ANNEXE B FCOC DOMICILIARY CARE REPORT

Final Version for submission

Acknowledgements

We would like to extend our sincere thanks to all those care providers who have contributed any cost data or other information to the York Council Fair Cost of Care exercise, or who have participated in our engagement activities. Thanks also to the Independent Care Group, York's local care provider association for their support to the exercise.

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1 About this document

Purpose of this document

This document has two purposes:

- To comply with the DHSC FCOC grant funding requirements, acting as a companion to Annex A and Annex C.

- As a locally published summary of how the FCOC exercise was carried out, and how the data and results will be used going forward, including:
    - How the exercise was approached, the methods used to obtain and review data.
    - The rationale applied to dealing with the cost submission data, and consequent conclusions as to the confidence we have in the data and results.
    - A summary of the results.
    - How we intend to further use the dataset and Annex A.

  We hope that this will be useful for care providers, whether they participated or not, and other local stakeholders. Further details on the Council's provisional action plan to build on this FCOC exercise are included in Annex C, which will not be published locally until a final version is produced next Spring, following further collaboration and consultation with local care providers.

Content of this document

Section 1 of this document is sector-independent and applies to both care sectors. It is reproduced in both Annex B documents. The same goes for most of sections 2 to 4, which describe the rationale for our approach to the FCOC exercise in York and how that has influenced our interpretation and use of the cost data submitted, and our intended treatment of the results. There are some elements of these sections that use sector-specific examples and for these elements the text will differ in the two versions of Annex B.

Use of the word "we" in this document generally refers to City of York Council.

Guidance or Policy references

Where necessary we have made references to certain national FCOC guidance or policy documents to help evidence our approach and information presented in this document. This should help not only the DHSC review team, but also readers of this document understand how we have interpreted and applied such guidance in the unique context of York. We also recognise that there may be other readers of this document who are not experts in the arena of social care provision or the FCOC programme and so we have tried to limit such references.

For commonly referenced sources, in order to help readability the entire document title is not reprinted each time the reference is made, but rather a shorthand reference is used as shown in the following table.

Guidance source document	Shorthand reference
Updated guidance note on data returns and fee setting following the DHSC's 2022 policy, "Market Sustainability and the Fair Cost of Care Fund guidance"; version 2, 28 September 2022	LGA legal guidance
References to above specific sections or paragraphs	LG (section para)
FCOC and charging reform policy note 25/08/22	Policy note
Cost of care: analysis, review and verification of provider submissions	LGA review guidance

2 Our application of the FCC Programme in York

Our approach and rationale

A delay in implementing the programme meant we have taken a pragmatic approach to the FCC exercise in York, with less time than desired to mobilise greater provider

participation. Our approach has also recognised that participating in this exercise is not a trivial thing for providers, and given that market conditions are extremely challenging, many will have had limited resources to devote to the exercise.

We decided that it was vital to retain experienced, independent consultants[1] to maximise the chances of a reasonable outcome from the exercise specifically because:

- York Council staffing limitations meant that it was impossible to commit sufficient resource to conduct the exercise in the time available without external help.
- There was limited time available and experienced consultants were more likely to be able to structure and manage a programme capable of delivering a reasonable return from the market under such circumstances.
- The external consultants were entirely independent of York Council and the local care economy.
- The external consultants used were highly experienced within the care sector and have owned and run their own care business, and thus have deep understanding of the challenges and issues affecting providers.
- The external consultants used have worked on FCC exercises elsewhere in the country.

Interpreting and checking of the data submissions

This section draws upon the latest legal guidance, specifically LG (C), which relates to how Councils should interpret the data submitted by providers. Our approach has been predicated upon undertaking a **reasonable** amount of checking and dialogue with providers; that is to say, reasonable within the circumstances and context of York (given the limitations pertaining to the exercise noted above) and which complies with LG (C). The term *reasonable* in this instance is used to reflect the following:

- the resource implications for providers of participating in the FCOC;
- respecting the pressures on care providers and only engaging in a dialogue during the exercise to the level where it would not be intrusive or disrupt provider operations;
- recognising the specific limitations of the York exercise - late start, with very limited time to receive and query submissions, taking place during the peak holiday period of the year when staff availability is most affected by holiday absences;
- maintaining a spirit of openness and trust between commissioners and providers;
- the limitations inherent in such an exercise, with particular respect to the data generated (and to some degree the methods used), and the consequential reliability of such data for planning purposes.

[1] Use of external consultants in FCC exercises is not unusual across the national programme.

