Confidential

Sheffield City Council

Report on the Care Home Market Strategic Analysis

March 2021 – Final Version

CordisBright

Table of contents

1 Care Home Market Development and Sustainability Delivery Plan 6

1.1 High level summary “plan on a page” 6

2 Detailed 1, 3, 5 and 10-year view of the care home market in Kirklees and Rotherham. 8

2.1 Demand Forecasts..... 9

3 Detailed benefit and outcome delivery milestones split by beneficiary against priority matrix. 13

4 Care Home Market Management Options 14

4.1 Option 1 – Minimal Intervention (as-is) 14

4.2 Option 2 – Medium Level Intervention 16

4.3 Option 3 – High Level Intervention..... 18

5 Key enablers required to deliver 22

6 Supporting analysis evidencing the opportunities (A set of detailed summaries of data with analysis which sets out the rationale for all recommendations) 24

7 Background – Market View 25

7.1 Demographics 25

7.2 Population and Demand Summary 44

7.3 Funding and Finance 46

7.4 Key interview findings from commissioners..... 50

7.5 Summary and conclusions 52

8 Operating and Finance Models 54

8.1 Funding Models 54

8.2 Diversification 54

8.3 Self-Funding 55

8.4 Alternatives to Care Home Provision 58

8.5 Future Options..... 63

8.6 New Developments / Care Homes..... 65

8.7 New Developments / Retirement Housing..... 65

8.8 Alternative Models for Local Authorities..... 66

9 Opportunity Lists 68

9.1 Market Management Strategies..... 68

9.2 Short Term Opportunities 71
9.3 Medium Term Opportunities 74
9.4 Long Term 79
9.5 Investment Opportunities and Sources 79
9.6 Digital – Business Systems & Care Technology 79
9.7 User and Carer Expectations 83
9.8 Workforce 85

10 Appendices 87

Appendix 1 – Care Needs Estimates by MSOA 87

10.1 Care Needs by MSOA 87

Appendix 2 – Adult Social Care Benchmarking Data – Yorkshire and Humberside Region 91

11 Introduction 91

12 Data – Older Adults (65+) 93

12.1 Expenditure on Adult Social Care for Older Adults 93
12.2 Care Home Commissioning Activity (65+) 95
12.3 Unit Cost Data – Older Adult (65+) care homes 100
12.4 Care Home Bed Supply 101
12.5 Population 106

13 Data – People with Learning Disabilities 108

13.1 Expenditure on Adult Social Care for people with learning disabilities 108
13.2 Care Home Commissioning Activity 111
13.3 Unit Cost Data – Learning Disabilities care homes 18-64 115
13.4 Accommodation Type – Settled and Unsettled Accommodation 116
13.5 Care Home Bed Supply 117
13.6 Population 121

14 Data – People with Mental Health Support Needs 123

14.1 Expenditure on Adult Social Care for people with mental health support needs 123
14.2 Care Home Commissioning Activity Mental Health 18-64 126
14.3 Unit Cost Data – Mental Health 18-64 care homes 130
14.4 Care Home Bed Supply 131
14.5 Population 135

15 Core Cities Group (Older Adults 65+) 137

15.1 Expenditure on Adult Social Care for Older Adults 137
15.2 Care Home Commissioning Activity (65+)..... 139
15.3 Unit Cost Data – Older Adult (65+) care homes 141
15.4 Care Home Bed Supply 142
15.5 Population 146

Table of Figures

Figure 1 - Market Interventions Matrix 7
Figure 2 - Demand Model for Care Home Beds 9
Figure 3 - Short, Medium and Long Term Market View 12
Figure 1 – Older Adult Care Home Beds and Care Home Beds per 100 of the 75+ population (Source: CQC, October 2020+ 26
Figure 2 – Older Adult Care Home Beds per 100 of the 75+ Population - Comparative data (Source: CQC, October 2020)..... 27
Figure 3 - Care Home Beds and England Care Home Occupancy 2012-20 (Source, Department of Health and Social Care, 2020)..... 27
Figure 4 - 2019 Care Home Occupancy by provider type and region. (Source, LaingBuisson)..... 28
Figure 5 - Influencing factors in the demand for care home beds 29
Figure 6 - Number of requests for social care support for people aged 65+ 2015-20. (Source, SALT Data, NHS Digital)..... 30
Figure 7 - Population aged 85+ as a percentage of the total population, 2019 to 2043 (Source, ONS Population Forecast, 2019 Mid-Year Estimates)..... 30
Figure 8 - Estimated older adults care demand and the location of older adult care homes in (Source: CQC October 2020, ONS mid-year population estimates 2019)..... 32
Figure 11 - Estimated care demand and the size of care homes in Sheffield (Source: CQC October 2020, ONS mid-year population estimates 2019)..... 33
Figure 9 - Age Standardised Demand estimates Source: ONS 2019 mid-year population estimates, 2011 Census Data)..... 34
Figure 10 - Care Home Bed demand based on Age-Standardised Demand (Source: ONS 2019 mid-year population estimates, 2011 Census Data) 34
Figure 12 - Care Home beds per the 85+ population by MSOA (Source: ONS 2019 Mid-Year Estimates, CQC Data February 2021)..... 35
Figure 13 - Care Demand in Yorkshire and Humberside by MSOA, ranked by Quartile of demand..... 36
Figure 14 - Care demand in the western authorities in Yorkshire and Humberside 37
Figure 15 - Yorkshire and Humberside local authorities ranked by the number of MSOAs falling into the top quartiles (4 & 5) for estimated care demand 38
Figure 16 - Estimated percentage change in care demand by MSOA 2022 (Source: ONS mid-year population forecasts 2019) 39
Figure 17 - Estimated percentage change in care demand by MSOA 2025 (Source: ONS mid-year population forecasts 2019) 40
Figure 18 - Estimated percentage change in care demand by MSOA 2030 (Source: ONS mid-year population forecasts 2019) 41
Figure 19 - Projected annual change in number of older people with a care need, 2019-2043 (Source, ONS Population estimates, Life Expectancy data from ONS 2015)..... 42

Figure 20 - Map of retirement housing locations and disability free live expectancy by MSOA in Sheffield (Source: Housing data from EAC, DFLE data from ONS, 2015)..... 43
Figure 21 - Dementia Prevalence by GP Practice (Source: QOF 2020, NHS Fingertips)... 44
Figure 22 - Location of Older Person's Retirement Housing in Sheffield (Source, EAC, 2018-19)..... 59
Figure 23 - Housing and support options for older adults 61
Figure 24 - Retirement housing locations and tenure type by LSOA (Source, EAC, National Statistics) 62
Figure 25 - Intervention opportunities by year..... 69
Figure 25 - Location and size of care homes and estimated care demand by area (Source: CQC, National Statistics mid-year population estimates 2019)..... 70
Figure 27 - Location and type of older persons' retirement housing..... 74
Figure 28 - Dormer Bungalow Development for older adults in Birmingham 77
Figure 29 - medium size older adults retirement housing development in the Midlands..... 78
Figure 30 - IT Resources in Care Homes (Source: Survey with Rotherham Care Homes, November 2020)..... 80
Figure 31 - Examples of technology-enabled services (Source: Tunstall - https://www.tunstall.co.uk/resources/case-studies/) 82
Figure 32 - Falls pathway for prevention..... 83
Figure 33 - Older people’s preferences should they need care (Wanless 2006)..... 84

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1 Care Home Market Development and Sustainability Delivery Plan

1.1 High level summary "plan on a page"

In common with local authorities across England, care homes in Sheffield are facing high vacancy levels. Whilst Covid-19 has worsened the situation, demand for care home beds has been falling across England for many years, as a response to the improving health of older people, changed commissioning priorities away from care homes, and changing customer attitudes.

Demand forecasting suggests that there is currently an over-supply of care home beds in Sheffield that will persist until at least 2025/26. If occupancy levels are to return to 90%, then this means that the number of care home beds available in Sheffield needs to reduce. Furthermore, demand for future care home places is likely to be from people with complex needs, requiring specialist support in environments suitable for people with reduced mobility or with advanced dementia.

The diagram below illustrates the options available to the Council overing the next 10 years:

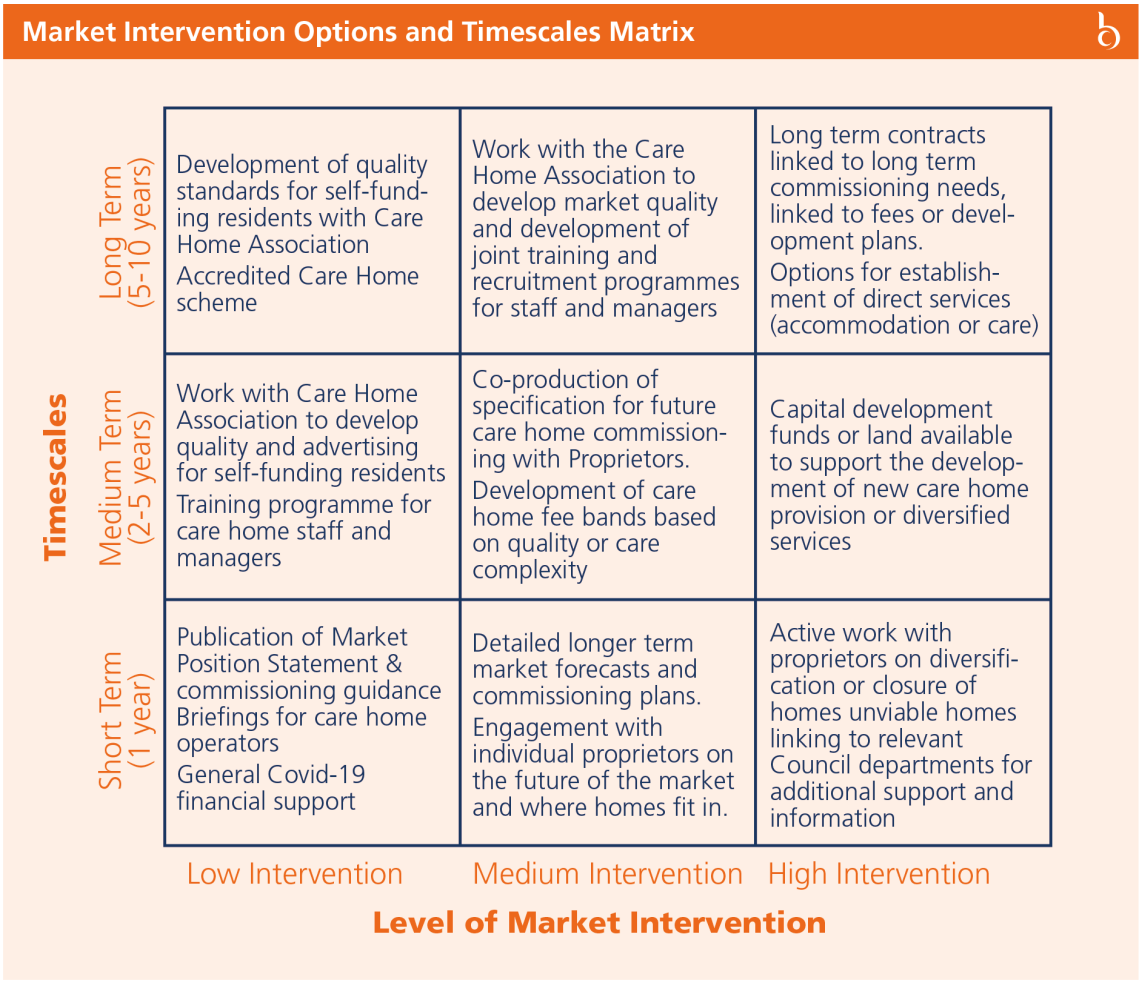


Figure 1 - Market Interventions Matrix

2 Detailed 1, 3, 5 and 10-year view of the care home market in Kirklees and Rotherham.

This document is based in the care home market strategic review undertaken by Cordis Bright and LaingBuisson. The review included interviews with care home proprietors, commissioners and other stakeholders, as well as analysis of demographic and care market data to develop a long-term view of the development of the care home market. The interviews and market data all suggest that the care home market has reached a pivotal moment, with reduced care home occupancy impacting on the viability of care home businesses and long-term changes in the commissioning of care home services, exacerbated by Covid-19, reducing demand for places.

Much of this document focuses on the older adult care home market (people aged 65+). Although there is a similar trend in reducing demand for care homes for working age adults with care and support needs, care homes have not generally faced the same impacts from Covid-19 as the older adult care home market. The options for the future are the same for both older adults and working age adult care home provision, but the pressures on the working age adult services are not as acute.

Current reduced occupancy levels in most local authority areas suggests excess capacity in the care home market and an ability for the market to withstand the loss of care home provision without impacting on the ability of local authorities or NHS commissioners to commission care home places to meet needs, notwithstanding the impact that home closures have on the residents, staff and owners of those homes. Current social care and demographic trends suggest, however, that increasing capacity will be required in the longer term and that current occupancy levels are a low point of demand. Discussions with care home proprietors as well as local authority and NHS commissioners suggest that the commissioned care home market is heading to a future of more complex placements for shorter periods of time This commissioning will be made up of two elements:

- short term placements as part of a program of rehabilitation for individuals being discharge from hospital, or individuals diverted from hospital admission following an increase in care needs due to illness or accident.

- End of life care for people who can no longer be supported to live, or wish to live, in their own homes or some form of supported housing in the community such as extra care or sheltered housing.

This future demand for shorter term, more complex care home provision has impacts not only on the size of the care home market, but also on the type of care home provision in terms of the type of building and the staff resources available to meet that demand.

The forecasts and options in this document are based on the following timescales:

- **Short term (1 year)** - These options are based on maintaining market stability during the period of low occupancy as a result of the reduction in arising from Covid-19 which for homes with a higher turnover of residents is causing significant levels of vacancies. Interventions in this period are focused on maintaining the operation of key care home

provision and ensuring that any care home closures are managed to reduce the impact on residents, staff and proprietors.

- **Medium Term (2 to 5 years)** – these options are based on longer term strategic development of the care home market alongside wider developments in alternative housing provision such as retirement housing or extra care. These take place in the context of a care home market which will be recovering from Covid-19 and structural changes to ensure that care homes can meet longer term needs.

- **Long Term (5 to 10 years)** – these options are based on maintaining a range of suitable care options to meet long term needs and the expectations of the next generation of older people. This period will see an increased focus on people with complex needs who will need a range of flexible health and social care settings to support.

2.1 Demand Forecasts

Although the demographic pressures are for a greater number of older people, this is in the context of increasing health leading to fewer people with care and support needs. This, combined with changed patterns of commissioning of services for older people with support needs and changing lifestyles of older people, reduce overall demand for care home beds. This is illustrated in the diagram below:

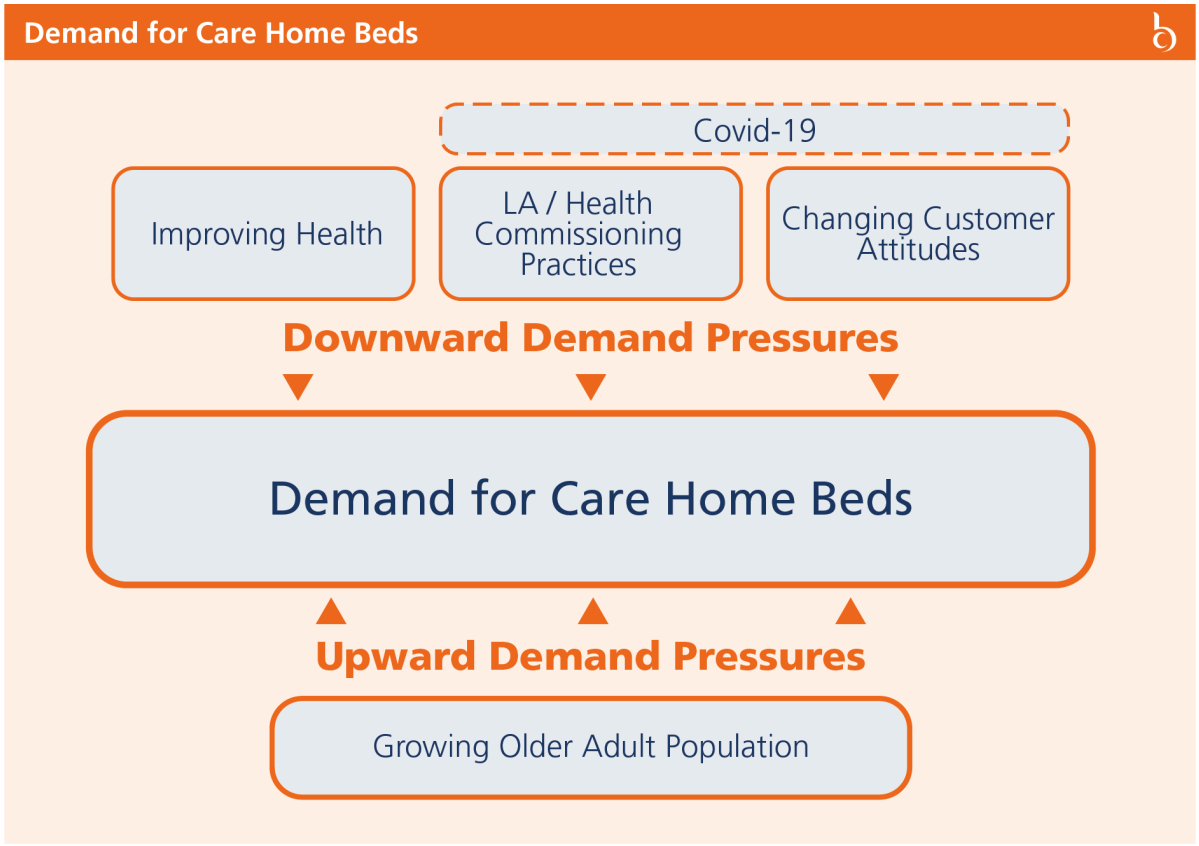


Figure 2 - Demand Model for Care Home Beds

Demand for care home beds has been falling since 2000, with CFAS (Cognitive Function and Ageing Study) suggesting that demand has been falling by 1% a year since 2000 as a result of improved health of older adults[1].

Figures from LaingBuisson[2] suggest that "for-profit" care homes in Yorkshire and Humberside in 2019 had an average occupancy of 81%, although with significant local variances.

In terms of the timescales for this report, the demand forecasts in terms of care home beds are as follows:

Time Period	Demand Forecast	Implications
Short Term (1 year)	Short term demand has been significantly impacted by Covid-19, both in terms of local authority referrals to care home places and self-funders. For care homes that have a high turnover of residents, or homes which have lost residents because of a Covid-19 outbreak, this has resulted in long term vacancies. It is not clear what baseline demand will be following Covid-19, but it seems unlikely that demand will return to pre-Covid levels.	High levels of vacancies threaten the viability of most care homes, with many homes requiring occupancy of 90%+ to be profitable and occupancy of less than 80% threatening viability. It is particularly difficult to forecast new baseline demand levels, particularly for the self-funder market, which is key to many homes' viability. Some of the large private home operators don't expect the self-funder market to return to pre-Covid-19 levels until 2023. There is likely to be an increase in demand during the summer of 2021 as the immediate crisis of Covid-19 passes and people who have delayed admission to a care home seek places. These individuals may have more complex needs than

[1] A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II – Fiona E Matthews, Antony Arthur, Linda E Barnes, John Bond, Carol Jagger, Louise Robinson, Carol Brayne, on behalf of the Medical Research Council Cognitive Function and Ageing Collaboration. Lancet, 2013, Matthews FE

[2] Care Homes for Older People – Market Report, 31st Edition, January 2021, LaingBuisson

Time Period	Demand Forecast	Implications
		admissions prior to Covid-19 The summer of 2021 is also likely to see a number of market exits from existing care homes or proprietors. The Council may need to consider direct interventions to keep key services operating or available for future care use.
Medium Term (2-5 years)	The immediate demand impacts of Covid-19 are likely to have passed by 2023 and the new baseline demand will be clearer. This will reflect the different population of older people with care as a result of Covid-19 as well as longer term changes in commissioning of care for older people and the level of the recovered self-funder market. During this period, additional housing-based support for older people is likely to become available (such as extra care housing), for those older people whose care and support needs cannot be met in their own homes. This is likely to have a direct impact on the demand for council-commissioned care home places and will compensate for the growth in the older persons' population over the same period.	Demand for care home places is likely to change significantly over this period, with an increasing focus on two main groups in terms of commissioned care: • Short term placements linked to rehabilitation either from people diverted from hospital care or those being discharged from hospital for rehabilitation before moving back home. • Support for people with complex needs who cannot be safely supported either in their own homes or in some form of supported housing for older people. There will also be a continued demand from people who are self-funding care home beds. It is probable that demand for non-specialist care in older care homes will reduce significantly unless the home is able to attract self-funding residents.

Time Period	Demand Forecast	Implications
Long Term (5 to 10 years)	The early part of this period is likely to see the completion of the consolidation of the care home market, and there are likely to be fewer, specialist care homes, with higher levels of occupancy. Towards the end of this period, there is likely to be an increase in demand as a result of population increases. Increases in health that had led a reduction in demand are likely to stop or decline, particularly affecting less affluent areas of the borough where life-expectancy is lower.	Changes in the way that care home places are commissioned should increase the level of communication between commissioners and care home proprietors about long term needs, so providers should increasingly be ready to meet the needs of people with complex needs being admitted.

Figure 3 - Short, Medium and Long Term Market View

3 Detailed benefit and outcome delivery milestones split by beneficiary against priority matrix.

This document sets out a set of three options for how Sheffield City Council can respond to the pressures on the care market outlined in the above section.

1. **Option 1** is based on minimal intervention similar to how many care home markets have been managed by Councils in the past. The Council would set out broad commissioning intentions through the Market Position Statement and continue to apply some pricing controls through standard fee rates for commissioned care home places. The Council would continue to work with providers to meet specific needs (such as step-down and S2A beds) and would intervene where necessary to ensure the safety of care home residents and to improve quality of provision overall.
2. **Option 2** is based on a medium level of intervention, providing much more detailed information to care home providers about the future of the market and the Council's (and NHS's) commissioning intentions in terms of the quantity and type of future commissioning in addition to Option 1. The Council would have options within this to directly influence the future shape of the market through the publication of specifications for future care home bed commissioning, or through more active price controls through tiered fee rates that recognise the quality of the care provided, the complexity of the support being provided, or some combination of the two. The Council would work more closely with the Care Association to increase the quality of the care home market for both commissioned places and for self-funding residents by, for example, jointly running staff training programmes.
3. **Option 3** is based on the highest level of intervention. In addition to the actions in Option 1 and 2, the Council would actively develop the care home market to meet longer term needs through direct partnership with key providers through long term contracts linked to the development of care home provision to meet identified future needs. This could involve some direct provision, either through the direct development of care home facilities or the provision of direct care and support particularly in relation to the provision of complex care services.

The sections below set out in more detail each of these options, looking at:

- What each option would consist of.
- Examples of where this is happening in other parts of the Country.
- Advantages and disadvantages of each of the option to both the Council, to care home proprietors and to the users of care home services.

Although these are set out as three distinct options, the reality is that any strategic planning of the care home market will include elements of all three because the "care home market" is made up of a number of smaller markets, each of which may require different interventions. This includes services for working age adults (learning disabilities, mental health and physical disabilities), services for self-funders or specialist care home services for older people. The choice is more about the balance of the three options that is applied over time.

4 Care Home Market Management Options

4.1 Option 1 – Minimal Intervention (as-is)

4.1.1 Interventions

This option is based on a continuation of the Council's current approach to care market management, which is common to most local authorities and most of which are already in place in Sheffield. This consists of:

- Publication of broad commissioning intentions via Market Position Statements outlining longer term needs and likely number of beds.
- Pricing controls through the use of standard fee levels for care home beds commissioned by the Council (or jointly with the CCG).
- Work to maintain and develop quality in the care market through contract teams and quality checking.
- Support of the Care Home Association and regular briefing sessions for care home proprietors and managers.
- Intervention in care homes maintain quality to ensure the safety of residents in response to concerns raised by commissioners or CQC, including placement embargos.
- Direct financial support to Care Homes through the Covid-19 pandemic.
- No direct control over care home development.

Recent intervention in the care market in the form of financial support for providers with high levels of vacancies represent a higher level of support than Local Authorities would usually provide, and one that is not universal across authorities.

4.1.2 Examples

This level of market intervention is common across the local authorities in England. It is made possible by lower occupancy levels (the average occupancy level in "for-profit" homes in Yorkshire and Humberside in 2019 was 81% according to LaingBuisson) which means that there is sufficient capacity in the market to withstand the loss of care home provision.

Where there is less supply in certain care home specialities, such as services for specific working age adults, local authorities will generally take a more active role in market management to ensure the ability to commission beds locally.

4.1.3 Advantages and Disadvantages

Sheffield City Council

For the local authority this option is attractive because intervention is generally difficult and costly (in terms of staff resources if not through the cost of care home provision). An excess supply of beds means that there is choice in the market and that Care Act responsibilities for management and sustainability can be met with minimal intervention.

The big disadvantage of this option is that there is little strategic planning of the care market to meet future needs. All local authorities have care homes which are not suitable to meet longer term commissioning needs but whilst these cover their operating costs (often through self-funded residents paying higher fees and through lower running costs) there is little incentive for providers to change. Standard fee levels are often not sufficient to allow for home proprietor investment in modernising care homes or developing new services unless they can attract self-funders, high top-ups or higher fees for specialist placements from out of area. This risk then is that over time the supply of beds available to the Council to commission reduces, particularly for residents with limited financial resources, although the total number of beds remains the same, leading to more costly out of area placements.

The other risk of this option is unplanned home closures. These can have a serious impact on the residents and staff of the home if a home closes with little notice. Although it is widely thought that is will be poorer quality homes (either in terms of the quality of the building or the quality of the support) it is often these homes that last the longest, whilst lower levels of occupancy due to an oversupply of care home beds can also affect the viability of the better-quality homes that the Council needs to retain to meet future needs.

Care Home Proprietors

Most providers express dissatisfaction with the amount of information Councils provide about their long-term commissioning intentions and about how many beds will be required in the future. However, though providers may recognise the impact of oversupply of care home beds on vacancy levels and profitability they find it hard to reflect this in the business plans for their own homes. This can result in sudden home closures if homes become insolvent, for example through a breach of loan covenants relating to occupancy, which no provider wants. This means that this option is often ultimately frustrating to providers who can see the issues in the market but have no ability to control this themselves. A number of proprietors would wish to see a greater level of intervention by the Council, particularly in relation to fee levels.

Overall

Although this option has been viable for both Councils and proprietors prior to Covid-19, the care home market has now reached a tipping point where more intervention is needed to reduce the risk of unplanned home closures, reduce the risk of the loss of high-quality providers and services, and to ensure that future care and support needs can be met in high quality services.

4.2 Option 2 – Medium Level Intervention

4.2.1 Interventions

In addition to the interventions in Option 1, this option includes more direct control of the development of the care market by the local authority, including the following:

- Publication of detailed plans for the future of the care market, including more detailed commissioning plans covering the types of supported required and expected numbers of people.
- The development (possibly co-produced with care home proprietors and managers) of specifications for the future commissioning of care homes covering expectations about the physical environment of the home and the way in which the home is staffed and the skills of staff to meet expected care needs.
- More active price controls, included fee banding based on quality or the complexity of care, including linking to the specification above.
- Closer work with the care association to develop quality in the care market, including joint work to develop the care home specification and the running of joint training programmes to develop the skills of existing staff and managers and to attract new staff. This would cover the commissioned care market as well as self-funders.
- Direct work with individual providers on the future trends in the care market and where their services fit, including advice and information for providers considering exiting the market.

4.2.2 Examples

The banding of care fees based on quality or dependence is used in many authorities. Bands are often uplifts from the base fee for specific quality measures or based on specific needs. For example, several local authorities in Yorkshire and Humberside pay additional fees for additional activities support. In the North East, many authorities use fee bands based on quality – Sunderland rates homes as Bronze, Silver or Gold based on a combination of CQC and LA quality assessments, with linked uplifts to fees.

Stoke on Trent have a framework and commission beds based on bids to meet the needs and outcomes of individual residents, to reflect differing fee levels, although there are mixed messages from providers about the effectiveness of this and the Council is currently introducing a new Framework agreement with care homes.

Longer term fee increase agreements are popular, particularly when combined with a phased cost of care exercise implementation. Wirral Council (among others) has explored linking fee increases for residential and nursing placements to a commitment by local providers to move staff from minimum wage to National Living Wage and Real Living Wage. Wirral Council offered a 10% increase to a national provider in 2020 to make this shift for relevant staff. (We note that in 2020 the Unison union made claims against The Old Garden care home at Hoylake, the Wirral, concerning loss of earnings of care home staff taken ill, as well as the low level of pay.) Barnsley have taken a similar approach to offer a 13% increase in fees.

Sheffield City Council's work with the Care Association to look at longer term demand, recently jointly commissioning a piece of work to look at longer-term demographic trends (funded by the local authority) is an example of higher levels of intervention. Other Councils have been working with Care Associations on training and development programme.

4.2.3 Advantages and Disadvantages

Sheffield City Council

For Sheffield City Council, a greater level of intervention helps to ensure that the care home market develops in a way that sustains the market and meets longer term needs.

Linking fees to quality and dependency levels helps to encourage providers to invest in improvements to the way in which they operate their homes and to plan longer term investments in buildings.

Dialogue with individual providers helps to ensure that the Council is aware of specific issues facing providers and helps providers understand their position in the changing market and their options. This dialogue helps to avoid unplanned closures.

Initiatives involving closer work with the Care Association are relatively low cost for significant benefits in terms of a cooperative partnership. Messages from the Care Association may be trusted more than those from the Council.

There is a disadvantage that these interventions are costly with little direct benefit. Stepped fee levels in particular can end up being very costly unless combined with strategies to reduce overall commissioning of care home beds. In the authorities looked at, additional fees were an addition to the current base. One way round this is to phase this by offering phased fee increases so that the costs increase more gradually over time.

The big challenge is that without specific work with individual providers to develop services, there is no guarantee that the incentives will result in the services that the Council wishes to commission.

Care Home Proprietors

All care home proprietors across the three authorities undertaking a market review have said that they want more information about the development of the market and where they fit in terms of future needs. A direct dialogue with the Council would allow proprietors understand the future options for their homes and identify other possibilities, such as supporting other client groups or offering different types of support.

Stepped fee levels address some of the concerns of providers about fee levels not reflecting either the cost of providing better quality care or supporting people with complex needs. There is a risk of increased bureaucracy in how such a scheme is developed and some providers have reported that in other areas Councils favour lower-cost homes when making placements. There remains a risk that providers will under-price for care to win the individual care package but then go back to ask for more money later.

The major disadvantage to this approach is that it might not create the conditions in which proprietors can invest in their services to meet future needs. This might require more

certainty about longer term income than is possible on a commissioning approach based on spot contracts, even if fee levels are higher.

4.2.4 Overall

This approach is based largely on more explicitly signalling to providers what the future of the market looks like and encouraging them to make the right decisions about their business. Fee levels also form a signal about what the Council is prepared to pay for in the hope that providers will do more of it.

The main disadvantage is that this approach is unlikely to result in large scale transformation of the care home market, which will require substantial investment (and disinvestment). This requires more direct intervention, as outlined below.

4.3 Option 3 – High Level Intervention

4.3.1 Interventions

This approach is based largely on developing longer term relationships with proprietors to develop the care home provision required to meet future needs. Such development requires investment in both buildings and support services which the higher level of intervention aims to achieve through partnership with providers.

- Capital development funds to help the Council invest in new care home provision, either independently or in partnership with a provider. This could take the form of a land transfer to a provider to enable a care home development, or the local authority could develop its own specialist care home provision which is then operated by an independent sector partner.

- Longer term contracts for care home provision either linked to long term agreements on fees or linked to specific care home redevelopment plans.

- Some authorities have set up (or are considering setting up) arms-length care companies to provide specialist care services, particularly where there are gaps in the market.

- Active work with providers on diversification initiatives where there is over-supply in a particular geographical area or needs group – conversion of services to different client groups, of converting care homes to supported living. This could include grants to aid the transition.

4.3.2 Examples

- **Sheffield City Council** has worked with a care home to configure and specify a 10-bed residential care setting for clients with dementia and challenging behaviour. The unit, which opened in August 2020 and has three residents currently (one self-funder; two referred by a CCG), was repurposed from an existing wing of the 50-bed care home. The bed rate is c £1,250 per week and is expected to rise to £1,700-£1,900 to bring it into line with similar specialist providers.

- **Somerset County Council** is working with a large local care provider on two diversification initiatives, the first being to develop homecare (and day care) outreach with existing management and care teams at residential care homes, acknowledging their installed base of expertise and the potential benefits to care homes of developing relationships with service users who may well need to enter a care home in time; the second, being the repurposing of a residential care home to offer solely intermediate care for patients being discharged from local hospitals and where a problem of 'lost' patients can be addressed as they move from an in-patient setting to a community setting. We note 'step-up' as well a 'step-down' initiatives under consideration at some local authorities including Sheffield City Council.

- **Lancashire County Council** has noted that *'Providers should be aware that we will continue to achieve significant savings through changing the way we support people to ensure they receive the right levels of support. We will also explore service remodelling, negotiation with existing service providers (where necessary) and some decommissioning, and where appropriate, reinvestment in more efficient services to better fit future needs'*. But it has given a clear indication of how it will work with providers going forward: '*We are also aware that it is often difficult for providers to develop long term business plans due to the short length of contracts we currently offer. We want to change, in future contracts, the way annual fees are negotiated, agreed, and uplifted to support providers to invest in their business. Messages for the market: We will be developing a new approach to the way we commission, purchase and pay for services, including: - options for offering contracts for longer periods of time, for example, up to 10 years; - clear approach for pricing, fees, and uplifts; - working with providers to understand more about how the way we commission services impacts on the market*.'

- One of the principal **Lincolnshire** commissioning bodies has opened discussions (January 2021) with a local not-for-profit provider of care for people with learning disabilities on a land and capital basis. The authority has an active capital programme and will bid for NHS capital. Part of its rationale is to mitigate the high ongoing costs of learning disability fee packages with upfront capital and other contributions, to the extent permissible. The intention is to align interests, maintain a focus on care outcomes but ensure a sustainable business proposition for the provider.

- **Sheffield City Council** had flagged a capital partnership programme to local providers, which has been delayed due to the COVID-19 pandemic. It was however welcomed by several providers who expressed interest in land and building partnerships for new-build care homes.

- **Suffolk County Council** entered into a three-way agreement between the council, care home freeholders and an operator. In this case, SCC entered into block contracts with the operator for an initial term of 30 years from 2012. The arrangements first arose from the consolidation of older and inefficient council owned care homes. This saw the redevelopment of 12 existing homes (essentially the land on which they stood) into 10 new, purpose-built care homes spread across Suffolk from February 2013 onwards. The resulting care home portfolio was bought by two parties (five assets each), who were financial investors and who in turn entered into multi-decade FRI leases with the operator. Suffolk County Council agreed to contribute the land towards the development of the new homes in return for an operator agreeing to a block contract. This meant that

SCC could continue to service its waiting list filling beds in new homes at local authority prices whilst also enabling the operator to benefit from a share of private pay occupants across several of the homes. Each of the homes have had and continue to have a very strong relationship with Suffolk County Council with vacant contract allocated beds filled promptly from their extensive waiting list.

- **Bristol City Council** tendered for a programme of extra care housing development with the linked development of care and nursing home provision, with providers bidding for both capital, land and long-term fee levels as part of a 25-year contract for the buildings and support.

- **Cambridgeshire County Council** developed a programme of in-house care home developments in partnership with care providers using a mixed model of Council-funded and self-funded beds to generate long term commissioned beds at fee levels less than the open market.

4.3.3 Advantages and Disadvantages

Sheffield City Council

These options allow the Council to commission exactly the types of support that it required to meet long term needs. Closer relationships with key providers make market management simpler. There will remain a self-funder market which would enable care homes not part of these arrangements to continue to operate and offer care beds for local authority commissioning.

This approach also has a significant advantage of being able to commission beyond just care homes – for example, it would allow for core and cluster schemes for people with learning disabilities with a registered care home at the core supporting a range of community-based clustered supported living services, or in rural areas small “care centre” developments which combine small scale supported housing and care home provision, including community outreach.

The main disadvantage is risk, as the Council will be more closely tied to providers through funding agreements, so would have to cover the cost of vacant block-booked beds, for example. It requires detailed long term commissioning plans to ensure that there is not a costly over-supply and to ensure that there is not a shortage of care home beds which could also push up costs. Capital or land agreements or long-term block contracts need to set up carefully to ensure that they don’t contravene regulations on state aid / subsidy control.

Care Home Proprietors

Care proprietors who want to develop their services and have an interested in closer work with the local authority, this provides a route to capital investment and longer-term contractual arrangements. A managed decommissioning of unsuitable care home provision could allow an exit route for providers with options for new service provision where appropriate. A reduction in overall bed capacity would increase occupancy in care homes overall.

There is a risk that smaller providers that are not willing or able to engage with long term contracts or capital investment could be left behind. Small providers constitute the majority of current provision and contractual arrangements would need to reflect the ability of smaller proprietors to engage.

5 Key enablers required to deliver

These enablers have been developed through conversations with care home proprietors, commissioners and other stakeholders of the care home market in Sheffield.

1. The Council should consider an exercise to identify strategic care home assets (care homes or providers) in the market that are essential for maintaining commissioned care home bed supply or ensuring sufficient choice in the market to meet Care Act responsibilities. This would aid decision-making on support requests by care home proprietors.
2. All people spoken to noted that the care home market was undergoing a period of significant change and that a response to this change requires a level of intervention by the local authority that has not been required previously. The main purpose of this intervention is to ensure that the care home market continues to meet demand now and in response to demographic and commissioning change.
3. Care home proprietors individually, and via the Care Home Association, have highlighted the need for the Council to provide them with information on the care home market going forward on which they can base business decisions. Specifically, proprietors need to know what future commissioning intentions are regarding the quantity and type of care home beds.
4. Smaller proprietors need additional support to make business decisions because they may not have access to the advice and information networks that larger providers can either purchase or employ.
5. All proprietors noted a need to address long term issues about staff recruitment, in particular social care workers, nurses and skilled and experienced care home managers.
6. Most proprietors operating nursing homes noted concerns about the recruitment of nurses, and a number felt that the current model is not sustainable. Several options were mentioned, including better pay, closer links to NHS services for training and development and more flexible staffing models. Some of these options would require regulatory change that is out of the control of the local authority or CCG, although some areas of the country are developing more flexible clinical support arrangements for care homes that may make staffing within care homes easier.
7. Although the focus of the project was on care homes, care homes sit within the wider context of social care services for older people and a wider set of linkages across the Council. For example, several providers of supported living services for people with learning disabilities noted issues with planning in terms of identifying potential sites for services. Discussions about diversifying care homes for older people need to include discussions with the planning department as well as housing. Discussion of the use of Council-owned land or property requires liaison with the Economy, Regeneration & Culture department.
8. Several providers noted an ambition to develop their services but noted difficulties in obtaining capital, particularly at the moment when banks are unwilling to lend. Other Councils have made available capital grants to support the development of new services.
9. Sheffield is a diverse borough, with a range of urban and rural communities that have specific needs, including, in some cases, dedicated care and support services. The development of long-term strategies for service development needs to include dialogue with those communities about how their needs may best be met. Plans also need to

include arrangements for protecting services in the South of the borough where the population is less dense, and it may be challenging to operate viable services.

6 Supporting analysis evidencing the opportunities (A set of detailed summaries of data with analysis which sets out the rationale for all recommendations)

This report is based on a strategic review of the Care Home market in Sheffield undertaken between December 2020 and February 2021. The review included the following key tasks:

- Engage with care home owners and operators.
- Engage with the local authority, CCG, regulators and other professional bodies.
- Identify the best and most innovative operating and funding models for different care home markets and how these could be applied in Sheffield.
- Identify urgent, short, medium and longer-term lists of priority evidence-based opportunities.
- Produce a Care Home Market Development and Sustainability Delivery Plan.

This project was undertaken by Cordis Bright with support from Laing Buisson. Cordis Bright is a health and social care consultancy and provides consultancy, advice and research aimed at improving public services. LaingBuisson is a business intelligence provider across healthcare, social care and education.

7 Background – Market View

This section of the report provides an overview of the current care home market in Sheffield, including:

- Demographics
- finance and finding
- highlight findings from engagement with care home providers, Council and CCG staff and other stakeholders
- Summary and conclusions.

The aim of the report is to provide a view of development of the care home market at 1, 3, 5 and 10 years and the report sets details demographic and market trends based on these intervals.

The overall trends in social care over the period is a continuing growth in demand for social care as a result of a growing and ageing population. Alongside these changes runs a transformation in the way in which care and support is delivered, with a move away from care homes (residential care and nursing care) and to a model based on housing-based support, be that in the individual's ordinary housing in the form of home care, or in specialist supported accommodation such as sheltered housing or supported living schemes.

Between 2012 and 2020 there was an overall reduction in the number of residential care and nursing care beds per 100 of the population aged 75+ in Sheffield of 11.7 in 2012 to 9.7 in 2020 (at the Yorkshire and Humberside average and above the 9.6 England average), highlighting the long-term trend away from care home provision to meet the needs of the older adult population.

7.1 Demographics

Demographic information looks at both the supply of care home beds and the growth in the population in needs of care and support in historical terms and estimated future demand.

