



HPC CARE HOME NEED ASSESSMENT

On behalf of Avery Healthcare Group

The Former Ascot Arms
Central Avenue
Gravesend
Kent
DA12 5AW

February 2021

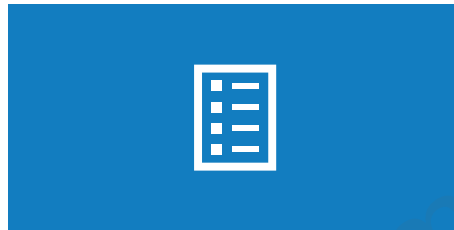
User Guide

Welcome to the HPC Care Home Need Assessment for The Former Ascot Arms, Central Avenue, Gravesend, Kent DA12 5AW.

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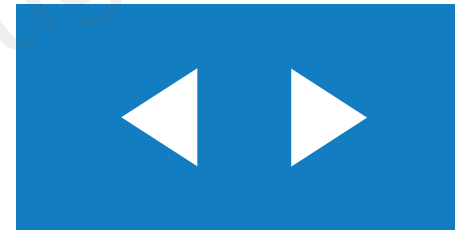
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Instruction

This report has been carried out on behalf of Avery Healthcare Group (The Client). Instruction was confirmed by way of email correspondence dated 10th February 2021.

Background

The purpose of this report is to provide an indication as to the need for the provision of registered care accommodation for the elderly in the area around the Former Ascot Arms, Central Avenue, Gravesend, Kent DA12 5AW (The Site).

The proposal is to demolish existing structures and redevelop to provide a new 62 bedroom care home (Use Class C2) together with associated access, car and cycle parking, structural landscaping and amenity space provision. We are advised that the completed development will be registered with the Care Quality Commission (CQC) for the provision of care to the elderly, with a specific focus upon dementia care. The proposed facility will be operated by The Client – an established and experienced provider of care.

Geography

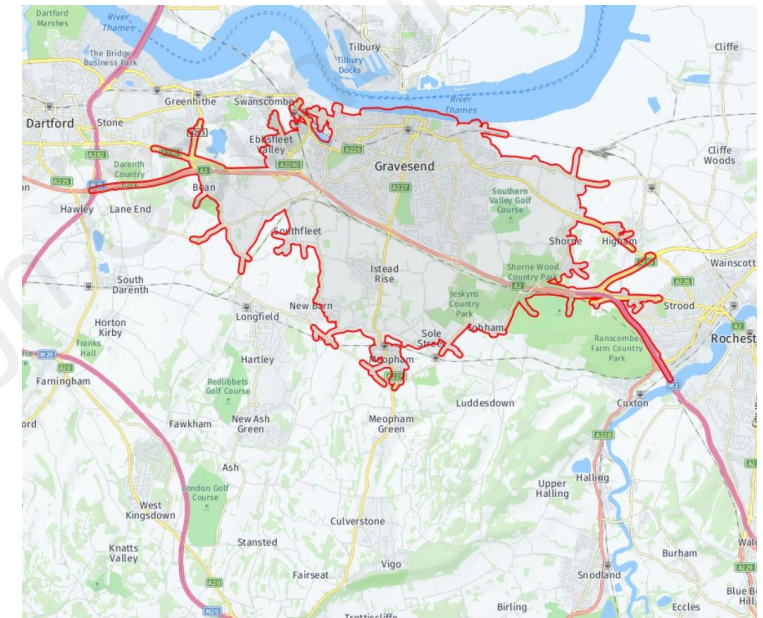
In carrying out our research we have focused upon an area within a 10 minute (off peak) drive time of The Site (hereafter referred to as the 'Target Area'). The drive time basis was selected (over the traditional straight line radius) in order to reflect the limitations posed by the neighbouring River Thames on access and, hence, market. We believe that this comprises the geography from which the proposed development is most likely to attract service users. Unless specifically detailed, comment and data within this document refer to the Target Area. The geography is identified alongside.

Content

The format has been selected to provide a clear indication of care need without being verbally exhaustive. The Site has not been inspected in relation to this report and comment is based upon data from a number of sources, each of which are detailed within Appendix V to this report.

The report focusses upon current supply levels (in terms of care beds) before estimating statistical demand and considering the supply / demand dynamics for the Target Area. As a point of reference we have further provided a Borough wide overview of Gravesham within Appendix II to the report.

This report has been prepared by Nigel Newton Taylor, a Director of HPC and Chartered Surveyor with over 30 years experience providing commercial property advice in both the public and private sectors. Specialising in care based property for the past 18 years, he has provided a mix of consultancy, valuation and transactional advice to a wide range of clients including Local Authorities, Lending Institutions, Not for Profit Organisations and Corporate Healthcare Operators.



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Executive Summary

Conclusion

On 26th June 2019 the Ministry of Housing, Communities & Local Government published planning guidance entitled 'Housing for Older and Disabled People'. The document included the provision of registered care home accommodation and the opening words set the tone:

'The need to provide housing for older people is critical. People are living longer lives and the proportion of older people in the population is increasing.'

The Target Area population over the age of 65 numbers almost 18,000. With the number of persons in the most elderly age bracket (85+) forecast to rise by 39% by 2035, now is the time to consider whether the current care home estate is sufficient.

However it is not merely numeric need that falls to be considered but also qualitative need. Appendix III to this document details the nature of accommodation expected by the Department of Health almost two decades ago. Although the standards are no longer in place, they served to set a benchmark in terms of environmental quality, detailing a requirement for newly registered facilities to restrict bedroom occupation to single occupancy and for all bedrooms to incorporate an en-suite facility. In our experience a single occupancy en-suite bedroom is now considered the appropriate standard throughout the country by providers and commissioners alike.

Whilst it is always appropriate to provide suitable accommodation for the elderly, the ongoing COVID-19 pandemic has highlighted the importance of environmental configuration – a subject explored in Section 8 to this report. There have (to date) been well in excess of 1,000 fatalities within Kent care homes where death has been attributed to COVID-19. Converted and dated homes not only lack the ability to lockdown 'mini units' but facilitate cross infection through use of communal bathing facilities. As lessons are being learned, so architects now have the opportunity to limit viral risk through the improved design of new purpose built homes.

The Target Area care home estate incorporates a variety of environment including converted former dwellings and purpose built facilities. Crucially, however, there has been no addition to the Target Area estate in the last decade. Modern design benefits are therefore limited whether that be increased room sizes, ensuite wetrooms or even incorporation of stretcher lifts as the age (and care needs) of clients continues to increase.

The locality is currently served by 13 registered care homes for the elderly – offering a mix of residential and nursing care (including care to clients with dementia). There are currently 574 registered beds in the Target Area serving the elderly population in total although this accommodation includes just 252 en suite bedrooms. As identified in the table alongside, this limited provision of appropriate accommodation results in a substantial statistical undersupply. With a rising elderly population, ongoing net bed loss due to attrition and a limited development pipeline, the shortfall is only likely to grow.

This statistical shortfall is mirrored across the wider Borough (Appendix II) with HPC analysis pointing towards a considerable shortfall exceeding 375 ensuite bedrooms. Whilst Kent County Council commissioning strategy (see Section 7) seeks quite rightly to maintain the independence of the elderly where possible, the requirement for appropriate alternatives is detailed within strategic priorities:

'Increase provision of nursing and dementia care homes that can support those with complex needs and behaviours that challenge due to Dementia'.

'Increase fit for purpose modern care homes and as a result reduce older converted care home provision'

The Client is seeking to develop a new residential care home for the elderly, with specific dementia care focus. Both statistical dynamics and local authority documentation point towards a justifiable need.

