COMPLETED ACQUISITION BY UNIVERSAL HEALTH SERVICES (UHS) OF THE CAMBIAN ADULT SERVICES DIVISION OF CAMBIAN GROUP PLC

RESPONSE TO PHASE 1 DECISION

17 MAY 2017

Confidential Information indicated by [✂].

COMPLETED ACQUISITION BY UNIVERSAL HEALTH SERVICES (UHS) OF THE

CAMBIAN ADULT SERVICES DIVISION OF CAMBIAN GROUP PLC

1. INTRODUCTION AND EXECUTIVE SUMMARY

1.1 As requested in the letter from the CMA Panel Chair to Ms Osteen dated 3 May 2017 (the **"First Day Letter"**), this document sets out the response of Universal Health Services, Inc (**"UHS"**), Cygnet Health Care Limited (**"Cygnet"**) and the Cambian Adult Services business (**"CAS"**) (together, the **"Parties"**) to the CMA's Phase 1 decision dated 21 April 2017 (the **"Decision"**).

1.2 As requested in the First Day Letter, this document focuses on those areas of fact, analysis and reasoning set out in the Decision with which the Parties disagree, and where they consider the CMA, during its Phase 2 review, should focus its evidence gathering and analysis.

Background

1.3 The transaction relates to the purchase, pursuant to a sale and purchase agreement dated 5 December 2016, by Cygnet of CAS from the Cambian Group plc.

1.4 UHS is a healthcare management company listed on the New York Stock Exchange. In 2014, UHS acquired Cygnet, which operates 19 mental health hospitals and two residential nursing homes for the elderly across the UK. Cygnet provides a range of services for individuals suffering from a variety of mental health conditions at different stages of the mental health care pathway. It focuses on providing treatment at the higher end of the security scale, e.g. in medium and low secure hospitals, and the higher end of the acuity scale, e.g. acute psychiatric services and psychiatric intensive care units (**"PICU"**).

1.5 CAS is a UK-based provider of specialist behavioural health services for adults in the UK. In particular, services provided by CAS include: providing specialist mental health and rehabilitation services, and residential care home services for patients with mental health conditions. In contrast to Cygnet, CAS focuses on providing services at the lower end of the security scale and mental health care pathway, e.g. providing community-focused rehabilitation services and residential care homes in the community sector, with only one site providing mental health treatment in a low secure environment. Accordingly, the transaction should be viewed as being largely complementary.

1.6 As set out in the Decision,[1] the only overlap between the Parties is in relation to the provision of rehabilitation services. This is consistent with the Parties' submissions in the Parties' merger notice of 20 February 2017 (**"Merger Notice"**)[2]. The Decision does not identify any overlaps between the Parties in relation to:

(a) CAS's single low secure facility (based in Nottingham);

(b) CAS's residential care homes in the community sector for patients with mental health disorders;

(c) the specialist PICU, Acute Psychiatric, and CAMHS services operated by Cygnet; or

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[1] Decision, footnote 2.

[2] Merger Notice, paragraphs 3.8-3.20.

(d) the specialist services provided by Cygnet to patients with addictions or eating disorders.

1.7 Accordingly, this submission focuses only on the provision of rehabilitation services, and, in particular, the sites where the Decision identified a realistic prospect of an SLC.

1.8 Although the announcement of the Decision stated that the CMA has identified concerns in relation to LTMH in eight areas, and in relation to PD services in four areas, the Parties consider that these areas are most logically considered grouped into six areas of overlap, as set out in the table below.

Table 1.1 - Summary of overlaps giving rise to a SLC in the Decision

Treatment type	Cygnet site	CAS overlap site(s)
LTMH male	Cygnet Derby (Wyvern ward)	Storthfield House The Limes Sherwood House
	Cygnet Brighouse*	Cambian Oaks
PD female	Bierley (Bowling Ward)*	Cambian Acer Clinic Cambian Aspen clinic
	Kewstoke (Knightstone Ward)	Cambian Alders
LTMH female	Cygnet Coventry (planned site)*	Raglan house
	Kewstoke (The Lodge)	St Teilo House

Source: The Decision. *These sites were not found to give rise to a separate SLC.

Over-arching issues

1.9 The Parties consider that there are a number of material flaws and/or inconsistencies in the Decision. In particular:

(a) **The cautious approach to assessing competition at the local level.** The Decision makes clear that a cautious approach was adopted to assessing competition at the local level owing to the fact that "*the merger represents the second major transaction in the sector in the past 12 months*".[3] However, the Parties were not made aware of any concerns with respect to consolidation at the national level until the Issues Meeting. The Decision acknowledges that the Parties' combined shares of supply do not give rise to any national concerns, therefore it remains unclear why this resulted in a cautious approach being adopted at the local level. No evidence was presented in the Decision to suggest that Clinical Commissioning Groups' (**"CCGs"**) referral decisions are limited to, or influenced by, those providers with a national coverage, nor does the Decision set out any evidence to indicate that the smaller operators do not compete effectively with the Parties at the local level.

(b) **Failure to take into account key evidence and arguments.** A number of important points raised in the response to the Issues Letter and in the Issues Meeting have not been taken into account or addressed in the Decision, including evidence in relation to: (i) the importance of CCG framework agreements (particularly in relation to the overlaps in the East Midlands), (ii) [✂] (iii) the competitive constraint of NHS providers, (iv) CCG referral patterns, (v) the constraint of more geographically proximate competitor sites; and (vi) the assumptions used to calculate market shares.

[3] Decision, paragraph 56. The first case being the acquisition of The Priory Group by Acadia.

(c) **Failure to take into account evidence of additional competitors.** Additional competitor evidence submitted in response to the Issues Letter has been given very limited evidential weight in the Decision on the basis that it was submitted "late in the process". The Parties disagree that submission of evidence with the response to the Issues Letter can be characterised as "late" given the limited visibility of competitor data in the relevant markets, the nature of the Phase 1 process and the fact the Parties were not informed of the areas of concern until the "state of play" call.

(d) **Exclusion of NHS bed capacity from the share of supply analysis**. The Parties consider that the Decision presents a flawed picture of competition by excluding the constraint provided by all NHS providers. The Parties consider that NHS providers clearly compete with private providers in the provision of mental health services. Firstly, the exclusion of NHS providers assumes that CCGs are placing patients in a manner inconsistent with the Department of Health's "Any Qualified Provider" guidance. Secondly, the reasons behind the decision to exclude the competitive constraint of NHS providers are inconsistent with (i) the analytical approach followed when assessing the competitive constraint of the Parties' sites on each other; and (ii) evidence provided in relation to the Parties' own dealings with CCGs.

(e) **The Decision relies heavily on a small number of third party comments**. It is unclear from the Decision: (i) how many complaints were made by commissioners in relation to the catchment areas in relation to which an SLC has been identified; (ii) the nature of those complaints; (iii) the number of third parties that were generally supportive or indifferent about the transaction; and (iv) whether third-party comments were verified against actual contemporaneous evidence (e.g. in relation to actual referral distances). The lack of any detailed disclosure of the third party comments received by the CMA has meant that it is difficult for the Parties to comment in any detail. Based on the limited information that has been set out in the Decision, the Parties consider that undue weight has been given to unrepresentative third party comments.

(f) **Third party comments are inconsistent and often taken out of context**. The Decision disregards third party comments which refer to (i) competitor sites located outside the catchment area, (ii) competition from NHS providers, or (iii) the differentiation in the Parties' services (in relation to PD), but appears to overstate any concerns raised (e.g. the Decision assigns the same third party comments to a number of sites in the East Midlands). Even where no third party concerns have been raised (e.g. in relation to Raglan House), the Decision indicates that limited weight can be placed on that fact.

Approach to assessing the geographic market

1.10 The Parties consider that the assessment of the relevant geographic markets on an overly-conservative basis is a key factor leading to the SLC conclusion in the relevant local areas. In particular:

(a) **The Decision underreports CCG views on patient referral distances** by: (i) placing too great an evidential weight on anecdotal CCG evidence, without testing it against actual referral behaviour; (ii) using median distances (rather than the mean) to "remove outliers" (i.e. excluding the views of commissioners that refer patients over a wider distance); and (iii) asking commissioners about a "typical" placement rather than investigating how far commissioners actually send patients or how they would respond in the event of a relative change in prices.

(b) **The Decision applies arbitrary and inconsistent approaches to the identification of catchment areas.** In a number of cases, the SLC conclusions

have been reached as a result of the arbitrary and inconsistent approaches to the identification of catchment areas (e.g. mixing treatment average and site-specific catchment areas), focusing on the approach which gives rise to the highest shares of supply numbers rather than the areas over which competition takes place. The approach adopted departs from: (i) ordinary market definition principles (including the "SSNIP" test), (ii) the CMA's decisional practice (including in Acadia/Priory), and (iii) the CMA's Commentary on Retail Mergers. It is important, therefore, for the CMA in Phase 2 to adopt a credible, consistent and evidence-based local geographic market based on solid economic principles.

(c) **Patient postcode data [✂]** The use of CCG postcode data where [✂] to assess 80 per cent catchment areas means that the catchment area data is subject to significant uncertainty owing to the following factors: (i) CCGs often cover large geographic areas, (ii) some CCGs use framework agreements when selecting providers, and (iii) some CCGs coordinate patient referral and funding (e.g. within the framework agreement) and are therefore over represented in the patient data.

(d) **The number of observations is too small and very sensitive to small changes.** The uncertainty around calculating site-specific catchment areas is compounded by the limited number of data points available at many of the sites in question, with the catchment areas being extremely sensitive to even very small changes in the number of patients considered. The Parties consider that calculating an average catchment area for each treatment type provides a more robust estimate, and provides a better representation of the behaviour of commissioners across England and Wales.

(e) **Catchment areas understate the scope of the geographic market**. The CMA's Merger Assessment Guidelines acknowledge that "*the geographic market identified using the hypothetical monopolist test will typically be wider than a catchment area*". Accordingly, the catchment area approach used in the Decision systematically understates the geographic area over which CCGs would be willing to send patients in the event of a hypothetical increase in price post-merger.

(f) **The Decision does not consider competition from outside the catchment area.** The sensitivity analysis around the geographic catchment areas used in the site by site analysis only appears to have been included in the local analysis where it results in a materially worse position for the Parties, and no weight has been given to competitors just outside the catchment area.

(g) **Market shares of the Parties are consistently overstated.** The Parties' market shares (calculated by number of beds) are also likely to be overstated for a number of methodological reasons. In particular:

- the list of competitors (and the breakdown between treatment types) that has been provided by the Parties is unlikely to represent an exhaustive list of all providers of rehabilitation services in Great Britain;
- the inclusion of the Parties' planned sites, but not those of rivals (which the Parties are unaware of);
- where rival hospitals provide more than one treatment type on the same ward, the number of beds have been allocated in fixed numbers between treatment types, when it is reasonable to assume that all beds could readily be used for either treatment offered; and
- where a competitor site is classed as a mixed gender ward, the beds have been arbitrarily allocated 65:35 towards male patients even when this is not the case, or the site has flexibility.

Male LTMH sites

1.11 The Decision identifies a realistic prospect of an SLC in relation to LTMH Male sites in two areas:

(a) the overlap in the East Midlands between Cygnet Hospital Derby and three CAS sites (Storthfield House, Sherwood House and The Limes); and

(b) the overlap in the North of England between Cygnet Brighouse and Cambian Oaks.

East Midlands sites

1.12 **Site-specific catchment areas are too narrow.** For each of the sites in the East Midlands the Decision has used the site-specific catchment area. The Parties presented a number of reasons why the site-specific catchment areas are too narrow in the response to the Issues Letter. The Decision has failed to address this evidence, which includes:

(a) the impact of [✂] being referred under the East Midlands Rehabilitation Framework agreement, which covers a much broader geographic area than the site specific catchment areas;

(b) CCG postcode data being a poor proxy for patient postcode data as, in relation to the East Midlands Rehabilitation Framework agreement, patient referral and funding is coordinated on a centralised basis, with a limited number of CCGs making referral decisions on behalf of others;

(c) CCG referral data of the Parties' five largest customers at each of the overlapping sites in the East Midlands, which indicates that almost all CCGs send patients to other LTMH sites of the Parties more than [✂] miles away;

(d) the Parties' sites treat patients from a [✂] than indicated by the site specific catchment areas; and

(e) third parties referred to competitors from outside the site specific catchment areas used in the Decision, which were ignored in the market share calculations.

1.13 **No analysis of the importance of the East Midlands Rehabilitation Framework.** The Decision provides no consideration as to how the Parties are constrained by the East Midlands Rehabilitation Framework agreement, which sets the terms under which services will be provided to [✂] CCGs in the East Midlands area, [✂].

1.14 **The market shares of the Parties are overstated** for the following reasons:

(a) **The role of NHS providers in the area has been ignored.** There are a number of significant NHS providers of male LTMH services in the area (including a number on the East Midlands framework agreement), which compete with the Parties, but which are not included in the Decision.

(b) **Additional competitor evidence.** If the additional competitors excluded from the share of supply analysis are considered, the Parties have a combined share of supply of less than [✂] per cent at all sites.

(c) **Competition from outside the catchment area.** The Parties identified a number of competing sites just outside the site specific catchment areas. Each of these competing sites will have a catchment area which overlaps (to a large extent) with that of certain of the CAS/Cygnet sites and therefore provides a further competitive constraint. The Decision does not provide any reason why the competitive constraint provided by these sites has been disregarded.

1.15 [✂].

1.16 **The Parties are not each other's closest competitors by geography.** Notwithstanding any statements to the contrary in the Decision, Cygnet Hospital Derby and the CAS facilities are not each other's closest competitors by geography.

1.17 **The emphasis on third party evidence and internal documents is overstated.** The Decision relies unduly on third party comments, which are not site specific, and applies the same third party comment to each site. The Decision has also relied heavily on a single internal document, taken out of context, to support its conclusion of an SLC in relation to all four sites in this area. This analysis is flawed and, when read in context, the document supports the Parties' arguments about the wide range of competition in the East Midlands, including from NHS providers.

Cambian Oaks/Cygnet Brighouse

1.18 The Decision has identified a realistic prospect of an SLC in relation to Cambian Oaks on the basis of the Parties having a combined market share of [✂] per cent (with a [✂] per cent increment). Given the large number of competing providers in the catchment area ([✂]) and a number of competing providers just outside the catchment area, there is no basis to identify an SLC in this area, and no concern was identified for the overlapping Cygnet site.

1.19 **The market shares of the Parties are, in any event, overstated** for the following reasons:

(a) **The role of NHS providers in the area has been ignored.** The Decision does not reflect the competitive constraint from NHS sites. This is despite at least one Commissioner telling the CMA that an NHS site (Coral Lodge) competes "*on an equal footing*" with Cambian Oaks. There are a number of other NHS sites which are either closer to Cambian Oaks than Coral Lodge or a similar distance away. It is not clear to the Parties why, if Coral Lodge is considered a competitive constraint on Cambian Oaks, these other NHS sites should not be taken into account.

(b) **Additional competitor evidence.** If the additional competitors submitted by the Parties in the response to the Issues Letter are considered, the Parties' combined market share is significantly lower than that presented in the Decision. Moreover, on the basis of the treatment average catchment area, the Parties would have a combined share of supply of less than [✂] per cent.

(c) **There are a number of competing sites just outside the catchment area**. The reduction in market shares in moving from the individual to the treatment average catchment area is a result of a number of competitors just outside the site specific catchment area. Each of these sites will have a catchment area which overlaps (in large part) with Cambian Oaks and provides a further competitive constraint on the Parties.

1.20 **Site-specific catchment area is too narrow.** The Decision does not address the evidence submitted in response to the Issues Letter which is consistent with a wider catchment area for Cambian Oaks:

(a) Cambian Oaks treats patients from a [✂] than the 80 per cent catchment area;

(b) the catchment area of Cygnet Brighouse is [✂] as Cambian Oaks, despite being only 21 miles away and both sites being considered by the CMA to offer closely competing services;

(c) CCG referral data indicates that all of the top five customers for Cambian Oaks refer LTMH patients to [✂]; and

(d) the 80 per cent catchment area is based on a small number of patients and subject to significant uncertainty.

LTMH Female

1.21 The Decision identifies a realistic prospect of an SLC in relation to LTMH Female sites in two areas:

(a) the overlap in the Midlands between Cambian Raglan House and Cygnet Hospital Coventry (a recently opened Cygnet site); and

(b) the overlap in Wales/South West England between Cygnet Hospital Kewstoke (The Lodge) and Cambian St Teilo House.

Cambian Raglan House/Cygnet Coventry

1.22 **There is no evidence of actual competition between the Parties**. The Cygnet Coventry site, which is considered to overlap with Raglan House, has only recently opened (in 2017). There is no evidence presented in the Decision of any actual competition taking place between Raglan House and Cygnet Coventry, and commissioners did not express any concerns about the transaction.

1.23 **The site-specific catchment area is too narrow**. There is limited reasoning in the Decision justifying the use of a site-specific catchment area for Raglan House, instead of the treatment average area (which was used for assessing Cygnet Coventry). Moreover, the Decision ignores evidence submitted in response to the Issues Letter, which includes:

(a) sensitivities around the parameters of the site-specific catchment area used for assessing Raglan House. The inclusion of just [✂] results in the 80 per cent catchment area increasing from [✂], which results in the Parties' combined market share dropping to just [✂] per cent; and

(b) CCG referral data of the five largest customers of Raglan House indicates that almost all CCGs send patients to [✂]).

1.24 **Market shares are overstated** for the following reasons:

(a) **Additional competitor evidence.** If the additional competitors are included in the market share calculations, the Parties' combined market share falls from [✂] per cent to [✂] per cent (in the site-specific catchment area of Raglan House).

(b) **Failure to take into account ability to flex bed use.** The approach followed in the Decision to calculate the Parties' share of supply fails to take into account the number of beds available at sites which are able to offer mixed specialisms or treat patients of different genders. For example:

- two of the closest competitor sites to Raglan House (PiC/Priory Beverley House and PiC/Priory Lakeside, which are located just 2 miles and 13 miles away respectively), are combined LTMH/PD sites. [✂]; and

- a number of competitor sites (PiC/Priory Lichfield Road, Rushcliffe's Aarons Specialist Unit, and Camino Healthcare's Cromwell House and Oak House) within a [✂] mile catchment area of Raglan House are mixed gender sites. Only [✂] per cent of the beds at these sites have been allocated to treating female patients. Even assuming a 50:50 ratio results in the Parties having a combined market share of just [✂] per cent.

(c) **The role of NHS providers in the area has been ignored.** There are a number of NHS providers of female LTMH services in the area, which have been

disregarded in the Decision. This is despite an internal document in relation to Cygnet Coventry which identifies [✂].

(d) **There is significant competition from outside the catchment area.** The Parties identified a number of competing sites just outside the site specific catchment area of Raglan House. Increasing the site specific catchment area around Raglan House by just [✂] miles, results in the Parties' combined market share dropping to just [✂] per cent.

1.25 **The Parties are not each other's closest competitors by geography.** As noted in the Decision, the Parties are not each other's closest competitors by geography, with four sites being closer to Raglan House than Cygnet Coventry. Even if proximity is a factor affecting CCGs' referral decisions, there are a range of other options available.

1.26 **The emphasis placed on an internal document is incorrect.** The Decision refers to an internal Cygnet document that [✂].

1.27 **No third party concerns were raised.** The Decision notes that no third parties raised any concerns regarding the overlap with Cambian Raglan House, but the CMA has over-ruled the views of commissioners in identifying a reasonable prospect of an SLC.

St Teilo House/Kewstoke (The Lodge)

1.28 **The Decision mixes average and site specific catchment areas.** The Decision adopts an inconsistent approach to assessing catchment areas by switching between the treatment average (Kewstoke) and site-specific catchment area (St Teilo House), depending on which approach gives rise to the highest combined shares of supply. Such an approach is unrelated to the correct application of the SSNIP test, and provides an erroneous basis for assessing the competitive effects of the transaction.