7.1.1 Covid-19

Covid-19 has made estimates of future demand harder to calculate because current care home occupancy and demand for care home places has been reduced by Covid-19. Historical data is useful to enable the changes brought about by Covid-19 to be placed in a historical context and might also help predict post-Covid-19 trends. Notwithstanding this, however, there is considerable uncertainty about the impact of Covid-19 on long term demand for care; in particular:

Are demand levels for care home places likely to return to pre-Covid-19 levels, particularly for people who self-fund care home places?

Will there be an increased demand or an increased complexity of need as a result of people delaying treatment or access to care homes?

It is likely to be several years before the impact of Covid-19 on care needs at an authority level is fully understood.

7.1.2 Care Home Supply and Demand

Historical Trends

The number of care home beds for older adults has reduced since 2012 both in absolute terms and as ratio of the number of beds per 100 of the population aged over 75:

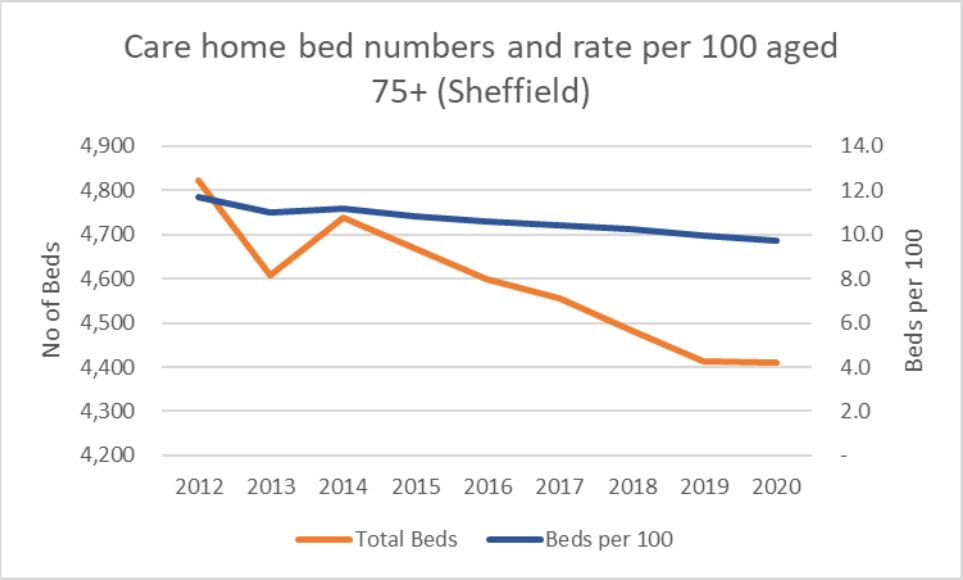


Figure 4 – Older Adult Care Home Beds and Care Home Beds per 100 of the 75+ population (Source: CQC, October 2020+

The fall in the number of beds per 100 of the 75+ population is in line with the Yorkshire and Humberside and the England rate.

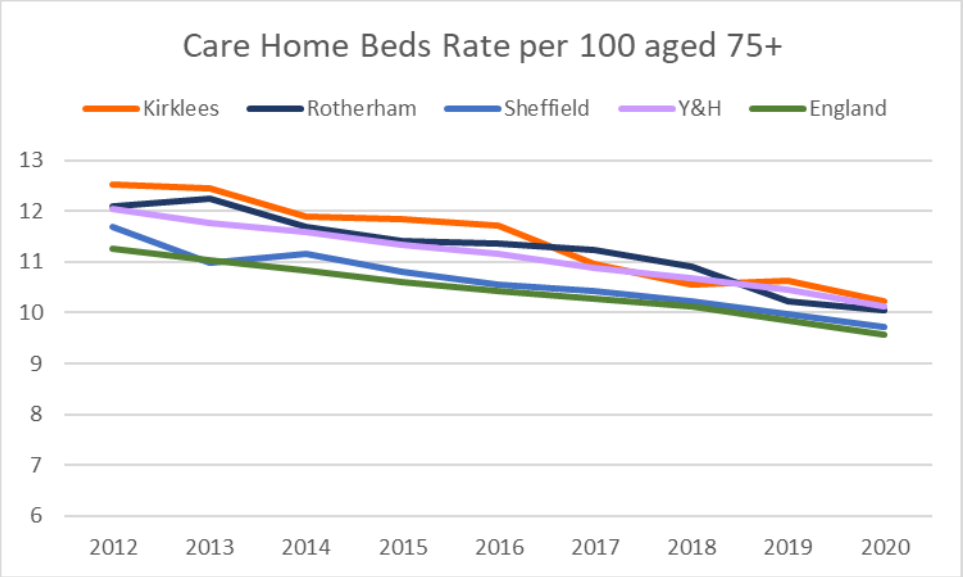


Figure 5 – Older Adult Care Home Beds per 100 of the 75+ Population - Comparative data (Source: CQC, October 2020)

Finally, absolute care home bed numbers have dropped over the period and there has been a corresponding increase in average occupancy across England until 2020 when occupancy was reduced by Covid-19.

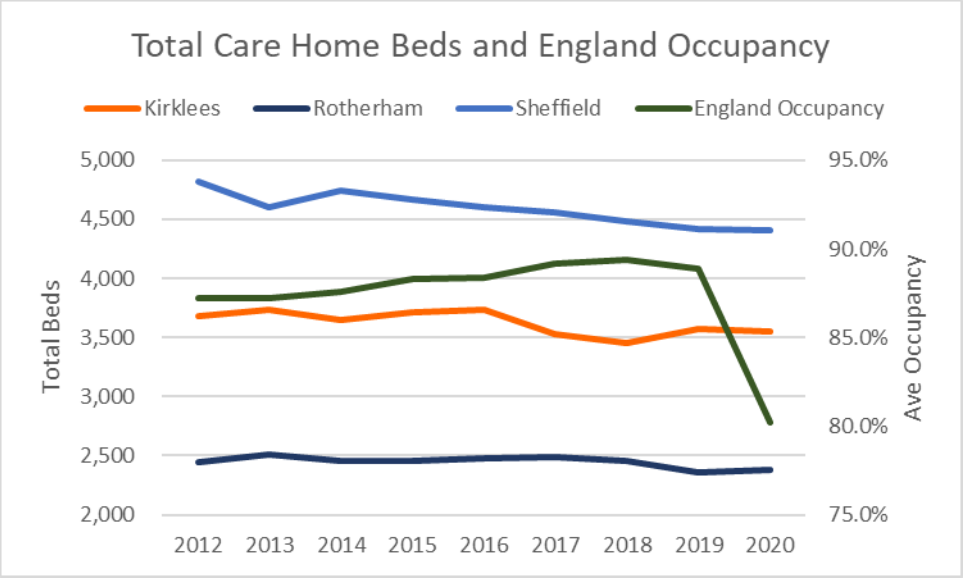


Figure 6 - Care Home Beds and England Care Home Occupancy 2012-20 (Source, Department of Health and Social Care, 2020)

Figures for 2019 from LaingBuisson show that overall occupancy for older adults in Yorkshire and Humberside was amongst the lowest in England:

Table 1.12
Average occupancy rates (occupied beds divided by registered beds) by region in for-profit and not-for-profit care homes for older people and dementia (65+), England 2019

	For-profit	Not-for-profit
North East	85%	86%
North West	86%	90%
Yorkshire & the Humber	81%	87%
East Midlands	82%	91%
West Midlands	86%	92%
East of England	84%	88%
Greater London	88%	91%
South East	83%	91%
South West	83%	85%
England	**84%**	**89%**

Figure 7 - 2019 Care Home Occupancy by provider type and region. (Source, LaingBuisson)

7.1.3 Future Trends

Future demand for care homes is affected by a number of factors, including:

- The growth in the population of older people which drives up demand for all care and support services including care home places. There is also an ongoing demand for self-funded care home places which would not be eligible for local authority support, although this part of the care home market has been significantly impacted by Covid-19
- The increasing supply of alternative provision of care and support, including home-based support (home care) and housing and support such as sheltered housing
- Changes in the desirability of different care options, particularly during Covid-19 but also a long-term trend.

These pressures are illustrated in the diagram below:

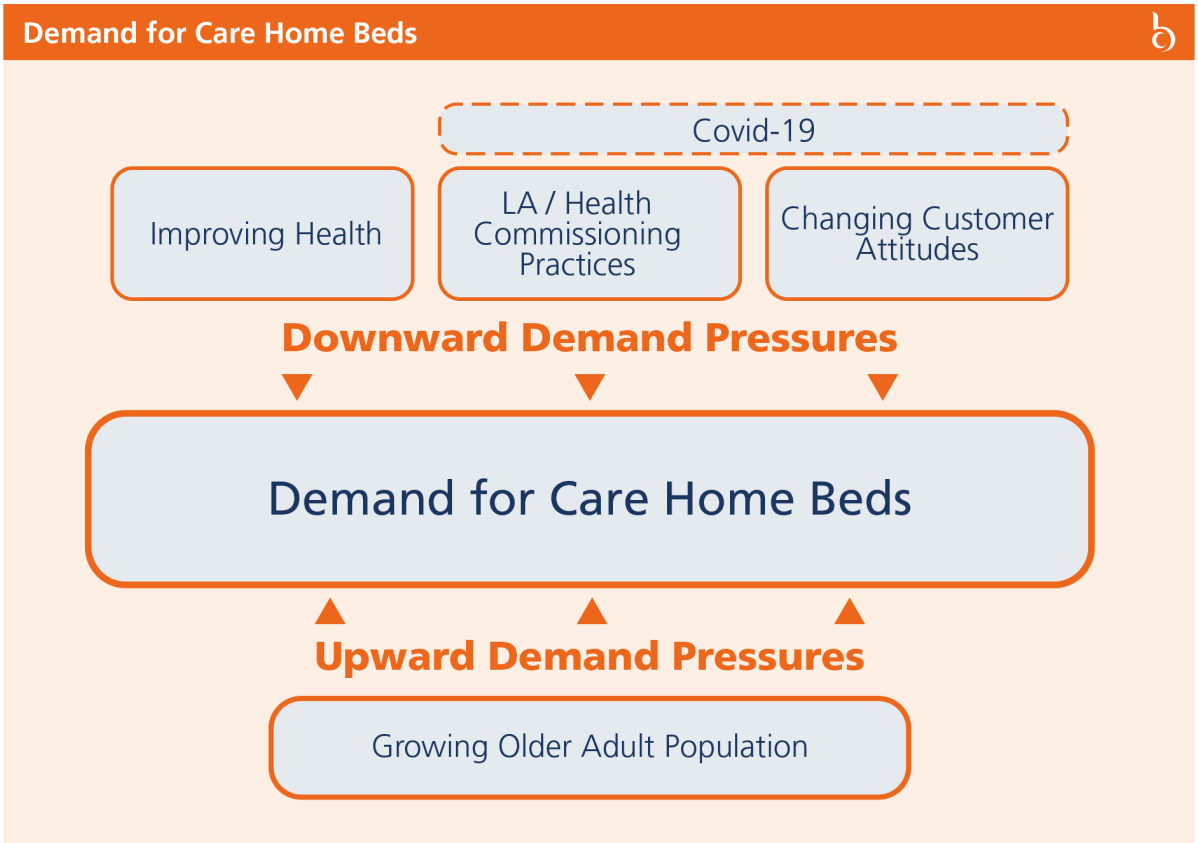


Figure 8 - Influencing factors in the demand for care home beds

For England, the number of new requests to social services for support has increased year on year since 2015-16. For Kirklees, Rotherham and Sheffield, the number of requests for support have varied year by year.

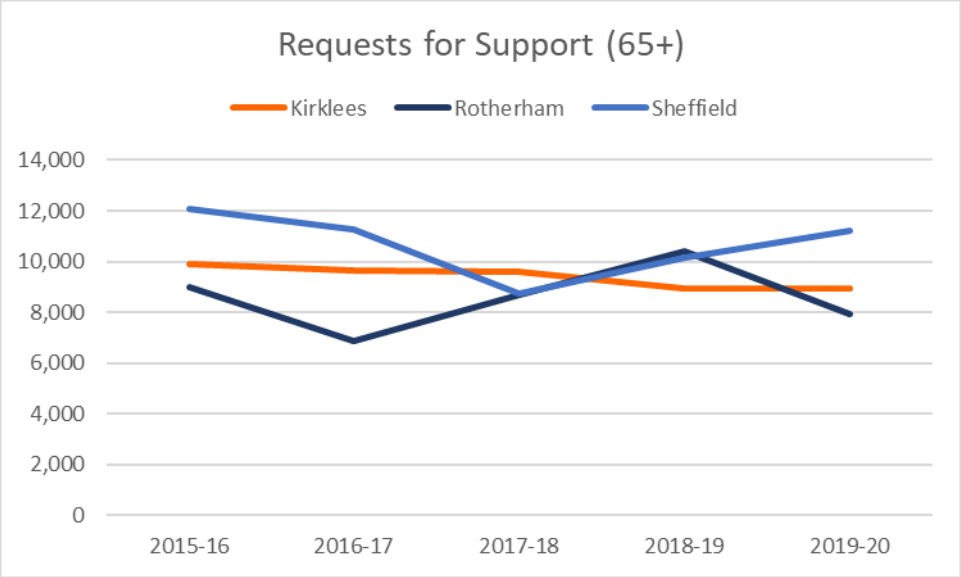


Figure 9 - Number of requests for social care support for people aged 65+ 2015-20. (Source, SALT Data, NHS Digital)

Looking specifically at the population aged 85 and over, who are most likely to have care needs and be admitted to a care home, the population is due to rise year on year through to 2043:

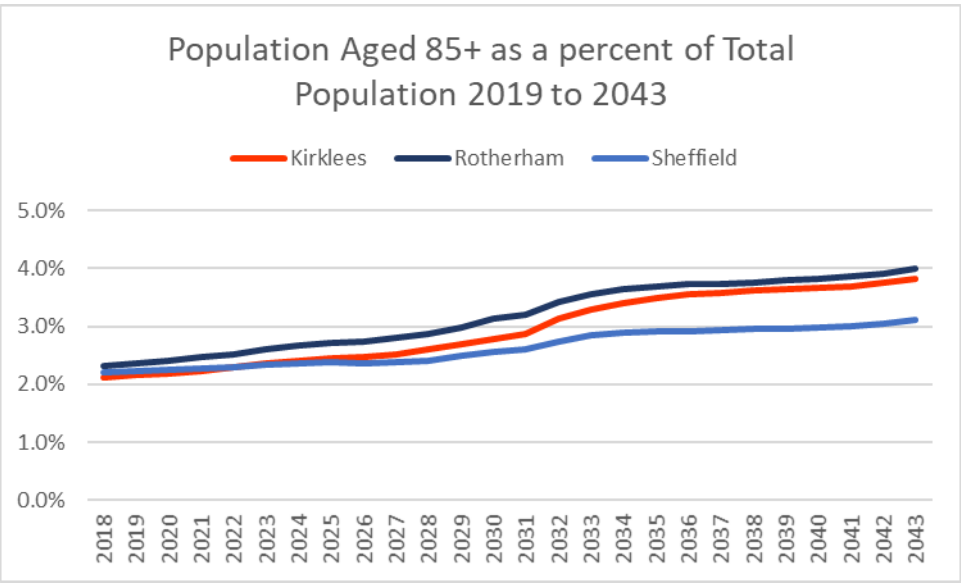


Figure 10 - Population aged 85+ as a percentage of the total population, 2019 to 2043 (Source, ONS Population Forecast, 2019 Mid-Year Estimates)

In number terms, this means, for Sheffield, an increase in the 85+ population of 368 from 2020 to 2022, 1770 from 2020 to 2025, and 1,836 from 2020 to 2030.

In 2018 it was estimated that just under 15% of over people aged 85 and older were in a care home, compared to 25% in 1996.

These downward trends have driven the reduction in overall care home beds over recent years. The impact of Covid-19 has had a significant impact on care home vacancies, particularly in Nursing Homes, where turnover of residents is higher and the impact of significantly reduced referrals from both Council-funded and self-funded residents has been felt most acutely.

Assessing Future Care Needs

Traditional care needs forecasting has been based on the age of the population because the care needs of people increase as their health and mobility of people decreases with age. However, as the Brookings Institute found, looking purely at the age of the population is not a good indicator of care needs, and two areas with similar numbers of older people aged over 85 may have very different patterns of care demand. The Brookings Institute found that proximity to end of life is a far better predictor of care needs, and that most care needs arise in the last year of people's lives.

An approach to measuring likely care needs based on proximity to end of life means that other factors, such deprivation and poor health, are taken into account. We have therefore based predictions of care needs on people aged within one year of average life expectancy for the locality and above. In general, basing care needs projections on proximity to end of life will increase the number of people expected to have care needs in more deprived localities where life expectancy is lower. For example, in Sheffield, where average life expectancy is 80.6, the population within 1 year of average life expectancy and above (79.6 and greater) and expected to have the highest care needs is much higher than that predicted by looking at the 85+ population. In Sheffield, in 2020, the 85+ population is estimated at 13,295 people, compared to 27,176 who are over 79.6 (Average Life Expectancy less one year).

The maps below show the estimated older adult population with a care need from 2020. population. The care demand is estimated at 12% of those with the highest needs. It is based on the 76 Middle Layer Super Output Areas in Sheffield. A table of these, with the population figures for each year, is in Appendix 1. The location of care homes is shown with a dot – orange for care homes and cyan for care homes with nursing.

The maps below are based on Middle Layer Super Output Areas (MSOAs). Each MSOA covers on average 7,500 people 3,000 households, and there are 70 of these areas in Sheffield.

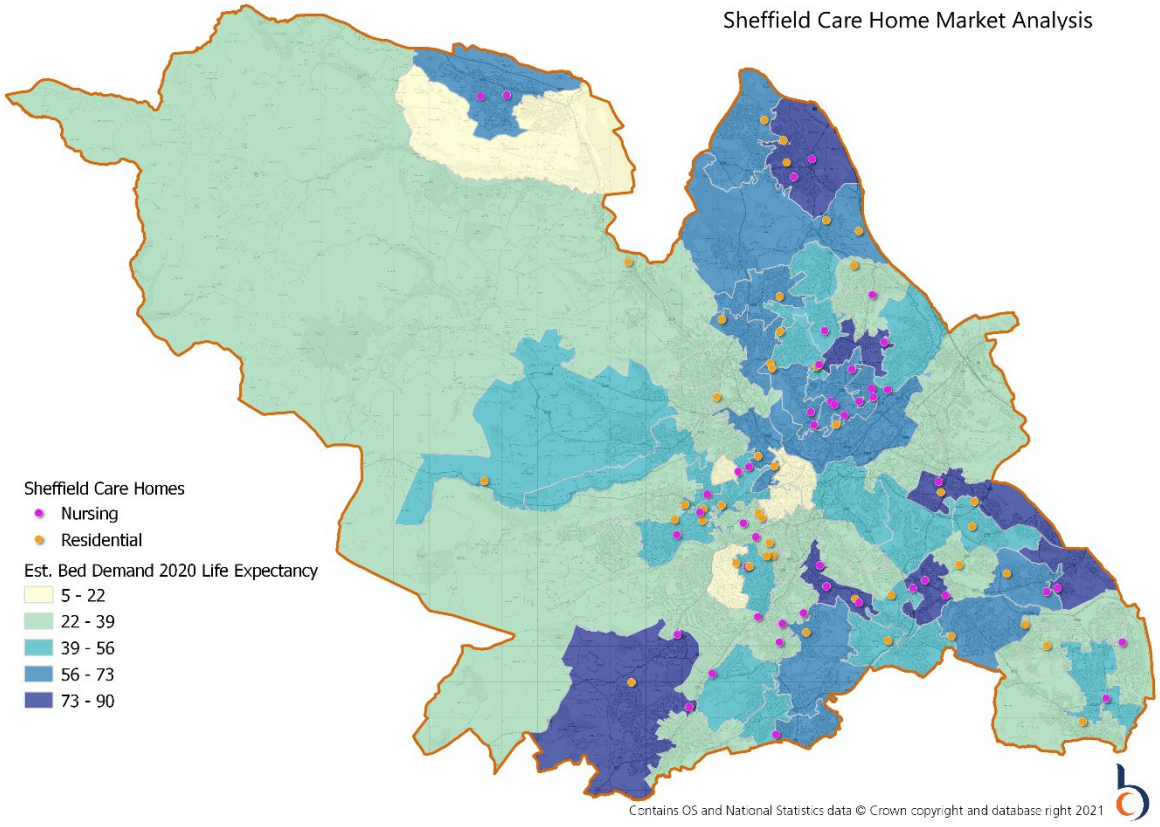


Figure 11 - Estimated older adults care demand and the location of older adult care homes in (Source: CQC October 2020, ONS mid-year population estimates 2019)

The following map shows the same data but shows the relative size of individual care homes through the size of the circle.

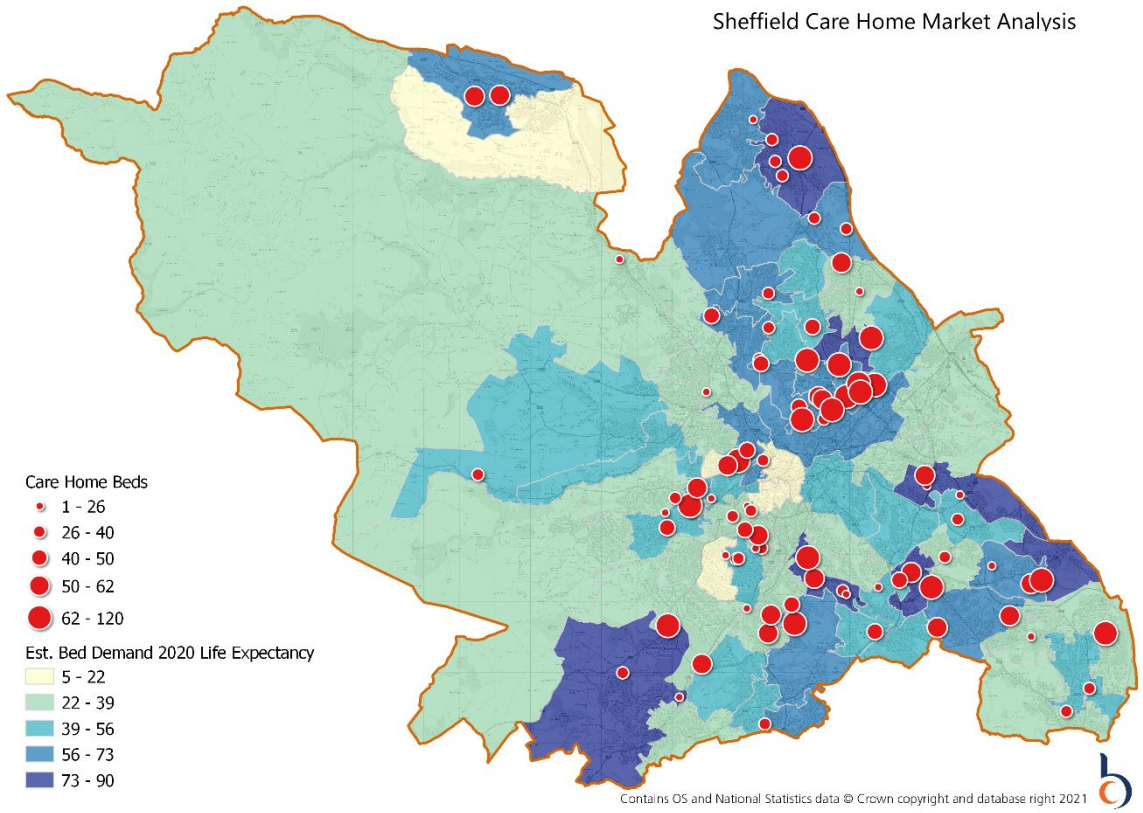


Figure 12 - Estimated care demand and the size of care homes in Sheffield (Source: CQC October 2020, ONS mid-year population estimates 2019)

Comparison of Approaches – Kingsbury Hill Fox and LaingBuisson

The approach to calculating care home bed demand used by Kingsbury Hill Fox is based on the percentage of older people going into care home based on age band. The most recent data on the percentage of care home admissions by age appears to be based on the 2011 Census, since when there has been a continuing drop in demand for care home places, as a result of changes in care needs in the population and changing commissioning patterns. The main criticism of this approach is that it does not take account of differing life expectancy across areas, commonly associated with the level of deprivation in area.

The table below uses care home population percentages to estimate demand for care home beds based on 2019 mid-year population estimates. The first figure looks at the overall 65+ admission rate at 3.2% before breaking it down into age groups:

	Percentage Care Home Rate	Total Beds
ASD 65+	**3.2%**	**3,022**
ASD 65-74	0.6%	294
ASD 75-84	2.8%	903

ASD 85+	13.7%	1,798
ASD Total by group		2,995.45

Figure 13 - Age Standardised Demand estimates Source: ONS 2019 mid-year population estimates, 2011 Census Data)

Broken down by area, this results in the following map, which is very different to the one based on proximity to end of life above:

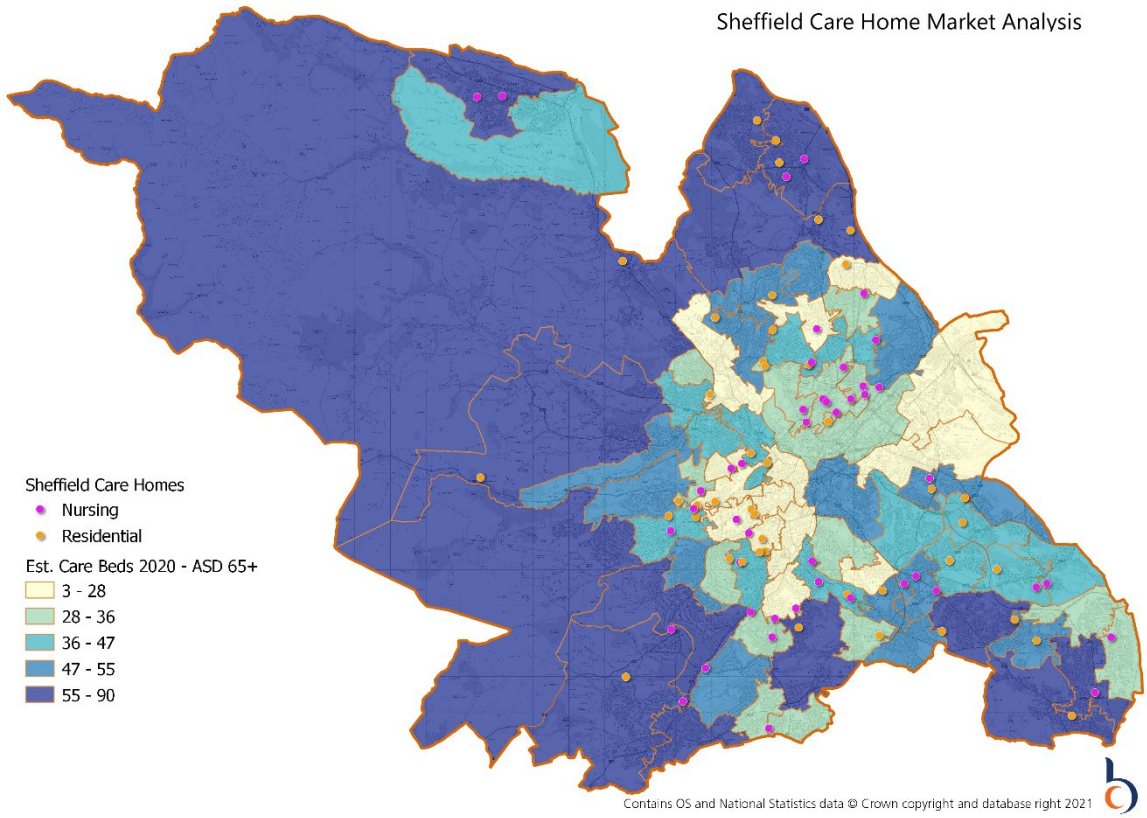


Figure 14 - Care Home Bed demand based on Age-Standardised Demand (Source: ONS 2019 mid-year population estimates, 2011 Census Data)

A comparison of the two methods of calculating care home demand is below:

Year	Kingsburyt Hill Fox ASD	LaingBuisson Proximity to EoL
2020	3,056	3,261
2022	3,155	3,332
2025	3,308	3,465
2030	--	3,716

As noted above, demographic pressures are only one of the demand drivers for care home placements, and possibly the least significant one, with changing commissioning practices by local authorities and CCGs driving the largest change in demand levels.

There are a number of ways to explore the number of care home beds in the Borough. The map below shows the number of beds per the 85+ population based on 2019 mid-year estimates:

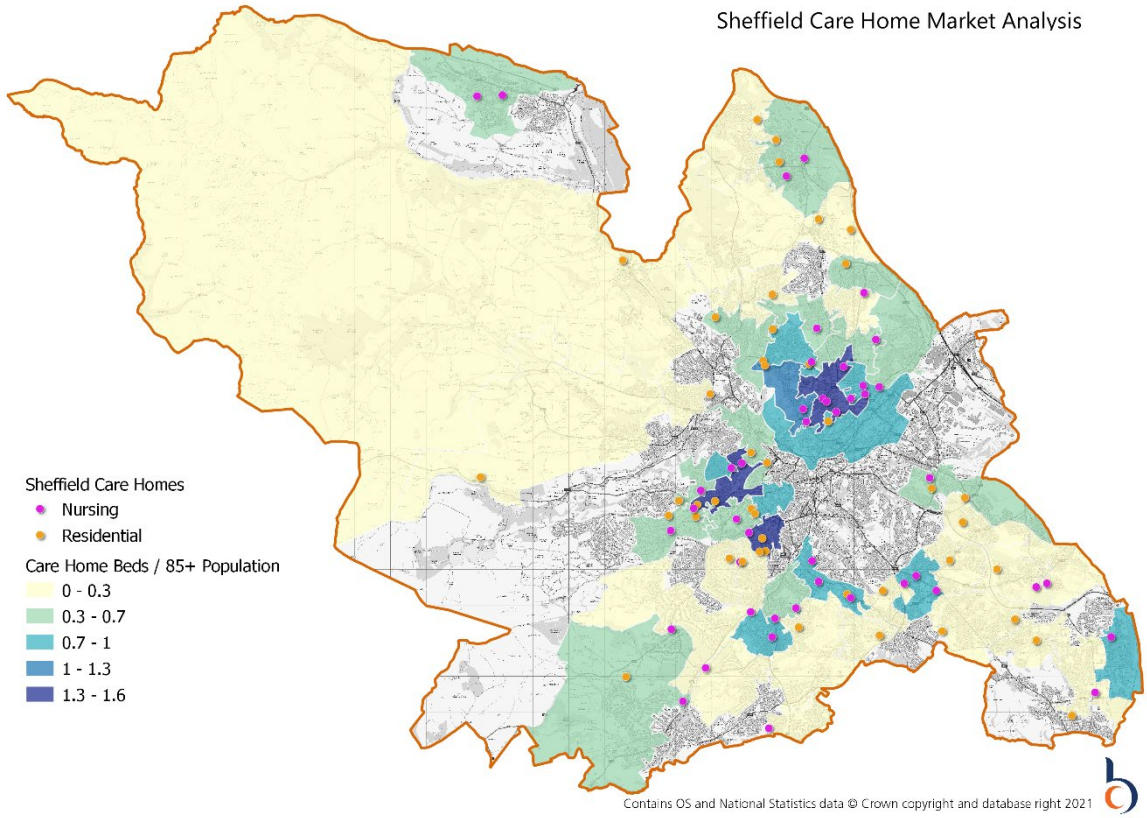


Figure 15 - Care Home beds per the 85+ population by MSOA (Source: ONS 2019 Mid-Year Estimates, CQC Data February 2021)

Comparing these figures with authorities in the Yorkshire and Humberside Region and the Core Cities Group, Sheffield is below the average for beds per 85+ of the population. However, it is important to note that these figures are pre-Covid and the care home market is changing rapidly.

Looking at commissioning activity in the Core Cities and within Yorkshire and Humberside, Sheffield is just above the Yorkshire and Humberside average of 6,265 bed weeks commissioned per 1000 of the 85+ population with 6,359 bed weeks commissioned (equivalent to 24 beds per year). The Core Cities average is 7,678 bed weeks commissioned, so Sheffield's rate is one of the lowest.

The maps below show care need levels across the Yorkshire and Humberside, ranking the number of people with care and support needs in quartiles. The first map shows the

Yorkshire and Humberside region, and the second focuses on the authorities in the west of the region:

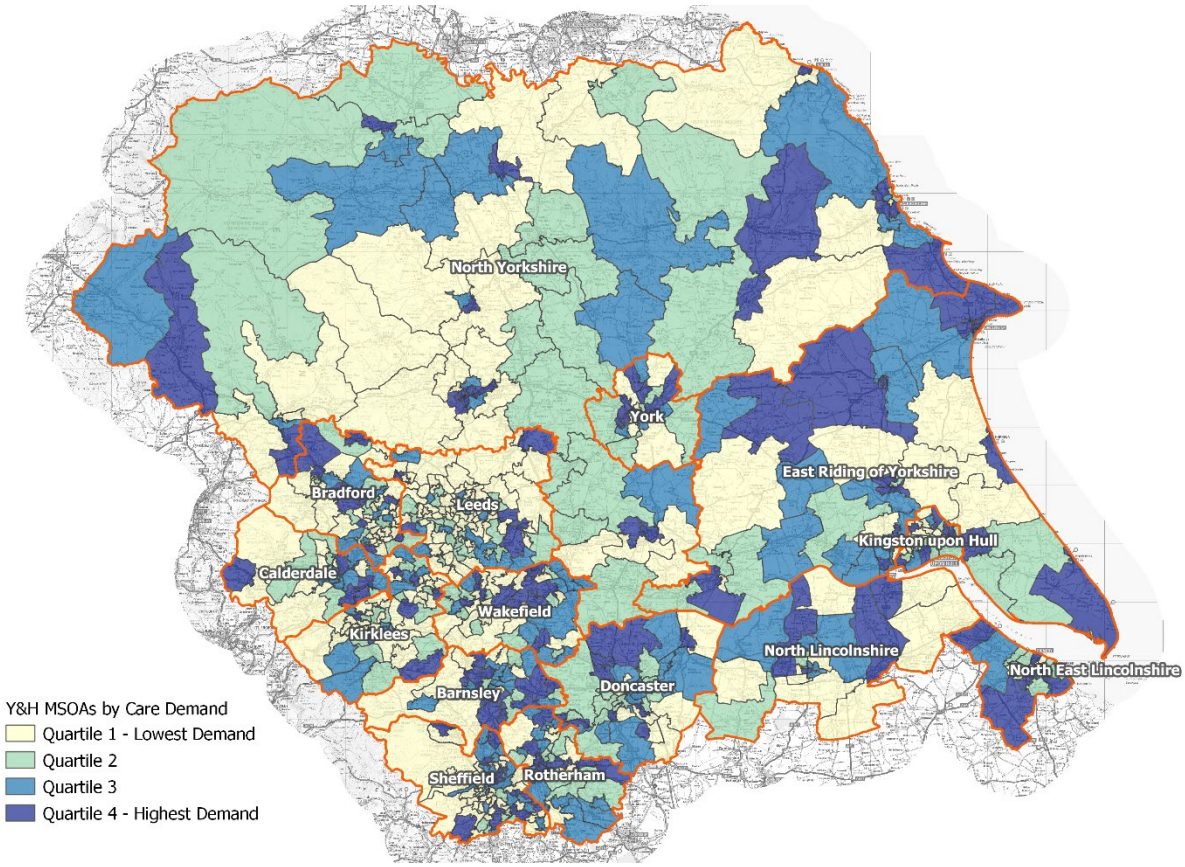


Figure 16 - Care Demand in Yorkshire and Humberside by MSOA, ranked by Quartile of demand.

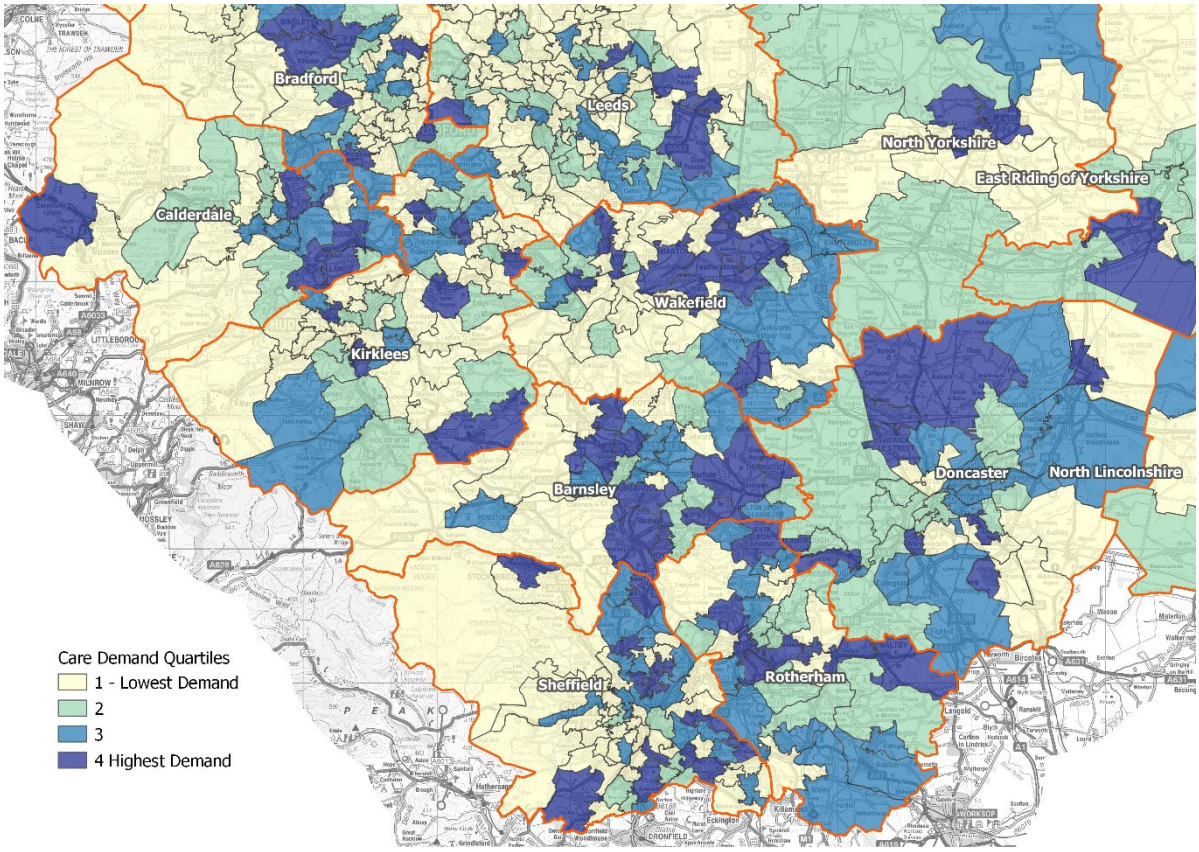


Figure 17 - Care demand in the western authorities in Yorkshire and Humberside

Sheffield is in the middle group of authorities in terms of the number of MSOAs in the top quartiles (Quartiles 4 and 5), with 40% of MSOAs falling into these quartiles.

