Sandwell MBC

Homecare Cost of Care Exercise 2022-23

Final

January 2023

ARCC-HR Ltd

Sandwell Metropolitan Borough Council

ARCC

Contents

1 Executive Summary

1.1 Context the Cost of Care Exercise

1.1.1 Fair Cost of Care & Market Sustainability

On the 16th December 2021 the Department of Health & Social Care (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 24th 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 for Sandwell Metropolitan Borough Council [Sandwell MBC] 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
- An approach to sensitivity analysis; based on costs being covered on a given volume of hours delivered by providers, in addition to whether costs change in relation to changes in volume
- 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 Sandwell

1.2 Provider Engagement

This review of cost of care has been informed by four months of engagement and data analysis work. A total of 82 providers within Sandwell were engaged for the exercise, which was later reduced to 47 providers in scope (for more detail see section 2.3.2). The engagement process comprised the following elements:

a) Provider survey and cost template: submitted to all providers within the homecare market, to gather data on both the costs and the operational experience of delivering homecare services in Sandwell

b) 1:1 deep-dive structured interviews: all providers were invited to express interest for a 1:1 session, with 10 interviews taking place with the senior Finance/ Operational leads for the respective organisations

c) Provider and commissioner workshops: following the launch session workshop, two further workshops were held with providers and commissioners in the market to maximise engagement

d) 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 provider costs:

- The current homecare market in Sandwell (structure, demand, and supply).
- Experience of commissioning and contracting with Sandwell MBC.
- Providers' business operating models, general market outlook, workforce, contract and quality monitoring, business costs, and future commissioning arrangements; and
- Deep dive with providers to understand operating costs and sensitivities that would impact cost.

After completion of the data collection, a total of 22 submissions had been received, 20 of these are considered in scope of the exercise. These 20 represent **43% of providers in the market,** and 71% of homecare hours commissioned by Sandwell MBC.

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 for the delivery of services which was reflective of 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 £20.49, which is a 28.06% increase on the current framework rate of £16.00. 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:	**£13.04**	**£13.51**	**£14.11**	**£15.15**	**£22.14**
Business costs:	**£3.29**	**£3.75**	**£4.48**	**£7.05**	**£11.37**
Surplus / Profit Contribution	**£0.63**	**£0.84**	**£0.89**	**£2.21**	**£3.58**
Total Cost Per Hour	**£17.54**	**£18.37**	**£20.49**	**£24.32**	**£35.06**

Table 1: *Lowest, Highest, Quartiles & Median*

The financial impact of this model is estimated to be £5,416,830 per annum on the basis of a £4.49 variance between the existing base rate and the median, multiplied by an estimated 1,206,421 hours of care required in the year, utilising historic annual volume of care commissioned by Sandwell MBC.

1.3.2 Scenario modelling

The above analysis represents analysis of cost of care submissions in what is currently a challenging market (see sections 3.3 and 3.4 commissioner and provider feedback).

DHSC guidance has requested the cost of care exercise consider cost differentials for 15, 30, 45 and 60-minute variations on the median cost per care hour. The key variation is the impact of standard travel time & mileage costs against a varying period of face-to-face care time allocated. We have identified below the respective variations. It should be noted that whilst DHSC required consideration for 15-minute visits, Sandwell MBC do not currently commission 15-minute visits. See section 4.5.3 for further details.

Discussions with key stakeholders regarding future market sustainability identified future commissioning scenarios which have subsequently been modelled utilising the median base cost established for 2022-23. Table 2 below identifies the three additional scenarios and the effective unit rates for care. See section 4.5 for further details.

Variants/Future Scenarios	Description	Unit Cost per care hour[1]
#1 Median Model	*Median model to facilitate scenarios 1a to 1d*	£20.47[2]
#1a 15-minute call duration	*Median cost adjusted to reflect av.15-minute call duration*	£24.57
#1b 30-minute call duration	*Median cost adjusted to reflect av.30-minute call duration*	£21.07
#1c 45-minute call duration	*Median cost adjusted to reflect av.45-minute call duration*	£19.90
#1d 60-minute call duration	*Median cost adjusted to reflect av.60-minute call duration*	£19.31
#2 Carer base pay at NHS Band 2 (+2 years' experience)	*Base carer pay set at £10.93p/h to reflect pay rates for an NHS Band 2 worker.*	£23.65
#3 Carer base pay at labour market average	*Base carer pay set at £13.00p/h to reflect local labour market average. See NOMIS profile*	£27.74

Table 2: Unit cost variants and scenario models

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 4.5.3 for further details
[2] This is the closest approximation of an operating model, utilising the cost model tool, hence the variance between the median of £20.49

1.3.3 Conclusions

The cost of care exercise was conducted during exceptionally challenging conditions for the sector nationally, not just in Sandwell. 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 consider how readily they are able to service their population's needs via existing contracting and pay mechanisms they have with the market, taking into account:

- The scale of customer waiting for and length of 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 £20.49, in the context of specific rates for care paid, 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 7.87% uplift, make adjustment (% 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 way is a primary indicator of how the market is performing. 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 alone, it is estimated that the Council would **require an additional £5,416,830 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 Recommendations summary

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

1. **Improved intelligence to support market management.** 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.
2. **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 cost for providers with minimal resource requirements from the local authority.
3. **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 £20.49, 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 7.87% uplift, make adjustment (% fee uplifts) to reflect changes to operating costs. It may also be prudent to continue to monitor rates based on the average visit lengths being commissioned in the market, as these have a consequential impact on paying travel time and other fixed costs (i.e., shorter visits).
4. **'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 for recruitment, e.g. schools and colleges.
5. **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 Sandwell homecare providers for their participation and openness in sharing data for the project. We are also grateful to West Midlands Care Association for helping with our engagement activities. Last but not least, we thank Sandwell MBC commissioning team for the opportunity to perform this work, their support and commitment throughout the project.

2 Project Overview

2.1 Policy Landscape

On 7th 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 financial support. A new £86,000 cap on the amount anyone in England will need to spend on their personal care over their lifetime is to be introduced, however the expected date of implementation has been delayed from the date originally intended. When introduced, it is anticipated that the charging reforms will 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 , 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 market. A final plan will be required in February 2023.

For the purpose of the policy, 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 the best value for the taxpayer*".[4]

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 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*

[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] See detailed guidance 24th March 2022.

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.'[5]

The cost of care exercise is an opportunity for Sandwell 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.

Sandwell – 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. Sandwell commissioners are attempting to meet these challenges of continuity and innovation within their commissioning strategies and this report represents a key step along 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"*[6].

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[7] and supported living. Whilst some community-based services were out of scope of this project, 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.

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 the Service Manager (Commissioning and Integration), Programme Manager, Operations Manager (Commissioning ASC), Better Care Fund Programme Manager, Principal Accountant, Older Adults Commissioner, PMO Manager, Operations Manager (Commissioning) and ARCC. This group met fortnightly to discuss progress, risks and mitigations

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

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 initially targeted to a cohort of 82 homecare providers, regardless of the contract type (whether a framework provider or having no contract with the council). This cohort was engaged with throughout the process. This cohort was later reduced to 47 providers through a screening process with commissioners; typical reasons included providers primarily delivering supported living which is out of scope or locations being dormant.

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 homecare services in Sandwell. 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 alternative returns such as the national homecare cost modelling toolkit[8] or alternative reports/accounts. In total 22 providers sent returns, of these 8 were the national toolkit and 14 were the dedicated cost survey. There was good representation from small, medium & large providers across various geographies (see section 3.1).

Some additional activities were also undertaken to maximise engagement opportunities with providers; these included:

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 took part in these.

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

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

- A closed (provider-only) *interim session at the end of the survey & 1:1 phase;* to feed back the results of the engagement to date; validate the aggregated cost data and agree the assumptions and scenarios for the cost model variants
- A further 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 & timeline via e-mail, and copies of workshop slides were distributed following each workshop[9]. Further requests for information/clarifications were conducted via e-mail and telephone, to provide further 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. of main activities is presented in figure 1.

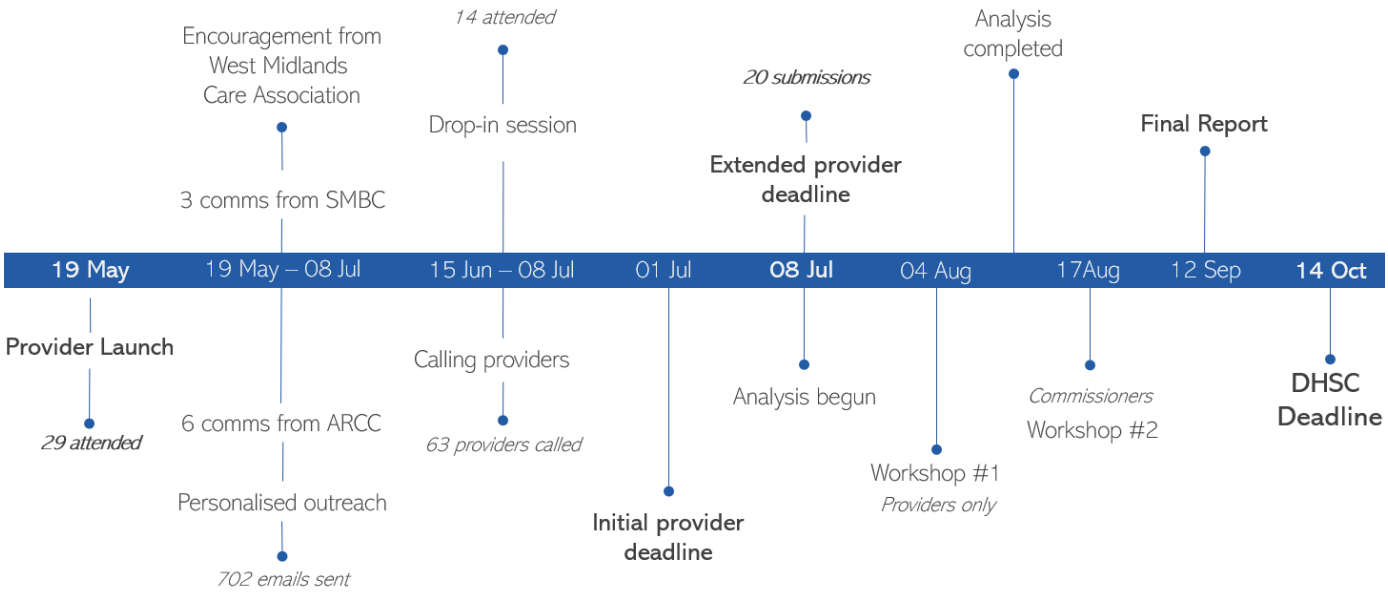


Figure 1: project timeline

Provider outreach

To give providers the best possible opportunity to engage with the exercise various forms of communication were utilised. Sandwell MBC invited all providers in the market to the initial launch session on the 19th May, which 29 attended. From this point onwards ARCC sent a total of 6x emails with additional information and support, including an invitation to a drop-in session/clinic to answer any queries providers may have had. The team 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 answer any questions they may have, e.g., regarding engagement process, confidentiality, or expected impact of the exercise. To further encourage engagement, the submission deadline was extended by one week from 01.07 to 08.07 as well as individual later

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

deadlines agreed with providers for supplementary information. No submissions were rejected because of late submission; the last submission was received on 15.07.