1.29 **Market shares are overstated** for the following reasons:

(a) **Additional competitors.** If the additional competitors excluded from the share of supply analysis are considered, the Parties' combined market share would be significantly reduced. Moreover, on the basis of the average catchment areas, the Parties would have a combined share of supply of at most [✂] per cent at each site.

(b) **Adjustments for "step-down" patients.** In the last 12 months between [✂] of the 12 beds at Kewstoke (the Lodge) are used for internal transfers within the Kewstoke site, and therefore are not available on the market for CCGs looking to place female LTMH patients.

(c) **Competitors planned sites have not been taken into account.** The Decision states that competitors did not identify any planned sites with the catchment areas considered. However, the Parties understand that there are a number other planned sites under contemplation or in early stages of development not included in the Decision. For example, Elysium has recently announced the opening of a new 34 bed LTMH locked rehabilitation hospital in Wrexham, which falls within [✂] of St Teilo House.

(d) **Availability of female beds in mixed gender wards has been underreported.** As mentioned above, the Decision assumes that mixed gender wards are split 65:35 male to female patients. However, the Decision ignores [✂], and another is able to flex the number of beds available to men and women.

(e) **The role of NHS providers in the area.** There are a number of significant NHS providers of female LTMH services in the area, which compete with the Parties, but have been disregarded in the Decision.

1.30 **The Parties are not the most geographically proximate sites.** There are four other competitor sites in Wales in closer proximity to St Teilo House than Kewstoke (The Lodge), and there are four other competitor sites in the South West of England that are in closer proximity to Kewstoke (The Lodge) than St Teilo House. The competitor sites in Wales are therefore likely to be closer competitors to St Teilo House, whilst the competitor sites in the South-West of England are closer competitors to Kewstoke (The Lodge).

1.31 **The CMA has previously considered competition in the area.** The CMA has previously considered competition for female LTMH services in the area around St Teilo House, in its Acadia/Priory decision (i.e. in relation to the Ty Gwyn Hall site, which, as noted above, is just 19 miles from St Teilo House). The CMA found that:

(a) PiC and Priory would have had a combined share of 50-60 per cent (of beds), with an increment of 20-30 per cent, and they were the first and second largest competitors in the area;

(b) Cambian (St Teilo House) was identified as the third largest competitor with a share of just 10-20 per cent of beds; and

(c) Cygnet Kewstoke (the Lodge) was not even mentioned as providing a relevant competitive constraint on these sites.

1.32 **Third party comments.** The Decision relies on third party comments to support its SLC finding with respect to Cambian St Teilo House and Cygnet Kewstoke (The Lodge). However, those third party comments do not raise merger specific concerns regarding either Cygnet Kewstoke (The Lodge) or Cambian St Teilo House, but merely identify that, in the eyes of some commissioners, the Parties compete.

Female PD

1.33 The Decision identifies a realistic prospect of an SLC in relation to female PD sites in two areas:

(a) the overlap in the North of England between Cygnet Hospital Bierley (Bowling Ward) and two CAS sites (Cambian Acer Clinic and Cambian Aspen Clinic); and

(b) the overlap in the South of England between Cygnet Hospital Kewstoke (Knightstone Ward) and Cambian Alders Clinic.

1.34 **The parties' PD sites provide a fundamentally different service.** The Decision in respect of the differentiation of the Parties's Female PD services appears to have been influenced by a limited number of third party comments which the Parties find surprising, are inconsistent with other comments received, and fail to reflect the complementary nature of the service provided. The key differences include:

(a) All of the Cygnet PD sites provide services to the Tier 4 level of PD service specification and accept patients with the highest level of challenging behaviour and risk. In comparison, the CQC reports for Cambian Alders Clinic and Cambian Aspen Clinic make clear both are Tier 3 PD services.

(b) The NHS England service specification document describes Tier 4 PD services as providing: "*specialist and intensive provision beyond that which can be provided within either local specialist (Tier 3 PD) services or other local mental health services including acute inpatient facilities*." It also highlights the complementary nature of Tier 3 and Tier 4 services.

(c) The Cygnet wards operate within a semi-secure hospital environment, as both hospitals operate low secure and PICU wards at that site, which enables them to accept service users that have higher levels of risk.

(d) The Cygnet PD wards offer intense and specialist PD treatment programmes for acutely unwell patients which run all day, for all groups of service users. Less specialised wards, [✂], do not have the staff qualified to provide full time DBT treatment.

(e) There is a [✂] at the more specialist Cygnet facilities, which is reflected in patients receiving a higher proportion of nursing and therapy hours.

(f) Due to the acuity of patients and the intensity of the treatment programme at Cygnet's PD wards, the length of stay is shorter and the price is higher.

(g) The [✂].

1.35 Whilst CAS and Cygnet both treat female patients with PD, they are treating patients with very different levels of risk, and at different stages of the care pathway. It would be [✂].

Cambian Acer Clinic and Cambian Aspen Clinic

1.36 **Market share analysis.** The Parties' PD sites provide very different services, therefore the Parties do not consider that the market share analysis in the Decision to be a reliable indicator of competition. Despite these concerns, it is notable that:

(a) In relation to Aspen Clinic, the Decision reports that the Parties have a combined share of supply of [✂] per cent (with a [✂] per cent increment), which is only [✂] above the initial filter used in the Decision (35 per cent).

(b) In relation to Acer Clinic, the Decision reports that the Parties have a combined share of supply of [✂] per cent (with a [✂] per cent increment). However, this is on the basis of the site specific catchment area of just [✂] miles, which is based on a sample of just [✂] patients. The treatment average catchment area gives rise to a lower combined share of supply of [✂] per cent (increment [✂] per cent).

1.37 **Additional beds.** It is clear that the CMA identified additional female PD beds in the catchment areas of both Acer Clinic and Aspen Clinic, as the Decision reports lower market shares than the Parties submitted in response to the Issues Letter. Therefore, on the basis of the treatment average catchment area the Parties' combined market share will be less than [✂] per cent.

1.38 **Constraint from LTMH sites.** The Decision does not address the extent to which LTMH sites constrain Acer Clinic or Aspen Clinic, although it recognises that switching costs are likely to be lower for combined PD/LTMH sites. Cambian Acer Clinic and Cambian Aspen Clinic both treat patients with less challenging needs, and provide a service similar to LTMH sites that also treat less demanding PD patients. If other female LTMH facilities are included within the market share calculations, the Parties' combined share drops significantly, and below [✂] per cent on all bases.

1.39 **Differences in catchment areas highlight the differentiation in service.** The difference in catchment areas evidences the differentiation in service provided by their respective sites. For example, the 80 per cent catchment area for the Bierley (Bowling Ward) is [✂] miles. In comparison, the 80 per cent catchment of Cambian Acer clinic is [✂] miles.

1.40 **Third party comments are overstated.** The Decision relies heavily on the comments from a single commissioner in concluding that the services provided at Cygnet Hospital Bierley and Cambian Aspen Clinic are substitutable. However, the comments fail to reflect the fundamental difference between the [✂] provided at CAS sites.

Cygnet Hospital Kewstoke (Knightstone Ward) and Cambian Alders Clinic

1.41 **The Decision's treatment of catchment areas is inconsistent.** In relation to both Cygnet Hospital Kewstoke and Alders Clinic the Decision has used the treatment average catchment area. If the Decision had applied a consistent approach and applied a site specific catchment area, it is unlikely that an SLC would have been identified as the Parties' combined market share would be below [✂] per cent.

1.42 **Constraint from LTMH sites.** The Decision does not address the extent to which LTMH sites constrain Alders Clinic which treats patients with less challenging needs, even though it recognises that switching costs are likely to be lower for combined PD/LTMH sites and it acknowledges that there are wards providing both PD and LTMH treatment.

1.43 **Differences in catchment areas**. The 80 per cent catchment area for the Kewstoke (Knightstone Ward) is [✂] miles, and a number of patients come from even further afield. The broad catchment area reflects the specialist nature of the service provided, with commissioners being prepared to refer patients long distances for treatment.

1.44 **Third party comments are overstated.** The Decision notes that commissioners confirmed that that there is a differentiation in the level of specialism offered at Cygnet Kewstoke (Knightstone Ward) and Cambian Alders clinic, but ignores these comments on the basis that "*at least some commissioners view them as alternatives*". However, the Parties find this latter comment surprising as it does not reflect the clinical reality of the different services provided.

2. OVER-ARCHING ISSUES

2.1 The Parties consider there to be a number of material flaws and/or inconsistencies in the Decision. In particular, the Decision:

(a) adopts a very conservative approach to assessing competition at the local level, on the basis of some unsupported and poorly articulated concerns at the national level, which were not raised with the Parties in detail prior to the Issues Meeting itself;

(b) failed to address a number of key arguments made by the Parties in the response to the Issues Letter, or to take into account the additional competitors that were identified by the Parties in the areas of concern identified in the Issues Letter;

(c) has excluded all NHS bed capacity, despite NHS provision providing a significant competitive constraint to the Parties; and

(d) has relied heavily on a small number of comments from third parties, which are internally inconsistent, not site-specific and which do not appear to have been supported with evidence of referral behaviour.

2.2 Each of these points is discussed in further detail below.

The Decision's "cautious approach"

2.3 The Decision sets out, at paragraph 5, that:

> "*consistent 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 identifying all potential competition concerns.*"

2.4 The reason given in the Decision for adopting a cautious approach is "*the level of consolidation in this market, the limited number of credible providers active on a national basis, and the significant barriers to entry (including the importance of an established track record and reputation*".[4]

2.5 The concern appears to have been heavily influenced by the fact that "*the merger represents the second major transaction in the sector in the past 12 months*".[5] However, this concern was not raised with the Parties during the Phase 1 investigation, was not mentioned on the State of Play call, and did not feature in the Issues Letter.[6] The first time the Parties were made aware of any potential concerns with respect to consolidation at the national level and that these concerns would form part of the CMA's approach was when this concern was mentioned by the decision-maker at the Issues Meeting. The Parties consider that it is unfortunate that this concern was not raised earlier in the process, not least because lack of competition at the national level is not supported by the evidence, or by the findings during the Phase 1 investigation.

2.6 The Decision acknowledges in paragraph 58 that the Parties' combined shares of supply "*on a national basis are at a level below which the CMA will typically identify concerns*", and notes that it "*has not received <u>any other evidence</u> to suggest that unilateral effects concerns could arise at the national level*".

2.7 In particular, the Decision refers to the [✂] per cent estimated share "*on an all-Rehabilitation Services basis*" as being consistent with the Parties' own estimates (in

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4 Decision, paragraph 58.

5 Decision, paragraph 56. The first case being the acquisition of The Priory Group by Acadia.

6 There is a limited reference to the "limited number of players" in paragraph 49 of the Issues Letter.

Annex 15.4 of RFI3).[7] Moreover, the [✂] per cent figure is significantly higher than the share submitted by the Parties.

2.8 Appendix 13.1 of RFI1 set out the Parties' estimate of their combined market share for all rehabilitation services for England and Wales is just [✂] per cent (increment [✂] per cent). As noted in the accompanying response to RFI1, the Parties consider this number is likely to be materially overstated as the Parties do not have full visibility of all providers of rehabilitation services in the UK. Notably, the Parties' estimate did not include any provider of rehabilitation services in Scotland (as there is no overlap between the Parties in Scotland), and the analysis focused on identifying providers of rehabilitation services in the areas of overlap with the Parties' sites at the local level, rather than seeking to identify all providers of rehabilitation services within the UK. Accordingly, whilst all of the Parties' sites providing rehabilitation services are included in the national market share calculations, the sites of certain competitors are likely to be excluded, which will overstate the Parties' position.

2.9 The Decision also acknowledges that rehabilitation services are purchased and negotiated at a local level,[8] which is consistent with the CMA's findings in the Acadia/Priory decision (and is supported by the evidence provided by commissioners). This further indicates that the key focus of competition for rehabilitation services is at the local level, and there is no clear nexus between the apparent concern over the limited number of credible national competitors, and the decision to adopt a cautious approach for the purposes of assessing competition at the local level.

2.10 It is clear (and not at issue in the Decision) that there are many different providers of rehabilitation services available throughout the UK, and even the small (single site) operators are commercially viable. In this regard, all providers of rehabilitation services are reliant on CCGs for patient referrals, and the standards of care are assessed on a consistent basis for similar services by the CQC. The Decision does not present any evidence to suggest that CCG referral decisions are limited to, or influenced by, those providers with a national coverage, nor does it set out any evidence to indicate that the smaller operators do not compete effectively with the Parties.

2.11 Accordingly, whilst the Parties acknowledge that the CMA has a margin of discretion for deciding whether a transaction gives rise to a realistic prospect of a SLC at Phase 1, the analysis set out in the Decision indicates that a cautious approach was adopted. Therefore, by implication, in deciding to refer the transaction, the CMA was acting close to the limits of that discretion.

Failure to take into account evidence

Points not addressed in the Decision

2.12 A review of the Decision indicates that it has failed to take into consideration a significant amount of additional evidence and argumentation that was submitted by the Parties in response to the Issues Letter.

2.13 As the Decision does not address a number of the points made by the Parties, it is unclear whether such evidence was not considered, was considered to be unimportant, or indeed whether the CMA agreed or disagreed with it. Examples include the following:

(a) the Decision does not address the importance of the East Midlands Rehabilitation Framework agreement to the Parties' sits in the East Midlands (as set out

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[7] Decision, footnote 24. This reference is confusing, since no such Annex was contained in RFI3, although the Parties consider it most likely to refer to Annex 15.3 to the Merger Notice, an updated version of which was provided with the response to RFI3.

[8] Decision, paragraph 55.

paragraphs 3.37-3.39 of the response to the Issue Letter). The East Midlands Rehabilitation Framework accounts for a [✂]. As acknowledged in paragraph 14 of the Issues Letter, in circumstances in which services are commissioned under broad framework agreements, prices are agreed upfront through competitive tender. In this regard, the Parties are aware of at least [✂] different operators on the framework agreement, including NHS providers;

(b) as set out in paragraph 3.40 of the response to the Issues Letter, [✂] and therefore is not a close competitor to the CAS sites in the East Midlands. The Decision does not even mention that this argument was raised, let alone address it;

(c) there is a significant amount of NHS provision identified within the overlap areas (see Tables 3.4, 3.7, 4.3 and 4.7 of the response to the Issue Letter). In this regard, the Decision asserts at paragraph 48 that "*there is little or no NHS provision for the specialisms in which the Parties overlap in most local areas*". No reference is made in the Decision to the NHS provision identified by the Parties;

(d) the Decision does not respond to the evidence submitted in relation to commissioner referral patterns, which indicates that the vast majority of CCGs refer patients to other sites operated by the Parties more than [✂] (see paragraphs 3.13, 3.52, 4.14, and 4.51-4.55 of the response to the Issue Letter). The evidence of actual CCG referral patterns is clearly inconsistent with some of the comments received by the CMA from Commissioners;

(e) despite the Decision setting out in paragraph 80(b) that the distance between the Parties' hospitals is important to the competitive assessment, the Decision has given limited weight, if any, to the Parties' analysis which demonstrates that there are, for most sites, a number of more geographically proximate competitor sites than the other sites operated by the Parties;

(f) the CMA has continued to use an arbitrary assumption for allocating bed numbers between male and female patients even where site-specific evidence has been provided by the Parties. For example, in relation to Kewstoke (The Lodge), an Elysium site (The Copse) is located just five miles away and evidence was submitted to show that it is split [✂] between male and female patients (see Figure 4.2 of the response to the Issues Letter). The Parties also understand that Elysium Ty Gwyn Hall, which is located just 19 miles from St Teilo House, is also [✂], which significantly reduces the Parties' combined market share. The Decision states "*The CMA did not have any evidence for the particular competitor sites in question to depart from this position*"[9] which, at least for the The Copse, is not correct; and

(g) the Decision does not address the point raised by the Parties that it has previously considered competition around St Teilo House in its *Acadia/Priory* decision. In particular, the CMA required Acadia/Priory to divest Ty Gwyn Hall (which, as mentioned above, is just 19 miles from St Teilo House) to Elysium on the basis that PiC and Priory would have had a combined share of 50-60 per cent (of beds), with an increment of 20-30 per cent. Cambian St Teilo House was specifically identified as the third largest competitor in the area with a share of just 10-20 per cent of beds, and Kewstoke (The Lodge) was not even mentioned as a competitor.

2.14 Whilst the Parties recognise that a CMA Phase 1 decision cannot cover every point discussed during Phase 1, the Parties consider that each of these points was clearly raised in the response to the Issues Letter and in the Issues Meeting and should have been addressed in the Decision.

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[9] Decision, paragraph 151.

Other competitors identified by the Parties

2.15 As noted above, the competitor information used in the market share analysis is based on the Parties' knowledge of their competitors and publicly available information, and was developed from scratch, focusing on the areas of overlap between the Parties. Given the number of sites involved in the transaction, and the resource intensive nature of this type of bottom-up analysis, the Parties highlighted to the CMA on a number of occasions in their responses to the requests for information that certain competitors may have been omitted from the initial market share calculations.

2.16 As is frequently the case, the first indication that the Parties were given of the areas of concern was during the state of play call with the case team on 17 March 2017. Following that call, Cygnet commissioned a piece of review work from a consultant [✂] to conduct a review of the local areas around the possible areas of concern and to identify any further rehabilitation sites that they are aware of where CCGs refer patients, and therefore provide a competitive alternative to the Parties in those areas. Following this further review, a number of additional competing sites were identified, which were listed in Annex 1 to the response to the Issues Letter, and revised market share calculations were included in the response.[10]

2.17 Paragraph 84 of the decision states that "*Late in the CMA's process, the Parties' submitted a list of further competitors which had not been previously identified by the Parties or Commissioners as credible alternatives*". The Parties do not consider that evidence submitted in the response to the Issues Letter within the specified deadlines can justifiably be considered to have been provided too "late" for it to be given due evidential weight bearing in mind: (i) the limited visibility of competitor data in the relevant markets, (ii) the nature of the Phase 1 process, and (iii) the fact that the areas of concern were not identified to the Parties until the state of play call. Accordingly, the market share analysis in the Decision should have taken due account of the additional competitor evidence submitted in the response to the Issues Letter. Indeed, the very purpose of the Issues Letter and seeking a response to it is to elicit additional evidence in the areas of focus to inform the CMA's decision.

2.18 The full breakdown of the Parties' and competitors' revised market shares for each of the overlapping sites is set out in Annex 2 of the response to the Issues Letter.

2.19 The Parties also note that various adjustments have been made to the Parties' market share calculations which have not been explained to them and which the Parties cannot reconcile, with the effect being to increase the Parties' shares in each case.

CMA has excluded all NHS provision

2.20 The Decision states[11] that the transaction has been assessed by excluding <u>all</u> NHS providers of rehabilitation services from the market.[12] The CMA's reasons for exercising such broad discretion in rejecting this source of competition appear to be: (i) that there is an overall shortage of supply within the NHS, and (ii) that some commissioners have indicated that they would generally use NHS beds first before considering private provision.

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10 Almost all of the additional sites identified have a current CQC or HIW report and are registered mental health hospitals, the vast majority of which provide LTMH rehabilitation services.

11 Decision, paragraph 51.

12 Although Decision, footnote 21 states that the CMA did consider NHS Trust facilities where they fell within a catchment area, this does not appear to be the case in the site-by-site analysis in the Decision, with the only reference being in paragraph 142 and even then this facility was not reflected in the local market shares, which would have dropped below 40 per cent.

2.21 The Parties do not consider this reasoning to be correct. The Parties consider that NHS-funded services clearly do compete with private providers in the provision of rehabilitation services, and NHS provision is a significant competitive constraint on the Parties that the CMA should take into account.

2.22 In particular, CCGs (the customer of mental health rehabilitation services) have a range of options available when looking to source treatment for rehabilitation patients. In this context, the Department of Health's guidance to CCGs emphasises the ability for commissioners and patients to choose services from "Any Qualified Provider", whether they be NHS or private sector providers. The NHS guidance makes clear that "Primary Care Psychological Therapies (adults)" are a priority area for the implementation of the any qualified provider policy.

