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

RESPONSE TO STATEMENT OF ISSUES

23 JUNE 2017

Confidential Information indicated by [✂].

COMPLETED ACQUISITION BY UNIVERSAL HEALTH SERVICES (UHS) OF THE

CAMBIAN ADULT SERVICES DIVISION OF CAMBIAN GROUP PLC

1. INTRODUCTION

1.1 On 9 June 2017 the CMA published a Statement of Issues in relation to the completed acquisition by Universal Health Services (**"UHS"**) of the Cambian Adult Services ("**CAS"**) division of Cambian Group plc (together, the **"Parties"**).

1.2 As the Statement of Issues largely reflects the issues raised in the CMA's Phase 1 Decision, the Parties have already responded to the majority of the points raised (see the Parties' response to the Phase 1 decision of 17 May 2017). In order to avoid repetition, this document provides a brief response to a small number of additional points raised in the Statement of Issues, which the Parties have not responded to in their opening submissions.

2. SPECIFIC COMMENTS

Description of the Parties' businesses

2.1 The Parties consider that paragraph 8 of the Statement of Issues does not provide a clear description of the different focus of the Parties' businesses. Whilst it is correct that "*The Parties each provide a range of mental health services for patients at their sites across the UK*", the Parties do not both provide the same range of services as could be incorrectly inferred from the list of services set out in the remainder of paragraph 8.

2.2 As set out in the Merger Notice, Cygnet's focus is on service users with high acuity needs and/or those requiring a secure setting. These include: medium secure, low secure, PICU, Acute Psychiatric and CAMHS services, which do not overlap with CAS.[1] Cygnet also provides specialist services for the treatment of addictions and eating disorders, which are services also not provided by CAS. In contrast, CAS' main focus is on service users with less demanding requirements, with a significant proportion of CAS' business being residential care homes in the community sector, which are not provided by Cygnet.

2.3 Accordingly, whilst it is correct that the Parties each provide a range of mental health services, they are not providing the same types of services. As correctly stated in paragraph 9 of the Statement of Issues, the only overlap between the Parties is in relation to the supply of Rehabilitation Services.

Geographic market

2.4 Paragraph 19 of the Statement of Issues refers to the supply of Rehabilitation Services taking place mainly at a local level local due to the following factors:

(a) services are purchased and negotiated at a local level;

(b) Commissioners have a strong and consistent preference across all Rehabilitation Services to minimise the distance between the patient's origin (usually their home) and where they are treated; and

(c) Commissioners frequently inspect facilities and monitor placements, so a manageable distance between Commissioners and the facility(ies) is important.

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[1] CAS has one low secure facility (Cambian Ansel Clinic) which provides treatment to male PD patients. As confirmed in the Phase 1 Decision, this does not overlap with any of the Cygnet low secure sites.

2.5 Whilst Rehabilitation Services are generally purchased by Commissioners at an individual site level, the Parties consider that the other two factors referred to above have been overstated and imply the CMA may be focusing on narrow geographic markets, which is inconsistent with the pattern of referral behaviour and the choices facing Commissioners.

2.6 In relation to (b), whilst Commissioners have an objective to try and keep patients close to their home, this is just one of a number of factors influencing their referral behaviour. In particular, the primary considerations for Commissioners is the quality of the service provided, so as to ensure that patients are treated in a safe, suitable and clinically effective environment, even if this means the patient has to travel further afield for treatment. Similarly, price, relapse rates and value for money of the service are also important considerations for Commissioners. Commissioners' referral behaviour therefore typically involves balancing a number of factors, with patient distance being just one of those factors taken into account.

2.7 In relation to (c), as set out in the response to the MQ, the Parties do not consider that the location of the Commissioner relative to the facility has a significant bearing on where they decide to refer patients. This reflects the fact that, contrary to the statement that Commissioners "frequently" inspect facilities, CCGs actually make relatively few visits to the Parties' sites (e.g. CCGs will generally carry out inspections of CAS' patients once a year, with patient monitoring meetings typically taking place every 3-6 months).

2.8 In this regard it is notable that many CCGs regularly refer patients over significant distances even if this means they need to travel over 100 miles to visit the site as required. For example, [✂]. Numerous other examples of Commissioners referring patients to the Parties' hospitals over significant distances were set out in the Parties' response to the Issues Letter (of 3 April 2017). Such patterns of referral behaviour are inconsistent with distance being a decisive factor affecting Commissioners' referral behaviour.

