

Working with care providers to understand costs

A guide for adult social care commissioners





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Contents

CHAPTER 1	Introduction and overview	4
CHAPTER 2	Understanding the challenge	6
CHAPTER 3	Understanding the independent sector	9
CHAPTER 4	Understanding costs	18
CHAPTER 5	Costing techniques and value for money	45
CHAPTER 6	Conclusion.....	48
APPENDIX A	Glossary of terms	50
APPENDIX B	Bibliography and further reading	53

CHAPTER 1

Introduction and overview

The Care Act (2014) introduced new duties for local authorities in England to facilitate and shape a diverse, sustainable market for quality care and support in their local area.¹ This practical guide is intended for adult social care commissioners who wish to develop their understanding of the costs involved in providing care to help them meet these duties. The aim is to enable and equip commissioners with the knowledge and skills to support informed dialogue with providers in the interest of working toward agreed fee rates which are affordable, good value for money and support market sustainability.

CIPFA was commissioned by the Department of Health, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) to co-ordinate production of this guide in agreement and consultation with the Care Provider Alliance (CPA), as part of a joint programme to support implementation of the Care Act.²

Commissioners are increasingly skilled at striking the delicate balance between making the most of limited resources and meeting the statutory requirements to shape sustainable care markets for their local populations. This growing wealth of experience provided the foundations for this guide, which was produced with extensive input from local authority commissioners, and also social care providers through a series of workshops and through consultations with individuals – all aimed at identifying and bringing together good practice. This process uncovered a variety of examples of collaborative and innovative approaches to costing, and identified means of generating efficiency savings in commissioning care. These findings inform every section within the pages that follow.

After this brief introduction, there is a short section outlining the challenge (chapter 2), followed by an overview of the independent sector environment within which care providers operate (chapter 3). Chapter 4 is perhaps the most important: it provides a detailed account of the costs associated with providing care, with worked examples and checklists specifically designed to illustrate the issues that need to be discussed with providers. The guide concludes with an overview of different ways commissioners can use costing techniques to work with providers to agree prices, and sets this within the context of commissioning good practice.

We recognise that there are many ways to meet people's care and support needs – e.g. making use of universal services and enabling and supporting people to employ personal assistants – but for simplicity the guide concentrates on the costs of providing residential care ('care homes' and 'nursing homes') and domiciliary care ('home care'). Many of the principles will be more widely applicable.

The guide has been written with a local authority audience in mind, and with an appreciation that a wide range of people in councils – both officers and elected members – play a role in commissioning adult social care. Inevitably, readers will have a range of professional backgrounds, different levels of experience, and varying levels of familiarity with accountancy, finance, business and economics terminology. Therefore, to make the guide as accessible as possible, while remaining relevant and useful to those who are more familiar with the concepts used, boxes highlighted in blue give introductory overviews of some basic economics and business concepts, and a glossary of terms has been included at the back (appendix A).

1 www.legislation.gov.uk/ukpga/2014/23/section/5/enacted

2 www.local.gov.uk/care-support-reform

This guide is designed to provide a framework for discussions between local authority commissioners and adult social care providers about costs and to help with negotiations about prices. All the figures used as examples in the guide are illustrative and may not be applicable in a local area or for any particular year. Direct use of these illustrative figures by either commissioners or providers is therefore inappropriate. Commissioners and providers should determine and agree, through dialogue grounded in an appropriate mechanism (discussed in chapter 4), what the actual costs are in an area for the period in question.

For those who wish to explore the issues in more depth, links to additional resources are included in a further reading section at appendix B.

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- Colin Angel, Policy Director, United Kingdom Homecare Association (UKHCA)
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- Ian Turner, Chair, Registered Nursing Home Association
- Simon Williams and other representatives from ADASS



CHAPTER 2

Understanding the challenge

Statutory guidance to the Care Act 2014 is unequivocal: when considering prices paid, councils should “assure themselves and have evidence that ... fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care” and “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...”³

Meeting this requirement is an important part of successfully discharging the wider duty for local authorities to shape sustainable and diverse local care markets offering a range of quality care and support services for people to choose from.⁴ While agreeing fair fees is a necessary part of this, it is not sufficient as there are many aspects to good market shaping. Commissioners and providers may be interested to see a range of guidance and support materials about market shaping, commissioning and market-related issues that have been co-produced by government, local government and the care sector recently brought together as an online hub on gov.uk.⁵

Within this context of market shaping, a local authority's own commissioning activity, the contract terms and the fees agreed for services play an important role in maintaining market sustainability and quality services. More broadly, for local authorities to successfully and effectively deliver on their commissioning and market shaping responsibilities, it is important that commissioners understand the relationship between the supply/demand balance, business viability and the commercial environment in which independent sector providers operate. Soundings from local authority commissioners gathered by the LGA and ADASS show that commissioners recognise these needs and that many would welcome practical support to improve understanding – the key driver in producing this guidance.

³ Department of Health (2016), Care and Support Statutory Guidance, paragraph 4.31. www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-4

⁴ Care Act (2014), section 5 available at <http://www.legislation.gov.uk/ukpga/2014/23/section/5/enacted>

⁵ www.gov.uk/government/publications/adult-social-care-market-shaping/adult-social-care-market-shaping

Box 1 – The basics of market economics

Supply and demand

- Demand is the quantity of something that consumers are willing and able to buy. The theory is that as price increases, quantity demanded falls.
- Supply is the quantity of something that providers are willing and able to sell. The theory is that as price increases, the quantity supplied increases.

The conditions for effective competition

Competitive markets have a number of different buyers and sellers in the marketplace which allows for price to change in response to supply and demand.

No market fulfils the textbook definition of perfect competition; so it is more practical to seek the conditions required for a market to function reasonably well. These are:

- There are many buyers and sellers (so that, for example, the consumers do not have unreasonably high prices forced on them by a monopoly (one seller, many buyers) or conversely, the sellers do not have unreasonably low prices forced on them by a monopsony (many sellers, one buyer).
- Buyers are well informed about the value to them of the good or service; and sellers are well informed about the cost of supplying the good.

In such a market, competition will lead to equilibrium where supply and demand are equal. The care market cannot be assumed to achieve equilibrium because of characteristics such as:

- the commissioners may not have full knowledge about the needs and wishes of all users of care and support in their area
- commissioners may be financially constrained for purchasing
- the market may be dominated by a single purchaser
- in some areas there may be little competition among suppliers.

The financial environment 2016 – 2020

All the partners who collaborated to produce this guide recognise the tight financial environment that both central and local government face and the economic pressures on the independent sector of adult social care provider organisations with new costs like the national living wage.

The economic environment means it is more important than ever that commissioners and providers work collaboratively together where possible to reach an agreement on fee levels that reflects the significant pressures each side is facing, and support progress toward the delivery of sustainable, effective, high quality care to support vulnerable people.

This guide builds on good practice to offer commissioners and providers information and support to inform conversations and negotiations that balance value and sustainability.

Within this context, the agreement of fees (prices) is one of the key challenges of effective and collaborative commissioning. From the local authority point of view, prices have a considerable effect on the overall bill for social care. For providers the price paid is the main determinant of the viability of their business.

In social care, just as in any market, the quantity available (supply) and the amount that is needed (demand) have a direct relationship with price (see box 1, above). The reality of operating within a market economy is that prices that are too low will have a long-term negative impact on the sufficiency of supply.

Value for money, affordability and quality of services are crucial considerations for commissioners, it is entirely reasonable to expect providers to recognise this during negotiations about prices. Conversely, when providers raise concerns about the level of fees and the impact on their viability, it is reasonable for them to expect these are taken seriously.

Decisions on fee rates need to be informed by both the need to achieve value for public money, and by an understanding of how prices which do not cover costs risks unnecessary or unplanned reductions in the supply or quality of care services, and crucially – the effect of commissioning decisions on the wellbeing of people with care needs and their outcomes. Both commissioners and care providers need to work toward structured engagement to discuss and negotiate services with quality and fees informed by an understanding of the actual costs of providing care.

Box 2 – Summary: understanding the challenge

In summary, for commissioning sustainable care to be a practical reality, council officers and elected members need to be confident that each social care commissioning decision results in:

- effective, quality services delivered to people with care and support needs
- a fair deal for care providers
- good value for public money.

and is informed by considerations of:

- long-term sufficiency of supply
- affordability and efficiency.

Without an understanding of the business environment in which independent sector providers operate it is not possible to truly understand their costs. During the consultation process to inform this guide, providers reported that there is wide variation in commissioner understanding of the costs and the economics of private and voluntary sector provision. Similarly, commissioners did not universally feel confident that they were fully informed about cost matters. Chapter 3 below, provides an overview of the key concepts which commissioners may find it helpful to understand.

Understanding the independent sector

Care is largely provided by independent businesses which need to generate sufficient income through fees to cover the costs incurred in both the short and longer term. Care providers may not have a formal guarantor who will intervene in the event of financial difficulty. Failure to a) cover costs and b) make a profit or surplus means a business will not be able to reinvest in the business either now or in the future. In short, where the costs of providing care are not covered including an allowance for a surplus, it is unrealistic to expect providers to be able to maintain a quality service, and ultimately to continue to provide services at all.

Cash availability

For independent sector operators – whether small or large, private or voluntary sector – practical considerations such as cash in the bank for the payroll are everyday concerns. Cash flow is important and some issues that are under the control of local authorities, such as delays in agreement of contracts and late payment of invoices, may put provider viability at risk. The importance of making payments on regular agreed dates and minimising delays in financial assessments needs to be understood throughout relevant parts of a local authority, from commissioners through to finance sections that pay invoices.

Inevitably disputes will occasionally occur. These should be dealt with separately from payments for services not in dispute, avoiding retrospective or delayed payments, with a reconciliation of the overall amount to be paid once the dispute is settled. By doing this, commissioners can make a real difference for providers, improving relationships and crucially ensuring continuity of services for people with care and support needs.

Box 3 – Cash flow statements

The cash flow statement is a financial statement that shows how changes in the business account and the operation of the business, affect the availability of cash. It reports how much cash was generated and how much was used during a given period. The statement is used by potential and current investors to assess how the company's operations are running, identify the sources of the company's money, and how it is being spent.

Risk

The nature of social care means there is an unavoidable variation in the levels of demand and consequently significant levels of risk for both providers and commissioners.

A sustainable market is more likely to be achieved where there is a fair balance of risk between commissioner and provider. In block contracting the local authority takes the risk of voids and providers take the risk of turning away customers who may have paid higher rates. In spot contracting the provider retains the flexibility to sell capacity – but has no guaranteed income stream, and commissioners have no guaranteed source of supply. Providers expect commissioners to take account of how their viability can be adversely affected if they shoulder a disproportionate amount of the risk. Equally, it is reasonable for commissioners to expect providers to recognise that if the local authority takes on too much risk they are likely to find themselves in a position which is neither affordable, nor justifiable to tax payers.

Other areas of risk include unexpected cost pressures, the introduction of new regulatory or legal requirements, and changes to the complexity and mix of the care needed (for example the growing trend for people to have care plans that require two homecare workers at one time).

One strategy for a more even distribution of risk is to use longer term contracts and arrangements, with funding over a period of years agreed and known to both the commissioner and providers. Transparency about volume and fee rates over a longer period provides more certainty to both parties, leading to a better informed overview of the market and ability to understand and predict future supply and demand. Longer term frameworks for contracts have to balance risk reduction with the continuing need to allow people with care needs effective choice.

Profit and surplus

Providers have to fulfil the requirements of banks, investors and suppliers, and also need to be able to reinvest in their business and incentivise others to do so. In the private sector, profit is the reward available for the risks which are taken when setting up and investing in a business, risks which can also result in losses or bankruptcy.

In the community and voluntary sector, while organisations are not seeking a profit, making a sufficient surplus is still critical – these providers need to generate a surplus so they can reinvest this in their business to ensure the continued delivery of their overall objectives and the organisation’s social purpose, and to ensure there are adequate reserves available for the future.

Effective commissioning should recognise that reasonable profit or surplus is an essential component of effective providers’ costs. Reasonable profit does not translate to ‘personal financial gain’: private sector providers use some of their profits to pay back their financial backers; not for profit providers use some of their surplus to invest in meeting their charitable or community interest aims. Any business strategy which did not aim to generate a reasonable return on investment would be unsustainable.⁶

The generation of profit is essential in enabling providers to invest to maintain and improve quality standards, to make a reasonable rate of return for investors, and to maintain reserves to respond appropriately to unforeseen events. Where there is a local need for increased levels of care provision, if existing providers are not able to make a surplus, it will neither be possible to attract new entrants, nor for existing providers to expand. Moreover, without sufficient profit or surplus providers are unable to remain in the market on a long term basis. The key issue is to understand what a reasonable level of surplus or profit is.