2.23 This approach is consistent with the Parties' experience, and with the feedback that they receive from CCGs. It is not the Parties' experience that CCGs only refer to independent providers when there is no NHS capacity. In particular, the Parties are often told they are competing directly with NHS providers and CCGs will refer patients to the Parties even when a nearby NHS site has spare capacity. The Parties are also sometimes asked to match the prices at NHS facilities, and in some locations understand from CCGs that NHS providers charge higher rates than the Parties. [✂].

2.24 In relation to the statement at paragraph 48 of the Decision that "*there is little or no NHS provision for the specialisms in which the parties overlap in most local areas*", the Parties consider this is not factually correct, as demonstrated in the Parties' response to the Issues Letter and as set out further below.

2.25 Rehabilitation services are also less time critical than other mental health services (e.g. PICU) and admissions can be delayed until a suitable facility becomes available. In this regard, the [✂]. Whilst the Decision expresses doubt at paragraph 50, many NHS wards, and indeed a number of the Parties' wards, operate significant waiting lists for rehabilitation patients (whilst there is capacity at other services). This would not be the case if commissioners were unwilling to wait for the service they consider most appropriate for the patient, with this willingness being possible because rehabilitation patients are, by definition, not acutely unwell.

2.26 The inconsistency in the CMA's reasoning is also evident when a comparison is made between the CMA's conclusions in respect of the competitive constraint provided by NHS providers and Cygnet Derby. In particular, as set out in paragraph 3.40 of the Parties' response to the Issues Letter, the [✂].

2.27 It is also notable that NHS providers often convert existing capacity or open new sites in order to meet changes in regional demand. For example, the Parties are aware of the following sites being converted or opened by the NHS in the last five years:

(a) in 2012 Leeds and York Partnership NHS Foundation Trust converted a 18 bed acute/older adults ward at the Newsam Centre, Seacroft Hospital into a new male lock LTMH ward to meet regional demand;

(b) in 2012 Lincolnshire Partnership NHS Foundation Trust opened a new site (Discovery House), a 45 bed male and female locked LTMH service to meet regional demand. Although some of the beds at this site replaced existing beds, a number were additional;

(c) in 2016 Greater Manchester West NHS Foundation Trust redeveloped Charles House, which was a 24 bed secure unit, into a 28 bed male locked LTMH service called Braeburn House. This was used to repatriate patients out of the independent sector and patients were transferred out of Cygnet Brighouse and Cambian Fountains; and

(d) in 2016 Avon and Wiltshire Mental Health Partnership NHS Trust opened a 10 bed mixed LTMH service (Larch Ward) at Callington Road Hospital, Bristol in order to meet regional demand.

2.28 These examples clearly suggest the NHS is competing with the Parties by making significant changes to meet changes in demand. This is also consistent with Cygnet's internal documents. For example, the internal Cygnet document referred to at paragraph 169 of the Decision makes reference to [✂].

2.29 Accordingly, in light of the above factors, the Parties consider that their respective market positions have been materially overstated as a significant part of the market has been overlooked. The Parties would therefore request that the CMA focuses on NHS provision as part of its Phase 2 investigation.

Third party comments are overstated

2.30 It is evident from the decision that it relies heavily on a small number of third party comments. However, it is unclear from the decision:

(a) precisely how many complaints were made by commissioners in relation to the overlaps identified in the Decision as giving rise to an SLC (the Decision states at paragraph 230 that "*many commissioners raised concerns with the merger*", which is a much stronger statement than was previously mentioned in the Issues Letter). Despite a request on behalf of the Parties following the state of play call for a broad statistical breakdown of how many CCGs were asked questions, how many responded and how many raised concerns, the CMA refused to provide this information to the Parties;

(b) the nature of the complaints raised (i.e. whether they include generalised complaints about the market which are not site specific and not related to the transaction);

(c) the format of the questions asked by the CMA. In particular, whether leading questions were asked in the market questionnaire as to whether commissioners were concerned about the transaction or not;

(d) a comparison of the number of complaints compared to the number of third parties that were either generally supportive of or neutral to the transaction. It is highly relevant to understand the reasons for the dissenting views of CCGs, particularly where CCGs are co-located and face similar choices for patient referrals; and

(e) whether the CMA sought to verify third-party comments against actual contemporaneous evidence. For example, as set out further below, a number of CCGs provided comments on the geographic scope of their patient referrals, but it is unclear whether these were tested against their actual referral behaviour.

2.31 The lack of any detailed disclosure of the third party comments received by the CMA has meant that it is difficult for the Parties to comment in any detail. The Parties would request that at Phase 2 the CMA asks for contemporaneous evidence from commissioners around actual referrals over time to support any comments made about commissioning behaviour.

Third party comments on referral distances

2.32 In relation to the catchment area analysis, the Decision states[13] that "*Commissioners tend to consider, as effective substitutes, the providers within a considerably narrower*

[13] Decision, paragraph 68.

geographic frame of reference than might be indicated by some measures of the site-specific 80% catchment area. Therefore, the CMA has paid particular consideration to the views of Commissioners when identifying the appropriate geographic frame of reference in each local area." Moreover, paragraph 69(b) states that "*the CMA asked Commissioners how far they would typically place patients from their origin. The most common response (ie. the mode) was 20-30 miles, while the median response was 40 miles*".

2.33 However, these comments are inconsistent with evidence of the actual referral behaviour of commissioners which, as submitted by the Parties, shows that the vast majority of CCGs send patients more than [✂] miles.

2.34 In addition, the Decision explains[14] that the reason for referring to the "median" distance is to deal with potential outliers. Clearly, this means that the average (mean) distance reported by third parties is much larger than the distances reported in the decision. It also means that certain commissioners confirmed that they refer patients a significant distance (hence the reference to outliers). A question that asks about the "typical" placement also fails to address the issue about: (i) how far commissioners actually send patients; or (ii) how commissioners would respond in the event of a relative change in prices (as is required using the SSNIP test).[15]

Examples of inconsistent reporting of third party comments

2.35 Set out below are a number of examples of third party comments referred to in the Decision which are inconsistent, taken out of context, or under/over-stated:

(a) in relation to competition from NHS services, the Decision refers to commissioners who indicated that they would "*use independent providers for more specialised treatment as they would be the only facilities available to meet the patient's medical needs*"[16] but fails to acknowledge that this does not apply to the majority of the overlaps between the Parties, since LTMH rehabilitation is not considered to be a specialist service;

(b) in relation to the assessment of Wyvern ward at Cygnet Derby, the Decision confirms[17] that "*two commissioners indicated that they would consider St Andrews in Northampton as an alternative supplier in the local area*". However, despite commissioners specifically referring to the St Andrew's site as an alternative, it has been excluded as a competitor from the market share calculations on the basis that it is [✂] miles from Cygnet Derby, whilst a narrow catchment area of [✂] miles has been used;

(c) the Decision appears to have referred to the same third party comments made in relation to Cygnet Derby (i.e. that "*some commissioners said that they consider the parties to be their two main options for the placement of men with LTMH issues*")[18] to each of the CAS sites in the East Midlands (Storthfield House, The Limes and Sherwood House). However, those comments are not site specific and therefore reliance on the same third party comment with respect to each CAS site is unlikely to be justified;

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14 Decision, footnote 35.

15 It is also unclear whether commissioners are referring to straight-line distances or road distances. Road distances have been used by the Parties, consistent with the CMA's Acadia/Priory decision, which generally result in higher numbers due to the configuration of the road lay-out.

16 Decision, paragraph 49.

17 Decision, paragraph 107.

18 Decision, paragraph 104.

(d) in relation to Cambian Oaks, paragraph 142 of the Decision states that "*one Commissioner stated that it considered Coral Lodge (an NHS facility) to be on an equal footing with Cambian Oaks*". However, this competitor has not been included in the market share calculations set out in the Decision in relation to Cambian Oaks;

(e) in relation to Kewstoke (The Lodge) and St Teilo House, the CMA does not appear to have received any specific third party complaints. The only third party evidence reported in the Decision (at paragraphs 154 and 160) is that third parties confirmed that "*the parties do compete with each other*";

(f) in relation to Raglan House, the Decision notes[19] that "*no third parties raised any merger specific concerns regarding Cambian Raglan House*". However, bizarrely, it goes on to state that "*the CMA has placed limited weight on this given that the potential overlap is with a planned site (Cygnet Coventry)*"; and

(g) in relation to the treatment of PD, the CMA acknowledges in paragraph 175 of the Decision that "*Commissioners confirmed that the parties' offerings were differentiated and may be better suited to different patients*". However, the Decision gives more weight to an unspecified number of commissioners which indicated that the Parties' PD sites were regarded as competitors.

2.36 In light of the above, the Parties consider that there is significant work for the CMA to do at Phase 2 to speak to commissioners, understand the nature of their concerns, and check their comments for consistency with the available evidence.

[19] Decision, paragraph 170.

3. APPROACH TO ASSESSING THE GEOGRAPHIC MARKET

3.1 The Parties recognise that in local markets cases at Phase 1, it is useful to apply a local filter to the Parties' sites in order to identify the overlaps that require more detailed examination. The Parties noted in the response to the Issues Letter a number of concerns in relation to the filters used in order to identify potential areas of concern. In particular, during Phase 1, in respect of each of the Parties' sites that, the CMA identified the catchment area producing the most conservative result (i.e. the highest combined market share). In justifying taking the most conservative approach when identifying catchment areas, the Decision states that:

> "*…the boundaries of the market do not determine mechanistically the outcome of the CMA's analysis of the competitive effects of the Merger. The CMA takes this into account in its competitive assessment and uses the shares of supply calculated for the site-specific and treatment-average catchment areas as the starting point only.*"[20]

3.2 However, for from only being a starting point, it is clear from the local assessments that the shares of supply calculated on this most conservative basis are a key factor relied upon in the Decision for the purposes of identifying a realistic prospect of an SLC in the relevant catchment areas. For this reason, the Parties consider that it is important for the CMA, at Phase 2, to re-consider these issues.

Average or site specific catchment areas

3.3 In order to inform the geographic market assessment, the Decision focuses on the catchment areas within which each of the target's sites derive the closest 80 per cent of its patients (by reference to the road distance between the patient's home and hospital postcodes). However, due to the uncertainty and small sample sizes (as mentioned below) associated with site-specific catchment areas, the Parties consider that calculating an "average" catchment area for each treatment type provides a far more robust estimate (by aggregating the number of observations together and reducing the variation that is inevitable from small sample sizes and limited patient data).

3.4 The average distance catchment area (by treatment type) also results in distance catchment areas that are consistent with those for the same treatment types in the CMA's Acadia/Priory decision, and provides a better representation of the behaviour of CCGs and NHS commissioners across England and Wales.

3.5 Using average distance catchment areas is also supported by the CMA's Commentary on Retail Mergers. The previous version stated at footnote 3 that the 80 per cent catchment *"is not typically assessed at an individual store level. Rather it is calculated as an average for a sample of stores of that profile*." The revised Commentary, issued on 10 April 2017, states:

> "*The CMA usually calculates an average catchment area for a sample of stores. However, in some cases the CMA has calculated the catchment area for individual stores as a sensitivity, or as the basis of the analysis.*
>
> "*Individual store catchment areas can be informative where people living in different places are willing to travel very different distances to visit a store, and where differences in travel patterns are not related to observable factors such as whether the area is in an urban or rural area. However, catchment areas for individual stores depend on the number of stores in the local area – customers do not need to travel far if there are lots of stores in the local area. Therefore, store catchment areas may not be related to customers' willingness to travel and it may*

[20] Decision, paragraph 70.

be preferable to use average catchment areas to identify overlaps." (paragraphs 2.21-2.22, emphasis added).

3.6 In this regard, the Decision provides no reasons for ignoring the typical average catchment area principle in favour of a site-specific approach despite the significant limitations of doing so. Indeed, the Decision appears to rely on the different levels of supply in different areas as a reason *for* using a site-specific catchment area,[21] when the Commentary indicates this will generally be a reason to use an average catchment.

3.7 The Decision acknowledges[22] that an inconsistent approach to assessing catchment areas has been adopted by switching between average and site-specific catchment areas, depending on which approach gives rise to the highest combined shares of supply, rather than focusing on the areas over which competition actually takes place. For example, in relation to the overlap between St Teilo House and Kewstoke (the Lodge), the CMA used the site specific catchment area for assessing St Teilo House (on the basis that it gives rise to a broad area which brings in some of the other sites operated by the Parties), whilst it has used the average catchment area for Kewstoke (the Lodge) on the basis that it gives rise to higher shares of supply.

3.8 Such an arbitrary and inconsistent approach is unrelated to the correct application of the SSNIP test, and provides an erroneous basis for assessing the competitive effects of the transaction. The fact that the resulting shares form a key part of the evidence cited in the Decision for each of the local areas where an SLC has been identified means that it is important for the CMA in Phase 2 to adopt a credible, consistent and evidence-based local geographic market.

3.9 Where average catchment areas have been relied on in the Decision, they have been presented on a gender specific basis, e.g. the average catchment areas for male LTMH sites. The Parties consider it more appropriate to use the gender neutral average catchment areas, e.g. the average catchment area for LTMH sites, on the basis that this makes use of a larger sample size and there is no reason identified in the Decision why local market definition for male and female patients differs.

[✂]

3.10 As explained when the data was submitted, for many patients [✂].

3.11 In particular, many patients are referred to the Parties' facilities from a different stage of the care pathway (e.g. low secure, acute or PICU) and, as a result, [✂],[23] the Parties used the address of the CCG funding that patient's treatment as a proxy for their home address, which introduces significant uncertainty as to the scope of the catchment areas.

3.12 There are a total of 211 CCGs across England, each commissioning care for over 200,000 patients. As a result, many CCGs are responsible for large geographic areas, with distances across the CCGs' respective areas of responsibility often exceeding 50 miles. Moreover, CCGs' addresses are not necessarily located in the centre of their respective areas of responsibility and they do not represent the average location of patients within their respective areas. Coupled with the small number of observations in respect of each CCG at any particular hospital (which may be just 1 or 2), the margin for error is significant.

3.13 For the Cygnet sites, [✂]. Where patient postcode data is available, we calculated the distance between each Cygnet site and the patient's home postcode. Where the patient home postcode was not available, we calculated the distance between the site and the

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21 Decision, paragraph 69(a).

22 Decision, paragraph 62.

23 In comparison, [✂].

address of the CCG funding the patient, which again introduces significant uncertainty into the catchment area analysis.

3.14 Concerns over the use of CCG postcode data is particularly relevant in relation to the overlap between Cygnet Derby (Wyvern ward) and CAS Storthfield House, Sherwood House and The Limes. [✂] of patients in the relevant area are referred under the East Midlands Rehabilitation Framework. [✂] Some of these CCGs coordinate patient referral and funding so that some CCGs are over represented in the patient data. This means that the 80 per catchment area based on CCG distances are subject to significant uncertainty as many of the patients are funded by a different CCG than appears in the customer records.

Number of observations is too small and very sensitive to small changes

3.15 In addition to the concerns over using CCG postcodes as a proxy for patient postcode data, the uncertainty around calculating site-specific catchment areas is compounded by the limited number of data points available at many of the sites in question, with the catchment areas being extremely sensitive to even very small changes in the number of patients considered. This reflects the fact that a number of the sites are relatively small and patients are treated for long periods of time, and therefore there is limited natural churn from patients being admitted and discharged.

3.16 As a justification for its rejection of the Parties' arguments, the Decision sets out[24] that in its *Acadia/Priory* decision the CMA estimated "*site specific catchment areas where 10 or more observations were available*", and mentioned in the issues letter that it considers at least 10 observations to be required to be considered "*a sufficiently robust basis for assessment*". The Decision provides no justification for setting this minimum number of observations, other than that consistency with *Acadia/Priory*. The Parties note that no justification was provided in *Acadia/Priory* for reliance being placed on such a small sample size, so this does not cure the deficiency in reasoning.

3.17 The Parties consider that it should be uncontroversial that small sample sizes do not provide a statistically robust basis for informing the relevant catchment area. The reason for this can be observed in the very wide variations that are evident from even the smallest of changes in the sample size. For example, if just three additional patients were included in the catchment area of Raglan House, the site level catchment area would increase from [✂] miles to [✂] miles. Similarly, if three additional patients are included in the catchment area for Cambian Oaks, it would increase from [✂] to [✂] miles.

3.18 Moreover, despite Cygnet Brighouse and Cambian Oaks being just 21 miles apart, the site-specific catchment areas are [✂] miles and [✂] miles respectively. This in itself should indicate that the site-specific catchment areas do not accurately represent a local geographic market.

3.19 As set out above, due to the small sample sizes and the sensitivity of the analysis to even very small changes in patient numbers, the Parties consider that calculating an average catchment area for each treatment provides a more robust estimate (by aggregating the number of observations together and reducing the variation), and provides a better representation of the behaviour of commissioners across England and Wales.

Catchment areas understate the scope of the geographic market

3.20 As set out above, the Decision uses catchment areas based on the closest 80 per cent of patients at each site in order to assess the geographic frame of reference. In addition to the methodological concerns set out above, this approach does not adequately reflect how customers (CCGs) would react in the event of a hypothetical increase in price, which is the

[24] Decision, paragraph 72.

relevant question to ask in applying the hypothetical monopolist (SSNIP) test. In this regard, the CMA's Merger Assessment Guidelines note that "*the geographic market identified using the hypothetical monopolist test will typically be wider than a catchment area*".[25]

3.21 Accordingly, the catchment area approach used in the Decision systematically understates the geographic area over which CCGs would be willing to send patients in the event of a hypothetical increase in price post-merger. It is also of note that this was recognised by the CMA in its recent Spire/St Anthony's decision where the CMA stated that it "*takes this into account in its competitive assessment and uses isochrones based on catchment areas only as a starting point of reference for its competitive assessment. As part of the assessment, we also considered the constraints posed on the Parties by rivals located outside of the isochrones as appropriate*".[26] As explained in the next section, this approach was not adopted in the Decision.

The Decision does not consider competition from outside the catchment area

3.22 The Decision states[27] that the CMA "*calculated the Parties' shares of supply at 10 and 20 mile intervals either side of the site-specific and treatment-average catchment areas*". However, it is clear from the site-by-site assessments that competition from competitors located just outside the catchment area has not been considered in the Decision, even for those competitors that would be expected to have a catchment area which overlaps (at least in part) with the Parties.

3.23 As set out in the Parties' response to the Issues Letter, the market share estimates for a number of the overlaps considered were extremely sensitive to the catchment area used. This reflects the large number of competitor sites located just outside the boundaries of the specific catchment area relied upon. For example:

(a) if the catchment area for Cygnet Hospital Derby increased from the site specific catchment area of [✂] miles to [✂] miles the Parties' combined market share falls from [✂] per cent to [✂] per cent;

(b) if the catchment area for Sherwood House increases from the site specific catchment area of [✂] miles to [✂] miles the Parties' combined market share falls from [✂] per cent to [✂] per cent;

(c) if the catchment area at Raglan house were increase by just 5 miles from the site specific catchment area of [✂] miles to [✂] miles, the Parties' combined market share drops to just [✂] per cent; and

(d) in relation to Cambian Oaks, there are four additional sites ([✂]) between [✂] miles and [✂] miles from Cambian Oaks (the CMA used a site specific catchment area of [✂] miles).

3.24 Accordingly, whilst the Decision claims that a sensitivity analysis has been undertaken with respect to the geographic catchment areas used in the site by site analysis, this only appears to have been included in the local analysis where it results in a materially worse position for the Parties, and no weight has been given to competitors just outside the catchment area.

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[25] Paragraph 5.2.25. "Merger Assessment Guidelines", A joint publication of the Competition Commission and the Office of Fair Trading, September 2010.

[26] Paragraph 40. Completed acquisition by Spire Healthcare Limited of certain assets and business of St Anthony's Hospital in Surrey, ME/6444/14

[27] Decision, paragraph 62.

