Cost of Care Annex B: Domiciliary Care

(Ealing Council)

Contents

Introduction and exercise constraints

For clarity, as defined by the Department of Health Guidance, the cost of care best describes the actual costs a care provider incurs in delivering care at the point in time that the exercise is undertaken. It is typically presented as a unit cost for an hour of domiciliary care or a bed per week in a care home. Fee rates or prices most commonly refer to the figure a local authority sets and/or agrees to pay a provider for a particular service and will vary in relation to the type of service, contractual framework or level of need. For reporting purposes for this exercise as defined by the Department of Health, and in terms of understanding the cost of care, "fair" means 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. Fair/median costs are considered *under this exercise* to be "what is sustainable for the local market." The government recognises that this may oversimplify what is a complex picture of care and support needs. But for data collection purposes it is necessary to find a way of standardising cost reporting. 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. However, as commissioners, we have a fundamental difference of opinion in the relevance of a median as sustainable. In statistical terms, given the wide variety of operating models within each setting, while a helpful benchmark, it is a very simplified model and would

not be used in lieu of detailed market analysis and more nuanced provider engagement and understanding to inform the councils direction of travel in relation to fees and sustainability.

This document provides key interpretation notes for the Cost of Care (CoC) home care outputs that have been provided in annexe A. We have several caveats, concerns, and qualifications about the validity the approach and results of this exercise, which we will attempt to illustrate in summary. While we recognise the benefit of attempting to establish a shared understanding of operating costs, we do not feel confident that this initial result is satisfactory or indicative of the reality for the range of home care providers who operate in the borough, or with whom we commission packages of care. We had a good response rate from the 58 home care providers in the borough (24 in total equating to a response rate of 41.4%) but a small sample of useable returns (the equivalent of 13 useable returns were included in the calculation equating to 22.4% of providers). However, in line with the guidance, the results provide a starting point for ongoing engagement with the market to understand and respond to a range of sustainability issues and continue to gear our fee/pricing approaches in a way that fulfils our statutory market shaping duties in a challenging economic climate.

It will also help us to continue the wider conversation about the impact of future changes outlined in section 18.3 of the Health and Care Act.

More detailed explanation about the approach, sample and results are provided in this Annexe. However, it has been difficult to work in this space given the uncertainty about the extent to which high or low CoC median values in this exercise will influence future grant funding. We expect challenges in managing expectations, the extent to which these medians anchor councils to commitments on future prices or rates, which is not the intention, but is something that will, along with our detailed local market analysis and understanding, inform council commissioning and the work we do with sub regional partners. There has been a notable lack of clarity on these issues which has left us, and other councils we have spoken to, in a very difficult position in relation to financial planning and market engagement. Unfortunately, in our view, in addition to issues about the method and statistical relevance of the data capture, this lack of clarity has contributed to questions about the usefulness of the entire exercise.

Response rate, sample size & standardisation

Ealing Council engaged a reputable external partner (Care Analytics) to conduct the statistical analysis on receipt of the submissions. Ealing has worked with this partner for many years to conduct similar pricing and commissioning analysis work. The same partner was used by 2 other neighbouring boroughs, which facilitated the mirroring of our existing sub regional commissioning and market management arrangements and was informed further by their existing understanding of the market in Northwest London. All eligible home care providers based in the Borough were engaged in this exercise, through written communication and a series of online provider forums, with and without the third party supporting the exercise, and electronic qualitative surveys. Support was provided by the partner agency, and the councils Market Management team conducted numerous telephone-based surveys to ascertain and increase the level of participation in the exercise. However, as outlined in this report, there are considerable issues with the relevance and accuracy of the calculated results based on the useable submissions, despite a comparatively high return rate.

As per our methodology for this exercise, we have had to often make interpretation decisions about the submitted surveys to be able to calculate a reliable unit cost for each provider. This includes using standardised assumptions where data is missing or unclear, as well as adjusting answers if there is a clear error and the survey is only coherent with a particular interpretation. Such changes have only been made once the query process closed.

However, we have not disallowed or excluded costs (whether back-office staffing, care worker rates of pay, or non-staff costs) simply on the basis that we consider them

unaffordable. But in some instances, if the provider would not respond to queries and the overall unit cost was deemed infeasible, surveys have been excluded.

There are 58 registered home care providers located in Ealing. Surveys were received from 24 homecare providers.

