Feasibility Study on a National Fee Methodology for Older People in Residential Care

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1 Executive Summary

This feasibility study was commissioned by the National Office for Care and Support in the Spring of 2025. It provides (1) an outline of the project methodology, (2) a summary of the legislative and policy context in which fee setting takes place, (3) a brief description of the market for older people's residential care across Wales, (4) a summary of fee setting approaches in place across Wales and in other home nations, (5) views of commissioners and providers on current approaches and potential alternatives, (6) findings and key themes, (6) an assessment of the feasibility of a national approach to fee setting and potential methodologies, (7) recommendations and (8) suggested steps for implementing those recommendations.

Our work involved extensive engagement with a range of stakeholders, including local health board and local authority commissioners, a range of national agencies, provider representatives and academic partners. Engagement took the form of structured interviews with individuals and groups, alongside online surveys. We spoke with representatives of more than 60 stakeholder organisations.

The work was undertaken within the context of increasing numbers of older people in Wales, with recent trends projected to continue in the coming decades, accompanying increases in complexity of need among those coming into residential care, and a range of sufficiency in local markets across Wales. Generally statutory agencies are struggling to meet need for nursing care, due to factors such as recruitment and retention difficulties.

Various legislation and policy drivers shape the environment for fee setting in Wales, including the NHS (Wales) Act 2006, which sets parameters for the NHS in setting fees that meet the costs of nursing care in this sector through Continuing Health Care (CHC) and Funded Nursing Care (FNC); the Social Services and Wellbeing (Wales) Act 2014, which requires integration of services and collaboration across partners on regional footprints in relation to fee setting; 'A Healthier Wales', the national plan for health and social care which calls for a sustainable funding model for both sectors; the Market Stability Reports code of practice and statutory guidance, which requires full understanding of the cost of care by commissioners when agreeing service prices with providers; 'Let's Agree to Agree', a national framework developed to support commissioners in the fee setting process; and the National Framework for the Commissioning of Care and Support Code of Practice, which advocates for regional approaches to fee setting. More generally, the Wellbeing of Future Generations (Wales) Act 2015 puts requirements on public bodies to think for the long term in planning and delivering services and to collaborate across agencies and with people in achieving wellbeing goals.

Detailed analysis of our engagement with stakeholders has informed a series of key conclusions, which are as follows:

- Demand for older people's residential and nursing care is growing and changing
- Resources required to meet the changing demand are not always available
- The resilience of the older people's residential market is variable
- Current arrangements for local authority fee setting are inconsistent and have significant shortcomings
- The lack of robust frameworks for fee setting are exacerbating these problems
- Agreed fee levels are often trumped by spot purchasing arrangements, undermining local fee setting approaches
- Fees for FNC and CHC are felt to be inadequate and this is exacerbated by a lack of confidence in the assessment processes for both payments
- Regional Partnership Boards are generally not being used to develop regional approaches to fee setting

- A majority of stakeholders are of the view that a national approach to fee setting would be a positive development
- A national approach could potentially lead to increased fee rates and additional cost pressures on local authorities, health boards and Welsh Government
- A more equitable approach to fee setting is one of several factors that will deliver a sustainable national care and support service
- A national approach to setting fees for older people's residential / nursing care should be accompanied by one for other adult groups
- Our assessment suggests a national approach to fee setting would be feasible, based on the following criteria: legislation and policy; 'Let's Agree to Agree' principles; commissioners' views; providers' views; and cost.

In view of this, we make the following seven recommendations:

1. The National Office for Care and Support should **mandate further work to develop and implement a national approach to setting fees for residential and nursing care for people aged 65 and over in Wales.** Here it is important to distinguish between a national approach and a national fee, which varying conditions across Wales and the experience of other parts of the UK suggest would be counter-productive and result in some providers not receiving the true cost of care and, potentially, others being overpaid. Our recommendation therefore is for the former.
2. Any such approach should as far as possible address the 'queries and considerations' identified from our stakeholder engagement and detailed in Section 5.
3. In developing such a model, **the opportunity should be taken for a national conversation between Welsh Government, the NHS and local government on the potential to integrate mechanisms for setting CHC and FNC rates**, providing a robust and evidenced basis for allocating costs fairly across each sector, enhancing assessment processes and strengthening collaboration.
4. There should be **further consideration of the feasibility of adopting CareCubed as a national solution**, in view of (1) its status as a not-for-profit organisation, (2) its potential applicability to other age groups, (3) the fact that it has already been adopted by a number of local authorities and providers across Wales and (4) its widespread use and preferred status among commissioners in England.
5. This work needs to be **aligned to other workstreams being taken forward in relation to development of a National Care and Support Service**, including national standards and design principles. This will ensure that different strands complement and inform each other and will help minimise duplication.
6. Consideration should be given to **developing a similar approach across other adult groups**, providing consistency for providers serving different cohorts and potentially realising savings in some areas which can be redirected to meet increased costs emerging for those aged 65 and over.
7. This work should be **facilitated by an independent organisation** unaffected by any shifts in costs and budgetary requirements, whilst being co-produced and effectively engaging with all affected parties.

We set out the following steps for the National Office for Care and Support to take in addressing our recommendations:

1. Undertake **further engagement with commissioners and providers through relevant national and regional forums**, to review current arrangements and test out the essential requirements in a national model and approach to implementation and implications as highlighted in this report.
2. Facilitate conversations between the NHS and local government to **explore opportunities for the integration of fee-setting for CHC, FNC and residential placements**.

3. Undertake a **full assessment of the CareCubed** and its potential as a national costing model
4. Run pilots of selected new approach to test effectiveness and impact.
5. Facilitate a **national conversation over how any additional costs might be met**, through additional investment and redirecting of existing funds within the system.

2 Background and context

This feasibility study was commissioned by the National Office for Care and Support in the Spring of 2025. As articulated within the tender documentation, its aims are to:

- Summarise and analyse current policies, guidance and reports relating to fee setting for older people in care homes, covering residential care, Funded Nursing Care (FNC) and Continuing Healthcare (CHC) and including any relevant audits, reviews and market reports relating to cost and fee setting in this market across the UK
- Analyse existing fee setting processes and methodologies used by commissioning authorities in Wales (including local authorities and local health boards), detailing (1) the risks and benefits of different approaches, (2) whether they are applied locally or regionally, (3) evidence used to determine fees and how this is collected, (4) whether they lead to individual fee levels, fee bandings or standard fees across a county or region (5) outcomes of any evaluations and (6) an assessment of their fit with the 'Let's Agree to Agree' Guidance[1]
- Conduct a feasibility assessment informed by the above, of either adopting an existing approach or bespoke methodology for fee setting, to include care commissioned by the NHS
- Set out recommended steps for implementing any proposed models, taking account of key considerations such as (1) the impact of partnership arrangements including pooled funds, lead commissioning and joint procurement, (2) potential impact on providers and (3) implications for rates paid by self-funders

The work stems from a specific recommendation within the Towards a National Care and Support Service for Wales Initial Implementation Plan[2] which calls for commencement of work towards the feasibility of creating national fee methodologies for care home placements.

In line with the above specification, this report provides (1) an outline of the project methodology, (2) a summary of the legislative and policy context in which fee setting takes place, (3) a brief description of the market for older people's residential care across Wales, (4) a summary of fee setting approaches in place across Wales and in other home nations, (5) views of commissioners and providers on current approaches and potential alternatives, (6) findings and key themes, (6) an assessment of the feasibility of a national approach to fee setting and potential methodologies, (7) recommendations and (8) suggested steps for implementing those recommendations.

A small Practice Solutions team undertook the evaluation. Team members were:

- Neil Ayling (Strategic Lead)
- Andrew Duggan (Project Manager)
- Martyn Palfreman (Project Associate)
- Caitlin Snuggs (Research Lead)

[1] Cost-of-Residential-Care-Toolkit-August-2018.pdf
[2] https://www.gov.wales/sites/default/files/publications/2023-12/Towards%20a%20National%20Care%20and%20Support%20Service%20initial%20implementation%20plan.pdf

3 Methodology

The methodology adopted for the evaluation involved:

- An inception meeting with the representatives of the National Office for Care and Support to agree parameters of the study, outcomes and approach to the work
- A comprehensive desk top review of the strategic context in which fee setting takes place
- Critiquing approaches to fee setting and equivalent methodologies in Scotland and England
- Engagement with a wide range of stakeholders through online surveys for commissioners and providers and 39 structured interviews with individuals and small groups, which focused on the lines of enquiry set out in Figure 1. A full list of organisations which were represented in survey responses and in our interviews is provided in Appendix 1 and detailed analysis of the engagement follows in Section 5.
- Analysis of qualitative data gathered through the engagement phase
- Assessment of possible approaches using set feasibility criteria
- Development of recommendations and steps for implementation.

Figure 1

Lines of enquiry	
1	Current and projected demand for older people's care home placements
2	Current fee setting approaches and perceived advantages and disadvantages
3	The extent to which current approaches include engagement with providers, service users and carers
4	The extent to which current approaches reflect principles set out in the 'Let's Agree to Agree' Guidance
5	Involvement of Regional Partnership Boards in fee discussions and impact of pooled funds/ joint commissioning arrangements
6	Interface between local authority fees, FNC and CHC
7	Perceived impact of current approaches on fee levels and the care home market
8	Views on a national approach including the practicability of such an approach, implications for other population groups and the desirability of regional fee setting as a first step

Throughout the evaluation, we held monthly meetings with representatives of the National Office for Care and Support, to update the client on progress and to test emerging findings.

In planning the engagement phase, we worked with the National Office for Care and Support to identify key stakeholders across health, social care and the third Sector, developing a stakeholder map of over 170 contacts. 61 of the individuals and organisations that we reached out to regarding this project indicated that they wished to be involved in the evaluation.

Online surveys were circulated to colleagues identified in the stakeholder map who had consented to engage with the project and to receive the survey. We asked stakeholders to circulate the survey to wider members of their organisations and networks that may have an interest. Due to low provider engagement, we undertook specific targeted exercises with this cohort and extended the survey deadline.

Structured interviews were held with:

- Representatives of individual local authorities and local health boards
- Regional commissioning boards
- Nursing leads from 6 local health boards in a joint conversation
- Representatives from the National Commissioning Board
- Care Forum Wales
- Unison
- Care Inspectorate Wales
- The Commercial Director of IESE Innovation Ltd. (the software company that developed the CareCubed[3] costing solution).

