Cygnet Health Care and Cambian Adult Services

A report on the completed acquisition by Cygnet Health Care Limited and Universal Health Services, Inc. of the Cambian Adult Services Division of Cambian Group plc

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 Some numbers have been replaced by a range.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

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Summary

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

2. The CMA must decide:

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

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

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

4. On 23 August, we published our notice of provisional findings and notice of possible remedies. Cygnet, CAS and some third parties responded to these documents and their views have been taken into account in preparing this final report.

The Parties and their operations

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

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

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

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

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

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

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

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

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

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

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

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[1] Joint Commissioning Panel for Mental Health (JCPMH) (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health needs.
[2] Not a clinical term. It can be defined as a range of psychological and psychiatric conditions or disorders with symptoms that cause significant distress and/or dysfunction, including cognitive, emotional, behavioural and interpersonal impairments. Other terms which we understand are synonymous include 'severe mental health conditions' and 'enduring mental illness'. We use LTMH as the Parties use this term.

Market background

16. The past six years has seen increased public and government focus on mental health. In January 2017, the government accepted the recommendations in *The Five Year Forward View for Mental Health* which include an increase in mental health funding by £1 billion a year by 2021.

17. In 2015 the UK market for all mental health services was estimated to be worth £15.9 billion. Hospital services (including rehabilitation services) accounted for 27% of this. Despite declining NHS bed numbers – down 23% during 2010 to 2015 compared with the independent sector where bed capacity grew by 8% – the NHS still has most of the mental health hospital bed capacity. The NHS has around 24,000 beds whilst the independent sector has around 10,000 beds.

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

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

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

21. Unlike some other healthcare sectors, the patient who needs to be admitted to a hospital providing rehabilitation services is rarely in a position to decide where they would like to be treated. It is CCGs that fulfil the role of customers, making the decisions as to where patients should be referred. Throughout this

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[3] See paragraphs 31 and 2.62 below.
[4] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p61.

document we use ‘customers’ to refer collectively to CCGs, the NHS trusts and the few local authorities that commission rehabilitation services.

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

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

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

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

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

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

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

Market definition

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

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

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

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

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

34. Customers have a strong preference to keep patients at nearby hospitals. We defined the relevant geographic market based on an average catchment area of 60 miles. The actual geographic market may vary from area to area, largely dependent on the behaviour of the customers in that area. We found that 80% of male and female LTMH patients and around 60% of female PD patients come from within a 60-mile area. We tested whether catchments may be wider in our local assessments.

Counterfactual

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

Competitive effects in local overlap areas

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

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

38. In the course of the inquiry, we sent questionnaires to 163 customers and 41 competitors of the Parties, particularly focusing on overlap areas. We undertook two site visits, held 16 third party hearings and spoke to 26 customers to understand and reflect the specifics of supply and demand in the local overlap areas and their view of the Merger.

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

40. Where we found that an SLC may be expected, we investigated any countervailing factors.

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

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

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

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

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

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

46. In the East Midlands male LTMH overlap, the Parties operate facilities that are particularly close geographically, they are the two largest providers and would have a post-Merger market share of [50–60]% with a [10–20]% increment. Although there are alternative providers, the next largest would have only [10–20]% of the market, making the merged firm almost five times larger than

its next closest competitor. Although one large customer was not concerned about the Merger, several smaller customers thought that the Merger could lead to higher prices or reduced quality, including a loss of variation in treatment options for patients.

47. We did not find that the Parties are sufficiently constrained in this area by the East Midlands Rehabilitation Framework (the Framework), which provides a mechanism for 17 CCGs to aggregate customer volume to collectively negotiate better terms with a number of providers. The Merger would result in the Parties having a very high combined share of supply of beds in the local area, reflecting that there is limited alternative capacity available. In our view this limits the alternative options available to the customers using the Framework, given that they have substantial supply requirements for rehabilitation services in aggregate.

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

49. In the West Midlands female LTMH overlap the evidence was more varied. The Parties are close competitors geographically and the merged firm would be the largest provider in the local area with a combined market share of [40–50]%. As a relatively new facility, Cygnet Coventry would have an incentive to compete for patients against CAS and the other providers in the area. This competitive constraint between the Parties will be removed by the Merger.

50. Given this we looked at possible future capacity. Inclusion of Camino Healthcare's planned facility in Nuneaton would reduce these market shares to [40–50]%. In addition, we found that the flexing of bed allocations by providers with mixed gender or combined specialism wards could further reduce market shares. While we did not consider that all of this flexing would necessarily occur in practice, in our view it could reduce the Parties' market shares to below 40%. Post-Merger, two large independent providers will remain, with market shares of [10–20]% and [10–20]%.

51. Evidence from customers was mixed. The largest customer representing [50–60]% of referrals said that although it did not know what impact the Merger would have on prices or service, it was not concerned about it as it believed it had bargaining power. One small customer said it was concerned that the Merger may increase prices or reduce quality.

52. In reaching our decision on the West Midlands overlap, our evaluation of the evidence on the constraints and incentives that will apply to the Parties post-Merger was finely balanced. Taking account of all the evidence in the round,

two of the four members of the Group concluded that the Merger was unlikely to result in the Parties increasing prices or reducing quality. The other two members took a different view, concluding that with a high post-Merger market share and increment, the Parties would not be sufficiently constrained by other actual and potential competitors.

53. A two-thirds majority is required for a CMA panel to find an SLC.[5] Therefore, we concluded that the Merger would not be expected to result in an SLC in the provision of female LTMH rehabilitation services in the West Midlands.

54. In light of our assessment, we conclude that the Merger may be expected to result in an SLC in one of the eight overlap areas, namely the provision of male LTMH rehabilitation services in the East Midlands.

Potential competition

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

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

National competitive effects

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

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

[5] Enterprise and Regulatory Reform Act 2013, Schedule 4, paragraphs 55 and 56.

59. The evidence in this investigation and the complementarity of much of the Parties' businesses supports the absence of an SLC at a national level at this time. However, the CMA notes that this is the second major transaction in the market over the past 12 months. During our investigation, we have seen further acquisitions. As consolidation continues, the national and local dynamics and the relative importance of different competitive parameters are evolving: the CMA will be mindful of this in future cases.

Conclusion

60. We conclude that the Merger may be expected to result in an SLC within the market for the provision of male LTMH rehabilitation services in the East Midlands. The SLC may be expected to result in adverse effects in terms of prices being higher than they would otherwise be and quality being lower than it would otherwise be.

Remedies

61. We considered what action should be taken to remedy, mitigate or prevent the SLC or any adverse effects which may be expected to result from the SLC. In our notice on possible remedies, we invited views on the structural remedy of requiring divestiture of the Parties' operations in the areas where we provisionally found an SLC. We also asked for views on behavioural remedies.

62. We concluded that a structural remedy in the form of a divestiture of one of the Parties' four sites: The Limes, Sherwood House, Storthfield House or Derby would be the only effective remedy. We have decided to require one of these to be divested to a suitable purchaser. In our judgement, this represents as comprehensive a solution as is reasonable and practicable to the SLC and the adverse effects which may be expected to result from it.

Findings

1. The reference

1.1 On 3 May 2017, the CMA in exercise of its duty under section 22(1) of the Enterprise Act 2002 (the Act) referred the completed acquisition by UHS via its subsidiary Cygnet, of CAS for a phase 2 investigation by the Inquiry Group (the Group).[6]

1.2 In exercise of its duty under section 35(1) of the Act, the CMA must decide:

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

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

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

1.4 This document, together with its appendices, constitutes our findings. Further information, including non-commercially-sensitive versions of the Parties' submissions and summaries of evidence from third parties can be found on our website.[7]

2. Background

2.1 This section provides an overview of mental health services in the UK. First we outline the legal and regulatory environment and the policy context, we then go on to explain how services are commissioned, the main providers and how patients move through the system. We focus on inpatient[8] rehabilitation services provided by independent[9] hospitals in England.

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

Legal and regulatory environment[10]

2.2 The legal and regulatory environment governing mental health services is complex. Legislation and regulations affect patient rights, the service obligations of providers, how and where services are provided and the procurement and commissioning of services. In addition, there are various regulatory bodies which set standards, regulate payment and monitor delivery and quality of services.

2.3 The primary legislation which impacts the provision of mental health services is:[11]

(a) The Mental Health Act 1983 (the 1983 Act) as amended includes provisions relating to the criteria for detention.

(b) The Health and Social Care Act 2008 (HSCA 2008) created the CQC as the new independent quality regulator of health and adult social care in England, and a unified legal framework for the regulation of both NHS and independent sector providers in England.[12]

(c) The Health and Social Care Act 2012 (HSCA 2012) made wide-ranging changes, including creating Monitor (now part of NHS Improvement)[13] as an economic regulator of all public and independent healthcare operators which provide care for NHS patients in England, and CCGs, which replaced primary care trusts on 1 April 2013.[14]

Categorisation of secure mental health services

2.4 The Department of Health has three levels of secure care: high, medium and low, with guidance governing provision at each level.[15] For each level a range of physical, relational and procedural measures are put in place to

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[10] In this section, we focus primarily on England but we have included references to Wales to highlight any key differences. We have not examined the mental health regimes in Scotland and Northern Ireland as the Parties' operations did not cover these areas. Appendix B sets out the legal regulatory environment in more detail.
[11] LaingBuisson, Mental Health Hospitals & Community Mental Health Services. UK Market Report, second edition, p117.
[12] Other countries of the UK have their own health and social care regulators under devolved powers. The legislative framework for regulating the safety and quality of independent sector providers, however, has many similarities with England's under the HSCA 2008. LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p121.
[13] 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.
[14] CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area (see also below paragraphs 2.36-2.39 and Appendix B).
[15] Department of Health, Secure mental health services.

ensure the provision of a safe and secure environment for the delivery of treatment.[16]

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

Table 1: Key differences of security levels

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

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

2.6 PD services use a tiered approach, which allows patients to be appropriately directed according to their needs, the complexity of their PD and their capacity to engage with services:

(a) Tier 1 refers to primary care.

(b) Tier 2 refers to generic mental healthcare, normally in a community mental health treatment.[17]

[16] See NHS, Your guide to relational security

[17] 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[18] specialist PD services which included non-hospital residential provision,[19] intensive day treatment, ie 'partial hospitalisation,' and access to acute inpatient care.

(d) Tier 4 mainly refers to residential low and medium secure specialist inpatient PD services.[20] These are for those patients whose safe treatment requires a higher level of containment than can be provided by hospital residential programmes, either through higher intensity and frequency of therapeutic input, or through a specialist residential therapeutic environment.[21]

(e) Tier 5 and 6 services are medium and high secure forensic[22] services.

Regulatory bodies[23]

2.7 The main bodies regulating rehabilitation providers are the CQC, NHS Improvement (NHSI) and Healthcare Inspectorate Wales (HIW).[24]

2.8 The CQC is the independent regulator of health and adult social care in England. Its statutory functions are:[25]

(a) registration;

(b) review and investigation; and

(c) specified functions under the 1983 Act.[26]

2.9 The CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. It rates all the services from 'Outstanding' to 'Inadequate'.[27]

2.10 The CQC has extensive civil and some criminal enforcement powers. It has the civil power to impose conditions and to suspend or cancel a registration. Its civil enforcement powers range from issuing Requirement and Warning

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[18] Local services cover narrow geographic areas or a small specified set of the population.
[19] Locations which offer intensive, short-term support to manage and resolve a crisis in a residential setting.
[20] 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.
[21] 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.
[22] Forensic services are services related to offenders.
[23] Further detail on the regulatory bodies are in Appendix B.
[24] Our report does not cover Scotland or Northern Ireland as the Parties do not have facilities there.
[25] Section 2 of the HSCA 2008.
[26] For instance, through monitoring how providers are caring for patients, and whether patients' rights are being protected.
[27] CQC: Ratings.

Notices, to imposing special measures on providers that require a higher than usual level of regulatory supervision.[28] Failure to comply with the steps required when it uses its civil powers is a criminal offence.

2.11 NHSI brought together six organisations (including Monitor) from 1 April 2016 to provide an oversight and improvement structure for foundation and NHS trusts and independent providers of NHS-funded care. The main duty of NHSI is to protect and promote the interests of people who use healthcare services by:

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

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

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

2.12 NHSI's main functions are:

(a) licensing health services providers; and

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

2.13 The HIW is the independent inspectorate and regulator of healthcare in Wales.[30] Its main functions are:

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

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

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

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[28] Services rated as 'Inadequate' overall will be placed straight into special measures and be re-inspected within a year. If, following re-inspection, sufficient progress has not been made, further action will be taken to prevent the service from operating, either by proposing to cancel their registration or varying the terms of their registration. There will then be a further inspection. Special measures do not replace the CQC's existing enforcement powers, ie the CQC will take enforcement action at the same time as placing a service into special measures. If services are rated as 'Requires Improvement', the CQC would generally try to re-inspect within two years.
[29] Section 62 of the HSCA 2012.
[30] Under the Care Standards Act 2000, and Health and Social Care (Community Health and Standards) Act 2003 legislation. See HIW website.

2.14 The HIW does not give providers ratings, but publishes reports on the findings of their inspections and investigations.

Providers' obligations

Registration

2.15 Providers of rehabilitation services regulated by the CQC must be registered and failure to do so is an offence.[31] The registration entails an application to the CQC, with the details about the provider, the regulated activities applied for, and the places at which, or from which, services will be provided.

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

2.17 The CQC has an objective in its Business Plan[32] to speed up the registration process (with the aim of it being able to be completed in ten weeks) and move to an online registration process.

2.18 The CQC's current approach is to register the body that directly runs local services, although these can be subsidiaries of larger corporate groups. The CQC is planning to reconsider this approach.[33]

Licensing

2.19 NHSI licenses and monitors all providers of NHS services (including providers of rehabilitation services) to ensure standards are maintained.

The licence

2.20 The criteria for a new provider to be granted a licence are:[34]

(a) registration with the CQC; and

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[31] 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.
[32] See the CQC Business plan 2017-18.
[33] See CQC, Shaping the Future – CQC's Strategy for 2016 to 2021.
[34] Pursuant to section 86 of the HSCA 2012 and the National Health Service (Approval of Licensing Criteria) Order 2013/2960.

(b) the directors or governors must meet NHSI's fit and proper test.[35]

2.21 In addition, there are several conditions which all licensees must fulfil:[36]

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

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

(c) Pricing conditions, which require the provider to comply with the NHS pricing rules (the National Tariff)[37] and provide pricing information to NHSI.

2.22 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.[38]

2.23 Because registration and licensing are pre-requisites to the provision of rehabilitation services we have assessed them further as potential barriers to entry/expansion (see Section 12).

Commissioning of mental health rehabilitation services

2.24 There are two main commissioning bodies in England: CCGs and NHSE. In Wales, rehabilitation services are commissioned by seven LHBs.[39]

NHSE

2.25 NHSE commissions some mental health services directly (such as adult secure services and Tier 4 PD services), and regulates the commissioning activities of CCGs.

2.26 NHSE's other functions include providing funding, guidance and assistance to CCGs and conducting an annual performance assessment of each CCG.

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[35] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) requires that 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.
[36] These are discussed in detail in Appendix B.
[37] See also below paragraph 2.64.
[38] Section 97(1)(a) of the HSCA 2012.
[39] See Appendix B for more detail.

NHSE has the power to make quality payments to CCGs reflecting their performance.

CCGs

2.27 The HSCA 2012 established CCGs which are statutory corporate bodies, created via a successful application to NHSE.

2.28 CCGs commission the majority of health services in their local areas including mental health care services. There are 211 CCGs in England which are responsible for £73.6 billion (being around two-thirds of the total current NHSE budget).[40]

2.29 In addition to the central programme budget, NHSE holds separate funds of £1.1 billion for both 2017/18 and 2018/19 allocated to support the implementation of the *Five Year Forward View*[41] focusing on priorities such as mental health services.[42] Around 25% of the total mental health budget is absorbed by rehabilitation services.[43]

2.30 CCGs and some local authorities[44] are responsible for the commissioning of rehabilitation services in England.[45]

Rules and practice related to contracting

2.31 Rehabilitation services are purchased using various agreements and contract types:

(a) The NHS Standard Contract,[46] which is the contractual form that must be used by customers when commissioning rehabilitation services (see also paragraph 8.9 below).

(b) Contracts under framework agreements, which should take the form of the NHS Standard Contract. A framework agreement is a procurement method that operates in a similar way to an approved provider list. Once the framework agreement is agreed it usually operates as a closed

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[40] As of August 2017, as reported in NHS Clinical Commissioners website.
[41] See below paragraphs 2.56 - 2.57, NHS Five Year Forward View.
[42] See NHSE (March 2017), NHS England Funding and Resource 2017-19: supporting 'Next Steps for the NHS Five Year Forward View'.
[43] See Joint Commissioning Panel for Mental Health (October 2016), Guidance for commissioners of rehabilitation services for people with complex mental health needs. The total budget allocated to all mental health services has not been reported.
[44] Local authorities take the lead for improving health and coordinating local efforts to protect the public's health and wellbeing.
[45] In Wales, rehabilitation services are commissioned by seven LHBs. See also Appendix B.
[46] NHSE is responsible for drafting standard terms and conditions which cannot be amended. Some of the quality and performance requirements are set nationally and others may be agreed locally.

system not allowing new providers. When a customer wants to procure services, they will approach suppliers listed on the agreement. They will either go directly to one provider or hold a mini-competition to determine the most suitable provider. See Appendix B for more detail.

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

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

Pricing regulation

National Tariff

2.32 NHSE and NHSI have a shared responsibility to set the prices and payment rules for customers and providers to use for certain health services. NHSE specifies the healthcare services for which a national price should be used, and NHSI sets the price which is known as the National Tariff.[47]

2.33 There is no National Tariff for rehabilitation services. Prices are negotiated and agreed locally but providers must comply with some rules specified in the 'National Tariff Price 2017/2018'.[48] When agreeing prices for services without a national price, customers and providers must:

(a) have regard to the efficiency and cost uplift factors;[49]

(b) take an approach which is in the best interests of patients;

(c) promote transparency;

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

[47] According to section 15 of the HCSA 2012, NHSI is responsible for designing the proposals for the methods for setting prices in the National Tariff, and the rules on setting local prices where there isn't a national price.
[48] See 2017/2018 and 2018/2019 National Tariff Payment System, published by NHSI and NHSE.
[49] 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%. In effect these factors should be used as a benchmark to inform local negotiations. The National Tariff inflator/deflator set by NHSI acts also as a benchmark that CCGs use in negotiating prices, see paragraph 12.64.

(e) engage constructively with each other when trying to agree local payment approaches.

Reference costs

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

2.35 NHSI is now accountable for the reference costs collection. NHSI's strategy for costing and cost collection to inform price setting is set out in its *Approved Costing Guidance*.[50]

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

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

Payments/reimbursement models in mental health services

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

Block contracts

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

2.40 The value of the contract can be set in various ways usually through a measure of patient need or simply based on the historical expenditure on a particular service.[51]

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

[50] NHSI, (2016) Approved Costing Guidance.
[51] British Medical Association, Models for paying providers – Block contracts (December 2015).

National Tariff. However, they continue to be used in mental health services, and are widely used in community care.

2.42 Overall, it has been found that block contracts are used to reimburse the majority of community services, and two-thirds of mental healthcare.[52]

2.43 More specifically, in the period 2015/16, around 58% of NHS trusts were expecting to have a block contract in place for mental health services.[53]

2.44 A more recent survey in October 2015, which surveyed 36 NHS mental health providers found that 89% of the respondents had block contracts in place although they expected that this percentage would fall in 2016/17.[54]

Payment system reforms

2.45 In a move towards delivery of *The Five Year Forward View for Mental Health*,[55] NHSE and NHSI are supporting providers and customers of mental health services to implement more transparent payment approaches.

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

2.47 In 2016 NHSI published detailed guidance documents which set out the different approaches to payment for adult and older people mental health services that providers and customers are required to adopt.[56]

Quality Incentive schemes/payments for performance

2.48 As a result of the emphasis on quality in mental health services, new types of payments have emerged in rehabilitation services.

2.49 These take the form of quality incentive schemes or payments that reward or penalise providers for aspects of their performance, most notably the Quality Premium scheme and the Commissioning for Quality and Innovation scheme (see also Appendix B for more detail).

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[52] See Nuffield Trust (2014), The NHS payment system: evolving policy and emerging evidence.
[53] See NHS Providers (April 2015), Funding for mental health services: Moving towards parity of esteem?
[54] 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.
[55] The Five Year Forward View for Mental Health. A report from the independent Mental Health Task Force (February 2016), Annex A.
[56] See New payment approaches for mental health services and Appendix B for more details.

Conclusion on legal and regulatory environment

2.50 Rehabilitation services are characterised by a complex legal and regulatory framework, with a variety of laws, rules and regulations governing all aspects of services both at the provider and customer level. There is a clear focus on quality monitoring and quality improvement. Providers of rehabilitation services are subject to a significant degree of regulation, especially through the licensing and registration process and the monitoring of quality and service standards.

2.51 Providers of rehabilitation services are also subject to a degree of pricing constraint in the form of NHS pricing benchmarks as well as increasing intervention regarding the content and the payment terms of their contracts with their customers.

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

Policy context

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

2.54 In 2011, the government published a mental health strategy document, *No health without mental health* setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma.[57]

2.55 In 2013, NHSE placed a moratorium on the commissioning of new capacity for certain centrally-commissioned specialised services including secure mental health services[58] (the moratorium). It remains in place.

2.56 The *Five Year Forward View* was developed by NHSE, the CQC, Public Health England[59] and NHSI and was published in October 2014. It is the key

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[57] Department of Health, (2011), No health without mental health. A cross-government mental health outcomes strategy for people of all ages.
[58] See Appendix C for a description of the main categories of mental health services.
[59] Public Health England was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service. It is an executive agency of the Department of Health, and a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

current policy document and provides a platform for many of the changes occurring across all levels in the NHS in England. In relation to mental health, the *Five Year Forward View* set out an ambition for the NHS to drive towards an equal response to mental and physical health, and towards the two being treated together to achieve genuine 'parity of esteem' between physical and mental health by 2020.[60]

2.57 In March 2015, NHSE launched an independent taskforce (the Taskforce) to develop a five-year strategy to improve mental health outcomes across the NHS.[61] The Taskforce's final report, *The Five Year Forward View for Mental Health* published in February 2016, highlighted that over the previous five years, public attitudes towards mental health had improved, and stressed the need to re-energise and improve mental healthcare across the NHS to meet increased demand and improve outcomes.[62] In July 2016, NHSE published an implementation plan detailing how it will deliver the recommendations made by the Taskforce working with its partner arms-length bodies.[63]

2.58 A LaingBuisson report published in February 2016 noted that:

> The fairly positive prospects for NHS health funding over the next five years mean that independent mental health operators will not face commissioners under extreme pressure to contain costs, but there will be no return to the benign NHS financial environment enjoyed prior to the global credit crisis. Continuing pressures of demand from population expansion and ageing, as well as advances in medical technology, mean that the NHS will continue to seek efficiency savings, to which independent sector mental health providers will be expected to respond…[64]

2.59 In January 2017, the government formally accepted the recommendations of the Taskforce, which envisaged an increase in mental health spending by £1 billion a year by 2020/21.[65,66,67]

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[60] NHS (October 2014), Five Year Forward View, p26.
[61] NHSE: Mental Health Taskforce.
[62] The Five Year Forward View for Mental Health. A report from the independent Mental Health Task Force (February 2016).
[63] NHS (July 2016), Implementing the Five Year Forward View for Mental Health.
[64] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p8.
[65] The Five Year Forward View for Mental Health. A report from the independent Mental Health Task Force (February 2016), p11.
[66] HM Government (9 January 2017). Mental Health: Written statement - HCWS397.
[67] Oral statement to Parliament by the Department of Health and Secretary of State for Health, Jeremy Hunt (9 January 2017): Mental health and NHS performance.

2.60 NHSE published *Next steps on the NHS Five Year Forward View* in March 2017, and announced that overall mental health funding in England was £1.4 billion higher (in real terms) compared with three years ago. It also set out key improvements planned for 2017/18 and 2018/19 to expand access to mental health services including the following:[68]

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

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

(c) Improved care for children and young people.

(d) Providing care closer to home.

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

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

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

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

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

2.61 In a recent report on the state of care in mental health services in England published in July 2017,[69] the CQC highlighted a number of significant pressures and challenges in providing specialist mental health services, including:

(a) high demand;

(b) shortage of mental health nurses;

(c) pressure on mental health acute wards;[70]

(d) out-of-area placements; and

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

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[68] NHS (March 2017), Next steps on the NHS Five Year Forward View, Chapter 5, pp26–27.
[69] CQC (July 2017), The state of care in mental health services 2014 to 2017, pp12–17.
[70] Acute wards provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness. Defining mental health services. Mental Health Network NHS Confederation (2012).

2.62 In its report, the CQC expressed concern about the high numbers of patients in locked rehabilitation[71,72,73] wards, which were often situated a long way from the patient's home. It stated:

> We think it possible that a significant number of patients in locked rehabilitation wards have the capacity to live in a setting of lower dependency and with fewer restrictions – provided there was suitable accommodation and intensive community support available in their local area to meet their needs.[74]

Conclusion on policy context

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

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

2.65 In February 2016, LaingBuisson noted that the moratorium will be lifted at some stage, triggering some expansion of independent sector capacity.[75] The moratorium is still in place and continues to affect services and how they are commissioned.

2.66 The CQC's recent report[76] may change the focus of the mental health policy agenda, encouraging a move away from locked rehabilitation services and out of area placements. In the meantime, the service portfolio of independent providers will continue to depend on a variety of factors,

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[71] According to the CQC, the purpose of locked mental health rehabilitation wards is poorly defined. Further, it pointed out that there was no central register to show how many beds of this type there were in England. CQC (July 2017), pp30–31.
[72] 2Gether Trust explained that stepped-down patients may need to go to locked rehabilitation facilities due to Ministry of Justice requirements. It explained that the terminology of 'locked' was a fluid description and a locked status did not always mean that there would be no access/exit. Further, it explained that low/medium secure facilities had mandated security requirements and were therefore more strictly defined.
[73] The Royal College of Psychiatrists does not recognise the term 'locked rehabilitation unit'. Many such units have a similar specification to a high-dependency rehabilitation unit but may have a higher level of staffing and greater physical security (similar to a PICU) and focus on people with especially challenging behaviours. Source: CQC (August 2016), Brief guide: inpatient mental health rehabilitation services – discharge.
[74] CQC (July 2017), The state of care in mental health services 2014 to 2017, p31.
[75] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p35.
[76] CQC (July 2017), The state of care in mental health services 2014 to 2017, pp12–17.

including the availability of suitable step-down[77] facilities in the community setting and the legal and regulatory environment outlined above.

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

Mental health services and the patient care pathway

2.68 The landscape of mental health service provision is complex. A range of services are provided both in hospital and community settings. While hospital-based treatment is provided both by the NHS and independent providers, community-based care is largely provided by the NHS and local authorities.

2.69 Mental health services can be categorised[78] based on various criteria, for example, the levels of security in which they are provided, the underlying health condition being treated, whether they are provided in acute care settings,[79] and the patient group treated (eg the elderly).

Rehabilitation services

2.70 The Parties treat a number of mental health conditions and overlap in the supply of rehabilitation services. The guidance for commissioners of rehabilitation services for people with complex mental health needs, published by the Joint Commissioning Panel for Mental Health (JCPMH)[80] defines mental health rehabilitation as:

> A whole systems approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support.[81]

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[77] See footnote to Paragraph 2.75 for a description of step-down services.
[78] Many of these are overlapping categories. In addition, different organisations and bodies use different terminology to describe categorisation of mental health services.
[79] 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.
[80] Launched in April 2011, the JCPMH is comprised of 'leading organisations who are 'aiming to inform high-quality mental health and learning disability commissioning in England.' JCPMH Briefing Guide.
[81] JCPMH (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health need. p6.

2.71 The mental health conditions treated by rehabilitation services include:[82]

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

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

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

(d) Acquired brain injuries (ABI), which include traumatic or non-traumatic injury or illness resulting in temporary or permanent impairment of brain function, with potential consequences for functional ability.[83]

(e) Long-term mental health (LTMH)[84] conditions, which can be defined as a range of psychological and psychiatric conditions or disorders with symptoms that cause significant distress and/or dysfunction, including cognitive, emotional, behavioural and interpersonal impairments.