The Benefits

It is anticipated that the proposed development will:

- 1) Assist in offsetting the significant existing statistical undersupply of appropriate accommodation across the Target Area.
- 2) Assist in offsetting the significant existing statistical undersupply of appropriate accommodation across the wider Borough.
- 3) Create additional capacity with dementia care focus - in line with Kent County Council strategy.
- 4) Improve the overall environmental quality and financial sustainability of the care home estate through development of substantial modern accommodation designed for purpose.
- 5) Offset the ongoing attrition which has resulted in net bed loss over recent years.
- 6) Reduce the impact risks of future pandemics through provision of environment specifically designed for purpose.
- 7) Assist in reducing the comparatively high number of Delayed Transfer of Care Days across the county – benefiting both the NHS purse and patient wellbeing.

Supply / Demand Dynamics

	Current	2025
Statistical Demand (elderly care beds)	585	628
Current supply of Ensuite Bedrooms	252	252
Under Supply	333	376



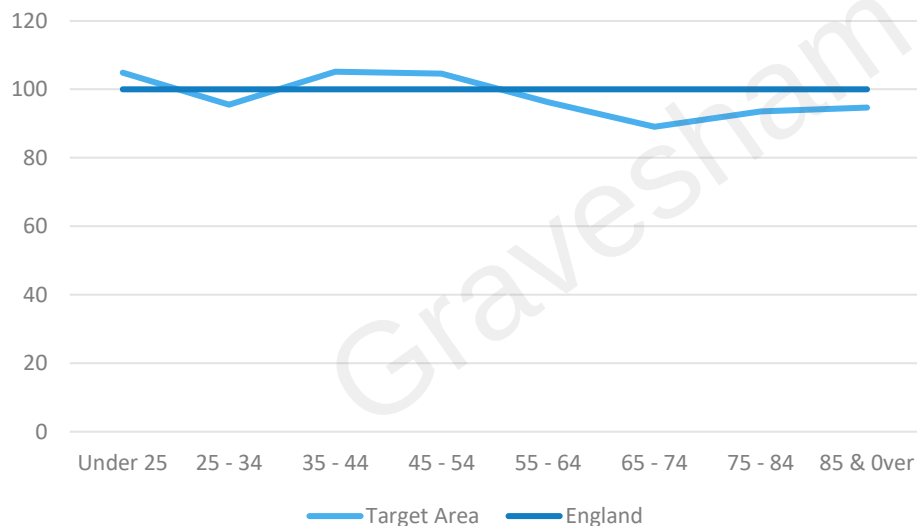
Age Profile

The raw data might best be considered graphically. The chart below represents the Index value in order to indicate over or under representation of population band within the Target Area in comparison to national data.

By way of illustration, an index of 100 indicates that the age band has the same representation locally as nationally whilst an index of 120 would show that it has a representation 20% higher than the corresponding national figure.

As identified, the local population breakdown fluctuates around the national profile with slight bias towards the early middle aged.

Age Band	Target Area
Under 25	32,220
25-34	13,246
35-44	14,040
45-54	14,128
55-64	12,499
65-74	9,166
75-84	6,081
85 & Over	2,497

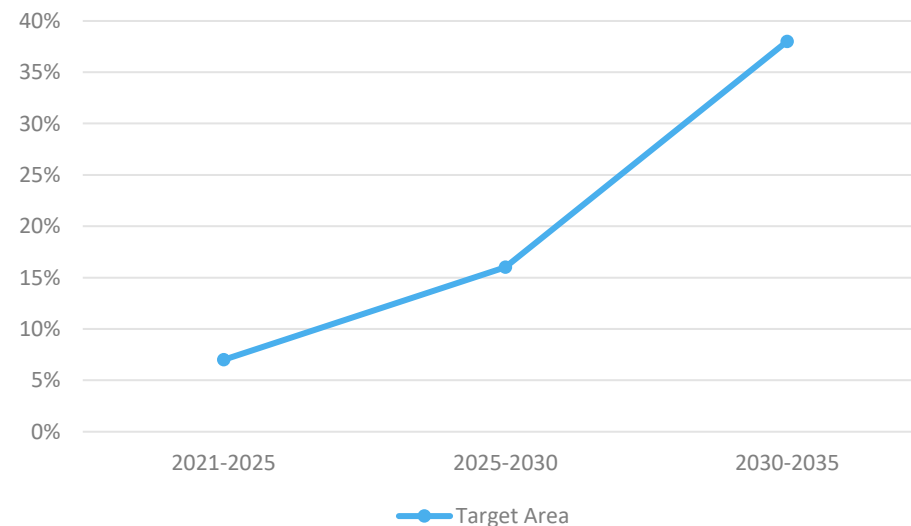


The following table details the projected population change in individuals over the age of 85 between 2021 and 2035:

	2021	2025	2030	2035
Projection	2,497	2,667	2,896	3,462

In terms of 5 yearly growth, the following chart identifies projected growth within the Target Area. The identified growth rate is cumulative over the period, measured against the base year of 2021.

The number of people across the Target Area over the age of 85 is forecast to rise by 39% by 2035.





Supply

4.1 Existing Care Home Overview

	Homes	Registered Beds	Dementia Beds	Total Rooms	Ensuite Rooms
Residential Care	10	345	266	326	169
Nursing Care	3	229	76	227	83
Total	13	574	342	553	252

A more detailed schedule of existing homes is provided within Appendix I to this report, along with a map of the Target Area identifying the individual locations.

Existing homes are split relatively evenly between those designed and built for purpose and those converted from private dwellings. Those falling into the former category date from various years over the past four decades, albeit with none being less than a decade old. As a direct result of the care home estate format, environmental configuration in terms of single occupancy and ensuite bedroom provision is disappointing.

	Target Area	UK
Single Rooms as a % of all bed spaces	93%	95%
% of all bed spaces with en suite wc	46%	72%
Average size of Nursing Home	76	53
Average size of Residential Home	35	31

4.2 Planning Activity

We have, in researching for this report, had regard to ongoing and recent planning activity in the Target Area. This has been carried out through utilisation of both the Barbour ABI and EGi planning directories. The search has encompassed planning applications relating to registered care home provision for the elderly lodged over the past 3 years where the outcome has been positive or, alternatively, a decision remains pending.

	Net New Ens. Beds
Consented New Homes	0
New Home Applications Pending Decision	0
Extensions to Existing Homes	27
Total Proposed Net Beds	27

Planning activity meeting the above criteria appears to be restricted to the following single application:

1. Hever Court care home, Goodwood Crescent, Gravesend DA12 5EY. Detailed planning consent dated 5th September 2019 for the extension and reconfiguration of ground floor areas. The resulting impact will be an increase in the number of ensuite bedrooms (27) with none of the existing ground floor bedrooms offering an ensuite. Ref: 20180682 Gravesham Borough Council.

4.3 Market Movement

Whilst the Care Quality Commission data in Section 4.1 provides a snapshot in time, it is also useful to look at the pattern of provision over recent years in terms of new facilities and closures. The two tables below identify such activity across the Target Area over the period from 1st January 2018 to date.

Home Closures		New Developments	
Pelham Lodge	10	-	-
Alexandria's	18	Total Registered Beds 0	
Kesson House	38		
Ashley Down	19		
Total Registered Beds	85		

It would appear that, in a little over 3 years, the local care home estate has reduced by 85 beds with no development taking place in order to offset attrition.

As a company, HPC monitor care home closures nationwide. Amongst the key reasons behind home closures are a lack of economy of scale (limited registration) and environmental provision no longer deemed fit for purpose.

In order to secure economy of scale, the average size of newly registered care home across the country is 61 beds. This contrasts with the average size of care home closing – 28 beds. Of concern is the fact that, across the Target Area, four of the 13 homes have a registration falling below 28 beds.

As a direct result, we would anticipate continued attrition across the Borough over the short/medium term with the level of development therefore required not only to accommodate the increasing elderly population but to offset accommodation lost through closure.



