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

Provisional findings report

Notified: 23 August 2017

The Competition and Markets Authority has excluded from this published version of the provisional findings report information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. Some numbers have been replaced by a range. These are shown in square brackets.

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Glossary

Summary

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.

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

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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.

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).

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

[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.

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 [✂] than 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.

Provisional findings

1. The reference

1.1 On 3 May 2017, the CMA in exercise of its duty under section 22(1) of the Enterprise Act 2002 (the Act) referred the completed acquisition by UHS via its subsidiary Cygnet, of CAS for a phase 2 investigation by the Inquiry Group (the Group).[5]

1.2 In exercise of its duty under section 35(1) of the Act, 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 an SLC within any market or markets in the United Kingdom for goods or services.

1.3 The Group's terms of reference, along with information on the conduct of the inquiry, are in Appendix A.

1.4 This document, together with its appendices, constitutes our provisional findings. Further information, including non-commercially-sensitive versions of the Parties' submissions and summaries of evidence from third parties can be found on our website.[6]

2. Industry background

2.1 This section provides an overview of the mental health services industry in the UK, with a focus on inpatient[7] rehabilitation services provided by independent[8] hospitals in England.

2.2 The landscape of the mental health services industry is complex. It provides a range of services both in hospital and community settings. While hospital-based treatment is provided both by the NHS and independent providers, community-based care is largely provided by the NHS and local authorities.

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[5] Section 22 (1) of the Act provides that the group is to be constituted under Schedule 4 to the Enterprise and Regulatory Reform Act 2013.
[6] Cygnet Healthcare / Cambian Adult Services merger inquiry.
[7] An inpatient service is defined as a unit with 'hospital beds' that provides 24-hour nursing care. Source: Mental Health Network NHS Federation (2012), Defining mental health services.
[8] This includes both for-profit and not-for-profit providers (excluding NHS providers).

Legal and regulatory environment[9]

2.3 The legal and regulatory environment governing mental health services is complex. 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 delivery and quality of services.

2.4 The primary legislation which impacts the provision of mental health services is:[10]

(a) The Mental Health Act 1983 (the 1983 Act) as amended by the Mental Health Act 2007 (the 2007 Act) includes provisions relating to the criteria for detention and supervised community treatment.

(b) The Health and Social Care Act 2008 (HSCA 2008) created the CQC as the new independent quality regulator of health and adult social care in England, and a unified legal framework for the regulation of both NHS and independent sector providers in England.[11]

(c) The Health and Social Care Act 2012 (HSCA 2012) made wide-ranging changes, including creating Monitor[12] as an economic regulator of all public and independent healthcare operators which provide care for NHS patients in England, and CCGs, which replaced primary care trusts on 1 April 2013.[13]

[9] In this section, we focus primarily on England but we have included references to the framework in Wales to highlight any key differences. Appendix B sets out the legal regulatory environment in more detail.
[10] LaingBuisson, Mental Health Hospitals & Community Mental Health Services. UK Market Report, second edition, p117.
[11] Other countries of the UK have their own health and social care regulators under devolved powers. The legislative framework for regulating the safety and quality of independent sector providers, however, has many similarities with England's under the HSCA 2008. LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p121.
[12] Since 1 April 2016, Monitor has been part of NHS Improvement (NHSI), which is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
[13] CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area (see also below paragraphs 2.36 -2.39 and Appendix B).

Patient rights[14]

Criteria for detention

2.5 The 1983 Act and the 2007 Act provide for the detention and treatment of a person without their consent. The legislation also provides safeguards against inappropriate detention and treatment.

2.6 Section 4 of the 2007 Act introduced a new 'appropriate medical treatment test' for detention[15] under section 3 of the 1983 Act. This provides that a patient may be admitted to a hospital, and detained there if, amongst other conditions,[16] appropriate medical treatment is available.

2.7 The 2007 Act also introduced supervised community treatments (SCT) for patients following a period of detention in hospital to enable a patient to live in the community whilst subject to certain conditions under the 1983 Act, to ensure they continue with their treatment.[17]

Categorisation of secure mental health services

2.8 The Department of Health has three levels of secure care: high, medium and low, with guidance governing provision at each level.[18] For each level a range of physical, relational and procedural measures are put in place to ensure the provision of a safe and secure environment for the delivery of the treatment.[19]

2.9 The purpose of security measures is to ensure the safety of patients and the public, to prevent escape and absconding and reduce the likelihood of patients failing to return from agreed periods of leave.

2.10 Depending on individual needs, patients may go through an integrated care and treatment pathway that spans one or more levels of care. There are no legal provisions that prescribe the criteria under which patients should be admitted.

2.11 Table 1 sets out the key features of each level. Further detail is in Appendix B.

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[14] Patient and patient family rights are explained in more detail in Appendix B.
[15] Under paragraph 6 of Schedule A1 to the Mental Capacity Act 2005 a detained resident is a person detained in a hospital or care home – for the purpose of being given care or treatment – in circumstances which amount to deprivation of the person's liberty.
[16] See Appendix B for more detail.
[17] The criteria for issuing a SCT are set out in Appendix B.
[18] Department of Health, Secure mental health services.
[19] See NHS, Your guide to relational security.

Table 1: Key differences of security levels

Level of security	*High*	*Medium*	*Low*
Security measures	Prison-equivalent security perimeter supported by the security procedures necessary for the safe and secure detention of patients posing a grave danger to the public.	5.2-metre perimeter fencing; secure locking systems and alarm systems.	Minimum 3-metre external perimeter fencing.
Admission criteria	Person presents a grave and immediate danger to the public and requires a significant period of treatment	Person who presents a significant danger.	Definable clinical risk to others or legal requirement to be in custody; may have history of offending behaviour with low levels of violence.
Eligible providers	NHS only. The NHS Act 2006 places a specific duty on the Secretary of State for Health to provide high secure hospital services which are part of an NHS trust.	NHS and Independent	NHS and Independent

Source: CMA; Department of Health Best Practice Guidance – Specification for Adult medium secure services (1 July 2007); Royal College of Psychiatrists (2012) Standards for low secure services.

2.12 PD services are often described using a tiered approach, which allows patients to be appropriately directed according to their needs, the complexity of their PD and their capacity to engage with services:

(a) Tier 1 refers to primary care.

(b) Tier 2 refers to generic mental healthcare, normally in a community mental health treatment.[20]

(c) Tier 3 refers to local[21] specialist PD services. These include non-hospital residential provision eg in crisis houses,[22] intensive day treatment ie 'partial hospitalisation', and access to acute inpatient care.

[20] Community mental health treatment is used to refer to a system of care in which the patient's community, not a specific facility such as a hospital, is the primary provider of care for people with a mental illness. The services may be provided by government organisations and mental health professionals across a geographical area, as well as private or charitable organisations.
[21] Local services cover narrow geographic areas or a small specified set of the population.
[22] Crisis houses offer intensive, short-term support to manage and resolve a crisis in a residential setting (rather than hospital).

(d) Tier 4 mainly refers to residential low and medium secure specialist inpatient PD services.[23] These are for those patients whose safe treatment requires a higher level of containment than can be provided by hospital residential programmes, either through higher intensity and frequency of therapeutic input, or through a specialist residential therapeutic environment.[24]

(e) Tier 5 and 6 services are medium and high secure forensic[25] services.

Regulatory bodies[26]

2.13 The main regulatory bodies are:

(a) The CQC, which licenses, inspects and can bring enforcement against providers. The CQC rates all the services it regulates from 'Outstanding' to 'Inadequate'.[27]

(b) NHS Improvement (NHSI), which from 1 April 2016 brought together several regulatory bodies – including Monitor – in order to provide an oversight and improvement structure for foundation and NHS trusts, as well as independent providers that provide NHS-funded care.

(c) The Healthcare Inspectorate Wales (HIW),[28] which regulates independent healthcare providers in Wales under the Care Standards Act 2000, and Health and Social Care (Community Health and Standards) Act 2003 legislation. The HIW does not give providers ratings, but publishes reports on the findings of their inspections and investigations.

2.14 The CQC is the independent regulator of health and adult social care in England. It has the following statutory functions:[29]

(a) registration;

(b) review and investigation; and

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[23] Specialised mental health Tier 4 services are commissioned centrally by NHSE. We note that there is currently an NHSE moratorium on the commissioning of new capacity in these services (see paragraph 2.96 below).
[24] We understand that this tiered approach and in particular, the distinction of Tier 3 and Tier 4 services is now most commonly used in Child and Adolescent Mental Health Services (CAMHS) rather than adult rehabilitation services.
[25] Forensic services are services related to offenders.
[26] Further detail on the regulatory bodies are in Appendix B.
[27] CQC: Ratings.
[28] See HIW website.
[29] Section 2 of the HSCA 2008.

(c) certain specified functions under the 1983 Act.[30]

2.15 The CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. It publishes its findings, including performance ratings to help people choose care.[31]

2.16 The CQC has summarised its regulatory intervention in five key questions about the services it regulates: are they safe, effective, caring, responsive to people's needs and well-led?

2.17 The CQC has extensive civil and some criminal enforcement powers. It has the civil power to impose conditions and to suspend or cancel a registration. Failure to comply with the steps required when it uses its civil powers is a criminal offence.

2.18 Its civil enforcement powers range from Requirement and Warning Notices, to special measures for providers that require a higher than usual level of regulatory supervision.[32]

2.19 We found that quality regulation and the CQC's powers play a significant role in this market and we have taken these into account in our assessment.

2.20 The main duty of NHSI is to protect and promote the interests of people who use healthcare services by:

(a) promoting provision of healthcare services that are economic, efficient and effective;

(b) maintaining or improving the quality of the services;[33] and

(c) preventing anti-competitive behaviour which is against the interests of patients.

2.21 NHSI's main functions are:

(a) licensing health services providers; and

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[30] For instance, through monitoring how providers are caring for patients, and whether patients' rights are being protected.
[31] See CQC website.
[32] Services rated as 'Inadequate' overall will be placed straight into special measures and be re-inspected within a year. If, following inspection, sufficient progress has not been made, further action will be taken to prevent the service from operating, either by proposing to cancel their registration or varying the terms of their registration. There will then be a further inspection. Special measures do not replace the CQC's existing enforcement powers, ie the CQC will take enforcement action at the same time as placing a service into special measures. If services are rated as 'Requires Improvement', the CQC would generally try to re-inspect within two years.
[33]Section 62 of the HSCA 2012.

(b) together with NHSE, regulating payments made by customers to providers for all NHS services.

2.22 The HIW is the independent inspectorate and regulator of healthcare in Wales. Its main functions are:

(a) registering and regulating independent healthcare providers in Wales;

(b) inspecting health services across Wales to check if standards are being met;

(c) continually monitoring all the information it holds about a service.

Providers' obligations

Provider registration

2.23 Providers regulated by the CQC must be registered and failure to do so is an offence.[34] This obligation applies for providers of rehabilitation services.

2.24 Under the HSCA 2008, providers are registered in respect of each regulated activity that they carry out. Therefore, if a provider decides to stop carrying out a regulated activity for which it is registered, it is required to cancel the registration of that activity.

2.25 The CQC has set an objective in its Business Plan[35] to speed up the registration process (with the aim of it being able to be completed in ten weeks) and move to an online registration process.

2.26 The CQC's current approach is to register the body that directly runs local services, although these can be subsidiaries of larger corporate groups. The CQC is planning to reconsider this approach.

Licensing

2.27 NHSI licenses independent providers of NHS services that have been registered by the CQC. Providers of rehabilitation services therefore need to be licensed by NHSI.

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[34] Section 10 of the HSCA 2008. Also, sections 33–37 of the same Act describe other registration-related offences relating to *(a)* failure to comply with conditions; *(b)* suspension or cancellation of registration; *(c)* contravention of regulations; *(d)* false description of concerns, premises etc; *(e)* false statements in applications.
[35] See the CQC Business plan 2017-18.

2.28 The criteria for a new provider to be granted a licence are:[36]

(a) registration with the CQC; and

(b) the directors or governors must meet NHSI's fit and proper test.[37]

2.29 In addition to the criteria above, there are several conditions which all licensees must fulfil. These are discussed in detail in Appendix B but may be summarised as follows:

(a) Integrated care condition, which requires the service delivery beneficial to integrated care.

(b) Choice and competition conditions, which require prevention of anti-competitive behaviour which is not in the interests of patients.

(c) Pricing conditions, which require the provider to comply with the NHS pricing rules (the National Tariff)[38] and provide pricing information to NHSI.

2.30 To apply for a licence, a provider must submit an online application. From April 2014, all providers requesting both CQC registration and an NHSI licence can apply through a single process.[39] NHSI must publish a register of licence holders.[40]

2.31 There is currently no fee for applying for or maintaining an NHS provider licence although HSCA 2012 has given NHSI the power to charge a fee.[41]

2.32 The CMA has found that registration and licensing are pre-requisite to the provision of rehabilitation services and has assessed them further as potential barriers to entry/expansion (see also Section 12).

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[36] Pursuant to section 86 of the HSCA 2012 and the National Health Service (Approval of Licensing Criteria) Order 2013/2960.
[37] According to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) providers must not appoint a person to an executive director level post (including associate directors) or to a non-executive director post unless they are *(a)* of good character; *(b)* have the necessary qualifications, skills and experience; *(c)* are able to perform the work that they are employed for after reasonable adjustments are made; *(d)* can supply information as set out in Schedule 3 of the Regulations. The definition of good character does not just mean the lack of criminal convictions but instead it is a judgement as to whether the person's character is such that they can be relied upon. The 2014 Regulations list categories of persons who are prevented from holding the office and for whom there is no discretion.
[38] See also below paragraph 2.64.
[39] See CQC (April 2014), Guidance for organisations applying for both registration and licensing as a new service provider.
[40] Section 93 of the HSCA 2012.
[41] Section 97(1)(a) of the HSCA 2012.

Duties of rehabilitation services customers

2.33 There are two main commissioning bodies in England: CCGs and NHSE. Established under the HSCA 2012, NHSE and (through NHSE) CCGs, are accountable to the Secretary of State. In Wales, rehabilitation services are commissioned by seven LHBs (see also Appendix B for more detail).

NHSE

2.34 NHSE commissions some services directly, and otherwise regulates the commissioning activities of CCGs.

2.35 NHSE's functions include providing funding, guidance and assistance to CCGs. It also conducts an annual performance assessment of each CCG and has the power to make quality payments to CCGs reflecting their performance.

CCGs

2.36 The HSCA 2012 abolished strategic health authorities and primary care trusts and established CCGs. CCGs are statutory corporate bodies, established on the grant of an application by NHSE.

2.37 These bodies commission the majority of health services. There are 207 CCGs in England which are responsible for approximately two-thirds of the total NHSE budget, £73.6 billion in 2017/18.[42]

2.38 In addition to the central programme budget, NHSE holds separate funds for transformation of £1.1 billion for both 2017/18 and 2018/19, allocated to support the implementation of the *Five Year Forward View*[43] focusing on priorities such as, among others, mental health services.[44] Around 25% of the total mental health budget is absorbed by rehabilitation services.[45]

2.39 CCGs and some local authorities[46] are responsible for the commissioning of rehabilitation services in England.[47]

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[42] As of August 2017, as reported in NHS Clinical Commissioners website.
[43] See below paragraphs 2.97 - 2.98, NHS Five Year Forward View.
[44] See NHSE (March 2017), NHS England Funding and Resource 2017-19: supporting 'Next Steps for the NHS Five Year Forward View'.
[45] See Joint Commissioning Panel for Mental Health (October 2016), Guidance for commissioners of rehabilitation services for people with complex mental health needs. The total budget allocated to all mental health services has not been reported.
[46] Local authorities take the lead for improving health and coordinating local efforts to protect the public's health and wellbeing.
[47] In Wales, rehabilitation services are commissioned by seven Local Health Boards (LHBs). See also Appendix B.

Rules relating to mental health services procurement

2.40 The following regulations govern the procurement of rehabilitation services:

(a) The National Health Service (Procurement, Patient Choice and Competition) (No2) Regulations 2013 (PPCCRs); and

(b) The Public Contracts Regulations 2015 (PCRs 2015).

The National Health Service (Procurement, Patient Choice and Competition) (No2) Regulations 2013

2.41 The PPCCRs came into force on 1 April 2013. Section 75 of the HSCA 2012 provides that the PPCCRs may impose certain requirements on customers to ensure that, among others, they treat providers equally and in a non-discriminatory way.

2.42 For instance, customers are required to not treat a particular provider or type of provider (for instance NHS or private providers) more favourably than others.

2.43 For the purposes of the NHS, NHSI's guidance makes it clear that the PPCCRs do not require every contract to be competitively tendered.[48]

The Public Contracts Regulations 2015

2.44 The PCRs 2015 implement the new Public Sector Procurement Directive (2014/24/EU)[49] which modernises rules for the procurement of goods, services by public authorities.[50]

2.45 The implementation of PCRs 2015 requires that customers act in an appropriately transparent way when taking procurement decisions and that where a decision is taken to award a contract above €750,000/£589,148 this should be advertised in the *Official Journal of the European Union*.

2.46 Guidance from the Department of Health has stressed that the requirement to advertise does not equate to a requirement to run a full competitive process

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[48] See NHSI (December 2013), Substantive guidance on the Procurement, Patient Choice and Competition Regulations, p36.
[49] See Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014 on public procurement and repealing Directive 2004/18/EC.
[50] The Public Contracts Regulations 2006 were replaced by the PCRs 2015 on 26th February 2015. The new provisions of the PCRs 2015 – relating to the award of clinical services – came into force for clinically commissioned work within the NHS on 18 April 2016. Any new healthcare services contract procurement procedure that commences on or after that date will need to comply with the requirements of the PCRs 2015.

for all contracts above that threshold. It also points out that the PCRs 2015 require a fair and transparent process to be followed, but contain a number of flexibilities that, where justified, can be used by customers to dispense with the need for open competition.[51]

Framework agreements

2.47 The PCRs 2015 define a framework agreement as: 'an agreement between one or more contracting authorities and one or more economic operators, the purpose of which is to establish the terms governing contracts to be awarded during a given period, in particular with regard to price and, where appropriate, the quantity envisaged.'[52]

2.48 A framework agreement is a procurement method that operates in a similar way to an approved provider list. Once the framework is agreed it usually operates as a closed system not allowing new providers.

2.49 Getting listed on a framework is not a guarantee of future contracts. Once a framework agreement has been established for a certain service area, when a customer wants to procure services, they will approach suppliers listed on the framework. They will either go directly to one provider or hold a mini-competition to determine the most suitable provider.

2.50 The PCRs 2015 provide that for contracts whose value exceeds £589,148, the term of a framework agreement shall not exceed four years, save in exceptional cases duly justified, in particular by the subject matter of the framework agreement.[53]

Any Qualified Provider

2.51 The government's Any Qualified Provider (AQP) policy is another means of procuring certain NHS services in England.

2.52 The AQP is similar to a framework agreement. Under AQP, any provider assessed as meeting quality requirements and who can deliver services to NHS prices is able to deliver the service.

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[51] See Department of Health (October 2016), The Public Contracts Regulations 2015 and NHS Commissioners.
[52] Regulation 33 of the PCRs 2015.
[53] ibid.

2.53 AQP providers can be from the NHS or private sector. Providers have no volume guarantees and customers will decide which providers to refer to on the basis of quality.

2.54 2012/13 was identified as a transitional year to test implementation of AQP, starting with a limited set of community and mental health services.[54] CCGs were required to select three of these services to roll out under the AQP model from April 2012.

2.55 From March 2014, the decision to extend choice of providers and establish services as AQP as well as the qualification of providers rests entirely with CCGs who can determine the services to be provided under AQP.

2.56 The CMA understands that customers that commission rehabilitation services are not under a duty to procure services under AQP and that the primary purpose of this policy is to increase patients' choice.

Rules and practice related to contracting

2.57 Rehabilitation services are purchased using various agreements and contract types. These are explained further in following sections and in Appendix B:

(a) The NHS Standard Contract, which is the contractual form that must be used by customers when commissioning rehabilitation services (see also paragraph 2.63 below).

(b) Contracts under framework agreements, as described above (paragraph 2.47)

(c) Block contracts whereby the payment of the service is made in advance of the service and the value of the contract is independent of the actual volume of patients treated or activity undertaken (see also paragraph 2.76 and onwards below).

(d) Service level agreements (SLAs) which refer to a written agreement between a provider and the customer setting out the range and level of services to be provided, the responsibilities and priorities and the fees. The SLA is not a contract.

[54] Adult Hearing, Diagnostic services closer to home, Venous Leg Ulcers, Podiatry, Primary Care Psychological Therapies for Adults, Community Continence, Wheelchair Services, Musculoskeletal Services.

The NHS Standard Contract

2.58 The NHS Standard Contract is used by customers to commission NHS funded acute, ambulance, community, mental health and learning disability services from all types of providers (NHS trusts, foundation trusts, independent, charitable and voluntary sectors).[55]

2.59 NHSE is responsible for drafting standard terms and conditions which cannot be amended. Some of the quality and performance requirements are set nationally and others may be agreed locally.

2.60 In case of framework agreements, an NHS Standard Contract can be entered into with each provider appointed to the framework.

2.61 Some of the service conditions usually prescribed under the NHS Standard Contract are:

(a) the provider and the Commissioner must comply with guidance issued by the Department of Health, NHSE and NHSI regarding patients' rights of choice of provider and consultant;[56]

(b) the provider must accept any referral of a patient made in accordance with the referral processes and clinical thresholds set out or referred to in this contract and/or as otherwise agreed, subject to providers' rights to withdraw or discontinue the service in certain occasions;[57]

(c) the provider must use its best efforts to avoid circumstances and transfers and/or discharges likely to lead to emergency readmissions or recommencement of care;

(d) non-discrimination clauses; and

(e) annual price review clauses.

2.62 Customers are also under a duty to offer an alternative provider[58] if a person has been referred to a provider and they or the customer have been notified that the person referred has not commenced appropriate treatment; or will not

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[55] See the 2017/18 NHS Standard Contract.
[56] For instance, see NHSE's Guidance on implementing patients' legal rights to choose the provider and team for their mental health care (December 2014).
[57] The provider is not required to provide or to continue to provide a service to, amongst others, a patient who in the provider's reasonable professional opinion is unsuitable to receive the relevant service, for as long as they remain unsuitable.
[58] Regulation 48 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

have commenced appropriate treatment, within 18 weeks, beginning with the start date.

2.63 According to NHSE guidance[59] customers must not:

(a) put in place locally-designed contracts or SLAs for healthcare services, instead of the NHS Standard Contract; or

(b) vary any provision of the NHS Standard Contract except as permitted by NHS guidance on permitted Variations Process;[60] or

(c) seek to override any aspect of the NHS Standard Contract.

Pricing regulation

Determining national prices and other pricing rules

2.64 NHSE and NHSI have a shared responsibility to set the prices and payment rules for customers and providers to use for certain health services. NHSE has a duty to specify those healthcare services for which it thinks a national price should be used, and NHSI has the duty to set that price. This is known as the National Tariff and it specifies rules governing not only how nationally set pricing will work, but also how local price-setting must operate. [61]

2.65 In rehabilitation services, there is currently no national price set by NHSI. Prices are negotiated and agreed locally. However, providers must comply with some rules specified in the 'National Tariff Price 2017/2018'.[62] The rules are set out briefly below.

2.66 When agreeing prices for services without a national price, the approach of customers and providers must:

(a) have regard to the efficiency and cost uplift factors.[63]

(b) be in the best interests of patients;

(c) promote transparency;

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[59] NHSE (November 2016), NHS Standard Contract 2017/18 and 2018/19 Technical Guidance.
[60] See NHSE (May 2015), NHS Standard Contract - Guidance on the Variations Process (GC30).
[61] According to section 15 of the HCSA 2012, NHSI is responsible for designing the proposals for the methods for setting prices in the National Tariff, and the rules on setting local prices where there isn't a national price.
[62] See 2017/2018 and 2018/2019 National Tariff Payment System, published by NHSI and NHSE.
[63] For 2017/18, the efficiency factor is 2% and the cost uplift factor is 2.1%. This gives a net increase of 0.1%. For 2018/19 the efficiency factor and cost uplift factors are 2% and 2.1% respectively. This results in a net increase of 0.1%.

(d) improve accountability and encourage the sharing of best practice; and

(e) the provider and customer(s) must engage constructively with each other when trying to agree local payment approaches.

2.67 Payment for rehabilitation services is governed by a 'currency' model which was first mandated in the 2013/14 Payment by Results policy.[64] This model designates providers of rehabilitation services into levels. These service levels have different service profiles and costs. In rehabilitation services, there are 25 currencies[65] based on patient complexity and provider/service type.

2.68 Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long-term condition. Tariffs are the set prices paid for each currency. They can be used as a contracting unit and the prices can be used as a guide or starting point for local negotiation.

2.69 Where a national currency is specified for a service, but the customer and provider of that service wish to move away from using it, they may agree a price without using the national currency, provided they adhere to some requirements which are intended to mirror the requirements for agreeing a local variation for a service with a national price.[66]

Reference costs

2.70 Reference costs are the average unit cost to the NHS of providing secondary healthcare to patients and they are used to set prices for NHS-funded services in England.

2.71 NHSI is now accountable for the reference costs collection. NHSI's strategy for costing and cost collection to inform price setting is set out in its *Approved Costing Guidance*.[67]

2.72 The NHSI intends to mandate the patient-level cost collection for all NHS acute providers for 2018/19, extending to all mental health providers (including rehabilitation services) for 2019/20.

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[64] See 'Payment by Results'.
[65] The determination of national currencies has been the result of the 'Payment by Results' policy introduced in 2013.
[66] See Appendix B for more detail.
[67] NHSI, (2016) Approved Costing Guidance.

2.73 In relation to independent providers, the NHSI is still considering its approach and will not be collecting cost data in 2017.

2.74 The CMA understands from the above that all providers of rehabilitation services are subject to some pricing constraints, in particular with regards to NHS pricing benchmarks. These constraints are further explored in Section 12.

Payments/reimbursement models in mental health services

2.75 The main types of payments chosen by customers and the reforms undertaken by NHSE in this field are set out below.[68]

Block contracts

2.76 A block contract is a payment made to a provider to deliver a specific, usually broadly defined, service. Block contracts are paid in advance of the service being undertaken and the value of the contract is independent of the actual volume of patients treated or activity undertaken. Payments are made on a regular, usually annual, basis.

2.77 The value of the contract can be set in various ways usually through a measure of patient need or simply based on the historical expenditure on a particular service.[69]

2.78 Since the NHS was established, block contracts have been the dominant payment system across the UK. In England, however, there has been a substantial shift away from block contracts, with the introduction of the National Tariff. However, they continue to be used in mental health services, and are widely used in community care.

2.79 Overall, it has been found that block contracts are used to reimburse the majority of community services, and two-thirds of mental healthcare.[70]

2.80 More specifically, in the period 2015/16, around 58% of NHS trusts were expecting to have a block contract in place for mental health services.[71]

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[68] Annex 2 to Appendix B sets out the various payment types, their differences and associated advantages and disadvantages.
[69] British Medical Association, Models for paying providers – Block contracts (December 2015).
[70] See Nuffield Trust (2014), The NHS payment system: evolving policy and emerging evidence.
[71] See NHS Providers (April 2015), Funding for mental health services: Moving towards parity of esteem?

2.81 A more recent survey in October 2015, which surveyed 36 NHS mental health providers found that 89% of the respondents had block contracts in place, and estimated that this percentage would fall to 47% in 2016/17.[72]

Payment system reforms

2.82 In a move towards delivery of *The Five Year Forward View for Mental Health*,[73] NHSE and NHSI are supporting providers and customers of mental health services to implement more transparent payment approaches.

2.83 Mental health providers (including providers of rehabilitation services) and customers are required to adopt transparent and robust payment approaches linked to outcomes.

2.84 In 2016 NHSI published detailed guidance documents which set out the different approaches to payment for adult and older people mental health services that providers and customers are required to adopt.[74]

Quality Incentive schemes/payments for performance

2.85 As a result of the emphasis on quality in mental health services, new types of payments have emerged in rehabilitation services. These take the form of quality incentive schemes or payments that reward or penalise providers for aspects of their performance.

Quality Premium

2.86 The Quality Premium (QP) rewards customers for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. [75]

2.87 The maximum QP payment for a customer is expressed as £5 per head of population. In mental health services (including rehabilitation services) the QP measure for the period 2017 to 2019 consists of three discrete indicators from which one will be chosen based upon the quality most pertinent to a given customer:

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[72] More specifically, providers were asked about their likely arrangements for 2016/17. See Healthcare Financial Management Association, Survey Report (November 2015). A key comment from providers captured in the survey report was that customers will push for block contracts, pointing out a difficult negotiation.
[73] See below paragraphs 2.97 -2.98, The Five Year Forward View for Mental Health. A report from the independent Mental Health Task Force (February 2016), Annex A.
[74] See New payment approaches for mental health services and Appendix B for more details.
[75] Section 223(K) of the NHS Act.

(a) Out-of-area placements.

(b) Equity of Access and outcomes in Improved access to Psychological Therapies (IAPT) services.[76]

(c) Improve inequitable rates of access to Children and Adolescent Mental Health Services.

Commissioning for Quality and Innovation scheme

2.88 The Commissioning for Quality and Innovation (CQUIN) scheme was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

2.89 According to the most recent CQUIN Guidance[77] published by NHSE, providers of rehabilitation services will be offered CQUIN at 2.5% of the actual annual value of the contract for improvements in quality and innovation, as the NHS works to take forward the findings of the Mental Health Taskforce.[78]

Provisional conclusion on legal and regulatory environment

2.90 Rehabilitation services are characterised by a complex legal and regulatory framework, with a variety of laws, rules and regulations governing all aspects of services both at the provider and customer level. There is a clear focus on quality monitoring and quality improvement both nationally and locally.

2.91 In particular, we have found that providers of rehabilitation services are subject to a significant degree of regulation, especially through the licensing and registration process and the monitoring of quality and service standards.

2.92 Providers of rehabilitation services are also subject to some pricing constraints in the form of NHS pricing benchmarks as well as increasing intervention regarding the content and the payment terms of their contracts with providers.

2.93 We note that there are currently substantial reforms taking place in rehabilitation services relating to the commissioning, pricing and payment of services. These might impact on providers' pricing conduct and on customers' procurement, commissioning and contracting behaviour in the longer term.

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[76] IAPT services provide evidence based treatments for people with anxiety and depression.
[77] See the NHSE Guidance 2016/2017 (March 2016) ('CQUIN Guidance').
[78] NHSE: Mental Health Taskforce,.

Policy context

2.94 This section provides an overview of some important policy interventions that have shaped the provision of mental health services since 2011.

2.95 In 2011, the government published a mental health strategy document, *No health without mental health* setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma.[79]

2.96 An 2013 an NHSE moratorium on the commissioning of new capacity for certain centrally-commissioned specialised services including secure mental health services[80] was introduced (the moratorium). It remains in place.

2.97 The *Five Year Forward View* was developed by NHSE, the CQC, Public Health England[81] and NHSI and was published in October 2014. It is the key current policy document and provides a platform for many of the changes occurring across all levels in the NHS in England. In relation to mental health, the *Five Year Forward View* set out an ambition for the NHS to drive towards an equal response to mental and physical health, and towards the two being treated together to achieve genuine 'parity of esteem' between physical and mental health by 2020.[82]

2.98 In March 2015, NHSE launched an independent taskforce (the Taskforce) to develop a five-year strategy to improve mental health outcomes across the NHS.[83] The Taskforce's final report, *The Five Year Forward View For Mental Health* published in February 2016, highlighted that over the previous five years, public attitudes towards mental health had improved, and stressed the need to re-energise and improve mental healthcare across the NHS to meet increased demand and improve outcomes.[84] In July 2016, NHSE published an Implementation Plan detailing how it will deliver the recommendations made by the Taskforce working with its partner arms-length bodies.[85]

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[79] Department of Health, (2011), No health without mental health. A cross-government mental health outcomes strategy for people of all ages.
[80] See Appendix C for a description of the main categories of mental health services.
[81] Public Health England was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service. It is an executive agency of the Department of Health, and a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.
[82] NHS (October 2014), Five Year Forward View, p26.
[83] NHSE: Mental Health Taskforce.
[84] The Five Year Forward View for Mental Health. A report from the independent Mental Health Task Force (February 2016).
[85] NHS (July 2016), Implementing the Five Year Forward View for Mental Health.

2.99 A LaingBuisson report published in February 2016 noted that

> The fairly positive prospects for NHS health funding over the next five years mean that independent mental health operators will not face commissioners under extreme pressure to contain costs, but there will be no return to the benign NHS financial environment enjoyed prior to the global credit crisis. Continuing pressures of demand from population expansion and ageing, as well as advances in medical technology, mean that the NHS will continue to seek efficiency savings, to which independent sector mental health providers will be expected to respond…[86]

2.100 In January 2017, the government formally accepted the recommendations of the Taskforce, which envisaged an increase in mental health spending by £1 billion a year by 2020/21.[87, 88,89]

2.101 NHSE published *Next steps on the NHS Five Year Forward View* in March 2017, and announced that overall mental health funding in England was £1.4 billion higher (in real terms) compared with three years ago. It also set out key improvements planned for 2017/18 and 2018/19 to expand access to mental health services including the following:[90]

(a) Increase in psychological ('talking') therapies.

(b) Better mental healthcare for new and expectant mothers.

(c) Improved care for children and young people.

(d) Providing care closer to home.

(e) Specialist mental healthcare in Accident and Emergency (A&E) services.

(f) Better physical health for people with mental illness.

(g) New specialist Transition, Intervention and Liaison (TIL) mental health services for veterans.

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[86] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p8.
[87] The Five Year Forward View for Mental Health. A report from the independent Mental Health Task Force (February 2016), p11.
[88] HM Government (9 January 2017). Mental Health: Written statement - HCWS397.
[89] Oral statement to Parliament by the Department of Health and Secretary of State for Health, Jeremy Hunt (9 January 2017): Mental health and NHS performance.
[90] NHS (March 2017), Next steps on the NHS Five Year Forward View, Chapter 5, pp26–27.

(h) New specifications for mental health provision for people in secure and detained settings.

(i) Investment in mental health provider technology through Mental Health Global Digital Exemplars.

2.102 In a recent report on the state of care in mental health services in England published in July 2017,[91] the CQC highlighted a number of significant pressures and challenges in providing specialist mental health services, including:

(a) high demand;

(b) shortage of mental health nurses;

(c) pressure on mental health acute wards;[92]

(d) out-of-area placements; and

(e) wide variation in indicators relating to mental health acute wards.

2.103 In its report, the CQC expressed concern about the high numbers of patients in locked rehabilitation[93,94,95] wards, which were often situated a long way from the patient's home. It stated:

> We think it possible that a significant number of patients in locked rehabilitation wards have the capacity to live in a setting of lower dependency and with fewer restrictions – provided there was suitable accommodation and intensive community support available in their local area to meet their needs.[96]

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[91] CQC (July 2017), The state of care in mental health services 2014 to 2017, pp12–17.
[92] Acute wards provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness. Defining mental health services. Mental Health Network NHS Confederation (2012).
[93] According to the CQC, the purpose of locked mental health rehabilitation wards is poorly defined. Further, it pointed out that there was no central register to show how many beds of this type there were in England. CQC (July 2017), pp30–31.
[94] 2Gether Trust explained that stepped-down patients may need to go to locked rehabilitation facilities due to Ministry of Justice requirements. It explained that the terminology of 'locked' was a fluid description and a locked status did not always mean that there would be no access/exit. Further, it explained that low/medium secure facilities had mandated security requirements and were therefore more strictly defined.
[95] The Royal College of Psychiatrists does not recognise the term 'locked rehabilitation unit'. Many such units have a similar specification to a high-dependency rehabilitation unit but may have a higher level of staffing and greater physical security (similar to a PICU) and focus on people with especially challenging behaviours. Source: CQC (August 2016), Brief guide: inpatient mental health rehabilitation services – discharge.
[96] CQC (July 2017), The state of care in mental health services 2014 to 2017, p31.

Provisional conclusion on policy context

2.104 In summary, the past six years has seen increased public and government attention on mental health, focusing on balancing the need to maintain provision and standards amid increasing demand and the financial pressures facing the NHS.

2.105 Although the government has committed to increase funding for mental health, independent hospital providers' revenue (including the Parties') will continue to depend on the level of outsourcing of mental health (including rehabilitation) services by the NHS, pricing trends and the overall funding situation faced by the NHS, NHSE, CCGs and local authorities.

2.106 In February 2016, Laing Buisson noted that the moratorium will be lifted at some stage, triggering some expansion of independent sector capacity.[97] The moratorium is still in place and continues to affect services and how they are commissioned.

2.107 The CQC's recent report[98] may change the focus of mental health policy agenda away from locked rehabilitation services and out of area placements. In the meantime, the service portfolio of independent providers will continue to depend on a variety of factors, including the availability of suitable step-down[99] facilities in the community setting and the legal and regulatory environment outlined above.

2.108 Overall, the policy context for mental health remains complex and dynamic. The volume and pace of change makes it difficult to predict with any degree of certainty how this might affect the prospects of the independent providers of rehabilitation services, including the Parties.

Mental health services and the patient care pathway

2.109 Mental health services can be categorised[100] based on various criteria, for example, the levels of security in which they are provided, the underlying health condition being treated, whether they are provided in acute care settings,[101] and the patient group treated (eg the elderly).

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[97] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p35.
[98] CQC (July 2017), The state of care in mental health services 2014 to 2017, pages 12-17.
[99] See footnote to Paragraph 2.115 for a description of step-down services.
[100] Many of these are overlapping categories. In addition, different organisations and bodies use different terminology to describe categorisation of mental health services.
[101] Acute care involves providing intensive support for people who are experiencing an acute, or a 'crisis' episode during their mental illness. Source: Southern Health NHS Foundation Trust.

2.110 The Parties treat a number of mental health conditions and overlap in the supply of rehabilitation services. The guidance for Commissioners of rehabilitation services for people with complex mental health needs, published by JCPMH[102] defines mental health rehabilitation 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 leads to successful community living through appropriate support.[103]

2.111 The mental health conditions treated by rehabilitation services include:[104]

(a) Personality disorders (PD), which are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

(b) Learning disabilities (LD), which refer to a lifelong reduced intellectual ability that has a lasting impact on capacity to learn new skills, understand new information, and to cope with independent living.

(c) Autism spectrum disorder (ASD), which is a range of conditions that affect social interaction, communication, interests and behaviour, the symptoms of which can often be recognised during early childhood.

