Brent Council Cost of Care Exercise

Homecare

1. Introduction

1.1 This report sets out the findings from Brent Council's cost of care exercise for homecare conducted between June and September 2022. Councils have been required to complete a cost of care exercise to support the implementation of the government's reform of adult social care set out in the white paper "People at the Heart of Care", published in December 2021. The purpose of the white paper was to set out a 10-year vision that puts personalised care and support at the heart of adult social care, ensuring that people:

- have the choice, control and support they need to live independent lives
- can access outstanding quality and tailored care and support
- find adult social care fair and accessible

1.2 Implementation of the Market Sustainability and Cost of Care Fund is seen as one of the first steps in the journey to achieve the vision for care in England.

1.3 The cost of care exercise was designed to be a process of engagement between local authorities and care providers, where through data collection and analysis local authorities and care providers can arrive at a shared understanding of the local cost of providing care. The cost of care exercise has helped Brent to identify the lower quartile, median and upper quartile costs in the local area for a series of care categories, specifically residential and nursing care for the over 65s and homecare services.

2. Homecare

2.1 In line with the guidance issued by DHSC, Brent's cost of care report on homecare sets out Brent's approach to the cost of care exercise, the steps taken to complete the work including engagement with care providers as well as information on the following areas, as required -

- the response rate of the exercise, as a percentage of those invited (excluding providers for whom the exercise turned out not to be relevant)
- the lower quartile/median/upper quartile of number of appointments per week by visit length (15/30/45/60 mins)
- justification of the proposed approach to return on operations
- one table for each care type, with each showing the count of observations, lower quartile, median and upper quartile (where relevant) of all items in Annex A, Section 3
- the full table in Annex A, Section 3, with one column of median values for each care type
- consistent with the identified cost per contact hour, the cost per visit for each of 15, 30, 45 and 60 minute visits (shorter visits have larger relative travel times so cost relatively more)

- a clear statement of when the results were collected (the base price year) and how they will be uplifted in future for inflation
- a full description of the questions asked/template used as part of the exercise

3. Overview of Brent's approach to the care cost of care exercise

3.1 There are 44 registered homecare providers in Brent. Of these 44 companies, 41 deliver homecare services, whilst three use a domiciliary care registration to deliver care from supported living provision. A small number do both, but for the purpose of this exercise Brent was working with a cohort of 41 providers.

3.2 Before beginning the cost of care exercise, Brent considered the way that it was going to be able to complete the work, ensure that it was well placed to comply with the requirements of the exercise and submit data returns that were as accurate as possible to reflect Brent's care market. Whilst tools and resources were made available to councils to support their cost of care exercises, Brent was concerned about having the capacity and expertise to be able to collect, analyse and challenge the data from provider returns to ensure that the costs submitted were a true reflection of costs required to deliver care in the local market.

3.3 To support the work, Brent commissioned Care Analytics to undertake our cost of care surveys and analysis. Care Analytics have a wealth of knowledge of Brent's care market. The company has worked with Brent and other councils in the West London Alliance over a number of years to help produce the residential and nursing care price bands that are used annually to set care home placement prices. They worked on a homecare cost model for Brent Council in 2018, ahead of the re-tendering of homecare contracts. Care Analytics also completed a review of the council's approaches to commissioning care services in 2021, to help provide benchmarks on the number of care placements/packages, and the prices paid for care to help develop our approaches to commissioning. They are very familiar with Brent's care market and could bring external rigor to this process.

3.4 Brent Council carried out a comprehensive cost of care exercise in 2018/19 ahead of our homecare tender that started in late 2019. The exercise used a homecare cost model tool developed with London ADASS, which was completed by local providers to help Brent confidently set an hourly rate for homecare that would enable the council to pay providers at a level that would allow them to pay care workers the London Living Wage. This was a key political commitment for the council.

3.5 The results of the homecare tender, completed in early 2021 due to a delay caused by the Covid-19 pandemic, was that lead provider contracts were awarded to seven older adult homecare providers, two learning disability and two mental health providers. They are paid a lead provider rate of £20 per hour, a rate that is London Living Wage compliant.

3.6 Brent's lead providers are tasked with accepting 80% of homecare packages in their patch areas, and they have been working towards this since Brent's homecare contracts went live in April 2021. Any care package that isn't placed with a lead provider is spot purchased from the market, at an hourly rate of £16. As a result, Brent has a split homecare market where providers are paid different rates depending on whether they are a lead provider or not.