Statistical Demand

5.1 Total Elderly Care Demand

In considering the potential demand for elderly care throughout the Target Area we analyse below the bed provision for key age groups based upon LaingBuisson research. This confirms the following proportions of UK population living in a care home or long stay hospital setting as at 2020 pre COVID levels:

- 65 – 74 years: 0.54%
- 75 – 84 years: 3.3%
- 85 and over: 13.4%

Future forecasts have been calculated having regard to population movement forecasts (across relevant age bands) coupled with the above breakdown of care home occupancy across the elderly population. There is, of course, a level of uncertainty attached to such forecasting. In a drive to retain an individual's independence, the Assisted Living concept has become a popular alternative to the provision of low need residential care to the frail elderly. The potential for this occurrence is likely to increase. Conversely, as the incidence of dementia rises across the elderly population, so total independence may become inappropriate for many of our population and the need for a care home environment will be the natural choice.

This methodology confirms a total requirement for 585 elderly care beds. This level of demand rises to 628 by 2025 and 673 by 2030.

5.2 Dementia Specific Care Demand

With over 900,000 elderly people in the UK with dementia it is essential that the demand for dementia care is recognised with appropriate provision within the Social Care sector. In November 2019 the Alzheimer's Society funded a study carried out by the Care Policy and Evaluation Centre (CPEC) at the London School of Economics. Entitled 'Projections of older people with dementia and costs of dementia care in the United Kingdom, 2019-2040', the report seeks to assess the medium term impact of dementia upon society in terms of both cost and care requirements.

The projections were produced using an updated version of a model developed by the CPEC for the Modelling Outcome and Cost Impacts of Interventions for Dementia (MODEM) study. The model produces projections of dementia care in England using the best available current data on dementia prevalence. Utilising population forecasts published by the ONS, assumptions include (crucially) the fact that a disease modifying treatment for dementia will not become available over the projection period.

With a base year of 2019, researchers estimated 885,000 older people within the UK to have dementia – a prevalence rate among older people of circa 7.1%. In terms of severity, the figure is further split as follows:

- Mild dementia 127,000
- Moderate dementia 246,000
- Severe dementia 511,000

The projected number of older people with dementia is forecast to increase by 80% to 1.59 million by 2040 although it is the specific breakdown of dementia growth that is of particular interest to care home provision. The projected increase in the number of people with severe dementia (2019-2040) is 109% in comparison to the projected increase in those with mild and moderate diagnosis (55% and 33% respectively).

The prevalence rate of dementia in the UK is projected to reach 8.8% (from the current 7.1%) by 2040. This increase in prevalence (and the number of people with dementia) is driven by continued population ageing in the UK, characterised by a rising proportion of people in advanced old age. Indeed, according to the ONS population projections, while the number of older people age 65 to 74 in the UK will increase by 20% between 2019 and 2040, the number of older people aged 85 and over will more than double. Concluding comment from the research document is clear in terms of impact upon future demand for dementia care provision:

'...the proportion of older people who have severe dementia is projected to rise in the next decades...the likelihood of living in a care home increases with severity of dementia, which means that in future a higher proportion of people with dementia will live in care homes rather than receive care in the community.'



Supply / Demand Dynamics

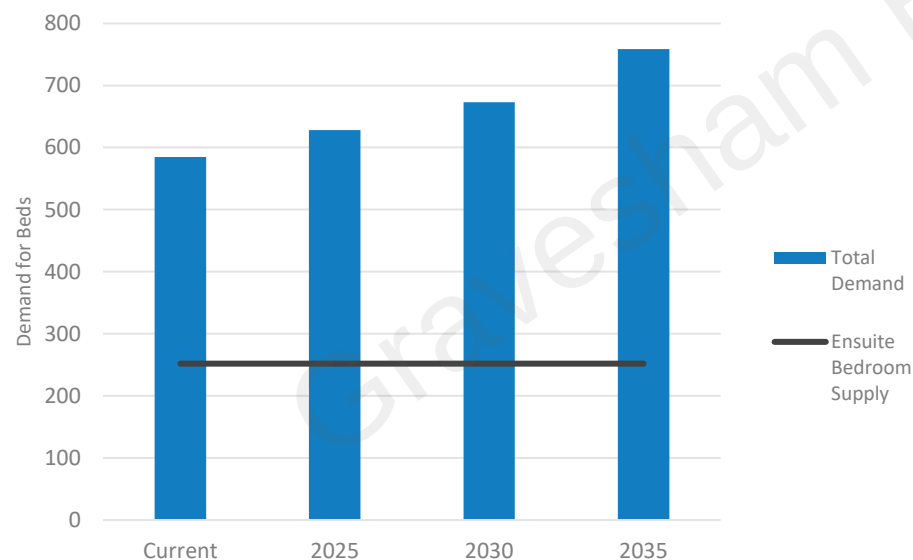
6.1 Total Elderly Care Dynamics

The chart details the total statistical bed requirement (current and forecast) within the Target Area as calculated in Section 5. In terms of supply, there are currently 252 ensuite bedrooms in the Target Area (Section 4). This level is detailed in the chart below by the horizontal black line.

As identified on the chart, a substantial statistical shortfall exists in terms of ensuite single occupancy bedrooms. This undersupply is forecast to increase, reflecting the growing elderly population, in the absence of further development.

In considering the future dynamics we have made a number of assumptions. Key assumptions which may impact if incorrect include:

1. Potential attrition is not reflected
2. The potential for further schemes coming on line is not reflected



6.2 Supply / Demand Dynamic Overview

	Current Total Elderly	2025 Total Elderly
Demand		
Statistical demand (incl. forecasts)	585	628
Supply		
Current supply of registered bed spaces	574	574
Current supply of en suite bedrooms	252	252
Dynamics		
Under or (over) supply in terms of registered beds	11	54
Under supply in terms of en suite bedrooms	333	376
Potential Supply Pipeline		
Undeveloped consented ensuite beds (net)	27	27
Undeveloped ensuite beds (net) awaiting decision	0	0

Attrition across existing bedstock in the short and medium term cannot be predicted with certainty. For this reason, we have assumed nil attrition. A key factor in respect of attrition potential includes environmental nature/configuration within existing facilities. The local care home estate is dated and includes a number of comparatively small homes. For this reason we would anticipate the level of attrition seen over recent years (Section 4.3) to continue over the short / medium term.

As detailed alongside, whilst virtual parity exists in terms of statistical supply/demand dynamics relating to registered beds in their totality, a significant shortfall exists in respect of appropriate accommodation – single occupancy ensuite bedrooms.

Detailed at the base of the table is the potential impact of further beds already in development or in the planning process at the time of reporting. What we are unable to predict is the potential level of further development yet to enter the planning process. The potential supply pipeline falls well short of undersupply levels.

6.3 Delayed Transfers of Care

Commonly referred to as “bed blocking”, delayed transfers of care occur when a patient is ready to depart from hospital care and is still occupying a bed. NHS England monitor delayed transfers, defining a patient ready for transfer as being when:

- A clinical decision has been made that the patient is ready for transfer and
- A multi-disciplinary team decision has been made that the patient is ready for transfer, and
- The patient is safe to discharge/transfer

The trend in respect of transfer delays has varied significantly over the past decade. The prevalence rose over the early part of the decade, peaking in 2016. Attracting significant media coverage at that point, pressure rose upon relevant public bodies to reduce delays (and associated costs). As a direct result, the country as a whole has experienced a quite significant drop in transfer delay towards the latter part of the decade.

Quite apart from the significant financial implications, there are also potential effects upon the patient. A longer stay in hospital is associated with increased risk of infection, low mood and reduced motivation, which can effect a patient’s health after they have been discharged and increase their odds of readmission.