Upon completion of the data collection exercise, a total of 22 submissions had been received, 20 of these considered in scope. These represent 43% of providers in scope of the exercise, and 71% of hours commissioned by Sandwell MBC.

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.

The Homecare Market in Sandwell

This section details the size and scale of the current homecare market in Sandwell 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.

2.4 Demand and Supply

A total of 47 homecare providers in scope of the exercise operated in Sandwell at the commencement of the cost of care exercise. As of the week commencing September 5th 2022, Sandwell MBC commissioned 23,822 hours of care, representing a typical week in this year. This leads to an estimate of approximately 1,238,744 hours to be commissioned this financial year making the local authority the largest purchaser of domiciliary care. This is supported by the recent ONS estimates of self-funders in community services (May 2022)[10]; Sandwell is significantly below both the regional and national averages (table 3) for the number of self-funders. The reliance on the local authority as the primary purchaser will have a significant impact upon the structure of the market locally; this was echoed through provider engagement (see section 3.4).

Community Care [by location]	Self-funded service users (%)	LCL (self-funded)	UCL (self-funded)	State-funded service users (%)	LCL (state-funded)	UCL (state-funded)
Sandwell	16.5	10.0	23.0	83.5	77.0	90.0
West Midlands	23.8	19.4	28.2	76.2	71.8	80.6
England	26.4	24.4	28.3	73.6	71.7	75.6

Table 3: *ONS estimates of community self-funders (May 2022)*

Of the providers whom Sandwell MBC commission homecare from, as of May 2022 90% of the volume (20,447 hours) was commissioned from 18 providers (38% of providers in the market). Of the 47 providers in scope, Sandwell held active packages with 31 of these, commissioning on average 733 hours per provider, ranging between 10.5 and 4,399 hours of care per provider per week.

At the time of analysis, the council had 7 framework providers from whom they commissioned 11,906 hours (52.4%), they had 30 core providers from whom they commissioned 10,802.6 hours (47.5%) and held one package with a provider that was neither core nor framework, from whom they commissioned 10.5h (0.05%). In the 21-22 financial year a total of 1,983,668 visits were conducted, delivering a total of 1,206,421 hours of care at a cost of £18,022,924 (average of £14.90 per hour of care). These visits had an average duration of 36.5 minutes. As of the start of this financial year (2022-23) Sandwell has 1,534 service users for whom they commission care, at an average package size of 15.5 hours of care per week and an average visit duration of 36 minutes. This is distributed between 25% short-term care, and 75% long-term care packages. Assuming all hours

[10] Estimating the size of the self-funding population in the community, England: 2021 to 2022. Access here.

are commissioned at the current local authority rate, this will result in an estimated spend of £19.8 million this financial year.

Sandwell is experiencing an increase in demand for homecare, with an **estimated 2.7% increase in care hours commissioned between 21/22 and 22/23**. As can be seen in Figure 2 however, the number of service users is not expected to increase in this period based on extrapolation of the in-year numbers[11], which indicates that care hours per service user is increasing. This is in part caused by Sandwell MBC working towards keeping service users out of residential care for longer, which increases the complexity of care required.

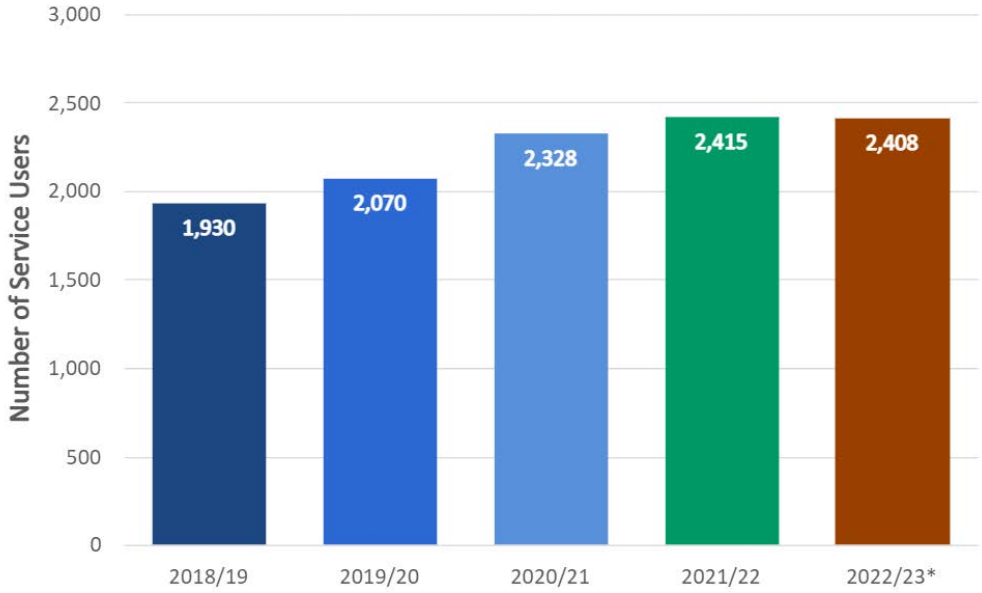


Figure 2: Total annual number of service users whom Sandwell MBC have commission short- or long-term homecare.

The market has seen a **slight decline in CQC quality ratings**. Whilst a majority of providers (see figure 3) are rated as "Good" (64%) the remainder are ranked as either "Requires Improvement" (21%), "Inadequate" (4%) or not yet assessed (11%). Based on historical data from the CQC website, of the providers who are currently assessed as "requires improvement" or "inadequate" (12 in total), 5 were previously rated higher than they are today.

Figure 3: Distribution of CQC ratings of all domiciliary care providers operating in Sandwell.

2.5 The Local Commissioning Framework

As of September, the total number of providers in the market has increased to 58 providers on the council's framework from 47 providers in scope in May, as the council are working towards increasing capacity in the market as some areas, particularly Rowley Regis and Cradley Heath, the council are overly reliant on a small

[11] As reporting year 2022/23 remains incomplete, this figure has been approximated based on 1,869 service users as of 5th September 2022.

number of providers. In the new commissioning system, all providers work across Sandwell, though in reality, a large number of providers focus on certain postcodes to minimise travel time and optimise care worker 'runs'. Sandwell MBC introduced a new commissioning system as of 1st September 2022, expanding tier 1 providers from 7 to 15[12], meaning that a smaller number of packages will be allocated to tier 2 providers, as they will only be offered packages not accepted by tier 1 providers. All tier 1 and 2 providers are receiving the council's standard rate. In the new system, the geographical zones shared between tier 1 providers are removed.

Framework providers commit to ensure that service is available 7.00-22.00, 7 days per week, 52 weeks per year, including bank holidays, and they may be expected to deliver services outside these hours as well, in certain instances. Geographical coverage is expected of the six towns of Sandwell (Oldbury, Smethwick, Tipton, Rowley, West Bromwich, and Wednesbury). While there are no regional allocations, it is assumed that providers will be operating locally and concentrate their attention to manage costs on travel.

All referrals for non-specialist homecare will be brokered via the e-brokerage system. However, in cases that require short-term, fast response in order to support a service user to safely leave the hospital or avoid hospital admission, they may refer cases directly to providers with packages between 24 hours and 6 weeks. Providers will receive a one-off payment of £25 assessment fee where providers complete assessment and commence service within 24 hours, and a one-off payment of £50 assessment fee where providers respond within one hour and complete assessment and commence service within three hours.

The current fee rates paid to providers is £16 per hour, which is a 7.87% uplift on the rate of £15.16 (prior to April 2022), which was informed by the change to national minimum wage as well as the increased National Insurance contribution. The rate is prorated in 15min intervals for visits that are shorter or longer than 60 minutes.

As of May 2022, under previous contracting arrangements, 65% of providers received this framework rate, with 35% of providers being paid below the framework rate on at least some of their packages. Only specific packages, based on complexity, are commissioned above this rate. As mentioned above, all providers from 1st September 2022 are now paid a uniform rate for non specialist domiciliary care.

Providers are paid on planned time as per the service user specific care plans and invoice once a month on 30-day payment terms. When a client is hospitalised, the package is paused immediately, however, should a care worker show up at the day of hospitalisation having not been informed, the provider will still be compensated for the visit. It is up to providers to decide whether they keep the package open during hospitalisation, however, they receive no compensation for this.

Sandwell MBC operates an in-house Short-Term Assessment and Reablement Service [STAR]. This has been used to pick up some domiciliary care packages where there is an urgent need. However, the primary focus of STAR is short-term reablement.

2.6 Internal Stakeholder Feedback

Throughout the project ARCC interviewed a number of internal stakeholders, as well a representative from the West Midlands Care Association, to develop an accurate picture of the current state of the homecare market within Sandwell. Conversations were held with an ASC Finance lead, Service Manager (Hospital Discharge),

[12] At time of writing this report only 14 have been appointed.

