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

Appendices and glossary

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Appendix A: Terms of reference and conduct of the inquiry

Terms of reference

1. On 3 May 2017 the CMA referred the completed acquisition by Universal Health Services, Inc. through its wholly owned subsidiary, Cygnet Health Care Limited of Care Aspirations Developments Limited, Cambian Healthcare Limited and Cambian Care Services Limited:

   1. In exercise of its duty under section 22(1) of the Enterprise Act 2002 (the Act) the Competition and Markets Authority (CMA) believes that it is or may be the case that:

      (a) a relevant merger situation has been created, in that:

      (i) enterprises carried on by Cygnet Health Care Limited and Universal Health Services, Inc (**Cygnet**) have ceased to be distinct from enterprises carried on by Care Aspirations Developments Limited, Cambian Healthcare Limited and Cambian Care Services Limited (**Cambian**); and

      (ii) the condition specified in section 23(1)(b) of the Act is satisfied; and

      (b) the creation of that situation has resulted, or may be expected to result, in a substantial lessening of competition within a market or markets in the United Kingdom for goods or services, including in the supply of hospital-based inpatient rehabilitation services to local authorities and NHS clinical commissioning groups (CCGs) in England, and to NHS Wales.

   2. Therefore, in exercise of its duty under section 22(1) of the Act, the CMA hereby makes a reference to its chair for the constitution of a group under Schedule 4 to the Enterprise and Regulatory Reform Act 2013 in order that the group may investigate and report, within a period ending on 17 October 2017, on the following questions in accordance with section 35(1) of the Act:

      (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 within any market or markets in the United Kingdom for goods or services.

Andrea Coscelli
Chief Executive
Competition and Markets Authority
3 May 2017

Conduct of the inquiry

3. We published biographies of the members of the inquiry group conducting the inquiry on 8 May 2017, and the administrative timetable for the inquiry was published on the CMA webpages on 12 May 2017.

4. We invited a wide range of interested parties to comment on the completed acquisition. These included competitors of Cygnet and CAS,[1] as well as NHS trusts, Clinical Commissioning Groups and government bodies. Evidence was obtained from third parties through hearings, written requests, questionnaires and telephone contact. Summaries of hearings can be found on our website.

5. We received written evidence from Cygnet and CAS, and a non-confidential version of their joint response to the phase 1 decision and the Merger Notice is on our website. We held a hearing with Cygnet and CAS on 20 July 2017.

6. On 9 June 2017, we published an issues statement on our website, setting out the areas of concern on which the inquiry would focus.

7. On 7 June 2017, members of the inquiry group, accompanied by staff, visited the sites of Cygnet and CAS.

8. During the course of our inquiry, we sent Cygnet and CAS a number of working papers, and other parties were sent extracts of those working papers, for comment.

9. A confidential version of the provisional findings report will be available on the CMA website.

10. We would like to thank all those who have assisted us in our inquiry so far.

Interim measures

11. We took steps to ensure that the business operations of Cygnet and CAS remained separate and independent during the course of the inquiry.

[1] We noted following completion the companies acquired were collectively referred to as Cambian Adult Services or CAS.

12. On 17 May 2017 the CMA made an Interim Order to ensure that no action was taken pending determination of the Reference which might prejudice the Reference or impede the application of effective remedies at the end of our inquiry, should they be required.

13. We also requested fortnightly updates from the Parties to confirm they remained separate and independent. We granted derogations from the order which were published on our website.

Appendix B: Legal and regulatory background

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Introduction

1. This appendix outlines the legal and regulatory environment in which mental health services and in particular rehabilitation services are provided in England. References to Wales are included to highlight any relevant key differences between the two regimes.

2. Annex 1 sets out the legislation in more detail and Annex 2 provides an overview of payment models in this industry.

Patients' rights

Criteria for detention

3. The Mental Health Act 1983 (the 1983 Act) is largely concerned with the circumstances in which a person with a mental disorder can be detained for treatment for that disorder without their consent.

4. It also sets out the processes that must be followed and the safeguards for patients, to ensure that they are not inappropriately detained or treated without their consent.

5. The 1983 Act was significantly amended by the Mental Health Act 2007 (the 2007 Act). In particular, section 4 of the 2007 Act introduced a new 'appropriate medical treatment test' into the criteria for detention[1] under section 3 of the 1983 Act. In more detail, a patient may be admitted to a hospital, and detained there for the period allowed by law, in pursuance of an application ('an application for admission for treatment') if:

   (a) they are suffering from a mental disorder of a nature or degree[2] which makes it appropriate for them to receive medical treatment[3] in a hospital; and

   (b) it is necessary for:

      (i) the health or safety of the patient or;

      (ii) for the protection of other persons that they should receive such treatment;

   and it cannot be provided unless they are detained under this section; and

   (c) appropriate medical treatment is available for him.

6. The previous test under the 1983 Act required that the treatment was likely to alleviate or prevent a deterioration of his condition, ie the treatability of the patient's condition.

7. The application for admission for treatment requires the written recommendations, in the prescribed form, of two registered medical practitioners including in each case a statement that in the opinion of the practitioner the conditions are complied with.

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[1] 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.

[2] It is not enough that appropriate treatment exists in theory for the patient's condition. Case law has established that 'nature' refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for disorder. 'Degree' refers to the current manifestation of the patient's disorder (*R v Mental Health Review Tribunal for the South Thames Region ex p. Smith* [1999] C.O.D. 148).

[3] A medical treatment is defined as including nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care, section 145(1) of the 1983 Act.

8. The two registered medical practitioners must also specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

9. Moreover, a patient admitted to hospital in pursuance of an application for admission for treatment, may be detained in a hospital for a period not exceeding six months beginning with the day of admission. Detention for any longer period is not permitted unless the authority for his detention is renewed.[4]

10. The 1983 Act also contains provisions in relation to admission for treatment and detention to hospitals as a result of a court order if a person is convicted of a criminal offence.[5]

11. The 2007 Act also introduced some other changes to the 1983 Act in relation to supervised community treatments (SCT).

12. The 2007 Act introduced SCT for patients following a period of detention in hospital. This is intended to allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act, to ensure they continue with the medical treatment that they need.

13. The relevant criteria for issuing an SCT are:[6]

    (a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

    (b) it is necessary for his health or safety or for the protection of other persons that they should receive such treatment;

    (c) subject to his being liable to be recalled, such treatment can be provided without his continuing to be detained in a hospital;

    (d) it is necessary that the responsible clinician should be able to exercise the power below to recall the patient to hospital; and

    (e) appropriate medical treatment is available for him.

14. In determining whether the patient can be recalled, the clinician should have regard to the patient's history of mental disorder and any other relevant

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[4] Section 20 of the 1983 Act as amended.
[5] Section 37 of the 1983 Act.
[6] Section 17A of the 1983 Act as amended.

factors as well as what risk there would be of a deterioration of the patient's condition if they were to continue not to be detained in a hospital.[7]

15. An SCT order ceases to be in force on expiry of the period of six months beginning with the day on which it was made.[8]

Classification of secure mental health services

16. There are no legal provisions that prescribe the criteria under which patients should be admitted in the different levels of secure mental health services (high, medium and low secure).

17. According to the Department of Health, ‘secure’ relates to the range of physical, relational and procedural measures put in place to ensure the provision of a safe and secure environment in which to deliver treatment.[9]

18. There are three levels of secure care: high, medium and low with guidance governing provision at each level.[10] Depending on individual needs, patients may go through an integrated care and treatment pathway that spans one or more levels of care.

19. 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.

20. Personality disorder (PD) services in particular are often described using a tiered approach which allows patients to be appropriately directed according to their needs and 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.[11]

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[7] Section 20A (7) of the 1983 Act
[8] Section 20A of the 1983 Act.
[9] See NHS, Your guide to relational security.
[10] Department of Health, Secure mental health services.
[11] 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.

(c) Tier 3 refers to local[12] specialist PD services. These services will usually offer

(i) consultation, training and support to local mainstream services;

(ii) local treatment programmes;

(iii) non-hospital residential provision eg in crisis houses[13] or respite provision;

(iv) intensive day treatment ie 'partial hospitalisation';

(v) access to acute inpatient care.

(d) Tier 4 mainly refers to residential low and medium secure specialist inpatient PD services.[14] The major treatment role for Tier 4 PD services will be for those patients whose safe treatment requires a higher level of containment than can be provided by local hospital residential programmes, either through higher intensity and frequency of therapeutic input, or through the specialist residential therapeutic environment. This may be as a short-term preparation or for long-term treatment programmes (a year or longer).[15]

(e) Tier 5 and 6 services are medium and high secure forensic[16] services.

High secure mental health services

21. High secure services are provided at Ashworth, Broadmoor and Rampton hospitals, each hospital being part of an NHS trust. At present, the Department of Health's relationship with high secure hospitals is different to the relationship to any other NHS service as the NHS Act 2006 (the NHS Act) places a specific duty on the Secretary of State for Health (SoS) to provide high secure hospital services.

22. Patients in high secure hospitals present a grave and immediate danger to the public and require a significant period of treatment.

[12] Local services cover narrow geographic areas or a small specified set of the population.
[13] Crisis houses offer intensive, short-term support to manage and resolve crisis in a residential setting (rather than hospital).
[14] 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.
[15] 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.
[16] Forensic services are services related to offenders.

23. High security hospitals have a 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. Those physical and procedural security policies are audited annually by the prison service.

24. Patients detained for therapeutic treatment in high security hospitals can be genuinely difficult to manage. They are admitted having been assessed as posing a grave and immediate danger to others. The prevalence of self-harm is high and patients frequently exhibit subversive, violent and assaultive behaviour.

25. Because of their nature, high secure services have a national performance management and oversight structure.[17]

Medium secure mental health services

26. Medium secure services are provided by a range of NHS and independent sector organisations, and are for people who present a significant danger.

27. Many patients will have a history of offending and some will have been transferred from prison or from court to receive inpatient treatment. Typically, patients will remain in treatment between two and five years.

28. Establishing who is eligible for medium secure services is complex. Admission criteria vary widely between different medium secure units and are dependent on a range of influencing factors from severity of offence to the absence of alternative arrangements. The risk a person is thought to pose, the diagnosis they are given and their offending history appear to be the most important criteria for admission.[18]

29. In July 2007, the Department of Health published guidance related to medium secure services. It sets out detailed best practice recommendations in relation to the safety and security requirements of the wards and premises, the governance of the hospitals and the quality of care.[19]

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[17] For more detailed guidance documents see Department of Health, Secure mental health services.
[18] See Centre for Mental Health (April 2011), Pathways to unlocking secure mental health care.
[19] See Department of Health (July 2007), Best Practice Guidance - Specification for adult medium-secure services.

Low secure mental health services

30. In 2002 the Department of Health published the *National minimum standards for general adult services in Psychiatric Intensive Care Units (PICU)*[20] *and Low Secure Environments* where it sets out the criteria for admission in PICUs and low secure environments.[21]

31. Patients admitted to the PICU/low secure environment will have behavioural difficulties that seriously compromise their physical or psychological well-being, or that of others and which cannot be safely assessed or treated in an open acute inpatient facility.

32. Patients will only be admitted if they display a significant risk of aggression, absconding with associated serious risk, suicide or vulnerability, in the context of a serious mental disorder.

33. In low secure units, patients may also be experiencing chronic behavioural disturbance.

34. The Department of Health emphasises that there must be mutual agreement between referrer and admitting unit on the positive therapeutic benefits expected to be gained from the time limited admission including a clear rationale for assessment and treatment.

Patients' rights when admitted to hospitals

35. The 1983 Act contains also the Code of Practice,[22] ie the guidance for medical practitioners in relation to the admission of patients to hospitals.[23] Section 2B requires the SoS to prepare the Code and ensure that the following matters are addressed:

    (a) Respect for patients' past and present wishes and feelings.

    (b) Respect for diversity, generally including, in particular, diversity of religion, culture and sexual orientation.

    (c) Minimising restrictions on liberty.

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[20] Psychiatric intensive care units defined care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder.
[21] See Department of Health, Mental Health Policy Implementation Guide National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments (2002, currently being updated).
[22] Section 118 of the 1983 Act.
[23] See the Mental Health 1983: Code of Practice (last updated in 2015).

(d) Involvement of patients in planning, developing and delivering care and treatment appropriate to them.

(e) Avoidance of unlawful discrimination.

(f) Effectiveness of treatment.

(g) Views of carers and other interested parties.

(h) Patient well-being and safety.

(i) Public safety.

36. The SoS shall also have regard to the desirability of ensuring:

(a) the efficient use of resources; and

(b) the equitable distribution of services.[24]

37. The Department of Health has published guidance[25] as part of its new *Positive and Safe* programme ('Positive and Proactive Care Guidance'). The Positive and Safe programme Guidance responded, in part, to the Department of Health report into the actions required following the Winterbourne View scandal,[26] and in part to the report published by Mind in June 2013 on the abuse of restraint techniques.[27]

38. The key actions that the Positive and Proactive Care Guidance has set out are as follows:

(a) If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.

(b) Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.

(c) Service customers must be informed by providers about restrictive interventions used for those for whom they have responsibility.

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[24] Section 118 (2C) of the 1983 Act.
[25] See Department of Health, Positive and Proactive Care: Reducing the need for restrictive interventions (April 2014).
[26] The Winterbourne View hospital inquiry occurred into Winterbourne View, a private hospital at Hambrook, South Gloucestershire. A television investigation broadcast in 2011 exposed the physical and psychological abuse suffered by people with learning disabilities and challenging behaviour at the care home.
[27] Mind (June 2013), Mental Health crisis care: Physician Restraint in Crisis.

(d) Accurate internal data must be gathered, aggregated and published by providers including progress against restrictive intervention reduction programmes and details of training and development in annual quality accounts or equivalent.

(e) The Care Quality Commission's (CQC's) monitoring and inspection against compliance with the regulation on use of restraint and its ratings of providers will be informed by the Positive and Proactive Care Guidance.

Regulatory bodies

NHS Improvement

39. The Health and Social Care Act 2012 (HSCA 2012) made changes to the way NHS service providers are regulated, and established Monitor as the system regulator for all NHS-funded services.[28]

40. 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.

41. The main duty of NHSI in exercising its functions is to protect and promote the interests of people who use healthcare services by:

(a) promoting the provision of healthcare services which is economic, efficient and effective;

(b) maintaining or improving the quality of the services;[29]

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

42. NHSI's main duties are:

(a) licensing health services providers; and

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

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[28] Section 61 of the HSCA 2012.
[29]Section 62 of the HSCA 2012.

Care Quality Commission

43. The CQC is the independent regulator of health and adult social care in England.

44. The Health and Social Care Act 2008 (HSCA 2008) established the CQC and replaced the Commission for Healthcare Audit and Inspection, the Commission for Social Care Inspection and the Mental Health Act Commission.

45. The CQC has the following statutory functions:[30]

(a) Registration functions (see further paragraph 60 and onwards below).

(b) Review and investigation functions.

(c) Functions under the Mental Health Act 1983.[31]

46. Its main objective in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services.

47. The CQC regulates any activity of a prescribed kind, ie any activity which involves, or is connected with, the provision of health or social care in, or in relation to, England.[32] This covers regulation of adult social care, primary medical care (eg GPs), NHS Healthcare (eg NHS trusts), independent healthcare and specialist services.

48. The CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety ('the Fundamental Standards') and it publishes its findings, including performance ratings to help people choose care.[33]

49. 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?

Quality monitoring and investigation powers

50. The CQC has the power to:

[30] Section 2 of the HSCA 2008.
[31] For instance, through monitoring the 1983 Act and how providers are caring for patients, and whether patients' rights are being protected.
[32] Section 8 of the HSCA 2008.
[33] See the Care Quality Commission website.

(a) require explanations;[34]

(b) carry out reviews and performance assessments and publish a report: the CQC may use different indicators each time it assesses the performance of service providers and can make different provisions as to the frequency or the methods it will use in each case;[35]

(c) conduct special reviews or investigations;[36]

(d) monitor by gathering and analysing data about services; and

(e) conduct inspections: the CQC may conduct inspections for the purposes of its regulatory functions or for registration purposes and publish a report.

51. The CQC has extensive powers to enter and examine premises, take copies of documents, access and operate computers and inspect any other items, as well as make private interviews with managers and the patients.[37]

52. The CQC may conduct two types of inspections: a comprehensive or a focused one. A comprehensive inspection is conducted at least every three years and it entails a one to four days announced site visit plus unannounced visits. The focused inspection is conducted as frequently as it can be required and its duration will vary depending on the circumstances of each case.[38]

53. The CQC can also perform unannounced inspections especially in situations where it has previously issued a warning notice to a provider.

54. The CQC will, as a result, rate the performance of service providers and publish the rating, which providers would need to display prominently.[39]

Enforcement

55. The CQC has extensive civil enforcement as well as criminal enforcement powers.

[34] Section 65 of the HSCA 2008 and Regulation 10 of the Care Quality Commission (Registration) Regulations 2009 ('the 2009 Regulations').
[35] Section 46 of the HSCA 2008 and Care Quality Commission (Reviews and Performance Assessments) Regulations 2014 ('the 2014 Regulations').
[36] Section 48 of the HSCA 2008.
[37] Section 60 of the HSCA 2008.
[38] See CQC (March 2015), How CQC regulates: Specialist mental health services – Provider Handbook.
[39] The CQC's current inspection approach does not include rating the corporate level of independent mental health providers but the CQC has reported that it will continue to keep this under review as it recognises the importance of the corporate level and the impact this can have on the quality of care.

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

57. Its civil enforcement powers will range from requirement and warning notices, to special measures for providers that require a higher-than-usual level of regulatory supervision.[40]

58. Moreover, the breach of certain regulations by service providers might constitute criminal offences.[41]

59. Its criminal powers will range from simple cautions, to penalty notices and ultimately prosecution when people using a registered service are harmed or placed at risk of harm.

Service providers' key obligations

Registration process

60. Rehabilitation services providers are required to register to the CQC, and failure to comply with this requirement is an offence.[42]

61. 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 on one regulated activity for which it is registered, it is required to cancel the registration of that activity.

62. If the provider decides to limit the locations for the provision of its services, it will need to submit a variation application and does not need to cancel its registration and re-register.

63. Similarly, if the provider wishes to amend a location address due to an expansion, the provider must submit an application to vary or remove a condition of registration to carry on a regulated activity explaining the changes

[40] Independent mental health services rated as 'Inadequate' overall will be placed straight into special measures and be re-inspected within one 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. Special measures do not replace 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.
[41] In particular, Regulations 11–14, 16–17, 20 and 20A of the 2014 Regulations and Regulations 12, 14–20 of the 2009 Regulations. For instance, this might cover failure to *(a)* safeguard users from abuse or improper treatment; *(b)* display performance assessments; *(c)* notify changes such as a change of the name of the manager.
[42] 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.

and the impact on people who use services. The CQC may need to visit the facilities as part of its assessment of this type of application.[43]

64. Part 4 of the 2009 Regulations sets out the registration requirements.

65. In practical terms, the CQC will require applicants to:

(a) ensure business premises are ready and fit for purpose;[44]

(b) perform a criminal record check;

(c) fill in an application which consists of:

(i) a Statement of Purpose: this will include information on the provider's aims and objectives, the services, the different needs served, contact details, the service's legal entity, the places where services are provided;[45]

(ii) a management policy/procedures document;

(iii) a safeguarding policy and procedures document;

(iv) planning permission (if applicable);

(v) building regulation document (if applicable); and

(vi) governance document.

66. In completing the application, the service provider must ensure that it demonstrates how the requirements of the HSCA 2008 – and associated

[43] See CQC (June 2016), Guidance for Providers - Applying to remove or vary conditions of registration. For instance, recently (April 2016) the CQC rejected Oakview's Estate Limited application to vary its registration for its 'West Hills House' service so that one of three buildings on its hospital site could become a nursing home for up to six people with a severe learning disability, autism and complex needs and who required intensive support. The CQC rejected the application because it did not support the national policy and evidence-based guidance to develop person-centred community services and to close inpatient hospital facilities for people with a severe learning disability and/or autism. A First-tier Tribunal dismissed the appeal from the provider for CQC's decision to be overturned.

