Completed acquisition by Cygnet Health Care Limited and Universal Health Services, Inc. of the Cambian Adult Services Division of Cambian Group plc

Summary of provisional findings report

Notified: 23 August 2017

1. On 3 May 2017, the Competition and Markets Authority (CMA) referred the completed acquisition by Universal Health Services, Inc. (UHS) via its subsidiary Cygnet Healthcare (Cygnet), of Cambian Adult Services (CAS) (the Merger) for an in-depth phase 2 investigation.

2. The CMA must decide:

   (a) whether a relevant merger situation has been created; and

   (b) if so, whether the creation of that situation has resulted or may be expected to result in a substantial lessening of competition (SLC) within any market or markets in the United Kingdom (UK) for goods or services.

3. We are satisfied that a relevant merger situation has been created and have provisionally found that this may be expected to give rise to an SLC in the supply of certain hospital-based inpatient mental health rehabilitation services (rehabilitation services) to local authorities and NHS clinical commissioning groups (CCGs) in the East Midlands and in the West Midlands.

4. UHS is a US healthcare management company that operates, through its subsidiaries, acute care hospitals, behavioural health facilities and ambulatory centres in the US, the UK, Puerto Rico and the US Virgin Islands. UHS acquired Cygnet in 2014.

5. Both Cygnet and CAS operate independent mental health facilities in the UK providing a range of services for patients suffering from a variety of different mental health conditions.

6. Throughout this document, Cygnet and CAS are referred to collectively as the Parties.

The Parties' operations

7. Mental health services are categorised according to various criteria, for example, the levels of security in which they are provided, the underlying diagnosis being treated, whether they are provided in acute care settings, and by patient group (eg the elderly).

8. The Parties state that the focus of their businesses is on different stages of the patient care pathway. Cygnet says that its focus is on patients with more acute conditions at the higher end of the security scale. CAS says that its focus is on patients with less acute conditions at the lower end of the security scale. The Parties submit that part of the rationale for the Merger is the complementarity of their businesses.

9. Although the Parties both operate residential care homes, the services they provide do not give rise to a competitive overlap. CAS's 44 homes treat adults with mental health conditions including learning disabilities and autism spectrum disorders whereas Cygnet has two residential nursing homes for the elderly.

10. CAS has one low secure facility, which only treats male patients with personality disorders (PD). Cygnet has only one low secure facility providing treatment for female patients with PD. Therefore, there is no current overlap between the Parties in respect of secure services.

11. The focus of our analysis is therefore the Parties' overlap in rehabilitation services. Mental health rehabilitation is defined as 'a whole systems approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and lead to successful community living through appropriate support.'[1]

12. In rehabilitation services Cygnet has 15 sites, comprising 25 wards and 338 beds. CAS has 25 sites, comprising 36 wards and 686 beds.

13. The mental health conditions or specialisms treated by rehabilitation services include PD, learning disabilities, autism spectrum disorder, acquired brain injuries, and long-term mental health (LTMH)[2] conditions.

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[1] Joint Commissioning Panel for Mental Health (JCPMH) (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health need.

[2] Not a clinical term. It can be defined as a range of psychological and psychiatric conditions or disorders with symptoms that cause significant distress and/or dysfunction, including cognitive, emotional, behavioural and interpersonal impairments. Other terms which we understand are synonymous include 'severe mental health conditions' and 'enduring mental illness'. We use LTMH as the both Cygnet and CAS use this term.

14. Although the Parties overlap in four of these specialisms, we do not consider autism spectrum disorder or learning disabilities further because of the lack of geographical proximity of the Parties' sites and the number and location of alternative providers. The focus of our analysis is solely on the Parties' overlaps in rehabilitation services for PD and LTMH.

Market background

15. The past six years has seen increased public and government focus on mental health. In January, the government accepted the recommendations in *The Five Year Forward View for Mental Health* which include an increase in mental health funding by £1 billion a year by 2021.

16. In 2015 the UK market for all mental health services was estimated to be £15.9 billion. Hospital services (including rehabilitation services) accounted for 27% of this. Despite declining NHS bed numbers – down 23% during 2010 to 2015 compared with the independent sector where bed capacity grew by 8%, the NHS still has most of the mental health hospital bed capacity.

