Lincolnshire COUNTY COUNCIL
Working for a better future

Open Report on behalf of Glen Garrod, Executive Director - Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**23 February 2022**
Subject:	**Learning Disability - Section 75 Agreement**

Summary:

Approval is being sought from the Executive on 1 March 2022 to enter a new Section 75 Agreement with the Lincolnshire Clinical Commissioning Group for Learning Disability Services for a period of five-years commencing from on 1 April 2022 and with the opportunity to extend for a further two years subject to the agreement by both parties.

Actions Required:

(1) To consider the attached report and to determine whether the Committee supports the recommendation(s) to the Executive set out in the report.

(2) To agree any additional comments to be passed to the Executive Councillor in relation to this item.

1. Background

The Learning Disability Section 75 agreement creates a pooled budget, a lead commissioner and provides an integrated assessment and care management function for Adult Social Care and NHS Continuing Healthcare. NHS Continuing Healthcare is for people with long-term health care needs which is funded solely by the NHS. Lincolnshire County Council is the existing and proposed lead commissioner for these arrangements.

2. Conclusion

The report to Executive on 1 March 2022 proposes entering a new S75 agreement for five years with Lincolnshire Clinical Commissioning Group. The Committee is asked to consider the proposed paper for Executive and the related Section 75 agreement and provide comments to the Executive on the recommendations being made.

3. Consultation

The Committee is being consulted on the proposals to the Executive, as set out in the attached report.

4. Appendices

These are listed below and attached at the back of the report	
Appendix 1	Report to the Executive – Learning Disability Section 75 Agreement

4. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Justin Hackney, who can be contacted on 07774 661042 or Justin.Hackney@lincolnshire.gov.uk.

Lincolnshire COUNTY COUNCIL
Working for a better future

Open Report on behalf of Glen Garrod, Executive Director – Adult Care and Community Wellbeing

Report to:	**Executive**
Date:	**01 March 2022**
Subject:	**Learning Disability - Section 75 Agreement**
Decision Reference:	**I025459**
Key decision?	**Yes**

Summary:

A Section 75 Agreement is a legal, contractual agreement between local authorities and NHS bodies. It allows one party to delegate delivery of specified functions to the other party if those arrangements will lead to improved outcomes.

The Learning Disability (LD) Section 75 (S75) is a commissioning Section 75 and effectively creates a pooled budget, a lead commissioner and also provides for an integrated assessment and care management function for Adult Social Care and Continuing Health Care. Lincolnshire County Council (LCC) are the lead commissioner the host for the pooled budget and the associated integrated arrangements.

The Learning Disability Section 75 arrangements have been in place between LCC and the responsible Health commissioners for over a decade and delivers outcomes and value for money that would not be achieved in the absence of these arrangements.

The existing Learning Disability Section 75 agreement formally ends on 31 March 2022 and there in no provision to extend the existing agreement past this date. A new agreement will therefore need to be developed and agreed for 1 April 2022 in order that the benefits gained through these arrangements can continue.

This would be as existing with only such changes as are necessary to

(i) adjust the finances to reflect the creation of a new Pooled Budget and

(ii) provide a mechanism for further amendments to allow the development of a new Section 75 agreement for adults with complex needs subject to future agreement by LCC and NHS organisations.

Members are asked to consider the information contained in this report regarding current and proposed commissioning arrangements for Adult Learning Disability Services and approve the recommendations made herein.

Approval is therefore sought for the entering into of a Section 75 Agreement with the

Lincolnshire Clinical Commissioning Group (LCCG) for Learning Disability Services for a period of five-years commencing from on 01 April 2022 and with the opportunity to extend for a further two years subject to the agreement by both parties.

Executive should be made aware that the Section 75 agreement will also need the formal approval of the Lincolnshire CCG and that a parallel decision process is being progressed by health colleagues. The proposed Section 75 agreement includes a draft risk share agreement that sets out respective contributions to the pooled budget for 2022-23 which is also subject to agreement. The risk share agreement is agreed annually traditionally as a delegated decision.

Recommendation(s):

1. That the Executive approves the establishment of a Section 75 Agreement between LCC and Lincolnshire Clinical Commissioning Group for Adult Learning Disability services based on the principles set out in this report.

2. That the Executive approves the Executive Councillor for Adult Care & Community Wellbeing and the Director of Adult Social Services to agree the annual risk share agreement on behalf of the Council within the principles set out in the Section 75.

Alternatives Considered:

Do Nothing

'Doing nothing' would result in the Section 75 Agreement lapsing and would require that the Clinical Commissioning Groups take on the commissioning function for those eligible. This is not recommended as Clinical Commissioning Groups do not have the infrastructure in place to lead commissioning within the timescales, it would result in a duplication in commissioning activity, and it would miss an opportunity to provide an integrated health and care function which utilises the expertise of partner agencies. As a result, both the Council and the people who use services would be placed at considerable risk. There would also be additional costs for LCC as the current assessment and care management arrangements are shared 50/50.

Clinical Commissioning Groups have confirmed that they see LCC as best placed to lead the commissioning of the service.

Reasons for Recommendation:

The Learning Disability Section 75 agreement that facilitates a pooled budget and lead commissioner arrangements for adults with a learning disability who are eligible for Adult Social Care and/or Continuing Health Care (CHC,) including an integrated assessment and care management function, has been in place for over a decade and continues to deliver joined up outcomes for service users and good value for money for both LCC and LCCG.

Work to strengthen and finalise improvements to the S75 Agreement and associated documents; including contractual terms and conditions, the various schedules and associated financial arrangements has now concluded. Therefore, a decision from the Executive Councillor is requested and recommended.

1. Background

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care.

The overarching aim of a S75 Agreement is to enable partners to join-together to design and deliver improved, cost effective and modernised services around the needs of users and carers, and to allow organisations to work around their individual boundaries.

Lincolnshire has a strong history of integrated working across Specialist Adult Services.

- There is a high level of aligned funding facilitated via Lincolnshire's Better Care Funding arrangements.
- The Learning Disability Section 75 agreement facilitates a pooled budget and lead commissioner arrangements for adults with a learning disability who are eligible for Adult Social Care and/or Continuing Health Care (CHC,) including an integrated assessment and care management function. This allows a more joined up approach to the market management of care services provided by the independent sector, enhanced value for money by allowing the sharing of transactional costs and a more joined up experience for eligible people.
- The LCC Section 75 agreement with Lincolnshire Partnership NHS Foundation Trust (LPFT) is another example of integrated working, in place for adults aged 18 to 64 with a primary support reason of mental illness.

The above examples provide enhanced co-ordination of health and social care services, development of expertise in managing particular support needs, a more joined up approach to procurement and contract management. These arrangements help to eliminate unnecessary gaps and duplications between services and reduce inequalities. Most importantly, these benefits also lead to improved outcomes for service users.

LCCG have confirmed that their preference is to commence a new S75 Agreement with LCC for Learning Disability services with LCC continuing to act as lead commissioner and pooled budget manager. This would be as existing with only such changes as are necessary to adjust the finances to reflect the creation of a new Pooled Budget for people with complex needs subject to the future agreement by LCC and relevant NHS organisations.

Pooled Budget Risk Share Agreement

An element of the existing Learning Disability Section 75 agreement is a risk share agreement that is updated each year to confirm the value of the partner contributions to the pooled fund based on certain formula of how cases supported within the pooled fund should be funded and splitting the costs of the integrated assessment and care management function.

The LCCG contribution to the pooled budget in 2021/22 in relation to CHC related costs is circa £18.282million. With the increased cost of care and forecast growth, the forecast full year cost for health in 2022/23 is £19.546million. LCC's contribution for Adult Social Care related costs will be approximately £51.965million per annum and £14.593 million Better Care Fund. This provides an indicative 2022-23 S75 Pooled Budget of £86.104 million. The proposal includes a continuation of the £0.700million Better Care Fund risk share agreement. Full details of the risk share agreement are included within Appendix 8 of the proposed Section 75 agreement provided with this report.

It is proposed the Section 75 Agreement will be for an initial period of 5 years (2022/23, 2023/24, 2024/25, 2025/26, 2026/27). This can be extended upon the written agreement of both parties for an additional 2 years. The Agreement could be terminated by either party providing one year's notice, which would allow time to support a transition of this level.

Compliance with Statutory Pre-Conditions

In order to have the power to enter into a Section 75 Agreement the Council must have complied with a number of statutory pre-conditions. These are set out below along with commentary on how they have been met for Learning Disability Services:

1. The parties must be able to show that such arrangements are likely to lead to an improvement in the way in which the NHS functions and the health-related functions are exercised.

The Section 75 Agreement for Adult Learning Disability Services generates several improvements and benefits. These include:

- Clarity on local priorities for service provision and improvements.
- A more joined up experience of care for Adults with a Learning Disability.
- The sharing of the cost of the assessment and care management function.
- A clearly defined and measurable performance reporting framework which will be regularly reviewed.
- Flexibilities which enable LCC and health partners to routinely respond to changes in national and local policy directives, financial requirements and efficiencies.
- Ongoing good working relationships with Lincolnshire Clinical Commissioning Group, within a legally described and formalised framework.
- Identification and effective management of financial resources and associated risks.
- Provision of rigorous governance arrangements in relation to the management of the pooled fund and respective commissioning responsibilities.

- Through partnership arrangements, the production of joined up strategies and the development of seamless care pathways.
- Easier identification of gaps in provision.
- Supporting supplier market development which can respond to the needs of local people in a flexible manner.

2. The parties must consult such persons as appear to the NHS body and the Local Authority to be affected by such arrangements.

Entering into a new Section 75 Agreement with LCCG will not change the way in which functions are currently exercised and services are provided. Consequently, persons should not be affected by such arrangements as they are like-for-like. Any changes to service provision that would affect persons would be subject to separate consultation as appropriate.

Engagement has taken place with individuals through Lincolnshire's Learning Disability Partnership Board who have confirmed support for the creation of the learning Disability Section 75 to allow the continuation of the existing arrangements.

3. The parties must be satisfied that such partnership arrangements fulfil the objectives set out in the health improvement plan of the health authority in whose area the arrangements are to operate.

The Section 75 arrangements have been discussed with partners within NHS Lincolnshire and Clinical Commissioning Group representatives to ensure that the proposals fulfil the objectives of the commissioning organisations. Other key benefits of the Section 75 Agreement include:

- Providing the best possible health and social care provisions for adults aged over 18 years with learning disabilities.
- Ensuring the best use of resources to achieve overarching aims.
- Commissioning health and social care services that meet people's assessed needs and deliver improved outcomes, within a contracting framework that is flexible and provides the necessary protection for service users and carers.
- Promoting and support integrated working and involve key stakeholders in service development.
- Ensuring that a stable market that meets local needs exists.
- Clarity about local priorities for service provision and improvements.

Members are assured that the continuation of existing arrangements under a new Section 75 Agreement is not considered to raise any issues with the Council's compliance with the Equalities Act 2010.

Compliance with Statutory Content of a Section 75 Agreement

The Section 75 Regulations set out certain matters that must be contained in any Section 75 Agreement which are as follows:

- Agreed aims and outcomes.
- Payments to be made by the NHS body to the Local Authority (or vice versa) and how those payments may be varied; and, where pooled funding arrangements are to be set up, further detailed requirements apply.
- NHS functions and health related functions to be exercised and the persons in respect of whom, and kind of services in respect of which, such functions may be exercised.
- Staff, goods, services or accommodation to be provided by the partners.
- Duration of the arrangements and the provision for the review or variation or termination of the arrangements.
- Arrangements for monitoring the exercise of the functions.
- In the case of the exercise of functions in respect of the provision of accommodation, the arrangements in place for determining the services in respect of which a user may be charged and informing users about such charges.

The proposed Section 75 Agreement will continue to fulfil these requirements.

2. Legal Issues:

Equality Act 2010

Under section 149 of the Equality Act 2010, the Council must, in the exercise of its functions, have due regard to the need to:

Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act.

Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

Having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

- Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic.
- Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it.

- Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to tackle prejudice, and promote understanding.

Compliance with the duties in section 149 may involve treating some persons more favourably than others.

The duty cannot be delegated and must be discharged by the decision-maker. To discharge the statutory duty the decision-maker must analyse all the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision making process.

The Equality Act duty has been reviewed but there are not considered to be any adverse impacts on people with a protected characteristic. In particular, the new Section 75 will continue to provide improved health and wellbeing outcomes to all regardless of protected characteristics where eligible.

The partners will keep under review the potential impacts of the services commissioned and undertake consultation as appropriate.

<u>The Care Act 2014</u>

Part 1 outlines the general responsibilities of local authorities that they must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market,

(a) has a variety of providers to choose from who (taken together) provide a variety of services,

(b) has a variety of high-quality services to choose from

A local authority must also have regard to the need to ensure that sufficient services are available for meeting the needs for care and support of adults in its area and the needs for support of carers in its area.

The new Section 75 Agreement and contractual arrangements will continue to generate improvements and benefits, including supporting market development which is able to respond to the needs of local people in a flexible manner.

The Section 75 ensures that commissioning and commercial levers are used to maximise

the value delivered by commissioning spend, including joint health and social care commissioning.

Joint Strategic Needs Analysis (JSNA and the Joint Health and Wellbeing Strategy (JHWS)

The Council must have regard to the Joint Strategic Needs Assessment (JSNA) and the Joint Health & Well Being Strategy (JHWS) in coming to a decision.

The Joint Health and Wellbeing Strategy aims to:

- have a strong focus on prevention and early intervention.
- ensure a focus on issues and needs which will require partnership and collective action across a range of organisations to deliver.
- deliver transformational change through shifting the health and care system towards preventing rather than treating ill health and disability.
- focus on tackling inequalities and equitable provision of services that support and promote health and wellbeing.

The services governed by the Section 75 Agreement for Learning Disabilities have a positive direct impact on the health and wellbeing of people LD and the changes included in the new Agreement are considered to improve the exercise of the Council's functions and health functions in this regard.

Crime and Disorder

Under section 17 of the Crime and Disorder Act 1998, the Council must exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent crime and disorder in its area (including anti-social and other behaviour adversely affecting the local environment), the misuse of drugs, alcohol and other substances in its area and re-offending in its area.

The Section 17 matters have been considered but there are not considered to be any implications arising out of this Report.

3. Conclusion

In summary, the new arrangements established through the Section 75 will provide a clear outcome for people who use services and where investment is being spent each year. The Section 75 represents the commitment demonstrated by LCC and LCCG to continue working in partnership through a common vision of health and wellbeing that will meet local needs.

4. Legal Comments:

The Council has power to enter into the proposed Agreement. The statutory pre-conditions to the entering into of a Section 75 Agreement and the matters that must be considered in reaching a decision are addressed in the Report.

The decision is consistent with the Policy Framework and within the remit of the Executive Councillor if it is within the budget.

5. Resource Comments:

With the uplift applicable to the cost of packages of care and growth in demand based on that seen during 2021-22, there is a forecast financial increase on CCG funded packages of approx. £1.264million. In previous S75, forecast uplifts have been funded through the CCGs increase in the Better Care Fund minimum contribution. The CCG are expecting a 5.3% uplift in 2022-23 however confirmation of its use can't be confirmed as the BCF framework hasn't yet been published nationally. The funding source for the CCG increase remains indicative at this point.

The forecast cost increase on social care packages has been built into the 2022-23 budget setting paper going to full council in February 2022.

6. Consultation

a) Has Local Member Been Consulted?

N/A

b) Has Executive Councillor Been Consulted?

Yes

c) Scrutiny Comments

The comments of the Scrutiny Committee will be reported to the Executive at its meeting on 1 March 2022

d) Risks and Impact Analysis

See the body of the report, appendices and Care Act considerations

7. Appendices

These are listed below and attached at the back of the report	
Appendix A	Learning Disability Section 75 Agreement to commence 1 April 2022
Appendix B	Equality Impact Assessment

8. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Justin Hackney, who can be contacted on 07774 661042 or justin.hackney@lincolnshire.gov.uk

AGREEMENT UNDER SECTION 75

OF THE NATIONAL HEALTH SERVICE ACT 2006

PARTNERSHIP AGREEMENT for Learning Disabilities

between

Lincolnshire County Council

and

Lincolnshire Clinical Commissioning Group

This Agreement is dated the day of 2021

BETWEEN

(1) Lincolnshire County Council of County Offices, Newland, Lincoln, LN1 1YL **("Council")**

(2) Lincolnshire Clinical Commissioning Group of Bridge House, The Point, Lions Way, Sleaford NG34 8GG ("CCG")

(each a "Partner" and together "the Partners")

BACKGROUND

(A) The Council is a Local Authority established under the Local Government Act 1972 (as amended); the Council is responsible inter alia for the provision of community care and accommodation for older people and other vulnerable adults who are residents of Lincolnshire.

(B) The CCG has the responsibility for commissioning health services pursuant to the National Health Service Act 2006 ("the NHS Act") on behalf of the registered population of Lincolnshire.

(C) The Council and the CCG have duties and powers to provide care to the population of Lincolnshire and Section 82 of the NHS Act requires both local authorities and NHS bodies, when exercising their respective functions, to cooperate to secure and advance health and welfare for the people of England and Wales. Furthermore, under relevant guidance, local authorities and NHS bodies are encouraged to consider partnership working, including through the use of certain flexibilities under the Act. Section 75 of the NHS Act 2016 gives powers to local authorities and clinical commissioning groups to exercise certain local authority and NHS functions for each other and to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of such prescribed local authority functions and prescribed NHS functions.

(D) The Partners wish to establish such partnership arrangements and pursuant to Section 75 of the National Health Service Act 2006 and pursuant to the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (Statutory Instrument 2000 No. 617) and any amendments thereto and subsequent re-enactments thereof, enter into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

(E) The Partners have jointly carried out consultations on the proposals for this Agreement with persons likely to be affected by the arrangements. Additional consultations will be undertaken as necessary, and in line with each Partner’s obligations regarding consultation with affected parties, in respect of any future proposals to vary the Individual Schemes. Following such consultations, the Partners are satisfied that the Partnership Arrangements will lead to an improvement in the way in which their Functions are exercised in relation to providing social care, and health services and the management of associated funds.

(F) This Agreement does not affect the liability of the Council or the CCG for the exercise of their respective functions, or any power or duty to recover charges for the provision of any services in the exercise of any local authority function.

(G) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will pool funds and align budgets as agreed between the Partners.

1. DEFINITIONS

In this Agreement the following expressions shall have the following meanings:

NHS Act	means the National Health Service Act 2006
Additional Services	means additional services or delegation of Functions in respect of those services that may be added to the Services during the life of the Agreement in accordance with Clause 18 (Variations and Change Control) of this Agreement
AdLD Services	means services for adults with learning disabilities
Agreement	means this Agreement between the Partners comprising these terms and conditions, together with all Appendices attached hereto
Aims and Objectives	means the agreed aims and objectives specified in Appendix 1.
Arrangements	has the meaning given to it at Clause 4.2 of this Agreement
Area	means the County of Lincolnshire
Authorised Officers	means the CCG's Authorised Officer and the Council's Authorised Officer
Assessment	The process of assessing the needs of a Service User in relation to the Services provided under this Agreement
Bank Holiday	means any day that is specified or proclaimed as a bank holiday in England and Wales pursuant to Section 1 of the Banks and Financial Dealings Act 1971
Best Value Duty	means the duty imposed on the Council by Section 3 of the Local Government Act 1999
Better Care Fund	means the Better Care Fund as described in NHS England Publications Gateway Ref No 00314 and NHS England Publications Gateway Ref No 00535 as relevant to the Partners
CCG Staff	Means any employee or employees or other persons engaged by the CCG to perform their obligations under this Agreement
CCG Statutory Duties	means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act
Change in Law	means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date

Commencement Date	means 00:01 hrs on 1 April 2022.
Confidential Information	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and: (a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history, (b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or (c) which is a trade secret.
Council Functions	means those functions of the Council being health related functions for the purposes of Regulation 6(a) of the Regulations specified in Part 2 of Appendix 2.
Council Staff	means any employee or employees or other persons engaged by the Council to carry out the Functions
Council's Authorised Officer	means the individual representative of the Council who has the power to make decisions on behalf of the Council in respect of the Partnership Arrangements
DPA	means the Data Protection Act 2018
Data Protection Legislation	means (i) the UK GDPR, (ii) the DPA to the extent that it relates to processing of personal data and privacy, (iii) all applicable Law about the processing of personal data and privacy.
Eligibility Criteria	means the criteria set out in Appendix 3 which a Service User must satisfy in order to receive the Services
Equality Legislation	means the Equality Act 2010 and any other relevant Acts and Legislation which ensures, amongst others; equality of access to goods and services; Promotion of good relations between groups in society; The provision of Reasonable Adjustments for people with disabilities
Essential Services	means those services or parts of the services which are designated as being essential services under Appendix 4.
Event of Force Majeure	means an event or circumstance which is beyond the reasonable control of the Party claiming relief under Clause 27 (Force Majeure) including without limitation war, civil war, armed conflict, terrorism, strikes or lock outs, riot, fire, flood or earthquake and which directly cause that Party to be unable to comply with all or a material part of its obligations under this Agreement.

Excluded Functions	means such Functions contained in Part 3 of Appendix 2 and/or such Functions as the Partners may agree from time to time are excluded from the Arrangements, together with any exclusions set out in the Regulations
Financial Contributions	means the financial contributions made by each Partner to a Pooled Fund in any Financial Year as set out in Appendix 8 and payable into the fund in accordance with this Agreement.
Financial Year	means each financial year running from 1 April in any year to 31 March in the following calendar year.
Force Majeure Event	means one or more of the following: (a) war, civil war (whether declared or undeclared), riot or armed conflict, (b) acts of terrorism, (c) acts of God, (d) fire or flood, (e) industrial action, (f) prevention from or hindrance in obtaining raw materials, energy or other supplies, (g) any form of contamination, pandemic or virus outbreak; and (h) any other event, in each case where such event is beyond the reasonable control of the Partner claiming relief
Function	means the Council Functions and the NHS Functions but excluding the Excluded Functions
Guidance	means the guidance on the Health Act 2006 Section 75 partnership arrangements published by the Department of Health
Host Partner	means the Council as the nominated partner to act as host of the Pooled Fund
Individual Scheme	means one of the schemes which has been agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.
Initial Term	Means the period from the Commencement Date to the expiry of this Agreement as set out in Clause 3.2
Integrated Commissioning	means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.
Joint (Aligned) Commissioning	means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Joint Commissioning Overview Group or JCOG	means the Joint Commissioning Overview Group described in this Agreement and more specifically in Appendix 5 to the Partnership Framework Agreement in fulfilment of its responsibility for monitoring and overseeing the implementation of the Partnership Arrangements relating to services covered within this Agreement as defined in Appendix 5 to this Agreement
Joint Delivery Board	means Adult Specialised Care Joint Delivery Board responsible for monitoring and overseeing the implementation of the Partnership Arrangements relating to services covered within this Agreement as defined in Appendix 5.
Lead Commissioner	means such Partner as shall be identified from time to time to exercise the Lead Commissioning Arrangements
Lead Commissioning Arrangements	means the Arrangements for the exercise by one of the Partners of the Lead Commissioning as set out in Clause 6.9 (Lead Commissioner Arrangements)
Lead Commissioning	means the mechanism by which the Lead Commissioner commissions services on behalf of the other Partners
Lead Partner	means the Partner responsible for commissioning an Individual Service under a Scheme Specification.
Law	means a statute, statutory provision or subordinate legislation
National Guidance	means any and all guidance in relation to the Scheme Specifications, as issued from to time to time by NHS England, the Department of Communities and Local Government, the Department of Health, either collectively or separately, including but not limited to FAQ on Building the Right Support dated October 2015.
NHS Functions	means the functions of the CCG being functions specified in Regulation 5 of the Regulations specified in Part 1 of Appendix 2 excluding the Excluded Functions
Non-Recurrent Payments	means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Appendix 8.
Overspend	means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.
Partners	means the Council and CCG and "Partner" means either the Council or CCG the term includes the organisation(s), their employees, agents and sub-contractors
Partnership Arrangements	means the arrangements for the establishment of a pooled fund and exercise of the Functions and provision of the services as set out under this Agreement

Partnership Framework Agreement	means the partnership framework agreement entered into between the Partners on 31st March 2015 titled Partnership Framework Agreement Relating to the Commissioning of Health and Social Care Services and the Pooling of Funds for the Purposes of the Better Care Fund
Partnership Board Quarterly Reports	means the reports that the Pooled Fund Manager shall produce and provide to the Partnership Board on a Quarterly basis
Performance Measures	means those measures to be established managed and monitored by the Partners in respect of the Partnership Arrangements in accordance with Appendix 7.
Personal Health Budget	means an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group
Pooled Fund	means the Pooled Fund as set out in Appendix 8, which is made up of contributions by the Partners and out of which payments may be made towards expenditure incurred in the exercise of the Functions, the responsibility and accountability for which is assigned to the Partners in accordance with the terms of this Agreement
Pooled Fund Arrangements	means the arrangements agreed by the Partners for establishing and maintaining the Pooled Fund for the purposes of Regulation 7 of the Regulations as set out in Appendix 8.
Pooled Fund Manager	means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 7.12.
Provider	means a provider of any Services commissioned under the arrangements set out in this Agreement [including the Council where the Council is a provider of any Services].
Quarter	means each of the following periods in the Financial Year: 1Aprilto 30 June, 1 July to 30 September, 1 October to 31 December, 1January to 31 March, and "Quarterly" shall be construed accordingly
Regulations	means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (Statutory Instrument 2000 No. 617) and any amendments thereto and subsequent re- enactments thereof
Section 75	means Section 75 of the National Health Services Act 2006

Services	means the Services set out at Appendix 9 to this Agreement as the same may be amended from time to time in accordance with Clause 18 (Variation and Change Control)
Service Agreements	means any agreements for the Services entered into by the Host Partner with third party service providers in accordance with the provisions of this Agreement
Service Users	means any individual for whose benefit the Services are provided as further identified at Appendix 10.
Staff	means the Council Staff and/or the CCG Staff
Term	means the period described in Clause 4 (Duration of Agreement)
Transforming Care Partnership Board	means the board set up to implement the Transforming Care Plan for the area
Transforming Care Plan	the plan agreed by the Transforming Care Partnership to improve health and care services so that more people can live in the community, with the right support, and close to home.
TUPE	means The Transfer of Undertakings (Protection of Employment) Regulations 2006
UK GDPR	means the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) (United Kingdom General Data Protection Regulation), as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018 (and see section 205(4)).
Working Day	means any day other than Saturday, Sunday or public or Bank Holiday in England and Wales'. means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

2. INTERPRETATION

2.1. In this Agreement (except where the context otherwise requires):

2.1.1. any reference to this Agreement includes the Appendices of or to this Agreement which form part of this Agreement and shall have effect as if set out in full in the body of this Agreement but not including the table of contents which is provided for convenience of reference only and shall not be construed as parts of this Agreement.

2.1.2. any reference to an Appendix is to an Appendix of or to this Agreement.

2.1.3. any reference to a Clause is to a provision of this Agreement that is uniquely identifiable by a preceding number and clauses may be nested so that a Clause may contain subordinate clauses each uniquely identifiable by a subordinate preceding number and any reference to a clause includes all other clauses nested within that clause.

2.1.4. any reference to a Paragraph is to a paragraph of an Appendix to this Agreement.

2.1.5. any reference to a statute, statutory provision or subordinate legislation (collectively referred to as "Legislation") shall be construed as referring to such legislation as amended and in force from time to time and to any legislation which re-enacts or consolidates (with or without modification) any such legislation provided that, unless the Partners agree otherwise, as between the Partners, no such amendment or modification shall apply for the purposes of this Agreement to the extent that it would impose any new or extended obligation, liability or restriction on, or otherwise adversely affect the rights of, any Partners.

2.1.6. any reference to a person or body shall not be restricted to natural persons and shall include natural persons, firms, partnerships, companies, corporations, associations, organisations, governments, states and foundations (in each case whether or not having separate legal personality).

2.1.7. clause headings of all kinds including those that stand above, run into or appear to the side of clauses are provided for convenience of reference only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the clauses to which they relate or in any other way affect the interpretation of this Agreement or include the unique identifying numbers that precede every clause.

2.1.8. where any conflict may arise between the provisions contained in the terms and conditions of this Agreement and Appendices or other documents referred to herein, the provisions of the terms and conditions of this Agreement shall prevail, except for any Legislation or other law or regulation which shall prevail over the provisions of this Agreement.

2.1.9. use of the singular shall include the plural and use of the plural shall include the singular.

2.1.10. use of any gender shall include the other genders.

2.1.11. any phrase introduced by the terms "including", "include", "in particular" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

3. DURATION OF AGREEMENT

3.1. This Agreement shall come into force on the Commencement Date and shall continue until midnight on 31 March 2027 unless extended in accordance with clause 3.2 below or terminated earlier in accordance with the provisions of Clause 15 (Termination).

3.2. The Partners may extend this Agreement for a period and on varied terms as they agree, beyond the Initial Term, subject to the approval of the Partners' boards.

3.3. In the event that the Partners shall extend this Agreement in accordance with Clause 3.2, they shall do all things necessary to vary this agreement to reflect such extension.

4. GENERAL PRINCIPLES

4.1. The Partners agree to:

4.1.1. treat each other with respect and an equality of esteem,
4.1.2. be open with information about the performance and financial status of each; and
4.1.3. provide early information and notice about relevant issues.

4.2. The Partners have agreed to enter into this Agreement for the integrated exercise of the Functions as set out in this Agreement (the "Arrangements").

4.3. The Partnership Arrangements shall comprise:

(a) the delegation by the CCG to the Council Authority of the NHS Functions, so that it may exercise the NHS Functions alongside the Council Functions and act as commissioner of the Services; and
(b) the establishment of a Pooled Fund for the Services in accordance with Appendix 9.

4.4. For the purposes of the implementation of the Partnership Arrangements, the CCG hereby delegates the exercise of the NHS Functions identified in this Agreement to the Council acts as commissioner of the Services.

4.5. The primary objectives of the Partners in entering into this Agreement are the Aims and Objectives set out in Appendix 1.

4.6. The Services shall be subject to regular monitoring and assessment and a formal annual review in accordance with this Agreement. As a result of ongoing needs assessment and service review, changes may be made to the Services commissioned through these Partnering Arrangements, subject to any addition, deletion or amendment of services to this Agreement or amendments to the budgets for the Services being agreed by all Partners pursuant to Clause 18 of this Agreement.

4.7. The partners shall establish a pooled fund and the Pooled Fund Arrangements are as set out at Appendix 8 of this Agreement.

4.8. The Joint Commissioning Oversight Group shall be responsible for the monitoring of the Functions and the Services and management of the Pooled Fund and shall otherwise undertake the role set out in Appendix 7.

4.9. The Joint Commissioning Oversight Group shall be responsible for the monitoring of the impact of the exercise of Functions and the Services, and the management of the Pooled Fund on the Better Care Fund as a whole as described in Appendix 8.

4.10. The Partners hereby represent that they have obtained all necessary consents sufficient to ensure the delegation of Functions provided for by this Agreement as outlined in Appendix 2 of this Agreement.

4.11. Nothing in this Agreement shall prejudice or affect:

(a) the rights and powers, duties and obligations of the Partners in the exercise of
(b) their functions as public bodies or in any other capacity,
(c) the liability of the Council to the Service Users in respect of the Council Functions; or
(d) the liability of the CCG to the Service Users in respect of the NHS Functions.

5. PARTNERSHIP FLEXIBILITIES

5.1. The Partners may secure the provision of additional health and social care services in accordance with the terms of this Agreement and as such, this Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the Individual Schemes in accordance with their obligations under this Agreement.

5.2. The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Appendix 2.

5.3. Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 18 (Variations). Each new Scheme Specification shall be substantially in the form set out in Appendix 9.

5.4. The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5. The introduction of any Individual Scheme will be subject to business case approval by the Joint Commissioning Oversight Group (in accordance with the variation procedure set out in Clause 18 (Variations)).

5.6. This Agreement sets out the mechanism through which the Partners will work together to commission services. This may include one or more of the following commissioning mechanisms:

i. Lead Commissioning Arrangements,
ii. Integrated Commissioning,
iii. Joint (Aligned) Commissioning,
iv. the establishment of one or more Pooled Funds in relation to Individual Schemes (the "Flexibilities")

5.7. Where there is a Lead Commissioning Arrangement and the Council is Lead Partner, the CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the health-Related Functions.

5.8. Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

6. COMMISSIONING ARRANGEMENTS

General

6.1. The Partners shall comply with the commissioning arrangements as set out in the relevant Scheme Specification and any such services in any additional Scheme Specification shall become the Services for the purposes of this Agreement.

6.2. The Partners shall comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned.

6.3. Each Partner shall keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including any Overspend or Underspend in a Pooled Fund.

6.4. Where there are Integrated Commissioning or Lead Commissioning Arrangements in respect of an Individual Scheme then prior to any new Services Contract being entered into the Partners shall agree in writing:

i. How the new Individual Scheme shall benefit relevant Service Users and shall undertake any appropriate consultation in accordance with the NHS Act,
ii. how the liability under each Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme; and
iii. whether the Services Contract should give rights to third parties (and in particular if a Partner is not a party to the Services Contract to that Partner, the Partners shall consider whether or not the Partner that is not to be a party to the Services Contract should be afforded any rights to enforce any terms of the Services Contract under the Contracts (Rights of Third Parties) Act 1999 and if it is agreed that such rights should be afforded the Partner entering the Services Contract shall ensure as far as is reasonably possible that such rights that have been agreed are included in the Services Contract and shall establish how liability under the Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme.);
iv. details of who shall be the Lead Partner of the Individual Scheme and how the services referred to therein shall be provided.

6.5. Integrated Commissioning

6.6. Where there are Integrated Commissioning arrangements in respect of the Scheme:

i. the Partners shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.
ii. Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.7. Appointment of a Lead Commissioner Partner

6.8. Where there are Lead Commissioning Arrangements in respect of the Scheme the Lead Partner shall:

i. exercise the NHS Functions in conjunction with the Health-Related Functions as identified in the Scheme Specification,
ii. endeavour to ensure that the NHS Functions and the Health-Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year,
iii. commission Services for individuals who meet the eligibility criteria set out in the Scheme Specification,
iv. contract with Provider(s) for the provision of the Services on terms agreed with the other Partner,
v. comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned,
vi. undertake performance management and contract monitoring of all Service Contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements,
vii. make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and
viii. keep the other Partner and Partnership Board regularly informed of the effectiveness of the arrangements including any Overspend or Underspend in a Pooled Fund.

6.9. Lead Commissioner Arrangements

6.10. The Partners agree that the Council shall act as Lead Commissioner to commission both health and social care in exercise of the Council Functions and NHS Functions in respect of AdLD, and that in respect of the exercise by the Council of the role of Lead Commissioner, the provisions of this Clause 6 will have effect.

6.11. The Council shall commission AdLD for and only for persons who meet the agreed Eligibility Criteria set out at Appendix 3 as the same may be amended from time to time in accordance with clause 18 of this Agreement.

6.12. The agreed Aims and Objectives of the Lead Commissioner Arrangements shall be the Aims and the Objectives as set out at Appendix 1.

6.13. The Council shall, in acting as Lead Commissioner in exercise of the Functions, comply with the requirements of this Agreement, the Guidance and any other relevant laws, regulations or other governmental guidance

6.14. The Council as Lead Commissioner shall, subject to any provisions relating to overspends and underspends set out at Appendix 8 only commission services using funds from the Pooled Fund.

6.15. Unless otherwise agreed between the Partners, the Council shall be responsible for tendering contracts for the Services with any appropriate providers on behalf of the Partners and all such contracts or service level agreements shall be entered into in the name of and executed by the Council unless agreed otherwise by all the Partners.

6.16. Partners will co-operate to ensure continuity of services to service users, and this shall be reflected in the winding down protocol arrangements in Appendix 14 of this agreement.

7. FUNDING ARRANGEMENTS

7.1. The Partners will comply with their respective obligations set out at Appendix 8 to this Agreement.

7.2. Any overspends or underspends in respect of the Pooled Fund that may occur throughout the term of this Agreement shall be dealt with according to the provisions of Appendix 8 Annex C to this Agreement.

7.3. The Partners agree that their respective contributions shall be treated for VAT purposes in accordance with the provisions set out in Appendix 8 to this Agreement.

7.4. Establishment of a Pooled Fund

7.5. In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as agreed by the Partners.

7.6. Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.7. Subject to Clause 7.8, it is agreed that the monies held in a Pooled Fund may only be expended on the following:

i. the Contract Price,
ii. where the Council is to be the Provider, the Permitted Budget,
iii. Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Partnership Board,
iv. Approved Expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Partnership Board

7.8. Permitted Expenditure

7.9. The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner [or Partnership Board].

7.10. For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners in accordance with Clause 7.8.

7.11. Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

i. holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners,
ii. providing the financial administrative systems for the Pooled Fund; and
iii. appointing the Pooled Fund Manager,
iv. ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

7.12. Pooled Fund Management

7.13. The Pooled Fund Manager for each Pooled Fund shall have the following duties and responsibilities:

i. the day-to-day operation and management of the Pooled Fund,
ii. ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
iii. maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
iv. ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund and liaising with internal and external auditors as necessary,
v. reporting to the Partnership Board as required by this Agreement and by the Partnership Board,
vi. ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement,
vii. preparing and submitting to the Partnership Board Quarterly Reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met including (without limitation) comply with any reporting requirements as may be required by relevant National Guidance and as agreed between the Partners.

7.14. In carrying out their responsibilities as provided under Clause 7.13, the Pooled Fund Manager shall:

i. have regard to the recommendations of the Partnership Board; and
ii. be accountable to the Partners for delivery of those responsibilities.

7.15. The Partnership Board may agree to the viring of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

7.16. Financial Contributions

7.17. The Financial Contribution of the CCG and the Council to any Pooled Fund for the first Financial Year of operation shall be as set out in Appendix 8.

7.18. The Financial Contribution of the CCG and the Council to any Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners.

7.19. Financial Contributions will be paid as set out in Appendix 8.

7.20. No provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board minutes and recorded in the budget statement as a separate item.

7.21. Non-Financial Contributions

7.22. Unless set out in a Scheme Specification or otherwise agreed by the Partners, each Partner shall provide the non-financial contributions for any Service that they are Lead Partner or as required in order to comply with its obligations under this Agreement in respect of the commissioning of a particular Service. [These contributions shall be provided at no charge to the other Partners or to the Pooled Fund.]

7.23. Each Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Services Contracts and the Pooled Fund).

7.24. Risk share arrangements

7.25. The Partners have agreed risk share arrangements as set out in Appendix 9, which provide for risk share arrangements arising within the commissioning of services from the Pooled Funds.

7.26. Overspends in Pooled Fund

7.27. Subject to Clause 7.2, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavors to ensure that the expenditure is limited to Permitted Expenditure.

7.28. The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT it has used reasonable endeavors to ensure that the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure.

7.29. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible, and the provisions of the relevant Scheme Specification and Appendix 9 shall apply.

7.30. Underspend

7.31. In the event that expenditure from any Pooled Fund or Non-Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year or where the expenditure in relation to an Individual Scheme is less than the agreed allocation to that particular Individual Scheme the Partners shall agree how the monies shall be spent, carried forward and/or returned to the Partners and the provisions of Appendix 9 shall apply. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

8. CAPITAL EXPENDITURE

8.1. Neither Pooled Funds nor Non-Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners. The Partners shall ensure that any arrangements for the sharing of capital expenditure shall be made separately and in accordance with Section 256 (or Section 76) of the NHS Act 2006 and directions made thereunder

9. AUDIT AND RIGHT OF ACCESS

9.1. All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund.

9.2. The Host Partner shall keep and maintain until 12 years after the agreement has been completed, or as long a period as may be agreed between the parties, full and accurate records of the agreement including:

i. the Services provided under it,
ii. all expenditure reimbursed by the Partners,
iii. all payments made by the Partners.

9.3. All internal and external auditors and all other persons authorised by all Partners will be given the right of access by them to any document, information or explanation they require from any employee or member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

9.4. The Partners shall comply with relevant NHS and the Council's finance and accounting obligations as required by relevant Law.

10. CHARGING

10.1. By virtue of Regulation 6(a) of the Regulations the Council retains the power to charge eligible Service Users for certain Council Functions and it is agreed that in accordance with the Guidance the income therefrom shall be paid to the Council, and the Council shall not account for such income in calculating its contribution to the Pooled Fund, which shall be paid by the Council gross.

10.2. The Council shall establish and maintain a Charging Policy and protocol to ensure that the delivery of health care through the performance of any of the NHS Functions pursuant to this Agreement shall remain free at the point of delivery whilst ensuring that effective procedures exist to facilitate the exercise by the Council of its charging function.

10.3. Where a package of services commissioned under the NHS Functions and services commissioned under the Council Functions are being provided to an eligible Service User and the services commissioned under the Council Functions are being charged, the care management team responsible for the care of the said eligible Service User shall ensure that it is explained to the eligible Service User as early as practically possible that the services commissioned under the NHS Functions continue to be provided free to avoid any misunderstanding that the services commissioned under the NHS Functions are being charged for.

11. SERVICE STANDARDS AND PERFORMANCE MANAGEMENT

11.1. The Council shall in commissioning Services under this Agreement ensure that such Services must be carried out in accordance with the following:

i. The Service Specification
ii. all applicable Law, national standards, local standards, policy or guidance that are set out in the Appendices of this Agreement applicable to the specific services,
iii. reasonable skill and care and any standards that apply to the Services that may be agreed by the JCOG or the Joint Delivery Board; and
iv. the Council's standing orders and standing financial instructions
v. required degree of care, skill and diligence in accordance with best practice in relation to performance of their duties under this Agreement and shall meet their obligations under this Agreement in accordance with the relevant laws, regulations and guidance.

11.2. The Services under this Agreement may be monitored by the Care Quality Commission.

11.3. Without prejudice to Clauses 11.1 and 11.2, the Council both as Host Partner and Lead Commissioner shall exercise its duties, obligations and the Functions arising out of or in relation to this Agreement effectively, efficiently, fairly and in good faith.

11.4. The Host Partner shall report to the Joint Delivery Board and JCOG monthly unless otherwise specified in Appendix 7, on the operation of the Arrangements (which, to avoid doubt, shall include but not be limited to, the operation of the Services and performance levels against agreed Performance Measures, targets and priorities), the management of the Pooled Fund and the exercise of the Functions by the Host Partner.

11.5. The Partners shall agree the format of, and the content to be included in, the reports to the Joint Delivery Board and JCOG referred to in Clause 11.4 above. Any disagreement as to the format of the content to be included in the reports may be referred to the Joint Delivery Board for its determination and/or instruction.

11.6. The Partners shall review the operation of the Partnership Arrangements and all or any procedures or requirements of this Agreement on the coming into force of any relevant Legislation or guidance affecting the Partnership Arrangements so as to ensure that the Partnership Arrangements comply with such Legislation.

11.7. As Host Partner and Lead Commissioner, the Council shall ensure that any requirements which the CCG reasonably require to meet their Best Use of Resources duties are incorporated and reflected in its delivery and performance of the Functions. For the avoidance of doubt, this may include efficiency savings or reconfiguration of services and the Partners shall undertake any appropriate consultation and where necessary formally vary the terms of this Agreement in accordance with Clause 11.8 prior to implementation

11.8. For the avoidance of doubt, this Agreement in no way releases any Partner from any requirement to comply with the general law or any internal standing order, regulation, directive, policy, financial procedure or decision of the Council & the CCG where to do so would not be inconsistent with this Agreement. The standing orders and standing financial instructions of the Host Partner as notified to the other Partners from time to time shall apply to the management of the Pooled Fund and the Lead Commissioning Arrangements.

11.9. Each Partner shall be entitled to make representations and recommendations to the other Partner relating to the other Partners' performance of its obligations under this Agreement. Each Partner shall in good faith give due regard to the other Partners' representations and recommendations, and shall promptly respond, in writing, giving reasons why such representations and/or recommendations were or were not followed.

11.10. Sub-standard performance by either Partner of its obligations under this Agreement shall be addressed through the Joint Commissioning Oversight Group.

11.11. The Joint Commissioning Board shall ensure that Service Users and their families fully participate in the Host Partner's work under these Arrangements and that an annual evaluation of the Host Partner takes place and includes outcomes which are qualitative as well as quantitative.

11.12. The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

11.13. The CCG is subject to the CCG Statutory Duties, and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

11.14. Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement and the provision of the Services within 3 Months of the end of each Financial Year.

11.15. Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith.

11.16. The Partners shall within 20 Working Days of the annual review prepare an Annual Report including but not limited to:

i. the performance of the Partnership Arrangements against the Aims and Outcomes,
ii. the performance of the individual Services against the Service Levels and other targets contained in the relevant contracts,
iii. plans to address any underperformance in the Services,
iv. actual expenditure compared with agreed budgets, and reasons for and plans to address any actual or potential underspends or overspends,
v. evidence of implementing recommendations of the Transforming Care Partnership Board,
vi. review of plans and performance levels for the following year,
vii. plans to respond to any changes in policy or legislation applicable to the Services or the Partnership Arrangements,
viii. a review of the non-financial contributions and whether to withdraw or substitute such non-financial contributions as agreed,
ix. review of targets and priorities for the forthcoming Financial Year.

11.17. The Host Partner shall prepare an annual report following the Annual Review for submission to each of the Partners respective Governing Bodies.

12. GOVERNANCE ARRANGEMENTS

12.1. The operation of this Agreement will be overseen by the Joint Delivery Board and the Joint Commissioning Oversight Group who will undertake their respective responsibilities as set out at Appendix 5 of this Agreement.

12.2. The CCG is subject to a duty of clinical governance, which (for the purposes of this Agreement) shall be defined as *"a framework through which it is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".*

12.3. The Council acknowledges that clinical governance (as described at Clause 12.2 above) applies to the treatment of NHS patients. Such patients are entitled to expect to receive services which are part of a clinical governance system irrespective of where they are treated.

12.4. The Arrangements will therefore be subject to clinical governance obligations and the Council shall use reasonable endeavors to co-operate with all reasonable requests from the CCG which the CCG considers necessary in order to fulfil its obligations.

12.5. The Host Partner shall comply with the principles and standards of corporate governance relevant to NHS bodies and local authorities.

12.6. Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisations are complied with.

13. COMPLAINTS

13.1. A complainant has the right to use any of the Partners' statutory complaints procedures where applicable.

13.2. Where required partners will collaborate to address the complaint and provide necessary information to resolve the complaint as far as is practically possible

13.3. During the Term of this Agreement the Partners may develop and operate a joint complaints system if it is deemed by the Joint Delivery Board appropriate and of value to do so. The application of a joint complaints system shall be without prejudice to a complainant's right to use either of the Partners' statutory complaints procedures where applicable.

14. INFORMATION SHARING

14.1. The Partners shall ensure that any processing of Personal Data is undertaken in accordance with Data Protection Legislation and that the Partnership Arrangements comply with all legislation, regulations and guidance on information sharing produced by the Government and shall be in line with Appendix 6 of the agreement.

14.2. The Partners shall establish and keep operational and ensure that there are kept operational:

i. procedures (including forms) for handling service user access and consent

ii. documentation for eligible service users which explains their rights of access, the relevance of their consent, rules and limits on confidentiality, and how information about them is treated; and
iii. such additional policies procedures and documentation as shall be necessary in order to meet the purposes, guidance and requirements of Government and of all relevant data protection legislation as they apply to the Partners and the Partnership Arrangements.

14.3. The Information Sharing Protocol set out at Appendix 6 of this Agreement is the current code of confidentiality for sharing information that shall apply to the Partnership Arrangements and may be extended, revised and amended from time to time to facilitate information sharing, subject to such amendments being agreed between the Partners in accordance with Clause 18 (Variations and Change Control).

15. TERMINATION

15.1. Either Partner may terminate this Agreement for convenience by giving not less than twelve (12) months written notice to the other Partners to expire at the end of a Financial Year.

16. EFFECTS OF TERMINATION

16.1. Upon termination of this Agreement for any reason whatsoever, the following shall apply:

i. each Partner shall (unless the Partners agree in writing otherwise) continue to perform its obligations under this Agreement throughout the relevant termination notice period,
ii. the Partners shall co-operate in good faith in order to ensure that the winding down and desegregation of joint activities is carried out smoothly and with as little disruption as possible to Service Users, the Client, Group as a whole, Staff, the Partners and third parties in accordance with Appendix 14 (Winding Down Protocol) of this Agreement,
iii. neither Partner shall be liable to make any payments to the other in respect of monies due to a third party until any losses suffered by that third party arising from the termination have been calculated and it is apparent that a sum is due,
iv. where the Council is acting as the Lead Commissioner for the Services, the Council will procure, where possible and appropriate, the assignment or novation of any Services Agreements pursuant to Clause 15 above,
v. any monies remaining in the Pooled Fund shall be dealt with in accordance with Appendix 8.

17. INDEMNITY AND LIMITATION OF LIABILITY

17.1. Nothing in this Agreement shall affect:

i. the liability of the CCG to the Service Users in respect of the NHS Functions; or
ii. the liability of the Council to the Service Users in respect of the Council Functions.

17.2. Each Partner ("**First Partner"**) shall indemnify and keep indemnified the other Partner ("**Second Partner"**) against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses whatsoever, whether arising in tort (including negligence), default or breach of this Agreement, to the extent that any loss or claim is due to the breach of contract, negligence, willful default or fraud of itself, the Indemnifying Partner's employees, or any of its Representatives or sub-contractors, except to the extent that the loss or claim is directly

caused by or directly arises from the negligence, breach of this Agreement, or applicable Law by the Indemnified Partner or its Representatives.

17.3. The First Partner shall not be liable for any indirect losses suffered by the Second Partner whether such losses or the potential for such losses were made known to the First Partner or not and, other than in respect of death or personal injury, the limit of each Partner's liability to the other under this Agreement shall not exceed one million pounds (£1,000,000).

17.4. If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to an indemnity under these provisions, the Second Partner shall:

i. as soon as reasonably practicable give written notice of that matter to the First Partner specifying in reasonable detail the nature of the relevant claim,
ii. not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the First Partner (such consent not to be unreasonably conditioned, withheld or delayed); and
iii. give the First Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the First Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary, defending, the relevant claim.

17.5. For the avoidance of doubt, the Partners shall be under a duty to mitigate any loss in accordance with the principles of common law and the indemnity given by the First Partner shall not extend to losses, costs, expenses, damages, liabilities, actions, claims or proceedings incurred by reason of or in consequence of any negligent act or omission, misconduct or breach of this Agreement committed by the Second Partner.

17.6. Without prejudice to the Partners rights under this Agreement, the Host Partner shall in respect of the performance of its obligations under this Agreement effect and maintain the following insurances at the following indemnity levels with a reputable insurance company

i. Public Liability insurance to a minimum of Five million pounds, (£5,000,000) and an indemnity to Principals Clause;
ii. Employers Liability insurance to a minimum of Ten million pounds (£10,000,000),
iii. Professional Indemnity insurance with an annual aggregate limit of Two million pounds (£2,000,000),
iv. Any other insurance as may be required by law

18. VARIATIONS AND CHANGE CONTROL

18.1. No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners subject to approval by the Joint Commissioning Oversight Group as set out in this Clause.

18.2. Where the Partners agree that there will be:
i. a new Pooled Fund;
ii. a new Individual Scheme; or
iii. an amendment to a current Individual Scheme,
iv. the Joint Commissioning Oversight Group shall agree the new or amended Individual Scheme and this must be signed by the Partners. A request to vary an

Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification may be made by any Partner but will require agreement from all of the Partners in accordance with the process set out in Clause 18. The notice period for any variation unless otherwise agreed by the Partners shall be 3 Months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

18.3. The following approach shall, unless otherwise agreed, be followed by the Joint Commissioning Oversight Group:

i. on receipt of a request from one Partners to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Joint Delivery Board will first undertake an impact assessment and identify those Service Contracts likely to be affected,
ii. the Joint Commissioning Oversight Group will agree whether those Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the Partners holding the Service Contract/s is not put in breach of contract, its statutory obligations or financially disadvantaged,
iii. wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and
iv. should this not be possible, and one Partner is left financially disadvantaged as a result of holding a Service Contract for which the budget has been reduced, then the financial risk will, unless otherwise agreed, be shared equally between the Partners.

18.4. If at any time during the Term of this Agreement:

i. the Council or CCG requests in writing any change to the Services described or any matter relating to this Agreement generally; or
ii. If at any time during the Term a change to the manner in which the Services are provided/commissioned is required by operation of NHS or Local Government law through statutes, orders, regulations, instruments and directions made by the Secretaries of State for Health and Local Government respectively or others duly authorised pursuant to statute or other changes in the law which relate to the powers, duties and responsibilities of the Partner and which have to be complied with, implemented or otherwise observed by the Partners in connection with the Functions for the time being; then the provisions of this Clause 18 shall apply.

18.5. The Partners shall jointly investigate the likely impact of the required change on the Services and any other aspect of the Agreement and shall prepare a report in writing, setting out:

i. the variation proposed,
ii. the date upon which it should take effect,
iii. a statement of whether the variation will result in an increase or decrease in contributions to the Pooled Fund by reference to the relevant component elements of the Service or Services that are the subject of the change,
iv. a statement on the individual responsibilities of the CCG and the Council for any implementation of the variation,
v. a timetable for implementation of the variation,
vi. a statement of any impact on, and any changes required to the Services,
vii. details of any proposed staff and employment implications; and viii. the date for expiry of the report.

18.6. Where the Partners are unable to agree on the terms of the variation then they may refer this matter to dispute resolution pursuant to Clause 25 The Partners shall confirm in writing their decision to proceed with the proposed variation and shall agree a formal variation. Where the Partners agree to vary the terms of this Agreement pursuant to this Clause 18, the variation must be signed in writing by all Partners' Authorised Officers.

18.7. The Partners shall comply with their respective duties to consult on any change in, or addition to, the Services in accordance with the Regulations.

19. HEALTHWATCH

19.1. The Parties shall promote and facilitate the involvement of Service Users, carers and members of the public in decision-making concerning the Partnership Arrangements.

19.2. The Authority shall ensure the effective discharge of its obligations in the establishment of Local Healthwatch and, in the interim, with the Local Involvement Network.

19.3. The Authority shall ensure its contracts with Service Providers require co-operation with Local Healthwatch and, in the interim, the Local Involvement Network.

20. STAFF

20.1. The Partners agree that services commissioned shall be facilitated by the Staff listed in Appendix 11 to this Agreement.

20.2. It is the Partner's view that TUPE will not apply on the commencement of this Agreement as all staff engaged in connection with the Service at the outset of this Agreement, however, where the Partners are of the view that TUPE will apply to any aspect of this Agreement or any action carried out under it, the Partners agree to comply in full with all obligations under TUPE including without limitation those under regulation 13 of TUPE.

20.3. In accordance with Fair Deal for Staff Pensions, the Council and/or each Sub-Contractor to which the employment of any Eligible Employee compulsorily transfers as a result of the award of this Contract, if not an NHS Body or other employer which participates automatically in the NHS Pension Scheme, must on or before the Transfer Date, each secure a Direction Letter to enable the Eligible Employees to retain either continuous active membership of or eligibility for, the NHS Pension Scheme, for so long as they remain employed in connection with the delivery of the Services under this Contract.

21. PREMISES

21.1. The Partners shall operate out of their own respective premises in the performance of this Agreement, save as set out in Appendix 12 (Premises) to this Agreement.

21.2. The Partners shall comply with the obligations set out at Appendix 12 (Premises) to this Agreement in relation to the Premises.

22. EQUIPMENT AND OTHER RESOURCES

22.1. The Partners will comply with the provisions of Appendix 13 (Equipment) to this Agreement.

23. DATA PROTECTION

23.1. The Partners acknowledge their respective duties under the UK GDPR and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

23.2. The Parties acknowledge that for the purposes of the Data Protection Legislation, the Council and the CCG are Joint Controllers.

23.3. In acting as a Host Partner and Data Processor (as such term is defined in the DPA) on behalf of the CCG, the Council shall, in particular, but without limitation:

i. only process such Personal Data as is necessary to perform its obligations under this Agreement, and only in accordance with any instruction given by the CCG under this Agreement; to the extent that such instruction is lawful and reasonable,
ii. put in place appropriate technical and organisational measures against any unauthorised or unlawful processing of such Personal Data, and against the accidental loss or destruction of or damage to such Personal Data having regard to the specific requirements in Clause iii,
iii. below, the state of technical development and the level of damages that may be suffered by a Data Subject (as such term is defined in the DPA) whose Personal Data is affected by such unauthorised or unlawful processing or by its loss, damage or destruction,
iv. take reasonable steps to ensure the reliability of employees who will have access to such Personal Data and ensure that such employees are aware of and trained in the policies and procedures identified in Clauses 23.3., 23.3.5 and 23.3.6 below,
v. not cause or allow such Personal Data to be transferred outside the European Economic Area without the prior consent of all partners.

23.4. The Host Partner shall ensure that Personal Data is safeguarded at all times in accordance with the DPA and other relevant data protection legislation, which shall include without limitation the obligation to:

i. perform an annual information governance self-assessment,
ii. have Information Governance Officers able to communicate with the JCB, who will take the lead for information governance and from whom the JCB shall receive regular reports on information governance matters including details of all data loss and confidentiality breaches,
iii. where transferred electronically only transfer essential data that is,
iv. necessary for performing this agreement, and
v. encrypted to the higher of the international data encryption standards for healthcare and the National Standards (this includes, but is not limited to, data transferred over wireless or wired networks, held on laptops, CDs, memory sticks and tapes),
vi. have policies which are rigorously applied that describe individual personal responsibilities for handling Personal Data,
vii. have agreed protocols for sharing Personal Data with other NHS organisations and non-NHS organisations; and
viii. have a system in place and a policy for the recording of any telephone calls, where appropriate, in relation to this agreement, including the retention and disposal of such recordings.

24. FREEDOM OF INFORMATION ACT 2000

24.1. Each Partner acknowledges that the other Partner are subject to the requirements of the Freedom of Information Act 2000 (the "FOIA") or the Environmental Information Regulations (the "EIR") and each Partner shall assist and cooperate with the others (each at their own expense) to enable the other Partners to comply with these information disclosure obligations.

24.2. Where a Partner receives a "request for information" under either the FOIA or EIR (as defined under those Acts) in relation to information which it is holding on behalf of the other Partners or any of them, it shall (and shall procure that its sub-contractors shall):

i. transfer the request for information to any relevant Partner as soon as practicable after receipt and in any event within two (2) Working Days of receiving a request for information;
ii. provide the relevant Partner with a copy of all information in its possession or power in the form that the other Partner requires within five (5) Working Days (or such other period as may be agreed) of the other Partner requesting that information; and
iii. provide all necessary assistance as reasonably requested to enable the relevant Partner to respond t6 a request for information within the time for compliance set out in the EIR or section 10 of the FOIA, as relevant.

24.3. Where a Partner receives a request for information which relates to the Agreement , it shall inform the other Partners of the request for information as soon as practicable after receipt and in any event within two (2) Working Days of receiving a request for information.

24.4. If any Partner determines that information must be disclosed pursuant to Clause 24.3, it shall notify the other Partners of that decision at least two (2) Working Days before disclosure.

24.5. Each Partner shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

24.6. Each Partner acknowledges that the other Partners may be obliged under the FOIA to disclose Information:

i. without consulting with the other Partners, or
ii. following consultation with the other Partners and having taken its views into account.

25. DISPUTE RESOLUTION

25.1. The Partners shall use their best efforts to negotiate in good faith and settle any dispute that may arise out of or relate to this Agreement. If any dispute cannot be settled amicably through ordinary negotiations, then it shall be referred to the Partners' Authorised Officers for discussion and resolution. In the event that the Partners' Authorised Officers cannot resolve the dispute between themselves within ten (10) Working Days, or such other period of time that may be agreed in writing between the Partners, the Partners may refer the matter to the Chief Executive of the Council and the Accountable Officers of CCG; and thereafter to the Chair of the CCG and the Leader of the Council.

25.2. Each Partner shall use all reasonable endeavors to reach a negotiated resolution to the dispute through the above dispute resolution procedure. If the dispute is not resolved the Partners shall use every endeavor to settle it by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure (the "Model Procedure").

25.3. To initiate the mediation a Partner must give notice in writing to the other Partner requesting mediation in accordance with Clause 25.2.

25.4. The procedure in the Model Procedure shall be amended to take account of:

i. any relevant provisions in this Agreement; and
ii. any other agreement which the Partners may enter into in relation to the conduct of the mediation.

25.5. The costs of the mediation shall be met in equal shares by the Partners and shall not be paid from the Pooled Fund.

25.6. This clause 25.5 shall not prevent either Partner from seeking injunctive relief at any time during the Term (regardless of whether the Dispute Resolution Procedure set out in this clause 25 has been exhausted or not) in the case of any breach or threatened breach by the other Partner of any obligation under this Agreement.

26. CONFIDENTIALITY

26.1. Except as required by law and specifically pursuant to Clause 26 (Freedom of Information Act 2000), each Partner agrees at all times during the continuance of this Agreement and after its termination to keep confidential any and all information, data and material of any nature which that Partner may receive or otherwise obtain in connection with the operation of this Agreement or otherwise relating in any way to the business, operations and activities of the other Partners, their employees, agents and/or any other person with whom they have dealings including any client of any Partner. For the avoidance of doubt this Clause shall not affect the rights of any workers under Section 43 A-L of the Employment Rights Act 1996.

26.2. Where a Partner receives a request to disclose Information that the other Partner has designated as confidential, the receiving Partner shall consult with the other Partner before deciding whether the Information is subject to disclosure.

27. FORCE MAJEURE

27.1. Save for Essential Services where a Partner is (or claims to be) affected by an Event of Force Majeure in respect of any or all of the Services, it shall take all reasonable steps to mitigate the consequences of it, resume performance of its obligations as soon as practicable and use all reasonable efforts to remedy its failure to perform.

27.2. Subject to Clause 27.1, the Partner claiming relief shall be relieved from liability under this Agreement to the extent that because of the Event of Force Majeure it is not able to perform its obligations under this Agreement.

27.3. The Partner claiming relief shall serve initial written notice on the other Partners immediately upon becoming aware of the Event of Force Majeure. This initial notice shall give sufficient details to identify the particular event.

27.4. The Partner claiming relief shall then either:

i. serve a detailed written notice within a further five (5) Working Days. This detailed notice shall contain all relevant available information relating to the failure to perform as is available, including the effect of the Event of Force Majeure, the mitigating action being taken and an estimate of the period of time required to overcome it; or

ii. in the event it reasonably believes that the effects of the Event of Force Majeure will make it impossible for the Partnership Arrangements to continue, serve notice of this to the other Partners and the Agreement will terminate forthwith on service of the notice

28. REGULATION AND INSPECTION

28.1. The Partners shall cooperate with any investigation undertaken by the Care Quality Commission and/or the Audit Commission or any regulatory authority body.

29. AUTHORISED OFFICERS

29.1. Each Partner will appoint an Authorised Officer in respect of this Agreement and shall notify the other Partner of the details of that Authorised Officer on commencement of this Agreement. For Lincolnshire County Council the Authorised Officer will be the Accountable Officer unless an alternative nominated officer is formally notified.

29.2. Where the identity of any Partner's Authorised Officer changes during the Term this shall be notified to the other Partners as soon as practicable in writing.

30. OTHER PROVISIONS

30.1. Public Relations

The Partners shall co-operate and consult with each other in respect of matters involving public relations in so far as reasonably practicable having regard to the nature and urgency of the issue involved. The Partners may agree protocols for the handling of public relations from time to time.

30.2. No Partnership

i. Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render any Partner directly liable to any third party for the debts, liabilities or obligations of the other.

ii. Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, no Partner shall have authority to, or hold itself out as having authority to:
   1. act as an agent of the others,
   2. make any representations or give any warranties to third parties on behalf of or in respect of the others; or
   3. bind the others in any way.

31. CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

31.1. The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

32. NOTICES

32.1. Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. A notice shall be deemed to have been served if:

i. Any notice of communication hereunder shall be in writing by an authorised officer and signed by a Director or an Authorised Officer of the Partners.
ii. Any notice or communication from one Partner to another shall be deemed effectively served if:
iii. sent by registered post or delivered by hand to the other Partner or Partners to the address set out above and marked for the attention of the Authorised Officer, or any other address which ·may be notified to the other partners from time to time,
iv. sent by email to the email address for the Partners' Authorised Officer, or any other email address which may be notified to the other Partners from time to time.
v. Any notice served by hand delivery or email shall be deemed to have been served on the date it is delivered to the addressee. Where notice is posted it shall be sufficient to prove that the notice was properly addressed and posted, and the addressee shall be deemed to have been served with the notice forty eight (48) hours after the time it was posted.

33. GOOD FAITH

33.1. The Partners shall act and deal in good faith towards each other in respect of all matters the subject of this Agreement

34. SEVERABILITY

34.1. If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect, the validity, legality or enforceability of the remaining parts of this Agreement.

35. ASSIGNMENT OR TRANSFER

35.1. This Agreement and any right and conditions contained in it may not be assigned or transferred by any Partner without the prior written consent of the other Partners except to any statutory successor to the relevant function.

36. WAIVER

36.1. The failure of any Partner to enforce at any time to or for any period of time any of the provisions of this Agreement shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Partner thereafter to enforce such provision.

36.2. No waiver in any one or more instance of a breach of any provision hereof shall be deemed to be a further or continuing waiver of such provision in other instances.

37. COSTS

37.1. Each Partner shall be liable for their own respective costs in relation to this Agreement.

38. CONFLICTS OF INTEREST

38.1. The Partners shall comply with the policy for identifying and managing conflicts of interest as agreed by the Partners from time to time.

39. SERIOUS INCIDENTS AND SAFEGUARDING

39.1. A serious incident is defined as:

i. The death of a Service User, excluding a death by natural causes,
ii. An occurrence where a Service User, member of staff or a member of the public is attacked, has sustained injuries, or has sustained harm in other ways (e.g. through drug overdose or self-harm), either on the Providers premises or during the delivery of this service;

39.2. Partners shall follow the agreed local protocols for the reporting of Serious Incidents and Safeguarding with reference to Appendix 15.

39.3. The Partners shall make the necessary arrangements to ensure compliance with all Laws relevant to the duty to safeguard and promote the welfare of children and vulnerable adults in the delivery of all aspects of the Service including but not limited to Section 11 of the Children Act 2004, the Safeguarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012) and The Mental Health Act 1983.

39.4. Each Partner, if it has responsibility for the management and control of Regulated Activity (as defined under the legislation identified below), shall make the necessary arrangements to ensure compliance with Section 11 of the Children Act 2004 (the duty to safeguard and promote the welfare of children in the delivery of all aspects of the Service) and the Safeguarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012).

39.5. The Parties shall make the necessary arrangements to ensure compliance with registration requirements with the Disclosure and Barring Service.

39.6. To fulfil the commitment to safeguard and promote the welfare of children and vulnerable adults, as appropriate, the Partners shall have:-

(a) Clear priorities for safeguarding and promoting the welfare of children/vulnerable adults explicitly stated in strategic policy documents,
(b) A clear commitment by senior management to the importance of safeguarding and promoting children/vulnerable adults' welfare,
(c) A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children/vulnerable adults,
(d) Recruitment and human resources procedures in order to safeguard and promote the welfare of children/vulnerable adults,
(e) Procedures for dealing with allegations of abuse against members of Staff and volunteers,
(f) Arrangements to ensure all Staff undertake appropriate training and refresher training to enable them to carry out their responsibilities effectively,
(g) Policies for safeguarding and promoting the welfare of children/vulnerable adults and

procedures that are in accordance with guidance and locally agreed inter-agency procedures,

(h) Arrangements to work effectively with other organisations to safeguard and promote the welfare of children/vulnerable adults including sharing of information,
(i) A culture of listening to and engaging in dialogue with children/vulnerable adults; and
(j) Appropriate whistle-blowing procedures.

39.7. The Parties shall immediately notify each other of any information it reasonably requests to enable it to be satisfied that the obligations in relation to this Clause 40 have been met.

40. EQUAL OPPORTUNITIES

40.1. All Partners shall observe the applicable provisions of Equality Legislation including, but not limited to, those provisions recommending the adoption, implementation, and monitoring of an equality opportunities policy.

40.2. The Host Partner shall impose on any sub-contractor obligations substantially similar to those imposed on the Host Partner by this Clause 41.

40.3. All Partners shall publicise to its customers that it has an Equal Opportunities policy and provide customers with the opportunity to have a copy upon request and/or access a relevant complaints process aligned to this policy. Any substantiated complaint needs to be referred to the Authorised Officers.

40.4. The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

41. ASSIGNMENT AND SUBCONTRACTING

41.1. The Host Partner shall not sub-contract any part of the Service, except for the hiring of agency staff, without the prior written consent of the JCOG. Where such consent is given, the Host Partner shall be responsible for the acts and omissions of its sub- Service Providers as though they are its own.

41.2. Where sub-contracting part or all of the service takes place, the Host Partner is required to establish clear arrangements to monitor and to manage service delivery.

42. OMBUDSMAN AND PROHIBITED ACTS

42.1. The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

42.2. Neither Partner shall do any of the following:

i. offer, give, or agree to give the other Partner (or any of its officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement or any other contract with the other Partner, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other contract with the other Partner; and

ii. in connection with this Agreement, pay or agree to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to the other Partner, (together "**Prohibited Acts**" for the purposes of Clauses 43.2 to 43.6).

42.3. If either Partner or its employees or agents (or anyone acting on its or their behalf) commits any Prohibited Act or commits any offence under the Bribery Act 2010 with or without the knowledge of the other Partner in relation to this Agreement, the non-defaulting Partner shall be entitled:

i. to exercise its right to terminate under clause 15 and to recover from the defaulting Partner the amount of any loss resulting from the termination; and
ii. to recover from the defaulting Partner the amount or value of any gift, consideration or commission concerned; and
iii. to recover from the defaulting Partner any loss or expense sustained in consequence of the carrying out of the Prohibited Act or the commission of the offence.

42.4. Each Partner must provide the other Partner upon written request with all reasonable assistance to enable that Partner to perform any activity required for the purposes of complying with the Bribery Act 2010. Should either Partner request such assistance the Partner requesting assistance must pay the reasonable expenses of the other Partner arising as a result of such request.

42.5. The Partners must have in place an anti-bribery policy for the purposes of preventing any of their staff from committing a prohibited act under the Bribery Act 2010. If either Partner requests the other Partner's policies to be disclosed, then the Partners shall endeavor to do so within a reasonable timescale and in any event within 20 Working Days.

42.6. Should the Partners become aware of or suspect any breach of Clauses 43.2 to 43.5, it will notify the other Partner immediately. Following such notification, the Partner must respond promptly and fully to any enquiries of the other Partner, co-operate with any investigation undertaken by the Partner and allow the Partner to audit any books, records and other relevant documentation.

43. EXCLUSION OF AGENCY

43.1. Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

43.1.1. act as an agent of the other,
43.1.2. make any representations or give any warranties to third parties on behalf of or in respect of the other; or
43.1.3. bind the other in any way.

44. ENTIRE AGREEMENT

44.1. The terms herein contained together with the contents of the Appendixes constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

44.2. No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

45. COUNTERPARTS

45.1. This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

46. GOVERNING LAW AND JURISDICTION

46.1. This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

46.2. Subject to Clause 25 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

47. CHANGE IN LAW

47.1. The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

47.2. On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

47.3. In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause **Error! Reference source not found.**5 (Dispute Resolution) shall apply.

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement[1]

THE CORPORATE SEAL of **THE COUNCIL OF [ ]** was hereunto affixed in the presence of:)

Signed for on behalf of **[ ] CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

APPENDIX 1 – AIMS AND OBJECTIVES

1. INTRODUCTION

1.1. The partners to this agreement have agreed the governance arrangements set out in Appendix 5.

1.2. Governance for this Agreement will be carried out through the Joint Delivery Board for Adult Specialised Services hereafter referred to as the Board in this Appendix. Through its meetings the Board will ensure that a co-ordinated approach is taken to commissioning and providing services in Lincolnshire for adults with specialised care needs which is adults with learning disabilities and/or autism whose care is commissioned from the pooled fund.

1.3. This Agreement specifically relates to adult learning disabilities as defined in Appendix 9.

1.4. The Board will also perform a function in terms of examining performance against key outputs and outcomes as identified within the Agreement.

1.5. In addition, the Board will ensure health and social care commissioners links to the following Boards which have service user representation to add an additional layer of governance and accountability: -

- Learning Disability Partnership Board
- All Age Partnership Board

1.6. The Adult Learning Disabilities (AdLD) services and functions listed in Appendix 9 are to be provided from the Commencement Date under Section 75 of the National Health Service Act 2006, Lead Commissioning and Pooled Fund arrangements with the Council acting as Lead Commissioner.

1.7. As Lead Commissioner and under these Partnership Arrangements, the Council will be responsible for commissioning services on behalf of the CCG in exercise of the NHS Functions. Funds to purchase services will be provided by the CCG to the Council to enable Lead Commissioning of services via a Pooled Fund arrangement as described in Appendix 8 to this Agreement. Expenditure will be subject to the requirements that these funds are spent in a way that reflects the financial contribution of each Partner as well as addressing locally assessed needs and ensuring that required outcomes and outputs are met.

1.8. In addition, this Agreement includes the arrangements for the local agreed transfer of social care funds by the CCG the Council as required by the Department of Health and any subsequent guidance. This is referred to herein as the Valuing People Now transfer (the "VPN transfer")

1.9. The AdLD services commissioned under this Agreement will be delivered under the terms of the appropriate form of the Council's standard conditions of contract.

1.10. W here the term Services is used it refers to both healthcare and social care services.

1.11. All contracting arrangements must reflect the healthcare and social care components and ensure robust monitoring processes in line with the performance framework at Appendix 7 to this agreement.

2. AIMS & OBJECTIVES OF THE AGREEMENT

2.1. The Partners wish to use this Agreement to enable the Council to act on behalf of the Council and the CCG for the Lead Commissioning of the Services to the Service Users to be funded by a Pooled Fund Arrangement of which the Council shall be the Host Partner.

2.2. Service Users are not expected to be adversely affected or affected any differently because of the implementation of this Agreement. The way in which the Functions are exercised, and the Services are provided immediately prior to the commencement of this Agreement will not change in the sense that the Partnership Arrangements themselves already exist in the same form in terms of the extent of the Functions delegated and the Services delivered in exercise of those Functions. To the effect that changes to these Services are proposed under this Agreement these would be subject to separate consultation as appropriate.

2.3. Without prejudice to the other provisions of this Agreement, the primary objective of the Partners in entering into this Agreement is to improve the commissioning and provision of the Healthcare and social Care services for adults with Learning Disabilities by:

- analysing local needs, gaps in current service provision and capacity and demand issues, to ensure investment is targeted and cost effective; and
- all partners working collaboratively to commission integrated services and seamless care pathways which will improve outcomes and Service User I carer experience of the Services, within resources available.
- offering choice through the commitment to develop services that meet people's needs.
- flexibility in the delivery of services with greater emphasis on them being locally accessible, responsive and provided in a range of settings.
- synergising business planning, reporting procedures and other bureaucratic requirements between the Partners.
- Pooling budgets to improve the efficiency and cost-effectiveness or Service provision/ commissioning.
- delivering a cultural change which ensures that the benefits for integrated and person-centred care are realised.
- establishing a meaningful outcome-based framework that maximises the opportunity for improved quality and efficiency of health and social care support services through joint commissioning, and the use of pooled funds.
- improved team working and priority setting; and
- higher level of accountability via the Joint Delivery Board and JCOG.

