



COUNTY CARE MARKETS UPDATE 2017

Financial challenges in the light of
proposals for long term care funding reform

Prepared for the County Councils Network

by LaingBuisson

October 2017

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EXECUTIVE SUMMARY

This report updates and extends a series of earlier reports on 'County Care Markets' prepared by LaingBuisson in 2015 for 12 counties within the County Councils Network (CCN). The 2015 reports focused specifically on risks of destabilisation of care home markets for older people in the light of the (then imminent, but subsequently postponed) implementation of the Dilnot long term care funding reforms. The context of this new (2017) report is continuing government austerity and a forthcoming government Green Paper which is expected to contain new proposals for long term care funding reform.

Background

As noted in the 2015 reports, more than five years of austerity have forced local authorities to reduce real terms fee rates paid to care homes. Care homes have typically responded by raising fees paid by private payers faster than inflation. As a result, public/private fee polarisation has become more deeply embedded as a structural feature of the care home market, with private fees more than 40% higher than publicly paid fees for the same level of amenity, and in all probability the same level of care. This brings with it risks of disinvestment by care providers serving public markets, falling capacity and 'crowding out' of public payers by private payers.

The risk of care market destabilisation is now compounded once again by the prospect of a new, revised set of long term care funding reforms, which could (as with Dilnot) drive 'payor shift' and 'market equalisation' to a degree that would undermine the commercial viability of care home operators, especially those in less affluent areas where 'payor shift' as a result of any major threshold extension would mean a large proportion of private payers (paying premium fees) qualifying for public support (at inadequate fees).

Councils' exposure to financial risk

Councils are exposed to significant financial risks because, without drawing on reserves, the fees they can afford to pay out of their council tax receipts and central government grants are in many cases insufficient to incentivise providers to make available the level of capacity that councils require to fulfil their statutory responsibilities.

The 'care home fee gap' is the largest financial risk that councils' social care departments face. It is defined as the difference between the usual fee paid by councils and the fee level necessary to offer care homes a reasonable return without a need for cross subsidy from private payers. Table 1 of the report shows that the gap varies widely, from as little as £10 per week for residential care for one of the twelve counties to as much as £285 for nursing care for another county.

A second potential financial risk is that central government funding may be inadequate to pay for the full costs of any long term care funding reforms that are implemented. This is inextricably bound up with the 'care home fee gap' risk because funding reforms may force councils to raise the fees they pay to fend off market destabilisation from payor shift and market equalisation.

Other financial risks include rising demographic pressure of demand for council funded care services.

Table 3 of the report quantifies councils' exposure to additional costs arising from these risks. For the 37 counties of the CCN, the aggregate exposure is estimated to be more than £1 billion a year, made up from:

- £670 million to eliminate the care home fee gap;
- £308 million to pay for the Conservative party proposal for a £100,000 single asset threshold for access to council supported care in a residential or nursing home; and
- A maximum of £122 million to pay for additional demographic pressure of demand (for nursing and residential care only) in 5 years' time (2022/23)

All these are projected additional annual costs at 2017/18 prices, compared with now, at a time in the future when the funding reforms will have reached steady state.

Inequitable geographical distribution of the benefits of proposed long term care funding reforms

A key finding from the 2015 report was that benefits to care service users from the Dilnot reforms would have been very unevenly distributed across counties.

A fresh analysis in 2017 confirms there would be a similarly uneven regional distribution of benefits for care service users from the 2017 Conservative party election manifesto proposal for a £100,000 'single threshold'.

Regional analysis, illustrated in Figure 3, demonstrates striking variances in the number and share of care home residents who are projected to benefit from 'Payor Shift' as a result of the £100,000 single threshold. There is a clear North / South divide, with the biggest benefits going to the North. Compared with today, there is a projected shift of 22% of the care home population in Yorkshire and Humberside from private pay to state support. The projected shift is high in in this generally non-affluent region because a large proportion of residential property values (the main source of individual wealth) are within spending-down distance of £100,000. In the affluent South East, in contrast, the corresponding payor shift is projected at only 4% because most property values are well in excess of £100,000.

Figure 4 illustrates the converse regional variances in the proportion of care home residents who would have reached a care cost cap of £72,000 at steady state, in up to 10 years' time. Care service users in the more affluent regions would be most likely to have reached the cap by the time the scheme reached maturity, headed by the South East and South West at 21% (ignoring London, which is anomalous), while those in less affluent regions are least likely, with the North West at the foot at 9%.

An alternative to threshold and cap – the Personal Asset Protection Guarantee concept

During the course of this work for the County Councils Network, it became apparent that the policy objectives of both the threshold and the care cost cap could be achieved in what is arguably a simpler and more equitable way, by defining individuals' eligibility for council support for residential care in terms of the percentage of each individual's assets (including owner-occupied property) which has been spent down since being assessed as needing care.

A simulation model built by LaingBuisson indicates that making individuals eligible for council support once they have spent down 28.5% of their assets would deliver similar policy objectives, more equitably, at the same public expenditure cost of a single threshold of £100,000 and a lifetime care cost cap of £72,000. It is called a Personal Asset Protection Guarantee because it guarantees that the state will not make any call on the remaining 71.5% of the individual's assets to pay for either care or the board and lodging costs of care homes, though individuals will (as now) be subject to charges based on their income.

Implications for local government reorganisation

The conclusions that may be drawn from data presented in this report are:

- Several districts within large counties generate a relatively limited level of demand, which may make it uneconomic for a district sized unitary authority to employ the full range of commissioning and market management skills;
- Inter-district resident flows would make it more difficult to pursue 'place-based' market management policies;
- Creation of additional unitary authorities would make it more complex to pursue health and social care integration initiatives involving collaboration between a multiplicity of health and local authorities;
- Inter-district resident flows would make it more difficult to balance supply and demand, potentially concentrating market weakness.

1. BACKGROUND

In 2015 LaingBuisson prepared a series of reports on care markets within 12 counties, on behalf of the County Councils Network (CCN).

For the first time, the reports quantified the magnitude of polarisation between privately and publicly funded care home fees, showing that private payers were paying over 40% more than council supported placements for the same physical accommodation, and in all probability for the same level of care, with the actual cost of care (including return on capital and operating profit) lying between the two in all 12 counties.

The origins of fee polarisation, which is now a key structural feature of care home markets throughout Britain, lie in the limited availability of public funds, private payers' lack of market power and the fact that most homes accommodate both private and public payers, thus making it possible for one set of fees to cross subsidise another. While no hard data is available on how private / public fee disparities have varied over time, it is likely they grew wider in the period of austerity leading up to the 2015 reports, as councils were forced by constrained budgets to set annual fee uplifts below the level of cost inflation and as providers compensated by setting above inflation fee uplifts for private payers.

While care markets have functioned adequately to date, in the sense that supply has thus far been sufficient to meet both publicly and privately paid demand, there is a concern that privately paid demand may start to crowd out publicly paid demand in some geographies in the future.

There is also a real risk that destabilisation of already fragile care markets in some geographies could be an unintended consequence of long term care funding reforms. These were identified in the 2015 reports for CCN as 'Payor shift' and 'Market equalisation':

- **'Payor shift'** is the term used to describe the transfer of a cohort of care home residents with modest assets out of private pay and into the ambit local authority support (at typically lower fee levels – unless topped up) as a result of extension of the asset limit for local authority support. Its impact is greatest in less affluent areas where prices of residential property (the main source of individual wealth) are clustered round the proposed £118,000 (under Dilnot) upper asset limit or the £100,000 single threshold proposed in the Conservative manifesto of 2017. LaingBuisson research in 2015 found that a third or more of privately paying care home residents in the least affluent areas of England would have become eligible for public support at a stroke and more would have spent down below the threshold during their stay in a care home. With private fees typically over 40% higher than local authority fees for like-for-like services, payor shift would have had a severe adverse impact on the margins of care homes in less affluent areas (most of them) which cater for a mix of publicly and privately paid residents. In contrast, payor shift would have had little effect on care homes in affluent areas where most property owners have assets well in excess of £100,000. This present report updates the 2015 analysis, using the newly proposed single threshold of £100,000 as the benchmark, rather than Dilnot's upper threshold of £118,000. Though the numbers differ, the conclusions (as described above) remain unchanged.

