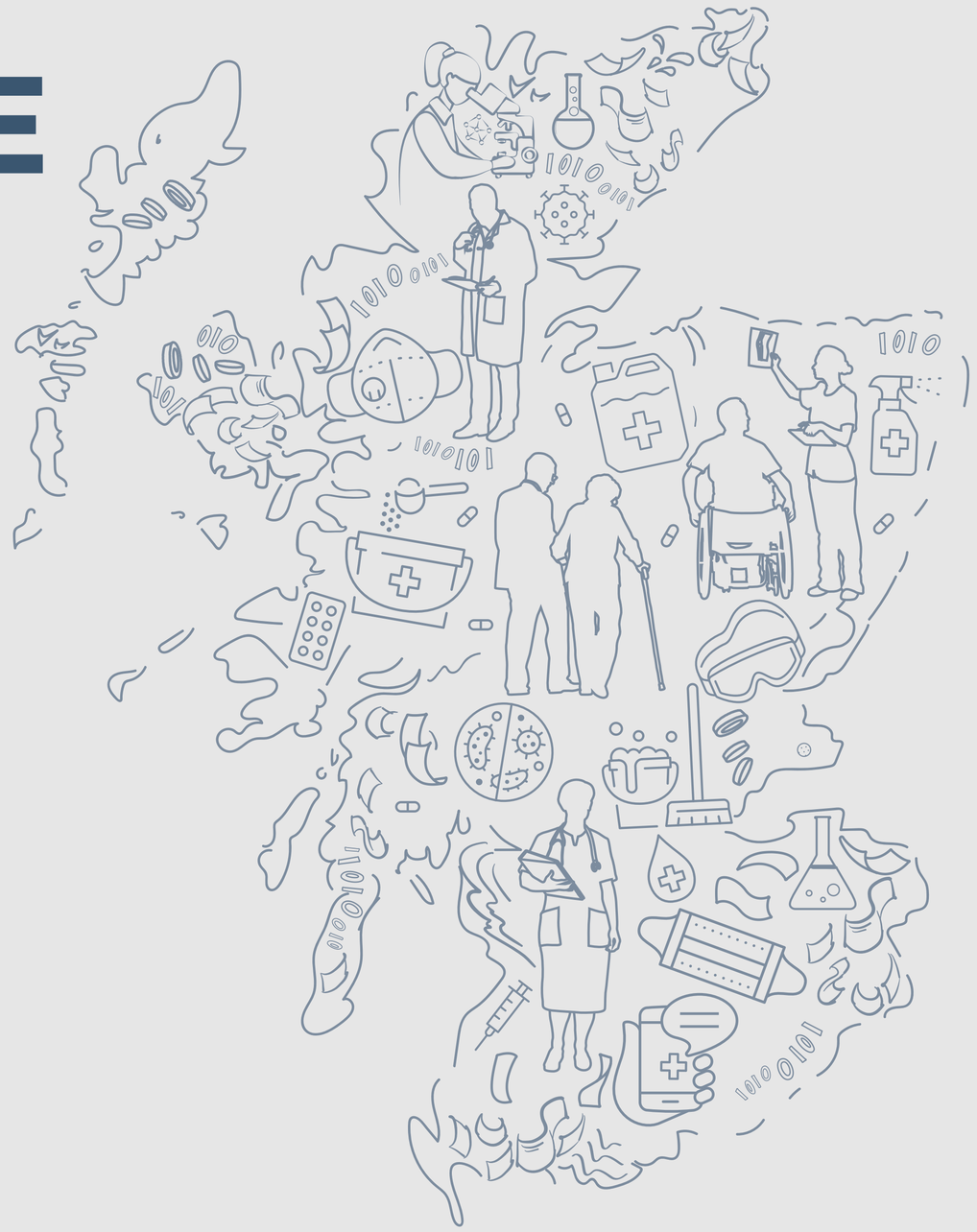
THE SOCIAL CARE CONUNDRUM



Addleshaw Goddard and
Fraser of Allander Institute

ADDLESHAW GODDARD

THE QUALITY OF ADULT SOCIAL CARE IS SOMETHING THAT MATTERS DEEPLY TO US ALL. THIS IS A MOMENT TO BE BOLD AND TO BUILD A SERVICE FIT FOR THE FUTURE. THE NATIONAL HEALTH SERVICE WAS BORN OUT OF THE TRAGEDY OF WORLD WAR TWO.

LET US RESOLVE THAT WE WILL BUILD OUT OF THIS COVID-19 CRISIS THE LASTING AND POSITIVE LEGACY OF A HIGH-QUALITY NATIONAL CARE SERVICE.

