ANNEXE B FCOC CARE HOMES REPORT

Final Version for submission

Acknowledgements

We would like to extend our sincere thanks to all those care providers who have contributed any cost data or other information to the York Council Fair Cost of Care exercise, or who have participated in our engagement activities. Thanks also to the Independent Care Group, York's local care provider association, for their support to the exercise.

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1 About this document

Purpose of this document

This document has two purposes:

- To comply with the DHSC FCOC grant funding requirements, acting as a companion to Annex A and Annex C.

- As a locally published summary of how the FCOC exercise was carried out, and how the data and results will be used going forward, including:

    - How the exercise was approached, the methods used to obtain and review data.
    - The rationale applied to dealing with the cost submission data, and consequent conclusions as to the confidence we have in the data and results.
    - A summary of the results.
    - How we intend to further use the dataset and Annex A.

We hope that this will be useful for care providers, whether they participated or not, and other local stakeholders. Further details on the Council's provisional action plan to build on this FCOC exercise are included in Annex C, which will not be published locally until a final version is produced next Spring, following further collaboration and consultation with local care providers.

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Content of this document

Section 1 of this document is sector-independent and applies to both care sectors. It is reproduced in both Annex B documents. The same goes for most of sections 2 to 4, which describe the rationale for our approach to the FCOC exercise in York and how that has influenced our interpretation and use of the cost data submitted, and our intended treatment of the results. There are some elements of these sections that use sector-specific examples and for these elements the text will differ in the two versions of Annex B.

Use of the word “we” in this document generally refers to City of York Council.

Guidance or Policy references

Where necessary we have made references to certain national FCOC guidance or policy documents to help evidence our approach and information presented in this document. This should help not only the DHSC review team, but also readers of this document understand how we have interpreted and applied such guidance in the unique context of York. We also recognise that there may be other readers of this document who are not experts in the arena of social care provision or the FCOC programme and so we have tried to limit such references.

For commonly referenced sources, in order to help readability the entire document title is not reprinted each time the reference is made, but rather a shorthand reference is used as shown in the following table.

Guidance source document	Shorthand reference
Updated guidance note on data returns and fee setting following the DHSC’s 2022 policy, “Market Sustainability and the Fair Cost of Care Fund guidance”; version 2, 28 September 2022	LGA legal guidance
References to above specific sections or paragraphs	LG (section para)
FCOC and charging reform policy note 25/08/22	Policy note
Cost of care: analysis, review and verification of provider submissions	LGA review guidance

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2 Our application of the FCC Programme in York

Our approach and rationale

A delay in implementing the programme meant we have taken a pragmatic approach to the FCC exercise in York, with less time than desired to mobilise greater provider participation. Our approach has also recognised that participating in this exercise is not a trivial thing for providers, and given that market conditions are extremely challenging, many will have had limited resources to devote to the exercise.

We decided that it was vital to retain experienced, independent consultants[1] to maximise the chances of a reasonable outcome from the exercise specifically because:

- York Council staffing limitations meant that it was impossible to commit sufficient resource to conduct the exercise in the time available without external help.
- There was limited time available and experienced consultants were more likely to be able to structure and manage a programme capable of delivering a reasonable return from the market under such circumstances.
- The external consultants were entirely independent of York Council and the local care economy.
- The external consultants used were highly experienced within the care sector and have owned and run their own care business, and thus have deep understanding of the challenges and issues affecting providers.
- The external consultants used have worked on FCC exercises elsewhere in the country.

Interpreting and checking of the data submissions

This section draws upon the latest legal guidance, specifically LG (C), which relates to how Councils should interpret the data submitted by providers. Our approach has been predicated upon undertaking a **reasonable** amount of checking and dialogue with providers; that is to say, reasonable within the circumstances and context of York (given the limitations pertaining to the exercise noted above) and which complies with LG (C). The term *reasonable* in this instance is used to reflect the following:

- the resource implications for providers of participating in the FCOC;
- respecting the pressures on care providers and only engaging in a dialogue during the exercise to the level where it would not be intrusive or disrupt provider operations;

[1] Use of external consultants in FCC exercises is not unusual across the national programme.

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- recognising the specific limitations of the York exercise - late start, with very limited time to receive and query submissions, taking place during the peak holiday period of the year when staff availability is most affected by holiday absences;
- maintaining a spirit of openness and trust between commissioners and providers;
- the limitations inherent in such an exercise, with particular respect to the data generated (and to some degree the methods used), and the consequential reliability of such data for planning purposes.