- **'Market equalisation'** was the term coined to describe the erosion of the price differential between privately and publicly paid care home services (over 40% on average). If the proposed £72,000 'care cap' had been introduced, many privately paying residents who registered for the cap would have realised for the first time that the 'usual costs' that councils were able to afford to pay fell far short of private pay fees set by care homes. The new price transparency, it was feared, would lead private payers and their families and advocates to seek a reduction in privately paid fees at least some way towards the local authority's 'usual costs', with an adverse impact on care home margins. Section 18(3) of the Care Act was even more worrying to care home operators. This is the section of the Care Act which gives local authorities a duty to assist everyone to meet their care needs, including private payers as well as people who qualify for council financial support. If councils were to interpret this as a duty to 'arrange care' for anyone that asked (i.e. arrange contracts on their behalf with care homes), this would have opened the door to a massive expansion of the group of residents currently referred to as 'full cost payers', whose means are too great to qualify for mandatory financial support from councils, but whom councils have voluntarily agreed to assist in arranging care, with full recovery of costs. There are around 10,000 of these full cost payers currently resident in English care homes who have the means to pay private fees but who are paying at council rates and are indistinguishable from other council paid residents from the care home perspective. A major increase in their numbers would have had a substantial adverse effect on care home margins. The government did recognise the risk and planned not to implement Section 18(3) in 2016, before the issue was rendered academic by the decision to postpone implementation of the entire Dilnot package. Market equalisation, in the form of private fees falling to public levels, would have affected the profit margins of care homes in all areas of the country, affluent and non-affluent, depending to the gap between public and private fees. The market equalisation scenario would have posed a dilemma for government policy. It is hard to argue against price transparency, which is desirable in all markets, and there are many cases in which transparency would have had a salutary effect in reducing private fees in those cases where care homes have set them at 'super-profit' level, relying on the information asymmetry between care home operator and individual privately paying resident. But, because of the scale of the private / public price differentials that have become endemic in the care home sector, 'desirable' transparency would have had the undesirable consequence of destabilising the market. One way of resolving the issue is for market equalisation to operate in the reverse direction, with public fees rising some way towards private fees. But this is equally problematic because local authorities generally cannot afford to pay more without additional government funding.

The risks of Payor Shift and Market Equalisation (exacerbated by the expected shock from imminent introduction of National Living Wage) are believed to have been an important factor in the decision by the government to postpone the Dilnot reforms, which had originally been planned for implementation in April 2016.

During the 2017 general election, the Conservative party put forward new proposals for long term funding which were at variance with the Dilnot reforms, and the new Conservative administration has now indicated that it intends to publish a Green Paper on long term funding in England, which may look at the whole issue afresh.

Whatever options are on the table, the clear message from the LaingBuisson reports prepared for CCN in 2015 is that policy solutions must address risks of market destabilisation as an unwanted consequence of funding reforms. The risks identified in 2015 remain just as potent now.

2. COUNCILS' EXPOSURE TO FINANCIAL RISK

The twelve counties' exposure to financial risk was summarised in Table 2.1 of the main 2015 report. It is reproduced here for reference. The largest item by far is the 'Care home fee gap', stemming from the divergence of council paid fees from a level necessary to offer care homes a reasonable return without a need for cross subsidy from private payers.

Table 2.1 (of 2015 report)

Financial impact comparisons across the study group, and across full CCN

	12 COUNTIES aggregate		37 COUNTIES aggregate	
	2016/17 £m	2020/21 £m	2016/17 £m	2020/21 £m
Care home fee gap	256	285 ³	684	761
Threshold extension to £118,000	27	30	72	80
SUB-TOTAL Market Equalisation (up to 'care cost benchmark)	283	315	756	841
Demographic Demand	-	55	-	147
TOTAL	283	370	756	988

Updated figures for 2017 are presented in Table 3, below – though in a different format to incorporate details of all 12 counties in addition to the aggregates.

First, however, (in Section 2.1) we restate the reasons why a care system with large structural disparities between private and publicly paid fee levels (care home fee gap) is in the long term unsustainable.

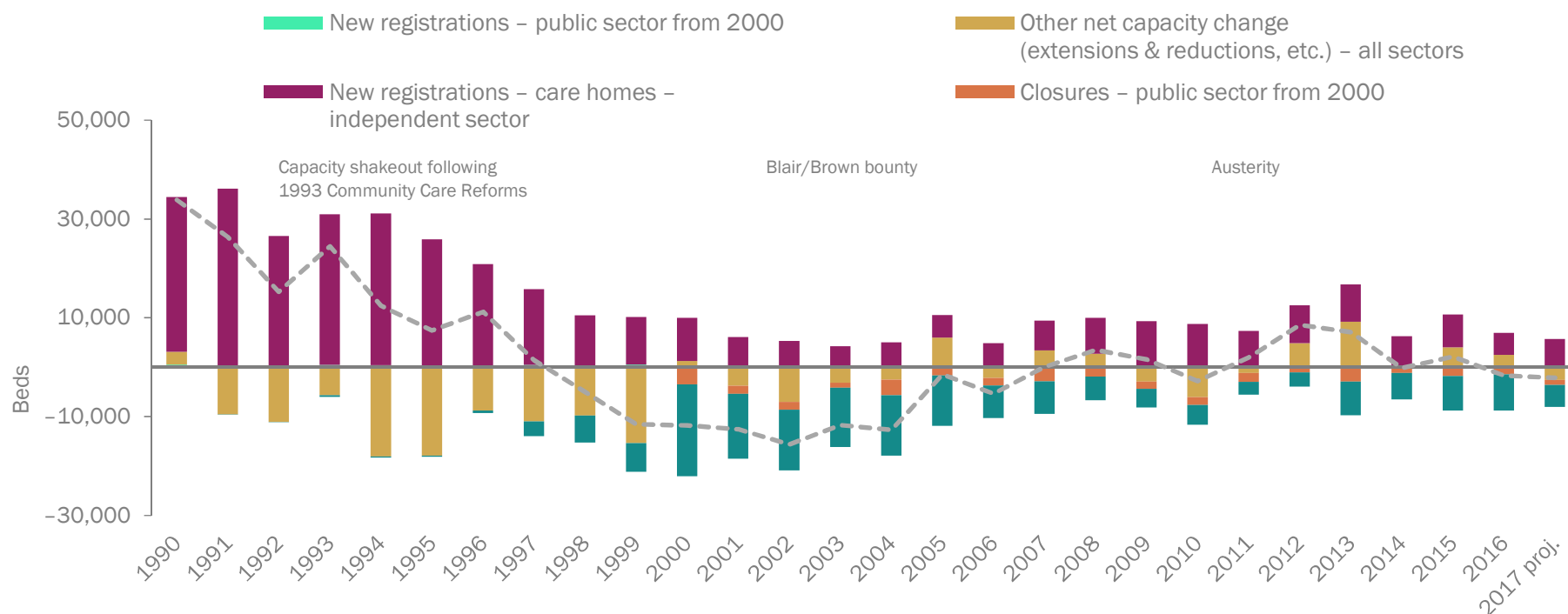
And in Section 2.2, in the interest of clarity, we present the data tables at county and district level which are used as the building blocks for Table 3.

2.1 Why are substantial care home fee gaps unsustainable in the long term?

About 90% of care home capacity is now provided by independent sector (mainly for-profit) organisations and they will not invest unless there is an adequate prospective return. As long as there is adequate capacity to meet private and publicly paid demand alike, there may be no immediate cause for concern. But there is continuing evidence that net capacity is declining in many areas as profitability is constrained. This is mainly as a result of real terms reductions in council paid fees during the first 5 years of austerity from the 'crunch' year for public expenditure of 2011/12. The national capacity picture is illustrated in Figure 1, which shows that closures now exceed new openings despite an acceleration in population ageing.

Figure 1

Bed capacity gains and losses from new registrations, closures and other net changes including extensions and reductions in registered beds in existing homes – all independent and public sector care homes for older people and dementia (65+), year ending March 31 1991-2017



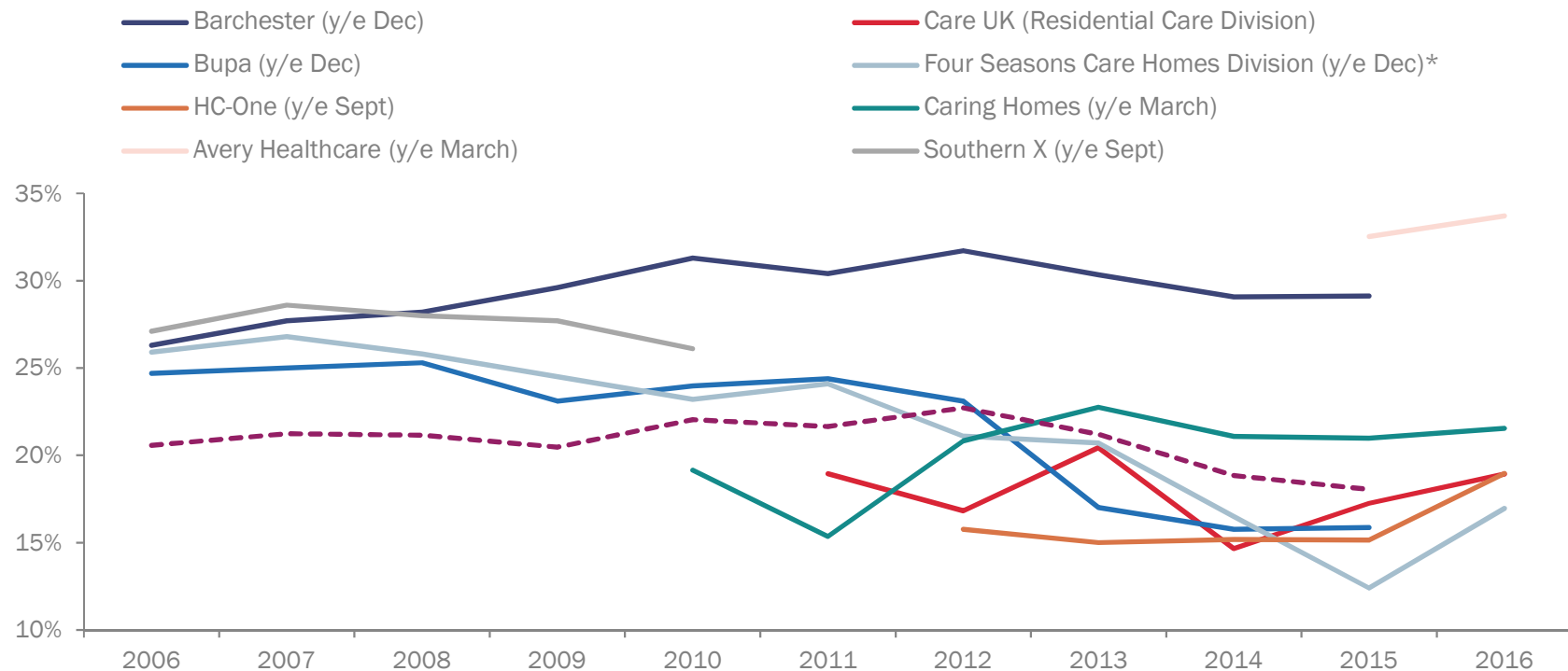
Source: Care of Older People Market Survey 28th edition. https://www.laingbuisson.com/shop/care-older-people_28th-edition/