17. Differences in categorisations make it difficult to calculate the value or shares with confidence but the independent sector has the vast majority of beds in what is known as 'locked rehabilitation'[3] services. In 2015 the UK market for these services was estimated at £304 million, of which £294 million, or almost 97%, was provided by the independent sector.[4]

18. With a combined share of around [20–30]%, the Parties told us that they have the largest share of independent sector rehabilitation services bed capacity, followed by Acadia Group (owner of Priory) at [10–20]%, Huntercombe at [5–10]%, Elysium and St Andrew's both at [5–10]%, and Barchester at [0–5]%. The remainder is held by many small providers.

19. The commissioning of mental health services in England is split between NHS England (NHSE) and CCGs. NHSE commissions what are called 'prescribed' specialist services centrally. The remainder are commissioned by the 211 CCGs which are responsible for around two-thirds of the current NHSE budget of £73.6 billion. CCGs are responsible for commissioning rehabilitation services in England. In Wales, they are commissioned by seven Local Health Boards (LHBs).

[3] We found no clear-cut distinction between locked and unlocked.
[4] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p61.

20. Unlike some other healthcare markets, the patient who needs to be admitted to a hospital providing rehabilitation services is rarely in a position to decide where they would like to be treated. It is CCGs that fulfil the role of customers, making the decisions as to where patients should be referred. Throughout this document we use ‘customers’ to refer collectively to CCGs, the NHS trusts and the few local authorities that commission rehabilitation services.

21. All our evidence emphasises the individualised nature of patient requirements. Diagnosis of mental health conditions is not straightforward. Patients are often diagnosed with more than one condition, and have different symptoms and manifestations of their illness that affect the referral decision.

22. Once patients are assessed, customers face different options implying different purchasing behaviours. Some need funding authorisation before assessing patients, others do not. Some require patients to be ‘approved’ by at least three providers after assessment before they refer, others do not. Some have specific clinical views that affect their referrals, for example believing that patients with PD should not be in hospital at all.

23. When choosing where to refer a patient, customers weigh up multiple factors including quality, price and service offering (eg the nature of and approach to treatment). We found that two of the most important factors concern quality, namely the Care Quality Commission (CQC) rating and the customers’ previous experience of that provider.

24. Even if a patient is assessed and the customer has decided on a hospital providing rehabilitation services that will meet the patient’s needs, it may not have a bed. If the hospital does have a bed, it can still reject a referral. This is usually because the hospital considers that the services at that hospital are not appropriate for the patient or the incumbent patient mix would not accommodate the new patient at that time.

25. These multiple intricate demand and supply interactions take place in the complex legal and regulatory environment governing mental health services. Legislation and regulations affect patient rights, the service obligations of providers, how and where services are provided and the procurement and commissioning of services. In addition, there are various regulatory oversight bodies which set standards, regulate payment and monitor the delivery and quality of services.

26. Against this backdrop, and in common with other NHS healthcare markets, competition is only one of a number of factors which influence the quality of services for patients.

27. This complex backdrop informed our assessment and how the operation of the key parameters of competition and their relative importance may be nuanced in this market.

Market definition

28. To determine the most significant competitive alternatives available to customers of the Parties, we looked at evidence for the delineation of rehabilitation services by specialism, gender and level of security of hospitals and wards.

29. We found that each specialism within rehabilitation services is largely distinct in that the different treatments for LTMH and PD cannot be considered as alternatives for most patients. The same is true of our evidence on gender. However, as some providers describe some of their wards as ‘LTMH/PD’ and ‘mixed gender’ and as they could be alternatives for some patients, we considered the possibility that specific mixed specialism or mixed gender wards may provide some constraint in our local competitive assessment.

30. We found that there is no clear-cut distinction between facilities described as ‘locked’ or ‘unlocked’ and given that only a small number of wards describe themselves as ‘unlocked’ we considered them all in the same product market but tested for sensitivities.

