Nottinghamshire County Council

REPORT OF THE CABINET MEMBER, ADULT SOCIAL CARE AND PUBLIC HEALTH

MARKET SUSTAINABILITY AND FAIR COST OF CARE FUND 2022 TO 2023

ANNEX B: COST OF CARE REPORT – DOMICILIARY CARE

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SECTION 1: BACKGROUND AND CONTEXT

1. The Market Sustainability and Fair Cost of Care Fund ('the fund') set out funding parameters in support of local authorities to prepare their markets for reform, including the further commencement of Section 18(3) of the Care Act 2014 in October 2023, and to specifically support local authorities to move towards paying providers a fair cost of care.
2. The fund parameters later changed to defer the implementation of section 18(3) in response to a consultation on statutory guidance to implement the government's flagship funding reforms. This meant the date for full implementation of this section was delayed to October 2025 with councils required to work towards this implementation date.
3. As a condition of receiving future funding, local authorities are required to evidence the work undertaken to prepare their markets for wider charging reform and thereby increase market sustainability. This required them to produce:
    - Cost of care exercises for 65+ care homes and 18+ domiciliary care.
    - A provisional market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market, with consideration given to the further commencement of Section 18(3) of the Care Act 2014, which is currently in force only for domiciliary care.
    - A spend report detailing how funding allocated for 2022 to 2023 is being spent in line with the fund's purpose.
4. The remainder of this report sets out the approach adopted in meeting the conditions of the fund and how the cost of care estimates submitted to DHSC were determined.

SECTION 2: INTRODUCTION

5. This report sets out the engagement and work undertaken with a range of care providers in responding to the Department of Health and Social Care (DHSC) Fair Cost of Care (FCoC) Guidance.
6. The report sets out the initial cost of care findings to satisfy the DHSC conditions in supporting the Council to secure important future grant funding based on meeting the specific conditions. These will help support some of the pressures that are being experienced across the local care marketplace but also seeks to present any gaps identified during the process.
7. The Council notes at the time of writing, that the national conditions for the adult social care market remain under significant challenge for the following reasons:

- Persistent capacity gap between demand and workforce supply due to recruitment and retention.
- Provider and staff wellbeing and resilience continue to be impacted by managing Covid and not yet recovered from the continued response.
- High demand from the NHS as the Council moves toward winter.
- The cost of living increases and impact on the workforce, such as fuel, and lower income care workers.
- Unstable and increasing inflation increasing costs.

SECTION 3: APPROACH TO THE EXERCISE

8. The Council, alongside other East Midlands local authorities, commissioned the services of Care Analytics, a specialist in the financial analysis of care markets and the cost of care, to undertake an independent 'Fair Cost of Care' (FCoC) detailed cost analysis exercise.
9. From May 2022, the Council engaged with the local and national care forums regarding the Cost of Care exercise, and the approach and tools Nottinghamshire County Council would use.
10. By connecting with national care forums, this provided insight into how other Councils and care providers have approached the national DHSC Fair Cost of Care Guidance and methodology allowing for a better quality of response.
11. It was essential that the Council was confident that contact was made with the correct people in organisations. Initial work was undertaken, prior to launch, to contact all care providers to ensure information held for each provider was accurate.
15. Several engagement approaches were used with care providers to promote the work and improve quality of responses, including:
    - Individual calls to care providers
    - Online interactive forums
    - In person forums
    - Presentations
    - Coordinated communication over email
12. All providers operating in the care market within the area of the Council were sent a detailed survey designed to capture the necessary operational and contextual detail to draw out the inherent costs of delivering care in the local market.

13. Reponses were received directly by Care Analytics, rather than by the Council, to address any concerns regarding anonymity of business data. These returns have been reviewed by Care Analytics, with responses clarified where needed, to produce the resulting data analysis of median and quartile costs required from this exercise.
14. The Council tracked response rates and provided support throughout the period to encourage providers to respond. The Cost of Care Survey formally closed 9 September 2022 and was then sent to Care Analytics.
15. As queries arose, Care Analytics requested additional data from several providers to ensure accuracy of information.
16. The Council deemed the engagement to be well received and collaborative, despite coming at a time of great challenge for the care providers.

