Care homes for the elderly: Where are we now?
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Foreword

Now is an inflection point for social care. There has never been a more critical time to focus on this area. How older people are cared for is the barometer of any civilised society so it is something we need to get right.

Flourishing communities are not a ‘nice to have’ but an essential part of our purpose of shaping a vibrant economy. Growth simply cannot happen sustainably if business is disconnected from society. That is why social care needs a positive growth framing. Far from being a burden, the sector employs more people than the NHS, is a crucible for technological innovation, and is a vital connector in community life. We need to think about social care as an asset and invest and nurture it accordingly.

There are opportunities to further invest to create innovative solutions that deliver improved tailored care packages to meet the needs of our ageing population.

Grant Thornton is passionate about data insight and bringing together narratives on complex issues in social care. Only by knowing where we are now can we understand where we need to go in the future. The Government is currently deciding how to fund care for older people in the long-term. With more information and insight fuelling the public debate around care services, better decisions can be made.

This report illuminates this debate. We have drawn on all our experience and knowledge of this market to create this overview. It aims to answer some of the key questions facing the sector. It also looks at the potential opportunities both now and in the future.

The conversation around creating a more caring society needs to continue. In producing this report, we aim to make a powerful and insightful contribution towards it. Care services are the heart of every community. Being looked after with dignity in old age is something we all aspire to. At Grant Thornton we want to supply the tools to make that happen.

Daniel Smith
Partner
Market structure, sustainability, quality & evolution

The market structure

An integral part of the British service economy, the UK care home market for over 65s does not follow a prescribed model. This is a relatively fragmented sector offering a rich and varied mix of businesses, from large corporate operators providing in excess of 10,000 beds to sole traders with one or two homes. Care homes operated by charities and other not-for-profit organisations also make up a significant part of this vibrant market, which comprises many constituent parts but, as a whole, is a vital social service.

The 10 largest for-profit providers make up under a quarter of the market, which is dominated by independent (non-public sector) operators. Around 38% of capacity is provided by smaller groups, with the remainder owned by operators with one or two homes.¹

Care homes for older people have been traditionally split between those that provide nursing care and those that do not. Fees at the former tend to be higher (an average of £841 per week compared to £600 for solely residential care²) due to the NHS-funded contribution for nursing care.

The market has grown organically, meaning there is no uniform model for successful homes, but new-build and recently converted homes now come with en-suite showering facilities and more spacious rooms. In recent years, a two-tier market has emerged with operators whose income is predominantly from local authority or NHS placements achieving significantly lower profits than those whose client base is self-paying.

Nursing and residential care beds in England 2016/17

Source: Care Quality Commission, 2017

¹ Care of older people UK market report (28th edition), LaingBuisson, May 2017

² Care homes for the elderly. Where are we now?
At March 2016, just under half (47.5%) of care home residents had their fees paid fully or partially by local authorities.\(^3\)

Around one quarter of care homes have more than 75% residents placed by local authorities. Average fees paid by local authorities were 10% less than the total cost of providing care, amounting to a £200 million to £300 million shortfall in funding. To counteract this, care homes charge self-funders around 40% more than they charge for UK council-funded placements.\(^4\)

The self-pay market is growing at a faster rate than its state-paid counterpart – a trend that is expected to continue – with local authority-funded operators increasingly repositioning their care homes to cater for private clients. This leaves a political and moral risk of the market fragmenting even further.

Demographic pressures means demand will outstrip supply

The public-pay UK care home market has been impacted by the preference of local authorities for commissioning homecare services (where fees are lower as there are no accommodation costs). The emergence of housing with care, where residents own or rent the property and care is provided at an additional cost, is also competing with care homes for clients but this sector is far from reaching maturity. In response, care home operators have moved further up the acuity chain, for example, accommodating people with severe dementia.

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\(^3\) Care of older people UK market report (28th edition), LaingBuisson, May 2017

\(^4\) Care homes market study, Competition and Markets Authority, November 2017 (assets.publishing.service.gov.uk/media/5a1fd30e5277a760b82533a/care-homes-market-study-final-report.pdf)
Care homes for the elderly: Where are we now?

The case for investment

The demographic case for investment in the UK elderly residential care sector is well rehearsed. The UK population of those aged 85+ is projected to increase from 1.6 million in 2016 to 2.8 million by 2031, an increase of c.75%. This ageing population will require access to care services, including residential care.

The projections are stark and point to a requirement for significant additional elderly residential capacity in the UK. However, although the growth rate in the 85+ population is forecast to accelerate over the next decade, this is not a new phenomenon. There has been an increase of more than 45% (or 500,000 individuals) in the 85+ population since 2001. Recent demographic movements have not translated into increased demand

Despite the increasing elderly population, the absolute number in long-term residential accommodation declined by 4.4% between 2001 and 2016. Further analysis indicates that this is a long-term trend. While the ageing population has increased, the proportion of the population in long-term residential accommodation has declined. In 2017 it was estimated that 14.8% of the 85+ population was in elderly residential accommodation. In 1996 the proportion was 25.2%.

If the proportion of over 85s in long-term residential care had remained constant since 1996, we estimate that an additional 167,000 individuals would be in long-term residential care.

Longer life expectancy will have played a part in reducing the proportion of over 85s in long-term residential care. However, the impact is likely to be marginal. After all the most common age of death in the UK is 86 for a male and 89 for a female. A more likely driver of this trend is the tightening of local authority budgets.

Growth in NHS admissions of the elderly, coupled with delays in discharge (due to the unavailability of suitable social care provision, or disagreements about funding), are having a significant impact on NHS resources. This pressure is, at least in part, a direct consequence of local authority policies to lengthen resource constraints.

Sources: LaingBuisson and Grant Thornton, 2017

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Proportion of the 85+ population in residential care

![Graph showing the proportion of the 85+ population in residential care from 1996 to 2017. The proportion declined from 25.2% in 1996 to 14.8% in 2017.](https://example.com/graph.png)

Sources: LaingBuisson and Grant Thornton, 2017
Has this model reached the end of the road?

Two key factors suggest that this trend cannot continue indefinitely:

1. The proportion of the 85+ population in care homes cannot continue to decline at the level it has done.
2. The rate of increase in the over 85 population is set to accelerate over the next 15 years.

Between 1996 and 2008, the proportion of over 85s in long-term elderly residential care fell by 0.75% per year on average. However, in the period 2008 to 2017 the rate of decline fell to 0.15% on average per year. This has increased the pressure on care home operators who face the increasing acuity of service users requiring more intensive care. This comes at an additional cost.

At the same time, the proportion of the over 85s in long-term residential care is stabilising and the absolute UK population of over 85s is projected to grow at an increased rate. In the 13 years between 2004 and 2017, the over 85 population increased by c.479,000 (40.0%). Over the next 13 years, this population is forecast to grow by over one million (62.6%).

This points to a significant increase in the demand for elderly care beds over the coming decade and beyond.

Bed supply

The supply of elderly care home beds has been broadly stable since the early 2000s, with a marginal overall decline.

However, this trend masks anecdotal evidence of a material variance between the self-funder focused private pay care homes and local authority-funded focused homes. The focus for new stock coming to market is self-funders, with care home closures focused on local authority-funded markets. Additionally, given the difficulties in recruiting and retaining nurses, as well as generating sufficient fees to deliver high quality nursing care, there is also a shift from nursing to residential provision. Homes are being repositioned as residential (often with a dementia focus) and 64% of new homes opening provide residential care rather than nursing provision.