Thus the level of checking and review we conducted had to be commensurate with the above factors to be considered reasonable. As an example, we did not engage in a more intense (or intrusive) level of checking such as requesting access to underlying records (ref LG (D50iv) because we judged that this would not have met our above criteria for what was reasonable *for this particular exercise*.

Thus the degree of checking data with providers focussed on aspects such as the following:

- Querying any obvious errors, such as the use of negative numbers
- Clarifying operational aspects of the business in order to better interpret the data
- Looking for inconsistencies or potential inaccuracies (as per page 4 of the DHSC guidance).
- Querying active bed number figures which were significantly lower than the CQC-derived bed number figures.
- Seeking clarification about inter-year variations, especially if costs were lower in the 2022 year than in the previous 2021-22 year.

For example, on checking with them, one provider confirmed that the care home in question was newly opened and that explained why the occupancy was low.

The checking stage resulted in some providers re-submitting their data, generally because of changes to specific fields only.

It is also worth pointing out that our exercise used LGA-approved data collection tools for both sectors. All submissions used one other of these tools (dependent on the sector in question). This hopefully will have introduced a level of consistency into the dataset (refer to DHSC guidance page 5), if only from the perspective of data collection and collation method.

In summary, the checking and review process involved reviewing the submissions for obvious errors and feeding back to providers who then either reconfirmed their original submissions or made revisions based on the comments provided.

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However, once this process was complete, the Council did not make any adjustments, which is explained in the following section.

Our approach to making adjustments

By adjustments we mean here *any further changes made or instigated by the Council to provider data* that were:

- not discussed or agreed with the provider;
- carried out following, or in addition to, any review dialogue with the provider.

Our prime considerations regarding making adjustments were to:

- preserve the integrity and provenance of the provider data, and
- apply consistency throughout for both sectors and all providers.

These considerations were paramount mainly because of the above-mentioned constraints on this exercise. For this reason we felt that the only option was to adopt a "no-adjustment" policy because we did not consider that making adjustments would improve the data sufficiently, when compared with the risk of distorting it.

In adopting this rationale we were particularly mindful of several things:

- The time limitations of the exercise, which would give a high probability that one or more adjustments would be poorly thought-through or result in greater error.
- The turn-round time in which to generate, discuss and confirm any queries and changes.
- The need to maintain consistency overall and not potentially disadvantage (or advantage) one provider compared with another.
- The need to maintain a very clear audit trail for the data (both provider-specific and in aggregate).
- The danger of excluding outliers from the dataset, without sufficient time to explore them further. On this point we also intend to focus more on *averages* in our modelling, rather than *medians*, because the latter automatically exclude outliers, and thus essentially lose data. However, in deference to the DHSC requirements we use medians in Annex A and replicate those results here in Annex B.

These factors led us to believe that it was better to leave the data unadjusted, rather than risk distorting it, given its likely weight and utility in enabling immediate decision making or expectation-setting (as explained in section 4.1).

We provide an example here of the practical application of our adjustment approach. Regarding LG (C36) the Council did not make any adjustments to any submission that was significantly deficient in information, following review and checking. Instead

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we assessed such a submission as non-compliant and thus it was included in the FCC data set.

<u>Example of a submission providing *insufficient information* as in LG (C36A):</u>

On querying its submission, one care home operating in York (but part of a company operating nationally) explained that it would not be providing the staff information necessary for the carecubed system to generate the key cost per bed type outputs required to feed annex A. It explained that this was principally due to its central finance team (who collated all their submissions nationally) being overwhelmed by the requirements of the national FCOC programme.

3 Limitations of the programme and data set

It is important to point out a number of factors that potentially place limitations on the accuracy and reliability of the data obtained and results. Some of these factors relate to the data collection and processing methodologies, tools and other factors inherent to the FCC programme, and others to characteristics of the care sectors.

Factors intrinsic to the FCC programme

Such factors include:

- The impact of covid policies and grant funding during the base 2021-22 year, but also potentially affecting 2022 data too.
- That the data are essentially a snapshot of a point in time, as opposed to the cumulative result of longitudinal (year by year) studies.
- Despite any uplifts used, the data are essentially historic, and so further modelling will be required regarding future projections. This point is referenced by the Care Provider Alliance[2] when it states *"the primary concern leading to both non-engagement in the FCoC process and the scepticism surrounding its impact has related to the data collected not being representative of the past or the required future state, to sustain the workforce and the sector and to address the impact of rising energy and agency costs, as well as rising inflation. It is the purpose of the FCoC exercise to identify accurately the gap between what is currently paid, and what rate is sustainable for the future."*

In addition to these factors there are also sources of variation and error relevant to this exercise, which are highlighted in the following section.