Market shares of the Parties are consistently overstated

3.25 As mentioned to the CMA on a number of occasions during Phase 1, the Parties are not aware of a national database of providers of mental health hospitals. The competitor information that has been used in the market share analysis is based on the Parties' knowledge of their competitors and publicly available information. In particular, it relies on a review of key competitors' websites, the knowledge of senior personnel within the business, and information available on the Care Quality Commission (CQC) website. As discussed with the staff during the Phase 2 staff meeting, the Parties would like to explore with the CMA during Phase 2 how best to produce a robust data-set of competitors to allow the Group to reach fully informed decisions.

3.26 As is inevitably the case with a manual exercise based on two market participants' information, the list of competitors (and the breakdown between treatment types) is unlikely to represent an exhaustive list of all providers of rehabilitation services in Great Britain. Accordingly, the Parties' own market shares are likely to be overstated in the calculations that have been used for the purposes of the Decision (and suffer from an upwards bias) due to the high likelihood that competitors in any particular area have been omitted.

3.27 As set out in the response to the Issues Letter, the Parties' market shares (calculated by number of beds) are also likely to be overstated for a number of additional methodological reasons. In particular:

(a) the Parties' provided details of their planned sites, which have been included in the market share calculations used in the Decision. However, whilst the Parties know the details of all of their own future plans, they only have limited visibility of competitors' planned sites. Accordingly, the market share calculations are likely to understate the expansion plans of competitors, thereby overstating the position of the Parties.[28]

The Parties note the comment at paragraph 225 of the Decision that "*Competitors have not, however, identified any pipeline sites in the catchment areas considered within this Decision*". It is unclear precisely what question was asked, but this statement is clearly incorrect and identifies a failure in the market testing undertaken during Phase 1. The Parties understand that there are a number other planned sites under contemplation or in early stages of development not included in the analysis relied upon in the Decision. For example Cygnet understands that Elysium Three Valleys Hospital is planning a 30 bed extension across the main hospital and step down services. Similarly, on 15 March 2017, Elysium announced the opening of a new 34 bed LTMH locked rehabilitation hospital in Wrexham, which the Parties were previously unaware of, and which would have fallen within the site specific catchment area of St Teilo House.[29] Accordingly, the market testing failed to adequately consider the expansion plans of rival operators. There is of course an opportunity for the CMA to address this during Phase 2;

(b) where rival hospitals provide more than one treatment type on the same ward, the number of beds have been allocated in fixed numbers between treatment types. However, the Parties consider that if a ward or site treats more than one mental health condition on the same ward, it is reasonable to assume that all beds could readily be used for either treatment (given that single treatment wards exist, it is clear there is no clinical reason this could not be done). This would not be double counting, but reflects the nature of the competitive constraint that they provide.

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[28] In order to carry out a like-with-like assessment, either all planned sites (including those of competitors for which the Parties do not have full information) should be included within the market share calculations, or all planned sites (including those of the Parties and their competitors) should be excluded.

[29] http://www.elysiumhealthcare.co.uk/elysiums-development-wrexham-track/

This is also evident in relation to the example cited in footnote 65 of the Decision, where a PD/LTMH site operated [✂] confirmed that all beds are currently being used for PD patients. Notwithstanding the concerns over possible supply-side substitution by the Parties, the Decision does not address this point and instead excluded this site entirely from the provision of LTMH services. This is despite the fact that the Decision acknowledges[30] that "*switching costs are, for this reason, likely to be lower in relation to treatment types that use the same physical environment such as LTMH/PD and ASD/LD*"; and

(c) where a competitor site is classed as a mixed gender ward, the beds have been arbitrarily allocated 65:35 towards male patients, based on what appears to be nothing more than an assumption previously applied in its Acadia/Priory decision.[31] Whilst the Parties do not operate any mixed gender rehabilitation wards or facilities, they are aware that some competitors do. The Parties consider that if male and female patients are treated on the same ward, it is reasonable to assume that they could vary the number of beds attributed to each gender.

Accordingly, the 65:35 ratio assumption fails to recognise the full extent of the constraint provided by these mixed gender facilities.[32] For example, the Decision states[33] that [✂], which was included by Cygnet due to its designation as a mixed gender facility on its website, its latest CQC Report and the East Midlands Rehabilitation Framework where it is included as a male and female rehabilitation site, is currently only admitting male patients. This demonstrates how mixed-gender wards can flex their capacity in order to adapt to local demand. Rather than recognising this fact, the Decision excludes [✂] from the market share calculations for female LTMH services altogether, which results in an important competitive constraint being omitted.

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30 Decision, paragraph 42.

31 Decision, paragraph 37.

32 The Parties understand that the configuration of many mixed gender wards (for example provision of private bathrooms) permits them to "flex" the proportion of male and female patients admitted in response to demand.

33 Decision, footnote 46.

4. LTMH MALE

4.1 The Decision identifies a realistic prospect of an SLC in relation to LTMH Male sites in two areas:

(a) the overlap in the East Midlands between Cygnet Hospital Derby and three CAS sites (Storthfield House, Sherwood House and The Limes); and

(b) the overlap in the North of England between Cygnet Brighouse and Cambian Oaks.

4.2 Each of these overlaps is discussed in turn below.

East Midlands sites

Background to the overlaps

4.3 Cygnet Hospital Derby is a large specialist mental health hospital with the following three wards:

(a) Litchurch Ward provides low secure treatment for up to 15 male patients with LTMH conditions;

(b) Alvaston Ward provides low secure treatment for up to 16 female PD patients; and

(c) Wyvern Ward is a locked LTMH rehabilitation ward with 19 beds for male patients.

4.4 There is no overlap in relation to the two low secure awards at Cygnet Hospital Derby, therefore the overlap focuses specifically on the Wyvern Ward. In all cases, the addition of Cygnet Derby adds just 19 male LTMH beds to the Parties' combined market share. Although this point was highlighted in the response to the Issues Letter, the Decision makes no reference to the argument that Derby adds only a small increment.

4.5 The Decision identifies three Cambian sites that overlap with Wyvern Ward at Cygnet Hospital Derby and give rise to a realistic prospect of an SLC:[34]

(a) Storthfield House – a male LTMH site with 22 beds located in Alfreton, 18 miles from Cygnet Hospital Derby;

(b) Sherwood House – a 30 bed male LTMH rehabilitation unit with specialist staff to treat patients that also have learning disabilities. Sherwood House is located 29 miles from Cygnet Hospital Derby. The Sherwood House site also includes two other wards, Sherwood Lodge (17 bed male LD rehabilitation) and Sherwood Lodge Step Down (nine bed male LD unit for patients stepping down from rehabilitation in Sherwood Lodge to the community/residential sector), which do not overlap with Cygnet Hospital Derby; and

(c) The Limes – a male LTMH site with 18 beds located in Mansfield, 32 miles from Cygnet Hospital Derby.

The catchment areas used are too narrow

4.6 For each of the sites in the East Midlands the Decision has used the site-specific catchment area as follows:

(a) [✂] miles for Cygnet Hospital Derby (based on a sample of [✂] patients);

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[34] Two other Cambian LTMH male sites (St Augustine's and Sedgley House and Lodge) are within the catchment area of Cygnet Hospital Derby but do not give rise to a SLC.

(b) [✂] miles for Storthfield House (based on a sample of [✂] CCG postcodes)[35];

(c) [✂] miles for The Limes (based on a sample of [✂] CCG postcodes); and

(d) [✂] miles for Sherwood House (based on a sample of [✂] CCG postcodes).

4.7 However, the Decision ignores the evidence submitted in response to the Issues Letter which is consistent with a wider catchment area for each of these sites. In particular, the Parties submitted the following evidence as to why market shares based on the site-specific catchment area of each individual site are unreliable.

The East Midlands Rehabilitation Framework covers a much broader area

4.8 As set out further below, [✂] patients at the Parties' sites in this area are referred under the East Midlands Rehabilitation Framework agreement. [✂] any CCG within the framework is able to refer patients to any operator on the framework.

4.9 In this regard, Figure 4.1 below highlights the large geographic area covered by the East Midland framework agreement (i.e. it includes all the shaded areas). In a straight line this area extends more than 100 miles North to South and more than 90 miles East to West. Given that [✂] to each of the Parties' sites in the East Midlands are referred under the framework agreement, this indicates that the CMA's site specific catchment areas are too narrow and fail to reflect the area over which CCGs are able to refer patients under the terms of the framework agreement.[36]

Figure 4.1: Map of CCGs in the East Midlands Rehabilitation Framework agreement

[✂]

CCG postcode data is a poor proxy for patient data in the East Midlands

4.10 As set out in section 3 above, for many patients a home address is not available due to the nature of the rehabilitation services they provide. [✂]. Accordingly, where patient data was not available, the Parties used the postcode of the CCG referring the patient as a proxy for the patient's address.

4.11 However, in relation to the East Midlands Rehabilitation Framework agreement, patient referral and funding is coordinated by certain CCGs on behalf of others, and therefore some CCGs are over represented in the patient data. For example, [✂]. As a result of this arrangement, in the CAS patient data, [✂] are recorded as being funded by [✂] but [✂] is funded by [✂].

4.12 Figure 4.1 above shows the CCGs that are part of the East Midlands Rehabilitation Framework agreement, [✂]. Accordingly the 80 per catchment area based on CCG distances in this area is subject to significant uncertainty as many of the patients are funded by a different CCG than appears in the customer records.

CCG referral data indicates a wider market

4.13 As set out in the response to the Issues Letter, CCG referral data of the Parties' five largest customers at each of the overlapping sites in the East Midlands indicates that almost all CCGs send patients to other LTMH sites of the Parties more than 75 miles away (from where the CCG is located), and, therefore, are also likely to do so in relation to

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[35] As mentioned in section 2, [✂]. Accordingly, the postcode of the CCG referring the patient was used instead, which adds significant uncertainty to this analysis.

[36] In addition, the distances quoted by the Parties and the CMA are road distances, which would imply an even shorter straight line distance.

competitor sites.[37] In other words, customers of these sites regularly demonstrate that they are not constrained in their LTMH choices to a limited catchment area around that site. This shows that for each of the sites identified in the Decision:

(a) three of the top five customers for Cygnet Hospital Derby refer LTMH patients to at least one CAS/Cygnet site more than [✂] miles away. For example, the largest customer, [✂];

(b) all of the top five customers for Storthfield House refer LTMH patients to at least one Cygnet/CAS site more than [✂] miles away, with the largest three customers sending patients more than [✂] miles. For example, [✂];

(c) three of the top four customers for Sherwood House refer LTMH patients to at least one CAS/Cygnet site more than [✂] miles away. For example, the largest customer, [✂]; and

(d) all of the top five customers for The Limes refer LTMH patients to at least one Cygnet/CAS site more than [✂] miles away. For example, [✂].

Patient referrals are also over a much broader area

4.14 It is also of note that the Parties' sites treat patients from a significantly wider area than indicated by the site specific catchment areas. For example:

(a) Cygnet Hospital Derby has [✂];

(b) Storthfield House has [✂];

(c) Sherwood House has [✂]; and

(d) The Limes has [✂].

4.15 The Parties also note that The Limes and Sherwood House are less than 20 miles apart. However, despite the close proximity of these sites, the Decision relies on the site specific catchment areas being [✂] miles for The Limes and [✂] miles for Sherwood House. It is improbable that the geographic market for Sherwood House is more than [✂] as The Limes, given that: (a) the two sites are so close together, (b) both sites are part of the East Midlands Rehabilitation Framework agreement, and (c) both sites admit patients from CCGs much further afield.

Third parties identified competitors outside the catchment area

4.16 It is noteworthy from the Decision that third parties also referred to a competitor from outside the site specific catchment areas used in the Decision, which further supports a broader geographic market. In particular, paragraph 107 of the Decision states that *"Two Commissioners indicated that they would consider St. Andrew's in Northampton as an alternative supplier in the local area and its CQC rating is currently 'good'".*

4.17 St Andrew's Northampton is, however, 67 miles from Cygnet Hospital Derby, i.e. [✂], and more than 75 miles from Storthfield House, The Limes and Sherwood House. As commissioners consider this to be an alternative supplier in the local area, this strongly suggests that the geographic market is wider than the site-specific catchment areas used by the CMA.

[37] The Parties only have information on where customers have referred patients to a Cygnet or CAS site.

The importance of the East Midlands Rehabilitation Framework

4.18 In response to the Issues Letter the Parties explained that they are also constrained by the East Midlands Rehabilitation Framework agreement.

4.19 As mentioned above, [✂] (as shown in Figure 4.1 above).

4.20 In this regard, in relation to each of the Parties' sites identified as giving rise to a SLC in the East Midlands, [✂] of patients are referred under the framework agreement:

(a) [✂] per cent of patients at [✂] are referred under the East Midlands Rehabilitation Framework;

(b) [✂] per cent of patients at [✂] are referred under the East Midlands Rehabilitation Framework;

(c) [✂] per cent of patients at [✂] are referred under the East Midlands Rehabilitation Framework; and

(d) [✂] per cent of patients at [✂] are referred under the East Midlands Rehabilitation Framework.

4.21 [✂].

4.22 As previously explained to the CMA, there are at least [✂] different providers of LTMH services on the framework agreement, including [✂] providers. This evidence highlights the wide range of competition facing the Parties.[38] It would be implausible, therefore, to suggest that competition could be reduced at the bidding stage as a result of the transaction, or that CCGs faced a limited number of choices in the area.

4.23 The Decision fails to consider how the East Midlands Rehabilitation Framework agreement influences competition in the area. During Phase 2, it is crucial that the CMA considers whether the unilateral theory of harm is credible when prices and service specifications in the East Midlands are agreed up-front through a competitive tender process.

Exclusion of all NHS providers in the area

4.24 As explained above, the Decision states that the transaction has been assessed excluding all NHS providers of rehabilitation services from the market.[39] One of the reasons given for adopting this position is the lack of NHS provision in certain geographic areas.

4.25 However, this is not the case in relation to male LTMH services in the East Midlands. As indicated by the Parties in the response to the Issues Letter, there are a number of significant NHS providers of male LTMH services in the area, which compete with the Parties. The NHS sites providing male LTMH treatment within 70 miles of one of the Parties sites are shown in the table below.

Table 4.1: NHS LTMH sites in the East Midlands and surrounding areas

NHS Trust	Site	Location	Distance to closest site	Number of beds
Derbyshire Healthcare NHS FT	Audrey House	Derby	4 miles (Cygnet Derby)	[✂]
Nottinghamshire Healthcare NHS FT	Bracken House	Mansfield	5 miles (Sherwood)	[✂]
Rotherham, Doncaster &	Goldcrest Ward,	Rotherham	14 miles	[✂]

[38] The Parties understand that these include, *inter alia*, the following: [✂].

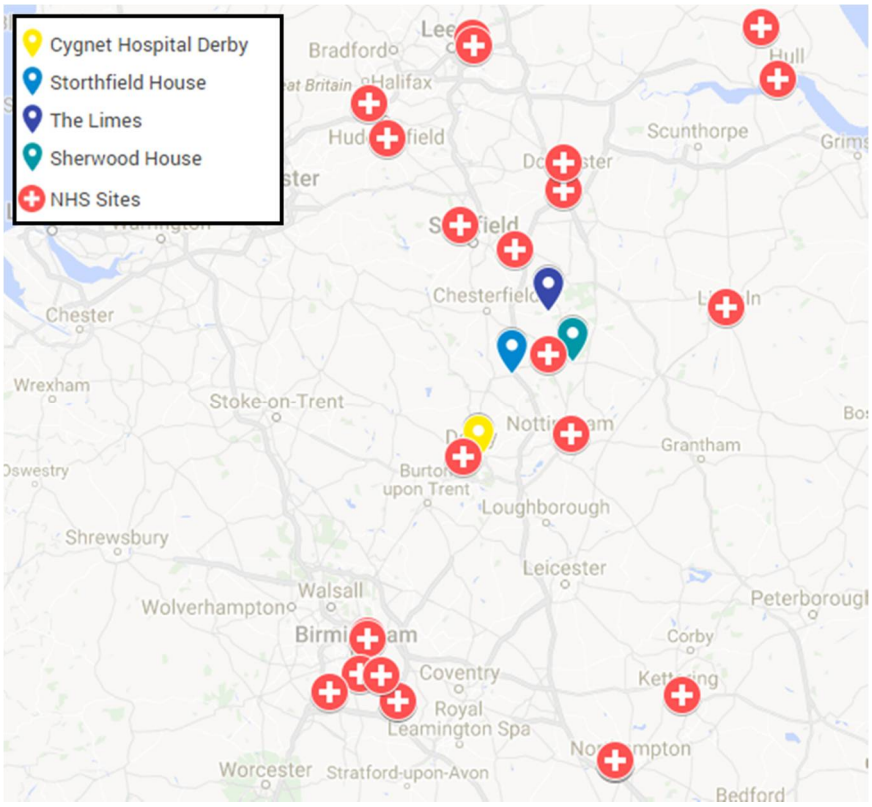
[39] Decision, paragraph 51,

S Humber NHS FT	Swallownest Court		(The Limes)	
Nottinghamshire Healthcare NHS FT	147 Thorneywood Mount	Nottingham	15 miles (Sherwood)	[✂]
Rotherham, Doncaster & S Humber NHS FT	Coral Lodge	Doncaster	27 miles (The Limes)	[✂]
Sheffield Health and Social Care Trust	Forest Close	Sheffield	27 miles (The Limes)	[✂]
Rotherham, Doncaster & S Humber NHS FT	Emerald Lodge	Doncaster	30 miles (The Limes)	[✂]
Lincolnshire Partnership NHS Trust	Discovery House	Lincoln	30 miles (The Limes)	[✂]
Birmingham and Solihull MH NHS FT	Endeavour Court	Birmingham	39 miles (Cygnet Derby)	[✂]
SW Yorkshire Partnership NHS FT	Enfield Down	Honley, Holmfirth	45 miles (The Limes)	[✂]
Birmingham and Solihull MH NHS FT	Forward House	Birmingham	46 miles (St Augustine's)	[✂]
Birmingham and Solihull MH NHS FT	David Bromley House	Birmingham	51 miles (Cygnet Derby)	[✂]
Birmingham and Solihull MH NHS FT	Dan Mooney House	Birmingham	51 mile (Cygnet Derby)	[✂]
Birmingham and Solihull MH NHS FT	Grove Avenue	Birmingham	52 miles (St Augustine's)	[✂]
Birmingham and Solihull MH NHS FT	Hertford House	Birmingham	52 miles (Cygnet Derby)	[✂]
Leeds & York Partnership NHS FT	Ward 5, The Newsam Centre	Leeds	55 miles (The Limes)	[✂]
Leeds & York Partnership NHS FT	Asket House & Asket Croft	Leeds	56 miles (The Limes)	[✂]
Birmingham and Solihull MH NHS FT	Ross House	Birmingham	57 miles (St Augustine's)	[✂]
Northamptonshire Health Care NHS FT	Meadowbank Ward, Berrywood Hospital	Northampton	60 miles (Cygnet Derby)	[✂]
Northamptonshire Health Care NHS FT	Cove Ward, Berrywood Hospital	Northampton	60 miles (Cygnet Derby)	[✂]
Northamptonshire Health Care NHS FT	Avocet Ward	Kettering	60 miles (Cygnet Derby)	[✂]
Northamptonshire Health Care NHS FT	Quayside, Berrywood Hospital	Northampton	63 miles (Cygnet Derby)	[✂]
SW Yorkshire Partnership NHS FT	Lyndhurst	Halifax	64 miles (The Limes)	[✂]
Humber NHS FT	Hawthhorne Court	Beverley, Nr Hull	67 miles (The Limes)	[✂]
Humber NHS FT	St Andrew's Place	Hull	69 miles (The Limes)	[✂]

Source: Cygnet

4.26 To illustrate the proximity of the NHS providers to the Parties, the Figure below shows a map of NHS providers in the East Midlands area as well as the Parties' sites. The map is based on the Parties review of publicly available information, and therefore is likely to exclude a number of other NHS-funded sites in this area.

