Tom Atherton, junior analyst, and **Adam Scott**, senior partner, at Mansfield Advisors LLP, provide analysis of the adult specialist sector and offer some insight as to where it is heading

How **special** will **specialist care** be?

Investors have always liked backing the long-term care needed by adults with intellectual and developmental disabilities – who need help and sometimes very high levels of assistance to be able to live both comfortably and safely in our communities.

In the UK, the terminology is learning disabilities, but the needs of c.55,000 people are substantial and last beyond education and throughout their entire lives.

They can also benefit from subtly distinctive housing provision and arrangements, attracting property investors.

Private equity has prospered when it has been backing the move away from institutions and residential facilities towards true home environments. Policymakers' general preference for supported living versus residential provision in smaller homes has been strong since the noughties.

In the last decade it has continued, and we have seen a further major shift even for the most complex c.3,500 individuals who had at times seemed likely to stay in larger facilities, perhaps 25–40 beds, legally categorised as hospitals.

This provision was no longer politically tenable after the Winterbourne scandal had demonstrated that this old-fashioned model posed unavoidable operational risk from poor working culture and site management.

In 2019 BBC's *Panorama* exposed further proof of the problems of these institutions in a documentary on Wharton Hall with nine of its care workers currently undergoing trial for ill treatment and wilful neglect.

Sector activity

The sector is fragmented with the top ten providing only 20.2% of private sector beds in 2020, from 18.2% in 2016 (see Figure One).

Private equity is also looking for a buy-and-build consolidation opportunity, but this has not happened outside of the higher cost challenging behaviour and highly complex market. Most providers remain small independents, often charities, at lower price per week, who are most often not straightforward to acquire and integrate.

After a quiet year, there is renewed private equity activity. In our personal experience, this market for corporate control saw the least impact from Covid, with processes and discussions continuing almost without pause through even

the uncertainty of the first lockdown.

In November 2020 Stirling Square acquired Consensus Support from its founders, the Caring Home Group. Intriva Capital acquired the Sequence Care Group from Horizon in September this year after eight years. Icon Infrastructure acquired a majority stake in Choice Care Group in October 2018 at 15.2x EBITDAR.

These EBITDAR multiples demonstrate the attractiveness of the sector to those with moderate return/lower risk expectations. We do expect OMERS' owned Lifeways, a pure supported living player, and Voyage Care (Duke Street/Partners' Group/Tikehau Capital) to be sold relatively soon, given their acquisitions from August Equity in 2012 and HgCapital in 2014 respectively.

AMP Capital is an Australasian infrastructure fund seeking higher returns in this sector through active ownership. They acquired The Regard Group in December 2017 at 17.3x EBITDAR and then the Care Management Group (CMG) 12 months later at 14.3x EBITDAR. These were then merged to form Achieve Together. The provider has been actively acquiring, including both United Health and RNID's residential and community services this year within three months. They certainly aspire to further consolidation.

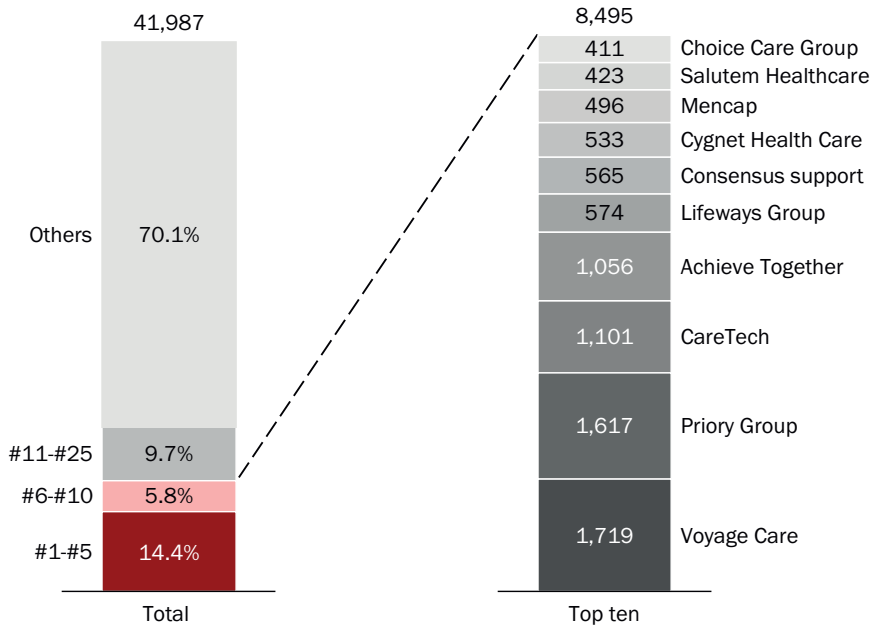
REITs encountering regulatory risk

The structural shift to supported living has presented new opportunities for property investment in the care market through real estate investment trusts (REITs).