SECTION 4: HOMECARE PRINCIPLES, CROSS-SUBSIDIES AND RURAL HOMECARE DELIVERY

17. Most councils pay for standard homecare using hourly rates. However, from a service delivery perspective, the fundamental unit of homecare is the visit.
18. Care Analytics considered the responses in line with several key principles for homecare commissioning:
    a) Pricing, the operating model (or commercial model), and zone boundaries all overlap to such an extent that they should not be considered in isolation. Decisions should be made as a whole system
    b) Incentive structures within the overall system usually matter more than formal rules.
    c) Commissioners should have realistic and clear expectations about providers 'cherry picking' which clients they support, insisting that providers meet all their contractual requirements can only go so far if the delivery of care in certain areas in unsustainable
    d) As far as possible, zones should align to 'natural' operating areas of key providers. This should consider where care workers come from as well as where clients live
    e) The overall system should also be designed around geographic and demographic constraints
    f) As far as possible, extreme visit 'cross-subsidies' should be minimised (where certain types of visit are profitable for a provider and others are loss making)
19. Providers often incur materially different costs for different types of visit:
    a) Visits of different length: average travel time and mileage are the same per visit, so shorter visits cost proportionately more per chargeable hour

b) Visits in different locations: there can be large differences in travel-related costs between the extremes of dense urban areas compared to isolated rural areas. There are also a range of other additional costs and complexities associated with rural delivery compared to urban homecare, such as greater coordination issues and challenges managing ad hoc situations (such as temporarily replacing a care worker)
c) Visits at different times of the day or days of the week: this can include obvious examples, such as higher pay for care workers at the weekend or in the evenings, or less obvious examples such as using different mixes of part-time and full-time staff at different times of day.

20. Even if providers pay their care workers in such a way that they do not incur materially different costs for different types of visit, there will still be implications for the effective hourly rate of pay for care workers and other working conditions.
21. In Care Analytics experience, it is common for councils to ignore the cost implications of different visit lengths and to inadequately reflect cost differences across the urban-rural continuum.
22. Pricing structures also serve as a signal for operational staff in the council to commission care, which can lead to inefficiencies from a system perspective. For example, if 2 x 15 minute visits cost the same to the council as 1 x 30 minute visit, then there is a misalignment between how the council and providers incur costs.
23. Given the complexity of homecare, a degree of visit cross-subsidisation is inevitable. However, the greater the mismatch between how providers incur costs and how they generate income, the greater the likelihood that problems in the system will emerge.
24. In Care analytics experience, it is rare for councils to adequately reflect the challenges of delivering rural homecare in the prices they pay. Even where the council pays higher prices for rural compared to urban delivery, it is often only sufficient to reflect the costs when rural homecare is ‘prefect’. At least to some extent, it is unavoidable that if higher prices are paid to more accurately reflect the complexities of rural delivery (to try to promote supply), this will often overpay compared to costs incurred by providers when clients fit seamlessly into existing rounds. The whole system implications of paying higher prices must also be considered as large homecare packages in isolated rural areas will be very expensive at higher hourly rates.

SECTION 5: THE SURVEY

25. The survey was designed by Care Analytics. It is an adapted version of the survey they have used to conduct their existing market review service. As Care Analytics’ market reviews have

a wider scope than the FCoC exercise required by DHSC, the survey includes a wider set of questions. This will enable a thorough analysis of the marketplace to be undertaken after the current FCoC process.

26. The survey used a dataset that is a client-level financial report that includes data fields to enable both a trend analysis and extensive snapshot analysis, as of the start of the 2022-23 financial year. The report does not contain either hours of support or visits, due to the way the information is recorded on the care system. This limits the scope of analysis.
27. Current council soft intelligence was also considered, including key history and trajectory from both discussions and various reports as well as semi-structured interviews with council staff.
28. Information was considered from public domain data such as provider websites, other online information, CQC inspection reports, wages and terms and conditions from job advertisements, statutory accounts of providers operating in the area and various public data sets, such as the CQC care directory, inflation indices, postcode and geospatial data, and various statutory returns completed by councils and published by the DHSC.
29. 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.
30. Care Analytics noted that utility costs have been far more variable than is usually the case during the period of the cost of care exercise.

SECTION 6: SURVEY RESPONSES

31. Care providers were not obligated to participate in the cost of care exercise and were not required to send any cost information to the Council as part of the process. As such, some providers decided not to get involved, despite the Council actively encouraging all care providers to engage.
32. Surveys were considered where they related to standard homecare. Standard homecare refers to homecare delivered in people's homes and paid for in units of time. It excludes non-standard homecare such as sleep-in support, waking night support and live-in care.
    a) 130 surveys were sent out (42 contracted and 78 non-contracted)
    b) 21 surveys were returned but 1 was out of scope
    c) 12 usable surveys (9%) out of 130
    d) These surveys accounted for 14,800 contracted hours per week
    e) At that point in time, the Council commissioned 20,000 hour per week from the market. The surveys represented 74% of the total hours commissioned by the Council

33. Queries were sent to every provider, even though not all providers responded, to try to ensure the data was as robust as possible.
34. 7 surveys were excluded on the grounds of data quality, mostly owing to:
    a) Gaps from unanswered questions or
    b) Inconceivably high unit costs not supported by other evidence and not validated via the query process.
35. A further survey was received too late after the deadline.

