Annex B

Cost of Care Report

Age 18+ Domiciliary Care / Home Care

14th October 2022

Contents

1 Executive Summary

A. Context the Cost of Care Exercise

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

As a condition of receiving future funding, local authorities 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.

B. Provider Engagement

This review of cost of care has been informed by four months' engagement and data analysis work. A total of 73 providers within Bolton were engaged for the exercise, which was later reduced to 49 providers in scope (for more detail see section 2.2.2). The engagement process comprised the following elements:

a) **Provider survey & cost template:** submitted to all of providers within the homecare market, to gather data on both the costs and the operational experience of delivering homecare services in Bolton.
b) **One to one deep-dive structured interviews:** all providers were invited to express interest for a one to one session, with three interviews taking place with finance and/or operational leads for the respective organisations.
c) **Provider & commissioner workshops:** following the launch session workshop, two further workshops were held with providers and commissioners 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 costs:

- Current homecare market in Bolton (structure, demand, and supply)
- Experience of commissioning and contracting with Bolton Council
- Business operating models, general market outlook, workforce, contract and quality monitoring, business costs and future commissioning arrangements
- Deep dive with providers to understand operating costs and sensitivities that would impact cost

After completion of the data collection, a total of 12 submissions had been received, all considered in scope of the exercise. These represent **25%** of providers in the market, and **58.6%** of homecare hours commissioned by Bolton Council.

2 Local Cost of Care Results

C. 2022-23 Cost of Care Median

As per the DHSC requirement, the exercise was required to identify a median cost of care which was reflective of provider's April 2022 cost pressures. Table 1 identifies the outcome of the analysis of provider returns; based on the data available the median rate has been calculated as **£21.42**. This represents an **11.4%** increase on the current Bolton standard framework hourly rate (including the quality premium) of **£19.22**, and a **12.8%** increase on the current average rate paid of **£18.99** which is an average of all providers**.** Section 3 provides a more detailed breakdown of the findings from the analysis.

All Providers	Lower Quartile Cost £	MEDIAN Cost £	Upper Quartile Cost £
Care worker costs:	£13.52	£14.77	£15.37
Business costs:	£2.97	£5.26	£7.02
Surplus / Profit Contribution	£1.22	£2.29	£2.90
Total Cost Per Hour	£19.19	£21.42	£24.91

Table 1 *cost range, upper and lower quartile, and median costs 2022-2023*

D. Conclusions

The cost of care exercise was conducted during exceptionally challenging conditions for the sector nationally, not just in Bolton. Recruitment and retention pressures post pandemic and most recently inflationary costs has meant intense pressure for the care workforce and providers alike.

It is important to note when commissioning care services, that the council is 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, 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. 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.

It should be emphasised that the council has a duty under Section 5 of the Care Act to ensure there is "sufficient" market to buy services from, however there is no duty to pay any specific "rate" for care. Rather, the council must o consider how readily it is able to service its population's needs via existing contracting and pay mechanisms they have with the market. This should take 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 care exercise may be to work towards an estimated median Fair Cost of Care, in the context of specific rates for care paid, DHSC guidance states that ***"fair means what is sustainable for the local market"***. The council will continue to monitor the pressure in the market (both staffing and business operating costs) through the fee exercise.

Achieving this median is not an indicator of a sustainable market; the ability to purchase the volume of care required in a timely manner is a primary indicator of how the market is performing. It is important to note that the council's ability to move towards this rate will be dependent upon the future allocation of the Fair Cost of Care fund by the DHSC. It is also important to have a vibrant local market that can meet the local need and demand.

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 the council's commissioning function is to continually review and adapt its understanding of costs and contracting practices regularly.

3 Project Overview

E. 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"[1].

The following services were out of scope: rapid response provision, short-term/reablement support, local authority in-house care, live in care, shifts or blocks of care, sitting services, extra care[2] and supported living. Whilst some community-based services were out of scope of this project, as alluded to above, it is considered that the base model and scenarios presented as part of the analysis and in this report may be applicable to elements of these services; and may be given future consideration by the Commissioning team.

F. Approach, Methods, and Limitations

3.1.1 Project Governance

In order to maximise engagement and ensure a robust and impartial analysis of provider data, Bolton Council commissioned ARCC-HR Ltd to undertake the cost of care exercise.

