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Leading Social Services in Wales

ADSS Cymru Feasibility Report: Creating a National Franchise / Cooperative Model of Domiciliary Care for Wales

Association of Directors of Social Services Wales

Authors: Linda Jones, Gwilym Morris, Jason Bennett, Imogen Blood, Glenda George, Sarah Day on behalf of ADSS Cymru

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Executive summary

Background

This project was born from the need to explore a radical alternative approach to domiciliary care, which is in crisis. Currently, Wales is missing approximately 5,000 domiciliary care workers. This equates to more than 4 million care hours that are not delivered yearly. Analysis of (unpublished) data provided by local authorities to the Welsh government indicates that around 1,500 people are waiting for care, around a third of whom have been waiting for more than three months. As well as placing massive pressure on the NHS, the lack of domiciliary care denies people the opportunity to live independently and safely in their homes.

Providers and staff are leaving the sector; although others are joining, we are losing capacity and experience. As well as these current challenges, it is also accepted that we must now make transformational changes if the sector is to flourish and meet the needs of our ageing population.

Both Welsh Labour and Plaid Cymru are committed to introducing a National Care Service for Wales. While the remit of this National Care Service is not yet clear, our feasibility study reflects this ambition, and we argue that the social franchise model could deliver similar outcomes to a single publicly owned National Care Service.

Purpose

This report presents the findings of a study to test the feasibility of a national franchise model for domiciliary care, which would:

- Address issues of recruitment and retention in domiciliary care.
- Provide affordable access to sector-specific “back-office” support for domiciliary care providers to improve their effectiveness and sustainability, allowing for money to be reinvested in front-line staff terms and conditions.
- Provide a mechanism through which a mixed market of businesses, third sector bodies, cooperatives and micro providers can work cooperatively with local authority and NHS commissioners and in-house services, to develop and implement a national model.
- Support clear and transparent standards and accountabilities that could lead to improved quality and enable the transformation of care models set out in the Welsh Government's White Paper: *Rebalancing care and support.*[1]

The study has gathered and reviewed wide range of evidence. This has included listening to business owners, care workers, people who use services and trades unions. We have conducted desk-based research, sought legal advice, and undertaken financial modelling.

Our analysis of this evidence indicates that a franchise model of domiciliary care should be developed. Although we do not underestimate the challenges, there is real enthusiasm for this approach, and we have identified clear and dramatic benefits.

[1] Welsh Government (2021) Rebalancing care and support

The social franchise

We are proposing the creation of a Social Franchise. This is a business model that blends traditional franchising principles with a commitment to broader social goals. As such, a social franchise is a unique approach to business, combining profit-making with social good. In this case, the social good is the efficient delivery of domiciliary care, an essential public service.

In the model, a national body (the franchisor) will license approaches to delivering business functions to domiciliary care providers (the franchisees). We have demonstrated that this arrangement has the potential to significantly reduce social care costs, primarily through system simplification and aggregation. Cooperative action will also enable the franchises to deploy technology in a way that would be almost impossible for a small business acting alone. The money released can then be recycled back into increased wages for domiciliary care workers, which will help tackle the recruitment and retention challenges in the sector. The system efficiencies will also ensure that small business owners can maintain and grow sustainable and transparent profits.

The franchisor

The business model we are setting out is transformative and radical. From the very first meeting we had with providers, the message we received was we had to be bold to make a difference.

Due to the complexity of setting up a social franchise in a well-developed market, we sought legal advice from Weightmans LLP on our approach and the best structure to embed the social franchise. As well as confirming that the approach was legally feasible, they recommended that the social franchisor be a new company limited by guarantee. This corporate structure will enable it to be nimble and focused on delivering services rapidly. It also means any profits will be re-invested into the franchise's development. They also recommended a contracting model which would enable the franchisor to trade at scale from the outset.

The social franchisor could exist as a completely independent entity. However, given the collegiate and cooperative nature, we believe it would make sense if it were hosted within a larger organisation within our health and social care ecosystem. For example, it could be hosted by a local authority, charity, social enterprise, membership body, university or company.

To succeed, the franchisor must have a mission combining Wales's proud history of entrepreneurial cooperation with an aggressive start-up mentality. The core staffing structure will be purposely lean. Instead of developing services, which is expensive and time-consuming, the small team will work with companies with existing capabilities to coordinate their services, so they meet the needs of domiciliary care organisations. This will be done in partnership with other national bodies to align these services to their requirements and existing resources.

Franchisees

The opportunity to purchase a social franchise licence and become a franchisee will be open to all registered providers of domiciliary care operating in Wales, including private, not-for-profit, and local authorities. Individuals looking to create new domiciliary care organisations could also access licences to develop their business models.

Although there is a broad range of domiciliary care providers in Wales, most are small businesses. Many are family-run, community-led or micro-businesses. The success of these kinds of businesses is central to the foundational economy.

We are realistic that domiciliary care providers may be initially nervous, and the franchising approach may not suit everyone. This is why the model we suggest should be as open and transparent as possible to demonstrate its financial and non-financial benefits. It is also why we have kept costs as low as possible and planned for a gradual voluntary adoption by the sector.

Like all franchise arrangements, the relationship between the franchisor and franchisee will be governed by a set of mutually beneficial agreements that include enhanced financial reporting. This includes a requirement to standardise minimum terms and conditions and reporting mechanisms.

Partners

Substantial changes are planned within the domiciliary care landscape in Wales, including the work of the National Commissioning Board, the plans to establish a National Care Office, and the development of minimum standard for terms, conditions, and progression frameworks for care workers by the Social Care Fair Work Forum.

The proposed national social franchise model depends on and is also key to the effective implementation of these national initiatives across a fragmented domiciliary care market. For example, by engaging providers in standardised software for recruitment, and for payroll, there is both a mechanism and an incentive for them to sign up to standard rates, and – hopefully – methods of invoicing. The impact of these changes on the sector can then be maximised – for example care workers on consistent terms and whose credentials are held on the national platform can then be readily deployed across agencies to cover fluctuations in demand or supply.

To ensure that existing resources are effectively channelled into the domiciliary care sector and that duplication is minimised, the national franchise will work closely in partnership with other key national bodies, including but not limited to Social Care Wales, the National Commissioning Board, the planned National Care Office, Care Inspectorate Wales, existing membership organisations and trades unions operating in this sector.

Cost and benefits

As well as being strategically important to our public services, domiciliary care is a significant industrial sector, with a total national spend of almost half a billion pounds.

We have identified that the social franchise could be created with an investment of £800,000 in year one and a further investment of £250,000 in year two; the franchise would begin to generate a significant return, which could be re-invested in developing new services and products by the end of year three.

We have also identified through a process of system simplification and standardisation the net benefit to the sector using a conservative measure of savings could be in the order of £50 million per year.

1. Evidence to inform the model

1.1. Introduction

This project was born from the need to explore a radical alternative approach to domiciliary care, which is in crisis. Both the Welsh Labour Party and Plaid Cymru have a policy commitment to introduce a National Care Service for Wales, "*free at the point of need, continuing as a public service"*[2]*.* Whilst the remit of this service is still being considered by an expert working group, ADSS Cymru wanted to explore the potential to grow a delivery mechanism to support this ambition within the sector. How might a mixed market of businesses, third sector bodies, cooperatives and micro providers work collaboratively together, and with local authority and NHS commissioners and in-house services, to develop and deliver a national model?

A briefing paper outlining a proposal for a franchise/ co-operative model of delivery for domiciliary care was produced by Jason Bennett, Chair of ADSS Cymru's All Wales Heads of Adult Service Group (AWASH). During early 2022, the paper was shared with key parts of the ADSS Cymru membership including members of AWASH Directors of Social Services and the ADSS Cymru Workforce Leadership Group.

The paper proposed that elements of a commercial franchise model – with consistent processes and standards and shared supporting resources – might be delivered using cooperative principles to bolster the sustainability of a mixed market domiciliary care sector.

With endorsement from ADSS Cymru members, the proposal was expanded, and funding was then secured from the Welsh Government Foundational Economy Challenge Fund to carry out a feasibility study to test and further develop the concept.

The feasibility study ran from October 2022 to October 2023, and was delivered by a project team hosted by Practice Solutions on behalf of ADSS Cymru. The structures for delivery and governance are described in section 1.2.1 below.

Through sector engagement, desk top research, design thinking, and financial modelling, the feasibility study aimed:

- To indicate if there is potential to implement the model
- To consider a variety of options for implementation
- To identify potential benefits and risks
- To link to, and be mindful of, other workstreams relevant to domiciliary care
- To avoid any unintended disruption to the current already unstable market.

The underlying questions identified at the outset and that underpin the brief are:

- Is a co-operative/ franchise model of domiciliary care for Wales feasible?
- Will it support sustainability of existing providers, as well as helping new providers become established in the sector?
- Will it enable innovation, good practice, and positive culture change?

This is the final report of the feasibility project; it builds on the findings and feedback of the interim report which was submitted to Welsh Government in May 2023. The interim report presented the findings of the initial desk top research and sector engagement, to better understand both the challenges and the existing resources within domiciliary care.

[2] Welsh Government (2021) The Co-operation Agreement

In its feedback on the interim report, Welsh Government particularly welcomed:

- The intention to support and sustain existing and new domiciliary care services
- The potential for a 'national brand' for domiciliary care
- The opportunity to facilitate greater cooperation and efficiency in the sector
- The prospect of improving recruitment and retention in domiciliary care.

Welsh Government was keen to understand in this final report:

- Potential for overlap, duplication, or synergy with existing initiatives, including in relation to wage structures (Social Care Fair Work Forum), Training and support (Social Care Wales/ SCWWDP), Recruitment (WeCare Wales, apprenticeships), Quality Standards (Care Inspectorate Wales) and the general functions of the National Care Office and the National Commissioning Framework.
- The legal status of the centralised body, financial arrangements, and liability, based on legal advice.
- The assumptions on which the feasibility of the model rests, especially in relation to the number of providers who sign up, and local authority commissioning.
- How the proposals will align with, and support the national *Further, Faster* programme and the Communities of Practice under the Regional Integration Fund, which will develop national service specifications/ models of care.

The focus of the second half of the project has been on developing the vision and high-level design of the proposed model and assessing its overall feasibility, taking account of the above priorities.

This report is organised in three sections:

- The first section expands on the interim report and describes the findings of desk research and sector engagement in relation to the current state of domiciliary care, the national strategic priorities and initiatives relating to the sector.
- Section two describes the proposed model, its organisational structure, and potential functions, describing two of these in some detail, before assessing risks, identifying assumptions, and considering possible cost benefits.
- Section three presents overall conclusions regarding feasibility and likely impact, and summarises options, recommendations and suggested next steps.

1.2. Methods and activities

1.2.1. Governance and delivery structure

The project has been led by ADSS Cymru, with Jason Bennett, (Head of Adult Services and Chair of All Wales Heads of Adult Services) acting as project director, and Jonathan Griffiths (Director of Social Services Pembrokeshire) and then (due to change in roles) Jenny Williams (Director of Social Services, Conwy and Chair of the Workforce Development Group) acting as project sponsor. A project manager was seconded from local authority adult social care to work alongside a team of Practice Solutions staff and associates. Legal, technical and Human Resources expertise was sub-contracted as required.

A Governance Group was established in January 2023 and met monthly over the duration of the project to provide governance and guidance to the project team. The group contained representatives from:

- ADSS Cymru Director
- Head of Commissioning
- HR/ Workforce
- Social Care Wales
- Care Forum Wales
- National Commissioning Board
- Health Board, Lived Experience/ Independent, and Third Sector representatives.
- Care Inspectorate Wales

1.2.2. Methodology

Research methodologies are the primary principles which guide a study[3]. It was clear from the outset that any model developed needed:

- To be coproduced with the domiciliary care sector and other key stakeholders, developing solutions in response to the challenges they face using design thinking principles.
- A Theory of Change which clearly describes the changes which the proposed model seeks to make and how it is expected to bring about these changes.
- To work financially – at least in principle – for providers, local government, NHS, and National Government.

In the remainder of this section, we give further definitions and a brief overview of how we applied Coproduction, Theory of Change and Dynamic Financially Modelling approaches with the feasibility study.

Coproduction
For the proposed franchise to be feasible it must focus on what matters to the people involved in domiciliary care – those running care organisations and their staff, those using care services, and other key stakeholders – commissioners, the community and voluntary sector and the NHS. The project team was committed to trying to co-produce the model with these diverse groups, as far as possible within the time and resources available.

[3] Dawson, C. (2019) Introduction to Research Methods 5th Edition: A Practical Guide for Anyone Undertaking a Research Project, Little Brown Book Group

Think Local Act Personal (TLAP)[4] proposes that:

> *"The term co-production refers to a way of working, whereby everybody works together on an equal basis to create a service or come to a decision which works for them all".*

Co-production Network for Wales[5] sets out five values underpinning coproduction:

- Value people and build on their strengths.
- Develop networks that operate across silos.
- Focus on what matters for the people involved.
- Build relationships of trust and shared power.
- Enable people to be the change-makers.

At the start of the project, the team did not have a fixed idea of how the model might work. We were keen to understand more about the day-to-day challenges and existing resources of domiciliary care providers and consider whether there was scope and appetite for a franchise model to develop solutions to these challenges through cooperation across silos.

Initially, we took the broad concept to several care provider forums, but it quicky become clear that this was too abstract to meaningfully engage busy providers who were juggling a huge number of practical challenges. We needed to flesh out one or two options of how the model might operate and develop ways of communicating these effectively to gather meaningful feedback from the sector.

The team developed six options for different levels of service which the franchise model might offer (these are listed in section 2.3) and ran two online engagement events in November 2022 and January 2023. We invited diverse stakeholders – from local authorities, the voluntary, community and cooperative sectors, from sector bodies, and policy officers – to feedback on these options and give us their alternative ideas, both during online sessions and through a 'Miro-board' (See Appendix 4) which could be accessed during, between and after the sessions. We used the collective efforts of these sessions to develop an outline of the model and materials (a video, a presentation, leaflets and a web page) to describe it to wider stakeholders.

Video Link: https://youtu.be/FpePpKyLFw4

We used these materials as the starting point for conversations at three face-to-face events in different parts of the country, and one online session. These were attended mostly by those commissioning or delivering care. Frontline workers were under-represented at these, so we ran a further series of events to engage them. Since the focus of the discussions was on back-office processes within the domiciliary care sector, it was harder to meaningfully involve people with lived experience of care, though some individual citizens did attend the events. We sought to mitigate this by employing two people with lived experience of care services to co-facilitate and participate in the online and face-to-face engagement events, and to sit on the project's Governance Group.

These events were supplemented by ongoing engagement throughout the project, with individual stakeholders, regular meetings with key bodies such as Social Care Wales, unions, care providers' membership organisations, and attendance at a range of local, regional, and national forums and networks.

[4] Think Local Act Personal: 'What is Coproduction?' accessed on 03/11/23 from: https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/what-is-co-production/

[5] Coproduction Network for Wales: 'What is Coproduction?' accessed on 03/11/23 from: https://copronet.wales/home/coproduction/?cn-reloaded=1&cn-reloaded=1

We have used the engagement to sense test the findings of our desk research and to inform further searches.

Design thinking
Design thinking provides an iterative, solution-based approach to solving complex problems. According to Interaction Design Foundation[6], it involves the following activities, though not necessarily in a linear process.

1. Empathise: understand end users' needs
2. Define: state end users' needs and priorities
3. Ideate: challenge assumptions and create ideas
4. Prototype: start to create solutions
5. Test solutions

Throughout the project, the team has been involved in each of these stages, through our engagement activity, our desk research, and ideas development.

In the final months of the project, having heard and defined the needs and ideas of the sector, our focus has been on designing solutions, within the parameters suggested by our legal advisers and informed by our financial modelling.

Theory of Change
A theory of change model is a structured framework that illustrates the causal relationships between inputs, activities, outcomes, and potential impacts of a project, investment or change in policy. It is particularly useful when considering complex multi-agency projects requiring a system change, making it particularly suitable for this project.

We have used a theory of change approach from the outset. It helped us refine and define the options in the interim report and has been particularly helpful in determining the relationship between the activities of providers, local government, national government and the regulator.

The social franchise will act as a system catalyst. That is, it will impact upstream (local government, national government, and the NHS) and downstream (provider organisations, domiciliary care workers and ultimately, people who receive care.) The theory of change sets this impact out systematically.

The Theory of Change has evolved over the course of the project, as it has become clearer from our engagement which functions the social franchise should initially focus, and how it might fit into the current landscape in domiciliary care. The final version is appended (Appendix 4).

Dynamic Financial Modelling
Dynamic financial modelling considers at a granular level if creating a social franchise could work for providers, local government, NHS and National Government.

At a practical level, dynamic financial modelling simply involves creating a model in a spreadsheet that enables analysis of financial and other data, incorporating assumptions and inputs to produce dynamic outputs. Dynamic simply means the outputs can, and have changed, depending on the inputs and assumptions. This has enabled us to test and change the model we are developing and alter the inputs. Dynamic modelling is evolutionary in that it continually adapts to changing inputs and assumptions.

- **Assumptions:** These are the foundation of the model and include all the relevant data. This is set out in Appendix 1.

[6] Dam, R. F. (2023, October 16). *The 5 Stages in the Design Thinking Process*. Interaction Design Foundation - IxDF. https://www.interaction-design.org/literature/article/5-stages-in-the-design-thinking-process

- **Inputs:** the model inputs are taken from the assumptions, feedback from providers and other experts and high-level costings.
- **Estimations and simplifications:** Although there is significant complexity in the system, we have attempted to keep the core underpinning calculations as simple as possible. This has required a level of estimation and simplification reflective of the fact we are producing a feasibility study and not a definitive fully costed model.
- **Scenario Analysis:** we created many different scenarios to explore their financial implications. The key scenario we have considered is the number of providers that would be needed to sign up for the model.
- **Dynamic Outputs:** The outputs that have been generated are purposely dynamic providing a comprehensive evolving view of the model. These have crucially enabled us to refine the model to test its feasibility.

1.2.3. Methods and activities

Having described our methodological approach in the previous section, we summarise here the activities carried out as part of the feasibility study.

Desk research
Desk research has been ongoing throughout the study, as we have searched for and reviewed relevant:

- National strategy and policy documents
- Datasets
- Reports of research and evaluation (mostly from the 'grey literature')
- Existing processes and initiatives
- Articles and web pages of initiatives which describe alternative models and structures.

We have reviewed in detail approximately 40 reports.

Engagement
141 individuals were formally engaged in the feasibility study, some via multiple methods, resulting in a total of 165 engagements. The following table summarises engagement by organisation type:

Organisation Type	Number	Attendance at existing group	Individual discussion	Attended initial MIRO workshops	Attended engagement event	*Total Attendances*
Private provider	37	5	10	1	28	***44***
Citizen (service user or councillor)	6	1	3	1	2	***7***
Regional partnership board	4	2	2	0	0	***4***
Sector body	5	0	7	2	0	***9***
Network/ Community of Practice	5	7	1	1	0	***9***
Local authority	33	5	3	11	14	***33***
CVS/ social/ micro enterprise	16	1	5	5	7	***18***
NHS	6	1	3	2	0	***6***
Trade Union	1	0	1	0	0	***1***
Government/ Regulatory	5	0	6	1	0	***7***
Social Care Wales/ We Care Wales	9	0	8	2	0	***10***
Researcher	3	0	6	0	0	***6***
Other	1	0	1	0	0	***1***
Care worker	10	0	0	0	10	***10***
Total	**141**	**22**	**56**	**26**	**61**	***165***

Advice from legal and other experts
We have drawn in specialist advice from the following experts:

Legal advisors: Legal advice was sought from experts with an understanding of domiciliary care in a Welsh context and models of cooperative working, to ascertain which legal frameworks were available to us for consideration and which would be most feasible to adopt. Their advice is summarised in section 2.3, and included in full in appendix 14.

HR expertise: At the outset, the plan had been to establish a workstream dedicated to HR and overseen by an HR specialist seconded from a local authority. However, this proved challenging due to lack of capacity within local authorities. Additional resource was allocated within the associate team and from the ADSS Cymru Business Unit to support this aspect of the study.

1.2.4. Overview of project journey

The project journey – as described in the above text – is summarised in the following table:

Months	Phase name	Phase activities	Outputs/ Implications
September – October 2022	Scoping stage	Initial desk research, engagement and thinking	Developed options for levels of service to test in engagement
November – January	Initial engagement	Sessions with professionals to discuss options, collectively formulated an additional option	There was appetite for something more ambitious than option 5 but not compulsory. Mind map of possible functions
Jan- March		Further desk research and development of model. Planning wider engagement	Produced video, presentation and comms materials. Invitation to stakeholder events.
March- April	Formal sector engagement	Engagement sessions (3 face-to-face, 1 online, and further events to engage frontline workers)	Understanding of needs, priorities, ideas and concerns in relation the proposed model
May	Interim reporting	Produced interim report Received feedback from WG on interim report	WG supportive but want reassurance that franchise would not duplicate existing initiatives.
June	Expert input	Expert input: legal advice, focus on technology to support elements of the HR function.	Set parameters: shared service and cooperative structure not feasible; limited company with lean structure operating social franchise
July-Sep	Design thinking	Ongoing meetings and updates with sector bodies Internal work to vision and describe future state	Finding balance between radical change and risk of destabilisation Developed high level proposals for franchise organisational structure, HR and Finance functions

Sep – October	Testing and writing up	Financial modelling Sense-checking high-level model and conclusions with key stakeholders Report writing	Presentations and meetings with ADSS, We Care Wales, Provider Forums Final report produced

1.3. Desk research findings

Our desk research focused on the following objectives:

- Understanding the current domiciliary care market, across Wales and how this differs across different local contexts, to inform the design of the entity, in particular:
    - The mix between private (including commercial franchise), local authority, third sector and microenterprise provision; and
    - The way in which domiciliary care services are purchased, by local authorities, health boards, self-funders and direct payment users.
- Understanding the challenges facing the sector – to evidence and better understand:
    - The problems which the proposed model might address and what is driving these; and
    - The impact these challenges are having on citizens, systems, and public spending: the business case for taking action.
- Understanding the strategic priorities and national initiatives relevant to the sector, to ensure alignment and avoid duplication.
- Reviewing alternative models in order to draw learning for the proposed central entity, including:
    - Commercial and social franchising
    - Cooperatives and
    - Shared services.

Proportionate to the scope and scale of the feasibility study, we employed a rapid evidence review approach, carrying out targeted online searches to find relevant publications with a focus on grey rather than academic literature. Through the desk top review, we also identified the assumptions and data which underpin our cost benefit modelling in section 2. These assumptions are presented together in Appendix 1, for ease of reference; key findings are also included in this section.

1.3.1. The domiciliary care market in Wales

A mixed economy of providers
The domiciliary care sector in Wales is a mixed economy. There are approximately 650 registered domiciliary care services registered with Care Inspectorate Wales. Of these, 525 are Limited Companies, 90 are charitable companies, 22 are local authorities which will often include reablement services, and the rest are a mixture of individual registrations and partnerships.[7]

Private sector
There are a relatively small number of commercial franchises operating in Wales; some larger, national care companies, many small local companies, and a rising number of micro-enterprises. Some companies have multiple services, and some provide other social care services, such as residential care homes.

There is a marked difference between rural areas, characterised by smaller, local organisations and micro-enterprises, and urban areas where there is typically more of a mix of small providers

[7]CIW data accessed via https://app.powerbi.com/view?r=eyJrIjoiMGZkYmYxOGMtZGJhZi00ZjZjLTg5YzctM2VkYWJkZjkxYTkyIiwidCI6ImEyY2MzNmM1LTkyODAtNGFlNy04ODg3LWQwNmRhYjg5MjE2YiJ9

and large, national ones, including the franchises. Unlike in children's social care[8] and the residential care home market[9], fewer domiciliary care providers are part of large group structures. The market contains a high number of smaller, often family-run companies and third-sector bodies which form the backbone of many communities, employing local people and recycling much of their profit into the Welsh economy. According to a survey conducted by Care Inspectorate Wales in 2016[10], a third of domiciliary care providers employed less than 25 people, and two-fifths described themselves as 'small family-run businesses'; 7% were part of a franchise.

Many providers deliver a mix of services commissioned through local authorities and health boards, alongside private customers – including both self-funders and users of direct payments; some providers operate in England as well as Wales.

Some private providers work predominantly or exclusively with self-funding individuals and their families since this arrangement is less bureaucratic, tends to generate higher net income and greater flexibility to work in innovative ways. There is no national data set collating intelligence on self-funders, and local authority systems are focused upon their commissioned activity only[11]. Research undertaken by the Homecare Association[12] estimates that across Wales, 21% of domiciliary care is purchased by self-funders.

Local authorities

A report by ADSS Cymru in 2020[13] estimated that local authorities were delivering 12% of the total number of hours of domiciliary care they commission using their own in-house teams. This has reduced from an estimated 39% in 2009/10[14]. However, the picture varies by area: four councils reported that all (or very nearly all) of their domiciliary care was delivered by private sector providers, and in a further seven local authority areas, the proportion delivered by the private sector was 90% or more.

Social Care Wales[15] estimates that local authorities employ 4,200 domiciliary carers directly, making up 22% of the total workforce. Local authority care workers typically enjoy better terms and conditions than those working for commissioned providers, though Social Care Wales also notes significant use of temporary and zero hours contracts by local authorities. Workers in local authorities are more likely to be older than those working in commissioned services, with local authority staff dominating the 46 to 65 age groups.

Third sector

The third or voluntary sector has historically been seen as a supplementary, rather than primary, source of care, strong in areas of prevention and lower-level non-statutory services, bringing good

[8] https://www.adss.cymru/en/blog/post/delivering-transformation-grant-programme-2019-20-rebalancing-social-care-a-report-on-adult-services

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1059604/Wales_summary.pdf

[9] https://cymru-wales.unison.org.uk/content/uploads/sites/9/2022/11/APSE-report-A-National-Care-Service-for-Wales-PRINT-19.10.22.pdf

[10] Care and Social Services Inspectorate Wales (2016) 'Above and Beyond' National Review of Domiciliary Care in Wales': https://www.careinspectorate.wales/sites/default/files/2018-03/161027aboveandbeyonden.pdf

[11] Institute of Public Care (2022) West Wales Care Partnership Market Stability Report 2022 (v12), February 2022 at: https://www.wwcp.org.uk/wp-content/uploads/2022/06/WWCP-MSR-Final-Feb-2022.pdf

[12] Homecare Association (2021) An overview of the UK Home Care Market

[13] Breeze, C. & Milsom, S. for ADSS Cymru (2020) Rebalancing Social Care: A Report on Adult Services

[14] United Kingdom Homecare Association (2021) An overview of the UK Home Care Market

[15] Social Care Wales (2022) Social Care Workforce Report 2022, Cardiff, Social Care Wales https://socialcare.wales/cms-assets/documents/Social-care-workforce-report-2022.pdf

local knowledge and a strong community base. The sector's role in providing commissioned domiciliary care services is small, with a report for ADSS Cymru in 2020[16], estimating that just 3% of domiciliary care commissioned by local authorities was delivered by it in 2018/19. Nevertheless, Section 16 (1) of the Social Services and Well-being (Wales) Act 2014 imposes a duty on local authorities to promote the development of social enterprises and co-operative organisations or arrangements and the availability of third sector organisations to provide care, support, and preventative services. There is also evidence of an aspiration for growth in this area on the part of community and voluntary sector organisations. Research commissioned by Social Care Wales in 2021[17] found that 90% of third sector organisations providing domiciliary care and 69% of those providing wider care and support planned to expand over the next three years.

Micro-enterprises

Micro-care is defined as care delivered either by a small team or an individual, to up to five clients, usually at a localised level[18]. Several local authorities have developed strong networks, working individually or in partnership with Community Catalysts to promote the development of micro-enterprise in social care, and to ensure that micro-entrepreneurs have the right support, access to training and vetting. Examples include Flintshire, Pembrokeshire, Carmarthenshire, Gwent and Monmouthshire. There is emerging evidence (Sanders 2021[19]) that the micro-enterprise model supports recruitment and retention in social care, by offering opportunities for flexible self-employment and for consistent relationships with a small number of individuals. The model can bring diversity and resilience, especially in more remote rural areas, S. & Phagoora, J. (2020) Community micro-enterprise as a driver of local economic development in social care https://neweconomics.org/uploads/files/Community-micro-enterprise2.pdf. Harrison & Pavia[20] however have argued that, being unregulated, micro-enterprises have a financial advantage as they do not bear the costs of a provider.

