Bradford MDC

Homecare Cost of Care Exercise 2022-23

October 2022

ARCC-HR Ltd

Contents

1 Executive Summary

1.1 Context the Cost of Care Exercise

1.1.1 Fair Cost of Care & Market Sustainability

On the 16 December 2021 DHSC released its policy paper: 'Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023' with further detailed guidance following on the 24 March 2022. The 2022-23 funding provided under this policy is designed to ensure local authorities can prepare their markets for reform (particularly the impact of section 18(3) and the right for self-funders to request that a local authority purchase care on their behalf at the 'usual council rate').

As a condition of receiving future funding, local authorities will need to evidence the work they are doing to prepare their markets and submit the following to DHSC by 14 October 2022.

1. Analysis of cost of care exercises conducted for 65+ care homes and 18+ domiciliary care. This includes a cost of care report and fully completed cost of care data table as found in Annex A, Section 3.
2. A provisional market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market, with particular consideration given to the further commencement of Section 18(3) of the Care Act 2014. A final detailed plan will be required in February 2023; in the interim a 5-page provisional plan should be submitted utilising the Annex C template.
3. A spend report detailing how funding allocated for 2022 to 2023 is being spent in line with the fund's purpose. A full breakdown of how funding has been allocated to support 65+ care home and 18+ domiciliary care markets (including domiciliary care providers who operate in extra care settings). This must specify whether, and how much, funding has been used for implementation activities and how much funding has been allocated towards fee increases, beyond pressures, funded by the Local Government Finance Settlement 2022 to 2023.

1.1.2 Scope of this report

This report has been prepared on behalf of Bradford Metropolitan District Council [BMDC] in response to the first requirement and presents the analysis and findings from the cost of care exercise conducted within 18+ domiciliary care. Throughout this report the terms 'domiciliary care' and 'homecare' are used interchangeably.

This report covers the following:

- The overall cost of care analysis, including the approach to engagement and data capture, methodology utilised and the formulae to inform future uplifts.
- Costs to consider when determining future fee rates based on different funding models, which includes the flexibility to accommodate a range of assumptions, for example: travel time, overheads, duration of visits, and other factors such as geographical coverage.
- Key findings and recommendations during the engagement to support future commissioning models in Bradford.

1.2 Provider Engagement

This review of the cost of care has been informed by four months of engagement and data analysis work. A total of 76 providers within Bradford were engaged for the exercise, which was later reduced to 47 providers in scope (see section 2.3.2). The engagement process comprised the following elements:

- **Provider Survey & Cost Template:** submitted to 76 of providers within the Bradford market, to gather data on both the costs and the operational experience of delivering services locally. Providers were given a £250 incentive for completing the template
- **1:1 deep-dive structured interviews:** all providers were invited to express interest for a 1:1 session, with 10 interviews taking place with finance and/or operational leads for the respective organisations.
- **Provider & Commissioner workshops:** following the launch session workshop, two further workshops were held with providers and commissioners to maximise engagement.
- **Closed feedback/questions:** conducted via e-mail to allow providers to consider additional questions and clarifications following the final workshop.

Engagement focused on the following key aspects of the market as well as a detailed study of costs:

- The current homecare market in Bradford (structure, demand, and supply)
- The experience of commissioning and contracting with Bradford MDC
- Provider's business operating models, general market outlook, workforce, contract and quality monitoring, business costs, and future commissioning arrangements
- Deep dive with providers to understand operating costs and sensitivities that would impact cost

After completion of the data collection, a total of 23 submissions had been received, 21 of these considered in scope for the exercise, representing **45% of providers in the market,** and 46.4% of homecare hours commissioned by BMDC.

1.3 Local Cost of Care Results

1.3.1 2022-23 cost of care median

As per the DHSC requirement, the exercise was required to identify a median cost of care which was reflective of provider's April 2022 cost pressures. Table 1 identifies the outcome of the analysis of provider returns; based on the data available the median rate has been calculated as £22.54 this represents a 16.19% increase on the current framework rate of £19.40. Section 4.3 provides a detailed breakdown of the analysis.

All Providers	LOW	25%	MEDIAN	75%	HIGH
Hourly Breakdown	Cost £	Cost £	Cost £	Cost £	Cost £
Care worker costs:	£11.99	£13.54	£14.14	£14.94	£19.00
Business costs:	£1.95	£4.81	£6.09	£7.02	£8.74
Surplus / Profit Contribution	£0.14	£1.09	£1.82	£2.39	£4.09
Total Cost Per Hour	£17.92	£20.20	£22.54	£24.13	£25.82

Table 1: *Outcome of the analysis of provider returns*

The financial impact of this model is estimated to be **£5,471,751 per annum** on the basis of a £3.14 variance between the existing base rate and the median, multiplied by an estimate 1,742,596 hours of care required in the year, utilising historic annual volume of care commissioned by BMDC.

1.3.2 Scenario modelling

Following the above analysis and reflecting commissioner and provider feedback in relation to current market sustainability, five additional scenarios were also considered utilising the base cost established for 2022-23. Table 2 identifies the effective unit rates for care calculated for the following scenario (further detail can be found in section 4.4).

Scenario Models	Description	Unit Cost per care hour[1]
#1 Median model	*Median model to facilitate scenarios 1a to 1d*	£22.54
#1a 15-minute call duration	*Median adjusted to reflect avg.15-minute call*	£22.91
#1b 30-minute call duration	*Median adjusted to reflect avg.30-minute call*	£22.57
#1c 45-minute call duration	*Median adjusted to reflect avg.45-minute call*	£22.46
#1d 60-minute call duration	*Median adjusted to reflect avg.60-minute call*	£22.41
#2 Inclusion of travel time	*Median adjusted to include 5 minutes travel and 2.5 miles per visit, paid at standard hourly rate*	£25.78
#3 Real Living Wage 2023	*Base carer pay set at £10.90p/h to reflect 2023 Real Living Wage[2]*	£23.92
#4 AfC NHS Band 2 (+2 years' experience)	*Base carer pay set at £10.93p/h + 10.1% RLW adjustment to reflect pay rates for an NHS Band 2 worker and 2023 RLW. Pay rate of £12.03*	£25.79
#5 Competitor sector £11.50 model	*Base carer pay set at £11.50p/h to reflect pay rates for similar sectors such as retail.*	£24.79

Table 2: *Effective unit rates for care calculated for different scenarios*

It is important to re-iterate that whilst the base hourly pay rate for carers was used as a proxy for modelling various unit costs, commissioners' fees are based on ***whole service costs*** and not simply the pay rate to the direct care workforce. Therefore, the breakdown of unit costs within each scenario is unlikely to directly replicate any single providers business and is intended simply to sustainably cover a range of business operating costs for the purposes of commissioners' understanding and decision-making regarding potential future prices for homecare services.

[1] The variations on call length are expressed as unit cost per care hour, however the actual cost per call should be derived by the proportion of 1 hour that call represents, e.g., for a 30-minute call, the cost per care hour should be halved to arrive at the unit cost per 30-minute call – see section 4.4.3 for further details.

[2] https://www.livingwage.org.uk/

1.3.3 Conclusions

The cost of care exercise was conducted during exceptionally challenging conditions for the sector nationally, not just in Bradford. Recruitment and retention pressures post-pandemic and most recently inflationary costs have put further pressures on the care workforce and providers alike.

It is important to note when commissioning care services, that councils are not responsible for setting individual budget or cost lines for providers. Whilst pay rates and other non-pay costs have been utilised for the purposes of constructing the median cost and scenario models, this does not in any way represent the absolute shape and size of each provider, rather they are guidelines for producing an overall "budget" unit cost per care hour. For instance, setting a "base" pay rate does not mean providers are only able to pay workers at that rate. They are free to work within their budgets to pay whatever they are able to retain a sustainable workforce. As such, any model (and subsequent breakdown of costs) should not be taken explicitly as the exact cost the business needs to, or should it be read that it is the absolute maximum limit of, what the provider's affordability will be for any and all costs incurred by their businesses. There are many other factors (such as the prevalence of self-funders and other customer types) that also affect independent care providers, and no exercise of this nature can take all of these into account.

Finally, it should be re-emphasised that any Council has a duty under Section 5 of the Care Act to ensure they have a "sufficient" market to buy services from, and it is not the duty of any local authority to pay any specific "rate" for care. Rather, local authorities will need to take into account how readily they are able to service their population's needs via the existing contracting and pay mechanisms they have with the market, which takes into account:

- The scale of customers waiting, and time taken to implement packages of care,
- the level of unmet needs in the market,
- the availability of services and coverage of the market at existing framework or negotiated rates
- and many other factors outside of simply cost.

This assessment feeds into the cost of care to determine what ultimately gives the Council assurance around the overall sufficiency of care they are able to purchase from the market.

Whilst a long-term intention, in line with this cost of exercise may be to work towards the estimated median of £22.54, in the context of specific rates paid for care, DHSC guidance states that ***"fair means what is sustainable for the local market"***. The council should continue to monitor the pressure in the market (both staffing and business operating costs) through the fee exercise, and as was the case for this financial year with a 6.5% uplift, make adjustments (% fee uplifts) to reflect changes to operating costs. No single exercise at any point in time becomes the "end" point for this assessment of market sustainability. It is an iterative process, and it is the duty of local authority commissioning to **continually review and adapt their understanding of costs and contracting practices regularly.**

Whilst the DHSC requirements are for local authorities to move towards paying the median rate, achieving this median is not an indicator of a sustainable market; the ability to purchase the volume of care required in a timely is a primary indicator of how the market is preforming. It is important to note that the ability to move towards this rate will be dependent upon future allocation of the Fair Cost of Care fund by the DHSC. Based on the exercise, it is estimated that the council would **require an additional £5,471,751 per annum to fully implement the assumed median cost.**

ARCC would like to thank all stakeholders engaged in the process. We hope that through this exercise, both commissioners and providers can continue both the positive dialogue and continued education across the market regarding business operating models and challenges for homecare as well as commissioners' needs and expectations.

1.4 Summary of recommendations

In concluding this exercise, we have noted the following recommendations for Bradford MDC, which take into consideration wider market sustainability and commissioning work locally (for further details, see section 5.2):

1.4.1 Continued dialogue with the market regarding a sustainable rate for care

Whilst a long-term intention, in line with this DHSC cost of care exercise, may be to work towards the estimated median of £22.54, DHSC guidance states that "fair means what is sustainable for the local market". The council should continue to monitor the pressure in the market (both staffing and business operating costs) through future fee exercises, and as was the case for this financial year's 6.5% uplift, make adjustments (% fee uplifts) to reflect changes to operating costs.

1.4.2 Future considerations for how the unit of care is purchased

It is our understanding the local framework is due to be recommissioned within the coming years. This provides an opportunity not only to consider the constituent operating model but also how care is purchased; considerations include:

- The present framework rate operates on the principle that travel forms part of the care hour; consideration should be given as to integrating the cost of this into the rate, following further analysis with the market. Alternatively, a separate per visit payment may be adopted.
- Considering the introduction of a differential rate, for reasons cited in section 5.1.3, to support take up of packages in areas where there are presently difficulties or delays in allocation
- Adopting weighted unit rates for 15, 30, 45 and 60-minute visits, where shorter visits are required, in which the effective hourly rate is increased to account for the fixed amount of travel time applied to each visit length.

1.4.3 Improved intelligence to support market management

More detailed analysis should be undertaken to understand the impact of the localities, and subsequent assignment of providers, in order to optimize provider resources when delivering the service. Similarly, further detailed work to review provider package distribution together with individual client postcode data (from internal datasets) to assess average distances and travel times. To support this analysis quality and contract monitoring KPIs may be re-imagined with the provider market which includes reducing requests for information in many areas by introducing a small number of impactful KPIs.

1.4.4 Reducing contractual and operational constraints

Undertake further engagement with the market in relation to how operational processes can be streamlined to provide efficiency to the market. This has the potential to reduce operational costs for providers with

minimal resource requirements from the local authority. Special attention should be taken into consideration around streamlining the commissioning framework, clearly defining functions for the brokerage teams (BEST and Support Options), assuring one single point of referral and the timely dissemination and simplification of paperwork upon allocation of packages.

1.4.5 'Deep dive' engagement with the market to explore current workforce recruitment and retention challenges

Explore what action the system (providers and commissioners) can take to tackle current challenges; this may include work locally to generate training and development opportunities, raise the profile of social care as a profession and build links between prospective sources of potential employees for recruitment, e.g., schools and colleges. This includes enhancing promoting existing free training offers and utilising the workforce strategy and associated internal lead promote the 'Bradford Cares' campaign.

1.4.6 Develop economic assessments of the local economic impact of homecare provision

Alongside the above, commissioners would benefit from developing a local economic impact tool, which would highlight the costs / benefits of homecare with respect to other forms of provision in the local health and care economy. This would greatly inform budget discussions and facilitate better, integrated working via the new emerging health and social care infrastructure.

Detailed observations in relation to the current and future commissioning model, as well as recommendations to support implementation of future fee rates are considered in sections 3.2, 5.1 and 5.2 of this report.

1.5 Acknowledgements

We extend our sincere thanks to Bradford homecare providers for their participation and openness in sharing data for the project. We are also grateful to Bradford Care Association for their continued support throughout the process. Last but not least, we thank Bradford MDC colleagues for the opportunity to perform this work and their support and commitment throughout the project.

2 Project Overview

2.1 Policy Landscape

On 7 September 2021, the government set out its new plan for adult social care reform in England. This included a lifetime cap on the amount anyone in England will need to spend on their personal care, alongside revisions to the means-test for local authority financial support. From October 2023, the government will introduce a new £86,000 cap on the amount anyone in England will need to spend on their personal care over their lifetime. The charging reforms also propose to extend Section 18(3) of the 2014 Care Act which allows self-funders to request that their local authority commissions their care, in the same way as those who are supported by the means test.

Section 18(3) commenced in 2015 in relation to domiciliary care and DHSC plan to extend this to residential and nursing care provision for older people. Whilst section 18(3) has been in place for domiciliary care for 7 years the uptake and financial impact remains unclear; however, in March 2022 the County Council's Network published an impact assessment on the implementation of section 18(3), which identified: "In its own impact assessment, the Government have not sought thus far to estimate the combined financial impact of Section 18(3) and FCC on care providers. But our analysis demonstrates that based on a 50% take up rate of Section 18(3) and current FCC funding levels for councils, providers across the country would experience significant financial challenges as a result of lost revenues amounting to £560m"[3].

On the 16th December 2021, following the release of People at the Heart of Care white paper, the DHSC released its policy paper: 'Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023'. As a condition of receiving future funding[4], local authorities will need to evidence the work they are doing to prepare their markets and submit the analysis of cost of care exercises for 65+ care homes and 18+ domiciliary care. There is a requirement to produce a provisional 5-page market sustainability plan (Annex C template), using the cost of care exercise as a key input to identify risks in the local market. A final plan will be required in February 2023.

