Response to Health Select Committee's enquiry into social care

About the BVCA: The British Private Equity & Venture Capital Association (BVCA) is the industry body and public policy advocate for the private equity and venture capital industry in the UK.

The BVCA Membership comprises over 230 private equity, midmarket and venture capital firms with an accumulated total of approximately £32 billion funds under management; as well as over 220 professional advisory firms, including legal, accounting, regulatory and tax advisers, corporate financiers, due diligence professionals, environmental advisers, transaction services providers, and placement agents. Additional members include international investors and funds-of-funds, secondary purchasers, university teams and academics and fellow national private equity and venture capital associations globally.

As a result of the BVCA's lobbying and reputation-building efforts, private equity and venture capital today have a public face. Venture capital is behind some of the most cutting-edge innovations coming out of the UK and that many of us take for granted: the medical diagnostic services we use in hospitals, the chips in our mobile phones, the manufactured components of our cars, and the bioethanol fuels that may run them in the future. Likewise, private equity is behind a range recognisable High Street brands, such as Boots, Phones4U, Birds Eye, National Grid and RAC.

Summary

- Demographic pressures will vastly increase demand in the social care sector, with the population aged over 80 more than doubling by 2080. With public provision more costly and in decline, the private and not for profit sector will have to pick up the slack
- Private equity represents a significant subsector of private provision in health and social care, having invested £1.6bn since 2006. Our services range from supported living, specialist care for Dementia and more conventional residential care homes
- With the private sector contributing significantly to service provision, it is imperative that the market drives up standards and quality. The latest survey suggests that 88% of private residential care homes were rated as good or excellent. However the Care Quality Commission has recently suspended its star ratings system. New metrics should be restored as soon as possible
- Social care provision involves looking after society's most vulnerable therefore everything must be done to ensure continuity of care where businesses get into difficulty. It is important to note that care homes do close on a regular basis (175 in the year to March 2010) and continuity of care has been maintained with 'little or no impact on residents'[1]. However Southern Cross has demonstrated that the measures available are haphazard and poorly communicated which has spread anxiety for residents and their families.
- Rather than new regulations on acceptable business models which would likely deter investment at the worst possible time, a comprehensive and universal failure regime should be consulted on and when devised, properly communicated to all stakeholders
- The regime for Local Authority Fees has been inconsistent which has rendered the investment climate more difficult and in some cases led to service providers getting into difficulty. To deliver the significant and long-term investment required, this regime should be overhauled to deliver more consistency in pricing

[1] NAO - *Oversight of user choice and provider competition in care markets*

Introduction

1) As significant contributors to the health and social care sector, the private equity and venture capital industry welcomes the opportunity to contribute to this enquiry. The UN's latest population projections see the population of those aged over 80 more than doubling to 9% in the UK or 6.6 million people by 2050[2]. By 2081, three and a half times as many people will require residential care[3]. This does not include those care recipients who receive it in their own homes. As owners and operators of residential care homes, domiciliary/supported living services and care facilities for adults with learning difficulties, we have a serious responsibility to participate in and contribute to a debate on the future of the sector. It is imperative that to secure the investment needed to deliver adequate provision to cope with changing demographics, but more importantly to ensure that provision delivers a high quality of care for some of society's most vulnerable citizens, we have a stable and consistent regulatory and funding environment for the benefit of all participants.

What we do

2) BVCA members invested £680m in healthcare providers in 2010 for a total of £1.8bn since 2006[4]. This ranges from large scale care home providers like Southern Cross which was owned by private equity until 2006 and niche care businesses like CASA Ltd, currently owned by Bridges Ventures, a social investment fund. Below are some detailed case studies of private equity ownership in social care.

Case Study: SLC Group – backed by ISIS Equity Partners 2006 to 2011

3) SLC is a leading provider of supported living services, providing support for adults with both learning and physical disabilities, challenging behaviours and mental health needs.