Overall, the level and breadth of engagement was encouraging and provided a robust evidence base for the study and its recommendations. We spoke with representatives from every local health board area, and every local authority. Highest levels of engagement were achieved with stakeholders in the North Wales, West Wales and Cardiff and Vale regions. The areas that provided us with the most responses were North Wales, West Wales and the Cardiff and Vale region, with the least represented area being Cwm Taf Morgannwg. We also spoke with several national bodies and providers. Stakeholders were given the opportunity to engage with us in either Welsh or English, with two respondents opting for the former.

We received 22 responses to our survey targeting stakeholders who are involved in the management or commissioning of care, and those who assess people for that care. We heard from a good blend of colleagues from health, social care and joint commissioning services. However, we were not successful in engaging with wider stakeholders such as policy leads, National Goal leads, or representatives from National Programmes of work. It proved challenging to engage directly with providers, despite undertaking several targeted exercises. This reflects challenges that statutory partners have reported with provider engagement.

[3] CareCubed - The National Care Costing Tool

4 Context

Demographics and trends

Demographic data[4] provides evidence of an increase in the number of older people in Wales over recent decades and indicates that this trend will continue. By mid-2032 people aged 65 and over are expected to account for almost a quarter (24.3%) of the total population. By 2060, the number of people in Wales over the age of 65 is projected to reach more than one million. Over the same period the number of people aged 75 and over is projected to increase by 22.1%.

These rises are likely to put additional pressure on health, social care and other public services, with more people likely to need care and support and the complexity of need expected to increase due to increased longevity of individuals. Overall ill health and, specifically, chronic conditions, co-morbidities and cognitive impairment are set to rise.

Implications for the residential and nursing sector include a rising number of older people entering care with complex needs, including dementia, with an associated need for more specialist support. Our work identified that these factors are already having an impact on provision and sustainability of the market across Wales; notwithstanding regional variations, there are clear indications of pressure on the system caused by a lack of nursing home capacity for example. They are likely to give rise to increased costs of care, and this will need to be reflected in any future approach to setting care fees.

Legislation and policy

Under the Social Services and Wellbeing (Wales) Act 2014 (SSWBWA) local authorities have a duty to assess the needs of people who may need care and support, to determine eligibility against a national framework, and to meet eligible needs.

Welsh Ministers are required under the NHS (Wales) Act 2006[5] to 'continue the promotion in Wales of a comprehensive health service, designed to secure improvement (a) in the physical and mental health of the people of Wales and (b) the prevention, diagnosis and treatment of illness.' They have a duty to secure the provision of services in accordance with the Act, alongside such other services or facilities for the prevention of illness, the care of persons suffering from illness and the aftercare of persons suffering from illness as they consider are appropriate as part of a health service, and such other services as are required for the diagnosis and treatment of illness.

With specified exceptions, a local authority may not meet a person's need for care or support by arranging for the provision of a service or facility which is required to be provided under a health enactment.

Within this context commissioners of care and support, local authorities and local health boards are required to negotiate a price for the care and support provided by independent and third sector residential and nursing homes in their area. Broadly speaking, the price of residential care needs to reflect the following costs:

- Land costs: relating to the land on which a home is built
- Labour costs: relating to a range of workers including carers, kitchen staff, cleaners, maintenance staff, managers and, where relevant, head office staff

[4] National population projections: 2022-based [HTML] | GOV.WALES
[5] National Health Service (Wales) Act 2006

- Capital costs: relating to fixed assets required to provide the service such as buildings, vehicles, uniforms and food
- Enterprise costs: a reasonable return to the home for organising and delivering the service.

In addition, fee levels are set by the NHS for Funded Nursing Care (FNC) and Continuing Health Care (CHC). FNC is the NHS contribution to a package of care within a care home where an assessment has indicated that an individual requires registered nursing care. The FNC rate is set nationally, using the Inflationary Uplift Mechanism (IUM) and comprises funding for registered nursing staff (based on mid-point of Band 5) and for continence supplies. Both are uplifted annually in line with the NHS pay award and CPI respectively.

Following a ruling by the Supreme Court in 2016, after a Judicial Review, paid breaks and time spent in supervision are also factored into the FNC rate.

CHC placement fees are set by individual local health boards. All those we spoke with mentioned using CHC Assessment Tools and applying Agenda for Change pay awards. Variations in fee levels arise from differentials across local authorities in a single area.

Part 9 of the SSWBWA sets out the role of Regional Partnership Boards (RPBs) in the design and delivery of integrated services. These Boards provide a forum for local authorities and local health boards, as well as provider organisations, to discuss approaches to fee setting and in so doing meet the aspiration within statutory guidance for an integrated approach to agreeing fees. RPBs are also required to establish pooled funds for older people's care homes.

Other legislation and a range of national policies provide further strategic context for the setting of care fees by local authorities and local health boards. These include:

- **A Healthier Wales**[6] – the Welsh Government's national plan for health and social care which includes an aspiration to maximise value for service users by achieving the best outcomes at the lowest cost. It also commits to a sustainable funding model for health and social care and a national conversation to explore 'more radical' funding options.

- The **Market Stability Reports code of practice and statutory guidance**[7] for local authorities and Local Health Boards in preparing and publishing their reports, which identifies that resources and the way they are used, and investment decisions, will have a major impact on the sufficiency and pattern of care and support in a given area. Commissioners will be expected to take strategic decisions on budget allocation as well as methods for agreeing fees for services. The code makes clear that the cost of delivery is fully understood when agreeing a service price with providers.

- The Let's **Agree to Agree Guidance**, a commissioners' toolkit for commissioners and providers of residential and nursing care developed by the Institute of Public Care and designed to assist with identifying costs of care as a basis for fee setting. Co-produced by commissioners across health and social care, providers and other stakeholder representatives, the toolkit was published in 2018 and has been actively promoted across Wales. Stakeholders with whom we engaged during our study indicated that it is used extensively in different parts of the country.

- The Report of the Expert Group[8] set up under 2021 Co-operation Agreement[9] to develop thinking on achieving a **National Care and Support Service for Wales**, which sets out clear

[6] A Healthier Wales
[7] https://www.gov.wales/sites/default/files/pdf-versions/2023/7/4/1689260027/market-stability-reports-code-practice.pdf
[8] Towards a National Care and Support Service for Wales
[9] The Co-Operation Agreement

recommendations and steps towards an equitable funding base for care and support, and in response to which this feasibility study was commissioned.

- The **National Framework for the Commissioning of Care and Support Code of Practice** (2024)[10], which sets out standards for commissioning care of support including 'setting fair and sustainable fees'. The Code recommends that 'statutory partners should use local, regional and/ or national cost methodologies or benchmarks to determine a fair and sustainable price for quality care and support'. Statutory agencies 'must be transparent and consistent when setting fee rates ensuring that they are assessing fair and sustainable costs of care and support and ensuring public value.' Commissioners are expected to confirm their fee rates to providers in a timely fashion before the start of each financial year and methodologies should take account of factors such as:
  - Geography
  - Organisational context
  - Care and labour market conditions
  - Fair work policy

  Commissioners should take account of the impact of their commissioning and procurement activity on the sufficiency of care and support and on market stability, and consistent methodologies should not detract from local democracy and decision-making on price determination.
- More generally, the **Well-being of Future Generations (Wales) Act 2015**[11], which requires public bodies to embrace five 'ways of working' in discharging their functions. These include thinking for the long term (ensuring sustainability of services and communities), collaboration between agencies and involvement of people in achieving wellbeing goals.

Current approaches

Alongside the methodologies in place for calculating CHC and FNC rates (see above), local authorities use a range of approaches when setting their fees. These include the Lang Buisson and CareCubed and locally developed approaches, some of which draw on elements of these set methodologies. Some work has been undertaken on developing regional approaches to fee setting, notably in North Wales and Gwent, although currently no region has a set and consistently applied model.

Many areas apply the principles within 'Let's Agree to Agree', although this is generally considered to provide broad guidance rather than a prescribed methodology. Some stakeholders expressed the view that this was regrettable.

Further details of current arrangements across Wales are provided in Section 5.

England and Scotland

In 2021 the UK Government announced its Market Sustainability and Fair Cost of Care Fund[12], aimed at supporting local authorities in preparing their care markets for reform and moving towards paying providers a fair cost of care. From 2022 a condition of funding applied by which councils were expected to start making genuine progress towards sustainable fee rates, leading to an anticipated increased fee rate and supported through a separate funding allocation to help them accommodate resulting cost pressures.

[10] National framework for commissioning care and support: code of practice
[11] https://www.legislation.gov.uk/anaw/2015/2/contents
[12] Market Sustainability and Fair Cost of Care Fund 2022 to 2023: guidance - GOV.UK

Care Cubed[13], an online care costing tool which supports open and transparent negotiation of cost of care placements by providing a simple and consistent approach to identifying individual needs and package requirements, is used by a significant proportion of local authority and NHS commissioners across England. It has also been adopted by several areas in Wales – see Section 5 for more details. It is estimated that around 600 commissioning bodies are using the tool across the UK. Its contribution to the development of sustainable services and optimising limited resources is well-documented, as is its value in offering consistency of approach across sectors and different parts of the country.

In England Integrated Care Boards, as part of Integrated Care Systems that bring together NHS bodies and local authorities, are responsible for the commissioning of services including those funded by CHC and FNC. This provides a useful example of bringing both sectors together in agreeing how placements will be funded.

In Scotland a National Care Home Contract (NCHC) is in place, with set rates for residential and nursing care. The NCHC is renewed on an annual basis by Scottish Care which represents providers and COSLA representing local government. Implementation of the NCHC has not been without its problems; the Contract is not signed by all homes and there has been controversy over the failure of the Scottish Government to achieve parity in uplifts for staffing costs between the NHS and local government. Scottish Care have asserted that this represents an effective failure by the Government to value care staff. The Scottish experience suggests that a national fee (as opposed to approach) can be problematic. Criticism of the extent to which non-nursing costs are met suggests a risk to potential future approaches in Wales, even if a national fee rate is not sought.

In Scotland CHC has been replaced by Hospital Based Complex Clinical Care. Eligibility for this funding is agreed by health boards through a multi-disciplinary approach. FNC payment rates are set nationally.

[13] CareCubed - The National Care Costing Tool

5 Analysis

Key findings from semi-structured interviews

As part of the engagement phase outlined in Section 3, we undertook semi-structured interviews with 39 respondents on an individual or small-group basis. Stakeholders spanned health, social care and the third sector, as detailed in Figure 2.

