COMPLETED ACQUISITION BY ACADIA HEALTHCARE COMPANY, INC. OF PRIORY GROUP NO. 1 LIMITED

Decision on relevant merger situation and substantial lessening of competition

ME/6587/16

The CMA's decision on reference under section 22(1) of the Enterprise Act 2002 given on 14 July 2016. Full text of the decision published on 15 August 2016.

Please note that [✂] indicates figures or text which have been deleted or replaced in ranges at the request of the parties for reasons of commercial confidentiality.

CONTENTS

SUMMARY

Background

1. On 16 February 2016, Acadia Healthcare Company, Inc. (**Acadia**), through its subsidiary Whitewell UK Investments 1 Limited, acquired the entire issued share capital of Priory Group No. 1 Limited (**Priory** or the **Target**) (the **Merger**). Acadia and Priory are together referred to as the **Parties**.[1]

2. The Competition and Markets Authority (**CMA**) believes that it is or may be the case that the Parties' enterprises have ceased to be distinct and that the turnover test is met. The four-month period for a decision, as extended by 20 working days with the consent of Acadia under section 25(2) of the Enterprise Act (**the Act**), has not yet expired. The CMA therefore believes that it is or may be the case that a relevant merger situation has been created.

3. Acadia, through its UK subsidiary Partnerships in Care (**PiC**) and Priory both supply a number of inpatient and outpatient mental healthcare and social care services to local authorities and to NHS organisations for children, adolescents and adults suffering from mental health conditions in the UK.[2]

4. NHS organisations include NHS England (**NHSE**) and NHS Wales (**NHSW**), local clinical commissioning groups (**CCGs**) and NHS trusts and NHS Foundation Trusts providing mental healthcare services) (**NHS trusts**).

Product frame of reference

5. The Parties overlap in the supply of the following five mental healthcare and social care services (the **Overlap Services**):[3]

    a) secure mental healthcare services (**Secure Services**) to NHSE and NHSW;

    b) specialist Tier 4 mental healthcare services for children and adolescents (**CAMHS Services**) to NHSE and NHSW;

    c) acute psychiatric services (**Acute Services**) to CCGs and NHS trusts;

---

[1] The CMA imposed an Initial Enforcement Order on Acadia and PiC on 17 February 2016. [✂].

[2] [✂]. For this reason, the supply of these services to non-NHS customers is not considered in detail in the CMA's assessment.

[3] The CMA notes that the Parties are active in other service lines, which do not overlap. Unless otherwise stated, these service lines are not considered by the CMA in its competitive assessment.

d) psychiatric intensive care unit services (**PICU Services**) to CCGs and NHS trusts; and

e) hospital-based inpatient rehabilitation services (**Rehabilitation Services**) to CCGs and local authorities.[4]

6. As a starting point, the CMA treated each Overlap Service as a separate product frame of reference within which to conduct its assessment, noting that there was little or no demand-side substitution between Overlap Services.[5]

7. The CMA also identified a number of further distinct segments within each Overlap Service, which themselves could constitute additional distinct frames of reference. Depending on the Overlap Service, these segmentations arose as a result of, for example, variations in the level of security required for specific patient groups (eg low or medium secure), a patient's gender (and therefore in many cases the need to treat that patient on a single-sex ward) and/or a patient's conditions or symptoms (which could require specialist clinical staff or could limit the categories of patients that could be treated alongside others with different conditions or symptoms).

8. The CMA has not previously investigated the mental healthcare market in-detail. In this case, and in line with its approach at phase 1 in identifying competition concerns on a 'may be the case' basis, the CMA has adopted a cautious approach to the product frame of reference to identify all potential competition concerns. It has also assessed the impact of the Merger on an either/or basis where appropriate, ie assessing the impact of the Merger on narrow segments, reflecting limited demand-side substitution, and more widely, aggregating two or more of these segments, reflecting possible supply-side substitution.

9. The CMA's approach to the product frame of reference in this case is explained further at paragraphs 33 to 49, and separately for each Overlap Service in the competitive assessment.

10. The CMA was told consistently by third parties that most Overlap Services[6] are provided in the first instance by the NHS trust that is responsible for the

---

[4] The Parties also overlap in the provision of inpatient and outpatient treatments for addiction, trauma and depression (**Addictions Services**) to private insurers and private patients; and residential care for adults and young people who need longer term psychiatric support (**Care Homes**) to NHS commissioners, private insurers and private patients. The CMA did not identify competition concerns in relation to these services.

[5] The Parties did not contest that these Overlap Services each constitute distinct frames of reference.

[6] With the exception of CAMHS ED, PICU and Rehabilitation Services, where private providers make up the majority of provision.

patient and that private providers will only be considered if that NHS trust is unable to admit the patient (ie private providers only compete for 'overspill' patients). The CMA was also told that, in many cases, private providers will only be considered for overspill patients after the options to place a patient in an alternative nearby NHS trust have been exhausted.

11. Further, the CMA understands that NHS trusts face severe capacity constraints, so the private sector is increasingly being relied upon to provide services to patients that cannot be admitted to an NHS trust, whether the NHS trust at which the patient was initially assessed or an alternative nearby NHS trust. The CMA believes that, in many cases, only private providers are able to admit these 'overspill' patients.

12. For these reasons, the CMA focussed its assessment of the potential impact of the Merger on the supply by private providers of each Overlap Service to overspill patients funded by the NHS in the first instance. This approach is discussed further at paragraphs 62 to 71 below and separately for each Overlap Service in the competitive assessment.

Geographic frame of reference

13. The CMA found that the supply of each Overlap Service had characteristics of local markets, particularly because those making referrals seek to minimise the distance which patients are required to travel from their homes.

14. However, the CMA found differences in the commissioning between different Overlap Services in England and Wales.

    (a) In England, for both Secure Services and CAMHS Services, NHSE negotiates a provider's single national contract and some minimum quality standards. These terms are generally the same across a provider's sites. However, quality may still vary on a local basis for these services in response to local demand. The CMA found that terms for other Overlap Services are fully determined on a local basis in England.

    (b) In Wales, NHSW holds a framework agreement which ranks providers of rehabilitation and secure services.[7]

15. The CMA therefore assessed the impact of the Merger on the supply of each Overlap Service (segmented further where relevant by level of security required, patient gender and/or patient condition) at a local level whilst also

[7] The Parties do not provide CAMHS services to NHSW.

taking into account where Services are negotiated by a central NHS organisation (eg NHSE or NHSW).

16. In assessing the impact of the Merger at a local level, the CMA used as a starting point the 80% catchment areas of the Parties' sites (by drive time). The CMA then identified the competitors in these catchment areas and calculated the Parties' share of supply (by number of beds).

17. The CMA's approach to the geographic frame of reference in this case is explained further at paragraphs 50 to 60 below and separately for each Overlap Service in the competitive assessment.

Competitive assessment

18. Parties either together or separately are the largest private provider in the relevant area, with high combined shares of supply and few outside options for commissioners and their patients.

19. The CMA identified competition concerns in relation to:

(a) the supply of certain Secure Services in the catchment areas of *Priory Cefn Carnau*, *Priory Chadwick Lodge and Eaglestone View*, *Priory Farmfield* and *Priory Thornford Park*;[8]

(b) the supply of certain CAMHS Services in the area between the Priory sites of *Roehampton* and *Chelmsford* and the PiC facility of *Rhodes Wood*;

(c) the supply of certain Acute Services in the catchment areas of *PiC Dene* and *PiC Kneesworth*;[9]

(d) the supply of certain PICU Services in the catchment area of *Priory Cheadle*;[10] and

(e) the supply of certain Rehabilitation Services in each of the catchment areas of the Priory sites at *Aberdare, Bristol, Chadwick Lodge and*

[8] The CMA refers to each of the four Priory sites supplying Secure Services whilst noting that concerns also arise when the catchment area is centred around the relevant PiC site(s) that overlap(s) with each Priory site.

[9] The CMA refers to each of the two PiC sites whilst noting that concerns also arise when the catchment area is centred around the relevant Priory site(s) that overlap(s) with each PiC site.

[10] The catchment area of Priory Cheadle includes [✂]. The concern arises in this local area as a result of the overlap between both of these Priory sites and the two nearby PiC sites, as discussed further in the competitive assessment.

Eaglestone View, Church Village, Hemel Hempstead, Highbank Center, Keighley, Middleton St George, Recovery First, St Neots, Sturt House, Ticehurst and *Ty Gwyn Hall*.[11]

20. The CMA does not believe that countervailing buyer power or potential entry or expansion would mitigate the concerns identified.

Decision

21. The CMA believes that the Merger gives rise to a realistic prospect of a substantial lessening of competition (**SLC**) as a result of unilateral horizontal effects in each of the frames of reference set out at paragraph 19 above.[12]

22. The CMA is therefore considering whether to accept undertakings under section 73 of the Enterprise Act 2002 (**the Act**). Acadia has until 21 July 2016 to offer an undertaking to the CMA that might be accepted by the CMA. If no such undertaking is offered, then the CMA will refer the Merger for a phase 2 investigation pursuant to sections 22(1) and 34ZA(2) of the Act.

[11] The CMA refers to each of the relevant Priory sites providing the affected services, whilst noting that concerns also arise when the catchment area is centred around nearby PiC sites that overlap with the Priory site.

[12] The specific product and geographic frames of reference in which a realistic prospect of an SLC was identified are explained in detail in the competitive assessment

ASSESSMENT

Parties

23. Acadia is a publicly-traded provider of behavioural healthcare services, with operations in the United States and the UK. Acadia is active in the UK through its subsidiary PiC, which provides a range of healthcare services for patients with diagnoses including mental health issues, learning difficulties and acquired brain injury. PiC provides low secure and medium secure services, rehabilitation, supported accommodation services, children's services, acute psychiatric services and addictions treatment.

24. The worldwide turnover for Acadia in the year ending 31 December 2015 was US$1.8 billion. Acadia's revenues for its UK operations in the year ending 31 December 2015 were US$360.7 million (£218.9 million).

25. Priory is incorporated and domiciled in the UK. Its principal activity is the provision of behavioural healthcare services. Priory also provides low secure and medium secure services, rehabilitation, supported accommodation services, acute psychiatric services, children's services, addictions treatment, and also specialist education services.

26. The turnover of Priory in the year ending 31 December 2015 was £571.2 million, all of which was generated in the UK.

Transaction

27. The Merger relates to the purchase, pursuant to a sale and purchase agreement dated 31 December 2015, by Acadia of the entire issued share capital of Priory, which completed on 16 February 2016.

28. The Merger is not subject to review in any other jurisdiction.

Jurisdiction

29. As a result of the Merger, the enterprises of Acadia and Priory have ceased to be distinct. The UK turnover of Priory exceeds £70 million, so the turnover test in section 23(1)(b) of the Act is satisfied. The Merger completed on 16 February 2016 and was made public on the same day. The four month deadline for a decision under section 24 of the Act is 14 July 2016, following an extension under section 25(2) of the Act. The CMA therefore believes that it is or may be the case that a relevant merger situation has been created.

30. The initial period for consideration of the Merger under section 34ZA(3) of the Act started on 18 May 2016 and the statutory 40 working day deadline for a decision is therefore 14 July 2016.

Counterfactual

31. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual). For completed mergers the CMA generally adopts the pre-merger conditions of competition as the counterfactual against which to assess the impact of the merger. However, the CMA will assess the merger against an alternative counterfactual where, based on the evidence available to it, it believes that, in the absence of the merger, the prospect of these conditions continuing is not realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions.[13]

32. In this case, there is no evidence supporting a different counterfactual, and the Parties and third parties have not put forward arguments in this respect. Therefore, the CMA believes the pre-Merger conditions of competition to be the relevant counterfactual.

Analytical framework

Frame of reference

33. Market definition provides a framework for assessing the competitive effects of a merger and involves an element of judgement. The boundaries of the market do not determine the outcome of the analysis of the competitive effects of the merger. There can be constraints on merger parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. The CMA takes these factors into account in its competitive assessment.[14]

34. The Parties overlap in the supply of Acute Services, Addictions Services, CAMHS Services, Care Homes, PICU Services, Rehabilitation Services and Secure Services. Competition for all of these services has local characteristics

[13] Merger Assessment Guidelines (OFT1254/CC2), September 2010, from paragraph 4.3.5. The Merger Assessment Guidelines have been adopted by the CMA (see Mergers: Guidance on the CMA's jurisdiction and procedure (CMA2), January 2014, Annex D).

[14] Merger Assessment Guidelines, paragraph 5.2.2.

whilst competition for Secure and CAMHS Services also involves central negotiation with NHSE and NHSW (as discussed at paragraph 14 above).

35. The CMA's approach in this case to the frame of reference is explained in the following paragraphs whilst the actual frame of reference adopted in respect of each Overlap Service is explained in the sections relating to each Overlap Service which follow.

Product frame of reference

36. The CMA first assessed the appropriate product frame of reference, taking into account:

(a) delineation by patient need, ie security-level, patient gender and specialist condition;

(b) delineation by payment, ie NHS patients, insured patients or self-pay patients;

(c) delineation by day-case, outpatient and inpatient; and

(d) possible aggregation of segments on the basis of supply-side substitution.

Patient need: security-level, gender and specialist condition

37. In common with previous decisional practice in mergers involving providers of healthcare services, and consistent with evidence gathered from third parties, the CMA has not, in this case, considered individual healthcare services substitutable from the perspective of the patient. Therefore, the CMA's starting point was one of narrow product markets for each healthcare service.[15]

38. The CMA sought to identify the individual treatments which both Parties provide. The CMA then considered whether there were specialities within those treatments (or specific patient cohorts) which had specific requirements, which could lead to narrower frames of reference.[16]

---

[15] Merger Assessment Guidelines, paragraph 5.2.6. See also Completed acquisition by Spire Healthcare Limited of certain assets and business comprising St Anthony's Hospital in Surrey (Spire/St Anthony's).

[16] See further CMA Private Healthcare Market Investigation, paragraph 5.53. Report on the anticipated merger of The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust and Poole Hospital NHS Foundation Trust (Poole/Bournemouth) paragraphs 24(c), 5.22 and 5.26. See also Anticipated acquisition by Frimley Park Hospital NHS Foundation Trust of Heatherwood and

39. This included consideration of the level of security required (eg locked/unlocked, low secure, medium secure, etc.), the patient's gender (and whether they require treatment on a single-sex ward) and the patient's conditions or symptoms.

40. As a result of the above, the CMA identified a number of distinct product frames of reference within each Overlap Service. These are discussed in detail in the relevant section for each Overlap Service.

Payment: NHS patients, insured patients and self-pay patients

41. In common with previous decisional practice, the CMA investigated whether it was appropriate to distinguish between services provided to NHS patients and services provided to insured and self-pay patients.[17]

42. With the exception of Addictions Services, [✂]. For this reason, except with Addiction Services, the CMA focussed its assessment on the supply of the relevant Overlap Service to NHS patients.

43. Commissioners located in different commissioning areas may have different approaches to commissioning services. The CMA has taken into account the different approaches of NHSE and NHSW when commissioning Secure and CAMHS Services in its competitive assessment.

Day-case, outpatient and inpatient

44. The CMA has sought to distinguish, where appropriate, services provided on a day-case, outpatient and inpatient basis. However, in relation to the Overlap Services, these are each provided exclusively on one or the other basis and so no further delineation by this segmentation was warranted in this case.

Possible aggregation of segments by supply-side substitutability

45. While the CMA generally determines the boundaries of the relevant product frame of reference by consideration of demand-side substitution alone,[18] the CMA may widen the scope where there is evidence of supply-side substitution (ie the ease with which a provider of one service could switch to supplying

---

Wexham Park Hospitals NHS Foundation Trust (Heatherwood-Wexham/Frimley Park), paragraphs 37 and 38. Also see Spire/St Anthony's.

[17] Ibid, footnote 6 above.

[18] Merger Assessment Guidelines, paragraph 5.2.17.

another service).[19] The CMA may also aggregate the supply of products and analyse them as one market when the same competitors compete to supply these different products and the conditions of competition between them are the same for each product.[20]

46. The CMA found that, although in some cases wards and clinicians could treat more than one particular condition,[21] in most cases, a ward providing services to one condition and/or gender cannot provide services to another. Similarly, whilst some conditions can be treated by the same clinician, other services require clinicians to specialise in the treatment of a particular condition.

47. The CMA considered whether, notwithstanding the limitations of existing wards treating different patient needs, it was possible that wards could be re-assigned from one service to another.

48. The CMA was provided with some evidence of supply-side substitution between specialities and the re-assignment of wards. However, the CMA found that providers face a number of barriers when switching a ward to an alternative service, so it typically could not be conducted quickly and easily. For example, it would often require a change in specialist staff (which can be in short supply),[22] and the patients in the provider's ward at the time of a re-designation must be placed in an appropriate alternative ward (either at that provider's own facilities or at another facility if that provider is capacity constrained).[23]

49. On a cautious basis, the CMA's approach in this case was not to widen each individual product frame of reference on the basis of supply-side substitution, but the CMA has considered whether doing so would give rise to additional competition concerns. Where supply-side substitution was considered, this is explained in the competitive assessment.

---

[19] For example, in its Private Healthcare Market Investigation, the CMA found that there is a significant degree of substitution across treatments within the same specialty, but that there is more limited supply-side substitution across treatments between specialties. CMA Private Healthcare Market Investigation, paragraphs 5.40 and 5.53. See also *Spire/St. Anthony's*.

[20] Merger Assessment Guidelines, paragraph 5.2.19.

[21] The Parties submitted that Priory does not distinguish between MI and PD services and PiC generally offers these services in parallel on the same ward. In addition, although there are different segments of ASD and LD, some facilities are able to treat both segments on the same ward if they have the relevant staff and the mix of patients is appropriate, allowing them to care for both segments of the patients. [✂].

[22] Third parties (commissioners and private providers) told the CMA that the limited availability of specialist staff generally has become an issue in the industry and could be an obstacle to switching. [✂].

[23] For example, [✂]. Appendix to Merger Notice – Overview of ward re-designations.

Geographic frame of reference

50. In common with previous decisional practice, the CMA investigated each Overlap Service to understand whether competition takes place at a national level (eg UK, Great Britain, England and Wales, England, Wales, etc.) and/or at a more local level.[24] The CMA has also taken account of the differences in approach to commissioning between national NHS commissioning bodies, local CCGs and individual NHS trusts.[25]

51. In relation to NHS-funded Overlap Services, whilst the commissioning of CAMHS Services and Secure Services is undertaken centrally by national NHS commissioning bodies, all other Overlap Services are purchased and negotiated at a local level.[26]

52. Further, across all Overlap Services, patient referrals are made locally (for some service lines, often by a local NHS trust) and the CMA has received consistent feedback across the Overlap Services that proximity to a patient's place of residence (or other significant location) is an important factor in determining to which provider that patient is referred.

53. The CMA has therefore adopted local frames of reference in its assessment of each Overlap Service, whilst recognising that the commissioning of CAMHS and Secure Services also has national characteristics.

54. Even when terms are negotiated for a particular service across a provider's entire estate (eg with Secure Services and CAMHS Services), the CMA expects that the conditions of local competition in which a provider operates will affect the negotiations over these terms. Therefore, the aggregate of local competition may be important in determining terms set nationally by NHSE for English patients and by NHSW for Welsh patients.

55. For example, if NHSE had less choice between private providers in a local area following the merger, then it would be in a weaker position to resist a price increase by the Parties in that area. NHSE may not feel capable of resisting the price increase by choosing to reduce the number of beds commissioned from the Parties, and expanding the number of beds commissioned in another part of the country, given the desire to have bed availability relatively close to patients' homes. In this way, a loss of local

[24] The CMA has received no evidence to suggest that the market is wider than national.

[25] The Parties do not overlap in the provision of Overlap Services in Scotland.

[26] With the exception of Rehabilitation Services in Wales, which are purchased by NHSW.

competition may affect terms negotiated centrally, including price and minimum quality standards.

Catchment areas

56. For each Overlap Service, the CMA asked the Parties to estimate the catchment area over which each of their hospitals draws 80% of its patients, measuring the road distance between the patient's home and hospital postcodes, centred on each of the Parties' respective sites.[27]

57. This approach seeks to capture the area over which competition is most likely to be affected for scenarios where location is an important factor in commissioning and referral decisions.[28]

58. The CMA has sought to calculate the Parties' combined share of supply within each catchment area using their share of the total number of beds within the area as a proxy.[29] If the Merger increases the Parties' share of supply and commissioners do not have sufficient alternatives, the Merger may give rise to competition concerns.

59. The CMA recognised that there are several limitations with this approach:

(a) Share of beds is a measure of the share of capacity and not the share of supply. The CMA does not have precise utilisation data to calculate the true share of supply, but is aware that the share of beds could potentially over- or under-estimate the true share of supply for a particular provider.

(b) For some Overlap Services, there is limited catchment area data available from the Parties.[30] A small number of observations (ie patients referred to a hospital for a particular service or specialism) makes the calculated hospital-specific catchment area less robust.

(c) Evidence from third parties (including other private providers, NHS trusts and Commissioners) has suggested that, for some services, catchment

---

[27] This is consistent with past decisional practice, for example in *Spire/St. Anthony's*. The Parties provided in the first instance average 80% catchment areas by service line (ie across all sites) and subsequently provided site-specific catchment areas where sufficient observations were available.

[28] The CMA does not use 100% catchment areas, as these are likely to overestimate the geographic area over which the Parties compete and risks including competitors that are not in fact exerting any material constraint on the Parties.

[29] The CMA has relied upon bed share data provided by the Parties and tested that with third parties where possible.

[30] For example, the Parties have only been able to provide observations in the single digits for a number of sites.

areas are smaller than those based on the Parties' data. It also suggests that competition within catchment areas is not homogenous.

(d) Competitors have not in all cases provided the CMA with their bed numbers broken down by all the relevant sub-categories. This has restricted the CMA's ability to calculate the appropriate share of beds.

60. As a result, in accordance with the CMA's decisional practice, the CMA has flexed the 80% catchment areas, where appropriate, to reflect these uncertainties and to ensure that it identifies all areas giving rise to potential competition concerns. This has meant, as a sensitivity analysis, both widening and narrowing the catchment areas.

Nature of competition

61. There are three overarching themes which are relevant to the assessment of competition for the supply of each Overlap Service, which are:

(a) capacity constraints at NHS trusts and the role of the private sector;

(b) the importance of price; and

(c) the importance of quality.

Capacity constraints at NHS trusts and the role of the private sector

62. The CMA received submissions from the Parties and a number of NHS organisations which indicated that there are shortages in NHS bed availability across all of the Overlap Services. In some cases this is the result of commissioner-led decisions (including a moratorium by NHSE on the commissioning of new beds for Secure Services or CAMHS Services), while more generally it is the result of a lack of investment in new wards and beds by NHS trusts.

63. The CMA found that demand for hospital-based mental healthcare services continues to increase year-on-year whilst NHS capacity remains largely static, resulting in NHS trusts facing serious challenges in meeting this demand. NHS trusts are unable to place some patients at their own facilities and therefore need to refer these 'overspill' patients to alternative providers.

64. Whilst the specifics vary by Overlap Service, the CMA believes that in general the incentive and ability of NHS trusts to compete and offer places for patients from other NHS trusts or CCG areas is likely to be limited. This is because most (if not all) NHS trusts face both extremely high capacity utilisation levels and a proven need to refer overspill patients to private providers, which

suggests that those NHS trusts will have little (or no) spare capacity to cater for patients from other NHS trusts or CCG areas. In contrast, private providers are dedicated to serving those patients which cannot be accommodated by an initial NHS trust making the assessment (ie private hospitals are dedicated to supplying services for overspill patients).

65. For these reasons, the CMA believes that private providers compete more closely with each other than with NHS trusts, although it recognises that some NHS trusts will from time-to-time have sufficient capacity to take patients referred from other NHS trusts. The CMA also recognises that private providers can face capacity constraints, given the high demand for mental health beds.[31]

66. The specific circumstances that lead private providers to compete with one another (rather than with NHS trusts) differs by Overlap Service, as discussed further below.

Secure and CAMHS Services

67. Third parties told the CMA that, for Secure and CAMHS Services, the medical professional who assesses the needs of the patient (an 'access assessor') will always try to admit the patient to the access assessor's own NHS trust, where it meets the needs of that specific patient. If a bed is not available at that Trust, the access assessor, working with NHSE, will attempt to place the patient at the nearest facility which meets that patient's needs. Two potential scenarios arise at this point:

(a) The CMA received some evidence that, where NHS trusts are located near to the access assessor's Trust and can offer the patient the correct service and have capacity to admit that patient, they may be considered the first port of call for any overspill demand (eg in London, where there are multiple NHS trusts). This is before *any* private provider is considered.[32] However, if the nearby trust(s) is also capacity constrained, then the referring trust will be limited to choosing between private providers.

(b) The CMA also received some evidence that, where there are no nearby NHS trusts able to admit the patient, private providers will be the only immediate alternative. The CMA was told that, given a number of factors,

[31] For example, in relation to Secure Services, the Parties and other private providers supplied information showing private capacity utilisation was in excess of 90%.