Engagement with providers

3.7 Brent Council started the latest cost of care exercise with homecare providers in June 2022, and completed its work in September 2022. Engagement with providers was focused on the managers of the Brent's homecare providers. In the vast majority of cases the local managers are also the owner (or franchiser) of their homecare company, with very few companies having large back-office functions that support multiple homecare offices. This meant that in

engagement terms, we could follow up on the cost of care exercise with homecare managers that we work with on a regular basis to manage issues around care package delivery. This helped during the process to ensure that a good sample of providers was achieved.

3.8 Two specific engagement meetings with care providers took place on 17th June, with managers of Brent care homes and homecare providers. Two identical sessions were held with managers to explain the cost of care exercise, and for Care Analytics to talk through the cost of care surveys. The surveys were then sent to all 41 homecare providers that day, with an original completion deadline of 8th July 2022.

3.9 The materials shared with providers at these engagement events are embedded at the end of this report for information.

3.10 A second follow up meeting was held with care providers a week after the surveys were sent out on 24th June. The purpose of this session was to answer any immediate queries from managers whilst completing the survey, and to do this relatively soon into the process to encourage providers to complete the survey by our initial 8th July deadline.

3.11 The meetings with care providers were followed up with individual phone calls and email communication with home care managers. Each service in Brent has a Provider Relationship Officer who was responsible for making sure that the cost of care exercise was addressed directly with each provider in scope, and that any questions about the survey directed to Care Analytics if necessary.

3.12 In order to give providers the time needed to complete the return, the deadline was extended from 8th July to 1st August, and ultimately to allow for as many returns as possible Care Analytics accepted completed surveys up to 1st September 2022. Allowing over 10 weeks was reasonable, given that each survey would have taken in the region of two hours to complete.

4. The response rate of the exercise and sample clarifications

4.1 Surveys were received from 24 homecare providers operating in Brent, out of 41 providers in scope. However, a number of surveys could not be used for various reasons -

- Two surveys were deemed outside of the scope of the exercise and so have been excluded on these grounds.
- Seven surveys were excluded on the grounds of data quality. Some of these providers are not based in Brent, though they do operate in the borough (based on the data submitted).

4.2 As a consequence, Brent has used a sample 15 homecare surveys in the cost of care return, or 37% of providers in scope. It should be noted that the providers that submitted surveys are delivering more than 50% of homecare hours provided in Brent on a weekly basis.

Data quality comments

4.3 It should be noted that just because Brent has included 15 surveys in the cost of care results, not all of the information is fully robust. Many of the surveys have reliability issues in some areas. However, we could not set a high qualifying threshold in terms of data quality as the sample size would become too small.

4.4 Several of the 15 providers with usable surveys did not respond to queries on their returns. The most common queries were in relation to pay levels, travel time, and the reliability of payroll data where it seemed unusual, and the respective providers did not answer such queries.

4.5 Seven of the 15 providers with usable surveys only operate in Brent (or at least Brent is the

only council for whom they deliver care). Delivering care in multiple boroughs can have a distorting impact where councils either have markedly different hourly rates and/or different payment rules, which is the case in NWL. Where providers identified that they paid care workers differently in the boroughs they work, we have calculated Brent-specific unit costs.

4.6 The mean visit length in the usable survey sample was extremely variable, ranging from 30 minutes to almost two hours. Some of the providers with long average visit lengths could potentially have been excluded, but as far as could be identified, all their hours were charged at similar hourly rates. They could therefore be included. However, it should be noted that many of the unit costs for each of the providers are not like-for-like owing to differences in mean visit length.

4.7 Some of the lead providers in the borough are not yet fully established with the scale needed for these types of providers to achieve efficiency. The homecare contract is still being implemented and lead providers are not yet delivering 80% of homecare hours in the borough, that they are contracted to deliver. This is certainly a confounding factor on the results (though it is unclear how the respective providers would account for central overheads/recharges if the branches hours significantly grow).

4.8 At least one provider in the survey sample mostly delivers care commissioned by the CCG. They have unit costs not typical of council-commissioned homecare.

4.9 Many of the usable surveys submitted included confusing payroll data. At least some of these instances are likely where the provider knew there would be anomalies in terms of either total wages not being high enough owing to the use of self-employed workers, or very low pension costs. Again, this has an impact on the outcome of the exercise.