Similar trends are being played out at differing paces throughout England, particularly in non-affluent areas where the number of (profitable) private payers is insufficient to offset inadequate returns from (unprofitable) public payers. These areas are concentrated largely to the north of a line between The Wash and the Bristol Channel.

The most recent hard evidence on profitability, at a national level, is presented in Figure 2 from the statutory accounts of major care home groups catering for older people.

Figure 2

Underlying profitability of major care home groups for older people, EBITDAR as a percentage of revenue, 2006-2016



Source: Care of Older People Market Survey 28th edition. https://www.laingbuisson.com/shop/care-older-people_28th-edition/

In summary, Figure 2 shows that the operating profitability of major groups with high exposure to council funded activity (Four Seasons, Bupa Care Homes and HC-One) all sank to dangerously low levels (EBITDAR¹ as a percentage of revenue below 15% compared with a sustainable level of around 20-25% plus in order to pay for capital costs and head office overheads), while the operating profitability of groups such as Barchester Healthcare, which cater mainly for private payers, has remained strong. It is notable that the groups focused on public pay (Four Seasons, Bupa and HC-One) all benefited from a profitability boost as a result of the hike in NHS Funded Nursing Care (NHS FNC) subsidy from £112pw to £155pw from April 2016, and from higher occupancy rates associated with a general reduction in sector capacity. But this profitability fillip may be short-lived. It is likely to be eroded by 6% plus per annum increases in National Living Wage in subsequent years, if austerity policies continue to be applied to central government funding of social care and councils do not have the resources to uplift fees in line with cost inflation.

Evidence on profitability at county and district level is illustrated in Appendix 1, in which two ‘heat maps’ are presented, one for nursing care of older people and people with dementia and one for residential care. It should be noted that a different measure of operating profitability is used, EBITDARM, which is EBITAR less central Management costs, denoted by ‘M’, which absorb about 5% of revenue. Prospective EBITDARM of around 25-30% plus is generally required to incentivise new investment (sufficient to pay for capital costs, central management overheads and a reasonable level of profit). In the heat maps, the districts with average EBITDARM of 25-34% (adequate to incentivise investment) are coloured in light green while the districts with average EBITDARM of 35% (investment strongly incentivised, subject to availability of land at a viable price) are coloured in dark green. Profitability is modelled in each county / district by calculating a weighted average of fees for each payor type (private, council, council with top-up and NHS) and deducting operating costs (mainly staff costs) derived with regional variations in staff pay rates from LaingBuisson’s Care Cost Benchmarks subscription product², using projections for financial year 2017/18.

The main conclusions to be drawn from the heat maps in Appendix 1 are:

- Residential care is typically more profitable than nursing care;
- There is a striking North / South divide, in which more affluent areas where prospective profitability is generally adequate to incentivise investment are concentrated south of a line from The Wash to the Bristol Channel, while those areas where profitability is generally inadequate to incentivise investment are concentrated north of a line from The Wash to the Bristol Channel;
- As expected, there are significant intra-county variations in operating profitability, for example in Kent and Essex, where the mix of payors and fees in affluent districts like Sevenoaks and Epping Forest will incentivise investment (35% plus EBITDARM for residential and 25-34% for nursing care), while less affluent coastal districts like Shepway, Dover, Medway and Thanet in Kent and Southend-on-Sea, Copeland and Tendring in Essex are not on average suitably profitable to incentivise investment (15-24% EBITDARM for residential and dropping to 5-14% in Medway, Hastings and Tendring for nursing care). Similar intra-county variations are found in the north, in Lancashire, though in this case the variation is between ‘amber’ (EBITDARM 5-14%) and ‘red’ (EBITDARM <5%) for nursing care and between ‘neutral’ (EBITDARM 15-24%) and ‘red’ (EBITDARM <5%) for residential care; Of course, an average district level profitability in the ‘amber’ to ‘red’ range does not necessarily mean that there will be no investment in care homes within their boundaries. There may be an investment case for a care home targeting the top decile or two of the market, even in a non-affluent area, and also for homes targeting a wider catchment area. Nuances such as these are accommodated in LaingBuisson’s soon-to-be-launched *CareSustain* subscription service, which extends the ‘static’ Appendix 1 heat maps into a dynamic model enabling probability distributions around average profitability to gauge the likelihood of care home investment

¹ EBITDAR - Earnings Before Interest Tax, Depreciation, Amortisation of goodwill and Rent on leased premises

² <https://www.laingbuisson.com/shop/care-cost-benchmarks/>

actually taking place. The heat maps in Appendix 1 also give a visual indication of where care homes are more or less likely to exit the market, with 'red' and 'amber' being indicators of concern. However, an average prospective EBITDARM rate in the 'red' band (<5%) does not mean that large numbers of homes are on a knife edge in which they are at high risk of tipping over into a cash negative situation and closing. CareSustain has built into it a concept of 'stressed costs' where care homes whose operating profit falls dangerously low may respond by cutting costs (delaying maintenance capital expenditure, not filling all slots where staff call in sick, etc.). There is a degree of variability in care home costs, and threatened businesses can use this as a buffer to remain open pending a hoped for return to better times.

2.1 Calculation of 'care home fee gaps'

The 'care home fee gap' in any given locality is defined as the difference between the average fee paid by the 'home' Council with Adult Social Services Responsibilities (CASSR) and the Care Cost Benchmark for that locality derived from LaingBuisson' Care Cost Benchmark model³. The Care Cost Benchmark in turn is defined as the rate which will offer a reasonable return on a 'non-stressed' cost base for care home investors and operators - currently set in the Care Cost Benchmark model at a 7% annual return on the property element (e.g the rental yield that a freehold investor typically expects to receive from an lease-holding operator with a moderate financial covenant) and a 10% profit mark-up on operating costs as a reasonable return for the operator.

This leaves the question of how to place a fair average value on the care home assets in any given locality, in order to determine what the 7% property return should be based on. LaingBuisson does this by valuing all new (since 2002) purpose built care homes at their replacement value (roughly £70,000 per bed plus land costs, being the 'ceiling' in the Care Cost Benchmark model) and assuming a linear distribution of values down to a 'floor' within the Care Cost Benchmark model of £30,000 per bed, including land costs (being about the lowest fair value for any care home whose physical environment is on the right side of the borderline of acceptability to any commissioning council. It follows that the average 'Care Cost Benchmark' can be calculated for any county (or district) by reference to the proportion of capacity in new, purpose built homes; the 'ceiling' and 'floor' cost benchmarks derived from the Care Cost Benchmarks for that locality; and the average fee paid by the 'home' CASSR. This is, of course, a simplification because it takes no account of fees paid by other CASSRs placing residents in homes within the boundaries of the 'home' CASSRs, but the simplification is acceptable for the purposes of modelling.

The 'care home fee gaps' thus defined are set out for each of the 12 counties in Table 1. There is a high degree of variability for residential care fees, from £10 per week (care home fee gap hardly exists) to £227 per week (a very substantial care home fee gap). There is less variability in care home fee gaps for nursing care, but their quantum is a lot higher.

