# CYGNET/CAS MERGER INQUIRY

## Summary of hearing with LaingBuisson on 5 July 2017

### Background

1. LaingBuisson (LB) said that the mental healthcare market was the segment of the healthcare economy which was the most difficult to define, understand and describe. It highlighted the fact that there was no one dataset that would show where people were being sent and what the specific units were in all the different hospitals. Hence the data had to be built up from the bottom, from multiple different sources over a number of years and then triangulated.

2. The independent sector was being driven by the exit of NHS from delivery. The NHS was not investing in new hospital facilities, or rather was disinvesting. This was due to shortages of capital and the fact that certain mental health services were delivered under block contracts so there were not the same incentives for providers to develop. Therefore the independent sector had benefited in terms of volumes of referrals from a slow withdrawal of the NHS. This was particularly visible in 2015 where there had been a massive c 10% increase in the revenue of independent sector hospitals and it had continued, to a lesser extent, in 2016. The big growth had come from small increases in capacity but large increases in occupancy.

3. LB said the trend at present was for the NHS to put resources into non-hospital/community services and the independent sector had not only stepped in with capacity, it had also filled the gaps in specialised services that the NHS had not provided for. LB said that the NHS provided generic services which responded to the needs of the local community, local meaning the boundaries within which the Trust operated, and the independent sector focused on services which may have a regional or sometimes even wider catchment area.

4. Whilst the independent sector was the overspill function, which picked up some of the more complex cases for which there was not capacity nowadays in the NHS due to the reduction of beds, in certain areas the independent sector had a larger share of the market than the NHS. For example, brain injury and secure treatment. Therefore some segments were becoming mainstream.

5. LB said the NHS was 100% occupied, with some places being 110% occupied when a patient's bed was occupied when they were on leave. Therefore in terms of occupancy rates, the NHS would invariably come out the fullest.

6. LB said there was an exit of NHS providers running rehabilitation services because they were so pushed for beds, but the market was complicated as there were different payment mechanisms. LB said that there were NHS providers on block contracts doing rehab work within their service, but there may also be framework agreements and CCGs in the North West especially had framework agreements. Hence the CCG would set a price point and then providers would apply to be on the framework, leaving the CCG to decide who would be the most suitable. Lastly there was spot purchasing where a CCG decided a price and then there was brokering with Commissioners knowing the patient and trying to work out the most appropriate care plan with the providers.

## Innovation and getting patients back into the community

7. LB said that innovation came from two areas, the NHS trying to find more efficient ways to do things, and competition within the private sector.

8. LB said there were two motives to innovate, financial and clinical. The independent sector was much better at responding to financial incentives. They re-tooled more proactively/repositioned wards for new services, or developed new services where there may be a niche that had a larger – even national footprint because it did not have a huge addressable market. In clinical innovation the NHS was extremely strong as it focused on improvements from a clinical perspective and was not so concerned with the bottom line. Hence LB saw the private and public sectors as complementary, but thought that while the NHS had centres of excellence and NHSE had some excellent ideas, the NHS was struggling, and always had struggled, to propagate them across the system.

9. For specialised services, including locked rehab, around 50% of Trusts were on block contracts and these did not incentivise the provider to develop new services or facilities. The other 50% were on a tariff, so half of them were looking at new ways of working and there was innovation in the sector.

10. LB thought the private sector was innovative about evidencing the extent to which people were moving down the levels of security and into the community. However, it said that the goal of moving people down the care pathway, back into the community and repatriating them into their own localities had been a goal for the last ten years – the theory was good, even

as a rationale for a merger, but there was little evidence of it succeeding in changing outcomes in practise. Therefore it was a gradual progression and success would depend on individual care plans. Whilst there was a will, LB stated that there were not always suitable community placements for people to go into, there was a lack of investment at the end of the pathway.

11. LB was sceptical that the NHS would succeed in its objective of placing people closer to home because while the NHS wanted specialised services, it was unable to provide them for just two or three people. Hence to provide an economically viable service, regional or wider catchment areas were necessary.

12. Whilst there had been successes of moving people down into lower levels of security and back into the community, every week there were stories of people who had either harmed others or themselves, so arguments continued about safe environments rather than people being placed in the community.

## Investment within the market

13. The overall market may not be growing that fast, but there was an outsourcing story, like elderly care. Elderly care used to be predominantly local-authority provided, but it was now about 90% independent or not-for-profits who provided the nursing homes in the UK. LB believed that this was the direction of travel for mental health and it said that investors liked growth markets.

14. Large operators in the US were looking for growth and there had been some consolidation, which meant that the two or three big providers in the US were looking for international opportunities. LB pointed out that the UK shared a language and US firms had a familiarity with the regulatory environment and understood the market, so they saw opportunities. It was seen as an attractive market because the reimbursement environment in the UK was less volatile than in the US and it allowed them to hedge their position across a different geography and a different currency.

15. A lot of investors had reservations about going into the mental health market due to the risk that inevitably came with the patients concerned, but LB said that the market needed investment, so there was potential and if one looked at EBITDAR as a percentage of revenue, it would be comparable to other property-based segments of the healthcare market.

16. Looking at mental health providers globally, there were large players in the US, UK, Germany and Australia, but no other markets had large corporate mental health providers who had the capital and risk appetite to build services, put in new hospitals and look at international opportunities.

17. Even though the length of patient stay was shortening, it did not impact on profitability. There was a higher velocity of movement of patients through the service, but if it was priced and managed well, profitability was not affected.