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

2.73 Figure 1 illustrates a typical rehabilitation care pathway, showing the 'direction of travel' for patients with complex and longer-term mental health conditions, from inpatient services through to community living.[85,86]

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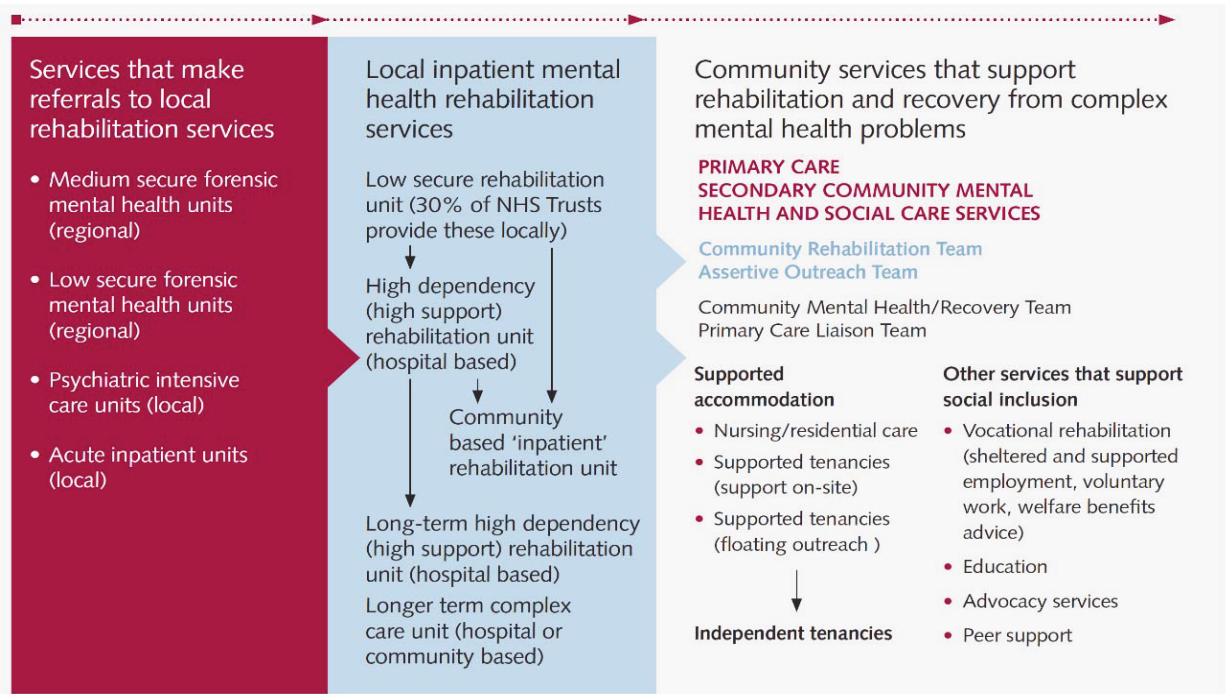
[82] Source: Merger Notice, pp17–18.
[83] A complete interruption of the supply of oxygen to the brain is referred to as cerebral anoxia. If there is still a partial supply of oxygen, but at a level which is inadequate to maintain normal brain function, this is known as cerebral hypoxia. Source: Headway.
[84] Long-term mental health is not a clinical term. Other synonymous terms are 'severe mental health conditions' and 'enduring mental illness'. We use LTMH as the Parties use this term.
[85] JCPMH (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health need.
[86] We note that patients can step up as well as down in the care pathway (see paragraph 7.8).

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



Source: JCPMH (November 2016), Guidance for commissioners of rehabilitation services for people with complex mental health needs, p8.

Customers

2.74 As outlined above, since April 2013, the commissioning of mental health services has been split (in England) between NHSE, which is responsible for a schedule of 'prescribed'[87] specialist services, commissioned centrally, and other mental health services (including rehabilitation services), commissioned locally by CCGs,[88] and by LHBs in Wales.[89]

2.75 The range of mental health services commissioned locally by customers in England covers acute psychiatry, adult eating disorders, addiction problems,

[87] The list of prescribed services commissioned by NHSE is provided in the Manual for Prescribed Specialised Services 2016/17.
[88] As we note in paragraph 2.30, some local authorities are also responsible for the commissioning of rehabilitation services in England.
[89] In England, for both secure Services and CAMHS, NHSE negotiates a provider's single national contract and some minimum quality standards. In Wales, NHS Wales holds a framework agreement which ranks providers of rehabilitation and secure services. Source: Acadia / Priory decision. See also Appendix B.

non-specialised ABI, non-secure and step-down[90] hospital services as well as community-based secondary mental health services.[91,92]

2.76 The bulk of CCGs' spend on secondary mental health services is on block contracts with local NHS mental health trusts for the full range of NHS hospital and community-based services. The remainder is spent mainly on independent sector hospitals.[93]

The mental health services market and main providers

2.77 Mental health services are provided by the NHS, independent providers and local authorities. The services are provided in hospital as well as community settings. The NHS accounts for the majority of supply. In 2015 it had approximately 71% share of all mental health hospital provision, both in terms of bed capacity and the estimated value of services. The remaining 29% was supplied by independent mental health hospitals. NHS outsourcing of community mental health services is currently very limited.[94]

2.78 Between 2010 and 2015, the combined NHS in-house mental health hospital bed capacity fell by 23% (from 31,520 to 24,270), while the independent sector bed capacity grew by 8% (from 9,275 to 10,018).[95] Overall bed capacity in mental health hospitals declined during 2010 to 2015.

2.79 Table 2 shows how capacity and market size for the independent mental health hospitals in the UK has changed during 2006 to 2015. According to LaingBuisson, following a halt to growth in 2011, when NHS commissioners reduced their outsourced placements in response to the post-global credit

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[90] Step-down services include rehabilitation units commissioned by CCGs; supported accommodation in the community, which may vary from 24-hour staffed support to 'floating support' at various times during the week (commissioned by health and/or social care services). JCPMH (May 2013), Guidance for commissioners of forensic mental health services.
[91] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p66.
[92] Secondary care refers to services provided by medical specialists who generally do not have the first contact with a patient, for instance a neurologist or a rehabilitation consultant. Secondary care services are usually based in a hospital or clinic as opposed to being in the community and patients are usually referred to secondary care by a primary care provider such as a general practitioner (GP). Multiple Sclerosis Trust website.
[93] At the end of 2015, each CCG in England spent on an average approximately £50 million year on secondary mental health services. LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p66.
[94] In 2015, the NHS had 24,270 beds across the UK, while the independent sector had 10,018 beds. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, pp2, 83 & 99.
[95] Ibid, p3, Table 2.2. 2010 bed numbers have been derived based on 2015 bed numbers and the percentage change during 2010-2015.

crisis downturn in government spending, growth in independent mental health hospital revenue was re-established during 2013 to 2015.[96]

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

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

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

2.80 In 2014/15 the total UK market for mental health services was estimated to be worth £15.9 billion, of which hospital services (including inpatient rehabilitation services) accounted for £4.27 billion or approximately 27%.[97] The turnover of independent mental health hospitals in the UK was about £1.3 billion in 2015,[98] which constituted 29.4% of the mental health hospital services (including those provided by the NHS) – see Table 3.[99,100]

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

£ million

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

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

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[96] Ibid, p11.
[97] The remaining £11.6 billion includes (i) NHS in-house community mental health services £4.1 billion; (ii) other NHS in-house expenditure on mental health and learning disabilities £ 7.5 billion (primary care, older people's mental health services, community services for learning disabilities, etc); (iii) independent sector provided community mental health services £0.1 billion. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p12 (Figure 2.1).
[98] Ibid, p11.
[99] Excluding privately paid psychotherapy, counselling services. Ibid, p2.
[100] Total turnover of the independent providers in 2014/15 was approximately £1.4 billion, which constituted 8.5% of all mental health services in the UK (including hospital and community mental health services). LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, pp11–12.

2.81 The independent hospital sector is highly dependent on continued NHS outsourcing; £1.1 billion or 87% of its total revenue of £1.3 billion in 2015 represented demand from the NHS.[101] The share of private patients or those funded by private medical insurance in the independent hospitals' revenues was relatively small at 13%. The independent sector's focus is almost exclusively on providing mental health services in hospital settings.

2.82 In 2015, about 30% of the independent mental health hospital bed capacity was in low secure or psychiatric intensive care units (PICUs), while only 10% was in medium secure units.[102, 103] In 2015, 'locked rehabilitation' services accounted for about 23% of all independent mental health hospital bed capacity in the UK – see Table 4.[104] In terms of value, the locked rehabilitation services market in the UK was estimated at about £304 million in 2015, out of which £294 million or almost 97% was provided by the independent sector.[105]

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

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

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

2.83 The Parties told us (see Figure 2) that as of February 2017, they had the largest rehabilitation bed capacity in England, with a combined share of [20–30]% (approximately [10–20]% CAS and [5–10]% Cygnet), followed by Acadia Group[106] at [10–20]%, Huntercombe [5–10]%, Elysium and St Andrew's both at [5–10]%, and Barchester at [0–5]%.[107]

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[101] Ibid, p1.
[102] See Table 1 for a description of secure services. See Appendix C for a description of various mental health services.
[103] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, pp17 & 3.
[104] Cambian was the pioneer of the locked rehabilitation model of treatment, as a lower cost option to lower secure treatment. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p91.
[105] LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p61.
[106] The Acadia Group acquired Partnerships in Care in June 2014 and the Priory Group in January 2016. Source: Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, pp87–88.
[107] The combined share of all other providers was [30–40]%.

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

[✂]

Source: The Parties. [✂]
* [✂]
† [✂. [✂][108]

2.84 September 2014 to January 2016 was a period of high M&A activity with the exit of two private equity groups from the UK mental health hospital sector (Cinven and Advent International) and the entry of two US-based trade buyers (Acadia Healthcare and UHS).[109,110]

2.85 Private equity operators continue to be active in the mental health hospital sector in the UK, which is evidenced by the recent divestment of specific sites by Acadia to BC Partners (a private equity firm) to address the CMA's concerns about Acadia's acquisition of Priory.[111] Elysium is the new entity established by BC Partners to operate these sites.

3. The Parties and their operations

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

Cygnet

3.2 Cygnet is incorporated in England and Wales. It was founded in 1988[112] and is a wholly-owned subsidiary of UHS.[113] Cygnet offers a range of services for individuals suffering from a variety of mental health conditions. It describes itself as a provider of 'secure and specialist mental health services.' Cygnet's turnover in the UK in the year ending 31 December 2016 was around £178 million.

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[108] The Parties also told us that "these estimates are likely to significantly overstate the position of the Parties", e mail to the CMA, 12 October 2017.
[109] Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p86.
[110] Acadia acquired Partnerships in Care from Cinven in 2014 and Priory Group from Advent International in 2016. UHS acquired Cygnet in September 2014, Alpha Hospitals in 2015.
[111] See Acadia / Priory merger inquiry: Undertakings in lieu of reference acceptance decision.
[112] The company has been subject to management buyouts on many occasions including in August 2000, November 2002 and March 2008. Source: LaingBuisson, Mental Health Hospitals & Community Mental Health Services, UK Market Report, second edition, p92.
[113] The behavioural health division of UHS acquired Cygnet in September 2014.

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

Cygnet's sites and services

3.4 Cygnet has 22 sites[114] that provide a range of mental health services in England – see Table 5 and Figure 3.

Table 5: Overview of Cygnet's services

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

Source: Merger Notice, p18, paragraph 3.17.
Note: Since many sites provide more than one service, the number of sites does not sum to the total number of sites, and is therefore not shown.

[114] Twenty mental health hospitals and two residential care homes for the elderly.

Figure 3: Location of Cygnet's sites

Source: The Parties

3.5 Cygnet's services are focused on providing treatment at the higher end of the security (eg in secure hospitals) and acuity scale (eg acute psychiatric services and PICUs).[115]

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

Figure 4: Cygnet's revenues by service – 2016

[✂]

Source: The Parties'
Note: [✂]

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

[115] Merger Notice, paragraph 4.

Figure 5: Location of Cygnet's rehabilitation sites

Source: The Parties

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

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

[✂]

Source: The Parties

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

Table 6: Number of Cygnet's rehabilitation wards

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

Source: Merger Notice, pg 9

Cygnet's financial performance and strategy

3.10 Cygnet told us that its core business trading [✂]. In 2014, it averaged [✂]% occupancy and revenues were £[✂]. It stated that in 2015 after it was acquired by UHS,[116] Cygnet [✂], [✂]% in 2015 (revenues of £[✂]), and [✂]% in 2016 (revenues of £[✂]).[117] The increase in revenues mainly reflected two acquisitions Cygnet completed during 2015, ie Orchard Portman and Alpha hospitals.

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

Table 7: Cygnet – summary financials

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

Source: Cygnet.

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

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

[116] Cygnet was acquired by UHS in September 2014.
[117] Net revenue before bad debt. [✂]

among the top three or four mental health hospital providers in the UK over the last decade.[118]

3.14 NHSE and CCGs are Cygnet's main customers. In 2016, NHSE accounted for [✂]% of Cygnet's revenues, CCGs accounted for [✂]%.[119] [✂]% of Cygnet's revenues are derived from services provided in hospitals, with the remaining [✂]% generated by the two nursing homes it operates.

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

CAS

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

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

CAS' sites and services

3.18 CAS has 61 sites providing a range of mental health services in England and Wales – see Table 7 and Figure 7.[120]

Table 8: Overview of CAS' services

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

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

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

Figure 7: Location of CAS' sites

Source: The Parties

3.19 CAS provides rehabilitation services and 'step-down'[121] community placements in social care settings to support patients with mental health diagnoses to move into the community. It told us that it focused on providing services at the lower end of the security and acuity scale of the care pathway (see paragraph 2.73).

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

Figure 8: CAS' revenues by service – 2016

[✂]

Source: The Parties
Note: [✂]

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

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

Figure 9: Location of CAS' rehabilitation sites

Source: The Parties

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

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

[✂]

Source: The Parties

3.23 Table 9 provides the breakdown of CAS' rehabilitation wards and beds by specialism and gender.[122]

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

Table 9: CAS' rehabilitation wards

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

Source: Merger Notice, p43

CAS' financial performance and strategy

3.24 According to Cambian's statutory accounts, in 2016 the total revenue of its adult services business (ie CAS) was £142.0 million compared with £129.4 million in 2015. CAS' adjusted EBITDA[123] increased from £24.1 million in 2015 to £28.8 million in 2016.[124]

Table 10: CAS – summary financials

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

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

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

[123] Adjusted EBITDA reflects earnings before interest, tax, depreciation, amortisation, profit or loss on disposal of assets, merger and acquisition costs, IPO share option charges and exceptional items.
[124] 2015 financials are re-presented to reflect transfers of sites before the sale of adult services was finalised.
Source: Cambian 2016 Annual Report, p9.

3.26 CAS' financials reflecting stand-alone profitability of the business, prepared by Deloitte for the purpose of vendor due diligence, [✂] – see Table 11.[125]

Table 11: CAS summary financials

£ million

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

Source: CAS

3.27 [✂]

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

3.29 CAS' top ten customers account for about [✂]% of its revenues. CCGs account for [✂]% of its revenues followed by local authorities at [✂]%.[126]

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

Overlap between the Parties' services

3.31 Although the Parties both operate residential care homes, the services they provide do not give rise to a competitive overlap. CAS' 44 homes treat adults with mental health conditions including LD and ASD whereas Cygnet has two residential nursing homes for the elderly.

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

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

(b) Rehabilitation services.[127]

3.33 CAS' low secure facility only treats male PD patients. The Parties told us that although Cygnet has a number of low secure mental health hospitals, it has only one low secure facility providing treatment for female patients with PD.[128]

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

3.34 In rehabilitation services, the Parties explained that there is no overlap between the Parties in relation to the treatment of:[129]

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

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

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

Other providers

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

Acadia Group[130]

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

3.38 In June 2014, Acadia acquired Partnerships in Care, which provides a variety of behavioural health treatment services at over 50 hospitals throughout the UK. These include medium and low secure services, inpatient rehabilitation and community housing to support patients' re-integration into the community. It provides a range of specialist services within mental illness, LD, PD, ABI and ASD.[131]

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

[129] Source: Merger Notice, paragraph 28.
[130] Acadia Healthcare website.
[131] Acadia Healthcare website: UK locations.

psychiatric services, children's services, addictions treatment and specialist education services.[132]

3.40 The worldwide turnover for Acadia in the year ending 31 December 2016 was $2.9 billion.[133] Acadia's revenues for its UK operations in the year ending 31 December 2015 were $360.7 million (£218.9 million). The turnover of Priory in the year ending 31 December 2015 was £571.2 million, all of which was generated in the UK.[134]

Four Seasons Healthcare/Huntercombe (Elli Investments Ltd)[135]

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

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

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

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

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

Elysium[136]

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

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[132] Acadia / Priory merger inquiry: Decision on relevant merger situation and substantial lessening of competition.
[133] Acadia 2016 Annual Report.
[134] Acadia / Priory merger inquiry: Decision on relevant merger situation and substantial lessening of competition.
[135] Elli Investments Limited Annual report and consolidated financial statements (31 December 2015).
[136] Elysium Healthcare website.

transaction value was £320 million.[137] In total, the divested sites had 1,000 beds and an estimated annual revenue of £132 million.[138]

3.44 In February 2017, Elysium acquired Raphael Healthcare, which provided low secure mental health services for women in Newark, Nottinghamshire and a site in Prescot, Lancashire where it intends to develop children's services.[139] In April 2017, Elysium acquired the Badby Group, a specialist neuro-disability care provider for people with neurological illnesses, ABI and spinal cord injuries.[140,141]

3.45 Elysium provides a range of mental health services including rehabilitation, acute/PICU, CAMHS and secure services at 22 facilities in the UK. Fourteen of these facilities provide rehabilitation services.[142]

St Andrew's Healthcare[143]

3.46 St Andrew's Healthcare is the largest not-for-profit provider of mental health hospitals in the UK. It is positioned at the secure end of the spectrum. St Andrew's Healthcare has also diversified into providing locked rehabilitation services.[144]

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

3.48 St Andrew's Healthcare reported a total income (revenue) of £199.1 million for 2016 and net income of £7.8 million.[145]

Barchester Healthcare[146]

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

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

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

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

3.51 According to its latest statutory accounts, Barchester's 2015 turnover was £535.6 million and its operating profit was £3.0 million.[147]

Lighthouse Healthcare[148]

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

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

3.54 Lighthouse Healthcare's turnover for the year ended 31 March 2016 was £23.5 million; its operating profit before amortisation and interest was £3.2 million.[149]

4. The Merger and relevant merger situation

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

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

Rationale for the Merger[150]

4.3 The Parties told us that the Merger was largely complementary as it would broaden the reach of Cygnet across the care pathway, and across different

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[147] Barchester Healthcare Limited. 2015 Annual Report and Consolidated Financial Statements.
[148] Lighthouse Healthcare website. On 11 August 2017, Lighthouse Healthcare was acquired by Elysium.
[149] Lighthouse Health Group Limited. Consolidated Financial Statements, 31 March 2016. Filing History, Companies House.
[150] Further details regarding the rationale for the Merger are in Appendix D.

treatment types. They said that Cygnet's focus was on patients with high acuity needs and/or those requiring a secure setting, while CAS' main focus was on the provision of different types of rehabilitation services to patients with less demanding requirements.

4.4 UHS told us that its strong financial position and access to capital would also enable it to invest in and support CAS' growth plans. [✂][151]

4.5 According to Cambian, selling CAS was a strategic move to enable it to focus its resources on becoming a high-quality provider of specialist education and behavioural health services for children, while, at the same time, repaying its existing debt.[152]

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

(a) the competitive sale process attracted a significant number of interested parties which ensured that the consideration (of £377 million) recognised the market position and prospects of CAS;[153]

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

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

(d) there was increasing demand for the children's services business, and significant potential for growth in what continues to be a highly-fragmented market in the UK;[154] and

(e) the anticipated growth and development of Cambian following the Merger focused solely on the children's services which was a potential source of future shareholder value.[155,156]

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[151] Prior to the Merger, UHS identified potential synergies of approximately £[✂] based on a high-level analysis of the central cost savings that could be expected to be achieved from the Merger. [✂].
[152] Cambian announcement regarding proposed disposal of the Adult Service Business, 5 December 2016.
[153] In a communication to its shareholders, Cambian announced that the purchase consideration represented an attractive enterprise valuation of approximately 2.9 times CAS' 2015 revenue of £129.5 million. Cambian announcement regarding proposed disposal of the Adult Service Business, 5 December 2016.
[154] Cambian circular relating to recommended proposals for the disposal of the Adult Services Business And Notice of General Meeting, 9 December 2016.
[155] Cambian announcement regarding proposed disposal of the Adult Service Business, 5 December 2016.
[156] The retained business was to be focused exclusively on the children's services business, and would keep the 'Cambian' name and brand. For the financial year ended 31 December 2015, the children's services business generated revenue of £160.7 million and adjusted EBITDA of £18.4million. Cambian circular relating to recommended proposals for the disposal of the Adult Services Business and Notice of General Meeting, 9 December 2016.

Relevant merger situation

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

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

4.9 Section 23 of the Act provides that a relevant merger situation has been created if two or more enterprises have ceased to be distinct within the statutory period for reference[157] and either the turnover test or the share of supply test is satisfied.[158]

4.10 We found that each of the Parties to the Merger provided, and both Cygnet and now CAS continue to provide services to customers on a commercial basis. We conclude that each are businesses within the meaning of the Act and the activities of each are 'enterprises' for the purposes of the Act.[159]

4.11 As a result of the Merger, the Cygnet enterprises and the CAS enterprises have been brought under the common ownership and control of UHS and have 'ceased to be distinct' within the meaning of the Act.[160]

4.12 The Merger completed on 28 December 2016 and was made public on the same day. The reference was made on 3 May 2017 within the four-month statutory extension period.[161] Accordingly, we conclude that Cygnet and CAS have 'ceased to be distinct' within the statutory timeframe.[162]

4.13 We found that the turnover in the UK for CAS, the enterprise acquired, was around £142 million. This establishes sufficient connection with the UK to give us jurisdiction to investigate.

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[157] As set out in section 24 of the Act.
[158] Section 23 of the Act provides that the value of the turnover in the UK of the enterprise being taken over must exceed £70 million or, in relation to the supply of goods or services, at least one quarter of all such goods or services which are supplied or acquired in the UK or a substantial part of the UK are supplied by or to one and the same person.
[159] Section 129(1) and (3) of the Act.
[160] Section 26 of the Act.
[161] Notice was given on 21 April 2017 that the four-month period would be extended until the earliest of (i) the giving of the undertakings concerned; (ii) the expiry of the period of ten working days beginning with the first day after the receipt by the CMA of a notice from Cygnet and UHS, Inc. stating that they did not intend to give the undertakings; or (iii) the cancellation by the CMA of the extension. On 28 April 2017 Cygnet and UHS gave notice that they would not give undertakings. The reference on 3 May was therefore within this extended period.
[162] Section 24 of the Act.

Conclusion on the relevant merger situation

4.14 We therefore conclude that that the Merger has resulted in the creation of a relevant merger situation.

5. Market definition

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

5.2 However, market definition is not an end in itself and it involves an element of judgement. The boundaries of the relevant market do not determine the outcome of our analysis of the competitive effects of the merger. In assessing whether a merger may give rise to an SLC, we may take into account constraints from outside the relevant market, segmentation within it and other ways in which certain constraints may be more important than others.[163]

5.3 The Merger Assessment Guidelines explain that the analysis underpinning the identification of the market and the assessment of the competitive effects of a merger overlap, with many of the factors affecting market definition being relevant to the assessment of competitive effects and vice versa. Therefore, market definition and the assessment of competitive effects should not be viewed as distinct analyses.[164]

Product market

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

5.5 The Parties overlap in the supply of rehabilitation services to customers. Most mental healthcare hospitals are divided into discrete specialised wards.

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[163] Merger Assessment Guidelines, paragraph 5.2.2.
[164] Merger Assessment Guidelines, paragraph 5.1.1.

Where a site has more than one ward, and offers different specialisms at each, a separate competitive assessment was carried out at a site-level for each of the specialisms offered.

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

(a) Delineation by specialism (ie patient diagnosis being treated).[165]

(b) Delineation by patient gender.

(c) Delineation by level of security.

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

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

Delineation by specialism

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

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

5.9 The Parties each treat a number of distinct patient conditions and overlap in the supply of rehabilitation services to patients with ASD, LD, LTMH and PD.

5.10 The approach of focusing on individual specialisms is consistent with the Parties' view that the different requirements of patients within each diagnosis mean that the different types of treatment cannot be considered as alternatives for most patients.[166] Several third parties (both competitors[167] and customers[168]) told us (with varying degrees of assertiveness) that the primary diagnosis of a patient's condition is key to the referral decision.

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[165] In one specialism, LTMH, we consider whether the frame of reference should be split by age.
[166] Merger Notice, paragraph 18.
[167] [✂]
[168] [✂]

Therefore, patients would in general not be referred to wards not specialising in treatment for their primary diagnosis.

5.11 We considered whether it would be appropriate for PD and LTMH rehabilitation services to be in the same product market on the basis that they could represent alternative treatments for some patients. We sought to understand the proportion of patients who could be treated both at wards specialising in PD and wards specialising in LTMH.

5.12 There are some wards owned by Priory and Elysium described as providing rehabilitation services for both PD and LTMH. Priory explained that some of these wards would offer specialist PD services. Others would generally take patients with a primary diagnosis of LTMH (Priory refers to a 'mental health diagnosis'), but patients often presented with co-morbid[169] conditions which might include PD traits. Elysium told us that some LTMH facilities could treat 'lower risk' PD patients with less challenging behaviour. We have incorporated evidence on specific LTMH/PD wards in our local competitive assessment.

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

5.14 In calculating shares of supply, for those sites providing treatment for both conditions in a single ward, we incorporated sensitivity analysis in our filtering, where on a cautious basis we tested the sensitivity of excluding these wards from market share calculations for filtering. We then considered evidence for the actual allocations within specific wards and whether these could be flexed in the local competitive assessments (see paragraph 9.17 below).

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

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[169] Comorbidity is the presence of one or more additional diseases or disorders co-occurring with (that is, concomitant or concurrent with) a primary disease or disorder; in the countable sense of the term, a comorbidity (plural comorbidities) is each additional disorder or disease. The additional disorder may be a behavioural or mental disorder.

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

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

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

5.17 The evidence is consistent with the Parties' submissions; in particular, that specialised facilities are generally required and there is a clear delineation in the age of the patient population between sites designated as LTMH and those designated as LTMH E. The CMA has therefore treated LTMH E as a distinct product market.[170]

5.18 PD services are often described using a tiered approach, which allows patients to be appropriately directed according to their needs, the nature of their PD diagnosis and their capacity to engage with services. The tiers range from Tier 1 (primary care) to Tiers 5 and 6 (medium and high secure forensic services).

5.19 In our competitive assessment, we considered the overlap between the Parties in Tier 3 PD services (local specialist services) and Tier 4 PD services (specialist and intensive provision beyond that which can be provided within either Tier 3 services or other local mental health services including acute inpatient services).[171]

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

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[170]Categories of LTMH referred to below (ie female LTMH, male LTMH and LTMH combined gender) therefore exclude elderly patients. As the Parties do not overlap in LTMH E it does not feature in our competitive assessment. However, given it is a separate market, providers of LTMH E have been excluded as competitors for our assessment of local overlaps and in Appendix E.
[171] See paragraph 2.6 for description of Tiers.

5.21 The Parties set out the differences between these two tiers (see paragraphs 9.41(a) to 9.41(b). They also told us that when the moratorium on new Tier 4 services is lifted, [✂].

5.22 Third parties provided mixed evidence on the extent to which the Parties' PD services for female patients can be treated as alternatives and this evidence varies from ward to ward.[172]

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

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

Delineation by gender

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

5.26 The CMA also notes that the Department of Health[173] requires all providers of all types of NHS-funded care to make provision for same-sex accommodation.[174] This requirement covers sleeping accommodation, bathroom/toilet accommodation and day rooms/lounges.