Authority	Top Quartiles %
East Riding of Yorkshire	65%
Scarborough	64%
Barnsley	60%
Rotherham	58%
Doncaster	51%
Craven	50%
Richmondshire	50%
Ryedale	50%
York	50%

Harrogate	48%
Calderdale	44%
Wakefield	44%
North Lincolnshire	43%
Sheffield	40%
North East Lincolnshire	39%
Hambleton	36%
Bradford	33%
Kingston upon Hull, City of	31%
Selby	30%
Kirklees	27%
Leeds	18%
Yorkshire and Humberside	40%

Figure 18 - Yorkshire and Humberside local authorities ranked by the number of MSOAs falling into the top quartiles (4 & 5) for estimated care demand

The following three maps show the change in the population in percentage terms in 2022, 2025 and 2030, all relative to 2020 figures. The change in population with a care need reflects the average life expectancy of individual areas:

Percentage Care Demand Change 2022

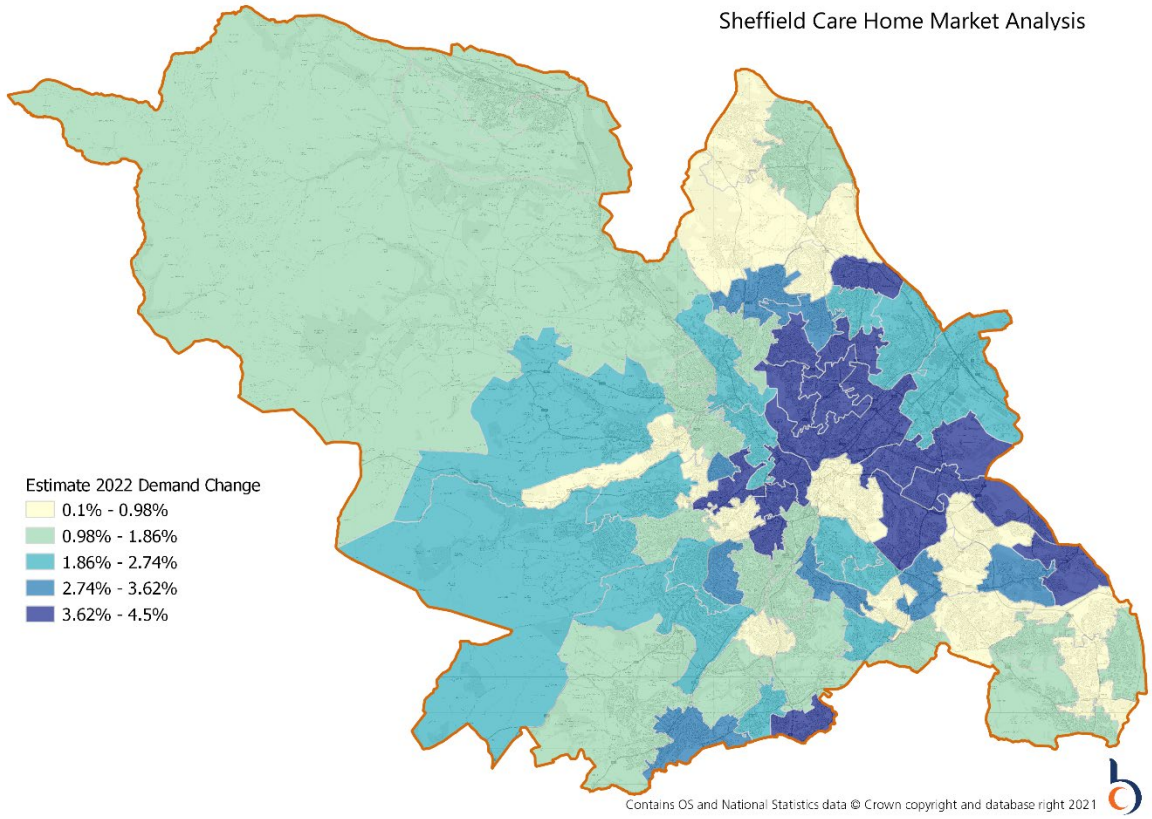


Figure 19 - Estimated percentage change in care demand by MSOA 2022 (Source: ONS mid-year population forecasts 2019)

Percentage Care Demand Change 2025

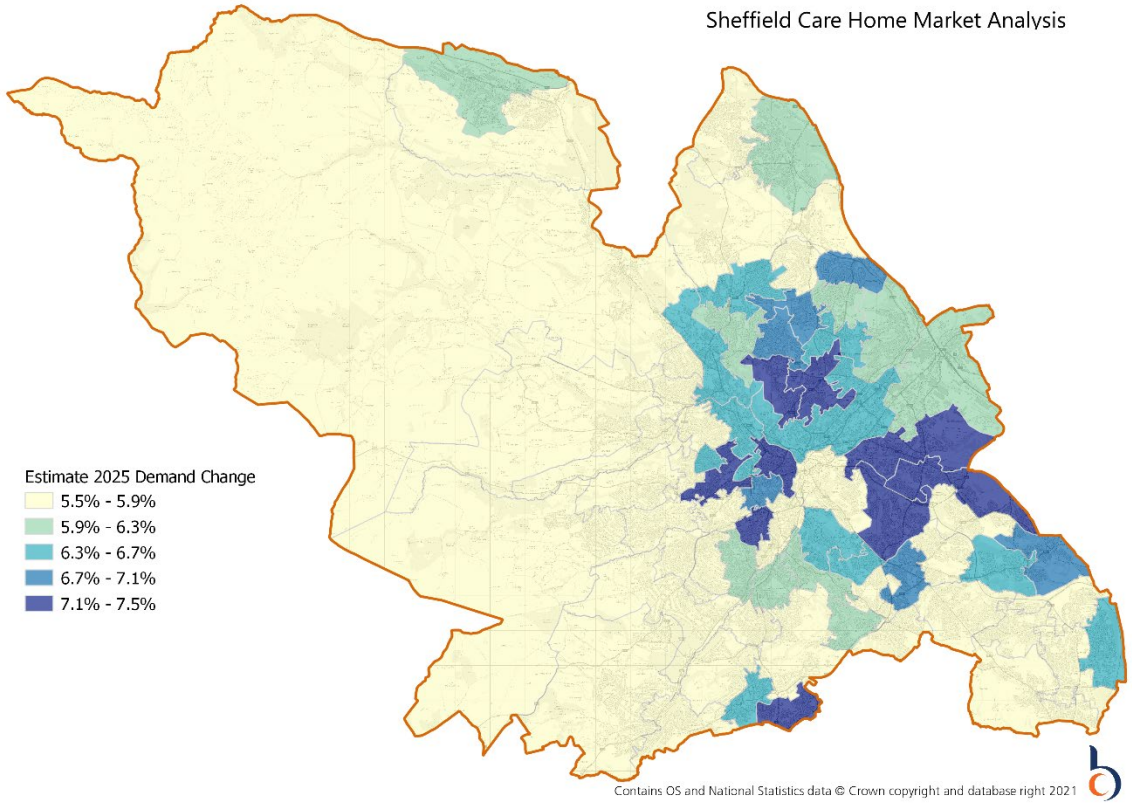


Figure 20 - Estimated percentage change in care demand by MSOA 2025 (Source: ONS mid-year population forecasts 2019)

Percentage Care Demand Change 2030

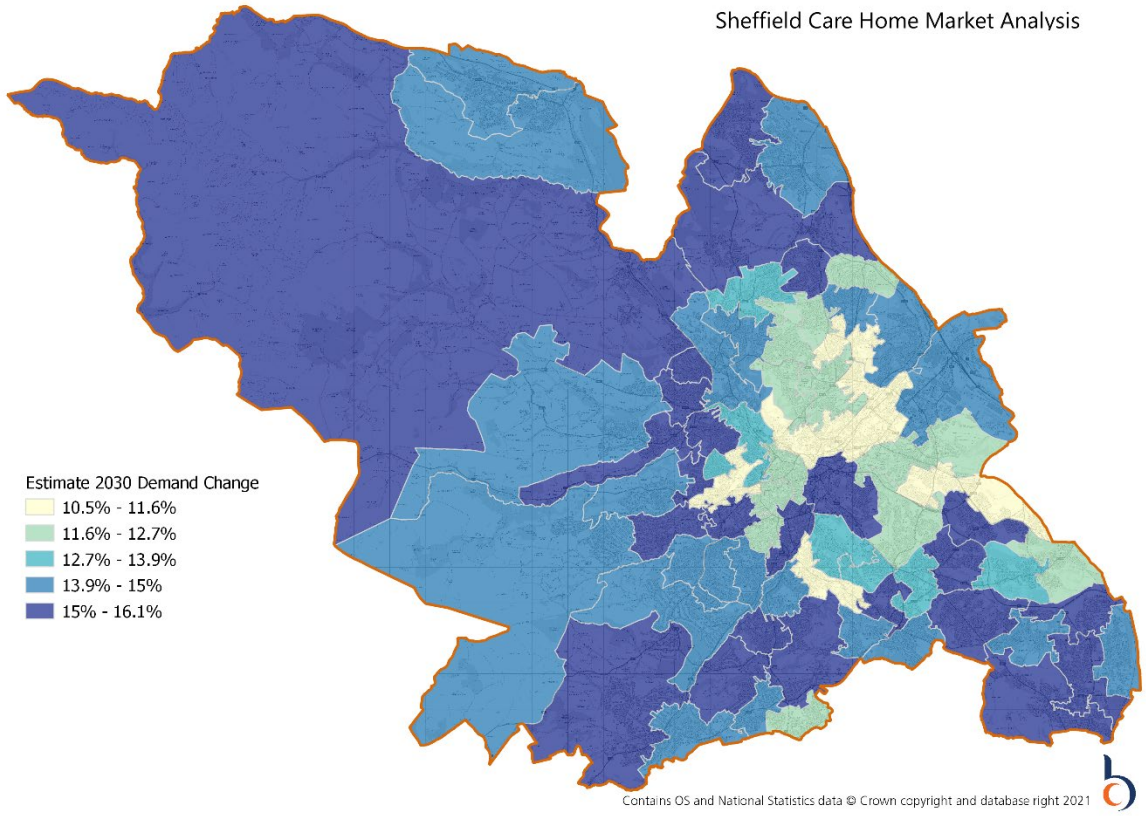


Figure 21 - Estimated percentage change in care demand by MSOA 2030 (Source: ONS mid-year population forecasts 2019)

Finally, the chart below looks at the change in the care and support needs of the population per year between 2019 and 2043, based on ONS Mid-Year Estimates for 2018. The DFLE line is the people who are aged above the average Disability Free Life Expectancy for Sheffield, which is 62 years for the whole authority. Above this age, demand for support may be expected to increase. The care population is as above.

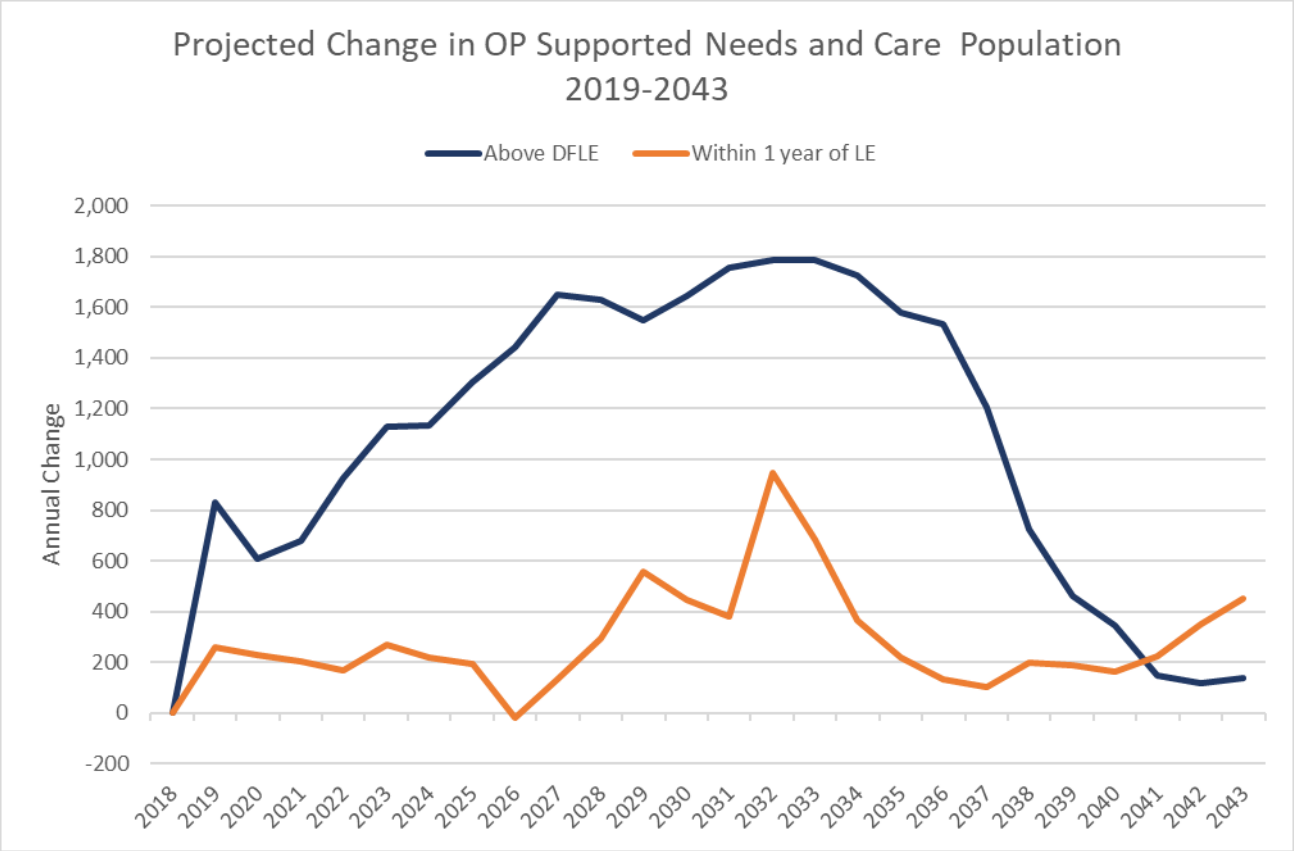


Figure 22 - Projected annual change in number of older people with a care need, 2019-2043 (Source, ONS Population estimates, Life Expectancy data from ONS 2015)

The spike in the population within 1 year of average life expectancy and over is due to a large population that is currently in their early-70s reaching 79 and falling into the care needs group.

There is a large variance in disability free life expectancy across the borough, which may have an impact on the targeting of preventative measures or the location of supported housing services for people who cannot manage in their own homes due to disability. This range is illustrated on the map below:

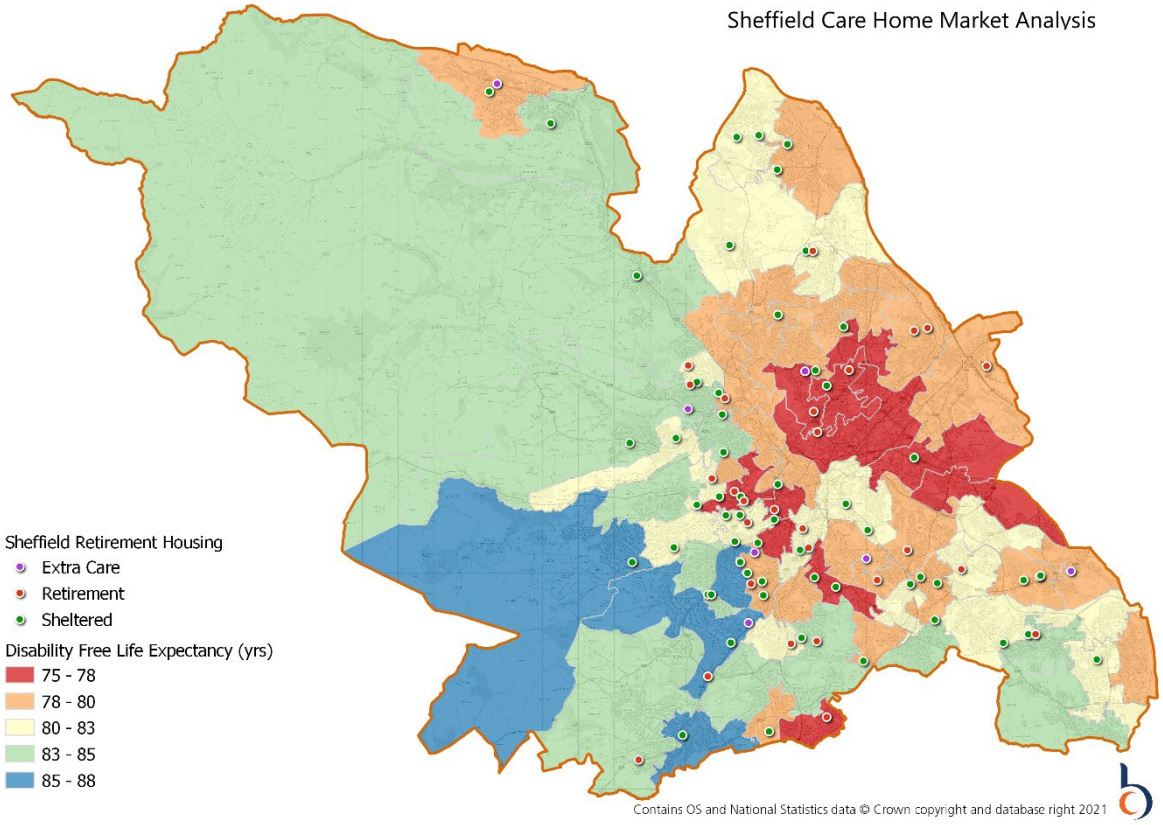


Figure 23 - Map of retirement housing locations and disability free live expectancy by MSOA in Sheffield (Source: Housing data from EAC, DFLE data from ONS, 2015)

7.1.4 Dementia Care

The map below shows the reported Dementia Prevalence rate (as a percentage of the patient list for each surgery) for 2019/20 for reporting GP practices in Sheffield, taken from QOF data. This data collection is optional, so not all GP practices participate.

This dementia prevalence percentage of individual GP practices is reflected in the size of the marker (in red). The map also shows the location of care and nursing homes. Note that some of this prevalence will be a reflection of the presence of care home residents on the individual GP practices' lists, so where there is a reporting GP practice close to the location of a care home it would be expected to see a higher prevalence.

The map does suggest that dementia prevalence reflects the age-related demand of the general population and that in most areas there is care home provision in proximity areas where there is greater dementia prevalence.

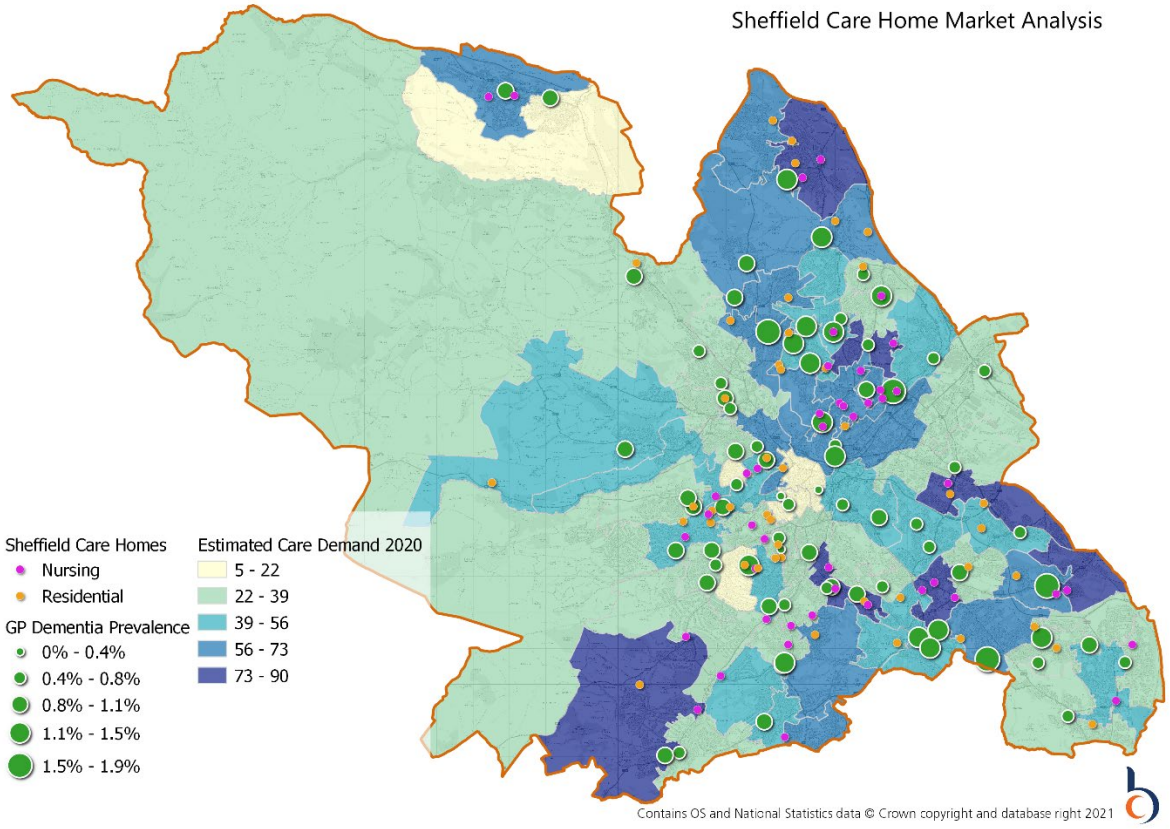


Figure 24 - Dementia Prevalence by GP Practice (Source: QOF 2020, NHS Fingertips)

Work undertaken by the Cognitive Function and Ageing Study (CFAS) undertook a two decade incidence comparison for older people aged 65+ with dementia and found a 20% drop in the incidence of dementia over the period, driven largely by improvement in the health of people aged 65+, particularly men. Notwithstanding this, CFAS estimate that there will be 209,600 new cases of dementia each year in the UK.

There is also evidence from a range of studies of increasing "compression of morbidity", which is a reduced amount of time spent in worse health[3]. This has implications for care home admissions which have already been identified by providers, in people being admitted later with more complex needs. This means that although the number of people eventually being admitted to a care home may remain stable, the length of stay reduces, which results in less overall occupancy.

7.2 Population and Demand Summary

Care needs will increase across the authority each year between 2020 and 2030, in line with the region and England as a whole. Although Covid-19 will have reduced demand in

[3] See for example "Health, functioning, and disability in older adults—present status and future implications", Chatterji, Byles, Cutler, Seeman and Verdes, The Lancet, Volme 385, issue 9967, February 2015 - https://doi.org/10.1016/S0140-6736(14)61462-8

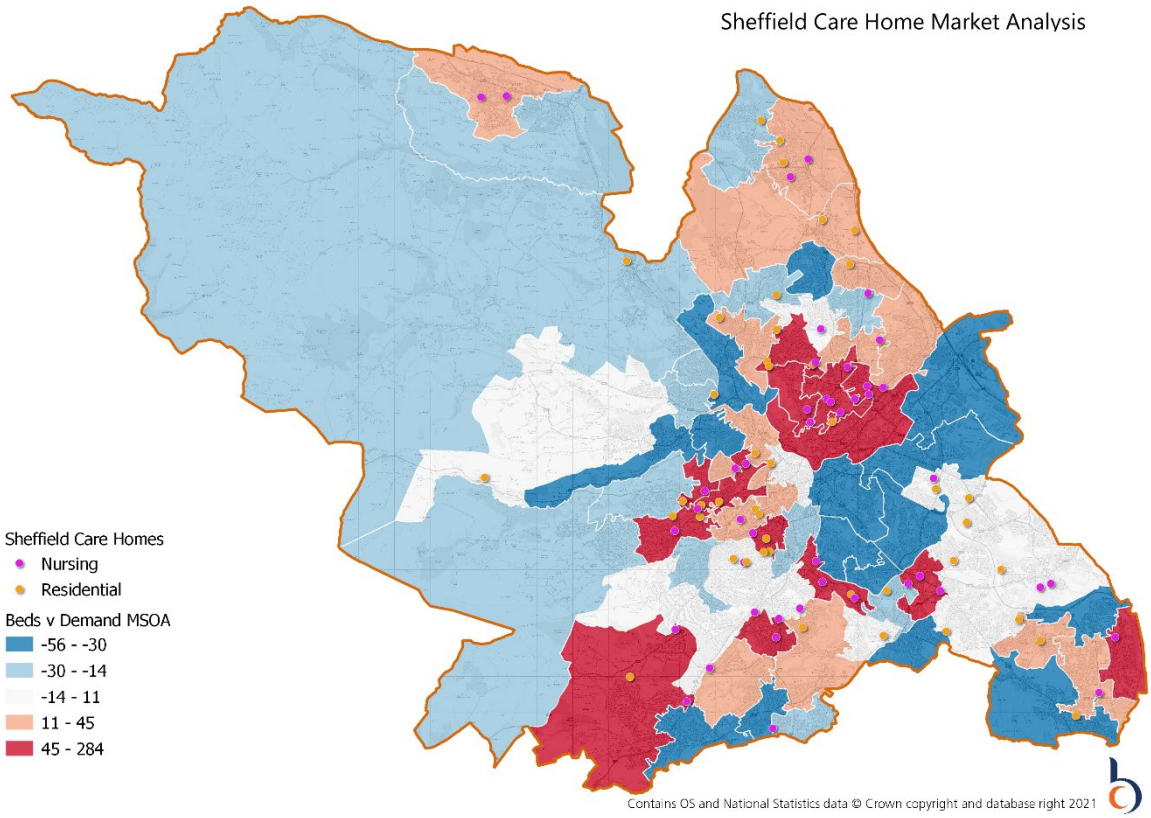
2020/21 overall, it is likely that has delayed demands for care, rather than removed them, so the figures for 2021 are likely to be higher.

In terms of demand for care home beds, it should be noted that these increases in population have been increasing demand for care year on year for the last 10 years, during which time demand for care home beds has been falling. There is nothing to suggest that this trend will change and there will be a continued reduction in demand for care home beds over the next 10 years, driven by a combination of a focus on a "home-first" approach to care for older people, and a change in customer demand for care home placements driven mainly by the improved availability and reliability of home care services. Covid-19 has accelerated this shift away from care homes by people with care needs and demand is likely to increase again as the risks of Covid-19 are diminished over the next 12 months, but demand is not likely to return to pre-Covid-19 levels.

7.2.1 Care Home Bed Requirements

Older Adults (65+)

The map below shows the current supply of care home beds relative to estimated demand for beds by MSOA. Areas in shades of blue have an overall undersupply of care home beds (the darker the shading the greater the undersupply. Areas shaded in pink or red have an over-supply of care home beds. Overall, the over-supply of beds is greater than the undersupply. Areas with current undersupply of care home beds are also those areas which will have longer term increases in potential demand.



There are currently 4,105 care home beds in Sheffield (CQC Data February 2021). Based on the current (December 2020) occupancy of 75%, 3,079 of these are occupied, with 864 vacancies.

Were this to become the new baseline care home bed demand, then based on 90% average occupancy, which is the assumption most providers work on, there would need to be 3,241 care home beds in Sheffield. Based on the number of beds per 100 of the 75+ population, this would be 7.14 beds per 100. This compares to the current rate of 7.67 beds per 100 for England based on the 80.2% occupancy.

This is the worst-case scenario, and it would be reasonable to assume that demand returns to some extent in 2021. Assuming that occupancy rises to 83% in Sheffield, there would be 3,407 occupied beds and 698 vacancies. Based on budgeted occupancy of 90%, there would need to be 3,786 beds, with an overall reduction based on the current 4,105 beds of 319. This would represent a rate of 8.34 beds per 100 of the 75+ population. The pre-Covid-19 2020 rate for England was 9.6.

The likely increase in the population with the highest care needs in Sheffield is 72 by 2022, 154 by 2025 and 324 by 2030. This means that unless there is a reduction in beds now, occupancy is likely to be significantly below 95% for the next 6+ years, assuming that the proportion of people admitted to a care home remains at pre-Covid-19 levels.

In the short to medium term, health improvements are likely to reduce the number of older people with care needs likely to require a care home admission, before taking into account changes in commissioning practices arising from the “home-first” approach to meeting care and support needs. The impact of Covid-19 is likely to further reduce demand for care home support, both as a result of people choosing not to move to a care home for fear of inflection, but also because of the deaths from Covid-19 within care homes and amongst older people living in the community.

Demand for care home places who pay for their care themselves is particularly hard to estimate and given the likelihood of impacts of Covid on care homes continuing through the remainder of 2020, it is probably that future demand will not be understood until 2022.

7.3 Funding and Finance

7.3.1 Overview

From a funding and finance perspective, 2020 has clearly been a very challenging year for care home operators in Sheffield, and across the country. There were challenging trading conditions at the beginning of the year, even before the first wave of the COVID 19 pandemic. Since then, the cumulative effects of the first and second wave have been widely summarised by many operators as ‘occupancy down, costs up’. This, coupled with limited, temporary support from most local authority payors, has affected operators at a home level and at a corporate level.

7.3.2 Macro/Corporate Financing Landscape

Care homes operated by private companies invariably rely on (1) cashflow from operations, (2) banking facilities, and (3) the ongoing support of equity shareholders, with the latter typically private or family investors or private equity sponsors. The three core funding pillars are interrelated and weakness in one affects the others.

In 2020, the elderly residential care market has seen general weakness in cash generation, as occupancy has fallen and therefore profitability; this is turn has led to a reduction in banking covenant headroom and the need for many operators to revisit their banking facilities. Some operators managed to obtain either revised covenants, or waivers to covenants; some also obtained loan facility payment holidays during Q2 and Q3 of 2020, but these are very likely to have ended by Q4.

The environment for new loans to care home operators, which range from development financing, term loans, refinancing facilities and revolving credit facilities very quickly turned negative at the start of the pandemic in Q2 2020. Since then, several 'high street' lenders have effectively closed their loan books to new business; others have kept dialogue going with prospective borrowers, but in most cases solely for standard and well-supported lending propositions. Development finance constraints will mean fewer new care home beds being brought to the market. The general appetite has been weak, despite the a favourable macroeconomic low-interest rate landscape. The lending environment is unlikely to improve until mid-/late-2021, with the added complexities of Brexit returning to overshadow the market.

There has also been a subdued equity picture including weak mergers and acquisitions activity, which was in part an overhang from 2018-2019 when the largest care home transactions, including the putative sales of Care UK, Barchester and Four Seasons Healthcare failed to materialise. The current year has seen selective divestments of small care home groups but at reduced multiples of EBITDA, the normal valuation metric for the sector. Examples of this trend are Four Seasons' divestment of homes in the North West and Greater Manchester, and similar disposals by Barchester Healthcare in the North West.

The exception to the overall subdued market transactions picture in 2020 has been a flurry of transactions in the learning disabilities arena, which we address separately.

7.3.3 Major Operators

The major, systemically important care home operators, also referred to by the Care Quality Commission as 'difficult-to-replace' by virtue of their size (typically 50-plus homes), include the likes of Four Seasons Health Care, HC-One, Barchester Healthcare, Anchor Hanover and Care UK. They have provided regulatory filings and anecdotal updates throughout 2020 which give a broad indication of market sentiment, which are likely to be similar to the larger regional operators that operate in Sheffield. One major operator told us:

'Occupancy has been painfully low, but we haven't had the spike in deaths in Wave 2. In Wave 1 there was a high spike in death rates, a very high number of discharges and a decline in admissions. In Wave 2, there has been a very small death rate and admissions have dried up again in November and December….Occupancy is sliding again now and somewhat undoing the hard work done over the summer' [He added he expected a better picture in the New Year and the impact of the vaccine rollout].

In September 2020, Care UK, which operates 112 care homes with circa 7,200 beds, reported: 'During March to June, occupancy rates were significantly impacted, with death rates materially above historic levels. Subsequently during July to September occupancy levels have improved, although still remain below pre-COVID levels. In addition, operating costs have been impacted by increased cost of procuring PPE and sanitisation.

The impact of the virus has had a significant impact on Care UK's profitability and cashflow.' It went on: 'the Directors cannot readily predict the longer-term impact of the crisis upon the Group, including: What the NHS / Local Authority and self-pay medium to long term demand for vacant beds will be; What the further impact of the crisis, including a second wave, will be on the death rate and occupancy levels within the Group's care homes; What the further impact of self-isolation, care home isolation and other social distancing measures, including PPE and sanitisation, will have on operating costs, particularly in light of a second wave.'

Care UK's directors also noted that they 'consider the downside risks of COVID-19 on the group's occupancy levels and cashflows and the impact this might have on the group's ability to meet its bank covenants to represent a material uncertainty that may cast doubt on the Group and the Company's ability to continue as a going concern…' It is noteworthy that Care UK's time horizon is as follows: 'These forecasts assume that occupancy returns to pre-Covid-19 levels by August 2021, including through the opening of new homes, with tight management of labour costs to accommodate increased running costs due to PPE and sanitisation.'

Four Seasons Health Care issued a trading update in mid-November 2020, which painted a broadly similar picture. The company said: 'Whilst we began to see a move towards normality during the back end of the summer, the onset of a second wave of [COVID-19] has meant a return to more difficult operating conditions.' Four Seasons' care homes business 'has been significantly affected by the impact of COVID-19' in three areas: occupancy decline, increase in care costs and payroll costs. Regarding occupancy: 'Reduced occupancy levels, with Q2 2020 closing spot occupancy of 79.8% representing a c8.5% decrease from the opening occupancy of 88.3%. Occupancy only partly recovered during Q3 2020, with a closing spot occupancy of 80.8%. The decline is consistent with that seen by other operators…Admissions, which dropped to c70% below pre Covid-19 levels, had recovered to levels which were only slightly lower than historical levels by September. However, recent KPIs show a decline in admissions, with admissions during October and November having decreased to c70% of what would normally be expected at this time of year.' Care costs increased significantly, with expenditure on PPE three times the c£1.5m spend in a 'normal year'. Regarding payroll costs, Four Seasons said: 'Shielding and self-isolation pushed staff absenteeism up to just under 11%, although this has now fallen back.'

Some large UK care home groups and Real Estate Investment Trusts (REITs) have reported more resilient market dynamics. Target Healthcare REIT, which is landlord to over 100 care homes across the UK, including homes in Doncaster and Sheffield, reported on 3 November: 'Rent collection continues to be resilient, with around 90% of the rent due and payable to date in respect of the current quarter…demonstrating the stable and secure nature of the portfolio's cashflows…The investment market for high-quality, modern, fit-for-purpose assets which meet the Group's investment criteria remains very competitive. We are witnessing strong appetite from market participants, inclusive of some new entrants to the UK alternatives asset class. The best properties and sites continue to transact at the pricing levels seen prior to the COVID-19 pandemic.'

Target's market commentary added: 'The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value.' The REIT's CEO Kenneth Mackenzie also noted: 'We have received positive feedback from care home managers that the standard of our real estate has made a real difference in their ability to successfully care for residents and manage their homes through the pandemic, in particular the full provision of private en suite wet-rooms.'

Overall, 35 providers in Sheffield were interviewed, giving a wide range of views on the care home market in the borough as well as providing information about other local authorities where they operate. As a number of the proprietors operate several care home in the borough, the interviews covered around 70%% of the care home beds in the borough.

In terms of urgency for providers and the number of times the issues came up, the list below represents the key findings from providers of older adult services:

10. A number of proprietors are very negative on low fees and low increases from medium-sized local / regional operators familiar to the council, (covering 7 homes in the city). Negative on SCC methodology, 'base rate' and engagement / communications. A number of these providers say that they have significant viability issues within 3 to 6 months

11. The views are less negative from not-for-profit operators with a larger national base (three homes). The current £505 is manageable but they seek minimum £60 top ups, which is now proving very difficult. No immediate viability issue, although one provider closed a home in Rotherham for viability issues. One complaint was having to fund specialist equipment, such as profile beds, which used to be lent by SCC. This same issue has been identified by other proprietors too, particularly those providing specialist services.

12. The views are neutral to negative from operators with longstanding council relationships (10+ homes) but warn that loss-per-bed has increased from £12 pp/bed/week at 90% occupancy to £130 pp/bed/week at current 75% occupancy. Also cited fact that 'real inflation' -- such as food, insurance and IT -- is greater than 1.9% and therefore CPI element of 1.9% does not reflect reality. This point was again picked up by a range of other providers who felt that using the basic CPI rate did not reflect the true increases in non-staff costs faced by care homes. Other councils use a basket of care home related costs to calculate annual inflation. Looking at reported operating costs of Care Homes (LaingBuisson Care of Older People Market Report) shows that after staffing costs the biggest expenditure areas for care homes are:

    - Repairs, maintenance and equipment servicing.
    - Food.
    - Utilities (fuel, water, telephone)

13. Providers who mainly have self-funders are neutral on the fee levels and increases, as expected (3 providers, 4 homes). One provider is achieving £800 pw and has a waiting list and another has a similar level of fees and has a higher level of vacancies and a drop in referrals / enquiries.

14. A majority of proprietors have questioned the rationale for having a flat £505 rate, when many other LA's differentiate between residential, residential EMI, nursing and nursing EMI. On the other hand, in authorities that do differentiate the fees, the proprietors often complain that the differentiation of £20 or £30 per week does not reflect the actual differential costs of providing care to people with complex needs.

15. Short/medium term viability issues also often attributable to financing structures / leverage / breaching bank covenants. This is obviously partly bound up with fees, but also driven by fact that the homes break-even only at 90%+ which means that they are unsustainable except in good times (3 homes in Sheffield, one in administration). A slow return of self-funders to the market could have a significant impact on these providers.

    - For smaller services, sustainability of businesses due pressures on owners and low returns. As noted above, the operating margins of smaller homes and providers mean that small reductions in occupancy have a significant impact. A small numbers of proprietors are at or over retirement age and will be looking at the care home market next year to assess the options for sale of the business or alternatively closure and sale of buildings. This was a particular issue for a number of learning disability services.
    - For larger services, long term financial viability of operations is a significant factor. These providers often have more of a financial buffer, and some have the ability to close parts of their homes to reduce costs. Most would be taking stock in summer 2021 to see whether demand is returning to pre-Covid-19 levels.

- A number of providers expressed a desire to modernise and improve their services, and a number noted that their current buildings were not suitable to meet changing needs. Fee levels were identified as a significant barrier to raising capital for redevelopment.

7.4 Key interview findings from commissioners

There are significant contrasts in the views of commissioners compared with providers, particularly in relation to future demand for care home places.

- Most commissioners felt that future demand would focus on nursing care provision. From the Local Authority's perspective, nursing care provided the greatest flexibility, as well as attracting additional NHS funding through the Free Nursing Care element. This is in marketed contrast to providers in the borough, who would avoid developing nursing care beds due to staffing issues, as noted above. Across the region there has been an overall loss of nursing care beds, whilst residential care bed provision has increased.

- The table below shows the changes in the number of CQC registered care and nursing home beds for older adults between June 2018 and October 2020

Local Authority	Type	2018	2020	Change	Change %	Net Change
Barnsley	Residential	1,294	1,482	188	15%	
	Nursing	836	669	-167	-20%	21

Bradford	Residential	2,092	2,025	-67	-3%	
	Nursing	1,905	1,877	-28	-1%	-95
Calderdale	Residential	672	687	15	2%	
	Nursing	748	675	-73	-10%	-58
Kirklees	Residential	1,542	1,690	148	10%	
	Nursing	1,413	1,385	-28	-2%	120
Leeds	Residential	2,624	2,669	45	2%	
	Nursing	2,503	2,586	83	3%	128
Rotherham	Residential	971	1,022	51	5%	
	Nursing	1,107	1,000	-107	-10%	-56
Sheffield	**Residential**	**1,555**	**1,593**	**38**	**2%**	
	Nursing	**2,725**	**2,552**	**-173**	**-6%**	**-135**
Wakefield	Residential	1,094	1,100	6	1%	
	Nursing	1,348	1,336	-12	-1%	-6
Residential	**Residential**	**11,844**	**12,268**	**424**	**4%**	
Nursing	**Nursing**	**12,585**	**12,080**	**-505**	**-4%**	**-81**

- There is a clear emphasis on a home-first approach, either back to the individual's own home, or to specialist supported housing such as extra care. Most commissioners felt that only a small proportion of people should be referred for long term care to a nursing or care home. There would continue to be a self-funded market although there was no clear view on how big this might be.

- Nursing care provision should be based on short-term rehabilitation with the individual returning to their own home or specialist housing afterwards.

- The need for more specialist nursing care was identified by most commissioners. In particular, there was a need for services for "younger" older people with dementia (55+) who were inappropriate for placement in EMI nursing homes where the average age and frailty of residents is considerably higher. This applied particularly to people with learning disabilities and people with mental health problems, although this was also an issue for drug and alcohol services.

- There was also an identified need for smaller scale services for people with complex needs transitioning from children's services. Although there is a projected small growth in the demand for care and support services for people with learning disabilities linked to the ageing population, there was a particular need in relation to transition, with children with particularly complex needs reaching adulthood and requiring specialist support services.

- There was a need to develop a broader range of smaller supported living services to support the needs of both people with learning disabilities and people with mental health problems. Access to suitable accommodation was identified as a major barrier to the development of new services, and the Council was exploring options for procuring suitable housing via specialist housing providers.

- A number of commissioners noted that the quality of some care home buildings meant that they would find it difficult to meet the needs of people with more complex needs and could prevent future placements. There were a number of cases where good providers operated from poor quality buildings and vice versa.

- For NHS commissioners there is a focus on hospital discharge, including discharge to assess and intermediate care services. The provision of nursing care services is a particular emphasis, although there were concerns about the capacity of existing nursing homes to provide the services required. It was also noted the take-up of intermediate care provision was not as high as expected, something providers also commented on. There were also some concerns about quality. The need to develop services specifically to address hospital discharge and diversion come up several times in the context of community hospitals and convalescent services. Most people felt that these types of services needed to be staffed separately from long term care for older people, requiring separate provision, which could be a dedicated unit within a larger home. There was also a strong emphasis on home-first approaches, and NHS commissioners in all the authorities noted that a home first approach was having a direct impact on nursing home placements.

- It was noted that the policy direction in NHS services for people with learning disabilities and people with mental health problems is community support services and this provides potential for joint working and joint commissioning opportunities for local authorities and CCGs, particularly within the ICS framework.

- All the people spoken to felt that the joint working between the CCG and the Council was effective and allowed for high level strategic planning of health and social care services, particularly in response to Covid-19..

- Most commissioners felt a need for the Council to be more "interventionalist" in the care market, specifying more clearly what is required to meet future needs and working more closely with providers to improve services.

7.5 Summary and conclusions

Evidence from demographic trends, the business outlook of proprietors and commission plans suggest that the care home market has reached a point of major change. A number

of providers are likely to exit the care home market in the summer of 2021, if they keep operating until then.

There is an overprovision of care home beds in the market in Sheffield that is likely to continue for at least 6 years. Left as it is, the market will adjust to new demand levels which will see homes closing and occupancy rising for the remaining homes.

The risk to the Council is from unplanned closure and its Care Act obligations in relation to provider failure. There is a risk that the homes that close or the providers that cease operating are the ones that the Council may need to meet future needs, even if there remains overall capacity within the care home market to accommodate everyone who is currently living in a care home or who needs a place.

The message from engagement with care home proprietors and commissioners is clear that there is an expectation that the Council will take a more active role in the management and shaping of the care home market going forward.

There are examples from across the country of operating and financial models that Councils are using to more actively manage their care home markets and these are set out in the section below before those options with the best fit for Sheffield are considered and action plans developed.

8 Operating and Finance Models

8.1 Funding Models

There are limited choices in terms of funding models for care homes. The market is dominated by private providers (some 95%, with the balance owned and operated by local authorities themselves), meaning that they operate within the same parameters as any other private business, are liable to the same tax regime, including corporation tax and tax on shareholder dividends, and the same statutory reporting requirements.

Generally, however, care home businesses are arguably systemically important in a way that a retail, hospitality or leisure businesses – even student accommodation or retirement living businesses – are not. They are also subject to a strict regulatory regime overseen by CQC which effectively means they have a high compliance-led cost base.

