Bradford Council

Care Homes

Cost of Care Exercise

2022-23

October 2022

ARCC-HR Ltd

Contents

1 Executive Summary

1.1 Context the Cost of Care Exercise

1.1.1 Fair Cost of Care & Market Sustainability

On the 16th December 2021 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 will 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 plan detailed plan will be required in February 2023; in the interim a 5-page provisional plan should be submitted utilising the Annex 3 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.

1.1.2 Scope of this report

This report has been prepared in response to the first requirement and presents the analysis and findings from the cost of care exercise conducted within 65+ care homes (residential and nursing). This report covers the following:

- The overall cost of care analysis, including the approach to engagement and data capture, methodology utilised and approach to inform future uplifts
- Costs to consider when determining future fee rates, which includes the flexibility to accommodate a range of assumptions, for example: occupancy, inflationary pressures and other factors such as staffing levels
- Key findings and recommendations during the engagement to support future commissioning models in Bradford.

1.2 Provider Engagement

This review of cost of care has been informed by 3 months' engagement and data analysis work, comprising the following elements:

a) IESE Carecubed cost template: submitted to 77 providers within the Bradford market, to gather data on both the costs and the operational experience of delivering residential care services in Bradford. Providers were given a £250 incentive for completing the template.

b) Provider & Commissioner workshops: following the launch session workshop, two further sessions were held

c) Closed feedback/questions: conducted via the IESE system to allow providers to consider additional questions and clarifications following the final workshop.

Engagement focused on the following key aspects of the provider market as well as a detailed study of provider costs:

1. The current residential care market in Bradford (structure, demand and supply)
2. Provider's business operating models, general market outlook, workforce, contract and quality monitoring, business costs, and future commissioning arrangements
3. Deep dive with providers to understand operating costs and sensitivities that would impact cost

After completion of the data collection, a total of 23 submissions had been received. 2 submissions were excluded from further analysis, 1 home due to lack of data 1 providing specialist placements. The remaining 21 submissions represents 30% of providers in scope of the exercise, 1,011 (30%) of 3,378 beds, and 277 of 975 (28.4%) of residential placements commissioned by Bradford MDC (as at 1st August 2022).

In terms of representative from the wider market, the average provider size was 55 registered beds for nursing in the whole market compared to 12 cost data submissions with an average bed capacity of 47. 2 submissions were from a National Group provider, 4 from a Small Group provider and the remaining 6 were from single homes. This is in comparison to 26% of all nursing homes from National Groups, 35% from Small Groups and 38% from independent/single homes in the nursing market as a whole.

For residential care, the average provider size was 35 registered beds in the whole market compared to 9 cost data submissions with an average bed capacity of 51. 4 submissions were from a National Group provider, 4 from a Small Group provider and the 1 was from a single/independent home. This is in comparison to 21% of all residential homes from National Groups, 45% from Small Groups and 33% from independent/single homes in the nursing market as a whole.

1.2.1 Workshops and Group Engagement

Engagement to submit cost data was promoted by Bradford Care Association, ARCC and a representative from Care Provider Alliance during the launch session on 5th July, via the national IESE web platform.

ARCC also sought group-wide feedback on the exercise as a whole; regarding the relative accuracy of data and supporting information to both aid the strategic and practical implementation of future commissioning approaches.

Whilst no effort was spared to engage with and encourage providers to take part and provide information, and the response was comparable, engagement outside of the submission of cost information was lower. 18 providers each attended the drop-in/clarification session and feedback workshop. In addition, 13 providers responded to clarifications submitted by ARCC via the IESE/Carecubed system. As at the time of writing, 6 submissions are still in query on IESE.

This is explored further in Section 2 of this report.

1.2.2 Cost information data quality

Further to section 1.2.1 above, cost information was checked against available information and clarifications were sought throughout the process between August and September 2022; described in further detail in Section 4.

ARCC identified several quality issues which potentially impact the accuracy and robustness of data within the original datasets submitted, which has likely resulted (in some instances) in significantly inflated unit costs compared to what would reasonably be expected, based subsequent clarification with providers, historical income data, current published fee rates (non-LA) and nationally recognised datasets such as Liang and Buisson's care home market reports[1].

Data quality issues are discussed further in Section 4.1; however at a high level these comprise of:

- Acquiring representative unit costs during COVID-19
- Impact of snapshot/actual or current occupancy vs. typical unit-cost based models
- Impact of additional grant funding
- Errors deduced via typical assessment of available income and expected profitability

IMPORTANT NOTE REGARDING QUANTIATIVE ANALYSIS IN THIS REPORT

Despite undertaking detailed analysis on the cost data returns, a significant number of clarifications are still outstanding with providers at the time of this writing this report; the details and impact of which are illustrated in section 4.1.

Over half of providers responded to clarifications, however no figures were altered or amended by providers as a result of clarifying information. As such, whilst some qualitative errors can be verified, these have not been rectified by the providers, and where no response has been received, potential unknowns will remain.

It is important to acknowledge this in the context of a national deadline to respond to the DHSC requirement by 14th October, for the purposes of accessing grant funding, to benefit cost uplifts in the sector as a whole over the next 3 years.

Therefore, ARCC and Bradford Council acknowledge discrepancies that may occur in the data analysis and will need to be contextualised for the purposes of this report.

Despite any existing data quality issues, ARCC utilised much of the cost information data to model unit costs at target occupancy and staffing ratios; which is explored further in Section 4. These are presented alongside the median values as required to be submitted within DHSC's Annex A report.

As part the recommendations within this report, ARCC advises further engagement to be completed with the market between October 2022 and February 2023 to present the costed scenarios back and discuss feasibility and co-develop a set of representative costs from across the market.

[1] For comparison, where referenced, ARCC uses LaingBuisson, CARE HOMES FOR OLDER PEOPLE UK MARKET REPORT, Thirtieth Edition [2019]

1.3 Local Cost of Care Results

1.3.1 2022-23 cost of care median

As per the Department of Health & Social Care's (DHSC) requirement, the exercise was required to identify a median cost of care for the delivery of services in financial year 2022-23 for the following types of care home placements:

- 65+ standard residential care;
- 65+ residential care for enhanced needs;
- 65+ nursing care; and
- 65+ nursing care for enhanced needs.

Table 1 below identifies the range and median rates across the 4 types of care. Section 4 provides a more detailed breakdown of the findings from the analysis.

Care Type	Median Unit Cost	Estimated annual impact
65+ care home places without nursing	£1,069.92	£14,818,350
65+ care home places without nursing, enhanced needs	£1,115.81	£0
65+ care home places with nursing	£1,448.97	£6,313,392
65+ care home places with nursing, enhanced needs	£1,484.31	£0

Table 1: *Median unit cost for all care types*

The financial impact of this model is estimated to be £21.1m per annum based on the variance between the existing average rate paid and the median, multiplied by an estimated number of placements as of August 2022.

1.3.2 Scenario modelling

Following the above analysis and reflecting on commissioner and provider feedback in relation to the accuracy of data, a number of additional scenarios were also considered utilising some of the base costs submitted for 2022-23 as well as expected norms in relation to:

a) Staffing vs. non-staffing costs as a proportion of total unit cost
b) Staffing ratios and hourly rates
c) Median rates for non-pay costs
d) Return on Operations and Return on Capital
e) Expected occupancy

Care Type	ARCC Modelled Unit Cost	Estimated annual impact
65+ care home places without nursing	£795.75	£5,889,039
65+ care home places without nursing, enhanced needs	£835.11	£0
65+ care home places with nursing	£932.26	£569,185
65+ care home places with nursing, enhanced needs	£1,005.45	£0

Table 2: *ARCC modelled scenarios at 85% occupancy*

The financial impact of this model at 85% occupancy is estimated to be **£6.5m per annum** based on the variance between the existing average rate paid and the presented scenarios, multiplied by an estimated number of placements as of August 2022.

It is important to re-iterate that whilst several data sources and assertions were used as a proxy for modelling various unit costs (such as pay rates to carers, staffing ratios and occupancy), commissioners' fees are based on ***whole service costs*** and not simply the pay rate to the direct care workforce, or any other individual cost element. Therefore, the breakdown of unit costs within each scenario is unlikely to directly replicate any single providers' business and is intended simply to sustainably cover a range of business operating costs for the purposes of commissioners' understanding and decision-making regarding potential future prices for care home services.

1.3.3 Conclusions

The cost of care exercise was conducted during exceptionally challenging conditions for the sector nationally, not just in Bradford. Recruitment and retention pressures arising during the Covid-19 outbreak and most recently inflationary costs have put further pressures on the care workforce and providers alike.

It is important to note when commissioning care services, that Councils are 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 and scenario models, 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 resident per week. 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 to, or should it be read that it is the absolute maximum limit of, what the provider's affordability will be for any and all costs incurred by their businesses. 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.

Finally, it should be re-emphasised that any Council has a duty under Section 5 of the Care Act to ensure they have a "sufficient" market to buy services from, and it is not the duty of any local authority to pay any specific "rate" for care. Rather, local authorities will need to consider how readily they are able to service their population's needs via existing contracting and pay mechanisms they have with the market, taking into account:

- the scale of customers waiting for a package of care; and length of time taken to fulfil placements,
- 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.

Ultimately, this assessment feeds into the cost of care to determine what gives the Council assurance around the overall sufficiency of care they are able to purchase from the market.

1.4 Summary of recommendations

We have noted the following recommendations (for further details, see Section 5):

1.4.1 Continued dialogue with the market regarding a sustainable rate for care

Whilst a long-term intention, in line with this DHSC cost of care exercise, may be to work towards the estimated unit costs within this report, DHSC guidance states that "fair means what is sustainable for the local market". In the context of care home costs in Bradford, most provision is provided at the contracted rates, and therefore it can be evidenced that the market has the ability to provide services at these rates.

The Council should however continue to monitor the pressure in the market (both staffing and business operating costs), as well as ability to population support needs via commissioning in the market through future fee exercises.

1.4.2 Model occupancy and market capacity for long-term market shaping

ARCC's analysis and subsequent costing toolkit provides Bradford commissioners with the ability to model market capacity and cost based on a changing occupancy landscape – lower occupancy, as has been experienced during the pandemic, puts cost pressures on providers and impacts sustainability in the medium-long term.

Whilst the market is in a recovery phase, it would be prudent to monitor target occupancy on a sliding scale from 85% up to standard expectations under normal day-to-day business operations. This will allow Bradford to take a staged approach over time to unit costing to mitigate the impact of occupancy.

Further to this, overall beds in the market are affected by changes in occupancy, as homes enter and exit the market, the overall availability of beds will push occupancy rates higher or lower, and therefore there exists a natural equilibrium (over time) that may be aspired to in this regard.

1.4.3 Quality and contract monitoring of care input

Bradford Council should continue to assess staffing ratios applied as part of on-going contract and quality monitoring. It was clear from this analysis of cost surveys that staff costs were highly variable across providers who submitted a return, suggested a highly irregular direct care input to residents, depending on setting, and which was not consistent across care types. Personalisation of care aside, it has not been evidenced that Bradford Council routinely commission highly-specified packages 1:1 time, and therefore the high level variability was not an expected result in this exercise.

Whilst existing safeguards (such as CQC; safeguarding and complaints processes) remain, it is recommended that implementing or enhancing existing measures of staffing ratios across settings will improve consistency.

1.5 Acknowledgements

We extend our sincere thanks to Bradford care home providers for their participation and openness in sharing data for the project. We are also grateful to Bradford Care Association for supporting engagement activities. Last but not least, we thank Bradford Council commissioning team for the opportunity to perform this work and their support and commitment throughout the project.

2 Project Overview

2.1 Policy Landscape

On 7th September 2021, government set out its new plan for adult social care reform in England. This included a lifetime cap on the amount anyone in England will need to spend on their personal care, alongside revisions to the means-test for local authority financial support. From October 2023, the government will introduce a new £86,000 cap on the amount anyone in England will need to spend on their personal care over their lifetime. The charging reforms also propose to extend Section 18(3) of the 2014 Care Act which allows self-funders to request that their local authority commissions their care, in the same way as those who are supported by the means test.