For the purpose of the policy, and in terms of understanding the cost of care, DHSC have defined 'fair' as "*the median actual operating costs for providing care in the local area (following completion of a cost of care exercise) for a series of care categories….and is, on average, what local authorities are required to move towards paying providers. In the context of specific rates for care paid, fair means what is sustainable for the local market. For providers, this means they will be able to cover the cost of care delivery and be able to make a reasonable profit (including re-investment in their business), surplus or meet their charitable objectives. For local authorities, it recognises the responsibility they have in stewarding public money, including securing best value for the taxpayer*".[5]

A cost of care exercise is a process of engagement, data collection and analysis between local authorities, commissioners and providers with the purpose of arriving at a shared understanding of the local cost of providing care. As per the DHSC requirement, the cost of care exercise will help local authorities identify the lower quartile, median and upper quartile costs in the local area for a series of care categories. Cost of

[3] Impact Assessment of the Implementation of Section 18(3) of The Care Act 2014 and Fair Cost of Care; The County Councils Network
[4] In total the fund amounts to £1.36 billion (of the £3.6 billion to deliver the charging reform programme). In 2022 to 2023, £162 million will be allocated. A further £600 million will be made available in each of 2023 to 2024 and 2024 to 2025. This funding profile allows for staged implementation that is deliverable, while also reflecting the timelines for charging reform.
[5] See detailed guidance 24th March 2022.

care best describes the actual costs a care provider incurs in delivering care at the point in time that the exercise is undertaken, it is not the fee that is charged. The outcome of the cost of care exercise is not intended to be a replacement for the fee-setting element of local authority commissioning processes or individual contract negotiation.

The Care Act 2014 states '*When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care… It should also allow retention of staff commensurate with delivering services to the agreed quality and encourage innovation and improvement. Local authorities should have regard to guidance on minimum fee levels necessary to provide this assurance, taking account of the local economic environment. This assurance should understand that reasonable fee levels allow for a reasonable rate of return by independent providers that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term.*'[6]

The cost of care exercise is an opportunity for Bradford commissioners and local care providers to work together to arrive at a shared understanding of what it costs to run quality and sustainable care provision in the local area and that is reflective of local circumstances. It is also a vital way for commissioners and providers to work together to shape and improve the local social care sector and identify improvements in relation to workforce, quality of care delivered, and choice available for people who draw on care.

Bradford – in common with councils nationally – is faced with the challenge of meeting ever growing social care service demands against static or even reduced budgets. Despite this pressure, and within the overall policy and operating environment, the adult social care sector is trying to ensure continued delivery whilst finding new ways of providing person-centred care and support in a cost effective and outcomes-based manner. Bradford commissioners are attempting to meet these challenges of continuity and innovation within their commissioning strategies and this report represents a key first step in this journey.

2.2 Project Scope

The scope of the project was determined by DHSC's Fair Cost of Care guidance, in which homecare was defined as: "*Local authority contracted domiciliary care agencies (for those aged 18+) providing long term care, with a regular pattern per week, consisting of relatively short visits to support a person living in their own home with daily living tasks*"[7].

The following services were deemed out of scope: rapid response provision, short term / reablement support, local authority in-house care, live in care, shifts or blocks of care, sitting services, extra care[8] and supported living. Whilst some community-based services were out of scope of this project, as alluded to above, it is considered that the base model and scenarios presented as part of the analysis and in this report may be applicable to elements of these services; and may be worth future consideration by commissioners.

[6] DHSC, section 4.31, Care and Support Statutory Guidance.
[7] DHSC FCoC guidance page 13.
[8] While extra care is in scope for use of the fund, cost of care exercises are not required for this setting.

2.3 Approach, Methods, and Limitations

2.3.1 Project Governance

ARCC's approach was to encourage as much engagement as possible from the market. In order to monitor progress and mitigate project risks a project governance group was formed consisting of Assistant Director Commissioning & Integration, Contract and Quality Senior Manager, Contract and Quality Manager and Care Sector Liaison Assistant, representatives from the Bradford Care Association (BCA) and ARCC. This group met fortnightly to discuss progress, risks and mitigations arising throughout the course of the project. Internally, ARCC's project team formally reviewed progress and risks on a daily basis with formal reporting through the governance channels established.

2.3.2 Engagement Activities and Timeline

Engagement activity was targeted to a cohort of 76 providers whom Bradford MDC currently commission homecare from, either on framework or via spot purchases. In order to engage with the full market, ARCC reached out to a total of 76 providers, giving them the opportunity to participate. Given the wide scope of this outreach, the list was subsequently reduced to 47 providers, for reasons including not having historically engaged with the council, providing more specialist (LD/MH) and supported living provision, and delivery out of area. Providers who did not participate or respond for any of these reasons, did continue to receive information throughout the exercise, as well as invitations to the workshop for transparency.

The engagement comprised the following key activities:

a) **Provider Survey & Cost Template:** Submitted to all providers in scope, to gather data on both the costs and the operational experience of delivering services locally. Any data ultimately submitted by the providers was sent directly to (and anonymised by) ARCC; confidentiality of provider's commercially sensitive information was paramount to the exercise. The survey consisted of 3 parts:

Part 1: Commissioning Survey with thematic questions:

- Organisational details
- General business outlook and market growth
- Market insight and key challenges

Part 2: 2022 Organisation and Workforce:

- Current volumes and rates
- Workforce breakdown and payroll rates
- Organisation workforce survey

Part 3: Historic costs 2021-22

- Historic revenue
- 2021-22 costs

The team also accepted returns such as the national homecare cost modelling toolkit[9] or alternative information sources such as accounts. In total 23 providers sent returns, 21 considered in scope. Of these

[9] Developed by ARCC and available at: Homecare Cost of Care Toolkit | Local Government Association

6 were the national toolkit and 15 were the dedicated cost survey. There was a good representation from small, medium & large providers across various geographies (see section 3.1).

The following additional activities were undertaken to maximise engagement opportunities with providers:

b) **1:1 deep-dive structured interviews:** interviews took place over 1-2 hours with senior Finance/Operational leads for provider organisations. All providers were invited to express interest for a 1:1 session and 10 providers in total took part in these.

c) **Provider & Commissioner workshops/clinics:** following the launch session workshop, two further workshops were held:

- Providers were invited to attend a closed (provider-only) interim session at the end of the survey and 1:1 phase to feed back the results of the engagement, validate aggregated cost data and agree scenarios for the cost model variants. Providers were given 2 weeks after the session to raise any queries relating to the analysis presented, no responses were received.
- A workshop was held with commissioners following this to present the scenarios to be modelled.

d) **Closed feedback/questions:** these were conducted via e-mail to allow providers to consider additional questions and clarifications following the final workshop.

Throughout the process, all providers in scope were kept appraised of the engagement feedback and timeline via e-mail and copies of workshop slides were distributed following each workshop[10]. Further requests for information/clarifications were conducted via e-mail and telephone, to provide opportunity for providers to submit data to input to the cost analysis.

The timeline for the various activities used to foster transparency and optimise engagement opportunities for providers is presented in Figure 1.

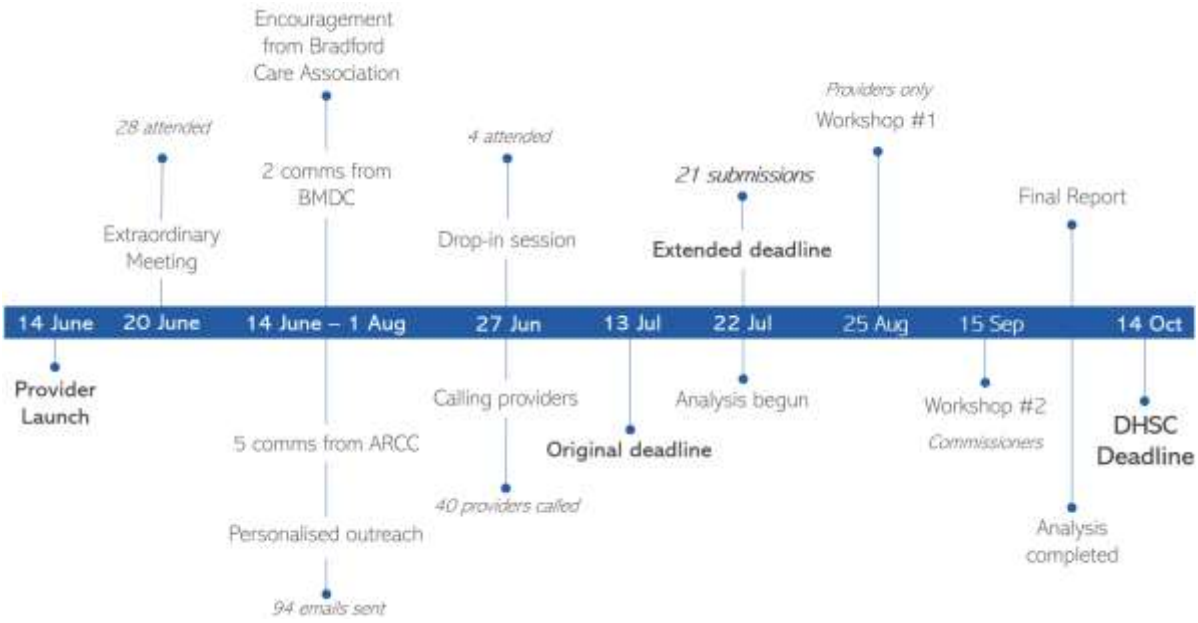


Figure 1: Timeline for the various activities to foster engagement with BMDC providers

[10] Copies of communications and slides shared within and following workshops are provided in Section 6 Appendices

Provider outreach

Bradford Care Association invited all providers in the market to an initial launch session on the 14th June followed by an extraordinary meeting called by Bradford MDC on the 20th June to ensure none BCA members were also made aware of the opportunity. From this point onwards ARCC sent a total of 5 market-wide emails with additional information and support, including an invitation to a drop-in session on the 27th June and the distribution of slides from the provider launch. The team furthermore conducted phone calls to providers to ensure the correct stakeholders within each organisation were informed of the exercise. Finally, providers who had previously been in touch either via email or phone calls, received personalised outreaches reminding them of the deadline and offering support.

Providers were able to seek support via email, phone calls, and Microsoft Teams meetings, where the team would guide the providers through the submission template and ask any questions they may have. To further encourage engagement, the submission deadline was extended by one week from 13th July to 22nd July as well as individual later deadlines agreed with providers. No submissions were rejected because of late submission.

Of the 47 providers in scope, 30 (63.8%) providers either expressed interest in the process or submitted returns. After completion of the data collection exercise, a total of 23 submissions had been received, 21 of these considered in scope. This represented 45% of providers in scope of the exercise, and 46% of hours commissioned by Bradford MDC.

2.3.3 Limitations

It is important to note the inherent and practical limitations of such an exercise and reflect particularly on what the outputs from any cost modelling exercise aims to achieve. Any single cost median or model will not reflect the diversity within a whole market due to the number of variables to take into consideration, in addition meaning that any attempt to include all variables would result in an unusably large range of outputs in any practical sense. Thus, the median and any subsequent modelling can only be a simplified version of reality, using some explicit assumptions, which are discussed and refined to stakeholders' satisfaction. Furthermore, as the DHSC requirement was to generate median, upper and lower quartiles for each respective cost line, the sum total will never add up to the profile of any specific local provider.

It should also be clearly understood that a cost exercise is not a magic formula that will set a "single" or "minimum", or "best" market price for all providers. The realistic expectation in this project is that the model simply outputs a set of figures that are indicative of costs incurred by providers (based on data that some have provided) at a point in time. The model can then help to highlight different costs and cost drivers and this in turn can promote a greater level of understanding, particularly for commissioners, when the commissioners come to consider future pricing.

3 The Homecare Market in Bradford

This section details the size and scale of the current homecare market in Bradford as well as observations in relation to commissioning, contracting, market structure and costs. In most economic markets, relative demand versus supply is key in determining prices. Local authority commissioning of homecare represents a monopsony market, in which they are the majority buyer.

Here the buyer is arguably most concerned with establishing the overall likely volume of demand and then setting a budget to match (though in practice inflationary uplifts are probably the most common form of annual adjustment), from which a price is derived. As this volume is a key driver of price, it was critical for us to understand the purchasing patterns to inform the future cost model.

3.1 Demand and Supply

A total of 47 homecare providers in scope of the exercise operated in Bradford at the commencement of the cost of care exercise. As of the 1st September 2022, Bradford MDC commissioned 34,105 hours of care, representing a typical week in this year. This led to an estimate of approximately 1,773,460 per annum.

Of the providers whom BMDC commission homecare from, as of May 2022, 80% of the volume was commissioned from 25 providers (53% of providers in the market), ranging between 10 and 3,681 hours of care per provider per week.

Demand for home care services has steadily increased over the last two years in the Bradford area, with an approximately 9% increase from 2020 to 2021 and is expected to increase an additional 4% in 2022 if the trend continues. Figure 2 shows the weekly number of hours commissioned per month from Bradford MDC from 2020 to 2022.

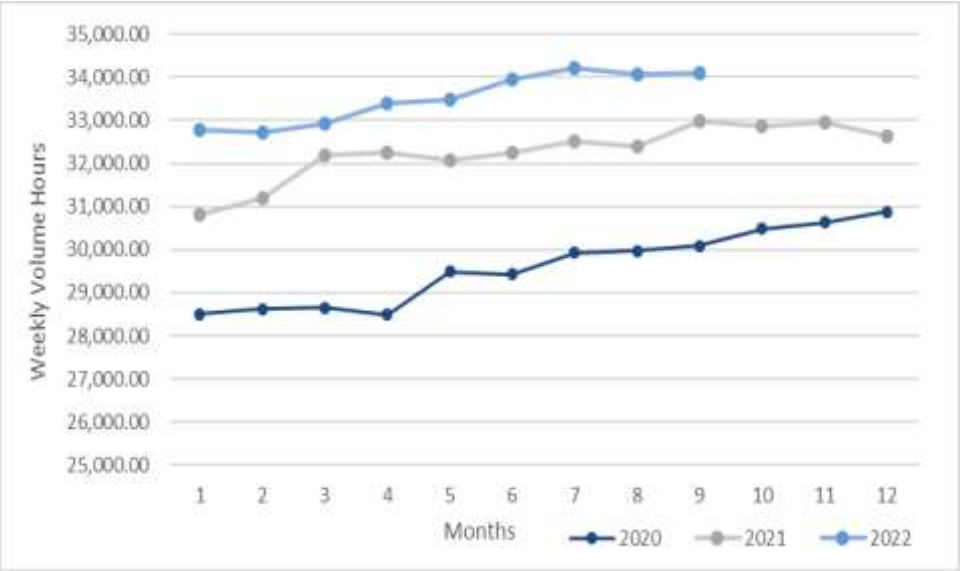


Figure 2: Weekly number of hours commissioned per month. BMDC 2020-2022

On average each service user receives 14 hours of support per week and approximately 44% of all home support provision requires 2 carers per visit. Bradford concentrates 50% of commissioned hours in 9 of the

35 locality areas, Heaton being the area with the highest concentration of hours as well as service users, with 143 individuals receiving care. Figure 3 figure shows the weekly hours of care commission per locality.