2.4. The Partners shared aims, the agreed Aims and Objectives of the commissioning arrangements for the purposes of Regulation 7(3) (a) of the Regulations, are to ensure that:

- the commissioning of services is based on an agreed model of needs rather than historical service configurations.
- the commissioned services present good value for money and best value and seeks to operate within identified resources available for each partner and for each service area.
- the Services seek to promote emotional and physical good health and work to overcome social exclusion.
- services are culturally competent in meeting the needs of people from black and minority ethnic communities.
- a holistic whole systems approach is taken to the commissioning and provision of services by preventing duplication of such services and to make more effective use of the current resources e.g. integrated care pathways;

- the way commissioned services are shaped and delivered have been influenced by people who use services.
- there is a robust framework for commissioning which supports ongoing financial stability for partner organisations.
- safeguarding must always be given the fullest consideration during the commissioning process.
- robust arrangements to collect perfon11ance management information are established and maintained and that the information is used to evaluate performance against targets, monitoring both the effectiveness of the commissioning process and the commissioned services and
- there is clear identification of the healthcare and the social care components of the service being commissioned I provided at an individual service user level and service level, where this is possible and both organisations shall agree the exceptions and that these be noted within Appendix 5 Services: Scope of Service, Eligibility and Access.

2.5. Through these partnership arrangements, the key aims of the Council and the CCG are as follows:

- To perform better in priority areas, spend within allocated budget, and be more agile.
- To ensure innovative, appropriate, cost effective and quality opportunities are available from a market that people have helped to shape and deliver.
- To promote quality of life through effective, innovative, and caring learning disability social care and health care community services.
- To maximise people's independence

2.6. The Council shall ensure that the Care Act 2014, Transforming Care, Putting People First, Personalisation and self-directed support agendas are supported across social care within current legal frameworks and in consideration of the agreed level of pooled resources.

APPENDIX 2 – FUNCTIONS

1. Introduction:

1.1. Section 75(2)(c) of the NHS Act 2006 enables the Trust and the Council to enter arrangements for the exercise of prescribed health related functions of the Council by the Trust in conjunction with the prescribed functions of the Trust where such arrangements would lead to an improvement in the way in which those functions are exercised. It is on this basis that the Parties have agreed to enter the Arrangements. The Agreement documents the terms on which the Trust agrees to exercise the delegated Health Related (ASC) Functions which are defined by reference to this Appendix 2 Part 3.

2. Part 1 - NHS Functions

2.1. The following NHS functions which LCC are expected to adhere to when commissioning or providing relevant services are noted below.

2.2. The following list is an indicative guide at a point in time and the list is illustrative and not exhaustive. It is noted that the NHS Act 2006 may have updated some of the references below.

2.3. The NHS Functions to be transferred relate solely to healthcare services for adults with learning disabilities as outlined within the service specification. The transferring of this function as enabled by S75 of the NHS Act 2006 requires the Council to work within the same legal framework 's that the CCG would be required to operate within if they were commissioning the services outlined in this agreement directly. This includes ensuring that directly commissioned healthcare service providers also act in a lawful way when providing the services. Specific Legislative Framework which is particularly relevant is but not exhaustive:

- NHS Act 2006 (replacing 1977 Act)
- Mental Capacity Act 2005 (Amended MH Act 2007)
- Mental Health Act 2007
- NHS Act 2009
- Mental health Act 1983 (amended MH Act 2007)
- Care Act 2014

2.4. The NHS Functions are.

2.5. the function of providing, or planning for the provision of, services:

- under sections 2 and 3(1) of the 1977 Act, including rehabilitation services and services intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services: and
- Appendix 1 to, the 1977 Act.

2.6. the functions under sections 25A, 25H, 117 and 130A of the Mental Health Act 1983.

2.7. the functions of making direct payments under:

- section 12A(1) of the National Health Service Act 2006 (direct payments for health care); and
- regulation 2(7) of the National Health Service (Direct Payments) Regulations 2010; and
- the functions under Appendix A1 of the Mental Capacity Act 2005.

3. Part 2 - Council Functions

3.1. Such functions of the Council being health related functions for the purposes of Regulation 6(a) of the Regulations as relate to the provision of services to adults with a learning disability.

4. Part 3 - Excluded Functions

4.1. The following service functions are also integral to the current pathway / customer journey; however, these responsibilities and/or decisions are not included within this agreement:

- People who do not meet the relevant eligibility criteria (see Appendix three).
- People with Autism Spectrum Disorder but without a primary support reason of Learning Disability.
- Secure Inpatient Care - Specialist Low, Medium or High Although joint working and interface will be a part of this agreement for those who are eligible under the terms of the section 75 and are working towards discharge.
- The Care Programme Approach (CPA) care co-ordination of people who are in inpatient care due to their Learning Disability, Mental Health or Autism. (Commissioned via CCG's core NHS provider).
- CCG commissioned inpatient care. Including: PICU - Psychiatric Intensive Care Unit, Locked
- & Open Rehabilitation, Inpatient Acute Mental Health, ATU - Assessment & Treatment Unit (Inpatient Specialised LO), Specialist Inpatient Autism Beds.
- Specific Specialist Learning Disability and Autism services commissioned by the CCG through LPFT which include Liaison Nursing (Mental Health, Autism, Physical Health), Specialist Community Health Hubs, Community Home Assessment and Treatment (CHAT), Allied health professionals (Occupational Therapy, Speech and Language Therapy, Psychology, Physiotherapy). Although joint working and interface will be a part of this agreement.
- Specific Mainstream Mental Health services commissioned by the CCG through LPFT which include IAPT, recovery CMHT teams, Complex and Forensic Teams and CRHT teams and the inpatient acute care pathway. Although joint working and interface will be a part of this agreement.
- Continuing Health Care (Responsible Commissioner) - The Responsible Commissioner Guidance will apply and where this guidance defines another NHS body as being the responsible commissioner or another County Council body as being the responsible commissioner then such activity and costs shall be excluded from this agreement.
- Funded Nursing Care.
- Local Authority and NHS Public Health Functions.
- Wider Universal Services for example Cancer Care, GP Primary Care and Neighbourhood Teams.

APPENDIX 3 – ELIGIBILITY

1. ELIGIBILITY

1.1. This Partnership Agreement covers individuals aged over 18 years with a diagnosis of Learning Disability and any one of the following:

- Eligible for Adult Social Care as defined within the Care Act 2014 and statutory guidance issued under the Care Act,
- Continuing Heath Care (CHC) health need that cannot be met by mainstream CHC due to the impact of the persons Learning Disability,
- Have a Health Care need that cannot be met by mainstream services due to the impact of the persons Learning Disability.

2. DEFINITION

2.1. A learning disability is defined by the Department of Health as a "significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning}, which started before adulthood". The absence of an IQ score should not in itself limit eligibility.

NOTE: On the commencement of the complex case section 75 arrangements the eligibility criteria in this Appendix will be updated.

APPENDIX 4 – ESSENTIAL SERVICES

1. Essential Services are those services which are deemed essential to be commissioned and or provided by partners in relation to this agreement. All services in relation to this agreement are deemed essential unless the Joint Commissioning Oversight Group deems otherwise.

APPENDIX 5 – GOVERNANCE

1. INTRODUCTION

1.1. The Joint Commissioning Oversight Group provides the overall strategic oversight of the pooled budget arrangement within this section 75 agreement and/ or monitoring performance against Appendix 7.and direction to the commissioning arrangements in Lincolnshire for services for adults with learning disabilities. The management of the pooled fund and related functions will operate within the Constitution of LCC. It is responsible for planning the way forward for integrated health and social care for adults with learning disabilities, autism and mental health. It will monitor the management by the Council as Host Partner of Pooled Fund for AdLD Services in accordance with Appendix 7 and 8 of this Agreement.

1.2. All relevant meetings will have appropriate Terms of Reference detailing aims and objectives and roles and responsibilities.

2. MEMBERSHIP

2.1. The Board comprises senior representatives from all Partners to this Agreement and is also attended by other officers as required.

2.2. Membership of the Board shall be comprised of the following individuals:
Representing Healthcare
- Chief Commissioning Manager, Lincolnshire CCG
- Deputy Chief Finance Officer, Lincolnshire CCG

2.3. Representing Lincolnshire County Council Director Adults Social Care LCC
- Assistant Director - Specialist Adult Services, Adult Care & Community Wellbeing
- Head of Finance Adults Services LC;
- County Manager (Learning Disability) LCC

2.4. The pooled Fund Manager and Commissioning Managers will report to the Adult Specialised Joint Delivery Board and will be observers to the Board and provide advice and support and attend in a non-voting capacity.

2.5. If positions or organisational structures change, the Board will ensure the balance of membership is maintained.

2.6. The quorum for meetings is a minimum of four members (or their appointed deputy) and at least two members from one or more CCG and two members from the Council present. Decisions must be unanimous. Where unanimous agreement is not reached the members will agree on the process to conclude a decision which shall involve the individual Partners. The matter will be escalated to a Director within each organisation in the first instance. Ultimately the disputes resolution process will apply.

2.7. Any changes to the finance contributions outlined in Appendix 8 Annex A require the written agreement of all partners by a variation to change as outlined in clause 18.

3. MEETINGS

3.1. The Board will as a minimum meet formally on a quarterly basis. Meeting dates will aim to be agreed 12 months in advance.

3.2. The Host Partner will provide the Secretariat function to the formal Board meetings.

3.3. All Board meetings will be closed to the press and public.

3.4. Meetings of the Board will be chaired by either the Accountable Officer (Lincolnshire CCG) or the Director of Adult Care (the Council) or their nominated deputy. The chair will be appointed /nominated by the Board members and will chair for a period of six months unless an alternative time period is agreed by all partners.

3.5. The agenda and all reports will aim to be published five working days before the meeting and a minimum of two working days before the meeting. Minutes of meetings I a report of the decisions taken at meetings will be kept and circulated to officers within five working days of meetings.

3.6. Decisions can be taken virtually and recorded by email out with the formal meetings and in accordance with the quoracy in paragraph 3.2 above when pressing issues arise and will be retrospectively minuted within the next board meeting.

3.7. The Partners may agree in writing from time to time to modify, extend or restrict the remit of the Board.

3.8. The Board may decide to meet informally by mutual agreement

3.9. Individual Service areas may also wish to report annually to the service specific Partnership Boards on the delivery of the Aims and Objectives through the mechanism of this Agreement

4. FUNCTIONS

4.1. The particular responsibilities of the Board are (without limitation) as follows:

4.2. be responsible for agreeing and monitoring the Annual Commissioning Plan including formalising the saving schemes which are required to achieve the savings identified in Appendix 8 Annex A to this Agreement and agreeing financial contributions from the CCG and the Council to the Pooled Fund.

4.3. To ensure there is a formally agreed work program with clear work streams which defines significant financial and service planning commitments across areas of joint commissioning responsibility for Pooled Fund provision. This should underpin the Annual Commissioning Plan including the saving schemes. The Board shall regularly review progress against this work program and take action as appropriate.

- to review and agree commissioning strategies.
- to receive feedback and reports from the Lead Commissioner on the Services commissioned /provided.
- to monitor, advise and agree resource allocation and highlight cost pressures to the Partners through reporting lines to be agreed between the Partners.
- to approve changes to the commissioning/ provision of the Services, within the terms of this Agreement.
- to ensure the Partners comply with this Agreement.
- to measure the performance and quality of the services outlined in Appendix 9;
- to pursue the Aims and Objectives as specified in Appendix 9.
- to maintain a risk register, review this quarterly and to agree actions arising from the reviews. To agree annually the risk assessment and risk sharing protocol.

APPENDIX 6 - JOINT INFORMATION SHARING PROTOCOL

1. The Information Sharing Protocol is as defined in Appendix 6 of the Partnership Framework Agreement

APPENDIX 7 – PERFORMANCE MANAGEMENT & MONITORING

1. Part 1 – General

1.1. Purpose:

- This Appendix outlines the performance management and monitoring arrangements for this Agreement with respect to AdLD Services,
- The performance framework aims to ensure that the Partners are enabled to plan, deliver, review and act upon performance related information and to work towards improved outcomes for people with learning disabilities receiving support.

1.2. The Partners shall adhere to the Performance Measures. The Performance Measures shall demonstrate:

i. how far the aims of the Partnership Arrangements are being achieved
ii. the extent to which the outputs including timescales and milestones are being met
iii. the extent to which agreed Aims and Objectives are being fulfilled, and targets met
iv. the financial inputs and outputs
v. the extent to which the exercise of the flexibilities in Section 75 of the Act is the reason for improved performance, or a reduction in the performance of the service; and

2. Performance Management

2.1. Performance Management is an essential part of monitoring how well the Agreement is working in achieving the Aims and Objectives of the Partners. Effective performance management enables relevant staff throughout the partnership to:

- Be clear about the outcomes expected to be delivered each year,
- Make informed decisions based on the facts regarding current performance and the agreed targets,
- Take action in a timely manner to ensure that targets and outcomes are met,
- Continuously improve overall performance thereby ensuring better quality services are delivered to local adults with learning disabilities.

2.2. Through the Agreement, the Host Partner shall report on the performance indicators delivered by the Host Partner.

2.3. The Host Partner shall have in place a system for monitoring the activities undertaken by the Council's Operational Team in exercise of the Functions of all Partners.

2.4. The Partners shall have in place a system for capturing and monitoring all relevant statutory requirements, service user satisfaction and outcomes achieved by Service Users through the Service.

2.5. During the term of this Agreement, representatives from all partners shall jointly review the performance metrics through the formal mechanism of the Joint Delivery Board and the Joint Commissioning Oversight Group. These meetings shall review operational reporting processes and procedures and shall enable each Partner to be promptly alerted to any difficulties related to performance and to respond to performance related issues proactively and in a timely manner.

2.6. During the term of the Agreement, the Partners shall jointly review processes and mechanisms in operation to collect service activity data in order to ensure accurate information is reported and the most appropriate methods of data collation are utilised.

2.7. Where necessary, the Partners shall agree on specific performance improvement initiatives in the instances where performance is significantly under par.

3. Performance Framework

3.1. Performance shall be examined across a number of performance measures that enable the Host Partner to evidence and demonstrate performance against the following key areas (outlined in part 2 below)

- Personalisation
- Operational performance
- Interface with health
- Customer Satisfaction
- Maximising Independence

3.2. The performance framework shall enable the Partners to demonstrate and report on the achievement of national and local Performance Indicator (PI) targets relevant to Learning Disability Services. Responsibility for the collation of data relating to these PIs has been passed to the Host Partner under this Agreement. This responsibility also applies to any contracted arrangements exercised by the Council as Lead Commissioner through this Agreement.

3.3. Performance related data shall form part of information gathering processes applied by the Partners for the purposes of auditing the Services contained within this Agreement and to inform strategic planning, including decommissioning plans.

3.4. It is the responsibility of the Host Partner to report on the performance indicators contained within the performance framework on a quarterly basis within four weeks of the end of the quarter reporting period. Performance shall be monitored and reviewed by the partners through the Adult Specialised Services Joint Delivery Board.

3.5. The performance framework shall be subject to change through re-negotiation between all partners and in accordance with and in response to any subsequent changes to national directives and local priorities.

3.6. Key Indicators will be agreed on an annual basis via the Adult Specialised Services Joint Commissioning Oversight Group.

3.7. Statutory Returns

3.8. All Partners shall provide completed and validated statutory returns on relevant activity relating to learning disabilities as defined by the Department of Health and Care Quality Commission and any successor organisations.

3.9. All Partners shall provide the statutory returns in line with the relevant stated timeframe requirements.

3.10. The statutory returns on social care activity upon which the Host Partner shall report are detailed in the Statutory Performance Reporting matrix.

PART 2 PERFORMANCE MEASURES TABLES

Indicator Type/ ASCOF Outcome	Indicator Description
Quality of Life	% of LD clients in receipt of long-term support who receive a direct payment (ASCOF 1C)
Quality of Life	% of LD clients in receipt of long-term support helped to be accommodated in the community (not in residential or nursing care)
Quality of Life	Permanent LD admissions to residential and nursing care homes - aged 18 to 64 (ASCOF 2A)
Quality of Life	Permanent LD admissions to residential and nursing care homes - aged 65+ (ASCOF 2A)
Quality of Life	% of LD clients, aged 18+ in paid employment or participating in volunteering
Quality of Life	% of LD clients, aged 18+ who live in their own homes or with family
Quality of Life	% of LD clients aged 18+ with a Personal Budget (Social Case and/or PHB)
Keeping people safe	% of LD clients in receipt of long-term support who have been reviewed
Keeping people safe	Number of clients whose Scheduled/ Unscheduled review is overdue
Keeping people safe	Number of clients who are Joint/ Fully Funded who are CHC Section whose Scheduled/Unscheduled review is overdue
Interface with Health	Number of people that are joint funded CHC
Interface with Health	The number of clients that are fully funded CHC
Interface with Health	The number of clients that are joint funded with outstanding review
Value for Money	Annual benchmark of gross unit cost with other Local Authorities
Value for Money	The number of people supported by the Section 75 Agreement each quarter
Positive experience	% of LD clients receiving services who have control over their daily life (ASCOF lB)
Positive experience	% of Overall satisfaction of care and support for LD clients receiving services (ASCOF 3A)
Positive experience	% of LD clients receiving services who feel safe (ASCOF 4A)
Positive experience	% of Overall satisfaction of carers for LD clients within Adult Care (ASCOF 3B)
Positive experience	% of Carers who feel included/consulted in discussions regarding the LD client they care for (ASCOF3C)
Positive experience	Number of LD Complaints received during year (Cumulative)
Positive experience	% of LD Complaints annually that had an outcome of Substantiated/Partly Substantiated
Transforming Care	Numbers of admissions to in-patient beds for mental and/or behavioural healthcare that have learning disabilities and were supported via the Section 75 Agreement

APPENDIX 8 – POOLED FUND ARRANGEMENTS

POOLED FUND ARRANGEMENTS

1. The Partners' Contributions shall be managed by the Pooled Fund Manager, appointed by the Host Partner.

2. Each Partners' Contributions for the 2022-23 financial year i.e. 1 April 2022 until 31 March 2023 shall be set out in Annex A to this Appendix 8.

3. The process for setting future year contributions - that is 2023/24 onwards - is set out in Annex B to this Appendix 8. Any overspends and underspends shall be dealt with in accordance with the provisions of Annex C of Appendix 8.

4. The Host Partner will be responsible for the accounts and providing timely information to support the audit of the Pooled Fund.

5. The Pooled Fund Manager will be responsible for:

   5.1 managing the Pooled Fund on behalf of the Host Partner,
   5.2 submitting to the Partners timely financial reports, about the income of, and expenditure from, the Pooled Fund and other information by which the Partners can monitor the effectiveness of the Pooled Fund Arrangements through the Joint Delivery Board,
   5.3 providing the other Partners with the necessary information they require to meet their financial governance arrangements,
   5.4 transacting payments from the Pooled Fund; and
   5.5 ensuring that management arrangements and reporting for the Pooled Fund comply with audit requirements.

6. The Standing Orders and Standing Financial Instructions of the Host Partner as notified to the other Partners from time to time shall apply to the management of the Pooled Fund.

7. The Host Partner shall arrange for the audit of the accounts of the Pooled Fund Arrangements.

8. The Host Partner shall make available information to support the Year end Audit of Partner organisations' accounts. The memorandum of accounts shall be made available to Partner organisations on its completion.

9. The monies in the Pooled Fund:

9.1 may be expended on the Functions in such proportions as the Partners shall agree is necessary to undertake the Functions and to procure or otherwise provide the Services,
9.2 shall be spent in accordance with any restrictions agreed in writing between the Partners from time to time; and
9.3 are specific to the Arrangements and shall not be used for any other purpose.

Annex A: Contributions for the Financial Year 2022/23

1. The total Pooled Fund contributions by all partners for 2022/23 is £86.104,050 as detailed in table one below:

Table 1 Learning Disabilities

`The opening Partner contributions for 2022-23 to the LD pooled fund Services are as follows:

	CCG Total	BCF	iBCF	LCC Total	Total
CCG Funded Care	17,922,492				17,922,492
LCC Funded Care		7,011,690	7,581,695	50,341,447	64,934,832
Sub total	**17,922,492**	**7,011,690**	**7,581,695**	**50,341,447**	**82,857,324**
Staffing	1,623,363			1,623,363	3,246,726
Total	**19,545,855**	**7,011,690**	**7,581,695**	**51,964,810**	**86,104,050**

2. The above table reflects the following principles
   - 2022-23 Provider rates to be paid from April 2022. These rates reflect the NMW/NLW as per the December 2021 Spending Review.
   - The financial position is built up from individual service users packages of care with the 2021-22 full year effect.
   - Net growth is built into the projections.

3. The Fund contributions for 2022-23 have been calculated by the Council's financial team and agreed with the Lincs CCG.

4. For 2022/23 the CCG direct contributions are projected to be £19,545,855 from CCG budgets.

5. Should the CCG costs exceed the direct contribution above a maximum additional contribution of £700,000 to CCG 2022-23 costs will be drawn down from Better Care Fund (iBCF)2022-23. If the maximum contribution from BCF is not required it will not be drawn down.

6. Within the financial parameters of the table outlined above, the CCGs will fund:
   - 50% of the actual staffing costs incurred by the Council in performing its role under this Agreement up to a fixed upper value of £1,623,363
   - 100% of the actual cost of existing and new packages of care which are agreed fully funded through the CHC agreement process and;
   - 35% of the actual cost of existing and new packages of care which are agreed joint funded through the CHC agreement process.

7. In relation to cases within the pooled fund that have eligibility for S117 funding the CCG and LCC will apportion cost in line with the Section 117 Policy and related procedures and funding agreement.

8. The "CHC agreement process" referred to in the paragraph above is the process set out in paragraph 5.2 of Appendix 9 to this Agreement.

9. In relation to the CHC agreement process the fund manager will retain a record of when the review was sent for consideration, the CCG will record when the details have been received and when considered and also when the decision has been communicated to the fund manager. All decisions must be confirmed electronically to the fund manager.

The complex CCG must provide the fund manager with an accurate list of any cases still awaiting decision at the end of each month.

10. The Council will invoice the CCG on a monthly basis for 1/12 of each CCGs total contribution to the Pooled Fund. The CCG will pay its contribution within 20 working days of receipt of invoice.

11. The Pooled Fund Manager will present monthly financial information at organisational and expenditure type level for year to date and forecast expenditure against budget. The financial information will be underpinned with an anonymised service user dataset to enable data quality checks to be carried out. Through this process the Pooled Fund Manager will provide each organisation with a reconciliation of the CCG's 1/12th contribution against actual expenditure on each of the above categories noted in Table 1 above to inform the determination of any underspends/overspends by the CCG of its contributions. Any over or underspends determined to have been made by the CCG will be invoiced by the CCG to the Council or by the Council to the CCG on a monthly basis. Invoices shall be paid within 20 working days of receipt.

12. A finance report will also be provided on a monthly basis to the Adult Specialist Joint Delivery Board supported on an exceptional basis by an interim report should there be financial risks or deviations which are material.

13. The management of any overall over and underspends is defined in Appendix 8 Annex C and for 2022/23. Any overall underspends will be returned to the contributing organization in accordance with Annex C.

14. The process for setting future contributions from financial years 2023-24 is set out in Appendix 8 Annex B.

15. The Joint Delivery Board is expected as part of its work plan to consider effective use of resources and to consider opportunities for improving value for money**.**

Annex B: Agreement of Financial Contributions

1. The 2022/23 Partner contributions are outlined in Annex A to this Appendix 8.

2. In establishing Partner contributions for 2023/24 and beyond, all Partners will collaborate to deliver against the agreed work programme included below to determine the scope of the S(75) pooled fund arrangements and to confirm a process for establishing contributions and for affirming the management of under/overspends.

3. To support continual strengthening of an integrated LD service for the Lincolnshire population, a work programme is being drafted to take this forward for 21/22. This is looking in part to assist our journey towards an Integrated Care System (ICS) and the further development of lead commissioner arrangements for Learning Disability, Mental Health and Transforming Care populations. The key components of the work programme are to:

- Continue to progress the development a pooled budget and lead commissioner arrangements for people with complex needs,
- Build the Section 256 agreement (and related schemes) between LCCG and LCC into monthly reporting,
- Continue the joint work between LCC/LCCG and LPFT in relation to the continuous improvement of demand management for Adult Care and CHC with a particular focus on maximising people's independence,
- Propose the development of a joint approach to the setting of provider rates for 2023+ taking into account the current market environment and the likely implications of the social care reforms.

ANNEX C: Overspends and Underspends

1. The Host Partner shall make the other Partners aware of any actual or forecast variances of spend against the Pooled Fund or financial risks as soon as it becomes aware of this possibility. The Host Partner will highlight reasons for the variance both current and projected, and make recommendations for action to bring the over-spend into alignment with the budget.

2. For 2022/23 the CCG direct contribution of £19,545,855 will be used to fund CCG's related care costs. Should the level of total CCG related care costs be below £19,545,855 related underspend will be returned the CCG. There is however a financial risk that total costs will exceed £19,545,855.

3. For 2022/23 an additional contribution towards the cost of CCG related care up to a maximum of £700,000 will be funded from the BCF. Any of the £700,000 not utilised to fund CCG related care within the Section 75 agreement will not be drawn down from the Better Care fund.

4. Any overspend of CCG related care above the £19,545,855 plus the £700,000 CCG related contributions will be funded by the Lincolnshire CCG.

5. For 2022-23 the Council will fund any overspends relating to social care functions including 65% of joint funded packages. The Council will also retain any underspends relating to social care functions including 65% of joint funded packages.

6. Any underspends will be transferred to the contributing organisation through the monthly reconciliation and invoicing process. For clarity underspends will relate directly to the areas funded by the contributing organisation as described in the table in Appendix A.

ANNEX D: VAT Regime

1. The Partners agree to adopt "Partnership Structure (a)" as described in the VAT Guidance through which the Partners agree that goods and services will be purchased in accordance with the Host Partner's VAT regime and reimbursed from the Partners' contributions.

APPENDIX 9 – SERVICE SPECIFICATION

1. INTRODUCTION

1.1. The following service specification describes the model of care and support to be commissioned by the Local Authority on behalf of the partners agencies subject to this agreement.

1.2. The Community Learning Disability Team in Lincolnshire provides integrated health and social care provision, this specification outlines the key functions and support to those people who are:

- Eligible within the scope of this agreement and their access arrangements, and,
- Outside the scope of the agreement i.e. not within pooled funding arrangements but within the "pathway" and commissioned by others

1.3. The Council as the lead commissioner will co-ordinate or directly commission the services for the people who meet the agreed "eligibility" criteria within Appendix 3 which may be amended from time to time in accordance with clause 18 of this Agreement.

1.4. The service specification will be reviewed annually in line with pooled fund contributions.

2. SCOPE OF THE SERVICE

2.1. Individuals with a learning disability as defined by Department of Health Guidance and eligible within the scope of this agreement as detailed at Appendix Three.,

2.2. Exclusions to the Agreement are provided at **Appendix 2 Part 3.**

3. ELIGIBILITY

3.1. Details of eligibility are provided in **Appendix 3**

4. PATHWAYS AND ACCESS

4.1. The Learning Disability pathway in Lincolnshire describes a whole system that supports individual needs within an integrated health and social care economy. The support provided via this agreement forms an important part of this overall pathway where Adults with a Learning Disability have an eligible need.

4.2. The service can be accessed by referral to the Community Learning Disability Team hosted by the Council. Referrals will normally be made via the Councils Customer Services Centre (CSC). Following referral an assessment will be undertaken to establish eligibility.

4.3. The Council provides generic information and advice to the public and people who are referred for assessment and will signpost people as appropriate where they do not meet the threshold for social care. The system of wider prevention and early intervention offered via Health, Public Health and the voluntary sector however sits outside of this agreement.

4.4. Whilst the Community Learning Disability Team provided by the Council may input to Care Treatment Reviews (CTR's) the CCG are responsible for the implementation of the Care and Treatment Review policy.

4.5. Whilst the Community Learning Disability Team provided by the Council may input into the admission pathway the accountability for the decision to admit to inpatient care does not sit with the Community Learning Disability Team.

4.6. The services provided via the pooled fund are predominately for people when they are not in crisis but will be commissioned in a way that supports care that seeks to prevent points of crisis.

4.7. Adult Social Care, Health and associated Universal and Specialist services commissioned or provided to support those with a Learning Disability are expected to promote referral to the Community hubs for specialised therapy and specialist health service above that of this agreement and for Community Home Assessment and Treatment (CHAT) for those individuals at immediate risk of admission to hospital due to their learning disability, behaviours of concern or mental health needs and to promote discharge from inpatient provision in line with the national transforming care agenda.

4.8. The Community Learning Disability Team includes the agreed Learning Disability Nurse function as defined in this specification.

4.9. The Community Learning Disability Team provided by the Council will work closely with Children's services to manage the effective transition of eligible young adults with a Learning Disability to Adulthood.

5. FUNCTIONS

5.1. Under the s75 arrangements the Council retains all if its statutory duties in relation to people with disabilities.

5.2. Within the agreement CCG's transfer to LCC responsibility for assessment for Continuing Health Care and responsibility for macro and micro commissioning of services and provision against Continuing Health care funding. Decisions on whether cases will be joint funded or fully funded CHG will be supported by a panel hosted by Lincolnshire CCG's but must also include input to the decision by the Council.

5.3. The Council carries out Social Care and Health functions for adults with learning disabilities on behalf of the Council and the CCG under this Agreement. It is recognised that some functions will be core components of healthcare and so will also be functions of CCG commissioned services outside of this agreement.

5.4. Planning of intervention to meet identified need, to be formalised in a care & support plan. This may include planning on how the service will meet the need (for example low level anxiety) or referral to other agencies for a formal assessment (for example for an autism diagnostic assessment if the identified need is a potential autism spectrum disorder).

5.5. The Council will on confirmation of eligibility provide a Personal Budget to enable the individual to meet their identified outcomes as defined in their assessment. For those with a defined health care need under continuing health care they will be provided with a Personal Health budget to meet their identified outcomes as defined in their assessment.

5.6. The personal budget or personal health budget may be taken as a direct payment and managed by the person with the Learning Disability and/or by a third party and services directly commissioned to meet assessed needs and outcomes in line with the personal budget and personal health budget policy and procedures. Such direct payments will be

subject to financial audit and claw-back when the personal budget is not fully utilised or if it is used inappropriately.

5.7. The Council will also put in place specifications and contracts with third party providers to confirm the outcomes and objectives to be achieved. Where necessary these will also confirm specific activities requires to ensure providers operate in line with National and local standards and relevant legislation.

6. COMMISSIONING INTENTIONS

6.1. The priority Outcomes for Specialist Adult Services including those for Adults with a Learning Disability will be confirmed within the Joint Commissioning Strategy for Specialist Adult Services. The Joint Commissioning Strategy for Specialist Adult Services will be developed via the Joint Commissioning Oversight Group and in consideration of the areas below:

- The Health and Wellbeing Strategy and related Joint Strategic Needs Assessment
- The Lincolnshire Clinical Commissioning Groups operational Plans
- The Councils Strategic Plans
- Specialist Adult Services Needs Assessments
- Input and feedback from key stakeholders and stakeholder groups
- National policy, legislation and guidance including but not limited to Transforming Care.

7. SERVICE MODEL

7.1. The Council shall provide an Integrated Assessment and Care Management function delivered within the Community Learning Disability Team that will respond to referrals for support, assessments of eligible need and where eligibility is confirmed co-produce Care and Support Plans and Personal Budgets to meet agreed needs. The team will also support regular reviews of care and support. Assessment and Care management will include CHC but exclude Funded Nursing Care.

7.2. The service model for Section 75 learning disabilities will be defined by the outcomes that have been identified to meet assessed health and social needs. Services will be commissioned in a way that seek to promote independence, choice, and control but also in consideration of available resources.

7.3. Residential and Nursing Care will be utilised where this will best meet assessed individual needs.

7.4. People may be supported in the community via several services including but not limited to Community Supported Living, External Day Care, and Personal Assistants.

7.5. Advocacy is not directly funded via the Section 75 agreement but there are separate arrangements in place (that will be funded by the Council and CCG's) to provide this support if it is needed.

7.6. Through the service review work jointly completed by the Council and Lincs CCG's it has been identified that there may be some gaps in the wider Learning Disability Pathways in Lincolnshire. The council and Lincs CCG's will work together through the Transforming Care Partnership (TCP) Board to clarify the wider pathways required and where necessary raise business cases via the Joint Commissioning Oversight Group to seek to address any gaps in provision confirmed.

8. **LD SECTION 75 Supplementary to Service Specification:**

Agreement I Service Specific Functions "Included"

8.1. The following provides both ASC and CCG functions undertaken as part of this agreement:

a) Information and Advice.
b) Adult Care Assessment, including social care, healthcare MH and Physical Health which then for eligible CHC cases informs Continuing Health Care.
c) Care Plans/ Personal Plans.
d) Care/ Case Management.
e) Continuing Health Care (specific to the LD Section 75).
f) Care Co-ordination (Including Care Programme Approach for those who meet criteria).
g) Referral to hub teams through Single Point of Access (SPA) as appropriate.
h) Reviews of assessment, care plan & risk (minimum of annual) social care and Continuing Health Care 6 monthly for Care Programme Approach.
i) Health Promotion other than that commissioned via public health.
j) Coordination and leading of Multi-Disciplinary Team processes and Professionals Meetings. Including the involvement of wider heath care professionals as appropriate e.g. GP, District Nurse, Mental health worker etc.
k) Safeguarding.
l) Transition planning including health & social care preparing for adulthood.
m) Professional Support.
n) Micro commissioning, procurement & brokerage e.g. Community Supported Living (CSL), residential/nursing, Home support, short breaks, day opportunities.
o) Personal budgets/personal health budgets, Integrated Personal Commissioning.
p) Direct Payments as a delivery mechanism.
q) Support process around Transforming Care: and reduced duration of Stay and reliance on use of inpatient admission.
r) Co-Production.
s) Financial assessments.
t) Carer assessments.
u) Awareness & promotion of assistive technology.
v) Promoting awareness and uptake of Annual Health Check.
w) Promoting awareness and uptake of Health Action Plan’s through review of personal plans & contract management.
x) Mental Capacity including DOL's & Best Interest process.
y) Planning & Delivery of evidence based clinical interventions.
z) LD Community Nursing see functions below.

DRAFT - **Supplementary** to Service Specification

Community Nurse Functions Delivered within the S75 LD Agreement:-

Task		Undertaken Yes/No
Assessment	Health needs including physical, mental, emotional and behavioural	Yes
	Regular on-going assessment for those with higher level needs	Yes
	Specific assessments or screening tools to enable referral or escalation to specialist intervention for example autism, ADHD, dementia, epilepsy, anxiety, depression screening or assessment to indicate further full assessment required. Or assessment of sleep difficulties to help inform the formulation or referral to other agencies by implementing sleep charts and then analysis of the charts in relation to key themes.	Yes
	Risk assessment and risk management plan including suicide and self- harm risk, risk of abuse and neglect	Yes
	Assessment of communication need (where specialist SALT input not required) which will lead to care plan and interventions as needed	Yes
Formulation	Including generating care plans	Yes
	To inform intervention	Yes
Advice and Guidance	To other health and social care professionals, families and carers and providers	Yes
	Sexual health advice and guidance	No
	Mental health promotion	Yes
	Physical health promotion	Yes
Intervention	Sleep hygiene	Yes
	All about me booklet	Yes
	Health passport	Yes
	Communication plan	Yes
	Psychosocial intervention	No
	Graded anxiety management	Partial
	Education around health needs in an accessible and meaningful format	No
	Training to family members, individual or support	No
	Person centred planning	Yes
	Administration of medication for example injections	No
	Development and implementation of crisis management	Yes

Task		Undertaken Yes/No
Coordination of care (either through CPA or as a CLOT)	CPA care coordination	Yes
	Making sure all care plans etc are accessible and meaningful and are delivered	Partially
	Being names point of contact for the individual and family	Yes
	Enhancing access to mainstream health care appointments or appointments associated with health and wellbeing through direct support to the individual (not to be confused with health liaison provision which is about ensuring services are reasonably adjusted and assisting with the service itself to provide the service to the person. This is about supporting the individual to access the services).	Yes
	Advocating for the individual (not as a formal advocate)	Yes
Monitoring of Prescribed medication	Efficacy of medication	Partially
	Symptom monitoring	Yes
	Side effect monitoring	Yes
	Height and weight if applicable	partially
	Blood pressure if applicable	No
Review	Care plan	Yes
	Interventions	Yes
	Treatment plans	Yes
	Risk assessment	Yes
	Crisis management plans	Yes
	Health action plan	No

APPENDIX 10 – SERVICE USERS

1. Service Users are those eligible for the services as outlined in Appendix 3.

APPENDIX 11 – STAFFING

1. All partners shall make available appropriate staff to deliver the service's needs who, as at the Commencement Date, carry out the Council/ CCG Functions.

2. Lincolnshire CCG shall make available the Learning Disabilities Complex Cases Team

APPENDIX 12 - PREMISES

1. All partners acknowledge that there is further work to be undertaken to determine over-arching principles in relation to estates and such principles shall be incorporated into this agreement in accordance with Section 15 once they have been confirmed.

2. The Council shall provide accommodation to the Learning Disabilities Complex Cases Team hosted by Lincolnshire CCG

3. The Host Partner shall ensure that the Premises are:
   3.1. suitable for the delivery of the Services.
   3.2. sufficient to meet the reasonable needs of Service Users; and
   3.3. where required by law, shall meet any and all regulatory standards (as appropriate) including but not limited to the Disability Discrimination Act 1995, the Care Standards Act 2000 and the Private and Voluntary Healthcare (England) Regulations 2001, together with any applicable NHS standards in force from time to time.

APPENDIX 13 – EQUIPMENT

1.1. All Partners acknowledge that there is further work to be undertaken to determine over-arching principles in relation to equipment and such principles shall be incorporated into this agreement in accordance with Section 15 once they have been confirmed. In the interim the following will apply:

1.2. The Host Partner shall ensure that any equipment being used for the provision of the Services is:

- suitable for the delivery of the Services.
- sufficient to meet the reasonable needs of Service Users.
- where required by law, shall meet any and all regulatory standards (as appropriate) including but not limited to the Disability Discrimination Act 1995, the Care Standards Act 2000 and the Private and Voluntary Healthcare (England) Regulations 2001, together with any applicable NHS standards in force from time to time.

1.3. The Host Partner shall:

- maintain in good and serviceable repair all equipment.
- ensure that the equipment integrates properly with hardware, software, products, or services which interface with or are used in conjunction with the Services; and
- not at any time introduce any computer virus or other contamination, whether knowingly or not onto any of the equipment.

1.4. Full legal, beneficial and equitable title to the Equipment shall remain with the Council at all times. Upon delivery of the NHS/Council equipment to the Host Partner at the Premises, risk in using the NHS/Council equipment will pass to the Host Partner and remain with the Host Partner until the NHS/Council equipment is returned to the NHS/Council on termination or expiry of this Agreement.

1.5. Whilst risk in the NHS/Council equipment remains with the Host, the Host Partner shall:

- be solely and absolutely responsible for any loss or damage to the NHS/ Council equipment.
- store and use the NHS/Council equipment at the Premises in a proper manner in conditions which adequately protect and preserve the NHS/Council equipment and shall not move it from the Premises without the NHS/Council's prior written consent.
- ensure that the equipment is clearly identified as belonging to the NHS/ Council and is not tampered with.
- use the NHS /Council equipment in a careful, safe and proper manner in accordance with any operating instructions provided to the Host Partner by the NHS /Council and all applicable statutes, regulations or codes of practice, and not for any purpose for which it was not designed or for any unlawful purpose.
- ensure that the equipment is used only for the purpose of providing the Services.
- immediately notify the NHS/Council of any breakdown or unsatisfactory working, loss, damage, theft, seizure or loss of possession of the NHS/ Council equipment.

APPENDIX 14 – WINDING DOWN PROTOCOL

1.1. Where an Individual Funding Stream (as defined in Annex A to Appendix 8 of this Agreement) ("Affected Stream") is not continued from one financial year ("final Scheme year") into the next financial year ("first post-Scheme year") and the Partners are not obliged to continue with the services or other activities funded through the Affected Stream, the Partners agree that in the 6 months prior to the end of the final Scheme year and in the first 6 months of the first post-Scheme year, they will work together and co-operate to ensure that the winding down of the Individual Funding Stream is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so.

1.2. In particular (without prejudice to the generality of Clause 1.1) where commissioning responsibility for the services covered by the Individual Funding Stream transfers from one Partner ("Affected Stream commissioner") to another Partner ("successor commissioner"),

1.2.1. the Partners will co-operate to transfer, so far as possible, any continuing contracts for the provision of services to the successor commissioner, provided that the Affected Stream commissioner shall remain responsible for, and shall indemnify the successor commissioner against, all costs, claims and liability arising in respect of periods prior to the commencement of the first post-Scheme year,

1.2.2. each of the Affected Stream comm1ss1oner and the successor commissioner will appoint a transition manager ("Transition Manager") and provide written notification of such appointment to the other party not less than 6 months prior to the end of the final Scheme year. The Affected Stream commissioner's Transition Manager will be responsible for ensuring that the Affected Stream commissioner and its employees, agents and sub-contractors comply with this Clause 1.2. The parties' Transition Managers will liaise with one another in relation to all issues relevant to the transfer of commissioning responsibility for the services and all matters connected with this Clause 1.2 and each party's compliance with it,

1.2.3. on reasonable notice, the Affected Stream commissioner shall provide to the successor commissioner, the following material and information in order to facilitate the transfer of commissioning responsibility and/or the preparation by the successor commissioner of any invitation to tender:

(a) details of the transferring service(s) and the service users
(b) details of the contracts held by the Affected Stream commissioner in relation to the Affected Stream; and
(c) all information the successor commissioner reasonably requires relating to employees of the Affected Stream commissioner whose employment will or may transfer to the successor commissioner by operation of law ("Transferring Employees")

1.2.4. in the 6 months prior to the end of the final Scheme year, the Affected Stream commissioner shall not alter the terms of employment or remuneration or benefits of any Transferring Employees or engage or assign any additional employees in connection with its role as Affected Stream commissioner (such that they would or might become Transferring Employees) without the agreement of the successor commissioner (such agreement not to be unreasonably withheld or delayed);

1.2.5. the Affected Stream commissioner shall indemnify the successor commissioner against all costs, claims and liability in relation to the Transferring Employees which relate to periods up to and including the end of the final Scheme year or arise from the acts or omissions of the Affected Stream commissioner during any such period and the successor commissioner shall indemnify the Affected Stream commissioner against all costs, claims and liability in relation to the Transferring Employees for which it is not entitled to indemnity from the Affected Stream commissioner; and

1.2.6. in addition to the indemnity in Clause 17, the Affected Stream commissioner shall indemnify the successor commissioner in respect of any claim made by or in respect of any person employed or engaged of formerly employed or engaged by the Affected Stream commissioner other than those who are either:

(d) on a list of the anticipated Transferring Employees provided by the Affected Stream commissioner to the successor commissioner not less than 2 months prior to the end of the final Scheme year, or

(e) subsequently engaged by the Affected Stream commissioner with the agreement of the successor commissioner given under Clause 17 above.

1.2.7. An Exit Plan will be agreed for each Affected Stream within 4 months of the end of the final Scheme year, which shall set out the proposed methodology for achieving an orderly wind-down (where there is no successor commissioner, in which case the Exit Plan shall be agreed between the Partners) or transition (where there is a successor commissioner, in which case the Exit Plan shall be agreed between the Affected Stream commissioner and the successor commissioner).

1.2.8. The Exit Plan shall, as appropriate make provision for

(a) the transfer of equipment and any other assets transferred from one Partner to another under the Arrangements 1.4.2 the continuation or termination of each Partners' rights of occupation of Premises owned or controlled by the other Partners shall cease insofar as applicable to the provision of the Services related to the Functions of that other Partner
(b) the retention or transfer of ownership of the records and information relating to the Functions and client files including any relevant records that were transferred to the other Partners as part of the Arrangements; and
(c) the management of debtors and creditors

1.2.9. All Partners agree that all such information as may be provided to the other may be passed on to any prospective or new service providers (in confidence) for the purposes of future provision of the Functions and obtaining advice only. Stream commissioner (such that they would or might become Transferring Employees) without the agreement of the successor commissioner (such agreement not to be unreasonably withheld or delayed)

1.2.10. the Affected Stream commissioner shall indemnify the successor commissioner against all costs, claims and liability in relation to the Transferring Employees which relate to periods up to and including the end of the final Scheme year or arise from the acts or omissions of the Affected Stream commissioner during any such period and the successor commissioner shall indemnify the Affected Stream commissioner against all costs, claims and liability in relation to the Transferring Employees for which it is not entitled to indemnity from the Affected Stream commissioner; and

1.2.11. in addition to the indemnity in Clause 17, the Affected Stream commissioner shall indemnify the successor commissioner in respect of any claim made by or in respect of any person employed or engaged of formerly employed or engaged by the Affected Stream commissioner other than those who are either:

(d) on a list of the anticipated Transferring Employees provided by the Affected Stream commissioner to the successor commissioner not less than 2 months prior to the end of the final Scheme year, or
(e) subsequently engaged by the Affected Stream commissioner with the agreement of the successor commissioner given under Clause 17 above.

1.2.12. An Exit Plan will be agreed for each Affected Stream within 4 months of the end of the final Scheme year, which shall set out the proposed methodology for achieving an orderly wind-down (where there is no successor commissioner, in which case the Exit Plan shall be agreed between the Partners) or transition (where there is a successor commissioner, in which case the Exit Plan shall be agreed between the Affected Stream commissioner and the successor commissioner).

1.2.13. The Exit Plan shall, as appropriate make provision for

(a) the transfer of equipment and any other assets transferred from one Partner to another under the Arrangements 1.4.2the continuation or termination of each Partners' rights of occupation of Premises owned or controlled by the other Partners shall cease insofar as applicable to the provision of the Services related to the Functions of that other Partner.
(b) the retention or transfer of ownership of the records and information relating to the Functions and client files including any relevant records that were transferred to the other Partners as part of the Arrangements; and
(c) the management of debtors and creditors
(d) All Partners agree that all such information as may be provided to the other may be passed on to any prospective or new service providers (in confidence) for the purposes of future provision of the Functions and obtaining advice only.

APPENDIX 15 – SAFEGUARDING ADULTS SELF-ASSESSMENT & ASSURANCE FRAMEWORK

1. Healthcare services and commissioners have a duty to safeguard patients who may be least able to protect themselves from harm.

2. The National Safeguarding Adults self-assessment and Assurance Framework (SAAF) for Health Care Services, or any subsequent framework agreed by the Lincolnshire Safeguarding Adults Board (LSAB), draws on existing standards and inspection frameworks including the Care Quality Commission (CQC) Essential Standards for Quality and Safety; Association of Directors of Adult Social Services (ADASS) standards for Adult Protection and the proposed NHS Outcomes Framework.

    2.1.1. The purpose of the SAAF is to support health organisations to effectively discharge their safeguarding responsibilities through:
    2.1.2. Safeguarding leadership at all levels
    2.1.3. Identification and appropriate actions of safeguarding issues Improved outcomes in terms of the prevention of harm occurring
    2.1.4. Deliver effective, patient centred responses where harm has occurred.

3. The SAAF aims to:
    3.1. Help services to review and benchmark their safeguarding adults' arrangements; Provide assurance and accountability for the organisation and to their commissioners, partners and patients.
    3.2. Assist organisations to develop action plans for improved outcomes; Identify evidence or gaps in provision that will be relevant in complying with Fundamental Standards of Care under the Health and Social Care Act 2008.

4. Identify and have processes in place in respect of vulnerable groups requiring proactive safeguarding, to include how people who cannot consent will be identified, what staff should do if uncertain about a patient 's ability to make a specific decision and that the experiences and views of those who lack capacity, and their families are specifically recorded and acted upon.

5. Support multi agency National, Regional and Local safeguarding adults' objectives, policies and procedures.

6. The safeguarding standards that the relevant organisation shall report to the designated Strategic Board in Lincolnshire, the Lincolnshire Safeguarding Adults Board, relate to measures that support good safeguarding. These reporting mechanisms include:

    - strategy,
    - systems,
    - workforce,
    - partnerships
    - intelligence
    - commissioning arrangements.

7. The Partners have agreed policies for safeguarding children and adults, and these may be found on the website link below. The host commissioner should ensure that providers of care should also be aware of the need to refer to guidance from both safeguarding boards, and their duty to keep themselves up to date by visiting the Lincolnshire Clinical Commissioning Group website and Safeguarding Boards websites regularly.

8. The website link for the safeguarding policies is :-
    - Lincolnshire CCG: Safeguarding – Lincolnshire CCG
    - Lincolnshire County Council: Safeguarding – Lincolnshire County Council
    - Lincolnshire Safeguarding Adults Board: Lincolnshire Safeguarding Adults Board – About the LSAB - Lincolnshire County Council
    - Lincolnshire Safeguarding Children Partnership: Lincolnshire Safeguarding Children Partnership – About the LSCP - Lincolnshire County Council

9. Although this Agreement is for adults it is accepted by the Partners that some service users are in transition between childhood and adult hood, plus those with learning disability may remain within children's service into adulthood until their mid-twenties. and the appropriate safeguarding policy should be applied. In addition: -

10. For Children:

    10.1. All service providers commissioned by the NHS and Local Authority are required to be compliant with Section 11 of Children Act 2004 regarding safeguarding children. The NHS requires compliance against the 'Markers of Good Practice' (MOGP) framework which demonstrates progress and compliance in support of this. The markers of good practice are assessed annually for both commissioning and provider organisations working to NHS contracts. The date of submission is before the 31 December each year.

    10.2. In addition, Lincolnshire Safeguarding Children Partnership (LSCP) which has the statutory mandate to receive assurance regarding Partner organisations compliance regarding CA S11 have developed a toolkit for organisations to self-assess against Section 11 compliance which is assessed every 3 years.

11. All NHS contracts shall be based upon the level of compliance and demonstrable progress towards complete compliance made by each organisation. The LSCP CA S11 audit is now electronically based, organisational updating can be undertaken on a continual basis in preparation for the next formal audits, the timescale of which is under review. It is likely to be more frequent than 3 years.

12. In the year that LSCP S11 is completed there is no need to re undertake a MOGP as well. However, there is a need to submit before the end of each year the MOGP e.g. before 31 December 2022 then annually.

13. For adults in the interest of safeguarding adults a national framework has been established that requires all services commissioned through the NHS to demonstrate progress and compliance in support of adults at risk of harm.

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Equality Impact Analysis to enable informed decisions

The purpose of this document is to:-

I. help decision makers fulfil their duties under the Equality Act 2010 and
II. for you to evidence the positive and adverse impacts of the proposed change on people with protected characteristics and ways to mitigate or eliminate any adverse impacts.

Using this form

This form must be updated and reviewed as your evidence on a proposal for a project/service change/policy/commissioning of a service or decommissioning of a service evolves taking into account any consultation feedback, significant changes to the proposals and data to support impacts of proposed changes. The key findings of the most up to date version of the Equality Impact Analysis must be explained in the report to the decision maker and the Equality Impact Analysis must be attached to the decision making report.

****Please make sure you read the information below so that you understand what is required under the Equality Act 2010****

Equality Act 2010

The Equality Act 2010 applies to both our workforce and our customers. Under the Equality Act 2010, decision makers are under a personal duty, to have due (that is proportionate) regard to the need to protect and promote the interests of persons with protected characteristics.

Protected characteristics

The protected characteristics under the Act are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Section 149 of the Equality Act 2010

Section 149 requires a public authority to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by/or under the Act
- Advance equality of opportunity between persons who share relevant protected characteristics and persons who do not share those characteristics
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The purpose of Section 149 is to get decision makers to consider the impact their decisions may or will have on those with protected characteristics and by evidencing the impacts on people with protected characteristics decision makers should be able to demonstrate 'due regard'.

Decision makers duty under the Act
Having had careful regard to the Equality Impact Analysis, and also the consultation responses, decision makers are under a personal duty to have due regard to the need to protect and promote the interests of persons with protected characteristics (see above) and to:-

(i) consider and analyse how the decision is likely to affect those with protected characteristics, in practical terms,
(ii) remove any unlawful discrimination, harassment, victimisation and other prohibited conduct,
(iii) consider whether practical steps should be taken to mitigate or avoid any adverse consequences that the decision is likely to have, for persons with protected characteristics and, indeed, to consider whether the decision should not be taken at all, in the interests of persons with protected characteristics,
(iv) consider whether steps should be taken to advance equality, foster good relations and generally promote the interests of persons with protected characteristics, either by varying the recommended decision or by taking some other decision.

Conducting an Impact Analysis

The Equality Impact Analysis is a process to identify the impact or likely impact a project, proposed service change, commissioning, decommissioning or policy will have on people with protected characteristics listed above. It should be considered at the beginning of the decision making process.

The Lead Officer responsibility
This is the person writing the report for the decision maker. It is the responsibility of the Lead Officer to make sure that the Equality Impact Analysis is robust and proportionate to the decision being taken.

Summary of findings
You must provide a clear and concise summary of the key findings of this Equality Impact Analysis in the decision making report and attach this Equality Impact Analysis to the report.

Impact – definition

An impact is an intentional or unintentional lasting consequence or significant change to people's lives brought about by an action or series of actions.

How much detail to include?
The Equality Impact Analysis should be proportionate to the impact of proposed change. In deciding this asking simple questions “Who might be affected by this decision?” "Which protected characteristics might be affected?" and “How might they be affected?” will help you consider the extent to which you already have evidence, information and data, and where there are gaps that you will need to explore. Ensure the source and date of any existing data is referenced.
You must consider both obvious and any less obvious impacts. Engaging with people with the protected characteristics will help you to identify less obvious impacts as these groups share their perspectives with you.

A given proposal may have a positive impact on one or more protected characteristics and have an adverse impact on others. You must capture these differences in this form to help decision makers to arrive at a view as to where the balance of advantage or disadvantage lies. If an adverse impact is unavoidable then it must be clearly justified and recorded as such, with an explanation as to why no steps can be taken to avoid the impact. Consequences must be included.

Proposals for more than one option If more than one option is being proposed you must ensure that the Equality Impact Analysis covers all options. Depending on the circumstances, it may be more appropriate to complete an Equality Impact Analysis for each option.

The information you provide in this form must be sufficient to allow the decision maker to fulfil their role as above. You must include the latest version of the Equality Impact Analysis with the report to the decision maker. Please be aware that the information in this form must be able to stand up to legal challenge.

Background Information

Title of the policy / project / service being considered	Learning Disability – Section 75 Agreement	**Person / people completing analysis**	Gareth Maddison
Service Area	Specialist Adult Services	**Lead Officer**	Justin Hackney, Assistant Director of Adult Care and Community Wellbeing
Who is the decision maker?	Executive Councillor for Adult Care and Community Wellbeing	**How was the Equality Impact Analysis undertaken?**	Desktop research and data analysis. Initial analysis using feedback from project group. Feedback & performance review of existing agreement. Further engagement is planned for January and February 2022.
Date of meeting when decision will be made	23/02/2022	**Version control**	220113
Is this proposed change to an existing policy/service/project or is it new?	Existing policy/service/project	**LCC directly delivered, commissioned, re-commissioned or de-commissioned?**	Directly delivered
Describe the proposed change	Summary: There is an existing Section 75 agreement in place (Health and Social Care Act 2006) between Lincolnshire County Council and the Lincolnshire CCG. Under this agreement the Council acts as lead commissioner for Adult Social Care and Continuing Health Care. As part of these arrangements the Council hosts a pooled budget from which is funded an integrated assessment and care management function as well as the provision of eligible services. The existing Section 75 Agreement ends on 31/03/2022 and therefore to continue these arrangements a new Section 75 Agreement will need to be agreed by the Council and the CCG. This agreement provides enhanced co-ordination of health and social care services, the use of expertise in managing particular support needs, reduced duplication of commissioning activities and a more joined up approach to market management. Most importantly, these benefits also		

lead to improved outcomes for service users. The dissolution of these arrangements would lead to poorer outcomes for people with learning disabilities and the responsible commissioning organisation.

A new agreement is being developed to commence 1 April 2022. This would be as existing with only such changes as are necessary to

(i) adjust the finances to reflect the creation of a new Pooled Budget and
(ii) provide a mechanism for further amendments to reflect any phasing to the roll out of new Complex Case arrangements should these be agreed in the future.

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. Lincolnshire has a strong history of integrated working across Specialist Adult Services. The Learning Disability Section 75 has been in place for over a decade and continues to deliver joined up outcomes for service users and good value for money for both LCC and LCCG.

LCCG have confirmed that their preference is to enter a new S75 Agreement with LCC for Learning Disability services with LCC continuing to act as lead commissioner and pooled budget manager. The Agreement aims to, provide the best possible health and social care provisions for adults aged over 18 years with learning disabilities, and to;

- Ensure the best use of resources to achieve overarching aims.
- Commission health and social care services that meet people's assessed needs and deliver improved outcomes, within a contracting framework that is flexible and provides the necessary protection for service users and carers.
- Promote and support integrated working and involve key stakeholders in service development.
- Ensure that a stable market that meets local needs exists.

Integrated care focuses on more coordinated and integrated forms of health & care provision. It is care that is planned with people who work together to understand the service user and their carers, puts them in control and coordinates and delivers services to achieve the best outcomes. This integrated care and LCC's Learning Disability support provide a focused approach to Strength Based Practice and Personalised Care and Support Plans.

Evidencing the impacts

In this section you will explain the difference that proposed changes are likely to make on people with protected characteristics.
To help you do this first consider the impacts the proposed changes may have on people without protected characteristics before then considering the impacts the proposed changes may have on people with protected characteristics.

You must evidence here who will benefit and how they will benefit. If there are no benefits that you can identify please state 'No perceived benefit' under the relevant protected characteristic. You can add sub categories under the protected characteristics to make clear the impacts. For example under Age you may have considered the impact on 0-5 year olds or people aged 65 and over, under Race you may have considered Eastern European migrants, under Sex you may have considered specific impacts on men.

Data to support impacts of proposed changes

When considering the equality impact of a decision it is important to know who the people are that will be affected by any change.

Population data and the Joint Strategic Needs Assessment

The Lincolnshire Research Observatory (LRO) holds a range of population data by the protected characteristics. This can help put a decision into context. Visit the LRO website and its population theme page by following this link: http://www.research-lincs.org.uk If you cannot find what you are looking for, or need more information, please contact the LRO team. You will also find information about the Joint Strategic Needs Assessment on the LRO website.

Workforce profiles

You can obtain information by many of the protected characteristics for the Council's workforce and comparisons with the labour market on the Council's website. As of 1st April 2015, managers can obtain workforce profile data by the protected characteristics for their specific areas using Agresso.

Positive impacts
The proposed change may have the following positive impacts on persons with protected characteristics – If no positive impact, please state *'no positive impact'.*

Age	• This service is for people aged 18 and over only. • It is restricted as an adult's service only because Children's Services have their own procedures in place. • This proposal is for the renewal of a Section 75 Agreement between LCC & LCCG that provides health and social care services that meet people's assessed needs. This acts as a renewal of an existing Section 75 Agreement and as such does not result in additional benefits however the integrated care results in many positive impacts on individuals such as: o more holistic care o more person-centred care o clearer access & more seamless pathways o improved experience for patient or user of services o improved outcomes o possible reduction in costs o greater focus on prevention o Dedicated assessment and care management team with identified key worker
Disability	• This proposal is for the renewal of a Section 75 Agreement between LCC & LCCG that provides health and social care services that meet people's assessed needs. This acts as a renewal of an existing Section 75 Agreement and as such does not result in additional benefits however the integrated care results in many positive impacts on individuals such as: o more holistic care o more person-centred care o clearer access & more seamless pathways o improved experience for patient or user of services o improved outcomes o possible reduction in costs to individuals o more focus on prevention o Dedicated assessment and care management team with identified key worker

Gender reassignment	No positive impact
Marriage and civil partnership	No positive impact
Pregnancy and maternity	No positive impact
Race	No positive impact
Religion or belief	No positive impact
Sex	No positive impact
Sexual orientation	No positive impact

If you have identified positive impacts for other groups not specifically covered by the protected characteristics in the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

- Enhanced oversight of the Quality of Care arrangements for agreed cohort of Adults
  - Clinical oversight of the cases enhanced
  - Insuring services being commissioned are delivering what they should
  - Support and challenge role with other providers
  - Greater oversight of out-of area cases

- Enhanced Market Management of providers of Care for people with learning disabilities
  - Improved VFM
  - Improved Quality of Care
  - Peoples Independence is Maximised
  - Providers have a re-ablement offer
  - Clearer understanding of what is being commissioned
  - More consistent procurement and contract management approaches
  - Reduced duplication and therefore reduced transaction costs (for the system)
  - Improved engagement with providers

The person in receipt of Social Care of CHC will have one key worker with individual support for people in receipt of services.

Adverse/negative impacts
You must evidence how people with protected characteristics will be adversely impacted and any proposed mitigation to reduce or eliminate adverse impacts. An adverse impact causes disadvantage or exclusion. If such an impact is identified please state how, as far as possible, it is justified; eliminated; minimised or counterbalanced by other measures.
If there are no adverse impacts that you can identify please state 'No perceived adverse impact' under the relevant protected characteristic.

Negative impacts of the proposed change and practical steps to mitigate or avoid any adverse consequences on people with protected characteristics are detailed below. If you have not identified any mitigating action to reduce an adverse impact please state *'No mitigating action identified'*.

Age	• This is a new service for vulnerable adults with learning disabilities over the age of 18 years old. This service does not support anyone under 18 years old. • No perceived adverse impact to those eligible for services.
Disability	• There are no specific negative impacts for people with the protected characteristic of disability.
Gender reassignment	• There are no specific negative impacts for people with the protected characteristic of gender reassignment.
Marriage and civil partnership	• There are no specific negative impacts for people with the protected characteristic of marriage and civil partnership.
Pregnancy and maternity	• There are no specific negative impacts for people with the protected characteristic of pregnancy and maternity.
Race	• There are no specific negative impacts for people with the protected characteristic of race .
Religion or belief	• There are no specific negative impacts for people with the protected characteristic of marriage religion or belief.
Sex	• There are no specific negative impacts for people with the protected characteristic of sex.
Sexual orientation	• There are no specific negative impacts for people with the protected characteristic of sexual orientation.

If you have identified negative impacts for other groups not specifically covered by the protected characteristics under the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Stakeholders

Stake holders are people or groups who may be directly affected (primary stakeholders) and indirectly affected (secondary stakeholders)

You must evidence here who you involved in gathering your evidence about benefits, adverse impacts and practical steps to mitigate or avoid any adverse consequences. You must be confident that any engagement was meaningful. The Community engagement team can help you to do this and you can contact them at engagement@lincolnshire.gov.uk

State clearly what (if any) consultation or engagement activity took place by stating who you involved when compiling this EIA under the protected characteristics. Include organisations you invited and organisations who attended, the date(s) they were involved and method of involvement i.e. Equality Impact Analysis workshop/email/telephone conversation/meeting/consultation. State clearly the objectives of the EIA consultation and findings from the EIA consultation under each of the protected characteristics. If you have not covered any of the protected characteristics please state the reasons why they were not consulted/engaged.

Objective(s) of the EIA consultation/engagement activity
In proposing to extend these arrangements via a new agreement we have consulted with Lincolnshire's Learning Disability Partnership Board to seek their views which were endorsing of the continuation of the existing arrangements. Part of the implementation of introducing this renewed service, included gathering feedback and suggestions from servicer users and key stakeholders. This included seeking the views of service users and whether introducing this type of service would be beneficial.

Who was involved in the EIA consultation/ engagement activity? Detail any findings identified by the protected characteristic

Age	N/A
Disability	Learning Disability Partnership Board
Gender reassignment	
Marriage and civil partnership	
Pregnancy and maternity	
Race	
Religion or belief	
Sex	
Sexual orientation	
Are you confident that everyone who should have been involved in producing this version of the Equality Impact Analysis has been involved in a meaningful way? The purpose is to make sure you have got the perspective of all the protected characteristics.	Yes
Once the changes have been implemented how will you undertake evaluation of the benefits and how effective the actions to reduce adverse impacts have been?	The Services under this Agreement may be monitored by the Care Quality Commission. LCC will report to the Joint Delivery Board and JCOG monthly, on the operation of the services and performance levels against agreed Performance Measures, targets and priorities, the management of the Pooled Fund and the exercise of the functions of this agreement. LCC & LCCG will review the operation and all or any procedures or requirements on the coming into force of any relevant Legislation or guidance affecting the agreement so as to ensure that the arrangements comply with such Legislation. The partnership board will ensure that service users and their families fully participate in arrangements through this

	agreement and that an annual evaluation of the LCC's performance takes place and includes outcomes which are qualitative as well as quantitative. Individuals receiving services will receive, as a minimum, an annual review of the service provision and care arrangements.

Further Details

Are you handling personal data?	Yes or no – please select If yes, please give details. Yes, A, Information Sharing Agreement is in place between LCCG and LCC produced in collaboration with the Information Governance Team. The case management system, Mosaic, will hold the personal details of all the service users that are supported from the Learning Disability service.

Actions required Include any actions identified in this analysis for on-going monitoring of impacts.	**Action**	**Lead officer**	**Timescale**

Version	Description	Created/amended by	Date created/amended	Approved by	Date approved

Open Report on behalf of Glen Garrod,
Executive Director - Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**23 February 2022**
Subject:	**Residential & Nursing Care Fee Levels within Adult Social Care**

Summary:

This item invites the Adult Care and Community Wellbeing Scrutiny Committee to consider a report on residential and nursing care fee levels within Adult Social Care, which is due to be considered by the Executive on 1 March 2022. The views of the Scrutiny Committee will be reported to the Executive, as part of its consideration of this item.

Actions Required:

(1) To consider the attached report and to determine whether the Committee supports the recommendation(s) to the Executive set out in the report.

(2) To agree any additional comments to be passed to the Executive in relation to this item.

1. Background

The Executive is due to consider a report entitled Residential and Nursing Care Fee Levels within Adult Social Care between the 28 February and 4 March 2022. The full report to the Executive is attached at Appendix 1 to this report.

2. Conclusion

Following consideration of the attached report, the Committee is requested to consider whether it supports the recommendations in the report and whether it wishes to make any additional comments to the Executive. The Committee's views will be reported to the Executive.

3. Consultation

a) Risks and Impact Analysis

A copy of the Equality Impact Assessment is attached at Appendix C

4. Appendices

These are listed below and attached at the back of the report	
Appendix 1	Report to the Executive– Residential and Nursing Care Fee Levels
Appendix A	Report for LCC on Older Adult Care Home Market 2021
Appendix B	Report for LCC on Learning Disability Care Home Market 2021
Appendix C	Equality Impact Assessment
Appendix D	Market Consultation Feedback and Responses
Appendix E	Residential Rate Model Adult Frailty and Long-Term Conditions
Appendix F	Residential Rate Model Specialist Adults Services

5. Background Papers

The following Background Papers within the meaning of section 100D of the Local Government Act 1972 were used in the preparation of the Report

Document title	Where the document can be viewed
Residential and Nursing Care Fee Levels within Adult Care 2018	Issue details - Residential and Nursing Care Fee Levels within Adult Social Care (moderngov.co.uk)

This report was written by Carl Miller, who can be contacted on 07879 412886 or carl.miller@lincolnshire.gov.uk.

Lincolnshire COUNTY COUNCIL
Working for a better future

Open Report on behalf of Glen Garrod,
Executive Director - Adult Care and Community Wellbeing

Report to:	**Executive**
Date:	**1 March 2022**
Subject:	**Residential and Nursing Care Fee Levels within Adult Social Care**
Decision Reference:	**I023033**
Key decision?	**Yes**

Summary:

On 22 February 2018 the Executive Councillor approved the setting of a number of usual costs for residential accommodation for the three-year period to 6 April 2021. A full-scale review of the Council's framework contract was underway in early 2020 in order to establish a new three-year agreement, together with revised Usual Costs. However, the advent of the COVID-19 pandemic meant that it was not possible to complete this review. As part of a wider set of COVID measures, approval was secured to issue a one-year contract spanning financial year 2021/22 at the existing Usual Costs with an inflationary uplift as an interim measure. While the impact of the pandemic is still having a major effect on council business and the market, it has been possible to complete an analysis of the market which will allow the council to move forward with a new framework agreement and Usual Costs in 2022.

In this context this report makes a recommendation which will set a Usual Cost for 3 levels of service: residential, nursing, and high dependency across all types of need (older people, physical disability, learning disability and mental health). However, due to ongoing uncertainties impacting the market, costs, and future funding, it is proposed that the new 3-year framework cycle will have an important distinction in that the Usual Costs will be set for the first 12 months only, this being intended to allow for greater flexibility and sensitivity in rate setting for subsequent years once there is greater clarity in developing market conditions and future funding, based on planned social care reforms.

The setting of the Council's Usual Costs for residential care is central to its compliance with statutory obligations. In particular, the rate that the Council establishes as its Usual Cost will contribute significantly to the viability and sustainability of a market which provides sufficient places capable of meeting need. The Usual Cost will also determine in many cases the personal budget against which the choice of accommodation provisions will be assessed.

As such any change to the rates paid for services will have a material impact on the effectiveness of services both in the short term and for the future. The aim of the exercise then is to establish a new set of contracts and associated rates for Residential services that are both affordable to the Council, and meets the Council's legal duties along with the necessary changes and improvements to the contract that will allow for successful operation of services over the next contract duration.

It is important to bear in mind that the Council must ensure two things. The first is due process the second is the reasonableness and logic underpinning the Usual Cost. The detail in the report should reassure the Executive that the process employed has been progressed having full regard to what is considered best practice. The report details what that process was, who was involved and the full details of consultation responses alongside views given by officers of the Council to address and respond to these.

In informing a Usual Cost, a model has been constructed which draws on both national and local (to Lincolnshire) data which provides a sophisticated approach to understanding costs to providers.

The recommendation in this report is that a Usual Cost should be set for the next 12 months taking into account the likely effect of changes to providers' costs, both National living Wage and forecast inflation to address non-pay costs. Given the volatility of market cost of care following the pandemic and in lieu of full details of the anticipated social care reforms, to help ensure the level of risk to the residential market is reduced and provide assurance about future income from the largest single purchaser of such care in Lincolnshire (the Council), a three-year contract with an annual rate review for years two and three is recommended to avoid Usual Costs losing pace going forward.

In addition to the changes to the Usual Cost there is a further recommendation to build on and update the framework agreement in 2022 as follows:

- Service specification updates and improvements
- Contractual changes necessary to address the planned and agreed move to gross payment during 2022
- A plan for undertaking a broader programme of ‘block purchasing’

Finally there is a recommendation to implement an interim measure whereby providers can apply to a Council operated hardship fund for financial support with those uncertain and volatile utilities and insurance costs

Recommendation(s):

That the Executive:

1. Approves the rates set out in the table at paragraph 5.6.1 of the Report as the Council’s Usual Costs for both new and existing Learning Disability service users in respect of residential and nursing care with effect from 1 April 2022 for the financial

year 2022/23

2. Approves the rates set out in the table at paragraph 5.6.2 of the Report as the Council's Usual Costs for both new and existing Older People service users in respect of residential, nursing and high dependency care with effect from 1 April 2022 for the year 2022/23

3. Approves the rates set out in the table at paragraph 5.6.3 of the Report as the Council's Usual Costs for both new and existing Physical Disability service users in respect of residential and nursing care with effect from 1 April 2022 for the year 2022/23

4. Approves the rates set out in the table at paragraph 5.6.4 of the Report as the Council's Usual Costs for both new and existing Mental Health service users (aged 18-65) in respect of residential and nursing care with effect from 1 April 2022 for the year 2022/23

5. Notes the proposed contractual updates set out in section 6 of the Report.

6 Approves the use of £1m from the Adult Care Grant Reserve to establish a fund for the making of payments to providers of residential care and residential with nursing care in Lincolnshire suffering hardship as a result of cost volatility relating to utilities costs and insurances

7 Delegates to the Executive Director – Adult Care and Community Wellbeing in consultation with the Executive Councillor for Adult Care and Public Health authority to determine the detailed conditions governing the fund including the criteria for the making of payments.

Alternatives Considered:

1. Issuing another one year, interim, contract that may allow for greater clarity in how market conditions may settle post pandemic.

   This is not an attractive option due to the following factors
   - The market has already tolerated a one-year contract that only offers an interim, short term, solution. Given the volatility in the market it is highly likely the number of providers that would not sign up to a one-year contract would be higher than would be acceptable.
   - It is not clear that a further year would in fact offer a sufficient level of clarity as pandemic impacts continue to be felt and will likely not settle within a one-year period.

2. No increases in Usual Costs are applied in April 2022 and that usual costs remain at their current level.

This option would cost the council £5.873m million less than the recommended options in 2022-23 and would allow the authority to reinvest this funding in alternative services. However, in light of the evidence available to the Council a failure to increase usual costs would leave the Council open to significant risk of legal challenge. It would greatly increase the risk of providers going out of business and would potentially lead to a fall in the overall quality of care in the county.

3. Increasing the Usual Costs by more than is set out in the Report.

Some of the feedback called for this and suggested that the proposed Usual Costs fail to address the true impact of business inflation being experienced by the sector. However, the Council has taken steps to establish costs within Lincolnshire, has engaged with and consulted the market on its model, taking account of feedback following consultation, and believes that the proposed Usual Costs accord with the cost of providing care within Lincolnshire. The proposed hardship fund allows the Council to step in and assist where appropriate in response to volatility in specific costs relating to utilities and insurance.

Reasons for Recommendation:

Adopting the recommendation will support providers' costs and see an increase in the rates paid whilst taking into account many of the points raised by providers in the consultation. It will provide assurance that the Council will be able to continue to meet its statutory obligation to meet assessed eligible need for vulnerable service users and will help facilitate the provision of care that meets the necessary CQC standards. It also meets the Council's legal obligation in establishing its Usual Costs.

As the economy emerges from Covid-19 the market for Adult Care services will continue to see volatility in costs. The unknown scale and varying impact by provider cannot be accommodated so as to identify an appropriate 3-year Usual Cost using the model. A one-year Usual Cost is proposed partly to address this issue. It is also proposed to contribute towards providers in-year additional costs, on an open book basis, through the development of a Hardship Fund whilst the market settles. Costs will be monitored throughout 2022-23.

In addition, the Adult Social Care (ASC) White Paper 'People at the Heart of Care: adult social care reform' stated additional funding to support the adult social care workforce would be made available. The intention is to continue to support providers, aligned to the conditions of the associated, as we have done throughout the pandemic.

1. Background

1.1. Residential and Nursing services represent one of the Council's highest spend and highest risk areas with an annual total of approx. £125m gross spend. As such any

change to the rates paid for services will have a material impact on the effectiveness of services both in the short term and for the future.

1.2. The ultimate aim is to establish a new set of contracts for Residential services that is both affordable to the Council, and meets the Council's legal duties, along with the necessary changes and improvements that will allow for successful operation of services over the next contract duration.

1.3. In order to reach this point a number of key activities have been undertaken by officers of the Council

(a) Commissioning and completing an independent review of the Residential market in Lincolnshire resulting in a set of reports issued to the Council for its consideration.

(b) Analysis of these reports to inform the decision-making process for establishing what the new Usual Costs may be.

(c) Consideration of any changes identified as necessary or beneficial to the current Usual Cost model.

(d) Consideration of the systematic impact of COVID-19 and an appreciation of the future direction of the market.

(e) A review of and identification of changes to the contract that are necessary or represent an improvement.

(f) Consideration of new contracting models that better fit the segments of the local care market.

(g) Development of a proposal for the new Usual Costs for each service based upon the analysis undertaken and the required changes to manage emerging market conditions.

(h) Engagement with the market throughout the process but specifically to share the proposed model, receive feedback and take this into consideration as is necessary.

1.4. The work undertaken has addressed the following services separately and distinctly

- Older People (Residential, Nursing, High Dependency)
- Learning Disabilities (Residential & Nursing)
- Physical Disabilities (Residential & Nursing)
- Mental Health (18 to 65) (Residential & Nursing)

1.5. The work undertaken via the market review phase has produced two reports, one for Care Home Costs relating to Working Age Adults and another on Older Adults.

Each of these reports has been considered and analysed to help produce a set of Usual Costs that share many fundamental similarities but will also be distinct for each service.

1.6. The review and changes to any contract terms of the Residential Framework agreement have been taken as a whole and applicable to all service streams.

1.7. There are no fundamental changes to the Specification or Contract which would result in a change of service or a restriction of service user choice. In fact, it is anticipated that through the changes to the contract the provision for Residential Care in Lincolnshire will improve and will also be in a stronger position to manage challenges in the future.

