Buying a Care Home? Residential and/or Nursing? And is Complex Dementia Care the Right Path for You?

A director's honest view of the most consequential decision a care home owner makes — in Scotland or England, in 2026.

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If you own a care home, or you are about to buy one, two decisions matter more than any others. Should you be a residential home or a nursing home? And should you provide complex care for people living with dementia? Get either wrong and almost everything downstream — fees, staffing, inspection outcomes, insurance, the relationship with your commissioner, even the eventual buyer of the home — works against you.

I have spent twenty years in the sector and am completing doctoral research on the lived experience of people with dementia in residential settings. What follows is the conversation I have with owners who come to Mac Research & Consultancy with one of two questions: "Should I convert?" and "Should I take the dementia work?" I will lay out the 2026/27 numbers, draw the line between Scotland and England, and end with the view I have arrived at after enough mistakes of my own to feel entitled to one.

The fundamental fork

Residential homes provide personal care. Nursing homes do all of that and add registered-nurse cover twenty-four hours a day, with the equipment, governance and clinical oversight that follows. In England the Care Quality Commission inspects both against the same five key questions; in Scotland the Care Inspectorate uses its quality framework for care homes for older people. The Health and Care (Staffing) (Scotland) Act 2019, in force from April 2024, has made staffing-to-assessed-need an explicit regulatory test — Quality Indicator 3.3, "staffing levels are right and staff work well together", is now where the conversation begins.

> *I have walked into residential homes doing nursing-level work without the registration or the registered nurses to support it. That is the most dangerous place a provider can be — and the easiest place to drift into as residents age in place.*

Registration drift is the most common failure mode. The seventy-eight-year-old who needed prompts five years ago is now eighty-three, with falls, a recent infection and early cognitive change. The home stretches a little — more medication management here, a little wound care there. None of it crosses a line on any single day, but in aggregate the home is providing care its registration does not cover, and the Local Authority is paying residential rates for it. That gap is where regulatory action begins.

Funding in England 2026/27

Four numbers anchor every English business case. The average self-funder pays roughly £1,298 per week for residential and £1,535 for nursing (April 2026). The Local Authority commissions at roughly £908 and £1,225 respectively. The nursing differential is therefore £237–£317 per week — and that gap has to pay for registered nurses, clinical governance, additional training and the higher employer National Insurance bill.

On top sits NHS-Funded Nursing Care (FNC): £267.68 per week from 1 April 2026, a 5.4 percent uplift; £368.24 for the pre-October 2007 legacy cohort. FNC is paid directly to the home for every clinically eligible resident regardless of means, and materially changes the unit economics of a conversion. NHS Continuing Healthcare goes further — where a resident has a "primary health need", the NHS funds the full package, with the rate negotiated between the home and the Integrated Care Board. A home with credible complex dementia capability becomes the home an ICB calls when it has a hard placement to make.

The means test sets the upper capital limit at £23,250 and the lower at £14,250. Above the upper limit the resident pays in full. The cross-subsidy is real and central: self-funders can pay £200–£250 a week more than the LA-commissioned rate for an identical bed. Without that gap most homes do not break even on LA placements; with it, viability is a function of your self-funder mix — and that mix is harder to attract into a residential home that does not credibly handle dementia.

Funding in Scotland 2026/27

Scotland's settlement has three pieces: the National Care Home Contract, which sets the LA-paid rate; Free Personal Care and Free Nursing Care, paid universally for every assessed resident; and a means-tested contribution to accommodation.

The National Care Home Contract

The NCHC is the annual collective agreement between COSLA and Scottish Care that sets a single national weekly rate every Scottish Local Authority pays for an LA-funded placement. There is no rate negotiation with individual councils — what is agreed nationally is what is paid locally. For 2025/26 the rate is £1,013.05 per week for nursing and £881.98 for residential, effective 7 April 2025, with uplifts of 6.68 per cent and 6.79 per cent respectively. The 2026/27 settlement is in process at the time of writing; uplifts are typically backdated to 1 April with the consolidated payment landing May–July.