2.9 It should also be noted that reference to the term "local level" should not be confused with narrow geographic markets which would be more typically associated with local retail mergers. In this context, even on the basis of the cautious approach adopted at Phase 1, the CMA identified instances of catchment areas being well over 100 miles, and catchment areas are often above 75 miles. Whilst these areas are referred to as "local" in the sense that they are sub-national, they cover a much broader geographic area than generally associated with local markets.

Catchment areas

2.10 In order to consider the scope of the relevant geographic market, the CMA states at paragraph 20 that it "*will consider the catchment areas for the Parties and their competitors*." The CMA also states that it will consider "*whether site-specific catchment areas or treatment-average catchment areas provide a more appropriate geographic market*". The Parties have already provided detailed comments on the approach to calculating the relevant geographic market in Section 3 of their response to the Phase 1 Decision, and these comments are not repeated here.

2.11 However, it is important to note that, whilst catchment areas may provide the starting point for the CMA's assessment, catchment areas typically understate the scope of the relevant geographic market. In this regard, 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*". It is important, therefore, that the CMA considers a geographic market that is broader than a patient catchment area, and takes into account the constraints from providers located outside the catchment area in its competitive assessment (e.g. as they will also have a catchment area that overlaps).

2.12 The Parties also reiterate that due to the uncertainty with the patient postcode data provided (as set out in paragraphs 3.10-3.14 of the response to the Phase 1 decision), and the sensitivity of site specific catchment areas to even very small changes in the number of patients considered, the Parties consider that a treatment "averages" provides a far more robust basis for estimating the relevant catchment area. Whilst site-specific catchment areas used at Phase 1 provided a cautious filter to assess whether a more in-depth review was appropriate, these did not adequately reflect the area over which competition takes place or the choices facing Commissioners. In this regard, it is also relevant to consider, from a Commissioner's perspective, the options that they face (based on their location) as well as their patterns of actual referral behaviour.

National factors to competition

2.13 Paragraph 22 of the Statement of Issues notes that the CMA will also assess "*how and in what way any national factors could impact on local conditions of competition.*" It goes on to state that "*Such factors could include reputation, scale, financial strength and viability and access to capital*."

2.14 The Parties do not consider that national factors have a significant influence on local competition in relation to the supply of Rehabilitation Services. As acknowledged in the Phase 1 Decision, Commissioning generally takes place by CCGs at a local level, and all providers of Rehabilitation Services are reliant on CCGs for patient referrals and funding. In this regard, there is clear evidence of a large number of smaller providers of Rehabilitation Services, which are highly regarded by Commissioners and the CQC, and which compete effectively with the Parties for patient referrals.

2.15 In relation to the reputation of providers of Rehabilitation Services, the Parties' hospitals are managed individually and assessed separately by the CQC. Accordingly, the Parties consider that each hospital needs to develop its own reputation with Commissioners, even if it forms part of a larger group. In this regard, [✂].

2.16 The Parties also do not consider that scale, financial strength or access to capital have any material bearing on the nature of competition at the local level. In relation to scale, there are a number of much smaller providers of Rehabilitation Services which do not have a national presence but are readily able to compete against the Parties for patient referrals from Commissioners. The costs involved in providing Rehabilitation Services, [✂].

2.17 In relation to financial strength or access to capital, the Parties note that prior to the Transaction, [✂]. As reported in the Financial Times in October 2016:[2] *"Cambian Group, a UK-listed mental healthcare specialist, is also selling some of its business as it struggles with mounting debts"*.

2.18 In light of these difficulties, [✂].

Theory of harm 1: the loss of actual competition in the supply of Rehabilitation Services at a local level

2.19 The Parties have already responded in detail to this theory of harm in their response to the Phase 1 decision, and therefore do not repeat the same points here.

Theory of harm 2: the loss of potential competition in the supply of Rehabilitation Services at a local level

2.20 The Statement of Issues states that the CMA is considering the possibility for unilateral effects arising from the loss of potential competition between the Parties in the supply of

[2] https://www.ft.com/content/33577aca-8658-11e6-a29c-6e7d9515ad15

Rehabilitation Services at a local level.[3] The CMA also states that the factors it will take into account in its assessment of potential competition include:

(a) whether the Parties' expansion plans would have been likely to lead to substantially greater competition in certain areas; and

(b) whether the Parties would have been likely to switch the use of a hospital or ward from the provision of one treatment or combination of treatments to another resulting in substantially greater competition in certain areas.

2.21 In relation to (a), whilst both Parties were looking for opportunities to develop their respective businesses absent the transaction (which is to be expected for all providers of Rehabilitation services), the Parties' respective expansion plans [✂].