There are multiple reasons as to why delays can occur including funding, housing issues, family disputes and waiting for appropriate equipment to be installed in the community. However, delayed transfers are significant in that they can be indicative of bed availability throughout the surrounding care home estate. For the purposes of this report we have focused upon the key category of delay (D) involving care home provision defined by NHS England as follows:

Delay awaiting residential / nursing home placement / availability

“This includes all patients whose assessment is complete but transfer is delayed due to awaiting nursing/residential home placement because of lack of availability of a suitable place to meet their assessed care needs. This does not include patients where local authority funding has been agreed, but they or their family are exercising their right to choose a home under the Choice of Accommodation Regulations and Guidance.”

The graph below illustrates the national pattern in respect of delayed transfer days attributable to category D over recent years. Levels are represented on a month by month basis.



Unfortunately, as a result of COVID-19, the NHS put monitoring of delayed transfer on hold during 2020. The most recent full year data available is 2019.

The total number of delayed transfer days across the county for the calendar year 2019 within the above category is 15,200 (9.6 days/1,000 persons local population). The corresponding national figure was 430,967 (7.5 days/1,000 persons).

The NHS England data therefore points towards Kent having a comfortably higher level of delayed transfer due to care home associated availability than would normally be expected.



The Local Authority Perspective

During compilation of the Need Assessment we have had regard to relevant strategic documentation relating to elderly care provision. Whilst Gravesham Borough Council is responsible for more traditional housing strategy, it is the role of Kent County Council (KCC) to commission care services.

The key strategic document we would normally consider is the Market Position Statement. At the point of compiling this report the KCC website advises as follows:

“With social care and health in the council we are moving towards integration between the services. We want current and potential providers of care and support services to understand the present and future demands of the service. We need to discover how we all can work together to face the challenges ahead of us.

We have a responsibility to find more effective ways of making public money go further and deliver better outcomes. This is more important than ever in the current challenging financial climate.

We want to restore and strengthen a diverse market for care that offers people choice. A care that allows them to be supported to remain as independent as possible, for as long as possible and enjoy a good quality of life within their local communities. To do this, we need a wide range of high quality services.

The Market Position Statement for Community Support Services will form part of our approach to shaping and development for care and support in Kent. The document will define our relationship with the market and our residents to offer greater choice in service delivery and greater transparency about the quality of care on offer.

The Market Position Statement is currently under review as of November 2019”

The most relevant current strategy published by KCC is entitled The Kent Adult Social Care and Health Accommodation Strategy (Right Homes: Right Place: Right Support) 2019 to 2021. The Adult Social Care Accommodation Strategy was originally launched in 2014 and sets out the county wide position. Relevant content (heavily summarised) is as follows:

- The desire to maintain independence across the elderly population is paramount
- The county has seen a 7% decline in the number of residential care beds and a 3% increase in the number of nursing care beds since 2015
- Placements into both residential and nursing homes by the local authority fell between 2014 and 2018
- The average care home size across the County has increased to circa.40 in line with the national profile
- 86% of care homes across the county offer below 60 places and are identified as falling below the ‘sustainability threshold’
- Rising Dementia prevalence in Kent is likely to have a significant impact on the lives of residents, their families and Adult Social Care and Health service provision.

Whilst the desired outcome across the county is to maintain the independence of the elderly, realism exists and an acceptance that registered care remains the most appropriate accommodation for many, with dementia prevalence and increasing nursing needs both rising. With this in mind Strategic Priorities 3 and 5 have particular relevance:

3. *‘Increase provision of nursing and dementia care homes that can support those with complex needs and behaviours that challenge due to Dementia’.*
5. *‘Increase fit for purpose modern care homes and as a result reduce older converted care home provision’*

Also provided on the KCC website are a series of District Profiles covering each District/Borough within the County. Unfortunately, these date from 2014. The outcome at that point in time (in terms of supply/demand dynamics) is of interest with the profile stating ‘Gravesham could benefit from more provision of nursing care with modern facilities’. Since 2014, when the District profile was compiled, the Borough has seen care homes close with no further development taking place.



COVID-19 Implications

8.1 Relevant Research

Given the fact that this comprises a recent (and ongoing) pandemic, meaningful research into the impact on registered care communities is limited. Indeed, we are aware of a single piece of comprehensive work only.

The Association between Nursing Home Crowding and Covid-19 Infection and Mortality in Ontario, Canada comprises a substantial piece of research published online by the Journal of the American Medical Association on 9th November 2020. The research is authored by Kevin Brown PhD, Aaron Jones MSc, Nick Daneman MD, MSc et al. Author affiliations include Public Health Ontario, the Dalla Lana School of Public Health (University of Toronto), the Department of Health Research Methods, Evidence, and Impact (McMaster University, Hamilton), Sunnybrook Research Institute (Division of Infectious Diseases, Toronto) and the Department of Medicine (University of Toronto).

The research sought to ascertain whether a correlation exists between Covid-19 infection and mortality prevalence and environmental configuration within registered care facilities. The authors obtained complete information in respect of 618 of the 623 Ontario nursing homes, encompassing 78,607 residents. As a guide to sample size, this is sizeable - equating to almost 20% of UK registered beds for the elderly. The research was conducted between March 29th and May 20th 2020.

Methodology

A nursing home crowding index was utilised which was defined as the mean number of occupants per room and bathroom across an entire home. Weighting was attributed to each bedroom dependent upon two key factors – number of occupants and availability of private bathing facility. A single occupancy room with private bathroom was ascribed the lowest weight (1) whilst the largest bedrooms, occupying 4 persons, were ascribed a weight of 4.

Across the province only single, double and quadruple bedded rooms are utilised – accommodating 36.9%, 37.3% and 25.8% of residents respectively. Analysis was restricted to elderly persons only of whom 54.6% were aged 85 or over and 69.8% were dementia diagnosed. All homes were then split into two categories as follows:

- High Crowding Index Homes: an average weighting of 2 or greater (the median)
- Low Crowding Index Homes: an average weighting below 2

Results

Unfortunately, of the 78,607 residents, 5,218 (6.6%) developed Covid-19 infection, and 1,452 (1.8%) died of Covid-19 infection as of May 20th 2020. This case fatality rate was 27.8%.

The research identified a clear correlation between Covid-19 incidences in high crowding index homes (9.7%) compared to low crowding index homes (4.5%). A key part of the research was to investigate the outcome impact had all homes been restricted to single occupancy rather than there being a level of shared accommodation. The following comprises a direct quote from the research:

'In the simulation in which all multiple-occupancy rooms were converted to single-occupancy rooms, we estimated that 1,641 infections (31.4%) and 437 deaths (30.1%) may have been prevented. In this scenario, an additional 29 871 new single-occupancy rooms would have been required, assuming current 4-bed and 2-bed rooms had been capped at single occupancy.'

Key Points (quoted verbatim and in full from the research) comprise:

- **Question** – What is the association of crowding in nursing homes, defined as the mean number of residents per bedroom and bathroom, with nursing home coronavirus disease 2019 (COVID-19) mortality?
- **Findings** - In this cohort study that included more than 78,000 residents of 618 nursing homes in Ontario, Canada, COVID-19 mortality in homes with low crowding was less than half (578 of 46,028 residents [1.3%]) than that of homes with high crowding (874 of 32,579 residents [2.7%]).
- **Meaning** - Shared bedrooms and bathrooms in nursing homes are associated with larger and deadlier COVID-19 outbreaks.

8.2 Pandemic Preparedness

Central government publish online a Policy Paper entitled 'UK Pandemic Preparedness' (www.gov.uk/government/publications/uk-pandemic-preparedness). The opening Overview (5th November 2020 update) sets out the government understanding of pandemic:

"Pandemics are a natural phenomenon; they are the result of a new pathogen emerging and spreading around the world and have occurred at infrequent and unpredictable intervals throughout human history. New and emerging diseases can affect humans anywhere and at any time, with zoonotic diseases (diseases that can spread from animals to humans), such as COVID-19, HIV, Ebola and avian influenza, a major cause of epidemics and pandemics. The acceleration of global mobility (for example, due to conflict or instability), population growth, urbanisation and poor sanitation, the ecological implications of climate change, and changes in food and agricultural systems (including intensification, biodiversity loss, trade in wildlife and livestock) all contribute to the risk of emergence of infectious diseases, and of antimicrobial resistance."