Personal Assistants

Direct payments were introduced as an alternative to traditionally commissioned care, aiming to empower individuals by handing choice and control to them. Individuals use the direct payment (the value of which is determined via an assessment of needs) to employ personal assistants (PAs) to deliver the outcomes of their statutory care plan, often resulting in more flexible, individualised, relationship-based and outcome-focussed care and support[21]. The number of people receiving a Direct Payment has gradually increased year on year, up to 6,262 in 2018-19[22]. Direct payments have mainly been used to support those with either learning disabilities or a physical disability, accounting for more than two-thirds (69%) of the spend in 2019-20.

[16] Breeze, C. & Milsom, S. for ADSS Cymru (2020) Rebalancing Social Care: A Report on Adult Services

[17] Wavehill Social and Economic Research/ Wales Co-operative Centre Consultancy (2021) Understanding the role and impact of the third sector in providing care and support services (commissioned by Social Care Wales)

[18] https://cynnalcymru.com/flintshire-county-council-investing-in-micro-care-to-strengthen-the-foundational-economy/

[19] Sanders, R (2021) New Models of Care at Home: ESSS Outline for Iriss: https://staging.iriss.org.uk/sites/default/files/2021-11/outline-new-models-of-care-at-home.pdf

[20] Harrison, N. & Pavia, P. (2020) Mapping Cooperative Provision – Domiciliary Care, Delivering Transformation Grant Programme, ADSS Cymru:

[21] Social Care Wales (2022) Direct Payments: A Guide, Cardiff, Social Care Wales: https://socialcare.wales/resources-guidance/improving-care-and-support/care-and-support-at-home/direct-payments-a-guide

[22] United Kingdom Homecare Association (2021) An overview of the UK Home Care Market

PAs often have more than one employer, and sometimes multiple contracts or none. Research carried out by the Welsh Government (Wallace et al 2022[23]) found significant variations in PA pay, driven by different rates set by Welsh local authorities rather than roles or responsibilities. Terms and conditions are inconsistent and often unclear. The study found a lack of consistent mandatory training, variable access to specialist training, and a lack of professional development opportunities for PAs. 65% of employers (i.e., individuals using Direct Payments) reported finding it difficult or very difficult to recruit PA, meaning that they often need to turn to domiciliary care agencies to provide carers, or where they exist, people choose to engage a micro-enterprise via their direct payment. This is one of the reasons why we have included 50% of the national spend on Direct payments in our calculations.

Implications of the mixed economy

There has been pressure from Unison Cymru Wales[24] to move away from privately-owned provision in the Welsh social care sector, with concerns about profits being generated by larger group structures (especially within the care home and children's markets), and about quality.

However, Care Inspectorate Wales's data tool[25] suggests minimal differences between private and non-private provision in terms of quality from a regulatory perspective. The following table shows domiciliary care providers' compliance with quality standards broken down by private versus public/ not-for-profit services.

	All providers	% of all providers	Private Ltd companies	% of all private ltd companies	Other providers	% of all other providers
Compliant	477	72%	382	71%	94	72%
Area(s) for improvement	170	25%	135	25%	35	27%
Priority Action Notice(s)	20	3%	18	3.4%	2	1.5%
Total	667	100%	535	100%	131	100%

Non-private providers (27%) are somewhat more likely than private providers (25%) to have one or more area for improvement identified by CIW; with private providers somewhat more likely to have a priority action notice (3.4% compared to 1.5%).

It can be argued that a mixed economy of care brings a variety of strengths and specialisms and increases choice for people who need care. Many self-funding customers are paying for lower-level services which local authorities may not fund, others chose this option as they do not want to engage with social services and would rather have self-determination, voice, and control. These services are helping them to remain independent and safe in their homes, where they might otherwise be at risk of being in hospital.

[23] Wallace, S., Llewellyn, M., Garthwaite, T., Randall, H. & Sullivan, S. (2022) Research on the Employment of Personal Assistants in Social Care. Cardiff, Welsh Government https://www.gov.wales/sites/default/files/publications/2022-09/research-on-the-employment-of-personal-assistants-in-social-care_0.pdf

[24] Mudd, A. & Cheetham, T. (2022) A National Care Service for Wales, Unison Cymru Wales/ apse solutions: https://cymru-wales.unison.org.uk/content/uploads/sites/9/2022/11/APSE-report-A-National-Care-Service-for-Wales-PRINT-19.10.22.pdf

[25] Care Inspectorate Wales data tool, accessed 26 October 2023

However, as Wales Fiscal Analysis (2020)[26] argues:

> *"This complex mixed economy presents significant challenges in terms of policy and planning. The Welsh Government has attempted to address this through several mechanisms, such as the Regional Partnership Boards and a more co-ordinated approach to commissioning. The key question is whether such approaches will overcome the challenges of fragmentation".*

Care Inspectorate Wales (2016) has also highlighted the challenges which this fragmentation presents in relation to 'market development, and reporting on the market, and registration and inspection' (p.74[27]). This fragmented market can make it challenging for sector bodies and government agencies to communicate and implement new initiatives consistently.

There are seven NHS health boards and 22 local authorities in Wales. Each has its own commissioning, contracting, care management and fee-setting approach. This creates considerable complexity for independent providers, leading to increased administrative burden (e.g., because of different invoicing arrangements, provider frameworks, and contract terms) and challenges around cash flow, as reflected in the CIW research cited above.

In a recent commentary, the Wales Centre for Public Policy highlighted the fact that:

> *"There are multiple employers, no single body for determining pay, and the price paid for care by Local Authorities is determined by individual negotiations between commissioners and independent providers[28].*
>
> *"The problem with complexity is not only that it is a significant driver of cost within a supply chain but that it also contributes to variability and uncertainty".[29]*

Bureaucracy, complexity, cash flow, and issues with staff recruitment and retention, combined with insufficient overall funding for social care are resulting in considerable churn within the sector – in terms of both registered services and care workers. The Homecare Association (2021)[30] reports that, despite the new registration of 65 services in 2019/20, there appeared to be 191 services de-registering.

On a positive, over the past four years, there has been a 30% increase in the net number of domiciliary care services registered with Care Inspectorate Wales[31]. This suggests a degree of market optimism, perhaps caused by the expansion of existing domiciliary care companies, growth of micro enterprises into new registered providers or new companies or third-sector organisations are entering the market for the first time. There is a clear opportunity to nurture these new market entrants whilst improving the stability of established quality providers.

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[26] The future of care in wales: resourcing social care for older adults 2020: https://www.cardiff.ac.uk/__data/assets/pdf_file/0019/2427400/social_care_final2_aug20.pdf

[27] Care and Social Services Inspectorate Wales (2016) 'Above and Beyond' National Review of Domiciliary Care in Wales': https://www.careinspectorate.wales/sites/default/files/2018-03/161027aboveandbeyonden.pdf

[28] Lloyd, A. (2022) Social care workforce crisis in Wales: what is causing it and what is being done to fix it? Wales Centre for Public Policy, Commentary, 11 October 2022: https://www.wcpp.org.uk/commentary/social-care-workforce-crisis-in-wales-what-is-causing-it-and-what-is-being-done-to-fix-it/#:~:text=Disparities%20between%20health%20and%20social,social%20care%20is%20highly%20fragmented.

[29] https://blog.som.cranfield.ac.uk/execdev/keeping-a-lid-on-supply-chain-complexity

[30] Homecare Association (2021) An overview of the UK Home Care Market

[31] CIW data accessed via https://app.powerbi.com/view?r=eyJrIjoiMGZkYmYxOGMtZGJhZi00ZjZjLTg5YzctM2VkYWJkZjkxYTkyIiwidCI6ImEyY2MzNmM1LTkyODAtNGFlNy04ODg3LWQwNmRhYjg5MjE2YiJ9

1.3.2. Challenges in the domiciliary care sector

Quality, experience, and safety
In the CIW research conducted in 2016[32], there was a concern about the quality of domiciliary care from all parties: those receiving care, those working in care, providers, and commissioners. CIW found:

> *"Providers do not believe that current fee levels offered by councils allow them to offer services that can be sustained and expanded in the future" (p.76).*

This study also highlights that continuity of staff to enable relationship-building and better communication is what matters most to those receiving care. This is not just a 'nice-to-have': workforce, turnover and lack of continuity has been shown to be related to higher rates of deaths amongst service users (Welsh Government 2016[33]).

Demand and capacity
Under the Social Services and Wellbeing Act (Wales) 2014, local authority social services have a duty to assess individuals and provide services to meet eligible needs. For most people, this will mean accessing domiciliary care either through directly commissioned services or Direct Payments. Social care, and primarily adult social services are the main commissioners of domiciliary care: this is where most resources are focussed – from assessing, commissioning, contract monitoring to delivering domiciliary care itself.

The total revenue for the domiciliary care sector in 2022 was £470M; of which £325M/ £360M (69%/ 77%) was local authority spend, including direct payments[34].

There is at present a significant shortfall in the supply of domiciliary care to respond to demand.

According to our analysis of (unpublished) data submitted to Welsh Government earlier in 2023, there were over 18,000 people receiving care, and around 1,500 waiting for care, around a third of whom had been waiting for more than three months. An additional 13.5K hours of domiciliary care is needed per week to meet the shortfall.

Demand for domiciliary care – including for diverse and specialist provision – is likely to increase significantly, given demographic trends. For example:

- 83% of adults receiving domiciliary care arranged or provided by local authorities were aged 65 or over: a figure that has remained constant since 2017-18 (Homecare Association 2021)
- The number of people over 65 who need assistance with the activities of daily living is projected to increase by 34%, from 2020 to 2040 (Audit Wales (2021).[35]
- Estimates suggest that, by 2040 in Wales, there will be 53,700 older

[32] Care and Social Services Inspectorate Wales (2016) 'Above and Beyond' National Review of Domiciliary Care in Wales': https://www.careinspectorate.wales/sites/default/files/2018-03/161027aboveandbeyonden.pdf

[33] Welsh Government (2016) Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care, Social Research Number 24/2016: https://www.gov.wales/sites/default/files/statistics-and-research/2019-07/160317-factors-affect-recruitment-retention-domiciliary-care-workers-final-en.pdf

[34] Welsh Government, StatsWales: Social services revenue outturn expenditure by client group, 2022/23: https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue/Social-Services/social-services-socialservicesrevenueexpenditure-by-clientgroup

[35] Audit Wales (2021) A Picture of Social Care, Report of the Auditor General for Wales, October 2021: https://www.audit.wales/sites/default/files/publications/POPS-Social-Care-Eng_1.pdf

adults living with severe dementia, nearly double the current number (Wales Fiscal Analysis 2020)[36].

- In Rebalancing Care (Welsh Government 2021[37]), the government identified that they expect significantly more older people from black and ethnic minorities will need access to social care in future.
- Anecdotal evidence from local authorities suggests that, in some areas, the age of people needing statutory support such as domiciliary care is falling due to obesity and long-term health conditions.

Workforce challenges
In 2022, Social Care Wales estimated that there are 19,571 individuals employed in domiciliary care[38]. The same report estimated around 1,728 vacancies in domiciliary care, meaning that around 8% of posts are vacant. Staff turnover is estimated to be around 32%[39].

A number of factors seem to be driving this picture:

- **Pay, conditions and value, given nature of role**

Following their recent rapid review on the topic, Edwards et al (2022, p.206[40]) concluded that:

> *"the reasons for the challenges in recruiting and retaining staff are manifold and include shortages of workers, poor perceptions of care work, low pay and poor working hours, and the demanding nature of care work."*

Unemployment rates are currently very low, resulting in high levels of competition and choice in the job market, alongside the cost-of-living increase which has made it increasingly difficult to survive on low pay. A decade ago, domiciliary care wages were higher than those in retail, but that is no longer true[41]. Unlike in retail, workers in domiciliary care tend not to be employed on regular shift patterns, are often not properly recompensed for travel time or costs, and are required to register, and complete extensive training and qualifications.

- **High vacancies and turnover creating a vicious cycle**

High turnover, or staff shortages have an impact on all involved in domiciliary care, as staff are more pressurised, have less time, and more changes are made to rotas, all impacting on service user experience. This in turn impacts on job satisfaction and retention.

This has been compounded by the impact of Brexit and the pandemic in recent years:

- **Brexit**

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[36] https://www.cardiff.ac.uk/__data/assets/pdf_file/0019/2427400/social_care_final2_aug20.pdf

[37] Welsh Government (2021) Rebalancing care and support: White Paper Number: WG41756: https://www.gov.wales/sites/default/files/consultations/2021-01/consutation-document.pdf

[38] Social Care Wales (2022) Social Care Workforce Report: https://socialcare.wales/cms-assets/documents/Social-care-workforce-report-2022.pdf

[39] https://research.senedd.wales/research-articles/the-future-of-social-care/

[40] Edwards, D, Trigg, L, Carrier, J, Cooper, A, Csontos, J, Day, J, Gillen, E, Lewis, R and Edwards, A. 2022. A rapid review of innovations for attraction, recruitment and retention of social care workers, and exploration of factors influencing turnover within the UK context. Journal of Long-Term Care, (2022), pp. 205–221.

[41] Home Care Association (2021) Homecare Deficit Report

Research conducted by Ipsos MORI on behalf of Welsh Government[42] at the start of 2019 estimated that 6.4% of staff within registered adult social care settings were non-UK EU nationals.

- **COVID-19 pandemic**

The OSCAR study[43], which investigated the impact of the pandemic on domiciliary care workers in Wales, found that 34% of all care workers required support for a mental health condition during or after the pandemic, with rates of attending a GP or receiving a relevant prescription increasing in frequency when compared to the four years preceding the onset of the pandemic. This may well have contributed to the increase in people leaving the sector, including people retiring early, after the pandemic.

The demographics of the workforce are also significant:

- Domiciliary care workers employed directly by local authorities tend to be older: 56% of domiciliary care staff employed by providers are under 45, whereas 52% of those employed by local authorities are over 46[44], which increases the risk of further vacancies in the coming decades. Anecdotally, older workers may be more likely to be put off by the requirements to register and gain qualifications in recent years.
- 88% of domiciliary care roles were filled by women in 2022[45]: low pay and poor work conditions are matter of gender inequality as Hayes (2017)[46] has described in detail.

Rurality can be a compounding factor:

- In rural areas, the rapidly increasing number of older people through natural demographic growth and in-migration, is not matched by the availability of younger people to work in domiciliary care. For example, Powys is experiencing a loss of approximately 600 people of a working age annually: many are unable to afford to live in such a rural setting, especially on carers' wages[47].

Impact of lack of capacity in the domiciliary care sector

Good quality domiciliary care is the corner stone of both the health and social care systems and is essential if citizens are to live well at home. Domiciliary care reduces pressure on unpaid carers, prevents deterioration and avoidable hospital or care home admissions. It facilitates early discharge and reablement and acts as the foundation for a range of national, regional, and local initiatives to support communities, primary care and acute hospitals.

The impact of the current crisis in domiciliary care is seen throughout the system and these patterns highlight the interdependency of health and social care services. For example:

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[42] Hutcheson, L; Ormston, R (2019). Research on Implications of Brexit on Social Care and Childcare Workforce in Wales. Cardiff: Welsh Government, GSR report number 14/2019; Available at: https://gov.wales/implications-brexit-social-care-and-childcare-workforce-0

[43] Robling, M. & Cannings-John, R. (2022) How has the COVID-19 pandemic affected the health of domiciliary care workers in Wales? OSCAR Study Policy Briefing, May 2022. Cardiff University Centre for Trials Research: https://www.cardiff.ac.uk/__data/assets/pdf_file/0009/2628063/OSCAR-policy-briefing-MAY2022.pdf

[44] Social Care Wales (2022) Social Care Workforce Report: https://socialcare.wales/cms-assets/documents/Social-care-workforce-report-2022.pdf

[45] Social Care Wales (2022) Social Care Workforce Report: https://socialcare.wales/cms-assets/documents/Social-care-workforce-report-2022.pdf

[46] LJB Hayes (2017) Stories of Care: A Labour of Law, Palgrave Socio-Legal Studies

[47] Dr Hugh Dylan Owen (2023) 'The Return of a National Service', The Welsh Agenda, 25 May 2023: https://www.iwa.wales/agenda/2023/05/care-services-wales-sustainable/

- Delays accessing care are having a significant detrimental impact on those individuals waiting, their carers, family, and their wider support network (Age Cymru 2023)[48].
- It is suggested that the lack of social care capacity is the biggest contributor to delayed hospital discharges; and there is evidence of people being placed as a short-term measure in residential care on discharge, but then not being able to return home due to a lack of domiciliary care.[49]
- In his review of Discharge to Assess arrangements, Bolton (2021)[50] highlights both the impact of a lack of availability of domiciliary care, whilst at the same time highlighting 'the restrictive over prescribing of care with little flexibility for providers' (p.6).

[48] Age Cymru (2023) Why are we still waiting? Delays in social care in Wales: https://www.ageuk.org.uk/globalassets/age-cymru/documents/why-are-we-still-waiting/age-cymru---why-are-we-still-waiting---delays-in-social-care-in-wales--july-2023---web.pdf

[49] Welsh Parliament: Health and Social Care Committee (2022) Hospital discharge and its impact on patient flows through hospital, June 2022: https://business.senedd.wales/documents/s126125/Hospital%20discharge%20and%20its%20impact%20on%20patient%20flow%20through%20hospitals%20-%2015%20June%202022.pdf

[50] Bolton, J. (2021) Developing a capacity and demand model for out-of-hospital care: Learning from supporting seven health and care systems, Local Government Association: https://www.local.gov.uk/sites/default/files/documents/25.200%20Developing%20a%20Capacity_04_1.pdf

1.3.3. Current strategic priorities

In its feedback on the feasibility study interim report, Welsh Government has emphasised the need to be mindful of other strategic priorities, initiatives, and resources in the sector, and demonstrate how the proposed model might align with, add value to and avoid duplication with them. Here, we outline the key strategic developments in this area and their relevance to the feasibility study.

Rebalancing Care and Support
The Rebalancing Care and Support White Paper[51] recognises the fragility and complexity of the current care and support market and aims to change the system by creating a clear national framework, where services are organised regionally and delivered locally:

'In doing so, we aim to rebalance social care so that there is neither an over reliance on the private sector, nor a monopoly in the other direction' (p.8).

A consultation on various strands of the Rebalancing Care and Support Programme ended in August 2023. This includes papers setting out proposals for:

- The national framework for the commissioning of care and support in Wales
- Proposals for a pay and progression framework for the social care workforce in Wales

National Care and Support Service and Office
Welsh Government has set up an expert group to explore the possibility of a National Care and Support Service, to support the government's vision for care and support services to be "fully resourced, sustainable, community-centred, person-directed and free at the point of need" (p.6[52]).

The report of the expert group in September 2022[53] identified key changes that would be required to facilitate the vision, including supporting and valuing the work force, improving prevention and early intervention; and partnering locally. Current barriers highlighted include: the lack of parity between the terms and conditions of NHS and care staff, and the lack of financial investment in social care, including a properly remunerated workforce.

The report also builds on the recommendation of the Rebalancing Care white paper, supporting the idea of

> *"a centralised national entity having responsibility for taking a 'birds eye view 'of all elements of the social care system in Wales, being responsible for a shared national vision and providing strong leadership towards implementation of the spirit of the Act through a unified National Care and Support Service"* (p.13).

The envisaged National Care and Support Office would potentially take on responsibility for key functions such as overseeing national terms and conditions, standards, and commissioning guidelines; and coordinating national support for workforce training and development.

[51] Welsh Government (2021) Rebalancing care and support: White Paper Number: WG41756: https://www.gov.wales/sites/default/files/consultations/2021-01/consutation-document.pdf

[52] Towards a National Care and Support Service for Wales: Report of the Expert Group, Welsh Government: https://www.gov.wales/sites/default/files/publications/2022-11/towards-a-national-care-and-support-service-for-wales_0.pdf

[53] Towards a National Care and Support Service for Wales: Report of the Expert Group, Welsh Government: https://www.gov.wales/sites/default/files/publications/2022-11/towards-a-national-care-and-support-service-for-wales_0.pdf

A Healthier Wales
The Healthier Wales policy[54] developed by Welsh Government in June 2018, outlines a vision for a health and social care sector that works together to focus on well-being and prevent illness, which leads to higher quality care and value, through less intensive clinical interventions and a reduction in variation, waste, and harm. It seeks to shift services out of hospital into communities and support people to live healthy, happy lives, ensuring they stay well at home. It is about enabling people to live independently for as long as they can, supported by new technologies and by integrated health and social care services that are delivered closer to home. For the ambition of a Healthier Wales to be realised, the domiciliary care market is a key player, and its stability is critical for this policy to be fully realised.

Further, Faster
As discussed above, the health and social care systems depend on each other to function effectively and a significant proportion of the 'flow' between them is influenced by the availability or otherwise of domiciliary care. Building Capacity through Community Care – Further Faster[55] recognises the impact which missed opportunities for prevention and early intervention in the community are having on individuals, communities and the health and care system. It sets out Welsh Government's vision for whole-system place-based care for older people. To date however there has been no additional funding for domiciliary care via this initiative.

The Social Care Fair Work Forum
The Social Care Fair Work Forum (SCFWF) aims to improve working conditions in social care. It is an independent body established by the Welsh Government in September 2020 following a recommendation from the Fair Work Wales Commission. It brings together representatives of trade unions, employers, stakeholders, and the Welsh Government to influence national policy and priorities[56].

In early 2023, SCFWF had drafted a pay and progression framework for the social care workforce in Wales[57], which, at the time of writing was out to consultation. A memorandum of understanding[58] has recently been produced for a Social Care Workforce Partnership Council to develop a minimum set of employment expectations for staff working in the independent social care sector, which will be adopted by employers, but critically on a voluntary basis only – certainly in the first instance.

One of the anticipated outcomes of the pay and progression framework, is that it will both support recruitment by providing social care employers and applicants/ workers a clear and consistent pathway for progression, setting out qualifications and roles on route and via different entry points. At the next stage of the SCFWF project, standardised job roles will be developed, and at a later point, a pay structure corresponding to these.

An annual progress update was published in March 2023[59], followed by a summary of consultation responses in Nov 2023 which detailed the mainly positive response to the framework, although it was noted due to the variations in pay across different employers and commissioners, a single

[54] https://www.gov.wales/healthier-wales-long-term-plan-health-and-social-care

[55] Building Capacity through Community Care – Further Faster: Welsh Government Statement of Intent, 2023

[56] Social Care Fair Work Forum: Terms of reference and membership, 8 January 2021

[57] Proposals for a pay and progression framework for the social care workforce in Wales, unpublished, 2023.

[58] Social Care Workforce Partnership Council: Minimum Standards of Employment for Social Care Workers, Memorandum of Understanding, 2023 unpublished.

[59] Welsh Government (2023) Social Care Fair Work Forum: annual progress update 2023, published 23 March 2023: https://www.gov.wales/sites/default/files/pdf-versions/2023/3/5/1679648891/social-care-fair-work-forum-annual-progress-update-2023.pdf https://www.gov.wales/sites/default/files/consultations/2023-11/summary-of-responses_0.pdf

approach will be complex. Feedback also indicated that unless the framework was mandatory in the long term there would be little sustainable effect, although there will be financial implications for this.

National Framework for Commissioning
As part of *Rebalancing care and support*, Welsh Government has announced a new national framework for commissioning, which will be set out in a statutory Code of Practice. This will be issued jointly under the Social Services and Well-being (Wales) Act 2014 and as guidance under the NHS (Wales) Act 2006. The National Office for Care and Support will oversee the implementation and adherence to the code.

Commissioning is critical to the domiciliary care sector, in terms of funding, and in setting direction and shaping practice. As Sanders (2021[60]) states, if outcomes-based commissioning and delivery of care is to take place, there needs to be a high level of trust between commissioners and providers, enabling information sharing and provider autonomy. This has often not been the case in commissioning relationships, where procurement processes and 'time and task' approaches have been used to control costs. The National Framework aims to support the core values of the Social Services and Wellbeing Act, shifting the focus from price towards quality, outcomes, and social value.

Given providers' concerns about the impact of procurement on quality and sustainability in domiciliary care[61], this strategic direction creates opportunities to reinvigorate the sector around delivering outcomes for individuals, and recruit and retain staff who share these values on a national footprint, removing the potential for postcode lottery in how care and support is delivered.

Foundational Economy
Welsh Government has defined the Foundational Economy as:

> *"the part of our economy that creates and distributes goods and services that we rely on for everyday life".*[62]

Care and health services are a key part of this definition, and within that, domiciliary care supports people to live independently, promoting health and wellbeing, reducing inequalities, and enabling them to participate fully in their communities, thereby increasing social cohesion. Promoting the Foundational Economy also aims to nurture local ownership of care provision, so that care is delivered as far as is possible within local communities and with any profits being reinvested in the local economy.

As Rebalancing Care and Support (Welsh Government 2021[63]) states, the social care workforce is an important part of the foundational economy in Wales, representing 6% of total employment and generating £2.2 billion in 2018. The strategic priority to develop the foundational economy aligns with the work to improve domiciliary care workers' wages and terms and conditions.

Other key national strategies and plans to consider
It should be recognised that the context of this work will also need to consider a range of other key national strategies and plans. These include but are not limited to the More than Just Words Welsh language plan, Anti-racist Wales Action Plan, LGBTQ+ Action Plan for Wales and the new Violence

[60] Sanders, R (2021) New Models of Care at Home: ESSS Outline for Iriss: https://staging.iriss.org.uk/sites/default/files/2021-11/outline-new-models-of-care-at-home.pdf

[61] Care and Social Services Inspectorate Wales (2016) 'Above and Beyond' National Review of Domiciliary Care in Wales': https://www.careinspectorate.wales/sites/default/files/2018-03/161027aboveandbeyonden.pdf

[62] Welsh Government: A Healthier Wales foundation economy programme: Guidance: https://www.gov.wales/healthier-wales-foundation-economy-programme#:~:text=Foundational%20economy%20(FE),housingc

[63] White paper, p.20

against Women, Domestic Abuse and Sexual Violence strategy. These would all need to be considered when developing any key resources that might support the sector through the social franchise.

1.3.4. National initiatives and resources

There are various organisations and initiatives at national, regional, and local level involved in shaping and supporting domiciliary care, and a range of resources and initiatives designed to develop the market and those working within it. Representatives from each of these have been engaged during the feasibility study, including within its Governance Group.

Social Care Wales
Social Care Wales is responsible for setting standards for the care and support workforce and making them accountable for their work. They also have the remit to develop the workforce, so they have the knowledge and skills to protect, empower and support those who need help. Social Care Wales also works with other key stakeholders to improve services for areas that are agreed as a national priority.

As part of the work to meet the ambitions of Healthier Wales, Social Care Wales and Health Education and Improvement Wales have developed the Health and Social Care Workforce Strategy[64]. This document drew attention to the differences in terms and conditions between health and social care, between local authorities, and providers of domiciliary care. It was acknowledged that Welsh Government has taken steps to fund increases to domiciliary care wages up to the Real Living Wage, but wage inflation in other sectors continues to put domiciliary care at a clear disadvantage when recruiting.

The Strategy was implemented in 2020 and is underpinned by seven key themes:

Theme	Descriptor
1. An Engaged, Motivated and Healthy Workforce	By 2030, the health and social care workforce will feel valued, fairly rewarded and supported wherever they work.
2. Attraction and Recruitment	By 2030, health and social care will be well established as a strong and recognisable brand and the sector of choice for our future workforce.
3. Seamless Workforce Models	By 2030, multi-professional and multi-agency workforce models will be the norm
4. Building a Digitally Ready Workforce	By 2030, the digital and technological capabilities of the workforce will be well developed and in widespread use to optimise the way we work, to help us deliver the best possible care for people.
5. Excellent Education and Learning	By 2030, the investment in education and learning for health and social care professionals will deliver the skills and capabilities needed to meet the future needs of people in Wales.
6. Leadership and Succession	By 2030, leaders in the health and social care system will display collective and compassionate leadership.

[64] https://heiw.nhs.wales/workforce/health-and-social-care-workforce-strategy/

7. Workforce Supply and Shape	By 2030, we will have a sustainable workforce in sufficient numbers to meet the health and social care needs of our population.

Social Care Wales has developed a direct care workforce plan[65] in response to A Healthier Wales – Our Workforce Strategy for Health and Social Care. Social care should provide personalised care in line with the Social Services and Wellbeing [Wales] Act 2014. The aim is to "build confidence in the workforce, and lead and support improvement in social care".

Since April 2020, individual domiciliary care workers have been legally required to register to practice – a process overseen by Social Care Wales, using the Social Care Wales (Registration) Rules 2022[66].

