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Financial review of the domiciliary care market in Jersey to establish the costs of independent sector services and provide options for standard pricing tariffs

FINAL REPORT

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1 EXECUTIVE SUMMARY

1.1 Government of Jersey objectives

In common with social care funding agencies across the developed world, Jersey's Long Term Care Fund (LTCF) faces significant pressures from substantially increased demand in the years and decades to come.

When the LTCF was established in 2014, the majority of long term care provision was residentially based and whilst nursing agencies were regulated, there was no regulation of domiciliary personal care services. This regulation was established by Jersey's Regulation of Care Law[1]. The Long Term Care Scheme (LTCS) is the scheme through which the LTCF is distributed to those who require care. It is currently funded through both central grants, and income-related contributions from income taxpayers.

The LTCS provided financial support for domiciliary care to all adult age groups for the first time and the Regulation of Care Law was brought into force in 2019, introducing the first regulatory framework for domiciliary care services.

Given the small market and the lack of regulation, the initial operation of the LTCS for domiciliary care providers was designed to support the development of the market, and providers were not constrained in their fee levels, other than to remain within the limit set by the Resource Allocation System. This has featured in LTC administration from the beginning but this has been used to set an overall care budget for a client with considerable flexibility afforded to individual care providers as to the fees charged against individual types of care within the overall budget available. This flexibility has also meant that the concept of co-payments has not been properly embedded within domiciliary care package funding.

Since 2014, the local care market has changed considerably. Many more care packages are now provided through a growing number of domiciliary care agencies and increased public expectation that care can be delivered safely and appropriately in one's own home.

Jersey's Long-Term Care scheme assists with the support of residential and home care costs for approximately 1,600 Islanders. Most of these individuals (approximately 1000) are receiving care in residential homes with the other 600 in receipt of domiciliary care – this is the section of the market that this review is focused on. With more people living longer, and Government seeking to encourage people to receive care in their own home for as long as possible, this shift towards greater care in the home, will mean this cohort will expand in the coming years – threatening the sustainability of the current approach.

[1] Regulation of Care (Jersey) Law 2014 (jerseylaw.je)

The flexibility that featured in the early development of the LTCS and helped the domiciliary care market grow to its present level, now presents challenges to the further development of a sustainable domiciliary care market. Whereas co-payments are an accepted and common feature of residential LTC packages, they have not been in regular use in domiciliary care packages. This creates the potential for inequity between users of residential LTC packages and uses of domiciliary care LTC packages, alongside the differential fee rates supported through the LTC scheme.

In looking to a sustainable future model, the Government of Jersey remains committed to the essential principle that all care provided through LTCS should be of a good standard. The LTCF will provide a contribution to the care costs of anyone who qualifies for the benefit and will ensure that the care available is of an appropriate level to meet the assessed needs of the claimant. However, people who receive care are not passive and have the opportunity to engage dynamically in their own care. It is appropriate that individuals, as active consumers, can choose their own care provider and make a contribution to their own care costs should they choose to do so. There will be a proportion of claimants who will not have the means to do this and, in order to ensure a functioning domiciliary care system, consideration should be given to whether providers should be required to accept a number of “standard” LTC packages, alongside packages where people choose to make a co-payment for their care, as a central element of a sustainable market.

The Government of Jersey commissioned LaingBuisson Ltd to undertake a financial review of the domiciliary care market, to establish the costs of services supplied by independent sector providers and provide options for standard tariffs based on this data, see Appendix 1, Remit.

LaingBuisson’s review looks at the current domiciliary care market with a view to improving ongoing sustainability by considering the introduction of standard domiciliary care tariffs based on local evidence. Its direction is informed by the structure of care provision within the existing residential care market, and the aim to provide government funding at a level that maintains the market, and that allows low income claimants to receive an appropriate package of care based on the tariff rates, whilst allowing other claimants to choose a package of care that may involve an additional co-payment.

1.2 Market characteristics

Key features of the domiciliary care market in Jersey include:

- Market value of approximately £20m per year, public and private funding combined.
- Predominantly publicly funded.[2]
- Expanding volume of demand, which is projected to continue to grow significantly to 2040. Older adults aged 65-79 to increase to 20,275 (+6,931), and those aged 80+ increasing to 8,518 (+3,198) by 2040[3];
- Rapid growth in LTC funded domiciliary care costs since the LTCS started in 2014.
- Prices in domiciliary care are variable, with providers charging a variety of rates.
- Limited price competition, as LTCF consumers are sheltered from payment and the 3rd party payor (LTCF) does not currently use its purchasing power to actively manage supplier prices. Rather, the total cost of the care package is constrained by a maximum value per care level and the outcome of the Resource Allocation System for the specific care package.
- Fewer domiciliary care service users per unit population in Jersey than in the UK[4], mainly due to the Jersey population's much higher use of residential care than in the UK.
- Small average client list – service users per agency half the UK level.[5]
- Fragmented supply, with potential for consolidation.
- No large-scale providers and probably limited financial capacity for investment, unlike the UK where there are many providers with access to substantial capital.
- Constrained supply chain (availability of labour), as in the UK.
- Limited visibility of travel time as a component of staffing costs, as in the UK.
- Regulation of care providers, including requirement to register with the Jersey Care Commission, introduced in 2019, as in England where the Care Quality Commission (CQC) is the regulator of domiciliary care and other health and social care services.

[2] Service users wholly or partly funded by LTCF are estimated at over 80% of all publicly and privately funded service users ('UK comparisons' tab of the Workbook).
[3] Government of Jersey Long Term Care Fund Actuarial review as at 31 December 2021
[4] 'Jersey UK comparisons' tab of Workbook
[5] 'Jersey UK comparisons' tab of Workbook

1.3 Economic model

Our conclusion from a review of the market is that the existing model of LTC domiciliary care funding in Jersey is not well suited to achieving optimal pricing structures from the perspective of LTCF. It is an essentially open-ended social insurance model and whilst care packages in domiciliary care are capped at the maximum equivalent residential care level, there are limited controls on prices set by independent sector providers which are the dominant suppliers of domiciliary care in Jersey.

1.3.1 Absence of price competition in the LTCF funded market

A key feature of the market is the absence of price competition in the majority LTCF funded segment. Care needs are assessed by a Social Worker and then costed using the "RAS" system. Currently, this system uses a fixed standard hourly rate, with the upper limit of any care package being set at the maximum benefit level that is included in LTC legislation. However as previously outlined, providers actual rates vary. Under RAS, domiciliary care is 'priced' at £29 per hour (in 2023), this creates an indicative price for administrative purposes and the rate of £29 is not imposed on the hourly rate charged by providers. At present, LTCF pays providers' valid invoices on behalf of LTC claimants as presented up to the maximum weekly amount available, and there is no additional mechanism which constrains providers' pricing decisions, other than in 2023 and 2024 when providers have been restricted to a percentage uprate based on their 2022 rates LTCF data show that actual prices range from £26.88 per contact hour for the least expensive provider to £35.01 per contact hour for the most expensive in 2023, Table 3. Absence of price competition is one possible explanation (though not necessarily the only one[6]) for the high degree of variance in the price per contact hour of domiciliary care.

1.3.2 Possible sub-optimal deployment of care staff resources

A linked feature of Jersey's domiciliary care market is that it probably makes inefficient use of visiting domiciliary care staff resources as a result of sub-optimal travel paths between clients. Travel time and expenses are a material element of visiting domiciliary care costs. Together they are estimated to

[6] This degree of price variance is higher than would be expected in any 'commodity' market, though homecare is not a commodity and price variations between providers may be explained by reasons other than efficiency or profit margin. Aside from quality of care, the basic metric of price per contact hour is determined by travel time and the distribution of visit lengths, both of which can vary between providers and potentially explain price variation, in part at least. However, we cannot take the analysis any further in the absence of hard data on the distribution of travel times and visit lengths among different providers.

account for 12% of average costs per contact hour, see Workbook, 'Cost Structures' tab. In the UK, it is well known that fragmentation of domiciliary care employers, with overlapping catchment areas, can mean that the travel paths of individual care workers frequently cross each other, leading to sub-optimal use of the scarce labour resource. Sub-optimal deployment of scarce visiting care resources, to the extent that it exists, raises both travel time and travel expenses. LaingBuisson found no direct evidence of the phenomenon in Jersey, but we would be surprised if it were not to exist to a similar extent as in the UK.

1.3.3 Sub-optimal scale of providers

We estimate that the average number of service users (LTCF-funded and pure self-funding[7] combined) per service is only 28 in Jersey compared with 46 in the UK, which itself is viewed as fragmented with large numbers of sub-scale businesses. In principle, there may be potential efficiency gains to be derived from modifications in the LTCF funding regime which encourage consolidation among businesses serving the LTCF funded market, such as to spread more activity over providers' fixed and semi-fixed overhead costs[8]

1.3.4 Ability of domiciliary care providers to control their costs

Domiciliary care providers are constrained in their ability to modify much of their cost base. They can exercise significant control over business overheads, travel time/expenses and profits. But the degree of discretion they can exercise is limited for pay rates and on-costs (which together usually account for the majority of costs). The reason for highlighting this point is that this report's recommendations on standard tariffs and cost sharing are based on the premise that there is scope for efficiencies in domiciliary care and it is important in the analysis to understand where efficiency savings may plausibly come from. The co-payment reform proposed in this report is one way of driving efficiencies as it will create a more equitable system for providers and "balance" the market creating a level playing field. The LTCS was designed to provide support for care costs, with the expectation that in some cases, top-up payments would be required (this is how the system works in Residential Care). There are established examples in Jersey of islanders receiving a subsidy from the Government to cover some of the cost towards a service, but the final cost of that service is determined by the provider e.g. General Practitioner services. In essence, people claiming LTC will receive the same standard contribution towards care costs (from Government) with variation

[7] Self-funders include people who are not eligible for LTCF support, such as those in the waiting period, as well as people who are eligible for LTCF support but prefer to arrange their own care and pay for themselves without any support from LTCF

on the exact package depending on care level but providers will be afforded the flexibility to offer those services at whatever rates they like with the expectation that if that rate is higher than the standard LTC rate, top-up will be required.