4) Since 1948, the government has been responsible for supporting adults with mental health needs. Increasingly, though more and more of this provision is by both the private and the independent sector – now as much as 68%. This is a societal need that is growing at 3% a year thanks to improved survival rates at birth and better diagnostics. Supported Living is fast becoming the primary means of delivering this service.

5) In partnership with local authorities, cost effectiveness is increased through contracting by the hour, which supports living as opposed to residential care support. This delivers heightened productivity and value for money for local authorities. It also allows the capacity for innovation in service delivery with flexibility being key for both commissioner and service user – any one user will have different technology needs as well location/property needs. Furthermore a competitive market means quality is paramount and the Care Quality Commission (CQC) recently awarded SLC a three star rating before this benchmark was discontinued

6) ISIS and SLC: ISIS acquired their stake in 2006 and since then it has built a professional management team capable of driving growth from a founder led business. This led to expansion from a local provider to a leader in the North of England. It has driven a strategy to develop differentiated service offerings in keeping with the increased personalisation of user needs.

[2] See http://esa.un.org/unpd/wpp/unpp/p2k0data.asp

[3] Laing and Buisson – Care of Elderly People UK Market Survey 2010

[4] BVCA statistics – 'healthcare providers' includes social care, domiciliary care and other types of healthcare.

Case Study: Care and Share Associates (CASA)–backed by Bridges Ventures Social Entrepreneurs Fund

7) CASA is the UK's leading employee-owned homecare social enterprise in the social care sector, delivering a range of independent living, home care and support services. Under a 'social franchise' model, CASA currently operates 5 companies across the North of England, providing more than 5000 hours of care per week. Through operating an employee-ownership model, CASA aims to provide more rewarding roles for employees and better patient care, which in turn allows the company to present a compelling offer to local authorities looking to tender out these services.

8) CASA's 'social franchise' model and resulting benefits: Staff in this typically low-paid industry are awarded a share of the profits from the business, and moreover input into how the organisation is run. This results in a better quality of care for the service-users, particularly as CASA is able to achieve considerably lower staff churn (c.3%-10% across their different sites - lower in the more established sites) than the rest of the industry (c.24% as private sector industry average[5]). Service users generally have one main carer (with others covering illness or holiday) rather than a permanently changing mix as is usually the case in the sector.

9) Through local ownership (each individual site or franchise company is majority owned by local employees), the model ensures surpluses are invested in the local community, while providing employment for those in the most deprived parts of the country (as at April 2011, 72% of carers lived in the bottom quartile of local wards, defined by the Index of Multiple Deprivation).

10) Bridges Ventures and CASA: The investment came from its Social Entrepreneurs Fund which puts social impact ahead of financial return when considering investments. Bridges invested £200,000 through a 'social loan' in May 2011 to strengthen the CASA's core business and provide a robust platform for future growth. With interest linked to CASA's revenue, investor returns are aligned both to CASA's commercial success and the scale of its social impact. It is envisaged that further funds will be invested by Bridges to support future roll-out through the employee-owned franchise company model with a mission to greatly enhance the sector by providing more rewarding roles for employees, and better care and outcomes for individuals receiving support.