1.8. The proposed set of Usual Costs have been shared with the market. This engagement activity has included LinCA as the representative body of Lincolnshire's care market, to inform them of the proposed changes. This has allowed for feedback from providers and sector representatives which has then been taken into consideration for the purposes of the Council in making its final determination of Usual Costs. Comments from the market have been recorded, considered and can be found in Appendix D.

2. THE COUNCIL'S USUAL COST MODEL PROCESS

2.1. The Council last set Usual Costs in March 2021 for a period of one year. The Usual Costs per resident per week for new and existing placements during this period are set out in Tables A and B below.

Category of Care	2021/22 Weekly Cost
Older People Standard Residential	£533
Older People Higher Dependency	£587
Older People Nursing	£588
Physical Disability	£687
Mental Health Standard	£555
Mental Health Nursing	£587

Table A – Older People, Physical Disability, Mental Health Usual Cost 2021-22

Complexity Band	2021-22 Weekly Cost		
	Standard 13+ Beds	Smaller 7-12 Beds	Smallest 1-6 beds
Band 1	£651	£697	£743
Band 2	£749	£795	£841
Band 3	£944	£990	£1,035

Table B - Learning Disability Usual Cost 2021-22

Fee Setting Methodology

2.2. The Council's fee setting methodology adopted in 2017 was informed by a cost model based on but not identical with the economic model created for the Joseph Rowntree Foundation in 2002 by Laing and Buisson healthcare consultancy, 'Calculating a Fair Price for Care: A Toolkit for Residential and Nursing Care Costs', ("the JRF toolkit"). This was based on the operating costs of efficient care homes for older people in England.

2.3. The Council undertook an assessment of the market during 2021 (described at sections 2.4 and 2.5) which enabled a review of the components of the County Council's 2017 cost model. This exercise has enabled the Council to further develop its cost model reflecting the data gathered by Care Analytics on its behalf.

Engagement of Care Analytics to collect and analyse Lincolnshire Data

2.4. To assist with the engagement of residential and nursing care providers for the purposes of collecting Lincolnshire specific data, the Council has worked with local market and the Lincolnshire Care Association, which represents some of the providers, to ensure a better shared understanding of costs, cost pressures, opportunities and market conditions within the market. In addition to the broader market engagement the Council also commissioned Care Analytics Ltd to undertake an independent assessment of the residential care market. This took the form of an assessment of revenue costs of care home places for older people and young disabled adults in Lincolnshire, based in large part on responses to a survey sent to all care homes in Lincolnshire. 216 homes were surveyed with a 50% return. The instruction to Care Analytics was to appraise residential costs and market conditions, with the following specific areas of focus:

- Overall appraisal of Residential Care Market showing a profile of providers, by number, type, scale, bed capacity and use, costs and charges. This should include cost pressures on providers as a result of market conditions, legislation, inspection and registration requirements.

- Separate and distinct analysis was requested for all service user groups including

  (a) Older People (Residential, Nursing, High Dependency)

  (b) Physical Disabilities (Residential & Nursing)

  (c) Mental Health 18 to 65 (Residential & Nursing)

  (d) Learning Disabilities (Residential & Nursing)

- Trends in Residential Care provision and demand such as growth or contraction.

- Benchmarking local provision with regional and national provision as well as costs and funding levels.

2.5. Care Analytics Ltd. reports produced in October and November 2021 are attached at Appendix A and Appendix B. Highlights from the reports are as follows:

2.5.1. For the Older Adults Market - Survey results were representative with 43% of all Older Adults homes submitting data. This is a strong sample size for the whole market, although there was a lower response rate from independent providers which has skewed the average costs. There was good geographic coverage too, presenting a much stronger evidence base than 2017.

2.5.2. Growth in the sector has come exclusively from larger organisations with a focus on self-funders. Available capacity based on the usual cost tends to be from smaller, older homes with sunk capital costs.

2.5.3. The existing basis for rate construction remains feasible but this could have consequences for the way in which the Council commissions care over the next three years. For example, it will require a greater focus on utilising the smaller independents with no corporate costs, which may result in an increased rate of Top Ups and a lack of new growth.

2.5.4. The sector of the Older Adults market geared towards accepting Usual Costs are smaller homes which tend to be older and will find it more difficult to invest or improve the property. Therefore, if the council desires to mitigate the impact of increased Third Party Top Ups and/or improve the growth of new capacity, then further investment will be required.

2.5.5. For the Physical Disability (PD) Market – The submission rate was 50%, but the local specialist PD market is extremely small. Commissioning practice tends to make specialist PD placements to out of county services because there are no similar in county services. Therefore, in future it may be beneficial to consider having a PD supplement to the standard Older People rate rather than a separate rate.

2.5.6. For the Mental Health (MH) Market – The submission rate was low even after multiple attempts at engagement and extensions of deadlines, with 33% giving a return. Unfortunately, these returns were also limited in scope, and as a result the scope for analysis of this sector was also limited. That said, local MH providers are generally able to accept packages at the Usual Cost, excepting for lower numbers of complex packages. Almost all MH capacity in the local market is focused on providing care at, or around, the Usual Cost rate, and there remains capacity in the local MH market.

2.5.7. Because the local 'markets' for MH and PD are too small for market-generalised analysis, it was recommended that the Council work towards a separate settlement with this part of the market with a longer term and open book approach for cost setting. This will require detailed and close work with these providers over a period of time.

2.5.8. For the Learning Disability (LD) Market - The submission rate was high at 74%. The variance in complexity and associated cost profiles within this sector of the market is too complex for the current 9 banded model to fully accommodate. On the whole, the local LD market is showing that it does not run at high profits, and there are good opportunities within the structure and capacity of the market to make the model work. Although the Council does not have the same monopsony buying power as in other sectors of the market, it does have a number of strategically important providers with whom it is a monopsony purchaser. The Council should therefore give consideration to additional or distinct purchasing models for highly used strategic providers.

2.5.9. Overall, there remain several factors that remain complex and difficult to predict, including the continued impact of Covid-19, wage increases and inflation, the governments new proposals relating to ASC funding and escalating workforce vacancies. The reports conclude that with the level of change and uncertainty in the system, it may be beneficial for the Council to consider publishing Usual Costs on an annual basis.

The Actual Cost Modelling Process

2.6. The Covid-19 pandemic has driven unprecedented pressure, not least in the adult social care sector. To support additional costs arising through the pandemic, LCC has passported government grants through to providers to cover additional costs associated with workforce, infection control, testing and vaccinations.

2.7. As we emerge from the pandemic, the sector continues to face significant challenges in recruitment and volatility of costs.

2.8. The Council recognises the challenges within this financial landscape and the market assessment undertaken enabled a review of the components of the existing 2017 model. The market assessment highlights that differences in operating policies and practices between providers (such as size of home, layout) add complexity when seeking to produce a standard cost model for the marketplace. However, the surveys and associated data gathered by Care Analytics as part of the 2021 market assessment exercise have enabled the further development of the cost model, which is representative of both the median of results and the trimmed mean.

2.9. The Council must assure itself that the fees are appropriate to provide the amount of care required to an agreed quality, including allowing for a reasonable rate of return that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term.

2.10. The Council recognises that the wage rates assumed in the previous model had lost pace with the market. This was to be expected given the 3-year rate for care was

established at the start of the contract. The wages in the 2022-23 model build on the median results and are increased further to reflect the 6.6% increase in National Living Wage from April 2022. The hourly rate includes public holiday premiums and whilst the survey indicated not all homes are paying this, this premium has been built in as standard in recognition of the pressures on workforce across the sector.

2.11. The Council is investing in wider initiatives targeted to improve recruitment into Lincolnshire. It is supporting local care providers by investing in a county-wide campaign to attract and retain staff into the care sector. This work will complement actions already identified through the Council's Workforce Strategy. The organisation commissioned to deliver this work is taking a partnership approach, working with key stakeholders including LinCA. They will deliver an attraction campaign that promotes care as a career across our main social care sectors; Homecare, Residential & Nursing Care and Community Supported Living. The campaign will align and build on national recruitment campaigns launched by the Department of Health and Social Care, such as 'Made with Care'. The work will also provide the sector with a range of creative design assets that can be used beyond the initial commission, including social media content, adverts, print materials, outdoor media, gifs, and localisation of national campaign materials.

2.12. The 2021 survey results highlighted the majority of non-pay areas are consistent with averages from 2017 assuming 2.0% annual uplift. The proposal increases the non-pay costs in the 2022-23 model by 4% in line with Provisional Spending Review published by the Government in December 2021. The volatility in the energy market has emerged since the survey was completed and since the Council published its proposed rates for consultation. This is addressed in section 5 below, which contains the Council's approach to supporting providers with these costs.

2.13. The model needs to include a reasonable rate of return. The methodology adopted and agreed previously continues into the 2022-23 model. The main asset deployed is the building used to deliver the service. Therefore, the number to feed into the calculation will be the capital cost of a room in Lincolnshire (£47,060) multiplied by the chosen rate of return.

2.14. In establishing what cost should be attributed to the Provider's use of assets, the rate of return used should reflect the relative risk of the investment. As the Council buys a substantial amount of placements (48% based on the Care Analytics Lincolnshire survey) which it has the resources to pay for, this significantly reduces the risk to providers businesses and the beneficial impact of this should be reflected through a return which reflects a low/medium business risk for providers.

2.15. The market indicators utilised previously are still valid and a 6% rate of return is applied. This represents an annual payment per room of £3,137 indicating the initial investment would be recouped over a 15-year period. This is a reasonable timescale for a business such as adult social care.

2.16. The market assessment highlighted areas the Council would like to undertake a deeper review of in the coming financial year. These areas, which will form part of the work programme to develop the future commissioning of residential and nursing care in Lincolnshire referenced at section 6.3 below, include:

- the financial structure of the learning disabilities rates currently shown in bandings.

- a joint piece of work with health colleagues to provide assurance that the higher cost care (e.g., nursing) is supported by the appropriate rates paid by both health and social care.

- where parts of the market were unable to respond to the survey and/or responses were disproportionate, a programme of work is to be agreed for 2022-23 to enable the identification of a fair cost of care e.g., mental health and physical disabilities rate construct

2.17. The ASC White Paper 'People at the Heart of Care: adult social care reform' confirmed additional funding announcements, a workforce fund being one. At the time of writing this report, the details of local allocations and access to the funds are still awaited. It is the intention of LCC to continue to support its providers in accordance with the conditions of the funds.

2.18. In addition, the Council has already agreed to move its residential payments onto a gross payment basis. This is scheduled to transition during the summer of 2022. This will support providers to reduce the significant administrative burden and will provide residential homes with one flow of income for the care delivered.

3. The Council's Proposed Rates

3.1. As a result of the work carried out to and referred to above, the Council proposed, for consultation with the market in December 2021, the rates set out in the tables below at paragraphs 3.2, 3.3 and 3.4 as the Council's Usual Costs for both new and existing service users as of 1 April 2022.

3.2. <u>Learning Disability Services</u>

3.2.1. The market analysis exercise concluded that the 9 banded Usual Cost model is functionally effective and works well overall, with 87% of core placement prices and over 50% of total placement prices being at one of the respective bands. However, this market is much more segmented than the Older Persons market, reflecting the wide range of needs being managed and support being delivered, and the limitations to the flexibility and sensitivity of the model necessitate bespoke pricing in more complex cases. In this respect it will be beneficial for the Council to undertake further analysis and engagement with the sector to develop its approach to Usual Costs, including consideration of alternatives to a standardised approach in appropriate

circumstances, for example use of provider specific cost models for high-cost high-need providers and block purchasing with strategically significant providers to improve leverage. With this in mind, the existing usual cost model was adjusted and updated in line with the methodology described at paragraphs 2.6 to 2.16 to arrive at the proposed costs for 2022-23, as shown below in table C, and shared with the market in the consultation exercise described at section 4. It is also proposed, as part of a future work programme to be initiated in 2022, to undertake further analysis and engagement with specialist sectors in order to develop the council's approach to purchasing and cost setting for future years.

Complexity Band	Standard 13+ Beds		Smaller 7-12 Beds		Smallest 1-6 beds	
	Current 2021/22	Proposed 2022/23	Current 2021/22	Proposed 2022/23	Current 2021/22	Proposed 2022/23
Band 1	£651	£675	£697	£722	£743	£769
Band 2	£749	£780	£795	£827	£841	£874
Band 3	£944	£987	£990	£1,033	£1,035	£1,080

Table C: Learning Disability Usual Costs, Current and 2022-23 proposed as part of December 2021 Market Consultation

3.3. Adult Frailty and Long-Term Conditions

3.3.1. Older Persons

The Survey results were representative with a strong sample size for the whole market providing a good level of evidence used for the review of the model for 2022-23. However, as there remain factors that are complex and difficult to predict in future years (i.e. continued impact of Covid-19, wage increases and inflation, the governments new proposals relating to ASC funding and escalating workforce vacancies), it is proposed that, in line with the review conclusions, usual costs are set for the next 12 months only at this stage. On this basis, and as the existing basis for rate construction remains feasible, the existing usual cost model has been adjusted and updated in line with the methodology described at paragraphs 2.6 to 2.16 to arrive at the proposed costs for 2022-23, as shown below in table D, and shared with the market in the consultation exercise described at section 4.

Category of Care	Current 2021/22	Proposed 2022/23
Older People Standard Residential	£533	£563
Older People Nursing	£588	£622
Older People Higher Dependence	£587	£621

Table D: Older Adults Usual Costs, Current and 2022-23 proposed as part of December 2021 Market Consultation

3.3.2. Physical Disability

There are low residential care placement numbers for this client group and close to 60% of those commissioned are in homes classified as predominantly supporting older adults. Analysis concluded that the local PD care home market is too small to lend itself to meaningful market-level cost analysis, so the anonymous survey approach will not be an effective mechanism to achieve this moving forward. Alternative strategies will need to be employed for future market engagements. This will form part of the future work programme to be initiated in 2022, with a view to developing an appropriate cost modelling approach for Physical Disabilities in future years, taking account of the local market structure, for example, consideration of potential to supplement the older peoples rate for more standard cases, unless or until there is development of more specialist Physical Disabilities services in Lincolnshire. For 2022-23, the existing usual cost model has been adjusted and updated in line with the methodology described at paragraphs 2.6 to 2.16 to arrive at the proposed costs for 2022-23, as shown below in table E, and shared with the market in the consultation exercise described at section 4.

Category of Care	Current 2021/22	Proposed 2022/23
Physical Disability	£687	£725

Table E: Physical Disability Usual Costs, Current and 2022-23 proposed as part of December 2021 Market Consultation

3.4. Mental Health

3.4.1. The market analysis identified that 58% of mental health placements in Lincolnshire are commissioned at the Usual Cost level, however this rate is not effectively used out-county, where the majority of the more complex cases are supported, largely due to a lack of specialist provision in county. There is recognition that a single-rate solution for Mental Health placements is not sustainable given the range of client needs it has to cater for, and there is an ambition to develop a more systematic solution to address more complex cases where needs cannot be met within the Usual Cost levels. However, the level of feedback and data received was insufficient to enable comprehensive remodelling of the Usual Cost setting approach for this part of the sector. As a result, the existing usual cost model was adjusted and updated in line with the methodology described at paragraphs 2.6 to 2.16 to arrive at the proposed costs for 2022-23, as shown below in table F, and shared with the market in the consultation exercise described at section 4. Further targeted engagement with and analysis of this market will form part of the future work programme to be initiated in 2022, to support the

development of a more inclusive pricing approach and cost modelling for this sector in future years.

Category of Care	Current 2021/22	Proposed 2022/23
Mental Health Standard	£555	£586
Mental Health Nursing	£587	£620

Table F: Mental Health Usual Costs, Current and 2022-23 proposed as part of December 2021 Market Consultation

4. Market Consultation

4.1. As indicated above the Council has worked with the market to support this process. Market engagement has taken place through December 2021 and January 2022, to share the proposed changes to the Usual Cost model with the provider market.

4.2. The Care Analytics Ltd Reports and the proposed cost models and supporting documents were released to all providers for their feedback and comments at the start of the engagement period.

4.3. Following this period of engagement, Providers have had an opportunity to present feedback and commentary on the proposed changes

4.4 Comments were received from 23 individual providers, representing 14.5% of total contracted providers who between them manage 34% of Lincolnshire's registered care homes, and one coordinated response from the Lincolnshire Care Association which represents over 130 Care Providers in the county. Detailed feedback, and the Council's responses to this feedback can be seen in appendix D, however key themes from the feedback are as follows:

4.4.1 Utilities – There is significant concern regarding the rising costs of utilities and the extent to which these costs have been factored into the 2022-23 Usual Cost proposals from providers in all market sectors.

4.4.2 Insurance – The Sector has become a high-risk sector for the Insurance Industry and the narrowing of choice has resulted in an increase in costs.

4.4.3 National Insurance – A key factor associated with the sufficiency of the proposal associated with wages is the NI contributions increase, which are set to rise by 1.25% in April 2022.

4.4.4 Workforce issues – Strong competition from other sectors where pay, conditions and incentives have led to workers leaving health and social care, combined effect of the pandemic and Brexit reducing the staff available to work in the sector.

5. The Council's Response to the Feedback and Recent Developments

5.1 The consultation on the rates was brought forward to provide the market with sufficient time for review. This meant that the provisional Local Government Settlement had not been published when the rates were shared. Since the market assessment was carried out, the settlement has been published and two material developments have occurred which, alongside the market feedback from the engagement have been considered in addition to the rates published:

5.1.1. The publication of the Market Sustainability and Fair Cost of Care Fund

5.1.2. Volatility in energy prices which won't be reflected in the modelling due to timing. The impact will vary between providers with those on a variable tariff likely to see the largest financial impact.

5.2. The Market Sustainability and Fair Cost Fund is to enable preparation across local markets for the announced social care reforms. The fund will be released over the next 3 years to support us to move towards paying a fair cost of care across residential and non-residential care. The Council has received £2.273m for the financial year 2022-23. Working through the conditions of the fund, and in consideration of feedback provided by the market as part of the consultation process, we are able to propose an increase to the rates published in December to take account of some of the additional pressures highlighted by the market. The proposed new rates include the increase in national insurance contributions and are shown in paragraph 5.6 below and (for Older People and Learning Disability) in Appendix E and F.

5.3. These rates will see the full £2.273m fund committed to ASC providers.

5.4. In addressing the volatility in energy prices, the model proposed as part of the consultation builds in utilities costs based on the median response from the surveys. Since the surveys were received energy prices have changed significantly and we recognise the anxiety resulting from this volatility. We also recognise the scale of its impact will vary from provider to provider. It is therefore proposed to create a 'Hardship Fund' during 2022-23. The fund will provide a contribution to providers for additional utility costs incurred. The mechanics of this fund are being worked through with the intention to publish further detail to providers during March 2022. In addition, the Council's commercial team is exploring an opportunity to facilitate collaborative energy buying on behalf of care homes through the Eastern Shires Purchasing Organisation (ESPO), of which the Council is a member authority. Enabling care homes to access energy at tariffs secured with the combined buying power of a wide range of public and private sector organisations offers potential to reduce their utilities costs and help mitigate the impact of the current market volatility.

5.5. As a result of the work carried out to date and following feedback in the consultation the recommendation is that the rates set out in section 5.6 are adopted as the Council's Usual Costs for both new and existing service users as of 1 April 2022. The cost of implementing this proposal in the first of the new 3-year contract is approximately £5.873 million. The governance processes surrounding third party top ups and bespoke packages of care for those with severe complexities for example are not included in the proposed 'usual cost' rates. These costs will continue to be managed through our existing processes.

5.6. The tables below show the updated rates proposal

5.6.1. Learning Disabilities:

Complexity Band	Standard 13+ Beds		Smaller 7-12 Beds		Smallest 1-6 beds	
	Current 2021/22	Proposed 2022/23	Current 2021/22	Proposed 2022/23	Current 2021/22	Proposed 2022/23
Band 1	£651	£678	£697	£725	£743	£772
Band 2	£749	£784	£795	£831	£841	£878
Band 3	£944	£993	£990	£1,039	£1,035	£1,086

5.6.2. Older Persons:

Category of Care	Current 2021/22	Proposed 2022/23
Older People Standard Residential	£533	£567
Older People Nursing	£588	£627
Older People Higher Dependence	£587	£626

5.6.3. Physical Disabilities:

Category of Care	Current 2021/22	Proposed 2022/23
Physical Disability	£687	£731

5.6.4. Mental Health:

Category of Care	Current 2021/22	Proposed 2022/23
Mental Health Standard	£555	£590
Mental Health Nursing	£587	£624

5.7. The Council's cost model including the assumptions made for the recommended proposal are attached at Appendices E and F. This has been used to form a view on

the actual costs of care in Lincolnshire using much of the information collected in the Care Analytics Lincolnshire Survey.

6. CONTRACTUAL UPDATES

6.1 A number of updates and improvements have been made to the service specification following a thorough review of current documentation by a working group consisting of a wide range of stakeholders, and benchmarking against other local authority specifications. It has been concluded that the existing specification is fit for purpose, comprehensive and in line with best practice. Minor updates and improvements have been made to reflect best practice, including addressing requirements around covid and flu vaccination; reinforcing care planning practice, in particular a Strengths Based Approach in relation to supporting individuals to remain as independent as possible; and developments in the digital agenda such as the use of NHS Mail and health monitoring technology.

6.2 Contractual changes have been necessary to address the planned and agreed move to gross payment in 2022, which as noted at section 2.18, will support providers to reduce the significant administrative burden and will provide residential homes with one flow of income for the care delivered, as well as procedural and practice changes regarding the effective management of Third-Party Top Ups.

6.3 <u>Future work programme</u>

A work programme to develop the future commissioning of residential and nursing care will follow the establishment of the new framework in 2022 and the initial 1-year rate setting, to enable development time for a more strategic approach in a number of important areas highlighted through the 2021 review. This will include:

6.3.1 Block purchasing – To better account for market conditions, exploration, planning and implementation of a broader programme of 'block purchasing' of residential and nursing beds to support market management, cost management and assurance of supply. Further work will be needed to establish categories of care, locations and volumes required.

6.3.2 Further work with specialist sectors, including learning disabilities, Mental Health and Physical Disabilities to ensure the usual cost model methodology and approach remains sustainable and effective in future years. Subject to the outcome of the further work and analysis, this could include appropriate revisions and adaptations to the existing model.

6.3.3 Developments towards fair cost of care and Usual Cost setting for 23-24 in line with the governments social care reforms.

7. Legal Issues:

Legal Background

7.1. The legal framework governing Care and Support in England is provided for by the Care Act 2014 (the Act), detailed secondary legislation by means of Regulations and the Care and Support Statutory Guidance to the Care Act 2014 ("the Guidance").

7.2. Under the Care Act the Council has a primary obligation to assess the needs of those that appear to have needs for care and support and to meet those needs where they meet eligibility criteria. One of the main ways that the Council meets need is through the provision of residential care and residential care with nursing across a range of needs.

7.3. The Care and Support and After Care (Choice of Accommodation) Regulations 2014 enable a person to have the right to choose a particular provider subject to certain conditions. Where the accommodation is of the same type as specified in the adult's care and support plan, the preferred accommodation is suitable and available and where the provider agrees to provide the accommodation on the local authority's terms, the local authority must provide or arrange the accommodation. The preferred accommodation must not cost the local authority more than the amount specified in the personal budget of the adult.

7.4. The Guidance provides that:-

- The Council must have regard to the actual cost of good quality care in deciding the personal budget to ensure that the amount is one that reflects local market conditions (para 11)
- The Council should not set arbitrary amounts or ceilings for particular types of accommodation that do not reflect a fair cost of care (para 11)
- A person must not be asked to pay a top up because of market inadequacies or commissioning failures and must ensure there is a genuine choice (para 12)
- The Council must ensure that at least one option is available that is affordable within a person's personal budget and should ensure that there is more than one (para 12)
- If no suitable accommodation is available and no preference expressed the Council must arrange care in a more expensive home and adjust the budget accordingly (para 12)
- The Council has a duty to shape and facilitate the market including ensuring sufficient supply (para 13)
- Where choice cannot be met the Council must give the individual an explanation in writing. (para 17)

7.5. The setting of the Council's Usual Costs is central to its compliance with these obligations. In particular the rate that the Council establishes as its Usual Cost will contribute significantly to the viability and sustainability of a market which provides sufficient places capable of meeting need. The Usual Cost will also determine in

many cases the personal budget against which the choice of accommodation provisions will be assessed.

7.6. In addition, the Council has general obligations under the Care Act. The most important of these in the current context is section 5 which states:-

"s.5(1) A local authority must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market
(a) has a variety of providers to choose from who (taken together) provide a variety of services
(b) has a variety of high-quality services to choose from
(c) has sufficient information to make an informed decision about how to meet the needs in question

7.7. Under section 5(2), when the council is considering the duty set out above, the Council must have regard to:-

- The need to ensure information is made available about the providers and the types of services they provide
- The current and likely future demand and how providers might meet that demand
- The importance of enabling, those that wish to do so, to participate in work, education or training
- The importance of ensuring sustainability of the market (in circumstances where it is effective as well as in circumstances where it is not)
- The importance of fostering continuous improvement in the quality, efficiency and effectiveness of the services and the encouragement of innovation
- The importance of fostering a workforce who are able to deliver high quality services (relevant skills and appropriate working conditions)

7.8. The Council must, when considering current and likely future demand ensure that there are sufficient services available to meet need and have regard to the importance of promoting wellbeing.

7.9. Chapter 4 of the Guidance (Market Shaping) provides guidance on s.5 of the Act in particular in the following paragraphs:-

"4.11 This statutory guidance describes, at a high level, the themes and Issues that local authorities should have regard to when carrying out duties to shape their local markets and commission services Market shaping, commissioning, procurement and contracting are inter-related activities and the themes of this guidance will apply to each to a greater or lesser extent depending on the specific activity…"

"4.27 Local authorities should commission services having regard to the cost effectiveness and value for money that the services offer for public funds. The Local

Government Association Adult Social Care Efficiency Programme(…) has advice on these issues and may be helpful …"

"4.31 When commissioning services local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care. This should support and promote the wellbeing of people who receive care and support and allow for the service provider ability to meet statutory obligations to pay at least the national minimum wage and provide effective training and development of staff. It should also allow retention of staff commensurate with delivering services to the agreed quality and encourage innovation and improvement. Local authorities should have regard to guidance on minimum fee levels necessary, taking account of the local economic environment. This assurance should understand that reasonable fee levels allow for a reasonable rate of return by independent providers that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term…"

7.10. The Usual Costs in this Report will continue to support a market within Lincolnshire that provides a choice of good quality care for Lincolnshire service users in a way which is sustainable both in terms of the businesses themselves but also in terms of a skilled workforce.

Equality Act 2010

7.11. Under section 149 of the Equality Act 2010, the Council must, in the exercise of its functions, have due regard to the need to:

* Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
* Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
* Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.12. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation

7.13. Having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

* Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic
* Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it
* Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low

7.14. The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities

7.15. Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to tackle prejudice, and promote understanding

7.16. Compliance with the duties in section 149 may involve treating some persons more favourably than others

7.17. The duty cannot be delegated and must be discharged by the decision-maker. To discharge the statutory duty the decision-maker must analyse all the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision-making process

If the Usual Cost is set at a level which is too low to cover costs then it is possible that there would be an adverse impact on people in residential care who are particularly vulnerable either by way of age or disability or both. This could happen because the rate paid by the Council was too low to maintain quality at current levels and as a consequence for example the number of activities available to residents could fall along with the catering standards or the amount of care hours available to individuals. In the event that rates were so low that providers could not maintain their business and homes closed residents would have to move. This could cause distress and upheaval particularly for those well settled residents with friends amongst the staff and other residents. Unless well managed it could also be injurious to health for the most vulnerable and cause confusion to dementia sufferers.

An Impact Analysis has been completed for Residential and Nursing Care rates for Adult Care 2022-23 which addresses the risk of adverse impact on service users which can be found as Appendix C and should be carefully considered along with the statutory duty itself as set out above. Two potential types of adverse impacts are identified. Firstly that the quality of service may be reduced and secondly that more Homes may close. The extent of each risk depends principally on a consideration as to whether or not the Council's Usual Costs are at or above the actual costs of care. The work the Council has done to get data from the market and model the actual costs means that in the view of the Council the Usual Cost is at or above the actual cost of care

The recommended proposal does increase all Usual Costs and does cover the providers' costs. The risk arising out of a fall in quality in these circumstances is therefore considered to be low. The proposed rate is above that residential care providers are currently paid and therefore there should be little economic need for providers to reduce the quality currently provided.

In any event the Council has procedures in place so that it can monitor the situation, so as to be able to manage both risks if they arise and thereby mitigate the risk of adverse impact arising out of either circumstance. In relation to quality the Council will specify the minimum quality requirements in its contracts which Homes will be required to sign. This will be monitored through contract management meetings with all providers to discuss

performance; issues raised by the homes; workforce development; commissioning plans; operational quality assurance and other matters as appropriate. The meetings will take place in the homes and will vary in frequency, large providers will have monthly meetings with the smaller providers having less but they will take place at least annually. The Council works closely with the Care Quality Commission and has a structured approach to quality data maintaining a current history on each home. This enables any quality issues to be quickly recognised. Where Safeguarding issues are raised a multi-party investigation is undertaken and the Assistant Director or Head of Strategic Safeguarding will suspend all new placements where appropriate. In those cases the Council will then work with the home to develop an improvement plan and will monitor the improvements. The suspension will only be lifted when satisfactory progress has been made.

As far as potential Home closures are concerned, the risk of a home closing will be monitored through contract management meeting and the Contract Risk Matrix. The Council would expect that homes starting to find themselves in difficulty would raise concerns with the Council. In the unusual and unlikely event that a home was going to close, rather than be sold as a going concern, there is sufficient capacity within the market to find alternative provision for residents. The Council has in place a "Loss of Provider Process" which enables action to be taken quickly and efficiently to enable a smooth transition. The Loss of Provider Process requires that a team of practitioners is set up to be dedicated to working with the home, residents and relatives to find suitable alternative placements. This team will work closely with NHS colleagues and the contracts, quality and safeguarding teams in the County Council to manage the transition of arrangements.

In addition to this and as part of the Council's general market shaping work the Council continually monitors capacity in the market and addresses issues through its commissioning methodologies.

It is considered that the adoption of the recommended proposal addresses the risks and adverse effects that might arise if the alternative option was adopted. The remaining potential for adverse effects is considered to be low and can be mitigated and managed as set out above. Adoption of the recommended proposal is therefore considered to be consistent with the Council's obligations under the Equality Act 2010.

Joint Strategic Needs Analysis (JSNA) and the Joint Health and Wellbeing Strategy (JHWS)

7.18. The Council must have regard to the Joint Strategic Needs Assessment (JSNA) and the Joint Health & Well Being Strategy (JHWS) in coming to a decision

The JSNA for Lincolnshire is an overarching needs assessment. A wide range of data and information was reviewed to identify key issues for the population to be used in planning, commissioning, and providing programmes and services to meet identified needs. This assessment underpins the JHWS which has the following themes:-

i. Promoting healthier lifestyles
ii. Improving the health and wellbeing of older people
iii. Delivering high quality systematic care for major causes of ill health and disability
iv. Improving health and social outcomes and reducing inequalities for children
v. Tackling the social determinants of health

Under the strategic theme of improving the health and wellbeing of older people in Lincolnshire there are 3 relevant priorities;

- Spend a greater proportion of our money on helping older people to stay safe and well at home
- Develop a network of services to help older people lead a more healthy and active life and cope with frailty
- Increase respect and support for older people within their communities.

The proposed increases to Residential and Nursing Care Fee Levels will contribute directly to the delivery of these priorities by helping to ensure that services for recipients of Adult's social care services are locally based, cost effective and sustainable.

Crime and Disorder

7.19. Under section 17 of the Crime and Disorder Act 1998, the Council must exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent crime and disorder in its area (including anti-social and other behaviour adversely affecting the local environment), the misuse of drugs, alcohol and other substances in its area and re-offending in its area

Section 17 matters have been taken into account in preparing the Report. The Proposals in this Report do not directly contribute to the furtherance of the section 17 matters and there is no risk of adverse impact identified.

8. Conclusion

8.1. The Council has worked with the sector to establish the costs of care within Lincolnshire. As part of that work the Council has consulted the sector on proposed rates set out in section 3 of the Report.

8.2 In the light of the feedback concerning the cost pressures within the sector and more recent developments especially the announcement of the Market Sustainability and Fair Cost Fund, it is recommended that the rates set out in paragraphs 5.6.1, 5.6.2, 5.6.3 and 5.6.4 are approved. These are rates for 2022/23 and will be further reviewed prior to the 2023/24 year to ensure that the Council's rates remain responsive to market fluctuations.

8.3 To further support the sector it is proposed to create a Hardship Fund to help manage fluctuations in utility and insurance costs.

8.4. For the reasons outlined in the report, the Usual Costs identified above represent an appropriate rate to enable the continued viability of the residential care market in

Lincolnshire and the continued provision of choice in good quality care for the residents of Lincolnshire and it is recommended that the Usual Costs are approved.

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9. Legal Comments:

The Council has the power to adopt the Usual Costs and establish the Hardship Fund as set out in the Report. The proposed rates are considered to have been arrived at through a lawful process which reflects case law, the Council's obligations under the Care Act and associated Guidance and which has appropriate regard to all relevant considerations.

Further detailed discussion of the legal implications of the decision are dealt with in the Report.

The decision is consistent with the Policy Framework and within the remit of the Executive.

10. Resource Comments:

To ensure compliance with its current and future legal obligations the Council must ensure it has a full understanding of the market provision of residential and nursing care and the cost at which such care can be made available by the market on a sustained basis. This will enable the Council to set a Usual Cost which it expects to pay for residential services in Lincolnshire to ensure a supply of service to meet identified need and to enable choice. This report details a proposed set of rates it believes the Council should adopt for 2022-23. The cost to the authority of implementing the proposed rates is estimated to be £5.873m over one year. The additional funding requirement for the first year of the agreement is within the financial envelope identified during the 2022-23 budget setting process. In the subsequent two years of the agreement there is some uncertainty around the delivery method for future funding of social care, which means it would not be reasonable to adopt the Usual Costs for a full three-year period at present. The review and setting of Usual Costs once future funding is clear will support the ongoing sustainability of the market and the Council's own longer term financial planning.

11. Consultation

a) Has Local Member Been Consulted?

N/A

b) Has Executive Councillor Been Consulted?

Yes

c) Scrutiny Comments

This Report will be considered by the Adult Care and Community Wellbeing Scrutiny Committee at its meeting on 23 February 2022 and the comments of the Committee will be reported to the Executive

d) Have Risks and Impact Analysis been carried out?

Yes

e) Risks and Impact Analysis

See the body of the Report

12. Appendices

These are listed below and attached at the back of the report
Appendix A – Report for LCC on Older Adult Care Home Market 2021 Appendix B – Report for LCC on Learning Disability Care Home Market 2021 Appendix C – Equality Impact Assessment Appendix D – Market Consultation Feedback and Responses Appendix E – Residential Rate Model Adult Frailty and Long-Term Conditions Appendix F – Residential Rate Model Specialist Adults Services

13. Background Papers

The following Background Papers within the meaning of section 100D of the Local Government Act 1972 were used in the preparation of the Report

Document title	Where the document can be viewed
Residential and Nursing Care Fee Levels within Adult Care 2018	Issue details - Residential and Nursing Care Fee Levels within Adult Social Care (moderngov.co.uk)

This report was written by Carl Miller, who can be contacted at carl.miller@lincolnshire.gov.uk.

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Lincolnshire older adult care home market review 2021-22

18 October 2021

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About

This report details the findings from Care Analytics independent review of the older adult care home market in Lincolnshire as of the summer 2021.

The appendix also includes brief analysis of the physical disability and mental health care home markets, as each of these markets is too small for its own detailed review. We have included as an appendix in this report as the respective client groups commission many placements in older adult care homes.

We have produced a separate independent report on the learning disability care home market as there is only minor overlap with the older adult market.

The market review was commissioned by Lincolnshire County Council (LCC) as part of its 3-year review of its care home commissioning. The main aims of the market review were:

- To analyse the costs of delivering older adult residential and nursing care in Lincolnshire to inform the 'usual costs' (weekly fees) that will be set by the council.
- To compile an evidence base to inform the development of the council's future commissioning and commercial strategy, including mapping geographical variations in costs, facilities, and services across the county.
- To identify local trends, issues, pressures, and opportunities, including comparisons against national trends.

Much of the analysis in this report is based on anonymised surveys completed by care home providers in Lincolnshire. Care Analytics would like to thank all care homes and provider groups who contributed to this review.

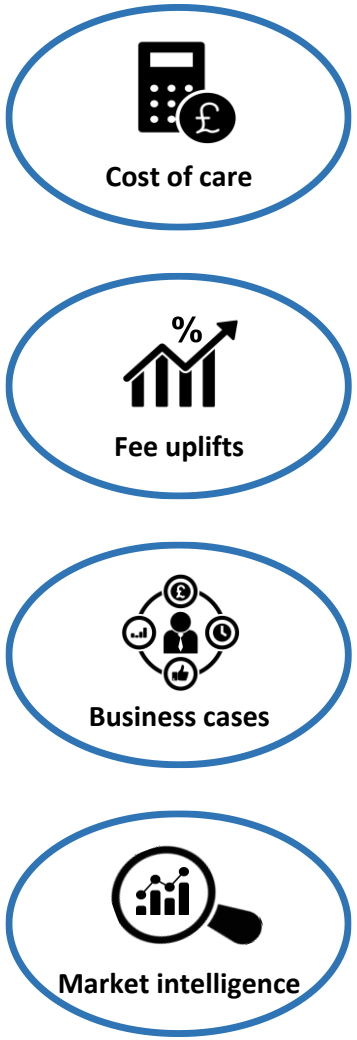
LCC will likely use the analysis within this report to create its own cost model to help inform its ‘usual’ rates for standard-rated care home placements. Care Analytics brief does not include recommending a specific cost model nor advising on what future ‘usual’ rates should be. Our role is to provide an evidence base to help the council make such decisions.

Whilst the primary aim of this report is to provide an evidence base to support council commissioning, we have tried to make the report as useful as possible for care home providers in Lincolnshire.

Disclaimers

Every effort was taken to ensure the accuracy of the information in this report at the time of writing. However, Care Analytics accepts no responsibility for any errors or omissions contained therein. Care Analytics also accepts no responsibility for actions taken or refrained from by reference to the contents of this and any related documents.

Care Analytics



- This project was undertaken by Care Analytics two directors, Jason Hedges and Chris Green, who between them have 30-years of experience working in adult social care and its interfaces.
- We specialise in the financial analysis of care and support services. Underpinning this, we have:
  - ✓ Wide-ranging experience analysing care markets.
  - ✓ In-depth knowledge of the cost of care for all client groups and care settings within adult social care.
  - ✓ Expertise in cost models, financial modelling, and business analysis.
  - ✓ Detailed knowledge of social care policy, regulation, and legislation.
  - ✓ Extensive experience developing business cases in the public, for-profit and voluntary sectors.
- Our customers are councils, CCGs, regional organisations, and care providers.
- More information about our services can be found on our website: https://careanalytics.co.uk/

Evidence used to inform the review

Provider data

- Anonymised provider surveys (discussed on the next page).
- Telephone conversations with three of the largest older adult providers in the county.

Public domain data

- Lincolnshire care home CQC inspection reports 2015-2021.
- Wages and terms & conditions from 500+ job advertisements.
- Skills for Care data about Lincolnshire and East Midlands.
- Statutory accounts of main provider groups operating in the county.
- House sales data at the location of each older adult care home in the county, including 58 properties with the exact address as the care home.
- Provider websites and other online information.
- Various public data sets, such as the CQC care directory, inflation indices, postcode and geospatial data, ASC-FR and other statutory returns.

Council data

- Care home placements data (snapshot as of July 2021).
- FNC data for council-funded placements.
- Data on 'top-ups' for each care home.
- Resident data based on weekly submissions by care homes to LCC ('Jadu' data).
- Covid-19 funding allocations.
- Semi-structured interviews with leads from each client group, and key staff within LCC's finance and commercial teams.

Care Analytics data

- Care Analytics care home database (which is based on the CQC care directory, but with extensive data cleansing and the addition of analytical fields to extend the range of possible analysis).
- Care Analytics extensive range of evidence about the cost of care.

Evidence from surveys

Older adult care home survey responses by national group size (number of care homes in England)

Survey status	<5 homes	5-19 homes	20+ homes	Total	<5 homes	5-19 homes	20+ homes	Total
Submitted a survey	32	7	39	78	30%	33%	72%	43%
No survey	74	14	15	103	70%	67%	28%	57%
Total care homes	106	21	54	181	100%	100%	100%	100%

- 78 out of 181 (43%) older adult care homes in Lincolnshire submitted surveys. Most of the surveys were thoroughly completed, though as is always the case, some care homes did not complete all the sections.
- The survey sample has good geographical coverage (not shown above).
- However, the sample is heavily skewed towards larger groups relative to the overall composition of the market. This is significant, as large groups and independent care homes often have different cost profiles. This also means it is likely that the sample is qualitatively different in some respects compared to the 2017 survey. Caveats are made throughout this report where there are likely to be issues comparing 2021 to 2017 survey data.
- We can only speculate for the reasons why independent care homes did not engage as much as large groups. However, the most likely reason is simply that many homes were simply overloaded given demands on them at the current time. As well as the additional demands resulting from Covid-19, the survey timeframe also overlapped with many other data requests which providers were contractually obliged to complete and/or had funding directly attached.
- Whilst the 2021 survey sample size is good, the lack of responses from independent care homes and the fact that the sample is self-selecting (and includes many homes with very low occupancy) means it is ‘leap’ to assume the sample will always be representative of the wider market. We note in context throughout this report where there are potentially material issues associated with the sample being unrepresentative. Please note that measures of statistical significance do not apply as sample is self-selecting.
- Finally, some analysis in this report is limited by the need to ensure the anonymity of each care homes data. Where care homes or providers are mentioned in the report, any analysis is solely based on information already in the public domain.

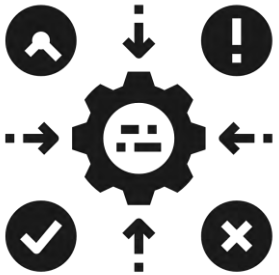
Analysis of the survey data

- Much of the analysis within this report is dependent on the accuracy of the information supplied by providers in their submitted surveys.
- However, Care Analytics extensive experience undertaking similar exercises (and working with care providers) means we can analyse the data from a critical perspective and provide commentary on how to interpret the data.
- Wherever possible, we have also provided supporting evidence from other data sources to validate and contextualise the survey data.
- We have tried to avoid the common mistakes that we often see when people analyse care home survey data. These include:
    i. Failing to recognise that the same cost can be recorded in different ways, such that some costs must be grouped together to ensure correct treatment.
    ii. Failing to adequately take into account that both staff roles and non-staff cost categories overlap, such that high or low values in one area are often offset by low or high values elsewhere.
    iii. Including low outliers in the data but excluding high outliers, therefore artificially reducing averages.
- More generally, we also recognise that averages have significant limitations and can often be misleading. For example, a mean average comprised of high and low values often has different implications in terms of how the data should be interpreted compared to the same mean average where all values are similar. Wherever possible, we show the distribution of results at various percentiles (minimum, 10th percentile, 25th percentile, median or 50th percentile, 75th percentile, 90th percentile and maximum) in addition to mean averages.
- We also calculate 'trimmed mean' results for much of the analysis. These are mean averages but ignore a certain percentage of the highest and lowest values. In this report, this is usually the lowest 10% and highest 10% of values, though sometimes we use a narrower range where we consider more results to be outliers (relative to standard-rated care home placements). While there is often no significant difference between the overall mean and the trimmed mean, the latter can be a more useful metric when a set of data has outliers.
- In summary, we have done our best to ensure the overall cost structure of the respective care homes who submitted surveys is as accurately represented as possible.

Glossary

LCC	Lincolnshire County Council
FNC	Funded Nursing Care. This is what the NHS pays for the nursing care component of nursing home fees.
Prw	Per resident week (such as food costs of £30 prw or 24.0 care worker hours prw).
Unit cost	The total cost needed to supply one unit of a particular product or service. In this instance, a care home placement per week.
Capital cost	Fixed, one-time expenses incurred on the purchase of land, buildings, construction, and equipment.
'Sunk' capital cost	Capital costs which have already been paid for and for which there is no outstanding finance cost (no loans or mortgage).
Operating profit	Profit but excluding consideration of capital costs (whether funded by loan finance or owner equity).
Economic return	Profit including taking into account a real or 'fair' cost of capital.
Percentile	The number below which a certain percentage of values occur. For example, the 10th percentile of a particular cost means 10% of the sample has lower costs and 90% higher costs.
Median	The middle number of a series ranked high to low. This is a type of average.
Mean	Add up all the numbers and divide by the number of instances. This is usually what people refer to when they talk of average.
Trimmed mean	The mean but ignoring a certain percentage of the highest and lowest values. In this report, unless otherwise stated, the trimmed mean ignores the lowest 10% and highest 10% of costs. This helps ensure outliers and data errors are excluded. It is sometimes necessary to exclude more than 10% of costs to ensure the sample is reflective of standard-rated care.
Independent care home	A provider who operates only one care home. In this report, care homes are grouped based on either brand or provider links in the CQC care directory. This misses many small groups where an owner operates multiple care homes as separate companies.
Provider group	A provider who operates more than one care home.

Key context



Overview of the older adult care home sector

- About 400,000 people in the UK are currently supported in care homes.
- Care homes deliver support and board and lodgings as part of a holistic service. Residents are not granted tenancy rights.
- Care homes are legally split between those that provide nursing care and those that do not.
- Care homes are regulated and quality assessed by the Care Quality Commission (CQC). However, there is a great deal of discretion in terms of how care and support is delivered. Much of the way the market operates has therefore developed organically.
- The sector is a fragmented one, varying from large national groups operating thousands of beds to small businesses with one or two care homes. Across England, the 10 largest providers collectively operate less than a quarter of the beds in the market.
- The older adult care home market has a complex interface with the public sector. There are three significant sources of public funding:
    1. Council funding where the person has both eligible care needs and meets the relevant means-tested requirements.
    2. Funded Nursing Contribution (FNC) paid by Clinical Commissioning Groups (CCG) to cover the cost of eligible nursing needs in nursing homes.
    3. Continuing Health Care (CHC) funding paid by CCGs where individuals are assessed as having predominant health needs.
- Public-sector funded placements are sometimes supplemented by third-party top-ups from family, friends, and charities to get preferred facilities.
- The other main funding source is ‘self-funders’ who usually commission their own support directly from their care provider.
- Both the initial self-funder fee level at the point of entering a care home and fee increases over time are unregulated. Providers can therefore charge whatever they think is appropriate.
- In recent decades, an increasingly two-tier market has emerged in many parts of the country, with providers who predominantly support self-funders achieving significantly higher profits than providers who predominantly support public-funded residents.
- As a consequence, the vast majority of new-build care homes in recent years have been built primarily for the self-funder market. There is therefore a growing difference in terms of the quality of facilities serving different segments of the market.

The evolution of rooms standards in new-build care homes

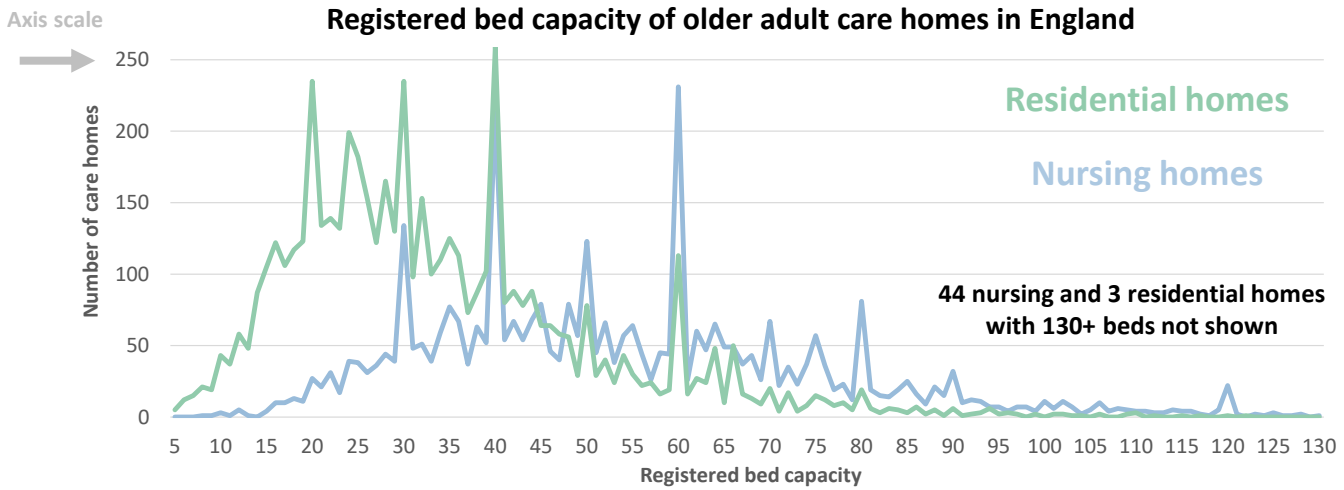
Category	1970s	1980s	1990s	2000s	2010s	2020s
Bathroom facilities	Communal bathrooms	Ensuite toilet and basin	Ensuite toilet and basin	Ensuite shower room	Ensuite shower/ wet room	Ensuite shower/ wet room
Usable floor space	c.9m²	c.10m²	c.12m²	c.12-16m²	c.14-18m²	c.16-20m²

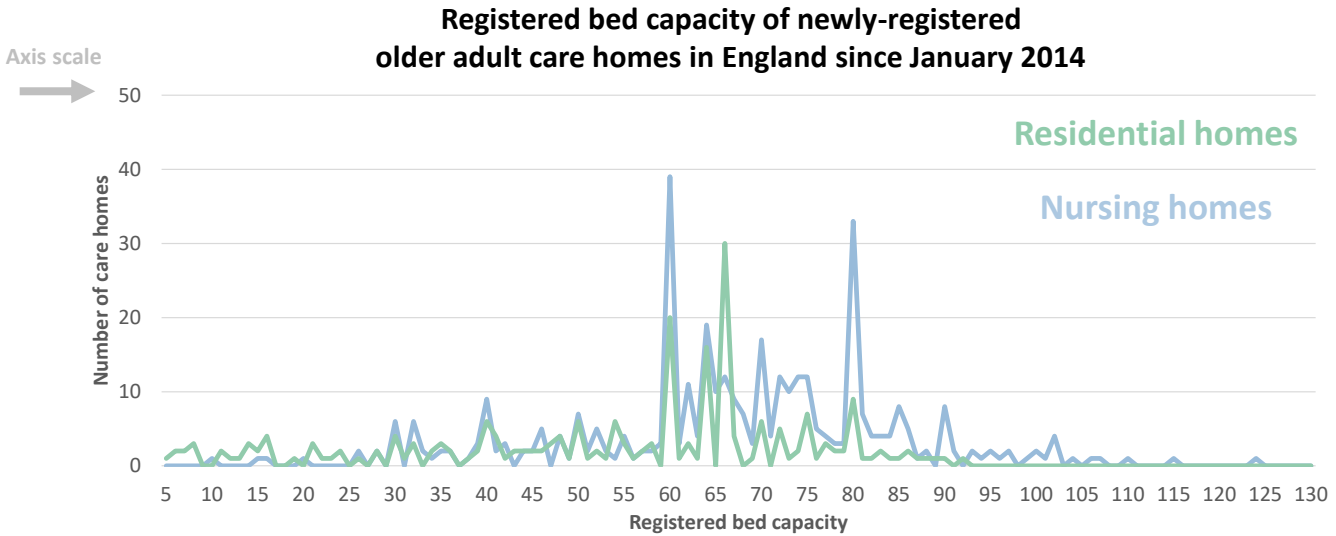
- The table above illustrates in ballpark terms the progression in typical minimum room standards for new-build care homes over time.
- Care homes aimed at the premium and luxury markets would obviously have higher specifications across the decades.
- Back in the 1970's, most of the care home market was an adjunct of the NHS and largely dealt with residents commissioned by the public sector.
- As the self-funder resident proportion of the market has grown, and the public sector has undergone multiple periods of austerity, care home providers have increasingly aimed their provision – particularly new provision – at the private pay market. Typical standards for new builds have progressively improved to reflect the more holistic requirements of self-funders, compared to public sector commissioners.
- The Care Standards Act 2000 specifies that new care homes must have at least 12m² usable floor space in each bedroom, plus an ensuite toilet. The original intention in the Act was that all care homes had to meet this standard by around 2007. However, this requirement was dropped after understandable pushback from the sector that this was unachievable. Two decades later, this requirement still does not apply retrospectively to pre-existing care homes. Indeed, a large minority of the care home market remains 'substandard' by new-build room standard requirements.
- While smaller rooms can be unsuitable for residents with wheelchairs and other mobility equipment, from the point of view of care, the higher room standards of modern new builds are unnecessary.
- Stakeholders are likely to have differing opinions about the importance of rooms size and the need for ensuite toilets, showers, and wet rooms.

Types of care in older adult care homes

- Care homes can be categorised between those that provide nursing care and those that do not. Nursing homes require a registered nurse to be on site at all times. This means nursing care is usually more expensive than residential care.
- Most nursing homes also support residents who do not have nursing needs. This can either be in separate residential care units or within a largely nursing unit. Such care homes are 'dual-registered'.
- In addition to the nursing split, older adult care homes can also be differentiated based on whether they provide dementia care or not. A larger care home might also have separate care units for clients with dementia-related needs.
- Consequently, a fourfold categorisation of nursing general, nursing dementia, residential general and residential dementia is a useful and relatively common way to classify either the entirety of an older adult care home or specific care units within larger homes.
- Care workers in older adult care homes typically support multiple residents across their shift on an as-and-when needed basis. Support can be described on a worker-to-resident ratio across a shift, e.g. 1 care worker to 6 residents (1 to 6). Nurses are sometimes included in quoted staffing ratios. Care worker support levels are usually higher during the day than the night for obvious reasons.
- Neither the Care Act nor the CQC set minimum care staffing levels in England. This means there is a wide variety of staffing levels across the marketplace. The CQC check to see if staffing levels are safe during their inspections, but what is considered safe varies based on the overall level of need of residents and the type and layout of facilities. Most care homes use one of many dependency tools to help calculate safe staffing levels.
- Both (i) the layout, facilities and equipment within a bedroom, and, (ii) the layout and size of the part of the care home used by residents, can significantly influence what constitutes a safe staffing level. For example, old care homes in converted properties sometimes require higher staffing levels because the facilities were not built to be disability friendly. Smaller care units are also often less efficient than larger care units, as care units often require a minimum level of staffing, even if this means staff are underutilised.
- Both the cost structure and the total costs can vary substantially between care homes. Whilst this can sometimes relate to factors such as poor cost control or inefficiency in the traditional sense of the word, by far the most important driver of cost variation is that care homes have different staffing levels, facility standards, financing costs, and business structures. There will always be difficulties trying to 'average' the cost structures of care homes which are qualitatively and not just quantitively different. For example, the difference in terms of the unit cost between a new care home facility and historic care home stock with low repurposing potential (and low capital cost value) is at least £100-150 per resident week (prw), even before considering potential differences in staffing and other day-to-day operating costs.

Residential and nursing care homes sizes

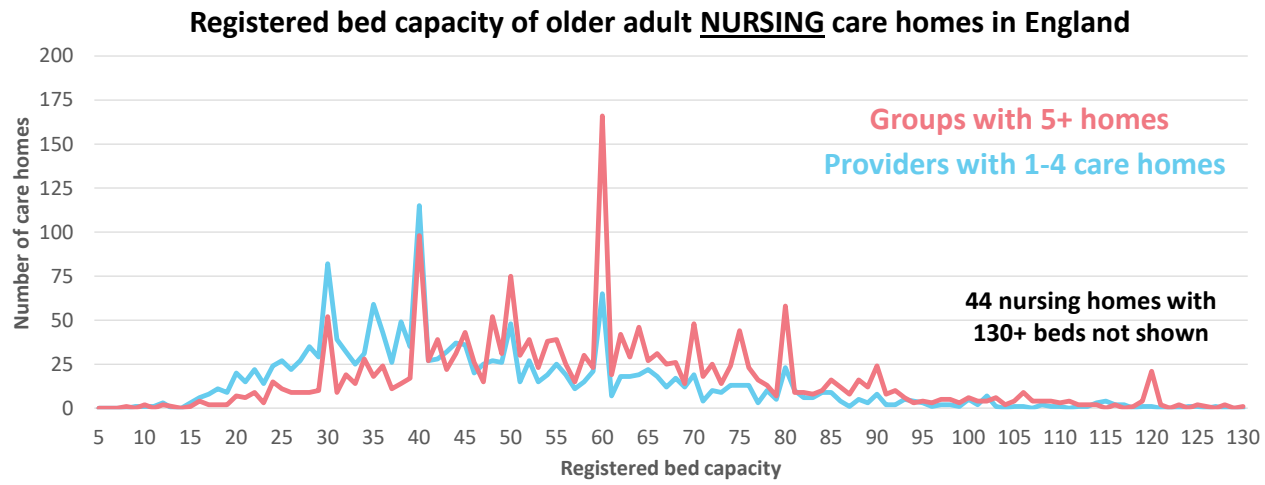


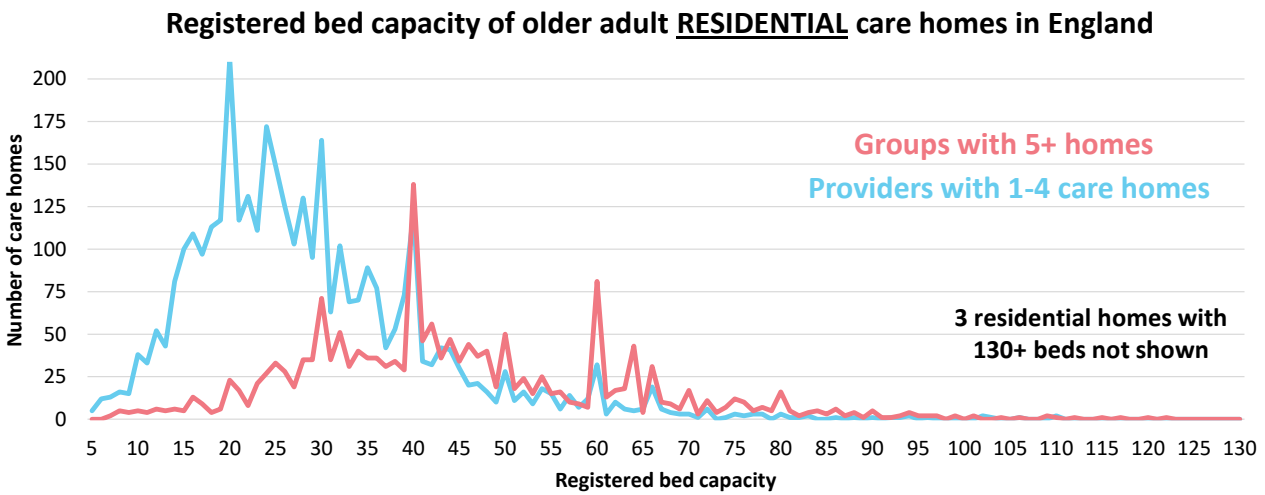


Data: Care Analytics care home database

- Nursing homes rarely operate below 30 beds owing to the efficiencies needed with the nurse. Nursing homes also require higher physical environmental standards and so tend to be in newer (and consequently larger) care homes.
- For various reasons, care homes below about 25 beds are more likely (but not always) to suffer from inefficient staffing, particularly with drops in occupancy. However, such homes are also more likely to have 'sunk' capital costs. They are also mostly independent care homes with no corporate overheads or portfolio management costs. Any higher costs from a lack of economies of scale can therefore often be (more than) offset so that the homes are competitive on price.
- Although there is not always a clear dividing line, caution must be taken analysing care homes that have qualitatively and not just quantitatively different costs.
- Most new builds are built to templates between 60-80 beds (bottom graph). This size of home allows flexible staffing, flexibility with care units (such as changing usage) and achieves good economies of scale. It also maintains appropriate spans of control and avoids some of the marketing, operational, and quality issues that are more likely to occur in larger homes.
- Many of the small homes shown on the bottom graph will not be new builds (just newly-registered facilities).

Care home sizes by provider group size





Data: Care Analytics care home database

- Although the cut-off point of operating 5 care homes nationally is a little arbitrary, we find this more reliable than differentiating independent care homes (as many small groups are not formally linked).
- There is no marked difference in the distribution of bed capacity for nursing homes between small providers and large groups. This is because there is less flexibility in terms of how nursing homes can operate with smaller home sizes.
- However, the distinction between smaller providers and larger groups for residential homes is stark.
- Groups do not usually operate small older adult care homes as (i) there is too high a risk of inefficient staffing, particularly with drops in occupancy, (ii) portfolio management costs relate as much to the number of homes as the number of beds, and (iii) small homes do not operate well to 'blueprints', as there are a myriad of ways homes can (and must) operationalise to be viable. This variability is somewhat incompatible with the corporate business model (though this argument should not be over-emphasised).
- The nursing market did not look like the top graph 20 years ago (looking more like the bottom graph), whilst the residential market will likely increasingly look more like the top graph over the next 20 or so years. Small homes will gradually exit the market and the large spikes between 60 and 80 beds will rise ever higher.

Self-funder fees in Lincolnshire

- The range of minimum self-funder fees in the market can be used to help demonstrate that: (i) there is no singular or 'true' cost of care, and (ii) not all care homes are delivering the same service (even if the care can be considered equivalent).
- Whilst there is not necessarily a proportional relationship between rising prices and costs, care homes charging £300+ more per week than other homes will nearly always have far higher costs. Whilst much of this higher cost relates to a combination of facility standards and costs associated with trying to achieve a 'hotel'-type experience, the costs still exist.
- The self-funder price variation is also sufficient to demonstrate that any analysis of average prices/costs has the potential to be vastly misleading.
- Based on the 2021 survey sample, the east of the county does not have the more luxury market with prices above £1,000 per week. However, all three broad geographical areas in Lincolnshire have a large range of minimum self-funder prices. In all areas, the difference between the 10th and 90th percentile of starting self-funder prices is about £300 to £400 per week.
- Whilst it is possible the sample is not representative of the entire market, minimum self-funder prices in nursing homes (including residential placements in nursing homes) are often considerably higher than residential homes. The main reasons are likely to be the costs of newer/better facilities and contributions to nurse costs outside of FNC.

Minimum self-funder fees in older adult care homes in Lincolnshire (excluding FNC, though FNC is often refunded to private residents if they are eligible)

	Residential general				Residential general			Residential dementia				Residential dementia			Nursing (excluding FNC)			
Category	East	West	South	All	Nursing homes	Res homes	All	East	West	South	All	Nursing homes	Res homes	All	East	West	South	All
Care homes	17	14	15	46	17	29	46	13	12	13	38	14	24	38	5	6	6	17
Min	£533	£600	£550	£533	£533	£533	£533	£588	£600	£573	£573	£588	£573	£573	£587	£780	£870	£587
10th percentile	£533	£691	£622	£582	£722	£568	£582	£622	£694	£827	£656	£624	£716	£656	£652	£810	£910	£768
Median	£759	£785	£859	£765	£912	£755	£765	£825	£883	£950	£885	£943	£880	£885	£820	£904	£1,025	£907
90th percentile	£912	£1,033	£1,140	£1,025	£1,200	£915	£1,025	£909	£1,056	£1,170	£1,054	£1,200	£943	£1,054	£898	£1,036	£1,200	£1,135
Max	£925	£1,200	£1,200	£1,200	£1,200	£962	£1,200	£925	£1,200	£1,200	£1,200	£1,200	£1,025	£1,200	£930	£1,091	£1,200	£1,200

Data: Anonymised care home surveys (2021)

Differential pricing

- It is common for businesses in many sectors to operate differential pricing structures for different types of customer. The reason they do this is to maximise absolute profit. Indeed, many businesses only make profits from certain types of customer (with other customers only contributing to fixed costs). There is a wide literature about how businesses can maximise profit from different customer types.
- The older adult care home market is well known for high levels of differential pricing in terms of the fee levels paid by self-funders, CCG's and councils.
- However, it should also be noted that fee levels for different self-funders can also vary by several hundred pounds per week based solely on room standards (size, location, aspect, etc.). This is also a form of differential pricing, as the differences often do not have a 'cost-plus' basis.
- For differential pricing to be effective, it is important that pricing decisions by different types of customer are disconnected. For example, councils can only pay lower prices, because it does not drag down self-funder prices. Higher prices for specific rooms must also be perceived as justified by the respective customers, irrespective of the extent to which the price difference is proportional (or not) to the underlying cost differences.
- As a high proportion of costs in a care home are mostly fixed for a set amount of capacity, it is rational for many care homes to sell beds to councils at a much lower rate than their usual self-funder fees. This is particularly the case for rooms that would otherwise be vacant, either because of a lack of self-funder demand or because certain rooms are 'substandard' and cannot easily be marketed to higher-paying residents.
- This is illustrated by the table below which shows ballpark unit cost impacts for varying occupancy levels relative to a 90% starting occupancy assumption. The numbers in the table are only intended to show the relationship between costs at varying levels of occupancy, not be indicative of a sustainable rate at a particular level of occupancy. As shown, the unit cost per resident changes markedly with different levels of occupancy.

Ballpark impact of changing occupancy on older adult care home unit costs prw (illustrative numbers only)

	Percentage occupancy					
Occupancy model	100%	95%	90%	85%	80%	75%
Care staffing is fully flexible	£595	£625	£650	£685	£720	£760
Care staffing is fixed and cannot change with occupancy	£570	£610	£650	£700	£755	£815

Care Act vs. balanced budget

- The Care Act 2014 gave local authorities key responsibilities for both market shaping and the commissioning of adult care and support.
- When commissioning, local authorities must ensure that they do not undertake actions which threaten the sustainability of markets. As part of this, they should assure themselves and have evidence that contract terms, conditions and fees are 'appropriate to provide the amount of care required to an agreed quality', including allowing 'for a reasonable rate of return that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term'.
- For market shaping, local authorities are required to collaborate closely with relevant partners to encourage and facilitate the whole market in its area for care, support and related services, irrespective of whoever is paying for those services. Market-shaping activity should stimulate a diverse range of appropriate high-quality services (both in terms of the types of services and the types of provider organisation) and ensure the market as a whole remains vibrant and sustainable.
- Alongside these Care Act duties, best value duties under Section 3 of the Local Government Act 1999 require local authorities to secure continuous improvement in the exercise of its functions having regard to economy, efficiency and effectiveness.
- Furthermore, in normal times local authorities must also set a balanced budget for each financial year.
- After more than a decade of austerity, financial constraints means there are severe tensions in many local authorities between their responsibilities under the Care Act and their requirements to secure best value and set a balanced budget. Ever narrower interpretations of Care Act duties are common.
- To indicate the scale of the problem, soon after the start of the Covid-19 pandemic, an ADASS survey published in June 2020 found that only 4% of social care directors were confident that their budgets were sufficient to meet their statutory duties.
- In many parts of the country (including Lincolnshire), in our opinion, if local authorities were to prioritise their responsibilities under the Care Act, they would have to 'choose' to pay more for older adult care home placements than is necessary given prevailing market forces. At the current time, most local authorities do not have the resources to make that choice even if they wanted.

CMA key findings (2017)

In 2017, the Competition and Markets Authority (CMA) undertook a market study into residential and nursing care homes for older people. The following are the extracts from their report which we consider the most relevant to this market review.

- "The demand for care home spaces, including spaces for LA-funded residents, is expected to increase in the future. This should be a signal to investors to develop new capacity for LA-funded residents. However, the evidence that we have gathered suggests that this has not been happening. Our analysis shows that this is because LAs, in aggregate, have been paying fees that have been below total cost, in part as costs have increased and LA fees have not increased at the same rate. We consider that this is the key factor affecting the profitability and sustainability of the industry." (para 4.77)
- "Already, nearly all new care homes being built are in areas where they can focus on self-funders." (para 42)
- "Our assessment is that the average fees paid by LAs are below the full costs involved in serving these residents. Our financial analysis of the sector shows that, looked at as a whole, the sector is just able to cover its operating costs and cover its cost of capital. However, this is not the case for those providers that are primarily serving state-funded residents." (para 35)
- "The incidence of differential pricing has increased markedly since 2005 when the Office of Fair Trading reported it found that only one in five homes charged differential prices [between LA-funded residents and self-funders]." (para 2.43)
- "Higher LA-fees will not necessarily result in downwards pressure on self-funder rates, but they would reduce the need for care homes to charge higher fees to self-funders." (para 66)
- "Where a care home is generating an economic loss, investors would not build new capacity, and would not have the incentive to undertake capital expenditure in existing homes. Some investors in existing care homes may choose to exit the market." (para 4.16)
- "On the other hand, if revenues are higher and sufficient to cover total costs (i.e. economic profit), and this is expected to continue in the future, then investors will remain in the industry, and are likely to be willing to undertake further capital expenditure." (para 4.17)
- "Providers making an economic loss (but operating profit) can be expected to remain in the industry only until they require significant levels of capital expenditure on their assets. These providers and care homes have been and can continue to operate profitably until such time." (para 4.40)

Care Analytics consider the CMA report to be an excellent piece of work given the constraints of such a high-level analysis. However, in our view, its main flaw is a lack of emphasis on frequently found differences in the facility standards of care homes serving different sections of the market, and the knock-on implications for unit costs and 'fair' economic returns.

EBITDAR

- EBITDAR (Earnings Before Interest, Tax, Depreciation, Amortisation and Rent), is a key profitability metric in capital intensive sectors like care homes, as it allows fairer comparisons of financial performance irrespective of the financing structure of each business.
- EBITDAR can be expressed as a monetary amount or as a percentage of revenue. The latter is usually referred to as EBITDAR margin and is calculated by EBITDAR divided by revenue (or price).
- For most care home cost models, EBITDAR is the combination of rent (or financing costs), capital maintenance (or depreciation), and surplus/profit.
- According to the Competitions and Market Authority (CMA), the average EBITDAR margin for 26 corporate providers in England was 21% between 2015 and 2017. However, providers who generated the most revenue from self-funders earned average EBITDAR margins of 27%, whilst those that generated the most revenue from council-funded residents earned margins of only 17%.
- The CMA also found that average EBITDAR margins in SME businesses are frequently lower, often less than 15%.
- A critical question, which in our opinion was not adequately addressed in the CMA analysis, is the extent to which lower EBITDARs for SMEs and providers generating the most revenue from council-funded residents can be explained (and at least partially justified) by lower capital costs relating to the age of stock and the standard of facilities.
- Where capital costs are ‘sunk’ or mostly ‘sunk’, an EBITDAR margin in the region of 10% should, in theory, allow buildings and facilities to be maintained (at least in the short to medium term) and allow the provider to earn a minimal operating profit. However, at this level, the provider is essentially not receiving any economic return for their invested capital. They would also struggle to cope with any substantive adverse events without other income. There is also a high risk of such providers exiting the market if they can realistically repurpose their asset.
- An EBITDAR margin between 15-20% is nowhere near enough to cover the associated capital costs for newer care facilities but could be an extremely high rate of return for older care home stock with low repurposing potential.
- The above analysis is not intended to downplay the complex interrelationships between the rates councils pay and the rates of return needed to incentivise new investment into the sector. However, Care Analytics believe that much of the narrative around questions of self-funder subsidy are overly simplified.
- In Care Analytics opinion, councils are increasingly going to have to find more effective ways of managing the fact that there are large differences in cost between support delivered in a new-build care home facility and in an old building with ‘sunk’ capital costs. Differential fees based on facility standards seems obvious at a superficial level, but this type of approach is not without a range of other issues.

The Covid-19 pandemic and care homes

- The first national Covid-19 action plan was announced on 3rd March 2020, the first guidance for reducing the risk of transmission in residential settings (including care homes) was published on 13th March 2020, and the first national 'lockdown' started on 23rd March 2020.
- Deaths in elderly care homes were high as the population is particularly vulnerable and infection control measures were not put in place early enough.
- The supply and use of personal protective equipment (PPE) was initially inconsistent and nothing like as comprehensive as current standards.
- Occupancy fell dramatically in many care homes from a combination of excess deaths and reduced new admissions.
- The evidence Care Analytics have seen from more than a dozen councils is that the impact of Covid-19 on older adult care homes has been variable, with a high degree of bifurcation. Some care homes have been completely unaffected in terms of occupancy levels. By contrast, other care homes have been hit by outbreaks and experienced much reduced occupancy – sometimes reducing to below 50% of their usual occupancy.
- Commentators believe occupancy will take 1-3 years to return to normal levels depending on the area. This is because (i) Covid-19 has brought forward many deaths that would have otherwise happened within the next couple of years, and (ii) as residents in older adult care homes typically die within the first 2 years (though there is a long tail who live much longer), occupancy will be rebuilt quickly provided decisions about entering care homes by self-funders and councils are not substantially affected by the pandemic (or other developments or events).
- New stringent, infection control measures are now in place. There are also additional testing requirements.
- Now much of the population is vaccinated, it is hoped the sector will return to largely standard operation by spring 2021, post the winter flu season. However, the impact of the requirement for care workers to be double vaccinated from mid-November 2021 rightly concerns many stakeholders.
- Given Covid-19 is now certain to remain an ongoing feature of the 'new normal', it is extremely likely the 'new normal' will require use of PPE and other infection control measures more stringent than historic practice. This will add additional cost to standard care home operations.
- Additional central government funding is likely to reduce/stop at some point in the future, so residual costs will fall on councils, CCG's and self-funders.
- The cost analysis in this report mentions in context where Covid-19 is likely influencing results. It is likely a significant factor in the higher staffing levels evidenced in some homes in the surveys (likely as a result of both higher hours and low occupancy).
- Such costs need to be considered at the point additional central government funding is withdrawn. However, it is not currently possible to reliably estimate the additional costs associated with the 'new normal', as it will depend on the requirements stipulated in government guidance (or what is deemed best practice) at the time.

New plans for adult social care

- At the time of writing, the government has recently announced its outline plan for the future of adult social care. At this stage, we do not have the necessary details to reach definitive conclusions about the implications. However, enough detail has been released to speculate.

National insurance increase

- National insurance costs for employers will increase by 1.25% percentage points. Once the qualifying threshold is taken into account, this will probably translate to about an additional 0.75% increase in staff costs for most older adult care homes.

Changes to financial assessment thresholds

- This changes the threshold for council-funded support. As councils will need to commission more care, there will likely be knock-on impacts on prices.

Lifetime cap care costs

- This does not directly affect the cost of care, though there are potentially huge ramifications.
- Councils will have to assess self-funders (probably at least annually) to determine if they have eligible needs and how much the council would in theory pay towards their care. Some form of self-assessment will likely be used to screen out obvious lack of eligibility and to reduce the assessment burden.
- As with Dilnot, we believe there is a reasonable chance that the cap on care costs will not happen. In our opinion, the administrative complexities and associated costs are huge (and possibly not fully appreciated). As such, there is a strong probability implementation will be delayed well beyond 2023.
- There are countless examples where guidance will be needed to manage issues associated with assessing eligibility, and managing (large) differences between the cost of care actually incurred and any notional entitlement for the metering of care costs (and what is paid after the cap is reached).

Self-funder rights to use local authority rates

- This is necessary for a cap on lifetime care costs to be feasible as you need a ‘metering’ rate at least in the ballpark of possible actual costs. This may be the primary reason the government plans to give self-funders the legal right to commission through their local authority.
- Depending on the specifics, this potentially has huge implications for care home markets. Major increases in adult social care budgets would also be needed to make this even close to being a reality. The analysis in this report includes critical context for understanding the implications of this change.