1.3.5 Potential efficiency gains

In summary, there are potential efficiency gains from minimising travel time and expenses and scale economies in the delivery of domiciliary care services. Providers, acting individually, may have limited incentives or discretion to realise such latent efficiencies. They could, however, be further incentivized to do so as part of a move towards tariffs and co-payment in the domiciliary care sector. Efficiencies may be driven by other initiatives as well, including the new pilot brokerage scheme.

We are unable to quantify such potential efficiency gains but in principle any released value may be shared between providers (in terms of lower costs per contact hour) and the LTCF (in terms of more stabilised prices than are presently paid).

The foregoing analysis of the existing model of domiciliary care funding and delivery in Jersey leads to some general recommendations, which are further fleshed out in the body of the report:

In considering the existing economic model and the potential for modifications, LaingBuisson proposes principles to underpin future considerations of the LTCF funding design. The design of the LTCF should:

- **promote price competition among providers by adopting a standard level of LTC contribution towards care packages, and factoring in a margin for profit, supplemented by top up levels set by individual providers.**
- **encourage consolidation, or cooperation among providers, to yield such economies of scale as potentially exist.**
- **promote efficient deployment of visiting domiciliary care staff, as regards travel time and expenses,**

It is vital that there is a collaborative approach between Government and the sector to ensure a sustainable and equitable care market as the value of any efficiency gains could in principle be shared between providers and LTCF.

1.4 Survey of providers

To obtain baseline data, we conducted a survey of the costs of 29 domiciliary care providers operating in Jersey. We engaged intensively with the provider community, following the methodology used by LaingBuisson in similar cost of care exercises in the UK. At the end of the process, we were able to obtain useful information from 14 survey respondents on three key data categories: - numbers of care staff employed; carer and senior carer gross pay rates for visiting care services; and average hourly charge-out rate for visiting care services. While there were many gaps in the information we sought to gather, this was the first time that such an exercise had been carried out in Jersey and the response for the three key data categories was within the range achieved in similar cost of care exercises carried out by LaingBuisson in the UK.

We supplemented data gathered in Jersey with information gathered in recent cost of care work undertaken in England, where the structure of the supply side of the domiciliary care sector is similar[9]. There is reasonable read-across in some areas where English data is richer than Jersey data. In particular, we are able to use detailed costs which were submitted by domiciliary care providers in the DHSC mandated 'Fair Cost of Care' exercise carried out in England during 2022. We have also taken account of domiciliary care cost structures published by the Jersey Care Federation (for Jersey) and the Homecare Association (for the UK). The two follow the same format and the former draws on the latter for some cost lines.

1.5 Indicative costs per contact hour of visiting domiciliary care

In the 'Cost Structures' tab of the Workbook, we have developed an interactive model for calculating indicative costs per contact hour in 2023 for visiting domiciliary care delivered by staff with different skill levels – £31.17 for carers and £34.53 for senior carers. These indicative costs (including a 5% benchmark allowance for profit) are based on assumptions that are appropriate to the objective of supporting independent sector provision of visiting domiciliary care for LTCF claimants who, according to means testing rules, do not have sufficient resources of their own to pay for domiciliary care privately. Key parameter cells, which can be varied to test the effects of modified assumptions, are colour coded yellow throughout the Workbook.

[9] While the demand side is very different. UK councils commission social care directly and typically seek to bear down vigorously on provider prices, in contrast to Jersey which has opted for a brokerage model.

1.6 Indicative costs per visit of visiting domiciliary care

'Cost per contact hour' for visiting home is a useful metric, but it cannot be made operational as a basis for paying providers of visiting domiciliary care unless it is expressed as a rate per unit of activity, calculated for 15, 30, 45 and 60 minute visits separately, or whatever other visit time options exist in Jersey. This is not just a matter of dividing the 'per contact hour' indicative costs by four or two for (for example) 15 and 30 minute visits. Data from the English Fair Cost of Care exercise of 2022 confirm that nearly all English councils take account of travel time per visit in their fee schedules, meaning that short visits attract a substantially higher tariff rate per contact hour than long visits. Most visits in Jersey are based on hourly slots.

A further interactive model has been constructed in the 'Cost variance by visit length' tab of the Workbook. The model calculates a schedule of indicative costs **per visit** for visiting domiciliary care in Jersey, drawing on indicative costs **per hour** in the 'Cost Structures' tab. For reference, we have used English Fair Cost of Care data on median travel times between visits as a proxy for unknown Jersey travel times, however it should be noted that Jersey's comparatively small size means that any direct comparisons to the UK may not be appropriate. Jersey's size does mean there is scope for efficiency in terms of which provider provides services where, though.

The resulting schedule of indicative provider costs by visit length and skill level for visiting domiciliary care in Jersey is presented in Table 1.

1.7 Indicative costs per hour for sessional /shift based domiciliary care

A minority of LTCF funded domiciliary care activity is delivered as sessional or shift-based care, including waking night-time care and sleeping night-time care. Shift sessions can vary widely in length. Therefore, for the purposes of setting tariffs, provider costs are best expressed on a **per hour** basis, rather than per visit.

Indicative cost per hour for shift-based domiciliary care are calculated in the interactive model in the 'Cost variance by visit length' tab of the Workbook (alongside indicative costs per visit for visiting domiciliary care). The key assumptions in the interactive model are:

- Based on experience in the UK, gross pay rates for waking night-time care are similar to day-time visiting care (per working hour – after stripping out the travel time distortion). Employers do not have to pay a premium for unsocial hours. We assume that the same applies in Jersey.

- The norm in the UK is for sleeping night-time care to attract lower rates than waking care. Many employers pay National Living Wage for sleeping care. In the absence of data from Jersey, we have assumed that sleeping night-time care on the island attracts gross pay of approximately 15% higher than the Island's 2023 minimum wage of £10.50 per hour i.e. £12.10 per hour.

- Employers in the UK do not pay travel time or travel expenses for shift-based care. We have assumed that this applies equally to Jersey, meaning that this component of cost can be ignored when calculating a schedule of tariffs adequate to support fully means-tested claimants.

- The resulting schedule of indicative costs (or tariffs) is presented in Table 1, for both visiting and shift-based domiciliary care services. The schedule as it stands is illustrative, pending entry of the actual distribution of LTCF funded hours by visit length in the 'Cost variance by visit length' tab of the Workbook. Following that, Table 1 stands as our proposed LTCF tariff schedule under the proposed co-payment reforms.

Table 1 Illustrative tariffs for domiciliary care delivered by independent sector providers in Jersey, 2023

Indicative cost **per visit**	Carer	Senior carer
15 minute	£10.24	£11.27
30 minute	£17.05	£18.85
45 minute	£23.85	£26.43
60 minute	£30.66	£34.02
Indicative cost **per hour**		
Waking shifts	£27.22	£30.43
Sleeping shifts	£24.78	£24.86

Source: Section 6.2, Table 7[10]

[10] The numbers in Table 1 are illustrative. Pending receipt of data on the actual distribution of LTCF funded visiting domiciliary care visits by visit length we have assumed that the great majority of domiciliary care visits are of 60 minutes' duration. Actual data on the distribution of visit lengths, if available, should be entered in cells B37:B43 in the 'Cost variance by visit length' tab of the Workbook, and the illustrative tariffs in Table 1 should be overwritten with results in rows 81-88 of the 'Cost variance by visit length' tab.

1.8 Indicative costs of other domiciliary care modalities

The proposed tariff schedule is believed to cover the bulk of LTCF spending. There will be a residue, however, which does not lend itself to tariffs. This will include bespoke night-time shifts which are part waking and part sleeping. It will also include live-in care, which typically has bespoke characteristics. In addition, we have been unable to access data on provider costs for live-in care and little UK data is available to us to use as a proxy for Jersey.

1.9 Options going forward

We understand that the Government of Jersey wishes to establish standard domiciliary care benefit rates payable by LTCF at a level that supports a sustainable market. The LTC scheme is designed to support a good standard level of care for anyone that uses the scheme. The scheme is based on the premise that providers may charge whatever rates they like, giving people claiming the benefit a choice in the provider they use, on the understanding that Government will provide funding at a standard level and if they want to use a more expensive provider, they will "top-up" the difference. In terms of people that do not have the means to pay top-up, Government needs to ensure that the agreed "standard benefit rate" can be supported across the overall market, acknowledging that a claimant in this position may not be offered a choice of providers. This is the model that is used across the residential care market and has operated successfully over the last ten years.

As such, we have focused attention on that broad option and on the steps that the Government of Jersey might take to realise that objective, including revision of the Approved Provider Framework Agreement, and the associated risks and mitigations.

The heart of our recommendation is that Jersey's Approved Provider Framework Agreement should be amended so that benefit claims are paid based on a fixed schedule of rates (these have been provisionally set out in Table 1, for the principal modalities of domiciliary care). The remainder of LTCF funded services are characteristically bespoke and are unlikely to fit well in a tariff schedule.

The other broad option that the Government of Jersey might have considered is replacement of the Approved Provider Framework Agreement by competitive tendering. At present, it is our understanding that the Government of Jersey wishes to continue to operate the existing brokerage model in Jersey and so LaingBuisson has not considered competitive tendering as an option it wishes to explore. For the record, we describe the advantages and disadvantages of competitive tendering in Appendix 2.

