

27 May 2020

Hampton Care Home Ltd  
Old Bridge House,  
40 Church St,  
Staines TW18 4EP

To whom it may concern

**Former Police Station, Station Road, Hampton, TW12 2AX (ref. 19/2822/FUL)  
Supplementary supporting evidence**

Carterwood prepared a need assessment, dated August 2019, in support of an application for the development of a care scheme to include a care home and care suite units at The Former Police Station, Station Road, Hampton TW12 2AX.

Following submission of the report, various queries have been raised by Di Manning, Head of Commissioning Services, which we have considered in turn in this letter. We emailed and left a voicemail for Di Manning on 24 and 27<sup>th</sup> of May, respectively, in order to discuss the below but appreciate that during the current lock-down period working hours may be restricted. We would be more than happy to arrange a separate call to agree common ground and discuss any outstanding areas of disagreement at a later date.

We provide our thoughts and observations on the key areas below that relate to our assessment of elderly care home need.

We have summarised the response below into three key areas, as follows:

- Category of care to be provided
- Financial implications
- Burden placed on local services.

We have also considered the following areas, two of which were raised as part of the review of the Management Plan that was submitted by Cinnamon Care (the operator name) solely in the areas that relate to need (other elements of the Management Plan considered separately by Cinnamon Care under separate cover) below:

- Appropriateness of the catchment area
- Dementia population estimates.

In addition to the above, there has been widespread disruption and impact upon the social care system following the outbreak of the COVID-19 pandemic. We have pre-empted any additional queries in terms of impact upon local need with some additional commentary to assist in the process and avoid any further delays to the application decision-making process.

We have detailed each relevant observation that relates to the need case in italics below and provided additional insight, clarity or evidence as appropriate.

**Category of care to be provided**

*“The Council’s Older Persons Housing Needs Analysis identifies the future need for specialist dementia residential beds and additional nursing beds for borough residents.”*

We agree with the commissioner's opinion that there is an accepted need for specialist dementia beds and additional nursing beds and our own evidence supports this, although the methodology we employ does not explicitly differentiate by care category but please note that Section 24 of our report provides a breakdown of the dementia population in the catchment likely to require residential care and which is sizeable across both the market and local authority catchment area.

*“People are living longer and are being supported to stay in their own homes for as long as possible with care if necessary.”*

This forms part of a wider national drive to support people in their own homes where possible. This is evidenced by a decline in the proportion of older people needing a care home as a percentage of the total elderly population, that has declined year on year over the past few years. However, care home occupancy has remained broadly stable over the same time period and this is due to the compensating increase in the absolute number of older people. Care home lengths of stay have reduced by delaying the placement decision for as long as possible and eligibility criteria has been squeezed to the point where it is very difficult to see how these can be reduced any further and this needs to be taken into account for future planning by care commissioners. This is particularly the case given the level of obsolescence in so much of the existing stock of homes in the area, which lack fundamentals such as private en-suite facilities. This is exacerbated, considering the COVID outbreak, where the unsuitability of the care home physical environments of a very high proportion of the existing supply to cater to the needs of the very frailest members of the community will become even more important in future bed planning. It is now impossible to rationalise how any commissioner of care can find it acceptable to place residents into homes where service users must share bathrooms and cannot appropriately self-isolate within their own bedrooms.

*“Placements of people into registered care homes is now taking place at a much later stage and degree of frailty and the Council is developing new extra-care schemes as an alternative to residential care.”*

This is certainly the case, and this is evidenced by length of stays, which are decreasing. However, extra care schemes are unable to cope with the needs of acute nursing care where 24-hour constant nursing provision is required and dementia care where, particularly in the private sector, it is inappropriate in many cases outside of a residential care setting.

*“Cinnamon Care have not made it clear whether there will be specialist dementia care in the proposed care home on this site.”*

This is an operational not a planning decision, as the proposed care home falls within a C2 residential institution use class which does not require that any categories be specified as part of the application consideration process.

Nevertheless, to provide some operational context, within the group's existing 12 care homes, 52% of current residents have a dementia diagnosis. Once developed and operational, it is highly likely that at least 50% of the beds will be dedicated solely towards specialist dementia care, with the remainder of the beds catering to general frail nursing (the residents of which are likely in many cases to also have a dementia diagnosis). Regardless, the home will be built on a flexible, unitised basis and this will allow the creation of best-practice, small living groups and future proof the building to cater for changing needs as dictated by the local market.

### **Financial implications**

*“Cinnamon Care specialise in luxury care homes aimed at affluent older people. They have 12 care homes across the UK and are recognised as one of the top 20 Care Home Groups in this particular market.”*

We agree that Cinnamon Care are a very high-quality provider with an excellent reputation.