Operating models and company structures

Table 1 below summarises of the main types of organisational form used by business or entities which provide social care, and brief details of the legal and financial frameworks within which they operate.⁷

Table 1: Independent sector operating entities

Entity type	Description
Charity	Must be established for charitable purposes (which must be for the public benefit) and can only undertake activities which are covered by these purposes. Most are registered with the charity commission and submit an annual report which follows a prescribed format. Charities do not have shareholders. They use any surplus to reinvest in their business, or hold in reserves for future use to further their charitable purposes. Charities take many and various organisational forms.

⁶ See also Institute of Public Care (2015), Market Shaping Toolkit, p11: ipc.brookes.ac.uk/docs/Market_Shaping_Toolkit-revised_2016.pdf

⁷ Unless otherwise stated, the definitions apply within all countries in the United Kingdom.

Entity type	Description
Community interest assets company (CIC)	<p>A type of company designed for social enterprises that want to use their profits and solely for the public good. They combine the flexibility and certainty of the company form, with some special features to ensure they are working for the benefit of the community.</p> <p>The Office of the Regulator of Community Interest Companies decides whether an organisation is eligible to become, or continue to operate as, a CIC.⁸</p>
Company limited by guarantee (LBG)	<p>This model is used primarily by community and voluntary sector organisations, for example charitable companies. The company does not usually have shareholders, instead having members who act as guarantors. The guarantors give an undertaking to contribute a nominal amount (typically very small) in the event of the winding up of the company.</p>
Limited companies	<p>These companies are incorporated, which means they have their own legal identity and can own assets in their own right. The ownership is divided into equal parts (shares) which are owned by shareholders. Shareholders have limited liability – i.e. are, in theory, not personally liable if the business fails, and are not necessarily involved in running the business itself.</p> <p>Limited companies are either private limited companies (Ltd) – which means shares do not trade on the stock exchange, or public limited companies (plc) where they do.</p>
Partnership	<p>A business owned by two or more people. Unlimited liability is shared among the partners. This is the company model most commonly used by GPs.</p>
Social enterprise	<p>The term ‘social enterprise’ describes the purpose of a business, not its legal form. It is defined as ‘a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners’.⁹</p>
Sole trader	<p>A business that is owned and controlled by one person. Sole traders do not have a separate legal existence from the business. This means the owner is personally liable for the firm’s debts – i.e. they face unlimited liability if the business fails.</p>
Unincorporated association	<p>An unincorporated association is an organisation of two or more people coming together to sell goods or services, who decide not to use a formal structure like a company.</p>

The limited company model is most common amongst the medium and larger independent providers, with a significant number of the smaller private providers being partnerships or sole traders.

Community and voluntary sector providers can be categorised as either charities (registered with the Charity Commission for England and Wales, Northern Ireland, or the Scottish Charity Regulator), social enterprises (e.g. partnerships, community interest companies and industrial and provident societies – businesses with primarily social objectives), or community groups and voluntary organisations (e.g. housing associations and charitable trusts).

⁸ See www.gov.uk/government/organisations/office-of-the-regulator-of-community-interest-companies/about for more detail.

⁹ A Guide to Legal Forms for Social Enterprise, Department for Business Innovation and Skills 2011. www.gov.uk/government/publications/legal-forms-for-social-enterprise-a-guide

Company structures

Company structures vary: limited companies can be owned by an individual (often the registered manager of a care home or home care agency), a group of individuals or a holding company. The organisational structure may be complex, particularly in larger companies, making it difficult to see clearly in the formal accounts whether – and how much – profit is being generated, or if the company is financially sound.

This complexity is most commonly the result of the history of acquisition of the businesses. When an existing care company acquires a new care home or home care business, the most cost effective way for them to do this is to purchase the company holding the asset. The company they have acquired then becomes a subsidiary of the acquirer, whilst the acquirer becomes the parent company. Transferring the new asset directly into the existing company might result in additional costs and taxes. Further, for some of the larger providers, organising their acquisitions in this way may be due to a wish to diversify and reduce risk, for example in case one of the businesses suddenly became unprofitable.

Whatever the company structure, legal operating entity, or size of business, care providers will consider the current and likely future balance between costs and revenue that give profit/surplus or loss. Care providers will develop business plans with adjustments to their service offering and capacity to meet the outcomes they have set.

Accounting for commissioners

Commissioners do not need to be accounting experts. However, a basic but solid comprehension of the terminology used is extremely useful. An understanding of the ways businesses classify and manage different costs, revenue, cash and profit, and some familiarity with the role of the various financial records kept, may help commissioners to have more effective conversations during fee negotiations with providers.

a) Business costs

There are three main ways in which costs are categorised. These are not mutually exclusive, but are used in different contexts to describe features of the particular cost:

Direct and indirect costs

- A cost is categorised as direct when it is an expense that is directly incurred in delivering a particular service. For example, care workers' wages, travel costs, food and uniforms.
- Indirect costs are the costs involved in running a business as a whole, and in the care sector will typically incorporate overhead costs. For example renting a head office, telephone bills, and management salaries.
- Care businesses need sales revenue both to cover direct costs and to make a contribution to indirect costs (including overheads).

Fixed and variable costs

- Fixed costs are those which do not vary in the short term with quantity of services provided. These are mostly indirect costs and would have to be paid even if the care business had no current clients. For example, the cost of maintaining the grounds of a care home is fixed as they do not vary with occupancy levels. Even fixed costs, though, can change in the long term, e.g. if a business is growing, its fixed costs will increase.
- Variable costs are those that increase with 'output' and are often direct costs. For example, the food bill will vary with occupancy levels.
- Some costs are semi-variable – i.e. they are largely fixed with an ability to vary at the margin. An example would be a worker who is contracted for a fixed number of hours but would also be willing to work additional overtime hours.

Average and marginal costs

- Average cost is the cost of supplying one unit (e.g. a week of care in a nursing home or an hour of home care). The average cost is the total cost (i.e. fixed costs + variable costs) divided by number of units provided. To make a profit a business must have prices that are above the average cost. Average costs usually fall as companies expand due to economies of scale.
- Marginal cost is the additional cost of supplying one more unit. Marginal cost informs the supplier about what price they need to supply further units.

Box 4 – Average and marginal costs: an illustration

A manufacturer makes 40,000 units of a product, and the total cost is £100,000

$$£100,000 \div 40,000 = £2.50$$

Therefore the *average* cost is £2.50. The average selling price needs to be *more than* £2.50 for the supplier to be willing to supply the product.

If the manufacturer increases output to 40,001 units and the new total cost is £100,002, the *marginal cost* of the 40,001st unit is:

$$£100,002 - £100,000 = £2$$

Thus, any additional orders would need to sell for more than £2 each, in order to be worth producing (assuming the first 40,000 units continue to be sold at more than £2.50 each on average).

b) Financial records

Businesses maintain various types of financial record in order to monitor their performance, fulfil their statutory reporting duties, and manage their taxation. These include a cash flow statement (see box 4), a profit and loss account, (also known as a revenue account, income and expenditure account or statement of comprehensive income) and a balance sheet (also referred to as a capital account or statement of financial position).¹⁰

Whether or not, in practice, it is practical or possible for providers to share these accounts, commissioners can gain greatly by having a broad understanding of the key terms, enough familiarity with accounts to ask the right questions of their finance colleagues, and ideally the knowledge and ability to understand the story the accounts tell.

i. Profit and loss account

This is a statement showing the financial results of a company's normal activities for a particular period of time, usually the financial year. The first part of this shows company turnover and the gross profit. The second part records all the direct and indirect costs of running the business. It does not include the costs of purchasing assets or undertaking investment.

¹⁰ These remain the commonly used terms for the financial statements. The introduction of international accounting standards is seeing the gradual change of name to Statement of Financial Position (from balance sheet), Statement of Comprehensive Income (from profit and loss/revenue account).

Box 5 – Understanding the profit and loss account

A simple example of a profit and loss account:

Sales revenue: £90,000
Cost of sales: £50,000
Gross profit: £40,000
Indirect costs (e.g. overheads): £30,000
Net profit £10,000

This shows the business has made a **gross profit** of £40,000 (Sales revenue: £90,000 – Cost of Sales (i.e. direct costs): £50,000 = gross profit: £40,000) before taking into account indirect costs.

And a **net profit** of £10,000:

Gross profit: £40,000 – Indirect costs: £30,000 = net profit: £10,000

To take this a little further, a simplified profit and loss account for a small care home might look like this:

	Note	Annual (£)
Turnover	1	889,000
Staff costs	2	(619,000)
Non-pay costs	3	(206,000)
Operating profit		64,000
Interest payable	4	(18,000)
Profit on ordinary activities before taxation		46,000
Taxation	5	(9,200)
Retained profit	6	36,800

Therefore the cash surplus the care provider makes will be what is described in the profit and loss account as retained profit, less any cash used for the repayment of capital, such as a regular loan repayment. In this example, if a cash loan repayment of £22,500 is due, then the cash generated by the business is £36,800 - £22,500 = £14,300 – giving a real world cash surplus of just over £14,000.

- Note 1** The example assumes a 32 bed care home which operates at 94% occupancy rates (i.e. 30 beds occupied) with average fees of £570 per week per bed.
- Note 2** The assumption of staff costs of £396.60 per occupied bed per week is based on Laing & Buisson data (2014/15).
- Note 3** The assumption of non-pay costs of £132.20 per occupied bed per week is based on Laing & Buisson data (2014/15).
- Note 4** Assumption of bank borrowing of £15K per bed (£450K) over 20 years at 4% per annum interest (Interest rates of 2% over Bank of England Base rate are available to experienced operators, subject to a 4% minimum).
- Note 5** Assumed to be operated by a limited company. A simple % has been taken for corporation tax purposes of 20%.
- Note 6** Repayment of capital of £22,500 would be payable annually from this retained profit.

ii. The balance sheet

The balance sheet is a snapshot of the company’s position at a given time, normally the end of the accounting year. In the balance sheet, the assets which a company uses to operate the business are balanced by their funding sources. Or, in other words, the means used to operate the company are balanced by the company’s financial obligations.

Assets – Liabilities = (Owners or Shareholders’) Equity; or, equally **Assets = Liabilities + Equity**.

Table 2 – understanding assets, liabilities and equity

	Assets	Liabilities
Current	Current Assets have an expected life of less than a year and can be converted into cash within the accounting period. Some will actually be cash at the bank, but bonds, accounts receivable and inventory (or stock) are also current assets. Stocks are consumables to be used in the organisation.	Current liabilities are due to be paid within a year. This includes both shorter-term borrowings, such as money owed to suppliers, together with the short term obligations associated with longer-term borrowing, such as the interest payments on a mortgage.
Long term	Non-current or fixed assets are not expected to be used within a year, and are less likely to be easily convertible to cash. They may be tangible items such as land, buildings or equipment. These assets typically depreciate over time, reducing their economic value, and so their value on the balance sheet is adjusted to reflect this depreciation. Some assets are intangible, such as goodwill – representing, for example, the value of a brand name or the reputation of a care home.	Long-term liabilities are debts and other financial obligations which are not due until at least a year after the date of the balance sheet.
Current and long term	Equity is the initial amount of money invested into a business, whether by shareholders or a single owner. Equity will be increased if net earnings (i.e. earnings after taxes) aren’t removed from the company: such retained earnings will be transferred from the income statement onto the balance sheet.	

A simplified balance sheet for the same care home in box 5 above, might look something like this:

Box 6 – Simplified balance sheet for a care home

	Note	£	£
Fixed assets			
Property	1		600,000
Tangible Assets	2		50,000
			Total: 650,000
Current assets			
Stock	3	18,000	
Debtors/payables	4	20,000	
Cash at hand	5	50,000	
		Total: 88,000	
Creditors/receivables due within one year	6	(40,000)	
Net current assets			38,000
Total assets less current liabilities			688,000
Long-term liability (due after more than one year)	7		337,500
Total shareholders' funds	8		350,500

Note 1 The property was purchased five years ago for £600,000 and has not been revalued

Note 2 Capital assets would include equipment and furniture with an economic life of more than twelve months

Note 3 Current one month's stock of food and other materials

Note 4 Resident invoices (including local authority payments) issued, or due, but not paid at year end

Note 5 Assumed to be sufficient to make one month's staff payment as minimum

Note 6 Includes one year's capital repayments plus any equipment lease

Note 7 In year five (out of twenty) of mortgage this is balance owed for the remaining 15 years.