Tendering is frequently used by local authorities in the UK as a means of obtaining keener prices and reducing reliance on fragile micro-businesses. Typically, local authorities seek to negotiate cost and volume contracts with a small number of providers, often offering contracts to be a lead provider in a defined area. We are not aware of any UK council that has contracted the entirety of its domiciliary care to a single provider. Typically, local authorities offer spot contracts to a wider set of approved providers in parallel with any block (cost and volume) contracts they have negotiated. Some risk averse local authorities have negated the whole purpose of block contracts by not offering volume guarantees to main contractors and allowing activity to 'leak out' to spot contracting.

LaingBuisson Recommendations

1. We recommend that the Jersey's Approved Provider Framework Agreement should be amended so that benefit claims are paid based on a fixed schedule of rates. Provisional fees for the principal modalities of domiciliary care have been set out in Table 1.
2. We recommend that the tariff schedule should be introduced with an eye to:
   a) Incentives to promote provider efficiencies, focusing on the two drivers of cost that providers are most able to influence:
      - Economies of scale, achieved by spreading larger volumes of activity over back office costs, whether by encouraging mergers and acquisition or, more informally, through lead provider models and provider partnerships.
      - Optimization of travel times and expenses of visiting care staff, by examining scheduling arrangements (including live software/ data/ analytics), shared recruitment initiatives and shared training / development approaches. Opportunities may also exist for an integrated approach to domiciliary care between commissioned services and those that are directly delivered.

   b) Mitigation of perverse incentives for providers to 'game' the system in response to margin pressures, for example by 'clipping' visits (the term used in the UK for the practice of cutting short visits before the full contracted time has expired, in order to move to the next client)

   c) Mitigation of the risk that newly introduced tariffs may be set too low to assure access for means-tested claimants. Such mitigation is likely to require enhanced, proactive brokerage and transitional arrangements to any new pricing model as well as a collaborative approach between Government and providers.

We do not recommend blanket tariff rate enhancements. Case by case enhancements, with a high bar for providers to access such enhancements, are likely to be more efficient, though requiring a greater brokerage resource.

2 THE BROADER CONTEXT FOR REFORM OF DOMICILIARY CARE SERVICES IN JERSEY

The following sections comprise brief, high level reviews of issues that the Government of Jersey wishes to address in parallel with the Fair Cost of Care exercise.

2.1 Quality of care

The Government of Jersey wishes to shape the domiciliary care market to enhance quality of care and build resilience and better outcomes, moving towards a more equitable and sustainable care market. It wishes to progress work on a reablement pilot and offer more TEC (assisted Technology), with the aim being to help keep people living at home and as self-sufficiently as possible, ideally delaying the need for them to move into institutional care.

The levers available for market shaping are at present relatively limited in Jersey. In principle, looking to experience in England, there are three basic approaches to quality enhancement: via commissioning, regulation and reliance on consumer choice. Currently, the Government of Jersey operates a brokerage model for domiciliary care, which limits the range of proactive quality promotion measures that might be implemented in a commissioning model.

Regulation of domiciliary care is carried out by the Jersey Care Commission (JCC). JCC regulation has much in common with CQC regulation. Inspection reports are published on the JCC website, and it is notable that all but 3 of the 37 domiciliary care services listed had an inspection in the last year. One major difference, however, is that JCC does not publish a rating for each service, whereas CQC in England publishes a rating (Outstanding, Good, Requires improvement or Inadequate) for each of five domains (Safe, Effective, Caring, Responsive to people's needs, and Well-led) plus an overall rating.

As regards consumer awareness and choice, service users and their families in Jersey can inspect JCC reports, but they are less user-friendly and informative than they might be because of the absence of ratings. It is also notable, that customer reviews on UK care service comparison websites (such as Autumna and Lottie) are not well populated with Jersey domiciliary care services, suggesting that consumer information via that route is less well developed than it is in England. Jersey is too small to make developing its own comparison website commercially viable. In the absence of JCC ratings, and limited Jersey coverage in the UK comparison platforms, people in Jersey are more likely to have to rely on informal sources of information on domiciliary care service quality, such as word of mouth.

In summary, improving domiciliary care quality and outcomes in Jersey is likely to require a multi-faceted approach by the Government of Jersey. It will be rendered more achievable if addressed in parallel with the co-payment options proposed in this report.

2.2 Affordability of care

It is necessary to achieve more equitable and sustainable control over the Government of Jersey spend on care services in Jersey, as the population ages and underlying pressure of demand grows. The co-payment options proposed in this report will foster cost awareness, which is lacking under the existing funding regime. They will also strengthen incentives for users of LTC funded domiciliary care to look carefully at prices.

2.3 Policy and strategic context

The lack of a commissioning function and the status of domiciliary care as a benefit limits the Government's ability to quickly pull levers that shape the market. The establishment of a standard rate and embedding of the principles of co-payment in domiciliary care are a good starting point to address this.

2.4 Collective responsibility for care

Jersey appears to be very risk averse with a high level of safeguarding. Responsibility for care needs to be shared with a shift in mindset to one of collective responsibility – involving an educational and culture recalibration so that Jersey residents better understand how they can contribute to their own wellbeing.

2.5 Relationship between LTCF / Government of Jersey and domiciliary care providers

When the LTC scheme was established, it was an accepted risk that whilst the LTCF ensured the provision of benefit payments to Islanders for their care, there was a risk that if non-care services were not prioritised by Government (for example, re-ablement services or support for low level care e.g. below LTC care level 1) it could result in a "feedback loop" meaning an increased need for care. The government has only recently implemented a brokerage pilot scheme which facilitates win/win positions with providers. Further development is needed in terms of personalisation and choice for those who choose to spend more or by incentivizing providers to work in partnership and assist with reabling people.

2.6 Productivity

Jersey needs its social care workforce to be tapping into what is known to work - strength-based approaches that place prevention and community capacity (alternative provision also including TEC) as their core offer.

Domiciliary care productivity within the existing 'payment per hour' model may be addressed through incentives (e.g. financial incentives embedded in revised contracts) and operational controls (e.g. using technology to monitor actual attendance for billed hours).

The Government of Jersey should also note the emergence of an entirely different vision surrounding the potential for domiciliary care. This model has been proposed by movements within the caring professions, often with an international dimension. A common feature is a reliance on more highly paid staff to exploit a variety of informal community resources. Part of it is mobilising low or zero cost community resources, and part is to do with 'coaching' individuals and their families to make better use of these resources as well as their own. They claim that despite higher paid staff it is possible to deliver better outcomes at an overall cost which is lower than traditional services.

One model is Local Area Coordination (LAC). It was first developed in Western Australia in 1986 where, according to proponents, it has proved highly effective. In the UK it is being championed by the Centre for Welfare Reform.[11]

Another, better known model is 'Buurtzorg', which originated in the Netherlands. It is a nurse-based model, delivered by groups of self-managing nurses, but is capable in principle of extension to senior carers without a nursing qualification. Its principles are described in a Guardian article in May 2017[12]. The model is promoted in Britain by Buurtzorg Britain and Ireland.[13] It has gained some traction with about 30 collaborations.

2.7 Continuing evolution of domiciliary care pricing strategies

The Government of Jersey should work towards identifying a 'fair cost' of care for a right-sized model. This would require analysis that examines the local economics of delivering sustainable domiciliary care and creates a framework for delivery at a workable market price, whilst driving efficiencies internally within a transparent and equitable governance framework and ethical commissioning model.

[11] http://www.centreforwelfarereform.org/news/local-area-cch-published/00226.html
[12] https://www.theguardian.com/social-care-network/2017/may/09/buurtzorg-dutch-model-neighbourhood-care
[13] https://buurtzorg.org.uk/

- Opportunities should be examined for an integrated approach to domiciliary care between commissioned services and those that are directly delivered. This could include examining shared scheduling arrangements (including live software/ data/ analytics), shared recruitment initiatives and shared training / development approaches, see Section 1.9. Also, better collaboration between providers and opportunities for the amalgamation of providers.
- There is a need for a clear delineation of what requires formal care in terms of complexity of need, and that which may be redirected to alternative provision from the community - culture, processes and market reshaping will need to be addressed to achieve this.
- There should be an examination of how the external market is best shaped, managed and incentivized to reflect delivery priorities. For example, you may want to consider lead provider models, provider partnerships and/or brokerage; when combined with a reablement ethos this can create significant culture change and support better demand management, see Section 1.9.
- The Government of Jersey should prioritise and review its approach to reablement which can recapture capacity, deliver better outcomes for individuals and reduce the levels of drift into early complex care dependency. Long term residential care should be examined is being used to ensure the right care is being given at the right time and in the right way.

Completing all of the above will support development of a draft pricing framework that enables providers to remain competitive in terms of recruitment and business sustainability, but within an affordable and equitable pricing framework - focusing on a move towards sustainability.

2.8 Future areas of focus

The following is a summary of topics that need to be kept under continuing review as the co-payment proposals in this report are implemented.

Theme	Key Question	Proposed Action
Care	What care do Islanders need to achieve good outcomes, and mitigate future demand?	Forecast future needs under different care models and engage stakeholders to understand the perspectives of domiciliary care providers, staff and people receiving care, informal carers and their families.
Contracts / Commissioning	How should care be commissioned across providers to drive affordable and high-quality care?	Baseline commissioning and contract management across the system reviewing strategy and contracts. Assess capacity for alternative provision and procurement routes.
Strategy/Policy	How does the strategy prioritise prevention, reablement and strength-based approaches?	Review current strategy, operating model, and policy context to engage stakeholders to understand how well the current model defaults to these approaches.
Performance	How can the operating model and key business processes be changed to deliver more care with the same resources?	Model in-house and provider service provision to identify opportunities and engage with providers to build insight and confidence to help shape potential solutions.
Workforce	What are the key challenges to the carer workforce, and what levers could be used to strengthen the labour market?	Analyse and model the Jersey labour market, perform benchmarking and engage with stakeholders to identify suitable recruitment, retention and upskilling levers to use.