The structural implications matter more than the headline rate. Your LA-paid rate is the same in Aberdeen, Argyll or the Borders, regardless of operating costs or product quality, and you have no individual negotiating leverage with the council. The Scottish nursing rate also sits roughly £212 per week below the English LA-commissioned nursing average of £1,225, so Scottish nursing margin is structurally thinner on the LA side and the self-funder differential becomes the only meaningful pricing lever.

> *The NCHC is the single most consequential number in Scottish care home economics. If your bottom-up cost build doesn't produce a margin against it, no amount of self-funder positioning will repair the home.*

Free Personal Care, Free Nursing Care, and the means test

Free Personal Care of £260.30 per week and Free Nursing Care of £117.10 per week are paid directly to the home for every assessed resident, regardless of means. Accommodation is means-tested separately: from April 2026 the upper capital threshold is £36,750 and the lower is £22,750 — both materially higher than the equivalent English limits. The Personal Expenses Allowance is £35.90 per week.

And no NHS-CHC equivalent paid into a care home

One additional cross-border point shapes the complex-dementia case: Scotland does not have an equivalent of NHS Continuing Healthcare paid into a care home. The pre-2015 framework was replaced on 1 June 2015 by Hospital Based Complex Clinical Care (DL(2015)11), which funds care in full but only within a hospital setting. The 100-per-cent NHS-funded, premium-rate

placement stream that an English nursing home can build into a complex-dementia business case has no Scottish counterpart in a care-home setting. The National Care Service remains the live political question behind all of this; if you are buying a Scottish nursing home in 2026, you are buying into a regime in transition, with the NCHC as its most settled building block.

The dementia question

The Alzheimer's Society estimates that around 70 per cent of older people in residential care in England — roughly 348,000 individuals — are living with dementia, severe memory problems or significant cognitive impairment. The Scottish proportion is broadly comparable. You are not choosing whether to take on dementia care; you are choosing whether to declare it, register for it, train for it, design for it and price for it — or whether to drift into it without doing any of those things. The CQC also reports that only around a third of care workers in England have received any dementia-specific training, and that gap shows up consistently in 2024/25 inspection findings for homes placed in special measures.

"Complex" dementia care, in current regulatory and clinical practice, means one or more of: behavioural and psychological symptoms of dementia (BPSD) that cannot be managed by general nursing techniques; co-existing physical conditions complicating cognitive presentation; advanced or end-stage dementia requiring full assistance with all activities of daily living; high falls risk in a person retaining independent ambulation; significant safeguarding risk. In practice, a complex dementia provider is a nursing home with a dementia-friendly environment, an RMN skill mix alongside RGNs, and non-pharmacological intervention as the first-line response to distress.

Workforce and training: can you staff what you are registering for?

The Skills for Care "State of the Adult Social Care Workforce in England 2025" report shows the workforce finally growing again — filled posts up 3.4 per cent in 2024/25, turnover down to 23.1 per cent, vacancies down to 7 per cent from a 2021/22 peak of 10.5 per cent. The harder fact is that around 16 per cent of registered nurses in adult social care are bank, pool or agency. Agency RGN cover at 2026 rates of £25–£30 per hour weekday — with premiums on top — will turn a viable unit unprofitable inside two quarters. If you cannot recruit a substantive RGN team, you cannot run a sustainable nursing home, full stop.

Training is the second pillar. England uses the Dementia Training Standards Framework — Tier 1 (awareness), Tier 2 (regular contact, the level expected for nurses, care assistants, activities and front-line hotel staff), and Tier 3 (clinical specialists). Scotland uses Promoting Excellence 2021, with four cumulative levels: Informed, Skilled, Enhanced and Expert. A realistic training spend for a nursing home with serious dementia commitment is £300–£550 per head per year before backfill cover — invariably the first line cut when occupancy slips, and the most expensive saving owners make.