Care homes derive revenues from two principal funding sources, namely care commissioning authorities (local authorities and clinical commissioning groups) and self-funders. A weakening in appetite or demand from either of these sources will directly and rapidly affect care homes ability to operate commercially, even if there is a balance of both types of resident in a care home. An unforeseen 'shock' such as the COVID-19 pandemic will have a disproportionate negative effect very quickly.

It should also be noted that neither funding sources pays except on a just-in-time basis – that is, there is no system for bulk advance payment and drawdown which might smooth long-term cashflow or act as a buffer against a shock. Many local authorities do enter into bulk contracts but these are not as prevalent as they once were. Even on a micro basis, it is not uncommon for care homes to have very limited visibility of their residents' own finances and how long, if they are a self-funder, such finances will last until they reach the threshold below which they will depend upon local authority funding.

The care home model is essentially a rental one, in that residents are renting a bed / room on a weekly basis, rather than buying or leasing longer-term (as they do in a retirement living setting, for example), with payment typically on a monthly standing order. Care home resident contracts are often relatively informal and limited.

8.2 Diversification

There is limited diversification of product in the care home market, beyond 'type of home' and 'type of bed' – such types typically being residential, nursing and dementia (or a combination of the last two). This contributes to the effect of a negative shock such as COVID 19. The lack of diversification is partly because of relatively narrow CQC registration criteria and partly because of issues such as the complexities of VAT as it is applied to construction and extension of care home sites, particularly for 'non-core' purposes.

Even within the range of residential, nursing and dementia services there are strong barriers to diversification. A provider of residential care must have a dual registration to provide nursing; likewise, they must recruit and retain qualified nursing staff and dementia specialists (or provide training thereto). The trend in deregistration of nursing beds – essentially reversing diversification – is testament to these inherent difficulties.

Diversification of revenue streams is particularly rare at home level – in other words, there are very rarely additional revenue streams from homecare services, for example. In some care settings, there is diversification into, for example, day-care provision on-site or nearby. These facilities are often run on a breakeven or less basis and used, often very effectively, as feeders for the care home itself. Typically, they offer daily socialisation and activities for elderly people who are still living in their own homes. A nominal attendance fee is charged. Transport costs (minibus or taxi) are either paid for by the attendee or by a local authority.

Diversification is more common at operator level, with the provision of learning disability care services being an example of an additional competency which leverages an operator's commissioning authority relationships. However, this diversification only occurs at scale and in largely the preserve of the large or medium-sized operators. Smaller operators, with one, two or three homes, will be unlikely to diversify from their core offer, which is most commonly residential care, nursing care and/or dementia care.

8.3 Self-Funding

Self-funders are the mainstay of profitability for care home operators, many of whom will make only small or in some cases nil profits from local authority-funded beds. Proportions of self-funders in care homes are not published, but a combination of interviews with proprietors and figures on local authority commissioning from SALT and ASC-FR data (see section 12.4.1 below) suggest that the local authority commissions around 40% the total care home market. Self-funders are not evenly distributed across homes in the borough – some homes have a high proportion of self-funder beds, whilst most have a small number. This homes with small numbers of self-funding beds report long term viability challenges related to fees, although those with higher proportions of self-funders are facing challenges where they have vacancies due to the low level of new self-funders entering the market due to Covid-19. A long-term reduction in demand from self-funders in Sheffield will have a significant impact on the market in Sheffield where a number of proprietors have noted that their long-term viability is based on self-funders because the fee levels in the Borough do not cover basic costs of providing care.

In recent years, price-points in the self-funder market have risen as the construction and development markets have become more concentrated, so that new-build supply has effectively stopped for lower-paying resident cohorts. Broadly speaking, in residential care provision, there is a large band of pricing in the range £600-800 per week, a narrow intermediate band of £800-1,000 per week and a narrower premium band up to £1,200 per week; nursing or specialist care fees add 20-30% to these illustrations. Increasingly noticeable, however, is that the £800-1,000 per week intermediate band is regarded as an entry-level for new operators and for new-build homes and as 'mid-market' rather than premium or 'luxury'.

There are currently very few beds built to service the lower range, with the bulk now focused on the 'mid-market'. The exemplar for this is LNT Developments, headquartered in Garforth, Leeds, which builds highly-specified, templated 66-bed homes for its own operator (Ideal Carehomes) or for onward purchase to a large client base of other operators on a 'turnkey' basis; the substantial volume of these homes – LNT Developments has delivered over 50 care facilities in the past 10 years, currently aims to build 16 care homes per annum and has a current pipeline of 34 sites – has given it a dominant position in mid-market, purpose built care home development.

Self-funding is driven by the economic circumstances of an elderly population typically within a 3-mile (sometimes 5-mile) radius of a care home. Clearly, operators who wish to attract self-funders will wish to be located in reasonably affluent areas.

New care homes have to build presence and reputation to attract residents; there are well-established marketing plans which aid the initial process. Typically fill-rates for newly-opened care homes will be 2-3 residents per month, implying at least an 18-month period to fill a medium-sized care home from inception. Anecdotal evidence – for example, a brand-new care home in Cheshire which opened during 2020 – suggests this fill rate is not currently achievable. The proprietor of a home recently taken over in Rotherham said that they were working on a 2 year period to get occupancy to 100%, although starting with a partially occupied home. They felt that opening a new home in the current climate would be a significant gamble.

For existing and well-established care homes, the challenge is clearly not so much to fill, as to stay full. In the self-funder market, this means a constant marketing effort, which encompasses word-of-mouth referrals, GP, social worker, church group and charity referrals, media activity and community engagement. In addition, there are specialist brokerage services who will refer residents on a commercial basis. Some care home operators are adept at this highly commercial aspect of care home management and may employ a 'family liaison' manager specifically for resident recruitment, a role distinct from that of the Home Manager. But this is a rarity and many operators, particularly those with smaller portfolios and older stock – are not equipped for this and the Home Manager will have an overtly commercial role as well as a managerial one. While it is certainly not always the case that larger operators attract all the self-funders in any given area, clearly they have advantages in terms of marketing spend and skills which the smaller ones do not.

The self-funding fee model has remained both simple and static, with the sole variables being weekly fee levels and annual fee increases (now usually accompanied by a breakdown of cost variables, providing transparency for residents and their families). Fees are negotiated on entry to a home, mostly between a prospective resident's family and the home manager. There is considerable deviation from 'ratecard' fees and bespoke arrangements are reasonably common.

Weekly fee levels vary widely across the UK. The most recent research (Carterwood, October 2020) suggests that the average residential care self-funded fee rate is £860 per week, while the average GB nursing self-funded fee rate is £1,142 per week. Care homes in the South East charge the highest average self-funded nursing care fee rates at £1,339 p/w. All countries and regions, except North East England and Wales, achieve average self-funded fees of over £1,000 p/w for nursing care. Providers in Sheffield were charging self-funders between £600 and £1,000 per week, depending on the room and facilities. Most aimed to charge a top-up of at least £25 a week and some between £50 and £100 a week. A number of proprietors in Sheffield, who are dependent on top-ups above the local authority fee rate, said that they had been finding it harder to get people to agree to the top-ups.

There are three other principal influences on average weekly fees, countrywide: first, that care homes with an 'Outstanding' CQC rating have on average 20.6% higher self-funded fee rates compared to homes rated Good. (There is little difference further down the scale, between homes rated Requires Improvement and Inadequate, although the latter will invariably have negative commercial consequences); second, that there is a 'strong

correlation' between the age of home and self-funded fee rates. Carterwood found that homes registered since 2010 charge on average 12.8% and 11.2% more than homes registered between 2000–2009 for nursing and residential care, respectively; and third, that 22% and 23% of nursing and personal care self-funded fee rates, respectively, show a premium for dementia care over general elderly frail rates where homes are registered for both care categories.

Self-funder fee differentials diminish substantially when dementia care is offered. Carterwood found that fees for nursing care dementia are on average only 1.1% higher than standard older people's nursing care, and residential care dementia fees are only 1.9% higher than those for standard residential care. Where homes have specialist dementia units in larger mixed registration homes and differentiate fee rates, the premiums are higher at 4.5% and 7.6%, for nursing and residential care, respectively. In our view, the dementia 'market' is still catching up with nursing care and nursing care fees. Dementia beds are likely to increase in price point in the coming years as demand outstrips supply significantly.

Self-funders will typically utilise savings and/or housing equity to pay for care. The figures above indicate that care fees can easily approach £50,000 per annum and are only modestly offset by family contributions (including top-ups). Many care home operators consult with their residents and families to ascertain when or if it is likely they will need local authority support with fees, as they approach the £23,250 capital (including the value of property) threshold, as set out in the Care Act 2014. There are several alternatives, including deferred payment agreements – essentially loans – from the local authority to help people to meet the costs of their care in a care home (or other setting such as supported living accommodation) without the need to sell their property. Since April 2015 local authorities must offer a deferred payment agreement to those that are eligible and have discretion to offer them to those that do not meet the criteria. Local authorities can also charge interest on the loan and include any reasonable administration costs. Where local authorities decide to charge interest this must not exceed the maximum specified in the regulations.

In terms of payor balance, the waning of local authority appetite for residential care placement poses a significant medium- and long-term threat to the future of care homes, particularly in the North of England and particularly in boroughs where there is a 'home first' strategy. Care home operators may be said to fall into a number of categories with attendant risk weightings:

16. Bias to Local Authority-funded residents; balance of self-funders. High Risk
17. Bias to Self-funders; balance of Local Authority-funded residents. Medium Risk
18. Full Self-funders with little or nil engagement with Local Authorities. Medium Risk

Clearly, operators of care homes in Category 1 face the largest fall in income if Local Authorities are withdrawing support in the form of residential placements at the same time as occupancy is falling because of COVID-19-related discharges, potentially becoming unviable very quickly. This is evident in the Sheffield and proximate areas in Q4 2020.

Care homes in Category 2 will mostly not regard their Local Authority-funded beds as profit centres but run them at break-even or just above. They will often, however, require top-ups and additional income (for example Funded Nursing Care) which make the beds viable. However, voids and unfilled voids will have a negative impact on both the operating

business and on 'group' considerations such as banking covenants (which will often include occupancy ratios as well as debt/EBITDA). Putting this in context, the average property value in Sheffield in 2020 was £210,951, which would fund around 5 years of care at £800 per week.

While care homes in Category 3 may not immediately be regarded as a concern for the Local Authority, they may become so, if the self-funding market weakens. At occupancy levels of <80%, self-funder biased care homes may quickly become unviable; closures remove overall capacity and have significant knock-on effects, most notably in local employment.

Engaging operators on Payor Balance in local markets is crucial to maintaining overall bed capacity and availability. It should be a key leading indicator for local authorities seeking to implement five- and ten-year strategic plans.

Current pricing pressures have their roots in a long-term decline. Operator B characterised the situation as follows:

'When we look back to say 1995, we were getting £269 per week and paying £2.10 per hour [to carers]. The wage rate has risen by four times, but the rate we are now receiving has barely risen twofold…We find ourselves paying up to 85% of income [revenue] on staff….What needs to be recognised is that it is not just about the fee level, but the type of care being delivered. For nursing providers in particular, fees are just not uplifting in line with costs….fees have eroded for at least the last five years.'

Operator B maintained that the minimum level for rates should be around £700 per week.

'*The cost of care model at our homes shows £679 per week, which in itself is £200 more than the current residential care rate.'*

While comparisons with other local authorities' rates are subject to caveats around local budgets and commissioning patterns, it is the clear that Sheffield rates are low end of the range in the Yorkshire and Humberside region, as detailed in section 12.3 below, based on ASC-FR data.

8.4 Alternatives to Care Home Provision

Sheffield has identified the shortage of alternative housing provision for older adults and has been discussing the development of extra care units and also has a well-established policy to promote the building of bungalows suitable for elderly physically and mentally frail. These two housing types do not obviate the need for care homes, however, and there is an acknowledgement that a baseload of care home beds will always be required.

There has been an identifiable cultural shift away from long-stay multi-year residential care in care home settings to shorter stays at end-of-life. And increasingly, it is often possible to have advanced care to end-of-life at home.

The overall vision in Sheffield is focused on care in people's own homes, rather than in a care setting wherever possible, a view reinforced in discussions with commissioners and stakeholders.

The map below identifies the location of current older person's retirement housing, including Retirement Housing, Sheltered Housing and Extra Care Housing.

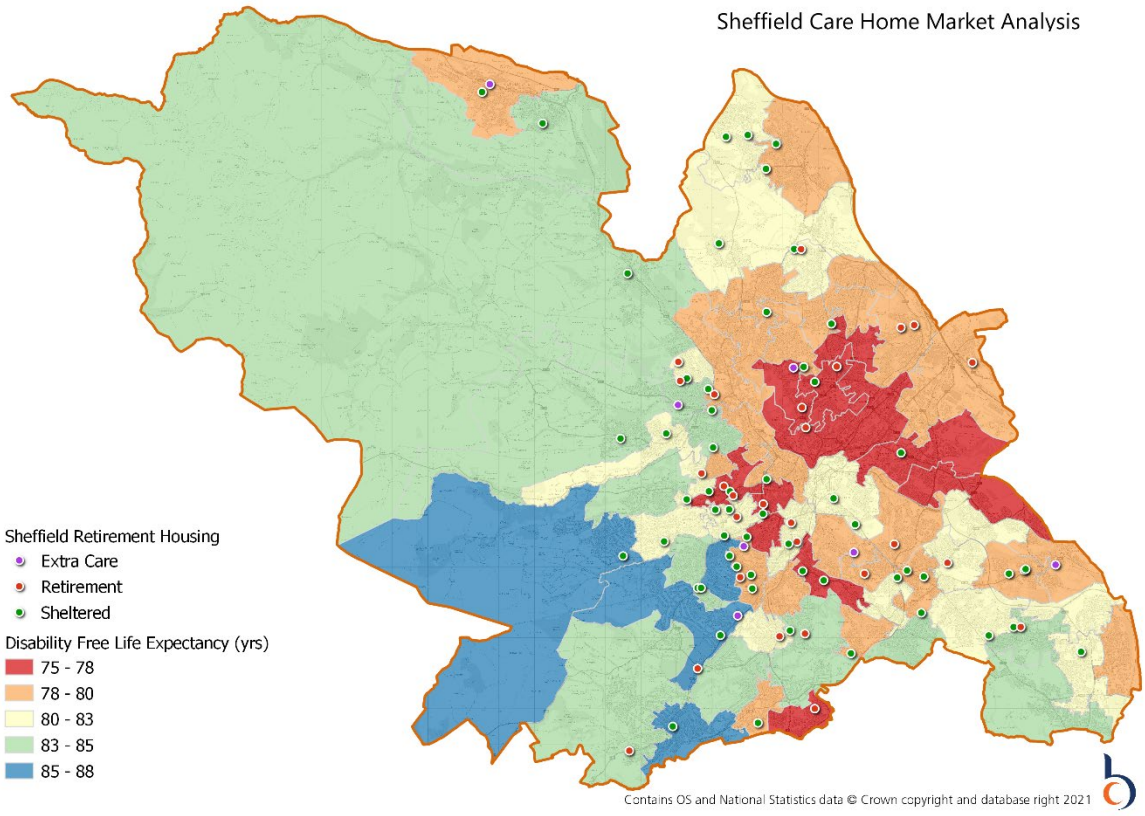


Figure 25 - Location of Older Person's Retirement Housing in Sheffield (Source, EAC, 2018-19)

Repeated surveys of older and frail people have been clear that people's priority is to be supported in their own homes, and this continues to be where the majority older people live (90% nationally[4]. The aim of the housing strategy should be to ensure that there is a sufficient supply of appropriate housing to ensure that people can maintain the independence for as long as possible, and such care and support that needs to be provided can be done so in the most cost-effective manner. The authority may choose to attempt to influence people's choice of housing into old age to respond to specific local pressures. For example, if there is a shortage of family housing in specific areas where there is also under-occupation of housing by older adults, development of high-quality age-specific accommodation coupled with the provision of good information services that ensure that people understand their housing options, could be an appropriate strategy.

The table below sets out the housing and support options available for older and frail people and the commissioning and social care implications of these:

[4] See "The role of home adaptations in improving later life" published by the Centre for Ageing Better, November 2017 - www.ageing-better.org.uk

Housing Type	Tenure Arrangements	Support
Own home	People supported to remain in their own home.	Access to Wellbeing Lifeline Service. Universal services for support, or domiciliary care services. Access to home adaptations to help people manage the effects of frailty or disability.
Age-exclusive housing	Housing aimed specifically at older people (55 years or more). Includes leasehold and rented accommodation. Accommodation usually designed to be accessible, may include blocks of apartments or bungalow accommodation.	Flats usually have access to community alarm systems, but in contrast to Sheltered Housing schemes do not provide regular on-site support to residents. Access to local authority domiciliary care services.
Sheltered Housing	Purpose built housing for older people, usually in blocks of apartments, although may include bungalows. Rent or leasehold	Sheltered housing has regular on-site access to a visiting support worker or, rarely, a resident warden providing housing related support and activities. Access to local authority domiciliary care services.
Extra care housing	Purpose built housing for older people, sometimes including sheltered and age-exclusive housing on the same site in the form of a “retirement village”. Available as rental or leasehold accommodation.	Support provision is often similar to sheltered accommodation, but Extra Care housing includes a dedicated social care service providing care to some or all of the people living in the scheme. Personal care delivery is regulated by CQC.
Residential care	Accommodation developed for the provision of housing and personal care, registered with CQC. Accommodation is occupied on a license. Residents may pay the weekly fees privately or	Care and support provided for all residents living in a care home.

	the service may be commissioned by the local authority and residents' contributions means-tested	
Nursing Care	As residential care, but registered to provide nursing care as well as personal care. CQC registered. Nursing care may be funded or part-funded by the NHS under continuing healthcare or free nursing care provisions.	Care and support provided for all residents living in a care home. Nursing may be provided to all or some residents.
Hospital	In-patient care provided at hospital either due to ill health or injury. Care is funded by the NHS	Provided by and funded by the NHS. NHS funded step-down or intermediate care services may be available to help people move out from hospital back into community-based services.

Figure 26 - Housing and support options for older adults

It is noted that there has been a substantial shift in the type of support available in sheltered housing schemes over the last 10-15 years, with the loss of residential wardens to be replaced with other support roles, including non-residential scheme managers, or visiting support workers, relying on an off-site community alarm monitoring service for out of hours support.

Housing options depend in part of the predominant tenure type on each area, and Sheffield shows a considerable variance in the proportion of home ownership. The map below shows the level of home ownership in each area, with darker shaded areas having higher levels of home ownership:

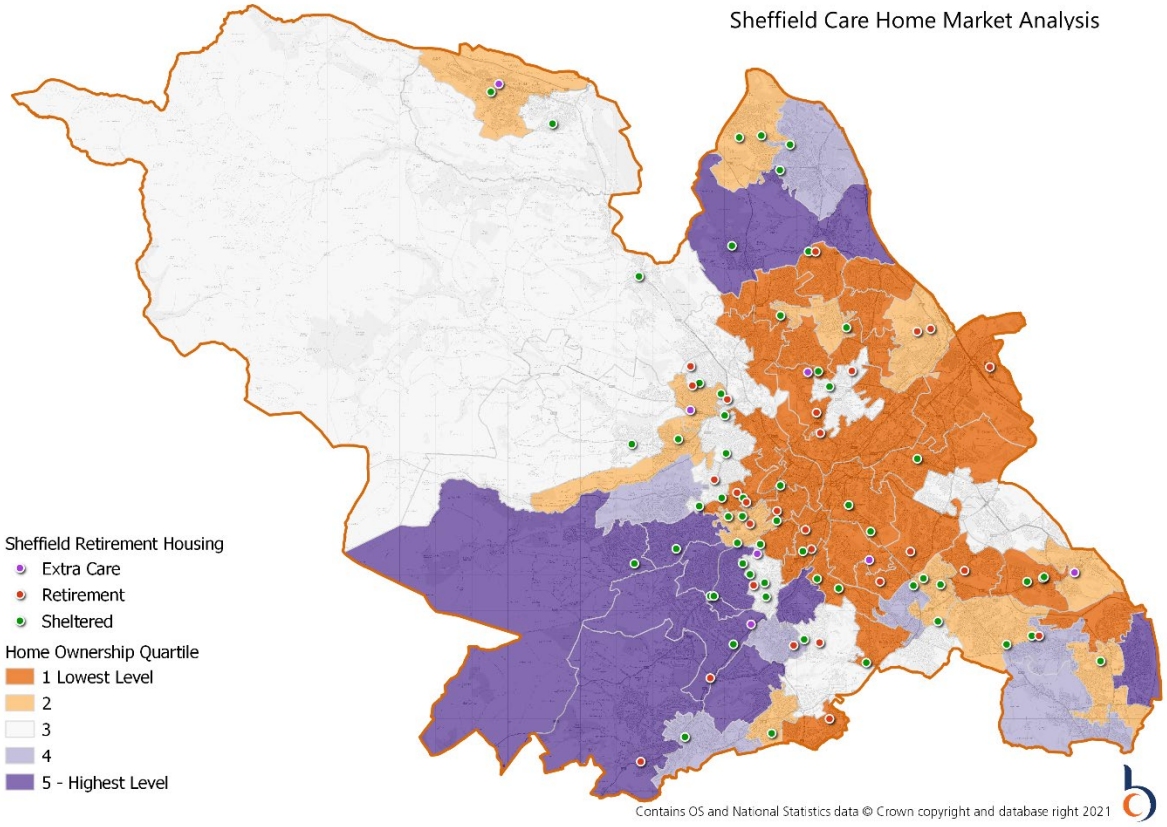


Figure 27 - Retirement housing locations and tenure type by LSOA (Source, EAC, National Statistics)

The areas with the lowest levels of owner occupation also correlate with areas with lower average life expectancy, suggesting areas where rental retirement housing would be a priority.

8.4.1 The Geographic Divide

A number of commissioners identified the need for smaller-scale services to meet the needs of the less densely populated areas of the borough, although the same considerations apply to some of the BAME communities where the populations are not high enough to make dedicate housing schemes viable.

One approach to this is the provision of a range of services from rural service locations, such as a small bungalow development which should include some flexible communal space that should also serve as a based for a community home care team supporting people living in the bungalows and in their own homes nearby. “Core and Cluster” services for people with learning disabilities or people with mental health problems have attempted to tackle the same issue by having a smaller base service to meet the needs of people with more complex needs whilst supporting a larger population of people living in independent accommodation or small supported living schemes with a few other people.

8.5 Future Options

The balance to be struck between care home provision and 'home first' is the challenge facing many local authorities. It is exacerbated by the disconnect between the priorities of private sector operators and state-funded commissioning authorities who may be able to make short-term interventions but will be highly unlikely to be able to make long-term subsidies into privately held companies.

The 'home first' philosophy has been adopted elsewhere in recent years and has caused care home operators to re-examine their offer, including to move into dementia and other specialist care as the appetite for residential care placement wanes rapidly. An example below from the North West of England:

Wirral Health & Care Commissioning Market Position Statement 2019-2024 (extract):

'Wirral Council is aiming in the long term to continue to reduce the number of long-term placements in residential and nursing settings as it continue to both improve and grow its domiciliary care offer and increase the number of Extra Care housing units.

The Council will continue to support and place people with only the most complex needs such as dementia. We will continue to provide respite care for people where all options of supporting in the community have been considered.

We will de-commission and reduce the number of placements for long term care in a care home setting and look at alternative accommodation models and we will increase care and support at home offer so that more people can be supported in their own homes.'

As this extract from the Wirral Health & Care Commissioning (WHaCC) MPS makes clear, the outlook for residential and nursing care placement by the Local Authority and CCG is not favourable We note that the prioritisation of complex needs placements, including dementia, will not favour care homes which currently offer no dementia care. WHaCC is actively seeking to increase its extra care provision, which will add further pressure on demand for elderly residential care. The same MPS states: '*Wirral already have 200 units of Extra Care accommodation in operation. This accommodation has been developed as an alternative to residential care and is a valued resource in the Borough. Extra Care will be increasingly used as an alternative to residential care...Recently we have been working with developers to increase the number of Extra Care units for older people…[by a further 300 units].*'

The decline in residential care placement has to some extent been anticipated by operators, particularly those of scale, with a widespread recognition that higher-acuity, higher-value beds represent a more certain and lucrative future. The caveats to this, however, is that average length of stay (ALoS), which is typically up to two years for residential care across the sector, is generally significantly lower for nursing, dementia and other specialist residents than that of residential care residents. Added to this, there are significantly higher costs for nursing staff and the specialist equipment or adaptions to the built environment which may be required.

8.5.1 Market Position

We have reviewed Sheffield Council's Market Position Statement (MPS) (version 1, dated August 2014), which could not account for the impact of COVID-19 by its publication date, but which makes clear that there will be growth in demand for care in most areas: (1) older people, (2) people living with dementia, (3) those living in, or requiring, specialist accommodation, and (4) people with learning disabilities, (5) people living with mental health issues, (6) with autism and / or (7) with physical disabilities.

Issues in the care market as it affects (1) older people and (2) people living with dementia are clearly strongly associated, particularly as one of the principal trends identified by Sheffield Council is the gradual decline in both need and funding appetite for residential care placements and the concomitant rise in the same for nursing and dementia care.

A major consequence of this shift in focus is that the market will have to adapt to shorter stays (at least for nursing beds), more intensive and palliative care. This shift is becoming widespread across the UK. It means that care providers are having to assess their bed numbers, configuration and staffing and repurpose care homes with a residential care bias into at least part-nursing care and/or part-dementia care. There are clearly opportunities to provide care for early-onset dementia, where there is very little specialist provision nationally.

As the process of reconfiguration and repurposing takes place, providers will also need to re-examine their own fee tariffs. It is still commonplace for care homes, particularly smaller, owner-operated homes, to offer a single, flat rate for varying types of care, rather than differential pricing.

The MPS noted the need for additional extra care housing capacity and other models of supported housing for older adults, and development of additional supported housing for older people is currently underway.

8.5.2 The Role of Carers

Key to addressing the increasing demands identified in the Market Position Statement and by Sheffield commissioners will be the role of carers.

While local care providers report strong workforce supply, with the exception of trained nursing staff, the focus going forward will be on the recruitment and retention of carers who feel valued and are supported. Developing care as a profession, rather than as a casual labour segment, is a long-term priority for most local authorities and Sheffield is no exception.

8.5.3 COVID Challenges & Outlook

The challenges pre-2020 are summarised as 'demand versus resource', particularly *vis a vis* pressures on adult social care teams. Complexity of care requirements was also a major factor; complexities included court of protection cases and Deprivation of Liberty Safeguards and issues caused by a high prevalence of drug and alcohol dependency and associated homelessness. These were in large part a consequence of the local demographic picture: older people living longer; an increasing population; poor lifestyles inducing conditions such as stroke; and issue connected with deprivation.

There has been a varied impact of COVID-19. Some care homes have been hit hard and there have been large-scale escalations (LSEs), which have affected the entire home. The second wave of the virus has highlighted that the care home sector will need to be retained and supported into 2021, notwithstanding the initial tranche of support measures introduced in the spring of 2020.

COVID-19 will drive long-term change, which will have to be acknowledged at a national level and involve external agencies such as insurers. The long-term isolation caused by COVID-19 and the two lockdowns is another concern voiced by commissioners and other stakeholders.

The Sheffield vision encompasses support for the voluntary and community sectors, keeping them vibrant so that people are supported to help themselves wherever possible and so that they do not fall back on state support until absolutely necessary.

Keeping people independent is, therefore, key; but the general health picture is mixed but trending negative, with a high incidence of Type 2 Diabetes and health conditions related to deprivation. Mental health remains a significant concern, particularly following COVID-19-related isolation. People's needs are likely to have intensified as a result of the pandemic.

It is not clear yet what the full impact of 'long COVID' will be for local authorities such as Sheffield Council. It is likely to be part of a mixed picture of increasing reliance upon carers, whether local authority-sponsored or provided by family groups.

8.6 New Developments / Care Homes

We refer above to the emergence of the 'mid-market' new-build care homes which are biased towards self-funders and target price points of £800-950 per week for residential care. We see very little evidence of new-build development activity below these levels.

The bulk of new-build care home activity is slated for Cheshire, northern Manchester and North Yorkshire. Major Operator A, which has a pipeline of four or five new build care home developments per annum for the foreseeable future, told us:

'[Our strategy] is towards private pay, where the money can be made. Public pay is not paying a fair fee. No way we would build a home premised on Local Authority funding. We would only build a new home on a 80-90% self-pay basis.'

The same operator, which has an extensive existing portfolio, in the north of England, cited staffing availability and land prices as key subsidiary factors in siting new-build homes. Housing equity is the key indicator of affordability for prospective residents: Operator A described its target residents as those able to afford c£900 per week for up to two years, with such sums mostly being drawn from release of such equity or from savings.

8.7 New Developments / Retirement Housing

An example of non-care home development which signals a growing trend, is the Anchor Hanover development at Heather Court retirement housing scheme in Bramley. This offers 30 one-bedroom apartments, 8 one-bedroom bungalows and 6 two-bedroom bungalows, all purpose-built properties for rent for people over the age of 55. This is essentially a

sheltered housing scheme with a monthly fee from £512.71 and normally includes rent, service charge, heating, hot water and water rates. The service charge covers all the cost of shared amenities. Residents are directed to the council for 'help paying your rent and service charge through housing benefit'.

Purely private-pay retirement housing, the majority of which is developed on a for-sale basis, is a nascent sub-sector of the overall housing-with-care market, which does not rely on local authority or other state entity intervention. It is, however, highly dependent on local residential housing values (almost all purchasers will need to sell their property to buy a unit on a scheme) and, from the developer's perspective, on sales rates, which have been slow in the last few years. The larger developers have focused on the south and south east of England, with the exception of Extra Care Charitable Trust (ECCT) and Anchor Hanover (which has a highly diversified portfolio of housing and housing with care, including retirement villages).

ECCT, a charity, operates one of its 21 retirement villages at Brunswick Gardens Village, near Sheffield, which houses circa 300 residents on a mixed tenure model of for-rent, for-purchase or shared ownership. ECCT's for-sale model include a so-called Event Fee or Assignment Fee, payable when the ownership of a retirement unit passes, usually upon death, and based upon an escalating percentage of the unit value over the length of residency. (This is a model imported from New Zealand and Australia, where it is well-established. It effectively boosts long-term returns for developer-operators). From a care perspective, ECCT states: Approximately a third of residents receive some help with their care. Dependent on individual circumstances, we can support residents with significant assessed care needs, including dementia. In contrast, St Monica Trust in Bristol guarantees to purchase back leasehold properties on the death of the resident for the original purchase value, which is an attractive option for families.

There has been no take up by local authorities in the UK of the for-sale retirement living model, to our knowledge, in their home-grown development of housing with care, but this may change. What may merit further investigation, however, is the for-rent or shared ownerships models, as deployed by ECCT. Other independent operators focused on the private rental sector include Birchgrove and Avery Healthcare (under its Hawthorns brand), as well as a handful of smaller developers such as the investor group behind Chantry Court, in Wiltshire. This sub-sector may lend itself to the sort of collaborations between Local Authorities and developer-operators which exist in the care home sector, the key common element being the rental of a unit by a resident, with care on site and mostly charged on a 15-minute or hourly basis.

8.8 Alternative Models for Local Authorities

One example is Suffolk County Council's (SCC) well-documented three-way agreement between the council, care home freeholders and an operator. In this case, SCC entered into block contracts with the operator for an initial term of 30 years from 2012. The arrangements first arose from the consolidation of older and inefficient council owned care homes. This saw the redevelopment of 12 existing homes (essentially the land on which they stood) into 10 new, purpose-built care homes spread across Suffolk from February 2013 onwards. The resulting care home portfolio was bought by two parties (five assets each), who were financial investors and who in turn entered into multi-decade FRI leases with the operator. Suffolk County Council agreed to contribute the land towards the

development of the new homes in return for an operator agreeing to a block contract. This meant that SCC could continue to service its waiting list filling beds in new homes at local authority prices whilst also enabling the operator to benefit from a share of private pay occupants across several of the homes. Each of the homes have had and continue to have a very strong relationship with Suffolk County Council with vacant contract allocated beds filled promptly from their extensive waiting list. (It is worth noting that in the event the Council was unable to fill these allocated bed spaces as part of the contract, they would still be required to cover the cost of that bed regardless).

The allocation by payor mix, and take-up by the council under the terms of the block contract, are noteworthy: of 340 registered beds in one of the five-care-home groups, there are 250 block contract beds at the prescribed rate subject to annual increases (see below). The remaining 90 beds are for the operator to let on an open market basis. The average take-up over recent years has been over 95% and in many cases 100%.

In terms of pricing, a review of block contracts of this type typically occurs annually. Various mechanisms are employed but we note that the most successful rely on a blended rate, which is, for example, 70% of the annual percentage increase in a basket of wages indicators and 30% of the annual percentage increase in the Retail Price Index, as published by ONS. The contract price (for both residential and nursing) has therefore, been hedged against wage growth (which has a greater weighting) and RPI to ensure this tracks any increases or decreases in costs. This protects the care homes' operator profitability and ensures it remains fair for both parties: the mechanism is effectively designed to ensure that the revenue keeps pace with staff and non-staff cost inflation. It is worth noting that the blended price for the contract beds will very much depend on the split between residential/residential dementia/nursing/nursing dementia at each of the homes which continues to changes depending on needs of occupiers on the Council's waiting list.

9 Opportunity Lists

As noted in the previous sections of the report, there are notable challenges facing both care home proprietors operating care homes and the commissioners of care and support services for older people.

Care markets at a significant transition point in terms of their future direction, a point which has been reached more rapidly due to Covid-19. Covid-19 also has the potential to impact on future needs and it is too early for these impacts to be fully understood and planned for. There are an number of broad questions which impact on the recommendations from this report for which answers are likely to be forthcoming over the next 12 months. These include:

- The impact of delayed medical treatment or care home admission on older people care needs
- The impact of “long Covid” on the health needs both of older people who have care needs now and those who would have been requiring care and support over the next 10 years.
- The impact of the excess mortality linked to directly to Covid-19 or indirectly through delays to medical treatment to patterns of long term care.

Each of these could have a significant impact on the planning for care needs over the next 10 years, but it is likely to be some time before the impacts are fully understood.

The other impact from Covid-19 is that the market sustainability challenges facing local authorities are new and fast approaching. Although the longer term opportunities set out in the sections above will remain valid, in the short term markets are likely to face a unique set of challenges in relation to care home closures.

9.1 Market Management Strategies

The broad approach to care market management is an increasingly active management of the market by the Council. This ensures that the Council has the resources require to meet future care and support needs whilst ensuring that people with care needs have a choice about where, and how, their care needs should be met.

This strategy develops in three broad phases:

Phase	Opportunities / Interventions
Urgent	Covid-19 brings a set of short term challenges that will need to be addressed within the longer term strategy. In particular, the Council may be required to provide direct support to individual providers to maintain market viability until alternative housing models become available in 2023 and beyond as detailed below)

Short Term (1 to 3 years)	Alongside the existing focus on "home first", the creation of a housing development strategy to ensure that people with housing and care or support needs can have their needs met either in their homes through aids and adaptations or through access to specialist supported housing services such as retirement housing, sheltered housing or extra care with options for ownership or rent. During this period, the Council will signal to the market longer term commissioning intentions to help providers decide what role they wish to play in the future market. This will take place over years 1 to 3 of the market development strategy. There are opportunities for coproduction of specifications for care home services with current providers, as well as direct support of providers considering exiting the market
Medium Term (3-5 years)	From year 3, new housing will be coming on stream, and a more active market management strategy can be implemented. One option is the linking of care home fees to the care home specification agreed with proprietors in the previous phase, together with active support of providers who wish to invest in the develop their existing services to meet the specification
Long Term (5 to 10 years)	From year 5 to 10, the care home market is likely to consist of providers who largely meet the care home specification, but there is likely to be an ongoing need for redevelopment of much of the existing supply to meet future needs. Here there are opportunities for the Council to actively support selected providers to modernise and redevelop services, with options for deals on land, higher fee levels or long term contracts to enable the necessary capital investment.

Figure 28 - Intervention opportunities by year

These phases are detailed in more detail below.

9.1.1 Urgent

The current care market, at 82% occupancy, is not sustainable. As noted above, to return the care home market to 95% occupancy would require the loss of between 500 and 640 beds. The challenge is that vacancies are spread across a wide range of homes, so any closures are likely to cause considerable disruption to residents, whilst some of the care homes most at risk may be in buildings that the Council wishes to retain to meet future needs or the proprietor is an important one to the authority. It is also likely that some homes will be key to meeting care needs in their locality and that their closure would have a significant impact on the meeting of needs in that area. This is particularly true of rural areas or areas with a high BAME population. The map below shows the distribution of homes across the authority and highlight how limited the supply is in some localities.

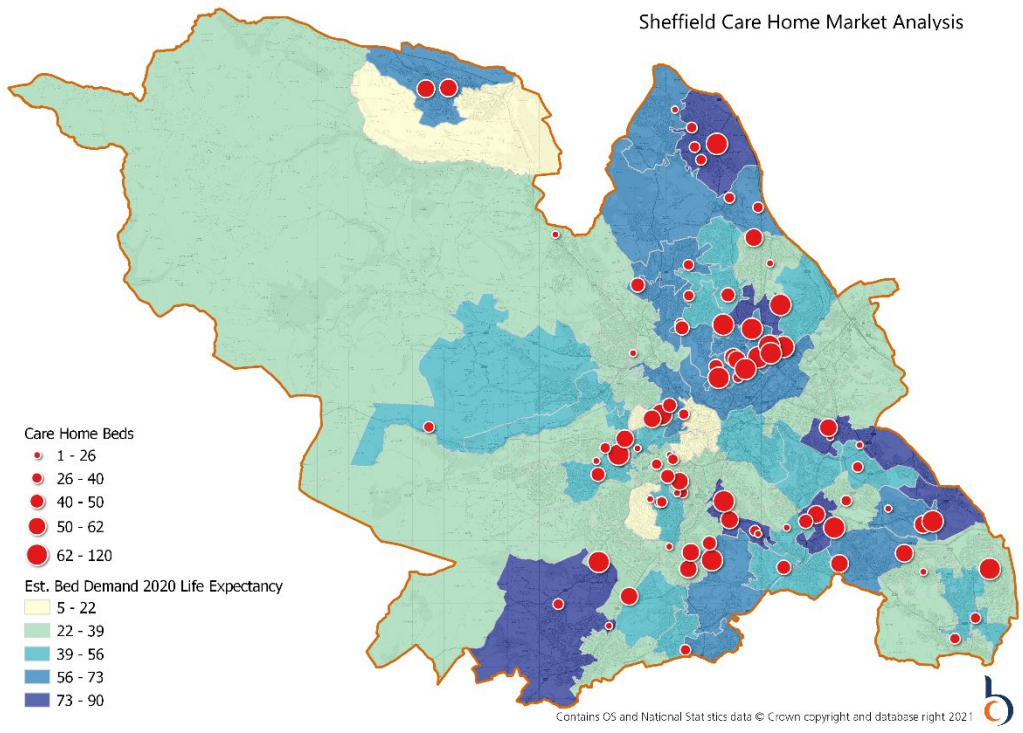


Figure 29 - Location and size of care homes and estimated care demand by area (Source: CQC, National Statistics mid-year population estimates 2019)

Most providers have indicated that they won't be making a decision about the future of their businesses until later in 2021 when the worst of Covid-19 is passed and they have had an opportunity to take stock and assess the market, occupancy and their options. This allows the Council some time to determine the priority services and providers.

In the event of one of these priority providers or homes signalling an intention to exit the market, the authority has a number of options, from no intervention to high intervention:

- Allowing the home to close
- Short term additional financial support, either through voids funding or a fees uplift to either delay closure or allow more time for alternative actions below.
- Supporting the provider to identify another provider to take over the operation of the service, possibly via the Care Association.
- Supporting another provider to take over the operation of the care home, with or without additional funding support.
- Purchase of the buildings to keep the home in the care market whilst identifying another provider to operate the home.
- Purchase of the building and business and taking them in-house as part of Council provision (on a short- or long-term basis).

The consideration of capital investment may be particularly important over the next 18 months because it is likely that private investment funds will be limited. Capital investment to purchase properties could either be short term until an alternative provider is able to raise capital) or long term as part of a strategy for maintaining control of key care assets, either as care homes or for alterative use such as retirement housing. Any capital investment decisions need to fit with State Aid / Subsidy Control regulations, which probably means some form of competitive process in the awarding of capital subsidy or long-term block contracts unless this fits within the definition of *de minimis* aid[5].

The impact of a sustained drop in demand for self-funded places also needs to be considered in this period. It is currently not known whether the current reduction in demand permanent or what level demand might return to. As noted earlier in the feedback from Providers, loss of self-funders has a disproportionate impact on care homes, and it could be the loss of self-funders rather than a loss of Council referrals that forces closures.

9.2 Short Term Opportunities

Short term strategies cover the 1-to-3-year period during which home-first approaches to care and support can continue to be developed but alternative housing options will not yet be available.

Other councils have identified ways in which a home-first commissioning approach can be supported without the development of alternative housing options:

9.2.1 Aids and adaptations

The barrier that most older people identify in remaining in their own homes is the lack of suitable aids and adaptations and long delays in arranging these. The Centre for Ageing Better (Room to Improve - The role of home adaptations in improving later life, November 2017) identified a range of ways in which local authorities can improve aids and adaptations and the benefits that this has for both individuals and authorities wishing to avoid admission to care homes, including more flexible use of Disabled Facilities Grants to fund small-scale adaptions.

