SERVICE COSTING CONSIDERATIONS

May, 2022

ABSTRACT

This exercise is based on a Service Costing Framework we have developed which is designed to build an actual service costing 'piece by piece'. It asks you to consider and enter information for a series of relevant costing components, and it then calculates the total price.

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May 2022

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Executive Summary

1. The purpose of this 'Service Costing Considerations' document is to promote dialogue and help establish a long overdue narrative around what is actually required to 'fix social care'.

2. Grounded in our development of our own comprehensive Service Costing Framework and Cost Pressure reports over the last decade, this document is designed to look at service costing requirements one issue at a time and to present these considerations in layperson's terms.

3. Everyone involved needs to understand the reality of costing social care services … and we see this as a perfect opportunity for some genuine coproduction.

4. It is widely recognised that funding models for social care services are not fit for purpose and are grounded far more in what local authorities (with very limited budgets) can afford to pay, rather than what needs to be paid in order to create and deliver the social care infrastructure that as a society, we need. As it stands local authorities are increasingly unable to meet their statutory duties as more and more providers are not picking up care or support packages (or they are handing them back) and people's needs are increasingly going unmet.

5. Against this backdrop, any recalibration exercise to try and establish a fair cost of care, needs to guard against using historic costs to establish future rates. We need a social care sector that is fit for purpose. Not the extension of one that is on its knees and haemorrhaging staff.

6. If we are going to get this right, we need to do away with the smoke and mirrors. We need transparency. As part of this, it would be useful for key 'indicator figures' used to measure the health of the marketplace to be more public. These should include:
    - levels of unmet need
    - the amount of care and support packages being handed back
    - the number and type of care providers that are leaving the marketplace
    - the number of new entrants to the marketplace.

7. If we are ever going to develop the social care workforce that society needs both now and into the future, the fundamental issue that needs to be addressed is that of staff pay. Not only are these staff significantly undervalued for the work they do, current rates of pay combined with the cost of living crisis, are meaning that more and more frontline staff are just not going to be able to afford to work in social care.

8. Research carried out by Unfair to Care demonstrated that many frontline social care workers would be paid 39% or nearly £7000 more a year, if they held equivalent positions within the NHS, local authorities and other public funded industries. This equates to a mid-scale point hourly rate of around £12.61 an hour … or a rise of 32.73% on the current National Minimum Wage of £9.50.

9. Unless social care pays a premium, we will lose staff to, and not be able to attract them from other sectors. We estimate that to secure the workforce needed to fix social care, the wage bill for the sector is going to have to rise to around a third more than it currently is.

10. It would be really helpful for there to be a clear pay structure for social care staff akin to that used by the NHS. We are wanting and needing to integrate health and social care. Putting staff in these sectors on a more equal footing, would be a good way to promote this.

11. An effective social care pay structure needs to include:
    a) Basic rates of pay for front line care and support staff that are sufficiently above the NMW (and other competing sectors) to enable the sector to recruit the staff it needs.
    b) A premium for working anti-social hours … including weekends, waking nights and bank holidays.
    c) A premium where staff are required to work split shifts or to lone work.
    d) A premium where staff are required to support or care for people with complex needs.
    e) A premium to reward experience / length of service.
    f) Further incentivising premiums for staff to take on greater levels of responsibility i.e. as Senior Carers, Senior Support Workers, Team Leaders, Deputy Managers etc.

12. Alongside increasing their basic rate of pay, social care staff need to be 'looked after' in the same way that NHS staff are in terms of the benefits they receive as part of their employment. This should include:
    - increasing the amount of paid holiday available to longer serving staff and / or those in more senior or demanding roles
    - better support for staff sickness … particularly where it is long term
    - having services such as Occupational Health and an Employee Assistance Programme as standard.

13. Considerations relating to 'on costs' need to find ways to adequately accommodate:
    - Employers National Insurance contribution … which has recently gone up.
    - Rates of paid holiday which better reflect and provide the opportunity to recover from the stresses and demands of the job.
    - Sick pay and maternity and paternity pay … the statutory minimums are just not adequate.
    - Health and wellbeing support services.
    - Suspension pay.
    - Time to attend training.
    - Employer's pension contribution.

- Non-contact time for such activities as record keeping, staff handovers and attending team meetings … which we estimate equates to around 12% of a front line care or support workers time
- Shadowing time for new staff.

14. This document estimates on costs in the region of 30.91%, although there are some notable omissions from the list above from this figure. Depending on whether other elements are included as an on cost, this figure could go even higher.

15. Being a Registered Manager has become an increasingly demanding and professional role. Skills for Care identify that the average annual turnover rate for Registered Managers is 20.7%. It is an increasingly stressful role and Registered Managers are getting burnt out, fed up and are leaving. We estimate that the expectations on Registered Managers in terms of their workload have increased by at least a quarter and potentially a third since CQC came into being.

16. There is a need to recalibrate the amount of management time that is required to deliver services to the level expected. As part of this, it needs to be recognised that the more complex a client's care or support needs are … and / or the more challenging their behaviour, the more management time that package will require.

17. Current annual uplift mechanisms are also essentially broken. At times agreed annual uplift formulae have not been applied at all, and when they have been, they have consistently failed to adequately compensate providers for the actual cost increases they have been subjected to. As part of this, providers experience RPI, never mind the (generally) lower CPI index as 'conservative' as insufficient to capture the inflationary cost pressures that they actually face.

18. In this document we propose a basket of goods and services that are more properly representative of a provider's costs. We recommend that providers track the year-on-year percentage change in these costs as more refined evidence of the actual cost pressures they are facing. We also feel that there is a strong case for this (or something similar) to form the basis of a much more relevant annual uplift formula.

19. To be effective any annual uplift process would need to:
    a) Maintain a viable differential between social care and other competitive sectors such as retail and hospitality … both of which have been significantly increasing their rates of pay … and then passing this on to customers.
    b) Be based on a basket of goods and services that are more representative of a social care provider's actual cost areas.

20. As continuous improvement is an expectation of both commissioners and regulators, it is effectively a 'requirement' of the service. As such it needs to be included as a cost line in its own right, rather than something providers are expected to deliver from their (extensively squeezed) profit margins 'if they can afford to'.

21. CQC are very clear that they expect properties to be maintained to a high standard and many of these properties are subject to a higher level of wear and tear than you would normally expect. The current amount included within bed prices for this is not sufficient. This either results in work remaining undone for longer than it should be, or in providers having to use their profit margins to cover some of their repairs and replacements costs.

