CYGNET/CAS MERGER INQUIRY

Summary of hearing with Priory Healthcare on 4 July 2017

Rehabilitation services market

1. Priory Healthcare (PH) said that personality disorder (PD) was a subset of what the CMA is calling long-term mental health. It was very specialised in terms of interventions. Nationally there was an under-provision of treatment for PD but there was beginning to be a better understanding of how it works and there was now more R&R and specialist in-patient treatment. PH said that [✂].

2. PH said that the NHS was decommissioning mental health beds generally, but it was too early to say whether [✂]. Any growth in PD provision would need to be carefully planned and managed to ensure that the skilled clinicians were available to provide care.

3. PH said that similarly with long-term mental health there was generally under-provision but the position varied between areas. There had been a large number of mental health beds cut in the last decade in the NHS and a move from higher levels of security to lower levels with more people being treated in rehabilitation services rather than secure units and then moved into community care.

Tier 4 female PD services

4. PH confirmed that its tier 4 female PD services were previously commissioned by NHSE. However, all of its PD services were now commissioned by CCGs and were not part of NHSE's specialist commissioning contracts.

NHSE new models of care

5. PH confirmed the drive by NHSE to treat patients closer to home and to minimise out-of-area placements, as well as trying to move patients 'downstream' where possible. There was a drive to reduce the number of in-patient beds being commissioned at the top end of the pathway and to reinvest in alternative treatments lower down the pathway. PH expected commissioners to be placing higher acuity patients into rehabilitation services

and that capacity for rehabilitation would remain consistent, but perhaps catering for slightly different patient needs.

6. PH said that [✂].

7. [✂]

Barriers to entry

8. PH confirmed that providers already in an area probably had a slight advantage in competing for referrals over a new provider. However, there was not a high threshold to enter the rehabilitation services market and it was not complex – new relationships could be built easily. So long as a new provider had a good site, registration and they were confident they had a good clinical team they could enter the market. In terms of costs, if there was spare capacity, or land, or buildings already available then capital costs could be relatively small.

9. PH said that in establishing new facilities and services, the building and recruitment work would be going on at the same time as the preparatory work with the Care Quality Commission (CQC) so that CQC could inspect as soon as the service was operationally ready. The CQC had well defined, prescribed benchmark standards and it was a relatively straightforward process.

10. PH said that larger providers possibly had the advantage of scale and expertise over smaller providers but may be competing in a more local market, so larger providers were not always at an advantage.

11. PH said that in terms of recruitment of staff, new entrants faced many of the same issues as existing providers. Salary, contract terms and location of work were key factors in attracting staff. Both NHS and the independent sector faced many of the same issues as there was a shortage of suitable staff.

Capacity constraints

12. PH said it had not experienced much difference in competition in circumstances where there was greater capacity of beds relative to demand against other scenarios. Geography was more important. Funding was the key driver in the market, so constraints were not around capacity.

13. PH were not aware of competitors' bed availability but obviously knew which of their own units had capacity. [✂] PH said they were a commercial enterprise and were constantly looking at ways of improving the occupancy of

sites with lower occupancy by, for instance, [✂]. Maximising the quality of the services PH provided was key. PH said that [✂].

14. PH said it was not particularly focused on what competitors were doing, especially not in rehabilitation. The focus was more on PH's own services.

Pricing

15. PH said that pricing for rehabilitation would to some extent depend on the previous prices that commissioners had paid. Commissioners had historic information on what had been paid to PH and other providers. There was no national benchmark. [✂]

Competition with NHS providers

16. PH said that the number of NHS providers in the country was variable by region. In London NHS provision had a maximum length of stay of about a year. Anyone that required a longer-term admission or more specialist provision tended to be treated by the independent sector.

17. The NHS would only provide rehabilitation services where they were commissioned to do so. NHS provision was likely to be a generic service. The NHS generally tended to use their own services first where the patient needed generic and not specialist treatment and where there was a block contract or existing pathway. The NHS had fewer specialist providers, including in PD.

18. If suitable generic provision was available, the NHS may try to allocate patients 'in-house' to NHS provision in the first instance. But it would depend on the 'in-house' provision.

19. Generic services for female PD tended to be cheaper than more specialist provision. When deciding on where to send a patient, commissioners would consider both generic and specialist provision. Commissioners were not always clear about the different services provided by different units.

Categorisation

20. PH clarified the categorisation and services supplied at a number of its facilities.

21. PH confirmed that quality of service had an impact on competition.

The Merger

22. PH had no strong views on the merger.

Other

23. PH stressed that even where ‘in-house’ NHS provision was available the key factor in commissioning should be about the individual patient’s needs and best value. There would also be other factors to take into account. For example, even where there was an NHS facility providing the right treatment, the issue of the patient mix in the facility would need to be considered.