Note 8 Assumes that £150,000 was initial capital to purchase the business

c) EBITDA(RM)

Another set of important terms to understand are the acronyms EBITDA and EBITDARM.

EDITDA stands for **Earnings before interest, taxation, depreciation and amortisation** (amortisation is in effect, a type of depreciation), and is a measure designed to ensure sensible comparisons between organisations' operational success by removing the distorting effects of financing decisions (e.g. interest paid), investment decisions (depreciation and amortisation) and taxation from the company profits. It provides a proxy measure of the amount of earnings which is attributable to the company *operations* in a particular period.

In the residential care sector, EBITDARM is often used. This stands for **Earnings before interest, taxation, depreciation, amortisation, rent and management fees**. Again, the aim is to remove 'distortions' to enable comparisons between organisations.

These measures are often used as a proxy measure to compare different companies' profit levels.

Business finance for commissioners

It is not necessary for commissioners to have an in-depth knowledge of business finance and investment but a basic and solid understanding of the key concepts may be helpful to commission for sustainability.

To enter the care market a provider needs to obtain the necessary assets. In residential care in particular, where a building is required to deliver the service, the investment needed can be significant.

In order to fund this, providers have a range of financing options available to them. A basic understanding of these and the differences between them, is helpful when it comes to understanding both providers' ongoing costs (e.g. interest on borrowings) and the investment made on which they will seek a return.

Table 3 – Comparison of financing options

Financing method:	Loan	Equity	Lease
Alternative name(s):	Debt, mortgage	Investment	Rental
Funding source	Bank/financial institution	Individual, group of individuals (e.g. shareholders), investment fund (e.g. pension fund)	Leasing company
'Payment' or 'return' to the lender	Interest (may be fixed or variable). Must be paid in line with an agreement made with the lender.	Dividend (share of profit, variable). May be waived for a short period if profitability is low	Rental/lease charges which need to cover the borrowing costs for the lease company and their overheads. Regular lease payments must be made in line with lease agreement.
Asset ownership	Lender often has rights over asset until loan is fully repaid. Once repaid, the asset is fully owned by the business.	Asset owned by the business but with some obligations to equity providers.	Lease company owns the asset. Business does not take ownership at the end of the lease period but may have the option to buy.

The key point for commissioners to note is that there is always a cost for finance, whether equity, loan or lease. EBITDA(RM) is the best way to compare profitability or surplus between organisations as it represents the fairest comparison between organisations using different financing methods.

CHAPTER 4

Understanding costs

In some local areas, the care market is highly competitive, with rates determined through open tendering. This makes it especially important for commissioners to understand what drives cost, and to be aware of the impact of price on long-term affordability, market sustainability and quality, to avoid tendering at (or accepting and contracting at) unfeasibly low rates.

This section runs through each of the main cost elements. There are sections below on domiciliary care and residential care which have some inevitable repetition, but have been designed so they can be read standalone.

For some costs, fictional examples are given for further clarification. Each sub-section here concludes with a checklist; these are designed to support commissioners during or in preparation for negotiations and discussions with providers.

The main cost elements consist of:

- direct staffing costs, both cost per employee and overall employment costs
- non-staffing direct costs
- indirect or overhead costs
- cost of capital/premises, where applicable.

Table 4 – Provider costs summary

Type of cost	Home care	Care homes
Direct staffing	Cost per employee Travel time costs Travel costs Training	Cost per employee Training
Non-staffing direct costs	Uniforms Care consumables	Food Repairs and maintenance Utilities, phone, council tax Cleaning, disposals, waste, laundry Uniforms Care consumables
Overhead/indirect costs	General administration overheads Insurance Registration fees	General administration overheads Insurance Registration fees Customer enhancements (TV, outings, etc)
Costs of capital	Return on investment	Cost of premises Return on investment

Commissioners should aim both to assure themselves both that they are taking due account of providers' actual costs, and also to take the opportunity to explore all the areas where there may be scope for efficiencies, without putting quality or sustainability at risk.

This text reflects the current understanding of published guidance by all agencies, including HMRC. Readers will note that guidance changes over time and hence will need to be aware of any changes to guidance made subsequent to the publication of this document.

Homecare

Staffing costs

The vast majority of the costs of providing homecare relate to workforce (including managerial and supervisory staff). Homecare costs are also significantly influenced by the need for employers to pay for their workers' travel time between visits. It is important that correct assumptions about wage rates and travel time are made to avoid serious risks of inadvertent non-compliance with the National Minimum Wage (NMW) Regulations and employers' ability to recruit and retain a quality workforce.

Basic pay

Overall pay costs in the care sector are very closely linked to statutory minimum pay rates, as this is a low paid sector, with the majority of care workers paid rates which are either at or just above the minimum wage. When national minimum rates change, as they did in April 2016 with the introduction of the National Living Wage (NLW) for all workers aged 25 or above, care worker pay rates also change and there is a close, but not exact correlation between the percentage change in the minimum wage and the percentage increase in the costs of delivering care. Because of the high proportion of pay rates at the national minimum rate, social care is one of the sectors where there is a particularly large impact.¹¹

In addition to statutory requirements, the rates individual providers pay their workers are influenced by a number of other factors including other national or locally agreed or voluntary pay scales (e.g. the NHS Agenda for Change pay scales or the London Living Wage) and labour market forces – e.g. where higher rates are needed in order to attract sufficient workers. Improved wages above the national minimum are likely to attract and retain employees with higher levels of skills and experience, which is a major factor in providing continuity of services and quality of care provision.

Perhaps less self-evident is the role of geography and demography. In some localities, there are specific geographical uplifts e.g. London weighting which is reasonably straightforward to understand and calculate. But beyond this, conditions within the **local labour market** also have significant impact on the pay rates in different parts of the country.

Commissioners need to have a good understanding of their local labour markets – both in adult social care and in other sectors that compete for the same workforce – particularly retail. For example if a provider reports that they need to increase wages because it is becoming more difficult to recruit and retain sufficient staff, a commissioner who is aware that a major retail park has just opened in the area the provider operates, and knows the typical local hourly rate for shop assistants, will be in a well-informed position to discuss wage costs. Evidence from providers, such as high levels of staff turnover may help commissioners understand the local situation and aid conversations. The Skills for Care National Minimum Dataset for Social Care¹² should help provide background information on the local workforce including skills levels and vacancy hot-spots and support an understanding of the dynamics of the market for care workers. This dataset may also provide information on qualification levels in the overall local market and within specific providers.

11 See Low Pay Commission report, 2014 www.gov.uk/government/uploads/system/uploads/attachment_data/file/414323/facts.pdf

12 www.nmds-sc-online.org.uk/help/Article.aspx?id=22

Box 7 – Rates of basic pay in homecare

Domiciliary care workers are generally paid at rates which are either at or just above the statutory minimum pay rate.

Nursing staff pay rates are linked broadly to NHS Agenda for Change pay scales which are determined nationally. The higher the grade the higher the pay; registered nursing staff grades start at band 5.^{13 14}

Supervisors are likely to be paid rates several pounds per hour above the minimum wage in order to recognise their particular responsibilities or to reflect market conditions. These rates closely track increases in the National Living Wage.

Registered managers have a wide range of duties, including staff and client management, and salary levels are significantly higher in recognition of this, and to some extent track increases in the National Living Wage.

Domestic staff (e.g. office cleaning staff) are generally paid the National Living Wage. Note that these staff may be directly employed or contracted in from a separate company. Where sub-contracted, these costs will appear in the non-pay rather than the pay section of the provider's accounts; this should be borne in mind and adjusted for when making comparisons between providers.

Administration staff wages will vary depending mainly on the market conditions and the level of skills required. It is important to note that in many smaller businesses, some administration, supervisory and management functions are provided by the business owner or their family. This is still a labour cost and in these cases sufficient allowance needs to be made for a higher 'profit' (see page 10), i.e. the owner's salary.

Enhanced rates often need to be paid for unsocial hours e.g. weekends, bank holidays and night duties. There can also be differences in rates incurred between different shifts within the daytimes during the Monday to Friday week. Providers may have to pay a higher rate to fill certain shifts where an increased incentive is needed due to local labour market conditions.

Staffing levels

Providers need to meet the CQC requirement that '*providers must provide **sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and... other regulatory requirements.***'¹⁵

Providers are free to determine how they meet this requirement – i.e. there is some discretion about what 'sufficient numbers' are. However, in practice there are some general 'rules of thumb' and other points of which commissioners would be well placed to be aware.

Some homecare visits require two care workers to be present - for example, to ensure safe moving and handling. The costs incurred and resulting fees paid for care should therefore reflect this. While these "double-up calls" may be a small proportion of total homecare visits, the impact on costs should not be underestimated. The wage costs to the employer (including travel time) are in most cases double for every one of these visits (though sometimes slightly less than double – for example if the workers travel in the same car while the costs of the travel time will double, the mileage costs will remain constant).

13 More information on agenda for change, including the latest pay rates can be found on the NHS employers website www.nhsemployers.org/your-workforce/pay-and-reward/pay/agenda-for-change-pay

14 The 2016 NHS Funded Nursing Care Review (Mazars 2016) www.mazars.co.uk/Home/Our-Sectors/Public-Services/Health/NHS-Funded-Nursing-Care-Review found that an average reasonable cost baseline for the nursing care element of care was assessed at £156.25 across all nursing homes, and the accordingly the Funded Nursing Care (FNC) Rate was increased from £112 in 2015/16 to £156.25 in 2016/17.

15 Regulation 18 (Staffing) at www.cqc.org.uk/content/regulation-18-staffing

In order to deliver a service that meets a person’s needs, commissioners need to consider and discuss with providers any specialist skills that care workers need. Some providers reflect recognise skills through different fee rates for care workers, e.g. “Standard” and “Complex”. Discussions and agreement about higher rates for specialist skills should be grounded in evidence that the skills are required and that specific care workers have those skills.

Oncosts

The cost of employing someone is not just their basic wage or salary. The cost to the employer of each unit of work (e.g. hour or day) is made up of the wage or salary paid to the individual worker (from which income tax, employee national insurance contributions and pension contributions are deducted) plus:

- employer national insurance contributions
- employer pension contributions
- employee pay for holidays and other paid absences (e.g. sickness or parental leave).

These costs are generally referred to as ‘oncosts’.

National insurance and pensions

Employer national insurance contributions of 13.8% (2016/17) are payable on all salaries and wages above the Primary Threshold (£112 per week, £486 per month, £5,824 per year in 2016/17). Figures are valid in 2016/17. Contributions to auto-enrolment pension schemes are now mandatory for most employees, with payments of at least 1% (rising to 3% by 2018) for employer pension contributions also now required.

Holiday pay

Employees are entitled to statutory **holiday pay**. Salaried employees are generally paid monthly with holiday weeks being rolled up within the cost of the annual salary. Most home care workers are paid an hourly wage for the time worked. For hourly paid staff, an allowance has to be made to take account of holiday in the total cost which needs to be recovered through fees. For every hour worked, the employer must generate additional income to cover holiday pay. This works out as an extra 12.1% cost as illustrated below.

Box 8 – Calculating the cost of holiday pay

Employees’ minimum paid holiday entitlement is 5.6 weeks (28 days including bank holidays) per annum.¹⁶

Working time is therefore:

$$52 \text{ weeks} - 5.6 \text{ weeks} = 46.4 \text{ weeks}$$

There is a simple equation to express this as a percentage:

$$(5.6 \div 46.4) \times 100 = 12.1\%$$

So the employer needs to add 12.1% onto the hourly rate as an allowance for the holiday pay.

Holiday pay is a statutory requirement and is therefore not something that commissioners should challenge.

¹⁶ See www.gov.uk/holiday-entitlement-rights/entitlement

Other paid absence

Employees are also entitled to paid absence during periods of parental leave and sickness absence. This has an impact on overall costs and care providers have to build in assumptions regarding the level of these, which is not always straightforward, as absence rates can be highly variable.

Government covers the costs of parental leave since the vast majority of maternity or paternity pay is deductible from taxes paid by the employer to HMRC. Sickness pay however, is paid for by the employer and hence can be a substantial cost.