(NICOLA STURGEON, FIRST MINISTER, SCOTLAND, SEPTEMBER 2020)

MY JOB IS TO PROTECT YOU OR YOUR PARENTS OR GRANDPARENTS FROM THE FEAR OF HAVING TO SELL YOUR HOME TO PAY FOR THE COSTS OF CARE.

AND SO I AM ANNOUNCING NOW – ON THE STEPS OF DOWNING STREET – THAT WE WILL FIX THE CRISIS IN SOCIAL CARE ONCE AND FOR ALL, AND WITH A CLEAR PLAN WE HAVE PREPARED TO GIVE EVERY OLDER PERSON THE DIGNITY AND SECURITY THEY DESERVE.

(BORIS JOHNSON, PRIME MINISTER, UNITED KINGDOM, AUGUST 2019)

CONTENTS

EXECUTIVE SUMMARY

The issue of social care is fraught with challenges. It affects every person in the country either directly or indirectly. Its failings are felt acutely and often painfully. Our need to improve it becomes more critical as every day passes. It is irretrievably bound up with the services delivered by the National Health Service, the darling of British social welfare and an untouchable leviathan in both reputation and spending terms.

And yet, society should be judged on how it treats its most vulnerable, its children and its elders. As the tragic events of 2020 and 2021 so far have shown, too many of our elders in the UK have suffered.

How we frame the conversation about social care now is critical. Because ultimately, this has to be about how we treat our elders: with care, with compassion and with dignity. How that is paid for, is politics, and it cannot be allowed to dictate our access to these fundamental human rights.

In this report, we have gathered the views of a number of leading experts in social care, both in Scotland and England, and from across various sectors. Included are views from those advising sitting governments, as well as those at the forefront of the provision of care services, operations, financing and development.

What we found is that there is no, one answer to the social care crisis. Instead, there are many, intertwining and complicated answers and half answers. Politics may not like this: complex solutions don't boil down to a single easy message that can be put in front of the electorate.

The legislative and fiscal nuances involved in change are many and extremely complex. And yet, they must be reviewed and updated urgently if we are to honour the social contract we have with our elderly.

*For the purposes of brevity, this report focuses on social care provision in Scotland and England.

With thanks to contributors: Fraser of Allander Institute, Shawbrook Bank, Downing, Knight Frank, Renaissance Care and others.

FOREWORD

In the past six months, activity in the healthcare and social care sectors has accelerated. The social care component of the market is particularly intense with an increasing number of developer, operator and funding deals.

The market has long been fragmented across the UK, but the onset of the coronavirus pandemic has accelerated consolidation appetite with aggregators increasingly looking to add service providers to portfolio ownership.

A number of bespoke funds have been established, specifically focused on the social care sector including supported living, care homes, nurseries and retirement villages. The span of assets available in the social care sector provides a strong mix of medium and long-term stable income and while highly regulated, investors see this as a quality advantage.

There is also huge scope for development, with significant appetite to fund new sites focused most strongly in the south of England where demographic need is concentrated and disposable wealth robust.

Investors are attracted by the combination of capital value in property portfolio ownership along with strong, long-term incomes supported by both public sector funding via local authorities and private sector fees. This provides stability and the perception of a guaranteed income floor, though in some locations, how the interplay between public and private sector funding is likely to evolve is causing some reticence to commit to new largescale developments.

Additionally, the plans set out by Scottish regulator the Care Inspectorate in April 2018 in the ‘Building better care homes for adults’ publication seem to suggest that many of the failings in dealing with the pandemic can be solved by changes in architecture. The proposed changes, if they come in to force, will have a marked impact on provision in the sector and do not appear to be backed with clear evidence of their need.

TOM SPEIRS
Partner,
+44 (0)131 222 9809
+44 (0)7918 630938
Tom.Speirs@addleshawgoddard.com

MURRAY JACK
Partner,
+44 (0)141 574 2371
+44 (0)7917 050784
Murray.Jack@addleshawgoddard.com

MOST PEOPLE WANT TO STAY IN THEIR HOMES FOR AS LONG AS POSSIBLE AND ONLY ENTER RESIDENTIAL CARE WHEN THEY NEED TO.

HOW THE SOCIAL CARE INDUSTRY ADDRESSES INDIVIDUALS’ WISHES TO MOVE FROM HOME TO RETIREMENT LIVING, TO SUPPORTED LIVING AND FINALLY TO NURSING HOMES OFFERS CONSIDERABLE OPPORTUNITY.

