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Data That Cares



About Us

Future Care Capital is a charity which undertakes research to advance ideas that will help shape future health and social care policy and deliver better outcomes for individuals living in the UK.

Beginning life as the National Nursery Examination Board in 1945, the charity has evolved throughout its 70-year history and we continue to have Her Majesty the Queen as our Royal Patron. For further information about us, see:

www.futurecarecapital.org.uk

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Acknowledgements

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Data That Cares

Foreword



Foreword

Data provides a way for us to understand and make informed decisions about our lives and our communities. This report, *Data That Cares*, looks specifically at the social care sector and the types of organisations that provide some aspects of social care. It should be useful for policymakers and local authorities to understand how provision differs across the country, how it changes over time, and the measurable and potential impact of these differences on people's lives.

Seeking understanding is itself a caring act. A sector and society that truly cared for the most vulnerable people in our communities would seek to understand their lived experience. It would gather information about the positives as well as the challenges and uncertainties encountered by those that need care, their families and their carers.

A society that cared would also aim to understand the nature of the social care system. Like any complex system, policies and interventions towards one goal can easily have unintended consequences. Monitoring the system and detecting issues early gives an opportunity to adjust for them. Like any devolved system, the fact that different areas can pursue slightly different approaches provides opportunities to learn about what works and what doesn't. This too requires comparable data at a local level.

Data is not just facts and numbers. It can and should tell stories, prompt questions and motivate action. The challenge from this report is to take action not only based on what the data can show us but also to fill the data gaps in areas where the evidence is currently hidden or foggy. This might mean improving the frequency, quality and standardisation of data that is already collected and published; proactively publishing data that can only currently be accessed through costly FOI requests; or collecting new data to answer specific policy questions. It might also mean developing novel techniques, like those explored in Part C of this report, to link unconnected data and uncover information.

As governments, businesses and charities seek to improve social care provision, we should remember to also strengthen the data infrastructure that supports it.

A society that cares needs data that cares.



Jeni Tennison, CEO – Open Data Institute





Executive Summary

There is little dispute that our care system is in crisis. Yet care is an area of life that we do not know or understand enough about, and this has implications for policy, practice and the lives of people administering and receiving care.

A Digital Duty of Care should mandate:

- the generation of high-quality social care data at source;
 - adherence to associated standards to facilitate interoperability and to provide a basis for robust research and analysis of pertinent datasets;
 - access to the data, insights and algorithmic tools generated by social care service providers to aid real-time monitoring of provision and safeguarding of individuals in receipt of care;
 - compliance with the Local Government Transparency Code (2015); and
 - stimulation of the use of the resultant open data by innovators and entrepreneurs to evolve the data-driven care technology market.
-

The Summary

There is little dispute that our care system is in crisis. From the severe gap between care needs and care provision to the long-term funding settlement, and from major workforce challenges to the precarity of many service providers, care is not on a stable or sustainable footing at present.

This is ultimately a very human crisis, and one which extends into the daily lives of millions of people in communities across the country.

Yet care is an area of life that we do not know or understand enough about, and this has implications for policy, practice and the lives of people administering and receiving care. In this report, we build on our previous research into the challenges of planning and managing adult social care provision in different parts of the country, the experience and support needs of unpaid carers, as well as the power of health and care data generated by service providers to better inform how provision is designed, commissioned, delivered and monitored.

In producing this report, we partnered with the Institute for Public Policy Research (IPPR), to whom we have donated the data and insights presented, where permissible, for their own independent use. We have examined broad-ranging datasets to better understand the structure and stability of social care markets in England and, in particular, the provision of residential social care for adults. At present, there are barriers to accessing and linking datasets about social care provision in England. This means that we are able to shed light on some aspects of care, but there are also areas which we are not able to explore in-depth in order to derive meaningful insights that we might then action to drive improvements in the continuity and quality of care that people receive.

Key Findings

In exploring the **structure and stability of residential social care markets**, we found that:

- The overall number of care home beds in care homes registered with the CQC has fallen over time and there has been a shift to larger care homes.
- There has been a fall in provision from small care homes in most areas.
- Care homes also appear to be catering to an increasing range of needs.
- Private companies are increasingly dominant, while not-for-profit provision declines.
- The private company market share has increased in almost all local authorities.

- Large provider brands remain significant but seemingly less so over time.
- At a local authority level, changes in older people's provision do not clearly track changes in population.

In examining the **performance of social care providers by size, type and location**, we found that:

- There are relatively few measures of quality that are publicly available data with which to assess social care provision.
- CQC inspection coverage and ratings have improved over time, but CQC ratings are a lagging indicator of quality.
- The private sector tends to be rated as lower quality than its public and not-for-profit counterparts.
- Smaller care homes tend to be rated as better quality than their larger counterparts.
- There is substantial variation in quality ratings at a local authority level, and area-level links to quality are more difficult to establish.
- Social care-related quality of life is not obviously correlated to private company market share.



Often, we use data to find the questions, not the answers. The answers come from people. We therefore acknowledge that our work should be read in conjunction with qualitative studies to further explore what we could not readily interpret – including:

- Whether changes in the number of care home beds in care homes registered with the CQC in a location is, in and of itself, 'good' or 'bad' – from the point of view of supply and demand; occupancy levels; growing emphasis upon prevention, reablement and independent living in later life.
- What explains the 'churn rates' amongst providers of residential social care services.
- What has driven the shift to larger care homes, the decline in provision from small care home operators and not-for-profit provision.

- Which care homes are providing services for different user groups at any one point in time. This might, for example, enable us to better understand the relationship between supply and demand at an area level; anticipate the potential for strain to impact different services; and assess the likelihood that challenges in one care market might ‘spill-over’ into another and/or lead to people being offered care in places that are nearer/further from friends and family members.
- How provider ownership structures and particularly multi-location brand operators of care homes change over time.
- Why older people’s provision does not clearly track changes in population (for example, whether it is because some local authorities do not coincide with care markets; whether there are differences in health which impacts the age at which people need care and the level and type of care needed; whether it reflects occupancy levels; or whether care needs are being met outside of care in extra care housing schemes and supported living facilities or simply going unmet).
- Why not-for-profit care home providers tend to be rated as higher quality than their private sector counterparts.
- Which areas as distinct from providers benefit from better quality provision.
- How both state-funded and self-funded service users rate the care they receive and the extent to which that maps to quality ratings conferred by the regulator.

In practice: modelling work to evolve data-driven tools to identify residential care providers that may be ‘at risk’ of failing from a financial perspective

In the course of our research, we developed a data-driven tool underpinned by open data to identify residential care providers that may be ‘at risk’ of failing from a financial perspective.

Subject to further work to see what best predicts a provider’s financial risk and, by extension, their risk of eventual failure without any intervention, such a tool could be evolved and provide actionable insights to improve residential care market oversight and contingency planning activities undertaken by local authorities and the regulator. Our proof of concept is, then, demonstrative of the scope for ‘data that cares’ to bring about tangible improvements to peoples’ quality of life and overall wellbeing.

Our data-driven tool is geared towards single care home provider entities but can be scaled up from a technical point of view.

This is useful to the extent that 75% of CQC registered providers are single care home provider entities, and councils and the CQC currently lack the capacity to monitor them on an ongoing basis. At a provider level, 75% of providers currently operate single-location care homes and, together, manage 38% of total beds.

The percentage of single-location providers, after those who operate under a multi-location brand have been removed, is 65% and they manage 30% of total beds. Notably, the CQC’s Market Oversight Team is currently only able to manually monitor x60 (mixed) domiciliary and residential care providers – covering an estimated 25% of the adult social care market (Care Quality Commission, 2015).

- If we extrapolate the findings from our sample to consider the implications of our modelling for England as a whole, 25,205 residential care home beds are (potentially) ‘at risk’ on the basis of our most cautious definition of risk.
- Some variation was found by region in the course of our analysis, with Yorkshire and the Humber having more care homes and beds deemed at risk than other regions, and London having fewer at immediate risk.
- In terms of size, both smaller care homes (with 7 or fewer beds) and large ones (with 45+ beds) appear to be at greater risk than others in our sample.
- Our analysis found no marked variation in risk by type of residential social care service provision, but the challenge when considering the results from our analysis in this way is that there is often and, increasingly, overlap in service categories.
- The overlap in categories makes national comparisons of different service types deemed to be more or less at risk challenging. National standards in this regard would go some way towards solving the problem and allow for greater transparency.
- Care homes rated as ‘Outstanding’ by the CQC were the least likely to be at risk in our sample, although we did not factor for quality in our model, and the CQC does not factor for financial risk in assigning quality ratings.

Rather than a signal of providers in distress and close to failure, the measures should be taken to signal those providers whose financial situations are unusual enough to warrant closer scrutiny and, subject to detailed investigation, subsequent intervention. This type of analysis could, nonetheless, help focus the use of limited resources to help ensure that the wellbeing of the most vulnerable in our society is better protected in future.

Recommendations

In seeking to promote the generation, publication and usage of 'data that cares', we recommend that the Government introduces a Digital Duty of Care applicable to all public bodies that are responsible for the commissioning, provision, monitoring and/or regulation of social care services.

A **Digital Duty of Care** should mandate:

- the generation of high-quality social care data at source;
- adherence to associated standards to facilitate interoperability and to provide a basis for robust research and analysis of pertinent datasets;
- access to the data, insights and algorithmic tools generated by social care service providers to aid real-time monitoring of provision and safeguarding of individuals in receipt of care;
- compliance with the Local Government Transparency Code (2015); and
- stimulation of the use of the resultant open data by innovators and entrepreneurs to evolve the data-driven care technology market.

The more technical recommendations which flow from the work outlined in this report are outlined below and are designed to promote care market shaping and stability, provider performance and quality as well as financial risk management in the interests of improving outcomes for our beneficiaries.

We recommend that:

- The Office for National Statistics (ONS) explores the scope to exercise its powers under the Digital Economy Act (2017) to generate useful open data and insights about the structure and stability of care markets which involve some form of accommodation by linking big datasets controlled by the CQC, MHCLG, DWP and local authorities. The ONS could, also, encourage better practice on the part of public sector commissioners of adult social care via the Cabinet Office's Supplier Code of Conduct.
- NHS Digital extends data collection via the Adult Social Care Outcomes Framework (ASCOF) so that it covers both state-funded and self-funding service users in future. It should ensure that the resultant dataset is open and published to a standard as well as in a format that can be readily linked with data about quality ratings published by the CQC to facilitate comparative analysis.
- The Cabinet Office promotes what we have elsewhere termed a 'data dividend' from regulatory or contracting arrangements with third party providers of residential social care and MHCLG explore the potential for it to flow from the conferment of planning permissions linked to the development and/or operation of accommodation involving some form of care.

We have made a number of practical recommendations linked to our financial modelling work to help councils and the CQC to automate monitoring of residential social care providers as well as highlighting areas for further research.

In particular, we recommend that Government mandates:

- the presentation of accounts in a machine-readable format where an organisation provides social care services;
- persistence of unique identifiers which would provide a means of long-lasting identification of digital objects that are global and standardised in beneficial ownership data - to render transparent who owns and/or controls organisations that provide social care services and, in particular, those bound up with complex group ownership structures; and
- the adoption of data standards for both beneficial ownership (the Open Ownership Standard) and spending data (the Open Contracting Data Standard).

We need data that are timely and granular so that they benefit from the explanatory power upon which to base critically important decisions impacting peoples' lives.

We need data that are meaningful from the point of view of regulators, commissioners and providers but they should, also, empower service users and their families as those intimately bound up with obtaining, supporting or receiving care. We need data that are published in accordance with standards to facilitate linkage for the purposes of robust research, analysis and data-driven tool development.

It is, however, easy to let the technicalities of data distance us from the lived experience that they imply.

The terms that we use in the data we share matter enormously. They remind us of the limits of our knowledge and the significance of the decisions we make based upon them. Ultimately, we need 'data that cares'.



Data That Cares

Introduction



Introduction

How we care for ourselves and one another has changed considerably and at regular intervals over the course of the past 75 years.

Amongst other things, the changes reflect the establishment of the welfare state and introduction of tax-payer funded care services; advocacy on the part of the independent living movement and the shift from institutional to community care; the impact of the campaign for women's rights and demographic changes on the labour market and, with them, care within families; and, more recently, the acceleration of private sector provision in the context of our ageing population.

Concern about care has ebbed and flowed against this backdrop, giving way over the course of the past decade to talk of a 'crisis'. This crisis is multi-faceted and, in some important respects, does not seem to resonate with the general public to the same extent as challenges impacting the NHS. It spans the absence of a long-term funding settlement, the current mismatch between need, provision and expectation, the relative precarity of service providers, persistent workforce challenges as well as strains upon carers and the quality of care that individuals experience. Ultimately, however, it is a crisis whose cost is all too human and extends to the daily lives of millions of people in communities across the country.

Yet care is an area of life that we do not know or understand enough about, statistically speaking - with discernible implications for policy and practice and, crucially, the lived experience of the (paid and unpaid) careforce and those in receipt of care.

We need data that are timely and granular to inform critically important decisions impacting peoples' lives. We need data that are meaningful from the point of view of regulators, commissioners and providers but they should, also, empower service users and their families as those intimately bound up with obtaining, supporting or receiving care. We need data that are published in accordance with standards to facilitate linkage for the purposes of robust research, analysis and data-driven tool development. However, we should not let the technicalities of data distance us from the lived experience that they imply. The terms that we use in the data we share matter enormously. They remind us of the limits of our knowledge and the significance of the decisions we make based upon them. In short, we need 'data that cares'.

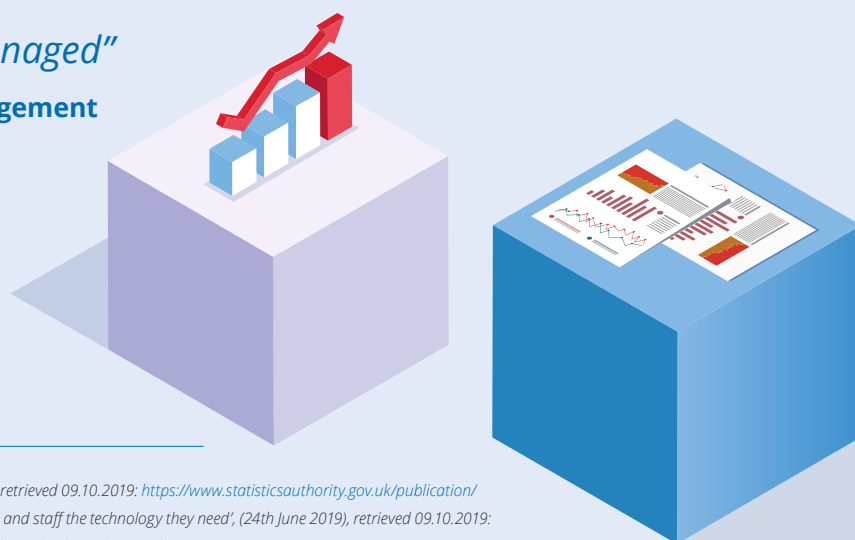
The Office for Statistics Regulation (OSR) has undertaken a systemic review of adult social care statistics across the UK with this in mind¹. Meanwhile, NHSX - a new unit established to drive forward the digital transformation of health and social care - has indicated that the development of data standards and social care are amongst the ten transformation programmes it will spearhead over the months ahead.²

"I am responsible for regulating data across economics, employment, health and more and it is social care that stands out by far for its low quality or even absent data. We need parity of measurement to have parity of policy. This is particularly significant when comparing social care to the data rich health system."

- Ed Humpherson, Director General - Office for Statistics Regulation

"What gets measured, gets managed"

- Peter Drucker, The Practice of Management



¹Office for Statistics Regulation, 'Systemic Review Outline: Adult Social Care', retrieved 09.10.2019: <https://www.statisticsauthority.gov.uk/publication/systemic-review-outline-adult-social-care/> ²Gould, M., 'NHSX: giving patients and staff the technology they need', (24th June 2019), retrieved 09.10.2019: <https://healthtech.blog.gov.uk/2019/06/24/nhsx-giving-patients-and-staff-the-technology-they-need/>

The Health Foundation and the Economic and Social Research Council (ESRC) have, for their parts, announced funding to establish a Centre dedicated to the use of high-quality research evidence to improve and support innovation within adult social care³.

But the scale of the challenge is considerable and, as others have pointed out, is exacerbated by the dearth of digital skills and tools available to the careforce (Doteveryone, 2019b, 2019a).

As a charity dedicated to advancing ideas that will help shape future health and social care policy to deliver better outcomes for society, Future Care Capital has established a programme of research to shed light on this critically important facet of modern life. We hope that this will, in turn, stimulate interest and investment in data and technology to bring about improvements to the quality of care people provide and experience.

In *Facilitating Care Insight to Develop Caring Economies*, we explored the challenges that different parts of the country face in planning and managing adult social care provision (Future Care Capital, 2018). We reflected upon the paucity of timely and granular information as well as the relative lack of analytic capability to make best use of data at a local level. More recently, we published the findings from primary research about the lived experience and support needs of unpaid carers – empowering carers to contribute to the evidence base that is needed to bring about a step-change in policies that affect them (Future Care Capital, 2019a). Then, in *Taking Next Steps to Harness the Value of Health and Care Data* (Future Care Capital, 2019b), we recommended that Government explores the scope to increase access to data and insights from contractual arrangements entered into by publicly-funded health and care organisations in order to better inform service design, commissioning and delivery.

Our latest research flows from a partnership with the Institute for Public Policy Research (IPPR), to whom we have donated the data and insights presented in what follows, where permissible, for their own independent use (Institute for Public Policy Research, 2019a, 2019b). It takes the structure and stability of social care markets as its principal focus – reflecting the top concern articulated by Directors of Adult Social Services in England (Association for Directors of Adult Social Services (ADASS), 2019) – and looks, in particular, at residential social care provision for adults.

Specifically, we have sought to make use of publicly available data to establish:

- 1 What we can currently ‘see’ of social care markets and, in particular, what it is possible to gauge about providers of residential social care services;
- 2 By extension, what we cannot see or readily interpret from the available data, and what that means for our ability to monitor the health of residential care markets; and
- 3 Whether, given growing evidence of care market fragility, there is scope to evolve data-driven tools to identify residential care providers that may be ‘at risk’ of failing from a financial perspective – thereby placing the well-being of the people they care for in jeopardy.

We acknowledge that social care provider instability is likely to impact negatively on more people in receipt of state-funded domiciliary care services than those being cared for in residential settings (Association for Directors of Adult Social Services (ADASS), 2019), such that our analysis and findings amount to only a partial take on care market stability. However, the ‘logic’ and functioning of the domiciliary care market differs from its residential counterpart and, even then, there are market segments to which different ‘sub-logics’ apply. A narrower focus than ‘social care markets’ is pursued in what follows to reflect as much. The residential care market has an estimated financial value of one and half to two times that of its domiciliary counterpart (National Audit Office, 2018). It also represents a more complex landscape in respect of which local authorities and the Care Quality Commission (CQC) have market ‘shaping’, ‘oversight’ and ‘contingency planning’ duties as a result of the Care Act (2014); in particular, to the extent that residential care providers are more readily subject to the activities of financial actors and institutions by virtue of their asset base. Residential social care therefore recommends itself as a topic for further research.

Our report considers the scope to bring about practical improvements in the interests of people whose quality of life depends upon the range of services it encompasses in the spirit of generating as well as calling for ‘data that cares’.

³Health Foundation, ‘The Health Foundation and the Economic and Social Research Council partner to support a new UK Centre to enhance the use of research evidence in adult social care’, retrieved 09.10.2019: <https://www.health.org.uk/news-and-comment/news/UK-Centre-research-evidence-adult-social-care>



As a charity dedicated to advancing ideas that will help shape future health and social care policy to deliver better outcomes for society, Future Care Capital has established a programme of research to shed light on this critically important facet of modern life.



Approach

The research we undertook, working in conjunction with Cambridge Econometrics and Spend Network, is presented in three parts.

Key Parts

Part A | In Part A we provide an analysis of publicly available and/or open data to assess the structure and stability of residential social care markets in England.

Part B | In Part B we examine the performance of social care providers by size, type and location to see what it might tell us about the quality of care offered.

Part C | In Part C we explore whether big data and machine learning techniques might be deployed to improve the ability of commissioners and the regulator to automate monitoring of residential social care markets and, in particular, the extent to which financial metrics could help to identify providers showing signs of (potential) financial distress.

Approach

The importance of data

Quantitative analysis and interpretation are heavily reliant upon the accessibility, quality, consistency and terms of use impacting the underlying data.

A crucial aspect of, and constraint on, this work is the analysis of data that are:

- closed – whether by virtue of commercial constraints, poor adherence to pertinent transparency codes or the file format used in publication;
- publicly available but subject to a license that limits their use; or
- open but not published in accordance with a uniform standard.

Wherever possible, we highlight gaps in data or areas in which they could be improved in the future. In making use of such data, we take the data as they are, accepting their current inconsistencies or gaps. We do this to illustrate both the advantages and disadvantages of existing data and with a view to making recommendations to improve those data at source.

Using data to understand the structure and performance of care markets

The first part of the analysis, which we undertook together with Cambridge Econometrics, sought to understand the structure and performance of residential social care markets. This strand of the work also served as an exercise to gauge the extent to which a data-driven picture can be assembled with existing data. It consists of an England-wide analysis disaggregating to councils with adult social services responsibilities and other breakdowns as relevant. The aim is to show what the data can reveal about local care markets, then, discern headline trends and questions raised by the analysis. In doing so, the work highlighted the complexity of local circumstances and a need for detailed investigation into their specificities. Further details of the method and data underpinning Parts A and B are provided at Appendix I and II respectively.

There might also be merit in undertaking a deep-dive exercise in one or more localities using ‘shared’ and/or ‘closed’ data for the purposes of comparing the scope to derive meaningful insights from them, but this is beyond the scope of the analysis presented in this report.

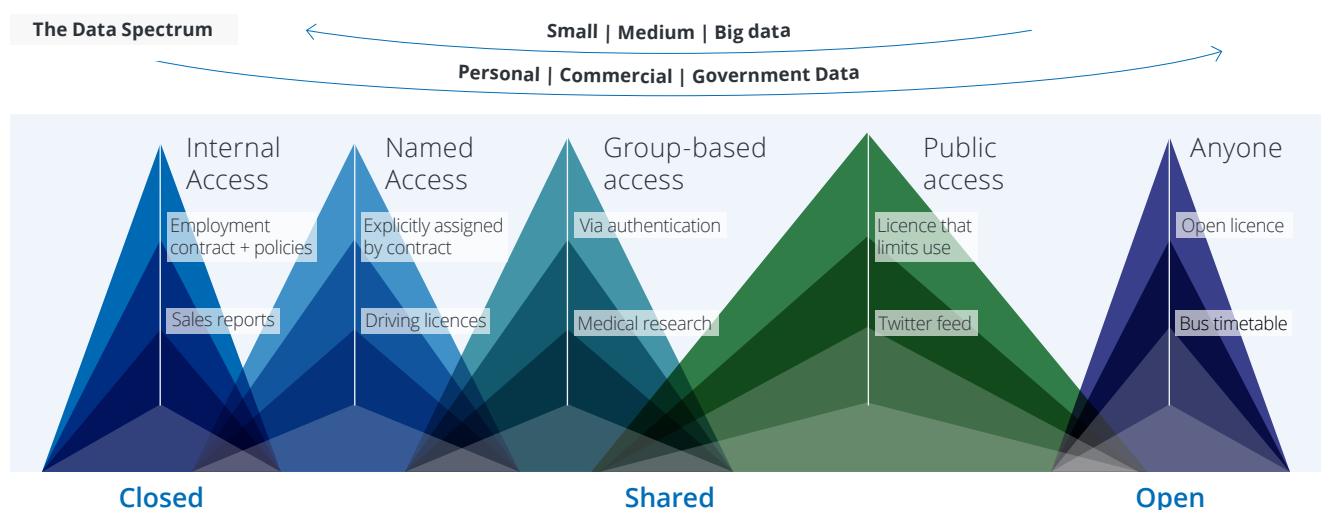


Image source: The Open Data Institute (ODI) under CC-BY license <https://theodi.org/about-the-odi/the-data-spectrum/>

Using data for market oversight

The practical aspect of the work we undertook in this area involved the construction of a new dataset of social care finances by Spend Network.

The datasets constructed in this research underpin a sample of linked data which combines open data about local government transactions (payments to social care providers), data about care home locations from the CQC and financial accounts made available by Companies House. It does not and, indeed, cannot take into consideration the extent to which the financial position of individual care providers might benefit from funding from other public bodies or, importantly, self-funders, since the data are, too often, unpublished, of poor quality or unavailable for the purposes of third party research. Because of the inherent

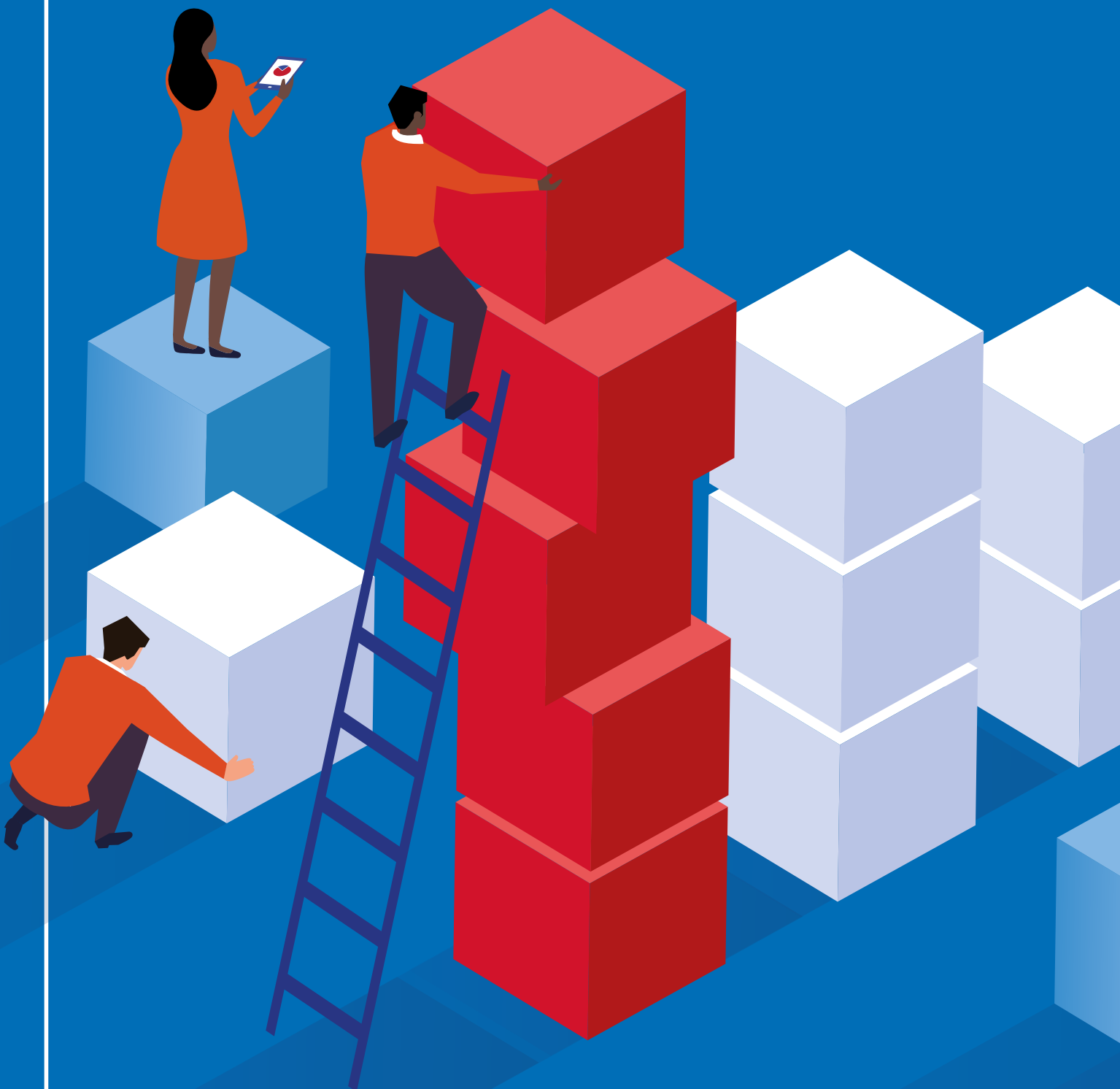
challenges in linking datasets that were not necessarily compiled with the express aim of data analysis for policy development, or to enable combination with other sources, the resulting datasets do not amount to a comprehensive database of financial information. However, the investigation considered what financial metrics could be derived from the dataset and how those metrics could be used to identify care homes which might be ‘at risk’ in the sense that they show signs that might suggest future financial difficulty if nothing changes.