Brent Payment Rules

4.10 Brent pays it lead providers (LLW) £20.00 an hour currently and its spot providers £16.00 per hour. For lead providers, the council pays based on actual contact time rounded to the nearest 15 minutes, other than visits cancelled at short notice which are paid on planned visit length. Five lead providers responded to the survey, and would be using these payment rules in their returns.

4.11 For providers that the council spot purchases care from, providers are paid on commissioned activity rather than delivered care. This is because the majority of those providers do not use electronic call monitoring to provide information on the exact care call duration, and with the number of hours commissioned it is not possible to check the length of time each care call takes. The impact of this is that providers will be paid somewhere in the region of 15-20% more than the actual hours delivered, based on calls being shorter than planned, cancelled at short notice or not delivered for another reason.

4.12 The combination of the different payment rates and payment approaches has an impact on the cost of care returns – five lead providers submitted survey return and are paid £20 an hour. The remainder of the returns were submitted by spot purchase providers, paid £16 an hour.

Cost of Care results versus council fee rates

4.13 The results from the cost of care exercise (based on a 5% return on operations) are £17.97 for the first quartile, £19.59 for the median, and £20.49 for the upper quartile. It is difficult to compare results with prices paid as the Brent market is bifurcated between the lead providers (LLW) and spot providers. Our lead provider costs are based on being London Living Wage compliant. This isn't the case for spot purchased providers, who only need to be National Living Wage compliant. As a consequence, there are two cost models being merged into one set of

median rates.

4.14 There will be other reasons for the cost of care medians differing to the prices paid. The main potential reasons for the higher results in the cost of care exercise are as follows -

- Visit shortening and unknown non-delivery that is still charged
- Sample composition (providers that are operating at the margins are more likely to have not completed surveys or more likely to have been excluded owing to data quality issues).
- Providers in transition of some sort and so incurring temporarily higher unit costs.
- Overstating costs in surveys or including exceptional one-off costs as standard recurring costs. The Covid-19 grants have almost certainly inflated some historic costs lines as many providers had more money to spend. There is only so much that high costs can be reviewed and there is no clear dividing line between inefficiency and simple outliers.

4.15 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. The most important of these are:

- Mean visit length: shorter visits have more travel time and travel-related costs relative to each chargeable hour of contact time. It is often difficult to establish a provider's visit breakdown or average visit duration, especially where there is ambiguity about whether long visits should be included or not. This results in an error margin in calculating the providers' actual unit cost. It should also be noted that other customers, usually CCG or private, tend to have much longer average visit lengths. In many instances, the impact of these longer visits for other customers will markedly lower the providers overall unit cost compared to that of delivering typical council-commissioned homecare.
- Mean travel time between visits: the council's payment rules, the extent of visit 'shortening' in practice, and the extent to which compliance with the statutory National Living Wage (NLW) is monitored (and enforced) collectively mean there is often a large difference between the time that is spent travelling between visits on a shift and the travel time that is actually paid to the care worker.
- Care worker wages: there are countless ways homecare workers are paid, so calculating a provider's 'real' hourly rate of pay is not always easy. Most homecare providers pay some form of contact-time rate of pay (paying care workers only for time spent with clients), so only incur actual costs for travel time in an indirect sense (or on an ad hoc basis for exceptional circumstances). Many providers also have a range of enhancements paid in particular circumstances that are not easy to cost unless the provider has actual data for a specified period (working out of area, picking up shifts at short notice, overtime, etc.).
- Type of care worker: there are direct (employment on-costs) and indirect (business overheads) cost differences between full-time and part-time workers. In terms of direct care worker costs, part-time workers are substantially cheaper per hour than full-time workers, as they will invariably have little to no pension or national insurance costs.

4.16 Of the above variables, the mean travel time between visits is the most complicated owing to the way it is impacted by the council's payment rules. If the council pays on planned contact time (or has generous rounding rules, like Brent), systematic shortening of visits can reduce the need for effective travel time, irrespective of whether it is considered bad practice, or a deliberate part of the system to ensure care workers are paid a reasonable amount for travel time.

4.17 There are also other key variables that, whilst not dynamic in relation to other variables, can substantially impact provider unit costs. These include:

- Mileage costs: costs are not only influenced by mileage rates (which may be temporarily

increased), but the number of miles paid depends on the geographical spread of clients.