Recent years have seen a further need in the UK to manage a series of high consequence infectious diseases (HCIDs) including Lassa fever, Ebola, MERS and monkeypox. Although HCIDs typically have a high fatality rate and few, or no, treatment options, they are regularly monitored and less likely to cause a pandemic.

Despite questions raised over the governments initial handling of the COVID-19 outbreak, the policy paper confirms large-scale cross-government preparedness exercise to be conducted at regular intervals in order to test the UK's response.

The common sense argument exists, however, that we should not rely solely upon effective central government based response but ensure that every preventative measure has been considered pre-outbreak. Within the context of social care this would include improving the environmental configuration of the care home estate in order to maximise the number of facilities deemed fit for purpose. This responsibility falls not only on the Care Quality Commission but also local authorities (Adult Social Care and Planning) and care home developer/operators.

8.3 Impact upon Design

Whilst the annual care home death rate results from a number of causes, the pandemic has illustrated the fact that a large proportion of the existing national care home estate does not incorporate appropriate design requirements for such a previously unforeseen outbreak. Moving forward, it is likely that the following will comprise key design considerations:

1. Converted facilities and those purpose built but pre dating the millennium frequently incorporate shared bedrooms. The experience of COVID-19 is likely to result in a long overdue re-consideration as to whether twin bedrooms are appropriate not only for privacy reasons but also, now, viral control.
2. Converted facilities and those purpose built but pre dating the millennium rarely incorporate full ensuite bathing facilities, necessitating communal bathrooms & shower rooms. This is a cross-infection nightmare. Conversely, it is extremely rare for new developments to lack ensuite wetrooms. The experience of COVID-19 is likely to result in a long overdue re-consideration as to whether bedrooms reliant upon communal bathing facilities should retain registration.
3. Care home operators have also been highlighting the impact of bedroom size upon mental wellbeing as residents have been in lockdown. Whilst the aforementioned National Minimum Standards brought in a minimum new registrable bedroom size of 12m², many rooms pre-dating the regulations fall (well) below this level. COVID-19 experience, with residents self-isolating in bedrooms, has highlighted the need for a larger bedroom footprint.
4. The COVID-19 experience has further highlighted to the sector the importance of incorporating, within design, the ability to isolate sections of a home. Future design of care homes is likely to incorporate individual units capable of being operated in isolation with unit specific day space, dining facilities and staff group in order to limit the potential for cross infection throughout the entire home.

8.4 Impact upon Population

The entire planet has been impacted by COVID 19 in one way or another and Kent has not been left unaffected – particularly over more recent months. The following comprises a summary of relevant data:

Population in General

- By 23rd February 2021 there had been 3,820 COVID 19 related deaths across Kent (276 being within Gravesham).
- By 23rd February 2021 111,096 county inhabitants tested positive to COVID 19 (9,981 being within Gravesham).
- COVID cases and deaths have been more prevalent (on a per capita basis) in Gravesham than either the wider county as a whole or the national figures.

Care Home Population

- Between 10th April and 19th February 2021 there were 1,048 deaths in Kent care homes attributable to COVID 19, peaking at 31 in one day during January.
- The number of COVID 19 related deaths throughout England care homes over the same period was 27,875.



hpc

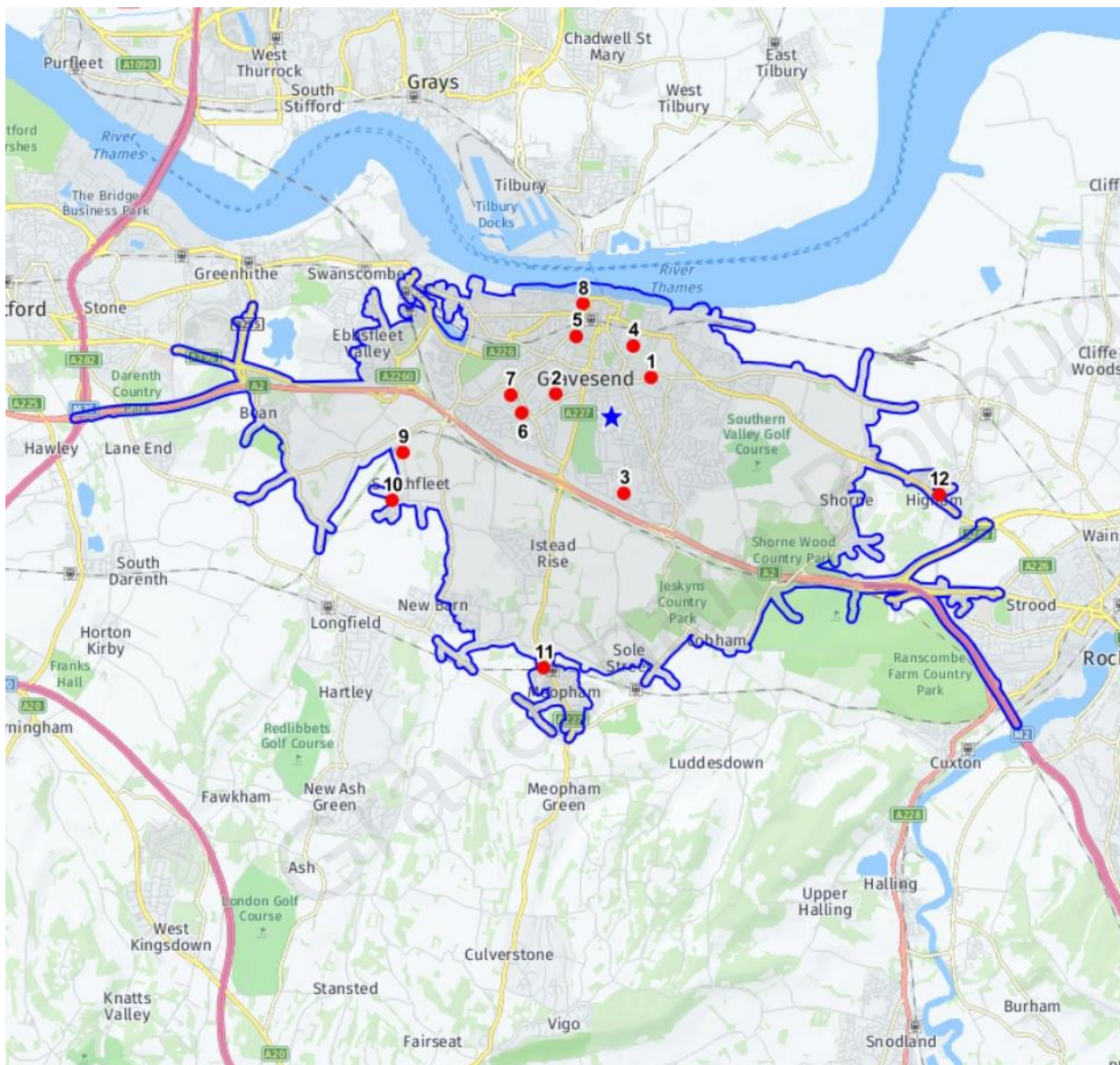
Appendices

Appendix I – Target Area Supply in Detail

Map Ref	Nursing / Residential	Name	Registration	Dementia	Provider	Distance (miles)
1	Residential	Orchard Cottage	10	0	Mrs Tersaim Khaira	0.6
2	Nursing	Mayflower	76	76	Mayflower Care Home (Northfleet) Ltd ¹	0.6
3	Residential	Hevercourt	47	47	Hevercourt Limited	0.7
4	Residential	Edward Moore House	39	39	Rapport Housing and Care	0.8
5	Residential	The Hollies	40	0	Evergreen Healthcare 2004 LTD	0.9
6	Residential	Dene Holm	47	47	Rapport Housing and Care	1.0
7	Nursing	Wombwell Hall	120	0	HC-One Oval Limited	1.1
8	Residential	Gravesham Place	80	80	Kent County Council	1.2
9	Residential	Dale Lodge	20	20	Nicholas James Care Homes Ltd	2.3
9	Residential	Dale Mount	13	13	Nicholas James Care Homes Ltd	2.3
10	Nursing	Withens	33	0	RCH Care Homes Limited	2.5
11	Residential	The Chestnuts	29	0	The Chestnuts Care Home LLP	2.8
12	Residential	Copperfields	20	20	Larchwood Court Limited	3.7
13		Total	574	342		

¹ Trading as Canford Healthcare

Appendix I – Target Area Supply in Detail



The map alongside details the Site and existing homes – the former appearing centrally (as a blue star) and the latter detailed as red circles. Reference numbers relate to the schedule of homes on the preceding page.