REITs purchase the supported-living accommodation facilities and then may have them administered by housing associations, who would be responsible for the accommodation. The monitoring and social care would then be provided by a specialist operator, who may or may not have own residential facilities themselves elsewhere.

Housing associations that utilise this model are usually relatively small. The risk of this type of investment was highlighted in early 2018 when First Priority Housing Association was forced into company voluntary arrangement with

FIGURE ONE – INDEPENDENT LD RESIDENTIAL BED CAPACITY
BEDS, JANUARY 2020

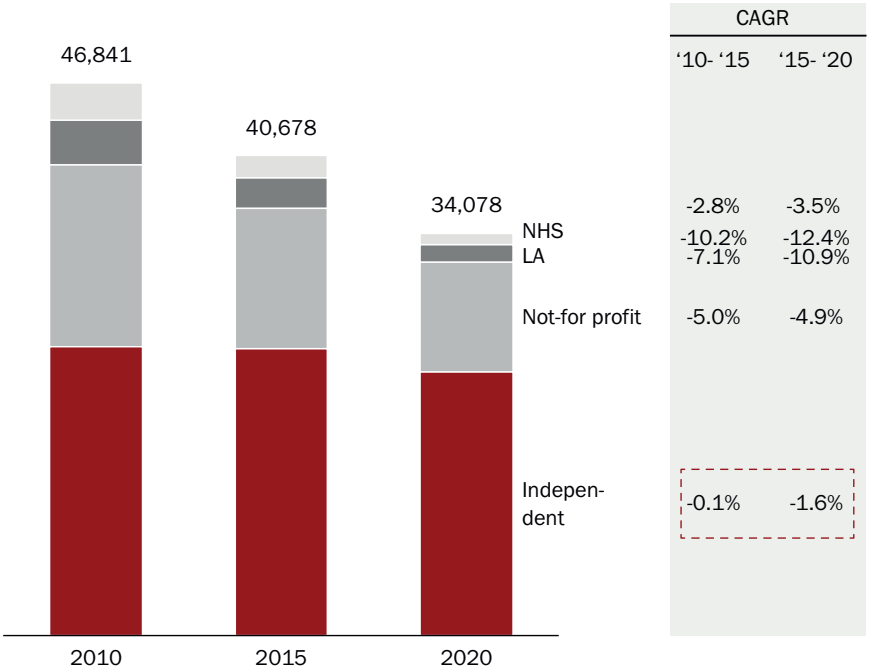


NOTE RESIDENTIAL BEDS AS OF JANUARY 2020 – LEARNING DIFFICULTIES ONLY
SOURCE LAINGBUISSON

creditors. This triggered the Regulator for Social Housing to publish an addendum to its October 2018 'sector risk profile' highlighting its disapproval of 'lease-based providers of specialised supported housing'.

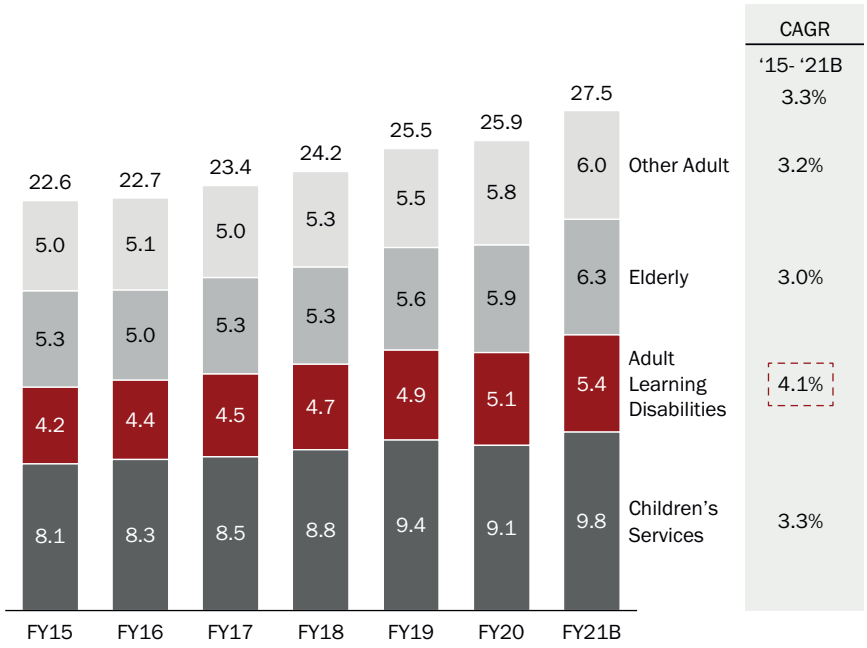
Civitas Social Housing REIT is a major player. Its growth stalled in 2019 when the regulator issued notices and downgraded its housing association counterparties owing to financial difficulties. Its rental contract income is only guaranteed short-term though it signed 25-year property leases with the REITs. Civitas's largest leaseholder, Auckland Housing Association, was issued a regulatory notice as recently as mid-August 2021. However, Civitas has continued to grow through the acquisition of the Heathcote Group's 72 freeholds in 2020 and more