UK elderly residential care bed capacity

Source: LaingBuisson, 2017
Care homes for the elderly: Where are we now?
Grant Thornton projection

Based on recent trends in the proportion of the elderly population in residential care and the recent contraction in supply, we forecast that the UK needs at least 75,000 additional elderly care beds by 2030 and that, based on recent trends, demand will outstrip supply by 2022.

The real position is almost certainly more urgent, as the figures are based on registered care bed capacity. However, the effective beds available will be lower as a result of dual occupancy rooms being utilised for single occupancy only, and the use of some registered bedrooms for alternative requirements (eg office space).

Sources: LaingBuisson, ONS and Grant Thornton, 2017
**Profitability of sector**

Earnings before interest, tax, depreciation, amortisation, rent and central management costs (EBITDARM) as a percentage of income among care home providers has fallen from 32.8% in 2006/07 to 25.2% in 2016/17.\(^5\) This drop has been attributed to increased food and property costs, the freezing of local authority fee rates in real terms and higher wage costs.

Despite the decline in underlying profitability of the major care home groups with high exposure to state paid fees, operators whose business model relied on self-paying clients fared better, with one-third of UK homes achieving EBITDARM as a percentage of income levels of more than 30%.\(^6\)

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Unit costs of a care home resident per annum

The blended average annual fees for elderly care homes in the UK were £38,899 in 2017. This amounts to a reduction of £1,825 in real terms, compared to 2007. But the biggest change in this period is in staffing costs, as the introduction of the National Living Wage and subsequent increases in NLW and minimum wage rates, combined with greater Care Quality Commission scrutiny, has increased real wages and staffing numbers (from c.53% of revenue in 2007 to 57.5% in 2017).

While there has been a marginal decline in direct costs (mostly food costs), in real terms both home overheads (e.g. utilities, property taxes, repairs and maintenance) and central management costs have increased.

At first glance, an EBITDARM percentage of 25.6% of income may still appear to represent a fairly handsome return. However, rent and/or financing costs are significant in the sector due to the capital cost of real estate and figures are stated before Capex (which amounts to at least £750 per bed per annum). In addition, these numbers are stated before central management costs which typically run at 5% of income.

Profitability differences

There are some noticeable differences in profitability dependent on the age and layout of the home. The differences are driven by the quantum of private pay fees and the size of the home driving economies of scale.

<table>
<thead>
<tr>
<th>Profitability differences</th>
<th>Average UK elderly care home comparison 2007 and 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDARM per annum profitability by property age</td>
<td></td>
</tr>
<tr>
<td>Opened before 2000</td>
<td>18%</td>
</tr>
<tr>
<td><strong>£7,354</strong></td>
<td></td>
</tr>
<tr>
<td>Opened between 2000-2009</td>
<td>28%</td>
</tr>
<tr>
<td><strong>£11,088</strong></td>
<td></td>
</tr>
<tr>
<td>Opened after 2010</td>
<td>32%</td>
</tr>
<tr>
<td><strong>£14,995</strong></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Knight Frank, Grant Thornton and UK CPI Index, 2017
* 2007 figures are inflation adjusted to 2017 rates for comparison

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Care home evolution

Evolution of room design – what does good look like?

1970s
- No en-suite
- c.9m² usable floor area

Late 1980s
- En-suite W.C. and basin
- c.10m² usable floor area

Mid 1990s
- En-suite W.C. and basin
- c.12m² usable floor area

Mid 2005
- En-suite shower room
- c.15m² usable floor area

Late 2017
- En-suite wet room
- c.20m² usable floor area

Source: Christie & Co., 2017

Size of care home matters on measuring EBITDARM, per bed, per annum

<table>
<thead>
<tr>
<th>EBITDARM profitability by property size</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of beds</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1-39</td>
</tr>
<tr>
<td>40-59</td>
</tr>
<tr>
<td>60-79</td>
</tr>
<tr>
<td>80-99</td>
</tr>
<tr>
<td>100+</td>
</tr>
<tr>
<td>All care homes</td>
</tr>
</tbody>
</table>

Source: Knight Frank, 2017

In terms of size, a home with between 80 and 99 beds hits the profitability sweet spot, achieving EBITDARM per bed of £11,694. This size of home commands an average weekly fee of £833, the highest of all homes, and is able to take advantage of economies of scale.
Care homes for the elderly: Where are we now?
Homes generating EBITDARM of more than £800,000 per annum

To get a feel for the KPIs of homes with strong financial performance, we have analysed the homes generating more than £800,000 from a representative sample of thousands of elderly residential care homes.

**KPI averages**

<table>
<thead>
<tr>
<th>KPI</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDARM %</td>
<td>37.3%</td>
</tr>
<tr>
<td>Beds</td>
<td>71</td>
</tr>
<tr>
<td>AWF</td>
<td>£878</td>
</tr>
<tr>
<td>Occupancy</td>
<td>95.3%</td>
</tr>
<tr>
<td>Staff costs as % of revenue</td>
<td>50.5%</td>
</tr>
</tbody>
</table>

Source: Grant Thornton, 2018

It is not surprising that the KPIs in respect of homes generating £800,000 EBITDARM or more are stronger than sector averages overall. Homes are larger than average at 71 beds, providing commercial support to the upwards trend in new-build home sizes in recent years.

We note that while average weekly fees are c.17.7% higher than UK averages, they do not represent the top of the exclusively private pay market at £1,500 or more. Although higher than average rates are clearly beneficial, it is a combination of the home’s size and strong occupancy (95.3% on average) that allows economies of scale to be delivered, reducing staff costs to c.50% of revenue and setting the foundations of strong financial performance to deliver EBITDARM returns of 37.3%.

Good financial returns can be made from homes catering to a blend of local authority-funded and private pay service users, as long as the facility is large enough and the quality of the facilities and care being delivered is sufficient to attract service users and deliver high occupancy.

**Staffing shortfall pressures**

Forecasts show that an additional 1.22 million social care workers will be needed between 2016 and 2036. These projections may be reduced as new technology and models of care are introduced. More conservative estimates are that a 31% increase in the social care workforce, equating to 500,000 jobs, would be needed by 2030 to meet demand.

At 2016-17 the care workforce in England comprised of 1.34 million jobs with a turnover rate of 27.8%. Turnover was particularly high for care workers (33.8%) and registered nurses (32.1%). The proportion of vacancies in care rose from 5.5% in 2012-13 to a peak of 7% in 2015-16, falling slightly to 6.6% in 2016-17. This is still significantly above the UK average of between 2.5% and 2.7%. We estimate that around 11.5% of care homes do not have a registered manager in place. Care homes without a registered manager are likely to be ranked as Requires Improvement by the Care Quality Commission (CQC).

Funding cuts led to a 44% drop in the number of full time equivalent district nurses between 2010 and 2017.

Despite this, there was a 6% drop in new nursing registrations in 2017/18 coupled by a 21% rise in de-registrations. In light of Brexit, there was also a sharp decline in the number of new EU nurse registrants from a high of 1,304 in July 2016 to just 46 in April 2017.

NHS bursaries for new nursing students were abolished in August 2017, leading to a 23% fall in applications by students in England to nursing and midwifery courses at British universities. This has led to further concerns about the future care home workforce.

We are aware that in certain areas of the country it is so difficult to recruit nurses that care home operators are moving away from providing nursing care in favour of residential care only.