> *Substantive registered nurses, well-led, are not the most expensive line in your budget. They are the most undervalued line. Lose them and you lose the home.*

Where the margin actually sits

Margin in care does not come primarily from fees. It comes, in this order, from occupancy, skill-mix discipline, agency avoidance and a self-funder mix high enough to absorb the LA cross-subsidy. Two findings recur. First, a well-run residential home with strong dementia capability — Tier 2 / Skilled-level practice, a dementia-friendly environment, robust admission policy — will

often outperform a struggling nursing home on margin, rating and retention, because its skill-mix bill is lower and its regulatory exposure is contained. Second, a nursing home with serious complex-dementia capability — substantive RGNs, an RMN clinical lead, purpose-designed environment, tight medication and falls governance — is the highest-fee, highest-demand, lowest-vacancy proposition in the sector. The barrier is operating capability, not demand.

A practical decision framework

When owners bring the conversion or complex-dementia question to Mac Research & Consultancy, we work through five sequential checks. None is conclusive alone; failed together they are an unambiguous answer.

Has the home, over the last 24 months, taken on residents whose assessed needs sit at the upper end of the residential band or above? If yes, registration drift is already underway — the choice is conversion or active discharge.

What is the supply of nursing beds within a 30-minute drive, and the demand for complex dementia placements from the local ICB or HSCP? In 2026 there are 8.3 care home beds per 100 people aged 75+, down 26 per cent since 2012. Supply is short almost everywhere; complex supply, shorter still.

Can you recruit substantive RGNs and a dementia clinical lead at Enhanced / Tier 3 level? If the answer relies on agency cover, you do not yet have a viable nursing home.

Have you budgeted for environmental redesign, equipment, training and the working capital to absorb the inevitable dip in occupancy and rating during conversion? A realistic conversion budget for a thirty-bed home is £250,000–£450,000.

Does your registered manager have the experience, dementia training and temperament to lead clinical staff? If not, the appointment is the single most important decision in the whole project.

A closing reflection

Doctoral research has the unhelpful effect of making me less, not more, certain about questions I used to answer briskly. Five years ago I would have told you that any care home with reasonable occupancy should convert to nursing and seek dementia accreditation, because that is where the money is. I no longer believe that. The right answer is the one your operating capability can sustain — and that capability is a function of leadership, workforce and culture far more than of registration.

There is a moment in fieldwork that has stayed with me. A small Scottish nursing home, not the smartest nor most highly rated, where every member of staff knew every resident's name and life history. The senior carer noticed the smallest change in a woman who had not spoken aloud for three years and acted on it within fifteen minutes. It was the best dementia care I have seen and the most viable business I have studied. That is what is actually for sale in this sector when it is done properly: not beds, not registrations, not fee differentials, but the small, patient, clinical, deeply human work of paying attention.

> *Do not register for capability you cannot staff. Everything else — funding, design, fees, marketing — follows the staffing decision, and the staffing decision follows leadership. Build the leadership first.*

Sources & about

Drawing on: CQC State of Care 2024/25; Skills for Care, State of the Adult Social Care Sector and Workforce in England 2025; LaingBuisson, Care Homes for Older People UK Market Report (35th & 36th editions); NHS England NHS-Funded Nursing Care guidance for April 2026; Care Information Scotland standard rates 2026/27; the 2025/26 National Care Home Contract (published by Scottish Care and HSCPs); Alzheimer's Society dementia statistics; the Dementia Training Standards Framework (Skills for Health, Skills for Care, NHS England); Promoting Excellence 2021 (NES and SSSC); Scottish Government Director-Letter DL(2015)11 on Hospital Based Complex Clinical Care; and the Health and Care (Staffing) (Scotland) Act 2019.

Mac Research & Consultancy supports care home owners with operational diagnostics, registration and conversion advice, dependency-based staffing modelling, training audit and acquisition diligence across Scotland and England. If you are weighing a residential-to-nursing conversion, considering a move into complex dementia care, or trying to understand whether your current registration still matches your residents, we would be glad to talk.