FIGURE TWO – LD OCCUPIED RESIDENTIAL BEDS
SERVICE USERS



SOURCE LAINGBUISSON; MANSFIELD DATABASE AND ANALYSIS

FIGURE THREE – LA SOCIAL CARE SPENDING
£BN, NET CURRENT EXPENDITURE, ENGLAND



NOTE INCLUDES 18-65 MENTAL HEALTH, 18-64 SENSORY, 18-64 MEMORY AND COGNITION, 18-64 PHYSICAL, ASSISTIVE EQUIPMENT AND TECHNOLOGY, CARE ASSESSMENT AND SAFEGUARDING, INFORMATION AND EARLY INTERVENTION, COMMISSIONING, STRATEGY AND ADMIN SUPPORT. NB THAT NHS FUNDING ACCOUNTS FOR A LARGE PROPORTION OF ELDERLY CARE SPENDING
SOURCE DEPARTMENT OF COMMUNITIES AND LOCAL GOVERNMENT: NET CURRENT EXPENDITURE; MANSFIELD DATABASE AND ANALYSIS

recently another 15 sites in Wales.

Short-seller Shadowfall has questioned the viability and quality of Civitas's revenue.

Another major REIT player, Triple Point Housing, also experienced the same indirect regulatory challenges, but similarly has continued to acquire, including 58 properties in 2020.

The challenges continue as The Falcon Housing Association, understood to be a major supplier to both, was issued regulatory notices more recently in November 2021.

BMO Global Asset Management aspires to overcome these challenges through variation of lease lengths with the care-provision contracts for its own expressly formed REIT. BMO was due to announce fundraising results in early October, but any initial public offering (IPO) has now been postponed owing to 'sector volatility'.

Despite these REITs having achieved such growth, these regulatory notices are a material risk for their business model. BMO's inventiveness could offer a solution, but it will need to achieve longer care contracts more than any reduction in leases.

Investment opportunities

Looking at the data, the residential segment has continued to decline (see Figure Two) yet this headline negativity is misleading. Packages have shifted, both directly and this past decade more by churn, into the supported living segment.

Supported living homes are not straightforward to distinguish from residential facilities. Both can be a large house of six, or more bedrooms, however for supported living people have individual tenancies for their bedrooms. Recently built accommodation is more likely to have studio apartments, with separate kitchenettes and bathrooms, with their own external front doors.

You might also assume that residential is more suited to challenging behaviour than supported living. Challenging behaviour being more than a lack of co-operation, but often a possibility of violence and self-harming.

Residential is never about physical security in the built environment, beyond sensible adaptations to prevent injury. The appropriate care relies on relational security, systematic processes, and well-supported, capable staff and this can be often done as well in supported living. Indeed, it could be better as the flexibility of supported living may allow for bespoke living arrangements more likely to avoid incidents.

Another source of high dependency and cost is severe physical disability. This is more suited to a residential package when combined with intellectual disabilities.

The average care package is £1,106 per week. Corporate providers charge more – we estimate c.£1,650 per week – as they support higher cost segments where their case handling, systems and process capabilities can be justified.

Charities accounted for 27% of residential occupancy in 2020. We believe they have disproportionately exited the market as wage costs have increased. For example, the not-for-profit Scope was a notable exit in 2018.

Changing operating models

Residential accommodation and care are provided by a single organisation. Supported living accommodation is paid by the state, and care staff are employed by a separate provider. New build supported living accommodation is clustered. Supported living accommodation is not paid from the social care budget, another reason for local authorities to prefer it.

Residential capacity continued to decline between 2015 and 2020, new annual bed registrations were c.500 and c.1,700 were deregistered. The long-term trend is obvious – from unnecessary institutionalisation towards actively supporting people in their own homes – and in the last decade it has gone further, perhaps to its apotheosis, as the policy was to move the most challenging and complex segment of 3,500 individuals, often with dual diagnosis with mental health, out from institutions into smaller home-like facilities.

The proximate cause of this level of ambition was the 2011 Winterbourne scandal, mentioned above. The gross abuse from staff at an inpatient facility in Gloucestershire was thought by policymakers to be an inherent risk of facilities with 30–50 residents.