Thus the level of checking and review we conducted had to be commensurate with the above factors to be considered reasonable. As an example, we did not engage in a more intense (or intrusive) level of checking such as requesting access to underlying records (ref LG (D50iv) because we judged that this would not have met our above criteria for what was reasonable *for this particular exercise*.

Thus the degree of checking data with providers focussed on aspects such as the following:

- Querying any obvious errors, such as the use of negative numbers
- Clarifying operational aspects of the business in order to better interpret the data
- Looking for inconsistencies or potential inaccuracies (as per page 4 of the DHSC guidance).
- Querying active bed number figures which were significantly lower than the CQC-derived bed number figures.
- Seeking clarification about inter-year variations, especially if costs were lower in the 2022 year than in the previous 2021-22 year.

The checking stage resulted in some providers re-submitting their data, generally because of changes to specific fields only.

It is also worth pointing out that our exercise used LGA-approved data collection tools for both sectors. All submissions used one other of these tools (dependent on the sector in question). This hopefully will have introduced a level of consistency into the dataset (refer to DHSC guidance page 5), if only from the perspective of data collection and collation method.

Extract from the LGA website page on the challenges of reviewing provider data returns[2]:

The result of these factors is that it is very difficult for councils that receive cost of care information to review it, analyse it, verify it and use it to inform their actions and decisions.

The extract above just serves to underline the challenges we faced, particularly bearing in mind our situation in York when we undertook the exercise.

In summary, the checking and review process involved reviewing the submissions for obvious errors and feeding back to providers who then either reconfirmed their original submissions or made revisions based on the comments provided.

[2] https://www.local.gov.uk/our-support/sector-support-offer/care-and-health-improvement/commissioning-and-market-shaping-2#appendix-1-how-to-use-the-home-care-export-template

However, once this process was complete, the Council did not make any adjustments, which is explained in the following section.

Our approach to making adjustments

By adjustments we mean here *any further changes made or instigated by the Council to provider data* that were:

- not discussed or agreed with the provider;
- carried out following, or in addition to, any review dialogue with the provider.

Our prime considerations regarding making adjustments were to:

- preserve the integrity and provenance of the provider data, and
- apply consistency throughout for both sectors and all providers.

These considerations were paramount mainly because of the above-mentioned constraints on this exercise. For this reason we felt that the best option was to adopt a "no-adjustment" policy because we did not consider that making adjustments would improve the data sufficiently, when compared with the risk of distorting it.

In adopting this rationale we were particularly mindful of several things:

- The time limitations of the exercise, which would give a high probability that one or more adjustments would be poorly thought-through or result in greater error.
- The turn-round time in which to generate, discuss and confirm any queries and changes.
- The need to maintain consistency overall and not potentially disadvantage (or advantage) one provider compared with another.
- The need to maintain a very clear audit trail for the data (both provider-specific and in aggregate).
- The danger of excluding outliers from the dataset, without sufficient time to explore them further. On this point we also intend to focus more on *averages* in our modelling, rather than *medians*, because the latter automatically exclude outliers, and thus essentially lose data. However, in deference to the DHSC requirements we use medians in Annex A and replicate those results here in Annex B.

These factors led us to believe that it was better to leave the data unadjusted, rather than risk distorting it, given its likely weight and utility in enabling immediate decision making or expectation-setting (as explained in section 4.2).

We provide an example here of the practical application of our adjustment approach. Regarding LG (C36) the Council did not make any adjustments to any submission that was significantly deficient in information, following review and checking. Instead

we assessed such a submission as non-compliant and thus it was included in the FCC data set.

Example of a submission Information *which is not that requested* as in LG C(36B):

A particular homecare provider's data submission, on further checking and dialogue with them, turned out to be predominantly outside the scope of the services included in FCC. Thus that provider's data was considered non-compliant, not because the data was insufficient (ie not for any reason of data deficiency), but because the services were out-of-scope. In fact the data supplied by this provider (suitably anonymised) may well be useful in the further development of the market by the Council, so the effort made by the particular provider should not be considered as wasted.

3 Limitations of the programme and data set

It is important to point out a number of factors that potentially place limitations on the accuracy and reliability of the data obtained and results. Some of these factors relate to the data collection and processing methodologies, tools and other factors inherent to the FCC programme, and others to characteristics of the care sectors.