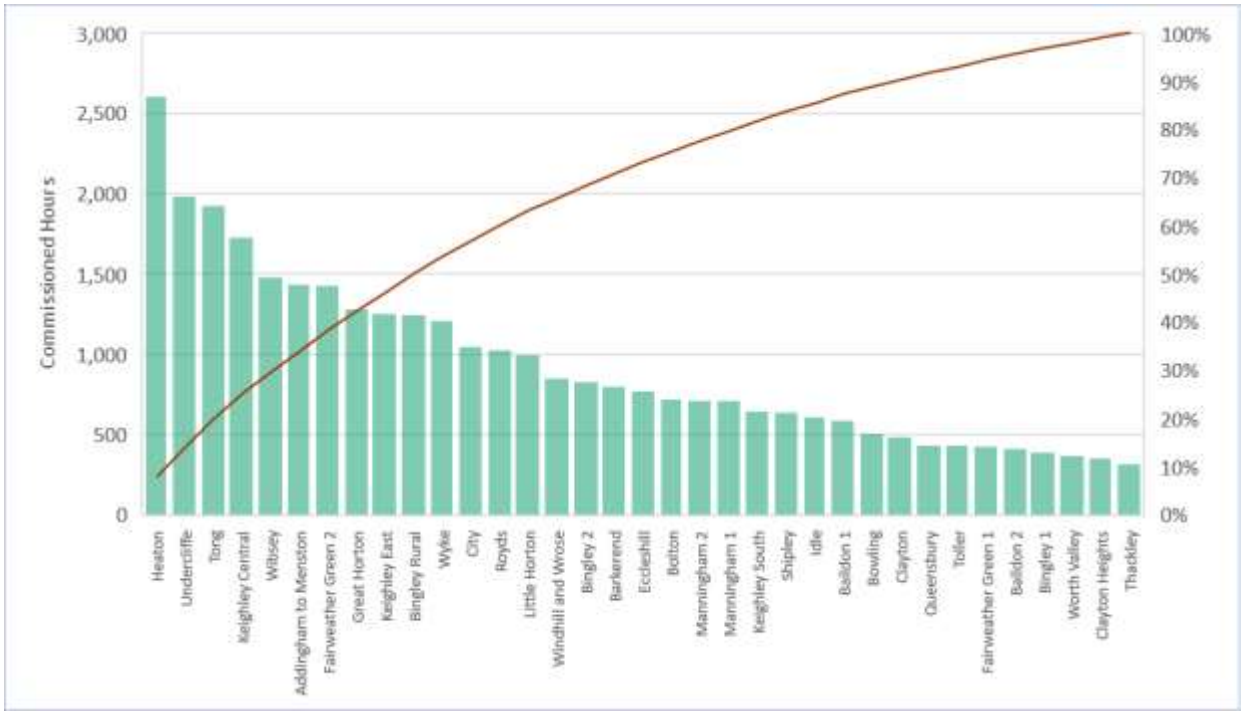


Figure 3: Weekly hours of care commission per locality area. BMDC

The quality of services in the Bradford area shows slightly below average for England for Good and Outstanding CQC ratings with Bradford at 83% (England average is 87.7%) and the remainder are ranked as either "Requires Improvement" (15%) or not yet assessed (2%) as shown in Figure 4. However, it is important to note that only a small number of providers in Bradford District have been subject to inspection in recent years, with 5 services being inspected and rated in 2021, and 2 services being inspected and rated in 2022 to date due to pandemic backlogs.

Figure 4: CQC quality ratings for providers in BMDC

3.2 The Local Commissioning Framework

BMDC currently manages 4 types of contracts with providers under a framework: Locality contracts, Individual Service Funds [ISF] contracts, Short Term Enhanced Provision [STEP] contracts and the pre-existing Integrated Personalised Support and Care [IPSAC] framework. Providers are able to hold more than one contract type with the council at the same time.

In April 2019, Bradford MDC introduced its locality contracts into the market. Currently, BMDC contracts with 16 providers operating in 35 geographical areas, as shown in Table 3. These areas are defined based on ward, population size and demographic data.

Geographical Areas		
• Baildon 2 • Fairweather Green 2 • Clayton • Little Horton • Manningham 2 • Baildon 1 • Wibsey • Keighley South • Bingley Rural • Shipley • Keighley East • Keighley Central & West Keighley	• Great Horton • Queensbury • Thackley • Bingley 1 • Windhill & Worse, Bolton Woods • Toller • Tong • Idle • Bingley 2 • Addingham, Burley, Ilkley & Menston • Worth Valley	• Fairweather Green/Thornton 1 • Bolton • City • Clayton Heights • Heaton • Manningham 1 • Eccleshill • Undercliffe • Barkerend • Bowling Royds • Wyke

Table 3: Bradford MDC - Locality Areas

The locality contract providers do not cover all support packages within their designated areas, for a host of different reasons. For example, early contract implementation issues due to lack of TUPE[11] transfers, existing service users not transferring across when provided with option to 'leave or remain' their existing provider, pre-existing framework call-offs, or option to choose an ISF1. Furthermore, in January 2020 BMDC introduced the STEP contracts to support the short-term needs of people requiring early intervention and immediate home support assistance. STEP contracts rate is higher than the locality framework rate, and currently set at £20.60 per hour. BDMC contracts with 5 providers who operate in 5 geographical areas (East, South, West, Shipley and Keighley).

In Addition to the locality and STEP contracts, BMDC introduced to the market the ISF1 Framework to enable people to remain with their providers who had been commissioned via the previous IPSAC framework. Supplementary to this, the Personalised Commissioning Team [PCT] at the CCG also makes placements using BMDC commissioning services, especially for complex healthcare requirements. However, if for any reason BMDC commissioned services are unable to meet the needs of a specific package, then spot purchases will be made with the CCG's own list of providers.

In April 2022 BMDC implemented a 6.5% uplift of the hourly homecare rate. Currently, the framework rate (With exception of STEP contracts) is set at £19.40 for OP/PD single and £ 38.80 for OP/PD double. Additional to the uplift made to the hourly rate of care, and in recognition of the recent sharp rise in petrol prices and the challenges this is causing providers, the BMDC implemented a grant to support providers. The fuel grant is based on a 20% increase in the standard mileage rate in the UKHCA model (35p) multiplied by the average miles per hour of travel (4), equating to an additional £0.28 per hour of home support delivered. The intention of the grant was for providers to pass this directly to staff in the form of additional mileage expense claims. In addition, BMDC offers providers a hospital retainer scheme, for suspended placements where providers are paid at the hourly rate for up to four weeks to keep the package open due to hospital admission.

[11] Transfers of Undertaking Protection of Appointment

The rates currently paid by BMDC are based on a pricing model which excludes travel time per visit into the hourly rate, instead there is an agreement with providers and service users that the hourly rate comprises of contact and travel time. It is our understanding that this arrangement is not in place for all of the contracts listed above. Furthermore, the model assumes a fix base rate pay for care staff and do not include differentials for Bank Holiday, weekends neither for qualifications nor seniority. Also, it assumes that all businesses are the same size and deliver the same volume of hours.

BMDC currently manages two brokerage teams: (1) Bradford Enablement Support Team [BEST] Duty Team for the general reablement and DTA support and (2) the Support Options Team for long-term support. The BEST Duty Team is an in-house team that provides short-term personal care and support to people at home. The BEST team will typically support people after hospital discharges for a period of 4 and 6 weeks, if the service user still needs care after this point, this is usually provided by a commissioned service. The BEST Duty Team can place with STEP providers but also use the wider market to pick up the work as needed. It is important to mention that the BEST team works 7 days a week and contact the providers directly to place packages. In contrast, the Support Options Team uses the platform Connect to Support to assign packages to locality providers. If a locality provider does not pick up for their area, the brokerage team will follow up and/or use the rest of the market to support.

3.3 Provider Feedback

3.3.1 Qualitative Insight & Business Challenges

As section 1.2 alludes to, the approach to engagement was varied to support maximum uptake in the process. Through multiple choice and free-text questions in the cost submission, one-to-one conversations, provider workshops and drop-in sessions, ARCC collected market insight from the providers. This section summarises this feedback on several different operational areas.

3.3.1.1 Business Outlook and Growth

Providers in Bradford generally reported a desire to grow the number of packages they have with the local authority, of which 10 of 13 providers stated their intentions to grow local authority packages. Only 3 providers shared that they would rather focus on maintaining and consolidating the hours they are currently delivering. In these cases, explanations were related to the current market pressures and a lack of resources to grow. In contrast, 4 providers were analysing the possibility to expand to other types of care, such as mental health and complex care within Bradford and the surrounding authorities[12]. There is some interest in growing in the self-funder market as well with providers reporting 5-15% growth targets; however, due to the current constraints on staffing capacity, most providers are focusing on addressing the growing demand from local authority packages. One provider reported that they do not want to set new growth targets because they first aim to match the demand coming from the locality areas. Generally, providers have set conservative growth targets for the next year; 6 providers reported that their growth target for care hours is around 10-100 hours per month and only 2 providers set targets at 400 and 1,000 hours per month respectively. Any aspirations in this area will be directly impacted by the availability of labour.

Providers had divided responses when asked *"How likely would you be to set up your business in this geographical area now, compared with 3 years ago?".* 42% of respondents answered that they would be

[12] 5 providers reported operating with neighbouring councils, most often Leeds.

less likely to set up a business while 35% of respondents answered that they would be more likely (**Error! Reference source not found.**), the remaining respondents were neutral. Further exploration with providers in the workshop on the 25th August identified that the divided response was partially influenced by the market fragmentation and the variety of frameworks currently in place; however, it was also noted responses were influenced by pressures in the market in general and not just limited to Bradford as a locality.

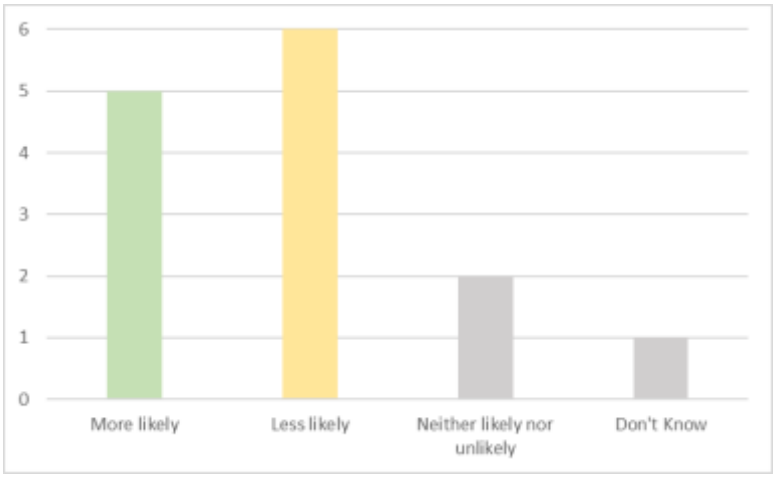


Figure 5: *Provider response to question: 'how likely would you be to set up your business in this geographical area now compared with 3 years ago?'*

3.3.1.2 Workforce

The main concern for providers regarding fulfilling capacity of homecare in the market is a lack of available workforce from which to recruit. Recruitment and retention are perceived as the single biggest challenge with virtually all providers reporting that the workforce challenge has worsened in 2022, with new hire rates, particularly those who are able to drive, falling. In addition to traditionally low pay rates for homecare workers in the sector, there are other factors that may exacerbate the current workforce challenges; in particular:

- Larger demands on the workforce as community care continues to be a growing service area both in volume and complexity, due to increasing frailty and acuity of service users.
- Staff 'burn out' post Covid and a sense that there are easier jobs for the same amount or more money. Indeed, a cursory review of jobs available identified several retail jobs in the Bradford area which offered hourly rates ranging between £9.50-£12.64 per hour. Indeed, the median local hourly rate is £13.85p/h, although this drops to £13.24 for female workers[13].
- Cost of living is resulting in a reluctance to use personal cars for work and in some cases is resulting in less people having transportation. We understand some areas of the city have significantly higher than the national average insurance premiums which means operation of car can be costly. Providers are generally receiving fewer applications from staff who can drive.
- The homecare sector is particularly hard hit in comparison to other industries in relation to the cost of fuel. This is due to care workers being required to use their own vehicles for transportation and only receiving minimum wage or slightly above. The costs incurred by the care staff are significantly increasing both at work and in their private life, and thus being a homecare worker becomes decreasingly attractive in comparison to other occupations paying more without requiring the use of private vehicles.

[13] Data taken from ONS Nomis profile available from: https://www.nomisweb.co.uk/reports/lmp/la/1946157124/report.aspx?town=bradford

- Terms and conditions are not as attractive as other sectors or types of health and social care provision (such as travel pay, working patterns/guaranteed hours and opportunity for progression).
- The continuing impact of Brexit on the potential availability of workers, providers who consider providing visas for overseas workers face significant financial barriers. The few providers who have considered sponsoring work visas are facing significant financial barriers that make it in many cases financially unsustainable to rely on EU workers that do not have pre-existing visas or Settled Status.
- Seasonal demands of the workforce (particularly retail services during the Christmas season and hospitality during summer months).

From conversations with providers, they all reported challenges with recruiting enough staff. It is also important to note the challenge is not simply to find people to 'fill vacancies' but to attract people who have the right values and want to work as a carer – reflecting the vocational importance of the career. Even in cases where the volume of applicants is high, providers have shared that the quality of candidates is not always what is required, with retention issues being experienced in the first 6-12 months as workers gain more understanding of what is required for the role. This has a financial burden on providers as the resources invested in training staff are often non-recoverable or require a volume of billable care hours to recoup. Some providers postulated that people who are new to care may not having a realistic perception of what the job entails and realising that the career is not for them, and that new care staff decide early on to move into residential care or the NHS for the more consistent work hours and to avoid having to utilise their own transport. In relation to the latter destination, providers felt the poor perception of social care as a career path was a compounding factor and are eager for the opportunity to shift this perception.

3.3.1.3 Working with Bradford Metropolitan District Council

Providers in Bradford generally reported a positive relationship with officers within BMDC. Error! Reference source not found. summarises providers' responses to statements regarding their engagement with the council, most of which were positive. Brokerage was the area with most disagreement and provider feedback reflected the complexity of the system at present, i.e., the range of contracts, routes for referral and timeliness of information shared with providers upon commencement of packages of care.

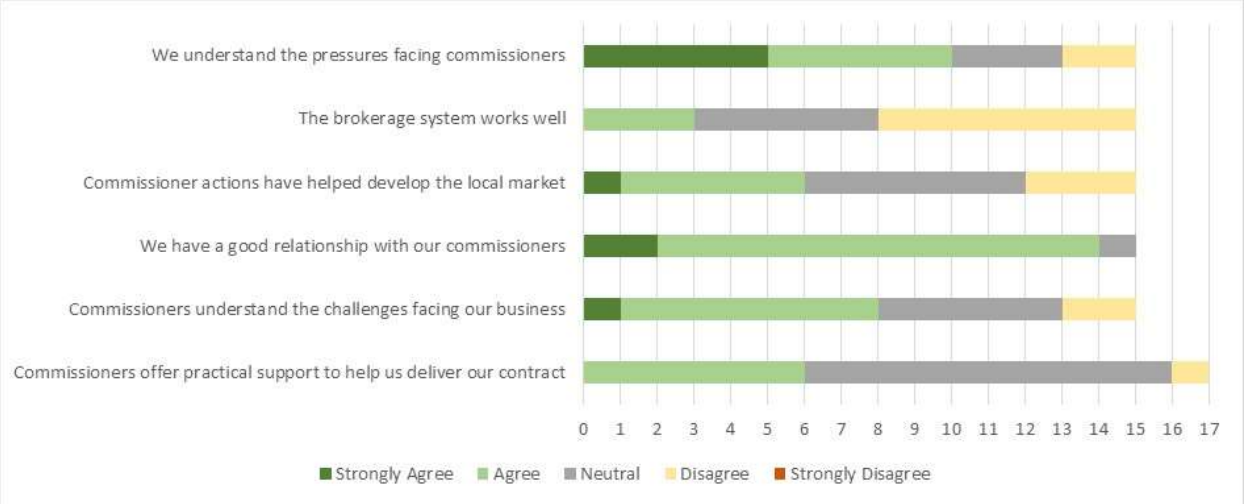


Figure 6: Commissioning functions & perceptions from providers who participated in the cost survey

Provider responses to the question how they would compare working with BMDC in comparison to other local authorities they supply (Error! Reference source not found.) show a significant proportion of providers c onsider it somewhat more difficult. This is likely to be attributed to general confusion around how the

framework is structured, the brokerage process, payment delays for additional work which can result in cash flow issues, and there was a special emphasis on the SS243 process (changes to packages) being particularly arduous. These findings have been echoed in a recent internal review of home support which identified that implementation of the framework has resulted in fragmented supply in some localities, i.e., a far larger number of service users opted to stay with their current provider rather than switch; impacting on providers ability to create 'optimum runs' and economies of scale. There is also a significant reliance on a smaller number of providers, as alluded to in section 3.1.

