Bristol City Council

Homecare Cost of Care Exercise 2022-23

Draft v0.2

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ARCC-HR Ltd

Contents

1 Executive Summary

1.1 Context the Cost of Care Exercise

1.1.1 Fair Cost of Care & Market Sustainability

On the 16th December 2021 DHSC released its policy paper: 'Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023' with further detailed guidance following on the 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 14th 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 Bristol City Council [BCC] 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 for analysis and the formulae to inform future uplifts
- Costs to consider when determining future fee rates based on different funding models, which includes the flexibility to accommodate a range of assumptions, for example: travel time, overheads, duration of visits, and other factors such as geographical coverage
- Key findings and recommendations during the engagement to support future commissioning models in Bristol

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 64 providers within Bristol were engaged for the exercise, which was later reduced to 42 providers in scope (for more detail see section 2.3.2). The engagement process comprised the following elements:

a) **Provider Survey & Cost Template:** submitted to 64 of providers within the Bristol market, to gather data on both the costs and the operational experience of delivering homecare services in Bristol

b) **1:1 deep-dive structured interviews:** All providers were invited to express interest for a 1:1 session, with 11 interviews taking place with the senior Finance/ Operational leads for the respective organisations

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

- current homecare market in Bristol (structure, demand and supply)
- experience of commissioning and contracting with BCC
- business operating models, general market outlook, workforce, contract and quality monitoring, business costs, and future commissioning arrangements
- a deep dive with providers to understand operating costs and sensitivities that would impact cost

After completion of the data collection, a total of 18 submissions had been received, representing 43% of providers in the market and 55% of homecare hours commissioned by BCC.

1.3 Local Cost of Care Results

1.3.1 2022-23 cost of care range and median

As per the DHSC requirement, the exercise was required to identify a median cost of care which was reflective of provider's April 2022 cost pressures. Table 1 identifies the outcome of the analysis of provider returns; based on the data available the median rate has been calculated as £23.51. This represents a 14.7% increase on the current framework rate of £20.50, and a 11.7% increase on the current average rate paid of £20.53 which reflect the impact of a small number of spot purchases. Section 4.3 provides a more detailed breakdown of the findings from the analysis.

All Providers	LOW	25%	MEDIAN	75%	HIGH
Hourly Breakdown	Unit Cost per Care Hour £				
Care worker costs:	£11.90	£13.98	£15.22	£15.77	£16.81
Business costs:	£3.64	£5.52	£7.30	£9.41	£12.89
Surplus / Profit Contribution	£0.00	£1.11	£1.47	£2.05	£2.96
Total Cost Per Hour	£17.10	£22.56	£23.51	£26.08	£30.68

Table 1: *Cost range, upper and lower quartile and median costs*

The financial impact of this model is estimated to be **£3,052,450 per annum** on the basis of a **£3.04 variance** between the existing average rate paid and the median, multiplied by an estimate 1,036,358 hours of care per annum, based on the total volume between 1st April and 29th August 2022[1].

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, Bristol City Council do not currently commission 15-minute visits. See section 4.4.3 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 two additional scenarios and the effective unit rates for care. See section 4.4 for further details.

Scenario Models[2]	Description	Unit Cost per care hour[3]
#1a 15-minute call duration	*Median cost adjusted to reflect avg.15-minute call duration*	£29.52
#1b 30-minute call duration	*Median cost adjusted to reflect avg.30-minute call duration*	£25.12
#1c 45-minute call duration	*Median cost adjusted to reflect avg.45-minute call duration*	£23.65
#1d 60-minute call duration	*Median cost adjusted to reflect avg.60-minute call duration*	£22.91
#2 AfC NHS Band 2 (+2 years' experience)	*Base carer pay set at £10.93p/h to reflect pay rates for an NHS Band 2 worker.*	£25.12
#3 Competitor sector £11.50 model	*Base carer pay set at £11.50p/h to reflect pay rates for similar sectors such as retail.*	£26.28

***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] Figures obtained from Bristol City Council Finance Team, 5th October 2022
[2] All scenario models are compliant with the Ethical Care Charter pay rate for all staff
[3] The variations on call length are expressed as unit cost per care hour, however the actual cost per call should be derived by the proportion of 1 hour that call represents, e.g. for a 30-minute call, the cost per care hour should be halved to arrive at the unit cost per 30 minute call – see section 4.4.3 for further details

1.3.3 Conclusions

The cost of care exercise was conducted during exceptionally challenging conditions for the sector nationally, not just in Bristol. 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 £23.51, 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 6.19% 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 is a primary indicator of how the market is preforming. It is important to note that the ability to move towards this rate will be dependent upon future allocation of the Fair Cost of Care fund by the DHSC.

Based on the exercise alone, it is estimated that the Council would **require an additional £2,938,706 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 Bristol City Council, which take into consideration wider market sustainability and commissioning work locally (for further details, see section 5.2):

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

Whilst a long-term intention, in line with this DHSC cost of care exercise, may be to work towards the estimated median of £23.51, 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), as well as ability to population support needs via commissioning in the market through future fee exercises.

1.4.2 Emerging findings from the AHSN Workforce Challenge Programme

During the time conducting this exercise with Bristol, ARCC have also been supporting the South West/West of England Academic Health Science Network (AHSN) and Health Education England's Domiciliary Workforce Challenge Programme which is being delivered by Procomp. ARCC supports some of the initial findings and recommendations emerging from the Programme, including support for more individual task-focused activity planning as opposed to time-and-task, as well as exploring efficiencies and better integration across the market between health and social care.

1.4.3 2024 homecare specification and re-commissioning

The requirement for BCC to re-tender contracts in 2024 provides a valuable opportunity to utilise the findings from this exercise together with the Procomp pilot. Specific considerations include:

a. New contracting and payment models such as exploring tiered or weighted rates for care
b. Improved intelligence to support market management including planned call monitoring and onboarding
c. Empowering provider and clients to have greater flexibilities in relation to how care is delivered
d. Streamlining to provide operational efficiencies within the market

1.4.4 Monitor and evaluate the implementation of the Ethical Care Charter

Evaluate the impact of Bristol CC's commitment to the Ethical Care Charter with a detailed survey to assess compliance to the Ethical Care Charter. Whilst implementation is within its infancy, analysis of cost suggests there are some areas of provider costs which do not currently meet the requirements.

1.4.5 Assessment of the impact of implementing the Clean Air Zone on homecare

Impact assessment of the introduction of further challenges are expected to arise once Bristol's Clean Air Zone[4] is introduced on the 28th November 2022, as charges will be levied to cars not meeting the emission standards. The Council may need to consider offsetting the costs to community social care workers or providers via:

a. Vouchers or discounted passes to care workers
b. Exemptions for employers
c. Offset costs via unit fee rates for care that can be passed down to care staff through provider businesses

1.4.6 Develop new 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 Bristol homecare providers for their participation and openness in sharing data for the project. We are also grateful to Care and Support West (C&SW) for helping our engagement activities. Last but not least, we thank Bristol City Council commissioning team for the opportunity to perform this work and their support and commitment throughout the project.

[4] Details can be found at https://www.bristol.gov.uk/residents/streets-travel/bristols-caz

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

Section 18(3) commenced in 2015 in relation to domiciliary care and DHSC plan to extend this to residential and nursing care provision for older people. Whilst section 18(3) has been in place for domiciliary care for 7 years the uptake and financial impact remains unclear; however, in March 2022 the County Council's Network published an impact assessment on the implementation of section 18(3), which identified: "In its own impact assessment, the Government have not sought thus far to estimate the combined financial impact of Section 18(3) and FCC on care providers. But our analysis demonstrates that based on a 50% take up rate of Section 18(3) and current FCC funding levels for councils, providers across the country would experience significant financial challenges as a result of lost revenues amounting to £560m"[5].

On the 16th December 2021, following the release of People at the Heart of Care white paper, 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[6], local authorities will need to evidence the work they are doing to prepare their markets for reform and submit the analysis of cost of care exercises for 65+ care homes and 18+ domiciliary care. There is also a requirement to produce a provisional market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market. A final plan will be required in February 2023; in the interim a 5-page provisional plan should be submitted utilising the Annex C template.

For the purpose of the policy, and in terms of understanding the cost of care, DHSC have defined 'fair' as *"the median actual operating costs for providing care in the local area (following completion of a cost of care exercise) for a series of care categories….and is, on average, what local authorities are required to move towards paying providers. In the context of specific rates for care paid, fair means what is sustainable for the local market. For providers, this means they will be able to cover the cost of care delivery and be able to make a reasonable profit (including re-investment in their business), surplus or meet their charitable objectives. For local authorities, it recognises the responsibility they have in stewarding public money, including securing the best value for the taxpayer"[7].*

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

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

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

The Care Act 2014 states *'When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care… It should also allow retention of staff commensurate with delivering services to the agreed quality and encourage innovation and improvement. Local authorities should have regard to guidance on minimum fee levels necessary to provide this assurance, taking account of the local economic environment. This assurance should understand that reasonable fee levels allow for a reasonable rate of return by independent providers that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term.'*[8]

The cost of care exercise is an opportunity for Bristol 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.

Bristol – 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. Bristol commissioners are attempting to meet these challenges of continuity and innovation within their commissioning strategies, as demonstrated through the workforce optimisation pilot being undertaken with Procomp; this report represents a further step along 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"*[9].

The following services were deemed out of scope: rapid response provision, short term / reablement support, local authority in-house care, live in care, sitting services, extra care[10] 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.

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

2.3 Approach, Methods and Limitations

2.3.1 Project Governance

ARCC's approach was to encourage as much engagement as possible from the market. In order to monitor progress and mitigate project risks a project governance group was formed consisting of the Deputy Director of Commissioning, Interim Strategic Commissioning Manager (Older People), Strategic Commissioning Manager, Finance Business Partner, and ARCC. This group met fortnightly to discuss progress, risks and mitigations arising throughout the course of the project. Internally, ARCC's project team formally reviewed progress and risks on a daily basis with formal reporting through the governance channels established.