Section 18(3) commenced in 2015 in relation to domiciliary care and DHSC plan to extend this to residential and nursing care provision for older people. Whilst section 18(3) has been in place for domiciliary care for 7 years the uptake and financial impact remains unclear; however, in March 2022 the County Council's Network published an impact assessment on the implementation of section 18(3), which identified: "In its own impact assessment, the Government have not sought thus far to estimate the combined financial impact of Section 18(3) and FCC on care providers. But our analysis demonstrates that based on a 50% take up rate of Section 18(3) and current FCC funding levels for councils, providers across the country would experience significant financial challenges as a result of lost revenues amounting to £560m"[2].

The government is implementing wide-ranging and ambitious reform of adult social care. In December 2021 the DHSC published a white paper, People at the Heart of Care, that outlined a 10-year vision that puts personalised care and support at the heart of adult social care and supports the realisation of the funding reform. Implementation of the Market Sustainability and Fair Cost of Care Fund is one of the first foundational steps in the journey to achieving this vision.

On the 16th December 2021 DHSC released its policy paper: **'Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023'**. As a condition of receiving future funding[3], local authorities will need to evidence the work they are doing to prepare their markets and submit the analysis of cost of care exercises for 65+ care homes and 18+ domiciliary care. There is also a requirement to produce a provisional market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market. A final detailed plan will be required in February 2023; in the interim a 5-page provisional plan should be submitted utilising the Annex 3 template.

For the purpose of the policy, and in terms of understanding the cost of care, DHSC have defined 'fair' as "*the median actual operating costs for providing care in the local area (following completion of a cost of care exercise) for a series of care categories….and is, on average, what local authorities are required to move towards paying providers. In the context of specific rates for care paid, fair means what is sustainable for the local market. For providers, this means they will be able to cover the cost of care delivery and be able to make a reasonable profit (including re-investment in their business), surplus or meet their charitable objectives. For local authorities, it recognises the responsibility they have in stewarding public money, including securing best value for the taxpayer*".[4]

[2] Impact Assessment of the Implementation of Section 18(3) of The Care Act 2014 and Fair Cost of Care; The County Councils Network

[3] In total the fund amounts to £1.36 billion (of the £3.6 billion to deliver the charging reform programme). In 2022 to 2023, £162 million will be allocated. A further £600 million will be made available in each of 2023 to 2024 and 2024 to 2025. This funding profile allows for staged implementation that is deliverable, while also reflecting the timelines for charging reform.

[4] See detailed guidance 24th March 2022.

A cost of care exercise is a process of engagement, data collection and analysis between local authorities, commissioners and providers with the purpose of arriving at a shared understanding of the local cost of providing care. As per the DHSC requirement, the cost of care exercise will help local authorities identify the lower quartile, median and upper quartile costs in the local area for a series of care categories. Cost of care best describes the actual costs a care provider incurs in delivering care at the point in time that the exercise is undertaken, it is not the fee that is charged. The outcome of the cost of care exercise is not intended to be a replacement for the fee-setting element of local authority commissioning processes or individual contract negotiation.

The Care Act 2014 states *'When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care… It should also allow retention of staff commensurate with delivering services to the agreed quality and encourage innovation and improvement. Local authorities should have regard to guidance on minimum fee levels necessary to provide this assurance, taking account of the local economic environment. This assurance should understand that reasonable fee levels allow for a reasonable rate of return by independent providers that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term.'*[5]

The cost of care exercise is an opportunity for Bradford commissioners and local care providers to work together to arrive at a shared understanding of what it costs to run quality and sustainable care provision in the local area and that is reflective of local circumstances. It is also a vital way for commissioners and providers to work together to shape and improve the local social care sector and identify improvements in relation to workforce, quality of care delivered, and choice available for people who draw on care.

2.2 Project Scope

The scope of the project was determined by DHSC's Fair Cost of Care guidance and specifically focused on care homes for older people (age 65+); although there was recognition that some residents in these homes may be aged under 65. The four types of care to be considered were:

- standard residential care;
- residential care for enhanced needs;
- nursing care; and
- nursing care for enhanced needs.

The following services were out of scope: local authority in-house services.

2.3 Approach, Methods and Limitations

2.3.1 Project Governance

ARCC's approach was to encourage as much engagement as possible from the market. In order to monitor progress and mitigate project risks a project governance group was formed consisting of the Assistant Director Commissioning & Integration, Contract and Quality Senior Manager, Contract and Quality Manager and Care Sector Liaison Assistant, representatives from the Bradford Care Association (BCA) and ARCC. This group met fortnightly to discuss progress, risks and mitigations arising throughout the course of the project. Internally,

[5] DHSC, section 4.31, Care and Support Statutory Guidance.

ARCC's project team formally reviewed progress and risks on a daily basis with formal reporting through the governance channels established.

2.3.2 Engagement Activities and Timeline

Engagement activity was targeted to a cohort of 77 care home providers (out of a total 98 homes registered in Bradford), regardless of the contract type (whether a framework provider or having no contract with the council). This cohort was engaged with throughout the process. The number of homes in scope was determined through IESE – the 22 homes marked as out of scope were either specialist homes or catered to under 65's care.

The engagement comprised the following key activities:

a) **IESE/Carecubed Cost Survey:** All homes were invited to register via IESE to submit a cost return. Any data ultimately submitted by the providers was sent directly to Bradford Council. Confidentiality of provider's commercially sensitive information was paramount to the exercise; however it is worth bearing in mind that by utilising the IESE Carecubed system, all providers have their information directly visible to Bradford commissioners. Providers were given an incentive of £250 for completing the submission.

   In total, **23** providers submitted a return, of which **21** were included in the data analysis. This represents **1,011 beds** (30%) within the local market.

b) **Provider & Commissioner workshops/clinics:** following the launch session workshop, three further sessions were held, with all providers invited:

   - A drop-in clinic/clarification session to support providers' completion of the toolkit or IESE Carecubed system, address any concerns and identify additional 1:1 support
   - Providers were invited to attend an *interim session at the end of the survey & 1:1 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 further workshop was then held to work through any assumptions for future cost modelling to resolve discrepancies with the initial data capture

c) **Closed feedback/questions:** these were conducted via the IESE platform to allow providers to consider additional questions and clarifications.

Throughout the process, all providers in scope were kept appraised of the engagement feedback & timeline via e-mail, and copies of workshop slides were distributed following each workshop[6]. 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.

[6] Copies of communications and slides shared within and following workshops are provided in **Section 6 Appendices**

The timeline of main activities is presented below:

Key Activity	Date
Provider launch session	5th July
Q&A drop-in session	14th July
Initial deadline	31st July
Extended deadline	15th August
Provider workshop	13th September
Follow-up provider workshop	28th September
DHSC return deadline	14th October

2.3.3 Provider outreach

To give providers the best possible opportunity to engage with the exercise various forms of communication were utilised. Bradford MDC invited all providers in the market to the initial launch session, which 7 attended. Bradford Council and Bradford Care Association (BCA) subsequently kept the market up to date via e-mail with additional information and support, including an invitation to a drop-in session/clinic to answer any queries providers may have had.

Bradford Council conducted phone calls to providers to ensure the correct stakeholders within each organisation were informed of the exercise, as well as distribution of communications via the BCA newsletters and Whatsapp group. Finally, providers who had previously been in touch either via email or phone calls, received personalised outreaches reminding them of the deadline and offering support. Providers were able to seek support via email, phone calls, and Microsoft Teams meetings, where the team would guide the providers through the submission template, and ask any questions they may have, e.g., regarding engagement process, confidentiality, or expected impact of the exercise.

To further encourage engagement, the submission deadline was extended by one week from 31st July to 15th August as well as individual later deadlines agreed with providers for supplementary information.

2.3.4 Provider engagement

Whilst no effort was spared to engage with and encourage providers to take part and provide information, and the response was comparable, engagement outside of the submission of cost information was low. Only 3 providers attended the drop-in/clarification session and feedback workshop. In addition, 6 out of 21 providers are still in query on IESE. As such, several potential inaccuracies exist in the current cost information, and so as part of the recommendations ARCC encourage Bradford to conduct further work based on the scenario models in Section 4.

Whilst the total number of returns was lower in care homes than the home care sector, engagement in the provider workshops was successful. Whilst we cannot be certain why there was a different response from the two markets, there are several likely contributing factors which may help explain the level of response from care home providers:

- Potential lack of trust that sensitive data could genuinely be kept confidential, and a resultant unwillingness to expand on such data.

- Local commissioning history may have impacted providers willingness to engage, such as previous exercises of a similar nature not resulting in positive changes. Thus, we can infer in some instances that there was no core motivation in the market to engage with the exercise.
- The exercise coincided with poor market conditions, most notably difficulties in recruitment and retention following the pandemic as well as increasing demand for homecare following lifting Covid-19 restrictions in the community. The resultant operational pressures facing providers made it difficult, especially for smaller organisations, to devote sufficient effort to an exercise of this nature.
- Many care home providers (particularly large national care home groups) had dedicated finance and administrative resource to completing the standard cost information at a national level, however were not in a position to offer tangible, qualitative and experiential input from operational managers or Directors (those with responsibility for commercial management of the business and/or financial responsibilities) as part of the process. This limited ARCC's ability to validate returns via 1:1s or an understanding of the operator's business model.
- The online data collection and cost template process had been criticised by some providers for being too onerous, which helped to put off some providers from submitting the cost data.

2.3.5 Cost Modelling

As a result of engaging with providers in the mid-September workshop, ARCC subsequently committed through this project to conduct some high-level cost modelling, informed by the outputs of the exercise, to create a "representative" set of unit costs, considering occupancy, staffing ratios and other care home-specific cost considerations. The cost model was built using a 'bottom up' approach, utilising cost and volume data provided by Bradford alongside input from providers (such as direct care staff wages; back-office costs, premises, overheads and other costs) to build the cost model alongside the agreed model assumptions at the workshop. More details on the approach to cost modelling is provided in Section 4.

The approach adopted was to gain consensus for the apportionment of cost lines, within a range, to contribute to the model & define and agree various scenarios for commissioners to consider (client complexity, average size of home, occupancy and staff pay rates). Using aggregated costs from the 21 provider settings, cost and model information was also triangulated from other sources such as available fee & income data from Bradford.

2.3.6 Limitations

It is important to note the inherent and practical limitations of such an exercise and reflect particularly on what the outputs to 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 meaning that any attempt to include all variables would result in an unusably large range of outputs in any practical sense. Thus, the median and any subsequent modelling can only be a simplified version of reality, using some explicit assumptions, which are discussed and refined to stakeholders' satisfaction. 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 the profile of a local provider.

It should be clearly understood that a cost exercise is not a magic formula that will set the '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.

We must also recognise that, when commissioning care services, Councils are 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 scenario models, 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 resident per week.

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. Equally, the way return on capital and return on operations is calculated may affect each individual business (such as whether capital expenditure has been amortised, applied per bed per week or as a % of total costs). The same applies for back-office costs, non-pay costs and profit. All of these are flexible and will change month-to-month based on the individual business situation.

This is already evidenced in the market when looking at existing local authority models that use an occupancy "target" as a guide for cost per resident per week, but then appreciate that care home organisations will flex their allocation of budgets and distribution of costs accordingly, based on their individual structure and capacity.

As such, any model (and subsequent breakdown of costs) should not be taken explicitly as the exact cost the business needs to, or should it be read that it is the absolute maximum limit of, what the provider's affordability will be for any and all costs incurred by their businesses. 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.

Finally, it should be re-emphasised that any Council has a duty under Section 5 of the Care Act to ensure they have a "sufficient" market to buy services from, and it is not the duty of any local authority to pay any specific "rate" for care. Rather, Councils will need to take into account how readily they are able to service their population's needs via the existing contracting and pay mechanisms they have with the market, which takes into account how long it takes to implement packages of care, the level of unmet need in the market, 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.