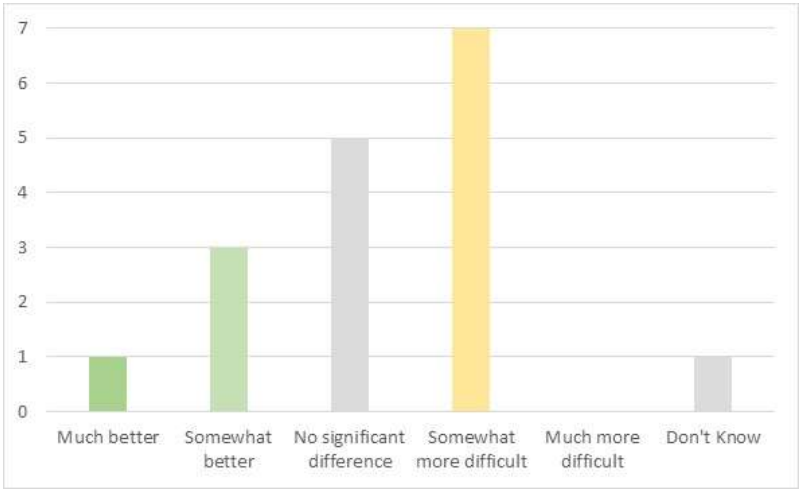


Figure 7: *Provider response to question: 'how would you compare working with this LA compared to others whom you supply?'*

3.3.1.4 Business Costs

To a certain extent the homecare market, unlike care homes, has been insulated from the inflationary pressures over the first 6 months of this financial year. However, as alluded to elsewhere, the pressures within the economy are likely to further compound the challenges within the labour supply (issues with recruitment and retention) which will further drive-up business costs. Where provider profit margins are tight there is less ability to absorb these increased costs presenting increased future risk of market failure and ability to fulfil demand. Providers were asked in one-to-one interviews what they believe fair pay rates for care staff should be, answers ranged between £11 and £12 per hour (parity with comparable NHS workers), a rate which should also be paid for travel time.

As both NI payments and the national minimum wage went up as of April 2022, providers are experiencing increasing costs, which to a certain extent has been offset by the local authorities' 6.5% fee uplift. However, additional cost burdens such as fuel and competition for staff are also having to be met within this cost envelope, although some of this pressure has been offset by BMDC's fuel grant payment (see above). Most providers engaged have either increased their mileage cost since last year or are looking to increase it in the near future.

Providers were concerned that the withdrawal by the government grants will have significant financial impact in future years, with a significant proportion stating that these grants have been the difference between breaking even and not. This position will need to be monitored in the coming months, particularly in the case of PPE, if this becomes a public expectation this will need to be appropriately funded.

3.3.1.5 Contract and Quality Monitoring

The layer of different contracts and the variety of frameworks have made the commissioning of packages a complex process. Some providers are on more than one framework (Locality Contracts and ISF Framework) and some providers that are still taking packages have not been through any recent accreditation (providers on the previous IPSAC framework). This creates a fragmented market of providers competing for the same packages. The internal home support review carried reflected that ISF1 framework take-up is higher than locality which can result in delays in the process and clarification for the reasons why ISF1 is required over a locality provider. Additionally, as STEP providers are paid at a higher rate there is not an incentive to move packages to the locality provider. In addition, the report suggests that there is an alternative approval process whereby providers who have been accredited by the CCG's Personalised Commissioning Team are added to the Council's payment system for jointly funded packages. However, if the contribution from CCG stops, they may continue to deliver the social care component without accreditation by the council itself.

3.3.2 Suggestions for Improvements to Market Sustainability

During the provider workshop and through one-to-one interviews, providers have been able to share what they believe a future commissioning landscape should look like. Unsurprisingly, all providers stated that improving the Council's rate per hour paid is the single most important action that commissioners can take to improve market sustainability. Other suggestions identified by providers were:

- A 'cost envelope' which allows provider to pay staff an appropriate rate of pay: improving care staffs' working conditions, not only hourly rate, but general contract structure. Discussion focused on parity with comparable roles such as NHS Band 2 workers (hence scenario models 3 to 5 have been created). Since providers are paid only for care time, with little or no guaranteed hours, most stated they cannot improve care staff contracts without greater certainty of income, i.e., the terms staff are engaged on are a mirror of the way services are contracted, i.e., no guarantee of volume or income.
- Provider collaboration: several providers suggested providers could be supported to facilitate collaboration to optimise delivery; these suggestions included trading packages between them to address geographical or capacity constraints.
- Perception of social care as a career path: one factor often referred to as a driver for the recruitment challenges, is the poor perception of social care as a career path. Several providers shared that they have attended career fairs and collaborated with local colleges in order to promote social care with minimal impact. Providers are eager for the opportunity to shift this perception amongst potential staff and particularly younger generations, to create a rewarding career trajectory within social care.
- Sustainable profit margins: providers were asked which percentage profit would be sustainable, responses ranged from 10% to 17% - this will reflect the impact volume has on apportionment of costs.
- Flexibility in rates for bank holidays: given the limited flexibility offered by the current LA rate for social care, four providers currently are not paying staff any salary uplifts for weekends and bank holidays, and packages which require enhancements to service them are less attractive. Providers suggested increased payment for care delivered on bank holidays.
- Support with training and development: suggestions included the council providing extra funding for training, provide centralised training courses for staff to create scales of economy or pay visits at different rates depending on the level of skill the care worker is required to have. For example, the local authority would pay an increased rate for visits requiring activities such as peg feeding, to reflect the training the carer is expected to have completed.

4 Cost Analysis and Scenario Modelling

4.1 Provider Cost Information & Data Quality

Following the 4-month period of engagement with providers and commissioners from June to September 2022, the ARCC project team assessed a range of cost data from providers, utilising the cost information templates, structured interviews and commissioning data on service levels. The following statistical approach has been utilised when undertaking analysis:

- Where we have received 2021-22 costs only, we have uplifted these based on current direct pay rates to carers, current back-office costs, latest month business volumes and any specified uplifts in overheads to reflect costs for trading April 2022.

- Queries have been raised with providers re. any discrepancies/anomalies, such as:
  - omissions in the data return
  - obvious errors when converting total expenditure into a cost per hour (e.g., direct pay costs less than NMW)
  - large cost variances vs. similar businesses
  - large variances between reported revenue & expenditure

- For any discrepancies that cannot be resolved, anomalous data has been removed or a "median" from other businesses' cost lines has been used to ensure all data is as representative as possible.

- DHSC have requested the following aggregated statistics: lowest value, lower quartile (25th percentile), median, upper quartile (75th percentile), and highest value across each cost line.

- Some lines are statistically zero. This means that the response to our questions for this section is a valid zero response (e.g., travel time, where this has been rolled up into the hourly rate, this is zero so it is not counted in two places per provider); other instances where there is missing data, we have not used zero but instead discounted these in the calculation of a median (e.g., where back office pay costs may be missing, we omitted these from the median calculation).

Out of the 23 submissions 2 were excluded from the final analysis. The 2 exclusions were made because providers exclusively provided supported living which was out of the scope of the exercise. Queries were raised with each of the remaining 21 providers, of which 16 submitted additional data or took part in virtual meetings to discuss their return. The remaining 5 providers where no response was received, were deemed to be of a sufficient standard/did not have a significant impact on the providers' cost output. It is important to note that all submissions could not be validated due to unanswered queries. We believe the analysis is the best estimate of the cost based on the information provided but should be treated with the appropriate level of caution.

4.2 Business Operating Model Observations

Below are some high-level observations on respondents' business operating models.

4.2.1 Volume

Data submitted by providers in Bradford reported an **average of 1,529 hours of care per week**, ranging between 414 and 6,000 hours and an average of 2,065.44 visits per week (ranging between 150 and 6,904 visits). Average hours per service user per week was 13.4 hours, with a range of 8.7 and 21.5 hours).

4.2.2 Carer Pay Rates

Care staff are typically paid at a standard hourly rate Monday to Friday, with some instances of uplifts for weekends and bank holidays. Some providers have an additional uplift for Christmas and New Years' days. The base hourly rates for carers range from **£9.50 - £11.50 per hour**, the average being £10.05, correspondingly, the senior carer pay rate ranges from £9.65 to £12.20, with an average of £10.79.

The weekend pay rates range from £9.50 - £12.02 with an average of £10.34. Bank holiday pay ranges from **£9.50 - £19.80** with an average of £12.95. 4 providers detailed the amount they pay for Christmas Day which ranges from £19 - £20 with an average of £19.55. Some providers also offer uplifts if the carer drives, and one provider differentiates the pay by age categories.

Some providers offered increase pay rates based on staff's seniority, in addition to this, some providers offer increased pay rated dependant on staff becoming qualified e.g., holding at least a level 2 Diploma in Adult Health & Social Care or depending on years of experience.

The average weekly paid hours for care workers is **23.4 hours**.

4.2.3 Mileage and Travel

The majority providers in Bradford roll payment for travel time into the hourly rate and pay monthly top-ups when required, this will be due to the way framework providers account for travel within the contact hour. 3 providers reported that they pay for travel time separately from the hourly rate.

Of the 21 providers, all pays for mileage ranging between **£0.15 and £0.60 per mile**, with an average of £0.37 per mile. In conversations with providers, most mentioned that they have either recently increased, or will be increasing, their mileage rate to reflect the increased fuel prices which the care staff are facing. One provider is also in the process of investing in pool cars.

Of the 10 providers who shared information regarding travel compensation for walkers, eight pay no travel expenses for walkers. General explanations for this were that staff are not required to travel far between service users, or that walkers are paired up with drivers. The remaining operate various schemes, with some providers having company drivers to transport walkers, whilst others pay expenses for busses and taxi fares. 13 providers shared information on the proportion of their workforce who are walkers with an **average of 23% of staff are walkers**, ranging between 2% and 40%.

4.2.4 Training and Supervision

All providers reported paying for training and supervision. Of the 14 providers sharing this information, 11 pay training and supervision at carers' base rate. Training and supervision days varied from 1 to 10 days per staff member per year, with an average of 3.95 days. One provider reported that in addition to training requirements staff received 3 face-to-face 1-to-1 supervision quarterly meetings.

Induction training pay responses were varied across providers with some paying the base rate, and one provider reported to be paying a standard fee of £285 for training and shadowing requirements. Several providers required potential recruits to complete an online competency-based assessment (not payable) as part of the recruitment process and there was one example of a contractual clause which required staff to repay induction payments if they leave within 6 months of induction.

Providers also reported a range of specialist training in relation to the needs of the service users they support, such as end of life care, catheter care, peg feeding, tracheostomy, dementia/mental health, Buccal administration, Epilepsy, Parkinson's, Dysphasia, medication and communication training, among others.

4.2.5 Holiday, Sick Pay, Terms and Conditions

All providers pay up to the standard 28 days (5.6 weeks full-time equivalent) annual leave entitlement.

In line with the prevailing industry practice, all providers reported operating the statutory sick pay scheme [SSP]. Providers who shared information on their historical number of sick days reported between 49 and 475 days. With 3 of these providers sharing that they had more than 150 sick days in the year 2020-2021. This data should be treated with caution due to the small sample size, but also the impact of the pandemic and the workforce grants provided during this time period which topped up pay from SSP to average earnings where people were required to self-isolate. It is likely that the impact of the latter will have temporarily inflated the number of sick days reported.

Of the 14 providers who submitted data on contract arrangements, 5 providers offer only guarantee hours contracts [GHC], and 6 providers offer only zero hours contracts. One provider stated that they offer varied hour contracts to care assistants, but Seniors and Team Leaders are on GHC Contracts. One provider calls the zero-hour contracts a 'Flexible Hour Contract' to highlight the fact that they will always try to give their care staff the number of hours they want each week. One provider states they offer GHC contracts to all new employees after their 6-month probation.

Figure 8: Percentage of Staff on GHC or Zero Hour Contracts from whom submitted this data on their submission to ARCC

4.2.6 Other Operating Model and Market Considerations

Outside of operational factors, there are also a variety of overarching operating models in the homecare sector, and it is important to at least consider the differences in these models and their impact on the sufficiency, variety, and quality in the market. Below are ARCC's findings and views in relation to each of these and what impact they may have on the overall market structure:

Corporate Group/Private investment: larger corporate organisations tend to provide higher volumes and typically provide a significant proportion of local authority care packages. Corporate group structures benefit from economies of scale; however, this can sometimes be offset by larger overheads, regional and national costs, or complex ownership structures. Standardised approaches and investment in elements such as training and IT infrastructure supports consistent delivery of services, however, can make it more challenging to flex to different customer bases and tend instead to operate more reliably on higher volumes and fixed margins.

Franchise models: in Bradford, as has been experienced by ARCC elsewhere, there has been increased interest from franchisees in the homecare market. We believe this is a growing market as franchise models benefit from being able to start up quickly and come with a variety of standardised tools, such as:

- standardised suite of policies and operating procedures
- brand value that supports competitive growth in the independent market
- access to commercial advice and guidance
- access to operating infrastructure such as training courses, IT, Electronic Care Monitoring (ECM) and other assets.

Franchise models tend to operate predominantly in the independent (self-funder) market, as care fees can be higher than average, however, have increasingly looked to top-up their volume of business with spot local authority care packages, which help to maintain sustainability of shifts and runs of care work for staff.

The "business-in-a-box" model has the ability to establish itself and provide services quickly in a community with the benefit of standardised operating models. This all supports provision from a more sustainable market. The disadvantage however is that franchisees can incur longer-term costs associated with the model. Franchisees have told us fees can range from 6-9% of total revenue (not profit/surplus); meaning there is always pressure to manage income and operating costs carefully outside of this fixed overhead.

Ltd/single owner-operator business: a smaller homecare business that operates a small number of branches typically has increased control over elements of resource, infrastructure and quality. Whilst it is harder to benefit from economies of scale, which can increase unit costs, smaller back-office structures are typically evidenced in these businesses. Ltd companies can operate more flexibly and may deliver a mixed model of services across self-funders and local authority care packages. In Bradford this is the prevailing business model.

Charity/social enterprise: The lack of a profit-making element can be an aid to providing more operational focus on customers and quality services, however the type of business structure is not always able to attract the level of commercial acumen which is also needed to maintain a sustainable business in the market, and therefore often come under long-term pressure due to cost pressures resulting in typically lower income levels.

4.3 Median Analysis of Provider Cost Data

Analysis of the provider cost information submitted by Bradford providers, including the range, upper/lower quartile and median has been presented in Table 4. The reference data tables (presented as % of costs in each cost line to preserve anonymity) is included in Appendix C.