18. LB said that acuity was not the driver, rather it was the market dynamics around the service provided. Secure services were paid for by NHS England, which added a further incentive as providers would prefer to be funded by NHS England than the Clinical Commissioning Groups (CCGs). NHSE has 100% purchasing power, but it exercised the power responsibly and allowed reasonable returns. CCGs were more driven by their budgets and although they lacked market power as they only accounted for a small amount of any one provider's demand and were dispersed in local areas, they were seen by many as being rather difficult/unpredictable purchasers.

19. LB said there were significant not-for-profits in the sector, with St Andrew's being one of the largest charities in the country. Therefore there were large providers out there who were not American corporates or private equity backed providers.

## Barriers to entry and a national presence

20. There were synergies in this sector. LB said that there were advantages in terms of scale due to back-office functions and also when delivering a service. For example, if a provider needed to reconfigure some wards to a different service, if it had the clinical know-how to do that within its network, it gave it a competitive advantage. Also, if a provider were building something around a speciality, it would create a knowledgebase and a network. In this respect, mental health was similar to physical health with providers focusing on a specialism.

21. LB believed there was an advantage to having a national network as if the aim was to repatriate patients to where they came from, a national network would allow that patient to be kept within the service. With scale, there was also a lower cost of capital.

22. LB said that if a patient was in a facility and was about to step down, in theory the provider would be in a better position as it could offer the next stage to suit the patient. It was important that the client knew and trusted the clinical team and it may be that the patient would be trialled at a step down location and it would not work, so they would then have to go back to a higher security setting. LB said it was much easier for the client and staff if they had been together for the whole journey. All clinicians wanted a smooth transition clinically and the more joined-up a provider was between systems, the better it was. There was more opportunity for this to happen in an enlarged group

and whilst it may be the case that it did not happen, the opportunity was at least there.

23. New entrants were coming into the market to provide rehab services, but they tended to be at the lower levels of security as it was difficult to develop an entirely new secure unit for treatment. To do it to the best standards, one would be looking at a particular design of building because the patients were complicated, so it was not just a case of buying a venue and then using it as a rehab hospital. To develop the facility would be beyond smaller operators' financial capabilities. Whilst one could enter the care home market with a couple of hundred thousand pounds, it would cost a couple of million to get into the rehab market on any meaningful scale.

24. In addition to this, one would need to register and get inspected and a CQC rating. The right level of staff would also be needed and they would have to be trained. Therefore, whilst it was possible for a new provider to start up a rehab hospital, it would be challenging.

25. LB highlighted that any ward was sub-specialised within mental health and that meant multidisciplinary staff needed to be trained in that speciality area. Staffing was the number one issue of healthcare and there was a shortage of healthcare assistants and psychiatrists. Therefore staffing was the one area where a provider could make quite significant synergies if it could decrease its locum and agency usage as this was a huge expense.

26. LB said that a provider could build a whole service around senior clinicians so if a provider was in a position to be an attractive employer, it was better positioned as a larger entity as you could offer training, but also academic aspects and career prospects as well. More investment could be made in the infrastructure and offering benefits to clinicians. Also, if a clinician was not working out, the larger organisations had the scale to move them and get the right person in. If it was a smaller operator and it only had two or three key clinicians, it could not move them on so easily as they were a fundamental part of the business. Hence a larger organisation could manage quality on a more strategic basis.

27. LB advised that whilst it was important to gather local data to understand the market, some of the services may be national – it would depend on the speciality of what they were doing.

## CQC ratings

28. LB said that NHS hospitals provide lots of services and there would be wards that were doing very different things, so one CQC rating by hospital would not

be relevant for all of them and the CQC acknowledged that within a complex hospital, an overall rating could be misleading as it really was down to the individual departments within that hospital. There was also a lot of nuance to CQC ratings and the CQC was aware that there was a certain amount of variation on the ground in terms of where the reports come out. They were not gospel.

29. It also pointed out that both private equity and for-profit providers were very focused on quality as a 'requires improvement' rating would have a material impact financially if they do not get the referral flows.

## A joined-up system

30. LB said it had never seen Commissioners interested in a brand. They, and the advocates of the client, were focused on ensuring the wellbeing of the patient, so it did not really matter who was providing the low secure, medium secure and rehab parts of the pathway. If there were three providers, it would not be problematic as long as they are all working synergistically.

31. LB described the system as being very fragmented due to the switch between funding and said the choice of facility was personal to the Commissioner and what they wanted to do, so brand was irrelevant. There was a transition from the specialist services that were commissioned by NHS England to the more local services which were commissioned by the CCGs, but the transitions could be very difficult whilst the patient was waiting for funding to be changed between the two.

32. LB stated that if providers could offer that linked care pathway, it should be a smoother transition and having one provider with a complete pathway might be the direction of travel. However, LB did not believe that this was happening today and said that the percentage of people that providers managed to hold on to was negligible.

33. LB said that capacity was not the main driver in mental health, rather it was the clinical need of the patient. Patients came with their own care package designed by the clinical team, so it was not the case that if there was a free bed, the patient would be put in it.

## The merger

34. LB said it understood the rationale for the merger, ie the trends towards consolidation and the returns available. It also said that it thought that the Parties were in direct competition with the NHS.

35. It believed that things had evolved over the last decade and that the independent sector worked much more synergistically than just being an overspill unit. The independent sector had developed into having much more specialised care and more sub-disciplines. The NHS could compete if it wanted to, but overall it made sense from a business perspective for providers to want to link up care pathways.

36. To determine the closeness of competition LB said that one needed a clinical answer regarding whether the services were suitable; an answer from the Commissioner who would be paying having made the decision to refer; and then an answer from the provider regarding if they would take the patient. It also mentioned that providers would quite frequently turn down a patient if they did not want to disturb their ward and so if the patient did not fit clinically, providers would not take them.

37. LB believed that if Cygnet had not bought CAS, someone else would have done so, including standalone PE firms.