PEOPLE WANT TO HAVE THE DIGNITY OF CHOICE AND IT IS UP TO THE INDUSTRY TO PROVIDE OPTIONS IN TERMS OF PRIVATE SECTOR PROVISION AND IN THE RANGE OF CARE AVAILABLE.

TOM SPEIRS, PARTNER, ADDLESHAW GODDARD

THE SOCIAL CARE CONUNDRUM

1.6 MILLION
OVER 85s IN THE UK
IN 2020

2.1 MILLION
OVER 85s IN THE UK
IN 2030

3.7 MILLION
OVER 85s IN THE UK
IN 2050

12,170 CARE HOMES IN THE UK **IN 2020**

479,600 BEDS IN UK SOCIAL CARE **IN 2020**

AVERAGE CARE HOME HAS **40 BEDS IN 2020**

7,058 BEDS
IN 122 HOMES WERE NEWLY REGISTERED IN THE UK IN 2019/20

6,789 BEDS
IN 233 HOMES WERE DE-REGISTERED IN THE UK IN 2019/20

58 PER CENT OF DEREGISTERED HOMES IN ENGLAND WERE RATED AS '**INADEQUATE**' OR 'REQUIRES IMPROVEMENT' BY THE CARE QUALITY COMMISSION

£950 PER WEEK IS THE ANECDOTAL AVERAGE COST OF A BED IN A CARE HOME

£3,500 PER WEEK IS THE ANECDOTAL AVERAGE COST OF A BED IN A HOSPITAL

SOURCE: KNIGHT FRANK

THE SOCIAL CARE CONUNDRUM

Politicians across the UK have publicly recognised the necessity of urgent reform in the way social care is provided to meet the ever-increasing need from Britain's ageing population. Office for National Statistics forecasts the UK population will pass 70 million by mid-2031, reaching 72.4 million by 25 years into the projection in mid-2043. There will be an increasing number of older people, with the proportion aged 85 years and over projected to almost double over the next 25 years.

This shift in population dynamics presents a number of significant policy challenges for government, not least, the provision of social care for the rising number of individuals in need of full-time nursing care in their final years. However, a growing population across age brackets will also mean rising demand for supported living for those suffering with mental health conditions and special needs as well as increased provision of basic childcare.

Putting the patient at the centre of how the health and social care system is designed has been tabled time and again by industry leaders and political players asked to review the sector. But while no-one would disagree with this approach, putting it into practice has proved virtually impossible given the complexity of funding decisions and, often, conflicted stakeholders involved in making those decisions. Following the devolution of health and social care policy to national and regional governments, the political landscape is even more diverse.

There is now broad recognition that this must be addressed, urgently: those who contributed to this report repeated, to a person, that social care is 'the Cinderella of healthcare'. It comes second. Social carers are not considered key workers. Nursing staff are paid less in care homes than in hospitals. Public spending on social care is done through local authorities, many of which are struggling financially, while the NHS and healthcare receives its funding directly from central or devolved governments (themselves under financial strain).

Care for those in later life particularly is more complex than the transition from at-home care to care home. Social care policy interacts not just with the provision of healthcare, but also with pension and housing policy.

Large numbers of older homeowners live in properties that become unfit for purpose as mobility becomes more restricted, but the cost of stamp duty levies coupled with an insufficient supply of suitable retirement homes, discourages downsizing. Care at home can be provided through dedicated supported living, though many opt not to pay sizeable fees for these services, instead relying on ad hoc emergency healthcare from the NHS. Bed blocking is therefore a severe problem in the UK, exacerbated by the separation of funding sources and mechanisms for health and social care.

THE SOCIAL CARE CONUNDRUM

It costs the taxpayer more to fund a hospital bed than it does to fund a bed in a care home. But to the patient, the hospital bed is ‘free’ and the care home bed must be paid for, either by the local authority following means testing, or privately. Often, it will be a combination of both – especially in local authorities where social care benefits are insufficient to meet the cost of care.

Families who feel unable to afford to pay for care fees prolong hospital stays in favour of moving patients to a care home or home with at-home care provided.

This makes sense only in a world dictated by bureaucratic entrenchment. The taxpayer pays more for this patient’s care in hospital than in social care. The hospital diverts resource and beds to patients who would be better cared for in the social care system. Social care receives less income from both local authority fees and from individuals. Less money is reinvested into social care provision. The NHS calls for more funding to alleviate the stress placed on its resource by patients who should be in the social care system.

Working backwards, a simple solution is to increase local authority funding for care homes so that more patients who feel unable to pay for care privately, can access it for ‘free’.

But optics are critical: for where does this funding come from? If it frees up hospital beds, should it be diverted from the NHS budget? What government wants to be responsible for NHS funding cuts – even when they make broader social and financial sense?