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1 The social care deficit, all our futures, JLL, September 2017 (www.jll.co.uk/united-golden-research/healthcare-social-care-deficit-all-our-futures-2017)
2 The state of the adult social care sector and workforce in England, Skills for Care, September 2017 (www.skillsforcare.org.uk/Documents/NMDS-SC-and-intelligence/NMDS-SC/Analy-
4 funding-staffing-bed-blocking.pdf)
6 Freedom of Information request to the Nursing and Midwifery Council, Health Foundation, June 2017 (www.health.org.uk/news/new-data-show-96-drop-nurses-eu-july-last-year)
The quality and regulatory agenda

All care homes in England must be registered with the CQC. In Scotland it is the Care Inspectorate, the Care Inspectorate Wales is responsible for regulation in Wales and in Northern Ireland it is the Regulation and Quality Improvement Authority. In England the care regulator conducts inspections, which results in facilities receiving one of four gradings, dependent on how well the care home is graded against five key lines of enquiry: is it safe; effective; caring; responsive to people’s needs; and well-led?

There has been much debate over the correlation between poor care services and low local authority spending but research studies have not found a link. The two maps on the next page demonstrate this, as the region with the highest proportion of Inadequate homes also spends the most on social care.

In recent years the regulatory environment has become more stringent in an effort to drive up quality.

In addition, in 2015 the CQC acquired Health and Safety Executive powers. It has handed down fines of £1.5 million to Embrace Group and £1.6 million to Maria Mallaband Care Group for Health and Safety breaches.
Analysis of CQC inspection reports has found a correlation between the size of a care home and its quality rating. Homes with 10 or fewer beds achieve a better grade than those with more than 49 beds. Corporate providers with 20 or more locations, however, have been historically better at improving their rating, with 15% of locations remaining Inadequate after their last rating, compared to 22% of non-corporate locations. Both these trends were attributed to strong leadership. CQC data shows that if a service is rated as Good or Outstanding in the well-led category, it is more likely to be rated as Good or Outstanding overall, compared with any other key question.
As we see from this infographic, segmenting the care provider market highlights the differences in organisational focus, and their relative strengths and weaknesses. In any fragmented market where nine companies represent 12.68% of the total supply in a market, and a group consisting of over 4,000 companies is responsible for 28.41%, there are likely to be stark differences in operating models and customer focus.

For example, nursing care is a key offering for the largest providers (Group A), whereas the smaller privately-owned care companies (Group G) focus much less on this, attributing less than 30% of their beds to nursing on average. One of the most obvious differences will be the size of the assets that make up the different portfolios, where the average sizes of homes in terms of beds reduces from 55 (Group A) to 18 (Group G), with a number of the mid-tier providers providing homes with an average of 30 beds.
Care homes for the elderly: Where are we now?

A key point of interest is how the overall CQC ratings are attributed, and how each group is more or less likely than average to receive a certain rating. Group A offer no surprises in that their likelihood of receiving a Good CQC rating is no more than average, and whereas their likelihood of Requires Improvement is slightly higher, the likelihood of receiving an Inadequate rating is over 40% lower. Groups E and F are very interesting. They exhibit a much higher likelihood of receiving an Outstanding rating, but when it comes to Inadequate ratings they are also some of the highest. These Groups are the most polarised in CQC ratings; in a lot of cases they are either very well run homes, or deemed as Inadequate by the regulator. Conversely, businesses running a single care home (Group G), they are less likely to be judged by the regulator as being Inadequate, Requiring Improvement, or Outstanding. These homes are 5% more likely to receive a Good rating.

There are significant and long-term financial ramifications of a care home being rated as Inadequate by the CQC. The home will typically have to deal with declining occupancy at the same time that its costs are increasing in order to address CQC concerns. This can also lead to problems with recruitment and staff retention.

While the impact on financial performance and cash flow is considerable, as a result of declining multiples associated with under-performance, the resulting impact on value will be even more dramatic, as our case study opposite illustrates.

<table>
<thead>
<tr>
<th># providers in segment</th>
<th>9</th>
<th>34</th>
<th>40</th>
<th>66</th>
<th>417</th>
<th>1120</th>
<th>4411</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
<td>F</td>
<td>G</td>
</tr>
<tr>
<td>Outstanding</td>
<td>↓ 12.7%</td>
<td>↓10.2%</td>
<td>↓19.5%</td>
<td>↓2%</td>
<td>↑11.5%</td>
<td>↑21.8%</td>
<td>↓6.5%</td>
</tr>
<tr>
<td>Good</td>
<td>↑0.5%</td>
<td>↑0.7%</td>
<td>↑2.3%</td>
<td>↑0.5%</td>
<td>↓5.5%</td>
<td>↓5.5%</td>
<td>↑5.1%</td>
</tr>
<tr>
<td>Requires improvement</td>
<td>↑4.2%</td>
<td>↓1.9%</td>
<td>↑10.9%</td>
<td>↑1.6%</td>
<td>↑8.9%</td>
<td>↑6%</td>
<td>↓12.3%</td>
</tr>
<tr>
<td>Inadequate</td>
<td>↓41.3%</td>
<td>↑9.5%</td>
<td>↓25.2%</td>
<td>↓75.5%</td>
<td>↑48.8%</td>
<td>↑15%</td>
<td>↓12.6%</td>
</tr>
</tbody>
</table>

↑ More likely than average to achieve stated rating
↓ Less likely than average to achieve stated rating
% Degree of likelihood to achieve stated rating
At the time of its Inadequate rating in June 2014 (downgraded from Good) the home generated a rolling 12-month EBITDAM of over £1 million. The home faced a local authority embargo placed on new service users as a result of the rating downgrade and the recruitment of additional staff and consultants required to address the CQC concerns. Consequently, rolling EBITDAM reduced to c.£450,000 in March 2016, despite the home being re-rated as Good in December 2014. The time lag between addressing any problems, and rebuilding the home’s occupancy and reputation, is evident.

Relative to the financial performance demonstrated in the period ended June 2014 the cumulative negative impact on the home’s cash flow by March 2017 amounted to c.£1.2 million in less than three years.

Investors in the sector should be mindful of the potential for material variances in the rolling 12-month or annual financial results and the current run-rate of the home based on monthly or quarterly performance.

The impact on value for owners, investors and lenders is even more pronounced. In this example the home’s value is estimated at over £8 million at the time of the Inadequate CQC rating, based on an x8 multiple. As underlying performance deteriorates, the multiple a purchaser is willing to pay also reduces, as the purchaser is factoring in a discount for the run-rate performance and turnaround required. While the exact multiples achievable are unique to each situation, x5.5 would not be uncommon in a turnaround situation.

The impact on value in this case is dramatic as the business is faced with declining multiples compounded by deteriorating financial performance. The value bottoms out at c.£2.5 million in December 2015, a reduction of more than £5.5 million.

This can have a significant impact on loan-to-value ratios and financial covenants.
Sustainability of the market in its current form

Against a backdrop of cuts to local authorities’ budgets and the increasingly stringently-applied eligibility criteria for support, it is widely thought that a care home business model that mostly relies on local authority placements is unsustainable in the current economic climate.

The average weekly fee for residential (non-nursing care) has been estimated at £600 in 2016/17 but the average English council pays £486 per week. LaingBuisson founder William Laing has stated that the adoption of the National Living Wage and requirements to employ more carers to support residents with increasingly complex dependencies had fuelled an ‘inexorable rise’ in care home costs. He said: “A minority of councils have seen the light and have raised fees in order to sustain supply, but large shortfalls continue for care homes in most council areas … it will cost £1 billion to plug the hole in fees, before even starting to think about additional services.”