Sources of error and variation

[2] Provider Market Sustainability Planning Support to Councils – executive summary.

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The data obtainable, and then reported, by contributing providers are subject to a number of sources of error and/or variation, including.

- The information processing and financial regimes governing the particular provider organisation. Factors here include the sophistication, frequency and scope of management accounting, or the payroll regime.
- The sophistication and capabilities of the information sources, systems involved in capturing operational data and organising it for management and financial purposes. Of particular relevance here are scheduling systems, electronic call monitoring, payroll and HR systems, and accounting software.
- The sophistication and capabilities of the staff involved in gathering, collating and reviewing, and then organising the data prior to submitting the returns.
- The heterogeneity of the providers – in both sectors there is a wide range of provider size, from very small companies with little or no support staff to large, multi-million turnover organisations with corporate structures. The operating models of providers can also vary, with no "one size fits all" approach.
- The business performance and strategies of providers. Some providers, at the time of sampling, may be in different stages of their business and investment cycles. For example a newly opened care home or branch may have different profiles than a well-established one, which could well make their cost ratios, and surplus targets, very different.
- The nature and limitations of both toolkits[3] used in the FCC exercise meant that a certain degree of interpretation and judgement has to be used by the person, or people, generating the data submission. Moreover, not all the data used in the provider organisations is a "natural fit" to all the input requirements of the toolkits and so there may have to be a degree of translation of the source data into the format required by the toolkits, a process which can itself be subject to variation or errors.
- The arithmetic effects of nils and nulls on median and average values. In general, including zero values instead of nulls will reduce these values, and in the case of a median figure may result in a zero result. These effects are most fully felt on smaller sample sizes.

4 Our confidence in the data and Annex A

Our confidence weightings

[3] There are also benefits to using the iESE and ARCC toolkits, which help ensure a consistent, systematic approach to collection and analysis of the data.

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So our confidence in the data and Annex A being an accurate and reliable source for setting the fair cost of care can be seen as a function of two things:

- Firstly, the necessities of our pragmatic approach as described in section 2.
- Secondly, the inherent limitations of the FCC programme and any resultant data, as described in section 3.

The latest legal guidance, specifically LG (C) relates to how Councils should interpret the data, and LG (D) concerns how Councils may assign a weight to the data. So our confidence rating is essentially what weight we give to the data and thus to Annex A. Before we do this, we must firstly distinguish two things:

- Our confidence in the results as they stand being sufficiently reliable to draw definitive conclusions or set definitive targets for a cost of care.
- Confidence in the results as being a useful set of data to guide further analysis and refinement, and inform a productive dialogue with the market.

So we have stated two confidence weights to reflect this important distinction, as follows.

Definitive conclusions & targets	To guide further analysis and refinement
LOW	MEDIUM
We cannot assign much weight to Annex A without further analysis and dialogue with providers	We believe the FCC data gathered will be helpful in guiding our dialogue with providers as part of paying a fair, York cost of care

It is important to stress that the Annex A figure, whilst being important for the purposes of accessing grant funding from the DHSC's Fair Cost of Care Fund, is only a starting point on the journey towards a fair cost of care. DHSC guidance on page 2 of the 25/8/22 policy note states merely that actual fees paid to providers will be *informed* by the FCOC exercise.

Extract from FCOC policy note: Defining "moving towards"

Our policy expectation is that local authorities make as much progress as possible towards the fair cost of care identified locally in your exercise within this Spending Review period.

Our policy guidance talks about "moving towards" because we recognise that this is a journey. Although we expect local authorities to move towards paying a fair cost of care, we know local authorities will be starting from different points, with some further away from the fair cost of care than others.

This means some local authorities will reach the fair cost of care for their local area in this Spending Review period, whereas others are on a longer journey and will not. Our policy expectation is therefore that you make as much progress as possible.

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We echo the above in our approach to the FCC results, and also the legal guidance, specifically:

- with reference to LG (C28-31) we regard the Annex A figures submitted as preliminary, indicative figures which will inform our plans.
- regarding LG (E66-67) we are committed to making as much progress as possible to paying a fair cost of care in York over the Spending Review period and beyond, and it is our Market Development Programme (described in Annex C) that will be the means of achieving this, working closely with our providers to do so.