The aim of registration is to ensure that workers have the right skills, values, and training:

- New starters have up to 6 months to complete the process, which involves creating an account on the online SCW portal, uploading relevant documents and paying a £30 fee at registration and annually.
- Individuals' records of Continuous Professional Development can be stored online and used to support their renewal, which must take place every three years, after the first one-year renewal.
- Domiciliary care workers are required either to have a Level 2 or 3 qualification in Health and Social Care (Diploma, QCF or NVQ) or equivalent in order to register; or complete an online course which then allows them to practice provided they complete the qualification within six years.
- They must agree to follow the Code of Professional Practice[67] and Practice Guidance[68] for their role.
- Registered workers can also access a Care Worker card, which recognises them as key worker and entitles them to a number of discounts and benefits.

In June 2023, there were 20,892 domiciliary care workers and 967 domiciliary care managers on the register[69]. Social Care Wales regularly surveys the workforce, reporting nationally on their characteristics, and linking those on the register to a range of resources, such as events and guidance.

Social Care Wales provides a range of other resources relevant to the domiciliary care workforce, including:

- We Care Wales, an attraction campaign and jobs portal for the social care workforce – we discuss this in more detail in chapter 4.
- Online training resources for care workers, including an Introduction to Social care for those considering joining the workforce.

[65] https://socialcare.wales/about-us/workforce-strategy/direct-care-workforce-plan-2022-to-2025

[66] Social Care Wales (2022) The Social Care Wales Registration Rules, October 2022

[67] Social Care Wales (2017) Code of Professional Practice for Social Care

[68] Social Care Wales (2018) The Domiciliary Care Worker: Practice guidance for domiciliary care workers registered with Social Care Wales

[69] Social Care Wales Registration Data, June 2023, accessed from https://socialcare.wales/registration/why-we-register

- Resources and guidance to promote health and wellbeing at work, including Your Wellbeing Matters: workforce health and wellbeing framework[70], the use of CANOPI, all which aims to help social care organisations create workplaces which support workers' wellbeing.
- The Social Care Wales Workforce Development Programme (SCWWDP), which provides £12 million funding annually to local authorities and other partners to deliver training locally to the whole social care workforce. The grant helps fund a range of work programmes, including learning, development and qualifications. Funding is distributed across the seven Regions and is managed by local authority Workforce Development Teams who coordinate and support training and development in Wales in partnership with social care providers. Training and development are designed around the learning needs of the statutory, independent and third sector, including mandatory training. Some Local Authorities also offer bespoke specialised courses as required which are open to all private domiciliary care staff, usually at no cost.

Regional Partnership Boards and the Health and Social Care Regional Integration Fund
Part 9 of the Social Services and Wellbeing (Wales) Act 2014 (SSWBWA) places a requirement on local authorities and Local Health Boards to establish RPBs 'to manage and develop services to secure strategic planning and partnership working … and to ensure effective services, care and support are in place to best meet the needs of their respective populations'.[71][1]

Through the work of Regional Partnership Boards[72], Welsh Government has established six Communities of Practice to share learning and actively support the development of six models of integrated care. Two of these focus on community-based care and one on home from hospital services – all of which relate directly to and depend on the provision of domiciliary care. However, our understanding and observation is that the Communities of Practice themselves have not been particularly successful in engaging independent providers.

Care Inspectorate Wales
Care Inspectorate Wales (CIW) is responsible for inspection and regulation on behalf of Welsh Ministers, with the aims of ensuring safety and quality and driving improvement in social care services. Ultimately, they decide who provides the service, by agreeing the registration of any new providers. As well as inspecting all providers, they undertake national reviews and respond to concerns raised. They provide support and toolkits to enable providers to meet their statutory obligations and quality standards.

Care Forum Wales
Care Forum Wales is a membership organisation representing care homes, nursing homes and other independent health and social care providers across Wales. It operates as a not-for-profit organisation and aims to give health and social care providers a collective voice in the debate about how to provide the best outcomes for those who need social care. They work closely with Welsh Government on relevant workstreams and policy discussions, and offers training updates, advice, and discounted DBS checks to their members.

[70] Social Care Wales (2023) Your wellbeing matters: workforce health and wellbeing framework, accessed 27 Oct 2023 from: https://socialcare.wales/resources-guidance/health-and-well-being-resources/your-wellbeing-matters-workforce-health-and-wellbeing-framework

[71] Social Services and Wellbeing Wales Act 2014: Part 9 Statutory Guidance (Partnership Arrangements)

[72] See for example Welsh Government Health and Social Care Regional Integration Fund, Revenue Guidance 2022-27 at: https://www.gov.wales/sites/default/files/publications/2022-02/health-and-social-care-regional-integration-fund-revenue-guidance-2022-2027.pdf

The Homecare Association
The Homecare Association is a UK membership-based organisation for domiciliary care providers. It campaigns for, and produces influential reports on the home care market, and a minimum price for the provision of homecare. It also provides training, webinars, specialist member helplines and conferences and offers a DBS service and other discounts.

National Commissioning Board
The National Commissioning Board (sitting within Commissioning Care Wales) aims to improve the quality of social care and health commissioning in Wales and to develop effective practice in relation to integrated commissioning between local authorities and local health boards. The Board is hosted by the Welsh Local Government Association and brings together a range of stakeholders from NHS, local authorities, Regional Partnership Boards, providers and other key national stakeholders.

As part of the implementation of the Rebalancing Care and Support programme, key priorities of the Board[73] that are of relevance to this feasibility study include:

- Maintaining an overview of national market balance and stability
- Supporting the development of practice to promote commissioning of social value models of delivery.

1.4. Engagement with the sector

In this section, we present the key findings from our engagement with the sector. As summarised in section 1.2.3, this included:

- Engagement with representatives of 37 private domiciliary care providers, 10 care workers, 33 local authority officers, 16 CVS/ social/ microenterprise organisations, through a series of face-to-face and online events and individual discussions.
- Ongoing discussions with membership bodies operating in the sector who were also represented within the project's Governance Group, including Homecare Association (HCA), Care Forum Wales (CFW). We received a formal letter summarising feedback from HCA and have included points from it in this section.

At the engagement events, we:

- Introduced the concept of the franchise model and the types of functions it *might* potentially cover, explaining that the purpose of the session was to hear participants' ideas about whether and how this model could respond to their needs and contexts. We made it clear that the final form, function, and financial details of the model had not been formulated and that stakeholders' feedback would be used to develop the high-level model which would be presented at the end of the feasibility study.
- Facilitated small group discussions to gather attendees' responses to this concept and to explore their needs, contexts, and ideas in more detail.
- Provided a range of other methods for capturing feedback – one-to-one discussions, informal conversations, and the opportunity to write comments on post-it notes.

Further detail on our engagement methods and activities is included in Appendix 4.

[73] Commissioning Care Wales Work Programme 2023/24: https://www.wlga.wales/SharedFiles/Download.aspx?pageid=62&mid=665&fileid=3268

Several general points regarding the operating context and where the model might sit within it were evident from these discussions:

- There is huge variation of provider types, in terms of size, resources, ways of working, localities served, personal preferences and styles. These factors inevitably influence which – if any – parts of a potential franchise offer providers might welcome in the short- to medium-term. Subsequently, some of the larger providers or existing franchisees we engaged were less convinced that the proposed franchise would add direct value to their *specific functions*, such as HR or accounting, since these resources were already available to them internally or via their commercial franchisor. However, many of the representatives of these organisations did see the potential value of the social franchise to the sector as a whole and could anticipate indirect or longer-term benefits to their operations, e.g., from greater consistency, coordination of recruitment efforts, etc.
- Nevertheless, it was clear from the conversations that reducing the burden for smaller providers must remain a priority: some of these providers described themselves as being 'already very lean' and often 'exhausted'.

  > *'Nice to see something that could really work for a small provider if done properly. It could effectively provide for smaller providers what larger providers already have'* (Care provider)

- Many independent providers reported feeling overwhelmed by the volume of initiatives, information and requirements placed on them from national bodies, as well as from local authorities and regional structures. The franchise model must not add to this complexity but must instead actively streamline and maximise the impact of these resources for the independent domiciliary care sector.

In the following sections, we present themes from the engagement in relation to specific business functions. At the end of this section, we present more general feedback and conclusions from sector engagement about the potential benefits and risks of the model.

1.4.1. Human Resources (HR)

The effective delivery of care hinges on the quality and consistency of the **people** working as carers.

Recruitment and retention of staff was reported to be the biggest challenge for domiciliary care providers. The vacant posts and high turnover of staff highlighted previously, and the number of steps involved in the highly regulated onboarding process mean that employers spend a lot of time and money on this function. Despite this, they still struggle to meet demand and provide the continuity of relationships which citizens value.

There are clear structural challenges driving this situation, as both providers and the organisations representing them were keen to emphasise. These include the under-funding of social care and issues with the procurement-led, time and task way in which it is commissioned in many areas. This means that care work is low paid, care visits are typically rushed, and workers lack autonomy to respond flexibly to people's changing needs: all points raised by the care workers we met.

However, our sector engagement also identified many inefficiencies and challenges relating to **process** and **technology** which are further compounding these issues and which providers recognised could potentially be addressed by the proposed franchise model. Below, we present themes, illustrative quotes, and suggested solutions against different HR functions.

Attraction of new recruits
More needs to be done to encourage people to join the care workforce. Most providers were aware of the work being carried out by WeCare but were not seeing the desired results.

Employers use job portals such as Indeed and pay for these per adverts per day, which can be very costly, and not particularly effective:

> *"We often only get 6 or 7 people apply [through Indeed] but half of them come from the job centre and only apply so they don't lose their benefit – they aren't interested in a care job and are wasting everyone's time".*
> (Senior care worker)

A consistent back-office recruitment portal was proposed; though it was also suggested that this might be hidden from potential candidates, who may prefer to access via a local web page.

Some suggested that pooling recruitment efforts on a national level could help to increase the profile of domiciliary care. They suggested that new partnerships – for example encouraging older people into the workforce via the University of the 3rd Age (U3A) – might help strengthen existing efforts. There needs to be a way of linking local initiatives to attract new recruits with regional and national initiatives.

Overseas recruitment is particularly time-consuming and complex; yet there is need to source more domiciliary care workers from abroad to meet current demand. Providers suggested that the proposed model might coordinate processes, partnering with overseas recruitment agencies and perhaps acting as the sponsored body for foreign workers or students. In this capacity, it would check people have the appropriate training and qualifications and might also provide access to interpreting and translation services, and support around cultural needs.

Onboarding and checks
Providers told us that the length of time it takes to onboard new staff (including DBS, registration and other checks and processes), means that posts remain vacant for longer than they should. This also increases the risk of candidates finding other work with a high rate of drop-out.

The All-Wales Induction Framework was reported to be onerous and costly, especially for smaller providers: there is a risk of losing people from care because of the amount of time it takes. Providers and workers also flagged duplication and waste where workers are inducted into more than one organisation.

Providers reported delays waiting for Disclosure and Barring Service (DBS) applications:

> *"DBS needs to be speeded up. There are a lot of unusually lengthy delays in DBS checks."*
> (Care worker)

Providers understand the link between registration and attempts to professionalise the sector, but it was felt that the system asks a lot from workers, without giving them a commensurate increase in terms and conditions. There were concerns that having to pay for registration acted as a barrier for new workers. There is inconsistency here since some providers pay registration fees for staff; some do not. There was also felt to be a lack of support for workers to achieve registration.

Participants envisaged that the proposed entity might improve the portability of workers from one organisation to the next, perhaps through some form of care worker 'passport', in which digital records of registration, training, DBS, references might 'wrap around the individual worker.' This could pave the way to tackling 'access to trusted agency/ bank/ or pool of staff for cover', which providers highlighted as a current gap, since it could facilitate providers to swap or share staff, confident they had been checked and trained and without having to pay fees to a commercial intermediary staffing agency.

Terms and Conditions
In addition to the challenges with poor terms and conditions, we also heard many examples of how the current *variation* in roles, pay, terms and conditions destabilises the sector, by encouraging the movement of workers between care providers, local authorities, and between care and health.

> *"[The franchise] is a good idea, I work for a small company, they spend budget on training staff and getting them registered and then they go to work for larger organisations. We can't grow as a company; can this new model stop this from happening?"*
> (Care Worker)

> "*Pay and conditions should be standardised across Wales. Currently staff are paid differently in different areas, some have access to health care, discounts in shops, etc. There needs to be consistency. Pay rates are too low".*
> (Care worker)

This fragmentation also impacts on career progression and reduces staff retention. Different providers use different terms to describe slightly different roles, and varied ways of banding pay. Those engaged felt there was a need for competency-based bands with consistent pay grades attached; there could for example be specialist care roles, e.g., relating to dementia, which require and reward higher levels of training and experience.

Care workers highlighted the impact which lack of choice regarding hours worked has on quality of life and on recruitment and retention:

> *"Improve staff rotas, recruiting is difficult because young people struggle with childcare when rotas are 7 days on. Work life balance is hard to achieve, especially as there is not much notice given of the next week's rota. This puts people off working for us, especially young people with families".*
> (Care worker)

Providers explained they struggle to give staff consistent working patterns, due to the way in which care is commissioned by local authorities and how this differs between authorities. It was hoped that a national approach to commissioning would support a move to common working arrangements, which would be beneficial. At the same time, it was important to recognise that highly flexible ('gig economy') work is also attractive to a portion of the current and potential workforce. The sector needs to innovate to deliver this in a way that supports the worker, whilst ensuring quality and consistency for people using services. The 'carer passport' idea could be a first step towards this.

Staff wellbeing
Care providers reported concerns about the increasing numbers of staff experiencing challenges with their mental and physical health, especially post-pandemic. Sometimes this required specialist occupational health support or clinical supervision (e.g., around clients' end of life) which smaller providers did not have access to.

There were discussions at engagement events about whether a franchise model might purchase or negotiate on behalf of its members benefits and incentives such as dental insurance, sick pay insurance, discounted fuel, electric vehicles or driving lessons, as well as helplines or other resources to support care workers legally, financially, emotionally or in relation to wider wellbeing.

1.4.2. Training

The need for more effective provision of training emerged as a theme from the engagement. It was felt that a more coordinated approach across the domiciliary care sector could generate economies of scale in the procurement and delivery of high-quality training. One attendee suggested the vision of a national 'training academy' for domiciliary care.

We heard that there is some confusion at present regarding what training is recommended and what is mandatory. There was also frustration at the lack of portability of mandatory training, which was felt to cause unnecessary duplication and waste:

> *"I don't have to retake my driving test every time I change a car, why do people have to do retraining when they change jobs or get a new piece of equipment?'*
> (Care provider)

Many providers cannot afford to pay workers to attend training and pay to back-fill their substantive role so they can attend (even if they can find workers to provide cover).

> *"The only way to afford training in a private company is to operate short staffed".*
> (Care worker)

Some private providers explained that they use private training companies or hire venues for training and then employ a trainer separately – both options are expensive. It appeared that the Social Care Workforce Development Programme (SCWDP) is not meeting the training needs of many private providers, either because the right training is not available at the right time in the right location, or because of lack of awareness of the offer within the private sector.

> *"There needs to be a consistent approach to training between public and private sector. Whoever you work for in the care sector, you should be trained to the same standard and you can learn more from your peers".*
> (Care worker)

Assuring the quality of training and ensuring it aligns with national standards, frameworks, regulatory standards, and best practice was very important to providers. Whilst they could see a place for online learning, there was also a strong sense that many topics were best covered in face-to-face group settings. Attendees could envisage the franchise model helping to coordinate both offers, whilst reducing the risk of duplicating existing resources.

Some providers were interested in innovative training methods (such as the use of Virtual Reality (VR), which small providers could not currently afford) or specialist modules (such as more advanced dementia training) and could see the potential of a mechanism which facilitated them to access these resources collectively and hence more affordably.

1.4.3. Technology

From the engagement sessions, it was clear that there are multiple IT systems in use within the domiciliary care sector. Some systems are required by commissioners, e.g., for invoicing – though these often vary between local authorities and/or the NHS; providers are also purchasing software individually to support their own business functions. Some providers described the difficulty of having to manage multiple IT and reporting systems; ensuring and demonstrating cybersecurity was another challenge and expense for small businesses.

Whilst the potential of IT systems to streamline processes was recognised, many smaller providers explained that they have neither time nor expertise to select the most appropriate system. Buying software solutions can be expensive, but the biggest investment tends to be in time to set up systems, populate them and train others to use them.

> *'You go to one of the domiciliary care events. There are all these IT companies showcasing their newest system. Then when you install it, you realise it doesn't do what you want it to do.'* (Care provider)

It was acknowledged that having one system for all providers and commissioners would be a huge challenge that sits outside the scope of this project. Providers had different views on the desirability of national processes and systems; for example, some felt a centralised payroll system would help,

others were clear they would not be interested because they had their own existing arrangements. The consistent message was that support to identify and purchase the most appropriate systems and technology would be welcomed, but that these had to save them time and resources – if providers still have to manually input data for a system to work, that was of little benefit to them.

1.4.4. Finance and procurement

In relation to finances and accounting, the fragmentation of processes, policies and systems is again causing huge challenges for the sustainability of providers, especially smaller ones.

Local authority and health board commissioners pay different rates, on different cycles, and using different systems. One provider explained that they work for ten local authorities and several health boards, and each organisation pays on different cycles; yet their staff cannot wait to be paid which results in huge cash flow challenges and expensive borrowing. Others confirmed that these challenges can 'kill businesses'; a synchronised payment schedule via a unified system would make a huge difference.

Providers also highlighted various opportunities for centralised purchasing within the sector, or coordination of shared resources including:

- Insurance, e.g., professional indemnity (where premiums were reported to have increased by 50%), insurance against sick pay/ communicable diseases compensation.
- Equipment, e.g., PPE
- Transport, e.g., pool cars, drivers, 4x4 vehicles (to reach remote areas in poor weather)
- HR/ specialist legal advice

1.4.5. Overall feedback and conclusions

Potential benefits and opportunities
Many of those attending the engagement events could see potential benefits from the proposed franchise model. Overall, these included:

- The potential to generate savings, through economies of scale and collaboration, which could in turn promote sustainability.

  "This model, if carefully crafted, could save back-office costs and enable savings to be passed onto carers".
  (Care Provider)

- The opportunity to have a collective voice specifically for the domiciliary care sector

  "There's a gap in the sector of collecting representative views. There's no way of having a conversation with the domiciliary care sector currently, so they can't influence national policy".
  (Care Worker)

- A collaborative approach to finding solutions to practical issues within the sector, such as improving the recruitment process, coordinating quality training, etc.

- Supporting more consistent roll-out of technology across the sector to improve effectiveness:

  "Technology has helped us streamline and eradicate a lot of our middle management…. however, it is not being used consistently across the sector in ways which could maximise impact".
  (Care Provider)

Risks and concerns

- Pricing must be affordable to small providers and generate real benefits to them, ideally offering tiers of service at different price points:

  "…. for a franchise model to be feasible it needs to offer a service that providers want at a price that they are able and willing to pay. Preferably in such a way that improves outcomes for people who are being supported".
  (HCA letter)

- There were concerns that the not-for-profit nature of the 'social' franchise meant that domiciliary care providers themselves could not make fair profit from their businesses without being judged for doing so; this is not the case.

- Risk of the franchise model duplicating existing activity by Social Care Wales or We Care Wales, etc and adding to tasks for providers instead of streamlining them.

  "It can't just be another Quango". (Care Provider)

- Risk of increased regulation/ process 'through the back door', for example if the model required further national standards in addition to those already in situ, and without being fully costed.

- Risk of 'off the shelf' policies and processes which do not take account of the nuances of individual organisations or the local contexts in which they operate.

- Risk that the franchise might disproportionately benefit micro-enterprises (who already benefit from an absence of regulation) and that this may disrupt the market.

- That providers should not be penalised for choosing not to join (especially since there may be fewer immediate benefits for larger companies, or those already operating franchises).

- That the franchise is over-ambitious at the outset and fails to deliver; it should instead identify a few key priorities and focus on these at the outset:

  "Add modules, rather than run before you can walk' (Care Provider)

In section 2, we explain how and why we have selected certain priority functions for the franchise model to focus on at the outset, and where we see potential for this to be expanded to include other functions once the foundations are in place.

We also present at the start of section 2 the key principles which we have drawn from the sector engagement to inform the development of the social franchise.

2. The Proposed Model

2.1. Key principles from engagement to inform model development

The feasibility study has co-produced the structure and priorities for the initial high-level operating model and functions set out in section two of this report. We have done this by listening to the priorities, concerns and feedback of diverse care providers and workers– as summarised in the previous section – and designing the model to respond to as many of these as possible.

The guiding principles we drew from the sector engagement were that any franchise model or similar solution must:

- Be open to all – can't create barriers
- Provide low-cost services
- Lower business costs
- Increase cost transparency
- Increase workforce wages
- Maintain an element of profitability
- Continue to respond in an agile way to the priorities of the provider sector.

It will be essential to continue co-producing and market testing with the provider market as the practical details of the franchise model and how it might be implemented are developed, beyond this initial study.

2.2. Desk research on alternative models

Franchising
A commercial franchise is a business arrangement where a franchisor grants a franchisee the right to operate a separate business using a tightly controlled proprietary model. Many franchises are incredibly successful. Some highly recognised franchises include McDonald's, Subway, Costa Coffee, Domino's Pizza, and Kwik Fit.

Franchising is already a standard business model in the domiciliary care sector where franchises include Caremark, Right at Home, Everycare and Sylvian. In their 2016 review of the Welsh domiciliary care sector, CIW[74] identified examples where the 7% of care companies in their survey sample had benefitted from being part of a franchise.

A commercial franchise is a popular way for individuals to start and run their own businesses with the support and backing of an established brand and business system. Research by NatWest[75] indicates that this model is more attractive to women and people under 30 than other business models. They report that a quarter of franchisees and over a third of all new franchisees are women.

Standardisation is a critical aspect of franchising. It ensures that customers and staff have a consistent experience across independently owned and managed businesses. It also ensures quality and reduces cost. This is achieved by the franchisor controlling operating processes, rationalising supply chains, enforcing best practices and rigid overarching quality control mechanisms.

[74] Care and Social Services Inspectorate Wales (2016) 'Above and Beyond' National Review of Domiciliary Care in Wales': https://www.careinspectorate.wales/sites/default/files/2018-03/161027aboveandbeyonden.pdf

[75] https://www.natwest.com/business/insights/sector-trends/agriculture/women-and-millennials-help-drive-franchise-sector-to-rec-levels.html

Franchisors offer comprehensive training and support programs to help franchisees understand and implement the rigid business model effectively. Once the franchisees have established their business, ongoing support from the franchisor includes marketing, operational guidance, and access to ongoing investment.

An agreement to use the franchisor's brand is at the heart of the business arrangement. This allows franchisees to leverage the reputation and recognition of an established brand to attract customers and build trust in the market. It enables entrepreneurs with commercial skills to deliver services in areas with little or no experience. This includes domiciliary care.

Franchisees pay various fees to the franchisor. These fees include an initial franchise fee, varying between £15,000 and £30,000 in the domiciliary care sector. In addition, franchisees must pay ongoing royalties, a percentage of their revenue or profit. These fees start from 4.5% of turnover. In Appendix 1, we have included how Caremark describes this support and costs on its website.[76]

The business arrangement requires a very high level of commercial transparency between the franchisor and franchisee.

The CIW (2016) study gave the following definition of the current commercial franchise model in care:

> *"Franchising is where a business is given a contract to operate an agency under a brand, such as Care Watch or Home Instead. The agency has to pay a management cost (around 5 to 7 per cent). The agency also has to pay for other customised or branded services (for example, bespoke call-monitoring systems, training packages, employment documents and financial systems). Franchises tend to guard their reputations fiercely. They are selective about who they allow to use their name and have rigorous internal quality control systems" (CIW 2016, p.109/110)".*

Providers in the CIW study reported that:

- They valued the support they receive from their franchisers: especially when new to the business, they described it as a 'safe and supportive way of building up a new agency and reduces the chance of making mistakes' (CIW 2016, p.110).
- The costs of being part of a franchise are usually offset by the marketing advantage of being part of a brand.
- Franchisers tend to be very England-centric and the guidance they offer does not reflect the context of working in Wales, especially the different regulatory landscape.
- The report concluded by recommending that Welsh Government could "encourage the development of a Welsh-branded domiciliary care franchise to support smaller and new domiciliary care businesses" (p.9), "possibly as a social interest enterprise" (p.209).

Social franchises

Social franchising uses elements of proven commercial franchising models to achieve a social impact.

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76 https://franchise.caremark.co.uk/?utm_source=google&utm_medium=cpc&utm_campaign=Care_Franchise&utm_term=care%20franchise&gclid =CjwKCAjw-eKpBhAbEiwAqFL0mkATk8JJ1qVsTG3nX3DOzV6AiR-16yT2utWtPbyC3SMn5wV1FnVr_xoCFTIQAvD_BwE

Wales Centre for Public Policy (2020)[77] conducted a review of alternative models of domiciliary care and highlighted several existing social (not-for-profit and/or subsidised) versions of the franchise model. They provided the following definition:

> *"Social franchises operate in a similar way to commercial franchises, using an existing structure and brand name to support replicating or scaling of proven models through contractual partnerships. In social franchises profits are reinvested"*
> (Wales Centre for Public Policy 2020, p.13)

Another definition is provided by Ziókowska (2018)[78]:

> *"Social franchise is the use of a commercial franchising approach to replicate and share proven organisational model for greater social impact, at the same time maintaining quality and productivity schemes based on the standardization that is present in all franchises" (Ziókowska 2018, p.96)*

Wales Centre for Public Policy (2020) give the example of **Care and Share Associates (CASA)** (now Be Caring), which started a social franchise model in the North East of England in 2004, with European start-up funding before becoming self-financing (by charging a 4.2% royalty fee when a new franchise company breaks even). CASA provided a range of back-office support to franchisees, including support with business aspects such as registering with regulatory bodies, developing business plans, HR processes, help with accessing approved provider lists, start-up funding and training for staff. It was re-launched as an employee-owned business in 2019 and, as Be Caring, it is now the UK's largest employee-owned social care provider.

Wales Centre for Public Policy (2020) also draws some parallels between this model and the back-office support around contracting, regulation, and training for the development of microenterprises which the social enterprise Community Catalysts provides, albeit without the formal legal franchising relationship in place.

Wales Centre for Public Policy (2020) concluded that:

> *"Franchise arrangements may facilitate entry to the market for smaller providers by providing practical and financial support, as well as improving access to training and knowledge to develop quality of care" (p.14).*

However, they confirmed a lack of formal evaluation of franchising models in the care sector, also demonstrated within the evidence review for this feasibility study.

The Health Foundation funded the programme Exploring Social Franchising between 2017 and 2021. With initial funding from the Foundation and social franchising expertise from Spring Impact, each of four Health Innovators designed its own bespoke social franchise model and developed social franchising systems and documents to support the replication of their models across the NHS. The aims of this programme are significantly different to those of our study, since the Health Foundation work aimed to codify and replicate innovation, rather than standard business operating models. The independent evaluation[79] emphasised the amount of time and resource required at

[77] Wales Centre for Public Policy (Bennett, L., Park, M. & Martin, S.) (2020) Alternative Models of Domiciliary Care, December 2020, https://www.wcpp.org.uk/wp-content/uploads/2020/12/Alternative-Models-of-Domiciliary-Care.pdf

[78] Ziotkowska, M. (2018) Social enterprise scaling up strategy – franchise development, Studia i Materia□y, 1/2018 (26): 95– 104: https://cor.sgh.waw.pl/bitstream/handle/20.500.12182/845/3social%20enterprise_2018H.pdf?sequence=2&isAllowed=y

[79] Health Foundation/ Cordis Bright (2022) Exploring Social Franchising Programme, Final Evaluation Report and Summary, June 2022. https://www.cordisbright.co.uk/news/exploring-social-franchising-programme

the start of the project to develop standardised manuals and tools to support replication of the models in other contexts, but also the value of this work.

The ability to use the existing national initiatives as a springboard for social franchising in the Welsh domiciliary care sector provides a huge advantage – much of the work to standardise frameworks is well underway.

The evaluation also identified overarching messages which seem applicable to our feasibility study around the importance of networking to establish a 'brand' or sense of belonging, learning, and adapting, ensuring 'fit' with wider strategy and policy, ensuring 'buy- in' at a senior level, and also commitment and enthusiasm from local stakeholders.

Cumberland & Litalien (2018[80]) completed a systematic review of social franchising. They identify over 95 social franchises in the UK, taking on different forms from limited companies, to registered charities to companies limited by guarantee. They range from large, international companies involved with health and social care, such as Marie Stopes, to environmental or community organisations, such as Greenworks.