Figure 2

Stakeholder Group	Contacted	Consented to Engage	Undertook Interview	Completed Survey
National Programme Leads*	14	0	0	0
NHS	62	14	10	8
Social care	73	33	20	13
Care cost calculators	3	1	1	0
Care Sector	8	1	1	7
Joint Commissioning	1	3	3	0
Other	12	7	5	1

**This includes a wide range of roles such as the Leads of National Programmes of Work like the 6 Goals for Urgent and Emergency Care.*

Our interview questions focussed on key areas of interest drawn from the specification for this work, as outlined in Section 3, and a full list of the questions used can be found in Appendix 2. We also created opportunities during our conversations for stakeholders to share other key thoughts, feelings and information, which led to the tracking and analysis of **emergent themes**. Emergent themes can be summarised as themes that sat outside of our original lines of enquiry, but due to the frequency and urgency with which they were raised by stakeholders during the process became evident as critical considerations.

Where possible, we used Microsoft Teams to transcribe the interviews. This enabled thorough qualitative analysis using a blended discourse and thematic approach as well as frequency counts. Our analysis involved recording original responses and key quotes participant number, geographical location and type of stakeholder to track trends whilst ensuring anonymity; whilst trends analysis was conducted separately to ensure that participants' identities were protected. A summary of the key findings is provided in this Section, with summary conclusions drawn from these and set out in Section 6.

Current challenges with residential care, including FNC and CHC, for adults over 65s in Wales

As part of our semi-structured interview process, we asked participants to give us an overview of the current position of care for adults over 65 in their area, including the provision of CHC and FNC. Most participants shared that they were struggling to secure capacity, particularly affordable and responsive capacity, for adults with dementia, EMI needs, nursing needs, and other complex needs. This was for longer-term placement, for respite to prevent breakdown of care in the community, and also for hospital discharge. Some of the key challenges people were experiencing are as follows:

People are requiring care later in their lives, when their needs are more complex.
With the shift towards community-based care, which was viewed positively, professionals reported that people were coming into care later in their lives. The over 85s age-bracket requiring residential and nursing care was significantly larger than predicted.

This effect has been exacerbated by the aging population in Wales, and by the gap between 'life expectancy' and 'healthy life expectancy'.

A knock-on effect of this upon care services, in addition to the increased need for complex care provision, is that individuals are spending less time in care services before they reach the end of their lives. This is resulting in frequent changes to care occupancy and to the types of specialisms required to keep somebody safe and happy in a care environment. These additional demands upon providers, along with high levels of occupancy changes, are leading in some places to the closure of smaller providers and/or providers with limited capacity for this type of placement.

There is a lack of suitable provision to meet people's needs.
Alongside the challenge of an ageing population, and in line with our brief narrative on demographics in Section 4, we heard that people coming into care have increasingly complex needs; meaning that more people need nursing care, dementia care, and EMI provision. Due to the complexity of need, and the fact that people are increasingly sitting across multiple types of care, cost categories are becoming less reflective of the people who need care. An increasing number of bespoke care packages are required, which leads to bespoke cost negotiations between providers, local authorities and local health boards. Statutory partners in some areas are having to look at placements out-of-area, including in England, due to the different pressures and capacities existing within regions. It should be noted that in some parts of Wales there is a reported excess of non-nursing placements, probably reflecting historic provision and the reduced demand for this type of care.

As a result, in some areas there is an inadequate supply of suitably skilled and trained staff working in the care sector to meet the needs of the people who require care and support. Specific reasons for this were reported as:

i. Providers facing difficulties in releasing staff for additional training due to operational pressures;
ii. Difficulty securing appropriate training and/or funding for that training;
iii. Challenges around recruitment and retention in the care industry for individuals willing to take on the demand and complexity of care roles at the wage offered (often minimum or living wage);
iv. Reliance on overseas workers, negatively impacted by Brexit;
v. The cost of agency staff; and
vi. A lack of registered nurses to take on supervisory roles.

Alongside this, the buildings available, which have been in use often for decades, are not suitable to meet the needs of the people who require care and support. The fees currently paid to providers do not allow for reinvestment in services, and private companies are not eligible for grant funding to improve their buildings. This leads to a lack of available environments for the people who need care the most.

A lack of suitable capacity to meet the needs of the population leads to a "provider's market" for those who can.
The above challenges mean that providers who can provide these types of placements, and who were frequently described as being 'closed' with their costs, are in a good position to negotiate enhanced fees or fees that are substantially more than local authority and local health board averages and budgets allow for. This leaves commissioners in a position of having to either pay for the care or leave a person in crisis or in

an acute setting. As a result, a significant proportion of fees require “top-ups” often equating to hundreds of pounds per person, per week.

These difficulties are exacerbated by the number of care services that are owned by large private corporations, particularly private equity companies, versus the number that are owned and run by statutory bodies or small local partners. Most of the professionals we spoke to shared that only a very small percentage of the services available in their area are operated by statutory partners, and that an increasing number of small, local partners are having to close their services.

Many partners that we spoke to have strategies in place to alleviate some of these pressures in the long-term, but they are programmes of work that will take years to complete and do not provide answers in the short-term.

In summary, statutory partners report that this leaves them in a poor position to negotiate fees, with little leverage. They describe it as a ‘provider’s market’.

The True Cost of Care

During our semi-structured interviews, we asked participants about the fee structures in their area. An emergent theme was around the ‘true cost of care’. Some statutory partners reported that capturing this is a challenge for them due to the opacity of some care providers, whilst others speculated that such a cost was likely to be beyond their budgetary constraints. Observations emerging from this included:

The risk of a costing exercise
Most of the people we spoke to, across the board, felt that it was likely that a national methodology identifying and operationalising the true cost of care would identify a significant gap between what is currently being paid, and what care in Wales actually costs. It was noted that statutory partners tend to pay providers in line with budgetary constraints, rather than based on costing exercises. One local authority reported that it is in the middle of a process to address this gap, but that it is likely to take several years.

Equally, it was also noted that a ‘true’ costing exercise was challenging to undertake with both low provider engagement and the obscurity of provider charging systems. This was particularly reported in care organisations operating as private corporations or with private equity partners, in which there were significant overheads that were reported as debts or losses leaving minimal or insufficient profit and reinvestment margins despite the equity company itself having significant profits held elsewhere.

In some cases, it was noted that robust costing exercises had indicated that providers were charging rates that were considerably higher than the ‘fair cost of care’ calculators had indicated. However, given the scarcity of placements that meet the need of the population in certain regions or with certain needs and the pressure to move people out of the acute health system, statutory partners were often left in a position of having no choice but to pay these fees.

In summary, it was felt that until a robust costing exercise was conducted, with providers engaging in a transparent manner, it was impossible to predict the cost of care or establish ‘reasonable’ fee levels. However, this comes with the risk of identifying underpayments and a query around how this shortfall will be paid.

The impact of current uplifts
In a similar vein, it was noted that current annual uplifts both to the budgets of statutory partners and therefore to the uplifts that could be passed on to providers, are insufficient. Colleagues reported that the profit margins of most providers is minimal, leaving them in a position where they do not have the funds to improve and enhance their services. This can contribute to poor living and working environments, staff without sufficient skills, poor remuneration for staff leading to low recruitment and retention, and a lack of

necessary equipment to manage the complexity of the people requiring the service. It was also noted that private providers are not eligible for Welsh Government grants designed to support the care industry in this area.

It was also noted by stakeholders in all groups that the annual uplifts given to local authorities by Welsh Government prevents adequate investment in community and progressive services. This in turn places demand on acute services and increases hidden care costs both regionally and nationally. One stakeholder described it as follows:

"Get social care right, and so many other parts of the health economy will be dealt with".

Uplifts to FNC and CHC Rates

It was widely noted that the rate of FNC and CHC paid is now significantly lower than the cost of providing care at this level. In some areas, FNC fees are lower than the average local authority rate for residential care and therefore seen as inadequate for complex care. It was noted that there are many factors at play here, such as the High Court ruling on fees and also the way that the care landscape has changed. Some of the costs of providing FNC and CHC care not covered in current fees were identified as follows:

i. Consumables
ii. Maintenance of equipment
iii. Band 7 nursing duties: The model allows for nursing at a Band 5 level, but the duties involved in this care sit at the higher band
iv. Employment of agency staff, where necessary, compounded where a lack of healthcare assistants forces the use of higher paid staff to undertake their duties
v. The high level of nursing and social care oversight required to manage the complexity of FNC and CHC placements.

In some cases, additional costs are being passed over to local authorities, leaving them in a position of paying significant 'top-up' fees to provide an FNC or CHC placement. In others, providers were absorbing some of the costs to the detriment of their other services or to the maintenance and improvement of the current services. In some areas, this has led to providers refusing to take FNC and CHC placements, or to setting their own fees thus leaving local authorities in a weak negotiating position.

It is therefore felt that the CHC and FNC rates need reviewing and uplifting, with clear and updated guidance given based on who is responsible for which costs. It was noted that this was a financial risk. Stakeholders noted that it was often not possible to discuss CHC and FNC rates with health colleagues – it was described as a 'stonewall'. Health professionals also reported that they do not negotiate, they refer back to the High Court ruling.

Respective roles of local health boards and local authorities

We detected a broader theme concerning the respective roles and remits of local health boards and local authorities in commissioning, managing and paying for residential services for adults over the age of 65, including FNC and CHC. Stakeholders were sympathetic to the challenges each sector faces, and there is no discernible 'culture of blame'. However, each party recognised that decisions and challenges made by their organisations, funding bodies and the High Court were having an impact on the national ability to provide and oversee sufficient, sustainable and affordable care for the population group in question. Some of the key issues reported are as follows:

The challenge of being separate organisations

A common theme throughout our engagement was the challenge of different organisational priorities and policies governing partners who need to work together across the system. It was noted that health

colleagues are answerable to the NHS nationally, whilst local authorities are answerable to elected members and communities. Both are answerable to legislation, in terms of their statutory responsibilities. This makes it challenging to negotiate, with the prevailing view being that they should be one organisation if they are going to truly work together.

Another challenge noted was the limited observable impact of having pooled budgets for older people's residential care, all of which across Wales are virtual in nature. It was reported that this has not led to alignment of fees, nor made it easier for fee negotiations to take place.

Furthermore, the increasing complexity of individuals requiring care and support is leading to disagreements regarding what should be paid for by health, and what should be paid for by social care.

It was the view of the majority of stakeholders that these issues ideally need addressing as part of any national fee methodology proposed.

FNC and CHC Placements
Other challenges with FNC and CHC placements were noted.

Several of those with whom we engaged reported that there has been a reduction in the number of CHC placements, with local health boards funding fewer individuals in nursing placements at the same time as local authorities are seeing a significant increase. Health colleagues report that they are supporting significantly more people in the community via CHC funding, which may account for some of this difference.