[32] Some NHS trusts in London noted that access assessors may have a preference to use NHS trusts first before considering private providers.

including the very high levels of capacity utilisation at NHS trusts, in the majority of cases the only overspill options available to an NHS trust were private providers. The CMA was told that this was the case whether or not the initial NHS trust had sought first to exhaust options to place the patient in a nearby NHS trust.[33]

68. The CMA notes that, in either of these scenarios, when private providers are considered, they are considered alongside other private providers, whether or not nearby NHS trusts have been considered first. For Secure Services and CAMHS Services, the CMA received limited evidence to suggest that private providers are ever considered for overspill demand at the same time as nearby NHS trusts. This implies that NHS trusts provide little (if any) competitive constraint on private providers for these services at the time a referral to a private provider is considered.

Acute and PICU Services

69. Third parties in the commissioning areas where PiC hospitals are based told the CMA that, for Acute and PICU Services, private providers are used only when the patient cannot be accommodated at the NHS trust. They said that, in this overspill scenario, private providers are most likely to have a bed available to admit a patient. In many instances where demand is placed on a private provider for a bed, it may be that the only providers with capacity to admit the specific patient are private providers (such as the Parties, Cygnet, St Andrews and Huntercombe) as NHS supply is not possible for one or more reasons (eg capacity, distance, not having the required facilities, etc.).

Rehabilitation Services

70. Third parties told the CMA that, in relation to Rehabilitation Services, they did not consider NHS and private provision as equivalent. Rather, customers said that they used NHS bed provision first and they only used the private sector when NHS provision was unavailable. This was consistent with evidence received from competitors.

[33] Third party responses to CMA's questionnaires. A potential alternative view is that, in some areas, access accessors will have a preference for NHS trusts either in area or out of area. However, even if this is true for some areas or in some specific cases, this does not change the view that private providers are competing with each other and not with NHS trusts.

Conclusion on capacity constraints at NHS trusts and the role of the private sector

71. In light of the above, and on a cautious basis, the CMA believes that, in each overlap area, the appropriate frame of reference is the provision of NHS-funded services by private providers (ie excluding provision by NHS trusts).[34]

The importance of price in mental healthcare services

72. Mental healthcare services provided to NHS organisations, unlike most physical healthcare services, do not have a standard national tariff (ie a single standardised price across all providers for a given service). As such, NHS organisations negotiate prices with providers, whether upfront in relation to framework agreements, locally or nationally, or on a spot or block basis.[35]

73. In general, a block contract 'pre-purchases' a set number of beds for a particular price regardless of actual utilisation. Spot-purchasing involves price and service negotiation on an individual patient/bed basis. Framework agreements admit patients under pre-agreed terms between the commissioner and the hospital. For example, they may specify the day-rate for a particular patient type (e.g. medium secure male), adjusted for particular circumstances.

74. For Secure Services and CAMHS Services, these prices are negotiated centrally by national NHS commissioning bodies (NHSE and NHSW). The CMA received evidence that the discounts that these bodies were able to secure year-on-year differed between the Parties, suggesting some difference in the Parties' respective bargaining positions against these bodies. As discussed later in the Secure Services section, this may be a result of their differing scales in the two service lines.

75. For Acute, PICU and Rehabilitation Services, prices are negotiated locally by individual CCGs, Local Authorities or NHS trusts. Although price is typically ranked below quality and location by these referrers, competition can help ensure the commissioners receive the best price available.

---

[34] Notwithstanding this, the CMA has sought where possible to run sensitivity analysis on some Overlap Services to determine whether including some beds at NHS trusts would affect its competitive assessment.

[35] For details of the National Tariff system developed by NHS Improvement and NHSE, see https://www.gov.uk/government/collections/the-nhs-payment-system-regulating-prices-for-nhs-funded-healthcare.

The importance of quality in mental healthcare services

76. In common with previous decisional practice, the CMA expects that the number and quality of alternative providers in a local area will have an impact not only on the price that a customer may negotiate but also on the providers' incentives to deliver the quality that is important to patients.[36]

77. Examples of the quality benefits deriving from greater competition between providers include better (including more individualised) patient care, faster admissions, better facilities for patients, shorter stays (eg as a result of more focussed care) and more timely discharge. In the present case, the CMA's investigation found that the decision by a referrer of where to send a patient or class of patients was based largely on where they would receive the best quality of care.[37]

Assessment of horizontal unilateral effects

78. Horizontal unilateral effects may arise when one firm merges with a competitor that previously provided a competitive constraint, allowing the merged firm profitably to raise prices or degrade quality on its own and without needing to coordinate with its rivals.[38] Horizontal unilateral effects are more likely when the merger parties are close competitors.

79. The concern under this theory of harm is that the removal of one party as a competitor could allow the Parties to increase prices, lower quality, reduce the range of their services and/or reduce innovation. If referrers have materially reduced choice of providers locally, then the parties' incentives to improve quality in order to win referrals is likely to be reduced. Similar effects may arise in relation to price. This is particularly likely to be the case if local competitors to the Parties face capacity constraints, such that they could not easily absorb any patients which commissioners sought to switch away from the parties, and there are barriers to entry and expansion. The CMA has considered this theory of harm at a local and national level.

80. The CMA has therefore assessed whether it is or may be the case that the Merger has resulted in an SLC in relation to unilateral horizontal effects in each of the following seven services: *Acute Services, Addictions Services,*

---

[36] See further, in relation to competition in the NHS and healthcare more generally, the CMA's Guidance on the Review of NHS Mergers (**Guidance on NHS Mergers**), *Spire/St Anthony's*, and Report on the anticipated merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust (***Ashford/St Peter's***).

[37] Third party responses.

[38] Merger Assessment Guidelines, from paragraph 5.4.1.

CAMHS Services, Care Homes, PICU Services, Rehabilitation Services and Secure Services.

81. In relation to each Overlap Service, or sub-service, the focus of the CMA's assessment has been on areas where the Parties have combined market shares, for a given product frame of reference, over 30%. The purpose of this threshold was to filter out sites where the CMA does not believe that competition concerns will arise.

82. Where the Parties' share of supply exceeds 30%, in order to assess the likelihood of the Merger resulting in horizontal unilateral effects, the CMA has considered:

(a) the location and distance between the Parties' hospitals;

(b) the shares of supply of the Parties;

(c) the number of competing hospitals;

(d) evidence of competition between the Parties; and

(e) competitive constraints from alternative suppliers.

Barriers to Entry and expansion

83. Entry, or expansion of existing firms, can mitigate the initial effect of the acquisition on competition, and in some cases may mean that there is no SLC. In assessing whether entry or expansion might prevent an SLC, the CMA considers whether such entry or expansion would be timely, likely and sufficient.[39] In terms of timeliness, the CMA's guidelines indicate that the CMA will look for entry to occur within two years.[40]

84. The evidence received by the CMA from third parties does not indicate that any entry or expansion will be timely, likely or sufficient to mitigate any of the SLCs identified in the Overlap Services.

85. The CMA has explained its assessment in relation to the extent of any barriers to entry or expansion in its competitive assessment of each Overlap Service.

---

[39] Merger Assessment Guidelines, paragraph 5.8.3.

[40] Merger Assessment Guidelines, paragraph 5.8.11.

Countervailing buyer power

86. The Parties submitted that the NHS has substantial buyer power which would countervail any attempt by the Parties to increase prices or degrade quality post-Merger across the Overlap Services.

87. In general, the CMA believes that there are a number of factors which would make it difficult for the NHS to respond to a post-Merger increase in price or a degradation in quality by the Parties. These factors include:

(a) The cost of expanding NHS supply, or sponsoring other private provider expansion, may require the building of new wards, or a new hospital. This would be a high cost investment in response to a deterioration of competitive terms with the Parties and the funding challenges that the NHS faces would make this even more difficult.

(b) There has been a growth in demand for mental health services over the past 10 years but a limited response from NHS trusts in meeting this demand. This has led to NHS capacity constraints becoming increasingly binding.

(c) There is currently a moratorium on any expansion of mental health beds being procured by the NHS (whether from NHS trusts or private providers) in relation to Secure Services and CAMHS Services. However, to the extent that expansion is, or will be, possible, the CMA understands that private providers are better placed to expand. An NHS trust seeking to expand its provision of mental health beds would need to engage in a lengthy public consultation with an uncertain outcome, while private providers face no such constraints.

88. The CMA has explained its assessment of the extent of buyer power in relation to each of the Overlap Services in it competitive assessment.

Secure Services

Background

89. Adult secure mental healthcare services are inpatient services for adults with mental health conditions who present a significant risk to others or who are already in the criminal justice system and require mental healthcare services. All patients in secure services are detained under the Mental Health Act 1983 (England) (**MHA**). Providers of secure mental healthcare services must meet certain security requirements, which vary depending on the security level.

90. There are three recognised levels of secure mental healthcare services: high secure, medium secure and low secure. High secure services are provided only by NHS trusts, while medium and low secure mental healthcare services are provided by both NHS trusts and private providers. The Parties overlap in both medium secure and low secure services.

NHSE Commissioning

91. Secure Services are commissioned by NHSE through framework agreements. Different service specifications are defined in these agreements and a contract is negotiated with a provider for all services. The price at which providers will deliver Secure Services is typically the same across all sites of the same provider but varies between providers. Negotiations with individual providers is delegated to a local area team.[41] A provider must meet the relevant NHSE minimum service quality specifications, meet Care Quality Commission (**CQC**) standards and be accredited by the relevant RCPsych Peer Review Group.[42]

92. There is no standard national tariff for secure mental health services. However, NHSE adjusts annually the price it pays to providers of these and other specialised services in line with the national tariff deflator that is used by Monitor and NHSE as part of the national tariff setting process. The price adjustment is then agreed through annual negotiations between providers and NHSE.

93. Currently, there is a moratorium on the commissioning by NHSE of additional Secure Service beds and so no provider can either open or expand Secure Services or change the type of Secure Services offered at a facility.[43] In the

---

[41] [✂].

[42] Merger Notice, Appendix F. CMA internal commissioning note, as amended by [✂].

[43] Merger Notice, Appendix F.

last three years, PiC and Priory have expanded their respective Secure Services only through acquisitions of other providers. NHSW is not subject to the moratorium.

NHSW Commissioning

94. The Velindre NHS trust hosts a framework agreement under which all of the Welsh Local Health Boards (WLHB) and NHSW commission mental health services. The framework agreement sets the terms of provision for private providers and NHSE providers to NHSW, while NHSW facilities are contracted separately. Private and NHSE providers are periodically invited to submit bids for the framework agreement. This allows potential new providers to tender for appointment on the framework and existing providers to amend or expand their service offering by adjusting prices or by changing/adding units.

95. All successful bidders are ranked on a quality (or assurance) rating and on price following the tender process. Ranking is affected by the outcome of quality audits which are undertaken at least annually.

Referrals for and admission to Secure Services

96. Referrals to Secure Services originate from three pathways: criminal justice services (prison or courts), other Secure Services (eg step-up or step-down), or other general mental health services.

97. In England, NHSE area teams employ local mental health case managers who are responsible for placing low and medium secure patients. When a patient is referred for admission to a secure facility, the initial referral is to the secure clinical service geographically responsible for the patient who will assess the patient's appropriateness for secure care and will advise on a treatment pathway. If admission to the assessing unit is appropriate, the patient will be admitted. However if an out of area or specialist treatment is required, then the referral is managed further by the case manager.[44] The decision where a patient will be admitted is ultimately made by the case manager.

98. Both the Parties and [✂] told the CMA that, in making this referral decision, the case manager does not consider price.[45]

---

[44] [✂].

[45] [✂]. See also Parties' submissions.

99. In Wales, each patient placed in a secure service is placed under an individual patient placement agreement. Case managers working under the WLHB are responsible for placing patients. When placing a patient, consideration is given to the patient's clinical, geographical and social needs, but, when deciding between facilities that meet those needs, commissioners consider the facilities' ranking on the framework, which includes its quality rating and its price.

Frame of reference

Product frame of reference

100. The Parties submitted that the relevant frame of reference for Secure Services is the provision of secure mental healthcare services supplied under contract with NHSE and NHSW. The Parties told the CMA that the NHS commissions secure mental healthcare services for patients with LD and general mental healthcare secure services separately, and for male patients and female patients separately.[46] No providers have mixed gender wards. The Parties also told the CMA that Secure Services are provided on separate wards to other services, and are subject to different regulatory specifications.[47]

101. Third parties identified further specialities within low secure and medium secure mental healthcare services, based on the patient's primary diagnosis and needs, which they said were not substitutable for the patient on the demand-side. Specifically:

(a) [✂] and case managers emphasised the particular importance of ensuring that a patient receives the services appropriate to their needs.[48] [✂] provided the CMA with a list of the services that are commissioned [✂] from NHS trusts and private providers, which included different categories for ABI, ASD, LD, MI and PD.[49]

---

[46] Appendix F to the Merger Notice.

[47] The Parties submitted that they do not overlap in ASD services and medium secure LD services because Priory does not provide ASD services and medium secure LD services. The Parties also submitted that they do not overlap in older adults, deaf and ABI secure service segments.

[48] [✂]. A third party [✂] also submitted that patients with a diagnosis of PD often struggle in [✂] services and benefit from specialist provision. [✂].

[49] [✂].

(b) Several third parties said that it is not common practice to treat patients with a primary diagnosis of ABI, ASD, MI or PD on the same ward.[50] If a patient has more than one condition, they will generally be assigned to the ward which treats their primary condition.[51]

(c) All competing private providers which responded to the CMA's questions said that there are recognised segmentations between male and female, and within each of these segmentations, further sub-specialities, the most common of which are ASD, LD, MI and PD.[52,53]

102. On the basis of this evidence, the CMA identified the following different segmentations that it believes constitute distinct frames of reference and in which the Parties overlap.[54]

Table 1: Overlapping segments between the Parties in Secure Services		
Medium secure	Female	MI
		PD
	Male	MI
		PD
Low secure	Female	MI
		PD
		LD
	Male	MI
		PD
		LD

103. While the CMA generally determines the boundaries of the relevant product frame of reference by considerations of demand-side substitution alone,[55] the CMA may widen the scope where there is evidence of supply-side substitution.

---

[50] The CMA understands that, whilst the NHSW National Framework Agreement does not specifically commission further sub-specialties within secure mental healthcare services, the treatment of ABI, ASD, PD and others are considered 'specialist provision' within the agreement. Conversely, the treatment of LD and general MI are considered 'regular' secure services. Third Party questionnaire responses.[✂].

[51] Information from a number of third parties, including commissioners. [✂].

[52] Responses from private providers. [✂].

[53] [✂] and two private providers said there might be further segments for deaf patients and older adult patients. Third party responses. [✂].

[54] The CMA notes that for some patients there may be more than one ward that can meet their needs, particularly when they have a number of conditions or where better-targeted specialist services are unavailable at the time due to capacity constraints. However, the CMA does not see this as a form of economic substitution between specialities which would imply the presence of competitive constraints.

[55] Merger Assessment Guidelines, paragraph 5.2.17.

104. The CMA understands that wards may be re-assigned from one service to another, which could give rise to potential supply-side substitution when appropriately trained staff are available to facilitate the switch and it is possible to place patients for the previous service in appropriate alternative facilities. The CMA has seen some evidence of supply-side substitution between specialities.[56]

105. The Parties did not provide any submission on the potential extent of supply-side substitution in relation to the supply of Secure Services. However, they did provide some evidence of ward re-assignment, both within low secure and medium secure services and from other services to/from low/medium secure.

106. However, the CMA considers that providers face a number of significant barriers when switching a ward to an alternative service and so this would not be quick and easy.

107. First, changing the service provided in a ward may often require a change in specialist staff. Third parties (commissioners and private providers) told the CMA that the limited availability of specialist staff generally has become an issue in the industry and could be an obstacle to switching.[57]

108. A commissioner [✂] told the CMA that there are two main types of specialist nurse training in secure services: LD and MI. That commissioner said that, once staff have this specialist training, they can build on their skills through further training to manage specific types of patient, such as ASD or PD.[58] This indicates that specialist training is required to treat patients presenting with conditions other than MI or LD. Another commissioner [✂] also told the CMA that staff on wards caring for patients with different conditions will have specific training, skills and/or experience for the different specialties.[59] A private provider [✂] said that to retrain a low secure mental healthcare service team to become a low secure LD mental healthcare service team, or to recruit a new team, would be a considerable investment. It said it could take 6 to 12 months to set up a new service.

---

[56] For example, the CMA understands that some wards are able to treat more than one condition. For example, ASD and LD secure patients can be treated on the same ward. Although there are different segments of ASD and LD, some facilities are able to treat both segments on the same ward if they have the relevant staff and the mix of patients is appropriate, allowing them to care for both segments of the patients. Third party provider and commissioner responses [✂].

[57] Responses from providers. [✂] (they submitted "*it is relatively easy if staff can be recruited*").

[58] CMA internal commissioning note, [✂].

[59] [✂] Commissioner response. In addition, [✂] two private providers told the CMA that there is a different staff skill set in LD services.

109. Second, the patients admitted to a providers' ward at the time of a re-designation must be placed in an appropriate alternative ward (either at that provider's own facilities or at another facility if that provider does not have additional capacity or is capacity constrained). For this reason, it may take some time before a provider is able to change the speciality offered by the ward, even if it did have appropriately trained staff available. For example, [✂].[60] The CMA acknowledges that this example refers to a rehabilitation unit, however it indicates that it may take some time to find an alternative placement for patients when wishing to re-designate a ward.

110. For these reasons and, in particular, given that there is no supply-side substitution between genders and the difficulty in re-locating patients where a ward re-designation was required, the CMA did not consider it appropriate to broaden the frames of reference on the basis of supply-side substitution in relation to Secure Services.

Geographic frame of reference

111. The Parties submitted that, because providers of Secure Services negotiate national contracts with NHSE and NHSW, they do not compete on the basis of price or quality. They also submitted that the relevant geographic frame of reference is 'England and Wales' as patients from England are placed in facilities in Wales, and vice versa.[61]

NHSE commissioning area (England)

112. The CMA's investigation confirmed that competition for patients is based on factors including the distance from the patient's place of origin (usually their home or the home of a relative or carer), the ability to treat that patient's specific needs and the provider's reputation and quality of service. The vast majority of providers which responded to the CMA's questions indicated quality to be among the most important factors in a referral decision, with other important factors including bed availability and location.

113. The CMA's investigation also confirmed that quality varies between providers. While NHSE sets the minimum quality standards under the contract, providers can and do increase their offered quality above the minimum level.[62]

---

[60] Appendix to Merger Notice – Overview of ward re-designations.

[61] Merger Notice, Appendix F, p13.

[62] A third party [✂] told the CMA that some referrers stopped referring patients to a provider when the quality of the service decreased (eg because the average length of stay increased without clinical justification), despite that provider otherwise being the first choice on the basis of distance. In

114. On the basis of this evidence, the CMA believes that there is local competition for patients, in part based on the quality of service. Therefore, the CMA considers that there are local markets in relation to competition for patients based in England (and so the responsibility of NHSE) requiring Secure Services.[63]

115. The Parties submitted 80% catchment areas for each of the service lines indicated in Table 1,[64] which the CMA used as the starting point in its analysis. This is consistent with the approach used in *Spire/St Anthony's* and *Royal Bournemouth/Poole*.[65] The CMA used PiC catchment areas in England because Priory had a very low number of observations and therefore PiC catchment areas were more reliable.[66]

NHSW commissioning area (Wales)

116. The CMA's investigation also emphasised the importance of quality of service and proximity for a patient located in Wales.

117. The Parties submitted that, depending on the relevant catchment area adopted around the Parties' hospitals in Wales, hospitals in England may compete to provide services to some patients in Wales. This was confirmed by the CMA's analysis of NHSW admission data.

118. The CMA therefore used 80% catchment areas in Wales as a starting point for its local analysis, including hospitals in England falling within these

---

addition, the Parties said at the Issues Meeting that they seek to provide better quality than the minimum standards would require.

[63] Depending on the location of the patient, the local area might include hospitals in both England and Wales.

[64] The 80% catchment area for PiC ranged from [100-125] miles for low secure male mental health services to [125-150] miles for medium secure male mental health services.

[65] Report on the anticipated merger of The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust and Poole Hospital NHS Foundation Trust (**Poole/Bournemouth**) and Completed acquisition by Spire Healthcare Limited of certain assets and business comprising St Anthony's Hospital in Surrey (**Spire/St Anthony's**).

[66] The CMA also sensitivity checked the results by changing the distance from the centred site.

catchment areas.[67] On a cautious basis, the CMA used Priory's 80% catchment areas[68] in Wales of [100-125 miles] miles.[69]

Conclusion on geographic frame of reference

119. For these reasons the CMA adopted as its geographic frame of reference for each product frame of reference a local area defined in each case by the Parties' catchment areas for the given service line. However, the CMA has also taken account of the national aspects of competition in its competitive assessment.

Assessment of horizontal unilateral effects

120. In relation to Secure Services, the CMA has focussed its assessment of unilateral effects in the supply of overlapping Secure Services on local catchment areas because referrers consider both quality and distance to be important factors in their local referral decision.

121. However, the CMA also notes that the loss of competition in local areas as a result of the Merger could weaken the ability of NHSE or NHSW to centrally negotiate price and minimum quality levels across a provider's estate of facilities supplying Secure Services. If, as a result of the Merger, the Parties gain a relatively strong presence in Secure Services in a number of local areas, this could also increase their negotiating power against NHSE and NHSW overall.

122. In order to assess the likelihood of the Merger resulting in unilateral effects in Secure Services, the CMA considered (i) the Parties' shares of supply within England and Wales and within local catchment areas; (ii) the closeness of competition between the Parties; and (iii) evidence of any competitive constraints from alternative suppliers.

---

[67] For example, NHS-funded low secure LD patients currently in Priory facilities in England must have originated from Wales (ie via NHSW) since NHSE does not commission these services from Priory in England.

[68] The average 80% catchment area for Priory sites in Wales was [100-125] miles. The number of observations for Priory's LD patients was also sufficiently high to calculate a specific catchment area for these patients (ie 23 observations). The CMA considered it inappropriate to use PiC's average 80% catchment area because this was so large as to apply to all patients in England and Wales.

[69] The CMA also sensitivity checked the results by changing the distance from the centred site.

Shares of supply

123. There are 4 Priory sites and 20 PiC sites in England and Wales providing Secure Services. Three Priory sites, all located in England, provide more than one specialism which overlaps with those offered by local PiC sites; while one Priory site (*Cefn Carnau*), located in Wales, provides only one specialism which overlaps with those offered by local PiC sites.

124. The CMA used the number of beds at each facility as a proxy for the Parties' combined share of supply of low and medium secure services provided to NHS patients in England and Wales.[70] As discussed at paragraphs 62 to 71 above, the CMA found that private providers (such as the Parties) may face little constraint from NHS trusts and therefore, on a cautious basis, NHS trusts were excluded from the bed share analysis. The CMA did consider the extent of the constraint from NHS trusts in Secure Services, as discussed later at paragraphs 151 to 169.

125. The Parties provided estimated bed shares for each service line but were unable to provide MI and PD separately or LD and ASD separately.[71] Table 2 therefore shows the Parties' share of supply at a national level (ie England and Wales) for MI and PD services together and ASD and LD services together.

Table 2 - National shares of low and medium secure services (%)

	PiC	**Priory**	**Combined**
Low secure female MI/PD	[20-30]	[5-10]	[30-40]
Low secure male MI/PD	[30-40]	[10-20]	[40-50]
Low secure female ASD/LD	[50-60]	[10-20]	[60-70]
Low secure male ASD/LD	[40-50]	[5-10]	[40-50]
Medium secure female MI/PD	[40-50]	[5-10]	[40-50]
Medium secure male MI/PD	[40-50]	[20-30]	[60-70]

[70] PiC in addition has one facility providing Secure Services in Scotland, but Priory has no Secure Services facilities in Scotland. (Merger Notice, Annex F, p.12). The shares were calculated using the bed shares provided by the Parties (Annex – All Services Pivot Table 180516). The shares exclude number of beds provided [✂]. (Section 109 Response 15 March 2016, p.2). The shares also exclude [✂]. Given that it is unclear when the moratorium will be lifted and whether NHSE will commission the services from this site when the moratorium is lifted (and how many beds NHSE will commission), the CMA does not include this site in the calculation.

[71] The Parties told the CMA that they are unable to distinguish between MI and PD and between LD and ASD services for their rivals and therefore could not estimate their own share of supply for these specialities. The Parties also said that Priory does not distinguish between MI and PD services and PiC generally offers these services on the same ward. Priory does not provide ASD secure services.

126. This indicates that the Parties' national shares are high across all specialisms, ranging between [30-40]% and [60-70]%.

127. Table 3 presents the combined bed shares[72] by specialism for the 80% catchment areas centred on each Priory site, again excluding NHS provision.[73]

Table 3 Combined bed shares in 80% catchment area[74] when centering on Priory site

Priory site	MS male MI/PD ([125-150] miles)	MS female MI/PD ([125-150] miles)	LS male MI/PD ([100-125] miles)	LS female MI/PD ([100-125] miles)	LS male ASD/LD ([100-125] miles)	LS female ASD/LD ([100-125] miles)
Chadwick Lodge[75]	[60-70]	[40-50]	[40-50]	[20-30]	[0-5]	n/a
Thornford Park	[60-70]	n/a	[50-60]	n/a	n/a	n/a
Farmfield	[60-70]	n/a	[50-60]	n/a	n/a	n/a
Cefn Carnau[76]	n/a	n/a	n/a	n/a	[60-70]	[0-5]

Notes:
1. [✂].
2. 'N/A' means that that site does not offer the relevant service.
3. 'No overlap' means no overlap in the service line within the catchment area.