A project governance group was formed consisting of the Assistant Director for Social Care & Public Health Commissioning, Head of Strategic Commissioning Ageing Well, Head of Quality Assurance and Improvement, Head of Finance, Principal Quality Assurance, and Improvement Officer, Commissioning Officer Ageing Well, and ARCC. This group met fortnightly to discuss progress, risks and mitigations arising throughout the course of the project.

3.1.2 Engagement Activities and Timeline

Engagement activity was targeted to a cohort of 73 homecare providers, including those Bolton Council currently commission homecare hours from, either on framework or via spot purchases. In order to engage with the full market, ARCC reached out to a total of 73 providers who according to the CQC were registered in Bolton as homecare providers, giving them the opportunity to participate. Given the wide scope of this outreach, the list was subsequently reduced to 49 providers, for reasons including not having historically engaged with the council or providing more specialist (Learning Disability/Mental Health) provision and supporting living that fell outside of DHSC's defined scope. 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.

[1] DHSC FCoC guidance page 13.
[2] While extra care is in scope for use of the fund, cost of care exercises are not required for this setting.

The engagement comprised the following key activities:

a) Provider survey & cost template (see Annex A): submitted to all providers in scope, to gather data on both the costs and the operational experience of delivering homecare services in Bolton. Any data submitted by the providers was sent directly to (and anonymised by) ARCC. The survey consisted of 3 parts:

***Part 1*:** Commissioning survey with thematic questions:

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

Part 2: 2022 Organisation and workforce:

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

Part 3: Historic costs 2021-22:

- Historic revenue
- 2021-22 costs

The team also accepted alternative returns such as the national homecare cost modelling toolkit[3] or alternative reports/accounts. In total 12 providers sent returns, of which one was the national toolkit, another was a set of accounts for the year 2021 and ten were the dedicated cost survey.

b) One to One deep-dive structured interviews: interviews took place over one to two hours with senior finance and/or operational leads for provider organisations. All providers were invited to express interest for a one to one session and three providers in total took part in these.

c) Provider & commissioner workshops/clinics (see Annex A): following the launch session workshop, two further workshops were held:

- A closed (provider-only) *interim session at the end of the survey & one to one 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 with commissioners following this to present the scenarios to be modelled.

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

Throughout the process, all providers in scope were kept appraised of the engagement feedback and timeline via e-mail, and copies of workshop slides were distributed following each workshop[4]. Further requests for information/clarifications were conducted via e-mail and telephone, to provide further opportunity for providers to submit data to input to the cost analysis.

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

[4] Copies of communications and slides shared within and following workshops are provided in Section 4 Appendices.