³ Care Cost Benchmarks, 2016/17 with projections to 2017/18. <https://www.laingbuisson.com/shop/care-cost-benchmarks/>

Table 1

Care home fee gaps across 12 counties within the County Councils Network, 2017/18 £ per week

	A) Privately Paid £ per week	B) Council Paid ¹ (without top-up) £ per week	C) Care Cost Benchmark ¹ £ per week	D) Weekly fee gap (C - B) £ per week	Independent sector capacity % purpose built £ per week
RESIDENTIAL CARE					
CASSR1	943	674	684	10	54
CASSR2	805	498	637	138	30
CASSR3	815	593	662	70	43
CASSR4	812	498	651	153	52
CASSR5	792	429	656	227	30
CASSR6	634	446	619	173	37
CASSR7	729	542	617	76	27
CASSR8	661	538	627	88	52
CASSR9	905	632	677	45	47
CASSR10	682	483	626	143	38
CASSR11	1,018	567	680	113	37
CASSR12	762	618	670	52	59
NURSING CARE (Inc. NHS FNC)					
CASSR1	1,140	794	906	112	54
CASSR2	974	650	848	198	30
CASSR3	985	708	873	165	43
CASSR4	982	657	862	205	52
CASSR5	958	634	879	245	30
CASSR6	766	611	830	220	37
CASSR7	882	669	824	155	27
CASSR8	799	714	839	177	52
CASSR9	1,094	742	899	157	47

CASSR10	825	558	843	285	38
CASSR11	1,231	661	903	241	37
CASSR12	921	726	880	154	59

1. Care Cost Benchmarks, 2016/17 with projections to 2017/18. <https://www.laingbuisson.com/shop/care-cost-benchmarks/>

Table 2 takes the care home fee gap calculation to the next stage by applying the weekly fee gap to the number of older care home residents supported by each county. The cost of completely bridging all care home fee gaps for all of the 12 counties is estimated at £247 million in 2017/18 prices, and by extrapolation pro rata on population, £670 million for all 37 members of the County Councils Network.

These headline numbers are slightly down on the corresponding numbers, £256 million and £684 million respectively, as presented in the 2015 report (see Table 2.1 from the 2015 report, above). This is not surprising since the number of placements is believed not to have risen while council fees since, in contrast with the early years of austerity, council paid fees across England since 2015/16 (plus NHS FNC) have generally kept pace with care home cost inflation.

Table 2

Potential annual cost to counties of filling the care home fee gap at 2017/18 prices

	Number of nursing placements 65+ No.	Number of residential placements 65+ No.	Annual cost of bridging the fee gap ¹ £ million per year
CASSR1	605	644	4
CASSR2	183	506	6
CASSR3	273	819	5
CASSR4	533	3,912	37
CASSR5	1,576	3,274	59
CASSR6	1,054	3,438	43
CASSR7	645	926	9
CASSR8	1,169	2,326	18
CASSR9	924	722	9
CASSR10	899	1,405	24

CASSR11	1,312	1,641	26
CASSR12	637	883	8
12 COUNTIES AGGREGATE	9,809	20,497	247
EXTRAPOLATION TO 37 COUNTIES IN THE COUNTY COUNCILS NETWORK			670

1. Cost of raising fees to 'Care Cost Benchmark' (= placements X weekly fee gap (Column D, Table 1) X 52 / 1,000,000

2.2 Calculation of counties' combined exposure to financial risk from fee gaps, demographic pressure and LTC funding reforms

Table 3 sets out counties' combined exposure at 2017/18 prices, corresponding to the 2015 analysis in Table 2.1 from that report, reproduced above. As noted, the care home fee gap figures come out slightly lower in the 2017 update.

Table 3

Potential annual costs to councils of filling the care home fee gap, demographic pressure and proposed changes in long term care funding at 2017/18 prices across 12 counties within the County Councils Network and extrapolation to all 37 counties in the County Councils Network

	ANNUAL COST TO COUNCILS AT STEADY STATE WHEN CHANGES HAVE FULLY WORKED THROUGH			OTHER COSTS AND CLAWBACKS		
	Elimination of the care home fee gap ¹ £m	Single threshold of £100,000 ² £m	TOTAL fee gap + threshold extension £m	Maximum 5 year demographic pressure to 2022/23 ³ £m	Cap on lifetime care costs ⁴	Central government clawback from single threshold costs via Attendance Allowance savings £m
CASSR1	4	2	6	0.9	n/a	-0
CASSR2	6	1	7	1.1	n/a	-0
CASSR3	5	4	9	1.0	n/a	-1
CASSR4	37	10	47	5.9	n/a	-2
CASSR5	59	14	73	9.2	n/a	-3
CASSR6	43	30	73	8.0	n/a	-8
CASSR7	9	9	18	2.2	n/a	-2
CASSR8	18	21	39	5.0	n/a	-5

CASSR9	9	2	11	1.5	n/a	-0
CASSR10	24	12	36	5.1	n/a	-3
CASSR11	26	4	30	3.5	n/a	-1
CASSR12	8	5	13	1.9	n/a	-1
12 COUNTIES AGGREGATE	247	114	361	45	122	-27
EXTRAPOLATION TO 37 COUNTIES IN THE COUNTY COUNCILS NETWORK	670	308	978	122	330	-73

1. See Table 2

2. Net additional cost to councils after deducting user charges assumed to be 55% of gross unit costs for newly enfranchised residents, who are likely to have higher incomes than those qualifying under the £23,250 upper threshold. The number of otherwise privately paying care home residents who will become a charge on the council as a result of the £100,000 single threshold is projected using a simulation model developed by LaingBuisson. At the heart of the model is the Land Registry database of over 1 million residential property transactions in England in calendar 2016. Residential property is by far the most important source of personal wealth that is taken into account in councils' means test for eligibility for funding. After adjusting to include financial wealth in overall personal wealth distributions for each CASSR in England, the model calculates the proportion of care home residents who will qualify for financial support under the £100,000 single threshold, either immediately or through spending down, at steady state when the reform has fully worked its way through the system.

3. Maximum additional demand is calculated pro rata with ONS projections of population change in age groups at risk of care home placement (weighted by the national care home resident age profile (source: LaingBuisson). There is an alternative view of demand (referred to as the Brookings Institute assumption, originally proposed in the USA) which assumed that demand is not a function of the number of people in age groups at risk of care home placement but, rather, it is a function of the number of people approaching the end of their lives. This assumption leads to substantially lower projections of demand growth. In recent years, demand for care home places in the UK has tracked closer to the Brookings Institute assumption than to the assumption that demand increases pro rata with the number of people in age groups at risk of care home placement.

4. It has not been possible reliably to model the care cap cost at county level

2.2.1 Potential additional costs from demographic pressure

The maximum 'demographic pressure' cost in the revised 2017 analysis is calculated in Table 3 at £45 million a year for the 12 counties at 2017/18 prices by 2022/23 (in 5 years), and £122 million by extrapolation to all 37 counties in the County Councils Network. It is calculated from ONS population projections of age groups 65-74, 75-84 and 85+ by applying age specific care home usage rates from 2017 to projected populations in 2022/23. The weighted average increase in underlying demand across England works out at 14% over 5 years – equivalent to a Compound Annual Growth Rate (CAGR) of 2.7%. However, LaingBuisson is becoming increasingly sceptical about this approach to projecting demand, in the light of the fact that observed demand has consistently fallen short of population-based projections in recent years. There is an alternative approach, using what has been term the Brookings Institute assumption. This refers to modelling work carried out by the Brookings Institute in the USA which projected demand for care home services as a function of the number of approaching deaths, on the basis that care home entry is an event close to the end of life rather than event associated with age *per se*. There are counter arguments, but there is sufficient uncertainty about population-based demand projections to describe them as 'maximum' projections, with the likelihood that observed changes in demand will be much lower.

2.2.2 Potential additional costs from LTC funding reforms

- £100,000 single threshold

The headline 'threshold' cost in the revised 2017 analysis set out in Table 3 is £114 million a year for the 12 counties at 2017/18 prices (£100,000 single threshold). This is much higher than the £27 million in the 2015 report (£118,000 upper threshold).

When extrapolated for the 37 CCN member councils the headline 'threshold' cost of the implementation of the £100,000 single threshold is estimated at £308 million at 2017/18 prices, compared to £72 million in the 2015 report (£118,000 upper threshold). The disparity stems from user charges. The 2015 calculation was based on modelling of the £118,000 upper threshold which would have allowed councils to recoup much of their additional costs from residents' income, in particular from 'tariff income' at an effective rate of 20% of any assets between the lower (£17,000) and upper (£118,000) threshold limits. If collected, this would have reduced the net direct cost to the council of supporting many newly 'enfranchised' care home residents to virtually zero, and this accounts for the low 'threshold' cost reported in the 2015 report. The Conservative manifesto proposal, on the other hand was for a single threshold (of £100,000), implying that there would be no lower threshold and therefore no tariff income clawback.

In the model developed to cost the Conservative manifesto £100,000 single threshold proposal, LaingBuisson has set user charges for newly enfranchised residents as a parameter, set at 55% of gross cost (higher than the pre-existing average user charges of 34% of gross cost in England, as reported by NHS Digital, because of their probably higher income levels).

Sensitivity analysis shows that the user charge rate is by far the most important variable governing the net cost of the threshold to counties, should it be implemented.

Another important point to note about the threshold cost of £114 million a year for the 12 counties, and £308 million for all 37 CCN member councils, is that it does not represent a year one or year two cost. Rather it represents the projected annual cost at 2017/18 prices at a future time in which Long Term Care funding reforms have worked their way through and a steady state has been reached. Because the length of stay in care homes is relatively short (around two years) a steady state will be approached in three or four years when the remaining tail of long stayers is approaching stability.