All Providers	LOW	25%	MEDIAN	75%	HIGH
Hourly Breakdown	Cost £				
Care worker costs:	**£11.99**	**£13.54**	**£14.14**	**£14.94**	**£19.00**
Direct Care	£9.51	£9.92	£10.19	£10.51	£11.81
Travel Time	£0.00	£0.00	£0.00	£0.25	£1.73
Mileage	£0.09	£0.29	£0.51	£0.90	£2.29
PPE	£0.00	£0.00	£0.00	£0.05	£0.36
Training (staff time)	£0.00	£0.14	£0.17	£0.36	£1.07
Holiday	£1.19	£1.26	£1.29	£1.38	£1.60
Additional Non-Contact Pay Costs	£0.00	£0.00	£0.00	£0.17	£2.05
Sickness/Maternity & Paternity Pay	£0.00	£0.07	£0.21	£0.29	£0.49
Notice/Suspension Pay	£0.00	£0.00	£0.00	£0.00	£0.05
NI (direct care hours)	£0.09	£0.56	£0.84	£0.89	£1.28
Pension (direct care hours)	£0.15	£0.27	£0.35	£0.37	£1.01
Business costs:	**£1.95**	**£4.81**	**£6.09**	**£7.02**	**£8.74**
Back Office Staff	£1.30	£2.49	£3.42	£4.64	£6.47
Travel Costs (parking/vehicle lease etc.)	£0.00	£0.00	£0.00	£0.00	£0.00
Rent / Rates / Utilities	£0.00	£0.14	£0.41	£0.58	£0.90
Recruitment / DBS	£0.00	£0.02	£0.05	£0.10	£0.37
Training (3rd party)	£0.00	£0.00	£0.08	£0.12	£0.33
IT (Hardware, Software CRM, ECM)	£0.00	£0.14	£0.31	£0.60	£0.84
Telephony	£0.00	£0.05	£0.14	£0.23	£0.45
Stationery / Postage	£0.00	£0.03	£0.05	£0.07	£0.17
Insurance	£0.00	£0.10	£0.13	£0.18	£0.22
Legal / Finance / Professional Fees	£0.00	£0.03	£0.08	£0.13	£0.56
Marketing	£0.00	£0.00	£0.03	£0.05	£0.42
Audit & Compliance	£0.00	£0.00	£0.03	£0.06	£0.26
Uniforms & Other Consumables	£0.00	£0.02	£0.05	£0.08	£0.18
Assistive Technology	£0.00	£0.00	£0.00	£0.00	£0.16
Central / Head Office Recharges	£0.00	£0.00	£0.00	£0.00	£1.83
Additional Overheads (Total)	£0.00	£0.00	£0.03	£0.15	£0.62
PPE	£0.00	£0.00	£0.00	£0.04	£0.20
CQC Registration Fees	£0.05	£0.07	£0.09	£0.11	£0.25
Surplus / Profit Contribution	**£0.14**	**£1.09**	**£1.82**	**£2.39**	**£4.09**
Total Cost Per Hour	**£17.92**	**£20.20**	**£22.54**	**£24.13**	**£25.82**

Table 4: *Summary of the cost output from Annex A of the cost of care analysis.*

There were certain cost lines where providers differed significantly. One example is back-office staff (which ranged from 7.2% to 26.4%) where headcount was not directly related to volume of care. Providers offered different explanations for this, e.g., that they rely heavily on in-area supervision, or having dedicated marketing/recruitment/trainers in the organisation. To illustrate, providers ranged between 95.0 hours and

333.3 care hours per week per FTE back-office staff member, showing the great difference in back-office size, with an average of 180 hours. Similarly, direct care staff pay ranged between 36.8% to 57.2%.

It is important to note that whilst some providers were not able to split out all costs from the organisation, through the process of queries we have checked with providers (that responded) that all costs are included in the model and are representative of the businesses, despite some providers not able to accurately split out all overhead or indirect pay costs.

ARCC express Return on Operations [ROO] as Earnings Before Interest and Tax (otherwise known as the 'EBIT') – this ensures that the value calculated allows an envelope for retained profit/cash in the business after all normal costs of business (including where mortgages, rents, and other financing costs such as depreciation and amortisation) are taken into account. Where a provider did not submit a profit or surplus; we adopted two approaches:

- Queried the provider's actual profit/loss for the year 2021/22
- If the provider was unable to provide a figure, we used a standard figure of 5% (mark-up on costs) for the purposes of modelling costs across the range of providers.

4.3.1 Treatment of zero "£0" cost lines

In the order of analysing returns, it is true that some cost lines will be statistically zero. This means that the response to our questions for this section is a valid zero response (e.g., travel time, where this has been rolled up into the hourly rate, this is zero so it is not counted in two places per provider); other instances where there is missing data, we have not used zero but instead discounted these in the calculation of a median (e.g., where back office pay costs may be missing, we omitted these from the median calculation).

4.4 Factors that affect the median cost of care

It should be noted that the median cost of care the exercise may not match any particular fee rate – nor might it be expected to. The exercise is aimed at understanding the unit cost and ***not aimed at*** disaggregating different levels of income or price points paid for care. Whilst both "sources of funding" and "expenditure" should ideally match in order to assure the validity of any set of costs; exploring income and profit in detail is ***not the purpose of the exercise*** and therefore checks and balances must always be applied. It is not uncommon however for any typical observer to want to understand why this variance exists, and so it is important for ARCC to offer context in this report as to how the outputs results can be impacted by real-life business operations.

- Not all customers are equal: Customers do not always buy care from the same provider at the same fee rate. Providers receive varying fees from the host local authority, outside local authorities, self-funders and continuing health care (CHC). Evidently, arriving at a single "unit" cost will be reflective of the blended average rate across the income and sources of funding received from all customers. In addition, other variances such as whether someone purchases care on a bank holiday; or needs a materially different package of care from a different level of trained staff will affect portions of cost from all aspects of the business.

- Impact of costs during the pandemic: Reviewing actual costs in 2021-22 is a helpful comparator when married alongside the DHSC requirement to model "expected" cost as of April 2022, which inevitably

requires some form of forecasting and cannot always be guaranteed to be accurate. However, we must be cognisant that the last two years have also been exceptional and therefore may not represent the most ideal situation in which to assess future costs. This is made more complex by the exceptional amount of grant funding applied to the sector to cover extraordinary costs in this year, and whilst some providers may make effort to disaggregate any expenditure via these routes, it can never be guaranteed that all costs are considered "normal" costs and so may be affected by additional non-typical costs during the pandemic years.

- Variances between what is paid for and what is delivered: The homecare sector currently predominantly applies the same unit of measure in order to define the cost and price point of services provided. This is almost universally recognised as paying for time-and-task, which we will refer to as the "currency" of care. The reality is that paying for a care "visit" for 60 minutes' worth of time, may not always equal 60 minutes' worth of pay in direct face-to-face care with a customer or individual.

  Inevitably, variances occur where a 60-minute "paid for" call may be in some order shorter or longer than this, which can ultimately impact the cost paid to the carer, or other associated costs – the effect of which, over time, is compounded. Modelling the "unit cost per care hour" assumes that all pay costs are equal, however, where "care time" may be less than the perceived time paid for, the output unit costs predictably look higher than expected.

  Note that this is not a comment on whether quality services have been provided – the assumption in all cost of care exercises is that all services are delivered equally, as ultimately more efficient homecare providers may be able to deliver the required amount of quality activities in less than the time allocated, in which case, the cost is made up by efficiencies in the delivery of care. Where this causes problems however is when quality suffers, yet again, no evidence has been requested nor produced as part of this exercise to this end.

- Changes to UK fiscal policy: It is worth noting that this undertaking cannot forecast with any certainty the costs that providers will ultimately experience over the next 2-3 years, against the market's current estimates. Whilst the current economic situation remains uncertain; recent announcement will also have an impact on the entire analysis within this report:
  - The reversal of the additional 1.25% on employer's NI payments will reduce provider costs; whilst the levy was initially intended to fund health and social care the UK government has also said this will not impact on the availability of funding to the sector
  - The business energy bill relief scheme will no doubt curb future energy costs, and is indeed difficult to predict due to the nature of variable tariffs in the market as well as fixed term contracts many providers will have secured over a period of time
  - Cancellation of the planned rise in corporation tax will also continue to support provider's bottom-line profit/surplus

  As detail of these changes are still being released by Government and have been introduced late in the process, it is not possible to measure the impact of these policy changes other than to hypothesise that the combined impact is likely to reduce the increased cost impact presented in this report.

4.5 Scenario Modelling

In recognition that the current operating costs for 2022-23 do not represent a sustainable market given the continued (and increasing) challenges being experienced with recruitment, retention and capacity of providers; stakeholders were asked to consider what interventions in the cost ('scenarios') could help mitigate some of these challenges.

Potential scenarios and variants were discussed with providers at the workshop held on the 25th August and also the commissioner workshop held on the 15th September; the following scenarios were proposed:

- **Scenario #1** "median model" provider at unit cost of £22.54, with weighted average costs for 15-, 30-, 45- and 60-minute calls: as per the DHSC guidance, local authorities were asked to consider weighted costs where the pro-rata element of the hourly unit costs may not accurately reflect the actual cost incurred per visit
- **Scenario #2** median adjusted to include 5 minutes travel and 2.5 miles per visit, carer paid at base hourly rate, i.e., does not default to NLW.
- **Scenario #3** base carer pay set at £10.90p/h to reflect 2023 Real Living Wage[14]
- **Scenario #4** base carer pay set at £10.93p/h to reflect pay rates for an NHS Band 2 worker + an assumed uplift of 10.1% for 2023-24 in line with the RLW 2023-24. Pay rate of £12.03
- **Scenario #5** base carer pay set at £11.50p/h to reflect pay rates for similar sectors such as retail.

4.5.1 Underlying Assumptions for the Cost Modelling

Typically, cost of care analyses uses the starting point of an hourly 'rate' of care, and then break down the apportionment of cost lines to arrive at a unit rate that is representative of either local benchmarking or meets local needs. ARCC's approach[15] was to create a bottom-up model, which utilises annualised costs and volumes of care delivery for a 'typical' provider size within the local area, and aggregates costs on an annual business, from which an indicative "cost per hour" can be derived. This more accurately represents a 'profit and loss' statement (or budget) for the purposes of simulating representative business costs. Critically, all costs are then taken into account ***in the context of the reference provider business size***, i.e., representing the costs a business of that size typically incurs.

Within the homecare model, all business costs are built up using the following formula:

Figure 9: *Underlying Assumptions to the Modelling of Costs*

[14] https://www.livingwage.org.uk/
[15] For further information regarding ARCC's cost of care toolkit and methodology visit: https://www.costofcaretoolkit.co.uk/

Whilst variances in relation to the volume of hours an individual provider or branch may deliver was not explicitly covered in the scenarios, a 'model' branch/provider size was determined for the purposes of simulating the reference costs (Appendix C: data reference tables). Key underlying assumptions for each of the modelled scenarios (unless stated otherwise) are:

- The cost per hour outputs is presented as x1 hour of commissioned care delivered by x1 care worker (double-ups would require 2x hourly units of pay)
- The branch model is a small-medium provider (52,096 hours p/annum; 1002 hrs per week)
- A weighted average visit duration of 33.6 mins
- Profit mark-up is set at 5%
- Senior carers deliver 3% of hours on an enhanced rate
- Bank Holidays have a 65% enhancement applied to the base rate
- All hours (including non-contact hours) are paid at the same rate as F2F hours
- Does not include billed hours which accrue less than full cost i.e., hospital payments

Volume of Care Hours (Units) p.a		52,096								
Hourly Breakdown	#1 MEDIAN BASE		#2 INC. TRAVEL		#3 RLW		#4 AfC BAND 2		#5 COMPETITOR	
	Cost £	%	Cost £	%	Cost £	%	Cost £	%	Cost £	%
Direct Care	£10.22	45.4%	£10.22	39.7%	£11.07	46.3%	£12.21	47.4%	£11.67	47.1%
Travel Time	£0.00	0.0%	£1.52	5.9%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%
Mileage	£0.29	1.3%	£1.43	5.5%	£0.29	1.2%	£0.29	1.1%	£0.29	1.2%
PPE	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%
Training (staff time)	£0.14	0.6%	£0.14	0.6%	£0.15	0.6%	£0.17	0.7%	£0.16	0.7%
Holiday	£1.28	5.7%	£1.47	5.7%	£1.39	5.8%	£1.53	5.9%	£1.46	5.9%
Additional Non-Contact Pay Costs	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%
Sickness/Maternity & Paternity Pay	£0.40	1.8%	£0.46	1.8%	£0.44	1.8%	£0.48	1.9%	£0.46	1.9%
Notice/Suspension Pay	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%
NI (direct care hours)	£0.84	3.7%	£0.97	3.8%	£0.91	3.8%	£1.01	3.9%	£0.96	3.9%
Pension (direct care hours)	£0.36	1.6%	£0.41	1.6%	£0.39	1.6%	£0.43	1.7%	£0.41	1.7%
Back Office Staff	£4.41	19.6%	£4.41	17.1%	£4.64	19.4%	£4.93	19.1%	£4.67	18.8%
Travel Costs (parking/vehicle lease etc.)	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%
Rent / Rates / Utilities	£0.45	2.0%	£0.45	1.7%	£0.45	1.9%	£0.45	1.7%	£0.45	1.8%
Recruitment / DBS	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%
Training (3rd party)	£0.12	0.5%	£0.12	0.4%	£0.12	0.5%	£0.12	0.4%	£0.12	0.5%
IT (Hardware, Software CRM, ECM)	£0.37	1.6%	£0.37	1.4%	£0.37	1.5%	£0.37	1.4%	£0.37	1.5%
Telephony	£0.28	1.2%	£0.28	1.1%	£0.28	1.2%	£0.28	1.1%	£0.28	1.1%
Stationery / Postage	£0.07	0.3%	£0.07	0.3%	£0.07	0.3%	£0.07	0.3%	£0.07	0.3%
Insurance	£0.10	0.4%	£0.10	0.4%	£0.10	0.4%	£0.10	0.4%	£0.10	0.4%
Legal / Finance / Professional Fees	£0.07	0.3%	£0.07	0.3%	£0.07	0.3%	£0.07	0.3%	£0.07	0.3%
Marketing	£0.23	1.0%	£0.23	0.9%	£0.23	1.0%	£0.23	0.9%	£0.23	0.9%
Audit & Compliance	£0.03	0.1%	£0.03	0.1%	£0.03	0.1%	£0.03	0.1%	£0.03	0.1%
Uniforms & Other Consumables	£0.05	0.2%	£0.05	0.2%	£0.05	0.2%	£0.05	0.2%	£0.05	0.2%
Assistive Technology	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%	£0.00	0.0%
Central / Head Office Recharges	£1.44	6.4%	£1.44	5.6%	£1.44	6.0%	£1.44	5.6%	£1.44	5.8%
Vehicle Insurance	£0.08	0.3%	£0.08	0.3%	£0.08	0.3%	£0.08	0.3%	£0.08	0.3%
Equipment Hire / Lease	£0.04	0.2%	£0.04	0.1%	£0.04	0.2%	£0.04	0.1%	£0.04	0.2%
Maintenance & Premises Expenses	£0.06	0.3%	£0.06	0.2%	£0.06	0.2%	£0.06	0.2%	£0.06	0.2%
Additional Overhead 1	£0.06	0.3%	£0.06	0.2%	£0.06	0.2%	£0.06	0.2%	£0.06	0.2%
Additional Overhead 2	£0.01	0.0%	£0.01	0.0%	£0.01	0.0%	£0.01	0.0%	£0.01	0.0%
CQC Registration Fees(4)	£0.09	0.4%	£0.09	0.3%	£0.09	0.4%	£0.09	0.3%	£0.09	0.3%
Surplus / Profit Contribution	**£1.07**	**4.8%**	**£1.23**	**4.8%**	**£1.14**	**4.8%**	**£1.23**	**4.8%**	**£1.18**	**4.8%**
Total Cost Per Hour	**£22.54**	**100.0%**	**£25.78**	**100.0%**	**£23.92**	**100.0%**	**£25.79**	**100.0%**	**£24.79**	**100.0%**

Table 5: costed scenarios 1-5

4.5.2 Scenario #1 median "model provider"

The median "model provider" (£22.54) has been informed by the median cost lines in Table 7. It should be noted that by the nature of using aggregated figures across a range of provider data, the "median" model does not represent any one particular provider, however the total unit cost does represent the "median" provider within the dataset. Therefore, it can be assumed that the breakdown of costs is at least

appropriate to the make-up of a modelled business, albeit no single setting may have the exact costs incurred within this model.