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

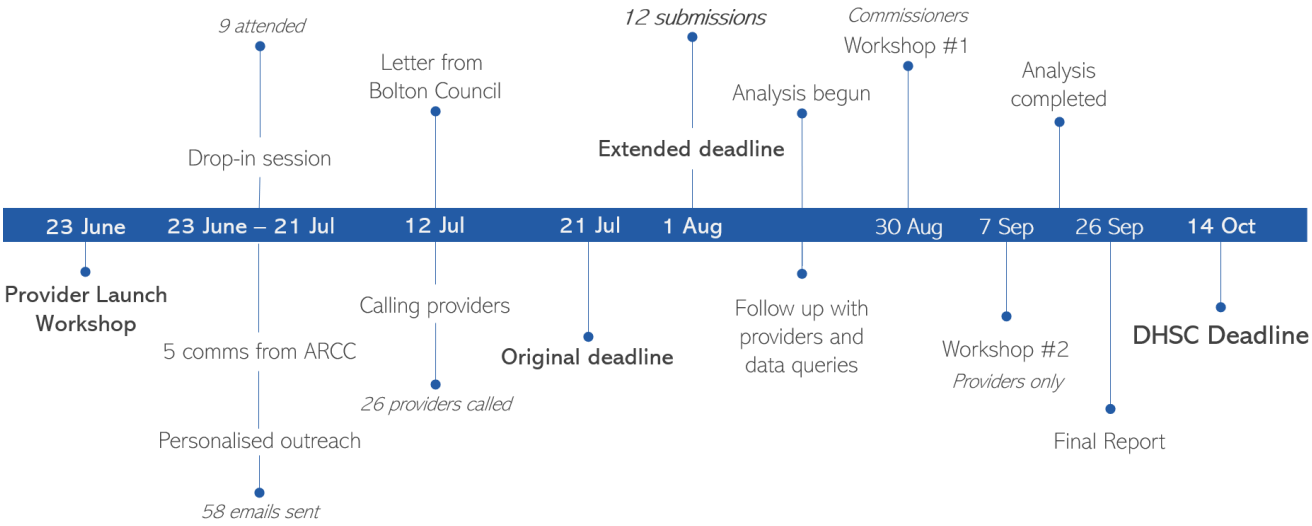

Figure 1: *Project Timeline.*

Provider outreach

To give providers the best possible opportunity to engage with the exercise, they received various forms of communications throughout the process. Bolton Council invited all providers in the market to the initial launch session on the 23rd June 2022. From this point onwards ARCC sent a total of 5 market-wide emails with additional information and support, including an invitation to a drop-in session to answer any queries providers may have had. Additionally, two personalised emails were sent to 25 providers, offering additional support to complete the survey.

The team conducted phone calls to 44 providers each of which were called at least once during this process. The purpose of the calls was to ensure that communications had been received and were directed to the correct person within the organisation. As a result of the calls, we were able to ascertain that eight (16.3%) agreed to participate but ultimately did not submit, two (4.1%) informed us that they would not submit, 7 (14.3%) attempted contacted was made but were not reached, two (4.1%) were spoken with but did not receive indication of commitment and one (2%) requested an extension via phone. Additionally, Tier 1 providers received personalised emails and phone calls from Bolton Council to increase uptake and as reminders of the exercise deadline.

Providers who had previously been in touch either via email or phone calls, received personalised outreaches reminding them of the deadline and offering 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. To further encourage engagement, the submission deadline was extended by ten days, from 21st July to 1st August, as well as individual later deadlines agreed with providers for supplementary information. No submissions were rejected because of late submission; indeed, the last submissions were received on the 16th September 2022. Note, every effort and means were explored to engage with all providers.

Of the 49 providers in scope, 12 submitted cost returns. These submissions represent 25% of providers in the market, and 58.6% of homecare hours commissioned by Bolton Council.

3.1.3 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, this means that any attempt to include all variables would result in an unusably large range of outputs in any practical sense. 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 an individual provider.

It should also be clearly understood that a cost exercise is not an absolute 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.

Although the many efforts undertaken to engage with the market (see section 2.3.2) the level of participation from the providers was lower than expected. We identified three main reasons as to why there was a seemingly low level of engagement:

1. **Time constraints**: the project was launched 23rd June and the original deadline for submission was decided to be the 21st July. Providers felt that having only four weeks to complete the survey was not enough considering that the period coincided with general holidays of staff, hence the timescales were extended.
2. **Availability of information**: at the commencement of the exercise, some providers had not completed their annual figures for the year, thus, more effort was needed from providers to obtain their costs figures without the set of accounts ready.
3. **Burden on small providers**: the size of the providers impacted their willingness to proceed with the cost of care exercise, mainly because of a lack of affordability. Small providers needed to rely on their accountants to help them complete the cost figures of their business. However, this task was not free, and the accountants charge them with a fee which discouraged providers from taking place in the exercise.

4 Cost Analysis

G. Provider Cost Information and Data Quality

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

- Where ARCC received 2021-22 costs only, these have been uplifted based on current direct pay rates to carers, current back-office costs, latest month business volumes and any specified uplifts in overheads to reflect **costs for trading April 2022**.
- Queries were 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 could not be resolved, anomalous data has been removed to ensure all data is as representative as possible.
- DHSC have requested the following aggregated statistics: lower quartile (25th percentile), median, and upper quartile (75th percentile) across each cost line.
- Some lines are statistically zero. This means that the response to the 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); in other instances where there is missing data, zero has not been used and has instead been discounted in the calculation of a median (e.g., where back office pay costs may be missing, they were omitted these from the median calculation).

Out of the 12 submissions two were excluded from the final analysis as the providers were unable to submit a complete set of operational costs (overheads, and back-office costs respectively) and the omissions of these impacted the unit cost directly which had the potential to skew the analysis.