Figure 4.2: Map of male LTMH NHS providers in the East Midlands



4.27 As explained in Section 2 above, the Parties remain strongly of the view that NHS-funded services compete with private providers in the provision of rehabilitation services. Given the large number of NHS providers in this area, the Parties consider it vital that the CMA considers the potential competitive constraint from NHS-funded sites.

Market shares are over-stated

4.28 For the reasons set out above, the Parties consider that the transaction should be assessed on the basis of average catchment areas rather than site specific catchment areas. On this basis, the market shares presented in the Decision significantly overstate the Parties' combined market position.

4.29 The Decision has also failed to reflect the additional competitors in this area that the Parties identified in the response to the Issues Letter. The Decision has not stated specific concerns with regard to the credibility of these competitors and appears to rely instead on the general statement in paragraph 84 of the Decision:

> *"The CMA sought to verify where possible the existence and extent of the competitive offering of these competitors where the inclusion of these additional competitors would materially change shares of supply for those facilities which the CMA had not already excluded from more detailed assessment. The only site for which this applied was Cambian Oaks with respect to the treatment of male LTMH patients. In all other cases the Parties' combined share remained above* [✂]% *even when taking into account all additional competitors."*

4.30 Whilst it is correct that the inclusion of these competitors would not reduce the Parties' combined market share below [✂] per cent on the basis of site specific catchment areas, they do have a material impact on the shares of supply.

4.31 The table below shows the Parties' combined market shares for catchment areas centred on each of the sites based on the following measures:[40]

(a) the CMA's estimated market share;

(b) the Parties' estimated market share on the same catchment area as the CMA but including additional competitors;

(c) the Parties' estimated market share on the gender specific treatment average catchment area ([✂] miles for Cygnet and [✂] miles for CAS); and

(d) the Parties' estimated market share on the gender neutral treatment average catchment area ([✂] miles for Cygnet and [✂] miles for CAS).

Table 4.2: The Parties' combined share of supply for male LTMH sites in the East Midlands

	CMA shares	Shares including additional competitors:		
		Site specific catchment	Gender specific average	Gender neutral average
Cygnet Derby – Wyvern Ward	[✂]	[✂]	[✂]	[✂]
Storthfield House	[✂]	[✂]	[✂]	[✂]
The Limes	[✂]	[✂]	[✂]	[✂]
Sherwood House	[✂]	[✂]	[✂]	[✂]

4.33 It is clear from the table above that the inclusion of the additional competitors, significantly reduces the Parties' combined market shares. Moreover, on the basis of the average catchment areas, the Parties have a combined share of supply of less than [✂] per cent at all sites.

Exclusion of competitors just outside the individual catchment areas

4.34 In the response to the Issues Letter, the Parties highlighted a number of competing sites just outside the site specific catchment areas. Each of these competing sites will have a catchment area which overlaps (to a great extent) with that of the CAS/Cygnet sites and therefore provides a further competitive constraint. These include the following sites:

(a) three additional PiC/Priory sites ([✂]) and one Options for Care site ([✂]) between [✂] miles and [✂] miles from Cygnet Hospital Derby. In total these four sites have 66 male beds and 10 mixed beds;

(b) two additional PiC/Priory sites ([✂]) and one Options for Care site ([✂]) between [✂] miles and [✂] miles from Storthfield House. In total these three sites have 70 male beds;

(c) two additional PiC/Priory sites ([✂]) and one Options for Care site ([✂]) between [✂] miles and [✂] miles from Sherwood House. In total these three sites have 70 male beds; and

(d) one PiC/Priory site ([✂]) and one Rushcliffe Care Group site ([✂]) between [✂] miles and [✂] miles from The Limes. In total these two sites have 22 male beds and 10 mixed beds.

4.35 Figure 4.3 below shows the location of competitor sites within [✂] miles of Storthfield House. Competitors within the site specific catchment area are highlighted in green and

[40] The market shares have been updated compared to the Issues Letter response to correct a mistake in the number of beds available at Cheswold Park Hospital. [✂]

competitors just outside the catchment area, but within [✂] miles of Storthfield House, are highlighted in red. Comparable maps for Cygnet Hospital Derby, The Limes and Sherwood House are provided at Annex 1.

Figure 4.3: Map of competitor sites within [✂] miles of Storthfield House

[✂]

4.36 The Decision fails to explain why these sites would not exert a competitive constraint on the Parties such that they should be excluded from the analysis entirely.

4.37 Although the Decision states[41] that it has *"calculated the Parties' shares of supply at 10 and 20 mile intervals either side of the site-specific"* catchment area, there is no evidence of this in relation to the East Midlands sites. The Decision does not report shares of supply on the basis of a wider catchment area for any of these sites, which are significantly lower and in many case below [✂] per cent.

The Parties are not each other's closest competitor by geography

4.38 The Decision[42] notes that "*Apart from one smaller hospital located in Derby at two miles from Cygnet Derby (eight beds, mixed gender), the Parties are each other's closest competitors by geography*" (which presumably is a comment made in relation to Storthfields House, which is the closest CAS site to Cygnet Derby).[43] However, in relation to the assessment of Storthfields house, the Decision states[44] that "*the parties are not each other's closest competitors by geography*", which is clearly inconsistent.

4.39 The Decision mentions two sites in paragraph 107, but does not reflect this in its assessment of competition: *"There are two more competitors with 18 beds (The Huntercombe) and 12 mixed gender beds (Turning Point, Nottingham Transition Unit) in Nottingham at a similar distance to the closest Cambian site, Storthfields House in Alfreton, Derbyshire."*

4.40 The Parties therefore disagree with the statement in relation to Cygnet Hospital Derby that the CAS facilities are *"each other's closest competitors by geography"*.

The assessment of internal documents and third party comments is overstated

4.41 The Decision relies on third party concerns as a reason for identifying a realistic prospect of an SLC in relation to the East Midlands sites. In particular, paragraph 104 notes that:

> *"Commissioners indicated that the Parties compete closely in the local area. Some Commissioners said that they consider the Parties to be their two main options for placement of men with LTMH issues."*

4.42 This comment has been referred to in relation to all of the sites in this area. However, the comments do not appears to be site specific and therefore applying the same third party comment to each site is unlikely to be justified.

4.43 This is particularly true in relation to Sherwood House where the Parties put forward an argument that there is a level of differentiation between the Parties sites because

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41 Decision, paragraph 62.

42 Decision, paragraph 104).

43 The smaller hospital mentioned in paragraph 104 is operated by Craegmoor, which is part of the Priory Group. Given the proximity of this site to Cygnet Hospital Derby, the Parties consider that [✂] on Cygnet Hospital Derby and should not be dismissed by the CMA.

44 Decision, paragraph 113.

Sherwood House has specialist staff to treat patients with a secondary diagnosis of LD. The Decision dismisses any differentiation on the basis of the same third party comments:

> *"The CMA notes however that this is contrary to the views received from Commissioners, as set out in paragraph 104 above, that the Parties compete closely in the local area and for some Commissioners are considered the two main options for placement of men with LTMH issues."*

4.44 The general commissioner comments in paragraph 104 are clearly not sufficient to conclude whether or not Sherwood House provides a specialist service for patients with a secondary diagnosis of LD.

4.45 Likewise, the Decision has relied on analysis of a single internal document to support its conclusion of a SLC in relation to all four sites in this area: [✂].[45]

4.46 [✂].

4.47 [✂].

4.48 [✂].

4.49 [✂].

4.50 [✂].

4.51 These points were made in response to the Issues Letter but have not been addressed in the Decision.

Cambian Oaks / Cygnet Brighouse

4.52 Cambian Oaks is a 36 bed male LTMH facility located in Barnsley.

4.53 The only Cygnet site within the site specific catchment area of Cambian Oaks is Cygnet Brighouse, a 24 bed male LTMH site located in Brighouse (near Huddersfield) in West Yorkshire, 21 miles from Cambian Oaks. Unlike a number of other Cygnet facilities, Cygnet Brighouse only provides treatment for male patients with LTMH.

4.54 The Decision does not identify a separate SLC in relation to Cygnet Brighouse. Given the proximity of these two sites to one another, this reinforces the point made above that the Decision has failed to have regard to additional competitors just outside the specified catchment area.

The Parties' combined market share is 40 per cent or less

4.55 The Decision has identified a realistic prospect of an SLC in relation to Cambian Oaks on the basis of the Parties having a combined market share of [✂] per cent. Given the large number of competing providers in the catchment area (six including the Parties), there is no basis to identify an SLC with market shares at this level.

4.56 The Decision appears to justify the use of such a low threshold on the basis that for a narrow catchment area, the Parties have a higher combined share:[46]

> *"Applying a stepped catchment analysis (as outlined in paragraph 68) also demonstrated that the Parties' combined share and increment is even more significant in a catchment slightly narrower than the site-specific catchment area (peaking at* [✂]*% at* [✂] *miles)."*

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[45] Decision, paragraph 108.

[46] Decision, paragraph 136.

4.57 However, there is no evidence to support an even narrower catchment area. To the contrary, as set out below, there is significant evidence to suggest a wider catchment area, on which basis the Parties have a combined market share of less than [✂] per cent. In other words, the only reason for identifying a narrow catchment area was with a view to identifying the area within which the Parties' combined market share would be highest. That exercise has nothing to do with the dynamics of local competition.

4.58 The Decision does not reflect the additional competitors the Parties identified in response to the Issues Letter. Cambian Oaks is the only site where the Decision acknowledges that the inclusion of these competitors would have a material impact on its analysis, but in any event chooses not to include them:[47]

> *"when taking into account these additional competitors, the Parties combined share of supply in the catchment area of Cambian Oaks falls below [✂]%, to [✂]%. However, the CMA confirmed that one of the competitors identified by the Parties did not operate a hospital on the site identified and, with respect to the second, one Commissioner informed the CMA that it had only referred patients with LD and not LTMH to the facility. The CMA's investigation indicated that the third does offer rehabilitation services for male patients suffering from LTMH. However, as the inclusion of this third competitor would in any event not materially alter the Parties' combined share of supply, it has not been necessary to further verify the existence of this competitor. On a cautious basis, therefore, the CMA has not altered the shares of supply in this paragraph or the subsequent paragraph to reflect the additional competitors identified by the Parties."*

4.59 As the Decision has not provided the names of the hospitals it investigated, it is impossible for the Parties to comment in specific terms. Nonetheless even if only one of these competitors treats male LTMH patients in the catchment area of Cambian Oaks, that evidence would be sufficient to reduce the Parties' combined market share below [✂] per cent. The suggestion that the Decision has not included a competitor on *"a cautious basis"* is unsatisfactory in the absence of evidence that the competitor in question does not provide a competitive constraint on the Parties in the relevant area.

4.60 The table below shows the Parties' combined market shares for different catchment areas centred on Cambian Oaks on the following measures:

(a) the CMA's estimated market share;

(b) the Parties' estimated market share on the same catchment area as the CMA but including additional competitors;

(c) the Parties' estimated market share on the gender specific treatment average catchment area ([✂] miles); and

(d) the Parties' estimated market share on the gender neutral treatment average catchment area ([✂] miles).

Table 4.3: The Parties' combined share of supply for Cambian Oaks

	CMA shares	Shares including additional competitors:		
		Site specific catchment	Gender specific average	Gender neutral average
Cambian Oaks	[✂]	[✂]	[✂]	[✂]

4.61 The reduction in market shares when analysing local markets by reference to the treatment average catchment area (rather than the site-specific catchment area) results

[47] Decision, footnote 51.

from the inclusion in the analysis of competitors just outside the site specific catchment area. In particular there are four additional sites ([✂]) between [✂] from Cambian Oaks. In total these four sites have 42 male beds and 20 mixed beds.

4.62 Figure 4.4 below shows the location of competitor sites within [✂] miles of Cambian Oaks. Competitors within the site specific catchment area are highlighted in green and competitors just outside the catchment area, but within [✂] miles of Cambian Oaks, are highlighted in red.

Figure 4.4: Map of competitors within [✂] miles of Cambian Oaks

[✂]

4.63 Even if these sites were considered to fall just outside the catchment area, each of these competing sites will have a catchment area which overlaps (in large part) with Cambian Oaks and therefore provides a further competitive constraint.

Failure to take into account the competitive constraint from NHS sites

4.64 As explained in Section 2 above, the Decision does not reflect the competitive constraint from NHS sites. In particular, in the case of Cambian Oaks, the Decision notes that at least one commissioner told the CMA that an NHS site competes with the Parties:

> *"The CMA notes that one Commissioner stated that it considered Coral Lodge (an NHS facility) to be on an equal footing with Cambian Oaks. The CMA has therefore taken into account that this facility may pose some constraint on the Parties, although it was not sufficient to mitigate the concerns identified."*

4.65 Notwithstanding any statements to the contrary in the Decision, it does not appear as though the constraint provided by Coral Lodge has been taken into account in the local market analysis. Given the Parties have a combined market share of just [✂] per cent, the inclusion of an additional competitor with 16 male beds would reduce the Parties' combined market share to [✂] per cent. This is only [✂] the 35 per cent threshold the CMA has set for filtering out sites.

4.66 Moreover, Table 4.4. below shows that there are a number of other NHS sites which are either closer to Cambian Oaks than Coral Lodge or a similar distance away (Coral Lodge is 17 miles from Cambian Oaks).

Table 4.4: NHS LTMH sites around Cambian Oaks

NHS Trust	Site	Location	Distance from Oaks	Number of beds
Sheffield Health and Social Care Trust	Forest Close	Sheffield	12 miles	[✂]
Rotherham, Doncaster & S Humber NHS FT	Emerald Lodge	Doncaster	16 miles	[✂]
SW Yorkshire Partnership NHS FT	Enfield Down	Honley, Holmfirth	17 miles	[✂]
Rotherham, Doncaster & S Humber NHS FT	Coral Lodge	Doncaster	17 miles	[✂]
Rotherham, Doncaster & S Humber NHS FT	Goldcrest Ward, Swallownest Court	Rotherham	17 miles	[✂]
Leeds & York Partnership NHS FT	Ward 5, The Newsam Centre	Leeds	26 miles	[✂]
Leeds & York Partnership NHS FT	Asket House & Asket Croft	Leeds	28 miles	[✂]
SW Yorkshire Partnership NHS FT	Lyndhurst	Halifax	36 miles	[✂]

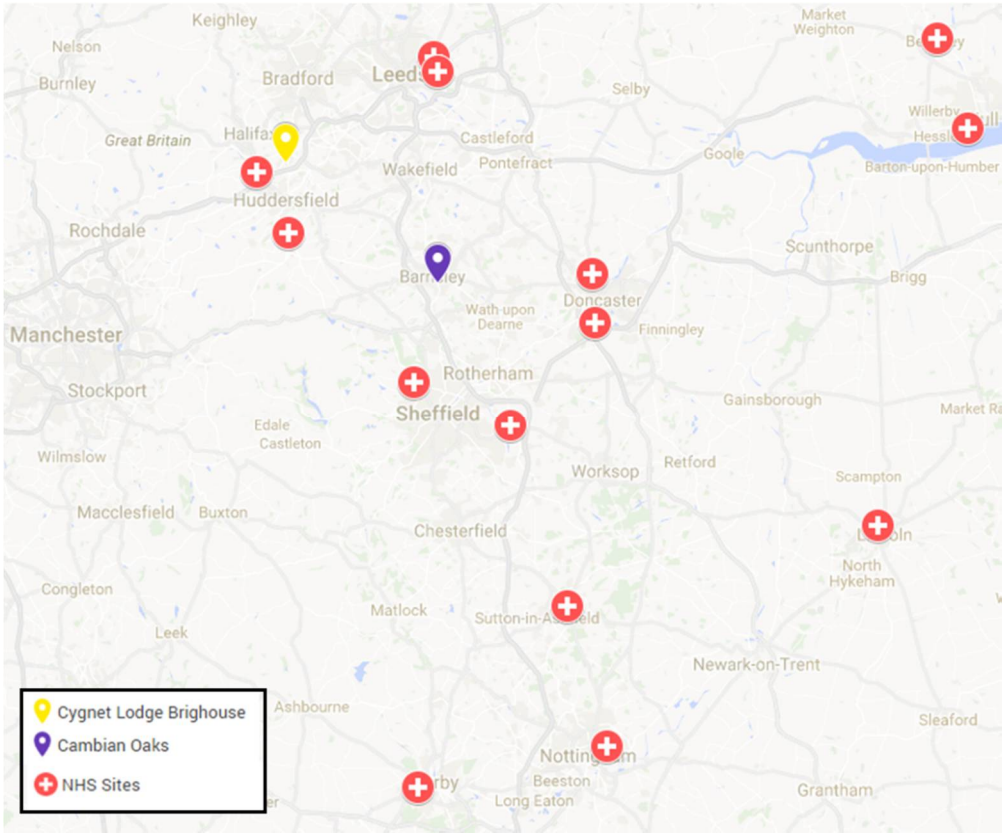
Nottinghamshire Healthcare NHS FT	Bracken House	Mansfield	37 miles	[✂]
Nottinghamshire Healthcare NHS FT	147 Thorneywood Mount	Nottingham	53 miles	[✂]
Lincolnshire Partnership NHS Trust	Discovery House	Lincoln	53 miles	[✂]
Derbyshire Healthcare NHS FT	Audrey House	Derby	54 miles	[✂]
Humber NHS FT	Hawthhorne Court	Beverley, Nr Hull	58 miles	[✂]
Humber NHS FT	St Andrew's Place	Hull	60 miles	[✂]

Source: Cygnet

4.67 It is not clear to the Parties why, if Coral Lodge is considered to provide a competitive constraint, these other NHS sites should not also be taken into account in the local market analysis. It is also clearly apparent that the Decision cannot simply dismiss the constraint from NHS hospitals on the basis of a lack of LTMH facilities in the area.

4.68 To illustrate the proximity of the NHS providers to the Parties, the Figure below shows a map of NHS providers around Cambian Oaks as well as the Parties' sites. The map is based on the Parties review of publicly available information, and therefore is likely to exclude a number of other NHS-funded sites in this area.

Figure 4.5: Map of NHS providers around Cambian Oaks



The catchment area used is too narrow

4.69 In relation to Cambian Oaks the Decision uses the site specific catchment area of [✂] miles.

4.70 However, the Decision ignores the evidence submitted in response to the Issues Letter which is consistent with a wider catchment area for Cambian Oaks. In particular, the

Parties submitted the following evidence as to why market shares based on the site-specific catchment area are unreliable:

(a) a geographic market based on the hypothetical monopolist test will typically be wider than the 80 per cent catchment area based on patient data. The exclusion of the most distant 20 per cent of patients is likely to significantly understate the loss of profits in response to a hypothetical price increase or deterioration in quality/service standards. In this regard Cambian Oaks treats patients from a significantly wider area than the 80 per cent catchment area. For example, Cambian Oaks has [✂];

(b) it is unclear why, and the Decision makes no attempt to explore or explain, the catchment area of Cygnet Brighouse is [✂] as Cambian Oaks, despite being only 21 miles away, and apparently both sites are considered to offer closely competing services (for which one would expect conditions of competition to be similar);

(c) CCG referral data indicates that all of the top five customers for Cambian Oaks refer LTMH patients to at least one Cygnet/CAS site more than [✂] miles away. For example, [✂];

(d) the 80 per cent catchment area is based on a small number of patients and therefore subject to significant uncertainty. In particular, the calculation is sensitive to small changes in the number of patients used to calculate the catchment area. If three additional patients are included in the Cambian Oaks catchment area, it would increase from [✂]. On this basis the Parties have a combined market share of below [✂] per cent.

5. LTMH FEMALE

5.1 The Decision identifies a realistic prospect of a SLC in relation to LTMH female sites in two areas:

(a) the overlap in the Midlands between Cambian Raglan House and Cygnet Hospital Coventry (a recently opened Cygnet site); and

(b) the overlap in Wales/South West England between Cygnet Hospital Kewstoke (The Lodge) and Cambian St Teilo House.