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

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[172] See paragraphs 9.55 to 9.60 for more detailed discussion

[173] The Chief Nursing Officer and Deputy NHS Chief Executive required all providers of NHS funded care to declare by 1 April 2011 that all hospital accommodation was same sex. Same sex accommodation is also mandated under the 1983 Act Code of Practice and the 2014 Regulations. Mixing however may be justified if it is in the overall best interest of the patient or reflects their personal choice, notably in a clinical emergency. See, Department of Health, Eliminating Mixed-Sex Accommodation (MSA).

[174] Same-sex accommodation is where male and female patients sleep in separate areas and have access to toilets and washing facilities used only by their own sex. In mixed-sex wards, same-sex accommodation can be provided either as: *(a)* single rooms with same-sex toilet and washing facilities (preferably en-suite); *(b)* multi-bed bays or rooms occupied solely by either men or women with their own same-sex toilet and washing facilities. Patients should not need to pass through mixed communal areas or sleeping areas, toilet or washing facilities used by the opposite sex to get to their own.

5.28 The evidence received throughout our inquiry supports distinct markets for male and female patients.

5.29 In calculating shares of supply, if a competitor site provides treatment for both male and female patients (ie a mixed ward), we have sought to verify with the site owner the actual number of beds dedicated to each gender and the site owner's ability to flex this allocation between genders (this may vary from case to case). We incorporated this information into our local competitive assessment. Where this information was not available, we have adopted the assumption that on average competitors have a 65:35 split of male and female patients in mixed wards.[175]

Delineation by level of security

5.30 The Parties overlap in the provision of 'locked' rehabilitation services.[176]

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

5.32 Evidence from several competitors is consistent with the view that no major difference exists between 'open' and 'locked' rehabilitation services. One competitor[177] told us that although security is a standard requirement there is occasional flex around the concept. Another competitor[178] told us that delineation by security level for rehabilitation services is a 'branding' distinction rather than a point of substance. Another competitor[179] told us that the security level is determined by the clinician and is often a topic of controversy between clinicians and customers as even in locked rehabilitation facilities 'there is no formal gatekeeping'.

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

5.34 The evidence supports 'locked' and 'unlocked' rehabilitation facilities being within the same product market. We note that in practice only a small

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[175] Acadia/Priory, paragraph 391.
[176] See paragraph 2.6 for security levels ascribed to treatment of PD and refer to paragraph 2.62 for a description of locked rehabilitation.
[177] [✂]
[178] [✂]
[179] [✂]

minority of wards are described as 'open' or 'unlocked'. However, we have tested the sensitivity of our filtering analysis to excluding unlocked facilities.

Supply-side substitution

5.35 As set out in the Merger Assessment Guidelines, the boundaries of the relevant product market are generally determined by reference to demand-side substitution alone.[180]

5.36 In Acadia/Priory, the CMA considered whether an identified product frame of reference (for example, rehabilitation services provided to female PD patients) should be widened to take account of supply-side substitution.[181] Whilst the CMA focused its analysis in that case on narrow frames of reference, on a cautious basis and recognising the possibility of some supply-side substitution, the CMA also considered the potential impact of that merger within speciality-combined and gender-combined frames of reference.[182]

5.37 The CMA may aggregate the supply of products and analyse them as one market where there is evidence of supply-side substitution. In assessing the possibility of supply-side substitution, we have considered both the ease with which a provider of one service could 'reconfigure' to supply another service (or the same service to the other gender) as well as the provider's incentive to do so.[183]

5.38 The Parties submitted that services for different specialisms and genders within rehabilitation services give rise to separate markets and that there is not sufficient supply-side substitution to aggregate them. The Parties stated that reconfiguring a ward is a 'significant task and not undertaken lightly'.[184]

5.39 We reviewed evidence of the Parties' reconfiguring sites in the past four years, including relevant internal documents, and evidence received from third parties on reconfiguration.[185] The evidence suggests that *(a)* the costs of reconfiguring vary significantly from case to case; and *(b)* reconfiguring is relatively infrequent.

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[180] Merger Assessment Guidelines, paragraph 5.2.17.
[181] Acadia/Priory, paragraph 391.
[182] Acadia/Priory, paragraph 352.
[183] The second condition for supply-side substitution is set out in paragraph 5.2.17 of the Merger Assessment Guidelines, namely: that 'the same firms compete to supply these different products and the conditions of competition between the firms are the same for each product …'. We have not considered this second condition as the first condition is not satisfied.
[184] Merger Notice, paragraph 13.26.
[185] See paragraphs 10.14–10.36 below.

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

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

5.42 Our investigation confirmed that any reconfiguration between genders or specialisms would, at a minimum, require that all existing patients in a ward are moved elsewhere prior to the ward starting to offer treatment of different specialisms/genders. Given that rehabilitation patients are typically treated for long periods of time, there are practical difficulties in accommodating patients during any transition.[186]

5.43 In our view, the incentive for a provider to reconfigure will depend on the relative profitability of the new and old service. Our analysis of the Parties' approach to opening or acquiring new wards or reconfiguring existing wards[187] suggests that the key determinant of this relative profitability is the difference in occupancy that could be achieved through reconfiguration.

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

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

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

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

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

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

NHS versus independent providers

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

The Parties' submissions

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

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

(b) Exclusion of NHS providers implies that CCGs' referral behaviour does not comply with the Department of Health Any Qualified Provider (AQP) guidance.[188]

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

(d) There is evidence of actual competition with NHS providers such as: occasions where NHS trust capacity expansions have impacted occupancy at the Parties' sites; internal documents regularly reference competition from and developments by NHS trusts in the same way in which they consider developments in the independent sector;[189] CCGs will generally invite three providers to assess the patient and attend a funding panel meeting and that, in their experience, one of these providers will often be an NHS provider.

(e) NHS providers make beds available for out-of-area patients. Several examples are provided by the Parties.[190]

(f) Some framework agreements include a mixture of independent and NHS providers and that requirements set out in the Public Contracts Regulations 2015[191] mean that awarding bodies using the framework agreement must either:

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

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

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[188] Under AQP, any provider assessed as meeting rigorous quality requirements, and who can deliver services to NHS prices, is able to deliver the service. Once the opportunity is advertised, providers are assessed using a nationally consistent qualification process. For more detail see Appendix B, paragraph 91 and onwards.
[189] [✂]
[190] [✂]
[191] For more detail on these regulations and other rules governing mental health services procurement see Appendix B, paragraphs 73-90.

Evidence from third parties

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

(a) Eleven, accounting for 43% of total referrals to the Parties' overlap sites, told us that NHS wards typically have no spare capacity or do not offer rehabilitation services within the referral area.[192]

(b) Twelve, accounting for 49% of total referrals to the Parties' overlap sites from those customers that responded, said they use NHS providers first and refer patients to independent providers only if NHS providers do not have availability or are not appropriate for the patient's condition.[193]

(c) Four, accounting for 8% of total referrals to the Parties' overlap sites from those customers that responded, told us that the referral process primarily considers the patients' needs. Thus, both NHS and independent sector clinics are considered equally based on appropriateness of treatment offered.[194]

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

5.52 The Parties identified 37 wards operated by NHS trusts providing rehabilitation services in the areas where they overlap.[195] We asked those NHS trusts relevant to the East Midlands, Yorkshire and the Humber and West Midlands overlaps[196] for data on the occupancy of these wards over the last three years. We also asked whether there are any block contracts relating to the wards in question and whether in their view local customers tended to fill the NHS wards before considering independent providers.

5.53 Thirteen out of the 15 NHS trusts[197] that we contacted told us that customers would use their NHS wards providing rehabilitation services first and place patients with independent providers only if the NHS providers do not have availability or are not appropriate for the patient's condition. The two

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[192] For example, [✂] said that locked rehab is not available from local NHS providers and therefore only the independent sector is considered. We heard the same from [✂]
[193] [✂]
[194] [✂]
[195] Parties' response to the phase 1 decision.
[196] We focused on those areas where we had greatest potential concern. We did not prioritise the South West and Southern Wales overlap as we did not have concerns in this area even without accounting for NHS provision.
[197] The fifteen NHS trusts we received this information for [✂].

remaining trusts told us that some of the beds in their rehabilitation wards would compete with independent provision:

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

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

5.54 The evidence that customers would use their NHS wards providing rehabilitation services first and place patients with independent providers only if the NHS providers do not have availability or are not appropriate for the patient's condition was corroborated by occupancy information provided by the trusts. Occupancy was generally high for NHS providers with ten out of the 15 providers having average occupancy rates higher than 90% for all of their wards. [✂] told us that it was considering plans to reduce the number of rehabilitation beds across its wards. [✂] told us customers may choose not to fill available block contract beds either where there is a clinical need for a specialist package or environment, or where the patient who is proposed for admission would not be suited to the existing patient mix or staffing establishment.

5.55 Overall, 95% of the NHS trust rehabilitation beds would be used by customers before independent providers were considered. 94%[198] of NHS Trust rehabilitation beds were covered by block contracts with customers.

Our assessment

5.56 In our view, the evidence from NHS trusts and customers supports our conclusions that NHS providers of rehabilitation services do not in general compete with independent providers for the majority of referrals. In the vast majority of cases, customers will use NHS providers first and place patients with independent providers only if NHS provision is not available or not

[198] Two NHS Trusts [✂] stated that they block contract a proportion of their beds but did not provide the proportions. We have excluded them from this calculation.

appropriate for the patient's condition. We note that there are some exceptions to this, which have been identified in the evidence we have received from trusts (as discussed in paragraph 5.53 above), but these are rare.

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

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

(b) We do not believe it is possible to assess the occupancy of NHS rehabilitation services from looking at the overall occupancy across all NHS mental health services (which the Parties told us is [80–90]% – see paragraph 5.50 above). In our view this evidence is consistent with NHS rehabilitation wards operating at near full capacity, with a small number of exceptions. We note that the majority of the NHS providers we contacted had rehabilitation wards that were operating near full capacity, and that the two that were not have block contracts with customers.

(c) In our view, the evidence the Parties have provided on competition with NHS providers (as described in paragraph 5.50 above) is consistent customers using NHS providers first and placing patients with independent providers only if the NHS providers are not available or not appropriate for the patient's condition. The fact that NHS trust capacity expansions have impacted occupancy at the Parties' sites reflects what we would expect to see if customers choose to use NHS providers first. In our view this evidence reflects a one-off shift in the overall demand for private provision of rehabilitation services rather than implying ongoing competition between NHS trusts and independent providers. Given that NHS provision may affect demand for independent providers, the fact that internal documents refer to NHS providers is also unsurprising. We have heard from the Parties, in the context of their PD services, that the fact that customers may seek assessments from multiple providers to find out

what sort of service may be appropriate for that patient does not imply a trade-off between those providers.[199]

(d) All of the NHS trusts we heard from had block contracts with customers, covering nearly all of the beds in their rehabilitation wards. These block contracts mean customers would use these beds first when they are appropriate for the patient. The prevalence of block contracts is not consistent with the Parties' submission that there has been a substantial shift away from them. In our view, it is too speculative to assume that the phasing out of block contracts would result in sufficient competition between NHS providers and independent providers in time to resolve any adverse effects of the Merger.[200]

(e) Similarly, it did not appear to us that the Department of Health AQP guidance would result in an imminent change to the customer behaviour we observed. We understand that the AQP policy primarily aims to increase patients' choice. Moreover, we note that currently there is no strict requirement for customers to change their procurement behaviour to the AQP model and that CCGs in particular have been slow in applying this policy,[201] as the Parties have acknowledged.[202]

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

Conclusion on competition from NHS providers

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

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[199] Response to phase 1 decision, paragraph 6.9.
[200] See also Section 2, paragraphs 2.39-2.44.
[201] In particular, we note that 'limited enthusiasm at a national level' and 'patchy use of it at a local level' have been publicly reported, The King's Fund (19 March 2015), Is the NHS being privatised?.
[202] See also Appendix B, paragraphs 91–95.

Geographic market

Introduction

5.59 The geographic market aims to identify only the most significant competitive alternatives available, yet needs to include at least the competitors relevant to satisfy the hypothetical monopolist test.[203] The geographic market definition does not lead mechanistically to the outcome of the local competitive assessment, which will take account of possible constraints both inside and outside of the market.[204]

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

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

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

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

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

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

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

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

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[203] Merger Assessment Guidelines, paragraph 5.2.1.
[204] Merger Assessment Guidelines, paragraph 5.2.2.

Methodology

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

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

5.65 A pragmatic approach to identify geographic markets is the use of catchment areas, ie the area over which the providers' customers originate. The Merger Assessment Guidelines state that while catchment areas are a pragmatic approximation for a candidate market to which the hypothetical monopolist test can be applied, the use of catchment areas is not an alternative conceptual approach.[205]

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

Patient distance catchment areas versus customer-defined areas

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

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

Customer behaviour

5.69 We asked customers if they had a typical area or distance within which they would attempt to keep rehabilitation patients (our customer questionnaire is discussed in more detail in 7.11 to 7.19 below). Of the 46 customers who

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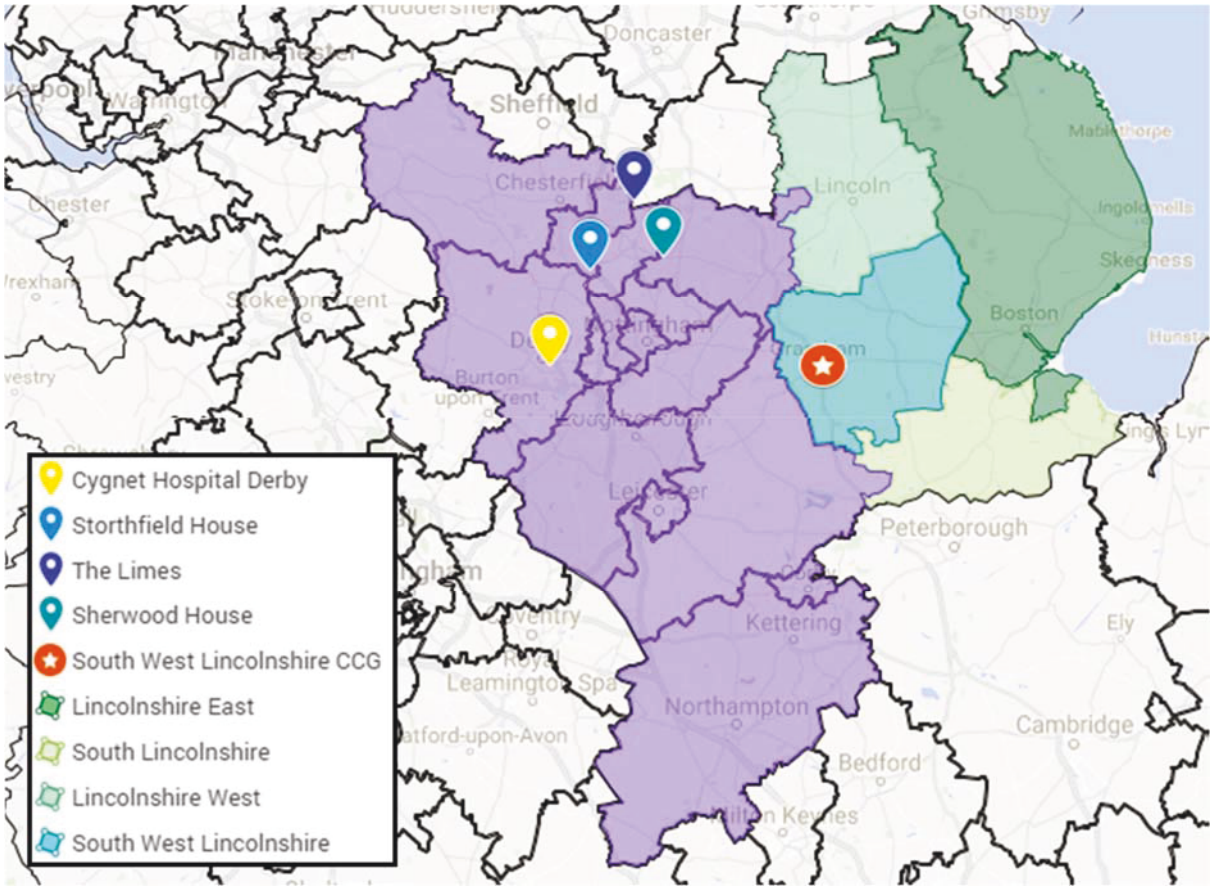
[205] Merger Assessment Guidelines, paragraph 5.2.25.

responded to this question 83% stated that they did have a typical area or distance and 17% said they did not.

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

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

Figure 11: East Midlands framework area



Source: Parties
Note: Shaded areas represents the geographic area covered by the Framework. Since this map was produced Corby and Nene have left the Framework.

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

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

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

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

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

5.73 96% of customers said that there were circumstances where patients would be placed beyond their typical referral area. Customers provided several reasons for such out-of-area placements, the two most common being to find more specialist services or because of a lack of local capacity.

5.74 By way of example, [✂][206] submitted that placements are made in partnership with the patient and carers to find the most clinically effective treatment. Normally this would be within a 60 miles radius but may be further.

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

Our approach

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

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

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[206] [✂]

Customer location data as proxy for patient location data

5.78 [✂] Both the parties, however, collect and provided information on CCGs, which are typically responsible for the area in which the patient is located. For these reasons, we have relied on customer location as a proxy for patient location data.[207]

5.79 The Parties submitted that[208] the catchment area data is subject to significant uncertainty as:

(a) CCGs often cover large geographic areas.

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

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

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

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

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

Average catchment areas rather than site-specific catchment areas

5.82 Our usual starting point in mergers in local markets is to calculate an average catchment area and apply this catchment area to identify competitors or measure concentration across all of the merging parties' overlaps.[209] The reason for using a consistent average catchment area is that it should capture a consistent relationship between customer behaviour, ie the relationship between preference over distance and preferences over other factors. Some previous cases have differentiated between customer behaviour in urban and rural areas (with wider catchment areas being used in the latter) but rarely are site-specific catchment areas used.

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

5.84 At phase 1, the CMA took a cautious approach to assess the geographic market.[210] It followed three steps:

(a) First, in its filter, shares of supply within 'stepped catchments' from 40 miles to 130 miles, in 10-mile increments, road distances were considered from each site.[211]

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

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

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

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[209] Retail Mergers Commentary, paragraph 2.21.
[210] The approach follows closely the most recent mental healthcare merger (Acadia/Priory).
[211] It used ten different geographical frames of reference for the filter, including competitors within the following road distance of its site: (i) 40 miles, (ii) 50 miles, (iii) 60 miles, (iv) 70-miles, (v) 80 miles, (vi) 90 miles, (vii) 100 miles, (viii) 110 miles, (ix) 120 miles and (x) 130 miles.

Parties' submissions

5.86 The Parties argued that an average distance catchment area of all the sites of each provider by treatment should be used. They said that it was more robust to use the average of all their sites, because: each site has a limited amount of data due to low turnover of patients; the reliance on the CCG postcode instead of patient home address introduces uncertainty; and average figures better represent the customers' behaviour over time.[212] The Parties argued that the cautious approach employed at phase 1 was:

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

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

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

Capacity constraints

5.87 As discussed further in paragraphs 8.44 to 8.51 below, capacity constraints are a common feature of the market for rehabilitation services. A shortage of locally available supply means that customers may refer their patients to locations further away than their underlying preferences over distance would dictate. This means that regions with relatively abundant supply may receive patients from further away, who have been unable to find an available local bed in areas with relative supply shortages. For areas with supply shortages, notably the South West of England, customers provided substantially greater maximum typical distances to refer patients, sometimes of a hundred miles and above.[213]

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

[212] Merger Notice, paragraph 13.47.
[213] Devon Partnership NHS Trust, Avon and Wilshire NHS, Bath and North East Somerset.

constraints in adjoining areas. In these cases, it might be inappropriate to include competitors from these areas.

Our approach

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

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

(b) These areas will be smaller where there are many competitors within a smaller local area and customers would send patients to these competitors, even when they would be prepared to go to competitors located further away before accepting a price rise.[214]

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

5.90 The issues with average catchment areas are:

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

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

5.91 Customer evidence supports that out-of-area referrals due to limited bed availability are a common feature in rehabilitation services, as discussed in

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[214] Merger Assessment Guidelines, paragraph 5.3.2.

paragraph 7.16. In our view this is likely to cause catchment areas to be biased upwards in general. As a result, we were particularly concerned about the possibility that site-specific catchment areas would be biased by customers referring patients out-of-area because of limited bed availability, and because site-specific catchment areas would rely on small samples of patients. In our view this feature also meant that average catchment areas were likely to be biased upwards and that in areas with sufficient provision, competition would be likely to occur over a smaller area than the average catchment area.

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

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

(b) test sensitivities to the catchment area chosen by considering the implications of wider or narrower catchments;

(c) consider the possibility of catchments defined by specific customer preferences in our local competitive assessment;

(d) consider constraints from outside the catchment area in our local competitive assessments.

The appropriate distance for the average catchment area(s)

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

(a) the Parties' submissions; and

(b) our analysis of referral patterns.

Parties' submissions

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

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

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

5.97 To address the Parties' concern, for LTMH patients we considered the sensitivity of the catchment area to excluding patients that were admitted to the Parties' sites prior to 2014 but weighted by length of patient stay. We also tested the sensitivity of excluding patients admitted prior to 2015. The resulting average catchment areas are shown in Table 12 below.

Table 12: Weighting sensitivities

miles

	*Baseline**	*Excl. admissions† before 2014*	*Excl. admissions‡ before 2015*	*Unweighted*
Catchment area	[50-75]	[50-75]	[50-75]	[50-75]

Source: CMA calculations based on the referral data submitted by the Parties.
* Baseline weights referrals by the patient's length of stay.
† This column drops all admissions to the Parties' sites prior to 2014 from the data and weights referrals for the remaining patients by their length of stay.
‡ The third column drops all admissions to the Parties' sites prior to 2015 from the data and weights referrals for the remaining patients by their length of stay.
§ The catchment area has been calculated on the basis of all the Parties' sites offering LTMH rehabilitation services, excluding outlier sites (see paragraph 5.107). Catchment area is defined as the area within which 80% of patient funding falls.

5.98 Excluding patients admitted earlier than 2014 results in a catchment area of [50-75] miles when weighting by patient stay. Excluding patients that were admitted before 2015 results in a catchment area of [50-75] miles. Based on this analysis, we decided to use weighted data, but only including those patients admitted to the Parties' sites after 2014. We believe that this addresses the Parties' point that weighting by length of stay places greater weight on the locations of patients that were referred a number of years ago, whilst retaining a weighting approach, that we believe is more appropriate for the reasons set out above.

Analysis of referral patterns

5.99 To assess referral patterns, we aggregated the patients across all the Parties' PD and LTMH rehabilitation sites and ordered distances to the provider (using customer locations) from the least to the greatest to calculate percentiles, weighted by the patient's length of stay in the last three years. This is shown in Figures 12 to 16 below.

Figure 12: All patients

[✂]

Source: CMA calculation based on Parties' data.

5.100 As shown figure 12 above, for all patients:

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

(b) [60–70]% of patients come from within 45 miles;

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

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

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

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

(a) specialism and gender;

(b) provider; and

(c) site.

Delineation by specialism and gender

5.103 As shown in Figure 13, the catchment areas for male LTMH, female LTMH and female PD differ. Female PD has the widest catchment area with [80–90]% of patients coming from about 110 miles. [80–90]% of female LTMH patients come from a catchment area of about 90 miles and [80–90]% of male LTMH patients come from a catchment area of just above 60 miles.

Figure 13: Specialism split

Source: CMA calculation based on Parties' data.

Delineation by specialism, gender and provider

5.104 As illustrated in Figure 14 and Figure 15, the Parties have broadly similar catchment areas for similar proportions of their patients for male LTMH and female LTMH patients. This is consistent with the assumption that customers have underlying preferences based on quality and the approach to treatment of the service, not the identity of the provider.

Figure 14: Provider split, male LTMH

Source: CMA calculation based on Parties' data

Figure 15: Provider split, female LTMH

Source: CMA calculation based on Parties' data

5.105 Figure 16 shows that the referral distance for female PD patients is greater for Cygnet than for CAS. As discussed in paragraph 9.48 below, in our view this is to some extent a reflection of differences in the nature of the services offered by CAS and by Cygnet at these sites.

Figure 16: Provider split, female PD all areas

Source: CMA calculation based on Parties' data

Variation in catchment areas and exclusion of outliers

5.106 Table 13 below shows that there is considerable variation in site-specific catchment areas.

Table 13: Variation in catchment areas

CAS female LTMH		*CAS male LTMH*	
Aspen House	[75-100]	Oaks	[75-100]
Appletree	**[125-150]**	Churchill Hospital	[50-75]
Delfryn Lodge	[50-75]	Delfryn House	[75-100]
Raglan House	[25-50]	Saint Augustine's	[50-75]
Saint Teilo	**[125-150]**	Sedgleys	[25-50]
		Sherwood House	[50-75]
		Storthfield House	[50-75]
		The Fountains	[25-50]
		The Limes	[50-75]
		Victoria House	**[100-125]**
Cygnet female LTMH		*Cygnet male LTMH*	
Bury	[25-50]	**Brighouse**	**[100-125]**
Coventry	[50-75]	Derby	[50-75]
Kenton	75-100]	Lewisham	[50-75]
Kewstoke	**[125-150]**	Woking Lodge	[25-50]
Sheffield	[50-75]		

CAS female PD		*Cygnet female PD*	
Aspen Lodge	[75-100]	**Bierley**	**[150-175]**
Acer Clinic	[50-75]	**Coventry**	**[150-175]**
Alders	**[100-125]**	**Kewstoke**	**[125-150]**

Source: Parties' data

5.107 In areas where the evidence confirms that CCGs have limited options, several of the Parties' sites have particularly wide catchment areas (exceeding 110 miles):

(a) CAS St Teilo and Cygnet Kewstoke (The Lodge) for example, located in South Wales and the South West of England, where we understand there to be limited supply, have catchment areas of [125-150] and [125-150] miles respectively.[215]

(b) CAS Appletree in Durham and CAS Victoria House in Darlington have catchment areas of [125-150] miles and [100-125] miles, consistent with there being limited bed availability in the North East. We note that the only other hospital offering LTMH rehabilitation services to female patients within 60 miles is Priory Hospital Middleton St George.[216]

(c) We also note that a number of the Parties' sites offering PD rehabilitation services for female patients, namely CAS Alders, Cygnet Kewstoke (Knightstone) and Cygnet Bierley have catchment areas above 100 miles. This is consistent with our understanding that there is limited provision of PD

[215] For example, [✂] believe there is a lack of local supply in the area for female LTMH patients.
[216] According to the data set originally submitted to us by the Parties.

services across the country. For example, Priory stated that it believed there to be an under provision of treatment for PD nationally.

5.108 In our view, average catchment areas may be biased by the inclusion of these outliers. We therefore calculated separate average catchment areas for LTMH and excluded these outliers from our calculations. We have not excluded outliers from our average catchment calculation for PD for the reasons given below in paragraph 5.110.

5.109 For LTMH we excluded the following CAS and Cygnet sites with catchment areas of greater than 100 miles: CAS St. Teilo, Cygnet Kewstoke (The Lodge), CAS Appletree, CAS Victoria House and Cygnet Brighouse.[217] Exclusion of these outliers results in an 80% catchment area[218] of 60 miles for male LTMH and 60 miles for female LTMH.

5.110 For PD, the average 80% catchment area is [100-125] miles. In our view this distance is likely to reflect the limited provision of PD services across the country. We also note that there is considerable variation in the site-specific catchment areas in PD. In our view, this is likely to reflect variation in the availability of these services in different areas. However, given the small number of the Parties' PD sites, we did not consider it appropriate to follow a similar approach of excluding outliers in PD. Instead, we initially applied the LTMH average 80% catchment area (excluding outliers) to PD overlaps, as evidence did not suggest that customer preferences were different for PD patients. We recognise that this approach is likely to be cautious.