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Appendix II The Bigger Picture

We have given additional consideration to the dynamics across the Borough of Gravesham in terms of registered care provision for the elderly. Tabulated below is a breakdown of existing registered care for the elderly within a residential / nursing environment. The nature (and extent) of registration has been derived directly from CQC with bed breakdown sourced from the sector directory www.carehome.co.uk.

	Homes	Registered Beds	Dementia Beds	Total Rooms	Ensuite Rooms
Residential Care	8	312	233	299	165
Nursing Care	2	196	76	196	76
Total	10	508	309	495	241

	Gravesham	UK
Single Rooms as a % of all bed spaces	95%	95%
% of all bed spaces with en suite wc	49%	72%
Average size of Nursing Home	98	53
Average size of Residential Home	39	31

Utilising the same methodology as in Section 5, applying to the Borough wide population, we have calculated the statistical level of demand across Gravesham. The table alongside compares the demand level with aforementioned supply. As identified, there is a significant (and rising) level of statistical under supply of appropriate accommodation across the Borough.

	Current Total Elderly	2025 Total Elderly
Demand		
Statistical demand (incl. forecasts)	620	665
Supply		
Current supply of registered bed spaces	508	508
Current supply of en suite bedrooms	241	241
Dynamics		
Under supply in terms of registered beds	112	157
Under supply in terms of en suite bedrooms	379	424

Public Health England now provide Palliative and End of Life Care profiles through the website www.phe.org.uk. Within the data sets supplied by PHE is analysis of registered bed provision for the elderly on a district by district basis. Analysis is provided on the basis of care home beds per 100 people over the age of 75 and Key Findings are as follows:

- Gravesham provision per capita is below every other District within the County except Tonbridge & Malling
- Gravesham provision per capita is comfortably below the average level for Kent.
- Gravesham provision per capita is comfortably below the national level.
- Over the past decade, the absolute number of care home beds for the elderly across Gravesham has fallen – particularly those registered for nursing care provision

Appendix III The Care Home Environment

National Minimum Standards for Care Homes for Older People

In line with the Care Standards Act 2000, national minimum standards were published by the Department of Health in 2002. The minimum standards were to be used by the National Care Standards Commission inspectors when carrying out inspections of care homes.

Included within the standards were environmental requirements including:

- A minimum communal space provision of 4.1m² per resident
- An ensuite facility for each bedroom (WC and wash hand basin as a minimum)
- Single occupancy room provision only
- Each bedroom to measure, as a minimum, 12m² (net of ensuite facility)

Private providers argued that the cost of meeting such standards would force many to close and, after widespread opposition, the original document was redrafted and published in February 2003. The redrafted document limited the impact of the aforementioned environmental requirements to new accommodation developed post 2002.

Whilst the original requirements were watered down and the standards are no longer in use, their publication served as a huge statement by the Department of Health. It is fair to say that, since that point in time, the market has seen the provision of ensuite single bedroom accommodation with increased footprint as the appropriate market offering.

Appendix IV Industry Comment

Elderly Care Home Market Overview

There are currently approximately 463,000 beds in registered care homes across the UK registered for elderly care provision with ownership shared between private operators, Not for Profit providers and, to decreasing extent, public bodies (local authority and NHS). With an increasing number of older people now living longer and, as a direct result, often attracting more significant care need, the profile of this sector has never been higher.

The care home sector has varied greatly in size over recent decades. Whilst initial provision had principally been provided by local authorities through, typically, purpose built facilities developed during the 1960's and 70's, the private sector grew significantly during the 1980's - attracted by the relative ease at which converted accommodation might be registered, coupled with the willingness of local authorities to fund placements at attractive financial levels. The late 1990's saw a tightening of budgets and eligibility criteria, leading to reduced growth in the market before the current period of net bed loss resulting, in part, from the financial turmoil/funding pressure.

Care homes are a regulated business and require registration –for either the provision of residential care or nursing care. The original registration process was overseen by the relevant local authorities in which care homes were located. In an effort to create a level of regulatory uniformity, the Royal Commission on Long Term Care recommended, in 1999, a national regulatory body. As a direct result, following a series of national bodies, the Care Quality Commission took responsibility in March 2009. CQC remain responsible for the registration and regulation of care homes for the elderly. Whilst CQC is responsible for care home registration across England, the corresponding bodies in Wales and Scotland are known as Care Inspectorates.

At the turn of this millennium, in a further effort to secure uniformity in quality, the Department of Health (under the Care Standards Act 2002) published the document “Care Homes For Older People – National Minimum Standards”. This document, quite rightly, set out a high level of aspiration for care homes – specifically environmental expectations. Unfortunately, amidst significant concerns that enforcement of the standards would lead to wholesale home closures, the standards were watered down rapidly before being re-published in April 2003.

Care home operators can reasonably be categorised under the categories Private Groups, Small Independent Operators, Local Authorities and Not for Profit providers. The 1980's and 1990's saw a significant growth in the number of family businesses operating a single care home – frequently a converted and extended dwelling. The proportion of accommodation in the hands of small independent operators continues to fall with such accommodation typically unfit for purpose in this day and age and the regulatory pressures ever increasing.

Whilst many local authorities throughout the country have maintained a foothold in elderly care provision, the extent of care home operation is generally restricted to one or two homes per council. Although there are, admittedly, notable exceptions, local authorities appear to be increasingly comfortably in outsourcing long-term care provision whilst restricting in-house care to post hospitalisation reablement/rehabilitation. Current economic conditions ensure that this level will reduce further over forthcoming years.

Despite the reducing local authority presence in the market, the sector remains comparatively fragmented in comparison to other British service industries. Whilst the industry had experienced continued consolidation from the early 1990's, this trend plateaued before effectively going into reverse at the turn of this decade. Indeed, the market share of the 10 largest private groups (21.3% of registered beds) has fallen from its peak of 28.7%. This is, in part, due to the break up of Southern Cross Healthcare in 2011/12 (formerly the largest UK provider) and also a refocus by corporate operators upon the development of new high quality facilities rather than “bulk acquisition” of smaller groups with questionable environmental quality.

Responsibility for the payment of fees would generally fall upon the individual service user although, subject to means test, a proportion of care home residents can be funded by the local authority or (dependent upon care need) the NHS. The current approximate breakdown in terms of the funding of service users is as follows:

- Local Authority – 33%
- Local Authority (with third party top-up) – 14%
- NHS – 10%
- Self-fund – 43%

Appendix IV Industry Comment

Elderly Care Home Market Overview

National austerity over the past decade has seen restricted uplift in terms of fees being paid nationwide by local authorities. As a direct consequence, many care homes are now reliant upon self-funding service users to “subsidise” those benefiting from local authority funding.