10 surveys were excluded on the grounds of data quality. Some of these providers are not based in Ealing, though they do operate in the borough (based on the data submitted). There are varied and valid reasons for excluding submissions including size of operation, small number of hours, inconsistency with lines of data, payroll reconciliation, access to accounts, partial returns or non-engagement to resolve queries. The data submitted within the excluded surveys will contribute to our understanding of the local market on a selective basis. However, it would require a disproportionate amount of work and engagement with these providers to try to produce a reliable unit cost for their delivery in the time available.

We have been able to use up to 13 homecare surveys in the council's draft CoC return.

However please note that just because we have included 13 surveys, it does not mean that the information is fully robust. Many (if not most) of the surveys had significant reliability issues in some areas. However, we did not set a high qualifying threshold in terms of data quality as the sample size would become too small. Most of the 13 providers were not available or willing to respond to follow up queries before the cut off period, and therefore standardised assumptions have been made.

The following are the most important points regarding both data quality and composition of the usable surveys.

- Only 3 of the 13 providers with usable surveys **only** operate in Ealing. This can have a distorting impact where other councils either have markedly different hourly rates and/or different payment rules. Where providers identified that they paid care workers differently in the boroughs they work, we have calculated Ealing-specific unit costs.
- 5 of the 13 providers were unable or unwilling to aggregate visit information only supplying the number of hours they deliver. For these providers, we have had to use a standardised 50-minute average visit duration to be able to calculate their care-worker unit cost, which is representative of Ealing homecare providers.

We are advised that a sample size of this nature has not been unusual for home care cost exercises. Intelligence provided by the partner agency suggests that this typically

accounts for most of the market in terms of hours in some areas, so small sample sizes are often unavoidable.

However, with a sample size of this order, and given the limitations, the error margin for reporting median and quartile results as required by the DHSC can be very large.

Whilst our extensive query process has tried to close or reduce uncertainties to a minimum, there remain reliability issues with some surveys that we have no choice but to use for CoC returns. It is generally better with small samples to use equal weighting for each provider, rather than weight results by branch size.

This is because treating each survey equally minimises the impact of error caused by individual surveys. However, in other respects, this is not ideal as small providers have undue influence on the results.

We have a buoyant home care market in Ealing with a range of providers working under our Dynamic Purchasing System providing sufficient CQC (Care Quality Commission) rated Good care to meet the Councils requirements. There are 147 provider agencies on our home care DPS (Dynamic Purchasing System) (Dynamic Purchasing System), and 58 located in the borough (though we do not commission care from all of them). Arguably the market has over the years developed to reflect the councils' DPS contract terms, commissioning priorities and payment methods. This has resulted in the growth of smaller more agile and competitive provider market, with perhaps more limited administrative capacity to undertake these sorts of tasks.

We are aware that Ealing has had a long history of lean commissioning for home care provision, with some of the most efficient contractual pricing arrangements in London. Price bandings for new packages of care are reviewed annually, following a borough and sub regional price analysis, but we recognise that even with uplifts applied, we have operated contractually from a price base that is lower than London averages.

Unlike Care Homes, the costs incurred by homecare providers do not exist independently from how councils commission and pay for homecare. Most homecare branches (at least those above a certain size) deliver most of their care for councils. Only a minority of larger branches have other customers in any great scale. For most providers, there is therefore no possibility of widespread subsidy from other customers in the traditional sense of the word. The ratio of fixed-to-variable operating costs also does not support the business case for widespread subsidy. It would be erroneous to assume the same type of market dynamics that apply in the elderly care home sector also apply homecare. In most markets, there are simply not that many homecare providers that deliver significant

numbers of hours for both private and council-funded residents. The actual situation in most councils is that they have monopsony power over their homecare market, and the market that exists is largely determined by the historical momentum of past commissioning decisions, and notably payment rules.

We now have a funded Corporate Plan commitment to move our DPS homecare provision to be compliant with the Real Living Wage, and plans are in place to transact this change from November 2022, which falls outside the timeframe for this exercise. We have adjusted for the forecast impact of this in calculating the average rates paid for the current year in the attempt to compare fees to the initial results of this cost of care exercise.

This move to RLW (Real Living Wage) is an important and significant price adjustment and reflects our commitment to support the social care workforce which is a major factor in sustainability, cost and price for home care provision in particular. A key factor in these plans will be to provide more detailed audit and intelligence on workforce issues, employment terms, payroll and visit data within this sector. As outlined, this is an area that has not been interrogated sufficiently in this exercise due to time, data availability, provider engagement and/or poor data quality. There are inconsistencies in the data provided for this exercise, from useable and unusable samples, that confirm this needs to be an area for of further engagement and clarification.