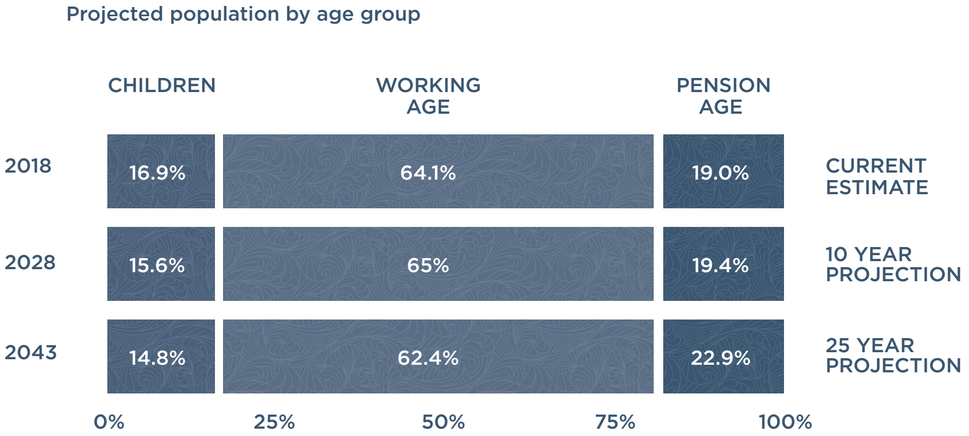
Another challenge is that the cost of a care home bed provided by the private sector is lower than one provided by the public sector. Financially, it makes sense to use local authority social care budget to pay for beds in private homes which will cost the taxpayer less and likely provide the patient with a better care experience. But politically, outsourcing healthcare and social care to the private sector is a scaldingly hot potato.

Yet these are the decisions that must be given priority if care provision is to be improved both from a patient experience perspective, and from a financial efficiency standpoint. And quickly.

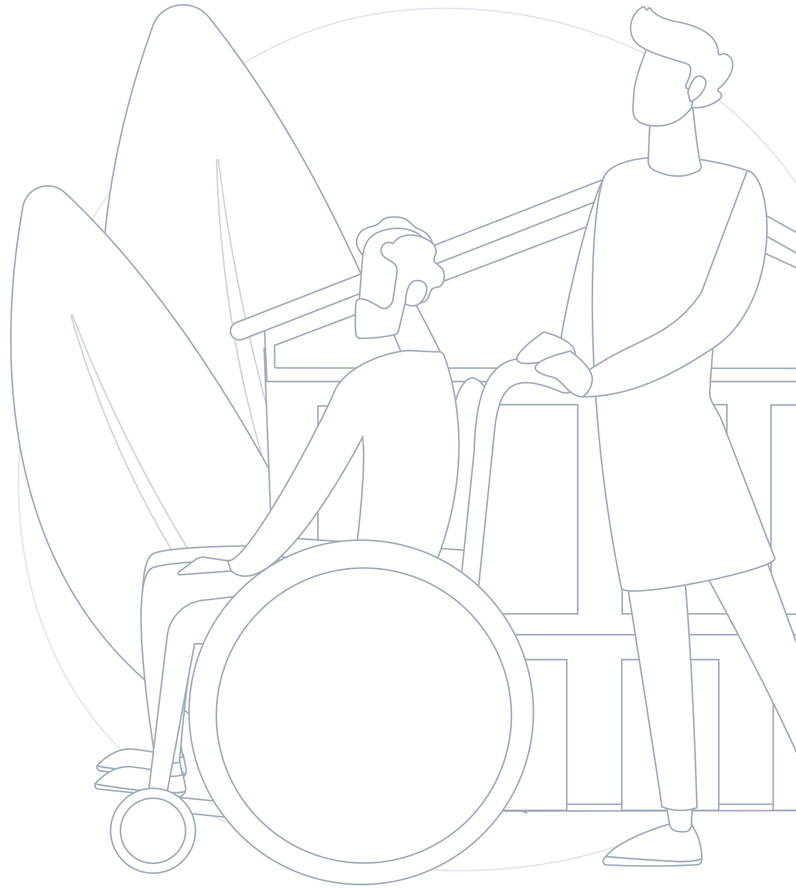
> **GOVERNMENT FUNDING FOR LOCAL AUTHORITIES FELL BY AN ESTIMATED 49.1 PER CENT IN REAL TERMS FROM 2010-11 TO 2017-18.**
>
> NATIONAL AUDIT OFFICE

INTEGRATING HEALTHCARE AND SOCIAL CARE POLICY AND FUNDING

SCOTLAND



SOURCE: NATIONAL RECORDS OF SCOTLAND



Integration between healthcare and social care provision is, in the opinion of one contributor, ‘much more advanced in Scotland than England’. Scotland’s social care regulator the Care Inspectorate was called ‘a better partner for the social care sector’ than its equivalent, the Care Quality Commission, in England.