These social franchises are distinguished from their commercial counterparts by:

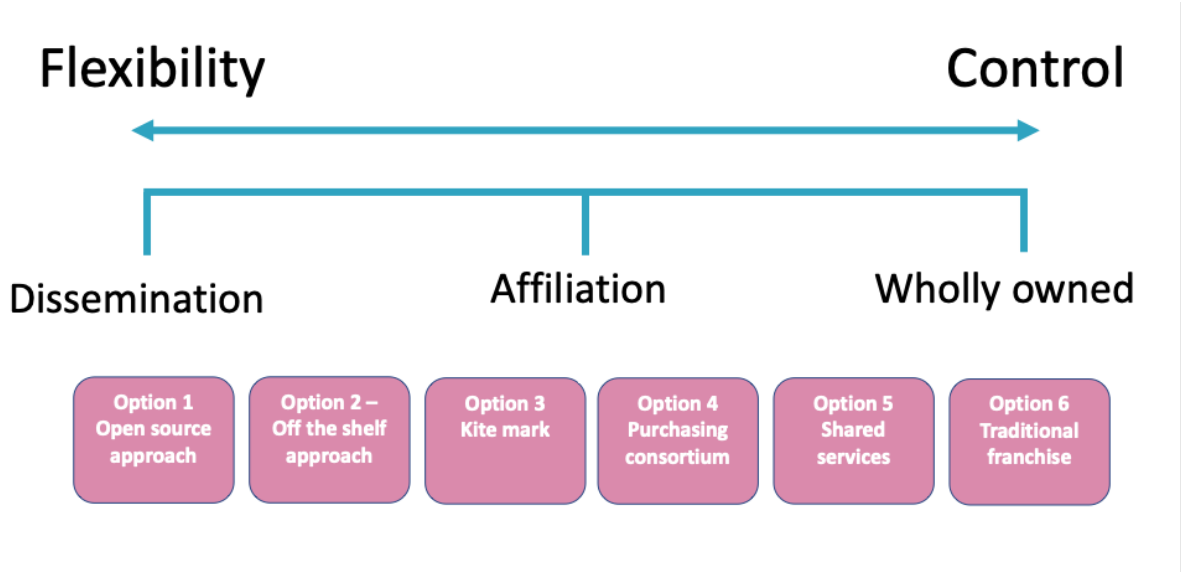
- shared values and co-operation between members,
- the presence of an independent coordinating network or central support unit, and
- their objectives to meet social needs.

2.3. Degree of control within a franchise model

Having considered the broad function, purpose and potential benefits of the proposed franchise model, it became clear that this model could be developed at very different levels of control. For example, this might range from the 'independent coordinating network' described by Cumberland & Litalien (2018) right up to the highly controlled roll out of a commercial brand through a franchise model, underpinned by legal contracts.

At the outset of the feasibility study, the team developed a continuum of options each implying different levels of control, as illustrated in the following visual, and the descriptions of the different options beneath it:

[80] Cumberland, D.M. & Litalien, B.C. (2018) Social franchising: a systematic review, Journal of Marketing Channels, 2018, VOL. 25, NO. 3, 137–156: https://paulcollege.unh.edu/sites/default/files/media/2022/07/cumberlanda_and_litalien_2018.pdf



Option 1: Open source
A central organisation creates and disseminates individual best practice approaches (and associated documentation, training etc) to providers. Providers simply agree to receive and consider using processes or documents, which remain the property of the central organisation.

Option 2: Off the shelf
A central organisation develops a national model for running a domiciliary care organisation. This includes all the documentation and processes that a provider would need to run a successful domiciliary care organisation in the context of Welsh systems. The provider agrees to use the processes or documents, which remain the property of the franchise organisation.

Option 3: Kite mark
A central organisation develops a national model for running a domiciliary care organisation. Providers adopt the approach, and if they do, the central organisation will monitor quality and then award a kite mark.

Option 4: Purchasing consortium
A central organisation acts as a purchasing consortium for providers, buying goods and services on behalf of them to achieve economies of scale.

Option 5: Shared service
A central organisation develops back-office functions that are required to run a successful domiciliary care organisation. Providers access these services paying a fee or a subscription.

Option 6: Traditional franchise
Organisations that deliver domiciliary care adopt the national service using a mandated approach for all elements of delivering a service. This creates a single national system. Providers must follow the business model that will be created.

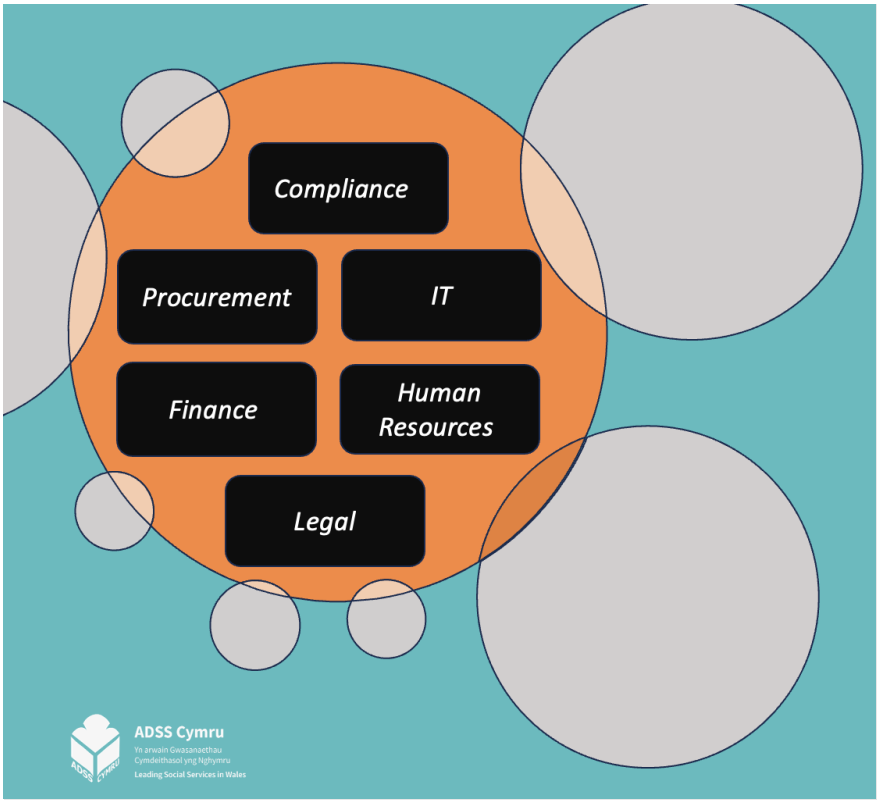
2.4. Alternative structures for the central body

Alongside the above range of options, there are potentially different models for the organisational structure of the central body. We present these here, along with their advantages and disadvantages.

Shared Service

In a Shared Service arrangement, several large organisations or business units centralise and share common services. In the public sector, this typically includes functions such as legal, finance

and Human Resources. As the following diagram illustrates, this requires a degree of integration of each participating organisation or unit (represented by the circles around the edge).



Advantages

- Shared services can be transformative and have the potential to generate clear costs efficiencies (e.g., Local Government Association 2012[81])

Disadvantages

- Rigid service provision
- Complex governance which can make them very expensive to set up, especially between multiple organisations with different legal structures.

Cooperative

According to Cooperatives UK[82], there are seven core principles that define how a cooperative operates:

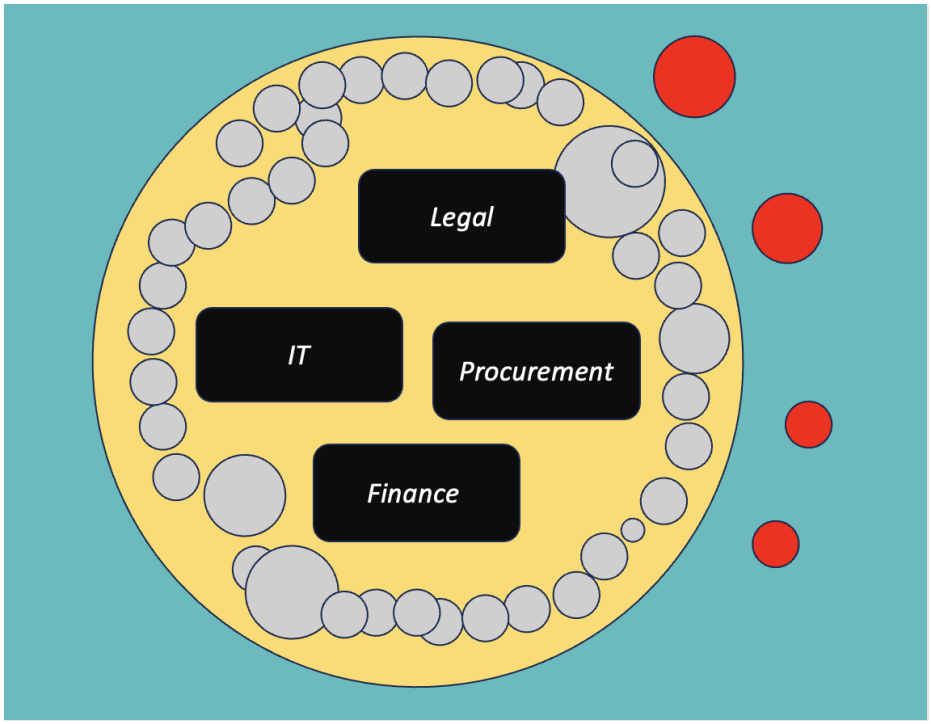
- It is owned and controlled by its members. It exists for the benefit of its members, who, in this instance would be care providers.
- It is democratic – this means every member has an equal say in how it is run and how profits are used.
- Every member contributes financially in some way – from buying products, working for the co-op, investing in it or deciding how to spend its profits.

[81] Local Government Association/ Drummond MacFarlane (2012) Services shared: costs spared? An analysis of the financial and non-financial benefits of local authority shared services: https://www.local.gov.uk/sites/default/files/documents/services-shared-costs-spa-61b.pdf

[82] Co-operatives UK: Co-op values and principles, accessed 27 October 2023 from: https://www.uk.coop/ValuesPrinciples

- It is an independent business, owned and controlled by its members.
- It offers education and training to everyone involved, so they can develop the co-op and promote the benefits of co-operation.
- It co-operates, works with and supports other co-ops.
- It supports the communities it works with.

This structure is represented by the following diagram, in which care providers choose to join together to create a cooperative which delivers core functions, or procures services on the behalf of the collective.



Advantages

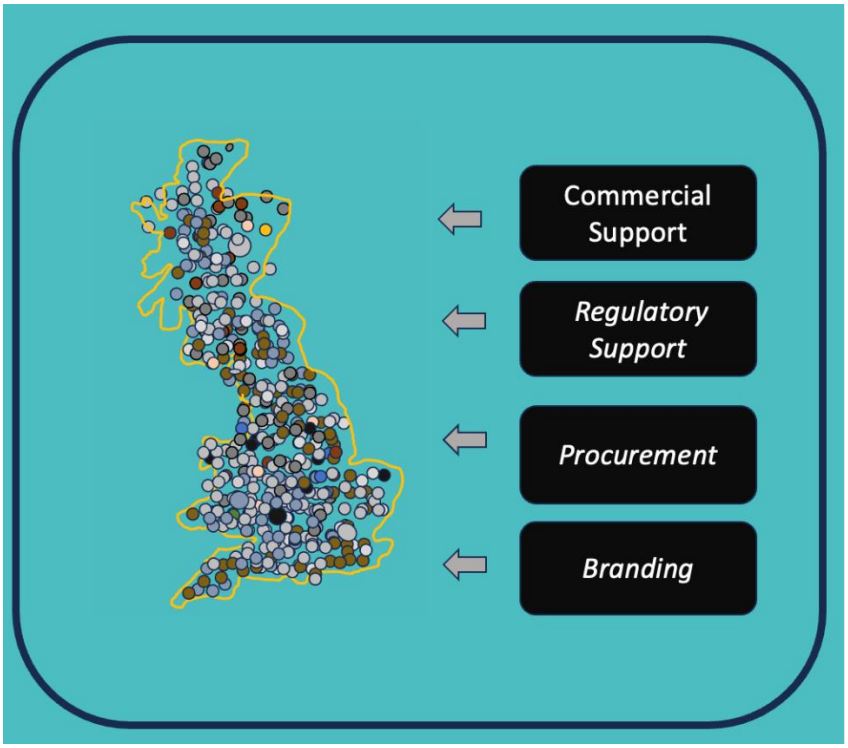
- Provider-focused
- Democratic
- Potential to generate significant financial efficiencies

Disadvantages

- Complex bureaucracy
- Rigid structure
- Binary – providers are either in or out

Traditional Franchise

Small businesses which are similar to each other in function and structure license product, territory, branding and business processes from a central organisation. The following visual illustrates how each agency might divide territory in this model.



Advantages

- Intensive start-up support for new member businesses
- Transparent business processes
- Promotes standardisation and consistency of products and services

Disadvantages

- High start-up costs for new providers
- Ongoing fees
- Restrictive

2.5. Summary of legal advice

ADSS Cymru, supported by Practice Solutions, instructed Vincent King of Weightmans LLP to investigate the possible establishment of a new legal entity to provide services to social care providers in Wales.

Weightmans recommendations in summary were:

1. Whilst it is theoretically possible to set this up as a purely contractual arrangement, without the need to set up a new entity, in our view it would be better to deliver the services through a new legal entity.
2. This new legal entity is likely to have a relatively small number of staff who administer the arrangements (secondments may also be possible) and as such it will need to enter into contracts with third party service providers to deliver the services to members.
3. A company limited by guarantee is our recommended model as this is a flexible and well understood not-for-profit corporate model that would work well here; charity status is probably not feasible.
4. Governance of the entity: as a company limited by guarantee, the governance model would be set out in the bespoke articles of association and would be kept under review over time

– this would cover the appointment and removal of directors (who will have statutory responsibilities under the Companies Act), the size of the board and how it operates.

5. Funding model: The most likely source of funding is from members, which could be in the form of a fixed subscription fee and a variable payment linked to the consumption of services. If any public sector bodies are contributing financing, the subsidy control regime will need to be checked.
6. Contracting model: the entity could set up frameworks with third party service providers, which would enable members to contract directly with providers for those services that they wish to call-off, possibly with a small commission payment to the entity expressed as a percentage of the charges that are paid for services received.
7. Corporate services (i.e., to support the operation of the entity): it may be preferable for the entity to buy any services that it needs to support its operations from third-party service providers, rather than from members, provided that it has the means to do so. This avoids the need to consider the possible application of the subsidy control regime if any public sector bodies were to provide this support.
8. Staffing of the entity: Set up the entity with a relatively small number of directly employed staff, on the assumption that it will not itself provide many, or any, services to members. Members could also second staff, as long as in the case of public sector members this is paid for on an arms' length basis, so as not to constitute a subsidy. Keep the arrangements under review, with the staffing model evolving as needed.

The proposed organisational structure, which is described in the next section, has been informed by the legal advice, the existing published evidence and the principles emerging from sector engagement.

2.6. Organisational structure

This section of the report deals with three big questions.

- What is the nature of the social franchise we are proposing?
- What are the commercial arrangements between the social franchise, domiciliary care providers, local authorities, and Welsh Government?
- How will the entity deliver the services, and what are the costs and benefits associated with these services?

2.6.1. The nature of the entity

We are proposing the entity has three clear objectives linked to the standardisation of business processes to:

1. Reduce costs for domiciliary care organisations, enabling:
    a. Sustainable profits or surpluses
    b. A more significant proportion of the national investment into domiciliary care to be spent on domiciliary care workers' wages.
2. Support people with a wide range of skills and lived experience to start new domiciliary care services, including social enterprises and cooperatives.
3. Ensure there are efficient national mechanisms to support the domiciliary care sector in efficiently responding to increased demand, for example, by supporting the recruitment and retention of the workforce.

Social franchise
At the heart of the model is a social franchise. We have, however, considered some elements used in traditional, commercial franchising, e.g.:

- High levels of operational consistency
- Active support for entrepreneurs entering a market.
- Focus on SME profitability.
- Financial transparency

Unlike a commercial franchise, the fundamental principle is social value and not profit, and it is based on collaboration, not competition – on cooperative principles (but not a cooperative legal structure). This does not mean providers should not be supported to make a profit or compete against each other.

Company Limited by Guarantee
Following the legal advice, we are proposing that a Company Limited by Guarantee will develop and maintain the social franchise.

This corporate structure is commonly used by not-for-profit organisations, charities, social enterprises, clubs, and other entities that do not intend to distribute profits to their members or shareholders. Instead of having shareholders, a company limited by guarantee has members who act as guarantors.

It provides the benefits of limited liability while allowing organisations to pursue their objectives without focusing on profit distribution.

The members (guarantors) of the company agree to contribute a specific amount of money (usually a nominal sum, such as £1) towards the company's debts if it is wound up. Their liability is limited to this amount, so their personal assets are not at risk.

Members of a company limited by guarantee may be individuals or other organisations, and they have voting rights in the company's decisions.

2.6.2. How will the entity deliver the services?

Rather than developing and directly delivering services, the role of the social franchise is to identify, coordinate and support domiciliary care organisations with services that enable them to deliver a critical business function at the same cost or higher quality at a lower cost.

This will also involve a high degree of system coordination with local authorities, regulators, and national government, who will be required to ensure their systems efficiently interface with each other and the entity to ensure total system efficiency.

The helicopter view is that 650 services are ostensibly delivering the same service. However, each service manages each business function differently. Sometimes, these differences can be profound, such as the employment contracts they offer for staff. As we saw in Chapter 1, this complexity is compounded by local authorities requiring providers to do things differently, even when they provide services within the same health and social care system.

This can mean that even if two services have the same owner, they must be run differently if they cover different authorities. During the consultation phase, one provider described the arrangements they were making to smooth working across two local authorities, where one authority paid an hourly rate five pounds higher than the other. Both authorities were in the same local economy and had similar geography. It is important to note the differential was not caused by a factor such as rurality. This complexity is then further compounded by the NHS, which contracts differently.

2.6.3. People processes and technology.

We considered business functions to have three elements.

- People
- Process
- Technology

This is sometimes called the “people, process, and tools” triad. It is a common and well-tested approach used across many sectors to examine how a business or a system functions.

People
The staff and management of a domiciliary care provider organisation are responsible for delivering critical business functions. They are responsible for carrying out tasks – including direct care, making decisions, setting out business strategy and tactics, and securing new work. At a system level, people in many other organisations interact with those working for a domiciliary care organisation to support the delivery of domiciliary care services. This includes commissioners and regulators.

Process
Processes represent the systematic and organised series of steps or activities a business undertakes to deliver services, produce products, develop, and secure business opportunities, and manage its business affairs. Efficient and well-defined processes ensure the organisation’s productivity and quality. Examples of processes in a domiciliary care organisation include recruitment, onboarding, paying invoices or creating profit and loss statements. Organisations within a supply chain also depend on processes managed by other organisations. Sometimes, these are tightly controlled and regulated by third parties. In franchise arrangements, the franchisor determines and closely controls many processes.

Technology
This includes all the technological tools, systems, and infrastructure to support and enhance its operations. This encompasses hardware, software, data management, communication systems, and other technological resources. Technology is increasingly significant in improving efficiency, enabling data-driven decision-making, enhancing customer interactions, and staying competitive.

Technology supports processes: Businesses employ technology to automate and streamline processes, reducing manual effort and potential errors. For example, inventory management systems can optimise supply chain processes.

People follow processes: Employees adhere to established procedures and workflows to ensure consistency and efficiency in their work. Practical training and clear process documentation are crucial to this aspect.

2.6.4. Licensing agreements

A licensing agreement is a legal contract between two parties that grants one party the right to use specific intellectual property or assets owned or controlled by the other party. Licencing agreements are at the heart of franchise arrangements, and we seek to replicate this approach here.

In this case, we suggest the social franchisor enters into licensing agreements with domiciliary care organisations to use proprietary business processes aligned to deliver domiciliary care efficiently. We have explored in detail two functional business areas – finance and HR in the following two chapters.

Specifically, a licensing agreement allows our small to medium-sized company to access specialist advice and standard business processes, enabling us to achieve greater efficiency in harnessing the power of cloud-based technology.

This will require a cooperative agreement with local government, the regulators, and the Welsh Government. Central to this agreement will be a rate card for the services delivered. This will specify the cost to the service provider, which must be directly related to fees paid to domiciliary care organisations. The mechanisms of this are discussed in the next section of this chapter.

The social franchise would obtain income through selling services through licencing agreements. It might also receive fees for acting as a coordinating agent for local authorities, regulators, and the Welsh Government.

2.7. Sub-functions under consideration

We identified the following list of common business functions within domiciliary care providers via a series of steps:

- We used cost headings from the National Commissioning Board data and the Fair Cost of Care exercise in England to generate a long list of business functions which are relevant to the domiciliary care sector.
- We considered as a team which business functions might potentially be covered by a social franchise model.

This produced the following list:

- **Regulation**: compliance, audit
- **HR**: Recruitment and selection, checks and onboarding, terms & conditions, HR policies
- **Finance**: Payroll, pensions, invoicing, expenses, payments
- **Training**: Manual handling, health & safety, continuous professional development
- **IT**: Hardware, software, Customer Relationship Management (CRM), Content Management Systems (CMS), Assistive Technology
- **Purchasing**: Uniforms, vehicle leasing, marketing, utilities, insurance, legal, banking

We explored potential for the model to cover these and other functions through the two initial engagement events, the collective development of a MIRO board (Appendix x), and the wider sector engagement (as described in section 1)

We concluded that there is appetite and potential for each of these functions to be included within a national franchise model.

However, given the resources available within the feasibility study, we selected two of these functions to work up in more detail. We chose Finance and Human Resources on the grounds that existing technology could be employed at relatively low cost to have a significant impact on these functions. Human Resources emerged as a key priority from the engagement and evidence review; it is clear that the potential impact on the whole health and care system from improving recruitment processes would be considerable. The next two chapters consider these two functions in turn, effectively providing a detailed case study on current and envisaged future states for each.

3. Finance and Accounting

3.1. Introduction

In this chapter, we explore the feasibility of the ***Social Franchise*** delivering systems and processes to support provider organisations with critical business functions related to finance and accounting. For ease, we will describe these as “finance functions”.

We will provide a brief context to the importance of the finance function to domiciliary care organisations, set out the arrangements as they are now (the “current state”) and then in a scenario where the franchisor is supporting the finance functions of individual domiciliary care organisations (the “future state’).

A consideration of the financial cost and benefit of developing a finance function is then included in Chapter 5: A Cost Benefit Analysis.

3.2. Context

3.2.1. Financial systems and franchising

Standardising and integrating the finance functions of a franchisor and franchisees is the cornerstone of any franchising model. This is because one of the foundational features of a franchising contract is a high degree of two-way financial transparency, with set responsibilities and obligations between both parties to provide data.

The franchisor and the franchisee require a common understanding of operational and supply chain costs, acceptable pricing, and margin. This intelligence-driven arrangement clearly benefits the franchisor, but it also empowers franchisees to make informed decisions that support their financial objectives and contribute to the franchise system’s viability, efficiency, and adaptability.

3.2.2. Finance Functions and SME’s

The following are some standard finance functions that many SMEs must have in place to deliver their finance function.

Accounting Sub-function

- Accounting: A system to manage financial transactions, including recording income and expenses.
- Invoicing and billing: A system to create invoices, track payments and manage accounts receivable.
- Financial reporting: A system to generate basic reports like balance sheets and Profit and loss statements.
- Cash Flow: A system to monitor and forecast cash flow.

Remuneration Sub-function

- Payroll: A system calculates and distributes employee wages, manages deductions, and generates payslips.
- Pensions: A system to manage enrolment, eligibility tracking, contribution calculations, and reporting for benefits offered to employees

Operations Sub-function

- Inventory Management: A system to track inventory levels.

- Business Development, Sustainability and Operational Growth: tendering/ getting on frameworks, collaboration and partnerships.

Compliance and Tax Management Sub-function

- Tax Management: A system to calculate taxes, file tax returns, and demonstrate compliance with tax regulations.

Together, these functions make up the financial control centre of any small-to-medium-sized business. In our cost modelling that is described in the cost benefit chapter we have focused on the **Accounting and Remuneration Sub-functions**.

Individual business owners will have their own expectations about growth, profit, and appetite for risk, however there is remarkable consistency in the day-to-day financial processing all domiciliary care organisations must undertake.

This is because they have:

- Similar operating models, in that they are subject to controlled commercial arrangements[83]
- Had to move to cloud-based systems that HMRC specifies to ensure compliance with the Making Tax Digital programme.

Making Tax Digital (MTD)

Making Tax Digital (MTD) is an initiative by His Majesty's Treasury (HMT) that aims to digitise and modernise the tax system. It requires businesses to maintain digital records, submit tax returns digitally, and use compatible software to ensure accurate and efficient tax reporting. Since 2019, MTD has required VAT-registered businesses with taxable turnover above the VAT £85,000 threshold to keep digital records and use compatible software to submit their VAT tax returns directly to His Majesty's Revenue & Customs (HMRC).

This policy has significantly changed how small businesses manage critical business functions, including their finance function described above. Businesses have had to adopt or upgrade their financial systems to ensure compatibility with MTD requirements. This has led to increased digitisation of financial records, automated data entry, and improved accuracy in tax reporting.

MTD also ensures that tax arrangements can keep up with wider economic changes, including how businesses interact with an increasingly dispersed and fragmented labour market. An example is ensuring the effective tax management of people who rapidly move between employers within a single sector or who have multiple taxable jobs.[84]

3.3. Current State

The paradox of the current state is that there is already a high degree of natural commonality in the delivery of the financial functions by domiciliary care organisations. However, because these functions are not aligned, there is a high degree of complexity which adds cost to the overall system.

Despite the high-level sector consistency, each organisation has its own slightly different approach to their finance function. A wide diversity of business management techniques and technology are used. The systems and processes they are forced to use are not standardised within a single market, as local authorities often take very different approaches. The consequence is that

[83] These can, for example, involve local authorities mandating the use of certain financial systems and approaches.

[84] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/621174/20170620_OTS_Gig_economy_Focus_paper_update.pdf

providers must constantly juggle multiple financial arrangements with a few commercially dominant customers.

There is remarkable consistency in the day-to-day financial processing all domiciliary care organisations must undertake because they have:

- Similar operating models, in that they are subject to controlled commercial arrangements defined by local authorities and other commissioner[85]
- Moved many financial functions to cloud-based finance platforms that HMRC specifies to ensure SME compliance with the Making Tax Digital imitative.

Despite this superficial sector consistency, each organisation has its own slightly different approach to their finance function. Providers also buy technology that is functionally similar and meets MTD compliance but is not standardised.

In addition, local authorities often take very different approaches to financial reporting, service delivery models and pricing. The consequence is that providers must constantly juggle multiple financial arrangements with a few commercially dominant customers. This complexity has both benefits and challenges for providers, and the wider health and social care system.

Benefits

- **Autonomy:** owners and managers of domiciliary care organisations can use their preferred financial systems. This gives them autonomy and control over their financial management processes enabling them to follow their established financial procedures, reporting formats, and internal controls. Some owners have told us they feel it is essential to maintain this business autonomy. Other owners have said to us that a standard single system that integrates with local authorities would be beneficial.

- **Flexibility:** owners and managers can choose a system that aligns with their needs, requirements, and skills. Some owners are technology orientated; others prefer to have greater manual control.

Challenges

- **Interoperability:** the diversity of approaches means different financial systems do not integrate, making it challenging to exchange financial information and collaborate on financial processes. This is a significant weakness since it prevents cooperative activity between businesses and between businesses and local authorities, to support the strategic objectives of both local and national government. A good example of this was the challenge government had in ensuring real living wage increases were passed on to frontline workers.

- **Complexity of Financial Oversight:** With multiple domiciliary care organisations using slightly different financial systems, local authorities can still face complexities in managing and reconciling financial data, such as invoices, payments, and financial statements. This can result in increased administrative burden and potential errors if proper processes and controls are not in place.

- **Lack of support to help domiciliary care organisations shaping their future growth:** Currently Market Position Statements are developed regionally to communicate the future requirements of commissioners to providers. These documents can be difficult to interpret. Commissioners are not allowed to support individual businesses due to procurement rules.

[85] These can, for example, involve local authorities mandating the use of certain financial systems and approaches.

3.4. Commercial franchise arrangement

Where a domiciliary care organisation is already in a commercial franchise arrangement, it is subject to a high-level of financial transparency. Typically, the franchise agreement will include clauses granting the franchisor the authority to monitor the complete financial framework of the franchise. This is seen as a benefit of owning a franchise as the trade-off is early active support by the franchisor if key financial metrics demonstrate underperformance.