In addition, 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 local authority commissioning to continually review and adapt their understanding of costs and contracting practices regularly.

3 The Care Home Market in Bradford

This section details the size and scale of the current care home market in Bradford as well as observations in relation to commissioning, contracting, market structure and costs.

In most economic markets, relative demand versus supply is key in determining prices. Local authority commissioning of care homes can sometimes represent a monopsony market, in which they are the majority buyer. Here the buyer is arguably most concerned with establishing the overall likely volume of demand and then setting a budget to match (though in practice inflationary uplifts are probably the most common form of annual adjustment), from which a price is derived. As this volume is a key driver of price, it was critical for us to understand the purchasing patterns to inform the future cost model.

3.1 Supply, Demand and Quality

Bradford currently has 77 registered care homes (3,378 beds) for older people, of which 34 offer nursing placements. Occupancy levels in residential care average 82% in 2021-22 and 79% 2022-23 year-to-date; with nursing care averages of 79% in 2021-22 and 77% 2022-23 year-to-date.

As at 1st July, there was an estimated 801 vacant beds in the system. Therefore, availability of supply locally is not a significant concern at present although the significant under-occupancy across the market generally may lead to a future sustainability issue for care homes and

Whilst locally, the supply of beds is not a concern, costs pressures have increased the burden on providers nationally. There is some evidence that providers who would usually charge rates above the contracted rates are now accepting places at the base rates due to low occupancy. This may lead to future sustainability issues for these homes.

Further work is required to improve the quality of local provision, with 59% (45) of homes rated 'Good' or 'Outstanding', and 37% (28) homes rated as CQC 'Requires Improvement' or 'Inadequate'. There is no correlation between the size of the home and the CQC quality rating. The Council should continue to invest in care quality monitoring to support registered managers to improve the quality of provision.

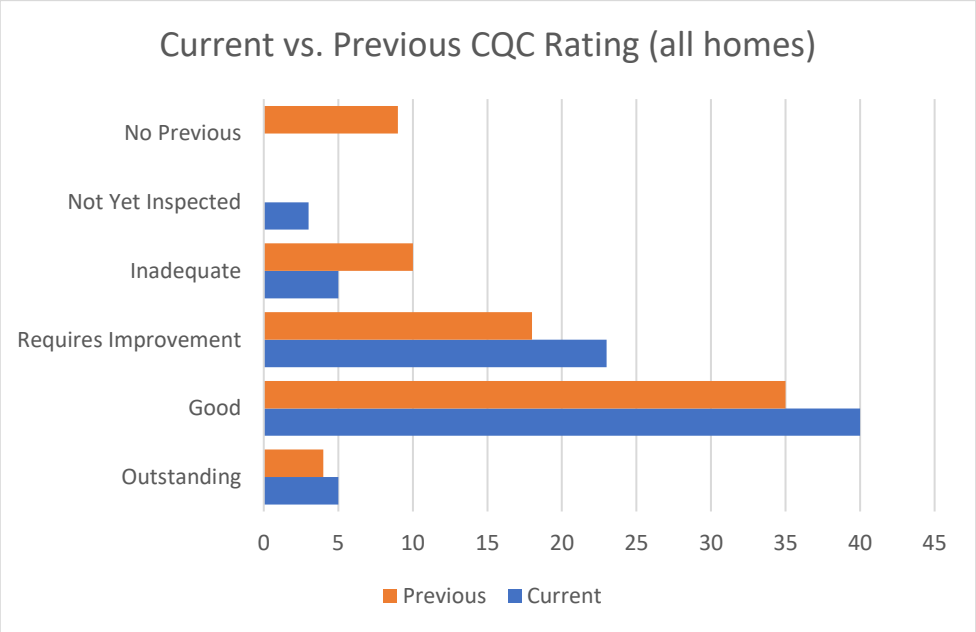


Figure 1: *CQC ratings in Bradford (all homes)*

The below table identifies the ONS estimates of self-funders (May 2022); Bradford is significantly below both the regional and national averages which contributes to the current shape of the market but also suggests that the impact of Section 18(3) may not be as severe as other areas; however, this does place more urgency in resolving cost pressures sooner as the low self-funder numbers locally provide less opportunity for the market to have rate differentials, i.e. there are a less funding streams in the local market to offset cost pressures.

Geographic area – Care Homes	Self-funded service users (%)	LCL (self-funded)	UCL (self-funded)	State-funded service users (%)	LCL (state-funded)	UCL (state-funded)
Bradford	28.2	19.2	37.2	71.8	62.8	80.8
Yorkshire & Humber	32.0	28.6	35.4	68.0	64.6	71.4
England	34.9	32.7	37.1	65.1	62.9	67.3

Table 3: *Care homes and estimating the self-funding population, England: 2021 to 2022 (ONS, July 2022)*

3.1.1 Local labour market

Analysis of labour market statistics[7] identifies that Bradford has lower levels of economic activity in 16-64 years than both the regional and national averages at 77.8% and 78.5% respectively. This is reflected in the higher levels of unemployment at 5.5% (see Table 5 below).

All People	Bradford (no.'s)	Bradford (%)	Yorkshire & Humber (%)	England (%)
Economically Active	256,200	76.8	77.8	78.5
In Employment	243,800	72.9	74.3	75.2
Employees	216,300	65.0	65.8	65.6
Self Employed	27,500	8.0	8.4	9.3
Unemployed (Model-Based)	14,200	5.5	4.3	4.1

Table 4: *Labour market employment statistics, ONS 2022*

Average weekly and hourly earnings also shows figures less than the regional and national averages, however are still somewhat higher than the rates of pay within the care sector at an average hourly rate of £10.47 from the provider submissions in IESE.

	Bradford (£)	Yorkshire & Humber (£)	Great Britain (£)
Gross Weekly Pay			
In Employment	£545.10	£568.50	£613.10
Hourly Pay (excluding overtime)			
Full-time workers	£13.85	£14.21	£15.65

Table 5: *ONS annual survey of hours and earnings - resident analysis*

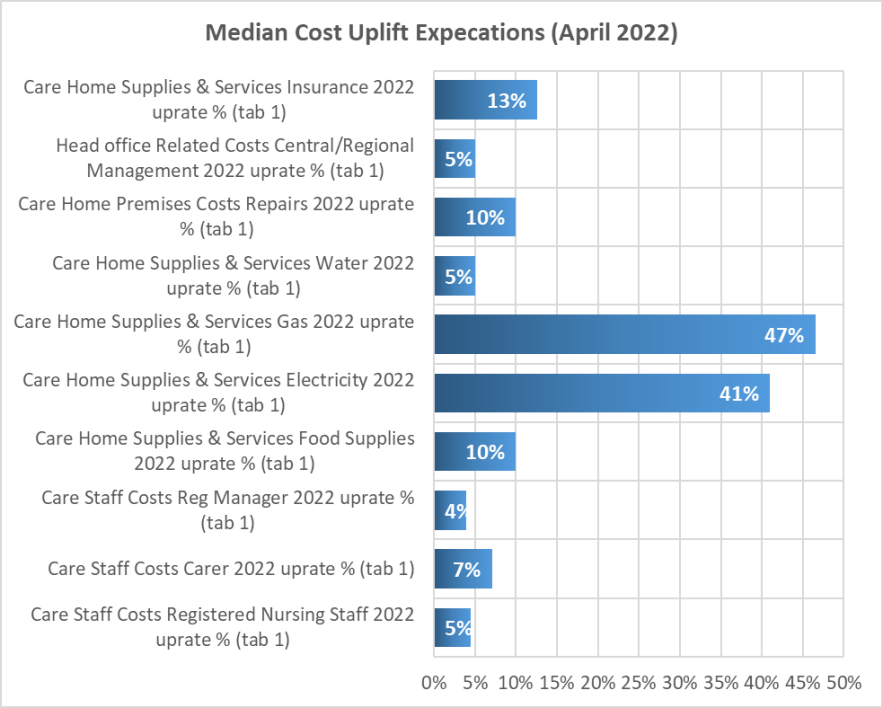
[7] Available from Nomis click here.

3.1.2 Business Challenges

The greatest business challenges identified by providers was:

- Need to pay more than minimum wage to maintain a stable workforce
- Ability to focus on not just filling posts but **attracting the right type of people**
- The impact Covid-19 has had (and continues to have) on bed availability
- Expectations of service quality not matching fees being paid
- Unsustainable increases in utilities costs

More generally, financial stability, increasing cost pressures, in particular increased use of agency staff, utilities, insurance and food given the well documented increases in inflation and growing cost of energy was also cited – providers identified average uplifts of **50%** to energy bills, with the cost of insurance, repairs and food all adding the most pressure to costs in the short-medium term.



In relation to the business challenges, the government's phased removal of measures to support the market during the pandemic, such as workforce grants to support staff to receive full pay (as opposed to SSP) during isolation are likely to further exacerbate some of these challenges.

Concerns have also been raised in ARCC's work elsewhere in relation to the impact on future sustainability and that the typically low fees would no-longer be sustainable given the current workforce and cost of living crisis which is likely to force some homes to close given the significant cost pressures experienced around agency staff, utilities, insurance, food.

3.4.2.3 Sufficiency and occupancy

Providers typically identify that funding needs to come from growing the business and from other income sources, however also highlight that business growth is limited and that continued sufficiency also relies heavily on rate uplifts. Providers also strongly indicated that reducing costs is extremely difficult given that majority of costs are fixed due to staffing requirements and fixed buildings/asset costs. Providers cited already operating lean management structures that met compliance standards.

Finally, the impact of the Section 18(3) charging reforms regarding self-funders moving to LA fee rates were also a concern to providers, implying there is less room to offset costs incurred via higher fees to independent residents.

3.1.3 Suggestions for Improvements to Market Sustainability

For providers, improving the Council's fee rate is likely the single most important action that commissioners can take to improve market sustainability. Other identified by ARCC'S wider work with the market is as follows:

- Support for energy efficiency utilising green grants or incentives to support the generation of green energy, particularly for schemes such as solar panels/grants
- Utilising group purchasing power for consumables which may assist in reducing unit costs when purchasing significantly higher volumes.
- Providing more seamless 'in-reach' support from across the local authority and health, including designated social workers, GP's and other practitioners, which reduces the burden on provider staff.
- Provide activities programme for within homes, including linking community services into the homes to provide enrichment activities.
- Screening the development of new homes and cultivating existing business relationships, including supporting capital refurbishment programmes.
- Support in relation to issues with VAT; this was particularly important issue around agency fees.

4 Cost Analysis and Scenario Modelling

4.1 Provider Cost Information & Data Quality

Following the 3-month period of engagement with providers and commissioners from July 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:

- Minimum staffing ratios were amended to reflect views of providers on the workshop and were broadly reflective as a range for different care types
- There is always a need for minimum staffing which needs to be taken into account i.e. 3-5 staff 24 hours a day at various grades and dependent on size of home
- Approach to capital costs is highly variable dependent on size of home and ownership structure

Despite undertaking detailed analysis on the cost data returns, a significant number of clarifications are still outstanding with providers at the time of this writing this report; the details and impact of which are illustrated in this section.

It is important to acknowledge this in the context of a national deadline to respond to the DHSC requirement by **14th October**, for the purposes of accessing grant funding to benefit cost uplifts in the sector as a whole over the next 3 years.

4.1.1 Provider Clarifications

The additional analysis held between **July-September 2022** allowed the market to engage with the process further, once ARCC had completed the initial returns.

This element of our approach is of critical importance to ARCC's approach to cost of care exercises in general, however it was of even more significance in this engagement:

a) DHSC's requirement that the exercise is conducted with the three pillars of **Consistency, Transparency** and **Partnership** in mind

b) Significant contextual impact of the results to inform costs nationwide as part of adult social care charging reforms

Table 7 (below) identifies some of the thematic queries which were issued to providers.