22. Once occupancy levels have fully recovered following the impact of the pandemic, a VOIDS contingency of between 7.5% and 10% needs to be built into the bed price in order to help mitigate the risks associated with reduced occupancy.

23. If clients have additional needs that cannot be adequately met by the core staffing profile, without compromising the service's ability to meet other clients' needs, then these additional hours need to be costed 'in addition', as Extra Special Needs (ESN) payments.

24. Profit is not a dirty word, and it needs to be recognised and properly understood that it is actually the life blood of social care provision in this country. No profit or surplus … no service. Inadequate levels of return … no incentive for investment. If as a society we want people and organisations to develop social care services, then there absolutely needs to be a financial motivation for them to do so.

25. Broadly, the key factors driving profit margins are:
    a) The level of investment needed. The higher the investment, the greater the expected return.
    b) The amount of time and effort that people need to put in. The more demanding it is, the greater the reward people will expect for their endeavours.
    c) The level of risk associated with developing and maintaining the service. The riskier the venture, the higher the level of return that would be expected.

26. For any social care organisation, it is not the percentage level of profit that they aspire to that is important, it is the percentage level that they actually achieve that is the critical figure.

27. The current culture is all too often one where local authorities are trying to squeeze 'aspirational' profit margins. On top of that they are expecting these already highly squeezed margins to operate like some form of black hole and absorb a whole range of elements that historically have not been covered by annual uplifts.

28. The justification for underpaying providers because it 'comes from the public purse' is a naive and dangerous one. The public purse is there to fund societal infrastructure. Whilst there is a clear case for this to be done in a cost-effective manner, the use of the public purse justification to systematically underfund this vital infrastructure that society needs, is pushing the social care sector to the very edge of existence. That is the opposite of the good use of public money.

29. There is a lack of clarity and agreement around what represents a justifiable profit margin or surplus. We therefore include some 'guide figures' and some justifications for these. These are the types of profitability figures that we believe conversations need to be based around, if we are going to fix social care.

30. Our estimates are that for the market to be adequately incentivised, a reasonable rate of 'achieved return' on both financial (including capital) and 'time and effort' investment for a good service would be in the region of 10%. That would be after tax … so you are then looking at the need to achieve a higher gross profit margin … say 12% to 13% depending on how much corporation tax is needing to be paid.

31. If a company / organisation is looking to provide higher quality services … or services for more complex individuals … or ventures with more inherent risk (or where the provider carries all the risk), then they would / should be looking to achieve a higher level of return … maybe 15% … or 17% to 18% before tax.

32. If we continue to operate in a climate where annual uplifts are not fit for purpose and profit margins are seen as an all-consuming black hole, providers will need to build an additional 'buffer' into their costings, in order to maintain effective levels of incentive.

33. The extent of this will vary depending on the particular circumstance each year and so is difficult to predict precisely, but you are probably looking at around an additional 2% to 3.5%.

34. The current social care marketplace has been 'distorted and constrained' by sustained underfunding so that it is no longer fit for purpose. Far from being 'fixed' it is as close to collapse as it has ever been.

35. In order to maintain a healthy social care marketplace and ensure the necessary climate for investment, private providers should look to include profit margins in the region of 14% to 16.5% for good quality reasonable provision and in the region of 19% to 21.5% for higher quality provision, for more complex provision and / or where the provider is taken significant business risk.

36. Within the current economic paradigm, we will only have a robust social care sector if the principles of free market economics are allowed to operate unimpeded. Social Care costs what it costs. Free market economics has its own checks and balances built in.

37. Whilst the market might need stimulating if certain types of services are needed where there is a known under supply, overall, for providers to remain profitable, supply will not be able to outstrip demand. The market will find an equilibrium where clients will be offered choice and competition between providers will keep prices in check.

38. If the social care marketplace is destroyed, it is not going to be able to just 'bounce back'. There will be a catastrophic shortfall between supply and demand, the implications of which we have not even begun to compute.

39. As with climate change, the trick is to see what is coming down the tracks and to take evasive action before it is too late. There is a fast-closing window of opportunity here. Do we have the collective wisdom needed to see this and to take that opportunity?

Introduction

1. The purpose of this 'Service Costing Considerations' document is to promote dialogue and help establish a long overdue narrative around what is actually required to 'fix social care'. The considerations at times are complex but there is still a degree of 'smoke and mirrors' in relation to what actually constitutes a fair price for care. This document is designed to look at service costing requirements one issue at a time in an attempt to both demystify them and to present these considerations in layperson's terms.

2. Our understanding is in part grounded in our comprehensive Service Costing Framework which we developed to enable providers to consider each component of their service in turn in order to build the actual cost for the service.

3. In addition, it is based on our learning as a Care Association from developing Cost Pressures reports over the last decade, not least on this year's report (Adult Social Care sector cost pressures representation for 2022 – 23) that lays out a salary scale for social care staff (akin to that used by the NHS) which could be used to 'fix social care'.

4. Providers of social care services are best place to know how much they cost to deliver. The considerations outlined in this report are the very real situations and challenges that they face, and we need to ensure that their voice is clearly and fully heard. If we are going to genuinely establish a fair cost of care, any recalibration exercise that is done needs to be done 'with providers' rather than 'to them'.

5. Providers of these services want to help fix social care and they deserve to be a full and active partner in this process. We see this as a perfect opportunity for some genuine coproduction.

6. In the conversations that we have had with providers over the years, they are advocating an approach that:
   a) is comprehensive in its consideration of cost areas. If there is a requirement of providers to deliver it, then there needs to be a line within a costing tool to capture it.
   b) is based on what 'needs to be' rather than what 'has been'. The sector is on its knees and as such there is limited value in using historic costs to establish viable future prices. That is particularly the case when we are in the midst of 30-year highs in the rates of inflation.
   c) works in tandem with an annual uplift process that accurately reflects the increase in costs that providers experience.

7. It needs to be recognised, that rather than just recalibrating rates to enable the sector to stave off the next crisis, fixing social care is about paying rates that enable the social care sector to function as it needs to. The sector has been dramatically underfunded for too long and it is because of this, that it is now going to require significant amounts of new money.

8. The government will also need to recognise the fact that insufficient amounts of the new Health and Social Care levy are currently being earmarked to fix social care … and the money that has been earmarked, is not going to arrive in time.

9. In this recalibration exercise we need to remove the cross subsidisation of local authority funded clients by clients who are self-funded. It is morally indefensible that people who are using their own private capital to pay for their care are having their fees inflated in order to subsidise clients who are funded by local authorities.