*“Three of their homes are in London (one in Battersea and two in Blackheath). The target audience for this type of dwelling is self-funding clients and the facility would not be accessed by people supported by the Council.”*

Currently only a small number of referrals within Cinnamon Care are funded by either Social Services or the NHS through Continuing Health Care funding and the key target market for the proposed development is the self-funding, private pay market. This is a requirement of the proposed development due to the well-publicised under-funding of social care over the last decade and the low fee rates set by the Borough. In addition, Richmond-upon-Thames is one of the most affluent Boroughs in London and across the UK. The self-funding, private pay market is the dominant source of referral funding in this market (as many care home residents will not meet the relevant financial eligibility criteria enforced by the Council), to which this home will predominately cater.

*“However, any care home resident who runs out of personal funds would become the responsibility of the Council and as such, the Council has a vested interest in understanding how the beds in any new care home are marketed.”*

Like all high-quality providers who have the interests of their residents in mind, Cinnamon Care insist on receipt of three years of proof of funding prior to admission into the home. According to LaingBuisson’s latest Care Homes for Older People report (30th edition), the current average length of stay in a care home is 16 months for nursing and 30 months for personal care. However, they note that this is weighted upwards and is an over-estimate due to a small proportion of residents that stay for very long time periods, and that the median (which would be a better measure) is likely much lower.

Therefore, given the proof of funding required, the proposed home will provide more than enough comfort of fee affordability for most of the residents who will enter the home. These referrals have taken pressure off the local government system for the three+ years that they were self-funding and have actively, therefore, assisted the local council’s budget for the period that they were funding their own care.

Notwithstanding the above, it is inappropriate for financial considerations and viability to be confused during consideration of a planning application. We set out below an extract from an appeal decision from Cheshire East planning authority (reference: APP/R0660/A/12/2188195) in respect of a care village development in Handforth. Paragraph 62 of the appeal decision (for which planning permission was granted) is as follows:

*“The Council has suggested that, due to a lack of need, new residents from outside Cheshire East could have to enter the home to ensure its viability. They would then represent a risk that the Council could be responsible for their future care. The financial concerns of the Council are however not material considerations in this case, as has been found on many other occasions including in the Health and Safety Executive v Wolverhampton City Council & Victoria Hall Ltd [2012] UKSC 34 case. This is the situation notwithstanding an annual increase in those needing Council support in care homes and the Council’s 2011/12 expenditure of some £2.2m of support to those unable to afford fees previously met privately.”*

#### **Burden placed on local services**

*“The application states that there will be 67 beds, 22 suites and 44 staff. If the suites are occupied by couples, then there could be over 100 vulnerable people living on this site. This would potentially have a significant impact on the local NHS services, which are currently stretched.”*

The response considers that the proposed care home will ‘place additional burdens on the local NHS services’. The elderly people who will be resident in the proposed care home will be there due to their care needs. Such needs will not have increased as a result of their move into a care home. The concentration of elderly residents in one place should assist in reducing the burden on community

nurses and there are also advantages to having those with care needs in one location. For example, a suitable area of the new care home can be made available for a visiting GP to combine appointments by holding an in-house surgery for residents, if required. This may serve to limit the number of GP visits, and care and nursing staff within the care home should also reduce the number of unnecessary trips to the GP or A&E.

There is no doubt that several referrals will move into an area when a new home is developed; however, there are other new schemes in neighbouring boroughs that will have the same affect and draw residents away. Placements by social services to and from neighbouring and surrounding local authorities often compensate for each other. In effect, there are just as likely to be as many people leaving the area as there are migrating into the council area, and these two factors effectively cancel each other out.

### **Appropriateness of the catchment area**

*'Their claim that the majority of clients will come from a 4-mile radius is not a credible one'*

Section 20 on page 32 outlines the empirical evidence base upon which our care home catchment area was determined. We produced the need analysis in our report relating to a market catchment based upon empirical evidence as to where people are drawn from in other similar care home developments.

Any assessment of a market catchment area is to some degree a matter of opinion and judgement; there are a host of factors that in practice influence the catchment, including but not limited to:

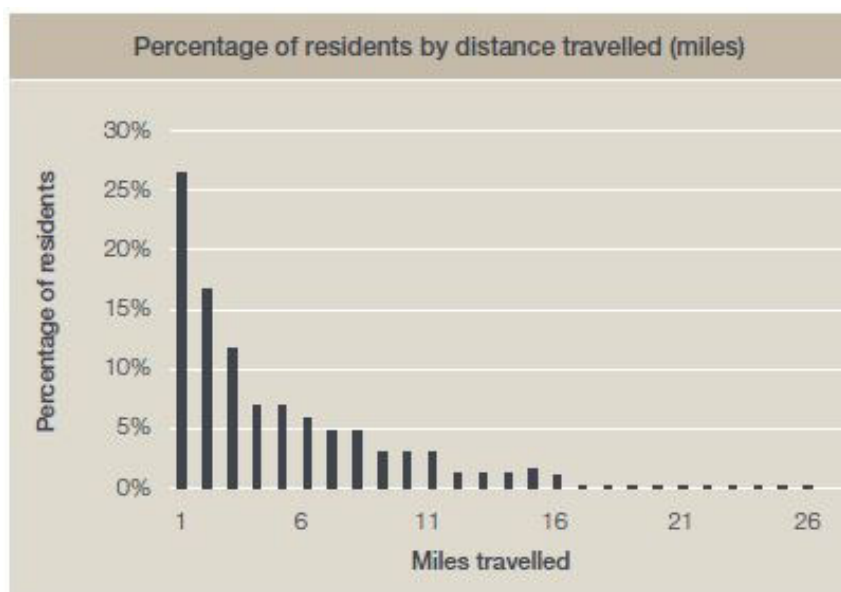
- Accessibility to major transport networks;
- Proximity to other settlements;
- Rural or urban location;
- Target market of the proposed home;
- Size of population area.