(d) Acquired brain injuries (ABI), which include traumatic or non-traumatic injury or illness resulting in temporary or permanent impairment of brain function, with potential consequences for functional ability. Common causes include accidents and stroke, and can include the effects of alcoholism, drug abuse, and anoxic/hypoxic injury.[105]

(e) Long-term mental health (LTMH)[106] conditions, which can be defined as a range of psychological and psychiatric conditions or disorders with

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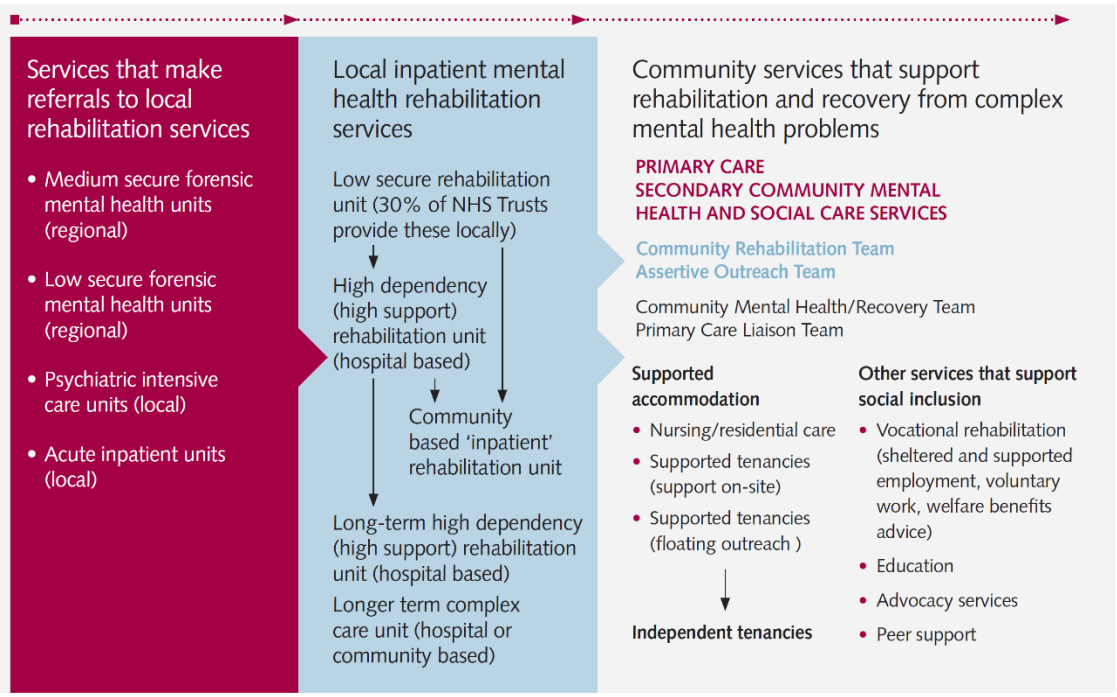
[102] Launched in April 2011, the JCPMH is comprised of 'leading organisations who are 'aiming to inform high-quality mental health and learning disability commissioning in England.' JCPMH Briefing Guide.
[103] JCPMH (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health need. p6.
[104] Source: Merger Notice, pp17–18.
[105] A complete interruption of the supply of oxygen to the brain is referred to as cerebral anoxia. If there is still a partial supply of oxygen, but at a level which is inadequate to maintain normal brain function, this is known as cerebral hypoxia. Source: Headway.
[106] Long-term mental health is not a clinical term. Some object to the reference to 'long-term mental health, for example Mind. Other terms which we understand are synonymous are 'severe mental health conditions' and 'enduring mental illness'. We use LTMH as the Parties use this term.

symptoms that cause significant distress and/or dysfunction, including cognitive, emotional, behavioural and interpersonal impairments.

2.112 Depending on their needs and conditions, patients with mental health conditions can pass through different stages of a care pathway, for example patients can move from a secure into a less secure setting or can be referred from a hospital providing rehabilitation services to a secure facility.

2.113 Figure 1 illustrates a typical rehabilitation care pathway, showing the 'direction of travel' for patients with complex and longer-term mental health conditions, from inpatient services through to community living.[107,108]

Figure 1: Components of a 'whole system' rehabilitation care pathway



Source: JCPMH (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health needs, p8.
Note: The service components in the rehabilitation care pathway are shown in blue.

Customers

2.114 As discussed in paragraphs 2.33 to 2.39, since April 2013, the commissioning of mental health services has been split (in England) between NHSE, which is responsible for a schedule of 'prescribed'[109] specialist services, commissioned centrally, and other mental health services (including

[107] JCPMH (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health need.
[108] We note (see paragraph 7.8) that patients can step up as well as down in the care pathway.
[109] The list of prescribed services commissioned by NHSE is provided in the Manual for Prescribed Specialised Services 2016/17.

rehabilitation services), commissioned locally by CCGs[110], and by LHBs in Wales.[111]

2.115 The range of mental health services commissioned locally by customers in England covers acute psychiatry, adult eating disorders, addiction problems, non-specialised ABI, non-secure and step-down[112] hospital services as well as community-based secondary mental health services.[113,114]

2.116 The bulk of CCG's spend on secondary mental health services is on block contracts (see paragraphs 2.76 to 2.81) with local NHS mental health trusts for the full range of NHS hospital and community-based services. The remainder is spent mainly on independent sector hospitals.[115]

The mental health services industry and main providers

2.117 Mental health services are provided by the NHS, independent providers and local authorities. The services are provided in hospital as well as community settings. The NHS owns the majority of supply. In 2015 it had approximately 71% share of all mental health hospital provision, both in terms of bed capacity and the estimated value of services. The remaining 29% was supplied by independent mental health hospitals. NHS outsourcing of community mental health services is currently very limited.[116]

2.118 Between 2010 and 2015, the combined NHS in-house mental health and LD hospital bed capacity fell by 23% (from 31,520 to 24,270), while the

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[110] As we note in paragraph 2.39, some local authorities are also responsible for the commissioning of rehabilitation services in England.
[111] In England, for both secure Services and CAMHS, NHSE negotiates a provider's single national contract and some minimum quality standards. In Wales, NHS Wales holds a framework agreement which ranks providers of rehabilitation and secure services. Source: Acadia / Priory decision. See also Appendix B.
[112] Step-down services include rehabilitation units commissioned by CCGs; supported accommodation in the community, which may vary from 24-hour staffed support to 'floating support' at various times during the week (commissioned by health and/or social care services). JCPMH (May 2013), Guidance for commissioners of forensic mental health services.
[113] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p66.
[114] Secondary care refers to services provided by medical specialists who generally do not have the first contact with a patient, for instance a neurologist or a rehabilitation consultant. Secondary care services are usually based in a hospital or clinic as opposed to being in the community and patients are usually referred to secondary care by a primary care provider such as a general practitioner (GP). Multiple Sclerosis Trust website.
[115] At the end of 2015, each CCG in England spent on an average approximately £50 million year on secondary mental health services. LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p66.
[116] In 2015, the NHS had 24,270 beds across the UK, while the independent sector had 10,018 beds. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, pp2, 83 & 99.

independent sector bed capacity grew by 8% (from 9,275 to 10,018).[117] Overall bed capacity in mental health hospitals declined during 2010 to 2015.

2.119 Table 2 shows how capacity and market size for the independent mental health hospitals in the UK has changed during 2006 to 2015. According to Laing Buisson, following a halt to growth in 2011, when NHS commissioners reduced their outsourced placements in response to the post-global credit crisis downturn in government spending, growth in independent mental health hospital revenue was re-established during 2013 to 2015.[118]

Table 2: Independent mental health hospitals, capacity and turnover, UK 2006-2015

Year	*Bed capacity*	*Turnover (£ million)*	*Turnover growth rate (%)*
2006	7,616	875	12.8
2007	8,030	919	5.1
2008	8,614	1,008	9.7
2009	9,027	1,067	5.9
2010	9,291	1,095	2.6
2011	9,865	1,092	–0.3
2012	9,900	1,109	1.5
2013	9,916	1,159	4.5
2014	9,784	1,207	4.2
2015	10,018	1,255	4.0

Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p11.

2.120 In 2014/15 the total UK market for mental health services was estimated to be £15.9 billion, of which hospital services (including inpatient rehabilitation services) accounted for £4.27 billion or approximately 27%.[119] The turnover of independent mental health hospitals in the UK was about £1.3 billion in 2015,[120] which constituted 29.4% of the mental health hospital services (including those provided by the NHS) – see Table 3.[121,122]

[117] Ibid, p3, Table 2.2. 2010 bed numbers have been derived based on 2015 bed numbers and the percentage change during 2010-2015.
[118] Ibid, p11.
[119] The remaining £11.6 billion includes (i) NHS in-house community mental health services £4.1 billion; (ii) other NHS in-house expenditure on mental health and learning disabilities £ 7.5 billion (primary care, older people's mental health services, community services for learning disabilities, etc); (iii) independent sector provided community mental health services £0.1 billion. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p12 (Figure 2.1).
[120] Ibid, p11.
[121] Excluding privately paid psychotherapy, counselling services. Ibid, p2.
[122] Total turnover of the independent providers in 2014/15 was approximately £1.4 billion, which constituted 8.5% of all mental health services in the UK (including hospital and community mental health services). LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, pp11–12.

Table 3: UK market for mental health and learning disability services – 2014/15

£ million

	Hospital services	*Community services*	*Total*
Independent sector			
Mental health and learning disability hospital revenue – NHS paid	1,094	-	1,094
Mental health hospital revenue – private medical insurance and self-pay	161	-	161
Community mental health services – NHS paid	-	100	100
Subtotal independent sector	*1,255*	*100*	*1,355*
NHS			
Mental health and learning disabilities hospitals	3,016	-	3,016
Community mental health services for young adults and children	-	4,063	4,063
Other expenditure on mental health and learning disabilities	-	7,466	7,466
Subtotal NHS	*3,016*	*11,529*	*14,545*
Total	4,271	11,629	15,900
Share of the independent sector	29.4%	0.9%	8.5%

Source: Based on data presented in Laing Buisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p12 (Figure 2.1).

2.121 The independent hospital sector is highly dependent on continued NHS outsourcing; £1.1 billion or 87% of its total revenue of £1.3 billion in 2015 represented demand from the NHS.[123] The share of private patients or those funded by private medical insurance in the independent hospitals' revenues was relatively small at 13%. The independent sector's focus is almost exclusively on providing mental health services in hospital settings.

2.122 In 2015, about 30% of the independent mental health hospital bed capacity was in low secure or psychiatric intensive care units (PICUs), while only 10% was in medium secure units.[124] [125] In 2015, 'locked rehabilitation' services accounted for about 23% of all independent mental health hospital bed capacity in the UK – see Table 4.[126] In terms of value, the locked rehabilitation services market in the UK was estimated at about £304 million in 2015, out of which £294 million or almost 97% was provided by the independent sector.[127]

[123] Ibid, p1.
[124] See Table 1 for a description of secure services. See Appendix C for a description of various mental health services.
[125] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, pp17 & 3.
[126] Cambian was the pioneer of the locked rehabilitation model of treatment, as a lower cost option to lower secure treatment. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p91.
[127] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p61.

Table 4: Independent sector mental health bed capacity, UK 2015

Type of service	*Bed capacity*	*% of total*
Medium secure	1,030	10.3
Low secure	2,517	25.1
PICU	408	4.1
Locked rehabilitation	2,333	23.3
Other non secure	2,681	26.8
All other (security level not known)	1,049	10.5
Total	10,018	100.0

Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p16 (Table 2.3A).

2.123 The Parties told us (see Figure 2) that as of February 2017, they had the largest rehabilitation bed capacity, with a combined share of [✂] [20–30]% (approximately [✂] [10–20]% CAS and [✂] [5–10]% Cygnet), followed by Acadia Group[128] at [✂] [10–20]%, Huntercombe [✂] [5–10] %, Elysium and St Andrew's both at [✂] [5–10]%, and Barchester at [✂] [0–5]%.[129]

Figure 2: Rehabilitation beds* by provider (independent hospitals) – February 2017†

[✂]

Source: The Parties.
* [✂]
† [✂]

2.124 September 2014 to January 2016 was a period of high M&A activity with the exit of two private equity groups from the UK mental health hospital sector (Cinven and Advent International) and the entry of two US-based trade buyers (Acadia Healthcare and UHS).[130,131]

2.125 Private equity operators continue to be active in the mental health hospital sector in the UK, which is evidenced by the recent divestment of specific sites by Acadia to B C Partners (a private equity firm) to address the CMA's concerns about Acadia's acquisition of Priory.[132] Elysium is the new entity established by B C Partners to operate these sites.

[128] The Acadia Group acquired Partnership in Care in June 2014 and the Priory Group in in January 2016. Source: Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, pp87–88.
[129] The combined share of all other providers was [✂] [30–40]%.
[130] Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p86.
[131] Acadia acquired Partnership in Care from Cinven in 2014 and Priory Group from Advent International in 2016. UHS acquired Cygnet in September 2014, Alpha Hospitals in 2015.
[132] See Acadia / Priory merger inquiry: Undertakings in lieu of reference acceptance decision.

3. The Parties and their operations

3.1 The Parties both operate independent mental health hospitals in the UK. This section provides an overview of the Parties and the services they provide. Further details are in Appendix C.

Cygnet

3.2 Cygnet is incorporated in England and Wales. It was founded in 1988[133] and is a wholly-owned subsidiary of UHS.[134] Cygnet offers a range of services for individuals suffering from a variety of mental health conditions. It describes itself as a provider of 'secure and specialist mental health services.' Cygnet's turnover in the UK in the year ending 31 December 2016 was around £178 million.

3.3 UHS is a US company incorporated in 1979. It is listed on the New York Stock Exchange, and its principal business is owning and operating, through its subsidiaries, acute care hospitals and outpatient facilities and behavioural healthcare facilities. The worldwide turnover for UHS in the year ending 31 December 2016 was around £7,204 million.

Cygnet's sites and services

3.4 Cygnet has 22 sites[135] that provide a range of mental health services in England – see Table 5 and Figure 3.

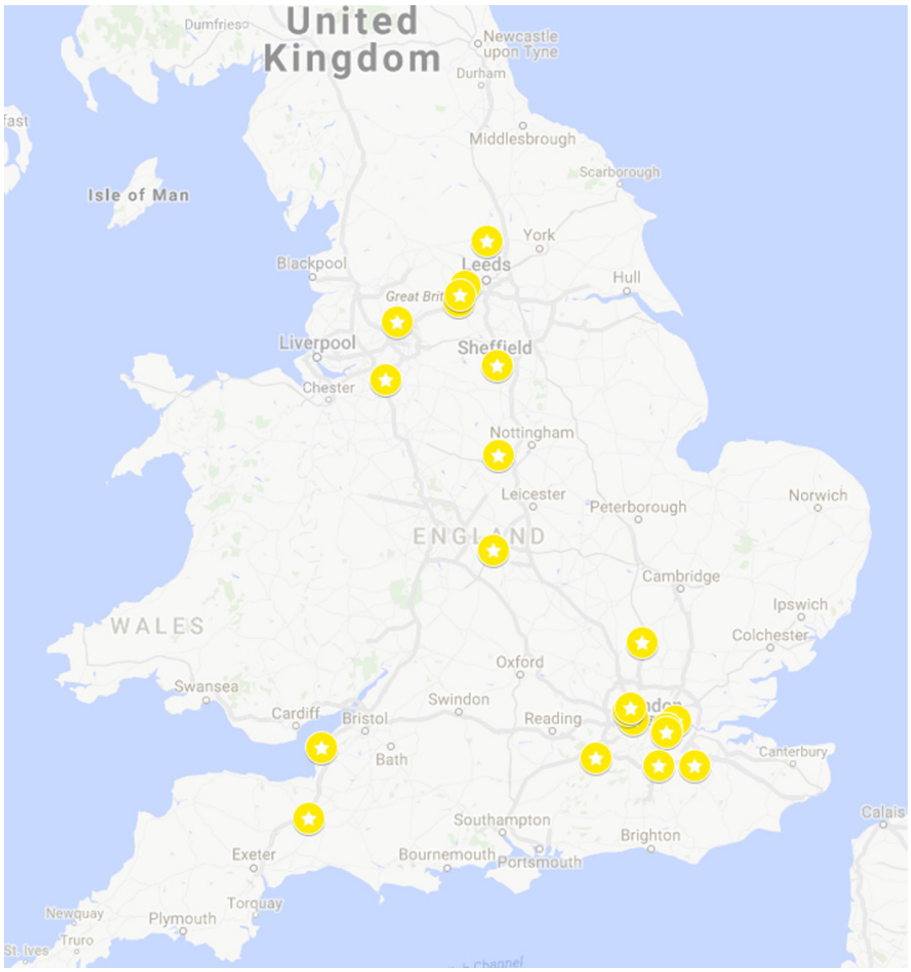
Table 5: Overview of Cygnet's services

Type of service	*Number of beds*	*Number of sites, where services are provided*
Medium secure	80	2
Low secure	273	10
Rehabilitation	338	15
Community	81	2
Acute and PICU	200	9
Addiction services	3	1
Eating disorders	17	1
CAMHS	122	4
Total	**1,114**	

Source: Merger Notice, p18, paragraph 3.17.
Note: Since many services are provided at more than one site, number of sites do not sum to the total number of sites, and is therefore not shown.

[133] The company has been subject to management buyouts on many occasions including in August 2000, November 2002 and March 2008. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p92.
[134] The behavioural health division of UHS acquired Cygnet in September 2014.
[135] Twenty mental health hospitals and two residential care homes for the elderly.

Figure 3: Location of Cygnet's sites



Source: The Parties

3.5 According to Cygnet, its services are focused on providing treatment at the higher end of the security (eg in secure hospitals) and acuity scale (eg acute psychiatric services and PICUs).[136]

3.6 Figure 4 shows the contribution of Cygnet's main services to its 2016 revenues.

Figure 4: Cygnet's revenues by service – 2016

[✂]

Source: The Parties.
Note: [✂]

3.7 In rehabilitation services, Cygnet has 15 sites (see Figure 5) comprising 25 wards and 338 beds.

[136] Merger Notice, paragraph 4.

Figure 5: Location of Cygnet's rehabilitation sites

Source: The Parties

3.8 Figure 6 provides the breakdown of Cygnet's 2016 revenue from rehabilitation services by specialism.

Figure 6: Cygnet's revenue from rehabilitation services by specialism – 2016

[✂]

Source: The Parties

3.9 Table 6 provides the breakdown of Cygnet's rehabilitation wards and beds by specialism and gender.

Table 6: Number of Cygnet's rehabilitation wards

Treatment type	*Male/ female*	*Number of wards*	*Number of beds*
Acquired brain injury (ABI)	M	-	-
	F	-	-
Learning disabilities (LD)	M	-	-
	F	1	13
Personality disorders (PD)	M	-	-
	F	6	88
Autistic spectrum disorders (ASD)	M	1	10
	F	-	-
Long-term mental health conditions (LTMH) – adults	M	6	91
	F	5	68
Long-term mental health conditions (LTMH) – elderly	M	5	59
	F	1	9
Total		25	338

Source: Merger Notice, p9

Cygnet's financial performance and strategy

3.10 Cygnet told us that its core business trading [✂]. In 2014, it averaged [✂]% occupancy and revenues were £[✂]. It stated that in 2015 after it was acquired by UHS,[137] Cygnet [✂],[✂]% in 2015 (revenues of £[✂]), and [✂]% in 2016 (revenues of £[✂]).[138] The increase in revenues also reflected two acquisitions Cygnet completed during 2015, ie Orchard Portman and Alpha hospitals.

3.11 Cygnet's earnings before interest, tax, depreciation and amortisation (EBITDA) increased from £[✂] in 2015 to £[✂] in 2016.

Table 7: Cygnet – summary financials

			£ million
	2016	*2015*	*2014*
Revenues	[✂]	[✂]	[✂]
EBITDA	[✂]	[✂]	[✂]

Source: Cygnet.

3.12 Cygnet told us that the main drivers of its profitability were occupancy levels (ie the percentage of bed capacity that is in use), price and operating costs.

3.13 According to Laing Buisson, Cygnet's underlying profitability (earnings before interest, tax, depreciation, amortisation and rent (EBITDAR)) placed it among

[137] Cygnet was acquired by UHS in September 2014.
[138] Net revenue before bad debt.

the top three or four mental health hospital providers in the UK over the last decade.[139]

3.14 NHSE and CCGs are Cygnet's main customers. In 2016, NHSE accounted for [✂]% of Cygnet's revenues, CCGs accounted for [✂]%.[140] [✂]% of Cygnet's revenues are derived from services provided in hospitals, with the remaining [✂]% generated by the two nursing homes it operates.

3.15 Cygnet told us that its strategy since 2014 has been to [✂].

CAS

3.16 CAS, formerly a division of Cambian, is a provider of specialist mental health services and residential care homes for patients with mental health conditions across England and Wales. The turnover of CAS for 2016 was around £142 million.

3.17 Cambian is a UK-based provider of behavioural health services for children, adolescents and (until the Merger) adults (the latter provided by CAS) in England and Wales.

CAS's sites and services

3.18 CAS has 61 sites providing a range of mental health services in England and Wales – see Table 8 and Figure 7.[141]

Table 8: Overview of CAS's services

Type of service	*Number of beds*	*Number of sites, where services are provided*
Low secure	24	1
Rehabilitation	686	25
Community*	513	41
Total	**1,223**	

Source: Merger Notice, p18
* Community services include inpatient residential care home services and day community services.
Note: Since many services are provided at more than one site, number of sites do not sum to the total number of sites, and is therefore not shown.

[139] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p92. According to this report (p130), EBITDAR figures facilitate comparisons between providers, which may own or lease their assets.
[140] The balance [✂]% related to local authorities, self-paying and private insurance patients.
[141] Source: Merger Notice, p19.

Figure 7: Location of CAS's sites

Source: The Parties

3.19 CAS provides rehabilitation services and 'step-down'[142] community placements in social care settings to support patients with mental health diagnoses to move into the community. It told us that it focused on providing services at the lower end of the security and acuity scale of the care pathway (see paragraph 2.113).

3.20 Figure 8 provides a breakdown of CAS's revenues by type of mental health service.

Figure 8: CAS's revenues by service – 2016

[✂]

Source: The Parties
Note: [✂]

[142] Step-down services include rehabilitation units commissioned by CCGs (which are often described as 'locked rehabilitation units'); supported accommodation in the community, which may vary from 24-hour staffed support to 'floating support' at various times during the week (commissioned by health and/or social care services). JCPMH (May 2013), Guidance for commissioners of forensic mental health services.

3.21 In rehabilitation services CAS has 25 sites (see Figure 9) comprising 36 wards and 686 beds.

Figure 9: Location of CAS's rehabilitation sites

Source: The Parties.

3.22 Figure 10 provides the breakdown of CAS' 2016 revenue from rehabilitation services by specialism.

Figure 10: CAS's revenue from rehabilitation services by specialism – 2016

[✂]

Source: The Parties.

3.23 Table 9 provides the breakdown of CAS's rehabilitation wards and beds by specialism and gender.[143]

[143] There are, in total, 686 rehabilitation beds. Source: Merger Notice, p19.

Table 9: CAS's rehabilitation wards

Treatment type	*Male/ female*	*Number of wards*	*Number of beds*
Acquired brain injury (ABI)	M	3	36
	F	-	-
Learning disabilities (LD)	M	9	116
	F	3	31
Personality disorders (PD)	M	-	-
	F	4	64
Autistic spectrum disorders (ASD)	M	1	4
	F	-	-
Long-term mental health conditions (LTMH) – adults	M	11	317
	F	5	118
Long-term mental health conditions (LTMH) – elderly	M	-	-
	F	-	-
Total		36	686

Source: Merger Notice, p43.

CAS's financial performance and strategy

3.24 According to Cambian's statutory accounts, in 2016 the total revenue of its adult services business (ie CAS) was £142.0 million compared with £129.4 million in 2015. CAS' adjusted EBITDA[144] increased from £24.1 million in 2015 to £28.8 million in 2016.[145,146]

Table 10: CAS – summary financials

			£ million
	2016	*2015*	*2014*
Revenue	142.0	129.4	100.6
Adjusted EBITDA	28.8	24.1	24.6

Source: Cambian Annual Reports, 2016 p9 (for 2016 and 2015 financials) and Cambian Annual Report, 2014 p22 (for 2014 financials).

3.25 The Parties stated that the Cambian statutory accounts for 2016 segmented the Cambian business by discontinued and continued operations, and the cost allocation between the two was not representative of the CAS business outside of Cambian plc.

[144] Adjusted EBITDA reflects earnings before interest, tax, depreciation, amortisation, profit or loss on disposal of assets, merger and acquisition costs, IPO share option charges and exceptional items.
[145] 2015 financials are re-presented to reflect transfers of sites before the sale of adult services was finalised. Source: Cambian 2016 Annual Report, p9.
[146] CAS' financials were presented as 'discontinued' business in Cambian 2016 Annual Report, p9.

3.26 CAS's financials reflecting stand-alone profitability of the business, prepared by Deloitte for the purpose of vendor due diligence, [✂] – see Table 11.[147]

Table 11: CAS summary financials

£ million

	2016	*2015*	*2014*
Revenue	[✂]	[✂]	[✂]
EBITDA	[✂]	[✂]	[✂]

Source: CAS.

3.27 [✂]

3.28 CAS told us that in early 2016, most of the 2015 improvement works were complete, and 2016 saw an improvement [✂].

3.29 CAS's top ten customers account for about [✂]% of its revenues. CCGs account for [✂]% of its revenues followed by local authorities at [✂]%.[148]

3.30 CAS told us that since 2014, its strategy has focused on [✂].

Overlap between the Parties' services

3.31 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 LD and ASD whereas Cygnet has two residential nursing homes for the elderly.

3.32 The only overlaps between the Parties' services were in relation to:

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

(b) Rehabilitation services.[149]

3.33 CAS's low secure facility only treats PD patients. The Parties told us that although Cygnet has a number of low secure mental health hospitals, it has only one low secure facility providing treatment for female patients with PD.[150]

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[147] According to Deloitte, acquisitions made during 2015 (Woodleigh – acquired in December 2014 and Ansel – acquired in September 2014) [✂]. Ansel is a 24-bed hospital in Nottingham, providing secure services for men with complex mental health needs, challenging behaviours and PDs.
[148] NHS Foundation Trusts, Partnerships Trusts and NHSE accounted for [✂]% of CAS's revenues.
[149] The Parties stated that they do not overlap in relation to (a) medium secure services; (b) CAMHS; (c) acute psychiatric and PICU services; (d) addiction services, and (h) eating disorder services, since CAS does not have any mental hospitals that provide these services. Source: Merger Notice, paragraph 16.
[150] Merger Notice, Paragraph 22.

3.34 In rehabilitation services, the Parties explained that there is no overlap between the Parties in relation to the treatment of:[151]

(a) ABI, as Cygnet does not have any facilities that offer this specialism; and

(b) LTMH conditions affecting the elderly, as CAS does not have any facilities providing treatment to elderly patients.

3.35 In our issues statement, we noted that the Parties overlap in the supply of rehabilitation services (ie to treat PD and LTMH conditions) to various customers. Further, we stated that although the Parties overlap in two other specialisms (ASD and LD), due to the lack of geographical proximity of the Parties' sites and the number and location of alternative providers, we would not be investigating these further unless we received evidence of concerns. As we have not received any such evidence or been made aware of any concerns, our analysis is focused on overlaps between the Parties in PD Female and LTMH Male and LTMH Female in our competitive assessment.

Other providers

3.36 This section provides a brief overview of the other main providers of mental health services.

Acadia Group[152]

3.37 Acadia is a publicly-traded provider of behavioural healthcare services, with operations in the US and the UK.

3.38 In June 2014, Acadia acquired Partnership in Care, which provides a variety of behavioural health treatment services at over 50 hospitals throughout the UK. These include medium and low secure services, inpatient rehabilitation and community housing to support patients' re-integration into the community. It provides a range of specialist services within mental illness, LD, PD, ABI and ASD.[153]

3.39 In February 2016, Acadia acquired Priory Group, which is incorporated and domiciled in the UK. Priory provides low secure and medium secure services,

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[151] Source: Merger Notice. Paragraph 28.
[152] Acadia Healthcare website.
[153] Acadia Healthcare website: UK locations.

rehabilitation, supported accommodation services, acute psychiatric services, children's services, addictions treatment and specialist education services.[154]

3.40 The worldwide turnover for Acadia in the year ending 31 December 2016 was $2.9 billion.[155] Acadia's revenues for its UK operations in the year ending 31 December 2015 were $360.7 million (£218.9 million). The turnover of Priory in the year ending 31 December 2015 was £571.2 million, all of which was generated in the UK.[156]

Four Seasons Healthcare/Huntercombe (Elli Investments Ltd)[157]

3.41 Elli Investments Limited is a parent company of the Four Seasons Health Care group of companies comprising Four Seasons Health Care, Brighterkind and The Huntercombe Group. The company is ultimately owned by funds managed by Terra Firma Investments (GP) 3 Limited. A brief description of the three businesses is given below:

(a) Four Seasons Health Care – a national network of around 340 homes offering dementia care together with other specialist and nursing capabilities to meet the anticipated growing demand of people requiring dementia care.

(b) Brighterkind – a group of homes offering elderly care together with 'hotel-standard' services and activity programmes designed for residents who see the option of a care home as a life-enhancing choice.

(c) The Huntercombe Group – specialist units providing care, treatment and rehabilitation services in mental health, ABI and neuro-disability that are complementary to, and in partnership with, the NHS.

3.42 The total turnover for 2015 was £688.1 million and EBITDA before exceptional items was £38.7 million. Turnover for the Huntercombe Group was £116.7 million in 2015.

Elysium[158]

3.43 Elysium Healthcare launched in December 2016. The company, backed by BC Partners, brought together sites from the portfolio of Partnerships in Care and the Priory Group when these were sold by Acadia Healthcare. The

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[154] Acadia / Priory merger inquiry: Decision on relevant merger situation and substantial lessening of competition.
[155] Acadia 2016 Annual Report.
[156] Acadia / Priory merger inquiry: Decision on relevant merger situation and substantial lessening of competition.
[157] Elli Investments Limited Annual report and consolidated financial statements (31 December 2015).
[158] Elysium Healthcare website.

transaction value was £320 million.[159] In total, the divested sites had 1,000 beds and an estimated annual revenue of £132 million.[160]

3.44 In February 2017, Elysium acquired Raphael Healthcare, which provided low secure mental health services for women in Newark, Nottinghamshire and a site in Prescot, Lancashire where it intends to develop children's services.[161] In April 2017, Elysium acquired the Badby Group, a specialist neuro-disability care provider for people with neurological illnesses, ABI and spinal cord injuries.[162,163]

3.45 Elysium provides a range of mental health services including rehabilitation, acute/PICU, CAMHS and secure services at 22 facilities in the UK. Fourteen of these facilities provide rehabilitation services.[164]

St Andrew's Healthcare[165]

3.46 St Andrew's Healthcare is the largest not-for-profit provider of mental health hospitals in the UK. It is positioned at the secure end of the spectrum. St Andrew's Healthcare has also diversified into providing locked rehabilitation services.[166]

3.47 It operates mental healthcare facilities in Northampton, Birmingham, Nottinghamshire and Essex, providing a range of mental health services including medium and low secure, locked rehabilitation and community step-down services.

3.48 St Andrew's Healthcare reported a total income (revenue) of £199.1 million for 2016 and net income of £7.8 million.[167]

Barchester Healthcare[168]

3.49 Barchester provides nursing care services for older people in need of support or for those living with dementia, as well as accommodation and care for

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[159] BC Partners website.
[160] Insider Media Limited news story (21 Oct 2016): BC partners agrees £320m deal for 22 Priory clinics.
[161] East Midlands Business Link news story (17 February 2017): Newark healthcare business sold to Herts firm.
[162] Elysium Healthcare news story (7 April): Patron Capital sells the Badby Group to Elysium Healthcare.
[163] Badby Group.
[164] Elysium Healthcare: our locations.
[165] St Andrew's Healthcare website.
[166] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p96.
[167] St Andrew's Healthcare Annual Report and Financial Statements for the year ended 31 March 2016
[168] Barchester Healthcare website.

people looking for assisted living. It also offers care for adults with a range of disabilities.

3.50 Barchester's mental health hospitals support adults with a range of mental health conditions, provide rehabilitation-focused, step-down services.

3.51 According to its latest statutory accounts, Barchester's (Barchester Healthcare Limited) 2015 turnover was £ 535.6 million, EBITDAR of £154.7 million and operating profit of £3.0 million.[169]

Lighthouse Healthcare[170]

3.52 Lighthouse Healthcare offers a range of specialist services to people with LD, ASD, mental health problems and PDs. Its principal activity is the provision of LD and mental health services, across both hospital and residential care settings.

3.53 It offers a pathway of integrated care through its six hospitals and five social care services. Lighthouse Healthcare has services across the East Midlands, West Midlands, North Lincolnshire and Powys.

3.54 Lighthouse (Lighthouse Healthcare Group Limited) turnover for the year ended 31 March 2016 was £23.5 million; the operating profit before amortisation and interest was £3.2 million.[171]

4. The Merger and relevant merger situation

4.1 On 28 December 2016 Cygnet acquired CAS pursuant to a sale and purchase agreement (SPA) dated 5 December 2016. The Parties' operations remain distinct pending the completion of the CMA's inquiry.

4.2 This followed Cambian's decision to sell CAS after undertaking a strategic review of its business, and involved a two-stage sales process. A summary of the main events that took place in the run-up to the completion of the Merger and the key terms of the SPA is in Appendix D.

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[169] Barchester Healthcare Limited. 2015 Annual Report and Consolidated Financial Statements.
[170] Lighthouse Healthcare website. On 11 August 2017, Lighthouse Healthcare was acquired by Elysium.
[171] Lighthouse Health Group Limited. Consolidated Financial Statements, 31 March 2016. Filing History, Companies House.

Rationale for the Merger[172]

4.3 The Parties told us that the Merger was largely complementary as it would broaden the reach of Cygnet across the care pathway, and across different treatment types. They said that Cygnet's focus was on patients with high acuity needs and/or those requiring a secure setting, while CAS's main focus was on the provision of different types of rehabilitation services to patients with less demanding requirements.

4.4 UHS told us that its strong financial position and access to capital would also enable it to invest in and support CAS's growth plans. [✂].[173]

4.5 According to Cambian, selling CAS was a strategic move to enable it to focus its resources on becoming a high-quality provider of specialist education and behavioural health services for children, while, at the same time, repaying its existing debt.[174]

4.6 Cambian's board thought that the proposed sale to Cygnet was highly attractive and in the best interests of its shareholders because:

(a) the competitive sale process attracted a significant number of interested parties which ensured that the consideration (of £377 million) recognised the market position and prospects of CAS;[175]

(b) it improved Cambian's financial position significantly by enabling the repayment of all the Group's existing bank debt;

(c) it allowed a £40 million return of capital to shareholders;

(d) there was increasing demand for the children's services business, and significant potential for growth in what continues to be a highly-fragmented market in the UK;[176] and

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[172] Further details regarding rationale for the Merger are provided in Appendix D.
[173] Prior to the Merger, UHS identified potential synergies of approximately £[✂] based on a high-level analysis of the central cost savings that could be expected to be achieved from the Merger. [✂]
[174] Cambian announcement regarding proposed disposal of the Adult Service Business, 5 December 2016.
[175] In a communication to its shareholders, Cambian announced that the purchase consideration represented an attractive enterprise valuation of approximately 2.9 times CAS's 2015 revenue of £129.5 million. Cambian announcement regarding proposed disposal of the Adult Service Business, 5 December 2016.
[176] Cambian circular relating to recommended proposals for the disposal of the Adult Services Business And Notice of General Meeting, 9 December 2016.

(e) the anticipated growth and development of Cambian following the Merger focused solely on the children's services which was a potential source of future shareholder value.[177,178]

Relevant merger situation

4.7 Pursuant to section 35 of the Act and our terms of reference (Appendix A) we are required to investigate and report on two statutory questions: whether a relevant merger situation has been created and if so, whether that has resulted or may be expected to result in an SLC within any market or markets in the UK for goods or services.

4.8 We address the first of the statutory questions in this section.

Enterprises ceasing to be distinct

4.9 Section 23 of the Act provides that a relevant merger situation has been created if two or more enterprises have ceased to be distinct within the statutory period for reference[179] and either the turnover test or the share of supply test is satisfied.[180]

4.10 The Act defines an 'enterprise' as 'the activities or part of the activities of a business'. A 'business' is defined as 'including a professional practice and includes any other undertaking which is carried on for gain or reward or which is an undertaking in the course of which goods or services are supplied otherwise than free of charge'.[181]

4.11 Each of the Parties to the Merger provided, and both Cygnet and now CAS continue to provide services to customers on a commercial basis. We are therefore satisfied that each are businesses within the meaning of the Act and the activities of each therefore are 'enterprises' for the purposes of the Act.

4.12 Section 26 of the Act provides that enterprises cease to be distinct once they are brought under common ownership or common control.

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[177] Cambian announcement regarding proposed disposal of the Adult Service Business, 5 December 2016.
[178] The retained business was to be focused exclusively on the children's services business, and would keep the 'Cambian' name and brand. For the financial year ended 31 December 2015, the children's services business generated revenue of £160.7 million and adjusted EBITDA of £18.4million. Cambian circular relating to recommended proposals for the disposal of the Adult Services Business and Notice of General Meeting, 9 December 2016.
[179] As set out in section 24 of the Act.
[180] Section 23 of the Act provides that the value of the turnover in the UK of the enterprise being taken over must exceed £70 million or, in relation to the supply of goods or services, at least one quarter of all such goods or services which are supplied or acquired in the UK or a substantial part of the UK are supplied by or to one and the same person.
[181] Section 129(1) and (3) of the Act.

4.13 As a result of the Merger, the Cygnet enterprises and the CAS enterprises have been brought under the common ownership and control of UHS. Accordingly, we are satisfied that Cygnet and CAS have 'ceased to be distinct' within the meaning of the Act.

4.14 To meet the criteria for a relevant merger situation, either the enterprises must have ceased to be distinct not more than four months before the date on which the reference relating to the Merger is made or notice of material facts about the Merger has not been given to the CMA or made public *(a)* prior to the entering into of the Merger, or *(b)* more than four months before the date on which the reference relating to Merger is made.[182]

4.15 The Merger completed on 28 December 2016 and was made public on the same day. The four-month period which ended on 28 April 2017 was extended in accordance with section 25 of the Act until 15 May 2017.[183] The reference was made on 3 May 2017.

4.16 We are satisfied that Cygnet and CAS have 'ceased to be distinct' not more than four months prior to the date on which the reference was made.

Jurisdiction

4.17 The second element of the test seeks to establish sufficient connection with the UK on a turnover or share of supply basis to give us jurisdiction to investigate.

4.18 The turnover test is satisfied where the value of the turnover in the UK of the enterprise acquired exceeds £70 million. The turnover of CAS for 2016 was around £142 million in the UK.

Provisional conclusion on the relevant merger situation

4.19 In the light of the above assessment, we provisionally conclude that that the Merger has resulted in the creation of a relevant merger situation.

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[182] Section 24 of the Act.
[183] Notice was given on 21 April 2017 that the four-month period would be extended until the earliest of (i) the giving of the undertakings concerned; (ii) the expiry of the period of ten working days beginning with the first day after the receipt by the CMA of a notice from Cygnet and UHS, Inc. stating that they did not intend to give the undertakings; or (iii) the cancellation by the CMA of the extension. On 28 April 2017 Cygnet and UHS gave notice that they would not give undertakings. The reference on 3 May was therefore within this extended period.

5. Market definition

5.1 The CMA's Merger Assessment Guidelines state that the purpose of market definition in a merger inquiry is to provide a framework for assessing the competitive effects of a merger. The market definition contains the most significant competitive alternatives available to customers of the merged companies.

5.2 However, market definition is not an end in itself and it involves an element of judgement. The boundaries of the relevant market do not determine the outcome of our analysis of the competitive effects of the merger. In assessing whether a merger may give rise to an SLC, we may take into account constraints from outside the relevant market, segmentation within it and other ways in which certain constraints may be more important than others.[184]

5.3 The Merger Assessment Guidelines explain that the analysis underpinning the identification of the market and the assessment of the competitive effects of a merger overlap, with many of the factors affecting market definition being relevant to the assessment of competitive effects and vice versa. Therefore, market definition and the assessment of competitive effects should not be viewed as distinct analyses.[185]

Product market

5.4 In this case, there are elements of product market definition which may not generalise across local areas as evidence suggests they depend on the behaviour of the relevant local group of customers. Consequently, we consider that direct analysis of competition on a local specific basis is more appropriate than attempting to generalise findings in the relevant product market. In practice, the relevant product market is most important for our initial filtering, via which we identify local areas of potential concern.

5.5 The Parties overlap in the supply of rehabilitation services to customers. Most mental healthcare hospitals are divided into discrete specialised wards. Where a site has more than one ward, and offers different specialisms at each, a separate competitive assessment was carried out at a unit-level for each of the specialisms offered.

5.6 We assessed each of the following to establish the relevant product market:

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[184] Merger Assessment Guidelines, paragraph 5.2.2.
[185] Merger Assessment Guidelines, paragraph 5.1.1.

(a) Delineation by specialism (ie patient diagnosis being treated).[186]

(b) Delineation by patient gender.

(c) Delineation by level of security.

(d) Aggregation of separate frames of reference on the basis of supply-side substitution.

(a) Whether a distinction between the supply of these services by NHS hospitals and independent (ie private) providers is appropriate.

Delineation by specialism

5.7 In Acadia/Priory, the CMA established each specialism within rehabilitation services as a distinct frame of reference, on the basis that treatment of different patient conditions within rehabilitation services takes place at dedicated wards and patients with one condition would not usually be sent to a ward which specialises in the treatment of a different condition.