The Centre for Ageing Better[6] identified a range of good practice interventions:

- Raising awareness of what is possible amongst older people and professionals, including the availability and benefits of home adaptations.
- Helping older people navigate the system to access adaptations advice, funding, practical help and related services.
- Speedy delivery of home adaptations

[5] See BEIS consultation documents on Subsidy Control at https://www.gov.uk/government/consultations/subsidy-control-designing-a-new-approach-for-the-uk

[6] Sue Adams and Martin Hodges, "Adapting for ageing: Good practice and innovation in home adaptations", Centre for Ageing Better, 2018

- Involving older people in home adaptation service design
- Including home adaptations in strategic planning
- Integration of home adaptations with health and care
- Linking adaptations with home repairs
- Working with handyperson services
- Involving social housing providers in adaptation provision
- Taking a preventative approach

Support for people requiring aids and adaptations across all tenures is particularly important with easy access to services that can provide paid-for adaptation services where the individual does not qualify for a DFG.

9.2.2 Community Support

Work by Cordis Bright for Luton Borough Council on the older person's housing strategy found through engagement with older people that community-based support was particularly important in maintaining people in their homes. Luton had a network of Wellbeing Clubs which provided meals, activities and advice several days a week, which were very popular with people who used them and addresses issues with social isolation.

In Luton, Wellbeing Groups were operated by local support groups with grant support from the Council, providing a cost-effective intervention which older people viewed as a "lifeline", not only providing support to the people attending the groups, but also members unable to attend due to illness.

9.2.3 Social Work Services

The final major short term intervention option is investment in social work support for people being supported at home, including ongoing care management and assessment where people are receiving homecare services. Although a number of authorities have used Dynamic Purchasing Systems to give providers more scope to adapt the support provided to meet agreed outcomes, including Rotherham, there is still an ongoing need for local authority oversight both to assure the quality of individual support packages but also to provide a strategic-level oversight of developing needs to ensure that services are available to meet growing needs.

One of the reasons that families identifying wanting an older person to move into a care home is concern about social isolation.

9.2.4 Care Home Market Development

This period provides an opportunity for the Council to signal long term commissioning intention to providers to help providers decide whether they should remain in the market.

The development of a service specification for care home buildings and staffing is a good way to signal to the market what the Council will be commissioning in the future and help providers decide whether they want to remain in the market. There are opportunities for the co-production of such a specification alongside the Care Association, which would increase the credibility of the proposals.

A number of authorities already have a model for working closely with Care Home Associations to develop their market. For example, Sheffield has provided funding for the Care Association to commission a review of demand for care homes in the area.

The development of a strategy for older person's housing can help care home providers decide whether to convert older care home buildings into retirement housing. There are opportunities for the Council to support providers directly or via the Care Association by providing advice and information and supporting planning applications for change of use.

Towards the end of this period, the first of the housing-based alternatives should be becoming available, and the Council will need a development plan for Care Home commissioning to ensure that it will have the right homes in the right place to meet expected future demand. There are again opportunities to co-develop this alongside the Care Association, particularly in considering the self-funding market alongside commissioned beds.

9.2.5 NHS and Integrated Services

Running alongside the short- and medium-term plans for social care services will be moves to integrate health and social care. Integrated Care Systems will become an increasingly important part of the health and social care landscape during this period, and this is both an opportunity and a threat to local authority social care commissioning.

Closer integration of nursing care services into acute care could help to address some of the current challenges of nursing home staffing. A number of commissioners raised the possibility of NHS nursing teams providing specialist support to both nursing homes and care homes to meet the medical needs of residents as well as support to people living in their own homes. Such models are already in place in some areas is England, with CCGs commissioning nursing homes with close links to hospitals to provide a clear discharge route. Such approaches could help to address the difficulty in recruiting nursing staff which is currently stifling the development of nursing care beds, but also provide a more flexible discharge and reablement services.

The risk of the development of the ICS and the focus on nursing care and hospital discharge is that this is where the focus of health and social care integration will be, and the care market will split into Continuing Health Care funded nursing care provision commissioned through ICSs, and social care services mainly commissioned by social services. This could leave care homes as "second class citizens" compared to nursing care services, which could get better funding and better terms and conditions for staff.

Joint working on care home specifications alongside CCG colleagues will go some way towards avoiding a divergence of the nursing and residential markets. Peripatetic nursing care teams providing nursing care support into a range of community settings, including residential care homes, supported housing services and people's own homes would be one

way ensuring that nursing provision remains central to community support services across all client groups.

9.3 Medium Term Opportunities

The medium-term opportunities largely provide housing-based alternatives to people who would previously have entered a care home because they cannot continue in their own homes. The options include a wide range of retirement housing options, from retirement apartments (such as McCarthy and Stone), bungalow accommodation, sheltered housing or extra care. Kirklees already has a development program for extra care housing, and the map below shows the location of all housing for older people (based in 2018 data).

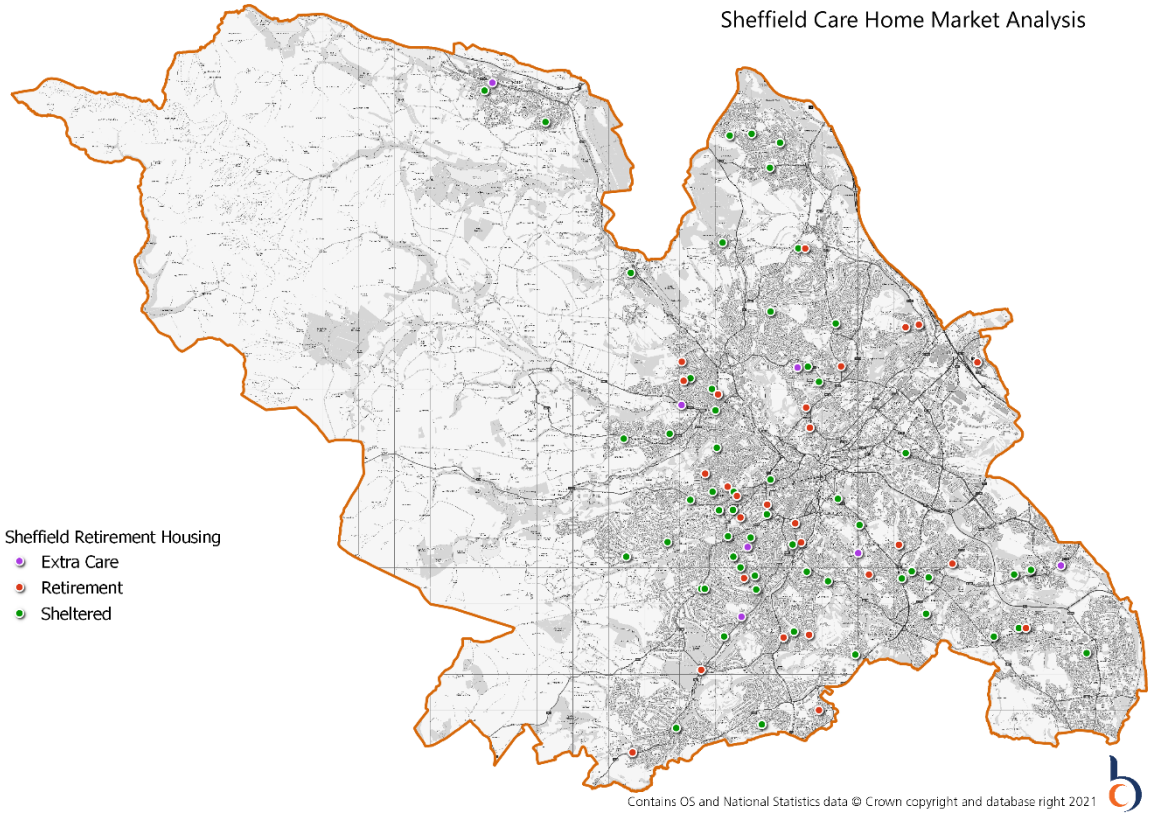


Figure 30 - Location and type of older persons' retirement housing

- **Extra Care housing** provides facilities for care and support alongside self-contained flats. Extra Care schemes frequently had additional facilities, such as a catering service, a range of communal spaces, and larger developments may include shops, hairdressing facilities and gyms. They can also serve as a hub for a range of other services – either to other retirement housing such as bungalows developed at the same time, or to the wider community. Schemes have a dedicated care staff team based on site, with an option of a dedicated night staff team or access to a mobile care team overnight.
- **Sheltered Housing** schemes are larger blocks containing flats or apartments but with generally limited communal space. They were not originally developed to meet

care needs, although may schemes have visiting home care workers. Some schemes have added a care base by converting an existing flat, to create smaller-scale extra care schemes[7]. Sheltered housing schemes usually have a warden, although the warden may be mobile and cover several schemes.

- **Retirement Housing** (Age exclusive housing) is housing aimed at older adults, both private developed, RSL and Council stock, including flats and bungalows. Most schemes include some form of community alarm but not usually a warden. Example private developers include McCarthy and Stone.

9.3.1 Older Person's Housing Development Opportunities

Development Types

There are three broad development options, depending on the area:

- **Rural areas** – small-scale developments of 4 to 10 units based on dormer bungalows (North western areas of Sheffield)
- **Semi-rural areas** – smaller scale retirement apartment developments of 10-30 units (towns and larger villages)
- **Urban areas** – larger scale modern sheltered housing developments of 30 to 60 units (Sheffield central and south western areas)

The general assumption is that developments should be smaller scale, maximising units and minimising communal space to reduce the number of units required for viability. This is an approach that Sheffield is taking in future older person's housing with care developments.

Maximising flexibility of use by avoiding the development of specialist housing, but ensuring Lifetime Homes standards (or HAPPI)

Extra Care

Extra Care Housing remains a popular option with local authorities, particularly where it can be used to reduce demand for care home places. There are a number of challenges to the provision of extra care housing which means that it is not always a suitable option:

- The expectations of what facilities should be included in extra care schemes, such as gyms, cinemas, shops, flexible use communal areas, etc, means that schemes have to be considerably larger to achieve viability. The minimum viable scheme size is now 75 units or more. Developments of 150 or more units are not uncommon. There may be opportunities for additional such developments in Sheffield if the right site could be found, as large scale schemes will generally attract residents from across the region.

[7] North Hertfordshire Council's Flexicare model is based in part on converted sheltered housing provision - https://housingcare.org/service/ser-info-2532-north-hertfordshire-homes-lim

- The main development opportunities in Sheffield are for smaller-scale developments (10-60 units), below the level of viable extra care developments.
- Management of care and support needs within extra care is increasingly complex as the needs of individuals referred to extra care housing increases alongside the increasing needs of residents due to the ageing process.
- There are growing concerns about the affordability of extra care for social housing tenants, particularly those who are just over benefit thresholds.

There are still opportunities for extra care development, which include:

- Schemes led by one of the large national extra care developers who can develop for-sale property within the development to subsidise the development costs of the rental units to keep rents affordable (Extra Care Charitable Trust will sometimes do this, particularly where land is included as part of the deal).
- Extra Care developments included as part of a larger housing development where land or build costs can be substantially reduced as part of the wider development.
- Smaller scale developments where the care and support features can be provided without affecting viability (such as adding a care staff base within a larger modern sheltered housing development). Clinical Commissioning Groups have provided capital for additional care facilities in some areas, as part of a step up / step down care scheme)

Small Scale Developments

Rural areas are not suitable for larger developments, but lend themselves to smaller developments of flats or bungalows, particularly targeting people under-occupying larger houses, developing mobility problems or to address the needs of specific groups, such as supported living for people with learning disabilities with mobility problems.

Dormer bungalows maximise mobility whilst adding a second bedroom on the first floor to ensure flexible use without a large footprint and can be particularly useful where staff may be required to be present 24 hours a day to support someone with physical disabilities.

- Options for redeveloping existing bungalow developments.
- Suitable for smaller infill sites or as a part of a larger development – 30-40 dwellings per hectare (DPH)

The Retirement Housing Group (HAPPI 4[8]) note that a 10-person bungalow development requires a population 880 households (a single village) to support it, compared to a population of 2,775 households (3 villages) to support a 50 bed scheme. Developing a communal space can serve as a community hub for outreach services.

[8] Rural Housing for an Ageing Population: Preserving Independence (HAPPI 4), Housing LIN, April 2018 (https://www.housinglin.org.uk/Topics/type/Rural-Housing-for-an-Ageing-Population-Preserving-Independence-HAPPI-4/)

Figure 31 - Dormer Bungalow Development for older adults in Birmingham

Semi-Urban Developments

Semi-urban areas can support larger developments, but land availability may limit the size of plots available, suggesting apartment developments over 2 or 3 storeys at 110 Dwellings per Hectare. These are suitable for larger urban areas such as large villages or towns. They are also suitable for meeting needs of specific BAME communities. An example of this is the Gharana Nivas retirement housing scheme for Asian elders in Wellingborough (Accord Housing Association), which as 26 flats.

- Floor areas larger than general needs units to allow for mobility needs. Communal lounge / kitchenette to allow for communal events
- Development costs of £100,000 per unit (depending on specification, and scale of development)
- Suitable for sale or rent

Figure 32 - medium size older adults retirement housing development in the Midlands

Large Scale Developments

Urban areas (Sheffield central, eastern and south west areas, etc) will support larger scale developments, assuming that suitable land is available.

- The larger scale of the units (30-60 units) will support a larger amount of communal space, making them similar to current sheltered units, with a lounge, office space and options for additional space for community facilities.

- Development costs of £115,000 with a larger footprint (90 dwellings per hectare to allow for greater communal facilities)

9.3.2 Care Home Market Development

During this period, the Council should be working with care home proprietors to reduce capacity in the market. The specification developed in the previous phase can be used to actively manage commissioning, with an option to link this directly to the pricing of services.

There are also opportunities to more directly link fees to the needs of individual residents particularly if this can be done through closer relationships with homes similar to the dynamic purchasing systems currently used by some Councils for the commissioning of home care. Such an approach should allow for a more flexible approach to short term rehabilitation and encourage providers to support residents to prepare for a safe discharge home.

9.4 Long Term

In the longer-term phase, from years 5 to 10, new housing-based alternatives to care home provision will continue to become available, but demographic data also suggests that there will be a growing demand for more complex care that may require care home or nursing home support. The previous 5 years should have helped the Council develop a good picture of future care needs and the capacity of the market to meet these.

One opportunity during this period is to redevelop and modernise the existing care home provision to meet more complex needs. Longer term relationships with trusted providers means that providers have opportunities to make larger capital investments in care home developments to meet the needs of people with complex needs. The example of Suffolk above illustrates how a long-term contract with key partner providers can allow for capital investment. The council has a choice about the extent to which is participates in the development of the market. A light-touch approach could be based on longer term contracts to enable providers to access capital for developments. A more active role could be through working with providers to identify suitable Council land to help reduce long term care costs. At the higher end of intervention would be the direct purchase or development of care homes and let contracts to providers to provide the care service or operate the services though an arms-length provider as Norsecare does in Norfolk and the East of England.

9.5 Investment Opportunities and Sources

Evidence from other local authorities (detailed in the options section) and comments from existing care home proprietors identify a number of opportunities for investment.

In terms of older adult services, a number of local authorities have looked at utilising existing land ownership to subsidise or stimulate the development of services for older people, both care home provision and retirement housing. In some cases, long term, low cost leases have been used to encourage the development of new services, particularly in areas where land values are higher and would affect the overall viability of new services if purchased at open market values. Some authorities have asked providers to include the value of low cost land as part of a long term development and care contract with an aim to reduce the long term costs of care home provision. Other Councils have made available capital development funds to support the development of new care home or supported housing provision, again reflecting the value of the capital element in a long term reduction in contract costs.

A common cause for concern for local authorities is the linking of provision of housing and the provision of care and support through the same provider, as this can reduce choice for the people using services. This can either be resolved contractually by separating the provision of housing and support, or by the Council commissioning the provision separately from the support. The capital support options identified above may also be available to reduce the revenue impact of capital developments.

9.6 Digital – Business Systems & Care Technology

There are two main impacts of digital technologies in care homes and community support of older adults:

- Electronic planning and rostering systems in care homes
- Telecare and telehealth systems for people living in care homes and to support people living in their own homes or in supported housing.

9.6.1 Digital Systems in Care Homes

A survey undertaken with care home managers are part of the Care Home Market Review in Kirklees and Rotherham asked a series of questions about the implementation of digital systems within care homes in Rotherham, which are broadly representative of the care home market more generally, including Sheffield.

The chart below shows a summary of the responses to these questions:

11. Please select which of the following you have in your home.

		Response Percent	Response Total
High speed internet access		71.43%	20
Facilities for video calls for the manager / staff		96.43%	27
Facilities for video calls for residents		100.00%	28
Wifi access throughout the home for staff		85.71%	24
Wifi access throughout the home for residents		89.29%	25
Mobile devices (phones or tablets) for staff to access or record care data		75.00%	21
Electronic care planning systems		35.71%	10
Electronic staff rostering systems		14.29%	4
Facilities for secure email (such as a nhs.net email address)		92.86%	26
Other (please specify):		0.00%	0

Figure 33 - IT Resources in Care Homes (Source: Survey with Rotherham Care Homes, November 2020)

It is notable that the vast majority of homes have facilities for video calls for staff and residents and these facilities have been very important in enabling residents and families to remain in touch during the Covid-19 pandemic. Video calling has also been used

extensively by commissioners and others to keep in touch with care home managers and staff. Coupled to this, most homes have good WiFi access through the accommodation, so residents with their own devices can use them in their rooms.

High speed internet access was reported by 71% of homes surveyed, which would limit the homes opportunities for video calling and for telehealth and telecare systems for nearly 1/3 of homes.

Only 35% of homes have electronic care planning systems, and 14% of homes have electronic staff rostering systems. The use of electronic care planning systems is a good proxy for the home's readiness for other digital business systems and care technologies and suggests a need for more development. The cost of the implementation of these systems is often a significant barrier for proprietors, particularly the smaller ones that may struggle with the support of these systems. 92% of homes report having access to secure email (nhs.net email, for example) which is vital for the secure exchange of care and medical data on residents.

There are clear benefits for care homes and commissioners of the implementation of digital business systems within care homes, both in terms of management efficiency, but also because these systems are often a prerequisite of telecare and telehealth systems. Some work has already been undertaken by the Council with care homes on these issues and a system of support for the development of systems and staff training, particularly for smaller providers, would be a significant benefit for the care home market as a whole.

9.6.2 Telehealth and Telecare Systems

There has been an increased interest in telecare and telehealth systems to enable remote monitoring and support of people with health and care needs during the Covid-19 pandemic, although these systems have been developing for a number of years. Tunstall, a provider of assistive technology, has identified evidence of the benefit of the implementation of such systems both in people's own homes in combination with home care services and in care homes:

- **Telecare and home care** - In London Borough of Havering, robust, longitudinal analysis showed overall hospital admissions reduced by 50% and hospital admissions due to falls were reduced by 44%, with an estimated annual saving of £2.24m as a result of telecare[9].

- **Telecare and reablement** - In Blackburn with Darwen Council, residential care admissions have been reduced by 18%, with total net savings achieved for telecare and reablement of £2.2m in 2011-12 and further reduction of £1.2m 2013/14 (direct budget costs)[10].

[9] London Borough of Havering, Health and Wellbeing Board, Assistive Technology Report, January 2014 http://democracy.havering.gov.uk/documents/s9914/HWB%20-%20paper%20on%20AT%20v5.pdf

[10] http://www.tunstall.co.uk/Uploads/Documents/Blackburn%20with%20Darwen%20-%20Improving%20efficiency%20and%20outcomes%20through%20telehealthcare.pdf

- **Telecare and telehealth in care homes** - In Calderdale care homes, between April 2014 and April 2015 the number of hospital stays following emergency admissions to hospital for care home residents supported by telecare and telehealth, was 25% lower than the same period in 2013/14. This represents healthcare savings of over £450,000. Plus GP home visits were down by 60%[11].

The use of remote blood/oxygen level monitoring of people suffering with Covid-19 through "virtual wards" has got particular attention during the pandemic, but there are a wide range of systems already in use across the UK and the world, as identified by this graphic by Tunstall:

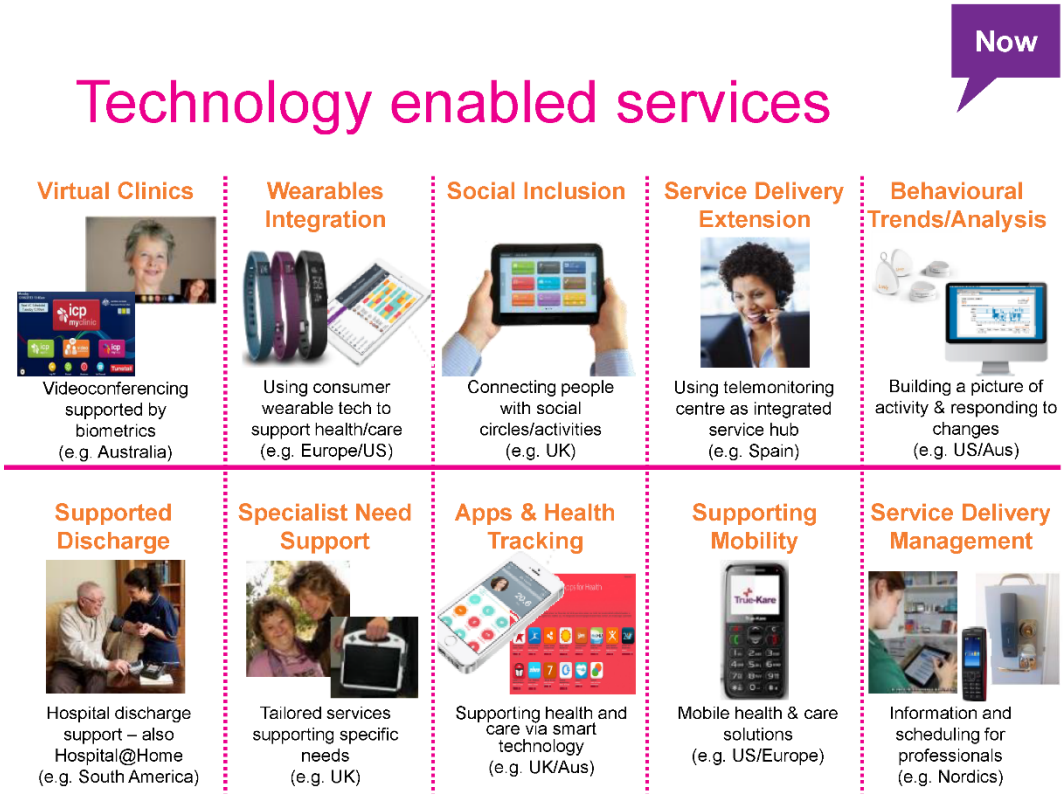


Figure 34 - Examples of technology-enabled services (Source: Tunstall - https://www.tunstall.co.uk/resources/case-studies/)

The graphic below illustrates the use of technology in falls prevention, with electronic monitoring using a variety of systems, used to both identify risk of falls and support early intervention and to quickly identify and respond to falls to minimise the impact.

[11] http://www.tunstall.co.uk/news/468/calderdale-care-home-initiative-in-the-running-for-a-health-service-journal-value-in-healthcare-award

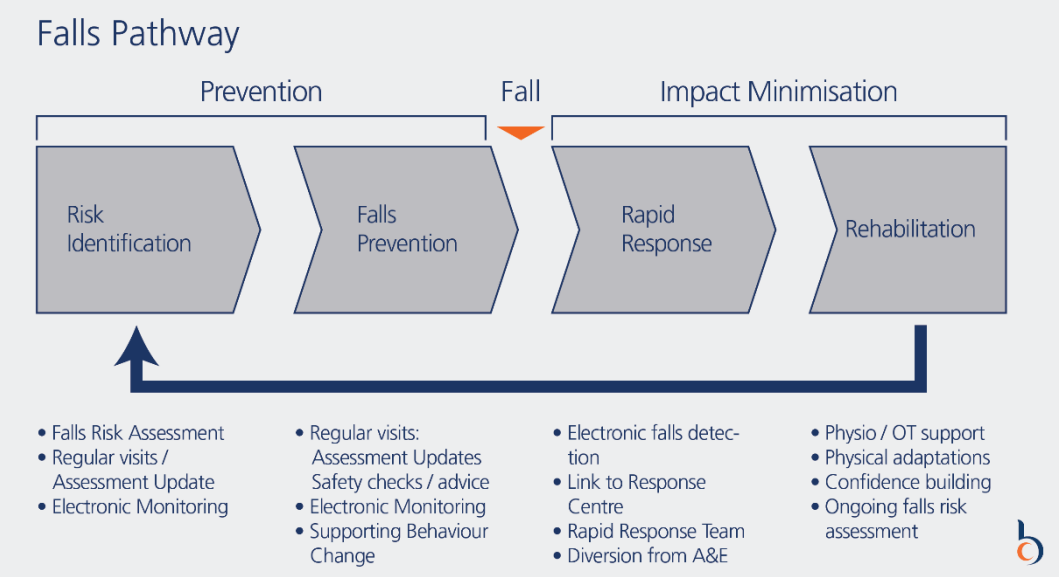


Figure 35 - Falls pathway for prevention

9.7 User and Carer Expectations

This project did not directly seek the views of users and carers in terms of the care home market, although there is clear evidence that most people wish to be (and indeed are) supported to live in their own home, which could include retirement housing such as sheltered housing or extra care housing.

Derek Wanless[12] identified what older people's preferences are should they require care and support, and more recent surveys suggest that these percentages had not shifted significantly prior to Covid-19.

Older people's preferences should they need care	%
Stay in my own home with care and support from friends and family	62
Stay in my own home but with care and support from trained workers	56
Move to a smaller home of my own	35
Move to sheltered housing with a warden	27
Move to sheltered housing with a warden and other social care services	25
Move in with son or daughter	14
Move to a private residential home	11

[12] Wanless D. Securing our future health: taking a long-term view. Final report. London: HM Treasury, 2002.

Move to a local council residential home	7
Move to a residential home provided by a charitable organisation	3
None	1
Don't know	2

Figure 36 - Older people's preferences should they need care (Wanless 2006)

Surveys have suggested that a third of people would not like to move under any circumstances and approximately three quarters of older people would prefer to stay in their home and receive services if they became disabled, or have their home adapted[13]. Focus groups conducted by the CRESR[14] supported this, finding that participants "expressed a clear preference for independence [and] there was a tendency to equate independent living with general needs housing" (2015 p.46).

However, other reports have suggested there is potentially a greater appetite among older people to move than suggested in figure 44 above. For example, a study conducted by Demos (2014), based on the English Longitudinal Study of Ageing (ELSA), found that approximately one in four over 60 would be interested in buying a retirement property (encapsulating all variations of sheltered or extra care housing but not residential/ nursing homes), which is equivalent to approximately 3.5m people nationally[15].

It also found an even greater proportion of people over 60 were interested in moving in general (58%), including 33% of over 60s who would like to downsize – equating to approximately 4.6m people nationally.

Within discussions of older people as a whole, several reports highlighted the differing experiences of a range of minority groups:

- **BAME older people**. Reports found that older people in the BAME community often lacked knowledge about the housing options that were available to them, including how to access home care support, or what sheltered housing or extra care entailed. This is similar to the wider older population.

- **LGBT older people**. While all older people generally expressed a preference to remain in their own existing home, older LGBT people particularly identified that they had some concerns relating to the views of staff and residents in sheltered housing options.

- **Older people with disabilities**. Older people with disabilities reported that, despite aspirations to remain living at home with care where possible, some felt vulnerable to

[13] See National Care Forum (2013) 'Personnel statistics report', Coventry: National Care Forum and Rankin, J. and Regan, S. (2004) 'Meeting complex needs: The future of social care', London: Institute for Public Policy.

[14] Green, S., Robinson, D. and Wilson, I (2015) The Housing Options of Older People in Doncaster. Sheffield: Centre for Regional Economic and Social Research, Sheffield Hallam.

[15] Wood, Claudia (2014) The top of the ladder. London: Demos

poor service – especially those who did not have family to help support them accessing services.

Work undertaken by Cordis Bright with Luton Borough Council in 2018 involved asking a wide range of older people about their views of what their housing needs were. The main finding was that older people want easily accessible information to support their decision-making about their housing and support needs. However, it is also clear that passive information services are not adequate, and that older and frail people need active support to consider their options, through a number of routes:

- Provision of information to "gatekeepers" who older and frail people may approach for advice and information, or who may identify people with housing and support needs.

- Provision of proactive advice and information services that are available to gatekeepers and people who make direct contact with older and frail people, such as the "Community Navigator" model used in some areas. The proactive element should come from active case-finding - attending existing older persons' groups, as well as identifying older and frail people who may have housing and support needs from other services (such as Telelink [Luton's community alarm monitoring service), the One Stop Shop, health and social care services).

- Specific support to help older and frail people assess, plan and organise aids and adaptations. This should include a prioritisation process to ensure that those most at risk due to mobility issues in their own homes should receive prompt support.

- Information services should be co-produced with older and frail people to ensure that they met their needs. It was clear from older people that internet-based services are not an effective way of reaching older people – the majority of the older people spoken to did not have regular internet access and did not like it as a way of gathering information.

It was also noted by that the views of the next generation of older people (currently in their 50s and early 60s) are likely to be very different in their expectations of how and where are and support should be provided and that there is little research evidence currently to identify these views.

9.8 Workforce

Most care home proprietors interviewed said that they did not have difficulty in recruiting social care support staff, although most reported difficulties in recruiting nursing staff.

Whilst recruitment was not identified as a major issue for care homes, the training and development of staff was, with most providers noting the difficulties in recruiting skilled staff and the challenge of finding appropriate training courses for staff, particularly outside of the core statutory training requirements. This was particularly true in services providing specialist services for people with complex needs, including services for people with learning disabilities, people with mental health problems and older people with dementia.

The lack of appropriately skilled and experienced staff is most evident in nursing care services, where the difficultly in recruiting nursing staff has lead to some providers ceasing to provide nursing care, despite the need for these services. However, lack of skilled staff

also hampers the ability of home to support the needs of people with complex needs. A number of providers noted that in the past the Council had provided some training, which meant that providers knew that training was of a good quality and was consistent.

There is also a longer term issue specifically relating to the managers of care homes. The future lack of skilled and experienced managers has been highlighted in the past few years by organisations such as Skills for Care. The impact of Covid-19 on managers is likely to lead to the loss of a number of managers of care homes over the next 6 to 12 months, which could result in a recruitment crisis for suitable replacements. Given the fundamental role of the manager in ensuring the quality of services and ensuring a good flow of referrals, a shortage of managers is likely to cause additional difficulties for care home proprietors.

A number of providers suggested that the Council could play a role in providing training for the next generation of care home managers, and indeed the Council has already done some work in this area. It is also an opportunity for the Care Home Association and the Council to work together to develop the specification for an appropriate training programme and identify trainers.

10 Appendices

Appendix 1 – Care Needs Estimates by MSOA

10.1 Care Needs by MSOA

MSOA Name	Estimated Population with highest support needs	Estimated Care Bed Demand
Stocksbridge	610	73
Deepcar & Bolsterstone	165	20
High Green & Burncross	505	61
Chapeltown	761	91
Grenoside & Ecclesfield North	518	62
Ecclesfield South	456	55
Shiregreen North	297	36
Oughtibridge & Bradfield	327	39
Parson Cross	565	68
Shiregreen South	297	36
Sheffield Lane Top & Longley Park	341	41
Southey Green West	538	65
Firth Park	645	77
Brightside & Wincobank	448	54
Southey Green East	443	53
Wadsley & Marlcliffe	246	29
Hillsborough, Owlerton & Wadsley Bridge	271	32
Tinsley & Carbrook	306	37
Shirecliffe & Parkwood Springs	569	68

MSOA Name	Estimated Population with highest support needs	Estimated Care Bed Demand
Crabtree & Fir Vale	565	68
Malin Bridge & Wisewood	283	34
Burngreave & Grimesthorpe	542	65
Upper Stannington & Loxley	357	43
Walkley	307	37
Lower Stannington	471	57
Upperthorpe, Netherthorpe & Langsett	511	61
Darnall	334	40
Springvale & Steel Bank	155	19
Crookes	342	41
Broomhill & Lower Crookesmoor	400	48
Littledale & Handsworth North	756	91
Sandygate & Crosspool	238	29
Broomhall	242	29
Handsworth South	445	53
Endcliffe & Ranmoor	340	41
Woodthorpe	453	54
Sharrow	272	33
Fulwood & Lodge Moor	196	24
Highfield & Lowfield	224	27
Norfolk Park	325	39
Woodhouse Mill	704	84
Richmond & Stradbroke	328	39
Brincliffe & Sharrow Vale	154	19

MSOA Name	Estimated Population with highest support needs	Estimated Care Bed Demand
Ecclesall & Greystones	229	28
Arbourthorne	254	30
Woodhouse West	508	61
Nether Edge	444	53
Heeley & Newfield Green	754	90
Intake	766	92
Meersbrook	264	32
Gleadless	386	46
Bents Green & Millhouses	315	38
Beighton	249	30
Woodseats	321	39
Herdings & Gleadless Valley	396	48
Hackenthorpe	261	31
Charnock & Basegreen	395	47
Sothall	284	34
Norton & Norton Lees	570	68
Westfield & Waterthorpe	452	54
Beauchief	365	44
Dore & Whirlow	691	83
Greenhill & Lowedges	422	51
Batemoor & Jordanthorpe	510	61
Totley & Bradway	283	34
Mosborough & Halfway	265	32
Cathedral & Kelham	41	5

MSOA Name	Estimated Population with highest support needs	Estimated Care Bed Demand
Devonshire Quarter	112	13
Park Hill & Wybourn	405	49
Birley	575	69

Appendix 2 – Adult Social Care Benchmarking Data – Yorkshire and Humberside Region

11 Introduction

This document summarises the data from the 2019/20 **Adult Social Care Financial Return** (ASC-FR) and **Short and Long Term Support** data (SALT) published by NHS Digital in December 2020. It looks at support for working age adults, 18-64, specifically people with learning disabilities and people with mental health support needs:

- Total expenditure on adult social care for older adults (65+) and expenditure per 100 of the relevant 18-64 population
- Total bed/weeks of care home provision purchased and bed/weeks per 100 of the relevant older adults and 18-64 population
- Unit costs of residential and nursing care purchasing (based on ASC-FR expenditure and activity data)
- The split between settled accommodation, residential care and residential care (for people with learning disabilities)
- Commissioned care home bed/weeks as a percentage of the total available bed/weeks in CQC registered care homes.

The Yorkshire and Humberside region covers the following local authorities:

- Barnsley
- Bradford
- Calderdale
- Doncaster
- East Riding of Yorkshire
- Kingston upon Hull, City of
- Kirklees
- Leeds
- North East Lincolnshire
- North Lincolnshire
- North Yorkshire
- Rotherham
- Sheffield
- Wakefield
- York

11.1.1 Population Estimates

For older adults, population data are taken from the latest mid-year estimates (currently 2019, published in July 2020) and ONS population projections based on 2018 mid-year estimates.

For the working age population data are taken from PANSI[16] estimates for the relevant client group for 2020:

- **Learning Disabilities**: The LD population is based on the 18-64 population with moderate or severe learning disabilities based on the PANSI classifications.
- **Mental Health**: The MH population is based on the 18-64 population with two or more psychiatric disorders based on the increased likelihood of these individuals requiring social care support to live in the community.

Data on services for people with learning disabilities comes first, followed by people with mental health support needs.

[16] Projecting Adult Needs and Service Information, Institute for Public Care - www.pansi.org.uk

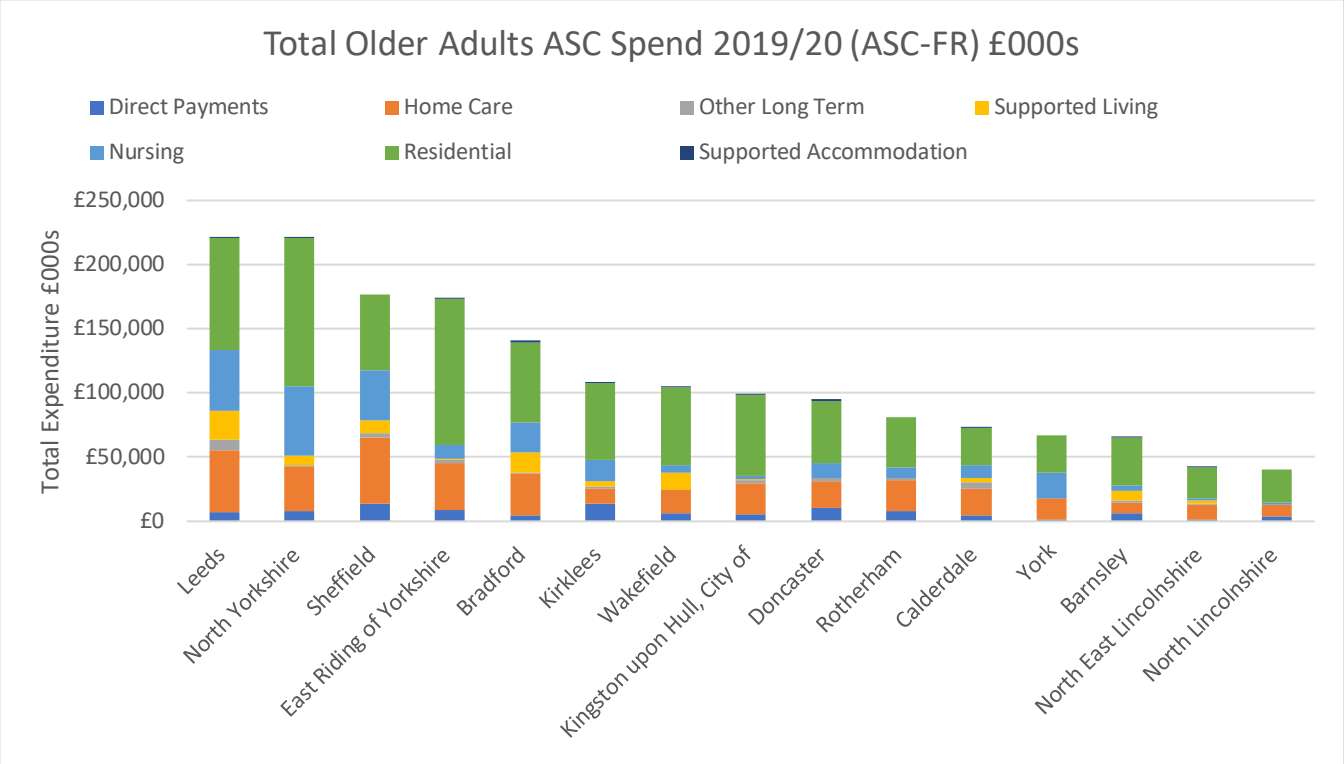
12 Data – Older Adults (65+)

12.1 Expenditure on Adult Social Care for Older Adults

The following expenditure figures are in £000s covering all adult social care expenditure (gross costs).

Table 1 - Gross older adult social care costs (ASC-FR 2019/20)

	Direct Payments	Home Care	Other Long Term	Supported Living	Nursing	Residential	Supported Accommodation	Total
Leeds	£7,460	£47,834	£8,572	£21,844	£47,906	£87,470	£250	£221,336
North Yorkshire	£8,040	£34,566	£1,442	£7,268	£54,188	£115,160	£24	£220,688
Sheffield	£13,647	£51,816	£3,088	£10,160	£38,797	£58,989	£0	£176,498
East Riding of Yorkshire	£8,434	£37,300	£2,426	£274	£11,270	£113,666	£58	£173,428
Bradford	£4,370	£32,873	£327	£16,330	£22,883	£62,532	£1,613	£140,928
Kirklees	£13,615	£12,091	£1,197	£4,345	£16,784	£59,609	£329	£107,971
Wakefield	£6,552	£17,762	£618	£12,927	£6,000	£60,262	£875	£104,996
Kingston upon Hull, City of	£5,674	£23,692	£2,344	£1,460	£2,638	£63,132	£570	£99,510
Doncaster	£10,554	£20,666	£2,872	£0	£11,140	£48,304	£1,602	£95,138
Rotherham	£7,844	£24,494	£1,462	£0	£8,346	£38,870	£0	£81,016
Calderdale	£4,804	£20,350	£5,273	£3,640	£9,584	£29,425	£289	£73,365
York	£1,160	£16,674	£28	£0	£19,862	£29,042	£0	£66,766
Barnsley	£6,452	£8,396	£1,126	£7,430	£4,628	£37,192	£30	£65,254
North East Lincolnshire	£954	£11,746	£1,504	£2,158	£1,398	£24,584	£40	£42,384
North Lincolnshire	£3,504	£9,589	£0	£0	£1,643	£25,302	£0	£40,038

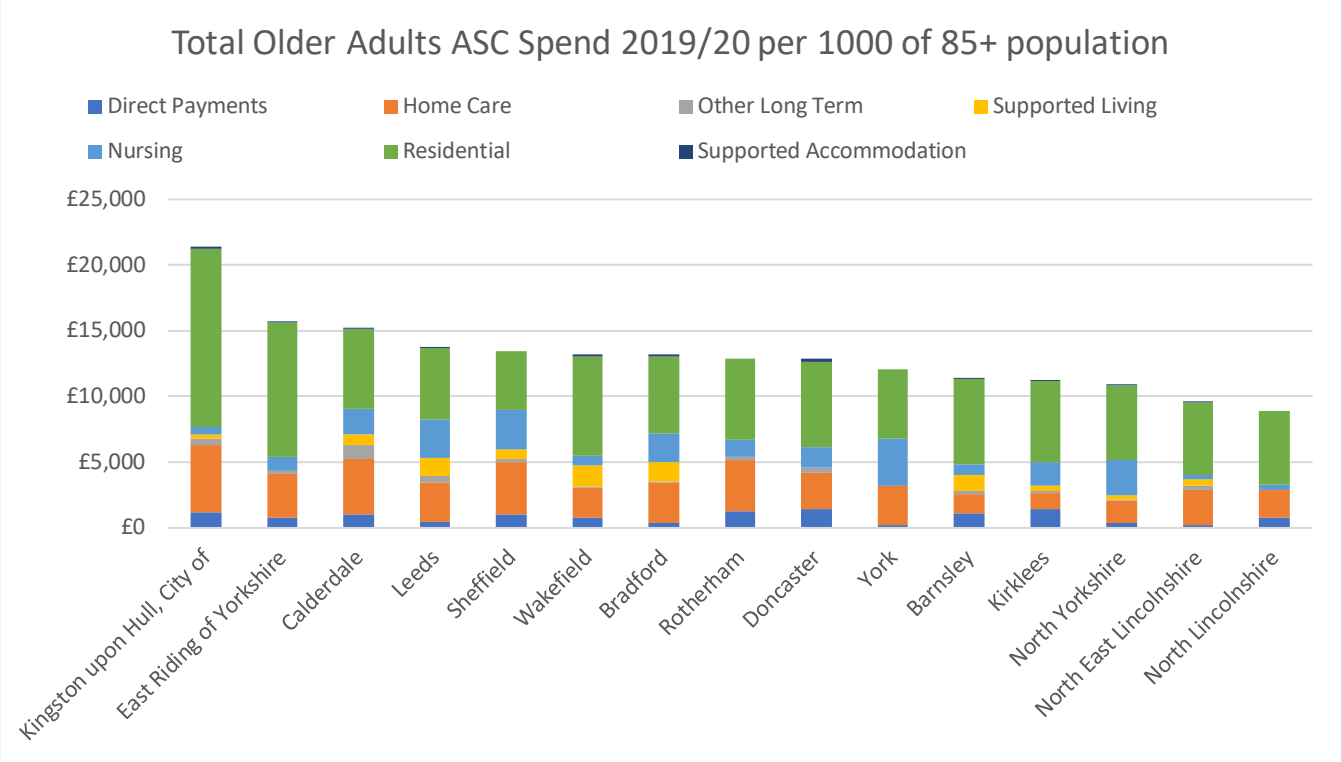


The following table and chart show the same expenditure in terms of the cost per 1000 of the population aged 85+, to balance out the population size differences between the authorities.