[44] The CQC emphasises that it will not be able to assess compliance with the registration requirements *(a)* where there are substantial outstanding building works; *(b)* where essential equipment, staff or other resources are not yet available; and *(c)* where the systems, procedures and policies that will be needed are not in place. However, it recognises that new providers may not be able to demonstrate actual compliance with all requirements as they are not yet providing the service. Because of this, it will assess whether the 'inputs' and 'processes' applicants have put in place are likely to enable them to comply with the registration requirements. See CQC, Guidance for organisations applying for both registration and licensing as a new service provider (April 2014), p18.

[45] Service providers are also required to keep their Statement of Purpose up to date and notify the CQC of any changes within 28 days since the change occurred.

regulations – will be met, ie its compliance with some basic standards ('the Fundamental Standards').[46] These are:

(a) Fit and proper persons (for directors).[47]

(b) Person-centred care.

(c) Dignity and respect.

(d) Need for consent.

(e) Safe care and treatment.

(f) Safeguarding patients from abuse and improper treatment.

(g) Meeting nutritional and hydration needs.

(h) Keeping premises and equipment clean, secure and properly maintained.

(i) Receiving and acting on complaints.

(j) Good governance.

(k) Suitably qualified, competent, skilled and experienced staff who receive continuous training and qualifications.

(l) Act in an open and transparent way and notify incidents.

(m) Display the performance assessments in particular the rating in any website maintained by or on behalf of any service provider, their premises and the providers' principal place of business.

67. The CQC has published statutory guidance explaining these standards in more detail.[48]

68. The CQC has the power to set regulatory fees, subject to consultation,[49] so as to recover its chargeable costs.

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[46] In particular, the requirements of the 2014 Regulations and 2009 Regulations.
[47] According to 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.
[48] Section 23 of the HSCA 2008 requires the CQC to publish guidance. See Guidance for providers meeting the regulations (March 2015).
[49] The CQC's latest consultation on its regulatory fees took place in October 2016 and closed in January 2017.

69. For rehabilitation services providers, the fee is based on the number of locations the provider is registered for, according to the fee bands set out in the CQC's Fee Scheme 2017/2018.[50] The fees can range from £10,698 to £193,390.

70. Every registered provider will pay a single annual fee on the same date each year. This fee will cover all registration and compliance requirements for all locations.

71. There is no fee for an application to make a variation or to add a new regulated activity to an existing registration.[51]

72. Where the CQC is not satisfied that the provider will be able to meet the Fundamental Standards, it can issue a Notice of Proposal to refuse an application or to impose conditions on the registration.[52]

73. The CQC should be notified of any changes relating to the services of registered providers. Independent mental health providers are required to notify the CQC in the event of any of the following:[53]

    (a) Death of a person using the service.

    (b) Deprivation of liberty application.[54]

    (c) Abuse or allegations of abuse.

    (d) Serious injury.

    (e) Incidents reported to the police.

74. The CQC has the power to cancel or suspend a registration. Suspension or cancellation of a registration will cover all of the locations where the provider provides service.

75. The CQC may cancel a registration on the grounds that the registered person:

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[50] See CQC Fee Scheme 2017/2018.
[51] Regulatory fees 2017/18: Guidance for providers (March 2017), p6.
[52] The CQC reported that from January to December 2016 it issued 343 such notices. The CQC completed almost 35,000 registration processes in the year to 31 March 2016. The overwhelming majority of applications for new registrations or applications by providers or managers to vary conditions were granted (99%), but a small minority were refused, for example where it was not satisfied about the provider's fitness or its compliance with the requirements. For more information see CQC (October 2016), The state of health care and adult social care in England 2015/2016.
[53] See Regulations 16–18 of the 2009 Regulations.
[54] This is an application to the court pursuant to section 16(2)(a) of the Mental Capacity Act 2005 to make decisions about personal welfare or property and affairs for persons lacking capacity or to appoint a deputy to do so.

(a) has made a statement which is false or misleading in a material respect or provided false information in relation to any application for:

(i) registration; and/or

(ii) the variation or removal of a condition in relation to their registration;

(b) has failed to pay any fees payable;

(c) if the registered person is a service provider, is not, and has not been for a continuous period of 12 months carrying on that regulated activity.[55,56]

76. In a recent review conducted by the CQC, overall 90% of new registered providers and managers said that they had a good or very good experience with registration. However, some providers reported that they found the process of registration frustrating or time consuming, in particular when having to re-submit forms multiple times for administrative reasons.[57]

77. Another complaint from patients was that the process is slow. The CQC reported that from October 2015 to March 2016, completing registration ranged from 40 to 62 days.[58]

78. One of the main objectives of the CQC, set out in its Business Plan,[59] is to speed up the registration process (with the aim of it being able to be completed in ten weeks) as well move to an online registration process.

79. The CQC has also mentioned that it aims to move to a more risk-based assessment of registrations, focusing on areas of greater risk and against set criteria. These criteria might include the nature of people using the service, the provider's track record on quality and whether individuals are subject to other regulation or scrutiny. Moreover, some applications (for instance, the change of branch office address) might become more streamlined.

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[55] Section 17 of the HSCA 2008 and Regulation 6 of the 2009 Regulations.
[56] For instance, in January 2016 the CQC cancelled the registration of a nursing home provider, Barrisle Care Home Limited, in Leyland, Lancashire. During an unannounced inspection in October 2015 inspectors found that the provider was still failing to ensure people living at the home were safe and properly cared for. Previous inspections in May 2015 had observed 13 breaches of the regulations and a continued failure by the provider to make the required improvements. At its latest inspection in October 2015, the CQC found continued concerns regarding the homes induction and supervision of staff; people's right to consent to care and treatment; nutritional support; safety of some areas of the home; record keeping not reflecting people's needs accurately; and leadership.
[57] See CQC (April 2017), Review of CQC's impact on quality and improvement in health and social care, p10.
[58] See CQC (April 2017), Review of CQC's impact on quality and improvement in health and social care.
[59] See the CQC Business plan 2017-18.

80. 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 also planning to reconsider this approach.

Licensing

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

82. The HSCA 2012 requires NHSI to determine and publish the general and special conditions to be included in each licence.[60]

83. The licensing criteria for a new provider to be granted a licence are:[61]

   (a) registration with the CQC;

   (b) the directors or governors must meet NHSI's fit and proper test.[62]

84. There are a number of conditions for all licensees:

   (c) General conditions: There are nine general conditions that need to be met, covering areas such as providing and publishing information, paying fees, fit and proper persons requirements, and a requirement for providers to be registered with the CQC.

   (d) Integrated care condition: This condition allows NHSI to take action if the service provider acts in a way that is detrimental to the delivery of integrated care.[63]

   (e) Choice and competition conditions: The competition condition aims to prevent anti-competitive behaviour that is not in the interests of patients. The condition prevents providers from entering into or maintaining any agreement, or engaging in any other conduct, which prevents, restricts or

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[60] Section 91 of the HSCA 2012. See also NHS provider licence.
[61] Pursuant to section 86 of the HSCA 2012 and the National Health Service (Approval of Licensing Criteria) Order 2013/2960.
[62] According to 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.
[63] For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs. This requirement would cover both integration between service types (such as between health and social care) and integration between different types of health services (such as hospital and community care).

distorts competition where this is against the interests of healthcare users. The choice condition requires the provider to notify patients when they have a right of choice of provider, and to tell them where they can find information about the choices they have. This condition applies wherever patients have a choice of provider under the NHS Constitution[64] or a choice that has been conferred locally by customers. It also prohibits providers from offering inducements to clinicians, customers and other third parties to refer patients or commission services.

(f) Pricing conditions: The pricing conditions of the licence require the provider to comply with the National Tariff and to provide NHSI with information on costing (see also paragraphs 146 and onwards below).

85. To apply for a licence, a provider must submit an online application form. From April 2014, all providers requesting both CQC registration and a licence from NHSI are able to apply through a single process.[65] NHSI must publish a register of licence holders.[66]

86. 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.[67]

87. NHSI can take action if:[68]

(a) a licensee breaches a licence condition or a requirement to provide information; and/or

(b) a prospective provider provides NHS services without holding a licence when they are required to have one.

88. This action can include requiring the provider to put things right and, in certain circumstances, imposing a fine.[69]

Planning permission

89. The Town and Country Planning (Use Classes) Order 1987 ('the 1987 Order') puts uses of land and buildings into various categories ('use classes').

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[64] The NHS Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. See NHS Constitution for England.
[65] See CQC (April 2014), Guidance for organisations applying for both registration and licensing as a new service provider.
[66] Section 93 of the HSCA 2012.
[67] Section 97(1)(a) of the HSCA 2012.
[68] Section 104 of the HSCA 2012.
[69] Sections 105 and 106 of the HSCA 2012.

90. It is generally the case that someone will need planning permission to change from one use class to another, although there are exceptions where the legislation does allow some changes between uses.

91. Planning permission is not needed when the existing and the proposed uses fall within the same 'use class'.

92. In 2006, the Town and Country Planning (Application of Subordinate Legislation to the Crown) Order 2006 amended the 1987 Order to include an additional class C2A for secure residential institutions.

93. These institutions include those used for the provision of secure residential accommodation, including use as a prison, young offenders' institution, detention centre, secure training centre, custody centre, short-term holding centre, secure hospital, secure local authority accommodation or use as military barracks.

94. Following this legislative change, secure hospital providers will need to apply for a specific planning permission. However, the legislation does not clarify which secure services fall inside the scope of this provision, nor does it define the term 'secure'.

Duties of rehabilitation services customers

95. The HSCA 2012 made significant changes to a number of existing Acts, most notably the NHS Act.

96. The main aims of the NHS Act were to change how NHS care is commissioned through the greater involvement of clinicians and a new NHS Commissioning Board, to improve accountability and patient voice, to give NHS providers new freedoms, to improve quality of care and to establish a provider regulator to promote economic, efficient and effective provision.

97. The HSCA 2012 established a new non-departmental public body to be known as the National Health Service Commissioning Board (NHS Commissioning Board), known as NHS England (NHSE), accountable to the SoS.

98. NHSE commissions some services directly itself, and otherwise regulates the commissioning activities of CCGs, which commission the majority of NHS services. Its functions include:

    (a) considering and determining applications to establish CCGs from 2013 and applications thereafter to vary the constitutions of existing CCGs;

(b) determining the basis for payments by CCGs to providers;

(c) providing funding to CCGs to meet their expenditure;

(d) providing guidance to CCGs on the discharge of their commissioning functions;

(e) exercising functions on behalf of CCGs at their request; and

(f) providing assistance or support to CCGs.

99. NHSE must conduct an annual performance assessment of each CCG and has power to make quality payments to CCGs reflecting their performance.

100. NHSE must perform its functions in accordance with an annual 'mandate' from the SoS, which specifies the objectives that NHSE should seek to achieve and any requirements that the SoS considers it necessary to impose on NHSE in order to ensure it achieves those objectives.

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

102. These bodies are now responsible for commissioning the majority of health services. New sections 14P to 14Z24 have been added into the NHS Act, which contain CCGs' duties, and powers, and provision for the NHSE to intervene in the event of failure.

103. Section 14Z3 of NHS Act also sets out that any two or more CCGs have the power to make arrangements (ie to delegate or exercise functions jointly). CCGs entering into arrangements under this section may establish and maintain a pooled fund.

104. There are now 207 CCGs in England which are responsible for approximately two-thirds of the total NHS England budget; or £73.6 billion in 2017/18.[70] In addition to the central programme budget, NHSE holds separately funds for transformation of £1.1 billion for both 2017/18 and 2018/19, which are

[70] As of August 2017, as reported in NHS Clinical Commissioners website.

allocated to support the implementation of the Five Year Forward View[71] focusing on priorities such as, among others, mental health services.[72]

105. Moreover, rehabilitation services account for around 25% of the total mental health budget.[73]

106. According to a recent survey, over 90% of providers and 60% of customers were not confident that the £1 billion additional investment will be sufficient to meet the challenges faced by mental health services. The most common areas for additional investment in 2015/16 were: child and adolescent mental health services, adults of working age and older peopl services.[74]

107. The CCGs' duties include:

(a) promoting the NHS Constitution;[75]

(b) exercising its functions with effectiveness and efficiency etc;

(c) improving the quality of services;

(d) promoting the quality of primary medical services;

(e) reducing inequalities;

(f) promoting involvement of each patient;

(g) respecting patient choice;

(h) obtaining appropriate advice;

(i) promoting innovation;

(j) promotion of research;

(k) promoting education and training; and

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[71] The NHS Five Year Forward View, published in October 2014 by NHSE, set out a positive vision for the future of health services based around seven new models of care: multi-speciality community providers, primary and acute care systems, urgent and emergency care networks, acute care collaborations, specialised care, modern maternity services and enhanced health in care homes. See NHS Five Year Forward View.

[72] See NHSE (March 2017), NHS England Funding and Resource 2017-19: supporting 'Next Steps for the NHS Five Year Forward View'.

[73] See Joint Commissioning Panel for Mental Health (November 2015), Guidance for commissioners of rehabilitation services for people with complex mental health needs.

[74] See NHS Providers (May 2016), Funding Mental Health at Local Level - Unpicking the Variation.

[75] The NHS Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. See NHS Constitution for England.

(l) promoting integration.

108. NHSE has broadly the same duties when commissioning services, as set out in sections 13C to 13P of the NHS Act.

109. The services which NHSE may be required to commission[76] include services which can be more effectively commissioned at national level, or which it would be inappropriate or impractical for CCGs to commission.[77]

110. The NHS Act provides, at section 13Z, that NHSE's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHSE England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHSE and the CCG.

111. CCGs and some local authorities[78] are responsible for the commissioning of rehabilitation services in England.

Procurement and contracting rules and practice

Rules relating to mental health services procurement

112. Procurement in rehabilitation services is underpinned by two key sets of regulations for customers:

(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

113. The PPCCRs came into force on 1 April 2013. They consist of requirements as to procurement, patient choice and competition.

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[76] Section 3B of the NHS Act.
[77] Those services include some dental services, specialised services, prison health services and health services for the armed forces.
[78] Local authorities take the lead for improving health and coordinating local efforts to protect the public's health and wellbeing.

114. According to Regulation 7 of the PPCCRs, procuring services includes taking the following decisions, for which the customers must establish and apply transparent, proportionate and non-discriminatory criteria:

   (a) Determining which providers qualify to be included on a list from which a patient is offered a choice of provider in respect of first outpatient appointment with a consultant or a member of a consultant's team.

   (b) Determining which providers qualify to be included on a list from which a patient is otherwise offered a choice of provider.

   (c) Determining which providers to enter into a framework agreement and selecting providers to bid for potential future contracts to provide healthcare services for the purposes of the NHS.

115. NHSI's guidance ('the Procurement, Patient Choice and Competition Guidance') assists in interpreting these requirements. In particular, the Procurement, Patient Choice and Competition Guidance makes it clear that the PPCCRs do not require every contract to be competitively tendered.[79]

116. The PPCCRs place further requirements on customers to ensure accountability and transparency in their expenditure. In particular, they need:

   (a) to record the rationale for their decisions and how they have met their duties as to quality, effectiveness and the promotion of integration;

   (b) to publish details of the contracts that they have awarded;

   (c) to not award contracts where conflicts or potential conflicts of interest have affected, or appear to affect, the integrity of the decision; and;

   (d) not to engage in anti-competitive behaviour unless to do so is in the interest of patients.

117. Regulation 5 of the PPCCRs in particular provides for customers being able to award a new contract to a single provider without advertising where he is satisfied that the services to which the contract relates are capable of being provided only by that provider.

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[79] See NHSI (December 2013), Substantive guidance on the Procurement, Patient Choice and Competition Regulations, p36.

118. The PCRs 2015 implement the new Public Sector Procurement Directive (2014/24/EU)[80] which provides modernised rules for the procurement of goods, services and works above certain thresholds by public authorities.[81]

119. The implementation of PCRs 2015 requires that customers act in an appropriately transparent way when taking procurement decisions and, in particular, that where a decision is taken to award a contract for services above a value of €750,000/£589,148 this should be advertised in the *Official Journal of the European Union* (what has been called a 'light-touch regime').[82]

120. Under the light-touch regime, customers have the freedom to determine the procurement procedure to use when awarding a contract, provided that they satisfy the principles of transparency and equal treatment of providers.

121. Some of the factors that customers may take into account when designing and running their procurement processes include:[83]

    (a) ensuring quality, continuity, accessibility, affordability, availability and comprehensiveness of the services;

    (b) the specific needs of different categories of users, including disadvantaged and vulnerable groups;

    (c) the involvement and empowerment of users;

    (d) innovation; and

    (e) any other relevant consideration.

122. Guidance from the Department of Health ('the PCRs 2015 Guidance') has stressed that the requirement to advertise does not equate to a requirement to run a full competitive process 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.[84]

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[80] 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.
[81] 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 18th 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
[82] Regulation 74 and Schedule 3 of the PCRs 2015.
[83] Regulation 67 of the PCRs 2015.
[84] See Department of Health, (October 2016), The Public Contracts Regulations 2015 and NHS Commissioners.

123. The light-touch regime retains a procurement exemption under the ‘negotiated procedure without prior publication’. Customers retain the ability to use the negotiated procedure without prior publication, in line with Regulation 32 of the PCRs 2015, where its use can be fully justified. This will be the case where:

(a) the customer has received no tenders, no suitable tenders, no requests to participate or no suitable requests to participate in response to an open procedure or a restricted procedure, provided that the initial conditions of the contract are not substantially altered; or

(b) where the services can be supplied only by a particular provider for the following reasons:

(i) competition is absent for technical reasons; or

(i) the protection of exclusive rights, including intellectual property rights;

but only where, in both cases, no reasonable alternative or substitute exists and the absence of competition is not the result of an artificial narrowing down of the parameters of the procurement.

124. Once a contacting opportunity has been advertised, if the customer receives more than one expression of interest, they must then use some form of competitive procurement procedure. There is clear requirement that the procurement procedures methodology in selecting the winning provider must be both transparent and fair.

Framework agreements

125. 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’.[85]

126. 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 entrants.

127. 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

[85] Regulation 33 of the PCRs 2015.

framework. They will either go directly to one provider or hold a mini-competition to determine the most suitable provider. These individual contracts are referred to as call-offs.

128. According to the PCRs 2015 (applying to 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.[86]

129. Where the terms laid down in the framework agreement set out all the terms governing the provision of the specific requirement, and the terms or procurement documents set out the objective conditions for determining which of the economic operators should perform the contract, the customer can award the call-off without doing a competition on the framework.

130. The PCRs 2015 do not specify how this should be done, but the mechanism used should comply with general principles including transparency and non-discrimination.[87]

Any Qualified Provider

131. The government's Any Qualified Provider (AQP) policy provides a means of procuring certain NHS services in England.

132. The AQP is similar to a framework agreement. The purpose of this policy is to increase patients' choice. Under AQP, any provider assessed as meeting rigorous quality requirements, and who can deliver services to NHS prices, is able to deliver the service. AQP providers can be from the NHS or private sector. Providers have no volume guarantees and customers will decide which providers to refer on the basis of quality.

133. Once the opportunity is advertised, providers are assessed using the nationally consistent qualification process and should qualify if they can:

(a) meet rigorous quality requirements;

(b) meet the terms and conditions of the NHS Standard Contract;

(c) accept the NHS price for the service; and

[86] Ibid.
[87] Ibid.

(d) provide assurances that they are capable of delivering the agreed service requirements that have been set and can comply with referral protocols.

134. All providers must meet the qualification criteria set for a particular service and once qualified their service will appear on ‘Choose and Book’[88] for patients to select. Competition on the AQP procurement model is based on quality and not price: all providers will be paid the same price for a particular service.

135. The period 2012 to 2013 was identified as a transitional year to test implementation of AQP, starting with a limited set of services (community mental health services). From March 2014 onwards, the decision to extend choice of providers and establish services as AQP and qualification of providers rests entirely with CCGs.

Rules and practice related to contracting

The NHS Standard Contract

136. Under Regulation 17 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (‘the 2012 Regulations’), NHSE must draft terms and conditions for inclusion in commissioning contracts entered into by a relevant body and may draft model commissioning contracts.