Stakeholders across sectors reported difficulties around FNC and CHC reassessment processes, with lengthy delays often leading to challenging outcomes. In some cases, reassessment demonstrated that individuals had a higher, sometimes even acute, level of need, leaving providers struggling to meet the need and not willing to take the risk on further placements. We also heard of reassessments concluding that an individual is not eligible for local health board funding, forcing practitioners to navigate challenging conversations with individuals, families and carers around the future of their care and support.

Legal and Professional Challenges to Decisions Made
Health colleagues reported a perceived increase in the number of legal and professional challenges made to them around FNC and CHC funding agreements. They described an increased pressure and scrutiny from professional partners, which they felt was down to the budgetary constraints of those organisations; explaining that they were being frequently or even routinely challenged on FNC and CHC decisions. They also reported an increased number of successful legal challenges from the public regarding their FNC and CHC decision-making process, which they felt was due to an increase in "no win, no fee" solicitors advertising services in this area through social media. We have not independently verified whether there has been a notable increase in such challenges, however colleagues across Wales described these experiences and felt that they were increasing.

Similarly, Local authority partners reported that some health services were hiring private consultants to support them in reviewing and reducing the health contribution to packages of care, leaving councils to pick up the costs.

Again, all parties agreed that these issues would need addressing as part of a national fee methodology.

The impact of budgetary constraints

This was a key concern for stakeholders of all groups with whom we engaged. Colleagues noted challenges in budgets due to the impacts of austerity, Brexit and Covid-19 as well as perceived difficulties with settlements for Wales.

Many noted that it was challenging to support providers financially with the required improvements to their services and environments, and that it was largely impossible to provide any form of capital returns.

A particular challenge was reported around self-funders choosing high-end placements from the private market, leaving local health boards and local authorities in a difficult position at the points where they were required to take the placement on. There is a conflict between the ethical position of moving somebody towards the end of their life, and the budgetary reality of supporting a placement that can be 2-3 times the weekly 'fair cost of care'.

One stakeholder summarised the challenges faced by statutory parties as:

"The golden thread running through it all is money, and not having enough."

Provider Markets and Competition

This brings us to one of the substantial themes emerging from our engagement, relating to markets, profits and losses, and competition. Some of the key issues identified are as follows:

The role and value of the small / medium provider
Many of the partners we spoke to discussed the value and importance of having small / medium local providers with a local workforce, who they had strong working relationships with. However, it was noted that there has been a significant loss of such care services across Wales in recent years with smaller providers closing and larger corporations taking over a significant number of services. Some of the reasons for closure included:

- Many voids in certain services, such as residential, following the shift to community care, and providers not having the resources or staffing to change their service in line with the change in complexity of need
- Challenges with recruitment and retention, as well as the upskilling of staff, leading to insufficient skills mixes and a heavy reliance on agency staff at additional cost
- The increased costs of running care services, including utilities, property prices, National Insurance increases, Living Wage requirements, food and other consumables
- Difficulties improving or maintaining environments and equipment on the fees received, such as installing bariatric rails, wet-rooms, medical equipment and lifts
- Long-standing providers retiring and handing services over to private corporations or equity partners.

Demand, capacity and market stability
The prevailing view across stakeholder groups was that the current fragmentation of the care services available nationally, and the lack of capacity in specific areas such as dementia, nursing, EMI and Welsh Language services, was leading to a 'provider's market'. Statutory bodies described scenarios in which they have no leverage, due to lack of available alternatives without out-sourcing to England, or in which they are simply told to pay the fees requested or receive notice on a person's care placement. Partners have described paying 'exception rates', 'consumables charges' or 'top-ups' on an almost routine basis to meet their statutory responsibilities in terms of providing suitable care, honouring patient choice, and easing hospital flow.

The care market was described as 'fragile' by many stakeholders from across stakeholder groups, with clear examples given of service closures, changes in use, or of provider dominance in certain geographical locations or service types. Statutory bodies described their ability to negotiate and leverage as minimal, as ultimately, they rely on the care industry to meet the needs of the population, and they lack viable alternatives such as in-house provision.

People told us that:

> *"At the end of the day, it's a market"*
>
> *"They are the providers, we are the buyers"*
>
> *"We do have certain clients where there is no alternative, and we then at the end of the process have to pay the fee"*
>
> *"The market drives behaviour"*
>
> *"There are no other choices".*

In summary, stakeholders were clear that the lack of options, particularly for complex care, and the fragility of the care market was leading to a position in which they were required to pay fees considerably above those agreed as 'fair' or 'reasonable' in joint costing exercises that they had undertaken. Stakeholders are hopeful that a national fee methodology will help to address such challenges but feel that demand and capacity modelling will be required.

Provider profit margins

A contentious emergent theme was that of provider profit margins. It was noted that many care services, particularly those small-medium local enterprises, had a minimal profit margin – if any. However, stakeholder experiences and national research indicate a problem of 'profiteering' in the care industry by some types of care providers, namely those backed by private equity companies.

It was described to us that some care providers have their buildings and contracts purchased by private companies, who then 'lease' the service back to the individuals providing the care; leaving them with significant debts and overheads. Any uplifts or fee additionalities were offset against the debt, leaving the providers themselves to continue to operate on very small amounts of money and often working for below the real living wage despite moves to address this on a national level. Meanwhile, the private equity company is making a significant amount of profit through the terms and conditions of the lease as well as owning the capital asset: namely a large building in a prime location. It was described to us that there was little room for negotiation with such corporations, as the response was always that they would simply convert and sell the building – leaving no care services in the area at all.

With this in mind, it was the view of stakeholders that a thorough exploration of fees, costs and operational overheads would be welcome in the form of a national fee methodology; but that this would be difficult to achieve and could, furthermore, result in some challenge and contention. It was felt that a 'removal of profit' agenda was necessary, but that there was some sensitivity required regarding providers who were genuinely supportive of the population.

Is a national fee methodology feasible, and would it be welcomed?

None of the people we spoke to felt it was possible to set a national fee rate. However, of the 39 people we interviewed, 35 felt that a national methodology was both feasible and welcome. Of the 4 remaining, there was agreement that in principle it was a good idea, but they were not sure that it was possible. Their hesitations were around issues such as:

- How would having a national fee methodology change the realities we face now?
- What happens if providers don't agree to it – what can you do to enforce it, in our market context?

- Whilst a clear methodology would help to resolve some of the disagreements and challenges we currently face, it wouldn't address the issues underneath – namely profiteering in care by private equity companies.
- Evidence from when this has previously been attempted, both here in Wales and elsewhere, suggests that local authorities are so underfunded that attempting to meet the true cost of care becomes controversial and has unintended consequences.
- It is challenging to identify a 'true cost of care' due to the opacity of care organisations. How do you agree what a 'fair' profit is, or work out the cost of care for a provider with an unreasonably expensive lease? How do you define a rate with such information asymmetry?

These are key considerations and concerns for any implementation of a national fee methodology.

On the other hand, most stakeholders felt positive about the implementation of a national fee methodology; viewing it as an opportunity to rebalance demand and capacity, have a consistent method, and address some of the challenges they currently face. The risks and benefits that they identified and shared with us are explored below; as well as some of the queries they raised in response to this project.

Respondents also felt that it was possible to set a fee methodology for this group in isolation, but they did raise interdependencies with other areas of work and other age-groups. They described it as a 'good place to start'. It was also raised that whilst a national methodology for this group of people was likely to result in uplifts to current care fees, if a similar exercise were undertaken with younger groups these would likely demonstrate a decrease leading to an overall levelling of the care market.

We asked respondents whether they felt it would be helpful to implement a methodology on a regional level, as a phased implementation. The prevailing view was that this would have little impact, and that a strong move to a single, national methodology would have a wider, more positive impact.

What are the risks of a national methodology?

Participants across stakeholder groups identified several potential risks that apply to partners, providers, and individuals in need of care and support. The most frequently raised and explored risks are summarised as follows:

Risk 1 – There is a risk that the development of a National Methodology will identify that the 'true cost of care' is not currently being met

Risk 2 – There is a risk that statutory bodies cannot pay the difference in fees between current rates and the 'true cost of care'

Risk 3 – There is a risk that a national methodology will negatively impact upon existing good relationships with providers.

Risk 4 – There is a risk that the national methodology could be completed and interpreted differently, leading to different costs/results and causing tension.

Risk 5 – There is a risk that the quality-of-care provision will decrease.

Risk 6 – There is a risk of destabilising existing markets and placements.

Risk 7 – There is a risk that if a national methodology were implemented without the development of clear guidance, principles and standards, it would lead to poor outcomes for all involved.

Risk 8 – There is a risk that a national methodology will have no impact, because providers will simply refuse to accept fees that they don't agree with.

Risk 9 – There is a risk that a national methodology will not resolve the issues currently affecting care services, aka those of demand and capacity, skills and environment, recruitment and retention, and profiteering.

Risk 10 – There is a risk that implementing a national methodology will be viewed more contentiously than anticipated and raise unexpected challenges around the care market such as the prevalence of private equity companies and the challenge of quantifying a 'fair fee' under leasing conditions.

What are the perceived benefits of a national methodology?

Despite the risks identified, the prevailing view was that a National Fee Methodology would be a positive thing for Wales. Participants described many potential benefits that applied across the system and to the population of Wales. The most frequently raised and explored benefits are summarised as follows:

Benefit 1 – A national methodology would be transparent, understood by all parties, and evidence-based, minimising the need for lengthy annual negotiations.

Benefit 2 – A methodology based on a 'true cost of care' calculation, with clear and evidence-based parameters, would enable statutory partners to evidence the demand for and cost of care; leading to increased awareness in Government regarding the position of care and support and the budget required.

Benefit 3 – A national methodology will minimise the disparity between health funding and LA funding and provide clarity around who is paying for what. It also has the potential, with the right framework and standards around it, to address the challenges around CHC and FNC funding.

Benefit 4 – A national methodology will reduce the risk and burden (in terms of finances and personnel time) of successful legal challenges from providers and members of the public.

Benefit 5 – A national methodology will prevent larger organisations with care services in different regions from being able to capitalise on regional differences in funding.

Benefit 6 – A national methodology will stabilise the care market, providing security and stability for small-medium providers, and reducing the need for statutory partners to pay 'top-ups' or 'exception' fees.

Benefit 7 – A national methodology will reduce the ability of certain private companies to 'profiteer' in the care industry and ensure that fees and funding are reaching the staff and provision.

Benefit 8 – A national methodology will bring care costs together by focussing on core deliverable elements of quality care, such as the number of hours of care a person is receiving in a care setting. This outcome could be facilitated further by a clear set of accompanying national standards and would address the issues of current fee levels not being representative of population needs.