Estimated change in local authority spending power, 2010-11 to 2019-20

Spending power has been falling since 2010-11

![Graph showing estimated change in local authority spending power from 2010-11 to 2019-20](image)

Notes

1 Our measure of spending power uses data published annually by the Ministry of Housing, Communities and Local Government. However we exclude public health grant, the Better Care Fund and NHS transfers for social care where they are included in the years 2011-12 to 2015-16. We use a chain-linking approach in order to address discontinuities in the definition of spending power from 2010-11 to 2015-16. We use the method set out by Robjohns, J, ‘Methodology Notes: Annual Chain Linking’, Economic Trends, Number 630, Office for National Statistics, May 2006.

Source: National Audit Office, 2018

Spending on care by local authorities (including funds transferred from the NHS through the Better Care Fund) fell by 5.3% in real terms between 2010-11 and 2016-17 and is forecast to drop a further 0.2% in real terms between 2017-18 and 2019-20, despite rising demand, increasing cost pressures and higher acuity of service users.16

The role of the public sector and regulators in social care market shaping

The proportion of council spending on adult social care was due to increase to 36.9% of their total budgets in 2017/18, with total cumulative savings in adult social care since 2010 standing at more than £6 billion by the end of March 2018. England’s 152 councils with social care responsibilities were given authority to raise funding via a precept in 2016/17. Almost all these authorities (147) reported that they are considering or have approved an adult social care precept in 2018/19 to raise an extra £548 million.

Map of residential and nursing care spend for 65+ (£/week)

- 53,546 - 168,574
- 28,998 - 53,546
- 23,105 - 28,998
- 16,823 - 23,105
- 1,124 - 16,823

Source: Grant Thornton, 2018

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Under the Care Act 2014, local authorities “should take the lead to engage with a wide range of stakeholders and citizens in order to develop effective approaches to care and support, including through developing the joint strategic needs assessment and a market position statement.”

The main aim of a market position statement (MPS) is to encourage commissioners, people who use services, carers and provider organisations to work together to explain what care services and support is needed in the area and to help shape the local market for social care. They are opportunities to assess their local market and devise an effective strategy to accommodate the prospective needs of the community.

A Grant Thornton review of 27 MPSs, comprising three from each English region, found very few had been able to articulate care capacity requirements and, as such, commission care strategically.

We established a group of criteria to assess their content and approach and graded them on each one of these.

The criteria were as follows:

- **Context** – Place, demography, age profile, care needs, socio-economics
- **Supply** – Existing market characteristics – including supply by care type, pricing, market structure, market exit/entry, significant market gaps, market mix, areas for development
- **Demand** – Capacity forecasting, demand by care, supply/demand gap, detailed overview of requirements etc, demand for staffing and nursing, property needs
- **Commissioning** – Including any plans to develop capacity or shape market, procurement plan, plans for diversity of provision, decommissioning and commissioning
- **Market intervention** – Including risk analysis, action plan, provider business failure, safeguarding, support to providers, investment plans, creation of new capacity – eg land/property.

No statement covered all our criteria extensively and fully and all statements were weak on their commissioning intentions and market intervention/risk plans. The majority of statements highlighted the historical and current position, rather than looking significantly forward, with limited capacity forecasting, and market intervention and shaping plans virtually non-existent.

This finding mirrors consensus in the sector that market development/management has not been prioritised strongly by councils, potentially due to the lack of regulatory force in this area, and staffing cuts in the commercial areas of expertise required.
### Criteria

<table>
<thead>
<tr>
<th>Context</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Place, demography, age profile, care needs, socio-economics</td>
<td>On average the score for context was 3.2 (1 being the lowest, 5 the highest). The majority of statements were strong on the current demographics of their region. Most also outlined their care profiles, although this was missing in many and the ONS data was the only demographic information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supply</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Existing market characteristics – including supply by care type, pricing, market structure, market exit/entry, significant market gaps, market mix, areas for development</td>
<td>On average again the score for this section was 3.2. Supply by care type in varying degrees of detail was largely covered by all statements. The structure and current supply of beds and details of where these are provided was also universally covered. However no attention was paid to market mix or gaps or areas where the supply needs to be improved and developed. A limited number had information about pricing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demand</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Capacity forecasting, demand by care, supply/demand gap, detailed overview of requirements etc, demand for staffing and nursing, property needs</td>
<td>Score on average for this section was 2.9. Only two statements fulfilled our criteria with significant capacity forecasting by type. The majority of statements only forecast population and types of need rather than detail of the complex care needs and demands. Staffing was highlighted in a number of reports and the potential shortage in the future (and presently). However no statement really grasped the full complexity of future need and covered the supply/demand gap effectively. Property and development was not discussed in any statement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commissioning</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Including any plans to develop capacity or shape market, procurement plan, plans for diversity of provision, decommissioning and commissioning</td>
<td>Score on average for this section was 2.2. Commissioning was probably the most patchy of all the criteria. Most mentioned existing commitments (although not all) and some elements of their commissioning plans for the future. No statement used the MPS as an opportunity to outline commissioning strategy to alleviate demand or devise a plan to commit their commissioning intentions to solving the current issues. A large number did not even include a section on commissioning in the statement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Market intervention</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Including risk analysis, action plan, provider business failure, safeguarding, support to providers, investment plans, creation of new capacity – eg land/property</td>
<td>Score on average for this section was 1.4. Market intervention was the poorest of all the criteria we looked at. Only 1 of the 27 had any clear plan highlighted on provider failure and how they would manage the increased demand should this occur. The majority completely ignored this area as a component of the MPS and had limited information on the support they give to providers. There was no risk analysis or discussion of how they could mitigate this in their forward planning.</td>
</tr>
</tbody>
</table>
In March 2018, the Government stated it was preparing guidance for local authorities on how local development plans should address the housing needs of older and disabled people.19

Following the collapse of Southern Cross, care regulator the CQC was given a statutory responsibility under the Care Act to assess the financial sustainability of care operators who would be the most difficult to replace if they failed. Collectively, these providers represent around 30% of the adult social care market in England, and are included within the CQC Market Oversight scheme. To date, the only warning issued to a local authority by the CQC concerned a single facility run by Orchard Care Homes in the north east of England.

It has also been suggested that the CQC should oversee the planning and commissioning of services in England and Northern Ireland.20 Scotland and Wales are currently developing their own systems.

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**Case study: Sustainable models of funding**

CEO of care consultancy Healthcare Management Solutions, Tony Stein, said the benefits of contracting with local authorities (regular payments and steady income) were outweighed by the risks involved. Funding constraints have meant that the vast majority of councils will only support people with critical needs, with some local authorities actually rationing care home places. “Local authorities are cash-strapped and austerity continues to bite.”

“I think it is getting less of a sustainable model. The public pay model is not really sustainable without a subsidy. Local authorities don’t want to or can’t afford to pay the true cost of care.” Stein said this had created a situation where operators struggled to meet CQC standards. “At the moment we are measured by one set of standards but funded to meet another set of lower standards.”

Stein also said a lot of homes were surviving on low interest rates and no longer investing in upgrading their properties. Once these operators exited the market, quality should rise but, until then, the sector would “limp along with low fee increases”.

One solution was to limit public-paying residents’ choice of home so providers could be guaranteed occupancy rates of 90% or more, making the operation more sustainable.