137. The NHS Standard Contract is used to commission NHS-funded services from all types of providers (NHS trusts, foundation trusts, independent, charitable and voluntary sectors).[89]

138. The contracts include standard terms which cannot be amended and which record agreements reached by the customers and providers across a range of requirements relating to the services commissioned and associated quality and performance requirements. Some of the quality and performance requirements are set nationally and others may be agreed locally.

139. The NHS Standard Contract is mandated by NHSE for use by customers for all contracts for healthcare services other than primary care, therefore including mental healthcare and more specifically rehabilitation services.

[88] The ‘Choose and Book’ is an e-booking software application for the NHS in England which enables patients to choose which hospital they are referred to and to book a convenient date and time for an appointment.
[89] See the 2017/18 NHS Standard Contract.

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

141. Some of the service conditions usually prescribed under the NHS Standard Contract are as follows:

(a) Choice: The provider and the customer must comply with guidance issued by the Department of Health, NHSE and NHSI regarding patients' rights to choice of provider and/or consultant.[90]

(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 the contract and/or as otherwise agreed, subject to providers' rights to withdraw or discontinue the service in certain occasions.[91]

(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.

(e) Annual price review clauses.

142. A commissioning contract must[92] contain terms and conditions that ensure that the service provider complies with the duty of candour.[93]

143. Customers are also under a duty to offer an alternative provider[94] if a person has been referred to a service provider and they have been notified that the person referred has not commenced appropriate treatment; or will not have commenced appropriate treatment, within 18 weeks, beginning with the start date.

144. According to NHSE's guidance[95] customers must not:

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

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[90] For instance, see NHSE's Guidance on implementing patients' legal rights to choose the provider and team for their mental health care (December 2014).
[91] However, the provider is not required to provide or to continue to provide a service to, among 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.
[92] Regulation 16 of the 2012 Regulations.
[93] This requires that the service provider complies with all the duties imposed upon a registered person by regulation 20 of the 2014 Regulations, ie the duty to act in an open and transparent way.
[94] Regulation 48 of the 2012 Regulations.
[95] NHSE (November 2016), NHS Standard Contract 2017/18 and 2018/19 Technical Guidance.

(b) vary any provision of the NHS Standard Contract except as permitted by NHS guidance on permitted Variations Process;[96] or

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

Pricing and payments regulation

Pricing regulation

Determining national tariffs and other pricing rules

145. NHSI sets the rules that govern the prices paid for services, while the grouping of services for payment purposes is done by NHSE.[97]

146. NHSI will gather, analyse and share the cost and quality information that will underpin rules and prices that promote better care for patients. NHSI and NHSE then agree all the components of the proposals, reflecting each other's views.

147. In carrying out this task, NHSE is guided by its mandate from the SoS, its clinical priorities and its commitment to understand and act on the needs of patients. NHSI is similarly guided by its primary duty to protect and promote the interests of patients.

148. In rehabilitation services, there is currently no national tariff and tariffs are locally negotiated and agreed. However, providers must comply with some rules specified in the 'National Tariff Price 2017/2018'.[98]

149. In particular, providers and customers must apply the following principles when agreeing prices for services without a national price:

    (a) The approach must be in the best interests of patients.

    (b) The approach must promote transparency.

    (c) The approach must improve accountability and encourage the sharing of best practice.

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[96] See NHSE (May 2015), NHS Standard Contract - Guidance on the Variations Process (GC30).
[97] 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 is not a national price.
[98] See 2017/2018 and 2018/2019 National Tariff Payment System, published by NHSI and NHSE.

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

150. 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 for 2017/18 and 2018/19, respectively.[99]

151. Moreover, the currency model has been mandated in rehabilitation services following the 2013/14 Payment by Results policy.[100] It designates providers into levels of specialist rehabilitation services. These service levels have different service profiles and differing costs. In specialist rehabilitation services, there are 25 currencies[101] based on patient complexity and provider/service type.

152. During a patient's admitted stay on a specialist rehabilitation unit, clinicians must use the Rehabilitation Complexity Scale (RCS-Ev12) tool to assess the patient's needs. The combination of the type of rehabilitation unit where the patient is treated and the serially collected RCS-E score will determine the currency and the locally agreed daily rate price.[102]

153. Where a national currency is used as the basis for local price-setting, providers must also submit details of the agreed unit prices for those services to NHSI using the standard templates provided by NHSI.

154. Where there is a national currency specified for a service, but the customer and provider of that service wish to move away from using it, the customer and provider may agree a price without using the national currency. When doing so, providers and customers must adhere to the following requirements which are intended to mirror the requirements for agreeing a local variation for a service with a national price:

(a) The agreement must be documented in the NHS Standard Contract between the customer and provider which covers the service in question.

[99] 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%.
[100] See Department of Health (25 March 2013), A Simple Guide to Payment by Results.
[101] 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. The determination of national currencies has been the result of the Payment by Results policy introduced in 2013.
[102] See NHS (December 2016), Guidance on currencies without national prices.

(b) The customer must maintain and publish a written statement of the agreement and submit it to NHSI.

(c) All providers of services covered by the care cluster currencies[103] must record and submit the cluster data to NHS Digital as part of the Mental Health Services Dataset, whether or not they have used the care clusters as the basis of payment.

(d) Providers and customers must link prices for mental health services for working age adults and older people to locally agreed quality and outcome measures and the delivery of access and wait standards.

Reference costs

155. NHSI also collects and publishes reference costs, which form the basis for nationally set prices and locally agreed prices.

156. Reference costs are the average unit cost to the NHS of providing secondary healthcare to NHS patients. The latest reference costs published are the NHS reference costs for 2015 to 2016.[104]

157. NHSI has published guidance in relation to the costing approach it encourages providers to adopt.[105]

158. NHSI intends to mandate a patient-level cost collection for all NHS acute providers for the 2018/19 submission, extending to all mental health for the 2019/20 submission and community providers in 2020/21.

159. In relation to independent providers, NHSI is still considering its approach but it will not be collecting cost data from them in 2017.

Payments/reimbursement models in mental health services

160. We set out below the main types of payments chosen by customers and the reforms undertaken by NHSE in this field. Annex 2 contains a table setting out the various payment types, their differences and associated advantages and disadvantages.

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[103] Cluster is a description of a group of patients with similar level of acuity. Each cluster is linked to a set of interventions (care packages) which have a total cost, and for which a price would be paid by customers.
[104] See Department of Health, NHS reference costs 2015 to 2016.
[105] See NHSI (2017), Approved Costing Guidance.

Block contracts

161. A block contract is a payment made to a provider to deliver a specific, usually broadly defined, service.

162. 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 the activity undertaken. Payments are made on a regular, usually annual, basis.

163. The value of the contract can be set in various ways, often through a measure of patient need or simply based on the historical expenditure on a particular service.[106]

164. Since the NHS was established, block contracts have been the main payment system across the UK. In England, however, there has been a substantial shift away from block contracts, with the introduction of a national tariff.

165. Overall, it has been found that block contracts are used to reimburse around 90% of community services, and two thirds of mental healthcare.[107]

166. Block contracts continue to be used in rehabilitation services, and are widely used in community care. For instance, in the period 2015/16 it has been reported that 58% of NHS trusts were expecting to have a block contract in place for mental health services.[108]

167. A more recent survey from the Healthcare Financial Management Association in October 2015, which surveyed 36 NHS mental health providers, found that 89% of the respondents had block contracts in place, but this percentage would fall to 47% for 2016/17.[109]

168. However, further reform is planned in that respect.[110] This is expected to be implemented for adult mental health (including rehabilitation services) from 2017/18. NHSE and NHSI have published resources and begun to deliver workshops to support providers and customers to implement new payment approaches.

169. An overarching concern about block contracts is the lack of transparency and accountability after a payment has been made to a provider. As block

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[106] British Medical Association (December 2015), Models for paying providers – Block contracts.
[107] See Nuffield Trust (2014), The NHS payment system: evolving policy and emerging evidence.
[108] See, NHS providers (April 2015), Funding for mental health services: Moving towards parity of esteem?.
[109] 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.
[110] See NHS Five Year Forward View.

contracts are made in advance of a service being delivered, unexpected pressures such as increased patient demand or cost of care are not taken into account.

Payment system reforms

170. There is currently a plan to change the payment system gradually. In a move towards delivery of the Five Year Forward View[111] for mental health, NHSE and NHSI are supporting providers and customers of mental health services to implement more transparent payment approaches.

171. Rehabilitation services providers and customers are required to adopt transparent and robust payment approaches linked to outcomes.

172. In particular, in 2016 NHSI published detailed guidance documents which set out the different approaches for payment for adult and older people mental health services that providers and customers must adopt.[112]

173. The two payment options that providers and customers can choose between are a capitated payment approach, or an episode of treatment (year-of-care) payment approach. Providers can still choose an alternative payment approach agreed in accordance with the requirements of rules of local pricing.

174. A capitated payment is one where a provider or a group of providers are paid to cover a range of care for an identified population, made on a per-person basis and adjusted to reflect the different needs of people with mental ill health.

175. An episodic payment approach is the payment of an agreed price for all the healthcare provided to a patient during an agreed time period – the episode. The price paid will depend on the cluster to which the patient has been assigned.

Quality incentive schemes/payments for performance

176. As a result of the emphasis given 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.

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[111] See NHS Five Year Forward View.
[112] See New payment approaches for mental health services.

Quality Premium

177. Under the NHS Act, NHSE has the power to make payments to CCGs to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities.[113]

178. The Quality Premium (QP) is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

179. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.

180. The maximum QP payment for a CCG is expressed as £5 per head of population. NHSE reserves the right not to make any quality premium payments to a CCG in cases of serious quality failure, ie where it is identified that, for instance, a local provider has been subject to enforcement action by the CQC or it has been flagged as a quality compliance risk and/or has requirements in place around breaches of provider licence conditions.

181. As an alternative to withholding the QP in the circumstances above, NHSE may, at its discretion, make the quality premium available to the relevant CCG if the CCG agrees to use the QP payment to help resolve the serious quality failure.

182. QP payments can only be used for the purposes set out in associated regulations and each CCG is required to publish an explanation of how it has spent a QP payment.[114]

183. The QP Regulations[115] state that QP payments should be used by CCGs to secure improvement in:

    (a) the quality of health services;

    (b) the outcomes achieved from the provision of health services; or

    (c) reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved.

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[113] Section 223(K) of the NHS Act.
[114] Section 223K(7) NHS Act.
[115] The National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013 (‘the QP Regulations’).

184. 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 equality most pertinent to a given CCG:

(a) Out-of-area placements.

(b) Equity of Access and outcomes in to Improved access to Psychological Therapies (IAPT) services.[116]

(c) Improve inequitable rates of access to Children & Young People's Mental Health Services.

185. In relation to out-of-area placements, the NHSE published guidance ('the QP Guidance') which explains that the total number of bed days relating to out-of-area placements should have reduced by 33% of the baseline number as at 1 April 2017 and that during 2017/18 this measure refers to adult acute, older adult acute and PICU[117] beds only. However, in future years there is likely to be an expectation to reduce out-of-area placements for all CCG-commissioned beds (eg rehabilitation).[118]

186. This is also in line with the NHS objective to eliminate all inappropriate out-of-area placements in acute mental health services by 2020/21.[119]

Commissioning for Quality and Innovation scheme

187. The Commissioning for Quality and Innovation (CQUIN) scheme system 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.

188. According to the most recent CQUIN Guidance published by NHSE, mental health providers will be offered CQUIN at 2.5% of the actual annual value of the contract as the NHS works to take forward the findings of the Taskforce.[120]

189. Customers can also plan and agree local CQUIN schemes available for providers. Within local CQUIN schemes, NHSE considers it reasonable and legitimate for customers to prioritise indicators that focus on quality improvements and also deliver efficiency savings. However, CQUIN schemes

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[116] IAPT services provide evidence based treatments for people with anxiety and depression.
[117] Psychiatric intensive care units defined care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder.
[118] See the Quality Premium Guidance 2017-2019 for CCGs ('the QP Guidance').
[119] See NHS, Implementing the Five Year Forward Review for Mental Health.
[120] See the NHSE (March 2016), Guidance 2016/2017 ('CQUIN Guidance').

must not be used to incentivise actions by providers which will in any way damage patient care.

190. It is possible for customers, at their discretion, to offer additional incentives to providers, on top of the main national scheme. CCGs are encouraged, for instance, to use funding they expect to earn through the QP to offer additional incentives to providers. Such schemes should be recorded as Local Incentive Schemes in the relevant schedule of the NHS Standard Contract.

191. NHSE recognises that, particularly where a competitive procurement approach is being used, customers may choose, as an explicit part of setting a local price for a contract, to create a broader local incentive scheme, incorporating the national CQUIN scheme but linking a higher proportion of contract value (above the 2.5% envisaged) to agreed quality and outcome measures, rather than activity levels. This is considered a legitimate approach, and there is no requirement in this situation for the customer to offer a further 2.5% CQUIN scheme to the provider, on top of the agreed local price.

The legal and regulatory framework in mental health services in Wales

Key differences

192. The key differences between the Welsh legal and regulatory framework and that in England are set out below.

193. In Wales the Healthcare Inspectorate Wales (HIW)[121] regulates independent healthcare providers under the Care Standards Act 2000, and Health and Social Care (Community Health and Standards) Act 2003 legislation. Its powers are broadly similar to those of the CQC in England. However, the HIW does not give providers ratings, but produces and publishes reports on the findings of its inspections and investigations.

194. The NHS in Wales went through a major reorganisation in October 2009. Through this reorganisation, the 22 local health bodies (which commissioned services) and the seven NHS trusts which provided services were merged into seven new 'unified' bodies which both commission and provide services. These are still called Local Health Boards (LHBs).

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[121] See the Healthcare Inspectorate Wales website.

195. In 2012 the Welsh Government produced *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales,* which set out a ten-year strategy for improving the lives of people using mental health services, their carers and their families.[122]

196. At the heart of the strategy is the Mental Health (Wales) Measure 2010,[123] which places legal duties on health boards and local authorities to improve support for people with mental ill-health. The Measure introduced local primary support services for lower level problems and ensures that all people in specialist mental healthcare have holistic care and treatment plans, rights to re-access assessment when discharged and rights to advocacy for people who are in hospital.

197. Although England and Wales share a Mental Health Act, they have two separate Codes of Practice.

198. Wales has no 'high secure' care and always has used Ashworth and Rampton hospitals in England, wherever necessary.

199. Prior to 2012 non-NHS Wales mental health and learning disabilities hospital services were commissioned separately by each LHB or through the Welsh Health Specialised Services Committee. These commissioning arrangements led to disparity in costs, contractual obligations, standards and performance management across NHS Wales.

200. In March 2012 a National Framework for medium and low secure care was launched. Subsequently the Chief Executives of the NHS Wales LHBs considered that a broader suite of services required the assurance of a national collaborative framework and developed the NHS Wales *National Collaborative Framework for Adult Mental Health & Learning Disability Hospitals* which commenced in April 2014.

201. The *NHS Wales National Collaborative Framework for Adult Mental Health & Learning Disability Hospitals* is a formal agreement and mechanism that enables NHS Wales to procure and performance manage services under the pre-agreed standards, costs, terms and conditions of a contract in a compliant manner in accordance with EU and UK Procurement Regulations.

[122] Welsh Government (2012), Together for Mental Health – A Strategy for Mental Health and Wellbeing in Wales.
[123] See Mental Health (Wales) Measure 2010.

202. The scope of the National Framework covers medium and low secure mental health services as well as rehabilitation services (locked and unlocked, known as controlled/uncontrolled egress services in Wales).[124]

[124] See also NHS Wales Collaborative Commissioning (June 2015), NHS Wales National Collaborative Framework for Adult Mental Health & Learning Disability Hospitals – Annual Report 2014-2015.

Annex 1: Legislation

Acts

Mental Health Act 1983

1. The Mental Health Act 1983 (‘the 1983 Act’) is largely concerned with the circumstances in which a person with a mental disorder can be detained for treatment for that disorder without their consent.

2. It also sets out the processes that must be followed and the safeguards for patients, to ensure that they are not inappropriately detained or treated without their consent.

3. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others.

Detention criteria

4. The 1983 Act has been significantly amended by the Mental Health Act 2007 (the 2007 Act). In particular, section 4 of the 2007 Act has introduced a new ‘appropriate medical treatment test’ into the criteria for detention under section 3 of the 1983 Act.

5. The effect is that the criteria for detention cannot be met unless medical treatment is available to the patient in question, which is appropriate, taking account of the nature and degree of the patient’s mental disorder and all other circumstances of the case.

6. In more detail, a patient may be admitted to a hospital and detained there for the period allowed by law in pursuance of an application (‘an application for admission for treatment’) if:

   (a) they are suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in a hospital; and

   (b) it is necessary for the health or safety of the patient; or

   (c) for the protection of other persons that they should receive such treatment;

   and it cannot be provided unless they are detained under this section;

(d) appropriate medical treatment is available for them.

7. The previous test under the 1983 Act required that the treatment was likely to alleviate or prevent a deterioration of their condition, ie the treatability of the patient's condition.

8. The application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners.

9. The 1983 Act also contains provisions in relation to admission for treatment and detention to hospitals as a result of a court order if a person is convicted of a criminal offence.[125]

Duration for detention

10. Moreover, a patient admitted to hospital in pursuance of an application for admission for treatment, may be detained in a hospital for a period not exceeding six months beginning with the day on which they were admitted and shall not be so detained or kept for any longer period unless the authority for their detention is renewed.[126]

Additional changes

11. The 2007 Act also introduced some other changes to the 1983 Act in relation to:

   (a) professional roles: it has broadened the group of practitioners who can take on the functions currently performed by the approved social worker and responsible medical officer;

   (b) nearest relative (NR): it gave patients the right to make an application to displace their NR and enabled courts to displace an NR where there are reasonable grounds for doing so. The provisions for determining the NR are amended to include civil partners among the list of relatives.

   (c) supervised community treatment (SCT): it introduced SCT for patients following a period of detention in hospital. It is expected that this will allow a small number of patients with a mental disorder to live in the community

[125] Section 37 of the 1983 Act.
[126] Section 20 of the 1983 Act as amended.

whilst subject to certain conditions under the 1983 Act, to ensure they continue with the medical treatment that they need.

The relevant criteria for issuing an SCT order are:[127]

(i) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;

(ii) it is necessary for their health or safety or for the protection of other persons that they should receive such treatment;

(iii) subject to their being liable to be recalled, such treatment can be provided without their continuing to be detained in a hospital;

(iv) it is necessary that the responsible clinician should be able to exercise the power below to recall the patient to hospital; and

(v) appropriate medical treatment is available for them.

In determining whether the patient can be recalled, the clinician should have regard to the patient's history of mental disorder and any other relevant factors as well as what risk there would be of a deterioration of the patient's condition if they were to continue not to be detained in a hospital.[128]

A SCT order shall cease to be in force on expiry of the period of six months beginning with the day on which it was made.[129]

(d) Mental Health Review Tribunal (MHRT): it introduced an order-making power to reduce the time before a case has to be referred to the MHRT by the hospital managers. It also introduced a single Tribunal for England, the one in Wales remaining in being.

(e) 'Code of Practice',[130] ie the guidance for medical practitioners in relation to the admission of patients to hospitals: Section 2B requires the SoS in preparing the Code to ensure that the following matters are addressed:

(i) respect for patients' past and present wishes and feelings;

(ii) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation;

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[127] Section 17A of the 1983 Act as amended.
[128] Section 20A (7) of the 1983 Act
[129] Section 20A of the 1983 Act.
[130] Section 118 of the 1983 Act.

(iii) minimising restrictions on liberty;

(iv) involvement of patients in planning, developing and delivering care and treatment appropriate to them;

(v) avoidance of unlawful discrimination;

(vi) effectiveness of treatment;

(vii) views of carers and other interested parties;

(viii) patient wellbeing and safety; and

(ix) public safety.

Mental Capacity Act 2005

12. The Mental Capacity Act 2005 (the MCA), covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future.

13. It sets out who can take decisions, in which situations, and how they should go about this. The legal framework provided by the MCA is supported by this Code of Practice which provides guidance and information about how the MCA works in practice.[131]

Patients lacking capacity

14. Where healthcare professionals are concerned that a patient lacks the capacity to make an informed decision and they do not meet the criteria for detention under the 1983 Act, a full assessment of their capacity in relation to this decision should be undertaken under the standards of the MCA.