Category	Clarification	Rationale
Furnishings / Fixtures and fittings	Please provide a breakdown, including whether this includes capital expenditure (capex) costs, including confirmation of the capex budget for the year	Expenditure should be recurrent costs only. Non-recurrent costs should be appropriately depreciated to accurately reflect the in-year cost to be attributed per unit (e.g. if the cost relates to full cost for replacement of furnishings such as sofa/beds etc. that will last several years, it is appropriate to apportion a fraction of the cost reflecting the number of years the asset will be used for.
Repairs and maintenance	Please provide a breakdown, including whether this includes planned and reactive maintenance,	Planned maintenance is recurrent / or should be costed at 50% if it is conducted bi-annually (i.e., fire checks/ventilation etc.). Reactive maintenance should be appropriately depreciated give the length of time the repair is expected to last.

Category	Clarification	Rationale
	and a breakdown of planned maintenance costs	
Central / regional management	Please provide a breakdown, including whether this includes interest, depreciation, what staff and apportionment	Some capital costs may have also been included in Expenditure in the IESE questionnaire. This is aimed at determining whether costs that would ordinarily be included in a return on capital (ROC) figure have already been included elsewhere in the IESE CareCubed platform.
Support services	Please provide a breakdown e.g., the individual charge from head office for H&S, Finance, property Team, HR etc. – are staffing and non-staff costs included?	This allows ARCC to determine parity between larger "group" homes with centralised costs and smaller groups or single homes where these costs would form part of normal supplies and services
Head office costs / ROO / ROC	Are director's remuneration / loan / pension costs included?	As with central & regional management costs, this is aimed at determining whether costs that would ordinarily be included in a return on capital (ROC) figure have already been included elsewhere in the platform

Table 6: *thematic queries issued to providers*

ARCC raised awareness through the mechanisms described in **section 2.3** to emphasise the importance of feeding back to the market to further refine the cost modelling and report an ***agreed, representative median set of costs*** in this Annex B report.

ARCC has taken feedback into account and presented further scenario models in **section 4.3** which will require presentation back to the market, and further refinement between October 2022 and February 2023.

4.1.2 Identified Data Quality Issues

ARCC identified several quality issues which potentially impact the accuracy and robustness of data within the original datasets submitted, which has likely resulted (in some instances) in significantly inflated unit costs compared to what would reasonably be expected, based subsequent clarification with providers, historical income data, current published fee rates (non-LA) and nationally recognised datasets such as Liang and Buisson's care home market reports[8]. In summary, these comprise of:

- Acquiring representative unit costs during COVID-19
- Impact of snapshot/actual or current occupancy vs. typical unit-cost based models
- Impact of additional grant funding
- Errors deduced via typical assessment of available income and expected profitability

Over half of providers responded to clarifications, however no figures were altered or amended by providers as a result of clarifying information. At the time or writing, **6 of 19 submissions were still in clarification on IESE.** As such, whilst some qualitative identification of errors has been identified, it has not been updated by the provider, and where no response has been received, potential unknowns will remain.

Despite any existing data quality issues, ARCC utilised much of the cost information gathered in Carecubed to model unit costs at target occupancy and staffing ratios, which is detailed in **Section 4.3.** These are presented alongside the median values as required to be submitted within DHSC's Annex A report.

[8] For comparison, where referenced, ARCC uses LaingBuisson, CARE HOMES FOR OLDER PEOPLE UK MARKET REPORT, Thirtieth Edition [2019]

4.2 Median Analysis of Provider Cost Data

The low, lower quartile (25th percentile), median, upper quartile (75th percentile) and high provider cost information submitted by 21 providers has been presented in Table 8 below. The reference data tables (presented as £ per resident per week costs in each cost line against the total average unit rate for the provider, to preserve anonymity) is included in Appendix C-F.

Care Type	LOW	LQ 25th %	Median	UQ 75TH %	HIGH
65+ care home places without nursing	£670.15	£947.81	£1,069.92	£1,250.41	£1,326.93
65+ care home places w/out nursing, enhanced needs	£670.15	£979.12	£1,115.81	£1,237.65	£1,272.52
65+ care home places with nursing	£881.52	£1,200.74	£1,448.97	£1,565.90	£1,809.85
65+ care home places with nursing, enhanced needs	£881.52	£1,319.41	£1,484.31	£1,737.30	£1,945.38

Table 7: *cost range, upper and lower quartile and median by care type*

4.2.1 Provider workshop feedback

ARCC presented the current unit costs back to providers at a workshop alongside Bradford commissioners on 13th September. Providers on the workshop agreed the costs were wholly not representative of the actual expected costs within the market and that there were serious discrepancies with the data that had been submitted. Various reasons were discussed as to why the costs may be incorrect, the main points have been highlighted below:

a. Low occupancy figures: As can be seen in the chart Figure 2 below, occupancy both in the financial year 2021-22 and in April 2022 was very low, with averages of 79% and 77% across the two time periods. The IESE system automatically calculates cost per occupied bed per week, and therefore lower occupancies will inflate unit costs.

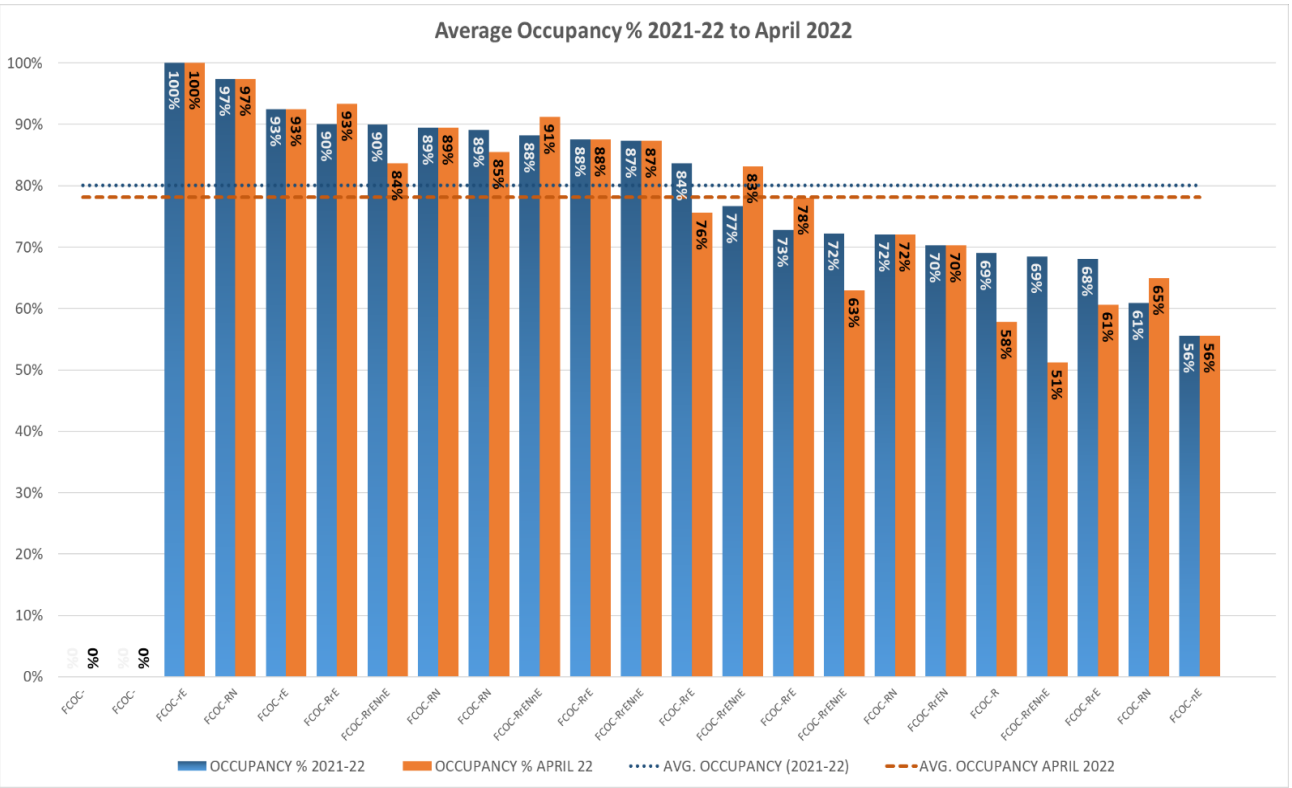


Figure 2: *Bradford care home occupancy vs. average*

b. Staffing vs. non-staffing costs: Providers felt that the split of costs was not broadly reflective:

- 55% of costs attributable to staffing was low; providers felt that this should be closer to 70% as a portion of whole costs
- When taking into account prospective future pay rates (i.e., attracting staff over and above minimum wage); then this ratio could increase even further

Some figures may be skewing this ratio; unlikely to see providers with staffing cost less than 60% of their total business costs; which has been addressed in the scenario modelling

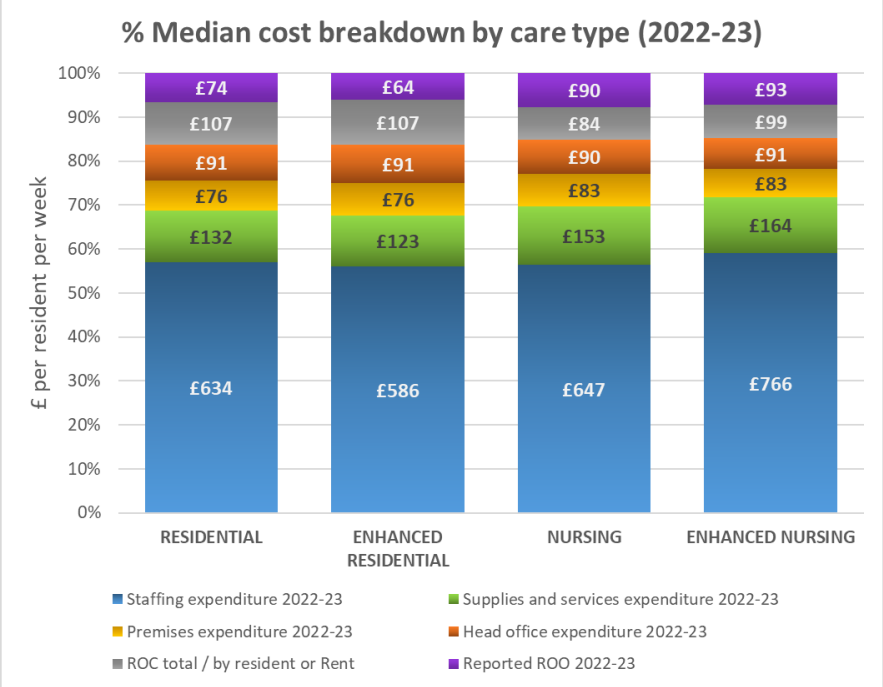


Figure 3. *Analysis of cost categories; 100% breakdown*

c. Non-staffing average unit costs: There was no consistency in increased cost expectations across all providers; however, increasing some standard cost lines by current CPI was discussed, as well as some specific cost lines that have increased over and above this:

- Utilities were the main cost pressure/increase
- Insurance quotes have also increased in some instances
- Elements such as food have also been impacted by

In some instances, the combined costs for premises and ROC represented up to 20% of the total value of the home, meaning that if these costs were to recur annually, the total value of the home would need to be reinvested in 5 years.

This does not seem reflective of the expected net life value of the home, and therefore indicates the home is either not returning value to the investor, or costs have not been appropriately apportioned across multiple years to reflect the fact that cash expenditure in 1 year relates to value across multiple years, and therefore unit costs must be depreciated appropriately.

In order to address some of these concerns, ARCC offered to run a further workshop to determine more reasonable and reflective costs in some of the major areas of discrepancy, which is presented in Section 4.3 below.

4.3 Scenario Modelling

In recognition that the current dataset for 2022-23 requires more work to represent "typical" costs as illustrated in Section 4.1, potential scenarios and variants were discussed with Bradford Council and the provider market on **28th September**.