How we will treat the Annex A results

So we can summarise our approach to Annex A as follows. It is important, but it is the *starting point* in the journey towards a sustainable cost of care for York. It is the underlying aggregated data set that will be further analysed and refined in conjunction with providers, alongside detailed discussions around future commissioning strategy. These discussions will not take place in isolation from each other, nor on a piecemeal basis, but will be brought together as part of a comprehensive Market Development Programme where all providers can take part.

We are committed to commencing this programme following the completion of the FCC exercise. Further details on the programme are included in Annex C.

We believe our approach is consistent with both the spirit and the letter of the legal guidance LG (E66-68) and LG (H).

Finally in this section we wish to stress that our comments in this section are not a criticism of the DHSC FCOC programme in general, and indeed we recognise that the DHSC had to start somewhere in an attempt to bring a greater robustness, consistency and objectivity to the whole issue of Council fee rate settlements that recognises the pressures on care providers and their consequent costs.

Neither should our comments here be taken as any criticism of the providers who have taken part in the exercise, or as downplaying the importance in them having done so. On the contrary, the inputs from our providers will form a crucial starting point and base to build from as we move forward and will help shape a productive, collaborative dialogue as we begin the journey towards achieving a sustainable and fair York cost of care.

5 Engagement with Providers

Scope and excluded services

The scope of care services included in the FCC was as defined by the DHSC, namely:

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65+ care homes:

- standard residential care
- residential care for enhanced needs
- standard nursing care
- nursing care for enhanced needs

The scope of York's FCC exercise included 33 in-area care homes – 11 with nursing beds and 22 without. Supported living accommodation was not included in the exercise.

Engagement approach

York Council's FCOC exercise was particularly challenging because it was not commenced until late July 2022, allowing very little time to engage the local market providers, orient them to the FCOC programme, and then get them up to speed sufficiently to submit their returns.

Our approach was applied equitably across the two care sectors and any group sessions we ran were available to attendees from both. We also engaged with the local care provider association, Independent Care Group (ICG) throughout the engagement process so that they could also encourage participation and help answer questions from providers about the national programme and the local exercise.

Engagement activities

These were led and conducted principally by the external consultants, in conjunction with the Council and ICG. The engagement activity covered the broad elements summarised in the following table.

Awareness and orientation	Publicising and launching the FCOC exercise and encouraging providers to participate. This took place via a combination of methods including emails, publications, and phone-rounds. All providers were invited to a formal launch webinar. Slides used at the webinar were circulated to providers who were not able to attend the launch event.
Guidance and sign-posting	All useful sources of information regarding the national FCOC programme, the toolkits being used, and local contacts for the exercise were circulated to providers. Advice was also given to providers on how to prepare for and produce the cost submissions, including tips for data collection and collation.

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Training and support	Providers were made aware of the national training available on the toolkits. Also the external consultants held specific walk-through sessions with anyone requesting support. ICG the local care provider association also offered support and specific toolkit training.
Checking and review	This was conducted principally by our external consultants, based on reviewing the submissions posted to the carecubed portal. Queries posted on the portal were supplemented by conversations or email dialogue with providers where possible.
Communications updates	These were issued at regular periods throughout the exercise to keep providers apprised of progress and events.

In addition and in parallel to the focus on the cost submissions, we also sought views and feedback from providers about sustainability of the market. The main focus for generating feedback and ideas was a specific survey issued to all providers. We accepted survey submissions from any provider, regardless of whether they completed a cost submission.

Some of the specific engagement activities or milestones are shown in the following table.

Event	Dates	Activity
Fair Cost of Care launch event	27th July 2022	Presentation given to home care and care home providers providing an overview of the FCOC exercise and outlining the timescales and requirements of providers participating.
Independent Care Group (ICG) Newsletter	29th July 2022	York FCOC exercise featured in ICG weekly Provider newsletter.
Independent Care Group – training on FCOC tools	9th August 2022 18th August	Online training sessions delivered by ICG on the LGA and ADASS-approved ARCC homecare toolkit.
FCOC original submissions deadline	22nd August 2022	1st deadline set for FCOC submissions
FCOC Submissions extension	29th August 2022	2nd deadline to facilitate further FCOC returns from the market.

In addition to the structured sessions our external consultants held 1-1 sessions with providers who requested assistance in completing the costing toolkits. We also undertook quality assurance and challenge on the results with the providers (as previously described) before undertaking the aggregation and analysis.