This was largely put down to legislation introduced in 2016 by the Scottish government to establish 31 integration authorities in Scotland, each required to work with local communities and providers of care to ensure care is responsive to people’s needs. These are now responsible for £8.5billion of funding for local services, previously managed separately by NHS boards and local authorities.

The Scottish government has also confirmed plans to invest more than £700million over 2019 to 2020 in health and social care integration. It is currently consulting on the provision of a national care service. Clarity on the role of this body in the sector, and the future role for private social care providers, is not as yet forthcoming.

INTEGRATING HEALTHCARE AND SOCIAL CARE POLICY AND FUNDING

ENGLAND

There have been several recent government policies to promote integration between the health and social care systems, summarised succinctly in House of Commons Library briefing paper number 7902, 17 December 2019.

This notes: ‘These have included the creation of Health and Wellbeing Boards, local strategic planning forums with representatives from health and social care services, and the Better Care Fund, a pooled budget between the NHS and local authorities, to which the government committed £7.8billion in 2018/19.’

A review of the Better Care Fund is underway after questions were raised about the return on investment it offered. One contributor noted: ‘The answer to the social care problem is absolutely not to throw more money at it. Funding labelled for care homes has been snaffled into leaky buckets repeatedly, never reaching the care front lines at all.’

CONFLICT IN A NUTSHELL

Local authorities must, by law, set a balanced budget. Local health bodies are held accountable by NHS England and NHS Improvement for meeting their individual control totals (financial targets). The mismatch between the drive to spend co-operatively and for individual organisations to meet financial requirements makes it difficult for organisations to pool budgets, share financial risks and commission services jointly.

The Care Quality Commission explains that the need for individual organisations to meet their own financial targets is precluding them from adopting a ‘whole person’ approach that focuses on a patient’s journey through the health and social care system.

SOURCE: HOUSE OF COMMONS LIBRARY BRIEFING PAPER NUMBER 7902, 17 DECEMBER 2019

SOCIAL CARE: THE INVESTMENT CASE

PROPERTY

The investment opportunity in the bricks and mortar of social care in the UK is enormous. There is an existing shortage of beds and the delivery rate of new beds is insufficient when measured against population growth forecasts. Additionally, Knight Frank analysis shows 70 per cent of existing care home property stock is over 20 years old and not physically fit for purpose, particularly in the aftermath of the Covid pandemic where isolation and social distancing measures are vital.

Indeed, their research shows there are over 6,500 homes below the 40-bed marker and half of these homes lack en suite or wet room provision – one of many things needed to support social distancing. According to the firm's calculations, upgrading existing care homes can result in a 10 per cent increase in income per bed. Newly developed care homes and facilities also command the same fee premium.

One contributor called the need for investment into purpose built care facilities in the UK 'desperate' and suggested that insufficient funding was being allocated in the north of the country. Another, offered the view that this presented a major opportunity, though admitted political uncertainty was hindering decisions to invest in Scotland, in particular.

The commercial property sector in the UK, and worldwide given the pandemic, is facing an ambivalent future. Remote working and social distancing have changed many businesses' view of office space requirements. Retail premises, on a longer term decline driven by the rise in online shopping, have been hit extremely hard by social lockdowns which have persisted through 2020 and likely beyond. Unexpired leases on commercial units average just two years. The social care sector meanwhile, offers exposure to capital assets with good income and yield over a much longer timeframe.

SOCIAL CARE: THE INVESTMENT CASE

INCOME AND FEES

While both Westminster and the Scottish government have pledged to address the social care crisis, neither government has infinite funding to deliver the scale of solution required. The politically sensitive nature of the sector also offers private investors reassurance that wholesale exit of public spending is highly unlikely.

Knight Frank analysis suggests the majority of care homes derive their funding from a combination of local authorities and self-funded private-paying residents.

‘The split varies significantly across regions. In the North East and London, a significant amount of residents qualify for full local authority support, or at least part-funding. In contrast, more affluent areas like the South East and South West of England derive more of their income from private-paying residents. Average weekly fee rates in the UK private-pay market measured £1,086 in 2019/20, compared to £746 a week for local authority funded fees.’