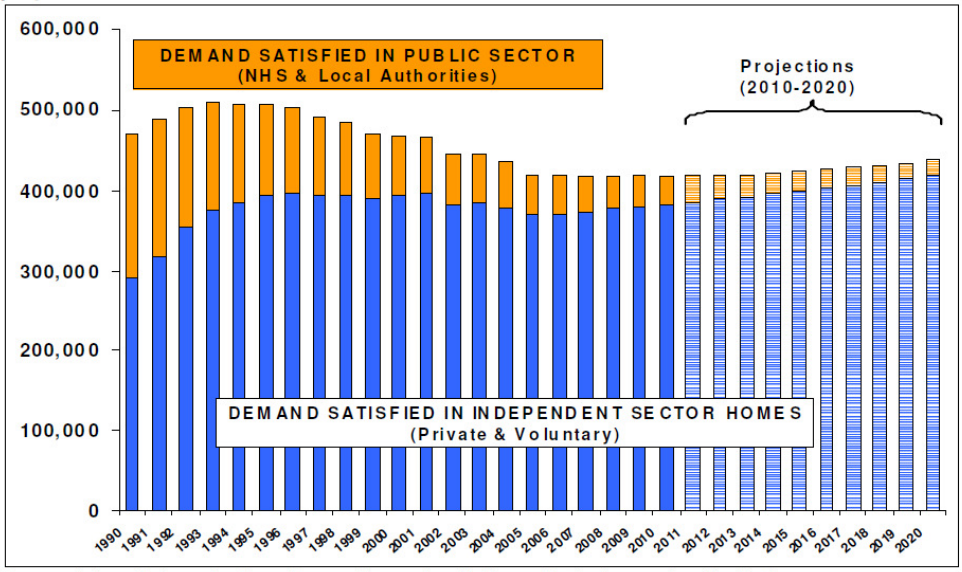
State of the Care Market

11) By 2081, 1.5m people will require residential care and there remains the question of who will provide it? The annual value of the market is £14bn of which the private sector makes up £9.9bn. In domiciliary care, 60% is provided by the independent sector.

12) Demand is set to increase though with total occupancy across all provider types increasing from 418,000 today to 437,000 by 2020, an extra 19,000 places. However as the below indicates, public sector supply is reducing so the private sector must add capacity.

[5] Source: National Minimum Dataset for Social Care, produced by Skills for Care April 2010

Figure 5.2 Demand for places in care homes (nursing and residential) for elderly and physically disabled people in the independent and public sector, UK 1990-2010 and projections for 2011-2020



Sources: Laing & Buisson database. Demand figures from Table 5.1. Projections as described in the text.

13) It is also worthy of note, that where public sector provision pertains, it is far more expensive than private provision. Data published by the NHS Information Centre shows a per resident cost of £824 per week in 2008/9 vs £445 for 'other' providers. In this time of spending restraint for Local Authorities, it is predictable and necessary for this trend of greater reliance on private provision to continue so private investment into the sector must be encouraged.

Case Study: Voyage backed by HG Capital

14) Voyage is a leading provider of high acuity services for adults with learning difficulties. There are an estimated 800,000 people in England with a learning disability, of 137,000 receive some sort of support. 80,000 of these are in a residential setting and the vast majority of these services are funded by Local Authorities. Much of the provision is commissioned in the independent sector as costs in Local Authority provision are 40% higher. There is a significant shortage of residential provision of this type so securing more investment is vital.

15) In what is a highly fragmented market of 75,000 beds, Voyage is the market leader with 1924, specialising in moderate to severe learning disabilities and challenging behaviour. Voyage covers the full spectrum of learning difficulties in either a residential, supported living or own-home setting. With near complete coverage in England as well as facilities in Wales and Scotland, Voyage provides over 250 services across the UK, supporting 2,000 individuals.

16) A key strength is longstanding relationships with PCTs and local authorities based on a reputation for high quality provision. Over 95% of Voyage's registered services rated good or excellent in 2010 and this has increased from 75% in 2008 (HG Capital invested in 2006).

Quality

17) With the private sector likely to continue its pre-eminence, legitimate concerns about quality will be raised, particularly in light of service being provided at significantly lower cost than local authority provision. Unfortunately the CQC recently ended its 'star ratings' regime for care homes in favour of new, universal measures for social care and all other health care services. At this stage we do not when this scheme will be up and running. Laing and Buisson described this rating system as 'a significant driver of quality'. Indeed the final L&B analysis of CQC data as of June 2010, show that 88% of private home operators scored good or excellent (as against 94% for voluntary sector). It is important that there is a drive to get both of these sectors to as close to 100% as possible so a new ratings system and inspection regime must be agreed as soon as possible.