Factors intrinsic to the FCC programme

Such factors include:

- The impact of covid policies and grant funding during the base 2021-22 year, but also potentially affecting 2022 data too.
- That the data are essentially a snapshot of a point in time, as opposed to the cumulative result of longitudinal (year by year) studies.
- Despite any uplifts used, the data are essentially historic, and so further modelling will be required regarding future projections. This point is referenced by the Care Provider Alliance[3] when it states *"the primary concern leading to both non-engagement in the FCoC process and the scepticism surrounding its impact has related to the data collected not being representative of the past or the required future state, to sustain the workforce and the sector and to address the impact of rising energy and agency costs, as well as rising inflation. It is the purpose of the FCoC exercise to identify accurately the gap between what is currently paid, and what rate is sustainable for the future."*

In addition to these factors there are also sources of variation and error relevant to this exercise, which are highlighted in the following section.

[3] Provider Market Sustainability Planning Support to Councils – executive summary.

Sources of error and variation

The data obtainable, and then reported, by contributing providers are subject to a number of sources of error and/or variation, including.

- The information processing and financial regimes governing the particular provider organisation. Factors here include the sophistication, frequency and scope of management accounting, or the payroll regime.

- The sophistication and capabilities of the information sources, systems involved in capturing operational data and organising it for management and financial purposes. Of particular relevance here are scheduling systems, electronic call monitoring, payroll and HR systems, and accounting software.

- The sophistication and capabilities of the staff involved in gathering, collating and reviewing, and then organising the data prior to submitting the returns.

- The heterogeneity of the providers – in both sectors there is a wide range of provider size, from very small companies with little or no support staff to large, multi-million turnover organisations with corporate structures. The operating models of providers can also vary, with no "one size fits all" approach. For instance, in one provider a single branch might serve one local authority area only, whereas in another provider a branch might serve multiple local authorities, resulting in the latter having to sub-divide or apportion its data to the local authority in question.

- The business performance and strategies of providers. Some providers, at the time of sampling, may be in different stages of their business and investment cycles. For example a newly opened homecare branch may have a very different cost profile to a well-established one, with investment in key staff such as a registered manager making costs look high for the (inevitably) low weekly care hours delivered while volumes are grown.

- The nature and limitations of both toolkits[4] used in the FCC exercise meant that a certain degree of interpretation and judgement has to be used by the person, or people, generating the data submission. Moreover, not all the data used in the provider organisations is a "natural fit" to all the input requirements of the toolkits and so there may have to be a degree of translation of the source data into the format required by the toolkits, a process which can itself be subject to variation or errors.

- The arithmetic effects of nils and nulls on median and average values. In general, including zero values instead of nulls will reduce these values, and in

[4] There are also benefits to using the iESE and ARCC toolkits, which help ensure a consistent, systematic approach to collection and analysis of the data.

the case of a median figure may result in a zero result. These effects are most fully felt on smaller sample sizes.

4 Our confidence in the data and Annex A

Our confidence weightings

So our confidence in the data and Annex A being an accurate and reliable source for setting the fair cost of care can be seen as a function of two things:

- Firstly, the necessities of our pragmatic approach as described in section 2.
- Secondly, the inherent limitations of the FCC programme and any resultant data, as described in section 3.

The latest legal guidance, specifically LG (C) relates to how Councils should interpret the data, and LG (D) concerns how Councils may assign a weight to the data. So our confidence rating is essentially what weight we give to the data and thus to Annex A. Before we do this, we must firstly distinguish two things:

- Our confidence in the results as they stand being sufficiently reliable to draw definitive conclusions or set definitive targets for a cost of care.
- Confidence in the results as being a useful set of data to guide further analysis and refinement, and inform a productive dialogue with the market.

So we have stated two confidence weights to reflect this important distinction, as follows.

Definitive conclusions & targets	**To guide further analysis and refinement**
LOW	MEDIUM
We cannot assign much weight to Annex A without further analysis and dialogue with providers	We believe the FCC data gathered will be helpful in guiding our dialogue with providers as part of paying a fair, York cost of care

It is important to stress that the Annex A figure, whilst being important for the purposes of accessing grant funding from the DHSC's Fair Cost of Care Fund, is only a starting point on the journey towards a fair cost of care. DHSC guidance on page 2 of the 25/8/22 policy note states merely that actual fees paid to providers will be *informed* by the FCOC exercise.

Extract from FCOC policy note: Defining "moving towards"

> Our policy expectation is that local authorities make as much progress as possible towards the fair cost of care identified locally in your exercise within this Spending Review period.
>
> Our policy guidance talks about "moving towards" because we recognise that this is a journey. Although we expect local authorities to move towards paying a fair cost of care, we know local authorities will be starting from different points, with some further away from the fair cost of care than others.
>
> This means some local authorities will reach the fair cost of care for their local area in this Spending Review period, whereas others are on a longer journey and will not. Our policy expectation is therefore that you make as much progress as possible.