2.3.2 Engagement Activities and Timeline

Initial outreach was targeted at a cohort of 37 providers whom Bristol City Council currently commission homecare from, either on framework or via spot purchases. In order to engage with the full market, ARCC reached out to a total of 64 providers who according to the CQC are registered in Bristol as homecare providers, giving them the opportunity to participate.

Given the wide scope of this expansion, the list was subsequently reduced to 42 providers, for reasons including not having historically engaged with the council and focusing solely on work for the independent market, providing more specialist (LD/MH) provision that fell outside of DHSC's defined scope, or not having yet commenced operation and thus not having cost information to share. Providers who did not participate or respond for any of these reasons, did continue to receive information throughout the exercise, as well as invitations to the workshop for transparency.

The engagement comprised the following key activities:

a) **Provider Survey & Cost Template:** Submitted to all 64 providers, to gather data on both the costs and the operational experience of delivering homecare services in Bristol. Any data ultimately submitted by the providers was sent directly to (and anonymised by) ARCC. Confidentiality of provider's commercially sensitive information was paramount to the exercise. The survey consisted of 3 parts:

Part 1: Commissioning Survey with thematic questions:

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

Part 2: 2022 Organisation and Workforce:

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

Part 3: Historic costs 2021-22

- Historic revenue
- 2021-22 costs

The team also accepted returns such as ARCC's national homecare cost modelling toolkit[11] or alternative reports/accounts. In total, 18 providers sent returns, of these 2 were ARCC's national toolkit and 16 were the dedicated cost survey. There was good representation from small, medium & large providers across various geographies.

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 11 providers in total took part.

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

- 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 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[12]. Further requests for information/clarifications were conducted via e-mail and telephone, to provide opportunity for providers to submit data to input to the cost analysis.

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

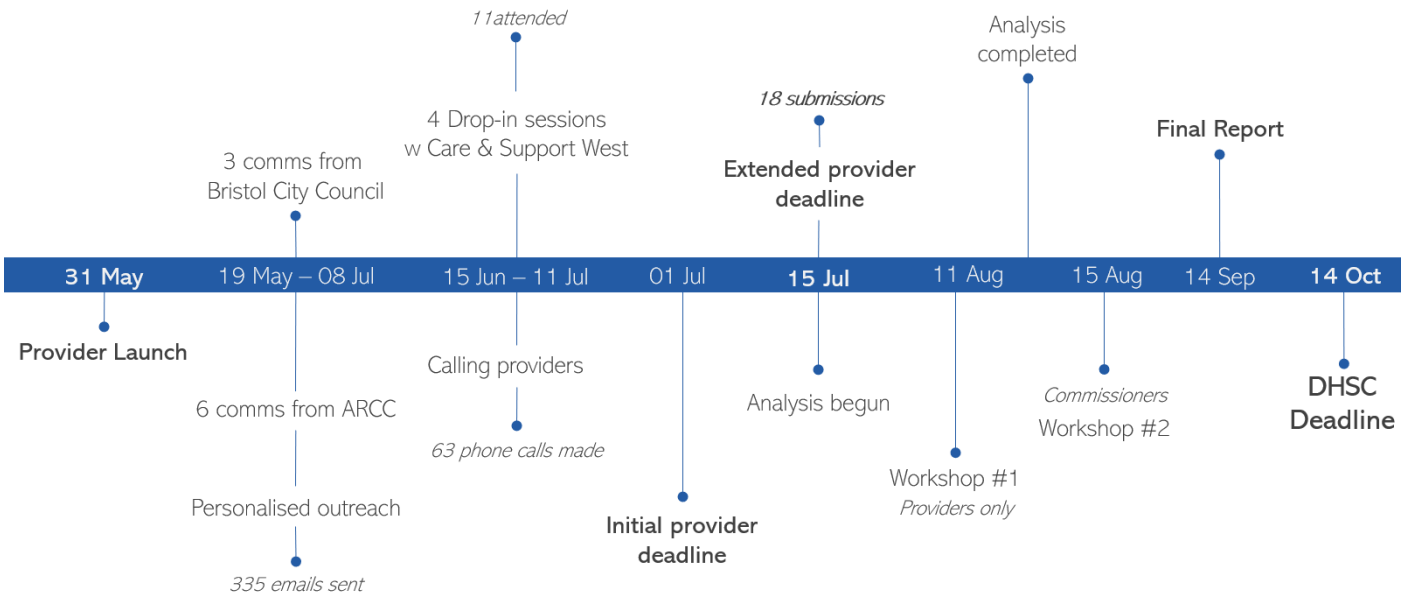


***Figure 1:** project timeline*

[11] Developed by ARCC and available at: Homecare Cost of Care Toolkit | Local Government Association
[12] Copies of communications and slides shared within and following workshops are provided in Section A Appendices.

Provider outreach

To give providers the best possible opportunity to engage with the exercise various forms of communication were utilised. Bristol CC invited all providers in the market to the initial launch session, which was held as part of their recurring provider forum. From this point onwards ARCC sent a total of 6x market-wide emails with additional information and support, including an invitation to 3x drop-in session/clinics co-hosted by Bristol City Council and Care & Support West 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 e-mail, phone calls, and Microsoft Teams meetings, where the team would guide the providers through the submission template, and answer any questions 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 15.07 as well as individual later deadlines agreed with providers for supplementary information. No submissions were rejected because of late submission; the last submission was received on 01.08.

Of the 42 providers in scope, 18 (43%) submitted cost returns (representing 55% of commissioned hours), 6 (14%) agreed to participate but ultimately did not submit, 3 (7%) informed us that they would not submit, spoke with 6 (14%) but did not receive commitment, and 9 (21%) providers were not reached through phone or email.

2.3.3 Limitations

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

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

3 The Homecare Market in Bristol

This section details the size and scale of the current homecare market in Bristol 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 typically represents a monopsony market, in which they are the majority buyer.

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

3.1 Demand and Supply

A total of 42 homecare providers (as defined by the scope) currently operate in Bristol, with an additional two providers who are in the process of commencing operation. As of week commencing 5th September 2022, Bristol commissioned 22,973 hours of care, extrapolating this week we estimate an annual volume of care to be 1,194,596 hours, an increase of 15.5% on 2021-22. Historical data of homecare provision in Bristol, as illustrated in Figure 2 displays not only the consistent increase in active number of service users, but also a consistent increase in average hours of care per week for each service user.

This was also reflected by stakeholders in the council who have indicated that an increasing number of service users enter long-term care at a younger age, thus require the services for longer, and that service users generally are frailer and therefore need higher intensity of support to remain within the community.

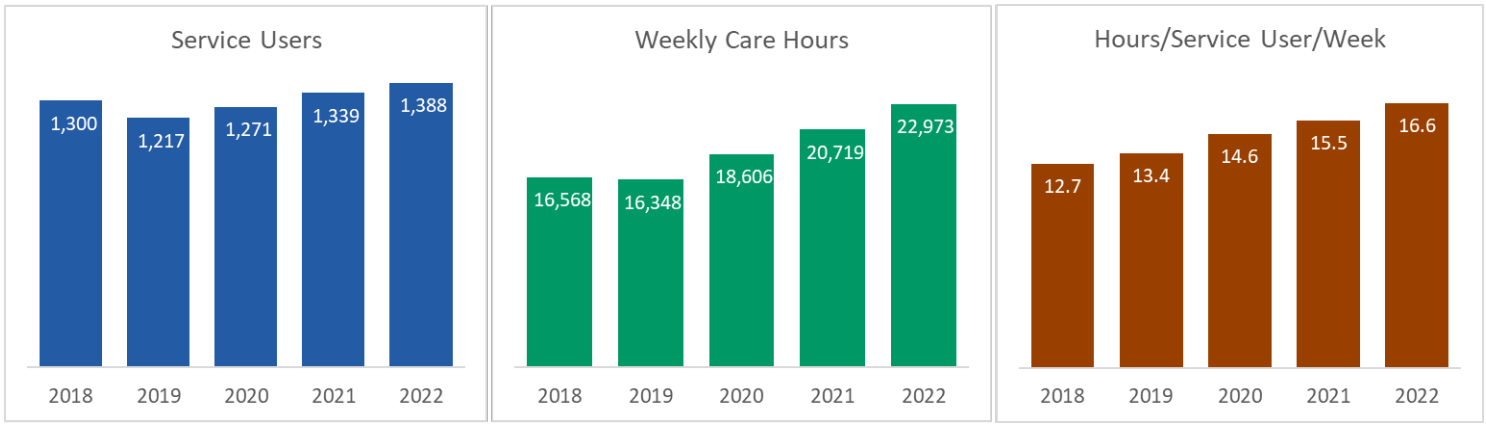


Figure 2: *Number of service users, average weekly volume, and average volume of weekly hours per client (reporting period 8th September).*

Of the providers whom Bristol City Council commission homecare from, 90% of the volume (16,412 hours) was commissioned from 20 providers (48% of providers in the market)[13]. Of the 42 providers, Bristol held active packages with 36 of these, commissioning on average 507 hours per provider, ranging between 7.5 and 2,358 hours of care per provider per week. The council has 30 framework providers from whom they commissioned 15,678 hours (86%); they had 12 off-framework providers from whom they commissioned 1,241 hours (7%). The Council is actively working to ensure all providers whom they contract with can adopt the framework terms.

[13] As of May 2022

Figure 3 illustrates the distribution of Care Quality Commission (CQC) quality ratings among providers in the market, of which a vast majority are assessed as "Good" or above (88.1%). There has been some fluctuation in the market since the beginning of Covid-19 which has led several exits and entrants; therefore a small number have not yet been assessed by CQC.