Interim Assistant Director (Assessment and Care Management), Operations Manager (Commissioning ASC) Commissioning Manager (Domiciliary and Residential Care), and the CEO at West Midlands Care Association. Here we summarise relevant comments and observations arising from our engagement with stakeholders as well as from a desktop review of contract documentation.

Recruitment and retention: many of the internal stakeholders reflected on the challenges which providers are currently facing when it comes to recruitment and retention of care staff. Although providers have received workforce recruitment and retention grants, these have now ended, and wider labour market shortages are resulting in staff leaving the sector for more attractive pay, terms and conditions. The council has supported providers by organising recruitment events, however, it remains a concern that fewer people are choosing social care as a career path. It was recognised that further work is required to understand what is contributing to this issue, but initial feedback suggests pay, terms and conditions, a lack of career progression and burn out are significant contributing factors.

Capacity: commissioners have commented on the challenges of allocating packages due to limited capacity among providers, as a result of the above. The changes to the framework structure are intended to reduce the impact of this, by expanding the list of tier 1 providers. However, some concern remains on whether there are enough tier 2 providers to cover the packages which tier 1 providers do not accept. During the beginning of 2022 there was a particularly high pressure on the industry due to care staff on sick leave with Covid-19. At this time, the council introduced time windows for visits, e.g., 3-hour windows for breakfast visits. This gives the providers more flexibility in delivering care. Furthermore, given the aging population across the UK, it is expected that demand will continue to increase, especially as the strategic direction of travel is to support people in their own homes for longer; therefore, stable capacity within the market is essential.

Increased costs: current increases in both fuel costs and cost of living are putting increasing pressures on the homecare market, providers and employees alike. Commissioners reflected on packages being handed back due to fuel costs being too high. Furthermore, the current rate of inflation and increases in the cost of living raises the question of sustainable pay to care workers. It is expected that national minimum wage may increase significantly again in the next financial year, which will have a direct impact on provider costs and subsequently needs to be reflected in future local authority pay rates. Some council stakeholders have concerns that providers may pull out of the new framework contracts due to the rate being insufficient to remain profitable, as one tier 1 provider has already withdrawn from the new contract.

2.7 Provider Feedback

2.7.1 Qualitative Insight

As section 1.2 alludes to, the approach to engagement was varied to support maximum engagement. 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.

3.4.1.1 Business Outlook and Growth

Due to the recent changes in the local authority's commissioning framework, the number of framework providers has increased from September 2022. Therefore, a number of the providers who were engaged in the exercise were at the time in the process of increasing their capacity in terms of care and back-office staff, in

order to be able to deliver increased volume of care from September. These providers generally discussed their business growth from increased numbers of local authority packages due to the relatively low numbers of self-funders. Providers reported that this strategy requires a focus on large volumes to address the smaller profit margin on each package.

Many providers highlighted the difficulty in securing self-funder clients and therefore rely on the local authority packages, even if they do not consider the rate of compensation sustainable. Only two providers shared that they focus exclusively on self-funder clients, where they are able to charge rates that they find more appropriate for delivering care.

Of the 13 providers reporting on which local authorities they work with, only two providers take contracts exclusively in Sandwell. The remaining 11 work with a number of different local authorities, including Birmingham, Dudley, Coventry, Wednesbury, and Walsall. In many cases, fees from self-funders, NHS contracts, and packages from other local authorities are reported to help offset the lower rates received from Sandwell MBC. Similarly, providers often operate multiple services alongside homecare. Examples of these include live-in care, supported living, and a 65+ day centre. Several providers mentioned that they are able to fund the deficit in their accounts caused by their homecare operation from other arms of the organisations, and that as of now, homecare is not sustainable as a stand-alone service. These providers also mentioned that they can draw in care staff from other services they provide, to create a reliable contingency plan for changes to volume or workforce, which reduces reliance on using agencies in case of emergency. Other providers who currently only provide homecare, are currently considering expanding to other types of care in order to increase profitability.

There are several charitable organisations providing homecare in Sandwell. Of the 19 submissions three of these were from registered charities. These providers highlighted that they have more flexibility in operation as they are not accountable to shareholders and receive some funding from donations; although the need to generate an operating surplus to reinvest in the service has been significantly impaired over recent years.

Sandwell MBC has a unique variety of providers in their market due to differences in provider sizes, organisation types (business or charity), range of different services, and contract types (local authority tier 1, tier 2, or self-funders only). This highlights the differences in the experiences among providers due to the diverse operating models.

3.4.1.2 Workforce

The main concern for providers regarding fulfilling capacity of homecare (and business growth) 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 2021, with new hire rates falling as a result.

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 or more money. Similarly, staff are still required to isolate when symptomatic or positive but workforce grants to support people with full pay (SSP is common in the sector) have been removed.
- 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. Providers are generally receiving fewer applications from staff who can drive.
- Overall 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.
- Seasonal demands of the workforce (particularly retail services during the Christmas season and hospitality during summer months)
- It was also mentioned by several providers that they are worried that the new council run short-term residential unit, Harvest View, can provide care staff conditions which providers cannot compete with.

From conversations with providers all reported challenges with recruiting enough staff. It 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 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. Anecdotally, providers reported cost impact of £350 per worker who leaves within the first few months.

Some providers did report that though they are having challenges with recruiting new staff, they are experiencing good retention rates for staff who stay past the probation period. Of the three providers who reported good retention rates, there are no significant differences from the other providers featured in the analysis in terms of pay rates or contract type.

Although a key feature of past recruitment strategies, the increase in fuel costs has exacerbated the focus on targeting recruitment in close proximity to service users. This also leads to several providers only taking packages that are within reasonable travel distance of other active packages, as a result of this strategy it is possible that more affluent areas of the borough may have greater difficulty servicing packages. Some providers reported between 3.5 and 5 minutes as the maximum travel time they would accept. This is particularly the case for providers who pay for travel time outside of the hourly rate, or, who have a large workforce of walkers and was not a common observation for those tier 1 framework providers. The providers who were previously on the framework or who joined the framework in September seemed less concerned with travel distance and they shared that they are willing to accept packages across the council.

3.4.1.3 Working with Sandwell

Providers in Sandwell generally reported very positive relationships with officers within the local authority. Figure 4 summarises 13 providers' responses to statements regarding their engagement with the council, for

most of which there were more positive responses than negative. Providers feel particularly strongly that they understand the pressures the commissioners are currently facing, and that they have good relationships. On the other hand, some providers find that commissioners could do more to help develop the local market, and that the commissioners do not fully understand the challenges which the providers are facing. In relation to the latter, the benefit of a cost of care exercise is the increased understanding of both financial and operational challenges.

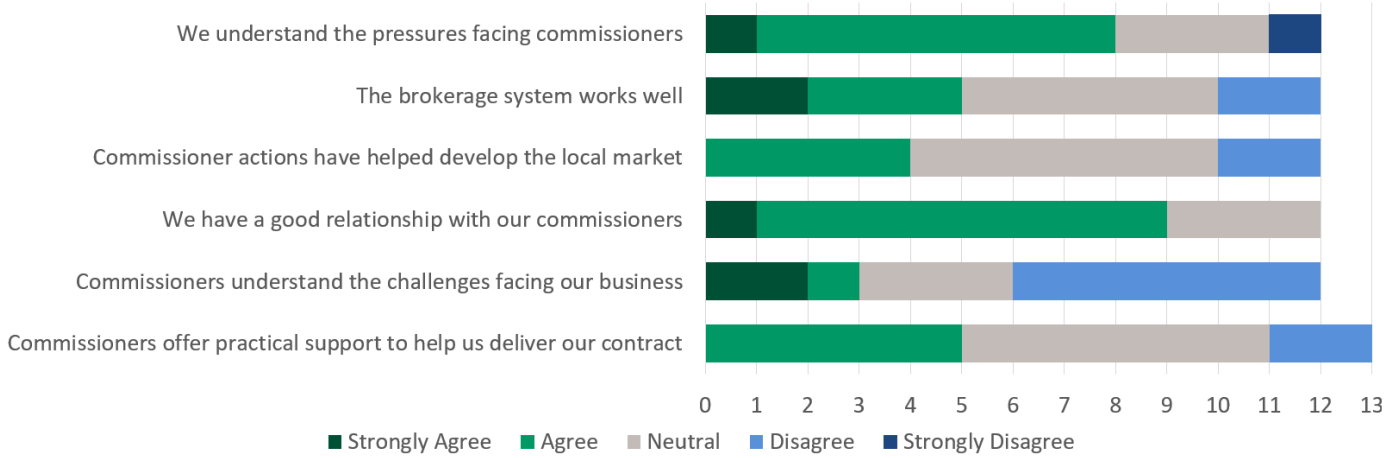
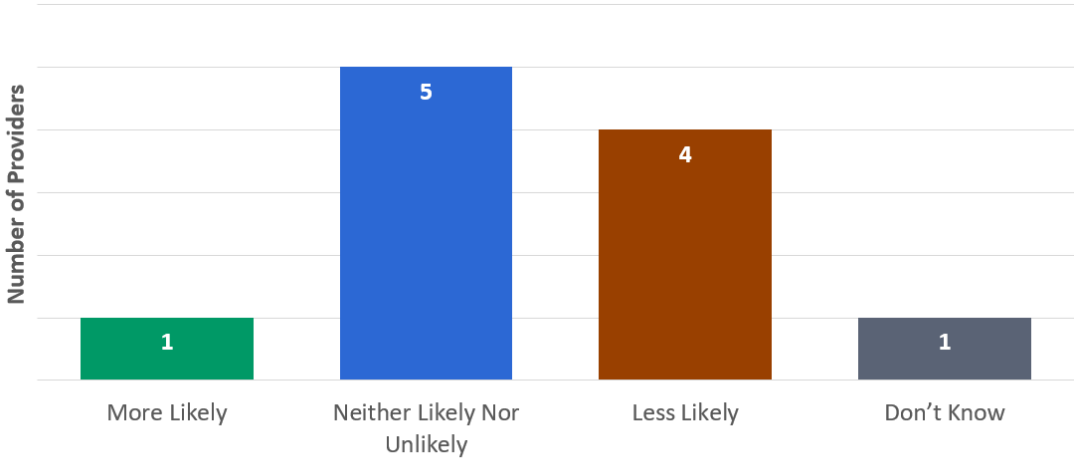


Figure 4: Providers' responses to six different questions concerning their opinion on working with Sandwell MBC.