SECTION 7: RETURN ON OPERATIONS

36. In data provided for the Cost of Care exercise, return on operations was initially set at 5% however the Council's current modelling allows for 3% return. As our payment mechanisms are generous, this can be considered an additional 10% return, resulting in more of a 13% return on operations.
37. Care Analytics stated that a surplus below 5% can only be considered sustainable where the assumed costs have considerable slack. By contrast, a 10% assumption may be reasonable (or even necessary) where the operating costs are assumed to be extremely efficient.
38. Based on the surveys received from all the areas where Care Analytics is working during 2022-23, providers stated sustainable operating profit levels ranged from circa 3% (usually with a caveat about the need for large volumes) to upwards of 30%. This range is largely reflected in the surveys for providers operating in Nottinghamshire.
39. Many of the highest stated sustainable profit levels were from independent providers where the owners time working for the business is not fully reflected as a cost (though Care Analytics have added modest notional costs in many such instances for both commensurability with other businesses and to ensure 'costs' are not unduly understated). It can be difficult to interpret some provider's expected or desired 'profit' in the more common use of the term.
40. Profit levels in company accounts across the exercises range from small losses to high profits (upwards of 20%), though again this can be distorted by unpaid owner input (paying themselves via dividends).
41. For information the rates would vary as follows with either 3% or 5% return on operations:

	1st quartile	**Median**	**3rd quartile**

Total with a 3% return on operations	**£19.26**	**£20.52**	**£22.66**
Total with a 5% return on operations	**£19.63**	**£20.91**	**£23.10**

	15 minutes	**30 minutes**	**45 minutes**	**60 minutes**
Total with a 3% return on operations	**£24.40**	**£20.99**	**£19.85**	**£19.28**
Total with a 5% return on operations	**£24.88**	**£21.39**	**£20.23**	**£19.65**

SECTION 8: SURVEY ANALYSIS

Section 8.1: Initial findings for upper and lower quartile - derived from usable surveys

Cost of care exercise results - all cells should be £ per contact hour, MEDIANS.	Response rates by question	1st quartile	Median	3rd quartile
Total Careworker Costs	**12**	**£14.58**	**£15.01**	**£15.48**
Direct care	12	£9.63	£9.70	£9.82
Travel time	12	£1.18	£1.73	£2.10
Mileage	12	£0.36	£0.40	£0.69
PPE	10	£0.01	£0.04	£0.08
Training (staff time)	12	£0.20	£0.20	£0.21
Holiday	12	£1.36	£1.42	£1.43
Additional noncontact pay costs	1	£0.28	£0.28	£0.28
Sickness/maternity and paternity pay	12	£0.11	£0.12	£0.12
Notice/suspension pay	12	£0.03	£0.03	£0.03
NI (direct care hours)	12	£0.76	£0.90	£0.99
Pension (direct care hours)	12	£0.21	£0.22	£0.27
Total Business Costs	**12**	**£4.11**	**£4.91**	**£6.52**
Back office staff	12	£1.92	£2.37	£3.56
Travel costs (parking/vehicle lease et cetera)	8	£0.02	£0.04	£0.19
Rent/rates/utilities	12	£0.30	£0.40	£0.44
Recruitment/DBS	12	£0.03	£0.04	£0.11
Training (third party)	9	£0.07	£0.08	£0.14
IT (hardware, software CRM, ECM)	11	£0.22	£0.30	£0.36
Telephony	12	£0.08	£0.12	£0.17
Stationery/postage	12	£0.05	£0.07	£0.08
Insurance	12	£0.08	£0.10	£0.12
Legal/finance/professional fees	10	£0.07	£0.14	£0.24
Marketing	10	£0.05	£0.15	£0.18
Audit and compliance	4	£0.13	£0.14	£0.14
Uniforms and other consumables	10	£0.03	£0.04	£0.15
Assistive technology	3	£0.01	£0.02	£0.04
Central/head office recharges	8	£0.54	£0.60	£0.97
Other overheads	12	£0.08	£0.27	£0.35
CQC fees	12	£0.09	£0.09	£0.10
Total Return on Operations		**£0.93**	**£1.00**	**£1.10**
TOTAL		**£19.63**	**£20.91**	**£23.10**