Benefit 9 – A national methodology will create accountability across the system, as there will be a transparent process demonstrating exactly what is being commissioned, who is paying for it, and what is required of the provider.

Benefit 10 – A national methodology will create transparency. Larger providers will not be able to use opaque fee systems.

Benefit 11 – A national methodology will increase understanding and awareness of safe staffing levels, environmental reinvestment required, and the skills/training required. This, in turn, will improve the

standards of care and enable more services to achieve 'good' ratings and individuals to achieve positive outcomes.

Benefit 12 – A national methodology will promote parity across Wales and prevent the 'postcode lottery' that people are currently experiencing.

What are people's views on existing methodologies?

During our interviews, we asked stakeholders about their current fee setting processes. They described the processes they currently use, the impact of this process upon fees and market stability in their region, the benefits and limitations to their approach, and what they would like to see in the future. Our key findings are summarised below:

Bespoke methods and modelling
Several regions had undertaken significant calculations and fee-setting methodologies in their area; working closely with partners and providers, and often independent consultants, to achieve standard or baseline fees across care categories. In some regions, this has had a positive impact; leading to improved relationships with providers, increased funding and therefore fee-levels, and the stabilisation of local care markets. In others, it has had little or no tangible positive impact with some stakeholders experiencing minimal provider engagement or finding that providers who had previously agreed to fee levels did not actually agree in practice.

All stakeholders described their fee-setting, review and methodology process as bureaucratic, time-consuming and challenging; and saw the shift to a national methodology as a way of alleviating this annual burden.

Experiences of existing methods and modelling
Several regions had previously used models such as 'The Fair Cost of Care Calculator', 'Let's Agree to Agree', LaingBuisson or 'Graham Level'. However, in each of these cases, the calculations had to be adapted for the Welsh market and local/regional challenges. We explored the reasons behind this through discussions with other countries and researchers and discovered that when the models had been developed there had been little inclusion of the Welsh market, population or demand and capacity modelling in some of these approaches, which may explain why these models were not a full solution.

People also shared views that previous methodologies haven't changed the way that providers interact with statutory bodies – they described them as not being "strong enough" and explained that, ultimately, due to the shape of the Welsh care market, providers can still charge over and above the calculations due to the lack of suitable alternatives.

Providers felt that the current methodologies are a 'blunt instrument' that doesn't allow for the nuances of providing the types of care that they were now being asked to provide, compared to several years ago.

Thoughts on the future of fee methodologies
10 of the groups we spoke to shared that they were exploring Care Cubed, a methodology that, as noted in Section 4, has been adopted by many organisations in England. Some of the reasons for this were described as follows:

- The benefits of having a 'ready-built' methodology that outlined the true cost of care
- Being able to conduct true 'like for like' comparisons due to the ability to manipulate inputs
- The ability to generate benchmarks
- Shifting the burden of proof of cost on to providers
- The provision of strategic and policy intelligence around care

- Providers viewing the use of Care Cubed positively, and therefore being more likely to engage
- Having a robust costing tool that allows for evidence-based negotiation between all parties
- Allows for scrutiny of inputs and assumptions.

However, there were some challenges reported including the potential for providers to manipulate the information they input, particularly around capital assets and profit margins, as well as the financial burden of purchasing and implementing the tool itself.

Queries and considerations

During our discussions, stakeholders raised a number of queries and considerations regarding how a National Fee Methodology might be developed and implemented; and what the purpose and remit of it might be. These thoughts are captured here, for the consideration of the National Office for Care and Support:

1. Will the methodology be prescriptive, or will it allow for regional flexibility that may be required?
2. How will quality be monitored and assured, to make certain that providers focus on delivering quality care rather than cheap care?
3. If there is a national goal to ensure that people remain in their own home wherever possible, what is the benefit of doing additional work around residential services rather than community services?
4. How would you ensure that all parties operated in line with the agreements made? If there are already difficulties around top-ups and exception fees due to market forces, how would this help?
5. How would a national methodology change the reality of the market? If we lack provision in certain areas or service types, what leverage do we have?
6. There are already a number of different targets and priorities for statutory partners from Welsh Government. How would the National Office for Care and Support ensure that there were no conflicts, or that people could prioritise this implementation?
7. To be robust, a national methodology would need to be held within a framework of reviewed and updated CHC and FNC funding, national principles, policies, costs and minimum standards. How would this be achieved?
8. To be effective, a national methodology would need to be supported by a robust and evidence-based demand and capacity model based on future predictions. How will this be achieved?

There were also three key recurring questions, as follows:

1. How will the implementation of a national fee methodology be paid for, and how will any resultant costs be met?
2. What is the problem that Welsh Government are trying to fix?
3. What does success look like?

Key findings from surveys

To extend the reach of our project, we undertook two digital surveys hosted on Microsoft Forms. These enabled professionals experiencing substantial operational demand to engage with the project in their own time. We provided two surveys, one aimed at those involved in the commissioning, monitoring and assessing of care provision for the target group, and one aimed at providers. Both surveys were available in English and Welsh, with two people completing the Welsh survey.

We had minimal provider uptake, despite undertaking several targeted engagement exercises and reaching out through contacts and forums that they are involved with. In total, 7 providers completed the survey (1 of which was an incomplete submission), and 22 wider stakeholders.

We analysed responses to quantitative questions by category of respondent, and blended thematic and discourse approaches to analyse those to open-ended questions.

The key themes emerging from our analysis are explored below.

Models and Approaches Currently in Use Across Wales

As with our semi-structured interviews, respondents to the questionnaire shared that several different approaches are currently in use across Wales and have been for a long time. The table below provides a summary of the information we received from the discussions and survey responses. Organisation details have been removed to preserve anonymity of participants:

Method in Use	Impact	Plans for the Future
"Fair Cost of Care" exercise	Rates are set in line with other LAs, but only one-third of providers accept the fee without a third-party top-up.	Regional work to further develop this was due to start in 2023.
Local methodology and "Let's Agree to Agree"	Challenging annual process, many providers do not complete the costing template. In some years, it has not been possible to complete the costing exercise.	Additional work to take place around fees for complex needs.
Local methodology by percentage uplift & staffing costs	Some challenges with providers due to querying specific costs such as 1-1 hours.	Some areas within the region are looking at CareCubed.
LangBuisson, with CareCubed for bespoke placements	Have been able to compromise with providers and robustly challenge in certain areas. Still approximately 10 providers who reject fees.	Looking to introduce CareCubed across all placement types, but the cost of implementation is a consideration.
Bespoke incremental method based on pay and non-pay costs.	Increasingly difficult to maintain approach due to uplifts by other regions and successful legal challenge.	Looking to implement CareCubed.
Local methodology	*Not provided*	Looking to implement CareCubed.
CareCubed	Agreements with all providers except one have been secured. There is a clarity of cost and supply, and there have been savings in some specialist placements. However, it evidenced that some fees were too low. Providers are now positive about the tool.	Remaining with CareCubed.
LaingBuisson	Increased the fees that were being paid to providers.	*Not provided*
Local Methodology & "Let's Agree", with an annual review template for	There are different rates across the region, particularly where top-ups are concerned. Unit costs vary due to the difference in models used across the footprint. There are challenges around setting	Feel that fee categories need reviewing.

providers and exploration of ratios and hours.	averages across the sector, including things like the hours of care or ratio of staff required, and managing the change in acuity of people needing care.	
"Fair Cost of Care" exercise using provider costs, care delivery, CPI and real living wage.	It was initially effective and saw excellent provider uptake; but long-term impact has been less stable due to capacity issues.	Looking at CareCubed.
IPC Exercise using provider costs, care policies, CPI NI, and real living wage.	Limited information was given by providers, and neighbouring areas completed the same exercise with different results. A fee was established but not accepted by providers.	*Not provided*
Local methodology based on incremental percentage increase incorporating NI, RLW, CPI and inflation.	In a position of paying "exception rates" and "top-ups" to ease hospital flow, which affects the market as providers can refuse to accept lower rates.	*Not provided*
Regional methodology using provider information and a sliding scale.	Had to increase fees to bring providers into the same rate structure, and introduce a social care additionality that considered costs of time.	Looking at CareCubed.
Local methodology with annual uplift based on affordability and NI.	Providers go through the annual review process, accept the model, and then add top-up fees to placements before accepting them.	*Not provided*

As in the table above, some areas report using methodologies such as LaingBuisson or "Let's Agree to Agree", whilst others had developed their own regional methodologies based on providers submitting costing information. Many partners described lengthy negotiations between statutory bodies and care providers around fee-setting, which takes place on an annual basis. Health partners reported using CHC assessment tools and A4C staffing awards, with one reporting that they ended up with several different fee rates across their footprint due to the differing approaches of the local authorities in their area.

Most of the providers who engaged with the survey had strong views about the methodologies currently in place, describing them as "flawed" or as being based on outdated information. They shared that there was limited engagement from providers to statutory partners around fee setting, which we had also heard from statutory partners during the semi-structured interviews and in their own survey responses.

Many of the providers described processes in which they shared their costs and the required uplift and were offered something lower in line with the available budget of the statutory partners, or that they were simply told what the fee would be with no room for discussion or negotiation. This was also disclosed during discussions and surveys undertaken with statutory partners.

People told us that:

> *"Little regard is paid to provider concerns, and they are dismissed as not thematic due to low sector engagement."*
>
> *"The uplift methodology was not consulted on or approved by providers".*
>
> *"We seem to give (our statutory partner) our costs and estimates for the year; they seem to ignore it."*
>
> *"There is no discussion/negotiation or model in place."*
>
> *"Take it or leave it".*

Several stakeholders across all groups again raised the potential for using Care Cubed in the future, and this seemed to be viewed positively across stakeholder groups; though as explored above there were hesitations regarding the financial risk of both implementation and the resulting calculations.

In summary, a national fee methodology would alleviate some of these issues; contingent upon provider engagement with the process and enough budgetary capacity to pay any resultant uplifts required.

The advantages and disadvantages of the current approach

Advantages to current methodologies were noted, and they included aspects such as:

- Building relationships with providers
- Budgetary management for statutory partners
- Providers knowing the cost of their care and being able to set a fair fee
- Using a strong local or regional evidence base to develop the fee models
- Having a clear understanding of the local care market
- Taking a joint approach between statutory partners
- Creating opportunities to listen to providers and receive feedback
- Being able to flexibly respond to local needs
- Having positive experiences with care providers as a result
- Having a robust "tried and tested" methodology in place.

However, it is worth noting that of the 6 providers who responded to this question, 5 stated that they felt there were 'no advantages' to the current process.