Both these employee rights have a disproportionate impact on small employers. Larger employers are likely to have vacancies across their care business and hence are able to accommodate changes in working patterns much more easily than smaller employers. Similarly, it may be easier for employers to accommodate absences of care staff – where there are multiple staff performing identical tasks – than for absences in roles such as the registered manager, where there is only one. The logistical effect of absences of key staff such as supervisors and managers can be significant where there is no easily available substitute to provide cover.

Travel time and travel costs

Understanding staffing costs in homecare, and some residential care where employees work at more than one site, is made more complex by the need to take account of travel time and costs. It is necessary to distinguish between “travel time” (the time spent travelling) and “travel costs”, which cover mileage payments or the reimbursement of fares on public transport).

Under minimum wage legislation “working time” is averaged over a “pay reference period” (up to a month) to be paid at National Minimum Wage (or higher). Working time includes business travel (i.e. between care appointments) but excludes journeys from home to the workplace and the journey back home. Under minimum wage legislation, workers are assessed as working when travelling between care appointments and therefore this time will need to be paid by the employer at minimum wage levels at least.¹⁷

Travel can form a significant proportion of homecare costs, particularly when workers are visiting multiple clients on any given day. Homecare providers need to pay workers for their time spent travelling between appointments and **also** reimburse them for travel expenses. It is important to note that when HMRC assesses providers’ compliance with minimum wage legislation they count travel hours as “working time” and deduct a reasonable estimate for any travel expenses not reimbursed when making the calculation.

Travel time in homecare is highly variable and is influenced by different localities’ population and geographical characteristics, e.g. whether urban or rural, and by the extent to which a provider can allocate care workers to a cluster of service users who live in a local area. In rural locations, travel times may be relatively long, and public transport options more limited. In contrast, workers in cities may have better access to public transport, yet costs may be high due to congestion slowing progress or making driving a less realistic option.

Note that for the purposes of the National Minimum Wage Regulations, “working time” (which must be paid at or above the National Minimum Wage) includes not just time spent travelling, but also:

- time spent waiting to travel (e.g. waiting for a bus)
- time spent between the end of a journey and beginning the next assignment (e.g. arriving earlier than the agreed time of the next visit).

The length of homecare visits has an impact on the amount of time spent travelling as part of their working day: a care worker doing longer calls will have less travel time over their working day than one doing lots of shorter calls. This will vary locally depending on what care packages have been agreed. In all circumstances any informed discussion about travel costs will include careful consideration of the impact of visit lengths on costs and service quality.

¹⁷ Department for Business, Energy and Industrial Strategy, Minimum Wage for Different Types of Work www.gov.uk/minimum-wage-different-types-work

There is widespread recognition that short homecare visits may be associated with poor service quality. This is expressed in both the statutory guidance to the Care Act¹⁸ and NICE guidelines.¹⁹ However, both recognise that short visits can be appropriate as part of a wider package of care. When (for example) 15 minute visits are used, the higher proportion of travel time to service provision time increases the unit cost (i.e. cost per hour of care delivered). This leads to providers needing either to charge more for half an hour’s care split across two visits than for a single half hour visit, or else to increase the hourly rate for all visits to compensate. It is worth checking that the pattern of appointment lengths has been thought through and consulted on, and it is important to understand the relative patterns in any benchmarking comparisons being made.

To illustrate, assume a care worker takes 10 minutes to travel between each visit and does three visits each day.²⁰ Travel time is a much larger proportion of “working time” on short visits than longer visits, as follows:

Table 5 – Effect of short home care visits on costs

	Short visits	Longer visits
Travel from home [not counted]		
Visit 1	15 mins	30 mins
Travel to next visit	10 mins	10 mins
Visit 2	15 mins	30 mins
Travel to next visit	10 mins	10 mins
Visit 3	15 mins	30 mins
Travel back home [not counted]		
Time spent on visits:	45 mins	90 mins
Time spent travelling	20 mins	20 mins
Total “working time”	65 mins	110 mins
Travel time as % of working time:	31%	18%

Given that it is in the providers’, commissioners’ and the care workers’ interests to reduce the time spent travelling between appointments, discussions about travel time might be a useful opportunity to explore options to collaborate to minimise time spent travelling. Statutory Guidance to the Care Act encourages commissioners to work with partners to develop outcome-based commissioning of homecare – i.e. to move away from ‘time-and-task’ to commissioning for outcomes. Conversations about visit length and travel time can be one place to begin to explore possibilities about a different approach.

Reimbursing workers’ **travel costs** is in almost all cases a significant element of the costs involved in providing homecare. Statutory requirements on minimum wages are clear that “out of pocket” expenses paid by workers are excluded from calculations of compliance with the National Minimum Wage. These costs need to be recognised as additional.

18 Paragraph 4.101 of www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-4

19 National Institute for Care Excellence, 2015, Guideline 21, sections 1.4.1 - 1.4.3: www.nice.org.uk/guidance/ng21/chapter/Recommendations#delivering-home-care

20 Note that travel from home to work and from work back home does not usually count towards “working time” for the purposes of the National Minimum Wage Regulations (but it may apply for the Working Time Regulations, which are a different area of law).

A starting point for discussions with providers about travel costs might include:

- the assumption used by UKHCA in their calculations that a minimum reimbursement rate for travel undertaken by private car is £0.35 per mile.²¹
- local authority travel policies for their employed staff that include mileage rates (these are usually agreed with trade unions).
- the maximum “Mileage Allowance Payment” for cars permitted by Government before tax is due, which is currently 45 pence/mile for the first 10,000 miles and 25 pence/mile thereafter.²²
- in urban areas where care workers use public transport, it is usually possible to calculate average journey times through knowledge of bus frequency and times between stops.

Training and development costs

Regular, effective training and development is clearly important for retention of staff and quality of care, highlighted by the regulator CQC. In its report on the State of Adult Social Care 2015/16, CQC found that:

“Recruiting nurses remains a significant concern. Some providers have considered providing residential but not nursing care, because they could not recruit enough staff. Others have responded by training and developing other care staff to expand their roles and making links with universities to encourage nurse recruitment as well as offering apprenticeship schemes.”²³

Skills for Care provide practical tools and support to help adult social care organisations in England recruit, develop and lead their workforce. They recommend that within a contract to commission social care, an allowance of 3% should be made for training costs. An allowance of this order should be considered to cover the three main areas of staff learning and development, in order to effectively retain high quality staff and provide quality services. The three areas are set out in the table below.

Table 6 – Types of training in homecare

	Mandatory training	Recommended training
Induction training	All new employees must undertake identified mandatory training e.g. moving and handling, safeguarding fire safety, working with hazardous substances, equality and diversity and food hygiene.	The Care Certificate is the national induction programme for people new to health and adult social care in England. It is the recommended qualification for healthcare assistants and social care support workers. CQC expects all organisations which employ these groups of staff to work to the care certificate standards. ²⁴
Training to develop skills to provide care		Level 2-5 qualifications [Qualifications Credit Framework or equivalent successor Framework of Regulated Qualification] for frontline staff and managers depending on role and experience. Skills for Care estimate that this costs on average £2,000 per worker undertaking qualifications per year.

²¹ Angel, C (2015) A Minimum Price for Homecare, Version 3.1. London: United Kingdom Homecare Association, pages 19-20. See: www.ukhca.co.uk/downloads.aspx?ID=434.

²² See: www.gov.uk/expenses-and-benefits-business-travel-mileage/rules-for-tax.

²³ CQC report, State of Adult Care 2015/16 www.cqc.org.uk/content/state-of-care

²⁴ Skills for Care, Recommendations for CQC Providers Guide (section 4 learning and development) www.skillsforcare.org.uk/Documents/Standards-legislation/CQC/Section-4-Induction-Learning-and-Development.pdf

	Mandatory training	Recommended training
Ongoing workforce development	Regular updates of mandatory training as set out above.	Continuous professional and skills development is a key part of maintaining a quality workforce and retaining staff. It is expected that care staff stay up to date with developments in practice and expand their knowledge and skills. Guidance on ongoing learning and development is provided by Skills for Care. ²⁵

In order to enhance the overall understanding of the social care workforce in a particular area, local authorities can access the National Minimum Data set for Social Care which includes detailed information on what training individual workers have undertaken.²⁶

25 Skills for Care, Ongoing Learning and Development Guide: www.skillsforcare.org.uk/Documents/Learning-and-development/Ongoing-learning-and-development-guide.pdf

26 For further information on the National Minimum Data set for Social Care see www.skillsforcare.org.uk/NMDS-SC-intelligence/NMDS-SC-and-intelligence.aspx

Box 9 – Calculating homecare staffing costs – including travel time and travel costs

A homecare worker earning the National Living Wage provides **25 hours** of care to a range of different clients each week. He travels between assignments, with a total travel time of **5 hours**. Total weekly hours to be paid are therefore **30 hours per week**.

£7.20 per hour x 30 hours = £216 (basic weekly pay).

Income tax, employee’s national insurance and pension contributions are deducted from the employee’s pay, so his weekly take-home pay would be lower.

The employer must pay Employer’s National Insurance Contributions (“ENIC”) and at least a 1% towards the worker’s pension (both are calculated on earnings above specific thresholds):

$$£216 + £8.42 + £1.04 = £225.46$$

Basic pay + Employer’s NI contribution + Employer’s pension contribution = per week

The cost of the employer’s contribution towards NI and pension (oncost) is therefore £9.46 per week in this example, adding 4.4% to the basic cost (£9.46/£216).

However, the employer will also have to cover the costs of holiday pay, time spent training and provision for sick pay. Although the employee is paid these amounts when they are not providing care, the money to pay these must be generated from the fees the employer charges for the work undertaken. Holiday pay is 12.1% (see box 8 above), and UKHCA estimate that training and sick pay adds a further 2.5% totalling a further 14.6% or £31.54 per week.

In addition, the employee reclaims mileage costs for travelling between his visits.

In this example the worker travelled 26 miles, and received 35 pence per mile adding a further £9.10 that week. The mileage costs are reimbursed through the employer’s payroll system, increasing the amount paid to the employee to £225.10 (basic pay + mileage reimbursement, note that travel costs are not taxable as they are a reimbursement of expenses).

The employee’s basic pay of £216 has become a total cost to the employer of £266.10, once all the additional costs have been included (£216 basic pay + £9.46 (oncosts) + £31.54 (holiday, sickness and training) + £9.10 travel = £266.10).

The additional costs of £50.10 have added an extra 23.2% to the cost of basic pay.

Note that homecare providers’ fees are generally calculated according to the length of the visit (also called “contact time”) which is 25 hours per week in this example. As can be seen there is a significant difference between the 30 hours of “working time” which must be covered in the worker’s wages and the 25 chargeable hours. As a result, the hourly rate needed for “contact time” needs to be significantly higher to reflect the ‘hidden’ employment costs.

Checklist 1 – staffing costs in homecare

This checklist is intended as a guideline to enable constructive discussions between providers and commissioners rather than mandatory or an exhaustive list. When exploring staff costs, commissioners and providers should bear in mind the effect reasonable remuneration has on attracting and retaining a quality workforce required to deliver a safe, high quality care. Discussions and agreements need to balance this with current workforce market conditions and commissioners’ financial pressures.

Checklist 1 – Staff costs in homecare

Cost element	Overview	Areas to explore with providers	✓
Basic pay and basic oncosts	Fees need to cover the costs of: <ul style="list-style-type: none"> ■ Pay that is at least the statutory minimum ■ Employer’s National Insurance contributions ■ Employers’ pension contributions ■ Holiday pay 	Both the council and the provider have statutory requirements to fulfil so this is not an area where there is likely to be significant scope for negotiating savings. It is important to consider the local labour market conditions and the impact on wage rates required to attract and retain staff.	
Sickness absence	Fees need to cover the cost of the SSP which is usually of the order of 1% of total costs but could be higher if not managed well and could indicate poor workforce morale.	Where the allowance for sickness absence is out of line with similar providers commissioners will wish to understand the reasons for this. Commissioners might challenge provider’s costs for paying statutory sick pay if they seem high and question what HR activity takes place to manage sickness. (For example The Bradford Factor approach is commonly used to assess whether employee’s sickness records are reasonable).	
Recruitment costs	Will vary depending on turnover and expansion. Includes advertising, selection, interviewing, background checks and appointment costs.		
Agency staffing	Providers may need to build in an allowance for agency staffing, which generally incurs a premium. Providers typically seek to minimise the amount of agency staff, not simply on the basis of cost, but also due to the fact that it does not provide a good continuity of care. Agency costs may be shown separately from other staff costs in providers’ financial statements.	Continued and significant use of agency staffing in an area may well indicate significant recruitment challenges which commissioners and providers need to work collaboratively to resolve.	
Training and development	Training costs are a combination of the payments for the courses and the paid staff time required to undertake them. UKHCA calculates that care workers’ training time adds a minimum of 1.73% to the provider’s wage bill (the costs of the training course, trainers, etc. are in addition to this).	Commissioners and providers might usefully agree how many hours or days of training care workers need in order to remain up-to-date and sufficiently skilled to meet their service users’ needs. The council may also be able to achieve economies of scale by facilitating (free or low cost) training for care workers.	