3.5. Future State

In the future state we are proposing that the franchisor supports the provider organisations with their finance function. At the heart of this will be a single national approach that local authorities and providers will adhere to, a suite of technology or technological approaches to manage their financial function. This will replicate many of the processes that are available in a commercial franchise.

3.5.1. Cloud-Based Platform

To support the finance systems within the model, a high-level technology alignment is essential, and it is proposed that this is delivered through a single Cloud-Based Finance Platform. Cloud-based platforms provide a scalable and flexible foundation for shared financial systems. They enable people delivering a finance function within a domiciliary care organisation to access the system from anywhere, facilitating collaboration, and allowing for seamless integration with other business applications. Cloud infrastructure ensures high availability, data security, and facilitates real-time updates and backups.

The exact commercial arrangements through which a single Cloud-Based Finance Platform have not been explored in this study. However as set out earlier it is proposed that the franchisor will sell licence to domiciliary care organisations to access a process.

Commercial characteristics of cloud-based pricing agreements are characterised by per month licences. The fees for this service increase depending on the size of the organisation and the number of users using the system. Where providers are already deploying similar technology, we believe the charges for the social franchise system will be similar. There will be some costs associated with employing a small number of people within the central organisations to support the finance, payroll and accountancy function.

The following table describes the key shifts between the current and future state: by providing support to providers in the form of people, process and technology, the proposed solution will enable them to deliver their finance function more efficiently.

	Current	Future
People	Provider organisations employ people to undertake transactional job activity related to their finance and accountancy function. These people often have administrative job roles. Provider organisations employ people to undertake managerial job activity related to their finance and accountancy function. These people	Transactional job activity is largely now automated. MTD has already started this process. All remaining transactional job activity is delivered by through cloud-based applications that automate administrative tasks. Some client management activity related to the finance and accountancy function is delivered by

	often have supervisory or management job roles. Some provider organisations employ people to undertake strategic activity related to their finance and accountancy function.	the franchisor. This could include setting or agreeing rates All strategic commercial activity remains with within provider organisation.
Process	Each provider has its own process playbook. These have often developed over time. Increasingly processes are mandated by local authorities. There is however little consistency between processes mandated by local authorities. Many key finance functions are mandated by HMRC through the Making Tax Digital programme. Within this context provider organisation have flexibility to arrange and manage some of their finance and accountancy functions.	Most outward facing finance and accountancy functions are designed by the central body. There are very high levels of consistency by all local authorities across Wales. Within this context provider organisation have flexibility to arrange and manage independently financial functions related to their own business strategy including internal reporting.
Technology	There are multiple technologies deployed in the sector. Technologies are developed to be bespoke to the organisation and not the Welsh social care sector. Approaches such self-service employee and self-service management are not widely embedded. Latest technology is not deployed.	A single suite of finance and applications is defined by the central organisation. This will be delivered by third parties. A suit of applications ensures interoperability with local authority systems across Wales. There is significant support for the use of applications in a Welsh context.

Benefits
Integrating finance functions of domiciliary care organisations has many compelling benefits

- By consolidating finance functions, providers can achieve significant cost savings. The model standardises processes improving operational efficiency. This is set out further in ***Chapter 5: A Cost Benefit Analysis***
- The model allows providers to access advanced financial technologies and specialised expertise that may have been cost-prohibitive otherwise. Providers can leverage cutting-edge accounting software, data analytics tools, and automation solutions by pooling resources. These technologies optimise financial management processes, enhance data accuracy, and provide valuable insights, enabling providers to make informed decisions and gain a competitive edge.

- Providers can collectively enhance their financial management capabilities by exchanging best practices, experiences, and ideas. This collaborative environment fuels creativity, encourages adaptive strategies, and unlocks new business opportunities, bolstering their commercial growth.
- Providers enhance stakeholder trust and credibility by aligning financial reporting structures and adhering to standardised processes. This trust, in turn, opens doors to new partnerships, attracts investors, and strengthens market positioning, driving further commercial success.
- Providers can optimise costs, access advanced technologies, collaborate for growth, and establish a solid financial foundation that enables them to thrive in a competitive business landscape.

The following benefits relate to the development of the foundational economy:

- **Supporting Resilient Local Economies:** Effective finance systems enable domiciliary care organisation to maintain financial stability, ensuring the provision of essential services within local communities. They promote economic resilience by supporting businesses deeply rooted in the local economy.
- **Collaboration and Partnership:** Finance systems facilitate collaboration and partnership between SMEs in the Foundational Economy, allowing them to work together towards common goals. This can include joint financing initiatives, shared financial resources, and coordinated financial planning to address community needs effectively.
- **Ethical and Responsible Financial Practices:** Effective finance systems promote ethical and responsible financial practices within SMEs in the Foundational Economy. They enable businesses to uphold principles such as fair wages, responsible procurement, and sustainable resource management, aligning with the values of the Foundational Economy policy direction.

Risks

It is important to note that these risks and barriers are not insurmountable but should be proactively addressed during the planning and implementation stages of integrating shared financial systems.

- **Compatibility Issues:** Integrating financial systems across 500+ SMEs may encounter challenges due to variations in software, data formats, or accounting practices. Ensuring compatibility and smooth data transfer between systems can require significant technical effort and customization, potentially leading to delays and additional costs.
- **Resistance to Change:** Implementing shared financial systems will require the sector to adopt new processes, technologies, and workflows. Resistance to change from employees or stakeholders within providers can hinder successful integration. Overcoming resistance through effective change management strategies and clear communication will be essential.
- **Data Security and Privacy Concerns:** Sharing financial data between multiple providers raises security and privacy concerns. Ensuring robust data protection measures, including encryption, access controls, and compliance with relevant regulations, is crucial. Providers must have confidence in the security of their financial information when participating in shared systems.
- **Governance and Decision-making:** Establishing a governance structure for shared financial systems can be complex, particularly when multiple providers are involved.

Decision-making processes, data ownership, and accountability need to be clearly defined to avoid conflicts and ensure effective management of the shared system.

- **Trust and Collaboration:** Building trust and fostering collaboration among providers can be a challenge. Sharing financial information requires a high level of trust among participating businesses. Providers must overcome potential concerns regarding confidentiality, competition, and the fair distribution of benefits to ensure a successful and sustainable shared financial system.

3.5.2. Conclusion

We have set out that significant benefits can be accrued from moving an operating model where Social Franchise facilitates a common approach to transactional financial activity for the sector.

4. Human Resources

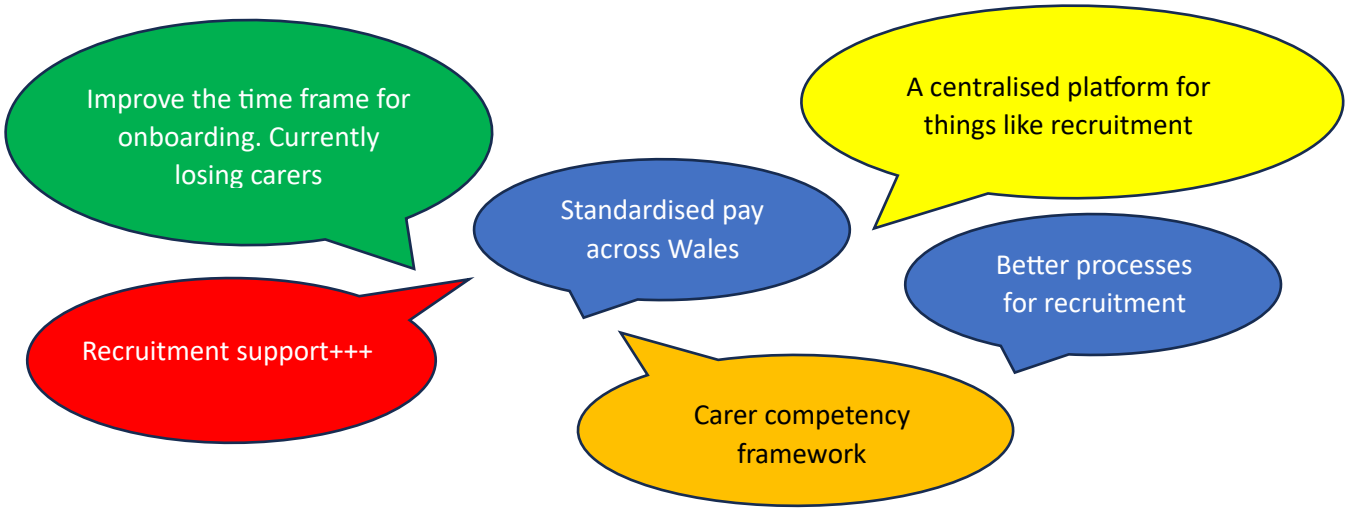
In this chapter, we explore the feasibility of the social franchise delivering systems and processes to support provider organisations with key business functions related to Human Resources (HR). For ease we will describe these as “HR functions”.

To do this, we will set out the arrangements as they are now (current state) and then in a scenario where the central organisation is delivering some of the HR functions in support of individual domiciliary care organisations (future state).

HR has been considered in some detail within the study and the findings of different research activities have been presented in previous sections of the report. For example:

- Relevant desk-based research findings related to workforce challenges are presented in section 1.3.2.
- The activity of the Social Care Fair Work Forum in developing minimum standards for pay and a consistent progression framework is described in section 1.3.3
- The considerable amount of resource and activity supplied in this area by Social Care Wales is described in section 1.3.4
- The feedback from the sector in relation to HR is presented in section 1.4.1; key findings included:
    - Recruitment and retention are huge challenges for domiciliary care agencies
    - Onboarding and checks – which necessarily involve a number of steps to ensure safety and quality – are taking much longer than they should
    - There is a need for better coordination of training activity
    - A lack of portability of checks and mandatory training leads to delays and duplication, and hampers mobility and progression of worker
    - Investment in a plethora of resources to support this area nationally and regionally are often not connecting with the fragmented care provider market
    - The potential which technological solutions are bringing to other sectors is not being consistently realised in domiciliary care due to lack of time, confidence, skill and money.

Direct quotes from participants’ feedback notes at engagement events included:



4.1. HR Functions

In this section, we identify common HR functions and explain our rationale for the prioritisation and phasing of these, both within the study and the proposed solutions.

The following are typical HR functions that domiciliary care providers are likely to be familiar with:

- **Attraction, Recruitment & Selection**: Recruiting, interviewing, and hiring new employees.
- **Background checks**: Disclosure & Barring Service (DBS) checks, Right to Work and references.
- **Onboarding and induction**: Welcoming and integrating new hires in the organisation.
- **Training and Development**: Providing learning opportunities to enhance employee skills and knowledge.
- **Payroll and Benefits**: Managing pay and employee benefits.
- **Wellbeing:** Promoting health and safety of the work environment
- **HR Policies**: Ensuring adherence to employment laws and regulations.

Prioritising and phasing functions for the proposed franchise
We considered the various HR functions against the following principles:

- **Prioritise what matters most to the independent domiciliary care sector:** our engagement (as presented in section 1.4.1) confirmed that recruitment and onboarding is a massive challenge for providers and one which is hampering effectiveness.

- **Prioritise what is doable**: whilst the long-term ambition of the proposed franchise model is wide, we have focused in the first phase of implementation on functions where scalable and financially feasible solutions can bring about maximum impact, within the parameters of legal advice. For example, we discounted a shared services approach to HR because of the high cost and enormous complexity of contracting and set-up which this would involve. Whilst we see opportunities to develop a more a more coherent strategic approach to HR through the social franchise, we recognise the need to deliver operational support first, since this is the priority and we believe it will be more attractive to providers, many of whom reported feel overwhelmed by strategic initiatives which do not address their most pressing concerns.

- **Avoid the risk of de-stabilising the sector**: In our engagement, there were some concerns from providers about the risk of secondary regulation resulting from the franchise. Providers want something which will simplify and create economies of scale, not add additional requirements, which they would directly or indirectly be required to fund from within the existing envelope of resources.

- **Avoid the risk of duplication**: Social Care Wales is already delivering various initiatives and resources to improve attraction, induction, training and development of care workers, and further expansion is planned. Some local authorities also provide support with recruitment, for example the Carmarthenshire Care Academi and Cardiff Cares Academy. The proposed future state has been designed to pick up at the boundaries of these initiatives, bolting onto them rather than duplicating them, and adding value by acting as a conduit between these resources and domiciliary care providers. It will therefore be essential that the next stage of implementation planning is done in partnership with Social Care Wales and Workforce Development leads.

The table overleaf shows how, using these principles and evidence collected and reviewed, the team decided which HR functions to include initially or at a later stage, or to exclude.

4.1.1. Rationale for inclusion of HR functions within the proposed solution

HR function	Examples of possible tasks/ solutions	Feedback from engagement	Decision	Rationale for inclusion/ exclusion
Recruitment & selection	Job descriptions/ advertising, applicant tracking/ screening/ sifting; employment offers/ contracts	Clear demand from providers for practical support to improve effectiveness and administrative reduce burden	Include in first phase	Real potential to streamline recruitment by using a platform model, as demonstrated in other sectors (e.g., Uber, Beamery)
Background checks	References, Right to Work/ registration/ qualification/ DBS checks	These processes often create unreasonable delays in onboarding	Include in first phase	Potential to streamline communications with central bodies (DBS, SCW) and to add references securely
Onboarding & induction	Local onboarding and coordination of new starter induction programme (AWIF)	AWIF can be onerous for small providers and there is duplication where people move between providers	Include tracking of this process in phase 1	Scope to track attendance, completion, drop-outs from standardised induction aligned with AWIF in later phase of platform development
Training and development	Portable training record; coordination and monitoring of core training	The need for portable, quality assured core training, bespoke to domiciliary care, and clarity around what is required/ on offer; providers had mixed feelings about trusting external, especially online providers	Seek to include elements of this in later phase	Scope to act as a portal, guiding workers and employers to existing resources provided by WeCare Wales/ SCW/ SCWWDP and local authority Workforce Development Teams, and to gather evidence to shape their future development
Payroll & benefits	Processing payroll data, annual leave entitlement monitoring, auto enrolment	Payroll was raised by providers as an area where efficiencies could be made	Covered in separate function	Payroll covered in Finance & Accounting functions; links between the recruitment and finance platforms could be designed in via Application Programming Interface, API.

Wellbeing	Helplines or other resources for managers and employees	Promoting staff wellbeing was raised as an important issue in engagement	Not included initially	Helplines require high ongoing revenue and there is already significant resource available via Social Care Wales and Canopi; there may be opportunities to include access to wellbeing apps/ Canopi/ negotiated benefits to platform at a later stage.
HR policies	Policy guidance/ review, templates, resources, helpline	Some desire to improve efficiency and compliance through some standardisation/ specialist support for HR challenges as costly to buy in	Those specific to recruitment included in first phase Wider policies not included initially	The assumption is that standard policies will be developed by the Social Care Fair Work Forum in line with the introduction of the minimum standards as part of the Pay & Progression Framework. Standard recruitment, induction and onboarding policies will be included in phase 1 to support the new way of working via the new recruitment platform. However, the wider development of other HR related policies may be developed in later stages as the social franchise and its products grows.
Staff cover	Supply of temporary staff to cover absences or vacancies	Access to trusted and affordable agency or bank staff was raised as an important issue	Not included initially	Challenging to establish this initially due to legal issues, costs and need to recruit to bank; however, platform development could be a step on route to facilitating rapid deployment of workers across areas and agencies once standardisation in place (Terms & Conditions, checks and training, established app, etc)
Exit and terminations	Processing resignations, retirements, terminations; exit interviews	Did not emerge as a key theme in engagement; however, this suggests a missed opportunity for wider retention across the sector	Covered in separate function Not included initially	Payroll covered in Finance & Accounting functions; links between the recruitment and finance platforms could be designed in via Application Programming Interface, (API), e.g., Ensuring leavers are paid correctly and informing pension providers etc… Could be further scope to add features to platform to track staff leaving a provider, ask both parties to rate each other; offer alternatives if still interested in/ suitable for care work, maybe through bank.

4.2. Current State

Based on the engagement with providers and evidence reviewed as part of this feasibility study, the following broad conclusions about the overall state of HR within the domiciliary care sector in Wales were reached, which form assumptions within our modelling:

- **Domiciliary care providers have widely varying approaches to their HR functions, have different terms and conditions, and have different policies, processes, and systems.**

For example, Welsh Government (2016)[86] found that '*No local authorities required adoption of specified terms and conditions of employment in their commissioning processes/ contracts*' (p.61) and there were subsequently a range of terms, conditions, policies, and practice in place within the independent domiciliary care sector in Wales.

- **There seems to be a gap in expertise and knowledge gap relating to HR within smaller provider organisations: few have specialist or even dedicated HR resource.**

There is little existing published evidence on this point specifically in relation to the independent domiciliary care sector in Wales; however, more general research[87] about the HR development of SMEs in the UK shows that smaller companies have limited resources to invest in HR practices and are less likely to have specialist expertise available in-house; we understand that some outsource their HR functions and pay a monthly amount. This aligns with the findings of the Workforce Planning Approaches report carried out by Practice Solutions and Social Care Wales[88] which focused on local authority approaches to workforce planning. Research carried out by Skills for Care[89] found that, even out of adult social employers with staff turnover of less than 10%, only 54% had a recruitment plan.

Another evidence review[90] found that, as a result of resource poverty (in terms of both time and money), SMEs '*may be reluctant to invest in dedicated HR specialists, at least until they have reached a viable size threshold'* and that in small family-run businesses or others where ownership is concentrated, there "*can be a reluctance to delegate HR tasks"* (p.3177/8).

Purple Tribe (a care recruitment specialist based in England) reports that:

> *"….most care providers have no in-house recruiter, little time, systems, or effective recruitment process…."*[91]

[86] https://www.gov.wales/sites/default/files/statistics-and-research/2019-07/160317-factors-affect-recruitment-retention-domiciliary-care-workers-final-en.pdf

87 Antcliff, V., Ben Lupton, B. & Atkinson, C. (2021) Why do small businesses seek support for managing people? Implications for theory and policy from an analysis of UK small business survey data, International Small Business Journal: Researching Entrepreneurship 2021, Vol. 39(6) 532–553

[88] Social Care Wales, Social care workforce planning fit for the future, August 2023: https://socialcare.wales/workforce-planning-executive-summary

[89] Figgett, D. (2017) Recruitment and retention in adult social care: secrets of success: Learning from employers what works well, May 2017, Skills for Care

[90] Brian Harney, Mark Gilman, Susan Mayson & Simon Raby (2022) Advancing understanding of HRM in small and medium-sized enterprises (SMEs): critical questions
and future prospects, The International Journal of Human Resource Management, 33:16, 3175-3196, DOI: 10.1080/09585192.2022.2109375

[91] https://purpletribe.co.uk/carer-recruitment-the-3-myths-holding-carer-recruitment-back-busted/

A further detailed survey of the Welsh domiciliary care sector is recommended if the decision is made in principle to pursue the development of the social franchise.

- **Recruitment is a major challenge for the sector, both in terms of finding enough good candidates, but also in terms of the frequency with which recruitment processes need to take place, given high turnover in the sector.**

Welsh Government (2016[92]) found that *'the general view [from managers of independent care providers] was that recruitment systems could be improved' (p.11).* As in the engagement carried out for our study, themes included: wordy application forms, online advertising that was not as effective as it might be, delays with DBS checks, and lengthy onboarding which sometimes led to attrition of candidates.

- **There is growing evidence of what works in effective recruitment and selection of care staff on which proposed solutions can and should build**

For example, Skills for Care[93] conducted research amongst English adult social care employers with a turnover of less than 10% to explore what contributes to their success in relation to recruitment and retention. Key findings include: values-based recruitment, refer-a-friend, and giving potential candidates a good insight into what the roles involves.

In the remainder of this chapter, we focus on recruitment and onboarding, describing current processes before presenting the envisaged future state via the national franchise model.

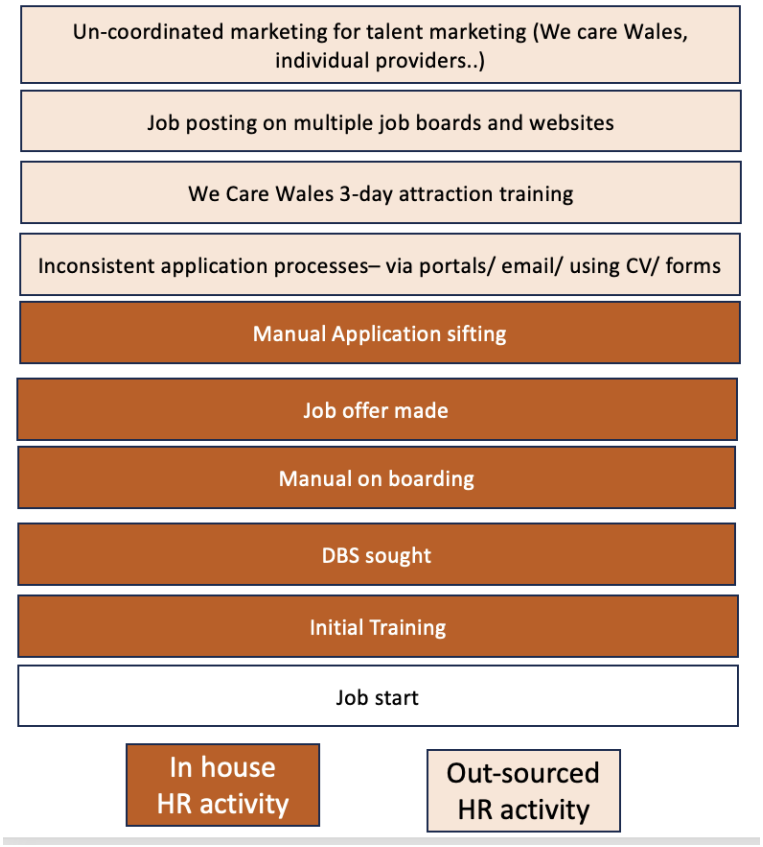
Recruitment and onboarding: current state

As demonstrated in section 1, there are major challenges in relation to recruitment and retention within the domiciliary sector. There are significant structural barriers driving these challenges – pay and conditions, demographic change, rurality, gender segregation, the fallout of Covid leading to "The Great Resignation" and of course, Brexit. Nevertheless, it is clear from the evidence collected and reviewed in this study that fragmented and inefficient recruitment and selection processes are also contributing to the problem and will reduce the impact of any further investment in marketing, and terms and conditions.

The current process for recruitment and selection within provider organisations is shown in the visual below; each stage is described and discussed in the following section. Those steps in the process undertaken by providers in-house are highlighted in dark orange, representing high administrative burden.

[92] ibid

[93] Figgett, D. (2017) Recruitment and retention in adult social care: secrets of success: Learning from employers what works well, May 2017, Skills for Care



Talent marketing

Nationally, Social Care Wales has developed the We Care web site, which aims to promote social care jobs, and provides a range of resources to give potential applicants an insight into what different care roles typically involve.

Social Care Wales has a marketing budget of £200,000 per annum. This covers all of Social Care, Early Years, Childcare and Play. Given the range of their work, they do not have a dedicated budget specifically for domiciliary care. Talent marketing activity primarily involves social media boosting and in previous years, due to an increased budget, they have been able to fund wider activity, such as TV advertising. Major campaigns are evaluated to gain insight on reach / engagement[94].

Figures about Social Care Wales' investment and impact are included in the Assumptions section. At this stage, the current platform-specific data is limited; however, with the development of the new website in 2024, Social Care Wales will have far more robust data on activity on the site and the jobs portal. This means they will be able to understand volumes of specific job roles, and then triangulate against region, locality and employer. However, since the site does not bolt onto one consistent recruitment platform (as proposed here), they will still not be able to track applicants through to employment.

The awareness raising activity is clearly having an impact in terms of traffic to the online site; however, the conversion rate to actual applicants and employees is relatively low, given the size of the investment. This reflects feedback from providers during engagement who felt that WeCare did not deliver enough candidates. They therefore continue to use it alongside other jobs portals. In

[94] WeCare Wales - Job Portal Advert Evaluation. 25th March 2022 - 8th April 2022

addition to structural challenges with pay and demographics, a key challenge here is that WeCare Wales is only attracting, not recruiting candidates. A recent report for WeCare Wales by Urban Foresight[95] highlighted the gap, since they found that obstacles within recruitment, such as lengthy, inconsistent, inaccessible recruitment processes and time wasted in ineligible or unsuitable candidates are also getting in the way of the initiative's conversion rate. This is the very gap which the proposed solution seeks to fill.

Social Care Wales continuously develops a range of resources to support the recruitment and development of the social care sector workforce, both directly and indirectly through the SCWWDP programme. However, again there appears to be something of a disconnect between this activity and the domiciliary care sector on the ground. For example, in our engagement, domiciliary providers told us that they were either not aware of all the resources available, or do not have the capacity to navigate and make best use of them.

Social Care Wales have also established the **Regional Care Career Connector** role with one individual being employed within each of the seven regions in Wales, with funding of £50,000 per region. The purpose of the post is to connect the national work of WeCare Wales and the activity to support talent acquisition at a regional and local level. The regional role is often supported by WeCare Ambassadors and could include attending careers events, working with schools, colleges, employability programmes, job centres and Careers Wales. Social Care Wales are currently carrying out an evaluation of the regional role.

We Care Wales offers **a free 3-day Introduction to Social Care** for those wanting to enter the sector. This is a tailored training course which aims to give an overview of social care. It explains:

- Roles within social care
- Qualities and expectations of roles within social care
- How to find a job in social care
- Duty of care, risk and safeguarding
- The Social Services and Well-being [Wales] Act 2014
- Multi-agency working, the codes of professional practice
- Communication, Welsh Language and barriers
- Confidentiality and consent
- Promoting independence
- Personal resilience and wellbeing
- Dementia

The product was developed in response to market research findings[96] which suggested that the public lacked awareness about what care work involves and the different roles available within the sector. It was launched in January 2022, following a pilot within a local authority in 2021. The programme has continued to evolve throughout the months, adding modules on cultural differences and the wellbeing of workers, to ensure that the programme incorporates many of the core elements of working in social care.

A total of 744 participants had signed up in 2022, with 410 (55%) completing between January and November 2022. 88 (21%) had gained employment/ education or a volunteer opportunity by December of that year; 62 of them in social care including bank work.

[95] Urban Foresight (2023) Understanding social care attraction and recruitment in Wales and the role of We Care Wales. Key Findings and Recommendations, 1 March 2023, Social Care Wales

[96] We Care Wales Report December 2022

Job advertising
There are multiple job portals in use within the sector, including Indeed, We Care Wales, and Join Social Care. Since no single platform has sufficient volume and quality of prospective candidates, recruiters may post on multiple sites, increasing the time and money spent on the process. Potential applicants may need to search various job portals, often having to register on different sites, or click through to providers' sites, sometimes then needing to email providers outside of the portal to request application forms. Terms and conditions vary, and it is difficult to compare different roles.

We Care Wales contains a searchable database of care providers, and a job search which can be filtered by location, client group (children/ adults) and contract type. Individuals can register to receive email alerts for relevant roles and can save job adverts which they are interested in within their personal log-in space. Providers can post job advertisements for free on the site, can access an Employers' Toolkit with downloadable resources, and can view and edit all their current and closed vacancies. The functionality of the site is constantly being developed – for example, we understand that where care jobs are posted on local authority websites, they now automatically appear on the We Care Wales portal too.

A recent[97] evaluation highlights the learning from and limitations of We Care Wales to date. The evaluation heard positive feedback for the initiative from many of those engaged, but also a lack of awareness and coverage (especially in mid/North Wales); low engagement with the job portal and feedback from users that this is confusing. The report recommends partnership with 'a bigger player' in relation to the portal, better support for applicants to understand registration and qualifications, and the standardisation of processes.

Existing online recruitment platforms and solutions being used by the care sector include:

- Join Social Care – a recruitment platform which focuses on the social care sector and has some coverage in Wales; employers can post jobs and search for registered candidates in their area. The offer is not free to employers (the site talks about discussing the 'most cost-effective options' for your business); however, potential candidates can register for free and are then connected with over 2000 employers who are using the site, according to marketing information.
- **Indeed** has impressive reach as a mainstream jobs board, and this creates the opportunity to reach general jobseekers with news of care vacancies; however, providers frequently reported limited success generating good quality applicants from their adverts on the site. Free job postings can be made; however, employers must pay significant amounts to sponsor job postings or access the Indeed Hiring Platform, which offers some automation. According to reviews, the hiring platform is generally well-received, but can be difficult and time-consuming to customise, which would be critical to unlocking the potential of automation for the domiciliary care sector, given the very specific processes required in relation to employment and suitability checks and training.

Application processes
There is a mix of approaches to the application process, depending on:

- The preferences of each provider for application form or CV.
- Whether and which multiple portals or other methods are used for advertising a post.
- The functionality of different jobs portals.
- Whether or not applicants are registered on job portals.