Council and CCG commissioning

LCC placements by location, age group, and client group

Age group and location of care home placements for the older adult client group

	Age group									
Location	18-25	26-44	45-54	55-64	65-74	75-84	85-94	95+	Total	Percent
Lincolnshire	-	-	-	9	181	563	865	196	1,814	97.2%
North Lincolnshire	-	-	-	-	5	5	3	1	14	0.7%
NE Lincolnshire	-	-	-	-	1	1	4	1	7	0.4%
Nottinghamshire	-	-	-	-	2	2	3	-	7	0.4%
Other	-	-	-	-	5	5	13	2	25	1.3%
Total	**-**	**-**	**-**	**9**	**194**	**576**	**888**	**200**	**1,867**	100.0%

Data: Placements data supplied by LCC finance linked to Care Analytics care home database

Client group and age group of LCC placements in older adult care homes in Lincolnshire

	Age group									
Client group	18-25	26-44	45-54	55-64	65-74	75-84	85-94	95+	Total	Percent
Older adult	-	0	0	6	152	550	861	195	1,764	95.1%
Physical disability	-	1	4	23	1	1	-	-	30	1.6%
Mental health	-	4	2	19	-	-	-	-	25	1.3%
Learning disability	-	7	4	8	10	6	-	-	35	1.9%
Total	**-**	**12**	**10**	**56**	**163**	**557**	**861**	**195**	**1,854**	100.0%

Data: Placements data supplied by LCC finance linked to Care Analytics care home database

- The top table shows care home placements commissioned by LCC's older adult client group (in all types of care home).
- The bottom table are placements commissioned by LCC (by all client groups) in care homes that predominantly support older adults.
- LCC commissions nearly all its older adult care home placements within Lincolnshire.
- Such a high percentage (97.2%) suggests a strong in-county preference as care homes located in other council jurisdictions may be closer geographically for many people will live close to the borders of the county.
- Only 4.9% of LCC placements in older adult care homes in Lincolnshire are commissioned by working-age adult client groups. Whilst there is a funding dynamic here (in that LCC transfer funding responsibility for adults in the physical disability and mental health client groups at age 65+), this indicates few older adult homes have specialist care units (for working-age adults) within their homes.

Usual rates comparisons with neighbouring councils 2020-21

Published council fee levels for 2020-21 (rounded to £1)

Area	Lowest rate	Highest rate
Rutland	£469	£545
Rotherham	£479	£547
Nottinghamshire	£493	£726
North Lincolnshire	£496	£527
North East Lincolnshire	£517	£517
Lincolnshire	**£521**	**£574**
Doncaster	£537	£588
Norfolk	£568	£660
Leicestershire	£603	£664

Data: Rates published on respective council websites

- The fee levels shown on this page are taken from respective council websites. They relate to the last financial year, as there are many more rates published. More up-to-figures are not essential, as the important thing is to see Lincolnshire's relative position to other councils.
- The respective councils are those neighbouring Lincolnshire, bar Cambridgeshire and Peterborough who do not appear to have official 'usual' rates.
- The 'usual' rates quoted are exclusive of Funded Nursing Contribution (FNC) if applicable to nursing.
- Councils differ in the types of care categories they use. For the councils left, this varies from 2 categories (nursing and residential) to 10 categories. For commensurability, we have only included the lowest and highest 'usual' rate from each council.
- Rates are ordered low to high using the lowest rate.
- Nottinghamshire is an outlier because its highest rate is far above the others. Nottinghamshire has a complex system of five tiered bands each with a potential dementia supplement.
- Lincolnshire has the 4th highest 'usual' rate out of nine councils (based on the lowest rate). The lowest rate in Rutland is £50 below Lincolnshire's lowest rate.
- What is not known is how frequently the respective councils only pay their 'usual' rate.
- As discussed elsewhere in this report, rates which can be viable in old care homes with 'sunk' capital costs, are far lower than the full unit cost of placements in newer care facilities. Whether explicit or not, for understandable reasons, financial austerity has caused 'usual' rates in many councils to be aligned to costs in older facilities.

ASC-FR weekly unit cost comparisons (aged 65+)

Comparison of aged 65+ ASC-FR care home weekly unit costs

	Nursing		Residential	
Area	2018-19	2019-20	2018-19	2019-20
North Lincolnshire	£484	£504	£480	£504
North East Lincolnshire	£590	£631	£489	£507
Cambridgeshire	£795	£633	£615	£522
Lincolnshire	**£529**	**£581**	**£536**	**£568**
Peterborough	£763	£265	£632	£585
Rotherham	£555	£559	£554	£591
Nottinghamshire	£672	£700	£601	£607
Doncaster	£601	£613	£660	£616
East Midlands	£595	£615	£620	£624
Leicestershire	£601	£608	£591	£637
Yorkshire and The Humber	£639	£708	£597	£639
England	£678	£715	£636	£662
East of England	£672	£654	£644	£680
Rutland	£421	£668	£662	£716
Norfolk	£656	£627	£650	£718

Data: Published by NHS Digital.

- ASC-FR stands for Adult Social Care Activity and Finance Report.
- This return is collected annually from councils.
- This is obviously a trailing indicator from 2-3 financial years ago, though comparisons are still informative.
- Numbers are rounded to the nearest £1.
- Nursing costs are shown net of Funded Nursing Contribution (FNC).
- Results are ordered low to high in the far right column.
- Judgment is needed as specific council figures are not always reliable from year to year. As an example, we would note that the 2020-21 nursing cost for Peterborough is an obvious error.
- Unit cost comparisons are also affected by the cost of in-house provision and block contracts (often with ex-council owned facilities) which are included within the numbers. This can be an upward or downward financial impact depending on how the council accounts for the various costs involved.
- Both North Lincolnshire and North East Lincolnshire councils appear to pay markedly less for care home placements than the other councils. These are Lincolnshire's immediate neighbours to the north.

People accessing long-term support (aged 65+)

People aged 65+ accessing long-term support during the year by support setting: Lincolnshire County Council

Financial year	Nursing	Residential	Care home sub-total	Community direct payment only	Community part direct payment	Community managed personal budget	Community commissioned support only	Total people
2016-17	1,025	2,520	**3,545**	905	120	3,945	*	**8,520**
2017-18	1,075	2,650	**3,725**	770	225	3,575	10	**8,310**
2018-19	980	2,695	**3,675**	620	255	3,535	5	**8,100**
2019-20	935	2,845	**3,780**	675	205	3,610	5	**8,275**

Data: Published by NHS Digital.

- This data is also from the Adult Social Care Activity and Finance Report.
- This element of the ASC-FR is usually more reliable than the data on unit costs (as it is more straightforward to record activity levels than unit costs).
- This is obviously a trailing indicator of people receiving services from 2 or more financial years ago, though comparisons are still informative as they show the trend in total care home placement numbers over this 4 year period.
- LCC care home placements for adults aged 65+ have increased by over 200 since 2016-17. However, this includes a fall in nursing placements of nearly 100, and increase in residential placements of over 300. This change in the balance of residential and nursing placements is likely an effect of the seeming tighter policy by the CCG with regard eligibility for Funded Nursing Contribution (see next page).

CHC and FNC eligibility

NHS Funded Nursing Care and Continuing Healthcare numbers since Q1 2017-18 (snapshots at the end of each quarter)

Organisation Area	17-18 Q1	17-18 Q2	17-18 Q3	17-18 Q4	18-19 Q1	18-19 Q2	18-19 Q3	18-19 Q4	19-20 Q1	19-20 Q2	19-20 Q3	19-20 Q4	20-21 Q1	20-21 Q2	20-21 Q3	20-21 Q4
Eligible for Funded Nursing Care (FNC): total snapshot at end of quarter												**Covid-19**				
England	79,383	80,322	79,040	76,822	76,868	77,411	77,741	78,589	79,328	80,769	79,951	78,546	65,912	62,880	64,757	66,078
Lincolnshire STP	1,093	1,206	1,132	1,061	1,088	1,019	1,000	988	984	983	954	903	765	758	739	713
Change per quarter																
England		939	-1,282	-2,218	46	543	330	848	739	1,441	-818	-1,405	-12,634	-3,032	1,877	1,321
Lincolnshire STP		113	-74	-71	27	-69	-19	-12	-4	-1	-29	-51	-138	-7	-19	-26
Change since 2017-18 Q1																
England	-	939	-343	-2,561	-2,515	-1,972	-1,642	-794	-55	1,386	568	-837	-13,471	-16,503	-14,626	-13,305
Lincolnshire STP	-	113	39	-32	-5	-74	-93	-105	-109	-110	-139	-190	-328	-335	-354	-380
Percentage change since 2017-18 Q1																
England	100%	101%	100%	97%	97%	98%	98%	99%	100%	102%	101%	99%	83%	79%	82%	83%
Lincolnshire STP	100%	110%	104%	97%	100%	93%	91%	90%	90%	90%	87%	83%	70%	69%	68%	65%
Eligible for Continuing Healthcare (CHC): total snapshot at end of quarter																
LINCOLNSHIRE STP	630	725	631	674	905	982	1,096	1,193	820	846	855	821	670	782	811	810

Data: CHC and FNC data published by NHS England

- At the end of September 2017, Lincolnshire STP was funding 1,206 care home residents with FNC. This was about 100 residents higher than the previous quarter, so this appears to be a peak. However, this fell to 903 residents by March 2020 (the start of the Covid-19 pandemic), and further fell to 713 at the last published quarter in 2020-21.
- CHC eligibility is so variable over this period that an accurate picture of trends is hard to identify. However, it appears that numbers have risen over the period, as the 3 of the 4 snapshots in 2017-18 were around 650 people, while 3 of the 4 snapshots in 2020-21 were close to 800 people.
- The implications of the above data is discussed further on the next page.

CCG and FNC eligibility

- Since the start of Covid-19 pandemic, reported FNC numbers have collapsed across England, dropping by 20% in a little over a year. This is presumably a combination of (i) generally reduced demand, and (ii) reduced accounting for FNC as CCG's have been directly paying for more care packages under Covid-19 funding.
- Lincolnshire has experienced a similar fall in FNC numbers since the start of the pandemic. However, this is in addition to a fall between the start of 2017 and the start of the pandemic. Combined, this is a large reduction in FNC-funded residents and may mean that FNC will not be covering the full cost of their nurses in an increasing number of homes.
- This situation will be partly offset by the above inflation increases in FNC over this period. The standard rate of FNC was £155.05 in 2017-18 and has increased to £187.60 by 2021-22. This also followed a much larger increase from £112.00 for 2015-16.
- This situation may also be offset in some homes by increased numbers of residents eligible for CHC funding, though the CHC data on the previous page is too variable to reach any strong conclusions about whether this might be the case.
- 13 older adult care homes in Lincolnshire have deregistered for nursing since January 2014. This contrasts starkly with national trends where registered capacity in nursing homes continues to grow. However, if the data reported by NHS England is correct, this is unsurprising in the context of significantly falling FNC numbers in the county (at least in the past 4 years).
- Unfortunately, we do not have a comprehensive picture of FNC and CHC numbers broken down by care home to inform this review.
- Whilst we can only speculate without a full picture of the data, it is possible that there is too much nursing capacity in some parts of the county. For example, based on data provided by the council, as of the start of June 2021, there were 20 nursing homes in Lincolnshire where the home had fewer than 5 council-funded residents with FNC, and 50 nursing homes with fewer than 10 such residents (data not shown).
- We recommend that LCC does more work to ascertain a comprehensive picture of nursing residents in each nursing home in the county, as well as periodically monitoring this information with the CCG.

Older adult care home market

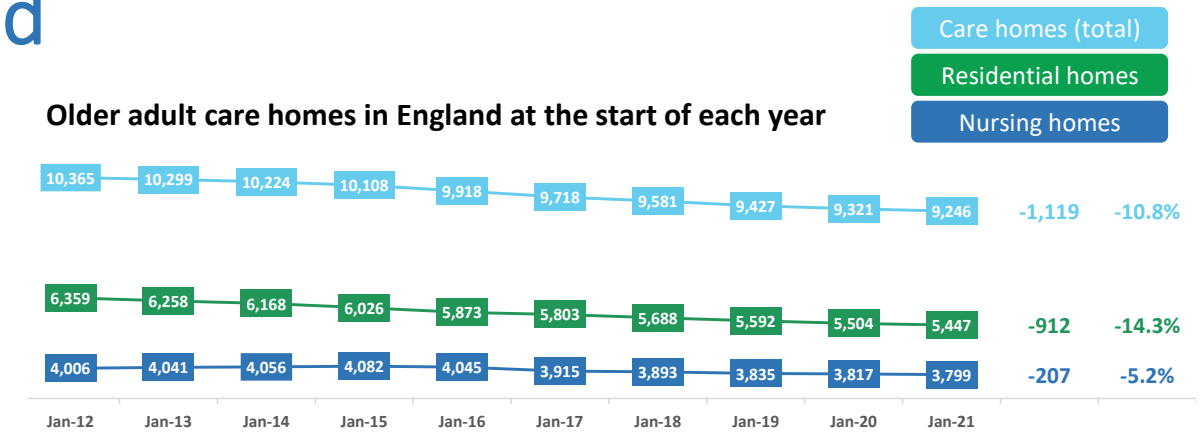
Market capacity across England

Registered beds in older adult care homes (Apr 21)

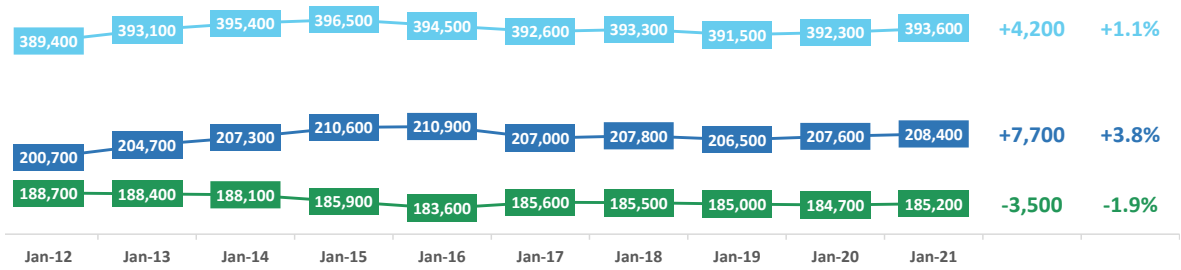
Area	Beds	Beds per 1,000 population: Age 65+	Beds per 1,000 population: Age 75+
London	28,044	25.4	55.7
East of England	45,516	36.2	76.7
South West	47,137	37.0	78.4
West Midlands	41,932	37.5	78.9
England	393,519	37.5	80.4
Shire Counties	218,228	38.1	81.1
Lincolnshire	6,951	38.0	82.7
South East	72,234	39.7	83.2
East Midlands	36,951	38.5	84.5
Yorkshire & The Humber	41,435	39.6	86.4
North West	56,736	40.8	89.2
North East	23,534	43.7	97.2

Data: Care Analytics care home database and ONS population data (2020)

Older adult care homes in England at the start of each year



Beds in older adult care homes in England at the start of each year



Data: Care Analytics care home database

- Lincolnshire's older adult market capacity is close to both the national average per capita and the average per capita for shire counties.
- Across England, the number of older adult care homes is reducing (down 10.8% since January 2012), but total bed capacity is increasing (up 1.1%). This is because newly-built care homes tend to be much larger than the homes exiting the market. New-build care homes also have fewer twin rooms on average than homes exiting the market, so the rise in genuine capacity is greater than indicated by registered beds.
- Nursing homes also have residential care units. There is no definitive source of nursing bed capacity across the country. Nursing capacity would also be subject to change as care units can be repurposed.

Market capacity in Lincolnshire

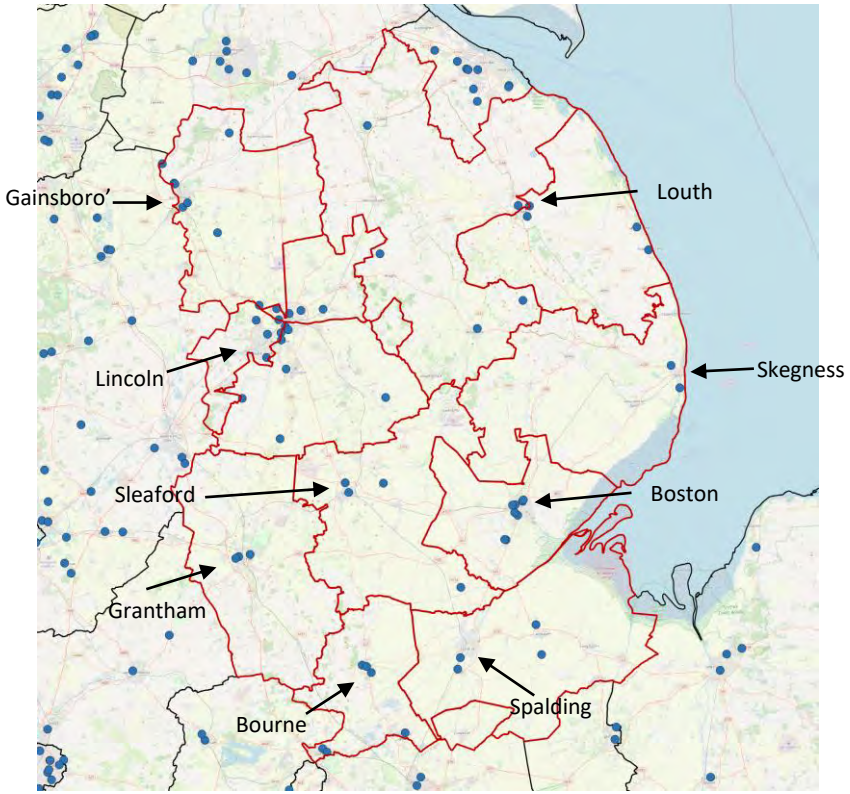
					East				West				South			
Category	East	West	South	Total	Boston	Louth	Market Rasen	Skegness	Gainsboro'	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
Older adult care homes																
Nursing homes	19	23	17	59	8	3	6	2	7	4	5	7	3	4	4	6
Residential home	48	30	44	122	8	10	14	16	8	8	3	11	8	11	14	11
Care homes (total)	67	53	61	181	16	13	20	18	15	12	8	18	11	15	18	17
Registered beds in older adult care homes																
Nursing homes	862	1,088	982	2,932	352	129	296	85	309	207	292	280	205	202	224	351
Residential homes	1,513	1,009	1,496	4,018	308	287	422	496	256	260	109	384	267	336	520	373
Care homes (total)	2,375	2,097	2,478	6,950	660	416	718	581	565	467	401	664	472	538	744	724
Beds per 1,000 people aged 75+																
Nursing homes	32	47	32	36	54	23	37	12	53	34	56	45	29	30	24	46
Residential	56	43	48	49	47	51	53	70	44	43	21	61	37	49	56	48
Care homes (total)	87	90	80	85	101	73	91	82	97	78	77	106	66	79	80	94

Data: Care Analytics care home database combined with team postcodes supplied by LCC

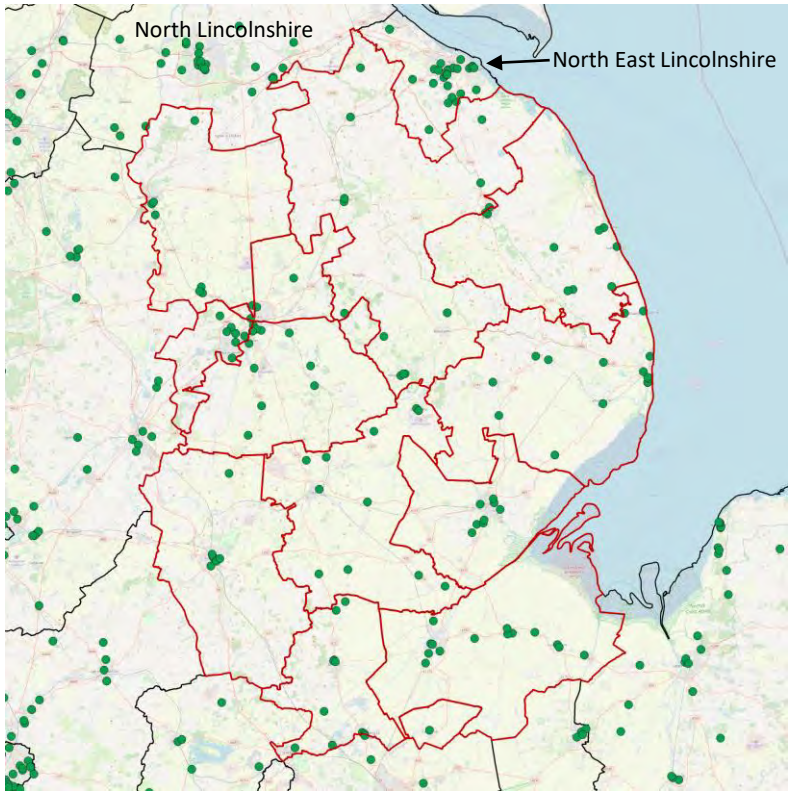
- There is less registered bed capacity in older adult care homes in the south of the county relative to the size of the elderly population.
- Skegness only has two nursing homes. Louth and Spalding also have a low number of beds in nursing homes relative to elderly population size.
- Boston and three of the four older adult care teams in the west have comparatively high numbers of beds in nursing homes, though we do not know true nursing capacity as there is no definitive and comprehensive data source for nursing bed capacity.

Older adult care homes in Lincolnshire

Nursing homes (Apr 21)



Residential homes (Apr 21)



- There are a few parts of the county where there are several older adult residential homes but no nursing homes.
- There are also several areas where there are few nursing homes.
- Nursing homes tend to be in urban rather than rural areas. This can likely be explained by the following logic chain: (1) Nursing homes have higher minimum building requirements and so tend to be newer, (2) new homes are mostly built by corporate providers, and (3) corporate providers tend to prefer urban rather than rural locations.

- The red boundaries show the approximate boundaries for LCC's 12 older adult care teams.
- See page 114 for the above maps classified by build decade.

Twin rooms and implications for true capacity

Twin rooms in older adult care homes in Lincolnshire

Category	Nursing homes	Residential homes	Care homes (total)	Urban'	Rural	Small providers (<5 homes)	Groups (5+ homes)
Total rooms	2,800	3,765	6,565	3,600	2,965	3,267	6,565
Twin rooms	110	225	335	133	202	229	106
Percent twin	3.9%	6.0%	5.1%	3.7%	6.8%	7.0%	3.2%

Twin rooms in older adult care homes in Lincolnshire by older adult care team

	East				West				South			
Category	Boston	Louth	Market Rasen	Skegness	Gainsboro'	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
Total rooms	627	391	673	540	537	451	400	589	443	503	707	704
Twin rooms	24	24	46	39	26	11	2	70	20	32	27	14
Percent twin	3.8%	6.1%	6.8%	7.2%	4.8%	2.4%	0.5%	11.9%	4.5%	6.4%	3.8%	2.0%

Data: Surveys plus internet research, linked to Care Analytics care home database combined with team postcodes supplied by LCC

- This analysis has an error margin as we are combining data from the surveys with unvalidated data found on the internet.
- The market is probably 5% smaller than indicated by registered bed capacity owing to twin rooms (which are often used as large singles).
- It is possible that twin rooms are distorting the view of bed capacity in some localities.
- The geographical areas with the most twin rooms relative to market size are Lincoln South, Sleaford, and the east of the county (Boston aside).
- The differences between nursing/residential homes, urban/rural locations, and group size can all be explained by the age of the respective care home stock. See pages 113-114 in the Capital cost and facilities section for analysis of build decade.

Changes in registered bed capacity

Changes in registered bed capacity by type of change: January 2014 to January 2021

Category	Lincolnshire	England	East Midlands	Shire Counties	Unitary Authorities	Metropolitan Districts
Beds as of January 2014	6,724	395,341	35,708	216,402	67,413	81,443
Beds in newly built care homes	549	38,442	4,030	22,032	6,895	7,221
Beds in newly registered homes	50	332	50	115	67	110
Increased beds in same home	150	10,351	1,070	6,113	1,685	1,750
Beds in deregistered homes	-465	-47,226	-3,635	-24,528	-8,119	-9,659
Reduced beds in same home	-57	-3,721	-272	-1,906	-871	-688
Beds as of January 2021	6,951	393,519	36,951	218,228	67,070	80,177
Beds as a percentage of registered capacity as of January 2014						
Beds in newly built care homes	8.2%	9.7%	11.3%	10.2%	10.2%	8.9%
Beds in newly registered homes	0.7%	0.1%	0.1%	0.1%	0.1%	0.1%
Increased beds in same home	2.2%	2.6%	3.0%	2.8%	2.5%	2.1%
Beds in deregistered homes	-6.9%	-11.9%	-10.2%	-11.3%	-12.0%	-11.9%
Reduced beds in same home	-0.8%	-0.9%	-0.8%	-0.9%	-1.3%	-0.8%
Net change in registered beds	227	-1,822	1,243	1,826	-343	-1,266
% net change	3.4%	-0.5%	3.5%	0.8%	-0.5%	-1.6%

Data: Care Analytics care home database

- Caution is required in that results for Lincolnshire can be materially changed by only a few new builds and home closures. However, the data suggests that old stock in the county is staying open for longer than it might in other areas. This will be influenced by low repurposing potential of land in certain areas, especially in the east of the county. This has a myriad of consequences for market forces.

- This analysis is based on 'linking' new CQC location IDs in Care Analytics care home database (so a new registration of an existing home is not counted as new). If a care home is knocked down and rebuilt, we may not know if the home did not deregister for a significant period.
- Shire counties are the best comparison for Lincolnshire, as there are differences to solely urban areas. National results are also distorted by London, where new builds are much sparser owing to high land and build costs.
- Lincolnshire's market is growing in terms of net change in registered bed capacity (+3.4% since January 2014). However, relative to market size, both investment in new stock and home closures in the county are lower than the averages for both England and shire counties.

Deregistered (closed) older adult care homes

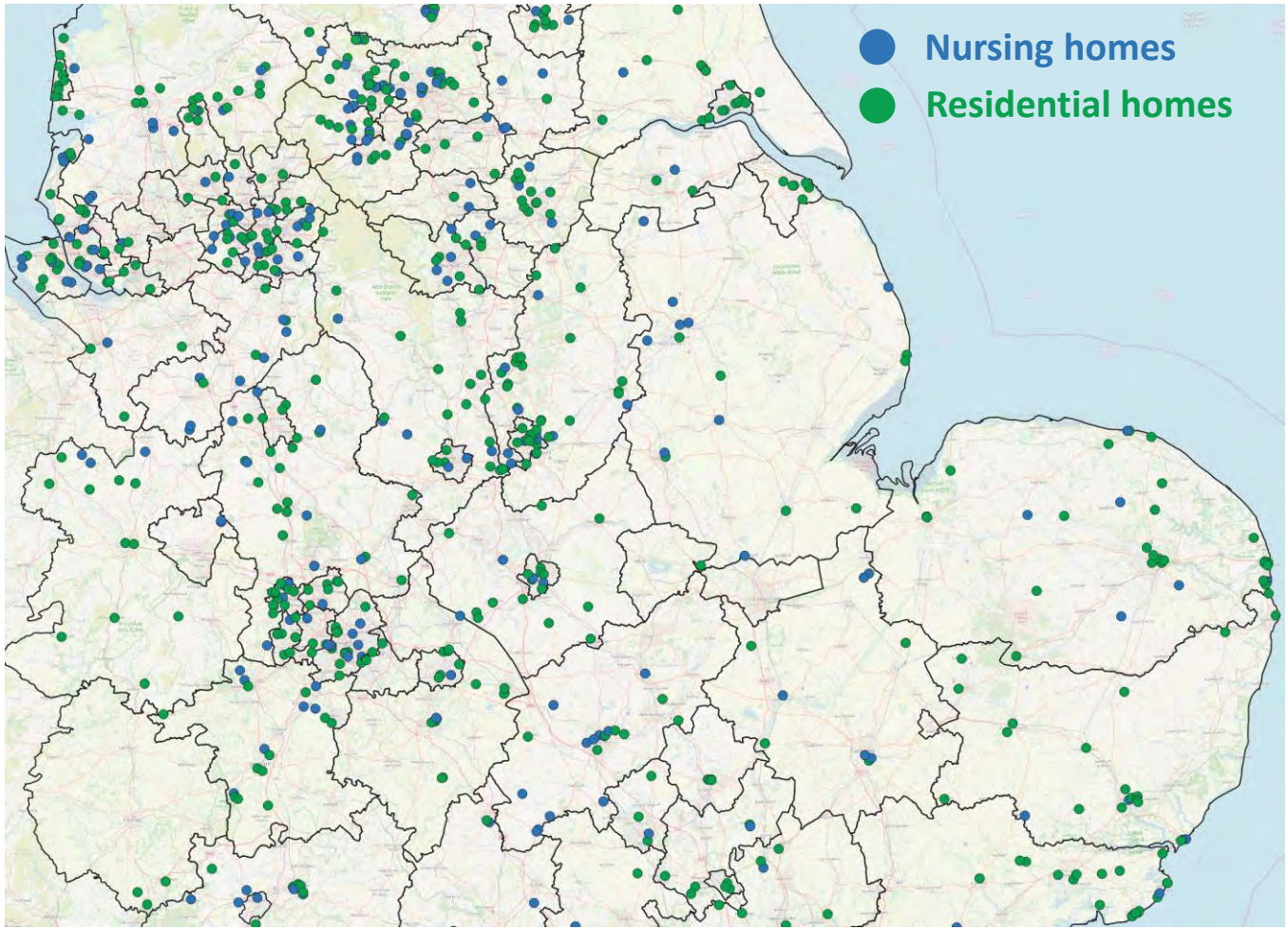
					East				West				South			
Category	East	West	South	Total	Boston	Louth	Market Rasen	Skegness	Gainsboro'	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
Closed care homes since January 2014																
Nursing homes	1	5	3	9	-	1	-	-	2	1	2	-	1	1	-	1
Residential homes	4	4	9	17	-	2	-	2	-	1	1	2	2	1	4	2
Care homes (total)	5	9	12	26	-	3	-	2	2	2	3	2	3	2	4	3
Deregistered beds in closed care homes																
Nursing homes	34	162	46	242	-	34	-	-	62	29	71	-	13	20	-	13
Residential homes	103	129	229	461	-	62	-	41	-	42	27	60	55	30	109	35
Care homes (total)	137	291	275	703	-	96	-	41	62	71	98	60	68	50	109	48
Deregistered beds as a % of current beds																
Nursing homes	4%	15%	5%	8%	-	26%	-	-	20%	14%	24%	-	6%	10%	-	4%
Residential homes	7%	13%	15%	11%	-	22%	-	8%	-	16%	25%	16%	21%	9%	21%	9%
Care homes (total)	6%	14%	11%	10%	-	23%	-	7%	11%	15%	24%	9%	14%	9%	15%	7%

Data: Care Analytics care home database combined with team postcodes supplied by LCC

- The west of Lincolnshire has seen the most closures, though still has the largest market per capita (see page 31).
- The east of the county has had fewer closures. This is probably related to lower property values, and thus low opportunity costs for repurposing land.
- Some team localities have seen many closures (including nursing homes, though we do not know how many nursing residents the homes usually had). In small geographical areas, the addition or removal of a single care home can have profound impacts on market supply and demand dynamics.
- A common pattern across England (including Lincolnshire) is that homes exiting the market are smaller than new care homes.

Deregistered (closed) older adult care homes

- Deregistered care homes since January 2014.
- Home closures in the east of Lincolnshire appear quite sparse when pictured.
- There is obviously more density of care homes in urban areas, so the larger map may be misleading.
- Many more residential homes close than nursing. This is as partly a result of the age of stock.



Data: Care Analytics care home database

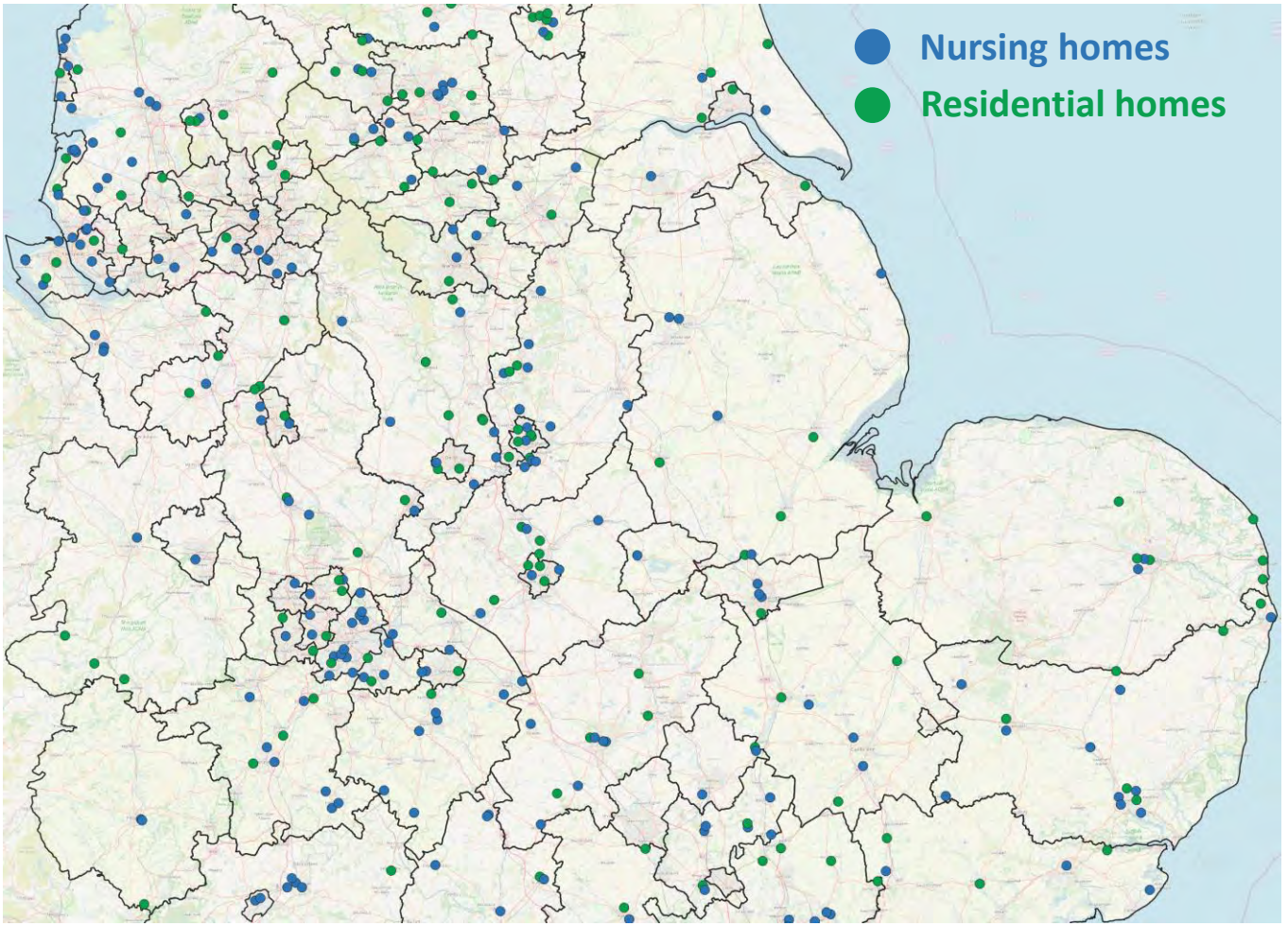
Newly-registered older adult care homes

					East				West				South			
Category	East	West	South	Total	Boston	Louth	Market Rasen	Skegness	Gainsboro'	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
New care homes since January 2014																
Nursing homes	2	3	2	7	-	1	1	-	1	-	2	-	-	1	-	1
Residential homes	1	-	4	5	1	-	-	-	-	-	-	-	1	-	1	2
Care homes (total)	3	3	6	12	1	1	1	-	1	-	2	-	1	1	1	3
Beds in new care homes																
Nursing homes	106	182	134	422	-	40	66	-	60	-	61	-	-	74	-	60
Residential homes	66	-	207	273	66	-	-	-	-	-	-	-	64	-	60	42
Care homes (total)	172	182	341	695	66	40	66	-	60	-	61	-	64	74	60	48
Beds in new homes as a % of current beds																
Nursing homes	12%	17%	14%	14%	-	31%	22%	-	19%	-	42%	-	-	37%	-	17%
Residential homes	4%	-	14%	7%	21%	-	-	-	-	-	-	-	24%	-	12%	22%
Care homes (total)	7%	9%	14%	10%	10%	10%	9%	-	11%	-	30%	-	14%	14%	8%	20%
Net change in registered bed capacity																
New less closed	35	-109	66	8	66	-56	66	-41	-2	-71	24	-60	-4	24	-49	95
% of current beds	1%	-5%	3%	0%	10%	-13%	9%	-7%	0%	-15%	6%	-9%	-1%	4%	-7%	13%

Data: Care Analytics care home database combined with team postcodes supplied by LCC

- The market has generally replenished with newly-registered care homes offsetting closures.
- There are more new builds in the south of the county almost certainly because of levels of affluence. New care homes are generally built for self-funders.
- Much of the new stock is built to the circa 60-bed template.

Newly-registered older adult care homes



- Newly-registered care home locations since January 2014 (or same location with complete rebuild).
- There is obviously more density of care homes in urban areas, so the larger map may be misleading.
- Although the number of closures (see pages 35-36) is far greater than the number of new homes, total bed capacity is increasing as new homes are larger.

Data: Care Analytics care home database

Changes in nursing home status

Older adult care homes which have deregistered for nursing since January 2014 but stayed open

					East				West				South			
Category	East	West	South	Total	Boston	Louth	Market Rasen	Skegness	Gainsboro'	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
Care homes	6	4	3	13	2	1	3	-	1	2	1	-	1	1	1	-
Beds	268	146	149	563	75	52	141	-	47	67	32	-	29	52	68	-

Data: Care Analytics care home database combined with team postcodes supplied by LCC

Residents with NHS Funded Nursing Care (FNC) in Lincolnshire since the start of 2017-18 (snapshots at the end of each quarter)

Organisation Area	17-18 Q1	17-18 Q2	17-18 Q3	17-18 Q4	18-19 Q1	18-19 Q2	18-19 Q3	18-19 Q4	19-20 Q1	19-20 Q2	19-20 Q3	19-20 Q4	20-21 Q1	20-21 Q2	20-21 Q3	20-21 Q4
Residents with FNC	1,093	1,206	1,132	1,061	1,088	1,019	1,000	988	984	983	954	903	765	758	739	713
Change (△) per quarter		113	-74	-71	27	-69	-19	-12	-4	-1	-29	-51	-138	-7	-19	-26
△ since 2017-18 Q1	-	113	39	-32	-5	-74	-93	-105	-109	-110	-139	-190	-328	-335	-354	-380
% of 2017-18 Q1	100%	110%	104%	97%	100%	93%	91%	90%	90%	90%	87%	83%	70%	69%	68%	65%

Data: FNC data published by NHS England

- 13 older adult care homes in Lincolnshire have deregistered for nursing since January 2014. This contrasts starkly with national trends.
- However, if the data reported by NHS England is correct, this is unsurprising in the context of significant falls in FNC numbers in the county.
- Only 1 residential home that was already open in January 2014 subsequently registered for nursing (data not shown)
- One provider who recently deregistered a home for nursing told us that difficulties recruiting nurses was a contributory factor but far from the sole driver.

CQC inspection ratings

Latest CQC inspection rating as of April 2021

Category	Outstanding	Good	Req. Imp.	Inadequate	No info	Total
Lincolnshire care homes						
Older adult nursing homes	-	40	17	-	2	59
Older adult residential homes	5	91	18	5	3	122
Older adult care homes (total)	5	131	35	5	5	181
Lincolnshire percentages						
Older adult nursing homes	-	68%	29%	-	3%	100%
Older adult residential homes	4%	75%	15%	4%	2%	100%
Older adult care homes (all)	3%	72%	19%	3%	3%	100%
England						
Older adult care homes	4%	72%	19%	2%	3%	100%
Learning disability care homes	4%	81%	9%	1%	5%	100%
Lincolnshire inspections 2015-2019						
2015	1%	48%	48%	2%	-	100%
2016	-	47%	50%	3%	-	100%
2017	1%	50%	47%	2%	-	100%
2018	1%	61%	28%	10%	-	100%
2019	3%	59%	30%	7%	1%	100%

Data: CQC care directory as of April 2021, linked to Care Analytics care home database

- The profile of results for older adult care homes in Lincolnshire are normal. Care Analytics rarely, if ever, see a pattern materially different to that shown in the table.
- Lincolnshire appeared to have a problem with inadequate ratings in 2018 and 2019. As well as obvious issues, this can reduce the supply of available beds if homes are embargoed or cannot take on new residents.
- The analysis of CQC inspection ratings stops at the end of 2019 owing to Covid-19.
- Comparative results for learning disability care homes in England are shown for reference, as it highlights the need to categorise care homes before undertaking market-wide analysis. The better results are largely a consequence of the much smaller size homes compared to older adult homes. The CQC recommends no more than 6 beds.

Occupancy and resident mix

Occupancy pre-pandemic

Sample of occupancy in older adult care homes using CQC inspection reports

Occupancy	2015	2016	2017	2018	2019	2020	2021	2015	2016	2017	2018	2019	2020	2021
<50%	6	-	3	2	3	3	4	7%	-	3%	3%	3%	3%	17%
50-55%	1	-	2	-	1	4	1	1%	-	2%	-	1%	5%	4%
55-60%	2	2	5	5	2	7	2	2%	2%	4%	8%	2%	8%	9%
60-65%	-	5	5	3	6	5	-	-	5%	4%	5%	6%	6%	-
65-70%	1	7	6	4	4	12	2	1%	7%	5%	6%	4%	14%	9%
70-75%	7	2	6	1	3	14	4	8%	2%	5%	2%	3%	16%	17%
75-80%	7	9	9	11	9	14	4	8%	9%	8%	17%	9%	16%	17%
80-85%	8	9	11	9	13	9	1	10%	9%	9%	14%	13%	10%	4%
85-90%	14	25	19	11	21	6	3	17%	24%	16%	17%	20%	7%	13%
90-95%	15	18	23	9	22	2	1	18%	17%	20%	14%	21%	2%	4%
95-100%	23	28	28	9	19	10	1	27%	27%	24%	14%	18%	12%	4%
Total	84	105	117	64	103	86	23	100%	100%	100%	100%	100%	100%	100%
Mean occupancy	**85%**	**87%**	**84%**	**81%**	**84%**	**74%**	**71%**							

Data: CQC inspection reports (to the end of March 2021) where the total number of residents in the home is stated

Mean occupancy in 2017 surveys

Category	Of all beds	Of used beds
Residential homes	90%	92%
Nursing homes	87%	93%
All surveys	89%	92%

Data: Reported 2017 survey data

- Registered bed capacity counts twin rooms at 2 beds.
- Unit costs are heavily impacted by levels of occupancy.
- See page 16 for a discussion of marginal costing implications of changes in occupancy.

- There is a clear drop in occupancy as a result of Covid-19. However, based on the sample of CQC inspections in each year, something like 20% of older adult care homes were already operating below 70% of registered capacity prior to the pandemic. Only about 40-45% of homes were operating above 90% of registered capacity prior to the pandemic. This differs markedly from reported results in 2017 based on submitted surveys at the time.
- Some commentators say 90% is a sustainable occupancy level for a market (not too low to be inefficient and not too high so that there are difficulties finding vacant beds). However, average occupancy statistics are usually misleading as they are nearly always comprised of a spread of occupancy from homes with waiting lists to homes operating below 50% of registered beds. Many of the beds in care homes with very low occupancy are likely not operational, either in the short term (mothballed units) or at all (such as twin rooms).

Recent occupancy

Occupancy and vacancies as a percentage of registered beds in older adult care homes

	Residents as a percentage of registered bed capacity											
Category	20-39%	40-59%	60-64%	65-69%	70-74%	75-79%	80-84%	85-89%	90-94%	95-99%	100%	Total
Number of care homes												
Nursing homes	1	7	6	3	10	2	7	6	10	3	4	59
Residential homes	1	14	6	6	19	19	15	16	17	6	3	122
Care homes (total)	2	21	12	9	29	21	22	22	27	9	7	181
Maximum theoretical bed vacancies												
Nursing homes	30	162	108	75	138	28	57	35	41	7	-	681
Residential homes	43	251	74	78	169	140	75	72	37	10	-	949
Care homes (total)	73	413	182	153	307	168	132	107	78	17	-	1,630

Data: Combined survey data and weekly submissions by care homes to LCC if no survey (June/July 2021), linked to Care Analytics care home database

- There are major occupancy issues in the market across the county (as of the start of July 2021). However, this analysis is slightly misleading as circa 20% of care homes were already operating below 70% of registered capacity prior to Covid-19 (see previous page).
- We have been told by LCC staff at the start of September that occupancy levels in the market have started to improve.
- In aggregate across the whole county, the market already had enough spare capacity prior to Covid-19, with an average occupancy somewhere around the 85% mark. This would probably raise to about 90% of rooms once an adjustment is made for twin rooms.
- In aggregate, there is no difference in vacancy levels between residential and nursing homes. Both have vacancies in aggregate of circa 23% of registered bed capacity (data not shown).
- However, once twin rooms and mothballed capacity are taken into account, vacancies in particular geographical locations can be materially different to a calculation of registered capacity minus current residents.

Resident mix in Lincolnshire older adult care homes

Category	Funder (percentage of residents)								Funder (percentage of beds)								
	LCC (inc. joint)	Other council	Lincs CCG	Other CCG	Unknown CCG	Self funder	Other funder	Total residents	LCC (inc. joint)	Other council	Lincs CCG	Other CCG	Unknown CCG	Self funder	Other funder	Total residents	Registered capacity
All older adult care homes																	
Nursing homes	43%	3%	10%	2%	8%	34%	1%	100%	33%	2%	8%	2%	6%	26%	<1%	77%	100%
Residential homes	54%	2%	1%	<1%	1%	42%	<1%	100%	41%	2%	<1%	<1%	1%	32%	<1%	76%	100%
Care homes (all)	49%	3%	5%	1%	4%	38%	<1%	100%	38%	2%	4%	1%	3%	29%	<1%	77%	100%
Nursing homes by broad-geographical area																	
East	48%	2%	13%	2%	6%	29%	<1%	100%	37%	2%	10%	2%	5%	22%	<1%	77%	100%
West	47%	3%	7%	3%	5%	33%	1%	100%	36%	3%	6%	2%	4%	25%	1%	76%	100%
South	34%	3%	12%	2%	12%	39%	-	100%	26%	2%	9%	1%	9%	30%	-	78%	100%
Residential homes by broad-geographical area																	
East	56%	2%	1%	<1%	1%	40%	<1%	100%	40%	2%	<1%	<1%	<1%	29%	<1%	72%	100%
West	53%	1%	<1%	-	1%	44%	-	100%	43%	1%	<1%	-	1%	36%	-	81%	100%
South	52%	3%	1%	<1%	2%	42%	<1%	100%	41%	2%	1%	<1%	1%	33%	<1%	78%	100%

Data: Combined survey data and weekly submissions by care homes to LCC if no survey, linked to Care Analytics care home database and area postcodes supplied by LCC

- The above analysis has an error margin as it combines survey data and data from weekly submissions to the council (Jadu data).
- Changes in the demand caused by the Covid-19 pandemic may also be materially impacting the above analysis.
- Self-funder market share is higher in the south of the county, but not by much. However, based on these combined datasets, CCG's buy a greater proportion of the beds in the market in the south compared to both the east and west. There is also a corresponding reduction in council-funded placements in the south. If accurate, there may be supply-side and demand-driven drivers behinds these patterns.

Lincolnshire County Council (LCC) market share

					East				West				South			
Category	East	West	South	Total	Boston	Louth	Market Rasen	Skegness	Gainsboro,	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
LCC Placements (including joint-funded)																
Nursing homes	184	223	127	534	83	29	48	24	52	37	68	66	30	32	38	27
Residential homes	479	334	502	1,315	63	109	127	180	70	77	38	149	78	129	182	113
Total (care homes)	663	559	632	1,854	146	138	175	204	122	116	106	215	108	161	221	142
LCC placements in nursing homes																
With FNC	127	137	102	366	58	18	36	15	31	36	26	44	23	17	39	23
Without FNC	57	86	25	168	25	11	12	9	21	1	42	22	7	15	-	4
LCC % res in nursing	31%	39%	20%	31%	30%	38%	25%	38%	40%	3%	62%	33%	23%	47%	0%	15%
LCC market share (% of registered beds)																
Nursing homes	21%	20%	13%	18%	24%	22%	16%	28%	17%	18%	23%	24%	15%	16%	17%	8%
Residential homes	32%	33%	34%	33%	20%	38%	30%	36%	27%	30%	35%	39%	29%	38%	35%	30%
Total (care homes)	28%	27%	26%	27%	22%	33%	24%	35%	22%	25%	26%	32%	23%	30%	30%	20%

Data: Placements and FNC data supplied by LCC, linked to Care Analytics care home database and team postcodes supplied by LCC

- The above analysis is based solely on council-supplied data.
- LCC residential placements in nursing homes is calculated by subtracting LCC-funded placements qualifying for FNC from the total number of LCC-funded placements in each home.
- We were unable to acquire a care-home level breakdown of CCG-funded nursing placements in time to inform this review.
- LCC market share (% of registered beds) in nursing homes in the south of the county is much lower than both the east and west.

Public-sector market share

Number care homes by the proportion of public-funded residents (all councils and CCG's)

	Broad location				Nursing status		Group size		Nursing status		Group size	
Percent public funded	East	West	South	Total	Nursing homes	Res only homes	Small providers (<5 homes)	Groups (5+ homes)	Nursing homes	Res only homes	Small providers (<5 homes)	Groups (5+ homes)
<10%	1	2	2	5	1	4	2	3	2%	3%	2%	4%
10-19%	1	-	-	1	-	1	1	-	-	1%	1%	-
20-29%	3	4	5	12	2	10	9	3	3%	8%	9%	4%
30-39%	7	3	5	15	5	10	9	6	8%	8%	9%	8%
40-49%	6	3	6	15	5	10	9	6	8%	8%	9%	8%
50-59%	11	8	11	30	5	25	18	12	8%	21%	17%	16%
60-69%	5	11	11	27	7	20	11	16	12%	17%	10%	21%
70-79%	22	15	8	45	19	26	27	18	32%	21%	26%	24%
80-89%	9	6	10	25	13	12	16	9	22%	10%	15%	12%
90-99%	2	1	2	5	2	3	3	2	3%	2%	3%	3%
Total	67	53	60	180	59	121	105	75	100%	100%	100%	100%

Data: Combined survey data and weekly submissions by care homes to LCC if no survey (circa July 21), linked to Care Analytics care home database and area postcodes supplied by LCC

- The above analysis is based on residents (not registered bed capacity). Vacancies are excluded from the percentage analysis.
- The analysis excludes one care home where there is no data (the home did not submit a survey and has no recent data submission to the council).
- The reverse of the above data (100% less result) are self-funders. Covid-19 may have lowered the usual proportion of self-funders in care homes.
- Care homes with markedly different percentage of residents who are public funded, have different opportunity costs in terms of their willingness and ability to sell beds based on marginal costing considerations (see page 16).

Third-party ‘top-ups’

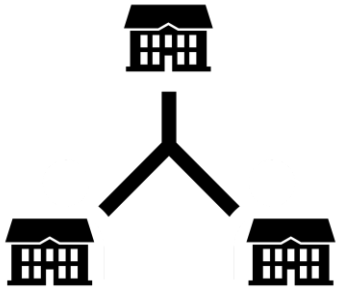
Number of third-party top-ups from the survey sample

				East				West				South			
Category	Nursing homes	Res homes	Total	Boston	Louth	Market Rasen	Skegness	Gainsboro’	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
LCC placements	398	453	851	118	54	63	33	43	97	62	71	24	51	195	40
Third-party top-ups	138	108	246	41	17	12	4	6	33	16	14	1	37	54	11
Percent	**35%**	**24%**	**29%**	**35%**	**31%**	**19%**	**12%**	**14%**	**34%**	**26%**	**20%**	**4%**	**73%**	**28%**	**28%**
Homes with survey	26	34	60	8	5	6	3	3	8	4	4	3	4	9	3
% coverage homes	44%	28%	33%	50%	38%	30%	17%	20%	67%	50%	22%	27%	27%	50%	18%
% coverage beds	46%	31%	37%	58%	36%	34%	16%	27%	72%	52%	24%	22%	38%	57%	18%

Data: Anonymised surveys (2021)

- Based on the survey data, 35% of LCC-funded placements in older adult nursing homes have third-party top-ups, compared to only 24% of placements in older adult residential homes. The data for nursing homes has more chance of being representative of the overall market as there is greater coverage in terms survey data (44% of nursing homes submitted a survey with answers this section vs 28% for residential).
- There appears to be a local practice whereby various types of enhanced payments made by the council are called ‘tops-ups’. It is possible that this local terminology may have undermined the reliability of the survey data on third-party top-ups. Furthermore, given that the surveys are skewed towards groups, it is a leap to assume the sample is representative of the overall market. The extent to which older adult care homes in Lincolnshire charge third-party top-ups in practice therefore remains an area of uncertainty. Despite this, our working assumption in the above analysis is that the stated number of third-party top-ups in the surveys are genuine ones paid by a third-party.
- The data on the right-hand side of the table shows combined residential and nursing placements by geographical area. Based on the survey data, differences between the locality teams in a particular area are as large as differences between the three broad areas (East, West, and South). Caution should therefore be applied making generalisations about broad geographical areas; although a more complete sample may show a different picture.

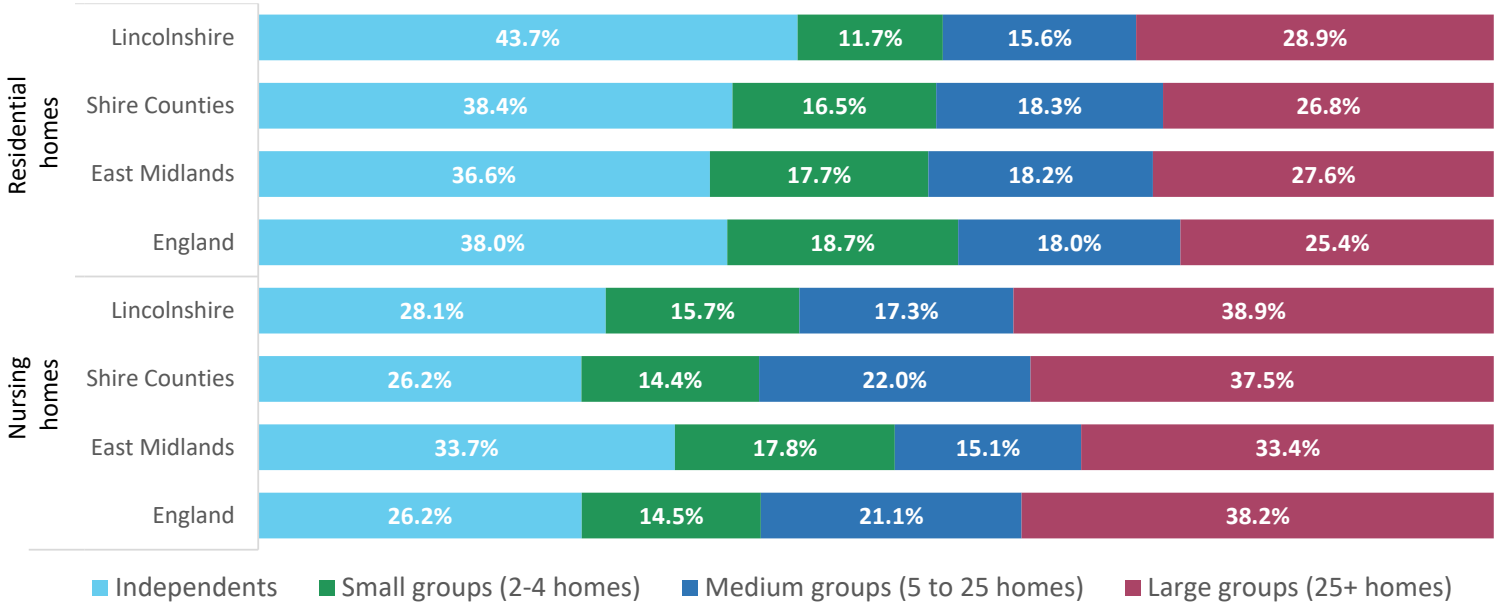
Older adult care home providers



Market composition by provider group size

Percentage of registered beds in the older adult care home market operated by different sized groups

Data: Care Analytics care home database



- Care Analytics link care homes in the CQC care directory using brand and provider ID's. Many small and medium groups are not always linked in the care directory (as they are registered through separate companies for various reasons). This means the number of independent care homes are overstated, and small groups correspondingly understated.
- Although the demarcation points for group sizes are a little arbitrary, there are consistent patterns in terms of market composition in almost all older adult care home markets.

- Lincolnshire's nursing home market is typical in terms of group composition, comprised of about 28% of beds operated by independent care homes (including small groups without formal links in the CQC care directory) and the rest a typical mix of small-to-large groups.
- However, Lincolnshire's residential care home market has a larger-than-average independent footprint, with 44% of beds operated by independent care homes compared to 38% for both England and shire counties.
- A greater number of independent care homes has implications for market forces in terms of both client choice and price competition. A related factor is that independent care homes tend to be significantly smaller on average.

Older adult care home providers in Lincolnshire by market share

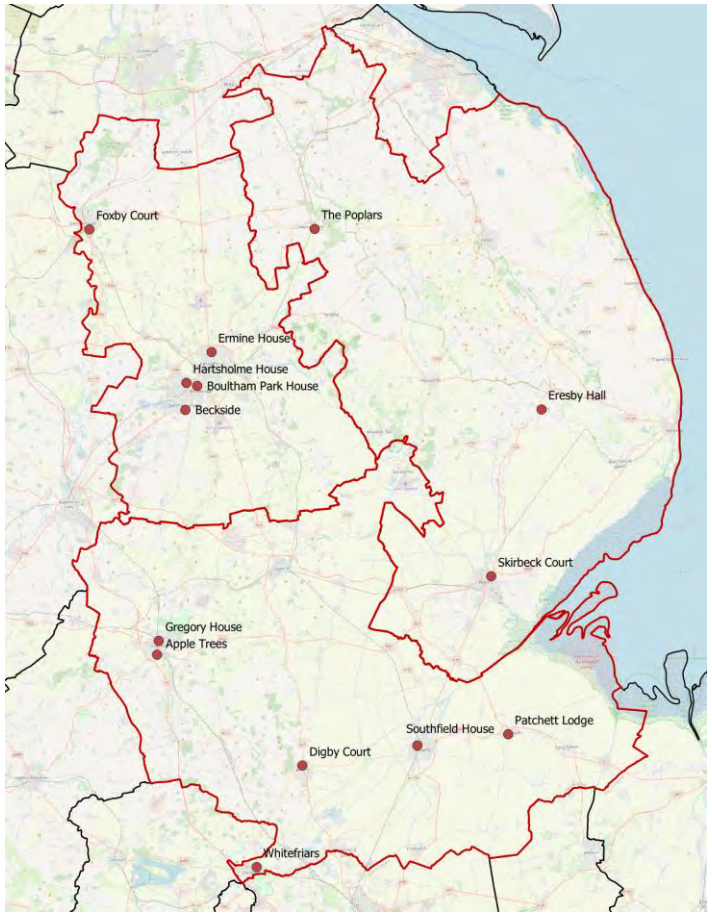
Provider	Homes in Lincs	Beds in Lincs	Percent	Cumulative	Group size (homes)
Orders of St John C.T.	14	611	8.8%	8.8%	68
Country Court Care	11	489	7.0%	15.8%	32
Barchester Healthcare	6	433	6.2%	22.1%	207
Tanglewood Care Services	6	393	5.7%	27.7%	6
HC-One	5	252	3.6%	31.3%	266
St Philips Care	6	201	2.9%	34.2%	20
Prime Life	4	170	2.4%	36.7%	56
Bhandal Care Services	6	144	2.1%	38.7%	7
Knightingale Care	3	128	1.8%	40.6%	7
Care For Your Life	3	109	1.6%	42.2%	3
Priory Group	1	88	1.3%	43.4%	213
Halcyon Care	2	86	1.2%	44.7%	2
Burlington Care	1	86	1.2%	45.9%	31
Carecall	2	82	1.2%	47.1%	2
United Health Group	1	78	1.1%	48.2%	2
Four Seasons Group	2	76	1.1%	49.3%	119
Glenholme Senior Living	1	74	1.1%	50.4%	3
Other care homes	107	3,450	50.4%	100.0%	
Total	181	6,950	100.0%		

Data: Care Analytics care home database (April 2021)

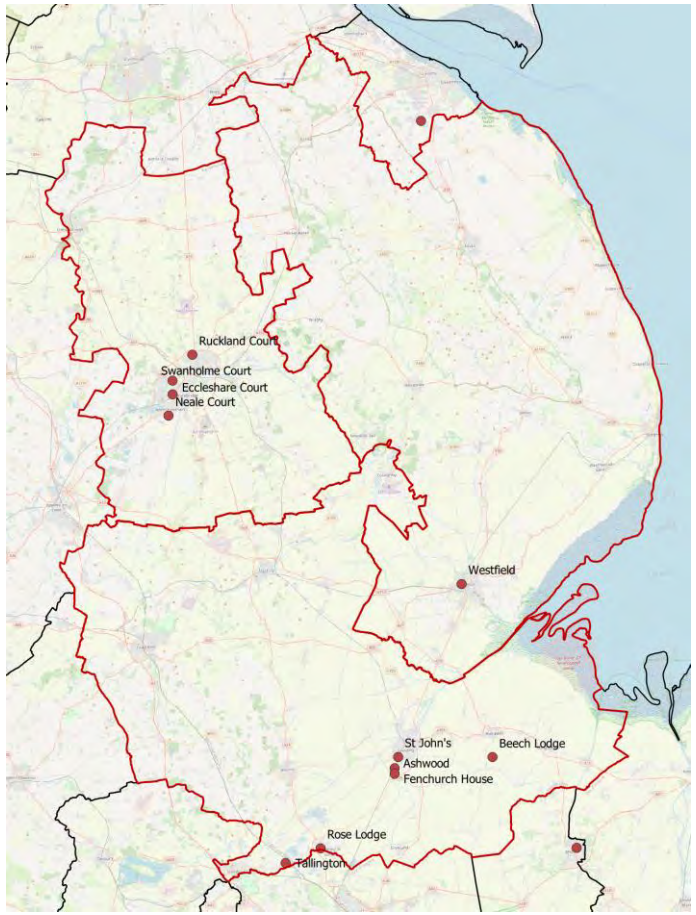
- Care Analytics link care homes in our database using brand and provider IDs in the CQC care directory. However, many small and medium groups are not always linked in the care directory as, for various reasons, they are registered through separate companies. This means some care homes we classify as independent may in fact be part of a group.
- The older adult care home market in Lincolnshire is diverse, with only a handful of providers with what could be described as a substantial market share.
- 31% of the beds in the market are operated by five groups (OSJCT, Country Court, Barchester, Tanglewood, and HC-One). Past that, the market is very diverse.
- Most of the 107 ‘other’ care homes not shown in the table are either independent care homes or groups who only operate a single care home in the county.
- Some providers also operate a few care homes predominantly supporting adults in other client groups. These care homes are not included in the table to the left.
- Maps showing the approximate locations of the largest groups in the county can be found on the next three pages.

Older adult care homes (Apr 21)

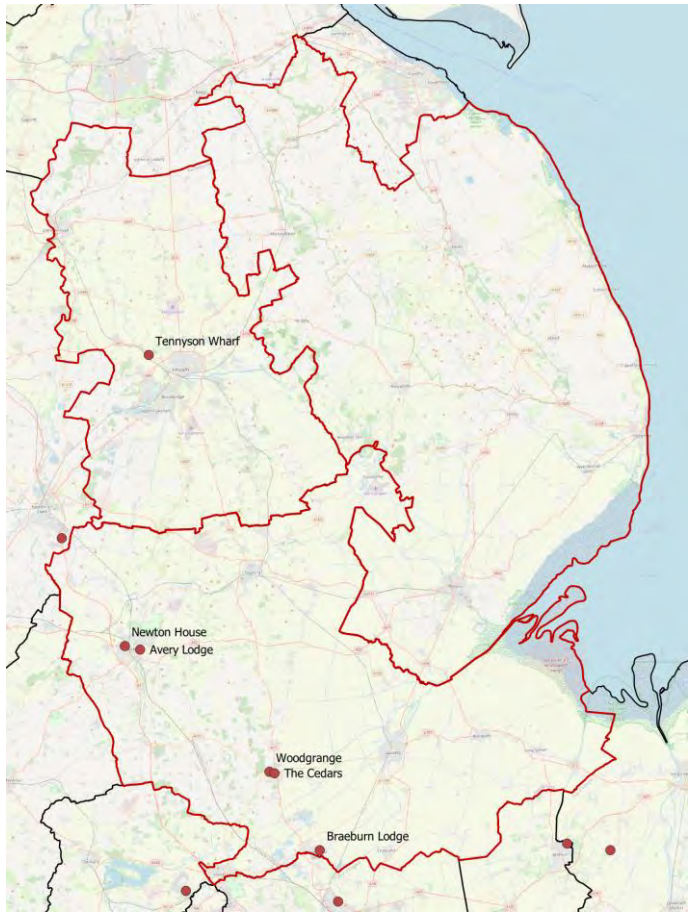
Order of St Johns (14 homes)



Country Court (11 homes)



Barchester (6 homes)



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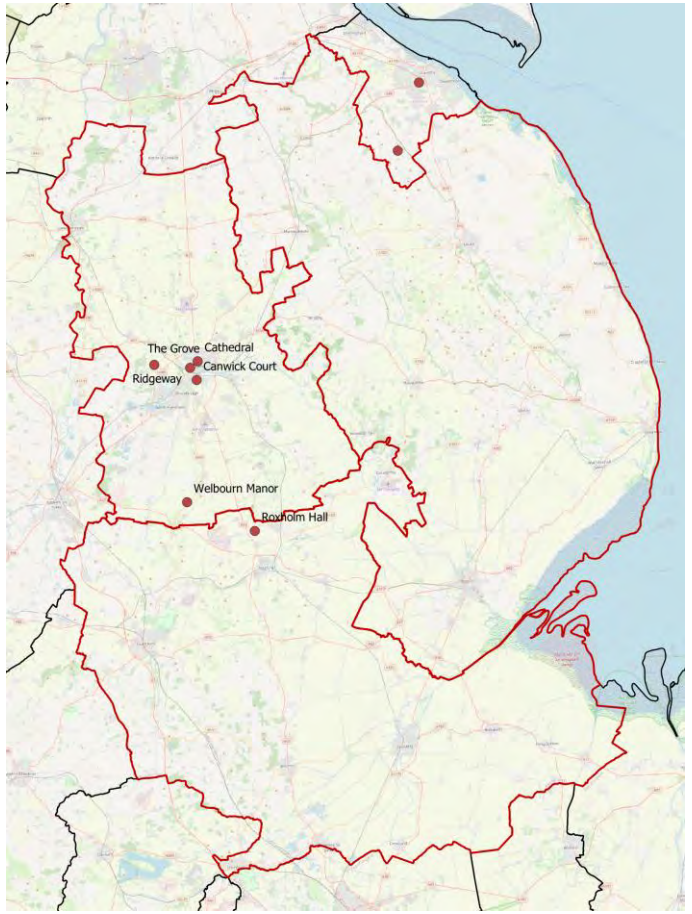
The red boundaries on the map show the three broad-geographical areas in the county: East, West and South

Older adult care homes (Apr 21)

Tanglewood (6 homes)

St Phillips Care (6 homes)



Bhandal Group (6 homes)

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The red boundaries on the map show the three broad-geographical areas in the county: East, West and South

Older adult care homes (Apr 21)

HC-One (5 homes)

- Corporate groups will generally have different business models (and cost profiles) to most independent care homes.
- Groups often operate in clusters as there can be synergies operating nearby care homes. Some synergies have been (temporarily) lost as a result of the Covid-19 pandemic.
- Outside of Boston, Tanglewood and OSJCT are the only larger groups in the county with a significant footprint in the east of the county.
- The larger provider groups in Lincolnshire generally appear to be concentrated in urban areas, despite that half of the older adult care homes in the county are in rural locations. This is because larger country houses were a significant source of converted care homes and large corporate providers are more likely to operate from purpose-built facilities. Some groups also consider rural provision a greater risk, owing to greater difficulties with recruitment and less certainty about demand.
- Based on a combination of survey data and jobs advertised on the internet, all the provider groups operating in multiple locations in the county appeared to have identical pay structures and staff terms and conditions. This suggests any differences in cost drivers within more localised economies are not that strong, as they are not material enough for providers to change their pay structures. The only variations we found were for nurses, where there were sometimes differences in pay in different care homes (albeit with no clear and consistent geographical pattern).

The red boundaries on the map show the three broad-geographical areas in the county: East, West and South

Operating policies and practices

Introduction

- The government does not strongly prescribe how care homes must operate. The Care Standards Act 2000, enacted in 2002, sets various minimum standards for operating a care home, but it leaves a great deal of latitude to providers (and managers).
- Many of the operating policies and practices in the sector have therefore developed organically.
- Operating policies and practices vary based on factors such as the provider, size of home, layout of home, and the manager. For example:
    - Larger care homes are usually more similar to each other, whilst small care homes often have more variability.
    - Small care homes often have multi-functional roles (such as dual care worker/domestic staff). As homes increase in size, most roles are specialised.
    - For obvious reasons, homes run by large groups tend to have more standardised practices.
    - The layout of a care home significantly influences operating practice, such as staffing ratios in care units during the day night and night.
    - Care Analytics often find differences in average staffing levels between for-profit providers, charities and public-sector operated homes.
    - On average, corporate groups are more likely to use agency staff than independent care homes.
    - Within constraints, managers run homes in different ways.
- These differences in practice add complexity when seeking to produce a standard cost model for the marketplace to inform council ‘usual’ rates.
- The analysis within this section includes aspects of operating practice where we were able to capture sufficient data to provide benchmarks. We have also commented based on Care Analytics wider experience working in the sector.
- Most of the analysis in this section comes from either the staffing or rota sections within the survey. These are both snapshots at the current time, where each care home only counts once in the respective analysis.
- However, some of the analysis comes from cost breakdowns supplied within the survey. These are historic and can include the same care home twice, albeit in different financial years.

Length of night shift

Length of night shift in older adult care homes by nursing status of the home

Shift length	Care homes			Percentages		
	Nursing homes	Residential homes	All homes (total)	Nursing homes	Residential homes	All homes (total)
8 hours	1	-	1	3%	-	2%
9 hours	1	-	1	3%	-	2%
9.5 hours	-	2	2	-	6%	3%
10 hours	5	10	15	16%	32%	24%
11 hours	3	3	6	10%	10%	10%
12 hours	21	16	37	68%	52%	60%
Total	31	31	62	100%	100%	100%

Data: Rotas included within anonymised surveys (2021)

- The analysis to the left has a slight error margin as we tried to remove the impact of handover time where it was included as part of the stated shift pattern.
- In most care homes, increasing the length of the night shift lowers costs, as there are nearly always fewer care workers to each resident at night (sometimes half as many depending on the set-up of the home).
- Some nursing homes also operate with fewer nurses at night, though this depends on both the home set-up and the ratio of nursing residents to nurses.

- Most nursing homes run 12-hour shift patterns for nurses and 6-6-12 or 12-12 hour shift patterns for all care staff. This is because it has the lowest costs where homes can reduce nurse and/or care worker staffing at night.
- The two nursing homes with short nights of 8-9 hours are a little anomalous. If we have interpreted their surveys correctly, they both reduce staffing in the evening compared to the daytime, before further reducing for a shorter night shift.
- A surprisingly large number of nursing homes that completed the surveys run 10- or 11-hour night shifts. Some of these could be inaccurate answers. It is also possible that there are more residential than nursing residents in the respective homes. Some operated with 1 nurse 24-hours per day, so longer night shifts were less important financially. Otherwise, we found no obvious consistent patterns in terms of home size or staffing within these 8 homes.
- We are also surprised that 16 out of 31 (52%) older adult residential homes operate 12-hour night shifts. Whilst this could relate simply to sample representativeness, it could also be a consequence of pressures to operate more efficiently. Moving from an arguably – and certainly historically – more typical 10-hour night for residential homes to a 12-hour night can potentially save more than £20 prw in combined wages and employment on-costs.

Paid or unpaid breaks

Treatment of breaks during shifts for both nurses and care workers in older adult care homes in Lincolnshire

	Nurses					Care workers						
		Group size		Location			Group size		Location		Home nursing status	
Category	Total	1-4 homes	5+ homes	Urban	Rural	Total	1-4 homes	5+ homes	Urban	Rural	Nursing	Res only
Breaks unpaid	14	5	9	10	4	35	11	24	25	10	19	16
Partial breaks paid	3	3	-	-	3	5	5	-	-	5	3	2
All breaks on shift are paid	15	4	11	10	5	37	15	22	21	16	10	27
Total survey responses / average	32	12	20	20	12	77	31	46	46	31	32	45
Percentages												
Breaks unpaid	44%	42%	45%	50%	33%	45%	35%	52%	54%	32%	59%	36%
Partial breaks paid	9%	25%	-	-	25%	7%	16%	-	-	16%	9%	4%
All breaks on shift are paid	47%	33%	55%	50%	42%	48%	48%	48%	46%	52%	31%	60%
Total survey responses / average	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Data: Staffing tab within anonymised surveys (2021)

- The impact of paid breaks should not be underestimated as it can have a material impact on costs. For some job roles (especially nurses), it is impossible to fairly compare wages until you know whether breaks during shifts are paid.
- We were a little surprised so many nursing homes do not pay nurses for breaks during shifts (44% unpaid). It is more common for nurses to be paid for breaks (often providers do not want to leave care units without a nurse on breaks and paid breaks include the requirements to stay in the building).
- Some of the 'partial' answers explicitly mentioned that breaks are only paid at night, or for tea breaks but not lunch. Others were unspecified.
- There may be a rural impact in terms of paid breaks, though this would require more evidence to be certain.

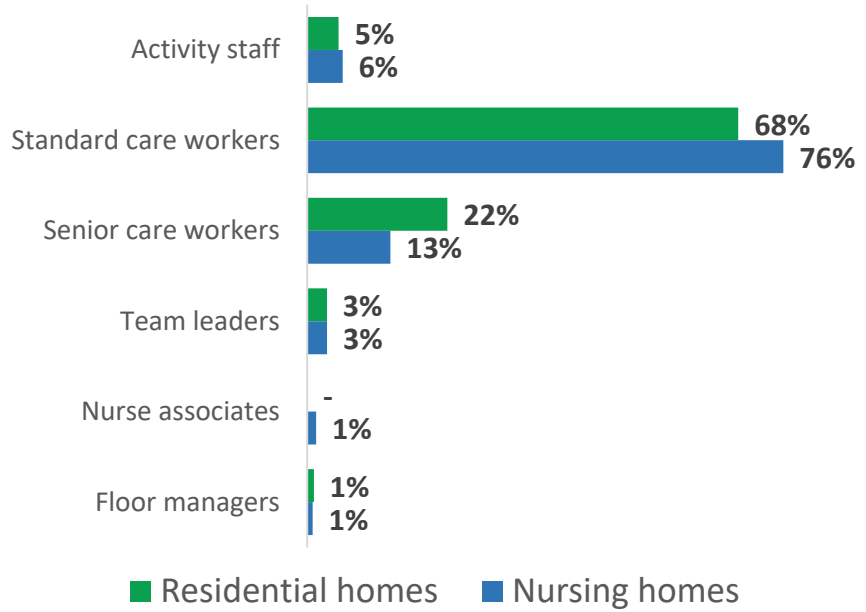
Mix of standard and senior care staff

Senior care staff as a percentage of total care workers in older adult care homes in Lincolnshire

	Care homes			Percentage		
Percent senior care staff	Nursing homes	Residential homes	Total	Nursing homes	Residential homes	Total
0-5%	-	-	-	-	-	-
5-10%	2	1	3	10%	3%	0%
10-15%	3	2	5	15%	6%	6%
15-20%	3	6	9	15%	19%	10%
20-25%	7	7	14	35%	23%	18%
25-30%	1	8	9	5%	26%	27%
30-35%	3	4	7	15%	13%	18%
35-40%	-	1	1	-	3%	14%
40%+	1	2	3	5%	6%	2%
Total care homes	**20**	**31**	**51**	100%	100%	6%

Data: Staffing tab within anonymised surveys (2021)

Total breakdown of care worker hours in surveys



- In the above analysis, senior care staff are considered either a (i) senior care worker, (ii) team leader, (iii) nurse associate, or (iv) floor manager if there is also a deputy manager in the respective care home (else the floor manager is treated as management).
- We expect to see lower senior care staff percentages in nursing homes, as nurses are also a senior role.
- The above results are typical, though the distribution demonstrates there are potential error margins if a sample is not representative.
- There is always an issue of 'labelling' with this type of analysis. Some senior care staff are paid a marked premium to standard care workers, whilst others only a modest higher rate of pay. Senior care staff in some homes may also be paid less than standard care workers in others.