5.8 On the basis of the evidence available to us and the lack of any submissions to the contrary, we considered that this was an appropriate approach and we therefore adopted the same approach here.

5.9 The Parties each treat a number of distinct patient conditions and overlap in the supply of rehabilitation services to patients with autistic spectrum disorders (ASD), learning difficulties (LD), long-term mental health conditions (LTMH) and personality disorders (PD).

5.10 The approach of focusing on individual specialisms is consistent with the Parties' view that the different requirements of patients within each diagnosis mean that the different types of treatment cannot be considered as alternatives for most patients.[187] Several third parties (both competitors[188] and customers[189]) told us (with varying degrees of assertiveness) that the primary diagnosis of a patient's condition is key to the referral decision. Therefore, patients would in general not be referred to wards not specialising in treatment for their primary diagnosis.

5.11 We considered whether it would be appropriate for PD and LTMH rehabilitation services to be in the same product market on the basis that they could represent alternative treatments for some patients. We sought to

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[186] In one specialism, LTMH, we consider whether the frame of reference should be split by age.
[187] Merger Notice, paragraph 18.
[188] [✂]
[189] [✂]

understand the proportion of patients who could be treated both at wards specialising in PD and wards specialising in LTMH.

5.12 There are some wards owned by Priory and Elysium described as providing rehabilitation services for both PD and LTMH. Priory explained that some of these wards would offer specialist PD services. Others would generally take patients with a primary diagnosis of LTMH (Priory refers to a 'mental health diagnosis'), but patients often presented with co-morbid conditions which might include PD traits. Elysium told us that some LTMH facilities could treat 'lower risk' PD patients with less challenging behaviour. We have incorporated evidence on specific PD/LTMH wards in our local competitive assessment.

5.13 Overall, the evidence received from third parties suggests only a limited degree of demand-side substitutability between PD and LTMH and that this may vary from ward to ward. We will consider the extent to which specific LTMH wards provide some competitive constraint on the provision of PD (and vice versa) in our local competitive assessment.

5.14 In calculating shares of supply, for those sites providing treatment for both conditions in a single ward, we have incorporated sensitivity analysis in our filtering, where on a cautious basis we have tested the sensitivity of excluding these wards from market share calculations for filtering. We then consider evidence for how specific wards are allocated in more detail in the local competitive assessments (see paragraph 9.18 below).

5.15 We considered whether it would be appropriate to define a narrower market within PD or within LTMH. In the referral process the patient's symptoms and risk level are often assessed against the ward's specific patient mix, and specific wards may have more specialised treatments suitable for specific, narrower groups of patients.

5.16 In this regard, the Parties provide LTMH services specifically to elderly patients (LTMH E) and submitted that this should be considered as a separate product market (distinct from LTMH services for other adults), given that:

(a) there are specialised facilities that provide treatment relating to mental health conditions associated with old age; and

(b) there are significant demand-side differences, in practice, between elderly and adult services: for example, less than [✂]% of patients in adult LTMH facilities are 65+, and the average age at LTMH E sites is typically well above 65+ (at [✂] years), with all patients having mental health conditions relating to old age.

5.17 The evidence is consistent with the Parties' submissions; in particular, that specialised facilities are generally required and there is a clear delineation in the age of the patient population between sites designated as LTMH and those designated as LTMH E. The CMA has therefore treated LTMH E as a distinct product market.[190]

5.18 PD services are often described using a tiered approach, which allows patients to be appropriately directed according to their needs, the nature of their PD diagnosis and their capacity to engage with services. The tiers range from Tier 1 (primary care) to Tiers 5 and 6 (medium and high secure forensic services). In our competitive assessment, we consider the overlap between the Parties in Tier 3 PD services (local specialist services) and Tier 4 PD services (specialist and intensive provision beyond that which can be provided within either Tier 3 services or other local mental health services including acute inpatient services).

5.19 The Parties told us that they are not close competitors in the provision of rehabilitation services for female patients with PD. They argued that this is because CAS clinics offer Tier 3 services and do not treat patients with more acute or challenging needs, while Cygnet's services are Tier 4 (even if not designated as such) and focus on the upper end of the PD acuity spectrum.

5.20 The Parties set out the differences between these two tiers (see paragraphs 9.47(a) to 9.47(b). They also told us that when the moratorium on new Tier 4 services is lifted, [✂].

5.21 Third parties have provided us with mixed evidence on the extent to which the Parties' PD services for female patients can be treated as alternatives and this evidence varies from ward to ward.[191]

5.22 We have taken as our starting point that PD is a relevant product market. However, PD is a complex diagnosis. There are multiple and varied ways in which it can manifest itself, both by type and acuity of symptoms and in turn the requirements and approach to treatment for an individual patient.

5.23 In light of this complexity, in our competitive assessment we have investigated the degree of differentiation between the Parties' PD provision in order to assess the competitive constraints between the Parties.

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[190]Categories of LTMH referred to below (ie LTMH female, LTMH male and LTMH combined gender) therefore exclude elderly patients. As the Parties do not overlap in LTMH E it does not feature in our competitive assessment. However, given it is a separate market, providers of LTMH E have been excluded as competitors for our assessment of local overlaps and in Appendix E.
[191] See paragraphs 9.62 to 9.67 for more detailed discussion

Delineation by gender

5.24 In Acadia/Priory, the CMA distinguished between the supply of rehabilitation services for patients of different genders on the basis that, from a demand-side perspective, mixed gender wards did not represent an alternative for most patients, and that in most cases patients of one gender would not be sent to wards treating the other gender.

5.25 The CMA also notes that the Department of Health[192] requires all providers of all types of NHS-funded care to make provision for same-sex accommodation.[193] This requirement covers sleeping accommodation, bathroom/toilet accommodation and day rooms/lounges.

5.26 In addition, the CQC has mandated that wards should be single sex for the dignity and respect of patients. Breaches of the rules on same-sex accommodation identified during CQC inspections may result in enforcement action.

5.27 The evidence received supports distinct markets for male and female patients.

5.28 In calculating shares of supply, if a competitor site provides treatment for both male and female patients (ie a mixed ward), we have sought to verify with the site owner the actual number of beds dedicated to each gender and the site owner's ability to flex this allocation between genders (this may vary from case to case). We have incorporated this information into our local competitive assessment. Where this information was not available, we have adopted the assumption from Acadia/Priory that on average competitors have a 65:35 split of male and female patients in mixed wards.[194]

Delineation by level of security

5.29 The Parties overlap in the provision of 'locked' rehabilitation services.

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[192] The Chief Nursing Officer and Deputy NHS Chief Executive required all providers of NHS funded care to declare by 1 April 2011 that all hospital accommodation was same sex. Same sex accommodation is also mandated under the 1983 Act Code of Practice and the 2014 Regulations. Mixing however may be justified if it is in the overall best interest of the patient or reflects their personal choice, notably in a clinical emergency. See, Department of Health, Eliminating Mixed-Sex Accommodation (MSA).
[193] Same-sex accommodation is where male and female patients sleep in separate areas and have access to toilets and washing facilities used only by their own sex. In mixed-sex wards, same-sex accommodation can be provided either as: *(a)* single rooms with same-sex toilet and washing facilities (preferably en-suite); *(b)* multi-bed bays or rooms occupied solely by either men or women with their own same-sex toilet and washing facilities. Patients should not need to pass through mixed communal areas or sleeping areas, toilet or washing facilities used by the opposite sex to get to their own.
[194] Acadia/Priory, paragraph 391.

5.30 The Parties agree that there is no clear-cut distinction between locked and unlocked facilities. In addition, the Parties have submitted that most 'open' facilities are still required to have a locked front door and are therefore treated as 'locked facilities'.

5.31 Evidence from several competitors is consistent with the view that no major difference exists between 'open' and 'locked' rehabilitation services. One competitor[195] told us that although security is a standard requirement there is occasional flex around the concept. Another competitor[196] told us that delineation by security level for rehabilitation services is a 'branding' distinction rather than a point of substance. Another competitor[197] told us that the security level is determined by the clinician and is often a topic of controversy between clinicians and customers as even in locked rehabilitation facilities 'there is no formal gatekeeping'.

5.32 Evidence from customers suggests that there are varying degrees of perceived differences between locked and unlocked rehabilitation services.

5.33 The evidence supports 'locked' and 'unlocked' rehabilitation facilities being within the same product market. We note that in practice only a small minority of wards are described as 'open' or 'unlocked'. However, we have tested the sensitivity of our filtering analysis to excluding unlocked facilities.

Supply-side substitution

5.34 As set out in the Merger Assessment Guidelines, the boundaries of the relevant product market are generally determined by reference to demand-side substitution alone.[198]

5.35 In Acadia/Priory, the CMA considered whether an identified product frame of reference (for example, rehabilitation services provided to female PD patients) should be widened to take account of supply-side substitution.[199] Whilst the CMA focused its analysis in that case on narrow frames of reference, on a cautious basis and recognising the possibility of some supply-side substitution, the CMA also considered the potential impact of that merger within speciality-combined and gender-combined frames of reference.[200]

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[195] [✂]
[196] [✂]
[197] [✂]
[198] Merger Assessment Guidelines, paragraph 5.2.17.
[199] Acadia/Priory, paragraph 391.
[200] Acadia/Priory, paragraph 352.

5.36 The CMA may aggregate the supply of products and analyse them as one market where there is evidence of supply-side substitution. In assessing the possibility of supply-side substitution, we have considered both the ease with which a provider of one service could 'reconfigure' to supply another service (or the same service to the other gender) as well as the provider's incentive to do so.[201]

5.37 The Parties submitted that services for different specialisms and genders within rehabilitation services give rise to separate markets and that there is not sufficient supply-side substitution to aggregate them. The Parties stated that reconfiguring a ward is a 'significant task and not undertaken lightly'.[202]

5.38 We reviewed evidence of the Parties' reconfiguring sites in the past four years, including relevant internal documents, and evidence received from third parties on reconfiguration.[203] The evidence suggests that *(a)* the costs of reconfiguring may vary significantly from case to case; and *(b)* reconfiguring is relatively infrequent.

5.39 The factors likely to affect reconfiguration costs are the change of use sought, the size of the unit, staffing costs and whether the changes would require the ward to remain closed during reconfiguration. In most cases, a ward providing services for one condition and/or gender cannot immediately provide services for another condition and/or gender, and therefore some physical conversion is necessary. For this reason, reconfiguration costs are likely to be lower for specialisms that use the same physical environment such as LTMH/PD and ASD/LD.

5.40 While some specialisms can be treated by the same clinician, other specialisms may require the deployment of clinicians who specialise in the treatment of those conditions.

5.41 Our investigation confirmed that any reconfiguration between genders or specialisms would, at a minimum, require that all existing patients in a ward are moved elsewhere prior to the ward starting to offer treatment of different specialisms/genders. Given that rehabilitation patients are typically treated for

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[201] The second condition for supply-side substitution is set out in paragraph 5.2.17 of the Merger Assessment Guidelines, namely: that 'the same firms compete to supply these different products and the conditions of competition between the firms are the same for each product …'. We have not considered this second condition as the first condition is not satisfied.
[202] Merger Notice, paragraph 13.26.
[203] See paragraphs 10.14–10.36 below.

long periods of time, there are practical difficulties in accommodating patients during any transition.[204]

5.42 In our view, the incentive for a provider to reconfigure will depend on the relative profitability of the new and old service. Our analysis of the Parties' approach to opening or acquiring new wards or reconfiguring existing wards[205] suggests that the key determinant of this relative profitability is the difference in occupancy that could be achieved through reconfiguration.

5.43 In practice, this suggests that reconfiguration is only likely where both: *(a)* occupancy at an existing ward was low; and *(b)* there was sufficient excess demand for the specialism and gender type to which the ward was being switched, to achieve a substantial increase in occupancy. In this regard the CMA notes that many wards already operate at high levels of occupancy, suggesting this incentive would be limited for these wards.

5.44 This is supported by consistent evidence from the Parties and third parties that the key driver for reconfiguration would be to meet unsatisfied local demand for a service, rather than to respond to short to medium-term changes in price or quality.

5.45 Elysium told us that switching wards (between either treatments or genders) would primarily be motivated by low occupancy rates rather than price increases of the order [✂] to [✂]%.

5.46 Based on the evidence described above, we have defined separate product markets by specialism and gender. We consider that many providers would be unlikely to have the incentive to reconfigure in response to small changes in price or quality for a particular service, even if it was possible for them to do so.

5.47 Consequently, it is not appropriate to consider combined market shares based on supply-side substitution as this would assume such reconfiguration was likely. However, we consider the possibility that specific wards may be reconfigured in our assessment of potential competition between the Parties and of whether entry or expansion by competitors may offset any effects of the Merger on competition.

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[204] This is consistent with the CMA's findings in Acadia/Priory: see, for example, paragraphs 349 and 351 of that decision, which deal, respectively with the practical difficulties of converting wards between specialisms and from one gender to the other.
[205] Sections 8 and 10.

NHS versus independent providers

5.48 In Acadia/Priory we concluded that independent providers did not face competition from NHS providers as CCGs would first seek to place patients in NHS facilities before considering other options. We concluded because of this that competition occurred only between independent providers for 'overspill' patients. We consider this in more detail in the following paragraphs.

The Parties' submissions

5.49 The Parties submitted that NHS mental healthcare services compete with private/independent providers. They did not agree with the findings in Acadia/Priory for the following reasons:

(a) NHS occupancy levels across all mental health services are similar to the independent sector, averaging approximately [✂] [80–90]%, confirming that independent providers are used before all NHS beds are occupied. Several trusts contacted by the Parties have reported average occupancy below 90%.

(b) Exclusion of NHS providers implies that CCGs' referral behaviour does not comply with the Department of Health AQP guidance.

(c) Although customers can enter block contracts with NHS providers, there has been a substantial shift away from block contracts with the introduction of the National Tariff which applies to secondary care activity so the phasing out of block contracts will mean that NHS providers who have previously relied on such contracts in respect of a proportion of their capacity will have to compete for a greater number of patients and will be subject to the same operating requirements as independent providers (ie maintaining capacity levels above break-even levels). This means that the competitive constraint of NHS providers will only increase over time.

(d) There is evidence of actual competition with NHS providers such as: occasions where NHS trust capacity expansions have impacted occupancy at the Parties' sites; internal documents regularly reference competition from and developments by NHS trusts in the same way in which they consider developments in the independent sector;[206] CCGs will generally invite three providers to assess the patient and attend a

[206] [✂]

funding panel meeting and that, in their experience, one of these providers will often be an NHS provider.

(e) NHS providers make beds available for out-of-area patients. Several examples are provided by the Parties.[207]

(f) Some frameworks include a mixture of independent and NHS providers and that requirements set out in the PCRs 2015 mean that awarding bodies using the framework must either:

(i) if awarding a specific contract without further competition, do so on the basis of objective conditions; or

(ii) if awarding a contract with further competition, do so on the basis of the award criteria set out in the framework agreement, inviting all capable suppliers on the framework to participate.

Evidence from third parties

5.50 We asked customers whether they considered that NHS services compete with those of independent providers. We received responses from 30 customers, accounting for 45% of the total referrals to the Parties' overlap sites since the start 2016. Of these customers:

(a) Eleven, accounting for 43% of total referrals to the Parties' overlap sites, told us that NHS wards typically have no spare capacity or do not offer rehabilitation services within the referral area.[208]

(b) Twelve, accounting for 49% of total referrals to the Parties' overlap sites from those customers that responded, said they use NHS providers first and refer patients to independent providers only if NHS providers do not have availability or are not appropriate for the patient's condition.[209]

(c) Four, accounting for 8% of total referrals to the Parties' overlap sites from those customers that responded, told us that the referral process primarily considers the patients' needs. Thus, both NHS and independent sector clinics are considered equally based on appropriateness of treatment offered.[210]

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[207] [✂]
[208] For example, [✂] said that locked rehab is not available from local NHS providers and therefore only the independent sector is considered. We heard the same from the [✂]
[209] [✂]
[210] [✂]

(d) Three, none of whom had referred to the Parties' overlap sites since 2016, gave ambiguous answers.

5.51 The Parties identified 37 wards operated by NHS trusts providing rehabilitation services in the areas where they overlap.[211] We asked those NHS trusts relevant to the East Midlands, Yorkshire and The Humber and West Midlands overlaps[212] for data on the occupancy of these wards over the last three years. We also asked whether there are any block contracts relating to the wards in question and whether in their view local customers tended to fill the NHS wards before considering independent providers.

5.52 Eight out of the ten NHS trusts[213] that we contacted told us that customers would use their NHS wards providing rehabilitation services first and place patients with independent providers only if the NHS providers do not have availability or are not appropriate for the patient's condition. The two remaining trusts told us that some of the beds in their rehabilitation wards would compete with independent provision:

(a) [✂] told us that all the beds for its [✂], were covered by a block contract with its local customers as part of the main mental health contract it holds with them. However, it told us that its other rehabilitation ward, [✂], is part of the Framework agreement. It told us that its local customers may choose between this unit and those provided by independent providers based on individual clinical need.

(b) [✂] told us that customers seek to fill block-contract-commissioned NHS beds first, but that there was no such preference for beds not covered by block contract. Two of its wards and just under half of the beds in its third ward ([✂]) were covered by block contracts, leaving nine beds for open competition.

5.53 That customers would use their NHS wards providing rehabilitation services first and place patients with independent providers only if the NHS providers do not have availability or are not appropriate for the patient's condition was corroborated by occupancy information provided by the trusts. All of the rehabilitation wards we asked about, with the exception of those operated by [✂] had occupancy greater than 90%. [✂] told us that it was considering plans to reduce the number of rehabilitation beds across its wards. [✂] told us customers may choose not to fill available block contract beds either where there is a clinical need for a specialist package or environment, or where the

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[211] Parties' response to the phase 1 decision.
[212] We focused on those areas where we had greatest potential concern. We did not prioritise the South West and Southern Wales overlap as we did not have concerns in this area even without accounting for NHS provision.
[213] The ten NHS trusts we received this information for [✂].

patient who is proposed for admission would not be suited to the existing patient mix or staffing establishment.

5.54 Overall, 93% of the NHS trust rehabilitation beds would be used by customers before independent providers were considered. 92% of NHS Trust rehabilitation beds were covered by block contracts with customers.

Our assessment

5.55 In our view, the evidence from NHS trusts and customers supports the view that NHS providers of rehabilitation services do not in general compete with independent providers for the majority of referrals. In the vast majority of cases, customers will use NHS providers first and place patients with independent providers only if NHS provision is not available or not appropriate for the patient's condition. We note that there are some exceptions to this, which have been identified in the evidence we have received from trusts (as discussed in paragraph 5.52 above), but these are rare.

5.56 We have considered the Parties' arguments in light of the evidence received from third parties:

(a) In our view, it is not a necessary condition that all NHS rehabilitation wards are full for them not to be competing with independent providers. Customers have told us that they may consider independent providers despite having available capacity at NHS rehabilitation wards, where the services provided at NHS wards is not appropriate (for example because more specialist treatment is required). For these patients, NHS provision would not be a viable alternative and so is not competing.

(b) We do not believe it is possible to assess the occupancy of NHS rehabilitation services from looking at the overall occupancy across all NHS mental health services (which the Parties submit is [✂] [80–90]% – see paragraph 5.49 above). In our view this evidence is consistent with NHS rehabilitation wards operating at near full capacity, with a small number of exceptions. We note that all but two of the NHS trusts we contacted had rehabilitation wards that were operating near full capacity, and that the two that were not have block contracts with customers.

(c) In our view, the evidence the Parties have provided on competition with NHS providers (as described in paragraph 5.49 above) is consistent with the proposition that customers use NHS providers first and place patients with independent providers only if the NHS providers are not available or not appropriate for the patient's condition. The fact that NHS trust capacity expansions have impacted occupancy at the Parties' sites reflects what

we would expect to see if customers choose to use NHS providers first. In our view this evidence reflects a one-off shift in the overall demand for private provision of rehabilitation services rather than implying ongoing competition between NHS trusts and independent providers. Given that NHS provision may affect demand for independent providers, the fact that internal documents refer to NHS providers is also unsurprising. We have heard from the Parties, in the context of their PD services, that the fact that customers may seek assessments from multiple providers to find out what sort of service may be appropriate for that patient does not imply a trade-off between those providers.[214]

(d) All of the NHS trusts we heard from had block contracts with customers, covering nearly all of the beds in their rehabilitation wards. These block contracts mean customers would use these beds first. The prevalence of block contracts is not consistent with the Parties' submission that there has been a substantial shift away from them. In our view, it is too speculative to assume, based on policy statements and guidance, that block contracts will be phased out in rehabilitation services in the foreseeable future and that this would result in competition between NHS providers and independent providers in time to resolve any adverse effects of the Merger.[215]

(e) Similarly, it did not appear to us that the Department of Health AQP guidance would result in an imminent change to the customer behaviour we observe. We understand that the AQP policy primarily aims to increase patients' choice. Moreover, we note that currently there is no strict requirement for customers to change their procurement behaviour to the AQP model and that CCGs in particular have been slow in applying this policy,[216] as the Parties have acknowledged.[217]

(f) We note the three examples provided by the Parties of NHS providers making capacity available for out-of-area placements. In our view, these examples are consistent with the evidence from customers, which identifies a small number of exceptional cases where NHS providers may be competing with independent providers.

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[214] Response to phase 1 decision, paragraph 6.9.
[215] See also Section 2, paragraphs above 2.90-2.93 above.
[216] In particular, we note that 'limited enthusiasm at a national level' and 'patchy use of it at a local level' have been publicly reported, The King's Fund (19 March 2015), Is the NHS being privatised?
[217] See also Section 2, paragraph 2.56 above.

Provisional conclusion on competition from NHS providers

5.57 We have found that customers use NHS provision first where it is available and appropriate for the patient, before choosing between independent providers. We have therefore not included NHS providers within the relevant product market. However, we note that there are rare exceptions to this. We consider the extent to which these exceptions provide a competitive constraint in our assessment of competition in local overlap areas and, where relevant, include them in our market share calculations.

Geographic market

Introduction

5.58 The geographic market aims to identify only the most significant competitive alternatives available, yet needs to include at least the competitors relevant to satisfy the hypothetical monopolist test.[218] The geographic market definition does not lead mechanistically to the outcome of the local competitive assessment, which will take account of possible constraints both inside and outside of the market.[219]

5.59 As with the product market definition, we note that there are elements of geographic market definition which may not generalise across local areas as they depend on the behaviour of the relevant local group of customers. Consequently, we consider that in many cases direct analysis of competition on a local specific basis is more appropriate than attempting to generalise findings in the geographic market definition.

5.60 We test the sensitivity of the geographic market definition in the light of evidence of customers' responses, competitive decisions, and links between distance and market outcomes, such as price and quality.[220]

5.61 In the following sections, we set out our approach to various methodological issues in geographic market definition, including:

(a) that geographic definition for filtering should focus on patient distance catchment areas rather than on customer-defined areas for pragmatic reasons;

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[218] Merger Assessment Guidelines, paragraph 5.2.1.
[219] Merger Assessment Guidelines, paragraph 5.2.2.
[220] Our analysis is based on information currently available. We received submissions that we were unable to test prior to provisional findings but we will take these into account in reaching our final decision.

(b) that we can rely on customer location data as a proxy for patient location data;

(c) that average catchment areas are a more appropriate starting point than site-specific catchment areas, particularly when accounting for the impact of capacity constraints;

(d) that the appropriate patient distance for our geographic market is 60-miles; and

(e) that we should use public transport times and drive-times in and around London.

Methodology

5.62 The geographic market definition is the smallest area over which a hypothetical monopolist provider would be able to significantly increase prices above the current level (or reduce quality below it).

5.63 In principle, geographic market definition is motivated by the underlying relationship between customer preferences over distance and the other factors over which providers compete, such as price and quality. This relationship determines the distance at which customers would decide to accept a small but significant price rise (or fall in quality) rather than seek an alternative more distant provider.

5.64 A pragmatic approach to identify geographic markets is the use of catchment areas, ie the area over which the providers' customers originate. The Merger Assessment Guidelines state that while catchment areas are a pragmatic approximation for a candidate market to which the hypothetical monopolist test can be applied, the use of catchment areas is not an alternative conceptual approach.[221]

5.65 In this case, we believe that an approach to geographic definition based on catchment areas is the only practical approach available for filtering. Below we discuss methodological issues with the use of catchment areas in this inquiry and how our approach seeks to mitigate them, primarily through employing cautious assumptions that are then tested in more detail in our local competitive assessments.

[221] Merger Assessment Guidelines, paragraph 5.2.25.

Patient distance catchment areas versus customer-defined areas

5.66 As set out above and in more detail in Section 7, CCGs, NHS trusts and local authorities are the customers for rehabilitation services. The geographic market definition is therefore determined in practice predominately by how these customers make their choices.

5.67 In this section, we consider how location affects customer behaviour and how this should affect our approach to geographic market definition.

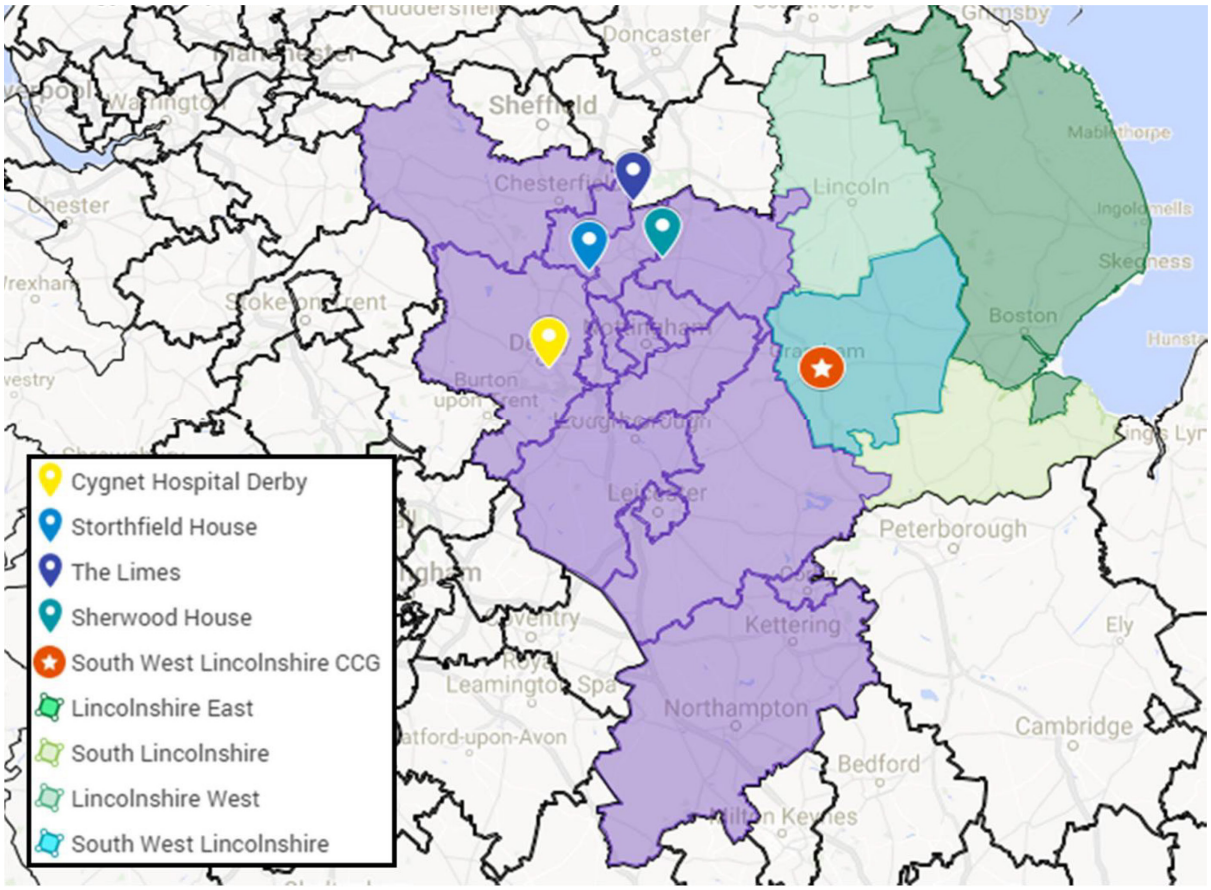
Customer behaviour

5.68 We asked customers if they had a typical area or distance within which they would attempt to keep rehabilitation patients (our customer questionnaire is discussed in more detail in 7.11 to 7.18 below). Of the 46 customers who responded to this question 83% stated that they did have a typical area or distance and 17% said they did not.

5.69 Customers were asked how they defined these areas. They gave a variety of answers; some focused on drive-time or distance from the patient, including that they would endeavour to keep patients as close to family as possible, others defined their areas based on county borders.

5.70 An example of a typical area is the East Midlands Framework. The 17 different CCGs on the East Midlands Framework have grouped together to pre-negotiate preferential terms with providers within a fairly wide area shown in the map below.

Figure 11: East Midlands framework area



Source: Parties.
Note: Shaded areas represents the geographic area covered by the East Midland framework agreement. Since this map was produced two Northamptonshire CCGs (Corby and Nene) have left the Framework.

5.71 In addition to minimising distance from the patient's home, customer preferences are affected by other factors, including:

(a) customers' existing relationships with providers, including pre-negotiated agreements with these providers and their links with the local community and local facilities;

(b) care co-ordinators' recommendations to panels in terms of their preferred choice of provider (considering at times patients', families' and/or friends' preferences);

(c) factors which might be specific to the patient, for example forced out-of-area placement for patients who may have issues with substance abuse and have contacts in the local area; and

(d) pre-negotiated agreements with certain providers who are within the local area where those customers would typically refer patients. Customers expressed preferences to use these providers where possible.

5.72 96% of customers said that there were circumstances where patients would be placed beyond their typical area. Customers provided several reasons for such out-of-area placements, the two most common being to find more specialist services or because of a lack of local capacity.

5.73 By way of example, St Helens CCG submitted that it would ideally treat patients as close to their home as possible but if a placement was identified at, for example, 50 miles that would meet the needs of the patient and make a real difference to the patient's quality of life, then it would prefer that placement for the period of rehabilitation services.

5.74 In out-of-area placements, customers would typically seek to return patients as soon as possible back in-area and into the local community.

Our approach

5.75 As shown above customer preferences and behaviours vary significantly. As a result, it is not possible to accurately determine systematically the boundaries of locations which are considered in-area and out-of-area. In addition, we note that the Parties have a wide range of customers referring to each of their hospitals, who may have preferences that are specific to local demand and supply characteristics. Consequently, this approach is not practical for filtering.

5.76 Instead, our approach to filtering is to use catchment areas based on the distance between providers' sites and patient location. To account for idiosyncratic customer behaviour in different areas, we consider evidence on how customers see their catchment areas in our local competitive assessment.

Customer location data as proxy for patient location data

5.77 [✂] Both the parties, however, collect and provided information on CCGs, which are typically responsible for the area in which the patient is located. For these reasons, we have relied on customer location as a proxy for patient location data.[222]

5.78 The Parties submitted that[223] the catchment area data is subject to significant uncertainty owing to the following factors:

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[222] The parties provided data on their patients' funder CCG location in the past three years until December 2016. [✂]
[223] Response to phase 1 decision, paragraph 1.10 c).

(a) CCGs often cover large geographic areas.

(b) Some CCGs use framework agreements when selecting providers.

(c) Some CCGs co-ordinate patient referral and funding (eg within the framework agreement) and are therefore over-represented in the patient data. [✂]

5.79 For the majority of cases, in addition to being the only practical option due to data availability, we consider that distances based on CCGs postcode data are likely to be an appropriate measure for the purpose of geographic market definition. In many cases CCG location is likely to be a good proxy for patient location (as many CCG areas are relatively small in-area and patients are being sent from within the area). In addition, as discussed above, customer choice in this market is determined by customer behaviour rather than patient willingness to travel. While one factor that drives this choice is the preference to minimise the distance between the chosen provider and the patient's home address, this is not the only factor. Our discussions with customers suggested that their choices are often determined to a large extent by their existing relationships with providers and previous experience of them.

5.80 We note the Parties' arguments about how the use of CCG location data can result in bias where certain CCGs are making referral decisions on behalf of others ([✂]). We believe that our approach of considering average rather than site-specific catchment areas mitigates this bias.

Average catchment areas rather than site-specific catchment areas

5.81 Our usual starting point in mergers in local markets is to calculate an average catchment area and apply this catchment area to identify competitors or measure concentration across all of the merging parties' overlaps.[224] The reason for using a consistent average catchment area is that it should capture a consistent relationship between customer behaviour, ie the relationship between preference over distance and preferences over other factors. Sometimes previous cases have differentiated between customer behaviour in urban and rural areas (with wider catchment areas being used in the latter) but rarely are site-specific catchment areas used.

[224] Retail Mergers Commentary, paragraph 2.21.

5.82 However, in this inquiry we considered whether site-specific catchment areas may be more appropriate due to the specifics and variety of customer behaviour in different areas.

5.83 At phase 1, the CMA took a cautious approach to assess the geographic market.[225] It followed three steps:

(a) First, in its filter, shares of supply within 'stepped catchments' from 40 miles to 130 miles, in 10-mile increments, road distances were considered from each site.[226]

(b) Second, in its site-level assessment, it then used either the (i) site-specific 80% customer catchment area for each treatment and gender for each site, or (ii) the average of its 80% catchment areas by treatment and gender, dependent on the more conservative of the measures.

(c) Finally, sensitivity checks were conducted within 10 and 20 miles of both site-specific and average catchment areas, rounded to the nearest 10 miles.

5.84 Below we set out the Parties' submissions and consider the impact of capacity constraints on the appropriate catchment area to use before setting out our approach.

Parties' submissions

5.85 The Parties argued that an average distance catchment area of all the sites of each provider by treatment should be used. They said that it was more robust to use the average of all their sites, because: each site has a limited amount of data due to low turnover of patients; the reliance on the CCG postcode instead of patient home address introduces uncertainty; and average figures better represent the customers' behaviour over time.[227] The Parties argued that the cautious approach employed at Phase 1 was:

(a) inconsistent in mixing treatment average and site-specific catchment areas;

(b) sensitive to small changes in the number of patients considered;

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[225] The approach follows closely the most recent mental healthcare merger (Acadia/Priory).
[226] It used ten different geographical frames of reference for the filter, including competitors within the following road distance of its site: (i) 40 miles, (ii) 50 miles, (iii) 60-miles, (iv) 70-miles, (v) 80 miles, (vi) 90 miles, (vii) 100 miles, (viii) 110 miles, (ix) 120 miles and (x) 130 miles.
[227] Merger Notice, paragraph 13.47.

(c) likely to understate the scope of the geographical market over which a hypothetical monopolist would be able to raise price.

Capacity constraints

5.86 As discussed further in paragraphs 9.20 to 9.29 below, capacity constraints are a common feature of the market for rehabilitation services. A shortage of locally available supply means that customers may refer their patients to locations further away than their underlying preferences over distance would dictate. This means that regions with relatively abundant supply may receive patients from further away, who have been unable to find an available local bed in areas with relative supply shortages. For areas with supply shortages, notably the South West of England, customers provided substantially greater maximum typical distances to refer patients, sometimes of a hundred miles and above.[228]

5.87 Capacity constraints can create bias in the use of catchment areas to identify competitors to be included in the geographic market. The use of catchment areas to identify the competitors within the geographic market is motivated by the fact that customers would typically consider those competitors nearer their point of origin as substitutes. However, in this case the reason that some patients are being sent much further away may often be because the nearby provider is capacity constrained. Wide site-specific catchment areas consequently may often be the result of capacity constraints in adjoining areas. In these cases, it might be inappropriate to include competitors from these areas.

Our approach

5.88 There are methodological issues both with site-specific catchment areas and with average catchment areas. In the case of site-specific catchment areas, we note that:

(a) These areas will be greater if competitors face capacity constraints (as patients will then be sent further, potentially to the Parties' sites and so included in the Parties' catchment). The result is that we could include competitors' sites in the market definition even when these more distant competitors are capacity constrained and not actually competing.

[228] Devon Partnership NHS Trust, Avon and Wilshire NHS, Bath and North East Somerset.

(b) These areas will be smaller where there are many competitors within a smaller local area and customers would send patients to these competitors, even when they would be prepared to go to competitors located further away before accepting a price rise.[229]

(c) Conversely, these areas will be greater if there is a shortage of local supply, which leads to a greater merger impact due to greater dependency on existing suppliers in the area.

(d) For some wards, there is only data from a relatively small number of referrals to calculate site-specific catchment areas. In these cases, the size of the catchment area can be sensitive to the inclusion or exclusion of one additional patient.

5.89 The issues with average catchment areas are:

(a) There may be factors particular to local customer behaviour that mean that there is variation in the relationship between customer preference over distance and their preference over price/quality. This means that in some areas it may be the case that customers were prepared to refer patients further away before accepting a price rise than in other areas.

(b) Where there are insufficient alternatives within the local area, the use of average catchment areas doesn't account for the fact that this would result in a pre-merger incentive to raise prices (or lower quality) up to the point at which customers were prepared to send patients further away. Competition would already occur over a larger area but at a higher price level.

5.90 Customer evidence supports that out-of-area referrals due to limited bed availability are a common feature in rehabilitation services, as discussed in paragraph 7.15. In our view this is likely to cause catchment areas to be biased upwards in general. As a result, we were particularly concerned about the possibility that site-specific catchment areas would be biased by customers referring patients out of area because of limited bed availability, and because site-specific catchment areas would rely on small samples of patients. In our view this feature also meant that average catchment areas were likely to be biased upwards and that in areas with sufficient provision, competition would be likely to occur over a smaller area than the average catchment area.

[229] Merger Assessment Guidelines, paragraph 5.3.2.

5.91 On the basis of the above, we decided that the most appropriate starting point was to use average catchment areas for our filtering and:

(a) introduce a degree of caution (ie use somewhat narrower catchment areas) to account for the possibility that observed catchment areas are on average wider than geographic markets because of capacity constraints;

(b) where the nearest overlap between the Parties is at a greater distance than the average catchment area, increase the distance to take account of the possibility that they are nonetheless competing and to capture the other providers competing over this wider distance. The local assessment will then consider in more detail whether the Parties are competing at this greater distance;

(c) test sensitivities to the catchment area chosen by considering the implications of wider or narrower catchments (5 mile increments);

(d) consider the possibility of catchments defined by particular and specific customer preferences and actual capacity constraints in our local competitive assessment.

5.92 As noted above, in the local competitive assessment, we will consider constraints from outside the catchment area.

The appropriate distance for the average catchment area(s)

5.93 In assessing the appropriate distance for the average catchment area we considered:

(a) the Parties' submissions; and

(b) our analysis of referral patterns.

Parties' submissions

5.94 The Parties calculated their catchment area based on an average of their own sites. The Parties believe that distance within which 80% of patients are located is appropriate. The Parties use different catchment areas sizes for LTMH ([✂] [70–80] miles) and PD ([✂] [95–110] miles).

5.95 The Parties submit that weighting patients according to the number of days they have stayed at the Parties' sites inadvertently places greater weight on the locations of patients that were referred a number of years ago, rather than new patients which are more likely to provide insight into the current referral behaviour of customers.

5.96 We note that weighting according to length of patient stay will place less weight on patients that have been referred more recently and so are yet to complete their stay in a given ward. However, our view on balance is that this approach is more appropriate as it is more reflective of the revenues attributable to each patient and so the Parties' incentives to compete. In addition, failing to weight according to patient length of stay would not take account of the fact that customers referring patients 'out-of-area' would typically seek to return patients as soon as possible back in-area and into the local community. Consequently, it would be likely to result in catchment areas that were biased upwards.

Analysis of referral patterns

5.97 To assess referral patterns, we aggregated the patients across all the Parties' PD and LTMH rehabilitation sites and ordered distances to the provider (using customer locations) from the least to the greatest to calculate percentiles, weighted by the patient's length of stay in the last three years. This is shown in the figures below.

Figure 12: All patients

[✂]

Source: CMA calculation based on Parties' data.

5.98 As shown in the figure above for all patients:

(a) [✂] [30-40]% of patients come from within 20 miles;

(b) [✂] [60–70]% of patients come from within 40 miles;

(c) [✂] [70–80]% of patients come from within 60 miles; and

(d) [✂] [80–90]% of patients come from within 70 miles.[230]

5.99 These referral patterns appear consistent with the preference of customers to place patients locally, but to go further afield in the absence of suitable local available beds. For a minority of placements it might be necessary to refer patients to greater distances – in particular at sites located more than 60-miles, and occasionally substantially greater distances.