Sensitivities to account for local transport infrastructure

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

[217] Although there are a number of male LTMH providers in the area surrounding Cygnet Brighouse, we note that the catchment area for Cygnet Brighouse is greater than 100 miles and that this is driven by several patients who have been referred from a very long distance. The area within which 80% of patient funding for Brighouse falls from [100-125] miles down to [75-100] miles if three referrals from 270 to 300 miles away are dropped from the sample. Given such anomalies for the referral patterns for Brighouse we have considered it would be more appropriate to exclude it from the analysis.
[218] The area within which 80% of patient funding for Brighouse falls from [100-125] miles down to [75-100] miles if three referrals from 270 to 300 miles away are dropped from the sample. Given such anomalies for the referral patterns for Brighouse we have considered it would be more appropriate to exclude it from the analysis.

5.112 The Parties' referral patterns for sites in London show that a [✂] share of their referrals come from [✂] catchment areas measured in miles of road distance.

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

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

Conclusion on the geographic market

5.115 On the basis of the evidence above, we adopted a catchment area of 60 miles, as this corresponded to the average catchment area for male LTMH and female LTMH after excluding outlier sites (ie sites with catchment areas beyond 100 miles). We applied this catchment area to both LTMH and PD overlaps. We recognised that for PD this approach is likely to be cautious.

5.116 We considered the possibility that the providers may be competing over larger distances in areas with limited bed availability. Where the nearest overlap between the Parties is at a greater distance than the average catchment area, we increased the size of the catchment area to capture the possibility that the Parties and other providers may be competing over this greater distance. We then considered the extent to which competition occurred at this greater distance in our local competitive assessments.

5.117 Where relevant in our local competitive assessments, we also tested sensitivities to the catchment area chosen by considering the implications of wider or narrower catchments and the possibility of catchments defined by specific customer preferences. For overlaps in the London area we applied the sensitivity as described in paragraph 5.111 to 5.114 above.

6. Counterfactual

6.1 To assess the effects of the Merger on competition we need to consider what would have been the competitive situation without the Merger. This is called the 'counterfactual'.[219]

6.2 The counterfactual is an analytical tool used to help answer the question of whether the Merger has or may be expected to result in an SLC.[220] It does this by providing the basis for a comparison of the competitive situation with the Merger against the likely future competitive situation absent the Merger.[221] The CMA's approach to the counterfactual is set out in our Merger Assessment Guidelines.[222]

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

The Parties' view

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

Our assessment

6.5 Although Cambian's board had been reviewing the company's strategic options in light of the need to repay debt[223] (in September 2017), as well as the wider business situation faced by the company, there was no risk of financial failure. In its 2015 Annual Report, Cambian emphasised that 'despite the challenges we faced, we should not lose sight of the fact that Cambian remains fundamentally a good business with a strong value proposition for its customers.'[224]

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

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[219] Merger Assessment Guidelines, paragraph 4.3.1.
[220] Merger Assessment Guidelines, paragraph 4.3.1.
[221] Merger Assessment Guidelines, paragraphs 4.3.1 & 4.3.6
[222] Merger Assessment Guidelines, Section 4.3.
[223] See Appendix D for details.
[224] Cambian 2015 Annual Report and Accounts, 29 April 2016, p7.

6.7 The Merger involved a two-stage sale process.[225] There were [✂] bidders in the first stage with [✂] progressing to the second stage. Some bidders were private equity firms and could be expected to address the financial constraints that Cambian was facing. However, the extent to which any improvements in performance would arise following a purchase from such a bidder is by its nature speculative and uncertain.

Conclusion on the counterfactual

6.8 We found that given the interest from potential purchasers revealed by the sale process, the most likely scenario is that CAS would have been sold to another well-capitalised bidder and would have remained in the market, but without the financial constraints that Cambian was facing. Accordingly, we conclude that the appropriate counterfactual is that the conditions of competition would be broadly similar to those prevailing at the time of the Merger.

7. Customer behaviour and choice of facility

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

7.2 There are numerous types of mental healthcare providers and settings, from domiciliary care in the community to high security hospitals. Patients will typically first receive treatment in acute settings before moving on to rehabilitation services and then to community based care.[226] This is referred to as the 'care pathway'. While acute services[227] are most commonly provided by NHS trusts or foundation trusts, some are provided by independent sector providers, including Cygnet.

Customer Choice

7.3 In this market, unlike some other healthcare sectors, the patient is rarely in a position to decide where they would like to be treated. Therefore, CCGs fulfil

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[225] See Appendix D.
[226] [✂]% of Cygnet's LTMH patients and [✂]% of its PD patients are stepping down from other services (the remainder is either 'moving sideways' from other rehabilitation services, for example to move closer to family, or 'moving up' from community services). A very small proportion, only [✂]%, of patients are admitted directly to rehabilitation services from their home or usual place of residence.
[227] Acute psychiatric services are provided to patients in mental health crisis who require short-term admissions of around three to six weeks (compared with between 12 months and three years for rehabilitation services). As defined in Appendix C, paragraph 13.

the role of customers, making decisions as to where patients should be referred.

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

(a) **Clinical needs established**: Once a patient has been admitted into the 'care pathway', under the NHS Care Programme Approach (CPA), care co-ordinators[228] employed by the NHS trust concerned will assess, plan, co-ordinate and review their needs. Patients referred to rehabilitation services tend to be 'existing patients' (already resident in a mental health facility) rather than 'new patients' (not currently resident in a mental health facility). Care co-ordinators may recommend a move to a rehabilitation services site where a patient:[229]

(i) is ready to 'step-down' from secure services to rehabilitation services;[230]

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

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

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

(b) '**Initial contact with several potential providers**: When a decision is made to move the patient to rehabilitation services, the customer will contact several potential providers' sites (referrals are made to specific sites). If the customer has not decided on the exact treatment approach for a patient, they may approach a range of different providers offering different types of rehabilitation services. The Parties told us that customers would generally approach at least three providers, but this may vary.'[231]

(c) '**Provider assessment**: Providers will then assess the patient's clinical needs and the suitability of their facility to treat them, inform the customer and if relevant submit a treatment plan for the patient plus key commercial

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[228] CPA care co-ordinators are usually nurses, social workers or occupational therapists.
[229] But as noted below in (b) it is the customer who makes the decision to which provider the patient is referred.
[230] The impact on competition of possible links along the 'care pathway' is considered in more detail in paragraph 7.2 above and below at paragraph 7.7 onwards.
[231] Customers told us that they often don't approach multiple providers in practice, either because there are limited options available or because they already have a good idea of the single best option for the patient.

terms (which will tend to have been pre-negotiated with the customer). Cygnet rejects on average [✂]% of patients that it assesses, and in 2016, [✂]% of patients were rejected by CAS. This is usually because the services available at the relevant site are not appropriate for the patient, or not appropriate for them at that time given the incumbent patient mix.[232] Customers may then seek additional proposals from alternative providers if they haven't received as many responses as they would have liked.'

(d) '**Customer funding decision**: A funding panel (comprising clinical and non-clinical staff) will consider the provider offers. The panel may take into account the suitability of the treatment for the patient, its cost, location and in most cases the patient's preferences.[233] The funding panel may take some time to reach a decision for a particular patient as they tend not to meet frequently. On average, it takes [✂] days for CAS rehabilitation patients to get through the funding panel[234] (i.e. to receive final approval, which includes the resolution of any queries from the funding panel).'

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

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

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

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

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

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

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[232] In circumstances in which the Parties are not able to admit a patient to a particular site requested by a customer, if suitable, they may offer a place at an alternative site. Some customers will consider such an alternative proposal, although examples of this are not common.
[233] We note that some customers have told us that in general they would not account for patient preferences.
[234] This does not include the duration of the previous steps.

Choice of facility when moving along the 'care pathway'

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

7.8 The Parties submitted that a move along the care pathway triggers a change in a patient's funding. Such changes need to be approved by customers (see 8.1(d) 7.4(d)) and as such result in the re-opening of competition between providers for a patient. This has been confirmed by customers,[235] who have told us that all patient referral decisions are treated independently, regardless of where the patient is currently receiving care.

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

7.10 In our view, this suggests that the decision to refer a patient in rehabilitation services can in general be treated independently of the provider's position on other parts of the care pathway. Our approach to the local competitive assessment considers the possibility of any exceptions to this on a case-by-case basis.

Factors affecting customer choice

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

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

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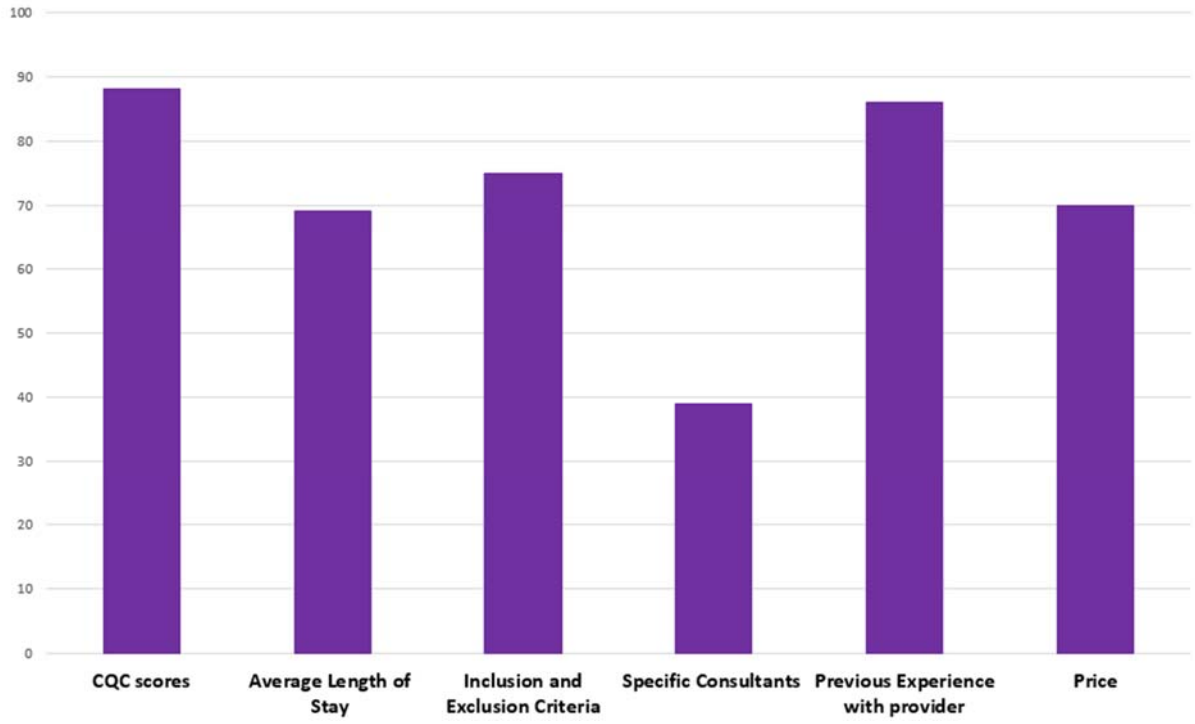
[235] [✂]

7.13 Customers were asked to rate the importance (out of 100) of six factors that may impact their decision-making. These factors were: CQC quality scores; the average length of previous patient stay;[236] the hospital's inclusion and exclusion criteria;[237] the specific consultant or consultants at the hospital; their experience of previous placements with the provider; and the price charged for services.[238] The aggregate results are shown below in Figure 17.

Figure 17: Customer decision-making factors



Source: Response to CMA customer questionnaire.

7.14 As can be seen, CQC ratings and previous experience with providers are the key drivers of customer behaviour. Customers indicated that they focus on providing the best possible outcomes for their patients. Both CQC ratings and previous experience are comprised of a range of underlying quality factors for example; Birmingham CrossCity CCG told us "We will always have a look in the CQC report and take a guidance of that. Each time we

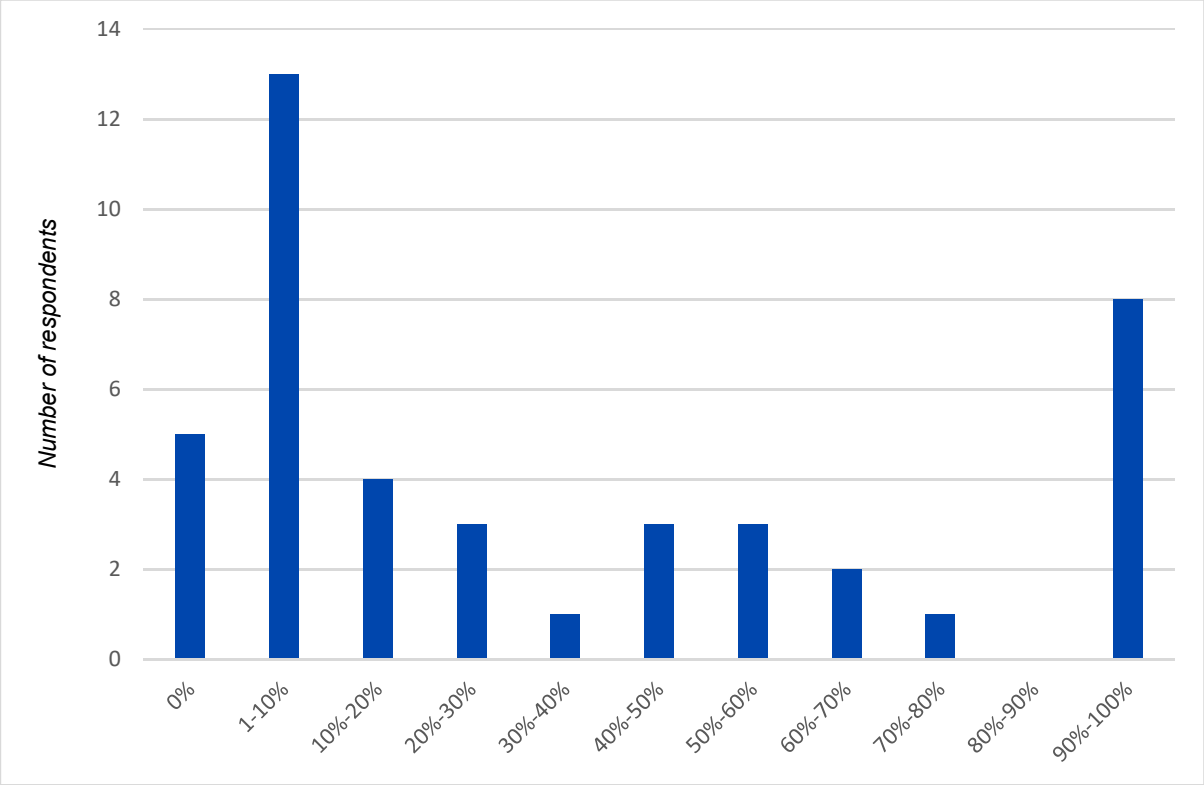
[236] Measured by the Parties for every patient from entry to a facility, until discharge. Other things being equal, customers prefer shorter lengths of stay as this implies the patient has recovered more quickly. Expectations for length of stay may vary for different types of patients. What matters to customers is length of stay relative to expectations.
[237] These refer to the specification of characteristics of the types of patients that the hospital would admit and the types of patients that the hospital would not admit. For example, a hospital might exclude patients who demonstrated certain challenging behaviours.
[238] An example of the importance of these quality factors was given by NHS Redditch and Bromsgrove, NHS South Worcestershire and NHS Wyre Forest CCGs when asked to provide comment on their expectations of a new site operator as part of our remedies consultation "We would have significant concerns should the sale result in a change of clinical staff or management within these units, and would expect the current standard of length of stay and clinical outcomes to be maintained."

visit we bring back intelligence in terms of the facility and we will embargo providers if we are not happy about their record clinically, or something has happened there safeguarding, so we will not use them during those periods."

7.15 Price, whilst important (a score of 70), is less important than quality as shown in Figure 17 above. Price was commonly viewed as secondary decision making factor. A typical example of this was given by Surrey and Borders NHS Foundation Trust in response to a question about how they weigh up quality and price; they stated 'It is the outcomes, predominantly; of course, value for money becomes part of that. We are, predominantly, driven by the outcomes and what that provider would give in terms of that.'

7.16 As discussed in paragraph 5.69 to 5.75, location is an important choice factor for customers, with most having a preference to refer patients within their local area. However, customers are willing to refer a proportion of their patients to sites outside their area, particularly when there is a lack of beds locally, as shown in Figure 18 below.

Figure 18: At any one time, approximately what proportion of all patients requiring inpatient LTMH or PD rehabilitation services have been sent 'out-of-area' as a result of limited bed availability? Please give your answer as a percentage.



Source: Response to CMA customer questionnaire.

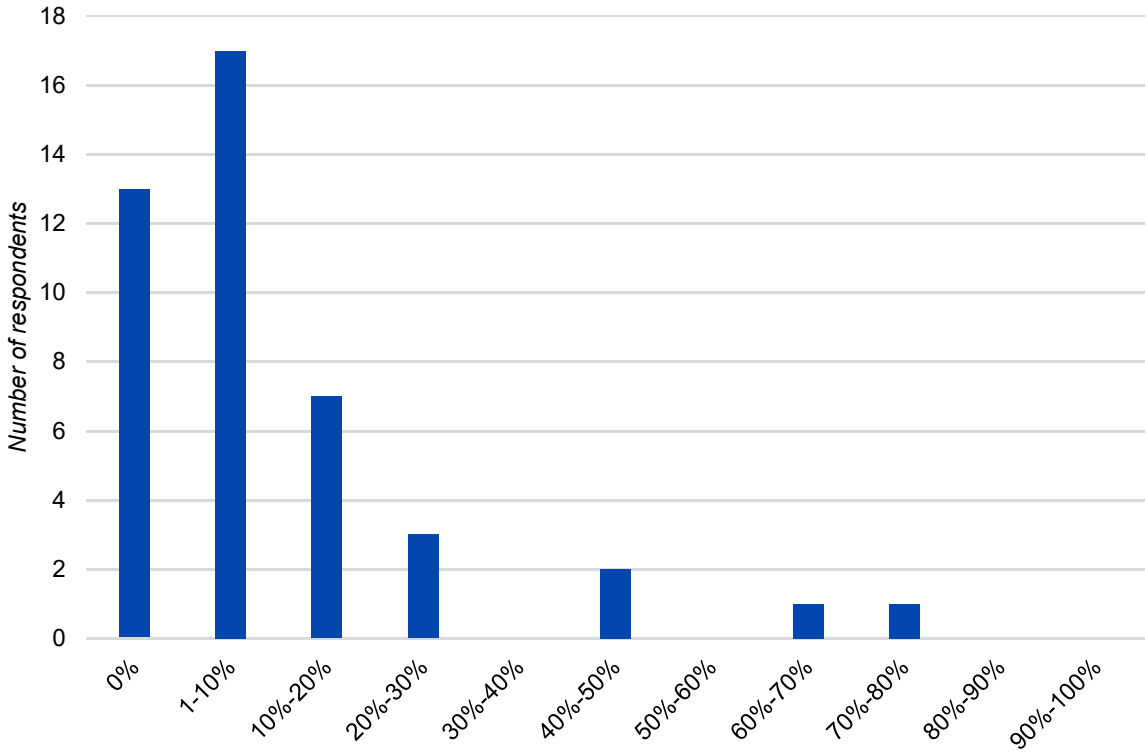
7.17 Eight out of the 43 customers that responded to this question suggested that they sent all their patients out-of-area. In our view this proportion seems high and may reflect that some respondents interpreted the question differently.

However, we note that some of the customers are in more remote areas of England where there may be very little or no appropriate local supply or availability.[239]

7.18 The Parties submitted that [✂].

7.19 Customers told us that in general they do not like to delay referrals as acute or secure wards (from which most rehabilitation patients step-down) are often full and they need to free up capacity there as quickly as possible. [240] Moreover, customers told us they were keen to avoid patients being in facilities that were no longer appropriate for their diagnosis or position on the care pathway, as it could harm their recovery and progress.

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



Source: Response to CMA customer questionnaire.

Conclusion on customer behaviour

7.20 Customers focus on quality and geographic locality when making their referral decisions. The ability to find quality hospitals in close geographic proximity can be impacted by a lack of capacity. The ability of customers to

[239] [✂]
[240] [✂]

delay referrals does not substantially affect this. Price is also important but less important than quality.

8. The nature of pre-Merger competition

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

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

Parties' contractual arrangements

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

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

(a) pre-negotiated agreements for rehabilitation services, often procured through a tendering process and based on the NHS Standard Contract;[241] and

(b) locally developed SLAs.[242]

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

8.6 In the previous 12 months, Cygnet derived [✂]% of its revenues[243] from pre-negotiated agreements. In contrast, in April and May 2017,[244] CAS derived [✂]% of its revenues from pre-negotiated agreements.

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[241] [✂]
[242] SLAs refer to a written agreement between a provider and the customer setting out the range and level of services to be provided, the responsibilities and priorities and the fees. See also Section 2, paragraph 2.57.
[243] [✂]% of customers had pre-negotiated SLAs/ contracts in place.
[244] CAS was not able to provide directly comparable data.

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

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

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

8.8 The Parties indicated that all SLAs have a one-year term and that longer-term NHS Standard Contracts under a framework agreement have an annual pricing review. Annual reviews take place on 1 April with pricing proposals circulated in/around January. These proposals are followed by a series of negotiations.

8.9 The NHS Standard Contract contains standard terms, which can only be varied centrally by the NHS. Similarly, terms cannot be changed during the life of the contract, which is usually one year, but can be up to three. When formulating these contracts, providers will be asked to provide CQC certificates, NHSI licences, insurance certificates, the information governance assessment report, and relevant operational policies and procedures.[245]

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

Competition on quality

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

[245] See also Section 2, paragraph 2.34 and Appendix B for more information on contracting.

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

(a) readmission rates;

(b) length of stay;[246]

(c) CQC scores;

(d) inclusion/exclusion criteria;

(e) staff training;[247]

(f) specialist treatments offered;

(g) equipment/facilities;

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

(i) ratios of permanent to temporary staff;

(j) incident and complaint levels; and

(k) levels of patient attendance at therapy.

8.13 The Parties told us that CQC reports and ratings constitute a particularly key measure of quality from a provider's perspective. CQC reports are based on inspections by CQC staff, which rate individual sites against pre-set scoring criteria.[248]

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

8.15 CQC inspections generally take place on a set schedule, and therefore it is usually necessary to wait for the next review (which can be up to two years

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[246] Measured by the Parties for every patient from entry to a facility, until discharge. Other things being equal, customers prefer shorter lengths of stay as this implies the patient has recovered more quickly. Expectations for length of stay may vary for different types of patients. What matters to customers is length of stay relative to expectations.
[247] Measured and monitored in several ways, including staff spend per head, on an annual basis.
[248] Further information provided on CQC report in regulatory bodies section, paragraphs 2.8 and 2.15 to 2.18.

later) for a rating to be updated. However, occasionally inspectors are willing to review a site sooner if an action plan has been implemented quickly and effectively.

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

(a) length of stay,[249] and details of overall outcomes;

(b) staffing summaries;[250]

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

(d) details of CQC inspections and updates.

Internal documents

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

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

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

Evidence from third parties

8.20 As outlined above, customers rely on information contained within CQC reports, their own assessments and previous experience of providers in assessing quality. Customers told us that, resources permitting, they would

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[249] For both current and completed episodes, and on the basis of planned admissions and emergency admissions.
[250] Including vacancies; clinical supervision; staff sickness levels; agency worker usage/overtime; staff annual safeguarding training; and details of statutory and mandatory training.

typically send nurses to carry out inspections of potential providers periodically and sometimes for specific patients.

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

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

(a) [✂]

(b) [✂]

(c) [✂]

Our assessment

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

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

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

Competition on price

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

8.27 The Parties told us that [✂].

8.28 [✂] [251]

8.29 [✂]

Evidence from the Parties

8.30 We have been unable to compare prices for the Parties in a systematic way controlling for the multiple factors that affect prices.[252] However, we found that the data and internal pricing documents provided by the Parties [✂].

8.31 Table 14 shows [✂].

8.32 [✂]

Table 14: [✂]

[✂]

Source: [✂]
* [✂].
† [✂]
‡ [✂]
§ [✂]

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

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

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

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

(a) [✂]

(b) [✂]

8.37 CAS [✂] their price for PD services by [✂]% between 2015 and 2017. CAS stated that this was due to their initial [✂].In our view, this suggests that providers of rehabilitation services may have the ability to materially change prices without losing customers.

[251] [✂]
[252] Including the Parties' costs and volume of patient referrals by customer.

Evidence from third parties

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

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

8.40 One customer[253] indicated that it believed that previous mergers had led to consolidation in the market, which has in turn affected price and choice in their area.

Our assessment

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

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

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

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[253] [✂]

Capacity constraints

8.44 Providers of rehabilitation services have a limited number of beds in each ward. Capacity is constrained where the demand for a provider's beds exceeds the number of beds it has available. Capacity constraints can be identified by looking at the occupancy rate. If occupancy is at or close to 100% then the provider is capacity constrained.[254]

8.45 Whether providers have an incentive and the ability to compete will in part depend on whether they have, or can create, sufficient capacity to treat additional patients.[255] If providers are capacity constrained, they may not be able to take new patients. This will limit the competitive constraint they impose at least in the short term.

Evidence from the Parties

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

Table 15: Parties' average occupancy for rehabilitation services

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

Source: Parties

8.47 Table 15 shows that on average the Parties' are operating [✂].

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

Evidence from third parties

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

[254] Given that patients in rehabilitation wards will have their own rooms, in general it is not possible for providers to flex the numbers of beds in a ward to meet additional demand.
[255] Or to seek to maintain existing patient volumes in the face of competitive pressures from other providers.

customer questionnaire, as set out in Section 7, also indicated that bed availability was a key factor affecting choice.

Our assessment

8.50 In the event of a price rise or reduction in quality by a provider, the extent to which a customer will be able to refer to an alternative ward is determined by bed availability in that ward. The likelihood of bed availability at a given provider's ward will depend primarily on the provider's total number of beds:[256] as the more beds a provider has, the more likely one is to be available at a given time. In our view, this supports focusing on share of beds as a primary indicator of the competitive constraint imposed by each provider.

8.51 We considered the extent to which capacity constraints may limit the competitive constraint imposed by providers that are operating at very high levels of occupancy. In our view the extent to which capacity constraints reduce competition is limited for the following reasons:

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

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

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

[256] It will also depend on the length of stay of the patients.

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

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

Competition on entry and expansion

Evidence from the Parties

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

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

(a) [✂]

(b) [✂]

(i) 'Curocare: [✂]

(ii) 'Nuovita: [✂]

(iii) 'PIC Kneesworth: [✂]

(iv) 'Glencare: [✂]

(c) [✂]

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

(a) produced an estimate of [✂];

(b) analysed how [✂]; and

(c) [✂]

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

Our assessment

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

Conclusion on pre-Merger competition

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

8.58 We found evidence that each of the Parties will focus on the quality of their facilities and have taken action aimed at improving quality at a local level. The Parties will market these quality improvements to customers. Evidence showed that customers are responsive to changes in quality, which can lead to a significant change in their referral patterns. Parties and competitors agreed that quality is an important factor and that it can influence demand for a service.

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

8.60 In our view, the number of beds in a provider's ward will be indicative of the competitive constraint imposed by that ward on other providers, as reflected in market shares. This is because the extent to which a customer will be able to refer to an alternative ward suitable for a patient is determined by the number of beds in that ward and whether they are available.

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

Framework for analysing competitive parameters in local areas

9.1 In this section, we:

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

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

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

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

Approach to identifying potentially problematic local overlaps

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

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

9.4 We then looked in detail at the areas that failed the filter further examining maps of the areas, considering in detail more granular features such as those set out in Section 8 above in order to decide whether the Merger may be expected to result in an SLC in any given local overlap area.

Initial filters to identify potentially problematic local overlaps

9.5 The first stage in our approach was to identify a mechanistic rule which could filter out unproblematic areas. We filtered on the basis of the Parties' combined share of beds within the 60-mile catchment area[257] around each of their sites.

[257] The reasoning behind the 60-mile geographic area is set out in paragraphs 5.82–5.115.