The forthcoming Green Paper should also consider encouraging local authorities to raise finance through bonds to build new, high-quality care homes that would be run by management companies. Stein said: “I think this is one model that could play out. Otherwise we are stuck with stock that is getting older and older and people do not deserve that.”

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Delayed transfers of care

A critical problem within acute hospitals is delays in getting patients discharged, causing high-profile issues throughout the rest of the hospital including delays admitting ambulances and patients into A&E.

From April 2017 to March 2018 there were 1,290,430 delayed discharge days from acute hospitals. Of these, just under 40% were due to people awaiting care home placements.\textsuperscript{21} There were 154,600 days in March 2018 compared to 199,600 the same time last year. Despite this improvement, it still falls short of the NHS England target that no more than 3.5% of available NHS beds should be occupied by patients fit for discharge.

Issues with funding and budgets are crucial factors, as is the lack of joined-up commissioning. The acute hospital is the end of a care pathway as patients are admitted but it needs to be the start of a recovery or longer-term care plan that bridges back into social care. With healthcare being free at the point of care but social care being funded from a separate budget or being privately-funded, there is a tension over identifying the right care package for medically fit (often elderly) patients that can leave the hospital but need a lower level of care support.

Another barrier to joined-up pathways is the treatment of certain illnesses such as heart conditions and cancer being funded and treated by the NHS, whereas others, for example, dementia and Huntingdon’s disease, fall principally under local authority budgets.

Delays occur as new funding needs to be accessed. In many cases, patients do not meet eligibility criteria for social care funding, and the current care provision is not necessarily set up for hospital discharge rehabilitation.

Grant Thornton’s work with NHS trusts had revealed that many were unable to take this systematic approach because limited resources meant they were fire-fighting on a daily basis. Turnaround work, involving going into trusts who find themselves in financial difficulties, has shown it has almost become a day-by-day model of “we need a bed” or “we can discharge today” as opposed to being systematic.

Care providers have also reported transfers being slowed by poor channels of communication, leaving Clinical Commissioning Groups (CCGs) so stretched that they often over-commission care services to compensate for this. Some have put forward the idea of Trusts appointing a dedicated person or even a team to get patients out of hospital and into a more appropriate care service. A more preventative approach is identifying those patients most in need before they are even admitted to hospital through projects such as the Primary Care Home Model. This brings together a range of health and social care professionals to provide enhanced personalised and preventative care for their local community.

Care home operators are beginning to provide the level of support and rehabilitation that is required and there are good examples of operators accessing CCG-funded Packages. However, there remains a significant problem and therefore a potentially significant opportunity if the funding and commissioning structures can be clarified.

Forest Healthcare works with the CQC’s to unblock hospital beds by using Continuing Healthcare funding, awarded by the NHS to care for people with significant ongoing health conditions. Based in the south east of England, the operator provides end of life care in its homes, typically for up to 10 weeks per resident. Chief financial officer Colin Haig said: “It is a strong source of residents for our nursing homes. We are talking about taking someone from hospital who can’t have anything more done for them.

“It is a sensible fee, well-earned as it will involve intensive nursing. In central London around a third of our beds are on Continuing Healthcare funding, which is about the right balance for us. Our experience is that most contracts are in London. As you move out of London you see less of these type of contracts.”

Haig said “Continuing Healthcare contracts tended to be renewed automatically, compared to the fixed-term contracts it holds for step-down or intermediate care, which are drying up due to NHS and local authority budget constraints.”
Future funding changes and the political agenda

Policy changes to address the long-term funding of care home places

This autumn’s Green Paper will focus on creating “a sustainable funding model for social care supported by a diverse, vibrant and stable market,” said then Health Secretary Jeremy Hunt earlier this year.

Measures have already been taken to prop up the market, including increasing council tax through the social care precept and £2 billion funding in the March 2017 Budget through the Improved Better Care Fund to work more closely with the NHS.

While a review of 20 councils’ commissioning practices by the CQC found some examples of health and care organisations working well together, there was too much ineffective co-ordination of health and care services, leading to fragmented care. This was reinforced by funding, commissioning, performance management and regulation that encouraged organisations to focus on individual performance rather than positive outcomes for people.22

In June 2016 the NHS-funded contribution to care homes costs unexpectedly rose by 40% to £156.25 per week. However, there still remains a gap between public funding and the actual cost of care.

Based on maintaining the current system of eligibility and means testing for social care in each of the four UK nations, spending on social care would increase from 1.1% of GDP in 2018/19 to 1.5% in 2033/34. If England introduced a cap on lifetime care costs and reformed the means test in line with the proposals in the Conservative party manifesto in 2017, this would add £6.7 billion to the funding shortfall.23

The government are intending to issue a Green Paper to focus on the growing funding gap. At a policy level, government will need to decide whether to continue with the current system of a low floor for personal asset depletion, or alternatively raise the floor and introduce a lifetime cost cap.

A further option may be to introduce ‘Free Personal Care’ as has operated in Scotland for the last 10 years. All policy options are expensive and the government has indicated that they must be funded via taxation rather than borrowing. A range of possibilities have been discussed including raising National Insurance both in quantum and age, additional inheritance taxes, income tax and council tax/business rates.

There are equity of distribution issues associated with both the policy and taxation options that could result in ‘winners and losers’. The relative low public salience of social care in relation to healthcare/NHS is a factor – prior attempts to resolve these issues such as the Dilnot Commission have not been implemented.

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22 Beyond Barriers, Care Quality Commission, July 2018 (www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf)
23 Securing the future: funding health and social care to the 2030s, Institute for Fiscal Studies, May 2018 (www.ifs.org.uk/publications/12994)
Tax options for funding the gap

The size of the future gap is dependent on the policy option government decides to adopt. As the following chart shows, retention of the current policy framework (where personal assets are protected to a floor of £23,250 and there is no lifetime cap in place) results in a funding gap by 2031/32 of at least £6.1 billion. This gap rises to £14.6 billion for a ‘Free Personal Care’ model based on the Scottish Government system. It is only marginally less expensive to adopt the ‘cap and floor’ model set out in the Conservative Party manifesto of 2017.

The funding requirement for potential Green Paper policy options

Source: The Health Foundation/The Kings Fund, 2018
Grant Thornton, with and for Independent Age, has conducted an analysis of the tax requirement for funding the gap given different policy scenarios. We looked at the effectiveness in terms of tax yield of the following scenarios:

<table>
<thead>
<tr>
<th>Funding option</th>
<th>Rank</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income tax</td>
<td>1</td>
<td>This scenario analyses the additional funding raised by a 1% increase in the rate of income tax. The increase has been applied to the basic rate, higher rate and additional rate.</td>
</tr>
<tr>
<td>Contribution at age 65</td>
<td>2</td>
<td>This scenario analyses the additional funding raised by the introduction of a tax contribution of £10,000 at the age of 65.</td>
</tr>
<tr>
<td>Age related levy</td>
<td>3</td>
<td>This scenario analyses the additional funding raised by an age-related levy applied to the working population aged 40 and above in England from 2018. At the age of 40 a levy of 0.7% is applied to both the employer and employee.</td>
</tr>
<tr>
<td>Change in NI rates</td>
<td>4</td>
<td>This scenario analyses the additional funding raised by a 0.5% increase to national insurance rates. The 0.5% increase is applied to the employee main rate, employee additional rate and employer rate.</td>
</tr>
<tr>
<td>Corporation tax</td>
<td>5</td>
<td>This scenario analyses the additional funding raised by a 1% increase to the corporation tax rate.</td>
</tr>
<tr>
<td>Charging NI to those aged 65 and over</td>
<td>6</td>
<td>This scenario analyses the additional funding raised by the introduction of national insurance collection for the working population aged over 65.</td>
</tr>
<tr>
<td>Business rates</td>
<td>7</td>
<td>This scenario analyses the additional funding raised by a 3% increase in the business rate.</td>
</tr>
<tr>
<td>Council tax</td>
<td>8</td>
<td>This scenario analyses the additional funding raised by a 3% increase in the rate of council tax.</td>
</tr>
<tr>
<td>Changes to inheritance tax</td>
<td>9</td>
<td>This scenario analyses the additional funding raised by an increase in inheritance tax of 2%.</td>
</tr>
</tbody>
</table>

Sources: Grant Thornton and Independent Age, 2018
The modelling demonstrated that while some taxes at the levels set out above are able to bridge the gap for the short-term, few are able to bring tax and spend into balance in the longer-term.