15. The MCA covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions for themselves. These can be decisions about day-to-day matters or more important decisions such as the decision to be transferred in a different environment.

16. The MCA applies more generally to everyone who looks after, or cares for, someone who lacks capacity to make particular decisions for themselves. This includes people acting in a professional capacity such as healthcare

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[131] Section 42 of the MCA requires the Lord Chancellor to produce a Code of Practice for the guidance of a range of people with different duties and functions under the MCA.

staff, social care staff and others who may occasionally be involved in the care of people.

17. Under the MCA, they are required to make an assessment of capacity before carrying out any care or treatment; the more serious the decision, the more formal the assessment of capacity needs to be.

18. In order to decide whether an individual has the capacity to make a particular decision they must answer two questions:

(a) Is there an impairment of or disturbance in the functioning of a person's mind or brain? If so,

(b) Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

19. Any assessment should be governed by the following principles:

(a) A person must be assumed to have capacity unless it is established that they lack capacity.

(b) A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

(c) A person is not to be treated as unable to make a decision merely because they make an unwise decision.

(d) An act done, or decision made, under the MCA for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

(e) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

20. It is useful to consider the principles chronologically: principles (a) to (b) will support the process before or at the point of determining whether someone lacks capacity. Principles (d) and (e) should support the decision-making process.

21. The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

(a) Understand information given to them.

(b) Retain that information long enough to be able to make the decision.

(c) Weigh up the information available to make the decision.

(d) Communicate their decision.

22. Moreover the MCA contains The Deprivation of Liberty Safeguards (DoLS).[132] The DoLS under the MCA allow restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes but only if they are in a person's best interests.[133]

23. To deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority.

Other provisions

24. Attorneys appointed under Lasting Powers of Attorney – the MCA introduces a new form of Power of Attorney which allows people over the age of 18 to formally appoint one or more people to look after their health, welfare and/or financial decisions, if at some time in the future they lack capacity to make those decisions for themselves.

25. Court of Protection and Deputies – the MCA created a new court and a new public official to protect people who lack capacity and to supervise those making decisions on their behalf.

26. The Public Guardian – the role of the Public Guardian is to protect people who lack capacity from abuse. The Public Guardian is supported by the Office of the Public Guardian.

27. Independent mental capacity advocate (IMCA) – IMCAs are a statutory safeguard for people who lack capacity to make some important decisions. This includes decisions about where the person lives and serious medical treatment when the person does not have family of friends who can represent them.

28. Advance decisions to refuse treatment – the MCA creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future.

29. A criminal offence – the MCA introduces a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity.

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[132] Section 4A of the MCA.
[133] Schedule A1, section 16 of the MCA.

Health and Social Care Act 2008

CQC establishment

30. The Health and Social Care Act 2008 (HSCA 2008) introduced an improved and integrated regulation of the health and social care system by establishing and making provision in connection with the CQC.

31. HSCA 2008 sought to enhance professional regulation and create a new integrated regulator, the CQC, for health and adult social care, with a focus on providing assurance about the safety and quality of care for patients.

32. In particular, it contains several provisions in relation to the CQC registration requirements, its review and performance assessment functions, its enforcement and investigation powers.

33. Moreover, the HSCA 2008 has provided for the transfer of certain functions of the SoS in connection to the 1983 Act to the CQC, notably the appointment of registered medical practitioners and CQC's power to conduct investigations under the 1983 Act in relation to the assessment of the provision of after-care services.

Other provisions

34. The HSCA 2008 also contains provisions:

    (a) establishing the Office of the Health Professions Adjudicator;

    (b) conferring powers to modify the regulation of social care workers; and

    (c) providing for the payment of a grant to women in connection with pregnancy.

Health and Social Care Act 2012

35. The Health and Social Care Act 2012 (HSCA 2012) contains 12 Parts and 23 Schedules addressing a range of issues relating to health and social care.

36. The HSCA 2012 made significant changes to a number of existing statutes, most notably the National Health Service Act 2006 (the NHS Act), giving effect to the policies that were set out in the White Paper *Equity and Excellence: Liberating the NHS* which was published in July 2010.[134]

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[134] See Department of Health (July 2010), Liberating the NHS White Paper.

37. The main aims of the HSCA 2012 were to change how NHS care is commissioned through the greater involvement of clinicians and a new NHS Commissioning Board, to improve accountability and patient voice, to give NHS providers new freedoms, to improve quality of care and to establish a provider regulator to promote economic, efficient and effective provision.

38. The key relevant changes are set out below.

NHS England

39. The establishment of a new non-departmental public body to be known as the National Health Service Commissioning Board (NHS Commissioning Board), known as NHS England (NHSE), accountable to the SoS.

40. NHSE has broad overarching duties, in conjunction with the SoS, to promote the comprehensive health service and to exercise its functions so as to secure that services are provided for the purposes of the comprehensive health service.

41. NHSE commissions some services directly itself, and otherwise regulates the commissioning activities of CCGs, which commission the majority of NHS services. Its functions include:

   (a) considering and determining applications to establish CCGs from 2013 and applications thereafter to vary the constitutions of existing CCGs;

   (b) determining the basis for payments by CCGs to providers;

   (c) providing funding to CCGs to meet their expenditure;

   (d) providing guidance to CCGs on the discharge of their commissioning functions;

   (e) exercising functions on behalf of CCGs at their request; and

   (f) providing assistance or support to CCGs.

42. NHSE must conduct an annual performance assessment of each CCG and has power to make quality payments to CCGs reflecting their performance.

43. NHSE must perform its functions in accordance with an annual ‘mandate’ from the SoS, which specifies the objectives that NHSE should seek to achieve and any requirements that the SoS considers it necessary to impose on NHSE in order to ensure it achieves those objectives.

Clinical Commissioning Groups

44. The establishment of the CCGs, which are statutory corporate bodies, established on the grant of an application by the NHSE and the subsequent abolition of strategic health authorities and primary care trusts.

45. These bodies are now responsible for commissioning the majority of health services. New sections 14P to 14Z24 have been added into the NHS Act, which contain CCGs' duties, and powers, and provision for the NHSE to intervene in the event of failure.

46. The services which the NHSE may, by regulations, be required to commission are described in new section 3B and include services which can be more effectively commissioned at national level, or which it would be inappropriate or impractical for CCGs to commission. Those services include some dental services, specialised services, prison health services and health services for the armed forces. The NHSE is also responsible for commissioning primary care services and high secure psychiatric services according to new section 3A of the NHS Act.

NHS Improvement

47. The establishment of the role of the sector regulator, known as Monitor (now NHS Improvement (NHSI)). In particular, the HSCA 2012 outlines NHSI's general duties and gives it the necessary powers to run a system of licensing of providers of NHS services.

Healthwatch England

48. The creation of a new national body, Healthwatch England, to be established as a statutory committee within the CQC. HSCA 2012 also made provision about Local Healthwatch organisations in each local authority area.

National Institute for Health and Clinical Excellence

49. The re-establishment of the National Institute for Health and Clinical Excellence Special Health Authority as a non-departmental public body which was re-named as the National Institute for Health and Care Excellence (NICE). It also sets out how NICE will develop quality standards, give advice, guidance or provide information, and make recommendations on areas including medicines and treatment must commission services in accordance with the NHS Act.

Integrated health and social care

50. The expansion of local authorities' responsibilities for ensuring integration in the approach to health and social care provision in its area. The HSCA 2012 requires the establishment of a new arm of the local authority to carry out these functions. The role of Health and Wellbeing Boards has been strengthened to make clear their involvement throughout the process of developing CCG commissioning plans.

Health and Care Professions Council

51. Sections 213 to 220 of the HSCA 2012 established the Health and Care Professions Council and its functions as the regulator of healthcare professionals.

52. The Health and Care Professions Council regulates, among other, social workers and practitioner/clinical psychologists.

NHS (Wales) Act 2006

53. The statutory powers and duties of the NHS in Wales are mainly contained within the NHS (Wales) Act 2006. Whilst the NHS Act applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales.

54. The NHS (Wales) Act 2006 consolidates a range of regulatory requirements relating to the promotion and provision of the health service in Wales. It sets out:

    (a) Welsh Ministers' duty to promote health service;

    (b) general power to provide services;

    (c) provision of particular services;

    (d) provision of services otherwise than in Wales;

    (e) NHS Contracts; and

    (f) provision of services otherwise than by Welsh Ministers.

Statutory Instruments

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

55. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the 2014 Regulations') set out which are the regulated activities that fall within the scope of CQC's functions.

56. They also set out requirements relating to persons carrying on or managing a regulated activity and deal with the fit and proper person test, the duty of candour and the fundamental standards care and safety that registered providers should comply with.

Care Quality Commission (Registration) Regulations 2009; Care Quality Commission (Reviews and Performance Assessments) Regulations 2014 and the Care Quality Commission (Fees) (Reviews and Performance Assessments) Regulations 2016

57. Care Quality Commission (Registration) Regulations 2009 ('the 2009 Regulations') contain provisions relating to the CQC registration process and set out in detail the registration requirements under the CQC registration regime.

58. Section 46 of the HSCA 2008 imposes a duty on the CQC to conduct reviews and performance assessments on registered service providers and to publish reports of such assessments. The Care Quality Commission (Reviews and Performance Assessments) Regulations 2014 contain detailed provisions in relation to this function.

59. Section 85(1)(b) of the HSCA 2008 permits the CQC, with the consent of the SoS, to make and publish provisions requiring a fee to be paid by English NHS bodies, English local authorities, and registered persons in respect of the exercise by the CQC of its functions. The Care Quality Commission (Fees) (Reviews and Performance Assessments) Regulations 2016 Regulations contain detailed provisions in this regard.

National Health Service (Licence Exemptions, etc) Regulations 2013, the National Health Service (Approval of Licensing Criteria) Order 2013

60. The National Health Service (Licence Exemptions, etc) Regulations 2013 make provision in relation to the licensing of providers of healthcare services for the purposes of the NHS under Chapter 3 of Part 3 of the HSCA 2012.

61. They contain provisions:

(a) in relation to the persons to be regarded as the person who provides a healthcare service for the purposes of the licensing regime;

(b) in relation to the grant of exemptions from the requirement for providers to hold a licence;

(c) exempting NHS trusts from the requirement to hold a licence.

62. The National Health Service (Approval of Licensing Criteria) Order 2013 sets out the criteria which NHSI has set in order for a person to be granted a license and which the SoS has approved.

Public Contracts Regulations 2015

63. The Public Contracts Regulations 2015 (PCRs 2015) revoke and replace the Public Contracts Regulations 2006.

64. Part 2 of the PCRs 2015 implements Directive 2014/24/EU of the European Parliament and of the Council on public procurement and repealing Directive 2004/18/EC.[135]

65. PCRs 2015 impose obligations on public bodies in relation to how they award public contracts for the execution of works, the supply of products or the provision of services.

66. They also contain detailed rules to be followed in relation to procurement procedures and establishes procurement regimes for the procurement of social and other specific services.

67. They also impose certain requirements in relation to records and reports, including requirements about retaining copies of contracts above a certain value, drawing up individual reports about procurements, sending information about procurements to the Cabinet Office and European Commission on request, and documenting the progress of procurement procedures.

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

68. The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (‘the 2012 Regulations’) provide for a range of matters relating to the functions and commissioning responsibilities of the NHSE and CCGs. They

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[135] 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.

are made under powers in the NHS Act and the 1983 Act and powers in the HSCA 2012.

69. In particular, Part 5 of the 2012 Regulations makes provision as to matters which must be included in contracts to commission healthcare services entered into by customers.

70. Part 2 of the 2012 Regulations makes provision in respect of persons for whom a CCG must or may commission services. Part 3 of the 2012 Regulations is made under section 3B(1) of the NHS Act and make provision in respect of the services which the NHSE is required to arrange.

71. Regulation 4(1) and Schedule 1 of the 2012 Regulations set out that CCGs will have the responsibility of every person who is a qualifying patient under the 1983 Act[136] and is liable to be detained under that Act in a hospital or registered establishment.

National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500[137]

72. Section 75 of the HSCA 2012 provides that the PPCCRs may impose certain requirements on customers to ensure that, with reference to healthcare services:

    (a) Good practice in relation to procurement is adhered to.

    (b) The right of patients to make choices with respect to treatment or other healthcare services provided for the purposes of the NHS is promoted.

    (c) Anti-competitive behaviour which is against the interests of the people who use such services is not engaged in.

73. It also allows for the PPCCRs to include specific procedural requirements on competitive tendering. The PPCCRs also address conflicts of interest.

74. Part 2 of the PPCCRs imposes requirements on the customers in relation to procurement, patient choice and anti-competitive behaviour.

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[136] Section 130C of the 1983 Act define a ‘qualifying patient’ as the patient *(a)* liable to be detained under this Act and the hospital or registered establishment in which he is liable to be detained is situated in England; *(b)* subject to guardianship under this Act and the area of the responsible local social services authority within the meaning of section 34(3) above is situated in England; *(c)* a community patient and the responsible hospital is situated in England.

[137] The PPCCRs revoke the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013.

75. The remaining provisions:

   (a) lay down a general objective for relevant bodies when procuring healthcare services for the purposes of the NHS and general requirements which are to apply to the procurement of healthcare services for the purposes of the NHS, especially requirements relating to transparency in the award of contracts for the provision of healthcare services for the purposes of the NHS; and

   (b) provide NHSI with powers to investigate and take enforcement action in relation to breaches of the requirements imposed by the PPCCRs.

The National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013

76. The National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013 ('the 2013 Regulations') make provision in relation to payments to customers in respect of quality. They set out the principles or other matters that NHSE must take into account in assessing the factors in relation to quality of services, outcomes achieved from the provision of those services and improvements to such quality and outcomes set out in sections 223K(2) and (3) of the NHS Act.

The Town and Country Planning (Use Classes) Order 1987 as amended by the Town and Country Planning (Application of Subordinate Legislation to the Crown) Order 2006

77. The Town and Country Planning (Use Classes) Order 1987 ('the 1987 Order') puts uses of land and buildings into various categories ('use classes'). It is generally the case that someone will need planning permission to change from one use class to another, although there are exceptions where the legislation does allow some changes between uses.

78. Planning permission is not needed when the existing and the proposed uses fall within the same 'use class'.

79. In 2006, the Town and Country Planning (Application of Subordinate Legislation to the Crown) Order 2006 amended the 1987 Order to include an additional class C2A for secure residential institutions.

Annex 2: Payment models

	Block	Capitated	Episodic/case-based	Pay for performance
Definition	Provision of services for a specific time period	Provision of care for a specific patient population	Provision of fixed sum for episodes of care	Payment that rewards or penalises providers for aspects of their performance
Payment Basis	Historic prices	Population characteristics and demographics	Episode of care	Achievement of performance thresholds
Advantages	1. Low transaction costs 2. Budget is predictable, allowing for financial control 3. Flexibility for providers to change services offered	1. Relatively low transaction costs 2. Budget is predictable 3. Budget is adjusted according to population characteristics and demographics 4. Takes into consideration social and health inequalities	1. Increased competition can boost care quality where tariffs are fixed 2. Providers incentivised to reduce cost per episode since ‘currency’ is fixed 3. Quality improvement might be incentivised to attract patients 4. More transparency around cost allocation and activity	1. Potential to enhance quality and efficiency of care 2. Financial reward and penalties incentivises providers to comply with guidelines 3. System that enables providers, increasing competition 4. Full transparency around cost allocation and activity

	Block	Capitated	Episodic/case-based	Pay for performance
Disadvantages	1. Lack of transparency and accountability 2. Spending limit constrains volume of services provided 3. Risk posed by increased activity and cost of care 4. Pressure on 'good' providers that attract more activity	1. Risk posed by increased activity and cost of care 2. Risk posed by sudden demographic changes 3. Incentive for provider to not deliver care that is complex/costly	1. Providers are incentivised to increase activity in not he most effective care setting 2. Incorrect coding can result in over or underpayment 3. Higher transaction costs	1. Frequently rewards compliance with processes of care rather than outcomes 2. Risk of becoming a 'tick-box' exercise 3. Attention shift: risk that unrewarded work might be sacrificed 4. Higher transaction costs

Source: The table has been taken from Contracting for Outcomes (Outcomes Based Healthcare, July 2014) and adjusted for the purposes of this appendix.

Appendix C: Industry background and the Parties' operations

Introduction

1. This appendix provides further background information on the mental health services industry and the Parties' operations.

Industry background

2. A King's Fund report published in 2008 found that most of the mental health disorders in England were expected to show a small but significant increase between 2007 and 2026, due to changes in the age structure of the population, reflecting variations in prevalence by age.[1]

Table 1: Number of people (million) in England with specific mental disorders

	2007	*2026 projection*
Depression	1.2	1.5
Anxiety disorders	2.3	2.6
Schizophrenic disorders	0.2	0.2
Bipolar disorders and related conditions	1.1	1.2
Eating disorders	0.1	0.1
Personality disorder	2.5	2.6
Child/adolescent disorders	0.6	0.7
Dementia	0.6	0.9
Total	**8.6**	**9.8**

Source: King's Fund (2008), Paying the Price. The cost of mental health care in England to 2026. Table 1.

Policy context

3. In 2011, the government published a mental health strategy document, which set out the government's ambition to 'mainstream mental health and establish "parity of esteem" between services for people with mental and physical health problems'.[2,3] The implementation guide to this mental health strategy strongly supported investment in rehabilitation services.[4]

4. In March 2015, NHS England (NHSE) launched an Independent Taskforce ('the Taskforce') to develop a five-year strategy to improve mental health

[1] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p9.
[2] Department of Health (2011), No health without mental health. A cross government mental health outcomes strategy for all ages.
[3] National Audit Office (21 April 2016), Mental health services: preparations for improving access, p4. Foreword.
[4] As cited in Joint Commissioning Panel for Mental Health (JCMPH) (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health need.

outcomes across the NHS.[5] The Taskforce made 58 recommendations to improve mental health services, including calling for an expansion of community-based services for people with severe mental health problems who needed support to live safely and well, as close to home as possible. Further, it stated that more 'step-down'[6] help should be provided from secure care, such as residential rehabilitation, supported housing and forensic[7,8] outreach teams.

5. According to the Taskforce, the priority areas it had identified required an additional £1 billion investment in 2020/21, which 'will contribute to plugging critical gaps in the care the NHS is currently unable to provide.'[9]

6. A report of the House of Commons Committee of Public Accounts (published in September 2016) concluded that the additional money announced by the government was not ring-fenced, and there was a risk that commissioners and providers, already under financial pressure, would have no choice other than to deprioritise other mental or physical health services if they were to meet the new standards.[10]

Categorisation of mental health services

7. Mental health services can be categorised[11] based on various criteria, for example, the levels of security in which they are provided, underlying health condition being treated, whether they are provided in acute care settings[12] and the patient group treated (eg the elderly).

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[5] NHSE: Mental Health Taskforce.

[6] 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.

[7] Forensic mental health services are provided for *(a)* individuals with a mental disorder (including neurodevelopmental disorders) who *(b)* pose, or have posed, risks to others and *(c)* where that risk is usually related to their mental disorder. They may be placed in: hospitals (particularly secure hospitals), the community or prison. JCPMH, Forensic mental health services.

[8] The forensic outreach service provides aftercare and support for men and women aged 18 and over who are returning to the community from forensic inpatient care. It is provided for those people who are discharged from inpatient forensic services and for those who are referred from other sources. West London Mental Health NHS Trust: Forensic outreach service.

[9] The Five Year Forward View For Mental Health. A Report from the independent Mental Health Task Force. February 2016.

[10] In 2014/15, the NHS spent an estimated £11.7 billion on mental health services, which represented approximately 12% of total NHS spending. House of Commons Committee of Public Accounts (7 September 2016), Improving access to mental health services. Sixteenth Report of Session 2016–17.

[11] Many of these are overlapping categories. In addition, different organisations and bodies use different terminology to describe categorisation of mental health services.

[12] 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.