Supporting information on important cost drivers used in the calculations:	Response rates by question	1st quartile	Median	3rd quartile
Number of location level survey responses received	12	12	12	12
Number of locations eligible to fill in the survey (excluding those found to b	22	22	22	22
Carer basic pay per hour	12	£9.50	£9.57	£9.77
Minutes of travel per contact hour	12	7.1	10.7	13.1
Mileage payment per mile	12	£0.25	£0.25	£0.30
Total direct care hours per annum	12	36,306	54,565	81,204

Section 8.2: Costs split by visit length- derived from usable surveys

Cost of care exercise results - all cells should be £ per contact hour, MEDIANS.	15 minutes	30 minutes	45 minutes	60 minutes
Total Careworker Costs	**£18.79**	**£15.47**	**£14.36**	**£13.81**
Direct care	£9.70	£9.70	£9.70	£9.70
Travel time	£3.98	£1.99	£1.33	£1.00
Mileage	£0.92	£0.46	£0.31	£0.23
PPE	£0.08	£0.04	£0.03	£0.02
Training (staff time)	£0.24	£0.21	£0.19	£0.19
Holiday	£1.69	£1.45	£1.37	£1.32
Additional noncontact pay costs	£0.65	£0.33	£0.22	£0.16
Sickness/maternity and paternity pay	£0.14	£0.12	£0.11	£0.11
Notice/suspension pay	£0.04	£0.03	£0.03	£0.03
NI (direct care hours)	£1.08	£0.92	£0.87	£0.84
Pension (direct care hours)	£0.26	£0.23	£0.21	£0.21
Total Business Costs	**£4.91**	**£4.91**	**£4.91**	**£4.91**
Back office staff	£2.37	£2.37	£2.37	£2.37
Travel costs (parking/vehicle lease et cetera)	£0.04	£0.04	£0.04	£0.04
Rent/rates/utilities	£0.40	£0.40	£0.40	£0.40
Recruitment/DBS	£0.04	£0.04	£0.04	£0.04
Training (third party)	£0.08	£0.08	£0.08	£0.08
IT (hardware, software CRM, ECM)	£0.30	£0.30	£0.30	£0.30
Telephony	£0.12	£0.12	£0.12	£0.12
Stationery/postage	£0.07	£0.07	£0.07	£0.07
Insurance	£0.10	£0.10	£0.10	£0.10
Legal/finance/professional fees	£0.14	£0.14	£0.14	£0.14
Marketing	£0.15	£0.15	£0.15	£0.15
Audit and compliance	£0.14	£0.14	£0.14	£0.14
Uniforms and other consumables	£0.04	£0.04	£0.04	£0.04
Assistive technology	£0.02	£0.02	£0.02	£0.02
Central/head office recharges	£0.60	£0.60	£0.60	£0.60
Other overheads	£0.27	£0.27	£0.27	£0.27
CQC fees	£0.09	£0.09	£0.09	£0.09
Total Return on Operations	**£1.18**	**£1.02**	**£0.96**	**£0.94**
TOTAL	**£24.88**	**£21.39**	**£20.23**	**£19.65**

Section 8.3: Initial findings, median costs per hour - derived from usable surveys

Cost of care exercise results - all cells should be £ per contact hour, MEDIANS.	18+ domiciliary care
Total Careworker Costs	**£15.01**
Direct care	£9.70
Travel time	£1.73
Mileage	£0.40
PPE	£0.04
Training (staff time)	£0.20
Holiday	£1.42
Additional noncontact pay costs	£0.28
Sickness/maternity and paternity pay	£0.12
Notice/suspension pay	£0.03
NI (direct care hours)	£0.90
Pension (direct care hours)	£0.22
Total Business Costs	**£4.91**
Back office staff	£2.37
Travel costs (parking/vehicle lease et cetera)	£0.04
Rent/rates/utilities	£0.40
Recruitment/DBS	£0.04
Training (third party)	£0.08
IT (hardware, software CRM, ECM)	£0.30
Telephony	£0.12
Stationery/postage	£0.07
Insurance	£0.10
Legal/finance/professional fees	£0.14
Marketing	£0.15
Audit and compliance	£0.14
Uniforms and other consumables	£0.04
Assistive technology	£0.02
Central/head office recharges	£0.60
Other overheads	£0.27
CQC fees	£0.09
Total Return on Operations	**£1.00**
TOTAL	**£20.91**

Supporting information on important cost drivers used in the calculations:	18+ domiciliary care
Number of location level survey responses received	12.00
Number of locations eligible to fill in the survey (excluding th	22.00
Carer basic pay per hour	9.57
Minutes of travel per contact hour	10.68
Mileage payment per mile	0.25
Total direct care hours per annum	54,565

Section 8.4: Number of appointments per week by visit length

The information below is taken from the Council's Electronic Call Monitoring (ECM) data for week commencing 28 March 2022.

