Gemini House
Bartholomew's Walk
Cambridgeshire Business Park
Angel Drove, Ely
Cambridgeshire CB7 4EA

Email: capccg.freedomofinformation1@nhs.net

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Dear NHS Cambridgeshire and Peterborough CCG,

2021 Fee Increase

Care England is the adult social care sectors largest representative body. Our members run and manage approximately 4,000 care services, amongst them single care homes, small local groups, national provider and not-for-profit voluntary organisations and associations, as well as private providers. Members provide over 120,000 beds and various services for older people and those with long-term conditions, learning disabilities and mental health problems.

Firstly, it is worth stating that we wish to build close relations between national and local spheres of adult social care and see such correspondence as an essential means of fulfilling this. We would, therefore, be grateful for any other way in which relations may be developed, including future meetings with you as commissioners of adult social care.

I am writing to inquire about those processes that informed your clinical commissioning group's 2021-22 fee uplift offer to care providers. A number of our members have cited their disappointment at this offer and its failure to account for the true cost of care. We believe that your offer of 2% uplift may not be commensurate for maintaining a stable care market.

Collaboration, communication and integration:

In light of these discussions, I would be very grateful for any information regarding the processes which informed the 2% uplift. Ultimately, we want to see evidence that your fee uplift has taken sufficient account of the new reality imposed by the Covid-19 pandemic.

Therefore, I would be very grateful if you could answer the following questions:

1. Has Covid-19 impacted those provider engagement processes which you usually would have conducted?
2. What engagement have you conducted with your local care market?

This is particularly important when one considers how Section 6.1 of 2020/21 National Tariff states that commissioners and providers must, when agreeing a local payment approach, do the following:

- The approach must promote transparency to improve accountability and encourage the sharing of best practice.
- The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches.

As CHC services are not specified within the national tariff, section 115(2) of the Health & Social Care Act 2012 ('the HSCA') requires the rates to be set in accordance with the rules contained in the national tariff. The '2020/21 National Tariff Payment System' is the current operative national tariff and will continue to be so until the 21/22 system shortly comes into effect.

Any evidence to the effect that you have abided by the above principles would, therefore, be much appreciated.

Taking account of cost increases:

This year, the National Living Wage increased by 2.2%; given that many care staff are paid at or just above the National Living wage, does a deficit not arise? This is especially pertinent when considered alongside the plethora of other costs that providers face annual increases in. If you believe this not to be the case, I would be very grateful if you could point me towards why this is not so.

Also, as you will be aware, the Covid-19 pandemic has increased the costs associated with the running and operation of care homes imposing a whole new operational reality upon the care sector. In addition, as a result of higher mortality rates and decreased admissions, the occupancy levels of providers have reduced. We understand that many are still experiencing occupancy levels that sit well below pre-Covid levels from discussions with our members. Many local authorities and clinical commissioning groups across England are basing their fees on pre-Covid occupancy levels. Occupancy rates are fundamentally intertwined with the base costs associated with the provision of care.

Whilst, at a recent Public Account Committee oral evidence session on adult social care markets, Ian Trenholm, Chief Executive Officer of the CQC, said:

"We would typically calculate that, to make a modest margin, a care home would be looking at a 90% occupancy rate. What we saw last year was an 80% average occupancy rate—that is about the level where most care homes would break even. Some care homes are operating below a break-even point, and are being kept alive by that support."

Again, the need to take account of such realities in fee setting is covered as part of 2020/21 National Tariff Payment System states that:

"Rule 2: Commissioners and providers should have regard to the cost uplift and efficiency factors for 2020/21 (as set out in Sections 4.7 and 4.8) when setting local prices for services without a national price for 2020/21."

Those principles require the consideration of a provider's unit costs when determining what price is necessary in order to be in the best interests of patients. They also require constructive engagement between CCG and providers.

Again, I would be grateful for any further information that evidences the fact that you did take consideration of Rule 2 when making the above fee uplift.

Emerging issues:

We too have been in talks with NHS England and Sir Simon Stevens regarding the following issues that have been cited to us, including:

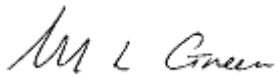
- There is a distinct absence of any framework by CCGs providing for their engagement with providers and/or the establishment of what the unit costs of CHC provision actually are and (by reference to those costs), what CHC rates need to be so as to ensure that the price is sufficient so as to meet the above mandated criteria.
- Some CCGs are wrongly saying to providers that national guidance requires them to offer only 0.2% fee increases for 21/22.
- This 0.2% is derived from a 1.3% inflation figure, less a 1.1% efficiency factor. The use of this efficiency factor within the care home sector is both irrational and inappropriate. It is based on work completed 5 years ago by Deloitte and is not based upon any evidence from the non-acute sector, nor was it ever intended to reflect the non-acute sector. Rather, it was based entirely on NHS acute hospitals

We would, therefore, ask that the above is taken into account in determining the CHC rates for 2021/22 alongside the changes to CQUIN. If you have chosen to apply the irrational 1.1% efficiency factor, I would be very grateful for any explanation of your choice to do so.

Please do not hesitate to include any other information which you think might be relevant. Lastly, it is worth noting that we plan to share your reply with members in order to assist their communications with yourselves.

I look forward to hearing from you.

Yours sincerely,



Professor Martin Green OBE

Chief Executive: Care England

DH: Independent Sector Dementia Champion