**Funding raised in 2020/21 - in current prices**

<table>
<thead>
<tr>
<th>Tax Type</th>
<th>Funding Raised £billion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income tax</td>
<td>6.10</td>
</tr>
<tr>
<td>Contribution at 65</td>
<td>5.73</td>
</tr>
<tr>
<td>Age related levy</td>
<td>5.62</td>
</tr>
<tr>
<td>Change in NI rates</td>
<td>9.92</td>
</tr>
<tr>
<td>Corporation tax</td>
<td>2.50</td>
</tr>
<tr>
<td>Change NI over 65</td>
<td>1.54</td>
</tr>
<tr>
<td>Business rates</td>
<td>0.76</td>
</tr>
<tr>
<td>Council tax</td>
<td>0.71</td>
</tr>
<tr>
<td>Inheritance tax</td>
<td>0.29</td>
</tr>
</tbody>
</table>

**Funding raised in 2030/31 - in current prices**

<table>
<thead>
<tr>
<th>Tax Type</th>
<th>Funding Raised £billion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income tax</td>
<td>7.47</td>
</tr>
<tr>
<td>Contribution at 65</td>
<td>6.52</td>
</tr>
<tr>
<td>Age related levy</td>
<td>5.80</td>
</tr>
<tr>
<td>Change in NI rates</td>
<td>5.25</td>
</tr>
<tr>
<td>Corporation tax</td>
<td>2.88</td>
</tr>
<tr>
<td>Change NI over 65</td>
<td>1.94</td>
</tr>
<tr>
<td>Business rates</td>
<td>0.77</td>
</tr>
<tr>
<td>Council tax</td>
<td>0.76</td>
</tr>
<tr>
<td>Inheritance tax</td>
<td>0.43</td>
</tr>
</tbody>
</table>

The conclusions for policy makers are stark. Should the appetite exist for moving social care funding to a more sustainable footing, tax rises (or new taxes) are likely needed. Moreover, the rate of taxation will require an increase by the mid-2020s. For example, a change in NI rates of 0.5% will fund a reasonably generous cap and floor model in the short-term, but by 2031 the rate will need to be doubled to 1.0%. The analysis also shows that locally collected and spent taxes are both insufficient and distributionally unequal.

Any new or increased taxes for social care are liable to generate significant political and public debate. Inertia is therefore liable to be a powerful force, especially given the policy and legislative preoccupation with Brexit. The sector may therefore see a range of shorter-term funding interventions by government over the medium-term, based on relatively little change in policy.

Sources: Grant Thornton and Independent Age, 2018
The Australian government introduced a new funding model in 2014 with new regulations to address the shortage in care home beds for older people. “It has kicked-started a transformation in aged care,” explained AMP Capital’s global head of social care Julie-Anne Mizzi.

There are three elements to the model. The first is tied to the acuity of care needed with potential residents assessed with their needs assigned to one of 48 levels. For each level there is a set payment from the government. The older person is also means-tested to ascertain whether this payment should be fully or part-funded by the state.

The second element is for personal care, for example, the cost of food, showering and laundry. For residents with a full pension, up to 85% can be taken from their pension and paid directly to the care provider to cover these costs. If they do not have a full pension, the resident has to make up the difference.

Accommodation costs are also mean-tested, with the government funding or part-funding those with income and assets below a certain level. This is around 35% of people across all areas. Those who do not qualify for this assistance pay a refundable accommodation deposit [RAD] (on average AUSS300,000 or £173,000), which is held by the operator and returned to the family on the death of the resident. Those who cannot afford this can make a daily payment.

The operator can only use this money to build new homes or refurbish existing ones in its estate. Mizzi explains: “It is a liability on your balance sheet but it is a free debt. Development has been speeded up due to the RAD. Like-for-like growth in aged care is not that high. The way you can get growth is through the RAD.”

The amount the RAD is set at is also tied to the local property market, so there is usually an uplift when one deposit is refunded and replaced with a new one. “This model is definitely transferable,” Mizzi added. “I would like to see the UK government pick it up.”
The investment, capital and financing landscape

Acquisitions/M&A activity
Care homes accounted for 60% of all healthcare deals in 2017, eclipsing traditional asset classes including primary care and hospitals, as some investors exited the market for strategic reasons. This put large-scale portfolios on the market and enabled new capital to enter the market, for example, infrastructure fund AMP Capital acquiring The Regard Group.

Healthcare yields v other specialist sectors – Q4 2017

<table>
<thead>
<tr>
<th>Sector</th>
<th>Going concern</th>
<th>Fixed income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care home (Prime)</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Surgeries (Prime)</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Private Acute Hospitals (Prime)</td>
<td>4.75%</td>
<td>4.75%</td>
</tr>
<tr>
<td>Specialist Care Homes (Prime)</td>
<td>6.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Specialist Schools (Prime)</td>
<td>6.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>London hotels (Prime)</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>London hotels (Secondary)</td>
<td>4.25%</td>
<td>6%</td>
</tr>
<tr>
<td>Regional UK hotels (Prime)</td>
<td>4.25%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Regional UK hotels (Secondary)</td>
<td>4.75%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Student Accommodation Regional UK</td>
<td>4.5%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Knight Frank, 2018
Healthcare transactions increased by 103.7% in the year to November 2017 due to healthcare now being seen as a more attractive mainstream lower-risk asset class – attracting interest from REITS and low yield low-risk property funds as well as infrastructure funds. Interestingly the REIT interest in particular has now moved away from just super prime private pay and to more balanced portfolios with a higher proportion of local-authority funding, for example, Impact Healthcare REIT.

Arguably the deal of 2017 was the sale of 122 Bupa care homes to HC-One for £300 million, which made the latter the largest care home group in the UK, providing in excess of 22,000 beds.

With the increased activity of the longer-term, lower-return investors, private equity’s involvement in elderly care has become less prevalent and the private equity investors’ focus is now on the different ends of the market where the higher returns are still achievable. There have been a number of successful investments by private equity in developing and building out new high-end, purpose-built homes and then selling the homes and the development pipeline into the REIT-fuelled, high-value, super-prime, private-pay established homes market. Patron Capital’s interest in Gracewell Homes and Phoenix Capital’s in Porthaven Homes are both good examples of very successfully executed development investments and Synova Capital are backing Oakland Primecare to further develop their group.

At the other end of the market there has been private equity activity looking to buy, restructure and turnaround less well performing groups, such as Alchemy Partners’ investment in Orchard Homes and operating company. This investment strategy has not been so successful so far as continued margin pressure in the local authority-funded market has meant the turnarounds have proved very challenging and in a number of cases unachievable.