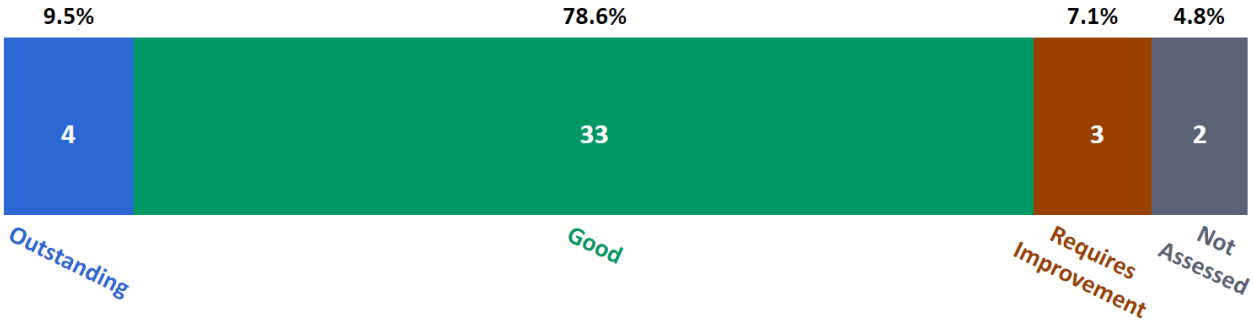


***Figure 3**:* Distribution of CQC ratings among homecare providers operating in Bristol.

3.2 The Local Commissioning Framework

Bristol CC currently have 27 providers on the framework and 15 providers from whom they spot purchase, with the aim being to have all providers they commission from on their framework. Spot purchases from non-framework providers are only used in emergency cases and requires approval from either a Head of Service or a Team Manager. The council currently works with two providers outside Bristol on a non-framework basis.

Providers are paid 4 -weekly on planned time and can, when unforeseen events or changes to service users' needs, retroactively invoice for increased time once this has been approved by the council. The current hourly homecare rate is £20.50 p/h, a 6.19% uplift from the previous rate of £19.32. Packages are typically commissioned at the framework rate, however deviations can occur in cases of specific service user needs. The current average hourly rate is £21.05.

The Bristol area is a mix of urban and rural population densities; the most rural areas being the north, and to some extent, the south of the authority. Bristol has a densely populated city centre, which provides specific challenges for the delivery of homecare and is generally difficult to drive and park in. Further challenges are expected to arise once Bristol's Clean Air Zone is introduced on the 28th November 2022, as charges will be levied to cars not meeting the emission standards.

Currently, packages are not allocated based on geography, although Bristol CC did previously operate zones and whilst these have been disbanded, there are some legacy packages with providers concentrated in several neighbourhoods. Given the current pressure on fuel costs, as well as some providers paying care staff for travel time, many providers are only accepting packages within certain areas, to minimise travel to far away service users. Stakeholders within the Council have shared that it can be challenging to allocate new packages within certain geographical regions, particularly in the north, which can cause delays in customers receiving care packages.

Despite pressures and waiting lists over the pandemic, it has been monitored recently within Brisotl that there has been an improving situation in homecare in relation to being to allocate packages more effectively and reduce waiting times, indicating that market sustainability is returning.

In March 2021, Bristol City Council signed up to the Ethical Care Charter[14] and working with providers to improve working conditions for carers in areas such as Real Living Wage, paying care staff for travel time, moving away from zero-hours contracts, and moving towards all workers being covered by an occupational sick pay scheme.

Bristol City council are currently working with the West of England and South West AHSNs, Health Education England and Procomp (a logistics planning and optimisation company) to test three different scenarios, each of which aims to reduce the distance travelled by care workers and increase their capacity:

(1) To explore increased flexibility around start times and enabling a flatter demand throughout the day and avoiding the usual peaks and troughs.

(2) Focusing on the density or spread of home care providers and how providers might better collaborate to deliver services.

(3) Finally to look at integration to consider how health and social care providers more generally can work together better. Bristol City Council are currently working closely with one major provider to optimise travel time and waits between calls, and Procomp has subsequently produced several recommendations, some of which are discussed in more detail in this report section 5.2.

3.3 Internal Stakeholder Feedback

Throughout the project ARCC interviewed internal stakeholders, as well representatives from Care and Support West, to build a picture of the current state of the homecare market within Bristol.

Conversations were held with the Council's Principal Accountant, Brokerage Team Manager, Operational Manager for Hospital and Front Door, Principal Social Worker, Business Relationship Manager, and the CEO at Care and Support West. Here we summarise relevant comments and observations arising from our engagement with stakeholders as well as from a desktop review of contract documentation.

Recruitment & Retention: certain geographical areas such as the north of Bristol, as well as to some extent the outer skirts and the west have been flagged as particularly challenging to recruit staff which has an impact of localised capacity. It is assumed by several internal stakeholders that recruitment challenges are the main reason for providers not being able to take on new packages or in some instances fulfil existing demand. Although providers have received workforce recruitment and retention grants, one continuous challenge is that providers (as often is the case) compete within a limited geographic pool of resource for the same care staff, hence the importance of minimising the deviation from the framework rate to avoid competition for staff which is driven by rate and therefore, pay differentials.

Package Allocation: Since the beginning of 2022, the council has experienced some challenges regarding managing hand-backs from providers who have exited the Bristol market, as well as a steady increase in demand (see figure 2). Some providers have been unable to deliver the volume of care they have committed to or have been forced to relocate and accommodate staff from other branches elsewhere. To minimise travel and accommodate localised staff bases, providers tend to operate in preferred localities (despite the system of zoning having been disbanded). This has resulted in some difficulties in making placements within some areas of the city. The typical wait time for package commencement is 2-3 weeks, although this is dependent on where the service user is based. Once a package is allocated to a provider, it typically takes around 7 days before care

[14] https://southwest.unison.org.uk/news/2021/03/bristol-city-council-signs-unisons-ethical-care-charter-virtual-ceremony/

begins, this can however range from immediate up to 6 weeks, depending on the pressures on the market. There are currently no contractual obligations as to how soon a provider is required to commence care once a package is accepted.

Geography: As discussed above, geographical location can have an impact on the timeliness and ease with which the service user receives care. The areas that internal stakeholders have highlighted as challenging are the outskirts of the Bristol region, and particularly the North. Another region that presents its own challenges is the city centre. Currently, providers must in some instances spend funds on either bus or parking passes within the city. It is also expected that once Bristol's Clean Air Zone will come into effect later this year, carers may no longer be able to drive their own cars in the city centre without additional charges.

Care at Home: whilst hospital discharge is a priority when allocating care packages, the location of the service user within Bristol can cause delays in transitioning people discharged from hospitals directly to social care, or, to social care after a period in reablement. The council are experiencing a shift in the profile of social care need, people are entering services at a younger age and staying in services for longer and providers are seeing greater levels of frailty/higher intensity of needs as more people are supported in the homes. The upshot of this strategy is an increase in the volume of care being commissioned in the community and resulting package sizes.

To offset some of this demand pressure, the council are using assistive technology to reduce the amount of care needed, particularly at night-time. An assistive technology hub, provided by the NHS, which supplies residents with different equipment to reduce the dependency on sit-in services has been set up to provide equipment such as sensor mats, strip-lighting, and self-turning beds and community alarms that can provide alternative support which does not require the attendance of a carer. This has reduced the amount of night packages, but not removed the need completely.

Service User Choice: The council has experienced challenges in timing preferences, e.g., the service user will only receive their morning call at 8.00 AM, which can be difficult to accommodate when many service users likely have a similar preference. The council are working towards defining contracts with time bands for visits rather than specific times, to give the providers more flexibility in delivering care. Some service users also have language requirements, or a preference for the gender or ethnicity of the carer, which can create delays in package allocation and additional challenges in recruitment.

Communication: Several stakeholders within the council that more direct communication with providers would be beneficial; regarding social workers communicating directly with providers concerning the needs of service users, as well as brokerage teams being more easily able to allocate packages over the phone as opposed to email. The Principal Social Worker suggested the benefit of moving towards a micro-commissioning system, giving the social worker more commissioning responsibilities and therefore being able to tailor the commissioned support to the service user.

3.4 Provider Feedback

3.4.1 Qualitative Insight

As referenced in section 1.2, the approach to engagement was varied to support maximum engagement. Through multiple choice and free-text questions in the cost submission template; 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

Providers in Bristol generally reported a desire to grow the number of packages they have with the local authority, of which 4/16 providers stated their intention is to only grow local authority packages. Only 3 providers shared that they would either focus on, or exclusively take self-funder packages. In these cases, explanations were related to the local authority rate not being compatible with their operating costs. Some providers also expressed interest in expanding into, or growing contracts in other areas such as mental health, complex care, CCG and live-in care. Of the 16 providers, 6 operate exclusively in the Bristol area, whilst 10 reported also operating with neighbouring councils, most often South Gloucestershire and North Somerset.

3 providers explicitly stated that future growth targets are significantly limited due to their challenges with recruitment; each of these providers anticipated being able to deliver a significant increase in care hours if they were able to recruit increased staff. Though not all providers stated this, almost all did report that recruitment and/or retention are among their main business challenges, and therefore it is likely that more providers share this specific limiting factor on their delivery capacity.

Of the 13 providers who reported on their profit from the financial year 2021-22, 8 providers reported a profit, 3 providers reported a loss, and 2 providers are so new in the market that their operation is not yet profitable. Of the providers reporting profits, 2 stated that they would have made a loss without Covid-related grants and the provision of free PPE. In one-to-one conversations, providers were asked about their profit expectations, of 6 providers reporting a profit, only 2 stated that this is in line with, or above, what they would expect to generate as a business. When asked about what a sustainable profit margin would be, answers range between 6-15%. It is important to note that given the variance in operation size, 6% may be much more sustainable for a large organisation or branch of a national business, than for a smaller provider only delivering a small volume of care in comparison.