Public holiday pay enhancements

Public holiday pay enhancements in older adult care homes in Lincolnshire

	Number of care homes			Percentage of care homes			Mark-up on hourly pay		
	Group size			Group size			Group size		
Category	1-4 homes	5+ homes	Total	1-4 homes	5+ homes	Total	1-4 homes	5+ homes	Total
All paid at double time	3	17	20	15%	43%	33%	2.2%	2.2%	2.2%
All paid at 50%	2	2	4	10%	5%	7%	1.1%	1.1%	1.1%
All paid at 25%	1	-	1	5%	-	2%	0.5%	-	0.5%
Mixed (varies by public holiday)	13	21	34	65%	53%	57%	0.8%	0.7%	0.7%
No public holiday premiums	1	-	1	5%	-	2%	-	-	-
Total survey responses / average	20	40	60	100%	100%	100%	**0.9%**	**1.3%**	**1.2%**

Data: Staffing tab within anonymised surveys (2021)

East	0.7%
West	1.3%
South	1.6%
All	1.2%

- Only one care home out of 60 who completed this part of the survey did not pay any pay enhancements on public holidays.
- 57% of older adult care homes in the sample have pay enhancements which vary based on the public holiday. A common answer was double pay but only for 3 public holidays, though there were a variety of configurations of days and amounts.
- The percentage mark-up on hourly wages has been calculated on the right-hand side of the table. Double time for 8 public holidays calculates as a 2.2% increase in wages, though occasionally there are additional public holidays in some years.
- The average 1.2% mark-up on wages for affected roles is a little more than all public holidays paid at time-and-a-half pay. However, larger groups appear to be more generous with respect of public holiday pay. As the sample is skewed towards larger groups, the 'true' market average may be less.
- Whilst there can be no guarantee of the representativeness of the sample, there appears to be more generous public holiday enhancements in the south of the county (1.6% average mark-up) and less in the east (0.7%). The west (1.3%) is closer to the south.

Other terms and conditions

Holiday entitlement

- Only two individual care homes and one group with multiple homes stated they had higher than statutory holiday entitlements.
- The more generous holiday pay was nearly always a reward for length of service and so entitlement was statutory when starting employment.

Sick pay

- No older adult care home who submitted a survey had automatic occupational sickness for hourly paid staff.
- Almost all care homes who submitted a survey only pay statutory sick pay (SSP). This is a near universal norm in the sector.
- One provider and a handful of other care homes had paid sickness absence after a qualifying period. Examples include: full pay if Covid, else sick pay after 5 years; Statutory till 1 year, then 1-week full pay for each year of service to 4 weeks; 8 days full pay after 6 months / supervisory roles 4 weeks.
- We have chosen not to show statistical results as they are distorted by a single provider and so would give a misleading signal about the market.

Weekend pay

- Based on the survey sample, only one provider and one other care home pay weekend pay premiums. These are small (only circa £0.20p per hour). As part of the analysis, we have added these premiums to the respective care homes hourly rate of pay on a pro rata basis.
- We have chosen not to show statistical results for weekend pay as it would either risk anonymity or give a misleading signal about the market.

Other pay enhancements

- Some care homes pay premiums for overtime and working at short notice. This has substantially increased as a result of the Covid-19 pandemic and related central government grants.

Apprenticeship Levy

- Based on the survey sample, 69% of care homes paid the levy. However, this is simply a product of each provider's size. The proportion of the overall market who pay the levy is much lower given that independent care homes are underrepresented in the survey sample.

National insurance costs

National insurance costs as a percentage of wages in older adult care homes in Lincolnshire

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	30	6.2%	3.8%	4.9%	5.5%	6.2%	7.2%	7.5%	8.4%	24	6.2%
2020-21	31	6.4%	4.0%	5.3%	5.8%	6.4%	7.3%	7.7%	8.3%	25	6.5%
2021-22 (forecast)	12	6.3%	3.7%	4.4%	5.6%	6.3%	7.6%	7.9%	8.3%	8	6.5%

Data: Calculated from anonymised surveys (2021) where care homes supplied both total wages and employer national insurance costs

- Survey results are as expected.
- Percentages increase as either wages rise and/or a greater proportion of staff work full-time hours. Extensive use of overtime can also raise employer national insurance costs.
- The lower end of percentages will be based on a combination of comparatively low wages and high numbers of part-time workers (though the results below 5.0% would require a heavily part-time workforce).
- We found nothing significant when we analysed the survey data by group size, nursing status of each home, and care home size.
- Logically, the cost of nurses and higher paid managerial staff means nursing homes would be expected to have slightly higher national insurance costs. However, the difference caused by these higher paid staff is not significant enough to stand out given the underlying variation in the data.
- We also analysed the statutory accounts of five older adult care home provider groups operating in the county. These accounts had employer national insurance costs between 5.7% and 7.6% of total wages (and a simple mean of 6.5%). This is therefore consistent with the survey results.
- Central staff would generally have higher national insurance costs than home-based staff, but this would rarely be enough to distort overall averages.
- The recently announced 1.25 percentage point increase in national insurance costs is obviously not included in the survey data or historic accounts. Once employment thresholds are taken into account, this will likely cost older adult care home providers between 0.5% and 0.75% of wages.

Pension costs

Pension costs as a percentage of wages in older adult care homes in Lincolnshire

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	31	1.8%	0.4%	1.3%	1.5%	1.7%	2.0%	2.3%	2.8%	25	1.8%
2020-21	31	1.7%	0.7%	1.4%	1.5%	1.7%	1.9%	2.0%	3.1%	25	1.7%
2021-22 (forecast)	12	1.8%	0.6%	1.3%	1.7%	1.8%	2.0%	2.1%	2.8%	8	1.8%

Data: Calculated from anonymised surveys (2021) where care homes supplied both total wages and employer pension costs

- Survey results are as expected.
- Percentages increase as either wages rise and/or a greater proportion of staff work full-time hours (especially extensive use of overtime).
- The lower end of percentages will be based on a combination of comparatively low wages and high numbers of part-time workers. The lowest pension costs also indicate high numbers of staff either being ineligible or opting out of pension auto-enrolment.
- We found nothing significant when we analysed the survey data by group size, nursing status of each home, and care home size.
- We also analysed the statutory accounts of five older adult care home provider groups operating in the county. These accounts had pension costs between 1.2% and 2.4% of total wages. This is therefore consistent with the survey results.
- The highest pension costs will either be because pension contributions are paid based on all wages (rather than statutory qualifying wages) or the provider has legacy pensions within their portfolio when they have taken over contracts (usually from local authorities).
- It is common for providers to make higher pension contributions for managerial and central staff. However, the impact on overall pension costs as a percentage of wages is usually negligible as they only account for a small fraction of total staff spend.
- For the avoidance of doubt, the combination of employees opting-out, ineligible workers, and non-qualifying wages substantially reduce pension costs in percentage terms below the 3.0% statutory rate.

Agency staffing (1)

Agency staffing as a percentage of total staffing costs in older adult care homes in Lincolnshire (for care homes who used agency staff)

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	17	6.0%	0.3%	2.1%	2.7%	4.6%	8.2%	12.3%	14.5%	13	5.5%
2020-21	19	5.6%	0.1%	0.3%	1.4%	3.6%	7.5%	15.8%	18.7%	15	4.7%
2021-22 (forecast)	10	3.4%	0.0%	0.1%	0.4%	2.0%	5.9%	8.6%	9.7%	8	3.0%

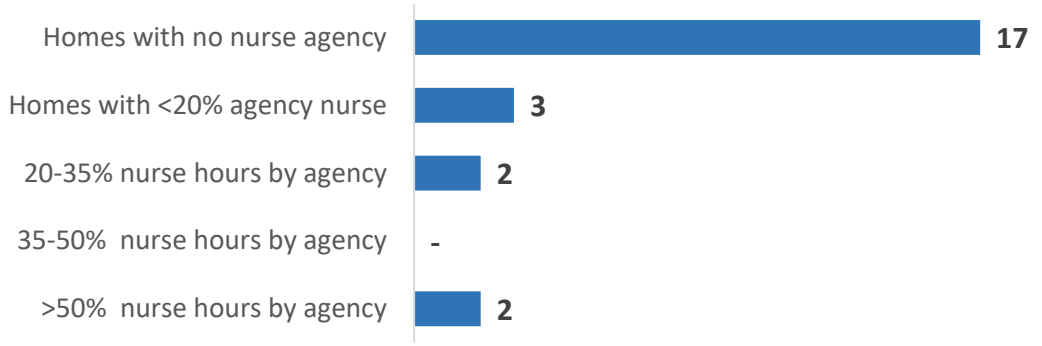
Data: Calculated from anonymised surveys (2021) where care homes supplied both total staffing costs and agency costs

- The above analysis does not include about one-third of care homes who supplied cost breakdowns but had no agency costs. This is common in the sector. As indicated by comments in the surveys, many care homes clearly took pride in the fact that they had not used agency staff in many years.
- The 'true' results for agency usage for both the overall sample (and likely the wider market) would therefore be substantially lower than indicated above – both in terms of averages and the distribution.
- These results are unsurprising as many care homes operate with little to no agency, whilst others systematically use agency (for short periods of time).
- The risk of Covid-19 infection has, by all accounts, reduced the use of agency staff. There is some supporting evidence in the 2021-22 forecasts.
- We found nothing significant when we analysed the survey data by both group size and care home size.
- However, analysis showed nursing homes (various averages between 4.5% to 6.0%) had much higher typical agency costs than residential homes (various averages between 0.6% to 3.6%). This is unsurprising as much of the agency costs in older adult care homes are for nurses.
- In the staffing tab within the surveys (separate from the above analysis), 24 nursing homes supplied staffing information. This includes two specialist nursing homes in addition to the 22 older adult care homes. Of these, 7 (29%) were currently using agency nurses on their rota and 17 (71%) were not.
- Where homes were currently using agency nurses, they accounted for 26% of nurse hours. However, across all 24 nursing homes, agency nurses only account for 7% of nurse hours.

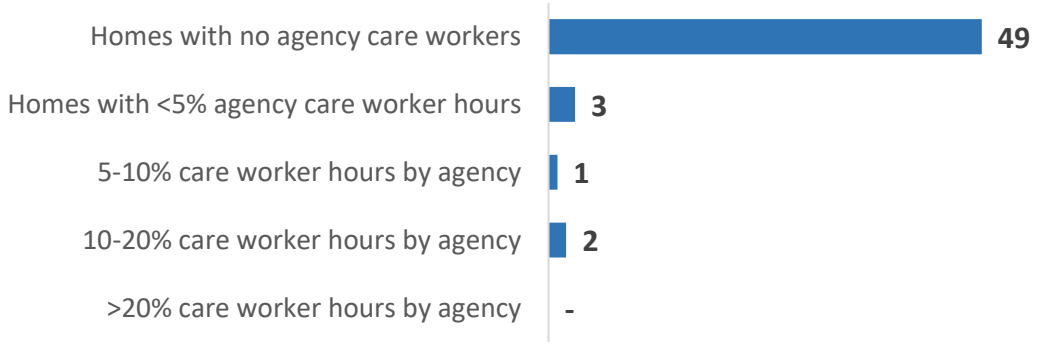
Agency staffing (2)

- The nursing data shown right is discussed on the previous page.
- On the staffing tab in the survey, 55 older adult care homes supplied care worker hours, of which 6 identified agency staff (11%).
- The total care worker hours delivered by agency staff was 7% of total hours in the 6 homes currently using agency care workers. However, this is less than 1% of all care worker hours for all 55 care homes.
- Agency staffing levels are currently lower than usual in the market owing to Covid-19 and the additional funding provided. Many care homes have indicated they are paying overtime instead of using agency staff.

Number of older adult care homes by percentage of **nurse** hours delivered by agency staff



Number of older adult care homes by percentage of **care worker** hours delivered by agency staff



Data: Calculated from anonymised surveys (2021) where care homes supplied staffing data

Agency hourly rates (inclusive of VAT) included within the surveys

Senior nurse	1 x £35.00 per hour / 1 x £32.00 at night // 1 x £36.50 at night
Nurse	1 x £34.00 per hour / 1 x £32.00 per hour / 1 x £28.50 per hour
Senior carer	1 x group for multiple homes @ £18.00 per hour (day and night)
Care worker	1 x group for multiple homes @ £16.00 per hour (day and night) 1 x £15.00 per hour / 1 x £18.00 per hour

Staff hours

Staff hours

- The analysis of staff hours uses data from two sections of the survey: (i) the staffing tab (total hours per week) and (ii) the care rota tab.
- In the care rota tab, some surveys included the rota for each care unit, whilst other surveys supplied the current care rota for their whole home. Depending on the set-up of the home, it can be difficult to allocate all care staff to specific care units.
- Many care units support residents with different categories of need. We have classified each unit or home based on the predominant type of support provided.
- Many staff roles in older adult care homes overlap with each other, such that higher-than-usual hours for one group of staff are often offset by lower hours for other staff. This means that there are risks when analysing individual staff roles in isolation from each other. Throughout this section, we provide analysis of multiple groupings of staff categories to give a more holistic picture of overlapping roles. We also provide an analysis of total staffing within each care home.
- For most of this report we calculate trimmed means using data between the 10th and 90th percentile. The aim of this metric is to exclude outliers. However, for care workers, the 90th percentile is often still too high to cover standard-rated care home placements. In some cases, we therefore use defined ranges of hours to calculate a trimmed mean. The ranges are stated in the context on the relevant page. We also show the overall mean based on all data so readers can assess the impact of using defined ranges to exclude outliers.
- It is also worth stressing at the outset that many of the care homes where staffing information was provided in their survey were suffering from extremely low occupancy. For several staff roles, this clearly increases the hours per resident week (prw) compared to business-as-usual practice. The context of the Covid-19 pandemic, and the fact that additional funding has been made available to care homes, means many care homes may not have reduced staffing levels as they ordinarily would have done with lower occupancy.
- In our analysis, we treat activity staff as care workers. We have only done this to ensure comparability to the 2017 analysis. We also start the section with activity staff to provide context before analysing care workers.

Activity staff hours

Activity lead and activity staff hours prw

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding homes	54	1.4	1.3	0.6	0.8	1.0	1.3	1.6	2.2	3.7
Nursing homes	23	1.4	1.3	0.6	0.8	1.1	1.3	1.6	2.0	2.7
Residential homes	31	1.4	1.3	0.7	0.8	1.0	1.4	1.6	2.3	3.7
Occupancy above 75%	37	1.3	1.3	0.6	0.8	1.0	1.2	1.6	1.9	2.4
40+ residents	18	1.3	1.2	0.6	0.8	1.0	1.2	1.4	2.0	2.4

Data: Anonymised care home surveys (2021)

- Averages and distribution of activity staff hours prw are consistent across most cuts of the 2021 survey data.
- Based on Care Analytics previous experience, the above averages and distribution are typical, though a little higher than usual.
- Many of the highest hours prw are caused by a combination of small homes and low occupancy. In such circumstances, it should be possible to reduce staffing to compensate. However, the respective care homes may have preferred to reduce care worker hours while maintaining activity staffing levels. For various reasons, it will often be easier to reduce care worker hours, particularly if activity staff are contracted for a specified number of hours per week.
- The other relevant factor for the higher-than-usual hours is that only 18 of the 54 responding care homes had more than 40 residents.

Notes

- The published 2017 survey results do not analyse activity staff as a separate staff category. Instead, activity staff are only shown as a percentage of total care worker hours.
- Care Analytics do not always treat activity staff as care workers. However, we have done so on subsequent pages to ensure consistency with the 2017 analysis.
- The above analysis excludes two small care homes (<20 beds) and one other home with low occupancy where there are no activity staff, but where full staffing is supplied. Many small care homes do not employ activity staff as a dedicated role.
- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. For the above data, this is arguably still too wide a range to represent staffing for standard-rated care home placements.

Care worker hours in residential homes (total hours)

Care worker hours prw in older adult residential homes

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding care homes	32	29.9	25.0	17.9	22.7	25.0	28.8	34.0	37.7	45.2
Occupancy above 75%	21	26.8	24.7	17.9	22.7	23.9	26.5	30.6	33.4	35.0
40+ residents	7	27.1	24.6	22.7	23.4	24.6	26.3	28.9	31.5	33.7

Data: Anonymised care home surveys (2021)

- The analysis on this page is based on the staffing section of the survey.
- Most care units support residents with a range of needs. It was not possible to differentiate between standard and high-dependency care units, other than using the actual hours of support prw as a reference.
- Both the averages and distribution of care worker hours are markedly higher than 2017. This is strongly influenced by homes with low occupancy, seemingly as a result of the Covid-19 pandemic. The additional funding made available has enabled care homes to maintain staffing at levels they probably would not have done in 'normal' times with lower occupancy.
- It is also possible that a high proportion of the independent care homes who did not submit surveys operate with low-dependency staffing, which would lower the results shown above.
- We consider the trimmed mean to be a more useful metric than the mean, as it at least partially adjusts for lower occupancy in 2021 compared to 2017.
- However, owing to the pandemic, this data is probably not stable enough for the council to use as a firm basis to make decisions about fees going forward.

2017 survey results prw

	Minimum	Median	Mean	Maximum
Frail older people	20.6	23.4	23.6	31.1
Dementia	16.6	23.2	24.2	48.8

Notes

- Care worker hours are inclusive of activity staff.
- The trimmed mean is calculated as the mean of results between 18.0 to 30.0 hours prw. Care hours outside this range is deemed non-standard, as either low dependency or very high dependency.
- The mean from 2017 is a weighted average based on care home size.
- The 2017 report calculates totals (combining frail and dementia) inclusive of mental health and physical disability care homes. This distorts the results for all older adult care homes (all residents), so we have not shown the 2017 totals.

Care worker hours in residential homes (rota)

Care workers staffing ratio on morning shift (from care rota and excluding activity staff)

Type of unit	Sample	>1 to 7.5	<1 to 7.5	<1 to 7.0	<1 to 6.5	<1 to 6.0	<1 to 5.5	<1 to 5.0	<1 to 4.5	<1 to 4.0	<1 to 3.5
Residential general	26	1	1	2	3	1	5	4	3	4	2
Residential dementia	20	2	-	-	1	1	2	2	4	8	-
Residential (all)	46	3	1	2	4	2	7	6	7	12	2

Data: Anonymised care home surveys (2021)

Care worker hours per resident week calculated from the care rota (including an assumed 1.2 hours for activity staff)

				Distribution						
Category	Sample size	Mean	Trimmed mean	Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
Residential general	27	27.5	24.4	16.6	20.2	22.5	24.9	28.7	37.2	62.8
Residential dementia	20	29.1	25.0	19.9	21.2	23.4	28.5	33.8	37.8	43.2
Residential (all)	47	28.2	24.6	16.6	20.2	22.9	26.9	32.1	37.9	62.8

Data: Anonymised care home surveys (2021)

- The results here are from the care rota section of the surveys. This is different to data on the previous page (total weekly hours), though the results are similar.
- The overall range of staffing ratios is similar to data we have seen in our previous work elsewhere, though the proportion of higher staffing ratios are higher than normal. Again, this is likely caused by lower occupancy caused by the pandemic (and the additional funding made available).

Notes

- Care worker hours in the bottom table are inclusive of a standardised 1.2 hours prw for activity staff. This allows comparability to the previous page.
- The trimmed mean is calculated as the mean of results between 18.0 to 30.0 hours prw. Care hours outside this range are deemed non-standard, as either low dependency or very high dependency.
- See previous page for 2017 results for comparison.

Nurse hours

Nurse hours prw in older adult nursing homes (by all residents)

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding care homes	23	4.8	4.5	2.1	2.4	3.5	4.2	5.3	7.7	11.9
Occupancy above 75%	17	4.7	4.0	2.1	2.6	3.4	3.8	4.9	8.1	11.9
40+ residents	10	3.6	4.0	2.1	2.3	3.1	3.6	4.0	4.9	5.6

Data: Anonymised care home surveys (2021)

- The hours prw for the 2021 survey data are calculated using all residents in the home as we do not have comprehensive data for the number of nursing residents in each care home. Unfortunately, this also means we cannot compare nurse hours per nursing resident to the 2017 data.
- The low number of nurse hours per resident for about half the survey sample indicates that many nursing homes are operating largely as residential homes, despite the presence of nurses. This raises concerns that more homes in the county may end their nursing registration.
- The homes with nurse hours above about 8.0 prw likely have few or no residential residents.
- We have no explanation for the 2017 survey maximums, other than that the data could be erroneous.
- In practice, nurses carry out tasks supporting all residents in the home, not only those with nursing needs (and associated funding). This is especially the case in homes with a low ratio of nursing residents to each nurse – which appears to be common in Lincolnshire.

2017 survey results prw (by nursing residents)

	Minimum	Median	Mean	Maximum
Frail older people	4.7	10.3	9.7	16.2
Dementia	6.6	9.7	8.8	19.3

Notes

- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile.
- The mean from 2017 is a weighted average based on care home size.
- The 2017 report calculates totals (combining frail and dementia) inclusive of mental health and physical disability care homes. This distorts the results for all older adult care homes, so we have not shown them.
- For several reasons beyond our control, we do not have comprehensive data on the number of residents in each care home with nursing needs.

Care worker hours in nursing homes

Care worker hours prw in older adult nursing homes

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding care homes	25	25.0	25.1	16.2	20.6	22.7	24.6	28.6	29.6	30.4
Occupancy above 75%	18	25.5	25.8	16.2	21.8	23.5	25.3	29.0	29.7	30.4
40+ residents	12	26.5	26.1	22.2	23.0	24.4	25.9	29.3	29.8	30.4

Data: Anonymised care home surveys (2021)

- The analysis on this page is based on the staffing section of the survey.
- Most care units support residents with a range of needs. It was not possible to reliably differentiate between standard and high dependency care units, other than using the actual hours of support prw as a reference.
- Further, as shown on the next page, consideration of care worker hours in nursing homes is misleading without combining with nurses.
- Despite this, the averages of care worker hours are markedly higher than 2017. This is strongly influenced by homes with low occupancy as a result of the pandemic. The additional funding made available has enabled care homes to maintain staffing at levels they probably would not have done at their current levels of occupancy in 'normal' times.
- It is also possible that a high proportion of the independent care homes who did not submit surveys operate with low-dependency staffing.
- Owing to the pandemic, this data is probably not stable enough for the council to use as a basis to make decisions about fee levels going forward.

2017 survey results prw

	Minimum	Median	Mean	Maximum
Frail older people	18.1	20.7	21.4	24.8
Dementia	15.6	21.5	27.0	41.3

Notes

- Care worker hours are inclusive of activity staff.
- The trimmed mean is calculated as the mean of results between 18.0 to 30.0 hours prw. However, the results are similar as the range is narrow, with few results outside of this range.
- The mean from 2017 is a weighted average based on care home size.
- The 2017 report calculates totals (combining frail and dementia) inclusive of mental health and physical disability care homes. This distorts the results for all older adult care homes, so we have not shown them.

Combined care worker and nurse hours in nursing homes

Nurse and care worker hours prw in older adult nursing homes

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding care homes	25	29.4	29.4	22.2	24.7	27.0	28.2	33.5	34.3	35.7
Occupancy above 75%	18	30.0	29.7	24.1	26.9	27.8	28.3	33.6	34.2	35.5
40+ residents	12	29.5	29.8	22.2	27.1	27.8	28.2	33.5	34.1	34.5

Data: Anonymised care home surveys (2021)

- The analysis on this page is based on the staffing section of the survey.
- In practice, you cannot fully separate nurses and care workers in care homes as the overlap in duties is substantial.
- As occupancy drops, the proportion of care workers to nurses will drop, as the homes must have at least one nurse onsite 24/7.
- The 2021 survey data suggests total care staffing hours in nursing homes (nurses + care workers) is lower than usual. However, this is likely impacted by a combination of two factors: (1) nursing homes operating with low numbers of nursing residents and so with staffing more closely aligned to residential homes, and (2) many of the homes submitting surveys have low occupancy, and as such reduce care workers rather than nurses, supernumerary management and other ancillary roles.

Notes

- Care worker and nurse combined hours are inclusive of activity staff.
- There is no comparative data from 2017 as the results were not published even if the analysis was carried out.
- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. The results are almost identical to the overall mean as the range is narrow, with few outlier results.

Combined care worker and nurse hours in nursing homes (rota)

Combined nurse and care worker staffing ratio on morning shift (from care rota)

Type of unit	Sample	>1 to 7.5	<1 to 7.5	<1 to 7.0	<1 to 6.5	<1 to 6.0	<1 to 5.5	<1 to 5.0	<1 to 4.5	<1 to 4.0	<1 to 3.5
Nursing general	13	-	-	-	-	-	2	2	6	3	-
Nursing dementia	15	-	-	-	-	-	1	2	4	2	6
Nursing (all)	28	-	-	-	-	-	3	4	10	5	6

Data: Anonymised care home surveys (2021)

Combined nurse and care worker hours per resident week calculated from the care rota (including 1.2 hours for activity staff)

				Distribution						
Category	Sample size	Mean	Trimmed mean	Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
Nursing general	13	30.0	30.0	23.4	26.7	28.2	30.5	32.0	33.8	34.8
Nursing dementia	15	41.3	31.7	26.0	26.4	28.6	34.7	39.1	73.8	93.6
Nursing (all)	28	36.1	30.8	23.4	26.4	28.3	31.1	34.8	48.4	93.6

Data: Anonymised care home surveys (2021)

- The results here are from the care rota section of the surveys. This is different to data on the previous page (total weekly hours).
- The nursing general care units have similar distributions than the previous page. However, the distribution of hours for nursing dementia is higher, especially past the median.
- Many of the low care worker hours (page 71) disappear when nurses are included.

Notes

- Care worker and nurse combined hours are inclusive of activity staff.
- The trimmed means are calculated between 20.0-50.0 hours prw for care workers and nurses combined. Support levels outside that are deemed non-standard, as either low dependency or very high dependency.
- See previous page for 2017 results for comparison.

Chef and cook hours

Chef and cook hours prw (excludes kitchen assistants)

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding homes	54	2.3	2.2	1.0	1.1	1.7	2.1	2.8	3.4	5.6
Nursing homes	23	1.9	2.2	1.0	1.1	1.3	1.7	2.5	2.8	3.4
Residential homes	31	2.6	2.2	1.2	1.6	1.9	2.3	3.1	3.5	5.6
Occupancy above 75%	37	2.2	2.2	1.0	1.1	1.6	2.0	2.7	3.3	5.6
40+ residents	18	1.7	1.9	1.0	1.1	1.1	1.7	2.0	2.4	3.4

Data: Anonymised care home surveys (2021)

- It is important to be careful interpreting chef and cook hours, as there is an overlap with kitchen assistants, and consequently also with domestic staff. Where there is an overlap, chef and cook hours are low. Results for combined kitchen and domestic staff can be found on page 76.
- Care Analytics are a little surprised by some of the very low numbers (below 1.2 hours prw). Some homes may have outsourced part of their kitchen function, though this was not explicitly stated in any survey.
- The 90th percentile is very high at 3.4 hours prw. However, this is a small-home effect, as the 90th percentile of care homes with more than 40 residents is much lower at 2.4 hours prw. The same 2.4 hours prw at the 90th percentile also applies to homes with 30-40 residents (not shown).
- The 2021 results are higher than 2017. The overlap with other staff roles means this could be a consequence of different samples. However, the most likely explanation is low occupancy in the 2021 sample.

2017 survey results prw

	Minimum	Median	Mean	Maximum
Nursing homes	1.1	1.7	1.7	3.1
Residential homes	0.8	1.8	1.8	5.8
All responding care homes	0.8	1.6	1.7	5.8

Notes

- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. For the above data, this is still arguably too wide a range to represent staffing for standard-rated care home placements.
- The mean from 2017 is a weighted average based on care home size.

Domestic staff hours

Housekeepers, domestic staff, and kitchen assistant hours prw

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding homes	54	5.5	5.5	1.3	2.9	4.0	5.6	6.8	7.8	10.8
Nursing homes	23	5.8	5.9	1.3	2.9	4.8	6.2	7.2	7.9	9.9
Residential homes	31	5.3	5.2	1.7	3.0	3.9	5.4	6.5	7.2	10.8
Occupancy above 75%	37	5.3	5.5	1.3	2.9	4.1	5.7	6.4	7.1	9.6
40+ residents	18	6.0	5.9	1.3	4.6	5.3	6.1	6.7	7.7	9.6

Data: Anonymised care home surveys (2021)

- Like the previous page, overlaps between kitchen and domestic roles mean caution is required interpreting hours. There is also an overlap with care workers in small homes, who more frequently have all-purpose roles.
- The 2017 report did not include combined domestic and housekeeper hours. We have summed the median and mean to produce the results right, though this has an error margin associated with adding averages.
- Irrespective of the error margin with interpreting the 2017 data, there has clearly been a marked increase in domestic staff hours. The overall median has increased by roughly 1.7 hours prw and the mean by 1.4 hours prw.
- This is almost certainly a Covid-19 effect given additional infection control requirements (and the fact additional funding has been made available).
- As with 2017, there are higher average hours in nursing homes compared to residential (though the distributions heavily overlap).

2017 survey results prw

	Minimum	Median	Mean	Maximum
Nursing homes	Unknown	4.5	4.6	Unknown
Residential homes	Unknown	3.6	4.0	Unknown
All responding care homes	Unknown	3.9	4.1	Unknown

Notes

- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. For the above data, this is still arguably too wide a range to represent staffing for standard-rated care home placements.
- The mean from 2017 is a weighted average based on care home size.

Combined kitchen and domestic staff hours

Chefs, cooks, kitchen assistants, housekeepers, and domestic staff hours prw

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding homes	56	7.8	7.7	3.5	5.3	6.4	7.6	9.2	10.4	12.7
Nursing homes	24	7.8	7.9	3.5	5.4	6.3	7.5	9.2	9.9	12.7
Residential homes	32	7.8	7.6	3.6	5.4	6.4	7.6	9.2	10.6	12.6
Occupancy above 75%	38	7.6	7.6	3.6	5.5	6.5	7.5	8.9	9.7	11.5
40+ residents	19	7.7	7.7	5.3	6.4	6.9	7.5	8.5	9.3	10.8

Data: Anonymised care home surveys (2021)

- The page combines the analysis from the previous two pages.
- By combining the different kitchen and domestic staff roles, many of the differences between types of home disappear.
- The large-home efficiencies in terms of chef and cook hours disappear. This is because larger homes have more junior kitchen and domestic staff roles, and so similar overall staffing in terms of hours. This is still a small cost efficiency as chefs and cooks cost more per hour than kitchen assistants and other domestic staff.
- The 2017 results have an error margin as it is based on adding multiple averages from different staff categories. Despite this, there is a clear Covid-19 impact with much higher averages in 2021.

2017 survey results prw

	Minimum	Median	Mean	Maximum
Nursing homes	Unknown	6.2	6.3	Unknown
Residential homes	Unknown	5.4	5.8	Unknown
All responding care homes	Unknown	5.5	5.8	Unknown

Notes

- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. For the above data, this is still arguably too wide a range to represent staffing for standard-rated care home placements.
- The mean from 2017 is a weighted average based on care home size.

Maintenance staff hours

Maintenance and handyperson staff hours prw

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding homes	51	1.3	1.2	0.3	0.7	0.9	1.2	1.5	2.0	5.1
Nursing homes	23	1.2	1.2	0.7	0.8	0.9	1.1	1.4	1.8	2.5
Residential homes	28	1.5	1.3	0.3	0.7	1.0	1.3	1.7	2.3	5.1
Occupancy above 75%	35	1.2	1.2	0.3	0.7	0.9	1.1	1.4	1.6	2.5
40+ residents	17	1.0	1.0	0.7	0.7	0.8	0.9	1.0	1.3	1.5

Data: Anonymised care home surveys (2021)

- The above analysis for 2021 excludes 5 care homes where there is no handyperson or maintenance staff but where full staffing is supplied.
- Maintenance tasks will still need doing, so the averages shown above are valid. The homes with no maintenance staff are likely to have a service delivered on a contract or as-and-when needed by external contractors.
- Both the results above in comparison to 2017 and the raw data shows clear issues with occupancy in the market. Other than in extremis, maintenance staff hours are difficult to flex with lower-than-usual occupancy.
- We are aware that some care homes have taken the opportunity of lower-than-usual occupancy to undertake improvement works.

2017 survey results prw

	Minimum	Median	Mean	Maximum
Nursing homes	0.6	0.9	1.0	1.4
Residential homes	0.5	1.0	1.0	2.6
All responding care homes	0.5	0.9	1.0	2.6

Notes

- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. For the above data, this is still arguably too wide a range to represent staffing for standard-rated care home placements.
- The mean from 2017 is a weighted average based on care home size.

Management hours

Home manager, deputy managers, and floor managers (if no deputy manager) hours prw

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding homes	56	2.7	2.6	0.9	1.5	1.8	2.4	3.5	4.0	6.4
Nursing homes	24	2.0	2.2	0.9	1.2	1.5	1.9	2.3	2.9	4.1
Residential homes	32	3.2	2.8	1.6	1.8	2.3	3.0	3.8	4.7	6.4
Occupancy above 75%	38	2.5	2.5	0.9	1.5	1.8	2.3	3.1	4.0	4.9
40+ residents	19	1.8	2.0	0.9	1.2	1.5	1.7	2.0	2.7	2.8

Data: Anonymised care home surveys (2021)

- There is a real complexity trying to compare the mix of hours and wages for this combination of staffing, as it directly relates to home size. Wages increase for the manager in larger homes, but then more junior managers lower average wages. There are also economies of scale in terms of hours, though they tend to be modest past about 30 beds.
- It is probably more accurate to say that small homes are more likely to suffer from a lack of economies of scale.
- As nursing homes tend to be larger homes, there are economies on hours, which partially offset much higher wages (see page 13).
- Some owner-managed care homes stated very high manager hours (80+ hours per week). We have reduced these to 40 hours, as otherwise it is distorting for wage and other analysis. However, it should be noted that many of the low hours in the table above can only be achieved by owner-managers working extended hours.

Notes

- The published 2017 survey results did not include enough data to be able to meaningfully analyse management staff hours.
- Caution should be applied interpreting management hours in isolation from administrative staff as there is often an overlap. There is also often an overlap between management and team leaders or other senior staff on the care rota.
- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. For the above data, this is still arguably too wide a range to represent staffing for standard-rated care home placements.

Management and administrative staff hours

Home manager, deputy managers, floor managers (if no deputy managers), senior administrators, administrators, and reception staff hours prw

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding homes	56	4.0	3.8	1.8	2.5	2.9	3.6	4.7	6.5	8.4
Nursing homes	24	3.3	3.6	1.8	2.3	2.6	3.4	3.9	4.4	5.4
Residential homes	32	4.5	3.9	2.5	2.8	3.1	3.8	5.6	7.0	8.4
Occupancy above 75%	38	3.7	3.7	1.8	2.4	2.7	3.5	4.3	5.5	7.6
40+ residents	19	3.2	3.5	1.8	2.3	2.5	2.9	3.6	3.8	4.7

Data: Anonymised care home surveys (2021)

- There are some homes with very high management and administrative hours (5.0+ hours prw), though many of the extreme results are caused by very low occupancy. Whilst speculative, others may be caused by family-run companies employing family members. There are also labelling issues in that homes with more managers can operate with fewer care staff.
- It is not necessary to have very large older adult care homes to have efficient staffing, and past about 30-40 beds any further economies tend to be modest. However, homes with fewer than 25-30 residents run a far higher risk of inefficient staffing, particularly with lower-than-usual occupancy.

Notes

- The published 2017 survey results did not include enough data to be able to meaningfully analyse management and administrative staff hours in total.
- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. For the above data, this is still arguably too wide a range to represent staffing for standard-rated care home placements.

Hours for all home-based staff

All home-based staff hours prw in older adult care homes

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
Nursing homes										
All responding homes	25	41.2	41.2	28.4	33.2	37.6	40.9	46.0	49.5	53.4
Occupancy above 75%	18	41.2	41.4	28.4	36.3	38.2	41.0	46.0	46.9	51.3
40+ residents	12	40.9	41.8	30.8	36.7	38.5	40.6	45.9	46.1	47.0
Residential homes										
All responding homes	32	43.5	42.5	30.2	33.6	36.3	41.3	49.6	56.2	66.1
Occupancy above 75%	21	39.5	41.3	30.2	33.0	34.7	38.9	43.7	49.5	50.1
40+ residents	7	39.1	39.1	34.3	34.9	36.6	38.6	41.5	43.6	44.4

Data: Anonymised care home surveys (2021)

- Although the sample sizes become small, it is clearly noticeable that many of the high hours do not exist in larger homes (40+ residents) and homes with occupancy above 75% of registered beds (which is still a very low occupancy threshold from an efficiency perspective). The effects are large enough to significantly raise the averages, including the trimmed mean.
- We are surprised at some of the low hours in nursing homes. If the data is accurate, the most likely explanation is that these homes do not have many nursing clients, and so are basically running like residential homes (albeit with a nurse doing the team leader role and part-time nursing).

Notes

- The published 2017 survey results did not include enough data to be able to analyse whole-home staffing.
- The trimmed mean is calculated as the mean of results between the 10th and 90th percentile. This is still arguably too wide a range to represent staffing for standard-rated care home placements.

Wages

Care home wages

- This section analysis wages in the 2021 surveys. It also includes comparisons to the 2017 reported results uplifted for inflation in ballpark terms.
- Throughout this section, there is a common theme that job titles can be misleading. Senior roles in some care homes (by job title) are often paid less than roles in other care homes with a more junior job title. To compensate, we present results both at a granular level for individual job roles and using weighted averages of different staff roles for a particular category.
- Some care homes supplied wage information but not staff hours. As both are needed to calculate a weighted average for staff roles with different levels of seniority, the weighted averages are calculated using a smaller subset of the data than analysis for individual job roles. For example, 67 older adult care homes supplied care worker wage data, but only 47 care homes supplied both wages and staff hours.
- Throughout this section, hourly rates are inclusive of weekend, night, and public holiday enhancements where applicable. This is the best way to analyse wages as some providers have comparatively high base pay and no enhancements (and vice versa).
- It is important to note that where wages are slightly higher than the prevailing statutory National Living Wage (NLW) for adults over 23 years of age (£8.91 per hour), this is often the result of public-holiday enhancements. For example, a provider who pays double time for all 8 public holidays but otherwise pays the NLW, has a composite hourly rate of pay of £9.11 across the year.
- Specific analysis of public-holiday pay enhancements can be found on page 59 in the Operating policies and practices section.
- Both the mean and trimmed mean averages are used in this section. The trimmed mean calculates a mean average where results below the 10th percentile and above the 90th percentile are excluded. This is designed to exclude outliers where they have an undue influence on the mean. The exception in our analysis is where the 10th or 90th percentile result is the same as the minimum or maximum. In these rare instances, the respective low-and high-end results are not excluded as the rate covers at least 10% of the sample (and so is not an outlier).
- There is often no significant difference between the mean and trimmed mean, and depending on the distribution of results, the trimmed mean can be either higher or lower than the mean. Both metrics are consistently shown throughout this section for readers to compare.
- This section also includes geographical analysis. However, it should be noted that whenever the data is cut geographically, the sample sizes reduce considerably. This means results can more easily be affected by only a handful of care homes. Differences between broad geographic areas should therefore be treated cautiously.

Overview of care home wages

Weighted average hourly pay in Lincolnshire older adult care homes as of Summer 2021 (inclusive of weekend, night, and public holiday pay enhancements)

Category of staff	Care homes	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Care homes	Trimmed mean
Nurses	20	£17.40	£15.50	£16.29	£17.00	£17.33	£18.12	£18.48	£18.63	16	£17.44
Carer workers	47	£9.32	£8.91	£8.99	£9.10	£9.23	£9.50	£9.77	£10.14	37	£9.28
Activity staff	47	£9.21	£8.91	£8.95	£8.97	£9.15	£9.34	£9.45	£11.11	37	£9.15
Domestic staff	48	£9.09	£8.91	£8.93	£8.99	£9.07	£9.17	£9.26	£9.58	38	£9.07
Chefs and cooks	47	£10.13	£8.91	£9.09	£9.45	£10.03	£10.64	£11.42	£12.65	37	£10.02
Maintenance staff	46	£9.56	£8.91	£8.92	£9.04	£9.39	£9.75	£10.36	£13.00	36	£9.43
Manager (nursing homes)	22	£23.68	£12.47	£20.53	£20.72	£23.97	£25.92	£28.74	£35.96	16	£23.27
Manager (residential homes)	36	£19.51	£9.84	£13.94	£16.78	£21.16	£21.22	£24.45	£31.17	28	£19.45
Deputy manager (nurse)	15	£18.69	£16.81	£16.89	£17.44	£18.40	£19.34	£19.58	£24.93	11	£18.38
Deputy manager (non-nurse)	39	£11.92	£9.50	£10.30	£10.55	£10.74	£12.25	£15.68	£20.00	32	£11.35
Senior Administrator	11	£11.82	£9.50	£10.00	£10.60	£12.00	£12.94	£13.21	£14.22	9	£11.81
Administrator	44	£9.72	£8.91	£9.03	£9.18	£9.42	£9.86	£10.89	£13.58	34	£9.49
Receptionist	18	£9.13	£8.91	£8.91	£8.91	£8.91	£9.00	£9.50	£10.94	16	£8.99

Data: Anonymised care home surveys (2021)

- The above analysis merges all grades for a specific job category to produce a weighted average for each home. The analysis is limited to care homes where both wages and hours were supplied, as both are needed to calculate a weighted average. Analysis by more granular grades of job can be found on subsequent pages in this section. These are based on larger samples as some care homes only supplied wage data.

Hourly wage comparisons between 2017 and 2021

Hourly wage comparisons in older adult care homes in Lincolnshire between 2017 and 2021 (inclusive of weekend, night, and public holiday pay enhancements)

	2017 survey results			2017 uplifted to 2021		2021 survey results		Difference	
Category	Median	Mean	Uplift rate	Median	Mean	Median	Mean	Median	Mean
Nurses	£14.37	£14.86	8.2%	£15.55	£16.08	£17.33	£17.40	£1.78	£1.32
Care workers (all grades)	£7.73	£7.81	18.8%	£9.18	£9.28	£9.23	£9.32	£0.05	£0.04
Activity staff	£7.78	£7.77	18.8%	£9.24	£9.23	£9.15	£9.21	-£0.09	-£0.02
Domestic staff (all grades)	£7.58	£7.71	18.8%	£9.00	£9.16	£9.07	£9.09	£0.07	-£0.06
Chefs & cooks	£8.12	£8.58	18.8%	£9.65	£10.19	£10.03	£10.13	£0.38	-£0.06
Maintenance staff	£8.03	£8.22	18.8%	£9.54	£9.77	£9.39	£9.56	-£0.15	-£0.21
Deputy manager (nurse)	£15.06	£15.40	8.2%	£16.30	£16.67	£18.40	£18.69	£2.10	£2.02
Deputy manager (non-nurse)	£10.04	£11.58	8.2%	£10.87	£12.53	£10.74	£11.92	-£0.13	-£0.61
Administrator	£8.38	£8.81	8.2%	£9.07	£9.54	£9.42	£9.72	£0.35	£0.18
Reception	£8.01	£7.81	18.8%	£9.52	£9.28	£8.91	£9.13	-£0.61	-£0.15

Data: Anonymised care home surveys (2021) combined with manipulated survey results from 2017

- The above table does not include all staffing categories shown on the previous page owing the way the 2017 data was presented.
- For 2017, we have created weighted averages for care workers and domestic staff using the overall ratios of hours reported at the time. This has an error margin as it is essentially combining average results for wages and average results for hours.
- The above comparison obviously depends on deciding on how to uplift wages for each job category. 8.2% is a compounding 2.0% annual increase, whilst 18.8% is the percentage increase on the statutory National Living Wage from 2017-18 to 2021-22 (£7.50 to £8.91).
- The table above is discussed further on the next page.

Hourly wage comparisons between 2017 and 2021

- For reference, the statutory National Living Wage (NLW) at the time of the 2017 survey was £7.50 per hour.
- All hourly rates on the previous page are weighted averages inclusive of applicable pay enhancements for weekends, nights, and public holidays. This is the only robust way to make comparisons, as some providers have higher base rates of pay and fewer pay enhancements, and vice versa.
- The published results from the 2017 survey included differences between weekday daytime, weekday night, weekend daytime, weekend night, and public holidays. However, the published results did not show weighted average results. For the analysis on the previous page, we have calculated a single average wage using the published results for each of these time periods. This should be materially accurate but has an error margin as it calculating a composite hourly rate using averages of averages.
- Apart from nurses and deputy manager nurses, all hourly wages from 2021 are within the expected ballpark given the starting wages for 2017 and the increase in the statutory NLW from 2017.
- Once both anti-social pay enhancements and the increase in the NLW are taken into account, there has been essentially no change in average pay for care workers, activity staff, and domestic staff. These are obviously the roles with rates of pay closest to statutory levels.
- Although there are some differences in average pay for other roles (housekeepers, chefs, admin, reception), they are not large enough to indicate significant changes in terms of wages within the market. The changes in average wages are more likely to be caused by differences in the samples and the labelling of job roles. For example, although housekeeper average pay appears to have increased, the small difference between average pay and the NLW in 2017 means the sample must have included a high proportion of domestic staff with a more senior job title. As another example, the results for chefs and cooks could easily be changed by the balance of different grades of job.
- By contrast, average nurse wages by 2021-22 have increased by almost £1.50-2.00 per hour over and above an assumed 2.0% annual level of inflation.
- A key driver for the higher nurse pay has been above inflation NHS pay increases for nurses over this period, as care homes compete with hospitals for the same pool of nurses. However, there is no robust way to quantify actual NHS nurse wage inflation over this period as it has involved (i) standard inflation increases, (i) regrading of roles leading to a significant proportion of staff receiving higher pay, and (iii) shorter periods to qualify for higher grades.
- Once employment on-costs are taken into account, the increase in nurse pay adds something like £15-25 prw on average, with the range depending on the actual increase in specific care homes and the nurse hours per resident. This will have therefore offset much of the structural increase in FNC that has taken place in recent years.

Nurse wages

Nurse hourly pay (inclusive of weekend, night, and public holiday pay enhancements where applicable)

			Distribution							10-90th percentile	
Category	Care homes	Mean	Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Care homes	Trimmed mean
Senior nurse	9	£18.92	£17.03	£17.41	£18.13	£18.41	£20.44	£20.44	£20.44	8	£19.16
Nurse	27	£17.48	£15.50	£16.23	£17.00	£17.58	£18.24	£18.58	£18.91	21	£17.53
Nurse (night)	8	£17.57	£16.12	£17.06	£17.49	£17.58	£17.91	£18.13	£18.44	6	£17.67
Weighted average	20	£17.40	£15.50	£16.29	£17.00	£17.33	£18.12	£18.48	£18.63	16	£17.44

Nurse hourly wages (as above) by broad-geographical area

	East		West		South	
Category	Care homes	Trimmed mean	Care homes	Trimmed mean	Care homes	Trimmed mean
Senior nurse	-	-	3	£18.38	5	£19.62
Nurse	6	£17.26	7	£17.58	8	£17.70
Nurse (night)	1	£17.50	2	£17.75	3	£17.67
Weighted average	6	£17.34	7	£17.43	3	£17.67

- There will be an overlap in some care homes between senior nurse and deputy manager roles.
- Sample sizes are small so are subject to material movements by data from a handful of homes.
- There are still some homes able to employ nurses at 2017 wage levels adjusted for inflation, but these are rare. We found nothing in job adverts on the internet to question the validity or representativeness of the survey results.

2017 survey results uplifted by 2.0% each year	
Median: £15.55	Mean: £16.08

Notes

- The weighted average is calculated for every care home who supplied both wages and hours for care staff. This is less than all wage data as some surveys did not include hours, and both are needed to calculate a weighted average.
- We applied a rule that a care home could only have senior nurses if they also had nurses, else we moved the senior nurse wage into nurse.

Care worker wages

Care worker hourly pay (inclusive of weekend, night, and public holiday pay enhancements where applicable)

Category	Care homes	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Care homes	Trimmed mean
Standard care worker	67	£9.15	£8.91	£8.95	£8.98	£9.11	£9.30	£9.34	£9.84	57	£9.15
Standard care worker (night)	31	£9.55	£8.91	£8.95	£9.03	£9.79	£9.84	£9.84	£12.13	26	£9.49
Senior care worker	58	£9.93	£9.01	£9.22	£9.41	£10.09	£10.35	£10.35	£11.24	50	£9.91
Senior care worker (night)	14	£10.12	£9.01	£9.04	£9.70	£9.98	£10.25	£11.15	£12.85	10	£9.94
Team Leader	20	£10.55	£9.05	£9.35	£9.67	£10.71	£11.24	£11.25	£13.00	16	£10.53
Floor managers as care workers	10	£11.88	£9.50	£9.95	£10.96	£11.25	£12.18	£14.37	£16.48	8	£11.60
Weighted average	**47**	**£9.32**	**£8.91**	**£8.99**	**£9.10**	**£9.23**	**£9.50**	**£9.77**	**£10.14**	**37**	**£9.28**

Data: Anonymised care home surveys (2021)

- Weighted averages also include a handful of nurse associates and night team leaders. These are too few to be worthwhile showing in the table.
- The true night pay average is less than shown above, as most providers left this answer blank. The above only includes results where the care home supplied separate day and night staffing.
- Within our analysis, we treated floor managers as care workers if the care home also had a deputy manager. This was necessary to ensure comparability of hours and pay. This would not be an appropriate approach in very large care homes, but there are not any in the sample.
- We analysed the data by group size, nursing status, and home size, and weighted averages generally do not change by more than £0.05p. Location analysis is shown on the next page.
- The above analysis counts all care homes once. We also analysed the data giving different weightings by bed capacity and LCC-funded placements. No averages materially changed.

2017 survey results uplifted by the % increase in NLW	
Median: £9.18	Mean: £9.28

Notes

- The weighted average is calculated for every care home who supplied both wages and hours. This is less than all wage data as some surveys did not include hours, and both are needed to calculate a weighted average.

Care worker wages by broad-geographical area

Care worker hourly pay (inclusive of weekend, night, and public holiday pay enhancements where applicable)

	East		West		South	
Category	Care homes	Trimmed mean	Care homes	Trimmed mean	Care homes	Trimmed mean
Standard care worker	15	£9.09	20	£9.13	22	£9.20
Standard care worker (night)	6	£9.58	11	£9.39	9	£9.56
Senior care worker	12	£9.73	20	£9.79	18	£10.15
Senior care worker (night)	3	£9.95	6	£9.97	1	£9.77
Team Leader	4	£9.88	5	£10.50	7	£10.92
Floor managers as care workers	5	£11.13	-	-	3	£12.38
Weighted average	**14**	**£9.24**	**14**	**£9.26**	**9**	**£9.38**

Data: Anonymised care home surveys (2021)

2017 survey results uplifted by the % increase in NLW	
Median: £9.18	Mean: £9.28

Notes

- The weighted average is calculated for every care home who supplied both wages and hours. This is less than all wage data as some surveys did not include hours, and both are needed to calculate a weighted average.
- Weighted averages also include a handful of nurse associates and night team leaders. These are too few to show in the table.

- See the previous page for descriptions of the job roles and our treatment of the data.
- For the above analysis, the trimmed mean is calculated excluding the top and bottom 10% of all data, not the specific sample for each geographical area. This helps ensure outliers are excluded without unnecessarily reducing the size of each sample.
- There is evidence that wages are a little higher in the south of the county, but not by much. This finding should be treated cautiously as it could be a random variation caused by the sample. Some providers with multiple care homes are large enough to skew the results when the data is cut geographically. Furthermore, as sample sizes reduce, results are more easily influenced by a handful of care homes. It should also be noted that the sample is self-selecting in that care homes were not mandated to submit surveys.
- The weighted averages from 2021 are close to the 2017 results once both anti-social pay enhancements and the increase in the NLW are taken into account.

Activity staff wages

Activity staff hourly pay (inclusive of weekend and public holiday pay enhancements where applicable)

Category	Care homes	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Care homes	Trimmed mean
Activity coordinator (lead)	23	£9.44	£8.91	£8.95	£9.04	£9.20	£9.42	£9.96	£13.00	17	£9.24
Activity staff	43	£9.16	£8.91	£8.95	£8.99	£9.20	£9.34	£9.37	£9.63	33	£9.16
Weighted average	47	£9.21	£8.91	£8.95	£8.97	£9.15	£9.34	£9.45	£11.11	37	£9.15

Activity staff hourly pay (as above) by broad-geographical area

Category	East		West		South	
	Care homes	Trimmed mean	Care homes	Trimmed mean	Care homes	Trimmed mean
Activity coordinator (lead)	6	£9.19	5	£9.22	6	£9.30
Activity staff	11	£9.10	11	£9.16	11	£9.21
Weighted average	13	£9.09	15	£9.17	9	£9.23

2017 survey results uplifted by the % increase in NLW	
Median: £9.24	Mean: £9.23

- The rates of pay for activity staff follow similar averages and distribution as standard care workers in the daytime. This is typical based on our work elsewhere.
- Care Analytics sometimes find activity staff are paid a slight wage premium to standard care workers, though wages are usually the same or similar.
- Average pay is slightly higher in the south of the county. Though as with care workers, the difference is not large enough to be meaningful.

Notes

- The weighted average is calculated for every care home who supplied both wages and hours. This is less than all wage data as some surveys did not include hours, and both are needed to calculate a weighted average.
- Most care homes only employ one level of activity staff. However, as can be seen by the wage distributions above, job titles can be misleading. Activity 'leads' in some homes are equivalent to standard staff in other homes.

Domestic staff wages

Domestic staff hourly pay (inclusive of weekend and public holiday pay enhancements where applicable)

Category	Care homes	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Care homes	Trimmed mean
Head housekeeper	39	£9.64	£8.95	£9.10	£9.27	£9.54	£10.00	£10.20	£11.24	31	£9.58
Domestic staff	65	£9.08	£8.91	£8.93	£8.97	£9.10	£9.17	£9.21	£9.50	55	£9.08
Kitchen assistant	55	£9.09	£8.91	£8.95	£8.97	£9.11	£9.17	£9.21	£9.50	48	£9.09
Weighted average	48	£9.09	£8.91	£8.93	£8.99	£9.07	£9.17	£9.26	£9.58	38	£9.07

Domestic staff hourly pay by broad-geographical area

Category	East		West		South	
	Care homes	Trimmed mean	Care homes	Trimmed mean	Care homes	Trimmed mean
Head housekeeper	9	£9.67	13	£9.49	9	£9.62
Domestic staff	15	£9.02	20	£9.07	20	£9.14
Kitchen assistant	13	£9.04	16	£9.08	19	£9.14
Weighted average	14	£9.05	17	£9.08	7	£9.11

- Although Head housekeeper pay is usually considerably higher than other domestic staff, the impact on the weighted average is small as the hours are usually heavily diluted.
- It is unsurprising that domestic staff and kitchen assistants have near identical results. They will invariably be paid the same wage, and sometimes staff will undertake both roles. In some care homes (and in some parts of the country), wages for standard care workers are noticeably higher than domestic staff. This is not the case in Lincolnshire.

2017 survey results uplifted by the % increase in NLW	
Median: £9.00	Mean: £9.16

Notes

- The weighted average is calculated for every care home who supplied both wages and hours. This is less than all wage data as some surveys did not include hours, and both are needed to calculate a weighted average.
- Job titles can be misleading. The low end of pay for housekeepers are likely domestic staff only, while the high end are likely more senior roles.

Chefs and cook wages

Chefs and cook hourly pay (inclusive of weekend and public holiday pay enhancements where applicable)

Category	Care homes	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Care homes	Trimmed mean
Chef Manager	27	£11.42	£9.00	£9.31	£10.25	£11.31	£12.27	£13.72	£14.31	21	£11.36
Chef	39	£9.97	£9.00	£9.24	£9.47	£10.04	£10.41	£10.41	£11.00	33	£9.99
Cook	34	£9.39	£8.91	£8.95	£9.13	£9.40	£9.40	£9.63	£11.50	26	£9.32
Weighted average	47	£10.13	£8.91	£9.09	£9.45	£10.03	£10.64	£11.42	£12.65	37	£10.02

Chefs and cook hourly pay (as above) by broad-geographical area

Category	East		West		South	
	Care homes	Trimmed mean	Care homes	Trimmed mean	Care homes	Trimmed mean
Chef Manager	8	£11.22	6	£11.00	7	£11.82
Chef	12	£9.80	10	£10.02	11	£10.15
Cook	7	£9.27	9	£9.34	10	£9.34
Weighted average	15	£9.99	13	£9.94	9	£10.21

- Whilst there is a progression of wages with job title, there are clear overlaps indicating a lack of equivalency of job titles in many care homes.
- Weighted average wages are considerably lower in smaller homes (£9.53 with fewer than 30 beds, not shown above) as Chef Managers are seldom used. Small homes partially offset a lack of economies on chef and cook hours by having lower grades in this area or paying a lower rate than would be the case in a large home for the same grade.

2017 survey results uplifted by the % increase in NLW	
Median: £9.65	Mean: £10.19

Notes

- The weighted average is calculated for every care home who supplied both wages and hours. This is less than all wage data as some surveys did not include hours, and both are needed to calculate a weighted average.
- Most larger care homes employ multiple levels of chefs and cook, including a more senior Chef Manager role. However, as can be seen by the wage distributions, job titles can be misleading.

Maintenance staff wages

Maintenance staff hourly pay (basic pay only)

Category	Care homes	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Care homes	Trimmed mean
Head of maintenance	25	£10.01	£8.91	£8.93	£9.10	£9.53	£10.43	£12.74	£15.00	20	£9.76
Handyperson / Gardener	45	£9.45	£8.91	£8.91	£8.94	£9.22	£9.51	£10.00	£12.50	41	£9.22
Weighted average	46	£9.56	£8.91	£8.92	£9.04	£9.39	£9.75	£10.36	£13.00	36	£9.43

Maintenance staff hourly pay by broad-geographical area

Category	East		West		South	
	Care homes	Trimmed mean	Care homes	Trimmed mean	Care homes	Trimmed mean
Head of maintenance	6	£9.70	7	£9.38	7	£10.18
Handyperson / Gardener	14	£9.14	14	£9.30	13	£9.21
Weighted average	12	£9.38	15	£9.40	9	£9.53

- Some care homes may pay anti-social hours pay enhancements for maintenance staff. However, as we could not ensure consistent treatment, the above is based on basic rates of pay only.
- Almost all cares homes who submitted a survey had hourly maintenance staff. Presumably, maintenance contracts are therefore rare (at least within the sample).
- In some areas Care Analytics have worked, maintenance staff tend to be paid considerably higher wages than above. There is obviously likely to be a skill difference between a handyman paid close to statutory wages and those earning considerably higher pay.

2017 survey results uplifted by the % increase in NLW	
Median: £9.54	Mean: £9.77

Notes

- The weighted average is calculated for every care home who supplied both wages and hours. This is less than all wage data as some surveys did not include hours, and both are needed to calculate a weighted average.
- Most homes only employ one level of maintenance staff. However, as can be seen by the wage distribution, job titles can be misleading. 'Heads' in some homes are equivalent to standard staff in other homes

Management, admin and reception wages 1

Management, admin & reception hourly pay (basic pay only)

Category	Care homes	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Care homes	Trimmed mean
Manager (nursing homes)	22	£23.68	£12.47	£20.53	£20.72	£23.97	£25.92	£28.74	£35.96	16	£23.27
Manager (residential homes)	36	£19.51	£9.84	£13.94	£16.78	£21.16	£21.22	£24.45	£31.17	28	£19.45
Deputy manager (nurse)	15	£18.69	£16.81	£16.89	£17.44	£18.40	£19.34	£19.58	£24.93	11	£18.38
Deputy manager (non-nurse)	39	£11.92	£9.50	£10.30	£10.55	£10.74	£12.25	£15.68	£20.00	32	£11.35
Senior Administrator	11	£11.82	£9.50	£10.00	£10.60	£12.00	£12.94	£13.21	£14.22	9	£11.81
Administrator	44	£9.72	£8.91	£9.03	£9.18	£9.42	£9.86	£10.89	£13.58	34	£9.49
Receptionist	18	£9.13	£8.91	£8.91	£8.91	£8.91	£9.00	£9.50	£10.94	16	£8.99
Weighted average (nursing)	23	£15.83	£7.21	£13.44	£15.18	£16.43	£17.51	£17.85	£19.36	17	£16.31
Weighted average (residential)	26	£13.60	£9.84	£11.09	£12.50	£13.30	£15.10	£15.94	£18.75	20	£13.47

- It is difficult to compare management and administrative roles in older adult care homes as there are multiple ways homes can organise themselves, particularly small homes.
- There is an overlap between senior administrators and deputy managers, as well as functions in groups carried out by central staff.
- The reception role is quite rare and only exists in group homes (and usually premium-type facilities). More than half of the 18 care homes above are from only two providers.
- Further notes on the table above are on the next page.

Notes

- The weighted average is calculated for every care home who supplied both wages and hours for care staff. This is less than all wage data as some surveys did not include hours, and both are needed to calculate a weighted average.

Management, admin & reception wages 2

- Different staffing structures between care homes make comparisons between management and administrative roles difficult.
- Within the survey data, almost all floor managers were treated as care workers. This is because (i) there was already a deputy manager in the home and (ii) given the size of the homes and the rates of pay, most floor managers were the equivalent of team leaders (in care staff). Apart from very large homes (of which there are none in the sample), in homes with both a manager and deputy manager, floor managers are better compared with team leaders. While in a home with only a single manager, a team leader might be the equivalent of a deputy manager.
- Some of the lowest manager pay are owners or perhaps family members. Within some surveys hourly rates were under £5.00 per hour as very high hours were included. We standardised any hours above 40 per week to ensure comparability.
- Managers and deputy managers in nursing homes are usually paid more than (smaller) residential care homes. However, there also usually some economies of scale on hours to offset the additional costs.
- We have chosen not to show geographical differences as the results are distorted by confounding factors such as home size and group size.

Non-staff operating costs

Non-staff operating costs

- Non-staff operating costs are the costs required to operate a care home on a day-to-day basis, excluding staffing and any capital costs or rental considerations. This includes the cost of a corporate function where applicable.
- Within this section, we have rounded results to the nearest £0.25 prw. This is for two reasons:
    i. We do not want to create a perception of false accuracy. Results can easily be moved by even a single additional entry, so analysis at the level of pence is unnecessary. Some cost categories would be better rounded to the nearest £1, though this is too granular for some low-value cost categories. We have therefore kept with rounding to the nearest £0.25 for consistency.
    ii. The numbers are easier to read and compare when rounded.
- Providers have different start and end dates for their financial years. As the variation between providers is nearly always greater than cost inflation even over several years, we have simply allocated costs based on the most months in the financial year April to March.
- Some providers only gave data for one financial year, whilst others gave two financial years (so are doubly counted in the data).
- Any 2021-22 costs will be forecasts.
- Results for 2019-20 and 2020-21 are shown without uplifts for inflation. However, when calculating averages using all the data, amounts for historic financial years have been crudely uplifted using 2.0% per year. Whilst it is, of course, possible to use more precise indices for specific cost lines, it is immaterial given the additional work involved and the timelines with which we had to undertake the analysis.
- Covid-19-related funding would have partially offset some non-staff costs in 2020-21. However, the data in this section will not generally include ongoing additional costs associated with Covid-19 as most of the data is historic.
- With the type of data analysed in this section, it is inevitable that there will be high and low outliers. This is both because of differences in costs incurred and differences in recording practices. Given the sample sizes, we therefore consider the trimmed mean (ignoring the lowest and highest 10% of costs) to usually be a more robust metric than the mean. The difference is not always significant, but sometimes outliers can have a material impact on the mean. The trimmed mean is often close to the median of unit costs. This is because, aside from outliers, non-staff operating costs tend to follow normal distribution characteristics.
- Finally, please note that ‘rent’ and financing costs are not analysed here as they are covered in the capital costs and facilities section.

Low-value cost lines

- A general issue with these types of exercises is that many non-staff operating costs are low, particularly when expressed as a cost per resident week. Many costs are therefore not separately accounted for by providers and, either end up in grouped categories or in 'other'.
- The following cost lines could not be meaningfully analysed as either the sample size was too small and/or the median amounts were too low.

Low-value cost lines prw

Category	Minimum	Median	Maximum
Uniform	£0.07	£0.79	£9.44
Activities and entertainment	£0.02	£1.53	£17.70
Travel and vehicles	£0.01	£0.96	£17.70
IT costs	£0.22	£3.20	£26.56
Professional subscriptions	£0.06	£0.81	£10.70
Recruitment and DBS	£0.01	£0.54	£33.93
Training	£0.17	£1.86	£11.93
Marketing	£0.01	£1.09	£71.20

Data: Anonymised care home surveys (2021)

- All the cost categories to the left only had partial entries such that some care homes did not separately account for the items. The minimums therefore only reflect the lowest value where costs were supplied against the respective cost line.
- Please also note that the median is calculated based on uplifting historic values to 2021-22 using a crude 2.0% annual rate of inflation (so are at 2021-22 price levels). However, the minimums and maximums are as calculated for the particular year in which they relate.
- We have chosen not to show the mean average, as it is a meaningless metric given these types of distribution pattern.
- All the cost categories to the left have been grouped under 'other' in our analysis which follows (page 107).

- There are a few other cost categories which are low-value amounts in older adult care homes when expressed as a cost per resident week. Examples are insurance and CQC inspection fees. However, we have chosen to maintain these as their own category as the cost profiles are narrow, almost all homes had costs against these categories, and there is little error margin with interpretation.
- Please note that no surveys identified GP services as a cost despite it being an explicit cost line in the survey template. In our experience, where care homes pay for enhanced GP services, the amounts can be material as a cost per resident week.

Food

Food costs prw (single cost line)

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	38	£28.25	£18.50	£21.50	£25.25	£27.50	£30.50	£36.75	£41.50	30	£27.75
2020-21	39	£29.50	£16.75	£23.50	£26.00	£28.00	£32.50	£37.25	£41.25	31	£29.50
2021-22 (forecast)	14	£29.25	£17.25	£24.75	£29.00	£30.00	£32.50	£33.50	£34.75	10	£30.00

Data: Anonymised care home surveys (2021)

Food costs prw 2021-22:
uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	71	£29.50
Nursing homes	36	£30.00
Residential homes	35	£29.25
Independents	12	£30.00
Groups	59	£29.50
Fewer than 30 beds	14	£30.00
30-49 beds	28	£30.00
50+ beds	29	£29.00

Data: Anonymised care home surveys (2021)

2017 weighted average food costs (£25.37) uplifted by 2.0% for 4 financial years is £27.46

- The distribution of food costs in the sample is as we would expect.
- Although there is a distribution of costs of circa £25.00 to £35.00 prw between the 10th and 90th percentile (ballpark figures), in whatever way the data is cut, all averages are in the region of £29.00 to £30.00 prw. This implies there is no strong economies of scale with either group size or home size.
- The averages from the 2021 survey data are circa £2.00 to £2.50 prw more than the sample in 2017 uplifted by 2.0% each year to 2021-22. Possible explanations include:
    i. Food cost inflation higher than 2.0% per year (though we would note that total CPI inflation for food was only 3.4% between 2017 and 2020, substantially below the 8.2% assumed).
    ii. The 2017 sample may have had more homes with consistently lower costs compared to 2021.
    iii. The possible inclusion of low value outliers when calculating averages in 2017.
- Although higher-than-usual inflation for food costs is likely over the coming years, the impact will not be that material in isolation as a total cost prw. Several surveys already mentioned that higher food costs were already being incurred.

Utilities

Utilities costs prw: Gas, electricity, oil, water, utilities, telephone and internet

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	38	£23.00	£8.75	£13.50	£17.25	£22.25	£25.75	£29.50	£59.50	30	£21.50
2020-21	41	£26.00	£12.50	£16.25	£19.25	£23.25	£30.25	£42.00	£62.00	33	£24.75
2021-22 (forecast)	14	£27.00	£13.50	£15.75	£16.25	£20.50	£37.50	£41.50	£55.75	10	£25.00

Data: Anonymised care home surveys (2021)

2017 weighted average utilities costs (£22.06) uplifted by 2.0% for 4 financial years is £23.88

Utilities prw 2021-22:
uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	73	£24.00
Nursing homes	34	£24.00
Residential homes	39	£24.00
Independents	9	£25.75
Groups	64	£23.75
Fewer than 30 beds	12	£24.50
30-49 beds	30	£26.25
50+ beds	31	£21.50

Data: Anonymised care home surveys (2021)

- These costs had to be grouped for analysis owing to the level of overlap and the fact that some surveys did not provide more granular cost breakdowns.
- The distribution of utilities costs is quite wide, both lower and higher than most averages, and with particularly large jumps after the median. This is unsurprising and typical from previous data we have seen. There may be an effect caused by locking in tariffs for a fixed time, as well as different costs associated with energy efficiency in converted homes and purpose-built homes of various ages.
- We reviewed all results under £17.50 prw and found nothing obvious for why the costs are so low.
- As far as we can tell, the £21.50 trimmed mean for the homes with 50+ beds is a genuine difference caused by economies of scale or better energy efficiency of the respective homes. However, we would note that the distribution for homes above 50+ beds is still almost as wide as other groupings.
- The 2021 survey results are consistent with averages from 2017 assuming 2.0% annual inflation.
- Large gas price increases are in the news at the time of writing. This is potentially a major risk area as care homes are not protected from price increases in the same way as domestic properties.

Insurance

Insurance costs prw: Home-based and central cost lines combined

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	28	£4.50	£1.25	£1.50	£2.75	£3.50	£4.75	£5.75	£28.75	22	£3.75
2020-21	31	£5.75	£1.25	£2.75	£3.50	£5.25	£6.00	£7.50	£26.75	25	£5.00
2021-22 (forecast)	14	£6.75	£1.00	£2.00	£4.50	£5.75	£8.00	£11.75	£18.25	10	£6.25

Data: Anonymised care home surveys (2021)

Insurance prw 2021-22:
uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	57	£4.75
Nursing homes	29	£5.00
Residential homes	28	£4.50
Independents	15	£4.75
Groups	42	£5.00
Fewer than 30 beds	10	£4.25
30-49 beds	21	£5.00
50+ beds	26	£5.00

Data: Anonymised care home surveys (2021)

2017 weighted average insurance costs (£2.86) uplifted by 2.0% for 4 financial years is £3.10

- The interquartile range (25th to 75th percentiles) is generally as expected in 2019-20 and 2020-21. However, the full range is odd both at the low and high end. We are surprised that insurance can be as low as £1.00 prw, and if accurate, the high-end costs must either relate specialist services or an enhanced type and level of insurance.
- It should be noted that the sample size has dropped compared to food and utilities on the previous two pages. This implies that some care homes do not separately account for insurance (at least at the level with which they have supplied cost data).
- We were told by multiple providers that insurance costs are likely to increase by 30% for most older adult care homes going forward. Comparing results for 2019-20 to the next two financial years, this already appears to be evident in data. This should be monitored as it may be subject to further change.
- The effect of large increases on individual cost lines like insurance will not be unduly significant to total placement unit costs on its own. However, it nevertheless adds to the cumulative effect of above-usual-inflation increases for multiple cost lines.

CQC fees

CQC costs prw: Home-based and central cost lines combined

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	31	£3.50	<£0.25	£2.75	£3.00	£3.25	£3.75	£4.75	£8.00	25	£3.50
2020-21	36	£4.00	£2.00	£3.25	£3.50	£3.50	£4.25	£5.00	£6.75	28	£3.75
2021-22 (forecast)	11	£4.50	£3.00	£3.25	£3.50	£3.75	£4.50	£6.50	£7.75	9	£4.25

Data: Anonymised care home surveys (2021)

CQC fees prw 2021-22:
with no uplift of historic costs

Category	Sample size	Trimmed mean
All care homes	62	£3.75
Nursing homes	32	£3.75
Residential homes	30	£3.50
Independents	9	£3.75
Groups	53	£3.75
Fewer than 30 beds	9	£3.50
30-49 beds	27	£4.00
50+ beds	26	£3.50

Data: Anonymised care home surveys (2021)

2017 weighted average insurance costs (£3.45) uplifted by 2.0% for 2 financial years is £3.59

- Although most care homes reported CQC fees as a separate cost line, about 10-15% of homes did not. This implies either they consider the amount too low to be its own summary cost line, or costs are accounted for centrally.
- The CQC fee structure has not changed since 2019-20, with no increases for 2 years. Fees vary based on the number of service users supported by a provider (or registered bed capacity for a care home).
- The range should be £1.50 to £3.91 per bed week unless a care home has other types of CQC activity, such as a domiciliary care services operating from the same location. The maximum possible charge for a care home is £6.00, though this only applies for a services supporting a single service user.
- For providers with more than 26 service users, CQC fees should be between £2.73 and £3.35 before adjusting for vacancies.
- The range of unit costs in the surveys will be a combination of vacancies and the cost line being used to record other costs, such as registration fees for other professional bodies.

Repairs and maintenance

Repairs and maintenance costs prw: Single cost line

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	38	£23.25	£5.00	£13.50	£17.00	£22.50	£28.25	£34.75	£44.75	30	£23.00
2020-21	41	£25.00	£5.00	£7.75	£16.75	£24.50	£31.00	£42.25	£62.50	33	£23.75
2021-22 (forecast)	14	£30.25	£10.25	£17.25	£22.25	£28.75	£34.25	£47.25	£58.50	10	£29.00

Data: Anonymised care home surveys (2021)

Repairs and maintenance prw 2021-22: uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	73	£24.75
Nursing homes	34	£24.75
Residential homes	39	£24.75
Independents	12	£21.00
Groups	61	£25.50
Fewer than 30 beds	8	£23.25
30-49 beds	32	£24.50
50+ beds	33	£25.25

Data: Anonymised care home surveys (2021)

It is difficult to interpret 2017 data to make a comparison

- Almost all care homes separately reported repairs and maintenance costs.
- There is nothing unusual about this distribution of costs, though it is obviously a wide range.
- Repairs and maintenance costs can vary substantially from year to year depending on whether significant issues arise.
- The quality of facilities have implications for repairs and maintenance in that it costs more to maintain and repair a higher specification facility than lower specification. For example, there is a higher maintenance cost for homes with entirely ensuite showers versus shared bathrooms.
- Good practice is obviously to invest a reasonable amount in ongoing maintenance to minimise the need for future repairs. However, the inevitable temptation for some providers is to minimise repairs and maintenance spend to maximise short-term profits / achieve a breakeven position – especially in times of financial difficulty.

Medical and clinical supplies

Medical and clinical supplies costs prw in nursing homes (single cost line)

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	18	£8.25	£3.25	£5.00	£6.00	£7.25	£8.50	£12.50	£20.25	14	£7.50
2020-21	18	£10.00	£3.50	£4.00	£6.25	£8.50	£11.75	£15.50	£28.25	14	£9.25
2021-22 (forecast)	7	£7.75	£4.75	£5.00	£5.75	£7.50	£9.00	£10.75	£11.75	5	£7.50

Data: Anonymised care home surveys (2021)

2017 weighted average costs (£7.77) uplifted by 2.0% for 4 financial years is £8.41

Medical and clinical supplies costs prw in residential homes (single cost line)

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	18	£3.50	<£0.25	£1.25	£1.75	£2.00	£2.75	£8.75	£15.25	14	£2.50
2020-21	20	£4.50	<£0.25	£0.25	£0.50	£1.25	£6.75	£9.00	£27.50	16	£2.75
2021-22 (forecast)	4	£2.75	£1.25	£1.50	£1.75	£2.75	£3.50	£4.00	£4.25	2	£2.75

Data: Anonymised care home surveys (2021)

2017 weighted average costs (£2.17) uplifted by 2.0% for 4 financial years is £2.35

- As many nursing homes have residential residents, there is a case that the true cost per nursing resident is higher than indicated by the above results. However, a larger sample of evidence would be needed to confirm and quantify any differences in Lincolnshire care homes.
- The average costs in 2021 are broadly consistent with 2017 results. Any differences comfortably fall within the error margin caused by differences in the sample.