Checklist 2: Non-staffing costs in home care

While workforce costs are the biggest element of homecare provider costs they are not the only ones. The checklist below runs through the other costs. If using this for the basis of discussion with specific providers it is important to bear in mind that while all providers are likely to incur all of these costs, they may group them differently in their accounts.

Checklist 2 – non-staff costs in homecare

Cost element	Overview	Areas to explore with providers	
Insurance	Providers usually buy insurance from brokers, who recommend the most cost effective option for the level of cover required. All insurance costs are covered including those which insure the provider against the actions or inactions of its workers. While there is some competition on price, the largest variation in cost often comes from the levels of insurance cover required by the local authorities.	The risks that must be insured are fairly standard across the homecare sector, but on occasions it may be worth exploring with providers whether the current insurance is higher than is necessary. Checking that contracts require insurances are in line with industry standards can help providers reduce their insurance costs.	
Care consumables	Care consumables are items such as personal protective equipment for care workers (gloves, aprons, hand-wash, etc.), and any specific equipment required to deliver care to the service users they support (excluding those supplied by the NHS or the person or their family themselves). There may be some variability in these costs based on the service user group supported.	Authorities may be able to secure bulk purchase deals for their homecare and residential providers which can offset the providers' costs of purchasing smaller quantities.	
IT equipment and telephony	IT equipment costs are mainly licenses and fees (replacement equipment is generally funded as capital expenditure). These costs may be heavily influenced by the fees payable for electronic call monitoring (ECM) and licenses for care worker rostering systems. Commissioners can prevent escalation in some of these costs by being flexible about required systems. Clearly, if a contract requires providers to use a specific ECM system, when a provider already invests in a different one, the provider will incur a cost which could have been avoided.	Providers may be able to reduce telephony rental by changing their supplier at the end of individual contracts, particularly where mobile phones are provided for care-workers.	

Cost element	Overview	Areas to explore with providers	✓
Rent, business rates and utilities	<p>The majority of homecare providers will rent business premises (and therefore pay rent), rather than purchase premises (and pay a mortgage).</p> <p>Providers sometimes move to new premises in response to changing volumes, because they need more or fewer office-based staff. Most providers will require access to training rooms.</p> <p>Providers that rely on being able to recruit workers regularly may require a 'high-street' location to attract new staff; such locations generally attract higher prices per square metre. In general terms, urban locations attract higher rents than rural locations. Utilities include building maintenance, water, lighting and heating, cleaning and equipment hire.</p>	<p>Providers may be able to reduce costs by locating offices in less costly areas, however, they may need a premium location such as a high street in order to attract and recruit staff.</p> <p>Local authorities could consider offering providers rooms and facilities for training at competitive prices which might lower costs by reducing the size of the offices required or the cost of room rentals.</p> <p>It would be appropriate to explore with providers whether they regularly 'shop around' for the best available deals on utilities.</p>	
Equipment hire	<p>Equipment hire may include office equipment or specialist equipment which would be too expensive to purchase from capital expenditure</p>	<p>A local authority might offer to share its own facilities to reduce provider costs.</p>	
Finance costs	<p>Setting up a homecare business requires cash to be paid (invested); in exchange for this cash the business takes ownership of asset</p> <p>Cash is rarely available without a cost. Financing costs compensate the lender for the opportunities they have given up by no longer having the cash available and are need to be considered during fee negotiations.</p>	<p>Commissioners need to ensure that the overall market is sustainable, with quality provision that meets local needed remaining in place. If fee levels are negotiated that do not allow for financing costs or reasonable rate of return, it will be more likely that homecare business owners will sell their businesses and invest elsewhere, thus reducing the supply of care available.</p> <p>Effective commissioning should seek to understand the financing costs which relate to a major contract, including the point at which any loans or lease payments come to an end.</p> <p>Local authorities may wish to consider undertaking joint investment schemes with providers, particularly where new provision is required in order to provide capital at below market rates.</p>	

Cost element	Overview	Areas to explore with providers	✓
Profit /surplus	Home care providers and UKHCA report that businesses providing social care typically make profits or surplus at a rate of 2-3% return on investment (rarely more than 5%). ²⁷ The level of profit /surplus will inform investors' and business owners' decisions about whether to invest, or continue to invest in any particular business.	The profit/surplus as a proportion of the total price may be helpful to discuss with providers. This is likely to be particularly relevant where pay costs, length of appointments and geographic factors cannot explain differentials, but benchmarking – within a region and across the country – or cost comparison, suggests a providers'prices are unusually high or low.	

UKHCA suggest levels of the staffing and non-staffing costs in their 'A Minimum Price for Homecare'.²⁸ The calculation in table 7, provided by UKHCA, could be used as a starting point for discussions between commissioners and homecare providers, both to develop and agree local models, or for individual agreements. This is illustrative and may be helpful to indicate the range and levels of costs; it is not intended to be definitive or recommended by the authors of this guide.

²⁷ UKHCA A Minimum Price for Homecare www.ukhca.co.uk/pdfs/AMPFHC_150719.pdf

²⁸ Angel, C (2015) A Minimum Price for Homecare, Version 3.1. www.ukhca.co.uk/downloads.aspx?ID=434

Table 7 – UKHCA breakdown of the price of an hour of homecare

(Wage rates are based on the National Minimum Wage and National Living Wage between 1 April and 30 September 2016. All figures are rounded to the nearest whole penny.)

Cost	Assumption	Per hour
Hourly rate for “contact time”	Combined NMW and NLW	£7.13
Unsocial hours enhancements, etc	0% of basic hourly rate	£0.00
Travel time	11.4 min per hr of contact time	£1.36
Gross pay		£8.49
National Insurance contributions	9.5% of gross pay	£0.81
Holiday pay	12.07% of gross pay	£1.02
Training and supervisory time	1.73% of gross pay	£0.15
Pension contributions	1% of gross pay	£0.08
Travel costs	4 miles at £0.35 per mile	£1.40
Oncosts		£3.46
Costs of sale	(Gross pay + oncosts)	£11.95
Insurance	1% of costs of sale	£0.12
Care consumables	1% of costs of sale	£0.12
IT equipment	4% of costs of sale	£0.48
Telephony	1% of costs of sale	£0.12
Management/office staff	18.7% of costs of sale	£2.23
Rent, rates and utilities	3% of costs of sale	£0.36
Equipment hire	1% of costs of sale	£0.12
Recruitment	2% of costs of sale	£0.24
Cost of finance	2% of costs of sale	£0.24
Other office overheads	2% of costs of sale	£0.24
Profit/surplus	3% of costs of sale	£0.49
Overheads		£4.76
Total price per hour	(Costs of sale + overheads)	£16.70

Summary of assumptions

UKHCA’s assumptions have been made to reach a theoretical minimum price for an hour of homecare commissioned by local authorities. **Wage assumptions do not take into account employers’ ability to be competitive within their local employment market.** The general principles are:

- payment to the provider is calculated solely by reference to “contact time” (the time the worker spends in a service user’s home)
- workers are paid a flat-rate at the prevailing National Minimum Wage (if under 25 years) or the National Living Wage (if aged 25 years or above) workers receive no enhanced pay rates for working unsocial hours, weekends or public holidays
- workers are paid for other elements which constitute “working time” (i.e. applicable travel time, and when undergoing supervision and approved training) at the same hourly rate as for “contact time”
- business mileage is reimbursed at a reasonable rate
- workers receive statutory paid holiday entitlements
- workers are enrolled in a Workplace Pension scheme
- the care provider covers reasonable operating costs and a profit/surplus that enables a sustainable business.

How the basic pay rate is calculated

To produce the pay rate at the applicable National Minimum Wage and the National Living Wage, UKHCA calculated the proportion of workers above and below 25 years of age, based on data from the National Minimum Dataset for Social Care (NMDS-SC), as follows:

Table 8

Workers’ age	Proportion of workforce	Applicable hourly wage rate from April 2016
National Minimum Wage (assumed to be paid to all workers under 25 years of age)	13.7%	£6.70
National Living Wage paid to workers aged 25 years and above	86.3%	£7.20
Combined rate		£7.13

This information here is presented for reference, as an illustration of how costs can be broken down and as an aid to discussion. It may be helpful for commissioners in considering costs in their area and to construct local cost models.

Care homes

Staffing costs

While the costs of providing residential care are higher than home care, the majority of the costs also relate to workforce (including managerial and supervisory staff).

Box 10 – Basic pay rates in care homes

Residential care workers are generally paid at rates which are either at or just above the statutory minimum pay rate.

Nursing staff salary rates are linked broadly to NHS Agenda for Change pay scales which are determined nationally. The higher the grade the higher the pay; registered nursing staff grades start at band 5.^{29 30}

Supervisors are likely to be paid rates several pounds per hour above the minimum wage in order to recognise their particular responsibilities or to reflect market conditions. These closely track increases in the National Living Wage.

Registered managers have a wide range of duties, including staff and client management, and salary levels are significantly higher in recognition of this, and to some extent track increases in the National Living Wage.

Domestic staff (e.g. cleaning, catering and grounds maintenance staff) are generally paid the National Living Wage. Note that these staff may be directly employed or contracted in from a separate company. Where sub-contracted, these costs will appear in the non-pay rather than the pay section of the provider's accounts; this should be borne in mind and adjusted for when making comparisons between providers.

Administration staff wages will vary depending mainly on the market conditions and the level of skills required.

It is important to note that in many smaller businesses, some of these administration, supervisory and management functions are provided by the business owner or their family. This is still a labour cost and in these cases sufficient allowance need to be made for a higher 'profit' (see section 3), i.e. the owners' salary.

Enhanced rates often need to be paid for unsocial hours e.g. weekends, bank holidays and night duties. There can also be differences in rates incurred between different shifts within the daytimes during the Monday to Friday week. Providers may have to pay a higher rate to fill certain shifts where an increased incentive is needed due to local labour market conditions.

Staffing levels

Care home providers need to meet the CQC requirement that *'providers must provide **sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times** and... other regulatory requirements.'*³¹

Providers are free to determine *how* they meet this requirement – i.e. there is some discretion about what 'sufficient numbers' are. In practice, residential care providers will tend to use established ratios to determine staffing levels. Over and above the requirement to provide a safe service, there are a number of other factors which play into decisions about staff numbers required:

²⁹ More information on agenda for change, including the latest pay rates can be found on the NHS employers website www.nhsemployers.org/your-workforce/pay-and-reward/pay/agenda-for-change-pay

³⁰ The 2016 NHS Funded Nursing Care Review (Mazars 2016³⁰) www.mazars.co.uk/Home/Our-Sectors/Public-Services/Health/NHS-Funded-Nursing-Care-Review found that an average reasonable cost baseline for the nursing care element of care was assessed at £156.25 across all nursing homes, and the accordingly the Funded Nursing Care (FNC) Rate was increased from £112 in 2015/16 to £156.25 in 2016/17.

³¹ Regulation 18 (Staffing) at www.cqc.org.uk/content/regulation-18-staffing

- **Type of service provided.** The distinction between nursing or residential care is the most significant factor, with nursing provision increasing costs significantly. The client group being cared for also has an impact, for example dementia care on average requires higher levels of staffing per resident.
- **Resident age.** The Funded Nursing Care Review suggest that for nursing home care 8.2 hours of registered nurse time per resident per week on average is provided to residents aged 18-64, and 7.3 hours of registered nurse time per resident per week for those over 65.³²
- **Home size.** Many larger homes are able to manage resources more flexibly and take advantage of economies of scale, e.g. staffing resources can be more easily spread over a larger number of clients (within the allowed ratios). However, other factors such as the layout of the home and the extent to which assistive technology is in place will both feature in the staffing requirements.
- **Staffing a 24/7 service** requires significant numbers of employees to cover a rota. As a working guide, approximately 3.5 full time staff (or full time equivalents (FTE)/whole time equivalent (WTE)) are required to provide one member of staff for 'round-the-clock' cover. While this may seem high, allowances need to be made for weekends, holidays, sickness or other absence, training and sleeping.