The issue of cash flow and speed in which providers are paid was raised on several occasions. When abnormalities appear in invoices it can take the council a long time to address these, and thus hold up the process of payment (3-6 months was common, although one example of 18 months was given). Examples, of the issues included:

- processing of the package post service commencement;
- changes in the needs of service users which is communicated to the social worker and agreed but the necessary paperwork is not put in place; and
- if the service user has an accident and must wait for an ambulance. Within shorter extensions of 15-20 minutes, providers believe the council expects providers to absorb the additional time, however, some providers mentioned examples such as 4-8 hour waits for ambulances which they have to compensate care staff for, and later struggle with getting the council to pay.

Maintaining cashflow within a business to pay workers is fundamental and any delays can result in providers incurring costs for servicing the debt, e.g., invoice factoring or bank over drafts – in some extreme cases this can take 3% off the turnover which has a significant difference on the bottom line.



As can be seen in Figure 5, providers responded to a question regarding how likely they would be to set up their business in Sandwell now in comparison to 3 years ago. The responses, based on 11 providers, shows that a majority of providers reported that they would be less likely (or neutral) to set up in Sandwell today. It is important to note that this may be a reflection of the challenges in the sector as a whole and not just limited to Sandwell as a locality. Similarly, Figure 6 (how providers find working with Sandwell MBC in comparison to other councils they supply), indicates that provider preference is neutral or towards other local authorities. The current fee rate (in comparison to neighbouring local authorities) coupled with the increasing cost of living and fuel costs are reported to be major factors driving this response. As previously discussed, most providers are taking local authority packages from different councils, and thus can directly compare their operations.

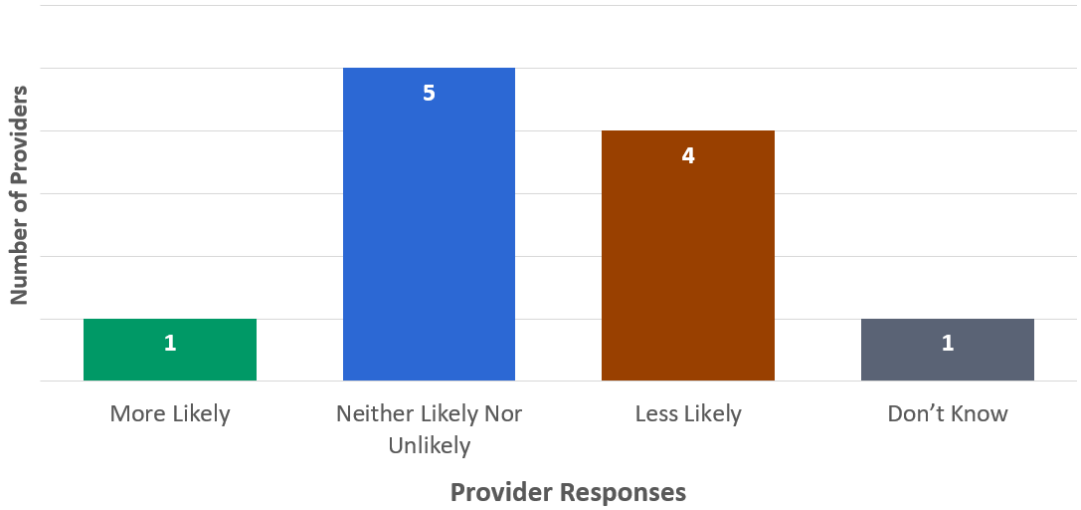


Figure 5: Providers responses to the question "How likely would you be to set up your business in this geographical area now compared with 3 years ago?".

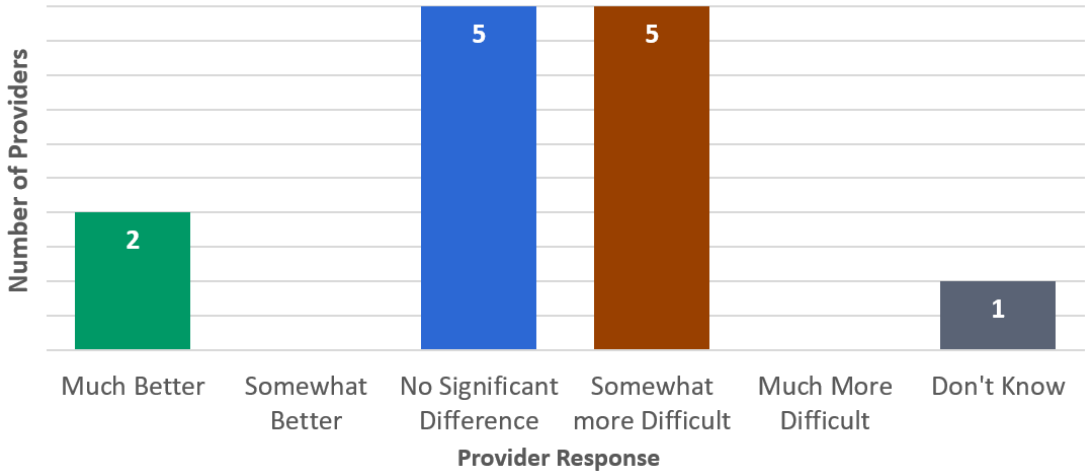


Figure 6: Providers responses to the question "How would you compare working with this Local Authority compared to others whom you supply?".

3.4.1.4 Business Costs

As across the rest of the UK, Sandwell providers are experiencing significant cost increases in areas such as fuel, utilities, insurance and workforce. Of 19 submissions to our cost survey, 4 providers reported a loss in the last financial year. Several other providers reported that their homecare business is being funded by other business streams, or, that rates from other authorities and the limited number of self-funders are what generates profit.

To a certain extent the domiciliary care 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.

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' 7.87% fee uplift. However, additional cost burdens such as fuel and competition for staff are also having to be met within this cost envelope. Indeed, most providers engaged have either increased their mileage cost since last year or are looking to increase it in the near future. Some providers reported handing back packages which are at a distance that are failing too break-even. Similarly, as care staff typically receive minimum wage or slightly higher, providers are having to spend more money recruiting or trying to retain staff. 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.

Some providers reported challenges with getting the local authority to review active care packages. Providers generally viewed support plans produced by the council to be informative, however, all providers will perform their own care assessment that often are not fully consistent with the council's reports. Some providers are asking to be compensated to perform assessments as this is a none recoverable cost.

2.7.2 Business Challenges

Through submissions, workshops, and conversations with providers, a great number of business challenges have been shared. Most frequently mentioned, were **recruitment**, **retention** and **increased costs** coupled with low

local authority rates for reasons alluded to above. Besides these major challenges above, providers shared a number of other challenges. These include:

- Cashflow: delays in payments can lead to increase cost to service the business.
- Brexit: the requirement for EU workers to have work visas when working in the UK has significantly reduced the number of overseas workers and the few providers who have considered sponsoring work visas are facing significant financial barriers that makes it, in many cases, financially unsustainable to rely on EU workers that do not have pre-existing visas or Settled Status.
- Training costs: increased staff turnover and new training requirements due to increased acuity in the care needs of people (as people stay at home for longer) is increasing the business cost which is unrecoverable outside of the care hour delivered.
- Limited self-funder market: low (est. 16.5%; see table 3) self-funder numbers provide less opportunity for the market to have rate differentials, i.e., there are a fewer funding streams in the local market to offset cost pressures.
- End of grants and free PPE: providers were concerned that the withdrawal by the government will have significant financial impact, 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.

2.7.3 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 focussed on parity with comparable roles such as NHS Band 2 workers (hence scenario model 1 has been created). Since providers are paid only for care time, with little or no guaranteed hours, most argue that they cannot improve care staff contracts as is it was stated that the terms staff are engaged on are a mirror of the way services are contracted, i.e., no guarantee of volume or income. During one-to-one conversations, providers were asked what they believe would be a sustainable hourly rate for the council to pay. Responses ranged from £18 to £25 with all except one response being £20 or above. Almost all providers either said that this is what it would cost to be sustainable as a business with their current costs, or, that the increased rates would primarily go to better pay and conditions for care staff.
- 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, and providers banding together to be able to reduce back-office and overhead expenses.
- 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, however, for reasons cited earlier in the report, very few people are tempted to enter this field.

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 for them to make. Here, responses ranged from 10% to 17%, with one large, national provider reporting 5% - 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 remaining providers struggle with making a profit on calls which require pay rate enhancements. Providers suggested increase payment for care delivered on bank holidays, to be able to reward care staff for spending this time away from home without making a loss.
- 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.

3 Cost Analysis and Scenario Modelling

3.1 Provider Cost Information & Data Quality

Following the 4-month period of engagement with providers and commissioners from May 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, 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. Where no percentage uplifts were shared by the provider, a standard 8.2% uplift was applied in line with CPI.
- 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 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
- 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 22 submissions, 3 were excluded from the final analysis. One was excluded due to exclusively providing non-CQC regulated care, one exclusively provided supported living which was out of scope of the exercise, and one stated 90% supported living and only 10% homecare and were unable to break down their costs specifically for homecare. The last of these providers is however included in the commentary on providers experience in the market, as they took part in a one-to-one interview to discuss their homecare operation.

Queries were raised with each of the 19 providers utilised for the analysis, of which 14 submitted additional data or took part in virtual meetings to discuss their return. The remaining 5 submissions where no response was received, were deemed to be of a sufficient standard or 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.