- Lifetime cap on care costs

It has not been possible reliably to model the cost of the lifetime cap at individual county level. Based on an England-wide estimate, however, it is possible to extrapolate (on the basis of population) to the 12 counties and the 37 counties as a whole. The results, as entered in Table 3 show the cost of the lifetime cap at £122 million a year for the 12 counties and £330 million a year for the 37 counties of the CCN, at steady state (in approaching a decade's time). Varying the value at which the care cap is set gives the following results:

Annual lifetime care cost cap at steady state	£50,000	£72,000	£80,000	£90,000	£100,000	£120,000
- 12 counties	£255m	£122m	£89m	£61m	£39m	£15m
- 37 counties	£691m	£330m	£242m	£165m	£106m	£41m

- Other matters relating to LTC funding reforms

Nor have we made any attempt to cost, at county level, the Conservative manifesto proposal to remove the automatic disregard of the value of owner-occupied property when determining eligibility for council support for care at home services: meaning that, for the first time, users of non-residential care services would have to spend down their capital until it reached a threshold (£100,000) at which point they would be eligible for council financial support. In work carried out for another client, LaingBuisson has calculated that the net savings to councils could be very substantial – up to £1.3 billion a year across England, though some of this would be absorbed in administering means tests and much expanded Deferred Payment schemes which asset rich / income poor non-residential care service users would depend on for liquidity to pay for their current care needs

Finally, Table 3 identifies that value of Attendance Allowance payments that central government would claw back as a result of Payor Shift stemming from the Single Threshold, since private payers who become entitled to council financial support in a care home lose their entitlement to Attendance Allowance. The sums involved are not insignificant, at £27 million a year at steady state in 2017/18 prices for the 12 counties and (by extrapolation pro rata with population) £73 million for all 37 counties of the County Councils Network. These savings would accrue to central government, not directly to councils unless passed on.

3. INEQUITABLE GEOGRAPHICAL DISTRIBUTION OF BENEFITS OF PROPOSED LONG TERM CARE FUNDING REFORMS

LaingBuisson's 2015 report for CCN found that the Dilnot funding reforms would have given rise to geographically unequal distribution of benefits to recipients of care services, with the benefits from the £118,000 upper threshold concentrated mainly in the non-affluent north. The same is the case for the £100,000 single threshold variation.

Conversely, the lifetime care cost cap benefit would / will mainly benefit people in the affluent south (with some notable exceptions).

3.1 The £100k single threshold

In common with the Dilnot upper threshold, the Conservative manifesto's £100,000 single threshold would, if implemented, work mainly to the benefit of people in non-affluent areas. This is an inevitable consequence of any LTC funding reform based on asset thresholds, since the value of residential property, which is by far the largest source of personal wealth in Britain, varies widely between affluent and non-affluent areas. The model developed by LaingBuisson in 2017 to re-project the financial impact of threshold changes incorporates a land Registry data set with the value of over 1 million residential property transactions in England and Wales in 2016 linked to postcodes and administrative area. This makes possible a highly granular segmentation of levels of personal property wealth across the country from which the geographical distribution of benefits can be calculated – see Appendix 2 for methodology details.

The results of the analysis for the 12 counties are presented in Table 4. They show a marked north / south divide, with Payor Shift (the proportion of private payers in care homes who would qualify for council support at steady state) calculated at 56%, 45% and 38% respectively for three counties in the North West and Midlands and, at the other end of the affluence spectrum, 3%, 4% and 4% respectively for three counties in the South East.

There would also be significant intra-county variations in the projected Payor Shift from implementation of the £100,000 single threshold (Table 5). In relatively affluent Kent, for example, Payor Shift is calculated at 3% in Sevenoaks and 25% in Thanet, compared with the Kent average of 13%. And in Lancashire (average 56%) projected Payor Shift is calculated at 25% in Ribble Valley ranging up to 91% for Burnley.

In addition to the equity issue, such wide variations mean that any local authority reorganisation in the future, possibly involving the creation of unitary authorities from county districts, would require more than standard needs measures in order adequately to distribute social services funding according to council need under any upper threshold or single threshold LTC funding reforms – see Section 4.

Table 4

Projected payor shift (numbers of residents) from private pay to council support following a capital threshold uplift to £100,000, residential and nursing care for older people (65+), 12 COUNTIES AT STEADY STATE WHEN CHANGES HAVE FULLY WORKED THROUGH

	Current privately funded (2017) Residents	Shift from private pay to council pay following capital threshold uplift to £100,000 (at steady state) Residents	Shift from private pay to council pay following capital threshold uplift to £100,000 (at steady state) %
CASSR1	1,892	70	4
CASSR2	468	53	11
CASSR3	1,740	178	10
CASSR4	4,793	505	11
CASSR5	5,737	733	13
CASSR6	3,565	1,985	56
CASSR7	2,047	497	24
CASSR8	2,653	1,190	45
CASSR9	2,315	102	4
CASSR10	2,001	752	38
CASSR11	5,036	171	3
CASSR12	1,827	257	14

For payor shift projection methodology, see notes to Table 3.

Table 5

Projected payor shift (numbers of residents) from private pay to council support following a capital threshold uplift to £100,000, residential and nursing care for older people (65+), DISTRICTS WITHIN 12 LARGEST COUNTIES

	Current private pay (2017) Residents	Shift from private pay to council pay following capital threshold uplift to £100,000 (at steady state) Residents	Shift from private pay to council pay following capital threshold uplift to £100,000 (at steady state) %
Essex County Council	4,793	505	11
Basildon	362	32	9
Braintree	579	66	11
Brentwood	373	10	3
CastlePoint	280	26	9
Chelmsford	508	29	6
Colchester	572	81	14
EppingForest	549	14	3
Harlow	153	20	13
Maldon	199	13	6
Rochford	148	9	6
Tendring	776	196	25
Uttlesford	293	8	3
Kent	5,737	733	13
Ashford Borough Council	403	44	11
Canterbury City Council	763	73	10
Dartford Borough Council	356	32	9
Dover District Council	550	107	19
Gravesham Borough Council	265	32	12
Maidstone Borough Council	658	63	10
Sevenoaks District Council	390	11	3

Shepway District Council	500	89	18
Swale Borough Council	413	83	20
Thanet District Council	683	171	25
Tonbridge & Malling Borough Council	240	10	4
Tunbridge Wells Borough Council	515	17	3
Lancashire	3,565	1,985	56
Burnley Borough Council	267	243	91
Chorley Borough Council	306	132	43
Fylde Borough Council	378	129	34
Hyndburn Borough Council	244	202	83
Lancaster City Council	406	234	58
Pendle Borough Council	211	175	83
Preston Borough Council	330	209	63
Ribble Valley Borough Council	172	43	25
Rossendale Borough Council	216	149	69
South Ribble Borough Council	248	112	45
West Lancashire District Council	411	160	39
Wyre Borough Council	375	197	52
Nottinghamshire	2,653	1,190	45
Ashfield District Council	392	238	61
Bassetlaw District Council	424	220	52
Broxtowe Borough Council	365	148	41
Gedling Borough Council	412	167	41
Mansfield District Council	342	213	62
Newark & Sherwood District Council	409	162	40
Rushcliffe Borough Council	308	43	14
Surrey	5,036	171	3
Elmbridge Borough Council	637	13	2

Epsom & Ewell Borough Council	200	7	3
Guildford Borough Council	463	16	4
Mole Valley District Council	383	10	3
Reigate & Banstead Borough Council	862	32	4
Runnymede Borough Council	266	10	4
Spelthorne Borough Council	311	14	4
Surrey Heath Borough Council	383	14	4
Tandridge District Council	452	16	4
Waverley Borough Council	634	22	3
Woking Borough Council	443	16	4

For payor shift projection methodology, see notes to Table 3.

3.2 The Lifetime Care Cost Cap

The 2015 report found that the care cost cap (of £72,000) would give rise to opposite geographical inequalities, with the benefits accruing predominantly to older care recipients in affluent areas and less to those in non-affluent areas. The major reason for the disparities, which would be amenable to change, was the decision to adopt a single national rate (£210 per week) for the board and accommodation element of care home costs. This meant that 'care' costs counting towards the cap would be calculated as the difference between the council's 'usual costs' (i.e. the usual fee rate paid by the council for nursing and residential care), and since (with exceptions) 'usual costs' are typically significantly lower in non-affluent areas compared with affluent areas, it follows that, after deducting the national £210 per week (or equivalent in 2017) for board and accommodation, lower weekly amounts count towards the care cap.

The impact of such a system, if applied in 2017 using average council fee rates as an indicator for 'usual costs' and an uprated national standard of (say) £220 per week for board and accommodation, is presented in Table 6. Wide variability is evident. In some councils, care home residents would reach the cap after a 3 year stay in a care home, by which time about 25% would still be alive. Other councils vary up to 7 years or more. At 7 years, fewer than 3% of care home residents would still be alive.

A 'postcode lottery' of this magnitude is not, however, a necessary corollary of a lifetime cap on care costs. The variability in the length of time taken to reach the cap could be greatly reduced or even eliminated by different rules to define what costs counts towards the cap.