Our analysis and determination of the market catchment area is sourced from empirical evidence based upon the following sources:

- National research project for the National Care Forum (NCF), the principal trade association for the voluntary sector. We undertook a project covering over 3,000 individuals across nearly 100 homes throughout the UK.
- Individual home analysis for large and small operators alike who have commissioned us to undertake catchment analysis. For reasons of confidentiality, we cannot name the parties, but conservatively this additional data covers several thousand more records of data.

Based upon the results of the two sources of data there is one overwhelming, unequivocal driver of the way in which residents occupy places in care establishments, and therefore how catchment areas should be drawn. Local geography is the overwhelming dominant factor – and there is a heavy weighting of demand by closest proximity to any care home.

The following is an extract of our findings from our bulletin prepared for the NCF, which clearly shows the dominance of local geography:



#### Geographical proximity

- 66.5 per cent of referrals travel 5 miles or less.
- 43 per cent of referrals come from within 2 miles.
- However, there will always be a significant minority of referrals driven by other factors – influence of family and friends in the decision making process, area relocation, specialist service, choice, etc.

The radius of the catchment is assessed based on our analysis of resident data provided by multiple care home operators with high-quality schemes, similar to the subject care home. The distance travelled to move into a care home varies and is based on the specific location and its accessibility. The table below sets out the average distance travelled based on five different types of location.

Average distance travelled to a care home	
Comparable location	Average distance travelled by resident (miles)
Location 1: Rural location	5.7
Location 2: Rural location with good A-road links	5.4
Location 3: Urban location	4.3
Overall average	5.2

Source: Carterwood.

The location accords most closely to Location 3 in the table above; however, the catchment adopted extends from 3.4 to 4.9 miles and is broadly based upon an average 4-mile radius. This catchment reflects the high levels of accessibility and proximity to the M3.

The exact perimeter of the catchment is not a perfect shape given the constraints of data adopted and the use of the Census 2011-defined 'Output Areas' for our analysis of the catchment population. There are approximately 180,000 'Output Areas' across England and Wales comprising collections of, on average, 300 people. They are 'socially homogenous' which means they are drawn based on households of a similar type and tenure.

Output Areas are the base unit of analysis for all Census data and allow for a very granular level of analysis. They vary in size and shape considerably, covering very small areas in urban districts, (sometimes a single tower block), and much larger areas in rural communities. This is driven by the fact all have to include circa 300 people of similar housing types/tenures.

It is therefore not possible to base our analysis on a perfect radius around a site or a specific catchment area as no data fits perfectly. The catchment will always be based on a nearest match to the relevant Output Areas data.

In respect of therefore adopting a circa 4-mile catchment area and the importance of local geography, we consider that the catchment area we have adopted is highly robust, given market norms across a data set amounting to thousands of records.

The need assessment report also assessed the need requirement within The London Borough of Richmond upon Thames for additional robustness, which also showed a significant shortfall of bedspaces.

#### **Dementia provision**

*“there is no reference to how many people with dementia can be supported (this is our main area of growth in need locally).”*

This is discussed in section “Category Care to be provided” above – under sub-section “Cinnamon Care have not made it clear whether there will be specialist dementia care in the proposed care home on this site.”

#### **COVID-19 market impact**

Since our instructions were received, the coronavirus has made a significant impact on the care home and wider national and international markets. At this early stage, it is impossible to predict the eventual impact and outcome on the care home sector. However, at a national level, our earliest preliminary estimate projects an approximate reduction in occupancy in the short term of 8 percentage points over the next 12 months before occupancy returns to pre-COVID-19 outbreak levels in 2022 - 2023, before continuing to increase with elderly population growth over the next few decades.

It is also impossible to accurately predict the number of home closures that outbreaks in individual homes, or the financial and staffing challenges may have on the current supply or the volume of new planned stock coming through.

Any local market assessment will need to be based upon a detailed local level investigation into the specific homes in the area to ascertain the true impact on the local market. It is a binary equation and homes will either be affected, and some will not and therefore any impact will be localised to the individual home level. It is totally inappropriate to contact homes for such a purpose at this time of national need.

Our view overall, is that occupancy levels will recover to at or very close to previous levels at the time when this home will become operational, given the 2 year development and construction period and therefore the net impact of coronavirus at this stage for this site will be broadly neutral and does not materially impact upon our recommendations at this time.

I trust that the above is sufficient for your purposes, but if you have any more queries then please do not hesitate to contact me to discuss.

Yours sincerely

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