3 ANALYSIS OF THE DOMICILIARY CARE MARKET IN JERSEY

The domiciliary care market under review consists of the delivery of personal care and assistance with activities of daily living such as bathing, grooming, dressing and eating to adults (aged 18 years or over) in their own homes, whether by visiting carers (the bulk of activity) or live-in care (a minority of activity). The definition excludes healthcare services delivered by medically qualified staff or professions allied to medicine, as well as all children's services.

Eligible residents are entitled to financial support from Jersey's Long Term Care Fund (LTCF). Financial support begins immediately for those passing a means test, with assets valued at up to £419,000 and after a waiting time of between about one and three years for other claimants.

Key features of the domiciliary care market in Jersey, which are relevant to this report, are listed below. See Table 2 for supporting data and comparisons with mainland UK.

a) Domiciliary care market value of approximately £20m per year, public and private funding combined.
b) Predominantly (over 70%) publicly funded, by LTCF.
c) Expanding volume of demand, driven by population ageing.
d) Strongly rising price of care services in recent years
e) Limited price competition, as LTCF consumers are sheltered from payment and the 3rd party payor (LTCF) does not use its purchasing power to actively manage supplier prices.
f) Thin market - fewer domiciliary care service users per unit population in Jersey than in the UK, mainly due to the Jersey population's much higher use of residential care than in the UK.
g) Small average client list – service users per agency half the UK level.
h) Highly fragmented supply, with potential for consolidation.
i) No large-scale providers and probably limited financial capacity for investment, unlike the UK where there are many providers with access to substantial capital.
j) Constrained supply chain (availability of labour), as in the UK.

In the context of a review of pricing structure options, an important aspect of the market is the balance of market power between domiciliary care providers and the Long Term Care Fund, which funds the bulk of care services in Jersey. This is considered further in Section 5.

Table 2 Key features of the Jersey domiciliary care market compared with the UK

Key Feature	Evidence	Jersey	UK
Public funding is dominant in Jersey.	*Sur.*	It has not been possible to refine LTCF estimates of the public/private market share from the results of the LaingBuisson provider survey, or to split out residential from domiciliary care.	Private pay share estimated at 30%, but with a wide margin of error due to unreliability of data sources
Lower numbers of domiciliary care workers per 1,000 adults	*Aon's Actuarial review of the LTCF dated December 2021 (page 56) cites 546 adults claiming domiciliary care from LTCF, and 889 residential care (1,426 total), in November 2022. Claimants have since risen to over 1,500 in 2023.*	Extrapolation of LTCF funded domiciliary care users by a factor of 100/73 gives an estimated total of 800 domiciliary care users, all funding sources. 9 users per 1,000 adult population 89 users per 1,000 population aged 75+ Fewer than the UK, probably because residential care use in Jersey is substantially higher than the UK	12 domiciliary care users per 1,000 adult population 112 domiciliary care users per 1,000 population aged 75+ Public and private payers combined
Rapidly expanding volume of demand	*Driven by population ageing*	75+ Jersey population expanding as a Compound Average Growth Rate (CAGR) of 3.2% 2015 – 2025	Similar expansion of older population across UK
Provider price inflation	*Driven primarily by minimum wage uplifts in recent years*	Minimum wage uplift of 10.8% in Jan 21, 13.9% in Nov 22 and prospectively 10.9% in Jan 24	UK domiciliary care fee rates have been subject to similar inflationary pressures, recently exacerbated by the general economy price inflation triggered by the Ukraine war
Key Feature	Evidence	Jersey	UK

Limited price competition in Jersey	*Contrasts with strong price competition in UK*	The Long Term Care Fund does not currently use its purchasing power to actively manage supplier prices. Following a care needs assessment by a HCS Social Worker, an indicative budget is generated, and the claimant allocated to one of four care levels, each with a cost cap, and LTCF eligibility rules control access overall, but hourly care rates are set by provider and the LTCF is essentially a 'price taker'. Price (and quality & convenience) competition applies only in the (minority) private pay segment, mainly consisting of domiciliary care users in the waiting period before qualifying for LTCF support.	Price competition is much more prevalent in the UK. Many UK local authorities award contracts on the basis of price and use their monopsony purchasing power to drive down the price of care services generally, arguably below sustainable levels in many cases. For private payers, suppliers compete on price as well as quality and convenience.
Competitive provider market	*More domiciliary care agencies in Jersey, pro rata, than the UK. Providers compete on quality and convenience rather than price*	34 agencies per 100,000 adult population	27 agencies per 100,000 adult population
Client list per provider substantially smaller than UK equivalent	*Average number of users per agency in Jersey is half that in the UK*	27 users per agency	46 users per agency
Absence of large-scale providers in Jersey	*Providers consist of SMEs and micro-enterprises, many of which may be ill-equipped to respond to change on the market environment*	No providers with annual revenue >£25m pa	Approx 60 providers with revenue >£25m pa

Source: Workbook 'Jersey UK comparisons' tab

4. ECONOMIC MODEL FOR OPTIMAL PRICING STRUCTURE

The existing model of LTCF financed domiciliary care is not well suited to achieving optimal pricing structures. It is an essentially open-ended social insurance model with care package costs variable within a maximum weekly budget which might otherwise focus attention on challenging questions related to service provision through either (a) service rationing, or (b) price controls.

Historically, the Republic of Ireland has operated domiciliary care services under an annual set budget. This has led to de facto service rationing as annually set budgets rarely met all demand growth on top of maintaining existing packages. A statutory right to domiciliary care creates challenges in limiting provision and may place the focus more heavily on price as a control mechanism. A budget cap forces a greater consideration of price constraints on providers to ensure full-service provision.

Price competition is largely absent since the LTCF supported consumer is sheltered from the cost of consumption and historically neither the LTCF nor Customer and Local Services have actively managed supplier prices. For 2023 and 2024, hourly rates have been linked to the 22 rate plus a 12% uprate in 2023, and a 7.7% update in 2024.

Price (and quality and convenience) competition is limited to the minority private pay segment of the domiciliary care market.

Absence of price competition is one possible explanation (though not necessarily the only one) for the high degree of variance in the price of visiting domiciliary care charged by different providers. Evidence of variance is illustrated in Table 5, Section 5.1.3, though for only a small number of providers responding to the LaingBuisson survey. More comprehensive evidence is available from the average hourly prices charged by 25 different providers in 2022 and 2023, Table 3.

Table 3 Average hourly price of visiting domiciliary care services funded by the Long Term Care Fund (LTCF) in Jersey

Provider	2023 rate
Provider 1	£35.01
Provider 2	£33.60
Provider 3	£33.60
Provider 4	£33.60

Provider 5	£32.48
Provider 6	£32.36
Provider 7	£31.92
Provider 8	£31.92
Provider 9	£31.45
Provider 10	£31.36
Provider 11	£31.36
Provider 12	£31.36
Provider 13	£30.24
Provider 14	£30.24
Provider 15	£30.24
Provider 16	£30.24
Provider 17	£29.12
Provider 18	£29.12
Provider 19	£29.12
Provider 20	£28.00
Provider 21	£28.00
Provider 22	£27.55
Provider 23	£26.88
Provider 24	£26.88
Provider 25	£26.88

Source: Data provided by the Government of Jersey.

The Government of Jersey commissioned this report to better understand options for managing provider prices more actively. When considering such options, the Government will face the same challenges as other publicly paid and independently supplied social care systems, in the UK and elsewhere. The situation in which the consumers of publicly funded services do not bear the costs of consumption and are agnostic on price, creates a relevant challenge.

In this situation, control of independent sector provider prices falls on 3rd party payors who typically have an incomplete understanding of the costs of provision. As a consequence, public payers need to find a balance between over-paying and generating super-profits for providers and, on the other hand, underpaying and threatening the sustainability of providers and the quality and reliability of the services they provide.

5 PROVIDER COST SURVEY

5.1 Methodology

We sought to conduct a comprehensive survey of the costs of domiciliary care providers operating in Jersey. The survey questions are listed in Appendix 4. The questions are based on similar 'cost of care' surveys carried out by LaingBuisson in England, notably as part of the national Fair Cost of Care exercise mandated by the English Department of Health and Social Care in 2022, in which LaingBuisson supported 10 English local authorities to calculate median costs of domiciliary care and residential care.

We undertook a brief pilot by telephone, calling a sample of providers to test the ease with which respondents could answer the proposed survey questions. Having received sign off from the Government of Jersey, we sent the full online survey by email to 29 providers whose names and contact details were provided by the Government of Jersey. We subsequently made definitive contact with each of the providers and, if necessary, re-sent the survey to another individual within the organization.

We engaged intensively with the provider community, following the methodology used by LaingBuisson in similar cost of care exercises in the UK. At the end of the process, we were able to obtain useful information from 14 survey respondents on three key data categories: - numbers of care staff employed; carer and senior carer gross pay rates for visiting care services; and average hourly charge-out rate for visiting care services. While there were many gaps in the information we sought to gather, this was the first time that such an exercise had been carried out in Jersey and the response for the three key data categories was within the range achieved in similar cost of care exercises carried out by LaingBuisson in the UK.

We have supplemented data gathered in Jersey with information gathered in recent cost of care work undertaken in England, where the structure of the supply side of the domiciliary care sector is similar[14]. There is reasonable read-across in some areas where English data is richer than Jersey data. In particular, we are able to use detailed costs which were submitted by domiciliary care providers in the DHSC mandated 'Fair Cost of Care' exercise carried out in England during 2022. We have also taken account of domiciliary care cost structures published by the Jersey Care Federation (for Jersey) and the Homecare Association (for the UK). The two follow the same format and the former draws on the latter for some cost lines.

[14] While the demand side is very different. UK councils commission social care directly and typically seek to bear down vigorously on provider prices, in contrast to Jersey which has opted for a brokerage model.