3.2 Business Operating Model Observations

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

3.2.1 Volume

The providers who submitted their cost data reported an **average of 1,339 hours of care** and an average of 2,761 visits per week. Average hours per service user per week was 13.8 hours (range of 6.8 and 25.4 hours). Care Schedulers/Care Coordinators manage on average 670.3 hours per week, ranging between 303.2 and 1,151.5 hours.

3.2.2 Carer Pay Rates

Care staff are typically paid at a standard hourly rate Monday to Friday, depending on seniority, often with uplifts on weekends and bank holidays. Some providers have an additional uplift for Christmas and New Year's days. Base hourly rates for carers range from **£9.50 - £10.50 per hour**, the average being £9.79. The senior carer pay rates range from £9.86 to £13.00, with an average of £10.60. All except four providers pay an increased rate for bank holidays with pay ranging from £9.50 - £20.60 per hour, the average being £14.32.

Of the 19 providers, 11 roll travel costs into the hourly rate and pay a top-up at the end of the month should it be necessary. The remaining 8 pay for travel time separately.

The average weekly paid hours for care workers from the data set was **28.75 hours per week**, with a range from 19 to 41.6 hours.

3.2.3 Mileage and Travel

The majority of providers in Sandwell roll payment for travel time into the hourly rate and pay monthly top-ups when required; 8 providers reported that they pay for travel time separately from the hourly rate. All except three providers pay for mileage; of the three, one does not pay mileage (but does pay travel time), and two providers pay a higher hourly rate for drivers, respectively 35p and 50p above normal rate. Where mileage is paid this ranges between **15p and 50p per mile**, with an average of 0.32p 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.

Of the 13 providers who shared information regarding travel compensation for walkers (an average of 31.5% of staff are walkers, ranging between 5.4% and 61.11%), four 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, two providers have company drivers to transport walkers, two pay expenses for buses, two pay for taxis out of hours, and one pays a flat rate of £20 per month.

3.2.4 Training and Supervision

All providers reported paying for training and supervision except one. Of the 11 providers sharing this information, 9 pay induction and refresher training at carers' base rate, 1 does not pay for induction (but for refresher training at base rate) and 1 does not pay for the induction but pays for shadowing. Providers reported on **average 7 annual full-time training and supervision days**, ranging between 3 and 15 days a year.

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. 3 providers stated they do not offer any specialist training. One provider offers higher levels of NVQ qualifications up to level 5.

3.2.5 Holiday, Sick Pay, Terms and Conditions

All providers reported that their staff receive 28 days holiday, there were no exceptions to this.

In line with the prevailing industry practice, providers operate the statutory sick pay scheme [SSP], with the exception of one that initially uses occupational sickness pay [OSP] for the first 5 days, then followed by SSP. One other provider offers OSP for different levels of staff such as call schedulers, alongside SSP for some staff to have the ability to choose. Only four providers were able to share their historical number of sick days for the past financial year. They reported respectively 595 days (27 days per staff), 304 days (8.4 days per staff), 120 days (3.75 per staff), and 29 days (unknown headcount). 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 11 providers who submitted data on contract arrangements, all providers offer zero-hour contracts, 6 of these also offer guaranteed hours contracts [GHC]. An average 67.4% of staff are on zero-hour contracts and 32.6% on GHC across the providers surveyed. A summary of the distribution of contract types can be seen in Figure 7 below.

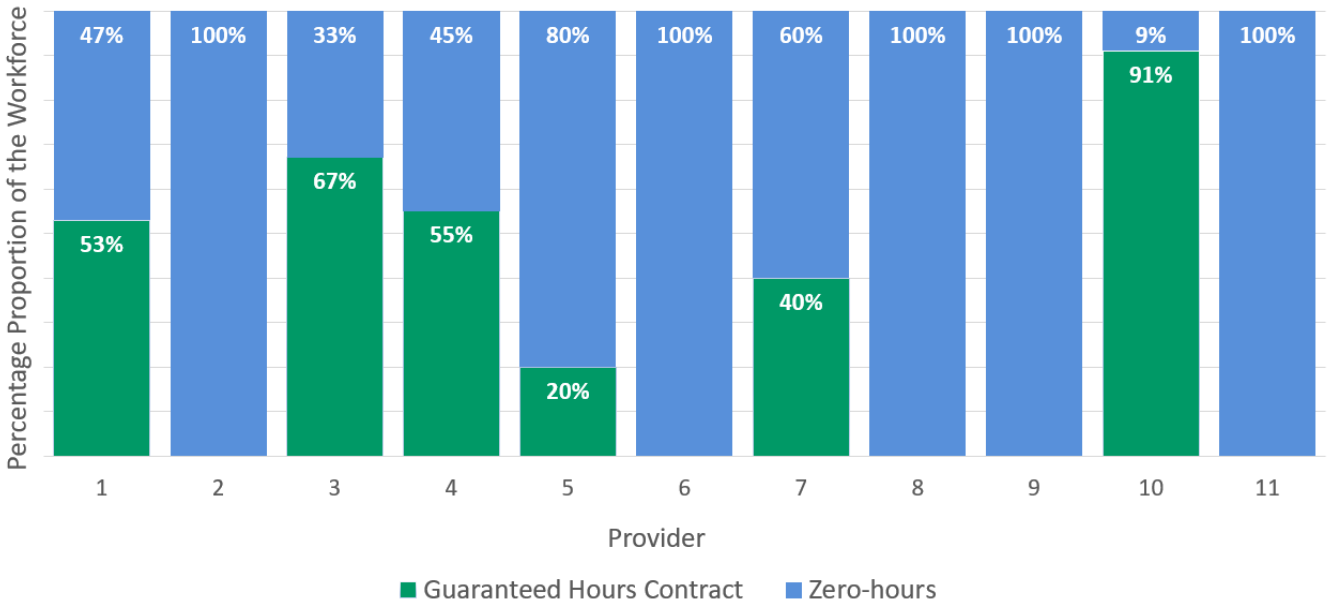


Figure 7: Proportion of zero-hour contracts vs. GHC from 11 providers' submitted data.

3.2.6 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, especially as Sandwell has a mix of these models. 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: ARCC has observed increased interest in the franchisee model nationally and we believe this is a growing market in homecare. Franchise models tend to operate predominantly in the independent (self-funder) market as fees tend to be higher than average; however, the prevalence of this model locally may be limited locally due to the lower than average number of self-funders. The model benefits from being able to start up quickly and come with a variety of standardised tools, such as:

  a) standardised suite of policies and operating procedures
  b) brand value that supports competitive growth in the independent market
  c) access to commercial advice and guidance
  d) access to operating infrastructure, e.g. training courses, IT and Electronic Care Monitoring (ECM).

  The "business-in-a-box" 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. Franchisees have reported particular concern with the current framework rate in Sandwell, as they have to factor in this reduction in revenue, adding further pressure to an already narrow profit margin.

- Ltd/single owner-operator business: A smaller homecare business that operates one or a few settings 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.

- 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. Several charitable organisations are operating in the Sandwell homecare market, most of these report that other business streams are currently funding their homecare operation.

3.3 Median Analysis of Provider Cost Data

Analysis of the provider cost information submitted by Sandwell providers, including the range, upper/lower quartile and median has been presented in Table 4. Generally speaking, "medians" can only be applied on one set of numbers at a time (i.e. each individual cost line), as such, the median of each cost line will not add up to

any single identifiable provider. Reference data tables (presented as % of costs in each cost line against the total average unit rate for the provider, to preserve anonymity) are included in Appendix C.

All Providers	LOW	25%	MEDIAN	75%	HIGH
Hourly Breakdown	Cost £				
Care worker costs:	**£13.04**	**£13.51**	**£14.11**	**£15.15**	**£22.14**
Direct Care	£9.55	£9.77	£9.89	£10.24	£10.93
Travel Time	£0.00	£0.00	£0.00	£0.53	£4.31
Mileage	£0.00	£0.16	£0.35	£0.77	£2.67
PPE	£0.00	£0.00	£0.07	£0.33	£1.46
Training (staff time)	£0.12	£0.22	£0.25	£0.31	£0.77
Holiday	£1.23	£1.27	£1.29	£1.41	£1.92
Additional Non-Contact Pay Costs	£0.00	£0.00	£0.00	£0.28	£1.65
Sickness/Maternity & Paternity Pay	£0.00	£0.18	£0.28	£0.37	£1.57
Notice/Suspension Pay	£0.00	£0.00	£0.00	£0.02	£0.25
NI (direct care hours)	£0.11	£0.67	£0.78	£0.85	£1.18
Pension (direct care hours)	£0.00	£0.24	£0.32	£0.35	£0.54
Business costs:	**£3.29**	**£3.75**	**£4.48**	**£7.05**	**£11.37**
Back Office Staff	£1.03	£2.05	£2.81	£3.94	£8.74
Travel Costs (parking/vehicle lease etc.)	£0.00	£0.00	£0.00	£0.00	£0.12
Rent / Rates / Utilities	£0.03	£0.14	£0.22	£0.51	£1.10
Recruitment / DBS	£0.00	£0.02	£0.12	£0.14	£0.96
Training (3rd party)	£0.00	£0.00	£0.05	£0.09	£1.20
IT (Hardware, Software CRM, ECM)	£0.00	£0.13	£0.25	£0.47	£0.86
Telephony	£0.02	£0.05	£0.09	£0.15	£1.61
Stationery / Postage	£0.00	£0.02	£0.05	£0.06	£0.51
Insurance	£0.00	£0.06	£0.09	£0.17	£0.35
Legal / Finance / Professional Fees	£0.00	£0.01	£0.03	£0.10	£0.31
Marketing	£0.00	£0.00	£0.03	£0.06	£0.72
Audit & Compliance	£0.00	£0.00	£0.00	£0.07	£0.35
Uniforms & Other Consumables	£0.00	£0.03	£0.09	£0.14	£0.73
Assistive Technology	£0.00	£0.00	£0.00	£0.00	£0.07
Central / Head Office Recharges	£0.00	£0.00	£0.00	£0.35	£1.77
Additional Overheads (Total)	£0.00	£0.00	£0.01	£0.05	£0.27
PPE	£0.00	£0.00	£0.00	£0.02	£0.52
CQC Registration Fees	£0.05	£0.07	£0.08	£0.10	£0.32
Surplus / Profit Contribution	**£0.63**	**£0.84**	**£0.89**	**£2.21**	**£3.58**
Total Cost Per Hour	**£17.54**	**£18.37**	**£20.49**	**£24.32**	**£35.06**

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 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 **58.4 hours and 464.3 hours** of care per week per FTE back-office staff member, showing the great difference in back-office size. Another point of difference is the head-office recharge; for some providers, particularly franchisees and branches of larger national organisations, this is a significant cost point. Finally, we saw significant variations in "Additional Overhead" costs, this again shows

how business operating models differ, and typical cost points entered include bank charges, training equipment, equipment hire, vehicle lease, and HR/health & safety consultants.