Following discussions with Bradford Council, the project governance group including Bradford Care Alliance, it was agreed that ARCC should use further intelligence from previous work completed by Bradford Council and the BCA in 2021, alongside market intelligence gathered through this exercise and our own cost modelling toolkit to create a more representative picture of costs to present in this report. All parties, including providers present at the workshop on 13th September, were keen to present a more "typical" view of costs as part of the DHSC Market Sustainability and Fair Cost of Care Fund, so as not to risk discounting the exercise as a whole given the wide variation in costs originally received.

ARCC conducted a further detailed workshop with the market to walk through some key cost lines from the purposes of remodelling the original dataset, which providers on the session responded incredibly positively.

It is important also to note the role of the work conducted in 2021 between BCA and Bradford Council in this additional exercise; which utilised a hybrid model of staffing costs and CIPFA non-staff categories during 21/22, which draws out some key similarities in unit costs in relation to nursing and enhanced nursing care categories. Whilst this section 4.3 goes above and beyond the original ask as part of the DHSC Annex B report, it does highlight positive working towards an agreed and sustainable cost of care. Given the fact that this additional data has been largely supported by the market that attended feedback workshops in September, ARCC conclude that a solid foundation has been built by which to work on an agreed set of costs for future years which can be further developed and discussed in the full Market Sustainability Plan to be completed by February 2023.

As a result of this discussion, the following initial draft scenarios are proposed in this report:

- **Residential** unit costs are based on a setting size of 35 beds and applied staffing ratio of 24.3 hours per resident per week, or 1 carer to 6 residents per day, and 1 carer to 10 residents per night
- **Enhanced residential** unit costs are based on a setting size of 35 beds and applied staffing ratio of 27.4 hours per resident per week, or 1 carer to 5 residents per day, and 1 carer to 10 residents per night
- **Nursing** unit costs are based on a setting size of 35 beds and applied staffing ratio of 24.3 hours per resident per week, or 1 direct care staff (carer/nurse) to 6 residents per day, and 1 direct care staff (carer/nurse) to 10 residents per night
- **Enhanced nursing** unit costs are based on a setting size of 35 beds and applied staffing ratio of 30 hours per resident per week, or 1 direct care staff (carer/nurse) to 5 residents per day, and 1 direct care staff (carer/nurse) to 8 residents per night

It should be noted that **further work should be done to present these models to the provider market and refine between October 2022 and February 2023**, as part of the DHSC requirement for a full Market Sustainability Plan to be submitted in February 2023.

4.3.1.1 Standard Residential

Model B illustrates a staffing ratio of 24.3 hours per resident per week, or 1 carer to 6 residents per day, and 1 carer to 10 residents per night.

Residential Occupancy Scenarios	**Base**	**Model:** **Model 1A**	**Model 1B**	**Model 1C**
Total Bed Capacity	35	**35**	**35**	**35**
Annualised Occupancy (no. beds)	27	**29.75**	**30.625**	**31.5**
Occupancy %	**77%**	**85.0%**	**87.5%**	**90.0%**
Direct Hours per Resident per Week	Median	24.3	23.6	23.0
Carer:Resident Ratio (Day)		1 to 5.95	1 to 6.13	1 to 6.3
Carer:Resident Ratio (Night)		1 to 9.92	1 to 10.21	1 to 10.5
Direct staffing pay cost per Bed (£)	£395	£318	£309	£300
Indirect staffing pay cost per Bed (£)	£159	£149	£145	£141
Weekly pay cost per Bed (£) **(a + b)**	**£553**	**£467**	**£454**	**£441**
Weekly non-pay cost per Bed (£)	**£158**	**£147**	**£144**	**£141**
Weekly EBITDARM per Bed (£)	**£200**	**£181**	**£176**	**£171**
Weekly EBITDARM per Bed (%)	**22.0%**	**22.8%**	**22.8%**	**22.7%**
Total Weekly cost per Bed (£)	**£912**	**£796**	**£774**	**£754**
Care / Non-care / EBITDA Split				
Care related cost/bed (£)	**£570**	**£482**	**£468**	**£456**
Non-care **(daily living)** cost/bed (£)	**£342**	**£314**	**£306**	**£298**
of which (c) EBITDA per Bed (£)	**£54**	**£48**	**£47**	**£46**
Weekly EBITDA per Bed (%)	**5.9%**	**6.1%**	**6.1%**	**6.1%**

4.3.1.2 Enhanced Residential

Model B illustrates a staffing ratio of 27.4 hours per resident per week, or 1 carer to 5.4 residents per day, and 1 carer to 10 residents per night.

Residential EMI Occupancy Scenarios	**Base**	**Model:** **Model 2A**	**Model 2B**	**Model 2C**
Total Bed Capacity	35	**35**	**35**	**35**
Annualised Occupancy (no. beds)	27	**29.75**	**30.625**	**31.5**
Occupancy %	**77%**	**85.0%**	**87.5%**	**90.0%**
Direct Hours per Resident per Week	Median	27.4	26.6	25.9
Carer:Resident Ratio (Day)		1 to 4.96	1 to 5.1	1 to 5.25
Carer:Resident Ratio (Night)		1 to 9.92	1 to 10.21	1 to 10.5
Direct staffing pay cost per Bed (£)	£421	£358	£348	£338
Indirect staffing pay cost per Bed (£)	£157	£149	£145	£141
Weekly pay cost per Bed (£) **(a + b)**	**£578**	**£507**	**£492**	**£479**
Weekly non-pay cost per Bed (£)	**£165**	**£153**	**£150**	**£147**
Weekly EBITDARM per Bed (£)	**£188**	**£175**	**£171**	**£168**
Weekly EBITDARM per Bed (%)	**20.1%**	**20.9%**	**21.1%**	**21.2%**
Total Weekly cost per Bed (£)	**£931**	**£835**	**£814**	**£794**
Care / Non-care / EBITDA Split				
Care related cost/bed (£)	**£595**	**£522**	**£507**	**£493**
Non-care **(daily living)** cost/bed (£)	**£336**	**£313**	**£307**	**£301**
of which (c) EBITDA per Bed (£)	**£54**	**£54**	**£54**	**£54**
Weekly EBITDA per Bed (%)	**5.8%**	**6.4%**	**6.6%**	**6.7%**

4.3.1.3 Standard Nursing

Model B illustrates a staffing ratio of 29 hours per resident per week, or 1 direct care staff (carer/nurse) to 4.5 residents per day, and 1 direct care staff (carer/nurse) to 10 residents per night.

Nursing		**Model:**		
Occupancy Scenarios	**Base**	**Model 3A**	**Model 3B**	**Model 3C**
Total Bed Capacity	35	**35**	**35**	**35**
Annualised Occupancy (no. beds)	27	**29.75**	**30.625**	**31.5**
Occupancy %	**77%**	**85.0%**	**87.5%**	**90.0%**
Direct Hours per Resident per Week	Median	24.3	23.6	23.0
Carer:Resident Ratio (Day)		1 to 5.95	1 to 6.13	1 to 6.3
Carer:Resident Ratio (Night)		1 to 9.92	1 to 10.21	1 to 10.5
Direct staffing pay cost per Bed (£)	£674	£437	£424	£412
Indirect staffing pay cost per Bed (£)	£159	£149	£145	£141
Weekly pay cost per Bed (£) **(a + b)**	**£833**	**£586**	**£569**	**£553**
Weekly non-pay cost per Bed (£)	**£177**	**£165**	**£161**	**£158**
Weekly EBITDARM per Bed (£)	**£195**	**£182**	**£178**	**£175**
Weekly EBITDARM per Bed (%)	**16.2%**	**19.5%**	**19.6%**	**19.7%**
Total Weekly cost per Bed (£)	**£1,205**	**£932**	**£908**	**£886**
Care / Non-care / EBITDA Split				
Care related cost/bed (£)	**£850**	**£602**	**£585**	**£568**
Non-care **(daily living)** cost/bed (£)	**£355**	**£331**	**£324**	**£318**
of which (c) EBITDA per Bed (£)	**£54**	**£54**	**£54**	**£54**
Weekly EBITDA per Bed (%)	**4.4%**	**5.7%**	**5.9%**	**6.0%**

4.3.1.4 Enhanced Nursing

Model B illustrates a staffing ratio of 33.6 hours per resident per week, or 1 direct care staff (carer/nurse) to 4 residents per day, and 1 direct care staff (carer/nurse) to 8 residents per night.

Nursing EMI Occupancy Scenarios	**Base**	**Model:** **Model 4A**	**Model 4B**	**Model 4C**
Total Bed Capacity	35	**35**	**35**	**35**
Annualised Occupancy (no. beds)	27	**29.75**	**30.625**	**31.5**
Occupancy %	**77%**	**85.0%**	**87.5%**	**90.0%**
Direct Hours per Resident per Week	Median	30.0	29.1	28.3
Carer:Resident Ratio (Day)		1 to 4.96	1 to 5.1	1 to 5.25
Carer:Resident Ratio (Night)		1 to 7.44	1 to 7.66	1 to 7.88
Direct staffing pay cost per Bed (£)	£725	£510	£495	£481
Indirect staffing pay cost per Bed (£)	£168	£149	£145	£141
Weekly pay cost per Bed (£) **(a + b)**	**£893**	**£659**	**£640**	**£622**
Weekly non-pay cost per Bed (£)	**£184**	**£171**	**£167**	**£164**
Weekly EBITDARM per Bed (£)	**£188**	**£176**	**£173**	**£169**
Weekly EBITDARM per Bed (%)	**14.9%**	**17.5%**	**17.6%**	**17.7%**
Total Weekly cost per Bed (£)	**£1,266**	**£1,005**	**£980**	**£955**
Care / Non-care / EBITDA Split				
Care related cost/bed (£)	**£912**	**£676**	**£656**	**£638**
Non-care **(daily living)** cost/bed (£)	**£354**	**£330**	**£323**	**£317**
of which (c) EBITDA per Bed (£)	**£57**	**£57**	**£57**	**£57**
Weekly EBITDA per Bed (%)	**4.5%**	**5.7%**	**5.8%**	**6.0%**

4.3.2 Underlying Assumptions for the Cost Modelling

ARCC utilised our care homes cost modelling toolkit to derive scenarios based on the following underlying assumptions, informed by costs from Bradford care homes data submissions:

- All scenario models represent staffing proportion of costs between 60-70% of all costs
- Staffing ratios determined for each of the four care types, by no. direct care staff by day and night
- All beds were costed at an average provider size of 35 beds
- Non-pay costs (supplies & head office costs) make up a minimum 10% of all costs
- Return on capital (all premises and capital costs) including operating surpluses make up a minimum of 17.5-23% of all costs

4.4 Summary Budget Impact

Table 7 identifies the current estimated annual cost incurred; Bradford Council have both advertised framework rates and spot rates, depending on individual needs negotiated with providers. ARCC have extrapolated the current average price paid vs. the existing framework rate for the purposes of comparison.

Care Type	(a) Bradford Framework 22/23	(b) Average Price Paid	(c) No. Clients	(d) Estimated annual expenditure @ current rates [b * c * 52]
Residential	£541.10	£614.93	625	£19,972,434
Residential Enhanced/EMI	£595.98	N/A	N/A	N/A
Nursing (incl. FNC)	£821.87	£881.10	213	£9,768,227
Nursing Enhanced/EMI (incl. FNC)	£912.45	N/A	N/A	N/A
Total annualised cost	-	-	X	£29,740,661

***Table 8**: estimated cost incurred 2022-23*

Using the above annualised figure for comparison, we have extrapolated costs at the median unit rates in **section 4.2** in Table 8. If the median cost of care was to be paid by Bradford; this would require an additional **£23.5m** pounds per annum.