Due to the way social care is funded by government, local authority fees vary significantly. Investors are generally opting to fund new developments, purchase and refurbishments in locations offering higher local authority fees, as well as where there is a concentration of older, more affluent residents likely to self-fund privately either fully or partially.

This has led to talk of a north/south divide, with money anecdotally ‘less keen’ to back developments in the north of England and north of the border. Contributors noted ongoing investor nervousness where new care home provision in Scotland was concerned, with uncertainty lingering around the political appetite to nationalise social care. More than one contributor noted the political capital gained by remaining publicly reticent on a decision in the run up to the Scottish elections in May 2021, however, which does not preclude inaction later.

While fees in the south east and London offer investors significant income potential, capital outlays are also higher. One contributor pointed to yields outside of this corner of England offering much quicker return on capital, dubbing the north/south divide ‘a myth’.

‘Developments anywhere can make sense if the cost of funds, purchase price and scale is right.
Strong and experienced senior management teams are therefore crucial,’ he added.

SOCIAL CARE: THE INVESTMENT CASE

CONSOLIDATION

Social care in both Scotland and England is a highly fragmented sector with large numbers of small and medium sized portfolio owners and care operators. The top four or five care home providers in the UK account for just 15 per cent of the market. In spite of this, during a year fraught with volatility, social care has proven robust in its performance. Occupancy levels have fallen amid the pandemic, but not dramatically.

According to Knight Frank: ‘Occupancy fell by 8.5 per cent across our main survey respondents during the second quarter of 2020. However, additional weekly tracking shows an estimated recovery of 1.2 per cent in the third quarter as death rates normalised and operators have begun to confidently admit new residents.’

Quality ratings have been consistently high in England, with 80 per cent of care homes rated good or outstanding by the Care Quality Commission.

Those considering consolidation as a growth play are looking to use scale to reinvest in upgrading existing care home stock with a view to improving profitability. Both debt and equity funding are available with broad appetite to finance consolidation strong at the close of the year.

The average internal rate of return on equity investments was put around 30 per cent, while debt returns came in around 4 per cent. The blended return offered ‘usually comes in around the low teens,’ said one contributor.

Traditional advantages are also abundant: better use of technology to reduce inefficient use of staff time, data and wearable tech to improve diagnosis and care provision and the usual reduction in overheads that comes with acquisition and consolidation all contribute to a compelling case for cost reductions.

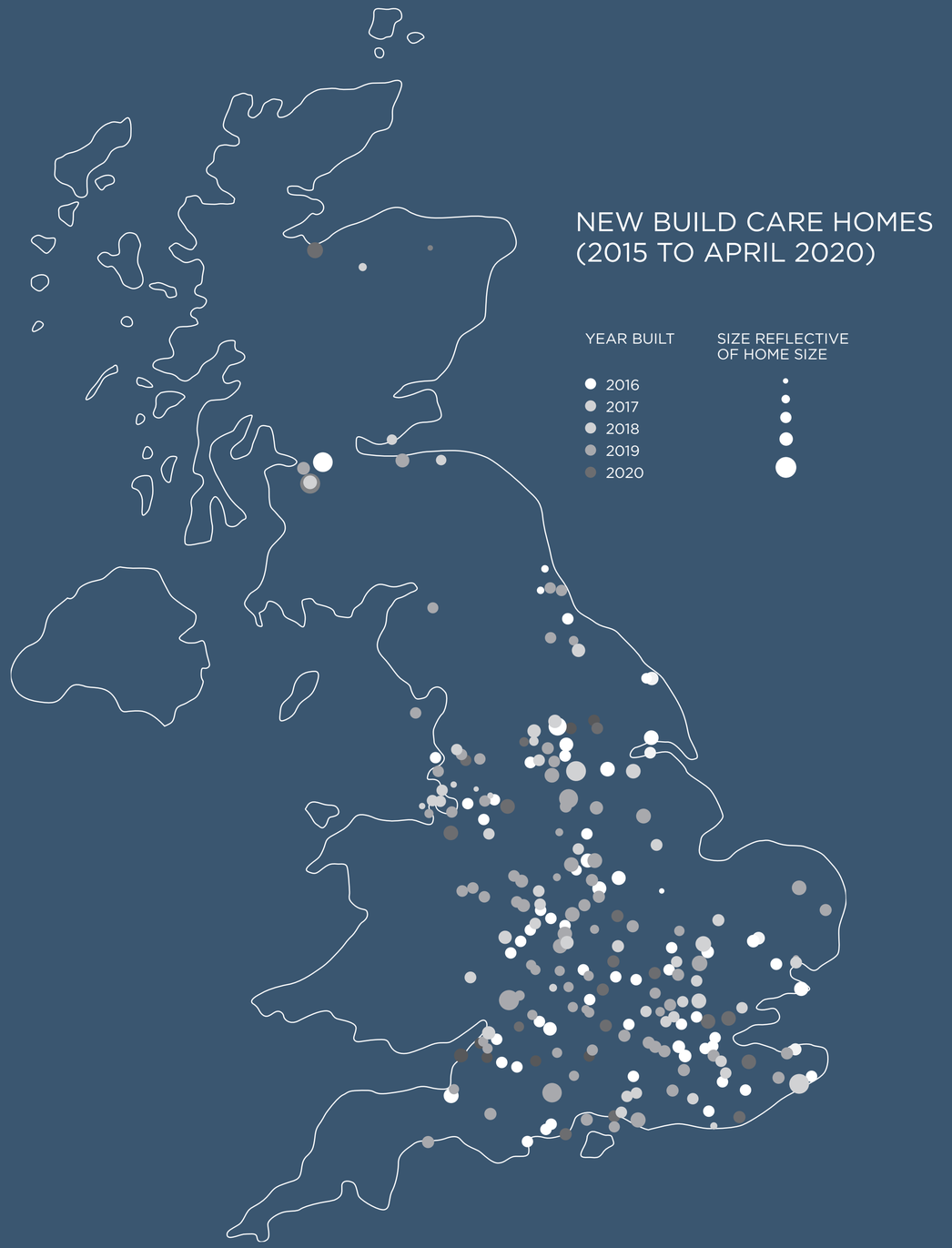
Most contributors agreed that the optimum size of care home portfolio, particularly where operations are centrally managed, was around the 40 home mark. Larger than this, they warned, and management became too top down and care and service quality suffered. Smaller, and profitability and reinvestment potential was curbed.