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 2021-22 and into the new financial year.

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 (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 is also important to note that 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. One provider expressed a desire for allowing new recruits to shadow before completing training to give them a better idea of the job, however, this is a challenge as most new carers do not have a DBS check at this stage.

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. From the four providers who reported good retention rates, factors such as offering block contracts, paying for travel time, and providing care staff flexibility in which hours they work, were suggested as influencing factors.

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. Several providers reported having a maximum travel distance they would accept new packages at, these ranging from 2-5 miles. 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. Geographies that have been reported as particularly difficult are the city centre, the postcodes BS1 and BS2, and any rural areas.

3.4.1.3 Working with Bristol

Providers in Bristol generally reported very positive relationships with officers within the local authority. **Figure 4** summarises 17 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 brokerage system could work better. It is important to note however, that even for these two statements with the most "Disagree" responses, there were still as many or more "Agree" responses.

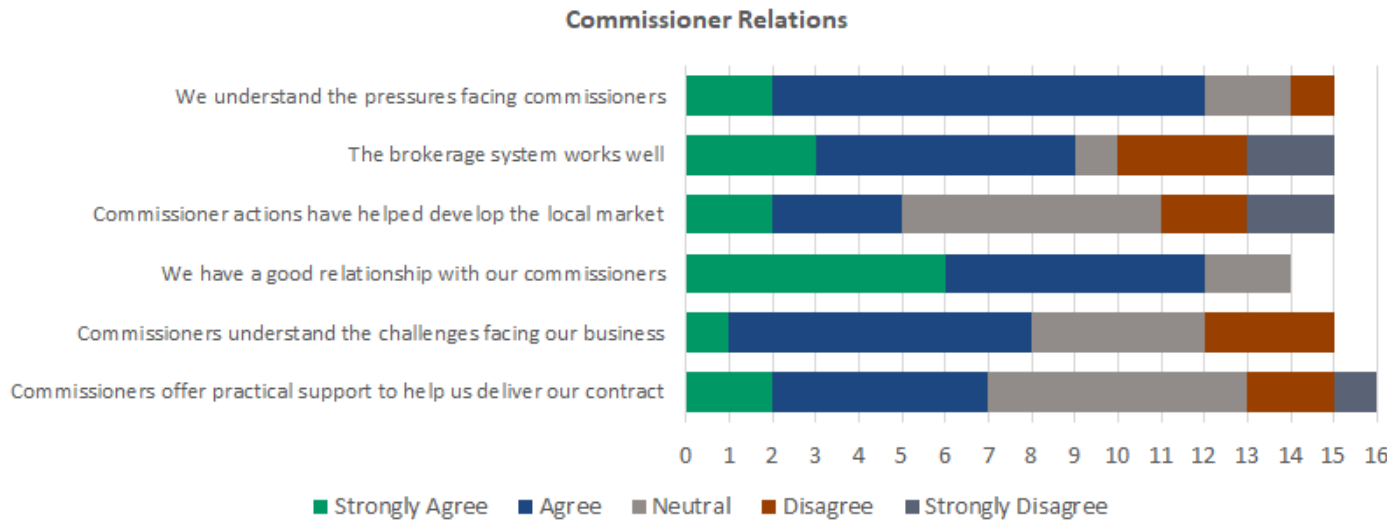


Figure 4: *Providers' responses to six questions concerning their relationship with, and perception of, the local authority.*

As can be seen in **Figure 5**, providers responded to a question regarding how likely they would be to set up their business in Bristol now in comparison to 3 years ago. The responses, based on 15 providers, shows that a slight majority of providers reported that they would be less likely (or neutral) to set up in Bristol today.

Similarly, **Figure 6** (how providers find working with Bristol City Council in comparison to other councils they supply), indicates that provider preference is generally indifferent between councils, or with a slight preference for other local authorities. As previously discussed, most providers are taking local authority packages from different councils, and thus can directly compare their operations.

From providers who have commented on their relationship with Bristol in comparison to other local authorities, typical comments have been on slightly higher pay rates elsewhere, as well as higher rates paid for bank holidays, and that other councils may be faster to respond when providers recommend changes to service users' care plans.

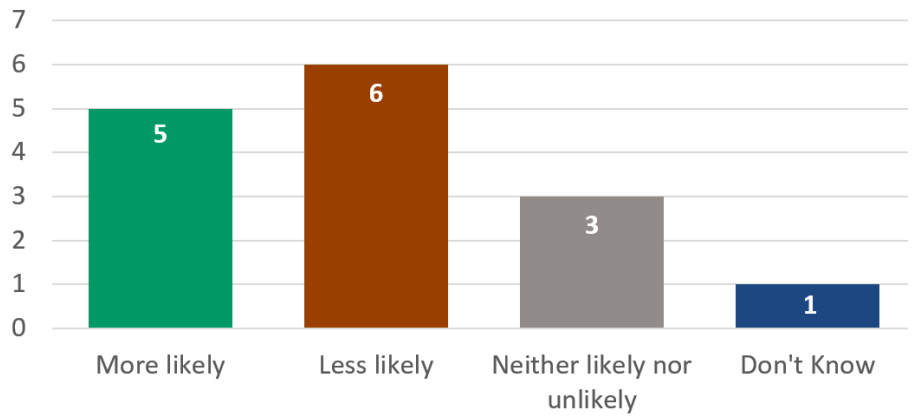


Figure 5: *Providers' responses to the question "How likely would you be to set up your business in this geographical area now compared with 3 years ago?".*

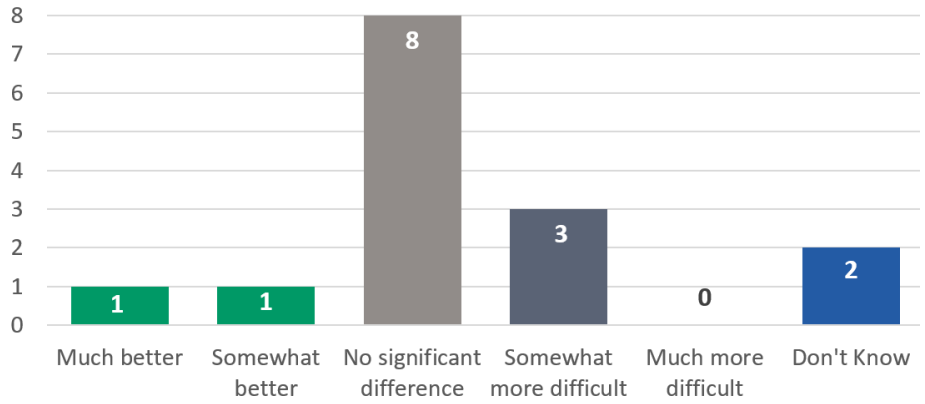


***Figure 6**: Providers' responses to the question "How would you compare working with this Local Authority compared to others whom you supply?".*

To elaborate on the above, a primary concern raised through the engagement was a challenge with having care packages reassessed, when the provider finds the service user's needs to have deteriorated and thus require additional care. Concerns were related to the slow response time, as well as challenges with billing based on 'verbal' agreements with social workers, which are on occasion not processed appropriately within the system and thus result in delayed payments. Some providers highlighted that in certain cases, the cost and resources spent on chasing down the payment from the council can be larger than the payment itself.

Linked to the above, providers articulated some instances where staff are having to take on responsibilities for service users that should lie with the social worker. As discussed above, the providers are responsible for making the council aware of changes in needs, however, several providers also mentioned that they are instances of helping service users getting referred to services outside their remit, as well as time spent assisting service users with navigating the council's systems and processes. One provider discussed how previously each service user was assigned to a social worker, who would take a greater responsibility in following and assisting the service user after package allocation.

Some providers mentioned how packages are allocated at random rather than to providers best able to address the service user's needs, and that the social workers have little to no engagement with the service user past package allocation. In these areas the general ask from providers was that the social workers and brokerage teams have more conversations with providers both at package allocation as well as throughout the duration of the service user receiving care, to ensure the best and most seamless care is delivered based on the individual needs of service users. This was sentiment that was echoed in the internal stakeholder feedback (section 3.3).

3.4.1.4 Business Costs

As across the rest of the UK, Bristol providers are experiencing significant cost increases in areas such as fuel, utilities, insurance and workforce. Of 16 submissions in the ARCC cost survey format, 3 providers reported a loss in the last financial year. Several other providers reported that their homecare business would have made a loss if they had not received financial grants. Several providers are looking to diversify their operation to other types of care that are more profitable, as well limit the geographical area where they take packages, as packages are not profitable above a certain travel distance.

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 increased as of April 2022, providers are experiencing increasing costs, which to a certain extent has been offset by the local authorities' 6.19% 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.

As care staff typically receive minimum wage or slightly higher, providers are having to spend more money recruiting or trying to retain staff. There appears to be a general sentiment among providers that how care staff are compensated needs to change; paying staff salaries was a commonly cited example as it provided stability to carers and providers alike. Indeed, some providers in Bristol are starting to offer salaried contracts to care staff, but many argue that it is not viable for providers as long as they are not paid block contracts from the council. Providers need to be able to rely on a guaranteed volume before they can commit to offering guaranteed income for their staff.

3.4.1.5 Contract and Quality Monitoring

Bristol City Council's Quality Assurance team are working towards supporting all homecare providers to receive "Good" or "Outstanding" CQC ratings. Providers are required to complete a workbook review every 6 months focused on KPIs and work towards adhering to the Ethical Care Charter.