We echo the above in our approach to the FCC results, and also the legal guidance, specifically:

- with reference to LG (C28-31) we regard the Annex A figures submitted as preliminary, indicative figures which will inform our plans.
- regarding LG (E66-67) we are committed to making as much progress as possible to paying a fair cost of care in York over the Spending Review period and beyond, and it is our Market Development Programme (described in Annex C) that will be the means of achieving this, working closely with our providers to do so.

How we will treat the Annex A results

So we can summarise our approach to Annex A as follows. It is important, but it is the *starting point* in the journey towards a sustainable cost of care for York. It is the underlying aggregated data set that will be further analysed and refined in conjunction with providers, alongside detailed discussions around future commissioning strategy. These discussions will not take place in isolation from each other, nor on a piecemeal basis, but will be brought together as part of a comprehensive Market Development Programme where all providers can take part.

We are committed to commencing this programme following the completion of the FCC exercise. Further details on the programme are included in Annex C.

We believe our approach is consistent with both the spirit and the letter of the legal guidance LG (E66-68) and LG (H).

Finally in this section we wish to stress that are comments in this section are not a criticism of the DHSC FCOC programme in general, and indeed we recognise that the DHSC had to start somewhere in an attempt to bring a greater robustness, consistency and objectivity to the whole issue of Council fee rate settlements that recognises the pressures on care providers and their consequent costs.

Neither should our comments here be taken as any criticism of the providers who have taken part in the exercise, or as downplaying the importance in them having done so. On the contrary, the inputs from our providers will form a starting point and base to build from as we move forward and will help shape a productive, collaborative dialogue as we begin the journey towards achieving a sustainable fee rate settlement for York.

5 Engagement with Providers

Scope and excluded services

The scope of care services included in the FCC was as defined by the DHSC, namely:

18+ domiciliary care (excluding extra-care, learning difficulties, specialist mental health, reablement, rapid response and supported living).

York's FCC exercise included 26 homecare framework providers and 6 exception[5] providers. Supported living accommodation was not included in the exercise.

Engagement approach

York Council's FCOC exercise was particularly challenging because it was not commenced until late July 2022, allowing very little time to engage the local market providers, orient them to the FCOC programme, and then get them up to speed sufficiently to submit their returns.

Our approach was applied equitably across the two care sectors and any group sessions we ran were available to attendees from both.

We also engaged with the local care provider association, Independent Care Group (ICG) throughout the engagement process so that they could also encourage participation and help answer questions from providers about the national programme and the local exercise. ICG also offered specific support activities whereby they provided training on the ARCC toolkit.

Engagement activities

[5] Those not on the framework contractually, but who deliver significant amounts of care hours.

These were led and conducted principally by the external consultants, in conjunction with the Council and ICG. The engagement activity covered the broad elements summarised in the following table.

Awareness and orientation	Publicising and launching the FCOC exercise and encouraging providers to participate. This took place via a combination of methods including emails, publications, and phone-rounds. All providers were invited to a formal launch webinar. Slides used at the webinar were circulated to providers who were not able to attend the launch event.
Guidance and sign-posting	All useful sources of information regarding the national FCOC programme, the toolkits being used, and local contacts for the exercise were circulated to providers. Advice was also given to providers on how to prepare for and produce the cost submissions, including tips for data collection and collation.
Training and support	Providers were made aware of the national training available on the toolkits. Also the external consultants held specific walk-through sessions with anyone requesting support. ICG the local care provider association also offered support and specific toolkit training.
Checking and review	This was done exclusively between our external consultants and each provider. The Council did not see any of the individual submissions. All completed cost submissions and surveys were emailed directly to our consultants, not the Council.
Communications updates	These were issued at regular periods throughout the exercise to keep providers apprised of progress and events.

The engagement activities were well generally received and attended. Headlines are:

- Launch workshop – 21 attendees
- Submitted cost templates – 9 (1 non-compliant), thus 8 included which represents 25% of the providers in the market.
- Market sustainability workshops – attended by 12 organisations
- Completed market sustainability surveys 12 organisation completed the surveys which represents 17.4% of the total care home and homecare market.

All providers were contacted both by telephone and email (based on the Council contact list) by our external consultants, and sometimes by the Council strategic commissioning manager in an attempt to maximise the response rate.