Care Type	(g) Analysis of median costs	% uplift from (b) average price paid	(h) Estimated annual cost @ median [g * c * 52]	(i) Estimated impact (£) based on ARCC modelled cost [h - d]
Residential	**£1,069.92**	97.7%	£34,750,146	£14,777,771
Residential Enhanced/EMI	**£1,115.81**	87.2%	N/A	N/A
Nursing (incl. FNC)	**£1,448.97**	76.3%	£16,063,861	£6,295,634
Nursing Enhanced/EMI (incl. FNC)	**£1,484.31**	62.7%	N/A	N/A
Total annualised cost	xx% (blended)		£50,814,007	£21,073,345

***Table 9:** estimated impact of the median on current rates*

We have extrapolated costs at the ARCC modelled scenario unit rates in **section 4.3** in Table 9. If these model costs were to be paid by Bradford, this would require an additional **£6.5m** pounds per annum.

Care Type	(e) ARCC modelled costs (@ 85% occupancy)	% uplift from (b) average price paid	(f) Estimated annual cost @ ARCC modelled cost [e * c * 52]	Estimated impact (£) based on ARCC modelled cost [f - d]
Residential	**£795.75**	**47.1%**	£25,845,323	£5,872,889
Residential Enhanced/EMI	**£835.11**	**40.1%**	N/A	N/A
Nursing (incl. FNC)	**£932.26**	**13.4%**	£10,335,407	£569,180
Nursing Enhanced/EMI (incl. FNC)	**£1,005.45**	**10.2%**	N/A	N/A
Total annualised cost	XX% (blended)		£36,180,731	£6,440,069

***Table 10:** estimated impact of the ARCC modelled costs on current rates*

4.5 Future Fee Uplifts and Sensitivity Analysis

Whilst future year cost impact is not yet fully known, providers were asked during the course of the engagement what they considered was the most accurate and transparent method for future years fee uplifts. Broadly the consensus was:

- **Pay costs** reflecting changes to factors such as NLW and National Insurance increases; and
- **Non-pay**, i.e., business costs being adjusted to reflect CPI.

Whilst in principle, the above is common practice, there are some important considerations which can have both a positive and negative impact on provider sustainability:

- Establishing a more realistic picture of **market occupancy levels**, currently modelled at 85%, which includes the historic trend alongside the impact Covid-19 has had and continues to have on the market through temporary suspensions in line with government and local guidance, continues to impact occupancy levels.
- Staff ratios and the level of **care per resident per week**.

Of course, the intention of an analysis of this nature is never to arrive at a *specific cost to each provider business. The cost model merely aggregates different provider data to provide an indicative set of figures for consideration.* It is the role of commissioners to assure themselves that the rate paid is inclusive and commensurate with a 'cost envelope' that supports a sustainable, diverse and quality market as per the Care Act.

Commissioners and providers recognise that the role of any fee-setting is ***not*** to specify the absolute operating costs at every level of a provider's business. In reality, using pensions as an example, this means being absolutely clear with commissioners that setting a budget line for all staff pension costs does not mean all providers ***must*** incur 100% pension costs at 3%, to be eligible for the full 'offered' rate to the market (i.e., due to typical opt-out rates of c.15%). Equally, providers are not expected to 'rebate' to the public purse any cost savings made due to operating decisions that take their costs below the typical cost lines presented. Therefore, this variation between providers' day-to-day operating costs and efficiencies will always exist and may not (nor could they be) eliminated in all cases.

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
- The current and expected future rise in interest rates affecting borrowing/cost of capital

As the 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 aimed at, likely to, reducing the increased cost impact against these figures presented in this report.

5 Future Commissioning Considerations

ARCC would like to thank all stakeholders engaged in the process. We hope that through this exercise, both commissioners and providers can continue both the positive dialogue and continued education across the market regarding business operating models and challenges as well as commissioners' needs and expectations.

This report has focused predominantly on the method of engagement and subsequent analysis to establish an indication of the current costs of care in line with the DHSC's requirements. This was the prime purpose of the project, however, ARCC also recognise that informing the future price point for care home placements is only part of a good sustainable commissioning model. This section therefore presents our main conclusions which we believe commissioners should consider for the future, drawn from engagement with the local market and ARCC's experience of good commissioning practice locally and elsewhere.

5.1 Ensuring the Services are Fit for the Future

As previously discussed in this report, competition for staff will likely drive up pay costs and result in increasing usage of agency staff. The impact of staff shortages is not only fiscal, but may also affect continuity of care, which in turn may impact upon increased individual needs. Stability and experience of staff will have a contributing factor on the ability to support people with more complex needs.

The ability to meet high dependency and acuity will be dictated by the ability to staff homes (numbers and experience) which is in turn somewhat governed by the 'cost envelope'. Discussions with commissioners in relation to findings from the cost data and market engagement indicate that staffing ratios are an important factor understanding the cost of care.

Whilst there is no clear mandate on the staff to resident ratio requirement from either CQC or Bradford, other than to operate a staff dependency tool. However, ratios of 1:6 as a minimum to maintain a safe and effective service are recognised within the industry and Laing Buisson market analysis (30th edition, 2019) identified: *"Staffing intensity benchmarks ('on shift' staff hours per resident per week)….for nursing care for older people and dementia is 39.8 hours per resident per week, for residential care of frail older people it is 28 hours per week and for residential care of older people with dementia it is 32.2 hours per resident per week".*

Despite this potential change in the profile of needs, the cost envelope for staffing on core remains the same (+CPI and pay legislation adjustments) which will have a 'knock-on' effect on how beds are utilised as the staff that can be deployed by homes is regulated by the fees and any additional monies that can be levered such as top up or FNC. Given the earlier point about higher levels of presenting needs, homes will be cautious of accepting residents who have needs beyond shared care hours, i.e., requiring more focused 1:1 or 2:1 personal care as the resource may simply not stretch this far despite the needs not being acute enough for more 'higher acuity' beds. The result is that these clients become 'difficult to place' and may end up occupying a more acute bed than is necessary due to the rate differential.

Work needs to be undertaken on the future specifications to ensure that services reflect the current needs of people and the strategic direction for commissioning of local services. Expectations such as acuity of need and dependency can be addressed through setting service level expectations such as support ratios or hotel + care bandings to reflect needs.

5.2 Market Management

Quality of service provision and financial sustainability are the two biggest measures in effectively monitoring delivery of contracts. Over the course of contracts, it is often the case that information requirements grow, and can inadvertently represent an administrative burden for providers, without necessarily providing the required insight for commissioners. Whilst commissioners recognise the need to understand more about provider delivery, more data can lead to less time for meaningful exploration and insight into the impact that changing quality and financial measures are having on market dynamics. As such, a "less is more" approach is advocated – by focusing on fewer, more important indicators, commissioners can learn more and intervene more effectively, in a more collaborative, mutually beneficial arrangement, which does not lessen commissioners' right to take decisive action where warranted.

Commissioners are working towards the implementation of the PAMMs system which will be used to manage the market and maintain an efficient dialogue with providers..

Working closely with the planning department to ensure that new developments meet local market requirements and are not adding additional capacity to the market where this is not required which will compound the challenges experienced with occupancy. Further work is required to understand the condition of the homes within the area and whether they are physically fit-for-purpose. Depending upon the outcome of this review it may be that Bradford Council's strategy focuses on investment to develop existing settings as opposed the formation of new build homes.

5.3 Continued Market Dialogue & Working Towards the FCoC

Continued dialogue with the market is essential to understand factors that will impact the future price for care from 2023/24 and beyond. ARCC advises further engagement to be completed with the market between October 2022 and February 2023 to present the costed scenarios back and discuss feasibility and co-develop a set of representative costs from across the market. Similarly, the charging reforms proposal of a notional £200 per week daily living cost is unlikely to be sufficient to meet local needs; therefore, further detailed work in relation to top up charges will need to be undertaken once the charging reforms are fully implemented. This includes, but is not limited to:

- Movement towards an identified and agreed representative "median" rate; taking into account existing data quality issues and further engagement required from the market between now and February 2023
- Approach market sustainability by **combining the price point with commissioning improvement activities** (see section 5.4 below)
- **Inflationary factors –** reviewing uplifts for pay rates (including Real Living Wage) as well as inflationary uplifts on non-pay costs (i.e., insurance costs etc.)
- **Market size future service requirements** – this includes meeting the objectives of commissioners to create a cost envelope that can reflect a broad range of business sizes and operating models, whilst also reflecting the demand, and availability of residential and nursing beds required across the local authority

5.4 Identifying ways to support the market beyond fees

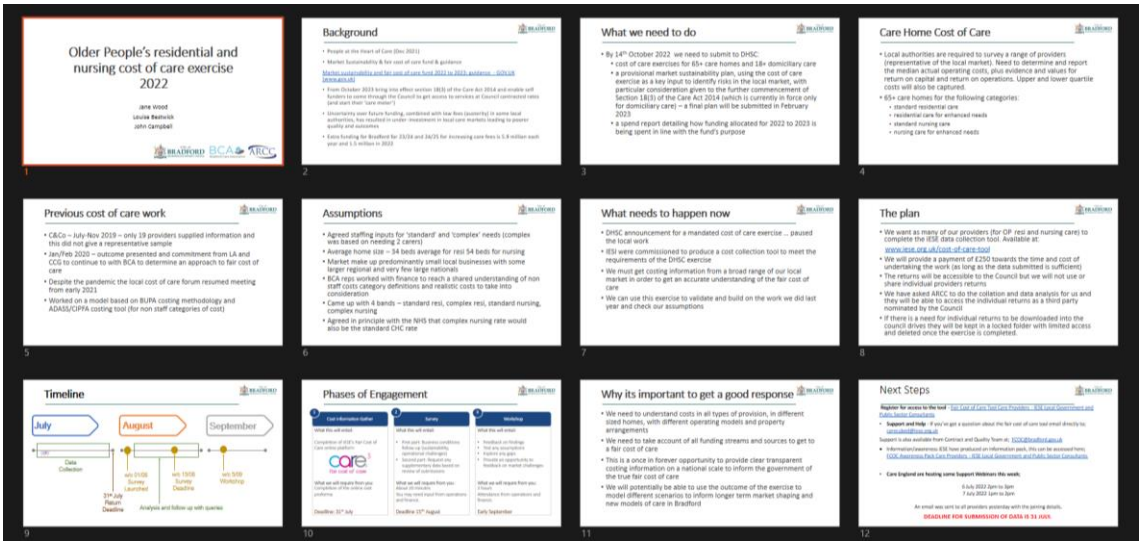
Bradford Council's ability to meter towards a fair cost will be governed by DHSC's future allocation of the Market Sustainability and Fair Cost of Care fund. However, there are actions that commissioners may be able to undertake which could support the local market to offset costs; these include:

- Support for energy efficiency, utilising any green grants or incentives to support the generation of green energy such as solar panel installation.
- Utilising group purchasing power for consumables which may assist in reducing unit costs when purchasing significantly higher volumes.
- Seamless 'in-reach' support from across the local authority and health, including designated social workers, GP's and other practitioners, which reduces administrative burden on provider staff.
- Screening the development of new homes and cultivating existing business relationships, including supporting capital refurbishment programmes.
- Assistive technology to offset staff capacity issues.
- Explore what support commissioners can provide to support current workforce challenges, for example: recruitment campaigns and increasing uptake of free training offers.