At the end of the process, there were three data categories that LaingBuisson was able to obtain a response rate high enough to generate usable information returns.

- Numbers of care staff employed
- Carer and senior carer gross pay rates per contact hour for visiting care services
- Average hourly charge-out rate for visiting care services

Some key areas where the survey did not yield usable data include:

- Carer and senior carer gross pay rates per working hour
- Split of direct payroll costs for visiting domiciliary care into contact time and travel time
- Distribution of travel times per visit
- Business overhead costs
- Operating profit

5.1.1 Numbers of care staff employed

All 14 survey respondents answered this question. About one third of care workers declared were part time, see Workbook 'selected LB survey results' tab. In contrast, Skills for Care estimates that about half of care workers in England are part time.

Extrapolation of the 14 respondent results to the 29 domiciliary care providers, and assuming part-time is equivalent to half-time, gives an estimated total of about 730 full time equivalent domiciliary care workers employed by independent sector domiciliary care providers in Jersey.

5.1.2 Care staff gross pay rates for visiting care

Seven respondents answered the question about gross pay rates for visiting carers. Variance was unexpectedly high, in comparison with pay rate variance typically observed in surveys of UK domiciliary care providers. The weighted average gross pay rate (for carers and senior carers combined) was £16.75 per hour, Table 4.

It is important to note that gross pay is expressed as a rate per hour of *contact time*. There is no separate item for travel time. In other words, carer pay is stated at an elevated rate per hour of contact time, to compensate for travel time not being payable. Domiciliary care workers are typically paid on a similar basis in the UK. Payment on contact time de-risks providers. Staff paid on contact time only are highly motivated to minimise travel time in between client appointments.

Table 4 Care staff gross pay rates for visiting care

	Carer	No.	Senior carer	No.	Weighted average
Provider 1	£16.12	53	£17.00	6	
Provider 2	£16.26	26	£20.33	11	
Provider 3	£15.41	6	£17.45	1	
Provider 4	£17.60	15	£19.25	3	
Provider 5	£16.00	8	£17.50	4	
Provider 6	£17.00	4	£19.00	1	
Provider 7	£14.50	4	£18.50	1	
Weighted average	£16.27		£18.83		£16.75

See Workbook, 'selected LB survey results' tab

5.1.3 Average hourly charge-out rates for visiting care

Only five respondents answered the question about charge-out rates for visiting carers. The number of respondents is too small to be representative, but the results are consistent with a high degree of variance in charge-out rates, as well as carer pay rates, Table 5.

Table 5 Hourly charge-out rates for visiting care

	£ per hour
Provider A	£28.00
Provider B	£29.50
Provider C	£31.00
Provider D	£32.36
Provider E	£37.00

See Workbook, 'selected LB survey results' tab

6. ESTIMATION OF AVERAGE COST OF VISITING DOMICILIARY CARE IN JERSEY

6.1 Indicative costs per hour in 2023

Because of the limited response to the domiciliary care provider survey, LaingBuisson has made judicious use of such cost data as do exist, whether from the survey or from other robust and reliable data sources that can be used as points of comparison.

We have taken the 2023 domiciliary care cost structure published by the Jersey Care Federation (see Workbook 'Cost Structures tab) as a starting point and adjusted each of the cost lines according to the evidence we can adduce from the survey of Jersey providers and other reliable sources of information. The results are presented as an 'indicative cost structure for independent sector domiciliary care providers in Jersey' in Table 6. The adjustments are described in the following five sections.

6.1.1 Payroll

The holiday pay on-cost allowance is adjusted from 11.25% (the UK allowance) to 9.2% of gross pay and social security on-costs, to allow for Jersey's statutory minimum holiday entitlement which is 3 weeks + 9 bank holidays as compared with 4 weeks + 8 bank holidays in the UK.

6.1.1 Adjustment to business costs

Business costs, which we define here to include reimbursement of care staff inter-visit travel expenses (usually car mileage) represent the largest single cost line after payroll. Alongside profit targets, it is the cost category over which providers potentially have the greatest control. The Jersey Care Federation's published cost structure for 2023 (see Workbook 'Cost Structures' tab) includes an allowance of £10.52 per contact hour for 'Business Costs, representing a 48% add-on to care staff payroll costs. The survey of Jersey domiciliary care providers yielded no usable corroborating information on the level of business overheads in Jersey, or how they vary according to business characteristics such as scale and client focus. We were obliged, therefore, to look outside Jersey (to the UK) for business overhead benchmarks.

Table 6 Indicative cost structure for independent sector domiciliary care providers in Jersey, £ per contact hour in 2023

	Carer	Senior carer	Weighted average Carers & Senior Carers
Estimated gross pay per direct care **working** hour [1]	£13.95	£16.14	£14.36
Estimated travel time add-on [1]	£2.32	£2.69	£2.39
Gross pay per direct care **contact** hour [2]	£16.27	£18.83	£16.75
Employers Social Security @ 6.5% gross pay	£1.06	£1.22	£1.09
Maternity / Paternity leave @ 1.0% gross pay	£0.16	£0.19	£0.17
Holiday pay @ 9.2% of gross pay and social security on-cost [3]	£1.61	£1.86	£1.66
Training time @ 3.45% of gross pay and social security on-cost	£0.60	£0.70	£0.62
Sickness Pay / Health Cashback Schemes @ 3.8% of gross pay and social security on-cost	£0.66	£0.77	£0.68
Notice & Suspension Pay @ 0.3% of gross pay and social security on-cost	£0.05	£0.06	£0.05
Travel expenses reimbursement (using English data as a proxy) [4]	£1.47	£1.47	£1.47
Business costs (using English data as a proxy) [5]	£7.79	£7.79	£7.79
Profit [6]	£1.48	£1.64	£1.51
Cashflow buffer [7]	£0.00	£0.00	£0.00
Indicative charge-out rate per contact hour	£31.17	£34.53	£31.80

[1] Gross pay per working hour is calculated as 100/117 times the gross pay rate per contact hour, using the English average travel time add-on (see cell D25 of the 'Travel time 8 English councils' tab of the Workbook) as a proxy for Jersey. The travel time add-on in Jersey is calculated as the remaining 17/117 of the gross pay rate per contact hour, using the same English data as a proxy for Jersey.
[2] Select from options under 'Variations on gross pay rates'
[3] Adjusted from 11.25% to 9.2%. Jersey's minimum paid holiday entitlement is 3 weeks + 9 bank holidays. UK's is 4 weeks + 8 bank holidays
[4] Using the median of validated submissions by individual domiciliary care providers located within the boundaries of the 8 councils with social services responsibilities which were supported by LaingBuisson in the national, DHSC mandated, Fair Cost of Care exercise carried out in England in 2022 - multiplied by the ratio of the Jersey Care Federation's cited number of 50p per mile for 2023 with the UK HMRC allowance of 45p per mile in 2022/23.
[5] Using the lower quartile of validated submissions by individual domiciliary care providers located within the boundaries of the 8 councils with social services responsibilities which were supported by LaingBuisson in the national, DHSC mandated, Fair Cost of Care exercise carried out in England in 2022. The lower quartile is used to embed a 'stretch' target for providers, most of which operate sub-scale.
[6] Adjusted from 15% to 5%; Source: Workbook 'Cost Structures' tab

We considered a number of approaches to estimating a reasonable 'business costs' line for Jersey domiciliary care providers. One approach was to inspect the statutory accounts of UK companies with revenues in excess of about £5 million, which post full profit and loss accounts at Companies House. This proved not to yield any useful information because, among other things, companies usually do not identify care staff costs separately from administrative staff costs.

A second approach was to use the domiciliary care cost structure published by the Homecare Association for the UK, as set out in the Workbook 'Cost Structures' tab. Their 'Business Costs' were stated at £6.98 per contact hour, representing a 41% add-on to care staff payroll costs.

A third approach was to use data held by LaingBuisson from the 10 English local authorities that LaingBuisson supported in the national Fair Cost of Care exercise carried out in 2022. Lower quartile 'Business Costs' for that sample worked out at 37% of care staff payroll costs. The lower quartile is used to embed a 'stretch' target for providers, most of which operate sub-scale. This 37% benchmark, working out at £7.79 per contact hour has been applied to LB calculated payroll costs (see Workbook 'Cost Structures' tab) as a reasonable allowance for business costs in the indicative domiciliary care cost structure calculated by LaingBuisson for Jersey.