Providers often express staffing requirements in terms of nursing or care hours per occupied day, a number which should vary based on the dependency of the residents at any one time. That might, for example, equate to one carer per five residents by day and one per ten residents at night (at lower dependency levels, with higher ratios needed for nursing care or dementia).

An alternative method of assessing the sufficiency of staffing is to determine the number of care hours per week per bed. For residential or personal care this has historically been at a level of 18 care hours per week per bed, with the equivalent figure being 21 care hours per week per bed for personal care with nursing and 24 care hours per week per bed for dementia. These levels will invariably be increased for end of life, or other specialist care.

This list is intended as a guideline for constructive discussions with providers rather than mandatory or indeed an exhaustive list. When exploring whether there is scope for savings in staff costs, it is important to bear in mind how much of a role care workers play in the delivery of safe, quality care and the influence of remuneration and working conditions in attracting and retaining an effective workforce.

Oncosts

The cost of employing someone is not just their basic wage or salary. The cost to the employer of each unit of work (e.g. hour or day) is made up of the wage or salary paid to the individual worker (from which income tax, employee National Insurance contributions and pension contributions are deducted) plus:

- employer National Insurance contributions
- employer pension contributions
- employee pay for holidays and other paid absences (e.g. sickness or parental leave).

These costs are generally referred to as 'oncosts'.

National Insurance and pensions

Employer National Insurance contributions of 13.8% (2016/17) are payable on all salaries and wages above the Primary Threshold (£112 per week, £486 per month, £5,824 per year in 2016/17). Figures are valid in 2016/17. Contributions to auto-enrolment pension schemes are now mandatory for most employees, with payments of at least 1% (rising to 3% by 2018) for employer pension contributions also now required.

³² The NHS Funded Nursing Care Review – Mazars, 2016: www.mazars.co.uk/Home/Our-Sectors/Public-Services/Health/NHS-Funded-Nursing-Care-Review.

Holiday pay

Employees are entitled to statutory **holiday pay**. Salaried employees are generally paid monthly with holiday weeks being rolled up within the cost of the annual salary. Most care home workers are paid an hourly wage for the time worked. For hourly paid staff, an allowance has to be made to take account of holiday in the total cost which needs to be recovered through fees. For every hour worked, the employer must generate additional income to cover holiday pay. This works out as an extra 12.1% cost as illustrated below.

Box 11 – calculating the cost of holiday pay

Employees' minimum paid holiday entitlement is 5.6 weeks (28 days including bank holidays) per annum.³³

Working time is therefore:

52 weeks - 5.6 weeks = 46.4 weeks

There is a simple equation to express this as a percentage:

$(5.6 \div 46.4) \times 100 = 12.1\%$

So the employer needs to add 12.1% onto the hourly rate as an allowance for the holiday pay.

Holiday pay is a statutory requirement and is therefore not something that should be challenged.

Other paid absence

Employees are also entitled to paid absence during periods of parental leave and sickness absence. This has an impact on overall costs and care providers have to build in assumptions regarding the level of these, which is not always straightforward, as absence rates can be highly variable.

Government covers the costs of parental leave since the vast majority of maternity or paternity pay is deductible from taxes paid by the employer to HMRC. Sickness pay however, is paid for by the employer and hence can be a substantial cost.

Both these employee rights have a disproportionate impact on small employers. Larger employers are likely to have vacancies across their care business and hence are able to accommodate changes in working patterns much more easily than smaller employers. Similarly, it may be easier for employers to accommodate absences of care staff – where there are multiple staff performing identical tasks – than for absences in roles such as the registered manager, where there is only one. The logistical effect of absences of key staff such as supervisors and managers can have a significant effect on a care business where there is no easily available substitute to provide cover.

Training and development costs

Training and development is as important in residential care as it is in home care. Regular, effective training and development is clearly important for retention of staff and quality of care, highlighted by the regulator CQC. In its report on the State of Adult Social Care 2015/16, CQC found that **“Recruiting nurses remains a significant concern. Some providers have considered providing residential but not nursing care, because they could not recruit enough staff. Others have responded by training and developing other care staff to expand their roles and making links with universities to encourage nurse recruitment as well as offering apprenticeship schemes”**.³⁴

³³ See www.gov.uk/holiday-entitlement-rights/entitlement

³⁴ CQC report, State of Adult Care 2014/15 www.cqc.org.uk/sites/default/files/CQC_State_of_Care_Report_adult_social_care.pdf

Skills for Care provide practical tools and support to help adult social care organisations in England recruit, develop and lead their workforce. They recommend that within a contract to commission social care, an allowance of 3% should be made for training costs. An allowance of this order should be considered to cover the three main areas of staff learning and development effectively, in order to retain high quality staff and provide quality services. The three areas are set out in the table below.

Table 9 – types of training in residential care

	Mandatory training	Recommended training
Induction training	All new employees must undertake identified mandatory training e.g. moving and handling, safeguarding fire safety, working with hazardous substances, equality and diversity and food hygiene.	The Care Certificate is the national induction programme for people new to health and adult social care in England. It is the recommended qualification for healthcare assistants and social care support workers. CQC expects all organisations which employ these groups of staff to work to the care certificate standards. ³⁵
Training to develop skills to provide care		Level 2-5 qualifications [Qualifications Credit Framework or equivalent successor Framework of Regulated Qualification] for frontline staff and managers depending on role and experience. Skills for Care estimate that this costs on average £2,000 per worker undertaking qualifications per year.
Ongoing workforce development	Regular updates of mandatory training as set out above.	Continuous professional and skills development is a key part of maintaining and quality workforce and retaining staff. It is expected that care staff stay up to date with developments in practice and expand their knowledge and skills. Guidance on ongoing learning and development is provided by Skills for Care. ³⁶

In order to enhance the overall understanding of the social care workforce in a particular area, local authorities can access the National Minimum Data set for Social Care which includes detailed information on what training individual workers have undertaken.³⁷

35 Skills for Care, Recommendations for CQC Providers Guide (section 4 learning and development) www.skillsforcare.org.uk/Documents/Standards-legislation/CQC/Section-4-Induction-Learning-and-Development.pdf

36 Skills for Care, Ongoing Learning and Development Guide www.skillsforcare.org.uk/Documents/Learning-and-development/Ongoing-learning-and-development-guide.pdf

37 For further information on the National Minimum Data set for Social Care see www.skillsforcare.org.uk/NMDS-SC-intelligence/NMDS-SC-and-intelligence.aspx

Travel time and travel costs

Paid travel costs do not feature significantly in care homes. There is a broad discussion in the section on home care above.

Checklist 3 – Staff costs in residential care

Cost element	Overview	Areas to consider and explore with providers	✓
Client group / level of needs	The level of need of people receiving care is the key determinant of staffing levels required, e.g. care for people with dementia will require more staff per person. Other determinants will relate to age, the size and layout of the home and the need for 24 hour cover.	Whether current arrangements are efficient, if organising rotas differently might reduce costs.	
Basic pay and basic oncosts	Fees need to cover the costs of: <ul style="list-style-type: none"> ■ Pay that is at least the statutory minimum ■ Employer’s National Insurance contributions ■ Employers’ pension contributions ■ Holiday pay 	Both the council and the provider have statutory requirements to fulfil so this is not an area where there is likely to be significant scope for negotiating savings. It is important to consider the local labour market conditions and the impact on wage rates required to attract and retain staff.	
Sickness absence	Providers are likely to build in allowance for sickness absence. Fees need to cover the cost of the SSP which is usually of the order of 1% of total costs but could be higher if not managed well and could indicate poor workforce morale.	Where the allowance for sickness absence is out of line with similar providers commissioners will wish to understand the reasons for this. Commissioners might challenge provider’s costs for paying statutory sick pay if they seem high and question what HR activity takes place to manage sickness. For example The Bradford Factor approach is commonly used to assess whether employee’s sickness records are reasonable.	
Recruitment costs	Will vary depending on turnover and expansion. Includes advertising, selection, interviewing, background checks and appointment costs.		

Cost element	Overview	Areas to consider and explore with providers	
Agency staffing	<p>Providers may need to build in an allowance for agency staffing, which generally incurs a premium. Providers typically seek to minimise the amount of agency staff, not simply on the basis of cost, but also due to the fact that it does not provide a good continuity of care.</p> <p>Agency costs may be shown separately from other staff costs in providers' financial statements.</p>	<p>Continued and significant use of agency staffing in an area may well indicate significant recruitment challenges which commissioners and providers need to work collaboratively to resolve</p>	
Training and development	<p>Training costs are a combination of the payments for the courses and the paid staff time required to undertake them. Skills for Care suggest that care workers in residential care should include training time of approximately 3% and should be considered for inclusion in contracts to the provider's wage bill.</p>	<p>Commissioners and providers might usefully come to an agreement how many hours or days of training care workers need in order to remain up-to-date and sufficiently skilled to meet their service users' needs.</p> <p>The council may also be able to achieve economies of scale by facilitating (free or low cost) training for care workers.</p>	

Non-staff costs

Many of the non-staff related cost elements involved in providing residential care can be classified under broadly the same headers as those in home care. But because, residential care – by definition requires property, there are some significant differences. Primary among these are the finance costs which are greater, because of the investment in land and buildings needed to provide the service.

A) Repairs and maintenance

Running a care home requires the building to be maintained to an acceptable standard. Just as in a domestic home, a certain amount of redecoration, renovation and repairs should ideally be undertaken regularly to maintain standards and retain the value of the property. There are also specific issues relating to buildings which are used to provide residential care which have an impact on costs.

- The sector is subject to certain specific guidance and regulations. Care homes must comply with national minimum standards and undertake repairs and maintenance accordingly. Regular inspections by the CQC look at the quality of the buildings, the fixtures and fittings and systems in place to audit and maintain these. For example, if carpets or flooring are worn or soiled they will be required to be replaced on the grounds of health and safety or infection prevention.
- A range of legislation governs the activities of care providers including infection control, fire, environmental health, safeguarding and equipment. There are costs associated with ensuring services are provided to a common standard, including the need to regularly service heating boilers and requirements to install and maintain a range of safety equipment e.g. window restrictors, radiator covers and temperature-limiting taps.

B) Food costs

Food is central to the health, well-being and satisfaction of care home residents and therefore the quality of the service. Age UK's Care Home Checklist, for example, devotes a full page to questions about food.³⁸

Care homes need to meet the nutritional needs of their residents and to consider specialist dietary requirements needs (e.g. where residents have trouble swallowing, or where there are cultural or religious requirements).

Different methods of supply and quantities purchased have an impact on per-capita costs. Larger providers may be able to achieve some economies of scale through bulk buy discounts. Some care homes purchase pre-prepared food which is chilled or frozen which results in higher costs of the food itself, but lower staff costs of preparing the food. When there are significant numbers of residents who require special diets then buying pre-prepared food can lead to a lower overall food bill, provided that wastage levels are managed.

C) Utilities and property tax and insurance

The costs of utilities (electricity, gas, oil and water) and property tax form will be familiar to most people, but there are some differences between care homes and other domestic settings, and consequently different cost implications:

- In addition to council tax, which is charged based on the value and size of the property, business rates will also apply if there is a separate management or administration building.
- Business tariff prices (which are lower than domestic prices) may be available for some utilities.
- Care homes need to be maintained at a higher temperature than the average home due to the frailty of the residents.
- The type and level of insurance required may be influenced by specific requirements set down in the commissioning contract.

D) Cleaning, uniforms, disposal, waste and care consumables

Care homes are subject to minimum standards regarding many of these categories of expenditure and they have a significant impact on quality. Provider accounts often group these costs together which can make it difficult to make accurate cost comparisons. Some commissioners request a cost breakdown from providers for any areas of expenditure which total more than 5% of the total costs.

E) Other areas of cost to consider

Other areas of cost are typically small scale, making up only a small proportion of costs. However, there are a few elements which are worth highlighting:

Registration fees (CQC) are based on the number of residents. The 2016/17 range of costs is £309 (up to three beds) to £15,499 (more than 90 beds), with for example a 60 bed home paying £8,673.³⁹

Overhead costs represent a range of different activities associated with running a business. Examples include accountancy fees, bank charges and IT costs.