128. As a sensitivity check, the CMA flexed the catchment area by +/- 20 miles. For three sites, the results are the same. However, for Priory *Cefn Carnau*, when considering the smaller catchment distance of [75-100] miles, the Parties' combined bed share increases to [90-100]% in LS male ASD/LD secure services.

129. When centring on *Chadwick Lodge* for LS female MI/PD services, the shares are relatively low ([30-40]%). However, the CMA found that when centring on

[72] The combined bed shares excludes [✂]. However, the shares of supply are only slightly higher if this new sites is included and it does not affect the CMA's competitive assessment either way.

[73] The CMA notes that concerns also arise when the catchment area is centred around the relevant PiC site that overlaps with each Priory site.

[74] Using data provided by the Parties. See Annex – All Services Pivot Table (18.05.16).

[75] References to Priory *Chadwick Lodge* are references to Priory *Chadwick Lodge and Eaglestone View*.

[76] Using data provided by the Parties. See Annex – All Services Pivot Table (18.05.16)

PiC's *Dene* site, using the same [100-125] catchment area, the Parties' combined bed share is [40-50]%.[77]

130. The CMA considers that the Parties' combined shares of supply in these local areas are high enough to raise *prima facie* competition concerns across all overlapping specialisms.

131. Table 4 shows the number of alternative private providers within the 80% catchment areas centred on each of Priory's sites. This shows that that there is a small number of alternative providers in the relevant catchment areas, particularly in relation to medium secure male and female services.

Table 4 - Alternative private providers within catchment area when centring on Priory

Priory site	MS male MI/PD	MS female MI/PD	LS male MI/PD	LS female MI/PD	LS male ASD/LD	LS female ASD/LD
Chadwick Lodge	3	2	4	4	n/a	n/a
Thornford Park	2	n/a	4	n/a	n/a	n/a
Farmfield	2	n/a	5	n/a	n/a	n/a
Cefn Carnau[1]	n/a	n/a	n/a	n/a	1	No overlap

Notes:
1. [✂].
2. The only two facilities located in Wales which provide male LD services are PiC and Priory sites. The competitor for these services within the *Cefn Carnau* catchment area is located in England.
3. 'N/A' means that that site does not offer the relevant service.
4. 'No overlap' means no overlap in the service line within the catchment area.

Closeness of competition

132. The Parties submitted that they are not each other's closest competitor for Secure Services. The Parties said that they are often not the closest facility geographically to each other. They also said that NHSW referral data indicates that other competitors account for the majority of the market, and that the increment in share arising from the Merger is marginal. They added that their internal documents list other competitors as well as each other.[78]

[77] When considering a smaller catchment area of [75-100] miles, *Chadwick Lodge* is not in *Dene's* catchment area. When considering radius of [125-150] miles, the combined bed share is [30-40]%.

[78] Parties response to Issues Paper, slide B-20.

133. The CMA has examined the closeness of competition between the Parties and considered within its assessment (i) third party views; (ii) the distance between the sites of the Parties; (iii) NHSW data; and (iv) internal documents.

Third party views

134. All NHS trusts which submitted a view[79] on this question said that the Parties closely competed. One NHS trust explained that '*They have always competed with each other and this has helped drive up to some extent quality of the four major providers*'. Another NHS trust said similarly that '*they are in direct competition which has helped drive up quality*'.

135. All private providers which responded to the CMA's questions said that the Parties competed very closely with each other. [80] Another third party [✂] said that the Parties both operate units for low and medium secure, but that PiC *Dene* provides female services, while Priory *Farmfield* provides male services. One competitor [✂] said that the Parties competed because they both provide the same low secure male services in the same geographic areas. Another competitor [✂] said that the Parties are significant competitors to each other, with a high degree of geographical overlap. It said that they hold a similar position in the market in terms of quality and price.

136. [✂] told the CMA that the Parties compete for low secure services in England and Wales. It said that, for medium secure services, Priory does not have any sites in Wales and therefore the Parties do not compete for these services in Wales; however, in England they are the two largest providers competing for medium secure services.

137. [✂] said that the Parties competed with one another and provide the same services.[81]

Distance between the sites of the Parties

138. The CMA analysed the distance between each of the Priory sites and the closest PiC site, which provides the same overlapping specialism.[82] The CMA found that, for most services, there was at least one closer competitor by distance. However, the difference between the nearest competitor to Priory and the nearest PiC site is small given the overall catchment areas of [100-

---

[79] Responses from NHS trusts. [✂].

[80] Responses from private providers. [✂].

[81] [✂].

[82] Again, the CMA applied PiC catchment areas due to low number of observations for Priory sites.

125]-[125-150] miles, ranging in many cases between 10 and 20 miles, and in some cases being as little as 1-10 miles.

NHSW data

139. The CMA also considered the shares of admissions for patients being referred by NHSW in the period between April 2013 and March 2016. Table 5 shows the shares of admissions from NHSW to PiC and Priory sites as a percentage of referrals to all facilities under its framework (ie the shares of 'overspill' patients), whether in Wales or in England.

Table 5 - Number and share of NHSW referrals

	PiC		Priory		Combined
	Share (%)	Total number of referrals	Share (%)	Total number of referrals	Share (%)
Low secure male	[60-70]	[✂]	[5-10]	[✂]	[80-90]
Low secure female	[40-50]	[✂]	[0-5]	[✂]	[50-60]
Medium secure male	[30-40]	[✂]	[0-5]	[✂]	[30-40]
Medium secure female	[60-70]	[✂]	[0-5]	[✂]	[60-70]
Low secure LD male	[40-50]	[✂]	[10-20]	[✂]	[60-70]
Low secure LD female	[10-20]	[✂]	[40-50]	[✂]	[60-70]

140. The NHSW data indicates that both PiC and Priory admitted patients from NHSW (with the exception of medium secure female). It shows that, for patients in Wales, Priory is receiving small numbers of patients in low secure female, medium secure male and medium secure female, which suggests that, pre-Merger, Priory is exerting a limited constraint on PiC in relation to these specialisms for patients from NHSW. However, the CMA notes that the small number of total referrals limits the inferences that can be drawn from the data on these specialisms.

141. Conversely, the Parties' high combined shares of referrals from NHSW for low secure male and low secure male LD services suggest that they are closer competitors for these specialisms. The data shows, for example, that [60-70]% of patients for low secure male LD were admitted to either PiC ([✂]) or Priory ([✂]) facilities.

Internal documents

142. The CMA reviewed the Parties' internal documents to ascertain the extent to which the Parties view each other as close competitors. The CMA noted that:

a) In a presentation commissioned by PiC, Priory was listed as competing in Secure Services.[83]

b) In a Priory Board Meeting presentation, a slide shows PiC performance, with an added comment that [✂].[84] The same slide notes that one alternative competitor is struggling, indicating that it may be a lesser constraint on the Parties.

143. The CMA notes that internal documents, whilst mentioning some other competitors, clearly show that the Parties consider each other as close competitors.

Conclusion on closeness of competition

144. On the basis of this evidence, the CMA believes that the Parties are close competitors to each other across all Secure Services in which they overlap. In some specialisms in some local catchment areas they are likely to be each other's closest competitor.

Alternative providers

145. The Parties submitted that, across England and Wales, there will be a large number of alternative providers of Secure Services remaining post-Merger. The Parties submitted that NHS trusts will remain by far the largest providers of secure mental health services and that there are also a significant number of private providers.[85]

Private providers

146. All private providers which responded to the CMA's questions said that they compete with both Priory and PiC for Secure Services. NHS trusts most often cited Cygnet, St Andrew's and, to lesser extent, Huntercombe, Cambian and Raphael as private competitors to the Parties. However, the CMA notes that some alternative providers are only active in one or two specialisms and are small. For example, the CMA understands that Mental Health Care UK has only one 12 bed facility providing low secure male services.

147. As shown in Tables 3 and 5 above, the Parties have more than a 60% combined bed share in the provision of medium secure male services, in the

---

[83] Merger Notice, Slide 4, Annex Q10.1-107

[84] Merger Notice, Slide 7, Annex Q18-6

[85] Merger Notice, Appendix F, p16.

relevant catchment areas, with a limited number of alternative providers operating in these areas.

148. Similarly, in the provision of medium secure female services, there are only two other alternative providers in the *Chadwick Lodge* catchment area.

149. There are slightly more alternative providers in the provision of low secure male services, third parties generally only mentioned St Andrew's, Cygnet and Inmind as competitors to the Parties. One third party mentioned Cambian as another competitor for these services but the Cambian website states that its site in the relevant catchment area provides PD specialist services,[86] indicating that it may be a constraint on the Parties only in relation to that specialism.

150. On the basis of this evidence, the CMA believes that the extent of the relevant local constraint exerted by competitors is broadly reflected in the bed share analysis (see paragraphs 127 to 131). All competing private providers are reflected in that analysis.

NHS trusts

151. The CMA has not included NHS trusts in the relevant product frame of reference, given in particular the evidence it has received across all service lines indicating that NHS trusts face severe capacity constraints, may be expected to prioritise patients in their own areas, and the limited evidence that they receive out of area placements from other NHS trusts (see paragraphs 62 to 71 above).

152. Nevertheless, the CMA assessed separately the extent to which NHS trusts exert a competitive constraint on private providers of Secure Services. In its assessment, the CMA considered England and Wales separately, assessing evidence from the Parties, the NHS and third parties.

- *NHS trusts in England*

153. The Parties submitted that NHS trusts are the largest providers of secure mental health services,[87] and that the Parties compete with both NHS trusts and private providers for contracts to supply services to NHSE.[88]

---

[86] http://www.cambiangroup.com/ourservices/service/home.aspx?Id=179&s=29

[87] Merger Notice, Appendix F, p16.

[88] Issues meeting, slide B-15.

154. The Parties provided four emails from [✂] case managers seeking an available bed, which were sent to both NHS and private providers. The Parties said that this was evidence that private providers compete with the NHS.[89] However, the CMA notes that each of the emails were addressed to several private providers (eg Priory, PiC, St Andrew's, Cygnet, Alpha Hospitals, Ludlow Street Healthcare) but only one NHS trust. Therefore, these emails suggest that, at the point of overspill demand, referrers rely more on private providers than NHS trusts. In any event, the CMA places limited weight on a small selection of emails.

155. The Parties also submitted a list of those providers which received the patients PiC could not admit after an initial assessment. Most of the referrals ([50-60]% of [✂] referrals) were referred to NHS trusts, while the rest ([40-50]% of [✂] referrals) were referred to other private providers.[90] However, the CMA notes that it was not clear from this evidence whether the referrals to NHS trusts were referrals back to the access assessor's NHS trust or onwards to another NHS trust.

156. The Parties also submitted that they face similar capacity constraints to NHS trusts.[91] The Parties said that the high levels of capacity utilisation by all providers, whether NHS or private, means that patients are referred to wherever there is an available bed.[92]

157. [✂] told the CMA that the NHS trust at which the local access assessor is based would usually attempt to admit the patient. If that NHS trust had no beds available for the required speciality, or was otherwise unable to meet the needs of the patient, the local assessor would then attempt to admit the patient to the nearest provider that could meet their needs.[93]

158. [✂] told the CMA that it is rare for multiple NHS trusts to offer the same services within a local commissioning area and, where the local NHS trust was unable to admit the patient, the referral would usually be out of area. [✂] added that out of area NHS trusts would rarely have capacity to admit patients

---

[89] Issues meeting, slides Annex B-23 – B-26.

[90] Issues meeting, slide B-17. The CMA notes a small number of referrals.

[91] The Parties said that their occupancy rates between March and May 2016 for Secure Services were on average [✂]% for Priory and [✂]% for PiC.

[92] Issues meeting, slide B-15.

[93] [✂].

so, in practice, the vast majority of overspill referrals were to private providers.[94]

159. Most NHS trusts[95] confirmed that access assessors initially explored whether it was possible to place the patient in their own NHS trust or a nearby NHS trust. Some NHS trusts [✂] said that there was a preference for NHS provision because lengths of stay were usually shorter. One NHS trust [✂] said that whether the provider was private or NHS was not a factor.

160. One NHS trust [✂] said that its overspill patients are referred out of area to private providers. Another NHS trust [✂] said that, if it cannot accept a patient, case managers will most likely approach other NHS trusts in London (because they provide pathways into community and are local to patients)[96] but, as they often have no beds, case managers often refer to private providers.

161. Competing private providers [✂] submitted that case managers tend to seek NHS placements before using private facilities. Two private providers [✂] noted that distance considerations may affect the preference for NHS providers and referrers may prefer a local private provider to a distant NHS provider. Competing providers [✂] also submitted that, for complex patients, it is much more common for case managers to seek private sector placements.

162. This evidence consistently suggests that access assessors always seek to place a patient at their own NHS trust before considering other providers. Therefore, competition in Secure Services is for those patients who cannot be placed at the access assessor's NHS trust (ie for overspill demand).

163. The CMA identified a number of potential scenarios that could arise when a patient cannot be admitted to the access assessor's trust:

(a) The access assessor has a preference for using local NHS trusts and exhausts these options before considering *any* private provider. In this scenario private providers will compete for residual overspill demand but will not compete with NHS trusts.

(b) The access assessor has a preference for private providers, eg where the patient has particularly complex needs. Again, private providers will compete for this demand and will not compete with NHS trusts.

---

[94] [✂].

[95] Responses from NHS trusts. [✂].

[96] The NHS trust noted that this may reflect the fact that there is limited private provision in London.

(c) The access assessor does not have a preference for using another NHS trusts rather than a private provider and will consider all providers with available beds, making a decision based principally on proximity and quality.[97]

164. However, in relation to the final scenario, the CMA has been told consistently that NHS trusts have very limited capacity, and that this is particularly problematic in Secure Services where the moratorium on new beds has prevented NHS trusts expanding their capacity. The CMA recognises that private providers, including the Parties, are also operating at high utilisation rates for Secure Services, but third party evidence suggests that they have slightly more spare capacity than NHS trusts.

165. In light of the above, the CMA believes that NHS trusts could impose some constraint on private providers of Secure Services in England but, given referrers preference for NHS provision in the first instance and in the second instance the pervasive NHS capacity constraints, this competitive constraint is very limited.

- *NHS trusts in Wales*

166. [✂] submitted[98] that, if an appropriate bed is available at an NHSW facility, a patient will be admitted to this facility before being considered for admission to private providers. However, no NHSW facilities supply low secure female and low secure LD services.[99] If an NHSW bed is not available, either because of capacity constraints or because the local NHS trust does not provide the services required, a commissioner would use providers on the framework, which includes NHS trusts in England and private providers.[100]

167. [✂] said that, when placing a patient outside of NHSW facilities, consideration is given to the patient's clinical, geographical and social needs. If multiple facilities meet those needs equally, commissioners consider the facility's ranking on a framework, which includes an assurance rating and ranking by price. It said that, when selecting providers on the framework, there is no preference for NHS trusts in England above private providers.

---

[97] The Parties submitted that case managers do not discriminate between NHS and private providers when seeking beds for patients. Response to Issues Letter slide B-16.

[98] Third party response. [✂].

[99] Third party response. [✂].

[100] Commissioner response. [✂].

168. The CMA analysed NHSW referral data and found that, in the period between April 2013 and March 2016, only [✂] secure service patients out of [✂] were admitted to NHS trusts in England, indicating that NHSW very rarely sends patients to NHS trusts in England.[101] The remainder were referred to private providers, whether located in Wales or in England. The CMA notes that this is consistent with evidence a Wales Health Board [✂], which submitted that it does not normally consider NHS trusts in England as they do not have capacity.[102]

169. In light of the above, the CMA believes that NHS trusts, whether located in Wales or England, do not constrain the private provision of Secure Services to NHSW patients and that the only constraint on the Parties for Secure Services supplied to NHSW patients comes from other private providers.

Conclusion on competitive effects

170. The CMA believes that the Parties have high combined shares of supply in all Secure Service specialisms and in all catchment areas in which they overlap, and are close competitors. Post-Merger the Parties would face limited competition from other private providers. The CMA believes that NHS trusts impose a very limited constraint on the Parties for patients in England and no constraint for patients in Wales.

171. For these reasons, the CMA believes that the Merger gives rise to a realistic prospect of an SLC in relation to the following sites and service lines:[103]

    a) Priory *Chadwick Lodge* (medium secure male MI, medium secure male PD, medium secure female MI, medium secure female PD, low secure male MI, low secure male PD, low secure female MI, and low secure female PD);

    b) Priory *Farmfield* (medium secure male MI, medium secure male PD, low secure male MI and low secure male PD);

    c) Priory *Thornford Park* (medium secure male MI, medium secure male PD, low secure male MI and low secure male PD); and

    d) Priory *Cefn Carnau* (low secure male LD).

---

[101] Services considered: low secure male and female, low secure male and female LD, medium secure male and female.

[102] Response from NHS trust. [✂].

[103] The CMA refers to the four Priory sites whilst noting that concerns also arise when the catchment area is centred around the relevant PiC site that overlaps with the Priory site.

NHSE and NHSW buyer power

172. The Parties submitted that the NHS exerts significant buyer power and would continue to constrain the Parties in price and quality post-Merger. The Parties submitted that NHSE and NHSW are the Parties' only customers for Secure Services and the Parties' dependence on these purchasers conveys buyer power on them.

173. While the CMA acknowledges the Parties reliance on contracts with NHSE and NHSW for Secure Services provision, given the limited number of available private sector beds, it is not clear that NHSE and NHSW have buyer power. If there is a limited choice of suppliers and demand which needs to be satisfied, NHSE and NHSW may have few available alternatives.

174. [✂].[104] The CMA notes that these options would become significantly more limited post-Merger.

175. The Parties also submitted that NHSE dictates terms on price, quality and capacity through annual contracting.[105] The Parties provided the CMA with information regarding the price increases that they had sought during their respective negotiations with NHSE and the price changes that were finally applied. [✂].[106]

176. However, the CMA notes that this data shows clearly that there is some price negotiation between private providers and NHSE for Secure Services, and NHSE does not dictate prices.[107] While there might not be evidence of NHSE 'playing off' one provider against another, the presence of multiple private providers would be expected to provide some price constraint in these negotiations. The CMA also notes that the [✂] is indicative of NHSE having some buyer power.

177. For example, in negotiations with Priory, [✂]. In negotiations with PiC, [✂].[108] The CMA notes that PiC, the larger provider of Secure Services, [✂]. This suggests that NHSE is not able to dictate prices and engages in negotiations which produce results which differ between providers, according to the balance of their negotiating positions.

---

[104] [✂].

[105] Issues meeting, slide B-6.

[106] The Parties also submitted that [✂].

[107] [✂].

[108] Issues meeting, slides Annex B-18 and B-19.

178. The CMA also notes that the Parties indicated [✂], which indicates that NHSE is not able to exert much buyer power,[109] and that they strive for a level of quality which goes beyond the minimum quality standards set by NHSE, which is also indicative of a lack of buyer power pre-Merger.[110]

179. The CMA also notes that NHSW does not negotiate contracts annually and instead, as discussed above, runs a procurement process for admission to its framework contract for Secure Services.[111]

180. Furthermore, the CMA notes that local conditions of competition can incentivise providers to improve their quality offering beyond the minimum standards set down centrally by NHSE or NHSW, which suggests that any central buyer power is less relevant to standards of quality at a local level.

181. For all these reasons, the CMA believes that any buyer power possessed by NHSE or NHSW is insufficient to mitigate the SLCs identified.

Barriers to entry and expansion

182. The Parties submitted that NHSE and NHSW control entry and expansion in Secure Services, and have the ability to shift supply between areas and suppliers.[112] The Parties provided examples of when NHSE influenced the provision of Secure Services. These included an [✂].[113] Another example involved [✂].[114]

183. The Parties submitted that there are several suppliers willing to enter the market if the moratorium is lifted. The Parties submitted that Cygnet has built wards to secure specifications in anticipation of a potential procurement exercise in the future, and that Riverside, Raphael's and Pastoral have all obtained planning permissions for sites that could meet the standards for Secure Services.

184. The CMA recognises that NHSE and NHSW have control over the supply of Secure Services and that they have the ability to facilitate new entry. However, the CMA notes that, for as long as the moratorium is in place, there is a complete constraint on any new entry into the market. The CMA received

---

[109] Issues meeting, oral evidence.

[110] Issues meeting, oral evidence.

[111] Merger Notice, Annex F, p.20.

[112] Issues meeting, slides B-2.

[113] Issues meeting, B-12 and Annex B-20 – B-21.

[114] Issues meeting, B-13.

evidence that consideration is being given to the moratorium being lifted in the next year or two, but the Parties and third parties noted that a lifting of the moratorium had previously been signalled and had not happened. Therefore, on a cautious basis, the CMA does not believe it can put any weight on other providers being ready to enter while the moratorium remains indefinitely in place.

185. The evidence received by the CMA from third parties also does not indicate that entry or expansion will be timely, likely or sufficient to mitigate any SLC arising. For example, third parties (commissioners and private providers) told the CMA that the availability of trained staff has already become an issue and could be an obstacle to growth.[115] One competitor [✂] said that to re-train a low secure service team to become a low secure LD service team, or to recruit a new team, would be a considerable investment. It said that, for this reason, it could take 6 to 12 months to establish a new service.

186. The CMA notes that entry also involves substantial costs. The Parties submitted that it took [✂], and it cost £7.5 million for Greater Manchester West Mental Health NHS trust to build a new site.[116] A competitor [✂] told the CMA that it costs approximately £5 million to build a 12-bed ward, and another competing provider [✂] also said that building a new facility is very expensive.[117] An NHS trust [✂] said that it would be difficult for current NHS providers to expand due to limits on capital funding available for such developments and changes in commissioning.

187. The CMA also notes that the necessity to contract with NHSE or NHSW in order to receive referrals may act as a barrier to entry as this process takes time and involves some uncertainty.[118] An NHS trust [✂].

188. For all these reasons, the CMA does not believe that the ability of NHSE and NHSW to facilitate new entry or expansion, and the apparent readiness of some competitors to enter or expand, is sufficient to mitigate the SLCs identified.

---

[115] Responses from third parties. [✂].

[116] Merger Notice, Appendix F, p.18.

[117] [✂] Submissions from third parties. [✂] One provider also noted that conversion costs of existing low secure facilities are minimal. Large financial investment necessary was also mentioned by two NHS trusts. [✂].

[118] Merger Notice, Appendix F, p.17.

Conclusion on horizontal unilateral effects in the supply of Secure Services

189. The CMA believes that the Merger gives rise to an SLC in relation to the service lines and local areas listed at paragraph 170 above. The CMA does not believe that these SLCs will be mitigated as a result of buyer power or by possible entry or expansion.

Children and Adolescent Mental Health Services

Background

190. CAMHS Services are made up of four tiers (in ascending order of specialisation) and provided through a network of services which includes universal services such as early years services and primary care (CAMHS Tier 1); targeted services such as youth offending teams, primary mental health workers, and school and youth counselling (including social care and education) (CAMHS Tier 2), through to specialist community CAMHS (CAMHS Tier 3) and highly specialist services such as inpatient services and very specialised outpatient services (CAMHS Tier 4).[119]

191. CAMHS Tier 4 Services are specialised inpatient and outpatient mental healthcare services provided to children and adolescents (**CAMHS Tier 4 Services**) and are commissioned by NHSE. The Parties do not supply these services to NHSW.

192. Within CAMHS Tier 4 Services, the Parties overlap in the provision of:

(a) CAMHS Tier 4 inpatient eating disorder (ED) services (**CAMHS ED**), and

(b) CAMHS Tier 4 low secure services (**CAMHS low secure**).

193. There are a number of other CAMHS Tier 4 Services where the Parties do not overlap.[120]

Frame of reference

194. The Parties overlap in CAMHS ED services and CAMHS low secure services. There is no demand side substitution between these services. The CMA considered whether any further segmentation within these services was appropriate.

---

[119] Joint Commissioning Panel for Mental Health: Guidance for commissioners of child and adolescent mental health services.

[120] Specifically, Priory provides general CAMHS Tier 4 services, some CAMHS Tier 4 outpatient services and a CAMHS Tier 4 psychiatric intensive care unit. PiC provides CAMHS Tier 4 inpatient Learning Disabilities, a CAMHS Tier 4 Children's Unit which treats patients under 13 years of age and CAMHS Tier 4 inpatient Autistic Spectrum Disorder services.

CAMHS ED

195. The CMA investigated whether any delineation by patient type or gender was appropriate within the supply of CAMHS ED services.

196. The CMA understands that most children and young people (ie patients aged 6-18 years old) with eating disorders are treated within general CAMHS Tier 4 units,[121] where the Parties do not overlap (only Priory provides these services). This includes young patients with a primary diagnosis of mental illness and a secondary diagnosis of ED.