Our broken social care system

10. It is widely acknowledged that our social care system is extensively broken. Local Authorities are increasingly unable to meet their statutory duties as more and more providers are not picking up care or support packages and people's needs are going unmet. This is happening because providers are either leaving the market or handing back packages and not picking them up as they can no longer afford to provide them, and / or they can't recruit the staff they need to deliver them.

11. The situation in relation to staff recruitment and retention has been getting progressively worse over the last decade. In their 'The state of the adult social care sector and workforce in England 2021' report, Skills for Care state that nationally 105,000 social care vacancies were being advertised on an average day 2020/21. At 31.1% (and arguably rising) staff turnover rates in the independent sector are more than double the national average turnover rate for all sectors.

12. Social Care has an aging workforce and is not recruiting young people into the sector in anything like the numbers it needs. Not only is this compromising the sector's ability to meet people's needs now, it also has serious implications for our ability as a nation to meet the increasing needs of our aging population. Unless something significant is done to address this issue the increasing gap between the demand for social care and the supply of available services is going to become unbridgeable.

13. The worsening financial situation combined with an increasing inability to recruit staff, is going to lead to more and more providers leaving the marketplace and the conditions will just not be in place for others to join.

14. The social care system is broken now. If we do not sort this situation out, it is going to become irreversibly destroyed.

The need to 'recalibrate' the cost of social care

15. Something significant needs to be done and it needs to be done soon. In its bid to 'fix' social care, the government has recently launched a new initiative in which it is requiring local authorities to carry out cost of care exercises with providers of residential and nursing services for older people and to create a provisional market sustainability plan. (Market sustainability and fair cost of care fund 2022 to 2023: guidance - GOV.UK (www.gov.uk)).

16. We will use this 'Service Costing Considerations' document to go through a number of key costing areas and to make suggestions around how these need to be thought about and 'recalibrated' going forward.

Ensuring pay rates that will recruit and retain the staff we need … and steadily grow the workforce

17. Staff recruitment has not been at all easy within social care for a long time, but the situation has become increasingly desperate. The reasons for this are layered but essentially care and support work is seen as unglamorous and low skilled. The value of caring for vulnerable people is not recognised by society and the media perpetuates the problem by using its headlines to sensationalise (relatively rare) bad practice … rather than acknowledge the sector for the valiant work it does and support it in its struggles.

18. As a consequence of this backdrop, social care workers are significantly under paid for the work that they do. In their report '*Understanding The Social Care Pay Gap and How To Close It*', Unfair To Care provide empirical evidence that frontline carers receive an unfair deal in comparison to other publicly-funded roles as they seek to break the stereotype that social care is a 'low-skilled' sector.

19. Being a competent care or support worker is not a 'minimum wage job' and it is increasingly evident that attempting to recruit and retain staff at National Minimum Wage rates is a futile exercise. These staff deserve to be paid what they are worth, not what we think we can get away with.

20. Unfair To Care's research demonstrates that many frontline social care workers would be paid 39% or nearly £7000 more a year, if they held equivalent positions within the NHS, local authorities and other public funded industries". This equates to a mid-scale point hourly rate of around £12.61 an hour … or a rise of 32.73% on the current National Minimum Wage of £9.50.

21. To their credit ADASS (Association of Directors of Adult Social Services) are recognizing the severity of the issue, and in their submission to the Budget and Comprehensive Spending Review (September 2021) called for the introduction of a specific Adult Social Care Living Wage of around £11.50 an hour or equivalent to NHS Band 3.

22. From our perspective, we welcome ADASS's recognition and recommendation that their needs to be a 'premium' for working in social care. We however believe that in itself this will not be enough to fix the situation, but £11.50 could form the starting point for a range for front line staff that rises to £13.72 with £12.61 as the midpoint.

23. As part of developing our understanding as to why social care struggles to recruit and retain the staff it needs, it needs to be recognised that although money is important, financial reward is not the primary concern for people if they are able to fit their work around their life. However, if (as happens extensively in social care), people are required to fit their life around their work then they expect to be compensated financially.'

24. Combined with being in receipt of low wages, there is the requirement for social care staff to work shifts. This includes lots of anti-social hours … evenings, weekends, bank holidays, sleep ins and waking nights.

25. In domiciliary care services this also includes the requirement for staff to work split shifts … early in the morning … well into the evening, out in the community going from house to house in all weathers and often on their own.

26. Providing support to people in their own homes for as long as this can be done safely is rightfully a cornerstone of consecutive government's national care strategy. However, this is reliant on securing a workforce that is large and robust enough to deliver care in this way.

27. It is increasingly recognised that it is even more difficult to recruit staff in domiciliary care because of the working conditions already highlighted. To secure the Domiciliary Care workforce we need, we may actually have to extend the range for frontline workers and this might need to be more akin to £12.50 to £15.00 an hour.

28. As part of their minimum price for homecare 2022-23, the Homecare Association cite a competitive labour market hourly rate of £12.50, which when rolled up to contain all the associated on costs, equates to £29.90 an hour… [Homecare Association Minimum Price for Homecare 2022-2023]

29. Earning your living from care work currently places you amongst the ranks of the working poor. As our cost-of-living crisis deepens and people are subject to price increases that we haven't experienced for over 30 years, we will need to address this and soon, or more and more people will just not be able to afford to work in social care.

30. Other sectors that people consider as alternatives to working in social care such as retail or hospitality are seen as more straight forward. There is less responsibility and there is not the same perpetual demand to work extra shifts.

31. In addition, employers in these sectors are able to raise wages and pass the cost of this on to their customers, which is not something social care providers have been able to do to the same degree. This combination of factors is putting these sectors at an advantage and social care will continue to be disadvantaged as a consequence.

32. Unless social care pays a premium, we will lose staff to … and not be able to attract staff from these other sectors.

