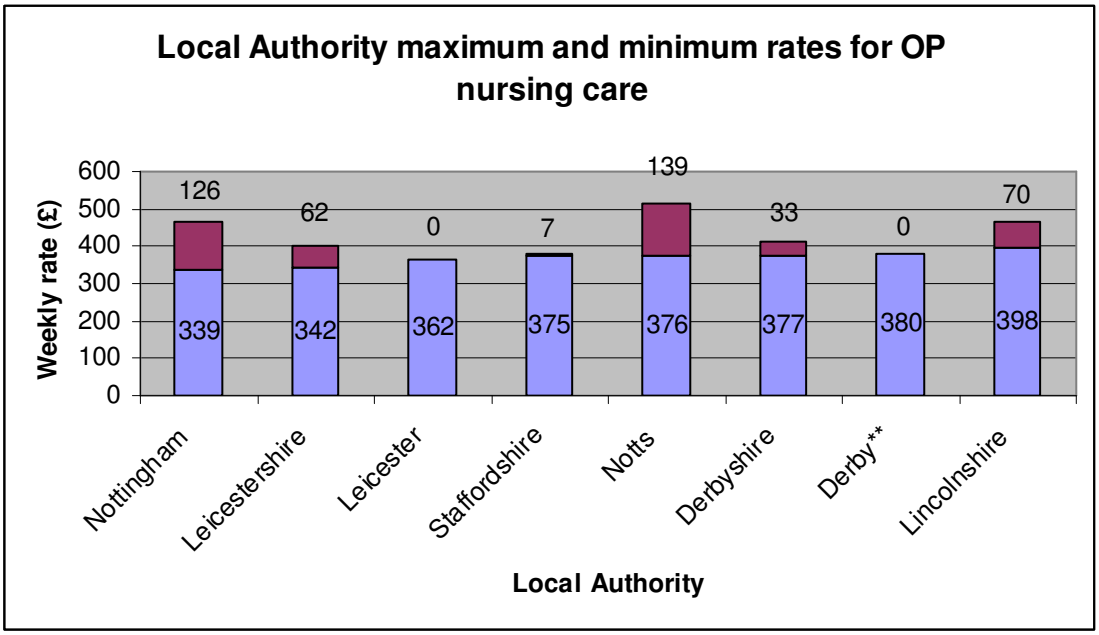
7.0 Benchmarking care home rates

7.1 The charts overleaf show how Derby compares to neighbouring authorities in terms of 2010-11 care home fee rates for older people. The bottom figure is the lowest rate the authority pays, and the top figure is the premium paid for the highest rate. All Local Authorities surveyed paid different rates at different specialisms (as Derby does with the "Elderly Mentally Ill" and "Very Dependent Elderly" rates). Some authorities had fee rates where premiums were paid in relation to quality markers. Most of these did not depend solely on Care Quality Commission ratings like Derby.

7.2



7.3



** Only premium rates are used for Derby in both charts. Using the lowest rates will distort the picture presuming recommendations 2.1 and 2.2 are accepted.

7.4 The tables are designed to highlight two issues:

- The level of the lowest rate (which might be best regarded as each Local Authority's perception of the amount necessary to deliver basic care)
- The amount of variation each Local Authority builds in to fee levels

7.5 Derby has the fourth highest base residential care rate and the second highest nursing home rate. In both residential and nursing care three of the lowest payers (Leicester, Leicestershire and Staffordshire) did not inflate their rate between 2009-10 and 2010-11 while Derby inflated by 1%.

7.6 The tables only show the range of fees. They do not show the number of placements that each Local Authority makes at each rate. For example, Derby funds three times as many people at its top rate than its bottom rate. The table below also illustrates how anachronistic the EMI rate is.

	Percentage of new placements		
Fee rate	**2007-8**	**2008-9**	**2009-10**
Elderly (£328)	27%	21%	24%
Very Dependent Elderly (£369)	71%	78%	73%
Elderly Mentally Ill (£352)	2%	1%	3%

7.7 In summary, fee rate comparisons with other Local Authorities are not very helpful in determining a local fair rate because they lack key details about local market conditions and placement patterns. However they do provide a very visible benchmark, and are often assembled by organisations acting on behalf of care homes via Freedom of Information requests.

8.0 Dementia fee rates for residential care homes

8.1 The proposed £404 fee rate for dementia in residential homes would be related to a clear specification on staffing (levels and competency, linked to Council training initiatives) and design (informed by the University of Stirling toolkit).

8.2 The specification will need to be high enough to enable a real quality improvement in dementia care, but not so high that existing providers have no incentive to apply. It is also important that demand is managed within the available dementia budget, which is sufficient to support the addition of approximately 90 specialist dementia beds each year for the next three years.

8.3 Residential homes will need to be assessed according to their adherence to the specification before being admitted on to the new fee rate. Each assessment will be carried out within the commissioning section and approved by the Head of Integrated Commissioning for Older People and Enablement.