5.100 To better understand the underlying drivers of the described referral pattern, we looked at differences in catchments across the following dimensions:

[230] To be exact to the nearest mile, instead of nearest 5 miles, 20 miles, 40 miles, 60 miles are in this and following sections 19 miles, 41 miles and 62 miles.

(a) Specialism and gender.

(b) Provider.

(c) Site.

Delineation by specialism and gender

5.101 As shown in Figure 13 below, the catchment areas for LTMH male, LTMH female and PD female differ. PD female has the widest catchment area with [✂] [80–90]% of patients coming from about 100 miles. [✂] [80–90]% of LTMH female patients come from about 80 miles and [✂] [80–90]% of male LTMH patients come from a catchment area of about 60 miles.

Figure 13: Specialism split

[✂]

Source: CMA calculation based on Parties' data.

Delineation by specialism, gender and provider

5.102 Both parties have broadly similar catchment areas for similar proportions of their patients for LTMH male and LTMH female patients. This is consistent with the assumption that customers have underlying preferences based on quality and the approach to treatment of the service, not the identity of the provider.

5.103 The referral distance for some PD female patients appears larger for Cygnet than CAS, however, this also depends on the proportion of patients considered.

Figure 14: Provider split, LTMH Male

[✂]

Source: CMA calculation based on Parties' data.

Figure 15: Provider split, LTMH Female

[✂]

Source: CMA calculation based on Parties' data.

Figure 16: Provider split, PD Female all areas

[✂]

Source: CMA calculation based on Parties' data.

Provisional conclusion

5.104 On the basis of the evidence above we consider that it is appropriate to adopt a catchment area of 60 miles for the following reasons:

(a) 60 miles corresponds with the area within which [✂] [70–80]% of all patient funding falls. While the CMA has frequently used catchment areas within which 80% of all customers are located,[231] due to the possible impact of capacity constraints in this market resulting in catchment areas wider than the actual geographic market, we consider it is more appropriate to use a narrower catchment area of 75%.[232]

(b) Related to this, 60 miles is the catchment area within which [✂] [80–90]% of all the Parties' LTMH male patients fall. This distance is smaller than those for LTMH female patients or PD female patients. However, evidence does not suggest that customer preferences are different for female patients. Our view is that the observed differences in average catchment areas are likely to arise because there are fewer wards available for female PD and LTMH compared with male LTMH, rather than because of underlying differences in customer preferences. In our view, the 80% catchment area for LTMH male patients provides an approach which is less likely biased due to such capacity constraints.

(c) For both LTMH female and PD female, a large proportion of patients fall within 60 miles (approximately [✂] [70–80]%).

Sensitivities to account for local transport infrastructure

5.105 Different catchment areas have been used for urban areas compared with rural areas in the analysis of mergers.[233] However, the large catchment areas we have used mean most sites outside of the major urban conurbations have a large proportion of referrals from both more urban and more rural areas.

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[231] The CMA's Retail Mergers Commentary states in paragraph 2.21: 'The CMA has usually used catchment areas that capture 80% of a store's sales or customers.' It continues: However, the CMA may adjust its starting point where there is evidence that this is appropriate'. It provides two examples, both for which narrower catchment areas were used, including: 'In Pure Gym/The Gym (2014), the CMA found that the Parties assessed competition over a narrower area than the 80% catchment and analysed each overlap area in detail instead of relying on a catchment area-based filter'.
[232] In a previous healthcare case, the Office of Fair Trading conducted a sensitivity check to verify the distance required to capture 60%, 70% and 80% of their residents (Advent/Priory, p7, paragraph 22).
[233] For instance, Celesio / Sainsbury's Pharmacy merger inquiry.

5.106 The Parties' referral patterns for sites in London and Birmingham show that a large share of their referrals come from narrower catchment areas measured in miles of road distance.[234]

5.107 Road distance might not be as appropriate in and around London and Birmingham to measure customer distances. Instead, drive-times and public transport travel times in London reflect the amount of time it takes to cover similar road distance in London.

5.108 To address the overlap in Greater London and nearby surrounding areas, we calculated *(a)* driving, and *(b)* public transport travel times in minutes, instead of road distances in miles, centred on the overlap sites in London and surrounding areas: Cygnet Woking, Cygnet Lewisham, and CAS Churchill.[235]

6. Counterfactual

6.1 To assess the effects of the Merger on competition we need to consider what would have been the competitive situation without the Merger. This is called the 'counterfactual'.[236]

6.2 The counterfactual is an analytical tool used to help answer the question of whether the Merger has or may be expected to result in an SLC.[237] It does this by providing the basis for a comparison of the competitive situation with the Merger against the likely future competitive situation absent the Merger.[238] The CMA's approach to the counterfactual is set out in our Merger Assessment Guidelines.[239]

6.3 In order to determine the counterfactual, we have considered, based on the evidence, what would have been the most likely scenario had CAS not been sold to Cygnet.

The Parties' view

6.4 The Parties' view is that absent the Merger, the market would have continued under the pre-Merger conditions of competition.

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[234] For instance, [✂] of patients in CAS Churchill in London, [✂] of patients in Cygnet Lewisham, and [✂] of patients of CAS Sedgley in Birmingham are funded within a 26-mile catchment area.
[235] www.doogal.co.uk/DrivingDistances.php. 'Driving' and 'Public transport' departing after 10am accurate on Saturday 4 June.
[236] Merger Assessment Guidelines, paragraph 4.3.1.
[237] Merger Assessment Guidelines, paragraph 4.3.1.
[238] Merger Assessment Guidelines, paragraphs 4.3.1 & 4.3.6.
[239] Merger Assessment Guidelines, Section 4.3.

Our assessment

6.5 Although Cambian's board had been reviewing the company's strategic options in light of the need to repay debt[240] (in September 2017), as well as the wider business situation faced by the company, there was no risk of financial failure. In its 2015 Annual Report, Cambian emphasised that 'despite the challenges we faced, we should not lose sight of the fact that Cambian remains fundamentally a good business with a strong value proposition for its customers.'[241]

6.6 Despite this, Cambian needed to raise funds to pay its debts, but there is no evidence that Cambian would have exited the market had the sale of CAS not occurred.

6.7 The Merger involved a two-stage sale process.[242] There were [✂] bidders in the first stage with [✂] progressing to the second stage. Some bidders were private equity firms and could be expected to address the financial constraints that Cambian was facing. However, the extent to which any improvements in performance would arise following a purchase from such a bidder is by its nature speculative and uncertain.

Provisional conclusion on the counterfactual

6.8 We found that given the interest from potential purchasers revealed by the sale process, 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.

7. Customer behaviour and choice of facility

7.1 In this section, we first consider how patients end up being treated at the Parties' facilities and linked to this, how customers choose between different mental health providers. Based on this, we conclude which parameters are important for customers when choosing between mental health providers.

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[240] See Appendix D for details.
[241] Cambian 2015 Annual Report and Accounts, 29 April 2016, p7.
[242] See Appendix D.

7.2 There are numerous types of mental healthcare providers and settings, from domiciliary care in the community to high security hospitals. Patients will typically first receive treatment in acute settings before moving on to rehabilitation services and then to community based care.[243] This is referred to as the 'care pathway'. While acute services[244] are most commonly provided by NHS trusts or foundation trusts, some are provided by independent sector providers, including Cygnet.

Customer Choice

7.3 In this market, unlike some other healthcare markets, the patient is rarely in a position to decide where they would like to be treated. Therefore, CCGs fulfil the role of customers, making decisions as to where patients should be referred.

7.4 The Parties told us that customers will typically go through the following steps when seeking to place a patient into a facility providing rehabilitation services:

(a) **'Clinical needs established**: Once a patient has been admitted into the 'care pathway', under the NHS Care Programme Approach (CPA), care co-ordinators[245] employed by the NHS trust concerned will assess, plan, co-ordinate and review their needs. Patients referred to rehabilitation services tend to be 'existing patients' (already resident in a mental health facility) rather than 'new patients' (not currently resident in a mental health facility). Care co-ordinators may recommend a move to a rehabilitation services site where a patient:[246]

(i) is ready to 'step-down' from secure services to rehabilitation services;[247]

(ii) needs more time to recover from a mental health illness after being admitted to an acute psychiatric services facility or in a PICU;

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[243] [✂]% of Cygnet's LTMH patient and [✂]% of its PD patients are stepping down from other services (the remainder is either 'moving sideways' from other rehabilitation services, for example to move closer to family, or 'moving up' from community services). A very small proportion, only [✂]%, of patients are admitted directly to rehabilitation services from their home or usual place of residence.
[244] Acute psychiatric services are provided to patients in mental health crisis who require short-term admissions of around three to six weeks (compared with between 12 months and three years for rehabilitation services). As defined in Appendix C, paragraph 13.
[245] CPA care coordinators are usually nurses, social workers or occupational therapists.
[246] But as noted below in (b) it is the customer which makes the decision to which provider the patient is allocated.
[247] The impact on competition of possible links along the 'care pathway' is considered in more detail in the next section.

(iii) has been in community accommodation, but needs more care; or

(iv) is moving sideways from another rehabilitation facility.'

(b) **'Initial contact with several potential providers**: When a decision is made to move the patient to rehabilitation services, the customer will contact several potential providers' sites (referrals are made to specific sites). If the customer has not decided on the exact treatment approach for a patient, they may approach a range of different providers offering different types of rehabilitation services. The Parties told us that customers would generally approach at least three providers, but this may vary.'[248]

(c) **'Provider assessment**: Providers will then assess the patient's clinical needs and the suitability of their facility to treat them, inform the customer and if relevant submit a treatment plan for the patient plus key commercial terms (which will tend to have been pre-negotiated with the customer). Cygnet rejects on average [✂]% of patients that it assesses, and in 2016, [✂]% of patients were rejected by CAS. This is usually because the services available at the relevant site are not appropriate for the patient, or not appropriate for them at that time given the incumbent patient mix.[249] Customers may then seek additional proposals from alternative providers if they haven't received as many responses as they would have liked.'

(d) **'Customer funding decision**: A funding panel (comprising clinical and non-clinical staff) will consider the provider offers. The panel may take into account the suitability of the treatment for the patient, its cost, location and in most cases the patient's preferences.[250] The funding panel may take some time to reach a decision for a particular patient as they tend not to meet frequently. On average, it takes [✂]days for CAS rehabilitation patients to get through the funding panel[251] (i.e. to receive final approval, which includes the resolution of any queries from the funding panel).'

7.5 The Parties told us that the patient journey and decision-making does not change whether the customer is a CCG, an NHS Trust or a local authority.

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[248] Customers have suggested that they may often not approach multiple providers in practice either because there are limited options available or because they already have a good idea of the single best option for the patient.
[249] In circumstances in which the Parties are not able to admit a patient to a particular site requested by a customer, if suitable, they may offer a place at an alternative site. Some customers will consider such an alternative proposal, although examples of this are not common.
[250] However, we note that some customers have told us that in general they would not account for patient preferences.
[251] This does not include the duration of the previous steps.

7.6 The Parties highlighted the following differences in purchasing behaviour across customers:

(a) Some require patients to be approved by at least three providers after assessment before deciding to accept an offer, others do not.

(b) Some need authorisation for funding before carrying out assessments, others do not.

(c) Many routinely procure outside of their catchment area for a broad range of services. However, certain customers have a greater focus on maintaining the greatest possible number of patients in their catchment.

(d) A limited number have specific clinical views that change their decision-making. For example, Northumberland, Tyne and Wear Foundation Trust does not refer PD cases to rehabilitation services as it does not believe that patients with PD should be in hospital.

Choice of facility when moving up (or down) the 'care pathway'

7.7 Cygnet operates both acute and rehabilitation facilities. Since patients are commonly referred into rehabilitation services after being treated in an acute or higher security setting, providers who operate at both levels of the supply chain might be thought to have an advantage in gaining patient referrals.

7.8 The Parties submit that a move up or down the care pathway triggers a change in a patient's funding. Such changes need to be approved by customers (see 8.1(d)7.4(d)) and as such result in the re-opening of competition between providers for a patient. This has been confirmed by customers,[252] who have told us that all patient referral decisions are treated independently regardless of where the patient is currently receiving care.

7.9 The Parties note that it can be easier to secure a contract to continue treating an existing patient when there is greater continuity between the two services (eg they are provided at different wards on the same site and the same consultant or team is involved at each stage of the care pathway). Customers explained that this was because in some cases there can be benefits to the patients staying at different wards on the same site, which they would consider in their decision-making.

7.10 In our view, this suggests that the decision to refer a patient in rehabilitation services can in general be treated independently of the provider's position on

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[252] [✂]

other parts of the care pathway. Our approach to the local competitive assessment will consider the possibility of any exceptions to this on a case-by-case basis.

Factors affecting customer choice

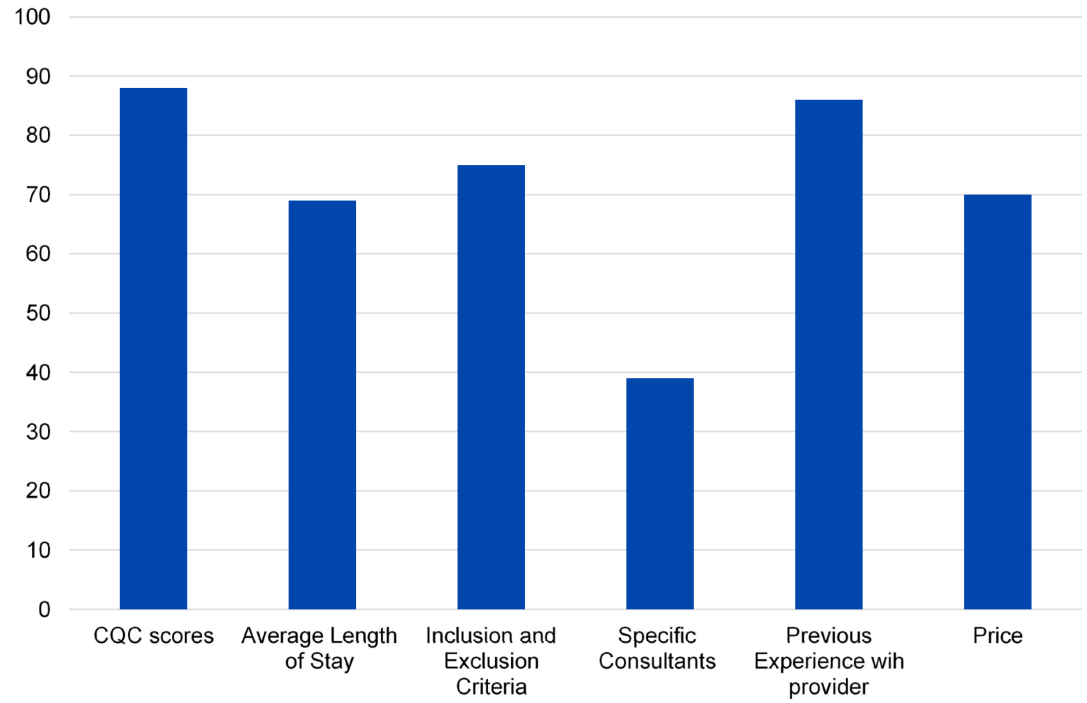
7.11 Evidence from customers suggests that several factors are important in customer choice. These are quality factors such as CQC ratings, previous experience with a hospital and the ability of a hospital to rehabilitate patients in a timely manner, and price. As outlined above, customers also prefer patients to remain in their area but may send patients out-of-area if there is no local provision or a patient needs specialist treatment.

7.12 We sent a questionnaire to 158 of the Parties' customers, receiving 48 responses. Collectively, these responses account for around 42% of referrals to the Parties' sites in overlap areas, since the start of 2016.

7.13 Customers were asked to rate the importance (out of 100) of six factors that may impact their decision-making. These factors were: CQC quality scores; the average length of previous patient stay; the hospital's inclusion and exclusion criteria[253]; the specific consultant or consultants at the hospital; their experience of previous placements with the provider; and the price charged for services. The aggregate results are shown below in Figure 17.

[253] These refer to the specification of characteristics of the types of patients that the hospital would admit and the types of patients that the hospital would not admit. For example, a hospital might exclude patients who demonstrated certain challenging behaviours.

Figure 17: Customer decision-making factors



Source: Response to CMA customer questionnaire.

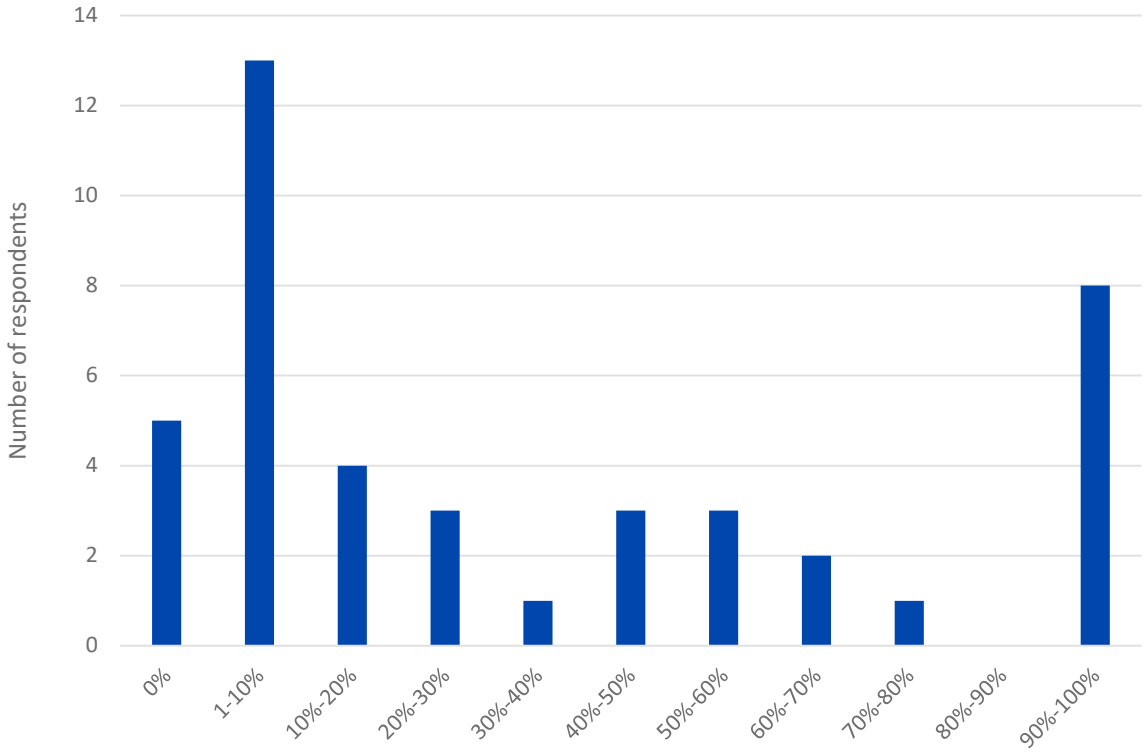
7.14 As can be seen, CQC ratings and previous experience with providers are the key drivers of customer behaviour. Customers indicated that they focus on providing the best possible outcomes for their patients. Both CQC ratings and previous experience are comprised of a range of underlying quality factors. Price, whilst being important (a score of 70), is less important than quality.

7.15 As discussed in paragraph 5.68 to 5.74 location is an important choice factor for customers, with most having a preference to refer patients within their local area. However, customers are willing to refer a proportion of their patients to sites outside their area, particularly when there is a lack of beds locally, as shown in the Figure 18 below.

7.16 Eight out of the 43 customers that responded to this question suggested that they sent all their patients out-of-area. In our view this proportion seems high and may reflect that some respondents interpreted the question differently. However, we note that some of the customers are in more remote areas of England where there may be very little or no appropriate local supply or availability.[254]

[254] [✂]

Figure 18: At any one time, approximately what proportion of hospitals that you would consider suitable for a patient requiring inpatient LTMH or PD rehabilitation do not have bed availability?

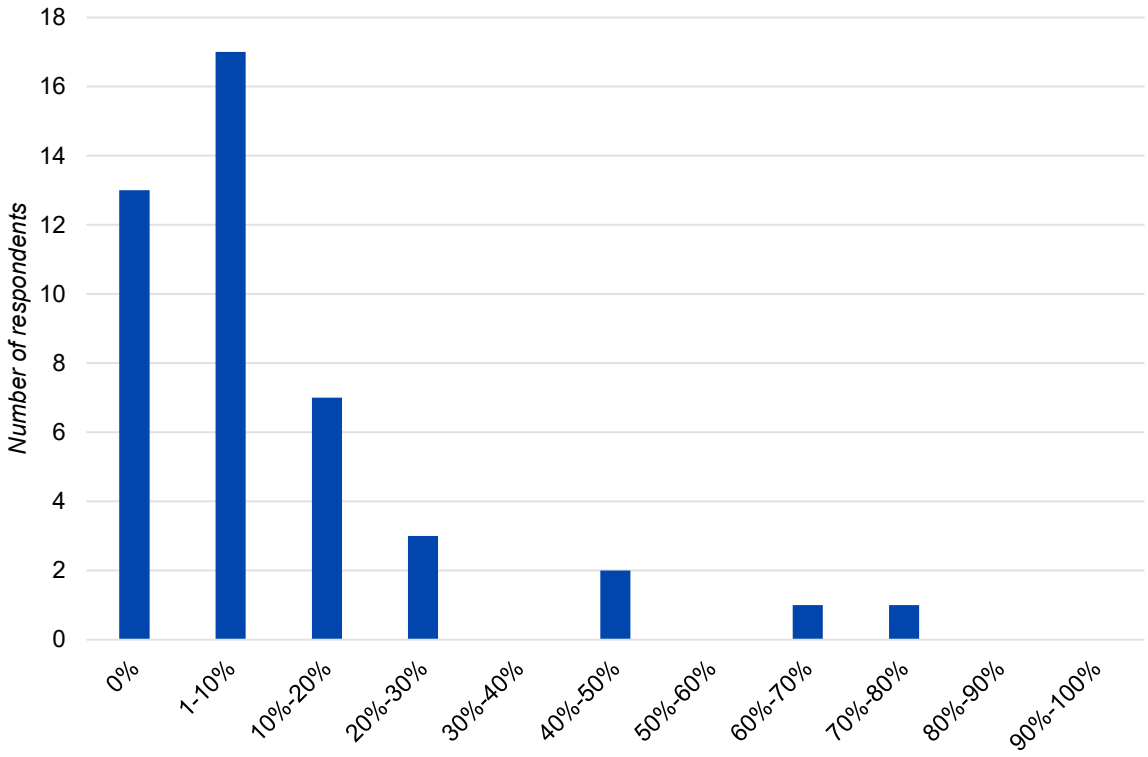


Source: Response to CMA customer questionnaire.

7.17 The Parties submitted that [✂].

7.18 Customers told us that in general they do not like to delay referrals as acute or secure wards (from which most rehabilitation patients step down) are often full and they need to free up capacity there as quickly as possible. Moreover, customers told us they were keen to avoid patients being in facilities that were no longer appropriate for their diagnosis or position on the care pathway, as it could harm their recovery and progress.

Figure 19: At any one time, for approximately what proportion of patients are you delaying admission for inpatient LTMH or PD rehabilitation services while you wait for a bed to become available?



Source: Response to CMA customer questionnaire.

Provisional conclusion

7.19 Customers focus on quality and geographic locality when making their referral decisions. The ability to find quality hospitals in close geographic proximity can be impacted by a lack of capacity. The ability of customers to delay referrals does not substantially affect this. Price is also important but less important than quality.

8. The nature of pre-Merger competition

8.1 The Parties are both active in the provision of rehabilitation services, from various sites within the UK. As set out in paragraphs 7.3 to 7.6 the Parties negotiate with customers over the provision of rehabilitation services to patients. Customers value several different elements of the offering, including; quality, location and price.

8.2 In assessing the nature and extent of pre-Merger competition between the Parties we first set out their contractual arrangements. We then outline how they compete over quality, price and expansion.

Parties' contractual arrangements

8.3 In broad terms, the parties have two types of contractual arrangements with their customers – some form of an agreement or an ad hoc arrangement by individual patient, sometimes called a 'spot-price'.

8.4 The Parties submit that there are two main forms of agreements between rehabilitation service providers and customers:

(a) pre-negotiated agreements for rehabilitation services, often procured through a tendering process and based on the NHS Standard Contract;[255] and

(b) locally developed SLAs[256].

8.5 Customers without pre-negotiated agreements will negotiate terms on an individual patient basis, though commonly with reference to a provider's standard tariff.

8.6 In the previous 12 months, Cygnet derived [✂]% of its revenues[257] from pre-negotiated agreements. In contrast, in April and May 2017,[258] CAS derived [✂]% of its revenues from pre-negotiated agreements.

8.7 The Parties indicated that contracts are often awarded based on the price and quality of potential providers:

(a) Prices for framework agreements, are proposed as part of a tender process. These can be revised based on discussions with the customer. For other forms of contract, prices and terms are negotiated between the customer and provider, often based on a standard tariff.

(b) NHS Standard Contracts contain quality reporting schedules, which require providers to report on and demonstrate compliance with various quality metrics on a regular basis (in the form of the quarterly Service Quality Report). The Parties told us that customers often place considerable weight on the results of these reports when determining if a service is suitable for it to refer patients to.

8.8 The Parties indicated that all SLAs have a one-year term and that longer-term NHS Standard Contracts under a framework agreement have an annual

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[255] [✂]
[256] SLAs refer to a written agreement between a provider and the customer setting out the range and level of services to be provided, the responsibilities and priorities and the fees. See also Section 2, paragraph 2.57.
[257] [✂]% of customers had pre-negotiated SLAs/ contracts in place.
[258] CAS was not able to provide directly comparable data.

pricing review. Annual reviews take place on 1 April with pricing proposals circulated in/around January. These proposals are followed by a series of negotiations.

8.9 The NHS Standard Contract contains standard terms, which can only be varied centrally by the NHS. Similarly, terms cannot be changed during the life of the contract, which is usually one year, but can be up to three. When formulating these contracts, providers will be asked to provide CQC certificates, NHSI licences, insurance certificates, the information governance (IG) assessment report, and relevant operational policies and procedures.[259]

8.10 Customers who do not have a contract that stipulates the treatment price will negotiate over the purchase of rehabilitation services while finding a provider for an individual patient.

Competition on quality

8.11 Quality competition takes place at two broad levels. The first is at a ward/site level and is demonstrated, for example, by CQC ratings. The second is at a patient level and includes patient care plans and a customer's past experience of the facility.

8.12 The Parties submit that the main differentiating factors and measures of quality in respect of rehabilitation services include:

(a) readmission rates;

(b) length of stay;[260]

(c) CQC scores;

(d) inclusion/exclusion criteria;

(e) staff training;[261]

(f) specialist treatments offered;

(g) equipment/facilities;

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[259] See also Section 2, paragraphs 2.58 to 2.63 and onwards and Appendix B for more information on contracting.
[260] Measured by the Parties for every patient from entry to a facility, until discharge. Other things being equal, customers prefer lower length of stay as this implies the patient has recovered more quickly. Expectations for length of stay may vary for different types of patients and what matters to customers is length of stay relative to expectations.
[261] Measured and monitored in several ways, including staff spend per head, on an annual basis.

(h) location (ie in terms of links with the local community and local facilities);

(i) ratios of permanent to temporary staff;

(j) incident and complaint levels;

(k) levels of patient attendance at therapy.

8.13 The Parties told us that CQC reports and ratings constitute a particularly key measure of quality from a provider's perspective. CQC reports are based on inspections by CQC staff, which rate individual sites against pre-set scoring criteria.[262]

8.14 The Parties told us that they target high CQC ratings for all their facilities, which includes aiming for the highest quality of staff training, clinical approach, and safety procedures. Following a CQC inspection, to the extent applicable, the site will work towards implementing any recommendations/ points for development. If a site receives an 'Inadequate' or a 'Requires Improvement' rating, or any development points from the CQC, the Parties will immediately work to set and carry out an action plan for improvement. Both Parties oversee these local remediation plans at group level.

8.15 CQC inspections generally take place on a set schedule, and therefore it is usually necessary to wait for the next review (which can be up to two years later) for a rating to be updated. However, occasionally inspectors are willing to review a site sooner if an action plan has been implemented quickly and effectively.

8.16 In addition to CQC reports, providers often send compliance data to their customers, in the form of a Service Quality Report, which combines the reporting requirements contained within the relevant schedules of the NHS Standard Contract. These reports are generally not sent to non-contract customers, although they are available on request. These reports contain various quality-related data, including:

(a) length of stay,[263] and details of overall outcomes;

(b) staffing summaries;[264]

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[262] Further information provided on CQC report in regulatory bodies section, paragraphs 2.14 to 2.19 and 2.23 to 2.26.
[263] For both current and completed episodes, and on the basis of planned admissions and emergency admissions.
[264] Including vacancies; clinical supervision; staff sickness levels; agency worker usage/overtime; staff annual safeguarding training; and details of statutory and mandatory training.

(c) complaints, incidents and results of satisfaction surveys; and

(d) details of CQC inspections and updates.

Internal documents

8.17 We reviewed the Parties internal documents to assess the importance of quality as a source and driver of competitive interaction.

8.18 The Parties' internal documents often include detailed information about various quality metrics at a site level. They also regularly highlight actions or strategies to improve particular quality measures. Cygnet's sales plans highlight performance on key quality parameters to customers. They deal with issues such as: CQC Reports and length of stay; they set out the importance of publicising positive outcomes such as improvements to services on websites, e-newsletters and in e-mails to customers; and they cover developments in the skills of their staff.

8.19 Internal documents also show that customers have been responsive to changes in the quality at a site. For instance, [✂].

Evidence from third parties

8.20 As outlined above, customers rely on information contained within CQC reports, their own assessments and previous experience of providers in assessing quality. Customers told us that, resources allowing, they would typically send nurses to carry out inspections of potential providers periodically and sometimes for specific patients.

8.21 Elysium told us that quality is also an important factor in all markets. In their experience, where there is an undersupply of beds customers will usually try to work with the service provider with poor quality to improve its quality (they do not wish to lose much needed beds). Where there is an oversupply, a bad quality rating may influence admissions but a very high quality rating will not automatically lead to more patient referrals or admissions.

8.22 Customers also provided examples of when they have either stopped, or reduced the number of, referrals to a facility following a change in quality:

(a) [✂][265]

[265] [✂]

(b) [✂][266]

(c) [✂][267]

Our assessment

8.23 Customers have told us that alongside location, quality is the most important factor for them when deciding where to refer patients. Therefore, providers are likely to have the incentive to maintain or improve their quality, for example through the quality of their patient care plans, in order to maintain and increase the number of patient referrals.

8.24 Regulatory supervision and intervention in rehabilitation services also focuses on quality monitoring and improvement as is further detailed in the Legal and Regulatory framework section and Appendix B.

8.25 Internal documents and third party evidence show that providers in general, and the Parties in particular, have taken actions aimed at improving the quality of their services. They have promoted these to customers. Additionally, internal documents show that customers are responsive to changes in quality. Therefore, we consider that the Parties compete over quality.

Competition on price

8.26 The Parties submit that location is not a significant determinant of pricing.

8.27 The Parties told us that [✂].

8.28 [✂][268]

8.29 [✂]

Evidence from the Parties

8.30 We have been unable to compare prices for the Parties in a systematic way controlling for factors that affect prices.[269] However, we found that the data and internal pricing documents provided by the Parties [✂].

8.31 Table 12 shows [✂].

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[266] [✂]
[267] [✂]
[268] [✂]
[269] [✂]

8.32 [✂]

Table 12: [✂]

[✂]

Source: Parties.
* [✂]
† [✂]
‡ [✂]
§ [✂]

8.33 CAS told us they typically use their [✂].

8.34 Evidence submitted by the Parties shows that [✂] in the period between April and July 2016 [✂]. This accounted for [✂]% of admissions made to CAS in this four-month period. [✂]

8.35 There is also evidence in one of Cygnet's internal documents about [✂]. This showed that [✂]

8.36 Cygnet also provided examples of where customers had switched to an alternative provider due to price competition.

(a) [✂]

(b) [✂]

8.37 CAS [✂] their price for PD services by [✂]% between 2015 and 2017. CAS stated that this was due to their initial [✂]. In our view, this suggests that providers in rehabilitation services may have the ability to materially change prices.

Evidence from third parties

8.38 Elysium told us that in a market where the number of available beds matches or exceeds the local demand, the most important factors will be specialisation of the service and price.

8.39 St Andrew's indicated that CAS has a history of pricing very competitively in order to fill beds. St Andrew's also noted that it believes that CAS's reputation for quality has been compromised by its pricing strategy. St Andrew's submitted that the Merger would result in a reduction in historical levels of price competition, although CAS had significantly reduced its heavy discounting in the last couple of years. We note that this view is consistent with the evidence described in paragraph 8.37 above of CAS having [✂] prices for its PD services.

8.40 One customer[270] indicated that it believed that previous mergers had led to consolidation in the market, which has in turn affected price and choice in their area.

Our assessment

8.41 Customers have told us that price is an important factor for them, when they are deciding where to refer patients. Therefore, where there is rivalry we consider that providers are likely to have the incentive to compete on price on occasion to try to maintain their current level of referrals and to gain more patient referrals.

8.42 We found prices can change at the start of new agreements and at certain times during longer-term agreements. We also found that sequential changes in prices or the range within which prices have to stay in longer-term agreements may also be agreed at the start of the agreement. We consider therefore that competition takes place at the start of new or the extension of existing agreements.

8.43 Evidence from the Parties and third parties is that providers in general, [✂], have varied prices at a local level. We have found [✂]. However, we have found there is little evidence of price competition in the short-term, for example, on a day-to-day basis. As noted in the previous paragraph, price competition takes place over the longer term. We therefore consider that the Parties compete over price at a local level.

Competition on entry and expansion

Evidence from the Parties

8.44 The Parties' internal documents show that the [✂]factor in deciding whether to open a new facility or to expand an existing one is the level of unmet demand in a local area. The Parties will assess [✂].

8.45 For example, in assessing the case to open a facility in Harrow, Cygnet:

(a) [✂]

(b) [✂]

(i) 'Curocare: [✂].'

---

[270] [✂]

(ii) ‘Nuovita: [✂].’

(iii) ‘PIC Kneesworth: [✂].’

(iv) ‘Glencare: [✂].’

(c) [✂]

8.46 Evidence from CAS showed it followed a similar approach when assessing a potential new site. In deciding whether to open a [✂] site near [✂], CAS:

(a) produced an estimate of [✂];

(b) analysed how [✂]; and

(c) [✂]

8.47 CAS also [✂]. Following that the initial plans for the site to provide [✂] treatment were changed as the site and its immediate environment was not suitable for a rehabilitation service where time in the community is part of the treatment. Therefore, the business case was reshaped around [✂].

Our assessment

8.48 The evidence from the Parties’ indicates that previous expansion decisions by the Parties have primarily been driven by identifying areas where there is excess demand. While the Parties’ plans to expand often refer to local competitors’ facilities, the Parties’ evidence did not show how competition affects incentives to expand.

8.49 In our view a provider with a higher existing share of capacity has a reduced incentive to expand capacity compared with one with a lower share of current capacity – as adding more capacity may lower the market price it earns for its existing capacity. In our view, a provider’s share of existing capacity is therefore likely to affect its incentive to expand capacity further.

Provisional conclusion on pre-Merger competition

8.50 The Parties are active in the provision of rehabilitation services at numerous sites in the UK. Customers are responsible for referring patients and do so primarily based on the quality, location and price of different providers.

8.51 We found evidence that each of the Parties will focus on the quality of their facilities and have taken action aimed at improving quality at a local level. The Parties will market these quality improvements to customers. Evidence shows that customers are responsive to changes in quality, which can lead to a

significant change in their referral patterns. Parties and competitors agreed that quality is an important factor and that it can influence demand for a service.

8.52 We found that price competition takes place at the start of an agreement, at review stages and at extension of existing agreements. We found that [✂]. Competitors agreed that price is an important factor and that it can influence demand for a service.

8.53 While we did not receive evidence of how competition had affected the Parties' previous expansion decisions, in our view, a provider's share of existing capacity is likely to affect its incentive to expand capacity further.

9. Effect of the Merger on competition in local overlap areas

Framework for analysing competitive parameters in local areas

9.1 In this section, we:

(a) set out our approach to identifying potentially problematic local overlaps;

(b) establish a filtering methodology to screen out non-problematic overlaps and identify local overlaps where we consider that the Merger might lead to an SLC and further analysis is required;

(c) set out a methodology for further analysis in overlaps identified by the filter; and

(d) set out our more detailed analysis of individual local overlaps.

Approach to identifying potentially problematic local overlaps

9.2 Our approach has been to look first for mechanistic rules which can filter out unproblematic areas, and then to carry out more detailed competitive assessments in the remaining local areas.

9.3 In developing filtering rules, we have taken account of the evidence that informed our assessment of pre-merger competition. We adopted a conservative approach to the initial screening process so that we were confident we would identify all the potentially problematic areas.

9.4 We then looked in detail at the areas that failed the filter further examining maps of the areas, considering in detail more granular features such as those

set out in Section 8 above in order to decide whether the Merger may be expected to result in an SLC in any given local overlap area.

Initial filters to identify potentially problematic local overlaps

9.5 The first stage in our approach was to identify a mechanistic rule which could filter out unproblematic areas. We filtered on the basis of the Parties' combined share of beds within the 60-mile catchment area[271] around each of their sites.

9.6 We used a threshold of 40% combined share of beds. In deciding this threshold, we had regard to our previous decisions in Acadia/Priory and phase 1 of this case where a realistic prospect of a substantial lessening of competition was found only where market shares exceeded 40%. We note that the number of distinct geographic areas identified for further analysis remains unchanged when we increase the threshold to 50%, ie a filter threshold of 50% would identify the same areas.

9.7 As a sensitivity check, where there is no overlap within the 60-mile catchment area, we extended the catchment until the Parties' services overlap. We included additional sites only if on the sensitivity check the combined market shares were high (ie above 40 %) and the market share remained above 40 % when extending the catchment area further. This is to capture the possibility that providers of rehabilitation services may compete over larger distances where there are no closer alternative providers. In practice this was only relevant to Cygnet Kewstoke and CAS St Teilo for LTMH Female, which overlapped at 80 miles.

9.8 As discussed in paragraphs 5.105-5.108, for sites in London we used public transport travel times as well as distance in our filtering, as we believe this may more appropriately reflect the convenience and time taken to travel in this area. The Cygnet Woking, Cygnet Lewisham and CAS Churchill sites are identified for further analysis based on a filter using public transport travel times of 90 minutes. In addition, all three sites are also identified for further analysis by the sensitivity checks using the 40% combined market shares filter threshold on 60-minute drive-time.

9.9 At the filtering stage we excluded NHS hospitals, wards providing treatments to the opposite gender and treatments to patients with a different primary

[271] The reasoning behind the 60-mile geographic area is set out in paragraphs 5.81–5.104.

diagnosis.[272] We then assessed these competitors in more detail in our local assessments.

9.10 Similarly, we conducted sensitivity checks through the exclusion of wards based on the following three characteristics:

(a) Security level – while it appears likely that wards with unlocked or unknown level of security compete with locked rehabilitation wards, as discussed in the product market definition, as a sensitivity check we excluded these wards.

(b) Gender – mixed gender wards. As a starting point, we assumed a 65:35 ratio of male to female beds. However, as a sensitivity check we also excluded all beds for mixed gender wards.

(c) Specialism – some wards were identified as combined treatment, most notably LTMH/PD. As a starting point, we used a 50:50 split for these treatments but also tested the sensitivity of excluding these wards from the competitor set.

9.11 From this filtering, nineteen wards were identified for further analysis which we grouped into the following eight local overlap areas:

(a) **Yorkshire and Humber – female PD**: CAS Aspen Lodge, CAS Acer Clinic and Cygnet Bierley located in South Yorkshire and West Yorkshire.

(b) **The South West – female PD**: Cygnet Kewstoke (Knightstone Ward) and CAS Alders.