	15 mins	30 mins	45 mins	60 mins	>60 mins	Total	
First quartile	0.0	36.0	12.0	2.0	0.0	74.8	
Median	9.0	178.0	67.0	17.0	1.0	383.5	
Third quartile	60.0	338.0	126.0	55.0	6.0	550.0	

SECTION 9: INTERPRETATION OF RESULTS

42. Care is recorded by package and not by hour meaning analysis and benchmarking is challenging. It has been possible to derive the number of hours for open care packages at the end of March 2022 by dividing the total cost of the care package by the hourly rate charged by the respective providers in the relevant 'Lot' and/or for the relevant contract type. This has a significant error margin, as (i) hourly rates are recorded in the system for many of the DPS and spot providers (so a £20.00 rate has been applied) not the lead, additional or supplementary providers, and (ii) it is not always obvious which hourly rate applies where providers have different rates in different areas and for different contracts.
43. Double-handed care refers to homecare visits where there are 2 care workers supporting the client at the same time. When analysing homecare hours, each care worker is counted separately on doublehanded visits (1 hour of doublehanded support is counted as 2 hours). Even with the derived hours, it is still not possible to differentiate between singlehanded and doublehanded care in Nottinghamshire's data due to the way the data has been pseudonymised.
44. In most councils, doublehanded care usually represents 40-50% of homecare delivery (in terms of hours), and it is also usually the area of most growth. Nottinghamshire County Council has a high proportion of homecare clients receiving more than 28 hours of care per week. Further analysis is required to differentiate between single and doublehanded care.
45. Whilst it is fair to say that the median is less skewed by high outlier values as opposed to mathematical averages, the median values themselves can be skewed if the dataset does not comprise an appropriate and representative sample of the existing make-up of care providers in the local market. Although Nottinghamshire's survey response resulted in a reasonably good sample size for care homes, work is still being undertaken on whether this was representative of the care home market.
46. It is difficult to draw sound conclusions from incomplete or inaccurate data. Some providers did not respond to queries raised leaving their information incomplete.
47. In some instances, providers submitted data that was unable to be substantiated through queries or financial analysis.

SECTION 10: NEXT STEPS

48. The Council will use this data to influence the market sustainability plan and future fee strategy which will be published in March 2023. In addition to the survey responses, the following will also be considered when determining the fee uplift:

- National Living Wage and statutory changes
- National Inflation
- Care Analytics wider market analysis has not yet concluded
- Grant funding available
- Likely market capacity required to meet adult social care demand locally in line with our strategy

49. The Fair Cost of Care exercise was undertaken at a significantly challenged and volatile point in time with unprecedented levels of cost changes in a number areas that significantly impact on the care market. The Council needs to determine which areas are likely to become permanently changed.

SECTION 11: NOTTINGHAMSHIRE'S CARE MARKET

50. Now, and in the coming years, Nottinghamshire County Council will be required to meet the care and support needs of an ever-increasing proportion of the elderly population. Resident expectations, and those of their families and unpaid carers, will rightly require innovation and modernisation of services through maximising the use of public funding to provide a variety of options to meet an increasingly diverse range of need.
51. The draft Market Sustainability Strategy (2023 to 2026)will be developed to strengthen a care and support marketplace that helps us to deliver the ambition underpinned by the Council Plan to be *Healthy, Prosperous, Green,* and the Health and Wellbeing Strategy 2022-2026 focused on *wellness and the benefits of longer term integration with health….on the communities we all support*.
52. The care sector provides valuable care that has a significant role in supporting prevention, delaying the escalation of needs and in empowering people to live more independently. The initial findings of this exercise are the start of a journey to collaborate with local care partners and better understand how services can be shaped and improved to support A Life, Lived Well for all. In this ambition work has commenced in engaging, consulting, and coproducing, what the future could look like through Better Together and Your Voice.

Better together | Nottinghamshire County Council

Co-production: working together | Nottinghamshire County Council

APPENDIX A: The questionnaire template

Care Analytics
homecare commissic

The Council want to thank care providers that took part in the local cost of care exercise, and we look forward to furthering our engagement.