4.5.3 Scenario #1 1a, 1b, 1c and 1d weighted average costs for 15-, 30-, 45- and 60-minute calls

The variation in cost for different visit lengths is due to the cost per hour being different from the cost per visit. Travel time and mileage can typically be worked out (on average) per visit, however it cannot be worked out the same on average per hour. This is why the cost base materially changes depending on the average visit time and the number of visits. In addition, accruing more travel time will accrue more holiday pay and employer's NI, further impacting unit costs. The cost model only produces one rate at a time.

It is by its nature a COST model, not a PRICING model. It is more accurate and straightforward to model (from a cost perspective) a single, aggregate number of visits and annual hours. The variations on this (table 8 below) can be modelled using the same volume of hours, by increasing the total visits needed to achieve the same care volume.

Scenario Models[16]	Description	Unit Cost per care hour[17]
#1a 15-minute call duration	*Median cost adjusted to reflect avg.15-minute call duration*	£22.91
#1b 30-minute call duration	*Median cost adjusted to reflect avg.30-minute call duration*	£22.57
#1c 45-minute call duration	*Median cost adjusted to reflect avg.45-minute call duration*	£22.46
#1d 60-minute call duration	*Median cost adjusted to reflect avg.60-minute call duration*	£22.41

Table 6: weighted average costs for 15-, 30-, 45- and 60-minute calls

Figure 10 shows the effective unit cost at different call lengths with the corresponding actual weighted "visit" cost is also shown by the orange line on the chart. Ordinarily, the blue line would show a starker correlation with the orange; however, the practice of absorbing travel time into the care hour means travel as a variable is not a factor that is impacted by the call duration.

[16] All scenario models are compliant with the Ethical Care Charter pay rate for all staff

[17] The variations on call length are expressed as unit cost per care hour, however the actual cost per call should be derived by the proportion of 1 hour that call represents, e.g., for a 30-minute call, the cost per care hour should be halved to arrive at the unit cost per 30-minute call

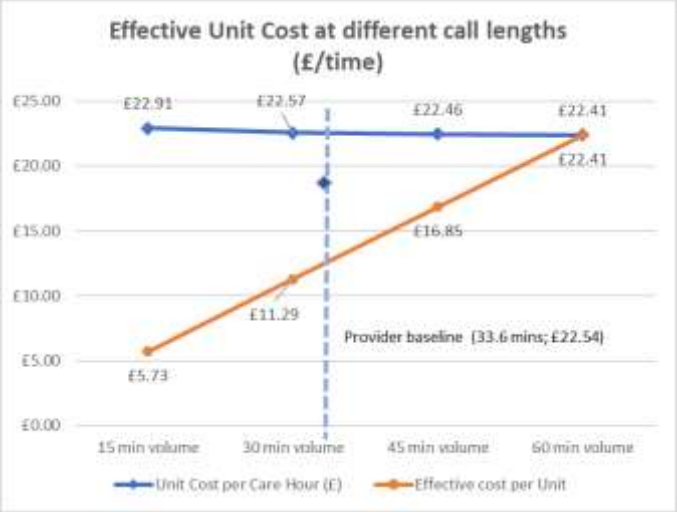


Figure 10: effective unit cost at different call lengths (£/time)

4.5.4 Scenario #2 inclusion of travel time within the hourly rate.

Locality providers at present operate with the agreement that the hour of care includes, contact and none contact time, i.e., travel time. There is no provision within the model for travel so hypothetically an hour of care may comprise of 50 mins face-to-face contact and 10 mins travel. This scenario applies the median cost and visit duration of and is adjusted to include 5 minutes travel and 2.5 miles per visit, paid at standard hourly rate, on top of the contact time. The modelled cost per hour for this scenario is £25.78 (see Table 5).

4.5.5 Scenario #3 real living wage 2023

To account for a more competitive working environment, the carer rate of pay (for all working time has been adjusted to reflect The Real Living Wage Foundations announcement of a £10.90 p/h rate from 2023. Senior carers and back-office staff costs have also been uplifted to account for commensurate increase in wages for front line staff, to maintain a consistent level of retention across the provider model. In addition, it should be noted that increases in holiday, training and other pay costs also apply. The modelled cost per hour for this scenario is £23.92 (see Table 5).

4.5.6 Scenario #4 AfC NHS Band 2 (+2 years' experience)

Agenda for Change NHS Band 2 with 2+ years' experience is currently £10.93 per hour. In light of the recent RLW announcement, we envisage that the rate of pay for this band will be increased in the coming months. As a proxy measure, we have increased the band by 10.1% in line with the RLW rate which gives an estimated £12.03 p/h. The base pay rate for carers in the model has been increased to account for this. As with scenario #3, back-office staff costs have also been uplifted and increases in holiday, training and other pay costs also apply. The modelled cost per hour for this scenario is £25.79 (see Table 5).

4.5.7 Scenario #5 carer pay rate commensurate with local labour market

A cursory review of jobs available identified several retail jobs in the Bradford area which offered hourly rates ranging between £9.50-£12.64 per hour. Furthermore, the median local hourly rate is £13.85p/h for 2021. Therefore, this model uses £11.50 per hour as the base pay rate for carers to account for this. All other factors remain the same as scenarios 2 and 3. The modelled cost per hour for this scenario is £24.79 (see Table 5).

4.6 Future Fee Uplifts and Sensitivity Analysis

The ARCC/CHIP homecare cost toolkit (Cost Models provided in Annex A) includes provision to model variances including rates of pay, employer's NI thresholds and other non-pay costs to estimate future fee uplifts. Whilst future years' cost impacts are not yet fully known, providers were asked during the course of the engagement what they considered was the most accurate and transparent method for future years' fee uplifts. Broadly, the consensus was an adjustment based on:

- Pay costs reflecting changes to factors such as NLW and National Insurance increases; and
- Non-pay, i.e., business costs being adjusted, not simply as a reflection of CPI but to take an approach to a social care sector "basket of goods" which is more specifically related cost pressure such as utilities, fuel, capital costs etc.

Whilst in principle, the above is common practice, there are some important considerations which can have both a positive and negative impact on provider sustainability:

- Efficiency of provider shifts/call runs: An efficient run minimises travel distance and time between calls, and several calls in a small neighbourhood (within a street or block for example) will not attract the same travel time or mileage as disparate calls in the more rural areas of the city. It is considered that this may be offset by traveling from one area to another, and personal choice (preferred call time of day) may impact the ability to efficiently schedule calls.

- Volume of provision: Larger volume providers may benefit from economies of scale, which allows for fixed costs (back office and overheads) to be spread over a larger volume of hours. Whilst this is not a completely linear equation, and it is recognised that there is a natural 'cap' or 'upper limit' to the potential size of a branch before more investment is required in infrastructure, larger business currently operate with the same fee rates whilst still being able to invest in larger governance structures due to their size and scale. It should not be considered that larger organisations offer better value for money or improved service quality to the market, rather that scenario costs are inclusive of as much size and scale that the market has to offer, and that a mix of both large and small business is obtainable in any given market.

- Weighted average visit lengths: Travel time is not dictated by visit lengths, and therefore time required to travel to a client is the same regardless of whether a 30-minute or 60-minute call is being delivered. This is why it was important to reflect the weighted average visit length within the models, to account for the fact that travel as a proportion % of call time will naturally vary. Of course, the individual mix of calls each provider delivers will differ, and the models are simply intended to reflect a typical cost.

- Staff turnover and hours: The average employee's earnings impact the cost to businesses in the form of employee's national insurance (ENI) contributions. Fewer staff working longer hours will increase ENI costs, whereas more staff working less hours will have the opposite effect. The opposite is true for training costs – as these need to be delivered per worker, a larger staff base will increase training costs in proportion to other costs.

Of course, the intention of an analysis of this nature is never to arrive at a *specific cost to each provider's business. The cost model merely aggregates a sample of provider data to provide an indicative set of figures for consideration.* It is the role of commissioners to assure themselves that the rate paid is inclusive

and commensurate with a 'cost envelope' that supports a sustainable, diverse and quality market as per the Care Act.

Commissioners and providers should recognise that the role of any fee-setting is ***not*** to specify the absolute operating costs at every level of a provider's business. Using pensions as an example, this means being absolutely clear that setting a budget line for all staff pension costs does not mean all providers ***must*** incur 100% pension costs at 3%, to be eligible for the full 'offered' rate to the market (i.e., due to typical opt-out rates of c.15%). Equally, providers are not expected to 'rebate' to the public purse any cost savings made due to operating decisions that take their costs below the typical cost lines presented. Therefore, this variation between providers' day-to-day operating costs and efficiencies will always exist and may not (nor could they be) eliminated in all cases.

5 Future Commissioning Considerations

5.1 Future Commissioning Considerations

This report has focused predominantly on the method of engagement and subsequent analysis to establish an indication of the current costs of care in line with the DHSC's requirements. This was the prime purpose of the project. ARCC also recognise that informing the future price point for homecare is only part of a good sustainable commissioning model. This section therefore presents our main conclusions which we believe commissioners should consider for the future, drawn from engagement with the local market and ARCC's experience of good commissioning practice locally and elsewhere.

5.1.1 Sustainable Homecare Delivery

The below factors represent feedback from ARCC's experience and provider engagement, that may indirectly impact the costs and efficiencies within the local care market:

- Care scheduling: whilst homecare providers typically expressed to ARCC the resource and effort that goes into scheduling as a factor of the 'hours' required per day/week; it is important to recognise that scheduling care delivery is also affected by the following:
    - The total number of visits (i.e., more visits require more scheduling effort)
    - Changes to rotas, staffing or client choice (i.e., time of day) requires duplication and rework
    - Emergency visits, hospital admissions or respite also affects runs and may require rescheduling
    - Seasonal working (such as winter planning where staff and service user's family will operate different patterns and affect the required deployment of resource to provide care)
    - Fragmentation of market (reduced optimisation of runs due to increased spot provision or a number of services operating within zones)

- Staff turnover and competition: staff turnover is typically high in homecare compared to other industries and has been an even greater challenge post pandemic. Whilst it is not the commissioners' role to dictate staff terms and conditions, understanding what drives good employers will help to retain staff and reduce the transient workforce. This includes recognising the benefits of standardised pay rates for contact, travel, and training, as well as stable shift patterns and, for those who request it, guaranteed hours contracts, to retain staff.

- Supporting cross-agency provision: commissioners hold data spanning a large proportion of providers and care packages in the market, with the ability to co-ordinate and disseminate market knowledge to the benefit of local care provision. This may mean that packages of care can be better "shared" amongst providers (i.e., to fit into available runs) through commissioners setting up regular mechanisms and forums for providers to collaborate, for example, to optimise runs.

- Better quality and financial KPIs: quality of service provision and financial sustainability are the two biggest measures in effectively monitoring delivery of contracts. Over the course of contracts, it is often the case that information requirements grow, and can inadvertently represent an administrative burden for providers, without necessarily providing the required insight for commissioners. Whilst commissioners recognise the need to understand more about provider delivery, more data can lead to less time for meaningful exploration and insight into the impact that changing quality and financial

measures are having on market dynamics. As such, a "less is more" approach is advocated – by focusing on fewer, more important indicators, commissioners can learn more and intervene more effectively, in a more collaborative, mutually beneficial arrangement (see section 5.2.3).

- Support Planning and Review: regular support planning and review is critical to the success of outcomes-based homecare. Commissioners and practitioners can support the market to maximise independence only if regular review mechanisms are in place, which requires empowered homecare organisations, as well as social work capacity. Repeated and consistent lower actual hours delivered against commissioned support plans are a key indicator of changing support needs. Flexible support planning thrives where collaborative working relationships between providers and practitioners are supported, as well as considering trusted assessor models to support capacity and delivery.

- Varying market operating models: Whilst the aim of this exercise is to establish a typical set of reference costs for provider businesses, providers and commissioners are both clear that specific cost lines are not a dictation of how providers allocate funds to operate, sustain and grow their businesses. The key purpose is to ensure that the 'cost envelope' in its entirety is reflective of current market costs and commissioner's expectations. Some providers may spend more on front line staffing, whereas others may focus on back-office costs or head office infrastructure that supports their individual operational growth. The purpose of the exercise is to validate that future fee rates set by commissioners has a strong existing base with which to understand various cost pressures, as well as recognise that a range of operating models (large and small providers) should be able to operate in any single market.

5.1.2 Care packages rather than care hours

Whilst an appreciation of the volume of care being delivered is important to understanding the 'contract currency', the prominence of care 'hours' reinforces the emphasis on volume and time, rather than on service user wellbeing and the overall impact of homecare. Often, it is more helpful to focus on the care packages themselves, rather than the care hours that make them up. In this way the real 'unit' of homecare is the care package. Each service user has only one care package, though each package will vary in terms of its content and make-up of tasks required per week. It is at the level of the care package where attention should be focused and so it makes sense to develop commissioning models and contracts that emphasise, rather than detract from this. Bringing the emphasis closer to the client / provider also has the opportunity to bring innovation and flexibility to the delivery of services which in turn may improve outcomes for individuals and operational efficiencies for providers.

5.1.3 Geographical zones, localities and volume considerations

The recent service review of home support identified that the design of the current framework and localities was intended to align with operational localities, creating smaller areas which would aid with recruitment of drivers; however, as alluded to earlier implementation was not as planned and service users did not automatically switch to the new providers resulting in market fragmentation and impacting providers ability to create 'optimal runs', i.e. reduce the transactional (travel) component of the service. There are areas that are particularly more challenging than others, these include Ilkley/ Burley/ Menston, which cover a significant geographical area that is not walkable, suffers with poor public transport and is more difficult to recruit to locally due to relative affluence.

Providers echoed the concerns of this review and felt some localities (such as the aforementioned) are too big for one provider and may benefit from further restructuring (or rate differentials to reflect localised

challenges) as part of the future recommissioning/design of the framework. A more detail analysis needs to be done to understand the impact of the localities and how to divide or assign providers to localities to optimize providers resources when delivering the service.

As travel time is currently 'rolled-up' into service delivery and therefore there is an absence of sufficient data for modelling purposes. ARCC recommends that it would be sensible to review provider distribution together with individual client postcode data (from internal datasets) to assess average distances and travel times using geo-mapping software such as Google Maps, to match that of provider's own estimates.

Volume is a critical factor in understanding the unit costs of any business (as these are a combination of both fixed and variable costs, which are inevitably affected by the volume of "units" being delivered). Commissioners' role is to set a fee rate that allows a variety of business models (in both size and infrastructure) to operate – as such, it is not in the spirit of any cost analysis (or subsequent published rate) to dictate the size or structure of the organisation, despite requiring an 'aggregated' model to be developed to simulate such unit costs.