Levels of security

8. Secure mental health services are inpatient services[13] for patients with mental health conditions who present a significant risk to others or themselves or are already in the criminal justice system. Patients in secure services are detained under the Mental Health Act 1983, and the providers of secure mental healthcare services must meet certain security requirements, which vary depending on the security level.

9. There are three recognised levels of security: high, medium and low:[14]

   (a) High and medium secure services are for patients whose mental illness makes them a risk to themselves or to others, or who are subject to custody and cannot be transferred to open conditions due to the nature of their offence. High secure services are provided only by the NHS.

   (b) Low secure services are for those patients who have long-standing and complex problems and cannot be safely or successfully cared for in acute inpatient wards.[15] Whilst these facilities do not have the same security requirements as medium/high secure services, patients present a level of risk greater than general mental health services could safely address.

Mental health conditions

10. Terminology used to describe a mental health condition can vary, and continues to evolves over time. There are a range of mental health conditions ranging from conditions such as mild depression and anxiety disorders, to more severe conditions, such as schizophrenia and bipolar affective disorder – which require different levels of care. Other mental health conditions include drug or alcohol addiction and eating disorders.

11. Therefore, the term ‘mental health condition’ can be understood to refer collectively to the range of conditions that can affect a person’s mental health.[16]

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[13] An inpatient service is defined as a unit with ‘hospital beds’ that provides 24-hour nursing care. Source: Mental Health Network NHS Confederation, Defining Mental Health Services.

[14] See Section 2 - Legal and Regulatory framework (paragraphs 2.8–2.11) of our provisional findings for details regarding criteria under which patients should be admitted in the different levels of secure mental health services.

[15] Acute inpatient wards provide care and treatment for people who are acutely unwell and whose mental health problems are such that they cannot be treated and supported safely or effectively at home. This core service does not include wards where people are accommodated for longer periods of time (for example, long-stay or rehabilitation wards). Source: Care Quality Commission (CQC) (March 2015), Mental Health Provider Handbook Appendices.

[16] British Medical Association (BMA) (2017), Breaking down barriers – the challenge of improving mental health. p4.

Acute psychiatric services and Psychiatric Intensive Care Units[17]

12. Acute psychiatric services[18] 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).

13. Services provided at Psychiatric Intensive Care Units (PICUs) are designed for patients who cannot be managed on acute wards due to the level of risk they pose to themselves or others.

Patient category

14. Some mental health services are aimed at specific patient groups, for example:

    (a) Child and adolescent mental health services (CAMHS) provided in hospital are highly specialised services that provide assessment, care and treatment for children and young people with severe and complex mental health needs.[19]

    (b) Services aimed at providing assessment, care and treatment for older[20] people with mental health conditions, often relating to ageing; this may include a combination of psychological, cognitive, functional, behavioural, physical and social problems.

Rehabilitation services and the care pathway

15. Rehabilitation services operate as a whole system that includes a range of inpatient and community services, supported accommodation and vocational rehabilitation services provided by statutory, independent and voluntary sector organisations. Patients who use rehabilitation services often have co-morbid[21] physical health problems and require close liaison with primary care services.

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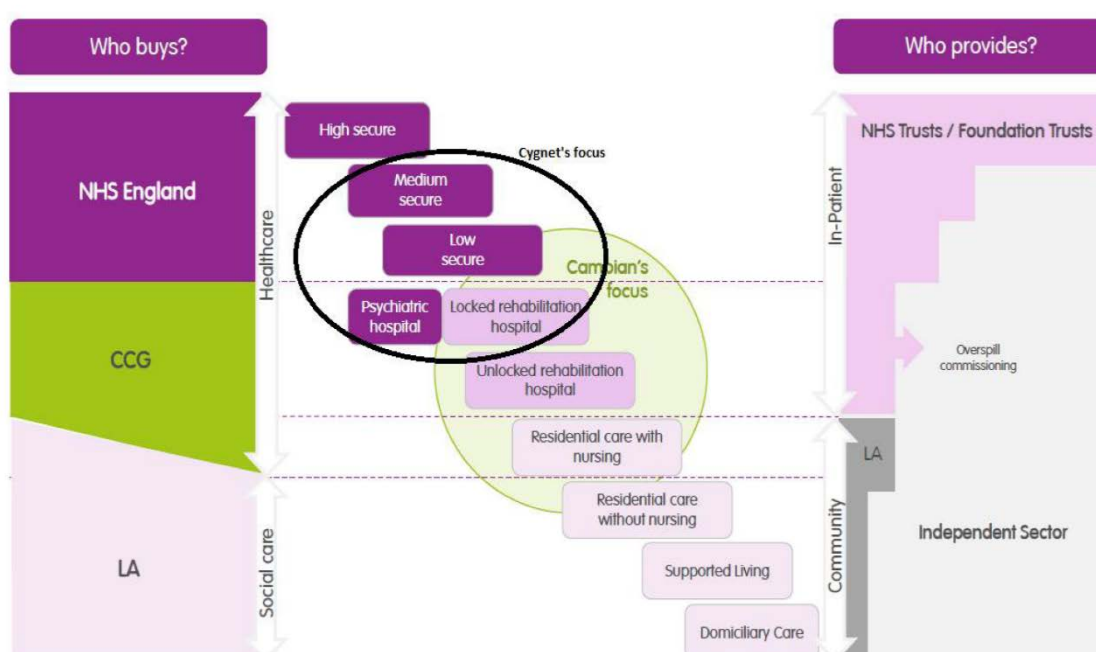
[17] Source: Merger Notice. Paragraph 3.11.
[18] Acute psychiatric care is the treatment and support provided to people who are either experiencing, at risk of, or recovering from a mental health crisis. This could include inpatient care on acute psychiatric wards, care in the community by a crisis resolution and home treatment (CRHT) team, care in acute day services or in crisis/ recovery houses. The Commission to review the provision of acute inpatient psychiatric care for adults (February 2016), Old Problems New Solutions.
[19] CAMHS is structured in four tiers, 1–4, in respect of how a child or young person accesses the service. Tiers 3 and 4 include provision of specialist services. JCPMH (October 2013), Guidance for commissioners of child and adolescent mental health services.
[20] There are many ways of defining 'older people'. For example, the Office of National Statistics commonly quotes data on individuals aged over 65. The World Health Organisation defines an 'older' person whose age has passed the median life expectancy at birth (which in the UK is currently 81.2 for men and women combined). BMA (2017), Breaking down barriers – the challenge of improving mental health outcomes.
[21] An illness or condition happening at the same time as another illness or condition.

Further, where appropriate, secondary care medical services[22] can play an important role for rehabilitation practitioners.[23]

16. People who do not recover adequately after acute admission to a mental health unit to be able to be discharged home are referred to rehabilitation services. Most referrals to rehabilitation services therefore come from general adult inpatient services. Rehabilitation services also provide step-down for those patients moving on from secure mental health services who have longer term and complex mental health needs.[24]

17. Figure 1 shows the various stages of the care pathway, along with the Parties' superimposition of the focus of their activities within this pathway.

Figure 1: Care pathway



Source: The Parties (Merger Notice).

18. Most (80%) people are referred to rehabilitation services from an acute inpatient ward and 20% from secure mental health services. The process of rehabilitation often takes many years and individuals may require repeat attempts to progress successfully from one stage to another. Nevertheless, 70% are able to achieve successful community discharge within 18 months of admission to an inpatient rehabilitation unit.[25]

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[22] Secondary care services are usually based in a hospital or clinic as opposed to being in the community.
[23] JCPMH (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health need.
[24] Ibid.
[25] CQC (August 2016), Brief guide: inpatient mental health rehabilitation services – discharge.

19. A rehabilitation inpatient unit usually provides part of a pathway from acute and forensic services (including acute and longer-term secure services) to a community residence of some kind. It can also form a pathway from an unsuccessful community placement to a successful placement.[26]

20. According to the CQC guide on rehabilitation services,[27] a multidisciplinary team should deliver individualised, collaborative care planning and working with patients to help them develop self-management skills and strategies.

Customers

21. Mental health care services in the UK are funded or purchased[28] primarily by various NHS bodies such as NHSE and CCGs. Local authorities also fund and/or purchase mental health care services, but these tend to be more in the realm of social care, for example, provided in residential care homes and supported living.[29]

Independent mental health hospitals

22. In late 2015, there were 271 independent hospitals or units in the UK providing mental health services with a total of 10,018 mental health beds While the net capacity of independent sector mental health hospital beds has been fairly stable, there has been a small shift in composition with a move to non-secure and step-down facilities.[30]

23. According to a Laing Buisson report published in 2016, the independent mental health hospital sector was witnessing robust demand, and a return to growth. Further, the report pointed out that the demand trends had been favourable to independent mental health hospitals in the last few years because of constraints on NHS in-house capacity as a result of:

    (a) an NHSE moratorium on commissioning of new capacity (for centrally commissioned services); and

[26] Royal College of Psychiatrists, Enabling recovery for people with complex mental health needs: A template for rehabilitation services, p28.
[27] CQC (August 2016), Brief guide: inpatient mental health rehabilitation services – discharge.
[28] On behalf of the patients.
[29] Residential/community care facilities are long-term placements in a social care setting. Patients are able to manage their mental health conditions (ie they do not require further rehabilitation), but are unable to live unsupported in society.
[30] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p1.

(b) a continuing reduction in NHS in-house capacity.[31]

24. According to Laing Buisson, aggregate EBITDAR[32] as a percentage of revenue for the six 'major independent mental health hospital operators' covered in their report[33] slipped from a peak of 28.6% in 2010 to 23.3% in 2014.[34] Commenting on the reasons for this downward trend, Laing Buisson stated that[35]

> The downward trend in operating profitability is consistent with the more challenging financial environment within the NHS since public sector austerity measures began around the turn of the decade, when NHS commissioners began to exert stronger downward pressure on provider prices across the board.

Mergers and acquisitions

25. Table 2 provides a summary of some recent Mergers and acquisitions (M&A) deals in the sector.

[31] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p1.
[32] According to LaingBuisson, EBITDAR was the best measure of underlying operating profitability, independent of capital structure. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p84.
[33] The companies covered in this analysis were Alpha Hospitals, Cambian, Cygnet, Partnership in Care, St Andrew's Healthcare and Priory Group.
[34] Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p84.
[35] Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p85.

Table 2: M&A deals by mental health hospital operators

Date	*Target*	*Acquirer*	*Enterprise value/ property price*	*Exit multiple*
January 2016	Priory Group	Acadia Healthcare	£1,500 million	10 times annualised EBITDAR for the first three quarters of 2015
August 2015	Alpha Hospitals	UHS/Cygnet	£95 million	12 times historic peak historic EBITDAR for the year ending March 2013
December 2014	Woodleigh Community Care	Cambian	£63 million	9.3 times EBITDA for the year ending September 2014
September 2014	Cygnet	UHS	£205 million	8.6 times EBITDAR for the year ending October 2013
June 2014	Partnership in Care	Acadia Healthcare	£395 million ($660 million)	9.0 times EBITDA for the year ending December 2013
April 2014	Cambian	Floatation	£540 million	12.6 times historical EBITDAR for the year ending December 2013
January 2011	Priory Group	Advent International	£925 million	9.3 times EBITDAR for calendar year 2010

Source: Based on data presented in Laing Buisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p88.

26. In an update on healthcare M&A, Catalyst Corporate Finance stated that 'Further consolidation [in the mental health sector] is likely; mental health received a funding injection in the recent [Comprehensive] Spending Review and this, together with strong corporate activity, will underpin investor appetite this year [2016].'[36]

27. According to the Parties, there are various drivers of M&A in the mental health sector in the UK, including:

    (a) the desire to offer an extended pathway to customers, which will lead to benefits for both the patients and customers, and the providers;

    (b) obtaining access to additional capital, in order to implement growth plans and invest in services;

    (c) benefits from combined/ enhanced management teams, in order to drive performance and quality and reduce costs. In addition, a provider may consider that a merger could lead to any poor quality issues being corrected;

    (d) extending geographical coverage, service offerings, or facilities; and

[36] Catalyst Health M&A update Winter 2015/16.

(e) increased regulation/ CQC scrutiny and litigation in the area may encourage consolidation.

28. PiC/Priory told us that the drivers of M&A in the mental healthcare industry in the UK were generic (ie applied generally to M&A transactions), and included:

(a) financial and quality performance of the target group;

(b) growth potential;

(c) quality of estate/property including type of tenure; and

(d) anticipated changes in the market (eg regulatory, service line specifications).

29. Elysium told us that the consolidation in the mental healthcare industry in the UK would continue as larger organisations were able to invest in governance, IT and data analysis tools to ensure that increasing requirements (eg customer requirements for data on outcomes) could be met in a cost-efficient manner. Further, it stated that there were further benefits in respect of the need to share clinical practices, peer review and workforce flexibility that made consolidation attractive.

The Parties' operations

30. This section provides further background information on the Parties and their operations.

Cygnet

31. In total, Cygnet has 20 mental health hospitals, and two residential care homes for the elderly that provide the following services:[37]

(a) medium secure services on six wards at two sites in Stevenage and Bury;

(b) low secure services on 19 wards at ten sites in Godden Green, Bierley, Kewstoke, Beckton, Blackheath, Derby, Harrow, Stevenage, Bury, Sheffield and Woking;

(c) rehabilitation services on 25 wards at 15 sites in Bierley, Kewstoke, Beckton, Brighouse, Derby, Ealing, Harrow, Wyke, Lewisham, Kenton, Taunton, Bury, Sheffield, and Woking and Coventry;

[37] Source: Merger Notice, paragraph 3.17.

(d) community services at two residential nursing homes in Cheshire and Surrey, both of which provide residential care for patients aged 50+ with dementia and age-related mental health conditions;

(e) acute and PICU services on 13 wards at nine sites in Bierley, Coventry, Kewstoke, Beckton, Blackheath, Harrogate, Harrow, Stevenage and Wyke;

(f) addiction services on one ward in Harrogate;

(g) eating disorder services on one ward in Ealing; and

(h) CAMHS on 12 wards at four sites in Godden Green, Bury, Sheffield and Woking.

32. Cygnet's staffing categories can be segmented into (i) permanent employees; (ii) bank (or temporary) workers; and (iii) agency workers. [✂]

33. [✂]

34. Staff costs are [✂] the largest proportion (approximately [✂]% in 2016) of Cygnet's total costs. Other costs include food, cleaning, and management overheads. [✂]

35. Cygnet stated that [✂].

36. During 2015, Cygnet completed two acquisitions – Orchard Portman and Alpha Hospital Holdings. Orchard Portman was a 46-bed mental hospital located near Taunton, Somerset that provided a range of specialist services to older patients with a mental illness. The Alpha hospitals acquisition included four hospitals located in Bury, Sheffield and Woking, which provided a range of specialist services to adolescents and adults with a mental illness.[38,39]

CAS

37. CAS divides its services into treating the following mental health conditions:

(a) Learning (or intellectual) disabilities and autism: provided at rehabilitation hospitals, step-down and residential services and day services.

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[38] The turnover of Alpha hospitals was £42.1 million for the year ending 31 March 2014.
[39] Cygnet Healthcare Financial Accounts. 2015, p1.

(b) Mental health and personality disorder (PD): provided at rehabilitation hospitals and step-down and residential services.

(c) Acquired brain injury: provided at rehabilitation hospitals.[40]

38. In total, CAS has 61 sites in England and Wales[41] that provide the following services:

(a) low secure services at one site in Nottingham;

(b) rehabilitation services at 25 sites (36 wards); and

(c) inpatient residential care home services and day community services (comprising, in total, 41 sites).

39. According to CAS, its services are delivered by a multidisciplinary team (MDT) of clinical staff, ie doctors, psychologists, occupational therapists, speech and language therapists and nurses, as well as operations personnel including hospital managers, care and support workers.

40. The majority of CAS's staff are specific to one site, [✂].

41. CAS told us that staff costs were its single largest cost item,[42] and [✂]. CAS has a central fixed cost base that is sufficient to manage additional capacity as and when this arises. Consequently, [✂].

42. CAS told us that its profitability remained subject to the [✂].

43. In December 2014, Cambian acquired Woodleigh, which provides community-based residential care for adults with LD.[43] This increased the number of CAS sites by 18 and the number of beds by 151. CAS sees the [✂].

44. More generally, CAS's growth strategy (since 2014) has focused on:

[✂]

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[40] Cambian's announcement of 5 December 2016.
[41] Most of CAS's sites are located in the Midlands and Yorkshire. See Appendix B for further details of CAS's services and location of its sites.
[42] [✂]
[43] Merger Notice, p22.

Appendix D: The Merger and its rationale

Introduction

1. This appendix provides 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 sale and purchase agreement (SPA). It also provides further details on the rationale for the Merger.

Cambian's profit warnings and strategic review of the business

2. Cambian issued profit warnings about its expected 2015 trading results on 22 October 2015 and 9 February 2016. On 9 February 2016, it also announced that it was entering into discussions with its lending banks to agree revised future covenants.

3. On 29 February 2016, Rothschild,[1] Cambian's adviser, in light of the company's financial situation, identified and presented various strategic options to Cambian's board. These included:[2,3]

   (a) [✄];

   (b) [✄];[4] and

   (c) [✄].

4. On 11 March 2016, Cambian issued another profit warning about its expected 2015 results, and announced that as a result it would not be in compliance with its financial covenants. It also announced that it had agreed a temporary waiver with its lending banks to address this possibility, and to facilitate continuing discussions with them.[5,6]

5. In a presentation made to Cambian's board on 22 March 2016, Rothschild spelt out [✄] strategic options for Cambian:

   (a) [✄];

   (b) [✄];[7] and

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[1] www.rothschild.com.
[2] [✄]
[3] [✄]
[4] [✄]
[5] Cambian announcement. 11 March 2016.
[6] [✄]
[7] [✄]

(c) [✂].

6. Rothschild concluded that both in terms of the feasibility of a transaction and the attractiveness of the remaining business, a carve out of CAS was the preferred option.

7. On 9 April 2016, Cambian's board agreed to seek the repayment of its bank debt through the sale of CAS.

8. In its 2015 annual report and accounts published on 29 April 2016, Cambian stated that its board had been reviewing the company's strategic options in light of the need to repay Tranche A of its existing borrowings in September 2017, as well as the wider business situation faced by the company. It also announced that advisers had been appointed to review the options for CAS, including a potential sale, and that its board had commenced market testing to assess potential interest of potential buyers.

The sale process

9. The sale was a two-stage process, run by Rothschild, Cambian's financial adviser.[8]

Round 1

10. [✂]

11. [✂]

12. [✂]

Round 2

13. [✂] parties UHS and [✂] were invited to Round 2, and submitted the following revised offers:,[9]

(a) UHS via Cygnet £[✂]

[✂]

14. [✂] [10]

[8] Rothschild advised Cambian on the sale process of CAS, which included evaluation of bids received.
[9] [✂]
[10] [✂]

15. Cambian's board considered Round 2 bids in its meeting of 16 November 2016, and agreed that:

    (a) [✂];

    (b) [✂];

    (c) [✂]; and

    (d) [✂].

16. Following a period of negotiation, Round 2 offers were revised higher [✂]

17. [✂].[11] [12]

18. Cambian's board approved the Merger in its meeting of 4 December 2016, noting that the Merger would promote the success of Cambian for the benefits of its shareholders.

Completion of the Merger

19. Negotiations between UHS and Cambian culminated in the signing of the SPA on 5 December 2016. The SPA provided that completion of the deal was conditional on Cambian obtaining the approval of its shareholders.

Legal entities

20. The legal entities involved in the Merger were:

    (a) Cygnet, a company incorporated in England and Wales (referred to in the SPA as the 'Buyer').

    (b) UHS, a company incorporated in Delaware, USA, (which owns Cygnet) (referred to in the SPA as the 'Buyer's Guarantor').

    (c) Cambian Group Holdings Limited (CGHL), a company incorporated in England and Wales which owned the entire issued share capital of:

        (i) Care Aspirations Developments, Limited (CADL), a company incorporated in England and Wales; and of

[11] [✂]
[12] [✂]

(ii) Cambian Healthcare Limited, a company incorporated in England and Wales (CHL).

(d) Cambian Education Services Limited **(CES)**, a company incorporated in England and Wales which owned the entire issued share capital of:

(i) Cambian Care Services Limited **(CCSL)**, a company incorporated in England and Wales.