(c) **London – male LTMH**: Cygnet Woking, Cygnet Lewisham and CAS Churchill.

(d) **Yorkshire – male LTMH**: Cygnet Brighouse and CAS Oaks.

(e) **Northern Wales and the North West – female LTMH**: CAS Delfryn Lodge and Cygnet Bury.

(f) **Southern Wales and The South West – female LTMH**: Cygnet Kewstoke (The Lodge) and CAS St Teilo.

(g) **The East Midlands – male LTMH**:– CAS Storthfields House, CAS Sherwood House, CAS The Limes, Cygnet Derby.

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[272] At phase 1, the CMA found no additional SLCs due to combining treatments and/or genders.

(h) **The West Midlands – female LTMH**: Cygnet Coventry and CAS Raglan House.

Methodology for further analysis in areas identified by the initial filter

9.12 In each of the overlaps identified for further assessment, we then took account of:

(a) **Market shares**: the Parties' combined share of beds, the number of alternative providers remaining and whether they are national providers.

(b) **Capacity constraints**: whether some competitors are less likely to have bed availability and the effect on the constraint that they provide.

(c) **Geographic differentiation**: the extent to which the Parties are closer competitors geographically than other providers.

(d) **Closeness of competition**: over quality and prices.

(e) **Customer evidence:** on closeness of competition and whether there are customers that are concerned about the effect of the Merger.

(f) **Internal documents:** relating to competition in the specific local overlap area.

(g) **Competition from NHS:** the competitive constraint posed by NHS hospitals in each local area.

9.13 For each overlap we identified the relevant providers and collated information on their prices, occupancy, average length of patient stay and CQC rating. This information is set out in Annex E.

Market shares

9.14 Providers of rehabilitation services have a limited number of beds in each ward. In our view, the number of beds in a provider's ward will be reflective of the competitive constraint imposed by that ward on the Parties. This is because the extent to which a customer will be able to switch (or threaten to switch) referrals to that ward in the event of a price rise or reduction in quality by the Parties is determined by the number of beds in that ward and whether they are available.

9.15 As a result, we have focused our assessment primarily on the combined market share (of beds) of the Parties and the increment resulting from the Merger. In our view, this is a key indicator of the competitive constraints that the Parties impose on each other relative to other providers.

9.16 In order to calculate the Parties' combined market shares, we have identified the relevant competitor set for each area, that is the providers in the area offering comparable services to the Parties (in accordance with the product market definition). To identify the relevant competitor set we have used information provided to us by the Parties on the providers within 60-miles of each site.

9.17 We then excluded certain providers from the competitor set, where they do not appear to pose a competitive constraint to the Parties. We assessed this based on publicly-available information and evidence provided by third parties which suggests that the specialism, age group, gender and/or treatment offered by these providers is not comparable to that offered by the Parties.

9.18 In addition, to calculate bed numbers for combined treatment or mixed gender wards, we have sought information from providers on the current allocation of patients by specialism and/or by gender on that ward and their ability to flex this allocation. Where this information was available, we have assumed that the current allocation is reflective of the bed numbers typically available to each treatment or gender. Where this information was not available, we used assumptions to allocate patients by gender[273] or treatment type.[274]

9.19 The Parties submitted that male patients with a primary PD diagnosis typically exhibit very violent behaviour to others and that most male PD patients are either in prison or in a secure hospital environment.[275] The Parties have therefore argued that to the extent that the CMA has identified combined LTMH/PD sites for male patients, these are likely to be LTMH-only sites. We have tested the sensitivity of our results by adjusting the bed allocation of such sites as per the Parties' suggestion. Where relevant, we have also considered the sensitivity of the resulting allocations to reflect the possibility that providers may be able to flex the current allocation.

Capacity constraints

9.20 Whether the Parties have an incentive and the ability to compete will in part depend on whether they have, or can create, sufficient capacity to treat additional patients where they overlap.[276] If providers are capacity constrained, they may not be able to take new patients. This will limit the competitive constraint they impose at least in the short term.

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[273] We have assumed a 65:35 allocation between male and female patients. See paragraph 5.28.
[274] We have assumed a 50:50 allocation between PD and LTMH.
[275] Parties' Response to the Local Assessment Working paper paragraph 6.24.
[276] Or to seek to maintain existing patient volumes in the face of competitive pressures from other providers.

9.21 Capacity is constrained where the demand for a provider's beds exceeds the number of beds it has available. Capacity constraints can be identified by looking at the occupancy rate of the beds at the ward. If occupancy is at or close to 100% then the provider is capacity constrained.

9.22 For any given patient and customer, the effective competitor set is limited to the set of providers with current bed availability. The likelihood that a provider has bed availability will depend on:

(a) Its total capacity, ie the more beds it has the more likely that one will be available at any given point.

(b) Its capacity utilisation, ie the proportion of beds that a provider has available.

(c) Its average length of stay, more beds become free more often the shorter the average length of stay.

9.23 The Parties told us that capacity constraints do not limit the ability of providers to compete, as even providers with high occupancy would periodically have beds available as patients were discharged.

9.24 One competitor told us that bed availability was a key factor affecting competition. It said that in markets where the number of available beds matches or exceeds the local demand, the most important factors will be specialisation of the service and price, while in markets where there is an undersupply of beds, the specialisation will become less relevant and the relationship with local customers will be more important, working to expand services to ensure they meet the local needs as best that they can.

9.25 The Parties provided data for capacity utilisation for 2014, 2015 and 2016 for each of their sites.

Table 13: Parties' average occupancy for rehabilitation services

	Average occupancy (%)		
	2014	*2015*	*2016*
Cygnet	[✂]	[✂]	[✂]
CAS	[✂]	[✂]	[✂]

Source: Parties.

9.26 Table 13 shows that on average the Parties' are operating [✂].

9.27 We asked providers in the competitor set for data on average occupancy over the past three years and have calculated the respective average occupancy rates. We have also considered the occupancy for the most recent year (2016) and the year the site opened to account for cases where the ward has

recently opened and therefore it may not yet have reached mature occupancy. These data are shown in Appendix E.

9.28 We have considered the extent to which capacity constraints may limit the competitive constraint imposed by providers that are operating at very high levels of occupancy. We note that the extent to which a customer will be able to switch (or threaten to switch) referrals to that ward in the event of a price rise or reduction in quality by the Parties is likely to be affected by bed availability in that ward. However, in our view the extent to which capacity constraints affect competition is limited for the following reasons:

(a) Even providers with high occupancy would periodically have beds available as patients were discharged. This is particularly relevant where providers have a larger share of the overall beds – for example, a provider with 24 beds and average length of stay of one year would have two beds available each month on average.

(b) The evidence we have received suggests that providers are not typically aware of each other's occupancy rates or available capacity. They may therefore face the threat of customer switching, even if alternative providers are in fact at high occupancy.

(c) Providers, including the Parties, do not change pricing on a day-to-day basis but rather less frequently. The overall local demand for beds, and consequently the capacity of their competitors over this time period, is likely to be uncertain. Therefore, the threat of customer switching to alternative providers may be credible at the point at which prices are set, even if these providers ultimately become full. Similarly, as patient length of stay is often one year or greater, providers may face uncertain occupancy at the time when they provide patient care plans for specific patients.

(d) The current pattern of capacity utilisation across providers is not necessarily fixed and a static view based on this pattern may not reflect the longer-term constraints that each provider imposes.

(e) Capacity constraints do not limit the prospect of competition over expansion of capacity. Shares of existing capacity may affect incentives to expand capacity further. A firm with a high share of current capacity has a reduced incentive to expand capacity compared to one with a low share of current capacity – as adding more capacity may lower the market price it earns for its existing capacity. The Merger may consequently affect incentives to expand capacity regardless of capacity constraints.

9.29 We acknowledge that the Parties face capacity constraints in some local areas and that in these local areas this will limit the competitive constraint they impose on each other to some extent. Nevertheless, we believe that there is scope for the Parties to accommodate additional patients in these local areas for the reasons we have given above, such that incentives exist to attract additional patient referrals. Further, in some local areas, the Parties have excess capacity and in these local areas they have incentives to attract additional patients.

Geographic differentiation

9.30 In the initial filter, we calculated shares of capacity in the 60-mile catchment area around each site. This catchment area is an average approximation of the size of the geographic market. As discussed in paragraphs 5.88-5.89, the actual geographic market may vary from area to area to some extent, largely depending on the behaviour of the customers in that area.

9.31 Additionally, calculating a share of capacity based on the catchment area assumes that each bed within the catchment is an equally effective competitor to the Parties, no matter where it is located, and that no providers outside of the catchment area are competitors. In reality, providers further away from the Parties but within the catchment area may be less of a competitive constraint (as a smaller proportion of the Parties' customers may perceive it to be an alternative), and providers just outside the catchment area may be an alternative for some customers.

9.32 While we believe that shares of capacity within the 60-mile catchment area is a suitable starting point, we need to consider the sensitivity of market shares to including providers located just outside the area. Therefore, in our assessments of each local overlap area below we have:

(a) Considered the geographic differentiation between the Parties' sites. Where they are very close to one another they are likely to be substitutes for a greater proportion of the Parties' customers. As such, where the Parties' sites are very close the market shares may understate competition concerns. Where the Parties' sites are closer to one another than other providers' sites, as a sensitivity we have also calculated market shares on a narrower geographic basis.

(b) Tested the sensitivity of our results to extending the catchment area to 65 miles to take into account the competition that the Parties' sites face from sites located just outside the catchment area. Where this makes a substantial difference to market shares this indicates that the Parties may face competition from outside the catchment area and we should be less

concerned at a given market share level. This is particularly relevant where the Parties' sites are distant from one another.

(c) When we have received evidence from customers or other providers that the Parties' sites compete with facilities that do not fall within the 60-mile catchment area and are not captured by our sensitivity test of extending the catchment area to 65 miles, we have sought to verify whether these sites pose a competitive constraint on the Parties and whether we should therefore include them in our relevant competitor set.

(d) We have adopted a different approach for the London and Woking overlap area where we have instead identified providers within 90 minutes' drive-time and 90 minutes' public transport travel time around each of the sites as 90 minutes' travel time approximates to 60 miles' road distance on average across the country.

Closeness of competition over quality and price

9.33 As discussed above, CQC ratings are a widely accepted measure of quality in the mental healthcare sector. We have therefore used CQC ratings[277] as a proxy for providers' quality in our analysis.

9.34 The CQC has a four-point rating scale for assessing hospitals or wards;[278] Outstanding, Good, Requires Improvement,[279] and Inadequate.[280] We understand that many customers are not likely to refer patients to wards rated as 'Inadequate', and as such consider these wards to impose a limited constraint on the Parties. Therefore, we have calculated market shares excluding wards rated as 'Inadequate'.[281]

9.35 The Parties have confirmed that in their experience, an 'Inadequate' CQC rating is likely to result in some customers referring some patients to alternative sites. However, the Parties also said that it is not the case that

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[277] CQC ratings are publicly available. Therefore, when CQC ratings were not included in the providers' submissions/market questionnaire responses we have been able to retrieve them from the CQC website and the CQC database (7 July 2017). However, we note that in several cases we have only been able to identify the overall hospital rating as opposed to ward-specific rating, which may not be the best measure of quality for certain facilities. We further note that we have not been able to identify the CQC ratings of all the sites in the database of mental healthcare facilities provided to us by the Parties. This has been the case for sites that have been archived by the CQC either because they no longer operate or because they have changed provider. In addition, we have not obtained the respective information for sites that are subject to the HIW in Wales as these are not published.
[278] See also Section 2, paragraph 2.13(a) and Appendix B for more detail.
[279] The service isn't performing as well as it should and we have told the service how it must improve.
[280] The service is performing badly and we've taken action against the person or organisation that runs it.
[281] We note that there is only one female PD site with 'Inadequate' CQC rating in the areas of interest, namely The Retreat, York. The Parties submitted that the latest CQC inspection of the Retreat York focused on the older adult wards and will therefore not have an impact on PD referrals. We note however that including or excluding this site will not affect our results.

customers will stop referring patients to an inadequate site. Additionally, the Parties emphasised that an 'Inadequate' site will not remain 'Inadequate' indefinitely and cite the example of Cygnet Hospital Taunton which received such a rating in February 2016 but its rating improved to 'Good' in July 2017.

9.36 We compared the average occupancy rates for wards rated as 'Requires Improvement', 'Good' or 'Outstanding'. We found that wards rated as 'Good' have an average occupancy of 85%, while wards rated as 'Requires Improvement' have an average occupancy of 82%. This is consistent with 'Requires Improvement' ratings having limited impact on referrals, on average.

9.37 Third parties told us that the likelihood of a customer referring to a facility that has a 'Requires Improvement' rating varies on a case-by-case basis. They indicated that the main factors in this decision will be whether the customer is satisfied that the facility is taking measures to improve its service, or the areas for improvement would not affect its patients, and the availability of beds in the local area.

9.38 We tested the sensitivity of our results by excluding providers that are rated 'Requires Improvement' from our relevant competitor set. However, in our view this is likely to materially understate the constraints imposed on the Parties by these facilities. We also considered the pattern of CQC ratings alongside occupancy in each of the local areas in our assessment of closeness of competition. Where we found that many of the Parties' competitors have 'Requires Improvement' ratings and lower occupancy, this suggests that these competitors are likely to impose a weaker constraint, such that concerns may exist at a lower level of combined market share. We have also taken into account the possibility of a reduced competitive constraint from providers which do not have lower occupancy but do have weaker CQC ratings than other providers.

Third party evidence

9.39 We sought evidence from customers and competitors to identify whether providers identified by the Parties should be excluded from the competitor set on the basis that these providers do not provide comparable services to the Parties. We have been cautious with this evidence, as we found that customers were not always well-informed about the current services offered by the providers in their area. We sought to corroborate this evidence from more than one source and our own desk research.

9.40 We have taken account of customer evidence including their views on competition from the NHS and any specific concerns in our assessments in each of the local overlaps.

Local competitive assessments

9.41 Below we assess each of the local overlaps identified as possible problem areas by our filtering. We start by looking at the PD female overlaps which we consider together given the role played by product differentiation. We then go on to assess each of the LTMH overlap areas in turn.

9.42 In some local areas the Parties' market shares are below the 40% threshold used in the various filters. This is the result of the conservative assumptions used in the filtering process so as not to miss any possible problematic local areas. The market shares in the assessments below are based on the further work carried in the more detailed local competitive assessments and are therefore a more accurate representation of the competitive situation.

Female PD

9.43 We investigated the two overlaps in female PD we identified between:

(a) Cygnet Hospital Bierley (Bowling ward) and two CAS sites (CAS Acer and CAS Aspen) (Yorkshire and The Humber).

(b) Cygnet Hospital Kewstoke (Knightstone ward) and CAS Alders (the South West); and

9.44 These sites were identified as requiring further analysis by our filter on the basis of the Parties having greater than [✂] [40–50]% combined market shares following the Merger on a 60 mile basis ([✂] [80–90]% for the South West overlap and [✂] [40–50]% for the Yorkshire and The Humber overlap). However, given our assessment of closeness of competition between the Parties in the following paragraphs, in our view these market shares are not meaningful.

9.45 The Parties submitted that they do not compete in the provision of female PD rehabilitation services as their services are targeted at different types of patients with distinct needs and characteristics for whom the Parties' sites are not suitable alternatives. In relation to both overlaps the Parties submitted that Cygnet and CAS provide fundamentally different services in that Cygnet's hospitals offered more intense and more specialised PD treatment programmes and accepted higher risk patients with particularly challenging behaviour compared with all the CAS PD sites.

9.46 We focused our local assessments on determining how closely the Parties' PD sites compete. We considered evidence on closeness of competition for both areas together reflecting the Parties' submissions on PD treatment differentiation for the two overlap areas.

The Parties' submissions on closeness of competition

9.47 The Parties submitted that the key differences between the Cygnet and CAS wards are:[282]

(a) 'All of the Cygnet PD sites provide services to the Tier 4 level of PD service specification[283] and accept patients with the highest level of challenging behaviour and risk. The CQC reports for Cambian Alders Clinic and Cambian Aspen Clinic make clear that both are Tier 3 PD services.'

(b) 'The NHSE 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.' However, it also highlights the complementary nature of Tier 3 and Tier 4 services.'

(c) 'The Cygnet PD wards operate within a semi-secure hospital environment, as both of the relevant hospitals operate low secure and PICU wards, 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 PD 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) [✂]

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[282] Parties' response to the phase 1 decision, paragraph 1.34.
[283] As discussed in paragraph 2.12(d).

(h) [✂]

9.48 As a result, the Parties submitted that, 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 clinically inappropriate to refer patients requiring the level of treatment at the Cygnet services to the CAS facilities and Cygnet's facilities would be clinically unsuitable settings for patients who do not require the level of treatment offered at these facilities.

Our assessment

9.49 We note that CAS Acer, Alders and Aspen wards are characterised as a Tier 3 PD service in CQC reports, while Cygnet wards are characterised as a Tier 4 PD service. In our view this distinction supports the Parties' submissions that Cygnet wards provide specialist and intensive provision beyond that which can be provided by CAS (including a more secure environment and the provision of full time DBT treatment).

9.50 When we analysed the Parties' data on the staff to patient ratio, we found that the patient staff ratios at the Parties' wards were [✂]. Cygnet Knightstone has [✂] clinical staff per patient while CAS Alders has [✂] clinical staff per patient. Cygnet Bierley has [✂] clinical staff per patient while CAS Aspen has [✂] clinical staff per patient and CAS Alders has [✂] staff per patient. The Parties submitted that, [✂], the type of care provided is very different.

9.51 The Parties provided information on the differences in the average daily rate (2017 year to date) for PD between Cygnet and CAS sites. This showed that Cygnet Bierley is [✂]% more expensive than Cambian Acer (wing 1) and [✂]% more expensive than Cambian Aspen. Cygnet Kewstoke is [✂]% more expensive than Cambian Alders. In our view these price differentials suggest that the services provided by the Parties are likely to be substantially differentiated.

9.52 With respect to differences in the average length of stay between Cygnet and CAS wards, the evidence is mixed. We did not find that the average length of stay at Kewstoke (Knightstone ward) differed materially from Cambian Alders. Both had an average length of stay of [✂] years. The average length of stay at Cygnet Bierley is [✂] years while for CAS Aspen it is [✂] years.[284] In our

[284] We did not include CAS Acer in this comparison as its wards have recently opened. The first ward opened in June 2015 and the second in March 2017.

view, this evidence supports the Parties' submission, that differentiation between the Parties is reflected in [✂].

9.53 The Parties submitted that exclusion criteria at all CAS sites includes (i) 'no patients who need seclusion or have had recent admissions in seclusion'; and (ii) 'recent history of violence to staff and patients that has a complexity, severity or frequency that would inhibit care or pose a risk to self (through retaliation) and/or others'. In our view this supports their submission that CAS would not be able to take on many of the patients targeted by Cygnet.

9.54 We note that the 80% catchment area for Cygnet's PD sites is approximately [✂] [120-140] miles whilst the 80% catchment area for CAS's PD sites is only [✂] [60-80] miles. In our view this is consistent with the Parties' submission that this may reflect the specialist nature of the services provided by Cygnet.

Impact study of the Parties' PD sites

9.55 The Parties provided details of the following two events where a CAS PD site either opened or expanded, in support of the submission that there was [✂] at the nearby Cygnet PD sites:

(a) The opening of CAS Alders (PD) in June 2015 to see whether there was any associated impact on Knightstone Ward at Cygnet Kewstoke.

(b) The opening of CAS Acer (PD) in June 2015 and expansion in March 2017, to see if there was any associated impact on Bowling Ward at Cygnet Bierley.

9.56 In the case of CAS Alders, the Parties have provided a chart showing the average monthly occupancy at Knightstone Ward and CAS Alders before and after CAS Alders opened. This chart showed [✂] of the opening of CAS Alders on the occupancy at Knightstone ward, which remained [✂] for the entire period.[285] Similarly, the Parties showed that the opening of CAS Alders did not have [✂] on the average daily rate charged at Knightstone Ward. The Parties submitted that if there is competition between CAS Alders Clinic and Knightstone Ward at Cygnet Hospital Kewstoke, it would be evident from an analysis of occupancy rates and daily rates charged at Knightstone Ward following the opening of CAS Alders Clinic in June 2015, which more than doubled the available PD bed capacity that was available at Kewstoke.

[285] [✂]

Figure 20: Average occupancy at Knightstone Ward and Alders Clinic

[✂]

Source: Parties.

9.57 We note that this evidence does not control for other factors that may affect demand for the Parties' services in this area, for example whether demand for female PD was increasing over the period. We also consider that it is consistent with the continued existence of unmet demand for female PD services in this area. As discussed in paragraphs 8.44 to 8.49, we note that the Parties' previous expansion decisions, including the re-provisioning at CAS Alders to female PD, have focused on identifying areas where there is excess demand.

9.58 However, we note that the opening of CAS Alders resulted in a significant expansion of capacity of female PD services in the local area, approximately doubling the number of beds allocated to female PD within 60miles of Cygnet Kewstoke.

9.59 The Parties have provided a chart showing the impact of the opening and expansion of CAS Acer on Cygnet Bierley. Similarly, the Parties said this shows that the opening of CAS Acer did not have [✂] on the average daily rate charged at Cygnet Bierley.

Figure 21: Average occupancy at Bowling Ward and Acer Clinic

[✂]

Source: Parties.

9.60 The Parties submit that this chart is consistent with the opening and expansion of CAS Acer having [✂] on Cygnet Hospital Bierley. In this case, we note that occupancy at Bierley has [✂]. As discussed in paragraph 9.66 below, our understanding is that this is due to issues customers experienced at Bierley over the period. This makes it harder to discern whether or not the opening of Cambian Acer had an impact on Cygnet Bierley relative to the counterfactual.

9.61 Overall, given the scale of the opening and expansion of both Cambian Alders and Cambian Acer, in our view [✂] on Cygnet Kewstoke and Cygnet Bierley is consistent with limited competition between them.

Customer evidence on closeness of competition

9.62 We received information from five customers comparing Cygnet Kewstoke Knighstone Ward and CAS Alders. These five customers account for 37% of the referrals to the two sites since 1 January 2016.

9.63 The evidence from customers on whether they saw Cygnet Kewstoke Knighstone Ward and CAS Alders as alternatives was mixed. Three customers[286] representing 46% of referrals (of the 37% who answered the question) told us that they see the Parties' sites as alternatives for at least some patients, while two[287] customers representing 54% of referrals told us that the Parties' sites are not alternatives. One[288] customer believed that the services are similar but differentiated by the size of wards. They had sent a particularly difficult patient to Alders instead of Kewstoke because they felt that they would be too disruptive in the smaller environment. They said that if either of the Parties sites were full they were each other's next best alternative.

9.64 We noted that, while customers representing 54% of referrals (out of those that answered the question) suggested that the Parties do not compete, these customers have only referred to Cygnet Kewstoke and not to CAS Alders. On the other hand, the customers who believed the sites were alternatives for some patients had all sent a small number of patients to either site in the past. However, these customers thought that the sites were only alternatives for some patients.

9.65 We received customer information comparing the services of Cygnet Bierley's Bowling ward with the two CAS facilities, Acer Clinic and Aspen Lodge, from four customers.[289] These four customers account for 40% of the referrals to the three sites since 1 January 2016.

9.66 Evidence from customers on whether they saw Cygnet Bierley and CAS Aspen and CAS Acer as alternatives was mixed. All customers told us that there was substantial differentiation between the Parties' wards. However, most[290] also told us that the same type of patient could be sent to either Cygnet or CAS. One customer[291] stated that the range of facilities offered at Cygnet Bierley, particularly PICU, meant they were better placed to handle emergencies and therefore were better suited for complex patients than the stand-alone sites of CAS. Another[292] said that the same types of patient could be sent to either CAS sites or to Cygnet Bierley, but they offered different treatments and the outcomes would not necessarily be the same. Treatments offered by Cygnet were more specialised than those offered by CAS and

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286 [✂]
287 [✂]
288 [✂]
289 [✂]
290 [✂]
291 [✂]
292 [✂]

therefore tended to produce better results. Two customers stated that although they did treat the same patient groups they would only use one of the providers. One[293] because CAS is too far South and the other[294] because they were unhappy with the service provided by Cygnet Bierley.

9.67 The customer evidence we received was mixed and in some cases based on a small number of patients sent to Cygnet and/or CAS sites.

Provisional conclusion on closeness of competition

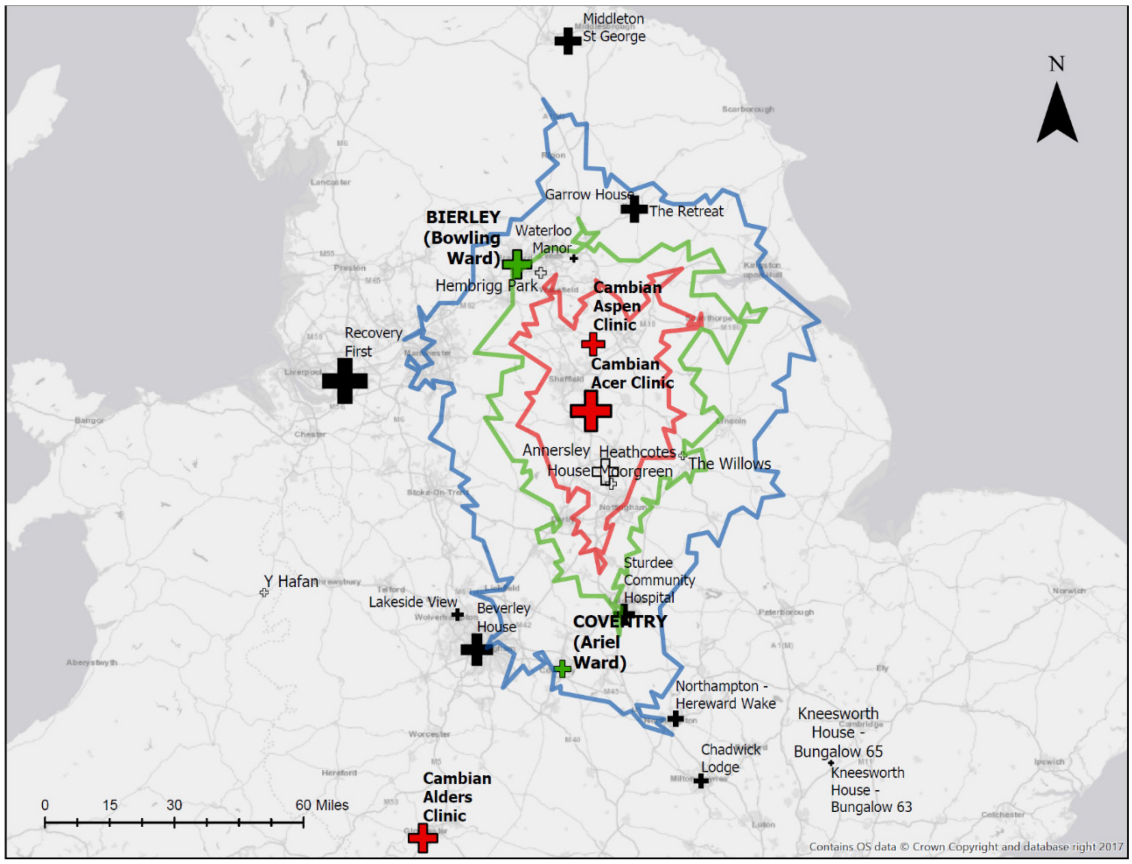
9.68 We received evidence showing that Cygnet and CAS serve different types of PD patients. The evidence from customers is mixed and it is based on a small number of customers using Cygnet and/or CAS sites. On balance, whilst there is likely to be some overlap in the parties' offerings, given the degree of differentiation between the Parties' PD facilities, this overlap is likely to be small. Therefore, our provisional view is that the Parties do not closely compete in female PD and are likely to represent a limited competitive constraint on each other, something which we take into account in our local assessments below.

Yorkshire and Humber – female PD

9.69 We investigated the overlap between CAS's two female PD sites (Acer and Aspen) and Cygnet's Bierley (Bowling Ward). We centred the catchment areas on CAS's Acer site. We assessed market shares, capacity constraints, geographic differentiation and quality competition. Third party views are covered above in the assessment of product differentiation.

[293] [✂]
[294] [✂]

Figure 22: The catchment areas for female PD in Yorkshire and Humber



45, 60, 90 minutes drive time
Centroid

Polygons
ToBreak
45 Cutoff Range: 0 - 45
60 Cutoff Range: 45 - 60
90 Cutoff Range: 60 - 90

Cambian Beds
20

Cygnet Beds
10

Competitor Beds
20

Competitor Beds (Sensitivity)
10

Source: CMA analysis.

Market shares

9.70 Table 14 shows the market shares of the Parties and of their competitors.

Table 14: Market shares for female PD in Yorkshire and The Humber

	%	
	Base-case 60 miles	*Extending to 65 miles*
CAS	[✂] [30–40]	[✂] [30–40]
Cygnet	[✂] [10–20]	[✂] [10–20]
Combined	[✂] **[40–50]**	[✂] **[40–50]**
Priory	[✂] [5–10]	[✂] [5–10]
Heathcotes Group	[✂] [10–20]	[✂]10–20]
Lighthouse	[✂] [0–5]	[✂] [0–5]
Inmind	[✂] [20–30]	[✂] [20–30]
Northern Pathways	[✂] [0–5]	[✂] [5–10]

Source: CMA calculations based on data submitted by the Parties.

9.71 In calculating market shares, we excluded the following competitors identified to us by the Parties, based on the evidence provided to us: Elysium Brierley Court Independent Hospital,[295] The Retreat York,[296] and Priory 255 Lichfield Road.[297]

9.72 The Parties have combined market shares of [✂] [40–50]% with an increment of [✂] [10–20]%. They are the first and third largest providers. There are two other large providers (Inmind with a [✂] [20–30]% share and (Heathcotes Group with a [✂] [10–20]% share) and two other smaller providers (Priory with a [✂] [5–10]% share) and (Lighthouse with a [✂] [0–5]% share).

Capacity constraints

9.73 The CAS sites are operating [✂]. This is also true for the Cygnet site for 2016 but over the three-year period 2014 to 2016 this site has had [✂]. Given that we provisionally find that the Merger may not be expected to result in an SLC in this local overlap area, we do not need to conclude on capacity constraints.

Geographic differentiation

9.74 The Parties' sites are within 54 miles of one another and therefore are not close geographic competitors. There are four sites that are closer to CAS Acer than Cygnet Bierley: Priory Annesley (20 miles), Heathcote's Moorgreen and Heathcote's Hembrigg Park (24 and 44 miles from CAS Acer respectively) and Inmind Waterloo Manor (45.6 miles from CAS Acer). Inmind Sturdee Community Hospital is 57 miles from CAS Acer.

Closeness of competition on quality

9.75 The Parties sites have 'Good' CQC ratings as does Priory Annesley and Inmind Sturdee Community Hospital. Heathcote's Moorgreen and Inmind Waterloo Manor have 'Requires Improvement' CQC ratings and Heathcote's Hembrigg Park has not been inspected. We have no occupancy rates for these three sites.

[295] [✂]
[296] This hospital has a CQC 'Inadequate' rating and we understand it does not compete for new referrals. This may change if / when it addresses its CQC rating.
[297] This provider has told us that this unit is not a specialised PD unit but can accommodate PD comorbidities.

Provisional conclusion

9.76 The Parties' post-Merger combined market share is [✂] [40–50]% with a [✂] [10–20]% increment. There is one other large provider, which has a [✂] [20–30]% share and two smaller providers. The Parties are not close geographic competitors. Moreover, our assessment of product differentiation shows that to the extent that the Parties compete, they do so only over a very small group of patients. They are not close competitors.

9.77 Based on the above, we provisionally conclude that the Merger may not be expected to result in an SLC in female PD for the overlap in Yorkshire and The Humber.

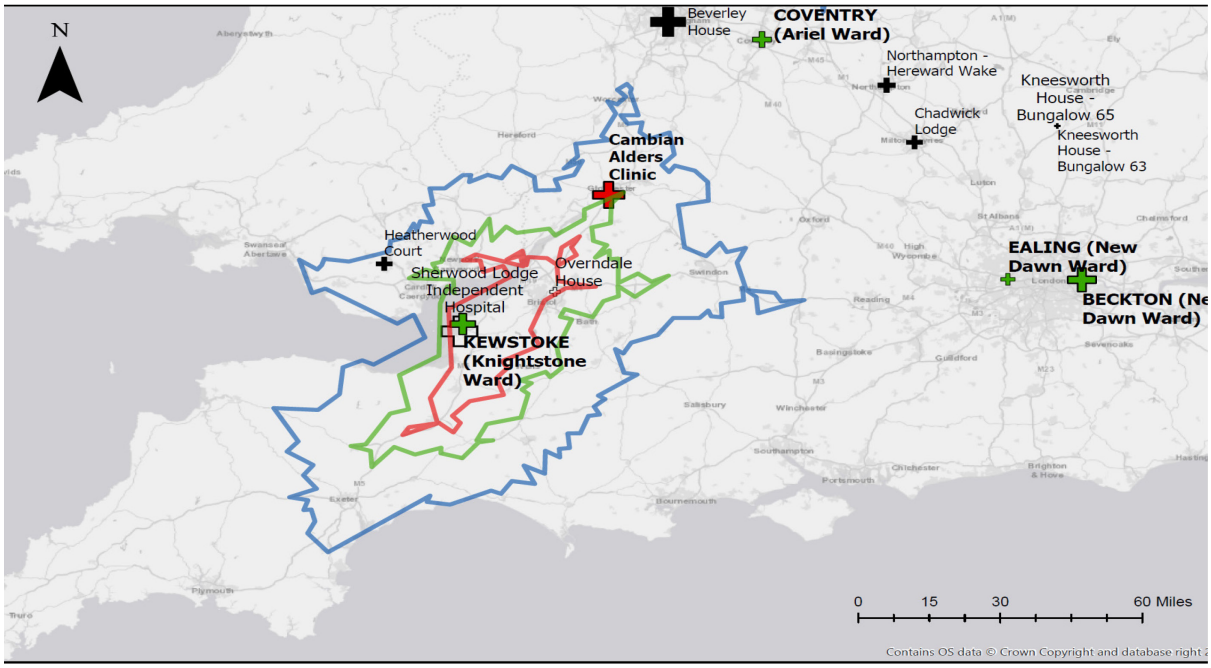
Countervailing factors.

9.78 Because of our provisional finding that the Merger may not be expected to result in an SLC, we did not investigate countervailing factors.

South West – female PD

9.79 We investigated the overlap between Cygnet's Kewstoke (Knightstone Ward) and CAS's Alders Clinic. We centred the catchment areas on Cygnet Kewstoke. We assessed market shares, capacity constraints, geographic differentiation and quality competition. Third party views are covered above in the assessment of product differentiation.

Figure 23: The catchment areas for female PD in South West England and South Wales



Source: CMA analysis.

Market shares

9.80 Table 15[298] shows the market shares of the Parties and of their competitors.

Table 15: Market shares for female PD in South West England and South Wales

%

	Base-case 60 miles	*Extending to 65 miles*
Cygnet	[✂] [30–40]	[✂] [20–30]
CAS	[✂] [40–50]	[✂] [30–40]
Combined	[✂] [80–90]	[✂] [60–70]
Sherwood Lodge	[✂] [10–20]	[✂] [5–10]
Ocean Community Services	[✂] [5–10]	[✂] [5–10]
Ludlow Street Healthcare	[✂] [0–5]	[✂] [20–30]

Source: CMA calculations based on data submitted by the Parties.

9.81 In calculating market shares, we excluded the following competitors identified to us by the Parties, based on evidence provided to us by third parties or our

[298] Market shares may not sum to 100% due to rounding.

own desk research, seeking to corroborate from more than one source where possible: Elysium The Copse[299] and Priory Hospital Bristol.[300]

9.82 The Parties would have post-Merger combined market share of [✂] [80–90]% with an increment of [✂] [40–50]%. They are by far the largest two providers. The other two providers each have shares of [✂] [10–20]% or less.

Capacity constraints

9.83 The Cygnet site has an average occupancy rate of around [✂]% whereas that of the CAS site is around [✂]%.

Geographic differentiation

9.84 The Parties' hospitals are within 49 miles of one another and therefore are not very close geographic competitors. The other two providers are much closer to Cygnet Kewstoke: Sherwood Lodge is 4 miles away and Ocean Community Services is 30 miles away.

Closeness of competition on quality

9.85 The Parties sites both have 'Good' CQC ratings as does Ocean Community Services. Sherwood Lodge has an 'Requires Improvement' CQC rating but its occupancy is high indicating that its CQC rating does not materially impact its competitiveness.

Provisional conclusion

9.86 The Parties' market shares are very high with a very high increment. They are not, however, close geographic competitors. These findings would suggest that the Merger might be expected to result in an SLC. However, our assessment of product differentiation shows that to the extent that the Parties compete, they do so only over a very small group of patients. They are not close competitors, so the market shares are not a good representation of the closeness of competition. We believe that the evidence supporting the finding on product differentiation is more persuasive than market shares.

9.87 Based on the above, on balance, we provisionally conclude that the Merger may not be expected to result in an SLC in female PD for the South West England and South Wales overlaps.

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[299] The provider told us it did not compete with PD sites as it is mainly an LTMH site.
[300] The provider told us it was not a specialist PD site.

Countervailing factors

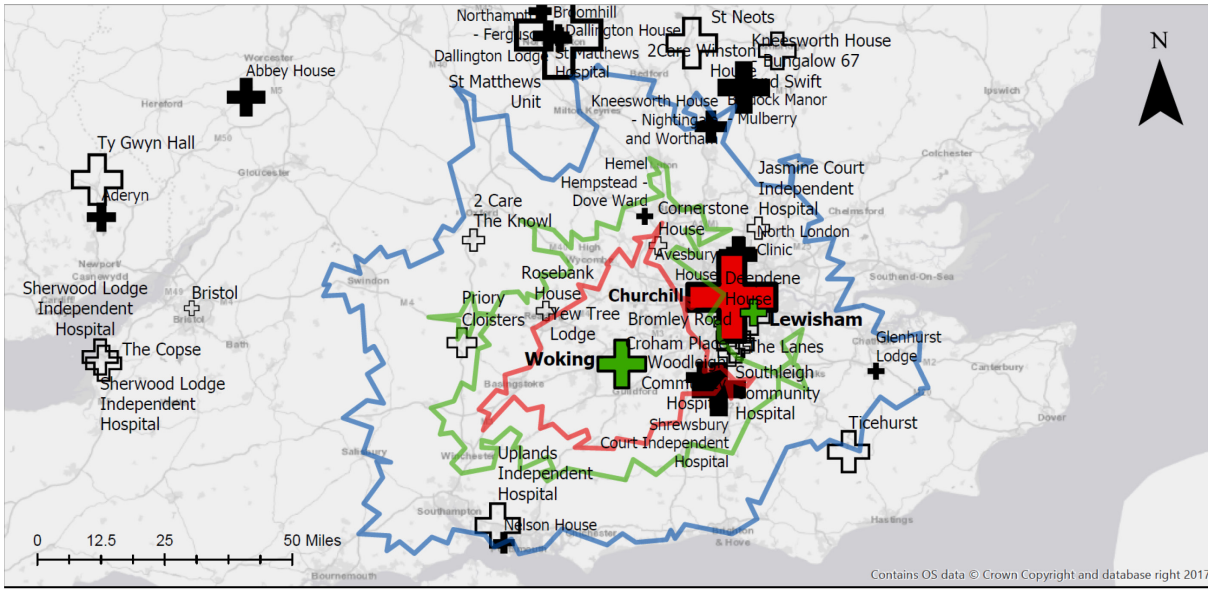
9.88 Because of our provisional finding that the Merger may not be expected to result in an SLC, we did not investigate countervailing factors.

London – male LTMH

9.89 We analysed the overlap between Cygnet Hospital Woking, Cygnet Hospital Lewisham and CAS Churchill. The Cygnet Woking, Cygnet Lewisham and CAS Churchill sites were identified for further analysis based on a filter using public transport travel times of 90 minutes.

9.90 Our analysis focused on the extent to which the Merger would reduce the choice of customers referring patients to Cygnet Woking by removing the independent alternative that the CAS Churchill site may currently provide to those customers.