Government Policy

18) In its *Vision for Adult Social Care*, the Government reiterated a commitment to the personalisation of services in the context of a vibrant and diverse market for social care services. As can be seen from paragraph two, BVCA members are significant investors in this market as well as representing the whole spectrum of provision and support services from large scale care homes, to small scale in home care operators. We believe that fostering such a market is vital to drive innovation and improve quality of care. It is that ability to innovate that attracts private equity and venture capital to invest in the sector.

19) We do though recognise that there is nothing more important, nor sensitive, than how we look after society's most vulnerable. So when we talk of market entry and exit it is important to keep in mind at all times, the service users and how they might be impacted by any change in ownership. Continuity of care is paramount. The National Audit Office, in its recent report *Oversight of user choice and provider competition in care markets,* concluded that entry and exit in both care homes and domiciliary care provision is a common feature of care markets and invariably, other providers come in to run services with no little or no impact on users. However they also stated that more work was needed to protect users from provider failure.

20) A Discussion Paper from the Department of Health, *Oversight of the Social Care Markets* puts this relative success in care continuity down to a lack of concentration in the market. Before the ongoing closure and transfer of Southern Cross care homes, the largest four providers made up 23.7% of total provision[6]. This is also a figure in decline as condition in credit and property markets have become more adverse. This level of consolidation compares favourably with other markets but it is an issue that should be monitored carefully. In recent testimony to the Public Accounts Committee, the Permanent Secretary for the Department of Health was asked by members to put a number on acceptable market share, either nationally or locally. Naturally she was reluctant to do so and we understand this approach as there is no magic number. What is more important is that where one provider is gaining market share, there should be adequate safeguards should they get into difficulty. The transfer of homes from Southern Cross to new providers is ongoing and so far has been successful but we must make sure that best practice is assessed and that a formal regime is incepted and communicated

[6] Laing and Buisson

Fees

21) With labour costs making up around half of the total for care provision, the relationship between wages and Local Authority fees paid will go some way to determine the viability of investing in the sector – as of April 2010, 52% of independent care home residents had their fees paid by local authorities. But this primary source of revenue has been highly changeable. Indeed in the last 15 years, Laing and Buisson cite three different periods of funding. The first was from the mid-nineties to the turn of the century where the sector struggled with lack of demand and under-capacity and such Local Authorities imposed RPI fee increases whilst wages accelerated faster. By 2002/03, under-capacity had been largely dealt with and fee increases were running at 8%, significantly above wage and price inflation. However this 'golden period' soon ended with public spending restraint leading to fee increase of just 0.8% for 2010/11 – significantly below care home cost inflation. Laing and Buisson estimate that 2.1% increases are required for margins to be steady. Such chopping and changing creates significant uncertainty for investors. The Government should consult on a mechanism for fee stabilisation so investors can plan and implement long term strategies.

Failure Regime

22) We have seen this debate play out in banking, with continuity of service being paramount for so vital a function. Social care provision is surely even more important. Given that preventing market exit and particularly entry is not desirable, we would emphasise the importance of a sensible failure regime over onerous restrictions and interventions on business models and financials. It should not be for the CQC, the Department of Health or Local Authorities to determine what is risky behaviour, after all this is a private market. However because in social care we are dealing with society's most vulnerable, a failure regime that guarantees continuity of care is a must.

23) Our starting point is the same as that of the Department of Health who stated that new measures should encourage rather than hinder the market and not place 'undue burdens on businesses'. We would caution against onerous restrictions on acquisition as this will likely curtail investment significantly. It is the medium to long term health of the company that is of greater importance. Southern Cross was in sound financial health both when it was acquired and sold by private equity. However, proper monitoring of its period in public ownership would have highlighted the subsequent deterioration.

24) The Government has mooted the model used by the travel industry whereby licensed providers pay for a bond that covers the cost of repatriating holidaymakers in the event of provider failure. A similar model could be used in social care and certainly warrants further study. This would be much simpler than asking the CQC to regulate business models of providers either pre or post acquisition, it would guarantee continuity of care and should have a modest impact on investment into the sector.