21. At completion, CADL, CHL and CCSL and their respective subsidiary undertakings were to comprise Cambian's CAS business to be sold under the terms of the SPA.

The Sale and Purchase Agreement

22. The SPA reflects, the Merger involved:

(a) CGHL agreeing to sell to Cygnet (and Cygnet agreeing to buy from CGHL) the CADL shares and the CHL shares; and

(b) CES agreeing to sell to Cygnet (and Cygnet agreeing to buy from CES) the CCSL shares.

Principal terms and conditions

23. The principal terms and conditions of the Merger included the following:

(a) the sellers (CES and CGHL) agreed to sell the entire issued share capital of the target companies (CADL, CHL and CCSL) to the buyer (Cygnet) for £377 million, subject to customary adjustments, payable in cash on completion, subject to a post-completion adjustment;[13]

(b) completion was expected to occur by the end of December 2016 [✄]; and

(c) at completion, [✄].[14]

24. [✄]

25. [✄]

26. On 27 December 2016, Cambian shareholders passed a resolution to approve the sale of CAS to UHS via Cygnet,[15] following which the Merger

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[13] For example, working capital, intra-group payables and receivables etc.
[14] [✄]
[15] Source: Results of the General Meeting. 27 December 2016.

completed on 28 December 2016 by acquisition by Cygnet of the shares of the legal entities that operated CAS.

Rationale for the Merger

For the Parties

27. A management presentation to the executive committee of UHS's board set out the Merger rationale for UHS that:

    (a) [✂];

    (b) [✂];

    (c) [✂];

    (d) [✂];

    (e) [✂];

    (f) [✂];[16] and

    (g) [✂].

28. UHS told us that its strong financial position and access to capital would enable it to invest in and support Cambian's growth plan, and therefore, the merged entity would be in a better position to invest in projects such as [✂], which in turn would benefit patients.[17] UHS stated that its experience with acquisitions made in the USA had been that they helped the successful growth [✂] of the acquired business. It believed the same result could be achieved in respect of growth opportunities pursued in the UK, ie investment in CAS.

29. [✂]

30. The Parties stated that the Merger would also be beneficial to patients as it would ease the transitions between different stages of the care pathway (eg as patients step down from a secure to a less secure setting). This in turn, could minimise the instability and upheaval that can occur to patients in transitioning between different stages in the care pathway.[18]

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[16] Source: Merger Notice, paragraphs 2.8 & 2.9.
[17] Source: Merger Notice, paragraph 2.12.
[18] Merger Notice, paragraph 2.10.

31. The Parties also stated that the Merger would benefit their customers by ensuring the continuity of care throughout the different stages of the care pathway.[19] Further, they reasoned that any improvement to patient outcomes in the treatment of mental health conditions would also benefit the purchasers of those services through lower costs (eg if patients could get back into the community sooner, or could be treated at a lower level of security).[20]

32. The Parties considered that the Merger was likely to give rise to efficiencies and benefits for service users, predominantly because of easing the transitions between different stages of the care pathway. In particular, the Merger would broaden the reach of the Parties across the mental health care pathway and enable a greater number of smoother transitions, which would be less disruptive for patients.[21]

33. The Parties stated that this approach to treating mental health conditions was also in line with changes underway in commissioning structures to address the current situation, where different parts of the care pathway were 'owned' by different Commissioners, often leading to significant delays when a patient moved from one to another.[22,23]

34. A cross section of stock analysts' reports provided by the Parties to the CMA suggested that Cambian's decision to sell CAS was beneficial for UHS. For example:

(a) [✂]; and

(b) [✂].

For Cambian

35. In its 2016 results presentation on 26 April 2017, Cambian announced that with the sale of CAS, it now had the opportunity to invest in and grow the remaining business through a combination of organic growth and, in the medium term, bolt-on acquisitions.[24] Cambian also highlighted that the final

[19] Care pathway refers to different stages for patients with mental health conditions, for example patients can step down from a secure to a less secure setting.
[20] Source: Merger Notice, paragraph 2.11.
[21] Source: Merger Notice, paragraph 29.1.
[22] An example of one of the potential changes mentioned by the Parties is NHS England's devolution of forensic commissioning to lead provider partnerships. In this regard, NHSE has chosen four pilot areas to test devolving mental health secure commissioning to partnership organisations (which will be a mixture of NHS and independent organisations).
[23] Source: Merger Notice, paragraph 29.3.
[24] Cambian Results for the year ended 31 December 2016. 26 April 2017.

disposal consideration of £[✂] million[25] enabled settlement of all the bank debt.[26]

36. Stock analysts' reports provided to the CMA by Cambian indicated that the sale proceeds represented [✂] for CAS, for example:

(a) [✂][27]

(b) [✂][28]

37. A subsequent [✂] stock analyst report (issued after the Merger was completed) stated that Cambian 'achieved a better multiple for its disposed adult business, faster repayment of debts in full and stabilised financial performance at the retained Children's Services. The company appears well positioned to grow with a clean balance sheet, high care quality ratings and experienced management.'[29]

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[25] [✂]
[26] [✂]
[27] [✂]
[28] [✂]
[29] [✂]

Appendix E: Local competition

Introduction

1. In Section 9 of the provisional findings, we have summarised the key themes from the evidence gathered from the Parties and third parties on the effect of the Merger on competition in local overlap areas.

2. This appendix summarises further details regarding the providers of rehabilitation services for male and female LTMH patients and female PD patients in each of the eight 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.

3. In particular, for each of the overlap areas we have identified the local providers of rehabilitation services treating patients of the same gender and condition as the Parties. These providers have been identified on the basis of their geographical distance from the Parties' centroid site. Moreover, we have gathered information on the total number of beds, the security level of these facilities, their average occupancy, the date the site/ward opened, the list prices charged, the patients' average length of stay (AvLoS) and CQC ratings.

Yorkshire and the Humber – female PD

4. We have identified the following providers of mental health services for female PD patients within 65 miles from CAS Acer. In particular, the upper pane features all providers located within 60 miles of CAS Acer (base-case

catchment area) while the lower pane includes more providers located on the edge of the catchment area defined at 65 miles. Table 1 below lists these facilities and their characteristics.[1]

[1] When calculating market shares some of the providers listed above have not been considered on the basis of information submitted by these providers, third parties and CMA desk research. This clarification applies to all the tables in this appendix.

Table 1: Providers of mental health services for female PD patients in the Yorkshire and the Humber overlap area

Provider	Site	Specialism	Security level	Gender	Number of beds[1]	Average occupancy (%) Over 3 yrs	Average occupancy (%) 2016	Date opened[2]	List price (£)[3]	AvLoS (years)	CQC rating	Distance from centroid (miles)
CAS	CAS Acer Clinic	PD	Locked	Female	28	[✂]	[✂]	n/a	[✂]	[✂]	Good	0
Priory	Annesley House	LTMH/PD	n/a	Female	11	[✂]	[✂]	Site 1999	[✂]	[✂]	Good	20
Priory	Annesley House	LTMH/PD	n/a	Female	8	[✂]	[✂]	Site 1999	[✂]	[✂]	Good	20
CAS	CAS Aspen Clinic	PD	Locked	Female	16	[✂]	[✂]	n/a	[✂]	[✂]	Good	21
Heathcotes Group	Heathcotes Moorgreen	PD	n/a	Female	8			n/a	[✂]	[✂]	Requires Improvement	24
Priory	The Willows	LTMH/PD	n/a	Female	1	[✂]	[✂]	Site 2002	[✂]	[✂]	Good	30
Lighthouse	Ballington House	LTMH/PD	n/a	Female	10	[✂]	[✂]	Mar-11	[✂]	[✂]	Good	38
Priory	Park Villa	LTMH/PD	n/a	Female	11	[✂]	[✂]	Site 1996	[✂]	[✂]	Good	42
Heathcotes Group	Hembrigg Park	PD	n/a	Female	8			No info	[✂]		not inspected	44
Inmind	Waterloo Manor	PD	n/a	Female	6			Nov-16	[✂]	[✂]	Requires improvement	46
Priory	Priory Hospital Romiley	LTMH/PD	n/a	Female	10	[✂]	[✂]	n/a	[✂]	[✂]	Opening Aug 17	50
Cygnet	BIERLEY (Bowling)	PD	Locked	Female	20	[✂]	[✂]	n/a	[✂]	[✂]	Good	54
Inmind	Sturdee Community	PD	n/a	Female	12			Jun-05	[✂]	[✂]	Good	57
Inmind	Sturdee Community	PD	n/a	Female	4			Jun-05	[✂]	[✂]	Good	57
Inmind	Sturdee Community	PD	n/a	Female	8			Jun-05	[✂]	[✂]	Good	57
Inmind	Sturdee Community	PD	n/a	Female	9			Jun-05	[✂]	[✂]	Good	57
Elysium	Brierley Court	LTMH/PD	n/a	Mixed	21	[✂]	[✂]	Jun-15	[✂]	[✂]	Good	60
Cygnet	SHEFFIELD (Shepherd Ward)	LTMH	Locked	Female	13	[✂]	[✂]	n/a	[✂]	[✂]	Requires Improvement	10
Turning Point	The Corner House	LTMH	Locked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Good	14
Debdale Specialist Care Ltd	Thistle Hill Hall	LTMH	n/a	Mixed	18	[✂]	[✂]	n/a	[✂]	[✂]	Outstanding	14
Barchester	Forest Hospital	LTMH	n/a	Female	15	[✂]	[✂]	Mar-13	[✂]	[✂]	Requires improvement	16
CAS	Aspen House	LTMH	Locked	Female	20	[✂]	[✂]	n/a	[✂]	[✂]	Good	21
Turning Point	Nottingham Transition Unit	LTMH	Locked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Not registered	33
John Munroe Group	Edith Shaw Unit	LTMH	Locked	Female	14	[✂]	[✂]	n/a	[✂]	[✂]	Good	37
John Munroe Group	John Munroe Hospital	LTMH	Locked	Female	20	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	40
Rushcliffe Care Group	Aaron's Specialist Unit	LTMH	n/a	Mixed	10	[✂]	[✂]	n/a	[✂]	[✂]	Good	44
Deepdene Care	Norton Street	LTMH	Unlocked	Mixed	30	[✂]	[✂]	n/a	[✂]	[✂]	Good	57
Elysium	Springwood Lodge	LTMH	n/a	Female	17	[✂]	[✂]	Nov-15	[✂]	[✂]	Awaiting first inspection	58
Elysium	Springwood Lodge	LTMH	n/a	Female	5	[✂]	[✂]	Nov-15	[✂]	[✂]	Awaiting first inspection	58

Provider	Site	Specialism	Security level	Gender	Number of beds[1]	Average occupancy (%) Over 3 yrs	2016	Date opened[2]	List price (£)[3]	AvLoS (years)	CQC rating	Distance from centroid (miles)
Alternative Futures	Millbrook	LTMH/PD	n/a	Mixed	12	[✂]	[✂]	Aug-01	[✂]	[✂]	Good	61
Northern Pathways	Garrow House	PD	Locked	Female	12			n/a	[✂]	[✂]	Not sufficient evidence to rate	62
The Retreat	The Retreat	PD	Locked	Female	20			n/a	[✂]	[✂]	Inadequate	62
Priory	255 Lichfield Road	LTMH/PD	n/a	Mixed	20	[✂]	[✂]	Site 2013	[✂]	[✂]	Good	63
Priory	255 Lichfield Road	LTMH/PD	n/a	Female	4	[✂]	[✂]	Site 2013	[✂]	[✂]	Good	63

Source: CMA analysis.
Notes:
1. The number of beds cited for mixed gender and/or combined specialism providers refers to the total number of beds not the beds dedicated the specialism/gender in question. In Section 9 we specify the assumptions employed when calculating the respective market shares.
2. The column titled 'Date opened' contains information about the date the site (or ward where relevant) was opened, repositioned or acquired from another provider depending on what data different providers have submitted. This clarification applies to following tables.
3. Unless specified otherwise the list price is per day. This clarification applies to all tables in this appendix.

The South West – female PD

5. We have identified the following providers of mental health services for female PD patients within 65 miles of Cygnet Kewstoke (the upper pane represents our base-case catchment area and in the lower pane we extend to 65 miles). Table 2 below lists these facilities and their characteristics.

Table 2: Providers of mental health services for female PD patients in the South West England and South Wales overlap area

Provider	*Site*	*Specialism*	*Security level*	*Gender*	*Number of beds*	*Average occupancy (%)*		*Date opened*	*List price*	*AvLoS (years)*	*CQC rating*	*Distance from centroid (miles)*
						Over 3 yrs	*2016*					
Cygnet	KEWSTOKE (Knightstone)	PD	Locked	Female	16	[✂]	[✂]	n/a	[✂]	[✂]	Good	0
CAS	CAS Alders Clinic	PD	Locked	Female	20	[✂]	[✂]	n/a	[✂]	[✂]	Good	49
Sherwood Lodge Independent Healthcare	Sherwood Lodge	LTMH/PD		Mixed	24	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	4
Elysium	The Copse	LTMH/PD		Female	6	[✂]	[✂]	Dec-16	[✂]	[✂]	Good	5
Ocean Community Services	Overndale House	LTMH/PD	Unlocked	Female	7	[✂]	[✂]	n/a	[✂]	[✂]	Good	30
Priory	Priory Hospital Bristol	LTMH/PD		Female	5	[✂]	[✂]	Site 2005	[✂]	[✂]	Good	32
Priory	Ty Catrin	LTMH/PD		Female	3	[✂]	[✂]	Site 2009	[✂]	[✂]	Non-compliant	54
Ludlow Street Healthcare	Heatherwood Court	PD	Locked	Female	11	[✂]	[✂]	n/a	[✂]	[✂]	n/a	61

Source: CMA analysis.

London – male LTMH

6. We have identified the following providers of mental health services for male patients with LTMH within a 90-minute drive-time of Cygnet Woking. Table 3 below lists these facilities and their characteristics.

Table 3: Providers of mental health services for male LTMH patients in the Surrey and Greater London overlap area

Provider	*Site*	*Specialism*	*Security level*	*Gender*	*Number of beds*	*Average occupancy (%)*		*Date opened*	*List price (£)*	*AvLoS (years)*	*CQC rating*	*Distance from centroid site (DT)*
						Over 3 yrs	*2016*					
Cygnet	WOKING (The Lodge Upper/ Lower and Step Down House)	LTMH	Locked	Male	31	[✂]	[✂]	Aug-15	[✂]	[✂]	Good	0
Elysium	Sturt House	LTMH	n/a	Male	21	[✂]	[✂]	Nov-16	[✂]	[✂]	Good	38
Whitepost	Shrewsbury Court Independent Hospital	LTMH	n/a	Male	9	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	40
Whitepost	Shrewsbury Court Independent Hospital	LTMH	n/a	Male	13	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	40
Whitepost	Shrewsbury Court Independent Hospital	LTMH	n/a	Male	13	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	40
Vision Healthcare	Cornerstone House	LTMH	Unlocked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Good	46
Vision Healthcare	Cornerstone House	LTMH/PD		Mixed	23	[✂]	[✂]	n/a	[✂]	[✂]	Good	46
The Lane Project	The Lanes	LTMH	Unlocked	Male	18	[✂]	[✂]	n/a	[✂]	[✂]	n/a	47
Elysium	Rosebank House	LTMH	n/a	Mixed	13	[✂]	[✂]	Jun-15	[✂]	[✂]	Requires improvement	47
Priory	Priory Hospital Hemel Hempstead	LTMH/PD	n/a	Male	15	[✂]	[✂]	Site 2004	[✂]	[✂]	Good	52
Inmind	Southleigh	LTMH	Locked	Mixed	19	[✂]	[✂]	2002	[✂]	[✂]	Good	53
Inmind	Southleigh	LTMH	Unlocked	Mixed	6	[✂]	[✂]	2002	[✂]	[✂]	Good	53
Bramley Health	Croham Place	LTMH	n/a	Mixed	14	[✂]	[✂]	n/a	[✂]	[✂]	Good	54
Deepdene Care	Deepdene House	LTMH	Unlocked	Mixed	20	[✂]	[✂]	n/a	[✂]	[✂]	Good	58
Inmind	Woodleigh	LTMH	n/a	Mixed	23	[✂]	[✂]	2002	[✂]	[✂]	Good	58
Priory	Priory Cloisters	LTMH/PD	n/a	Male	12	[✂]	[✂]	Dec-16	[✂]	[✂]	Good	59
Priory	Priory Cloisters	LTMH/PD	n/a	Male	8		[✂]	Dec-16	[✂]	[✂]	Good	59
CAS	CAS Churchill	LTMH	Locked	Male	57	[✂]	[✂]	n/a	[✂]	[✂]	Good	67
Priory	Nelson House	LTMH/PD	n/a	Male	14	[✂]	[✂]	Site 2012	[✂]	[✂]	Requires improvement	68
Priory	Nelson House	LTMH/PD	n/a	Mixed	4	[✂]	[✂]	Site 2012	[✂]	[✂]	Requires improvement	68
Bramley Health	Glenhurst Lodge	LTMH	Locked	Male	11	[✂]	[✂]	n/a	[✂]	[✂]	Good	69
Richmond Fellowship	2Care The Knowl	LTMH	n/a	Mixed	15	[✂]	[✂]	n/a	[✂]	[✂]	Not inspected	73
Nouvita	Baldock Manor - Mulberry	LTMH	Locked	Male	21	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	75
Cygnet	CYGNET LODGE LEWISHAM	LTMH	Locked	Male	17	[✂]	[✂]	n/a	[✂]	[✂]	Good	75
Priory	North London Clinic	LTMH/PD	n/a	Male	19	[✂]	[✂]	Site 1995	[✂]	[✂]	Outstanding	75
Elysium	Bromley Road	LTMH	n/a	Mixed	17	[✂]	[✂]	Apr-15	[✂]	[✂]	Requires improvement	76
Priory	Priory Hospital Ticehurst	LTMH/PD	n/a	Mixed	14	[✂]	[✂]	Site 1792	[✂]	[✂]	Requires improvement	84
Priory	Ticehurst	LTMH/PD	n/a	Male	4	[✂]	[✂]	Site 1792	[✂]	[✂]	Requires improvement	84

Provider	Site	Specialism	Security level	Gender	Number of beds	Average occupancy (%) Over 3 yrs	2016	Date opened	List price (£)	AvLoS (years)	CQC rating	Distance from centroid site (DT)
Priory	Kneesworth House	LTMH/PD	n/a	Male	4	[✂]	[✂]	Site 1985	[✂]	[✂]	Requires improvement	85
Priory	Kneesworth House	LTMH/PD	n/a	Male	4	[✂]	[✂]	Site 1985	[✂]	[✂]	Requires improvement	85
Priory	Kneesworth House	LTMH/PD	n/a	Male	17	[✂]	[✂]	Site 1985	[✂]	[✂]	Requires improvement	85
Priory	Kneesworth House	LTMH/PD	n/a	Male	4	[✂]	[✂]	Site 1985	[✂]	[✂]	Requires improvement	85
Priory	Kneesworth House	LTMH/PD	n/a	Male	17	[✂]	[✂]	Site 1985	[✂]	[✂]	Requires improvement	85

Source: CMA analysis.

Yorkshire – male LTMH

7. We have identified the following providers of mental health services for male patients with LTMH within 65 miles of CAS Oaks (the upper pane represents our base-case catchment area and in the lower pane we extend to 65 miles). Table 4 below lists these facilities and their characteristics.[2]

[2] The number of beds for NHS providers only includes beds that are not dedicated to block contracts. This point also applies with respect to Table 7.