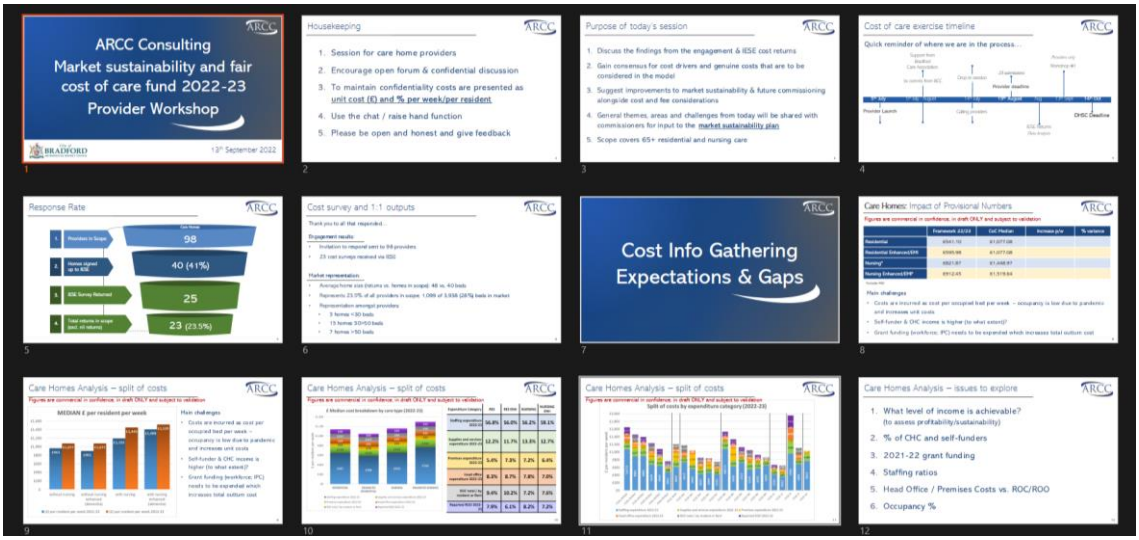
6 Appendices

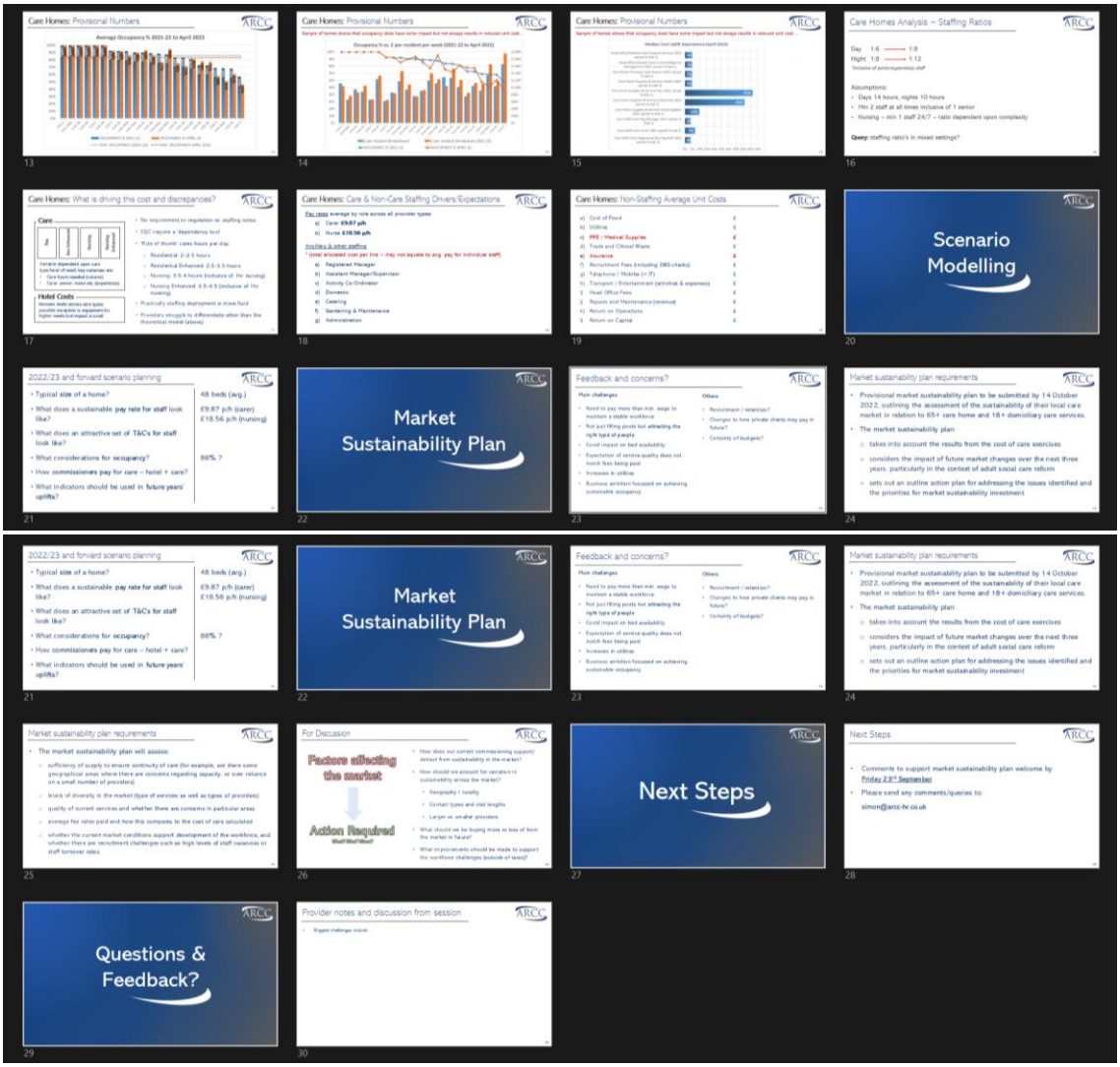
A. Provider Workshop Slides

Care Home Launch Workshop 5th July 2022



Care Home Provider Workshop 13th September 2022





B. Engagement List of Internal Stakeholders & Provider Organisations

Bradford Council

- Assistant Director Commissioning & Integration
- Contract and Quality Senior Manager,
- Contract and Quality Manager
- Care Sector Liaison Assistant

Bradford Care Association

Invited Care Home Providers

With thanks to all who participated in the project, including senior operational and finance staff from the organisations who took the time to contribute with a cost survey and engage in 1:1s and workshops.

C. Reference Data Tables [care homes without nursing]

IESE Location ID / Location Name	LOW	LQ (25%)	MEDIAN	UQ (75%)	HIGH
Therapy Staff (£)	£0.00	£0.00	£0.00	£0.00	£15.60
Activity Staff (£)	£0.00	£6.58	£11.71	£14.14	£24.38
Service Management (£)	£31.23	£39.22	£46.57	£51.68	£107.12
Reception (£)	£1.77	£8.74	£16.42	£23.86	£41.13
Chefs/Cooks (£)	£8.20	£26.45	£28.52	£39.32	£81.60
Domestic Staff (£)	£21.69	£44.33	£53.64	£67.21	£85.18
Maintenance Staff (£)	£2.45	£10.89	£13.48	£16.36	£33.26
Other Care Home Staff (£)	£0.00	£0.00	£0.00	£0.00	£29.66
Staffing Costs	**£392.15**	**£494.65**	**£578.87**	**£613.96**	**£747.06**
Premises - Fixtures and Fittings (£)	£0.00	£0.00	£0.00	£20.33	£261.27
Premises - Repairs & Maintenance (£)	£19.41	£26.06	£31.43	£50.53	£216.27
Premises - Furniture, Furnishings and Equipment (£)	£0.00	£0.00	£4.88	£7.40	£18.59
Premises - Other Premises Costs (£)	£0.00	£0.00	£2.29	£38.93	£102.79
Premises Costs	**£30.11**	**£47.16**	**£83.77**	**£135.56**	**£320.23**
Premises - Food Costs (£)	£24.43	£33.09	£37.15	£40.93	£43.99
Supplies and Services - Domestic cleaning (£)	£3.94	£7.17	£9.57	£13.30	£17.21
Supplies and Services - Medical Supplies (£)	£0.00	£0.52	£3.81	£4.64	£24.13
Supplies and Services - PPE (£)	£0.00	£0.00	£0.66	£0.96	£9.39
Supplies and Services - Office Supplies (£)	£0.85	£1.87	£3.04	£6.23	£10.42
Supplies and Services - Insurance (£)	£0.00	£4.51	£7.14	£12.02	£19.13
Supplies and Services - Reg Fees (£)	£1.80	£2.92	£3.73	£4.40	£8.87
Supplies and Services - Telephone & Internet (£)	£1.17	£1.80	£2.77	£4.55	£12.21
Supplies and Services - Council Tax (£)	£0.53	£0.79	£0.91	£1.12	£2.92
Supplies and Services - Electricity, Gas & Water (£)	£21.10	£32.22	£37.13	£61.67	£82.07
Supplies and Services - Trade Waste (£)	£1.33	£4.59	£5.19	£5.98	£9.42
Supplies and Services - Transport (£)	£0.74	£1.07	£2.79	£5.30	£17.96
Staffing - Other Care Home Staff (£)	£0.00	£1.40	£5.79	£20.82	£31.14
Supplies and Services Costs	**£88.32**	**£127.01**	**£152.42**	**£159.68**	**£178.56**
Head Office - Central/Regional Management Staff (£)	£0.00	£27.45	£43.64	£46.47	£67.06
Head Office - Support Services (£)	£4.95	£10.92	£24.80	£28.89	£151.34
Head Office - Recruitment (£)	£0.00	£1.44	£5.66	£11.58	£39.07
Head Office - Other Head Office Costs (£)	£0.00	£2.15	£19.09	£21.98	£29.06
Head Office Costs	**£12.40**	**£79.49**	**£90.76**	**£105.73**	**£199.92**
Carer Staff (£) - without nursing residents	**£231.37**	**£341.92**	**£383.04**	**£427.54**	**£480.93**
Return on operations 2022 (£)	£0.00	£52.44	£64.12	£120.78	£176.86
Return on capital 2022 (£)	£0.00	£80.90	£101.43	£107.17	£139.36
Total (£) - care home occupied beds without nursing	**£670.15**	**£947.81**	**£1,069.92**	**£1,250.41**	**£1,326.93**
Occupancy April 2022	**18**	**27**	**35**	**44.08**	**67.4**
Total unit costs EXCL. Direct Staff (incl. ROC + ROO)	£438.79	£599.80	£658.38	£795.83	£943.55
Variance/direct staffing costs not included above	£231.36	£341.90	£383.04	£427.55	£480.94