In addition and in parallel to the focus on the cost submissions, we also sought views and feedback from providers about sustainability of the market. The main focus for generating feedback and ideas was a specific survey issued to all providers. We accepted survey submissions from any provider, regardless of whether they completed a cost submission.

Some of the specific engagement activities or milestones are shown in the following table.

Method	Dates	Activity
Fair Cost of Care launch event	27th July 2022	Presentation given to home care and care home providers providing an overview of the FCOC exercise and outlining the timescales and requirements of providers participating.
Independent Care Group (ICG) Newsletter	29th July 2022	York FCOC exercise featured in ICG weekly Provider newsletter.
Independent Care Group – training on FCOC tools	9th August 18th August	Online training sessions delivered by ICG on the LGA and ADASS-approved ARCC homecare toolkit.
FCOC original submissions deadline	22nd August 2022	1st deadline set for FCOC submissions
FCOC Submissions extension	29th August 2022	2nd deadline to facilitate further FCOC returns from the market.

In addition to the structured sessions our external consultants held 1-1 sessions with providers who requested assistance in completing the costing toolkits. These sessions included detailed line by line walking and talking through all the cost lines in the toolkit and how they build up the cost outputs.

We also undertook quality assurance and challenge on the results with the providers (as previously described) before undertaking the aggregation and analysis.

Nine provider submissions were initially included in the aggregated data, but on further checking with one of the providers it turned out that too much of their work c 90%) is actually non-standard homecare activity, not involving scheduled and rostered care visits, and thus the data were out of scope. Thus in accordance with our review policy (as explained in section 2.2) the submission was deemed to be

non-compliant and excluded from the aggregated data set used to populate Annex A.

All the submissions were reviewed and checked before the aggregated data median values were loaded into Annex A. In most cases the checking and review carried out by our consultants resulted in the provider revising their cost submissions to some extent, sometimes because of minor errors, or often just as a result of clarifying operational procedures or better interpretation of what specifically certain cost fields were expecting. All changes were agreed with each provider and the provider resubmitted their toolkit.

The most common queries involved travel time data and to what extent travel time is included in carer pay, or paid separately. There is a degree of variation in how providers do this nationally, and York is no exception.

Other queries concerned areas such as:

- Treatment and interpretation of overhead costs
- Apportionment of costs from other branches or where the York branch delivered care to other local authority areas.
- Checking how providers' on-call arrangements worked to help arrive at accurate estimates for this element of the service.

The engagement activities were well received and attended. The launch workshop was attended by 21 attendees. The market sustainability workshops were attended by 12 provider organisations.

Completed market sustainability surveys were returned by 12 provider organisations, covering both care sectors, representing about 17% of all included providers across both sectors. Further information about the sustainability survey is included in Annex C.

6 Results

This section focuses primarily on the requirement to complete and submit Annex A. We do not describe the full aggregated data results here, nor how that data will be used in future modelling; suffice it to say that the data will be used, and further refined, in collaboration with providers, as part of our Market Development Programme which will follow once the DHSC has reviewed our submission. Further details are included in section 7.

Template used

We used the CHIP ARCC CoC tool and did not ask for any other information from providers, nor use any other data collection template. Providers either downloaded the toolkit from the CHIP website or our consultants emailed them a copy.

Response rate

We received 9 cost submissions from a total of 32 framework and exception providers, equating to a 28% return rate. On review of the submissions one was excluded because the figures predominantly related to non-standard homecare activity.

Thus the results and analysis are based on 8 submissions, which represents 25% of the providers.

Submissions received were from both framework and exception providers representing a variety of sizes, from smaller providers to larger, regional providers.

Data period used

We asked providers if possible to submit data no older than 2021, for which they were confident that they had either a full audited (or accounted for) year, or a reasonable period based on management accounts.

Most of the providers indicated that at least a large proportion of their data related to no further back than year ending 31/3/22. Most of the staff pay data submitted was based on current rates at the time of the completing the toolkit (ie August 2022).

Caveat on the Annex A figures

One of the requirements from the DHSC is for the figures submitted in Annex A to be included in Annex B. There has been much discussion nationally on this and whether it is useful to include such figures in this Annex B, especially if a Council has significant concerns about the reliability of the methods used and the consequent reliability of the data.

We have already described our concerns previously in this document, principally our low confidence in the results at the current time, without further refinement.

We have decided to publish the data submitted because it will enable readers, and particularly care providers, to at least see for themselves the numeric results of the exercise.