31. We considered the possibility of providers reconfiguring wards to accommodate different specialisms or genders. The cost of reconfiguration varies significantly, depending on the change of use, the size of the unit and whether current patients need to be moved. The evidence on reconfiguration does not support widening the relevant product market. Instead we took it into account in our local assessments and when considering potential competition.

32. We found that customers tend to use NHS hospitals first before referring patients to independent providers. Since most NHS facilities have high occupancy – sometimes over 100% when a bed of a patient on leave is used whilst they are not there, we excluded NHS providers from the relevant product market. Where the evidence indicates that specific NHS facilities may be posing some competitive constraint, we took this into account in our local assessments.

33. Customers have a strong preference to keep patients at nearby hospitals. We defined the relevant geographic market based on an average catchment area of 60 miles. 80% of male LTMH patients, 75% of female LTMH patients and around 70% of female PD patients come from within 60 miles. We tested whether catchments may be wider in our local assessments.

Counterfactual

34. Before examining the competitive effects of the Merger, we assessed what would have happened to CAS if it had not been acquired by Cygnet (the counterfactual). Given the interest from potential purchasers that the CAS sale generated, the most likely scenario is that CAS would have been sold to another well-capitalised bidder and would have remained in the market, but without the financial constraints that Cambian was facing. Accordingly, we provisionally conclude that the appropriate counterfactual is that the conditions of competition would be broadly similar to those prevailing at the time of the Merger.

Competitive effects in local overlap areas

35. As outlined above, the focus of our analysis is on the Parties' overlaps in PD and LTMH rehabilitation services.

36. Our filtering of the Parties' combined share of beds in the 60-mile catchment identified 19 wards which we grouped into eight local overlap areas for further assessment. Two female PD overlaps in the South West and Yorkshire and Humber. Three male LTMH overlaps in London, the East Midlands and Yorkshire. And three female LTMH overlaps in Northern Wales and the North West, Southern Wales and the South West and the West Midlands.

37. We sent questionnaires to 158 customers and 41 competitors of the Parties. We undertook two site visits, held 11 third party hearings and spoke to 26 customers to understand and reflect the specifics of supply and demand in the local overlap areas and their view of the Merger.

38. In each of these eight local overlaps we assessed market shares and the nature and type of alternative provision in the area, including the presence of other national providers and NHS provision. We looked at capacity constraints, geographic differentiation and closeness of competition on quality and price.

39. Where we found that an SLC may be expected, we investigated any countervailing factors in each local area.

40. For the two PD overlaps, the key issue is the extent to which the Parties' offerings were competing. Although some customers saw them as alternatives for some patients, others were adamant they were not. We assessed evidence on closeness of competition including impact studies and the different catchments areas for the sites. On balance, we provisionally conclude that the Parties do not compete in PD to such an extent that the

Merger might be expected to result in an SLC in either the South West or Yorkshire and Humber.

41. In the London male LTMH overlap, the Parties have low market shares and are geographically distant. Customer evidence suggests that the Parties are not close competitors. The customers that did express concerns accounted for only a very small number of referrals. Finally, the presence and relative share of large alternative providers led us to provisionally conclude that the Merger may not be expected to result in an SLC in this overlap area.

42. In the Yorkshire male LTMH overlap, the Parties are closer geographically and we received evidence of closeness of competition on quality. We heard concerns from two customers, collectively representing 18% of referrals to the Parties' sites. One of the concerns was not Merger-specific and the other is likely to have been driven by the specific location of the customer. The Parties would have a post-Merger share of [30–40]% with a relatively small increment. The merged firm would continue to face competition from Priory, currently the second largest provider, and nine other smaller providers. As a result, we provisionally conclude that the Merger may not be expected to result in an SLC in this overlap area.

43. In the Northern Wales and North West female LTMH overlap, the Parties are geographically distant and would have a low post-Merger market share of [20–30] %. One customer representing 11% of referrals was concerned about the Merger. The merged firm will continue to face competition from several large and multiple small alternative providers after the Merger. Many of these providers are geographically closer competitors to the Parties than they are to each other. As a result, we provisionally conclude that the merger may not be expected to result in an SLC in this overlap area.