D. Reference Data Tables [care homes without nursing, enhanced]

IESE Location ID / Location Name	LOW	LQ (25%)	MEDIAN	UQ (75%)	HIGH
Therapy Staff (£)	£0.00	£0.00	£0.00	£0.00	£15.60
Activity Staff (£)	£0.00	£5.31	£9.19	£13.50	£16.49
Service Management (£)	£31.23	£42.44	£46.71	£51.43	£107.12
Reception (£)	£1.77	£8.96	£17.26	£22.91	£41.13
Chefs/Cooks (£)	£8.20	£24.97	£29.25	£38.52	£81.60
Domestic Staff (£)	£21.69	£40.58	£50.78	£67.01	£85.18
Maintenance Staff (£)	£2.45	£8.90	£13.24	£16.19	£33.26
Other Care Home Staff (£)	£0.00	£0.00	£0.00	£0.00	£15.78
Staffing Costs	**£392.15**	**£568.08**	**£606.21**	**£632.51**	**£692.65**
Premises - Fixtures and Fittings (£)	£0.00	£0.00	£1.96	£5.27	£44.28
Premises - Repairs & Maintenance (£)	£19.41	£27.12	£32.55	£53.04	£216.27
Premises - Furniture, Furnishings and Equipment (£)	£0.00	£0.71	£4.06	£6.45	£12.31
Premises - Other Premises Costs (£)	£0.00	£0.08	£3.20	£65.78	£102.79
Premises Costs	**£30.11**	**£64.94**	**£83.47**	**£129.63**	**£216.27**
Premises - Food Costs (£)	£24.43	£29.64	£37.02	£41.83	£43.99
Supplies and Services - Domestic cleaning (£)	£3.94	£6.82	£7.87	£13.52	£18.62
Supplies and Services - Medical Supplies (£)	£0.00	£1.22	£3.78	£4.94	£9.05
Supplies and Services - PPE (£)	£0.00	£0.00	£0.68	£1.11	£2.05
Supplies and Services - Office Supplies (£)	£0.85	£2.04	£2.84	£6.12	£10.42
Supplies and Services - Insurance (£)	£0.00	£4.20	£6.17	£10.80	£19.13
Supplies and Services - Reg Fees (£)	£2.43	£3.11	£3.68	£5.10	£8.87
Supplies and Services - Telephone & Internet (£)	£1.17	£1.81	£3.31	£4.29	£12.21
Supplies and Services - Council Tax (£)	£0.53	£0.78	£0.89	£0.99	£2.92
Supplies and Services - Electricity, Gas & Water (£)	£25.57	£32.38	£46.80	£66.74	£82.07
Supplies and Services - Trade Waste (£)	£1.33	£4.36	£5.16	£5.74	£8.63
Supplies and Services - Transport (£)	£0.74	£1.10	£2.92	£4.94	£17.96
Staffing - Other Care Home Staff (£)	£0.00	£0.64	£1.94	£17.06	£31.14
Supplies and Services Costs	**£88.32**	**£120.96**	**£144.30**	**£162.94**	**£178.56**
Head Office - Central/Regional Management Staff (£)	£0.00	£12.43	£39.16	£46.33	£58.75
Head Office - Support Services (£)	£0.00	£9.72	£19.75	£27.96	£151.34
Head Office - Recruitment (£)	£0.19	£1.34	£2.63	£10.03	£15.47
Head Office - Other Head Office Costs (£)	£0.00	£2.06	£18.98	£21.88	£29.06
Head Office Costs	**£0.19**	**£32.82**	**£91.47**	**£107.33**	**£199.92**
Carer Staff (£) - without nursing enhanced (dementia	**£231.37**	**£384.16**	**£412.00**	**£450.06**	**£474.58**
Return on operations 2021 (£)	£0.00	£39.95	£62.82	£113.74	£176.86
Return on capital 2021 (£)	£0.00	£81.56	£103.22	£112.43	£139.36
Total (£) - care home occupied beds without nursing	**£670.15**	**£979.12**	**£1,115.81**	**£1,237.65**	**£1,272.52**
Occupancy April 2022	**18**	**27**	**35**	**44.08**	**67.4**
Total unit costs EXCL. Direct Staff (incl. ROC + ROO)	£438.79	£565.53	£711.22	£790.42	£852.94
Variance/direct staffing costs not included above	£231.36	£384.16	£412.00	£450.07	£474.61

E. Reference Data Tables [care homes with nursing]

IESE Location ID / Location Name	LOW	LQ (25%)	MEDIAN	UQ (75%)	HIGH
Therapy Staff (£)	£0.00	£0.00	£0.00	£0.00	£15.60
Activity Staff (£)	£0.00	£7.26	£12.70	£14.93	£24.38
Service Management (£)	£31.23	£39.16	£43.14	£51.31	£107.12
Reception (£)	£7.34	£11.64	£19.99	£27.20	£41.13
Chefs/Cooks (£)	£8.20	£26.52	£28.52	£39.45	£81.60
Domestic Staff (£)	£37.68	£45.42	£53.64	£68.68	£85.18
Maintenance Staff (£)	£2.45	£11.43	£13.87	£19.23	£33.26
Other Care Home Staff (£)	£0.00	£0.00	£0.00	£0.00	£29.66
Staffing Costs	**£603.52**	**£772.46**	**£840.91**	**£928.26**	**£1,237.40**
Premises - Fixtures and Fittings (£)	£0.00	£0.00	£3.91	£22.34	£261.27
Premises - Repairs & Maintenance (£)	£19.41	£26.06	£31.43	£47.01	£216.27
Premises - Furniture, Furnishings and Equipment (£)	£0.00	£0.00	£5.67	£8.22	£18.59
Premises - Other Premises Costs (£)	£0.00	£0.00	£0.57	£6.13	£102.79
Premises Costs	**£30.11**	**£45.90**	**£83.77**	**£123.70**	**£320.23**
Premises - Food Costs (£)	£24.43	£32.11	£37.15	£41.53	£43.99
Supplies and Services - Domestic cleaning (£)	£3.94	£7.87	£11.70	£14.07	£17.21
Supplies and Services - Medical Supplies (£)	£0.00	£1.74	£3.84	£6.06	£24.13
Supplies and Services - PPE (£)	£0.00	£0.00	£0.66	£1.06	£9.39
Supplies and Services - Office Supplies (£)	£0.85	£1.91	£3.04	£7.19	£10.42
Supplies and Services - Insurance (£)	£0.00	£4.69	£7.14	£10.73	£19.13
Supplies and Services - Reg Fees (£)	£1.80	£2.85	£3.62	£4.88	£8.87
Supplies and Services - Telephone & Internet (£)	£1.17	£1.57	£2.77	£4.03	£5.97
Supplies and Services - Council Tax (£)	£0.53	£0.83	£0.99	£1.15	£2.92
Supplies and Services - Electricity, Gas & Water (£)	£21.10	£33.57	£37.13	£63.06	£82.07
Supplies and Services - Trade Waste (£)	£1.33	£4.06	£5.33	£6.34	£9.42
Supplies and Services - Transport (£)	£0.74	£1.37	£3.85	£5.49	£17.96
Staffing - Other Care Home Staff (£)	£0.00	£0.90	£18.24	£22.34	£31.14
Supplies and Services Costs	**£88.32**	**£138.96**	**£154.47**	**£161.85**	**£178.56**
Head Office - Central/Regional Management Staff (£)	£0.00	£23.84	£39.08	£49.71	£67.06
Head Office - Support Services (£)	£4.95	£10.28	£24.80	£29.62	£151.34
Head Office - Recruitment (£)	£0.00	£1.74	£5.66	£11.71	£39.07
Head Office - Other Head Office Costs (£)	£0.00	£1.08	£18.86	£22.10	£29.06
Head Office Costs	**£12.40**	**£77.68**	**£90.76**	**£106.81**	**£199.92**
Carer Staff (£) - nursing residents	**£231.37**	**£327.50**	**£387.37**	**£442.55**	**£497.53**
Nursing Staff (£) - nursing residents	**£198.56**	**£228.48**	**£273.72**	**£341.04**	**£548.52**
Return on operations 2021 (£)	£0.00	£59.53	£84.39	£121.71	£176.86
Return on capital 2021 (£)	£0.00	£80.69	£83.52	£110.72	£139.36
Total (£) - care home occupied beds with nursing	**£881.52**	**£1,200.74**	**£1,448.97**	**£1,565.90**	**£1,809.85**
Occupancy April 2022	**18**	**27**	**35**	**44.08**	**67.4**
Total unit costs EXCL. Direct Staff (incl. ROC + ROO)	£438.79	£606.07	£771.80	£820.91	£943.55
Variance/direct staffing costs not included above	£442.73	£594.81	£663.88	£723.36	£1,014.02

F. Reference Data Tables [care homes with nursing, enhanced]

IESE Location ID / Location Name	LOW	LQ (25%)	MEDIAN	UQ (75%)	HIGH
Therapy Staff (£)	£0.00	£0.00	£0.00	£0.00	£15.60
Activity Staff (£)	£0.00	£11.96	£13.24	£15.23	£16.49
Service Management (£)	£31.23	£40.20	£44.86	£60.46	£107.12
Reception (£)	£7.34	£10.80	£21.93	£29.40	£41.13
Chefs/Cooks (£)	£8.20	£27.82	£35.62	£67.63	£81.60
Domestic Staff (£)	£37.68	£40.97	£50.78	£72.92	£85.18
Maintenance Staff (£)	£2.45	£9.42	£14.68	£20.66	£33.26
Other Care Home Staff (£)	£0.00	£0.00	£0.00	£0.00	£0.00
Staffing Costs	**£603.52**	**£819.62**	**£897.28**	**£1,166.46**	**£1,365.51**
Premises - Fixtures and Fittings (£)	£0.00	£0.98	£4.58	£16.56	£44.28
Premises - Repairs & Maintenance (£)	£19.41	£26.40	£29.43	£33.11	£50.53
Premises - Furniture, Furnishings and Equipment (£)	£0.00	£5.08	£6.19	£7.23	£12.31
Premises - Other Premises Costs (£)	£0.00	£0.39	£3.20	£57.50	£102.79
Premises Costs	**£30.11**	**£50.09**	**£83.47**	**£104.82**	**£135.56**
Premises - Food Costs (£)	£24.43	£29.64	£37.01	£42.35	£43.99
Supplies and Services - Domestic cleaning (£)	£3.94	£7.22	£7.87	£13.22	£16.70
Supplies and Services - Medical Supplies (£)	£0.00	£3.46	£4.24	£6.77	£9.05
Supplies and Services - PPE (£)	£0.00	£0.17	£0.81	£1.11	£1.24
Supplies and Services - Office Supplies (£)	£0.85	£2.56	£2.84	£5.11	£9.27
Supplies and Services - Insurance (£)	£0.00	£4.25	£6.17	£7.05	£12.56
Supplies and Services - Reg Fees (£)	£2.43	£2.93	£3.52	£5.49	£8.87
Supplies and Services - Telephone & Internet (£)	£1.17	£1.46	£2.65	£4.29	£5.97
Supplies and Services - Council Tax (£)	£0.53	£0.79	£0.89	£0.97	£2.92
Supplies and Services - Electricity, Gas & Water (£)	£32.17	£41.36	£63.06	£76.73	£82.07
Supplies and Services - Trade Waste (£)	£1.33	£3.93	£5.23	£5.74	£8.63
Supplies and Services - Transport (£)	£0.74	£3.06	£4.58	£6.54	£17.96
Staffing - Other Care Home Staff (£)	£0.15	£0.64	£1.72	£16.13	£31.14
Supplies and Services Costs	**£88.32**	**£140.24**	**£158.22**	**£173.45**	**£178.56**
Head Office - Central/Regional Management Staff (£)	£0.00	£12.43	£31.06	£43.10	£53.51
Head Office - Support Services (£)	£4.95	£13.19	£26.85	£38.11	£151.34
Head Office - Recruitment (£)	£1.19	£1.52	£2.63	£5.02	£11.58
Head Office - Other Head Office Costs (£)	£0.00	£2.06	£13.56	£21.20	£27.67
Head Office Costs	**£12.40**	**£33.60**	**£98.22**	**£107.33**	**£199.92**
Carer Staff (£) - nursing residents	**£231.37**	**£389.90**	**£427.52**	**£463.54**	**£631.25**
Nursing Staff (£) - nursing residents	**£198.56**	**£207.57**	**£284.73**	**£440.62**	**£548.52**
Return on operations 2021 (£)	£52.44	£62.17	£93.38	£125.82	£176.86
Return on capital 2021 (£)	£0.00	£81.56	£98.89	£129.68	£139.36
Total (£) - care home occupied beds with nursing enh	**£881.52**	**£1,319.41**	**£1,484.31**	**£1,737.30**	**£1,945.38**
Occupancy April 2022	**18**	**27**	**35**	**44.08**	**67.4**
Total unit costs EXCL. Direct Staff (incl. ROC + ROO)	£438.79	£652.81	£785.02	£833.45	£852.94
Variance/direct staffing costs not included above	£442.73	£612.99	£704.66	£946.88	£1,099.39

Copyright Notice

Disclaimer

This document has been produced independently by ARCC-HR Ltd (ARCC) on the request of the Client. The views expressed in this document are not necessarily the views of the Client or its partners. The information, statements, statistics and commentary (together the 'Information') contained in this document have been prepared by ARCC from commercially sensitive material and discussions held with stakeholders. The document does not express an opinion as to the accuracy or completeness of the information provided, the assumptions made by the parties that provided the information or any conclusions reached by those parties.

ARCC have based this document on information received or obtained, on the basis that such information is accurate and, where it is represented to ARCC as such, complete. Whilst we have made every attempt to ensure that the information contained in this document has been obtained from reliable sources, ARCC is not responsible nor may be held liable for any errors or omissions, or for the results obtained from the use of this information. No responsibility can be accepted by ARCC for loss occasioned to any person acting or refraining from acting due to any material in this Report. Nothing herein shall to any extent substitute for the independent investigations and the sound technical and business judgment of the reader.