However, we must stress to all readers to treat these results carefully. For the reasons previously stated these figures cannot be regarded as the fair cost of care in York. They are not at all *definitive*; they are merely *indicative* of costs reported by a sample of providers at a particular snapshot in time.

We stress that the Council will not ignore these results, but will use the underlying aggregated data to help inform our collaboration with providers over the coming months in our proposed Market Development Programme, which is described more fully in Annex C. A summary is reproduced here in Annex B because this Annex B is the only document actually being published at this point in time and it is useful to signal the likely breadth of the programme

We will be elaborating much more about this programme with providers in due course.

Annex A results

The homecare dataset from the ARCC tool outputs a set of cost lines and ultimately a final cost for an hour of care.

Annex A requires these final figures and the underlying cost lines to be presented.

Note that the DHSC requires median values to be used in Annex A and so we use these values here. We prefer the use of averages because they include all variation in the data set and thus are more complete for modelling purposes.

Regardless of whether average or median figures are used it is important to stress that these values are simply derived from the aggregated data set from the FCC submissions from providers. These figures will not match any single provider's costs and no provider should infer that the medians somehow represent some idealised cost profile to which they should aspire. They are merely reflective of the submissions received during this exercise.

Approach taken regarding return on operations

We decided not to apply any adjustments to the figures received. The aggregated data result was within a reasonable range that would be expected of homecare providers. We will finalise our approach to ROO as part of our fee-setting process, which will be informed by our market development programme.

Inflationary uplift in Annex A

No adjustments were made to the aggregated data set following the checking and review process for the reasons given previously in section 2.3.

For the purposes of Annex A we decided not to apply an inflationary uplift. This was because most of the submissions had used recent figures from summer 2022 for at least a considerable proportion of their costs.

The Council is currently considering what inflationary uplifts to be used for future years. For the purposes of this document (ie to help meet the funding requirements

of the DHSC) the following indicative rates are included below, but note that these will be subject to change in accordance with emerging economic factors and as a result of planned market development activities (these activities are outlined in Annex C, the provisional Market Sustainability Plan).

The Council in developing a model with the market will consider appropriate inflationary uplifts as part of its annual budget setting process. It is not possible to give any further assurance around this, given that local authorities do not yet know what their allocation will be for 23/24 and beyond.

Submitted Annex A figures

The figures shown in the table below are the final figures for our Annex A submission replicated from Annex A section 3. They are the medians for each cost line, which constitute the total cost per hour of care.

Cost line medians table

Direct care	£11.77
Travel time	£2.11
Mileage	£1.06
PPE	£0.31
Training (staff time)	£0.24
Holiday	£1.70
Additional noncontact pay costs	£0.00
Sickness/maternity and paternity pay	£0.39
Notice/suspension pay	£0.00
NI (direct care hours)	£1.05
Pension (direct care hours)	£0.49
Total Careworker Costs	£19.13
Back office staff	£4.37
Travel costs (parking/vehicle lease et cetera)	£0.01
Rent/rates/utilities	£0.52
Recruitment/DBS	£0.08
Training (third party)	£0.06
IT (hardware, software CRM, ECM)	£0.47
Telephony	£0.12
Stationery/postage	£0.05
Insurance	£0.19
Legal/finance/professional fees	£0.08
Marketing	£0.07
Audit and compliance	£0.00
Uniforms and other consumables	£0.08

Assistive technology	£0.00
Central/head office recharges	£0.00
Other overheads	£0.11
CQC fees	£0.11
Total Business Costs	£6.30
Total Return on Operations	£1.71
TOTAL	**£28.58**

All figures are cost per contact hour. Note that these median figures do not sum exactly to the figures in the final row because of the way medians work.