Queries were raised with each of the 12 providers, of which ten submitted additional data or took part in virtual meetings to discuss their return. Although each of the remaining providers received at least three follow-up emails and one phone call, the two providers mentioned above did not submit the remaining figures. It is important to note that all submissions could not be validated due to some unanswered queries. We believe the analysis is the best estimate of the cost based on the information provided but should be treated with the appropriate level of caution.

H. Business Operating Model Observations

Providers reported an average of **1,077 hours** of care and an average of **1,580 visits** per week. The average hours per service user per week was 15.2 hours, ranging between 7.6 and 25.7 hours. Once outlier calls, i.e., greater than 60 minutes were removed from the data set, the average visit duration was **36.8 minutes**.

I. Median Analysis of Provider Cost Data

Analysis of the provider cost information submitted by providers, including the upper/lower quartiles and median of each cost line has been presented in Table 2 (below).

Generally speaking, “medians” can only be applied on one set of numbers at a time (i.e., each individual cost line), as such, the median of each cost line will not add up to any single identifiable provider. Note, using the median total unit cost for each provider means that the individual cost lines (as can be seen below) will not add up to the median cost of care rate calculated.

All Providers	LOWER QUARTILE	MEDIAN	UPPER QUARTILE	COUNT[5]
Hourly Breakdown	Cost £			
Care worker costs:	**£13.52**	**£14.77**	**£15.48**	**10**
Direct Care	£10.08	£10.81	£11.30	10
Travel Time	£0.00	£0.00	£0.96	4
Mileage	£0.10	£0.44	£0.55	8
PPE	£0.00	£0.00	£0.01	3
Training (staff time)	£0.23	£0.29	£0.39	10
Holiday	£1.29	£1.34	£1.46	10
Additional Non-Contact Pay Costs	£0.00	£0.00	£0.03	3
Sickness/Maternity & Paternity Pay	£0.00	£0.10	£0.27	6
Notice/Suspension Pay	£0.00	£0.00	£0.00	0
NI (direct care hours)	£0.52	£0.68	£0.97	10
Pension (direct care hours)	£0.30	£0.33	£0.38	10
Business costs:	**£2.97**	**£5.26**	**£7.02**	**10**
Back Office Staff	£1.87	£2.31	£4.11	10
Travel Costs (parking/vehicle lease etc.)	£0.00	£0.00	£0.00	0
Rent / Rates / Utilities	£0.21	£0.40	£0.54	9
Recruitment / DBS	£0.01	£0.12	£0.14	7
Training (3rd party)	£0.00	£0.05	£0.20	7

[5] Number of values counted from returns, please refer to section 3.3.2 for treatment of zero values.

All Providers	LOWER QUARTILE	MEDIAN	UPPER QUARTILE	COUNT[5]
IT (Hardware, Software CRM, ECM)	£0.07	£0.19	£0.37	8
Telephony	£0.04	£0.06	£0.17	9
Stationery / Postage	£0.02	£0.06	£0.08	9
Insurance	£0.04	£0.08	£0.12	8
Legal / Finance / Professional Fees	£0.00	£0.01	£0.02	5
Marketing	£0.00	£0.03	£0.06	6
Audit & Compliance	£0.00	£0.00	£0.08	4
Uniforms & Other Consumables	£0.00	£0.01	£0.02	5
Assistive Technology	£0.00	£0.00	£0.00	0
Central / Head Office Recharges	£0.00	£0.42	£1.09	6
Additional Overheads (Total)	£0.01	£0.13	£0.23	8
CQC Registration Fees	£0.06	£0.08	£0.11	10
Surplus / Profit Contribution	**£1.22**	**£2.34**	**£2.90**	**10**
Total Cost Per Hour	**£19.19**	**£21.42**	**£24.91**	**10**

Table 2: *Summary table of cost of care median values, upper and lower quartiles*

Whilst some providers were not able to split out all costs from the organisation, through the process of queries ARCC 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 being able to accurately split out all overhead or indirect pay costs.

There were certain cost lines where providers differed significantly. To illustrate, providers ranged between 78.68 hours and 500 hours of care per week per FTE back-office staff member, showing the great difference in back-office size, despite headcount not being 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.