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The engagement activities were well received and attended. The launch workshop was attended by 21 attendees. The market sustainability workshops were attended by 12 provider organisations.

Completed market sustainability surveys were returned by 12 provider organisations, covering both care sectors, representing about 19% of all included providers across both sectors. Further information about the sustainability survey is included in Annex C.

A note on the cost submissions

Note also that one of the largest, national care home companies who submitted three care home submissions for the York catchment did not specify any uplift and only submitted FY21-22 data. This company also entered into national dialogue with the LGA about its cost returns, which were not compliant in York (or anywhere else) because they did not include sufficient data (for instance about staffing). The company refused to deal with any local authorities. The outcome of the national negotiation resulted in iESE making adjustments to the submitted returns and then posting these into the carecubed data submission system. No details were provide to local authorities other than an alert to inform the local authority when the revised submissions were posted.

Given that these submissions represent one quarter of the dataset then this places further caveats on the confidence we can have in the data.

6 Results

This section focuses primarily on the requirement to complete and submit Annex A. We do not describe the full aggregated data results here, nor how that data will be used in future modelling; suffice it to say that the data will be used, and further refined, in collaboration with providers, as part of our Market Development Programme which will follow once the DHSC has reviewed our submission. Further details are included in section 7.

Template used

We used the CHIP iESE CoC tool and did not ask for any other information from providers, nor use any other data collection template. This template is loaded into an online portal called carecubed. Providers registered for access on the carecubed portal, to which they could then upload their data, or fill in online while logged in.

The Council had its own login access to the portal. From here we were able to review submissions and highlight queries. There was a particular procedure for doing this, and providers could then respond to the query by either amending or reconfirming the data.

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Once this process was complete a download of all the provider submissions was taken, using the carecubed data extraction tool. This data extract was then converted into a master, aggregated spreadsheet, which organised the data to help with loading into the Annex A data table.

We experienced some issues with data integrity within the iESE dataset, principally that certain fields required by Annex A were not actually present as addressable fields in the data set because the data dictionary did not include sufficient field names in the data extract and did not in all cases map these accurately across the bed categories or data periods. This necessitated a degree of workarounds.

Another property of the carecubed data extract was that it outputted a combination of nils (zero values) and nulls (no data) over a considerable proportion of the dataset. This does not represent an error as such, but given the different impacts of these two data types on median values we considered what approach would best suit our exercise. On balance we decided to use nulls rather than nils because use of zeroes delivered too many median values for cost lines that were themselves zero. This approach was also recommended in general by iESE. There may be specific circumstances where a nil value would actually be more appropriate to use, but to determine this for sure would require a much closer and more detailed dialogue with the providers (for example to clarify their staffing models and operational procedures), which was not possible during the exercise.

We decided not to formally approve any submissions on the carecubed portal prior to submission of the FCC outputs to the DHSC.

Response rate

We received 13 submissions from the eligible providers. We also received one submission, which stated that the particular facility was not a care home.

Of the 13 submissions, one was incomplete and in accordance with our review policy (as explained in section 2.2) this was deemed to be non-compliant and excluded from the aggregated data set used to populate Annex A.

The remaining 12 submissions represented 37% of the in-area care homes. This compares with the national care home response rate of around 32% quoted by the Care Provider Alliance in their executive summary paper “Provider Market Sustainability Planning Support to Councils”.

NOTE:

- Each submission received was for a care home, not the owning provider organisation. Thus the number of submissions (12) was higher than the number of providers taking part (8).

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- Of the submissions, 8 were from care homes that delivered non-nursing and nursing care, and 9 that delivered enhanced needs care.
- Only 7 of the care homes submitted figures for 2022, but note that carecubed automatically rolls-forward the FY21-22 data in these cases.

Data periods used

The carecubed data template required providers to submit data for tax year 2021-22. Each provider then had the option of specifying a series of “uplift” percentage values that it could apply to different cost items, in order to act as a proxy for increased current costs. Some providers chose to do this and others did not, which generated a source of error and variation, which could be handled by the Council applying an additional inflation factor if so desired. The way in which we did this is explained in section 6.6.

Caveat on the Annex A figures

One of the requirements from the DHSC is for the figures submitted in Annex A to be included in Annex B. There has been much discussion nationally on this and whether it is useful to include such figures in this Annex B, especially if a Council has significant concerns about the reliability of the methods used and the consequent reliability of the data.