Providers reported very positively on the council's quality monitoring efforts; besides being a formal requirement, many providers referred to it as being very helpful with constructive feedback and improvement recommendations.

3.4.1.6 Future Commissioning Arrangements

Bristol City Council are working on several initiatives to improve market sustainability and optimise the care which they pay for. Some of these initiatives include:

- Integrated care: Bristol City Council are working towards better integrating social care with healthcare services. This would provide better information sharing, staff overlap, and overall, a smoother transition through the system for service users. Given that healthcare services are experiencing better recruitment rates as well as payrates, the staff sharing of such a system has the potential to alleviate part of the recruitment challenge experienced in the homecare sector.

- Homecare staff providing homecare: Given the limited capacity of homecare providers in Bristol, the council are working towards ensuring that the task they are completing are appropriate for homecare services. Many of the tasks currently completed by CQC registered homecare providers such as doing laundry, escorting, shopping, sit-in services, etc. could equally well be performed by non-regulated carers which would come at a lower cost to the council.

- Ethical care charter: Since March 2021 Bristol City Council has been signed up to the Ethical Care Charter. This is leading to changes within how the council work with providers, e.g. suspending 15 minutes calls. It also impacts the quality monitoring they are conducting, in order to make sure providers are working towards living up to the Ethical Care Charter in areas such as ensuring minimum staff pay rates and paying for travel time.

- Procomp: As earlier mentioned, Bristol City Council are working with Procomp to optimise route scheduling. Procomp are currently trialling their initiative local with Care 1st, where they are allocating packages and creating rotas more optimal for care delivery and 'flattening demand' at peak times, i.e. considering whether visits are time sensitive or can be delivered at alternative times of the day.

3.4.2 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 also shared the following:

- **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.

- **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.

3.4.3 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.

- **Sustainable profit margins:** providers were asked which percentage profit would be sustainable for them to make. Here, responses ranged from 6% to 15% - this will reflect the impact volume has on apportionment of costs.

- Closer communication with the council: though it is important to stress that providers generally reflected positive relationships with brokerage teams, commissioning teams, and social workers, there is a general desire for closer communication with the council. This is both in regards to allocation of packages, as many providers do not think they receive the packages which are optimal for them, and in regards to defining care needs both at the outset and as time passes. This also reflects a wish from the providers that the social workers keep closer contact with the service users directly, to not further increase care worker's responsibility for the service user, unnecessarily increasing their workload.

- 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.

4 Cost Analysis and Scenario Modelling

4.1 Provider Cost Information & Data Quality

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

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

- 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).

Queries were raised with each of the 18 providers, of which 14 submitted additional data or took part in virtual meetings to discuss their return. The remaining 4 providers received a minimum of 3x engagement e-mails, offering different ways for them to address our queries. Following final analysis of the data, the queries which remained unanswered did not have a significant impact on the providers' cost output, and therefore no providers were excluded due to poor data quality.

4.2 Business Operating Model Observations

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

4.2.1 Volume

The providers who shared their data delivers an average of 826 hours of care and 1,228 visits per week, giving an average visit length of 40 minutes. At the lower end of the spectrum a provider delivered 56 hours and 94 visits, and at the upper end a provider delivered 1,805 hours 3,506 visits. Providers delivered on average 12.5

hours of care to each service user per week, ranging between 6.4 and 22 hours. Each provider manages on average 477 hours per care scheduler.

4.2.2 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 days. Three providers among those who submitted operate salaried contracts, and thus pay the staff who opt into this for the entire working day; these providers also have zero-hour contracts for the staff who prefers this. Care staff are reported to work on average 27.4 hours per week.

Base hourly rates range from £9.50 to £12.10 per hour, with weekend and bank holiday rates going up to £22.53 per hour. Providers who have Senior Carers pay them a base rate within £10 to £15 per hour, with weekend and bank holiday rates going up to £22.53.

Of the 18 submissions, 12 providers roll the travel pay into the hourly rate and pay a top-up at the end of the month should it be necessary. Five providers pay travel time separately at the hourly rate, one of these only recently started doing so in 2022.

4.2.3 Mileage and Travel

All providers who participated pay mileage to their drivers except one where this is rolled up into the hourly rate. This is also the provider with the highest pay rate for direct care. Mileage rates ranges from 25p to 45p per mile, with the average rate being 37p. Providers reported that their mileage expenses have increased between 0 and 80% since the last financial year, at an average of 21.1% increase in costs.

Of the 18 submissions, two providers reported no walkers, four did not submit data and the remaining 12 reported on average that 25% of their workforce are walkers, ranging between 2 and 70%.

Of the 13 providers sharing information on travel support for walkers, five do not provide any financial assistance. Of the remaining, seven are reimbursing or providing bus passes, two are paying travel time at the hourly rate (one of these on top of bus fare). Besides this, some providers reported additional support such as covering taxi fare for emergency covers, bike allowances, and paying cyclists 20p mileage (50% of the 40p mileage drivers receive).

Providers reported on average 1.3 miles between service users (Procomp analysis suggests this is higher at 2.18 miles and 6.67 minutes of travel time), and in the 1-to-1 meetings held with providers, it was often made clear that they are careful to only take packages within areas where they already have service users. 3-5 miles were typically mentioned as the maximum distance they will have care workers travel between service users for the package to be profitable.

4.2.4 Training and Supervision

All providers reported paying for training and supervision, except one provider not paying staff for induction training and shadowing. Of 13 providers sharing this information, eight pay induction and refresher training at carers' base rate, four pay at national minimum wage, and one pays national minimum wage for refresher training, but nothing for induction. Providers reported on average 4 annual full-time training days, ranging between 1 and 7.

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, stoma, Dementia, Parkinson's, stroke, PEG feed, BIPAP, and medication (ears, eyes, nasal sprays). Two providers also offer QCF qualification provided by colleges. Four providers stated that they currently do not provide any specialist training, though this can be sourced as needed by their service users.

4.2.5 Holiday, Sick Pay, Terms and Conditions

All providers reported that care 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], one provider added the comment that they have occupational sickness pay (OSP) in exceptional circumstances but otherwise operate SSP. Most providers were unable to report historical number of sick days in 2020-21, the two providers sharing this information reported respectively 60 days (total of 10 care workers) and 72 days (total of 43 care workers).

Providers in Bristol operate a mix of zero-hour contracts, guaranteed hour contracts (GHC) and salaried contracts. As can be seen in Figure 8, most providers offer different types of contracts to their care staff. Two providers reported conditions based on employment time to be able to opt into GHC.

Provider 7 in the graph below reported that they offer all care staff GCH and salaried contracts, however, no care staff have opted for this. Provider 4 and 11, who both operates salaried contracts, have reported that they encourage staff to choose this option, but that some care staff prefer the flexibility of GHC and zero-hour contracts. On average, 61% of staff are on zero-hour contracts, 31% on GHC, and 8% on salaried contracts.

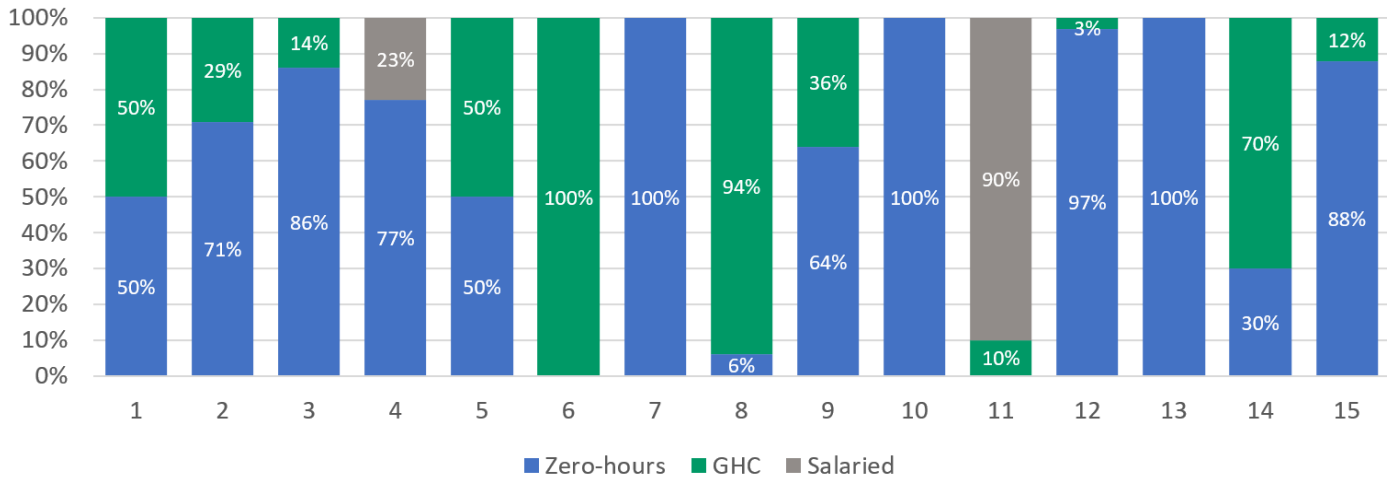


Figure 7: *Distribution of contract types which providers who submitted data on this currently hold with their care staff.*

4.2.6 Other Operating Model and Market Considerations

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

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

- Franchise models: In Bristol, as has been experienced by ARCC elsewhere, there has been increased interest from franchisees in the homecare market. We believe this is a growing market in homecare. Franchise models benefit 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 such as training courses, IT, Electronic Care Monitoring (ECM) and other assets.

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

  Owners of franchises have generally told us that they were able to grow during the pandemic, as other homecare providers either diminished or closed support; some business owners looked to how they could provide other forms of support in the community within the limitations and restrictions or access due to COVID.

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

- Ltd/single owner-operator business: A smaller homecare business that operates 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.