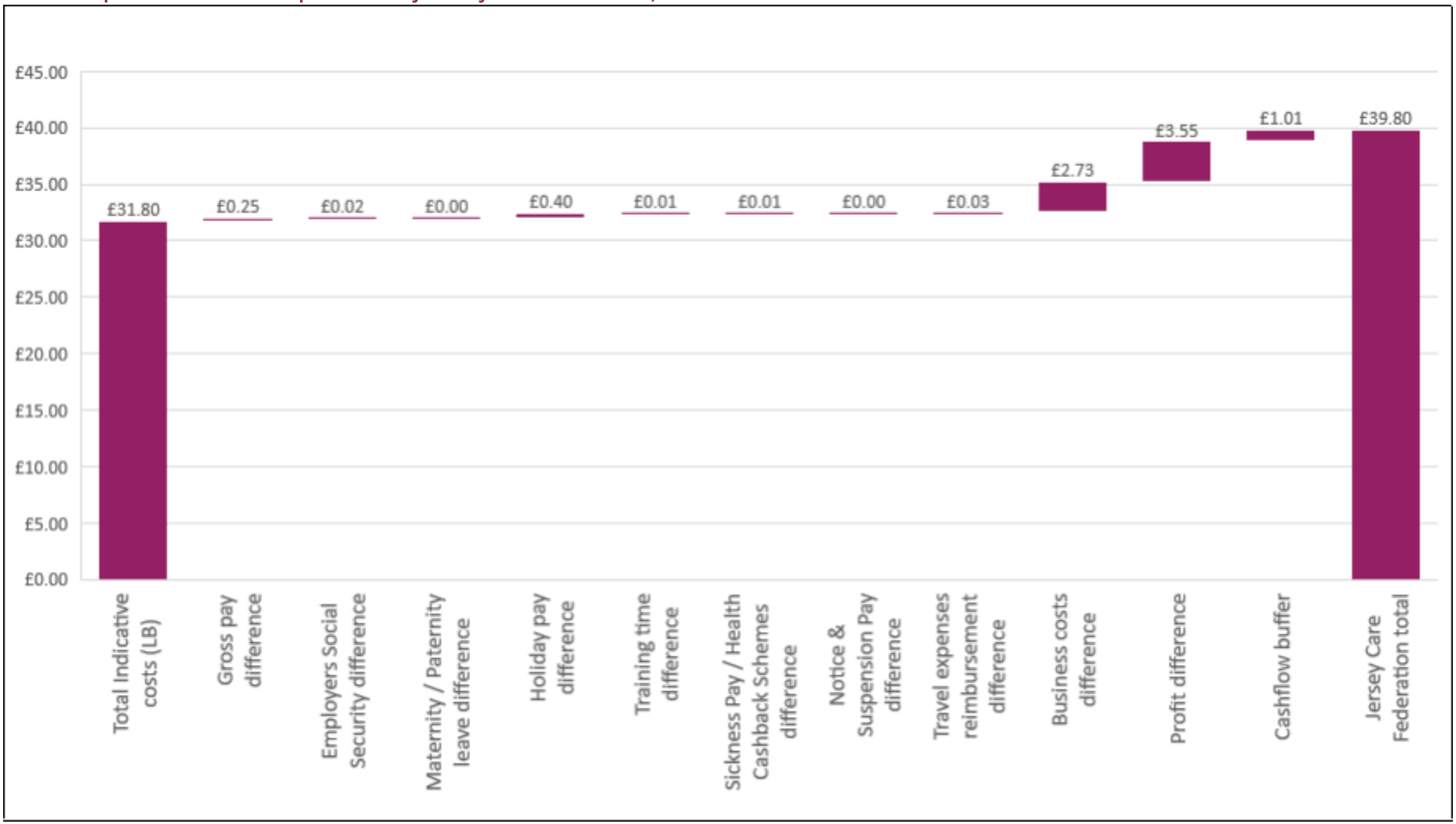
6.1.2 Adjustment to operating profit

The allowance for profit is adjusted from 15% as proposed by Jersey Care Federation to 5% in the indicative cost structure in Table 5. LaingBuisson usually recommends a profit benchmark of 10% of operating costs for market sustainability, see Appendix 3, but this has been reduced to 5% for the purposes of setting tariff rates payable by LTCF. The rationale is that the LTC rate represents a floor for income generation and the Jersey system allows providers to set their own rates above that floor. The 5% rate mitigates the risk that providers may withdraw from serving clients who do not provide any top up to the LTCF- rate. It is expected that providers will, in many if not most cases, be able to supplement payments made at LTCF rates with co-payments from individual service users, thus enabling them to generate aggregate profit margins at a sustainable rate in a competitive market.

6.1.3 Adjustment to the cashflow buffer

The 'cashflow buffer' of 3% of operating costs is removed from the indicative cost structure in Table 5. It is a questionable item which the Jersey Care Federation considers necessary to compensate for delays in LTC payments and uncertainties over LTCF pricing. The item does not appear in the Homecare Association's cost structure for the UK. If there is a late payment issue, it would be better addressed by the LTCF as part of a review of domiciliary care contracts and administrative procedures.

Figure 1 Bridge between indicative domiciliary care costs per contact hour for independent sector providers in Jersey, as calculated by LaingBuisson, and costs per contact hour as published by Jersey Care Federation, 2023



Source: Workbook, 'Cost Structures' tab

6.1.4 Adjustment to carer gross pay rates

In the Workbook, 'Cost Structures' tab, three options are selectable for the gross carer pay rate line:

1 £17.00 per hour, as estimated by the Jersey Care Federation
2 £16.75 per hour, being the weighted average gross pay rate from the seven survey respondents which answered this question'
this is the rate recommended by LaingBuisson for the calculation of indicative costs in Table 6
3 £16.21 per hour, being the weighted average of entry level hourly pay rates (£15.94 for carers and £17.27 for senior carers) offered by Jersey's public sector provider Health and Community Services (HCA) in 2023

6.1.5 Difference between the Jersey Care Federation cost structure and indicative costs as calculated in Table 7

A 'bridge' between our calculation of indicative costs (£31.80 per hour, Table 6) and the Jersey Care Federation' estimate of costs (£39.80) is illustrated in Figure 1. Most of the difference is accounted for by three cost items: profit (3.55 per hour), business costs (£2.73) and cashflow buffer (£1.01). Gross pay accounts for 25 pence per hour of the difference. The total difference is £8.00 per hour.

6.2 Proposed domiciliary care tariff rates

'Cost per contact hour' for visiting domiciliary care (Table 7) is a useful metric, but it cannot be made operational as a 'tariff' for paying providers of visiting domiciliary care unless it is expressed as a rate per unit of activity, calculated for 15, 30, 45 and 60 minute visits separately, or whatever other visit time options exist in Jersey. This is not just a matter of dividing the 'per contact hour' indicative costs by four or two for (for example) 15 and 30 minute visits. Data from the English Fair Cost of Care exercise of 2022 confirm that nearly all English councils take account of travel time per visit in their fee schedules, meaning that short visits attract a substantially higher tariff rate per contact hour than long visits. The great majority of visits in Jersey are provided as 60 minute sessions.

A further interactive model has been constructed in the 'Cost variance by visit length' tab of the Workbook. The model calculates a schedule of indicative costs **per visit** for visiting domiciliary care in Jersey, drawing on indicative costs **per hour** in the 'Cost Structures' tab. We have used English Fair Cost of Care data on median travel times between visits as a proxy for unknown Jersey travel times.

The resulting schedule of indicative provider costs by visit length and skill level for visiting domiciliary care in Jersey is presented in Table 7. We propose that this should be embedded as a tariff schedule in the Approved Provider Framework Agreement which governs the administration of LTC invoices.

The effect will be to create a standard level of benefit payment across all providers. This will reduce LTC benefit per unit of activity from LTCF for many (though not all) providers. Under the proposed reforms, LTCF will expect providers to serve the minority of fully means-tested clients without supplement. Most LTCF-funded clients, however, will be able to afford co-payments, in negotiation with their chosen provider, and this will enable providers to maintain their revenues and profit margins at a sustainable level in a competitive marketplace.

Table 7 Indicative tariffs for domiciliary care delivered by independent sector providers in Jersey, 2023

Indicative cost **per visit**	Carer	Senior carer
15 minute	£10.24	£11.27
30 minute	£17.05	£18.85
45 minute	£23.85	£26.43
60 minute	£30.66	£34.02
Indicative cost **per hour**		
Waking shifts	£27.22	£30.43
Sleeping shifts	£24.78	£24.86

Source: Workbook, 'Cost variance by visit length' tab [15]

[15] The numbers in Table 1 are illustrative. Pending receipt of data on the actual distribution of LTCF funded visiting domiciliary care visits by visit length we have assumed that the great majority of domiciliary care visits are of 60 minutes' duration. Actual data on the distribution of visit lengths, if available, should be entered in cells B37:B43 in the 'Cost variance by visit length' tab of the Workbook, and the illustrative tariffs in Table 1 should be overwritten with results in rows 81-88 of the 'Cost variance by visit length' tab.

6.2.1 Tariffs for sessional /shift based domiciliary care

A minority of LTCF funded domiciliary care activity is delivered as sessional or shift-based care, including waking night-time care and sleeping night-time care. Shift sessions can vary widely in length. Therefore, for the purposes of setting tariffs, provider costs are best expressed on a **per hour** basis, rather than per visit.

Indicative cost per hour for shift-based domiciliary care are calculated in the interactive model in the 'Cost variance by visit length' tab of the Workbook (alongside indicative costs per visit for visiting domiciliary care). The key assumptions in the interactive model are:

- Based on experience in the UK, gross pay rates for waking night-time care are similar to day-time visiting care (per working hour – after stripping out the travel time distortion). Employers do not have to pay a premium for unsocial hours. We assume that the same applies in Jersey.
- The norm in the UK is for sleeping night-time care to attract lower rates than waking care. Many employers pay National Living Wage for sleeping care. In the absence of data from Jersey, we have assumed that sleeping night-time care on the island attracts gross pay at approximately 15% higher than the Island's 2023 minimum wage of £10.50 per hour i.e. £12.10 per hour.
- Employers in the UK do not pay travel time or travel expenses for shift-based care. We have assumed that this applies equally to Jersey, meaning that this component of cost can be ignored when calculating a schedule of tariffs adequate to support fully means-tested claimants.

The resulting schedule of indicative costs (or tariffs) is presented in Table 1, for both visiting and shift-based domiciliary care services. The schedule as it stands is illustrative, pending entry of the actual distribution of LTCF funded hours by visit length in the 'Cost variance by visit length' tab of the Workbook. Following that, Table 1 stands as our proposed LTCF tariff schedule under the proposed co-payment reforms.

6.2.2 Tariffs for sessional /shift based domiciliary care

The proposed tariff schedule is believed to cover the bulk of LTCF spending. There will be a residue, however, which does not lend itself to tariffs. This will include bespoke night-time shifts which are part waking and part sleeping. It will also include live-in care, which typically has bespoke characteristics. In addition, we have been unable to access data on provider costs for live-in care and little UK data is available to us to use as a proxy for Jersey.