We have already described our concerns previously in this document, principally our low confidence in the results at the current time, without further refinement.

In keeping with the DHSC guidance we have published the data submitted because it will enable readers, and particularly care providers, to at least see for themselves the numeric results of the exercise.

However, we must stress to all readers to treat these results carefully. For the reasons previously stated these figures cannot be regarded as the fair cost of care in York. They are not at all *definitive*; they are merely *indicative* of costs reported by a sample of providers at a particular snapshot in time.

We stress that the Council will not ignore these results, but will use the underlying aggregated data to help inform our collaboration with providers over the coming months in our proposed Market Development Programme, which is described more fully in Annex C. A summary is reproduced here in Annex B because this Annex B is the only document actually being published at this point in time and it is useful to signal the likely breadth of the programme

We will be elaborating much more about this programme with providers in due course.

Annex A results

The care homes dataset from the iESE carecubed tool outputs a set of cost lines and ultimately a final cost for a resident in a bed for a week for four “bed type” categories

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based on whether nursing or dementia care is required or not. The four categories are shown below.

	Description[4]	Dementia	Nursing
Cat 1	Residential private (long-term)	No	No
Cat 2	Dementia Residential private (long-term)	Yes	No
Cat 3	Nursing (long-term)	No	Yes
Cat 4	Dementia Nursing (long-term)	Yes	Yes

Annex A requires these final figures and some of the underlying cost lines to be presented.

Note that the DHSC requires median values to be used in Annex A and so we use these values here. We prefer the use of averages because they include all variation in the data set and thus are more complete for modelling purposes.

Regardless of whether average or median figures are used it is important to stress that these values are simply derived from the aggregated data set from the FCC submissions from providers. These figures will not match any single provider's costs and no provider should infer that the medians somehow represent some idealised cost profile to which they should aspire. They are merely reflective of the submissions received during this exercise.

Inflationary uplift in Annex A

No adjustments were made to the aggregated data set following the checking and review process for the reasons given previously in section 2.3.

For the purposes of Annex A we decided to apply an inflationary uplift. This change was made for the purposes of making the carecubed data more consistent. This was done to balance the fact that carecubed merely pulls forward 2122 rates for providers not specifying an uplift – which in our opinion risks underestimating costs.

We kept the uplift very straightforward and easy to track – merely a simple addition of an inflation figure based on CPI as at August 2022 (9.9% rounded to 10% for simplicity). This is the minimum recommended by the Care Provider Alliance.

This figure was applied to the cost line medians as shown in section 6.8, but only for those providers who had not specified an uplift to April 2022.

Treatment of ROO & ROC

The medians show the ROO figures varying from to 8% to about 9.5%. The ROO medians are more likely to vary across the categories as they reflect the care staffing costs encumbent in operational management of the bed types.

[4] These descriptions come from the Council's Mosaic system.

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This variability across bed type is less relevant to ROC. The carecubed data extract did not vary these figures across bed types.

Of the care homes submissions that broke down the resident numbers by funder category, the data shows that the majority of residents are private self-funders. So it could be inferred that this contributes to higher ROO and / or ROC figures, and that lower percentages could be applied in a more Council-funded profile for care home beds, though this would need exploration in the subsequent modelling.

We rolled forward two care homes' ROO figures from FY21-22 (who had not specified an uplift to 2022) and inflation adjusted them to 2022. Four care homes that did not specify any ROO were left blank.

For ROC, just one care home provided a FY21-22 figure, but no 2022 uplift, and so this care home's ROC figure was rolled forward and inflation adjusted to 2022. Six care homes did not specify an ROC and these were left blank.

We made no other adjustments to the ROO or ROC figures for the purposes of the Annex A submission and the Council will consider how it deals with them in the final fee-setting process.

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Submitted Annex A figures

The figures shown below are the final figures for our Annex A submission, including the inflationary uplift, replicated from Annex A section 3.

With the exception of cost lines for nursing and carer staff, we populated only the sub-totals rather than the individual cost lines as we believe this is much simpler and easier to understand for readers of this document. Also, the portal submission requirements only need these rows to be completed for this part of the template.

The following table shows the medians for rows 34, 35, 36, 45, 50, 64, 69-71 in the template. The subsequent supporting information table is taken from rows 74 to 82. As per the DHSC requirement, the lower and upper quartile values for these cost lines are shown, along with the observation count, in section 6.10.