Table 6

Projected time taken to reach a lifetime care cost cap of £72,000 across the 12 counties

	Council paid fees (as proxy for 'usual costs') £ per week	LESS national Board and Accommodation allowance £ per week	Amount counting toward Lifetime Cap of Care Costs £ per week	Time taken to reach a care cost cap of £72,000 Years
RESIDENTIAL CARE				
CASSR1	674	220	454	3.0
CASSR2	498	220	278	5.0
CASSR3	593	220	373	3.7
CASSR4	498	220	278	5.0
CASSR5	429	220	209	6.6
CASSR6	446	220	226	6.1
CASSR7	542	220	322	4.3
CASSR8	540	220	320	4.3
CASSR9	632	220	412	3.4
CASSR10	483	220	263	5.3
CASSR11	567	220	347	4.0
CASSR12	618	220	398	3.5
NURSING CARE (LESS NHS FNC)				
CASSR1	639	220	419	3.3
CASSR2	495	220	275	5.0
CASSR3	553	220	333	4.2
CASSR4	502	220	282	4.9
CASSR5	479	220	259	5.3
CASSR6	456	220	236	5.9
CASSR7	514	220	294	4.7
CASSR8	508	220	288	4.8

CASSR9	587	220	367	3.8
CASSR10	403	220	183	7.6
CASSR11	506	220	286	4.8
CASSR12	571	220	351	3.9

3.3 An alternative to threshold and cap – the Personal Asset Protection Guarantee concept

LaingBuisson's 2015 report to the County Councils Network identified major geographical disparities in the proportion of care recipients likely to benefit from the two key elements of the Dilnot reforms, the threshold extension and the care cost cap. Updates of the unequal regional distribution of benefits are illustrated in Figure 3 and Figure 4.

During the course of this work for the County Councils Network, and overlapping work for the Alzheimer's Society, it became apparent that the policy objectives of both the threshold and the care cost cap could be achieved in what is arguably a simpler and more equitable way, by defining individuals' eligibility for council support for residential care in terms of the percentage of each individual's assets (including owner-occupied property) which has been spent down since being assessed as needing care. The concept of a Personal Asset Protection Guarantee (PAPG) will be described in full in a 'White Paper' to be published by LaingBuisson in autumn 2017. The key features of PAPGs are as follows, assuming it applies to care in residential settings only, with access to non-residential care remaining as it is now.

The baseline for the value of each individual's assets is crystallised at the time when that individual seeks an assessment from his/her local council and is found to need care, followed by an assessment of means (no difference in principle from the current regime);

The individual is guaranteed that once X% of his or her baseline assets have been spent down (other than through inappropriate divestment, which is already defined in CRAG rules) he/she will be eligible for financial support from the council in the usual way, subject to income related user charges;

The individual may seek a further assessment at any time and, if care is still needed and assets have been depleted by X% or more, the individual will be eligible for council support (note that the council will have a record of the prior value of any property at the time of the initial assessment, which will make any re-valuation easier);

The attractiveness of PAPG's, as a complete and self-contained alternative to combinations of threshold and care cost cap, will of course depend on the value of 'X'. We have used the spreadsheet model to calculate 'X' at 27%, to deliver similar policy objectives, more equitably, at the same public expenditure cost of a single threshold of £100,000 and a lifetime care cost cap of £72,000.

Thus, an individual with baseline assets of £500,000 would be guaranteed that he/she would retain £365,000, while an individual with baseline assets of £100,000 would be guaranteed that they would retain £73,000, and subsequently have their fees paid by their council, subject to income related charges only. These examples illustrate the principal effect of a PAPG arrangement, which is to give some financial benefit (or peace of mind) to the full range of property owners (who make up over

70% of the older population at risk of entry into care homes) rather than concentrating the benefits on property owners of modest means (around £100,000 in assets) or a small minority of the care home population which survives for several years⁴.

In summary, the advantages of PAPGs, as a complete alternative to any combination of threshold or cap, are:

- The concept is simple to understand;
- It delivers benefits (in terms of peace of mind) to the full range of property owners, not just those in 'spending down' sight of any feasible threshold;
- Minimal change to the current means testing regime and no need to track actual spending on care services
- The geographical distribution of benefits from PAPGs would be more equitable than under a threshold extension (see Figure 1) and a care cost cap (see Figure 2);
- The propensity of individuals and their financial advisors to 'game' PAPGs by divesting property assets would be no greater than the current incentive to divest property assets to circumvent the £23,250 upper threshold;
- The opportunities for developing new long term care insurance products around PAPG entitlements are at least as great as building them around combinations of threshold and cap, and probably greater; and
- The 'payor shift' threat to the stability of the commercial care home sector in less affluent areas of the country would be diluted (though it would not disappear⁵).

3.3.1 Regional disparities in the proportions of care recipients who will benefit from a) a threshold extension and b) a care cost cap

Regional analysis demonstrates striking variances in the number and share of care home residents who are projected to benefit from 'Payor Shift' as a result of the £100,000 single threshold. The results are illustrated in Figure 3. They show a clear North / South divide, with the biggest benefits to the North. Compared with today, there is a projected shift of 22% of the care home population in Yorkshire and Humberside from private pay to state support. In the affluent South East, in contrast, the corresponding payor shift is projected at only 4%.

Figure 4 illustrates the converse regional variances in the proportion of care home residents who will have reached a care cost cap of £72,000 at steady state, in up to ten years' time. Care service users in the more affluent regions would be most likely to have reached the cap by the time the scheme reached maturity, headed by

⁴ Using these examples, an individual with assets of £500,000, who wished to pass on his/her wealth to several grandchildren, would gain much more peace of mind from a PAPG at 71.5% than an asset threshold of £100,000. His / her benefit would be paid for by requiring the individual with modest assets of (say) £100,000 to spend down £28,500 of it before being eligible for council support. These are the trade-offs which need to be considered to determine which of the policies on offer is the fairer and more desirable.

⁵ To eradicate the 'payor shift' threat to care homes, particularly in less affluent areas, it would be necessary substantially to reduce the 40% plus gap between privately paid fees and the fee levels that councils are able and willing to pay.

the South East and South West at 21% (ignoring London, which is anomalous), while those in less affluent regions are least likely, with the North West at the foot at 9%.

If the analysis is taken down to sub-regional level, it will show some pockets in the North where care service users' chances of reaching the lifetime care cap (at present council fee rates) would be less than 5%. It has to be emphasised, however, that these numbers are not set in stone. The time taken for service users to reach the cap could be shortened and equalised by a variety of means, including:

- Uplifts in councils' usual costs (the expensive option); and
- Modifying the care cap rules (as originally devised for implementation in April, 2016) so that the board and lodging element of fees is no longer set at a national rate (£12,000 a year) but varies by region in line with actual board and lodging costs. This would mean that the remaining care cost element of fees in less affluent areas would be greater, allowing the lifetime cap on care costs to be reached sooner.

Figure 3

Projected payor shift from private pay to council support following a capital threshold uplift to £100,000, England residential and nursing care for older people (65+) with dementia