³⁸ www.ageuk.org.uk/Documents/EN-GB/Information-guides/AgeUKIL5_care_home_checklist_inf.pdf

³⁹ Full details of fees are at www.cqc.org.uk/organisations-we-regulate/registered-services/fees

F) Capital costs and profit/surplus

Financing costs are not something that can be ignored. Providers report that a minority of commissioners are unfamiliar with capital charges and the implications for costs of provision.

Providing a residential service requires a building (or set of buildings). Buying or constructing buildings requires cash to be paid (invested); in exchange for this cash the business takes ownership of the building as a capital asset.

Cash is rarely available without a cost. Financing costs compensate the lender for the opportunities they have given up by no longer having the cash available. Even in the simplest scenario, where a care home owner-manager has purchased a single home using her/his own savings, there are capital costs: the owner-manager has foregone the opportunity to use that cash elsewhere, where they could have received a return (e.g. interest from the bank).

There is debate about whether prices paid for social care should cover financing costs after, say, a mortgage has been repaid. There are two considerations here:

- Prices required by the provider will have been informed by a long-term business plan for the organisation. This is likely to have assumed that a level of return is paid to the business owner after the bank loan has been repaid – i.e. very little profit may have been planned during the loan repayment period.
- It is important to ensure that the market is sustainable, with quality provision that meets local need remaining in place. If a reasonable rate of return cannot be achieved, then funds will be reinvested elsewhere. In other words, failure to pay a reasonable rate of return will encourage care home owners to sell their properties and invest elsewhere.

There are three main methods of financing residential care businesses, which result in different charging arrangements:

Loan finance

- Loan finance operates just like a domestic mortgage. There will be an arrangement fee on initial set up which will be repeated every five years. Interest will be payable at around 4% (2016 prices).⁴⁰ The capital repayments are usually over a 20 year term, but can be shorter, and the bank will require covenants.

Equity finance

- Equity financing is the process of raising capital through the sale of shares in a business. The business receives cash to buy the asset from investors who require returns on their investment.

Lease/rental arrangement

- Lease arrangements are where the owner of the building is not the operator of the care business. In such cases the property company will require rental payments on a monthly or quarterly basis.

The different rates of return which arise from the three main financing methods used and the way they are accounted for means that comparing finance costs and relative profit levels can be difficult.

Statutory guidance is clear that commissioners should understand that reasonable fee levels allow for a reasonable rate of return.⁴¹ The industry norm for comparing relative returns is earnings before interest, tax, depreciation, amortization, rent and management charges (EBITDARM), and many commissioners base their assessments on this but if in doubt it may be advisable to take expert advice from the council corporate procurement or finance teams or external organisations.

⁴⁰ Interest rates of 2% over Bank of England Base rate are typically available to experienced operators, subject to a 4% minimum (in 2016).

⁴¹ Department of Health (2016), Care and Support Statutory Guidance, paragraph 4.31. www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-4

The essential point for commissioners is that in order to assure themselves that fee levels support quality and sustainability, an allowance must be made for the costs of cash and for profit/surplus. If such allowances are not considered, it is not reasonable to expect continued investment and continuing services in the sector.

Checklist 4 – non-pay costs in residential care

Cost element	Overview	Areas to consider and explore with providers	✓
Repairs and maintenance	<p>Money needs to be allocated for repairs and maintenance for buildings, fittings and plant. This will depend on the age and quality of materials used and how old they are. Spend on repairs and maintenance is often not smooth with spikes of spending in some periods.</p>	<p>If challenging relatively high costs for these elements it is important to consider whether any particular large items of maintenance have occurred in the period, such that the need to spend on similar maintenance items should reduce for the coming few years. An example would be commercial laundry equipment, (washing machines and tumble driers) which have a life of about five years given the high degree of usage within a care home. Typically such equipment for a 40 bed care home will cost £20,000 (2016 prices). An equivalent domestic example would be the replacement of a boiler once every 10-15 years.</p>	
Food	<p>Comparisons can be made between providers to look at the cost per resident over a consistent time period e.g. food costs per resident per week.</p> <p>It is important to acknowledge that some residents may have complex nutritional needs which will need to be adjusted for in any comparison. Ideally, costs for special diets would be recorded separately by the provider; in the absence of this an adjustment for the proportion of specialist diets should be made.</p>	<p>Commissioners should consider:</p> <ul style="list-style-type: none"> ■ level of choice available to residents, special health or cultural dietary needs and preferences of people living in the care home. ■ Method of service provision (bought in pre-prepared or cooked on site). ■ Mix between hot and cold provision (e.g. cooked/cold breakfasts and lunches). 	

Cost element	Overview	Areas to consider and explore with providers	
Utilities	<p>The relative size of the home and the number of occupants for a particular size home will have an impact on the cost per occupant, a very large building is likely to have higher heating costs for example than a smaller one with the same number of occupants.</p>	<p>The extent to which energy saving measures are in place, for example low energy lighting, automatic light switching in closed rooms such as storage, and insulation.</p> <p>The age of a building will have a significant effect on the cost of heating, due to the different insulation standards required at the time the building was constructed.</p> <p>Whether the business has negotiated deals with utility providers and regularly checks what competitive prices are available.</p> <p>The average heating temperature the management aims to maintain.</p> <p>The arrangements for resident use of phones.</p>	
Care consumables, laundry and waste	<p>These are self-explanatory items.</p>	<p>It may be worth discussing which services are provided in house and which are contracted out, and the cost effectiveness and quality of current and alternative methods and suppliers.</p> <p>The provider may be able to negotiate deals with care consumable and service providers and achieve savings by regularly testing the market to ensure prices are competitive.</p> <p>There may be a value in exploring whether savings can be generated by working with local public sector organisations to access lower rates for items such as uniforms or office supplies.</p>	
Overheads	<p>This includes costs required to run any business, such as accountancy fees, bank charges and IT systems.</p>	<p>Where overhead costs are relatively high, it may be useful to ask for a breakdown to ensure that costs such as insurance or registration fees have not been grouped into this category. Once a comparable set of overheads has been established, comparisons between providers can be made to ensure all costs are covered, that all costs are reasonable, and where there may be scope for efficiency savings.</p>	

Cost element	Overview	Areas to consider and explore with providers	✓
Insurance	Providers usually buy insurance from brokers, who recommend the most cost effective option for the level of cover required. All insurance costs are covered including those which insure the provider against the actions or inactions of its workers. While there is some competition on price, the largest variation in cost often comes from the levels of insurance cover required by the local authorities.	It may be worth exploring with providers whether the current insurance is higher than is necessary. Checking that contracts require insurances are in line with industry standards can help providers reduce their insurance costs.	

LaingBuisson and ADASS both provide cost breakdowns, based on snapshots of actual costs, that may help understand costs in residential care. The figures are based on 2016 data, but the relative split between categories should remain a useful guide into the future. These are illustrative and helpful to indicate the range and levels of costs and is not intended to be definitive or used for actual fee negotiations.

LaingBuisson breakdown of costs in residential care

[note that this breakdown excludes rent]

Revenue cost head – sample breakdown	2016 – estimate <i>Illustrative</i>	
	Nursing £	Personal £
Nursing costs	151.74	
Care costs	201.75	201.75
Domestic and other hourly-paid staff	85.66	85.66
Salaried staff	31.58	31.58
Food	26.71	26.71
Utilities, phone, Council Tax	24.99	24.99
Insurance	4.94	4.94
Registration fees	3.47	3.47
Recruitment	2.73	2.73
Direct training expenses	1.89	4.18
Cleaning, uniforms, disposal, waste,	16.72	12.09
Travel, outings, TV	2.02	2.92
Externally purchased services	4.10	4.71
Other non-staff current expenses	13.04	13.04
Repairs and maintenance	39.03	39.03
General overheads	3.79	3.79
Total of these revenue costs	614.16	461.60

ADASS breakdown of costs in residential care

[note that this breakdown includes rent]

Residential care	2015/16 model	Uplifted rate 2016/17
Bed number	48	48
Occupancy	94%	94%
Beds filled	45	45
Cost heads per resident per week		
Care costs per resident		
Qualified nurse staff		
Care assistant staff (including activities)	160	176
Management/administration/reception staff	33	33
Catering, cleaning and laundry staff cost per resident	45	46
Training expenses	5	5
Registration fees and recruitment	4	5
Corporate overhead	25	27
Total staff	271	292
Accommodation costs per resident		
Food	26	26
Utilities (gas, oil, electricity, water, telephone)	10	13
Catering, cleaning and laundry staff cost per resident		
Handyman and gardening (on contract)	7	7
Insurance	5	5
Non-food supplies and rentals	4	4
Repairs and maintenance (revenue costs)	16	16
Rent and mortgage payment	92	92
Corporate overhead	8	8
Total accommodation costs	168	171
Total of these revenue costs (add assumed £151 for nursing care)	439	463

Costing techniques and value for money

There are a number of ways in which commissioners can use costing techniques to work with providers to agree prices for care which balance the need to achieve value for public money with supporting a quality and sustainable market. This section runs through some of the main methods by which a commissioner can work with providers to get this balance right.

Cost benchmarking

Comparing or benchmarking costs is a helpful means of understanding the relative costs of care in a particular area. Comparisons might be:

- between providers
- between local authorities, including similar authorities in different regions
- national and regional benchmarking.

It is important to understand that there might be legitimate reasons for differences in provider costs. For example, regional variations in staff pay rates and property prices will have a significant impact. When making comparisons, these differences should be minimised by choosing appropriate groupings and adjusting or making exclusions from the comparison sample; it is important to compare 'apples with apples'.

If using cost benchmarking it is advisable to undertake this on a regular basis as circumstances in the market change quickly and it easy for the prices within a given area to move out of line.

Open book accounting and local cost comparisons

Understanding the actual costs involved in providing care is key to establishing an appropriate price.

There are a number of ways in which commissioners can approach getting the cost information from providers in order to make comparisons and inform prices.

Open book contracting

Open book contracting is where the commissioner is given access to an individual provider's accounts which show the actual costs incurred. It can be harder to use when the local authority contracts with many care providers and is most often employed where there are substantial and/or variable purchases from a particular provider.

It can also provide positive outcomes in negotiating an individual's care package where needs vary – where sometimes the person needs care on a one-to-one, 24 hour-a-day basis, and other times a smaller care package meets their needs. In such a case, provider and commissioner may find it mutually beneficial to agree a schedule of prices which offers the provider a guaranteed margin above the agreed costs. The advantages are twofold: first, the local authority and the provider have aligned incentives to reduce costs, which could lead to savings that are greater than would have arisen through a straightforward single fee per day model; second, is easier to ensure the individual

receives a personalised service. Moreover, by working in this transparent, and mutually dependent way, it is easier to forge a positive, trusting relationship between provider and commissioner.

Use of agreed and accredited calculation methods

A range of national or regional costing tools are available to assist with calculations on the cost of care, including the Care Funding Calculator, the UKHCA costing model⁴², the annual report on unit costs of care published by the University of Kent PSSRU⁴³, and the LaingBuisson Care Cost Benchmarks toolkit (currently in its seventh edition, with former editions issued as 'Fair Price for Care').⁴⁴

When using tools it is important to ensure that the information used is up to date and that the assumptions which lie behind the tool are clearly understood by all parties.

Local cost collection

An alternative is to work with local providers to analyse costs locally in a cost collection exercise: the commissioner and care providers collaborate to agree a cost model and acquire the data to populate it in a consistent manner. The aim is to assess and compare actual local costs, as opposed to the theoretical costs used in national models, but to do so in a lighter touch and more manageable way than through full open book accounting approaches. The checklists provided in chapter 4 may be a useful in this type of approach.

Neither provider nor commissioner will want to agree to unacceptably low levels for any element in the cost model – for example, staff costs that do not account for oncosts, or fail to account for the impact of the local labour market conditions. Undertaking a local cost collection exercise may mean the local authority is better able to assure themselves and evidence the fact that staff are remunerated appropriately to retain an effective workforce and comply with the national minimum wage legislation.⁴⁵

This approach does entail a significant time commitment from local authority and provider staff involved. But, if the exercise is undertaken effectively, the costing analysis needs only to be fully updated periodically, say every three or four years. Inflationary adjustments can be used to update prices in the meantime; common indices such as RPI and CPI are often used, though an index linked to increases in minimum wage rates may be more appropriate.⁴⁶

Councils considering local cost collection exercises may want to bear in mind:

- providers' willingness to participate will be improved if there is a genuine belief that the exercise is open, fair and is likely to influence prices paid
- it is important to ensure any forms or templates used for providers to submit data are appropriate, accurate and function correctly
- existing data, routinely collected across the system, should wherever possible be used and where possible shared between organisations.