4.3 Median Analysis of Provider Cost Data

Analysis of the provider cost information submitted by Bristol providers, including the range, upper/lower quartile and median has been presented in Table 2. The reference data tables (presented as % of costs in each cost line against the total average unit rate for the provider, to preserve anonymity) is included in Appendix C.

All Providers	LOW	25%	MEDIAN	75%	HIGH
Hourly Breakdown	**Cost £**				
Care worker costs:	**£11.90**	**£13.98**	**£15.22**	**£15.77**	**£16.81**
Direct Care	£9.60	£10.13	£10.39	£11.40	£12.47
Travel Time	£0.00	£0.00	£0.00	£0.00	£1.77
Mileage	£0.00	£0.46	£0.65	£0.94	£1.27
PPE	£0.00	£0.00	£0.00	£0.19	£1.56
Training (staff time)	£0.00	£0.09	£0.20	£0.24	£0.97
Holiday	£1.18	£1.25	£1.36	£1.44	£1.59
Additional Non-Contact Pay Costs	£0.00	£0.00	£0.06	£0.37	£0.99
Sickness/Maternity & Paternity Pay	£0.00	£0.01	£0.19	£0.32	£0.73
Notice/Suspension Pay	£0.00	£0.00	£0.00	£0.00	£0.03
NI (direct care hours)	£0.01	£0.57	£0.74	£1.00	£1.32
Pension (direct care hours)	£0.00	£0.28	£0.35	£0.40	£0.45
Business costs:	**£3.64**	**£5.52**	**£7.30**	**£9.41**	**£12.89**
Back Office Staff	£2.21	£3.46	£4.38	£4.81	£8.78
Travel Costs (parking/vehicle lease etc.)	£0.00	£0.00	£0.00	£0.00	£0.00
Rent / Rates / Utilities	£0.01	£0.36	£0.55	£0.74	£0.88
Recruitment / DBS	£0.00	£0.05	£0.09	£0.59	£3.58
Training (3rd party)	£0.00	£0.00	£0.02	£0.18	£0.51
IT (Hardware, Software CRM, ECM)	£0.00	£0.18	£0.28	£0.47	£0.81
Telephony	£0.02	£0.05	£0.11	£0.18	£2.98
Stationery / Postage	£0.00	£0.06	£0.07	£0.09	£0.23
Insurance	£0.00	£0.05	£0.15	£0.19	£0.69
Legal / Finance / Professional Fees	£0.00	£0.01	£0.07	£0.21	£0.37
Marketing	£0.00	£0.00	£0.02	£0.19	£0.43
Audit & Compliance	£0.00	£0.00	£0.01	£0.04	£0.62
Uniforms & Other Consumables	£0.00	£0.00	£0.02	£0.07	£0.22
Assistive Technology	£0.00	£0.00	£0.00	£0.00	£0.11
Central / Head Office Recharges	£0.00	£0.00	£0.08	£1.22	£2.56
Additional Overheads (Total)	£0.00	£0.02	£0.05	£0.11	£0.95
CQC Registration Fees	£0.03	£0.08	£0.10	£0.13	£1.06
Surplus / Profit Contribution	**£0.00**	**£1.11**	**£1.47**	**£2.05**	**£2.96**
Total Cost Per Hour	**£17.10**	**£22.56**	**£23.51**	**£26.08**	**£30.68**

Table 3: *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 58.1 hours and 315.8 hours of care per week per FTE back-office staff member, showing the great difference in back-office size, with an average of 204.6 hours.

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, equipment hire, employee accommodation, pool car maintenance, and health & safety expenses.

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 all costs are included in the model. Therefore, the overall costs are representative of the businesses, despite some providers not able to accurately split out all overhead or indirect pay costs.

ARCC expresses Return on Operations [ROO] in Homecare 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

4.3.1 Treatment of zero "£0" cost lines

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

4.4 Factors that affect the median cost of care

It should be noted that the median cost of care the exercise may not match any particular fee rate – nor might it be expected to. The exercise is aimed at understanding the unit cost and *not aimed at* disaggregating different levels of income or price points paid for care. Whilst both "sources of funding" and "expenditure" should ideally match in order to assure the validity of any set of costs; exploring income and profit in detail is *not the purpose of the exercise* and therefore checks and balances must always be applied.

It is not uncommon however for any typical observer to want to understand why this variance exists, and so it is important for ARCC to offer context in this report as to how the outputs results can be impacted by real-life business operations.

- **Not all customers are equal:** Customers do not always buy care from the same provider at the same fee rate. Providers receive varying fees from the host local authority, outside local authorities, self-funders and

continuing health care (CHC). Evidently, arriving at a single "unit" cost will be reflective of the **blended average rate** across the income and sources of funding received from all customers. In addition, other variances such as whether someone purchases care on a bank holiday; or needs a materially different package of care from a different level of trained staff will affect portions of cost from all aspects of the business.

- **Impact of costs during the pandemic:** Reviewing actual costs in 2021-22 is a helpful comparator when married alongside the DHSC requirement to model "expected" cost as of April 2022, which inevitably requires some form of forecasting and cannot always be guaranteed to be accurate. However, we must be cognisant that the last two years have also been exceptional and therefore may not represent the most ideal situation in which to assess future costs. This is made more complex by the exceptional amount of grant funding applied to the sector to cover extraordinary costs in this year, and whilst some providers may make effort to disaggregate any expenditure via these routes, it can never be guaranteed that all costs are considered "normal" costs and so may be affected by additional non-typical costs during the pandemic years.

- **Variances between what is paid for and what is delivered:** The homecare sector currently predominantly applies the same unit of measure in order to define the cost and price point of services provided. This is almost universally recognised as paying for time-and-task, which we will refer to as the "currency" of care. The reality 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.

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

4.5 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 11th August 2022 and also the commissioner workshop held on the 15th August 2022. For the purposes of this report, the following scenarios have since been modelled:

- **Scenario #1** **"median model" provider at unit cost of £23.51,** 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** base carer pay set at £10.93p/h to reflect pay rates for an NHS Band 2 worker

- **Scenario #3** base carer pay set at £11.50p/h to reflect pay rates for competitive sectors for the workforce, such as retail

4.5.1 Underlying Assumptions for the Cost Modelling

Typically, cost of care analyses use the starting point of an hourly 'rate' of care, and then break down the apportionment of cost lines to arrive at a unit rate that is representative of either local benchmarking or meets local needs.

ARCC's approach[15] was to create a bottom-up model, which utilises annualised costs and volumes of care delivery for the 'median' provider size within the local area, and aggregates costs on an annual basis, from which an indicative "cost per hour" can be derived. This more accurately represents a 'profit and loss' statement (or budget) for the purposes of simulating representative business costs. Critically, all costs are then taken into account *in the context of the reference provider business size*, i.e. representing the costs a business of that size typically incurs.

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

$$\frac{\text{Variable Costs (costs vary with the volume of care hours delivered, such as contact pay, travel pay, direct care related on-costs)} + \text{Fixed Costs (such as back office staff costs and overheads)} + \text{Profit Margin (\% mark-up applied for sustainability and growth)}}{\text{Total care hours commissioned (i.e. the unit of time to be paid for)}} = \text{Effective Hourly Unit Rate}$$

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 used 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 are 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 (35,187 hours p/annum; c.677 hrs per week)
- The median weighted average visit duration of 47.3 minutes
- PPE included as overhead costs £0.20p per hour
- Profit mark-up is set at 6.2%
- Bank Holidays have a 50% enhancement applied to the base rate (depending on level of staff)
- Team Leaders/back office staff are super numeri
- All care staff working hours (including non-contact hours such as travel and training) are paid at the same rate as F2F hours
- Assumes 100% of staff on 3% pension
- Does not include billed hours which accrue less than full cost i.e. hospital payments

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

4.5.2 Scenario #1 median "model provider"

The median "model provider" (£23.51) has been informed by the median cost lines in Table 2. It should be noted that by the nature of using aggregated figures across a range of provider data, the "median" model does not represent any one particular provider, however the total unit cost does represent the "median" provider within the dataset. Therefore, it can be assumed that the breakdown of costs is at least appropriate to the make-up of a modelled business, albeit no single setting may have the exact costs incurred within this model.

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

The variation in cost for different visit lengths is due to the cost per hour being different from the cost per visit.

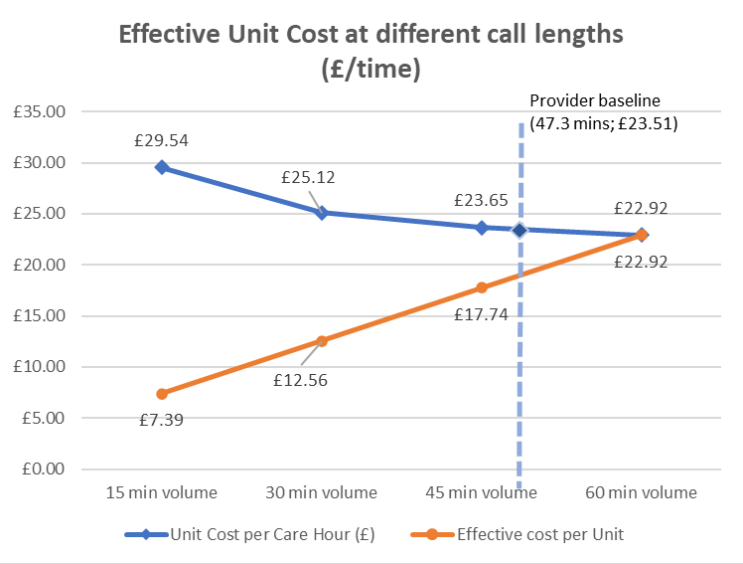
Travel time and mileage can typically be worked out (on average) per visit, however it cannot be worked out the same on average per hour. This is why the cost base materially changes depending on the average visit time and the number of visits.