In several important respects, producing a cost model (or establishing a unit cost) for homecare is simpler than for care homes. For example, the complications associated with large capital costs and the need to apportion staff costs to different customers do not exist to anywhere near the same extent for homecare as they do for care homes. Despite this, there are other complications that mean that producing robust cost models or unit costs for homecare is more complicated overall than for care homes. This is because homecare has multiple dynamic, interacting variables that can all have a profound impact on unit costs. These include visit length, travel time, worker wages, types of workers (e.g., full or part time) as well as branch size and overheads. The reason the above variables interact is that changes in one variable usually also affects the magnitude of any changes in the other variables. Given the dynamic approach to commissioning (and the fact that our contracts do not offer any guaranteed minimum volumes), the market tends to supply in response to demand, and even localised geographical demand given travel time considerations.

Another factor is that homecare branches quite often deliver a range of different services. This can include homecare in extra care settings, live-in care charged at an hourly rate, live-in care charged at a weekly or daily rate (at a much lower effective

hourly rate), waking nights, sleep-in care, sessional support, supported living, and more. Although less common, some also double as recruitment agencies or have other business activities accounted for using the same company.

This often requires judgement about how to apportion back-office and other business overhead costs to different services so that a unit cost for standard visit-based homecare can be calculated. Again, this can have an error margin.

The point of the above is not to bring into question the value of homecare cost modelling. Producing robust cost models is an important part of both (i) illustrating the various cost drivers in the sector, and (ii) helping ensure that council fee levels are broadly aligned to the rough cost of delivering care based on reasonable operating assumptions.

However, the fact remains that in any homecare cost model (or unit cost exercise) there are at least 7-8 areas where costs can be under or overstated by circa 1-2% of the overall unit cost (with a much greater error margin in relation to paid travel time assumptions).

Ultimately, this is about balance. If all these 7-8 areas are generously interpreted, the total unit cost could be overstated by circa 10-15%. Similarly, if all assumptions are 'tight', the total unit cost could be understated by a similar amount.

The reported PPE costs were found generally a reasonable indication of costs for 2022-23, whilst the government portal remains open. If the portal closes next year, the cost implications will largely depend on government guidelines on mask usage and mask unit costs at the time. This would be an additional cost next year (compared to the reported CoC results), potentially in the region of £0.25 per hour (total cost, not additional cost).

Standardised assumptions have been applied where necessary to the treatment of these variables such as return on operations, travel time, contact time, training and supervision, holiday pay, statutory sick pay as well as employer national insurance and pension costs. This is a useful starting point but will require further analysis and engagement in our forthcoming detailed commissioning analysis. This is not available for the submission on median costs. It is noted that various ways in which elements of worker pay, and other non-pay cost lines are reported and interpreted can vary the output of reported operating costs relative to council rates. However, our process of (i) scrutinising costs, (ii) excluding the most unreliable surveys, and (iii standardising assumptions to a reasonable level may also result in CoC median costs that are likely to be lower than those of many other councils who have used different data collection methods.

Return on Operations

Previous analysis has modelled a lean "floor" minimum price and an expectation of a sustainable surplus normally ranging from 3% to 10%. The context for this can vary considerably. For the purpose of this exercise, we have exercised judgement on sustainable models being 5%. The interplay of contractual payment rules on return on operations is also a factor for further analysis.

This is one of a few standard assumptions that have had to be applied in order to provide this first cut of data but based on interpretation could vary the cost models by +/- £1 – 2 per hour.

The modelling of the impact on the hourly rate at different Return on Operation percentages is shown ***below for illustrative purposes***

Illustrative totals	**18+ domiciliary care**	**15 minutes**	**30 minutes**	**45 minutes**	**60 minutes**
Total with a 3% return on operations	**£17.58**	**£19.39**	**£18.08**	**£17.64**	**£17.42**
Total with a 5% return on operations	**£17.92**	**£19.77**	**£18.43**	**£17.98**	**£17.75**
Total with a 7.5% return on operations	**£18.35**	**£20.24**	**£18.86**	**£18.41**	**£18.18**
Total with a 10% return on operations	**£18.78**	**£20.71**	**£19.30**	**£18.83**	**£18.60**

Date of sample and adjustments for inflation

The data from providers was collected during July and August 2022, with the queries and clarification process ongoing well into September. The financial year was 2022-23.