The Transforming Care programme in 2015 has been responsible for this. The NHS's 2019 long-term plan by 2023/24 aspires for only three in 100,000 adults residing permanently in an inpatient facility.

Other actions of regulators also indirectly favour supported living. The official guidance from the Care Quality Commission (CQC) states there is no maximum

number of beds in residential. However, any provider will tell you that successfully registering more than six on a site is very difficult. No such constraints exist on the amount of supported living activity that can be managed through a single back office or in a single location.

Lower acuity supported living often has 'floating support' which is similar to domiciliary care. A larger supported living cluster is easier to achieve, offers economies of scale along with greater independence and care choice. However, CQC are not going to sit back as you build something that resembles a campus – the accommodation can be clustered but still needs to give the resident their independence.

Investment risks

Care for people with a learning disability is paid for by the local authority. Many local authorities are in financial deficit, but adult social care has remained protected against cuts. There is a very limited possibility of families paying for care, though of course there is much informal care in early adulthood from parents. This segment of adult social care is growing fastest (see Figure Three).

All councils – with adult social service responsibilities – have used their 'precept' authority to increase taxes to pay for social care. The government confirmed the precept will be extended to FY22 and FY23 with the option to raise 3% in either year or split this between them. This will provide £610m for adult social care in FY22.

Four local authorities – Bexley, Eastbourne, Luton and Peterborough – have been recently bailed out by the state after having been in the equivalent of bankruptcy.[1] Overall, funding for the sector looks to be safe for the foreseeable future.

Unfortunately, Covid-19 has highlighted the vulnerability of those under care. Public Health England reported that people with learning difficulties had a Covid death rate 4.1 times that of the general population, adjusted for demographics, between March and June 2020. Therefore, providers have been challenged operationally to protect their service users but have been supported financially to do so. Local authorities' total grants of £3.2bn supported social care. Additionally, the state budgeted £1.15bn of an infection control fund for adult social care and another £120m to support the workforce.

> THERE IS NO REASON WHY PROVIDERS SHOULD NOT INCLUDE BOTH SUPPORTED LIVING AND HIGH ACUITY RESIDENTIAL

Minimum wage increases in the National Living Wage (NLW) have challenged the profitability of the sector. Providers are dependent on low paid staff, thus margins have been affected.

Aggregate EBITDAR for the seven largest corporate providers had fallen from a pre-austerity peak of around 25% in 2011 to 18% in 2018. The local authority precept barely covers the increases in NLW that have come into place. In the autumn 2021 budget review, chancellor Rishi Sunak announced a further rise in the NLW from next April.

In better news, the long-standing 'sleep-in' issue has been resolved in favour of care providers, whereby operators do not need to pay workers the NLW for time they are asleep. A legal case involving Mencap, a non-profit specialist care provider, had the potential to cost operators £400m if the decision had not gone in their favour.

Overseas

Private equity is highly active in the American behavioural health sector, and increasingly so within intellectual and developmental disabilities (IDD), their term for learning disabilities.

Corporates are now material in provision, including larger players. Centerbridge Partners' Sevita Health's employs 40,000 and reports EBITDA at $300m (£226.2m). Sevita is acquiring actively, including Good Neighbor in Virginia and Caring R Us, the Cameron Group and JEM Homecare Solutions in Massachusetts.

More recently in October, it acquired 379 residential, 'supportive living' and day centre programs across seven states from Help at Home. (Note that the largest UK provider, Voyage Care, has only 259 sites.) Another player, Caregiver Inc. has made 24 acquisitions since 2015 and was acquired last year by the private equity firm WindRose Health Investors.

Corporatisation of the sector – large chains of multi-site providers with professional investors – is obviously well underway. We would expect that there are multiple learnings and capabilities that UK investors should be able to apply here, and these should also apply to similar opportunities in EU countries closer to home.

Outlook

The opportunities from policy shifts may be lower in the next decade, as more individuals – including the most complex – are thankfully in the right setting for them. There will remain local opportunities for more supported living developments, but they require tactical skill – good local authority relationships and understanding of need – to ensure good fill-rates.

Consolidation remains a great opportunity, especially as supported living can scale better than residential and is asset light.

There is no operational nor commercial reason why major providers should not include both supported living and high acuity residential. The challenges of compliance and staffing have already partly consolidated the challenging behaviour segment, and this will extend further down the care complexity pyramid into larger segments.

Investors earlier this decade who sought to ride the wave of consolidation appear correct, but perhaps were too early. Those investors who focused on high acuity did obviously benefit from the policy shift towards community care packages for the highest complexity individuals, even if implementation was slower than they might have liked. Now those providers appear best placed to us to lead on broader sector consolidation into the 2020s.

NOTES

1 https://www.bbc.co.uk/news/uk-politics-56018438