As both small and extremely large providers co-exist in the current market at rates lower than presented in this report, it is feasible to estimate that both types of organisations can continue to co-exist in the market and is an important consideration for any future retendering activity. This brings about several benefits in terms of quality, scalability, capacity for growth, speed of response and service user choice to the local care market. It is therefore sensible to enable a variety of providers, to operate in the market. Currently, there is an over dependency upon one locality provider accounting for approximately 10% of the commission hours. High dependency on one provider could mean higher risk of not being able to deliver services in the event of market failure or exit; temporary reliance on spot purchases to cover those areas would mean higher costs for the Council until finding the capacity in current providers to cover those contracts.

5.1.4 Commissioning Fixed or Minimum Volumes

As previously referenced, the certainty of income has a bearing on the terms by which staff are employed. There are several means by which this may be achieved, one such example is commissioning minimum volumes or "blocks" of hours which has some advantages, as it may:

- Reduce the burden of administration for providers.
- Give certainty to providers that floor revenue will be maintained for the term of a contract, and
- Improve flexibility across different service users and packages to manage the 'budget' of hours within the provider's allocated cohort of clients

There are also several key disadvantages to contracting minimum volumes that must be considered:

- Reduces focus on individual packages (i.e., if providers invoice a block of hours instead of weekly hours per customer, commissioners will be inclined to focus on the total quantity as opposed to whether individual service users are getting the appropriate support plans met), which is not in the interests of service user choice and independence,
- Creates additional 'waste' in the system (i.e., if demand falls below the minimum threshold, or if clients cannot be serviced (for whatever reason), charges are still otherwise billable which wouldn't be the case for other arrangements)

- Establishes an expectation that minimum business sizes represent an economic advantage (i.e., potentially 'freezing out' smaller providers who may not be able to deliver certain volumes and who may otherwise add diversity to the market via spot provision)

In addition, providers may only be incentivised to maximise independence and taper care and support if the current cohort of client packages is ***above*** the block volume of hours provisioned, as well as there being known packages of care (i.e., on the existing waiting list to backfill available capacity). Without close collaboration and review, establishing block volumes can risk adverse behaviour in the market in continuing to maintain existing packages, rather than accepting new packages. Whilst there may be some advantages to commissioning minimum volumes, ARCC's view is that this could only be done in the most mature of commissioning environments where there are clear, strong relationships between commissioners and providers and requires two established factors, including strict monitoring and quality arrangements:

- A consistently accurate prediction of future demand volumes (to ensure blocks are fully utilised)
- Clear incentives, capacity and capability for both providers and assessment and care management teams to frequently review and monitor service user outcomes

5.1.5 Continued Market Dialogue

Continued dialogue with the market is essential to understand factors that will impact the future price for care from 2023/24 and beyond. This includes:

1) Inflationary factors – reviewing uplifts for pay rates (including Real Living Wage) as well as inflationary uplifts on non-pay costs (i.e., insurance costs etc.)
2) Organisation size & geography – the objective of commissioners is to create a cost envelope that can reflect both service expectations and market structure (broad range of business sizes and operating models), as well as reflecting the costs of delivering care in 'hard-to-reach' areas, such as Ilkley, Burley and Menston. Regular monitoring should be conducted where localities or neighbourhoods are becoming more difficult to service (i.e., waiting list increases).

5.2 Recommendations

ARCC would like to thank all stakeholders engaged in the process. We hope that through this exercise, both commissioners and providers can continue both the positive dialogue and continued education across the market regarding business operating models and challenges for homecare as well as commissioners' needs and expectations. Our key recommendations following completion of this report are detailed below:

5.2.1 Continued dialogue with the market regarding a sustainable rate for care

ARCC have presented a median cost from the range of data made available from respondents, plus several costed scenarios, based on varying base pay rates for care workers. This reflects the current workforce challenges providers reported. It should be emphasised that any Council has a duty under Section 5 of the Care Act to ensure they have a "sufficient" market to buy services from, and it is not the duty of any local authority to pay any specific "rate" for care. Rather, local authorities will need to take into account how readily they are able to service their population's needs via the existing contracting and pay mechanisms they have with the market, which takes into account how long it takes to implement packages of care, the

level of unmet need in the market, and many other factors outside of simply cost. This assessment feeds into the cost of care to determine what ultimately gives the Council assurance around the overall sufficiency of care they are able to purchase from the market.

Whilst a long-term intention, in line with this DHSC cost of care exercise, may be to work towards the estimated median of £22.54, DHSC guidance states that *"fair means what is sustainable for the local market".* The council should continue to monitor the pressure in the market (both staffing and business operating costs) through the fee exercise, and as was the case for this financial year with a 6.5% uplift, make adjustment (% fee uplifts) to reflect changes to operating costs.

5.2.2 Future considerations for how the unit of care is purchased

It is our understanding the local framework is due to be recommissioned within the coming year. This provides an opportunity not only to consider the constituent operating model but also how care is purchased; considerations include:

- The present framework rate operates on the principle that travel forms part of the care hour; consideration should be given as to integrating the cost of this into the rate, following further analysis with the market. Alternatively, a separate per visit payment may be adopted.
- Considering the introduction of a differential rate, for reasons cited in section 5.1.3, to support take up of packages in areas where there are presently difficulties or delays in allocation
- Adopting weighted unit rates for 15, 30, 45 and 60-minute visits, where shorter visits are required, in which the effective hourly rate is increased to account for the fixed amount of travel time applied to each visit length.

5.2.3 Improved intelligence to support market management

More detailed analysis should be undertaken to understand the impact of the localities, and subsequent assignment of providers, in order to optimize providers resources when delivering the service. Similarly, further detailed work to review provider package distribution together with individual client postcode data (from internal datasets) to assess average distances and travel times which using geo-mapping software such as Google Maps, to match that of provider's own estimates.

To support this analysis quality and contract monitoring KPIs may be re-imagined with the provider market which includes reducing requests for information in many areas by introducing a small number of impactful KPIs such as below. Many of the below indicators can be determined via a single monthly or quarterly data request:

- Monthly planned call monitoring using sensitivity analysis to check the schedule of visits/duration being delivered is still in line with sustainable provider costs.
- Weekly package hours being delivered, identify where hours are consistently higher or lower than planned support, and flag clients for review, either via the provider's own assessment capacity or via Bradford MDC's assessment and care management.
- Proportion of packages picked up within 'X' days to understand provider capacity challenges.
- Market "stability" indicators to help monitor risk, this includes the % share.

5.2.4 Reducing contractual and operational constraints

Undertake further engagement with the market in relation to how operational processes can be streamlined to provide efficiency to the market. This has the potential to reduce operational costs for providers with minimal resource requirements from the local authority. Special attention should be given to:

- Streamlining how the commissioning framework has been set up and clearly communicating to stakeholders the difference between frameworks (Locality, STEP, ISF1 and IPSAC). Clarify internal processes and standardise procedures, communicate and train stakeholders to manage/utilise the different frameworks in the appropriate manner.
- Clearly defining functions for the brokerage teams (BEST and Support Options), assuring one single point of referral and the timely dissemination of paperwork upon allocation of packages.
- Reduce bureaucracy and paperwork – automate manual processes such as the form SS243 and create user friendly applications for providers to help reduce the administrative burden.

5.2.5 'Deep dive' engagement with the market to explore recruitment and retention challenges.

Explore what action the system (providers and commissioners) can take to tackle current challenges; this may include work locally to generate training and development opportunities, a renewed emphasis on raising the profile of social care as a profession through the workforce strategy and 'Bradford Cares' campaign.

5.2.6 Develop economic assessments of the local economic impact of homecare provision

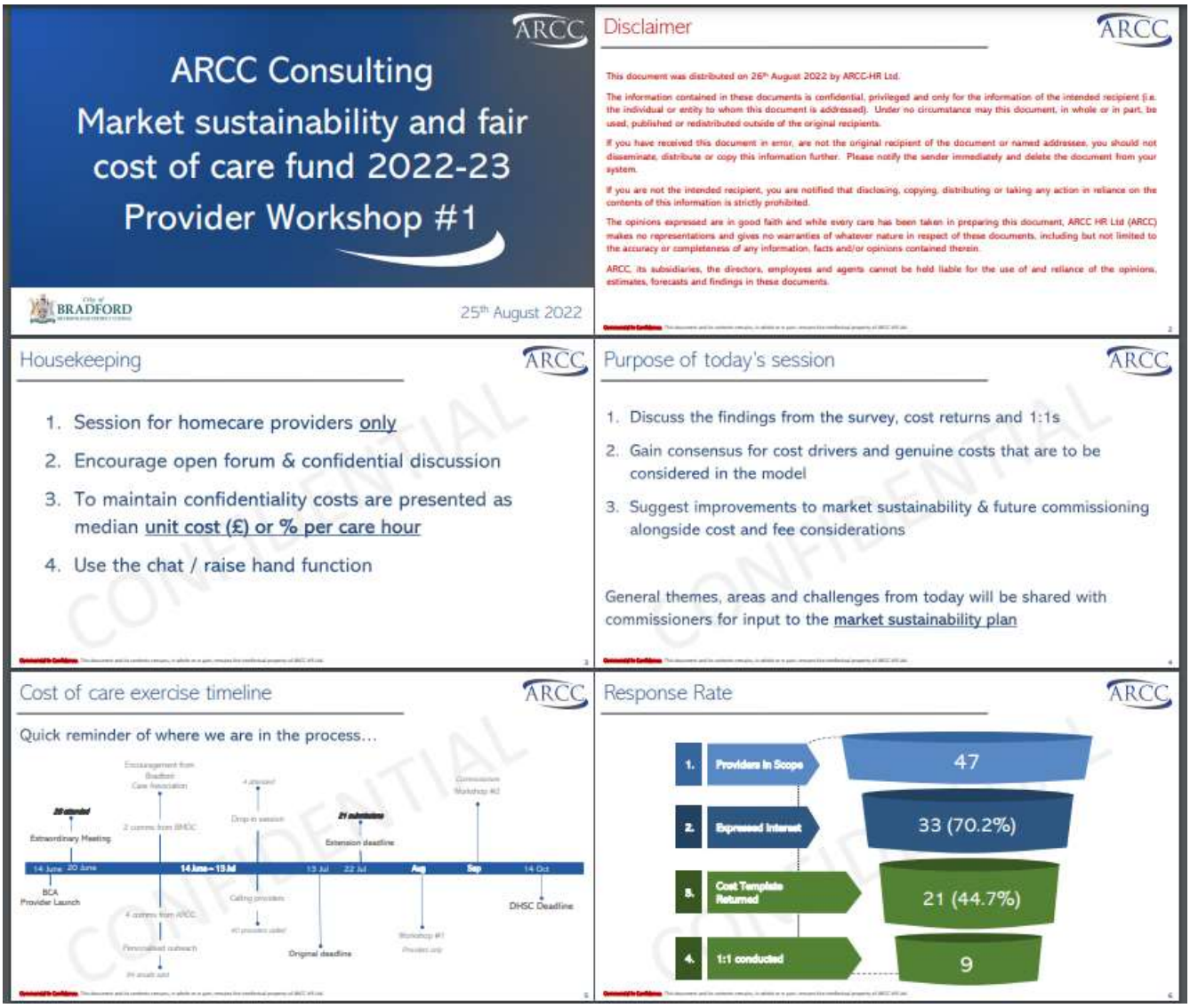
Alongside the above, commissioners would benefit from developing a local economic impact tool, which would highlight the costs / benefits of homecare with respect to other forms of provision in the local health and care economy. This would greatly inform budget discussions and facilitate better, integrated working via the new emerging health and social care infrastructure.

6 Appendices

A. Provider Cost Survey & Workshop Slides

Homecare Cost Survey Distributed 15th June 2022 (Attached)

Homecare Provider Workshop 25th August 2022



Cost survey and 1:1 outputs

Thank you to all that responded…

Engagement results:

- 21 cost surveys received (including 4 cost toolkit templates)

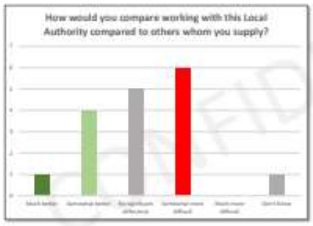
Market representation:

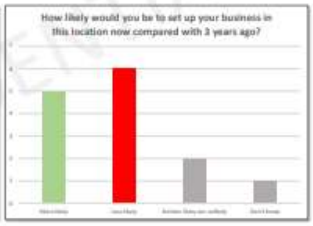
- Represents 44.7% of all providers in scope
- 46.4% of local authority commissioned hours in the market
- Small/medium/large providers and varying geographies

Emerging Findings

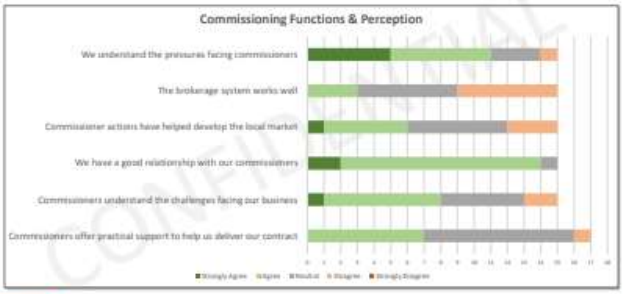
Analysis from survey responses

- 30 % of responses compared working with Bradford as better than other LAs / 30 % no difference / 35 % worse
- 36 % of businesses would be more likely to set up business in Bradford compared with previously





Analysis from survey responses

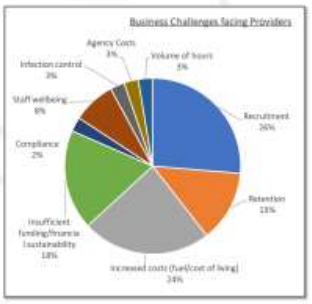


General themes from the 1:1s

Main challenges

- Significant struggles with recruitment and retention
- Increases to the general cost of care through higher prices for fuel, cost of living, utilities, etc.
- Above impacts staff attraction and ability to be mobile
- Workforce challenges – capacity – financial sustainability ('vicious circle')

Is there anything missing?