Historic cost data was used for non-staff cost categories based on the providers most recent completed accounts. Each cost was uplifted to a 2022-23 baseline using an appropriate CPI index. This was done at the most granular level possible so that inflation adjustments are as accurate as possible. Each cost line was updated from the middle of their respective financial year to May 2022 (close to the start of the 2022-23 financial year).

Providers were asked to identify any costs that had or would increase for 2022-23 to an extent that would not be reflected using CPI measures of inflation. Many providers took advantage of this by providing details about structural cost increases. Each providers costs were updated to reflect any new baseline where data was supplied.

Payroll data was collected from a recent payroll period in the 2022-23 financial year to inform employer national insurance and pension contributions as a percentage of wages.

All non-staff operating costs have been uplifted to May 2022 (around the start of the current financial year). However, the rate of inflation continues to increase. It should therefore be noted that some cost lines reported may already be significantly behind current costs.

This is much less of an issue for homecare compared to care homes, as most costs for homecare providers only tend to only increase once a year (such as staffing, rent, CQC fees, insurance, etc.).

Where mileage forms a significant part of the cost of homecare delivery in an area, the impact of recent large increases in fuel costs are obviously highly relevant. However, mileage costs will not necessarily increase costs for providers unless they increase mileage rates paid to staff. Instead, higher fuel costs will represent a large effective pay cut for affected care workers (particularly those working in rural areas).

The increase in costs for second-hand cars is another indirect variable that is not reflected in the CoC returns as it will not directly impact on the costs of most providers. However, in some areas, this is relevant to care workers and the attractiveness of working in the sector.

Note that Ealing will be moving to pay RLW of £11.05 as a minimum hourly rate for carers on the DPS home care contract from 14th November 2022. This uplift will not be reflected in the submissions but has been adjusted and accounted (as much as possible) in our forecast average costs for the 22/23 year.

Data collection method

The survey was designed by Care Analytics. It is an adapted version of the survey that they used to conduct their market review service. As Care Analytics market reviews have a wider scope than the CoC exercise required by the DHSC, the survey includes a wider set of questions to enable a thorough analysis of the marketplace.

The survey asks detailed questions about homecare delivery and the operating practices of each branch.

It asks for a detailed breakdown of current back-office staffing and wages/salary by role.

It asks a series of questions about care worker pay rates, including supporting information so a reliable average rate of pay can be calculated. Providers had the opportunity to present their pay structure in whatever format was easiest to them. This is essential for homecare owing to the diverse ways homecare providers pay their care workers.

The survey collects information about employment terms and conditions so employment on-costs can be accurately calculated.

Non-staff operating costs are collected from previous or current financial years at a granular level. To promote engagement, providers were offered the opportunity to submit financial information in whatever format is exported from their finance system or is already available in their accounts. Care Analytics then standardised the data into the required format for analysis. Many providers took advantage of this opportunity as it can save considerable time.

Finally, providers had the opportunity to answer a variety of questions in their own words to inform the market review.

Appendix Median and Visit Length

Table 1: Visit Duration/Quartiles – Commissioned Data

This data is reported directly from commissioning systems and has not been adjusted for cost reporting reasons. This shows the lower quartile/median/upper quartile of number of appointments per week by visit length (15/30/45/60 mins)

	30 mins	35 mins	40 mins	45 mins	50 mins	55 mins	60 mins	>60 mins	Total
First quartile	7.0	0.0	0.0	7.0	0.0	0.0	0.0	0.0	38.0
Median	63.0	35.0	15.5	37.5	0.0	0.0	17.5	8.0	211.0
Third quartile	292.0	220.5	42.0	129.8	28.0	0.0	70.5	28.5	861.0

Table 2: Visits Duration/Quartiles – Cost Model

These are theoretical models, calculated on the assumption that the only variable that changes is the contact time (visit duration).