8.4 Dementia fee rates are not proposed for nursing homes. This is because nursing home residents with significant levels of dementia are most often funded under NHS Continuing Healthcare arrangements.

9.0 Consultation with care home and home care providers

9.1 Both sets of providers are invited to quarterly consultation meetings chaired by the Council and also attended by the local NHS. The issue of setting fees for 2011-12 was raised in these meetings by the Council in late 2010 (care homes: 13th October, home care: 8th December). Both sets of providers, as in previous years, were invited to make any representations they wished to on this to reflect their perceptions of pressures. The Council did not receive feedback from any providers.

9.2 Both home care and care home providers were written to in early March 2011 and advised of the proposals within this paper, with a planned implementation date of 11th April 2011.

9.3 Follow up consultation meetings were set up with home care and care home providers in March (care homes: 11th, home care: 23rd) after they had been notified of the Council's proposals. Feedback from both meetings is summarised below.

9.4 **Care home providers** were concerned about the Council's approach.

- As above, there was strong feedback from care home providers within the meeting that they did not support the Council moving away from tiered fee rates and would want to see this reintroduced for 2012-13.
- Providers felt the Council's increase did not reflect actual inflationary pressures and costs that providers faced
- Providers felt the Council's approach should be linked more closely to the modelling of actual care home costs
- Providers felt that the Council's approach to consultation needed to improve, both in terms of offering clearer consultation opportunities and acting on the outcomes of consultation.

9.5 As a response to this, it was agreed at the meeting that the Derbyshire Care Home Association would send the Council a rationale for a modelled rate based on actual costs. This would then provide a basis for structured discussion over 2011 with the aim of informing decision-making on 2012-13 fee rates.

9.5 Although **home care providers** made it clear they faced pressures, in particular from travel costs via increasing fuel prices, they stated they understood the national public sector financial position and expected that the Council would ask them to make efficiencies. No providers at the meeting objected to any of the current proposals. Since the meeting the Council has received correspondence challenging the proposed approach from one national home care provider who was not represented.

OTHER OPTIONS CONSIDERED

10.1 The Council cannot presume that care providers who were assessed by the Care Quality Commission in 2010 or earlier as "adequate" rather than "good" or "excellent" ought to stay on a lower fee rate. The previous quality rating system has by definition disappeared with the change to CQC registration.

10.2 Maintaining a quality-based tiered fee rate system would require the Council to develop its own approach to defining, implementing and reviewing those rates. The Council does not have identified staffing capacity to do this for 2011-12. This report suggests that small increments in fees are not very effective in incentivising quality improvements in any case. However, in view of the strong feedback from care home providers in particular to reintroduce quality-based fee rates, the Council should explore whether an effective and practicable approach to this can be found for 2012-13.

10.3 Not introducing a higher fee rate linked to dementia would mean Derby was out of step with regional authorities, and not acknowledging the higher level of staffing and environmental resource required to deliver effective dementia care.

This report has been approved by the following officers:

Legal officer	Robin Constable
Financial officer	Roger Taylor
Human Resources officer	
Service Director(s)	
Other(s)	

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Background papers:	None
List of appendices:	Appendix 1 – Implications

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 Current records in indicate that there are 53 residential home placements and a further 53 nursing home placements that are funded beneath the premium rate. Inflating these to the premium rate level would cost an extra £27,560 per year (£5 per placement per week).

1.2 Current records indicate that inflating all domiciliary care arrangements to the premium rate would cost a maximum of £18,390 per year based on the current activity of the four providers affected. This is likely to be an over-estimate because an assumption of £0.20 per hour inflation has been applied to all care packages. Actual costs cannot be calculated without looking through individual care packages.

1.3 Establishing a new dementia rate with a £35 per week premium on top of the current Very Dependent Elderly rate will create a funding pressure of £162,000 in 2011-12, £323,000 in 2012-13 and £474,000 in 2013-14 presuming a linear growth to the projected requirement of specialist dementia care beds. This is funded by the growth budget that has been set aside for dementia care.

Legal

2.1 Legal advice has already been sought on care home fee increases because of the Pembrokeshire judgement. The most important conclusions other than the need for clear communication with providers and adopting a proper methodology for calculations seem to be:

- The Council is fully entitled to take into account its own financial position when determining the level of accommodation and care services upon the minimum required by section 21 [National Assistance Act] and in setting the fee rate for those who provide those services, but
- decisions should be made on the basis of proper consideration of effects on providers and/or residents
- the local conditions should be considered
- inflation and any changes in legislation affecting care home providers should also be taken into account

Personnel

3.1 None arising from this report.

Equalities Impact

4.1 None arising from this report.

Health and Safety

5.1 Providers need to be funded to a level that supports them providing a safe service that promotes healthy outcomes.

Environmental Sustainability

6.1 None arising from this report.

Asset Management

7.1 None arising from this report.

Risk Management

8.1 Risk management issues are outlined in the main report.

Corporate objectives and priorities for change

9.1 HC2: To increase the range and quality of regulated and non-regulated adults social care services

9.2 COD2: To deliver value for money across all services