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

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

9.8 As discussed in paragraph 5.114, for sites in London we used public transport travel times as well as drive times in our filtering, as we believe this more appropriately reflected the convenience and time taken to travel in this area. The Cygnet Woking, Cygnet Lewisham and CAS Churchill sites were identified for further analysis based on a filter using public transport travel times of 90 minutes. In addition, all three sites were identified for further analysis by the sensitivity checks using the 40% combined market shares filter threshold on 60-minute drive-time.

9.9 At the filtering stage, we excluded NHS hospitals, wards providing treatments to the opposite gender and treatments to patients with a different primary diagnosis.[258] We then assessed these competitors in more detail in our local assessments.

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

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

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

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

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

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

(a) **Yorkshire and the 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 The 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 Storthfield House, CAS Sherwood House, CAS The Limes, Cygnet Derby.

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

Methodology for further analysis in areas identified by the initial filter

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

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

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

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

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

(e) Customer evidence: on closeness of competition and whether there are customers that are concerned about the effect of the Merger.[259]

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

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

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

Market shares

9.14 In our view, as set out in Section 8, the number of beds in a provider's ward will be reflective of the competitive constraint imposed by that ward on the Parties. As a result, we have focused our assessment primarily on the combined market share (of beds) of the Parties and the increment resulting from the Merger. In our view, this is a key indicator of the competitive constraints that the Parties impose on each other relative to other providers.

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

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

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[259] Unlike physical health care referrals where we have access to Hospital Episode Statistics and data on GP referrals, there are not official consolidated records of mental health care patient referrals. We have therefore needed to rely on evidence from customers to a greater extent than in other healthcare mergers.

9.17 In addition, to calculate bed numbers for combined treatment or mixed gender wards, we sought information from providers on the current allocation of patients by specialism and/or by gender on that ward and their ability to flex this allocation. Where this information was available, we have assumed that the current allocation is reflective of the bed numbers typically available to each treatment or gender.[260] Where this information was not available, we used assumptions to allocate patients by gender[261] or treatment type.[262]

9.18 The Parties submitted that male patients with a primary diagnosis of PD typically exhibit very violent behaviour to others and that most male PD patients are either in prison or in a secure hospital environment.[263] The Parties have therefore argued that to the extent that the CMA has identified combined LTMH/PD sites for male patients, these are likely to be LTMH-only sites. We tested the sensitivity of our results by adjusting the bed allocation of such sites as per the Parties' suggestion. Where relevant, we also considered the sensitivity of the resulting allocations to reflect the possibility that providers may be able to flex the current allocation.

Occupancy

9.19 We considered the occupancy of providers within the overlap areas to assess whether they may face capacity constraints.

9.20 We asked providers in the competitor set for data on average occupancy over the past three years and calculated their respective average occupancy rates. We also considered the occupancy for the most recent year (2016) and the year the site opened to account for cases where the ward has recently opened and therefore may not yet have reached mature occupancy. These data are shown in Appendix E.

9.21 We acknowledge that the Parties and other providers face capacity constraints in some local areas and that this will limit the competitive constraint they impose on each other in these local areas to some extent. Nevertheless, we believe that there is scope for the Parties to accommodate additional patients in these local areas for the reasons we have given in paragraph 8.51 above, such that incentives exist to attract additional patient

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[260] We focused gathering this evidence particularly in the East Midlands and West Midlands where we provisionally found that the Merger may be expected to result in an SLC in our provisional findings, in order to eliminate the use of assumptions in these areas.
[261] We have assumed a 65:35 allocation between male and female patients. See paragraph 5.29.
[262] We have assumed a 50:50 allocation between PD and LTMH.
[263] Parties' Response to the Local Assessment Working paper paragraph 6.24.

referrals. Further, in some local areas, the Parties have spare capacity and in these local areas they have incentives to attract additional patients.

Geographic differentiation

9.22 In the initial filter, we calculated shares of capacity in the 60-mile catchment area around each site. This catchment area is an average approximation of the size of the geographic market. As discussed in paragraphs 5.89-5.90, the actual geographic market may vary from area to area to some extent, largely depending on the behaviour of the customers in that area.

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

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

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

(b) Tested the sensitivity of our results to extending the catchment area to 65 miles to take into account the competition that the Parties' sites face from sites located just outside the catchment area. Where this made a substantial difference to market shares this indicates that the Parties may face competition from outside the catchment area and we should be less concerned at a given market share level. This is particularly relevant where the Parties' sites are distant from one another.

(c) When we have received evidence from customers or other providers that the Parties' sites compete with facilities that do not fall within the 60-mile catchment area and are not captured by our sensitivity test of extending

the catchment area to 65 miles, we sought to verify whether these sites pose a competitive constraint on the Parties and whether we should therefore include them in our relevant competitor set.

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

Competition over quality

9.25 As discussed above, CQC ratings are a widely-accepted measure of quality in the mental healthcare sector. The CQC has a four-point rating scale for assessing hospitals or wards;[264] Outstanding, Good, Requires Improvement,[265] and Inadequate.[266] We understand that many customers are not likely to refer patients to wards rated as 'Inadequate', and as such we consider these wards to impose a limited constraint on the Parties. Therefore, we calculated market shares excluding wards rated as 'Inadequate'.[267]

9.26 The Parties have confirmed that in their experience, an 'Inadequate' CQC rating is likely to result in some customers referring some patients to alternative sites. However, the Parties also said that it is not the case that customers will stop referring patients to an 'Inadequate' site. Additionally, the Parties emphasised that an 'Inadequate' site will not remain 'Inadequate' indefinitely and cited the example of Cygnet Hospital Taunton which received such a rating in February 2016 but its rating improved to 'Good' in July 2017.

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

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[264] See also Section 2, paragraph 2.7 and Appendix B for more detail.
[265] The service isn't performing as well as it should and we have told the service how it must improve.
[266] The service is performing badly and we've taken action against the person or organisation that runs it.
[267] We note that there is only one female PD site with 'Inadequate' CQC rating in the areas of interest, namely The Retreat, York. The Parties submitted that the latest CQC inspection of the Retreat York focused on the older adult wards and will therefore not have an impact on PD referrals. We note however that including or excluding this site will not affect our results.

9.28 We compared the 2016 average occupancy rates in hospitals rated as Requires Improvement, Good or Outstanding.[268] When CQC ratings were not included in information received from providers, we sourced them from the CQC website and database.[269] However, in some cases we have only the overall hospital rating as opposed to the ward-specific rating. In these cases, the CQC rating may not be as good an indicator of quality. We have not been able to identify the CQC ratings of all the sites in the database of mental healthcare facilities provided to us by the Parties. This is the case for sites that have been archived by the CQC either because they no longer operate or because their ownership has changed to another provider.[270] For these reasons we interpreted the results of this comparison with some caution.

9.29 We found that hospitals rated as Good have an average occupancy of 83%, while hospitals rated as Requires Improvement have an average occupancy of 75%. We note that some of the CQC ratings were published after the period for which we have occupancy information.[271] It is therefore not possible to interpret this as an analysis of the effect of a change in CQC rating on occupancy. Rather, we have interpreted this analysis as showing a weak relationship between CQC rating and occupancy. In our view, this analysis supports the use of CQC ratings as a proxy for quality.

9.30 On the basis of the evidence above, we have used CQC ratings as a proxy for providers' quality in our analysis.

9.31 To investigate what impact a change in rating might have on occupancy over the following months, we looked at how occupancy was affected at a sample[272] of the Parties' sites in the months following them receiving a Requires Improvement rating.[273] We did not find evidence that a Requires Improvement rating had a significant effect on occupancy at these sites,[274] though we did not put much weight on this analysis due to the small sample

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[268] This analysis used average occupancy information provided to the CMA by Active Pathways, Active Futures, Barchester, CAS, Cygnet, Elysium, Lighthouse, Priory, Sherwood Lodge, St Andrew's, Vision Healthcare and Whitepost. The latest CQC ratings for the sites in the sample were supplied by the providers or sourced from the CQC website.
[269] 7 July 2017
[270] In addition, we have not obtained the respective information for sites that are subject to the HIW in Wales as these are not published.
[271] Many CQC ratings were dated in 2017 or late 2016.
[272] This analysis relied on four wards: three Cygnet wards [✂], as well as one CAS ward: [✂].
[273] For this analysis, we were restricted to using Cygnet and CAS sites as they were the only providers for whom we had the necessary monthly data.
[274] Two of the wards had a [✂] increase in occupancy nine months after being given a rating of requires improvement rating [✂], one had [✂] change in occupancy [✂] and one had a [✂] decrease [✂]. It should be noted that CAS [✂] rating was improved to 'Good' within the nine-month period after receiving a 'Requires Improvement' rating.

size, the short time period considered and the fact that we did not account for other factors which may influence occupancy.

9.32 We considered the pattern of CQC ratings alongside occupancy in each of the local areas in our assessment of closeness of competition. Where we found that many of the Parties' competitors had Requires Improvement ratings and lower occupancy, this suggested that these competitors are likely to impose a weaker constraint, such that concerns may exist at a lower level of combined market share. We also took into account the possibility of a reduced competitive constraint from providers which did not have lower occupancy but do have worse CQC ratings than other providers.

Third party evidence

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

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

Local competitive assessments

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

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

Female PD

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

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

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

9.38 These sites were identified as requiring further analysis by our filter on the basis of the Parties having greater than 40% combined market shares following the Merger on a 60-mile basis [80–90]% for the South West overlap and [40–50]% for the Yorkshire and the Humber overlap). These market shares are shown in Table 16 and Table 17 below. However, given our assessment in the following paragraphs that the Parties do not compete closely, in our view these market shares are not meaningful.

Table 16: Market shares for female PD in Yorkshire and the Humber

	Base-case 60 miles
CAS	[40–50]
Cygnet	[10–20]
Combined	**[40–50]**
Priory	[5–10]
Heathcotes Group	[10–20]
Lighthouse	[5–10]
Inmind	[10–20]

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

Table 17: Market shares for female PD in South West England and South Wales

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

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

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

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

Closeness of competition

The Parties' submissions

9.41 The Parties submitted that the key differences between the Cygnet and CAS wards are:[275]

(a) 'All of the Cygnet PD sites provide services to the Tier 4 level of PD service specification[276] and accept patients with the highest level of challenging behaviour and risk. The CQC reports for CAS Alders Clinic and CAS Aspen Clinic make clear that both are Tier 3 PD services.'

(b) 'The NHSE service specification document describes Tier 4 PD services as providing: 'specialist and intensive provision beyond that which can be provided within either local specialist (Tier 3 PD) services or other local mental health services including acute inpatient facilities.' However, it also highlights the complementary nature of Tier 3 and Tier 4 services.

(c) 'The Cygnet PD wards operate within a semi-secure hospital environment, as both of the relevant hospitals operate low secure and PICU wards, which enables them to accept service users that have higher levels of risk.'

(d) 'The Cygnet PD wards offer intense and specialist PD treatment programmes for acutely unwell patients which run all day, for all groups of service users. Less specialised wards, [✂], do not have the staff qualified to provide full time DBT treatment.'[277]

(e) 'There is a [✂]at the more specialist Cygnet PD facilities, which is reflected in patients receiving a higher proportion of nursing and therapy hours.'

[275] Parties' response to the phase 1 decision, paragraph 1.34.
[276] As discussed in paragraph 2.6(d)
[277] DBT refers to dialectical behavioural therapy, a type of talking therapy mainly used to treat problems associated with borderline personality disorder. It has also been used more recently to treat a number of other different types of mental health problems.

(f) ‘Due to the acuity of patients and the intensity of the treatment programme at Cygnet’s PD wards, the length of stay is shorter and the price is higher.’

(g) [✂]

(h) [✂]

9.42 As a result, the Parties submitted that, whilst CAS and Cygnet both treat female patients with PD, they are treating patients with very different levels of risk, and at different stages of the care pathway. It would be clinically inappropriate to refer patients requiring the level of treatment at the Cygnet services to the CAS facilities and Cygnet’s facilities would be clinically unsuitable settings for patients who do not require the level of treatment offered at these facilities.

Our assessment of the Parties’ submissions

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

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

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

9.46 With respect to differences in the average length of stay between Cygnet and CAS wards, the evidence is mixed. We did not find that the average length of stay at Kewstoke (Knightstone ward) differed materially from CAS Alders. Both had an average length of stay of [✂] years. The average length

of stay at Cygnet Bierley is [✂] years while for CAS Aspen it is [✂] years.[278] In our view, this evidence supports the Parties' submission, that differentiation between the Parties is reflected in [✂].

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

9.48 As set out in Table 10, we note that the 80% catchment areas of Cygnet's PD sites are consistently substantially greater than the 80% catchment areas of CAS' PD sites.[279] In our view this is consistent with the Parties' submission that this may reflect the specialist nature of the services provided by Cygnet.

Impact study of the Parties' PD sites

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

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

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

9.50 In the case of CAS Alders, the Parties provided a chart showing the average monthly occupancy at Knightstone Ward and CAS Alders before and after CAS Alders opened. This chart showed [✂] of the opening of CAS Alders on the occupancy at Knightstone ward, which remained [✂] for the entire period.[280] Similarly, the Parties submission showed that the opening of CAS Alders did not have [✂]on the average daily rate charged at Knightstone Ward. The Parties said that if there is competition between CAS Alders Clinic and Knightstone Ward at Cygnet Hospital Kewstoke, it would be evident from an analysis of occupancy rates and daily rates charged at

[278] We did not include CAS Acer in this comparison as its wards have recently opened. The first ward opened in June 2015 and the second in March 2017.
[279] The catchment areas are CAS Aspen Lodge ([75-100] miles), CAS Acer Clinic ([50-75] miles), CAS Alders ([100-125] miles), Cygnet Bierley ([150-175] miles), Cygnet Coventry ([150-175] miles) and Cygnet Kewstoke ([125-150] miles)
[280] [✂]

Knightstone Ward following the opening of CAS Alders Clinic in June 2015, which more than doubled the available PD bed capacity that was available at Kewstoke.

Figure 20: Average occupancy at Knightstone Ward and Alders Clinic

[✂]

Source: Parties

9.51 We note that this evidence does not control for other factors that may affect demand for the Parties' services in this area, for example whether demand for female PD was increasing over the period. We also consider that it is consistent with the continued existence of unmet demand for female PD services in this area. As discussed in paragraph 8.52, we note that the Parties' previous expansion decisions, including the re-provisioning at CAS Alders to female PD, have focused on identifying areas where there is excess demand.

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

Figure 21: Average occupancy at Bowling Ward and Acer Clinic

[✂]

Source: Parties

9.53 The Parties submitted that this chart is consistent with the opening and expansion of CAS Acer having [✂] on Cygnet Hospital Bierley. In this case, we note that occupancy at Bierley has [✂]. As discussed in paragraph 9.59 below, our understanding is that this is due to issues customers experienced at Bierley over the period. This makes it harder to discern whether or not the opening of CAS Acer had an impact on Cygnet Bierley relative to the counterfactual.

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

Customer evidence on closeness of competition

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

9.56 The evidence from customers on whether they saw Cygnet Kewstoke Knighstone Ward and CAS Alders as alternatives was mixed. Three customers[281] representing 46% of referrals (of the 37% who answered the question) told us that they see the Parties' sites as alternatives for at least some patients, while two[282] customers representing 54% of referrals told us that the Parties' sites are not alternatives. One[283] customer believed that the services are similar but differentiated by the size of wards. They had sent a particularly difficult patient to Alders instead of Kewstoke because they felt that they would be too disruptive in the smaller environment. They said that if either of the Parties' sites were full they were each other's next best alternative.

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

9.58 We received customer information comparing the services of Cygnet Bierley's Bowling ward with the two CAS facilities, Acer Clinic and Aspen Lodge, from four customers.[284] These four customers account for 40% of the referrals to the three sites since 1 January 2016.

9.59 Evidence from customers on whether they saw Cygnet Bierley and CAS Aspen and CAS Acer as alternatives was mixed. All customers told us that there was substantial differentiation between the Parties' wards. However, most[285] also told us that the same type of patient could be sent to either Cygnet or CAS. One customer[286] stated that the range of facilities offered at Cygnet Bierley, particularly PICU, meant they were better placed to handle emergencies and therefore were better suited for complex patients than the

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[281] [✂]
[282] [✂]
[283] [✂]
[284] [✂]
[285] [✂]
[286] [✂]

stand-alone sites of CAS. Another[287] said that the same types of patient could be sent to either CAS sites or to Cygnet Bierley, but they offered different treatments and the outcomes would not necessarily be the same. Treatments offered by Cygnet were more specialised than those offered by CAS and therefore tended to produce better results. Two customers stated that although they did treat the same patient groups they would only use one of the providers. One[288] because CAS is too far south and the other[289] because they were unhappy with the service provided by Cygnet Bierley.

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

Conclusion on female PD

9.61 We received evidence showing that Cygnet and CAS serve different types of PD patients. The evidence from customers was mixed and based on a small number of the customers using Cygnet and CAS sites. Whilst there is likely to be some overlap in the Parties' offerings for some patients, given the high degree of differentiation between the Parties' PD facilities, this overlap is likely to be small. Therefore, our view is that the Parties do not compete closely in female PD and are likely to represent a limited competitive constraint on each other.

9.62 Based on the above, we conclude that the Merger may not be expected to result in an SLC in female PD for the overlaps in Yorkshire and the Humber or in the South West.

Countervailing factors

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

London – male LTMH

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

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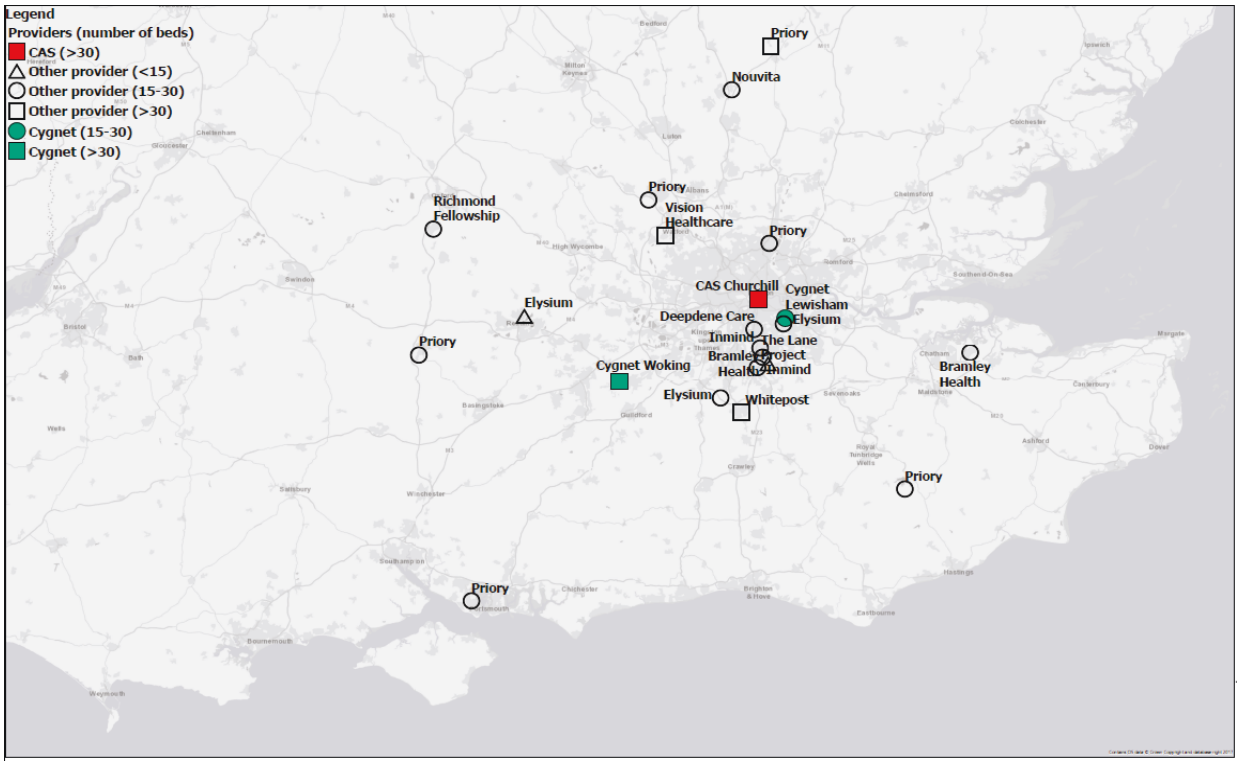
[287] [✂]
[288] [✂]
[289] [✂]

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

Figure 22: male LTMH providers located within 90 minutes' drive time of Cygnet Woking



Source: CMA analysis.
Only those providers within 90 minutes' drive time of Cygnet Woking are included.
Some providers included on the map may not be included for the purposes of calculating market shares. See discussion of market shares in the body of our report and tables of providers in Appendix E.
NHS providers are not included in the map.

Market shares

9.66 In order to determine market shares in this overlap, we used drive-times and public transport travel times rather than road distance because in our view, travel time was a more appropriate measure than distance in this area. We found that 90 minutes' drive-time approximated to 60-mile road distance on average across the country and used this to identify competitors.

9.67 Our analysis centred on Cygnet Woking as combined market shares were highest here. We investigated whether drive-time or public transport travel time were likely to be relevant modes of transport from the perspective of Woking. We thought public transport may be more relevant for journeys into London and drive-time may be more relevant for travel outside of London in Surrey. Therefore, we thought it appropriate to combine competitor sets based on both drive-time and public transport travel time when calculating market shares.

9.68 We found that the competitors identified when defining the catchment area in terms of public transport travel time were a subset of the set of competitors identified when defining the catchment area in terms of drive-time. We therefore focused on market shares based on a 90-minute drive-time from Woking. On this basis, we found the Parties have a combined market share of [20–30]% with a [10–20]% increment. They are currently the second and third largest providers within the catchment area. Priory is the largest provider and would remain the largest provider following the Merger. This information is set out in Table 18 below.[290]

Table 18: Market shares for male LTMH in London

	%
	Base-case 90 minutes' drive-time
Cygnet	[10–20]
CAS	[10–20]
Combined	**[20–30]**
Elysium	[10–20]
Whitepost	[5–10]
Vision Healthcare	[0–5]
The Lane Project	[0–5]
Priory	[20–30]
Inmind	[5–10]
Bramley Health	[5–10]
Deepdene Care	[0–5]
Richmond Fellowship	[0–5]
Nouvita	[5–10]

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

Capacity constraints

9.69 We found that the Parties have [✂] across their sites in this overlap.

Geographic differentiation

9.70 We found that Cygnet Woking and CAS Churchill are distant (67 minutes' drive-time or 77 minutes' public transport time). Although CAS Churchill is the closest competitor by public transport to Cygnet Woking, there are other competitors that are closer in terms of drive-time, including Elysium, Whitepost, Inmind and Priory. Based on this evidence, in our view the Parties' sites are unlikely to be close competitors in terms of location.

Closeness of competition on quality

9.71 The Parties sites both have a Good CQC rating and accordingly appear to be close competitors on quality. A large proportion of the local competitors

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

have received a Requires Improvement CQC rating and a small number of other providers in the area are rated Good. However, we note that several providers rated as Requires Improvement, were operating at high occupancy. This was consistent with the weak relationship that we observed at a national level between a CQC 'Requires Improvement' rating and occupancy. We therefore concluded there was no basis for excluding competitors that have received a 'Requires Improvement' rating from the relevant competitor set but we took into account whether they would exert a weaker competitive constraint.

Third party evidence

9.72 Customer evidence suggests that the Parties are not close competitors. In particular, [✂].

9.73 Three of the Parties' customers had concerns about the Merger, but these customers accounted for only 6% of referrals since 1 January 2016. The concerns related to the possibility that the merged entity would increase prices.[291] One customer was also concerned that there may be reconfiguration of services post-Merger which could restrict supply in certain markets.[292]

NHS providers

9.74 Nine customers collectively responsible for 27% of referrals to the Parties' sites in the area since 1 January 2016 gave us evidence on the use of NHS rehabilitation services. Five[293] (accounting for 45% of referrals from responding customers) stated that there was no local supply of NHS services, two[294] (accounting for 27% of referrals from responding customers) stated that they use NHS providers first and two[295] (accounting for 27% of referrals from responding customers) said that they treat the NHS providers and private sector providers equally. Overall, in our view, this evidence suggested that NHS providers do not compete with independent providers, at least from the perspective of most customers in the London area. However, we did not need to conclude on this point as we found an SLC was not expected to result from the Merger, even without accounting for NHS provision.

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[291] [✂]
[292] [✂]
[293] [✂]
[294] [✂]
[295] [✂]

Conclusion on London male LTMH

9.75 The Parties have low market shares and are geographically distant. We found the CQC rating was not a strong competitive differentiator in terms of closeness of competition and customer evidence on closeness of competition was mixed. Taking into account weaker competitive constraints from providers with 'Requires Improvement' CQC ratings did not alter these results. Based on the evidence outlined above, we conclude that the Merger may not be expected to result in an SLC in this overlap area.

Countervailing factors

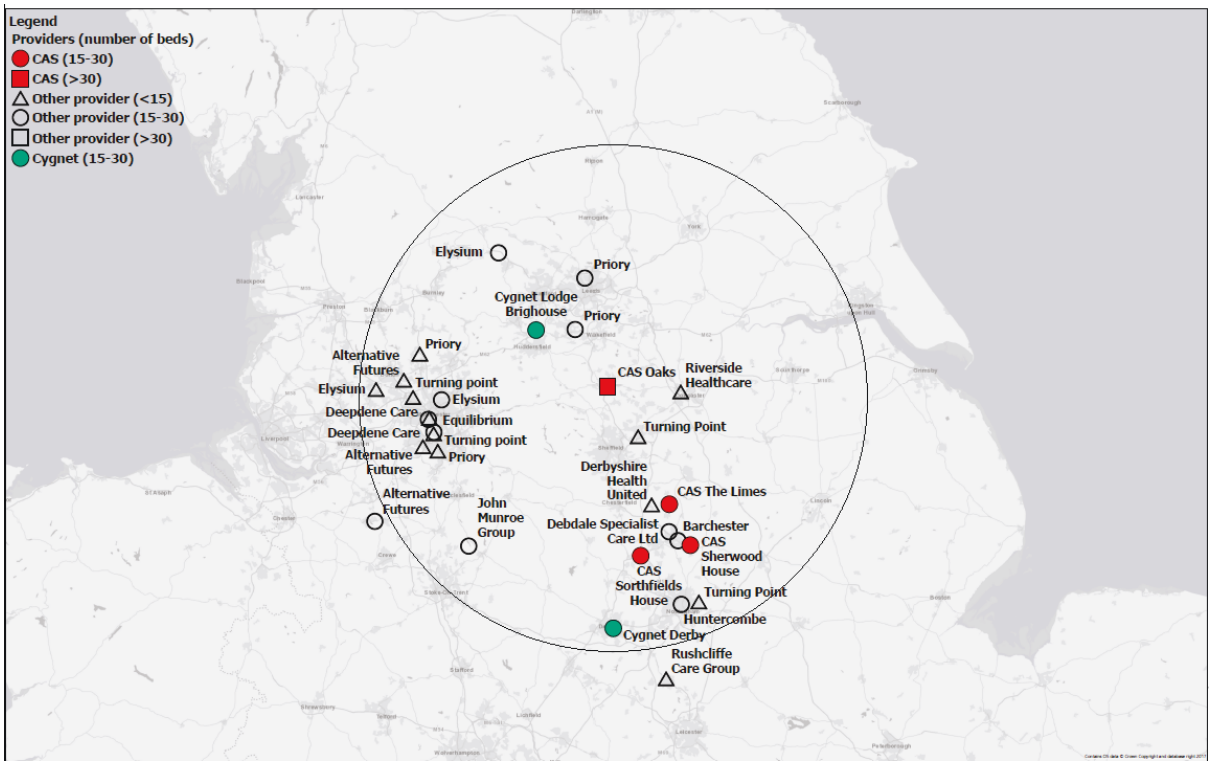
9.76 Because of our finding that the Merger may not be expected to result in an SLC, we did not investigate countervailing factors.

Yorkshire – male LTMH

9.77 The catchment area for male LTMH in Yorkshire overlaps to some extent with the catchment area for male LTMH in the East Midlands although, as we show below, the degree of competition between the Parties and the other providers is different.