33. As part of our overall consideration we need to recognise the growing body of research that shows that lower income households are hit disproportionally hard by inflation … [Household inflation and income inequality in the UK - Office for National Statistics (ons.gov.uk)]

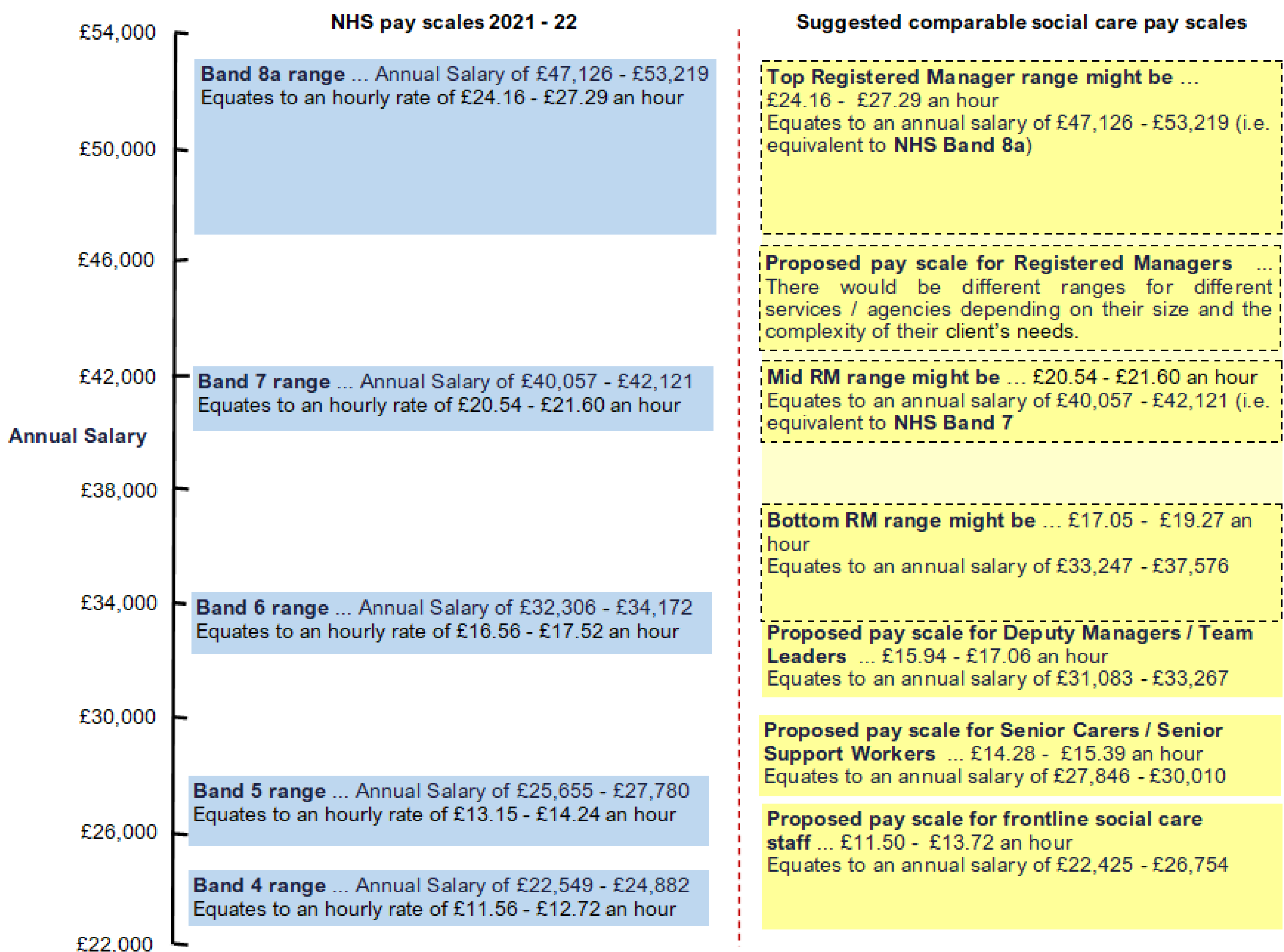
34. Because of the nature of people's care and support needs, social care is a 24 hour a day, 7 days a week, 365 days a year service. We can't change that. Where the movement needs to be therefore is in what staff are paid in order for us to be able to deliver these services.

35. As we have argued in our [Adult Social Care sector cost pressures representation for 2022 – 23], there needs to be a clear pay structure for social care staff akin to that used by the NHS.

36. For this to be viable, it needs to include:
    a) Basic rates of pay for front line care and support staff that are sufficiently above the NMW (and other competing sectors) to enable the sector to recruit the staff it needs.
    b) A premium for working anti-social hours … including weekends, waking nights and bank holidays.
    c) A premium where staff are required to work split shifts or to lone work.
    d) A premium where staff are required to support or care for people with complex needs.
    e) A premium to reward experience / length of service.
    f) Further incentivising premiums for staff to take on greater levels of responsibility i.e. as Senior Carers, Senior Support Workers, Team Leaders, Deputy Managers etc.

37. As a starting point, we believe that the following could provide a pay structure that not only more closely pays social care staff what they are worth, but which would also play a major contribution to fixing social care.

38. If we are committed to fixing social care … and indeed to reversing what, if we are not careful, will result in its terminal decline, society is looking at a pay increase of around a third for front line staff … and as a knock on from that, potentially the whole social care workforce.



Rewarding staff and looking after their wellbeing

39. Alongside increasing their basic rate of pay, social care staff need to be 'looked after' in the same way that NHS staff are in terms of the benefits they receive as part of their employment. They are providing a similar valuable role for our society … in turn as a society, we need to be looking after them. What moral reason is there for not doing this?

Paid holiday

40. The sector generally provides its staff with the statutory minimum paid holiday requirement of 5.6 weeks (or 28 days) including Bank Holidays. Increasing this could again more fully recognise the work social care staff do and provide a further reason why staff might choose to work in social care over other sectors.

41. If you were to increase this to say 7 weeks (or 35 days), then these extra days leave would be something that staff would earn over time as a result of length of service … and / or taking on more responsible and demanding roles. These would form part of a package to help promote staff retention.

Paid sickness

42. In their 'The state of the adult social care sector and workforce in England 2021' report, Skills for Care identify that the average annual rate of sickness for senior carers was 9.3 days and for care workers was 9.8 days. This is effectively 10 days a year.

43. To our mind, social care staff should be brought in line with NHS staff in relation to paid sick / compassionate leave. The problem however with public sector sickness packages is that whilst these are significantly more generous than Statutory Sick Pay, by paying staff when they are off sick, this can encourage some staff to take advantage of the system.

44. Our view is that social care staff absolutely deserve a system that is 'there for them' if they have a genuine long-term illness. The last thing people need if they were to find themselves in this unfortunate position is to have their financial viability critically undermined.

45. However, for short term sickness, we think further exploration would be useful around how you might reward staff (maybe by paying a small monthly premium) if staff are not sick, rather than penalising them if they are.

Health and wellbeing

46. Staff welfare is rightfully an increasing area of focus and we feel that as a minimum providers should be able to cost access to Occupational Health services and an Employee Assistance Programme, into their service cost. The more viable staff rates of pay are, the less pressure there would be to provide additional Employee Benefit Platforms such as Perkbox.