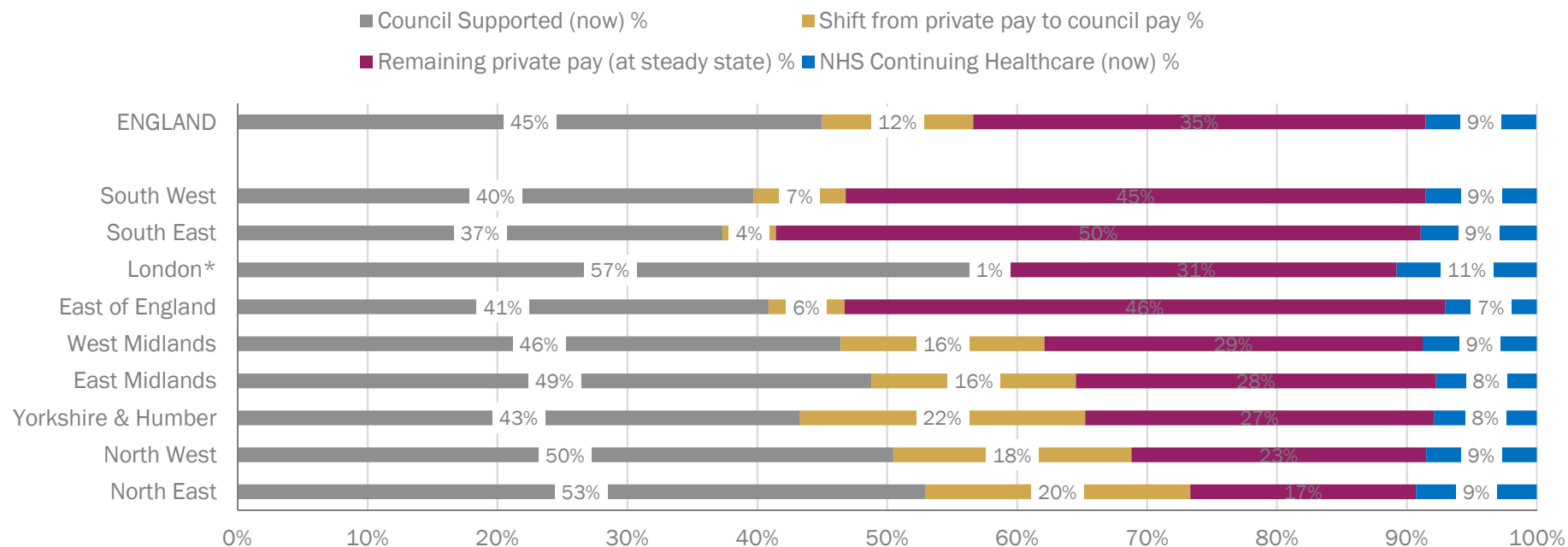
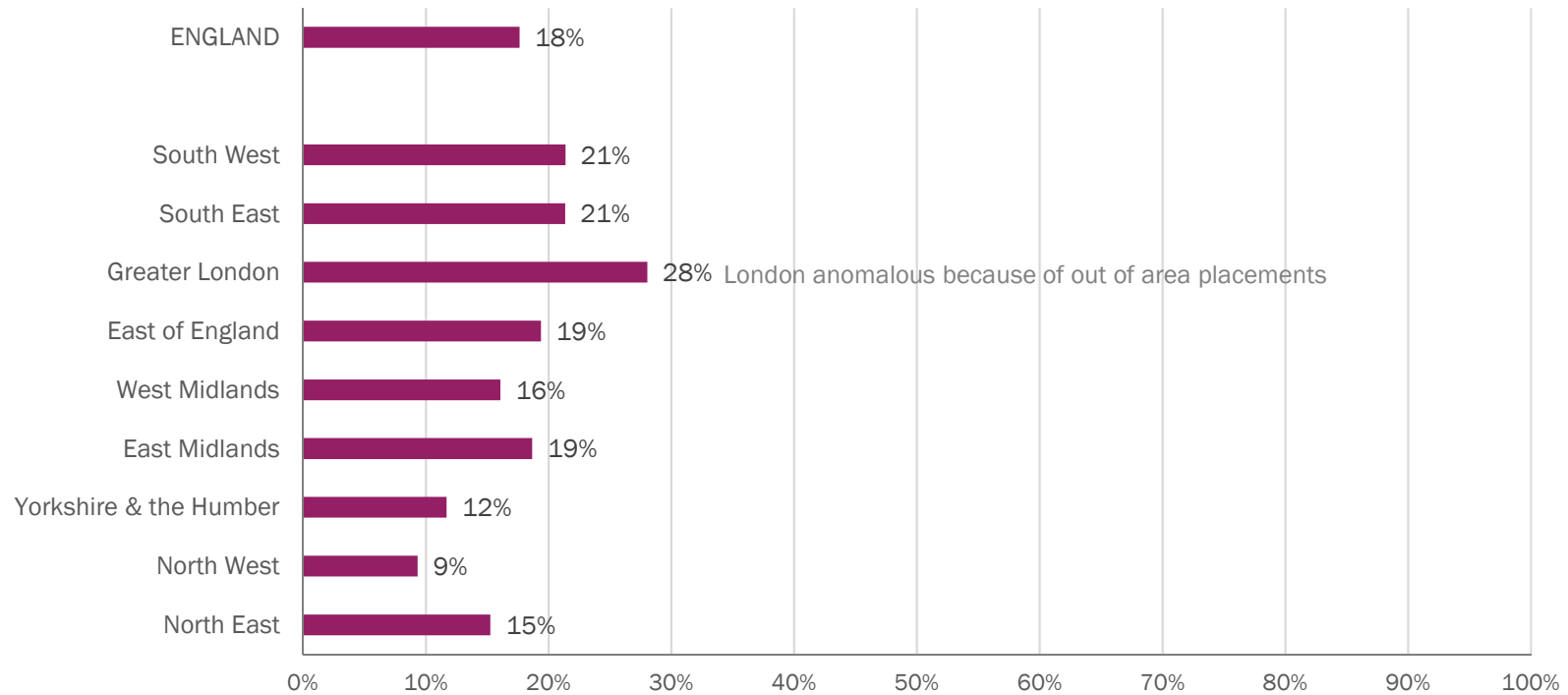


Figure 4

Share of eligible care service users who will have reached a lifetime care cost cap of £72,000 at 'steady state' point of time (in up to ten years), England by region



4. IMPLICATIONS FOR LOCAL GOVERNMENT REORGANISATION

Social care is now the largest single spending head for first tier local authorities in England, and expenditure on care homes is the largest element of that. The most appropriate scale for exercising the social care commissioning function is, therefore, highly relevant to any debate of local government organisation involving the option of splitting large counties into several unitary authorities. The district level data presented in this report is relevant to this debate, demonstrating as it does the high degree of intra-county variation. Further analysis presented in Table 7 also demonstrates that there are typically large cross district flows of care home residents within large counties. Demand generated in one district with relatively low capacity is very often fulfilled in another with higher capacity. Districts are rarely self-contained care economies.

The conclusions that may be drawn from this and other data presented in this report are:

Several districts within large counties generate a relatively limited level of demand, which may make it uneconomic for a district sized unitary authority to employ the full range of commissioning and market management skills. In the absence of an overarching commissioning and market management body, alternative structures are likely to be needed in order to exercise these functions at the necessary scale to make them economical and ensure they are able to sustainably fulfil market management duties. A detailed understanding of, and associated costs from, these diseconomies of scale and the disruption in arrangements between commissioning authorities and care home providers would need to be central to any structural reform proposals.

Inter-district resident flows would make it more difficult to balance supply and demand, potential concentrating market weakness. The data below shows that while bed capacity varies district by district, immediate neighbouring districts tend to have similar capacity ratios. Demand generated in one district is not just offset in a neighbouring district, but districts in other geographical areas of a single county. District sized unitary authorities or geographical 'clusters' of district councils within counties, that join together and form larger sub-county unitary authorities, could lock in and concentrate areas of high and low capacity. Sub-county level unitary authorities could therefore potentially exacerbate underlying weakness in care markets in some areas.

Inter-district resident flows would make it more difficult to pursue 'place-based' market management policies; While county geographies themselves are not self-contained markets, involving varying levels of cross-border placements, the findings demonstrate that the scale provided by existing county council commissioning units provides the opportunity to better balance demand and supply across an area. Sub-county unitary structures could limit the ability of commissioning authorities to pursue sustainable place-based market management policies. For instance, while the challenges facing small unitary authorities (particularly in the North-East and West) are principally driven by weaker underlying market conditions described elsewhere in this report, their ability to respond to these challenges is not assisted by their small geographical footprints and increased reliance on the use of cross-border placements within neighbouring authorities.

Creation of additional unitary authorities would make it more complex to pursue health and social care integration initiatives involving collaboration between a multiplicity of health and local authorities. Replacing county councils with several sub-county unitary structures would increase both the complexity in commissioning arrangements but also the wider integration landscape.

Table 7

Council supported demand and local capacity, by district within five counties

	A) Residents supported by the home council (in homes within or outside the authority's boundaries). CASSR numbers from March 2014 and district level numbers estimated pro rata with population	B) Estimated residents of homes located within the authority's boundaries who are supported by councils (home or otherwise)	C) Net Export / Import Ratio (= Column A / Column C) INDEX Exports and Imports in balance = 1.00	D) Bed capacity (all sectors) per unit population aged 75+ in care homes located within the authority's boundaries, INDEX ENGLAND = 1.00
Essex County Council	4,445	4,148	1.07	0.94
Basildon	473	315	1.50	0.68
Braintree	427	502	0.85	1.19
Brentwood	253	323	0.78	1.30
CastlePoint	327	243	1.34	0.75
Chelmsford	499	441	1.13	0.90
Colchester	473	496	0.95	1.06
EppingForest	395	477	0.83	1.22
Harlow	214	134	1.59	0.64
Maldon	214	170	1.25	0.81
Rochford	291	128	2.28	0.44
Tendring	635	664	0.96	1.06
Uttlesford	246	254	0.97	1.04
Kent	4,850	4,030	1.20	0.99
Ashford Borough Council	369	318	1.16	0.96
Canterbury City Council	531	498	1.07	1.16
Dartford Borough Council	259	233	1.11	1.12

Dover District Council	404	388	1.04	1.14
Gravesham Borough Council	293	245	1.20	0.85
Maidstone Borough Council	507	431	1.18	1.06
Sevenoaks District Council	404	255	1.58	0.79
Shepway District Council	421	368	1.14	1.01
Swale Borough Council	407	302	1.35	0.87
Thanet District Council	510	498	1.03	1.14
Tonbridge & Malling Borough Council	379	158	2.41	0.52
Tunbridge Wells Borough Council	366	337	1.08	1.15
Lancashire	4,492	5,691	0.79	1.25
Burnley Borough Council	284	447	0.64	1.53
Chorley Borough Council	383	475	0.81	1.24
Fylde Borough Council	416	575	0.72	1.39
Hyndburn Borough Council	260	384	0.68	1.47
Lancaster City Council	540	650	0.83	1.19
Pendle Borough Council	288	379	0.76	1.24
Preston Borough Council	400	549	0.73	1.34
Ribble Valley Borough Council	260	284	0.91	1.07
Rossendale Borough Council	210	344	0.61	1.62
South Ribble Borough Council	416	391	1.07	0.94
West Lancashire District Council	453	622	0.73	1.39
Wyre Borough Council	577	592	0.97	1.00
Nottinghamshire	3,125	3,394	0.92	1.22
Ashfield District Council	435	473	0.92	1.25
Bassetlaw District Council	448	584	0.77	1.40
Broxtowe Borough Council	439	441	1.00	1.16
Gedling Borough Council	464	532	0.87	1.28
Mansfield District Council	384	414	0.93	1.24