[97] Urban Foresight for Social Care Wales (2023) Understanding social care attraction and recruitment in Wales and the role of WeCare Wales: Key Findings and Recommendations

- Whether the provider is using free or paid-for functions on portals.

Although many of the jobs portals listed above offer to collate applications, if adverts have been posted on multiple sites and some applicants have called or emailed directly, recruiters are likely to end up with applications in different formats and locations.

From applicants' perspectives, posts must be applied for separately and forms may ask different questions.

Sifting of applicants
Although We Care Wales has created a range of resources to attempt to filter out those who do not understand what the job involves or are not suited to it, it is up to providers to sift through applications and short-list candidates. This can be time-consuming, especially if there are a lot of applications from people who have been required to demonstrate activity as part of their Universal Credit Journal.

Job offers and onboarding
Once providers have interviewed and selected candidates, the responsibility lies with them to send out provisional job offers, explain the necessary conditions, guide candidates through the process of essential checks (Right to Work, DBS, references) before a formal offer can be made.

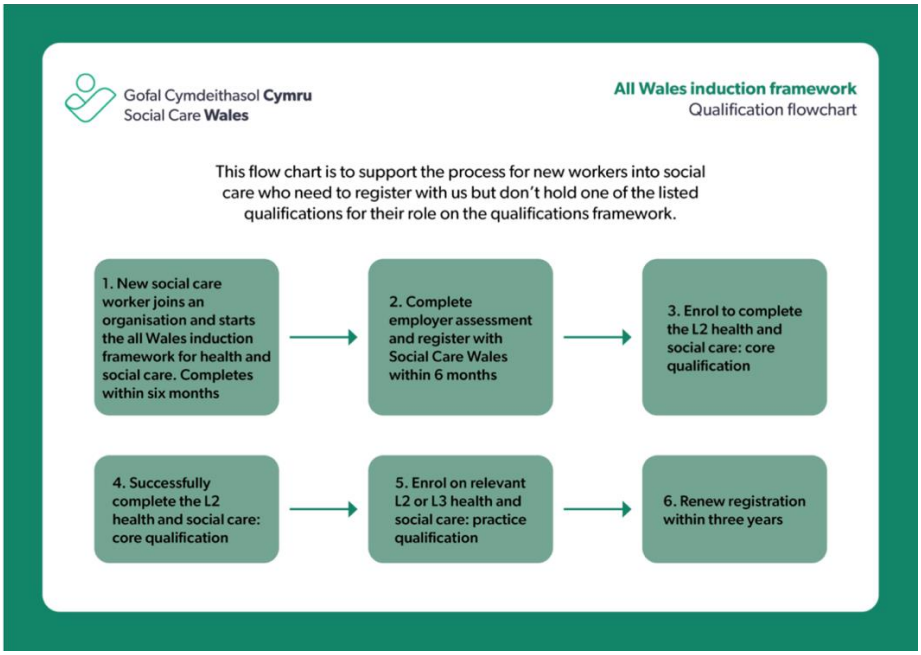
In smaller companies, which do not have a dedicated HR function, this is a time-consuming process with risk of delays at each stage, given all the other operational pressures of running a care agency. Even where local authorities have carried out successful talent marketing campaigns, we have heard that local providers often do not have the capacity to onboard new starters, even though they may be desperate to fill vacancies.

Onboarding is also an onerous process from the applicant's perspective, relative to the terms and conditions of the work, and there is a high risk of candidates dropping out and taking up jobs in retail or hospitality where there are fewer barriers to starting a new job.

Induction – All Wales Induction Framework
Once contracts have been signed, the induction process must be arranged and delivered.

The statutory guidance for Service Regulations 36 (see details overleaf) states service providers must ensure they have an induction programme that equips all new staff to be confident in their roles and practice and enables them to make a positive contribution to the wellbeing of individuals using the service[98]. Social Care Wales has produced the following flowchart which explains the process for this, which should take place in the first six months after appointment, as set out in the All Wales Induction Framework (AWIF).

[98] Social Care Wales (2019) All Wales induction framework for health and social care: Introduction and Guidance



From Social Care Wales: Social Care Worker Flow Chart (2023): for original version and more details see https://socialcare.wales/qualifications-funding/induction-frameworks/induction-for-health-and-social-care-awif/social-care-worker-flow-chart

The sections of the AWIF are:

- Section 1 and 2: Principles and values of health and social care
- Section 3 and 4: Health and well-being
- Section 5: Professional practice as a health and social care worker
- Section 6: Safeguarding individuals
- Section 7: Health and safety in health and social care.

Any mandatory training should be aligned with the sections of the AWIF and the workers role. Registered workers will also be expected to complete 45 hours of continuing professional development (CPD) during their registration period (3 years). The CPD may include refresher mandatory training if required. Also, registered workers will be required to attain the required qualification for their role – currently a two-part qualification (Health and Social Care Core and Practice). Recent registration changes have resulted in an extension of the time given to attain the qualifications.

SCW recognise and expect that many people can complete the qualification in three years, but all social care workers will have six years to complete the required qualification for their role. There are some learning materials on the Social Care Wales website[99] to help workers with learning – these are free to access, and SCW is developing a range of additional modules, some focusing specifically on elements of the AWIF and designed to help workers to register with SCW through the Employer Assessment Route. There will also be modules for wider learning such as Welsh language, strengths-based practice etc.

Social Care Wales recognises that some employers use external training providers like further education providers or local training companies to help people gain the supporting knowledge and

[99] Social Care Wales | Learning modules

understanding needed to complete the AWIF – some of this may be part of the local SCWWDP offer[100], which is overseen by Training/ Workforce Managers in local authorities. Each Local Authority or region determines how much SCWWDP grant is allocated to domiciliary care, and it is our understanding is that, at least in some areas, the focus is on developing in-house care staff.

There seem, however, to be a number of challenges at present with:

- Employers and employees in the independent domiciliary care sector finding out about these resources, despite various methods of communication (provider forums, emails, newsletters, social media) being used by SCW and the local SCWWDP leads.
- All parties being clear about what is mandatory and what is best practice
- Employers being able to afford to pay workers to attend training and back-fill their substantive roles

Other elements, relating to practice or to the organisation's policies and procedures, still need to be completed in the workplace. Workbooks on each of the seven core topics are available to support learning, and a progress log has been designed to check progress. 'Accredited evidence' can be passported to another employer to save having to repeat the whole process if the worker moves to a different agency.

Feedback from employers during engagement conducted as part of this study suggests that many find this framework 'onerous' and there is some confusion about what is mandatory and what is only recommended as best practice. Meanwhile, there is varying practice around how much of employees' time to complete training is paid, and challenges around releasing people from regular duties to complete the framework. All of this can contribute to the attrition of new workers from the sector.

4.3. Future state [Year 1 & 2]

We are suggesting that the central resource coordinates a national end-to-end user centric pathway to manage the recruitment and onboarding of domiciliary care workers. By implementing the pathway, the sector will streamline hiring procedures ensuring that potential workers are efficiently identified, assessed, and onboarded. This will optimise administrative efficiency across the sector whist retaining the independence of providers to select their own staff.

The recruitment pathway has four discrete, but linked elements. We have assumed that it will start with a national coordinated attraction campaign, delivered by WeCare Wales, and end with the deployment of a worker that has completed their initial training.

Some components of each of the elements are outside the direct control of the central resource or providers. The pathway therefore requires the active involvement of regulators, local government, and Welsh Government to support the pathway and deploy funds to maximise its impact. The overall principle is one of cooperation and coordination to bring together what is a currently a very fragmented and clearly broken recruitment system.

This will require system change, with:

- Providers acting in a consistent way, adopting technology, using standard policies and processes, and adopting the minimum standards in relation to unified pay and terms and conditions in line with the pay and progression framework.

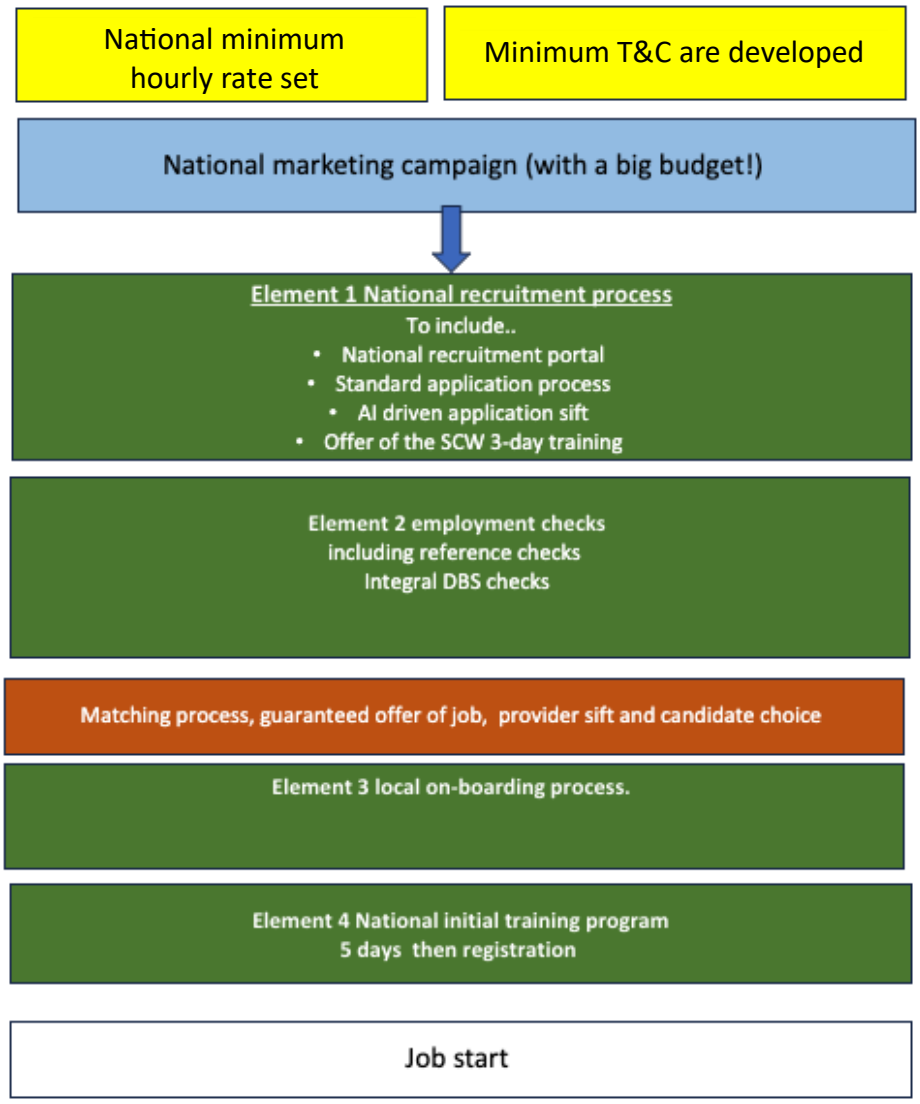
[100] Social Care Wales workforce development grant programme (SCWWDP) is a large fund to help the social care sector workforce develop in Wales.

- Social Care Wales to continue to deploy and integrate resources to support talent attraction at a national level attraction campaign, and additional regional/ local activity (including both local authorities and providers) also directing traffic to the platform
- Welsh Government and local government recognising the true cost of mandatory training and setting a minimum hourly rate of pay for domiciliary care workers.

The following visual describes the future state. Key dependencies and assumptions are indicated in yellow and blue at the top, the elements to be carried out by the central resource are shown in green and those which would be retained by the employer in brown.

The four key elements of the solution are then described in more detail in the text below. Risks, assumptions, and dependencies are summarised, along with an overall assessment of feasibility and cost benefits at the end of the chapter.

Fig 1: Visual summarising the envisaged future state



Element 1: Recruitment

Jobs portals are now used by most companies at the start of a recruitment process. A recruitment portal is a website or software that can simplify the hiring process, by allowing recruiters to post job advertisements with custom application questions and efficiently search for candidates. Some

recruitment portals allow employers to find candidates by searching the site for registered job seekers, rather than waiting for people to apply[101].

As we saw in the previous section, there are many existing portals available on the market – some have free versions, many require subscriptions to access features. For smaller care providers in particular, the barriers may also include having time, technical and HR skills and confidence to select and customise the right product. Most importantly though, these platforms will only deliver a pool of candidates if people with an interest in and aptitude for care are registering on them. This requires central coordination of all the money and effort being invested in both national and local advertising campaigns, as proposed here.

The centralised portal:

- Would link to existing and planned advertising campaigns to ensure that all interested applicants are directed to the same portal.
- The portal would contain:
    - Standard application processes
    - An Artificial Intelligence (AI)- driven sift of potential candidates, based on the results of an aptitude test and other applicant details (e.g., location, availability, CV).
    - Aptitude tests and algorithms to inform AI-sifting would be based on existing evidence/ tools for values-based recruitment. There is a growing body of evidence that a values-based approach to recruitment can result in lower recruitment costs, positive return on investment, lower staff turnover, better staff performance, and improved retention of staff[102].

A small team, consisting of people with HR experience who are fully confident of how the platform works, will work in the background, providing the following services:

- On-boarding providers, advising them on the use of the platform and evaluating its performance in selecting the best candidates
- Quality assurance, myth-busting and highlighting any snags within the platform
- Providing some assistance for potential applicants, and recruiters, who are struggling to use the technology.

This model would benefit employers by streamlining and automating as much of the process as possible, so that new recruitment processes can be triggered in moments, will reach as many 'warm' candidates as possible in one place, and all the processes related to recruitment and selection are contained in one portal.

The model assumes that AI can improve the way in which the system attracts and recruits currently under-represented groups in the care sector. We have reviewed existing evidence on this topic and present headlines, references, and implications in the Technology Requirements section below.

Element 2: Employment checks
Before they can be employed, applicants for care jobs must have verified their right to work, have had a DBS check, submitted references, and – for some posts – NVQ certificates or other qualifications will be relevant.

[101] Taken from Indeed: https://www.indeed.com/career-advice/career-development/recruitment-portals

[102] See for example: Skills for Care (2021) **Evidence review and sector consultation to inform Skills for Care strategy,** Final sector report, February 2021

Disclosure and Barring Service
Our engagement has highlighted delays in the recruitment process due to Disclosure and Barring Service applications.

However, performance management data published by the DBS[103] suggests average turnaround times of:

- South Wales: 5.4 days
- North Wales: 5.9 days
- Dyfed-Powys: 5.2 days
- Gwent: 5.1 days

DBS highlights that online requests are much faster than postal ones and that standard or enhanced checks are more involved since they must be verified by the employer. Results can be provided much quicker via an online link, where certificates take longer to come through the post.

It may of course be that these average times are masking seasonal variations; however, this data suggests that the collection of evidence and the phasing of approvals to support the submission to DBS may be a key cause of the delays reported by providers, rather than these being primarily caused by the DBS agency itself. Errors or delays in the application process could be significantly reduced by AI within the proposed platform.

We understand that it is the responsibility of the employer to make DBS checks; however there seems to be an opportunity to better streamline this process in order to:

- Coordinate the process of employers requesting (and applicants/ employees consenting to) DBS checks via the platform so that automatic chasing occurs, the interface with DBS and the domiciliary care sector is centralised and hence more efficient.
- Improve the speed with which workers who are new to the sector can be checked and onboarded, perhaps whereby the central resource initiates DBS's Adult First service at filtering stage. If this initial search (costing £6 per person) reveals that 'no match exists for this person on the current DBS adults barred list', they are permitted to start work, under supervision (which could allow for in-person onboarding, training, shadowing), with vulnerable adults before a DBS certificate has been obtained[104].
- Enable the portability of workers between settings (e.g. by attaching current DBS certificate to a worker's profile on the system so it could be checked by other employers, e.g. using the person for temporary cover). If roles are standardised, it will improve efficiency and accuracy in checking candidate suitability.
- Coordinate prompts to commence automatic renewals of DBS status checks on existing employees.

The expectation is that DBS would be a key partner in the development stage of the platform and its processes.

By guiding potential applicants through as many of the pre-employment checks as possible, ideally in advance of the recruitment and selection process, the envisaged platform will reduce delays at

[103] DBS checks, Turnaround Times for DBS checks by region, accessed 13 Nov 2023 https://www.dbschecks.org.uk/turnaround-times-for-dbs-checks-by-region/#:~:text=Greater%20Manchester%20(18.5%20days),Surrey%20(20.9%20days)

[104] See here for further details of how the scheme works

onboarding stage and minimise the burden on employers to initiate and chase progress on each of these checks.

The AI driven prompts within the platform would explain the requirements clearly to potential candidates, enabling them to upload relevant documents (e.g., qualifications, ID, etc), linking them directly to relevant sites where needed, and initiating and chasing different parties (e.g. referees) throughout the process. Our assumption is that an Adult Fast Track DBS might be initiated at this stage (as described above). Registration with Social Care Wales and full DBS would then follow once a candidate has been selected for a post (see next section). Where applicants have already been employed as carers, this information could be added to individuals' profiles, increasing portability between employers.

The pool of potential candidates is therefore as prepared and ready to work as they can be *before* the point of selection. Employers will still retain control over the ultimate selection process; however, the proposed solution will automate many of the other steps which surround that decision-making and help to plan for 'real life' onboarding. Again, the small team supporting the platform will be responsible for regular and consistent engagement with DBS, We Care Wales, Social Care Wales as needed and will proactively chase, nudge and provide human troubleshooting and follow-up where it is needed.

Element 3: Local onboarding

As described above, there are a number of steps to be taken at this stage: sending out a conditional job offer letter, explaining the conditions for this offer, requesting references, completing a full DBS check. The platform would automate the administration for these key steps, using templates and AI-driven prompts, informed by set processes. For example, the offer letter can be populated and sent using a template [driven by AI]; referees can be emailed once applicants have added their details and they can be asked to add or upload their reference [driven by AI]; DBS applications could potentially be activated, based on applicant information already contained within the profile, asking the employer to sign this and the applicant to consent [driven by AI, but will need input from the small HR team]. Throughout the process, the various parties can be nudged, reminded, updated on progress, informed that the next step has been completed to minimise delays and sustain candidate engagement.

Once the necessary steps are complete, a formal offer and contract could be automatically generated from a template and both parties asked to sign.

Unified terms and conditions would make it much easier to implement standard contract templates and approaches. The proposals for a pay and progression framework[105] refer to minimum standards (described here as 'the national minimum standards'). At the time of writing, our understanding is that these will be voluntary, however, those providers subscribing to the social franchise model will need to agree to introduce the minimum standards to their workforce.

It not yet clear whether and how these national minimum standards will impact on wider HR policies, e.g. maternity, sickness, allowances, pensions, etc. Given this uncertainty, further development will be needed to understand and account for the impact of this evolving area of work, which will may require additional investment. It is likely that there will continue to be an ongoing differential between local authority and independent staff, at least in relation to pensions and other benefits.

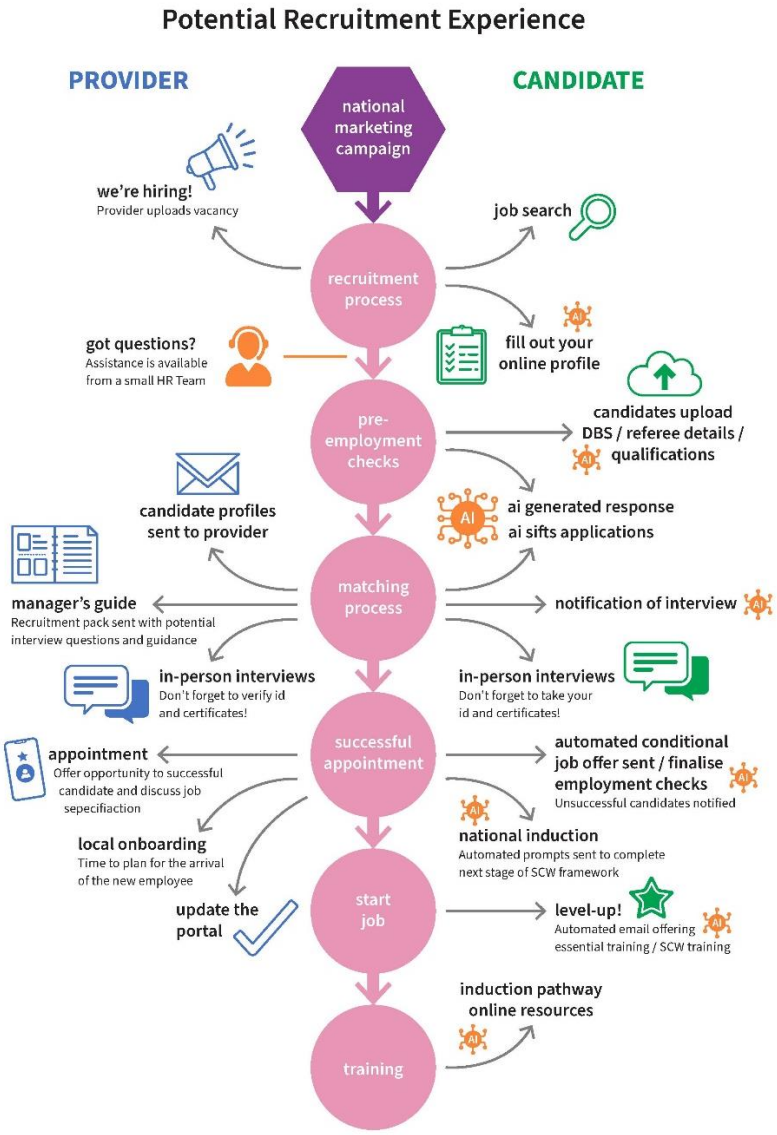
However, it feels clear that the mechanism which will be established through the social franchise will provide a valuable platform from which to respond collectively and effectively to these national changes.

[105] https://www.gov.wales/sites/default/files/consultations/2023-05/proposals-for-a-pay-and-progression-framework.pdf

If recommended pay rates are increased by the national workstream, it is not yet clear how this will be funded nationally, and this is beyond the scope of the current study. However, the social franchise can potentially play a key part in this, by generating cost savings in back-office functions which domiciliary care providers can then use to fund additional pay, pension contributions, sickness, maternity and any other relevant allowances.

It is not yet clear whether and which body/ies will be responsible for the further engagement and potential consultation with employees regarding the changes proposed by the Social Care Fair Work Forum; again, the social franchise might be well-placed to manage and coordinate any formal consultation. Legal advice will be needed to understand the responsibilities of franchisor and franchisees (and this may be different for statutory and independent providers). Again, this may require additional investment during the development phase.

The envisaged future pathway is summarised in the visual below.



Element 4: Training
Once the contract has been signed, the induction planning can begin. We saw in the previous section that it can be challenging for smaller providers to implement the All Wales Induction Framework.

The proposed platform could potentially support Social Care Wales and Workforce Development Teams to reach independent domiciliary care providers with the materials and training offer outlined above, and reduce costs for providers by enabling them to access free or low-cost quality-assured training resources wherever possible. By offering an integrated system which will enable people, once they have completed onboarding, to coordinate these different offers and resources, the platform might, for example:

- Send prompts to employer and employee reminding them to complete the next stage of the framework as quickly as possible
- Provide personalised notifications to both employer and employee about upcoming scheduled training events related to the next stage of the training programme.
- Prompt employers to confirm whether the individual is authorised to attend a session
- Send a reminder to the individual to attend the session and upload certificates
- Direct the individual to existing SCW online modules, specific workbook sections, and guidance at relevant stages in their personal induction programme. Note this would effectively act as a personalised portal to *existing* materials.

Over time, we can envisage further potential (though this sits out with our initial costings) for the platform to:

- Generate evidence for SCWWDP about how many individuals in their area will require different elements of the training and over what time period, to inform the commissioning, scheduling and targeted communication of the local offer
- Provide paid-for advertising opportunities for training providers to alert candidates of relevant training resources.
- Allow ‘accredited evidence’ to be uploaded and added to the individual’s profile, to support potential portability, linking to SCW registration portal in which the individual’s progress log is held in the cloud. This would depend on the ability to integrate – or create seamlessness from the end-users’ perspectives – the payroll and the recruitment platforms to create one platform for ongoing talent management.
- Enable provider-level reports to be produced easily for use as evidence during Care Inspectorate Wales inspections.

The longer-term ambition is that a standardised initial national training programme can be developed to further streamline this process and maximise economies of scale, and that the coordination of this would be delivered nationally with employees paid centrally for attending.

Longer term ambition
Once this initial functionality is established, the ambition would then be to widen the functions on offer both on the platform and potentially by the team, led by feedback from employers. In relation to HR, this might, for example, include:

- Buying in additional services from a central team to provide direct support with selection processes

- Centralising existing, as well as new, employee HR records to facilitate a ‘Carers’ Passport’ type scheme, which could potentially enable care workers to manage registration, qualifications, DBS updates, payroll, rotas, requests for additional shifts/ annual leave through a single portal.

- Gathering analytics at national and regional levels to inform *a more strategic* approach, in which top-down resources and local structures are properly aligned. Evidence gathered by the end-to-end platform could inform investment in long term workforce planning to better meet continuing pressures and demands. This might include:
    - Targeted overseas recruitment or other talent acquisition approaches
    - Re-modelling of roles, perhaps including training to take on basic healthcare tasks

The social franchise can pave the way for the more strategic approach to HR which is urgently needed if the sector's recruitment and retention challenges are to be sustainably addressed, given demographic change. The model can achieve this by reducing current constraints to more coordinated approaches, which include local governance models, technology limitations, capacity, capability, inflexible budget frameworks and variations in HR policies, processes and practice. This could be a first step to better optimising strategic workforce planning and allowing for Human Capital Management strategies that mirror the flexibility, agility and innovative working models required for implementation and advancement. This aligns well with work carried out by the WLGA and the paper which Social Care Wales will present to their Improvement Committee in December 2023 to propose a national approach to training for workforce planning approaches.

4.4. Technology requirements

We present here the key findings of our review of AI in supporting recruitment and selection processes.

What do we mean by AI in this context?
'AI' itself refers to "a system's ability to interpret external data correctly, to learn from such data, and to use those learnings to achieve specific goals and tasks through flexible adaptation (p.17).[106]"

The functions which AI might support at different stages of the recruitment process, include:

- **Outreach:** AI can be leveraged for targeted communication across online platforms and social media
- **Screening**: algorithms can be used to screen applicants' CVs and derive a short list of the most promising candidates
- **Assessment**: AI-powered and gamified skill tests can be used to assess further qualities, such as persistence or motivation.
- **Facilitation**: AI can also be leveraged to facilitate the selection process, for example, in scheduling activities.

Potential benefits

- HR professionals in organisations in other sectors that use AI solutions in their recruitment have reported benefits such as cost reduction, increased number of job applicants, improved job applicant matching, easier application processes for job applicants, and a higher response rate to job applicants' feedback[107].
- AI systems function impartially, screening candidates in a fair manner that offers equal opportunities to all applicants. Furthermore, AI systems allow for providing feedback to

[106] Kaplan, A., Haenlein, M.: Siri, Siri, in my hand: who's the fairest in the land? On the interpretations, illustrations, and implications of artificial intelligence. Business Horizons, 62. 15-25 (2019).

[107] Okolie U. C., Irabor I. E. 2017. "E-recruitment: practices, opportunities and challenges". *European Journal of Business and Management* 9.11, pp. 116–122.

candidates who were not selected for a particular job vacancy, offering insights into their qualifications and skills that can be developed in the future[108].
- AI is particularly useful in evaluating, ranking, and qualifying job applicants, enabling recruiters to start the recruitment process with the most potential job candidates[109].

Risks and mitigations
There may be concerns in the sector about the ethics and accuracy of using AI.

A review of the human rights implications of using AI to support recruitment[110] concluded:

- The risks related to AI recruiting are not inevitable consequences of using AI in recruiting; they instead arise from inflated expectations and can be exacerbated by unreflective use of AI recruiting tools.
- Criteria such as social skills and team fit should continue to be assessed by humans as long as there are no valid and scientifically tested AI-supported tools for this purpose – clearly these skills are absolutely central to the delivery of quality care. Hiring decisions should always be made by an AI-informed human rather than by AI alone.
- A recent thesis on this topic concluded that 'it remains essential for every company to carefully consider [data validation and quality assurance] and potentially conduct tests to validate and ensure the superiority of candidates sourced through AI compared to conventional recruitment methods' (p.29[111]). We have therefore costed for a small team who will work closely with providers to evaluate the performance of the platform.
- Lack of humanity and transparency in AI systems can raise doubts and concerns among job applicants[112] – it is therefore important that selection criteria and methods are clear.