This research explored a range of ideas to develop both the indicators and the benchmarks against which providers might be judged in such a risk assessment. This proof of concept shows promise and appears able to identify care homes which may warrant further investigation. Part C provides full details of the approach and results, while further information about dataset construction is provided at Appendix III.



Part A

The Structure & Stability of Residential Social Care Markets



Introduction

Part A considers residential social care provision across England, in keeping with the CQC's definition of the same, and the extent to which open and/or publicly available data can shed light on the structure of associated markets.

We present findings from an analysis of national datasets for England and local authorities (councils with adult social services responsibilities [CASSRs]) to explore the structure of social care markets and how their composition has changed over time. We analyse social care provided by care homes in England to identify various trends and developments in the sector. This gives an indication of the markets that councils are tasked by the Care Act (2014) to shape. We also consider, for a form of provision for which the source of need should be clearer (older people), the extent to which population changes and care provision are related. We find that this relationship seems to be true at an England level but does not hold at a local authority level for various candidate reasons.

The analysis in this section makes use of readily available public and/or open data, drawing mainly on data published by the CQC. Consequently, what is assessed is constrained by what policymakers and statisticians have previously decided is important (whether implicitly or explicitly). There is, then, a focus on formal or funded social care provision and links to it. This is because it must be measured from a regulatory standpoint, whereas other forms of provision typically remain unseen.

Care Quality Commission Data: Caveats

The core of this analysis draws on data published by the CQC – full details of which are provided at Appendix II.

As we note in the sections that follow, the coverage and level of detail of those data seem to increase over time. Some of the trends identified in this chapter might then represent some combination of 'true' changes in the underlying structure of the care market and changes in data coverage/quality.

We also identified some features of the data that should be borne in mind when interpreting the results that follow. Specifically, some of the care homes appear more than once in the data so there is at least some degree of double counting in the figures and a degree of over-estimation in the numbers is likely as a result. A full explanation of this issue, which flows from dual registrations, is included at Appendix I. However, unless otherwise stated, this means that the analysis should be interpreted as 'best estimates' in light of both known and unknown challenges that accompany the data.

Structure of social care markets

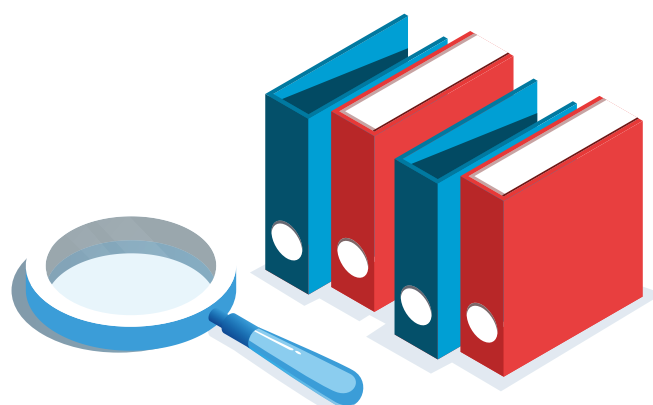
We present our analysis of CQC data about care homes over time here to illustrate the changing structure of social care markets in England.



Our headline findings are:

- The number of care home beds in care homes registered with the CQC has been ***falling over time alongside a shift to larger care homes.***
- Most local authorities have seen ***a fall in provision from small care homes.***
- Care homes appear to be catering to ***an increasing range of needs.***
- Private companies are increasingly dominant, ***while not-for-profit provision declines.***
- The private company market share has ***increased in almost all local authorities.***
- ***Large providers remain significant*** but seemingly less so over time.
- At a local authority level, ***changes in older people's provision do not clearly track changes in population.***

We present each of these in more detail on the next page and comment on data issues as appropriate.





The number of care home beds in care homes operated by providers registered with the CQC has been falling over time alongside a shift to larger care homes

Table 1 shows the number of care homes operated by providers registered with the CQC in July of each year for the period 2012-19 and the total number of beds in those care homes. The data points to the number of such care homes having fallen steadily from 17,744 care homes in 2012 to 15,661 in 2019. Between 2015 and 2019, the decline was equivalent to the loss of more than 300 homes (2%) each year, whereas the decline in the total number of beds has been more gradual - only beginning in 2015 and falling by less than 0.5% per annum since then. This represents an annual decrease of more than 1,000 beds each year and, in 2019, that decrease was especially large, at around 2,300 beds. Since 2014, just before the decline began, the total number of care home beds has decreased by over 7,000 (1.6%).

The trends are not, in and of themselves, 'good' or 'bad' since they could represent reductions in demand for residential social care services brought about by preventative measures and/or greater emphasis on living independently. They are, nonetheless, illustrative of structural changes in these markets with discernible implications for other aspects of social care policy and provision – for example, demands upon domiciliary care provision, 'lengths of stay' (LOS) and delayed transfers of care (DTocS).

Table 1: Total beds and care homes, 2012-19

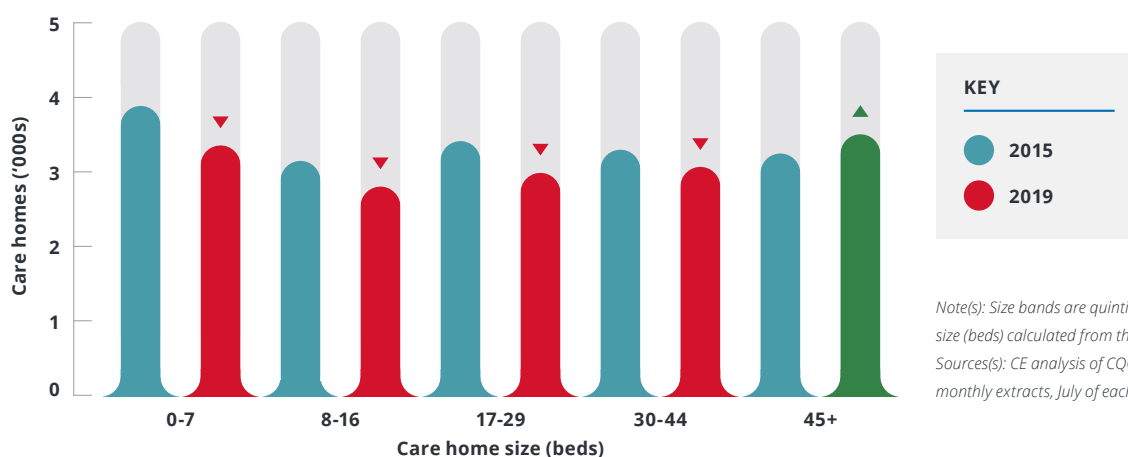
Numbers	2012	2013	2014	2015	2016	2017	2018	2019
Beds	463,649	463,494	463,752	462,650	461,313	460,186	458,844	456,545
Homes	17,744	17,474	17,295	16,999	16,667	16,302	15,972	15,661
Annual change								
Beds	11,601	-155	258	-1,102	-1,337	-1,127	-1,342	-2,299
Homes	220	-270	-179	-296	-332	-365	-330	-311
Annual change (%)								
Beds	2.6%	0.0%	0.1%	-0.2%	-0.3%	-0.2%	-0.3%	-0.5%
Homes	1.3%	-1.5%	-1.0%	-1.7%	-2.0%	-2.2%	-2.0%	-2.0%

Note(s): 'Homes' reports the number of care homes with a recorded number of beds. If a care home has no entry for the number of beds, it is excluded from the count.

Sources(s): CE analysis of CQC care directory monthly extracts, July of each year, 2012-19.

The steeper decline in the number of care homes compared to beds implies an increase in the average size of a care home over time, from 26.8 beds in 2014 (just before the number of beds started to fall) to 29.2 by 2019. This can be seen in **Figure 1** which show the number of care homes in five size bands. Split into these size bands (by quintile), only large care homes – defined, here, as having 45 or more beds – have increased in number. Overall, however, reductions in the number of smaller care homes (i.e. of less than 45 beds) have outweighed increases in the number of larger ones.

Figure 1: Changes in the number of care homes by size band, 2015-19



The residential social care market comprised of providers registered with the CQC has seen a gradual decline in the number of beds since 2014, totalling some 7,000 beds (1.6%) in the last five years. Over the same period, the number of care homes has fallen by around 1,600 (9.4%). These developments reflect a marked decrease in the number of smaller care homes outweighing more modest growth in the number of larger care homes.

When analysed in isolation, these data tell only a partial story about the residential social care market in England – one that is circumscribed by the regulator’s definition of the same as well as the challenges inherent in linking CQC data to other publicly available and/or open datasets.

The data analysed do not, for example, explore provider registrations with the CQC to track and explain ‘churn rates’ amongst providers⁴. This is a complex issue to the extent that some de-registrations are liable to reflect provider name changes and/or mergers and acquisitions. Others could point to temporary deregistration while refurbishment work is undertaken, financial difficulties or, even, insolvency. Using Companies House data to bolster the explanatory power of the data analysed here would constitute a significant and ongoing task. Others have, however, combined publicly available data with proprietary and survey data from care home developers and operators to explore this in more depth (Knight Frank, 2019).

The publicly available and/or open data we analysed also cannot tell us about the extent to which business might be opting to develop or operate supported living facilities or extra care housing schemes, or whether “deactivated locations” (to use the CQC’s term) might equate to conversion of an existing business to one that is kindred but not regulated or, else, regulated to the same extent by the CQC. In the case of the former, a thorough analysis of planning data is needed. In the case of the latter, it is technically feasible to link deactivation data (which includes postcode data) to planning data published by local government in order to explore the timing of deactivation with, for example, change of use requests. However, the lack of common standards deployed by local government in the generation and publication of planning data currently serves as a barrier to such analysis (at least, until such time as the Ministry for Housing, Communities and Local Government (MHCLG) takes steps to mandate the use of pertinent standards and/or centralise publication of such data).

Since 2014, the total number of care home beds has decreased by over 7,000 (1.6%)

Over the same period, the number of care homes has fallen by around 1,600 (9.4%)



The publicly available data are, then, necessary but insufficient. If the aim is to derive real meaning from them about structural changes to the residential social care sector in England, the publication of more structured, standardised data for the purposes of linking datasets amassed by a number of Government departments and public bodies is essential.

⁴ See ‘Deactivated Locations’ (retrieved 21.10.2019): <https://www.cqc.org.uk/about-us/transparency/using-cqc-data#directory>



Most local authorities have seen a fall in provision from small care homes

Taking 'small' care homes to be those with fewer than 30 beds, the market share of small care homes has been falling over time⁵.

In July 2015, small care homes provided 29% of all beds in England. By July 2019, this share had fallen to 25%.

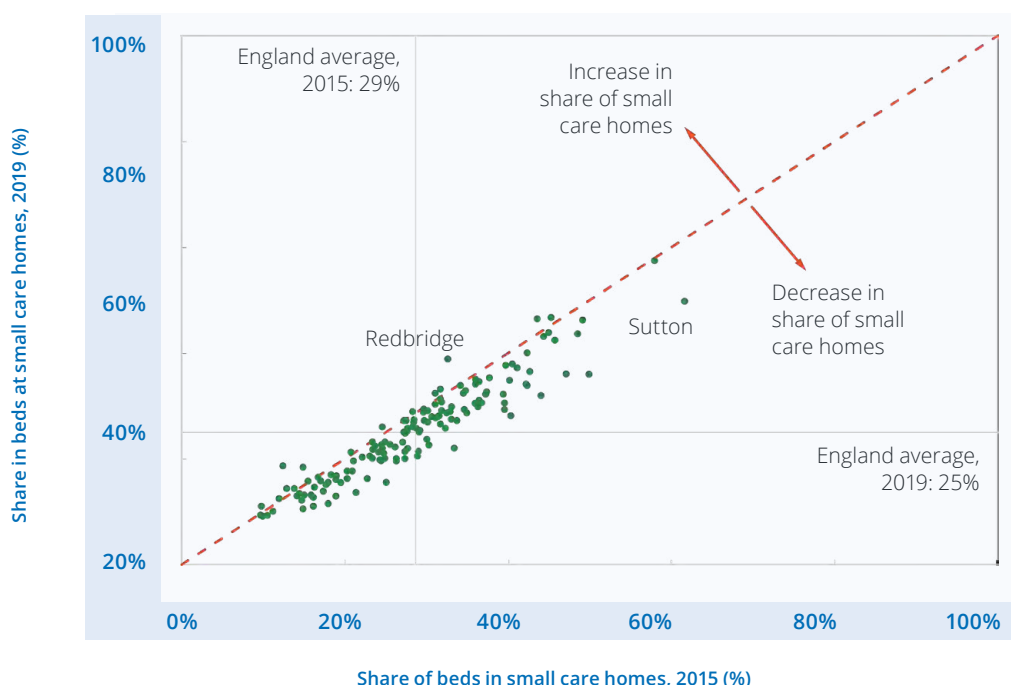
The shift has implications for the quality of care provided in England as per the analysis outlined in Part B of this report.

Broken down by local authority (CASSR), the overall decline in provision from small care homes is broad-based.

Figure 2 plots, for each local authority in England, the share of beds accounted for by small care homes in 2015 and 2019.

Any points (one per local authority) on the dashed line at 45° indicate local authorities for which small care homes account for a similar share of beds in 2019 as they did in 2015. Points below the line indicate local authorities in which provision from small care homes has fallen while points above the line indicate an increase in the proportion of beds in small care homes.

Figure 2: Share of beds provided by small care homes in local authorities, 2015-19



Just 14 local authorities (less than one in ten) have seen an increase in the market share of small care homes, compared to 124 (more than 80%) that have seen decreases.

Note(s): The chart shows small care home bed shares for 147 of the 151 local authorities in England. The chart excludes the City of London (no data) and Isles of Scilly (small; no change). It also excludes the new local authority of 'Bournemouth, Christchurch and Poole', and Dorset (from which Christchurch was redistricted). These changes took place in April 2019 and comparable historical data cannot be constructed readily. Small care homes are defined as those having fewer than 30 beds. Source(s): CE analysis of CQC care directory monthly extracts, July of each year, 2015 and 2019

Figure 2 shows that most local authorities have seen a fall in the share of beds provided by small care homes: most of the points lie below the 45° line. Just 14 local authorities (less than one in ten) have seen an increase in the market share of small care homes, compared to 124 (more than 80%) that have seen decreases⁶.

Across England, the number and share of beds in small care homes, with fewer than 30 beds, has fallen from 29% in 2015 to 25% in 2019. By local authority, most councils (over 80%) have seen a reduction in the share of beds provided by small care homes. Larger care homes have been providing proportionally more beds over time.

⁵A threshold of 30 beds identifies, on average, the smallest 60% of care homes each year. ⁶Nine local authorities have seen relatively little change between 2015 and 2019, as judged by a change of less than 0.5 percentage points between the two years.

Care homes appear to be catering to an increasing range of needs

The CQC publishes data which includes information about individual care homes – amongst it, their ‘service user bands’.

These bands identify the characteristics of the people who use each care home’s services (e.g. older people or those with learning disabilities)⁷. We have used this information as a proxy for the types of care home in operation (i.e. to whom they cater). Service user bands are, however, crude in the sense that care homes can list multiple bands and there is no indication in the CQC data of how many beds might be available/used for each purpose or in what combination. For example, a care home may have 20 beds and list older people and those with dementia as its service user bands.

We cannot know from this precisely how many:

- older people are catered for;
- people with dementia are catered for; and
- people are catered for who fall into both categories

All we can say is that the care home provides for people with one or more of the listed characteristics. The implication of this overlap is that, if we were to add up all beds in care homes listed for older people and add that number to the sum of all beds in care homes listed for those with dementia, the combined

figure would exceed the total number of beds in England. There is, then, double counting. Nevertheless, we can use the information about service user bands to identify the number of beds that are, in principle, available for different purposes.

Table 2 shows the total number of beds (‘All’) as well as the number of beds in care homes that provide for, in turn: older people, those with learning disabilities and those in need of care for mental health. There are many service user bands in the CQC data and we have chosen these three to highlight users who represent the traditional conception of social care (older people); a form of provision that is of growing concern to at least some councils (learning disabilities); and a service that has seen marked growth in provision over time (mental health).

While the total number of beds has fallen gradually over time, the number of beds in care homes reporting that they cater for older people has risen, from 397,440 in 2012 to 408,439 in 2019. This equates to a 2.8% increase in beds for older people against an overall decline of 1.5% for all beds in England. Consequently, almost 90% of beds are in care homes that now say they provide for older people.

There has been a 2.8% increase in beds for old people, whilst all beds in England have declined by 1.5% overall.

Table 2: Beds by selected service user band, 2011-19

	2011	2012	2013	2014	2015	2016	2017	2018	2019
All	452,048	463,649	463,494	463,752	462,650	461,313	460,186	458,844	456,545
Older people	383,907	397,440	399,693	401,728	402,397	403,644	407,333	408,823	408,439
Learning disabilities	65,276	67,607	67,343	68,016	68,066	68,231	67,950	67,140	66,524
Mental Health	77,532	82,702	83,516	85,279	88,120	91,140	94,867	97,728	100,490

Share of ‘All’ (%)	2011	2012	2013	2014	2015	2016	2017	2018	2019
Older people	84.9%	85.7%	86.2%	86.6%	87.0%	87.5%	88.5%	89.1%	89.5%
Learning disabilities	14.4%	14.6%	14.5%	14.7%	14.7%	14.8%	14.8%	14.6%	14.6%
Mental Health	17.2%	17.8%	18.0%	18.4%	19.0%	19.8%	20.6%	21.3%	22.0%

Note(s): ‘All’ is the sum of care home beds and matches the totals in Table 1. The other rows list selected service user bands and the number of beds in care homes that indicate that they cater to such users. Service user bands are declared at a care home level and care homes can list multiple bands. There is then scope for double counting because a care home may list, for example, both older people and learning disabilities: the beds would appear in both rows of the table. Sources(s): CE analysis of CQC care directory monthly extracts, July of each year, 2011-19.

⁷Further explanation of how care homes identify their service user bands is available from the CQC website: <https://www.cqc.org.uk/guidance-providers/registration-notifications/applying-new-provider-guidance#69>.

In contrast, the number of beds in care homes providing for those with learning disabilities was stable between 2014 and 2016 but has since fallen. From a peak of 68,231 beds in 2016, there were 66,524 beds in 2019. This is a reduction of some 1,700 beds (2.5%) and could well reflect implementation of the Department of Health and Social Care's 'Transforming Care' policy (NHS England, n.d.).

Mental health provision appears to have surged over the period covered by the CQC data, rising from 82,702 beds in 2012 to over 100,000 beds by 2019. This is an increase of almost 18,000 beds (21.5%). In the context of the overall decline in care home beds, the share of beds in care homes with mental health provision has grown from around 18% in 2012 to 22% in 2019. However, here, we would advise caution reflecting upon our earlier note about double-counting in the available data because nearly all other service user bands identified in the CQC data saw increases in the number of beds. In a period in which the total number of beds has declined somewhat, care homes would appear to be providing services to cater to a greater variety of needs. This is consistent with the idea that there is greater pressure from commissioners for care homes to take on people with more complex needs (Care Quality Commission, 2018) but could also reflect the development of larger care homes.

While there has been a decline in the total number of care home beds in England, there are more beds in homes that care for older people. This feature, of an increasing number of beds in different service user bands, despite an overall fall in bed numbers, seems to be the case for many of the service user bands defined by the CQC. This suggests a growing need for care homes to cater to an increasing range of needs. The growth in mental health provision has been one of the most rapid in this regard, whereas there has been a decline in the number of residential beds provided for people with learning disabilities, and despite the double-counting which impacts the underlying data here.

In contrast with beds for older people, beds for those with learning disabilities were stable but have now seen a reduction of

2.5%

Mental health provision appears to have surged over the past seven years, seeing an increase of

21.5%



Private companies are increasingly dominant, while not-for-profit provision declines

The CQC data list individual care homes alongside the provider organisation which operates them.

There are other pieces of information in the CQC data from which we can infer the 'type' of those providers (i.e. whether they are part of the private, public or not-for-profit sectors). We have derived this classification from the information in the CQC data. The accuracy of the classification depends on the extent to which the underlying data are coded consistently⁸. The data to construct a classification are available from 2015 onwards but, as **Table 3** shows, there is a break in the data between 2017 and 2018, when more information becomes available.

From 2018 onwards, it is possible to construct a breakdown that comprises:

Private providers into Companies House-registered providers, partnerships & individuals (three subcategories);

Public providers into 'predominantly councils' and hospitals (two subcategories)⁹

Not-for-profit providers into those either registered as companies or not; and registered societies (three subcategories)¹⁰.

Before 2018, the CQC data did not include a field for ownership type (individual, partnership, organisation or NHS body). The absence of this field restricts the number of distinct provider types we can identify before 2018 to private companies (only those registered with Companies House); not-for-profit providers (charities), split into those registered as companies and those not; and not-for-profit registered societies. All other types fall into the 'unclassified' category of **Table 3**. Further detail about our classification can be found at Appendix 1.

We note that the number of beds and care homes that go unclassified in 2017 is greater than the corresponding number of each in 2018 across private individuals and partnerships, predominantly councils and hospitals:

Beds

2017: 61,058 unclassified

2018: 46,663 across private individuals and partnerships, predominantly councils and hospitals

Care homes

2017: 2,677 unclassified

2018: 2,299 across private individuals and partnerships, predominantly councils and hospitals

The change in bed numbers between the two years is significant and coincides with a marked increase in provision by private companies.

These shifts are larger than the overall mild decline in total beds between the two years and further investigation would be needed to understand how much of these changes reflect true developments in the sector and how much is due to changes (corrections) in the coding of CQC data. Comparisons between 2015-17 and 2018 onwards at the highest level of detail (greatest number of provider type categories) should therefore be made with caution.

Nevertheless, **Table 3** highlights the dominance of private companies (which, here, excludes care homes run by partnerships or individuals). As of July 1st 2019, private companies operated 69% of the care homes and almost 77% of the beds. This implies a larger average care home size than other provider types: 32.3 beds per care home in 2019 compared with 22.0 for all other care homes. Taking the not-for-profit sector as a whole, between 2015 and 2019 there has been a decrease of close to 600 homes and some 7,400 beds.

Consequently, the not-for-profit sector's share of beds and care homes has fallen:

- Beds from 15.1% in 2015 to 13.6% in 2019
- Care homes from 19.6% in 2015 to 17.5% in 2019

Of note is that the number of care homes run by 'Predominantly councils' fell slightly between 2018 and 2019 while the number of beds rose. Here, a similar number of care homes entered this segment as exited it, whether by opening/closing or changing hands, leading to a net change of just four fewer homes. The difference comes about because the 'new' care homes in 2019 tended to be larger than the 'old' care homes from 2018. A significant source of increase in beds in this provider type took place in Surrey, with the expiration of a 20-year lease on care homes operated by Anchor Trust. Those homes have now returned to council ownership.

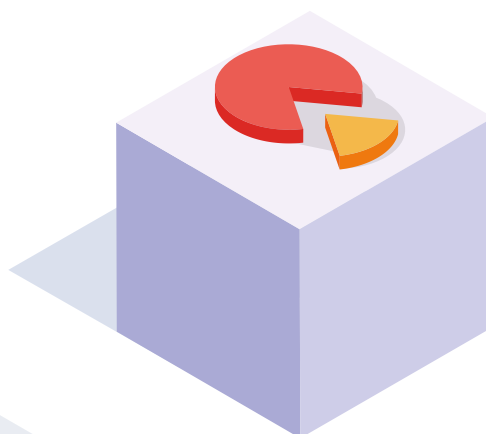
⁸As we point out later, there continue to be at least some inconsistencies in the CQC data in this regard. ⁹As in the footnote to Table 3, the category 'predominantly councils', which we derived from the available CQC fields, seems to include at least some providers that have been misclassified (by our approach using the CQC data directly). Many of them appear to be private companies and at least some appear to have Companies House numbers, but which are not listed in the CQC data. ¹⁰We identify registered societies as those with Companies House numbers but not a charity number. The Companies House number has a prefix or suffix that indicates their status and we group them in the not-for-profit sector because of the way in which they treat their profits. This puts them in contrast to what would otherwise be thought of as the private sector.