Table 2 - 65+ Adult Social Care Costs per 1000 of the 85+ population

	Direct Payments	Home Care	Other Long Term	Supported Living	Nursing	Residential	Supported Accommodation	Total
Kingston upon Hull, City of	£1,220	£5,095	£504	£314	£567	£13,577	£123	£21,400
East Riding of Yorkshire	£762	£3,372	£219	£25	£1,019	£10,275	£5	£15,678
Calderdale	£999	£4,230	£1,096	£757	£1,992	£6,116	£60	£15,249
Leeds	£463	£2,966	£532	£1,355	£2,971	£5,424	£16	£13,726
Sheffield	£1,040	£3,949	£235	£774	£2,956	£4,495	£0	£13,449
Wakefield	£823	£2,231	£78	£1,624	£754	£7,571	£110	£13,190

Bradford	£409	£3,075	£31	£1,527	£2,140	£5,848	£151	£13,181
Rotherham	£1,247	£3,895	£233	£0	£1,327	£6,182	£0	£12,884
Doncaster	£1,426	£2,792	£388	£0	£1,505	£6,526	£216	£12,853
York	£210	£3,019	£5	£0	£3,596	£5,258	£0	£12,089
Barnsley	£1,122	£1,460	£196	£1,292	£805	£6,467	£5	£11,347
Kirklees	£1,418	£1,259	£125	£453	£1,748	£6,209	£34	£11,246
North Yorkshire	£395	£1,698	£71	£357	£2,663	£5,659	£1	£10,844
North East Lincolnshire	£215	£2,652	£340	£487	£316	£5,551	£9	£9,570
North Lincolnshire	£778	£2,130	£0	£0	£365	£5,620	£0	£8,893

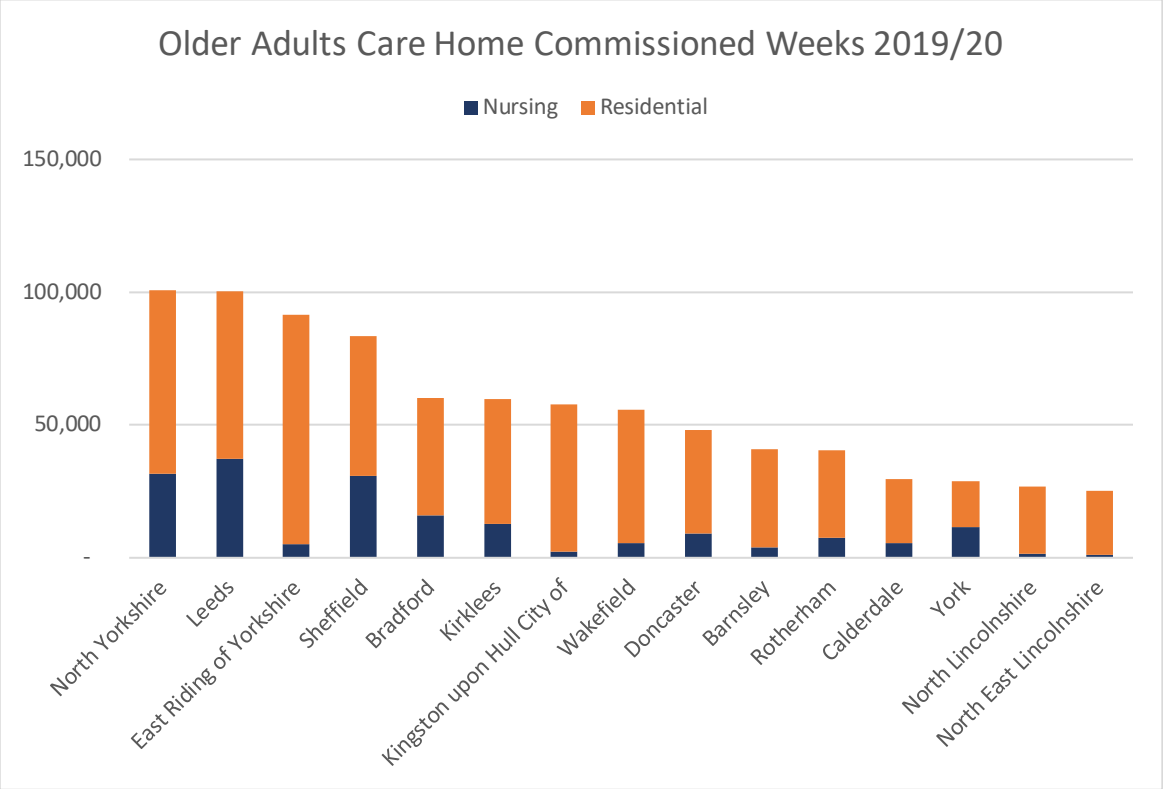


12.2 Care Home Commissioning Activity (65+)

ASC-FR activity data for 2019/20 provide information on the purchasing of care home bed weeks over the year. Again, this data is provided in terms of raw activity and then adjusted for the 85+ population to take account of different population sizes across the authorities.

Table 3 - Total commissioned care home bed weeks (ASC-FR 2019/20)

	Nursing	Residential	Total
North Yorkshire	31,830	68,782	100,612
Leeds	37,259	63,107	100,366
East Riding of Yorkshire	4,945	86,460	91,405
Sheffield	30,810	52,642	83,452
Bradford	16,140	43,945	60,085
Kirklees	12,562	47,115	59,677
Kingston upon Hull City of	2,143	55,540	57,684
Wakefield	5,678	50,234	55,913
Doncaster	9,087	39,227	48,314
Barnsley	3,887	37,033	40,920
Rotherham	7,467	32,883	40,350
Calderdale	5,669	24,007	29,676
York	11,408	17,324	28,732
North Lincolnshire	1,630	25,100	26,731
North East Lincolnshire	1,069	24,125	25,194

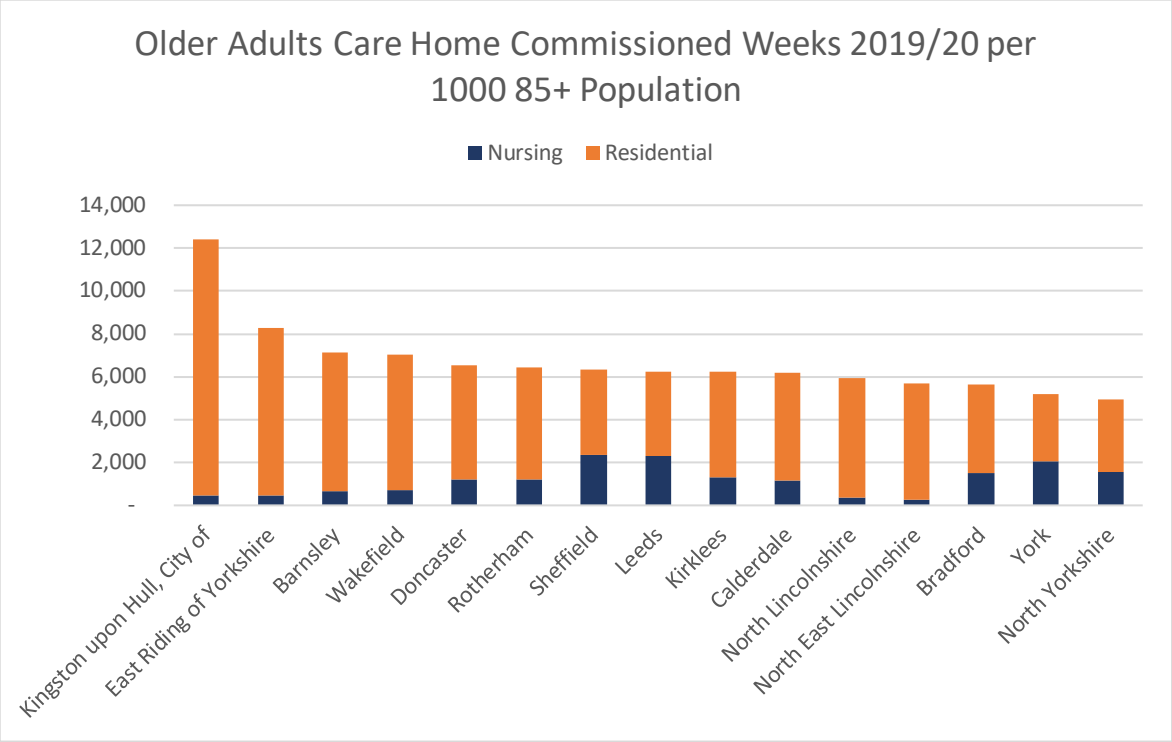


There is a notable split between the top three authorities in terms of commissioned care home weeks and the rest of the authorities. The other areas of large variance is the split between residential and nursing care commissioned weeks, with some authorities (East Riding, Hull, North Lincolnshire and NE Lincolnshire in particular) commissioning very little nursing care compared to the others. This might be due to variances in the way in which nursing care is commissioned in these authorities.

Table 4 - Commissioned Care Home Bed/Weeks per 1000 of the 85+ population

	Nursing	Residential	Total
Kingston upon Hull, City of	461	11,944	12,405
East Riding of Yorkshire	447	7,816	8,263
Barnsley	676	6,439	7,115
Wakefield	713	6,311	7,024
Doncaster	1,228	5,299	6,527
Rotherham	1,188	5,229	6,417
Sheffield	2,348	4,011	6,359

Leeds	2,311	3,914	6,224
Kirklees	1,308	4,907	6,216
Calderdale	1,178	4,990	6,168
North Lincolnshire	362	5,575	5,938
North East Lincolnshire	241	5,447	5,688
Bradford	1,510	4,110	5,620
York	2,066	3,137	5,202
North Yorkshire	1,564	3,380	4,944

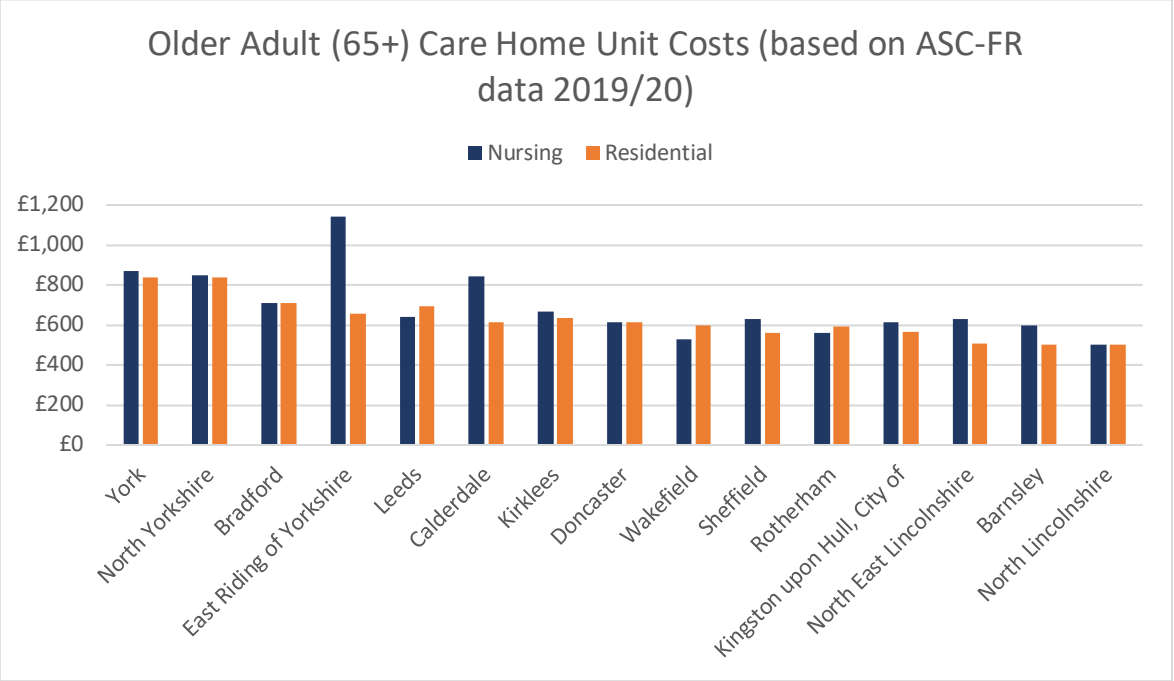


12.3 Unit Cost Data – Older Adult (65+) care homes

The ASC-FR provides data on the unit cost of residential and nursing care beds commissioned. This is based on a calculation (costs / activity) and **not on the actual fee rates of the authorities**.

Table 5 - Unit Cost data for care homes from the ASC-FR 2019/20

	Nursing	Residential	Combined
York	£871	£838	£851
North Yorkshire	£851	£837	£842
Bradford	£709	£711	£711
East Riding of Yorkshire	£1,139	£657	£683
Leeds	£643	£693	£674
Calderdale	£845	£613	£657
Kirklees	£668	£633	£640
Doncaster	£613	£616	£615
Wakefield	£528	£600	£593
Sheffield	£630	£560	£586
Rotherham	£559	£591	£585
Kingston upon Hull, City of	£615	£568	£570
North East Lincolnshire	£631	£507	£513
Barnsley	£595	£502	£511
North Lincolnshire	£504	£504	£504



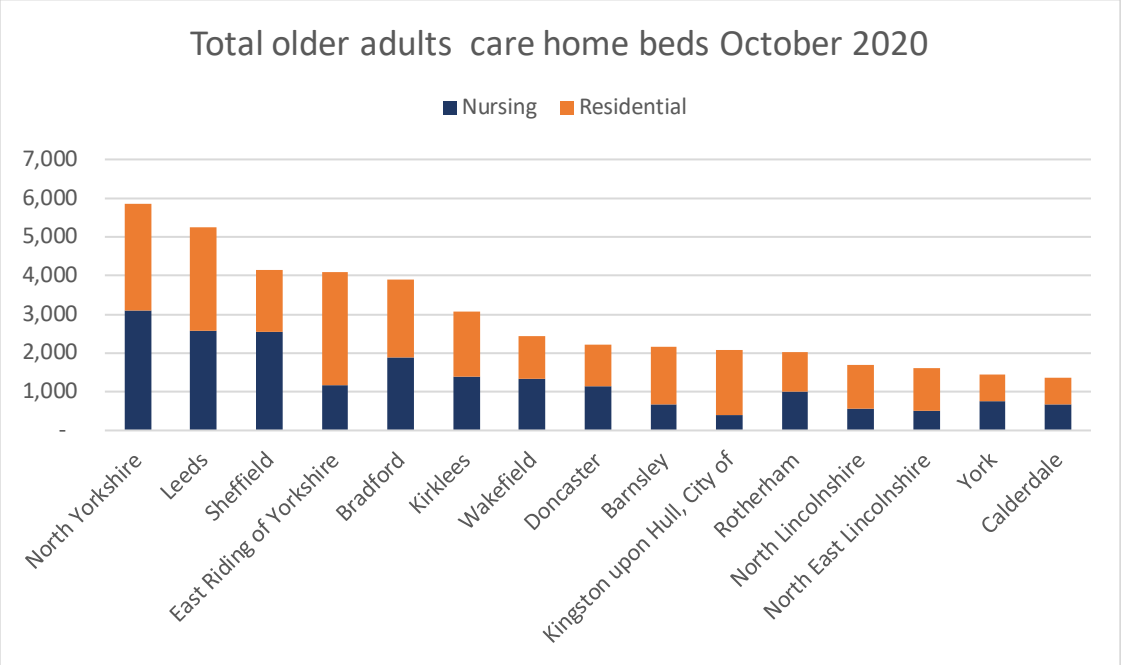
12.4 Care Home Bed Supply

CQC data from October 2020 are used to look at the overall supply of residential and nursing care beds in each of the core cities.

In terms of raw numbers, there is a considerable variance, reflecting the different population sizes:

Table 6 - Total CQC registered care home beds, October 2020

Local Authority	Nursing	Residential	Total
North Yorkshire	3,102	2,741	5,843
Leeds	2,586	2,669	5,255
Sheffield	2,552	1,593	4,145
East Riding of Yorkshire	1,162	2,932	4,094
Bradford	1,877	2,025	3,902
Kirklees	1,385	1,690	3,075
Wakefield	1,336	1,100	2,436
Doncaster	1,137	1,093	2,230
Barnsley	669	1,482	2,151
Kingston upon Hull, City of	403	1,685	2,088
Rotherham	1,000	1,022	2,022
North Lincolnshire	553	1,153	1,706
North East Lincolnshire	516	1,101	1,617
York	758	698	1,456
Calderdale	675	687	1,362

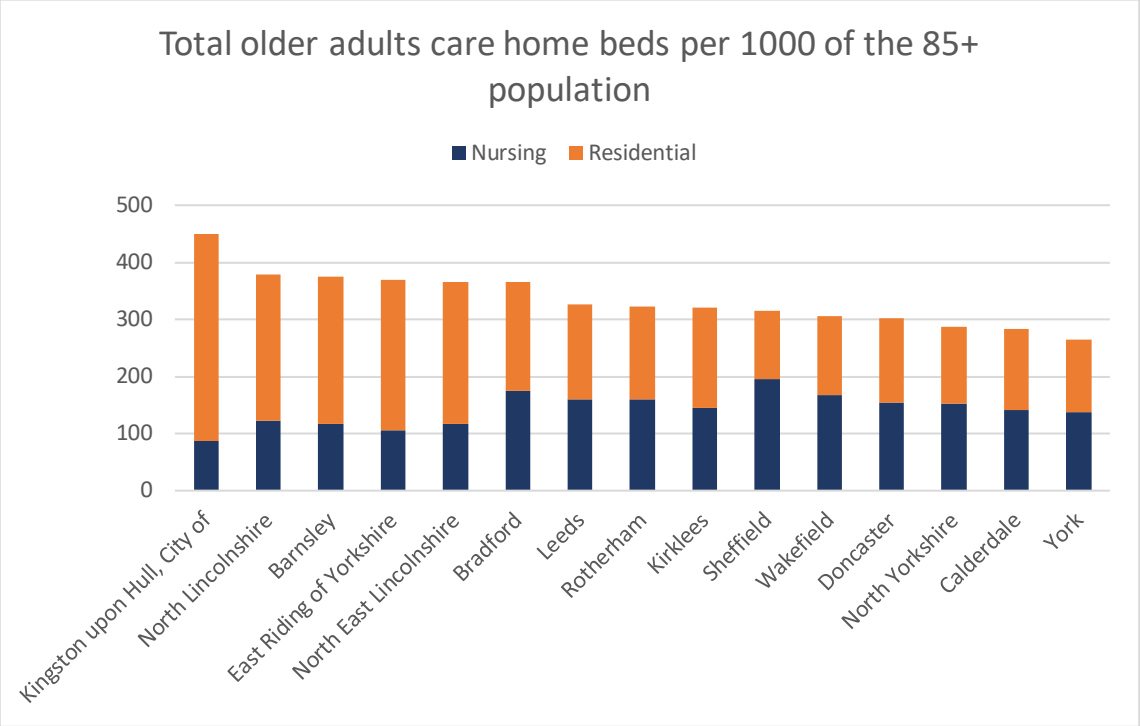


In terms of population adjusted care home bed supply (beds per 1000 of the 85+ population), the overall supply figures are fairly similar across the authorities. There is a more even split in the supply of nursing care beds, with the exception of Hull.

Table 7 - Care Home Beds per 1000 of the 85+ population (CQC, October 2020)

	Nursing	Residential	Total
Kingston upon Hull, City of	87	362	449
North Lincolnshire	123	256	379
Barnsley	116	258	374
East Riding of Yorkshire	105	265	370
North East Lincolnshire	117	249	365
Bradford	176	189	365
Leeds	160	166	326
Rotherham	159	163	322
Kirklees	144	176	320
Sheffield	194	121	316
Wakefield	168	138	306

Doncaster	154	148	301
North Yorkshire	152	135	287
Calderdale	140	143	283
York	137	126	264



Comparing CQC registered beds between June 2018 and October 2020 suggests that there has been a net loss of nursing care beds of about 4% (505 beds) and a gain of about 4% in residential care beds (424 beds)..

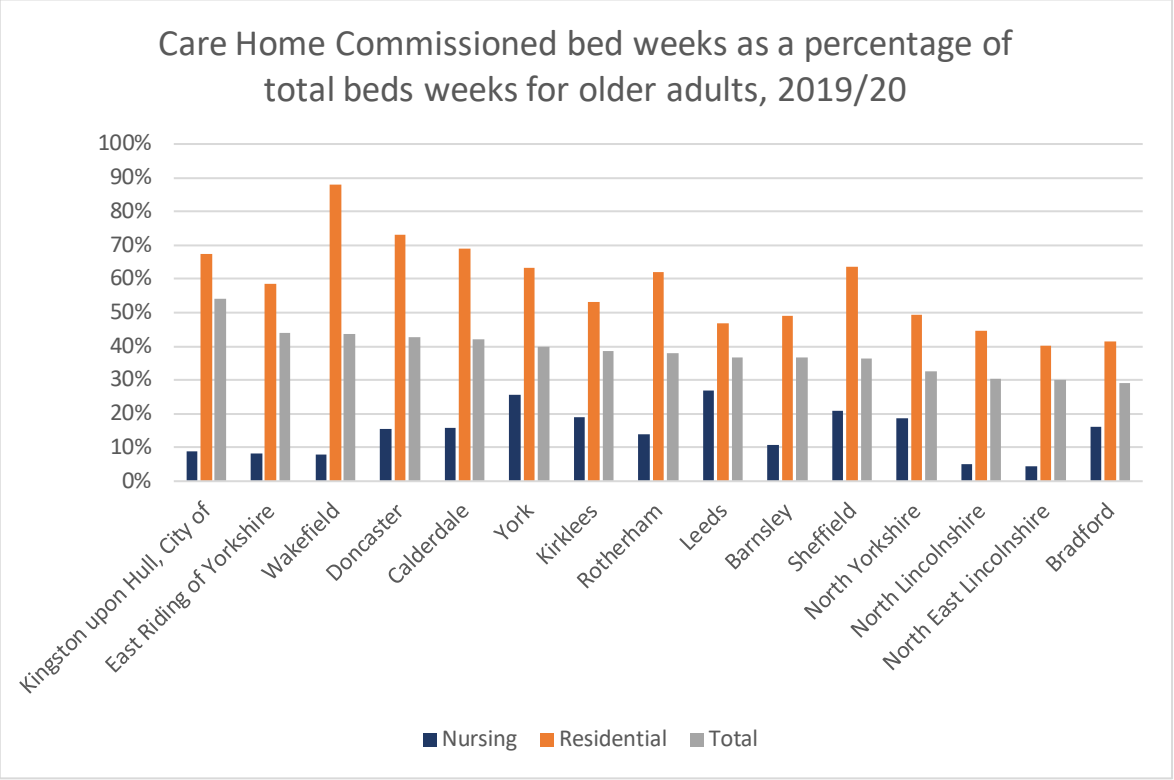
12.4.1 Commissioned Care Home Beds

Finally, the registered care home bed data from CQC can be compared with the activity data from the ASC-FR return to get an indication of the proportion of the total care home bed supply that is commissioned by the local authority (although the data do not distinguish between care home beds purchased locally and those purchased out of area). CQC registered bed data from July 2019 have been used for this calculation because the ASC-FR data relate to 2019/20.

CQC data classify homes as either residential or nursing and cannot reflect split use.

Table 8 - Commissioned bed/weeks as a percentage of total available (CQC, July 2019)

	Nursing	Residential	Total
Kingston upon Hull, City of	9%	67%	54%
East Riding of Yorkshire	8%	58%	44%
Wakefield	8%	88%	44%
Doncaster	15%	73%	43%
Calderdale	16%	69%	42%
York	26%	63%	40%
Kirklees	19%	53%	39%
Rotherham	14%	62%	38%
Leeds	27%	47%	37%
Barnsley	11%	49%	37%
Sheffield	21%	64%	36%
North Yorkshire	19%	49%	33%
North Lincolnshire	5%	45%	30%
North East Lincolnshire	4%	40%	30%
Bradford	16%	41%	29%



The average percentage of beds commissioned by local authorities of the total supply in England is about 40%, so these figures are broadly in line with that. The remaining beds are made up of NHS purchased beds, beds purchased by other local authorities, self-funded beds and vacancies. Data for 2019 (LaingBuisson, Market Report) suggest that bed occupancy rate in that year was 84% for “for-profit” care homes in England, and 81% in Yorkshire and Humberside.

12.5 Population

Population figures are based on 2019 Mid-Year Estimates, published in 2020. The table below shows the population figures for the 65+ population, 75+ population and the 85+ population. The 85+ population has been used to calculate population-level comparisons because that is the age at which the majority of older people are admitted into care homes, and therefore reflects the relative size of the highest need age group.

The final column is the 85+ population as a percentage of the 65+ population.

Table 9 - Mid Year Population estimates 2019

	65+	75+	85+	85+ as a percent of 65+ pop
Barnsley	48,162	21,257	5,751	12%
Bradford	80,899	36,201	10,692	13%
Calderdale	39,755	17,293	4,811	12%
Doncaster	59,745	26,783	7,402	12%
East Riding of Yorkshire	89,346	40,304	11,062	12%
Kingston upon Hull, City of	39,323	16,983	4,650	12%
Kirklees	78,097	34,682	9,601	12%
Leeds	123,516	56,887	16,125	13%
North East Lincolnshire	32,871	15,288	4,429	13%
North Lincolnshire	36,656	16,222	4,502	12%
North Yorkshire	152,657	70,346	20,351	13%
Rotherham	52,299	23,704	6,288	12%
Sheffield	94,440	45,382	13,123	14%
Wakefield	66,276	29,496	7,960	12%
York	38,735	18,477	5,523	14%
Barnsley	48,162	21,257	5,751	12%

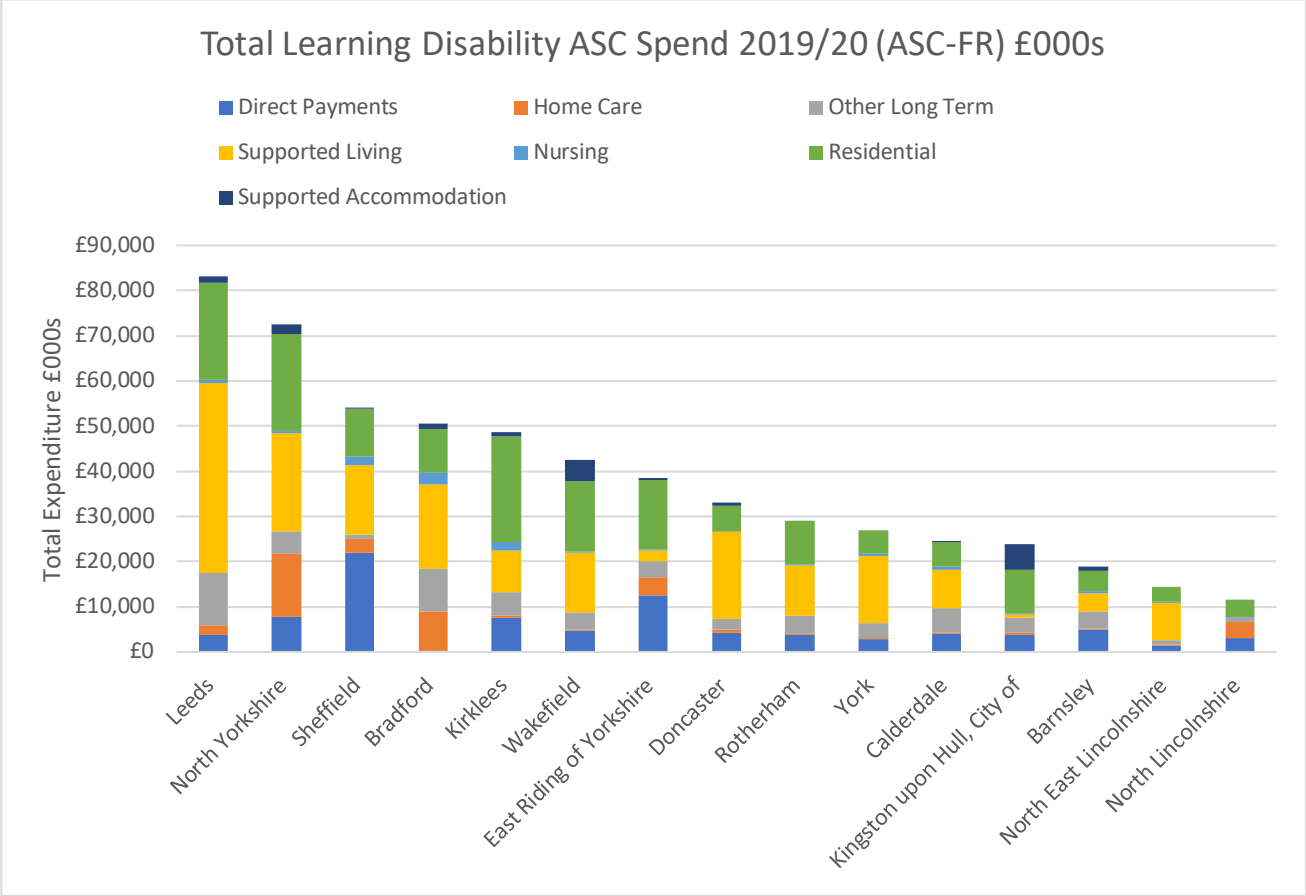
13 Data – People with Learning Disabilities

13.1 Expenditure on Adult Social Care for people with learning disabilities

The following expenditure figures are in £000s covering all adult social care expenditure (gross costs).

Table 10 - Gross learning disabilities social care costs 18-64 (ASC-FR 2019/20)

	Direct Payments	Home Care	Other Long Term	Supported Living	Nursing	Residential	Supported Accommodation	Total
Leeds	£3,766	£2,074	£11,719	£41,981	£585	£21,630	£1,294	£83,049
North Yorkshire	£7,701	£14,074	£4,962	£21,632	£525	£21,496	£2,130	£72,520
Sheffield	£21,981	£3,084	£924	£15,361	£1,814	£10,680	£312	£54,156
Bradford	£258	£8,805	£9,244	£18,864	£2,516	£9,680	£1,130	£50,497
Kirklees	£7,450	£507	£5,204	£9,319	£1,787	£23,451	£1,021	£48,739
Wakefield	£4,758	£135	£3,766	£13,402	£27	£15,766	£4,558	£42,411
East Riding of Yorkshire	£12,574	£3,881	£3,611	£2,334	£300	£15,421	£412	£38,533
Doncaster	£4,200	£696	£2,315	£19,395	£82	£5,681	£592	£32,961
Rotherham	£3,665	£228	£4,240	£10,912	£333	£9,660	£0	£29,038
York	£2,748	£226	£3,406	£14,874	£409	£5,210	£0	£26,873
Calderdale	£4,072	£191	£5,517	£8,430	£593	£5,445	£321	£24,569
Kingston upon Hull, City of	£3,738	£458	£3,273	£770	£184	£9,779	£5,740	£23,942
Barnsley	£5,013	£268	£3,709	£3,953	£517	£4,389	£1,152	£19,001
North East Lincolnshire	£1,341	£347	£935	£8,272	£102	£3,316	£0	£14,313
North Lincolnshire	£2,983	£3,727	£992	£0	£187	£3,622	£0	£11,511

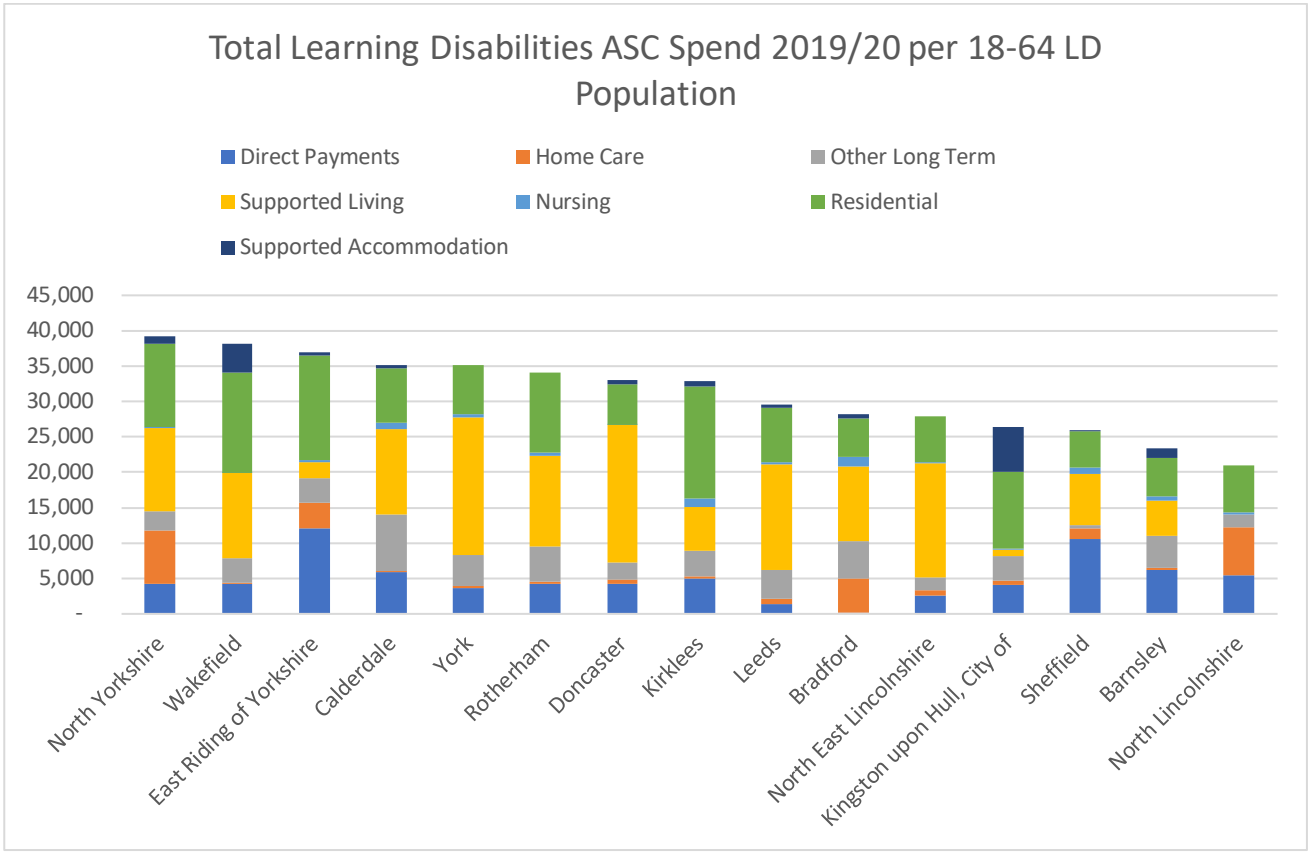


The following table and chart show the same expenditure in terms of the cost per 100 of the learning disabilities population aged 18-64, to balance out the population size differences between the authorities.

Table 11 – Learning Disabilities social care costs per 100 of the LD population 18-64

	Direct Payments	Home Care	Other Long Term	Supported Living	Nursing	Residential	Supported Accommodation	Total
North Yorkshire	4,169	7,620	2,687	11,712	284	11,638	1,153	39,264
Wakefield	4,286	121	3,393	12,074	24	14,204	4,106	38,209
East Riding of Yorkshire	12,044	3,717	3,459	2,236	287	14,771	395	36,909
Calderdale	5,833	273	7,904	12,077	850	7,801	461	35,199

York	3,587	295	4,446	19,418	534	6,802	-	35,082
Rotherham	4,312	268	4,988	12,838	392	11,365	-	34,162
Doncaster	4,213	698	2,322	19,453	82	5,698	594	33,060
Kirklees	5,020	341	3,507	6,280	1,204	15,802	688	32,843
Leeds	1,338	737	4,165	14,919	208	7,687	460	29,513
Bradford	144	4,924	5,170	10,550	1,407	5,414	632	28,242
North East Lincolnshire	2,619	678	1,826	16,156	199	6,477	-	27,955
Kingston upon Hull, City of	4,121	505	3,609	849	203	10,782	6,329	26,397
Sheffield	10,547	1,480	443	7,371	871	5,125	150	25,987
Barnsley	6,189	331	4,579	4,880	638	5,419	1,422	23,458
North Lincolnshire	5,443	6,802	1,810	-	340	6,610	-	21,006

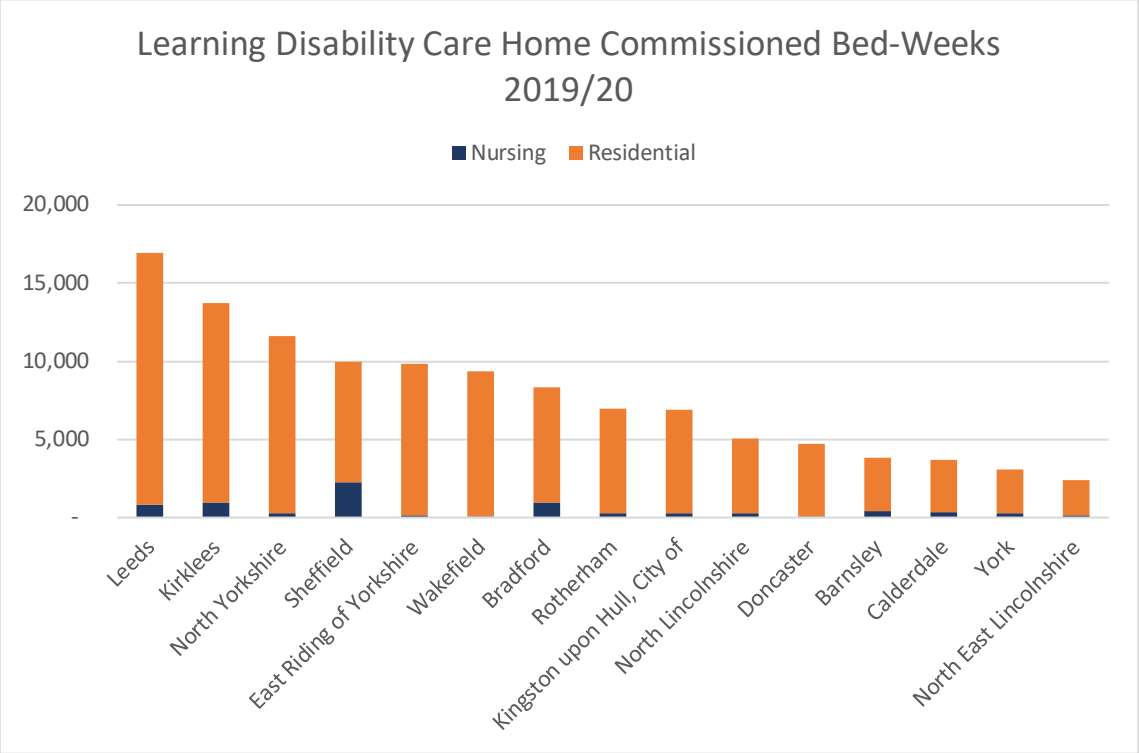


13.2 Care Home Commissioning Activity

ASC-FR activity data for 2019/20 provide information on the purchasing of care home bed weeks over the year. Again, this data is provided in terms of raw activity and then adjusted for the size of the learning disabilities 18-64 population to take account of different population sizes across the authorities.