5.2 Each of these overlaps is discussed in turn below.

Cambian Raglan House / Cygnet Hospital Coventry

5.3 Raglan House is located in Birmingham and has 25 female LTMH beds.

5.4 The Decision identifies[48] a realistic prospect of an SLC in the supply of LTMH Rehabilitation Services for female patients in the site-specific 80 per cent catchment area of Cambian Raglan House, in relation to the overlap with Cygnet's Middlemarch Ward and Ariel Court in Coventry (located 28 miles from Raglan House).

The site specific catchment area is too narrow

5.5 As acknowledged at paragraph 162 of the Decision, the Raglan House site-specific catchment area ([✂] miles) is narrower than the treatment-average 80 per cent catchment area ([✂] miles). There is limited reasoning in the Decision justifying the use of a site-specific catchment area for Raglan House, instead of the treatment average area (which was used for assessing Cygnet Coventry).

5.6 Based on the partial reasoning set out in the Decision in respect of Raglan House, the finding of a realistic prospect of an SLC appears to have been influenced by the fact that the Parties' combined share and increment is significantly higher in the catchment area just narrower than the site-specific catchment area (i.e. [✂] as compared with [✂]).[49] However, the Decision identifies no site-specific evidence justifying the need to consider the level of concentration in a narrower catchment area than the site-specific 80 per cent catchment area. Indeed, for the reasons set out above, the Parties consider it clear that the site-specific catchment area itself is already unduly narrow.

5.7 In addition, the Decision does not address the arguments and evidence set out in the Parties' response to the Issues Letter which:

(a) demonstrates clear sensitivities around the parameters of the site-specific catchment area used for assessing Raglan House; and

(b) justifies using a wider geographic market for the purposes of assessing the impact of the transaction on local competition.

5.8 Firstly, the Decision does not address the evidence highlighted in the Parties' response to the Issues Letter that the addition of just [✂] results in the 80 per cent catchment area increasing to [✂], which results in the Parties having a combined market share of just [✂] per cent (with an increment of [✂] per cent).

5.9 Secondly, the Decision does not address the evidence supplied by the Parties in the response to the Issues Letter of their analysis of CCG referral patterns for the Top 5

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[48] Decision, paragraph 171.

[49] Decision, paragraph 164.

customers at Raglan House. That analysis was carried out to assess the area over which CCGs are willing to send LTMH patients. As explained in the response, the analysis shows that each of the top 5 CCG customers at Raglan House currently send LTMH patients to other CAS/Cygnet sites that are more than [✂] miles away from the CCG's address, and in most cases they send LTMH patients more than [✂] miles away.

5.10 In light of the above, the individual site catchment area for Raglan House referred to in the Decision is likely to materially understate the actual geographic market. This is illustrated by the fact that an increase in catchment area of just [✂] miles results in the Parties' combined market share dropping from [✂] per cent to [✂] per cent, which clearly highlights the sensitivity of this analysis.

Market shares are overstated

Omission of new competitors

5.11 The Decision[50] states that the transaction gives rise to a share of supply in the LTMH female segment of [✂] per cent with a [✂] per cent increment. However, the Decision acknowledges that the share of supply figures do not reflect revised market shares submitted by the Parties following the identification of additional competitors.[51]

5.12 In order to justify failing to take into account the new competitor evidence, the Decision merely cross refers to the statement at paragraph 84 of the Decision:

> "*The CMA sought to verify where possible the existence and extent of the competitive offering of those competitors where these additional competitors would materially change the shares of supply for those facilities which the CMA had already excluded from more detailed assessment. The only site for which this applied was Cambian Oaks with respect to the treatment of male LTMH patients. In all other cases the Parties' combined share remained above* [✂]*% even when taking into account all additional competitors*."

5.13 The summary of the approach to the assessment of the new competitor evidence is difficult to reconcile with the approach it actually followed in respect of Cambian Raglan House. In particular, it is not clear to the Parties why the CMA chose not to verify the existence and extent of the competitive offering of the additional competitors identified by the Parties, even though that evidence, if it had been accepted, would have materially changed the Parties' combined share of supply from [✂] per cent to [✂] per cent.

5.14 Moreover, if the additional competitors are taken into account and the wider treatment average catchment area is used, the Parties' combined market shares fall to [✂] per cent or below. The table below shows the Parties' combined market shares for different catchment areas centred on Cambian Oaks on the following measures:

(a) the CMA's estimated market share;

(b) the Parties' estimated market share on the same catchment area as the CMA but including additional competitors;

(c) the Parties' estimated market share on the gender specific treatment average catchment area ([✂] miles); and

(d) the Parties' estimated market share on the gender neutral treatment average catchment area ([✂] miles).

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50 Decision, paragraph 163.

51 Decision, footnote 58.

Table 5.1: The Parties' combined share of supply for Raglan House

	CMA shares	Shares including additional competitors:		
		Site specific catchment	Gender specific average	Gender neutral average
Cambian Raglan House	[✂]	[✂]	[✂]	[✂]

Exclusion of competitors just outside the individual catchment area

5.15 In response to the Issues Letter the Parties highlighted a number of competing sites just outside the site specific catchment area of Raglan House. Each of these competing sites will have a catchment area which overlaps (in large part) with the catchment area for Raglan House and therefore provides a further competitive constraint.

5.16 The competing sites within a [✂] mile catchment area of Raglan House include:

(a) PiC/Priory has five sites with 79 female beds and 28 mixed beds;

(b) St Matthews Healthcare has two sites with a total of 20 female beds and 78 mixed beds;

(c) John Munroe Group has two wards with a total of 34 female beds; and

(d) there are a range of other competitors including Inmind, St Andrews and Options for Care, and a number of other smaller competitors (as mentioned on page 53 of the Merger Notice).

5.17 Figure 5.1 below shows the location of competitor sites within [✂] miles of Raglan House. Competitors within the site specific catchment area are highlighted in green and competitors just outside the catchment area, but within [✂] miles of Raglan House, are highlighted in red.

Figure 5.1: Map of competitor sites within [✂] miles of Raglan House

[✂]

5.18 The Decision provides no explanation as to why competitor sites on the edge of the site specific catchment area would not exert a competitive constraint on the Parties such that they should be excluded from the analysis entirely.

5.19 Figure 5.1 shows that, as noted in the Decision, the Parties are not each other's closest competitors by geography, with four sites being closer to Raglan House than Cygnet Coventry. Even if proximity is a factor affecting CCGs' referral decisions, there are a range of other options available.

Failure to take into account ability to flex bed use

5.20 The Decision does not adequately explain the reason for its approach with respect to the number of available beds at sites which are able to offer mixed specialisms or treat patients of different genders. For example:

(a) two of the closest competitor sites to Raglan House (PiC/Priory Beverley House and PiC/Priory Lakeside, which are located just 2 miles and 13 miles away respectively), are combined LTMH/PD sites. [✂]. Clearly, if these sites can accommodate more LTMH patients, the Parties' combined market share drops significantly; and

(b) a number of competitor sites (PiC/Priory Lichfield Road, Rushcliffe's Aarons Specialist Unit, and Camino Healthcare's Cromwell House and Oak House) are

within a [✂] catchment area of Raglan House and are included in the market share analysis as mixed gender sites. Accordingly, only 35 per cent of the beds at these sites have been allocated to treating female patients. If these sites can accommodate all female patients, in response to changes in demand the Parties' combined market share on a [✂] catchment drops from [✂] per cent to just [✂] per cent (increment [✂] per cent). Even assuming a 50:50 ratio results in the Parties having a combined market share of just 35 per cent. In this regard, the PiC/Priory website state that the Lichfield Road site consists of 28 beds, with 20 beds being in individual apartments (and two four-bed wards), which indicates that it is feasible to accommodate a higher proportion of women.[52]

The Decision has not considered the competitive constraint from NHS sites

5.21 As explained in Section 2 above, the Parties remain strongly of the view that NHS-funded services compete with private providers in the provision of mental health treatment.

5.22 In this regard, contrary to the assertion at paragraph 48 of the Decision that "*there is little or no NHS provision for the specialisms in which the Parties overlap in most local areas*", the Parties note that there are a number of NHS mental health LTMH rehabilitation hospitals in the region, which are summarised in the table below.

Table 5.2: NHS LTMH sites in the West Midlands and surrounding areas

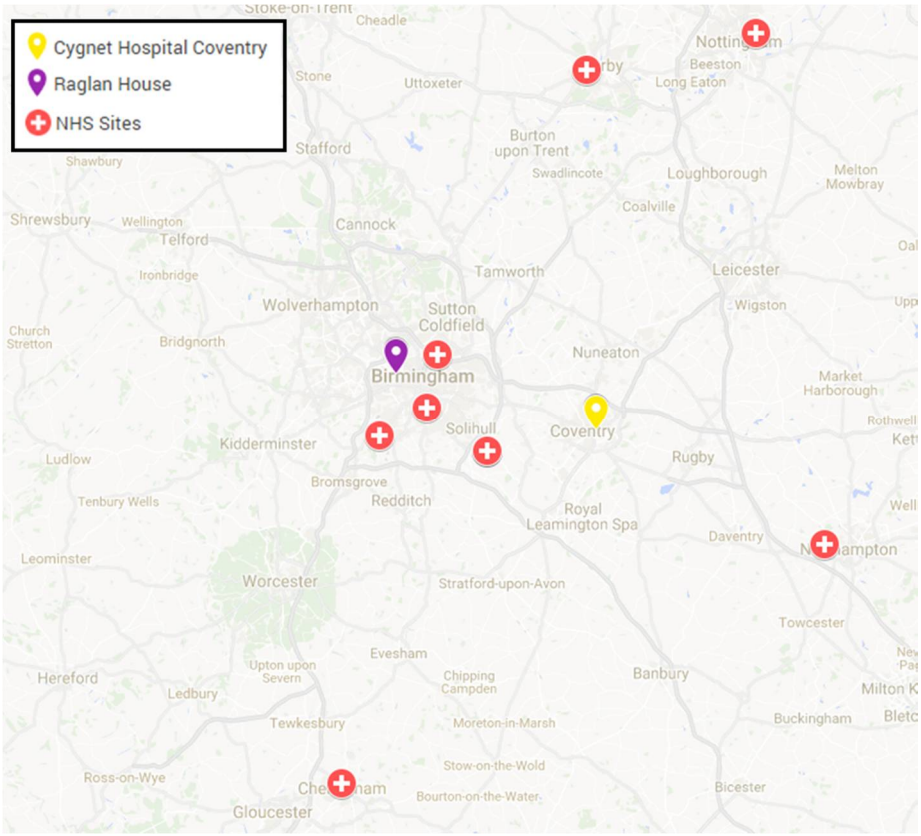
NHS Trust	Site	Location	Distance from Raglan House	Number of beds
Birmingham and Solihull MH NHS FT	Grove Avenue	Birmingham	5 miles	[✂]
Birmingham and Solihull MH NHS FT	Forward House	Birmingham	7 miles	[✂]
Birmingham and Solihull MH NHS FT	Endeavour Court	Birmingham	7 miles	[✂]
Birmingham and Solihull MH NHS FT	Ross House	Birmingham	8 miles	[✂]
Birmingham and Solihull MH NHS FT	David Bromley House	Birmingham	22 miles	[✂]
Birmingham and Solihull MH NHS FT	Dan Mooney House	Birmingham	22 miles	[✂]
Derbyshire Healthcare NHS FT	Audrey House	Derby	50 miles	[✂]
2Gether NHS FT	Laurel House	Cheltenham	51 miles	[✂]
Northamptonshire Health Care NHS FT	Meadowbank Ward, Berrywood Hospital	Northampton	55 miles	[✂]
Nottinghamshire Healthcare NHS FT	147 Thorneywood Mount	Nottingham	55 miles	[✂]

Source: Cygnet

5.23 To illustrate the proximity of the NHS providers to the Parties, the Figure below shows a map of NHS providers around Raglan House as well as the Parties' sites. The map is based on the Parties review of publicly available information, and therefore is likely to exclude a number of other NHS-funded sites in this area.

[52] http://www.partnershipsincare.co.uk/hospitals/255-lichfield-road

Figure 5.2: Map of NHS providers around Raglan House



The emphasis placed on an internal document is incorrect

5.24 The Decision refers to an internal Cygnet document[53] that "*notes Cambian Raglan House as one of only two facilities which would compete with the Coventry site in Rehabilitation Services for women with LTMH issues*".[54] This is incorrect. The "review of competitors," which does not purport to be comprehensive, lists [✂].

5.25 Moreover, it is plain from the document that the Decision has failed to include those aspects of the document that would support the Parties' arguments, including:

(a) the indication of the broad geographic area over which the hospital is expected to compete: [✂]; and

(b) competition from NHS providers (page 13).

No third party concerns were raised

5.26 At paragraph 170 of the Decision, the CMA notes that no third parties raised any merger specific concerns regarding Cambian Raglan House, but it has put limited weight on this given that the potential overlap is with a planned site. We find this conclusion puzzling given the reliance that the CMA has placed on patchy and unrepresentative third party evidence elsewhere in the Decision.

5.27 Accordingly, in light of the various factors set out above, the Parties consider that there is no risk of the transaction giving rise to a SLC in relation to the overlap between CAS Raglan House and the planned site at Cygnet Coventry for female LTMH patients.

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53 Appendix 20.3 to RFI1, Cygnet business case for Coventry.

54 Decision, paragraph 169.

St Teilo House / Cygnet Hospital Kewstoke (The Lodge)

5.28 Cygnet Hospital Kewstoke is a large specialist mental health hospital in Weston-Super-Mare in the South West of England, with the following five wards:

(a) Milton Ward is a low secure ward for up to 16 female patients with LTMH conditions;

(b) Knightstone Ward is a locked Tier 4 ward for up to 16 female patients with PD (and is considered separately in this response);

(c) Nash Ward is a PICU ward with up to 12 beds for male patients;

(d) Sandford Ward is an Acute psychiatry ward for up to 16 male patients; and

(e) The Lodge is a locked rehabilitation ward that treats up to 12 female LTMH patients.

5.29 St Teilo House is located in Gwent, South Wales 73 miles away from Kewstoke and the opposite side of the Severn estuary. It has capacity to treat up to 23 female LTMH patients.[55]

The Decision mixes average and site specific catchment areas

5.30 As noted in Section 2 above, the Decision acknowledges that it has adopted an inconsistent approach to assessing catchment areas by switching between treatment average and site-specific catchment areas, depending on which approach gives rise to the highest combined shares of supply, rather than focusing on the areas over which competition actually takes place. For example,

(a) the CMA used the site specific catchment area (of [✂]) for assessing St Teilo House (on the basis that it gives rise to a broad area which brings in some of the other sites operated by the Parties in the Midlands). The treatment average catchment area cited in the Decision was [✂] miles; and

(b) it has used the treatment average catchment area (of [✂] miles) for Kewstoke (the Lodge) on the basis that it gives rise to higher shares of supply. The site specific catchment area cited in the Decision was much wider at [✂].

5.31 Such an arbitrary and inconsistent approach is unrelated to the correct application of the SSNIP test, and provides an erroneous basis for assessing the competitive effects of the transaction. The fact that the resulting shares form a key part of the evidence cited in the Decision means that it is important for the CMA in Phase 2 to adopt a credible, consistent and evidence-based local geographic market.

The Parties' market shares are overstated

5.32 On the basis of the catchment areas set out above, the Decision states that the Parties have a combined market share of [✂] per cent (with a [✂] per cent increment) within the Kewstoke (The Lodge) catchment area,[56] and the parties would have a combined market share of [✂] per cent (with a [✂] per cent increment) in the Cambian St Teilo catchment area.[57] However, there are a number of reasons to consider these estimates to be materially overstated.

Omission of new competitor evidence

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55 The Parties note that paragraph 155 of the Decision incorrectly refers to St Teilo House having 9 female beds.

56 Decision, paragraph 146.

57 Decision, paragraph 156.

5.33 The Decision notes that the share of supply figures do not reflect the revised market shares submitted by the Parties following the identification of additional competitors.[58]

5.34 As noted at paragraph 2.17 above, the justification for not taking into account the new competitor evidence is set out elsewhere in the Decision.[59] However, that justification is difficult to reconcile with the approach and evidence described in the Decision in respect of the Cygnet Kewstoke and Cambian St Teilo House site level analysis. In particular, it is not clear why the existence and extent of the competitive offering of the additional competitors identified by the Parties was not verified, as it would have materially changed the Parties' combined share of supply in the catchment areas of Cygnet Kewstoke (The Lodge) and Cambian St Teilo House.

5.35 The table below shows the Parties' combined market shares for catchment areas centred on each of the sites based on the following measures:

(a) the estimated market share in the Decision;

(b) the Parties' estimated market share on the same catchment area as the CMA but including additional competitors;

(c) the Parties' estimated market share on the gender specific treatment average catchment area ([✂] miles for Cygnet and [✂] miles for CAS); and

(d) the Parties' estimated market share on the gender neutral treatment average catchment area ([✂] miles for Cygnet and [✂] miles for CAS).

Table 5.3: The Parties' combined share of supply for female LTMH services in the South East[60]

	CMA shares	Shares including additional competitors:		
		Site specific catchment	Gender specific average	Gender neutral average
Cygnet Kewstoke (The Lodge)	[✂]	[✂]	[✂]	[✂]
Cambian St Teilo House	[✂]	[✂]	[✂]	[✂]

5.37 It is clear from the table above that the inclusion of the additional competitors, significantly reduces the Parties' combined market shares. Moreover, on the basis of the average catchment areas, the Parties have a combined share of supply of at most [✂] per cent at each site.

Only beds which are available on the open market should have be taken into account

5.38 In the Response to the Issues Letter, the Parties noted that the Lodge provides a step down for patients from the other wards within the Kewstoke site (e.g. for patients that transfer from a secure environment or from acute and PD services). In the last 12 months, [✂] of patients admitted to the Lodge have stepped down from another ward within Kewstoke.

5.39 Accordingly, between [✂] of the 12 beds at the Lodge are typically used for internal transfers within the Kewstoke site, and therefore are not available on the market for CCGs looking to place female LTMH patients. This differentiates the Lodge significantly from St

58 Decision, footnote 53.

59 Decision, paragraph 84.

60 The Parties understand that [✂] this would reduce the Parties' combined market share in relation to St Teilo House and Kewstoke.

Teilo House, which only provides treatment for female LTMH patients (and therefore does not have internal transfers), with all beds being available on the market for CCGs.

5.40 The Decision does not adjust its market share estimates to take into account the impact of internal patient transfers on the basis that (i) evidence of the number of beds used by Kewstoke's own step-down patients will vary and (ii) any adjustment would need to be reflected for competitors that have step-down facilities. However, it is the Parties' understanding that there are very few female LTMH sites within the catchment areas of Kewstoke (The Lodge) and St Teilo House that provide internal transfers for patients from other wards within the same site. Accordingly, the Decision is likely to overstate the Parties' combined market shares.

Competitors planned sites have not been taken into account

5.41 As noted above, paragraph 225 of the Decision states that "*Competitors have not, however, identified any pipeline sites in the catchment areas considered within this Decision*". However, the Parties understand that there are a number other planned sites under contemplation or in early stages of development not included in the Decision. For example, recently Elysium announced the opening of a new 34 bed LTMH locked rehabilitation hospital in Wrexham, which the Parties were previously unaware of, and which would have fallen within the site specific catchment area of St Teilo House.[61]

The availability of female beds in mixed gender wards has been underreported

5.42 As regards the allocation of beds at sites which have mixed-gender wards and where the actual split of genders is unknown, the Decision notes that:

> *"the CMA has assumed (consistent with the position in Acadia/Priory) a 65:35 male to female split for the purposes of its market share calculations. The CMA did not have any evidence for the particular competitor sites in question to depart from this position."*[62]

5.43 Contrary to the above statement, in the response to the Issues Letter the Parties did point to evidence that the mixed gender sites in question are able to flex the proportion of male and female patients treated such that assuming a 65:35 male to female split would be overly cautious.