7. PRICING FRAMEWORK

7.1 Co-payment supported by tariff rates for LTCF funded services

This option would involve a revision of the 'Approved Provider Framework Agreement For the Provision of Home Care Services', specifically clauses 2.10 and 2.11.

Clause 2.10 requires the domiciliary care provider to send invoices to both the service user (the individual / agent) and Customer and Local Services, with a number of specified details including 'the unit cost of the service'. Currently, it is the provider who enters the unit cost, without reference (we understand) to any guidance or pricing schedule from the LTCF or Customer and Local Services. However, we note that for 2023 and 2024 providers have been required to use hourly rates based on their 2022 rates with set % uplifts applied each year.

We consider that LTCF can address the issue of price management most simply by introduction of a price (tariff) schedule that any provider-signatory of the Framework Agreement must conform to when entering the unit cost.

Any such schedule should take account of significant cost drivers which are not under the control of providers, otherwise it risks overcompensating some services and undercompensating others, with no guarantee than variances will be evened out for any given provider. The most important cost driver, which is to a large extent outside the control of the provider, is the skill mix required to fulfil the needs of the client. What is required, therefore, is a simple staff grading schedule which separates out differential rates for services delivered by Carers and Senior Carers, each with a standard price attached, as per the proposed tariff rates set out in Table 7.

In parallel with this, to reinforce the use of appropriate skill mixes, it will be necessary for social workers to expand the content of Personal Support Plans by specifying the expected skill mix for each service user supported by LTCF.

The other significant cost driver which is to a large extent outside the control of the provider is travel time. It would, however, be problematic to separate out the amount of travel time embodied in the unit cost of an hour of contact time. It is not recommended, therefore, that amendment of the Approved Provider Framework Agreement should initially address the travel time issue. Rather, providers should be incentivized to minimise travel time by virtue of being faced with fixed tariff rates. Wherever possible, CLS and HCS should support providers to be able to minimise travel times within their clients. We do not recommend blanket tariff rate enhancements for providers serving rural areas. That would risk baking in a general supplement which may not always be needed. Case by case enhancements, with a high bar for providers' access to such enhancements, are likely to be more efficient, though requiring greater brokerage resource.

There may be some forms of service provision undertaken by domiciliary care agencies that may sit outside of a revised framework agreement or require adaptation to the above methodology. For instance, live-in care services may require a separate form of calculation but could still have a fixed unit cost. However, there may be a small number of more specialised service requirements that would be best served by off-framework contracts built around incorporating a particular need that may be unable to be fulfilled without a specialist skillset.

Some of the potential benefits from efficiency gains which may flow from the proposed co-payment reforms are identified in Section 7.1.1. Risks, costs and mitigations are described in Section 7.3.1.

7.1.1 Potential efficiency gains from market restructuring flowing from the proposed co-payment reforms

7.1.1.1 Travel time

We have been unable to access any usable information on travel times between domiciliary care visits in Jersey, which would enable us to separate out the cost of contact time and travel time without recourse to proxy data from England. It is notable that the Jersey Care Federation bundle the two (contact time + travel time) in their published cost of care calculation (see the 'Cost Structures' tab in the Workbook). Similarly, all respondents to the provider survey bundled contact time and travel time in a composite gross pay per contact hour rate. Consequently, the weighted average gross pay rate of £16.27 for carers and £18.83 for senior carers submitted by survey respondents represents gross pay per contact hour, (see the 'Selected LB survey results in the Workbook). The equivalent rate per working hour will be lower, depending on the amount of travel time that is bundled in, but that is not transparent.

The domiciliary care market is similarly opaque in the UK, where most (but not all) providers cite pay rates per contact hour (not per working hour). A degree of transparency was introduced for the first time in England in 2022 when all home care providers were asked by the DHSC to participate in a cost of care exercise. Detailed data gathered by LaingBuisson from providers within the boundaries of the eight local authorities that we supported enable us to calculate a median travel time add-on of 17%, which equates to 10 minutes per contract hour or 6 minutes per visit, after taking account of sub-60 minute visits (see Workbook, '8 English Councils data' tab), Inter-area and inter-provider variance was high. Inspection of the English data indicates, however, that rurality is not the only factor driving travel times.

In the absence of travel time data in the public domain in Jersey, we have used English travel time data as a proxy in some of the calculations in this report - in particular the calculation of indicative domiciliary care costs for short visits in the 'Cost variance by visit length' tab of the Workbook.

Whatever Jersey's actual travel time distribution is, the geography of the island is such as to suggest there may be at least some potential for reducing the travel cost component of providers' costs through more optimal deployment of staff.

7.1.1.2 Economies of scale

In general, we would expect domiciliary care costs per contact hour to decline as the volume of activity of any given provider increases, allowing more activity to be spread over fixed and semi-fixed overhead costs. There are some exceptions, however, which relate particularly to micro-businesses with a very small customer base. It is recognised in the UK market that the profitability of providers as they develop from micro too small to medium sized businesses can follow a 'hockey stick' curve, starting high as the micro-provider performs all business functions alone, dipping as managerial staff are taken on to deal with the increased scale and complexity of the business, then rising again as the business reaps economies of scale.

Overall, however, we consider that the impact of the co-payment reforms proposed in this report will be cost reducing to the extent that it fosters mergers, acquisitions and other forms of providers collaboration such as lead provider arrangements.

7.2 Competitive tenders

It is LaingBuisson's understanding that a competitive approach to tendering for domiciliary care is not viewed as a viable solution at this present time. As such, we have not included it as an option for consideration under the pricing framework. Further details about competitive tendering, the opportunity, the risks and mitigation, can be found in Appendix 2.

7.3 Risks and mitigations

7.3.1 Option 1: Co-payment supported by tariff rates for LTCF funded services

As with any change, there is always risk and, in this case, a sudden move from a provider lead market to one where the LTC scheme pays a standard rate for benefit services may cause concern or even disruption to the sector if it is not properly discussed and phased in.

However, in keeping with delivering a fully equitably system across social care for older people, the domiciliary care market needs to adapt to reflect the "co-payment" model that already exists in residential care, this will likely take time and Government should be mindful of phasing in any planned changes, with collaboration and plenty of notice given to providers as well as the establishment of legacy arrangements for existing packages of care.

Government funded benefits are aimed at assisting Islanders and whilst some profit margin needs to be accounted for, it is not reasonable to expect the Government to fully support the profit margins of commercial businesses. The scheme and the fund must be equitable and sustainable, and decisions made in the interests of everyone involved, including the Island's taxpayers – who fund the scheme.

There is existing precedent for Government subsidizing services – General Practitioners, as private businesses, are free to charge whatever they like for a GP appointment, in the knowledge that Government provides a fixed, standard subsidy towards this service

There is a risk that substituting LTCF determined standard prices ('unit costs') for provider determined prices may trigger withdrawal of some domiciliary care providers from serving LTCF supported service users. The risk is clearly greatest for the most expensive providers, whose bottom line would be adversely affected by a move to fixed LTCF prices and who may not be confident of making up shortfalls through co-payments from individual clients. These providers may or may not be able to adjust their business models to accommodate the new pricing structure while still making a surplus.

Such market adjustments carry with them the risk of disruption and gaps in local services, and this in turn may create a need for more proactive market management on the part of LTCF and/or Customer Local Services than has been necessary to date. For example, a sudden, partial or full, provider withdrawal may leave some vulnerable LTCF funded service users without a service, necessitating a rapid response. LTCF and/or Customer Local Services would be faced with an increased need to plan for and respond to such eventualities, and such proactive management will have a cost attached to it. It will be possible to mitigate the risks and costs, for example by giving providers an extended period of notice before implementing a new fixed price structure. However, there will inevitably be some residual risks and associated costs.

In addition to local and short-term disruptions, there is a potential longer term risk of polarisation of the domiciliary market, in which public provision may be crowded out by private pay demand, as providers re-focus on a more profitable private pay market. The severity of this risk depends essentially on the balance of market power between domiciliary carer providers on the one hand and the Long Term Care Fund, which pays for the bulk of care services, on the other. However, this risk is mitigated in Jersey by the use of co-payments which will allow providers to set their own rates with clients all receiving the same level of government support through the LTCF and choosing the level of top up payment they wish to commit to.

According to Aon's recent actuarial review of the LTCF, 73% of domiciliary and residential care spending in Jersey is LTCF funded, with the remaining 27% paid by individuals. Aon did not identify the public/private share specifically for domiciliary care, but the exact numbers are unimportant. We consider that the dominance of LTCF funding, in a thin market, is such that most if not all providers would find it challenging to withdraw from serving LTCF funded service users in the event of disagreement with any proposed standard pricing tariff.

The private pay segment mainly consists of people in the waiting period of one to three years before qualifying for LTCF support. This means that providers focusing on the private pay market would face continuing attrition of their client base and the need to find new clients from fresh cohorts of

people entering the waiting period. While there is a risk of some polarisation of the provider market into private and public pay, it is unlikely that a substantial number of providers would be able successfully to pursue a strategy of serving private payers only – even those providers (of which there are at least two according to survey returns) whose current client list is split half and half between private and public pay. The balance of market power, which appears to be uniform across Jersey, contrasts with many affluent areas of the UK, where the publicly paid segment of the domiciliary care market is sufficiently small, and the privately paid segment sufficiently large to make a private pay only strategy viable.