The focus of care homes has changed significantly since the 1960’s/70’s local authority development boom. Whilst categorisation of care homes for the elderly remains somewhat antiquated (people over the age of 65), current expectations are for services users to be significantly older. Indeed, the majority of care home residents are now over the age of 80 with younger individuals with no or limited nursing need encouraged to remain independent either within their own home or within specialist housing for the elderly (with or without care). Whereas, in decades gone by, care home residents frequently spent several years in institutional care, the average length of stay has fallen dramatically – largely as a direct result of local authorities refusing funding/placement until care need is substantial. The average length of occupancy for a care home resident is currently in the region of 24 months.

Dementia Specialism

Dementia specific research published in 2015 by the World Health Organisation and Alzheimer’s Disease International identified there to be 47½ million people estimated to be living with dementia worldwide. Indeed, with 7.7 million new cases of dementia each year this implies a new case of dementia somewhere in the world occurring very four seconds. The prevalence and incidence projections indicate that the number of people living with dementia will continue to grow, particularly amongst the oldest old.

As previously detailed, the prevalence of dementia across the elderly population is projected to increase over forthcoming years. Costs are already significant with total costs of dementia in the UK (2019) amounting to £34.7 billion according to the Care Policy and Evaluation Centre (CPEC) at the London School of Economics and Political Science. Those costs include all associated with supporting older people with dementia rather than the extra costs attributable specifically to dementia itself.

In terms of apportionment, approximately 45% of those aforementioned costs are attributed to social care with the remainder accounted for by unpaid care (40%) and health care (14%). With the number of individuals requiring dementia care forecast to increase significantly, this results in a significant projected cost increase from £34.7 billion (2019) to £94.1 billion in 2040 (at constant prices). It is social care that will bear the brunt of the cost due to the disproportionate increase in individuals with severe dementia necessitating care home provision rather than care in the community.

Care home operators seeking to provide dementia care require appropriate registration with the relevant regulatory body (CQC or Care Inspectorate). For some time now operators have identified the increasing need for dementia care provision and, more often than not, care homes registered to provide care to the elderly now also incorporate dementia care registration. New developments over the past decade also have increasingly incorporated environmental design criteria based upon ongoing research. Although frequently advertising specialist dementia care, it remains comparatively rare within the UK for care homes to have absolute specialisation and sole focus on dementia clients. It is usually the case that a care home will accept both frail elderly service users and individuals in need of dementia care – frequently the latter in a separate unit. Other European countries appear somewhat more advanced in the provision of dementia care. The Netherlands is a prime example of this point, hosting concepts such as the revolutionary De Hogeweyk Dementia Village and Martha Flora specialist boutique care homes.

Appendix IV Industry Comment

Nature of Care

For more than a decade now we have seen both central and local government spokespersons extolling the virtue of keeping individuals in their home environment for the maximum period. This has been extremely popular with the general public but is only practical to a degree. Whilst there is an undoubted case for frail elderly individuals of sound mind and with limited (if any) nursing need to maintain a non institutional lifestyle, there will always be the need for the care home environment as the level of need increases. What the market therefore continues to see is a movement away from the historic residential care provision for people aged over 65 towards more intense nursing based care for increasingly aged service users with higher level medical needs. Such needs are not only physical but, increasingly, mental with dementia care being in high demand.

Existing Care Provision

The aforementioned pattern of growth within the care industry has left the sector with a potentially massive dilemma as we move forward. The vast majority of current facilities were either converted from former dwellings or comprise the first generation of purpose built bed-stock constructed during the 1960's and 1970's. Those homes were built (and properties converted) at a time when environmental expectations fell significantly below those of modern society. It is no longer acceptable for service users to share bedroom accommodation and it is a reasonable expectation that an en-suite facility should be made available. There is a strong likelihood that, over the next decade, the UK will see significant attrition across the care home estate as properties are deemed unfit for the future. This will coincide with the huge population growth in the elderly age bracket. Without significant development of appropriate care facilities there is a distinct risk of forthcoming bed shortages.

Development

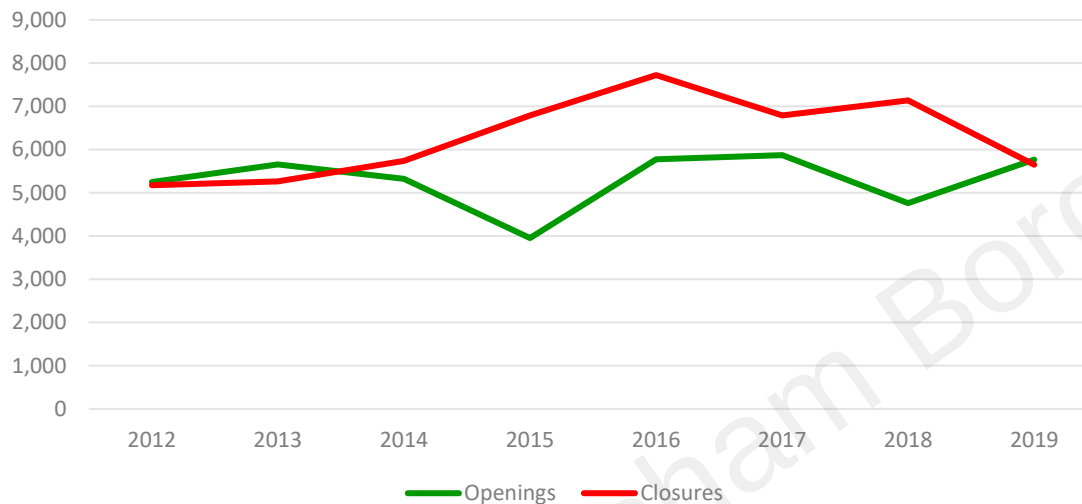
The care home market, in comparison to other property based markets such as retail and industry, has historically been extremely naive in development. For decades the retail industry has analysed demographic breakdown to the nth degree prior to investing in new stores. Conversely, there has been a significant historic tendency for care home developers to develop facilities on a random basis based on 'gut feel' and (as importantly) the availability of cheap land. It is only in recent years, as funding constraints have hit and occupancy levels fallen, that care home developers (and associated operators) have begun to appropriately consider site selection.

Recent years have seen a strengthening of the economy and an increase in the appetite of residential developers throughout the UK. This has directly impacted upon the ability of care home operators/developers to secure appropriate sites - increasingly being outbid by the housing sector. This is having the affect of limiting growth in the social care sector.