AI-driven platforms: User cases
Applied was purpose-built to make recruitment more ethical and predictive. The recruitment platform can track and measure ethnic diversity, gender diversity, and disability status, etc across the whole entire hiring process to generate evidence-based insights into where issues may be occurring within the pipeline. The recruitment process uses science-backed, predictive assessments, underpinning anonymous hiring to reduce unconscious bias. See here for further details: https://www.beapplied.com/diversity-reporting

This may create opportunities to promote the objectives of the Anti-Racist Wales Action Plan.

Uber has successfully introduced a platform to onboard drivers as well as to connect them with fares and administer payments. It sets out the various requirements for becoming an Uber driver and allows people to apply online, linking them to other sites to access information about requirements, upload certificates and ID. Support is offered for those experiencing issues with the platform through online support pages, telephone call centre and also via one of their Greenlight Hubs, where existing drivers can book an appointment for in-person support. See here for details.

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[108] Upadhyay A. K., Khandelwal K. 2018. "Applying artificial intelligence: implications for recruitment". *Strategic HR Review* 17.5, pp. 255–258.

[109] Chowdhury, M. H. (2023) The Evolving Landscape of Hiring: Perceived Impact of AI based Recruitment, Uppsala University

[110] Hunkenschroer, A.L. & Kriebitz, A. (2022) Is AI recruiting (un)ethical? A human rights perspective on the use of AI for hiring. AI and Ethics (2023) 3:199–213

[111] Chowdhury, M. H. (2023) The Evolving Landscape of Hiring: Perceived Impact of AI based Recruitment, Uppsala University

[112] Jaser Z., Petrakaki D., Starr R., Oyarbide-Magaña E. 2022. "Where automated job interviews fall short". *Harvard Business Review*.

Beamery provides a software solution to manage the whole recruitment pathway, from attraction to hiring. It keeps potential recruits engaged with personalised campaigns and messaging across email, WhatsApp and SMS in order to build a pipeline of candidates 'ready for when you need them'.

Forrester (2023) has evaluated the impact on a large US customer (with 38,000 employees and 11,000 annual new hires (which is around twice the estimated size of the Welsh domiciliary care workforce, and with similar turnover). The organisation realised they had a gap in their previous systems in that their Applicant Tracking Systems responded only where candidates were applying for specific posts. They were losing sight of previous candidate pools and wanted instead to:

> "*create recruitment campaigns and message and target individuals en masse to nurture a passive candidate flow into the organization……. and effectively maintain talent pools*"[113].

The case study found that the organisation had saved an estimated 30,000 recruiting hours over a 12-month period through the automation provided by the Beamery platform, whilst reducing the time taken to fill vacancies by 30%. This produced a 467% return on investment for them.

Implications from the research evidence on AI
To maximise the potential benefits from AI for recruitment in domiciliary care, whilst mitigating these risks, we are proposing that:

- The tools and algorithms to inform AI within the platform build on existing evidence and resources emerging from the evidence base around values-based recruitment in domiciliary care, and – if this has not already happened – these principles are verified by a diverse group including people with lived experience of receiving care, family members, providers, frontline staff and commissioners, and shared transparently.
- The platform is over-seen by a small team who carry out random quality assurance tests on the AI-sifting process.
- Care providers still carry out interviews and make selection decisions: AI simply helps to sift unsuitable candidates, provide evidence and insights, maintain personalised engagement with candidates, and schedule and communicate these activities.

Non-financial benefits
The evidence gathered and reviewed in this study clearly demonstrates that there is considerable scope through the described future state to streamline recruitment processes to generate benefits for providers, applicants and workers, those commissioning and receiving care. We believe the proposed intervention can:

- Speed up the onboarding of suitable new workers to address current shortfalls in supply.
- Reduce the burden for domiciliary care providers, especially in the case of smaller firms, who at our engagement events described themselves as being 'already very lean' and often 'exhausted'.
- Ensure a consistently positive and personally tailored front-of-house experience for potential applicants who are currently reported to be dropping out of the sector due to delays, and lack of communication, clarity, or feedback.
- Maximise opportunities to attract and recruit suitable candidates from colleges, Job Centres, following large-scale redundancies, etc, linking in with Regional Care Career Connectors to maximise traffic through to the platform
- Pool and channel resources to make better use of national and social media to promote working in care.
- Reduce the risk of drop-out following appointment, where the worker did not fully

[113] P.6, Forrester: The Total Economic Impact of Beamery Talent Lifecycle Management, September 2023

understand the role or was not suitable for it.
- Implement national minimum standardised pay and conditions (once agreed via the Social Care Fair Work Forum) to reduce churn between providers caused by the current variations, which disrupt continuity for people receiving care, and generate additional recruitment costs for employers.
- Reduce the current barriers to the portability of workers between providers, so that workers can move between providers readily and safely to provide cover, take on additional or different work, move to new locations.
- Improve the selection of candidates by implementing values-based approaches more consistently. As Bibb & Kelly[114] have argued, "the process for understanding who the right people are is too superficial…. if we ignore the evidence-based characteristics that make someone a good care worker…. we will continue to see the high vacancy and turnover rates that characterise the care sector".

There are also non-financial benefits for Welsh Government and Social Care Wales at a strategic level:

- By starting to develop better data about the independent domiciliary care workforce, including conversion rates from talent acquisition, through recruitment, selection and retention, the platform and the wider work of the social franchise can inform and evaluate national and regional strategies to improve recruitment. For example, Social Care Wales cannot currently track whether and which categories of people apply for, secure and sustain domiciliary care jobs, having initially accessed WeCare, by centralising the recruitment processes to which candidates are directed, this becomes possible.

- The social franchise provides a vehicle through which new initiatives can be communicated to providers, and through which they can also be supported to implement them. For example, when a decision about national minimum standards for pay and conditions is reached by the Social Care Fair Work Forum, the franchise can provide standard templates for contracts, adverts and related policies for members to access.

Dependencies
The envisaged future state depends on:

- **Completion of the Pay and Progression Framework**, and implementation of national terms and conditions across the domiciliary care sector. Without this, the development of standard templates for job adverts, role descriptions, offer letters and contracts will be challenging, and the transformative potential of the platform significantly reduced. This is described in more detail in Section 1.3.3 where we present an overview of the work of the Social Care Fair Work Forum.

- **Adoption of standardised application processes** by a sufficient volume of providers, on the basis that the time and cost savings of accessing the recruitment portal outweigh the value of their unique approaches.

- **Agreement being reached with DBS** for a national coordinated approach, perhaps with Adult Fast Track checks being conducted by the entity, rather than by employers.

- **The ability of AI-driven processes** to sift and match candidates and jobs more efficiently than human recruiters, and sufficient trust in this. The platform will be customised by

[114] Bibb, S. & Kelly, A. (2021) Fixing recruitment challenges in social care – it's not about pay, Open Access Government, July 5 2021: https://www.openaccessgovernment.org/fixing-recruitment-challenges-in-social-care-its-not-about-pay/114711/

HR sector experts, using established tools and approaches for testing aptitude, and will quality assured by the human team.

- **Resources being made available** to identify, acquire and customise a suitable existing platform, and pay revenue costs for the small HR team until these costs can be covered by income from member subscriptions.
- That **sufficient volume and calibre of applicants can be generated** by further investment in national marketing campaigns and by funnelling applicants from these and from local marketing efforts into the same portal.
- **Prospective care workers and employers being willing and able to access the platform**, presumably mostly via a smartphone/ tablet app or online via a computer. This risk would be mitigated to an extent by the human back-up team and by selection of the most accessible and attractive platform.
- That **drop-out by applicants/ employees can be reduced** by streamlining the onboarding process and ideally being able to pay people to take part in initial training.
- **Being able to procure a suitable provider** to deliver the model on behalf of the entity – we understand there may be appetite from some local authorities to deliver this outside of their standard functions, and there are also other organisations and initiatives operating in the field who might be well-placed to tender for the role.
- **Being able to procure a suitable existing platform** which can be customised, configured and adapted in the ways envisaged, ensuring a smooth interface with existing websites (e.g., We Care Wales) from a supplier who is able to provide ongoing GDPR-compliant cloud storage and will continue to support, maintain and update the platform (e.g., as operating systems are updated). ***Depending on the outcomes of further work to develop technical specifications during implementation phases, there is a risk that the initial investment required may increase***.
- **That regulators (CIW, SCW) agree to at least some degree of portability** between employers of references, training evidence, employment checks. This might for example include building links to the SCW register at a later stage of development.
- **That the franchise can develop the necessary brand awareness and trust to engage a substantial volume of domiciliary care providers** – to increase the chances of success, it will be important to ensure the product responds directly to providers' business needs and is affordable. Being not-for-profit and government-backed should promote trust.
- **That care providers are not already tied into punitive contracts with commercial recruitment software companies, and do not have in-house HR staff which cannot be readily repurposed** (e.g., seconded to the entity or moved into different aspects of HR) – otherwise there may be a risk of some redundancies.
- **That domiciliary care workers pay is increased** – if the platform alone is to generate a significant improvement in the volume of applicants; however, if pay is increased, it may be more difficult to isolate the impact of platform and convince providers it is also needed.

LSE has identified international evidence that “when more than one intervention is introduced at the same time this can trigger a multiplier effect” (p.216)[115].

[115] Edwards, D, Trigg, L, Carrier, J, Cooper, A, Csontos, J, Day, J, Gillen, E, Lewis, R and Edwards, A. 2022. A rapid review of innovations for attraction, recruitment and retention of social care workers, and exploration of factors influencing turnover within the UK context. Journal of Long-Term Care, (2022), pp. 205–221. DOI: https://doi.org/10.31389/jltc.130

5. A Cost Benefit Analysis

5.1. Introduction

This section of the report aims to provide a pragmatic assessment of the project's potential feasibility by considering costs and then describing benefits. In both cases, we focus on financial costs and financial benefits.

In this chapter, we demonstrate:

- It is financially feasible for the Welsh Government and Welsh Local Authorities to create a Social Franchise to coordinate and support providers to deliver domiciliary care in Wales. The model we are suggesting is relatively low-cost to set up and run.
- The Social Franchise can deliver financial benefits to providers, local authorities, the Welsh Government, and people who access domiciliary care.

We are not suggesting a Social Franchise will solve all the problems the sector faces, and specifically, we are not suggesting that it will, on its own, solve the funding gap.

5.2. Approach

The cost-benefit analysis has been developed using two methodological approaches.

- **Dynamic Financial Modelling:** has played an essential role in shaping the social franchise's structure and evaluating the potential financial impact on providers.
- **The Theory of Change** has been used to examine broader system benefits, exploring how the social franchise could simplify the health and social care ecosystem system to reduce overall costs. A vital element of this was considering how to reduce system complexity. This is because, at the heart, franchising is a system of simplification that enables lower costs and improved quality. Moving from a complex to a more straightforward and nationally coherent system has many benefits.

Cost Benefit Analysis as a tool
The cost-benefit analysis (CBA) has been instrumental in shaping the trajectory of this feasibility study. As we developed our operating model, we iteratively evaluated options as they developed. For example, we considered if the Social Franchise could deliver a shared service for the sector, directly providing services through service-level agreements. This was discounted because of the high cost of establishing and maintaining an independent organisation with a traditional service delivery approach.

This CBA process has also enabled us to model feedback from the interim report and suggestions from our governance group and other stakeholders. Therefore, the CBA information presented in this chapter is an illustrative endpoint of this feasibility study rather than an exhaustive review of our journey through various staging posts and occasional dead-ends.

Assumptions
The assumptions underpinning our models are described throughout the report and summarised in Appendix 1. Although we often describe a single data point, we have tested the modelling at a minimum on the full range of data described in the assumptions.

Scenarios
In developing the CBA, we have looked at many different scenarios. Each scenario combines inputs, assumptions, and factors that could impact costs and benefits. These scenarios help

evaluate the robustness of the analysis under different conditions and provide insights into possible outcomes.

Expenditure and income
We have used several approaches to identify the actual expenditure cost and the potential income that could be generated. We have made reasonable attempts to stress test calculations, looking at a range of costs for both. In the calculations highlighted in this chapter, we have used what we regard as mid-point technology costs and high-cost people costs.

5.3. Commercial modelling

At the heart of the model is access to cloud-based software applications linked to business processes through a subscription-based system, where franchisees pay a recurring fee for access. We have not set out the exact commercial or contractual arrangements for this as inherent in the proposed process will involve providers entering coordinated contracts with third parties.

5.4. Section 1 Costs

5.4.1. A Financial Model for the Social Franchise

We have developed a reasonable financial model for the income and expenditure of the first three years of the social franchise. The social franchise would require an investment of £800,000 in Year 1 and £250,000 in Year 2 but return a surplus of £755,000 by Year 3.

Table 1: Financial Model

	Year 1 (£,000)	Year 2 (£,000)	Year 3 (£,000)
Income			
Revenue			
Licences			
- Core	60	288	840
- Finance (Core)	18	86	252
- Finance (Payroll)	68	326	950
- HR (Talent acquisition)	81	387	1129
Grants	800	250	0
Total Income	**1026**	**1337**	**3171**
Expenditure			
Staff			
- Core	242	264	340
- Finance	189	189	189
- HR	189	189	304
Totals Staff	**621**	**642**	**834**
Technology			
- Core	25	25	25
- Finance (Core)	12	58	168
- Finance (Payroll)	45	217	633
- HR	50	242	706
Totals Technology	133	542	1532

Other business costs			
- Hosting	40	40	50
- Marketing and Communications	150	50	0
- Legal and professional fees	65	50	0
- Other business costs totals	**255**	**140**	**50**
Total Expenditure	**1009**	**1324**	**2416**
Surplus	**18**	**13**	**755**

5.4.2. Illustrative licence fees

To develop the financial model, we have used a fee modelling structure based on the sale of licences. In a traditional franchise model, all the fees are usually bundled into a single licence. Since providers did not want a single all-in approach, we have developed a model with several linked but standalone licences covering discrete business areas.

In this analysis, we are setting out the costs for three licences.

- **Licence 1, Core:** A licence to enter into a franchise agreement. This is the base level licence that provider must have if they will receive beneficial treatment within the system including access to information and advice and proprietary templates.
- **Licence 2, Financial:** A licence to use the Social Franchises Financial Function as described in Chapter 3 focusing on the Accounting and Renumeration Sub-functions.
- **Licence 3,** A licence to use the Social Franchises HR as described in Chapter 4 focusing on elements 1-3

Table 2: Franchise licence fees

	Range of modelling	Fee used in model
Licence 1: Core	£100 to £300 per month	£200 per month
Licence 2: Financial	£80 to £100 per month	£100 per month
	£2 to £10 per worker per month	£5 per worker per month
Licence 3: HR	£65 to £100 per worker recruited	£78 per worker recruited

We have used three high-level inputs to make up the illustrative licence fees.

- **Technology:** we have used a range of estimated market prices for the cloud-based technology described in the report
- **People:** We have looked at staffing levels to support the delivery of services. These are set out in Table X
- **Margin:** we have used a range of margins on the combined people and technology costs.

5.4.3. Services joining the Social Franchise

The analysis uses data modelled on income on 50 services joining the social franchise from Q3 in Year 1, 150 services joining the social franchise in Year 2 and 350 services joining the social franchise in Year 3.

The breakeven point for services in the model is 150 services joining. This is less than a quarter of all Welsh domiciliary care services.

5.4.4. Staffing Expenditure

This table highlights the social franchise staffing expenditure for Years 1-3 based on delivering the licences described above.

This indicates an investment in technical staff in Year 1 to set up the systems and then an increase in support staff as the franchise grows.

Table 3: Franchisor Staffing

	Year 1		Year 2		Year 3	
	Roles	Cost	Roles	Cost	Roles	Cost
Director (Grade 6)	1	£91,500	1	£91,500	1	£91,500
HR Lead (Grade 7)	1	£74,300	1	£74,300	1	£74,300
Finance Lead (Grade 7)	1	£74,300	1	£74,300	1	£74,300
Technical Lead Core (Grade 6)	1	£74,300	1	£57,500	1	£57,500
Technical Lead finance (Grade 6)	1	£57,500	0	£0	0	£0
Technical Lead HR (Grade 6)	1	£57,500	0	£0	0	£0
Executive Officer Core (SEO)	0	£0	1	£57,500	1	£57,500
Executive Officer Finance (SEO)	1	£57,500	1	£57,500	1	£57,500
Executive Officer HR (SEO)	1	£57,500	2	£114,900	4	£229,800
Team Support	3	£76,500	3	£114,800	5	£191,300
Total	10	£620,900	11	£642,300	15	£833,700

5.5. Section 2 Potential Benefits

The following section seeks to provide some indication of the financial benefits that could be achieved by introducing a Social Franchise.

These financial benefits are not a result of inefficient activity or profiteering within individual providers but system inefficiencies that increase costs for providers. Nothing in this section should indicate that providers can reduce costs without system changes.

The figures here are, by design, approximations and should be considered as giving an order of magnitude.

A breakdown of the Welsh hourly rate
The domiciliary care hourly rate can be broken down into business costs and profit categories. These can be expressed in monetary terms or as a percentage of the total fee.

The National Commissioning Board's Wales Home Care Cost Matrix (NCB, WHCCM) sets this cost breakdown out.

Table 4: Breakdown of business costs and profit using NCB, WHCCM

	Amount (£)	% of total fee
Worker costs		
Hourly wage	10.90	35.9%
National insurance	0.67	2.2%
Pension	0.41	1.4%

Holiday pay	1.66	5.5%
Sick pay	0.56	1.8%
Travel		
Travel time	2.81	9.2%
Millage	1.91	6.3%
Training		
Training time	1.95	6.4%
Staffing, recruitment and training		
Management and supervisors	4.19	13.8%
Staff recruitment	0.39	1.3%
Training provider & qualification	0.71	2.3%
Worker registration costs	0.03	0.1%
Premises, utilities and services		
Rent, rates and utilities	0.37	1.2%
IT equipment, systems, support	0.35	1.1%
Telephony	0.15	0.5%
General overheads		
Equipment hire	0.04	0.1%
Stationery and postage	0.08	0.3%
Business travel	0.10	0.3%
General	0.13	0.4%
Consumables		
PPE & consumables	0.59	1.9%
Professional		
Cost of finance	0.08	0.3%
Insurance and governance	0.33	1.1%
Legal / professional	0.25	0.8%
Profit	1.72	5.7%
Welsh Hourly rate	30.40	100%

The matrix is a dynamic costing tool, so the above table estimates and simplifies an average domiciliary care provider's actual business costs and profit.

This table is an essential input into our dynamic financial model. We agreed with the project's governance group to use this matrix as the baseline for all calculations.

We have also inputted other breakdowns into the model. This includes breakdowns used by English local authorities for the Department for Health and Social Care's Fair Cost of Care Exercise. We have also inputted bespoke approaches developed by providers and commissioners.

The £30.40 fee suggested by the Wales Home Care Cost Matrix proposes an hourly rate which we recognise is higher than the rate commissioned by many local authorities in Wales.

We have assumed that the local authority rate is lower than the hourly rate paid by people who use direct payments to purchase their care, NHS commissioners and people buying care privately.

5.5.1. National aggregated spending on business functions delivered by domiciliary care organisations

We have used the percentages from the above and Assumptions 6-12 to identify aggregated national spending on business functions. That is the total spend by all providers on business functions.

Table 5 National aggregated spending on business functions delivered by all domiciliary care organisations.

	(£000,000)				
	Category A	**Category B**	**Category C**	**Category D**	**Category E**
Worker costs					
Hourly wage	5.1	6.9	1.0	2.8	10.8
National insurance	3.1	4.2	0.6	1.7	6.6
Pension	12.5	17.1	2.5	6.9	26.5
Holiday pay	4.2	5.8	0.8	2.3	9.0
Sick pay	5.1	6.9	1.0	2.8	10.8
Travel					
Travel time	21.0	28.9	4.2	11.7	44.8
Milage	14.3	19.7	2.9	8.0	30.5
Training					
Training time	14.6	20.0	2.9	8.1	31.1
Staffing, recruitment and training					
Management and supervisors	2.9	4.0	0.6	1.6	6.2
Staff recruitment	5.3	7.3	1.1	3.0	11.3
Training provider & qualification	0.2	0.3	0.0	0.1	0.5
Worker registration costs	31.4	43.1	6.3	17.5	66.9
Premises, utilities and services					
Rent, rates and utilities	2.7	3.8	0.5	1.5	5.8
IT equipment, systems, support	2.6	3.5	0.5	1.4	5.5
Telephony	1.1	1.5	0.2	0.6	2.3
General overheads					
Equipment hire	0.3	0.4	0.1	0.2	0.7
Stationery and postage	0.6	0.9	0.1	0.3	1.3
Business travel	0.8	1.1	0.2	0.4	1.7
General	1.0	1.4	0.2	0.6	2.1
Consumables					
PPE & consumables	4.4	6.0	0.9	2.4	9.3
Professional					
Cost of finance	0.6	0.9	0.1	0.3	1.3
Insurance and governance	2.5	3.4	0.5	1.4	5.3
Legal/professional	1.9	2.6	0.4	1.0	4.0
Profit	12.9	17.7	2.6	7.2	27.5
Total	227.8	312.4	45.6	126.7	484.8

Categories of spend[116]

- **Category A:** Only Local Authority commissioned care
- **Category B:** Local Authority commissioned care and Direct Payments[117]
- **Category C:** Direct Payments
- **Category D:** Privately purchased domiciliary care.
- **Category E:** Total

This table demonstrates the significant amount of money used to deliver business functions at All Wales. It also demonstrates the rough shape of the market.

5.5.2. Domiciliary care service spending on business functions

We used Table 3 and Assumptions X-Y to identify how much an average domiciliary care service spends on business functions. We also include the spending broken down for each full-time domiciliary care worker.

[116] Notable by its absence is domiciliary care commissioned directly by the NHS. We have not included this figure as we have been unable to extract this data.

[117] We have included Direct Payments in this category to reflect the approach taken by the Homecare Associations *An overview of the homecare market 2020 to include* Direct Payments. As set out in our assumptions we have only included 50% of this figure in our calculations recognising many people do not use their Direct Payment for domiciliary care.

Table 6: Domiciliary care services spending on business functions

	Per service (£,000)	Per FTE (£)
Worker costs		
Hourly wage	485	20,250
National insurance	30	1,250
Pension	18	750
Holiday pay	74	3,100
Sick pay	25	1,050
Travel		
Travel time	125	5,200
Milage	85	3,550
Training		
Training time	87	3,600
Staffing, recruitment and training		
Management and supervisors	186	7,800
Staff recruitment	17	700
Training provider & qualification	32	1,300
Worker registration costs	1	50
Apprenticeship levy		
Premises, utilities and services		
Rent, rates and utilities	16	700
IT equipment, systems, support	15	650
Telephony	7	250
General overheads		
Equipment hire	2	100
Stationery and postage	4	150
Business travel	5	200
General	6	250
Consumables		
PPE & consumables	26	1,100
Professional		
Cost of finance	4	150
Insurance and governance	15	600
Legal / professional	11	450
Profit	77	3,200

5.5.3. Business Functions the Social Franchise could impact

We then reviewed each business process, assessing opportunities for simplification and standardisation and assessed the impact the Social Franchise could have on each business function.

Table 7 The Social Franchise's Impact on Business Functions

	Impact	
Travel		
Travel time	**High**	Low levels of route planning or service delivery patterns result in resources being used for unnecessary travel.
Travel payment per mile @0.45		
Training		
Training time	**High**	Resources spent on training are frontloaded in workers' employment and are, therefore, a function of retention
Staffing, recruitment and training		
Management and supervisors	**Moderate**	Providers are SMEs and find it harder to access transformative technology, many manual processes still exist. Interactions with commissioners are cumbersome and uncoordinated.
Staff recruitment	**High**	Resources spent on training are frontloaded in workers' employment and are, therefore, a function of retention
Training provider & qualification		
Worker registration costs	**Moderate**	
Premises, utilities and services		
Rent, rates and utilities	**Moderate**	Procurement and category management can support a reduction in business costs
IT equipment, systems, support		
Telephony		
General overheads		
Equipment hire	**Low**	
Stationery and postage	**Low**	
Business travel	**Low**	
General	**Low**	
Consumables		
PPE & consumables	**Low**	Procurement and category management can support a reduction in business costs
Professional		
Cost of finance	**Low**	
Insurance and governance	**Low**	
Legal / professional	**High**	Providers are SMEs and find it harder to access legal professional support because of system complexity.

We have identified that a social franchise model could substantially impact various business functions, leading to significant cost savings in travel, training, management, and recruitment.

5.5.4. The difficulty of achieving standardisation and simplification

We then reviewed each business process, assessing how difficult it would be to achieve standardisation and simplification through a Social Franchise.

	Difficulty	
Travel		
Travel time	High	Would require a system change to dynamically coordinate package allocation. This could be achieved through a critical mass of providers cooperative managing packages
Mileage	High	
Training		
Training time	Low	Increasing retention would reduce training time
Staffing, recruitment and training		
Management and supervisors	Low	
Staff recruitment	Low	Simplifying and coordinating key management and supervisory tasks will reduce costs
Training provider & qualification	Low	
Worker registration costs	Low	
Premises, utilities and services		
Rent, rates and utilities	-	
IT equipment, systems, support	-	
Telephony	-	
General overheads		
Equipment hire	-	
Stationery and postage	-	
Business travel	-	
General	-	
Consumables		
PPE & consumables	**Moderate**	Access to procurement and category management will reduce business costs
Professional		
Cost of finance	-	
Insurance and governance	-	
Legal / professional	**Moderate**	Access legal professionals through a reduction in system complexity.

5.5.5. Savings that could be achieved

Utilising the impact and implementation assessments outlined above and the standard industry benchmarks, we systematically analysed each business function to develop a quantitative estimate of potential savings based on 4 scenarios:

- 1.a Very Conservative
- 1.b Conservative
- 1.c Ambitious
- 1.d Very Ambitious

This served as a foundation for calculating the quantum of savings that could be generated by implementing streamlined and standardised processes. The approach ensures that our projections are rooted in potential but realistic cost reductions and account for the practical challenges associated with implementation.

Table 8: Saving Scenarios

	System efficiency scenarios			
	1.a	**1.b**	**2.a**	**2.b**
Travel				
Travel time	10%	25%	40%	60%
Millage	10%	25%	40%	60%
Training				
Training time	10%	25%	40%	60%
Staffing, recruitment and training				
Management and supervisors	10%	25%	40%	40%
Staff recruitment	10%	25%	60%	80%
Training provider & qualification	10%	25%	40%	40%
Worker registration costs	10%	25%	40%	40%
Premises, utilities and services				
Rent, rates and utilities	0%	0%	0%	0%
IT equipment, systems, support	0%	0%	0%	0%
Telephony	0%	0%	0%	0%
General overheads				
Equipment hire	0%	0%	0%	0%
Stationery and postage	0%	0%	0%	0%
Business travel	0%	0%	0%	0%
General	0%	0%	0%	0%
Consumables				
PPE & consumables	5%	10%	12%	15%
Professional				
Cost of finance	0%	0%	0%	0%
Insurance and governance	0%	0%	0%	0%
Legal / professional	10%	25%	25%	25%

5.5.6. Estimated system savings that could be achieved

We systematically evaluated the costs of delivering business functions at a system level. By overlaying the projected savings onto the existing cost structure, we were able to identify a quantifiable measure of potential efficiency gains and financial benefits at the system level.

This analysis considers the individual impacts and implementation difficulties and provides a comprehensive perspective on the collective potential for cost reduction.

Table 9 System efficiency scenarios

	(£000,000)			
	System efficiency scenarios			
	1.a	1.b	2.a	2.b
Category A	9.7	23.7	37.5	48.2

Category B	13.2	32.5	51.5	66.1
Category C	1.9	4.7	7.5	9.7
Category D	5.4	13.2	20.9	26.8
Category E	20.6	50.5	79.8	102.6

We then considered what impact the scenarios would have if the savings were used to fund an increase in the base hourly rate from 10.90.

Table 10 Impact on the hourly rate

	(£)			
	System efficiency scenarios			
Hourly rate	12.07	13.78	15.45	16.75

6. Next Steps

6.1. Conclusions regarding feasibility

In producing this report, the authors have collaboratively explored the domiciliary care sector in Wales, in an iterative and co-productive way. Assumptions and co-dependencies have evolved because of engagement, learning, constructive challenge, and expert professional advice. There has never been a more compelling time to think differently to support a sector that is the very foundation of our health and social care system in Wales.

The original proposal to explore the feasibility of a "*Franchise Model of Domiciliary Care*", has been refined with a conclusion that a "Social Franchise" would be the most feasible model for implementation in Wales, to deliver on the original aspirations of the proposal in supporting and sustaining a vibrant domiciliary care sector. This model combines many of the elements of a traditional franchise without some of the restrictions and high costs associated with commercial franchises and embraces a spirit of joint working and coproduction seen in cooperative models.