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, varying from 0 to 6.8%. Smaller providers do not have this expense but do also not gain the operational benefits associated. Finally, we saw significant variations in “Additional Overhead” costs, this again shows how business operating models differ, where typical cost points entered included business travel, bank charges, training equipment, equipment hire, and vehicle lease.

4.1.1 Treatment of Return on Operations

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 remuneration) are considered. Whilst the ARCC cost of care toolkit expressly states that profit/surplus should be an EBIT figure, in certain circumstances this figure may contain elements of cost of finance and remuneration and therefore, should be considered as such.

Where a provider did not submit a profit or surplus; two approaches were adopted:

- The provider's actual profit/loss for the year 2021-22 was queried
- If the provider was unable to submit a figure, a standard figure of 5% (mark-up on costs) for the purposes of modelling costs across the range of providers was used, this has also been applied to providers who stated that they made a loss in 2021-22

Provider expectations for return on operations ranged from 2.9% to 23.1%, with the median being **9.5%** (mean 10.8%).

4.1.2 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 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).

4.1.3 Weighted average costs for 15-, 30-, 45- and 60-minute calls

ARCC's approach was to create a bottom-up model, which utilises annualised costs and volumes of care delivery for a 'typical' provider size within the local area, from which an indicative "cost per hour" can be derived. This 'typical' business was then utilised to model the variation in cost for different visit lengths. The cost per hour being different from the cost per visit.

Bolton Council currently pay on actual time delivered for the majority of care, delivered via our Framework providers and monitored via our Electronic Care Monitoring (ECM) system. Therefore, 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 more accurate and straightforward to model (from a cost perspective) a single, aggregate number of visits and annual hours. The variations (table 3 below) can be modelled using the same volume of hours, by increasing the total visits needed to achieve the same care volume. x

Weighted Time Models[6]	Description	Unit Cost per care hour[7]
#1a 15-minute call duration	Median cost adjusted to reflect avg.15-minute call duration	£22.65
#1b 30-minute call duration	Median cost adjusted to reflect avg.30-minute call duration	£21.61
#1c 45-minute call duration	Median cost adjusted to reflect avg.45-minute call duration	£21.26
#1d 60-minute call duration	Median cost adjusted to reflect avg.60-minute call duration	£21.09

Table 3: *weighted average costs for 15-, 30-, 45- and 60-minute calls*

Figure 3 shows the effective unit cost at different call lengths with the corresponding actual weighted "visit" cost is also shown by the orange line on the chart. Ordinarily, the blue line would show a starker correlation with the orange; however, the practice of absorbing travel time into the care hour means travel as a variable is not a factor that is impacted by the call duration.