Table 3: Trends in provider types, 2015-19

Beds

Numbers		2015	2016	2017	2018	2019
Private	Company	327,578	335,822	332,859	348,166	350,275
	Partnership	-	-	-	19,625	17,898
	Individual	-	-	-	15,203	13,351
Public	Predominantly council	-	892	888	11,102	12,020
	Hospital (mostly mental health services)	-	-	-	733	690
	Charitable company	45,116	44,302	44,411	43,545	38,372
Not for profit	Charity not registered as a company	11,088	10,380	9,418	9,227	9,107
	Registered Society	13,512	12,710	11,552	11,243	14,832
	Unclassified	65,356	57,207	61,058	-	-
	Total	462,650	461,313	460,186	458,844	456,545

Share of total each year%		2015	2016	2017	2018	2019
Private	Company	70.8%	72.8%	72.3%	75.9%	76.7%
	Partnership	-	-	-	4.3%	3.9%
	Individual	-	-	-	3.3%	2.9%
Public	Predominantly council	-	0.2%	0.2%	2.4%	2.6%
	Hospital (mostly mental health services)	-	-	-	0.2%	0.2%
	Charitable company	9.8%	9.6%	9.7%	9.5%	8.4%
Not for profit	Charity not registered as a company	2.4%	2.3%	2.0%	2.0%	2.0%
	Registered Society	2.9%	2.8%	2.5%	2.5%	3.2%
	Unclassified	14.1%	12.4%	13.3%	-	-



Care homes

Numbers		2015	2016	2017	2018	2019
Private	Company	10,384	10,554	10,576	10,803	10,830
	Partnership	-	-	-	916	824
	Individual	-	-	-	875	777
Public	Predominantly council	-	31	30	452	448
	Hospital (mostly mental health services)	-	-	-	56	47
Not for profit	Charitable company	2,304	2,214	2,167	2,055	1,873
	Charity not registered as a company	383	367	337	322	306
	Registered Society	645	595	515	493	556
	Unclassified	3,283	2,906	2,677	-	-
	Total	16,999	16,667	16,302	15,972	15,661

Share of total each year%		2015	2016	2017	2018	2019
Private	Company	61.1%	63.3%	64.9%	67.6%	69.2%
	Partnership	0.0%	0.0%	0.0%	5.7%	5.3%
	Individual	0.0%	0.0%	0.0%	5.5%	5.0%
Public	Predominantly council	0.0%	0.2%	0.2%	2.8%	2.9%
	Hospital (mostly mental health services)	0.0%	0.0%	0.0%	0.4%	0.3%
Not for profit	Charitable company	13.6%	13.3%	13.3%	12.9%	12.0%
	Charity not registered as a company	2.3%	2.2%	2.1%	2.0%	2.0%
	Registered Society	3.8%	3.6%	3.2%	3.1%	3.6%
	Unclassified	19.3%	17.4%	16.4%	-	-

Note(s): While councils make up the majority of the 'Predominantly council' category, manual inspection shows that this also includes some other, non council providers, some of which seem to be in private sector e.g. with a Companies House number, even though this is not listed in the CQC data. That category only has partial coverage in 2016 and 2017 because there is a Companies House-registered entity run by Cumbria County Council. Before 2018, 'Unclassified' covers provider types that could not be separately identified owing to a lower level of detail in the CQC data for these earlier years. This seems to cover private partnerships and individuals; and public providers. Breaks in the series are indicated by dashed vertical lines between 2017 and 2018.

Sources(s): CE analysis of CQC care directory monthly extracts, July of each year, 2015-19.

From the point of view of the three service user bands presented earlier (older people, learning disabilities and mental health), the growth of private companies is apparent throughout these individual segments. **Table 4** again shows our broader grouping of provider types, into private companies, not-for-profits and 'other'¹¹. The table is divided into four parts: the first aggregates the shares of beds from all care homes while the other three report the selected service user bands.

Table 4: Share of beds by broad provider type and service user band, 2015-19

All	2015	2016	2017	2018	2019
Private company	70.8%	72.8%	72.3%	75.9%	76.7%
Not for profit	15.1%	14.6%	14.2%	14.0%	13.6%
Other	14.1%	12.6%	13.5%	10.2%	9.6%
Beds	462,650	461,313	460,186	458,844	456,545
Older people	2015	2016	2017	2018	2019
Private company	73.3%	75.2%	73.9%	77.6%	78.4%
Not for profit	12.9%	12.5%	12.6%	12.6%	12.3%
Other	13.9%	12.3%	13.5%	9.9%	9.3%
Beds	402,397	403,644	407,333	408,823	408,439
Learning disabilities	2015	2016	2017	2018	2019
Private company	61.8%	63.6%	64.8%	67.4%	68.3%
Not for profit	24.1%	23.3%	22.7%	22.2%	21.5%
Other	14.0%	13.1%	12.5%	10.5%	10.3%
Beds	68,066	68,231	67,950	67,140	66,524
Mental health	2015	2016	2017	2018	2019
Private company	77.0%	79.0%	79.2%	81.0%	82.4%
Not for profit	8.9%	8.6%	8.6%	8.5%	7.9%
Other	14.1%	12.5%	12.2%	10.5%	9.7%
Beds	88,120	91,140	94,867	97,728	100,490

Note(s): Private company' exclude private individuals and partnerships (which are grouped in 'Other'). 'Not for profit' comprises providers with a charity number (they may or may not have a Companies House number). 'Other' includes: 'Unclassified' (before 2018); and 'Private individual', 'Private partnership', 'Predominantly council' and 'Hospital' (from 2018 onwards). The discontinuity in the underlying classification is marked with dashed vertical lines between 2017 and 2018. Sources(s): CE analysis of CQC care directory monthly extracts, July of each year, 2015-19.

Table 4 shows a somewhat higher market share for private companies in the segment that caters for older people:

78.4% compared to 76.7% for the market as a whole. The shares of not-for-profit and other providers are correspondingly lower. Noting the caveats about observed trends ('true' versus data/recorded), the number of beds provided by private companies appears to have increased over time, contrasting with decreases in the other two broad provider types.

Private company provision accounts for a smaller share of the market segment for learning disabilities than for other segments but remains the dominant source of care home beds, accounting for almost 70% of the stock. The private company share appears to have risen somewhat over time, whilst provision by other sectors has declined. It is the reduction in provision outside of private companies that has driven the recent overall fall in provision for learning disabilities (a fall of some 1,700 beds between 2016 and 2019). Even so, not-for-profit providers of beds for learning disabilities continue to have a significant presence in the market, accounting for almost 22% of the beds in 2019 (down from 24% in 2015).

¹¹Given the composition of the 'other' category, and the discontinuity highlighted previously between 2017 and 2018, particular caution is advised if attempting to interpret trends in this category.

As noted previously, mental health provision appears to represent a rapidly growing segment of the social care market. It is also a market segment that is dominated by private companies which accounted for over 80% of the beds recorded by the CQC as of July 1st 2019. For some reason, this is a segment in which not-for-profit provision is quite limited (8-9%), but which had been stable until 2019. The CQC data suggest a small but steady increase in not-for-profit beds until the fall in 2019. The growth in provision in this segment has been driven by sustained growth in private company provision.

From what we can infer from the CQC data, there has been an increasing concentration of care home beds in private companies because they have either expanded (older people, mental health) or maintained (learning disabilities) their provision. In contrast, not-for-profit providers seem to be retreating from the market, reducing their provision and, consequently, their market share.

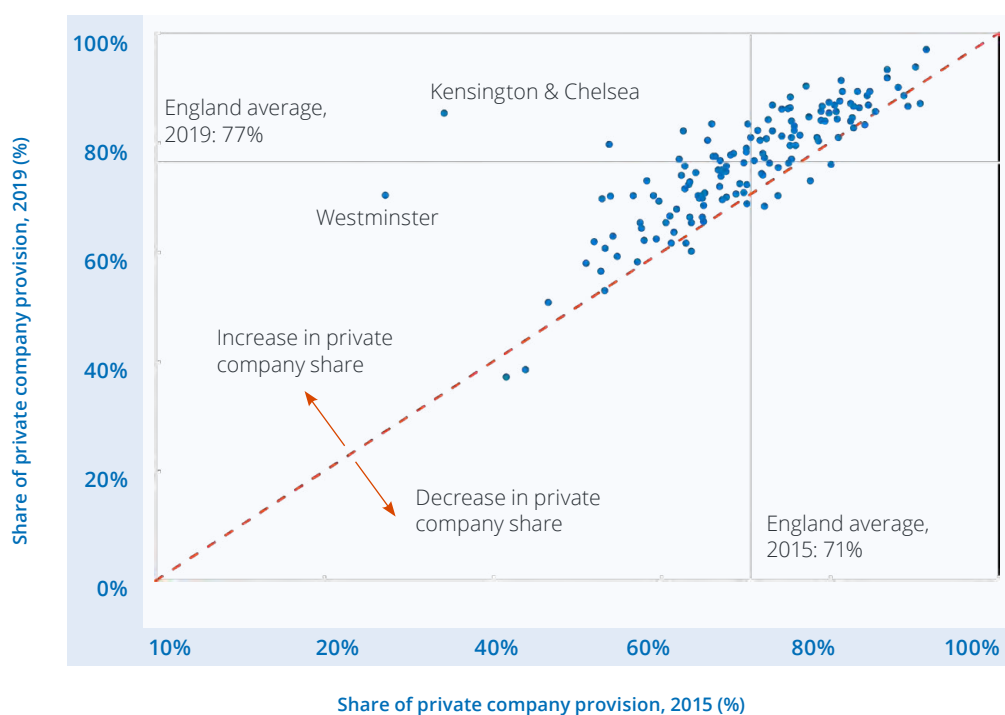


The private company market share has increased in almost all local authorities

The trend of an increase in beds in care homes operated by private companies at an England level is largely mirrored at a local authority level¹².

Figure 3 plots the 2015 share of beds run by private companies against the share in 2019. Here, a point (local authority) that lies above the 45° dashed line indicates an area in which the presence of private companies has increased. As **Figure 3** shows, almost all local authorities have seen an increase in the penetration of private companies (almost all points lie above the 45° line). Just 14 local authorities (less than one in ten) have seen a decrease in the private company share between 2015 and 2019 while 126 (over 80%) have seen an increase¹³.

Figure 3: Share of beds provided by private companies in local authorities, 2015-19



Note(s): The chart shows private company bed shares for 147 of the 151 local authorities in England. 'Private company' excludes private individuals and partnerships (which are grouped in 'Other'). Note that the change in shares here will represent some combination of a shift in the 'true' share as well as likely improvements in CQC data coding over time (leading to more companies being correctly identified as private companies). Source(s): CE analysis of CQC care directory monthly extracts, July of each year, 2015 and 2019.

¹²It is worth reiterating that it is unclear how much of this change can be attributed to an increase in privatisation rather than an improvement in CQC data coverage/quality. ¹³As with Figure 2 earlier local authorities with small changes in the percentage have not been counted as registering an increase or a decrease. Seven local authorities saw a change of less than 0.5 percentage points.

The location of the points in **Figure 3**, in the top-right of the chart, is also revealing because it shows how high private company market shares can be in local authorities across England.

Those private company market shares vary by local authority with, at the extremes:

- as little as 37% of the beds in an area, as is the case in Hackney, where not-for-profit beds account for 41%; and
- as much as 92-97% (effectively all) of the beds, in places like Newham, Rochdale, County Durham, Bracknell Forest and Tameside

While the number of private company beds ranges from around 40% to near-100%:

- nine out of ten councils have shares of 62% or more such that higher market shares are something of a relative concept: in general, private company market shares are high across the country; and
- these figures exclude other forms of private provision (partnerships and individuals) which, while smaller in size, also contribute to private care provision

Figure 4 shows the geographical distribution of the market shares as at 1 July 2019 for private companies (on the left) and not-for-profits (on the right)¹⁴. Elevated market shares for private companies can be seen in the East of England, much of the West Midlands, parts of the East Midlands, parts of the North West and parts of the North East. While not entirely a mirror image, the right-hand map of not-for-profits shows higher market shares in a region that straddles parts of the West Midlands, South West and South East.

**In Hackney, privately
provided beds
account for**

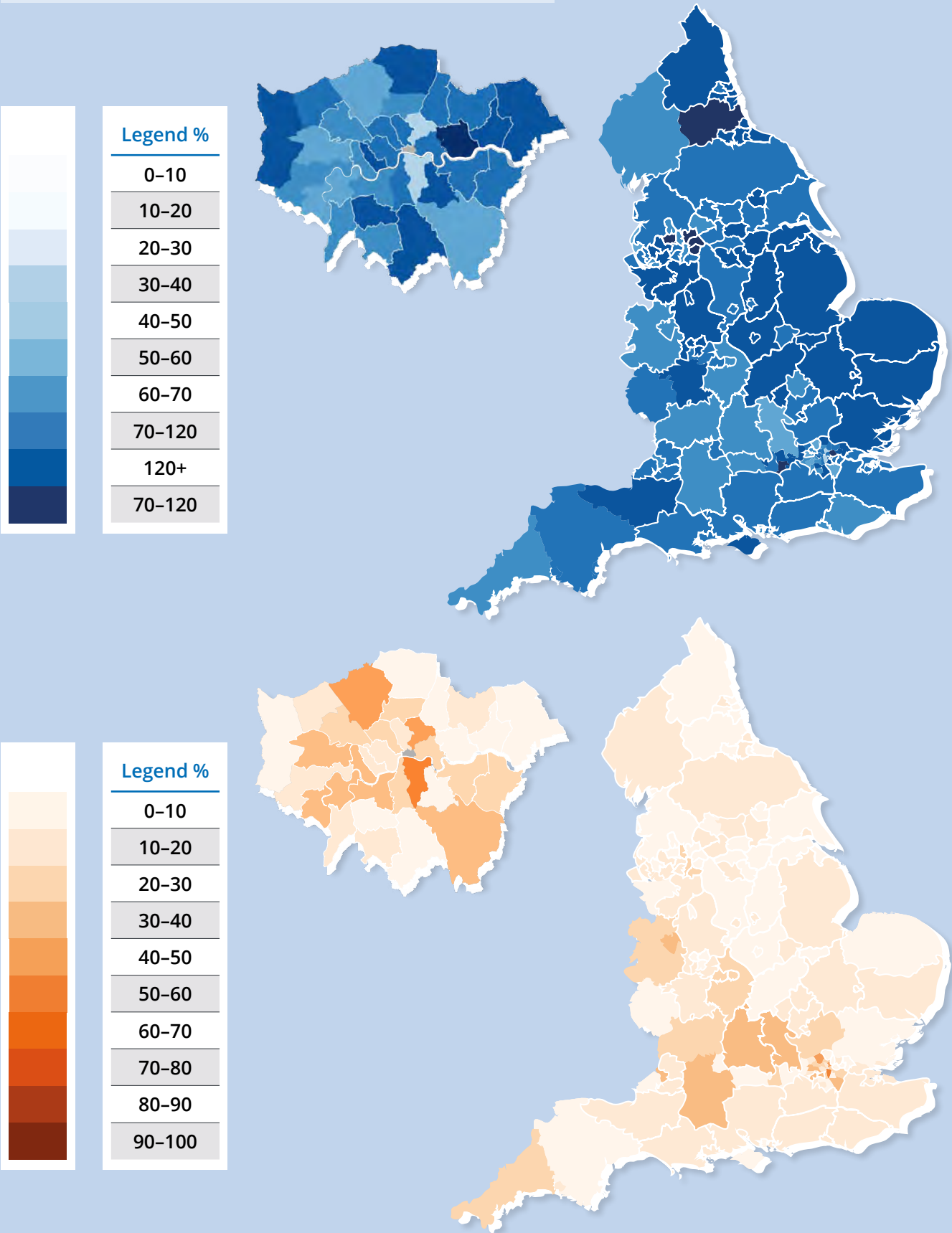
37%

**Privately provided
beds account for
92-97%
of the beds, in places
like Newham, Rochdale,
County Durham, Bracknell
Forest & Tameside**



¹⁴Results for other private providers and the public sector are not shown owing to low values and lower variation.

Figure 4: Market shares by beds of private companies and not-for-profits, 2019



Note(s): Not shown: market shares of other private providers (individuals, partnerships) and public sector; both of which are much smaller. Source(s): CE analysis of CQC care directory monthly extracts, 1 July 2019.



The market share of private companies in 2019 by local authority ranges from around two-fifths to practically all beds (up to 97%). In most (nine out of ten) local authorities, the market share is at least 62%. Between 2015 and 2019, most local authorities saw an increase in the private company share of beds.

Large providers remain significant but seemingly less so over time

From the CQC data, as well as large care homes, we can identify large providers as those who operate many care homes. Following Burns et al. (2016), we define 'large' providers as those operating at least 50 care homes.¹⁵

Table 5 shows that the number of large providers has been stable over time, at around 19 over 2014-19. From the data, the decrease in 2017 seems in part concerned with some changes in the number of care homes owned by various arms of Bupa Care Homes. While the number of care homes operated by large providers has fluctuated somewhat, the sustained decline of care homes operated by smaller providers means that larger providers account for somewhat more care homes (10.6% in 2019, up from 10.3% in 2015). However, by beds, greater decreases among large providers translate to a falling share of beds over time, from 13.6% in 2015 to 13.1% in 2019.

Table 5: Comparison of large and small care home providers, 2011-19

Number	2011	2012	2013	2014	2015	2016	2017	2018	2019
Large	19	21	21	19	19	19	18	19	19
Small	8,473	8,511	8,411	8,306	8,225	8,069	7,882	7,695	7,574
Total	8,492	8,532	8,432	8,325	8,244	8,088	7,900	7,714	7,593

Homes	2011	2012	2013	2014	2015	2016	2017	2018	2019
Large	1,500	1,797	1,800	1,779	1,746	1,698	1,655	1,687	1,658
Small	16,024	15,947	15,674	15,516	15,253	14,969	14,647	14,285	14,003
Total	17,524	17,744	17,474	17,295	16,999	16,667	16,302	15,972	15,661

Beds	2011	2012	2013	2014	2015	2016	2017	2018	2019
Large	48,955	58,646	63,400	64,151	63,073	63,416	61,818	61,701	59,695
Small	403,093	405,003	400,094	399,601	399,577	397,897	398,368	397,143	396,850
Total	452,048	463,649	463,494	463,752	462,650	461,313	460,186	458,844	456,545

The point about Bupa Care Homes above highlights another layer of organisation above individual providers. Groups of providers may, in turn, be structured into 'brands'. Taking Bupa Care Homes as an example, over 2015-19 our dataset identifies 17 distinct Bupa Care Home providers (here, individual limited companies), not all of which would qualify as 'large' by our definition above. Nevertheless, together, the Bupa brand/group can be considered as a significant operator of care homes in England.

Grouping by brand in this way, **Table 6** seeks to replicate the figures in Burns et al (2016) using CQC data¹⁶. While our figures on bed counts for 2015 come out somewhat lower, the cumulative percentages in the rightmost column are similar: the largest five brands in 2015 accounted for around 20% of the beds. On the same basis, we find that this share has fallen somewhat in 2019, to just under 17%.

¹⁵This threshold is mentioned in Burns et al (2016) when referring to 'large chains of more than 50 homes' (Page 18) ¹⁶The estimate for the total number of private company beds in this one case has been reduced in an attempt to account for at least some of the double counting inherent in our other estimates. This adjustment is a downward revision (reduction) and these figures are thus not directly comparable with other elements of the analysis in this report.

Table 6: Top five private provider brands for older people, 2015 and 2019

2015

Organisation	Total homes	Total beds	Beds as a share of those in private companies (%)	Cumulative
Four Seasons Group	317	17,432	5.9%	5.9%
BUPA Group	222	16,541	5.6%	11.5%
Barchester Healthcare	222	10,669	3.6%	15.1%
HC-One Limited	150	7,756	2.6%	17.8%
Care UK	107	6,806	2.3%	20.1%
Total	965	59,204		
Total private company beds for older people		294,837		

2019

Organisation	Total homes	Total beds	Beds as a share of those in private companies (%)	Cumulative
HC-One Limited	271	16,266	5.1%	5.1%
Four Seasons	214	11,856	3.7%	8.9%
Barchester Healthcare	165	10,559	3.3%	12.2%
Care UK	111	7,462	2.4%	14.6%
BUPA Group	118	6,972	2.2%	16.8%
Total	879	53,115		
Total private company beds for older people		316,338		

Note(s): Table seeks to replicate Exhibit 1 from Page 22 of Burns et al (2016) 'Top five major for-profit providers of care homes for older and physically disabled people, July 2015'. In contrast to the other analysis in this report, the 2019 figures have been checked and adjusted to explicitly account for identified instances of dual registration among what would otherwise (and incorrectly) have been identified as one of the five largest providers. Sources(s): CE analysis of CQC care directory monthly extracts, July of each year, 2011-19.

Large providers - those operating 50 or more care homes - retain a significant share of social care provision but, in terms of numbers of beds, their share has waned somewhat. Similarly, while the five largest brands continue to represent a substantial share of private company provision, they appear to account for a smaller share of beds in 2019 (16.8%) as compared with 2015 (20.1%).

Key At a local authority level, changes in older people's provision do not clearly track changes in population

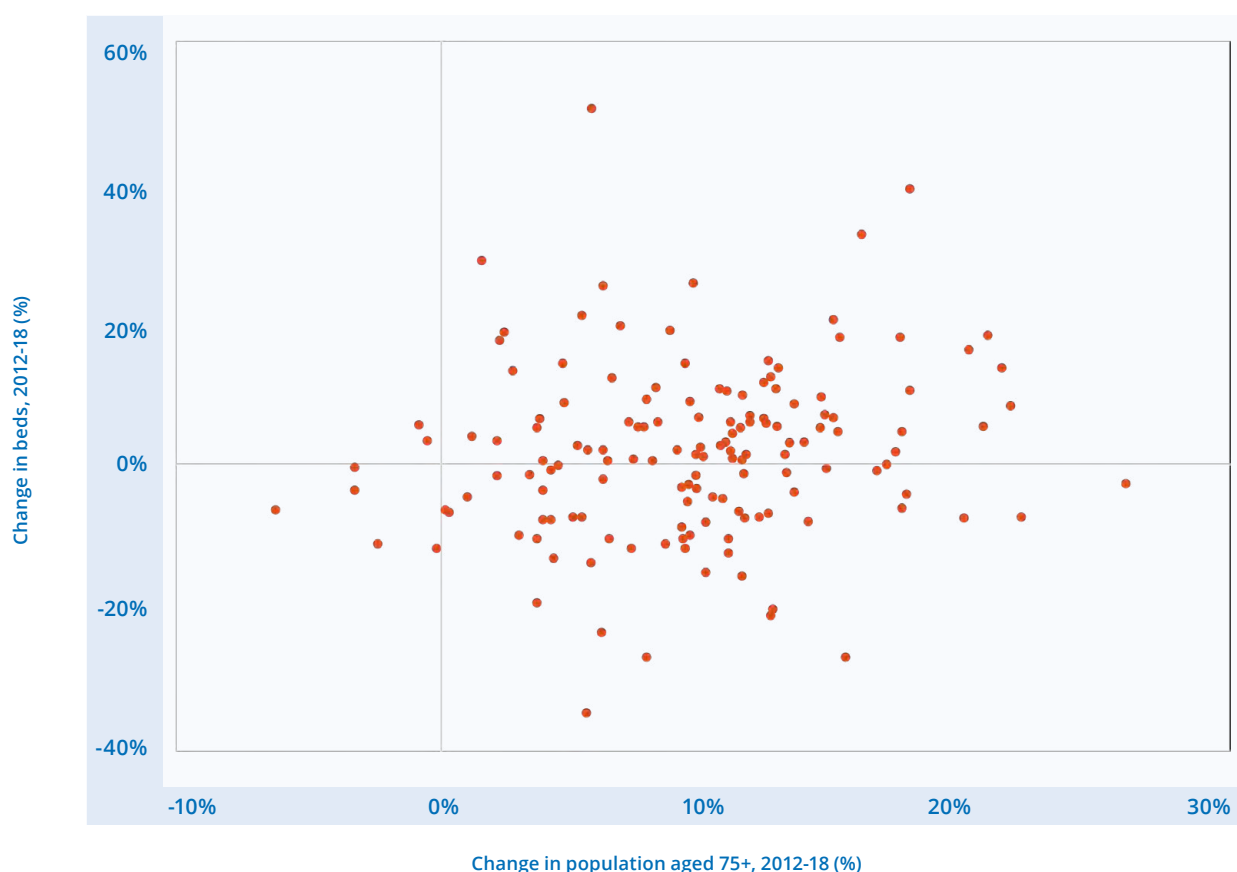
Focusing on older people, the level of provision appears to have increased over time, from 397,440 beds in 2012 to 408,439 in 2019.

This represents an almost 3% increase against the observed fall in total beds in England. Over a similar period, ONS mid-year population estimates suggest that the population aged 75+ in England has also increased, by almost 10% between 2012 (4.2m) and 2018 (4.6m).

Interestingly, while both population and provision have increased at an England level, this association does not clearly show itself at a local authority level. Areas with high growth in the population aged 75+ have not uniformly seen increases in the number of care home beds for older people (see **Figure 5**). Taking an increase in the number of older people as an indicator of need (and noting that, at an England level, provision has also increased), **Figure 5** suggests that it is not necessarily the case that provision is expanding (or contracting) in the areas where the number of older people is increasing (or decreasing).