Figure 24: The Catchments areas for male LTMH in London



45, 60, 90 minutes drive time Cygnet Cambian Competitors

Centroid

Polygons

ToBreak

45 Cutoff Range: 0 - 45

60 Cutoff Range: 45 - 60

90 Cutoff Range: 60 - 90

Beds 20

Beds 40

Competitor Beds 20

Competititors (sensitivity)

Competitor Beds (sensitivity) 30

Source: CMA analysis.

Market shares

9.91 In order to determine market shares in this overlap area, we used drive-times and public transport travel times rather than road distance because in our view, travel time was a more appropriate measure than distance in this area.

We found that 90 minutes' drive-time approximated a 60-mile road distance on average across the country and used this to identify competitors.

9.92 Our analysis centred on Cygnet Woking as combined market shares were highest here. We investigated whether drive-time or public transport travel time were likely to be relevant modes of transport from the perspective of Woking. We thought public transport may be more relevant for journeys into London and drive-time may be more relevant for travel outside of London in Surrey. Therefore, we thought it appropriate to combine competitor sets based on both drive-time and public transport travel time when calculating market shares. We found that the competitors identified when defining the catchment area in terms of public transport travel time were a subset of the set of competitors identified when defining the catchment area in terms of drive-time. We have therefore focused on market shares based on a 90-minute drive-time from Woking. On this basis, we found the Parties have a combined market share of [✂] [20–30]% with a [✂] [10–20]% increment. They are currently the second and third largest providers within the catchment area. Priory is the largest provider and would remain the largest provider following the Merger. This information is set out in the table below.[301]

Table 16: Market shares for male LTMH in London

	%
	Base-case 90 minutes' drive-time
Cygnet	[✂] [10–20]
CAS	[✂] [10–20]
Combined	[✂] **[20–30]**
Elysium	[✂] [10–20]
Whitepost	[✂] [5–10]
Vision Healthcare	[✂] [0–5]
The Lane Project	[✂] [0–5]
Priory	[✂] [20–30]
Inmind	[✂] [5–10]
Bramley Health	[✂] [5–10]
Deepdene Care	[✂] [0–5]
Richmond Fellowship	[✂] [0–5]
Nouvita	[✂] [5–10]

Source: CMA calculations based on data submitted by the Parties and other providers.

Capacity constraints

9.93 We found that the Parties have [✂] across their sites in this overlap.

[301] Market shares may not sum to 100% due to rounding.

Geographic differentiation

9.94 We found that Cygnet Woking and CAS Churchill were distant (67-minute drive-time or 77-minute public transport time). Although CAS Churchill is the closest competitor by public transport to Cygnet Woking, there are other competitors that are closer in terms of drive-time, including Elysium, Whitepost, Inmind, Priory. Based on this evidence, in our view the Parties' sites are unlikely to be close competitors in terms of location.

Closeness of competition on quality

9.95 The Parties sites both have a 'Good' CQC rating and accordingly appear to be close competitors on quality. A large proportion of the local competitors have received a 'Requires Improvement' CQC rating and a small number of other providers in the area rated 'Good'. However, we note that several providers rated as 'Requires Improvement', were operating at high occupancy. This was consistent with the weak relation between a 'Requires Improvement' rating by CQC and occupancy that we observed at a national level. We therefore concluded there was no basis for excluding competitors that have received a 'Requires Improvement' rating from the relevant competitor set but we took into account whether they would exert a weaker competitive constraint.

Third party evidence

9.96 Customer evidence suggests that the Parties are not close competitors. In particular, [✂].[302]

9.97 Three of the Parties' customers had concerns about the Merger, but these customers accounted for only 6% of referrals since 1 January 2016. The concerns related to the possibility that the merged entity would increase prices.[303] One customer was also concerned that there may be reconfiguration of services post-Merger which could restrict supply in certain markets.[304] We placed limited weight on these customers' evidence because of the low number of referrals.

NHS providers

9.98 Nine customers collectively responsible for 27% of referrals to the Parties' sites in the area since 1 January 2016 gave us evidence on the use of NHS

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[302] [✂]
[303] [✂]
[304] [✂]

rehabilitation services. Five[305] (accounting for 45% of referrals from responding customers) stated that there was no local supply of NHS services, two[306] (accounting for 27% of referrals from responding customers) stated that they use NHS providers first and two[307] (accounting for 27% of referrals from responding customers) stated that they treat the NHS providers and private sector providers equally. Overall, in our view, this evidence suggests that NHS providers do not compete with independent providers, at least from the perspective of most customers in the London area. However, we did not need to conclude on this point as we provisionally found an SLC was not expected to result from the Merger, even without accounting for NHS provision.

Provisional conclusion on London male LTMH

9.99 The Parties have low market shares and are geographically distant. We found the CQC rating was not a strong competitive differentiator in terms of closeness of competition and customer evidence on closeness of competition was mixed. Taking into account weaker competitive constraints from providers with 'Requires Improvement' CQC ratings does not alter these results. Based on the evidence outlined above, we provisionally conclude that the Merger may not be expected to result in an SLC in this overlap area.

Countervailing factors

9.100 Because of our provisional finding that the Merger may not be expected to result in an SLC, we did not investigate countervailing factors.

Yorkshire – male LTMH

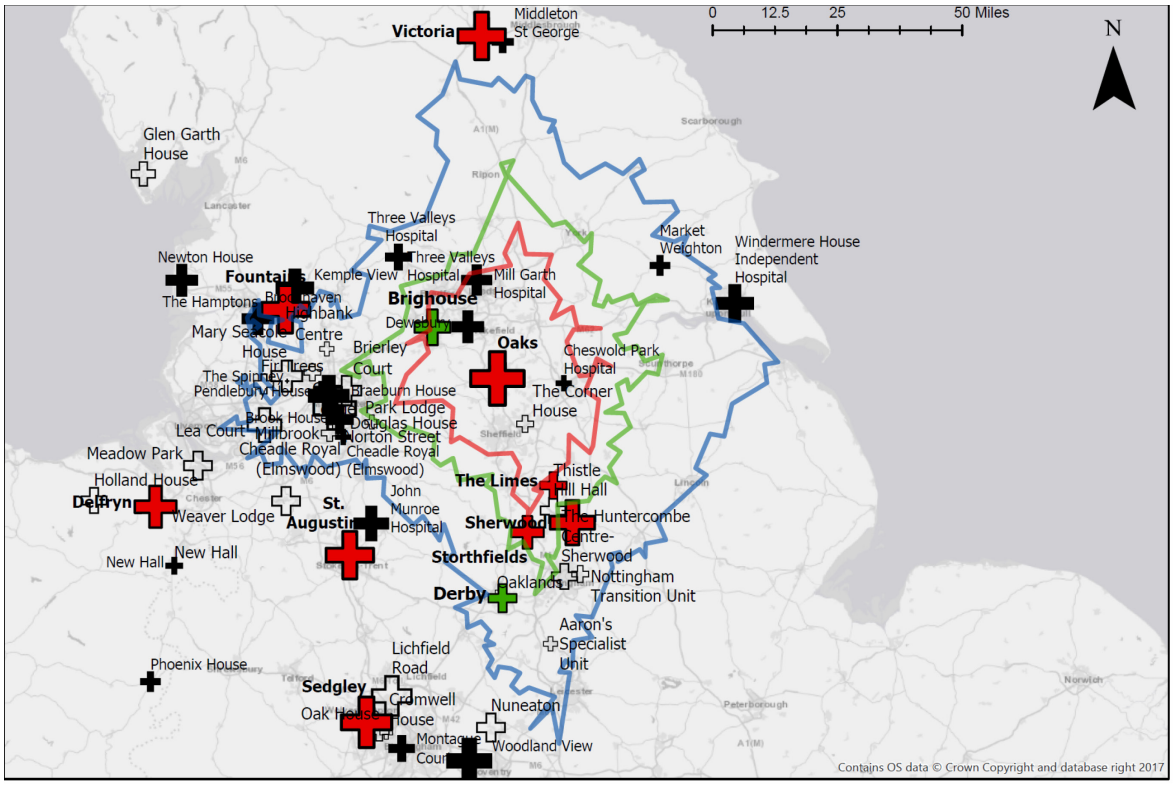
9.101 The catchment area for male LTMH in Yorkshire overlaps to some extent with the catchment area for male LTMH in East Midlands though, as we show below, the degree of competition between the Parties and the other providers is different.

9.102 We investigated the overlap we identified between Cygnet Brighouse and CAS Oaks. To assess market shares we centred on Cambian Oaks. The Parties also have the following wards within the 60-mile catchment area: CAS The Limes, CAS Storthfields House, CAS Sherwood House and Cygnet Derby. As these wards are within the catchment area and offer the same

[305] [✂]
[306] [✂]
[307] [✂]

services as Cygnet Brighouse and CAS Oaks, we included these wards in our calculations of market shares.

Figure 25: The catchment areas for male LTMH in Yorkshire



Source: CMA analysis.

Market shares

9.103 The Parties' post-Merger combined share of capacity is [✂] [30–40]% with a [✂] [10–20]% increment. These shares, along with the key competitors in the area are shown in the table below:[308]

[308] Market shares may not sum to 100% due to rounding.

Table 17: The market shares for male LTMH in Yorkshire

	%
	Base-case 60 miles
Cygnet	[✂] [10–20]
CAS	[✂] [20–30]
Combined	[✂] **[30–40]**
Turning Point	[✂] [5–10]
Priory	[✂] [10–20]
Riverside Healthcare	[✂] [0–5]
Debdale Specialist Care Ltd	[✂] [0–5]
Deepdene Care	[✂] [5–10]
Equilibrium	[✂] [5–10]
Elysium	[✂] [5–10]
Huntercombe	[✂] [0–5]
John Munroe Group	[✂] [5–10]
Nottinghamshire Healthcare NHS Foundation Trust	[✂] [0–5]
Rotherham, Doncaster and South Humber NHS Trust	[✂] [0–5]

Source: CMA calculations based on data submitted by the Parties and other providers.

9.104 In calculating market shares, we excluded the following competitors identified to us by the Parties, based on evidence provided to us by third parties and our own findings, seeking to corroborate from more than one source where possible: Barchester Forest Hospital and Arbour Lodge[309], Craegmoor Healthcare,[310] Alternative Futures[311] and Turning Point Nottingham Transition Unit.[312]

9.105 While we consider it appropriate to exclude these providers, we note that the Parties have told us that they consider themselves to compete with Turning Point Nottingham Transition Unit. Inclusion of these beds in our calculations would have a very limited effect, reducing market shares from [✂] [30–40]% to [✂] [30–40]%.

9.106 Re-allocating the beds in LTMH/PD facilities as per the Parties' suggestion would also have a minimal impact on the Parties' combined market share, reducing it to [✂] [30–40]%.

9.107 Based on these market shares, the Parties are the first and third largest providers of male LTMH rehabilitation services within the 60-mile catchment area. Priory is the second largest provider with a [✂] [10–20]% market share.

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[309] Arbour Lodge admission criteria on its website suggest that it is for over 50s and Forest Hospital mentions treatments for Huntingtons and dementia suggesting it is also for the elderly. Barchester submits that it does not compete with the Parties and one customer has confirmed that it provides services for elderly patients.
[310] This hospital does not have a website and is listed on the CQC website as having been acquired by Priory Dewsbury (which is already included in our competitor set).
[311] This provider has informed us that its services are not comparable to those of the Parties.
[312] The description of this facility and admission criteria from its website suggests that it focuses on short stay accommodation (maximum of eight weeks) for adults who are fit to be discharged rather than on long-term rehabilitation.

The remainder of the market is fragmented with nine other providers each with shares of less than 10%.

Capacity constraints

9.108 The evidence shows that all CAS sites in the overlap area [✂] whereas Cygnet Brighouse has [✂]. In addition, some competitors, including for example Priory Dewsbury, [✂]Given that we do not find a provisional SLC in this area, we do not need to conclude on capacity constraints.

Geographic differentiation

9.109 Brighouse, the closest Cygnet site to CAS Oaks is located 21 miles away. The only other competitor closer to CAS Oaks is the Cheswold Park Hospital at 16.9 miles. However, it is smaller (11 beds compared to CAS Oaks 36) and has an 'Requires Improvement' rating compared to CAS Oaks' 'Good'.

9.110 Whilst CAS Oaks and Cygnet Brighouse are geographically close competitors, we found calculating market shares on a narrower basis (for example 30 miles) did not substantially increase the Parties' market shares. This is because the Parties' market shares in a 60-mile catchment also included their beds at their East Midlands sites.[313]

9.111 Widening the catchment area to 65 miles did not materially affect the Parties' market shares. This is because the only site located between 60 and 65 miles from CAS Oaks is Alternative Future's Weaver Lodge, a 20-bed mixed gender unit for LTMH/PD patients. We have excluded the Alternative Futures sites from the relevant competitor set.[314]

9.112 Based on the evidence above, in our view, CAS Oaks and Cygnet Brighouse are close competitors geographically.

Closeness of competition on quality

9.113 All the Parties' facilities in this area have 'Good' CQC ratings, while some other local providers have a 'Requires Improvement' rating.[315] Priory told us that occupancy at Dewsbury was negatively affected by its 'Requires Improvement' rating but it is hoping for this rating to be upgraded soon. As discussed in paragraphs 9.36 to 9.38 above, we think providers with a 'Requires Improvement' rating would still exert a competitive constraint on the

[313] Cambian The Limes, Cambian Storthfields House, Cambian Sherwood House and Cygnet Derby
[314] Alternative Futures is a charity mental health provider. This provider told us that the services it provides do not compete with the Parties.
[315] [✂]

Parties and therefore do not exclude them from the calculation of capacity shares but in our view the fact that all of the Parties' sites have 'Good' CQC ratings suggests they are close competitors in terms of quality.

Third party evidence

9.114 The evidence suggests that the Parties' sites are comparable, with several customers citing CAS and Cygnet sites as alternatives. Customers also named a number of other providers, mentioning two male LTMH sites, Huntercombe's Centre-Sherwood site and Options for Care's Montague Court, as comparable to those of the Parties. One customer suggested Turning Point and Rushcliffe Care was comparable to the Parties' sites.[316] We note that these sites are outside the 60-mile catchment area. In our view this customer comment is evidence of constraints from out of area. However, we did not consider it sufficient evidence to include these providers within market share calculation, in particular as a customer's preferences are likely to be dependent on its own location.

9.115 One customer suggested that mixed LTMH/PD wards did not provide a good environment for either LTMH or PD patients.[317] This customer also suggested that mixed gender hospitals were not commonly used for rehabilitation services and that it was not aware of any in the area.

9.116 Two customers,[318] responsible for 18% of referrals to the Parties' overlap sites, expressed concerns about the effect of the Merger on male LTMH. The larger[319] of these customers was concerned that the merged firm would have a monopoly in its local vicinity and had concerns about increased concentration leading to poorer outcomes, such as increased prices or reduced quality. This customer said that it currently refers patients to Cygnet Brighouse and CAS Oaks and suggested that it would only consider options within a much narrower catchment area than the 60-mile area used. The other customer[320] felt that previous mergers had had a disruptive effect on patients, with changes in management affecting delivery of planned interventions.

9.117 In our overall assessment of this local area, we took account of the concern of the larger customer. However, we noted that it was driven by the customer's location and so we did not consider that it would necessarily extend to other customers. We did not think the concern from the other customer related to the competitive effects of the Merger and so did not give it weight in our

316 [✂]
317 [✂]
318 [✂]
319 [✂]
320 [✂]

overall assessment. We considered that the customer evidence overall provided a mixed view of the alternatives to the Parties' sites. While it suggested that the Parties were close competitors, it also corroborated the constraint from a number of the other providers, which are included in our competitor set for calculating market shares.

NHS providers

9.118 For the overlap in male LTMH in Yorkshire we have evidence on the use of NHS rehabilitation services from seven customers collectively responsible for 54% of the referrals to the Parties' sites in the area since 1 January 2016. Five[321] of them (accounting for 57% of referrals from responding customers) stated that there was no local supply of NHS services, one[322] (accounting for 38% of referrals from responding customers) stated that it uses local supply first and one[323] (accounting for 5% of responding customers) stated that it treats the NHS providers and private sector providers equally.

9.119 The Parties identified to us several possible NHS providers of rehabilitation services in the area. As discussed in paragraphs 5.52 above, only two of these wards appeared to compete with independent providers, [✂]. We have included these in the calculation of market shares.

Provisional conclusion on Yorkshire male LTMH

9.120 The Parties have post-Merger market share of [✂] [30–40]% with a relatively small increment ([✂] [10–20]%). This market share may be overestimated due to some of the locations of the Parties' sites. Post-Merger, there will be a large number of reasonably-sized providers, one of which is a national provider, which will exert competitive pressure on the Parties. Two customers were concerned about effects of the Merger. However, in our view the concerns of one of these customers reflected its particular location and we did not believe that its concerns would necessarily extend to other customers. In our view, the concerns of the other customer related to possible disruption rather than a competitive effect of the Merger.

9.121 On the basis of the above, we have provisionally concluded that the Merger may not be expected to result in an SLC in this local area.

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[321] [✂]
[322] [✂]
[323] [✂]

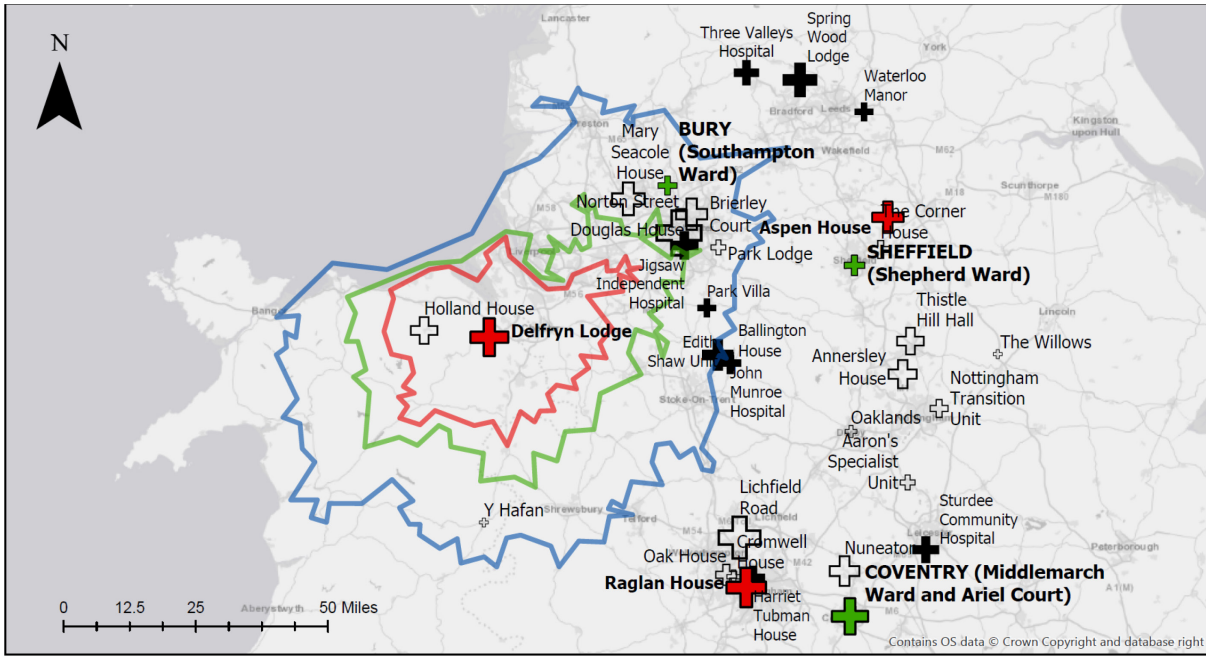
Countervailing factors

9.122 Because of our provisional finding that the Merger may not be expected to result in an SLC, we did not investigate countervailing factors.

Northern Wales and The North West – female LTMH

9.123 We investigated the overlap between Cygnet Bury, in North West England and CAS Delfryn Lodge in Northern Wales. Our filter identified this overlap for further assessment based on the sensitivity of excluding mixed gender wards.

Figure 26: The Catchment areas for female LTMH in the North West and Northern Wales



45, 60, 90 minutes drive time
Centroid
Polygons
ToBreak

90 Cutoff Range: 60 - 90
Competitor Beds (sensitivity)
20
Cygnet Beds

Competitor Beds
10
Cambian Beds
20

Source: CMA analysis.

Market shares

9.124 Cygnet Bury and CAS Delfryn Lodge are 59 miles apart. In order to determine market shares in this overlap area, we extended the catchment to 65 miles because of the distance between the Parties and the fact that several providers are located just beyond the catchment (to the East of Cygnet Bury). We also checked market shares on a 60-mile basis as a sensitivity.

Table 18: Market shares for female LTMH in the North West and Northern Wales

%

	Base case 65 miles	*60 miles*
CAS	[✂] [10–20]	[✂] [10–20]
Cygnet	[✂] [5–10]	[✂] [5–10]
Combined	[✂] [20–30]	[✂] [20–30]
John Munroe Group	[✂] [20–30]	[✂] [10–20]
Priory	[✂] [10–20]	[✂] [10–20]
Equilibrium	[✂] [10–20]	[✂] [10–20]
Deepdene Care	[✂] [5–10]	[✂] [5–10]
Lighthouse	[✂] [5–10]	[✂] [0–5]
Active Pathways	[✂] [0–5]	[✂] [0–5]
Northern Healthcare Ltd	[✂] [0–5]	[✂] [5–10]
MHC	[✂] [0–5]	[✂] [0–5]
Elysium	[✂] [10–20]	[✂] [10–20]
Turning Point	[✂] [0–5]	[✂] [0–5]

Source: CMA calculations based on data submitted by the Parties and other providers.

9.125 In a 65-mile catchment post-Merger, the Parties would have a combined market share of [✂] [20–30]% with a [✂] [5–10]% increment. The Parties are the second and fifth largest providers within the catchment area. There are three large competing providers, each with high market shares: John Munroe Group, Priory and Equilibrium.

Capacity constraints

9.126 We found that the Parties have [✂] across their sites in this overlap. Given that we have not found that the Merger may be expected to result in an SLC in this area, we do not need to conclude on capacity constraints.

Geographic differentiation

9.127 Cygnet Bury and CAS Delfryn Lodge are distant (59 miles) from one another and therefore are unlikely to compete closely geographically.

9.128 As illustrated on the map, most of the competitors captured within the 60-mile catchment area are located between the Parties' hospitals and so are geographically closer competitors to the Parties than they are to each other. In addition, there are several competitors located just outside the 60-mile catchment area, including Elysium Bierley Court, the John Munroe Hospital and Edith Shaw Unit, Active Pathways Bamber Bridge, and Lighthouse Ballington House. For this reason and given the Parties are approximately 60 miles from one another, we decided that greater weight should be placed on market shares calculated on a 65-mile catchment.

Closeness of competition on quality

9.129 The Parties have a 'Good' CQC rating and accordingly appear to be close competitors on quality. A small number of the competitors within the overlap area have received a 'Requires Improvement' rating and a small number of other providers in the area rated 'Good'. However, given the weak relation between 'Requires Improvement' CQC ratings and occupancy that we observed at a national level, we did not find a basis for excluding competitors that have received a 'Requires Improvement' rating from the relevant competitor set but we took into account whether they would exert a weaker competitive constraint.

Third party evidence

9.130 The evidence we received from one customer[324] responsible for 10% of referrals, was that Cygnet Bury was their preferred facility due to geographic locality, with CAS Delfryn Lodge the next best alternative and John Munroe Hospital as a next best alternative to Delfryn Lodge. This customer was concerned there would be limited price competition due to the Parties having a local monopoly.

9.131 We noted this concern in our overall assessment. However, we also noted that it came from only one customer responsible for a limited number of referrals.

NHS providers

9.132 We received no evidence from customers in this area on the use of NHS providers. However, we did not need to conclude on the constraint from NHS providers due to the Parties geographic differentiation and low combined market share, even without accounting for NHS provision.

Provisional conclusion on North West and northern Wales female LTMH

9.133 Based on the evidence outlined above, we provisionally conclude that the Merger may not be expected to result in an SLC in this overlap area. In particular, the post-Merger market shares of the Parties are low ([✂] [20–30] %) and they are geographically distant competitors. We also note they will continue to face significant competition from three large providers, which together account for a share over [✂] [40–50]% and number of other providers, which together account for a share over [✂] [30–40]%. Taking into

[324] [✂]

account weaker competitive constraints from providers with 'Requires Improvement' CQC ratings does not alter these results.

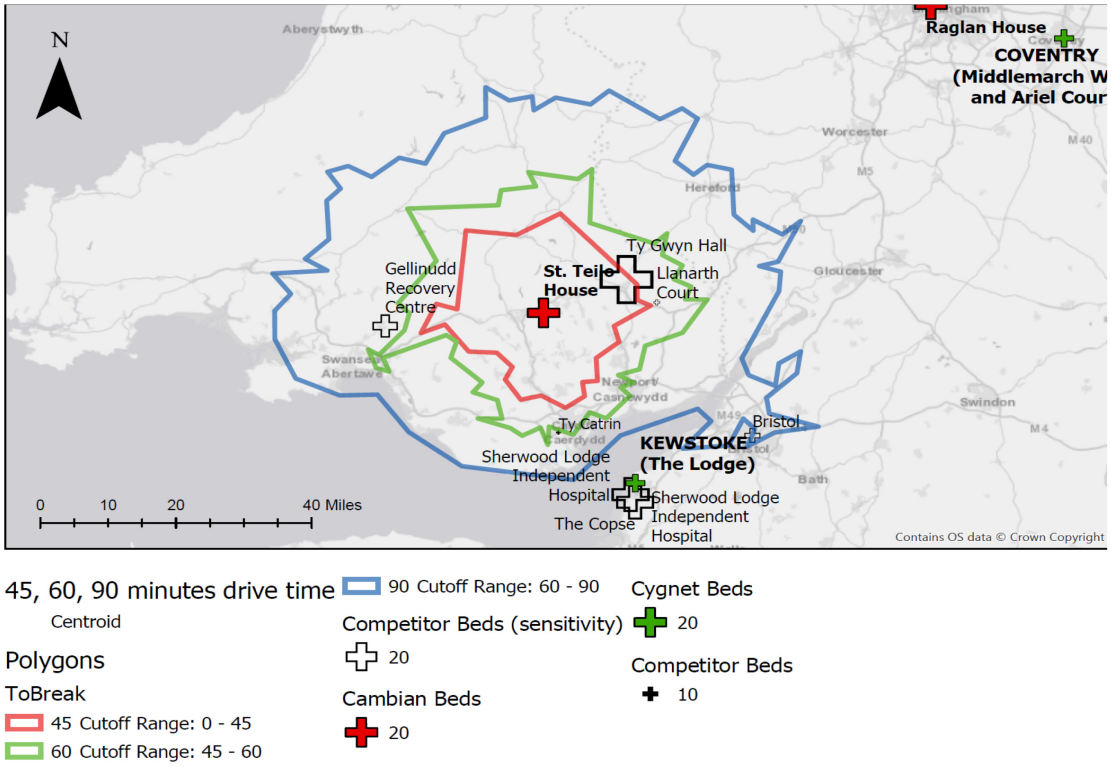
Countervailing factors

9.134 Because of our provisional finding that the Merger may not be expected to result in an SLC, we did not investigate countervailing factors.

Southern Wales and The South West – female LTMH

9.135 We have considered the overlap between Cygnet Kewstoke (The Lodge) and CAS St Teilo. Cygnet Kewstoke is located in South West England near Weston-Super-Mare, while Cambian St Teilo is in Southern Wales in Rhymney.

Figure 27: The Catchment areas for female LTMH in the Southern Wales and The South West



Source: CMA analysis.

Market shares

9.136 Because of the distance between the Parties' sites (74 miles), we calculated market shares within a wider catchment area of 80 miles. We centred our analysis of the competitor set and of market shares on CAS St Teilo as market shares were greater (and so had been identified for further analysis by our filter) on this basis.

9.137 The Parties have a post-Merger combined market share of [✂] [40–50]% with a [✂] [10–20]% increment. The Parties are the first and third largest providers within the catchment area. After the Merger the Parties would continue to face competition from two national providers, Elysium and Priory, one large competitor, Sherwood and two smaller competitors. Our calculated market shares are shown in the table below.

Table 19: Market shares for female LTMH in South West and South Wales

	80 miles (%)
CAS	[✂] [20–30]
Cygnet	[✂] [10–20]
Combined	[✂] **[40–50]**
Elysium	[✂] [20–30]
Priory	[✂] [5–10]
Hafal	[✂] [5–10]
Ocean Community Services	[✂] [0–5]
Sherwood Lodge	[✂] [10–20]

Source: CMA calculations based on data submitted by the Parties and other providers.

Capacity constraints

9.138 We found that both Cygnet Kewstoke and CAS St Teilo had spare capacity. On this basis, we did not find capacity constraints to be a factor limiting competition in this overlap.

Geographic differentiation

9.139 We found that CAS St Teilo and Cygnet Kewstoke (the Lodge) were geographically distant (74 miles). We noted that there were competitors located close to the Parties' sites, in particular that Elysium had sites close to both CAS St Teilo (19 miles) and Cygnet Kewstoke (5 miles). In addition, there are three other providers that are closer to CAS St Teilo than Cygnet Kewstoke. Accordingly, we did not view the Parties as close competitors geographically, relative to other providers.

9.140 In order to assess whether CAS St Teilo and Cygnet Kewstoke (the Lodge) were likely to be competing in spite of the geographic distance between them, we assessed referral data.

9.141 The Parties' and third parties' evidence was that NHS Wales commissions rehabilitation services on the basis of a national framework and tries to keep patients in Wales wherever possible tending not to refer to providers in England. Data from patient referrals to Cygnet Kewstoke The Lodge supported this with only [✂] of the [✂] referrals to The Lodge since the beginning of 2016 coming from Welsh customers.

9.142 We analysed the Parties' referral data to understand whether the same customers had referred patients to both Parties in the past.

9.143 We found that [✂] [20–30]% of the patients referred to St Teilo since 2015 were from customers who had also referred to Kewstoke The Lodge, and [✂] [40–50]% of the patients referred to Kewstoke The Lodge were from customers who had also referred to St Teilo. In our view, this evidence indicated that CAS St Teilo and Cygnet Kewstoke (the Lodge) may compete despite the distance between them.

Closeness of competition on quality

9.144 As noted in paragraph 2.13(c), facilities in Wales are assessed by the HIW. Because of the two different quality assessment regimes,[325] it is more difficult for us to make a direct comparison on whether the Parties compete closely on quality in this overlap.

9.145 Kewstoke was rated 'Good' by the CQC. Given the lack of data on quality from Wales, we could not conclude on whether the Parties were particularly close competitors on quality, relative to the other providers in the catchment area. While Sherwood Lodge has a 'Requires Improvement' rating, we also noted its high occupancy, suggesting that this rating did not materially affect referrals to it. This was consistent with the weak relation between 'Requires Improvement' ratings and occupancy that we observed at a national level but we took into account whether competitors with such ratings might exert a weaker competitive constraint. We therefore concluded there was no basis for excluding Sherwood Lodge from the relevant competitor set.

Third party evidence

9.146 Customer evidence in relation to this overlap did not suggest the Parties were particularly close competitors. One customer cited Elysium's the Copse as the next best alternative to CAS's St Teilo facility.[326] Another customer believed there were no nearby alternatives for female LTMH patients.[327] One customer believed that Kewstoke did not offer LTMH female services and instead considered Kewstoke The Lodge ward as a female PD ward.[328] On the other

[325] In particular, in Wales, the HIW does not publish quality ratings in contrast to the CQC's practice in England.
[326] [✂]
[327] [✂]
[328] [✂]

hand, one customer said that the two sites were broadly comparable and were its preferred sites in the area for female LTMH.[329]

9.147 Four[330] customers of the Parties' sites in this area had concerns about the Merger. These customers collectively account for 23% of the referrals to the Parties' sites since 1 January 2016. All four were concerned about potential increases in price. One[331] citing that previous mergers had impacted price and choice in the area. Another two[332] were concerned that the Merger would affect other parameters such as quality of service and length of stay.

NHS providers

9.148 We received evidence on the use of NHS rehabilitation services from seven customers collectively responsible for 39% of the referrals to the Parties' sites in the area since 1 January 2016. Three[333] (accounting for 50% of referrals from responding customers) stated that there is no local supply of NHS rehabilitation services. Four (accounting for 50% of referrals from responding customers) said that they used NHS providers first. None of these customers stated that they treat the NHS providers and private sector providers equally. In our view this evidence suggests that NHS providers do not act as a competitive constraint on the Parties.

Provisional conclusion on South West and Southern Wales female LTMH

9.149 Post-Merger the Parties will have a combined market share of [✂] [40–50]%. There are two other large competitors in the area accounting for broadly the same share as the Parties and a further three competitors, which together account for a [✂] [20–30] % share. The Parties are geographically distant and several other providers are geographically closer to the Parties' sites. Taking into account weaker competitive constraints from providers with 'Requires Improvement' CQC ratings does not alter these results. There were third party concerns, which we have taken into account in our overall assessment.

9.150 Based on the above evidence, on balance we provisionally conclude that the Merger may not be expected to result in an SLC in this overlap.

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[329] [✂]
[330] [✂]
[331] [✂]
[332] [✂]
[333] [✂]

Countervailing factors

9.151 Because of our provisional finding that the Merger may not be expected to result in an SLC, we did not investigate countervailing factors.

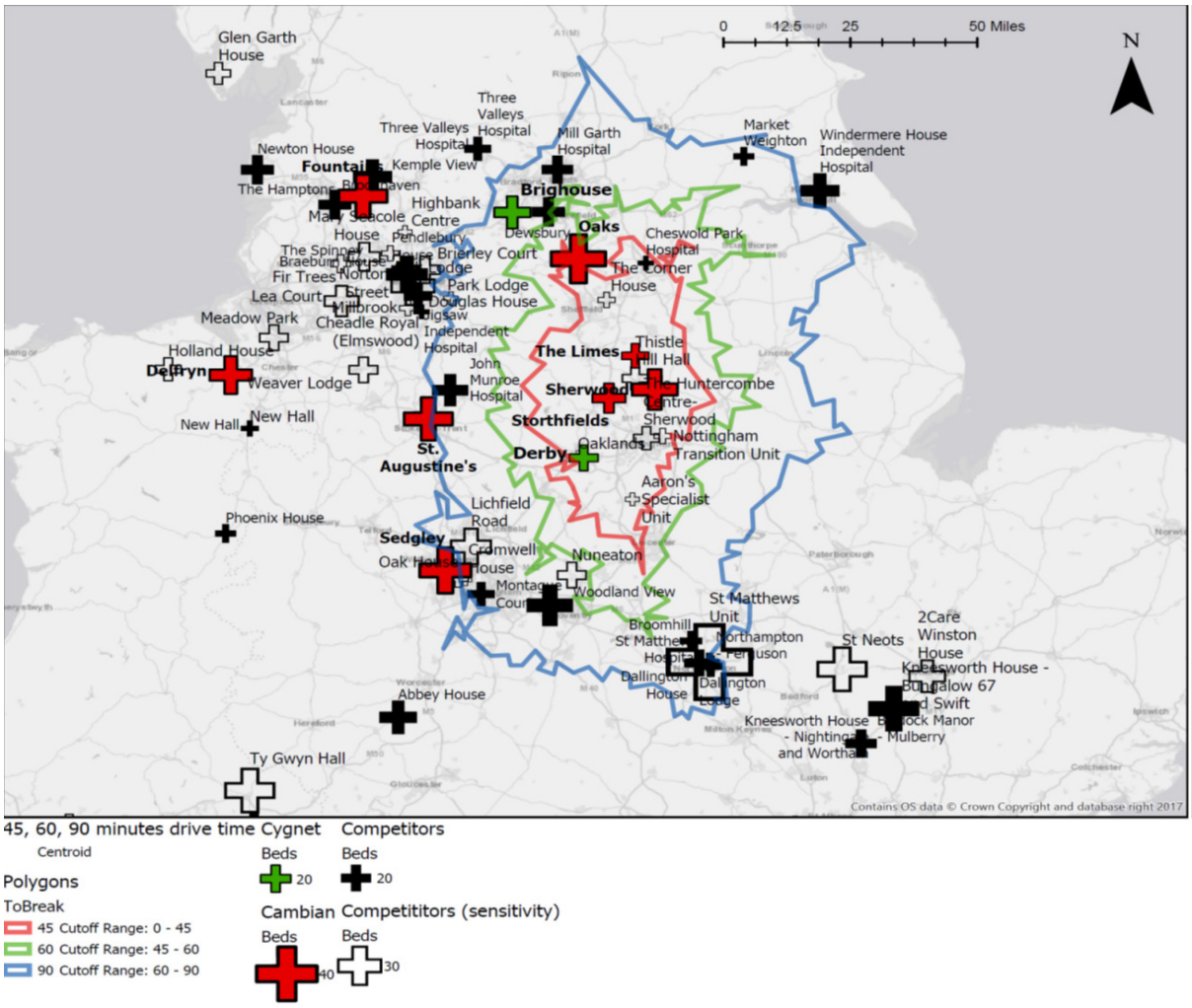
East Midlands – male LTMH

9.152 We investigated the overlap between Cygnet Hospital Derby (Wyvern Ward) and three CAS sites (Storthfield House, Sherwood House and The Limes). To assess capacity shares in this overlap we centred on CAS Storthfield House as this is where the Parties' market shares are highest. However, it makes little difference to the analysis as the market shares (shown in Table 20 below) are similar if centred on Cygnet Derby, CAS Sherwood House or CAS the Limes as they are all within 20 miles of each other.

9.153 Within the 60-mile catchment area, the Parties have additional wards providing male LTMH at Cygnet Lodge Brighouse and the CAS facilities St Augustine's and The Oaks. These are included when calculating shares of capacity, though our assessment here is not primarily focused on the overlaps with these wards.[334]

[334] Cygnet Brighouse is captured below in our assessment of 'Yorkshire – LTMH male'. The market shares when centred on CAS St Augustine's were not identified by our filtering as requiring further analysis.

Figure 28: The catchment areas for male LTMH in East Midlands



Source: CMA analysis.

Role of the East Midlands Rehabilitation Framework

9.154 The East Midlands Rehabilitation Framework agreement (the Framework) is an agreement administered by Hardwick CCG that covers 17 CCGs in the local area. The Framework provides a mechanism for these customers to collectively negotiate terms with providers of rehabilitation services. The Framework covers a range of rehabilitation services, including LTMH, PD, Asperger's, high-functioning autism and LD. It was implemented in April 2014 to last until end of March 2017 and was recently re-negotiated to last for an additional two years until March 2019.[335]

9.155 The Parties submitted that [✂].[336]

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[335] Parties response to phase 1 decision.
[336] Parties' response to the phase 1 decision, paragraphs 4.21 & 4.22.

9.156 The Parties submit that a [✂] proportion of patients are referred to its sites in this overlap area under the Framework. The Framework accounts for [✂]% of patients at Cygnet Hospital Derby, [✂]% of patients at Storthfield House, [✂]% of patients at Sherwood House and [✂]% of patients at The Limes.[337]

9.157 We compared prices for customers who have made referrals to Cygnet Derby using the Framework to customers who have made referrals to Cygnet Derby under other pre-negotiated agreements[338] or paid list prices.[339]

9.158 We found customers using the Framework paid a daily price of £[✂] for 2016/2017 for using Cygnet sites, [✂].Customers of the Parties' sites in this overlap with other pre-negotiated agreements paid [✂].[340]

9.159 While the Framework sets binding terms specifying price and quality, in our view it is still relevant to consider what effect the Merger may have on competition via the renegotiation of these terms with individual providers when it is renegotiated in 2019 and when prices are reviewed annually. If the Merger results in customers having fewer alternatives (or less alternative capacity) overall, then the merged firm may have the opportunity to negotiate higher prices than those that would arise absent the Merger, when the contracts with providers under the Framework are renegotiated. Similarly, the level of quality may be lower than it would be absent the Merger.

9.160 We do not agree with the Parties that [✂]. The Framework is not a traditional bidding market where there is competition 'for the market' and a single winner. Rather, it sets out a basis for aggregating customer volume to negotiate common terms with providers,[341] several of whom are needed to join the agreement to meet the substantial aggregate supply requirements of the customers on the Framework.