5.44 For example, as explained in the response to the Issues Statement, we understand that a 65:35 male to female split has been applied in respect of Elysium The Copse, which is located just 5 miles from Kewstoke. However, it is clear from page 3 of the hospital's brochure that the design of the hospital is such that it treats 50 per cent female patients, and therefore an unduly cautious assumption has been applied in the market share calculations. [63]

5.45 In addition, on the basis of the Parties' knowledge of [✂].

NHS-funded services should not be excluded from the market share analysis

5.46 As set out in section 2 above, the Parties remain strongly of the view that NHS-funded services compete with private providers in the provision of mental health treatment. However, all NHS beds have been excluded from the market share analysis which therefore understates the competitive constraints on the Parties.

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61 http://webcache.googleusercontent.com/search?q=cache:http://www.elysiumhealthcare.co.uk/elysiums-development-wrexham-track/

62 Decision, paragraph 151.

63 http://www.partnershipsincare.co.uk/sites/default/files/hospital/The%20Copse%20brochure.pdf

5.47 In this regard, the Parties are aware of the following NHS sites that provide treatment for LTMH patients in the South West of England and Wales. In addition, given the size of the individual site catchment areas, there are a number of other NHS sites further afield that are also providing treatment for female LTMH patients.

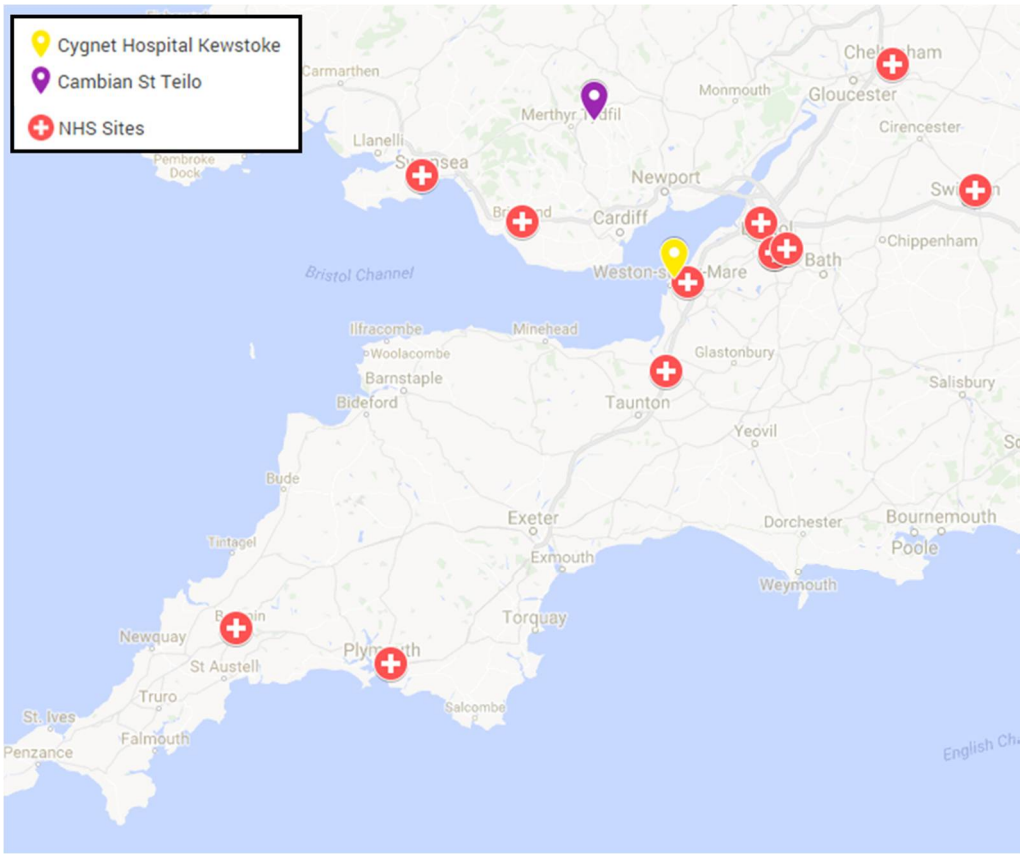
Table 5.4: NHS provider services in the South West of England and Wales

NHS provider	Site Name	Location	Distance	Number of beds
2Gether NHS FT	Laurel House	Cheltenham	58 miles (Kewstoke)	[✂]
Avon & Wiltshire Partnership Trust	Elmham Way	Worle, N Somerset	3 miles (Kewstoke)	[✂]
Avon & Wiltshire Partnership Trust	Larch Ward	Bristol	22 miles (Kewstoke)	[✂]
Avon & Wiltshire Partnership Trust	Alder Ward	Bristol	22 miles (Kewstoke)	[✂]
Somerset Partnership NHS FT	Willow Ward	Bridgewater, Somerset	22 miles (Kewstoke)	[✂]
Avon & Wiltshire Partnership Trust	Blaise View	Bristol	24 miles (Kewstoke)	[✂]
Avon & Wiltshire Partnership Trust	Whittuck Road	Hanham, S Gloucs.	35 miles (Kewstoke)	[✂]
Abertawe Bro Morgannwg University Health Board	Cefn Coed Hospital - Gwelfor Unit	Swansea	41 miles (St Teilo)	[✂]
Abertawe Bro Morgannwg University Health Board	Cefn YrAfon Community Rehab	Bridgend	41 miles (St Teilo)	[✂]
Avon & Wiltshire Partnership Trust	Windswept Campu	Swindon	69 miles (Kewstoke)	[✂]
Livewell Southwest	Greenfields	Lee Mill, Nr Ivybridge	104 miles (Kewstoke)	[✂]
Cornwall Partnership NHS FT	Fettle House Rehab Unit	Bodmin	128 miles (Kewstoke)	[✂]

Source: Cygnet

5.48 To illustrate the distances between the NHS sites, Figure 5.3 below shows a map of NHS sites in the South West.

Figure 5.3: Map of NHS sites in the South West



5.49 The Parties are only aware of the number of beds at a small number of these NHS competitor sites (as NHS providers typically do not have websites and therefore the specific site level information is more difficult to obtain). Therefore, the table and map above only include the NHS sites that the Parties are aware of.

5.50 However, even with the addition of the bed numbers from the small number of NHS sites in relation to which the Parties have bed data, the Parties' combined market shares fall well below 40 per cent.

Closeness of competition between the Parties

The Parties are not the most geographically proximate sites

5.51 As recognised in the Decision, with 73 miles between the overlapping sites, the Parties are not each other's closest competitors by geography.[64] This means that if proximity is a factor affecting commissioners' referral decisions, there are a range of other options that are closer to each of the Parties' sites (as shown in the Table below).

[64] Decision, paragraphs 148 and 157.

Table 5.5: The closest female LTMH competitors To Cygnet Kewstoke (The Lodge) and St Teilo House

	Three closest competitors	Distance	Number of beds
Cygnet Kewstoke (The Lodge) 12 female beds (4-5 used for internal transfers)	Sherwood Lodge Independent Mental Healthcare, Sherwood Lodge Independent Hospital	4 miles	24 mixed beds
	Elysium The Copse (England)	5 miles	24 mixed beds
	Ocean Community Services Overndale House (England)	30 miles	7 female beds
	PiC/Priory Bristol (England)	32 miles	10 mixed beds
	PiC/Priory Llanarth Court (Wales)	54 miles	4 female beds
	PiC/Priory Ty Catrin (Wales)	54 miles	3 female beds
	Elysium Ty Gwyn Hall (Wales)	61 miles	34 mixed beds
St Teilo House 23 female beds	Elysium Ty Gwyn Hall (Wales)	19 miles	34 mixed beds
	PiC/Priory Llanarth Court (Wales)	22 miles	4 female beds
	PiC/Priory Ty Catrin (Wales)	27 miles	3 female beds
	Hafal, Gellinudd Recovery Centre (Wales)	31 miles	16 mixed beds
	Ocean Community Services Overndale House (England)	61 miles	7 female beds
	PiC/Priory Bristol (England)	63 miles	10 mixed beds
	Elysium The Copse (England)	75 miles	24 mixed beds

5.52 The table above also shows that there are four other competitor sites in Wales in close proximity to St Teilo House (within [✂] miles), and there are four other competitor sites in the South West of England that are in close proximity to Kewstoke (The Lodge) (within [✂] miles). It is likely, therefore, particularly in light of the CCG referral patterns discussed below, that the competitor sites in Wales are closer competitors to St Teilo House than Kewstoke (The Lodge), whilst the competitor sites in the South-West of England are closer competitors to Kewstoke (The Lodge) than St Teilo House.

5.53 The Decision sets out at Paragraph 80 the factors taken into account in the competitive assessment. Of note, the "*distance between the Parties' hospitals*" and "*the number of competing hospitals*" are identified as two of the key factors taken into account. However, it is clear from Table 5.5 above that neither factor has received due consideration in relation to the overlap between Kewstoke (The Lodge) and St Teilo House, both of which face a number of competitors that are geographically more proximate than the other site operated by the Parties.

There is a clear distinction between England and Wales

5.54 The Decision relies on only two facts as evidence that the Parties are close competitors in the relevant catchment areas:

(a) the fact that Cygnet Kewstoke (The Lodge) has had [✂] female LTMH patients in the last three years funded by Local Health Boards (the Welsh equivalent of CCGs) from Wales (with [✂] patients being internal transfers within the Kewstoke pathway); and

(b) [✂] of patients at Cambian St Teilo House are funded by CCGs in England. However, the Decision does not comment on where those CCGs were located and the extent to which those CCGs also refer patients to Kewstoke.[65]

5.55 The Parties consider that the Decision places undue weight on the above evidence, and fails to take into account all the other options that are available to commissioners.

5.56 As set out in the response to the Issues Letter, the Parties consider that commissioners face a range of options. For commissioners based in Wales, it is noteworthy that:

(a) NHS Wales commissions rehabilitation services on the basis of a national framework, and [✂];[66]

(b) over the last 3 years, [✂] treated at Kewstoke (The Lodge) have come from Wales, with [✂] patients being internal transfers within the Kewstoke pathway; and

(c) NHS Wales commissioners have told Cygnet that there are a total of only [✂] placed in England at present.

5.57 Accordingly, there is very limited, if any, competition between the parties for female LTMH patients in Wales.

5.58 In relation to commissioners in England, the Decision finds that the patient placement data provided by the Parties does not support the conclusion that the Parties are not close competitors, but indicates that there is a significant degree of overlap.[67] Given the size of the catchment areas considered in the Decision, the Parties' sites will clearly overlap (as they do with many other competitor sites). The relevant question, therefore, is whether Kewstoke (The Lodge) is a significant competitor to St Teilo House (and vice versa).

5.59 As set out in the Issues Letter, for commissioners that refer patients to St Teilo House, the patient location data indicates patients being referred from [✂]:

(a) [✂];

(b) [✂];

(c) [✂]; and

(d) [✂].

The CMA has previously considered competition around St Teilo House

5.60 In the Response to the Issues Letter, the Parties noted that the CMA had already considered competition for female LTMH services in the area around St Teilo House, in its decision in Acadia/Priory (i.e. in relation to the Ty Gwyn Hall site, which, as noted above, is just 19 miles from St Teilo House and the closest competing site to St Teilo House).[68] Consistent with the sites present in the local area, the CMA concluded that:

(a) PiC and Priory would have had a combined share of 50-60 per cent (of beds), with an increment of 20-30 per cent, around the Ty Gwyn Hall site;

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65 Decision, paragraph 152.

66 For example see *"One Wales – A progressive agenda for the government of Wales"* http://www.weds.wales.nhs.uk/sitesplus/documents/1076/Onewales.pdf

67 Decision, paragraph 152.

68 Paragraph 527-533. Completed acquisition by Acadia Healthcare Company, INC. of Priory Group No. 1 Ltd (Case ME/6587/16).

(b) PiC and Priory were the first and second largest competitors in the relevant catchment area around Ty Gwyn Hall, accounting for around half of the facilities in the local area;

(c) Cambian (St Teilo House) was identified as the third largest competitor with a share of just 10-20 per cent of beds; and

(d) Cygnet Kewstoke (the Lodge) was not even mentioned as providing a relevant competitive constraint on these sites.

5.61 As explained in the response to the Issues Letter, given the close proximity of Ty Gwyn Hall to St Teilo House, the competitive conditions are unlikely to be materially different. However, the Decision fails to explain the reasons why the competitive conditions in the St Teilo House catchment area have materially changed since July 2016, when the decision in *Acadia/Priory* was announced. Indeed, the Decision does not even acknowledge that this argument was made by the Parties. The fact that two neighbouring sites have both now both been identified as giving rise to a SLC finding further highlights the implausibility of the analysis set out in the Decision.

Third party comments are overstated

5.62 The Decision relies on third party comments in respect of Cygnet Kewstoke to find a two-way SLC with respect to Cambian St Teilo House and Cygnet Kewstoke (The Lodge).[69]

5.63 Based on the limited disclosure of that third party evidence, the only conclusion that can be drawn from that evidence is that "the Parties compete with one another" which is an insufficient basis to identify a realistic prospect of a SLC.[70] Put another way, the CMA received no third party comments raising merger specific concerns regarding either Cygnet Kewstoke (The Lodge) or Cambian St Teilo House.

[69] Decision, paragraph 160.

[70] Decision, paragraph 160.

6. FEMALE PD

6.1 The Decision identifies a realistic prospect of an SLC in relation to female PD sites in two areas:

(a) the overlap in the North of England between Cygnet Hospital Bierley (Bowling Ward) and two CAS sites (Cambian Acer Clinic and Cambian Aspen Clinic); and

(b) the overlap in the South of England between Cygnet Hospital Kewstoke (Knightstone Ward) and Cambian Alders Clinic.

6.2 Before addressing the specific overlaps between these sites, the Parties have commented on the Decision's assessment of the differences in the PD service offering between the parties' PD sites.

The parties' PD sites provide a fundamentally different service

6.3 In the response to the Issues Letter, the Parties provided a detailed assessment of the differences in the service provide at the Cygnet and CAS PD sites. These differences include the following:

(a) Cygnet's PD sites provide services to the Tier 4 level of PD specification and accept patients with the highest level of challenging behaviour and risk, as evidenced by the CQC report for Cygnet Kewstoke (Knightstone ward). In comparison, the CQC reports for Cambian Alders Clinic and Cambian Aspen Clinic are both referred to as Tier 3 PD services, whilst the CQC report for Cambian Acer Clinic refers to it providing "*Long stay/rehabilitation mental health wards for working age adults*";[71]

(b) the NHS England service specification document describes Tier 4 PD services as providing: "*specialist and intensive provision beyond that which can be provided within either local specialist (Tier 3 PD) services or other local mental health services including acute inpatient facilities.*" It also highlights the complementary nature of Tier 3 and Tier 4 services, thereby providing clear evidence of the different level of treatment provided;

(c) the Cygnet wards operate within a secure hospital environment, as both hospitals operate low secure and PICU wards at that site. This enables those facilities to accept service users that have higher levels of risk ([✂]) and who could not be treated in a standalone facility, such as those operated by CAS;

(d) the Cygnet PD wards offer more intense and specialist PD treatment programmes. For example, the [✂]. Less specialised wards, [✂], do not [✂];

(e) there is a much [✂] the more specialist Cygnet facilities, which is reflected in patients receiving a higher proportion of nursing and therapy hours (which reflects the more intensive treatment provided);

(f) due to the acuity of patients and the intensity of the programme offered on Cygnet's highly specialised PD wards, the average length of stay is shorter and the price is generally higher;[72]

(g) [✂]; and

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[71] This reflects the fact that the CAS sites operate in a community facing environment, and therefore are expected to treat patients from, and release patients to, the community sector.

[72] For example, the average length of stay in Kewstoke (Knightstone Ward) is around [✂], rather than the usual [✂] in a normal locked rehabilitation ward

(h) the geographic catchment area for the two Cygnet PD sites is much wider than for the CAS facilities, which reflects the specialist nature of the service provided at those sites, and therefore that CCGs are prepared to refer patients much further afield in order to receive a specialist service.

6.4 Accordingly, whilst CAS and Cygnet both treat female patients with PD, they are treating patients with very different levels of risk, and at different stages of the care pathway. [✂].[73] In this regard, it is simply not correct that the Cygnet PD facilities are treating, or could treat, less acute patients on the same ward.

Third party comments

6.5 The Decision acknowledges that:

> "*Commissioners confirmed that the Parties' offerings were differentiated and may be better suited to different patients*" (paragraph 175) and that "*the CMA's investigation confirmed that there are differences between the approaches to treatment at the Parties' female PD sites*" (paragraph 181).

6.6 However, despite these comments, the Decision goes on to conclude that:

> "*a number* [of commissioners] *indicated they would nonetheless regard each of Cambian Alders / Cygnet Kewstoke and Cambian Acer and Aspen / Cygnet Bierley as competitors*" (paragraph 175) and that "*the CMA does not consider that the differentiation in the Parties' offering is sufficient to conclude that Cygnet could not be a meaningful competitive constraint on Cambian in relation to treatment of female PD patients (or vice versa)*." (paragraph 181)

6.7 The Parties cannot reconcile these comments. Whilst the Decision refers to "a number" of commissioners that indicated the Parties' PD sites were competitors, the number is not specified. The Parties find these comments surprising, [✂] and, in relation to the comments from competitors, incorrect. Despite a request on behalf of the Parties following the state of play call for a broad statistical breakdown of how many CCGs were asked questions, how many responded and how many raised concerns, the CMA refused to provide this information to the Parties.

6.8 Moreover, it is clear that the CMA received information from commissioners which clearly contradicts the conclusion reached in the Decision. The Decision has not tried to reconcile the inconsistent nature of the third party comments received, but has instead focused on the small number of comments which support its conclusion, and ignored all comments to the contrary. It remains unclear why some CCGs would identify the Parties' PD sites as being competitors, when other CCGs confirmed otherwise. Clearly, at Phase 2, it will be important for the CMA to understand the nature of the Parties' PD services.

6.9 It is also evident from the third party comments that the Decision has failed to adequately understand the complementary nature of the service provided by Tier 3 and Tier 4 PD providers. It is unsurprising and uncontroversial that "*a number of Commissioners said that they value being able to seek assessments of patients by different sites with different approaches*" (as set out in paragraph 176(a)). This reflects the fact that it is not always clear to commissioners which level of PD service is required. By seeking clinical assessments of patients at different PD sites, commissioners are better able to determine which level of PD service is required to meet the patient's clinical needs. This is not a trade-off between the parties' PD sites, but represents a clinical assessment as to which stage on the care pathway is the most clinically appropriate for the patient. The same patient could be assessed by both Parties' services, but may be inappropriate to be treated at one or other facility depending on risk and acuity.

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[73] [✂].

6.10 In this regard the Parties note that [✂].

6.11 In addition, the claim in the Decision that the DBT offering "*was merely a different approach*" (paragraph 176(d)) is not strictly correct. The DBT offering provided at the Cygnet PD facilities is specifically designed to treat patients with the highest level of challenging behaviour and risk. As explained in the response to the Issues Letter, [✂].

6.12 The evidence presented in the decision to support the CMA's conclusions appears to be nothing more than "*one Commissioner*" that told the CMA that they no longer place patients at Cygnet Bierley following a poor experience (paragraph 176(b)), and other commissioners that "*don't currently place patients at both Parties' sites*" (paragraph 176(c)). It is unclear why the CMA views of commissioners that do not currently refer patients to the parties' sites have been relied upon, as they are unable to provide an accurate assessment of the services provided at those sites.

6.13 The Decision also states (at paragraph 180) that "*in relation to whether it would be appropriate for more and less acute patients to be placed on the same ward, the evidence received by the CMA is mixed*". However, it is of note that the comments relied upon in the Decision were from a competitor (i.e. "*another provider told the CMA that acute and less acute patients could be placed on the same ward (depending on case-specific considerations around patient mix)*"). This statement fails to reflect the need to ensure that patients are treated in a facility appropriate to their condition, risk and treatment needs.