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, this has also been applied to providers who stated that they made a loss in 2021-22

3.3.1 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).

3.4 Factors that affect the median cost of care

It should be noted that the median cost of care 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 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 however 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 looks higher than expected. 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 announcements 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.

3.5 Scenario Modelling

In addition to presenting current costs back to the market; stakeholders were asked to consider what elements in the cost model might change in the future to support better market sustainability. Potential scenarios and variations were discussed with providers at the workshop held on the 4th August 2022 and also the

commissioner workshop held on the 17th August 2022. For the purposes of this report, the following scenarios have been modelled:

- Scenario #1 "median model" provider at unit cost of £20.49, 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 carer pay rate parity with NHS Band 2: carer pay rate commensurate with NHS Band 2 (assuming a base rate of £10.93) and instances of travel etc. should be paid equivalent to the face-to-face hourly rate (i.e., does not revert to NMW unless this is the rate for 'contact' time).
- Scenario #3a-d carer pay rate comparable with local median pay rates: as per scenario 1; however, carer pay rate adjusted to reflect local labour market average (assuming £13.00[13])

3.5.1 Underlying Assumptions for the Cost Modelling

Typically, cost of care analyses uses the starting point of an hourly 'rate' of care, and then breaks 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[14] was to create a bottom-up model, which utilises annualised costs and volumes of care delivery for the '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. For the purposes of scenario modelling, we have created a 'typical' business utilising the median cost and size (volume of care hours delivered).

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

Figure 8: underlying assumptions to the modelling of costs

Whilst variances in relation to the volume of hours an individual provider or branch may deliver was not explicitly covered in the scenarios, the 'median' 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 median branch model is a small-medium provider (c.58,796 hours p/annum; c.1,131 hrs per week)
- The median weighted average visit duration of c. 36.1 minutes

[13] *See NOMIS profile*
[14] For further information regarding ARCC's cost of care toolkit and methodology visit: https://www.costofcaretoolkit.co.uk/

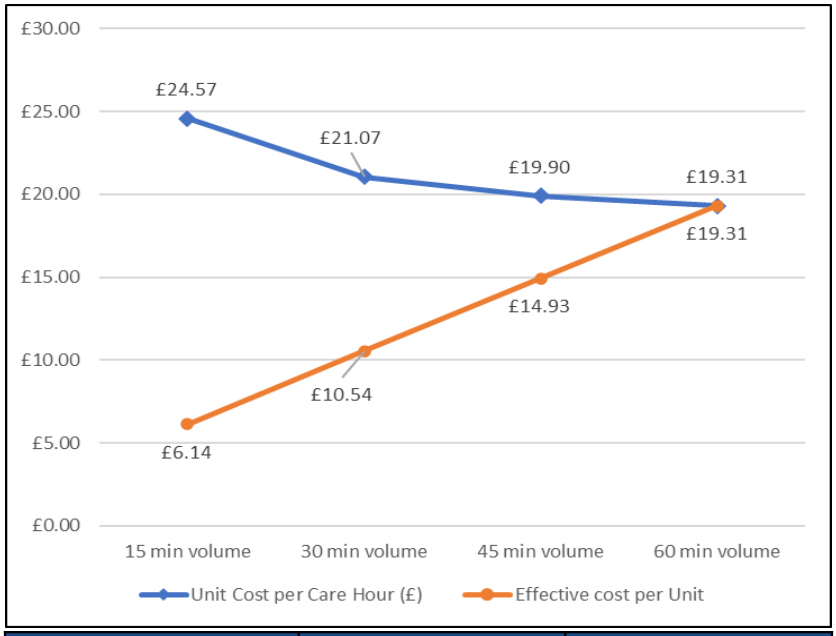
- Profit mark-up is set at **5.2%**
- All hours (including non-contact hours) are paid at the same rate as F2F hours
- Assumes 90% of staff on 3% pension
- Annual leave calculated at 12.07% and sickness is paid at SSP
- Does not include billed hours which accrue less than full cost i.e., hospital payments

3.5.2 Scenario #1 median "model provider"

The median "model provider" (£20.47[15]) has been informed by the median cost lines in Table 4. 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.

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

Different call durations have a direct bearing on the hourly rate paid – the median is based on the average visit call duration of 36.1 minutes. However, variants on this can then be modelled using the same volume of hours as travel time and mileage pay is the **same per visit, not per hour**. An 'hour of care' made up of shorter calls, e.g., 4x 15 minutes, will incur more transactional costs in the form of travel time and mileage pay as well as accruing more holiday pay and employer's NI, further impacting unit costs. Figure 9, identifies the unit rate modelled to reflect a range of visit lengths and correlation between the unit cost and different call lengths.



Effective Volume by avg. call time	Unit Cost per Care Hour (£) weighted by call volume	Effective cost per Unit/Visit
15 min volume	£24.57	£6.14
30 min volume	£21.07	£10.54
45 min volume	£19.90	£14.93
60 min volume	£19.31	£19.31

Figure 9: comparison of call lengths vs. unit cost

3.5.4 Scenario #2 carer pay rate parity with NHS Band

Scenario 2 represents an increase to the carers basic pay to bring this in line with NHS Band 2 workers at £10.93 (+2 years' experience), the model remains reflective of the median position and the above underlying assumptions with the following notable differences:

[15] This is the closest approximation of an operating model, utilising the cost model tool.

- Short notice pay enhancements are added at £1 per hour to the base rate for 5% of all calls
- Weekends have a 25% enhancement applied to the base rate (depending on the level of staff)
- Bank Holidays have a 50% enhancement applied to the base rate (depending on level of staff)
- Team Leaders hourly rate is inflated £1.50 p/h above the carer pay to maintain a competitive pay structure

The estimated unit cost of this scenario would be **£23.65 p/h** (see table 5), which represents a further 15.6% increase on the median of £20.49 p/h.

3.5.5 Scenario #3 carer pay rate comparable with local median pay rates

Scenario 3 represents an increase to the carers basic pay to bring this in line with the local median hourly rate identified in ONS labour market statistics[16] which stands at £13.00 p/h., the model remains reflective of the median position and the above underlying and scenario 2 assumptions.

As table 5 demonstrates, the estimated unit cost of this scenario would be **£27.74 p/h**, which represents a further 35.3% increase on the median of £20.49 p/h.

Scenario 2 Model			Median Base Model		
Volume of Care Hours (Units) per annum		58,796	Cost for	Variance	%
Hourly Breakdown	Cost £	%	Comparis	to Model	
Direct Care	£11.88	50.2%	£9.89	£1.99	48.3%
Travel Time	£1.98	8.4%	£1.65	£0.33	8.0%
Mileage	£0.46	1.9%	£0.46	£0.00	2.2%
PPE	£0.08	0.4%	£0.08	£0.00	0.4%
Training (staff time)	£0.28	1.2%	£0.25	£0.03	1.2%
Holiday	£1.61	6.8%	£1.46	£0.15	7.1%
Additional Non-Contact Pay Costs	£0.00	0.0%	£0.00	£0.00	0.0%
Sickness/Maternity & Paternity Pay	£0.36	1.5%	£0.32	£0.03	1.6%
Notice/Suspension Pay	£0.00	0.0%	£0.00	£0.00	0.0%
NI (direct care hours)	£1.35	5.7%	£0.97	£0.38	4.7%
Pension (direct care hours)	£0.43	1.8%	£0.37	£0.07	1.8%
Back Office Staff	£2.93	12.4%	£2.89	£0.04	14.1%
Travel Costs (parking/vehicle lease e	£0.00	0.0%	£0.00	£0.00	0.0%
Rent / Rates / Utilities	£0.22	0.9%	£0.22	£0.00	1.1%
Recruitment / DBS	£0.12	0.5%	£0.12	£0.00	0.6%
Training (3rd party)	£0.05	0.2%	£0.05	£0.00	0.2%
IT (Hardware, Software CRM, ECM)	£0.25	1.1%	£0.25	£0.00	1.2%
Telephony	£0.09	0.4%	£0.09	£0.00	0.4%
Stationery / Postage	£0.05	0.2%	£0.05	£0.00	0.2%
Insurance	£0.09	0.4%	£0.09	£0.00	0.4%
Legal / Finance / Professional Fees	£0.03	0.1%	£0.03	£0.00	0.2%
Marketing	£0.03	0.1%	£0.03	£0.00	0.1%
Audit & Compliance	£0.00	0.0%	£0.00	£0.00	0.0%
Uniforms & Other Consumables	£0.09	0.4%	£0.09	£0.00	0.4%
Assistive Technology	£0.00	0.0%	£0.00	£0.00	0.0%
Central / Head Office Recharges	£0.00	0.0%	£0.00	£0.00	0.0%
Other	£0.01	0.1%	£0.01	£0.00	0.1%
CQC Registration Fees	£0.09	0.4%	£0.09	£0.00	0.4%
Surplus / Profit Contribution	**£1.17**	**4.9%**	£1.01	£0.16	4.9%
Total Cost Per Hour	**£23.65**	**100.0%**	**£20.47**	**£3.18**	**100%**