Building on costs

47. We are looking at where there are cost areas that need to be included and which lend themselves to be incorporated within a rolled-up staff 'on cost'.

Employer's National Insurance contribution

48. The exact amount of Employer's National Insurance contribution that needs to be paid will vary depending on the makeup of an organisation's workforce. Up until 1st April 2022, it has been in the region of 8% of the wage bill. After the 1.25% increase in National Insurance in April 2022 (which will become the new Health and Social Care levy in April 2023), we are probably looking at closer to 9.25%.

49. Because of the variation between providers and the introduction of this new levy, we would recommend further discussion around what would constitute an appropriate percentage on cost to cover Employer's National Insurance contributions.

Paid holiday

50. Raising the holiday entitlement from the statutory minimum of 28 days to 35 days (including bank holidays) would increase your percentage on cost for this from 10.77% to 13.46% … based on there being 52 (weeks) x 5 (days) or 260 working days available each year.

51. The staff who would benefit from higher levels of annual leave would be longer serving staff and / or more senior staff who have higher levels of responsibility. In recognition that your workforce will have a range of annual leave entitlements, the median figure (between 10.77% and 13.46%) is 12.2% … so this might be a more reasonable starting point.

52. It should however be recognised that if we do create the conditions to fix social care, staff retention will be significantly improved … and will fall more in line with rates experienced by local authority provided services. In their 2021 'The State of the Adult Social Care Sector and Workforce' report, Skills for Care cite a turnover rate of 11.9% for local authority provided services compared to 31.1% for the independent sector.

53. If this were to happen, the midpoint would prove increasingly inadequate and the percentage contribution towards annual leave would need to increase.

Paid sickness

54. For the sector's average of 10 days sickness a year to be covered, you would be looking at a 4.31% on cost … 10 / 232 (260 days – 28 days holiday) = 4.31%. However, we believe that social care staff are no lesser beings than NHS staff and are performing no less a valuable social function. Sick pay … particularly in relation to support for long term sickness, therefore needs to be on a par.

Maternity and Paternity pay

55. Currently, statutory maternity pay is 90 per cent of the employee's average weekly earnings for the first six weeks, followed by a standard range of £151.97 a week, or 90 per cent of average weekly earnings if the employee earns less than this for the next 33 weeks. This is not particularly generous and a poll by XpertHR found 65 per cent of organisations pay some form of enhanced maternity pay. Three in five (61 per cent) provide enhanced paternity pay and a quarter (25 per

cent) now offer enhanced shared parental leave … Two-thirds of businesses now provide enhanced maternity pay, poll finds (peoplemanagement.co.uk)

56. Quite what would constitute a 'fair and reasonable' maternity and paternity leave package is a subject for discussion, but there seems to be a widespread recognition that the statutory minimum levels are insufficient.

Suspension pay

57. This is something that happens … hopefully not much, but when it does, it can end up being for weeks at a time. If local authorities and regulators require providers to act responsibly, particularly in relation to safeguarding clients, then this is something that needs to be built into the cost.

Training (staff attendance at)

58. The ability to ensure that staff are effectively trained is an important component of any social care service and a requirement of both commissioners and the regulator. Arguably we have seen training expectations rise (for example in relation to specialisms, whistle blowing, equality and diversity …) whilst seeing training budgets tighten and a greater reliance on e-learning to save costs.

59. Our view is that staff should be available for a minimum of 5 days training a year. As an on cost, this would equate to 2.15% … 5 out of the available 232 days a year (once holiday has been removed) x 100. This is only the cost of freeing staff up to attend training. It does not represent the cost of the training itself or its organisation.

Employer's Pension contribution

60. The Employer's pension contribution currently represents a 3% on cost.

Direct care / support time v 'non-contact time'

61. Within any transparent costing mechanism, there needs to be a clear breakdown of what represents a contribution towards the client's 'hours' … in which they should be in receipt of care or support, and what the contribution is towards staff 'non-contact time' in which they are meeting other associated requirements of the service.

62. For the sake of clarity, it would be useful to clearly define what elements of non-contact time should legitimately be included within a service costing.

63. As an attempt to do this, the following is a breakdown of key 'non-contact' requirements and an estimation of the amount of time a Full Time Equivalent (FTE) frontline member of staff would need to spend on each of these in a typical week.
    a) Attending team meetings … approximately 2 hours a month or 0.5 hours a week
    b) Staff handovers … approximately 0.3 hours (20 mins) a day … or 1.5 hours a week
    c) Record keeping … approximately 0.5 hours a day or 2.5 hours a week.

64. A FTE member of staff will therefore spend in a region of 4.5 of their 37.5 hours a week engaged in non-contact activities. This equates to 12% of their time.

65. Other staff roles are also made up of both direct care / support delivery and non-contact time, particularly the roles of Senior Carers / Support Workers, Team Leaders, and Deputy Managers. Although the amount of direct care / support hours will reduce as staff become more senior, the contact hours that they do deliver, will need to be paid at higher rates.

Shadowing time for new staff

66. In their 2021 'The State of the Adult Social Care Sector and Workforce' report, Skills for Care cite a staff turnover rate of 34.4% for frontline care staff. That's over a third of the frontline workforce.

67. In order to induct these new staff as effective replacements (assuming that they can be recruited), providers are expected to have these staff as supernumerary for a period of 2 weeks.

68. Although it is difficult to roll this into a consistent on cost, it is a real cost and there is currently a case for a cost line that equates to 2 weeks staffing hours (around 75 for a FTE post) *X* a third of the number of frontline care staff that the organisation or service has. If conditions improve and staff turnover rates start to fall, then this could be recalibrated based on the new evidence.

Summary of potential on costs

Employer's NI contribution	Approximately 9.25%
Paid holiday	In region of 12.2%
Paid sickness	4.31% (initial estimate)
Enhanced Maternity and Paternity leave	Nothing currently included
Health and wellbeing services	Nothing currently included
Suspension pay	Nothing currently included
Training (attendance at)	2.15% (for 5 days attendance)
Employer's pension contribution	3%
Staff non contact time	Could potentially be included as an on cost
Shadowing time for new staff	Nothing currently included
Total	Currently in the region of **30.91%** but with some notable omissions

Proportions of management time

69. Being a Registered Manager has become an increasingly demanding and professional role. The introduction of Safeguarding, the Mental Capacity Act 2005, and the Deprivation of Liberty Safeguards 2007 along with heightened regulation which requires far greater monitoring and oversight have all significantly added to the demands of the role … and that doesn't even start to consider the demands of Covid.