All submissions	**LOW**	**25%**	**ME-DIAN**	**75%**	**HIGH**
Hourly Breakdown	**Cost £**	**Cost £**	**Cost £**	**Cost £**	**Cost £**
Direct Care	£10.70	£10.97	£11.77	£12.16	£12.81
Travel Time	£1.25	£1.46	£2.11	£2.69	£4.06
Mileage	£0.60	£0.67	£1.06	£1.51	£1.56
PPE	£0.00	£0.07	£0.31	£0.74	£1.04
Training (staff time)	£0.00	£0.08	£0.24	£0.45	£1.28
Holiday	£1.45	£1.64	£1.70	£1.78	£1.88
Additional Non-Contact Pay Costs	£0.00	£0.00	£0.00	£0.00	£0.00
Sickness/Maternity & Paternity Pay	£0.25	£0.29	£0.39	£0.58	£1.09
Notice/Suspension Pay	£0.00	£0.00	£0.00	£0.00	£0.05
NI (direct care hours)	£0.09	£0.98	£1.05	£1.34	£2.36
Pension (direct care hours)	£0.45	£0.46	£0.49	£0.50	£0.52
Back Office Staff	£2.66	£3.63	£4.37	£5.15	£7.89
Travel Costs (parking/vehicle lease etc.)	£0.00	£0.00	£0.01	£0.12	£0.48
Rent / Rates / Utilities	£0.12	£0.38	£0.52	£0.55	£0.94
Recruitment / DBS	£0.00	£0.04	£0.08	£0.20	£0.35
Training (3rd party)	£0.00	£0.01	£0.06	£0.13	£0.30
IT (Hardware, Software CRM, ECM)	£0.11	£0.20	£0.47	£0.59	£0.82
Telephony	£0.07	£0.10	£0.12	£0.16	£0.18
Stationery / Postage	£0.00	£0.02	£0.05	£0.08	£0.13
Insurance	£0.01	£0.11	£0.19	£0.22	£0.30
Legal / Finance / Professional Fees	£0.00	£0.00	£0.08	£0.11	£0.42
Marketing	£0.00	£0.04	£0.07	£0.11	£1.28
Audit & Compliance	£0.00	£0.00	£0.00	£0.01	£0.08
Uniforms & Other Consumables	£0.01	£0.05	£0.08	£0.10	£0.19
Assistive Technology	£0.00	£0.00	£0.00	£0.00	£0.00
Central / Head Office Recharges	£0.00	£0.00	£0.00	£0.28	£1.95
Additional Overhead #1	£0.00	£0.00	£0.11	£0.18	£0.37
Additional Overhead #2	£0.00	£0.00	£0.00	£0.00	£0.13
Additional Overhead #3	£0.00	£0.00	£0.00	£0.00	£0.80

All submissions	LOW	25%	ME-DIAN	75%	HIGH
Hourly Breakdown	**Cost £**	**Cost £**	**Cost £**	**Cost £**	**Cost £**
Additional Overhead #4	£0.00	£0.00	£0.00	£0.00	£0.18
Additional Overhead #5	£0.00	£0.00	£0.00	£0.00	£0.01
CQC Registration Fees(4)	£0.08	£0.10	£0.11	£0.11	£0.14
Surplus / Profit Contribution	**£0.00**	**£1.27**	**£1.71**	**£2.58**	**£3.05**
Total Cost Per Hour	**£24.32**	**£27.12**	**£28.58**	**£30.44**	**£33.57**

Supporting information on important cost drivers used in the calculations:

Number of location level survey responses received	8
Number of locations eligible to fill in the survey*	32
Carer basic pay per hour	£11.60
Minutes of travel per contact hour	7
Mileage payment per mile	£0.31
Total direct care hours per annum	26,644

* (excluding those found to be ineligible)

Annex A section 4 figures are shown below.

Description	
Cost of care exercise result (from above)	£28.58
Average 2021/22 external provider fee rate	£22.38
Average 2022/23 external provider fee rate	£21.89
Hence distance from cost of care exercise result (%)	-23.41%
Hence 2022/23 fee uplift compared to 2021/22	-2.19%

The provider fee rates offered by the Council use the iBCF definitions.

Comments and themes for further exploration

The homecare dataset collected relates to a generic, standard service and is not broken down into any more specific service categories.

The issue of rurality[6] was not factored into the submissions or the results mainly because:

- The York catchment area is relatively small and does not feature large rural areas such as counties like Devon, Dorset or Norfolk.

[6] Whereby visits to more rural locations can attract higher travel costs and be more problematic for providers to deliver for this and other reasons.

- The ARCC toolkit does not explicitly cater for rurality, instead applying an average travel time and distance between visits for all visits.

We may include some degree of rurality modelling in our Market Development Programme to ensure that this issue is not underestimated.

The median care pay per hour figure of £11.60 is higher than the £11.26 (for about 89% of carers in July 2022) cited by the Care Provider Alliance. This is probably at least partly due to the relative affluence of the York area, which will tend to increase the rates of pay that providers must offer in order to attract staff.