Scenario 3 Model			Median Base Model		
Volume of Care Hours (Units) per annum		58,796	Cost for	Variance	%
Hourly Breakdown	Cost £	%	Comparis	to Model	
Direct Care	£14.12	50.9%	£9.89	£4.23	48.3%
Travel Time	£2.35	8.5%	£1.65	£0.70	8.0%
Mileage	£0.46	1.6%	£0.46	£0.00	2.2%
PPE	£0.08	0.3%	£0.08	£0.00	0.4%
Training (staff time)	£0.33	1.2%	£0.25	£0.08	1.2%
Holiday	£1.92	6.9%	£1.46	£0.46	7.1%
Additional Non-Contact Pay Costs	£0.00	0.0%	£0.00	£0.00	0.0%
Sickness/Maternity & Paternity Pay	£0.42	1.5%	£0.32	£0.10	1.6%
Notice/Suspension Pay	£0.00	0.0%	£0.00	£0.00	0.0%
NI (direct care hours)	£1.81	6.5%	£0.97	£0.84	4.7%
Pension (direct care hours)	£0.52	1.9%	£0.37	£0.15	1.8%
Back Office Staff	£3.25	11.7%	£2.89	£0.35	14.1%
Travel Costs (parking/vehicle lease et	£0.00	0.0%	£0.00	£0.00	0.0%
Rent / Rates / Utilities	£0.22	0.8%	£0.22	£0.00	1.1%
Recruitment / DBS	£0.12	0.4%	£0.12	£0.00	0.6%
Training (3rd party)	£0.05	0.2%	£0.05	£0.00	0.2%
IT (Hardware, Software CRM, ECM)	£0.25	0.9%	£0.25	£0.00	1.2%
Telephony	£0.09	0.3%	£0.09	£0.00	0.4%
Stationery / Postage	£0.05	0.2%	£0.05	£0.00	0.2%
Insurance	£0.09	0.3%	£0.09	£0.00	0.4%
Legal / Finance / Professional Fees	£0.03	0.1%	£0.03	£0.00	0.2%
Marketing	£0.03	0.1%	£0.03	£0.00	0.1%
Audit & Compliance	£0.00	0.0%	£0.00	£0.00	0.0%
Uniforms & Other Consumables	£0.09	0.3%	£0.09	£0.00	0.4%
Assistive Technology	£0.00	0.0%	£0.00	£0.00	0.0%
Central / Head Office Recharges	£0.00	0.0%	£0.00	£0.00	0.0%
Other	£0.01	0.1%	£0.01	£0.00	0.1%
CQC Registration Fees	£0.09	0.3%	£0.09	£0.00	0.4%
Surplus / Profit Contribution	**£1.37**	**4.9%**	£1.01	£0.36	4.9%
Total Cost Per Hour	**£27.74**	**100.0%**	**£20.47**	**£7.27**	**100%**

Table 5: *scenario 1 and 2 cost model analysis*

3.6 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

[16] See NOMIS profile; available at: https://www.nomisweb.co.uk/reports/lmp/la/1946157189/report.aspx?town=sandwell

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 to 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 across a rurality. 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 is likely to increase ENI costs, whereas more staff working less hours may 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.

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 different 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.

The role of any fee-setting is ***not*** to specify the absolute operating costs at every level of a provider's business. In reality, using pensions as an example, this means being absolutely clear with commissioners 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.

4 Future Commissioning Considerations

4.1 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. 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.

4.1.1 Sustainable Homecare Delivery

The below factors represent feedback from ARCC's experience and provider engagement, which 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 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, all of which can be impacted through the 'cost envelope' (fee rate) provided.

- 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. Given the new structure of commissioning in Sandwell this may prove especially relevant, as a larger number of providers will pick up packages across the local authority boundaries, and thus will benefit from collaboration to optimise care delivery.

- 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, a "less is more" approach can be advantageous – by focusing on fewer, more important indicators, commissioners can learn more and intervene more effectively, in a more collaborative, mutually beneficial arrangement, which does not lessen commissioners' right to take decisive action where warranted.

- 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 commissioners' 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. It is also important to recognise that Sandwell has a large number of charities and organisations providing a range of different care services, thus diversifying types of business operations further.

4.1.2 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.

4.1.3 Geographical zones, localities, and volume considerations

As described in Section 4.2.1, 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 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. 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.

Evidence shows that maintaining a reasonably diverse market is ultimately more sustainable over the longer term, not least because the provision of services (and therefore risk) is distributed across a wider economy. It is therefore sensible to enable a variety of providers, to operate in the market.

Notwithstanding the above, the type of contracting framework and barriers to entry (such as contract administration or brokerage processes) that may adversely impact smaller providers is also addressed in this report, which it is recommended that commissioners continually review and improve to grow a sustainable, local care market.

4.1.4 Locality Provision

In testing the travel time assumptions, reasonable travel times were discussed with providers; ARCC recommends that it would be sensible to continue to monitor with individual client postcode data (from internal datasets) to ensure that the average distances and travel times using geo-mapping software such as Google Maps, to match that of provider's own estimates and any shifts in the profile/underlying assumptions.

We have however considered provider's own feedback and no case was made to move away from the current flexible system, where providers can pick up packages across the council. Given that the new system has only just been introduced, it remains to be seen how providers will operate within it. It is expected from the council that providers will inherently attempt to concentrate their packages to reduce travel time, however, some providers informed us that they expect to be extending across the council to meet volume demand. Ideally, a system will be introduced for providers to allocate packages between them to prevent unnecessary travel time for care staff.

4.1.5 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 to manage costs for financial and accounting purposes
- Give certainty to providers that floor revenue will be maintained for the term of a contract, which subsequently gives them more security in offering staff guaranteed hours or salaried contracts
- 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 are not 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.

As an alternative, the policies in relation to suspension of placements could be adapted to provide income during instances of placement suspension, e.g., hospital episodes which allows providers to continue to pay staff – this was cited by several providers.

4.1.6 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:

- Inflationary factors – reviewing uplifts for pay rates (including legislative changes) as well as inflationary uplifts on non-pay costs (i.e., insurance costs etc.)
- Organisation size & geography – the objective of commissioners is to create a cost envelope that can reflect a broad range of business sizes and operating models – as well as reflecting the costs of delivering care in 'hard-to-reach' areas, regular monitoring should be conducting where localities or neighbourhoods are become difficult to service (i.e., waiting list increases)

4.2 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:

4.2.1 Improved intelligence to support market management

Monitoring of key indicators such as provider ability to fulfil packages (waiting times), staff retention, hand-backs etc. are key to the assessment of market sufficiency. 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 Sandwell MBC's assessment and care management, this again was strongly sought after by providers.
- **Proportion of packages picked up within 'X' days** to better understand provider capacity challenges.
- **Care package "stability" indicators and reporting** to help commissioners and providers alike generate useful local intelligence on care package management, including useful statistics and trends, client outcomes and risks, and financial impacts of homecare provision and alternatives.

Ideally, commissioners may build a dashboard with such indicators, which they would then use to manage the market and maintain an efficient performance dialogue with providers. In addition, regular monitoring of average visit times should be conducted to ensure the market rate remains sustainable, especially in light of recent changes to the framework and broadening the geographic distribution of providers.

Encourage and set up further mechanisms (via commissioning and social work teams) for providers to share workforce and client packages that both improve retention of staff as well as enable more efficient delivery of care across localities, this collaboration was also encouraged by providers who were engaged in the market.

4.2.2 Reducing contractual and operational constraints

Reviewing the brokerage process to reduce administrative requirements, improve relationships with and streamline processes. Providers reported issues with the timeliness of sign-off by brokerage and social work teams, particularly where there is deviation from the assessment. Issues with the timeliness of payments can also be addressed to ensure that cash-flow does not lead to additional and un-necessary costs. There is benefit in undertaking 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 cost for providers with minimal resource requirements from the local authority.

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

ARCC has 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 – reflecting 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 exercise, may be to work towards the estimated median of **£20.49**, 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 7.87% uplift, make adjustment (% fee uplifts) to reflect changes to operating costs.

It may also be prudent to continue to monitor rates based on the average visit lengths being commissioned in the market, as these have a consequential impact on paying travel time and other fixed costs (i.e., shorter visits). On this basis Sandwell MBC should consider the relative benefit of adopting weighted unit rates for 15, 30, 45 and 60-minute visits – where shorter visits are required, the effectively hourly rate is increased to account for the fixed amount of travel time applied to each visit length, see section 4.5.4.

4.2.4 '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, raise the profile of social care as a profession and build links between prospective sources of recruitment, e.g. schools and colleges.

4.2.5 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


ARCC-Sandwell%20Homecare%20Survey%

Homecare Cost Survey
Distributed 27th May 2022


Sandwell%20CoC%20Domiciliary%20Ca

Homecare Provider Workshop
4th August 2022

B. Engagement List of Internal Stakeholders & Provider Organisations

Sandwell Council

- Service Manager (Commissioning & Integration)
- Programme Manager
- Operations Manager (Commissioning)
- Better Care Fund Programme Manager
- Principal Accountant
- Older Adults Commissioner
- PMO Manager
- Operations Manager (Commissioning)