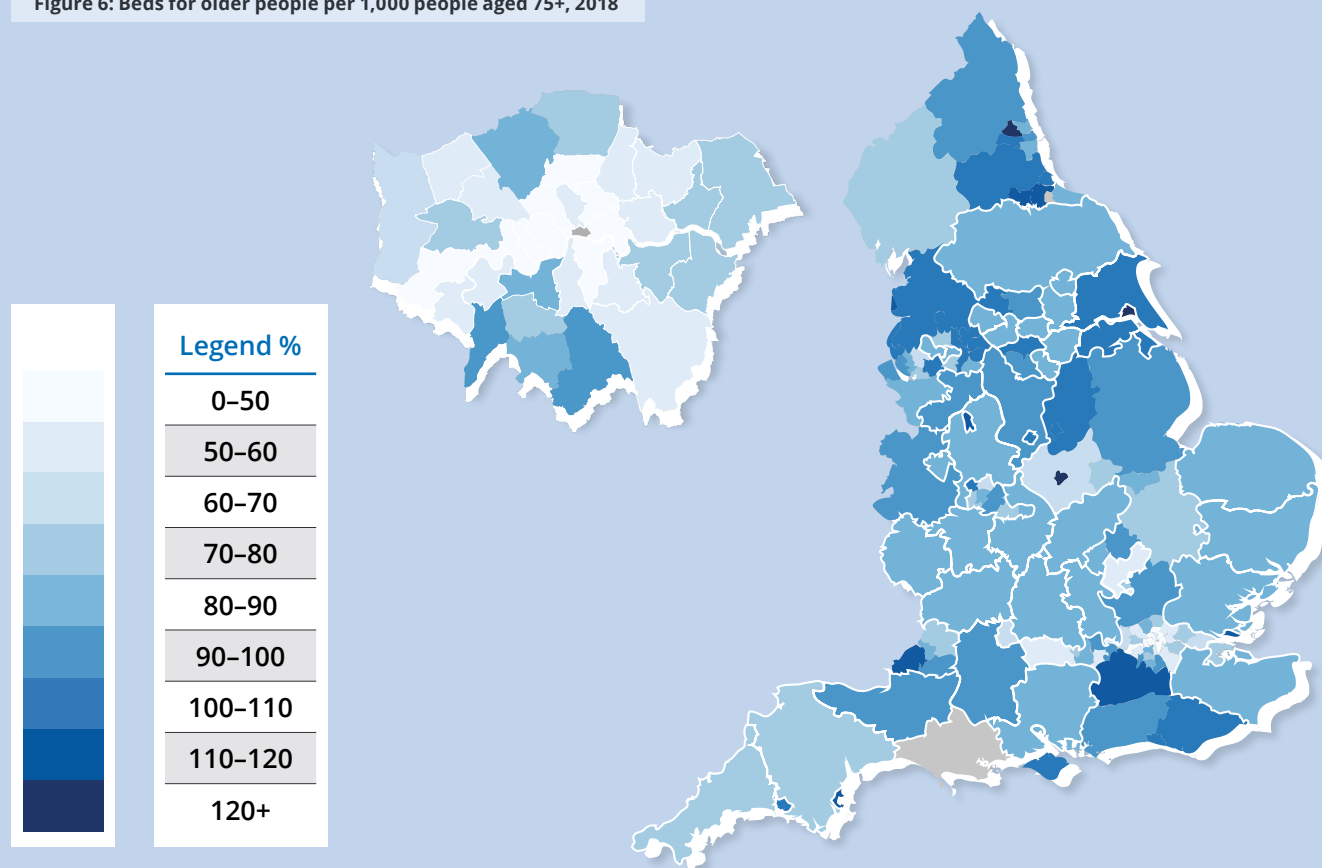


Figure 5: Changes in population aged 75+ and changes in care home beds for older people, 2012-18



The wide variation in provision can also be seen in **Figure 6** - with the number of beds for older people per 1,000 people aged 75+ in 2018 varying from as few as 25 beds to 173 beds. **Figure 5** and **Figure 6** show, respectively: differences in how local supply compares, weakly, to possible changes in demand and that the level of provision also differs across England.

Figure 6: Beds for older people per 1,000 people aged 75+, 2018



Sources(s): CE analysis of CQC care directory, July 2018; and ONS mid-year population estimates, 2018.

Birmingham and Lancashire: further analysis

Further analysis of two areas - Birmingham and Lancashire – illustrates the contrast between locales on a demographic and provision level.

Of note, here, is that:

- Over 2012-18, Birmingham has seen relatively modest growth in its population of older people (aged 75+) when compared to regional and national trends. However, alongside this has been strong growth in the number of care home beds for older people, such that the ratio of beds to older people has increased markedly. This runs counter to the trend observed in both the surrounding areas (the rest of the West Midlands Combined Authority as well as the West Midlands as a whole) and England, in which the ratio has fallen on average.
- Over the same period, Lancashire has seen stronger growth in the population of people aged 75+ and faster than both the regional (North West) and England averages. However, the provision of beds for older people in Lancashire over that period has only increased at a rate in line with the England average. Stronger population growth but slower beds growth means that the level of older people's provision per 1,000 people aged 75+ in Lancashire has fallen, albeit from a high initial level (111.4 beds per 1,000 people aged 75+ in 2012, to 103.6 in 2018). While in line with regional and national trends of a falling ratio of provision for older people, given the expectation of continued strong growth in the future, there might be some questions about the area's ability to provide care in the future if it is not already struggling. Of further concern in the case of Lancashire is that the change in provision over 2012-18 has not been smooth and sustained. Instead, provision grew over 2012-15 before seemingly falling over 2015-18. Despite overall growth over the period, this profile may also signal some concerns about the stability of provision in the county.

Our England-level results paired with deeper analysis of two areas looking at trends in the same data suggests that one or more of the following might be in effect:

- 1 At least some local authorities do not coincide with care markets. One example might be London, in which changes in one borough may need to be understood in the context of the wider region.
- 2 There are differences in health which either manifests as differences in the age at which people need care and/or differences in the level/type of need.
- 3 The CQC data only provides information on stocks (the number of beds in registered care locations). It is not known what the degree of utilisation might be across areas (how many beds are in use and for how long).
- 4 Care needs in some areas are either being met outside of care homes or simply going unmet which might, also, reflect the relative 'vibrancy' or supply in different care markets.

Of the above, the first is plausible as a confounding factor but does not demonstrate statistical significance without detailed individual level data of people's needs, where they live and where they are placed. Some wider care markets of this type are perhaps more obvious than others, but more data would be required to understand the nature and reasons for out-of-area placements. Taking London as an example, the average provision is 85 beds per 1,000 people aged 75+. This compares to the England average of 88.1 despite all but two London boroughs having a below-average level of provision. This result is driven by the much higher number of beds in Croydon: 2,351 beds in 2018 and a ratio of 98.5 older people's beds per 1,000 people aged 75+. The next largest London borough by older people's beds is Barnet (2,245 beds) with a ratio of 85.6. While it is possible that the levels of need in these boroughs are higher, it seems likely that at least some of that provision is intended to cater for people placed from other parts of London. From a caring economy perspective, this then creates a question as to where formal provision can be sited, whether for reasons such as proximity (to either people in need of services or workers) or cost.

Of course, greater dependency between some CASSRs in terms of care home provision is just one candidate explanation for differences in levels of provision. Health needs are another possible explanation.

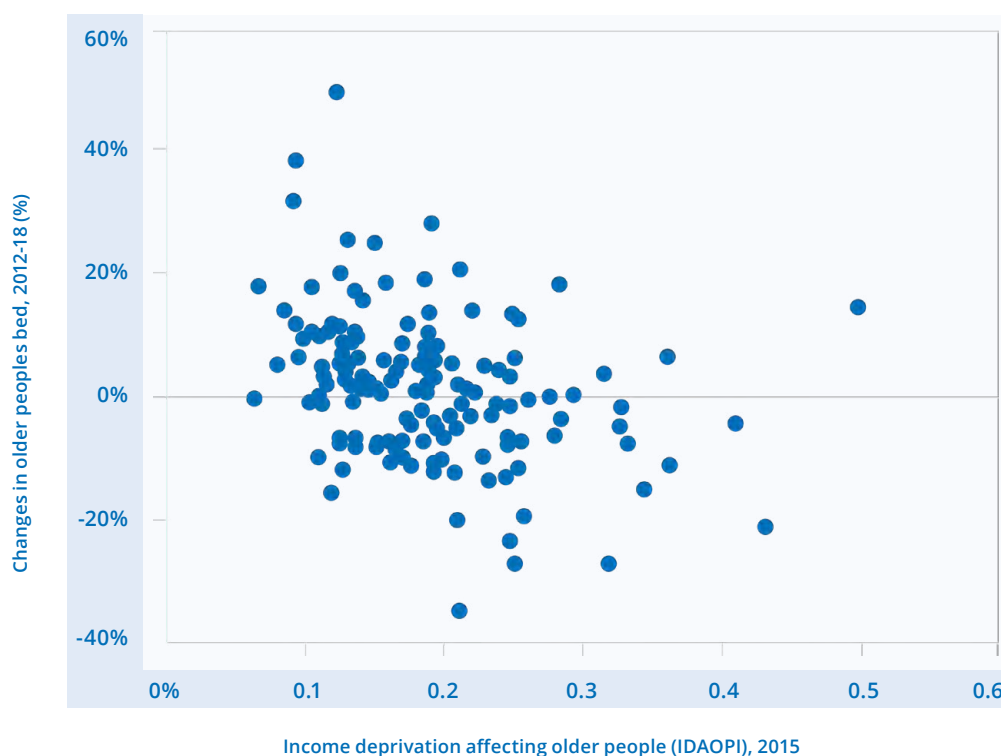
Health inequalities are known to persist across England and with a significant social gradient (i.e. higher deprivation is associated with worse health). This social gradient is perhaps worrisome for a related reason, in that a comparison of changes in older people's beds provision against the older people's income deprivation (from the 2015 English indices of deprivation) suggests a mild association between reductions in provision and higher deprivation (see **Figure 7**).

This is an equality concern but also raises some questions about the availability of care in areas where older people are, on average, poorer such that they may be more likely to fall within the means test for social care while in an area that, for whatever reason, has seen declining provision; once again, analyses of proprietary data lend explanatory power here (Knight Frank, 2019).



Comparisons show there is a mild association between reductions in bed provision for older people and higher deprivation of income.

Figure 7: Older people's Income deprivation, 2015, and changes in beds for older people, 2012-18



Source(s): CE analysis of CQC care directory monthly extracts, July of each year and English indices of deprivation, 2015.

A further reason for possible differences in the level of provision across areas, once set against changes in population, is that the CQC data tell us nothing about the level of care home utilisation (occupancy). Some areas may not have expanded their provision as fast as others because there might once have been spare capacity that has since been taken up. Alternatively, the length of time that people spend in a care home may differ by area. Again, this might affect the extent to which different areas might need additional capacity over time.

The final reason given for a lack of correlation between population and beds is that, in some areas, needs are either being met outside of care homes - whether in other settings or through informal care - or simply not being met at all.

These are aspects of the care system for which there are much less publicly available data and greater reliance on councils' annual market position statements, independent surveys and/or less regular or more expensive data collections such as the Census. This remains a significant gap in our knowledge about wider networks of care provision.

There does not appear to be a straightforward relationship between the change in an area's population and the provision of residential social care – at least, not based upon inferences from the available data.

Possible explanations include:

- geographical differences in the functional social care market compared with the administrative boundaries of councils;
- differing levels of health need across areas (as evidenced, for example, by disparities in healthy life expectancy);
- unknown/unobserved differences in capacity utilisation (bed occupancy); and
- the relative vibrancy of local care markets not captured in publicly available data that is readily analysable.

Summary

This first section took CQC data to assemble a picture of care home provision in England over time. We find an overall reduction in the number of care home beds with less provision coming from smaller care homes and more from larger ones. That shift away from smaller care homes is observed in almost all local authorities.

While the total number of beds has fallen, care homes seem to be catering increasingly for a wider range of needs. A weakness here is that, other than the service user bands that care homes declare, there is scant information about the number and types of people who are accessing different services. We have some idea of the increasing range of needs that care homes appear to be trying to meet but cannot know the precise composition of that need on the basis of publicly available information at present.

In terms of provider structures, the CQC data allow us to infer some information about the type of the provider with varying levels of further breakdown. While we have identified some inconsistencies in the underlying CQC data that preclude a precise mapping of types, the data do suggest at least some retreat from the sector by not-for-profit providers. While there are a substantial number of 'unclassified' providers in the data before 2018, there is a corresponding suggestion that some degree of privatisation has continued, possibly with private companies growing somewhat as private individuals and partnerships wane. That effect appears to be taking place in almost all local authorities in England.

While the data show some evidence of sustained privatisation in social care, it is less obvious that the market is concentrating in the very largest providers. Large providers, which may still fall under the auspices of an even larger brand, continue to be significant - accounting for some 13.1% of beds in 2019 - but that represents a mild decline in their share. Similarly, focusing on provision for older people by private companies, we find that the five largest brands (which may comprise many individual provider companies) continue to represent a large share of the private market (16.8%), but this also appears to represent a decline when compared with earlier years.

While both the number of beds and provision for older people in England have increased, these increases do not necessarily coincide at a local level. It is not necessarily the case that an area that has seen a large increase in the number of older people has also seen an increase in provision. We put forward various reasons why this might be the case, but further analysis would be needed to identify the balance of effects.





Part B

The Performance of Residential Social Care Markets & Provision



Introduction

Having assessed the structure of the residential social care market in England and commented upon the ability to make use of publicly available data to shed light on its stability from various angles, we now turn our attention to the performance of social care providers by size, type and location to see what it might tell us about quality.

There are relatively few measures of performance/quality available with which to assess social care,

and questions we have previously explored remain about the extent to which these measures give a complete view of the state of social care (Future Care Capital, 2018).

We, nonetheless, focus on two indicators of quality available from public sources:

- 1 CQC ratings from individual care home inspections; and
- 2 Social care-related quality of life scores from the Adult Social Care Outcomes Framework (ASCOF).

Here, we first use CQC data and accompanying ratings to see if there are any parts of the market for which quality tends to be higher. Of the above, only the CQC ratings can be linked back to individual care homes and we test the association at a care home level to see how quality might differ by segment as well as at a local authority level to explore whether it contributes additional explanatory value. We then consider whether there might be any association between quality and various local factors at an area level, such as level of private company market share, presence of small care homes and various workforce indicators.

CQC ratings

Alongside information on the individual care homes, the CQC publishes the accompanying ratings from the care home inspections it undertakes.

These follow a four-rating system in, descending order of quality:

- 1 Outstanding 2 Good
- 3 Requires improvement 4 Inadequate

Care homes are rated across five domains, corresponding to the CQC's key questions regarding:

- 1 Safety 2 Effectiveness 3 Caring
- 3 Responsiveness 4 Leadership

An overall rating is then derived from the domains.

The data available from the CQC website are monthly, in line with the snapshots from our care directory, and go back to September 2015. Given that our care home dataset takes the snapshot from July of each year, this means our dataset of quality ratings covers July of each year from 2016 to 2019.



CQC ratings are a lagging indicator of quality

The frequency with which care homes are inspected varies and, by extension, so does the frequency of updates to individual care home ratings.

For example, from the ratings snapshot from 1 July 2019, **Table 7** shows that 26.9% of ratings were updated that same year. A further 64.8% were updated in either 2018 or 2017.

Table 7: Year of last care home rating in 1 July 2019 CQC snapshot

	No rating	2014	2015	2016	2017	2018	2019	Total
Care homes	662	1	12	613	4,447	5,708	4,218	15,661
Share of total	4.2%	0.0%	0.1%	3.9%	28.4%	36.4%	26.9%	100.0%

Sources(s): CE analysis of CQC care ratings, July 2019.

As such, the ratings are a lagging indicator of care home quality, and care homes that are rated poorly are more likely to have another inspection soon - introducing a source of bias into which care homes with certain ratings are reviewed more frequently in keeping with the regulator's remit and focus. This may make it more difficult or slower to identify homes that were previously rated as good or outstanding, but which may now be declining in quality.

CQC inspection coverage and ratings have improved over time

Table 8 summarises the percentage of care home beds each year that are in a home whose current rating was either 'inadequate' or 'requires improvement'.

Those percentages are of care homes that have ratings. For example, as at 1st July 2016, the care homes that had an overall CQC rating represented 75.3% of the care home beds at that point in time. Of those beds, 38.9% were rated either 'inadequate' or 'requires improvement'.

It shows both an increase in inspection coverage over time and a steady improvement in ratings such that, by 1st July 2019, 23% of beds were in care homes rated 'inadequate' or 'requires improvement'. Similar trends can be seen in services for older people and mental health. For care homes catering for people with learning disabilities, there seemed to be a reduction in quality in 2018 (i.e. an increase to 19.2%) before falling once more in 2019 to 17.6%. Compared to the all-beds average, however, quality appears somewhat worse in older people's care and mental health and better for people with learning disabilities.



Table 8: Care home ratings by beds, 2016-19

All	2016	2017	2018	2019
Beds rated inadequate or requires improvement	38.9%	27.9%	26.6%	23.0%
Beds rated	75.3%	90.8%	92.8%	95.7%

Older people	2016	2017	2018	2019
Beds rated inadequate or requires improvement	40.6%	29.4%	28.1%	24.1%
Beds rated	75.7%	90.5%	92.4%	95.6%

Learning disabilities	2016	2017	2018	2019
Beds rated inadequate or requires improvement	28.0%	18.4%	19.2%	17.6%
Beds rated	74.5%	92.9%	95.4%	96.5%

Mental health	2016	2017	2018	2019
Beds rated inadequate or requires improvement	42.7%	29.8%	27.0%	23.9%
Beds rated	75.0%	87.7%	91.4%	94.2%

Note(s): Not all care homes have a listed rating. 'Beds rated' gives the percentage of beds in care homes that do have an overall CQC rating. The shares of beds rated inadequate or requires improvement have been calculated from those care homes with a CQC rating. Sources(s): CE analysis of CQC ratings monthly extracts, July of each year, 2016-19.

The private sector tends to be rated as lower quality, including by service user band

By provider type, quality is highest among not-for-profit providers, with just 16.4% of beds in homes managed by charitable companies, 15.8% of beds in those pertaining to non-incorporated charities and 12.0% of beds with registered societies rated as 'inadequate' or 'requires improvement' in 2019 (see [Table 9](#)).

Public sector providers are also rated well. Higher shares of beds in the private sector are in care homes rated 'inadequate' or 'requires improvement'. Private companies fare worst, with 24.8% in 2019 compared to 20.8% among private partnerships and individuals.



Table 9: Care home ratings by beds and provider type, 2016-19

Beds rated inadequate or requires improvement		2016	2017	2018	2019
Private	Company	41.4%	29.8%	28.4%	24.8%
	Partnership	--	--	27.4%	20.8%
	Individual	--	--	24.8%	20.8%
Public	Predominantly council	32.2%	4.7%	20.8%	17.4%
	Hospital (mostly mental health services)	--	--	22.0%	14.6%
Not for profit	Charitable company	28.6%	20.4%	19.3%	16.4%
	Charity not registered as a company	20.1%	15.0%	16.4%	15.8%
	Registered society	25.7%	17.7%	16.9%	12.0%
	Unclassified	38.1%	27.9%		

Beds rated		2016	2017	2018	2019
Private	Company	76.2%	91.4%	91.8%	95.3%
	Partnership	--	--	98.0%	99.0%
	Individual	--	--	97.8%	98.7%
Public	Predominantly council	48.0%	82.0%	92.3%	90.1%
	Hospital (mostly mental health services)	--	--	60.2%	69.7%
Not for profit	Charitable company	74.3%	93.7%	96.5%	97.7%
	Charity not registered as a company	72.8%	97.3%	98.0%	96.7%
	Registered society	74.1%	96.3%	93.8%	98.3%
	Unclassified	72.3%	83.4%		

Note(s): While councils make up the majority of the 'Predominantly council' category, manual inspection shows that this also includes some other, non-council providers, some of which seem to be in private sector e.g. with a Companies House number, even though this is not listed in the CQC data. Before 2018, 'Unclassified' covers provider types that could not be separately identified owing to a lower level of detail in the CQC data for these earlier years. This seems to cover private partnerships and individuals; and public providers. Breaks in the series are indicated by dashed vertical lines between 2017 and 2018. Sources(s): CE analysis of CQC ratings monthly extracts, July of each year, 2016-19.

By our condensed provider type classification (distinguishing private companies and not-for-profits while grouping everything else into 'other') and broken down by service type, private companies continue to provide more beds that are in care homes rated 'inadequate' or 'requires improvement'; when compared to not-for-profits (see **Table 10**). The gap is widest for mental health - for which private companies account for a high share of the beds: 82.4% - and narrowest for learning disabilities. Because older people's beds count for such a large share of provision, the percentage of beds rated 'inadequate' or 'requires improvement' is similar to (if somewhat higher than) the overall percentages from the earlier tables.

Table 10: Care home ratings by beds and provider type and service user band, 2016-19

Private companies	2016	2017	2018	2016
Older people	42.6%	31.0%	29.6%	25.8%
Learning disabilities	31.6%	21.0%	21.3%	19.5%
Mental health	44.9%	31.3%	28.0%	24.9%

Not for profit	2016	2017	2018	2016
Older people	29.0%	21.5%	20.5%	16.4%
Learning disabilities	16.3%	11.0%	13.8%	12.8%
Mental health	27.8%	20.7%	19.4%	12.9%

Other	2016	2017	2018	2016
Older people	39.7%	28.7%	24.1%	20.1%
Learning disabilities	29.6%	18.3%	16.7%	14.9%
Mental health	38.2%	26.7%	28.2%	22.9%

Note(s): 'Private company' exclude private individuals and partnerships (which are grouped in 'Other'). 'Not for profit' comprises providers with a charity number (they may or may not have a Companies House number). 'Other' includes: 'Unclassified' (before 2018); and 'Private individual', 'Private partnership', 'Predominantly council' and 'Hospital' (from 2018 onwards). The discontinuity in the underlying classification is marked with dashed vertical lines between 2017 and 2018. Sources(s): CE analysis of CQC ratings monthly extracts, July of each year, 2016-19



Small care homes tend to be rated better

Our analysis of the structure of social care provision highlighted a decline in small care homes.

As **Table 11** shows, this may be of concern because small care homes tend to be rated better. Moreover, the pattern of private providers tending to have worse CQC ratings persists when also broken down by care home size.

It is not easy to infer from the available CQC data why these differences exist. It may be that smaller care homes offer more personalisation and diversity than other care homes. If so, this would seem desirable from the point of view of the Care Act (2014) and, in particular, its aim of fostering 'vibrant and stable' markets. In any case, while the datasets available to us do not shed much light on these causes, this is perhaps a secondary concern to the finding that smaller care homes tend to be rated better but are in decline.

Table 11: CQC quality ratings by provider type and care home size (percentage rated inadequate or requires improvement), 2019

		Small (<30 beds)	Large (30+ beds)	All
Private	Company	17.1%	26.9%	24.8%
	Partnership	18.9%	23.2%	20.8%
	Individual	20.5%	21.5%	20.8%
Public	Predominantly council	9.5%	20.4%	17.4%
	Hospital (mostly mental health services)	0.0%	24.6%	14.6%
Not for profit	Charitable company	11.6%	18.9%	16.4%
	Charity not registered as a company	10.7%	17.6%	15.8%
	Registered society	11.1%	12.3%	12.0%
All		16.3%	25.3%	23.0%

Note(s): Small care homes are defined as those having fewer than 30 beds. Source(s): CE analysis of CQC ratings monthly extracts, July of each year, 2016-19

Acknowledging the time lag at which ratings are updated, care home quality appears to be improving over time, with 23% of all beds in 2019 in care homes rated inadequate or requires improvement. Quality of provision is somewhat worse in older people's provision and mental health but better for people with learning disabilities.

By provider type, the larger private sector segment (especially private companies) exhibits lower quality, compared with not-for-profits.

Smaller care homes tend to perform better than larger ones and this pattern holds true once, also, broken down by provider type. Small not-for-profit care homes are among the best-rated providers. However, as our earlier analysis shows, both small care homes and not-for-profits are a shrinking part of the sector.



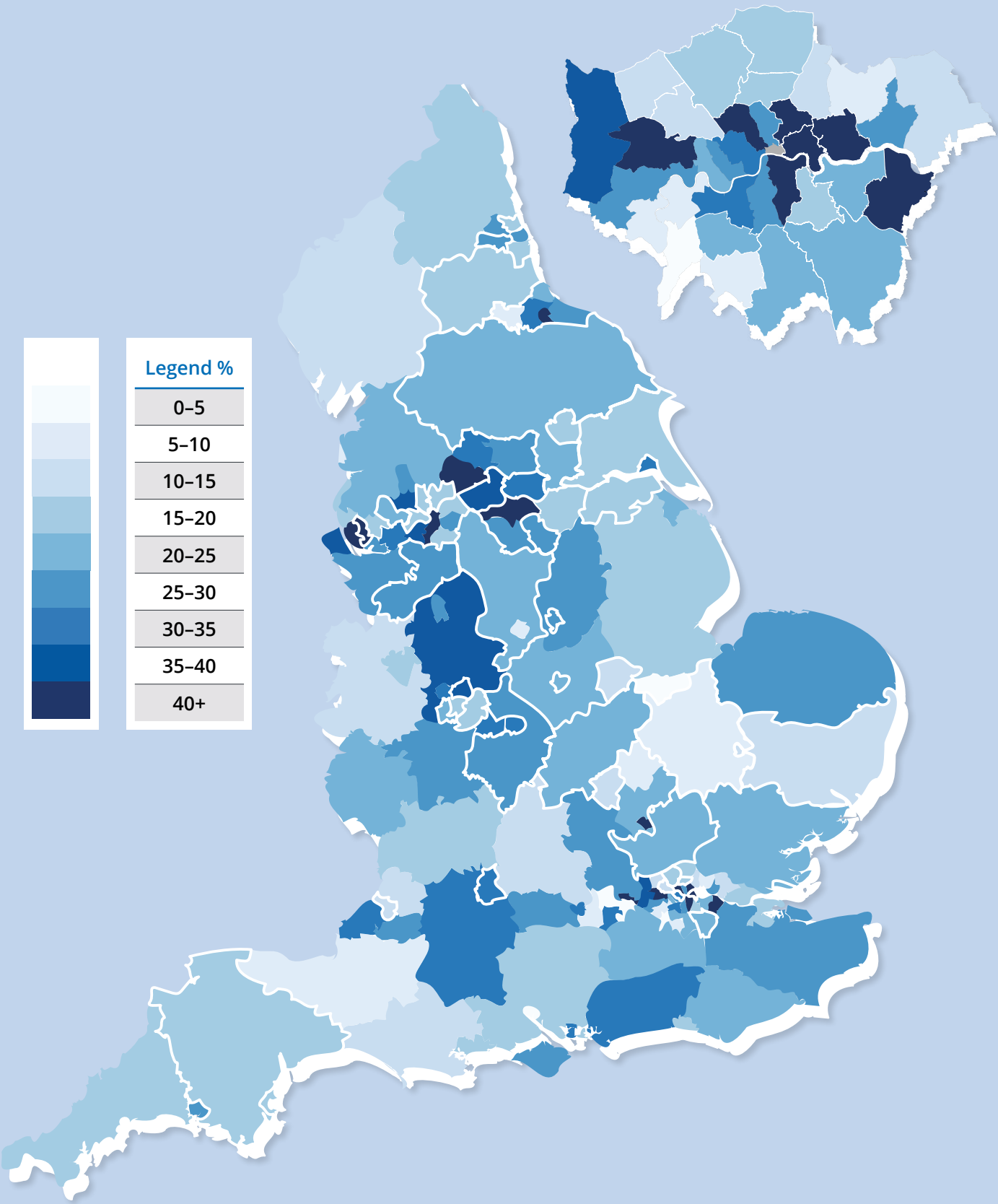
There is substantial variation in quality ratings at a local authority level

As Figure 8 shows, there is substantial variation in quality across local authorities.

Excluding the Isles of Scilly (which has just one care home that is rated good), the percentage of care home beds rated as 'inadequate' or 'requires improvement' is as low as 0.6% in Windsor and Maidenhead, rising to as high as 61.2% for Newham. Compared to the England average of 23%, the East of England and the South West are notable for having lower regional averages for poor quality: 19.2% and 18.5%, respectively. On average, Yorkshire and the Humber has the highest share of beds in homes rated 'inadequate' or 'requires improvement'.