Central overheads and professional services costs

- It is difficult to use survey data to reliably estimate central overheads and professional services costs. Any average must also be treated with extreme caution as it will be calculated using a large range of costs (from close to zero to several hundred pounds prw) depending on each provider's business model. This can be seen in the data on the next page.
- The Competitions and Markets Authority (CMA) analysis of the older adult care home market in 2017 found that group-level costs ranged from 5-10% of revenue. This is a very wide range when translated to costs prw. However, Care Analytics would note that the bottom of this range (circa 5%) would only be achievable for most groups with a significant proportion of revenue generated from higher/premium self-funder fees.
- Independent care home providers and most small (stable) groups generally do not incur the same level of cost for equivalent professional services as central overheads in larger groups. The three main reasons for this are:
    i. Groups have costs for portfolio management and growing their business. There are also costs associated with ensuring the business is structured efficiently for tax purposes (and restructured as necessary). These additional costs can be substantial compared to a stable portfolio with a simple business structure.
    ii. Over time, groups commonly fall victim to accumulating bureaucracy and the associated costs. This is rarer among small businesses as the owner(s) see the direct effects of bureaucracy on their profits. This is not a care home specific phenomena.
    iii. The owner of an independent care home or small group will often be responsible for many tasks that are managed by central staff in larger groups (procurement, finance, HR, strategy and policy, various admin, etc.). This input is often not an explicit cash cost as owners often primarily use dividends to take money out of the business (though small groups will often incur director renumeration as an equivalent to central costs).
- Ten older adult care homes within the survey sample included director remuneration payments within their cost breakdowns. These ranged from £10 to £167 prw, though 7 of the 10 had costs between £20-40 prw. Whilst the high end of the full range is clearly a form of profit extraction (rather than a legitimate cost for standard-rated placements), a £20-40 cost prw is not a high charge if attempting to cost the owner input for most independent care homes and small groups (in addition to any paid manager costs). As a ballpark example, £20-40 prw can be calculated by £30-50k per year (including on-costs) spread over 25 residents.
- In our opinion, central overheads and professional services costs above circa £50 prw can be considered as being any combination of (i) portfolio management costs associated with growing the business, (ii) profit extraction, (iii) inefficiency in terms of central staffing being poorly aligned to business size, (iv) inefficiency resulting from bureaucracy / complex business structures.

Professional services, directors, and central staff

Professional costs prw: Professional services, director renumeration, central staff

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	34	£46.25	£1.00	£2.25	£13.00	£39.25	£57.25	£91.50	£236.25	26	£39.00
2020-21	39	£40.50	<£0.25	£1.50	£3.25	£39.50	£58.25	£80.50	£235.25	31	£32.75
2021-22 (forecast)	13	£34.75	<£0.25	£0.25	£3.50	£40.00	£45.75	£65.25	£73.25	9	£35.00

Data: Anonymised care home surveys (2021)

Professional costs prw 2021-22: uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	66	£36.50
Nursing homes	30	£38.25
Residential homes	36	£35.00
Independents	17	£24.00
Groups	49	£40.75
Fewer than 30 beds	14	£20.50
30-49 beds	26	£48.50
50+ beds	26	£33.00

Data: Anonymised care home surveys (2021)

No data from 2017 as this appeared to be outside of scope of the analysis

- Almost all 2021 surveys with cost breakdowns included costs in one or more of these categories.
- Independent and small groups account for the low end of costs for reasons explained on the previous page.
- Where costs only relate to professional services, they are invariably very low as an amount prw. This is obviously only feasible where many tasks are undertaken by business owners without wage renumeration.
- If more of the independent care homes who did not submit surveys were included in the above, both the overall averages and distribution would almost certainly be much lower for the overall market.
- The trimmed mean for both independents and care homes with fewer than 30 beds (left) are misleading. They are averages comprised of very low costs and more 'usual' costs where director renumeration is charged.

Other central costs

- There were 54 total financial years within the 2021 survey data where cost breakdowns included central overheads. Of these, 46 had ‘other’ central costs above £50 prw (that is against the unspecified ‘other’ cost line). These 46 instances had a mean of £145 prw, whilst the highest was £362 prw.
- In addition to this, 18 of the 46 cost breakdowns with ‘other’ central costs above £50 prw also had ‘rents’ between £80 and £160 prw.
- Some of the costs in the ‘other’ central cost category can likely be explained as legitimate financing costs (where there is no rent). Unfortunately, we have no choice but to ignore large entries under ‘other’. We have chosen to exclude any costs in either the home-based or central ‘other’ category above £50 prw. At best, we would argue that such levels of unspecified costs are unlikely to relate to the commissioning of standard-rated council-funded placements.
- We are aware that this will exclude some legitimate costs but have no choice, as it would render analysis of cost lines which have to be grouped under ‘other’ as pointless. Such an approach also ensures greater commensurability between the costs of independent providers, SMEs, and large groups.
- We have carefully checked against all other material cost lines (food, utilities, repairs, depreciation, insurance, waste, cleaning, etc.), and as far as we can tell every single one of the 46 instances has typical cost profiles against key cost lines. The only exceptions are (i) 11 of the entries have no central staffing (so costs would be in ‘other’), and (ii) the rent already mentioned above.
- Excluding these entries should not materially affect the overall analysis . Because the respective cost breakdowns have no costs against rents or central staffing, they will not dilute the averages shown or impact on the distribution for those cost categories (though the results might be different).

Other non-staff operating costs

Other non-staff costs prw: waste collection / disposal, cleaning materials, recruitment and DBS, training, home-based office costs, activities and entertainment, marketing, uniforms, professional subscriptions, vehicles, travel, banking costs (if <£5 prw else treated as financing), other (if <£50 prw else excluded)

			Distribution							10-90th percentile	
Financial year	Sample size	Mean	Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	38	£30.50	£7.50	£13.50	£18.00	£23.75	£32.75	£62.25	£103.50	30	£27.25
2020-21	41	£35.00	£12.00	£14.75	£17.75	£25.50	£39.25	£63.75	£188.50	33	£28.75
2021-22 (forecast)	14	£42.50	£15.25	£20.75	£27.75	£39.75	£61.25	£66.00	£68.25	10	£42.25

Other non-staff costs prw 2021-22: uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	73	£30.50
Nursing homes	36	£31.75
Residential homes	37	£29.50
Independents	12	£35.75
Groups	61	£29.50
Fewer than 30 beds	13	£30.75
30-49 beds	30	£30.25
50+ beds	30	£31.00

Data: Anonymised care home surveys (2021)

It is difficult to interpret 2017 data for these costs to make a comparison

- Whilst this is a something of a cost ‘bucket’, we have grouped the categories as they are mostly low-value cost lines and not consistently accounted for by care homes in the survey data.
- We have preferred to treat as a cost ‘bucket’, as there is otherwise a risk of costs being understated. We regularly see averages of a series of low-value cost lines summed, ignoring the fact that entries are partial, and many costs are accounted for under ‘other’.
- We have disallowed any costs in either the home-based or central 'other’ categories which are greater than £50 prw. These are mostly large groups, and we found no obvious reduction in specific cost categories to justify such a high amount of unspecified costs. Whilst these exclusions only make a few pounds difference on the median and trimmed mean, they vastly inflate both the mean and distribution past the median.

Depreciation

Depreciation costs prw: Home-based depreciation and central depreciation

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	30	£28.75	£1.50	£6.00	£18.25	£24.00	£39.75	£46.50	£86.00	24	£27.00
2020-21	30	£28.50	<£0.25	£10.00	£18.00	£24.50	£36.75	£43.50	£95.00	24	£26.25
2021-22 (forecast)	6	£24.00	£4.50	£6.75	£10.00	£18.50	£36.75	£46.50	£52.25	4	£21.75

Data: Anonymised care home surveys (2021)

Depreciation prw 2021-22:
uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	52	£27.00
Nursing homes	26	£28.25
Residential homes	26	£25.50
Independents	8	£20.00
Groups	44	£28.25
Fewer than 30 beds	3	£16.25
30-49 beds	24	£31.00
50+ beds	25	£24.25

Data: Anonymised care home surveys (2021)

It is difficult to interpret 2017 data to make a comparison

- Only about 75% of care homes who supplied cost breakdowns reported depreciation costs. This is unsurprising as some care homes do not have assets still requiring depreciation (or the costs come from a separate part of their accounting system and so not readily available to the person completing the survey).
- It is likely that many of the independent care homes who did not submit surveys will have lower capital maintenance spend and associated depreciation costs than the above sample. Whilst this will not apply to all independents, this would likely be sufficient to materially drag down any average.
- Groups tend to have 'rolling' schedules of maintenance work and thus more consistent depreciation costs over their portfolio. Although a generalisation, groups are also more likely to take a long view, and consequently their maintenance spend will include upgrading facilities to improve marketability.
- High depreciation costs can include land and buildings associated with new-build facilities, which is equivalent to rent. As depreciation is hard to disentangle from rent/capital costs, we invariably account for them side-by-side in any cost models we produce (rather than as part of non-staff costs).

Repairs, maintenance, equipment and depreciation (RMED)

RMED costs prw: repairs and maintenance, equipment & furniture, depreciation, lease costs (if <£20 prw else treated as rent/financing costs), central property

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	38	£50.75	£12.25	£23.25	£34.00	£52.50	£63.50	£72.25	£114.50	30	£49.25
2020-21	41	£50.25	£5.75	£25.50	£36.75	£48.50	£61.25	£68.00	£132.25	33	£48.50
2021-22 (forecast)	14	£44.75	£15.25	£18.50	£25.25	£37.50	£63.75	£73.50	£89.50	10	£42.50

Data: Anonymised care home surveys (2021)

RMED costs prw 2021-22:
uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	73	£49.25
Nursing homes	37	£49.00
Residential homes	36	£49.50
Independents	13	£51.75
Groups	60	£48.75
Fewer than 30 beds	10	£47.75
30-49 beds	31	£52.75
50+ beds	32	£46.50

Data: Anonymised care home surveys (2021)

It is difficult to interpret 2017 data to make a comparison

- This page includes the cost lines from previous pages (repairs & maintenance and depreciation). It also includes equipment and furniture, which was a partial sample but has obvious overlap.
- These cost lines often cannot be separately analysed and compared as there is too much overlap. This is also a difficult area to analyse as it mixes revenue spend (incurred every year) and capital spend (investment, the cost of which is depreciated over multiple years).
- These results are not surprising as Care Analytics regularly sees this type of spread of costs for these combined categories. Both the median and trimmed mean averages are close to £50 prw for this collection of costs. This is on the high side for a market 'average'. However, these results are likely influenced by the data being weighted to groups, although, though there is no evidence of this from the independent homes in this sample.
- We analysed differences between residential and nursing homes and found little difference in terms of averages or distributions. However, we suspect differences would emerge if more independent residential care homes submitted surveys.

Facilities and capital costs

Facilities and capital costs

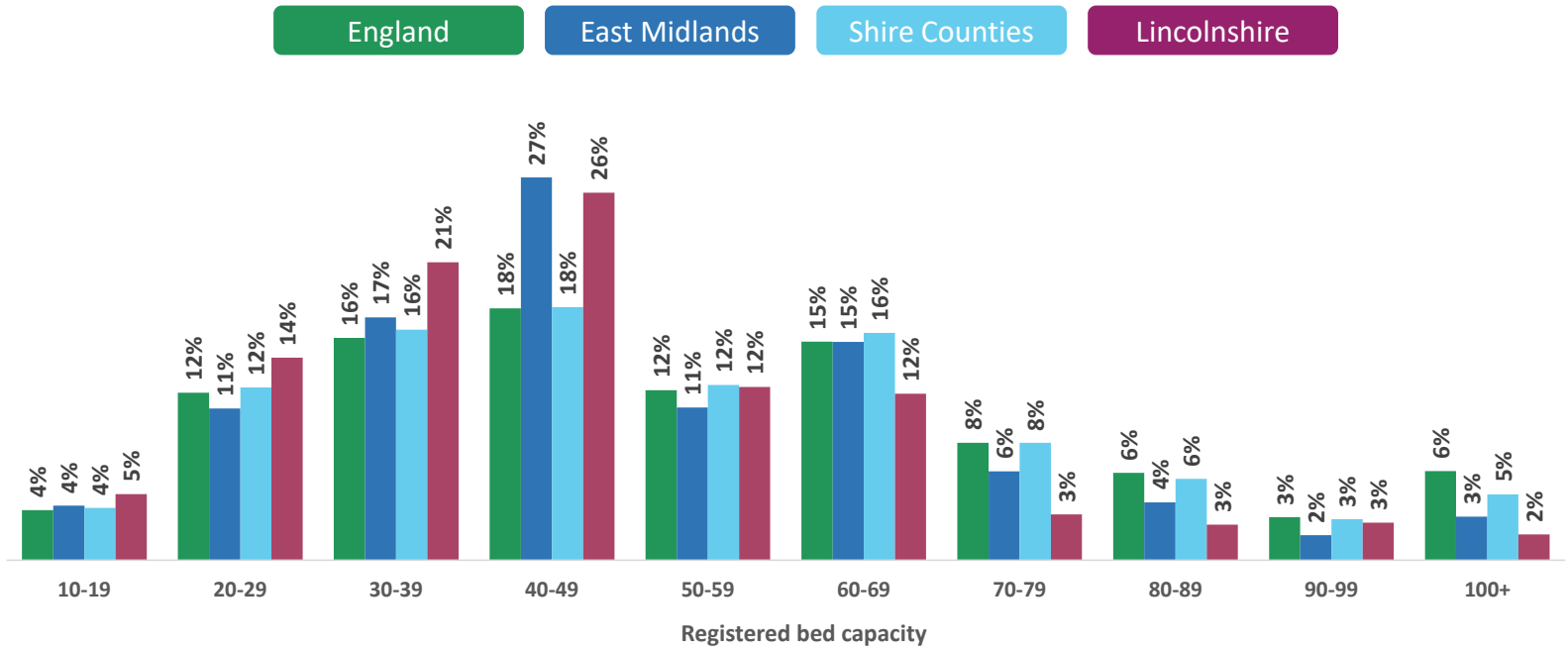
- Care home facilities can influence both the quality and cost of the support provided.
- Different types of care also have different minimum and ideal facility requirements.
- The older adult care home sector largely originated and expanded in the 20th century through converting large housing stock into care homes. Purpose-built facilities were not the norm until the late twentieth century.
- Throughout much of the 20th century, the care home market was also largely unregulated. National minimum facility standards were only established in the Care Standards Act 2000, though not enforced until 2002. Many minimum standards for new homes also do not apply retrospectively to old homes. See page 11 for a discussion of room standards over the decades.
- Most new care homes have been purpose-built since at least the 1990s, and conversions of general-purpose housing stock to care homes is a much rarer occurrence today.
- The age of care home stock is usually a good indicator of both the quality of the facilities and the capital costs incurred by providers, at least in ballpark terms. In general, the more recent the care home has been built, the better the facilities and the higher the likely capital costs. The key type of exception are converted mansions that predominantly serve the self-funder market. These type of mansions often have large bedrooms and have been updated in line with evolving expectations around facilities.
- The rule of thumb around age of care home stock and the relationship to capital costs breaks down when care homes are purchased by a new owner. At the point of sale, a revised cost of capital is created. This new valuation is often based on the expected returns of the care home as a business, not the 'bricks and mortar' valuation of the land, building and equipment.
- Care home size is another proxy indicator of the age and quality of facilities, albeit with a large error margin in each individual situation. As a rule of thumb, small care homes are likely to be older and have lower facility standards compared to larger purpose-built facilities.
- On average, nursing homes are likely to have better quality facilities and higher associated capital costs than residential homes. Nursing homes require higher physical environmental standards owing to the more complex needs of the clientele. This can include larger rooms for hoists, level-access for wheelchairs, ensuite facilities so largely bedbound residents can be washed, and more. This means nursing homes are less likely to be based in converted homes, and more likely to be in new (and consequently larger) purpose-built care homes.
- Some of the critical background for understanding this section can be found in the Context section of this report (pages 9-21).

Care home size comparisons

Distribution of beds in older adult care homes by registered bed capacity of the home

	Registered bed capacity											
Category	1-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100+	Total
England	<1%	4%	12%	16%	18%	12%	15%	8%	6%	3%	6%	100%
East Midlands	<1%	4%	11%	17%	27%	11%	15%	6%	4%	2%	3%	100%
Shire Counties	<1%	4%	12%	16%	18%	12%	16%	8%	6%	3%	5%	100%
Lincolnshire	-	5%	14%	21%	26%	12%	12%	3%	3%	3%	2%	100%

Data: Care Analytics care home database



- Lincolnshire has fewer large care homes than average and more smaller care homes. This almost certainly relates to the composition of the market in terms of the age of stock (see pages 113-114).
- The advantages (for councils and self-funders) of having more smaller care homes, rather than fewer larger ones, are: (i) downward pressure on prices from competition, (ii) greater likelihood of having more consistent geographical coverage ,and (iii) more choices for residents.
- Homes below circa 25-30 beds are more likely to suffer from higher staffing and other costs from a lack of economies of scale. However, they are also more likely to be independently-operated and have 'sunk' capital costs.

Age of care home stock in Lincolnshire

Estimated build decade: percentage of registered beds in Lincolnshire older adult care home market

Data: Online research validated by surveys where possible, linked to Care Analytics care home database (to April 2021)

Analysis has an error margin as external data sources are often unreliable for build or opening years

Build decade	Nursing homes	Residential homes	Care homes (total)	Urban	Rural	Small providers (<5 homes)	Groups (5+ homes)
No info	4%	2%	3%	3%	2%	3%	3%
Before 1990	34%	56%	47%	40%	55%	55%	47%
1990 to 1999	31%	21%	25%	29%	22%	19%	32%
2000 to 2009	9%	11%	10%	12%	9%	10%	11%
After 2010	21%	10%	15%	17%	12%	13%	17%
Total	100%	100%	100%	100%	100%	100%	100%

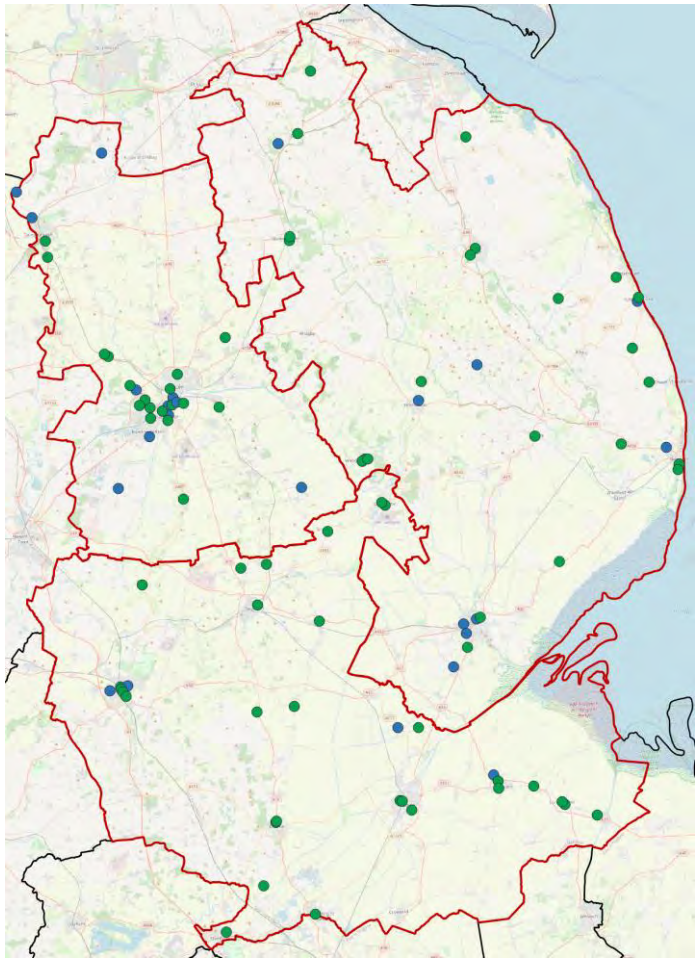
	East				West				South			
Build decade	Boston	Louth	Market Rasen	Skegness	Gainsboro'	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
No info	5%	-	-	-	-	-	19%	10%	-	-	-	-
Before 1990	32%	46%	63%	35%	39%	79%	27%	58%	46%	67%	50%	22%
1990 to 1999	24%	38%	28%	30%	23%	21%	13%	23%	27%	11%	25%	38%
2000 to 2009	16%	16%	-	34%	8%	-	-	9%	14%	8%	16%	-
After 2010	23%	-	9%	-	30%	-	40%	-	14%	14%	8%	40%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

- Only 25% of beds in the market are in care homes built (or first opened) after the Care Standards Act 2000.
- The difference between smaller providers (including independents) and groups is usually larger, with the former operating from older facilities. However, the data for Lincolnshire is heavily influenced by one provider who operates many care homes in old purpose-built facilities from the mid-20th century.
- On average, nursing care homes are newer than residential care homes.
- On average, rural properties are older stock compared to urban. This relates to the fact that groups operate less in rural areas in the county and groups tend to operate in newer facilities. It is not always clear what is the driver and what is the consequence.
- Boston aside, there are fewer new-build care homes in the east of the county.

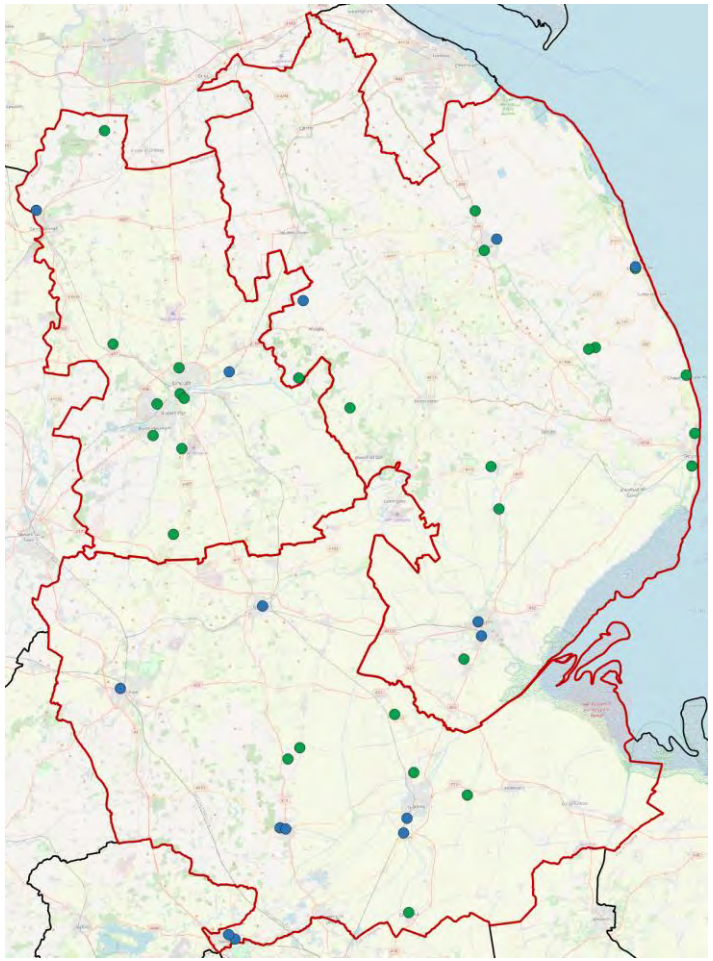
Older adult care homes in Lincolnshire

Nursing homes
Residential homes

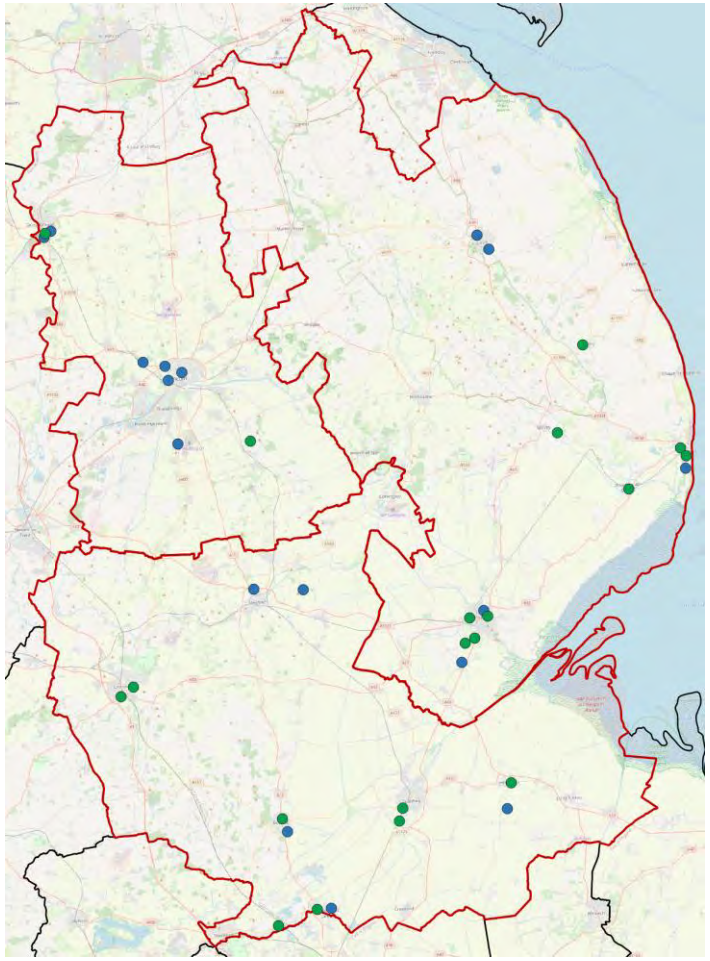
Built before 1990:
97 homes with 3,244 beds (mean 33 beds)



Built 1990 to 1999:
44 homes with 1,770 beds (mean 40 beds)



Built after 2000:
36 homes with 1,753 beds (mean 49 beds)



Analysis has an error margin as external data sources are often unreliable for build or opening years (excludes 4 homes with no data)

care ANALYTICS

Facility standards

Rooms standards in older adult care homes in Lincolnshire (surveys only)

Category	Nursing homes	Residential homes	Care homes (total)	Urban'	Rural	Indep-endents	Small groups (2-24 homes)	Large groups (25+ homes)
% of rooms with less than 12m^2 usable floor space	7%	19%	13%	13%	13%	19%	6%	13%
% of rooms with no ensuite toilet	21%	42%	32%	25%	43%	42%	34%	26%
% of rooms 'substandard' (minimum)	**22%**	**45%**	**34%**	**28%**	**44%**	**42%**	**34%**	**30%**
% of homes with at least one 'substandard' room	55%	65%	61%	53%	73%	71%	81%	46%

Data: Anonymous surveys (2021), linked to Care Analytics care home database

- A 'substandard' room relates solely to the requirements for newly-registered care homes as defined in the Care Standards Act 2000. No value judgement is inferred for the quality of care, or indeed the quality of facilities (other than that the rooms do not meet these specific standards).
- Based on the survey sample, 13% of rooms in older adult care homes have less than 12m^2 usable floor space (sometimes called 'undersized'), whilst 32% of rooms do not have an ensuite toilet. Combining the above metrics (the maximum of each result in all care homes), *at least* 34% of the rooms in the survey sample are either 'undersized' and/or rooms with no ensuite toilet. Many rooms will fail on both criteria.
- The true percentage of rooms in the Lincolnshire market not meeting minimum standards for newly-registered care homes ('substandard') is likely much higher given that independent care homes in older care home facilities are heavily underrepresented in the survey data.
- Unsurprisingly, the percentage of 'substandard' rooms is lower for nursing homes (22%) than residential homes (45%) in the survey sample. In other words, on average, room standards are demonstrably better in nursing homes than residential homes in Lincolnshire (like almost everywhere else). Again, we would expect this range to widen with a full picture of the market.
- Perhaps the more important metric is that 61% of older adult care homes in the survey sample have at least some rooms not meeting minimum new-build standards. In such homes, for understandable reasons from both commissioner and provider perspectives, it is likely the council is buying the rooms with the lowest standard of facilities. The same also applies to care homes where all the rooms meet minimum new-build standards, but not all rooms are of equivalent size, facilities, location, or aspect.
- Whilst there are always exceptions, smaller rooms, and rooms without ensuite facilities are less likely to be marketable to self-funders. It is reasonable to assume that many 'substandard' rooms would likely remain empty if they were not commissioned by the council.

Facility standards by geographical area

Rooms standards in older adult care homes in Lincolnshire (surveys only)

	East				West				South			
Category	Boston	Louth	Market Rasen	Skegness	Gainsboro'	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
% of rooms with less than 12m² usable floor space	22%	-	10%	4%	-	20%	26%	11%	10%	18%	5%	14%
% of rooms with no ensuite toilet	42%	49%	45%	83%	1%	27%	35%	32%	16%	44%	41%	9%
% of rooms 'substandard' (minimum)	**42%**	**49%**	**45%**	**83%**	**1%**	**32%**	**35%**	**32%**	**16%**	**44%**	**41%**	**22%**
% of homes with 'substandard' rooms	78%	60%	86%	100%	20%	44%	80%	75%	33%	80%	73%	25%

Data: Anonymous surveys (2021), linked to Care Analytics care home database

- Based on the survey sample, facilities in the east of the county are of a much lower standard on average, particularly in Skegness. Again, this is simply relative to the requirements for newly-registered care homes as defined in the Care Standards Act 2000.
- The simple explanation for geographical variations in terms of the proportion of the market with 'substandard' facilities is almost certainly simply a reflection of the age of care home stock. Areas with fewer new-build care homes and fewer home closures over the past two decades will have worse facilities relative to regulatory requirements for newly-registered care homes.
- Whilst questions of 'self-funder' subsidy are complicated, where room standards vary in a care home, and councils are buying rooms that would otherwise likely be vacant, in our opinion, there is greater defensibility for the respective council not covering the full unit cost in a care home. We would also note that we have seen price lists (albeit not in Lincolnshire) which have different rates for self-funders based solely on room standard which vary by multiple hundreds of pounds per week.
- Where rooms are of equivalent size, aspect, and standard, attitudes towards fee differentials will likely depend more on perspectives about market forces. As previously mentioned, affordability constraints do not currently leave many councils with much discretion in this area.
- Stakeholders are likely to have differing opinions about the importance of rooms size and the need for ensuite toilets, showers, and wet rooms.

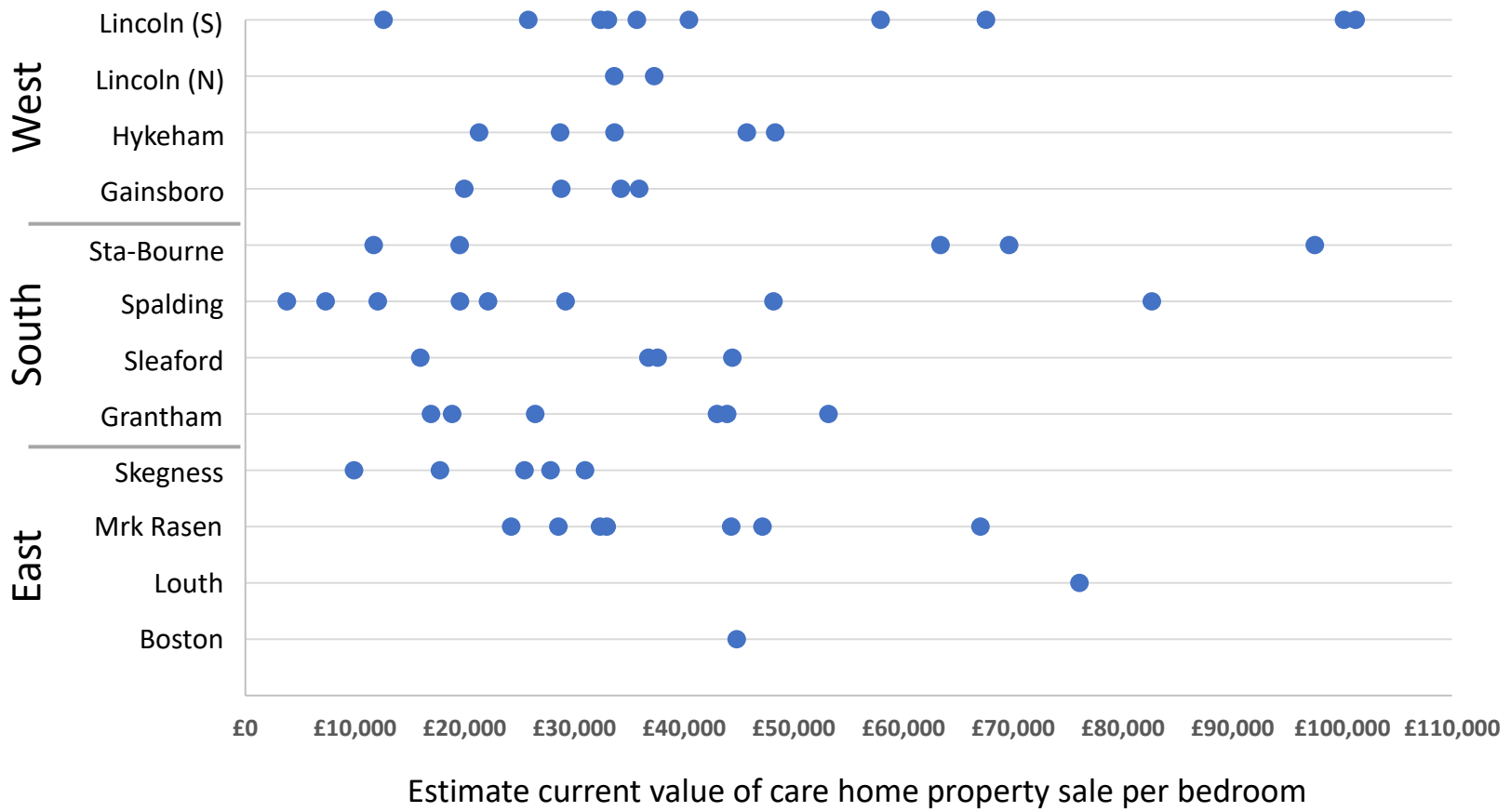
Care home sales between 2017 and 2021

Guide price per bed of advertised care home sales in and around the East Midlands between 2017 and 2021 (ordered low to high)

Location	Basic details	Beds	Per bed
Lincs (Spalding)	Land (permission for care home + flats)	117	£8,120
North East	Vacant possession	20	£19,750
East midlands	Established nursing home	59	£24,576
Lincs (Boston)	Land (estimated suitable for 60 beds)	60	£25,000
East Midlands	Purpose-built nursing home	46	£26,087
South Yorkshire	Retirement sale (all ensuite)	35	£27,143
Nottinghamshire	Retirement sale (large plot)	28	£31,964
East Midlands	Purpose-built nursing home	47	£32,979
East Midlands	Nursing home in affluent location	45	£35,556
East Midlands	Vacant site (former care home)	16	£37,188
East Midlands	Recently refurbished	39	£38,333
East Midlands	Potential for redevelopment (STP)	14	£39,286
East Midlands	Established home on large plot	40	£40,000
West Midlands	3 x home group	67	£40,299
Lincolnshire	Retirement sale	37	£40,405
Lincolnshire	Mostly purpose built (with extensions)	35	£42,143
East Midlands	Attractive residential care home	14	£42,500
East Midlands	Period property with extension	39	£43,462
East Midlands	Management run in affluent market town	19	£44,737
East Midlands	Retirement sale (market town)	12	£49,583
East Midlands	No details	30	£50,000
East Midlands	Group	71	£51,408
West Midlands	No details	31	£51,613
East Midlands	Boutique style home	24	£52,083
East Midlands	Nursing home in affluent suburb	31	£52,419
West Midlands	Profitable Specialist Dementia/MH Home	37	£52,703
East Midlands	Converted property (manager in place)	12	£54,167
East Midlands	Sought-after nursing Home	31	£54,839
West Midlands	Converted property	13	£55,769
West Midlands	Purpose built (1998)	60	£55,833
Derbyshire	Purpose built	20	£60,000
West Midlands	2 x purpose-built homes	137	£69,343
East Midlands	Purpose built (1992)	39	£70,513
Rochdale	New-build nursing home	57	£77,193
East Midlands	Profitable management run business	30	£81,667
Northamptonshire	Retirement sale	39	£85,256
Derbyshire	Retirement sale	25	£90,000
Leicestershire	Sale & leaseback (large ensuite bedrooms)	88	£95,455
Nottingham	Sale & leaseback	64	£118,750

- These care home sale guide prices were collated from various websites over the past 4 years. Actual sale prices are unknown.
- The range and distribution demonstrate the large spread of capital costs for purchasing an older adult care home.

Older adult care home property sales in Lincolnshire



- For clarification, this is not the same data as the previous page.
- The scatter graph shows 58 examples of older adult care home property sales (exact address) in Lincolnshire, with an algorithm-driven estimated current value per bedroom. The value is estimated by the website's algorithm, which adjusts for property price inflation since the sale date.
- Care Analytics have converted the total estimated value to a value per bedroom based on registered bed capacity.
- Each horizontal line represents the location for each older adult care team. The analysis is effectively 12 separate one-dimensional scatter graphs.
- Many low-value sales were for closed care homes, and so likely sold based solely on the land value.

- Sometimes, the property sale value per bedroom may be misleading for number of possible reasons. For example, (i) the sale may have been to a related party, (ii) the inflation algorithm is generic, (iii) the home may have been sold as a business with goodwill or (iv) may have had twin rooms.
- Despite these caveats, the overall dataset provides further evidence of the variability of capital costs when purchasing an existing or closed care home; and the fact that many of the old care homes in Lincolnshire are probably not worth much more than their land value.

care ANALYTICS

Property costs for general-purpose housing

Property value distributions for general-purpose housing at older adult care home locations in Lincolnshire (000)

					East				West				South			
Category	East	West	South	Total	Boston	Louth	Market Rasen	Skegness	Gainsboro'	Hykeham	Lincoln North	Lincoln South	Grantham	Sleaford	Spalding	Stamford-Bourne
Min	£20	£27	£36	£20	£36	£51	£33	£20	£27	£55	£48	£36	£38	£47	£44	£36
1st quartile	£54	£61	£63	£57	£46	£58	£69	£43	£59	£69	£62	£51	£57	£60	£67	£81
Median	£70	£74	£81	£75	£56	£76	£77	£64	£70	£77	£84	£65	£70	£78	£75	£95
3rd quartile	£86	£95	£95	£94	£65	£85	£104	£79	£87	£100	£104	£88	£86	£89	£89	£121
Maximum	£164	£161	£149	£164	£98	£94	£164	£124	£130	£161	£132	£146	£123	£149	£137	£135
Weighted mean	£72	£77	£84	£78	£59	£74	£88	£65	£70	£84	£83	£75	£71	£80	£78	£100

Data: House sale data collated from an online property valuation service, converted to a value per bedroom

- This is similar data to the previous page but is based on sales of general-purpose housing at (or as near as possible) to each older adult care home location in Lincolnshire. We prioritised larger detached and semi-detached properties when choosing which home to use for each location. We also excluded actual care homes to ensure the comparisons are as similar as possible. The sale also had to state the number of bedrooms so we could calculate a cost per bedroom.
- This analysis is **not** intended to reflect care home capital costs. It is simply to demonstrate large geographical differences in property valuations for general-purpose housing. Whilst not proportional, we would expect areas with high general-purpose housing costs to have higher land costs for care homes, better opportunity costs for repurposing old care home stock, and have more self-funders.
- The south has more high-value property, followed by the west.
- However, the most important point is that all localities have high- and low-value property at care home locations. Generalisations about broad-geographic areas should therefore only be made cautiously.

Rents and financing costs from surveys

Rent and financing costs: lease / rent costs (if >£20 prw else treated as equipment), bank & finance costs (if>£5 prw else treated as sundries)

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	20	£62.36	£8.79	£28.89	£37.56	£51.80	£84.87	£109.88	£132.05	16	£60.00
2020-21	22	£102.87	£7.13	£28.41	£63.97	£93.72	£133.78	£179.14	£315.52	16	£93.10
2021-22 (forecast)	9	£91.57	£25.52	£54.12	£65.91	£89.66	£102.55	£146.18	£146.97	7	£93.09

Data: Anonymised care home surveys (2021)

Rent prw 2021-22:
uplifting historic costs by 2.0% each year

Category	Sample size	Trimmed mean
All care homes	39	£81.28
Nursing homes	22	£88.61
Residential homes	17	£71.78
Independents	5	£55.67
Groups	34	£85.04
Fewer than 30 beds	8	£51.58
30-49 beds	16	£93.76
50+ beds	15	£83.80

Data: Anonymised care home surveys (2021)

- The analysis on this page shows combined rent and financing costs within the surveys. This analysis has an unavoidable error margin, both in terms of these specific cost lines themselves and overlap with depreciation and central costs (analysed earlier on pages 104-105, 107-108). The above analysis would also be subject to large volatility from small changes in any sample.
- The data does not include £0 cost lines, which were close to half of surveys that supplied cost breakdowns. A 'true' market average would therefore be much lower than indicated by the above.
- Based on evidence we have collated in recent years, a new-build older adult care home in Lincolnshire **without** premium rooms sizes and facilities would likely cost somewhere between £110k to £150k per room (including land). There are a myriad of factors that would have to be specified to narrow this range. In turn, this equates to £105 to £175 per bed week (before occupancy adjustment), assuming a finance cost between 5.0-6.0%. More premium facilities and prime locations would cost more.
- One provider we spoke with quoted much higher commercial rents for new-build leased care homes. However, these must be for more premium facilities or in prime locations, as their quoted rents far exceed our benchmarks for build costs and typical rental yields for leased care homes.
- Care homes built in the past would have incurred lower initial capital costs, as well as having much of the capital already repaid. Excluding a couple of outliers, the range of costs in the table above is therefore easily explained.

Capital costs conclusion

- The preceding analysis in this section shows that capital costs vary significantly in the Lincolnshire older adult care home market.
- At one end of the scale, the predominantly self-funder homes tend to have the best facilities and highest associated capital costs. This part of the market is made up large purpose-built facilities, usually recently built, and some large converted mansions often with newer extensions. Lower-than-usual occupancy may enable the council to commission more placements than usual in some of these homes.
- At the other end of the scale, there are care homes with lower standard facilities and lower (or 'sunk') capital costs. This part of market is largely made up of converted housing stock but also includes older purpose-built homes. Most rooms in this part of the market do not meet minimum standards for new-build care homes. Many of these homes also have no realistic option to upgrade facilities to meet with modern standards within the same building footprint (without disproportionately large investment and quite likely significant reductions in bed capacity). Consequently, it makes sense for owners to only fund essential maintenance in order to try to maximise profits for as long as they can stay in the market.
- This situation is not unique to Lincolnshire and will describe market realities in many parts of the country. In our opinion, councils are increasingly going to have to find better ways to manage the fact that there are large differences in cost between a newly-built care home facility (typically operated by a group) and care delivered in an old building with 'sunk' capital costs (especially when operated as an owner-managed business). Differential fees based on facility standards seems obvious at a superficial level, but this type of approach is not without a range of other issues.
- Local knowledge is needed to reach more definitive conclusions about the standards of facilities in different parts of Lincolnshire, as many care homes may be in good condition even if their rooms do not meet minimum standards for new-build care homes. As mentioned earlier, stakeholders are also likely to have differing opinions about the importance of rooms size and the need for ensuite toilets, showers, and wet rooms.
- It is our understanding that LCC, like many councils, is intending to facilitate growth in extracare facilities in the future. This will direct increasing numbers of clients with lower-level needs away from care homes. As such, for Lincolnshire, at an aggregate countywide-level (though not necessarily in all localities), there is unlikely to be a shortage of residential beds (without nursing) in the short and medium term. This is also likely to have implications for both staffing levels in residential homes and market forces in terms of vacancies in different types of facilities.
- The higher minimum facility standards in nursing homes and the fact that more of the market is newer in the county, means that there are likely to be different market forces in nursing compared to residential markets in the short- and medium-term.
- As a final point, several of the council staff we spoke with highlighted a lack of capacity in certain parts of the county. In our opinion, this needs careful consideration in terms of whether this perspective is caused by a lack of capacity per se, or a lack of capacity at the council's 'usual' rates. These are not the same thing, and for reasons explained in this report, no expansion of capacity would improve the latter.

Appendix: Physical disability and mental health markets

Survey data quality

Survey responses by predominant care category of each care home

Status	Elderly	LD / Autism	MH	PD	Other	Total	Elderly	LD / Autism	MH	PD	Other	Total
Submitted data	78	68	4	1	2	153	43%	74%	33%	50%	100%	53%
Not submitted anything	103	24	8	1	-	136	57%	26%	67%	50%	-	47%
Total care homes	181	92	12	2	2	289	100%	100%	100%	100%	100%	100%

- The physical disability (PD) care home market is too small to lend itself to meaningful market-level analysis. With only one survey response from a specialist physical disability care home, there is also nothing we can analyse that would not risk breaking the confidentiality rules under which the which they have supplied data.
- The same is also true for the mental health care home market given we only received data from 4 care homes. Data cannot easily be anonymised with such small samples, so we are limited in the type of analysis we can present.
- The data from the 4 mental health care homes who submitted surveys was also limited. None of the four provided cost breakdowns, only 1 provided resident information, 3 provided wages and terms & conditions, and 2 provided information about their facilities. This is not enough data to generalise about the market.
- We had hoped that the surveys would identify more specialist care units within older adult or specialist (other) care homes. However, as far as we can tell, these are rare within the local market.
- The learning disability market is large enough to undertake a market-level analysis. This has been done in a separate report as there is little overlap with older adult care homes.
- The physical disability and mental health markets are covered as an appendix here as much of the commissioning by the respective client groups is within older adult care homes.
- Care Analytics have recommended that for future exercises, the council takes a different approach to mapping and analysing the physical disability and mental health care home markets, as the size of the respective markets does not lend itself well to anonymised surveys.

PD placements by location, care home type, and age group

Age group and location for physical disability client group

	Age group						
Location	18-25	26-44	45-54	55-64	65+	Total	Percent
Lincolnshire	-	7	10	38	1	57	76%
North Lincolnshire	-	3	-	4	-	7	9%
North East Lincolnshire	-	-	-	3	-	3	4%
Nottinghamshire	-	-	-	-	-	-	-
Other	1	2	1	4	-	8	11%
Total	1	12	11	49	1	75	100%

Data: Placements data supplied by LCC finance linked to Care Analytics care home database

Age group and Care Analytics predominant care category for physical disability client group

	Age group						
Care home type	18-25	26-44	45-54	55-64	65+	Total	Percent
Older adult	-	1	4	32	2	39	52%
Physical disability	-	4	3	6	-	13	17%
Learning disability	1	5	2	2	-	10	13%
Mental health	-	2	-	2	-	4	5%
Other	-	-	2	7	-	9	12%
Total	1	12	11	49	2	75	100%

Data: Placements data supplied by LCC finance linked to Care Analytics care home database

- Only 76% (57 of 75) of the care home placements commissioned by the Physical Disability (PD) client group are in Lincolnshire. This may imply a historic shortfall in local facilities.
- The breakdown of placements by age group indicate physical disability clients have seldom been placed in care homes for over a generation.
- 57% (43 of 75) of the care home placements commissioned by the PD client group are in care homes that Care Analytics classify as predominantly supporting older adults. We found no evidence that a significant proportion of these placements are in specialist PD care units.
- There is a clear transfer of financial responsibility to the older adult client group at 65 years of age.

MH placements by location, care home type, and age group

Placements by the mental health client group by age group and location

	Age group						
Location	18-25	26-44	45-54	55-64	65+	Total	Percent
Lincolnshire	2	33	44	79	-	158	84%
North Lincolnshire	-	2	4	6	-	12	6%
North East Lincolnshire	-	1	1	1	-	3	2%
Nottinghamshire	2	1	1	3	-	7	4%
Other	-	1	2	4	-	7	4%
Total	4	38	52	93	-	187	100%

Data: Placements data supplied by LCC finance linked to Care Analytics care home database

Placements by the mental health client group by age group and care category

	Age group						
Care home type	18-25	26-44	45-54	55-64	65+	Total	Percent
Mental health	-	26	35	53	-	114	61%
Older adult	-	6	8	28	-	42	22%
Learning disability	4	5	3	5	-	17	9%
Other	-	-	5	7	-	12	6%
Physical disability	-	-	-	-	-	-	-
Total	4	38	52	93	-	187	100%

Data: Placements data supplied by LCC finance linked to Care Analytics care home database

- 84% of placements commissioned by the mental health client group are in-county.
- The fact that 16% of placements are out of county when there are vacancies in the local market suggests there is a lack of suitable facilities for certain types of care locally.
- The council have indicated that there is a lack of support for autism in care homes within the county and that they would like to manage more complex care residents in county.
- There are no care home placements in the mental health client group for adults aged 65+. This is because funding responsibility switches to the older adult client group. There are 31 older adult funded residents in mental health care homes (not shown left). Most of these people are likely to have started their placement funded by the mental health client group.
- The 55-64 age group is nearly twice as large as the 45-54 age group, which in turn is bigger than the aged 26-44 cohort. This likely indicates that care home eligibility thresholds for mental health residents were lower in the past. If so, there may be excess capacity in future as more residents exit the mental health service than enter.

Mental health care homes in Lincolnshire

						Client group commissioner		
Home type	Beds	Nursing status	Group size	Group name	Care home name	Mental health	Other	Total LCC
MH	33	Res	Large	Prime Life	Chestnut House	18	6	24
MH	18	Res	Ind.	Alderson	Alderson House	14	1	15
MH	16	Res	Small	United Health	West Deane	14	0	14
MH	24	Res	Large	Priory Group	Glebe House	14	1	15
MH	17	Res	Small	United Health	Lindum Park House	13	2	15
Other	83	Nur	Ind.	Howson CC	Howson Care Centre	12	18	30
MH	23	Res	Large	Prime Life	Byron House	10	7	17
MH	21	Res	Large	Prime Life	St Oggs	9	6	15
MH	29	Nur	Ind.	Life Care (UK)	Courtlands Lodge	7	6	12
MH	28	Nur	Ind.	Super Care	Miramar Nursing	5	7	12
MH	6	Res	Large	Priory Group	Middlegate Lodge	3	0	3
MH	14	Res	Ind	Genesis	Genesis	2	4	6

Data: Care Analytics care home database and LCC finance placements data

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- Howson Care Centre is a 'mixed' care home not specialising in a particular client group. It has a specialist mental health unit.
- There is only one mental health care home in the south (or nearby). Despite this, no significant localised issues were raised by LCC staff.
- Mental health care homes outside of Lincolnshire are shown on the map but not named. The exception is Phoenix Park (an older adult home with a specialist unit) as it is used extensively by the mental health client group.

Resident mix and occupancy in Lincolnshire market

Resident mix in mental health care homes

	Funder (percentage of residents)								
Category	LCC (inc. joint)	Other council	Lincs CCG	Other CCG	CCG unspecified	Self funder	Other funder	Total residents	Registered capacity
Residents	169	14	2	-	4	2	-	191	236
% of residents	88%	7%	1%	-	2%	1%	-	100%	
% of beds	72%	6%	1%	-	2%	1%	-	81%	100%

Data: Surveys and Jadu data (if no survey), June/July 2021

- Based on the 11 mental health care homes, 90% of residents are funded via LCC (including joint placements).
- Given the council is in a monopsony position – the market is dominated by single buyer – this raises questions about the best way for the council and the sector to work in partnership for the benefit of all.

Occupancy and vacancies as a percentage of registered beds in mental health care homes

Category	<40%	40%-59%	60%-64%	65%-69%	70%-74%	75%-79%	80%-84%	85%-89%	90%-94%	95%-99%	100%	Total
Care homes	-	1	-	2	-	-	1	3	2	1	1	11
Theoretical vacancies	-	6	-	19	-	-	1	8	3	1	-	38

Data: Surveys and Jadu data (if no survey), June/July 2021

- Based on the data self-reported to the council by care homes (Jadu data), there appears to be considerable spare capacity in the market.
- The care homes with low occupancy may have mothballed beds or their operational capacity may ordinarily be far lower than registered capacity.
- Low occupancy could increase the risk of homes closing. Though there is sometimes potential to convert facilities to the supported living model.

Wages in local mental health care homes

- 3 mental health care homes supplied wage data via surveys, though none supplied information about wages for management and administrative staff.
- All standard care worker wages were within a range of £9.11 to £9.22 inclusive of weekend and public holiday pay enhancements. This is basically the same as the average for older adult care homes.
- Senior care workers and team leaders in the mental health care homes were paid either £9.42 or £10.21 per hour inclusive of enhancements.
- There were no night pay rates different to the daytime.
- We also found several jobs in mental health care homes advertised on the internet. These job advertisements are consistent with the survey data and confirm that care worker pay is aligned to the older adult care home market. This is unsurprising as local mental health care homes do not generally appear to support individuals with complex needs.

Care worker and nurse hours

Care worker hours per resident week calculated from the care rota

Type of unit	Sample	Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
Care workers only								
Residential (MH)	1	18.3						
Nursing (MH)	1	18.6						
Residential (OA)	47	15.4	19.0	21.7	25.7	30.9	36.7	61.6
Nursing (OA)	28	14.4	18.7	20.5	22.7	27.2	38.6	77.0
Care workers & nurses combined								
Nursing (MH)	1	23.8						
Nursing (OA)	28	22.2	25.2	27.1	29.9	33.6	47.2	92.4

Data: Anonymous surveys

Notes:

1. The table is calculated from care rotas and include adjustments for unpaid breaks.
2. We are not aware of the staffing assumptions in any MH model with which to make any comparisons. However, compared to older adult care homes, this staffing in the mental health care homes is towards the low-need end of the market.

- Mental health units offering standard rates typically have lower staffing ratios than standard older adult care homes. There are multiple reasons for this including: (i) hands-on support with personal care is relatively rare; (ii) many residents can access the community independently; (iii) significant support from staff is often not needed with many residents unless they experience a crisis.
- The limited amount of data we have collected about the Lincolnshire care home market is consistent with this assumption.
- One mental health unit operates a 1 to 6.5 care worker ratio all daytime and more than 1 to 12 at night, totaling 18.3 hours per resident week.
- Another mental health residential unit for which we have data from a Healthwatch visit (not shown above) stated the home operated at 1 to 7 staffing ratio during both day and night, supplemented by a shared manager with another service. One of the workers at night is sleep-in.
- The nursing unit (above) operates a 1 to 5.5 staffing ratio including the nurse all daytime and 1 to 9 at night. This is a total of 18.6 hours per resident week. The unit shares a nurse at night with another nursing unit, so only has a total of 5.5 hours per resident week in addition to the care worker hours shown above. It is unclear how many residents in these units have nursing needs.

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Lincolnshire learning disability care home market review 2021-22

16 November 2021

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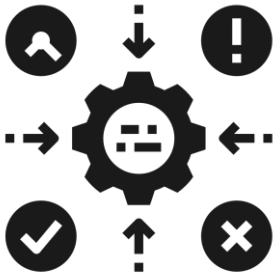
Introduction



About

This report details the findings from Care Analytics independent review of the learning disability care home market in Lincolnshire as of the summer 2021. The findings are limited to those we could publish in the public domain without breaching the commercial confidentiality of either the care home providers who supplied data for this review or the council.

Much of the analysis in this report is based on anonymised surveys completed by care home providers. Care Analytics would like to thank all care homes and provider groups who contributed to this review.

The market review was commissioned by Lincolnshire County Council (LCC) as part of its own review of its care home commissioning.

LCC have undertaken similar exercises on a 3-year basis to underpin its commissioning strategy since at least 2008.

The main aims of the market review from a council perspective were:

- To analyse the costs of service delivery in Lincolnshire care homes to inform the weekly fees that will be set by the council.
- To compile an evidence base to inform the development of the council's future commissioning and commercial strategy, including mapping geographical variations in costs, facilities, and services across the county.
- To identify local trends, issues, pressures, and opportunities, including comparisons against national trends.

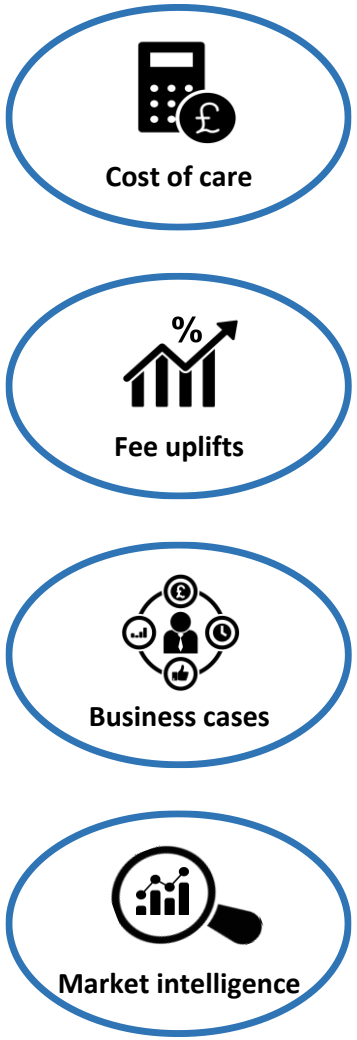
LCC may use the analysis within this report to create its own cost models to help inform its weekly rates for learning disability care home placements. Care Analytics brief is limited to providing an evidence base to help the council make such decisions.

Whilst the primary aim of this report is to provide an evidence base to support council commissioning, we have tried to make the report as useful as possible for care home providers in Lincolnshire.

Disclaimers

Every effort was taken to ensure the accuracy of the information in this report at the time of writing. However, Care Analytics accepts no responsibility for any errors or omissions contained therein. Care Analytics also accepts no responsibility for actions taken or refrained from by reference to the contents of this and any related documents.

Care Analytics



- This project was undertaken by Care Analytics two directors, Jason Hedges and Chris Green, who between them have 30-years of experience working in adult social care and its interfaces.
- We specialise in the financial analysis of care and support services. Underpinning this, we have:
  - ✓ Wide-ranging experience analysing care markets.
  - ✓ In-depth knowledge of the cost of care for all client groups and care settings within adult social care.
  - ✓ Expertise in cost models, financial modelling, and business analysis.
  - ✓ Detailed knowledge of social care policy, regulation, and legislation.
  - ✓ Extensive experience developing business cases in the public, for-profit and voluntary sectors.
- Our customers are councils, CCGs, regional organisations, and care providers.
- More information about our services can be found on our website: https://careanalytics.co.uk/

Glossary

LCC	Lincolnshire County Council.
CQC	Care Quality Commission. The CQC is the independent regulator of health and adult social care in England.
FNC	Funded Nursing Care. This is what the NHS pays for the nursing care component of nursing home fees.
Prw	Per resident week (such as food costs of £30 prw or 24.0 care worker hours prw).
Unit cost	The total cost needed to supply one unit of a particular product or service. In this instance, a care home placement per week.
Capital cost	Fixed, one-time expenses incurred on the purchase of land, buildings, construction, and equipment.
'Sunk' capital cost	Capital costs which have already been paid for and for which there is no outstanding finance cost (no loans or mortgage).
Operating profit	Profit but excluding consideration of capital costs (whether funded by loan finance or owner equity).
Percentile	The number below which a certain percentage of values occur. For example, the 10th percentile of a particular cost means 10% of the sample has lower costs and 90% higher costs.
Median	The middle number of a series ranked high to low. This is a type of average.
Mean	Add up all the numbers and divide by the number of instances. This is usually what people refer to when they talk of average.
Trimmed mean	The mean but ignoring a certain percentage of the highest and lowest values. In this report, unless otherwise stated, the trimmed mean ignores the lowest 10% and highest 10% of costs. This helps ensure outliers and data errors are excluded. It is sometimes necessary to exclude more than 10% of costs to ensure the sample is reflective of standard-rated care.
Independent care home	A provider who operates only one care home. In this report, care homes are grouped based on either brand or provider links in the CQC care directory. This misses many small groups where an owner operates multiple care homes as separate companies.
Provider group	A provider who operates more than one care home.

Evidence used to inform the review

Provider data

- Anonymised provider surveys (discussed on the next page).
- Telephone conversations with four of the largest providers of learning disability care homes in the county.

Public domain data

- Lincolnshire care home CQC inspection reports 2015-2021.
- Wages and terms & conditions from 200+ job advertisements.
- Skills for Care data about Lincolnshire and East Midlands.
- Statutory accounts of main provider groups operating in the county.
- House sales data at the location of each learning disability care home in the county, including 35 properties with the exact address as the care home.
- Provider websites and other online information.
- Various public data sets, such as the CQC care directory, inflation indices, postcode and geospatial data, ASC-FR and other statutory returns.

Council data

- Care home placements data (snapshot as of July 2021).
- FNC data for council-funded placements.
- Resident data based on weekly submissions by care homes to LCC ('Jadu' data).
- Covid-19 funding allocations.
- Semi-structured interviews with leads from each client group, and key staff within LCC's finance and commercial teams.

Care Analytics data

- Care Analytics care home database (which is based on the CQC care directory, but with extensive data cleansing and the addition of analytical fields to extend the range of possible analysis).
- Care Analytics extensive range of evidence about the cost of care.

Survey data quality

Learning disability care home survey responses by national group size (number of care homes in England)

Survey status	<5 homes	5-19 homes	20+ homes	Total homes	<5 homes	5-19 homes	20+ homes	Total Homes
Submitted something	6	17	45	68	50%	85%	75%	74%
Not submitted anything	6	3	15	24	50%	15%	25%	26%
Total care homes in Lincolnshire	12	20	60	92	100%	100%	100%	100%

- The learning disability care home market in Lincolnshire is dominated by medium-to-large provider groups. We were successful in achieving a good level of engagement from these providers, even though most groups in this sector rarely supply data for exercises like this one. In addition to confidentiality concerns, many providers claim that their services cannot be standardised or easily compared to market 'averages'. This is a view we have sympathy with, in so far as it is difficult to compare cost profiles for (i) large care homes and very small homes, (ii) homes with a shared daytime care rota and homes supplying one-to-one support as standard, and (iii) stand-alone homes versus those with more campus-style arrangements.
- Where we present data in this report, we try to caveat appropriately where results are likely to differ between different 'types' of learning disability care home. To give a fuller picture of the market, we also show the distribution of results at various percentiles (minimum, 10th percentile, 25th percentile, median or 50th percentile, 75th percentile, 90th percentile and maximum) in addition to averages.
- Owing to factors like the above, the survey data we have collated is of variable quality depending on the area of analysis. For example, we successfully collated care worker wages and terms and conditions for 72% of the learning disability care homes in the county. By contrast, data in relation to facility standards, staffing levels, and detailed cost breakdowns was more variable and limited.
- One provider group operating in the county supplied a detailed group-level cost breakdown. Another supplied a standardised unit cost template they provide to councils. Their cost data provides a useful contrast to the to other care home-specific cost data submitted. However, even though they collectively account for a large proportion of the care homes in the county, we cannot include the cost data for these two groups in much of the statistical analysis as it would be distorting. Such comparisons are discussed in context in the section on non-staff operating costs.
- Another provider group was happy to talk in detail about their services and costs but could not provide home-level cost data, as it would have entailed a significant accounting exercise for them (as they do not account for many costs at the home level).

Analysis and interpretation

- Much of the analysis in this report is dependent on the accuracy of the information supplied by the respective providers via either a survey or telephone interviews. However, Care Analytics extensive experience working in the sector means we can analyse the data from a critical perspective and provide commentary on how to interpret the data.
- Unlike the larger older adult care home market, for learning disability care homes, there are issues presenting some results based on sub-sets of the data (such as splits of the data by geography, type of provider, or home size). Even where we have excellent data from a good sample of care homes, we cannot give it greater focus in this report as it would risk breaching the confidentiality rules under which care homes have supplied their data. This is unavoidable, particularly given many providers operate in geographical clusters (see pages 31-33).
- Wherever possible, we have provided supporting evidence from other data sources to validate and contextualise the survey data.
- We have also included a range on analysis based on non-survey data to offer the best possible review of the market. However, we have excluded analysis using external datasets which we feel would be unfair for the respective provider to include in a public report. This includes analysis of statutory accounts of key providers in the county which we have shared with the council separately.
- We have also extensively analysed council commissioning data as part of this review. However, we have excluded any analysis which we feel would potentially be commercially confidential to either the council or the respective providers from whom the council buys services.
- Most of the non-survey analysis in this report, including comparisons between Lincolnshire and the rest of England, is based on care homes that Care Analytics have classified as predominantly supporting adults with a learning disability or autism. In practice, many care homes support individuals with a range of needs, including but not limited to combined learning and physical disability, and combined learning disability and mental health needs. This has a small error margin where judgement is required as to the predominant support category. However, this small error margin from classification is necessary, as without it, it is otherwise extremely difficult to compare different care markets across the country.
- We would also note that analysis using Care Analytics care home database varies throughout this report from either January 2021 or April 2021. There are some parts of our database we only update annually at the start of each year, and some quarterly. April was the latest complete quarter when we started this project.
- Finally, we would emphasis that interpreting care home markets is sometimes difficult without an understanding of both supported living and shared lives, as these are crucial alternative types of support for much of the client population. These services are outside of scope of our review. There is also no definitive data source for supported living and shared lives placements to benchmark nationally or regionally.

Overview of the learning disability care home sector

- Care homes deliver support plus board and lodgings as part of a holistic service. Residents are not granted tenancy rights. Care homes are legally and operationally split between those that provide nursing care and those that do not.
- Care homes are regulated and quality assessed by the Care Quality Commission (CQC). However, there is a great deal of discretion in terms of how care and support is delivered. Much of the way the market operates has therefore developed organically.
- Based on Care Analytics care home database, as of January 2021, there are 4,766 care homes in England which predominantly support adults with a learning disability. These homes collectively have a registered capacity of 38,357 beds. However, it should be noted that, for various reasons, registered capacity is often quite a bit higher than operational capacity in many learning disability care homes.
- Only 205 (4.3%) of the 4,766 care homes which predominantly support adults with a learning disability are registered for nursing.
- The sector is a fragmented one, varying from large national groups operating thousands of beds to small businesses with one or two care homes. Across England, the groups with more than 50 homes collectively operate only 25% of beds in the market (Care Analytics database January 2021).
- The vast majority of funding for placements within learning disability care homes are via councils and to a lesser extent CCG's.
- Unlike older adult care homes, only a very small minority of residents are 'self-funders' who pay for their own support in its entirety. Furthermore, public-sector funded placements are rarely supplemented by third-party top-ups from family, friends, and charities to live in preferred facilities.
- The 2019-20 Adult Social Care Finance Return indicates that there are 22,750 adults with a learning disability aged 18-64 and 5,265 adults with a learning disability aged 65+ funded by councils in care homes in England. Although most of the respective care homes will specialise in support for adults with a learning disability, some may be in older adult care homes, or in care homes that mainly support residents with other primary needs.
- Most of the other residents will be placed by NHS Clinical Commissioning Groups (CCGs). There is no statistics available for their numbers.
- A large number of care home residents with learning disabilities could potentially have their needs met in supported living or shared lives placements. The balance of clients in different care settings varies among councils and CCGs depending on commissioning practice and the availability of different services locally. This has also evolved over time with many care homes converting to supporting living.
- In any analysis we have undertaken of care markets for adults with a learning disability, prices drop significantly by age group. The are various reasons for this relating to acuity of need, risks associated with strength/frailty, and decisions about the appropriateness of care settings.

Registering the right to support

- Since their relatively new policy – Registering the right support – was introduced in 2017, the CQC have considered larger care homes supporting adults with a learning disability or campuses comprised of different units to be poor practice. The general intention appears to be that learning disability care homes should be indistinguishable, as far as practically possible, from general-purpose housing.
- New care home registrations in this client group must generally have 9 beds or fewer. The CQC policy also limits the ability of providers to expand the capacity of existing homes based on the same principles. This was mentioned in a few surveys submitted by providers as limiting options.
- The nine-bed rule is an informal rule of thumb, rather than an official policy. The CQC state it is about a care home being able to offer person-centred care. The average size of registrations since April 2018 is 4.75 beds. Of the homes registered since 2018, only 48 out of 319 have more than 6 beds and only 3 more than 9 beds. In the preceding 3 years, the average size was 6.15 beds, and more importantly 29 out of 354 home were over 9 beds.
- While the new rules have had a positive impact on preventing inappropriately large and non-personalised care homes, the rules around registering the right to support, in combination with the requirements for new registrations in the Care Standards Act, has implications for market incentives.
- First, few providers will build new care homes for working-age adults with more than nine beds, as CQC refusal of registration would be considered a catastrophic financial risk for any business case. At best, the site would have to have a subsequent (and costly) conversion to supported living. Indeed, a number of providers have indicated that the ‘safe’ size for registration is only six beds.
- Second, large existing facilities will likely stay in the market for longer than they would otherwise do as they will not be replaced.
- Third, the business case for building supported living flats is much strengthened as the CQC rules are less strict, with no restriction on the size of a facility, as registration is only for the delivery of personal care. Registration can also be for multiple sites, reducing management costs.
- Fourth, new-build care homes for adults with a learning disability are now mostly aimed at the high-need / high-cost market, essentially providing one-to-one support throughout the day as standard. Not only are the potential financial returns based on shared care models in smaller care homes much lower than one-to-one models, but the risks associated with reduced occupancy are much greater.
- Care Analytics believe the CQC policy is, at least to some extent, counterproductive. One-to-one care home models often offer limited prospects for increasing independence as there are unlikely to be other residents to share any reduced support. In turn, the policy may lead to people with a learning disability being permanently ‘trapped’ in small homes owing to the challenges involved in moving home to a service with lower support levels. Care Analytics view is that care homes with additional or nearby stepdown flats are supportive of enablement models of support, and we hope there will be more flexibility in this area in the future.

The Covid-19 pandemic and care homes

- The first national Covid-19 action plan was announced on 3rd March 2020, the first guidance for reducing the risk of transmission in residential settings (including care homes) was published on 13th March 2020, and the first national 'lockdown' started on 23rd March 2020.
- Initially, compared to older adults, there was not much focus on risks to people with a learning disability. Public Health England research in November 2020 and July 2020 flagged that people with a learning disability were between 4 and 8 times more likely to die of Covid than the general population.
- Within Lincolnshire, occupancy in learning disability care homes was reported at 90% in the 2017 analysis. Our analysis (see page 21) indicates an average occupancy of 80% now, though this likely exaggerates the true level of vacancies as some unoccupied beds will be non-operational. The comparison is also imperfect as the samples used in 2017 to calculate occupancy may not be commensurable to 2021. Our judgement is that there has been a fall in occupancy compared to 2017, though this may have happened prior to the Covid-19 pandemic.
- No learning disability care home provider mentioned that Covid-19 had materially affected their occupancy.
- It is believed that deaths in learning disability homes have remained lower than older adults both because of less susceptibility to the virus, and because homes are much smaller and there is therefore less risk of an infection outbreak.
- People with a learning disability in care homes were slightly less likely to die of Covid than those living in the community.
- New stringent, infection control measures are now in place. There are also additional testing requirements. Now much of the population is vaccinated, it is hoped the sector will return to largely standard operation by spring 2021, post the winter flu season. However, the impact of the requirement for care workers to be double vaccinated from November 2021 rightly concerns many stakeholders.
- Given Covid-19 is now certain to remain an ongoing feature of the 'new normal', it is extremely likely the 'new normal' will require use of PPE and other infection control measures more stringent than historic practice. This will add additional cost to standard care home operations.
- Additional central government funding, currently extended to the 31st March 2022, is likely to reduce/stop at some point in the future, so residual costs will fall on councils, CCG's and self-funders.
- Such costs need to be considered at the point additional central government funding is withdrawn. However, it is not currently possible to reliably estimate the additional costs associated with the 'new normal', as it will depend on the requirements stipulated in government guidance (or what is deemed best practice) at the time. However, as indicated by requests for government funding, additional ongoing Covid-19 costs in the learning disability care home sector are likely to be material but not highly significant cost moving forward.

Care home market

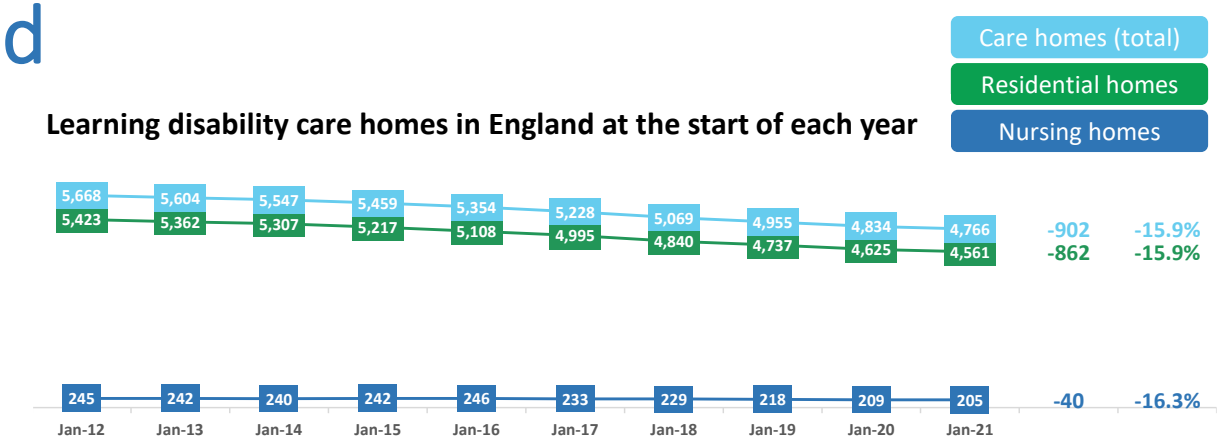
Market capacity across England

Registered beds in learning disability care homes (Apr 21)

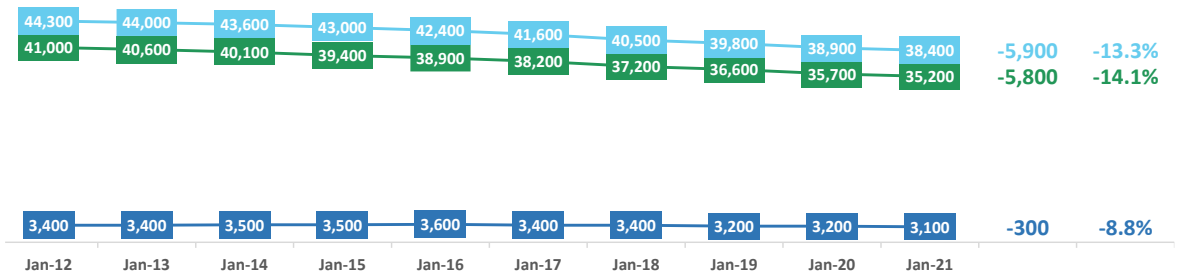
Area	Beds	Beds per 1,000 population Aged 15-64	Aged 15+
London	3,452	0.6	0.5
North West	2,809	0.6	0.5
North East	1,586	0.9	0.7
England	38,357	1.1	0.8
East of England	4,330	1.1	0.8
West Midlands	4,300	1.1	0.9
Yorkshire and The Humber	3,992	1.1	0.9
Shire Counties	21,471	1.3	1.0
East Midlands	4,424	1.4	1.1
South East	8,302	1.4	1.1
South West	5,162	1.5	1.1
Lincolnshire	933	2.0	1.5

Data: Care Analytics care home database and ONS population data (2020)

Learning disability care homes in England at the start of each year



Beds in learning disability care homes in England at the start of each year



Data: Care Analytics care home database

- Per capita, Lincolnshire has a very large learning disability care home market, almost twice the national average and roughly 50% bigger than the average for Shire Counties.
- LCC buys almost all its placements in learning disability care homes in county (p. 24). As such, the county is a large net importer of placements (p. 20), particularly in the high-need high-cost end of the market.
- Across England, the number of learning disability care home beds is reducing (down 13% since January 2012). However, our understanding, partly based on analysis elsewhere in other parts of the country, is that this is more a result of the growth in the supported living sector (and to a lesser extent shared lives), rather than any fundamental scaling back of capacity for placements providing 24-hour support.