Sandwell Care Association

- Chief Executive of West Midlands Care Association

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	11	12	13	14	15	16	18	20	21	22	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 £
Care worker costs:	**71.7%**	**60.9%**	**47.7%**	**76.8%**	**64.3%**	**57.5%**	**59.1%**	**61.8%**	**75.3%**	**64.5%**	**70.0%**	**71.1%**	**77.3%**	**79.7%**	**74.0%**	**74.5%**	**63.1%**	**75.9%**	**72.7%**	**47.7%**	**62.5%**	**71.1%**	**74.9%**	**79.7%**
Direct Care	52.4%	41.4%	36.1%	54.9%	50.8%	38.9%	41.8%	38.9%	56.0%	40.8%	51.5%	54.3%	54.4%	49.1%	56.8%	41.7%	27.6%	56.4%	53.4%	27.6%	41.1%	50.8%	54.4%	56.8%
Travel Time	0.0%	1.9%	0.0%	0.0%	1.8%	0.0%	0.0%	2.2%	0.0%	3.2%	0.0%	0.0%	0.0%	6.7%	0.0%	10.7%	12.3%	0.0%	2.8%	0.0%	0.0%	0.0%	2.5%	12.3%
Mileage	1.9%	1.8%	3.1%	4.0%	0.9%	0.8%	0.0%	7.3%	4.7%	1.9%	4.1%	0.0%	1.7%	3.0%	0.7%	0.5%	7.6%	1.5%	0.0%	0.0%	0.8%	1.8%	3.5%	7.6%
PPE	0.6%	1.3%	0.0%	0.4%	0.0%	5.8%	1.2%	0.0%	0.3%	0.4%	0.0%	1.8%	4.0%	3.2%	0.0%	0.2%	2.8%	0.0%	0.0%	0.0%	0.0%	0.4%	1.6%	5.8%
Training (staff time)	2.1%	0.5%	0.5%	1.6%	1.1%	0.9%	0.9%	0.8%	1.5%	1.0%	1.5%	1.4%	1.7%	3.8%	1.3%	1.7%	1.9%	1.4%	1.1%	0.5%	1.0%	1.4%	1.7%	3.8%
Holiday	6.8%	5.6%	4.5%	7.2%	6.0%	5.0%	5.8%	6.3%	7.0%	6.4%	6.4%	6.8%	6.9%	7.2%	7.1%	7.3%	5.5%	7.1%	7.2%	4.5%	5.9%	6.8%	7.1%	7.3%
Additional Non-Contact Pay Costs	0.0%	1.6%	1.6%	0.0%	0.0%	0.0%	3.3%	0.7%	0.3%	7.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.9%	7.0%
Sickness/Maternity & Paternity Pay	1.6%	1.8%	0.0%	3.4%	0.0%	0.8%	1.8%	1.0%	0.5%	1.1%	1.5%	0.8%	1.5%	0.6%	1.7%	6.7%	2.6%	1.3%	1.5%	0.0%	0.8%	1.5%	1.7%	6.7%
Notice/Suspension Pay	0.0%	0.1%	0.0%	0.0%	0.0%	1.0%	0.4%	0.1%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	1.0%
NI (direct care hours)	4.5%	3.4%	1.5%	4.0%	3.4%	3.0%	2.3%	3.3%	4.1%	2.4%	3.8%	3.3%	5.5%	4.2%	4.6%	3.7%	0.3%	6.5%	4.7%	0.3%	3.2%	3.7%	4.3%	6.5%
Pension (direct care hours)	1.9%	1.5%	0.3%	1.4%	0.3%	1.4%	1.6%	1.2%	1.0%	0.0%	1.2%	1.9%	1.5%	2.0%	1.8%	1.4%	1.5%	1.7%	1.3%	0.0%	1.2%	1.4%	1.7%	2.0%
Business costs:	**23.6%**	**24.7%**	**41.6%**	**19.7%**	**19.6%**	**31.6%**	**27.1%**	**33.4%**	**19.9%**	**32.3%**	**26.1%**	**24.2%**	**17.9%**	**16.4%**	**21.1%**	**20.7%**	**32.1%**	**19.4%**	**22.6%**	**16.4%**	**19.8%**	**23.6%**	**29.4%**	**41.6%**
Back Office Staff	12.6%	15.2%	17.6%	15.6%	8.9%	4.4%	19.3%	23.9%	5.8%	16.8%	19.2%	13.4%	6.6%	11.3%	19.5%	16.4%	24.9%	7.7%	12.2%	4.4%	10.1%	15.2%	18.4%	24.9%
Travel Costs (parking/vehicle lease etc.)	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%
Rent / Rates / Utilities	1.7%	0.8%	2.6%	1.2%	1.9%	3.5%	2.8%	0.8%	1.3%	2.6%	1.8%	0.7%	0.7%	0.5%	0.2%	0.8%	3.2%	0.8%	0.7%	0.2%	0.7%	1.2%	2.3%	3.5%
Recruitment / DBS	0.0%	0.6%	3.5%	0.6%	0.0%	0.6%	0.5%	0.4%	0.0%	0.0%	0.2%	0.6%	0.7%	0.8%	0.0%	0.4%	0.4%	0.7%	1.0%	0.0%	0.1%	0.5%	0.7%	3.5%
Training (3rd party)	0.7%	0.2%	4.4%	0.0%	0.4%	0.4%	0.2%	0.1%	0.0%	0.0%	0.9%	0.4%	0.0%	0.1%	0.0%	0.2%	0.5%	0.0%	0.4%	0.0%	0.0%	0.2%	0.4%	4.4%
IT (Hardware, Software CRM, ECM)	1.5%	2.6%	1.8%	0.6%	0.0%	3.4%	0.6%	1.1%	1.4%	2.1%	1.2%	2.5%	1.3%	1.9%	0.1%	0.5%	1.3%	1.3%	0.6%	0.0%	0.6%	1.3%	1.8%	3.4%
Telephony	0.3%	2.1%	0.5%	0.2%	0.3%	0.6%	0.1%	1.2%	0.2%	6.8%	0.5%	0.6%	0.4%	0.3%	0.3%	0.8%	0.1%	0.7%	0.5%	0.1%	0.3%	0.5%	0.6%	6.8%
Stationery / Postage	0.3%	0.2%	0.5%	0.1%	2.4%	0.9%	0.3%	0.2%	0.1%	0.2%	0.4%	0.2%	0.3%	0.1%	0.0%	0.0%	0.0%	0.3%	0.1%	0.0%	0.1%	0.2%	0.3%	2.4%
Insurance	1.9%	0.8%	0.4%	0.4%	0.2%	0.7%	0.7%	0.3%	0.6%	1.0%	0.3%	0.3%	0.5%	0.2%	0.0%	0.7%	0.2%	0.5%	1.0%	0.0%	0.3%	0.5%	0.7%	1.9%
Legal / Finance / Professional Fees	0.4%	0.3%	0.0%	0.1%	0.1%	1.0%	0.5%	0.1%	0.0%	0.4%	0.6%	0.3%	0.0%	0.1%	0.0%	0.1%	0.3%	0.0%	1.7%	0.0%	0.0%	0.1%	0.4%	1.7%
Marketing	0.3%	0.0%	2.6%	0.1%	0.0%	0.4%	0.2%	0.2%	0.0%	0.1%	0.1%	1.2%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.7%	0.0%	0.0%	0.1%	0.3%	2.6%
Audit & Compliance	1.9%	0.0%	0.0%	0.0%	0.0%	0.6%	0.3%	0.3%	0.0%	0.5%	0.0%	0.7%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.2%	0.0%	0.0%	0.0%	0.3%	1.9%
Uniforms & Other Consumables	0.2%	0.5%	0.5%	0.2%	3.4%	0.7%	0.6%	0.1%	0.8%	0.7%	0.4%	0.5%	0.0%	0.2%	0.0%	0.0%	0.1%	0.0%	0.8%	0.0%	0.1%	0.4%	0.6%	3.4%
Assistive Technology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%
Central / Head Office Recharges	0.0%	0.0%	6.5%	0.0%	1.7%	0.0%	0.0%	0.0%	8.8%	0.0%	0.0%	1.8%	6.8%	0.0%	0.9%	0.0%	0.0%	7.0%	0.2%	0.0%	0.0%	0.0%	1.7%	8.8%
Additional Overhead #1	0.7%	0.0%	0.2%	0.1%	0.0%	1.1%	0.7%	0.1%	0.3%	0.8%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.1%	0.3%	1.1%
Additional Overhead #2	0.6%	0.2%	0.0%	0.0%	0.0%	2.0%	0.0%	0.7%	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%	0.1%	2.0%
Additional Overhead #3	0.0%	0.3%	0.0%	0.0%	0.0%	9.1%	0.0%	2.2%	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%	9.1%
Additional Overhead #4	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.6%
Additional Overhead #5	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	1.0%
Additional Overhead #6	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%	0.0%	0.7%	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%	0.9%
Additional Overhead #7	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%
Additional Overhead #8	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%
CQC Registration Fees(4)	0.4%	0.3%	0.4%	0.5%	0.3%	0.2%	0.3%	0.3%	0.5%	0.4%	0.6%	0.5%	0.6%	0.6%	0.3%	0.7%	0.9%	0.4%	0.3%	0.2%	0.3%	0.4%	0.5%	0.9%
Surplus / Profit Contribution	**4.8%**	**14.5%**	**10.7%**	**3.5%**	**16.1%**	**10.9%**	**13.8%**	**4.8%**	**4.8%**	**3.2%**	**3.8%**	**4.8%**	**4.8%**	**3.8%**	**4.9%**	**4.8%**	**4.8%**	**4.8%**	**4.8%**	**3.2%**	**4.8%**	**4.8%**	**7.8%**	**16.1%**
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%**

Table 6: *respondent reference table*

D. Provider Queries and Responses

The queries below were received from providers following the provider workshop held on 4th August 2022. Providers were given two weeks to digest the information presented and raise any queries. No further queries were raised from the provider market.

Query 1:

Will the breakdown of costs of this current year after April 2022 be included in the final report, including the uplift % estimates provided by the returns received, to represent the expected cost increases?

Response 1:

The figures presented have been uplifted to reflect April 2022, this includes utilising the 2022 pay rates (increase in minimum wage and NI contributions) and where providers like yourself have included a % uplift, elsewhere we have assumed an uplift of 8.2% in line with CPI as of June 2022.

Query 2:

The profit/surplus % expectation range (4 to 24%) is surprising because we made a loss last year, not a profit. I assume other providers also struggled to reach a profit with the fixed hourly rate at only £15.16 last year, whilst all having similar care costs.

Response 2:

Regarding the profit/surplus expectations, we assume that all providers, charities included, would require a certain level of profit for the organisation to remain sustainable. Therefore, when calculating the costs, we have assumed that all providers would expect to make at least 5% profit when no other figures were reported, and this is reflected in each unit cost. It is important to note re: the deficit point that there is a variety of provider operating models accounted for in this analysis, i.e., size of branch, back office, number of self-funders etc.

Sandwell
Metropolitan Borough Council