However, this does not necessarily mean that quality in all local authorities in a region is high. In the case of the East of England, for example, Luton has a high share (44%) of beds in care homes rated either 'inadequate' or 'requires improvement'. This does not overly affect the regional average because Luton has the second-lowest number of beds of local authorities in the East of England: just 1,006. Nevertheless, it is indicative of a small caring economy in which formal social care provision is of comparatively lower quality; indeed, this share is the sixth highest of any local authority in 2019.

Fig 8: Share of beds in care homes rated inadequate or requires improvement, 2019 (%)



Sources(s): CE analysis of CQC care directory and ratings, July 2019.

Across regions, the East Midlands, South West and West Midlands show relatively lower variation in quality among constituent local authorities.

In contrast, the variation in quality in London (which is arguably a single care market, rather than its constituent boroughs) is much greater, with areas of:

- higher quality in boroughs like Kingston upon Thames, Richmond upon Thames, Sutton and Redbridge (less than 10% of beds are of poor quality); and
- in contrast, areas of lower quality in boroughs like Tower Hamlets, Camden, Newham (where 45% or more of the beds are in care homes of poor quality).

It is also difficult to identify a pattern in changes in quality by local authority over time. In line with the England-level trend of increasing quality over time (fewer beds in poor quality care homes), more local authorities have seen increases in quality than decreases. Nevertheless between 2017 and 2019 over one-third of local authorities saw an increase in the percentage of beds in care homes rated 'inadequate' or 'requires improvement' (i.e. a reduction in quality).

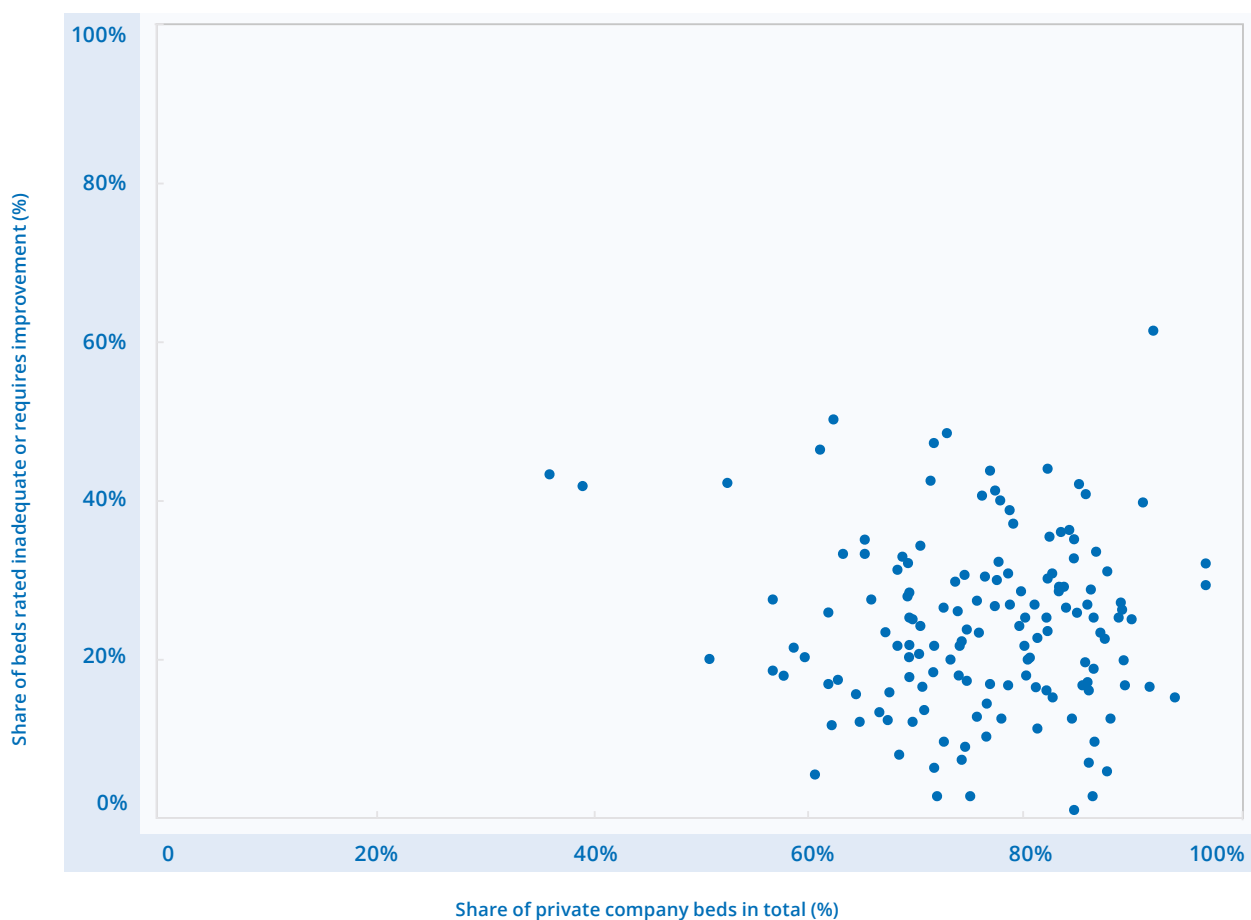


Area-level links to quality are more difficult to establish

From the earlier analysis, private company providers appear to exhibit lower CQC-rated quality compared to other provider types.

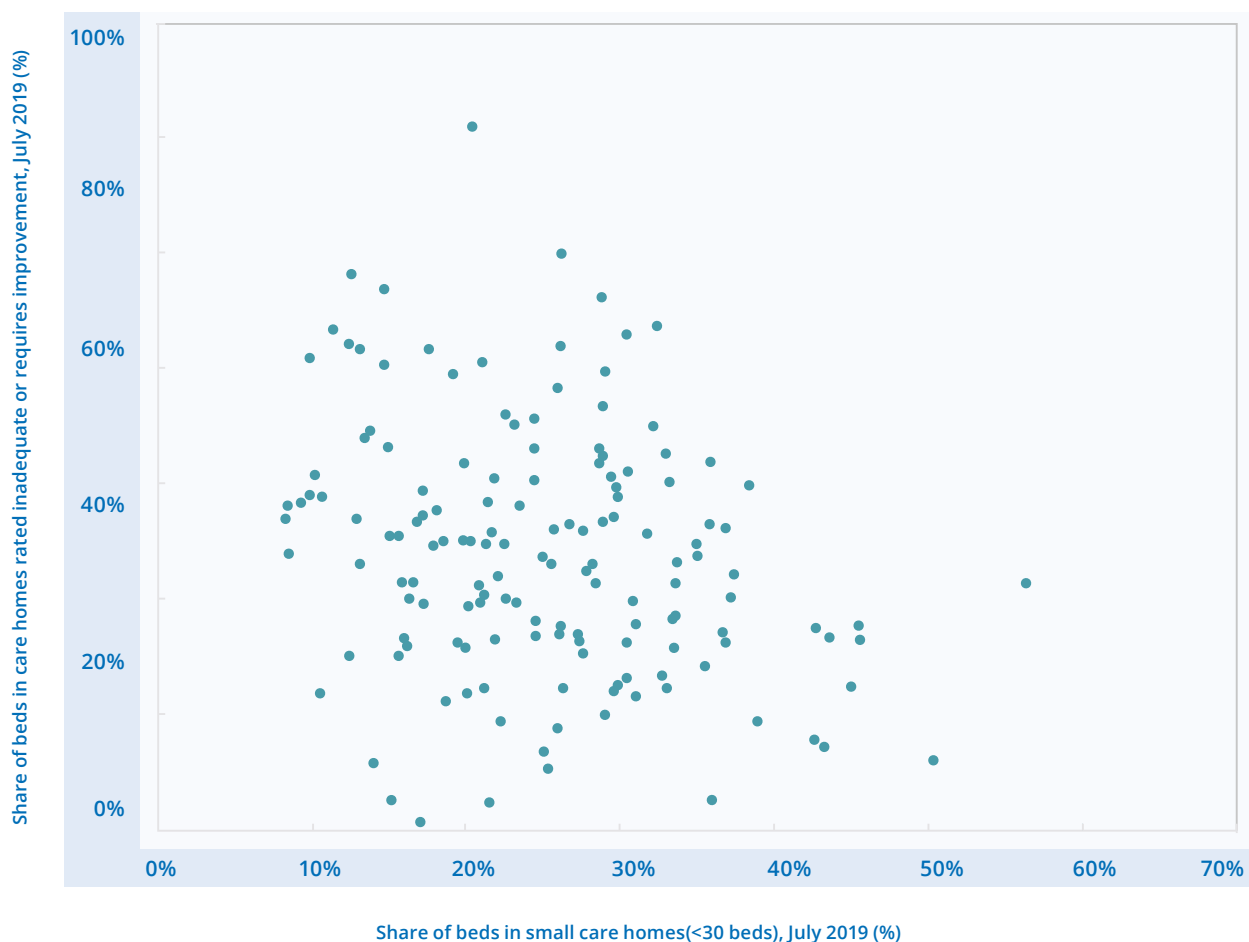
However, it is more difficult to establish that an area with a high market share of private company provision will necessarily have poorer quality on average. **Figure 9** plots, for 2019, the share of beds provided by private companies against the percentage of beds in care homes rated inadequate or requires improvement. From this, there is little indication at a local authority level that a high market share of private companies necessarily leads to lower quality. This may suggest that there are other factors that must be considered to understand local-level variations in provision. However, it may also be that the association is masked by the slow-moving nature of the CQC quality ratings and that it takes time for the effects of market share (structure) to translate into changes in quality.

Fig 9: Share of private company provision and share of beds rated poorly by local authority, 2019



Similarly, while small care homes tend to perform better, it is more difficult to say that areas with smaller care homes are areas that perform better on average (see **Figure 10**).

Fig 10: Share of small care home provision and share of beds rated poorly by local authority, 2019



Sources(s): CE analysis of CQC care directory and ratings, July 2019.

A final set of indicators we tested to explore whether they might correlate with quality were workforce indicators from Skills for Care. Skills for Care publishes local authority-level workforce data derived from the National Minimum Data Set for Social Care (NMDS-SC). While not an administrative dataset, the NMDS-SC does cover a sizeable proportion of care homes.

Of interest here are possible associations between CQC quality ratings (from 2017) and Skills for Care figures (2017/18) concerning:

- vacancies and workforce turnover;
- recruitment from within the adult social care sector;
- social care qualifications; and
- years of experience in adult social care.

However, as with other associations with quality at a local authority level, the relationships were found to be weak. This could reflect variable return rates or the relative 'quality' of data submissions which are themselves, potentially, a by-product of the lack of a requirement for 'data quality by design' from pertinent bodies.

A final set of indicators we tested to explore whether they might correlate with quality were workforce indicators from Skills for Care.

There is substantial variation in quality across caring economies with some areas having high proportions of beds in care homes of poor quality and others with low proportions. Regional averages are closer to the England average, but some regions show substantial variation across their constituent areas.

While there is evidence to suggest that private companies tend to have higher shares of beds rated inadequate or requires improvement, it is less clear that an area with high private company provision necessarily has lower quality provision. The area-level relationship between small care homes and quality is similarly difficult to identify.

At a local authority level, rather than a care home level, it is also not clear that there is an association between CQC ratings and various workforce-related indicators. However, the degrees of association (if there are underlying ones, either way) may be affected by the slow-moving nature of updates to the quality ratings.

Social care-related quality of life

The Adult Social Care Outcomes Framework (ASCOF) is published by NHS Digital and provides an array of measures with which to examine the performance of care and support services at both a national and local authority level.

In this analysis we focus on indicator 1A: social care-related quality of life. One advantage of this indicator over the CQC ratings is that it is compiled and updated on an annual basis, rather than from rolling CQC ratings (the 'lag effect' mentioned previously).

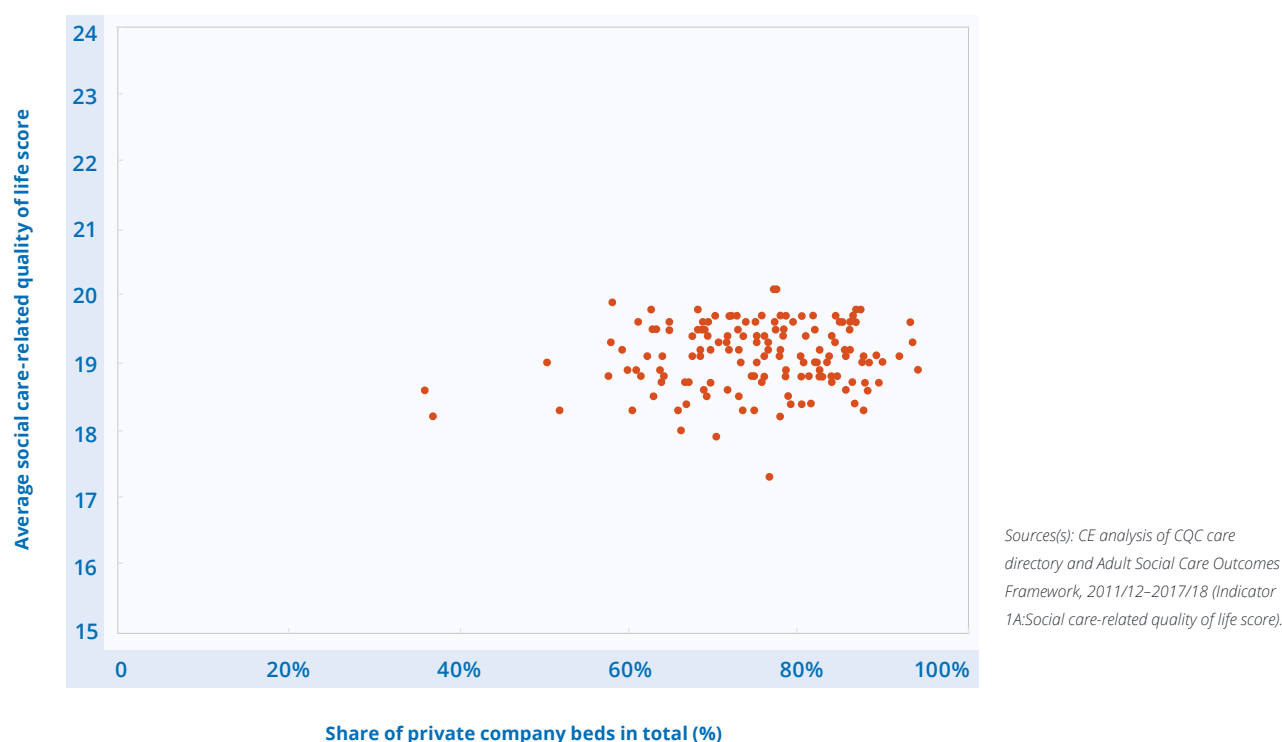
The indicator is an average quality of life score constructed from responses to the Adult Social Care Survey. It combines the responses to eight questions from the Survey, spanning a range of factors including control over one's daily life, personal care, nutrition, safety, social participation and dignity. A higher ASCOF score is better and, between 2011/12 and 2017/18, scores have generally increased over time.

As with the local authority-level relationship between private company market share and CQC ratings, we find little evidence of an association between private company market share and quality of life scores (see **Figure 11**). In this case, there is some suggestion of a positive relationship but, if there is one, it appears weak. One possible reason for a lack of association is that the sample frame for the adult social care survey is restricted to those in receipt of care that involves social services in at least some way. As such, people who pay for their own residential care in full are not covered by the survey.



A higher ASCOF score is better and, between 2011/12 and 2017/18, scores have generally increased over time.

Fig 11: Share of private company provision, 2018, and social care-related quality of life scores, 2017/18



Social care-related quality of life is not obviously related to private company market share but one reason for this may be that the survey that underpins the quality of life measure only goes out to recipients of at least some public provision. Self-funders will be excluded from the measure.

Summary

In our analysis of care home ratings, we identified private companies as those more likely to be rated poorly and public and not-for-profit providers as more likely to be rated better.

This relationship holds when dividing care homes into small and large ones. This may prompt some concern in a period in which both small care homes and not-for-profit providers appear to be exiting the market.

As with the local area-level analysis in the first part, it is more difficult to generalise results to local authorities, with no strong relationship between average quality and various measures of market structure (private care homes; small care homes) or local workforce factors. Again, this suggests a need to dig deeper into the specificities of local areas.

In terms of data quality, we note that the CQC quality ratings are slow to update and that ASCOF quality of life scores only cover a portion of social care. As such, it is still not clear that there are comprehensive and contemporaneous indicators of quality with which to monitor the state of social care in England. These may also be reasons why the associations between quality and other indicators are relatively weak.

A general issue revealed by the analysis is that area-level indicators (rather than, say, care home-level ones) do not exhibit strong associations with other area-level indicators. This could be because there are more confounding factors at work. Alternatively, it may be that such data are not at a level of detail or are not the appropriate unit with which to understand differences in caring economies. Certainly, in the case of care home provision, it would be useful to have more care-home level indicators to better understand the structure of formal care in an area. This is revealed to some extent by differences in quality by provider type and would also benefit more detailed monitoring of the market.



Part C

Financial Risks in Residential Social Care Markets



Introduction

The Care Act (2014) imposed new statutory duties upon local authorities to support the development, functioning and sustainability of markets for social care services working in conjunction with the CQC.

From the Department of Health & Social Care's (2017) guidance on the subject, the three ways to develop and support social care markets are:

- 1. Market shaping:** activities to stimulate a diverse range of services and thus provide choice to people and their carers (i.e. to promote a 'vibrant and stable' market).
- 2. Market oversight:** actions to monitor the performance and finances of social care providers to avoid the drastic consequences for people in care should a provider fail. In particular, the guidance directs councils' attention to large (i.e. hard to replace) providers and to monitor them in such a way as to gain as early a warning as possible of potential failure and this is supported by the CQC's own oversight regime.
- 3. Contingency planning:** to ensure that, should a provider fail, whether financially or in quality-of-service terms, there are contingency measures in place to ensure that people continue to receive the care and support they need.

There is, however, concern about the extent to which public bodies are able to carry out their statutory duties effectively and, not least, given the apparent fragility of some social care markets in England¹⁷. Results from the most recent ADASS budget survey report, for example, indicated that one-third of councils (52) with pertinent responsibilities had seen residential or nursing care providers close or cease trading in the previous six months, affecting an estimated 1,173 people (Association for Directors of Adult Social Services (ADASS), 2019).



In the same survey, 12 councils reported cases of residential or nursing care providers handing back contracts in the previous six months, affecting a further 310 people. Provider failure can flow from poor quality services, provision that is not fit for purpose or excess supply, amongst other things such that it does not always, in and of itself, represent a negative outcome. The growing incidence of residential care provider failure does, nonetheless, raise questions about how market oversight might be improved or supported given both the resource implications for councils and the CQC and, crucially, the human cost implied (Glasby, J., Allen, K., Robinson, 2018).

With this in mind, we sought to utilise open data to develop early warning indicators of providers that may be in financial difficulty ('at risk') because few, if any, organisations have the resources to manually review every provider in terms of its financial circumstances at regular intervals. There is an opportunity for computer-assisted techniques to, at the very least, filter the vast quantities of publicly available data to a narrower, more feasible subset for investigation and, here, we consider the recent rise of machine learning techniques to analyse large datasets as a promising avenue for investigation. If shown to be successful, this could yield a new set of tools with which to aid councils and regulators in discharging their market oversight functions.

There is an opportunity for computer-assisted techniques to, at the very least, filter the vast quantities of publicly available data to a narrower, more feasible subset for investigation.

¹⁷The CQC reported 8,500 domiciliary care services in 2016/17 – around 500 agencies were registering each quarter and 400 de-registering (Care Quality Commission, 2017). The UK care home market saw a slight decrease in the number of de-registered beds (down -4%) and a slight increase in the number of new registered beds (up 2%) in the 12 months to April 2019. The data shows that 219 existing homes and 6,459 beds were de-registered and a total of 133 new homes and 6,502 beds were added to the market. While this resulted in a net loss of 86 homes, the larger scale of new homes delivered meant the UK saw a marginal net gain of 43 beds. (Knight Frank, 2019).

Approach

Spend Network benefits from one of the largest datasets of publicly available spend transactions in the UK and was commissioned to generate as complete a picture as possible of spend data related to residential social care provision by public bodies in England.

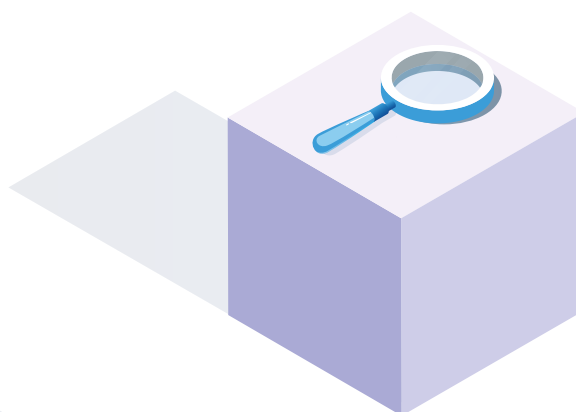
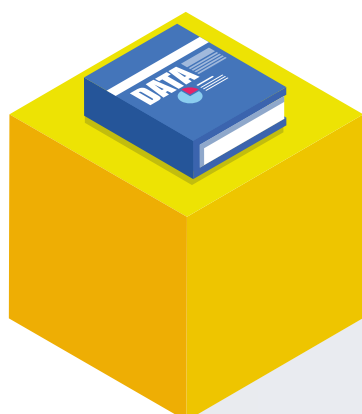
The application of pertinent search terms to its dataset resulted in >1.3m lines of spend data being made available for analysis from the period 2016-19 – representing almost £50bn in public spend – and spanned commissioning on the part of local authorities, the NHS and other public bodies in relation to the full range of social care services (i.e. including residential, domiciliary and other forms of care provision). The significant sums (£10.77bn) attached to NHS spend in the dataset, despite a reputedly poor record in publication of the same, demonstrates its influence upon provider market stability. As such, we believe there could be benefits in NHS Trusts sharing responsibility with local authorities for market shaping, oversight and contingency planning at the local level and, especially, in the context of ‘Integrated Care Systems’.

We asked Spend Network to generate a subset of the larger dataset comprised solely of council spend on social care. Broadly speaking, this resulted in our being able to identify 40% of spend by local authorities when compared with official statistics for the period 2016-19 (NHS Digital 2017, 2018, 2019) – albeit transaction data availability and quality varies across councils. This is because the Local Government Transparency Code utilises a ‘best efforts’ approach, rather than mandating a standard, which allows for inconsistent and, at times, low quality data publication (Ministry of Housing Communities & Local Government, 2015).

This resulted in the generation of a dataset limited to local authority spend but spanning the full range of social care services – whereas, in practice, we sought to focus on residential social care provision. We therefore asked Spend Network to link the council spend it found with care home location data published by the CQC.

For a location you can say with confidence that spend is related solely to residential social care. For providers, this is considerably less likely to be the case. This, in some respects, reflects the range of services they offer, but it also flows from the complexity of relationships between providers which operate integral to group structured companies.

This resulted in ‘match rates’ of transactions and spend which varied considerably from one council to the next – in short, producing a range from 0-35% (full details of which are provided in **Table 19** at Appendix III). However, crucially, there is a greater ambiguity of spend when linking to providers as compared with linking spend transaction data to care home locations. For a location you can say with confidence that spend is related solely to residential social care. For providers, this is considerably less likely to be the case. This, in some respects, reflects the range of services they offer, but it also flows from the complexity of relationships between providers which operate integral to group structured companies.