‘Particularly with the variety of local funding and regulation, there is a much stronger argument for a strong regional player than a large national one,’ observed one contributor. ‘There’s less risk and more stability.’

SOCIAL CARE: THE INVESTMENT CASE

- THE NUMBER OF HOMES HAS FALLEN MARGINALLY FROM THE **12,250** HOMES MEASURED IN **2019**
- THE NUMBER OF BEDS INCREASED BY **2,500** DUE TO RISE IN THE NUMBER OF LARGER PURPOSE-BUILT HOMES IN **2019**
- THE NUMBER OF CARE HOME BEDS PER 100 PEOPLE OVER THE AGE OF 85 HAS FALLEN FROM **33.7** TO **28.7** SINCE 2010
- **70%** OF UK CARE HOME FACILITIES WERE BUILT MORE THAN 20 YEARS AGO
- **884** UK CARE HOMES UNDERGOING REFURBISHMENT OR EXTENSION IN MARCH 2020
- CARE HOME FEES HAVE INCREASED **50%** IN NOMINAL TERMS SINCE 2008/09
- INFLATION-ADJUSTED GROWTH AMOUNTS TO **8%** OVER THE SAME PERIOD
- AVERAGE WEEKLY FEE FOR A NURSING HOME IN THE UK WAS **£953** IN 2020
- AVERAGE WEEKLY FEE FOR A PERSONAL CARE HOME IN THE UK WAS **£766** IN 2020
- CARE HOME DEVELOPERS HAVE ADDED AROUND **5,000** NEW CARE BEDS A YEAR SINCE 2015
- **79** NEW HOMES COMPLETED IN 2019
- 2020 WAS ON COURSE TO POST A SIMILAR NUMBER UNTIL CONSTRUCTION SITES WERE FROZEN IN THE COVID-19 OUTBREAK
- MOST NEW CARE HOMES TAKE AT LEAST **24 MONTHS** TO REACH MATURE LEVELS OF OCCUPANCY
- THERE IS HUGE VARIATION BETWEEN NEW HOMES – SOME REACHING MATURITY AFTER ONLY 12 MONTHS AND OTHERS ONLY **50%** OCCUPIED AFTER THREE YEARS OF TRADING
- DOCUMENTED HEALTHCARE PROPERTY TRANSACTIONS HIT A RECORD HIGH OF **£1.76BILLION** IN 2019, UP A FURTHER **17%** FROM THE **£1.49BILLION** SEEN IN 2018
- THIS COMPARES TO A DECLINE OF -**17%** ACROSS ALL COMMERCIAL PROPERTY, WITH OFFICE, INDUSTRIAL AND RETAIL SECTORS EXPERIENCING FALLS IN TRANSACTION ACTIVITY
- **8.7%** AVERAGE TOTAL RETURNS IN THE HEALTHCARE SECTOR OVER THE LAST FIVE YEARS

SOURCE: KNIGHT FRANK, GLENIGAN



SOCIAL CARE: THE INVESTMENT CASE

INVESTMENT CHALLENGES

There are 685,000 people working in care homes across the UK, most of whom are highly skilled but low paid nurses and carers. Nursing shortages in England are more pronounced; partly this corresponds to Scottish government bringing in the Scottish carers' living wage for all carers aged 18 and above. At £9.30 an hour for all hours worked, this is higher than the existing national living wage of £8.72 an hour, which applies to those aged 25 and over.