Appendix IV Industry Comment

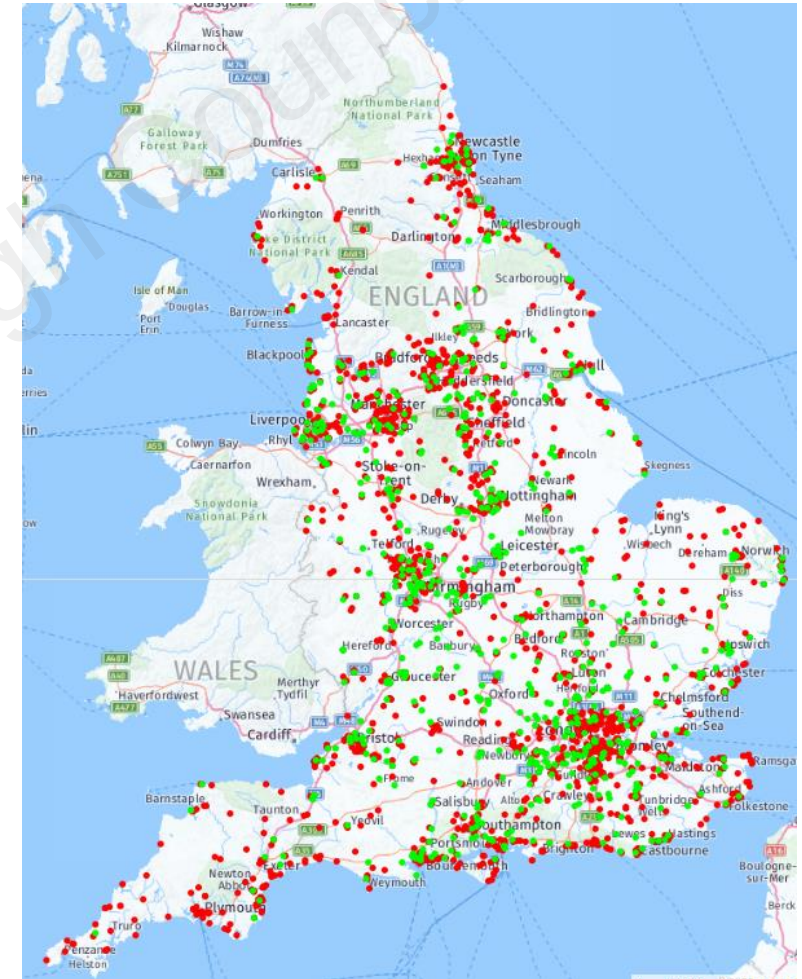
Market Movement - The National Picture

Over the past eight years HPC has carried out analysis of elderly care registration data supplied direct by the Care Quality Commission. The net loss/gain has fluctuated over the period with the cumulative outcome being a quite substantial net bed loss (circa. 8,000 beds). The data below reflects opening / closures and excludes extensions and registration reductions.



In terms of home (rather than bed) numbers, the annual number of newly opened homes is marginally below 100 with the corresponding closure figures exceeding 200. The average size of a new care home development over the past eight year period is 61 – contrasting with a mere 28 registered beds within homes closing.

With the exception of the extreme South West and North West, the geographic spread of homes opening is relatively even throughout the country. Whilst there is an understandable increase in density towards the larger urban areas, this is surprisingly slight. The comparative density in respect of closure activity around major urban areas (particularly London) is more noticeable with the other significant trend comprising the closure of homes in coastal resorts – specifically along the south coast.



● Openings

● Closures

Appendix V Data Source, Assumptions & Reservations

3 Age Group Distribution and Growth

All population age profiling data has been provided by Experian – one of only six suppliers approved by the Office of National Statistics (ONS) following Census release. The population figures provided are 2021 mid-year estimates OA level.

4 & Appendices I & II Supply

In order to ensure that the schedule of competing homes is as current as possible, the majority of information is drawn from the live web database of the Care Quality Commission. Supporting information in respect of room configuration is provided by the website www.carehome.co.uk and relevant websites of operating care homes.

4 Planning Activity

The suppliers of historic planning data from which we have extracted the enclosed information are both Barbour ABI and EGİ. Enquiries have been limited to activity over the 3 year period pre-ceding the date of this report (unless otherwise stated). Should development of the Site be considered further, formal enquiries of the local authority should be undertaken.

5 Statistical Demand—Total Elderly Care

We have relied upon LaingBuisson's Care of Older People UK Market Report (31st Edition) in providing figures for bed requirements among the elderly in total.

5 Statistical Demand—Dementia Specific Care

Projections of older people with dementia and costs of dementia care in the United Kingdom, 2019 – 2040; Care Policy & Evaluation Centre, The London School of Economics and Political Science, November 2019

6 Supply / Demand Dynamics - Delayed Transfers of Care

Data supplied monthly on line by NHS England.

7 The Local Authority Perspective

Provided direct by the relevant Local Authority to HPC or publicly available on the internet

8 COVID 19 Implications

All information in respect of UK cases and deaths has been sourced during report compilation from the following websites:

www.ons.gov.uk

www.coronavirus.data.gov.uk

Data on the sites was originally sourced from the Care Quality Commission and Office for National Statistics.

The research detailed was published online on 9th November 2020 by the Journal of the American Medical Association:

www.jamanetwork.com

Tenure and Reports on Title

Unless otherwise stated, HPC have not inspected the title deeds, leases and related legal documents and, unless otherwise disclosed to us, we have assumed that there are no onerous or restrictive covenants in the titles or leases likely to impact upon our findings.

Condition and Repair

HPC have not carried out a building survey in respect of The Site nor any competing facility referred to in this report. Indeed, we have not inspected woodwork or any other part of the structure whether covered or exposed, accessible or inaccessible. We are therefore unable to confirm whether any facilities are defect free. None of the services, drainage or service installations were tested and we are, therefore, unable to report upon their condition.

Environmental

HPC have not carried out soil, geological or any other tests or surveys in order to ascertain site conditions or environmental condition of The Site (or competing facilities). The report assumes that there are no unusual ground conditions, contamination etc. which would impact detrimentally on the operation of a development.

Local Authorities, Statutory Undertakings and Legal Searches

HPC have not made any formal searches or enquiries in respect of The Site and are therefore unable to accept any responsibility in this connection. We have assumed that all necessary consents, licences and permissions enabling The Site to be put to the proposed use will be obtained with no outstanding works or conditions required by statutory, local or other competent authorities.

We would specifically confirm that HPC have not contacted the Care Quality Commission in respect of the proposed development.

Business Performance

In instances where reliance has been placed on information supplied to us by the client, HPC accept no liability should such information subsequently prove to be inaccurate or unreliable.

Third Party Data Provision

As previously stated throughout this report, HPC have relied upon information sourced from third party data providers. HPC have made every effort to ensure the reliability of each provider but take no responsibility for omissions or erroneous data sourced.

Time Limitation

The potential of The Site is impacted by market movement outside of the control of HPC. For this reason, it is necessary to limit the period of time for which this report remains valid to four months from report date.

Instructing Party

The instructing source is detailed within Section 1 to this report. Reports have been provided for the use of the party to whom they are addressed. Whilst they may be disclosed to other professional advisors as part of the process, no responsibility is accepted to any third party for either the whole or any part of the content.

Liability Cap

HPC confirm that the extent of our liability in respect of this report is limited to a maximum sum of £2,000,000.

Appendix VI Author Overview

Nigel Newton Taylor is a Chartered Surveyor with over 30 years experience providing commercial property advice in both the public and private sectors. Specialising in care, he has provided a mix of consultancy, valuation and transactional advice to a wide range of clients including local authorities, lending institutions, not for profit organisations and corporate healthcare operators.

Relevant Qualifications:

- 1988 Bachelor of Science (with Honours) in Urban Estate Surveying
- 1990 Professional Associate of Royal Institution of Chartered Surveyors

Healthcare Property Consultants Ltd – 2008 to Date

Director

- Co-founder of business specialising solely in healthcare agency, valuation, consultancy and research
- Provision of consultancy advice in respect of development site selection to regional and national corporate operators
- Provision of consultancy advice alongside EY and PwC during 'Fair Price for Care' exercises
- Sale of registered care homes and independent hospitals on behalf of national corporate operators
- Feasibility provision to charitable organisations in respect of estate restructuring (YMCA, CLS Care Services)
- Expert Witness advice to legal and planning processes
- Rent review negotiations on behalf of UK's former largest corporate care home operator (Southern Cross)
- Consultancy advice provided to private operators and corporate providers including Care UK, BUPA, Maria Mallaband Care Group, Healthcare Homes, Avery Health and Bondcare.

GLP Taylors – 2005 to 2008

Director

- Managing Director of healthcare department
- Provision of consultancy advice and agency services to local authorities throughout care home externalisation processes (Essex County Council, London Borough of Havering)
- Provision of consultancy advice alongside PwC during 'Fair Price for Care' exercises across seven local authority areas

Christie & Co – 1997 to 2005

Director

- Manager of Leeds office
- Valuation and agency experience, specialising in healthcare, based (at various times) in Nottingham, Manchester and Leeds

Valuation Office Agency – 1988 to 1994

Senior Valuer

- Miscellaneous commercial, residential and agricultural valuation experience
- Training and supervision of graduate colleagues through RICS qualification



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