- Branch hours/size: homecare hours often fluctuate significantly, which has material implications for back-office unit costs.
- Central overheads: apportioning central overheads (or head-office costs) to homecare branches is often complex, particularly where providers operate in multiple sectors or are new to an area and trying to establish a local branch.
- 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.

5. The lower quartile/median/upper quartile of number of appointments per week by visit length (15/30/45/60 mins)

5.1 These data tables are pending.

6. Justification of the proposed approach to return on operations

6.1 There is a large amount of discretion around both return on operations and return on capital. There has not been much guidance from DHSC on how to approach this complex area for cost of care reporting and councils can decide what return on operations (or surplus) to include in their cost of care return.

6.2 It is important to recognise that this return on operations cannot all be taken out of the respective business as profit. The surplus is also needed to pay for both investment back into the business and exceptional costs that will inevitably arise from time to time.

6.3 Council expectations of sustainable surplus normally range from 3% to 10%. In the Brent surveys 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 therefore be difficult to interpret some provider's expected or desired 'profit' in the more common use of the term.

6.4 When determining an appropriate return on operations, councils should consider their payment rules, as comparatively generous payment rules can indirectly include a significant amount of surplus (generation of revenue without the normal associated costs). As set out above, Brent has relatively generous payment rules. For these reasons, Brent has used a 5% return on operations as the basis for Brent's cost of care medians.

6.5 Brent has made the following standardised assumptions for the draft cost of care returns:

- For statutory holiday (applicable to almost all providers), a 12% employment on-cost has been applied. This is a generous assumption for many providers, as costs will often be lower where providers calculate holiday pay based on strict interpretations of entitlements where employees work overtime (which is most employees given the preponderance of zero-hour contract in the sector).
- Although the survey includes detailed questions on training and supervision, this is mainly for analysis for the pending market review. Attempting to quantify these types of costs for

each provider is extremely difficult. For the cost of care return, a 3% standardised assumption (of total care worker time) is applied for combined paid training time (1.75%), sickness (1%), and notice/suspension pay (0.25%). The apportionment of the 3% could vary over time for each provider.

6.6 Based on all the evidence from the analysis, the total of 15% for these combined on-costs is a reasonable assumption for a market median. However, some providers will incur higher costs if they have more extensive paid training or a higher-than-usual number of staff off sick. Others will incur lower costs, as is the nature with averages.

7. Cost of care outcomes based on responses received to Brent's cost of care exercise

1st Quartile	Median	3rd Quartile
£17.97 per hour	£19.59 per hour	£20.49 per hour

8. Consistent with the identified cost per contact hour, the cost per visit for each of 15, 30, 45 and 60 minute visits (shorter visits have larger relative travel times so cost relatively more)

8.1 Please see cost of care outputs tab in accompanying excel file, columns K to N. These are theoretical models, calculated on the assumption that the only variable that changes is the contact time (visit duration).

8.2 In extremis, these theoretical cost models become unreliable. For example, a provider only delivering 15-minute visits would have a much higher back-office unit cost than a provider only delivering 60-minute visits. This complexity is ignored as it becomes too complicated to calculate all the potential implications. For the avoidance of doubt, Brent Council does not commission 15 minute care calls.

8.3 It is also assumed that there are no changes in average travel time between visits, sickness levels, and that workforce characteristics remain unchanged. Again, in extremis, these assumptions become implausible.

9. When the results were collected (the base price year) and how they will be uplifted in future for inflation

9.1 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.

9.2 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).

9.3 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.

9.4 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.

9.5 In future years, if the council is required to update the cost models non-staff costs should be uplifted using a using an appropriate CPI index. Direct care costs should be uplifted using a combination of the National Living Wage and London Living Wage (based on Brent's current model) for lower paid staff and any other reasonable method for higher paid back-office staff. Any inflation methodology should take into account structural changes relevant to homecare provider costs.

10. A full description of the questions asked/template used as part of the exercise

10.1 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 cost of care exercise required by the DHSC, the survey includes a wider set of questions to enable a thorough analysis of the marketplace.

10.2 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.

10.3 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.

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

Appendix 1

Provider Engagement documents

220615 - Cost of Care Meeting Launch

220617 - Care Analytics slides for co