The two largest operators, HC-One and Four Seasons, also have private equity involvement, but with both sets of investors appearing close to an exit the extent of private equity involvement in the care home market may reduce further. Barchester Healthcare, which is the third largest operator, running more than 200 care homes and owned by Grove Investments, has also been recently marketed for sale.

### Selected recent investments:

<table>
<thead>
<tr>
<th>Date</th>
<th>Acquirer</th>
<th>Care home group</th>
<th>Deal value (£million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2018</td>
<td>Revera</td>
<td>Signature Senior Lifestyle</td>
<td>Undisclosed</td>
</tr>
<tr>
<td>November 2017</td>
<td>Fremont Realty Capital</td>
<td>Porthaven Homes</td>
<td>Undisclosed</td>
</tr>
<tr>
<td>August 2017</td>
<td>HC-One</td>
<td>122 Bupa homes</td>
<td>£300</td>
</tr>
<tr>
<td>March 2017</td>
<td>Impact REIT</td>
<td>Minster Group freeholds</td>
<td>£149</td>
</tr>
<tr>
<td>January 2017</td>
<td>HC-One</td>
<td>Helen McArdle Care</td>
<td>Undisclosed</td>
</tr>
<tr>
<td>August 2016</td>
<td>The Carlyle Group</td>
<td>Akari Care</td>
<td>£39</td>
</tr>
<tr>
<td>July 2016</td>
<td>Synova Capital</td>
<td>Oakland Primecare</td>
<td>£30</td>
</tr>
<tr>
<td>August 2015</td>
<td>Alchemy Partners</td>
<td>Orchard Care Homes (OpCo)</td>
<td>Undisclosed</td>
</tr>
<tr>
<td>February 2015</td>
<td>HC-One</td>
<td>Meridian</td>
<td>£106 (8.8 x EBITDA)</td>
</tr>
<tr>
<td>November 2014</td>
<td>Formation Capital, Safanad, Court Cavendish</td>
<td>HC-One</td>
<td>£477</td>
</tr>
<tr>
<td>April 2012</td>
<td>Terra Firma</td>
<td>Four Seasons Health Care</td>
<td>£825 (8.6 x EBITDA)</td>
</tr>
<tr>
<td>March 2010</td>
<td>Bridgepoint</td>
<td>Care UK</td>
<td>£420 (7.1 x EBITDA)</td>
</tr>
</tbody>
</table>

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*Demand dramatically outstripping supply, CBRE, December 2017 (valuedinsights.cbre.co.uk/demand-dramatically-outstripping-supply/)*
Selected recent exits:

<table>
<thead>
<tr>
<th>Date</th>
<th>Disposer</th>
<th>Care home group</th>
<th>Acquirer</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2018</td>
<td>Downing</td>
<td>Five Care Concern homes</td>
<td>Undisclosed real estate investor</td>
</tr>
<tr>
<td>November 2017</td>
<td>Phoenix Equity</td>
<td>Porthaven</td>
<td>Fremont Realty Capital</td>
</tr>
<tr>
<td>August 2014</td>
<td>Patron Capital</td>
<td>Gracewell Healthcare</td>
<td>Welltower</td>
</tr>
<tr>
<td>August 2013</td>
<td>Graphite Capital</td>
<td>Avery Healthcare and Willowbrook</td>
<td>Welltower</td>
</tr>
</tbody>
</table>

Investment landscape

Five years ago, care homes, along with private hospitals and medical centres, accounted for up to 90% of investor demand. In 2018 that figure has fallen to 50%.²⁵

In the UK market, older homes tend to be sold off to neighbouring providers. If they are in a good location, the land is sold.

There is a preference among investors for lot sizes above £50 million, such as mid-tier care homes where demand is high but individual properties are relatively small. This suggests investors have an eye on aggregating assets wherever practicable, in order to release value through scale.²⁶

Below investment-grade homes (mid-market operators with high quality physical assets but without the corporate security of a strong balance sheet) are also being considered. This is due to a shortage of investment-grade homes and hospital stock.²⁷

Investors are now considering long-term holds, with more than half of the major groups looking at a 10-year hold or longer.²⁸

Significant rise in demand for care home properties for investment

Conservative estimates put at least £3.25 billion of new capital waiting to be invested in healthcare real estate.²⁹ The growing number of older homes that are no longer fit-for-purpose is driving new investment, along with increasing demand as the population ages.³⁰ Documented investment transactions reached £1.32 billion in 2017 – up 88% compared to the 10-year average.³¹

AXA’s acquisition of Retirement Villages and Legal & General’s purchase of Inspired Villages have signalled the arrival of retirement living as an actual asset class.³²

There are an insufficient number of care homes in development and built to meet demographic and investment demand. Coupled with registrations of new facilities slowing down, greater competition and cost of land increasing pressure on supply, there are now fertile selling conditions for asset holders.³³

Low-yield conditions in the bond market and a paucity of long-dated income in the broader property markets has further boosted the sector’s institutional appeal.³⁴

²⁵² Healthcare capital markets, Knight Frank, February 2018 (www.knightfrank.co.uk/research/healthcare-capital-markets-2018-5310.aspx)
²⁵³ Demand dramatically outstripping supply, CBRE, December 2017 (valuedinsights.cbre.co.uk/demand-dramatically-outstripping-supply/)
²⁵⁵ Healthcare capital markets, Knight Frank, February 2018 (www.knightfrank.co.uk/research/healthcare-capital-markets-2018-5310.aspx)
Pressure growing on future supply

A shortage of investment-grade care homes and hospital stock, compounded by the slowing of primary care development, means investors will have to employ different strategies to access healthcare assets.35

The care home market has also become highly polarised in recent years with developers focusing on locations with a strong self-pay market that attracts larger fees and stronger return on capital. As a result, new care home developments will be largely led by the availability of land. Development however is expected to remain static in the short-term due to competition from builders of general housing, student accommodation and hotels.36

In the South East it is not unusual to see sites of c.2 acres with planning permission for a new 80-bed care home changing hands in excess of £3.5 million. Additionally, the build cost for a modern care home runs at c.£100,000 per bed. These economics only work in the private pay market, where yield compression and investor appetite are driving significant property plays and where the gains achieved on a sale-and-leaseback provide a healthy return on the assets for outlay on the capital cost of developments. The future proof quality of the asset has become more important than the undergoing covenant strength of the operators.

<table>
<thead>
<tr>
<th>Case study: High end investment fundamentals, potential investment gain</th>
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<tbody>
<tr>
<td><strong>£ million</strong></td>
</tr>
<tr>
<td>Land price</td>
</tr>
<tr>
<td>Build costs (80 beds @ £100k p/b)</td>
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<tr>
<td>Capital Cost</td>
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<tr>
<td><strong>Forecast trading EBITDARM</strong></td>
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<tr>
<td>80 Beds x 90% occupancy x £1,250 per resident per week x 27% EBITDA = £1.26 million per annum</td>
</tr>
<tr>
<td><strong>Investment valuation:</strong></td>
</tr>
<tr>
<td>Rent cover = 1.7 x Rent (1.26/1.7) = £0.74 million</td>
</tr>
<tr>
<td>4.5% yield, capitalised off an annual rental of £0.74 million. Implies valuation of £16.5 million, against a capital outlay of £11.5 million</td>
</tr>
<tr>
<td><strong>Theoretical investment gain (£16.5 million - £11.5 million) = £5 million</strong></td>
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</tbody>
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Source: Grant Thornton analysis, 2018

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35 Demand dramatically outstripping supply, CBRE, December 2017 (valuedinsights.cbre.co.uk/demand-dramatically-outstripping-supply/)
Care homes for the elderly: Where are we now?
New funds and methods of finance

Different funding models evolving

The Opco-Propco model, notwithstanding the issues at Southern Cross plc, has re-emerged in recent years, albeit in a modified form.