70. There is absolutely no doubt to those who are directly involved in it that the 'professionalisation' of the sector has made the 'management burden' significantly more onerous. There are just not enough hours in the day and Registered Managers are needing to come in early … and / or stay on late … to take work home with them … or come in on their days off just to try and keep on top of the workload.

71. It is difficult to put a calculated figure on it, and we would suggest that further work is done around this … but we would suggest that the expectations on Registered Managers in terms of their workload have increased by at least a quarter and potentially a third since CQC came into being.

72. We have been operating within a culture where more and more has just been loaded upon managers with no real consideration given to the impact of this and what is realistic for a person to achieve within the hours available.

73. In their 'The state of the adult social care sector and workforce in England 2021' report, Skills for Care identify that the average annual turnover rate for Registered Managers is 20.7%. It is an increasingly stressful role and Registered Managers are getting burnt out, fed up and are leaving.

74. If we want to value and support our Registered Managers and retain them within the sector, then there is a strong case to revisit expectations of them and recalibrate the number of management hours required to reasonably deliver on these expectations.

75. An important related consideration when factoring in management time is the need to recognise that (in the main) the more complex a client's care or support needs are … and / or the more challenging their behaviour (and at times that of their relatives), the more management time that package will require.

Non staffing costs

76. Non staffing costs will vary from service type to service type and from organisation to organisation. Whilst there is a pressure to roll costs up into fewer cost lines, we advocate that providers keep key areas separate, particularly where they are needing to track how specific costs change over time. The more 'rolled up' costs are, the more difficult it is to do this.

77. Organisations will also vary in terms of where they allocate costs. Our view is that there is no right or wrong about this but something along the lines of the following would provide a reasonable level of useful detail in relation to non-direct care staff costs.

Service based non care staff costs

- Administrators / receptionists
- Domestic staff
- Catering staff
- Maintenance staff
- Gardening staff

Central management costs

- Central management function
- Finance and Payroll
- Training delivery and coordination
- HR department / HR consultancy
- IT department / IT service costs
- Marketing
- Management on call costs
- Management travel costs

Additional office costs

- Office rental and rates
- Utilities
- Phone and broadband
- IT equipment and Microsoft Business licences (or equivalent)
- Electronic systems
- Furniture and equipment
- Printing
- Stationary
- Postage
- Sundries

Property related costs

- Rent / property financing costs
- Rates, water and sewage
- Light and heat
- Telephone and internet
- Fixtures and fittings
- Repairs and maintenance
- Insurance (buildings and contents)
- Aids and adaptations

Household expenditure

- Food and household provisions
- Towels and bedding
- Cleaning and laundry
- Clothing and uniform
- TV licence and package subscriptions
- Activities
- Health and Safety costs
- Vehicle and travel costs

Professional fees

- CQC registration
- Insurance costs (Professional indemnity etc)
- Accountancy fees
- Legal fees
- Subscriptions, memberships, and accreditations
- Bank charges

Recruitment costs

- Advertising costs
- Enhanced DBS check costs

Tracking year on year changes to costs

78. Throughout the past decade when talking to providers as part of the development of our annual cost pressure reports, we have consistently been told that non staffing cost pressures as providers actually experience them, invariably exceed the RPI inflationary index for the year … never mind the (usually) lower CPI index.

79. We would argue that on a personally felt level, these indices are 'conservative' and don't adequately reflect increased costs pressures as we experience them. There is certainly a consistent message that they are too blunt a tool to capture the changes in the quite specific basket of costs experienced by social care services.

80. We would advocate providers using a basket of some of their key actual costs to track percentage year on year changes. Examples of this include:

Cost area	***Year 1 cost***	***Year 2 cost***	***% change***
Staffing related costs			
Care / Support Workers (weekday hourly rate)			
First line managers (weekday hourly rate)			
Registered managers (maximum weekday hourly rate)			
Registered managers (minimum weekday hourly rate)			
Sleep in rate (per night)			
Waking night (weekday hourly rate)			
Care / Support Workers (weekend rate)			
First line managers (weekend rate)			
Support Workers (bank holiday rate)			
First line managers (bank holiday rate)			
Sick pay (not covered by the IPC grant)			

Employer's National Insurance contribution (% rate)			
Employer's Pension contribution (% rate)			
Agency staff (overall spend)			
First line managers (bank holiday rate)			

Cost areas table cont'd …

Cost area	***Year 1 cost***	***Year 2 cost***	***% change***
Key non staffing cost areas			
Office rental costs			
Office running costs			
On call costs			
Insurance costs			
Recruitment costs			
Training costs			
CQC fees			
Accountancy fees			
Services … utility costs (electricity)			
Services … utility costs (oil)			
Services … utility costs (gas)			
Services … utility costs (water and sewage)			
Repairs and maintenance			
Renewals and replacements			
Food and household provisions			
Cleaning and laundry			
Waste disposal			
Phone and internet			
Additional 'development and improvement costs			
Governance and Quality Assurance			
IT and Data Security			
Electronic systems			
Care Planning			
Rota Management and Payroll			
Medication Administration Recording			

81. These are very clearly a very different basket of costs to those that make up either RPI or CPI. They also represent relatively consistent cost areas across different types of social care services, although domiciliary care providers will not have property related or household costs.

82. They represent a far more relevant basket of costs and we would recommend that providers track and are able to evidence, their year on year change in these key cost areas.

83. The problem with any Service Costing template used by local authorities to set bed prices is that, even if they are grounded in provider's actual costs, these costs will be 'historic' and will very soon be out of date.

84. Since 2008/09 (and probably well before) there hasn't been a single year where there has been zero (or negative) inflation. Occassionally inflation has been marginal, but in other years it has been significant.

85. The importance of an effective annual uplift mechanism in maintaining a fair cost of care cannot be underestimated. The historic 'snapshot' provided by costing templates combined with annual uplift formula that have either not been applied and / or have not been sufficiently sophisticated quickly lead to an accumulated year on year drift between the actual cost of care and the price being paid.

86. For example, the cost of electricity, gas, oil, petrol, and food have all gone up (significantly). Inflation is currently running at over 6% and may still be rising. Even if it was running at 2%, it would still be going up. The energy price cap is going to be relaxed again later this year which is likely to result in a further significant rise in prices.

87. Indemnity insurance costs have gone up vastly above rates of inflation. Whilst these costs could be 'recalibrated', it is a moving marketplace. Who is to say they are not going to increase significantly again next year as well?