2.22 In particular, [✂], which do not overlap with the services provided by CAS. In this regard, as set out in the Merger Notice:

(a) Cygnet recently opened a brand new hospital in Coventry with four wards, including providing PICU and PD services to the Tier 4 level of service specification;

(b) [✂]; and

(c) [✂].

2.23 In comparison, [✂], which do not overlap with the services provided by Cygnet. Details of the CAS expansion plans are set out in paragraphs 20.3-20.9 of the Merger Notice, and in response to Question 16 of the MQ. Of the [✂] planned sites identified in response to Question 16 of the MQ:

(a) [✂];

(b) [✂];

(c) [✂]; and

(d) [✂].

2.24 Accordingly, the Parties' expansion plans confirm that they would not have become closer competitors in the supply of Rehabilitation Services absent the transaction.

2.25 Similarly, in relation to (b), [✂].

2.26 Moreover, as explained above, prior to the Transaction, Cambian Group [✂] had issued two consecutive profit warnings. [✂]. This is consistent with statements made by Cambian Group, for example in February 2016 the Financial Times reported that:[4]

> *"Its £241m of debt is less than half the value of Cambian's properties, but twice its equity value. It must persuade lenders it can control costs without compromising occupancy rates, revenue growth or asset values… Management is focusing on filling the beds it has rather than making new ones and capex will halve to £20m."*

2.27 [✂] on re-provisioning some existing sites into residential community care for LD patients (e.g. Shear Meadow, Walkern Lodge and Chaseways). [✂].

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[3] Statement of Issues, Paragraph 33.

[4] https://www.ft.com/content/9e9611ea-d0cb-11e5-831d-09f7778e7377

2.28 Accordingly, the Parties consider that there is no evidence to suggest that the transaction could give rise to a loss of potential competition between the Parties at the local level, and therefore this theory of harm should be readily dismissed.

Theory of harm 3: the loss of potential competition in the supply of Rehabilitation Services at a national level

2.29 The Statement of Issues states that the CMA will also consider whether "*the increased concentration and reduction in the number of major providers would lead to a loss of actual or potential competition. This may be competition in innovation, expansion and investment, for example*."[5]

2.30 It is unclear to the Parties why this theory of harm is relevant, or how it could be expected to occur in practice. The Phase 1 Decision specifically acknowledged (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 it noted that it "*has not received any other evidence to suggest that unilateral effects concerns could arise at the national level*".

2.31 In this regard, Appendix 13.1 of RFI1 set out the Parties' estimate of their combined market share for all Rehabilitation Services for England and Wales, which is just [✂] per cent (increment [✂] per cent). Moreover, there are a number of reasons why this estimate is also likely to be materially overstated:

(a) all NHS provided beds for Rehabilitation Services were excluded from this estimate;

(b) 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;

(c) the Parties have limited visibility of competitors' planned sites, but have included in the national market shares all of the Parties' planned sites likely to be operational in the next two years; and

(d) the national market share estimate has not been updated to include the additional competitors identified by the Parties in response to the Phase 1 Issues Letter.

2.32 Therefore, 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 (including all NHS provision). It is also clear that there are a number of other large national providers of Rehabilitation Services including Priory Group (which has grown significantly following its recent acquisition of Partnerships in Care), Elysium Healthcare, St Andrews, Huntercombe, Inmind, Lighthouse and Danshell.

2.33 The Statement of Issues and the Phase 1 Decision also both acknowledge that Rehabilitation Services are purchased and negotiated at a local level (albeit often over significant distances),[6] which is consistent with the CMA's Acadia/Priory decision. This indicates that the focus of competition for Rehabilitation Services is not at the national level, and there is no clear nexus between the number of national competitors, and competition at the local level.

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5 Statement of Issues, paragraph 34.

6 Decision, paragraph 55.

2.34 It is also clear, and was not at issue in the Phase 1 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 Parties are not aware of any evidence to suggest that CCG referral decisions are limited to, or influenced by, those providers with a national coverage, or that the smaller operators do not compete effectively with the Parties.

2.35 Accordingly, the Parties consider that there is no evidence to suggest that the transaction could lead to a loss of potential competition in the supply of Rehabilitation Services at a national level, and therefore this theory of harm should be readily dismissed.

Countervailing buyer power

2.36 The Issues Statement notes that *"We will investigate whether Commissioners, individually or collectively have countervailing buyer power, and whether this buyer power would be sufficient to address any effects of an SLC in the local area."*[7] The Parties consider this is an important area for further investigation during Phase 2 as there is evidence that Commissioners and the NHS are able to exert significant competitive constraints on the Parties.