In terms of disadvantages, these largely followed the themes we saw in the semi-structured interviews and included challenges such as:

- Different uplifts being recognised and applied across localities within regions, leading to regional challenges and to some providers being paid different fees for the same services commissioned by different areas
- Some methodologies are 'over-simplistic'
- Methodologies are often based on affordability, rather than cost
- There is a significant time and cost burden to the annual review of fees across regions
- It is ineffective due to the diversity of provider care models
- There is no real clarity as to whether the proposed fee is too high, too low or sufficient
- It is difficult to accurately score needs within the domains
- The wording on tools can be unclear, causing difficulties with identifying the level of service required
- There is no way to enforce the fees offered in scenarios where providers set a rate that is higher than the cost of care exercise they have undertaken

- Low provider engagement affects the reliability of the data
- The tool in use doesn't consider the quality of services provided
- The tool in use is not compliant with the commissioning framework and standards
- The information used to create the baseline is dated, and doesn't consider local/regional factors
- Providers have little trust in the process
- There are gaps in the data, such as a lack of purely residential care data, which then impacts upon the accuracy of fee-setting in other types of care service
- The tool doesn't take into consideration changes in Government policy, such as National Insurance and National Minimum Wages changes
- In situations where the tool does demonstrate the level of uplift required, the fee offer is usually lower than this.

Review of current approaches and engagement with partners

As part of our survey and discussions, we asked stakeholders how often they currently review their fees. Across the board, this was reported as an annual process. We also asked partners how often they engaged with each other and with members of the public around the fee-setting process, due to considerations around self-funders. Whilst it was clear that partners engaged with each other, or at least provided the opportunity for engagement, on an annual basis; it was also clear that engagement with people currently receiving services, or the general population was minimal. Most areas did not undertake any activity in this area.

There were differing views as to whether information for self-funders and for those accessing care was easily available. Some people felt that they provided sufficient information in the form of leaflets or web-links, explaining costs and liabilities, whilst others felt that this was challenging to undertake due to the number of "hidden costs" such as consumables, incontinence materials or toiletries not being included in the base cost.

It is clear that as part of a national methodology, it would be helpful to develop clear guidance and information for people requiring care regarding exactly what is being paid for and what they will need to contribute on an individual and choice-led basis.

The sustainability of current fee Levels and the impact on market stability

We explored the impact of current fee-setting methodologies upon regional care industries and market stability. 100% of the providers we spoke to said that their fee levels were insufficient to cover their costs, and 100% said that they had a negative impact on their security as a provider. One provider told us that they had closed a 21-bed unit and were in the process of turning it into commercial flats, despite having been a small-medium care provider in the region for many years, due to concerns over the future of care in Wales and their ability to provide a safe service at the fees offered.

It is worth noting that this is a limited and self-selecting sample, meaning that the people who participated are more likely to be those with concerns to share. However, it is likely that these views are both reliable (replicable in other areas and over time) and valid (accurate) since they are corroborated by the more extensive sampling undertaken in both semi-structured interviews and the other stakeholder survey. Given that statutory bodies are reporting the same themes and challenges, the views that these providers have shared are likely to be representative of the national picture.

Providers went on to tell us:

> *"We have stopped working with them because it's of no benefit to us"*

> *"Homes have declined to accept our rates and only accept admissions from external parties where they pay a higher rate"*
>
> *"There is no desire to provide a fee that is sustainable and meets the actual costs, which is why 95% of homes in the region charge a top-up. It is out of necessity to survive."*
>
> *"Fee setting is a postcode lottery."*

In the stakeholder survey, we found a more mixed response. 80% of stakeholders reported that their costing exercise had resulted in a fee uplift for providers, and 41% felt that this had provided them with security. However, 10% felt that their approach to fees did not provide security to providers, and 32% were unsure of the impact that their costing exercise had. Other respondents chose to provide more nuanced answers, including:

- The requests for uplifts from providers sometimes sit around 20%, which fails to recognise the market and suggest that the business itself is not sustainable
- Providers are still saying that they are financially vulnerable
- Methodologies don't include costs that would allow providers to update their environments or reinvest in their services, which is acknowledged as a risk.

As with the semi-structured interviews, we saw a variety of responses from statutory partners regarding the influence of their fee-setting process upon market stability. Some areas reported that they were seeing positive changes in their care market following recent care calculations and uplifts. This included aspects such as positive feedback from providers and CIW, stronger two-way relationships with providers, increased investment in services, planning applications from new providers requesting to move into the area, and long-standing care providers remaining in the area. However, the majority shared that they were facing challenges in terms of demand and capacity, the number of "top-ups" requested, market fragility, increased costs for providers, challenges meeting provider costs due to budgetary constraints, and the ability of providers to refuse to accept referrals and instead take referrals from other areas with higher fee levels.

Is a national approach to fee setting feasible? If so, is it welcome?

50% of providers and 64% of statutory partners reported that they would welcome a national fee methodology, which is a slightly more mixed response to that received in the semi-structured interview. 33% of providers and 32% of statutory partners were unsure as to whether a national approach would be welcome, and 17% of providers and 5% of statutory partners felt that a national methodology would not be welcome.

When we explored the reasoning behind these responses, the following themes emerged:

- Views that it would need supporting by a standardised approach and key principles
- Changes would need to be managed carefully
- A national methodology would be welcome, but a national fee carries risks as it would not recognise local differences in operating costs and market variance
- Concerns around the risk of a potential uplift for providers, and how this would be paid
- Concerns around how a national methodology would work in practice
- Concerns that the cost of implementation would be prohibitive
- Views that it would need supporting by a national staffing level
- Concerns that a national methodology might have a negative impact if it does not take regional differences, for example in the cost of land or buildings, into consideration
- The view that it should be verified by an independent auditor to ensure the fee process is fair

What are the potential risks of a national methodology?

As in the semi-structured interviews, we asked respondents for their views on the potential risks and benefits of a national methodology. These followed similar themes to those above, and included the following frequently reported risks:

Risk 1 – A national methodology may demonstrate that uplift is required, and it's challenging to place that burden on local partners without assurance of the resources to pay for the commitment.

Risk 2 – It could be difficult to enforce a national methodology with providers.

Risk 3 – That incorrect, incomplete or insufficient data is used to inform the approach.

Risk 4 – That the resultant fees are too low, leading to a market crash or a "race to the bottom" from providers to the detriment of quality.

Risk 5 – That the impact upon some care providers or statutory services can't truly be known until the methodology is in place, and by then it is too late.

Risk 6 – That it could destabilise the current care market further and negatively impact on relationships with providers.

Risk 7 – That a national fee methodology is set in opposition to other priorities in Wales, such as achieving individualised, local outcomes.

Risk 8 – Challenges in the change management process with staff who have followed one process for a long period of time and may be uncertain about the proposed approach.

What are the potential benefits of a national methodology?

The overall view on adopting a national fee-setting methodology remained positive, if cautious. Views on potential benefits were aligned to those identified in semi-structured interviews, and included:

Benefit 1 – Having a national methodology would lead to a robust governance system for providers where statutory partners can feel confident that they are commissioning services that are financially stable for the future.

Benefit 2 – A national methodology would reduce the organisational risks of judicial review and successful legal challenges.

Benefit 3 – A national methodology would reduce the time and resource spent in renegotiating contracts each year, improving relationships and efficiencies and releasing capacity for statutory partners to monitor quality and outcomes.

Benefit 4 – A national methodology would help to ensure a transparent, consistent benchmark for the true cost of care, and to promote agreement around a "fair" level of fees.

Benefit 5 – A national methodology would reduce the ability of some care providers to "profiteer" in the care industry.

Benefit 6 – A national methodology would lead to better understanding from and relationships with providers.

Benefit 7 – A national methodology will ensure that people across Wales pay a consistent, fair fee for their care.

Benefit 8 – A national methodology supported by a clear costing exercise will ensure that care is paid for fairly between partners, such as local health boards and local authorities.

Benefit 9 – A national methodology creates the opportunity for a national response to key areas of pressure.

Benefit 10 – A national methodology reduces the ability of some providers to use regional variances to their benefit whilst negotiating fees.

Benefit 11 – A national methodology would eliminate the current "postcode lottery".

Benefit 12 – A national methodology would reduce the current culture of pressure and "bullying" in fee negotiations across parties.

Benefit 13 – A national methodology would stabilise the care market and give providers confidence about the future of care in Wales.

Benefit 14 – A national methodology would reduce the current duplication within the system.

Queries and considerations

We invited participants to share any other thoughts or queries they had around a national fee setting process. In addition to those outlined above, the following points were raised:

- It was felt that an independent body needed to be involved in the development of a national fee setting methodology, to ensure that they were accountable to all parties without being hindered by their own budgetary or statutory responsibilities.
- It was felt that a national fee setting methodology would benefit other groups, not just the over 65s group that was the framework for this project.
- It was noted that there are core underlying issues with CHC and FNC funding that need addressing as part of the national methodology.
- There was concern about "unethical" practice with some providers in Wales, and the ability of a national methodology to resolve these issues.

It is worth noting that again many regions were either in the process of adopting CareCubed or currently exploring it with a positive opinion. This was true across both partners and providers. Therefore, it is worth noting that if a national methodology were implemented that prevented organisations from continuing to utilise Care Cubed, there would be a significant financial risk to organisations who are currently contracted with them for the next few years.

6 Key conclusions emerging from the analysis

In this Section, we set out key conclusions emerging from our evaluation, drawing on the detailed analysis of the structured interviews and survey responses detailed in the preceding Section of the report.

Key Conclusions

Demand for older people's residential and nursing care is growing and changing

Recent trends have shown an increase in the complexity of need among older people entering residential care across Wales and, as set out in Section 3 of the report, these trends are expected to intensify in the coming decades. Generally, people are entering the residential sector at a later stage and, whilst this means that the average length of time an individual spends in care is seen to be decreasing, the level and specialism of care required is on the increase. The concept of an older person generally entering residential care in early old age and spending years or decades in care homes up until their death no longer applies.

These trends have clear implications for the volume and type of care needed.

Resources required to meet the changing demand are not always available

It is clear from our conversations that some providers are finding it difficult to recruit and retain nursing staff within the sector, resulting in some areas relying on out of county placements within, and in some cases outside, Wales (often at considerably higher cost) and non-nursing staff having to deliver care that previously would have been reserved for those with a medical qualification. Comparatively poor levels of pay, even with the Real Living Wage applied, compound this problem as providers experience similar struggles with recruitment and retention.