Further analysis to be undertaken

Though we have not made adjustments, with reference to LG (C36H) we have identified various analyses which will be undertaken post-FCC, as part of the follow-up dialogue with the market between October 2022 and February 2023. These include, but are not limited to the following:

- Travel time modelling, to reflect the different ways in which travel time is reported and paid to carers
- Back office staff costs
- Overhead costs

Regional comparisons

Another important aspect of our further analysis will be to compare the FCC data with neighbouring regional data. Caution should be used when comparing any specific local authority results with a wider dataset because there may be peculiarities within the subject local authority that are not replicated in the wider dataset. At this stage any regional comparison can only highlight areas for further exploration and analysis, rather than draw conclusions. Nevertheless we have used the emerging Yorkshire & Humberside regional FCOC results (version 11). Note that the Regional office has stated that their figures are subject to change.

The York FCC medians tend to be significantly higher than the rest of the region as shown in the below table.

Cost line	York	Region (excluding York)
Total cost per hour of care	£28.58	£22.73
Direct care	£11.66	£10.54
Travel time cost	£2.11	£1.38
Back office staff cost	£4.55	£3.17

Further analysis will be undertaken once the FCC exercise is completed.

Appointments per week by visit length

The overall median visit duration was 36.6 minutes, which is similar to other FCC exercises and the national picture, whereby most care visits tend to be planned to be 30 minutes.

The lower quartile/median/upper quartile of number of appointments per week by visit length (15-minute/30/45/60) are shown in the following table.

Duration	LOW	25%	MEDIAN	75%	HIGH
15	0	0	41	80	184
30	285	334	586	770	863
45	0	35	80	97	113
60	25	37	49	56	246

Cost per visit

Due primarily to the issue of travel time cost, the equivalent cost per hour of care increases as the visit duration decreases (assuming that travel time is costed at the same rate as carer pay cost) because a higher number of visits takes place each hour. The ARCC toolkit does not specifically calculate travel-related costs for each visit duration, but the following figures were calculated using the workaround specified in their online video provided for the FCC programme.

The following table shows the cost per visit for each of 15, 30, 45 and 60 minute visits.

	LOW	25%	MEDIAN	75%	HIGH
Cost per 15-min visit	£7.76	£8.03	£8.50	£9.77	£10.77
Cost per 30-min visit	£13.05	£13.94	£14.58	£15.83	£17.84
Cost per 45-min visit	£18.34	£19.83	£20.66	£21.63	£24.91
Cost per 60-min visit	£23.62	£25.59	£26.65	£27.55	£31.99

These figures were generated by running each of the provider submissions through the ARCC recommended workaround and then applying the functions above to the aggregated results.

7 Next steps

The immediate next step following the submission of our FCC required outputs (Annexes A to C) to the DHSC is for the outputs to be reviewed and commented

upon by the DHSC. The level of subsequent grant funding may be dependent on this review, but may also be influenced by government actions.

Next Steps

Over the period of the last 18 months the Commissioning and Contracts team has experienced a high level of vacancies within its team. York has recently undertaken a significant transformation of the teams and has now in place an All-Age Commissioning and Contracts team and a Head of All-Age Commissioning and Contracts from February 2023.

We are using the market engagement information from this FCOC exercise to engage with our York market through a series of workshops to develop and sustain the market. Ideas produced from the providers who took part in the surveys and 1:1's with Adams Consultants on behalf of York Council will continue to be reviewed together to look at the activities that can add value for money to market offer.

There will be a number of Workshops in March through to May 2023:

Workshop 1
Introduction to the Team – All Age Commissioning and Contracting
Where we are currently - present the high-level findings of the FCOC *Discrepancies in some of the data work with the market to understand these areas* *MPS (market position statement) areas to explore*

Workshop 2
Feedback on Progress to Date for Fee Setting for York Cost of Care
Contractual Frameworks Re-commissions

Workshop 3
Final Outcomes of Fee Settings and Contractual Mechanisms
How we will work with you going forward
Feedback on non-price elements from FCOC Exercise
Series of recommissioning of current frameworks to existing/new commissioning models to sustain the market

Market Engagement:

1. Re-introduce provider forums in a co-production approach providing the opportunity for both the providers and the council to have regular dialogue on areas that will enable sustainability of our markets

2. Re-introduce true coproduction with the market when recommissioning, redesigning, and commissioning of new services for our population at the earliest opportunity

3. Continue to work with the ICG (Independent Care Group) one of the voices of independent care

4. Continue to communicate with the market via the provider bulletin making available information, guidance for a range of topics and to deliver key messages to the market

5. Ensure that providers are aware of the Yor-tender service where opportunities are advertised and bid for and the necessary guidance to ensure fair, open and transparent opportunities for the market