Cost line medians by bed category

	Cat1	Cat2	Cat3	Cat4
Total Care Home Staffing	£648.64	£634.75	£844.24	£754.94
Nursing Staff			£290.21	£270.23
Care Staff	£391.11	£413.64	£340.81	£319.63
Total Care Home Premises	£47.31	£48.46	£53.17	£48.46
Total Care Home Supplies & Services	£155.74	£141.99	£148.07	£121.01
Total Head Office	£107.02	£106.55	£106.42	£106.55

	Cat1	Cat2	Cat3	Cat4
Total Return on Operations	£117.85	£117.85	£117.85	£117.85
Total Return on Capital	£130.15	£130.15	£130.15	£130.15
Total cost per resident pw	**£1,262.86**	**£1,243.31**	**£1,478.72**	**£1,164.61**

Note that these are median figures and do not sum to the figures in the final row. Each row is treated separately for the purposes of Annex A. The nursing staff cost and carer staff cost figures are specific cost lines within the care home staffing figure. This latter figure reflects all the different staff cost lines (including administrative and other staff).

	Cat1	Cat2	Cat3	Cat4
Nursing Staff			£290.21	£270.23
Care Staff Approximate % of total staff cost	£391.11 31%	£413.64 33%	£340.81 43%	£319.63 51%

	Cat1	Cat2	Cat3	Cat4
LOW	£774	£774	£1,045	£1,045
25%	£994	£985	£1,145	£1,087
MEDIAN	**£1,263**	**£1,243**	**£1,479**	**£1,165**
75%	£1,410	£1,383	£1,653	£1,635
HIGH	£2,034	£1,526	£2,738	£1,915

Supporting information on important cost drivers used in the calculations:

	Cat 1	Cat 2	Cat 3	Cat 4
Number of location level survey responses received	12	9	8	5
Number of locations eligible to fill in the survey	29	29	11	11
Number of residents covered by the responses	13.25	15.50	17.25	16.50
Number of carer hours per resident per week	33.63	27.00	25.43	25.89
Number of nursing hours per resident per week			8.03	6.70
Average carer basic pay per hour	£11.16	£11.16	£10.75	£10.57
Average nurse basic pay per hour			£18.75	£18.69
Average occupancy as a percentage of active beds	80.3%	80.3%	80.3%	80.3%
Freehold valuation per bed	£14,773	£14,773	£14,773	£14,773

Annex A section 4 figures are shown below.

Description	No nursing	With nursing

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Cost of care exercise result (from above)	£1,252.32	£1,325.16
Average 2021/22 external provider fee rate	£870.00	£995.00
Average 2022/23 external provider fee rate	£897.00	£1,025.00
NHS funded nursing care rate 2022/23	N/A	£209.19
Average 2022/23 external provider fee rate 3	£897.00	£1,234.19
Hence distance from cost of care exercise result (%)	-28.37%	-6.86%
Hence 2022/23 fee uplift compared to 2021/22 4	3.10%	3.02%

Both the provider fee rates offered by the Council use the iBCF definitions. The fee uplift figure in the final row excludes FNC.

Comments and themes for further exploration

The median care pay per hour figures show a 5.6% variation from £10.57 (cat4) to £11.16 (cat1 & cat2). We would expect this figure to be relatively consistent across the categories. The observed pay figures in Annex A compare with around £10.49 (for about 78% of carers in July 2022) cited by the Care Provider Alliance.

Observed cost results may be contributed to by the following underlying factors characteristic of the York catchment:

- Relative affluence and commissioning patterns.
- A high percentage of private funder residents in the sample submitted (a median of from 60% for FY2122 and 71% for 2022).

The observed aggregated data shows that the results for the four bed type categories did not trend upwards as one might expect and some figures were higher for "lower need" categories than for higher need categories. This seems somewhat implausible and will be followed up in the post FCOC programme.

The occupancy percentages in the data do not vary across the four bed categories, because of the way carecubed works. The actual costs per bed would be expected to be significantly dependent on occupancy and so this issue will need further investigation and modelling to reach any optimum occupancy profiles.

The cost of nursing staff exceeds the £209 funded nursing care (FNC) per week that providers receive to meet a resident's health needs. This would represent a shortfall to the Council and will need further exploration.

Further analysis to be undertaken

Though we have not made adjustments, regarding LG (C36H) we have identified various analyses which will be undertaken post-FCC, as part of the follow-up dialogue with the market between October 2022 and February 2023. These include, but are not limited to the following:

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- Review and validate occupancy levels.
- Analyse care cost variation across the bed categories in order to determine whether the observed median figures are indicative of wider anomalies or just the consequence of the particular submissions received.
- Numbers and proportions of self-funders.
- Validating care staff hours in residential versus nursing care and modelling optimum care profiles for the four bed categories.