Table 4: Providers of mental health services male LTMH patients in the Yorkshire overlap area

Provider	Site	Specialism	Security level	Gender	Number of beds	Average occupancy (%)		Date opened	List price (£)	AvLoS (years)	CQC rating	Distance from centroid (miles)
						Over 3 yrs	2016					
CAS	CAS Oaks	LTMH	Locked	Male	36	[✂]		n/a	[✂]	[✂]	Good	0
Turning Point	The Corner House	LTMH	Locked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Good	15
Priory	Priory Hospital Dewsbury	LTMH/PD		Male	22	[✂]	[✂]	Site 2012	[✂]	[✂]	Requires improvement	16
Riverside Healthcare	Cheswold Park Hospital	LTMH	Locked	Male	11	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	17
Rotherham, Doncaster and South Humber NHS Trust	Coral Lodge		n/a		9							17
Cygnet	Cygnet Lodge Brighouse	LTMH	Locked	Male	24	[✂]	[✂]	n/a	[✂]	[✂]	Good	21
Priory	Mill Garth	LTMH/PD		Male	21	[✂]	[✂]	Mar-16	[✂]	[✂]	Not inspected	28
CAS	The Limes	LTMH	Locked	Male	18	[✂]	[✂]	n/a	[✂]	[✂]	Good	31
Debdale Specialist Care Ltd	Thistle Hill Hall	LTMH	n/a	Mixed	18	[✂]	[✂]	n/a	[✂]	[✂]	Outstanding	36
Deepdene Care	Brook House	LTMH	Locked	Male	12	[✂]	[✂]	n/a	[✂]	[✂]	No longer registered	37
Nottinghamshire Healthcare NHS Foundation Trust	Bracken House		n/a		12							37
Deepdene Care	Norton Street	LTMH	Unlocked	Mixed	30	[✂]	[✂]	n/a	[✂]	[✂]	Good	38
CAS	Storthfields House	LTMH	Locked	Male	22	[✂]	[✂]	n/a	[✂]	[✂]	Good	38
Barchester	Forest Hospital	LTMH	n/a	Male	15	[✂]	[✂]	Mar-13	[✂]	[✂]	Requires improvement	38
Priory	Cheadle Royal	LTMH/PD	n/a	Male	11	[✂]	[✂]	Site 1842	[✂]	[✂]	Good	40
Alternative Futures	Millbrook	LTMH/PD	n/a	Mixed	12	[✂]	[✂]	Aug-01	[✂]	[✂]	Good	42
Turning point	Douglas House	LTMH	Unlocked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Outstanding	42
Equilibrium	Jigsaw Independent Hospital	LTMH	Locked	Male	19	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	42
CAS	Sherwood House	LTMH	Locked	Male	30	[✂]	[✂]	n/a	[✂]	[✂]	Good	43
Elysium	Three Valleys	LTMH	n/a	Male	12	[✂]	[✂]	Nov-16	[✂]	[✂]	Good	44
Elysium	Three Valleys	LTMH	n/a	Male	6	[✂]	[✂]	Nov-16	[✂]	[✂]	Good	44
Elysium	Three Valleys	LTMH	n/a	Male	4	[✂]	[✂]	Nov-16	[✂]	[✂]	Good	44
Huntercombe	Huntercombe Centre-Sherwood	LTMH	n/a	Male	18	[✂]	[✂]	n/a	[✂]	[✂]	Good	50
Turning Point	Nottingham Transition Unit	LTMH	Locked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Not registered	54
Cygnet	Derby (Wyvern)	LTMH	Locked	Male	19	[✂]	[✂]	n/a	[✂]	[✂]	Good	55
John Munroe Group	John Munroe Hospital	LTMH	Locked	Male	24	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	55
Turning point	Pendlebury House	LTMH	Locked	Male	10	[✂]	[✂]	n/a	[✂]	[✂]	Outstanding	58
Elysium	Brierley Court	LTMH/PD	n/a	Mixed	21	[✂]	[✂]	Jun-15	[✂]	[✂]	Good	59
Alternative Futures	Oak Lodge	LTMH/PD	n/a	Mixed	12	[✂]	[✂]	Aug-97	[✂]	[✂]	Good	60
Priory	Priory Highbank	LTMH/PD	n/a	Male	10	[✂]	[✂]	Site 1994	[✂]	[✂]	Good	60
Alternative Futures	Weaver Lodge	LTMH/PD	n/a	Mixed	20	[✂]	[✂]	Jun-95	[✂]	[✂]	Good	61

Source: CMA analysis.

Northern Wales and the North West – female LTMH

8. We have identified the following providers of mental health services for female LTMH patients within 65 miles of CAS Delfryn (the upper pane lists all providers within 60 miles and the lower pane lists the providers that are located within 65 miles of the centroid site). Table 5 below lists these facilities and their characteristics.[3]

[3] Cygnet Bury and CAS Delfryn Lodge are 59 miles apart. We have therefore extended the baseline 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 5: Providers of mental health services for female LTMH patients in the South West and southern Wales overlap area

Provider	*Site*	*Specialism*	*Security level*	*Gender*	*Number of beds*	*Average occupancy %*		*Date opened*	*list price (£)*	*AvLoS (years)*	*CQC rating*	*Distance from centroid (miles)*
						Over 3 yrs	*2016*					
CAS	Delfryn Lodge	LTMH	Locked	Female	24	[✂]	[✂]	n/a	[✂]	[✂]	Good	0
Alternative Futures	Meadow Park	LTMH/PD	n/a	Mixed	20	[✂]	[✂]	Oct-01	[✂]	[✂]	Good	14
MHC	Holland House	LTMH	Unlocked	Mixed	18	[✂]	[✂]	n/a	[✂]	[✂]	n/a	17
Elysium	Recovery First	LTMH/PD	n/a	Female	12	[✂]	[✂]	Nov-16	[✂]	[✂]	n/a	29
Elysium	Recovery First	LTMH/PD	n/a	Female	10	[✂]	[✂]	Nov-16	[✂]	[✂]	n/a	29
Elysium	Recovery First	LTMH/PD	n/a	Mixed	1	[✂]	[✂]	Nov-16	[✂]	[✂]	n/a	29
Elysium	Recovery First	LTMH/PD	n/a	Female	12	[✂]	[✂]	Nov-16	[✂]	[✂]	n/a	29
Alternative Futures	Weaver Lodge	LTMH/PD	n/a	Mixed	20	[✂]	[✂]	Jun-95	[✂]	[✂]	Good	31
Lighthouse	Phoenix House	LTMH/PD	n/a	Female	6	[✂]	[✂]	Jun-15	[✂]	[✂]	N/A HIW	40
Alternative Futures	Millbrook	LTMH/PD	n/a	Mixed	12	[✂]	[✂]	Aug-01	[✂]	[✂]	Good	43
Turning point	Douglas House	LTMH	Unlocked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Outstanding	45
Equilibrium	Jigsaw Independent Hospital	LTMH	Locked	Female	18	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	46
Alternative Futures	Fir trees	LTMH/PD	n/a	Mixed	14	[✂]	[✂]	Oct-96	[✂]	[✂]	Good	47
Deepdene Care	Norton Street	LTMH	Unlocked	Mixed	30	[✂]	[✂]	n/a	[✂]	[✂]	Good	48
Priory	Romiley (Renamed from Park Lodge)	LTMH/PD	n/a	Female	10	[✂]	[✂]	n/a	[✂]	[✂]	Opening Aug 17	52
Priory	Park Villa	LTMH/PD	n/a	Female	11	[✂]	[✂]	Site 1996	[✂]	[✂]	Good	52
Alternative Futures	Oak Lodge	LTMH/PD	n/a	Mixed	12	[✂]	[✂]	Aug-97	[✂]	[✂]	Good	54
Northern Healthcare Ltd	Mary Seacole House	LTMH	n/a	Mixed	22	[✂]	[✂]	n/a	[✂]	[✂]	Under inspection	56
Cygnet	BURY (Southampton)	LTMH	Locked	Female	12	[✂]	[✂]	n/a	[✂]	[✂]	Good	59
Elysium	Brierley Court	LTMH/PD	n/a	Mixed	21	[✂]	[✂]	Jun-15	[✂]	[✂]	Good	60
John Munroe Group	John Munroe Hospital	LTMH	Locked	Female	20	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	60
Active Pathways	Bamber Bridge	LTMH	n/a	Mixed	22	[✂]	[✂]	2008	[✂]	[✂]	Good	61
John Munroe Group	Edith Shaw Unit	LTMH	Locked	Female	14	[✂]	[✂]	n/a	[✂]	[✂]	Good	64
Lighthouse	Ballington House	LTMH/PD	n/a	Female	10	[✂]	[✂]	Mar-11	[✂]	[✂]	Good	64

Source: CMA analysis.

Southern Wales and the South West – female LTMH

9. We have identified the following providers of mental health services for female LTMH patients within 80 miles of CAS St Teilo.[4] Table 6 below lists these facilities and their characteristics.

[4] As discussed in the respective section because of the distance between the Parties' sites (74 miles), we calculated market shares within a wider catchment area of 80 miles.

Table 6: Providers of mental health services for female LTMH patients in the South West and southern Wales overlap area

Provider	*Site*	*Specialism*	*Security level*	*Gender*	*Number of beds*	*Avg. Occupancy (%)*		*Date opened*	*list price/ per day (£)*	*AvLoS (years)*	*CQC rating*	*Distance from centroid (miles)*
						Over 3 yrs	*2016*					
CAS	St Teilo House	LTMH	Locked	Female	23	[✂]	[✂]	n/a	[✂]	[✂]	N/A HIW	0
Elysium	Ty Gwyn Hall	LTMH	n/a	Mixed	4	[✂]	[✂]	Nov-16	[✂]	[✂]	N/A HIW	19
Elysium	Ty Gwyn Hall	LTMH	n/a	Mixed	12	[✂]	[✂]	Nov-16	[✂]	[✂]	N/A HIW	19
Elysium	Ty Gwyn Hall	LTMH	n/a	Mixed	18	[✂]	[✂]	Nov-16	[✂]	[✂]	N/A HIW	19
Priory	Ty Catrin	LTMH / PD	n/a	Female	3	[✂]	[✂]	Site 2009	[✂]	[✂]	Non-compliant (HIW)	27
Hafal	Gellinudd Recovery Centre	LTMH	n/a	Mixed	16	[✂]	[✂]	n/a	[✂]	[✂]	N/A HIW	32
Ocean Community Services	Overndale House	LTMH / PD	Unlocked	Female	7	[✂]	[✂]	n/a	[✂]	[✂]	Good	61
Priory	Priory Hospital Bristol	LTMH / PD	n/a	Female	5	[✂]	[✂]	Site 2005	[✂]	[✂]	Good	63
Cygnet	KEWSTOKE (The Lodge)	LTMH	Locked	Female	12	[✂]	[✂]	n/a	[✂]	[✂]	Good	74
Sherwood Lodge	Sherwood Lodge Independent Healthcare	LTMH / PD	n/a	Mixed	24	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	75
Elysium	The Copse	LTMH	n/a	Female	6	[✂]	[✂]	Dec-16	[✂]	[✂]	Good	75
Elysium	The Copse	LTMH / PD	n/a	Female	6	[✂]	[✂]	Dec-16	[✂]	[✂]	Good	75

Source: CMA analysis.

The East Midlands – male LTMH

10. We have identified the following providers of mental health services for male patients with LTMH within 65 miles of CAS Storthfield House (the upper pane represents our base-case catchment area and in the lower pane we extend to 65 miles). Table 7 below lists these facilities and their characteristics.

Table 7: Providers of mental health services for male LTMH patients in the East Midlands overlap area

Provider	*Site*	*Specialism*	*Security level*	*Gender*	*Number of beds*	*Average occupancy (%)*		*Date opened*	*List price (£)*	*AvLoS (years)*	*CQC rating*	*Distance from centroid site (miles)*
						Over 3 yrs	*2016*					
CAS	Storthfields House	LTMH	Locked	Male	22	[✂]	[✂]	n/a	[✂]	[✂]	Good	0
Nottinghamshire Healthcare NHS Foundation Trust	Bracken House		n/a		12							7
Debdale Specialist Care Ltd	Thistle Hill Hall	LTMH	n/a	Mixed	18	[✂]	[✂]	n/a	[✂]	[✂]	Outstanding	8
Barchester	Forest Hospital	LTMH	n/a	Male	15	[✂]	[✂]	Mar-13	[✂]	[✂]	Requires improvement	10
CAS	Sherwood House	LTMH	Locked	Male	30	[✂]	[✂]	n/a	[✂]	[✂]	Good	11
Derbyshire Health United	Bolsover Hospital	LTMH	n/a	Mixed	0	[✂]	[✂]	n/a	[✂]	[✂]	n/a	11
Huntercombe	Huntercombe Centre-Sherwood	LTMH	n/a	Male	18	[✂]	[✂]	n/a	[✂]	[✂]	Good	14
CAS	The Limes	LTMH	Locked	Male	18	[✂]	[✂]	n/a	[✂]	[✂]	Good	14
Cygnet	Derby (Wyvern)	LTMH	Locked	Male	19	[✂]	[✂]	n/a	[✂]	[✂]	Good	18
Turning Point	Nottingham Transition Unit	LTMH	Locked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Not registered	18
Turning Point	The Corner House	LTMH	Locked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Good	26
Rushcliffe Care Group	Aaron's Specialist Unit	LTMH	n/a	Mixed	10	[✂]	[✂]	n/a	[✂]	[✂]	Good	30
Rotherham, Doncaster and South Humber NHS Trust	Coral Lodge		n/a		9							33
Riverside Healthcare	Cheswold Park Hospital	LTMH	Locked	Male	11	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	35
CAS	CAS Oaks	LTMH	Locked	Male	36	[✂]	[✂]	n/a	[✂]	[✂]	Good	38
John Munroe Group	John Munroe Hospital	LTMH	Locked	Male	24	[✂]	[✂]	n/a	[✂]	[✂]	Requires improvement	46
Priory	255 Lichfield Road	LTMH/PD	n/a	Mixed	20	[✂]	[✂]	Site 2013	[✂]	[✂]	Good	48
Priory	255 Lichfield Road	LTMH/PD	n/a	Male	4	[✂]	[✂]	Site 2013	[✂]	[✂]	Good	48
Camino Healthcare	Nuneaton	LTMH	Unlocked	Mixed	20	[✂]	[✂]	n/a	[✂]	[✂]		49
Priory	Priory Hospital Dewsbury	LTMH/PD	n/a	Male	22	[✂]	[✂]	Site 2012	[✂]	[✂]	Requires improvement	51
CAS	St. Augustine's	LTMH	Locked	Male	32	[✂]	[✂]	n/a	[✂]	[✂]	Good	52
Priory	Priory Hospital Cheadle Royal	LTMH/PD	n/a	Male	11	[✂]	[✂]	Site 1842	[✂]	[✂]	Good	55
Cygnet	Cygnet Lodge Brighouse	LTMH	Locked	Male	24	[✂]	[✂]	n/a	[✂]	[✂]	Good	56
Priory	Woodland View	LTMH/PD	n/a	Male	10	[✂]	[✂]	n/a	[✂]	[✂]	Good	62
Priory	Woodland View	LTMH/PD	n/a	Male	10	[✂]	[✂]	n/a	[✂]	[✂]	Good	62
Priory	Woodland View	LTMH/PD	n/a	Male	11	[✂]	[✂]	n/a	[✂]	[✂]	Good	62
CAS	Sedgley HouseLodge	LTMH	Locked	Male	34	[✂]	[✂]	n/a	[✂]	[✂]	Good	62
Camino Healthcare	Oak House	LTMH	Unlocked	Mixed	14	[✂]	[✂]	n/a	[✂]	[✂]	Good	63
Priory	Mill Garth	LTMH/PD	n/a	Male	21	[✂]	[✂]	Mar-16	[✂]	[✂]	Not inspected	63
Options for Care	Montague Court	LTMH	Locked	Male	18	[✂]	[✂]	n/a	[✂]	[✂]	Good	64

Source: CMA analysis.

The West Midlands – female LTMH

11. We have identified the following providers of mental health services for female LTMH patients within 65 miles of Cygnet Coventry. The upper pane lists all providers within 60 miles, which is our base-case catchment area, and the lower pane extends to 65 miles to capture providers that are on the edge of the catchment area. Table 8 below lists these facilities and their characteristics.

Table 8: Providers of mental health services for female LTMH patients in the West Midlands overlap area

						Average occupancy (%)						
Provider	*Site*	*Specialism*	*Security level*	*Gender*	*Number of beds*	*Over 3 yrs*	*2016*	*Date opened*	*List price (£)*	*AvLoS (years)*	*CQC rating*	*Distance from centroid (miles)*
Cygnet	Coventry	LTMH	Locked	Female	16	[✂]	[✂]	n/a	[✂]		Not inspected	0
Camino Healthcare	Nuneaton	LTMH	Unlocked	Mixed	20	[✂]	[✂]	n/a	[✂]	[✂]	Not completed	11
Inmind	Sturdee Community	PD (/LTMH)	n/a	Female	12	[✂]	[✂]	2002	[✂]	[✂]	Good	22
Inmind	Sturdee Community	PD (/LTMH)	n/a	Female	4	[✂]	[✂]	2002	[✂]	[✂]	Good	22
Inmind	Sturdee Community	PD (/LTMH)	n/a	Female	8	[✂]	[✂]	2002	[✂]	[✂]	Good	22
Inmind	Sturdee Community	PD (/LTMH)	n/a	Female	9	[✂]	[✂]	2002	[✂]	[✂]	Good	22
Options for Care	Harriet Tubman House	LTMH	Locked	Female	15	[✂]	[✂]	n/a	[✂]	[✂]	Good	26
CAS	Raglan House	LTMH	Locked	Female	25	[✂]	[✂]	n/a	[✂]	[✂]	Good	27
Priory	Beverley House	LTMH/PD	n/a	Female	24	[✂]	[✂]	Site 2010	[✂]	[✂]	Good	27
Camino Healthcare	Cromwell House	LTMH	Unlocked	Mixed	9	[✂]	[✂]	n/a	[✂]	[✂]	Good	33
Camino Healthcare	Oak House	LTMH	Unlocked	Mixed	14	[✂]	[✂]	n/a	[✂]	[✂]	Good	34
Priory	Lakeside View	LTMH/PD	n/a	Female	4	[✂]	[✂]	No info	[✂]	[✂]	Good	35
Priory	Lakeside View	LTMH/PD	n/a	Female	8	[✂]	[✂]	No info	[✂]	[✂]	Good	35
Priory	Lakeside View	LTMH/PD	n/a	Female	6	[✂]	[✂]	No info	[✂]	[✂]	Good	35
Priory	Lakeside View	LTMH/PD	n/a	Female	12	[✂]	[✂]	No info	[✂]	[✂]	Good	35
Rushcliffe Care Group	Aaron's Specialist Unit	LTMH	n/a	Mixed	10	[✂]	[✂]	n/a	[✂]	[✂]	Good	35
Priory	255 Lichfield Road	LTMH/PD	n/a	Mixed	20	[✂]	[✂]	Site 2013	[✂]	[✂]	Good	36
Priory	255 Lichfield Road	LTMH/PD	n/a	Female	4	[✂]	[✂]	Site 2013	[✂]	[✂]	Good	36
St Andrews	Northampton	LTMH	n/a	female	15	[✂]	[✂]	Sep-08	[✂]	[✂]	N/A	37
Priory	Annesley House	LTMH/PD	n/a	Female	11	[✂]	[✂]	Site 1999	[✂]	[✂]	Good	56
Priory	Annesley House	LTMH/PD	n/a	Female	8	[✂]	[✂]	Site 1999	[✂]	[✂]	Good	56
Turning Point	Nottingham Transition Unit	LTMH	Locked	Mixed	12	[✂]	[✂]	n/a	[✂]	[✂]	Not registered	57
Barchester	Forest Hospital	LTMH	n/a	Female	15	[✂]	[✂]	Mar-13	[✂]	[✂]	Requires improvement	62
Priory	The Willows	LTMH/PD	n/a	Female	6	[✂]	[✂]	Site 2002	[✂]	[✂]	Good	63
Richmond Fellowship	2Care The Knowl	LTMH	n/a	Mixed	15	[✂]	[✂]	n/a	[✂]	[✂]	not inspected	64

Source: CMA analysis.

Appendix F: Countervailing factors

Introduction

1. In Section 12 of the provisional findings, we have summarised the key themes from the evidence gathered from the Parties and third parties regarding barriers to entry and expansion and buyer power in the provision of mental health, and in particular, rehabilitation services. This appendix provides further details of this evidence.