In addition, accruing more travel time will accrue more holiday pay and employer's NI, further impacting unit costs. The cost model only produces one rate at a time.

It is by its nature a COST model, not a PRICING model. It is more accurate and straightforward to model (from a cost perspective) a single, aggregate number of visits and annual hours.

The variations on this (table below) can be modelled using the same volume of hours, by increasing the total visits needed to achieve the same care volume.

Scenario Models[16]	Description	Unit Cost per care hour[17]
#1a 15-minute call duration	*Median cost adjusted to reflect avg.15-minute call duration*	£29.54
#1b 30-minute call duration	*Median cost adjusted to reflect avg.30-minute call duration*	£25.12
#1c 45-minute call duration	*Median cost adjusted to reflect avg.45-minute call duration*	£23.65
#1d 60-minute call duration	*Median cost adjusted to reflect avg.60-minute call duration*	£22.92



The effective unit cost is shown on the chart on the left at different call lengths.

The actual weighted "visit" cost is also shown by the orange line on the chart.

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

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

4.5.4 Scenario #2 carer pay rate commensurate with NHS Band 2

Agenda for Change NHS Band 2 with 2+ years' experience is currently £10.93 per hour. The base pay rate for carers in the model has been increased to account for this. Back office staff costs have also been uplifted to account for commensurate increase in wages for front line staff, to maintain a consistent level of retention across the provider model.

In addition, it should be noted that increases in holiday, training and other pay costs also apply.

4.5.5 Scenario #3 carer pay rate commensurate with other sectors

To account for a more competitive working environment, it can be considered that workforce retention within the sector can incur pressure from other sectors such as retail. Therefore, this model uses £11.50 per hour as the base pay rate for carers to account for this. As with scenario #2, Back office staff costs have also been uplifted to account for commensurate increase in wages for front line staff, to maintain a consistent level of retention across the provider model.

In addition, it should be noted that increases in holiday, training and other pay costs also apply.

4.6 Future Fee Uplifts and Sensitivity Analysis

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

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

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

- Efficiency of provider shifts/call runs: An efficient run minimises travel distance and time between calls, and several calls in a small neighbourhood (within a street or block for example) will not attract the same travel time or mileage as disparate calls 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 however be considered that larger organisations always offer better value for money or improved service quality to the market, rather that scenario costs are inclusive of as much size and scale that the market has to offer, and that a mix of both large and small business is obtainable in any given market.

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

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

Of course, the intention of an analysis of this nature is never to arrive at a *specific cost to each provider's business. The cost model merely aggregates a sample of provider data to provide an indicative set of figures for consideration.* It is the role of commissioners to assure themselves that the rate paid is inclusive and commensurate with a 'cost envelope' that supports a sustainable, diverse and quality market as per the Care Act.

Commissioners and providers should recognise that the role of any fee-setting is ***not*** to specify the absolute operating costs at every level of a provider's business. 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.

5 Future Commissioning Considerations

5.1 Future Commissioning Considerations

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

5.1.1 Sustainable Homecare Delivery

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

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

  The work Bristol City Council are currently conducting with Procomp is an important step towards not only optimising route planning, but also adjust the factors in package allocation and scheduling that will have the greatest impact on increasing productivity and minimise wating and travel time for care staff.

- **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.

- **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 that Bristol City Council previously allocated geographical areas to specific providers, these providers remain with very area-specific workforces, and thus benefit from continuing to be able to focus their packages accordingly through collaboration with providers that may have better coverage of other areas.

- **Better quality and financial KPIs:** Quality of service provision and financial sustainability are the two biggest measures in effectively monitoring delivery of contracts. Over the course of contracts, it is often the case that information requirements grow, and can inadvertently represent an administrative burden for providers, without necessarily providing the required insight for commissioners. Whilst commissioners recognise the need to understand more about provider delivery, more data can lead to less time for meaningful exploration and insight into the impact that changing quality and financial measures are having on market dynamics. As such, a "less is more" approach is advocated – by focusing on fewer, more important indicators, commissioners can learn more and intervene more effectively, in a more collaborative, mutually beneficial arrangement, 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 commissioner's expectations. Some providers may spend more on front line staffing, whereas others may focus on back-office costs or head office infrastructure that supports their individual operational growth. The purpose of the exercise is to validate that future fee rates set by commissioners has a strong existing base with which to understand various cost pressures, as well as recognise that a range of operating models (large and small providers) should be able to operate in any single market.

5.1.2 Care packages rather than care hours

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

5.1.3 Geographical zones, localities and volume considerations

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.

5.1.4 Locality Provision

In testing the travel time assumptions, reasonable travel times were discussed with providers; ARCC recommends that Bristol CC 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. Analysis from the Procomp pilot and data gathering from a wider representation of providers will also be beneficial.

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. Providers are free to take packages across the city, while in reality most providers engaged for the project target a specific geographical area. However, providers seeking to grow are free to expand to take packages in other regions.

5.1.5 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.

5.1.6 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 Real Living Wage) 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)

5.2 Recommendations

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

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

Whilst a long-term intention, in line with this DHSC cost of exercise, may be to work towards the estimated median of £23.51, DHSC guidance states that "fair means what is sustainable for the local market". The council should continue to monitor the pressure in the market (both staffing and business operating costs) through future fee exercises, and as was the case for this financial year with a 6.19% 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).

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.

5.2.2 Emerging findings from the AHSN Workforce Challenge Programme

During the time conducting this exercise with Bristol, ARCC have also been supporting the South West/West of England Academic Health Science Network (AHSN) and Health Education England's Domiciliary Workforce Challenge Programme which is being delivered by Procomp. ARCC supports some of the initial findings and recommendations emerging from the Programme, including support for more individual task-focused activity planning as opposed to time-and-task, as well as exploring efficiencies and better integration across the market between health and social care. Most notably:

a. Support/empower the provider market to have conversations regarding how **needs can be best met**; focussing on activities to support individuals as opposed to times and durations of calls (see 5.1.2).

b. Further explore the efficiencies that could be generated through the introduction of **delegated health tasks** into the homecare market, in light of emphasis on community-based care and new models of outcomes-based care commissioning.

c. Procomp analysis has identified currently 17-18% non-critical work being carried out across all care visits in their current pilot. Further work in this area to identify the nature of these **non-regulated activities** will be beneficial; this data can then be mapped against current 'non-regulated' (including VCSE provision) to identify potential referral pathways. In light of the growing demand for homecare (figure 2), this has the potential improve capacity in regulated personal care. It is important to note that this will require close collaboration with assessment and care management colleagues to understand and adjust how cases may be appropriately redirected to non-regulated community provision.

5.2.3 Explore improved community pathway opportunities

Bristol should also explore opportunities related to hospital discharge and identified pathways for customers, to ensure that people can be appropriately supported closer to home (i.e. particularly for any cohort of customers that may be on pathway 3 whom can be supported at home). This should also be considered in conjunction with the in-house Reablement model of care which provides both Reablement to independence and Reablement moving into homecare services for customers who require long-term packages of care.

Managing service user expectations will need to be done through effective setting of expectations at the point of hospital discharge, reablement and then communication and training for long-term care providers to further maximise independence.

5.2.4 2024 specification and re-commissioning

The requirement for BCC to re-tender contracts in 2024 provides a valuable opportunity to utilise the findings from this exercise together with the Procomp pilot. Specific considerations include:

d. New contracting and payment models such as exploring tiered or weighted rates for care and the relative benefit of adopting weighted unit rates for 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 4.4.4.

e. 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. Considerations include:

- 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 Bristol City Council'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.

f. Empowering provider and clients to have greater flexibilities in relation to how care is delivered; some examples include: adoption of a Trusted Assessor model, use of virtual Individual Service Budgets (ISB's)[18]. This will necessitate determining what new skills Bristol Council needs both externally from providers to instigate review and assessment capacity and internally within social work teams to support this.

g. 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.

5.2.5 Monitor and evaluate the implementation of the Ethical Care Charter

Evaluate the impact of Bristol CC's commitment to the Ethical Care Charter. Whilst implementation is within its infancy, analysis of cost suggests there are some areas of provider costs which don not currently meet the requirements.

It would be beneficial to follow up with the market with a detailed survey, as part of regular contract monitoring requirements, which assess what elements of working time are paid for and at what rates, including the elements of sick pay and other policies that support better workforce retention.

[18] For example better use of existing package 'hours' to be viewed as a 'virtual budget', with continued dialogue from providers as to how they propose to use this budget through a combination of reablement, technology, and virtual support to clients.