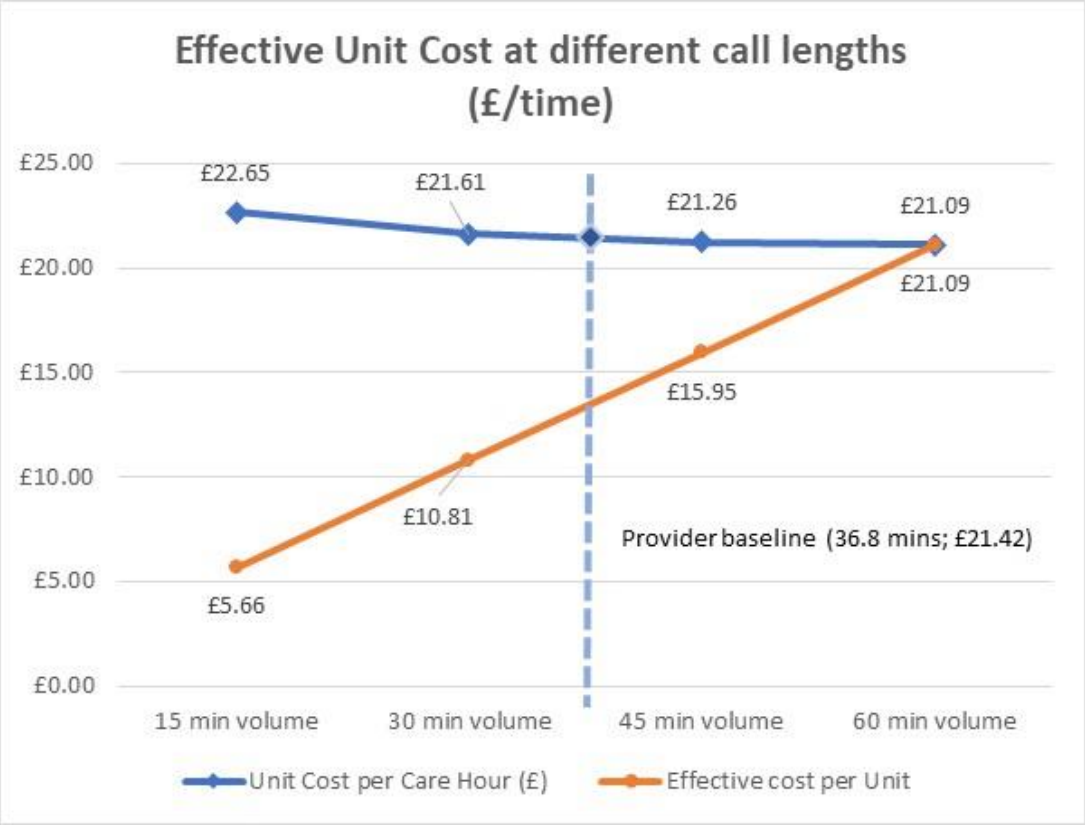

Figure 3: *effective unit cost at different call lengths (£/time)*

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

[7] 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

J. 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 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 for the same reason. 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, it must be remembered 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:** 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. Modelling the "unit cost per care hour" assumes that all pay costs are equal, however, where "care time" may be less than the perceived time paid for, the output unit costs predictably look higher than expected. However, the risk of this is mitigated within Bolton due to payment on actuals, as alluded to above.

- **Changes to UK fiscal policy:** It is worth noting that this undertaking cannot forecast with any certainty the costs that providers will ultimately experience over the next 2-3 years, against the market's current estimates. Whilst the current economic situation remains uncertain; recent announcement will also have an impact on the entire analysis within this report:
    - The reversal of the additional 1.25% on employer's NI payments will reduce provider costs; whilst the levy was initially intended to fund health and social care the UK government has also said this will not impact on the availability of funding to the sector

- The business energy bill relief scheme will no doubt curb future energy costs, and is indeed difficult to predict due to the nature of variable tariffs in the market as well as fixed term contracts many providers will have secured over a period of time
- Cancellation of the planned rise in corporation tax will also continue to support provider's bottom-line profit/surplus

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

K. Future Fee Uplifts

The council has a robust annual fee setting process and modelling which is based on the National Home Care Association's fee model. This is accompanied by sample checks of rotas to determine accurate average travel time. Note, normal provider data collection in 2022/23 budget setting was not carried out due to the pandemic response which particularly affected care providers. As part of the 2022/23 fee setting process, the council allowed for inflationary uplifts to be applied based on the Real Living Wage increases and other non-pay inflationary uplifts.

Whilst the information collected for this exercise has captured a large volume of data, due to the issues outlined above in section 3.4 this data will be used alongside the council's current fee setting models to help inform and enhance the future fee setting process. However, the council intends to further enhance it's approach to provider engagement.

The financial impact of the modelling considering commissioned home care, is estimated to be a minimum of £2.3m per annum based on 30th August data. However, this does not take into account the recent in year increase to the Real Living Wage. The Fair Cost of Care exercise has provided the data intelligence that will support a new service model (to be determined and commissioned) in a home care re-tender in 2023. The new home care service model will have a strong emphasis on Home First and principles of strength-based practice. It is important to note that the Fair Cost of Care exercise will have a wider fee and budget impact beyond the service in scope for this exercise. E.g., Supported Living, under 65 residential care, and Direct Payments.

The council's fee setting process for 2023/24 will take into account the data collected in this Fair Cost of Care exercise, whilst broadly reflecting the normal annual fee setting process noting that the council has already gathered the provider information.

Bolton is committed to continuing to financially support our care home provider market. Subject to grant funding conditions the council will passport allocated funding to care home providers to increase the fee paid and/or to support the management of demand.

5 Appendices

L. Provider Cost Survey and Workshop Slides

Homecare Cost Survey

Distributed 23rd June 2022

Homecare Interim Workshop (Providers)

7th September 2022