Cost of care exercise results - all cells should be £ per contact hour, MEDIANS.	18+ domiciliary care	15 minutes	30 minutes	45 minutes	60 minutes
Total Careworker Costs	£12.71	£14.47	£13.19	£12.76	£12.55
Direct care	£9.53	£9.53	£9.53	£9.53	£9.53
Travel time	£0.50	£1.60	£0.80	£0.53	£0.40
Mileage	£0.04	£0.13	£0.06	£0.04	£0.03
PPE	£0.14	£0.44	£0.22	£0.15	£0.11
Training (staff time)	£0.18	£0.19	£0.18	£0.18	£0.17
Holiday	£1.22	£1.35	£1.26	£1.23	£1.21
Additional non-contact pay costs	£0.00	£0.00	£0.00	£0.00	£0.00
Sickness/maternity and paternity pay	£0.10	£0.11	£0.10	£0.10	£0.10
Notice/suspension pay	£0.03	£0.03	£0.03	£0.03	£0.03
NI (direct care hours)	£0.78	£0.86	£0.80	£0.78	£0.77
Pension (direct care hours)	£0.20	£0.22	£0.20	£0.20	£0.20
Total Business Costs	£4.36	£4.36	£4.36	£4.36	£4.36
Back office staff	£2.16	£2.16	£2.16	£2.16	£2.16
Travel costs (parking/vehicle lease et cetera)	£0.08	£0.08	£0.08	£0.08	£0.08
Rent/rates/utilities	£0.41	£0.41	£0.41	£0.41	£0.41
Recruitment/DBS	£0.05	£0.05	£0.05	£0.05	£0.05
Training (third party)	£0.09	£0.09	£0.09	£0.09	£0.09
IT (hardware, software CRM, ECM)	£0.15	£0.15	£0.15	£0.15	£0.15
Telephony	£0.05	£0.05	£0.05	£0.05	£0.05
Stationery/postage	£0.10	£0.10	£0.10	£0.10	£0.10
Insurance	£0.06	£0.06	£0.06	£0.06	£0.06
Legal/finance/professional fees	£0.09	£0.09	£0.09	£0.09	£0.09
Marketing	£0.04	£0.04	£0.04	£0.04	£0.04
Audit and compliance	£0.04	£0.04	£0.04	£0.04	£0.04

Uniforms and other consumables	£0.03	£0.03	£0.03	£0.03	£0.03
Assistive technology	£0.08	£0.08	£0.08	£0.08	£0.08
Central/head office recharges	£0.19	£0.19	£0.19	£0.19	£0.19
Other overheads	£0.07	£0.07	£0.07	£0.07	£0.07
CQC fees	£0.06	£0.06	£0.06	£0.06	£0.06
Total Return on Operations	£0.85	£0.94	£0.88	£0.86	£0.85
TOTAL	£17.92	£19.77	£18.43	£17.98	£17.75

Table 3 Medians: To be included in the Coc analysis, the provider had to report enough data to be able to calculate all their care worker costs OR all their business overheads. If the total observation count is higher than the respective counts for the sub-sections, this will be because of a handful of providers where we could not report both sets of costs.

Type of Cost	Median
Total Care Worker Costs	**£12.71**
Direct care	£9.53
Travel time	£0.50
Mileage	£0.04
PPE	£0.14
Training (staff time)	£0.18
Holiday	£1.22
Additional non-contact pay costs	£0.00
Sickness/maternity and paternity pay	£0.10
Notice/suspension pay	£0.03
NI (direct care hours)	£0.78
Pension (direct care hours)	£0.20
Total Business Costs	**£4.36**
Back office staff	£2.16
Travel costs (parking/vehicle lease et cetera)	£0.08

Rent/rates/utilities	£0.41
Recruitment/DBS	£0.05
Training (third party)	£0.09
IT (hardware, software CRM, ECM)	£0.15
Telephony	£0.05
Stationery/postage	£0.10
Insurance	£0.06
Legal/finance/professional fees	£0.09
Marketing	£0.04
Audit and compliance	£0.04
Uniforms and other consumables	£0.03
Assistive technology	£0.08
Central/head office recharges	£0.19
Other overheads	£0.07
CQC fees	£0.06
Total Return on Operations	**£0.85**
TOTAL	£17.92

Table 4: Calculated Medians vs Average Paid (table 4 of Annex A)

Description	18+ homecare, £ per contact hour
Cost of care exercise result (from above)	£17.92
Average 2021/22 external provider fee rate (using iBCF definitions, consistently with 2022/23)	£15.65
Average 2022/23 external provider fee rate (using iBCF definitions)	£15.90
NHS funded nursing care rate 2022/23	Not applicable
Average 2022/23 external provider fee rate with FNC where applicable	£15.90
Hence distance from cost of care exercise result (%)	-11.29%
Hence 2022/23 fee uplift compared to 2021/22 (%, excluding FNC)	1.60%