9.78 We investigated the overlap we identified between Cygnet Brighouse and CAS Oaks. To assess market shares we centred on CAS The Oaks. The Parties also have the following wards within the 60-mile catchment area: CAS The Limes, CAS Storthfield House, CAS Sherwood House and Cygnet Derby. As these wards are within the catchment area and offer the same services as Cygnet Brighouse and CAS The Oaks, we included these wards in our calculations of market shares.

Figure 23: 60-mile catchment are for male LTMH in Yorkshire (centred on CAS The Oaks)



Source: CMA analysis.
The catchment area shown is not calculated exactly and is for illustrative purposes only.
Some providers included within the catchment area may not be included for the purposes of calculating market shares. See discussion of market shares in the body of our report and tables of providers in Appendix E.
NHS providers are not included in the map.

Market shares

9.79 The Parties' post-Merger combined share of capacity is [30–40]% with a [10–20]% increment. These shares, along with those of competitors in the area are shown in Table 16 below:[296]

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

Table 19: Market shares for male LTMH in Yorkshire

	%
	Base-case 60 miles
Cygnet	[10–20]
CAS	[20–30]
Combined	**[30–40]**
Turning Point	[0–5]
Priory	[10–20]
Riverside Healthcare	[0–5]
Debdale Specialist Care Ltd	[0–5]
Deepdene Care	[5–10]
Equilibrium	[5–10]
Elysium	[5–10]
Huntercombe	[5–10]
John Munroe Group	[5–10]
Nottinghamshire Healthcare NHS Foundation Trust	[0–5]
Rotherham, Doncaster and South Humber NHS Trust	[0–5]

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

9.80 In calculating market shares, we excluded the following competitors identified to us by the Parties, based on evidence provided to us by third parties and our own findings, seeking to corroborate from more than one source where possible: Barchester Forest Hospital and Arbour Lodge[297], Craegmoor Healthcare,[298] Alternative Futures,[299] Turning Point's Nottingham Transition Unit,[300] Douglas House[301] and The Corner House.[302]

9.81 Based on these market shares, the Parties are the first and third largest providers of male LTMH rehabilitation services within the 60-mile catchment area. Priory is the second largest provider with a [10–20]% market share. The remainder of the market is fragmented with nine other providers each with shares of less than 10%.

Capacity constraints

9.82 The evidence shows that all CAS sites in the overlap area [✂] whereas Cygnet Brighouse has [✂]. In addition, some competitors, including for

[297] Arbour Lodge admission criteria on its website suggest that it is for over 50s and Forest Hospital mentions treatments for Huntingtons and dementia suggesting it is also for the elderly. Barchester submitted that it does not compete with the Parties and one customer has confirmed that it provides services for elderly patients.
[298] This hospital does not have a website and is listed on the CQC website as having been acquired by Priory Dewsbury (which is already included in our competitor set).
[299] This provider has informed us that its services are not comparable to those of the Parties.
[300] The description of this facility and admission criteria from its website suggests that it focuses on short stay accommodation (maximum of eight weeks) for adults who are fit to be discharged rather than on long-term rehabilitation.
[301] Turning Point informed us that Douglas House does not compete with the Cygnet and CAS rehabilitation facilities.
[302] Turning Point has informed us that they are in the process of decommissioning their Corner House facility.

example Priory Dewsbury, [✂]. Given that we do not find an SLC may be expected in this area, we do not need to conclude on capacity constraints.

Geographic differentiation

9.83 Brighouse, the closest Cygnet site to CAS The Oaks is 21 miles away. The only other competitor closer to CAS The Oaks is the Cheswold Park Hospital at 17 miles. However, it is smaller (11 beds compared with CAS The Oaks' 36) and has a Requires Improvement rating compared to CAS The Oaks' Good.

9.84 Whilst CAS The Oaks and Cygnet Brighouse are geographically close competitors, we found calculating market shares on a narrower basis (for example 30 miles) did not substantially increase the Parties' market shares. This is because the Parties' market shares in a 60-mile catchment also included their beds at their East Midlands' sites.[303]

9.85 Widening the catchment area to 65 miles did not materially affect the Parties' market shares. This is because the only site located between 60 and 65 miles from CAS The Oaks is Alternative Future's Weaver Lodge, a 20-bed mixed gender unit for LTMH/PD patients. We excluded the Alternative Futures sites from the relevant competitor set.[304]

9.86 Based on the evidence above, in our view, CAS The Oaks and Cygnet Brighouse are close competitors geographically.

Closeness of competition on quality

9.87 All the Parties' facilities in this area have Good CQC ratings, while some other local providers have a Requires Improvement rating.[305] Priory told us that occupancy at Dewsbury was negatively affected by its 'Requires Improvement' rating but it is hoping for this rating to be upgraded soon. As discussed in paragraphs 9.27 to 9.32 above, we think providers with a Requires Improvement rating would still exert a competitive constraint on the Parties and therefore do not exclude them from the calculation of capacity shares but in our view the fact that all of the Parties' sites have Good CQC ratings suggests they are close competitors in terms of quality.

[303] CAS The Limes, CAS Storthfield House, CAS Sherwood House and Cygnet Derby
[304] Alternative Futures is a charity mental health provider. This provider told us that the services it provides do not compete with the Parties.
[305] [✂]

Third party evidence

9.88 The evidence suggested that the Parties' sites are comparable, with several customers citing CAS and Cygnet sites as alternatives. Customers also named a number of other providers, mentioning two male LTMH sites, Huntercombe's Centre-Sherwood site and Options for Care's Montague Court, as comparable to those of the Parties. One customer suggested Turning Point and Rushcliffe Care were comparable to the Parties' sites.[306] We note that these sites are outside the 60-mile catchment area. In our view this customer comment is evidence of constraints from out of area. However, we did not consider it sufficient evidence to include these providers within market share calculation, in particular as a customer's preferences are likely to be dependent on its own location.

9.89 One customer suggested that mixed LTMH/PD wards did not provide a good environment for either LTMH or PD patients.[307] This customer also suggested that mixed gender hospitals were not commonly used for rehabilitation services and that it was not aware of any in the area.

9.90 Two customers,[308] responsible for 18% of referrals to the Parties' overlap sites, expressed concerns about the effect of the Merger on male LTMH. The larger[309] of these customers was concerned that the merged firm would have a monopoly in its local vicinity and had concerns about increased concentration leading to poorer outcomes, such as increased prices or reduced quality. This customer said that it currently refers patients to Cygnet Brighouse and CAS The Oaks and suggested that it would only consider options within a much narrower catchment area than the 60-mile area used. The other customer[310] felt that previous mergers had had a disruptive effect on patients, with changes in management affecting delivery of planned interventions.

9.91 In our overall assessment of this local area, we took account of the concern of the larger customer. However, we noted that it was driven by the customer's location and so we did not consider that it would necessarily extend to other customers. We did not think the concern from the other customer related to the competitive effects of the Merger and so did not give it weight in our overall assessment. We considered that the customer evidence overall provided a mixed view of the alternatives to the Parties' sites. While it suggested that the Parties were close competitors, it also

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306 [✂]
307 [✂]
308 [✂]
309 [✂]
310 [✂]

corroborated the constraint from a number of the other providers, which are included in our competitor set for calculating market shares.

NHS providers

9.92 For the overlap in male LTMH in Yorkshire we have evidence on the use of NHS rehabilitation services from seven customers collectively responsible for 54% of the referrals to the Parties' sites in the area since 1 January 2016. Five[311] of them (accounting for 57% of referrals from responding customers) stated that there was no local supply of NHS services, one[312] (accounting for 38% of referrals from responding customers) said that it uses local supply first and one[313] (accounting for 5% of responding customers) stated that it treats the NHS providers and private sector providers equally.

9.93 The Parties identified to us several possible NHS providers of rehabilitation services in the area. As discussed in paragraphs 5.53 above, only two of these wards appeared to compete with independent providers, [✂]. We have included these in the calculation of market shares.

Conclusion on Yorkshire male LTMH

9.94 Numerically, the Parties have post-Merger market share of [30–40]% with a relatively small increment ([10–20]%). This market share may be overestimated due to some of the locations of the Parties' sites. Post-Merger, there will be a large number of reasonably-sized providers, one of which is a national provider, which will exert competitive pressure on the Parties. Two customers were concerned about effects of the Merger. However, in our view the concerns of one of these customers reflected its particular location and we did not consider that its concerns would necessarily extend to other customers. In our view, the concerns of the other customer related to possible disruption rather than a competitive effect of the Merger.

9.95 On the basis of the above, we concluded that the Merger may not be expected to result in an SLC in this local area.

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311 [✂]
312 [✂]
313 [✂]

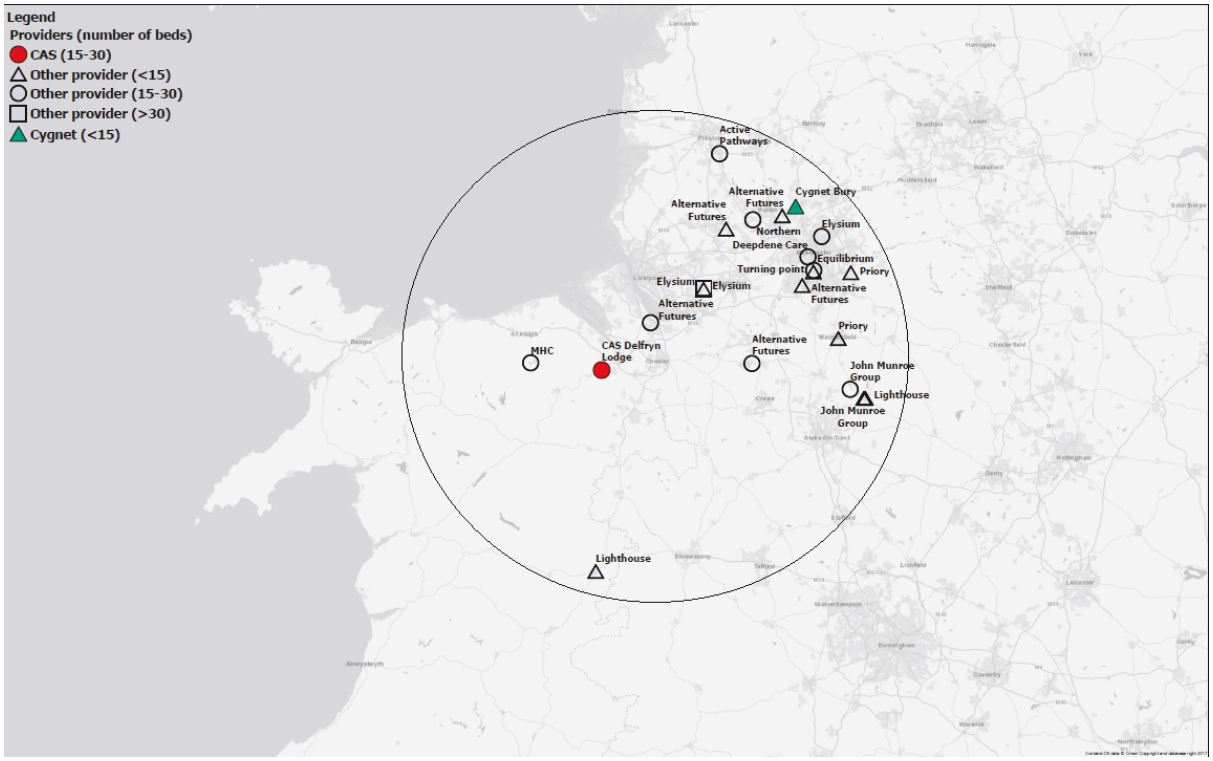
Countervailing factors

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

Northern Wales and The North West – female LTMH

9.97 We investigated the overlap between Cygnet Bury, in North West England and CAS Delfryn Lodge in Northern Wales. Our filter identified this overlap for further assessment based on the sensitivity of excluding mixed gender wards.

Figure 24: 65-mile catchment area for female LTMH in Northern Wales and the North West (centred on CAS Delfryn Lodge)



Source: CMA analysis.
The catchment area shown is not calculated exactly and is for illustrative purposes only.
Some providers included within the catchment area may not be included for the purposes of calculating market shares. See discussion of market shares in the body of our report and tables of providers in Appendix E.
NHS providers are not included in the map

Market shares

9.98 Cygnet Bury and CAS Delfryn Lodge are 59 miles apart. In order to determine market shares in this overlap area, we extended the catchment to 65 miles because of the distance between the Parties and the fact that several providers are located just beyond the catchment (to the East of Cygnet Bury). We also checked market shares on a 60-mile basis as a sensitivity.

Table 20: Market shares for female LTMH in the North West and Northern Wales

%

	Base case 65 miles	*60 miles*
CAS	[5–10]	[10–20]
Cygnet	[10–20]	[10–20]
Combined	[20–30]	[20–30]
John Munroe Group	[10–20]	[10–20]
Priory	[10–20]	[10–20]
Equilibrium	[10–20]	[10–20]
Deepdene Care	[5–10]	[5–10]
Lighthouse	[5–10]	[0–5]
Northern Healthcare Ltd	[5–10]	[5–10]
Active Pathways	[5–10]	[0–5]
MHC	[0–5]	[5–10]
Elysium	[0–5]	[0–5]

Source: CMA calculations based on data submitted by the Parties and other providers.
Notes: Lighthouse has been acquired by Elysium.

9.99 In a 65-mile catchment post-Merger, the Parties would have a combined market share of [20–30] % with a [5-10]% increment. The Parties are the second and fifth largest providers within the catchment area. There are three large competing providers, each with high market shares: John Munroe Group, Priory and Equilibrium.

Capacity constraints

9.100 We found that the Parties have [✂] across their sites in this overlap. Given that we have not found that the Merger may be expected to result in an SLC in this area, we do not need to conclude on capacity constraints.

Geographic differentiation

9.101 Cygnet Bury and CAS Delfryn Lodge are distant (59 miles) from one another and therefore are unlikely to compete closely geographically.

9.102 Most of the competitors captured within the 60-mile catchment area are located between the Parties' hospitals and so are geographically closer competitors to the Parties than they are to each other. In addition, there are several competitors located just outside the 60-mile catchment area, including Elysium Bierley Court, the John Munroe Hospital and Edith Shaw Unit, Active Pathways Bamber Bridge, and Lighthouse Ballington House. For this reason and given the Parties are approximately 60 miles from one another, we decided that greater weight should be placed on market shares calculated on a 65-mile catchment.

Closeness of competition on quality

9.103 The Parties have a Good CQC rating and accordingly appear to be close competitors on quality. A small number of the competitors within the overlap area have received a Requires Improvement rating and a small number of other providers in the area rated Good. However, given the weak relationship between Requires Improvement CQC ratings and occupancy that we observed at a national level, we did not find a basis for excluding competitors that have received a 'Requires Improvement' rating from the relevant competitor set but we took into account whether they would exert a weaker competitive constraint.

Third party evidence

9.104 The evidence we received from one customer[314] responsible for 10% of referrals, was that Cygnet Bury was their preferred facility due to geographic locality, with CAS Delfryn Lodge the next best alternative and John Munroe Hospital as a next best alternative to Delfryn Lodge. This customer was concerned that there would be limited price competition due to the Parties having a local monopoly.

9.105 We noted this concern in our overall assessment. However, we also noted that it came from only one customer responsible for a limited number of referrals.

NHS providers

9.106 We received no evidence from customers in this area on the use of NHS providers. However, we did not need to conclude on the constraint from NHS providers due to the Parties' geographic differentiation and low combined market share, even without accounting for NHS provision.

Conclusion on North West and Northern Wales female LTMH

9.107 Based on the evidence outlined above, we concluded that the Merger may not be expected to result in an SLC in this overlap area. In particular, the post-Merger market shares of the Parties are low ([20–30]%) and they are geographically distant. We also note they will continue to face significant competition from three large providers, which together account for a share over [40–50]% and a number of other providers, which together account for a share over [30–40]%. Taking into account weaker the competitive

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[314] [✂]

constraints from providers with Requires Improvement CQC ratings does not alter these results.

Countervailing factors

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

Southern Wales and The South West – female LTMH

9.109 We considered the overlap between Cygnet Kewstoke (The Lodge) and CAS St Teilo. Cygnet Kewstoke is located in South West England near Weston-Super-Mare, while CAS St Teilo is in Southern Wales in Rhymney.

Figure 25: 80-mile catchment area for female LTMH in Southern Wales and the South West (centred on CAS St. Teilo)

Source: CMA analysis
The catchment area shown is not calculated exactly and is for illustrative purposes only.
Some providers included within the catchment area may not be included for the purposes of calculating market shares.
See discussion of market shares in the body of our report and tables of providers in Appendix E.
NHS providers are not included in the map.

Market shares

9.110 Because of the distance between the Parties' sites (74 miles) we calculated market shares within a wider catchment area of 80 miles (as explained in 5.116). In the paragraphs below we consider whether St Teilo and Kewstoke impose a significant competitive constraint on each other over this distance.

In addition, we noted the size of St Teilo and Kewstoke's (The Lodge) site specific catchment areas, [125-150] miles and [125-150] miles respectively. These large site specific catchment areas suggest these sites receive patients from customers across a large geographic area and that 80 miles would be a conservatively narrow catchment area. In, any event we did not find a concern within this 80-mile catchment. We centred our analysis of the competitor set and of market shares on CAS St Teilo as market shares were greater (and so had been identified for further analysis by our filter) on this basis.

9.111 The Parties have a post-Merger combined market share of [40–50]% with a [10–20]% increment. The Parties are the first and third largest providers within the catchment area. After the Merger the Parties would continue to face competition from two national providers, Elysium and Priory, one large competitor, Sherwood Lodge and two smaller competitors. Our calculated market shares are shown in Table 18 below.

Table 21: Market shares for female LTMH in South West and South Wales

	80 miles (%)
CAS	[20–30]
Cygnet	[10–20]
Combined	**[40–50]**
Elysium	[20–30]
Priory	[5–10]
Hafal	[5–10]
Ocean Community Services	[0–5]
Sherwood Lodge	[10–20]

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

Capacity constraints

9.112 We found that both Cygnet Kewstoke and CAS St Teilo had spare capacity. On this basis, we did not find capacity constraints to be a factor limiting competition in this overlap.

Geographic differentiation

9.113 We found that CAS St Teilo and Cygnet Kewstoke (The Lodge) were geographically distant (74 miles). We noted that there were competitors located close to the Parties' sites, in particular that Elysium had sites close to both CAS St Teilo (19 miles) and Cygnet Kewstoke (5 miles). In addition, there are three other providers that are closer to CAS St Teilo than Cygnet Kewstoke. Accordingly, we did not view the Parties as close competitors geographically, relative to other providers.

9.114 In order to assess whether CAS St Teilo and Cygnet Kewstoke (the Lodge) were likely to be competing in spite of the geographic distance between them, we assessed referral data.

9.115 The Parties' and third parties' evidence was that NHS Wales commissions rehabilitation services on the basis of a national framework and tries to keep patients in Wales wherever possible tending not to refer to providers in England.[315] Data from patient referrals to Cygnet Kewstoke (The Lodge) supported this with only [✂] of the [✂] referrals to The Lodge since the beginning of 2016 coming from Welsh customers.

9.116 We analysed the Parties' referral data to understand whether the same customers had referred patients to both Cygnet and CAS in the past.

9.117 We found that [20–30]% of the patients referred to St Teilo since 2015 were from customers who had also referred to Kewstoke The Lodge, and [40–50]% of the patients referred to Kewstoke The Lodge were from customers who had also referred to St Teilo. In our view, this evidence indicated that CAS St Teilo and Cygnet Kewstoke (the Lodge) may compete despite the distance between them.

Closeness of competition on quality

9.118 As noted in paragraph 2.7, facilities in Wales are assessed by the HIW. Because of the two different quality assessment regimes,[316] it is more difficult for us to make a direct comparison on whether the Parties compete closely on quality in this overlap.

9.119 Kewstoke was rated Good by the CQC. Given the lack of data on quality from Wales, we could not conclude on whether the Parties were particularly close competitors on quality, relative to the other providers in the catchment area. While Sherwood Lodge has a Requires Improvement rating, we also noted its [✂] occupancy, suggesting that this rating did not materially affect referrals to it. This was consistent with the weak relationship between Requires Improvement ratings and occupancy that we observed at a national level but we took into account whether competitors with such ratings might exert a weaker competitive constraint. We therefore concluded there was no basis for excluding Sherwood Lodge from the relevant competitor set.

[315] See also Annex B for more detail on the Welsh National Framework.
[316] In particular, in Wales, the HIW does not publish quality ratings in contrast to the CQC's practice in England.

Third party evidence

9.120 Customer evidence in relation to this overlap did not suggest the Parties were particularly close competitors. One customer cited Elysium's the Copse as the next best alternative to CAS' St Teilo facility.[317] Another customer believed there were no nearby alternatives for female LTMH patients.[318] One customer believed that Kewstoke did not offer female LTMH services and instead considered Kewstoke (The Lodge) ward as a female PD ward.[319] On the other hand, one customer said that the two sites were broadly comparable and were its preferred sites in the area for female LTMH.[320]

9.121 Four[321] customers of the Parties' sites in this area had concerns about the Merger. These customers collectively account for 23% of the referrals to the Parties' sites since 1 January 2016. All four were concerned about potential increases in price. One[322] citing that previous mergers had impacted price and choice in the area. Another two[323] were concerned that the Merger would affect other parameters such as quality of service and length of stay.

NHS providers

9.122 We received evidence on the use of NHS rehabilitation services from seven customers collectively responsible for 39% of the referrals to the Parties' sites in the area since 1 January 2016. Three[324] (accounting for 50% of referrals from responding customers) stated that there is no local supply of NHS rehabilitation services. Four (accounting for 50% of referrals from responding customers) said that they used NHS providers first. None of these customers stated that they treat the NHS providers and private sector providers equally. In our view this evidence suggested that NHS providers do not act as a competitive constraint on the Parties.

Conclusion on South West and Southern Wales female LTMH

9.123 Post-Merger the Parties will have a combined market share of [40–50]%. There are two other large competitors in the area accounting for broadly the same share as the Parties and a further three competitors, which together account for a [20–30]% share. The Parties are geographically distant and several other providers are geographically closer to the Parties' sites. Taking

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317 [✂]
318 [✂]
319 [✂]
320 [✂]
321 [✂].
322 [✂]
323 [✂]
324 [✂]

into account weaker competitive constraints from providers with Requires Improvement CQC ratings does not alter these results. There were some third party concerns, which we have taken into account in our overall assessment.

9.124 Based on the above evidence, we conclude that the Merger may not be expected to result in an SLC in this overlap.

Countervailing factors

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

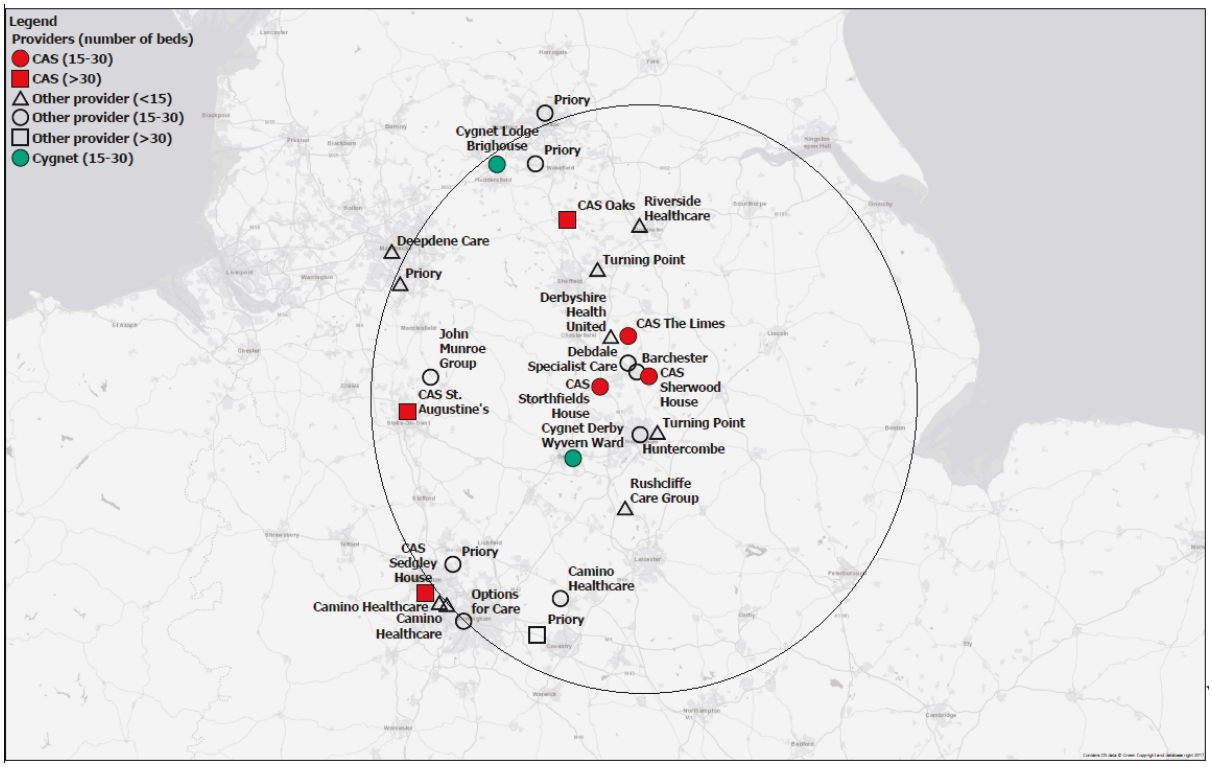
East Midlands – male LTMH

9.126 We considered the overlaps between the following facilities in the East Midlands: Cygnet Derby (Wyvern ward), Cygnet Lodge Brighouse, CAS Storthfield House, CAS Sherwood House, CAS The Limes, CAS St Augustine's and CAS The Oaks.

9.127 To assess capacity shares in this overlap we centred on CAS Storthfield House. We noted that the market shares (shown in Table 22 below) are similar if centred on CAS Sherwood House or CAS The Limes, which are near to each other. We noted that market shares are somewhat lower if centred on Cygnet Derby. However, we considered it more relevant to centre on Storthfield House as market shares were higher in this case.[325]

[325] In our competitive assessment, we consider both the competitive constraint that CAS imposes on Cygnet and vice versa. This implies we should look at market shares centred on CAS sites and on Cygnet sites. We also noted that there are more beds ([✂]) located at the CAS sites (Storthfield House, Sherwood House and The Limes), than at Cygnet Derby ([✂]).

Figure 26: 60-mile catchment area for male LTMH in East Midlands (centred on CAS Storthfield House)



Source: CMA analysis.
The catchment area shown is not calculated exactly and is for illustrative purposes only.
Some providers included within the catchment area may not be included for the purposes of calculating market shares.
See discussion of market shares in the body of our report and tables of providers in Appendix E.
NHS providers are not included in the map.

Role of the East Midlands Rehabilitation Framework

9.128 The Framework is an agreement administered by Hardwick CCG that covers 17 CCGs in the local area. The Framework provides a mechanism for these customers to negotiate terms collectively with providers of rehabilitation services. The Framework covers a range of rehabilitation services, including LTMH, PD, Asperger's, high-functioning autism and LD. It was implemented in April 2014 to last until end of March 2017 and was recently re-negotiated to last for an additional two years until March 2019.[326]

9.129 The Parties submitted that [✂].[327]

9.130 The Parties submitted that a [✂] proportion of patients are referred to its sites in this overlap area under the Framework. The Framework accounts for [✂]% of patients at Cygnet Hospital Derby, [✂]% of patients at Storthfield

[326] Parties' response to the phase 1 decision.
[327] Parties' response to the phase 1 decision, paragraphs 4.21 & 4.22.