Barchester Healthcare, which predominantly caters for self-paying clients, carried out a sale-and-leaseback deal on 160 of its care homes in 2013. CEO Dr Calveley said “I think the Southern Cross model was too aggressive in terms of rent cover together with a lack of attention to quality. Over time people have demonstrated, with new builds in particular, that you set your rent cover at a level that future proofs it for changes in the market. We have only done it once to solve the problem of refinancing and it has not constrained us since.”

However, not everyone is a fan of this model. Australian infrastructure fund AMP Capital said it would not invest in an operator that did not own the freehold to its properties.

Global Head of Social Care Julie-Anne Mizzi explained that it had invested in both Opco and Propco in the past. She said: “It does not work for either party. When you own the Opco, you have quite restricted rental arrangements but, more importantly in my view, you are limited in the changes you can provide.”

For example, 10 years ago ward-style bedrooms were the norm. Now people want their own bedroom with an en-suite. “If you don’t own the property, you would have to ask the landlord to provide extra capital and actually reduce the number of beds. You can’t get them to do that until occupancy has dropped off the cliff.”

Owning the Propco is also problematic as the reputation of a home is tied to the building itself, not the operator. “If you decide to part ways with one tenant, if the home has not got a good reputation, no-one will take it on,” she added.

American-based REITs have slowed down their acquisitive activity (due to a scarcity of scalable mainstream platforms and issues in the United States) and started to build out.

There is around £3.5 billion of UK private equity and £20 billion of overseas private equity looking to enter the UK care home market. Furthermore, there is £500 million of ground rent transactions in the deal pipeline for 2018. The long-term effect on operators’ business of selling their freehold for a long lease (ground rent transactions) to release capital has yet to be realised.
While there is a lot of appetite and capital to accelerate further market consolidation, there is a limited amount of suitable targets coming to market. Acquisition has now become a secondary route for growth that the larger operators and groups are pursuing behind developing their own new homes.

Identifying and acquiring suitable land is now just as competitive as the M&A market.

There is value in location for some of the older and less well performing homes, with operators increasingly seeing development potential for scarce sites.

Grant Thornton has seen some mid-sized groups who now have reached their preferred size (in terms of number of homes) that balances group infrastructure benefits against their ability to maintain quality and oversight. Their plan will be to continue to buy/develop a limited number of homes while selling off the older, lower-quality properties within the same timeframe and in roughly the same proportion of their portfolio.

The consolidation drivers that we have seen elsewhere in healthcare are still prevalent in the elderly care sector, namely increased regulation, higher specialism/care acuity requirements, challenges in recruiting and in a number of cases a management shareholder group getting closer to retirement themselves. There has also been growing appetite from new entrants who see opportunity from increasing future demand among the ageing population. They are also attracted by the opportunity to acquire a number of smaller operators that would not currently be suitable for larger institutional investors, with a view to create a group of scale more attractive to those investors.

Case study: A typical ground rent transaction

Care home Z has EBITDA of £750,000, currently valued at £6 million (8 x £750,000). A ground rent transaction is typically based on 10% of EBITDA (£75,000), capitalised at a yield of 3.5%, and provides a sale and long leaseback (100-year + term) at a value of £2.14 million. Whether this is value accretive will depend on the valuation of the residual long-leasehold interest – a subject that is currently vexing the valuation professionals. However, the company has received a timely injection of cash at a competitive cost.
The decline in the number of public-sector focused care home beds is a trend that looks set to continue in the medium-term. However, it cannot continue indefinitely as our research points to a significant rise in demand for elderly care beds over the coming decade and beyond.

To be able to deliver to changing demand, and to ensure that everyone who needs a care home bed can access one, market development and management needs to be a priority for all local authorities with responsibility for adult social services, working with providers and other key stakeholders, so the sector can grow in an efficient and effective way.

A strategic approach will also be needed to recruit and retain the large number of workers needed to care for the ageing population in the future. Efforts have already begun through education programmes such as Skills for Care’s ‘Care Ambassadors’ to promote social care as an attractive profession. But with the number of nurses falling across the NHS as well, the Government will need to address the current crisis.

Despite these challenges, the UK care home sector is one brimming with opportunities if providers are prepared to adapt and innovate.

The shortage of beds and pressure on NHS funding through delayed discharges will inevitably lead to an increase in the prices local authorities will need to pay. This may need to be funded by a continuation and increase in the social care precept concept established in 2015. We forecast that average fee increases agreed by local authorities for 2018/19 will be c.4.2% of which approximately c.2.5% is required solely to cover NLW increases.

Care home operators need to become more adept at managing and pricing rooms on a differential basis to take advantage of a relaxation in funding rules which allows family members to fund a ‘top-up’ over and above the weekly rate paid by local authorities. We expect to see this menu pricing of rooms to become more prevalent with more successful operators.

The market needs to evolve, not just by utilising top-ups more, but by entering into Continuing Healthcare contracts to provide higher-acuity care. Operators should focus on client groups that most suit their estates. For example, for high-acuity residents, safety is more paramount than luxury, and more specialised services need a larger catchment area.

The larger care home groups have found that there are no economies of scale achieved through operating from multiple sites. Introducing a professional manager often does not increase quality.

The recruitment and retention of a good care home manager will remain a commercial imperative. We expect to see generous bonus packages paid to care professionals who can drive quality, evidenced by higher ratings from the CQC, and take responsibility for delivering budgeted financial performance at their care home.

Reflecting their popularity in the hotel sector, we also expect to see more ground-rent deals emerging, even though there are currently some concerns around valuations of the remaining long leasehold interest. REITs will continue to play a key role in terms of sector investment despite the local challenges faced by those based in the United States. Infrastructure funds will also play their part in bidding-up the price of healthcare assets.
The growth of the retirement living market, also known as housing-with-care or extra care, will also gather pace. Its range of options from affordable rent to high-end luxury developments for sale (allowing older people to own or rent their homes while making use of care services) is currently taken up by around 0.5% of the over-65 population. Experts predict this sector could grow up to 5%, as it has in Australia and New Zealand. These developments typically only offer pre-high acuity care, suggesting this sector could complement rather than compete against UK care homes.

But the most important conversation that needs to be had is with the public around what kind of care services they would like to have and, crucially, how much they would be prepared to pay for them. Most solutions for sustainable funding for social care point towards increased taxation, which will generate significant political and public debate. With Brexit dominating the political agenda, and the government holding a precarious position in Parliament, shorter-term funding interventions by government over the medium-term look more likely than a root-and-branch reform of the current system. The sector, however, needs to know what choices politicians, and society as a whole, are prepared to make in order to plan for the future.

To discuss any of the issues detailed in this report, please contact:

Daniel Smith
Partner
T 020 7728 2139
E Daniel.R.Smith@uk.gt.com

Alex Khaldi
Partner
T 020 7184 45149
E Alex.S.Khaldi@uk.gt.com

Oliver Haunch
Director
T 020 7728 3162
E Oliver.Haunch@uk.gt.com

Peter Jennings
Director
T 020 7728 2083
E Peter.Jennings@uk.gt.com
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