197. However, patients who require nasogastric feeding while their therapeutic programme takes place are sent to a dedicated CAMHS ED ward.[122] [✂] told the CMA that it would not be appropriate to place a patient with ED as a primary condition, especially more severe cases, in a general CAMHS Tier 4 unit as they would not receive the specialised treatment required. A private provider [✂] also submitted that CAMHS ED wards admit acutely unwell patients and are run by staff who are trained to deal with the specifics of these patients.

198. The Parties submitted[123] that there is a distinction within CAMHS ED services between the treatment of children aged 12 years or younger and the treatment of adolescents between 13 and 18 years of age. The Parties said that NHSE typically requires that patients between 12 and 18 years old be admitted to Tier 4 CAMHS ED wards and that children under 12 be admitted to CAMHS children's units.[124]

199. The CMA notes that the environments in which CAMHS ED services are provided to these two age groups are different and, on the demand-side, there is no evidence that patients aged 12 and under are treated on wards for patients aged 13-18 (or vice versa). Further, the parties do not overlap in the provision of CAMHS ED services to children aged 12 years and under (as only PiC provides these services).

---

[121] [✂].

[122] [✂] told the CMA that general CAMHS Tier 4 wards do not typically admit patients who require tube feeding and are physically unwell. [✂].

[123] In Oral evidence at the Issues Meeting.

[124] This distinction is relevant because one of the Parties' facilities, Priory *Rhodes Wood*, has two wards, one for children under 12 and one for adolescents aged 12-18 years old.

200. In light of the above, the CMA identified a specific product frame of reference for the supply of CAMHS ED services to patients between 13 and 18 years of age.

201. The CMA understands that both male and female patients are treated alongside one another on these wards and so no further delineation by gender is appropriate in relation to these services.

CAMHS low secure services

202. The CMA investigated whether any delineation by patient condition or gender was appropriate within the supply of CAMHS low secure services.

203. [✂] said that patients will be referred according to their particular need, reflecting both specialism and gender considerations. [✂] told the CMA that hospitals providing CAMHS low secure services treat different patient conditions, including ABI, LD, MI or emerging PD, and that there was no overlap in the treatment of these conditions. The Parties confirmed this view and no third party provided a view to the contrary. [125]

204. In light of the above, the CMA believes that there are separate product frames of reference for the different CAMHS low secure specialisms.

205. Whilst PiC's CAMHS low secure facilities provide a range of specialisms, the Priory's single site offering CAMHS low secure services treats only female patients with emerging PD.

206. For this reason, the CMA identified a specific frame of reference for the supply of CAMHS low secure services to female patients with PD.

Supply side substitution

207. Some third parties [✂] submitted that it would be easier for a current provider of CAMHS Tier 4 services to start providing CAMHS ED and CAMHS low secure services than for a provider of other CAMHS services. Current providers of CAMHS ED and CAMHS low secure services told the CMA that the main obstacle would be hiring the relevant specialist staff. The CMA notes that there may also be challenges in placing patients elsewhere while a ward is re-designated.

208. One factor limiting supply side substitution is the willingness of NHSE to commission different beds. A hospital providing CAMHS Tier 4 Services

---

[125] [✂].

cannot change its service without obtaining NHSE permission. For example, NHSE would need to grant permission for a ward designated for 6-12 year olds to become a ward for 12-18 year olds, even if both wards specialised in CAMHS ED.

209. For these reasons, the CMA has not considered both CAMHS ED and CAMHS low secure services within the same product frame of reference, or aggregated specialties, on the basis of supply side substitution.[126]

NHS trusts vs. private providers

210. Third parties told the CMA that, in common with other Overlap Services, private providers of CAMHS Services compete in an overspill market once NHS trust provision is exhausted and NHS trusts do not compete with private provision in this overspill market.

211. [✂] told the CMA that it will always use NHS beds first before utilising the private sector. [✂] also provided data which shows that NHS trusts operate at very high utilisation rates for CAMHS Services (eg the [✂] NHS trust site has a 94.4% occupancy level). This is consistent with there being overspill demand.

212. Two private competitors [✂] confirmed that referrers will use local NHS provision before private providers.

213. Priory provided referral data which shows that, although the majority of its patients come from NHSE directly, some are referred from NHS trusts providing CAMHS services.[127] This suggests that some patients are initially referred to an NHS trust but then need to be referred on to a private provider. This could be due to the patient requiring specialist treatment which the NHS trust cannot provide or due to capacity constraints at the NHS trust.

214. The Parties submitted that NHS trusts compete with private providers for CAMHS ED referrals in the overspill market. They submitted evidence to show that patients and their families consider NHS trusts and private providers to be substitutes, and other evidence which they said showed that the NHS competes with private providers on an equal basis. This included

[126] Notwithstanding this, the CMA notes that doing so would not significantly alter its findings in relation to these services.

[127] For example [✂] both referred a patient to the Priory site in *Roehampton* in the last two years.

NHSE documents, documentation in relation to a death inquest,[128] emails from case managers (addressed to both NHS trusts and private providers), and discussions on web forums. The Parties also noted that they have high utilisation rates and waiting lists in the same way as NHS trusts.[129]

215. The CMA accepts that both NHS trusts and private providers supply CAMHS Services to NHSE referrers. However, the CMA believes that the evidence received from [✂] and other third parties indicates a strong preference by referrers for NHS trust provision, such that referrers will only use the private sector when NHS trust provision is not possible. The CMA believes that the Parties' evidence does not contradict this view as it principally demonstrates how referrers search for beds, and does not demonstrate that they ever choose a private provider in preference to an NHS provider when the NHS provider can treat the patient.

216. On the basis of this evidence, the CMA does not believe that NHS trusts compete with the Parties in relation to the supply of CAMHS Services and has focused its assessment on competition between private providers.

Conclusion on product frame of reference

217. For the reasons set out above, the CMA believes that the relevant product frames of reference for the CMA's assessment of the impact of the Merger on the supply of CAMHS Services are the supply of the following services by private providers to NHS-funded patients:

(a) CAMHS ED for patients aged 13-18 (**CAMHS ED 13-18**); and

(b) CAMHS low secure services provided to female patients with emerging PD (**CAMHS low secure female PD**).

Geographic frame of reference

218. The Parties' facilities for CAMHS ED 13-18 and CAMHS low secure female PD are located in the areas listed in Table 6 below.

---

[128] This evidence comes from a highly unusual context: [✂]. However, the CMA does not believe that [✂] uses the term 'overflow' in this document in the specialised manner in which the CMA does in this case. In particular, this evidence does not inform on referral preferences.

[129] See, for example, the Issues Meeting presentation, C16-C17

Table 6 - Location of Parties' facilities by overlapping service		
CAMHS ED 13-18		
	PiC	**Priory**
1	*Rhodes Wood*, Greater London	*Roehampton*, Greater London
2		*Chelmsford*, Essex
3		*Altrincham*, Greater Manchester
CAMHS low secure female PD		
	PiC	**Priory**
1	*Kent House*, Greater London	*Cheadle Royal*, Manchester
2	*Ellingham Hospital*, Norfolk	

219. The Parties submitted that the relevant frame of reference is national because providers negotiate national contracts with NHSE and do not compete at a local level for patient admissions on the basis of price or quality.

220. The CMA recognises that price and quality are, to some degree, negotiated centrally by NHSE. However, the Parties told the CMA that, even if NHSE sets minimum quality standards, providers will typically have incentives to compete locally by offering higher than the minimum quality service, in order to maintain positive clinical relationships and to continue to attract referrals.[130]

221. The CMA also notes that the supply of CAHMS ED 13-18 and CAMHS low secure female PD services have features of local markets. In particular, referrers told the CMA that they consider it important to minimise the distance which a patient must travel to receive treatment.

(a) [✂] told the CMA that the originating home address was the most important factor determining to which hospital to send a patient for these services.[131]

(b) Most private providers of CAMHS Services told the CMA that they would consider distance as at least of medium importance, despite these services being highly specialised and there being few providers.

(c) Catchment area analysis indicates that patients tend not to travel large distances for these services, despite capacity constraints, which supports the view that competition for these services has local features. The CMA found that Priory's 80% catchment areas[132] were [50-75] miles for CAMHS ED services and [75-100] miles for CAMHS low secure services

[130] Oral evidence at Issues Meeting.

[131] [✂].

[132] The 80% catchment area was used in *Spire/St Anthony*.

when averaged across all Priory's sites.[133] A private competitor [✂] had an 80% catchment area similar to Priory's average catchment area of [75-100] miles for CAMHS ED services.

222. On the basis of this evidence, the CMA has focussed its assessment at a local level for the overlapping CAMHS Tier 4 Services.[134]

Catchment areas for local analysis

223. The Parties submitted that PiC's 80% catchment area of [175-200] miles for all CAHMS Services was the appropriate catchment area.[135] However, the Parties also said that a hospital in north London did not compete strongly with one in south London due to close relationships between particular referrers and particular sites (ie referrers located in north London would tend to make referrals to the Parties' hospital in north London, and not refer to the Parties' hospital in south London; and vice versa).[136]

224. As a starting point for its competitive assessment, the CMA used, where possible, a hospital-specific 80% catchment area. Where there were insufficient observations to calculate a hospital-specific catchment area, the CMA used the service line specific 80% catchment area average across the Parties' sites.

225. On this basis, the Parties only overlap in the provision of CAMHS ED 13-18 services in the wider London area (ie there is an overlap between the Priory facilities at *Roehampton* and *Chelmsford* and the PiC facility at *Rhodes Wood* in Hertfordshire).

226. The Parties do not overlap at a local level in the provision of CAMHS low secure female PD services. Priory *Cheadle Royal* is approximately 220 miles away from the PiC facilities at *Kent House* and *Ellingham Hospital*, while the 80% hospital-specific catchment area for the three hospitals are all under [175-200] miles. For this reason, the CMA has not considered local effects in the supply of CAMHS low secure female PD services further.

---

[133] It was not possible to obtain PiC's specific catchment area for these services.

[134] The CMA also found that the Parties' hospital specific 80% catchment areas for CAMHS ED services were similar to the average across all sites. For example, Priory *Chelmsford* had a catchment area of [50-75] miles whilst *Roehampton* had a catchment area of [25-50] miles. Both of these are not dissimilar to the average of [50-75] miles.

[135] PiC patient data did not allow sub-specialities to be identified. Priory's patient did allow catchment areas to be calculated on a sub-speciality basis when there were sufficient numbers of observations. See Merger Notice Annex – Catchment Area Methodology paragraph 2.5

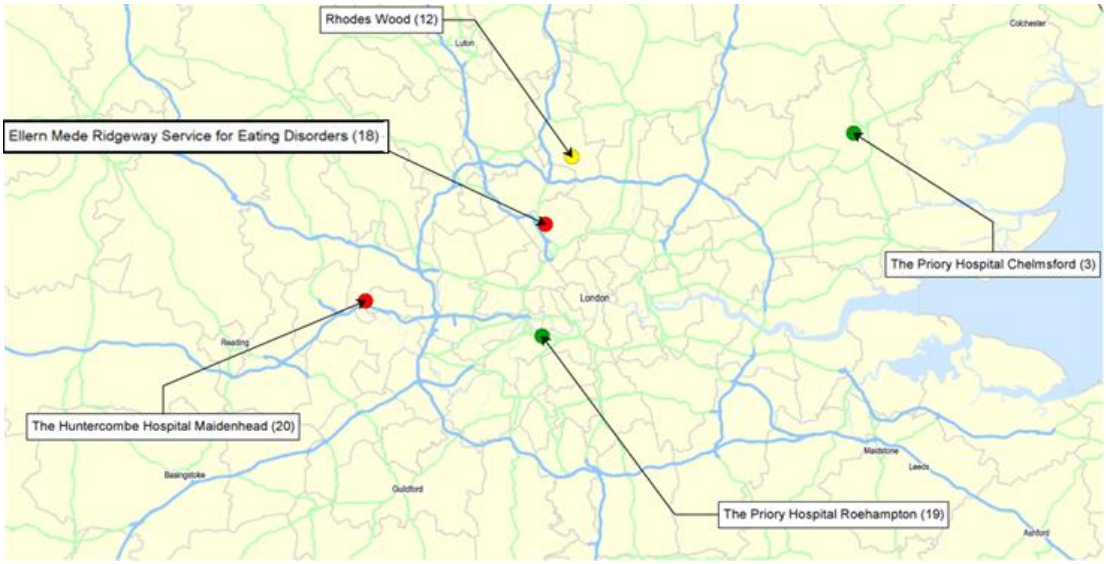
[136] Parties' response to the RFI of 28 June.

Competitive assessment of horizontal unilateral effects

227. The Parties only overlap at a local level in the supply of CAMHS ED 13-18 services in the wider London area. The CMA has therefore assessed potential unilateral horizontal effects arising through the loss of actual competition in the provision of this service in this area.

228. The relevant facilities are identified in the map below (Figure 1).

Figure 1 - Map of the Parties' and competitors' sites for the supply of CAMHS ED 13-18 services in the wider London area



229. The CMA first assessed shares of supply within the Parties' catchment areas, then the closeness of competition between the Parties and finally the extent of constraint from other providers.

Shares of supply

230. The CMA focussed its local analysis on the hospital-specific 80% catchment areas centred on the Priory hospitals at *Roehampton* and *Chelmsford*. These catchment areas are [25-50] miles and [50-75] miles respectively. Although the hospital at Chelmsford falls outside the catchment area of the hospital at Roehampton, the hospital at Roehampton is within the catchment area of the hospital at Chelmsford. The CMA then assessed the constraint from competitors by considering their bed share as a proxy for their share of supply and by taking into consideration the distances between the Parties and their competitors.

231. The bed share and distances between the Parties and their competitors in the wider London area are shown in Table 7 below.

Table 7 - Parties and Competitors' bed shares for CAMHS ED 13-18 services in the wider London area					
Operator Name	**Hospital Name**	**Town**	**Number of Beds**	**Share of Beds (%)**	**Distance from Priory R'hampton (miles)**
PiC	*Rhodes Wood*	Hatfield	12	[10-20]	29
Priory	*Roehampton*	London	19	[20-30]	
Priory	*Chelmsford*	Chelmsford	3	[0-5]	54
Combined			34	**[40-50]**	
Oak Tree Forest	*Ellern Mede Ridgeway*	London	[✂]	[20-30]	16
Huntercombe Group	*Maidenhead*	Maidenhead	[✂]	[20-30]	22

Source: RBB analysis of the Parties' data, CMA analysis

232. Table 7 shows that the combined share of supply of the Parties in the wider London area is high at [40-50]%, with an increment of [20]% arising. The CMA notes that *Rhodes Wood* has 15 additional CAMHS ED 13-18 beds, [✂]. If this spare capacity is included, the Parties' combined bed share increases to [50-60]%.[137]

233. The CMA notes that Priory *Chelmsford* which is located outside London has just three beds for CAMHS ED 13-18 services and its inclusion or exclusion has a limited effect on the Parties' combined share of supply.

234. Figure 1 (above) shows that, in the wider London area, the Merger can be characterised as a '4 to 3' in the supply of CAMHS ED 13-18 services, where the largest supplier is merging with another large player, giving the combined entity a share of supply significantly greater than its competitors. The CMA believes that, by removing a competitor, the merged entity may be more able to influence the price and quality of the service it offers to its customers within the wider London area.

Closeness of competition

235. Competitors told the CMA that the Parties compete with one another. One competitor [✂] said that there is always competition between providers within a specific service, referring specifically to CAMHS ED. [✂] told the CMA that the Parties do not compete when they provide different treatments or are in different locations. The CMA infers that the Parties do compete otherwise.

[137] Notwithstanding that the frame of reference focusses on the supply of CAMHS ED to patients aged between 13 and 18 years of age, if wards for children aged 6-12 are included, the Parties' combined bed share in the [50-75] mile area around Priory *Chelmsford* is [60-70]% and in the [25-50] mile area around Priory *Roehampton* is [40-50]%.

236. The CMA also noted examples in the Parties' internal document of them monitoring each other's facilities. [✂].[138]

237. The Parties submitted that they are not each other's closest competitor geographically. However, Table 7 above shows that PiC *Rhodes Wood* is only 29 miles from Priory *Roehampton*, which is well within the identified catchment area.

238. One private competitor [✂] told the CMA that, with regard to CAMHS Services, there was *'high competition* [between the Parties] *on a local geographical basis'.*

Alternative suppliers

239. The CMA considered whether there were alternative private providers of CAMHS ED 13-18 services in the wider London area which would provide a competitive constraint on the merged entity. The two alternative providers identified are shown in Figure 1. These are the Huntercombe Group hospital in Maidenhead and Oak Tree Forest hospital Ellern Mede Ridgeway.

240. The CMA understands that the Huntercombe hospital does not offer the same breadth of services as the Parties nor can it take the same level of acuity of patients.[139]

241. The Parties submitted that the CMA should include other third party providers, including Cygnet Ealing.[140] However, Cygnet Ealing treats patients aged 16-18 alongside adult patients. The CMA therefore considers that this site is likely to exert only a limited competitive constraint on the Parties' facilities which focus on providing care to 13-18 year olds.

242. In light of the above, the CMA believes that the merged entity would face limited competition from other private providers.

Conclusion on competitive assessment

243. The CMA notes that the Parties' combined share of supply for CAMHS ED 13-18 services in the wider London area is high and there will be limited alternative suppliers post-Merger. The CMA therefore believes that the Merger gives rise to a realistic prospect of an SLC in the supply of CAMHS

---

[138] Annex Q 10 – 110, [✂].

[139] [✂].

[140] Oral evidence at Issues Meeting. See further response to Issues Paper at C15 and C16.

ED 13-18 services in this local area (ie in the overlap between the Priory sites of *Roehampton* and *Chelmsford* and the PiC facility of *Rhodes Wood*).

Barriers to entry and expansion

244. The Parties submitted examples of entry and expansion in CAMHS Services by themselves and other providers.

245. Evidence from third parties on entry and expansion in CAMHS Services was mixed. A third party [✂] told the CMA that expansion would be easy if a provider currently provides CAMHS Tier 4 services, but unlikely if it only provides the other tiers of CAMHS services, though two other third parties [✂] told the CMA that there are barriers to entry because it is difficult to acquire the correct staff for the specialism that is to be provided, even if a provider currently provides CAMHS Tier 4 services. They said that most CAMHS staff are trained for a more general level of CAMHS Services so recruiting for CAMHS ED 13-18 services would be difficult. One of these third parties [✂] told the CMA that it had experienced difficulties recruiting qualified nurses even with an expansion of just 4 beds.

246. The CMA notes that CAMHS ED provision requires NHSE to commission a bed specifically for this service. Therefore, an entrant faces some risk that NHSE will not commission its services following entry. The CMA also notes that providers of CAHMS ED services require specialist staff familiar with nasal feeding.

247. For these reasons, the CMA does not believe that entry or expansion would be timely, likely and sufficient to mitigate the SLC identified in relation to the supply of CAMHS ED 13-18 services in this local area.

Buyer Power

248. The Parties submitted that the NHSE has buyer power, and so is able to countervail any potential SLC resulting from the merger. They submitted that NHSE is the only customer for the Parties' CAMHS ED services, NHSE controls bed numbers and could commission additional beds and NHSE controls the price and the level of quality required by CAMHS services.

249. The CMA does not consider that NHSE has any more ability to constrain the Parties in CAMHS than in Secure Services. The CMA considers that the reasoning set out at paragraphs 172 to 181 above also applies to CAMHS ED 13-18.

Conclusion on horizontal unilateral effects in the supply of CAMHS ED 13-18 services

250. The CMA therefore believes that the Merger gives rise to a realistic prospect of an SLC in the supply of CAMHS ED 13-18 services in this local area (ie in the overlap between the Priory sites of *Roehampton* and *Chelmsford* and the PiC facility of *Rhodes Wood*).

Acute Services and PICU Services

Background

251. The Parties overlap in the supply of Acute Services and PICU Services.[141]

252. Acute Services are provided to patients in mental health crisis who require a short term admission of around 3-6 weeks.[142] PICU Services are designed for patients that cannot be managed on Acute wards due to the level of risk the patients pose to themselves or to others. Patients admitted to an Acute ward may be admitted voluntarily or detained under the MHA while all Patients admitted to a PICU will be detained.[143]

253. Acute and PICU Services are commissioned directly by CCGs or by NHS trusts to accommodate patients who cannot be admitted by their local NHS trust. Typically, an NHS trust acts as the referrer, with the CCG responsible for the budget.[144]

254. As with other mental healthcare services, there is no standard national tariff and providers can negotiate different prices for their services with different customers. The Parties provide these services through various forms of contracting agreements, including block contracts, framework agreements and spot purchasing.[145]

255. The patient is assessed by a team at the local NHS trust and is either admitted at that trust or at another provider.

    (a) Patients are typically admitted to an Acute ward from a community setting, a hospital A&E or as a result of police action.

    (b) Patients are typically referred to a PICU from other mental health environments (eg rehabilitation, secure or acute) and in some circumstances following assessment by a psychiatrist via the criminal justice services (ie a court or the police).[146]

---

[141] The Parties do not admit (and so do not overlap in the supply of services to) patients who have a primary diagnosis of LD. Merger Notice, Appendix A, p.9

[142] For example, [✂].

[143] Merger Notice, Appendix A, p.4.

[144] Third party responses; [✂].

[145] Merger Notice, Appendix A.

[146] Comments by [✂] to the CMA commissioning note.

256. Third parties told the CMA that patients are usually only referred to private Acute and PICU Services when local NHS trust Acute or PICU facilities are unable to admit a patient, either because they do not have capacity or because they are otherwise unable to treat that patient. When considering which private provider to use, the referrer will take into account the patient's specific needs and will place the patient in the best available facility based on bed availability, provider location and provider service quality.

Frame of reference

Product frame of reference

257. As a starting point, the CMA considered there to be a separate product frame of reference for each of adult Acute Services and adult PICU Services to NHS-funded patients.[147] The CMA did not consider it appropriate to aggregate these services, in particular given that:

(a) PICU Services are considerably more expensive than Acute Services;[148]

(b) PICU Services require more staff and provide a more secure physical environment (ie PICU wards are locked and the entry and exit of patients is controlled);[149]

(c) referrers place great importance on ensuring that a patient receives the services appropriate to their needs and there is a clear difference between the patients who require Acute Services and PICU Services; and

(d) there are clear commissioning recommendations to place patients in the least restrictive environment.[150]

258. The CMA then considered whether further segmentation was appropriate, in particular by gender and by patient condition. The CMA also considered more specifically for these services the extent of the constraint from NHS trusts on private providers.

---

[147] References to Acute Services and PICU Services are references to inpatient services only unless otherwise stated.

[148] Data submitted by NHS trusts confirmed this to be the case. Submissions of NHS trusts. [✂].

[149] This is consistent with the Parties' submissions. Merger Notice, Appendix A

[150] As an example, http://politics.leics.gov.uk/documents/s77734/Appendix%201%20-%20Adult%20Mental%20Health%20Acute%20Care%20Pathway%20Model.pdf. However, the CMA notes that for some patients there may not be a clear demarcation about which service is appropriate for them (eg short stay Acute Services or longer term rehabilitation services).

Delineation by gender

259. The Parties submitted that they do not distinguish between male and female wards in the provision of Acute Services and PICU Services. The speed at which a ward can be re-designated (by gender or service line)[151] demonstrates strong supply-side substitution and all contractual arrangements that relate to Acute Services and PICU Services are for the general provision of these services (ie they are not differentiated by gender or treatment).[152]

260. The Parties also submitted that Acute Services and PICU Services can be provided in mixed wards,[153] with single sex accommodation to comply with the DSSA[154] requirement (ie mixed shared areas, but segregated sleeping quarters).[155]

261. The CMA considered whether it was appropriate to segment the frame of reference by gender for Acute Services and PICU Services. The CMA noted that:

(a) Many third parties [✂] submitted that there is female and male segmentation in Acute Services;[156] and all NHS trusts[157] and the two private competitors[158] that responded to the CMA's questions submitted that they consider male/female provision to be different segments for PICU Services.

(b) It appears that there is a category of patients which cannot be placed in mixed wards. An NHS trust [✂], which operates a mixed-sex PICU ward, indicated that it refers patients to other providers mainly due to some patients requiring single-sex PICU Services. Another NHS trust [✂]

---

[151] The Parties said that low secure wards could be most easily converted into PICU given similar security standards (Merger Notice, Appendix A, p.10).

[152] Merger Notice, Appendix A, p.9

[153] Merger Notice, Appendix A, p.9

[154] DSSA (Delivering Same Sex Accommodation) is a long standing commitment in the NHS as part of the drive to deliver the best possible experience for all patients. Providers face possible financial repercussions if they fail to deliver care that is up to standard.

[155]http://www.institute.nhs.uk/delivering_same_sex_accommodation/what_is_same_sex_accommodation/policy_and_guidance.html The Parties submitted that Priory operates some mixed gender wards. One third party [✂] submitted that they operate a mixed gender PICU ward.

[156] Responses from CCGs, an NHS trust and a private provider. [✂]. Responses from other third parties were inconclusive as to whether or not there was a gender split.

[157] Responses from NHS trusts. [✂].

[158] Responses from private providers [✂].

submitted that it requires wards to be separated by gender to maintain the dignity of the patients.