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Fig.12 Overview of beneficial ownership chain of one large care home provider

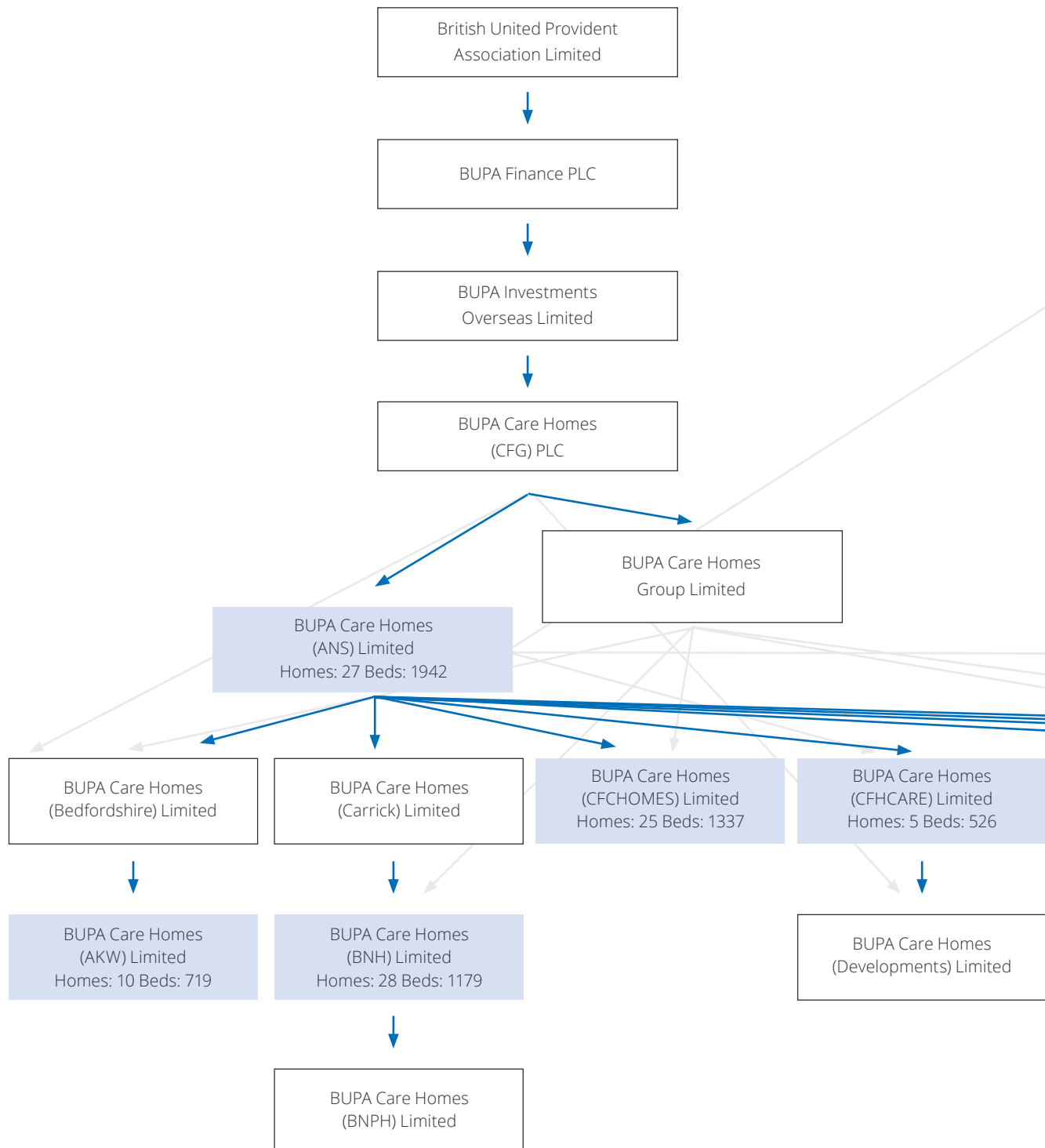
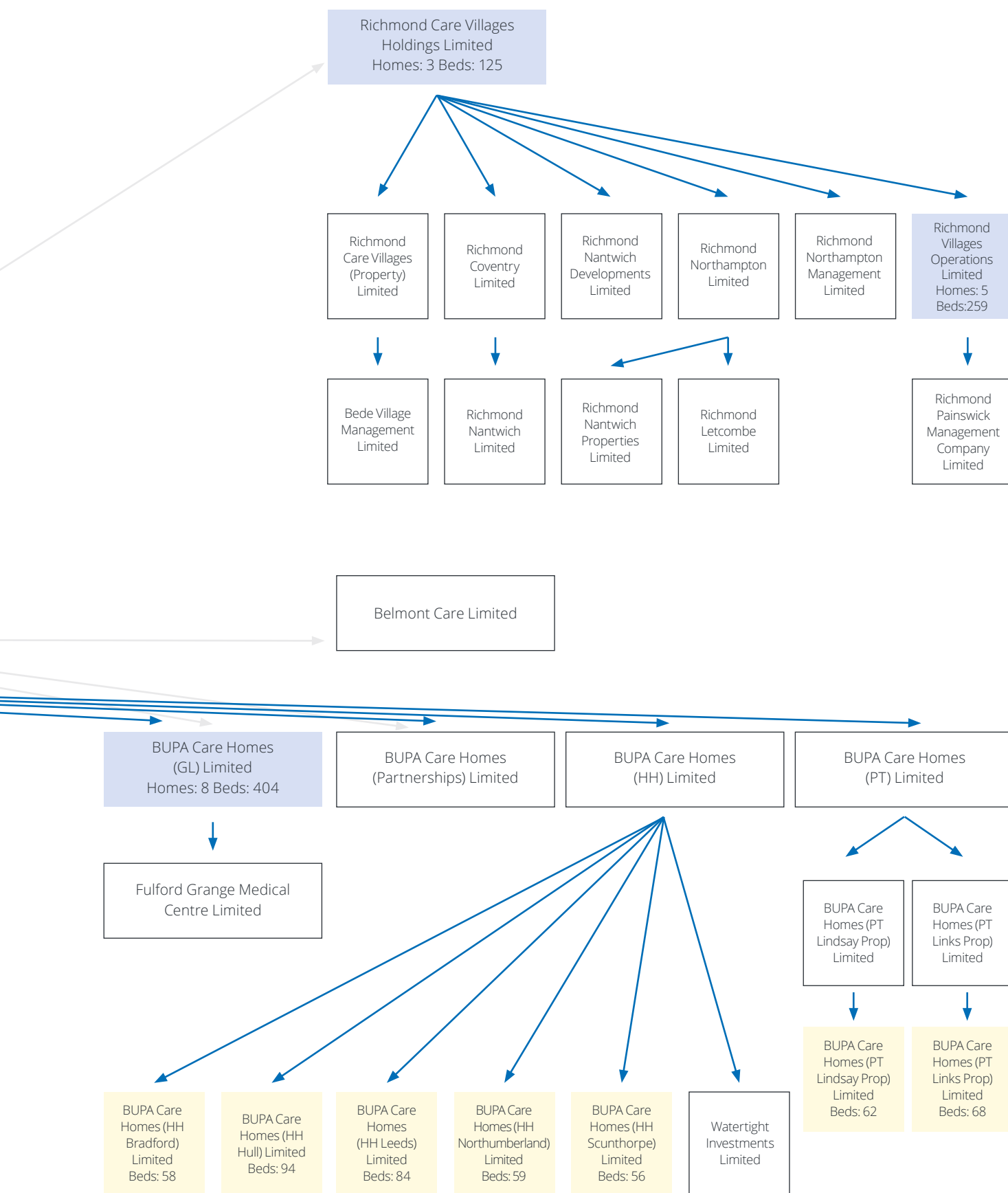


Figure 12 is included to illustrate the complexity of relationships between providers which operate integral to group-structured companies. Blue boxes denote companies which operate multiple care home locations, whilst yellow boxes denote companies that operate single care homes.



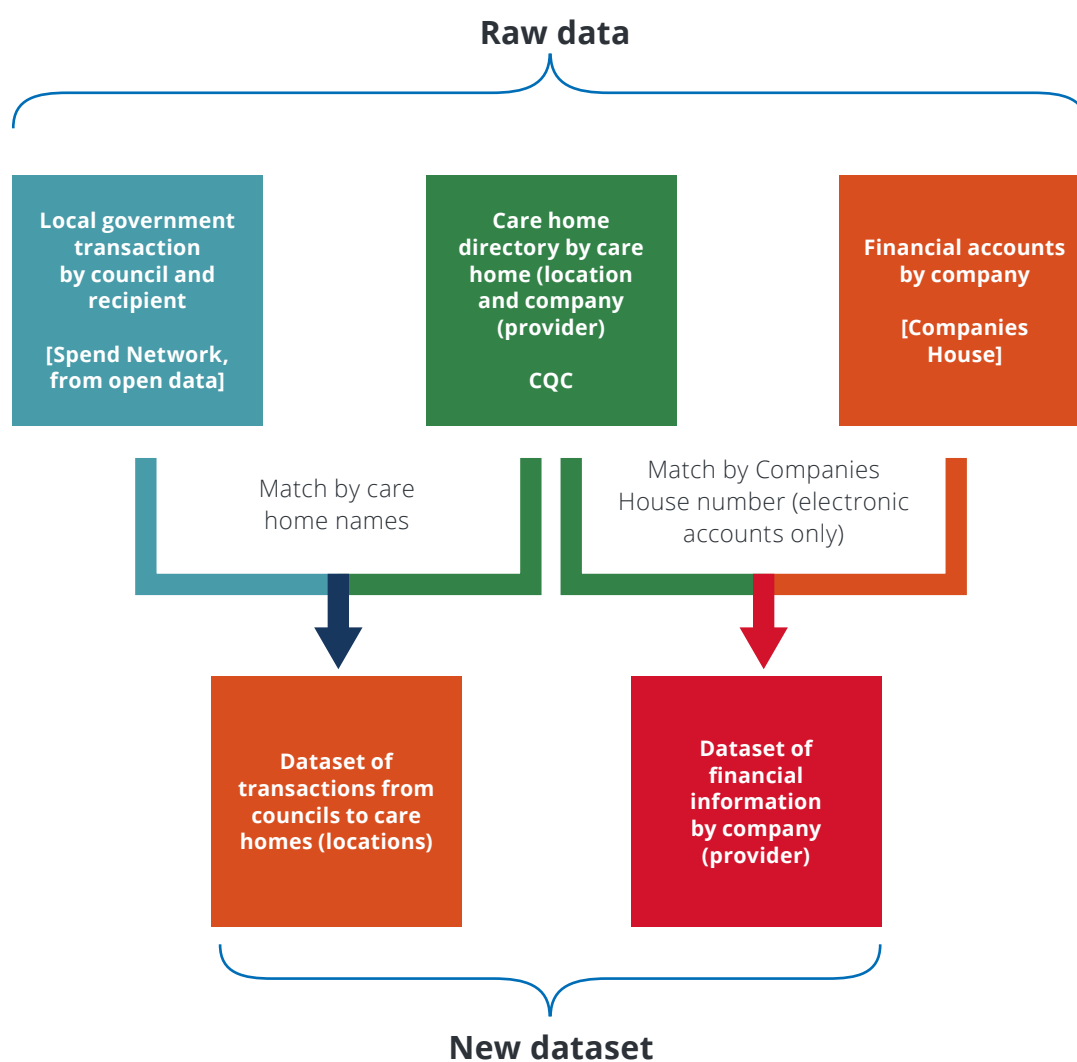
Data sources: The Open Ownership Register of beneficial ownership chains (<https://register.ownership.org/>; retrieved 03.10.19); and CQC care directory monthly extracts, July 201

A more comprehensive analysis can be undertaken to improve the match rates between council spend and residential care home providers but, at present, we are left with a reasonable view of council spend on the full range of social care services¹⁸, a partial view of council spend linked to CQC care home locations, and a circumscribed view of council spend linked to CQC registered providers owing to the reduction of population size with every dataset linked.

This, in turn, means that we cannot readily total the percentage of social care spend by individual councils in England on residential social care provision by provider or provider location without further modelling this data. Add to that the fact that most multi-location provider brands publish accounts in PDF format and employ group ownership structures which result in accounts that consolidate location performance along financial lines – and both make it difficult to develop a data-driven model to assess the extent to which they might be ‘at risk’ relative to single care home operators at present.

It was, nonetheless, possible to isolate a sample of provider locations being paid by local authorities, then, establish the companies that owned them through the CQC data in order to secure accounts for them (which we limited to accounts available from Companies House). Through this approach, we were able to gather sufficient data to undertake an analysis of the financial wellbeing of over 1,350 companies.

Fig.13 Overview of the process to construct a dataset for financial analysis



Further details of this process can be found in Appendix III of this report.

¹⁸ See Table 19 – as compared to the Adult Social Care Activity and Finance Reports for 2016-19 published by NHS Digital (<https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report>). Spend Network identified 43% of spend relating to adult social care in England overall for the same period. This varied considerable between individual councils and ranged from 5% in Wolverhampton, to 97% for Bath & North East Somerset.

Caveat: Accounts

Some accounts use different accounting frameworks and formats which can make comparisons difficult. Group accounts can be particularly complex and often involve intercompany transactions, management and loans. Subsidiaries can be under-capitalised as they often rely on parent company loans, such that they can appear much more (or less) 'at risk' than they really are.

Accounts are often very out of date. Filing is normally undertaken nine months after the year-end and by the time analysis is done the most recent information could be a year or more out of date. While risk issues can be present for the long term, it is often shorter-term issues that can lead to a sudden collapse.

Limitations of Publicly Available Spend Data

The CQC data and the Companies House data were well-formed and made available through an application programming interface (API), allowing us to gather contemporaneous data.

By contrast, the spend data is not formed uniformly to a standard, nor is it up to date. Instead, the data is poorly structured, challenging to interpret and, often, has to be sought using the provisions of the Freedom of Information Act (2000). Councils, too often, allow their publication routines to lapse, some publishers of spend data redact all data about social care, whilst others fail to publish sufficient details of the beneficiaries to link a payment to a register.

It was necessary to use a body of training data to configure a machine learning algorithm that matches details of payees to CQC listings and our processes ultimately matched over 4,300 care home locations to CQC records. In practice, this means that there is no comprehensive list of all the care home locations in receipt of public funds and their owners that is available to researchers, policymakers, commissioners and other interested parties. In addition, there is no indication of when the contracts with these care providers come to an end - nor is there an understanding of the services that individual providers are supplying to the public sector; a situation which is further compounded to the extent that councils have made us aware of >130 categories used to describe the residential social care services they commission.

Our work is therefore based on an extensive sample of social care providers, but not on an exhaustive registry of suppliers to the public sector.

Better data about spending with care providers is needed if we are to improve the data-driven models to support the statutory market oversight duties of pertinent public bodies.



Fiscal analysis

We sought to evaluate 'risk' over a period of two years using five key financial metrics:

- 1 Providers **having both negative assets and negative equity**, combining metrics 2 and 3 below
- 2 Providers **having negative assets**
Over the 2 years these organisations have held greater liabilities than they have assets. This metric indicates that the firm may not have sufficient coverage to service all of its debts, and this has been a persistent position over the sample period.
- 3 Providers **having negative equity** Negative equity indicates the shareholder value on the balance sheet is below zero over the period. Annual losses decrease shareholder value, so this negative equity position indicates that the organisations may have been consistently loss-making over the sample period.
- 4 Providers **having a negative debt to equity ratio trend**
The providers are in the top decile for debt/equity ratio trend of the sample, i.e. they are the highest 10% risers in debt/equity ratio. This indicates these providers' gearing is increasing relative to the rest of the sample, and thus they may be carrying excess risk in their financing position compared to the market.
- 5 Providers **having a negative current ratio trend**
The providers are in the bottom decile for current ratio trend of the sample, i.e. their current ratio is declining relative to the rest of the sample. This indicates that the providers may have unsustainable levels of current liabilities versus the coverage provided by their current assets, and the position is getting worse.

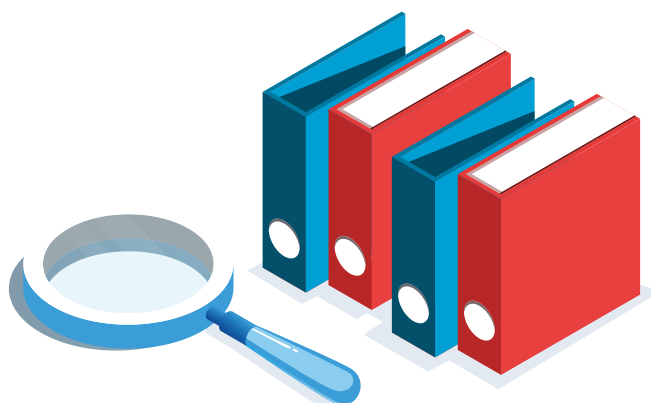
Of the above metrics, the first three are absolute measures that can be assessed on a company- by- company basis. The last two are relative measures, i.e. based on how companies perform relative to their peers. The relative nature of those last two metrics is important because a 'good' or a 'bad' ratio is sector-specific and depends on factors such as the underlying business models, its accompanying financial logic and how far along the business might be in carrying out its investment and strategic plans.

We adopted an approach to defining a provider as being 'at risk', where companies at greatest risk were deemed to have a negative trend in at least one of the first three scores. Those who scored in the bottom decile for their debt to equity ratio scores and their current ratio scores were categorised as being potentially at risk in the near future, should those negative trends continue. This meant that we were isolating not just those with worrying trends in both their equity and assets, but also those whose ratios significantly underperformed their peers during the two-year period. Then, once we had isolated the companies we deemed to be most at risk, we were able to determine where care homes were located, their size and the services that they were providing to the public sector.

Our data-driven tool, developed as a proof of concept, is currently geared towards single care home provider entities (79% of our eventual sample) but can be scaled up from a technical point of view. This is useful to the extent that 5,729 or 75% of CQC registered providers are single care home provider entities, and councils and the CQC currently lack the capacity to monitor them on an ongoing basis. Some single location providers captured in the 5,729 are operated by companies integral to multi-location brands (e.g. there are x 42 single-location providers operating under the 'Four Seasons' brand at the time of writing). At a provider level, 75% of providers currently operate single-location care homes and, together, manage 38% of total beds. The percentage of single-location providers, after those who operate under a multi-location brand have been removed, is 65% and manage 30% of total beds. Notably, the CQC's Market Oversight Team is currently only able to monitor x60 (mixed) domiciliary and residential care providers – covering an estimated 25% of the adult social care market (Care Quality Commission, 2015).

Notably, the CQC's Market Oversight Team is currently only able to monitor x60 (mixed) domiciliary and residential care providers – covering an estimated 25% of the adult social care market (Care Quality Commission, 2015).

It would require further testing over time to validate the metrics/ ratios deployed and would require additional metrics which contribute towards provider stability (e.g. property prices, workforce and quality changes over time), but this exercise is illustrative of the potential for such a tool to be developed in the interests of supporting market oversight activity in future. Further development, training and the capacity to deploy such a tool in practical settings would require additional funding but could significantly expand the scope and improve the efficacy of market oversight activities.



Caveat: Metrics

Whilst our financial metrics are reasonable (especially, given the limited data that can be solicited directly from year-end accounts), it is important to emphasise that anyone using them is aware of associated nuances and their limitations.

For example, negative assets/equity can be as a result of a significant pension deficit, even though the impact on cash flow may be relatively small. Similarly, the approach to the valuation of buildings can vary significantly but impacting net assets/reserves. Smaller providers are, also, more likely to have smaller figures on their balance sheets, so the impact of using ratios mean that variations are likely to be higher. For example, a change of £5k from £20k to £15k has a much larger impact than a £5k movement from £1m, but it does not mean that the change in risk is proportional.

Although we have limited our sample to providers that are registered with Companies House, charity accounts use different rules about recognising reserves. As such, two organisations that might be exactly the same in terms of their underlying position could be reported very differently - even when both are fully complying with the law and accounting rules.

Ultimately, lifting and analysing figures as we have done does not tell the whole story. It therefore needs to be considered integral to a wider “warning system”.

Fiscal analysis

As an illustration of the development and viability of the approach,

Table 12 sets out the results from the fiscal analysis of 1,389 companies described above.

77 companies (5.5%) were found to have a negative trend in at least one of the top three metrics and, as such, are deemed likely to be ‘at risk’. Those 77 companies, taken together, represent 98 (5.3%) care home locations and 2,430 beds (5.5%). A further 295 companies (21.2%) had a negative trend for metrics 4 or 5, indicating that they may be at risk in the near future.

Table 12: Number of companies, care homes and beds at risk in our sample

	Total in sample	Metrics 1-3 (most cautious definition of risk)		Metrics 4-5 (least cautious definition of risk)	
Companies	1,389	77	5.5%	295	21.2%
Care homes	1,860	98	5.3%	392	21.1%
Beds	44,473	2,430	5.5%	8,613	19.4%

We then looked at care homes at risk in our sample by region, care home size and service type. While only indicative of what may be happening at the national level at this stage, what is hopefully clear is that there is some promise to the methods we have developed.

If we extrapolate the findings from our sample to consider the implications of our modelling for England as a whole, 25,205 beds are at risk on the basis of our most cautious definition of risk, and a further 88,907 beds are at risk on the basis of our least cautious definition.

Regional variations

Some variation was found by region in the course of our analysis, with Yorkshire and the Humber having more care homes and beds deemed at risk than other regions, and London having fewer at immediate risk.

Looking at care homes at potential future risk (metrics 4-5), homes in London are however not at lower risk than other regions (except the South West and Yorkshire and the Humber), suggesting that while the immediate risk may be low, there could be 'at risk' providers there in the future.

The result for Yorkshire and the Humber may be of further concern given our finding earlier that, on average, this region has the highest share of homes rated 'inadequate' or 'requires improvement' by the CQC. From a monitoring perspective, some further investigation may be warranted to understand whether poor quality and financial risk may go hand-in-hand in that region. It is worth noting that the proportion of care homes at risk in the South West (4.9%) were slightly below the national average, while the proportion of beds at risk was the second highest of any region at 7.7% (**Table 13**). This could indicate that larger homes may be disproportionately at risk in this region. It is, however, worthwhile stating here that supply, demand and occupancy levels also need to be considered.

Table 13: Number of care homes and beds at risk in our sample

Region		Metrics 1-3 (most cautious definition of risk)		Metrics 4-5 (least cautious definition of risk)	
East Midlands	Care homes	9	4.5%	46	23.0%
	Beds	208	3.8%	1,320	24.4%
East of England	Care homes	11	5.4%	47	23.3%
	Beds	198	4.6%	1,165	26.9%
London	Care homes	3	2.0%	35	23.5%
	Beds	15	0.7%	425	18.6%
North East	Care homes	5	7.6%	9	13.6%
	Beds	99	5.4%	232	12.6%
North West	Care homes	15	5.6%	41	15.3%
	Beds	379	5.4%	1,120	16.2%
South East	Care homes	25	6.8%	64	17.3%
	Beds	593	6.8%	1,464	16.6%
South West	Care homes	13	4.9%	75	27.8%
	Beds	464	7.7%	1,628	26.9%
West Midlands	Care homes	6	3.2%	38	20.1%
	Beds	182	3.5%	814	19.3%
Yorkshire & the Humber	Care homes	11	7.5%	37	25.2%
	Beds	292	7.9%	749	20.2%
Total	Care homes	98*	5.3%	392*	21.1%
	Beds	2,430**	5.5%	8,917**	19.4%

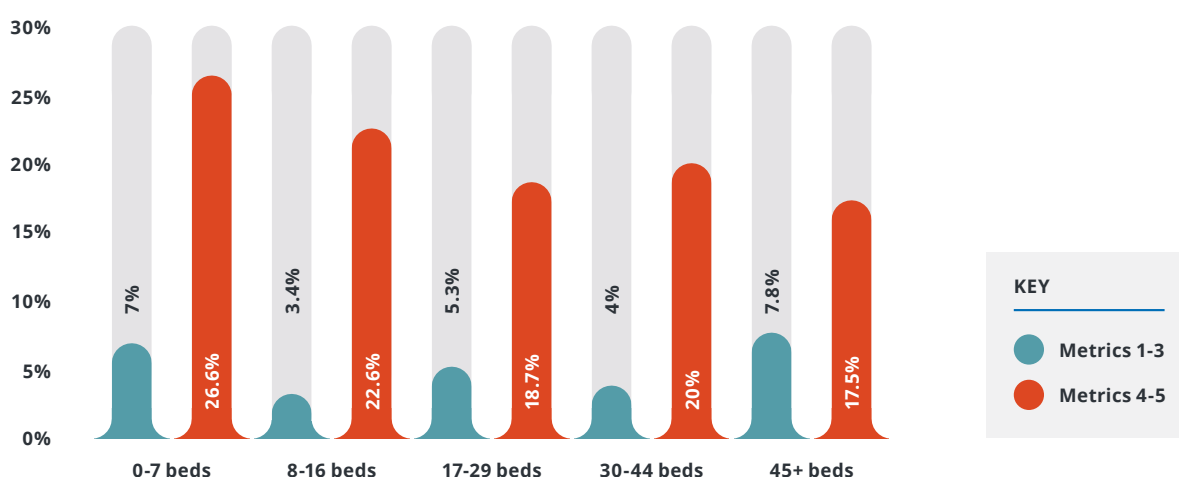
Note(s): * Out of a total 1860 in our sample **Out of a total 44473 in our sample Source: Spend Network analysis of companies' accounts and local authority spend data 2016-19

Size of care homes at risk

In terms of size, both smaller care homes (with 7 or fewer beds) and large ones (with 45+ beds) appear to be at greater risk than others in our sample when looking at metrics 1-3 (see **Figure 14**).

If looking only at metrics 4-5 (i.e. debt-to-equity and current ratios 'worsening' at a faster rate relative to other companies in the sample), there is a clearer relationship with care home size - with smaller homes more likely to be at risk by this measure.

Fig 14: Care homes at risk by care home size in our sample



Note(s): Out of a total 1860 care homes in our sample Source: Spend Network analysis of companies' accounts and local authority spend data 2016-19

Service types at risk

Our analysis found no marked variation in risk by type of residential social care service provision (**Table 14**).

Table 14: Number of care homes at risk in our sample by type of service provided

Type of service	Metrics 1-3 (most cautious definition of risk)		Metrics 4-5 (least cautious definition of risk)	
Care home with nursing	27/ 412*	6.5%	82	19.9%
Care home without nursing	72/ 1467*	4.9%	316	21.5%
Dementia	45/ 904*	4.9%	194	21.5%
Learning disability	29/ 552*	5.3%	132	23.9%
Mental health	33/ 536*	6.1%	111	20.7%
Older people	75/ 1351*	5.6%	273	20.2%
Physical disability	34/ 570*	6.0%	118	20.7%

Note(s): * Number of homes providing this type of service in our sample. Service user bands are declared at a care home level and care homes can list multiple bands. There is then scope for double counting because a care home may list, for example, both older people and learning disabilities. Source: Spend Network analysis of companies' accounts and local authority spend data 2016-19

The challenge when considering the results from our analysis in this way is that there is often and, increasingly, overlap in service categories. That is, a care home thought to be at risk may provide for both older people and those with physical disabilities. Such a care home would be double-counted and appear twice in each of the corresponding rows in the table previous.

Looking only at those considered to be at risk (metrics 1-3), we did however find some variation with regards to region when looking at which services were deemed vulnerable in different areas (**Table 15**). The North East, for example, had the highest proportion of dementia services deemed at risk (9.7%) followed by the South East (7.5%). Yorkshire and the Humber had the highest

proportion of learning disability services deemed at risk (9.5%) followed by the North East (9%). The North East also had the highest proportion of care homes with mental health services deemed at risk (13.3%) (followed by Yorkshire and the Humber and the South East - both 11.4%), and the highest proportion of homes with older people's services at risk (10.4%, followed by the South East at 7.9%). Finally, the highest proportion of care homes with physical disability services deemed at risk was in Yorkshire and the Humber (13.6%).

These patterns match the breakdown of care homes at risk by region (see **Table 15**), which shows the highest proportion of homes deemed at risk overall to be in Yorkshire and the Humber, the North East and the South East.

Table 15: Number of care homes at risk in our sample by service type and region

Region	Dementia		Learning disabilities		Mental health		Older people		Physical disability	
East Midlands	4	3.1%	1	2.2%	3	4.8%	7	4.2%	2	2.4%
East of England	5	5.0%	5	5.7%	4	7.4%	6	4.5%	4	5.9%
London	0	0.0%	1	2.0%	2	2.4%	0	0.0%	1	2.9%
North East	3	9.7%	2	9.0%	2	13.3%	5	10.4%	0	0.0%
North West	6	5.5%	3	5.8%	5	6.1%	13	6.3%	6	7.8%
South East	14	7.5%	8	7.0%	8	11.4%	21	7.9%	5	6.7%
South West	5	4.5%	3	3.3%	3	4.0%	11	5.5%	7	8.3%
West Midlands	4	3.5%	2	4.2%	2	3.3%	5	3.2%	3	3.7%
Yorkshire & the Humber	4	4.9%	4	9.5%	4	11.4%	7	6.3%	6	13.6%
Total care homes at risk	45	5.0%	29	5.3%	33	6.2%	75	5.6%	34	6.0%
Total care homes in sample	904		552		536		1,351		570	

Note(s): Service user bands are declared at a care home level and care homes can list multiple bands. There is then scope for double counting because a care home may list, for example, both older people and learning disabilities. Source: Spend Network analysis of companies' accounts and local authority spend data 2016-19

The overlap in categories make national comparisons of different service types deemed to be more or less 'at risk' challenging. National standards in this regard would go some way towards solving the problem and allow for greater transparency.

Quality implications

Care homes rated as 'Outstanding' by the CQC were the least likely to be deemed at risk in our sample, although we did not factor for quality in our model, and the CQC does not factor for financial risk in assigning quality ratings.