6.14 Finally, the Parties note that (in paragraph 180) "*The CMA was also told by one Commissioner that, in their experience, Cygnet does in fact mix patients of different levels of acuity within its female PD wards*". However, this is not consistent with the Parties experience, in particular, there are two reasons why Cygnet would not mix patients of different level of acuity and risk on the same ward:

(a) [✂]; and

(b) [✂].

Tier 4 level of service specification

6.15 As set out in the response to the Issues Letter, all of the Cygnet PD sites provide services to the Tier 4 level of PD service specification and accept patients with the highest level of challenging behaviour and risk.

6.16 In this regard, [✂]. As set out in the Decision, both Cygnet Hospital Beckton and Cygnet Hospital Ealing provide Tier 4 PD services, both are NHS England funded, and the service specification at these sites is determined by NHS England (i.e. unless the sites meet this service specification, NHS England will not refer patients to these sites). The only meaningful difference compared to Cygnet Hospital Kewstoke and Cygnet Hospital Bierley is the dates when these sites were opened, with Kewstoke being opened after the NHS moratorium came into force and Bierley finalising changes to bring it into line with the Tier 4 level of service specification after this date.[74]

6.17 However, despite the evidence presented to the CMA, the Decision expresses doubt as to whether the Cygnet sites are genuinely Tier 4 services. This is notwithstanding the fact that the CQC report for Kewstoke (Knightstone ward) clearly states that it is a Tier 4 service. The Parties would, therefore, encourage the CMA to discuss the Parties' different PD services with either the NHS England lead commissioner ([✂]) or someone from the NHS England PD Clinical Reference Group who should be in a position to provide an informed assessment.

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[74] When the NHS England moratorium on new services is lifted, [✂].

6.18 Finally, in paragraph 179, the Decision refers to an internal document and claims that this provides evidence to show that Cygnet Hospital Kewstoke and Cygnet Hospital Bierley are not Tier 4 services (i.e. with both sites being referred to as "Locked Rehab"). The Decision also states that only Cygnet Beckton and Cygnet Ealing were mentioned as Tier 4 services. However, as mentioned above, neither Cygnet Hospital Kewstoke nor Cygnet Hospital Bierley are NHS England funded services due to the NHS moratorium on new services. They are still run and operated to the same level of service specification as Cygnet's other PD sites (at Cygnet Beckton and Cygnet Ealing). It is unsurprising, therefore, that they are referred to internally within the broad "Locked Rehab" definition to avoid confusion as they are not currently NHS England funded services. Contrary to the assertion in the Decision, this does not provide any evidence to support a difference in service specification between Cygnet's different PD sites.

6.19 Paragraph 179 of the Decision also notes that *"the Cygnet website which identifies only Beckton and Ealing as Tier 4 facilities"*. However, the Cygnet website is worded to avoid confusion from NHS commissioners, i.e. CCGs thinking that NHS England will fund placements at Knightstone Ward and Bowling Ward.

Cambian Acer Clinic and Cambian Aspen Clinic / Cygnet Hospital Bierley

6.20 Cambian Acer Clinic is a female PD site located in Chesterfield with 28 beds.[75] The Decision has identified a realistic prospect of an SLC in relation to the overlap between Acer Clinic and Cygnet Hospital Bierley (Bowling Ward), which is located 54 miles away by road.

6.21 The Cambian Aspen site is located in Rotherham. It has two wards:

(a) Cambian Aspen House is a female LTMH locked rehabilitation ward with 20 beds (no issues have been raised by the CMA in relation to this ward); and

(b) Cambian Aspen Clinic is a female PD locked rehabilitation ward with 16 beds.

6.22 The Decision has identified a realistic prospect of an SLC in relation to the overlap between Aspen Clinic and Cygnet Hospital Bierley (Bowling Ward) which is 41 miles away. The Decision also identified a realistic prospect of an SLC in relation to Cygnet Hospital Coventry (Ariel Ward) which the Decision reported as 75 miles away from Aspen Clinic.[76] However, this is incorrect. Cygnet Hospital Coventry is 92 miles from Aspen Clinic by road. Cygnet Hospital Coventry is therefore outside of the site specific catchment area of Aspen Clinic.

6.23 Cygnet Hospital Bierley is a large mental health hospital located in Bradford and has the following four wards:

(a) Bronte Ward is a low secure ward that provides treatment for up to 12 female patients with LTMH conditions;

(b) Shelley Ward is a low secure ward for up to 16 male patients with LTMH conditions;

(c) Denholme Ward is a PICU ward with up to 15 beds for female patients; and

(d) Bowling Ward is a highly specialised PD rehabilitation ward with 20 beds for female patients.

6.24 As set out in the Merger Notice, there is no overlap between the Parties in relation to the low secure or PICU wards at Cygnet Hospital Bierley.

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[75] This includes 14 beds in Acer 2nd Wing which opened in February 2017.

[76] Decision, paragraph 205.

6.25 In relation to the Bowling Ward at Cygnet hospital Bierley, as mentioned above, it operates to a Tier 4 level of specification (as do all of the Cygnet PD wards), and [✂]. It also operates within a secure hospital, provides highly specialised DBT, has access to seclusion facilities, and accepts patients with a high level of challenging behaviour and risk (i.e. who are towards the upper end of the PD acuity spectrum).

6.26 In comparison, both Cambian Acer Clinic and Cambian Aspen Clinic treat PD patients with a lower level of acuity and risk, and both are seen as a step down from the Bowling Ward ([✂]). As mentioned above, the CQC report for Cambian Aspen Clinic refers to it as providing Tier 3 PD services,[77] which reflects the fact that it provides a community facing rehabilitation service, whilst the CQC report for Cambian Acer Clinic refers to it as providing "*Long stay/rehabilitation mental health wards for working age adults*", which suggests that its PD service is more akin to a general locked LTMH rehabilitation ward.

6.27 Accordingly, due to the fundamentally different PD service provided at Cygnet Bierley from the services provided at Cambian Acer Clinic and Cambian Aspen Clinic, the Parties do not consider that the Bowling Ward at Cygnet Bierley competes closely with the CAS PD sites, and vice versa. This is also reflected in the weight of the third party comments received by the CMA, a number of which referred to the differences in service provided at the Parties' sites. The Decision also did not identify a separate SLC centred on Cygnet Hospital Bierley.

The catchment area highlights a differentiation in service

6.28 In the response to the Issues Letter the Parties submitted evidence that the difference in catchment areas between Aspen Clinic/Acer Clinic and Cygnet Hospital Bierley provides evidence of the differentiation in service provided by Cygnet and CAS sites. The Decision has not referred to this evidence and therefore it is repeated below.

6.29 The 80 per cent catchment area for the Bowling Ward is [✂] miles (based on a sample of [✂] patients), which covers a large part of the country. Moreover, just 4 additional patients results in the Bowling Ward having a catchment area of [✂] miles on this basis. In this regard, CCG referral patterns also indicate that the Bowling Ward is drawing patient referrals from over a wide area. The CCGs referring patients to the Bowling Ward include:

(a) [✂];

(b) [✂];

(c) [✂];

(d) [✂]; and

(e) [✂].

6.30 In this regard, it is estimated that within the last 12 months, over [✂] of placements at the Bowling Ward were from out of area (defined by reference to NHS England regions, and excluding geographically proximate regions).

6.31 In comparison, the 80 per cent catchment of Cambian Acer clinic is just [✂] miles. Whilst this is based on a limited sample of patients, it is noteworthy that all bar one patient referred to that site was made by a CCG within [✂] miles of the facility. These include [✂]. In addition, the 80 per cent catchment area for the Aspen Lodge sites is [✂] miles

[77] The percentage of people who have been admitted to Cambian Aspen Clinic on an informal basis (i.e. not detained under the Mental Health Act) over the last 24 months is [✂], which reflects the lower severity of the conditions treated at this site.

(based on [✂] patients). The removal of just one patient reduces the catchment area to [✂] miles.

6.32 Accordingly, there are very clear differences over the area in which the Cygnet site is drawing patients, which is consistent with the highly specialised nature of the service offered, and further differentiates it from the services provided at Cambian Acer Clinic and Cambian Aspen Lodge. In this regard, it is widely recognised in healthcare mergers that patients typically travel further for specialist treatment. For example, in its GHG/Nuffield decision, which related to private hospitals rather than mental health hospitals, the OFT acknowledged that "*for more specialist/complex procedures patients may be willing to, and may have to, travel further, for example to regional centres of excellence*"[78].

6.33 Whilst Cambian Acer Clinic, Cambian Aspen Clinic and Cygnet Bierley (Bowling Ward) all treat female patients with PD, as set out above, they are treating patients with different levels of acuity and risk and drawing patients from different catchment areas. The Parties do not, therefore, consider that the Parties' PD sites to compete, and therefore any market share analysis will inevitably overstate the Parties' position.

Market share analysis

6.34 As set out above, as the Parties' PD sites provide very different services, the Parties do not consider that the market share analysis in the Decision (which considers the Parties' sites within the same market) to be a reliable indicator of competition. Despite these concerns, it is notable that:

(a) in relation to Aspen Clinic the Decision reports that the Parties have a combined share of supply of [✂] per cent (with a [✂] per cent increment). This is only [✂] the threshold of 35 per cent used in the Decision for filtering out sites that do not give rise to competition concerns.

(b) in relation to Acer Clinic, the Decision reports that the Parties have a combined share of supply of [✂] per cent (with a [✂] per cent increment). However, this is on the basis of the site specific catchment area of [✂], which is based on a sample of just [✂]. The treatment average catchment area gives rise to a lower combined share of supply of [✂] per cent (increment [✂] per cent).

6.35 Moreover, it is clear that the CMA identified additional female PD beds in the catchment areas of both Acer Clinic and Aspen Clinic, as the Decision reports lower market shares than the Parties submitted in their response to the Issues Letter.[79] Therefore, on the basis of the average catchment area, the Parties' combined market share will be less than [✂] per cent and could be below [✂] per cent.

Constraint from LTMH sites

6.36 In the response to the Issues Letter the Parties explained that Cambian Acer Clinic and Cambian Aspen Clinic both treat patients with less challenging needs, and therefore they are constrained by LTMH sites that also treat less demanding PD patients. In this regard, a number of CAS LTMH sites treat patients with the same description of mental health condition as its PD sites (i.e. "emotionally unstable personality disorder"). As mentioned above, the CQC report for Cambian Acer Clinic also refers to it as providing "*Long stay/rehabilitation mental health wards for working age adults*", which suggests that it is similar to a LTMH ward. This is also consistent with the Cygnet Hospital Derby document referred to in paragraph 108 of the Decision which lists Cambian Acer as *"28 bed Female Locked Rehab"*, rather than PD.

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[78] Completed acquisition by General Healthcare Group of assets of Nuffield Hospitals

[79] Decision, footnotes 71, 72, 76 and 77.

6.37 On the basis of a combined PD/LTMH market, the Parties' combined market shares are reported in the below table of the following catchment areas:

(a) the site specific catchment areas, i.e. [✂] for Aspen Clinic and [✂] for Acer Clinic;

(b) the PD average catchment area for CAS sites, i.e. [✂]; and

(c) the LTMH average catchment area for CAS sites, i.e. [✂].

Table 6.1: The Parties' combined market share based on a PD/LTMH market

Catchment centred on	Market shares on the basis of		
	Individual catchment	PD average catchment	LTMH average catchment
Cambian Acer Clinic	[✂]	[✂]	[✂]
Cambian Aspen Clinic	[✂]	[✂]	[✂]

6.38 The above table shows that if other female LTMH facilities are included within the market share calculations to reflect the constraint on the CAS PD sites, the Parties' combined market share drops to below [✂] per cent (with the only exception being the individual catchment area of Cambian Acer Clinic, which is based on just [✂] patients and therefore is not statistically reliable, but is still below [✂] per cent). However, despite the material impact including LTMH sites has on the Parties' combined market share, the Decision does not address the extent to which LTMH sites provide a constraint on Acer Clinic or Aspen Clinic.

Third party comments are overstated

6.39 In relation to the differentiation between services provided at Cygnet Hospital Bierley and Cambian Aspen Clinic, the Decision refers to a third party comment:[80]

> *"one Commissioner told the CMA that the Parties' approaches have become more similar recently, as Cambian have added DBT to their approach in the last twelve months"*

6.40 However, this third party has failed to reflect the fundamental difference between the [✂] programme provided at Cygnet sites and the [✂] services provided at CAS sites:

(a) [✂]; and

(b) [✂].

6.41 Therefore, while it is correct that Cambian have recently added DBT to their approach, this is not in competition to the services provided at Cygnet PD sites. Rather the addition of DBT to CAS' existing treatment programme, enables CAS sites to treat patients who are stepping down from a facility where they have already received a full programme of DBT treatment, e.g. a Cygnet PD site.

Cambian Alders Clinic / Cygnet Hospital Kewstoke

6.42 Cambian Alders Clinic is a female PD site with 20 beds in Gloucester. The Decision identifies a SLC in relation to the overlap with Cygnet Hospital Kewstoke, located 50 miles from Alders Clinic in Weston-Super-Mare and Cygnet Hospital Coventry, located 62 miles away.

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[80] Decision, paragraph 212.

6.43 Cygnet Hospital Kewstoke is a large mental health hospital and has the following five wards:

(a) Milton Ward is a low secure ward for up to 16 female patients with LTMH conditions;

(b) The Lodge is a locked rehabilitation ward that treats up to 12 female LTMH patients (which is considered separately above);

(c) Nash Ward is a PICU ward with up to 12 beds for male patients;

(d) Sanford Ward is an Acute psychiatry ward for up to 16 male patients; and

(e) Knightstone Ward is a female PD ward with 16 beds.

6.44 As set out in the Merger Notice, there is no overlap between the Parties in relation to the low secure, PICU or Acute psychiatry wards at Cygnet Hospital Kewstoke.

6.45 In relation to the Knightstone Ward, like Bowling Ward at Cygnet Hospital Bierley, it is a highly specialised PD service that accepts women with the most challenging behaviour and highest risk, and operates to the Tier 4 level of PD specification. As set out above, this is highlighted in the recent CQC report for Kewstoke (published on 7 June 2016), which clearly states that these are "*Tier 4 personality disorder services*". [✂] this facility is not currently an NHS England site is that it were opened after the NHS moratorium was introduced (on 1 April 2013).

6.46 In comparison, Cambian Alders Clinic treats patients with a lower level of acuity and risk. This is highlighted in the recent CQC report for Cambian Alders Clinic (published on 7 June 2016), which clearly states that this site provides a Tier 3 Personality Disorder service, which reflects the fact that it provides a community facing rehabilitation service. In this regard, patients would usually step-down from Knightstone Ward to a facility like Cambian Alders Clinic, which is considered to be the next stage on the care pathway ([✂]). This is also reflected by the average daily fees for the two sites; the average daily fee for Knightstone Ward is [✂], compared to [✂] for Cambian Alders Clinic.

6.47 The NHS England PD service specification document also highlights that Tier 4 providers would be expected to collaborate with local Tier 3 services so as to offer specialist assessment, consultation and support to those services, and offer intensive specialist therapy for individual people in Tier 3 with a particular need. Accordingly, it emphasises the different stages in the care pathway for PD services (and the different needs of patients at Tier 3 and Tier 4 respectively), which is clearly relevant to the assessment of the overlap between the Knightstone Ward and the Cambian Alders Clinic.

6.48 As previously mentioned to the CMA, in 2013, Cygnet Hospital Kewstoke went through a process of re-positioning and changed [✂] service lines to align the services with the demand from NHS commissioners. As a result of a lack of highly specialised PD services for women, especially a service that could take very challenging patients with an imminent risk of suicide and self-harm, patients were often travelling to receive PICU services in London and around the country (as alternative provision).

6.49 Cygnet therefore decided to re-align the services to meet the demand of NHS commissioners. As part of that change process, Cygnet converted one of its two female low secure wards (Knightstone ward) to provide highly specialised PD treatment for high risk female patients that needed a robust and semi-secure environment to manage the most challenging behaviour. The existing low secure environment reduced the need for additional investment as it already provided a secure environment for the most challenging patients. This transition reflects the highly specialised Tier 4 female PD service provided at Knightstone ward, which is set within a semi-secure environment (with a large perimeter fence around the Cygnet site), which could not be provided on a stand-alone locked rehabilitation ward.

6.50 Accordingly, whilst Cambian Alders Clinic and Cygnet Kewstoke (Knightstone Ward) both treat female patients with PD, they are treating patients with different levels of acuity and risk. The Parties do not, therefore, consider Cambian Alders Clinic and Knightstone Ward to be close competitors, and therefore there is minimal overlap between the Parties. The market share analysis set out in the Decision therefore fails to reflect these fundamental differences in the service provided.

The catchment area highlights a differentiation in service

6.51 As mentioned above for Bierley (Bowling Ward), the individual catchment area of Kewstoke (Knightstone Ward) is much broader than the CAS facility, reflecting the specialist nature of the PD service provided. The Parties put this point forward in response to the Issues Letter, but it was ignored in the Decision.

6.52 The 80 per cent catchment area for the Knightstone Ward is [✂] miles (based on a sample of [✂] patients), with just [✂] additional patient increasing the catchment area to [✂] miles. In this regard, CCG referral patterns indicate that the Knightstone Ward is drawing patient referrals from over a very wide area. These include:

(a) [✂];

(b) [✂]; and

(c) [✂].

6.53 In comparison, the 80 per cent catchment of Cambian Alders clinic is [✂] miles, although it is based on small number of just [✂] patients (and one fewer patients results in a catchment area of [✂] miles).

The Decision's treatment of catchment areas is inconsistent

6.54 For the reasons set out above, the Parties do not consider that the market share analysis in the Decision (which considers the Parties' sites within the same market) provides a reliable indication of the extent of competition in the relevant catchment areas. Despite this shortcoming, the Decision has only identified high market shares on the basis of the treatment average catchment area.

6.55 If the Decision had applied a consistent approach to the assessment of the geographic market, it is unlikely that a SLC would have been identified in relation to these sites as the Parties' combined market share is below [✂] per cent:

(a) the site specific catchment area for Kewstoke (Knightstone Ward) is [✂]. On this basis the Parties have a combined market share of [✂] per cent (increment [✂] per cent); and

(b) the site specific catchment area for Cambian Alders Clinic is [✂]. On this basis the Parties have a combined market share of [✂] per cent increment [✂] per cent.

6.56 The Decision also fails to address the extent to which LTMH sites constrain Alders Clinic which treats patients with less challenging needs, even though elsewhere the Decision recognises that:

(a) switching costs are likely to be lower for combined PD/LTMH sites;[81] and

(b) there are wards providing both PD and LTMH treatment.[82]

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[81] Decision, paragraph 42.

[82] Decision, paragraphs 207 and 218.

Third party comments and reliance on internal documents are overstated

6.57 The Decision notes that commissioners confirmed that that there is a differentiation in the level of specialism offered at Cygnet Kewstoke (Knightstone Ward) and Cambian Alders clinic, but ignores these comments on the basis that "*at least some commissioners view them as alternatives*".[83] However, the Parties find this latter comment surprising as it does not reflect the clinical reality of the different services provided.

6.58 The Decision also notes at paragraph 193 that *"One Commissioner emphasised that the variety of approaches to treatment is important as different approaches can result in better outcomes for different patients."* As explained above, the Parties consider that this is not a trade-off between the parties' PD sites, but represents a clinical assessment as to which stage on the care pathway is the most clinically appropriate for the patient.

6.59 It also fails to recognise that the Parties' sites treat patients with different levels of risk. While in some cases patients may benefit from a different approach to treatment, a low risk patient will not benefit from being placed in a highly specialised unit for high risk patients.

6.60 The Decision also refers to a Cambian internal document which [✂].

[83] Decision, paragraph 192.

ANNEX 1: MAPS OF COMPETITOR SITES IN THE EAST MIDLANDS

Figure A1.1: Map of competitor sites within [✂] miles of Cygnet Hospital Derby

[✂]

Figure A1.2: Map of competitor sites within [✂] miles of The Limes

[✂]

Figure A1.3: Map of competitor sites within [✂] miles of Sherwood House

[✂]