262. Table 8 sets out the CMA's findings in relation to the data submitted by the Parties on bed numbers by gender.[159]

Table 8 - Gender specification in wards for Acute and PICU services		
	Acute	**PICU**
Parties	PiC only operates single-sex wards, whilst most of Priory's wards are mixed.	Both PiC and Priory only operate single sex wards.
NHS trusts	Most operate both single-sex and mixed wards.	Most operate single-sex wards only.
Private providers	The only other private provider, Cygnet, has 2 mixed wards and 3 male only wards.	Among private providers, only one third party private provider, Huntercombe, has mixed wards.

263. Table 8 shows that, in relation to PICU Services, mixed wards are very rare. This is strongly indicative of a clear delineation of demand by gender for these services. Table 8 also shows that, in relation to Acute Services, the evidence is more mixed.

264. The CMA also considered the extent to which there could be supply-side substitution between male and female wards (and vice versa).

265. The Parties submitted that re-designating a single sex ward from one gender to another involved:

(a) fully discharging or transferring all existing patients to another ward; and

(b) shutting down the ward for necessary works to be undertaken.

266. The Parties submitted that the process is straightforward because the average length of patient stay is short[160] and the ward can be re-designated in about 18 days or less. The Parties submitted that they have on several occasions re-designated wards for use by males or females in order to meet gender-specific demand.[161]

---

[159] *Annex – All Regions Shares 180516*. The Parties submitted that as mixed beds can be used for both genders, the Parties have assigned the mixed beds to both genders.

[160] (Merger Notice, Appendix A, p.9). The Parties submitted that their patients' average length of stay is shorter [✂] than the average length of stay in an NHS ward. This is because sometimes patients are repatriated back to their local originating trust when a bed becomes available (Merger Notice, Appendix A, p7.)

[161] Merger Notice, Appendix A, p.9.

267. However, information submitted by the Parties also shows that, although a ward at the *Kneesworth* facility was re-designated from one gender to another on 4 occasions (out of 6 re-designations in total in this facility since April 2013), none of these re-designations involved Acute or PICU Services. It also shows that, although a ward at the *Dene* facility was re-designated from one gender to another on 3 occasions (out of 11 re-designations in total in this facility since April 2013),[162] this was either due to a re-designation from a female Acute High Dependency Unit (**HDU**)[163] to male low secure or due to a ward swap between male Acute and female low Secure Services. Therefore, these examples do not illustrate re-designation between male and female wards for Acute and PICU Services.

268. The Parties submitted that there were no service specifications by treatment or patient type specified by commissioners, referring to their contract with [✂]. However, the fact that NHS trusts or CCGs request wards to be re-designated along gender lines suggests that commissioners do have preferences for wards of a particular gender.

269. In light of the above, on a cautious basis, the CMA considered it appropriate to assess the impact of the Merger on the supply of Acute Services and PICU Services both for male and female patients separately and on a combined basis.[164]

Delineation by patient condition

270. The CMA investigated whether there could be a further delineation within Acute and PICU Services by treatment of a patient's particular condition. Some competing providers [✂] submitted that a PICU generally deals with all types of MI/LD conditions,[165] whilst other providers[166] said there could be some specialisation in both Acute and PICU Services, eg for ABI, ASD or PD.

271. However, the CMA noted that, although patients requiring Acute or PICU Services may have secondary conditions such as mild LD or ABI, the

---

[162] This includes 3 ward swaps.

[163] Acute units that are generally able to deal with more difficult patients, but not as difficult as those requiring PICU admission.

[164] The CMA notes that its competitive assessment would in any event be the same if male and female services were aggregated, given that PiC only provides female services at one site and only provides male services at its other site.

[165] Most providers did not explicitly state whether there are particular segments based on patient condition or not. However, a number of them described PICU as higher intensity Acute, suggesting that providers see Acute and PICU Services as similar services.

[166] [✂].

prevalent presenting problem must be associated with MI.[167] The Parties also told the CMA that they do not employ clinicians for specific sub-segments of either Acute or PICU patients.[168] Further, the Parties and third parties told the CMA that Acute and PICU wards are designed to address symptomatic relief and stabilisation regardless of the patient's underlying conditions.[169]

272. On the basis of this evidence, the CMA did not further segment Acute Services and PICU Services by patient condition.

Services supplied by private providers vs NHS trusts

273. The Parties submitted that private providers and NHS trusts compete for patients requiring Acute Services and PICU Services and NHS provision should not be entirely excluded from the competitor set.[170] The Parties submitted that:

(a) CCGs and NHS trusts purchase Acute Services from the Parties, other private providers and NHS providers;[171]

(b) private providers are 'first ports of call' for referrers of PICU patients and do not merely serve overspill patients when there is not available NHS capacity. In support of this, the Parties noted that 2 of the 5 NHS providers responding to the CMA indicated that they do compete with private providers;

(c) [✂], despite there being no other private providers of PICU services in the local area at the time; and

(d) commissioners may seek to purchase additional PICU services from private or NHS providers and have been encouraged to consider both sources.[172]

---

[167] One NHS trust [✂] told the CMA that Acute and PICU units might not always be an appropriate environment to treat certain categories of patients presenting with more severe secondary conditions (eg LD, ASD or other specific conditions). These patients would be referred to the Assessment and Treatment Units, which deal with patients presenting with more severe secondary conditions of LD or ASD. The Parties confirmed that none of their Acute and PICU facilities are capable of treating patients presenting with severe secondary conditions. Response to RFI request 13 May 2016. [✂].

[168] Merger Notice, Appendix A

[169] Submitted by the Parties (Merger Notice, Appendix A)

[170] Response to Issues letter and RFI dated 28 June 2016, p.1

[171] Merger Notice, Appendix A, p.15.

[172] The Parties provided the following quote by National Association of Psychiatric Intensive Care and the Mental Health Commissioners Network: "*Commissioners may wish to take action to stimulate the local market if shortages of PICU providers are identified at any point in the pathway and should note*

274. However, third parties, including referrers (ie CCGs and NHS trusts) and providers (ie NHS trusts and private competitors to the Parties),[173] told the CMA consistently that a referrer will first seek to admit a patient requiring Acute and PICU Services to the local NHS trust and, only if that trust is unable to serve the patient (eg because it is at full capacity or cannot provide the required service), will the referrer seek to place the patient elsewhere. Only at this point will private provision be considered.

275. On the basis of evidence from third parties, the CMA believes that, for both Acute and PICU Services, private providers compete only for 'overspill' patients and do not compete with NHS trusts for initial referrals.

276. Moreover, several referrers and competitors to the Parties indicated that demand for private services only arises at the point when NHS provision is not possible anywhere near the patient, whether at the initial NHS trust or at a nearby NHS trust. Most NHS trusts said that they prefer to refer to other NHS trusts and will only approach private providers when local NHS provision is impossible.[174] However, they said that it is often not possible to find another NHS trust able to take the patient given capacity constraints.

277. For example:

(a) One NHS trust [✂] told the CMA that other NHS trusts in its area were not an option because they often operate at full capacity.

(b) A second NHS trust [✂] submitted that NHS trusts which can accommodate patients with more specific needs (eg PD) usually have very long waiting lists.

(c) A third NHS trust [✂] told the CMA that the neighbouring NHS trust is usually at capacity at the times when the trust itself is also at capacity.

(d) A fourth NHS trust [✂] said that, generally, only private providers have the capacity to admit patients.

278. This evidence suggests that NHS trusts impose a weak competitive constraint (if any) on private providers for the supply of Acute and PICU Services to meet overspill demand.

---

that any qualified provider may include NHS and independent mental health care providers". (Merger Notice, annex A, p.15)

[173] Responses from NHS trusts and private competitors.

[174] Responses from NHS trusts.

279. The Parties submitted recent figures indicating that daily Acute bed occupancy rates at NHS trusts for 2014 and 2015 were as high as 98.6%.[175] This is consistent with data which the CMA obtained from some NHS trusts,[176] which indicated that they operate at more than 90-95% of capacity for both Acute and PICU Services. In contrast, PiC's utilisation rates for Acute and PICU Services for NHS patients ranged from [✂] whilst Priory's ranged [✂].[177] Two other private providers told the CMA that they operate at [✂]. These capacity figures suggest that the Parties and private providers may have lower levels of capacity utilisation for Acute and PICU Services than many NHS trusts, which supports the view that private providers are more likely to be able to take patients when there is overspill demand than other NHS trusts.

280. The CMA recognises that the incentive for NHS trusts to compete in the overspill market may vary across NHS trusts. Third parties submitted that NHS trusts will often not compete (eg if they wish to retain some spare capacity to meet their own demand) and so may offer only a very limited (if any) constraint.

281. For these reasons, the CMA believes that private providers compete principally with each other in an overspill market for Acute and PICU Services. Therefore, on a cautious basis, the CMA has assessed the impact of the Merger on Acute and PICU Services considering only constraints on the Parties from private providers. Nevertheless, the CMA has also considered the impact of the Merger if it is assumed that there is some constraint from NHS providers as a sensitivity check in its competitive assessment.[178]

Conclusion on product frame of reference

282. In light of the above, the CMA identified four frames of reference, in each case relating to the supply by private providers to NHS-funded patients:

(a) Acute male services;

(b) Acute female services;

---

[175] Merger Notice, Appendix A, page 7.

[176] Third party responses.

[177] [✂].

[178] As a sensitivity check, the CMA re-ran the shares of supply figures to include 5% of local NHS provision to see whether this significantly changed the Parties' shares of supply in the relevant catchment areas. It did not.

(c) Acute services (male and female combined);

(d) PICU male services;

(e) PICU female services; and

(f) PICU services (male and female combined).

Geographic frame of reference

283. There is no overlap between the Parties for either Acute or PICU Services in Wales and therefore the CMA's assessment has focussed on the Parties' activities in England.

284. Commissioning of Acute and PICU Services in England is undertaken locally by individual CCGs and NHS trusts and the CMA is not aware of any national parameters of competition.

285. In relation to Acute Services, Priory has 15 facilities in England, while PiC has two facilities:

(a) PiC *Kneesworth*, which treats female patients in the Hertfordshire area; and

(b) PiC *The Dene*, which treats male patients in the West Sussex area.

286. In relation to PICU Services, PiC has one facility at *The Spinney* in Manchester caring for male patients only, [✂]. Priory has [✂]:

(a) Priory *Cheadle*, which treats both male and female patients in Manchester;

(b) Priory *Thornford*, which treats male patients in Berkshire; and

(c) [✂].

Catchment areas

287. In line with the approach set out at paragraphs 50 to 60 above, as a starting point, the CMA sought to assess the impact of the Merger at a local level in the following catchment areas:

(a) for Acute Services, centred on each of PiC *Kneesworth* and PiC *The Dene*; and

(b) for PICU Services, centred on Priory *Cheadle*, [✂].[179]

Parties' views

288. The Parties submitted that the appropriate geographic frames of reference are catchment areas around each of the Parties' facilities. The Parties used the distance for 80% of their patients from their home as a starting point (based on the identified postcodes of patients) and submitted the following:[180]

(a) for Acute Services, an 80% catchment by driving distance of [75-100] miles, which generates overlaps between PiC and Priory facilities within the PiC *Dene* catchment area (in the West Sussex area) and within the PiC *Kneesworth* catchment area (the Hertfordshire area); and

(b) for PICU Services, an 80% catchment by driving distance of [200-225] miles,[181] which generates overlaps between PiC and Priory facilities within the Priory *Cheadle* catchment area (in the Manchester and Cheshire area).[182]

289. For Acute Services, the Parties' 80% catchment areas were similar to one another.[183]

290. For PICU Services, the CMA assessed whether it was appropriate to use the 80% catchment area of [200-225] miles proposed by the Parties (based on the PiC site) given that the Priory catchment area was considerably smaller at [125-150] miles.

291. The Parties submitted[184] that the wider catchment area was appropriate, given that both Parties serve key customers located over [200-225] miles

---

[179] It was not necessary to conduct a separate assessment of the Priory *Thornford* catchment area since there is no overlap with PiC *The Spinney* [✂] with this site when using the CMA's preferred catchment area of [125-150] miles when centred on Priory Thornford.

[180] The Parties used postcode sector locations for patients located at each of the Parties' facilities to calculate the drive time from their originating location to the facility. The Parties have applied catchment areas to each of their Acute and PICU facilities that represents the larger of the two Parties' catchment areas (ie [75-100] miles for Acute Services; [200-225] miles for PICU Services) when considering the distance for 80% of a Party's patients from where they receive Acute or PICU Services. The Parties submitted that this approach errs on the side of caution in identifying overlaps (as it typically results in more of the Parties' facilities being included in the analysis).

[181] The CMA notes that PiC's 80% catchment area is [200-225] miles, while Priory's 80% catchment area is [125-150] miles.

[182] A catchment area of [200-225] miles covers almost all of England, including another Priory site in the south of England, as well as the [✂].

[183] Priory's catchment area is [75-100] miles; PiC's catchment areas are [75-100 miles].

[184] Issues meeting follow-up, p.1.

away. For example, [✂].[185] The Parties said that this reflected actual market behaviour.[186]

292. The Parties also provided some PiC email correspondence with NHS trusts in the south of England regarding PICU bed availability, and said that Priory had distributed flyers about its PICU Services to a range of NHS trusts including those in the south of England (ie over [200-225] miles away).[187] The Parties further submitted that other competitors market their services nationally, showing examples of marketing materials from both Cygnet and St Andrew's aimed at a national audience.[188] Finally, the Parties submitted that the number of required beds varies significantly over time and therefore PICU providers have incentives to maintain the attractiveness of their services to a wide range of referrers.[189]

Third parties' views

293. Most referrers said that they try to keep patients in the same local or regional area.

(a) For Acute Services, most NHS trusts that responded to the CMA's questions [✂] said that the distance a patient travels is important and they aim to place patients as close to their home as possible. A competitor [✂] also submitted that distance is an important factor to referrers.

(b) For PICU Services, the majority of third party responses [✂] (either NHS trusts or CCGs) indicated that proximity to home is important. However, third parties also noted that they may send patients much further if necessary. Private providers also told the CMA that distance is very important to referrers. In addition, private providers identified catchment areas similar to Priory's smaller catchment area rather than the larger catchment area of PiC. [✂].

---

[185] Issues meeting, slide E-5 and E-6.

[186] The Parties said that flexing Priory's catchment area to 88% would extend the radius of the catchment area to [✂]. Issues meeting follow-up, p.1.

[187] Issues meeting, Annex slides E6-E22.

[188] Supplementary submission on the provision of PICU Services, 14 June, p.4. Annex PICU-8 and Annex PICU-9 (submitted on 14 June).

[189] Issues meeting, slide E-7.

CMA's assessment

294. For Acute Services, the CMA adopted a catchment area of [75-100] miles, which was derived by combining all Acute Services (male and female) across all Priory sites. This catchment area was very similar to the catchment area for PiC and consistent with third party views.

295. For PICU Services, the CMA noted that most of the patients admitted to Priory *Cheadle* originated from [✂]. Priory admission data indicates that, out of *Cheadle's* top 15 referrers, [✂], while the rest of its common referrers were located in or around [✂].[190]

296. The CMA also notes that information provided by the Parties indicates that most of PiC's PICU customers are also located in and around [✂].[191] In addition, the CMA found that, in the last 3 years, the Priory's [✂] customer in the south of England [✂] did not refer any patients to PiC, while PiC's [✂] customer in [✂] did not refer any patients to Priory. In comparison, [✂] is the biggest customer for both Parties. This indicates that the Parties are not particularly active in the south of England and, so, their supply of PICU services to customers in northern England is unlikely to be constrained by other private providers located in the south.[192]

297. The CMA further notes that the catchment areas of [✂] of PICU services have similar catchment areas to that of Priory.

298. For these reasons, for PICU Services, the CMA used Priory's catchment area of [125-150] miles when centring on Priory's *Cheadle* site.

Conclusion on geographic frame of reference

299. On the basis of this evidence, the CMA has assessed the impact of the Merger on competition for:

---

[190] Annex Question 9(b) – Priory admissions. The CMA considered the total number of referrals in the last three years.

[191] Map provided by the Parties at Issues meeting, slide E-4. Further, the CMA does not consider that PiC's relationship [✂] implies that hospitals considerably closer to the sites of the parties will also be willing to send patients as far as [✂] sends patients, or that the options which may be available to [✂] post-Merger would ensure effective competition for hospitals closer to the Parties' sites in Manchester or Cheshire.

[192] Further, the Parties can charge different prices and agree different service level agreements for customers located in the south of England and the north of England. Therefore, prices and quality negotiated by customers located in the south of England do not protect customers located in the north of England (and vice versa).

(a) the provision of Acute Services (male only, female only and combined) on the basis of [75-100] mile catchment areas centred on PiC's two hospitals; and

(b) the provision of PICU Services (male only, female only and combined) on the basis a [125-150] mile catchment area centred on Priory *Cheadle*.[193]

Assessment of horizontal unilateral effects

300. In relation to Acute Services and PICU Services, the CMA focussed its assessment on concerns in local catchment areas given that contracts are between individual CCGs or NHS trusts and providers of these services to overspill patients and, in particular, given that referrers consider distance from a patient's home to the nearest provider to be an important factor.

301. In order to assess the likelihood of the Merger resulting in horizontal unilateral effects in relation to Acute Services and PICU Services, the CMA considered:

(a) the Parties' shares of supply within local catchment areas;

(b) the closeness of competition between the Parties;

(c) evidence of any competitive constraints from alternative suppliers;

(d) buyer power; and

(e) barriers to entry and expansion.

Shares of supply

Acute Services

302. Table 9 shows the Parties' shares of supply for the provision of Acute Services in each relevant catchment area.[194] The CMA calculated the shares for Acute Services considering both genders, as well as considering male and

[193] As discussed further below the CMA also applied hospital and service-line specific catchment areas.

[194] The CMA used hospital-specific PiC 80% catchment area distances, based on PiC inpatient data and their location. The CMA also checked the sensitivity of the shares by flexing the distance from the centred site, but it provided the same results. See Annex – Question 4 – PiC Catchments (18.05.16).

female separately, where relevant. The analysis centres on each of the two PiC sites.[195]

303. The PiC *The Dene* site only provides male Acute Services. The PiC *Kneesworth* site only provides female Acute Services. Cygnet provides Acute Services at a mixed gender ward and is the only competing provider in the area.[196]

Table 9 - Acute Services bed shares excluding NHS beds[197i]				
	PiC *The Dene* catchment area		**PiC *Kneesworth* catchment area**	
	Male [75-100] miles	Both [75-100] miles	Female [75-100] miles	Both [75-100] miles
PiC %	[10-20]	[5-10]	[10-20]	[10-20]
Priory %	[70-80]	[60-70]	[80-90]	[80-90]
Combined %	**[90-100]**	**[70-80]**	**[90-100]**	**[90-100]**

304. Recognising that there could be some limited constraint from NHS trusts for overspill demand (see paragraph 278), as a sensitivity analysis the CMA considered the bed shares when including 5% of NHS beds in the catchment area.[198] Table 10 shows the results.

Table 10 - Acute Services bed shares, including 5% of NHS beds[199]				
	***Dene* catchment area**		***Kneesworth* catchment area**	
	Male [75-100] miles	Both [75-100] miles	Female [75-100] miles	Both [75-100] miles
PiC %	[5-10]	[5-10]	[5-10]	[0-5]
Priory %	[40-50]	[40-50]	[40-50]	[30-40]
Combined %	**[50-60]**	**[50-60]**	**[40-50]**	**[40-50]**

[195] The CMA refers to each of the two PiC sites whilst noting that concerns also arise when the catchment area is centred around the relevant Priory site(s) that overlap(s) with each PiC site.

[196] https://www.cygnethealth.co.uk/locations/cygnet-hospital-harrow/byron-ward/

[197] Calculated using Annex – All Services Pivot Table (18.05.16). This table does not include the new Priory sites that are yet to open as these sites are outside the catchment area. When beds can be used for both genders, then those beds are attached to one gender and then to another. For example, facility with 10 beds in total (mixed), would be considered as 10 male (when looking at male) and 10 female (when looking at female).

[198] This reflected the Parties' submissions that, on the basis of average NHS capacity utilisation of 90-95% for these Services, there could be occasions when an NHS trust was available to admit a patient from another NHS trust.

[199] Calculated using Annex – All Services Pivot Table (18.05.16).

305. The table indicates that, even if there was some constraint from NHS suppliers, which the CMA does not believe to be the case, the Parties' combined share of supply of Acute Services in the relevant catchment areas remains large.

PICU Services

306. Table 11 shows the Parties' shares of supply for the provision of PICU Services in each relevant catchment area. The CMA calculated the shares for PICU Services considering both genders, as well as considering male and female separately. The analysis centres on Priory's *Cheadle* site, but includes the bed shares from [✂].[200]

Table 11 - Parties' share of supply Priory *Cheadle* catchment area ([125-150] miles)[201]

	Private providers only			**Including 5% NHS**		
	Male	Female	Both genders	Male	Female	Both genders
PiC %	[10-20]	[20-30]	[30-40]	[10-20]	[20-30]	[10-20]
Priory %	[40-50]	[40-50]	[20-30]	[40-50]	[30-40]	[30-40]
Combined %	**[60-70]**	**[60-70]**	**[60-70]**	**[50-60]**	**[50-60]**	**[50-60]**

307. The CMA notes that [✂].[202]

CMA's assessment of shares of supply

308. The Parties' combined shares of supply by private providers for Acute Services and PICU Services (shown in tables 2 to 4) are high. The CMA believes that these shares of supply raise competition concerns:

(a) in the catchment area around the PiC *Dene* site in West Sussex providing male-only and combined Acute Services;

(b) the catchment area around the PiC *Kneesworth* site in Hertfordshire providing female-only and combined Acute Services; and

---

[200] [✂].

[201] Calculated using Annex - All Services Pivot Table (18.05.16)

[202] Response to questionnaire.

(c) in the catchment area around the Priory *Cheadle* site in Manchester/Cheshire providing male-only, female-only and combined PICU Services.

Closeness of competition

309. The Parties submitted that they do not compete closely with each other for Acute Services or PICU Services.[203]

310. The CMA has examined the closeness of competition between the Parties for Acute Services and PICU Services and considered third party views within its assessment. The CMA has also considered, to a lesser extent, internal documents, the distance between the sites of the Parties and evidence relating to common customers.

Third party comments

311. Only a small number of NHS providers responded to the question whether they believe PiC and Priory compete with each other for Acute and PICU Services. Of those that responded, three[204] indicated that they do compete and one [✂] said that they do not compete. One [✂] said that PiC and Priory compete on a macro level but there is little effective competition on a micro level when the referral is made (ie at the time of a referral, the choice is often limited by the bed availability). However, this trust [✂]. This indicates that there is clear competition between PiC and Priory for Acute patients from this NHS trust [✂].[205]

312. A third party [✂] told the CMA that the Parties are likely to be each other's closest competitors in the provision of Acute and PICU Services, while another third party [✂] submitted that, on the assumption that the Parties both have capacity, there will be a high degree of competition between them.

Internal documents

313. The CMA reviewed internal documents from the Parties to consider the extent to which the Parties view each other as close competitors. The Parties refer to each other as competitors in relation to Acute and PICU Services in a number of internal documents.

---

[203] Issues meeting, slide D-10.

[204] Responses from NHS trusts [✂].

[205] [✂].

Distance between the sites of the Parties

314. The Parties are geographically closest competitors for male acute services (PiC *Dene* catchment area) and male and female PICU Services (Priory *Cheadle* catchment area), while for female acute services (PiC *Kneesworth* catchment area), the closest private provider is Cygnet.[206]

Table 12 – Distance (miles) between Parties hospitals and private competitors

	PiC *Dene*	PiC *Kneesworth*	Priory *Cheadle*
Closest PiC/Priory	13	36	22
Closest competitors	65	21	44

Parties' common customers

315. The Parties submitted that, in PiC's *Dene* and *Kneesworth* catchment areas, slightly more than [40-50]% of customers did not use PiC or Priory for Acute Services.[207] The Parties also submitted that only [10-20]% of customers (in a wider catchment area of [125-150] miles) are common to both providers.[208] However, to calculate the total number of customers, the Parties used all CCGs and NHS trusts within the catchment areas. This leads to an overestimation of the total number of actual customers since some CCGs will never refer patients if their agreement with the relevant NHS trusts stipulates that the NHS trust is responsible for referring patients.

CMA's assessment of closeness of competition

316. On the basis of this evidence, in particular third party views and the geographic proximity of the parties' sites, the CMA believes that the Parties are close competitors, if not each other's closest competitor, for both Acute Services (around PiC's sites at *Dene* and *Kneesworth*) and PICU Services (around Priory *Cheadle*).

[206] The analysis did not consider gender combined services as PiC *The Dene* and PiC *Kneesworth* are gender specific.

[207] Issues meeting, slides D-10 and D-11.

[208] Issues meeting, slides E-18 and E17.