The resilience of the older people's residential market is variable

Our conversations with commissioners suggested a mixed picture regarding resilience of the market. In some areas, investment in the sector and the presence of larger providers mean that the market is reasonably buoyant. In other parts of the country we heard of increased costs, lack of investment and established smaller providers coming to the end of their working life, homes are closing down and the places lost are not necessarily being replaced. Councils with large geographic footprints are in some cases not able to secure provision in all areas.

Particularly in those areas that rely heavily on commissioned care home placements and have limited or no inhouse provision, this is having a detrimental impact on capacity and can drive up prices as competition for care placements grows.

More rapid turnover in occupancy, due to shorter stays by individuals in residential and nursing care (see above) also can result in more voids, adding to the vulnerability of some providers.

We heard of particular problems in some areas in relation to nursing and dementia placements.

A small number of authorities do have significant inhouse provision alongside commissioned placements and others (Carmarthenshire and Gwynedd) are actively pursuing the establishment of local authority run dual registered homes which can provide residential and nursing care. Whilst such developments may mitigate market risks to some degree, it is accepted that commissioned provision is likely to continue to dominate and there is a clear view that an approach to fee setting that inspires confidence within the sector and reflects the cost of care could be key to achieving stability in the sector.

Current arrangements for local authority fee setting are inconsistent and have significant shortcomings

A system in which local authorities set fees locally, there are varying degrees of engagement with providers, a range of methods are deployed for such engagement and the frequency with which fees are reviewed differs across different areas, results in the following:

- A sense among some commissioners and providers that the evidence base on which fees are set is insufficiently robust and that the true costs of care are not being identified.
- A view that providers are being short-changed and that fees are not sufficient for them to recoup costs incurred in providing care, realise reasonable profit or put aside resources for capital and other investments that would help make the market more sustainable. Here it should be noted that the issue of how providers deploy the fees they receive, and particularly how much is directed into provider profit, is a contentious one. There have been high profile cases such as that of two care homes in Carmarthenshire and Pembrokeshire having funding withdrawn due to concerns over financial irregularities, resulting in the level of resources made available for frontline care being far below that which the fees paid would suggest.
- Uncertain relationships and a lack of trust which hinders effective collaborative working.
- Providers feeling that when setting fees, councils are bound by budgetary constraints and that fee levels are more likely to reflect fiscal 'ceilings' than the costs that are incurred in providing care.

The lack of robust frameworks for fee setting are exacerbating these problems

Whilst some councils are using national approaches such as the LaingBuisson Care Cost Benchmarks Toolkit[14] and an increasing number are using CareCubed, many are relying on locally developed models for agreeing fees and these are not seen as sufficiently sophisticated or reliable.

Inevitable inconsistencies can also result in the fees paid to providers operating across more than one local authority area being different and confidence in the system being further eroded.

Many of the commissioners we spoke with said that their approaches were in keeping with the 'Let's Agree to Agree' Guidance (see Section 4); however, there is a sense that subscribing to what is essentially a set of principles, rather than a formally agreed approach, has limited value in practice.

Agreed fee levels are often trumped by spot purchasing arrangements, undermining local fee setting approaches

Some local authorities report that providers get around what they see as inadequate fee levels by 'holding them to ransom' and demanding an increased fee for individual placements. They do this in the knowledge that the local authority, with a duty to secure a placement for an individual, has no real choice in the matter. Such instances effectively render any agreed fee levels academic and our conversations with commissioners suggest they are not isolated.

The view was expressed that in such circumstances a more robust and transparent fee setting approach, in which all parties felt confidence and to which they were able to formally commit, would reduce the risk of this happening.

[14] Care Cost Benchmarks toolkit 13ed | LaingBuisson

Fees for FNC and CHC are felt to be inadequate, and this is exacerbated by a local lack of confidence in the assessment processes for both payments

The FNC fee rate is set nationally (as outlined in Section 4), and whilst this rate is technically advisory, our understanding is that no local health board currently deviates from it. We heard concerns over the inadequacy over funding, even with the additional components resulting from the Judicial Review and many feel that social care 'plugs the gap', by requiring care workers to undertake ancillary tasks that should technically be carried out by qualified nurses.

CHC fee levels are determined individually by local health boards. The lack of a consistent approach across Wales leads to similar criticisms to those levelled at local authority fees under current arrangements.

There are historic and present tensions between local authorities and local health boards around the assessment process, with several councils expressing the view that thresholds are too high, resulting in a situation whereby NHS contributions are seen as inadequate. We were told that in some areas, CHC spend is diminishing at the same time as demand, as outlined above, is increasing. Several councils have formally raised concerns over this at a national level.

Perhaps not surprisingly, local health boards generally believe that assessment for eligibility in relation to both funds is robust. The relative lack of trust in these areas, however, can be seen as a potential contributory factor in the fragility of the care home market.

There is a case to be made for CHC rates to be set using a consistent approach (ideally the same one as used by local authorities) and for FNC rates to be reviewed and, where appropriate, supplemented at local level in a similar way. Whilst the assessment of eligibility for either payment would not be automatically affected, the commitment of local government and the NHS to a shared approach to fee setting might inspire greater confidence across the system and enhance collaboration in paying for care. The integrated approach for agreeing CHC and FNC-funded placements in England is worth exploring further in this regard.

Regional Partnership Boards (RPBs) are generally not being used to develop regional approaches to fee setting

Part 9 of the SSWBWA clearly cites RPBs as forums through which greater collaboration between health, social care and other services, and the progressive integration of NHS and care services, can be achieved. Having these key partners around the same table on a regular basis provides a potential opportunity to address issues such as those listed above and develop consistent approaches to fee setting.

Specifically, the Act requires the establishment of pooled funds for elderly residential care homes across statutory partners in each region. It might be reasonable to expect that pooling arrangements could be a conduit to, or indeed to be successful rely on, a consistent approach to fee setting in that sector.

Whilst some regions, generally through regional commissioning boards sitting under the RPBs, have made some headway by agreeing regional approaches to fee setting this is by no means commonplace across other parts of Wales. And even in these cases adherence to agreed approaches is patchy across different local authority areas. Similarly, we found that pooled funds for care homes are universally 'notional' or 'in principle' rather than fully functional. They involve some level of aggregation of budgets held by each partner and joint reporting, but in practice do nothing to foster a transparent and fully integrated approach.

A majority of stakeholders with whom we engaged are of the view that a national approach to fee setting would be a positive development

Whilst we identified no support for a national fee across Wales, as it is generally felt it would be impossible on a practical level to reflect the range of costs resulting from, for example, variances in property values, the notion of a national approach to fee setting was backed by the vast majority of the stakeholders with whom we engaged during the evaluation.

Specifically, it is felt that a national approach or model has the potential to:

- Clarify genuine costs of care in different parts of Wales and provide a transparent evidence base for fee setting
- Establish agreed and consistent parameters for applying these costs on a consistent basis
- Build confidence among commissioners and providers regarding the basis on which fee levels are set
- Also be used as the basis for calculating CHC rates (and potentially, appropriate variations to the FNC rate)
- Secure shared ownership of the cost calculations and the resulting fees, reducing the risk of providers departing from the agreed levels and charging higher fees on an individual basis (see above) and strengthening general collaboration across partners
- Reduce the resource needs associated with commissioning agencies having to regularly update fees calculations and/ or review existing approaches to maintain the confidence of providers
- Reduce the 'politicisation' of local fee setting, whereby councils' decisions on fee levels are based more on prioritisation of investment across different service areas based on political priorities rather than an objective assessment of the amount needed to secure a sustainable care market.

Whilst we did not seek as part of the evaluation to actively explore the viability or desirability of particular models, we noted that CareCubed is already being used by several local authorities and some providers and has a notable level of credibility. Its potential value in providing consistency and robustness of evidence, alongside it being a not-for-profit initiative, would in our view justify more detailed exploration of its potential as part of a national approach moving forward.

A national approach could potentially lead to increased fee rates and additional cost pressures on local authorities, local health boards and Welsh Government

Contributors to the evaluation generally feel that there needed to be a debate about how increased costs emerging from a national approach to fee-setting might be met. Whilst it is acknowledged that local authorities and local health boards have a responsibility to ensure that their respective statutory duties are met in this area, a wider debate on paying for care is undoubtedly needed. This chimes with the conclusions in 'Towards a National Care Service for Wales' that long-term investment will be key to the establishment and sustainability of the service and that there is a need for a transparent and honest 'national conversation' about how it will be paid for.

A more equitable approach to fee setting is one of several factors that will deliver a sustainable national care and support service

During the evaluation we were frequently reminded of other changes that will be needed if provision of care and support is to be adequate and sustainable moving forward. These include:

- Ongoing development of new models of care such as Extra Care housing, which provides for seamless progression of individuals within a communal setting as their care and support needs

increase, mitigating the effects of ageing and impact of factors such as loneliness, and gradually reducing the need for residential and nursing care in its traditional form
- More investment in other forms of prevention and early intervention, promoting better quality of life, longer independence and avoidance of escalation and the need for intensive care and support
- Perhaps more controversially, a review of the current £100 cap on domiciliary care charges; there is a feeling that this (1) forces the diversion of funding within local authorities from residential to domiciliary care so as to ensure that the full costs of the latter are met and (2) provides an incentive for older people to stay at home for as long as possible thereby avoiding the more prohibitive costs of residential care and, in so doing, entering that sector when needs have become more intensive and complex
- Setting of national minimum quality standards as envisaged in 'Towards a National Care Service for Wales'.

A national approach to setting fees for older people's residential / nursing care should be accompanied by one for other adult groups

Older people sometimes need other care needs which need to be paid for, and services for other groups such as adults with learning and physical disabilities might also benefit from a consistent national approach to fee setting.

Fees methodologies for such groups are in place across Wales and there is an opportunity to look at a consistent national approach, perhaps using the same methodology as that for older people, improving transparency and supporting the financial sustainability of this sector.

7 Feasibility of a national approach to fee setting

Drawing on the data gathered through the evaluation and conclusions of our analysis, it is evident that there is widespread support across stakeholder groups for the notion of a national approach to fee setting for older people in residential care.

In line with our brief, we have tested the feasibility of a national approach against key criteria, as follows:

Criterion	Description
Legislation and policy	The extent to which a national model would support delivery of legislative requirements and national policy imperatives
Let's Agree to Agree principles	The extent to which a national model would support delivery of the principles set out in the Let's Agree to Agree Guidance
Commissioners' views	The likely acceptability of a national model to commissioners across Wales and the extent which it would address the shortcomings in current arrangements they identified
Providers' views	The likely acceptability of a national model to providers across Wales and the extent which it would address the shortcomings in current arrangements they identified
Cost	The likely cost of implementing a national model and predicted impact on future care costs

Details of our assessment are provided below.