House, [✂]% of patients at Sherwood House and [✂]% of patients at The Limes.[328]

9.131 We compared prices for customers who have made referrals to Cygnet Derby using the Framework to customers who have made referrals to Cygnet Derby under other pre-negotiated agreements[329] or paid list prices.[330]

9.132 We found customers using the Framework paid a daily price of £[✂] for 2016/2017 for using Cygnet sites, [✂]. Customers of the Parties' sites in this overlap with other pre-negotiated agreements paid [✂].[331] The Parties told us that this analysis failed to take account of [✂], and that when these factors are taken into account the prices paid on the Framework are [✂] other pre-negotiated agreements.[332] [✂]

9.133 While the Framework sets binding terms specifying price and minimum quality requirements, in our view it is still relevant to consider what effect the Merger may have on competition via the renegotiation of these terms with individual providers when it is renegotiated in 2019 and when prices are reviewed annually. If the Merger results in customers having fewer alternatives (or less alternative capacity) overall, then the merged firm may have the opportunity to negotiate higher prices than those that would arise absent the Merger, when the contracts with providers under the Framework are renegotiated. While the Framework contracts stipulate minimum quality requirements, competition on quality occurs on an ongoing basis and so the effect of the Merger on quality may occur before the Framework is renegotiated.

9.134 We did not agree with the Parties that [✂].[333] The Framework is not a so-called 'bidding' market where there is competition 'for the market' and a single winner. Rather, it sets out a basis for aggregating customer volume to negotiate common terms with providers,[334] several of whom are needed to join the agreement to meet the substantial aggregate supply requirements of the customers on the Framework.

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[328] Parties' response to the phase 1 decision, paragraph 4.20.
[329] The customers with pre-negotiated agreements but not on the Framework who have sent patients to Cygnet Derby since 2016 are [✂]
[330] The customers without pre-negotiated agreements who have sent patients to Cygnet Derby since 2016 are [✂]
[331] [✂]
[332] Parties' response to the provisional findings, paragraph 3.56.
[333] As argued in the response to the provisional findings, paragraph 3.66.
[334] Each customer will face the same terms when using a given provider on the Framework. However, terms vary across providers.

9.135 In our view, the Framework appears to be more relevant to allowing customers to exercise buyer power and we have examined that in paragraph 9.173 below.

Market shares

9.136 The Parties' post-Merger combined share of capacity is [50–60]% with a [10–20]% increment. These shares, along with those of competitors in the area are shown in the Table 19 below:[335]

Table 22: Market shares for male LTMH in East Midlands

		%
	Base-case 60 miles	*Extending to 70 miles*
CAS	[40–50]	[30–40]
Cygnet	[10–20]	[5–10]
Combined	**[50–60]**	**[40–50]**
Debdale Specialist Care Ltd	[0–5]	[0–5]
Huntercombe	[5–10]	[0–5]
Riverside Healthcare	[0–5]	[0–5]
John Munroe Group	[5–10]	[5–10]
Priory	[10–20]	[10–20]
Camino Healthcare	[0–5]	[0–5]
Options for Care	[5–10]	[5–10]
Bracken House (Nottinghamshire FT)	[0–5]	[0–5]
Coral Lodge (Rotherham, Doncaster and S Humber NHS Trust)	[0–5]	[0–5]
St Matthews	[0–5]	[0–5]
Deepdene Care	[0–5]	[5–10]

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

9.137 In calculating market shares, we have excluded the following competitors identified by the Parties, based on evidence provided to us which we corroborated from more than one source where possible: Barchester Forest Hospital and Arbour Lodge,[336] Derbyshire Health United Bolsover Hospital,[337] Camino Nuneaton Unit,[338] 255 Priory Lichfield Road (20-bed mixed ward),[339] Rushcliffe Care Group Aaron's Specialist Unit,[340] Craegmoor

[335] Shares may not sum due to rounding.
[336] Arbour Lodge admission criteria on its website suggest that it is for over 50s and Forest Hospital mentions treatments for Huntingtons and dementia suggesting it is also for the elderly. Barchester submitted that it does not compete with the Parties and one customer has confirmed that it provides services for elderly patients.
[337] We have found no evidence to suggest that this facility provides LTMH services.
[338] This hospital has not been completed. However, we have considered the impact of its entry into the market as part of our sensitivity analysis.
[339] Priory submitted that this ward is not a rehabilitation facility but a step-down facility comprising independent self-managed flats.
[340] Rushcliffe Care Group submitted that it does not compete with the Parties. On its website, this facility is described as a 30-bedded unit which is split evenly into three key areas and look after individuals with ABI, dementia and mental health difficulties and may put themselves or others at risk of harm.

Healthcare[341] and Turning Point Nottingham Transition Unit and Corner House.[342]

9.138 The Parties argued that we should include St. Andrews Northampton and St Matthews within the calculation of market shares as they are providers on the Framework, notwithstanding that they are located outside of the 60-mile catchment area for Storthfield House.[343] We did not consider that being on the Framework is sufficient in itself to justify inclusion within our market share calculations, as not all providers on the Framework were receiving referrals under it. However, we considered the evidence in relation to St Andrew's and St Matthews in more detail.

9.139 In relation to St Matthews, we noted that its facilities are located 71 miles away from Storthfield House. We also noted that [✂]. On the basis of the above, we did not consider that its capacity should be included in market share calculation.

9.140 In relation to St Andrew's Northampton, we noted that the facility is located 79 miles from Storthfield House. Hardwick CCG said it considers St Andrew's Northampton as a possible alternative given its good relationship with this provider, but said it does not currently send patients there. We also considered data on referrals to St Andrew's and to the Parties' sites. We noted that a significant proportion of the customers of St Andrew's Northampton and the Parties' sites had referred to both the Parties' sites and to St Andrew's Northampton. On the basis of the above, we considered that St. Andrew's Northampton may compete with the Parties sites to some extent despite its distance from the Parties' sites. We therefore calculated a sensitivity of including beds at St. Andrew's Northampton within our market share calculations. Inclusion of these beds within the market share calculation would make little difference, reducing the Parties' combined market share to [50–60] %.

9.141 The Parties submitted that Cygnet Brighouse does not compete with the Parties' sites in the East Midlands, despite falling within the 60-mile catchment area of Storthfield House.[344] They submited that the following

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[341] This hospital does not have a website and is listed on the CQC website as having been acquired by Priory Dewsbury (which is already included in our competitor set).
[342] The description of this facility and admission criteria from its website suggests that it focuses on short-stay accommodation (maximum of eight weeks) for adults who are fit to be discharged rather than on long-term rehabilitation. Turning Point has informed us that they are in the process of decommissioning their Corner House facility.
[343] Parties response to the provisional findings, paragraph 3.18.
[344] Parties' response to the provisional findings, paragraph 3.102.

evidence supports the lack of competition between Cygnet Brighouse and the Parties' sites in the East Midlands:

(a) Cygnet Brighouse is located 56 miles from Storthfield House and therefore on the periphery of the 60-mile catchment area, and is located outside the area covered by the Framework.

(b) The CMA considered Cygnet Brighouse in its assessment of male LTMH in Yorkshire and did not identify an SLC in this area.

(c) There is [✂] evidence that patients referred for assessment at Cygnet Brighouse have also been referred for assessment at the CAS sites in the East Midlands.

9.142 We do not consider the fact that Cygnet Brighouse is at the 'periphery' of the 60-mile catchment area is a reason not to include it within market shares. In addition, we note that the Parties have argued elsewhere that the 60-mile catchment area is overly cautious. Similarly, we do not consider the fact that Brighouse is outside of the area covered by the CCGs using the Framework is reason to exclude it. We note that Cygnet Brighouse has been referred patients under the Framework. The Parties have argued that other providers on the Framework should be included in market share calculations despite being located outside of the area covered by the CCGs using the Framework. In our view the area covered by the Framework does not provide a better approximation for the geographic market for the reasons outlined in paragraph 9.157.

9.143 We do not think the fact that Cygnet Brighouse was also considered in relation to our assessment of male LTMH in Yorkshire is relevant to whether it should be included in this overlap. Being within the 60-mile catchment, in our view, it is important to consider to what extent Cygnet Brighouse is an alternative for customers of CAS' sites at Storthfield House, Sherwood House and The Limes.

9.144 We considered the overlap in patient referrals to CAS' sites at Storthfield House, Sherwood House and The Limes and in patient referrals to Cygnet Brighouse. We note that [✂]% of the referrals ([✂]out of [✂]) to the three CAS sites since 2014 came from [✂] customers who have also referred at least one patient to Cygnet Brighouse over the same period. Most of this ([✂]%) is accounted for by [✂] who has sent [✂] patients to Brighouse over this period. [✂] told us that while Brighouse is not their preferred option due to its distance, it does still consider the site as an option for its male LTMH patients. We also noted that [✂]% of the Brighouse patients were referred by customers who had referred patients to at least one of CAS' sites at

Storthfield House, Sherwood House and The Limes. Overall, this evidence suggests that there is some competition between Brighouse and CAS' sites at Storthfield House, Sherwood House and The Limes, albeit that the degree of competition is consistent with the greater 56-mile distance between the Brighouse and the CAS sites.

9.145 The Parties are the two largest providers of male LTMH rehabilitation services and along with Priory ([10–20]% market share) are the only three national providers in the 60-mile catchment area. There are four other smaller providers, including Debdale Specialist Care, Huntercombe, Riverside and John Munroe.

9.146 We have considered the extent to which other providers in the East Midlands could flex their current bed allocation to accommodate male demand for LTMH patients. Within our baseline catchment area of 60 miles, we have identified one mixed gender site (among the sites we have included in the relevant competitors). We have tested the sensitivity of the market shares in the East Midlands to the assumption that Thistle Hill Hall would allocate all its capacity to male patients. Accounting for the possibility of flexing, the Parties' combined market share would go down marginally to [50–60] %.

Capacity constraints

9.147 The Parties submit that Cygnet's Wyvern ward at Derby is [✂], and therefore cannot be considered a close competitor to the CAS sites in the East Midlands.

9.148 Each of CAS' sites in and just outside the 60-mile catchment area has an occupancy rate of close to or over [✂]% averaged over the three-year period 2014 to 2016 and also in 2017. The same is true for Cygnet's Derby site, which is the closest Cygnet site to the CAS sites at the centre of the catchment area. However, given that the Parties have the largest number of beds dedicated to male LTMH patients in the 60-mile catchment area (178 beds accounting for [50–60]% of the market), patient discharges will periodically free-up several of the Parties' beds. In addition, Cygnet Brighouse has [✂] ([✂]% over the three-year period and [✂]% in 2016).

9.149 In our view these specific reasons together with the factors set out in paragraph 8.51 show that the Parties, while being capacity constrained to some extent, will have some available capacity that would give them the incentive and ability to compete for male LTMH patients in the East Midlands area absent the Merger.

Geographic differentiation

9.150 We considered the geographic closeness of competition between the Parties, including whether there is evidence specific to this area indicating that we should adopt a different catchment size.

9.151 The Parties submitted that there are eight sites located between 60 and 70 miles from Storthfield House and 11 sites located between 70 and 80 miles of Storthfield House.[345] They told us that these sites all have catchment areas that overlap with the catchment area of Storthfield House and so were options for some customers.

9.152 The Parties provided analysis where they re-centred the catchment areas on the customers.[346] This showed that the market shares in the 60-mile radius surrounding customers was lower for almost all customers. In our view this analysis is indicative that the Parties' market shares may underrepresent to some degree the competitive constraint from providers outside of the 60-mile catchment area.

9.153 We recognised that the use of market shares is a simplification, in that it places equal weight on providers inside the market (when the competitive constraint may not be equal) and zero weight on providers outside the market (when they may be alternatives for a minority of customers). The use of market shares may therefore underestimate competitive constraints from out of market in some cases, for example if there are a lot of providers just outside the catchment area.

9.154 To account for this, we carried out a sensitivity check by extending the catchment area to 70 miles. This resulted in the Parties' combined post-Merger market shares falling from [50–60]% to [40–50]%. In our view this change indicates that the 60-mile market shares may understate the constraint from providers located outside the 60-mile catchment area, in particular for customers located nearer the periphery of the catchment area. However, we noted that even the market shares at 70 miles were still significantly greater than 40%.

9.155 The Parties told us[347] that [✂] patients at the Parties' sites in this area are referred under the Framework and that the area covered by the Framework (as defined by the boundaries of the CCGs that use it) extends more than 100 miles north-to-south and 90 miles east-to-west. They submitted that this indicates that the site-specific catchment areas used by the CMA at phase 1

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[345] Parties' response to the provisional findings, paragraph 3.36.
[346] Parties' response to the provisional findings, paragraph 3.74.
[347] Parties' response to phase 1 decision, paragraph 4.8.

are too narrow and fail to reflect the area over which CCGs refer patients under the Framework.

9.156 While we used average catchment areas in our phase 2 inquiry, we nevertheless considered whether the area covered by the customers in the Framework might provide a better approximation of the geographic market.

9.157 We noted that the area covered by the Framework does not appear materially larger than the geographic area defined by our 60-mile catchment area.[348] As mentioned above, only about [✂] of the patients referred to the Parties' sites in this overlap are referred under the Framework. Moreover, as the Parties' main four overlapping sites are at the northernmost end of the area covered by the Framework, the use of it to define the catchment area is unlikely to capture accurately the alternatives for customers not using the Framework, in particular those situated to the north.[349] For these reasons, we did not consider that the area covered by the customers in the Framework provides a better approximation for the geographic market than the 60-mile catchment area around the Parties' sites.

9.158 The Parties highlighted that customer referral data of the largest customers at each of the overlapping sites shows that almost all customers send patients to the Parties' other LTMH sites more than 75 miles away. They submitted that this means customers are therefore likely to do so in relation to competitor sites. Similarly, the Parties noted that their sites treat some patients from a significantly wider catchment area than is indicated by the site-specific catchment areas.[350]

9.159 We did not consider that these reasons support adopting a different catchment area for this overlap. The analysis supporting the 60-mile catchment area set out in Section 5 already accounts for the fact that a minority of referrals are made to more distant alternatives.

9.160 In our view, the Parties are particularly close geographic competitors in this area. Specifically, Cygnet Derby is a geographically close competitor to CAS Storthfield House, Sherwood and The Limes, all within 20 miles' road distance of CAS Storthfield House. Within this 20-mile area, the Parties have a very high share of male LTMH beds ([60–70]%). In our view, this suggests that the Parties' market shares may understate the competitive constraint

[348] This area extends 120 miles (road distance) north to south and 120 miles east to west.
[349] The share of customers referred under the Framework is lower for the sites that are [✂], for example The Limes has only [✂]% on the Framework. A [✂] proportion of the Parties' recent patient referrals come from CCGs to the [✂].
[350] Parties', response to phase 1 decision, paragraphs 4.13 & 4.14.

they impose on one another, in particular for customers located nearer to the Parties' sites.

Closeness of competition on quality

9.161 All the Parties' male LTMH facilities in this local overlap have 'Good' CQC ratings, while some other local providers have a 'Requires Improvement' rating.[351] One competing provider, Debdale Thistle Hall, has an 'Outstanding' rating. As discussed in paragraphs 9.27 to 9.32, we consider that providers with a 'Requires Improvement' rating would still exert a competitive constraint on the Parties and therefore we do not exclude them from the calculation of capacity shares. However, we consider that they would exert a weaker competitive constraint than providers rated as 'Good' or 'Outstanding'.

Pre-Merger competition

9.162 The Parties submitted that there is a general lack of evidence contained in the provision findings which considers the degree of competition between Cygnet Derby and CAS' sites at Storthfield House, Sherwood House and The Limes.[352] The Parties submitted that the CMA's local market assessment relies heavily on market shares but fails to consider any evidence in order to assess whether the Parties' facilities have indeed been competing with each other for patients.

9.163 The Parties also provided analysis considering the extent to which the patients referred to Cygnet Derby and Cygnet Brighouse for assessment have also been assessed at CAS sites at Storthfield House, Sherwood House and The Limes[353]. This analysis showed that [✂] out of [✂] patients that were referred to Cygnet Brighouse for assessment since May 2016 were also referred for assessment to one of the three CAS sites and that [✂] of the [✂] patients that were referred for assessment to Cygnet Derby since May 2016 were also referred for assessment to one of the three CAS sites. The Parties considered that this shows that there is [✂] competition between Cygnet Brighouse and the CAS sites and that the level of competition with Cygnet Derby is not material.

9.164 We placed limited weight on this analysis as we do not have evidence on the extent to which the relevant customers have sought their patients to be

[351] Riverside Healthcare Cheswold Park Hospital, John Munroe Hospital.
[352] Parties' response to the provisional findings, paragraph 3.84.
[353] Parties' response to the provisional findings, paragraph 3.86.

assessed by multiple providers. We heard from CCGs that often they may not approach multiple providers in practice, either because there are limited options available or because they already have a good idea of the single best option for the patient.[354] As a result, a lack of overlap does not necessarily indicate a lack of competition. In our view the overlap in patient referrals for assessment between Cygnet Derby and the three CAS sites at Storthfield House, Sherwood House and The Limes indicates a degree of competition between these sites. The more limited overlap in patient assessments between Brighouse and the three CAS sites indicates that competition between these sites may be limited, consistent with the greater distance between these sites compared to the distance between Cygnet Derby and CAS' three sites. We note further that customer evidence, mentioned in 9.144 above, supports that there is some competition between Cygnet Brighouse and the CAS sites.

9.165 We considered evidence on competition on price and quality in Section 8 and found that the Parties compete on quality and have varied or considered varying prices at a local level due to competition. In relation to the East Midlands in particular, while we have not been able to carry out quantitative analysis of competition due to limited data availability, we have considered evidence from customers on competition between the Parties, as set out below.

Third party evidence

9.166 Testimony from customers suggests that the Parties' hospitals are competing for some patients, with several customers citing CAS and Cygnet hospitals as alternatives. One customer said that Barchester Forest Hospital is for older patients and therefore not competing with the Parties' sites.[355] Another customer stated that it did not use the mixed gender or mixed specialism (LTMH/PD) wards for rehabilitation services.[356]

9.167 Hardwick CCG (Derbyshire), which is [✂] customer of CAS Storthfield House and Cygnet Derby and the [✂] customer for CAS The Limes,[357] has sent only five patients (out of a total of 138) requiring rehabilitation services to providers other than the Parties' sites over the last three years (none in 2015/16).

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[354] For example: [✂] who informed us that sometimes it will not consider multiple providers. [✂] told us that it would have specific units in mind for specific patients, given its experience of referring patients to different providers.
[355] [✂]
[356] [✂]
[357] Based on the aggregate number of patient weeks spent at the site by all patients.

9.168 Notwithstanding the volume of male LTMH referrals from Hardwick CCG to the Parties' sites, it told us it was not concerned about the Merger. It stated that it did not believe Cygnet would change the terms of its current agreement with Hardwick CCG as it had not done so before when it acquired Alpha Hospitals. Hardwick CCG did not think that a combined Cygnet and CAS would attempt to 'massively change the terms of the conversation' at the expiry of the two-year window of the Framework. Hardwick CCG said that both providers were aware that there are pressures on them and 'if they attempted to do something too outrageous we might start placing people further away.' It stated that while 'it did not have the benefit of a lot of alternative options on the current agreement it did have options.'

9.169 Three other customers, responsible for 9% of the referrals to the Parties' sites in this overlap area expressed concerns about the Merger. Two[358] of these customers had concerns about increased concentration and less choice leading to poorer outcomes for customers such as increased prices or reduced quality. All three[359] customers were concerned about the loss of variation in the services provided by the Parties, one arguing that heterogeneous treatment styles offered more options for patients.[360]

NHS providers

9.170 We received responses on the use of NHS rehabilitation services from nine customers collectively responsible for 70% of the referrals to the Parties' overlap sites since 1 January 2016. Four[361] (accounting for 54% of referrals from responding customers) stated that there were no local NHS providers, three[362] (accounting for 42% of referrals from responding customers) stated that they use NHS supply first and two[363] (accounting for 4% of referrals from responding customers) stated that they treat the NHS providers and independent providers equally.

9.171 The Parties identified several possible NHS providers of rehabilitation services in the area. As explained in paragraph 5.53 above we contacted all of the 15 NHS trust identified by the Parties. Out of the 11[364] NHS trusts relevant in this area, only two of these wards appeared to compete with

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[358] [✂]
[359] [✂]
[360] The customer felt that different providers tended to offer different treatment approach for patients. Certain patients may respond more positively to one treatment approach than another. Their concern was that the merger may lead to facilities that previously offered different approaches would instead provide a singular treatment approach.
[361] [✂]
[362] [✂]
[363] [✂]
[364] [✂]

independent providers, [✂]. We have included these wards in the calculation of market shares.

Merger effect

9.172 The Parties are the two largest providers of male LTMH in the East Midlands and would have a high combined market share post-Merger. They will be almost five times larger than the next largest competitor, which in turn, is much larger than the other providers. The Parties will have some available capacity that will give them the incentive and ability to compete for patients. The Parties are particularly close competitors geographically, which may suggest that their market shares understate the competitive constraint they impose on one another, in particular for customers located nearer to the Parties' sites. They are also close competitors in terms of quality with each of their sites having Good CQC ratings. The shares of the Parties would be higher if providers with Requires Improvement CQC ratings exerted a weaker constraint. The largest customer for some of the Parties sites is not concerned about the Merger but several other customers are concerned about the impact of the Merger in this area.

Countervailing factors

9.173 We considered whether countervailing factors, including entry or expansion by competitors and buyer power could offset the impact of the Merger.[365]

9.174 Camino Healthcare told us that they plan to open a 20-bed mixed-gender LTMH facility in Nuneaton. We considered whether this entry would be timely, likely and sufficient.[366]

9.175 Camino Healthcare has received planning permission for the facility, is about to start development and is due to admit patients in January 2019. Camino Healthcare told us that this site will provide LTMH rehabilitation services in competition with the Parties. This facility will be 49 miles from CAS Storthfield House. Camino Healthcare currently expect that this facility will be evenly split between male and female patients. In our view, on balance, given that competitive parameters such as pricing are set relatively infrequently in rehabilitation services, this entry meets the conditions of timely and likely.

9.176 To assess whether it may be sufficient to offset any adverse impact from the Merger, we have included this facility within our calculation of market shares.

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[365] The Parties did not put any efficiency arguments to us.
[366] CMA Merger Assessment Guidelines, paragraph 5.8.3.

We note that market shares are reduced only marginally to [50–60]%. In addition, we have tested the possibility that the planned Nuneaton site would operate as a male-only site upon its completion. Again, this would only reduce the Parties' combined market shares marginally, bringing them down to [50–60]%.

9.177 We found no evidence of any other providers planning to expand in male LTMH in this local area. Given this and the limited impact of the planned Nuneaton site, we do not consider that entry or expansion by competitors would be timely, likely and sufficient to offset the adverse effects of the Merger in this local area.

9.178 We have considered the role of the Framework in protecting customers from any adverse effects arising from the Merger through the exercise of buyer power. In our view, while the aggregation of customer volume may improve the negotiating position of those customers using the Framework to some extent, it does not follow that the Framework would be sufficient to offset the adverse effects of the Merger.

9.179 Buyer power can only constrain suppliers to the extent that there are sufficient alternatives available to the buyer. In this regard, we note that the Framework does not provide for a bidding market, where 'competition for the market' can act as a competitive constraint provided there is sufficient number of credible bidders. Rather, as discussed in paragraph 9.128 to 9.135 above, the Framework sets out a basis for aggregating customer volume to negotiate common terms with providers,[367] several of whom are needed to join the Framework to meet the substantial aggregate supply requirements of the customers on the Framework.

9.180 The Merger would result in the Parties having a very high combined share of supply of beds in the local area, reflecting that there is limited alternative capacity available. In our view this limits the alternative options available to the customers using the Framework, given that they have substantial supply requirements for rehabilitation services in aggregate.

9.181 This view was not shared by the largest customer for some of the Parties' sites, which was not concerned by the Merger. Whilst this customer said it did not have a lot of options, it did say it had some. Whilst we understand this customer's view, we believe it is underestimating the situation it will face when the Framework is renegotiated in a two years' times. We also note that its view, to some extent, seems to be based on what Cygnet did after it

[367] Each customer will face the same terms when using a given provider on the Framework. However, terms vary across providers.

acquired another provider, which may not be a good indicator of post-merger behaviour following this Merger.

Conclusion on East Midlands male LTMH

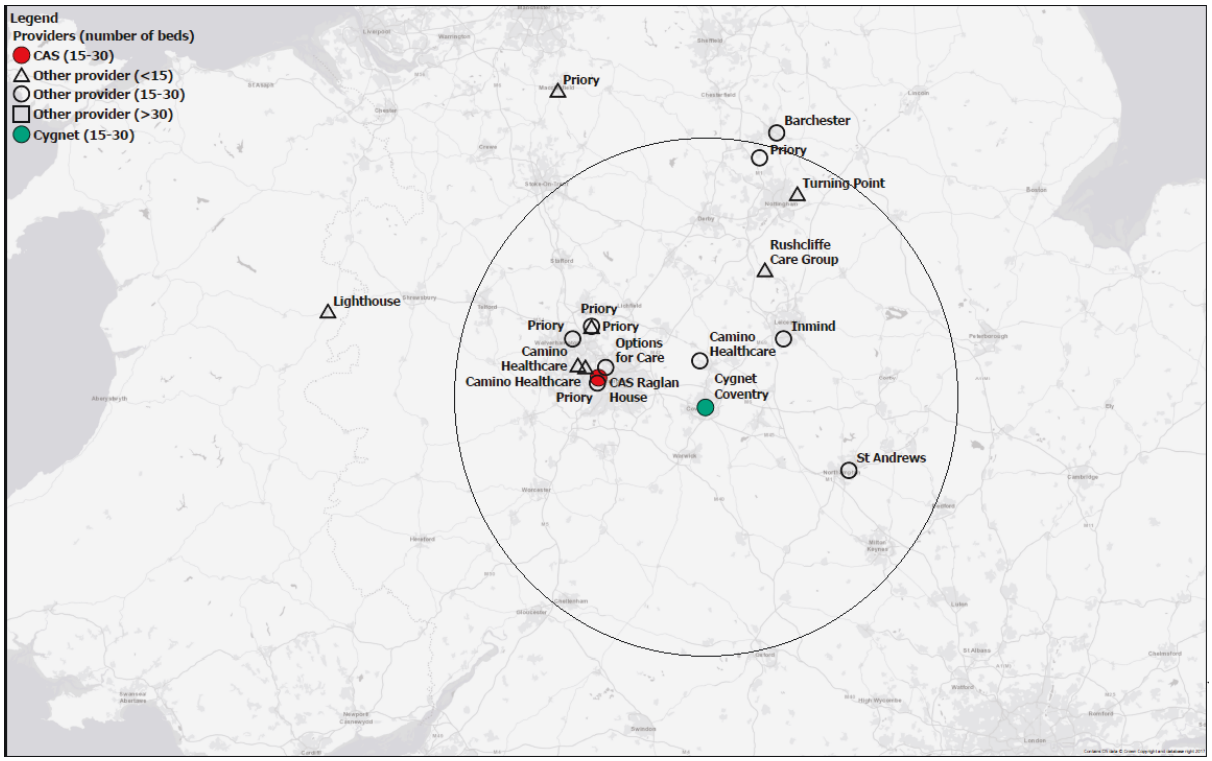
9.182 In light of our assessment above, we conclude that the Merger may be expected to result in an SLC in the provision of male LTMH rehabilitation services in the East Midlands overlap. The SLC may be expected to lead to adverse effects for customers and patients in terms of prices being higher than they would otherwise be and quality being lower than it would otherwise be.

9.183 Further, on the basis of our assessment of countervailing factors above, we do not consider that the SLC in the provision of male LTMH services in the East Midlands which we have found would be offset by countervailing factors.

West Midlands – female LTMH

9.184 We investigated the overlap between Cygnet Coventry and CAS Raglan House. Cygnet Coventry has only recently opened in March 2017.

Figure 27: 60-mile catchment area for female LTMH in West Midlands (centred on Cygnet Coventry)



Source: CMA analysis.
The catchment area shown is not calculated exactly and is for illustrative purposes only.
Some providers included within the catchment area may not be included for the purposes of calculating market shares. See discussion of market shares in the body of our report and tables of providers in Appendix E.
NHS providers are not included in the map.