Alternative private providers

317. The CMA considered the extent to which other private providers exert a competitive constraint on the Parties.

318. There are few alternative private providers of either Acute or PICU Services, especially Acute. At the national level (England and Wales together), there are only three private providers of Acute mental healthcare: Priory ([60-70]% of private bed share), Cygnet ([20-30]%) and PiC ([5-10]%). There are five private providers of PICU mental healthcare:[209] Cygnet ([30-40]% of private bed share), Huntercombe ([20-30]%), Priory ([20-30]%), PiC ([10-20]%) and St Andrew's ([10-20]%).[210]

319. The CMA notes that [✂]. The Parties submitted that Cygnet has secured an extension for its site in Harrow, which will provide 16 additional new beds (though it is not clear how many beds will be for Acute Services).[211]

320. One NHS provider [✂] submitted that it prefers not to refer patients to one of the third party PICU providers listed at paragraph 318 above because of quality concerns, while another NHS trust [✂] said that this third party PICU provider appears to be stagnating and focussing on debt management, indicating that it is currently a weak constraint on the Parties.

321. The CMA believes that, even taking into account Cygnet's expected new beds, alternative private providers will exert only a limited countervailing constraints on the Parties' entity post-merger

Buyer power

322. The Parties submitted that NHS trusts and CCGs are the only customers for the Parties in the supply of Acute and PICU Services and therefore they have strong bargaining power.[212]

323. The CMA believes that, if an NHS trust or a CCG has many alternative options, it might have some buyer power. However, this is not the case in relation to Acute or PICU Services.

---

[209] [✂].

[210] The data submitted by the Parties as a response to RFI dated 10 June.

[211] Merger Notice, Appendix A.

[212] Merger Notice, Appendix A, p.39

324. The Parties further submitted that NHS trusts can and have switched to self-supply.[213] The Parties listed several occasions when NHS trusts expanded or opened new acute wards (eg Southern Health NHS Trust and Lancashire Care FT have developed their own Acute Services because they were dissatisfied with their levels of overspill demand). The Parties also submitted that NHS trusts have been developing their own PICU beds (eg Mersey Care NHS trust, Sheffield Health and Social Care FT, Cheshire and Wirral Partnership FT and Lancashire Care FT).[214]

325. The CMA believes that, while the possibility of NHS trusts switching to self-supply may be a partial factor constraining the Parties in the longer term, it is unlikely that an NHS trust could respond to price rises or degradations in quality in the short term. The investment required to build new wards is significant and there would be a lengthy process to negotiate additional funding and consult with stakeholders. The CMA also notes that any individual NHS trust will be sending a small proportion of its patients to private providers (ie only those patients which it cannot serve itself and, in some cases, that it cannot place with another local NHS trust), which means that a trust may be unlikely to invest in expanding its own provision of Acute or PICU Services in response to a reduction in competition between private providers as the investment cost and risk may be greater than the perceived benefit, at least in the short term.

Barriers to Entry and expansion

326. The Parties submitted that there are no significant barriers to entry and expansion in Acute or PICU Services as evidenced by the number of NHS and private providers expanding their capacity, building new sites or reconfiguring their wards. The Parties provided 12 examples of entry or expansion in Acute Services by NHS and private providers since November 2013,[215] including occasions where Cygnet opened new wards in response to increased demand.[216]

327. The Parties submitted that CCGs and NHS trusts could encourage further expansion into Acute or PICU Services by private providers if they were unhappy with the services provided by the merged entity. However, the CMA notes that it is unclear what NHS trusts have done specifically to encourage

---

[213] Issues meeting, slide D-15.

[214] Issues meeting, slide E-17.

[215] Annex Question 21 – Entry and Expansion

[216] Issues meeting, slide D-14

new entry or expansion. The CMA observes that, over recent years [✂]. Indeed, one large provider [✂] has withdrawn and no longer provides Acute Services.

328. In relation to the possibility of existing or new competitors building new capacity, the CMA observed that:

(a) A private competitor [✂] submitted that it believed it would be easy to expand or start providing PICU Services. However, the competitor noted that building a suitable site and attracting key staff, together with understanding the legal framework for detention under the MHA, would be the main issue.

(b) Another private competitor [✂] submitted that staff changes are required when re-designating a ward and that there may be difficulties in sourcing suitably qualified staff. Staff issues were also mentioned by two NHS trusts [✂].

(c) Two NHS trusts [✂] submitted that it was not easy to open a new hospital or a new ward.

(d) Another NHS trust [✂] submitted that it had taken it six months to negotiate additional funding with CCGs to expand its PICU and younger adult capacity. This was because its plans had to incorporate public health analysis, master planning, master planning permission, build times, the availability of capital, and CCG commitment to revenue costs.

(e) A fourth NHS trust [✂] submitted that it had started to consider a new hospital to upgrade and consolidate its remaining Acute Services but it expected this project to have a 5 year timescale.

329. On the basis of the evidence, the CMA does not believe that entry or expansion will be timely, likely or sufficient to mitigate any SLC arising in Acute or PICU Services.

Conclusion on horizontal unilateral effects in the supply of Acute Services and PICU Services

330. The Merger gives rise to a very high concentration in Acute Services at the local level around PiC's sites at *Dene* and *Kneesworth*, and a high concentration in PICU Services at the local level around Priory's site at *Cheadle*. The Parties are close competitors for these services. There will be very limited constraints remaining from private competitors post-Merger and NHS trusts provide little (if any) constraint.

331. The CMA does not believe that buyer power or entry and expansion of existing or new private providers will not mitigate the loss of competition arising.

332. The CMA therefore believes that the Merger gives rise to a realistic prospect of an SLC in relation to:

(a) the supply of Acute Services in the catchment area of PiC *Dene* (male only and combined) and PiC *Kneesworth* (female only and combined);[217] and

(b) the supply of PICU Services in the catchment area of Priory *Cheadle* (male only, female only and combined).[218]

[217] The CMA refers to each of the two PiC sites whilst noting that concerns also arise when the catchment area is centred around the relevant Priory site(s) that overlap(s) with each PiC site.

[218] The catchment area of Priory Cheadle includes the [✂]. The concern arises in this local area as a result of the overlap between both of these Priory sites and the two nearby PiC sites, as discussed further in the competitive assessment.

Rehabilitation Services

Background

333. The Parties overlap in the supply of hospital-based inpatient Rehabilitation Services (**Rehabilitation Services**) for adult male and female patients. These services are provided to patients with one or more of the following conditions: ABI, ASD, LD, long-term mental health conditions (**LTHC**) and/or neuro-degenerative disorders (such as dementia).

334. The objective of Rehabilitation Services is to maximise an individual's skills and to minimise symptoms and functional impairments in order to promote independence, self-awareness and confidence and to prepare an individual for successful community living (with appropriate support, where required).[219]

335. A patient may be referred to a provider of Rehabilitation Services when stepping up from community living, stepping down from Acute or Secure Services or when moving across from other hospital settings such as specialised neurology wards or other mental health services. The Parties submitted that the average length of stay for a patient receiving Rehabilitation Services is 18 months to three years. Some service users may be detained under the MHA.[220]

336. In England, individual CCGs are the primarily commissioners of Rehabilitation Services. In Wales, it is the responsibility of NHSW.[221]

Product frame of reference

337. The Parties overlap[222] in the provision of Rehabilitation Services to patients with a primary diagnosis of ABI, LD and/or LTHC.[223] As a starting point, the CMA treated each of these patient conditions as a distinct frame of reference.

---

[219] Merger Notice, Appendix E, paragraph 2.2.

[220] Merger Notice, Appendix E, paragraph 2.3.

[221] Parties' response to RFI of 15 April (part 2), paragraph 5.2.

[222] Priory also provides Rehabilitation Services for patients with neuro-degenerative disorders. Separately, Priory also provides Rehabilitation services from facilities in the Channel Islands and the Isle of Man (but PiC does not).

[223] Some of PiC's LTHC hospitals are **HDUs** providing enhanced care. Priory does not classify its Rehabilitation Services using the term HDU and the Parties submitted that it is not a separate specialism. PiC said that '*all of its patients could be treated in a rehabilitation ward with enhanced support*'. Parties response to RFI of 27 June. The CMA does not treat HDU as a separate economic market within LTHC services for the purposes of its assessment.

338. The CMA then considered whether it was appropriate to:

(a) further segment each of these frames of reference by patient gender or more specialised patient condition; or

(b) to aggregate any of these frames of reference with each other, or with other Rehabilitation Services, in particular due to supply-side substitution.

339. The CMA then considered the extent to which NHS provision should be considered within the same frame of reference as the private provision of these services.

Patient condition and gender

Parties' views

340. The Parties submitted that the product frame of reference should be defined as the provision of all Rehabilitation Services, without differentiation between further specialisms or between genders. Specifically, the Parties submitted that *'apparent differentiation at the patient placement stage does not reflect the competitive dynamics of the marketplace',*[224] and that *'the Parties do not believe that a distinction between male and female [rehabilitation] services is sensible'.*[225]

341. However, the Parties also submitted that in the alternative the CMA should distinguish between ABI, LD and neurodegenerative disorders, and within these specialities by various sub-specialities such as PD, transition services for adults who had been in CAMHS services, and by co-morbidity (patients with more than one condition).

Demand-side substitution

342. Regarding gender, all customers which responded to the CMA's questions said that male patients would never be placed in wards dedicated to treating female patients (and vice versa). A competitor [✂] also told the CMA that it competes with the Parties only when the Parties offer the same gender ward.

343. Mixed wards may provide a demand side alternative for some male and female patients.[226] However, the number of mixed wards the Parties provide

---

[224] Final Merger Notice, Appendix E, paragraph 4.2

[225] Final Merger Notice, Appendix E, paragraph 4.11

[226] Some patients require single sex wards; for example, if they would be vulnerable in mixed services, show inappropriate sexual behaviour or have a history linked to sexual offences.

represents less than [10-20]% of their wards. The CMA understands that part of the reason for the prevalence of single sex wards rather than mixed wards is because the Care and Quality Commission (**CQC**) has mandated that wards should be single sex for the 'dignity and respect' of the patients.[227]

344. Regarding segmentation by patient condition, customers submitted that the care of patients with ABI, LD and/or LTHC takes place on different wards. Several customers [✂] told the CMA that it would only send a patient to a ward which can treat their specialist clinical needs. The Parties also told the CMA that, with the exception of one ward in one hospital, individual patients with a primary diagnosis of one condition would not be sent to a ward which specialises in the treatment of a different condition.[228]

345. On the basis of this demand-side evidence, the CMA identified separate product frames of reference within Rehabilitation Services for each of the three patient conditions in which the Parties overlap (ABI, LD and LTHC) and, within each specialty, for male and female patients separately.

Supply-side substitution

346. The CMA then considered whether it was appropriate to widen the scope of each of these frames of reference in light of potential supply-side substitution.

347. The Parties submitted that because of possible supply-side substitution the relevant product market should be broadened.

348. Regarding specialisms, the Parties submitted, as evidence of supply-side substitution, the fact that providers can change their facilities to treat different conditions (eg ABI, LD, etc.) and routinely do so.[229]

349. However, the CMA notes that:

(a) Rehabilitation patients are typically treated for long periods of time,[230] which gives rise to practical difficulties in accommodating patients during any transition. The CMA notes that, in one of the two examples of reconfiguration submitted by the Parties, the process took five months;

---

[227] Parties' response to RFI dated 14 June, paragraph 1.3 and 1.6.

[228] Parties' response to RFI dated 14 June, sections 2 and 3.

[229] Final Merger Notice, Appendix E, paragraph 4.2

[230] The Parties submitted that an average length of stay in a ward is 18 months to three years. Final Merger Notice, Appendix E, paragraph 2.3

(b) whilst it is possible for a hospital to change its facilities to treat different specialisms, the CMA has seen no evidence that this would occur in response to short to medium term changes in the competitive environment; and

(c) there is no evidence that the Parties' competitors have changed, or would change, ward specialisms.[231] Some competing rehabilitation hospitals have specialised in a particular specialism for many years (eg the Royal Hospital for Neuro-Disability) and the CMA has not seen evidence that these hospitals would switch specialism or open a new ward within the short to medium term.

350. Regarding gender, the Parties submitted that providers can easily and quickly change their facilities to cater for the other gender.[232] The Parties gave two examples where the conversion from male to female wards took a month or less.

351. However, the CMA notes that, for the same reasons as set out at paragraph 349(a) above, switching wards between genders is not straightforward and requires facilities to accommodate existing patients. Competitors also told the CMA that they only compete with the Parties when they offer the same gender ward, which indicates that they do not consider themselves constrained by the Parties' ability to switch wards between genders.

352. On the basis of this evidence, the CMA has focussed its analysis on the narrow frames of reference set out in paragraph 345. However, on a cautious basis and recognising the possibility of some supply-side substitution, the CMA has also considered the Merger within speciality-combined and gender-combined frames of reference.

Conclusion on segmentation by patient condition and gender

353. The CMA has assessed the impact of the Merger on Rehabilitation Services within separate frames of reference for each of the three patient conditions in which the Parties overlap (ABI, LD and LTHC), as well as considering them together, and, within each of these specialties, it has considered the Merger

[231] Response to RFI of 14 June 3.24

[232] Final Merger Notice, Appendix E, paragraph 4.3

by gender, again also considering the genders together.[233] This produces twelve product frames of reference.[234]

NHS and private provision generally

354. As with other Overlap Services, the CMA considered whether the supply of Rehabilitation Services by NHS trusts was in the same product frame of reference as supply by private providers.

355. The Parties submitted that CCGs look for the best value placement that meets the clinical needs of the patient. They submitted that this may be found at the local NHS trust or a private provider,[235] implying that there is no distinction from the demand side.

356. The Parties submitted that referrals are made to the Parties' hospitals from NHS trusts even when there is spare capacity in most local NHS trusts. The Parties submitted that such referrals to private providers are made:

(a) if the patient is not suitable for the NHS trust's own services (due to the trust's facilities, or its existing patient mix within its facilities);

(b) to access specialist treatments; or

(c) where the NHS trust reserves a number of beds for emergency or crisis situations.[236]

357. However, several customers told the CMA that they did not consider NHS trusts and private providers to compete. Rather, customers said that they used NHS provision first and only when this was no longer an option (ie when the required service was at capacity) would they use private providers. For example:

[233] The CMA considers that the contradictory submissions of the Parties noted at paragraph 351 above are consistent with the CMA taking a particularly cautious approach to the appropriate frame of reference by undertaking its assessment on narrow service lines and on a more aggregated basis.

[234] The CMA notes that the Parties do not overlap in the supply of female LD Rehabilitation Services.

[235] Final Merger Notice, Appendix E, paragraph 3.13

[236] Final Merger Notice, Appendix E, paragraph 3.14

(a) One NHS Trust [✂] noted that no NHS trusts in its area had locked Rehabilitation Services so NHS provision was not an option if locked services were required;[237]

(b) Another NHS Trust [✂] told the CMA that it did not use NHS trusts for out of area placements because they would be 'double-paying' the trust. The receiving NHS trust would get paid once by the original commissioner which had commissioned the NHS beds and then again by the referring trust.[238]

(c) One CCG [✂] said that specialist private rehabilitation placements are used only when a patient's needs cannot be met by NHS provision.

(d) Another CCG [✂] said that it only places rehabilitation patients in the private sector when local NHS services are unable to manage the condition.

358. A competitor [✂] submitted that it competes strongly with the NHS, but added that customers give "*consideration … to NHS providers first before considering private hospitals*". It submitted that limited NHS resources and bed capacity are the two primary drivers for referrers to use private providers.

359. On the basis of this evidence, the CMA believes that private providers compete primarily with each other for overspill patients and that NHS trusts provide little (if any) constraint.

NHS and private provision for patients based in Wales

360. The CMA understands that NHSW will initially refer patients to available beds at suitable NHS trust facilities in Wales. Only when there are no suitable beds available at these facilities will patients be sent to private providers or, occasionally, to NHS trusts in England. Therefore, NHS trusts in Wales do not constrain private providers at all. The CMA also believes that the constraint on private providers serving Welsh patients from NHS trusts in England is limited for the reasons set out above.

---

[237] The CMA did not consider locked rehabilitation as a separate frame of reference due to the fact that only certain patients would have security requirements and due to the ease of supply side substitutability: a locked facility can become an open facility by simply giving the patients a key.

[238] This would occur when the NHS Trust has a block contract with the original commissioner.

Conclusion on product frame of reference

361. For the reasons set out above, the CMA focussed its assessment on the provision of Rehabilitation Services by private providers to male and female (separately and combined) NHS-funded patients requiring treatment for ABI, LD or LTHC (separately and combined).

Geographic frame of reference

362. The Parties submitted that the appropriate geographic frame of reference is local and should be based on an 80% catchment area centred on each of their facilities. The Parties said that the catchment areas should be calculated for each of the Parties using an average for each patient condition across all of that Parties' facilities which offer that service and then, for each condition, the larger of the Parties' two catchment areas should be used.[239]

363. Using this approach, the Parties calculated the following catchment areas:

(a) [75-100] miles for LD;

(b) [75-100] miles for LTHC;

(c) [75-100] miles for the combined specialities (ABI, LD and LTHC); and

(d) [75-100] miles for ABI since there was no overlap between the Parties when using the only available 80% catchment area of [25-50] miles.

364. The Parties submitted that there is a preference amongst CCGs to place rehabilitation patients close to their home address.[240] This is consistent with evidence the CMA gathered from third parties. For example:

(a) One CCG [✂] said that it places patients out of area when local capacity is unavailable, but it would try to move patients back in area where possible to limit the distance to a patient's significant geographical location (eg where they live).

(b) A second CCG [✂] said that it places patients in the service closest to their home which can meet their specific clinical needs.

(c) A third CCG [✂] said that distance from a patient's point of origin was a primary consideration. This CCG said that distance affected the length of

---

[239] Since the number of patient observations at individual hospitals for these segments can be very low (ie less than 10).

[240] Final Merger Notice, Appendix E, paragraph 3.12

stay of a patient and mentioned the importance of the ability of the family and area clinical team to visit.

(d) One competitor [✂] noted that most of its Commissioners are within a 25 mile radius. This implies that most of its patients are also relatively close, as CCGs are typically responsible for patients within their own commissioning area.

(e) Another competitor [✂] said that distance was highly important and that it was desirable to have '*treatment as close to home as possible*'.

365. In light of this evidence, the CMA has assessed the impact of the Merger at a local level using catchment areas.

Catchment areas

366. The CMA used, as a starting point for the geographic frame of reference, the average 80% catchment area across all the Parties' sites for each of the relevant product frames of reference. However, where there were sufficient observations to form a hospital-specific catchment area (ie ten or more observations), this was used, since hospitals are likely to have different catchment areas reflecting the local competitive environment.[241] These catchment areas were not further delineated by gender.

367. The CMA investigated all instances where a hospital-specific catchment area differed significantly from the service-line average; for example, to ascertain whether this was because it was located within a large urban area or a particularly rural area, or whether it was because there were more hospitals offering the same service in the area. This assisted the CMA in understanding local characteristics of the nature of competition, which the CMA has taken into account where appropriate in its competitive assessment.

National aspects – Wales

368. In addition to its local analysis, the CMA notes that the commissioning of NHS-funded Rehabilitation Services in Wales has national characteristics. In particular, NHSW has a national framework which ranks hospitals according to their price and quality inspections. A referrer in Wales would normally use the ranking when determining a placement.

[241] If the hospital-specific 80% catchment area was close to the average area for the service line, the CMA used the service line average 80% catchment area for convenience (e.g. [75-100] miles for LT).

369. The CMA understands that the Parties' rehabilitation hospitals in England receive patients from NHSW and vice versa. For example, Priory *Aberdare* (based in Wales) received patients from three CCGs and two NHS trusts based in England [✂] in the last three years. For this reason, the CMA has included in its calculations all patients based in England and Wales that were sent to Priory's facilities in Wales.

370. The CMA considers that, to the extent that the Merger gives rises to concerns at a local level, the aggregation of these local effects may be expected to impact on competitive variables determined at the national level in Wales. This is because negotiation on price and some quality aspects occurs nationally between each of the Parties and NHSW.

371. Therefore, the CMA has additionally assessed whether the Merger gives rise to national competition concerns in Wales. These national concerns do not arise in relation to Rehabilitation Services supplied to commissioners in England because all competitive terms are set locally for these customers.

Conclusion on geographic frame of reference

372. Therefore, the CMA has adopted as its geographic frame of reference for each product frame of reference a local 80% catchment area (in relation to competition for patients) defined in each case by the Parties' catchment areas for a given hospital or on average for the given service line.

373. The CMA has also considered the impact of the Merger at a national level for Wales.

Conclusion on product and geographic frame of reference

374. The CMA has assessed the impact of the Merger on the provision of Rehabilitation Services by private providers to male and female (separately and combined) NHS-funded patients requiring treatment for ABI, LD or LTHC (separately and combined) within 80% catchment areas calculated on a hospital-specific basis (where possible) or on average across each service line (ie ABI, LD or LT).[242] In addition, the CMA has considered the impact of the Merger at a national level for Wales.

[242] The CMA did not distinguish service line catchment areas by gender due to limitations in the data available.

Assessment of horizontal unilateral effects

375. The CMA focussed its assessment on horizontal unilateral effects in the supply of Rehabilitation Services in the catchment areas of each of the 19 Priory sites.[243]

376. In order to assess the likelihood of the Merger resulting in unilateral effects, the CMA first considered the nature of competition in Rehabilitation Services and evidence from the Parties' internal documents. The CMA then assessed, for each local overlap area, shares of supply within the Parties' catchment areas, the closeness of competition between the Parties and the competitive constraints remaining post-Merger from alternative suppliers.

Nature of competition in the supply of Rehabilitation Services

377. The Parties submitted that, in England, CCGs, NHS trusts and local authorities are the key customers for Rehabilitation Services. Whilst CCGs are usually responsible for commissioning, they may delegate their responsibility for a cohort of patients to an NHS trust (known as 'secondary commissioning'). The NHS trust will then look for a suitable placement from within its own services, or will refer patients to a local service run by another provider. However, access assessment, on site review of clinical care and general case management, is usually provided by NHS trusts even when the contract is with CCGs.[244]

378. Therefore, whilst CCGs are ultimately responsible for paying providers (whether NHS trusts or private providers) for the relevant services, individual NHS trusts also play an important role in competition for these services. In particular, their interaction with private providers will impact on the wider negotiations with the overseeing CCG. The CMA's assessment therefore reflects the views of both CCGs and NHS trusts about the factors which influence their referral decision.

379. Many CCGs [✂] have block contracts with their local NHS trust to provide a certain number of beds. These trusts will then use private sector facilities either to cater for patients with specific needs or because of a lack of capacity within that trust.[245] However, the CMA notes that the majority of the Parties'

---

[243] The CMA focussed on the Priory sites as the Priory has fewer relevant sites than PiC. However, where the CMA identified a competitive concern centred on a Priory site, the concern could be equally expressed centred on nearby PiC sites.

[244] Parties' response to RFI of 14 April part 2, 5.5.

[245] Parties' response to RFI of 14 April part 2, 5.1-5.4.

beds are purchased on spot rates or framework agreements[246] rather than block contracts[247]. This may allow a provider to price discriminate between customers which have alternative suppliers and customers which do not. In addition, the CMA notes that high levels of capacity utilisation across this sector may force a customer to use a particular provider even when it is not the preferred provider. Both these factors make unilateral effects more likely to occur in scenarios where the Parties' combined shares of supply are high.

Evidence from the Parties' internal documents

380. The Priory's internal documents suggest that the Parties consider one another as competitors for Rehabilitation Services. For example, a presentation update to the Priory board states: [✂].[248]

381. The CMA also noted a business case for refurbishing a vacant Priory facility, which [✂].[249]

The CMA's approach to calculating shares of supply

382. As for the other Overlap Services, the CMA used bed shares as a proxy for shares of supply.

383. The CMA was cautious about using a single catchment area to determine shares of supply due to the strong stated preference from customers to place patients as close as possible to their home. This implied that, even if a commissioner would consider sending a patient further away, it might have a strong preference to send the patient to a closer hospital if there was one available. Therefore, the CMA conducted an extensive sensitivity analysis, calculating bed shares in each of the 12 segments identified at ten mile increments either side of the established catchment area (from [25-50] to [125-150] miles). This sensitivity analysis showed that results varied significantly depending on the catchment area chosen.

---

[246] Most of Priory's framework agreements do not specify a price. For PiC, [✂] contracts specify a price, and about [✂]% of patients enter under a framework agreement. Parties' response to RFI of 15 June.

[247] The only exceptions are for Priory between [✂].

[248] Annex Q18-6, June 15 Board Market Update, p7 and 9.

[249] Annex Q18-98, Charles House – Locked rehabilitation Business Case, p5.

Initial filtering exercise

384. The CMA first applied a filter to remove from its analysis local areas where the Parties' had a share of supply below 30% across all possible product frames of reference, applying the stepped catchment area analysis described at paragraph 383 and, where possible, the hospital-specific catchment area.

385. However, only *Market Weighton* was removed from the analysis by this filter. *Market Weighton* offers LD services to men and is located in the East Riding, Yorkshire. The nearest PiC male LD hospital is 156 miles away, which the CMA believes would make it a weak competitive constraint on *Market Weighton*. The CMA also notes that, within the catchment area of [75-100] miles, the Parties have a share of supply of less than 25% in the wider segment for all Rehabilitation Services, both for male-only and for male and female combined. Also the Parties are not each other's closest competitor geographically. For these reasons, the CMA did not consider *Market Weighton* further.