Barriers to entry and expansion

Registration and licensing

2. Cygnet mentioned that regulatory and contractual standards represented a barrier to entry in the provision of mental health services. A Cambian presentation highlighted the 'rigorous regulatory environment' as a significant barrier to entry in the supply of rehabilitation services.

3. According to Elysium,[1] the CQC's regulatory requirements for registering LD beds were a barrier to entry and expansion. However, it also told us that there were limited regulatory requirements to reconfigure a ward in respect of gender, and only a change to the 'Statement of Purpose' was required.

4. PiC/Priory[2] stated that reconfiguration may require new registration from the CQC, depending on what the ward had changed from, but this could be granted relatively quickly. It stated that if an application complied with the CQC's requirements, the registration process typically took between 10 and 12 weeks.

5. Alternative Futures Group's[3] view was that there were limited barriers to reconfiguring a bed or ward to serve another mental health condition, but the regulatory costs were prohibitively high, and compliance inspection and requirements could be arbitrary and inconsistent.

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[1] Elysium Healthcare was 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 they were sold by Acadia Healthcare.
[2] Partnership in Care (PiC) is an independent provider of specialist, secure and step-down care across the UK. Priory is an independent provider of behavioural care in the UK. It is organised into three divisions – healthcare, education and children's services, and adult care services. On 1 December 2016, PiC and Priory merged.
[3] Alternative Futures Group is a health and social care charity, which delivers support to people with a diverse range of care needs, including: learning disabilities, physical disabilities, mental health concerns, substance misuse issues, complex care, autism and young people in transition.

6. St Andrew's[4] told us that in the past, it had reconfigured low secure sites to locked rehabilitation[5] as its low secure sites did not meet the new specifications set at the time by NHSE. St Andrew's noted that every few years there was a new regulatory specification released, which resulted in St Andrew's having to consider how to optimise its sites.

Availability of clinical expertise and skilled staff

7. Inmind[6] told us that smaller competitors might face difficulties to recruit staff because of the stability offered by local larger organisations. It also mentioned a national shortage of nurses as a significant barrier to entry in the market. Inmind mentioned that competitors already present in a geographical area or region had the advantage in respect of the ability to utilise skilled staff in their facilities to support the opening of a new facility.

8. According to Elysium, recruiting sufficient qualified staff constituted a barrier to entry and expansion, and that many doctors preferred to be part of a network within a larger organisation, where they can share and exchange clinical knowledge with peers.

9. St Andrew's stated that 'within the spectrum of specialism from ASD, LD, ABI, and CAMHS to the more generic adult mental health services, key to any change of service was the availability of "a credible clinician".' Further, it stated that there might be a shortage of specialist staff, notably qualified nurses, to comply with service specifications (eg in LD).

Financial investment to enter, expand or reconfigure

Establishing a new mental health facility

10. According to Cygnet, the initial high level of investment required to establish a mental health hospital constituted a barrier to entry. It stated that the:

    (a) [✂];

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[4] St Andrew's is a charity providing specialist mental healthcare services, ie men's mental health, women's mental health, child and adolescent mental health services (CAMHS), neuropsychiatry, autistic spectrum disorder and learning Disability.
[5] Certain providers differentiate between 'locked rehabilitation' services and unlocked rehabilitation services. 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. CQC (August 2016), Brief guide: inpatient mental health rehabilitation services – discharge.
[6] Inmind Healthcare Group is a nationwide provider of care for males and females over the age of eighteen who have complex mental health, personality disorder and physical health needs.

(b) [✂]; and

(c) [✂].

11. Elysium stated that the cost of creating an appropriate physical environment to provide rehabilitation services constituted a barrier to entry. [✂]

12. PiC/Priory told us that while as with any business there were initial investment costs to set up a rehabilitation hospital service, it did not consider these to be prohibitive. It also pointed out that there are no specific environmental requirements, although CQC standards need to be complied with.

13. PiC/Priory stated that the costs of setting up a rehabilitation service varied depending on the situation. It noted differences between new site development, re-provisioning or extensions of existing sites and variations such as service specification and geographical location.

14. Inmind told us that the ability to expand capacity was generally driven by the number and size of providers already present in an area.

Reconfiguring a mental health facility

15. According to Inmind, the barriers to reconfiguring a hospital ward or bed included:

(a) financial restrictions including start-up costs;

(b) additional staffing including employment of specialised clinicians, nursing staff, training to meet the requirements of the new service;

(c) registration of new service with different regulatory bodies, and

(d) loss of income whilst the transfer of services took place.

16. In Elysium's experience, it was relatively straightforward from a physical environment perspective to reconfigure a ward in respect of gender, and it usually involved minimal training, recruitment, capital costs or loss of revenue. It stated that closure time varied depending on the occupancy levels of the ward at the time of making the decision. Further, if a ward had previously treated patients and then closed, to reopen it for a different gender would be very straightforward.

17. According to Elysium, the difficulty of reconfiguration depended on the treatment converted from and to. For example, environmental work was usually required for changing a mental health ward to an ABI ward, as ABI wards typically needed more space and different equipment. On the other

hand, to change an LD ward to a LTMH ward normally required fewer environmental changes.

18. According to PiC/Priory, if, for example, a provider wished to reconfigure a LTMH service to a specialist ABI service, there would be cost of equipment such as hoists, accessible bathrooms and wheelchair access. There might also be costs involved in recruiting staff with specialist skill sets. Similarly, if a provider wished to reconfigure a ward to a high acuity PD ward, then it was likely to require anti-ligature[7] works, and works to improve lines of sight on the ward.

19. PiC/Priory also told us that existing providers of medium or low secure services could reconfigure a ward to provide rehabilitation services relatively easily if there was adequate demand. It stated that environmental standards were more stringent for secure services than for rehabilitation services.

20. According to St Andrew's, it was straightforward to reconfigure wards between genders and between some treatments. It stated that where conversions involved changing the physical environment, this was a more extensive process. It stated that reconfiguring a ward between secure and locked was also possible, but St Andrew's would only do this if the ward could not be filled with secure patients. [8]

21. St Andrew's told us that depending on the level of staff recruitment and training required, reconfiguration to another treatment type could take two to six months. It stated that reconfiguration between genders in respect of changing a ward's physical environment generally took less than one month although the whole conversion process could take longer depending on the availability of staff with relevant expertise and experience.

Economies of scale and scope

22. Elysium told us that larger providers 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.

23. Inmind stated that smaller operators were at a disadvantage compared with larger international companies, which could subsidise where services had a

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[7] A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures. 'Anti-ligature' fittings cause a ligature to fall off or which collapse when a certain weight is applied. CQC (May 2015), Ligature Points. Brief guide for inspection teams.

[8] For example, ASD patients require a different physical environment to LTMH patients which needs to be larger and more spacious. For elderly patients, there might be additional physical requirements.

fall in occupancy or invest to maintain quality standards. Inmind's view was that smaller organisations were at a disadvantage when trying to enter or maintain their position in the market.

24. PiC/Priory told us that larger providers of rehabilitation services had the advantage of having more clinicians, who could be deployed to various sites. However, its view was that although larger providers might have access to more clinicians, this did not necessarily mean that smaller providers providing good, local services were at a disadvantage.

Reputation

25. Inmind told us that being an existing provider in a certain area was an advantage due to:

    (a) established links with the local community; and

    (b) a trusted and embedded relationship with stakeholders and commissioners.

26. Alternative Futures Group made the same point that being already present in a geographical area or region was beneficial for a provider because of the relationship with the Commissioners and practitioners, and knowledge of the market.

27. Elysium felt that when a provider already had a new hospital in an area, it could make the process of gaining referrals easier than breaking into a completely new area.

28. According to PiC/Priory, incumbency might be an advantage but it depended on the circumstances in each case.

29. However, PiC/Priory stated that it was not a 'requirement' for the providers necessarily to have a track record in providing rehabilitation services. It told us that there was not a very high threshold to enter this market, and the main challenge was finding the right clinical team. Overall, PiC/Priory's view was that reconfiguring to or setting up rehabilitation services was relatively straightforward.

Buyer power

30. In the Parties' experience, many CCGs are unwilling to agree to a price increase that is higher than the national inflator/deflator. For example, [✂].[9]

31. The Parties consider that Commissioners usually have a range of credible alternatives. In Cygnet's experience Commissioners often use this option to negotiate better prices, for example:[10]

    (a) [✂]; and

    (b) [✂].

32. The Parties provided a number of recent examples of NHS providers opening or reconfiguring rehabilitation facilities to react to regional demand. These include the following:[11]

    (a) In 2012 Leeds and York Partnership NHS Foundation Trust converted an 18-bed acute/older adults ward at the Newsam Centre, Seacroft Hospital into a new male locked LTMH ward to meet regional demand.

    (b) In 2012 Lincolnshire Partnership NHS Foundation Trust opened a new site (Discovery House), a 45-bed male and female locked LTMH service to meet regional demand. Although some of the beds at this site replaced existing beds, a number of additional beds were added.

    (c) In 2016 Greater Manchester West NHS Foundation Trust redeveloped Charles House, which was a 24-bed secure unit, into a 28-bed male locked LTMH service called Braeburn House. This was used to move patients out of the independent sector and patients were transferred out of Cygnet Brighouse and CAS Fountains.

    (d) In 2016 Avon and Wiltshire Mental Health Partnership NHS Trust opened a ten-bed mixed LTMH service (Larch Ward) at Callington Road Hospital, Bristol in order to meet regional demand.

33. The Parties submit that the East Midlands Framework contract (the largest framework in England and relevant to some of the overlap areas we are investigating) accounts for:[12]

    (a) [✂]% of the patients at Cygnet Derby;

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[9] Parties' response to the issues statement, paragraph 2.38
[10] Parties' response to the issues statement, paragraph 2.43
[11] Parties response to the Phase 1 Decision, paragraph 2.27
[12] Parties' response to the issues statement, paragraph 2.40

(b) [✂]% of the patients at CAS Storthfield House;

(c) [✂]% of the patients at CAS Sherwood House; and

(d) [✂]% of the patients at CAS The Limes.

34. The Parties provide an example of [✂] effectively using the national inflator as a benchmark to prevent Cygnet from raising prices. As noted above, for this example, the Parties also submit that [✂].

35. Customer concentration across the Parties' sites varies. For example:

(a) [✂];

(b) [✂];

(c) [✂]; and

(d) [✂].[13]

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[13] [✂]

Glossary

the 1983 Act	Mental Health Act 1983. A law (as amended by the Mental Health Act 2007) that applies to England and Wales and allows for the compulsory detention of people in hospital (**sectioned**) for assessment and treatment of a mental illness.
ABI	Acquired brain injuries. An injury caused to the brain after birth. There are many possible causes, including a fall, a road accident, infection, tumour and stroke.
Acute	An acute illness is one that develops suddenly. Acute conditions may or may not be severe and they usually last for a short amount of time. Acute services are provided to patients in mental health crisis who require short-term admissions of around three to six weeks.
Acute wards	These wards provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness. In order to provide evidence-based care a full range of disciplines, including pharmacists, psychologists, occupational therapists and housing and social care colleagues, need to be commissioned.
AQP	Any Qualified Provider. The model of procurement whereby patients are able to choose from a list of qualified **provider**s who meet **NHS** service quality requirements, prices and normal contractual obligations.
ASD	Autism spectrum disorder. The name for a range of similar conditions, including Asperger syndrome, that affect a person's social interaction, communication, interests and behaviour.
Block contract	A contract between a **Commissioner** and a **provider** that pays a fixed sum to purchase specified healthcare services for a given period.
CAMHS	Child and Adolescent Mental Health Services. CAMHS provide individual and family work helping children and young people under the age of 18 who experience emotional difficulties or mental health problems.

Care pathway	The route a patient follows through health services. The path continues through diagnosis, treatment, and care.
Catchment area	The area within a **CCG** boundary shown on the **CCG** maps maintained by **NHSE**.
CCG	Clinical Commissioning Groups, created by the **HSCA 2012**, and replaced primary care trusts on 1 April 2013. They are clinically led statutory **NHS** bodies responsible for the planning and commissioning of healthcare services for their local area. There are currently 207 CCGs in England.
Chronic condition	A condition that develops slowly and/or lasts a long time.
Commissioning	The process by which a **Commissioner** decides which services to purchase and which **provider** to purchase them from.
Community care	Care and support provided outside of a hospital setting.
CQC	Care Quality Commission, the independent regulator of all health and social care services in England.
CQUIN	Commissioning for Quality and Innovation, the scheme system 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.
Customers	The organisations that make arrangements for the provision and purchase **NHS** healthcare services for patients. These include **NHSE** (and its teams), **CCG**s (including where they act through commissioning support units), and local authorities exercising **NHS commissioning** functions under partnership arrangements.
DBT	Dialectical behavioural therapy, a type of talking therapy mainly used to treat problems associated with borderline personality disorder, but it has also been used more recently to treat a number of other different types of mental health problems.
Department of Health	The Department of Health is a ministerial department that leads, shapes and funds health and care in England.

the Framework	The East Midlands Rehabilitation Framework. The framework agreement negotiated between **CCG**s in the East Midlands and **providers** of **rehabilitation** services and administered by the Hardwick CCG.
Five Year Forward View for Mental Health	Five-year national strategy for mental health in England to 2020 produced by the **Taskforce**. Published on 15 February 2016, it outlines a strategic approach to improve mental health outcomes in partnership with the six arm's length bodies (which include **NHSE**, Public Health England, the **CQC**, Health Education England, **NHSI** and the National Institute for Health and Care Excellence (NICE)). It was followed in July 2016 by the Implementation Plan and in February 2017 with an update on progress, Five Year Forward View for Mental Health: One Year On.
Forensic services	Services that provide support to offenders with mental health problems.
Foundation trust	A trust that has been authorised as an NHS foundation trust by **NHSI**. Foundation trusts have more operational autonomy than **NHS trust**s.
Framework contract or framework	A contract under a framework agreement, ie an agreement between one or more contracting parties, the purpose of which is to establish the terms governing contracts to be awarded during a given period.
Functional mental health problems	A term for any mental illness in which there is no evidence of organic mental illness (as there is with dementia) even though physical performance is impaired.
HIW	Healthcare Inspectorate Wales. The independent healthcare regulator in Wales.
HSCA 2008	The Health and Social Care Act 2008, among others, 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 providers**.
HSCA 2012	The Health and Social Care Act 2012, which made wide-ranging changes, including creating Monitor as an economic

regulator of all public and independent healthcare operators and **CCGs**, which replaced primary care trusts.

In-area — Refers to services provided within a **CCG**'s **catchment area**.

Independent sector/ independent providers — Services where the patient is accommodated on a ward and receives treatment there from specialist health professionals. The term is used to differentiate with **NHS providers/ hospitals**.

Inpatient — A unit with hospital beds that provides 24-hour nursing care.

JCPMH — Joint Commissioning Panel for Mental Health. Launched in April 2011, it is comprised of leading organisations who are aiming to inform high-quality mental heal and **LD commissioning** in England.

LD — Learning disability, which affects the way a person understands information and how they communicate. This means they can have difficulty understanding new or complex information, learning new skills or coping independently.

LHBs — Local Health Boards, the responsible **commissioning** bodies in Wales.

Locked rehabilitation services — Services suitable for patients who need active **rehabilitation** and ongoing care and treatment, usually offered as a step down from secure services. Patients at a locked site are not allowed to leave without permission and their access is controlled. If a patient is **sectioned**, they will always be at a locked site and their status can be changed to **unlocked** only following clinical review.

Low secure mental health services — Intensive **rehabilitation** services for offenders who have mental health problems.

LTMH — Long-term mental health, also referred to as ‘severe and enduring’ mental health conditions or mental illness.

MDT — Multi-disciplinary team. A team made up of a range of both health and social care workers combining their skills to help people.

National Tariff	Encompasses a set of specified prices and a suite of pricing and payment rules and variations that apply in mental health services both nationally and locally.
National tariff annual deflator/inflator	The percentage of inflation cost uplift in health services. This is set by **NHSI**.
NHS	National Health Service.
NHSE	NHS England, an executive non-departmental public body. With the Secretary of State for Health, it shares the legal duty to promote a comprehensive health service in England in accordance with the NHS Act 2006 (as amended by the **HSCA 2012**). In 2016/17 it had a funding allocation from the Department of Health of £107 billion, which was used to commission healthcare services directly and via local **CCGs**. Together **CCG**s accounted for £76.5 billion of total commissioning expenditure
NHSI	NHS Improvement (formerly Monitor) is responsible for overseeing **foundation trusts** and **NHS trusts**, as well as **independent providers** that provide **NHS**-funded care. It brings together a number of organisations including Monitor.
NHS Standard Contract	The contract used to commission **NHS**-funded services from all types of **provider**s.
NHS Provider/NHS hospital	**NHS trusts** or **NHS foundation trusts** providing **rehabilitation** services
NHS Providers	**NHS Providers** is the membership organisation and trade association for the NHS **acute**, ambulance, community and mental health services that treat patients in the **NHS**.
NHS trust	Bodies established by order of the Secretary of State for Health to provide goods and services for the purposes of the health service. NHS trusts are legally directed by and financially accountable to **NHSI** on behalf of the Secretary of State for Health. They are different from **NHS foundation trusts.**

NICE	The National Institute for Health and Care Excellence. It provides national guidance and advice to improve health and social care.
Organic mental illness	Illness affecting memory and other functions that is often associated with old age. Dementia, including Alzheimer's Disease, is an organic mental illness.
Out-of-area placements	When a person with assessed **acute** mental health needs who requires adult mental health **acute** inpatient care, is admitted to a unit that does not form part of the usual local network of services.
Outpatient services	Services provided to someone who comes to a hospital for treatment, consultation, and advice but who does not require a stay in the hospital.
PCRs 2015	Public Procurement Regulations 2015.
PD	Personality disorder. A mental illness often characterised by rigid, structured, and repeated patterns of feeling, thinking and behaviour. The inflexible nature of these patterns can cause serious personal and social difficulties for the person and also those close to them.
PICU	Psychiatric intensive care unit. A locked ward in a hospital where some people detained under **the 1983 Act** may stay. They stay in the unit because they have been assessed as being at risk to themselves or others so cannot be safely or easily managed on an **acute** inpatient care ward. People normally stay in a PICU for a short time and will usually be transferred to an **acute ward** once the risk has reduced.
PPCCRs	The National Health Service (Procurement, Patient Choice and Competition) (No2) Regulations 2013.
Primary care	Health services that are the first point of contact for people with health concerns. Examples include GP surgeries, pharmacies, the local dentists, and opticians.
Provider	Generic term for those who provide services.
Psychosis	A mental state in which someone may show confused thinking, think that people are watching them, and see, feel, or hear things that other people cannot.

QP	Quality Premium. Intended to reward **CCG**s for improvements in the quality of the services that they commission.
Reconfiguring	Changing the treatment use or gender use of a ward.
Rehabilitation	A programme of therapy that aims to restore someone's independence and confidence and reduce disability.
Rehabilitation ward	Provides care and treatment for people whose complex needs are such that they require intensive and specialised **rehabilitation** over a longer period in hospital. They may also provide a 'step-down' for people moving on **acute wards** or secure services.
Secondary mental health services	Specialist mental health services usually provided by an **NHS trust**. Services include support and treatment in the community as well as in hospitals.
Sectioned	Someone detained in hospital under **the 1983 Act**. There are different types of sections, each with different rules. The length of time a patient can be detained in hospital depends on which section they are detained under.
Secure services	Secure mental health services are inpatient services for patients with mental health conditions who present a significant risk to others or themselves or are already in the criminal justice system. Patients in secure services are detained under **the 1983 Act**, and the **provider**s of secure mental healthcare services must meet certain security requirements, which vary depending on the security level. Secure services are divided in **low**, medium and high secure services according to the level of security required.
The Taskforce	Mental Health Taskforce. Formed in March 2015, the independent Taskforce brought together health and care leaders, people who use services and experts in the field to create a **Five Year Forward View for Mental Health** for **NHSE**.
Tier 3	Local specialist **PD** services.
Tier 4	Residential and **secure** specialist inpatient **PD** services.

Unlocked rehabilitation services	In contrast to **locked rehabilitation services** patients, unlocked **rehabilitation** services patients are free to enter or leave the site as they wish, without their access being controlled. The distinction with **locked rehabilitation services** however is not always clear-cut.