Table 12 - Total commissioned LD care home bed-weeks (ASC-FR 2019/20)

	Nursing	Residential	Total
Leeds	792	16,117	16,909
Kirklees	950	12,805	13,755
North Yorkshire	290	11,300	11,590
Sheffield	2,275	7,718	9,993
East Riding of Yorkshire	170	9,660	9,830
Wakefield	51	9,338	9,389
Bradford	952	7,376	8,328
Rotherham	281	6,682	6,963
Kingston upon Hull	245	6,644	6,889
North Lincolnshire	249	4,839	5,088
Doncaster	67	4,642	4,709
Barnsley	385	3,433	3,818
Calderdale	338	3,324	3,662
York	261	2,815	3,076
North East Lincolnshire	157	2,250	2,407

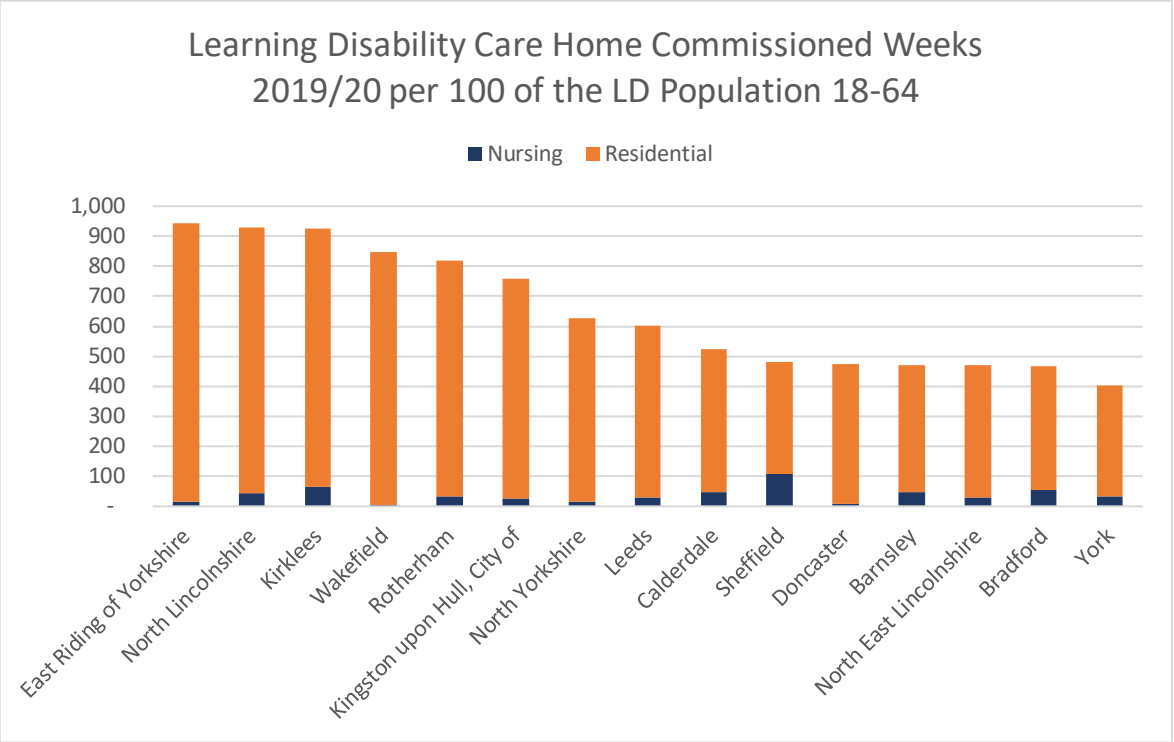


The table and chart below shows commissioned bed-weeks per 100 of the learning disabilities population aged 18-64, to adjust for population size variances.

Table 13 - Commissioned Care Home Bed/Weeks per 100 of the LD population aged 18-64

	Nursing	Residential	Total
East Riding of Yorkshire	16	925	942
North Lincolnshire	45	883	928
Kirklees	64	863	927
Wakefield	5	841	846
Rotherham	33	786	819
Kingston upon Hull, City of	27	733	760
North Yorkshire	16	612	628
Leeds	28	573	601
Calderdale	48	476	525
Sheffield	109	370	480

Doncaster	7	466	472
Barnsley	48	424	471
North East Lincolnshire	31	439	470
Bradford	53	413	466
York	34	367	402

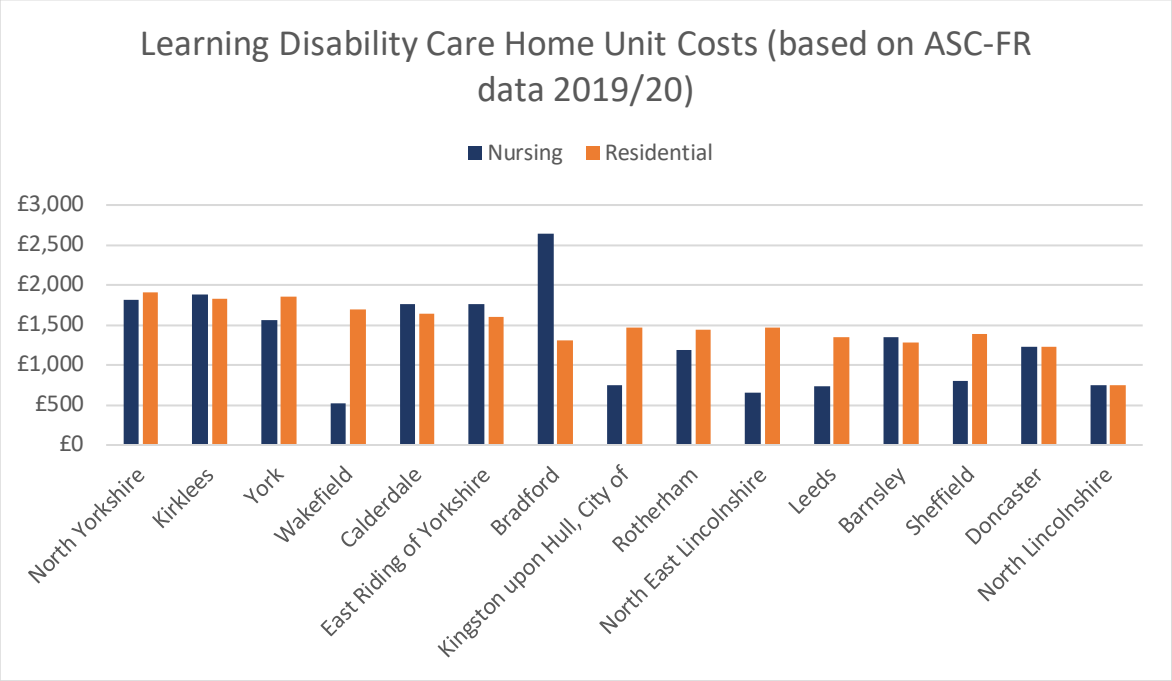


13.3 Unit Cost Data – Learning Disabilities care homes 18-64

The ASC-FR provides data on the unit cost of residential and nursing care beds commissioned. This is based on a calculation (costs / activity) and **not on the actual fee rates of the authorities**. Unit costs include placements outside of the local authority area, which are generally of higher cost and therefore increase the overall average cost reported below.

Table 14 - Unit Cost data for care homes from the ASC-FR 2019/20

	Nursing	Residential	Combined
North Yorkshire	£1,810	£1,902	£1,900
Kirklees	£1,881	£1,831	£1,835
York	£1,567	£1,851	£1,827
Wakefield	£525	£1,688	£1,682
Calderdale	£1,755	£1,638	£1,649
East Riding of Yorkshire	£1,765	£1,596	£1,599
Bradford	£2,643	£1,312	£1,464
Kingston upon Hull, City of	£751	£1,472	£1,446
Rotherham	£1,185	£1,446	£1,435
North East Lincolnshire	£650	£1,474	£1,420
Leeds	£739	£1,342	£1,314
Barnsley	£1,343	£1,278	£1,285
Sheffield	£798	£1,384	£1,250
Doncaster	£1,224	£1,224	£1,224
North Lincolnshire	£749	£749	£749



13.4 Accommodation Type – Settled and Unsettled Accommodation

For people with learning disabilities, Short and Long Term (SALT) Care data provides information on the type of accommodation that people living in. This is split between Settled accommodation (long term housing in the community) and unsettled (shorter term accommodation out of community settings or in care homes). This table below shows the split between care homes, nursing homes and settled accommodation for people with learning disabilities aged 18-64:

Local Authority	Residential	Nursing	Settled
North East Lincolnshire	5%	0%	93%
Calderdale	8%	0%	92%
Doncaster	11%	0%	89%
Barnsley	10%	2%	88%
Bradford	10%	1%	88%
York	16%	0%	84%
Wakefield	16%	1%	83%
Rotherham	17%	1%	81%
North Yorkshire	11%	0%	80%

North Lincolnshire	20%	0%	80%
Sheffield	8%	2%	79%
Kirklees	20%	2%	79%
Kingston upon Hull, City of	21%	1%	77%
East Riding of Yorkshire	24%	0%	76%
Leeds	6%	0%	75%

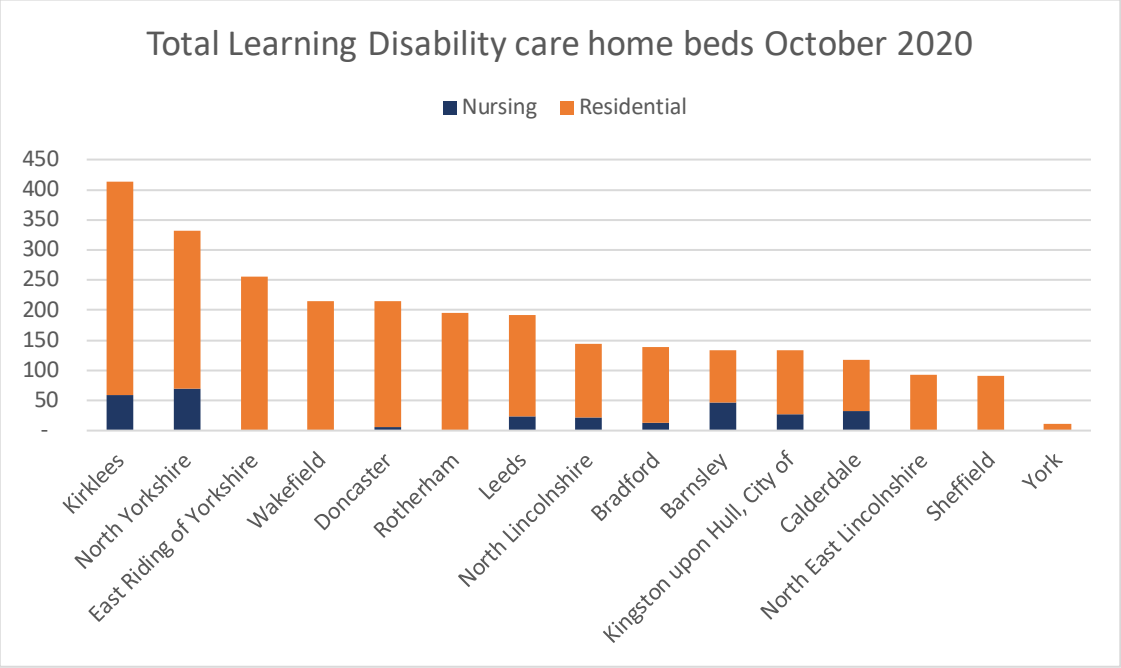
13.5 Care Home Bed Supply

CQC registration data are used to calculate the number of care home beds available as of October 2020. There is a notable variation in the supply of nursing care beds across the region.

Table 15 - Total CQC registered care home beds, October 2020

Local Authority	Nursing	Residential	Total
Kirklees	59	355	414
North Yorkshire	70	262	332
East Riding of Yorkshire		256	256
Wakefield		215	215
Doncaster	5	209	214
Rotherham		195	195
Leeds	23	169	192
North Lincolnshire	21	123	144
Bradford	13	125	138
Barnsley	46	87	133
Kingston upon Hull, City of	27	106	133
Calderdale	32	85	117
North East Lincolnshire		92	92

Sheffield		91	91
York		12	12

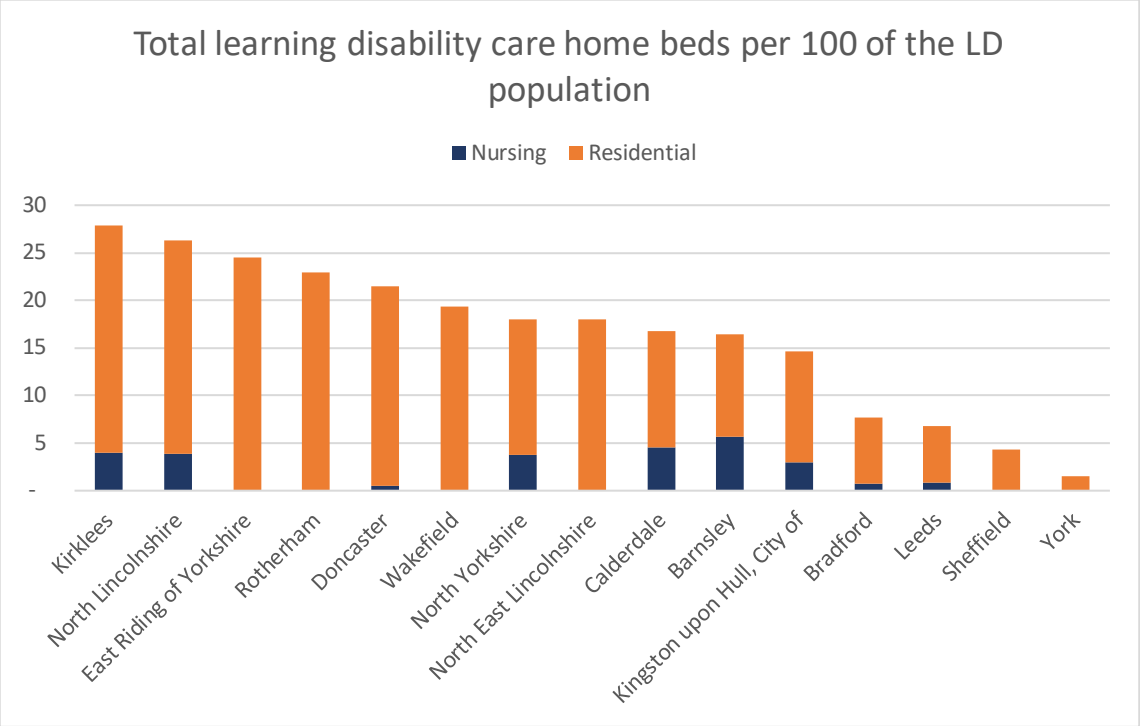


The table and chart below shows the population adjusted care home bed supply (beds per 100 of the LD 18-64 population),

Table 16 - Care Home Beds per 1000 of the LD 18-64 population (CQC, October 2020)

	Nursing	Residential	Total
Kirklees	4	24	28
North Lincolnshire	4	22	26
East Riding of Yorkshire	-	25	25
Rotherham	-	23	23
Doncaster	1	21	21
Wakefield	-	19	19
North Yorkshire	4	14	18
North East Lincolnshire	-	18	18
Calderdale	5	12	17

Barnsley	6	11	16
Kingston upon Hull, City of	3	12	15
Bradford	1	7	8
Leeds	1	6	7
Sheffield	-	4	4
York	-	2	2



Comparing CQC registered beds between July 2019 and October 2020 suggests that there has been an increase of 19 nursing home beds across the region and a loss of 300 residential care beds, with a net reduction of 281 beds for people with learning disabilities.

13.5.1 Commissioned Care Home Beds

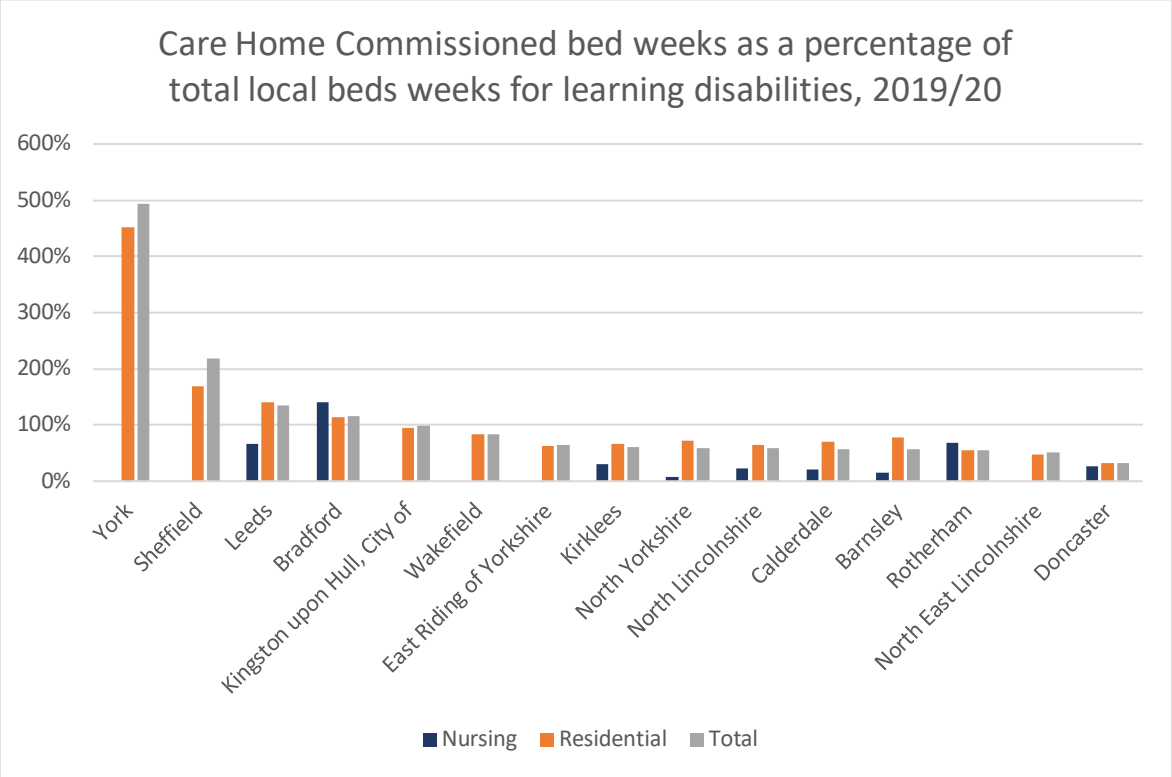
Finally, the registered care home bed data from CQC can be compared with the activity data from the ASC-FR return to get an indication of the proportion of the total care home bed supply that is commissioned by the local authority (although the data do not distinguish between care home beds purchased locally and those purchased out of area). CQC registered bed data from July 2019 have been used for this calculation because the ASC-FR data relate to 2019/20.

CQC data classify homes as either residential or nursing and cannot reflect split use.

Table 17 - Commissioned bed/weeks as a percentage of total available (CQC, July 2019)

	Nursing	Residential	Total
York	0%	451%	493%
Sheffield	0%	169%	218%
Leeds	66%	141%	134%
Bradford	141%	113%	116%
Kingston upon Hull, City of	0%	95%	99%
Wakefield	0%	84%	84%
East Riding of Yorkshire	0%	63%	64%
Kirklees	31%	66%	62%
North Yorkshire	8%	71%	59%
North Lincolnshire	23%	65%	59%
Calderdale	20%	70%	57%
Barnsley	16%	79%	56%
Rotherham	68%	55%	55%
North East Lincolnshire	0%	48%	51%
Doncaster	26%	33%	33%

Figures over 100% suggest that some commissioning takes place outside of the local authority area to meet care home bed requirements. Commissioning figures of less than 100% suggest that the authority has additional care home capacity which is probably purchased by other local authorities (or the NHS). Where the percentage shows as 0% this means that the authority does not have any of this type of this provision, so any commissioning takes place outside of the authority area.



13.6 Population

Population figures are based on PANSI data for 2020. The table below shows the estimated number of people with moderate or severe learning disabilities, so those most likely to rely on social care or nursing services to support them in the community.

Table 18 – Population with moderate to severe learning disabilities based on PANSI estimates for 2020

	65+
Barnsley	810
Bradford	1,788
Calderdale	698
Doncaster	997
East Riding of Yorkshire	1,044
Kingston upon Hull, City of	907
Kirklees	1,484
Leeds	2,814
North East Lincolnshire	512
North Lincolnshire	548
North Yorkshire	1,847
Rotherham	850
Sheffield	2,084
Wakefield	1,110
York	766
Barnsley	810

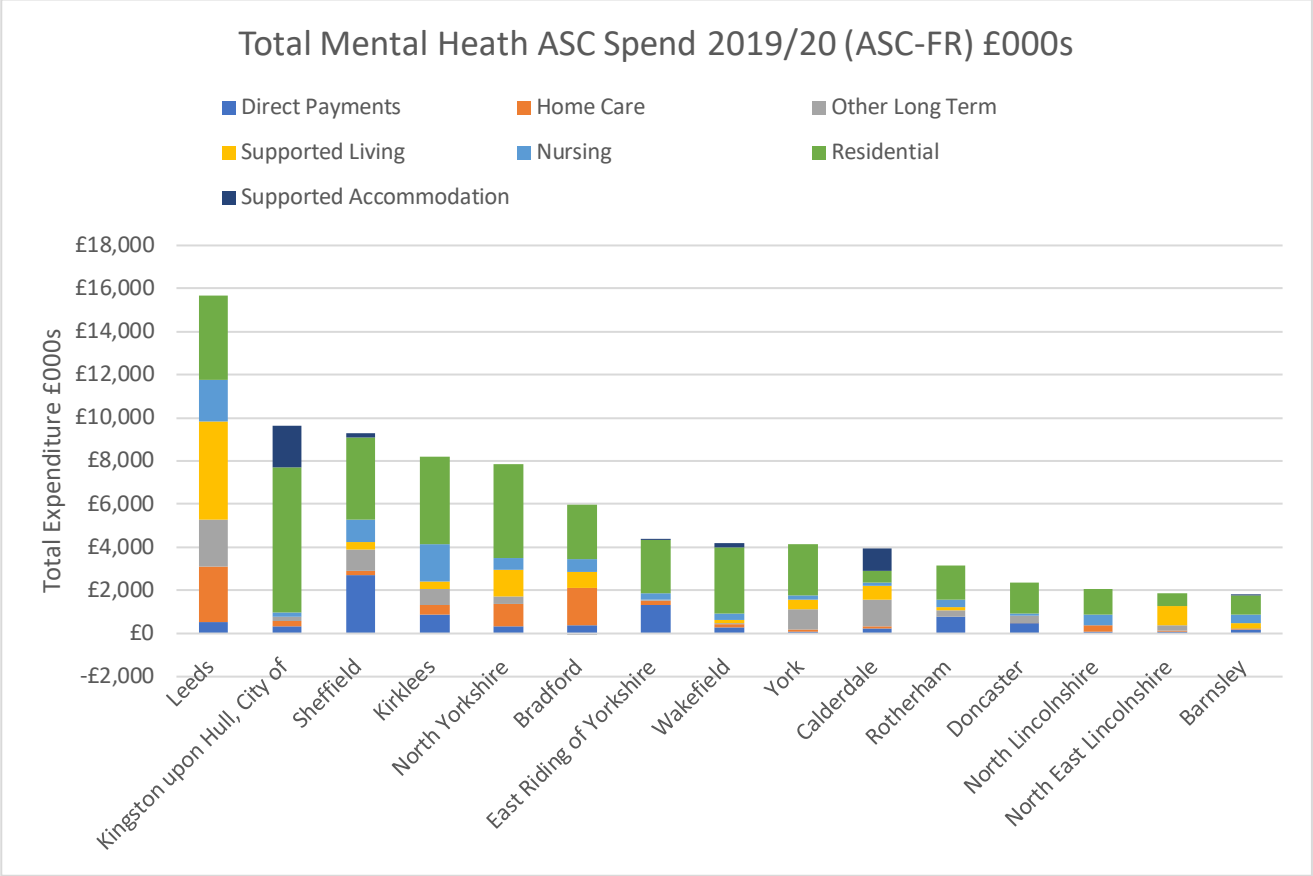
14 Data – People with Mental Health Support Needs

14.1 Expenditure on Adult Social Care for people with mental health support needs

The following expenditure figures are in £000s covering all adult social care expenditure (gross costs).

Table 19 - Gross Mental Health 18-64 social care costs (ASC-FR 2019/20)

	Direct Payments	Home Care	Other Long Term	Supported Living	Nursing	Residential	Supported Accommodation	Total
Leeds	£513	£2,602	£2,143	£4,598	£1,913	£3,896	£0	£15,665
Kingston upon Hull, City of	£329	£276	£169	£0	£194	£6,720	£1,936	£9,624
Sheffield	£2,701	£208	£1,006	£321	£1,048	£3,814	£191	£9,287
Kirklees	£864	£440	£755	£345	£1,759	£4,036	£0	£8,198
North Yorkshire	£335	£1,046	£328	£1,247	£523	£4,355	£0	£7,834
Bradford	£367	£1,757	-£43	£709	£625	£2,502	£0	£5,917
East Riding of Yorkshire	£1,300	£220	£47	£0	£289	£2,496	£14	£4,366
Wakefield	£271	£164	£32	£162	£284	£3,074	£219	£4,206
York	£66	£114	£965	£436	£195	£2,354	£0	£4,130
Calderdale	£218	£126	£1,229	£650	£116	£566	£1,059	£3,964
Rotherham	£803	£0	£286	£148	£349	£1,560	£0	£3,146
Doncaster	£488	£11	£333	£0	£95	£1,445	£0	£2,372
North Lincolnshire	£91	£296	£0	£0	£475	£1,195	£0	£2,057
North East Lincolnshire	£98	£24	£279	£864	£0	£588	£0	£1,853
Barnsley	£208	£14	£10	£272	£393	£891	£7	£1,795

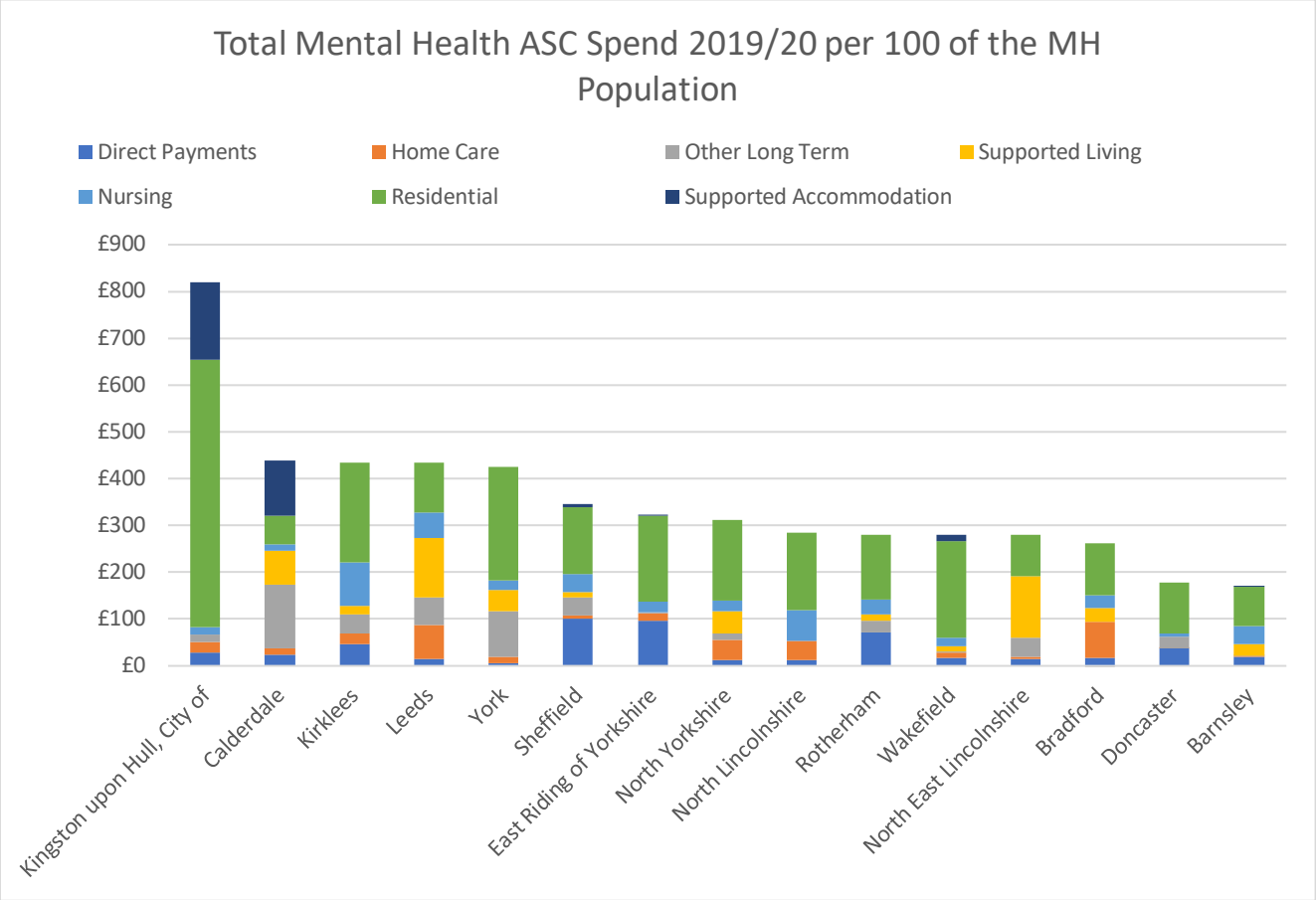


The following table and chart show the same expenditure in terms of the cost per 100 of the mental health population aged 18-64, to balance out the population size differences between the authorities.

Table 20 – Mental Health 18-64 Social Care Costs per 100 of the MH population

	Direct Payments	Home Care	Other Long Term	Supported Living	Nursing	Residential	Supported Accommodation	Total
Kingston upon Hull, City of	£28	£24	£14	£0	£17	£572	£165	£820
Calderdale	£24	£14	£136	£72	£13	£63	£117	£438
Kirklees	£46	£23	£40	£18	£93	£214	£0	£435
Leeds	£14	£72	£60	£128	£53	£108	£0	£435

York	£7	£12	£99	£45	£20	£242	£0	£424
Sheffield	£101	£8	£37	£12	£39	£142	£7	£346
East Riding of Yorkshire	£96	£16	£3	£0	£21	£184	£1	£321
North Yorkshire	£13	£42	£13	£50	£21	£174	£0	£313
North Lincolnshire	£13	£41	£0	£0	£66	£166	£0	£286
Rotherham	£72	£0	£26	£13	£31	£139	£0	£281
Wakefield	£18	£11	£2	£11	£19	£205	£15	£281
North East Lincolnshire	£15	£4	£42	£130	£0	£89	£0	£279
Bradford	£16	£77	-£2	£31	£27	£110	£0	£260
Doncaster	£37	£1	£25	£0	£7	£108	£0	£178
Barnsley	£20	£1	£1	£26	£37	£84	£1	£169



14.2 Care Home Commissioning Activity Mental Health 18-64

ASC-FR activity data for 2019/20 provide information on the purchasing of care home bed weeks over the year. Again, this data is provided in terms of raw activity and then adjusted for the mental health 18-64 population to take account of different population sizes across the authorities.

Table 21 - Total commissioned care home bed weeks (ASC-FR 2019/20)

	Nursing	Residential	Total
Sheffield	771	6,576	7,347
Leeds	2,955	3,664	6,619
Kingston upon Hull, City of	259	5,494	5,753
Bradford	928	3,786	4,714
Kirklees	1,081	2,890	3,971
North Yorkshire	543	3,109	3,652
Wakefield	168	3,376	3,545
North Lincolnshire	874	2,197	3,071
East Riding of Yorkshire	130	2,713	2,843
Doncaster	154	2,386	2,540
York	139	2,294	2,433
Rotherham	430	1,624	2,054
Barnsley	123	1,301	1,424
Calderdale	152	728	880
North East Lincolnshire	-	810	810

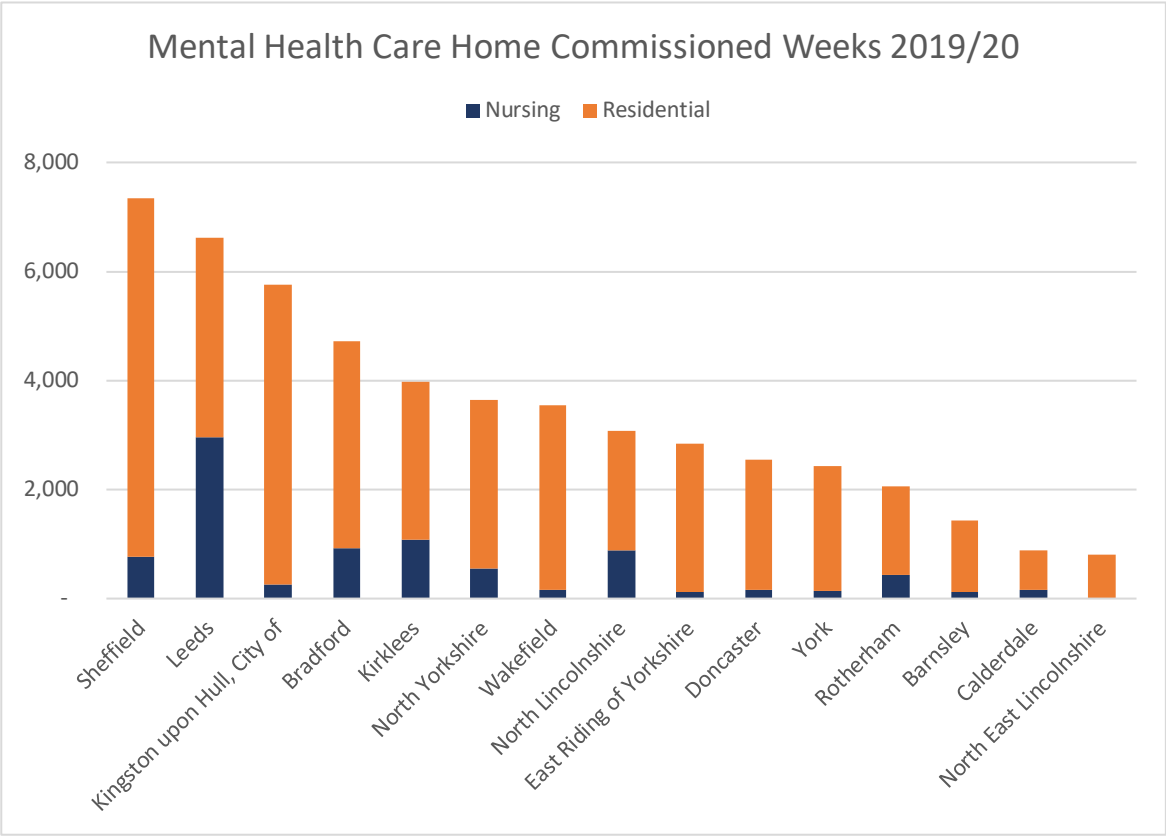
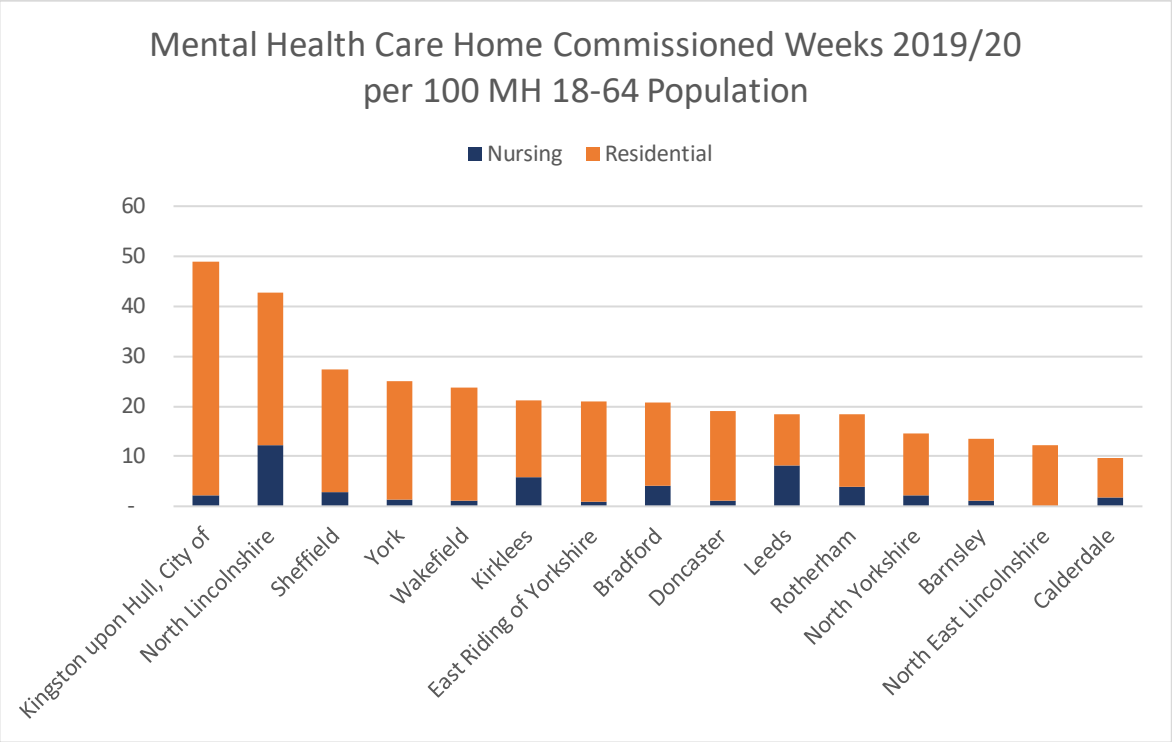


Table 22 - Commissioned Care Home Bed/Weeks per 100 of the mental health 18-64 population

	Nursing	Residential	Total
Kingston upon Hull, City of	2	47	49
North Lincolnshire	12	31	43
Sheffield	3	25	27
York	1	24	25
Wakefield	1	23	24
Kirklees	6	15	21
East Riding of Yorkshire	1	20	21
Bradford	4	17	21
Doncaster	1	18	19
Leeds	8	10	18

Rotherham	4	14	18
North Yorkshire	2	12	15
Barnsley	1	12	13
North East Lincolnshire	-	12	12
Calderdale	2	8	10

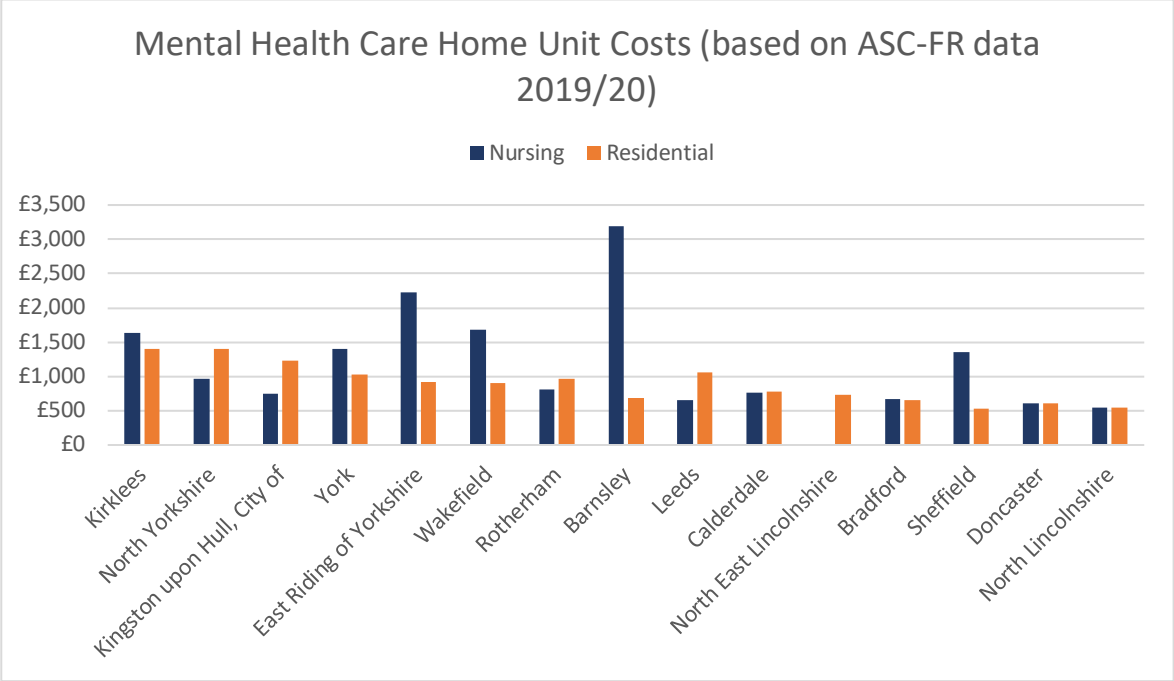


14.3 Unit Cost Data – Mental Health 18-64 care homes

The ASC-FR provides data on the unit cost of residential and nursing care beds commissioned. This is based on a calculation (costs / activity) and **not on the actual fee rates of the authorities**. Unit costs include placements outside of the local authority area, which are generally of higher cost and therefore increase the overall average cost reported below.

