CMA
Competition & Markets Authority

CYGNET/CAS MERGER INQUIRY

Summary of hearing with NHS Improvement on 26 June 2017

Background

1. NHS Improvement (NHSI) said that the NHS commissioned high, medium and low secure placements and alongside this there were clinical commissioning groups (CCGs) that commissioned locked rehab and open rehabilitation. It said that locked rehab and low secure were very similar and it thought the market for locked rehab was worth around £[✄] a year.

2. Presently NHS England only commissioned high, medium and low secure directly and NHSI believed this market was worth around £[✄] a year.

3. NHSI said that people were staying too long in the locked settings, commonly for several years, and it believed this was because there was insufficient community provision. It felt that more people could be looked after in a community setting, in their own accommodation.

4. NHSI said that the populations in low secure and locked rehab were essentially the same and that the main source of patients was from medium secure services. It said it was a mixed population comprising people with schizophrenia, bipolar, personality disorder, along with mild learning disability as well.

5. NHSI said there were around 57 NHS mental health providers, who were mainly foundation trusts. The CCGs also commissioned from private providers. Quite a few CCGs used framework agreements. They commissioned against a set of requirements of what they wanted for their local population and only those companies on the framework would be allowed to provide mental health services for the commissioning group's population. To get on to the framework, providers had to bid against quality criteria and their CQC registration would also get taken into account.

6. Some Commissioners grouped together to provide services across geographical areas that were bigger than their own.

7. NHSI said that when placing a patient, the first step was to look at who would take that particular patient, given their level of complexity. It stated that it was

not the diagnosis that was key, but the level of risk, ie the risk of self-harm or suicide. Along with the level of violence and the risk of harm to other patients and staff. If a lot of providers were willing to take the patient, there was more competition. However, the more complex a patient, the less competition there tended to be and NHSI said that [✄].

8. NHSI said it did not regulate or oversee prices for locked rehab. NHS England set the strategy and has the five-year forward view, but it did not cover locked rehab or personality disorder.

Out-of-area placements

9. NHSI said there were three sorts of out-of-area placement – one if you wanted a service that was only provided elsewhere (tertiary referral), two if it was unavoidable in that a patient had a breakdown in a different location and needed to be admitted immediately and finally if a patient needed to be referred out-of-area for reasons of privacy.

10. NHSI said that of the [✄] beds available, [✄] were locked rehab and around [✄]% were in the private sector. Most were out of area because not many were able to be provided locally.

11. NHSI wanted to get rid of out-of-area placements where people were admitted because of the lack of capacity within the local service and gave Sheffield as an example of what could be done by thinking differently and innovating.

12. In Sheffield, the vast majority of out-of-area placements in locked rehab had been brought back in area. Patients who originated in Sheffield had been brought back on a case-by-case basis. Many had been put into standard tenancies through a partnership with the South Yorkshire Housing Association. Then they had been provided with an ‘ultra-intensive’ Assertive Community Treatment Team that would see them 24-7 whenever needed. Routinely this would be three to four times a day and therefore their use of beds went from [✄] bed nights the year before they were taken back, to [✄] bed nights the year they took them back. The CCG had also paid for a small locked rehab facility [✄].

13. NHSI said that the crucial thing was to provide an intensive community team to support the patients and rehabilitate them within the community. Hence the model of care was not about putting them in a secure facility, but giving them intensive support to allow them not to be in a locked facility but instead be re-integrated into the community.

14. [✄]

15. To reopen a ‘mothballed’ ward for locked rehab in order to bring people back would not take long as it was not that difficult to find somewhere to reopen. Sheffield used to have around [✄] mental health beds around 35 years ago, but now it was down to around [✄]. Hence finding a ward was not hard and there should be capacity to open them without too much difficulty if the funding was available, the key issue was recruiting the staff. Sheffield had managed to do it in around a year.

16. An associate national clinical director has been appointed for out-of-area placements and the aim would be to get the out-of-area placements down in line with the Crisp report. [✄]

17. [✄]

18. If locked rehab was local, it meant patients could be moved to open rehab and then a community setting much more easily as they would be part of one service. NHSI said that private providers doing locked rehab should work very closely/be well integrated with the local NHS providers.

19. NHSI’s main concern was getting patients integrated back into local services so that they would have shorter lengths of stay and a greater chance of getting back into the community to live their lives as citizens.

20. NHSI said that it had incentivised CCGs with the quality premium. [✄]

Commissioning

21. NHSI said it was not currently directly involved in the commissioning of beds or influencing bed numbers, although it regulated mental health in-patient units of all kinds. [✄]

22. The CCGs commissioned within their geographical areas, and sometimes worked together to make a bigger geographical area with a lead commissioner who acted on behalf of various CCGs. [✄]

23. [✄]

The merger

24. NHSI said that there was a marketplace for locked rehab beds and it was important that as long as a market existed, there was competition around price and quality. It could be hard to get someone into a bed, so having a range of providers for an individual was important. The fewer providers there were that a CCG could go to, the more of a problem there was.