2.37 In the Phase 1 Decision the CMA dismissed the constraint from countervailing buyer power on the basis that:[8]

(a) Commissioners are dispersed and the Parties are not reliant on one single Commissioner; and

(b) buyer power can only constrain suppliers to the extent that there are sufficient alternatives available to the buyer.

2.38 In relation to (a), whilst commissioning is managed by individual CCGs rather than NHS England, the national tariff inflator/deflator set by NHS Improvements acts as a benchmark that all CCGs use in negotiating prices. In the Parties' experience, many CCGs are unwilling to agree to a price increase that is higher than the national inflator/deflator. [✂].

2.39 This is also consistent with third party evidence, in particular, the Laing & Buisson Report suggests that "[✂]." Accordingly, whilst CCGs may procure Rehabilitation Services individually, providers of Rehabilitation Services are subject to a broader constraint provided by NHS benchmarks which maintains pressure on prices.

2.40 It is also the case that CCGs are able to (and do) group together to commission Rehabilitation Services under a framework agreement, with the prevalence of framework agreements increasing. [✂]:

(a) [✂] of patients referred at [✂];

(b) [✂] of patients referred at [✂];

(c) [✂] of patients referred at [✂]; and

(d) [✂] of patients referred at [✂].

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7 Issues Statement, paragraph 37.

8 Decision, paragraphs 228 – 229.

2.41 There are also examples at specific sites where a single CCG can make up a large proportion of purchases. For example, [✂] of the [✂] current patients at Cygnet [✂] are funded by a single commissioner ([✂]). The loss of this single customer would therefore have a significant bearing on the financial performance of the site.

2.42 Moreover, as CCGs often refer patients to more than one of the Parties' sites (and therefore have visibility of the prices charged), in the event of a hypothetical price increase at a particular site, [✂] they are able to exert significant buyer power if the Parties attempted to increase prices at specific sites.

2.43 In relation to (b), the Parties consider that Commissioners usually have a range of credible alternatives. First, there are numerous other independent providers to which a Commissioner can switch, or threaten to switch, referrals. In Cygnet's experience Commissioners often use this option to negotiate better prices, for example:

(a) during the 2016/2017 contract year, [✂]; and

(b) in order to [✂].

2.44 Second, NHS Foundation Trusts have the option to enter a joint venture to provide Rehabilitation Services in partnership with independent providers. For example, at its Godden Green site Cygnet operates a low secure service for men which is run in a joint working arrangement with Kent and Medway Partnership NHS Foundation Trust.

2.45 Third, NHS Foundation Trusts have the option to open new Rehabilitation Services directly. Whilst at a national level there has been a decline in NHS provision, this has changed in recent years. In addition, at a regional level, the Parties have seen a number of examples of NHS Trusts expanding and improving their own in-patient Rehabilitation Services. In response to the Phase 1 Decision and Question 4 of the MQ, the Parties provided a number of recent examples of NHS providers opening or retooling rehabilitation facilities to react to regional demand. These include the following:

(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 locked LTMH ward [✂];

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

(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. [✂]; 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 [✂].

2.46 Accordingly, the Parties consider that Commissioners and the NHS have the ability to constrain providers of Rehabilitation Services in a variety of ways through their strong countervailing buyer power. It is important therefore that such constraints are taken into account in the CMA's assessment at Phase 2.

Competition from NHS sites

2.47 At paragraph 18 of the Statement of Issues the CMA notes that: *"We will also consider whether the provision of Rehabilitation Services by the NHS itself should be included in the product market definition."* As stated previously, the Parties consider that NHS-funded services clearly do compete with private providers in the provision of Rehabilitation

Services, and NHS provision provides a significant competitive constraint on the Parties. Key evidence that the CMA should investigate at Phase 2 includes:

(a) 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;

(b) it is not the Parties' experience that CCGs only refer patients to independent providers when there is no NHS capacity. In particular:

(i) [✂];

(ii) [✂];

(iii) [✂];

(iv) [✂];

(c) Rehabilitation Services are also less time critical than other mental health services (e.g. PICU) and [✂]; and

(d) as explained in paragraph 2.45 above, NHS providers are able to convert existing capacity or open new sites in order to meet changes in regional demand. In this regard, NHS Foundation Trusts are run as self-sufficient businesses and therefore they are looking for opportunities to generate revenue (and improve clinical outcomes) in the same way as independent providers.