386. The catchment areas of the remaining 18 Priory hospitals raised sufficient *prima facie* concerns, based on combined shares of beds on a number of different measures, to warrant further analysis. These hospitals are: *Aberdare, Braeburn House, Bristol, Chadwick Lodge & Eaglestone View, Cheadle Royal, Church Village, The Cloisters, Dewsbury, Hayes Grove, Highbank Centre, Hemel Hempstead, Keighley, Middleton St George, Recovery First, St Neots, Sturt House, Ticehurst* and *Ty Gwyn Hall*.

The CMA's approach to the detailed local assessment

387. For each local area, the CMA considered:

(a) the hospital-specific catchment area, if sufficient observations existed (typically ten or more), and other factors which might affect commissioner choices (eg whether the hospital is in an urban area) – where the hospital specific catchment area was close to the average catchment area for that service line, the CMA used the latter;

(b) the distance between the Parties and their competitors and, in particular, whether the Parties were each other's geographically closest provider;

(c) the combined shares of supply of the Parties in each catchment area and the size of the increment;

(d) whether the hospital was subject to a block contract with an NHS trust for all of its beds, since beds subject to a block contract will not be available for patients referred from other NHS trusts; and

(e) when looking at more aggregated market segments, whether competitors seemed likely to switch between service lines (eg some competitors are charities specialising in a particular service and may be less likely to change specialisation quickly enough to constrain the Parties).

388. Where the CMA did not use the hospital-specific catchment area, it used the average catchment area for the relevant service line (see paragraph 362). Table 13 presents these average catchment areas by service line.

Table 13: Average 80% catchment area for each service line

Service Line	Distance (miles)
All rehabilitation	[75-100]
ABI	[75-100]
LD	[75-100]
LTHC	[75-100]

389. The CMA first assessed the impact of the Merger on the segment where the Parties' combined share of supply was highest. This typically meant identifying the narrowest market where there is an overlap at the service line and gender level. For example, if Priory provides LTHC male services and there is an overlap in this segment with PiC, the CMA focussed on this LTHC male overlap and also assessed the LTHC combined gender segment if that was relevant. If this gave rise to significant competition concerns, the CMA did not further examine in detail more aggregated segments (eg all male combined services or all LTHC services for combined genders).

390. If there were no concerns on a narrow basis, the CMA then considered whether there were concerns on a more aggregated basis.

391. Where a hospital provides both male and female provision of a particular service line (eg LTHC), the CMA considered the competitive conditions in both segments. However, neither the CMA nor the Parties were able to determine the allocation of competitors' beds by gender. The CMA therefore adopted the assumption that, on average, competitors have a 65:35 split of male and female wards, consistent with the split in the Parties' supply of these services.[250]

[250] The Parties submit that "*this broadly reflects the Parties' internal business intelligence combined with desk research of rival providers' websites*". This figure is also generally in line with the gender split of the Parties' own rehab wards, which is around [✂] male:female (excluding mixed wards). Email from Parties 17/5/16

392. The Parties' mixed provision (less than [✂]% for both Parties) has been allocated to both male and female sub-categories on a conservative basis.

393. The CMA's assessment of each of the 18 local areas in which the Parties overlap (excluding *Market Weighton*) is set out below.

Aberdare

394. Priory *Aberdare* provides Rehabilitation Services to male and female patients (10 beds) in South Wales and specialises in LD.[251]

395. PiC has no female Rehabilitation Services in this area and no LD specific services in this area. Therefore the Parties only overlap in the frame of reference for ABI/LD/LTHC Rehabilitation Services on a combined basis for male patients and also on a combined gender basis.

396. The Parties provided 9 observations for an 80% catchment area, resulting in an estimate of [125-150] miles. The CMA considers this is an insufficient number of observations to use to define catchment areas and so instead used the average catchment area for all Rehabilitation Services, which is [75-100] miles.

397. In the segment for ABI/LD/LTHC Rehabilitation services on a combined basis for male patients, the Parties' combined share of supply is [50-60]% with an increment of [20-30]%.

398. Ludlow Street Healthcare is the only other significant competitor with several hospitals in this area. It has a share of supply of [20-30]%, and the next largest competitor has [5-10]%.

399. The closest Party hospital is the PiC facility in *Aderyn*. There are closer competitors, including the Ludlow Street Healthcare Group and a Cambian Group site. Hospital sizes in this area range from 7 beds to 34 beds.

400. The Merger results in the two largest providers of Rehabilitation Services in the area merging, leaving one large provider (Ludlow Street Healthcare Group) and a tail of smaller hospitals.

401. Competitive conditions are similar when considering the supply of services on a combined gender basis, so the Merger effect is likely to be the same in this segment.

---

[251] Rehab – Annex 1 – Description for Parties_facilities.pdf

402. In the Issues Meeting, the Parties submitted that *Aberdare* specialises in LD, as does the Ludlow Street Healthcare hospitals, but the PiC hospitals within its catchment area specialise in MI.[252] The Parties said that *Aberdare* focuses on patients with antisocial disorder or LD, and comorbid mental health problems. They said that this demonstrates that competitors offer a more closely competing service.

403. The CMA believes, on a cautious basis, and consistent with the Parties' submissions, that Priory *Aberdare* may currently be constrained by the threat of supply side substitution from mental illness into LD by PiC. The Parties have submitted evidence that this could be done easily, and within a year. Although certain third party sites may be competing more closely with *Aberdare*, the CMA notes that, post-Merger, PiC, with [20-30]% of the relevant beds in the area, would no longer provide this constraint. For this reason, the CMA believes that the Merger removes the second largest competitor within the catchment area.

404. In light of the above, the CMA believes that that, in this local area, there is a realistic prospect of an SLC in the supply of ABI/LD/LTHC Rehabilitation Services on a combined basis to male patients.

Braeburn House

405. Priory *Braeburn House* provides LTHC Rehabilitation Services to male patients in Salford.

406. There are no observations to form a hospital-specific catchment area and the CMA therefore used the average LTHC catchment area of [75-100] miles. In the segment for the supply of LTHC Rehabilitation Services to male patients, the Parties' share of supply is [20-30]%.

407. The CMA notes that Priory currently has a [✂].

408. *Braeburn House* failed the initial filter due to the Parties' high shares of supply within smaller catchment areas. However, the Parties are not each other's closest competitor geographically and there are multiple competitors nearby able to constrain the Parties post-Merger.

409. There are also no concerns in the segments for combined gender LTHC services, or for combined ABI/LD/LTHC services for men only or for combined genders.

---

[252] Response to Issues Letter.

410. No third parties raised any concerns about this area.

411. In light of the above, the CMA does not believe that there is a realistic prospect of an SLC in the supply of any Rehabilitation Services in this local area.

Bristol

412. Priory *Bristol* provides LTHC Rehabilitation Services to male and female patients (10 beds) in Bristol.

413. There are 40 hospital-specific observations to calculate an 80% catchment area, which is [75-100] miles. The CMA therefore used the LTHC service line average of [75-100] miles, which is similar.

414. The CMA assessed male and female LTHC segments separately.

415. In the LTHC male segment, the Parties have a combined share of supply ranging from [40-50]% to [60-70]% between 40 and 130 miles for each of the 10 mile increment catchment areas. At [75-100] miles, which is the average distance for all LTHC services, the Parties have a combined share of [60-70]%, with an increment of [20-30]%.

416. The two closest competitors geographically are the Cygnet hospital in Kewstoke, 32 miles away, and Sherwood Lodge, which is an independent facility, 33 miles away. Sherwood Lodge might currently exert a limited competitive constraint as it was rated 'requires improvement' in a recent CQC review.[253] The three next competitors are PiC's facilities in South Wales and Weston-super-Mare (*Copse* and *Adeyn*, 33 and 39 miles away respectively) and Priory's *Ty Gwn Hall* (50 miles away). The next largest provider in the catchment area is Cambian Group with [10-20]% share of supply, and then Cygnet with [5-10]%.

417. In the LTHC female segment, the Parties' bed share is slightly higher than in LTHC male, ranging from [50-60]% to [70-80]% between 40 and 130 miles. At [75-100] miles the bed share is [70-80]%, with an increment of [20-30]%. The combined share of supply is larger for female than male LTHC services due to the addition of the PiC's *Llanarth Court* site which has female and not male LTHC provision. Due to a lack of data distinguishing male and female services, the competitive conditions from third parties does not change in the analysis.

---

[253] http://www.cqc.org.uk/location/1-120261406

418. One CCG [✂] expressed concerns to the CMA about the acquisition of this site, saying that it sent patients to the Parties' sites, as well as to Cygnet and St Andrews in Northampton. An NHS trust [✂] also said that it had concerns about the reduction in the number of providers, saying that it sent patients to both *Bristol* and PiC sites (eg *Copse)*.

419. In the Issues Meeting, the Parties submitted that Priory *Bristol* can cater for patients that many other hospitals cannot as it can treat patients with high physical needs. They submitted that the closest PiC sites either treat less difficult patients (*Copse*), are a step earlier in the care pathway (*Aderyn*) [✂].

420. The Parties did not identify any key competitors but provided reasons to explain why all the LTHC hospitals in the area were differentiated and did not compete.

421. The CMA notes that, even if certain patients can only be sent to *Bristol* and not to PiC, it is not clear how many patients can be sent to both sites. Also, the CMA notes that the Parties arguments about detailed specialisation within LTHC services are not consistent with their submissions on supply-side substitutability. [✂].

422. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to (i) male patients; and (ii) female patients.

Chadwick Lodge and Eaglestone View

423. Priory *Chadwick Lodge* provides LTHC Rehabilitation Services to female patients (11 beds) in Milton Keynes.

424. There are no observations to calculate an 80% catchment share. Using the average catchment area for LTHC services ([75-100] miles), the Parties have a combined share of supply in LTHC female services of [50-60]%, with an increment of [10-20]%. The next largest competitor is Cambian Group, which has a bed share of [10-20]%.

425. The providers of LTHC female services are in three clusters around *Chadwick Lodge*: those in London, those in Birmingham, and those in between. *Kneesworth House* (PiC), *St Neots* (Priory) and *Hemel Hempstead* (Priory) are all in this region.

426. Competitive conditions are similar when aggregating across male and female LTHC services. Within a [75-100] mile catchment area, the Parties have a share of supply of LTHC on a combined gender basis of [40-50]%, with an increment of [10-20]%.

427. In the Issues Meeting, the Parties submitted that *Chadwick Lodge* is a specialised PD service for female patients. It has a one year programme and many patients have co-morbidities, such as eating disorders, post-traumatic stress disorder and/or substance misuse. The Parties submitted that several of PiC's facilities do not compete for these patients, while several competitors have more similar services and do compete for these patients.

428. In particular, the Parties identified *Kneesworth House* as catering to patients of lower risk to themselves (eg because they are able to cook and clean for themselves), whereas patients accepted by *Chadwick Lodge* would require closer supervision and would not be allowed free access to cleaning and cooking utensils, due to their heightened self-harm risk. The Parties identified some of the hospitals further away as not close competitors, because they are for a different gender (North London Clinic, Woodlands View, Abbey House), different patient needs (255 Lichfield Road, Lakeside View, Ellingham Hospital), [✂].

429. The Parties also submitted that other third party facilities are closer competitors. In particular, Cygnet Hospital Sheffield provides a 'dialectical behavioural therapy' programme which is aimed at self-harming patients, and Cambrian Acer Clinic also provides specialist PD locked Rehabilitation Services. The Parties submit that the patients the Priory treats are similar to some specialist Tier 4 residential PD facilities, which are NHSE funded.

430. The CMA notes that the Parties did not submit that PD formed its own segment separate from LTHC rehabilitation, and also did not identify it as a primary diagnosis segment.[254] The CMA also notes that there are concerns about the Merger in this area in both the market for LTHC female provision, and for LTHC combined gender services. The Parties' submissions regarding services for a different gender surrounding *Chadwick Lodge* do not appear consistent with their submissions concerning the distinction between male and female Rehabilitation Services generally (see paragraphs 340 and 341 above). The CMA is particularly cautious about relying on the Parties' submissions in the Issues Meeting that Tier 4 residential PD facilities funded by NHSE are key competitors, when hitherto the Parties had not submitted that they competed.

431. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to female patients and on a combined gender basis.

---

[254] Final Merger Notice, Appendix E, paragraph 4.1

Cheadle Royal

432. *Cheadle Royal* provides LTHC Rehabilitation Services to male patients in the Manchester area.

433. There are no observations to form a hospital specific catchment area. Using the [75-100] mile average catchment area, the combined gender LTHC share of supply is [30-40]%, which was why *Cheadle Royal* failed the initial filter. The shares of supply in male LTHC services are consistently lower than in combined gender LTHC services.

434. The CMA also notes that the Parties are not each other's closest competitor geographically and there are multiple competitors nearby able to constrain the Parties post-Merger. There are also no additional concerns in the aggregated segment for ABI/LD/LTHC combined services, either on a male or combined gender basis.

435. No third parties raised any concerns about this area.

436. In light of the above, the CMA does not believe that there is a realistic prospect of an SLC in the supply of any Rehabilitation Services in this local area.

Church Village

437. Priory *Church Village* provides LD Rehabilitation Services to female patients (12 beds) in South Wales, about 40 miles from Bristol.

438. Its 80% catchment area is [75-100] miles, based on 15 observations.

439. In the LD female segment, the nearest PiC facility is *Mildmay Oaks*, which is 126 miles away and provides 16 female LD beds. Within the [75-100] mile catchment area, there is one competing provider (Ludlow Street Healthcare Group), which is within 20 miles of *Church Village*. All other competitors are over 100 miles away. Within a 130 mile radius of *Church Village*, the parties have a [40-50]% share of supply (28 out of [✂] beds in total). The Parties' facilities are all larger than the competitors, although there is uncertainty over whether the competitors' facilities are male or female. However, given the significant distance between the overlapping facilities of the Parties, which is [✂] more than the 80% catchment area distance, and given the presence of both a large competitor much more locally, the CMA believes that the Parties impose only a limited constraint on each other in this segment.

440. In the LD combined gender segment, Priory *Aberdare* is 15 miles away, and there are no additional competitors within 100 miles. Within 130 miles the Parties have a [30-40]% share of supply (69 out of [✂] beds in total).

441. Using an [75-100] mile catchment area, the Parties have a share of supply of ABI/LD/LTHC Rehabilitation Services on a combined basis to female patients of [50-60]%, with an increment of [10-20]%. Priory and PiC are the largest and third largest providers of these services in this area. The closest PiC hospital is *Ty Catrin* 10 miles away. The closest hospital to *Church Village* is Heatherwood Court operated by the Ludlow Street Healthcare Group, but the Parties operate about half of the relevant hospitals in this area (8 out of 19).

442. In the Issues Meeting, the Parties submitted that, similar to *Aberdare*, Priory *Church Village* provides a speciality female-only service for patients with LD comorbid with PD. They submitted that they were not aware of any competitors replicating its specific service offering. They submitted that PiC's hospitals in this area do not treat the same patients as *Church Village*.

443. The CMA believes that, on a cautious basis and consistent with the Parties' other submissions, it is possible that *Church Village* is constrained through the threat of supply side substitution from LTHC and ABI facilities. The Parties have submitted evidence that this could be done easily, and within a year.

444. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of ABI/LD/LTHC Rehabilitation Services on a combined basis to female patients.

Cloisters

445. Priory *Cloisters* provides LTHC Rehabilitation Services to male patients (15 beds) and female patients (9 beds).

446. There is no data on the hospital-specific catchment area so the CMA used the average LTHC catchment area of [75-100] miles. [✂].[255] [✂] told the CMA that this was the legacy of a transfer of patients from when the NHS closed a different facility.

447. In the Issues Meeting the Parties submitted that [✂].[256]

448. On the basis of this evidence, the CMA believes that [✂].

---

[255] Final Merger Notice, Appendix E, paragraph 3.8.

[256] Parties' response to RFI (Email of 5 July 2016).

449. In light of the above, the CMA does not believe that the Merger gives rise to a realistic prospect of an SLC in relation to the supply of any Rehabilitation Services in this local area.

Dewsbury

450. Priory *Dewsbury* provides LTHC Rehabilitation Services to male patients in Yorkshire.

451. There are 26 observations which give an 80% catchment area of [0-25] miles. The CMA notes that notes that this is a smaller than average catchment area. However, as it is anomalously low, the CMA attached limited importance to it.

452. Within the LTHC average catchment area ([75-100] miles), the Parties' combined share of supply in LTHC male services is [20-30]%. The CMA observed that the market share in this segment is sensitive to the precise distance used, as at 50 miles the combined share of supply is [40-50]%, though this drops to [30-40]% within 60 miles.

453. The CMA found that the Parties are not each other's closest competitors geographically and there are multiple competitors nearby able to constrain the Parties post-Merger, including hospitals operated by Cambian Group, Cygnet and Inmind Healthcare Group.

454. In the LTHC combined gender segment the Parties combined share of supply is [20-30]%. The CMA identified no additional problems in the aggregated market for all Rehabilitation Services, either on a male only or combined gender basis.

455. No third parties raised any concerns in relation to the Merger in this area.

456. In light of the above, the CMA does not believe that the Merger gives rise to a realistic prospect of an SLC in relation to the supply of any Rehabilitation Services in this local area.

Hayes Grove

457. Priory *Hayes Grove* provides LD Rehabilitation services to male and female patients in Kent. The only overlap with PiC facilities is in the supply of LD Rehabilitation Services to male patients.

458. Its hospital specific catchment area is [50-75] miles based on 12 observations.

459. In the LD male segment, the nearest PiC facility is 58 miles away, just outside the 80% catchment area. There are also several closer LD hospitals run by

Cambian Group, Danshell Group, Cygnet, Sequence Care Group and Bramley Health, although these are smaller than the Parties' facilities. There is also a Cambian hospital in Colchester 69 miles away. This means the parties' share of supply is sensitive to the catchment area: there is no overlap at the hospital specific catchment area, but there is a share of [30-40]% at 60 miles and [20-30]% at 70 miles. The CMA puts weight on the fact that the Parties are not each other's closest competitors geographically and there are multiple competitors nearby able to constrain the Parties post-Merger.

460. The CMA identified no additional problems in the aggregated market for LD combined gender, or all ABI/LD/LHTC combined services either on the basis of male only or combined gender.

461. No third parties raised any concerns in relation to the Merger in this area.

462. In light of the above, the CMA does not believe that the Merger gives rise to a realistic prospect of an SLC in relation to the supply of any Rehabilitation Services in this local area.

Hemel Hempstead

463. Priory *Hemel Hempstead* provides LTHC Rehabilitation Services to female patients (20 beds).

464. Its hospital-specific 80% catchment area is [100-125] miles based on 34 observations. This catchment area includes all of London and extends almost to Bristol.

465. In the female LTHC segment, the closest competitors geographically to *Hemel Hempstead* are three Cygnet facilities within 30 miles. However, pre-Merger, the Parties were the two largest providers of female LTHC Rehabilitation Services in the catchment area. The Merger gives the Parties a combined share of [50-60]%, with an increment of [10-20]%. There are no other providers with more than 10% share of supply in this catchment area, with the next largest provider being Cambian Group with [5-10]%.

466. In the Issues Meeting, the Parties submitted that the Parties compete in this area but significant competitor constraints will remain post-Merger. The Parties submitted that, for example, the female-only Cygnet Kenton Lodge is closer to *Hemel Hempstead* than the overlapping PiC hospital, and four hospitals offer male and female services nearby which also compete. The Parties submitted that certain of their hospitals (*Chadwick Lodge and Eaglestone View*, *Annesley House*, *North London Clinic, Sturt House, Lakeside View, Ellingham Hospital, Abbey House, Dene, Woodland View*)

competed with *Hemel Hempstead* only weakly due to a particular speciality, including HDU, and/or because they treat only male patients.

467. The CMA considers it appropriate to include hospitals with a sub-specialism within LTHC, including HDU hospitals, based on the Parties own submissions about demand-side and supply-side substitutability. The CMA is aware that other providers operate in this area, including some which are closer in proximity to *Hemel Hempstead* than PiC's facilities, but considers that since the Merger is between the two largest providers of female LTHC Rehabilitation Services in this area there would still be a loss of an important competitive constraint between the Parties.

468. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to female patients.

Highbank Centre

469. *Highbank Centre* provides ABI Rehabilitation Services to male and female patients (15 beds) and LTHC Rehabilitation Services to male patients only (10 beds) in Bury, north of Manchester.[257]

470. Its hospital-specific 80% catchment area for both ABI and LTHC patients is [25-50] miles based on 33 observations.

471. In the ABI male and female segments the nearest overlapping PiC hospital is at *Burton Park*, 123 miles away. Given the small catchment area of *Highbank Centre*, the CMA believes that this hospital exerts only a weak competitive constraint due to its distance.

472. In the male LTHC segment, using a [25-50] mile catchment area, the Parties have a combined bed share of [40-50]%, with an increment of [20-30]%.

473. The Parties are the two largest providers of male LTHC services within a 40 mile catchment area. The next largest provider is Alternative Futures which has five hospitals and [10-20]% share of supply. There are also other national providers such as Cygnet and Cambian Group, and some independent facilities, which together account for [30-40]% of the market. Post-Merger, the Parties will also have a substantial amount of the provision by hospital count.

474. In the Issues Meeting, the Parties submitted that, due to ABI services being located on the hospital site, *Highbank Centre* can take male LTHC patients

[257] Annex 1 – Description of the Parties' facilities.

with higher physical needs, including patients with comorbid conditions such as dementia and ABI.

475. The Parties submitted that some of the hospitals identified by the CMA as competitors did not compete at all, while others were not close competitors. in particular, the Parties submitted that:

(a) *Highbank Centre* did not compete for referrals with *Spinney* since *Spinney* was filled by patients stepping down from its own secure services, [✂] and the fact it does not accept patients with physical health comorbidities.

(b) *Highbank Centre* did compete with *Cheadle* and *Keighley* (Priory), and *Brierly Court, Kemple View* and *Park Lodge* (PiC), but not closely since these hospitals cannot accommodate patients with the same level of physical needs as *Highbank Centre* (eg due to stairs).

476. In contrast, the Parties submitted that Cambian's Fountains hospital and Cygnet's Brighouse were closely competitors with the *Highbank Centre*. However, the Parties did not submit that these third party hospitals specialised in patients with a high level of physical needs, and they did not explain why these hospitals were close competitors.[258]

477. The CMA believes that the Parties' sites do compete. The CMA notes that:

(a) The [✂] at which point there will be a greater competitive constraint from this site.

(b) The Spinney has only three LTHC male beds so its inclusion or exclusion has only a small effect on the competitive dynamic in the area.

(c) For the remaining hospitals, even if some patients could only be sent to *Highbank Centre* due to its specialities, this facility also accepts patients who does not require these specialist services. Similarly to *Aberdare*, the CMA believes, on a cautious basis and consistent with the Parties' submissions, that it is possible that *Highbank Centre* is constrained through the threat of supply-side substitution. The Parties have submitted evidence that this could be done easily, and within a year.

478. The CMA does not consider that the Parties have demonstrated that the two listed third party hospitals compete more strongly with *Highbank Centre* than with the PiC facilities. In particular, it notes that the Parties did not submit that

---

[258] With regard to Cambian Fountains, the Parties said: "[*It] has a positive reputation in the local area regarding managing patients with complex mental health difficulties in a community setting*". The Parties did not say why Cygnet Brighouse is a closer competitor to *Highbank Centre* than PiC.

these third parties accept patients with comorbid conditions, or can deal with physical disabilities.

479. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to male patients.

Keighley

480. *Keighley* provides LTHC Rehabilitation Services to male and female patients.

481. There are 47 observations of distances to patients, and the 80% catchment area is [50-75] miles. The CMA used a catchment area of [50-75] miles to assess the competitive conditions around this hospital.

482. For the LTHC female segment, the Parties have a share of supply of [40-50]%, with an increment of [10-20]%. The Cambian Group has [10-20]% of the beds in this area and is the second largest provider. There are also facilities owned by Cygnet within this area, Waterloo Major Independent Hospital operated by Inmind Healthcare Group and other smaller providers.

483. The closest competitor geographically to *Keighley* is PiC's *Springwood Lodge* in Leeds. PiC's *Brierley Court* is also only 42 miles away.

484. For the LTHC male segment, Springwood Lodge is not counted as it does not offer male facilities, but other PiC facilities in Blackburn and Moston are within the catchment area, as is Priory's *Highbank Centre* in Bury. In the [50-75] mile catchment area, the Parties have a combined share of supply of [60-70]%, with an increment of [20-30]%. Due to limitations in the data from third parties, the CMA has been unable to distinguish competitors male and female LTHC provision. However, the Parties have more hospitals offering male LTHC within the catchment area than female LTHC, which is consistent with their higher bed share in this segment.

485. In the Issues Meeting the Parties submitted that *Keighley* provides LTHC services for people who require longer or ongoing hospital-level care. They said that, by contrast, PiC offers '*active Rehabilitation Services*', which is rehabilitation with the aim of patients progressing to future community placements. The Parties noted that *Kemple View* has patients who tend to move between low secure and LTHC sites. The Parties did not submit that any third party competitor had a relevant site closer to Keighley.