88. Staff recruitment costs have also increased significantly. Historically staff recruitment was something that organisations had to do periodically. Nowadays it is an area where many organisations have an ongoing cost, and this can be quite expensive particularly if they are engaging a recruitment agency.

89. Any 'snapshot' of costs that is taken to develop a fair price will become out of date very quickly if annual uplifts are not sophisticated enough to rectify the situation.

Creating an effective annual uplift formula

90. Whilst this is a separate issue to establishing a fair 'bed price' for care, it is critical to ensuring that any fair price is maintained.

91. Historically annual uplift formulae used by local authorities have been based on some derivation of 70% (some public sector pay indices) and 30% RPI. Whilst well intentioned these have not kept pace with the actual cost increases experienced by care providers.

92. To be effective any annual uplift formula needs to:
    a) Maintain a viable differential between social care and other competitive sectors such as retail and hospitality … both of which have been significantly increasing their rates of pay … and then passing this on to customers.
    b) Be based on a basket of goods and services that are more representative of a social care provider's actual cost areas.

Paying for continuous service improvement

93. There has not been a year over the past decade where care homes have not been expected to 'continuously improve' their services.

94. Improving their quality assurance processes has been a key requirement over the years. Ensuring effective digital security is a current focus … as is the introduction of more and more electronic and paperless systems.

95. Continuous improvement is an expectation of both commissioners and regulators. This makes it a requirement of the service and as such we would argue it needs to be considered as a 'cost line' in its own right.

96. As it stands, the culture is one where providers are being expected to deliver service improvements from within their profit margins which are already being unsustainably squeezed.

97. For charities and voluntary sector organisations, it could be argued that once adequate reserves have been built, their constitutions would require them to reinvest any surplus they make into the improvement of the service. This however is not necessarily the case for privately owned companies.

98. Whilst part of their motivation will be to continuously improve their business, they would also be well advised to build up some reserves and for many, they may see continuous improvement fund as a line on their balance sheet … rather than something that is solely taken out of their profit.

99. Our view is that as continued service improvement is an expectation from both commissioners and regulators, it is not unreasonable to take the view that it should be included as a 'cost line'. This would then embed it as an expectation rather than something providers do 'if they can afford to'.

Repairs and replacements

100. CQC are very clear that they expect properties to be maintained to a high standard. Residential Care and Nursing Homes are being constantly 'used' and are (demonstrably) subject to a higher level of wear and tear than domestic dwellings. On top of this, some clients are particularly hard on their environment in a range of ways, that requires higher levels of repairs, maintenance, deep cleaning and redecoration than you would normally expect.

101. Providers regularly report that the repairs and replacements (maintenance) budget that they are able to establish based on the bed prices that they are paid by local authorities are insufficient to cover the higher levels of wear and tear that their properties are subjected to. As a consequence, maintenance and replacement tasks can often take longer than they would ideally like.

102. This means that 'actual spend' in any given year on these tasks can often be lower than 'ideal spend' … and is not necessarily a good indicator of what should be being spent. Providers manage

the risk and if something needs to be done then they are likely to do it, but they will be left with no choice to fund it from their profit margin … and so eating into that.

103. Again, we would argue that there is a case for further conversation and recalibrating the amount of money that is available for repairs and replacements etc. If there are champagne (or even prosecco) expectations, then it needs to be recognised that these cannot be delivered from a lemonade budget.

Extra Special Needs payments

104. Whilst from a budget management perspective, we recognise the value for local authorities in setting bed prices for different service types, rather than dealing with individually costed services, it needs to be recognised that these bed prices will only relate to the core staffing profile.

105. Within different service types, (care homes with and without nursing … dementia care with or without nursing … residential care for people with learning disabilities … or mental health support needs), the needs and 'behaviours' of clients can differ dramatically. There is therefore not one size fits all in terms of bed price.

106. If clients have additional needs that cannot be adequately met by the core staffing profile, without compromising the service's ability to meet other clients' needs, then these additional hours will need to be costed 'in addition' … as an Extra Special Needs (ESN) payment.

107. Whilst these won't form part of any costing exercise to establish a fair cost of care, these exercises should not overshadow the fact that at times ESN payments will also need to be made.

Voids / occupancy levels

108. Voids are a major issue that need to be factored in, as sustained low occupancy levels will result in a service running at a loss and unless the situation is rectified, are likely to lead to its closure.

109. The nature of an older person's residential service is that people are frail and dependent and often near to end of life. People are going to pass and therefore there is always going to be a turnover of residents that will lead to empty beds.

110. There isn't the same culture around building in a contingency for voids into services for people with learning disabilities and / or mental health support needs, probably as these are generally much longer-term placements. It should however be recognised that these services are a lot smaller and so if they are not operating at full occupancy, that the proportion of income that is lost is far greater … and yet the costs for delivering the service will remain pretty much the same.

111. It is also the case that when these services have a vacancy, they may hold that vacancy for some considerable time as they try and find a new client that would represent a good fit with the existing clients. This can add months to the process.

112. In terms of services for older people, where these services have ‘waiting lists’ then empty bed levels can be kept to a minimum. In this situation services were potentially running at around 95% occupancy levels, although that was pre Covid.

113. Where services are reliant on brokerage services to fill their beds, this can take significantly longer and so percentage occupancy levels will be lower (estimated at around 90%).

114. The pandemic has reduced occupancy levels to around 80%. The State of the Adult Social Care Sector and Workforce 2021’ report, Skills for Care put the occupancy levels for Nursing Homes at 79% and those for Care Homes without Nursing at 81%.

115. These low levels are because of extraordinary circumstances relating to Covid and there are indications that occupancy levels are (slowly) recovering. However, it needs to be recognised that until a home’s occupancy levels have recovered, if it becomes financially unviable it will close which will remove further provision from the marketplace.

116. Extraordinary circumstances require additional and specific support. More generally (and once occupancy levels have fully recovered) you are probably looking at needing to build in a VOIDS contingency into your bed price of between 7.5% and 10%.

Generating a profit (or surplus)

117. If as a society we are tasking the private and voluntary sector to take responsibility for social care provision, then it needs to be recognised that this will only work in a climate where it is worth investing in the development and delivery of these services. If a sufficient volume of services cannot consistently make a surplus (i.e. be profitable), then the viability of the social care sector will be critically undermined.

118. Profit is not a dirty word. It is actually the life blood of our social care sector and that needs to be more fully appreciated than it currently is. If as a society we want people and organisations to develop services, then there absolutely needs to be a financial motivation for them to do so.