Appendix 1 – Remit

The agreed remit, as described in LaingBuisson's proposal of 15 June 2023, was as follows:

LaingBuisson agrees to supply the Government of Jersey with the following outputs, following a financial review of the domiciliary care market (circa 28 providers) to establish the costs of services and provide options for standard pricing tariffs based on this data:

- A written report with embedded Excel tables and charts
- A complementary Powerpoint slide presentation (if required)
- An on-line interactive presentation of results via Teams / Zoom

The written report will include:

- **Analysis of the domiciliary care market in Jersey**
  - Market size (value and volume)
  - Market trends (subject to available information)
  - Market drivers
  - Sources of funding (government of Jersey, private, other)
  - Supply chain (essentially the local labour market)
  - Market structure
    - Leading providers
    - Concentration ratio
    - Balance of market power between providers and customers (Government of Jersey in particular, and the ability of providers to withdraw services from the Government of Jersey in the event of disagreement with any proposed standard pricing tariff)

- **Analysis of provider costs including:**
  - Distribution of costs by provider
  - Distribution of provider costs by cost line
  - Commentary on variations in provider costs, and the drivers of such variations.
  - Summary of median costs of providers.

- **Description of an economic model** (taking into account supply and demand, costs, elasticity of demand, market competition, labour, etc. to test optimal pricing structures and to simulate different pricing options

- **Pricing Framework going forward**
    - Analysis of current pricing structures, variations and pressure points
    - Principles upon which a consistent pricing framework may be established
    - At least two pricing framework options to be considered
    - Evaluation of the risks, potential mitigation and cost of moving to a new pricing framework based on a set of standard tariffs applied to the current market.

Further information in relation to the delivery method for achieving the outputs listed above, and for detailed information in relation to the Engagement are contained in the document 'Government of Jersey – Domiciliary Care Proposal – 15 June 2023'

Full LaingBuisson terms and conditions can be found: https://www.laingbuisson.com/terms-and-conditions/.

Appendix 2 - Competitive tendering: opportunities, risks and mitigation

Competitive tendering of domiciliary care services is a means of identifying the provider(s) best able to offer a service to defined standards at the price(s) most advantageous to the purchaser. Each provider calculates a bid price which is expected to deliver a target return in the context of their own particular cost base. As such, it does not require the purchaser (LTCF) to have the same level of understanding of providers' cost structures as they need for setting fixed prices in a single call-off contract for the entire market. Competitive tendering is a well-established approach for public sector bodies, in the UK and elsewhere. It does, however, come with associated costs and risks.

Competitive tendering has been a mainstay of managing the domiciliary care market among local authorities in the UK. It has not always been successful and there are lessons that Jersey can learn. The UK experience can best be understood in the context of the severe financial pressure under which local authority commissioners of social care services have operated since the government austerity policies introduced from 2010/11. Many local authorities adopted competitive tendering as a means of shaking out the large number of providers operating under spot contracts with councils. They identified the opportunity of benefiting from keener prices from providers able to exploit economies of scale from running more activity through semi-fixed back-office infrastructures. But many local authorities undermined their own market restructuring efforts by seeking to shift risks too far onto providers

In particular, it became common practice not to offer volume guarantees for larger-scale cost and volume contracts, and to continue to offer spot contracts to other providers. This undermined the commercial value and viability of large -scale contracts as activity drained away from them. This was the background to the withdrawal of many providers from council contracts in many localities in England during the middle and late 2010's, giving rise to a spate of media reports of 'handing back contracts', when domiciliary care operators found themselves making losses from their council-paid business.

The experience offers an important lesson for the Government were it to adopt the competitive tendering approach to price control. Larger scale fixed price contracts may be compatible with some 'out of contract' activity in parallel, but not to the extent that it undermines the viability of the fixed price contracts.

The Government of Jersey should also be aware that the small scale of most domiciliary care providers in Jersey may mean that they will find it challenging to develop plans to move to a new scale of operation, and deal with the risks of a fixed price contract. While (approximately) 30 providers may appear to be a large enough pool from which to draw viable tender responses. The number may reduce to single figures after discounting micro-providers and others without the willingness and skills to respond to a tender.

Should competitive tendering become a future approach that the Government of Jersey is willing to explore then they may wish to consider the active encouragement of consortium bids from providers working together. Whilst it can be challenging for for-profit providers to work collaboratively on bids, there may be opportunities in for-profit and not-for-profit working together to offer a wider breadth of services, or alternatively small-scale providers working together to be able to offer services across a wider geographic catchment areas. This may be particularly relevant where there are pockets of rural isolation, where it is difficult to source cost-effective service provision.

The risks of competitive tendering may be reduced by introducing it slowly. In practice, this probably means restricting tendering in the first instance to one or two catchment zones within the island of Jersey, in order to review their effectiveness before moving on.

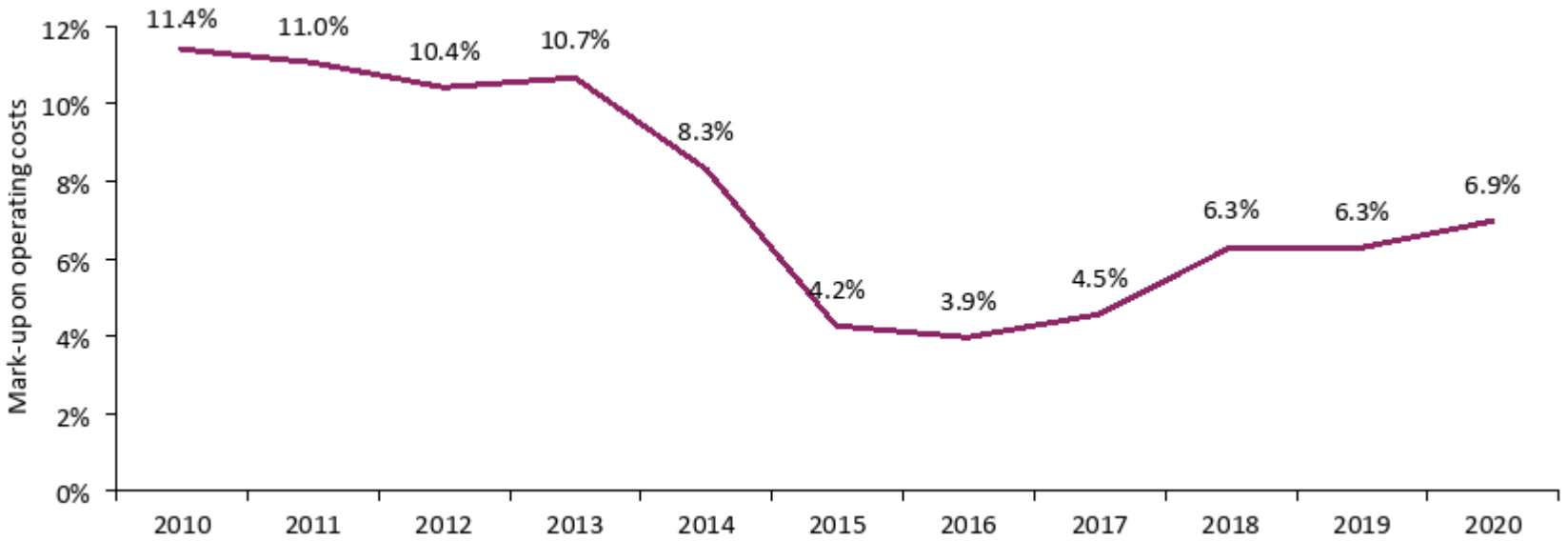
It also needs to be recognised that tendering has associated costs for LTCF administration, which need to be set against expected gains in keener provider prices. These costs include management and legal costs in drawing up contracts and the costs of managing contract compliance, terminations and handovers. Failure of a major contract may be associated with substantial costs.

There is a further variant of competitive tendering, in the form of outcome-based tendering, where providers are remunerated, in part at least, on defined outcomes (such as not entering residential care) rather than a purely time-based metric.

Appendix 3 - Evidence for a 10% profit benchmark

LaingBuisson maintains financial data from profit and loss accounts posted on Companies House (London) by the full range of independent sector operators of health and social care in the UK, going back for more than a decade. Nearly all domiciliary groups in this financial data set are for-profit. All not-for-profit groups specialise in supported living for younger adults. Trends in the profitability of for-profit groups over the period 2010 - 2020 are illustrated in Figure A.1.

Figure A.1. Aggregate mark-up on operating costs among larger, for-profit domiciliary care providers which have posted statutory accounts with full profit and loss at



Companies House, UK 2010 - 2020

The data supports a narrative frequently expressed by independent sector interests, which is that financial pressures following the implementation of austerity measures from 2011/12 had a negative impact on profitability. The aggregate mark-up of companies fell from a base of a little over 10% at

the turn of the decade to a low point of 3.6% for statutory account periods ending in 2016, before partially recovering to 6.9% for statutory account periods ending in 2020. Data for 2021 is as yet incomplete.

The aggregate revenue of for-profit domiciliary care companies covered in Figure A.1 in 2020 was £1.3 billion, which represents 20% of the total UK domiciliary care market of £6.4 billion in 2020/21, as estimated by LaingBuisson. Larger companies with full profit and loss accounts are more exposed to local authority funding than the market as a whole. Also, profitable franchise providers which typically focus on private pay are excluded from the analysis because their results do not consolidate their individual franchisees. Despite the skewed sample, LaingBuisson considers that the trends in profitability illustrated in Figure A.1 are supportive of 10% as a mark-up norm for a competitive sector during a time (pre-austerity) when it was not subject to excessive pressure on margins.

The cost of care is variable according to the form of care in question. As sleep-in and live-in domiciliary care visits tend to pay lower rates to carers, and feature longer visits which place a smaller burden in terms of administration on providers per hour, these tend to cost less than shorter domiciliary care visits per hour of care. This should not be taken to mean that providers with a higher proportion of sleep-in care for example, are cheaper for each hour of care as these visit types are not directly comparable.

The cost of providing one hour of visit care is higher than the cost of one hour of an ~8 hour sleep-in shift. Though this does not mean that the overall cost of one hour of domiciliary care can be averaged to a point lower than that for a single visit as these

Appendix 4 – Survey Questions

Jersey Homecare Survey.pdf