The report concludes that, by working differently, efficiencies can be made in "back office" functions which can release much needed funding to increase the terms and conditions of our critical front-line staff. It should be noted that this however should not be seen as managing costs, since without reinvestment to aide address terms and conditions for front line staff, staffing will continue to be a perennial challenge in the sector.

It is concluded that developing a social franchise could benefit the sector by:

- Supporting and sustaining existing and new domiciliary care services
- Creating the potential for a 'national brand' of domiciliary care, in which for example individual providers can choose retain their own brands but advertise that they are proud members of the national franchise.
- Creating an opportunity to facilitate greater cooperation and efficiency across the sector
- Providing an opportunity for investment in front line staff
- Improving recruitment and retention in domiciliary care
- Coordinating and making use of existing expertise, such as the materials developed by Social Care Wales for training and recruitment.
- Strategically aligning work with that of the National Office for Social Care and national commissioning frameworks.

The impact of improving terms and conditions for approximately 20,000 staff in Wales should not be underestimated. A social franchise can support this agenda but cannot be the only solution, the sector will continue to need investment from across public services in Wales, if we are to make a long term and sustained difference.

6.2. Recommendations

The report shows that a social franchise could make a significant difference to our Health and Social Care system in Wales. It is therefore recommended that ADSS Cymru, Local Government, Welsh Government, Social Care Wales, Care Inspectorate Wales consider the contents of the report and how their organisations could support its implementation.

Options
The report has referred to a range of potential options for hosting the new organisation; one of which would be for a local authority to host the organisation on behalf of the rest of Wales; another might be for an existing independent organisation to act as host. There is precedent here, for example with the business delivery unit of ADSS Cymru or with organisations such as Foster Wales and the National Adoption Service, though further impact assessment (including detailed consideration of any Teckel implications) will be required at implementation planning stage.

Co-dependencies
Domiciliary care is a complex and diverse area, and the report has therefore highlighted a range of co-dependencies. Whilst the social franchise can serve to support the sector, it cannot do this in isolation. Changes are needed in public perception, investment, creation of parity of esteem with other services such as the NHS. There will also need to be changes to Local Authority commissioning practices, and Social Care Wales and the Care Inspectorate Wales would need to work collaboratively with the social franchise if it is to succeed.

Future potential
Domiciliary care was felt to be an area of high impact, given the wide range of providers working with little co-operation and sometimes in competition. If a social franchise is developed and proves itself to be beneficial to the sector, there is potential for the organisation to offer some of its services to other areas of the care sector who may be facing similar challenges, such as independently run residential care provision.

6.3. Next steps

If the decision is made to pursue the high-level recommendations, the next step would be the development of a detailed implementation plan to cover:

- An implementation phase (0-2 years), where the main focus will be on:
    - Creating the legal entity for the social franchise and agreeing hosting arrangements – this will require further investigation, impact assessment and decisions regarding Teckel and procurement rules, and a selection process
    - Recruiting the small team to run the entity, and establishing the board of directors
    - A full survey of domiciliary care providers – ideally via CIW – to gain a full picture of existing processes, systems and appetite to join/ pay for different products
    - Production of technical requirements for the system by HR experts working in partnership with a number of supportive providers and with Social Care Wales and local authority workforce leads
    - An options appraisal of existing off-the-shelf software platforms in the light of the technical requirements. Negotiation with suppliers to provide and – where necessary – further develop their products for use by the social franchise
    - Establishing relationships across the sector to grow the membership

- Embedding phase (2-5 years) during which further services are introduced as a result of ongoing feedback from members.

It is recommended a bid is developed for the investment needed for years 0-2 which will then taper in years 2-5 as more agencies join the social franchise.

Appendix 1: Assumptions

Introduction

This section summarises all the data points we have used in our modelling. We have grouped data points into the key assumptions that underpin the feasibility study.

Numbers have been rounded.

Structure of the sector

Assumption 1: The domiciliary care sector in Wales is dominated by some medium-sized and many small companies and local authorities.

There are about 650 domiciliary care services registered with Care Inspectorate Wales. Of these, 525 are Limited Companies, 90 are charitable companies, 22 are local authorities, and the rest are a mixture of individual registrations and partnerships.[118]

A single organisation may register multiple services, often known as branches. These services are treated as individual entities by the Care Inspectorate Wales.

We estimated that about 525 individual organisations deliver domiciliary care in Wales.

Social Care Wales estimates that 19,600 people worked in domiciliary care in 2022.

Social Care Wales estimates that local authorities employed 4,200 (22% of the total workforce) people to deliver domiciliary care, and 15,300 (78%) were employed by commissioned service providers.

We can estimate that excluding local authorities, Welsh domiciliary care services had, on average, about 31 people working within them in frontline roles in 2022.

HMRC defines a company as medium-sized if it employs less than 250 people, small if it has under 50 employees and micro if it has under 10 employees.[119] Confusingly, the definition of a micro-provider in the context of social care is a provider employing less than 8 people. [120]

Some companies have multiple services, and some provide other social care services, such as residential care homes. Even so, most domiciliary care organisations would be classed as small organisations. This assumption is crucial to developing any approach as it helps frame the commercial model and the services that will make the most significant difference.

[118]CIW data accessed on 13 November 2023 via https://app.powerbi.com/view?r=eyJrIjoiMGZkYmYxOGMtZGJhZi00ZjZjLTg5YzctM2VkYWJkZjkxYTkyIiwidCI6ImEyY2MzNmM1LTkyODAtNGFlNy04ODg3LWQwNmRhYjg5MjE2YiJ9

[119] https://www.gov.uk/hmrc-internal-manuals/international-manual/intm412080

[120] https://www.careinspectorate.wales/sites/default/files/2018-03/161027aboveandbeyonden.pdf

Assumption 2: There are advantages and disadvantages, strengths and weaknesses to a sector dominated by smaller companies.

Earlier in this report, we discussed the importance of the foundational economy to Wales. However, it is worth restating that small domiciliary care companies and third-sector bodies form the backbone of many communities, employing local people and recycling much of the profits made into the Welsh economy. This contrasts with, for example, most providers of private and voluntary children's social care operating in Wales[121]

There are, however, undoubtedly some weaknesses to a sector dominated by smaller companies. Some SMEs, for example, find introducing technology-enabled new business approaches challenging because of their size. This was reflected in our engagement sessions where some providers outlined the inefficiencies, in terms of time and money, in identifying the 'right' technology.

The British Chambers of Commerce have identified:

- 37% of SMEs believe they lack the capacity to manage multiple ICT suppliers, contracts, and licences.
- 25% feel their current digital tools are not resilient enough to help protect their business from emerging challenges.
- 17% of SMEs disagree that their current connectivity tool suppliers help them adapt to changing circumstances.

Assumption 3: The domiciliary care ecosystem in Wales is fragmented, resulting in complexity, which can cause system inefficiency.

There are seven geographic NHS health boards and 22 local authorities. Each has its own commissioning, contracting, care management and fee-setting approach.

Domiciliary care is delivered by 650 services owned by 525 different entities. Each entity has its own approach to business functions. This is both a strength and a weakness. It results in operational flexibility across the sector, but significant differences in employment contracts, recruitment approaches, training, investment strategies, and targeted operating profit can also make strategic planning this difficult.

This complexity is further increased through national and regional programmes such as the Micro Carer programme[122] and the fact that people who receive direct payments can use this to contract with a domiciliary care agency directly.

Providers have indicated that this complexity increases business costs and makes business planning difficult. A good illustrative example of how this plays out is a provider described that they provide services in a relatively small area with a shared geography and a common socio-economic profile. This area, however, spans two local authorities. Each local authority has a different position on fees; one local authority pays approximately £5 per hour more than the other.

There have been several attempts to reduce complexity. National Commissioning Board has worked with the sector, including the Homecare Association, to agree on a common position on fees and the make-up of fees. This also enables authorities and providers to reach a common

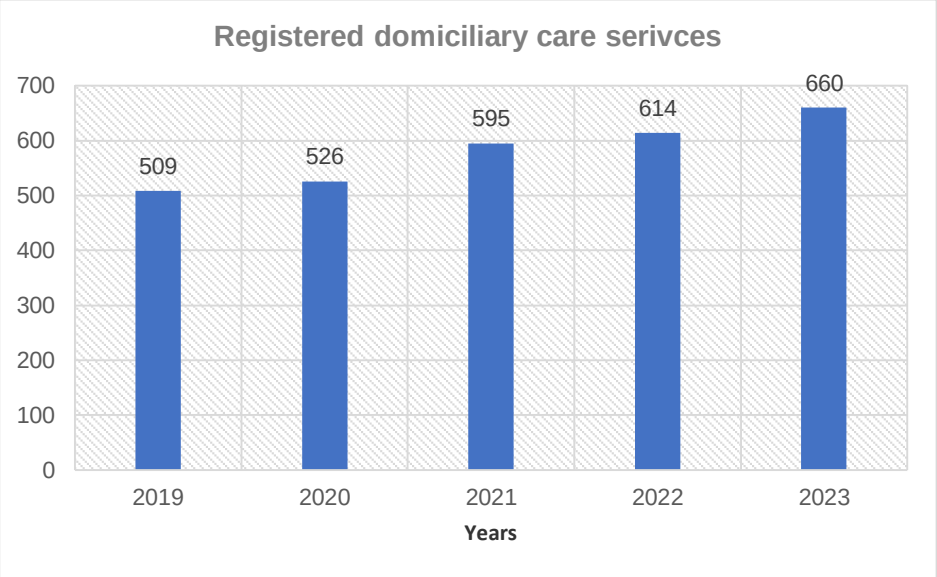
[121]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1059604/Wales_summary.pdf

[122] [122] https://www.monmouthshire.gov.uk/what-is-micro-care/?preview=true

position on fees considering local market issues such as rurality. This work has formed an important input into the dynamic cost modelling.

Assumption 4: The number of registered services has been increasing.

There has been a 30% increase in the net number of domiciliary care services registered with Care Inspectorate Wales over the last four years. [123] This indicates that many existing domiciliary care companies are expanding by creating new services, or new companies or third-sector organisations are entering the market for the first time.



Assumption 5: Domiciliary care organisations increasingly find recruiting and retaining staff difficult.

In 2021, Social Care Wales estimated that the domiciliary care workforce was 23,100 with 7.9% of posts fulfilled.[124] This would indicate that Wales needed around 25,000 domiciliary care workers.

However, by 2022, the same organisation estimated that only 19,600 people worked in domiciliary care. This is an 18% reduction.

Social Care Wales have indicated this reduction maybe caused by a change in calculating the workforce. However, as they have also stated this reflects anecdotal evidence.

We have calculated that Wales needs an additional used an additional 5,000 workers and this lack of capacity equates to 4million care hours.

In 2021 the Senedd research unit estimated staff turnover to be around 32%125. If there has been a further reduction in the workforce it is likely that this has dramatically increased the gross turnover rate.

[123] CIW data accessed via https://app.powerbi.com/view?r=eyJrIjoiMGZkYmYxOGMtZGJhZi00ZjZjLTg5YzctM2VkYWJkZjkxYTkyIiwidCI6ImEyY2MzNmM1LTkyODAtNGFlNy04ODg3LWQwNmRhYjg5MjE2YiJ9

[124] https://socialcare.wales/cms-assets/documents/Social-care-workforce-report-2022.pdf

[125] https://research.senedd.wales/research-articles/the-future-of-social-care/

Macro funding position

Assumption 6: The sector's economic value is nationally significant to Wales.

In 2018, Skills for Care and Development published a report[126] estimating the economic value of Wales's adult social care sector. It was estimated that in 2016, the adult social care sector's Gross Value Added (GVA) was £1.2 billion, representing 1.9% of the total GVA in Wales. This is higher than:

- agriculture, forestry and fishing; arts,
- entertainment and recreation,
- and the water supply, sewerage and waste management sectors.

The data presented in the report indicates that in 2016 Domiciliary Care had a GVA of £0.3bn, representing 0.5% of Wales GVA.

Assumption 6: The total spend by local authorities in Wales on commissioned domiciliary care is about £228m.
The following table shows the growth in spending by Welsh local authorities on domiciliary care for older people. [127] This assumption is used as the Category A estimate of the size of the national spend on domiciliary care in the Cost Benefit Analysis.

Table 11: Aggregated outturn spending by Welsh local authorities on domiciliary care

	(£000,000)						
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Older person	171	183	187	195	215	208	228

[126] https://socialcare.wales/cms-assets/documents/The-Economic-Value-of-the-Adult-Social-Care-Sector_Wales.pdf

[127] https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue/Social-Services/social-services-socialservicesrevenueexpenditure-by-clientgroup

Assumption 7: The total spend by local authorities in Wales on commissioned domiciliary care is about £312m.

The following table shows the growth in spending by Welsh local authorities on domiciliary care broken down into different groups of persons receiving care. [128] This assumption is used as the Category B estimate of the size of the national spend on domiciliary care in the Cost Benefit Analysis. We recognise that this outturn figure will include money spent by local authorities on

Table 12: Aggregated outturn spending by Welsh local authorities on domiciliary care

	(£000,000)						
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Older person	171	183	187	195	215	208	228
Physical Disabilities	24	25	24	25	23	26	31
Learning Disabilities	33	35	37	39	37	44	45
Mental Health	8	8	7	6	7	7	9
	236	250	254	265	282	286	312

Assumption 8: The total local authorities in Wales spend on commissioned direct payments is about £85m.

Table 13: Aggregated outturn spending by Welsh local authorities on direct payments (£millions)

	(£000,000)						
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Older person	17	18	20	22	24	25	30
Physical Disabilities	20	23	22	24	25	25	26
Learning Disabilities	26	25	27	28	29	32	33
Mental Health	1	1	2	2	2	2	2
Total	65	68	71	76	79	85	91
50% of total	32	34	36	38	40	42	46

We have assumed that 50% of direct payments will be used to purchase care independently from domiciliary care agencies.

[128] https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue/Social-Services/social-services-socialservicesrevenueexpenditure-by-clientgroup

Assumption 9: The total local authorities in Wales spent on commissioned domiciliary and direct payments care was about £360m in 2022-23.

This assumption combines all commissioned domiciliary care and 50% of the Direct payments. This assumption is used as the Category C estimate of the size of the national spend on domiciliary care in the Cost Benefit Analysis.

Table 14: Aggregated outturn spending by Welsh local authorities on both domiciliary care and 50% of direct payments

	(£000,000)						
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Spend by LAs	268	284	290	303	322	328	358

Assumption 10:The total spend by self-funders in Wales on domiciliary care was about £130m in 2022-23.

In 2018 Skills for Care and Development estimated the total value of the self-funder spend on domiciliary care was £95m in 2015-16.

Using a similar growth trajectory as money spent on commissioned domiciliary care this would indicate the 2022-23 self-funder spend would be £130m.

This assumption is used as the Category D estimate of the size of the national spend on domiciliary care in the Cost Benefit Analysis.

	(£000,000)						
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Self-funders	95	100	103	107	114	116	127

Assumption 11: The total national spend on domiciliary care was about £490m in 2022-23.

	(£000,000)						
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Self-funders	363	384	392	410	435	444	485

This assumption is used as the Category E estimate of the size of the national spend on domiciliary care in the Cost Benefit Analysis.

Assumption 12: On average, the turnover generated by each domiciliary care service was £728k in 2022-23.

Table 15 Turnover per registered service (£ thousands)

	2018-19	2019-20	2020-21	2021-22	2022-23
Services	509	526	595	614	666
	(£,000)				
Category A	337	361	367	371	362
Category B	499	504	474	465	469
Category C	569	576	541	534	538
Category D	201	204	191	189	190
Category E	771	780	732	723	728

As stated above, a single company may offer many domiciliary services or social care services to others.

There are 660 services, and we estimate 525 individual entities (companies/third sector organisation) delivering social care. However, this figure gives an order of magnitude.

Micro-funding

Assumption 13: Commissioning and contracting arrangements and domiciliary care provider's business and operation planning hinge on a contracting unit known as the "hourly rate".

The hourly rate is the fee paid by commissioners for the one person providing the equivalent of one hour of care. The hourly rate varies considerably between authorities.

The hourly cost to a provider is to deliver one person providing the equivalent of one hour of care. Profit is then added to this cost. The hourly cost, plus profit should be equal to the hourly rate.

Commissioners set the hourly rate, and this reflects market conditions.

The hourly cost depends on various factors, including fixed and variable costs.

Assumption 14: An increase in the hourly rate is not part of this feasibility study.

It has been noted that the Home Care Association has called for an increase in the hourly rate, as they believe that the current rate paid by local authorities is below the true cost of providing an hour of Domiciliary care.

The Homecare Association has indicated that the minimum price of providing one hour of domiciliary care in Wales in 2023-24 is £28.64 This price is made up of £27.55 cost and £1.09 profit.[129]

[129] https://www.homecareassociation.org.uk/resource/wales-minimum-price-for-homecare-2023-24.html

As the project governance group agreed, we have used the Homecare Association modelling and underpinning categorisation as the basis of our calculations. There are, however, several other approaches including that used in England during the *Fair Cost of Care* exercise[130].

Homecare Association & National Commissioning Board have developed a costing tool. This indicates a reasonable hourly rate paid to providers in Wales:

- with less than 2,000 hours could be £30.45,
- with more than 2,000 hours could be at £29.87.

In both cases, these prices comprise £28.72 cost; however, the model assumes 6% profit for the smaller company and a 4% profit for the larger companies. The tool can be adapted to local conditions in Wales, so the above figures are only included as a guide.

Assumption 15: There is significant variation between, for example, Wales and England.

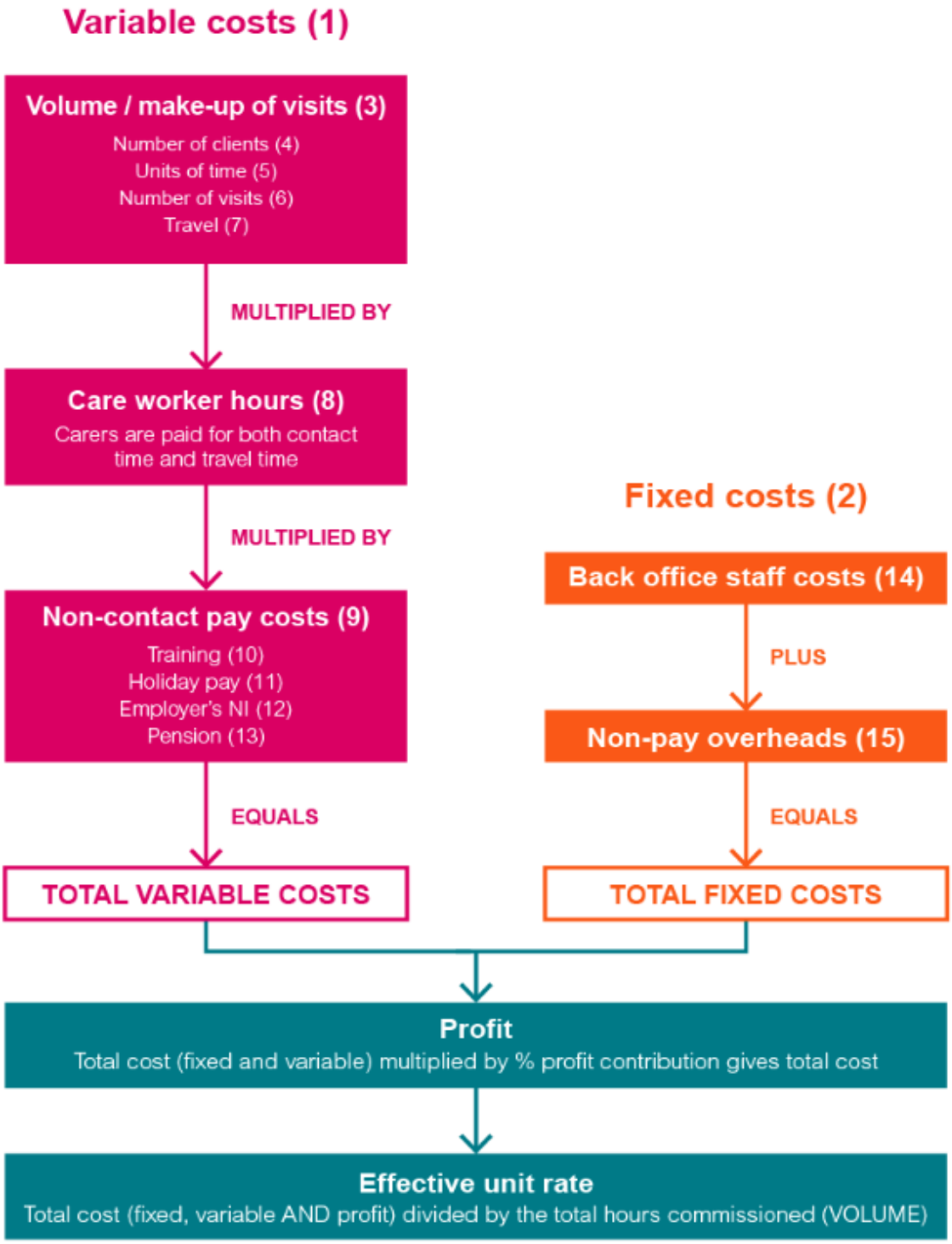
The Homecare Association has indicated that the minimum cost of providing one hour of domiciliary care in England in 2023-24 is £28.55[131]. This cost is made up of £27.55 cost and £1.00 profit.[132]

[130] https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance#:~:text=care%20home%20bed%27.-,Cost%20of%20care%20exercise,local%20cost%20of%20providing%20care.

[131] https://www.homecareassociation.org.uk/resource/minimum-price-for-homecare-2023-24.html

[132] https://www.homecareassociation.org.uk/resource/wales-minimum-price-for-homecare-2023-24.html

Assumption 16: The hourly cost can be broken down further, reflecting the cost of delivering essential business functions.



Organisations use different cost models to determine the hourly cost for a particular service. The above graphic describes the approach taken by England's Care and Health improvement programme (CHIP) [133].

The Homecare Association use the term Careworker Costs to describe variable costs and Gross Margin to describe fixed costs. These categories are further broken down into several subcategories and then sub-subcategories. This is set out in Appendix 1 – Assumptions.

We have identified that many business functions sit across the following sub-subcategories of fixed Gross Margin:

- Back-office functions
- Management and supervisor functions
- IT and telephony
- Finance legal and professional

Using the sub-subcategories of cost, we have identified the theoretical national expenditure in these sub-subcategories. This assumes these costs are fixed.

The calculation demonstrates a significant amount of money invested in these areas by Welsh local government and self-funders through fees.

This is spent in a distributed market sector dominated by many smaller organisations. This kind of sector is recognised as having significant business process inefficiencies. This may mean that national expenditure is not being spent effectively when considered as a whole.

Commercial modelling: HR function

Centralising the recruitment process from independent Domiciliary Care providers to one central platform is a complex endeavour that involves various assumptions and dependencies. We have considered overall assumptions and dependencies as well as those affecting each element of the process.https://practicesolutions786.sharepoint.com/:w:/s/FranchiseModelofCare-ADSSsharedteam/ERMfmi0j-spGp3l3tQgOPYMB1UtA9qG00GHav3JIePzhlQ?e=BXqejH

Assumptions:

HR Knowledge and experience: Assumption that there will be a lack of necessary HR expertise / knowledge of employment law and therefore providers may struggle to handle recruitment / employment issues effectively.

Limited time and resources: Assumption that providers are too small to have a dedicated HR resource and therefore struggle to dedicate sufficient time and resources for recruitment. This can result in delayed responses, and inadequate support to candidates.

National Terms & Conditions: Assumption that the Social Care Fair Work Forum have developed national terms and conditions and related HR policies in place from day one of implementation.

Standardisation of Processes: Assumption that all providers are willing to use the standardised recruitment processes, including job descriptions, qualifications, and candidate assessment criteria.

[133] https://www.local.gov.uk/our-support/partners-care-and-health/commissioning-and-market-shaping/costing-care/homecare-cost

Technology / digital competence: Assumption that the providers are willing and able to adopt a new system to manage their recruitment function.

Consistent Compliance: Assumption that all providers are compliant with legal and regulatory requirements in terms of recruitment, and that centralising will not introduce compliance issues.

Buy-In and Cooperation: Assumption that all providers are willing to buy into the national entity and actively cooperate throughout the transition.

Dependencies:

Local Authorities: All 22 Local Authorities will have signed up working within the parameters of the new entity.

Provider Readiness: The readiness and willingness of each individual provider to embrace the new recruitment platform is a critical dependency. Some providers may resist the change or face logistical challenges in adopting a new system.

Technology / digital competence: The success of centralization depends on effective integration with the providers' existing systems, which may vary widely in terms of technology and infrastructure.

Data Quality: Accurate recruitment data is essential for a smooth transition. Data quality is a significant dependency, and data cleansing may be required.

Legal and Regulatory Compliance: Dependencies on adherence to legal and regulatory requirements. Ensuring that centralisation does not compromise compliance is crucial.

Change Management: The ability to manage the changes effectively and obtain the buy-in of all providers is a significant dependency. Change management strategies are essential.

Resource Allocation: Allocating resources, both in terms of personnel and budget, to facilitate centralisation is a dependency that requires careful consideration.

Training and Support: Providers will depend on adequate training and ongoing support to adapt to the new central platform.

Stakeholder Communication: Effective communication with all stakeholders, including employees, management, trade unions and external partners, is a vital dependency.

Time and Phasing: The process of centralisation may need to be phased in over time to mitigate disruptions and dependencies on a smooth transition.

Performance Monitoring: The ability to monitor the performance and efficiency of the central platform, post-implementation, is a critical dependency.

Appendix 2: Organisations represented in engagement

We would like to thank the following organisations for their feedback over the course of the feasibility study:

Abacare
Abicare
ADSS
All Care Wales
All Wales HR Directors' Network
All Wales Training Managers' Network
Arian Care
Ategi
BAWSO
Believe Care
Cardiff Council
Care Cymru
Care Forum Wales
Care in Hand
Care Inspectorate Wales
Care Match
Care One 2 One
Careco Health Care
Carmarthenshire County Council
Centre for Digital Public Services/ Mimulus
Ceredigion Council
Collaborative Commissioning Workshop
Community Catalysts
Connect (Telecare)
Cornpoppy
CVCS
Cwmpass
Dementia and Domiciliary Care Research Project
Denbighshire County Council
Domiciliary Care Collaboration
ERDG
Flintshire County Council
Foundational Economy Challenge Community of Practice

GH Supported Living
Greater Swansea Community & Primary Care
Gwent Domiciliary Care Providers Forum
Gwent Social Services Board
Gwent Strategic Partnership
Habitat Home care
Health & Social Services Integration
Home Instead
Increasing Community Capacity (North/ South Wales)
Kent University
Liberty Care Ltd
Living at Home
Lougher HomeCare
Marie Curie
Michael Phillips Care Agency
Monmouthshire Adult Social Care
National Commissioning Board
Neath Port Talbot CBC (Learning & Development)
Newcross healthcare
Newport Council
NHS (Transformation)
North Wales Regional Workforce Board
Old Vicarage Care Home
Padda Care
Partnerships for Progress
Pembrokeshire Association of Voluntary Services
Pembrokeshire County Council
Pembrokeshire Older Persons Forum
Pembrokeshire Provider Forum
Planed
Powys County Council
Powys Teaching Health Board (Dementia Lead Nurse)
Premier Care Plus
Preseli Cares
RCT CB Council
Redcross
Regional Partnership Board (Leads)
Right at Home

RSD Homecare
Seren Care
Shared Services, NHS
Social Care Community of Practice
Social Care Wales
Swansea Council
Swansea Council for Voluntary Service
Swansea Providers' Network
Torfaen Housing and Social Care
UK Home Care Association
Unison
Vale of Glamorgan Council
We Care Wales
Welsh Government (Innovation)
Welsh Local Government Association
West Wales Care Partnership
Wrexham County Council

Appendix 3: List of key reference documents

1. Above and Beyond' National review of domiciliary care in Wales
2. The Economic Value of the Adult Social Care Sector – Wales
3. The homecare deficit
4. Homecare Association Minimum Price for Homecare 2023-24 (Wales)
5. Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care
6. Workforce data report 2022
7. Welsh Government Consultation – summary of response Domiciliary Care Workforce

Appendix 4: List of additional documents

- Legal Report: Final report on the possible establishment of a new legal entity to provide services to social care providers in Wales
- Miro Board
- Theory of Change
- Summary of Engagement
- Interim report