Market capacity across Lincolnshire

Learning disability care home market capacity across Lincolnshire (Apr 2021)

					East		West		South	
Category	East	West	South	Total	Boston & Skegness	Louth	Lincoln & Hykeham	West Lindsay	Grantham, Bo.&Stam.	Spalding & Sleaford
Care homes										
Nursing homes	1	6	1	8	-	-	2	5	-	1
Residential home	35	31	18	84	16	17	13	11	9	18
Care homes (total)	36	37	19	92	16	17	15	16	9	19
Registered beds										
Nursing homes	35	87	27	149	-	-	25	97	-	27
Residential homes	361	264	163	788	160	173	108	112	75	160
Care homes (total)	396	351	190	937	160	173	133	209	75	187
Beds per 1,000 people aged 18-64										
Nursing homes	0.3	0.6	0.2	0.3	-	-	0.2	1.8	-	0.3
Residential	2.9	1.8	1.0	1.8	2.3	3.7	1	2.1	0.9	2
Care homes (total)	3.2	2.4	1.2	2.2	2.3	3.7	1.3	3.9	0.9	2.3

Data: Care Analytics care home database combined with team postcodes supplied by LCC

- The boundaries for the six area teams do not precisely match the three broad areas (East, West, and South). This causes differences in results as shown.
- Per capita analysis is not always a good indication of supply and demand for learning disability care homes. However, there is a much lower registered bed capacity in Grantham, Bourne & Stamford compared to the other team areas.
- Capacity in learning disability nursing homes is predominately located in the west of county (6 out 8 homes). The two nursing homes in the south and east are large with 35 and 27 beds respectively. It is unclear why there are so many nursing homes in the west of the county. They are a mix of providers with one or two nursing homes.

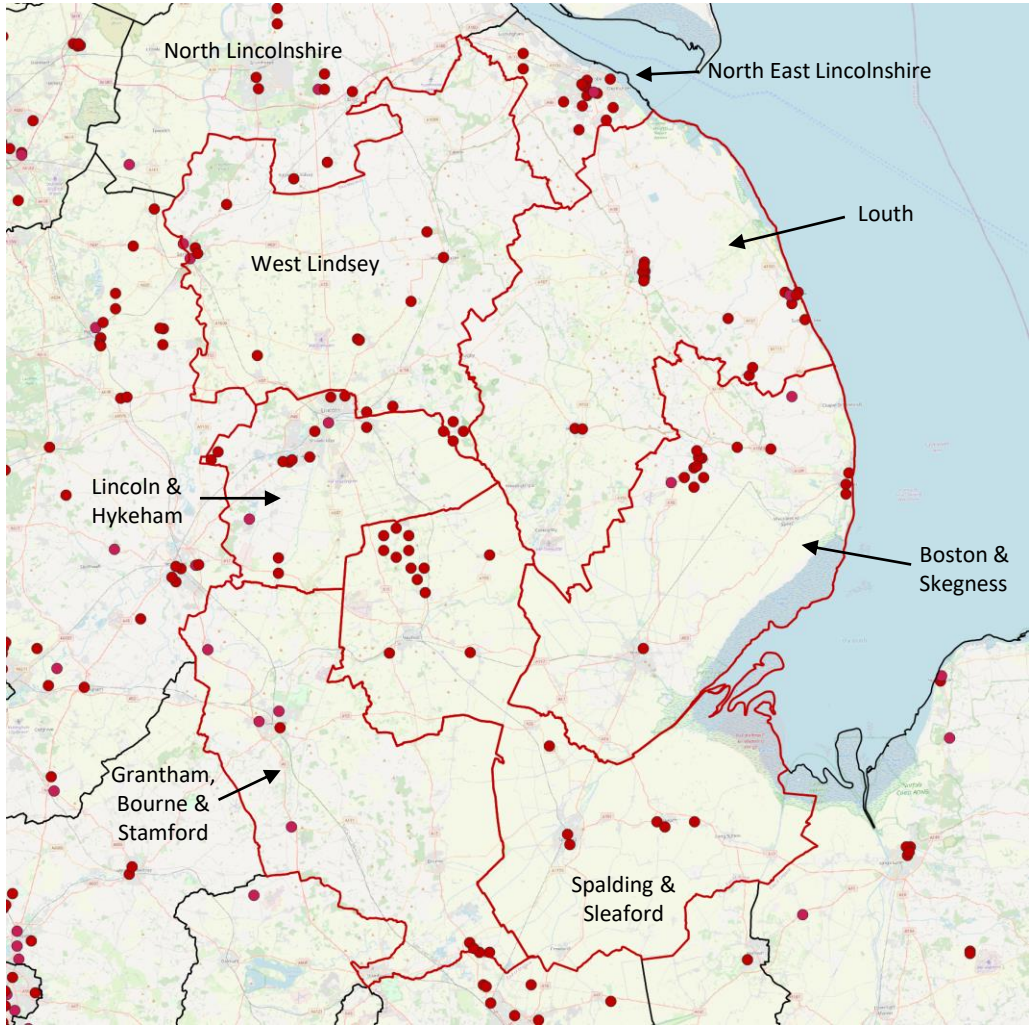
Learning disability care homes

Learning disability care homes in Lincolnshire (Apr 2021)

	East		West		South		
Category	Boston & Skegness	Louth	Lincoln & Hykeham	West Lindsey	Grantham, Bo.&Stam.	Spalding & Sleaford	Total
Care homes	16	17	15	16	9	19	92
Beds	160	173	133	209	75	187	937
Beds per 1k 18+	1.6	2.4	1.0	2.7	0.7	1.6	1.5
LCC placements	77	89	42	90	34	81	413
LCC % of beds	48%	51%	32%	43%	45%	43%	44%

Data: Care Analytics care home database combined with LCC commissioning data

- Team area boundaries on the map are approximate in some locations owing to postcodes allocated to a team outside of administrative boundaries.
- Some care homes on the map have point displacement (moved so they show up) as many homes operate at same postcode or nearby locations.
- Learning disability care homes are often clustered together. This relates to: (i) the location of towns, (ii) areas with large detached homes, (iii) providers concentrating services seeking operational synergies (see pages 31-33).
- There are clear differences in levels of supply throughout the county. This appears to often relate to where specific providers have chosen to operate, rather than anything more fundamental. However, Boston stands out as only having one learning disability care home.
- Local knowledge of supported living provision is often needed to make sense of patterns of learning disability care home supply.



Care home size

Comparison of registered bed capacity between Lincolnshire and other parts of England

	Registered bed capacity									
Category	1-2	3-4	5-6	7-8	9-10	11-15	16-25	26-40	41+	Total
Lincolnshire homes	4	4	20	20	15	15	10	4	-	92
Lincolnshire beds	7	15	115	154	142	192	186	126	-	937
Percentage of beds										
England	1%	8%	21%	18%	13%	16%	13%	5%	5%	100%
East Midlands	1%	5%	18%	14%	12%	17%	19%	11%	3%	100%
Shire Counties	1%	8%	21%	16%	14%	15%	13%	6%	7%	100%
Lincolnshire	1%	2%	12%	16%	15%	20%	20%	13%	-	100%

Data: Care Analytics care home database

- There are few small learning disability care homes in Lincolnshire. Only 9% (8 of 92) of homes have 1-4 registered beds, whilst only 30% (28 of 92) of homes have registered capacity of six beds or fewer. These homes only account for 3% and 15% of beds respectively in Lincolnshire. In this respect, Lincolnshire is an outlier compared to averages for England (30% of beds in home with fewer than 6 beds), the East Midlands (24%), and Shire counties (30%).
- Lincolnshire mirrors the East Midlands in having large learning disability come homes compared to averages for England and the Shire Counties.
- Some larger care homes will likely operate much like older adult care homes. In such homes, costs should correspond quite well. This said, home size is not always a reliable indicator of operational realities, as some of the larger care homes in the county are comprised of two or more buildings.
- New care home registrations in this client group must generally have fewer than 7-9 beds. See page 11 for a fuller discussion of the CQC policy: Registering the right support. A good proportion of the current care homes in the county would likely not be allowed to register if they were new.
- Care homes with materially different sizes are also likely to have qualitatively different staffing and cost profiles to varying extents. These are discussed in context in later sections throughout this report.

Changes in registered bed capacity

Changes in registered bed capacity by type of change: January 2014 to January 2021

Category	Lincolnshire	England	East Midlands	Shire Counties	Unitary Authorities	Metropolitan Districts
Beds as of January 2014	909	43,578	4,698	24,142	7,764	7,444
Beds in newly registered homes	71	4,412	622	2,308	798	986
Increased beds in same home	12	895	103	523	106	210
Beds in deregistered homes	-46	-9,728	-929	-5,017	-1,739	-1,895
Reduced beds in same home	-13	-800	-70	-485	-130	-110
Beds as of January 2021	933	38,357	4,424	21,471	6,799	6,635
Beds as a percentage of registered capacity as of January 2014						
Beds in newly registered homes	1.1%	1.1%	1.7%	1.1%	1.2%	1.2%
Increased beds in same home	0.2%	0.2%	0.3%	0.2%	0.2%	0.3%
Beds in deregistered homes	-0.7%	-2.5%	-2.6%	-2.3%	-2.6%	-2.3%
Reduced beds in same home	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.1%
Net change						
Net change in registered beds	24	-5,221	-274	-2,671	-965	-809
% net change	2.6%	-12.0%	-5.8%	-11.1%	-12.4%	-10.9%

Data: Care Analytics care home database

- This analysis is based on 'linking' new CQC location IDs in Care Analytics care home database (so a new registration of an existing home is not counted as new).
- Despite its large number of beds per capita, Lincolnshire's market is growing in terms of net change in registered bed capacity (+2.6% since January 2014). This compares to significant falls in capacity England, the East Midlands and all types of council grouping.
- This is a likely a consequence of lower property prices in the county compared to other nearby areas, making it attractive to register here.
- Another factor in local market growth is that the switch of care homes to supported living, which is common in wealthier areas of the country, does not appear to be occurring in Lincolnshire.

Changes in learning disability care homes

					East		West		South	
Category	East	West	South	Total	Boston & Skegness	Louth	Lincoln & Hykeham	West Lindsay	Grantham, Bo.&Stam.	Spalding & Sleaford
Care homes										
Deregistered homes	3	3	4	10	2	1	1	2	2	2
Newly registered homes	2	12	2	16	2	-	5	5	2	2
Net change	-1	9	-2	6	-	-1	4	3	-	-
Registered beds										
Deregistered homes	14	29	14	57	9	5	15	14	7	7
Newly registered homes	10	67	12	89	10	-	28	25	12	14
Net change	-4	38	-2	32	1	-5	13	11	5	7
Current beds	396	351	190	937	160	173	133	209	75	187
Net change as a %	-1%	11%	-1%	3%	1%	-3%	10%	5%	7%	4%

Data: Care Analytics care home database combined with team postcodes supplied by LCC

- The boundaries for the six area teams do not precisely match the three broad areas (East, West, and South). This causes differences in results as shown.
- Of the 10 deregistered homes, there are 2 homes from Voyage, Linkage and Sense respectively, plus 3 independents and one other group.
- 5 of the 16 newly registered homes are Home from Home Care, and 2 each from Boulevard, Kisimul, Elysium Healthcare, and Hopskotch Solutions.
- The market has disproportionately grown in the west of the county. Part of the reason is that Home from Home care is based in this region.
- This data should be cautiously interpreted. Learning disability care homes can register and deregister for various reasons. The data is also not necessarily indicative of care home closures as many care homes may have converted to supported living.

Resident mix

Resident mix in Lincolnshire learning disability care homes (excludes 13 care homes with no data) – LCC placements are by all client groups

Category	LCC (inc. joint)	Other council	Lincs CCG	Other CCG	CCG unspecified	Self funder	Other funder	Total residents	Registered capacity	Mean occupancy
Nursing homes	95	11	-	-	10	3	-	119	149	80%
Residential homes	322	240	13	19	18	4	5	621	788	79%
Care homes (total)	417	251	13	19	28	7	5	740	922	79%
% of residents	56%	34%	2%	3%	4%	1%	1%	100%		
% of beds	45%	27%	1%	2%	3%	1%	1%	80%	100%	

Data: Surveys and latest weekly Jadu data submissions to LCC (if no survey), June/July 2021

- There are 11 care homes where we have no survey or Jadu data. These include 4 Sense homes, 4 Kisimul homes, and 3 others. These appear to be mostly small homes supporting individuals with high needs and associated costs.
- A further 2 Linkage care homes with a total of 15 beds have no residents within their latest Jadu submission and so are excluded from the analysis on this page. This is likely a data error as LCC finance data suggest the council has a few placements in these homes.

Resident mix by broad geographic area (excludes 13 homes with no data)

Broad area	LCC (inc. joint)	Other council	CCG's	Other	Total
East	63%	33%	2%	2%	100%
West	42%	39%	17%	2%	100%
South	70%	25%	5%	0%	100%

Data: As above

- The exclusion of these 13 care homes distorts the analysis on this page a little as LCC's true market share in terms of the proportion of beds commissioned is lower than indicated.
- LCC (including joint funded) buy a greater proportion of beds in nursing homes (80% of residents compared to 52% in residential homes).
- There is geographical variation in resident mix, with many more CCG-funded placements in the west of the county (if the data is accurate). However, this may relate to the location of suitable providers more than anything else.

Occupancy

Occupancy and vacancies as a percentage of registered beds in learning disability care homes

	Occupancy (residents as a percentage of registered bed capacity)											
Category	<40%	40%-59%	60%-64%	65%-69%	70%-74%	75%-79%	80%-84%	85%-89%	90%-94%	95%-99%	100%	Total
Care homes	1	7	2	2	1	6	9	6	10	1	34	79
Percentage of homes	1%	9%	3%	3%	1%	8%	11%	8%	13%	1%	43%	100%
Theoretical vacancies	7	39	10	4	2	19	20	6	13	1	-	121
Mean vacancies per home	7.0	5.6	5.0	2.0	2.0	3.2	2.2	1.0	1.3	1.0	-	1.5
Percent of vacancies	6%	32%	8%	3%	2%	16%	17%	5%	11%	1%	-	100%

Data: Surveys and latest weekly Jadu data submissions to LCC (if no survey), June/July 2021

- The above analysis excludes 13 care homes where there is no survey or Jadu data. We do not know the occupancy in these homes, although we would note that many of them are small homes operated by providers who tend to support high-need individuals (4 are Kisimul and 4 are Sense).
- Average occupancy in the remaining learning disability care homes is 80% of registered beds (see previous page). This compares to a reported average of 90% in the 2017 analysis, though this was only based on a sample of 17 care homes (rather than the 79 above).
- The average occupancy is also not terribly meaningful because the market is heavily bifurcated.
- 43% of care homes report no vacancies whatsoever. This is similar to the 2017 analysis, where half of the sample of 17 homes reported no vacancies.
- By contrast, there are many learning disability care homes in the county seemingly with many vacancies. However, it is likely that much of this vacant capacity is not operational. For various reasons, it is common in the sector to have registered capacity higher than usual operational capacity.
- Occupancy analysis is also tricky where homes are small. For example, if a 5-bed home loses 2 residents in swift succession, occupancy drops to 60%.
- Multiple surveys explicitly stated that Covid-19 had not had an impact on occupancy, though one provider mentioned disruption to expansion plans.

CQC inspection ratings

Category	Outstanding	Good	Req. Imp.	Inadequate	No info	Total
Latest CQC inspection rating as of April 2021						
LD care homes in Lincolnshire	12	70	6	1	3	92
Lincolnshire % for LD homes	13%	76%	7%	1%	3%	100%
England % for LD care homes	4%	81%	9%	1%	5%	100%
England % of OA homes <20 beds	3%	76%	17%	2%	3%	100%
England % of OA homes 20+ beds	4%	72%	20%	2%	3%	100%
Lincolnshire inspections in LD care homes 2015-2019						
2015	-	93%	7%	-	-	100%
2016	-	82%	16%	2%	-	100%
2017		79%	15%	-	-	100%
2018	5%	74%	16%	5%	-	100%
2019	14%	70%	14%	2%	-	100%

Data: CQC care directory as of April 2021, linked to Care Analytics care home database

- The analysis of CQC inspection ratings stops at the end of 2019 owing to the Covid-19 pandemic. The CQC has limited its inspections to largely focus on infection control so later data would be incommensurate.
- The profile of results for learning disability care homes in Lincolnshire are fairly normal.
- However, Lincolnshire is exceptional in that it has a higher proportion of outstanding LD care homes resulting from inspections in 2019. This is unlikely to be just a one-year blip even though 2018 was much closer to national average.
- CQC ratings in learning disability care homes are on average markedly better than older adult (OA) care homes. A partial factor for this is the smaller average size of learning disability care homes. However, much of the difference remains even after this factor is taken into account.

LCC commissioning

LCC placements by location, care home type, and age group

Age group and location of care home placements for the learning disability client group

	Age group									
Location	18-25	26-44	45-54	55-64	65-74	75-84	85-94	95+	Total	Percent
Lincolnshire	24	136	97	88	69	24	1	-	439	90%
North Lincolnshire	1	3	3	4	2	1	-	-	14	3%
NE Lincolnshire	-	1	1	1	-	-	1	-	4	1%
Nottinghamshire	-	1	2	-	-	1	-	-	4	1%
Other	1	11	5	6	2	-	1	-	26	5%
Total	26	152	108	99	73	26	3	-	487	100%

Data: Placements data supplied by LCC finance linked to Care Analytics care home database

Age group and predominant care home type for placements by the learning disability client group

	Age group									
Care home type	18-25	26-44	45-54	55-64	65-74	75-84	85-94	95+	Total	Percent
Older adult	-	7	4	10	11	6	2	-	40	8%
Physical disability	-	1	2	-	1	-	-	-	4	1%
Learning disability	26	138	101	85	58	18	1	-	427	88%
Mental health	-	1	1	1	2	-	-	-	5	1%
Other	-	2	-	3	1	1	-	-	7	1%
Total	26	152	108	99	73	26	3	-	487	100%

Data: Placements data supplied by LCC finance linked to Care Analytics care home database

- LCC placements analysed on this page include those joint-funded with the CCG.
- 90% of LCC care home placements categorised as learning disability are in county.
- Many of the out-county placements are close to the borders. This indicates the county has most of the beds and type of supply LCC needs. Some urban councils we work with commission more than half of their placements in learning disability homes outside their boundaries.
- 88% (427 of 487) of LCC placements by the learning disability client group are – unsurprisingly – in care homes that Care Analytics classifies as predominantly supporting adults with learning disability or autism.
- 8% are in care homes that predominantly support older adults. However, there is one large older adult care home in Boston which is a mixed dementia and learning disability care home. We classify this home as older adult owing to the ratio of beds, and because most of its residents with a learning disability are elderly.
- We found no other evidence of learning disability care units in larger older adult homes in the county.

Price distributions by age group

Price distributions of placements by LCC in learning disability care homes by age group

	Percentile											
Category	10	20	30	40	50	60	70	80	90	Count	Mean	Mean age
All	£691	£749	£749	£749	£870	£990	£1,196	£1,853	£2,494	455	£1,261	49
Age under 30	£820	£990	£1,139	£1,626	£1,971	£2,339	£2,804	£3,104	£3,293	57	£2,002	25
Age 30 to 49	£749	£749	£795	£902	£990	£1,115	£1,591	£2,118	£2,557	179	£1,402	40
Age 50 to 64	£651	£749	£749	£749	£749	£843	£990	£1,087	£1,792	142	£991	56
Age 65+	£651	£697	£749	£749	£749	£749	£749	£749	£990	81	£858	72

Data: Placements data supplied by LCC finance (only includes placements in learning disability care homes, though placements can be made by any client group)

- In every council we have ever analysed learning disability care home placements data, price distributions and mean prices substantially decrease with each progressive age group.
- Among the under 30's, this is because only people with the most complex needs will be in care home placements, as this means family arrangements have broken down when they are young. With greater complexity and physical strength, the cost of support is much higher.
- High-need high-cost clients coming through transition with profound learning disabilities and complex physical disabilities and health conditions tend to die young. As such, this need profile (and the associated cost) is rare in the older age categories.
- Thresholds for entering care homes have also become higher over the years, and therefore many of the older residents with a learning disability would today be supported in the community. It is common to find older learning disability residents who can access the community independently.
- In addition, a mix of finding an appropriate care home, institutionalisation, and lower energy levels through age means the cost of support reduces for most clients as they age. The exceptions are those with progressive health conditions whose physical support needs increase.

Learning disability weekly unit cost comparisons (aged 18-64)

Care home weekly unit costs for learning disability clients aged 18-64

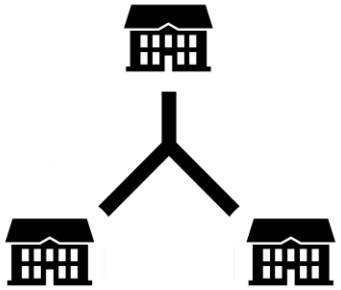
	Nursing		Residential	
Area	2018-19	2019-20	2018-19	2019-20
North Lincolnshire	£724	£749	£886	£749
Lincolnshire	£891	£943	£1,147	£1,187
Doncaster	£1,204	£1,224	£1,273	£1,224
Leicestershire	£960	£1,374	£1,296	£1,351
Norfolk	£1,274	£1,052	£1,064	£1,355
East Midlands	£1,073	£1,064	£1,376	£1,433
Rotherham	£1,056	£1,185	£1,185	£1,446
North East Lincolnshire	£681	£650	£1,474	£1,474
Peterborough	£1,771	£2,126	£1,496	£1,500
Yorkshire and The Humber	£1,638	£1,335	£1,452	£1,517
England	£1,316	£1,276	£1,523	£1,583
Nottinghamshire	£1,612	£1,951	£1,566	£1,618
East of England	£1,369	£1,440	£1,456	£1,620
Rutland	£0	£0	£1,617	£1,826
Cambridgeshire	£1,723	£2,451	£1,667	£2,571

Data: Adult Social Care Activity and Finance Report published by NHS Digital

- The Adult Social Care Activity and Finance Report (ASC-FR) is collected annually from councils.
- This is obviously a trailing indicator from 2-3 financial years ago, though comparisons are still informative.
- Numbers are rounded to the nearest £1.
- Nursing costs are shown net of Funded Nursing Contribution (FNC).
- Results are ordered low to high based on the far right column.
- Judgment is needed as specific council figures are not always reliable from year to year. There are also a great many confounding factors.
- The average level of need in care home settings can vary significantly depending on comparative use of supported living and shared lives in an area.
- Unit cost comparisons are also affected by the cost of in-house provision and block contracts (often with ex-council owned facilities) which are included within the numbers. This can be an upward or downward financial impact depending on how the council accounts for the various costs involved.
- Lincolnshire's unit costs are the second lowest. One reason will be the high number of beds per capita in the area, which lowers prices, and the large average size of care homes in the county, which lowers costs.

Lincolnshire learning disability care home market review

Care home providers



Providers in Lincolnshire by market share

Provider	Homes	Beds	Percent	Cumulative	Group size
Linkage Community Trust	17	158	17%	17%	Group
Prime Life	6	100	11%	28%	Group
Boulevard Care	8	78	8%	36%	Group
Home from Home Care	9	70	8%	44%	Group
Priory Group	3	63	7%	50%	Group
Kisimul Group	8	62	7%	57%	Group
Lifeways Community Care	6	47	5%	62%	Group
Sense	8	43	5%	67%	Group
United Health	1	35	4%	70%	Group
Cygnet Health Care	2	35	4%	74%	Group
Pearl Healthcare Group	1	34	4%	78%	Group
Grantham & District Mencap	1	22	2%	80%	Ind.
National Care Consortium	1	19	2%	82%	Group
Elysium Healthcare	3	17	2%	84%	Group
Voyage	2	16	2%	86%	Group
Kingsway (Clayton House)	1	16	2%	87%	Ind.
The Serenity Care Company	1	15	2%	89%	Ind.
Ayrshire House	1	15	2%	91%	Ind.
Mrs Sara Gibson	1	14	2%	92%	Ind.
Skitini Care Homes	1	11	1%	93%	Ind.
Other homes with <10 beds	10	63	7%	100%	Various
Total	91	933	100%		

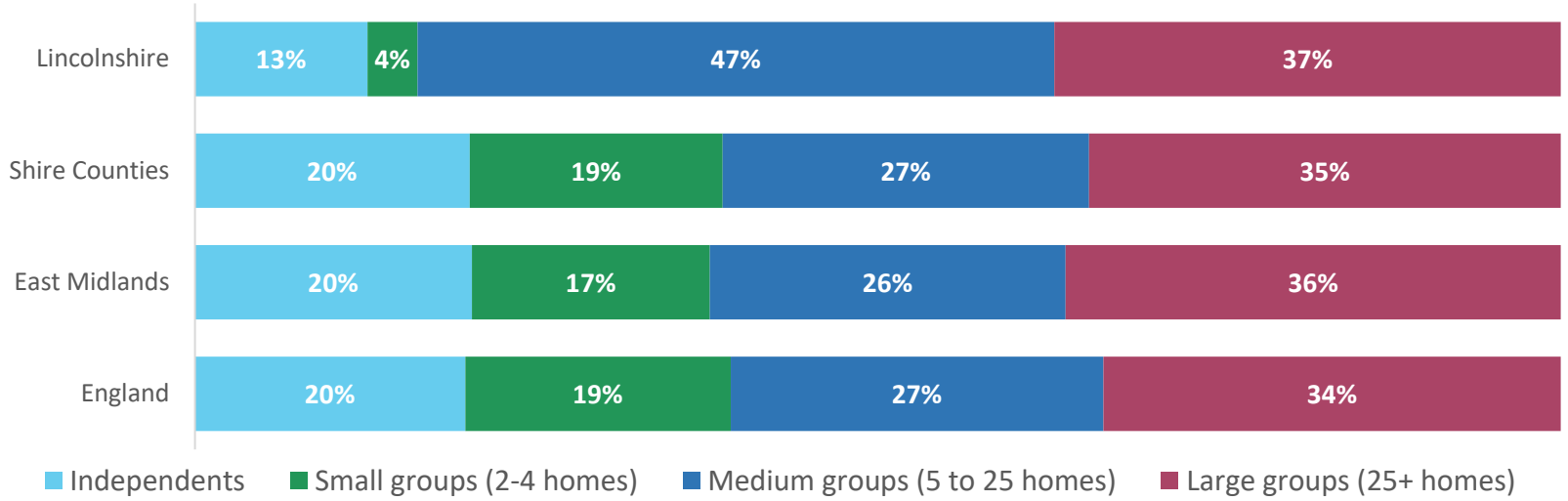
Data: Care Analytics database

- Care Analytics link care homes in our database using brand and provider IDs in the CQC care directory. However, many small and medium groups are not always linked in the directory as, for various reasons, they are registered through separate companies. This means some care homes we classify as independent may in fact be part of a group.
- The learning disability market in Lincolnshire is heavily concentrated among a few groups. 50% of registered beds are operated by only 5 groups, and 80% of beds by only 12 groups.
- The proportion of independent and small group providers is much smaller than regional and national comparisons (see next page).
- This is partly because Lincolnshire has three local providers which qualify as medium-to-large groups: Linkage, Boulevard and Home from Home Care.
- Of the other providers, Prime Life is largely based across the Midlands, whilst the Priory Group is a national provider who also operate mental health and older adult care homes.
- Kisimul, Lifeways and Sense are also national providers.

Market composition by provider group size

Percentage of registered beds in the learning disability care home market by national group size

Data: Care Analytics care home database



Care Analytics link care homes in the CQC care directory using brand and provider ID's. Many small and medium groups are not always linked in the care directory (as they are registered through separate companies for various reasons). This means the number of independent care homes are overstated, and small groups correspondingly understated.

- The learning disability care home market in Lincolnshire is dominated by medium-to-large provider groups.
- Although the demarcation point of 5 care homes is a little arbitrary, only 17% of beds in learning disability care homes are in Lincolnshire are operated by independent providers and small groups. This compares to circa 37-39% for the three regional and national comparisons.
- Marked differences in market composition compared to regional and national patterns is often a consequence of historical commissioning practices within a council. However, we lack a historical understanding of specific drivers of this pattern in Lincolnshire.
- Part of the explanation is that Lincolnshire has a few medium groups that are local to county and its immediate neighbours.
- Another explanation is that Lincolnshire appears to have a high proportion of homes operating one-to-one models of care, which is a largely corporate model of delivery. Most of the residents in these homes are 'imports' from out of county.

Care home sizes by provider

Comparison of registered bed capacity between providers in Lincolnshire

	Registered bed capacity								
Category	1-2	3-4	5-6	7-8	9-10	11-15	16-25	26+	Total
Linkage			2	5	7	2	1		17
Home from Home Care	1		3	1	2	2			9
Kisimul	1		2	1	3	1			8
Sense	1		6	1					8
Boulevard Care		1		3		4			8
Lifeways			2	2	2				6
Prime Life						2	4		6
Priory Group							3	1	3
Other providers	1		1	1	1	4	2		10

Data: Care Analytics care home database

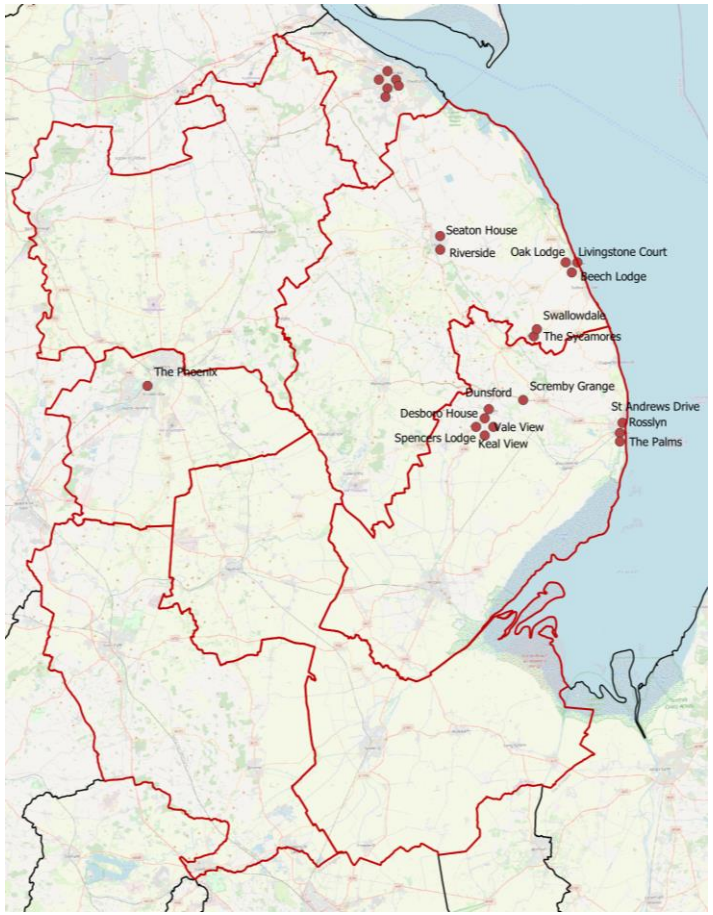
- Registered bed capacity is not necessarily an accurate reflection of operational realities. Some care homes will have a campus-style set-up, either with multiple buildings and potentially supported living flats on the same site. Supported living 'beds' will not be included in the care home registered capacity. Some care homes are also located very nearby to each other, which allows them to share staff.

- Differences in care home size between providers highlight different business models (and corresponding cost profiles).
- The Priory Group operates 2 nursing homes of 18 and 27 beds. This sort of minimum size is needed to reasonably efficiently cover the cost of a nurse.
- The main type of care home Prime Life operate are for older adults, though they also operate mental health and learning disability care homes. This may influence the type of provision they offer in their learning disability homes. Their smallest learning disability care home has 11 beds, and across England, their 15 learning disability care homes have an average of 19 beds.
- As far as we are aware, Home from Home Care, Kisimul, and Sense mostly operate high-need business models. As such they would not benefit from economies of scale associated with larger care home sizes.

Largest learning disability care home providers 1

Linkage Community Trust

17 care homes with 158 beds in Lincolnshire, which is 17% of all LD beds in the county.



Boulevard Care

8 care homes with 78 beds in Lincolnshire, which is 8% of all LD beds in the county.

Prime Life

13 care homes with 347 beds in Lincolnshire. Six of which are learning disability homes with a total of 100 beds.

Largest learning disability care home providers 2

Home From Home Care

9 care homes with 70 beds in Lincolnshire, which is 8% of all LD beds on in the county.

Kisimul Group

8 care homes with 62 beds in Lincolnshire, which is 7% of the LD beds in the county.

Priory Group

6 care homes with 181 beds in Lincolnshire. 3 of which are learning disability homes with a total of 63 beds.

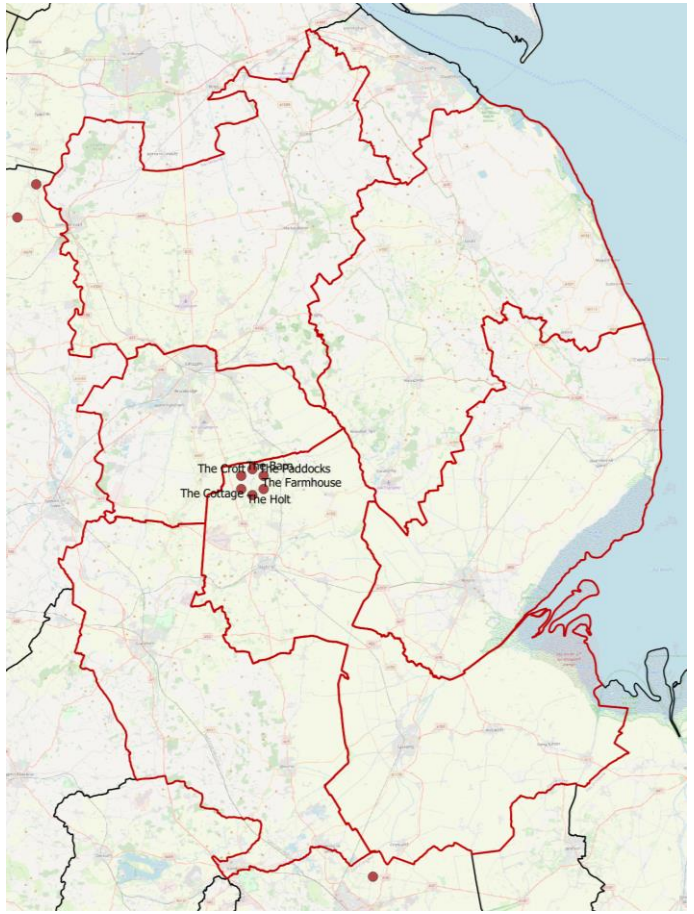
Largest learning disability care home providers 3

Sense

9 care homes with 50 beds, which is 5% of all LD beds in the county.

Lifeways Community Care

6 care homes with 47 beds, which is 5% of all LD beds in the county.



- The maps on these three pages have point displacement (moved so they show up) as many homes operate at same postcode or nearby locations.
- Lifeways operates 6 care homes, all located on Health Farm.
- Most of Sense's (see left) and Home from Home Care's (p.32) care homes are grouped in two locations. This (at least in theory) allows them to share management, back office functions and bank staff.
- Linkage and Boulevard's care homes are less tightly concentrated but are all grouped in the east of the county. (p.31)
- Kisimul mainly operate in the west of the county. (p.32)
- Priory (p.32) and Prime Life (p.31) both have care homes distributed across the county.

Staffing, wages and operating practices

Care staffing

Care worker hours prw in learning disability residential care homes

Category	Sample size	Mean	Trimmed mean	Distribution						
				Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
All responding care homes	23	33.0	33.0	8.2	11.2	21.4	30.3	40.9	52.3	86.7

- At least from the perspective of care staff, learning disability care homes can be split into two core business models.
- First, the more traditional model of delivery is based on shared staffing during for the day and night, with additional hourly support as required (usually during the day). The core staffing ratio during the day generally ranges between homes from 1 support worker to 8 residents to 1 support worker to 2 residents. The night-time staffing ratio is often lower, particularly when there is a relatively high number of staff to residents in the day. In this model, support at night is sometimes sleep-in but only where the residents have relatively low needs.
- We collected staffing data from 23 care homes offering the first, more traditional model. This data is shown in the table above. Hours varied from 8.2 hours per resident week (prw) to 72.44 hours. This analysis takes into account the occupancy of each home as it is based on the total hours on the weekly rota divided equally between all the residents in the home. Although the very low end of the range could be erroneous, there is nothing surprising about the range of hours as it is simply a function of the core staffing ratios plus sometimes an amount of additional one-to-one hours.
- Some of the homes with relatively low numbers of staff to resident ratios (e.g. one staff member to five or six residents during the day) function similarly to older adult homes. This is particularly the case in Lincolnshire because it has so many large learning disability care homes.
- The second, newer model of care delivery tends to have a default staffing ratio of one-to-one support during the day, with waking staff at night, usually based on some form of shared rota. With extremely high staffing levels, this model is largely designed to supporting residents with significant challenging behaviour. A common issue with this model of support is that there is no realistic prospect of stepdown support within many homes, as the standard (and often minimum) staffing ratio is one-to-one or above. This makes it difficult to offer less intensive support from the same care setting. It would also invariably represent a loss of revenue and profit for the provider.
- In both models, hours per resident are affected by the relative length of the daytime and night shifts. This is discussed on the next page.

Night-time shifts

Night shift length

Status	Homes	Percent
No survey	24	
No info (did not answer)	12	
8 hours	11	20%
9 hours	17	30%
10 hours	9	16%
11 hours	1	2%
12 hours	18	32%
Total responses	56	100%
Grand total	92	

Data: Anonymised surveys

- One provider influenced the above results. It is not common for learning disability care homes to operate 12-hour night shifts, as it is harder to reduce staffing levels when people are awake compared to older adult (mostly nursing) care homes.
- Many learning disability care homes also run multiple overlapping shifts throughout the day, so the definition of the night shift is not always as straightforward as is the case in older adult care homes.
- In most care homes, increasing the length of the night shift lowers costs, as the night staffing ratio is usually materially lower (less support).

Sleep-in night support

- Surveys included sleep-in rates from 20 care homes, though this was only from 6 different providers.
- Many care homes do not use sleep-in care workers.
- One provider paid £78.48 per night in all their homes.
- A national provider operating in the county paid £50.00 per night.
- A local provider paid between £45.00 and £55.00 per night depending on the staff members role / responsibility.
- One provider only paid £28.00 per night (if we have interpreted their survey correctly).

Care worker wages

Category	Care homes	Mean	Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
Team Leader	43	£10.20	£9.00	£9.50	£9.55	£9.91	£10.76	£11.67	£12.50
Senior care worker	22	£9.99	£9.32	£9.59	£9.59	£9.61	£10.21	£10.21	£12.50
Standard care worker	66	£9.32	£8.91	£9.00	£9.00	£9.09	£9.62	£10.28	£10.28
Team Leader (night)	9	£11.43	£9.52	£11.24	£11.67	£11.67	£11.67	£11.67	£11.67
Standard care worker (night)	33	£9.53	£8.99	£9.00	£9.39	£9.62	£9.65	£9.96	£9.96

Data: Anonymised surveys (with data confirmed by job advertisements where possible), with each care home counted once

- Hourly rates are inclusive of weekend and public holiday enhancements. Within this sector, there is often a trade-off in that providers sometimes have higher base pay with few enhancements, whilst others have lower base pay and more generous enhancements and other terms & conditions.
- All providers appear to have largely identical pay structures across each of their respective care homes. Distribution analysis by care home (as above) is therefore potentially misleading, as it is heavily influenced by the number of care homes operated by specific providers.
- A weighted average by beds would probably be lower than the overall mean as, on average, smaller care homes tend to be more specialist and pay higher wages. However, any average like this would itself be misleading, as (i) home size is not a good indication of total hours, and (ii) it would be an average of two or more things which are conceptually different.
- This also applies to some extent to the above sample. Many of the wages included in the above analysis in each category are not like for like. Even though all care homes may use ‘standard care worker’ (or equivalent) as a staffing category, there will be a skill component to some of the high wages, such as to deliver stepdown or for complex behavioural support.
- Any geographical differences we found relate appeared to relate to the providers operating in specific areas. We not found any obvious geographical patterns relating to more general local economic forces.
- The mean is higher than median because wages start to increase considerably past the median.
- As so many care homes supplied wages but not hours, we cannot calculate weighted averages using a large sample size.

Ancillary staff and managers

Category	Care homes	Mean	Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum
Activity staff	3	£9.22	£9.11	£9.11	£9.11	£9.11	£9.27	£9.38	£9.44
Nurse	3	£18.06	£17.37	£17.58	£17.88	£18.39	£18.41	£18.41	£18.42
Handyperson / Gardener	13	£10.91	£8.91	£8.91	£9.75	£11.83	£11.83	£11.83	£11.83
Cook	10	£11.35	£9.75	£9.97	£11.72	£11.72	£11.72	£11.72	£11.72
Domestic staff	5	£9.49	£9.11	£9.11	£9.11	£9.11	£9.44	£10.18	£10.67
Home Manager	25	£15.60	£12.50	£13.50	£13.88	£13.92	£14.65	£18.11	£31.17
Deputy Manager (non-nurse)	5	£12.86	£9.91	£9.91	£9.91	£9.91	£13.00	£18.15	£21.58
Deputy Manager (nurse)	1	£19.00	£19.00	£19.00	£19.00	£19.00	£19.00	£19.00	£19.00
Administrator	12	£9.55	£8.91	£9.47	£9.47	£9.47	£9.47	£10.12	£10.31

Data: Anonymised surveys (with data confirmed by job advertisements where possible), with each care home counted once

- There were no senior nurses, chef managers, head housekeepers, kitchen assistants, senior admin, or receptionists in any of the surveys.
- The sample sizes above (each care home counted once) are small as most learning disability care homes do not use many of these staff roles. Apart from large homes which operate more like an older adult care home, care workers are multi-functional roles in most learning disability care homes. In order to maximise independence, residents are often encouraged to clean and sometimes cook.
- Even where the sample size looks slightly larger (handyperson and cook), the fact that wages are the same for so much of the distribution is shows this is a single provider.
- Managers often work on the care rota for many of their hours. Depending on the set-up, home managers and deputy managers are often little more than team leaders. A lot of management in the traditional sense of the word will be undertaken centrally.
- Averages for these staff roles can therefore be misleading. In practice, roles with the same job title can be completely different. For example, a manager paid £31.17 per hour is not an equivalent job to a manager paid £12.50 per hour.

Recruitment

- The survey used a system of default answers about recruitment, i.e. the default was 'no recruitment issues' and required overwriting. This did not work well as most care homes did not complete this part of the survey. There is therefore little structured data to analyse.
- One provider stated that they are currently paying very high weekend premiums on a temporary basis to overcome recruitment difficulties.
- The following are free-text answers about recruitment included in learning disability care home surveys.
    - "*General staff recruitment is becoming more difficult. We currently have 20 vacancies centrally and across all locations.*"
    - "*Recruitment is the biggest challenge for staffing the home appropriately. Also, care staff leave after COVID-19 due to burning out and health issues. Staffing cost has been increased disproportionately*."
    - "*Recruiting is a big challenge, and it seems to be so irrespective, within reason, of the amount of hourly rate been offered.*"
    - "*It is very difficult to recruit in Louth*."
    - "*All recruitment in Louth is extremely difficult and this has been exacerbated by Covid 19. Although we have introduced the use of a <company> relief team we are forced to use more agency staff than we would choose*."
- Care Analytics would note that there are a disproportionally large number of learning disability care homes in a relatively small geographical area covering the south and east of Louth and the nearby north of the Boston & Skegness team. This may contribute to greater-than-usual difficulties with recruitment in these areas. (see page 16)

Non-staff operating costs

Non-staff operating costs

- Non-staff operating costs are the costs required to operate a care home on a day-to-day basis, excluding staffing and any capital costs or rental considerations. This includes the cost of a corporate function where applicable.
- Providers have different start and end dates for their financial years. As the variation between providers is nearly always greater than cost inflation even over several years, we have simply allocated costs based on the most months in the financial year April to March.
- Some providers only gave data for one financial year, whilst others gave two financial years (so are doubly counted in the data).
- Results for 2019-20 and 2020-21 are shown without uplifts for inflation.
- Covid-19-related funding would have partially offset some non-staff costs in 2020-21. However, the data in this section will not generally include ongoing additional costs associated with Covid-19 as most of the data is historic.
- Owing to the relatively small sample sizes for operating cost data, we have not excluded obvious outliers as this would obfuscate the data we received and prevents the reader from coming to their own judgements.
- Where commensurable, we have also included the results for the 2017 exercise. The results are often different. This is unsurprising as the samples are likely materially different. As discussed elsewhere in this report, learning disability care homes can have very different cost profiles depending on their home size and the type and level of support offered to residents.
- We have only presented data for a few of the significant cost lines as there was insufficient commensurable data to make it worthwhile to cover others. Even the cost lines presented have significant limitations.
- We considered omitting this section from the report. However, in the end we concluded that it was better to show the data as a way of highlighting its limitations. Furthermore, it would not be helpful for future exercise not to have a baseline, however limited.
- Our judgment is that in most respects, the non-staff operating costs reported for the older adult market review offer more reliable benchmarks of minimum cost and will be reasonably appropriate for larger learning disability care homes. However, such benchmarks will not scale well to learning disabilitycare homes with more intensive staffing. For the same reason, there are issues averaging results between different types of learning disability care home.
- We recommend that future exercises should seek to analyse ‘1-2-1’ providers and ‘core and additional’ providers separately, as this would be a more useful approach to both engaging with the market and analysing their costs.

Food

Food costs prw (single cost line)

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2017 exercise	Unknown	£40.15	£21.50						£63.00		
2019-20	19	£24.22	£4.02	£10.72	£17.33	£20.44	£28.59	£41.59	£54.18	15	£23.06
2020-21	21	£24.07	£3.85	£11.32	£17.85	£21.87	£27.29	£42.99	£49.00	17	£23.32

Data: Anonymised care home surveys (2021 unless stated)

- In general, these food costs are much lower than we would expect. This is likely either a combination of providers purchasing food centrally and not allocating in full to specific homes, or food costs being reported net of income for staff meals.
- The two group providers not included in the above analysis had food unit costs of £70-90 per resident week. This only appears to make sense if it includes the cost of feeding staff on 1-2-1 models of care (such that 2-3 people are being fed rather than 1). The only other explanation is that the cost lines include high-cost non-food items.
- On initial consideration the 2017 results appear very different to the data received in 2021. However, if we had included all the care homes of the two high-need / high-cost groups mentioned above, the average results would been in the same ballpark.
- With regard to a suitable cost benchmark for food costs for learning disability care homes, we would suggest the older adult data is more reliable starting point. A variety of different types of older adult care home all had averages between £29-£30 prw at 2020-21 cost levels. This includes care homes below 30 beds. Higher food costs would be appropriate in care homes with intensive staffing who offer free or subsidised food to staff, i.e. the food budget is feeding 2-3 people rather than 1.
- Although higher-than-usual inflation for food costs is likely over the coming years, the impact will not be that material in isolation as a total cost prw. However, it has the potential to add to combined high-than-usual increases across multiple cost lines.

Utilities

Utilities costs prw: Gas, electricity, oil, water, utilities, telephone and internet

			Distribution							10-90th percentile	
Financial year	Sample size	Mean	Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2017 exercise	Unknown	£31.78	£13.89						£46.00		
2019-20	19	£21.70	£8.13	£11.37	£13.26	£15.99	£27.76	£36.97	£64.96	15	£19.38
2020-21	22	£27.34	£8.44	£10.48	£12.93	£17.41	£35.77	£60.11	£87.70	16	£22.18

Data: Anonymised care home surveys (2021 unless stated)

- These costs had to be grouped for analysis owing to the level of overlap and the fact that some surveys did not provide more granular cost breakdowns.
- The distribution of utilities costs is quite wide. Some of this will be associated with relative levels of energy efficiency in converted homes and purpose-built homes of various ages.
- Some of the stated utilities costs are extremely low. This indicates the relevant providers either do not reliably account for certain costs at a home level or residents are out of the homes for most of the day.
- Utilities costs in the two excluded group submissions are £40-£65 prw. This ballpark is typically reported for homes operating 24/7 waking hours for staff.
- With regard to a suitable cost benchmark for utilities costs for learning disability care homes, we would suggest the older adult data is more reliable starting point. A variety of different types of older adult care home all had averages between £24-26 prw at 2020-21 cost levels. This includes care homes below 30 beds. Higher costs would be appropriate in learning disability homes with more intensive night staffing as utilities costs can markedly increase if the house effectively does not shut down at night.
- Large gas price increases are in the news at the time of writing. This is potentially a risk area as care homes are not protected from price increases in the same way as domestic properties.

Repairs and maintenance

Repairs and maintenance costs prw: Single cost line

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2017 exercise	Unknown	£28.33	£6.50						£58.23		
2019-20	19	£25.31	£8.42	£12.99	£15.22	£21.03	£30.06	£47.00	£59.62	15	£23.11
2020-21	22	£27.58	£1.76	£7.37	£11.88	£16.11	£28.55	£65.27	£116.12	16	£20.76

Data: Anonymised care home surveys (2021)

- Almost all care homes separately reported repairs and maintenance costs but we have grouped as they overlap.
- There is nothing unusual about this distribution of costs, though it is obviously a wide range. A similar wide range is shown in the results for older adult care homes from a much larger sample size.
- Repairs and maintenance costs can vary substantially from year to year depending on whether significant issues arise.
- The quality of facilities have implications for repairs and maintenance in that it costs more to maintain and repair a higher specification facility than lower specification. For example, there is a higher maintenance cost for homes with entirely ensuite showers versus shared bathrooms.
- Good practice is obviously to invest a reasonable amount in ongoing maintenance to minimise the need for future repairs. However, the inevitable temptation for some providers is to minimise repairs and maintenance spend to maximise short-term profits / achieve a breakeven position – especially in times of financial difficulty.

Professional and central costs

Central costs including staff

Financial year	Sample size	Mean	Distribution							10-90th percentile	
			Minimum	10th percentile	25th percentile	Median	75th percentile	90th percentile	Maximum	Sample size	Trimmed mean
2019-20	16	£92.90	£46.68	£56.21	£68.33	£83.57	£103.02	£139.75	£222.39	12	£84.90
2020-21	17	£105.53	£0.08	£32.73	£87.18	£95.87	£122.36	£161.84	£293.22	13	£100.29

Data: Anonymised care home surveys (2021)

- Market averages for professional and central costs are somewhat bogus. Any average must be treated with suspicion as it will be calculated on costs varying widely depending on each provider's business model. The wide range of costs presented here is consistent with our expectations.
- The smaller average size means these costs will typically be higher per resident for learning disability care homes than older adult homes.
- If more of the independent care homes who did not submit surveys were included in the above analysis, both the overall averages and distribution would be lower for the overall market. Independent care home providers and small owner-managed groups generally do not incur the same level of cost as groups. The three main reasons are:
    i. The owner of an independent care home or a small group will often be responsible for many tasks that are managed by central staff in larger groups (procurement, finance, HR, strategy and policy, various admin, etc.). This input is often not an explicit cash cost as owners often primarily use dividends to take money out of the business (though small groups will often incur director renumeration as an equivalent to central costs).
    ii. Over time, larger groups can fall victim to accumulating bureaucracy and the associated costs. This is rarer among businesses directly managed by the owner(s) as they see the direct effects of bureaucracy on their profits. This is not a care home specific phenomena.
    iii. Groups have costs for portfolio management and growing their business. There are also costs associated with ensuring the business is structured efficiently for tax purposes. These additional costs can be substantial compared to a stable portfolio with a simple business structure.
- Much of the 'central overhead is incurred per home, rather than per resident. However, for simplicity, central overheads in groups are usually apportioned either per resident or as a percentage of revenue. It should be noted that if overheads are split by resident this increases the price of low-cost residents compared to high-cost residents in a portfolio. While if overheads are split as a percentage of revenue, the opposite is true. There is no 'true' way to split overheads, it is ultimately an accounting decision.

Facilities and capital costs

Care home facility standards

- The Care Standards Act 2000, enacted in 2002, specifies that newly registered care homes must have at least 12m^2 floor space in each bedroom, plus at minimum an ensuite toilet. Any other ensuite facilities are also excluded from this floor space calculation. New registrations are inclusive of both new-build homes and converted properties.
- The original intention in the Act was that all care homes had to meet this minimum room size by around 2007. However, this requirement was dropped after understandable pushback from the industry that this was unachievable.
- Two decades later, this requirement still does not apply retrospectively to pre-existing care homes. Indeed, a large minority of the care home market nationally remains 'substandard' by new registration room standard requirements. The survey data shows this is also the case in Lincolnshire. Only in a few areas in the country are 'substandard' facilities rare or non-existent.
- It should be noted that for new registrations, the Care Standards Act specified that the minimum room size excluding any ensuite facilities was 15m^2 for wheelchair users and 16m^2 for shared rooms.
- Furthermore, newly registered care homes for working-age adults have a higher legal minimum specification than older-adult care homes in some respects. The key difference is that newly registered homes for working-age adults must have one shower and toilet between two people, compared to a 1 shower and toilet to 8 people in older adult care homes.
- In practice, new-build older adult care homes have much higher specifications than the minimum standards in order to attract self-funding residents – ensuite showers or wet rooms have been standard for some time.
- Stakeholders are likely to have differing opinions about the importance of rooms size and the need for ensuite toilets, showers, and wet rooms.
- As we discussed earlier on page 11, the CQC policy Registering the Right Support means that, in practice, new registrations for learning disability care homes are typically 6 beds or fewer.

Facilities: Room size

Category	East	West	South	Total	<5 homes	5-24 homes	25+ homes	Total
Rooms								
Smaller than 12m²	24	2	7	33	7	6	20	33
12-18m²	33	38	39	110	38	35	37	110
18-24m²	29	5	26	60	46	11	3	60
Larger than 24m²	20	61	10	91	2	88	1	91
Total rooms in survey	**106**	**106**	**82**	**294**	**93**	**140**	**61**	**294**
Room size known (survey)	27%	31%	45%	32%	50	33%	18%	32%
Care homes								
Care homes with room data	9	12	5	26	6	16	4	26
Homes with 1+ undersized room	3	2	2	7	2	2	3	7
Homes with some undersized rooms	33%	17%	40%	27%	33%	13%	75%	27%

Data: Anonymised care home surveys (2021)

- The survey data only comes from circa a third of the market both in terms of beds and homes. While this represents a substantial proportion of the market, the differences between types of care home means this cannot be assumed to be representative.
- Within the survey sample, only 11% of rooms are smaller than the minimum standard for new care homes of 12m².
- By contrast, 51% of rooms are larger than 18m². Given younger adults in this client group are more likely to be mobile and their care home is in many cases likely to be in their long-term home, it is good news that a large proportion of bedrooms are large. Obviously, larger rooms have implications for appropriate rents.
- As the sample is self-selecting, it is possible that homes with better quality facilities are more likely to have answered this question. If this is the case, this means that that the number of homes with smaller rooms would make up a larger proportion of the market.

Facilities: Bathroom facilities

Category	East	West	South	Total	<5 homes	5-24 homes	25+ homes	Total
Rooms								
Room with communal bathroom facilities	132	46	39	217	52	106	59	217
Toilet & basin only	13	36	22	71	16	53	2	71
Ensuite bath and/or shower	34	107	15	156	10	102	44	156
Separate private bathroom	9	6	1	16	1	12	3	16
Total rooms	**188**	**195**	**77**	**460**	**79**	**273**	**108**	**460**
Bathroom facilities known (survey)	48%	56%	42%	50%	64	64%	31%	50%
Care homes								
Care homes with bathroom data	18	12	5	35	5	31	10	46
Care homes with 'room only' rooms	15	7	2	24	3	14	7	24
Care homes with no ensuite toilet	83%	58%	40%	69%	60%	45%	70%	52%

Data: Anonymised care home surveys (2021)

- The survey data comes from circa half the market both in terms of beds and homes. Some surveys included answers about bathrooms facilities but not room sizes (see previous page).
- While this represents a substantial proportion of the market, the differences between types of care home means this cannot be assumed to be representative.
- Within the survey sample, 47% of rooms do not have an ensuite toilet. This a requirement for newly-registered facilities.
- As the sample is self-selecting, it is possible that homes with better quality facilities are more likely to have answered this question. If this is the case, this means that that the number of homes without ensuite toilets would make up a larger proportion of the market.

Facilities: 'Substandard' rooms

Category	East	West	South	Total	<5 homes	5-24 homes	25+ homes	Total
Rooms								
Max of undersized rooms and no ensuite toilet	133	47	46	226	59	106	61	226
% of rooms 'substandard'	71%	24%	51%	48%	63%	39%	56%	48%
Care homes								
Care homes with 'substandard' rooms	16	8	4	28	5	14	9	28
% homes with 'substandard' rooms	89%	35%	67%	60%	83%	45%	90%	60%

Data: Anonymised care home surveys (2021)

- A 'substandard' room relates solely to the requirements for newly-registered care homes as defined in the Care Standards Act 2000. No value judgement is inferred for the quality of care, or indeed the quality of facilities (other than that the rooms do not meet these specific standards).
- Based on the survey sample, 11% of rooms in learning disability care homes have less than 12m^2 usable floor space (sometimes called 'undersized'), whilst 47% of rooms do not have an ensuite toilet. Combining the above metrics (the maximum of each result in all care homes), *at least* 48% of the rooms in the survey sample are either 'undersized' and/or rooms with no ensuite toilet. Some rooms will fail on both criteria.
- Stakeholders are likely to have differing opinions about the importance of rooms size and the need for ensuite toilets, showers, and wet rooms.
- In our judgement, the requirement for an ensuite toilet is far less important where residents do not have mobility issues. This is typical for a large proportion of residents in learning disability care homes. As such, we find it unsurprising that a large proportion of homes have shared bathrooms.

Types of building

Category	East	West	South	Total	<5 homes	5-24 homes	25+ homes	Total
Converted property	10	7	1	18	1	16	1	18
Converted property with extension(s)	6	10	4	20	4	12	4	20
Purpose-built care home	6	7	1	14	1	6	7	14
Purpose-built with later extension(s)	-	-	-	-	-	-	-	-
Total responses	**22**	**24**	**6**	**52**	**6**	**34**	**12**	**52**
Building type known (survey)	61%	65%	32%	57%	55%	74%	35%	57%
Converted properties	73%	71%	83%	73%	83%	82%	42%	73%
Purpose built properties	27%	29%	17%	27%	17%	18%	58%	27%

Data: Anonymised care home surveys (2021)

- Whilst 52 out of 92 homes is a large proportion of the market, there is no guarantee it is representative. This is particularly the case given that, as discussed elsewhere, the sample is disproportionately skewed towards medium-to-large provider groups.
- 73% of care homes in the sample are in converted properties, although more than half of these have extensions.
- Given independent care homes are largely outside this sample, the proportion of homes in converted properties would likely increase with a full picture of all care homes.

Indicative property value variation based on house sale data

Value of per bedroom of general-purpose housing at learning disability care home locations in Lincolnshire

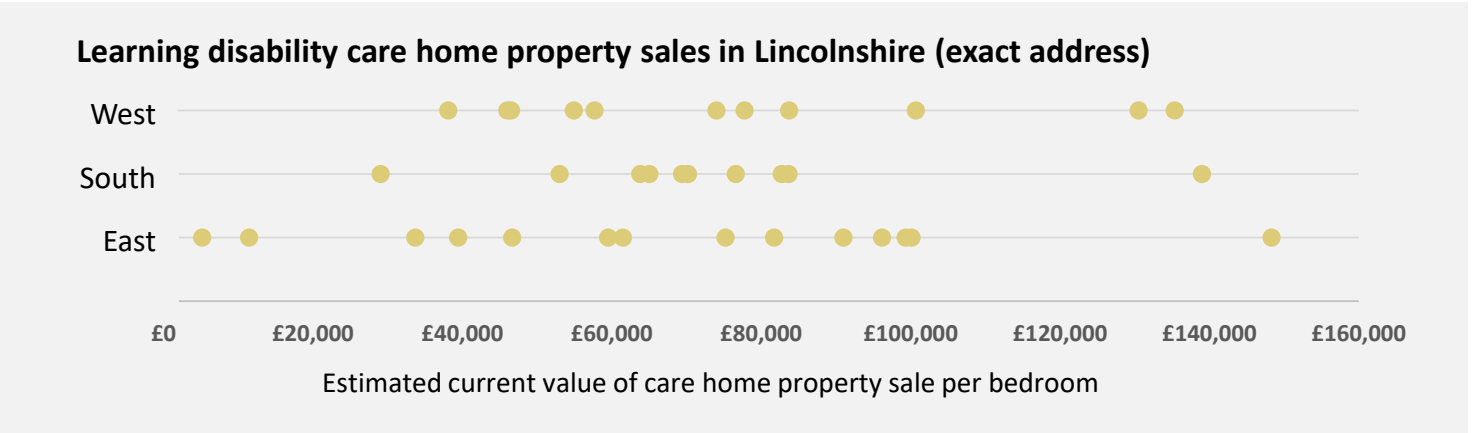
					East		West		South	
Category	East	West	South	Total	Boston & Skegness	Louth	Lincoln & Hykeham	West Lindsey	Grantham, Bourne & Stam.	Spalding & Sleaford
Minimum	£28k	£21k	£44k	£21k	£28k	£31k	£39k	£21k	£44k	£38k
1st quartile	£56k	£52k	£62k	£58k	£46k	£65k	£73k	£64k	£60k	£45k
Median	£65k	£67k	£78k	£66k	£58k	£66k	£81k	£66k	£85k	£62k
3rd quartile	£74k	£84k	£103k	£81k	£69k	£79k	£96k	£74k	£131k	£80k
Maximum	£153k	£133k	£145k	£153k	£153k	£127k	£133k	£97k	£145k	£131k

Data sources: Online property valuation service, linked to Care Analytics care home database

- We collated sale data for general-purpose housing as close as possible to all learning disability care homes in Lincolnshire.
- Based on the estimated current value of each property (using the website's uplift algorithm for property price inflation since the sale date), we then calculated an estimated capital cost per bedroom for each location. This analysis is not necessarily intended to be reflective of care home capital costs, but good enough to identify large geographical differences in property valuations.
- For many learning disability care homes in converted general-purpose housing, the property valuations will offer a good indication of opportunity costs for selling the respective home as a bricks and mortar asset.
- It is usual to see a range of property values for general-purpose housing. However, the most important point thing is that all localities have high- and low- value property at care home locations.
- This data is sufficient to demonstrate that there will be a large of range of legitimate 'rental' costs for learning disability care homes in the county, although the precise circumstances of individual care homes will generally be more important than any broad geographic location.

Care home and property sales

- The graph right shows 35 examples of learning disability care home property sales (exact address), with an algorithm-driven estimated current value per bedroom. The website's algorithm adjusts for property price inflation since the sale date.
- Each horizontal line represents the broad location of each care home.



- The property sale value per bedroom may be misleading if the sale is to a related party, the sale includes goodwill, or if the home had twin rooms.
- As with the previous page, these property sales show a wide range of property costs, and therefore wide range of legitimate 'rents' for placements.
- As shown in the table below, we only found four learning disability care home sales in and around the East Midlands. It is much rarer for sales to be made and advertised online compared to older adult care homes.
- Given the EBITDA and adjusted net profit levels in the below retirement sales, the bricks and mortar value of the properties must be quite low.

Learning disability care home sales found on various websites in and around the East Midlands

Location	Date	Beds	Guide Price	Per bed	Notes
Nottinghamshire	04/06/2019	17	£950,000	£55,882	No significant details provided.
Chesterfield	07/09/2020	8	£475,000	£59,375	Retirement sale. Modern-detached property. High occupancy. EBITDA of 39%.
East Midlands	08/07/2020	12	£950,000	£79,167	Retirement sale. 90%+ occupancy. Mean fees £900+. Net profit of 35%.
West Midlands	04/06/2019	4	£449,950	£112,488	Retirement sale. High EBITDA.

To request information about any of our services,
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Equality Impact Analysis to enable informed decisions

The purpose of this document is to:-

I. help decision makers fulfil their duties under the Equality Act 2010 and
II. for you to evidence the positive and adverse impacts of the proposed change on people with protected characteristics and ways to mitigate or eliminate any adverse impacts.

Using this form

This form must be updated and reviewed as your evidence on a proposal for a project/service change/policy/commissioning of a service or decommissioning of a service evolves taking into account any consultation feedback, significant changes to the proposals and data to support impacts of proposed changes. The key findings of the most up to date version of the Equality Impact Analysis must be explained in the report to the decision maker and the Equality Impact Analysis must be attached to the decision making report.

****Please make sure you read the information below so that you understand what is required under the Equality Act 2010****

Equality Act 2010

The Equality Act 2010 applies to both our workforce and our customers. Under the Equality Act 2010, decision makers are under a personal duty, to have due (that is proportionate) regard to the need to protect and promote the interests of persons with protected characteristics.

Protected characteristics

The protected characteristics under the Act are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Section 149 of the Equality Act 2010

Section 149 requires a public authority to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by/or under the Act
- Advance equality of opportunity between persons who share relevant protected characteristics and persons who do not share those characteristics
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The purpose of Section 149 is to get decision makers to consider the impact their decisions may or will have on those with protected characteristics and by evidencing the impacts on people with protected characteristics decision makers should be able to demonstrate 'due regard'.

Decision makers duty under the Act
Having had careful regard to the Equality Impact Analysis, and also the consultation responses, decision makers are under a personal duty to have due regard to the need to protect and promote the interests of persons with protected characteristics (see above) and to:-

(i) consider and analyse how the decision is likely to affect those with protected characteristics, in practical terms,
(ii) remove any unlawful discrimination, harassment, victimisation and other prohibited conduct,
(iii) consider whether practical steps should be taken to mitigate or avoid any adverse consequences that the decision is likely to have, for persons with protected characteristics and, indeed, to consider whether the decision should not be taken at all, in the interests of persons with protected characteristics,
(iv) consider whether steps should be taken to advance equality, foster good relations and generally promote the interests of persons with protected characteristics, either by varying the recommended decision or by taking some other decision.

Conducting an Impact Analysis

The Equality Impact Analysis is a process to identify the impact or likely impact a project, proposed service change, commissioning, decommissioning or policy will have on people with protected characteristics listed above. It should be considered at the beginning of the decision making process.

The Lead Officer responsibility
This is the person writing the report for the decision maker. It is the responsibility of the Lead Officer to make sure that the Equality Impact Analysis is robust and proportionate to the decision being taken.

Summary of findings
You must provide a clear and concise summary of the key findings of this Equality Impact Analysis in the decision making report and attach this Equality Impact Analysis to the report.

Impact – definition

An impact is an intentional or unintentional lasting consequence or significant change to people's lives brought about by an action or series of actions.

How much detail to include?
The Equality Impact Analysis should be proportionate to the impact of proposed change. In deciding this asking simple questions “Who might be affected by this decision?” "Which protected characteristics might be affected?" and “How might they be affected?” will help you consider the extent to which you already have evidence, information and data, and where there are gaps that you will need to explore. Ensure the source and date of any existing data is referenced.
You must consider both obvious and any less obvious impacts. Engaging with people with the protected characteristics will help you to identify less obvious impacts as these groups share their perspectives with you.

A given proposal may have a positive impact on one or more protected characteristics and have an adverse impact on others. You must capture these differences in this form to help decision makers to arrive at a view as to where the balance of advantage or disadvantage lies. If an adverse impact is unavoidable then it must be clearly justified and recorded as such, with an explanation as to why no steps can be taken to avoid the impact. Consequences must be included.

Proposals for more than one option If more than one option is being proposed you must ensure that the Equality Impact Analysis covers all options. Depending on the circumstances, it may be more appropriate to complete an Equality Impact Analysis for each option.

The information you provide in this form must be sufficient to allow the decision maker to fulfil their role as above. You must include the latest version of the Equality Impact Analysis with the report to the decision maker. Please be aware that the information in this form must be able to stand up to legal challenge.

Background Information

Title of the policy / project / service being considered	Residential Review Programme	**Person / people completing analysis**	Tracey Dowker
Service Area	Adult Care & Community Wellbeing	**Lead Officer**	Roz Cordy and Justin Hackney
Who is the decision maker?	Executive	**How was the Equality Impact Analysis undertaken?**	Desktop exercise
Date of meeting when decision will be made	01/03/2022	**Version control**	V0.04
Is this proposed change to an existing policy/service/project or is it new?	Existing policy/service/project	**LCC directly delivered, commissioned, re-commissioned or de-commissioned?**	Re-commissioned

Describe the proposed change

Lincolnshire County Council needs to ensure that it delivers its statutory obligations to people who are eligible for social care.

ASC supports people who have had their care needs assessed as substantial or critical. When those care needs are to be met by residential or nursing placements the care provider should offer a quality service. Quality is determined as providing a service which is safe, effective and delivers a positive experience of care. This is encompassed within regulatory standards.

We currently have 3,039 people paced in long term care:

Service Users By Age Band	Female	Male	Grand Total
18 - 24	6	18	24
25 - 34	31	61	92
35 - 44	45	64	109
45 - 54	82	99	181

55 - 64	111	147	258
65+	1680	695	2375
Grand Total	1955	1084	3039

Service User by Service Type	LTC Nursing	LTC Residential	Grand Total
A - Autism / Aspergers: Autism		1	1
A - Learning Disability Support	45	419	464
A - Mental Health Support	92	303	395
A - Physical Support: Access & mobility only	38	220	258
A - Physical Support: Personal care support	325	1306	1631
A - Sensory Support: Support for dual impairment		4	4
A - Sensory Support: Support for hearing impairment		1	1
A - Sensory Support: Support for visual impairment		6	6
A - Social Support: Substance misuse support		1	1
A - Social Support: Support for social isolation / other		20	20
A - Social Support: Support to carer	4	10	14
A - Support with Memory and Cognition	42	202	244
Grand Total	546	2493	3039

Lincolnshire County Council currently holds contracts with 159 different provider organisations, covering 273 Care Homes within Lincolnshire.

LCC is required to set Usual Costs for each year with an amount set per category of care.

The current fee levels were set in 2018 which incorporate an inflationary increase each year to 2020/21. Due to Covid a further inflationary increase was applied to 2021/22.

New fee rates are required from April 2022, in line with the end of the current Residential Framework Agreement.

In setting rates the Council must have due regard for the cost of providing care in Lincolnshire and the existing market conditions.

Proposed Changes

A proposed increase in residential fees will support Care Home providers in Lincolnshire to continue to provider a good quality service to residents.

A report was commissioned from Care Analytics to understand the current costs of delivering in care in Lincolnshire. The findings and recommendation in the Care Analytics report was informed by responses from Care Homes with a response rate of 43% of Older Adults Care Homes, 33% of Mental Health Care Homes, 74% of Learning Disability Care Homes and 50% of Physical Disability Care Homes.

The following uplift is proposed.

	Rates					% Uplift			
	2018/19	2019/20	2020/21	2021/22	**2022/23**	2019/20	2020/21	2021/22	**2022/23**
Residential Care									
Older Peoples Standard Residential Cost per Week	483	502	521	533	*567*	3.9%	3.8%	2.3%	*6.4%*
Older Peoples Nursing Residential Cost per Week	531	553	574	588	*627*	4.1%	3.8%	2.4%	*6.6%*
Older Peoples High Dependency Residential Cost per Week	531	552	573	587	*626*	4.0%	3.8%	2.4%	*6.6%*
Physical Disabilities Standard Residential Cost per Week	623	647	671	687	*731*	3.9%	3.7%	2.4%	*6.4%*
Mental Health Standard Residential Cost per Week	503	522	542	555	*590*	3.8%	3.8%	2.4%	*6.3%*
Mental Health Nursing Residential Cost per Week	531	552	573	587	*624*	4.0%	3.8%	2.4%	*6.3%*
Learning Disabilities									
Band 1									
- Standard	599	619	637	651	678	3.3%	2.9%	2.2%	*4.1%*
- Smaller	642	663	682	697	725	3.3%	2.9%	2.2%	*4.0%*
- Smallest	686	707	727	743	772	3.1%	2.8%	2.2%	*3.9%*
Band 2									
- Standard	686	711	733	749	784	3.6%	3.1%	2.2%	*4.7%*
- Smaller	729	755	778	795	831	3.6%	3.0%	2.2%	*4.5%*
- Smallest	773	799	823	841	878	3.4%	3.0%	2.2%	*4.4%*
Band 3									
- Standard	859	893	924	944	993	4.0%	3.5%	2.2%	*5.2%*
- Smaller	902	937	969	990	1039	3.9%	3.4%	2.2%	*4.9%*
- Smallest	945	980	1,013	1,035	1,086	3.7%	3.4%	2.2%	*4.9%*

The proposed fee levels allow Providers a rate of return of 6%.

The market for Adult Care services continues to face significant challenges from the impact of COVID-19 in addition to long

	standing cost pressures. Given the unpredictability of the markets cost of care following the pandemic and the anticipated social care reforms, the Council proposes to implement a multi-year contract with an annual rate review. To reflect emerging cost risks in relation to utilities and insurances the Council also proposes to establish a Hardship Fund that may be used to assist providers with increases in such costs.

Evidencing the impacts

In this section you will explain the difference that proposed changes are likely to make on people with protected characteristics.
To help you do this first consider the impacts the proposed changes may have on people without protected characteristics before then considering the impacts the proposed changes may have on people with protected characteristics.

You must evidence here who will benefit and how they will benefit. If there are no benefits that you can identify please state 'No perceived benefit' under the relevant protected characteristic. You can add sub categories under the protected characteristics to make clear the impacts. For example under Age you may have considered the impact on 0-5 year olds or people aged 65 and over, under Race you may have considered Eastern European migrants, under Sex you may have considered specific impacts on men.

Data to support impacts of proposed changes

When considering the equality impact of a decision it is important to know who the people are that will be affected by any change.

Population data and the Joint Strategic Needs Assessment

The Lincolnshire Research Observatory (LRO) holds a range of population data by the protected characteristics. This can help put a decision into context. Visit the LRO website and its population theme page by following this link: http://www.research-lincs.org.uk If you cannot find what you are looking for, or need more information, please contact the LRO team. You will also find information about the Joint Strategic Needs Assessment on the LRO website.

Workforce profiles

You can obtain information by many of the protected characteristics for the Council's workforce and comparisons with the labour market on the Council's website. As of 1st April 2015, managers can obtain workforce profile data by the protected characteristics for their specific areas using Agresso.

Positive impacts
The proposed change may have the following positive impacts on persons with protected characteristics – If no positive impact, please state *'no positive impact'.*

Age	The increased funding to care providers should provide additional assurance that there is sufficient capacity within Lincolnshire for quality residential services. Changes to the Terms and Conditions are also proposed in order to provide greater clarity to Service Users and their families when entering into agreements with the Council and/or Provider on financial matters. By fixing Top Up prices and further clarifying how deferred payments are handled Service Users and their families will be able to better plan for the future and avoid situations wherein costs may change year by year The proposed Hardship Fund will create a resource which can be used to assist providers manage the volatility of costs related to utilities and insurances.
Disability	The increased funding to care providers should provide additional assurance that there is sufficient capacity within Lincolnshire for quality residential services. In addition the existing rate model recognises the key challenges within Learning Disability provision, namely the high variability of complexity in care needs, which will further support providers as well as allow the Council to undertake new initiatives. Changes to the Terms and Conditions are also proposed in order to provide greater clarity to Service Users and their families when entering into agreements with the Council and/or Provider on financial matters. By fixing Top Up prices and further clarifying how deferred payments are handled Service Users and their families will be able to better plan for the future and avoid situations wherein costs may change year by year. The proposed Hardship Fund will create a resource which can be used to assist providers manage the volatility of costs related to utilities and insurances.
Gender reassignment	*No unique positive impact for this protected characteristic*

Marriage and civil partnership	*No unique positive impact for this protected characteristic*
Pregnancy and maternity	*No unique positive impact for this protected characteristic*
Race	*No unique positive impact for this protected characteristic*
Religion or belief	*No unique positive impact for this protected characteristic*
Sex	*No unique positive impact for this protected characteristic*
Sexual orientation	*No unique positive impact for this protected characteristic*

If you have identified positive impacts for other groups not specifically covered by the protected characteristics in the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Within the life of the new Residential Framework Agreement the council will be moving to a Gross payment model. Currently Lincolnshire County Council operates a net payment basis which sees the provider receiving one flow of funding from the Council and potentially two flows of funding from the service user for their cost of care and/or their third party.