9.161 In our view, the Framework appears to be more relevant to allowing customers to exercise buyer power and we have examined that in paragraph 9.185 to 9.192 below.

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[337] Parties' response to the phase 1 decision, paragraph 4.20.
[338] The customers with pre-negotiated agreements but not on the Framework who have sent patients to Cygnet Derby since 2016 are [✂].
[339] The customers without pre-negotiated agreements who have sent patients to Cygnet Derby since 2016 are [✂].
[340] [✂]
[341] Each customer will face the same terms when using a given provider on the Framework. However, terms vary across providers.

Market shares

9.162 The Parties' post-Merger combined share of capacity is [✂] [50–60]% with a [✂] [10–20]% increment. These shares, along with the key competitors in the area are shown in the table below:[342]

Table 20: Market Shares for male LTMH in East Midlands

%

	Base-case 60 miles	*Extending to 65 miles*
CAS	[✂] [40–50]	[✂] [40–50]
Cygnet	[✂] [10–20]	[✂] [10–20]
Combined	[✂] **[50–60]**	[✂] **[50–60]**
Debdale Specialist Care Ltd	[✂] [0–5]	[✂] [0–5]
Huntercombe	[✂] [5–10]	[✂] [0–5]
Turning Point	[✂] [0–5]	[✂] [0–5]
Riverside Healthcare	[✂] [0–5]	[✂] [0–5]
John Munroe Group	[✂] [5–10]	[✂] [5–10]
Priory	[✂] [10–20]	[✂] [20–30]
Camino Healthcare	[✂] [0–5]	[✂] [0–5]
Options for Care	[✂] [0–5]	[✂] [0–5]
Bracken House (Nottinghamshire FT)	[✂] [0–5]	[✂] [0–5]
Coral Lodge (Rotherham, Doncaster and S Humber NHS Trust)	[✂] [0–5]	[✂] [0–5]

Source: CMA calculations based on data submitted by the Parties and other providers.

9.163 In calculating market shares, we have excluded the following competitors identified by the Parties, based on evidence provided to us which we corroborated from more than one source where possible: Barchester Forest Hospital and Arbour Lodge,[343] Camino Nuneaton Unit,[344] 225 Priory Lichfield Road (20-bed mixed ward),[345] Rushcliffe Care Group Aaron's Specialist Unit,[346] Craegmoor Healthcare[347] and Turning Point Nottingham Transition Unit.[348] While we consider it appropriate to exclude these providers, we note that the Parties stated that they consider themselves to compete with Aaron's Specialist Unit and Turning Point Nottingham Transition Unit. Inclusion of these beds in our calculations would reduce capacity shares from [✂] [55–65]% to [✂] [50–60]%.

[342] Shares may not sum due to rounding.
[343] Arbour Lodge admission criteria on its website suggest that it is for over 50s and Forest Hospital mentions treatments for Huntingtons and dementia suggesting it is also for the elderly. Barchester submits that it does not compete with the Parties and one customer has confirmed that it provides services for elderly patients.
[344] This hospital does not appear to have been completed from its website.
[345] Priory submits that this ward is not a rehabilitation facility but a step-down facility comprising independent self-managed flats.
[346] Rushcliffe Care Group submits that it does not compete with the Parties. On its website, this facility is described as a 30-bedded unit which is split evenly into three key areas and look after individuals with ABI, dementia and mental health difficulties and may put themselves or others at risk of harm.
[347] This hospital does not have a website and is listed on the CQC website as having been acquired by Priory Dewsbury (which is already included in our competitor set).
[348] The description of this facility and admission criteria from its website suggests that it focuses on short-stay accommodation (maximum of eight weeks) for adults who are fit to be discharged rather than on long-term rehabilitation.

9.164 The Parties are the two largest providers of LTMH Male rehabilitation services and along with Priory ([✂] [10–20]% market share) are the only three national providers in the 60 mile catchment area. There are five other smaller providers, including Debdale Specialist Care, Huntercombe, Turning Point, Riverside and John Munroe.

Capacity constraints

9.165 The Parties submit that Cygnet's Wyvern ward at Derby is [✂], and therefore cannot be considered a close competitor to the CAS sites in the East Midlands.

9.166 Each of CAS' sites in and just outside the 60-mile catchment area has an occupancy rate of close to or over [✂]% averaged over the three-year period 2014 to 2016 and also in 2017. The same is true for Cygnet's Derby site, which is the closest Cygnet site to the CAS sites at the centre of the catchment area. However, given that the Parties have the largest number of beds dedicated to male LTMH patients in the 60-mile catchment area (181 beds accounting for [✂] [50–60]% of the market), patient discharges will periodically free-up several of the Parties' beds. In addition, Cygnet has another site towards the edge of the catchment area (56 miles from CAS Storthfields), which has [✂] ([✂]% over the three-year period and [✂]% in 2016).

9.167 In our view these specific reasons together with those set out in paragraphs 9.20 to 9.28 show that the Parties, while being capacity constrained to some extent, will have some excess capacity that will give them the incentive and ability to compete for Male LTMH patients in the East Midlands area.

Geographic differentiation

9.168 We have considered the geographic closeness of competition between the Parties, including whether there is evidence specific to this area indicating that we should adopt a different catchment size.

9.169 The Parties told us[349] that [✂] patients at the Parties' sites in this area are referred under the Framework and that the area covered by the Framework (as defined by the boundaries of the CCGs that use it) extends more than 100 miles north to south and 90 miles east to west. They submit that this indicates that the site-specific catchment areas used by the CMA at phase 1 are too

[349] Parties' response to phase 1 decision, paragraph 4.8.

narrow and fail to reflect the area over which CCGs refer patients under the Framework.

9.170 While we have used average catchment areas in our phase 2 inquiry, we have nevertheless considered whether the area covered by the customers in the Framework might provide a better approximation of the geographic market.

9.171 We note that the area covered by the Framework does not appear materially larger than the geographic area defined by our 60-mile catchment area.[350] As mentioned above, only about [✂] of the patients referred to the Parties' sites in this overlap are referred under the Framework. Moreover, as the Parties' main four overlapping sites are at the northernmost end of the area covered by the Framework, the use of it to define the catchment area is unlikely to accurately capture the alternatives for customers not using the Framework, in particular those situated to the north.[351] For these reasons, we do not consider that the area covered by the customers in the Framework provides a better approximation for the geographic market.

9.172 The Parties highlight that customer referral data of the largest customers at each of the overlapping sites shows that almost all customers send patients to the Parties' other LTMH sites more than 75 miles away. They submit that this means customers are therefore likely to do so in relation to competitor sites. Similarly, the Parties note that their sites treat some patients from a significantly wider catchment area than is indicated by the site-specific catchment areas.[352]

9.173 We do not consider that these reasons support adopting a different catchment area for this overlap. The analysis supporting the 60-mile catchment area set out in Section 5 already accounts for the fact that a minority of referrals are made to more distant alternatives.

9.174 In our view the Parties are particularly close geographic competitors. Cygnet Derby is a geographically close competitor to CAS Storthfields, Sherwood and the Limes, all within 20 miles' road distance of CAS Storthfields. Within this 20-mile area, the Parties have a very high share of male LTMH beds ([✂] [70–80]%). In our view the geographical proximity of the Parties' sites suggests that they are likely to be alternatives for a large proportion of the

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[350] This area extends 120 miles (road distance) north to south and 120 miles east to west.
[351] The share of customers referred under the Framework is lower for the sites that are [✂], for example The Limes has only [✂]% on the Framework. A [✂]proportion of the Parties' recent patient referrals come from CCGs to the [✂].
[352] Parties' response to phase 1 decision, paragraphs 4.13 & 4.14.

customers of these sites (while competitors located further away are likely to be alternatives for a smaller proportion of customers).

Closeness of competition on quality

9.175 All the Parties' male LTMH facilities in this local overlap have 'Good' CQC ratings, while some other local providers have a 'Requires Improvement' rating.[353] Priory told us that occupancy at Dewsbury was negatively affected by its 'Requires Improvement' rating but it is hoping for this rating to be upgraded soon. As discussed in paragraphs 9.36 to 9.38, we consider that providers with a 'Requires Improvement' rating would still exert a competitive constraint on the Parties and therefore we do not exclude them from the calculation of capacity shares but we took into account whether they would exert a weaker competitive constraint.

Third party evidence

9.176 The evidence suggests that the Parties' hospitals are competing for some patients, with several customers citing CAS and Cygnet hospitals as alternatives. One customer said that Barchester Forest Hospital is for older patients and therefore not competing with the Parties' sites.[354] Another customer stated that it did not use the mixed gender or mixed specialism (LTMH/PD) wards for rehabilitation services.[355]

9.177 Hardwick CCG (Derbyshire), which is [✂] customer of CAS Storthfields and Cygnet Derby and [✂] customer for CAS The Limes,[356] has sent only five patients (out of a total of 138) requiring rehabilitation services to providers other than the Parties' sites over the last three years (none in 2015/16).

9.178 Hardwick CCG said it considers St Andrew's Northampton as a possible alternative given its good relationship with this provider, but said it does not currently send patients there. As St Andrew's is outside the catchment area and Hardwick has not in fact sent any patients there we exclude it from our competitor set. However, we note that inclusion of St Andrew's beds within the market share calculation would reduce the Parties' combined market share to [✂] [50–60]%.

9.179 Despite the volume of male LTMH referrals from Hardwick CCG to the Parties' sites, it told us it was not concerned about the Merger. It stated that it

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[353] Riverside Healthcare Cheswold Park Hospital, John Munroe Hospital, Priory Hospital Dewsbury.
[354] [✂]
[355] [✂]
[356] Based on the aggregate number of patient weeks spent at the site by all patients.

did not believe Cygnet would change the terms of its current agreement with Hardwick CCG as it had not done so before when it acquired Alpha Hospitals. Hardwick CCG did not think that a combined Cygnet and CAS would attempt to 'massively change the terms of the conversation' at the expiry of the two-year window of the Framework. Hardwick CCG said that both providers were aware that there are pressures on them and 'if they attempted to do something too outrageous we might start placing people further away.' It stated that while 'it did not have the benefit of a lot of alternative options on the current agreement it did have options.'

9.180 Three other customers, responsible for 9% of the referrals to the Parties' sites in this overlap area expressed concerns about the Merger. Two[357] of these customers had concerns about increased concentration leading to poorer outcomes for customers such as increased prices or reduced quality. All three[358] customers were concerned about the loss of variation in the services provided by the Parties, one arguing that heterogeneous treatment styles offered more options for patients.[359]

NHS providers

9.181 We received responses on the use of NHS rehabilitation services from nine customers collectively responsible for 70% of the referrals to the Parties' overlap sites since 1 January 2016. Four[360] (accounting for 54% of referrals from responding customers) stated that there were no local NHS providers, three[361] (accounting for 42% of referrals from responding customers) stated that they use NHS supply first and two[362] (accounting for 4% of referrals from responding customers) stated that they treat the NHS providers and independent providers equally.

9.182 The Parties identified several possible NHS providers of rehabilitation services in the area. As discussed in paragraph 5.52 above, only two of these wards appeared to compete with independent providers, [✂]. We have included these wards in the calculation of market shares.

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[357] [✂]
[358] [✂]
[359] The customer felt that different providers tended to offer different treatment approach for patients. Certain patients may respond more positively to one treatment approach than another. Their concern was that the merger may lead to facilities that previously offered different approaches would instead provide a singular treatment approach.
[360] [✂]
[361] [✂]
[362] [✂]

Provisional conclusion on East Midlands male LTMH

9.183 The Parties are the two largest providers in the local area, they would have a high combined market share post-Merger. They will be five times larger than the third largest competitor, which in turn, is much larger than the other providers. The Parties will have some excess capacity that will give them the incentive and ability to compete for patients. The Parties are particularly close competitors geographically which may suggest that their market shares underestimate the competitive constraint they impose on one another. They are also close competitors in terms of quality with each of their sites having 'Good' CQC ratings. The shares of the Parties would be higher if providers with 'Requires Improvement' CQC ratings exerted a weaker constraint. The largest customer for some of the Parties sites is not concerned about the Merger but several customers are concerned about the impact of the Merger in this area.

9.184 In light of our assessment above, 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. The SLC may be expected to lead to adverse effects for customers and patients in terms of prices being higher than they would otherwise be and quality being lower than it would otherwise be.

Countervailing factors

9.185 We considered whether countervailing factors, including entry or expansion by competitors and buyer power could offset the impact of the Merger.[363]

9.186 We have identified one planned expansion relevant to the East Midlands overlap area. Camino Healthcare, according to its website, 'is proposing to submit a planning application for new 20-bed mixed-gender LTMH facility in Nuneaton.' We are further investigating the progress and timeline for this development in order to understand to what extent it would be timely and sufficient to constrain the Parties post-Merger.[364] Including Nuneaton would reduce the Parties' combined shares in the East Midlands to [✂] [50–60]%.

9.187 We found no evidence of any other providers planning to expand in male LTMH in this local area. We therefore do not consider that entry or expansion by competitors would be timely, likely and sufficient to offset the adverse effects of the Merger.

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[363] The Parties did not put any efficiency arguments to us.
[364] [✂]

9.188 We have considered the role of the Framework in protecting customers from any adverse effects arising from the Merger through the exercise of buyer power. In our view, while the aggregation of customer volume may improve the negotiating position of those customers using the Framework to some extent, it does not follow that the Framework would be sufficient to offset the adverse effects of the Merger.

9.189 Buyer power can only constrain suppliers to the extent that there are sufficient alternatives available to the buyer. In this regard, we note that the Framework does not provide for a bidding market, where 'competition for the market' can act as a competitive constraint provided there is sufficient number of credible bidders. Rather, as discussed in paragraph 9.154 to 9.161 above, the Framework sets out a basis for aggregating customer volume to negotiate common terms with providers,[365] several of whom are needed to join the Framework to meet the substantial aggregate supply requirements of the customers on the Framework.

9.190 The Merger would result in the Parties having a very high combined share of supply of beds in the local area, reflecting that there is limited alternative capacity available. In our view this limits the alternative options available to the customers using the Framework, given that they have substantial supply requirements for rehabilitation services in aggregate.

9.191 This view was not shared by the largest customer for some of the Parties' sites, which was not concerned by the Merger. Whilst this customer said it did not have a lot of options, it did say it had some. Whilst we understand this customer's view, we believe it is underestimating the situation it will face when the Framework is renegotiated in a two years' times. We also note that its view, to some extent, seems to be based on what Cygnet did after it acquired another provider, which may not be a good indicator of post-merger behaviour following this Merger.

9.192 The Framework would not protect the terms faced by approximately [✂]% of the patients that are referred by customers which are not part of the Framework and so have different contractual arrangements with providers. We note that customers not using the Framework were concerned about the Merger.

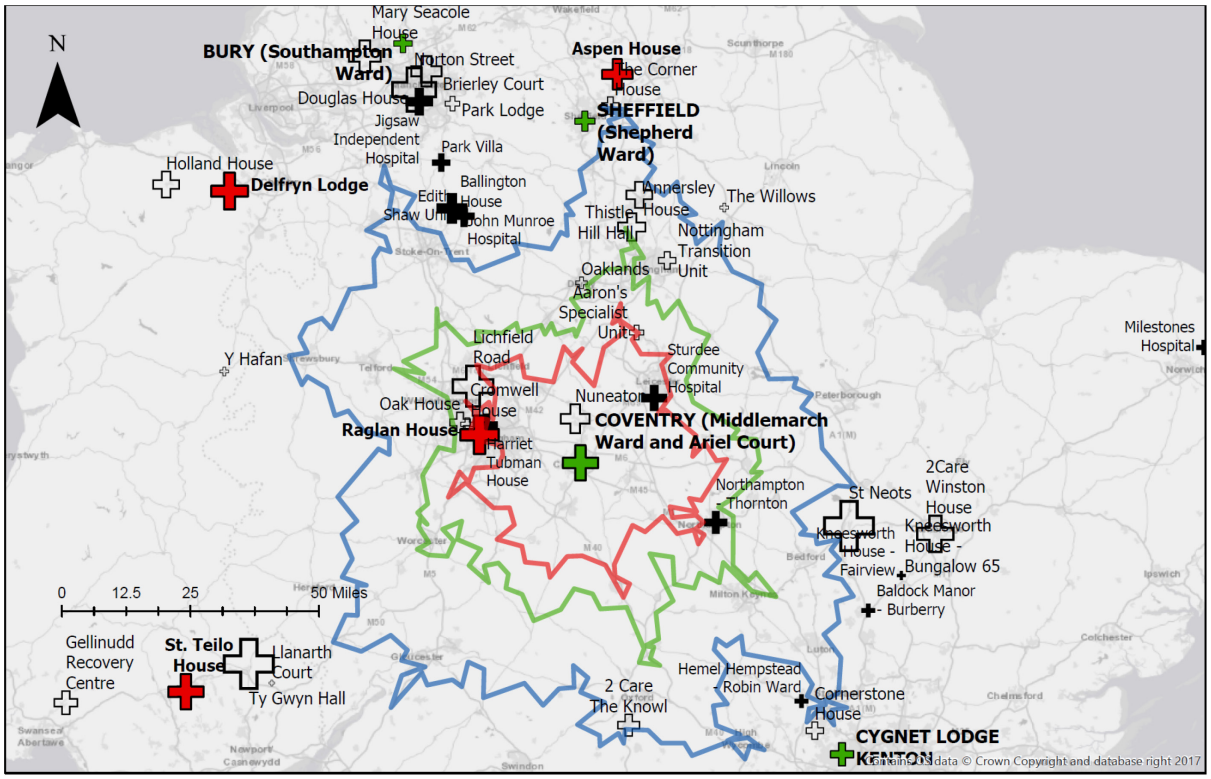
[365] Each customer will face the same terms when using a given provider on the Framework. However, terms vary across providers.

9.193 On the basis of the above, we do not consider that the SLC in East Midlands male LTMH which we have provisionally found would be offset by countervailing factors.

West Midlands – female LTMH

9.194 We investigated the overlap between Cygnet Coventry and CAS Raglan House. Cygnet Coventry has only recently opened in March 2017.

Figure 29: Catchment areas for female LTMH in the West Midlands



Source: CMA analysis.

Market shares

9.195 In order to determine market shares in this overlap area we excluded the following competitors identified by the Parties, based on evidence provided to

us: Barchester Forest Hospital,[366] Priory 255 Lichfield Road (the 20-bed mixed ward),[367] Rushcliffe Care Group Aaron's Specialist Unit,[368] Options for Care Harriet Tubman House,[369] Priory Beverley House,[370] and Priory Lakeside View.[371]

9.196 Post-Merger the Parties would have a combined market share of [✂] [50–60]% with a [✂] [20–30]% increment, centred on Cygnet Coventry. These shares and those of the main competitors in this overlap are shown in table 21 below.[372]

9.197 The Parties told us that at the time of the Merger Notice in February, Cygnet [✂] Ariel Court (due to open in 9 to 12 months) was included in the analysis as an LTMH ward. However, since Cygnet Coventry opened there has been [✂]. We have reflected this information in our market share calculations.

9.198 The Parties told us that Inmind Sturdee Hospital should also be included within this overlap. We are investigating this further. We note that including Inmind Sturdee Hospital would reduce the Parties' combined share materially to [✂] [40–50]%.

Table 21: Market shares for female LTMH in the West Midlands*

%

	Base case (60 miles)	*65 miles*	*56 miles*
Cygnet	[✂] [20–30]	[✂] [10–20]	[✂] [20–30]
Cambian	[✂] [30–40]	[✂] [20–30]	[✂] [30–40]
Combined	[✂] **[50–60]**	[✂] **[40–50]**	[✂] **[50–60]**
Camino Healthcare	[✂] [10–20]	[✂] [5–10]	[✂] [10–20]
Priory	[✂] [20–30]	[✂] [20–30]	[✂] [10–20]
St Andrews	[✂] [10–20]	[✂] [10–20]	[✂] [20–30'
Richmond Fellowship	[✂] [0–5]	[✂] [5–10]	[✂] [0–5]

Source: CMA calculations based on data submitted by the Parties and other providers.
* Market shares may not add to 100% due to rounding.

9.199 Cygnet Coventry and CAS Raglan House are the two largest providers of female LTMH in the local area. Two other large providers, Priory and St Andrew's will remain.

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[366] Forest Hospital mentions treatments for Huntingtons and dementia suggesting it is also for the elderly. Barchester submits that it does not compete with the Parties and one customer has confirmed that it provides services for elderly patients.
[367] Priory submits that this ward is not a rehabilitation facility but a step-down facility comprising independent self-managed flats.
[368] Rushcliffe Care Group submits that it does not compete with the Parties. On its website, this facility is described as a 30-bedded unit which is split evenly into three key areas and look after individuals with ABI, dementia and mental health difficulties and may put themselves or others at risk of harm.
[369] Birmingham Crosscity CCG told us that this site no longer offers female LTMH services. We were unable to find a website for Options for Care or record of Harriet Tubman House on the CQC website.
[370] Priory has submitted that Beverley House specialises in PD and currently only treats PD patients
[371] [✂]
[372] Shares may not sum due to rounding.

9.200 The Parties submitted that our calculation of market share failed to take account of the ability to flex beds at mixed gender and PD/LTMH wards. We note that:

(a) We have excluded one competitor, [✂].

(b) In relation to Beverley House it appears unlikely that this would flex bed allocation as it specialises in PD and currently only treats PD patients.

(c) For other Priory sites, we have used the current patient split as a starting point. However, we note that there may be ability to flex bed allocation at Annesley House (19 beds) and the Willows (six beds).

9.201 [✂]

9.202 We also considered the possibility of Priory flexing allocation of beds at Annesley House. Annesley House currently has one 12-bed ward evenly split between PD and LTMH patients and one eight-bed ward with four PD patients and one LTMH patient.[373] Given that Priory had told us that Annesley House offers specialist PD services we did not consider it likely that it would flex many beds to LTMH. However, we noted the spare capacity on the eight-bed ward and tested the sensitivity of five additional beds being allocated to LTMH.

9.203 We also considered the possibility of Camino Healthcare flexing allocation of beds at Cromwell House and Oak House. We do not have specific information for these wards and so have allocated 35% of beds to female LTMH according to our standard assumption. To account for the possibility that this assumption is not correct in this case and for the possibility of flexing we have tested the sensitivity of assuming a 50% allocation to female LTMH.

9.204 We noted that incorporating all of these sensitivities would result in combined post-Merger market share for the Parties of [✂] [40–50]% in a 60-mile catchment. We considered this sensitivity likely to reflect the maximum additional competitive constraint from competing providers flexing bed allocation in mixed and PD/LTMH wards towards female LMTH.

Capacity constraints

9.205 CAS Raglan House, which has 24 beds, operates at [✂]. However, Cygnet Coventry, which only opened in March 2017, has lots of spare capacity. Pre-Merger, it would have had a strong incentive to compete for patients against

[373] We assumed two beds allocated to LTMH for the eight-bed ward.

Raglan House and the other providers in the area. The competitive constraint between the Parties will be removed by the Merger. In our view, capacity constraints are therefore not a significant feature in this area.

Geographic differentiation

9.206 Raglan House is 27 miles from Cygnet Coventry with no other providers located closer. In our view this suggests that the Parties are close geographic competitors.

9.207 As in other overlaps, we carried out a sensitivity check by extending the catchment area to 65-miles. This resulted in the Parties' combined post-Merger market shares falling from [✂] [50–60]% to [✂] [50–60]%.

9.208 We note that while there are several providers within a 37-mile radius of Cygnet Coventry there is an absence of providers located between 37 and 56 miles away. We note that Birmingham Crosscity CCG, the main customer of Raglan House has sent the majority of its patients within a narrow area (in Birmingham) and has stated a desire to keep a greater proportion of customers within area. We have therefore carried out a sensitivity check excluding those providers beyond a 55 rather than a 60-mile radius. This would result in market shares of [✂] [60–70] %.

9.209 In our view, this evidence suggests overall that the Parties' combined market shares on a 60-mile basis are likely to understate the competitive constraint they impose on one another when taking into account their proximity and the absence of other competitors between 37 and 56 miles.

Closeness of competition on quality

9.210 We note that all providers within the catchment area are rated as 'Good' by the CQC. Therefore, we do not consider the Parties to be closer competitors on quality relative to other competitors.

Third party evidence

9.211 Cygnet's Coventry site is relatively new having only opened in March 2017 and having only admitted [✂] LTMH patients by 2 June. Given this we have focused on evidence from customers referring to the CAS Raglan House, in particular Birmingham Crosscity CCG, which is responsible for [✂] [50–60]% of the referrals to Raglan House since 2016.

9.212 We analysed female LTMH referrals by Birmingham Crosscity CCG over the last three years. It had sent the majority of its patients to Cambian Raglan

House, a substantial proportion to Beverley House and a small proportion to Priory 225 Lichfield Road and Hemel Hempstead.

9.213 Consistent with these referral patterns, Birmingham Crosscity CCG cited Beverley House as the next best alternative to Raglan House, although it noted that Beverley House had a small difference in focus as it generally offered a slower, longer-term rehabilitation programme. We noted that Priory acquired this facility in 2015 from Choice Lifestyles, which operated it as female LTMH locked rehabilitation ward. Priory told us that Beverley House currently offers specialised PD services and currently only treats female PD patients.

9.214 One[374] other customer of the Parties that accounted for 4% of the referrals since January 2016 said it was concerned that the Merger may increase price and/or reduce quality of the services provided. However, Birmingham Crosscity CCG was not concerned about the Merger as it felt it had bargaining power.

Internal documents

9.215 We reviewed Cygnet's Coventry Capital expenditure proposal document produced in 2014, in advance of the opening of Cygnet Coventry.

9.216 The Coventry Capital expenditure proposal document mentions rehabilitation providers under a 'Review of competitors' section. Although it is not consistently clear on specialism, security or acuity level or gender of each of the providers mentioned, our review of this document identified the following independent competitors as potentially relevant to female LTMH (Cygnet's comments from the document are included with each competitor):

(a) 'St Andrew's Healthcare – Birmingham (16 female locked beds [✂].'

(b) 'Raglan House – Cambian. [✂].'

(c) 'Huntercombe Centre Birmingham (18-bed mental health, LD or substance misuse hospital service). No care pathway is provided in this relatively small unit which provides for a mixture of diagnoses.'

(d) 'Choice Lifestyles – Beverley House (24-bed female rehabilitation) (this has since been taken over by Priory in 2015). Beverley House is a 24-bedded rehabilitation hospital for women over the age of 18, situated in the heart of the community in Birmingham. Patient admitted to Beverley

[374] [✂]

House may be informal or detained under the Mental Health Act with a primary diagnosis of mental health illness with complex needs. [✂].'

(e) St Matthews Hospital Northampton (14 beds mental health rehabilitation) There is no information available for this service and it has yet to be inspected by the CQC.

9.217 We note that St Andrew's Birmingham has not been identified to us by the Parties or referred to by Birmingham Crosscity CCG. St Matthews has told us it only provides male not female LTMH services. We identified Huntercombe Centre Birmingham as providing male LTMH rather than female LTMH and, as noted above, Beverley House has been acquired by Priory and now provides specialist PD services and is currently only treating PD patients.

9.218 The Coventry capital expenditure proposal document also discusses NHS trust and CCG needs. It states the following in relation to CCG needs for female LTMH:

(a) [✂]

(b) [✂]

(c) [✂]

(d) [✂]

(e) [✂]

9.219 In our view this evidence suggests that Cygnet saw Cambian (now CAS) and Choice Lifestyles as its key competitors for female LTMH in Coventry at the time the Coventry capital expenditure proposal document was produced. However, we note that Choice Lifestyles has since been bought by Priory and now specialises in PD.

9.220 In our view, the evidence from Cygnet's internal documents suggests that it viewed Cambian (now CAS) as its closest competitor in female LTMH (of those competitors still providing female LTMH). We note that this is consistent with our calculated market shares which show Cygnet and Cambian (now CAS) to be the two largest providers of female LTMH in this area by some margin.

NHS providers

9.221 Cygnet mentions the following NHS providers in its capital expenditure proposal for Coventry:

(a) ‘Hawkesbury Lodge – Coventry and Warwickshire NHS (Rehab & Recovery – 14 Beds). This is a local NHS service that provides open rehab.’

(b) ‘Rosewood Terrace – Coventry and Warwickshire NHS (10 High Support Beds plus 5 Step Down Beds). This is an open NHS service [✂] and deals with more enduring types of illness.’

(c) ‘Hazelwood Unit – Coventry and Warwickshire NHS (Challenging Behaviour/Complex Needs-6 beds)’

9.222 However, in our view this evidence does not mean that NHS facilities offered comparable services to the Parties or tell us anything about whether customers would refer to NHS providers before considering independent providers.

9.223 We have received evidence on the use of NHS rehabilitation services from two customers collectively responsible for 57% of the referrals to the Parties’ overlap sites since 1 January 2016. One[375] of them (accounting for 8% of referrals from responding customers) stated that there was no local supply of NHS services, the other[376] (accounting for 92% of referrals from responding customers) stated that it used NHS providers first before considering independent providers. Neither of these customers stated that they treat the NHS providers and private sector providers equally.

9.224 In addition, we noted that all the NHS trusts we contacted relevant to this overlap[377] told us that their rehabilitation wards were covered by block contracts and that customers would use them before considering independent providers.

9.225 Based on this evidence, we did not consider NHS providers to be a competitive constraint on the Parties in this overlap.

Provisional conclusion on the West Midlands

9.226 Pre-merger, there were four large providers, two of which were the Parties, each with a market share of about or over [✂] [20–30]%. Post-merger, the Parties would be the largest provider in the local area, having a high combined market shares with a high increment. The Parties are particularly close competitors geographically, which – as shown by the market shares, is likely to understate the competitive constraint they impose on each other. In

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[375] [✂]
[376] [✂]
[377] [✂]

our view, 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. Evidence from the Cygnet internal documents produced in 2014 before the opening of the Coventry facility suggests that it saw Cambian (now CAS) and Choices Lifestyle Beverley House as its two closest competitors at the time. Beverley House has since been acquired by Priory and now specialises in PD and currently only treats PD patients.

9.227 In light of our assessment, we provisionally find 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. The SLC may be expected to lead to adverse effects for customers and patients in terms of prices being higher than they would otherwise be and quality being lower than it would otherwise be.

Countervailing factors

9.228 In light of our provisional finding that the Merger could be expected to result in an SLC, we considered whether entry or buyer power may be countervailing factors that would offset any adverse effects from the Merger.

9.229 As discussed in paragraph 9.186 above, Camino Healthcare, according to public information in its website 'is proposing to submit a planning application for new 20-bed mixed-gender LTMH facility in Nuneaton'. We are further investigating the progress and timeline for this development in order to understand to what extent it would be timely and sufficient to constrain the Parties post-Merger. Including this facility would reduce the Parties' combined shares in the West Midlands to [✂] [40–50]%.

9.230 With respect to buyer power, we note that there are no relevant framework agreements locally or evidence that any are likely to occur in the future. Birmingham Crosscity CCG is the [✂] customer of the Parties and was not concerned about the Merger as it felt it had bargaining power.[378] However, it did not appear likely to us that, given the Parties' high combined market shares, Birmingham Crosscity CCG would have sufficient alternative options to be able to offset the effect of the Merger through exercising this bargaining power. More importantly, our provisional view is that even if Birmingham Crosscity CCG is able to exercise buyer power, this would not protect the prices paid by other customers.

[378] Birmingham Crosscity.

9.231 On the basis of the above we do not consider that the SLC in West Midlands female LTMH which we have provisionally found would be offset by countervailing factors.

10. The effect of the Merger on potential competition

10.1 This section considers whether the Merger may be expected to result in a loss of potential competition at a local or national level.

Potential competition at a local level

10.2 Our assessment of potential competition considers whether entry or expansion by one or both Parties would have occurred absent the Merger and led to greater competition. In particular, it considers the possibility that, absent the Merger:

(a) the Parties' expansion plans would be likely to lead to greater competition in certain local areas; and

(b) the Parties would be likely to switch the use of a hospital or ward from one specialism (or treatment type) or gender to another (reconfiguration), resulting in greater competition in certain local areas.

Expansion plans

10.3 Where the Parties' plans or those of other providers[379] have already been executed, any changes in capacity in the relevant market have been included in our assessment of actual competition at the local level.

10.4 For example, as outlined above, in March 2017 Cygnet opened a new hospital in Coventry with four wards. One of these is a 16-bed female LTMH ward which is included in our local assessment. Another is an 18-bed female PD ward which is excluded as it falls outside our catchment.[380]

10.5 Similarly, in March 2017, CAS opened a second wing at its Acer facility adding 14 female PD beds which is included. [✂]

[379] We have the expansion plans of [✂]providers. We do not have evidence of all plans from all providers in all local areas.
[380] The third ward provides female PICU (Dunsmore Ward). The fourth ward, Ariel Court, [✂].

Parties' expansion plans

10.6 In response to our Issues Statement the Parties submitted that whilst both were looking for opportunities to develop their respective businesses ('which is to be expected for all providers of rehabilitation services'[381]) absent the Merger, the Parties' respective plans largely focused on different treatment types and different stages in the care pathway.

10.7 The Parties submitted that Cygnet's expansion plans were consistent with the focus of its business, 'which is on providing treatment to service users with high acuity needs and/or those requiring a secure setting, which do not overlap with the services provided by CAS'.[382]

10.8 In this regard, Cygnet has plans to build [✂].

10.9 In comparison, CAS's expansion plans [✂].

10.10 Accordingly, the Parties submitted that their expansion plans confirm that they would not have become closer competitors at a local level in the supply of rehabilitation services absent the Merger.

Our assessment

10.11 The Parties [✂] planned expansion in LTMH rehabilitation services, [✂].

10.12 To assess the possible impact of this expansion plan on competition, we have considered it in the same framework as our assessment of actual competition, in other words applying the same filtering methodology followed by a more detailed competitive assessment where appropriate.

10.13 The implication of [✂] to our filtering methodology is not significant, ie it does not result in any additional sites being included for a more detailed competitive assessment.

[381] Parties' response to the issues statement, paragraph 2.21.
[382] Parties' response to the issues statement.

Potential competition from reconfiguration of existing wards

Parties' submission[383]

10.14 The Parties submitted that there is no evidence to suggest that the Parties would have changed services or specialisms at specific hospitals or on specific wards to become closer competitors to each other in future.

> On the contrary, the evidence consistently points towards their respective businesses having a different strategic focus with Cygnet focusing on high acuity needs and/or those service users requiring a secure setting whilst CAS is focusing on the community sector and/or rehabilitation services for ABI and ASD patients.[384]

10.15 The Parties also point to Cambian Group's financial difficulties prior to the Merger as likely to limit its access to capital to expand. [✂][385]

10.16 CAS told us it does not reconfigure wards. The 18-month average length of stay and the fact that many patients are in the process of transitioning back into the community makes reconfiguration 'tremendously difficult and disruptive'. Instead, CAS would rather expand or buy a completely new facility.

10.17 CAS also highlighted that the focus of its business and so the nature of its estate means most CAS facilities are in the centre of communities. The level of patient acuity and risk that can be contained in that setting is established by the location and by the form of the building. This means less opportunity for reconfiguration than Cygnet which has more inpatient hospitals in their own settings.

10.18 Finally, CAS noted that the main driver for reconfiguration, low occupancy, has never been an issue as its rehabilitation facilities have always had occupancy levels of around [✂]%.

10.19 Cygnet confirmed [✂] for reconfiguration, although it emphasised, [✂]. It said it would generally expect one or two reconfigurations per year across its entire portfolio of 50 to 60 wards. In LTMH and PD specifically, Cygnet cited only three reconfigurations since 2012 (Brighouse from mixed LTMH to male

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[383] Parties' response to the issues statement.
[384] Parties' response to the issues statement, paragraph 2.25.
[385] Parties' response to the issues statement, paragraph 2.26.

LTMH, one ward in Kewstoke from male LTMH to female LTMH and another ward in Kewstoke from female low secure to female PD).

Our assessment

10.20 The Parties' internal documents [✂].

10.21 To consider the possibility of a loss of potential competition from reconfiguring existing wards, we applied the analytical approach described in paragraphs 5.36 to 5.47 of the section on product market definition which showed that such reconfiguration is only likely where both:

(a) occupancy at an existing ward is low; and

(b) there is sufficient excess demand for the specialism and gender type to which the ward is being switched, to achieve a sufficient increase in occupancy.

10.22 As noted in the section on product market definition, ward reconfiguration costs are likely to be significantly lower between genders and between specialisms that use the same physical environment, such as LTMH/PD. Below, we consider the potential for such reconfigurations and then go on to examine reconfigurations from LTMH/PD to other specialisms.

10.23 To identify possible wards which may be reconfigured we have first sought to identify PD or LTMH wards with lower occupancy, assuming that the incentives to reconfigure will be greater here.

10.24 There was no consensus between the Parties on the level of occupancy that would trigger consideration of reconfiguration. Cygnet explained that a decision to reconfigure depended on what was driving the fall in occupancy rather than any particular occupancy level. For example, government policy to move patients out of locked LD hospitals would support a case to reconfigure, even if occupancy levels were high. CAS said that with occupancy of around [✂]%, it has never had to consider reconfiguration.

10.25 As a starting point for further examination we have considered the Parties' wards with occupancy currently below 80%. 80% is likely to be higher than the occupancy below which the Parties would be likely to reconfigure; it is a cautious starting point:

(a) Cambian Victoria House ([✂]% occupancy in 2016) – male LTMH.

(b) Cygnet Brighouse (occupancy – [✂]% (2014), [✂]% (2015), [✂]% (2016)) – male LTMH.

(c) Cygnet Bierley (occupancy – [✂]% (2014), [✂]% (2015), [✂]% (2016)) – female PD.

10.26 We note that Cygnet Bierley and Cygnet Brighouse overlap with CAS hospitals and are included in two of our local competitive assessments, following filtering. CAS Victoria House does not overlap with any Cygnet hospitals.

10.27 We have first considered the implications of these wards reconfiguring for our filtering and competitive assessment. Where the reconfiguration would make a difference, we have considered in more detail the likelihood of it actually happening.

10.28 For each we first repeated the filtering exercise to look at what would happen if capacity at each ward was allocated to each alternative specialism/gender combination (for example, if the ward is currently female PD, we considered what would be the implications of reconfiguring to male LTMH and to female LTMH). No new overlaps arising from these hypothetical reconfigurations would be included in our competitive assessment after the filtering.

10.29 The following changes would increase the Parties' market shares in overlaps we are already considering:

(a) Cygnet Brighouse switching from male LTMH to female PD would increase the Parties' share of supply (Cygnet Bierley/CAS Acer and Aspen). Cygnet Brighouse is 9 miles from Cygnet Bierley, 31 miles from CAS Aspen and 44 miles from CAS Acer.

(b) Cygnet Bierley switching from female PD to male LTMH would increase the Parties' shares of supply (Brighouse/CAS Oaks and Limes). Cygnet Bierley is 9 miles from Cygnet Brighouse, 30 miles from CAS Oaks and 58 miles from CAS Limes.

10.30 We consider the likelihood of Cygnet Brighouse reconfiguring to female PD is low, in particular because Cygnet Bierley has tended to operate with [✂] as discussed in paragraph 9.73 above.

10.31 The likelihood of Cygnet Bierley switching to male LTMH also appears low, [✂] (as shown in paragraph 9.166 above). In addition, we note that Cygnet Bierley female PD is a more specialised Tier 4 service able to deal with more complex patients and charges higher prices for this service. Finally, following issues we understand go back to 2012, we note that Bierley's occupancy is [✂] after being rated 'Good' by the CQC early this year. Past issues with trials of different approaches at Bierley which [✂] mean it is unlikely to be a good

candidate for further change. It therefore appears unlikely that Cygnet would wish to convert this ward to treat male LTMH patients.

10.32 As a second step, we considered the possibility that the Parties might reconfigure from PD or LTMH to other specialisms in rehabilitation services, notwithstanding that the cost and difficulty of doing so is likely to be greater than reconfiguration 'within' PD and LTMH rehabilitation services.