Regional comparisons

Another important aspect of our further analysis is to compare our FCC data with neighbouring regional data. There are considerable peculiarities around the York market that reduce its direct comparability with other authorities and so this has to be borne in mind. Nevertheless we thought it informative to use the emerging results from Yorkshire & Humber region for comparative purposes.

Unfortunately at the time of writing there were limited comparative data available for care homes, so the commentary on this is included only in the homecare version of Annex A.

Additional data tables

Quartile figures for Annex A submitted cost lines

Total Care Home Staffing	Cat1	Cat2	Cat3	Cat4
Lower (25%)	£572	£575	£753	£747
Upper (75%)	£925	£717	£1,206	£910
Count	12	9	8	5

Nursing Staff			Cat3	Cat4
Lower (25%)			£218	£179
Upper (75%)			£1,477	£1,165
Count			8	5

Care Staff	Cat1	Cat2	Cat3	Cat4
Lower (25%)	£319	£320	£311	£288
Upper (75%)	£554	£519	£437	£369
Count	12	9	8	5

Total care home premises	Cat1	Cat2	Cat3	Cat4
Lower (25%)	£38	£37	£45	£46
Upper (75%)	£60	£64	£67	£92
Count	12	9	8	5

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Premises costs include fixtures and fittings, maintenance, furniture and equipment.

Supplies and Services	Cat1	Cat2	Cat3	Cat4
Lower (25%)	£135	£127	£124	£114
Upper (75%)	£190	£178	£166	£146
Count	12	9	8	6

Supplies and services costs include food, cleaning PPE, utilities, office supplies, insurance, transport, and registration fees.

Total Head Office	Cat1	Cat2	Cat3	Cat4
Lower (25%)	£104	£97	£100	£83
Upper (75%)	£127	£111	£113	£125
Count	12	9	8	5

Head office costs include central management and support services (eg finance, HR).

Total Return on Operations (ROO)	Cat1-4
Lower (25%)	£99
Upper (75%)	£184
Count	8

Total Return on Capital (ROC)	Cat1-4
Lower (25%)	£97
Upper (75%)	£163
Count	6

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7 Next Steps

The immediate next step following the submission of our FCC required outputs (Annexes A to C) to the DHSC is for the outputs to be reviewed and commented upon by the DHSC. The level of subsequent grant funding may be dependent on this review, but may also be influenced by government actions.

Next Steps

Over the period of the last 18 months the Commissioning and Contracts team has experienced a high level of vacancies within its team. York has recently undertaken a significant transformation of the teams and has now in place an All-Age Commissioning and Contracts team and a Head of All-Age Commissioning and Contracts from February 2023.

We are using the market engagement information from this FCOC exercise to engage with our York market through a series of workshops to develop and sustain the market. Ideas produced from the providers who took part in the surveys and 1:1's with Adams Consultants on behalf of York Council will continue to be reviewed together to look at the activities that can add value for money to market offer.

There will be a number of Workshops in March through to May 2023:

Workshop 1
Introduction to the Team – All Age Commissioning and Contracting
Where we are currently - present the high-level findings of the FCOC *Discrepancies in some of the data work with the market to understand these areas* *MPS (market position statement) areas to explore*

Workshop 2
Feedback on Progress to Date for Fee Setting for York Cost of Care
Contractual Frameworks Re-commissions

Workshop 3
Final Outcomes of Fee Settings and Contractual Mechanisms
How we will work with you going forward
Feedback on non-price elements from FCOC Exercise
Series of recommissioning of current frameworks to existing/new commissioning models to sustain the market

Market Engagement:

1. Re-introduce provider forums in a co-production approach providing the opportunity for both the providers and the council to have regular dialogue on areas that will enable sustainability of our markets

2. Re-introduce true coproduction with the market when recommissioning, redesigning, and commissioning of new services for our population at the earliest opportunity

3. Continue to work with the ICG (Independent Care Group) one of the voices of independent care

4. Continue to communicate with the market via the provider bulletin making available information, guidance for a range of topics and to deliver key messages to the market

5. Ensure that providers are aware of the Yor-tender service where opportunities are advertised and bid for and the necessary guidance to ensure fair, open and transparent opportunities for the market

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