Newark & Sherwood District Council	477	579	0.82	1.30
Rushcliffe Borough Council	477	372	1.28	0.90
Surrey	2,953	3,390	0.87	1.12
Elmbridge Borough Council	332	418	0.79	1.26
Epsom & Ewell Borough Council	185	131	1.42	0.70
Guildford Borough Council	318	303	1.05	0.95
Mole Valley District Council	271	250	1.08	0.92
Reigate & Banstead Borough Council	348	610	0.57	1.64
Runnymede Borough Council	204	175	1.17	0.85
Spelthorne Borough Council	251	204	1.23	0.81
Surrey Heath Borough Council	224	296	0.76	1.19
Tandridge District Council	229	296	0.77	1.28
Waverley Borough Council	367	416	0.88	1.11
Woking Borough Council	224	291	0.77	1.30

APPENDIX 1. CARE HOME PROFITABILITY HEAT MAPS of ENGLAND BY DISTRICT

Figure A.1
EBITDARM as % of revenue for-profit nursing homes

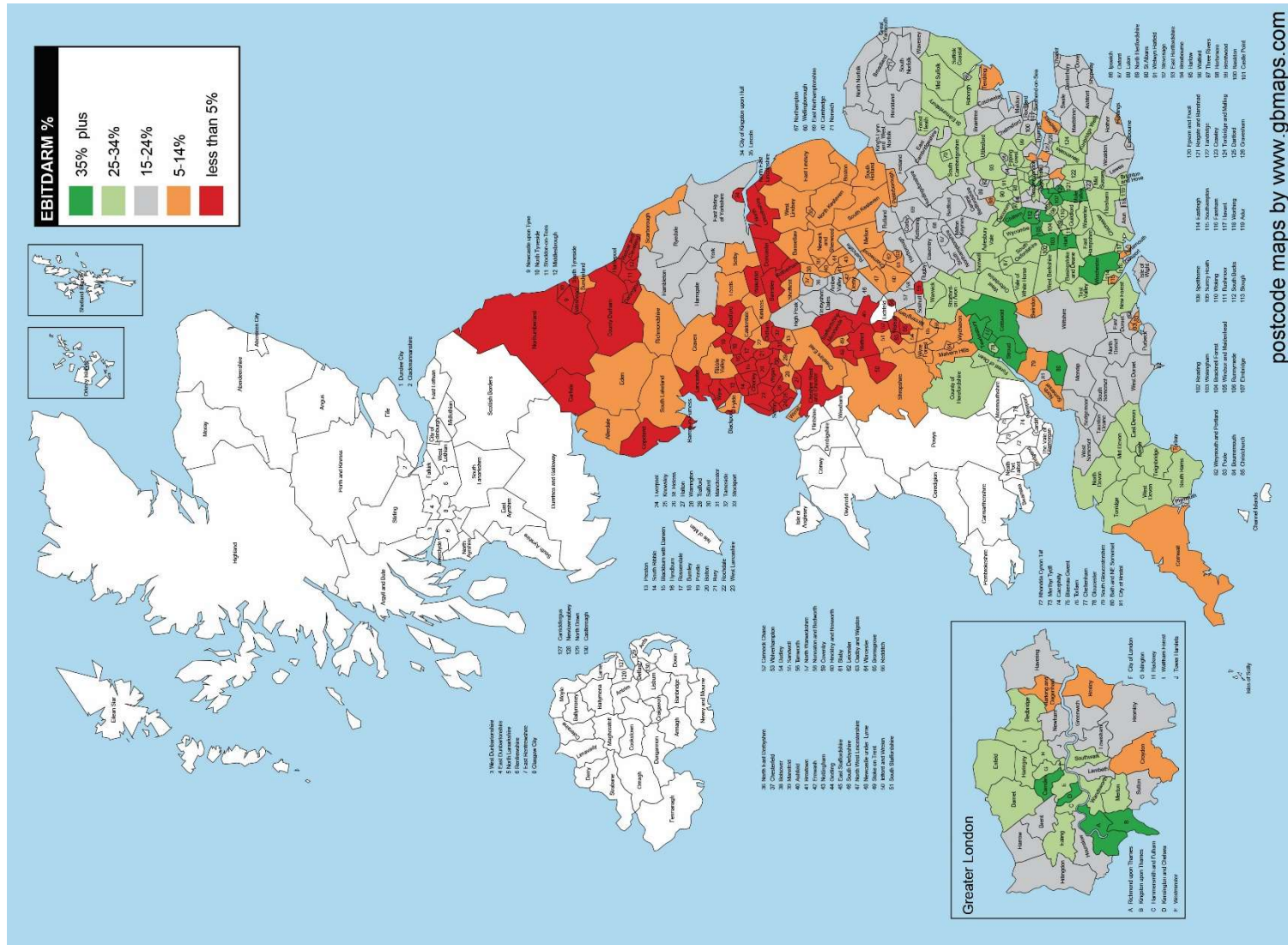
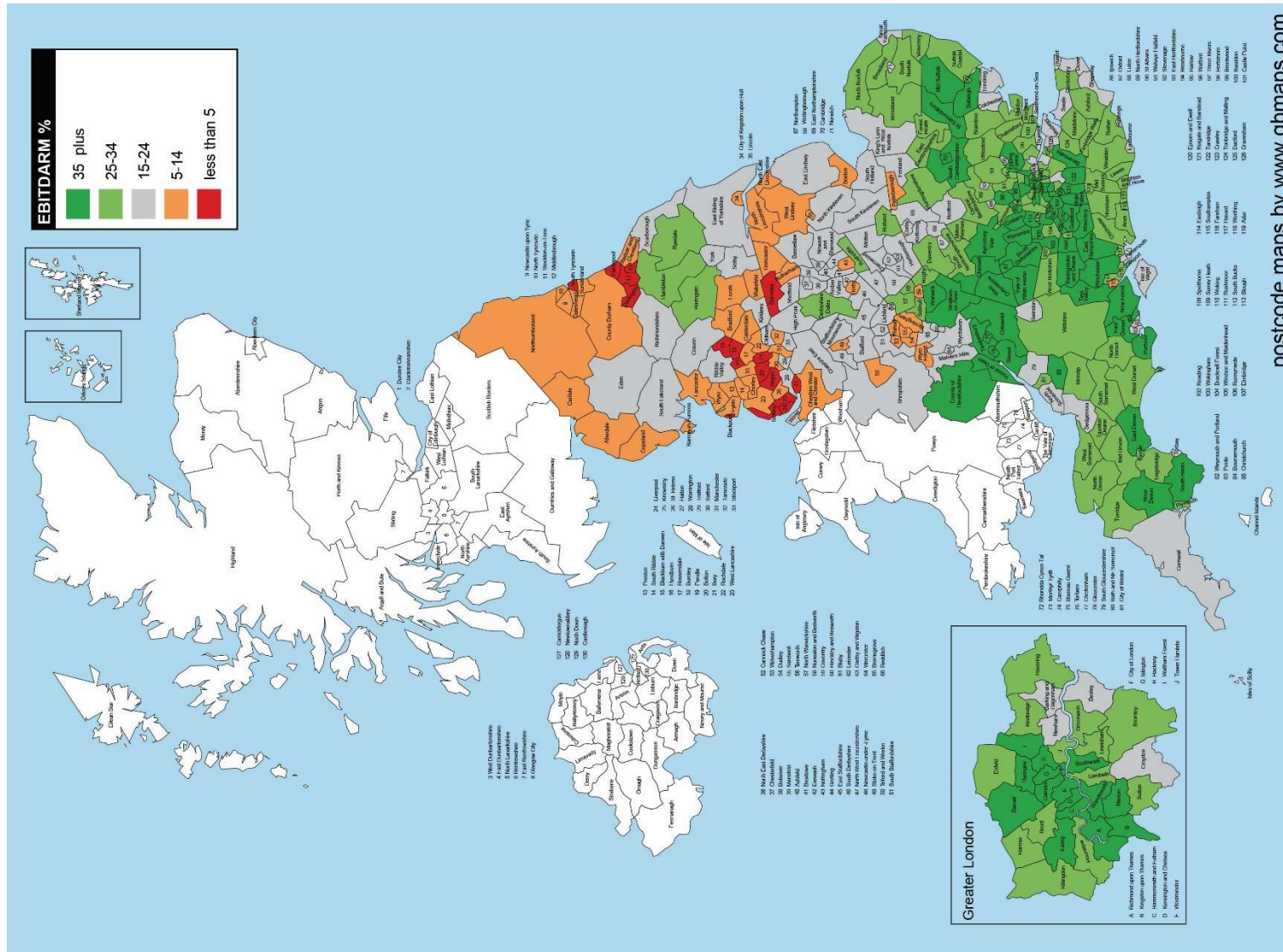


Figure A.2
EBITDARM as % of revenue for-profit residential homes



postcode maps by www.gbmaps.com