5.2.6 Assessment of the impact of implementing the Clean Air Zone on homecare

An impact assessment of the introduction of further challenges are expected to arise once Bristol's Clean Air Zone[19] is introduced on the 28th November 2022, as charges will be levied to cars not meeting the emission standards. The Council may need to consider offsetting the costs to community social care workers or providers via:

a. Vouchers or discounted passes to care workers
b. Exemptions for employers
c. Offset costs via unit fee rates for care that can be passed down to care staff through provider businesses

5.2.7 Develop new 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.

[19] Details can be found at https://www.bristol.gov.uk/residents/streets-travel/bristols-caz

6 Appendices

A. Provider Cost Survey & Workshop Slides

ARCC-Bristol%20Homecare%20Survey%20E	Homecare Cost Survey (distributed 31st May 2022)
Bristol Provider Workshop Presentat	Homecare Interim Workshop (Providers) 15th August 2022
BCC%202022-23%20Home%20Care%20An	Annex A Median Cost Analysis
BCC%202022-23%20Home%20Care%20Ne	Cost Models (FINAL) 12th-16th September

B. Engagement List of Internal Stakeholders & Provider Organisations

Bristol City Council

- Deputy Director of Commissioning
- Interim Strategic Commissioning Manager (Older People)
- Strategic Commissioning Manager
- Finance Business Partner
- Interim Principal Accountant (Adult Social Care and Public Health)
- Contracts and Quality Officer (Strategic Commissioning)
- Senior Contracts & Quality Officer for Home Care Contracts
- Commissioning Manager

Bristol Care Association

- Chief Executive of Care and Support West

Invited Homecare Providers

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

C. Reference Data Table [anonymised]

All Providers	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	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 £
Care worker costs:	**£15.64**	**£15.79**	**£16.34**	**£15.37**	**£16.81**	**£15.08**	**£13.56**	**£14.97**	**£14.36**	**£14.57**	**£16.56**	**£15.70**	**£16.76**	**£15.48**	**£13.85**	**£13.11**	**£11.90**	**£13.03**	**£11.90**	**£13.98**	**£15.22**	**£15.77**	**£16.81**
Direct Care	£11.71	£9.73	£11.53	£10.76	£11.42	£10.46	£10.00	£11.35	£10.20	£10.71	£12.47	£10.25	£11.49	£10.11	£10.28	£9.66	£9.60	£10.32	£9.60	£10.13	£10.39	£11.40	£12.47
Travel Time	£0.00	£1.50	£0.00	£0.00	£0.49	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£1.77	£0.00	£1.28	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£1.77
Mileage	£0.82	£0.92	£1.01	£0.90	£0.58	£1.27	£1.07	£0.21	£0.51	£0.95	£0.00	£0.59	£0.44	£0.72	£1.06	£0.54	£0.43	£0.24	£0.00	£0.46	£0.65	£0.94	£1.27
PPE	£0.23	£1.05	£0.19	£0.00	£0.00	£0.00	£0.00	£0.17	£0.31	£0.01	£0.02	£0.00	£1.56	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.19	£1.56
Training (staff time)	£0.04	£0.00	£0.05	£0.24	£0.24	£0.56	£0.00	£0.10	£0.23	£0.33	£0.97	£0.40	£0.19	£0.08	£0.16	£0.21	£0.19	£0.23	£0.00	£0.09	£0.20	£0.24	£0.97
Holiday	£1.39	£1.22	£1.40	£1.46	£1.56	£1.42	£1.21	£1.34	£1.30	£1.36	£1.59	£1.46	£1.36	£1.45	£1.24	£1.23	£1.18	£1.27	£1.18	£1.25	£1.36	£1.44	£1.59
Additional Non-Contact Pay Costs	£0.00	£0.32	£0.53	£0.61	£0.73	£0.99	£0.00	£0.39	£0.00	£0.24	£0.00	£0.02	£0.00	£0.25	£0.00	£0.11	£0.00	£0.00	£0.00	£0.00	£0.06	£0.37	£0.99
Sickness/Maternity & Paternity Pay	£0.20	£0.22	£0.00	£0.73	£0.43	£0.18	£0.00	£0.05	£0.43	£0.31	£0.00	£0.20	£0.00	£0.39	£0.14	£0.32	£0.00	£0.09	£0.00	£0.01	£0.19	£0.32	£0.73
Notice/Suspension Pay	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.03	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.01	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.03
NI (direct care hours)	£0.87	£0.43	£1.22	£0.66	£0.92	£0.01	£0.94	£1.10	£1.02	£0.48	£1.06	£0.61	£1.32	£0.78	£0.61	£0.69	£0.44	£0.55	£0.01	£0.57	£0.74	£1.00	£1.32
Pension (direct care hours)	£0.40	£0.39	£0.41	£0.00	£0.45	£0.18	£0.34	£0.27	£0.35	£0.17	£0.45	£0.39	£0.39	£0.41	£0.35	£0.35	£0.07	£0.31	£0.00	£0.28	£0.35	£0.40	£0.45
Business costs:	**£8.43**	**£12.89**	**£5.43**	**£7.95**	**£10.87**	**£8.09**	**£9.93**	**£5.69**	**£4.15**	**£7.67**	**£5.47**	**£9.74**	**£9.94**	**£6.93**	**£5.10**	**£5.95**	**£3.64**	**£6.52**	**£3.64**	**£5.52**	**£7.30**	**£9.41**	**£12.89**
Back Office Staff	£3.75	£3.43	£3.56	£4.69	£7.49	£4.44	£8.78	£3.11	£2.21	£4.84	£4.42	£6.58	£4.19	£4.35	£2.58	£5.12	£3.24	£4.50	£2.21	£3.46	£4.38	£4.81	£8.78
Travel Costs (parking/vehicle lease etc.)	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Rent / Rates / Utilities	£0.36	£0.80	£0.74	£0.88	£0.75	£0.30	£0.37	£0.47	£0.20	£0.72	£0.20	£0.62	£0.49	£0.70	£0.55	£0.01		£0.86	£0.01	£0.36	£0.55	£0.74	£0.88
Recruitment / DBS	£0.59	£3.58	£0.05	£0.00	£0.87	£1.00		£0.20	£0.09	£0.11	£0.05	£0.08	£0.27	£0.59	£0.04	£0.00	£0.06	£0.05	£0.00	£0.05	£0.09	£0.59	£3.58
Training (3rd party)	£0.24	£0.00	£0.31	£0.00	£0.29	£0.00		£0.10	£0.02	£0.17	£0.09	£0.01	£0.51	£0.00	£0.00	£0.00		£0.00	£0.00	£0.00	£0.02	£0.18	£0.51
IT (Hardware, Software CRM, ECM)	£0.64	£0.48	£0.27	£0.47	£0.51	£0.28		£0.18	£0.18	£0.12	£0.21	£0.45	£0.81	£0.39	£0.18	£0.00	£0.23	£0.37	£0.00	£0.18	£0.28	£0.47	£0.81
Telephony	£0.02	£2.98	£0.11	£0.12	£0.08	£0.48		£0.03	£0.07	£0.06	£0.02	£0.33	£0.05	£0.11	£0.18	£0.17	£0.03	£0.18	£0.02	£0.05	£0.11	£0.18	£2.98
Stationery / Postage	£0.16	£0.08	£0.08	£0.09	£0.12	£0.23		£0.04	£0.08	£0.06	£0.00	£0.08	£0.06	£0.07	£0.07	£0.00		£0.06	£0.00	£0.06	£0.07	£0.09	£0.23
Insurance	£0.15	£0.02	£0.06	£0.00	£0.23	£0.18	£0.69	£0.05	£0.05	£0.30	£0.24	£0.19	£0.10	£0.18	£0.00	£0.16		£0.11	£0.00	£0.05	£0.15	£0.19	£0.69
Legal / Finance / Professional Fees	£0.05	£0.02	£0.07	£0.00	£0.00	£0.32		£0.07	£0.07	£0.14	£0.00	£0.26	£0.37	£0.15	£0.00	£0.30		£0.20	£0.00	£0.01	£0.07	£0.21	£0.37
Marketing	£0.24	£0.02	£0.00	£0.18	£0.29	£0.43		£0.00	£0.02	£0.12	£0.02	£0.00	£0.22	£0.03	£0.00	£0.00		£0.00	£0.00	£0.00	£0.02	£0.19	£0.43
Audit & Compliance	£0.05	£0.02	£0.00	£0.00	£0.00	£0.04		£0.12	£0.01	£0.62	£0.00	£0.00	£0.09	£0.02	£0.00	£0.00		£0.02	£0.00	£0.00	£0.01	£0.04	£0.62
Uniforms & Other Consumables	£0.12	£0.01	£0.07	£0.00	£0.06	£0.08		£0.00	£0.02	£0.04	£0.07	£0.05	£0.00	£0.22	£0.00	£0.00	£0.02	£0.02	£0.00	£0.00	£0.02	£0.07	£0.22
Assistive Technology	£0.11	£0.00	£0.00	£0.00	£0.00	£0.00		£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00		£0.00	£0.00	£0.00	£0.00	£0.00	£0.11
Central / Head Office Recharges	£1.51	£0.40	£0.00	£1.33	£0.00	£0.16		£1.19	£0.88	£0.00	£0.00	£0.00	£2.56	£0.00	£1.34	£0.00		£0.00	£0.00	£0.00	£0.08	£1.22	£2.56
Additional Overheads (Total)	**£0.36**	**£0.00**	**£0.06**	**£0.02**	**£0.00**	**£0.02**	**£0.00**	**£0.04**	**£0.18**	**£0.23**	**£0.04**	**£0.95**	**£0.12**	**£0.10**	**£0.04**	**£0.05**	**£0.00**	**£0.08**	£0.00	£0.02	£0.05	£0.11	£0.95
CQC Registration Fees(4)	£0.09	£1.06	£0.06	£0.16	£0.19	£0.13	£0.09	£0.09	£0.06	£0.15	£0.11	£0.14	£0.09	£0.03	£0.12	£0.12	£0.06	£0.08	£0.03	£0.08	£0.10	£0.13	£1.06
Surplus / Profit Contribution	**£0.95**	**£2.01**	**£2.18**	**£2.96**	**£1.38**	**£2.32**	**£0.00**	**£2.07**	**£0.93**	**£0.89**	**£1.10**	**£1.27**	**£1.34**	**£1.12**	**£1.89**	**£1.91**	**£1.55**	**£2.95**	**£0.00**	**£1.11**	**£1.47**	**£2.05**	**£2.96**
Total Cost Per Hour	**£25.02**	**£30.68**	**£23.95**	**£26.28**	**£29.06**	**£25.48**	**£23.49**	**£22.73**	**£19.44**	**£23.13**	**£23.13**	**£26.71**	**£28.04**	**£23.54**	**£20.84**	**£20.97**	**£17.10**	**£22.50**	**£17.10**	**£22.56**	**£23.51**	**£26.08**	**£30.68**