General Feedback from the Market

Workforce, Recruitment & Retention

- Retention and loss of continuity of care and vocation/values
- Seasonal pressures
- Considering pool cars due to ability to recruit drivers
- Additional bonuses to help retain staff
- Impact of Covid – self isolating but on SSP hence retention challenges
- Safety at night in some areas

Processes & Fees

- Forward planning of packages in each of the areas
- Have to keep runs tight
- NHS same rate as LA – packages are more complex?
- Good relationships and feel have a voice
- Back-office pressures, e.g., time to be compliant with requirements
- Brokerage on Connect2Support is not always consistent

Cost Info Gathering Expectations & Gaps

Statistical approach to costing for 2022-23 impact

- Costs have been aggregated and anonymised; to present unit costs per hour of care time and % of total cost without presenting size of businesses; revenue & individual cost/profit lines
- Where we have received 2021-22 costs, we have uplifted these based on current direct pay rates to carers, current back office costs, latest month business volumes and any specified uplifts in overheads
- DHSC have asked for the following aggregated statistics: lowest value, lower quartile (25th percentile), median, upper quartile (75th percentile), and highest value across each individual cost line
- Queries have been raised with providers re. any discrepancies/anomalies; such as:
  - obvious errors when converting total expenditure into a cost per hour (e.g. direct pay costs less than NMW)
  - large cost variances vs. similar businesses
  - large variances between reported revenue & expenditure
- Some lines are statistically zero (e.g. instance travel time, where this has been rolled up into the hourly rate); others are missing data and have not been used to calculate a median (i.e. where back office pay costs may be missing)
- For any discrepancies that cannot be resolved, anomalous data has been removed or a "median" from other businesses' cost lines has been used to ensure all data is as representative as possible

Unit cost information gathering

- Each cost line represents a median of the returns and will not add up to any one typical provider
- Outstanding queries and clarifications
- As it stands:
  - Low is £15.58
  - Median is £22.54
  - High is £24.72
- Average home care cost for 22/23 is £19.38 so median is 16.3% increase

This is still subject to change as we receive clarifications

Business operating models

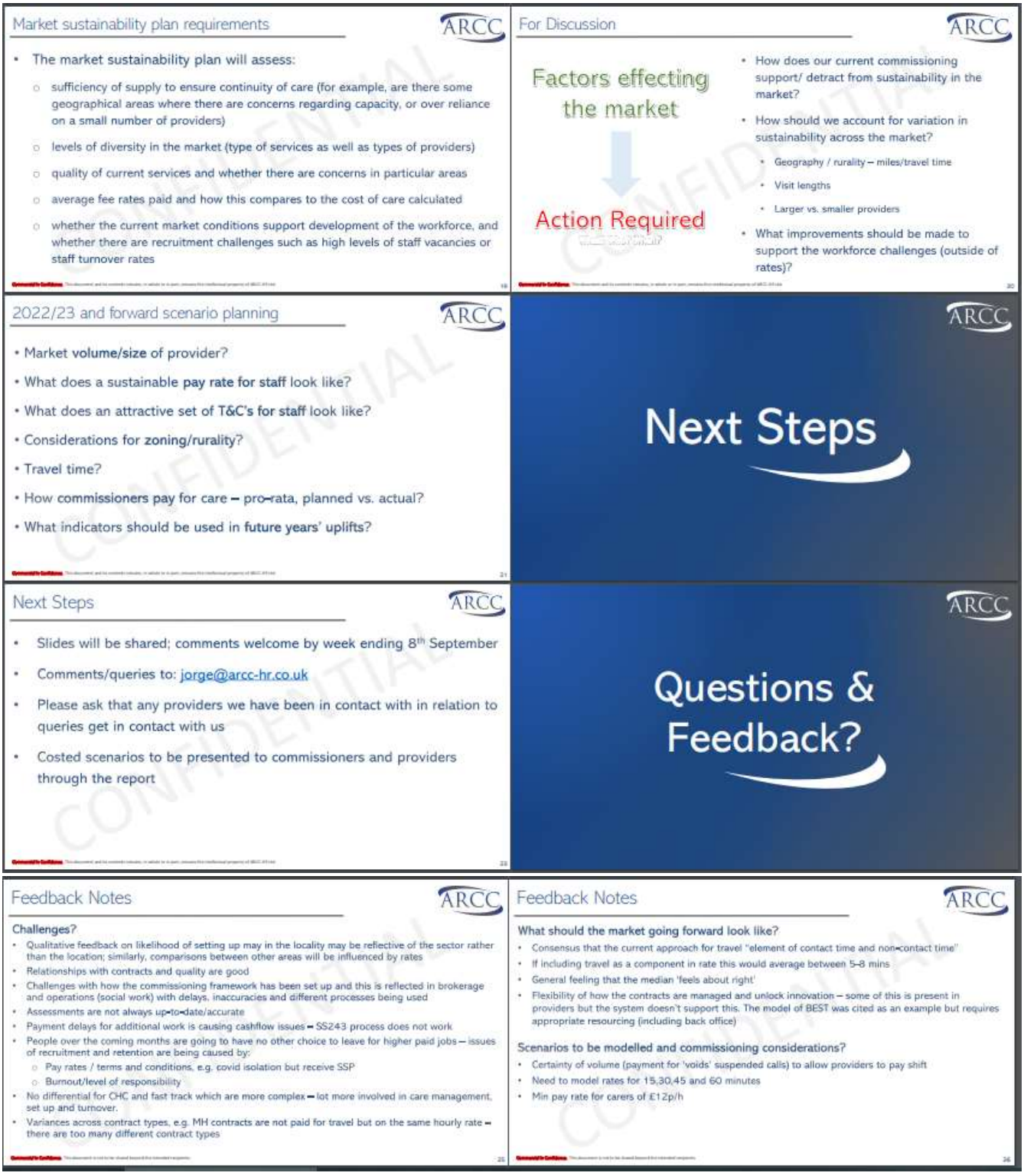
Current 2022 data shows…

- Average 1437 hours per week / 2481 visits per week
- Average call duration 30.4 minutes
- Client packages range from 8.9 to 28.6 hours per week
- Average travel distance 3 miles and time 0 minutes**
- Mileage paid between 25p and 45p
- 2022 basic pay rates range from £ 9.50<£ 11.50 per hour
- Average worker numbers suggest 28 contracted hours per week
- Profit/surplus expectation ranged from 0.7 to 16.7%

Market Sustainability & Scenario Modelling

Market sustainability plan requirements

- Provisional market sustainability plan to be submitted by 14 October 2022, outlining the assessment of the sustainability of their local care market in relation to 65+ care home and 18+ domiciliary care services.
- The market sustainability plan:
  - takes into account the results from the cost of care exercises
  - considers the impact of future market changes over the next three years, particularly in the context of adult social care reform
  - sets out an outline action plan for addressing the issues identified and the priorities for market sustainability investment



B. Engagement List of Internal Stakeholders & Provider Organisations

Bradford Metropolitan District Council

- ASC Finance lead
- Assistant director – Commissioning & Integration
- Senior Manager – Contract and Quality Team
- Contract and Quality Assurance Manager
- Service Manager – Short term
- Support Options Team Manager
- Internal Enablement service Manager

Bradford Care Association

- CEO Executive of Bradford Care Association
- Associate Director care 24/7

Invited Homecare Providers

With thanks to all who participated in the project, including senior operational and finance staff from the organisations who took the time to contribute with a cost survey and engage in 1:1s and workshops.

C. Reference Data Table [anonymised]

All Providers	1	2	3	4	5	6	7	8	9	10	11	12	14	15	16	18	19	20	21	22	23	LOW	25%	MEDIAN	75%	HIGH
Hourly Breakdown	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £	Cost £
Care worker costs:	**63.1%**	**64.3%**	**61.3%**	**66.4%**	**64.4%**	**63.5%**	**60.1%**	**57.0%**	**68.4%**	**62.0%**	**65.8%**	**69.4%**	**68.6%**	**53.5%**	**72.2%**	**69.4%**	**70.3%**	**77.3%**	**65.4%**	**78.4%**	**50.1%**	**60.1%**	**62.2%**	**63.5%**	**64.4%**	**66.4%**
Direct Care	42.3%	44.1%	49.1%	50.2%	45.9%	41.1%	45.4%	40.6%	49.2%	46.5%	50.9%	51.8%	54.5%	36.8%	50.8%	44.8%	49.1%	43.9%	46.0%	57.2%	40.3%	41.1%	43.2%	45.4%	47.5%	50.2%
Travel Time	0.0%	0.0%	0.0%	3.9%	0.0%	0.0%	0.0%	4.2%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.8%	0.0%	7.0%	1.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	3.9%
Mileage	0.3%	3.8%	1.3%	1.5%	3.8%	6.1%	1.3%	2.2%	1.0%	0.6%	2.2%	5.1%	2.8%	1.9%	7.2%	5.3%	4.4%	9.3%	1.5%	3.7%	0.7%	0.3%	1.3%	1.5%	3.8%	6.1%
PPE	0.2%	0.0%	0.1%	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%	1.7%	0.0%	0.0%	1.5%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	1.1%
Training (staff time)	0.6%	1.6%	0.8%	0.5%	1.1%	1.0%	0.6%	0.7%	0.7%	0.7%	0.0%	2.0%	0.0%	4.1%	0.7%	0.7%	1.6%	1.5%	2.7%	2.0%	0.4%	0.5%	0.6%	0.8%	1.1%	1.6%
Holiday	6.2%	6.0%	6.1%	6.6%	5.9%	5.5%	5.7%	5.6%	6.4%	5.7%	6.0%	6.3%	6.6%	5.0%	6.2%	6.0%	6.3%	6.5%	6.0%	7.1%	5.1%	5.5%	5.8%	6.0%	6.2%	6.6%
Additional Non-Contact Pay Costs	8.3%	3.7%	0.7%	0.3%	0.8%	2.6%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.9%	0.0%	0.0%	0.0%	0.5%	0.8%	3.2%	8.3%
Sickness/Maternity & Paternity Pay	1.2%	0.5%	0.4%	0.6%	2.2%	1.0%	1.8%	1.2%	0.7%	0.0%	0.0%	0.6%	0.2%	0.8%	0.2%	0.3%	2.2%	1.8%	0.9%	1.4%	1.1%	0.4%	0.5%	1.0%	1.5%	2.2%
Notice/Suspension Pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NI (direct care hours)	2.9%	3.8%	2.1%	1.2%	3.0%	3.9%	3.7%	1.6%	5.4%	3.9%	4.2%	1.7%	3.0%	3.4%	3.6%	4.8%	4.9%	4.0%	3.8%	4.9%	0.4%	1.2%	2.5%	3.0%	3.8%	3.9%
Pension (direct care hours)	1.0%	0.8%	0.8%	1.7%	1.7%	1.2%	1.6%	0.8%	1.7%	4.8%	1.7%	1.8%	1.5%	1.4%	1.7%	1.7%	1.7%	1.4%	1.7%	2.0%	1.0%	0.8%	0.9%	1.2%	1.6%	1.7%
Business costs:	**28.3%**	**25.1%**	**29.6%**	**29.5%**	**24.5%**	**31.1%**	**35.2%**	**35.6%**	**18.4%**	**28.9%**	**23.8%**	**29.9%**	**14.7%**	**31.3%**	**19.4%**	**26.6%**	**25.0%**	**18.0%**	**29.8%**	**10.9%**	**33.2%**	**24.5%**	**26.7%**	**29.5%**	**30.4%**	**35.2%**
Back Office Staff	19.1%	9.5%	23.9%	12.4%	15.4%	19.3%	19.6%	26.4%	10.4%	20.2%	16.9%	23.5%	8.8%	17.0%	15.6%	15.5%	10.7%	9.7%	12.9%	7.2%	19.0%	9.5%	13.9%	19.1%	19.4%	23.9%
Travel Costs (parking/vehicle lease etc.)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Rent / Rates / Utilities	2.8%	2.5%	0.7%	1.9%	1.5%	3.4%	2.0%	2.0%	1.7%	0.0%	0.2%	1.5%	1.4%	2.1%	0.5%	0.2%	2.9%	2.5%	3.9%	0.1%	2.9%	0.7%	1.7%	2.0%	2.7%	3.4%
Recruitment / DBS	0.2%	0.0%	0.2%	1.7%	0.1%	0.7%	0.0%	0.3%	0.4%	0.0%	0.0%	0.2%	0.3%	0.5%	0.3%	0.4%	0.8%	0.9%	0.2%	0.0%	0.1%	0.0%	0.1%	0.2%	0.5%	1.7%
Training (3rd party)	0.1%	0.0%	0.0%	1.6%	0.5%	1.0%	0.5%	0.3%	0.0%	0.0%	0.0%	0.4%	0.6%	0.5%	0.6%	0.3%	0.0%	0.8%	0.7%	0.0%	0.3%	0.0%	0.1%	0.5%	0.8%	1.6%
IT (Hardware, Software CRM, ECM)	2.5%	2.3%	1.3%	3.6%	1.5%	3.0%	1.6%	3.4%	1.3%	0.0%	0.0%	0.5%	0.7%	3.1%	0.2%	0.9%	1.4%	0.6%	2.6%	1.2%	2.4%	1.3%	1.6%	2.3%	2.8%	3.6%
Telephony	0.4%	0.1%	0.2%	0.9%	1.8%	1.1%	1.2%	0.2%	0.7%	0.0%	0.9%	0.0%	0.1%	1.7%	0.2%	0.6%	1.1%	0.8%	1.1%	0.7%	0.2%	0.1%	0.3%	0.9%	1.1%	1.8%
Stationery / Postage	0.2%	0.5%	0.3%	0.3%	0.2%	0.1%	0.3%	0.2%	0.1%	0.0%	0.3%	0.0%	0.0%	0.7%	0.4%	0.5%	0.6%	0.2%	0.1%	0.2%	0.1%	0.1%	0.2%	0.3%	0.3%	0.5%
Insurance	0.5%	0.9%	1.0%	0.8%	0.9%	0.8%	0.4%	0.4%	0.7%	0.0%	0.6%	0.2%	0.1%	0.8%	0.6%	0.6%	0.6%	0.6%	0.6%	0.2%	0.3%	0.4%	0.7%	0.8%	0.9%	1.0%
Legal / Finance / Professional Fees	0.4%	0.0%	0.4%	0.1%	0.4%	0.4%	0.3%	1.9%	0.7%	0.0%	0.5%	0.3%	1.1%	1.1%	0.0%	0.5%	0.0%	0.3%	0.0%	0.3%	2.3%	0.0%	0.2%	0.4%	0.4%	0.4%
Marketing	0.0%	0.3%	0.3%	0.7%	0.2%	0.3%	1.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.3%	0.0%	0.2%	0.1%	0.0%	0.2%	0.0%	0.1%	1.7%	0.0%	0.2%	0.3%	0.5%	1.0%
Audit & Compliance	0.0%	0.0%	0.3%	1.2%	0.2%	0.0%	0.1%	0.1%	0.0%	0.0%	0.8%	0.1%	0.2%	0.0%	0.0%	1.1%	0.0%	0.5%	0.0%	0.3%	0.5%	0.0%	0.0%	0.1%	0.3%	1.2%
Uniforms & Other Consumables	0.3%	0.2%	0.1%	0.4%	0.1%	0.8%	0.2%	0.0%	0.2%	0.0%	0.5%	0.2%	0.1%	0.4%	0.3%	0.6%	0.0%	0.3%	0.3%	0.1%	0.1%	0.1%	0.1%	0.2%	0.3%	0.8%
Assistive Technology	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.4%
Central / Head Office Recharges	0.0%	8.1%	0.0%	0.0%	0.0%	0.0%	6.4%	0.0%	0.0%	0.0%	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	6.4%	0.0%	7.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%	8.1%
Additional Overhead #1	0.1%	0.1%	0.5%	0.2%	0.1%	0.0%	0.3%	0.0%	1.8%	0.0%	2.6%	0.0%	0.8%	2.3%	0.0%	0.9%	0.0%	0.1%	0.0%	0.0%	2.5%	0.0%	0.1%	0.1%	0.3%	0.5%
PPE	0.5%	0.0%	0.0%	0.2%	0.2%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.9%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%	0.5%
CQC Registration Fees(4)	0.3%	0.5%	0.5%	0.4%	0.5%	0.2%	0.4%	0.4%	0.4%	1.2%	0.6%	0.4%	0.3%	0.3%	0.5%	0.3%	0.4%	0.5%	0.3%	0.4%	0.3%	0.2%	0.3%	0.4%	0.5%	0.5%
Surplus / Profit Contribution	**8.6%**	**10.5%**	**9.1%**	**4.1%**	**11.1%**	**5.4%**	**4.8%**	**7.4%**	**13.1%**	**9.1%**	**10.4%**	**0.7%**	**16.7%**	**15.2%**	**8.4%**	**4.0%**	**4.8%**	**4.8%**	**4.8%**	**10.7%**	**16.7%**	**4.1%**	**5.1%**	**8.6%**	**9.8%**	**11.1%**
Total Cost Per Hour	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 7: respondent reference table

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