In Scotland, this higher wage is funded jointly by the Scottish government and the private sector. A similar approach in England is possible but not currently under official consideration.

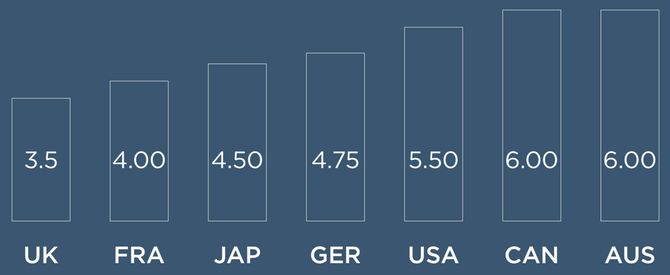
Knight Frank analysis found: 'Following the trend in recent years, staff costs across the index increased 3.7 per cent to an average of £26,956 per resident per annum for the 2019/20 financial year.'

The effect of Britain's exit from the European Union on labour was also cited as a concern by all contributors to the report. European social carers are not on the visa list for key workers, which could put considerable strain on the availability and therefore cost of staffing social care facilities with one contributor estimating around a third of the UK's social carers come from overseas.

Knight Frank analysis shows staffing costs already account for between 50 and 60 per cent of care home overheads, with one contributor damning the effect of high agency fees, which he said was 'killing profitability'. At 15 per cent, there is also still too wide a disparity between wages paid to nurses working in the NHS healthcare system and those nursing in social care. One contributor pointed to Westminster's reintroduction of the nurse's bursary, which funds training up to £5,000, as a positive step towards improving workforce availability. But added: 'While that's a start, it's not nearly enough.'

Insurance premiums and professional indemnity costs, a scourge on a rapidly widening range of sectors, were also cited as a drag on profitability. One contributor noted annual premiums rose 78 per cent over the course of 2020, and included a reduction in cover. Capital expenditure on making facilities Covid-secure has also weighed on profits over the past 12 months, though most contributors did not view this as a particular cause for investor concern long-term.

PRIME ELDERLY CARE HOME YIELDS (FIXED-INCOME %)



Yields in the UK are lower than elsewhere but the local authority contribution to fees is viewed by investors as a stabilising factor.

SOURCE: KNIGHT FRANK, GLENIGAN

OUTLOOK 2021 AND BEYOND

INVESTMENT CHALLENGES

All contributors expressed optimism for the future of the social care sector, with an overwhelming emphasis on governments ‘getting their acts together’. Consistency of public sector funding of social care fees was cited as a critical area for action. So was the need to ‘pull the social care sector up to the same fiscal standing as the NHS’.

‘It has been the poor sister for far too long,’ said one contributor. ‘It continuing as such is unsustainable.’

Calls on politicians from across the sector included the wish for stamp duty land tax relief for homeowners downsizing, perhaps linking to private care fee funding. A long term strategy for social care in both Scotland and England was also seen as vital. ‘It has to be taken out of the political cycle if these issues are to be addressed,’ said one. Another warned the bureaucracy that has grown up around health and social care since the inception of the NHS in 1948 made challenges ‘unbelievably complex’. All agreed that the sector had so far done a poor job of communicating the support required from government, with several contributors highlighting the need for a ‘single voice for social care’.

That aside, all viewed the investment opportunity in social care as underdeveloped and offering significant upside in the medium to long term.

‘There is a broad church of finance available and looking for a home,’ noted one contributor.

Another noted the early signs of a trend developing, with increasingly specialised funds establishing to back various niches including supported living, retirement homes and villages, care homes and nursing homes. Other fund strategies focused on nurturing start-up developers and providers or scale-ups looking to consolidate and offer growth opportunities. Match funding stable income-bearing assets with long-term liabilities was a third strategy, tipped for significant growth over the coming years.

PROBLEMS. POSSIBILITIES.
COMPLEXITY. CLARITY.
OBSTACLES. OPPORTUNITIES.
THE DIFFERENCE IS IMAGINATION.

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