Once the Council moves to a gross payment model, currently planned for Summer 2022, the provider would receive one payment for all residents for whom Lincolnshire County Council pays a financial contribution towards their care. The provider would no longer need to seek to collect funding directly from people in their care or their third parties. Collection of resident and third-party contributions will instead be managed by the Council. This represents a significant change in process, and will have a positive impact for providers, who will benefit from a reduced administrative burden and improved cash flow position.

Adverse/negative impacts
You must evidence how people with protected characteristics will be adversely impacted and any proposed mitigation to reduce or eliminate adverse impacts. An adverse impact causes disadvantage or exclusion. If such an impact is identified please state how, as far as possible, it is justified; eliminated; minimised or counter balanced by other measures.
If there are no adverse impacts that you can identify please state 'No perceived adverse impact' under the relevant protected characteristic.

Negative impacts of the proposed change and practical steps to mitigate or avoid any adverse consequences on people with protected characteristics are detailed below. If you have not identified any mitigating action to reduce an adverse impact please state *'No mitigating action identified'*.

Age	Adult Care services and budgets continue to be pressured and while the measures in the new contracts have been put forward to directly address this there are concerns that ongoing pressures in the wider Health and Social Care system may impact on the availability and quality of the care which is provided There are concerns that the fee rate impacts on the viability of the providers. If Providers decide to increase their prices above usual costs then there is the risk that service users could be required to find a third party to pay the additional amount. If there is no third party available then service users could be asked to move to an alternative home which could cause distress. The increased funding and improved terms offered through the new contracts supported by the proposed Hardship Fund represents an appropriate proposal to address these potential negative impacts based on the evidence of costs obtained by the Council from the market
Disability	Adult Care services and budgets continue to be pressured and while the measures in the new contracts have been put forward to directly address this there are concerns that ongoing pressures in the wider Health and Social Care system may impact on the availability and quality of the care which is provided There are concerns that the fee rate impacts on the viability on some of the Council's providers to deliver services.

	If Providers decide to increase their prices above expected costs then there is the risk that service users could be required to find a third party to pay the additional amount. If there is no third party available then service users could be asked to move to an alternative home which could cause distress. The increased funding and improved terms offered through the new contracts supported by the proposed Hardship Fund represents an appropriate proposal to address these potential negative impacts based on the evidence of costs obtained by the Council from the market.
Gender reassignment	This proposal is related to the residential care rate for Lincolnshire which is not specific to gender reassignment
Marriage and civil partnership	This proposal is related to the residential care rate for Lincolnshire which is not specific to marriage or civil partnership
Pregnancy and maternity	This proposal is related to the residential care rate for Lincolnshire which is not specific to pregnancy or maternity
Race	This proposal is related to the residential care rate for Lincolnshire which impacts on all placements and not specific to person's race.
Religion or belief	This proposal is related to the residential care rate for Lincolnshire which impacts on all placements and is not specific to a person's religion/belief.
Sex	This proposal is related to the care fee rate for Lincolnshire, which is not specific to sex. However data also shows that the rate will have a greater impact on woman as they have a longer life expectancy and therefore are proportionally more likely to receive residential or nursing care.

Sexual orientation	This proposal is related to the residential care rate for Lincolnshire which impacts on all placements and is not specific to a person's sexual orientation

If you have identified negative impacts for other groups not specifically covered by the protected characteristics under the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Stakeholders

Stake holders are people or groups who may be directly affected (primary stakeholders) and indirectly affected (secondary stakeholders)

You must evidence here who you involved in gathering your evidence about benefits, adverse impacts and practical steps to mitigate or avoid any adverse consequences. You must be confident that any engagement was meaningful. The Community engagement team can help you to do this and you can contact them at engagement@lincolnshire.gov.uk

State clearly what (if any) consultation or engagement activity took place by stating who you involved when compiling this EIA under the protected characteristics. Include organisations you invited and organisations who attended, the date(s) they were involved and method of involvement i.e. Equality Impact Analysis workshop/email/telephone conversation/meeting/consultation. State clearly the objectives of the EIA consultation and findings from the EIA consultation under each of the protected characteristics. If you have not covered any of the protected characteristics please state the reasons why they were not consulted/engaged.

Objective(s) of the EIA consultation/engagement activity
Engagement on the new model has been undertaken directly with Care Providers as the changes proposed are commercial in nature. There are no proposed changes on how Service Users will access or receive care services differently and it is expected that with the increased funding available through the proposal services in both Specialist Adults Services and Adult Frailty and Long-Term Conditions will be maintained at current quality if not improved.

Who was involved in the EIA consultation/engagement activity? Detail any findings identified by the protected characteristic

Age	
Disability	
Gender reassignment	
Marriage and civil partnership	
Pregnancy and maternity	
Race	
Religion or belief	

Sex	
Sexual orientation	
Are you confident that everyone who should have been involved in producing this version of the Equality Impact Analysis has been involved in a meaningful way? The purpose is to make sure you have got the perspective of all the protected characteristics.	Yes
Once the changes have been implemented how will you undertake evaluation of the benefits and how effective the actions to reduce adverse impacts have been?	As all residential providers are already managed closely further meetings with the care providers will be undertaken to address the implementation of the new contracts. These meetings will consider whether there are any emerging impacts against individual service users, particularly those who are protected under the Equality Act 2010.

Further Details

Are you handling personal data?	No If yes, please give details.

Actions required Include any actions identified in this analysis for on-going monitoring of impacts.	**Action**	**Lead officer**	**Timescale**

Version	Description	Created/amended by	Date created/amended	Approved by	Date approved
V0.4	Version issued to support decision making in the setting of Usual Costs for Residential & Nursing Care for financial year 2022-23	Tracey Dowker	2nd February 2022		

Examples of a Description:
'Version issued as part of procurement documentation'
'Issued following discussion with community groups'
'Issued following requirement for a service change; Issued following discussion with supplier'

PROVIDER FEEDBACK

Provider Feedback	LCC Response
Provider A	
We have read the letter in detail, it has been very helpful and we note that the fees mentioned within the letter cover standard care home provisions, and thus the fees mentioned would not be applicable to the specialist services that *Provider A* provides. The *Provider A* services, commissioned by Lincolnshire County Council, are packaged on an individual basis to help manage service users with complex needs and/or challenging behaviours, and therefore the staffing levels on site would be different to Care Homes that deliver a more standard level of care. *Provider A* is experiencing significant cost inflation in order to respond to the current workforce marketplace. This challenge is in part an effect of the pandemic, but also Brexit, which has led to a reduced number of staff available to work in the sector. There is also strong competition from other sectors where pay/conditions/incentives have led to workers leaving health and social care. To ensure we maintain delivery of safe, high quality care as required by the Care Act of 2014 *Provider A* have undertaken an annual review of its fees. This review has taken into account cost pressures, notably direct staff costs of recruiting/retaining and developing staff. We continue to maximise efficiency and have absorbed some costs. From 1st April 2022, we will be requesting a minimum uplift of 6.9% on the overall package for your placements. This is driven, in the main, by the 6.6% increase in National minimum wage which is unavoidable and presents a real issue for us all.	*The fees proposed are informed by responses to the Care Analytics survey and include standard care home and specialist services provision, incorporating and applicable to the vast majority of care packages commissioned by the Council. There are and will continue to be examples of bespoke packages of care commissioned for those with severe complexities for which costs are not included in the proposed 'usual cost' rates. In these cases, costs will continue to be managed through our existing processes.* *For non-standard cases, the % for that customer group is applied to the bed cost / hourly rate contained within the price make up.* *The Council recognises the workforce challenges across the whole of the Health and Social Care Sector, these challenges are not just a local issue but also a regional and national one. Locally LCC are investing in an attraction campaign to improve the perception of Care as a Career. We expect all Lincolnshire providers to benefit from this work.* *In relation to wages the model is based on the median results received back through the survey. The wage rates in the model include a 6.6% uplift to reflect the increase to the National Living Wage. It also includes public holiday premiums as standard, even though not all homes are paying this.* *Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1st April 2022.*

Provider Feedback	LCC Response
Provider B	
On April 1st, we are wondering how it is going to work with the User Contribution and the Third-Party Contribution. Will you invoice the Next of Kin and or Client?.	*A letter was sent to all providers on 11th January providing a further update on the move to gross payments.*

I am aware there will be more information sent out to us by March, but we are trying to gain a better understanding of the new procedure.	*At the point when we move to gross payments, LCC will be collecting user contributions and third party contributions directly from the individuals. Gross payments are expected to commence in July 2022. Payment Information Letters are continuing to be distributed, the last one was dated 11th January 2022.*

Provider Feedback	**LCC Response**
Provider C	
I am disappointed to see Mental Health nursing fees are lower than Older Persons Nursing fees. Earlier last year we were promised Mental Health fees would be brought into line with Learning Disability fees and nothing has been communicated. In my opinion the skills of the RNMH are not recognised or valued. We do not demand top-ups because our residents rarely have the means or a third party. If Mental Health fees remain low, the area runs the risk of losing a dual registered Nursing Home for Mental Health.	*This point is acknowledged. It was the Council's intention to utilise the 2021 survey data to inform the development of the fee structure and rates for mental health residential and nursing provision. Unfortunately, only 4 responses were received from providers in this category of care, and of the 4 mental health care homes who submitted responses, none provided the cost breakdowns requested. As a result, there was insufficient data to inform a bespoke financial model in this category of care.* *The Council plans to re-engage and work with Mental Health providers over the course of 2022/23 to encourage provision of the data needed to inform the development of a further changes to the fee structure for this category of care.*

Provider Feedback	**LCC Response**
Provider D	
I'm sure you are aware that as a provider of support for very complex individuals that our current weekly rates are much higher than those noted in the letter. Although we are currently signed up to the contract T&Cs we have separate pricing schedule – schedule 2 for each of our services and each individual's agreed weekly cost is listed within this document. I'm assuming that this approach will continue for us post April 2022, please can this be confirmed?	*We can confirm that costs relating to the small number of very complex individuals will continue to be managed through our existing processes with you.*

Provider Feedback	**LCC Response**
Provider E	
Thank you for the information provided however I do not believe we are currently on your core rates and so we would be looking for an idea of the percentage uplift award for your packages in FY22/23	*There are and will continue to be examples of bespoke packages of care commissioned for those with severe complexities for which costs are not included in the proposed 'usual cost' rates. In these cases, costs will continue to be managed*

	through our existing processes. *For non-standard cases, the % for that customer group is applied to the bed cost / hourly rate contained within the price make up.*

Provider Feedback	**LCC Response**
Provider F	

• Please confirm you acknowledge and will factor in the exponential increase in both staff and hotel costs currently being experienced and projected but not factored into organisational responses submitted in the Summer upon which the commissioned report is predicated.
 	
• Please can you confirm that whilst not referenced directly, there is scope for the cost of care delivered to this cohort to be negotiated outside of the 3 band structure.
  ○ You have previously acknowledged differences in need amongst the individuals whose LD care you commission and whilst we concur with the concept of bands, as we have said before, there is a 4th band that is missing, which is one for the most complex individuals.
  ○ As a specialist provider, placements for complex individuals are costed on the basis of needs. These impact the structure and cost of both the environment and the support, which must be tailored specifically to the individual and by their nature, are not capable of being banded, other than 'Any Other'.
 	
• What percentage increase are you proposing for Band 4 - "Any Other"?
 	
• Where is the shortfall in actual costs incurred in the 4 years to 31 March 2022 catered for?
  ○ You will be aware that from previous communications from us as a provider that costs incurred in delivering the placements we are commissioned to provide year on year far exceed the average of the increases LCC awarded under the 3 year framework as well as in the extended 4th year of its term.
 	
• Additionally, acknowledging that Lincolnshire is a net importer of placements, any LCC award of necessity impacts more placements than those
	The fees proposed are informed by responses to the Care Analytics survey and include standard care home and specialist services provision, incorporating and applicable to the vast majority of care packages commissioned by the Council.
	
	This year's rate increase is significantly higher than that in previous years in recognition of the cost increases.
	
	The wage rates in the model include a 6.6% uplift to reflect the increase to the National Living Wage. It also includes public holiday premiums as standard, even though not all homes are paying this. The 1.25% NI increase expected from 1Apr22 will be covered by the proposed increases to the rates following consultation funded from the Market Sustainability and Fair Cost Fund.
	
	The Comprehensive Spending Review forecast that inflation will average 4% across 2022 and this has been built into the models non pay costs.
	
	The council recognises that there are, and will continue to be, examples of bespoke packages of care commissioned for those with severe complexities for which costs are not included in the proposed 'usual cost' banded rates. In these cases, costs will continue to be managed through our existing processes.
	
	For non-standard cases, the % for that customer group is applied to the bed cost / hourly rate contained within the price make up.
	
	In addition to the allowance made in the model for non-pay costs, we recognise that for some providers utilities costs are significantly different to those submitted in the market survey. We also recognise the volatility of this market, therefore we are proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures. We will develop and publish the detail of this fund during Mar22.

commissioned directly where contractually an out of county commissioner pegs its annual fee increases to the host authority.	*In undertaking the market review work we have identified a number of areas we would like to review further. This includes the structure of the learning disabilities rates currently represented in the bandings. As part of this work programme we will be meeting with providers and look forward to engaging with you further.*

Provider Feedback	**LCC Response**
Provider G	
Whilst we are aware that there remains many budgetary pressures in relation to social care, we are also acutely aware that it is a sector that has suffered many problems and setbacks over the last 5 to 10 years and whilst there has been a number of political promises made at a national level none of these have really planned for the long term security of the sector. We also realise that the Local Authority can only affect the situation in a small way, though we do feel the move towards Gross Payment Basis is a welcome step made by LCC. With regard to the proposed fee increases we note that the increases are projected to be between 5.63% and 5.79%; this we have looked at in the context of the increased costs of running the homes. We have in this exercise ignored the additional costs related to COVID as these are specific to the pandemic; we have also concentrated on the 4 main cost centres relevant to running the home: Wages – The National Minimum Wage is to increase by 6.6% as per Government figures released in October. This is the very minimum increase required to attract or retain staff – there continues to be a shortage of workforce within the sector and this has resulted in a bout of wage inflation. It is our belief that employment costs have increased by around 12.5% for our businesses. There is already clear evidence that those providers aiming for the high end private market are looking to monopolise staff for their homes, thus leaving those willing to cater for the social care funded sector unable to attract staff. Food – Food inflation in relation to Brexit has increased prices by over 12% to date and is likely to continue to increase, especially with the current supply chain	*The Council recognises the workforce challenges across the whole of the Health and Social Care Sector, these challenges are not just a local issue but also a regional and national one. Locally LCC has in place a Workforce Strategy and are investing in an attraction campaign to improve the perception of Care as a career.* *In relation to wages the rates have been informed by responses to the Care Analytics survey. The model is based on the median results and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.* *Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1st April 2022.* *This year's rate increase is significantly higher than that in previous years. The Comprehensive Spending Review forecast that inflation will average 4% across 2022 and this has been built into the models non pay costs.* *We recognise that for some providers utilities and insurance costs are significantly different to those submitted in the market survey. We also recognise the volatility of this market, therefore we are proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures. We will develop and publish the detail of this fund during March 2022.* *In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities.*

pressure. Light & Heat – The Sector is a very energy intensive end user. The increased cost of heating and lighting has currently resulted in commercial price increases of around 21.2% with no sign that this is likely to reduce. Insurance – The Sector has become a high risk sector for the Insurance Industry and the narrowing of choice has resulted in an increase in costs. Currently we are looking at a rise of around 10% in Insurance costs. Clearly there is no way any rise can reflect all of these cost increase in full but we do feel that rises of less than 65 are inadequate to maintain viability and levels of service. Our suggestion would be around 10% increase on rates. This will still be less than the average increase in costs incurred but a lot more likely to retain some level of viability to state funded social care.	

Provider Feedback	**LCC Response**
Provider H	
1. Whilst any increase is warmly welcomed, it needs to reflect the commerciality in the market sector and the pressures that the NHS is struggling under for finding either step down facilities or permanent discharge beds. 2. The overall fee increase is some £30 which amounts to about 5.6%. 3. The actual reality is that there is a nationwide shortage of care workers and it has now become a competitive buyers market, so much so that we have already had to increase our pay rates twice in an 8 week period in November / December 2021 to well above NMW. This was either to retain or recruit experienced staff. This amount to a wage increase of 10% (including increased NIC and pension) on our wage bill pcm which equates to a wages bill of 53% for non nursing care, which is higher than market sector. 4. This is before any NMW increase in April (expected to be another £6.6%) or fee increase, so the October / November wages increase is already eroding any existing profit margin. 5. Work undertaken by us on January 13th 2022 showed that based on 30 residents the cost of care, excluding extensive refurbishment was £580 per room which against a basic fee of £533, gave a loss of £47pw per room. The loss element is before any head office costs. Our actual registration is 36 beds but due to the configuration of some of the rooms, the effective registration is 31, so we are near capacity.	*Point 1 is noted and the Local Authority continues to work closely with our Health colleagues in looking to create a single pathway for intermediate care.* *The Council recognises the workforce challenges across the whole of the Health and Social Care Sector, these challenges are not just a local issue but also a regional and national one. Locally we are working with LinCA as part of our Workforce Strategy to attract and retain the care workforce, this includes investing in an attraction campaign to improve the perception of Care as a Career.* *The market assessment highlights that differences in operating policies and practices between providers (such as size of home, layout) add complexity when seeking to produce a standard cost model for the marketplace. The 2022-23 cost model is built upon amounts representative of both the median of survey results and the trimmed mean.* *In relation to wages the model is based on the median results reported by providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.*

6. The only profit element that is made is from the private residents, and that is being eroded by the loss on the LA funded rooms. It is unfair on private residents to increase their fees in line with inflation and commerciality and to effectively also be subsidising losses. We cannot do this. 7. Energy costs are increasing on average some 20 - 30%, and these costs already represent some 15% of our gross proceeds. NIC is due to increase some 1.25% on NMW increases ranging from 4% to 9.8%, and because of our age demographic, our average increase will be ranging from 6.6% with a further 1.25% NIC increase, so a double tax impact. These costs also exclude increased petrol costs for staff travelling to work which they will expect to see reflected in any pay increase, even if it is held to NMW rather than market sector. And then there is the hidden cost of keeping the differential between the pay grades. 8. This downward decline is not sustainable given market pressure on wages and will only serve to result in homes closing down or having to accept more private residents who will pay a more realistic and commercially based fee. 9. The fee increase needs to be at least 10% to enable care homes to keep pace with market sector and recruit the best people for the job.	*Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.* *The ASC White Paper 'People at the Heart of Care: adult social care reform' confirmed additional funding announcements, a workforce fund being one. At the time of writing this report, the details of local allocations and access to the funds are still awaited. It is the intention of LCC to continue to support its providers in accordance with the conditions of the funds.* *We recognised that for some providers utilities costs are significantly different to those submitted in the market survey. We also recognise the volatility of this market, therefore we are proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.* *We believe that in undertaking the Market Review work we have been able to develop a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities.*

Provider Feedback	**LCC Response**
Provider I	
In responding to the proposed fee levels, which are a step in the right direction, but unfortunately and disappointingly, they don't go far enough to address the very serious underlying financial challenges facing residential and nursing home care providers. These include the following: 1. Inflationary pressures in the economy, which continue to rise, particularly pay, food, and utilities/energy costs and including the recent interest rate rise. 2. Wage inflation and its impact on the labour market both nationally and locally. This is resulting in Care Providers having to increase their reward packages to a level beyond the new national living wage increase, to enable them to recruit and retain staff of the right quantity and quality. 3. The financial impact of COVID-19 on staffing levels to ensure proper IPC	*Recognising the increases in inflation we have applied 4% in line with the predictions for 2022 as stated in the Autumn Budget and Spending Review published in October 2021.* *It has also been recognised that for some providers utilities costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.* *In relation to wages the model is based on the median results supplied by providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.*

arrangements are in place to protect residents and to manage visiting so that Care Homes can continue to provide high standards of care for residents. 4. The challenges arising from the dynamic impact of the pandemic on occupancy levels in some Care Homes and on the other hand the high level of demand in others to support hospital avoidance and early discharge. This latter challenge is having an impact on staffing levels to provide care for people with higher dependency needs, including end of life of care, and post-Covid syndrome 5. The potential for the above to impact adversely on staffing levels to the extent that this part of the social and health care system will not be able to respond to the Care Closer to Home policy and to the need to support hospital avoidance and early discharge – reducing hospital in-patient capacity. 6. There is also the question of whether the proposed fee adequately compensates Care Home providers for requirements in the new proposed services specification, which at the time of writing this response is outstanding and the Care Home sector has been unable to undertake a comparative evaluation exercise. 7. The review undertaken by Care ANALYTICS is a very useful analysis of the Care Home market and associated costs and challenges, but it is very difficult to reconcile the financial information in the report and LCC's fee offer and a 'fair price for care' approach. The financial pressures on Local Authorities, is recognised within the context of the macro national financial challenges, but in terms of priorities the care of older and disabled people, many of whom are the most vulnerable and at risk in society, should be seen as one of the highest priorities for Local Authorities, alongside children and young people, bearing in mind LA's statutory responsibilities. Local Authorities with Adult Social Care [ASC] responsibilities have the flexibility within the Council Tax precept arrangements to raise the precept by a maximum of 3% for ASC purposes. It is noted that this was not applied for 2021/22 financial year. This is viewed as a lost opportunity to support the Care System in Lincolnshire and it is hoped that this policy will be reviewed for 2022/23, which would reflect the County Council making care services for elderly and disabled people a top priority for investment.	*The Council recognises the workforce challenges across the whole of the Health and Social Care Sector, these challenges are not just a local issue but also a regional and national one. We are working closely with LinCA and other partners on the implementation of our Workforce Strategy. This includes a countywide attraction campaign to promote Care as a Career.* *Cost pressures associated with Covid-19 have been excluded from this work. The Council will continue to ensure all additional funding made available to address these pressures is passported directly to providers, as has been the case to date. Factors such as Covid are key in the rationale to only set rates for the 2022/23 financial year.* *A number of updates and improvements have been made to the service specification, however, it has been concluded that the existing specification is fit for purpose, comprehensive and in line with best practice.* *The Care Analytics survey has enabled us to further develop our cost model ensuring it is representatives of both the median of results and the trimmed mean shown in the reports shared. Since the market review exercise we have received further information in relation to the Market Sustainability and Fair Cost of Care Fund. This, in addition to the feedback received from the market, has been considered when finalising our usual costs. Use of the Fund has enabled us to propose increases to the rates following consultation which will cover the 1.25% NI increase expected from 1Apr22.* *The Council will consider its budget proposals for 2022/23 during February 2022 but is proposing a 3% increase in our adult care precept. [Revised budget proposals for 2022/23 – Lincolnshire County Council]* *In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities for 2022/23. We do however recognise the changing market conditions are therefore not proposing to set rates beyond one year at this time.*

Whilst it is recognised that there is a degree of unpredictability in the Care Market, resulting from the pandemic and future Adult Social Care reforms, the financial challenges have been with us for some time, exist now and are likely to continue because of COVID-19 variants and inflationary pressures. The LGA/ADASS have been making the case for some time that the care sector is underfunded by a quantum of £7BN and 1.4M people are not receiving the care they require to sustain acceptable levels of health and wellbeing. *Provider I*, along with some other similar Care Providers in the County is a charity and company limited by guarantee. The cost base is kept to a minimum because of a Committee of Management made up of Volunteers - reducing management overhead costs, being debt free with no debt servicing costs, and no dividend payments to shareholders. But despite this, our current nursing care bed costs are in the region of £900 per week, and with the fee rates proposed and FNC, that still leaves us with around a £100 per bed shortfall. Thank you for considering the points made in this letter and we hope that it makes a positive contribution to the County Council's review of fees as part of the Residential Review and Fee Settlement for 2022/23, which require a further uplift either now or mid-year 2022/23 to recognise the serious financial pressures being faced by Care Home providers in Lincolnshire.	

Provider Feedback	**LCC Response**
Provider J	
I have read the presentation provided by the external consultant retained by LCC and would like to request further information about their findings in two areas. Firstly, did the consultants provide any written analysis on the impact of care home insurance cost increases of over 200% into their calculations? Secondly, did the consultants provide any written analysis on the impact of the 400% wholesale energy price increases into their calculations? I ask this, because the proposed fee increase of £30 per bed per week does not adequately cover these costs. To provide calculations of some basic costs for my own care home, which are based on the home operating at an occupancy level of 40 residents. Costs per bed	*The work undertaken by Care Analytics did capture the current insurance costs, this analysis did not support a 200% cost increase. However, it did note that insurance could increase by 30% but that this should be monitored as it may be subject to further change. This is a factor in our decision to secure a one-year financial arrangement so that future arrangements can take into account further cost pressures.* *It has also been recognised that for some providers utilities and insurance costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.* *The 2022/23 cost model is built upon amounts representative of both the median of*

obviously increase if the home is not fully occupied. Cost increase per bed £ Wages & NI 26.83 Insurance 2.88 Food 1.87 Fuel 41.82 Total 73.40 *This is the estimated fuel increase we have been provided with by our energy supplier which will come into effect in June when our current fix rate expires. Against this cost backdrop, please provide the detailed calculations that justify how LCC has reached a proposed fee increase of £30 per bed per week. Please also provide details of how LCC proposes that care homes should cover these additional, non-discretionary costs, which are not covered by the proposed £30 per bed per week fee increase. I also draw your attention to the fact that in 2021, at the height of the pandemic, LCC increased the fees paid to providers by 2.1%. The justification for this was that the 2.1% increase was equal to the 2.1% increase in mandated wage rises. However, in 2020, wage rises increased by 6.1% but LCC only increased fees by 2.1%. In 2022, wages are increasing by 6.2% and national insurance contributions by 1.25%, thereby creating a wage rise increase of 7.45% for care homes, yet LCC is proposing a fee increase of only 5.6%. Please provide documentation setting out the evidential basis for the changes in LCC's funding policy and why at a minimum, fee increases are not to be linked in percentage terms to minimum wage increases. This would provide the most effective measure of ensuring the ability of care homes to provide the requisite level of care and to support the NHS in the discharge of medically fit patients.	*survey results and the trimmed mean. The model also includes a 4% inflationary uplift which is in line with predictions set out in the Autumn Budget and Spending Review published in October 2021.* *In relation to wages the model is based on the median results supplied by providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.* *Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.*

Provider Feedback	**LCC Response**
Provider K	
Thank you for the fee setting document and the enclosure of proposed fees for 22/23. We calculate this in an average offer increase of 5.7% across Residential and Nursing care Adult services. In response whilst we acknowledge the proposal this still falls short of our cost	*The 2022/23 cost model is built upon amounts representative of both the median of survey results and the trimmed mean. The model also includes a 4% inflationary uplift which is in line with predictions set out in the Autumn Budget and Spending Review published in October 2021.*

pressures for the coming year to which we have a calculated a rise of circa 9.2% in 22/23. For reference, this cost increase can by split by standard 22/23 cost pressure increases of a minimum 6%, plus an additional 3.2% brought about by the introduction of our new pay and reward strategy from January 22. Clearly the bulk of the 6% is in the increase in payroll costs (calculated to 6.6% plus 1.25% in NI Levy. Internally all payroll costs above NLW have been budgeted at a 3% increase, however as noted this excludes our pay and reward. In terms of non-staffing costs again we anticipate an increase of circa 3%, (separate to Food 10%, Insurance 20% and Utilities (estimated at a minimum 5% increase for 22/23, however clearly this could be higher). In addition our central costs are expected to rise from by circa 18% up to £40 per Resident per week.	*In relation to wages the model is based on the median results supplied by providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.* *Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.*

Provider Feedback	**LCC Response**
Provider L	
Please find below our comments in response to the Residential Review and Fee Settlement 2022 consultation: • The Lincolnshire older adult care home market review 2021 was completed prior to notification of the new national minimum wage rate increase due to come in to effect from 1st April 2022. The revised rate should have been the starting point for the review, however, as it stands, the review is out of date. • The review does not consider the extensive utility price hikes which are continuing to increase beyond recognisable historic rises. • The limited margin of profit left with the providers means that there is little available to be ploughed back into the homes for future refurbishment / development works to ensure the homes are fit for the future. • There is a national recruitment crisis which is causing care homes to pay additional fees to attract quality personnel into care homes. • COVID-19 – Expectations with regards to the level of detail for provision of care and reporting continue which does not appear to have been considered within the review of fees put forward for consultation. • Additional funding in relation to COVID-19 will come to an end (Infection control and Testing) which has been vital in the support of the homes during what continue to be very testing times.	*The review was undertaken on the most appropriate timeline given new contracts need to be in place from 1st April 2022. The increase to the national living wage is being taken into account in the final model.* *It has been recognised that for some providers utilities costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.* *The Council recognises the workforce challenges across the whole of the Health and Social Care Sector, these challenges are not just a local issue but also a regional and national one. Locally LCC are investing in an attraction campaign to improve the perception of Care as a career.* *In relation to wages the model is based on the median results supplied by providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.* *Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.*

• PPE Portal – although this has now been extended until March 2023, at the time the potential fees given to the providers had not considered the extra costs related to the provision of PPE when the portal was originally due to come to an end. As a general observation, located on the grid of Page 15 of the review it is evident that the average fee obtained for 2020-2021 is £759. LCC have not considered this as an average and have produced fees that start considerably lower than this. In summary, we feel that the revised rates currently in the market for consultation fall considerably short of what is required to ensure the continued safe and effective provision of care across the Lincolnshire sector.	*Cost pressures associated with Covid-19 have been excluded from this work. The Council will continue to ensure all additional funding made available to address these pressures is passported directly to providers, as has been the case to date. Factors such as Covid are key in the rationale to only establish a set rates for one year, rather than the usual three.* *We believe that the tables on Page 15 of the review refer to self-funder fees, not Local Authority fees.* *In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities.*

Provider Feedback	**LCC Response**
Provider M	
Whilst we welcome the decision to propose an increase to the current fee, we are concerned that the proposed increase does not go far enough to address the real and pressing concerns of providers. There can be no surprise that homes are facing closure under the current pressures faced as quality providers, like ourselves, endeavour to continue to provide high standards of care & maintain full compliance with CQC when the fees being paid are fundamentally inadequate. You will have noted the number of homes in the area that are closing due to their inability to sustain the financial pressures of the market today and yet, no replacement beds are being commissioned. Furthermore, it is the standard of the remaining beds which I am most concerned about, some of which would not even meet the current standards of homes today and are continually being found to 'Requires Improvement' or be 'Inadequate' in the views of the Care Quality Commission. As a group, we model our care staffing structures at all of our Homes as follows: · A ratio of anywhere between 20-25 hours per resident per day. · The span of salaries for managers is between £65,000 and £90,000 per annum, dependent on the size of the Home and local competition.	*In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities. We believe that the proposed rates enable providers to meet the CQC regulations.* *We contract with 95% of all care homes within Lincolnshire, across this provision there is a 16% vacancy rate. Therefore there is no need to commission further replacement beds at this time, however, we are mindful that there may be a need to secure block beds capacity. This is something we will be looking at during the course of this next year.* *In relation to wages the model is based on the median results supplied by providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.* *the 1.25% NI increase expected from 1Apr22.* *Cost pressures associated with Covid-19 have been excluded from this work. The Council will continue to ensure all additional funding made available to address*

National Living Wage (previously National Minimum Wage) alone has increased by more during the past 12 months than that being proposed, this is before even considering this year's NLW increase (which is an additional year on year increase of 6.6%). The fee increase proposed does not meet this additional cost which adds hundreds of thousands of pounds to our wage bill. I am more than happy to share with you our financial accounts for these homes which will support my point. The above, in addition to the ancillary and administrative staff required to operate a Home, equates to over 65% of our income being used to pay wages before indirect costs such as head office costs, finance costs, return on capital and a modest amount of profit considered. Furthermore, as a group we spend in excess of £500,000 per year in training and development ensuring our staff are not only compliant in their training knowledge, but also to provide excellent levels of care to the elderly residents they serve. To further highlight the concerns with the proposed fee, we have projected a cost per resident per week of circa. £675.00 for this financial year (2021/22) compared to £625.00 for the financial year 2020/21. Covid-19 has and also continues to have a significant financial impact upon the care home market. This impact will continue to endure through 2022/23. Subsequently, we have vastly increased HR costs as a result of the introduction of mandatory vaccinations in the social care sector, resulting in the extensive recruitment of overseas staff at significant cost to mitigate staffing shortages. As it has over the last five years, the effects of Brexit continue to impact Providers, with both food and utilities costs increasing by over 5% compared to previous years. Our primary concerns are: • The increase proposed at 6% which has been presented fails to pay any or adequate consideration to the financial pressures on the market at this time; costs per resident have never been higher. • Furthermore, there have been increased costs of registration fees, insurance, utilities without focussing on the increased requirement for medical supply/equipment hire costs, which have been passed onto care home providers. It is our understanding the Government has recently issued guidance on Market Sustainability and Fair Cost of Care Fund for 2022 to 2023. As detailed in the guidance, a significant number of local authorities are paying residential and domiciliary care providers less than it costs to deliver the care received. This is undermining their markets, creating unfairness, affecting sustainability and, at	*these pressures is passported directly to providers, as has been the case to date.* *Recognising the current pressures and volatility, including the impact of Covid-19, the council is proposing to set a one-year rate model rather than rates across three years.* *The 2022/23 cost model is built upon amounts representative of both the median of survey results and the trimmed mean. The model also includes a 4% inflationary uplift which is in line with predictions set out in the Autumn Budget and Spending Review published in October 2021.* *It has been recognised that for some providers utilities costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.* *The Market Sustainability and Fair Cost Fund is to enable preparation across local markets for the announced social care reforms. The fund will be released over the next 3 years to support us to move towards paying a fair cost of care across residential and non-residential care. The Council has received £2.273m for the financial year 2022-23. Working through the conditions of the fund, we are able to propose an increase to the rates published in December which will cover the 1.25% NI increase expected from 1Apr22. These rates will see the full £2.273m fund committed to ASC providers.* *The Council does not consider that the rates on which it consulted would, if confirmed, have been unlawful or in breach of any of its statutory obligations.* *In any event the Council has considered all the feedback received and taken account of changed circumstances including in particular the Market Sustainability and Fair Cost Fund and is proposing an increase in the Usual Costs above those originally consulted on to address concern about costs with the increased funding available.* *The Council's proposed Hardship Fund also directly addresses concerns expressed within the consultation responses including from yourselves.*

times, leading to poorer quality outcomes. It is noted that an additional £1.4 billion of funding is being provided over the next three years to assist local authorities with moving towards paying a fair cost of care. You will no doubt be aware that the 2022/23 funding, designed to ensure local authorities can prepare their markets for reform, requires local authorities to carry out a number of activities. As part of this, a true cost of care exercise is required to be conducted by local authorities to determine the sustainable fee rates and identify how close they are to it. It is essential that the Council sets sustainable fee rates. The care market is a critical front-line service and has been neglected by the Council over many years. It is our opinion the proposed fee increased does not meet the duties in the upcoming year. We would therefore welcome working together with you to assist the Government with their proposals for reform and to ensure the fee setting process is fair and sustainable to meet the obligations required in 2022/23 and in the future. To reiterate, the fee increase proposed is not adequate or in line with the current costs of care. We would be grateful if you could confirm that your market shaping exercise is only the first step in undertaking a fair review of the market and a true cost of care exercise. If the Council fails to increase the proposal and adopts it as a final decision, it will be acting unlawfully and in breach of its statutory duties to the market. We look forward to your prompt response and ask that you review your position before finalising your decision.	

Provider Feedback	**LCC Response**
Provider N	
We feel the amount for settlement is not adequate. A. The rate of inflation for 2021 has been 5.1%, the current figure is 5.4% and expected to reach 6% by late spring. The settlement figure suggested would be approximately 4% and would create a more negative position. B. Calculations as stated in the report are based on minimum wage payments	*The market assessment highlights that differences in operating policies and practices between providers (such as size of home, layout) add complexity when seeking to produce a standard cost model for the marketplace. The 2022-23 cost model is built upon amounts representative of both the median of survey results and the trimmed mean.* *The model includes a 4% inflationary uplift which is in line with predictions set out*

to staff, however we pay above national living wage for our staff retention and recruitment at £9.62 per hour. C. The associated wage costs regarding annual leave average entitlement and pension and NI contributions must be considered. D. Some providers in the report are able to supplement their income by their charitable status not afforded to private organisations. E. The sustainability fund has highlighted the shortfall to providers and with an acceptable increase the fund would not be required. F. The cost of living in Lincolnshire is now the same as most other counties including property prices, wages, daily cost for utilities, food etc. G. Lincolnshire unit weekly rate is way below adjacent counties, but the costs are now relatively the same. The average weekly cost is £1400 - £1500 per week which Lincolnshire remains well below. We need to be able to move through this very difficult time and trust that the feedback will help support a significant increase in the proposed settlement.	*in the Autumn Budget and Spending Review published in October 2021.* *In relation to wages the model is based on the median of results received from providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.* *Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.* *The sustainability fund was introduced due to specifically address pressures resulting from Covid-19. Cost pressures associated with Covid-19 have been excluded from this work. The Council will continue to ensure all additional funding made available to address these pressures is passported directly to providers, as has been the case to date.* *Recognising the current pressures and volatility, including the impact of Covid-19, the council is proposing to set a one-year rate model rather than rates across three years.* *The figures are based on the returns from Lincolnshire providers and therefore we believe that the rates adequately reflect the actual costs incurred by providers in Lincolnshire.*

Provider Feedback	**LCC Response**
Provider O	
Please find a basic business cost analysis for *Provider O* as an example. Please note that the fee proposals for any care home funded entirely through the local authority does not support itself. The fee proposal takes into consideration the £0.59p hourly rate increase, and assumes a 5% inflation rate on Overheads. Please note that the industry has seen considerable uplifts in Insurance rate, and finance rates. We are also going to be experiencing at least a 30 – 50 % increase in the basic utility costs. These factors would not have been taken into consideration in your fee proposals.	*The proposal submitted has been reviewed alongside all feedback received.* *The previous model was based upon 90% occupancy. The only element of the current model which includes occupancy in the calculation is the return of capital. All other costs are based on the median of survey results and the trimmed mean therefore occupancy rates will not impact on the pay and non pay parts of the model.* *It has been recognised that for some providers utilities and insurance costs are significantly different to those submitted in the market survey. We recognise the*

We propose a £659.50 HD rate to support LCC with up to 9 placements at *Provider O*.	*volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.*

Provider Feedback	**LCC Response**
Provider P	
Thank you for providing the opportunity for Providers to comment on the Fee Setting proposals for 2022/23. We appreciate the recognition by the Council of the challenges that providers face in terms of long standing cost pressures and Covid-19. I am currently undertaking a review of actual and budgeted costs, of all residential services, setting by setting to ensure viability of services. At the moment, the current framework model does not cover costs sufficiently to allow for sustainability of the services in the longer term. This is due to a number of reasons that are being worked through, one of these being that the weekly fee is eroded by a shortfall in funding for additional 1:1 support, and there is a practice of daycare provision being recharged to the residential care home, rather than funded separately. At this time, this means that many care homes are in deficit, with the cause being high 1:1 hours and/or daycare provision as well as a rise in costs generally felt and indicated by current inflation rates. *Provider P* will review our current services and come back to you in more detail re the above, and would like to make the following points. 1) Annual increases to fixed costs have not kept pace with cost increases. Fixed costs such as energy, gas, transport have all increased and contributed to rising inflation - 5.4% (CPI, Dec 2021) in the 12 months to December 2021. Homes have already been impacted by inflation rises. In addition, staff costs (wage costs, holidays, training, NI, insurances, HR) have not kept pace with cost increases felt by *Provider P*. Recruitment, retention, covering staff shortage with agency and/or overtime, induction and training costs all form part of increases in our overall operational costs. To some extent, this has been met by short term covid funding, which we are thankful for. The model proposes a varying %age increase in fees, *Provider P* homes are Band 2, £31 increase (4.14%) for large homes; £32 for medium size homes (4.03%) and £33 for smaller homes (3.92%). However,	*As part of this review work we have identified a number of areas we wish to consider further over the coming year, this includes working with the specialist sectors to ensure we continue to operate within a robust cost model.* *In the most recent years we had based inflation on the CPI average forecasts. 2022-23 is aligned to the spending review average forecast of 4%. It will differ month by month as highlighted in the spending review however the forecast is 4% across the year. We do recognise the potential volatility in costs and in response are proposing a 1 year rate only at this point. In addition, to support providers with potentially high energy costs, we are proposing a Hardship fund for 2022-23 – more details will follow on how to access this fund.* *In relation to wages the model is based on the median of results received from providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this. Where providers were paying more than the NLW, this is reflected in the median and means that the average wage rate included in the model is higher than the NLW in some cases.* *Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.* *We do recognise the current challenges being faced by Care Providers in relation to the recruitment of care workers, these challenges are being faced nationally, regionally and locally – LCC will continue work through the Workforce Strategy to support the sector, including a campaign promoting Care as a Career.* *In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities.*

longer term there is an expectation of higher instances of staff shortage and continued difficulties with recruitment. This may in part, be resolved by ensuring a **Real Living Wage** (9.90 – 11.1%) for support workers. Your proposed increase to our current fee level by 3.92% to 4.14% doesn't reflect the cost increases already felt by *Provider P* in 2021. At a minimum, your uplift must be sufficient to ensure funding required to cover fixed costs bearing in mind that inflation has been high (5.4% - CPI, Dec 2021), and is expected to increase further with forecasts that it may reach 7% by Spring 2022. *Provider P* have already absorbed increases in costs due to inflation. *Provider P* will be required to uplift support worker salaries to pay the national living wage (9.50 - 6.6%). We would wish to be funded at a level that would allow us to address staff issues and low pay in the sector, with a real living wage (11.1%).

2) *Provider P* welcome increases in wage rates for our staff. In April 2021, the National Living Wage (NLW) increased by 2.2% to £8.91, *Provider P* currently pay a slightly higher rate for our support worker roles of 9 pence. The mandatory 6.6% increase from 1st April, must be fully funded. In addition, *Provider P* would propose that it would be desirable for LCC to fund at a level that would equip providers to pay a Real Living Wage (11.1%). Please consider that take home pay for our workers, having benefitted from increases to NLW and *Provider P* commitment to fund at a higher level than this – will be diminished by the new health and social care levy. The need to fund at a higher level is supported by research.

3) The pressures of covid-19 on managers/team leaders has been substantial and we are seeing a higher level of attrition at these levels. The insufficient increases in fees in previous years and the mandatory increases in the NLW have led to an erosion of the pay differentials between support worker and these posts. At registered manager, team leader level, recent benchmarking indicates that *Provider P* are lagging behind for salary costs and the impact of this is felt through recruitment, retention, training, agency costs.

4) Energy costs and other fixed costs are likely to increase over the next financial year and this will impact the fixed cost base again. We are concerned about the shortfall in funding for 1:1 support, and would put forward our view that the proposed overall %age increases to current rates

are **insufficient**. The issue with underfunding 1:1 hours must be addressed separately. Following this, our view is that your proposed increase of around 4% falls around 3% short of the uplift required to keep pace with expected increases in operational costs. *Provider P* feel 7% for April 22 – March 23 would be the minimum required, with an 11% increase allowing *Provider P* to fund support workers at a Real Living Wage level. Fair and sustainable fee rates are an investment across the County. Further investment in the adult social care sector can boost local economies through increased demands for goods and services and increased spending by those employed in the sector.	

Provider Feedback	**LCC Response**
Provider Q	
We recognise and acknowledge that the financial pressures placed upon LCC are vast, complex and relentless, especially during these truly unique times. We know that you are trying to support us with Gross payments and ongoing Grant funding etc and continue to navigate through COVID-19 pandemic. We have noted the proposed increases to our fees for 2022 / 2023 and although at first glance, it may appear to be a reasonable uplift compared to previous years, we feel anxious that this is not a sustainable increase and will not place us in a viable position as we face unprecedented increases across our care home provision? Our ability to operate safely has always meant we have felt forced to rely on a higher ratio of privately placed residents to that of LCC placed residents, purely due to the difference in fees paid. This is to be compounded further should our costs continue to rise turbulently as they have been doing. We therefore must stress that the proposed increase will not offer us adequate financial input to be able to offer the required (& deserved) care to our LCC residents and just continues to place the burden of financial balance based on the ratios of private residents we can attract. Staffing pressures / overtime / uplift costs & National Living/minimum Wage costs are major stresses for the business, huge utility increases, nervous insurance	*The ASC White Paper 'People at the Heart of Care: adult social care reform' recognises that people who self-fund their care should not have to pay more than local authorities for the same service, it aims to ensure that self-funders can access the same rates for care costs in care homes that local authorities pay, ending the unfairness where self-funders have to pay more for the same care, while ensuring local authorities move towards paying a fair cost of care to providers. We are committed to working towards the aims set out in the white paper in accordance with the implementation timescale.* *In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities.* *We have recognised the increase in National Living Wage in the revised figures and following consultation are proposing to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.* *In relation to energy prices it has been recognised that for some providers utilities and insurance costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with*

companies and unprecedented premium increases, elevated premium on materials and labour for joinery, plumbing, electrical works is like never before along with interest rates of well over 5% all suggest that the proposed **Residential Review & Fee Settlement 2022** is insufficient. This does not even cover the usual increases of all other associated supplier costs for consumables, maintenance, inspection etc that are informing us of increases upwards of 8%. I hope we have been able to express our feedback adequately for you and that we are listened to. Thank you for consulting with us and the sector as a whole and we hope that further consultation can be achieved as we move forwards in partnership for the benefit of our most vulnerable.	*these unpredictable cost pressures.* *Inflation has been added in line with predictions set out in the Autumn Budget and Spending Review published in October 2021.* *A key reason to only set rates for the next financial year, 2022/23, is the recognition of the volatility of the costs associated with delivering care.*

Provider Feedback	**LCC Response**
Provider R	
The report seems mostly very thorough. Unfortunately, Care Analytics were gathering their information at a time of extraordinary change in our Socio-Economic climate. The partial collapse of the care labour market at expected costs is well documented, advertised posts for careers at £10+per hour unfulfilled which is 12% more than the current national minimum wage, and its knock-on effects with regard to pay differentials. Registered night nurses being directly employed at £25ph+oncosts; Energy Gas and Electricity are already rising for some providers by 100%; Insurance costs raising between 30%-80%; Building/Maintenance Materials up to 100%; Agency Nurse use and costs increasing dramatically. Much of this is not fully factored into their understanding of the base point up to March 2022 (i.e., before we even look at what will occur during 2022-2023). It should also be noted that many providers have provided figures from their filed accounts, and not from up-to-date monthly management reports; because smaller homes do not always have this information to hand, and this is particularly relevant during the latest period of Covid, inflation; and labour shortages. Once we fully understand the current cost base; then expected general domestic inflation expected to be 7-8% during 2022/2023 needs to be factored in along with any extraordinary inflation relevant to the Lincolnshire care sector. Such as sectors exposed to labour costs close to the National Minimum Wage, as this sector is always squeezed first. Given the uncertainty of the forthcoming year we feel a	*The market assessment highlights that differences in operating policies and practices between providers (such as size of home, layout) add complexity when seeking to produce a standard cost model for the marketplace. The 2022-23 cost model is built upon amounts representative of both the median of survey results and the trimmed mean.* *In relation to energy prices it has been recognised that for some providers utilities and insurance costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.* *We have applied an inflation rate of 4% in line with that predicted in the Autumn Budget and Spending Review published in October 2021. A key reason to only set rates for the next financial year, 2022/23, is the recognition of the unpredictability of the costs associated with delivering care.* *In relation to wages the model is based on the median of results received from providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this. Where providers were paying more than the NLW, this is reflected in the median and means that the average wage rate included in the model is higher than the NLW in some cases.*

mechanism needs to be developed that can automatically respond to spikes in costs; as other than energy costs (which if a provider choose to lock in, is circa 100% inflated), most of a care homes' costs are subject to suppliers increasing their costs with little or no notice, and this includes the labour market if new staff need recruiting. So, locking into a LCC yearlong fee structure is full of risk currently for providers; this could leave some providers having to rely on increasing third party top ups with little notice. **Below are some published statements, which supports why we believe current 2021/22 inflation is underestimated, and therefore the current fees do not meet the current costs of care, along with the data in the Care Analytics report; and what will happen in 2022/23 is also under estimated.** "Worst inflation in 40 years 7% surge" Various "Inflation rises 7% over past year, highest since 1982" - Financial Times `12 Jan 2022 Suppliers chain "PPI quote Nov20-Nov21 **9.9%** increase" ONS.gov.uk "RPI All Items – Dec 2020 – Dec201 **7.5%** increase" ONS.gov.uk "Unite said the true scale of the crisis has been revealed in the RPI rise of 7.5%, which it said is a more accurate figure than CPI." – Unite Union In these unprecedented disrupted socio-economic times, we believe any extrapolation of data and trends to predict future events in 2022/2023 should be treated with extreme caution. This includes the underlaying stability against all manner of metrics used to measure the outcomes and performance of the Adult Care Sector. We are also currently seeing some care homes who have traded successfully for years providing good care, start to slip and become distressed, which is a worrying development. We would have welcomed more analysis in the report on the scope and levels of Third-Party top ups, as we believe certain parts of the provider market deem these essential to deliver a high-quality sustainable service, which we believe no LCC clients should be totally excluded regardless of family financial circumstances; and also gives a competitive advantage to these providers when trying to secure scarce recourses such as staff. Third-Party Top ups and self-funders fees may give a better reflection of actual costs/fees as this is mostly a properly functioning competitive marketplace with	*Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.* *In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities.*

willing buyers and sellers agreeing a mutually acceptable fee for the goods and services offered.

There is also concern over the impact of cost of living will have on care staff, which is not covered by increases in the national minimum wage. Some staff will have holes in their family finances which they cannot plug without looking for increased hourly rates. Other suitable employers outside the care sector may be able to respond to wage inflation by passing on the costs; Tesco will quickly increase the costs of food, but care providers to LCC may not be able to respond in a similar manner. This is a very significant risk as it could drive workforce out of the care sector permanently. The burden on the registered managers to secure staff at affordable rates cannot be underestimated, particularly at a time when the sector has been battered by Covid; this is also impactful on a home's overall performance. General supervision and team spirit can also be affected, as managers become mindful about addressing staffs' individual performance, and the possible ensuing ramifications as the balance of power has shifted.

In Summary: -

We have not seen a detailed cost model from LCC which currently understands where we currently are based on Care Analytics data prior to April 2022 among other things. It would seem that LCC have based the current sector cost of care model on current LCC fee rates which were developed nearly 4 years ago and underestimates actual costs today. Our view is that this approach way underestimates the current environment.

We have not seen a detailed cost model predicting expected costs for 2022/2023. It would seem that LCC may have a general view of inflation running at 5-6% which has been added to current fee rates to arrive at a proposed fee rate for 2022/2023. Our view is that care costs will inflate by over 10% next year, based on actual costs today and not current LCC fee rates.

We believe that the strategic challenges facing our sector are huge, and that long lasting damage may be caused to the provision of care in Lincolnshire if these current proposed rates are formalised. Also, this will impact heavily on the health sector which has many challenges already. It will also unfairly impact on self-funders and third party top up fees as these face further disproportionate fee rises to plug the gap. We are currently witnessing a significant polarisation in the care

provider provision, with providers exposed largely to base LCC fee rates unable to secure labour against higher fee earning homes, this will only worsen under current LCC proposals. We believe that fee rate structure 2022/23 of circa £660pw – Residential £700pw – Residential/Higher Dependence £740pw – Nursing + FNC + FNC uplift Is justified and necessary. We also believe that it is affordable given LCC deferred the whole of last year's Adult Social Care allowed increase and this means that Lincolnshire County Council may increase council tax in 2022/23 by up to 6%. This would show real leadership and a forward-looking vision in maintaining and further developing our Care Sector. It would also show leadership within the ICS, as it would positively impact on Health. It would allow providers to seek extra staff from outside the sector and even outside Lincolnshire such as overseas sponsored staff which are currently unaffordable to many providers.	

Provider Feedback	**LCC Response**
Provider S	
Thank you for providing such a detailed report and market evaluation for the care homes in Lincolnshire, I think the information within it is very useful and helps us in understanding where we are currently in the market. There are some overriding principles and points that we would like you to consider as part of this process; • We have 3 homes in Lincolnshire and they are managed very well. Staffing in terms of recruitment and retention is an ongoing issue, and has been incredibly difficult given the current pandemic, and our own pay rates are now in excess of NLW increases, and incremental increases for other roles where we would like to offer incentives for career progression need to be identified and linked appropriately to higher and more realistic pay rates, such as Senior carers, Chefs, Housekeepers etc. • Occupancy is still an ongoing concern, we have 1 homes which is currently	*The proposed model is based on the information supplied by providers and takes into account actual wages paid in Lincolnshire. The rate has been increased to reflect the National Living Wage increase from 1st April. It also includes public holiday premiums as standard, even though not all homes are paying this.* *Following the response to the consultation the Council has been able to use the Market Sustainability and Fair Cost Fund to increase the proposed rates to a level which also includes the 1.25% NI increase expected from 1Apr22.* *The previous model was based upon 90% occupancy. The only element of the current model which includes occupancy in the calculation is the return on capital. All other costs are based on the median of survey results and the trimmed mean therefore occupancy rates will not impact on the pay and non pay parts of the model.*

at 80% and therefore difficult to even break-even in terms of costs/turnover, our other 2 homes are starting to recover but we think the occupancy range should be adjusted to 85% instead of the normal 90% expectation and costs linked to this more realistic occupancy position in terms of the cost of care model • The standard residential fee rate is still inherently too low even at the proposed £563 rate. Our direct costs for staffing is currently averaging between £471 in one home to £587 in another, this is before any additional costs such as facility and care expenses are included and is simply not covering even our basis costs. We think it would be more prudent to remove this band altogether and just consider the higher dependency rate for all new admissions. Residents dependency levels are much higher and more acute than ever before, and should be assessed on level of need. • Similarly the Mental Health standard at £555 also is inherently too low and we feel this rate/level should be removed entirely and all new admissions should come in on the higher dependency rates. • All homes in 2021 have continued to experience difficulties with staffing and have had excess agency costings which are unprecedented, *Provider S* has spent £183k YTD just on agency costs. The other 2 homes are in excess of £57k so we would like this to be considered as part of your costing review. Other additional costs for 2022, are both utility costs, insurance costs and food, additional NI contributions, please consider these as well, we look forward to your comments	*In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities.* *In relation to energy prices it has been recognised that for some providers utilities and insurance costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.*

Provider Feedback	**LCC Response**
Provider T	
Thank you for your letter dated 17 December 2021 with your proposal for the 2022/2023 fee increase. *Provider T* welcomed being part of the data gathering for the Care Analytics report, and the consideration that has been put into this year's annual increase.	*The market assessment highlights that differences in operating policies and practices between providers (such as size of home, layout) add complexity when seeking to produce a standard cost model for the marketplace. The 2022-23 cost model is built upon amounts representative of both the median of survey results and*

It is also encouraging to hear we will be moving to gross payments shortly and we welcome any trial of your new systems. Do let me know should you require any support from our Head of Transactional Finance.

Reading through the detail provided in your letter and the recent commissioned report, we would like to draw your attention to the following three areas:

1) Current 2021/2022 fee rates

Within your letter you have identified the current fee rate as a base for the annual increase to start from. This starting figure is not our understanding of a true cost of care.

You will recognise the following from your letter:

Care Group	Current 2021/22 Rate
Older People Standard Residential	£533
Older People Nursing	£588
Older People Higher Dependence	£587

We note you may have worked this out with 100% occupancy, and even with a full care home, there would be a reduction due to resident turnover, 95% for example. However, in your commissioned report by Care Analytics, it states a mean occupancy of 71% across the county.

Also within the report provided on the 22 November 2021, it states that the cost of care per week ranges from £760-£815 per bed, depending on whether staffing levels can be flexible with occupancy.

almost three quarters being placed in standard residential care. Therefore, your starting figures are not what we recognise to be covering our current cost of care for the annual fee increase to then be applied on top.

The rate of £749, as noted above, excludes government funding going forward from April 2022/2023, as we have assumed that the Government grants will not continue into the new financial year. However, we do account for free PPE via the Government portal which has been confirmed as extended for a further year.

And we have made an assumption that you are including actual NLW increase

the trimmed mean.

The wages rates included in the model are built on the median of survey results and the trimmed mean. Where providers were paying more than the NLW, this is reflected in the median and means that the average wage rate included in the model is higher than the NLW in some cases. The median was then uplifted to reflect the National Living Wage increases of 6.6% from April 22. The rates have also been uplifted following consultation to include the 1.25% increase in National Insurance.

The non pay elements have been uplifted by 4% aligned to the forecast inflation increase for 2022 confirmed in the comprehensive spending review. This was again compared to the median results of the surveys received back.

We recognise that for some providers utilities costs are significantly different to those submitted in the market survey. We also recognise the volatility of this market, therefore we are proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures. We will develop and publish the detail of this fund during Mar22.

The previous model was based upon 90% occupancy. The only element of the current model which includes occupancy in the calculation is the return of capital. All other costs are based on the median of survey results and the trimmed mean therefore occupancy rates will not impact on the pay and non pay parts of the model.

In undertaking the Market Review work we developed a robust model based on the information obtained and consider that the proposal overall meets the Council's responsibilities. We believe that the proposed rates enable providers to meet the CQC regulations.

within your figures.

2) LCC proposed increase

Following on from our starting point of a true cost of care, as above, this is how *Provider T* see the new financial year costs unfolding:

Descriptor	Weighted Average Fee Required
Social care levy	0.70%
Pay	6.10%
Increased housekeeping for infection control	2.50%
Insurance	0.30%
Estimate of other inflationary increases	1.91%
Total fee increase required excluding inflation on other costs	**11.51%**

The above is an increase of 11.51% on our standard costs of care.

You can see via the table below, that we are over £200 short of covering our costs when factoring in your starting position being too low and your increase of 5.6% not being high enough.

<<table deleted to ensure anonymous response >>

3) Market and sustainability

Following on from the Care Analytics report, which states that CQC audits show 30% of homes in Lincolnshire as Requiring Improvement (RI) compared to 19% nationally, and 7% inadequate compared to 1% nationally. We are proud of the care that we provide, and request support in sustaining a good quality of care through the fees the council pays. We currently have 11 homes with good ratings in Lincolnshire, and two with outstanding.

Low fee rates drive down the quality of care provided, whereas the rates that we have demonstrated would support the market and the sustainability needed to cover the cost of good to outstanding care as outlined by CQC. As such we are unable to see how your proposed fees of £563-£621 reflect the true cost of care as outlined in the Care Act. As one of the largest providers in Lincolnshire we would be happy to provide any further information that is required to support the costs that we have shared in order to secure additional funding for the sector. We also look forward to the tender opportunity for a block contract which you outlined in your letter, which would offer further stability for care homes within Lincolnshire. Thank you for your time and consideration, and so that you are aware, we are sharing all cost of care responses with the relevant bodies.	

Provider Feedback	**LCC Response**
Provider U	
We are writing in response to your letter presenting LCC's proposed fees for 2022/23. We welcome the opportunity to provide our feedback, and would like to bring to your attention the following: The proposed 2022/23 rate for Older People Higher Dependency is given as £621. This represents a 5.79% increase on the rate for the previous year. The letter states that this increase recognises the continued cost pressures on providers. However, we calculate that this 5.79% increase is insufficient to keep pace with current increases in provider costs, and in reality, represents a deficit to the provider of at least 0.59%. The table below displays the known cost increases for care providers during the period in question.	*The wages rates included in the model are built on the median of survey results and the trimmed mean. Where providers were paying more than the NLW, this is reflected in the median and means that the average wage rate included in the model is higher than the NLW in some cases. The median was then uplifted to reflect the National Living Wage increases of 6.6% from April 22. The rates have also been uplifted following consultation to include the 1.25% increase in National Insurance.* *A 4% inflationary uplift has been applied in line with the Autumn Budget and Spending Review published in October 2021.* *In relation to energy prices it has been recognised that for some providers utilities costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fundi during 2022/23 which can be accessed to support with these unpredictable cost pressures.* *We are unable to confirm the status of the grant funding that has been made available by National Government during the Covid-19 pandemic. You can however be assured that any monies that become available will be passported to ASC providers as has been the case to date.*

Affects	Rate of Increase	Detail	Source
Wages	6.60%	April 2022 increase in National Living Wage	https://www.gov.uk/government/publications/minimum-wage-rates-for-2022
Wages	1.25%	April 2022 increase in Employer's National Insurance (ENI) Contributions	https://www.gov.uk/government/news/record-36-billion-investment-to-reform-nhs-and-social-care
General Expenses	5.10%	Consumer Price Index (CPI) as of November 2021 (latest available data)	https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/d7g7/mm23

The following table represents the known cost increases as a percentage of provider sales.

Item	Item as a % of sales	Increase due to	Rate of increase	Increase represented as a % of sales
Wages	65%	National living wage increase	6.60%	4.29%
Wages	65%	ENI increase	1.25%	0.81%
General expenses	25%	CPI	5.10%	1.28%
			Total	**6.38%**

NB: The above table does not include the excess impact of energy and insurance.
The level of inflation for energy costs in 2022/23 is projected by all official sources to be higher than the current CPI. The same is projected for insurance, which remains historically high for the care sector.

The overall increase in costs, as a percentage of sales is 6.38%. This exceeds the proposed 5.79% increase in the weekly fee by 0.59%, which means that a provider of care for the elderly will be facing a deficit.

Therefore, we believe the fee increase should be higher. The above tables indicate that an increase of at least 6.38% will be necessary to keep pace with the known cost increases in 2022/23.

However, given that the government has widely publicised its plan to put extra money aside for the care sector (to compensate for years of underfunding, and address the difficult conditions under the Covid-19 pandemic, when most homes were operating at a loss) we expect the fee increase to be above this minimum of 6.38%, to acknowledge pandemic impacts and redress historic funding shortages.

We have noted that grants are available to assist with recruiting, retaining and training staff. We all know and understand that the recruitment and training challenge will stay with us for at least the next couple of years. Will the grants remain in place for this extraordinary situation?

We are happy to discuss any of the points raised above in more detail. We thank you for taking our comments into consideration and await the outcome of the Council's formal decision making process.

Provider Feedback	**LCC Response**

Provider V

We are writing in response to your letter presenting LCC's proposed fees for 2022/23. We welcome the opportunity to provide our feedback, and would like to bring to your attention the following:

The proposed 2022/23 standard Band 2 rate for providers specialising in Learning Disabilities is given as £780. This represents a 4.14% increase on the rate for the previous year. The letter states that this increase recognises the continued cost pressures on providers. However, we calculate that this 4.14% increase is insufficient to keep pace with current increases in provider costs, and in reality, represents a deficit to the provider of at least 2.24%.

The table below displays the known cost increases for care providers during the period in question.

Affects	Rate of Increase	Detail	Source
Wages	6.60%	April 2022 increase in National Living Wage	https://www.gov.uk/government/publications/minimum-wage-rates-for-2022
Wages	1.25%	April 2022 increase in Employer's National Insurance (ENI) Contributions	https://www.gov.uk/government/news/record-36-billion-investment-to-reform-nhs-and-social-care
General Expenses	5.10%	Consumer Price Index (CPI) as of November 2021 (latest available data)	https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/d7g7/mm23

The following table represents the known cost increases as a percentage of provider sales.

Item	Item as a % of sales	Increase due to	Rate of increase	Increase represented as a % of sales
Wages	65%	National living wage increase	6.60%	4.29%
Wages	65%	ENI increase	1.25%	0.81%
General expenses	25%	CPI	5.10%	1.28%
			Total	**6.38%**

NB: The above table does not include the excess impact of energy and insurance.
The level of inflation for energy costs in 2022/23 is projected by all official sources to be higher than the current CPI. The same is projected for insurance, which remains historically high for the care sector.

The overall increase in costs, as a percentage of sales is 6.38%. This exceeds the proposed 4.14% increase in the weekly fee by 2.24%, which means that a provider of care for the elderly will be facing a deficit.

The wages rates included in the model are built on the median of survey results and the trimmed mean. Where providers were paying more than the NLW, this is reflected in the median and means that the average wage rate included in the model is higher than the NLW in some cases. The median was then uplifted to reflect the National Living Wage increases of 6.6% from April 22. The on costs applied to the rates have also been uplifted by the 1.25% increase in National Insurance.

A 4% inflationary uplift has been applied in line with the Autumn Budget and Spending Review published in October 2021.

In relation to energy prices it has been recognised that for some providers utilities costs are significantly different to those submitted in the market survey. We recognise the volatility of this market and are therefore proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures.

We are unable to confirm the status of the grant funding that has been made available by National Government during the Covid-19 pandemic. You can however be assured that any monies that become available will be passported to ASC providers as has been the case to date.

Therefore, we believe the fee increase should be higher. The above tables indicate that an increase of at least 6.38% will be necessary to keep pace with the known cost increases in 2022/23. However, given that the government has widely publicised its plan to put extra money aside for the care sector (to compensate for years of underfunding, and address the difficult conditions under the Covid-19 pandemic, when most homes were operating at a loss) we expect the fee increase to be above this minimum of 6.38%, to acknowledge pandemic impacts and redress historic funding shortages. We have noted that grants are available to assist with recruiting, retaining and training staff. We all know and understand that the recruitment and training challenge will stay with us for at least the next couple of years. Will the grants remain in place for this extraordinary situation? We are happy to discuss any of the points raised above in more detail. We thank you for taking our comments into consideration and await the outcome of the Council's formal decision making process.	

Provider Feedback	LCC Response
Provider W	
Provider W is an 83 bed nursing home specialising in dementia, learning disabilities and mental health for young adults and the elderly. The majority i.e. over 70% of residents are funded by LCC, the remaining through CCG, other local authorities and a very small number of self-funders. Therefore, we heavily rely on LCC and vice versa. Following LCC's proposed Adult Social Care fees, I would like to add the following which highlights the pressures *Provider W* is facing: **Occupancy** • Knight Frank found average occupancy is down year-on-year from 87.9 per cent from 2019-20 to 79.4 per cent in 2020-21. • We have faced a similar trend, with occupancy decreasing by 6% from previous year. • We have never charged a third party top up fee, this however may need to be	*The previous model was based upon 90% occupancy. The only element of the current model which includes occupancy in the calculation is the return of capital. All other costs are based on the median of survey results and the trimmed mean therefore occupancy rates will not impact on the pay and non pay parts of the model.* *In relation to wages the model is based on the median of results received from providers and has been increased to reflect the increase to the National Living Wage (of 6.6%). It also includes public holiday premiums as standard, even though not all homes are paying this.* *The wages rates included in the model are built on the median of survey results and the trimmed mean. Where providers were paying more than the NLW, this is reflected in the median and means that the average wage rate included in the model is higher than the NLW in some cases. The median was*

considered in the near future. **Staffing** • We are finding it increasingly difficult to recruit and retain staff given that other competitors to the Care Sector offer higher wages with added welcome bonuses, which we simply cannot compete with given that funding has/is been below par. Our wage bill saw an increase of 12.13% from March 20 to March 21. • We must factor in our rural location and lack of public transport when recruiting staff. Such added barriers require new employees to drive. • Agency Staff: usage and cost have dramatically increased. Our agency bill saw an increase of 19% from previous year. In addition, we heavily rely on Agency Nurses specifically the Night shift. We hope that the Scottish Model of nurses on night shift is adopted in England to help ease pressure. • It is expected that employees, employers and the self-employed will all pay 1.25p more in the pound for National Insurance (NI) from April 2022 for a year - after which the extra tax will be collected as a new Health and Social Care Levy. **Other cost pressures:** • Utilities: Energy Gas and Electricity: it is a known fact the utilities are increasing at an alarming rate and even more so now with Political tension in Eastern Europe. • Insurance cost: our insurance premium increased by 26% from previous year. Other insurer providers quoted up to 160% increase for the same cover. • Cleaning & Medical: our cleaning and medical cost have risen by 37% from previous year. • Increasing base rate To conclude: we know that NLW will increase by 6.6% from April 2022. Staffing is the biggest cost pressure for all Care Homes, in addition as I have highlighted above the further cost pressures, it is wholly unreasonable that LCC's fee proposal does not take into account these percentages or cost pressures whether current or future. Furthermore, the LD proposed rates increments are not in line with other Categories of Care. <u>Thus, we do not feel that the proposed fee level would represent a fair cost of care.</u> The residents at *Provider W* are some of the most vulnerable residents within the	*then uplifted to reflect the National Living Wage increases of 6.6% from April 22. The rates have also been uplifted following consultation to include the 1.25% increase in National Insurance.* *The non pay elements have been uplifted by 4% aligned to the forecast inflation increase for 2022 confirmed in the comprehensive spending review. This was again compared to the median results of the surveys received back.* *We recognise that for some providers utilities costs are significantly different to those submitted in the market survey. We also recognise the volatility of this market, therefore we are proposing to create a Hardship Fund during 2022/23 which can be accessed to support with these unpredictable cost pressures. We will develop and publish the detail of this fund during Mar22.* *As a result of the market review work we have identified a number of areas to consider further during the next year. This includes further work with specialist sectors.*

community who need our support, in turn *Provider W* need the necessary support from LCC. Increments in fee levels in previous years have not reflected real inflation rates respectively, leaving a wide gap in the cost of care. We are proud to offer excellent care to our residents and wish to continue, however if we are not financially supported by the Council with a fair increment, the quality of care is likely to diminish. Without the Council support, inevitably our services will become unsustainable. Our residents deserve the best quality of life, without your support their quality of life will suffer	

Lincolnshire Care Association (LinCA) Feedback	**LCC Response**
Thank you for sight of the Care Analytics Lincs Older Adult Care Home Market review 2021-2022 dated 18th October 2021, and your proposed care home fees for 2022/2023 dated 17th December 2021. The report seems well commissioned and executed; however, we struggled to understand the way that the findings of the report had informed the proposed care home fees, particularly with respect to the specific concerns referred to below. Would it be possible to share this please? Without the detail of how the proposed fees were arrived at, we are concerned that some of the key cost pressures which the sector is facing may not have been addressed. Including: • Labour costs: The hardening of the labour market is well documented, with advertised posts for carers at more than £10 per hour going unfulfilled. This is 12% higher than the current national minimum wage and reflects the rising wage rates in retail and hospitality sectors which are competitors for our workforce. This increase to our base cost has a knock-on effect on the differential pay due to those with additional responsibilities. • Utilities: Energy Gas and Electricity are already rising for some providers by 100% • Insurance costs rising between 30%-80% • Building/Maintenance Materials up to 100%	*The fees proposed are informed by responses to the Care Analytics survey and include standard care home and specialist services provision, incorporating and applicable to the vast majority of care packages commissioned by the Council.* *The wages rates included in the model are built on the median of survey results and the trimmed mean. Where providers were paying more than the NLW, this is reflected in the median and means that the average wage rate included in the model is higher than the NLW in some cases. The median was then uplifted to reflect the National Living Wage increases of 6.6% from April 22. The rates have also been uplifted following consultation to include the 1.25% increase in National Insurance.* *Recognising the challenges in the workforce the Council continues to work with yourselves in both your role as the Care Association and in your role as the Strategic Market Support Provider in addressing the workforce pressures currently being faced. The Workforce Strategy and the current work with Social Change are all targeted at improving the image of care work and attracting more people to work in the industry. This is in addition to ensuring that all grant funding made available to the market has been passported directly through to providers.* *Energy rates are very concerning, however, the extent of price increases is not yet fully understood and will not impact on all providers equally. Therefore we are proposing to introduce a hardship fund in 2022/23 to support with these cost pressures.*

• Agency Staff use and costs increasing dramatically (particularly in our Nursing Homes) • 2% increase in National Insurance • Increasing interest rates due to the changing view of the care home market following the experience of COVID-19 In light of the pressures mentioned above, we are concerned that costs by March 2023 may be significantly in excess of those currently envisaged. Estimates of business inflation for 2022/23 vary significantly and in some cases are reported to be up to 10%. In these uncertain times would it be possible to review fees and cost pressures on a quarterly basis? This would also allow any grant income from national government to be taken into account. It is not lost on LinCA that significantly increasing fees is another inflationary pressure for others, however we cannot overstate that the sector is experiencing a crisis which we anticipate will worsen during 2022/2023, particularly for those care homes who are not in a position to generate additional income from top-ups or self-funders. We do not feel that the proposed fee levels would represent a fair cost of care that would sustain the sector through extra-ordinary times, in a manner that allows for high quality suitable care that meets the needs of Older Lincolnshire residents and adults with Learning Disabilities living in residential care, and indeed supports the regular delivery of Primary and Secondary Care within the ICS.	*The Comprehensive Spending Review forecast that inflation will average 4% across 2022 and this has been built into the models non pay costs.* *Cost pressures associated with Covid-19 have been excluded from this work. The Council will continue to ensure all additional funding made available to address these pressures is passported directly to providers, as has been the case to date.* *Factors such as Covid are key in the rationale to only set of rates for the 2022/23 financial year.* *The council is committed to a programme of work which will include a review of the structure of the learning disability rates, work with our health colleagues to ensure appropriate rates are paid by both health and social care for nursing placements, and to work with areas of the sector who were unable to respond to the survey, e.g. Mental Health providers.*

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Appendix E Older Peoples Rates

	Residential	Nursing	High Dependency
Total care worker hours	21	24	24
Care worker mean wage	£9.94	£9.95	£9.95
Total care worker cost *(inc on costs)*	£255.0	£298.0	£298.0
Total ancillary staff hours	7	7	8
Chefs & cooks wage	£10.72	£10.72	£10.72
Domestic staff wage	£9.70	£9.70	£9.70
Handyperson wage	£10.02	£10.02	£10.02
Total ancillary staff cost *(inc on costs)*	£90.0	£90.0	£105.0
Total management and admin hours	3	3	3
Management and admin mean wage	£13.72	£16.23	£13.60
Total management and admin cost *(inc on costs)*	£40.0	£48.0	£40.0
Total non-staff costs	£122.0	£130.0	£122.0
Cost of capital / rate of return	£60.0	£60.0	£60.0
Proposed Weekly Rate	**£567.0**	**£626.0**	**£625.0**

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Appendix F Learning Disability Rates

	Band 1	Band 2	Band 3
Total care worker hours	45	29	21
Care worker mean wage	£10.26	£10.26	£10.26
Total care worker cost *(inc on costs)*	£591.0	£382.0	£276.0
Total ancillary staff hours	5	5	5
Chefs & cooks wage	£12.50	£12.50	£12.50
Domestic staff wage	£9.71	£9.71	£9.71
Handyperson wage	£12.61	£12.61	£12.61
Total ancillary staff cost *(inc on costs)*	£69.0	£69.0	£69.0
Total management and admin hours	2	2	2
Management and admin mean wage	£15.96	£15.96	£15.96
Total management and admin cost *(inc on costs)*	£35.0	£35.0	£35.0
Total non-staff costs	£189.0	£189.0	£189.0
Cost of capital / rate of return	£109.0	£109.0	£109.0
Proposed Weekly Rate 13+beds	**£993.0**	**£784.0**	**£678.0**
Proposed Weekly Rate 7-12beds	**£1,039.0**	**£831.0**	**£725.0**
Proposed Weekly Rate 1-6beds	**£1,086.0**	**£878.0**	**£772.0**

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