⁴² www.ukhca.co.uk/CostingModel

⁴³ www.pssru.ac.uk/project-pages/unit-costs/2015

⁴⁴ www.laingbuisson.co.uk/Portals/1/DataSales/Documents/CareCostBenchmarking_7ed_Bro_WEB.pdf?ver=2016-02-11-142617-863

⁴⁵ Care and Support Statutory Guidance, paragraph 4.30. www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-4

⁴⁶ The care sector is characterised by relatively low wages in which staffing makes up the bulk of the spending – wages are not included in CPI nor RPI measures and therefore do not closely match the costs involved.

For smaller authorities in particular there can be merit in undertaking such an exercise in collaboration with other councils, or indeed with other care commissioners such as CCGs. Consideration of existing working agreements should be made to ensure that: requests for information are not duplicated, CQC regulatory assessment activity and councils' procurement and commissioning activity are complementary, and that resources are used effectively and efficiently so that the administrative burden on providers and other parties is minimised.

Authorities using a local costing approach have found it a good way to demonstrate how provider costs have been taken into account when setting fees, as required by the Care Act; and to explain the rationale for fee uplifts in a way which provides assurance to their corporate colleagues and elected members.

Negotiating reasonable discounts for local authority purchasers

Debate continues regarding whether it is appropriate for local authorities to pay less for the same care than private individuals would pay if arranging the contract for themselves, or conversely, for providers to charge private individuals more than they charge for local authority funded clients. An important consideration is whether provision for state-funded and 'self-funded' service users is 'like for like', for example superior rooms in care homes may attract premium rates.

As in any procurement exercise, it is appropriate to discuss with providers the level of discount they can offer to reflect:

- high volume of purchases
- regular supply (reducing risk)
- prompt payment and secure cashflows, which reduces providers' financing/borrowing costs. (of course prompt payment should not be seen as optional; rather, while providers can reasonably expect prompt payment from councils, some providers report more delays in payment from self-funders)
- any opportunities available from collaborative working to reduce overheads and transaction costs.

However, local authorities have duties to support the overall sustainability of their market and would want to consider how their purchasing power may result in price differentials which, in the long term, endanger market sustainability. This is why, while it is reasonable for volume, or 'bulk' purchasers to negotiate discounts, fee rates and prices paid still need to be grounded in analysis of actual costs.

Where commissioners do negotiate discounts with providers, they will need to consider carefully the impact of such discounts on people who self-fund their care, and whether the local authority rates are made available to people in their area who self-fund. Local authorities have powers to meet self-funders' needs by arranging their care, and the statutory guidance to the Care Act emphasises that these powers should be used where someone's well-being would otherwise be adversely affected.⁴⁷ The council needs to consider the impact of any such decisions on the overall sustainability of the care market in their area, and their duties to maintain and improve this.

Tendering and contracting

The purpose of this guide is to help local authorities and commissioners better understand costs so that sustainable contracts can be arranged that deliver quality services for people with care and support needs. Whilst local authorities must have regard to statutory guidance on reasonable fees, provider organisations should themselves have an understanding of their own cost base and not routinely tender for contracts or offer to accept work at rates that are not sustainable in the long term.

⁴⁷ Chapter 10 and Annex H of the Care Act Statutory Guidance revised 2016 www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

CHAPTER 6

Conclusion

Council officers and elected members have the difficult task of ensuring that there is a sustainable local care market. This sustainability needs to work for providers, in terms of adequate return on investment and of being able to recruit and retain staff, and it also needs to work for commissioners, in terms of the quality of the service provided to people with care needs, value for money and affordability. This guide aims to support them in this task.

It is worth highlighting that any costing analysis is only part of commissioning and procurement, and while it can usefully inform discussion, engagement and negotiation between commissioners and providers, it should not replace them. To conclude, some best practice principles are given below:

Process

- **Engage with providers – maintain dialogue** and try to understand their concerns and views about.
- **Start early** – a considered costing approach can take up to a year or more to agree and implement; start at least a year before fee levels are due to be reviewed, in time for any changes to be agreed prior to the relevant financial year.
- Where possible without compromising commercial sensitivity or personal data, **share relevant information on numbers and costs** – transparency helps everyone to have a better understanding of historic and current and future supply and demand.
- **Innovate** – encourage, and be open to new ideas from providers and stakeholders, including people who use services.
- **Maintain an evidence trail for the benefit of providers, local authority elected members and the public** – it is important to document how decisions about fee rates have been made.
- Consider how to ensure there is **clarity about payment terms and the agreement process**.

Costing approaches

- **Where possible, reflect actual costs incurred** when agreeing fee rate changes, and use up-to-date, relevant analysis that reflect current circumstances.
- **Use a common way of determining earnings and measuring returns** – the industry norm is earnings before interest, tax, depreciation, amortisation and rent (EBITDAR) and so it should form the basis for any assessment of the returns that providers receive.
- **Incentivise desirable new development** – engage with providers to jointly consider what scope there is to apply incentives such as higher rates of return where additional provision is needed to meet local need.
- **Review approach to costings for working age adults** – consider making more use of the approaches applied for older people (e.g. cost modelling for care homes/shared living arrangements) and the scope for open book contracting for higher cost placements which usually are smaller numbers.

Procurement

- **Consider longer term arrangements** – providing greater certainty for providers' financial planning and avoiding the additional costs of annual negotiations.
- Be **clear about, and ready to discuss** terms of business, minimise transaction costs and make timely payments.
- Be **open to challenge** about the procurement process and respond to communications in a timely and comprehensive way.

People's wellbeing at the heart of every decision

- Engage in **proactive discussions** about the quality and the expectations of the local authority funded services at the agreed rates.
- When people's needs or preferences change, ensure **re-assessment** is readily available.
- Be alert to **provider intelligence regarding individuals' additional or reduced care and support needs** and the impact on costs involved in meeting needs.
- Keep in mind that everyone's care and support needs are different, and follow statutory guidance on **person-centred care and support planning**.⁴⁸

Above all, a good understanding of costs should enable an open discussion about care costs and fees between commissioners and providers at a local level. It is hoped that this guidance and these local discussions will lead to markets which meet the care and support needs of people, now and in the future.

⁴⁸ www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#person-centred-care-and-support-planning

APPENDIX A

Glossary of terms

Term/abbreviation	Meaning
Amortisation	Most commonly refers to the process of paying off a debt over time through regular payments. Can also be a term used to describe depreciation of an intangible (non-physical) asset such as goodwill or internally developed software.
Asset	A resource with economic value that an individual, company or public body owns or controls, and is expected to provide future benefit.
Capital	Capital refers to items which benefit the business over more than the current year, e.g. land, buildings or equipment. Capital expenditure or capital cost refers to the one-time expenses for the purchase of these items.
Cash	Readily available funds. For accounting purposes, cash includes money in hand, petty cash, and balances held in investments such as banks or building societies.
Cash flow	The money flowing in and out of a business in a given period. A negative cash flow (where the business is spending more cash than is coming in) can cause problems even if there underlying assets of the business are healthy, i.e. assets cannot be converted easily into the cash to pay bills due.
Company	A business organisation that makes, buys, or sells goods or provides services in exchange for money.
CPI	The Consumer Price Index is an internationally comparable index which measures changes in the price level of a basket of consumer goods and services purchased by households. It is the most commonly used inflation index.
Covenant	A promise that certain activities will or will not be carried out. Covenants in finance most often relate to loan terms and are put in place by lenders to protect themselves from borrowers defaulting on their repayment obligations as a result of financial actions which would be detrimental to themselves or the business.
Demand-led service	A service in which changes in demand are the main causes of changes in the level of provision and ultimately the cost. For social care demand relates to the number of people coming forward who are judged eligible to receive services. It is not legally possible to refuse to provide social care because the budget has been spent in the way that it is possible, for example, to order no more library books because the budget has been spent.
Depreciation	A reduction in the value of an asset over its lifetime e.g. public sector equipment is often assessed to have useful life of five years, its costs are therefore charged (spread) over this five year period rather than when it is initially bought. These regular charges which spread out the costs of the asset are referred to as depreciation.

Term/abbreviation	Meaning
Dividend	A share of the after-tax profit of a company, distributed to its shareholders according to the shares held by them. The amount of dividend is decided by the directors of the company.
EBITDA	Earnings before Interest, taxation, depreciation and amortisation. EBITDA provides a comparable measure between organisations which removes the distorting effects of financing decisions (e.g. interest paid), investment decisions (depreciation and amortisation) and taxation from the company profits. It provides a proxy measure of the amount of earnings which is due to the company through its operations in a particular period.
EBITDAR(M)	Earnings Before Interest, taxation, depreciation, amortisation, rent (and management). EBITDAR and EBITDARM are measures equivalent to EBITDA which seek to provide good comparisons between care providers overall financial health, by removing the impact of rentals and in the case of EBITDARM, company management charges.
Economy of scale	The cost advantage that arises with increased volume, in the care sector typically by spreading fixed costs over a wider base.
Financing costs	Costs associated with paying for the assets of the business. These costs are incurred as charges resulting from accessing funds. The most common example is bank interest.
Goodwill	The value placed on a company beyond what could be sold separately, such as property, products, patents or brand names: effectively, the intangible asset of the company's reputation.
Guarantor	A person who guarantees to pay for someone else's debt if he or she should default on a loan obligation.
FNC	Funded nursing care: the NHS will pay a flat rate contribution directly to the care home towards the cost of registered nursing care.
Holding (or parent) company	One which controls, through majority share ownership, one or more subsidiaries.
Independent sector	Term used to refer to both private and voluntary sector providers.
Limited company	A private company, in which the owners are legally responsible for its debts only to the extent of the amount of (share) capital they have invested in it
Margin	Used interchangeably with profit margin, meaning an uplift of prices (income) over costs providing a profit or rate of return.
Monopoly	Market with many buyers but only one seller, such that buyers may have unreasonable prices forced on them.
Monopsony	Market with many sellers but only one buyer, such that providers may have unreasonable prices forced on them.
National Insurance (NI)	Contributions made by UK workers towards the costs of certain state benefits. NI is collected from employees and employers by HMRC.
Oncosts	A cost incurred by an employer has when they employ someone, in addition to the cost of paying the person's salary or wages. Oncosts include pension contributions and employers' National Insurance contributions.

Term/abbreviation	Meaning
Out of pocket expenses	An amount paid for by an employee on behalf of an employer which is later reimbursed e.g. bus fare for travel between care appointments.
Parent (or holding) company	One which controls, through majority share ownership, one or more subsidiaries.
Profit	The financial benefit which results when the amount of income from a business activity exceeds the expenses, costs and taxes needed to undertake the activity.
Rate of return	The annual income from an investment expressed as a proportion (usually a percentage) of the original investment.
Revenue	Used both as a term to mean ‘income’ for an individual or business and as shorthand for day to day income and expenditure. All income and expenditure is classified as revenue unless it meets the definition of.
RPI	The Retail Price Index (RPI) is a measure of inflation which measures the change in the cost of a representative sample of retail goods and services. It has now been mostly replaced by the CPI which excludes a range of elements such as mortgage interest.
Subsidiary	A company which is controlled by a parent (or holding) company which owns the majority of its shares.
Surplus/deficit	Public bodies tend to plan for a balanced budget, in which spending equals revenue. If income exceeds spending, that generates a surplus (the term ‘profit’ is not used except for any trading organisations owned by public bodies), which is added to balances. Where expenses exceed income, this results in a deficit, which will normally be covered from reserves.
Unit cost	The average expenditure incurred in producing one unit of a good or service, e.g. an hour of homecare or a week in a care home.
(Un)limited liability	Liability relates to the extent to which individuals such as shareholders or partners are personally responsible for the debts of the company. Limited liability means that recovery of debts is limited (restricted) at a particular level, e.g. shareholder contributions are limited to the value of their shares. Unlimited liability e.g. for partnerships means that the partners are required to pay the debts of the business personally.
Viability	A business’ ability to generate sufficient income to meet its operating expenses and financing costs, as well as providing the potential for future growth.
Winding up	The process of selling all the assets of a business, paying off creditors, distributing any remaining assets to the partners, shareholders or guarantors and then dissolving the business.

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- Care Providers Alliance: info@careproviders.org.uk