44. In the Southern Wales and the South West female LTMH overlap, the evidence was more finely balanced. As a result of the Merger, the market shares of the Parties would be [40–50]%. They are geographically distant. We have taken account of customer concerns but note that there are two other large competitors in the area after the Merger. Based on this evidence, on balance, we provisionally conclude that the Merger may not be expected to result in an SLC in this overlap.

45. In the East Midlands male LTMH overlap, the Parties are particularly close geographically, are the two largest providers and would have a post-Merger market share of [50–60]%. Although there are alternative providers, the next closest would have only [10–20]% of the market. Although one large customer was not concerned about the Merger, several smaller customers thought that

the Merger could lead to higher prices or reduced quality, including a loss of variation in treatment options for patients.

46. We have considered whether the Parties are constrained in this area by the East Midlands Rehabilitation Framework (the Framework) which provides a mechanism for 17 CCGs to aggregate customer volume to collectively negotiate better terms with a number of providers.

47. Our investigation found that around [✂]% of the patients referred are from customers who are not part of the Framework, so any constraint on the Parties would not extend to these customers. Second, we found that customers using the Framework [✂] customers with other forms of pre-negotiated agreements. Finally, when the Framework is renegotiated, the Merger may impact on competition as a result of customers having fewer alternatives or less capacity and they may, therefore, be subject to higher prices and reduced quality.

48. In light of our assessment, we provisionally conclude that the Merger may be expected to result in an SLC in the provision of male LTMH rehabilitation services in the East Midlands overlap area.

49. In the West Midlands female LTMH overlap, pre-merger, there were four large providers, two of which were the Parties, each with a market share of about or over [10–40]%. Post-merger, the Parties would be the largest provider in the local area, having a high combined market share with a high increment. The Parties are very close competitors geographically. Further, due to its spare capacity, Cygnet Coventry would have had a strong incentive to compete for patients against Raglan House and the other providers in the area. The competitive constraint between the Parties will be removed by the Merger.

50. The largest customer said it did not know what impact the Merger would have on prices or service but it was not concerned as it believed it had bargaining power. A small customer said it had concerns about the impact of the Merger on both price and quality.

51. Evidence from Cygnet internal documents produced in 2014 before the opening of the new Cygnet hospital in Coventry suggests that it saw CAS and another site as its two closest competitors at the time. The other site which has since been acquired by Priory, now specialises in PD and no longer provides LTMH rehabilitation services.

52. In light of our assessment, we provisionally conclude that the Merger may be expected to result in an SLC in the provision of female LTMH rehabilitation services in the West Midlands overlap area.

Potential competition

53. We looked at whether new entry or expansion by one or both of the Parties would have occurred absent the Merger and led to greater competition. We found that the Parties were not likely to reconfigure their wards or enter into competition with one another in a way that would have resulted in greater competition absent the Merger.

54. As a result of our analysis we provisionally conclude that the Merger may not be expected to result in an SLC in the supply of rehabilitation services as a result of a loss of potential competition.

National competitive effects

55. We considered whether the increased concentration and reduction in the number of larger providers would lead to a loss of competition at the national level.

56. Post-Merger, the Parties would be the largest provider in female PD and in both male and female LTMH. However, even the highest share would be below the level at which competition concerns typically arise. Overall, the national markets for rehabilitation services are still fairly fragmented with many smaller regional or local area providers. Further, the evidence consistently supports that the key parameters of competition are mainly varied locally.

57. The evidence in this investigation supports the absence of an SLC at a national level at this time. However, the CMA notes that this is the second major transaction in the market over the past 12 months. As consolidation continues, the national and local dynamics and the relative importance of different competitive parameters are evolving and may evolve further.

Provisional conclusion

58. We provisionally conclude that the Merger may be expected to result in an SLC within the market for the provision of certain hospital-based inpatient rehabilitation services for (i) male patients in the East Midlands and (ii) female patients in the West Midlands. The SLC may be expected to result in adverse effects in terms of prices being higher than they would otherwise be and quality being lower than it would otherwise be.