The proportion of care homes at risk (using metrics 1-3) then increased to 5.1% for homes rated 'Good' and 7.1% for homes rated as 'Requires Improvement' (Table 16). Notably, the proportion of care homes deemed at risk decreased to 4.2% for those rated as 'Inadequate', although this pattern does not hold when looking at homes which may be at risk in the future (metrics 4-5). For metrics 1-3, care homes without a rating were as likely to be at risk as those rated 'Requires Improvement' (7.5% of homes without a current rating).

It is worthwhile reiterating that CQC ratings do not represent a contemporaneous picture of quality across the sector. This is because of the time lags associated with updates to the ratings.

Care homes rated as 'Outstanding' by the CQC were the least likely to be deemed at risk.



Table 16: Number of care homes deemed at risk in our sample by CQC rating

CQC rating		Metrics 1-3 (most cautious definition of risk)		Metrics 4-5 (least cautious definition of risk)	
Outstanding	Care homes Beds	1	1.6%	10	18.0%
Good	Care homes Beds	3	0.3%	173	14.7%
Requires improvement	Care homes Beds	71	5.1%	309	21.6%
Inadequate	Care homes Beds	1532	4.7%	6652	20.4%
No rating	Care homes Beds	22	7.1%	57	18.4%
Total	Care homes Beds	769	8.5%	1495	16.5%
		1	4.2%	5	20.8%
		32	3.9%	188	22.6%
		3	7.5%	11	27.5%
		94	11.8%	105	13.2%
		98*	5.3%	392*	21.1%
		2,430**	5.5%	8,613**	19.4%

Note(s): *Out of a total 1,860 in our sample **Out of a total 44,473 in our sample Source: Spend Network analysis of companies' accounts and local authority spend data 2016-19

Future analysis

Given that market oversight is now a statutory responsibility of local government, working with the CQC, there is a case to be made for further investigation of the market in order to establish whether there are a range of common metrics that serve as indicators of a likely provider failure along financial lines.

Given that market oversight is now a statutory responsibility of local government, working with the CQC, there is a case to be made for further investigation of the market in order to establish whether there are a range of common metrics that serve as indicators of a likely provider failure along financial lines.

Caveat: Managing Risk

Larger provider brands should be subject to ongoing professional review because the impact of a failure is likely to be high and they represent financially complex organisations. Machine analysis could, nonetheless, be valuable for tracking small to medium-sized providers as there are many more of them and could assist with the targeting of CQC and local authority resources.

The data from further development of such a model would need to be handled with sensitivity and care, as machine-led analysis will sometimes highlight providers as higher risk when they are not and miss others which might actually be higher risk. As such, any data-driven alert system would need to be deployed alongside other information and knowledge.

Summary

This chapter sets out the preliminary findings from new and experimental research to see whether publicly available data might be combined to generate a linked dataset of financial performance in social care and, from there, consider how automated analysis techniques might, at scale, help to identify 'at risk' providers.

The aim of this work was to understand the extent to which such approaches might go beyond current practice and, in time, augment councils' (and the CQC's) ability to perform their market oversight functions.

To our knowledge, there is no similar work that has tried to look at financial risk in this way. Previous analysis by the Behavioural Insights Team (2017) has focused more on predicting quality, while work undertaken by the Competition and Markets Authority (2017) has looked more at competition, consumer choice and protections for both self-funded and local authority commissioned providers; this included profitability analysis at a transactional level with a particular focus on the effect of local authority fee rates on profitability.

From our sample results, 5-6% of providers might be considered 'at risk' based on the current and ongoing state of their financial health. That is, they have exhibited negative asset and/or negative equity over the last two years (metrics 1-3 above). By an alternative set of indicators (metrics 4-5 above), which consider the extent to which debt-to-equity and/or current ratios have worsened at a relatively faster rate than other social care providers (i.e. in the top decile of the group), the share of at-risk providers increases substantially, to over 20%. This 20% of providers may be on a financial trajectory that makes them of concern in the near future. While the former (metrics 1-3) is perhaps small in percentage terms, neither of these figures can be considered insignificant. On the assumption of a representative sample (which warrants further testing), if these figures were scaled up to the entire care market, at least 25,200 beds could be in an 'at risk' care home.

We stress that these measures are of provider risk only. Rather than a signal of providers in distress and close to failure, the measures should be taken to signal providers whose financial situations are unusual enough to warrant closer scrutiny and, subject to detailed investigation, subsequent intervention.

We also wish to reiterate the caveats about the characteristics of our sample outlined above, since larger and/or multi-brand providers may be more or less at risk than their smaller counterparts.

Of interest in our findings is how the pattern varies by region and care home size. This might signal wider differences and aspects of concern in different care markets beyond a focus on individual providers. Furthermore, since the proportion of care homes at risk increased with decreasing CQC ratings, it may be prudent that financial viability is assessed as part of the CQC inspections standards.

From the results presented in this section of the report, there is clear promise to the approach set out above and we are keen to explore this further. From what we have learned from the exercise:

- 1 automated analysis looks viable, subject to further work to see what best predicts a provider's financial risk and, by extension, their risk of eventual failure absent any intervention; and
- 2 there is much work that must be done to ensure the availability of consistent and high-quality public data to construct the necessary datasets.





Conclusions



Conclusions

At present, there are barriers to accessing and linking datasets about social care provision in England if the aim is to derive meaningful insights from them.

As a corollary, society is losing out on the opportunity to better understand an increasingly important facet of modern society and drive improvements in the continuity and quality of care that people receive. Looking ahead, we need what we have termed 'data that cares'.

Part A | In Part A, we provided an analysis of data published by the CQC to assess the structure and stability of residential social care markets.

Part B | In Part B, we examined the performance of social care providers by size, type and location to see what it might tell us about the quality of care offered and experienced. Our analysis highlighted, amongst other things, the complexity of local circumstances and a need for a more detailed investigation into their specificities.

Part C | In Part C, we explored how big data and machine learning techniques might be deployed to enable commissioners and the regulator to automate monitoring of residential social care markets. In particular, we tested the extent to which financial metrics could be deployed to help them identify providers showing signs of (potential) financial distress.



A crucial aspect of this work was the analysis of pertinent data published by local government, the CQC, Companies House and Office for National Statistics and, by extension, exploration of the limits to or, else, lack of standards impacting usage, linkage and reliance upon them.

In a nutshell: what we could see

In exploring the structure and stability of residential social care markets, we found that:

- The overall number of care home beds in care homes registered with the CQC has **fallen over time and there has been a shift to larger care homes.**
- There has also been **a fall in provision from small care homes in most areas.**
- Care homes also appear to be catering to **an increasing range of needs.**
- Private companies are increasingly dominant, **while not-for-profit provision declines.**
- The private company market share has **increased in almost all local authorities.**
- **Large provider brands remain significant** but seemingly less so over time.
- At a local authority level, **changes in older people's provision do not clearly track changes in population.**

In examining the performance of social care providers, we found that:

- There are **relatively few measures of quality that are publicly available** data with which to assess social care provision.
- CQC inspection coverage and ratings have improved over time, but **CQC ratings are a lagging indicator of quality**.
- The **private sector tends to be rated as lower quality** than its public and not-for-profit counterparts.
- **Smaller care homes tend to be rated as better quality** than their larger counterparts.
- There is **substantial variation in quality ratings** at a local authority level, and area-level links to quality are more difficult to establish.
- Social care-related quality of life is not obviously correlated to private company market share, but one reason for this may be that **people who self-fund 100% of their care are excluded from the survey** that underpins the quality of life measure we explored.

In a nutshell: what we could not see (or readily interpret)

- Whether changes in the number of care home beds in care homes registered with the CQC in a location is, in and of itself, 'good' or 'bad', e.g. from the point of view of supply and demand; occupancy levels; growing emphasis upon prevention, reablement and independent living in later life.
- What explains the 'churn rates' amongst providers of residential social care services.
- What has driven the shift to larger care homes, the decline in provision from small care home operators and not-for-profit provision.
- Which care homes are providing services for different user groups at any one point in time. This might, for example, enable us to better understand the relationship between supply and demand at an area level; anticipate the potential for strain to impact different services; and assess the likelihood that challenges in one care market might 'spill-over' into another and/or lead to people being offered care in places that are nearer/further from friends and family members.
- How provider ownership structures and particularly multi-location brand operators of care homes change over time
- Why older people's provision does not clearly track changes in population (for example, whether it is because some local authorities do not coincide with care markets; whether there are differences in health which impacts the age at which people need care and the level and type of care needed; whether it reflects occupancy levels; or whether care needs are being met outside of care in extra care housing schemes and supported living facilities or simply going unmet).
- Why not-for-profit care home providers tend to be rated as higher quality than their private sector counterparts.
- Which areas as distinct from providers benefit from better quality provision.
- How both state-funded and self-funded service users rate the care they receive and the extent to which that maps to quality ratings conferred by the regulator.

Often, we use data to find the questions, not the answers. The answers come from people. We therefore acknowledge that our work should be read in conjunction with qualitative studies to further explore what we could not readily interpret.

In practice: is there scope to evolve data-driven tools to identify residential care providers that may be 'at risk' of failing from a financial perspective?

In the course of our research, we developed a data-driven tool underpinned by open data to identify residential care providers that may be 'at risk' of failing from a financial perspective.

Subject to further work to see what best predicts a provider's financial risk and, by extension, their risk of eventual failure without any intervention, such a tool could be evolved and provide actionable insights to improve residential care market oversight and contingency planning activities undertaken by local authorities and the regulator. Our proof of concept is, then, demonstrative of the scope for 'data that cares' to bring about tangible improvements to peoples' quality of life and overall wellbeing.



Key findings from our modelling work and analysis

Our data-driven tool is geared towards single care home provider entities but can be scaled up from a technical point of view.

This is useful to the extent that 5,729 or 75% of CQC registered providers are single care home provider entities, and councils and the CQC currently lack the capacity to monitor them on an ongoing basis. At a provider level, 75% of providers currently operate single-location care homes and, together, manage 38% of total beds. The percentage of single-location providers, after those who operate under a multi-location brand have been removed, is 65% and manage 30% of total beds. Notably, the CQC's Market Oversight Team is currently only able to manually monitor x60 (mixed) domiciliary and residential care providers – covering an estimated 25% of the adult social care market (Care Quality Commission, 2015).

If we extrapolate the findings from our sample to consider the implications of our modelling for England as a whole, 25,205 residential care home beds are (potentially) 'at risk' on the basis of our most cautious definition of risk at present.

Some variation was found by region in the course of our analysis, with Yorkshire and the Humber having more care homes and beds deemed at risk than other regions, and London having fewer at immediate risk.

In terms of size, both smaller care homes (with 7 or fewer beds) and large ones (with 45+ beds) appear to be at greater risk than others in our sample.

Our analysis found no marked variation in risk by type of residential social care service provision, but the challenge when considering the results from our analysis in this way is that there is often and, increasingly, overlap in service categories.

The overlap in categories makes national comparisons of different service types deemed to be more or less at risk challenging. National standards in this regard would go some way towards solving the problem and allow for greater transparency.

Care homes rated as 'Outstanding' by the CQC were the least likely to be at risk in our sample, although we did not factor for quality in our model, and the CQC does not factor for financial risk in assigning quality ratings.

25,205
residential care home beds
are (potentially) 'at risk'

We stress that these measures are of provider risk only. Rather than a signal of providers in distress and close to failure, the measures should be taken to signal those providers whose financial situations are unusual enough to warrant closer scrutiny and, subject to detailed investigation, subsequent intervention. It is also worthwhile reiterating the caveats about the characteristics of our sample outlined in the body of the report, since larger and/or multi-brand providers may be more or less 'at risk' than their smaller counterparts, but that is not something we are able to comment on at present.

This type of analysis could, nonetheless, help focus the use of limited resources to help ensure that the wellbeing of the most vulnerable in our society is better protected in future. Investment and improvement in timely data about spending with care providers and the composition of providers with complex ownership models is needed if we are to improve upon our data-driven tool in future.





Data That Cares

Recommendations



Recommendations

In seeking to promote the generation, publication and usage of 'data that cares', we recommend that the Government introduces a Digital Duty of Care applicable to all public bodies that are responsible for the commissioning, provision, monitoring and/or regulation of social care services.

A Digital Duty of Care should mandate:

- the generation of high-quality social care data at source;
- adherence to associated standards to facilitate interoperability and to provide a basis for robust research and analysis of pertinent datasets;
- access to the data, insights and algorithmic tools generated by social care service providers to aid real-time monitoring of provision and safeguarding of individuals in receipt of care;
- compliance with the Local Government Transparency Code (2015); and
- stimulation of the use of the resultant open data by innovators and entrepreneurs to evolve the data-driven care technology market.

The more technical recommendations which flow from the work outlined in this report are outlined in what follows and are designed to promote care market shaping and stability, provider performance and quality as well as financial risk management in the interests of improving outcomes for our beneficiaries.

There is a danger that we have reached conclusions and made recommendations here based upon our quantitative analysis about the system 'as is' and not the system as it 'could be'. We hope, nonetheless, that our recommendations encourage the generation and publication of data that is useful and meaningful from the point of view of the regulator, commissioners, front-line staff and, crucially, carers and those in receipt of care themselves.

1 Care Market Shaping and Stability

Whilst we can interpret existing, publicly available data to say something with confidence about the structure and stability of residential social care markets, we have only a partial view of wider networks of paid and unpaid care providers.

Even then, it does not take in what, potentially, constitute significant structural changes to the market and 'adjacent markets' that extend beyond CQC registered care homes - for example, extra care housing schemes and supported living facilities. Neither does it assist us with understanding the self-funded component of these markets in any real depth, which is to say, the experience of people whose wellbeing the Care Act (2014) also confers a responsibility upon local authorities to steward.

The spend data associated with the state-funded care of people living in places that are, to all intents and purposes, 'intended to care' is more often than not limited to consideration of what is being spent by local government and the NHS. In practice, a large (and, possibly, growing) number of people are in receipt of state funds for care involving some form of accommodation from the Department for Work and Pensions (DWP), and living in locations that are best-known to local planning authorities (i.e. not councils with adult social care responsibilities themselves). The limits to publicly available data also serve to consign real 'market intelligence' to proprietary datasets and provider (data) monopolies which, as we have said elsewhere, could be better utilised in the design, commissioning, delivery and oversight of services impacting the care people receive (Future Care Capital, 2019b).



If the aim is to ensure that those in receipt of care enjoy a good quality of life, we need to better facilitate market shaping, oversight as well as contingency planning. Big data linkage across public bodies and analysis could reveal trends involving, for example, the ‘decoupling’ of registered care from caring accommodation, above and beyond those observed in our own analysis regarding ‘privatisation’ and, with that, help interested parties to discern any implications for the quality of care offered and experienced. This, in turn, could lead to more meaningful insights than publicly available data currently permit – albeit the steps taken must respect data protection provisions to safeguard person-identifiable data and, wherever possible, limit any additional burden upon providers and/or implications for competition and commercially sensitive matters.

We recommend:

- the Office for National Statistics explores the scope to exercise its powers under the Digital Economy Act (2017) in order to generate useful open data and insights about the structure and stability of care markets which involve some form of accommodation by linking big datasets controlled by the CQC, MHCLG, DWP and local authorities.
- It could, also, encourage better practice on the part of public sector commissioners of adult social care via the Cabinet Office’s Supplier Code of Conduct.

The latter would be in line with the Government’s Technology Innovation Strategy which states that: “...data is sometimes held by a supplier as part of a commercial agreement, so departments may not be able to access it easily. This clearly prevents reuse.

We will explore how to produce commercial agreements between government and external suppliers that recognise that the future use of data is a key factor in decisions over value for money” (Cabinet Office, 2019).

2 Provider Performance and Quality

There are relatively few measures of quality accessible via publicly available data and/or open data with which to assess social care and, in particular, to compare different places as distinct from providers.

Information about the experience of self-funding customers is, largely, limited to the Your Care Rating survey operated by Ipsos Mori¹⁹ - in respect of which, the England sample appears relatively limited in size (at present), and the data cannot be downloaded to link it at scale to CQC data about quality ratings.

As such, our knowledge and understanding of people’s lived experience of caring and care in different parts of the country is, at present, highly circumscribed. We have also said, elsewhere, that for person-centred care to be effective, we need a much better understanding of when and how people interact with the wider care ecosystem. The data needs are very different between the traditional service-oriented model of care and the modern person-centred, ecosystem-wide model (Future Care Capital, 2018).



¹⁹Your Care Rating: <https://www.yourcarerating.org/>

We recommend:

NHS Digital extends data collection via the Adult Social Care Outcomes Framework (ASCOF) so that it covers both state-funded and self-funding service users in future. It should ensure that the resultant dataset is open and published to a standard as well as in a format that can be readily linked with data about quality ratings published by the CQC to facilitate comparative analysis.

The Cabinet Office could, also, usefully promote what we've elsewhere termed a 'data dividend' from regulatory or contracting arrangements with third party providers of residential social care, or MHCLG explore the potential for it to flow from the conferment of planning permissions linked to the development and/or operation of accommodation involving some form of care.

3 Market Oversight and Financial Risk Management

Automated analysis of publicly available data to help identify residential care providers that may be 'at risk' of failing from a financial perspective looks viable, subject to further work to see what best predicts a provider's financial risk and, by extension, their risk of eventual failure without any intervention. There is, however, much work to be done to ensure the availability of consistent and high-quality data, and additional investment would be required to scale-up the tool described in the main body of this report. This tool would also need to be deployed integral to a broader based 'early warning system', underpinned by information other than that utilised in the course of our work.



We recommend that Government mandates:

- the presentation of accounts in a machine-readable format where an organisation provides social care services;
- persistence of unique identifiers which would provide a means of long-lasting identification of digital objects that are global and standardised in beneficial ownership data to render transparent who owns and/or controls organisations that provide social care services and, in particular, those bound up with complex group ownership structures; and
- the adoption of data standards for both beneficial ownership (the Open Ownership Standard) and spending data (the Open Contracting Data Standard).

There are also further avenues for research:

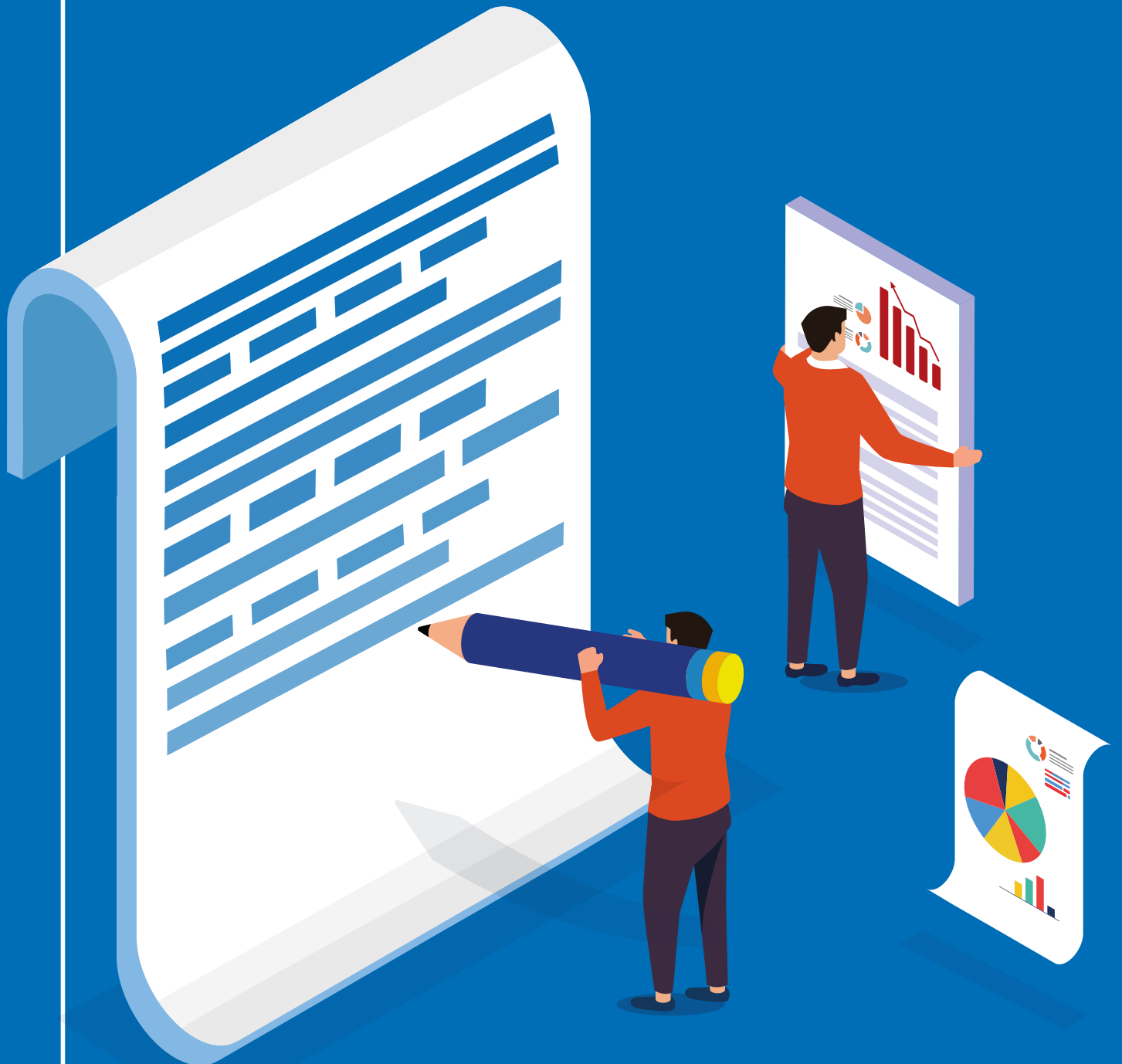
First, it is possible to link Companies House data about company accounts with company name changes over time. This would require a collection of all the historical data published and would constitute a substantial exercise – requiring the import of hundreds of millions of records and working with a dataset such as Open Corporates.

Second, a deep-dive into CQC registration and deregistration data could be considered in order to keep better track of provider entities and the larger residential care home operator brands through the use of data-driven tools.

However, the data published by the CQC does not yet meet the quality standards required for a full integration with Companies House and other entity registers, which would allow us to monitor changes in ownership and better explain the reasons why providers leave the market. The data being generated by the CQC is critical data infrastructure and needs to be recognised as such. It is clear that the CQC is doing its utmost to create and maintain this data with limited resources, but investment and, potentially, greater powers to demand access to – ideally, timely – data are needed to create reliable infrastructure from which meaningful financial insights may be derived.



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Data That Cares

Appendices



Appendix I

The data we have analysed in this report comes from a wide range of sources to try to establish a quantitative view of caring economies in England. The focus is at the level of councils with adult social services responsibilities (CASSRs), which represent the principal decision-making unit in England, with various duties conferred by the Care Act 2014 (Care Act 2014, c. 23). This appendix sets out various aspects of the (non-financial) data analysis in more detail.

Geography

In this report, we present local authority-level results at the level of CASSRs.

A complication in assembling a time-series of data is that various boundaries have been reorganised over time. The most notable and recent is the formation of Bournemouth, Christchurch and Poole Council in April 2019. This area brought together Bournemouth and Poole but also transferred Christchurch from Dorset. This creates a discontinuity between 2018 and 2019 such that comparisons over time are not possible. In general, we exclude these areas from any analysis that involves a comparison between periods before and after changes such as these.

Data

On its website, the CQC provides information on all CQC regulated locations²⁰. These data cover a range of services including care homes as well as, for example, GPs, hospitals, dentists and ambulances.

The CQC also publishes the accompanying quality ratings from its inspections. The CQC data are available as monthly snapshots taken close to, if not on, the first day of each month. Taking the July snapshot of each year, we have assembled an annual time series that represents, broadly, the mid-year state of formal care provision in England.

The data on care homes (provider name, number of beds, services provided, etc) go back to May 2011, leading to an annual time series over 2011-19, albeit with the level of detail available to construct certain aggregates (e.g. detailed provider types) quite limited in our dataset until 2018. In the main body of the report, we present data back to 2011 where available but note a marked increase in the numbers of beds between 2011 and 2012. In the interest of highlighting broader recent trends, we do not typically comment on the 2011 data.

The accompanying ratings data go back to September 2015, leading to an annual time series of mid-year (July) data covering 2016-19.

Dual Registrations

In the course of our analysis, we identified some features of the data that should be borne in mind when interpreting the results.

Specifically, some of the care homes in the data appear more than once such that there is at least some degree of double counting in the figures and, as such, some degree of over-estimation in the numbers is deemed likely. From selected manual checks, this was found to be the case for at least one provider brand in the CQC directory^{21,22}. In the cases identified, these duplicate entries were the result of dual registration, by which a care home is run by two companies. The two companies take joint responsibility for the service.

In such cases, the same care home appears twice and with a distinct location identifier for each entry (one per company), signalling two apparently different care homes. The two entries for the same care home do not share an identifier and each also lists the number of beds in the care home. With the same number of beds appearing twice in the dataset, there is the potential for double counting and thus an over-estimate of beds in the figures that are susceptible to this issue.

During the research, dual registration did not appear straightforward to identify unambiguously. For a small number of provider brands in 2019, we checked for care homes that shared a postcode as an initial filter for potential duplicates. We then checked these care homes manually against their corresponding listings on the CQC website and, if available, the website of the operating company.

From these checks (of a limited number of care homes in the dataset) we found that:

- a shared postcode (our initial filter for entries that might warrant further checking) does not definitively signal a duplicate/dual-registered care home because multiple locations may be legitimately registered to the same postcode (usually an identical address) e.g. different registrations for different forms of service provision
- some care homes are indeed dual registered, although this is not always made explicit on the CQC website: some pages have a notice at the top; others only mention it in the inspection report; elsewhere it goes unmentioned

²⁰<https://www.cqc.org.uk/about-us/transparency/using-cqc-data> ²¹It was not feasible to check all cases of potential duplicates. ²²The CQC provides data at the level of individual locations (loosely, care homes). Those care homes are run by a provider (company/organisation) and that provider may run multiple locations. Providers may, in turn, be grouped to brands. For example, the BUPA brand comprises a range of BUPA companies, some of which run care homes and thus appear in the CQC data.

- it is not necessarily the case that a dual-registered care home is mentioned as such on both CQC website entries: one may say it is dual-registered whereas the other may make no mention of it
- other information is not always consistently reported for the two care homes including:
 - the number of reported beds
 - the latest CQC quality rating: one may have it listed; the other may say that the care home is yet to be inspected
 - the services provided may be listed inconsistently i.e. one entry may list a slightly different set of services to the other

In such cases, manual intervention would be required to resolve these inconsistencies by, for example, reviewing the inspection reports (which sometimes say whether a care home is dual-registered; and sometimes report the number of beds in the care home) and information on the companies' websites.

Given the information available in the dataset itself, while there are methods by which we might identify candidates for further manual checks, it was not immediately obvious how automated procedures might be applied to confidently identify and resolve instances of dual-registered care homes.