Criterion	Assessment
Legislation and policy	National model would: • Support further collaboration on the planning and delivery of care and support as required under Part 9 of the SSWBWA and also promote joint commissioning approaches • Meet requirement within code of practice for Market Stability Reports for full understanding of the costs of care when agreeing a service price with providers • Support the aspiration within A Healthier Wales for a fair and sustainable funding model for health and social care • Support the identification of true costs of care as a precursor to the national funding conversation envisaged as part of the delivery of the National Care and Support Service • Align with the ways of working under the WFGA aimed at ensuring sustainability of services and communities, collaboration between agencies and involvement of people in achieving wellbeing goals
Let's Agree to Agree principles	National model would: • Support an inclusive and co-productive approach to fee setting • Establish a consistent approach to gathering data and intelligence around the cost of care including in relation to staffing, non-staffing costs, and overhead and management costs

Criterion	Assessment
	• Establish an agreed approach to deciding levels of profit and return on investment, occupancy levels and quality premiums • Introduce a consistent approach to annual uplifts
Commissioners' views	National model would: • Support an inclusive and co-productive approach to fee setting • Be supported by the vast majority of commissioners with whom we engaged during the evaluation • Reduce the administrative burden of annual fee setting using a local approach and regular review of local approaches • Reduce political tensions around fee-setting • Provide an evidence-based approach to prioritizing investment • Reduce tension with providers when setting fees • Identify true costs of care and help track deployment of fees within provider organisations • Reduce the likelihood of one-off negotiations over fee placements, often leading to increased costs • Allow an objective assessment of nursing costs within nationally-set parameters
Providers' views	National model would: • Support an inclusive and co-productive approach to fee setting • Have the support of a significant number of providers • Provide the opportunity for recognition of the true cost of care and this being met through agreed fees • Provide an objective basis for fee setting across local authority boundaries • Help ensure fees reflect the true cost of care and support sustainability
Costs	• Were a national model to be mandated locally there are likely to be immediate costs to commissioners in relation to acquiring software, training etc. Discussion would be needed on how these costs would be met and appropriate liabilities at national, regional and local levels. • Whilst difficult to accurately predict, a national model could increase overall costs of care. National sign-up to such a model would place an in-principle duty on commissioners to reflect those costs in their fees. Discussion would be needed on how those costs would be met and appropriate liabilities at national, regional and local levels. This accords with narrative within 'Towards a National Care and Support Service for Wales'

8 Recommendations

Based on the analysis and conclusions contained in preceding sections, we have formulated the following recommendations. In Section 9 we suggest initial steps in addressing the recommendations.

1. The National Care and Support Office should **mandate further work to develop and implement a national approach to setting fees for residential and nursing care for people aged 65 and over in Wales.** Here it is important to distinguish between a national approach and a national fee, which varying conditions across Wales and the experience of other parts of the UK suggest would be counter-productive and result in some providers not receiving the true cost of care and, potentially, others being overpaid. Our recommendation therefore is for the former.

2. Any such approach should as far as possible address the 'queries and considerations' identified from our stakeholder engagement and detailed in Section 5.

3. In developing such a model, **the opportunity should be taken for a national conversation between Welsh Government, the NHS and local government on the potential to integrate mechanisms for setting CHC and FNC rates**, providing a robust and evidenced basis for allocating costs fairly across each sector, enhancing assessment processes and strengthening collaboration.

4. There should be **further consideration of the feasibility of adopting CareCubed as a national solution**, in view of (1) its status as a not-for-profit organisation, (2) its potential applicability to other age groups, (3) the fact that it has already been adopted by a number of local authorities and providers across Wales and (4) its widespread use and preferred status among commissioners in England.

5. This work needs to be **aligned to other workstreams being taken forward in relation to development of a National Care and Support Service**, including national standards and design principles. This will ensure that different strands complement and inform each other and will help minimise duplication.

6. Consideration should be given to **developing a similar approach across other adult groups**, providing consistency for providers serving different cohorts and potentially realising savings in some areas which can be redirected to meet increased costs emerging for those aged 65 and over.

7. This work should be **facilitated by an independent organisation** unaffected by any shifts in costs and budgetary requirements, whilst being co-produced and effectively engaging with all affected parties.

9 Next steps

Immediate next steps for the National Office for Care and Support in implementing our recommendations should be as follows:

1. Undertake **further engagement with commissioners and providers through relevant national and regional forums**, to review current arrangements and test out the essential requirements in a national model and approach to implementation and implications as highlighted in this report.
2. Facilitate conversations between the NHS and local government to **explore opportunities for the integration of fee-setting for CHC, FNC and residential placements**.
3. Undertake a **full assessment of the CareCubed** and its potential as a national costing model
4. Run **pilots of selected new approach to test effectiveness and impact.**
5. Facilitate a **national conversation over how any additional costs might be met**, through additional investment and redirecting of existing funds within the system.

Appendix 1: Organisations with which we engaged

Survey responses were received from:

Representatives of one provider organisation operating across Wales and others based in the following local authority areas:

- Bridgend
- Pembrokeshire
- Rhondda Cynon Taf
- Swansea
- Torfaen (x 2)

Professionals working in the following organisations:

- Aneurin Bevan University Health Board
- Cardiff and Vale University Health Board
- Cardiff Council
- Hywel Dda University Health Board
- Newport Council
- Powys Teaching Health Board
- Swansea Bay University Health Board
- Torfaen County Borough Council
- Vale of Glamorgan Council

In addition, responses were received from:

- 3 local authorities in Gwent
- A Regional Partnership Board in South East Wales
- Individuals working in a local authority in North Wales
- An individual working in a local authority in West Wales
- An individual working in a local authority in the Cwm Taf Morgannwg region

In addition, we engaged with the following organisations in one-to-one and group interviews:

All Wales local health board nursing leads
Aneurin Bevan University Health Board
Betsi Cadwaladr University Health Board
Cardiff and Vale University Health Board
Cardiff Council
Care Forum Wales
Care Inspectorate Wales
Carmarthenshire County Council
Ceredigion County Council
Conwy County Borough Council
Cwm Taf Morgannwg University Health Board
Flintshire County Council
Gwynedd Council
Hywel Dda University Health Board
Isle of Anglesey County Council

Monmouthshire County Council
National Commissioning Board
North Wales Regional Commissioning Board
Powys County Council
Powys Teaching Health Board
Rhondda Cynon Taf County Borough Council
Torfaen County Borough Council
University of Birmingham
Unison
Vale of Glamorgan Council

Appendix 2: Stakeholder questions

The standard set of questions was adapted as appropriate for different audiences (e.g. to reflect the area of specialism of the agency with which we were engaging). All questions related to the key lines of enquiry identified for our study.

Local context

What is the current, and projected demand for care home placements for over 65s, including those receiving FNC or CHC in your area, and do you identify any challenges in meeting it now or into the future? *This could be difficulties with assessment, availability of suitable placements, or financial/budgetary challenges.*

How do you decide which providers to use to commission placements for people over 65? Would you say you have a choice?

Your approach

What model so you currently use for fee setting within your area? How was this model chosen? How long has it been in place? *Have there been any reviews of the approach? What did they find?*

What do you see as the advantages and disadvantages of your existing approach to fees setting? *Prompts could include relationships between partners, risk-sharing across partners, social value, local infrastructure, ability to have diverse offers across large/geographically disparate areas etc.*

If the parties in the discussion use the "Let's Agree to Agree Model": How far do you keep to the principles of the toolkit in agreeing fees/rates with providers? Does your model reflect the principles adequately? *Why/why not?*

To what extent does your fees model identify exceptions, and how does this work? *Is this something you would consider, if moving to a new model?*

How does your fees model reflect the wellbeing goals within the FGA (e.g. A Healthier Wales, A More Equal Wales, A Wales of Cohesive Communities?

How does it reflect the ways of working, for example involvement of users and carers in agreeing the approach to fee-setting, thinking for the Longer Term in terms of market sustainability/ affordability or collaborating with affected partners?

Would you be able to convey the general view of providers in your area to your current approach to fees setting? Would you say this is positive, negative or somewhere in between? *Please explain your answer.*

How you developed your approach and how you review it

To what extent, if at all, do you engage with people needing care and support, and their families and carers, in setting fee levels and what the implications are for them? *How do you do this? What have you learned? How has this affected or informed your approach? Do you have information readily available?*

Is information, advice and assistance readily available to inform people of fee levels for different kinds of care?

Has the Regional Partnership Board (RPB) been involved in the development or review of your current model? If so, how?

To what extent have discussions in relation to, and emerging arrangements for pooled funds for older people's care homes, led to alignment of care fees within your region?

Have such discussions clarified arrangements for and levels of FNC as part of overall care costs?

Impact of your approach

What impact would you say your current approach has had on fee levels? *Has it had a budgetary impact? (This could be it costing more or less to commission or receiving more or less funding). Has it provided security to local providers and commissioners? What have the advantages and disadvantages been?*

What impact has it had on the care homes market in your area?

How fair or appropriate would you say your current approach is?

To what extent did you assess the impact of your current fee methodology/approach on market sustainability when preparing your market stability report? *What risks were identified? Were any actions taken to address emergent risks?*

Has your approach to fee setting had an impact on self-funders? *How have you assessed this? What impact has it had? How have you engaged with people about this?*

Has your approach to fee setting had an impact on any other areas of care? *For example, care for children and young people? Care for people with LD or dementia? Care for adults?*

Are fee levels sustainable in your area? *What makes you say this? Do you think the Government's "Net Zero" pledge will have an impact on this? Are carers paid the Real Living Wage? If this is implemented, would it affect fee stability?*

FNC and CHC

How do you currently agree FNC and CHC fees across your area? Do you have local agreements, or use a specific methodology? *If the latter, which? Explore "where the buck stops" - if there is a disagreement between parties, how is consensus reached?*

How do you monitor and assure your current FNC and CHC provision? *Are you confident that the placements are of sufficient quality? Is this monitored on an outcomes basis? Is person-centred planning part of your monitoring and assurance? Do you consider wider factors such as sustainability, person-centred outcomes, improved wellbeing etc as per the WBFGA? How often do you engage with people in the services to find out what they, or their families and carers, think about services?*

Future approach

Would you welcome a national approach to fee-setting? *Why, or why not? What would the risks and benefits be? Do you feel that risks and benefits would be equally held across partners?*

Do you think it's possible to set a national approach to fees just for this group in isolation? *Do you think that it will have an impact on other groups and services?*

Would a regional approach be more achievable or a sensible first step? *Please explain*