10.33 In this regard, we note CAS's submission that it plans to expand in ABI, ASD and LD and note that its occupancy levels for these treatments across its sites were [✂]. Consequently, we believe it is unlikely that CAS would wish to reconfigure any wards providing these services to compete in PD and LTMH rehabilitation services. We also note CAS's statement that it does not reconfigure wards.

10.34 Cygnet explained that the cost of reconfiguration varies significantly. Two of the main factors are the costs of changing the physical space to comply with specifications and the length of time it takes existing patients to leave and new patients to be referred. Cygnet explained that in the early 2000s it undertook around 11 reconfigurations over three years. The most financially significant were going from low secure to more specialist services.

10.35 As well as the cost and disruption to occupancy, Cygnet explained that even where the physical environment does not change significantly, the reconfiguration process can be costly and lengthy due to the need to retrain staff in a new specialism. For example, in Kewstoke it was already a low secure service so the physical environment did not need to change that much to accommodate PD patients. However, several members of staff needed [✂] training. It compared a reconfiguration from PICU to acute which could be quicker and easier.

10.36 Limited expansion plans, the fact that only two wards have been reconfigured by Cygnet in the past five years and the absence of any current plans for reconfiguration in LTMH/PD, leads us to provisionally conclude that reconfiguration by one or both Parties is unlikely to have occurred absent the Merger and led to greater competition.

Potential competition at a national level

10.37 We have considered whether the effect of the Merger on the Parties' expansion plans (over and above the specific expansion plans already assessed) may be expected to give rise to an SLC, for instance if it reduces their incentives to expand into new areas and thereby create further overlap areas.

10.38 The following conditions would all need to be met for this to occur:[386]

(a) Absent the Merger, the Parties would expand into local areas in which they are not currently present thereby creating new additional local overlaps (over and above their specific entry plans).

(b) The Parties' capability or intentions to expand are such that they would be substantially more likely than other competitors to enter these new overlap areas.

(c) Entry into new overlap areas absent the Merger would have led to greater competition.

10.39 We consider each of these three conditions below.

Likelihood of new overlaps

10.40 We have considered evidence of additional planned expansion beyond specific sites. As a starting point, we note the Parties' response to our Issues Statement, set out in paragraph 10.7 that their respective expansion plans largely focus on different specialisms and treating patients at different stages in the care pathway.

10.41 The Parties submit that Cygnet's plans are focused on high acuity services and CAS are largely focused on developing services in the community sector or rehabilitation services for ABI or ASD patients. This submission is consistent with their submission of [✂].

10.42 However, a recent CAS business plan, [✂], appeared inconsistent with CAS's submission that its [✂]. The business plan suggested [✂].

10.43 We asked CAS about this apparent discrepancy. CAS explained that [✂]. This aligns with the fact that against moderate historical expansion, trebling capacity in one specialism seems unlikely at best.

10.44 CAS confirmed that it will revisit and revise expansion plans [✂]. It explained it wants to grow but how and where will be led by the 'demand matrix' of the market. According to CAS, this is driven by the demand from the NHS and the political agenda. For example, there have been recent changes in policy on LD to close beds and provide alternative community provision. Once it is clear demand is there, only then does CAS address other aspects of the matrix

[386] Retail Mergers Commentary, paragraph 1.21.

such as the finance and the ability to find a site and get planning permission. Expansion was described by CAS as '[✂]'.[387]

10.45 CAS noted the prospect of a policy change to move people out of rehabilitation beds back into the community. A CQC Report 'The state of care in mental health services 2014 to 2017' published on 20 July, included a clear view that they want to revisit the appropriateness of inpatient services for certain rehabilitation patients. In light of this CAS intimated it would be '[✂]'.

10.46 We have found no comparable information for Cygnet in internal documents. We asked Cygnet about its approach to identifying new areas for expansion.

10.47 Cygnet explained that it had not undertaken much expansion [✂].

10.48 Cygnet submitted it is also driven primarily by demand and relationships in local areas. Like CAS, it is affected by changes in government priorities as these often translate into customer demands. It gave the example of the drive to improve the availability of more local PICU facilities.

10.49 We have also considered historical expansion into PD by the Parties. We note that both CAS and Cygnet have been active in expanding in female PD. CAS has opened all its female PD wards over the past five years: Cambian Aspen, Acer and Alders (64 beds in total). Cygnet has opened two wards for female PD at Coventry and Kewstoke (27 beds in total).

10.50 We are satisfied by CAS's explanation of its internal document that [✂]. Although the historical pattern suggests that further expansion by CAS in PD might have occurred absent the Merger, [✂].

10.51 [✂] We therefore consider that the likelihood of this creating new overlaps between the Parties is low.

Entry more likely than by other competitors

10.52 We have considered the scale of historical expansion of the Parties relative to other competitors. We note the Parties have been actively expanding in female PD and we have not identified other competitors with historic expansion in PD over the last five years.

10.53 We have considered the scale of the Parties' current expansion plans in PD rehabilitation services relative to other competitors. The two other major providers currently offering female PD services are Priory and Elysium.

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[387] [✂]

10.54 [✂]

10.55 [✂]

10.56 [✂]

10.57 [✂]

10.58 Out of the 11 competitors who responded to the part of our questionnaire covering expansion, five had expanded in the past five years, six had plans for future expansion (of varying levels of firmness), one had a vacant site where it had yet to decide and only four had no plans to expand.

10.59 Overall, while the Parties have expanded more than other competitors in PD in the past, we note that [✂].

10.60 Most of the changes and drivers in the market that encourage or facilitate expansion are provider-agnostic. Although there could be some factors that may make it easier for larger players, there are no specific reasons why the Parties would be more capable of further expansion in PD than other providers, absent the Merger.

Entry into new overlaps would lead to greater competition

10.61 As discussed in detail in paragraphs 9.46 to 9.67 above, we have provisionally found that the Merger may not be expected to result in an SLC in any overlaps between the Parties in female PD due to the substantial differentiation between the services they offer. There is no evidence that the Parties intend to shift the focus of their PD services in the future. As a result, in our view it is unlikely that entry by the Parties into new PD overlaps would lead to greater competition, even if they did arise.

Provisional conclusion

10.62 Cygnet has [✂].

10.63 [✂] we have not found reasons why the Parties would be more capable of further expansion in PD than other competitors, absent the Merger. In addition, given the differentiation between the Parties, it is unlikely that entry by the Parties into new PD overlaps would lead to greater competition, even if such overlaps did arise. As a result, our provisional view is that the Merger may not be expected to result in an SLC from a loss of potential competition between the Parties.

11. National effects

11.1 Above we provisionally concluded that the Merger may not be expected to result in an SLC from a loss of potential competition at a national level. This section examines whether the increased concentration and reduction in the number of major providers might be expected to result in an SLC from a loss of actual competition at the national level. This may be competition in innovation, expansion or investment, for example.

11.2 To determine and assess the impact of any national effects of the Merger we considered:

(a) the extent to which any of the parameters of competition are national and the impact of any national aspects we have not explicitly considered at a local level;

(b) Parties' and third party submissions on the effect of the Merger at a national level; and

(c) the impact of the Merger at an aggregate level.

Parameters of competition set or flexed nationally and other national aspects

11.3 Incentives to compete are driven by increasing the occupancy of wards, due to the revenue earned from attracting patients. Evidence from customers shows a consistent and strong preference to refer patients to local providers where possible, subject to these providers being of sufficient quality. The evidence in our inquiry consistently supports that the key parameters of competition are mainly varied locally.

11.4 As a result, our analytical framework and assessment reflects the fact that the incentives to compete are predominantly local. This includes the incentive to change even those parameters of competition set 'nationally'. In the case of actual competition this means that an assessment of national competition is in practice an assessment of local competition in aggregate.[388]

11.5 We have been told that some providers address and adjust some parameters of competition centrally. For example, we understand some national providers have group-wide approaches to quality and [✂]. However, our investigation

[388] See the Retail Mergers Commentary, paragraphs 1.13–1.17. Previous decisions considering the effect of a merger on centrally-set parameters of competition include: Holland & Barrett/Julian Graves (2009); Sports Direct/JJB Sports (2010); Poundland/99p (2015); and Ladbrokes/Coral (2016). All looked at the impact of the merger on centrally set parameters of competition through analysis of the aggregate of local competition, including in particular the extent to which local stores overlapped.

confirms that even if centrally-set or monitored, price and particularly quality, tend to vary locally.

11.6 Quality[389] is ward-specific and varies locally. How customers view individual facilities and their experience of placing patients there is key, and in general not a function of national factors such as brand.

11.7 Pricing also varies locally. For Cygnet, [✂].[390]

11.8 While the key parameters of competition are predominantly varied locally, we have received evidence that characteristics of larger providers may affect these parameters across hospitals, ie that there are national factors which may affect local competition. These include:

(a) ability to expand or introduce new services;

(b) the management of quality;

(c) recruitment, career planning, deployment, training and retention of specialist staff;

(d) reputation from operating in numerous local areas;

(e) innovation capability arising from scale eg ability to trial and test new approaches/treatments;

(f) economies of scale and scope; and

(g) other management practices and culture etc.

Parties' and third party submissions on the effect of the Merger at a national level

11.9 The Parties do not consider that national factors have a significant influence on local competition in relation to the supply of rehabilitation services. They refer to the phase 1 decision which states that commissioning generally takes place by customers at a local level, and all providers of rehabilitation services are reliant on these customers for patient referrals and funding.

[389] See Section 8 on the nature of pre-Merger competition.
[390] See Section 8 on the nature of pre-Merger competition.

11.10 The Parties point to the 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.'[391]

11.11 In relation to the reputation of providers, the Parties told us that since hospitals are managed individually and assessed separately by the CQC, each hospital needs to develop its own reputation with customers, even if it forms part of a larger group. [✂], the Parties argued that just because a customer has had a good experience with one of the Parties' hospitals in the past, it does not guarantee that it will view its other hospitals in the same way (or vice versa).

11.12 The Parties do not consider that scale, financial strength or access to capital have any material bearing on the nature of competition at the local level. On scale, they point to the high number of smaller credible providers with no national presence. On cost, they submit that the provision of rehabilitation services is highly dependent on clinical and nursing staff, which means that there are very few scale benefits at the national level.[392]

11.13 Customer evidence generally confirms that customers are motivated by the quality and standards of care of the facility and their experience of them. Brand and national presence is not a significant factor in their decision on whether and where to refer patient.[393]

11.14 Other providers and third parties pointed to several advantages of being a larger provider, both in scale and scope. They mentioned the benefits of an integrated care pathway providing cross-selling opportunities, an ability to take a longer-term view of finances and sustain short-term fluctuations in occupancy, the lower cost of capital and the ability to invest and innovate.[394]

11.15 Although the large number of smaller credible providers suggests that economies of scale may be limited, we have received evidence from customers, competitors and third parties that there are benefits of scale and scope for larger providers. They have told us that these include cross-selling opportunities such as moving patients along the care pathway, cross-subsidies to address falls in occupancy or quality concerns, access to a larger pool of specialist staff and a better career offer for staff and access to capital and insulation against financial risks.

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[391] Parties' response to the issues statement, paragraph 214.
[392] Parties' response to the issues statement, paragraph 216.
[393] See section 7 on Customer behaviour and choice of facility.
[394] See paragraphs 12.40–12.55.

11.16 We have noted that benefits from scale may make expansion by larger providers somewhat easier and more likely than expansion by smaller suppliers.[395] We have taken account of these factors in our assessment of the possible impact of the Merger on competition through expansion in the Potential Competition section above.

The impact of the Merger at an aggregate level

11.17 The Parties have told us it is unclear to them why a national competition theory of harm is relevant, or how it could be expected to occur in practice.[396] They cite the CMA's phase 1 decision that the Parties' combined shares of supply 'on a national basis are at a level below which the CMA will typically identify concerns'.[397]

11.18 Based on data provided by the Parties, we calculated that post-Merger the Parties would have an aggregate share of [✂] [20–30]% of the market for rehabilitation services. This is broadly consistent with the Parties' calculations. On one hand, they may include some providers who are in practice less of constraint on the Parties, but on the other, as noted by the Parties, they may fail to capture others who may be relevant (such as NHS providers in some cases).

11.19 The Parties would be the largest national 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. Furthermore, the national markets for rehabilitation services are still fairly fragmented with many smaller regional or local area providers, as evident from the analysis in our detailed local assessments.

11.20 More importantly, aggregate market shares do not necessarily give a good indication of competition at a national level as they aggregate multiple local markets and do not capture the extent to which different providers overlap and thus compete at a local level. For example, two providers that focus on different regions could in principle not overlap at all but still have a high combined aggregate market share at a national level.

11.21 In addition, we have found that the Parties do not compete closely in PD. As a result, in our view the market share above overstates the degree of competition between the Parties that may be lost due to the Merger.

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[395] See section on the barriers to entry and expansion below at paragraphs 12.4–12.58.
[396] Parties' response to the issues statement, paragraph 230 and following.
[397] CMA phase 1 decision, paragraph 58.

Provisional conclusion on national effects of the Merger

11.22 Post-Merger, the Parties would be the largest national 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. This is further evident from the analysis in our local competitive assessments.

11.23 The evidence in this investigation supports the absence of a substantial effect on competition at a national level at this time.

11.24 However, the CMA notes that this is the second major transaction in the market over the past 12 months.[398] As consolidation continues, the national and local dynamics and the relative importance of different competitive parameters are evolving and may evolve further.

12. Countervailing factors

12.1 In considering whether a merger is likely to result in an SLC, we will consider the responses of others in the market (rivals, customers, potential new entrants) to take into account 'countervailing factors'. These are factors specific to the merger which may ameliorate the effect of the merger on competition. Countervailing factors include entry by new providers, expansion by existing providers and the ability of customers to exercise buyer power. We will also consider the effect of any efficiencies identified by the Parties on competition as a result of the Merger.

Entry and expansion

12.2 A merger may encourage other providers to enter the market or existing providers to expand their operations and in that way reduce the potential harm to competition a merger may cause. In order to prevent an SLC from arising, entry or expansion must be likely, timely and sufficient.[399]

12.3 We investigated what barriers to entry and expansion exist to the supply of rehabilitation services.[400] We assessed potential candidates for entry/expansion in the local areas (see paragraphs 9.186 and 9.229) where we identified a potential competition problem before reaching a provisional

[398] See Acadia/Priory.
[399] Merger Assessment Guidelines, paragraph 5.8.3.
[400] Further details on the views of the Parties and third parties are provided in Appendix F.

conclusion on the likelihood of entry and expansion and whether this would provide a sufficient competitive constraint on the Parties in a timely manner.

Barriers to entry and expansion

12.4 The Parties told us that the barriers to entry and expansion in the provision of mental health services vary depending on the stage of the care pathway. They stated that that the higher the level of security, and the acuity of the condition, the more significant the barriers.[401]

12.5 According to the Parties, there were barriers to entry to the provision of medium and low secure, acute and PICU services. They explained that high security requirements required purpose built/converted facilities, these were designed by clinicians and bespoke to the needs of patients, and often required significant investment. Further, they stated that building facilities for secure, acute and PICU services require planning permission,[402] and the higher the security levels of the service, the more stringent the planning requirements.[403]

12.6 The Parties submitted that barriers to entry are likely to be lower for rehabilitation services than secure services due to the reduced security requirements, and the slightly less resource-intensive nature of the care provided. [404]

12.7 We set out below the barriers to entry or expansion we have identified, the views of the Parties and the third parties on each and our assessment. Further details are provided in Appendix F.

Registration and licensing requirements

12.8 As set out above in the Legal and Regulatory section (paragraphs 2.14 to 2.19) and in more detail in Appendix B, mental health services are monitored, inspected and regulated in England by the CQC.[405]

12.9 The CQC reported that during October 2015 - March 2016, the time taken to complete the CQC registration process ranged from 40 to 62 days.[406,407]

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[401] Merger Notice, paragraphs 26.1 & 26.2.
[402] See also Appendix B for more information on planning regulations.
[403] Merger Notice, paragraphs 26.1–26.4.
[404] Merger Notice, paragraphs 26.1–26.4.
[405] The HIW regulates independent healthcare providers in Wales.
[406] See CQC (April 2017), Review of CQC's impact on quality and improvement in health and social care.
[407] The registration process requires submission of various details and documents, including a Statement of Purpose, References, Management policy/procedures, Safeguarding policy and procedures, Planning permission

Every registered provider pays a single annual fee, which covers all CQC registration and compliance requirements for all locations.[408]

12.10 NHSI licenses and monitors all NHS providers to make sure that the required standards are maintained (see Appendix B for details). NHS provider licences are free, and it usually takes 20 working days to receive a decision, unless queries or concerns are raised.[409]

- *Views of the Parties and third parties*

12.11 The Parties told us that all new sites needed to meet the following regulatory requirements:

(a) CQC registration;

(b) application to NHSI for a licence;[410] and

(c) submission of a completed Information Governance toolkit[411] to the NHS (NHS Digital).[412]

12.12 However, according to the Parties, the regulatory requirements did not amount to an 'absolute barrier to entry' for the provision of rehabilitation services (as they suggest they currently do for secure services).

12.13 Competitors generally expressed the view that the CQC registration needed to provide rehabilitation services is granted relatively quickly. Further, they told us that there were limited regulatory requirements to reconfigure a ward to serve a different gender.[413]

- *Our assessment*

12.14 The evidence indicates that there are no regulations that limit the number of market participants but all providers of rehabilitation services must undergo a registration and licensing process. This involves limited financial expenditure

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(optional), Building regulation (optional), Registered manager supporting evidence and Governance document. It also involves criminal record checks of relevant individuals. CQC: Providers' registration supporting documents.
[408] CQC website: Fees.
[409] Guidance: Independent providers of NHS funded services. 14 May 2014.
[410] The Parties stated that NHS contracts insisted that this was in place before referring patients.
[411] The IG Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments. Department of Health, Information Governance Toolkit.
[412] The Parties stated that some customers required this in their contract.
[413] See Appendix F for details.

(see Appendices B and F for details), and takes into account the number of locations of the applicant.

12.15 The time involved in CQC registration and obtaining an NHSI provider licence is relatively short, and there are plans to improve the registration process further.[414,415] Although providers need to apply for another CQC registration when reconfiguring their facilities, there is no fee for this, and based on submissions from the Parties and competitors (see Appendix F for details), the process is relatively straightforward in most cases.

12.16 Larger providers may be at a slight advantage in respect of being able to register many sites through a single CQC registration process.[416]

12.17 Overall, we found no regulatory issues that act as an insurmountable or costly barrier to entry.

Availability of clinical expertise and skilled staff

12.18 A recent report by the NHS Providers[417] finds that 'mental health trusts are struggling to find enough staff with the right skills to deliver existing services to the right quality, let alone being able to find new staff to extend services to new users or create new services.'[418] Similar concerns have been expressed by the CQC in its recent report, where it stated that the number of NHS mental health nurses has declined by 12% between January 2010 and January 2017.[419]

- *Views of the Parties and third parties*

12.19 The Parties told us that rehabilitation services required a high level of clinical expertise, and training and development of staff was key. They stated that whilst it was possible to recruit staff with the relevant experience, in some areas this could be challenging, in particular for highly specialised services.

12.20 Third parties[420] expressed a similar view that a shortage of specialist staff, including qualified nurses was a barrier to entry and expansion, especially for smaller competitors.

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[414] See paragraph 2.25.
[415] CQC registration and the NHSI licence can be requested through the same form.
[416] Although we note that the registration fee varies with the number of locations of the applicant.
[417] NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS.
[418] The state of the NHS provider sector (July 2017) p7.
[419] CQC (July 2017), The state of care in mental health services 2014 to 2017, p7.
[420] See Appendix F for details.

- *Our assessment*

12.21 The evidence indicates that the availability of qualified and experienced staff, especially mental health nurses is a barrier to entry and expansion in the provision of mental health services, including rehabilitation services.

12.22 Further, small providers might be at a disadvantage while trying to recruit staff, due to better stability of employment and potential career opportunities offered by larger organisations. Larger providers may also gain from greater flexibility in deploying their staff across their sites, depending on changing demand conditions.

Financial investment to enter, expand or reconfigure

- *Establishing a new mental health facility*[421]

  - *Views of the Parties and third parties*

12.23 According to Cygnet, the typical costs involved in establishing a mental health hospital in the UK varied depending on:

(a) the size of the hospital; and

(b) the stage of the care pathway, ie the higher the level of security, and the more acute the treatment required, the more significant the costs.

12.24 By way of a case study, Cygnet told us that the total cost of developing its most recent hospital, Cygnet Hospital Coventry,[422] was around £[✂].[423]

12.25 CAS provided us with [✂].[424]

12.26 One competitor[425] told us that the cost of creating an appropriate physical environment to provide rehabilitation services constituted a barrier to entry. However, another competitor[426] said that while there were initial investment

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[421] This can include a new hospital or a new ward.
[422] Cygnet Coventry provides an all-female specialist mental health service with 56 beds. Services include a psychiatric intensive care unit (PICU), a specialised personality disorder service also catering for those with dual diagnosis disordered eating, and a locked rehabilitation unit. Cygnet Coventry Brochure.
[423] Cygnet told us that Cygnet Hospital Coventry was designed as [✂].
[424] The location of this facility is about [✂]. According to the investment paper, the capital expenditure per bed was above the range of its recently completed services because of additional planning requirements/groundworks, and it being a specialised purpose-built facility that would be state-of-the-art when completed.
[425] [✂]
[426] [✂]

costs to set up a rehabilitation hospital service, it did not consider these to be prohibitive.

- *Our assessment*

12.27 Setting up a new rehabilitation facility requires significant financial investment which could be a barrier to entry.

12.28 However, the evidence shows that the Parties have recently set up new facilities, and also have plans to expand some of their existing facilities (see paragraphs 10.3 to 10.9). [✂] This indicates that providers have been able to source the required capital to set up new facilities or expand existing ones.

12.29 We note that the independent mental health hospital sector has seen a spate of M&A in the recent years (see paragraph 2.124). This suggests that whilst the financial investment required to set up a mental health facility providing rehabilitation services can be a barrier to entry, the sector remains attractive to potential buyers, and the providers can expect to recover their sunk costs, if they decide to exit the market.

- *Reconfiguring a mental health facility*

12.30 Instead of setting up a new mental health facility, providers can reconfigure existing facilities to provide other services, including rehabilitation services.

- *Views of the Parties and third parties*

12.31 The Parties stated that the financial investment required to reconfigure facilities constituted a barrier to entry.[427] They told us that reconfiguring a mental health facility involved three steps:

(a) discharging or relocating patients;

(b) re-training or recruiting staff, and adapting the building[428] if required; and

(c) admitting new patients.

12.32 According to the Parties, on average, reconfiguring a ward takes [✂].

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[427] Merger Notice, paragraph 26.4.
[428] The Parties told us that depending on the type of reconfiguration, it may be necessary to retool the ward to provide a different living environment. For example, when reconfiguring an LTMH ward into a specialist ward (ABI, ASD, LD or PD) it would usually be necessary to convert some of the bedrooms into additional community space and specialist treatment rooms. Merger Notice, paragraph 13.27 (b).

12.33 Cygnet told us that the largest cost in reconfiguring a ward was usually the lost revenues due to the ward not operating at a financially feasible occupancy. Cygnet told us that the average EBITDA loss from reconfiguring its wards in the last four years was about £[✂].[429]

12.34 CAS estimated the typical costs of reconfiguring an existing facility to provide rehabilitation services to be approximately £[✂] per bed. CAS told us that in addition to capital expenditure, other expenses generally incurred for reconfiguring a ward were:

(a) recruitment costs when sourcing new staff;

(b) additional wages of an increased staff headcount required to handle the additional patients; and

(c) the cost to provide relevant training to the staff.

12.35 Competitors were generally of the view that it was relatively straightforward to reconfigure wards between genders and between some specialisms. For example, one competitor[430] told us that the difficulty of reconfiguring a facility depended on the specialism converted from and to. It stated that, for example, environmental work was usually required to reconfigure an LTMH ward to an ABI ward, while changing an LD ward to an LTMH ward normally required fewer environmental changes. Another competitor[431] told us that that existing providers of medium or low secure services could reconfigure a ward to provide rehabilitation services relatively easily if there was adequate demand.

12.36 According to one competitor,[432] there were some barriers to reconfiguring a hospital ward or bed, including financial restrictions, additional staffing, registration of the new service and loss of income, whilst the transfer of services took place.

- *Our assessment*

12.37 We found that, in addition to capital investment, reconfiguring a mental health facility involves loss of revenue[433] and additional expenditure to recruit and

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[429] [✂]
[430] [✂]
[431] [✂]
[432] [✂]
[433] According to the Parties, the process of reconfiguring a ward typically involves discharging or relocating existing patients, retraining or recruiting staff and retooling the ward, and admitting new patients. This process according to the Parties is expected to take on average around [✂]. Merger Notice, paragraphs 13.26 & 13.27.

(re)train staff. Providers also incur opportunity cost on the invested capital during the reconfiguration.

12.38 As we discuss in paragraph 12.46, larger providers might be better equipped to reconfigure their facilities due to availability of financial resources. Overall, although reconfiguring an existing facility involves costs, it does not appear to be as significant a barrier as setting up a new rehabilitation facility.[434]

12.39 The incentive to reconfigure a facility depends on the relative profitability of providing the new service compared with the previous service. A key determinant of this relative profitability is the difference in occupancy that could be achieved through reconfiguration.[435] As we note in paragraph 5.46, providers would be unlikely to have the incentive to reconfigure in response to small changes in price or quality for a particular service, even if it was possible for them to do so.

Economies of scale and scope

- *View of the Parties and third parties*

12.40 The Parties told us that larger providers may be able to benefit from certain cross-selling opportunities, for example referring patients from low secure to rehabilitation services. However, they stated that in general, the economies of scale in the supply of rehabilitation services were limited, and this was evidenced by the large number of small credible providers of rehabilitation services.

12.41 Responses from competitors indicated that larger providers:

(a) were able to take a longer-term view of their finances, and were better placed to take the financial risk of not making profits for a certain period after making an investment in a mental health site;[436]

(b) could subsidise where services had a fall in occupancy or invest to maintain quality standards;[437] and

(c) had the advantage of having more clinicians, who could be deployed to various sites.[438]

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[434] See paragraphs 10.14–10.36 for our analysis of potential competition from reconfiguration of existing wards.
[435] See paragraphs 5.38–5.46 for an analysis of factors affecting reconfiguration decisions.
[436] [✂]
[437] [✂]
[438] [✂]

12.42 One customer told us that there were some benefits of scale, and the size of some larger providers, to a degree 'insulated them from the worst that the market can do to them.'[439]

12.43 The CQC told us that one advantage of scale was that larger providers could put in place more infrastructure to support quality teams and internal independent quality inspections. Conversely, larger providers needed to focus on many locations, and there could be a point when economies of scale potentially became diseconomies of scale, viewed from a quality of service perspective.

12.44 LaingBuisson told us that there was an advantage to having a national network since it would allow a patient to be kept within the same business. It stated that larger providers might also have a lower cost of capital.

12.45 LaingBuisson also told us that a larger provider could offer training and better career prospects to attract clinicians and be an attractive employer. It might also have more flexibility in moving clinicians across sites, and 'manage quality on a more strategic basis'.

- *Our assessment*

12.46 Larger providers might have some scale advantages in respect of being able to invest in and grow their services. Larger providers may also be better placed to bear the risk of not making a profit at a specific site for a certain period of time, and have better access to and lower cost of capital.

12.47 Larger providers could also benefit from economies scope in respect of being able to offer a greater range of services along the care pathway. This was in fact part of the rationale for the Merger (see paragraph 4.3). However, our analysis of the competitive process[440] indicates that although pathway benefits are possible, currently these are likely to be limited.

12.48 We note that a large proportion of the Parties' costs relate to their site operations,[441] rather than to divisional or central costs, which suggests limited opportunities to gain from cost synergies can be expected from the Merger.[442]

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[439] [✂]
[440] See paragraph 7.10.
[441] [✂]
[442] UHS estimated relatively cost synergies of £[✂] expected from the Merger.

Reputation and experience

- *Views of the Parties and third Parties*

12.49 The Parties told us that building a strong relationship with CCGs was an important success factor for providers, since CCGs were in control of patient referrals. The Parties argued that many small providers had demonstrated that they could develop strong relationships with CCGs in certain areas.

12.50 Third parties' responses indicated that being an existing provider in a certain area was an advantage due to:[443]

(a) established links with the local community;

(b) relationship with customers and practitioners; and

(c) knowledge of the market.

12.51 One competitor[444] told us that customers required providers to have an established reputation (in particular for PD) before placing patients. It also said that local customer support could be vital for the success of a new service since it might be possible to get references from other customers or to demonstrate successful similar hospitals in another geographic location.

12.52 Another competitor[445] told us that it was relatively easy for the NHS or private providers of secure services (for example) to switch to rehabilitation services without having a pre-existing presence in a particular area. But if an independent provider decided to open a new rehabilitation service in an area where it had existing provision, there would be some benefit from having knowledge of local market conditions in relation to commissioning and staffing.

- *Our assessment*

12.53 Based on the evidence we have seen, whilst providers with a proven track record and reputation can gain patient referrals from established relationships with customers and knowledge of the local market, they need to go through an evaluation process and customers need to be satisfied about the potential providers' capabilities and facilities before referring patients.

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[443] See Appendix F for details.
[444] [✂]
[445] [✂]

12.54 We noted in paragraph 7.10 that the decision to allocate in rehabilitation services can in general be treated independently of the provider's position on other parts of the care pathway.

12.55 Reputation and experience are important factors and may be more important for specialised rehabilitation services (eg PD), but evidence suggests it is less of a barrier in less specialised areas.

Provisional conclusion on barriers to entry and expansion

12.56 The evidence indicates that there are some barriers to entry and expansion in the provision of rehabilitation services, but in our view these are not sufficient to preclude the likelihood of entry.

12.57 As noted in paragraph 12.21, finding qualified and experienced staff, especially mental health nurses, remains a key challenge for both existing and potential providers of all mental health services.

12.58 We found that there are some advantages for larger providers, for example in relation to investing in the business, recruiting staff, offering services across the care pathway (economies of scope). However, we also noted that many smaller independent competitors continue to operate in the market.[446]

Buyer power

12.59 In this section, we consider the countervailing effect of buyer power. Buyer power refers to the ability of customers to use their negotiating strength to constrain the ability of the merged firm to raise prices or reduce quality. The existence of countervailing buyer power will be a factor in making an SLC finding less likely.[447]

12.60 The assessment of whether buyer power would be sufficient to address any effects of an SLC in the local area is however area specific and therefore has been captured in our local competitive assessments in the two overlap areas where an SLC is provisionally found.

Views of the Parties

12.61 The Parties told us that whilst commissioning is managed by individual CCGs rather than NHSE, the National Tariff inflator/deflator set by NHSI acts as a

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[446] We also note that there has been consolidation in the mental health services through M&A in recent years. See paragraph 2.124 and Appendix C.
[447] Merger Assessment Guidelines, paragraph 5.9.1.

benchmark that all CCGs use in negotiating prices.[448] In the Parties' experience, [✂].

12.62 The Parties told us that this was consistent with third party evidence. In particular they cited the LaingBuisson Report suggests that 'the average adjustment to national tariff prices for 2015/16 was -0.5%, with similar reductions expected in following years across all NHS services subject directly or indirectly to NHS tariffs.' Accordingly, whilst customers may procure rehabilitation services individually, providers of rehabilitation services are subject to a broader constraint provided by NHS benchmarks which maintains pressure on prices.

12.63 The Parties told us that that CCGs can (and do) group together to commission rehabilitation services and that the prevalence of framework agreements is increasing. They told us that the CCGs on the Framework can make up a significant proportion of purchases at specific sites, effectively operating as a single customer, with prices and service standards set through competitive tender.[449]

12.64 The Parties also gave examples at specific sites where a single CCG can make up a large proportion of purchases.[450] For example, [✂].

12.65 The Parties also told us that as customers 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, CCGs would be able to discipline the Parties in a number of ways, including by limiting referrals to other sites in other areas and/or for other specialisms (where there is no overlap between the Parties). According to the Parties, the option to discipline in this manner means that even where individual CCGs do not represent a significant proportion of revenues, they are able to exert significant buyer power if the Parties attempted to increase prices at specific sites.[451]

12.66 In addition, the Parties consider that customers have buyer power as they usually have a range of credible alternatives. First, there are numerous other independent providers to which a customer can switch, or threaten to switch, referrals. In Cygnet's experience customers often use this option to negotiate better prices.[452]

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[448] Parties' response to the issues statement, paragraph 2.38. See also Section 2 and Appendix B for more details on the National Tariff.
[449] Parties' response to the issues statement, paragraph 2.40.
[450] Parties' response to the issues statement, paragraph 2.41.
[451] Parties' response to the issues statement, paragraph 2.42.
[452] Parties' response to the issues statement, paragraph 2.43.

12.67 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 male low secure service which is run in a joint working arrangement with Kent and Medway Partnership NHS Foundation Trust.

12.68 Third, NHS foundation trusts have the option to open or reconfigure their own facilities to provide 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 cite a number of examples of NHS trusts expanding and improving their own inpatient rehabilitation services. The Parties provided a number of recent examples of NHS providers opening or reconfiguring rehabilitation facilities to react to regional demand. These are detailed in Appendix F.

12.69 Accordingly, the Parties consider that customers and the NHS have the ability to constrain providers of rehabilitation services in a variety of ways through their 'strong countervailing buyer power.'[453]

Our assessment

12.70 The assessment of whether buyer power would be sufficient to offset any effects of an SLC in the local area is captured in our local competitive assessments where provisional findings of an SLC are made. Below we discuss our analysis of the relevant factors which have informed these assessments.

Framework contracts

12.71 In our view, CCGs grouping together to commission rehabilitation services under a framework agreement may allow the customers using the framework to improve their negotiating position. However, we note that even where framework contracts are in place their impact may fall some way short of generating the countervailing buyer power that would protect prices and quality for all customers referring to providers in that area (see Appendix F for examples based on the Parties' submissions).

12.72 Without evidence that the customers referring to the Parties' hospitals are considering implementing one, it does not appear likely that a framework agreement would arise with the potential to offset concerns with a loss of actual competition from the Merger.

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[453] Parties' response to the issues statement, paragraph 2.46.

Use of NHS benchmarks

12.73 The Parties told us that the National Tariff inflator/deflator set by NHSI acts as a benchmark that all CCGs use in negotiating prices (see paragraph 12.61 above). As set out in paragraph 2.65, although there is no nationally set price for rehabilitation services, services and tariffs are negotiated and agreed locally, providers must comply with rules specified in the 'National Tariff Price 2017/18'.[454] Customers and providers should also have regard to the efficiency and cost uplift factors for 2017/18 and 2018/19 when setting local prices for services without a national price.[455]

12.74 Examples provided by the Parties[456] suggest that the ability to use benchmarks effectively to reduce prices may depend on the concentration of the individual customer and the availability of local alternatives (among other factors). More widely, [✂].

12.75 While NHS benchmarks may create constraints for some providers, there is evidence of competition between providers leading to better outcomes for customers above and beyond the impact of national benchmarks or quality regulation. The Parties have provided examples[457] of how the threat of switching or actual switching can act as a constraint on pricing or quality. In our view this is likely to explain some of the variation in prices across customers, in particular [✂].

12.76 Based on the above, our provisional view is that while NHS benchmarks are a factor that affect pricing, they do not remove the scope for competition on price or the potential for the Merger to adversely affect competition, such that they should be considered as a countervailing factor.

Customer concentration

12.77 We looked at customer concentration as a possible source of buyer power.

12.78 Customer concentration across the Parties' sites is varied (see Appendix F for examples). The Parties provided examples at specific sites where a single customer can make up a large proportion of purchases. However, we found customer concentration at other sites is lower. Consequently, customer

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[454] See the 2017/2018 and 2018/2019 National Tariff Payment System, published by NHSI and NHSE.
[455] For 2017/18, the efficiency factor is 2% and the cost uplift factor is 2.1%. This gives a net increase of 0.1%. For 2018/19 the efficiency factor and cost uplift factors are 2% and 2.1% respectively. This results in a net increase of 0.1%.
[456] See Appendix F.
[457] For example, [✂].

concentration needs to be considered on a case-by-case basis in the local competitive assessments.

12.79 In addition, our view is that any buyer power exercised by those customers responsible for a greater number of referrals would not always be sufficient to protect other customers. To the extent that buyer power is used as a constraint to ensure quality at the site, quality for other customers may also be protected. However, as prices are often individually negotiated, discounts negotiated using a large customer's buying power would not naturally extend to other customers. It therefore does not appear in general that buyer power exercised by larger customers could be relied on to protect smaller customers.

12.80 The Parties' submit that customers would be able to exercise buyer power by limiting referrals to their other sites in other areas and/or for other treatment types (where there is no overlap between the Parties).[458] However, given the large number of individual customers at the overlap sites, in our view it is unlikely that the Parties would be dependent on many of these individual customers across their network of hospitals. Consequently, it appears that many customers would not be able to discipline the Parties by limiting referrals to other sites in other areas.

Sponsoring of entry and self-supply

12.81 The Parties submitted that NHS trusts that have either entered joint ventures with independent providers to provide rehabilitation services or have opened new rehabilitation services themselves (see paragraphs 12.67 to 12.68).

12.82 We have heard from various third parties about new models of commissioning mental health services, currently being led by NHSE, which may have an impact on rehabilitation services in the longer term. These new models have objectives to reduce out-of-area placements (particularly for acute services) and, where possible and appropriate, to treat patients in less secure settings (for example, to move more patients from acute services to rehabilitation services and from rehabilitation services to community services).[459]

12.83 These new models are implemented through local Service Transformation Plans (STPs). It appears that STPs, where implemented, have the potential to substantially transform demand and supply for different services in the area. In this regard, Elysium submitted that: 'Where local areas are asked to devise STPs, these may or may not include independent providers and a provider

[458] Parties' response to the issues statement, paragraph 2.42.
[459] We are currently aware of two examples of such interventions in East London and Sheffield.

could find that it ends up with a hospital in a geographical location that is no longer commissioned, without any consultation or offer to be involved in the STPs.'

12.84 The possibility of implementing a local STP or investing in NHS capacity may in principle imply buyer power (provided it is timely, likely and sufficient to negate an SLC). However, this needs to be assessed on an area-specific basis.

Provisional conclusion on buyer power

12.85 Based on our analysis of the evidence as set out above, our provisional conclusion is that buyer power is unlikely to be an effective countervailing factor in general. Where relevant we considered the effect of this potential countervailing factor in our local area assessments in paragraphs 9.189 to 9.192 and 9.230 where an SLC has provisionally been found.

Efficiencies[460]

12.86 The Parties told us that the Merger was likely to give rise to efficiencies and benefits for patients, predominantly by easing the transitions between different stages of the care pathway. They said that the Merger would broaden the reach of the Parties across the care pathway and enable a greater number of smoother transitions, which would be less disruptive for patients.[461]

12.87 However, as noted in paragraph 7.10, the decision to allocate patients in rehabilitation services can in general be treated independently of the provider's position on other parts of the care pathway. Therefore, although pathway benefits are possible, in order for these efficiencies to be taken into account in our assessment, we expect the Parties to provide evidence that the efficiencies claimed are a direct consequence of the Merger, are rivalry enhancing and timely, likely and sufficient to prevent an SLC from arising.

12.88 We have not received evidence from the Parties showing that any efficiencies that might be generated would enhance rivalry in the provision of rehabilitation services.[462] We have therefore not placed any weight on the effect of efficiencies in our assessment of the Merger.

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[460] As explained in our guidance, efficiencies can be taken into account in two ways: efficiencies may enhance rivalry, with the result that the Merger does not give rise to an SLC or they may result in relevant customer benefits (RCBs) which are taken into account when deciding on remedial action (section 41(5) of the Act). Merger Assessment Guidelines, paragraphs 5.7.2 & 5.7.3.
[461] Source: Merger Notice, paragraph 29.1.
[462] Merger Assessment Guidelines, paragraph 5.7.4.

13. Provisional findings on the SLC test

13.1 As a result of our assessment 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, namely for:

(a) male LTMH patients in the East Midlands; and

(b) female LTMH patients in the West Midlands.

13.2 The SLC in these local areas may be expected to lead to adverse effects for customers and patients in terms of prices being higher than they would otherwise be and quality being lower than it would otherwise be.