Part of this research sought to update figures on the five largest providers in England, as presented previously by Burns et al. (2016). As part of this analysis, we examined what we thought to be the five largest private-company providers of beds for older people in England in 2019. Applying the initial filter of care homes within each brand that shared a postcode, we manually checked these possible duplicates against the information on both the CQC website and those of the operating companies.

For all but one of the initial five provider brands, we found that such care homes were indeed distinct locations and unlikely to be double counting the number of beds provided. For the remaining provider brand, however, dual registration was more common, reducing the 'true' number of care homes by 42 and the number of beds by 3,675. This removed this provider brand from the top five and a similar set of checks were run on the 'new' fifth-largest provider brand; again, finding no evidence of duplication.

The CQC data for 1 July 2019 lists 15,661 entries. Of these, the (initial) six largest provider brands by care home beds accounted for 966 locations (6% of the 15,661 care homes). By filtering to duplicate postcodes, we were able to reduce the number of care homes to check manually 145 (15% of the 966, but just 1% of the complete dataset for 2019). Even so, after paring down (by heuristic) the number of care homes to review to something manageable, the process of manual checks is time intensive. It was not considered feasible to apply this approach to the entire dataset:

- or 2019 alone the level of effort would be too high given the constraints of the project

- or earlier years (in principle, back to 2011), the high level of effort would likely be compounded by the need to establish the past status of the care homes, possibly requiring access to earlier versions of CQC data and company websites to piece together the necessary information.

Therefore, with part of the analysis intended to consider trends in care provision over time in a comparative manner, we opted not to attempt a full de-duplication exercise as part of this work. Moreover, for the most part, we have not reported figures that have been adjusted for the known duplicates in 2019. This avoids introducing a further complication to the analysis and what would risk being an ad hoc adjustment to a part of the data for a single (the most recent) year, potentially further distorting some comparisons over time. The one exception is the presentation of the five largest provider brands, for which accounting for dual registration is necessary to properly identify those largest brands.

The implication is that the main analysis likely over-estimates the number of care homes and beds in England. As set out above, it is not straightforward to assess the extent of that over-estimation but we do note that our raw (unadjusted) beds figures are not too far from those reported by the CQC (2018) in their annual state of care report. For April 2018, the CQC reports 458,905 beds²³. If this figure is indeed on a like-for-like basis, this compares to our own estimate (for July 2018) of 458,844 beds; a difference of less than 100 beds.

It is not possible to fully gauge the impact of dual registration on our figures or how it might change over time but, were the incidence of dual registration confined to the one provider brand identified, the total number of care homes in 2019 would fall by 42 (0.3%) and the total number of beds by 3,675 (0.8%). Insofar as we were unable to identify other cases of dual registration among the five largest providers (who accounted for almost 17% of private-company provision for older people in 2019), the effect of dual registration is potentially (though not definitely) small.

Unless otherwise stated, rather than attempt to account for potential dual registration in a manner that may introduce new sources of inconsistency to the analysis, we opt to present the data 'as is', accepting (and with the caveat) that double counting likely leads to some over-estimation of some figures. In this sense, the analysis should be interpreted as arising from results ultimately derived from the CQC data and presented as 'best estimates' in light of both known and unknown challenges that accompany the data.

²³This is reported as 238,266 residential home beds and 220,639 nursing home beds in Figure 1.12 on Page 44 of CQC (2018).

Provider types

In this report, we have inferred the classification of provider types from a combination of fields in the CQC data. We have mapped each combination of field values to a broad sector (e.g. private sector) and type (e.g. private company).

Alongside the names and field values in **Table 17**, we also report the number of care homes and beds in each category to give a sense of relative scale. The main body of the report presents trends in more detail.

Table 17: Identification of provider types in the CQC data

Sector	Provider Type	CQC data field			CQC data field	
		Companies House number?	Charity number?	Ownership type	Care homes	Beds
Private	Company	Yes (with exceptions listed in the rows below)	No	Organisation	10,830	350,275
	Partnership	No	No	Partnership	824	17,898
	Individual	No	No	Individual	777	13,351
Public	Predominantly councils	No (barring one case of a number with a unique 'PA' prefix: Cumbria County Council)	No	Organisation	448	12,020
	Hospitals (mostly mental health services)	No	No	NHS Body	47	690
Not for profit	Charitable companies	Yes	Yes	Organisation	1,873	38,372
	Charities not registered as a company		Yes	Organisation	306	9,107
	Registered society	Yes (either with a prefix of 'RS' or 'IP'; or a suffix of 'R')	No	Organisation	556	14,832
Total					15,661	456,545

Source(s): Care homes and Beds figures from CE analysis of CQC care directory, 1 July 2019.

The full classification above is only possible for the last two years of data (2018 and 2019), when the CQC introduced the ownership type field. Between 2015 and 2018 (strictly, June 2015 and November 2017), partnerships, individuals, predominantly councils and hospitals cannot be separately or comprehensively distinguished as they all lack both a Companies House number and a charity number: there is nothing else with which to easily distinguish these different provider types. In the main body of the report, before 2018, we allocate these providers to 'Unclassified'.

The accuracy of this classification depends on the consistency with which these fields are recorded in the CQC data and we note, for example, that at least one category, 'predominantly councils', arises because, while councils make up the bulk of provision in this category, at least some other provider types were evident from manual inspection of this group. Many of these non-council providers appear to be private companies and a follow-up search on Companies House sometimes revealed that the provider had a Companies House number which was not recorded in the CQC data.

Because the detail in the CQC data to create the classification increases over time, much of the analysis in the main report focuses on two provider types that we are able to identify from 2015 onwards:

1 Private companies, with a listed Companies House number in the CQC data

This excludes individuals and partnerships which also make up the private sector at large but, as the analysis shows, private companies are the largest component of the sector. There is also at least some suggestion that the private company share may have been increasing as these smaller private entities (individuals and partnerships) have declined.

2 Not-for-profits, with a listed charity number in the CQC data.

Private companies as a provider type

As set out in the main text, given the information available in the CQC data and how it changes (expands) over time, we can identify providers registered with Companies House in the CQC data.

It is these providers we refer to as 'private companies' in this report. It is important to be aware that these private companies exclude providers either set up as partnerships or who operate as individual proprietors. These would still fall under the overarching definition of the private sector but it is the private companies within that which we think we can identify with a reasonable degree of confidence from 2015 onwards (subject to the quality of the underlying CQC coding).

In any case, as **Table 17** shows, private companies are, by far, the largest segment of the private sector and, indeed, the entire market. The data for 2018 and 2019 also show that private companies are increasingly dominant in both. As a proxy for the extent of privatisation in the market, the presence of private companies (essentially the corporate providers) seems reasonable as an indicator.

Similarly, we use the presence of a recorded charity number to identify the not-for-profit sector from 2015 onwards. As noted in the main text, further information becomes available from 2018 onwards but there are too few data points to comment meaningfully on the trends here. The apparent break in series also complicates the analysis.

Appendix II

Table 18: Summary of data assessed to understand caring economies

Data	Publisher	Description	Comment
Care home information	CQC	Information about individual care homes including their size, services provided and owner (provider/company).	Only records number of beds and services provided by the care home (rather than how many beds for each).
Care home ratings	CQC	Ratings from CQC care home inspections.	As a stock measure, gives no indication of utilisation and thus the level of stress in the care system Available at a care home level, to allow more detailed analysis of the relationship between care home characteristics and quality.
Social care-related quality of life	NHS Digital	Indicator 1A: Social care-related quality of life score. Generated from a combination of responses to the Adult Social Care Survey.	However, slow to change over time because it depends on (re-) inspections by the CQC. Survey sample is restricted to those who have had at least some contact with public services: excludes self-funders. Only available as aggregates for different areas: difficult to tie to other area-level indicators (or indicative of the presence of confounding factors).
Workforce indicators	Skills for Care	Various indicators about the social care workforce by local authority.	While a sample, the coverage of the survey is considered relatively good. Only available as aggregates for different areas: difficult to tie to other area-level indicators (or indicative of the presence of confounding factors).
Mid-year population estimates	ONS	Detailed estimates by local authority of population by year of age and gender.	
English indices of deprivation 2015	Ministry of Housing, Communities and Local Government	Income Deprivation Affecting Older People Index (IDAOPi) by local authority	

Appendix III

The financial analysis presented in this report uses a new dataset constructed by Spend Network²⁴. This dataset comprises a sample of care payments by local government to individual care home locations alongside a sample of financial accounts tied to care home providers (companies).

Data

The dataset combines information from the following sources

- 1 **Spend Network's own database of transactions** compiled from open data which records payments from public bodies to companies;
- 2 **CQC data** on individual care homes and the companies ('providers') that own them (companies may operate multiple care homes); and
- 3 **Financial accounts from Companies House** containing information such as assets, liabilities and shareholder equity.

By linking the datasets, it becomes possible to analyse various financial aspects of care home locations and providers.

²⁴<https://www.spendnetwork.com>

Approach

The process of combining these sources into a single linked dataset is challenging. In the ideal case, entries in each dataset would have an identifier (e.g. a code) that uniquely distinguishes the entity of interest (e.g. a care home or company).

In practice, different datasets rarely adopt a common, standardised/accepted identification scheme and, even if they attempt to, there is no guarantee that the identifier will always accompany the entity in question (coding errors). Typically, data linkage is therefore an exercise in circumventing inconsistent coding and record-keeping.

For the financial analysis, the steps in the process are as follows, to assemble a database from January 2016 onwards:

1 Identify care suppliers from Spend Network's transactions database

Spend Network's database classifies transactions by type. That classification is derived from how public sector bodies classify their own spending. The first step was to isolate payments to care providers. As noted in the main body of this report, because of differences in how councils record their transactions (this is not done consistently across councils), the relevant category is perhaps best described as 'community and social care'.

Depending on the council, this category will represent some combination of community services, children's care and adult social care.

The unknown is the extent to which the payments by this category fully capture the body of social care-related transactions by councils and exclude non-social care-related transactions.

2 Link payees in transactions data to care providers (in CQC data)

The next step was to match the recipients of council payments from the transactions database to entities identified in the CQC directory. By making this link, the payments data can be analysed alongside care-related features of the payees (e.g. their location, the number of beds in the care home, service user bands etc). Moreover, from CQC identifiers, further linking is possible (e.g. to data on quality ratings).

The matching takes place at a care home level rather than a company level because a council-to-company payment cannot easily be traced to a specific care home. Council-to-company payments are thus excluded from the dataset. The extent to which councils make payments to care homes rather than companies varies. It is not necessarily the case that council-to-care-home payments can only be traced to small providers. As one example, payments to Barchester Healthcare homes are often made to the homes themselves.

The challenge here is that the name of the care home in the transactions data may not exactly match the name in the CQC data. As an example, in one dataset, the care home may be called 'Care Home Ltd' while in the other it is called 'Care Home Limited'.

At the scale at which matching must take place, the process must be carried out by computer, algorithmically.

The challenge at this stage lies in being able to identify the correspondence between payees in the transactions data and their counterpart entries in the CQC data (as detailed above).

3 Collect financial accounts from Companies House for care providers from the CQC data

The final step to construct the dataset was to link financial information from Companies House to the CQC data. In contrast to Step 2 above, which matched by individual care home, this part of the work must match by care home company (to have a counterpart set of accounts from Companies House).

This matching is on the basis of Companies House number, which is recorded in the CQC data and used as an identifier in the Companies House data.

A further complication in the Companies House data is that financial figures are not always labelled consistently (e.g. some accounts may report a figure for 'turnover' while others may call it 'revenue'). Further cleaning was necessary to try to make the dataset as consistent as possible.

Here, the matching depends on a provider having a Companies House number in the CQC data (to be able to retrieve a set of accounts from Companies House) and for those financial accounts to have been submitted electronically, rather than as a PDF file.

While the rate of matching may appear low on the face of it (and the strength of any conclusions drawn should be measured accordingly), to our knowledge, no linking exercise of this kind has been attempted previously, let alone at this scale. As an experimental/exploratory piece of work, this serves as a (replicable) proof of concept for future work.

Limitations

As mentioned above, the final dataset is but a sample of the ‘universe’ of transactions and financial data. The nature of the matching exercise (respectively, to handle inconsistencies in care home names, and collect accounts where there is both a matching Companies House number and an electronic set of accounts) means that the final dataset is not complete. Instead, the dataset represents a sample of the financial information on social care in England.

In the analysis presented in the main report, results are couched as such and Spend Network’s recommendation was that geographically disaggregated results (concerning care home-level transactions) would be more robustly expressed at a regional, rather than local authority, level.

Of the three input datasets, Spend Network’s database of transactions is compiled from open data on spending by public sector bodies. Those open data cover published transactions in excess of £500. While transactions below this threshold are therefore missing from Spend Network’s database (because they are not published by the relevant bodies), for the purposes of this work this is unlikely to be a constraint because few, if any, social care-related payments will be of less than £500. However, it is still possible that other transactions have been redacted by councils or simply not published.

The CQC data are complete in the sense that the CQC directory captures information for all regulated locations (of which care homes are a subset). The quality of the data depends on the quality of the underlying information captured by the CQC which is, in turn, provided by the companies that are registered with it.

Accounts information from Companies House is available either in

- electronic (machine-readable) form: financial figures are already isolated and identified e.g. there is a number labelled as the value of ‘assets’; or
- as a (scanned) PDF file which must be read either manually or using computer software.
- Processing PDF files is not straightforward even with computer software and, in the scope of this piece of work, Spend Network’s focus was restricted to electronic returns only

From the above, the principal constraints on the exercise are:

- 1 Underlying data quality: comprehensiveness of the raw data; availability and accuracy of identifying codes for matching
- 2 The ability to successfully match records in the event of inconsistent coding (e.g. care home names), requiring an algorithmic approach supplemented by manual intervention, but still leading to an overall low match rate
- 3 The availability of electronic financial accounts rather than PDF versions

Table 19 reports total council expenditure on items that can be broadly thought of as ‘community and social care’. The data come from Spend Network’s database of local government payments and the classification is derived from how local governments classify their transactions (and this is not necessarily done consistently across councils)²⁵. Consequently, the transactions category will represent some combination of community services, children’s care and adult care. Nevertheless, while there will be inconsistencies across areas (for the above reasons), from a transactions perspective, the table below does give some broad estimate of the financial resources that councils have put behind such services between the start of 2016 and the year (2019) to date. We have then compared these figures with overall council spend on adult social care from the Adult Social Care Activity and Finance Reports from 2016-19 (NHS Digital, 2017, 2018, 2019).

The data come from Spend Network’s database of local government payments and the classification is derived from how local governments classify their transactions.

²⁵Following a Freedom of Information Act request to Councils with Adult Social Services Responsibility (CASSR) in 2019, FCC identified more than 130 different categories used by councils to classify the residential social care they commission (report forthcoming).

Table 19 Spend on Adult Social Care by Local Authority 2016-2019, as identified by Spend Network and compared to data from the Adult Social Care and Finance Activity Report (NHS Digital)

Spend Network data		Adult Social Care Activity and Finance Report (NHS Digital)ii		
2016-19		2016-17	2017-18	2018-19
Total transactions (£m)iii	Of which successfully matched to CQC locations (%)iv	Total expenditure Adult Social Care (£m)v	Total expenditure Adult Social Care (£m)v	Total expenditure Adult Social Care (£m)v
£27,440.66	15%	£20,638.98	£21,323.17	£22,205.30
£138.10	10%	£65.58	£70.28	£76.60
£178.50	20%	£125.02	£128.10	£129.36
£148.60	9%	£78.42	£77.32	£72.56
£271.90	10%	£90.92	£93.04	£97.04
£96.30	9%	£66.89	£71.98	£76.40
£217.80	1%	£72.05	£82.27	£83.71
£607.90	24%	£415.51	£405.28	£415.47
£35.00	16%	£71.83	£71.37	£70.78
£165.00	18%	£68.61	£75.29	£80.80
£138.60	16%	£103.11	£109.31	£122.71
--	--	£74.88	£87.98	£79.99
£82.60	17%	£44.59	£46.42	£44.39
£321.20	26%	£174.84	£188.32	£197.36
£196.90	10%	£96.20	£110.07	£109.58
£178.60	13%	£118.48	£120.78	£131.89
£73.80	1%	£199.52	£213.81	£214.46
£135.80	11%	£95.30	£101.01	£107.89
£264.50	7%	£175.05	£190.05	£198.09
£114.70	19%	£88.80	£88.98	£90.99
£107.10	16%	£78.40	£81.72	£86.31
£253.80	12%	£220.09	£222.68	£238.41
£292.90	13%	£105.62	£104.52	£100.64
£107.50	14%	£92.82	£98.55	£108.13
£214.00	18%	£152.10	£148.97	£163.71
£166.40	13%	£120.09	£126.70	£135.93
--	--	£6.07	£6.34	£6.71

Cornwall	£307.50	15%	£209.97	£240.63	£254.46
County Durham	£349.60	22%	£105.42	£227.35	£231.93
Coventry	£95.90	12%	£134.62	£108.26	£115.41
Croydon	£236.80	14%	£220.99	£137.02	£152.74
Cumbria	£126.00	11%	£44.73	£227.75	£196.51
Darlington	£47.90	23%	£95.51	£44.13	£43.40
Derby	£362.80	32%	£310.53	£92.89	£95.34
Derbyshire	£254.40	13%	£298.97	£314.80	£337.32
Devon	£404.00	15%	£118.57	£312.85	£337.95
Doncaster	£143.40	19%	£180.73	£121.13	£124.93
Dorset	£77.60	0%	£120.31	£189.73	£198.12
Dudley	£140.60	19%	£225.82	£121.41	£127.78
Ealing	£63.70	6%	£126.08	£139.79	£132.35
East Riding of Yorkshire	£194.10	15%	£120.56	£149.21	£161.56
East Sussex	£38.60	8%	£252.97	£263.32	£271.44
Enfield	£156.40	17%	£108.03	£115.35	£124.07
Essex	£1,275.90	11%	£581.12	£587.65	£602.21
Gateshead	£127.90	12%	£87.19	£91.80	£96.49
Gloucestershire	£353.30	26%	£218.67	£221.47	£231.94
Greenwich	£88.90	19%	£112.63	£112.87	£120.05
Hackney	£130.70	18%	£94.91	£94.38	£108.43
Halton	£100.10	4%	£53.87	£67.12	£69.85
Hammersmith & Fulham	£140.60	22%	£87.53	£86.65	£81.12
Hampshire	£471.50	30%	£452.47	£459.91	£495.77
Haringey	£153.40	14%	£111.75	£106.99	£110.92
Harrow	£93.50	11%	£79.11	£84.80	£90.78
Hartlepool	£40.50	20%	£51.95	£53.12	£57.76
Havering	£110.10	10%	£82.16	£78.93	£82.13
Herefordshire, County of	£22.90	2%	£72.27	£82.51	£81.77
Hertfordshire	£569.00	16%	£425.36	£432.06	£452.98
Hillingdon	£130.80	25%	£101.69	£103.90	£107.87
Hounslow	£30.00	1%	£79.30	£75.37	£70.78
Isle of Wight	£92.80	9%	£75.90	£76.20	£76.12
Isles of Scilly	£0.30	1%	--	£1.35	£1.64
Islington	£54.00	13%	£109.07	£108.45	£112.33
Kensington & Chelsea	£70.20	18%	£66.96	£63.16	£63.82
Kent	£861.20	11%	£498.58	£518.52	£534.27
Kingston upon Hull, City of	£185.90	15%	£103.84	£108.81	£112.59
Kingston upon Thames	£12.60	14%	£64.04	£65.84	£68.04
Kirklees	£325.80	6%	£152.27	£158.71	£167.68
Knowsley	£82.40	18%	£75.86	£76.61	£77.95
Lambeth	£184.20	20%	£130.31	£123.56	£121.30
Lancashire	£374.80	22%	£508.48	£522.71	£547.68
Leeds	£406.80	12%	£283.51	£293.32	£317.35

Leicester	£131.70	9%	£151.49	£143.23	£151.55
Leicestershire	£254.60	3%	£226.17	£227.20	£232.52
Lewisham	£181.60	20%	£101.50	£105.22	£115.38
Lincolnshire	£421.20	26%	£277.95	£262.34	£286.30
Liverpool	£179.50	17%	£221.47	£225.90	£231.94
Luton	£114.30	8%	£69.68	£75.56	£76.58
Manchester	£63.90	2%	£187.04	£195.25	£201.92
Medway	£167.70	16%	£85.48	£91.89	£90.64
Merton	£45.80	34%	£71.46	£69.12	£68.41
Middlesbrough	£154.70	8%	£72.98	£74.20	£79.67
Milton Keynes	£63.30	6%	£78.34	£81.05	£84.19
Newcastle upon Tyne	£173.00	10%	£121.36	£129.90	£137.62
Newham	£206.60	11%	£93.60	£98.48	£103.88
Norfolk	£393.10	8%	£379.70	£397.53	£418.82
North East Lincolnshire	£16.60	0%	£54.32	£56.70	£58.40
North Lincolnshire	£32.60	24%	£55.58	£56.29	£58.91
North Somerset	£108.40	19%	£87.64	£90.42	£92.97
North Tyneside	£149.20	13%	£82.81	£85.78	£88.81
North Yorkshire	£272.20	1%	£229.75	£235.24	£255.63
Northamptonshire	£458.80	13%	£220.84	£230.02	£245.80
Northumberland	£378.04	28%	£121.61	£129.50	£142.26
Nottingham	£140.60	4%	£144.89	£153.24	£161.14
Nottinghamshire	£406.90	22%	£324.01	£343.71	£357.88
Oldham	£115.40	3%	£82.97	£84.97	£97.26
Oxfordshire	£306.00	33%	£237.72	£254.33	£256.30
Peterborough	£85.70	15%	£65.80	£69.26	£70.05
Plymouth	£175.00	10%	£97.04	£100.92	£106.49
Poole	--	--	£57.31	£58.62	£57.95
Portsmouth	£99.20	26%	£69.54	£76.19	£81.13
Reading	£98.80	23%	£62.03	£57.18	£58.53
Redbridge	£102.50	11%	£92.09	£93.17	£92.10
Redcar & Cleveland	£39.90	11%	£63.99	£67.17	£69.86
Richmond upon Thames	£93.20	32%	£78.78	£92.65	£82.51
Rochdale	£154.80	14%	£74.95	£82.43	£91.93
Rotherham	£130.00	5%	£105.16	£103.61	£106.57
Rutland	£14.10	9%	£15.33	£15.74	£16.55
Salford	£67.90	4%	£94.75	£92.73	£101.96
Sandwell	£212.70	20%	£115.27	£117.45	£137.00
Sefton	£159.70	17%	£118.18	£124.09	£126.30
Sheffield	£244.10	11%	£199.82	£198.20	£218.91
Shropshire	£221.80	14%	£115.42	£126.75	£136.56
Slough	£21.60	38%	£47.21	£49.30	£50.98
Solihull	£230.40	6%	£80.07	£80.87	£87.37
Somerset	£339.60	13%	£230.15	£224.08	£221.65
South Gloucestershire	£105.70	25%	£101.90	£112.03	£117.15
South Tyneside	£115.80	20%	£84.43	£84.24	£83.93

Southampton	£110.80	8%	£90.57	£103.45	£103.67
Southend-on-Sea	£103.20	8%	£62.37	£64.28	£68.23
Southwark	£207.60	14%	£132.57	£128.70	£114.53
St. Helens	£128.40	24%	£75.51	£80.14	£79.32
Staffordshire	£139.70	4%	£288.33	£314.67	£324.68
Stockport	£143.90	25%	£120.67	£128.50	£130.11
Stockton-on-Tees	£97.10	26%	£75.98	£74.94	£77.82
Stoke-on-Trent	£186.90	15%	£111.02	£119.34	£121.35
Suffolk	£370.10	26%	£279.10	£304.52	£315.30
Sunderland	£184.70	15%	£145.08	£110.77	£113.68
Surrey	£321.40	22%	£482.47	£483.60	£499.33
Sutton	£76.80	17%	£71.89	£72.66	£77.72
Swindon	£157.20	5%	£76.47	£80.95	£82.82
Tameside	£98.90	14%	£77.63	£86.86	£85.75
Telford & Wrekin	£42.80	1%	£58.34	£59.63	£64.58
Thurrock	£76.90	6%	£47.44	£50.44	£57.29
Torbay ^{vi}	£30.62	1%	£53.83	£56.21	£65.28
Tower Hamlets	£152.50	13%	£116.38	£120.55	£123.67
Trafford	£115.20	19%	£66.74	£69.44	£74.76
Wakefield	£135.30	8%	£119.10	£122.21	£129.42
Walsall	£237.50	17%	£92.36	£95.65	£89.75
Waltham Forest	£62.60	3%	£85.30	£85.86	£93.26
Wandsworth	£177.80	19%	£110.79	£111.21	£112.87
Warrington	£181.90	20%	£87.67	£97.01	£98.81
Warwickshire	£141.80	12%	£172.03	£178.87	£192.29
West Berkshire	£77.20	35%	£63.68	£66.04	£64.62
West Sussex	£411.00	11%	£296.74	£310.86	£328.12
Westminster	£217.00	17%	£100.58	£98.06	£106.38
Wigan	£235.10	13%	£115.49	£121.43	£130.65
Wiltshire	£232.20	15%	£169.90	£185.52	£202.91
Windsor & Maidenhead	£112.00	13%	£48.46	£49.70	£51.30
Wirral	£248.30	15%	£133.88	£141.71	£145.85
Wokingham	£55.00	33%	£56.74	£59.89	£60.10
Wolverhampton	£14.10	7%	£98.24	£97.21	£102.83
Worcestershire	£441.10	13%	£194.49	£209.13	£215.84
York	£70.90	16%	£76.22	£75.94	£83.39

Notes: i The last month for which data are recorded in the Spend Network figures goes up to July 2019 but the dataset is not necessarily up to date for all councils up to this point. In the table, the annual average expenditure per capita has been calculated as an approximate annualised average figure by dividing the total transactions data by 3.58, representing the three years of 2016-18 and the first seven months of 2019 (7/12).

ii Data from the Adult Social Care Activity and Finance Report, which includes data from the Adult Social Care Finance Return (ASC-FR) and Short and Long Term (SALT) collection <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report> (Accessed 22.10.2019)

iii Total transaction figures in Spend Network data exclude Bournemouth, Christchurch and Poole, which was created as a new local authority in April 2019

iv The value of transactions that have been subsequently matched by Spend Network to a CQC location (care home).

v Total includes Client Contributions, Joint Arrangements, NHS Income and Other Income

vi Torbay does not commission its social care provisions, the figures instead are for Torbay and South Devon NHS Foundation Trust



Further Information

For further details about us, our mission and values, the Board of Trustees and the Executive Team please visit our website or follow us on Twitter.

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