486. The CMA notes that the Parties have not submitted that 'active rehabilitation' forms a separate segment to LTHC. 'Active rehabilitation' was also not considered a speciality by any customers or competitors which responded to

the CMA. In any event, the CMA considers that the barriers to substituting on the supply side between the two services would be no more difficult than between the other rehabilitation specialisms.

487. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to (i) male patients and (ii) female patients.

Middleton St George

488. *Middleton St George* provides LTHC Rehabilitation Services to male patients (16 beds) and female patients (15 beds). The hospital is between Darlington and Middlesbrough.

489. The hospital-specific 80% catchment distance, based on 24 observations, is [125-150] miles.

490. In the LTHC female segment, the Parties' combined share of supply is greatest in an [75-100] mile catchment area, where they have combined bed share of [50-60]%. The nearest PiC facility is *Springwood Lodge* in Leeds, which is 62 miles away. There are several competitors closer than 62 miles, including two Cambian Group sites, and two sites run by the Retreat York. At 130 miles, the Parties have a combined share of supply of [30-40]%. Pre-Merger the Parties were the second and third largest providers of Rehabilitation Services in the area.

491. In the LTHC male segment, the Merger effect is much more limited. This is because it excludes the large PiC *Springwood Lodge* hospital. The Parties' combined share of supply in the [125-150] mile catchment area is [30-40]% with an increment of [10-20]%. The CMA was unable to distinguish third party male and female provision, so it was unable to compare the competitive constraints from third parties between these two segments (see paragraph 391), but the estimated share data suggested that the Parties would continue to face significant constraints from third parties in this segment.

492. In the Issues Meeting the Parties submitted that only two PiC facilities offer similar services to *Middleton St George*, namely *Willows* (114 miles away) and *Annesley House* (118 miles away). The remainder did not. This is because *Middleton St George* provides for females with complex mental health needs, and for females with PD. The Parties submitted that *Springwood Lodge* could accept patients with comorbid PD but the focus of treatment is not on patients with this as their primary diagnosis. The Parties submitted that third parties which offer specialist PD facilities, including Tier 4 residential PD services, compete more strongly with *Middleton St George*.

The Parties also said that, among facilities offering general LTHC services, Cambian's Appletree and Waterloo Manor Independent Hospital are both closer to *Middleton St George* than PiC's hospitals.

493. The CMA considers that, based on the Parties' submissions about supply-side substitutability, it is possible for Springwood Lodge or the Parties' other sites to compete with *Middleton St George* even if they do not offer precisely the same services. The CMA notes that the Parties did not submit that PD was a separate segment and previous Party submissions grouped hospitals providing PD services with those providing other LTHC services. The CMA also notes that not all of *Middleton St George's* facilities are for females with a primary diagnosis of PD so, even if PD were a further sub-segment, *Springwood Lodge* would still compete with *Middleton St George's* complex mental health ward.

494. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to female patients.

Recovery First

495. *Recovery First* provides LTHC Rehabilitation Services to female patients in Cheshire.[259]

496. There are not enough observations to form a catchment area, so the CMA used the average catchment area for LTHC rehab of [75-100] miles.

497. In the LTHC female segment, the Parties have a combined share of supply of [40-50]% with an increment of [10-20]%. PiC was the largest provider pre-Merger, and the Priory was the third largest provider after Cambian Group.

498. The Parties are not each other's closest competitors geographically. There are several competitors including six Alternative Future hospitals within the 27 mile distance between *Recovery First* and the nearest PiC site, which is *Brierley Court*. However, these competitors have fewer beds than the Parties. In terms of capacity, the Merger changes the market from having one large supplier with three medium competitors and a long tail of smaller competitors to having an even larger supplier and two medium competitors, with the same long tail.

499. In the Issues Meeting the Parties submitted that the Parties' facilities in this catchment area are not closely competing because PiC offers different

[259] Annex 1 - Description of Parties facilities

services. They said that third party competitors offered similar services to Priory.

500. The Parties submitted that *Brierley Court*, the closest PiC site, admits lower acuity patients than *Recovery First* so, in practise, commissioners do not choose between *Recovery First* and *Brierley Court*. The Parties identified other sites further away as less close competitors because they (i) treat less complex patients (*Lichfield Road*), (ii) are transitional service for individuals who have been in CAMHS services (*Lakeside View*), or (iii) because they are based in a residential setting (*Park Lodge, Park Villa, Beverly House*). However, they identified Cambian Group's Delfryn Lodge and Bradford Distinct NHS Care FT's Daisy Hill House as competitors with similar services to *Recovery First*.

501. The CMA considers that, based on the Parties' submissions about supply-side substitutability, it is possible for Brierley Court or the other sites of the Parties to compete with *Recovery First* even if they do not offer precisely the same services. The Parties asserted that "*in practise commissioners do not choose between Recovery First and Brierley Court*"[260] but provided no evidence to support this assertion.

502. The CMA accepts that the Delfryn Lodge facility competes with the Parties in this area, but does not believe that Bradford District NHS Care FT will provide much constraint on the Parties (see paragraphs 354 to 359).

503. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to female patients.

St Neots

504. Priory *St Neots* provides LTHC Rehabilitation Services to female patients (19 beds) and male patients (15 beds) in Cambridgeshire.

505. There are 60 observations to form an 80% catchment area, which is [100-125] miles. The catchment area for female LTHC ([100-125] miles using 24 observations) is marginally higher than the catchment area for male LTHC ([75-100] miles using 36 observations). The CMA used the average catchment area for all LTHC services, which is [75-100] miles, as this is similar to the hospital-specific area for both genders. This catchment area includes Birmingham and London.

---

[260] Issues Meeting presentation F-19

506. In the LTHC female segment, the Parties' combined share of supply is [50-60]%, with an increment of [10-20]%. The next largest competitor is Cambian Group which has [10-20]% of the market. The Parties have a share of supply above 40% in this segment for every catchment area between 40 and 130 miles.

507. In the LTHC male segment, the combined share of supply is [30-40]% with an increment of [5-10]%. The CMA is unable to distinguish third party male and female provision so the analysis of third party constraints is the same for both gender segments, as noted in paragraph 391.

508. The Parties are each other's closest competitors as *Kneesworth House* is just 19 miles away from *St Neot's*. Baldock Manor, operated by Nouvita, is also 19 miles away.

509. A competitor, [✂], based over 80 miles away told the CMA that it competed 'moderately' with PiC and the Priory, commenting on the distance between them.

510. In the Issues Meeting, the Parties argued that, although the Parties compete in the *St Neot's* catchment area, significant competitive constraints will remain. They accepted that *Kneesworth House* does compete but said that many other competitors provide similar services at a similar distance. The Parties listed Nouvita, which the CMA noted above, but also Whitepost Health Care Group's Shrewsbury Court, which is 96 miles away. The Parties submitted that the CMA had included certain hospitals which, due to there being specialisms within LTHC, did not overlap with PiC.

511. The CMA noted that Shrewsbury Court was on the edge of the catchment area of *St.Neot's* and therefore imposed less of a constraint on *St.Neot's* than *Kneesworth House* and Nouvita. The CMA also notes that the Parties' evidence on supply-side substitution pointed towards LTHC being a segment in which competition took place, notwithstanding some specialisms within it.

512. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to (i) male patients and (ii) female patients.

Sturt House

513. Priory *Sturt House* provides LTHC Rehabilitation Services to male patients (21 beds) in Surrey.

514. There are insufficient observations to calculate a hospital-specific catchment area, so the CMA used the average catchment area for the LTHC service line of [75-100] miles.

515. In the LTHC male segment, the Parties combined share of supply is [30-40]%, with an increment of [10-20]%. The Merger is between the largest and second largest supplier in this segment. The largest third party competitor has a share of supply of [10-20]% and the next largest has [10-20]%.

516. The closest hospital of the Parties is 18 miles away from Sturt House. However, the Parties are not one another's closest competitor geographically as there are several other hospitals including two run by the Inmind Healthcare Group and the Whitepost Health Care Group.

517. In the Issues Meeting, the Parties submitted that, although the Parties compete in the *Sturt House* catchment area, significant competitive constraints will remain. This includes NHS provision, the Whitepost Health Care Group sites noted above, and Cambian Churchill. The Parties submitted that some of the Parties' sites did not offer a step-down service like *Sturt House*, although they did not identify which competitors offered this service either.

518. The CMA recognises that *Sturt House* might be particularly well-suited for some LTHC patients. However, consistent with the Parties' submissions on the ease of supply-side substitutability, the CMA does not have reason to believe that step-down services are distinct from a demand or supply side perspective. The CMA recognises that there are several competing providers in the area but notes that the Parties are the largest providers in the area and close competitors.

519. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to male patients.

Ticehurst

520. Priory *Ticehurst* provides LTHC Rehabilitation Services to male patients (22 beds) and female patients (6 beds).

521. There are not sufficient observations to form a hospital-specific catchment area, so the CMA used the LTHC average catchment area of [75-100] miles.

522. In the LTHC female segment, the Parties have a combined share of supply of [40-50]% with an increment of [10-20]%. The next largest competitors are

Bramley Health with [10-20]% of the beds and Cygnet Health with [5-10]% of the beds.

523. PiC is not the closest competitor to the Priory geographically, although it is the second closest at 34 miles away. There is also a 21 bed PiC facility of *Pelham Woods* 55 miles away, and a 24 bed PiC facility in *Bromley Road* 44 miles away. These are larger than the Parties' competitors' hospitals, although the CMA notes the uncertainty about the precise number of female beds at these sites (see paragraph 61).

524. In the LTHC male segment, the Parties' combined share of supply is [20-30]%, with an increment of [10-20]%. The Parties have a comparable number of beds within the catchment area for male and female (100 and 93 beds respectively), but the share of supply difference is due to the assumption about the competitive provision of single gender wards (see paragraph 391). However, given that the CMA has no reason to believe that the split of male and female LTHC beds is different in this area to nationally, the CMA does not believe that the Parties' share of supply in the LTHC male segment is indicative of competition concerns in this local area.

525. The CMA considered whether Priory *Ticehurst* was competing with the PiC facilities at *Dene* and *Pelham Woods* as these hospitals were defined as offering HDU rather than LTHC services. However, the Parties' submitted that "*all of [PiC's] patients could be treated in a rehabilitation ward with enhanced support*", which suggests that they compete with Ticehurst from a demand perspective; and the Parties also said that "*PiC would use the same staff on an HDU ward as on a rehabilitation ward*", which suggests that it may be possible to switch between HDU and standard LTHC provision from a supply perspective. Therefore, the CMA believes that, pre-Merger, these two PiC hospitals compete with Priory *Ticehurst*.

526. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to female patients.

Ty Gwyn Hall

527. Ty Gwyn Hall provides LTHC Rehabilitation services to male and female patients in South Wales. [261]

[261] Annex 1 – Description of Parties' facilities. It can also treat patients with mild LD as a secondary condition.

528. There are 33 observations to form an 80% catchment distance, which is [75-100] miles. The CMA used the LTHC average catchment area of [75-100] miles, given this is similar.

529. In the LTHC female segment the Parties have a combined share of supply of [50-60]%, with an increment of [20-30]%. Before the Merger, the Parties were the two largest providers of LTHC female rehabilitation. Post-Merger the next largest provider is Cambian Group with [10-20]% of the beds. PiC *Llanarth Court* is the closest competitor to *Ty Gwyn* geographically, with the next closest being St Teilo House run by Cambian Group. About half the facilities in the local area are operated by the Parties.

530. Competitive conditions in the LTHC male segment are similar. The Parties have a slightly lower combined share of supply of [40-50]%, with an increment of [20-30]%. They are also each other's closest competitors geographically in this segment and the competitor hospitals are the same.

531. In the Issues Meeting, the Parties submitted that, although the Parties compete in the *Ty Gwyn* catchment area, significant competitive constraints will remain. The Parties cited Ludlow Street Healthcare, Rushcliffe Care Group and Cambian St Teilo House as key competitors. The Parties accepted that their closest hospital to *Ty Gwyn* in the LTHC male segment, PiC *Aderyn*, competed with *Ty Gwyn Hall,* but said that *Llanarth Court*, their closest hospital to *Ty Gwyn* in the LTHC female segment, [✂]. Other Party sites were also identified as not competing for referrals because either (i) [✂] (*Ty Catrin*); or (ii) they dealt with more complex patients (*Bristol*). However, the Parties accepted that *Abbey House* and *Copse* competed with *Ty Gwyn*.

532. *Ty Gwyn* offers a locked ward, an open ward and a step-down unit, which illustrates how one hospital can provide several facilities even within one segment such as LTHC. The CMA also notes that, even under the Parties' submission, the Merger is causing the loss of the closest geographic competitor in the LTHC male segment. More broadly, consistent with the Parties' submission on supply-side substitution, the CMA believes that there is also a loss of competition from the Parties' other LTHC sites, even if some of these sites currently focus on particular patients within LTHC.

533. In light of the above, the CMA believes that, in this local area, there is a realistic prospect of an SLC in the supply of LTHC Rehabilitation Services to (i) male patients; and (ii) female patients.

Barriers to entry and expansion

534. The evidence received by the CMA from third parties did not indicate that entry or expansion will be timely, likely or sufficient to mitigate any SLC arising. One competitor [✂] told the CMA that it had not re-designated an existing ward in the past two years and had no plans to expand. Another [✂] told the CMA that it was opening a new service in [✂] but the CMA does not consider that this materially affects its local competition assessment because, although it will affect slightly some of the shares of supply in some catchment areas used in the local analysis, this is unlikely to be significant and it will not be the closest hospital to the Priory in any of the areas of concern.

Buyer power

535. The Parties told the CMA that, since the delivery of Rehabilitation Services is almost exclusively funded by public authorities, this allows public authorities to exercise a very substantial degree of buyer power, which they use to achieve significant price reductions. They said that Commissioners also multi-source Rehabilitation Services from a number of qualified suppliers, and are able to easily switch providers at short notice, since patient placement decisions are made on a case-by-case basis.

536. The CMA considers that, at present, public authorities may be able to negotiate between different competing providers of Rehabilitation Services to obtain a discount. The CMA also considers that the Merger will reduce the number of competing providers so the ability of authorities to gain such a discount will be reduced.

537. The CMA does not believe that any pre-existing buyer power would mitigate any of the identified SLCs arising from the Merger.

Conclusion on competitive assessment

538. For the reasons explained above, the CMA does not believe that the Merger gives rise to a realistic prospect of an SLC in relation to the supply of Rehabilitation Services in the local catchment areas of six Priory sites: *Braeburn House, Cheadle Royal, Cloisters, Dewsbury, Hayes Grove* and *Market Weighton*.

539. For the reasons explained above, the CMA believes that the Merger gives rise to a realistic prospect of an SLC in relation to the provision of certain Rehabilitation Services by private providers in the catchment areas of 13 Priory sites: *Aberdare, Chadwick Lodge and Eaglestone View, Bristol, Church*

Village, Keighley, Hemel Hempstead, Highbank Center, Middleton St George, Recovery First, St Neots, Sturt House, Ticehurst and *Ty Gwyn Hall.*[262]

[262] The relevant product frame of reference in which a realistic prospect of an SLC was identified is set out in the detailed local assessment.

Addictions Services

540. The Parties both provide Addictions Services, including for patients requiring a detoxification stage (for sufferers of substance abuse), rehabilitation and also aftercare through outpatient services. Addictions, such as substance misuse, can also be treated in acute or secure settings or addressed through other services when patients (who may have an addiction problem) suffering from other mental health issues are admitted to inpatient care.

541. PiC only provides these services at one facility in Southampton, whilst Priory provides these services at 20 facilities across the country.[263]

542. The vast majority of the Parties' turnover for this Overlap Service is in relation to private patients (whether insured or self-pay). The CMA focussed its assessment on the supply of Addictions Services to private patients.[264]

543. The CMA investigated whether there were further segments within the supply of Addictions Services that could constitute distinct frames of references. The parties submitted that addictions should not be segmented further by the treatment of patients suffering from addictions to alcohol, drugs, gambling, etc., because facilities treating one addiction will be capable of treating any other addictions. The CMA's investigation supported this submission.

544. The CMA notes that the market could potentially be widened to include Addictions Services provided at care homes or in other clinical settings (such as Acute hospitals). However, widening the market in this way did not change the CMA's assessment of this Overlap Service. The CMA did not need to conclude on the precise product frame of reference with regard to Addictions Services since the Merger does not give rise to concerns on any plausible basis.

545. The CMA believes that the supply of Addictions Services is likely to be local though, again, the CMA did not need to conclude on the precise geographic frame of reference with regard to Addictions Services since the Merger does not give rise to concerns on any plausible basis.

546. The Parties' 80% catchment areas for Addictions Services were [125-150] miles for the PiC facility and an average of [25-50] miles for Priory's facilities.

---

[263] PiC's Manor Clinic operates from a registered care home, which may not be able to offer more complex treatments for co-occurring disorders to all types of patients. [✂] do not offer a 'detox' stage, which is required for patients with substance misuse.

[264] The CMA notes that, for PiC, of the [✂] patients admitted in 2015, only [✂] were NHS patients. Similarly, for Priory, of the [✂] patients admitted in 2015, only [✂] were NHS patients.

When these catchment areas were applied to the PiC facility in Southampton and the nearest Priory facility (ie the only local overlap), the combined shares of supply were between [10-20]% with an increment of [0-5]%.

547. Post-Merger, there will be at least 8 other providers (using Priory's catchment area centred on the PiC facility) and 30 (using PiC's catchment area centred on the PiC facility).

548. The CMA did not receive any concerns from customers or competitors in relation to this Overlap Service.

549. In light of the above, the CMA does not believe that there is a realistic prospect of an SLC as a result of the Merger in relation to the supply of Addictions Services in any market or markets in the UK.

Care Homes

550. The Parties both operate care homes (also known as 'social care services') to individuals with severe and/or enduring mental health problems, including LD, ASD, ABI, neuro-degenerative disorders (such as dementia), and/or physical disabilities. Care homes are distinct from rehabilitation services, which are provided in hospitals and focus on treating an individual preparing them for community living.[265]

551. PiC and Priory both offer care home services to individuals with ABI, LD, MI. PiC provides some care homes for CAMHS where the Priory does not. The Priory also provides residential care homes for the elderly and for dementia residents but PiC does not.[266]

552. The Priory has 225 care homes and PiC has 25 care homes in the UK.[267] The Parties supply the vast majority of these services to local authorities responsible for social services or the NHS.[268]

553. Consistent with its approach in relation to other Overlap Services, the CMA conducted its assessment by considering narrower segments (eg for patients suffering from ABI) to determine whether this gave rise to additional concerns. The CMA understands that there is limited demand for single gender care homes: for example, only 3 out of 36 of PiC's care home wards for adults are single gender.

554. The Parties further submitted that, if the frame of reference was further segmented (specifically between care homes for individuals with LD and MI in line with the OFT's approach in *Advent/Priory*), the Transaction would not give rise to any local overlaps due to there being no care homes in the same segment within the same local authority area.[269]

555. Consistent with past decisional practice,[270] the CMA assessed the potential impact of the Merger at a local level on the basis of catchment areas of 10 miles, centred on each PiC and Priory site to identify the extent of any

---

[265] Merger Notice, Appendix D, paragraph 2.2.

[266] Merger Notice, Appendix D, paragraph 4.2.

[267] Merger Notice, Appendix D, paragraph 1.3.

[268] Merger Notice, Appendix D, paragraph 3.1.

[269] Merger Notice, Appendix D, paragraph 8.3.

[270] *Anticipated acquisition by Advent International Corporation of Priory Investments Holdings Limited* (Advent/Priory).

overlap, and on the basis of a common local authority area.[271] As a further sensitivity check, the CMA also assessed whether potential competition concerns could arise on a wider catchment area of 20 miles.

556. The CMA found that:

(a) in a local authority catchment area, there were three local authorities where the Parties overlapped. However, in each of these areas the Parties' share of supply was 25% or less and the increment was [0-10%];

(b) on a 10 mile catchment area, there were 12 local areas where the Parties overlapped. However, in each of these areas the Parties' share of supply was 25% or less and the increment was [0-10%]; and

(c) on a 20 mile catchment area, there were 58 local areas where the Parties overlapped. However, in each of these areas the Parties' share of supply was 25% or less and the increment was [0-10%].

557. The CMA found that, in the areas where the Parties overlap on the basis of either being in the same local authority, or a 10 mile or 20 mile catchment area, the Parties were not each other's closest competitors (by location) and that there would be numerous alternative providers present post-Merger. As noted in paragraph 554, they also did not have the same specialism.

558. The CMA did not receive any concerns from customers or competitors in relation to this Overlap Service.

559. In light of the above, the CMA does not believe that the Merger gives rise to a realistic prospect of an SLC in relation to the supply of Care Homes in any market or markets in the UK.

[271] Ibid, above.

Third party views

560. The CMA contacted customers and competitors of the Parties, including NHS Improvement, NHSE, NHSW, NHS Scotland, NHS CCGs, NHS trusts and private healthcare providers. Many customers raised concerns with the Merger, including that it could lead to an increase in the price or a decrease in the quality of services supplied to the NHS in a number of the relevant product frames of reference.

561. Third party comments have been taken into account where appropriate in the competitive assessment above.

Conclusion on substantial lessening of competition

562. Based on the evidence set out above, the CMA believes that it is or may be the case that the Merger has resulted, or may be expected to result, in an SLC as a result of horizontal unilateral effects in relation to:

(a) the supply of low secure male LD Secure Services in the catchment area of *Priory Cefn Carnau* to national NHS commissioning bodies;

(b) the supply of medium secure male MI/PD Secure Services, medium secure female MI/PD Secure Services, low secure male MI/PD Secure Services, and low secure female MI/PD Secure Services in the catchment area of *Priory Chadwick Lodge and Eaglestone View* to national NHS commissioning bodies;

(c) the supply of medium secure male MI/PD Secure Services and low secure female MI/PD Secure Services in the catchment area of *Priory Farmfield* to national NHS commissioning bodies;

(d) the supply of medium secure male MI/PD Secure Services and low secure male MI/PD Secure Services in the catchment area of *Priory Thornford Park* to national NHS commissioning bodies;[272]

(e) the supply of CAMHS ED 13-18 Services in the area between the Priory sites of *Roehampton* and *Chelmsford* and the PiC facility of *Rhodes Wood*;

[272] The CMA refers to each of the four Priory sites supplying the relevant Secure Services whilst noting that concerns also arise when the catchment area is centred around the relevant PiC site(s) that overlap(s) with each of the identified Priory sites.

(f) the supply of Acute Services in the catchment area of *PiC Dene* (male only and combined);

(g) the supply of Acute Services in the catchment area of *PiC Kneesworth* (female only and combined);[273]

(h) the supply of PICU Services in the catchment area of *Priory Cheadle* (male only, female only and combined);[274] and

(i) the supply of certain Rehabilitation Services in each of the catchment areas of the Priory sites at *Aberdare, Bristol, Chadwick Lodge and Eaglestone View, Church Village, Hemel Hempstead, Highbank Center, Keighley, Middleton St George, Recovery First, St Neots, Sturt House, Ticehurst* and *Ty Gwyn Hall* to CCGs, NHS trusts and local authorities.[275]

Decision

563. Consequently, the CMA believes that it is or may be the case that the Merger has resulted, or may be expected to result, in an SLC within a market or markets in the United Kingdom.

564. The CMA therefore believes that it is under a duty to refer under section 22(1) of the Act. However, the duty to refer is not exercised[276] whilst the CMA is considering whether to accept undertakings[277] instead of making such a reference. Acadia has until 21 July 2016[278] to offer an undertaking to the CMA.[279] The CMA will refer the Merger for a phase 2 investigation[280] if Acadia does not offer an undertaking by this date; if Acadia indicates before this date

---

[273] The CMA refers to each of the two PiC sites supplying Acute Services whilst noting that concerns also arise when the catchment area is centred around the relevant Priory site(s) that overlap(s) with each PiC site.

[274] The catchment area of Priory Cheadle includes [✂]. The concern arises in this local area as a result of the overlap between both of these Priory sites and the two nearby PiC sites, as discussed further in the competitive assessment.

[275] The specific segments within Rehabilitation Services for each of the relevant catchment areas where a realistic prospect of an SLC has been identified are set out in the competitive assessment of Rehabilitation Services. The CMA refers to each of the relevant Priory sites providing the affected services, whilst noting that concerns also arise when the catchment area is centred around nearby PiC sites that overlap with the Priory site.

[276] Section 22(3)(b) of the Act.

[277] Section 73 of the Act.

[278] Section 73A(1) of the Act.

[279] Section 73(2) of the Act.

[280] Sections 22(1) and 34ZA(2) of the Act.

that it does not wish to offer an undertaking; or if the CMA decides[281] by 28 July 2016 that there are no reasonable grounds for believing that it might accept the undertaking offered by Acadia or a modified version of it.

Andrea Coscelli
Acting Chief Executive
Competition and Markets Authority, 14 July 2016

---

[i] With reference to Table 9, the CMA wishes to correct the figures in columns 3 and 5 of the final decision, which were inadvertently swapped. The Parties' combined Acute Services bed share for combined genders was in fact [90-100]% in relation to PiC The Dene and [70-80]% in relation to PiC Kneesworth.

[281] Section 73A(2) of the Act.