119. Accountancy speak around profitability is layered with complexities, but in a nutshell companies and organisations are looking to make a return on any financial investment that has been made (including capital that they have employed) as well as for the time and effort that is put in to providing their services.

120. Broadly, the key factors driving profit margins are:
    a) The level of investment needed. The higher the investment, the greater the expected return.
    b) The amount of time and effort that people need to put in. The more demanding it is, the greater the reward people will expect for their endeavours.
    c) The level of risk associated with developing and maintaining the service. The riskier the venture, the higher the level of return that would be expected.

121. If an individual or an organisation borrows money from a bank to develop a social care service, they will have to pay that money back plus interest. If they use their own money to invest, or that of shareholders, then they will expect to see a reasonable level of return on that investment.

122. If people can't make a reasonable return on their investment, then they are going to choose not to invest, or they will invest in other sectors or commodities. There needs to be a positive investment climate if we want the sector to develop.

123. For any company, it is not the percentage level of profit that they aspire to (which is what they build into their costings) that is important, it is the percentage level that they actually achieve that is the critical figure.

124. The current culture is all too often one where local authorities are trying to squeeze 'aspirational' profit margins … down to say 8% within the rates that they pay. We've even seen it down to as low as 5%. On top of that they are expecting these already unrealistically squeezed margins to operate like some form of black hole and absorb any element that they see fit.

125. Examples over recent times of additional costs that providers have been required to cover have included:
    a) Statutory requirements including increases in staff rates via the National Minimum Wage (increased by 32% since April 2016), increases in employer National Insurance contributions and employer pension contributions.
    b) Inflation of a range of non-staffing costs that have risen far in excess of RPI … never mind the (generally) lower CPI index.
    c) Essential maintenance and replacement costs that exceed the available budgets for these things.
    d) Levels of voids that are higher than have been factored in.
    e) The cost of continually developing the service such as improving quality assurance systems, meeting digital security requirements and introducing electronic systems. Currently these things are neither included in the initial bed price or annual uplifts.

126. Since April 2008 the total rise in RPI has been 40.54% … in CPI it has been 32.47%. Annual uplifts form local authorities over that time period haven't even kept up with these and as previously stated, providers have long argued that neither of these indices ever adequately reflect the cost pressures they actually face each year.

127. The annual uplift system is not working. Year on year providers are just being expected to absorb more and more costs, making the position of many of them increasingly untenable.

128. Other sectors meet increased costs and maintain their profitability by raising their prices as and when they need to. In social care, this is only possible when the client is self-funded … and the fact that it is not possible for local authority funded clients means that private clients experience even further hikes to their rates to subsidise the increasing local authority shortfall.

129. It needs to be remembered that private companies are subject to Corporation Tax of 19% if they make a profit under £300K and 30% if they make profits over £300K. So, any gross profit or surplus that they achieve will then be taxed.

130. It is equally critical that Charitable Trusts consistently make a surplus. They won't pay corporation tax or need to pay dividends, so they could achieve a lower percentage profit to get to the same place. If out of their surplus, they are able to build reserves equating to three months operating expenditure (which is no mean feat in the current climate), their constitutions may require them to reinvest their surplus in the further development and continuous development of the organisation.

131. For the market to be adequately incentivised, a reasonable rate of '<u>achieved return</u>' on both financial (including capital) and 'time and effort' investment would be in the region of 10%. That would be after tax … so you are then looking at the need to <u>achieve</u> a higher gross profit margin … say 12% to 13% depending on how much corporation tax is needing to be paid.

132. If the focus of the company / organisation is to provide higher quality services … or services for more complex individuals … or ventures with more inherent risk (or where the provider carries all the risk), then they would / should be looking to <u>achieve</u> a higher level of return … maybe 15% … or 17% to 18% before tax.

133. Then it is about whether the profit margin is seen as a black hole. If it isn't and there is a commitment that providers can put their prices up or annual uplifts each year will reflect the actual increase in costs that providers experience, then these figures are probably about right.

134. If however the current culture continues where annual uplifts are inadequate then there needs to be a built in buffer. The extent of this will vary depending on the particular circumstance each year … and so is difficult to predict precisely, but you are probably looking at an additional built in 'buffer' of around 2% to 3.5%.

135. So in the current climate, without adequate annual uplifts and the expectations for providers to just absorb costs, we would estimate that in order to maintain a healthy social care market place and ensure the necessary climate for investment, private providers should look to include profit margins in the region of 14% to 16.5% for good quality reasonable provision and in the region of 19% to 21.5% for higher quality provision, for more complex provision and / or where the provider is taken significant business risk.

136. These are just 'guide figures' but for the reasons stated, these are the types of figures that conversations need to be based around.

Conclusion

137. We have got to the stage we have because the social care sector has been subjected to systemic neglect for over a decade. That is why it is on its knees, and that is why the task of 'fixing social care' has become so formidable. We really didn't need to be here … we just needed more realistic rates to be paid on an ongoing basis.

138. The justification for underpaying providers because it 'comes from the public purse' is a naive and dangerous one. The public purse is there to fund societal infrastructure. Whilst there is a clear case for this to be done in a cost-effective manner, the 'we are responsible for the public purse' justification to systematically underfund this vital infrastructure that society needs, is pushing the social care sector to the very edge of existence. That is the opposite of the good use of public money.

139. We are not inherent free market economists, we are social care providers, but we recognise that within the current economic paradigm, we will only have a successful social care sector if the principles of free market economics are allowed to operate unimpeded. Social Care costs what it costs. Free market economics has its own checks and balances built in.

140. Whilst the market might need stimulating if certain types of services are needed where there is a known under supply, overall, for providers to remain profitable, supply will not be able to outstrip demand. The market will find an equilibrium where clients will be offered choice and competition between providers will keep prices in check.

141. The current marketplace for social care is not based on free market economics. It has become distorted and is largely controlled by what local authorities can afford to pay. It is this (pretty much universally acknowledged) underfunding of the sector that is critically undermining it and systematically destroying it.

142. If the social care marketplace is destroyed, it is not just going to 'bounce back'. There will be a catastrophic shortfall between supply and demand, the implications of which we have not even begun to compute, and any providers who remain will be able to charge pretty much what they like.

143. This Service Costing Considerations document lays out a raft of areas that need to be properly considered and accommodated if we are going to find our way out of our current increasing dire predicament and both save … and fix social care.

144. As with climate change, the trick is to see what is coming down the tracks and to take evasive action before it is too late. There is a fast-closing window of opportunity here. Do we have the collective wisdom needed to see this and to take that opportunity?

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