Table 23 - Unit Cost data for care homes from the ASC-FR 2019/20

	Nursing	Residential	Combined
Kirklees	£1,627	£1,397	£1,459
North Yorkshire	£963	£1,401	£1,336
Kingston upon Hull, City of	£749	£1,223	£1,202
York	£1,403	£1,026	£1,048
East Riding of Yorkshire	£2,223	£920	£980
Wakefield	£1,688	£910	£947
Rotherham	£812	£961	£929
Barnsley	£3,195	£685	£902
Leeds	£647	£1,063	£878
Calderdale	£765	£777	£775
North East Lincolnshire	£0	£726	£726
Bradford	£674	£661	£663
Sheffield	£1,359	£535	£621
Doncaster	£615	£606	£606
North Lincolnshire	£544	£544	£544



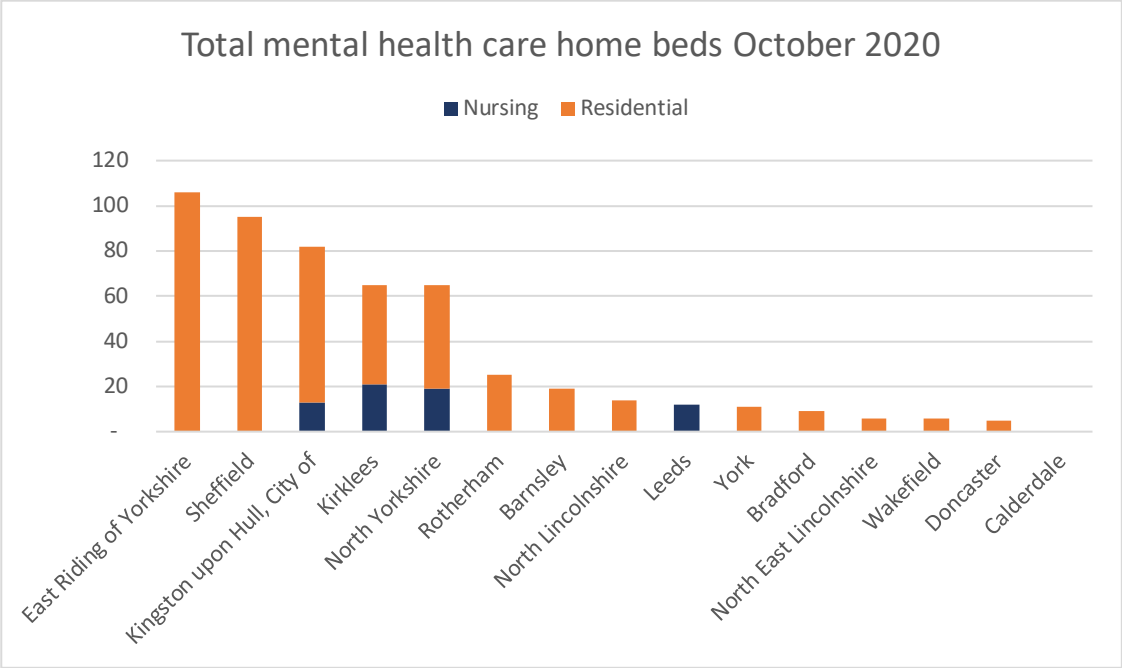
14.4 Care Home Bed Supply

The tables and charts below looks at the care homes registered with CQC to provide support to people with learning disabilities and not other client groups.

Table 24 - Total CQC registered care home beds, October 2020

Local Authority	Nursing	Residential	Total
East Riding of Yorkshire		106	106
Sheffield		95	95
Kingston upon Hull, City of	13	69	82
Kirklees	21	44	65
North Yorkshire	19	46	65
Rotherham		25	25
Barnsley		19	19
North Lincolnshire		14	14
Leeds	12		12
York		11	11

Bradford		9	9
North East Lincolnshire		6	6
Wakefield		6	6
Doncaster		5	5
Calderdale			-

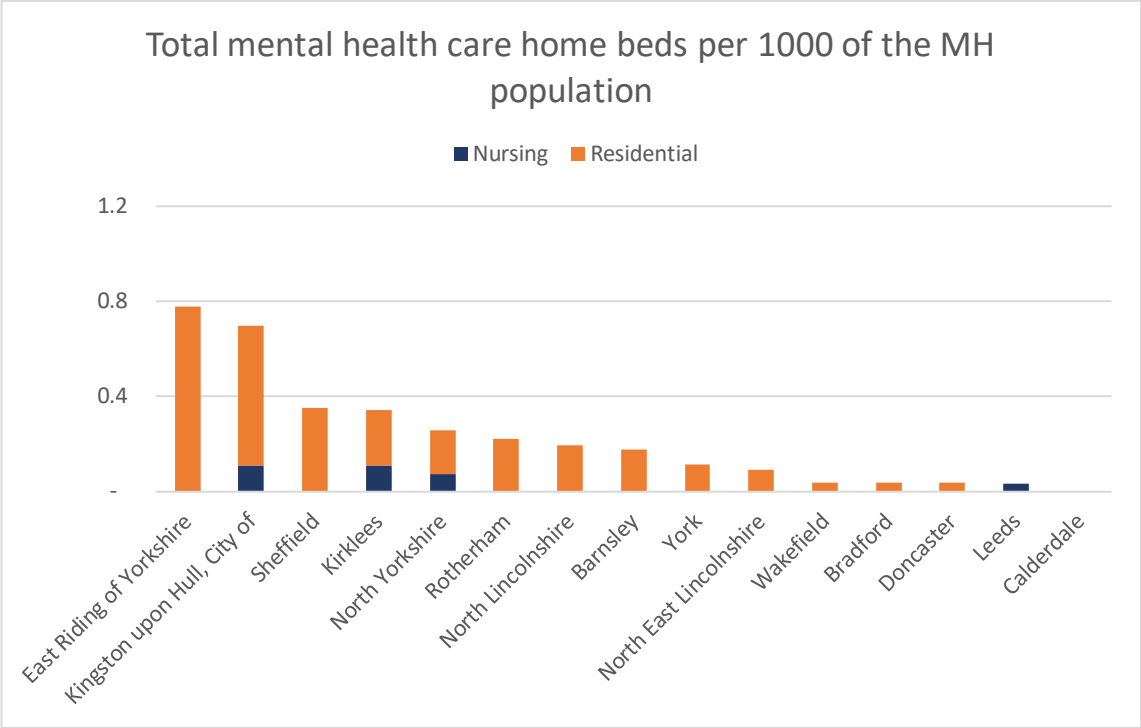


In terms of population adjusted care home bed supply (beds per 100 of the MH 18-64 population).

Table 25 - Care Home Beds per 100 of the MH 18-64 population (CQC, October 2020)

	Nursing	Residential	Total
East Riding of Yorkshire	-	0.8	0.8
Kingston upon Hull, City of	0.1	0.6	0.7
Sheffield	-	0.4	0.4
Kirklees	0.1	0.2	0.3
North Yorkshire	0.1	0.2	0.3
Rotherham	-	0.2	0.2

North Lincolnshire	-	0.2	0.2
Barnsley	-	0.2	0.2
York	-	0.1	0.1
North East Lincolnshire	-	0.1	0.1
Wakefield	-	0.0	0.0
Bradford	-	0.0	0.0
Doncaster	-	0.0	0.0
Leeds	0.0	-	0.0
Calderdale	-	-	-



Comparing CQC registered beds between July 2019 and October 2020 suggests that there has been increase of 19 nursing home beds across the region, and a gain of 3 residential beds, with a net increase in registered beds of 22.

14.4.1 Commissioned Care Home Beds

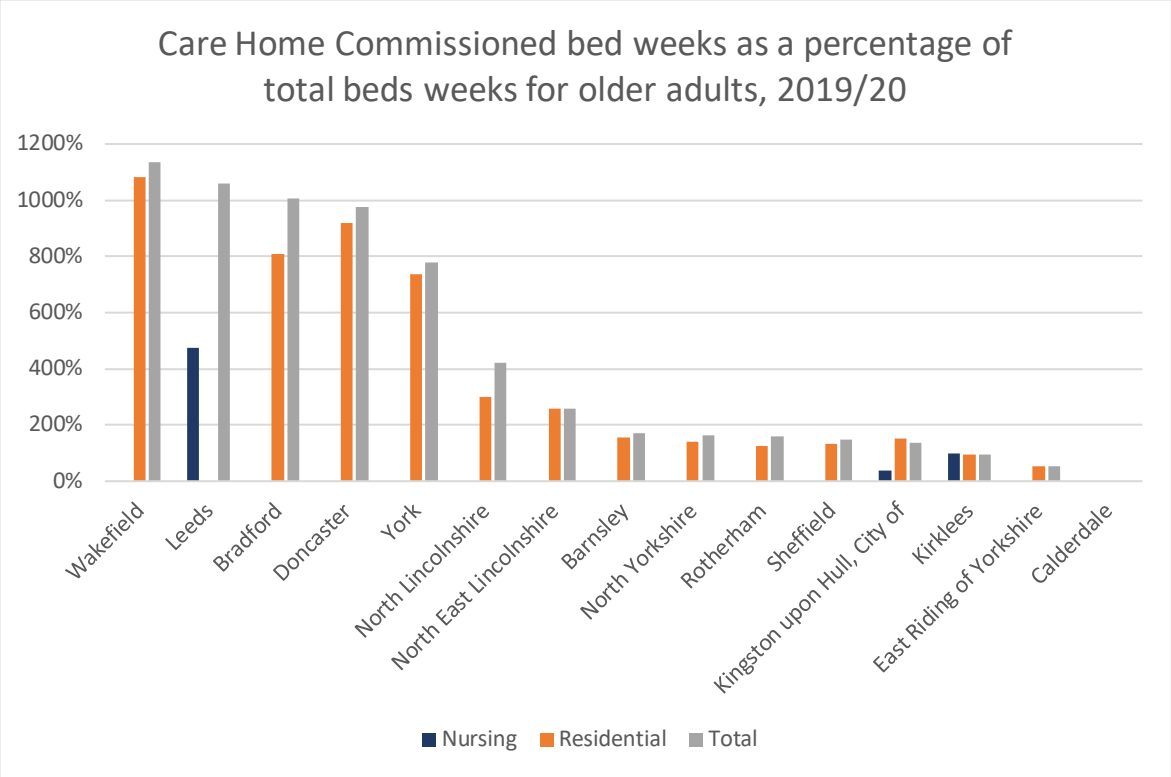
Finally, the registered care home bed data from CQC can be compared with the activity data from the ASC-FR return to get an indication of the proportion of the total care home bed supply that is commissioned by the local authority (although the data do not distinguish

between care home beds purchased locally and those purchased out of area). CQC registered bed data from July 2019 have been used for this calculation because the ASC-FR data relate to 2019/20.

CQC data classify homes as either residential or nursing and cannot reflect split use.

Table 26 - Commissioned bed/weeks as a percentage of total available (CQC, July 2019)

	Nursing	Residential	Total
Wakefield	0%	1082%	1136%
Leeds	474%	0%	1061%
Bradford	0%	809%	1007%
Doncaster	0%	918%	977%
York	0%	735%	780%
North Lincolnshire	0%	302%	422%
North East Lincolnshire	0%	260%	260%
Barnsley	0%	156%	171%
North Yorkshire	0%	139%	163%
Rotherham	0%	125%	158%
Sheffield	0%	133%	149%
Kingston upon Hull, City of	38%	153%	135%
Kirklees	99%	96%	97%
East Riding of Yorkshire	0%	52%	55%
Calderdale	0%	0%	0%



Figures over 100% suggest that some commissioning takes place outside of the local authority area to meet care home bed requirements. Commissioning figures of less than 100% suggest that the authority has additional care home capacity which is probably purchased by other local authorities (or the NHS). Where the percentage shows as 0% this means that the authority does not have any of this type of this provision, so any commissioning takes place outside of the authority area.

14.5 Population

Population figures are based on PANSI data for 2020. The table below shows the estimated number of people with moderate or severe learning disabilities, so those most likely to rely on social care or nursing services to support them in the community.

Table 27 – Estimated population with two or more psychiatric disorders based on PANSI estimates for 2020

	18-64
Barnsley	10,629
Bradford	22,773
Calderdale	9,042
Doncaster	13,336
East Riding of Yorkshire	13,592
Kingston upon Hull, City of	11,742
Kirklees	18,835
Leeds	36,014
North East Lincolnshire	6,637
North Lincolnshire	7,200
North Yorkshire	25,054
Rotherham	11,202
Sheffield	26,833
Wakefield	14,990
York	9,739
Barnsley	10,629

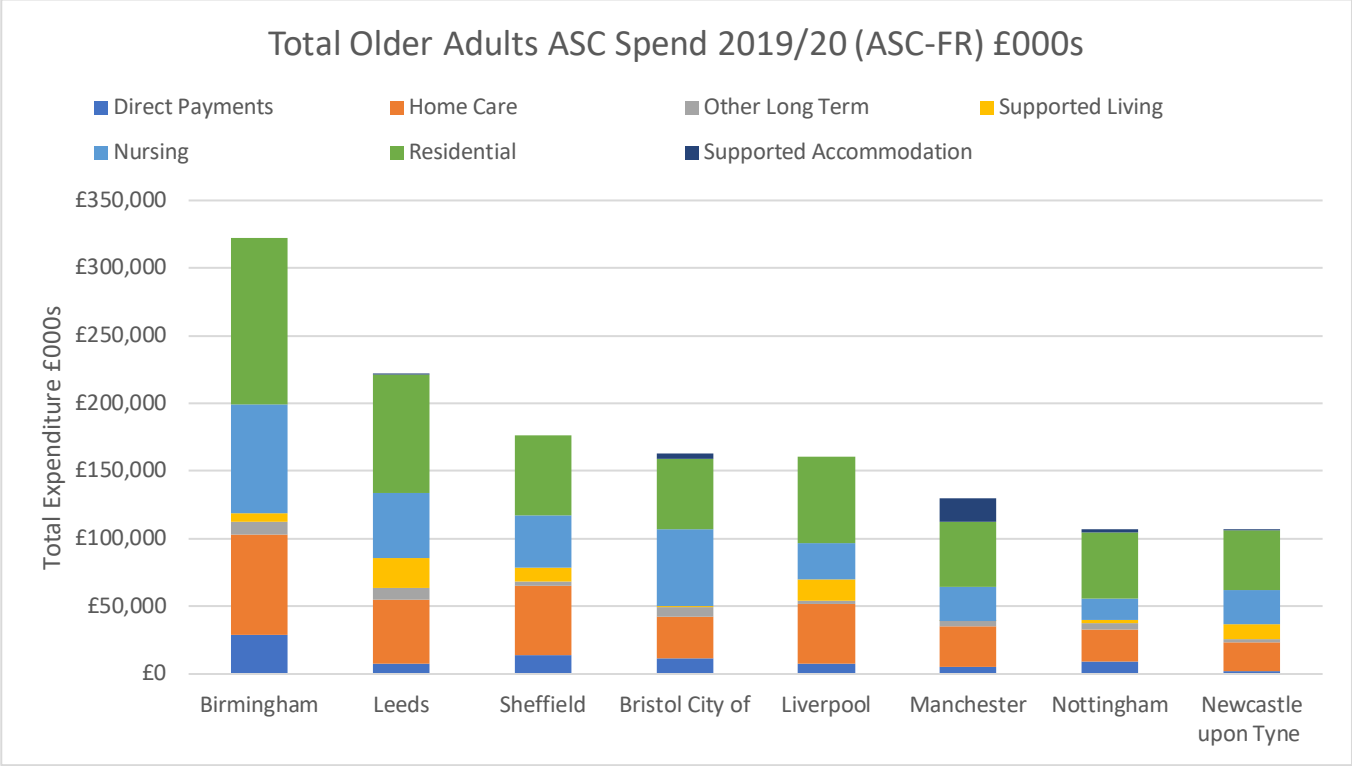
15 Core Cities Group (Older Adults 65+)

15.1 Expenditure on Adult Social Care for Older Adults

The following expenditure figures are in £000s. Sheffield is in the middle of the group in terms of overall expenditure.

Table 28 - Gross older adult social care costs (ASC-FR 2019/20)

	Direct Payments	Home Care	Other Long Term	Supported Living	Nursing	Residential	Supported Accommodation	Total
Birmingham	£28,712	£74,038	£9,642	£6,636	£80,554	£122,320	£0	£321,902
Leeds	£7,460	£47,834	£8,572	£21,844	£47,906	£87,470	£250	£221,336
Sheffield	£13,647	£51,816	£3,088	£10,160	£38,797	£58,989	£0	£176,498
Bristol City of	£11,340	£31,318	£6,500	£1,304	£56,418	£52,304	£3,848	£163,032
Liverpool	£7,269	£44,703	£2,347	£15,500	£27,224	£63,211	£0	£160,254
Manchester	£5,244	£29,740	£4,208	£284	£24,572	£48,768	£16,824	£129,640
Nottingham	£9,322	£23,788	£4,728	£2,260	£15,598	£49,222	£1,846	£106,764
Newcastle upon Tyne	£2,205	£21,328	£2,447	£10,734	£25,675	£43,706	£47	£106,141

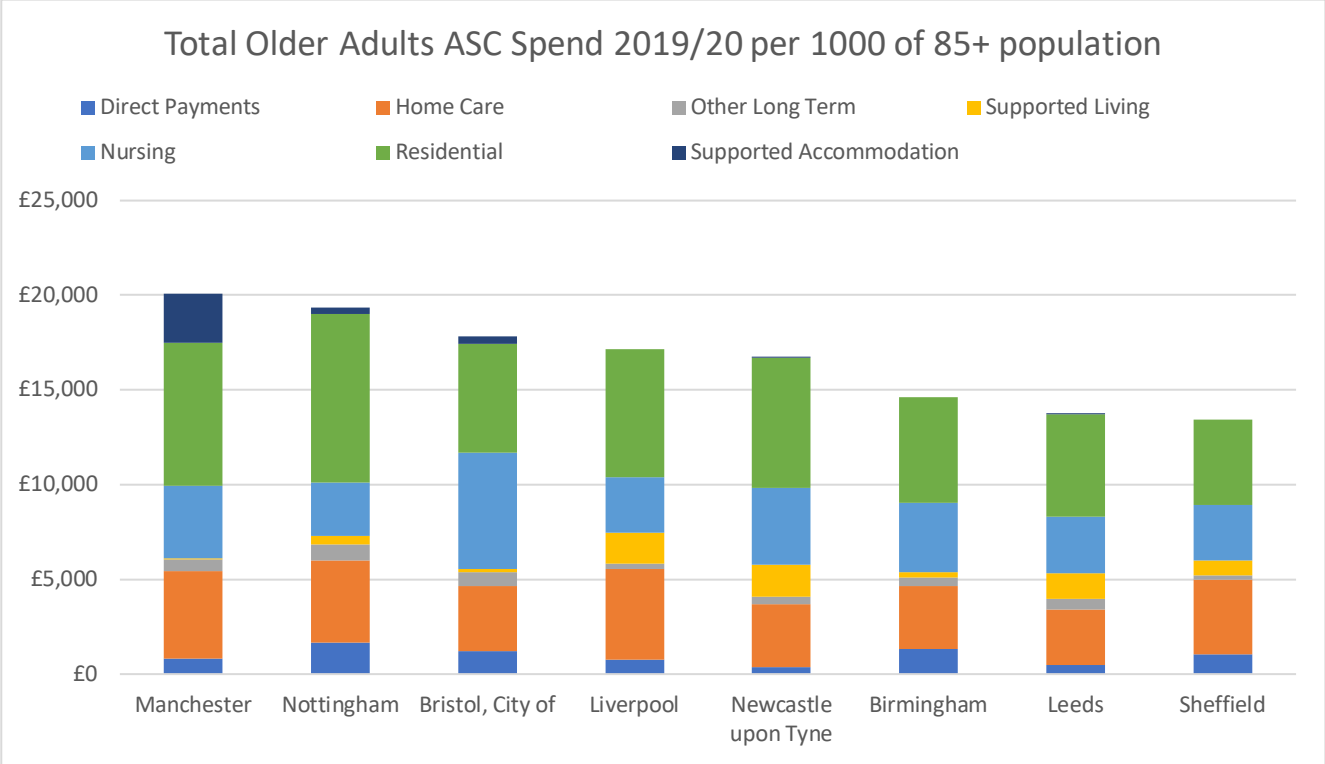


The following table and chart show the same expenditure in terms of the cost per 1000 of the population aged 85+, to balance out the population size differences between the cities. This shows that Sheffield's overall expenditure per head is at the bottom of the group.

Table 29 - 65+ Adult Social Care Costs per 1000 of the 85+ population

	Direct Payments	Home Care	Other Long Term	Supported Living	Nursing	Residential	Supported Accommodation	Total
Manchester	£813	£4,609	£652	£44	£3,808	£7,557	£2,607	£20,090
Nottingham	£1,692	£4,317	£858	£410	£2,831	£8,933	£335	£19,376
Bristol, City of	£1,241	£3,428	£711	£143	£6,175	£5,725	£421	£17,845
Liverpool	£778	£4,784	£251	£1,659	£2,914	£6,765	£0	£17,151
Newcastle upon Tyne	£347	£3,357	£385	£1,689	£4,041	£6,878	£7	£16,705
Birmingham	£1,303	£3,360	£438	£301	£3,655	£5,551	£0	£14,607

Leeds	£463	£2,966	£532	£1,355	£2,971	£5,424	£16	£13,726
Sheffield	£1,040	£3,949	£235	£774	£2,956	£4,495	£0	£13,449



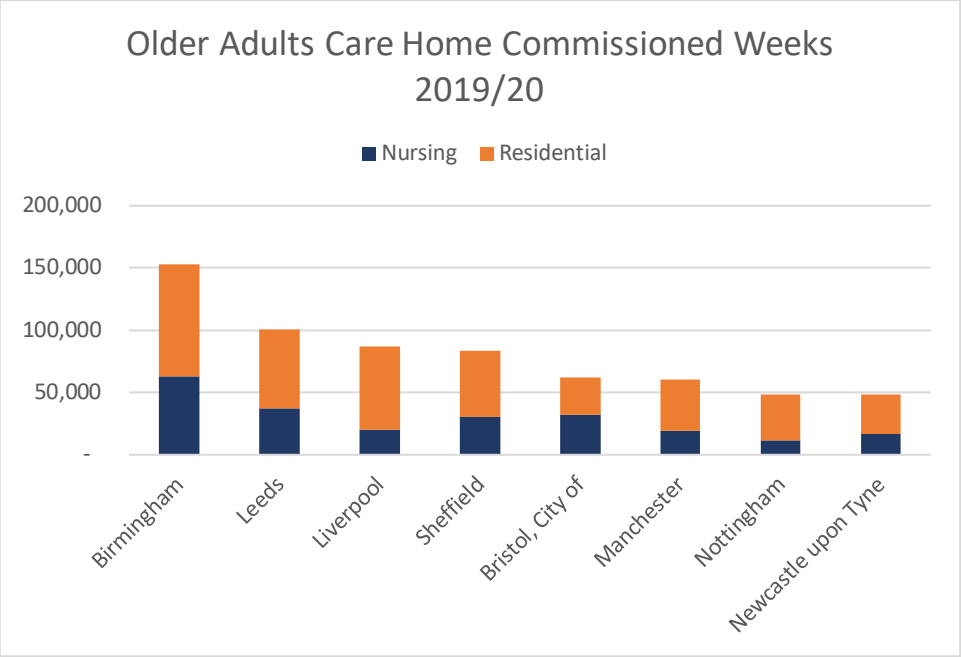
15.2 Care Home Commissioning Activity (65+)

ASC-FR activity data for 2019/20 provide information on the purchasing of care home bed weeks over the year. Again, this data is provided in terms of raw activity and then adjusted for the 85+ population to take account of different population sizes across the cities.

In terms of the overall bed/weeks commissioned Sheffield is in the middle of the group:

Table 30 - Total commissioned care home bed weeks (ASC-FR 2019/20)

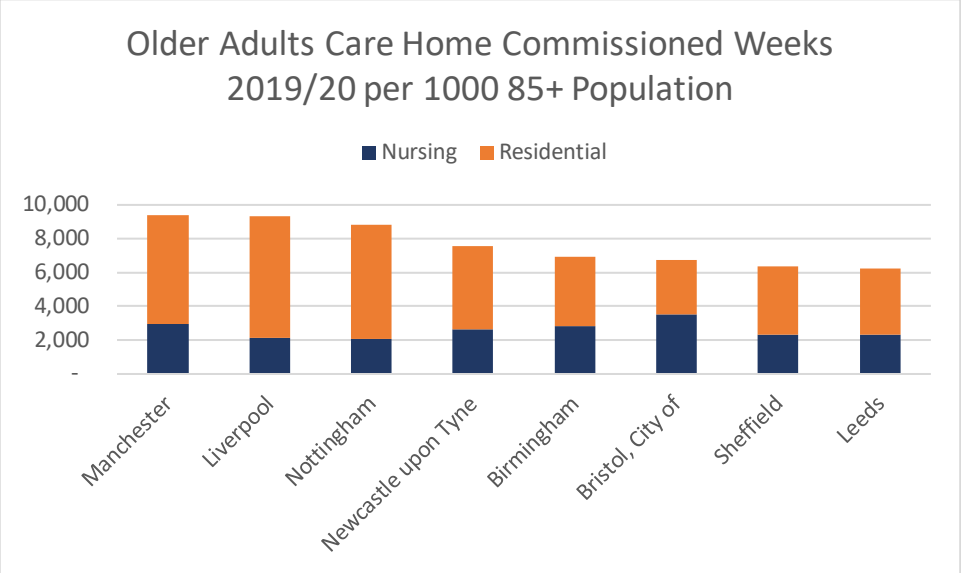
	Nursing	Residential	Total
Birmingham	62,955	89,823	152,778
Leeds	37,259	63,107	100,366
Liverpool	20,016	67,222	87,238
Sheffield	30,810	52,642	83,452
Bristol, City of	32,383	29,288	61,671
Manchester	19,193	41,517	60,710
Nottingham	11,394	37,287	48,681
Newcastle upon Tyne	16,624	31,505	48,129



Adjusted for the 85+ population, Sheffield is towards the bottom of the group, with an overall level of bed/week commissioning just above Leeds, although commissioning of nursing beds is in the middle of the group. There is considerably more variance in the per capita rate of residential care commissioning compared to nursing care, with Manchester, Liverpool and Nottingham purchasing more residential care than the other authorities.

Table 31 - Commissioned Care Home Bed/Weeks per 1000 of the 85+ population

	Nursing	Residential	Total
Manchester	2,974	6,434	9,408
Liverpool	2,142	7,194	9,336
Nottingham	2,068	6,767	8,835
Newcastle upon Tyne	2,616	4,958	7,575
Birmingham	2,857	4,076	6,933
Bristol, City of	3,545	3,206	6,750
Sheffield	2,348	4,011	6,359
Leeds	2,311	3,914	6,224



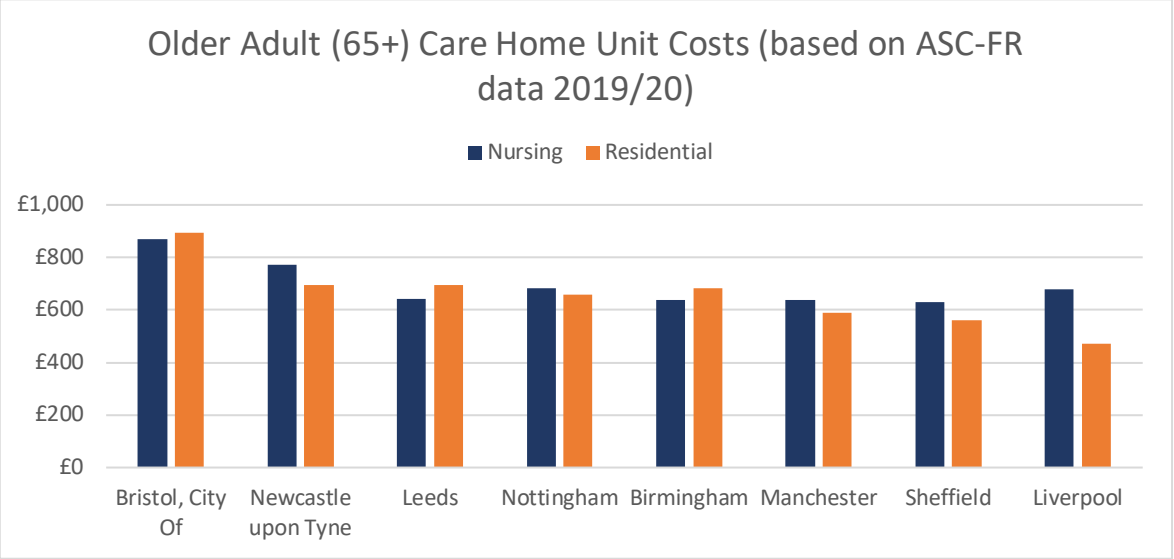
15.3 Unit Cost Data – Older Adult (65+) care homes

The ASC-FR provides data on the unit cost of residential and nursing care beds commissioned. This is based on a calculation (costs / activity) and **not on the actual fee rates of the authorities**.

Sheffield has the lowest nursing care unit cost, and the second lowest residential care unit cost and combined cost (which is the total paid for residential and nursing care divided by the number of residential and nursing care bed/weeks purchased and not the average. Liverpool is the lowest unit cost by some margin.

Table 32 - Unit Cost data for care homes from the ASC-FR 2019/20

	Nursing	Residential	Combined
Bristol, City Of	£871	£893	£881
Newcastle upon Tyne	£772	£694	£771
Leeds	£643	£693	£674
Nottingham	£685	£660	£666
Birmingham	£640	£681	£664
Manchester	£639	£587	£604
Sheffield	£630	£560	£586
Liverpool	£680	£470	£518



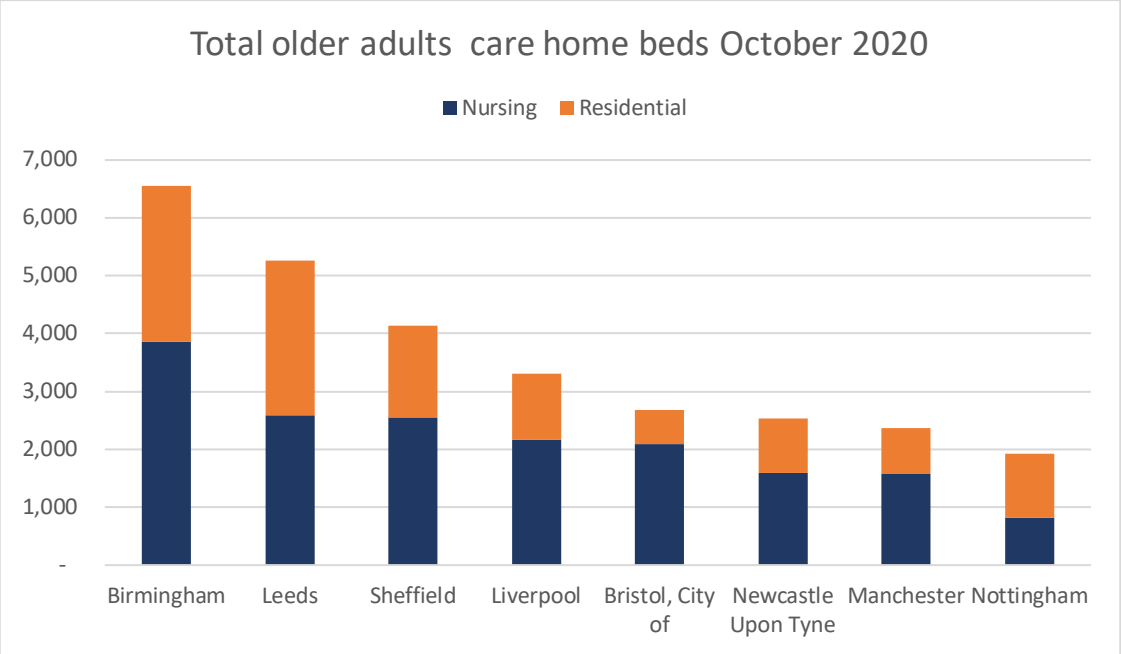
15.4 Care Home Bed Supply

CQC data from October 2020 are used to look at the overall supply of residential and nursing care beds in each of the core cities.

In terms of raw numbers, there is a considerable variance, reflecting the different population sizes:

Table 33 - Total CQC registered care home beds, October 2020

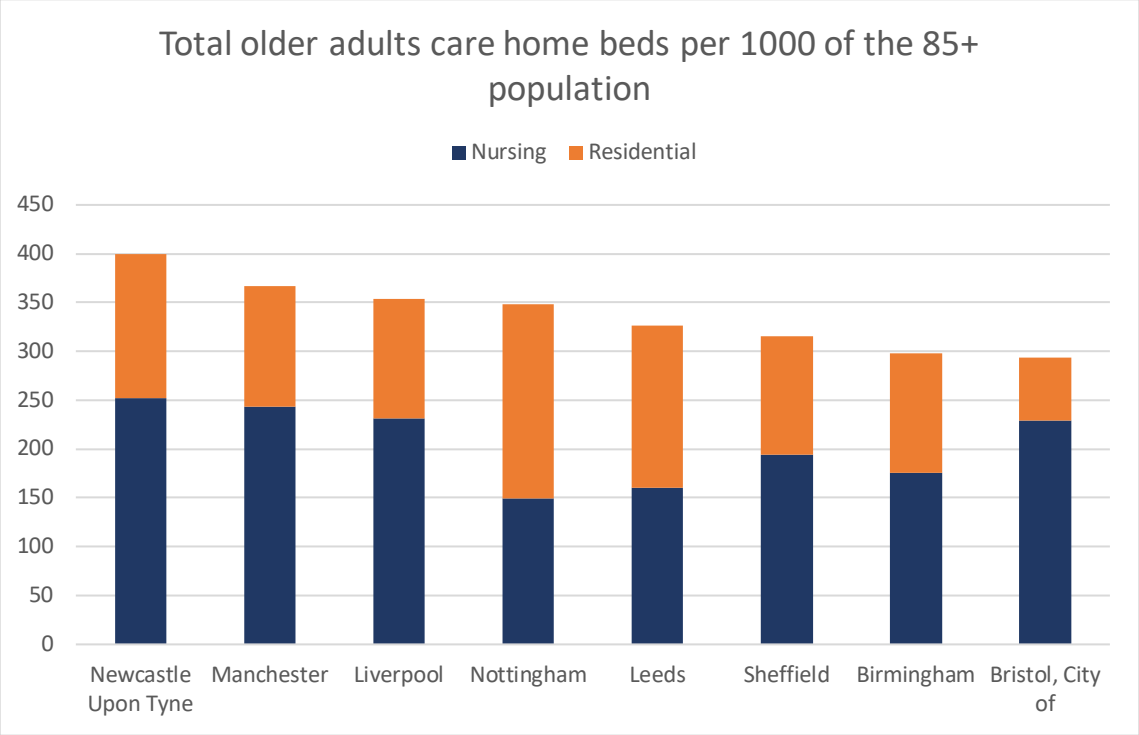
Local Authority	Nursing	Residential	Total
Birmingham	3,862	2,696	6,558
Leeds	2,586	2,669	5,255
Sheffield	2,552	1,593	4,145
Liverpool	2,166	1,136	3,302
Bristol, City of	2,094	586	2,680
Newcastle Upon Tyne	1,600	941	2,541
Manchester	1,569	796	2,365
Nottingham	825	1,092	1,917



In terms of population adjusted care home bed supply (beds per 1000 of the 85+ population), the overall supply figures are fairly similar across the authorities. There is more variance in the supply of nursing home beds, with Nottingham and Leeds having fewer nursing care beds per 1000 of the 85+ population than the other core cities.

Table 34 - Care Home Beds per 1000 of the 85+ population (CQC, October 2020)

	Nursing	Residential	Total
Newcastle Upon Tyne	252	148	400
Manchester	243	123	366
Liverpool	232	122	353
Nottingham	150	198	348
Leeds	160	166	326
Sheffield	194	121	316
Birmingham	175	122	298
Bristol, City of	229	64	293



Sheffield is in the middle in terms of nursing care beds per capita and the lowest in terms of residential beds (although only just behind Birmingham, Liverpool and Manchester).

Comparing CQC registered beds between June 2018 and October 2020 suggests that there has been a net loss of nursing care beds of about 4% (505 beds) and a gain of about 4% in residential care beds (424 beds). In Sheffield over that period, there was a reduction

of 6% in nursing care beds (173 beds) and a gain of 2% in residential care beds (38 beds). Leeds, in contrast, added 3% nursing care beds (83) and 2% residential beds (45).

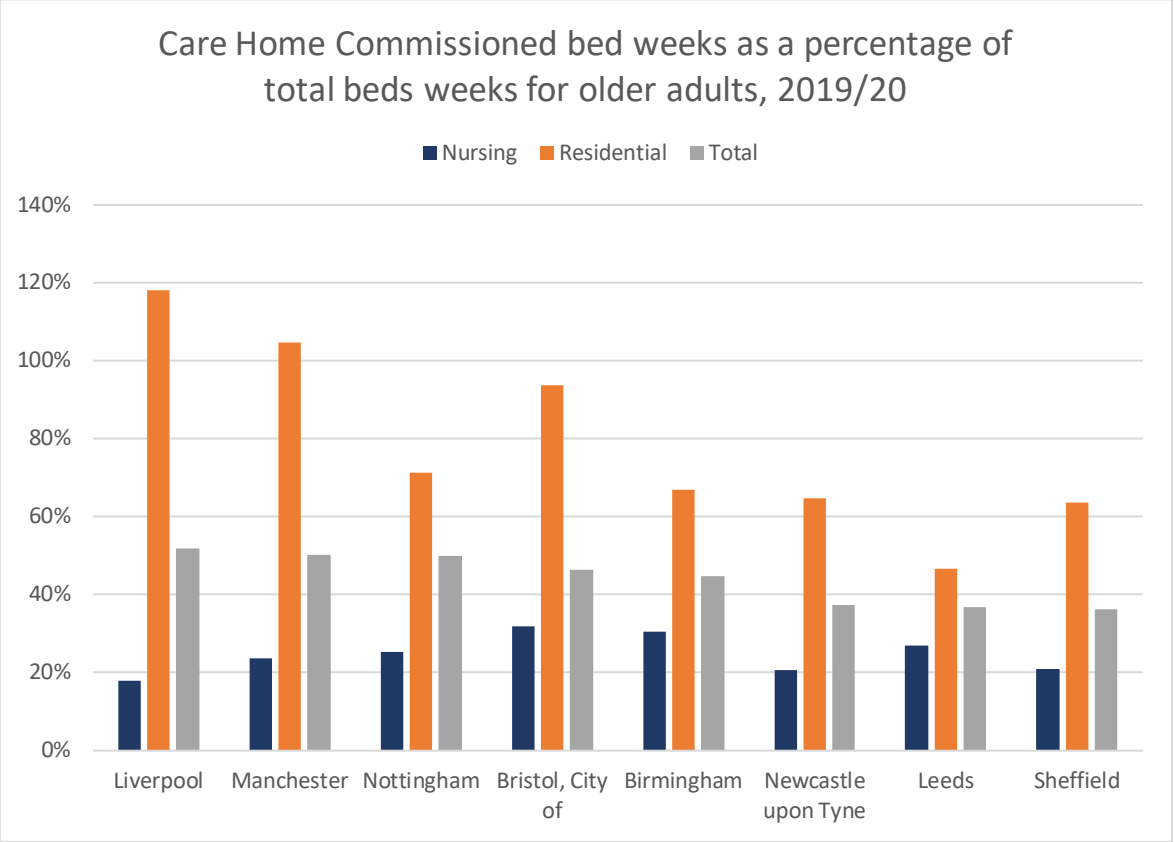
15.4.1 Commissioned Care Home Beds

Finally, the registered care home bed data from CQC can be compared with the activity data from the ASC-FR return to get an indication of the proportion of the total care home bed supply that is commissioned by the local authority (although the data do not distinguish between care home beds purchased locally and those purchased out of area). CQC registered bed data from July 2019 have been used for this calculation because the ASC-FR data relate to 2019/20.

Sheffield has the lowest level of bed/week commissioning compared to the overall available bed weeks. Note that were the commissioning percentage is greater than 100% for residential care, it suggests that residential beds are being commissioned in nursing homes. CQC data classify homes as either residential or nursing and cannot reflect split use.

Table 35 - Commissioned bed/weeks as a percentage of total available (CQC, July 2019)

	Nursing	Residential	Total
Liverpool	18%	118%	52%
Manchester	24%	105%	50%
Nottingham	25%	71%	50%
Bristol, City of	32%	94%	46%
Birmingham	30%	67%	45%
Newcastle upon Tyne	21%	65%	37%
Leeds	27%	47%	37%
Sheffield	21%	64%	36%



The average percentage of beds commissioned by local authorities of the total supply in England is about 40%, so these figures are broadly in line with that. The remaining beds are made up of NHS purchased beds, beds purchased by other local authorities, self-funded beds and vacancies. Data for 2019 (LaingBuisson, Market Report) suggest that bed occupancy rate in that year was 84% for “for-profit” care homes in England, and 81% in Yorkshire and Humberside.

15.5 Population

Population figures are based on 2019 Mid-Year Estimates, published in 2020. The table below shows the population figures for the 65+ population, 75+ population and the 85+ population. The 85+ population has been used to calculate population-level comparisons because that is the age at which the majority of older people are admitted into care homes, and therefore reflects the relative size of the highest need age group.

The final column is the 85+ population as a percentage of the 65+ population. This is broadly similar across the Core Cities group and Sheffield is in the middle of the range.

Table 36 - Mid Year Population estimates 2019

	65+	75+	85+	85+ as a percent of 65+ pop
Birmingham	149,418	71,797	22,037	15%
Leeds	123,516	56,887	16,125	13%
Liverpool	73,514	32,925	9,344	13%
Manchester	51,441	22,496	6,453	13%
Nottingham	38,779	17,625	5,510	14%
Sheffield	94,440	45,382	13,123	14%
Bristol, City of	60,345	28,426	9,136	15%
Newcastle upon Tyne	43,840	20,250	6,354	14%

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