Market shares

9.185 In order to determine market shares in this overlap area we excluded the following competitors identified by the Parties, based on evidence provided to us which we corroborated from more than one source where possible: Barchester Forest Hospital,[368] Priory 255 Lichfield Road (the 20-bed mixed ward),[369] Rushcliffe Care Group Aaron's Specialist Unit,[370] Options for Care Harriet Tubman House,[371] Priory Beverley House,[372] and Priory Lakeside View.[373]

[368] Forest Hospital treats patients with Huntingtons and dementia, suggesting it is also for the elderly. Barchester submitted that it does not compete with the Parties and one customer has confirmed that it provides services for elderly patients.
[369] Priory submitted that this ward is not a rehabilitation facility but a step-down facility comprising independent self-managed flats.
[370] Rushcliffe Care Group submitted that it does not compete with the Parties. On its website, this facility is described as a 30-bedded unit which is split evenly into three key areas and look after individuals with ABI, dementia and mental health difficulties and may put themselves or others at risk of harm.
[371] Options for Care informed us that Harriet Tubam House no longer offers female LTMH services: the site is used to treat male LTMH patients under the name Dartmouth House.
[372] Priory has submitted that Beverley House specialises in PD and currently only treats PD patients
[373] [✂]

9.186 With respect to Priory 255 Lichfield Road, the Parties argued that an additional 20 beds provided in individual apartments should be included in the market shares in addition to the four-bed female intensive unit. The Parties' provided evidence from customers who stated that the Priory Lichfield Road facility is appropriate for LTMH patients.[374] However, these customers did not appear to differentiate between the intensive unit and the individual apartments. Priory itself told us that these facilities probably would not compete with other locked rehabilitation facilities as they treat patients of lower acuity. We placed greater weight on the evidence from Priory, as the operator of the facility, and therefore excluded the additional 20 beds provided in the individual apartment setting.

9.187 With respect to Priory Beverley House, the Parties submitted that Beverley House treats LTMH patients with a diagnosis of PD in a similar way to Raglan House or Middlemarch Ward at Cygnet Coventry. They noted that both Raglan House and Middlemarch Ward treat a [✂] proportion of LTMH patients with PD diagnoses. For example, since 1 January 2015, [✂] patients have been admitted to Raglan House, [✂] of these patients ([✂]%) had a [✂]of PD and [✂] patients ([✂]%) had a [✂]of PD. The Parties submitted the following evidence in support:[375]

(a) The latest CQC report for Beverley House which describes it as a 'recovery/rehabilitation unit that only provides care for women who have a mental health problem or diagnosis';

(b) The Priory website which explains that 'Patients admitted to Beverley House may be informal or detained under the Mental Health Act with a primary diagnosis of mental illness and personality disorder with complex needs';

(c) The admission criteria for Beverley House set out on the Priory website as being: 'Women aged 18 years and over', 'Have a primary mental health or personality disorder diagnosis', 'Informal or detained under the Mental Health Act (1983)' and 'Severe, complex and enduring mental health needs which might include treatment resistant conditions, dual-diagnosis or learning difficulty'; and

(d) [✂]

(e) Evidence from customers, including [✂], who told the Parties that [✂].

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[374] Evidence from [✂].
[375] Response to the provisional findings (paragraphs 2.28–2.36)

9.188 This evidence directly conflicted with evidence from Priory, who told us that:

(a) Beverley House provides specialist PD services, including DBT therapy and that all 24 of its patients were PD patients.

(b) Beverley House competes with Raglan House and Middlemarch Ward only for those patients with PD or comorbid PD and LTMH.

(c) Beverley House was no more likely than Priory Lakeside View to provide services for LTMH rather than PD patients (though Lakeside View provides a more intensive approach to therapeutic treatment).

9.189 The latter point is relevant as Birmingham CrossCity believed Lakeside View to be an LTMH service while Beverley House was a PD service. In relation to Birmingham CrossCity, we also note that it was not aware that Cygnet Coventry provides female LTMH services.

9.190 Taking all of the above in the round, in our view Beverley House competes primarily for PD rather than LTMH patients but may compete with the Parties for a minority of patients who have comorbid PD and LTMH diagnoses. Consequently, we believe it may impose some competitive constraint on the Parties but to a lesser extent than other providers of LTMH and that it would be incorrect to include all of its beds in the market share calculations. To account for the constraint from Beverley House we included a third of its beds in the market share calculations (consistent with the proportion of patients treated at Raglan House with PD comorbidity).

9.191 The Parties told us that at the time of the Merger Notice in February, Cygnet envisaged greater demand for LTMH services and therefore Ariel Court (due to open in nine to 12 months) was included in the analysis as an LTMH ward. However, since Cygnet Coventry opened there has been greater demand for PD services. Given the greater demand for PD services and the shorter average length of stay for PD patients, the Parties submitted it is now highly likely that Ariel Court will be used for PD patients stepping down from Ariel Ward. Therefore, the Parties submitted that the number of LTMH beds at Cygnet Hospital Coventry should be reduced from 23 to 16. We accepted this submission and have reflected it in our market share calculations.

9.192 The Parties told us that Inmind Sturdee Hospital should also be included within this overlap. In response to information received from Inmind Sturdee Hospital, its Rutland Ward has been included in the market share calculations on the basis that [✂] of its [✂] current patients are LTMH patients, the other [✂] are PD. Sturdee Hospital's Aylestone apartments have been excluded from the market share analysis on the basis that they are step-down facilities.

9.193 Cygnet Hospital Coventry and CAS Raglan House are the first and third largest providers of female LTMH in the local area. Post-Merger the Parties would have a combined market share of [40–50]% with an [10–20]% increment, centred on Cygnet Coventry. Two other large providers, Priory and St Andrew's will remain, each with just under [10–20]% of the market. The shares in this overlap are shown in Table 201 below.[376]

Table 23: Market shares for female LTMH in the West Midlands*

			%
	Base case (60 miles)	*70 miles*	*56 miles*
Cygnet	[10–20]	[10–20]	[20–30]
CAS	[20–30]	[20–30]	[30–40]
Combined	[40–50]	[30–40]	[50–60]
Inmind	[5-10]	[0-5]	[5-10]
Camino Healthcare	[10–20]	[10–20]	[10–20]
Priory	[10–20]	[10–20]	[10–20]
St Andrew's	[10–20]	[10–20]	[10–20]
Richmond Fellowship	[0–5]	[5–10]	[0–5]
Elysium	[0–5]	[10–20]	[0–5]

Source: CMA calculations based on data submitted by the Parties and other providers.
* Market shares may not add to 100% due to rounding.

9.194 As discussed in paragraph 9.235 below, we found that Camino Healthcare's facility in Nuneaton due to open in January 2019 should be considered as entry that was, on balance, both timely and likely. The inclusion of this new entry would reduce the Parties' combined post-Merger market shares to [40–50]%.

9.195 The Parties submitted that our calculation of market share failed to take account of the ability to flex beds at mixed gender and LTMH/PD wards.[377] We note that:

(a) We have excluded one competitor, [✂].

(b) In relation to Beverley House it appears less likely that this would flex bed allocation as it specialises in PD and currently only treats PD patients.

(c) For other Priory sites, we used the current patient split as a starting point. However, we agree that there may be ability to flex bed allocation at Annesley House (19 beds) and the Willows (six beds).

9.196 [✂]

[376] Shares may not sum due to rounding.
[377] [✂]

9.197 We considered the possibility of Priory flexing allocation of beds at Annesley House. Annesley House has one 12-bed ward currently evenly split between PD and LTMH patients and one eight-bed ward with four PD patients and one LTMH patient.[378] Given that Priory told us that Annesley House offers specialist PD services we did not consider it likely that it would flex many beds to LTMH. However, we noted the spare capacity on the eight-bed ward and tested the sensitivity of five additional beds being allocated to LTMH.

9.198 We also considered the possibility of Camino Healthcare flexing the allocation of beds at Cromwell House and Oak House between genders. Cromwell House currently [✂] female LTMH patients out of [✂] beds and Oak House currently has [✂] female LTMH patients out of [✂] beds. Camino told us that it is able to change the gender allocation at both sites. To account for this ability to flex, we tested the sensitivity of Camino allocating the remaining beds in these facilities to female LTMH rather than male LTMH.

9.199 As noted in paragraph 9.191, [✂] Cygnet Coventry Hospital was [✂]. We have therefore considered the possibility of the Parties reallocating [✂]. In our view, the likelihood of this occurring is similar [✂], discussed in paragraphs 9.194 and 9.196 above, as we consider that these hospitals would be exposed to similar demand conditions in PD and in LTMH.

9.200 Incorporating these sensitivities would reduce the combined post-Merger market share of the Parties to below 40% in the 60-mile catchment area.

Capacity constraints

9.201 CAS Raglan House has 24 beds and operates at [✂]. However, Cygnet Coventry Middlemarch Ward, which only opened in March 2017, has lots of spare capacity. In our view, capacity constraints are therefore not a significant feature in this area.

9.202 In our view Cygnet Coventry would have had an incentive to compete for patients against Raglan House and the other providers in the area pre-Merger. This competitive constraint is removed by the Merger.

9.203 The Parties submitted evidence showing that the [✂].[379] They argued that this shows that Cygnet Coventry has not had an incentive to [✂] for patients with Raglan House.

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[378] We assumed two beds allocated to LTMH for the eight-bed ward.
[379] Parties' response to the provisional findings, paragraph 2.96.

9.204 In our view the Parties' analysis is not very persuasive for a number of reasons. First, [✂] of the patients have [✂] because they are on bespoke packages that Cygnet has put together for patients with highly complex needs. Therefore, the comparison is not like-for-like. Second, as Cygnet charges [✂] to most of its individual customers [✂], [✂] at Middlemarch Ward will depend on [✂]. Given this, we did not consider that a sample of [✂] patient referrals is sufficient to derive meaningful results. Third we note that this considers competition on price but not on quality. Finally, we note that these [✂] have been set after the Merger has taken place.

Geographic differentiation

9.205 Raglan House is 27 miles away from Cygnet Coventry and there are no other providers in between. We note that while there are several providers within a 37-mile radius of Cygnet Coventry, there is an absence of providers located between 37 and 56 miles away. In our view this suggests that the Parties are close geographic competitors.

9.206 Further, Birmingham CrossCity CCG, the main customer of Raglan House, has sent the majority of its patients within a narrow area (in Birmingham) and has stated a desire to keep a greater proportion of customers within area. We therefore carried out a sensitivity check excluding those providers beyond a 55- rather than a 60-mile radius. This would result in a higher combined post-Merger market share of [50–60]%. The Parties submitted that the 60-mile catchment used to assess market shares is too narrow. To support this, the Parties submitted analysis of data on the location of CCGs from whom they have received requests for assessment at Middlemarch Ward, Cygnet Coventry.[380] The Parties argued that this shows that CCGs are requesting patient assessments over an area that is much wider than 60-miles.

9.207 We have placed limited weight on this analysis for the following reasons:

- It relates to requests for assessment[381] rather than to actual patient referrals/admissions. We heard from the Parties that sometimes CCGs may test whether a site is suitable for a patient by seeking assessments for the patient at multiple sites, even if ultimately the different sites are not comparable;[382]

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[380] Parties' response to the provisional findings, paragraph 2.66. The Parties refer to this as 'referring for' or 'referrals for assessment'. We use referral to mean admission.
[381] As set out in paragraph 7.4, before a customer makes a referral to a provider, it will ask the provider to assess the patient to assess its suitability for the services provided.
[382] Parties' response to the phase 1 decision, paragraph 6.9.

- The sample of [✂] used in this analysis is small and the results sensitive to the inclusion or exclusion of a small number of patients;

- As Cygnet Coventry has recently opened, we considered it likely that it would seek admissions from further away to fill the ward but that this may change once it is more full;

- As Cygnet Coventry has opened since the Merger has taken place, the geographic distribution of its referrals may reflect a lack of competition between Cygnet Coventry and Raglan House.

9.208 The Parties argued that there are three competing sites located between 60 and 70 miles of Cygnet Coventry and seven located between 70 and 80 miles. They submitted that these sites all have catchment areas that overlap with the catchment area of Cygnet Coventry and so were options for some customers.[383]

9.209 The Parties also provided analysis where they re-centred the catchment areas on the customers.[384] This showed that the market shares in the 60-mile radius surrounding customers of the Parties' sites was lower for almost all customers than the market shares centred on Cygnet Coventry. Market shares centred on customers ranged from [20–30]% to [50–60]%, with [✂] out of the [✂] customers having shares of over 40% ([✂]). In our view, this analysis does suggest that the Parties' market shares may underrepresent the competitive constraint from providers outside of the 60-mile catchment area centred on the Parties' sites.

9.210 We recognise that the use of market shares is a simplification, in that it places equal weight on providers inside the market (when the competitive constraint may not be equal) and zero weight on providers outside the market (when they may be alternatives for a minority of customers). The use of market shares may therefore underestimate competitive constraints from out of market in some cases, for example if there are a lot of providers just outside the catchment area. To account for this, we carried out a sensitivity check by extending the catchment area to 70 miles. This resulted in the Parties' combined post-Merger market shares falling from [40–50]% to [30–40]%.

9.211 The Parties' combined market shares on a 60-mile basis centred on the Parties' sites do not take into account their proximity and the absence of other competitors between 37 and 56 miles, ie they do not attach more

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[383] Parties' response to the provisional findings, paragraphs 2.69–2.71.
[384] Parties' response to the provisional findings, paragraphs 2.75–2.82.

weight to competitors that are closer and attach the same weight to competitors which are further away. On the other hand, by not centring on customer locations, they do not adequately reflect all the options that individual customers may have, ie certain providers may be outside catchment areas centred on the Parties' site but inside catchment areas centred on customer locations.

Closeness of competition on quality

9.212 All providers within the catchment area are rated as Good by the CQC. Therefore, we did not consider the Parties to be closer competitors on quality relative to other competitors.

Pre-Merger competition

9.213 The Parties provided analysis showing that the opening of Cygnet Middlemarch Ward has had [✂] on Raglan House [✂].[385] In our view, this analysis does not provide any meaningful evidence on competition between the Parties' sites given the short time period considered, the small number of patients currently admitted thus far at Middlemarch Ward and the fact that any impact on occupancy at Raglan could be observed only when patients were discharged from there.

9.214 The Parties also provided analysis on the extent to which patients referred for assessment for possible admission to Middlemarch Ward have also been referred for assessment for possible admission to Raglan House. This showed that since January 2017, Middlemarch Ward has assessed [✂] female LTMH patients and only [✂] of these have also been assessed at Raglan House. The Parties submitted that this evidence shows a lack of competition between Middlemarch Ward and Raglan House. We placed limited weight on this analysis for the following reasons:

(a) The time period considered is short and covers the time where Middlemarch Ward has been trying to increase its occupancy. It may consequently be seeking referrals from a wider catchment area (as indicated by the wide geographic distribution of these referrals).

(b) It is not clear to what extent the CCGs that have requested assessments from Middlemarch Ward have also sought assessments from other providers. We heard from CCGs that often in practice they may not approach multiple providers either because there are limited options

[385] Parties' response to the provisional findings, paragraph 2.88.

available or because they already have a good idea of the single best option for the patient. As a result, a lack of overlap does not necessarily indicate a lack of competition. It is also unclear to what extent customers may have avoided seeking assessments at Raglan House, [✂].

9.215 We did not consider any other evidence of pre-existing competition between the Parties given that Cygnet Coventry started admitting patients only recently in April 2017, after the Merger.[386]

Third party evidence

9.216 Cygnet's Coventry site is relatively new having only opened in March 2017 and having only admitted [✂] LTMH patients by 14 September. Given this we have focused on evidence from customers referring to the CAS Raglan House, in particular Birmingham CrossCity CCG, which is responsible for [50–60]% of the referrals to Raglan House since 2016.

9.217 We analysed female LTMH referrals by Birmingham CrossCity CCG over the last three years. It sent the majority of its patients to CAS Raglan House, a substantial proportion to Beverley House and a small proportion to Priory 225 Lichfield Road and Hemel Hempstead.

9.218 Consistent with these referral patterns, Birmingham CrossCity CCG cited Beverley House as the next best alternative to Raglan House, although it noted that Beverley House had a difference in focus as it generally offered a slower, longer-term rehabilitation programme. As noted in paragraph 9.190 above, in our view Beverley House competes with the Parties' sites in the West Midlands to some extent, but less than its market share suggests.

9.219 One[387] customer of the Parties that accounted for 4% of the referrals (one referral) since January 2016 said it was concerned that the Merger may increase price or reduce the quality of the services provided. However, [✂], responsible for over 50% of the referrals, was unconcerned about the Merger as it felt it had bargaining power.[388] We note that [✂] was not aware that Cygnet Coventry provided female LTMH services.[389] Therefore, it may not have appreciated that this competition between the Parties may be lost due to the Merger.

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[386] In response to points raised in the response to provisional findings, paragraph 2.83.
[387] [✂]
[388] [✂]
[389] [✂]

Internal documents

9.220 We reviewed Cygnet's Coventry capital expenditure proposal document produced in 2014, in advance of the opening of Cygnet Coventry. This document mentions rehabilitation providers under a 'Review of competitors' section. Although not consistently clear on specialism, security or acuity level or gender of each of the providers mentioned, our review of the document identified the following independent competitors as potentially relevant to female LTMH (Cygnet's comments from the document are included with each competitor):

(a) 'St Andrew's Healthcare – Birmingham (16 female locked beds [✂].

(b) 'St. Andrew's Northampton also offer 10 low secure personality disorder beds at circa £[✂] and 12 locked beds at circa £[✂]. This could be seen as a challenge to the locked service at Coventry.'

(c) 'Raglan House – Cambian. [✂].

(d) 'Huntercombe Centre Birmingham (18-bed mental health, LD or substance misuse hospital service). No care pathway is provided in this relatively small unit which provides for a mixture of diagnoses.'

(e) 'Choice Lifestyles – Beverley House (24-bed female rehabilitation) (this has since been taken over by Priory in 2015). Beverley House is a 24-bedded rehabilitation hospital for women over the age of 18, situated in the heart of the community in Birmingham. Patient admitted to Beverley House may be informal or detained under the Mental Health Act with a primary diagnosis of mental health illness with complex needs. [✂]

(f) St Matthews Hospital Northampton (14 beds mental health rehabilitation) There is no information available for this service and it has yet to be inspected by the CQC.

9.221 St Andrew's Birmingham has not been identified to us by the Parties or referred to by Birmingham CrossCity CCG. St. Andrew's Northampton has been included in our market share calculations. St Matthews told us it only provides male not female LTMH services. We identified Huntercombe Centre Birmingham as providing male LTMH rather than female LTMH. As noted above, Beverley House has been acquired by Priory and now provides specialist PD services and is currently only treating PD patients. We also note that a number of new sites were opened or converted to provide female LTMH since 2014, including Camino Oak House and Inmind Sturdee hospital.

9.222 The Coventry capital expenditure proposal document also discusses NHS trust and CCG needs. It states the following in relation to CCG needs for female LTMH:

(a) [✂]

(b) [✂] Sedgley House,[390] [✂].

(c) [✂]

(d) [✂]

(e) '[✂]

9.223 This evidence suggests that Cygnet saw Cambian (now CAS) and Choice Lifestyles as its key competitors for female LTMH in Coventry in 2014, at the time the Coventry capital expenditure proposal document was produced. However, we note that two of the five customers[391] mention different facilities to Raglan House and that Choice Lifestyles has since been bought by Priory and now specialises in PD.

9.224 The Parties submitted that the Cygnet capital expenditure proposal also includes aspects that support their arguments.[392] They highlight that page three of the document indicates the broad geographic area over which the hospital is expected to compete: [✂]. In our view this statement does not provide any specific information relevant to the appropriate geographic area for considering competition in female LTMH.

9.225 In our view, the evidence from Cygnet's internal documents suggests that it viewed Cambian (now CAS) as its closest competitor in female LTMH (of those competitors still providing female LTMH). This is consistent with our calculated market shares.

NHS providers

9.226 Cygnet mentions the following NHS providers in its capital expenditure proposal for Coventry:

(a) 'Hawkesbury Lodge – Coventry and Warwickshire NHS (Rehab & Recovery – 14 Beds). This is a local NHS service that provides open rehab.'

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[390] Sedgley House provides male LTMH and is located in Wolverhampton.
[391] As referred to in the Parties' response to the provisional findings, paragraph 2.117.
[392] Parties' response to the provisional findings, paragraph 2.118.

(b) 'Rosewood Terrace – Coventry and Warwickshire NHS (10 High Support Beds plus 5 Step-Down Beds). This is an open NHS service [✂] and deals with more enduring types of illness.'

(c) 'Hazelwood Unit – Coventry and Warwickshire NHS (Challenging Behaviour/Complex Needs-6 beds)'

9.227 In our view this evidence does not mean that NHS facilities offered comparable services to the Parties or tell us anything about whether customers would refer to NHS providers before considering independent providers.

9.228 We received evidence on the use of NHS rehabilitation services from two customers collectively responsible for 57% of the referrals to the Parties' overlap sites since 1 January 2016. One[393] of them (accounting for 8% of referrals from responding customers) stated that there was no local supply of NHS services, the other[394] (accounting for 92% of referrals from responding customers) stated that it used NHS providers first before considering independent providers. Neither of these customers stated that they treat the NHS providers and private sector providers equally.

9.229 In addition, all the NHS trusts we contacted relevant to this overlap[395] told us that their rehabilitation wards were covered by block contracts and that customers would use them before considering independent providers.

9.230 Based on this evidence, we did not consider NHS providers to be a competitive constraint on the Parties in this overlap.

Merger effect

9.231 The Parties are close competitors geographically, which means that market shares may understate the competitive constraint they impose on each other for certain customers located closer to the Parties' sites, such as [✂]. Nevertheless, [✂], the [✂] customer representing [50–60]% of referrals, said that although it did not know what impact the Merger would have on prices or service, it was not concerned about it as it believed it had bargaining power. One small customer said it was concerned that the Merger may increase prices or reduce quality.

9.232 Pre-merger but allowing for the opening of Cygnet Coventry, there were four large providers, two of which were the Parties, with market shares of [10–

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[393] [✂]
[394] [✂]
[395] [✂]

20]% and [20–30]%. Post-merger, the Parties would be the largest provider in the local area, with a market share of [40–50]%. As a relatively new facility with spare capacity, Cygnet Coventry would have an incentive to compete for patients against CAS and the other providers in the area. The competitive constraint between the Parties will be removed by the Merger.

9.233 Inclusion of Camino Healthcare's planned facility in Nuneaton as discussed in paragraph 9.235 below, would reduce these market shares to [40–50]%. In addition, the flexing of bed allocations by providers with mixed gender or combined specialism wards could further reduce market shares. While we did not consider that all of this flexing would necessarily occur in practice, in our view it could reduce the Parties' market shares to below 40%. Post-Merger, two large independent providers will remain, with market shares of [10–20]% and [10–20]%.

Countervailing factors

9.234 We considered whether entry or buyer power may be countervailing factors that would offset any adverse effects from the Merger.

9.235 Camino Healthcare confirmed that they plan to open a 20-bed mixed-gender LTMH facility in Nuneaton. We considered whether this entry would be timely, likely and sufficient.[396] In our view, on balance, this entry was timely and likely for the reasons in paragraph 9.175. To assess whether it may be sufficient to offset any adverse impact from the Merger, we have included this facility within our calculation of market shares. This results in a further ten female LTMH beds and reduces market shares to [40–50]%.

9.236 With respect to buyer power, we note that there are no relevant framework agreements locally or evidence that any are likely to occur in the future. [✂] is the largest customer of the Parties by some margin and was unconcerned about the Merger as it felt it had bargaining power. We noted that even if [✂] is able to exercise buyer power, this would not protect the prices paid by other customers.

Conclusion on West Midlands

9.237 On the basis of the evidence outlined above, two Panel Members were of the view that the Merger is not likely to result in an SLC in the provision of female LTMH rehabilitation services in the West Midlands. In their view, the Parties' market shares are not at a level that suggests an SLC is likely. The

[396] CMA Merger Assessment Guidelines, paragraph 5.8.3.

largest customer by some margin was unconcerned about the Merger and the market shares indicate that customers have sufficient alternatives to ensure that competition would continue to occur effectively post-Merger, and that any competition lost from the Merger would not be substantial.

9.238 The other two Panel Members were of the view that the Merger is likely to result in an SLC in the provision of female LTMH rehabilitation services in the West Midlands. In their view, absent the Merger, Cygnet Coventry would have been likely to be a closer competitor to CAS Raglan House. The Parties are particularly close competitors geographically, which means that market shares may understate the competitive constraint they impose on each other for certain customers located closer to the Parties' sites. The Merger represented a reduction from four to three large independent providers and the size of the increment suggested that the extent of competition lost by the Merger would be substantial.

9.239 A two-thirds majority is required for a CMA panel to find an SLC.[397] Therefore, we concluded that the Merger is not likely to result in an SLC in the provision of female LTMH rehabilitation services in the West Midlands.

10. The effect of the Merger on potential competition

10.1 This section considers whether the Merger may be expected to result in a loss of potential competition at a local or national level.

Potential competition at a local level

10.2 Our assessment of potential competition considers whether entry or expansion by one or both Parties would have occurred absent the Merger and led to greater competition. In particular, it considers the possibility that, absent the Merger:

(a) the Parties' expansion plans would be likely to lead to greater competition in certain local areas; and

(b) the Parties would be likely to switch the use of a hospital or ward from one specialism (or treatment type) or gender to another (reconfiguration), resulting in greater competition in certain local areas.

[397] Enterprise and Regulatory Reform Act 2013, Schedule 4, paragraphs 55 & 56.

Expansion plans

10.3 Where the Parties' plans or those of other providers[398] have already been executed, any changes in capacity in the relevant market have been included in our assessment of actual competition at the local level.

10.4 For example, as outlined above, in March 2017 Cygnet opened a new hospital in Coventry with four wards. One of these is a 16-bed female LTMH ward which is included in our local assessment. Another is an 18-bed female PD ward which is excluded as it falls outside our catchment.[399]

10.5 Similarly, in March 2017, CAS opened a second wing at its Acer facility adding 14 female PD beds which is included. [✂]

Parties' expansion plans

10.6 In response to our issues statement the Parties submitted that whilst both were looking for opportunities to develop their respective businesses ('which is to be expected for all providers of rehabilitation services'[400]) absent the Merger, the Parties' respective plans largely focused on different treatment types and different stages in the care pathway.

10.7 The Parties submitted that Cygnet's expansion plans were consistent with the focus of its business, 'which is on providing treatment to service users with high acuity needs and/or those requiring a secure setting, which do not overlap with the services provided by CAS.[401]

10.8 In this regard, Cygnet has plans to build [✂]

10.9 In comparison, CAS' expansion plans [✂]

10.10 Accordingly, the Parties submitted that their expansion plans confirm that they would not have become closer competitors at a local level in the supply of rehabilitation services absent the Merger.

Our assessment

10.11 The Parties [✂] planned expansion in LTMH rehabilitation services, [✂].

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[398] We have the expansion plans of [✂] providers. We do not have evidence of all plans from all providers in all local areas.
[399] The third ward provides female PICU (Dunsmore Ward). The fourth ward, Ariel Court, [✂].
[400] Parties' response to the issues statement, paragraph 2.21.
[401] Parties' response to the issues statement.

10.12 To assess the possible impact of this expansion plan on competition, we have considered it in the same framework as our assessment of actual competition, in other words applying the same filtering methodology followed by a more detailed competitive assessment where appropriate.

10.13 The implication of [✂] to our filtering methodology is not significant, ie it does not result in any additional sites being included for a more detailed competitive assessment.

Potential competition from reconfiguration of existing wards

Parties' submission[402]

10.14 The Parties submitted that there is no evidence to suggest that the Parties would have changed services or specialisms at specific hospitals or on specific wards to become closer competitors to each other in future. On the contrary, the evidence consistently points towards their respective businesses having a different strategic focus with Cygnet focusing on high acuity needs and/or those service users requiring a secure setting whilst CAS is focusing on the community sector and/or rehabilitation services for ABI and ASD patients.[403]

10.15 The Parties also point to Cambian Group's financial difficulties prior to the Merger as likely to limit its access to capital to expand. [✂].[404]

10.16 CAS told us it does not reconfigure wards. The 18-month average length of stay and the fact that many patients are in the process of transitioning back into the community makes reconfiguration 'tremendously difficult and disruptive'. Instead, CAS would rather expand or buy a completely new facility.

10.17 CAS also highlighted that the focus of its business and so the nature of its estate means most CAS facilities are in the centre of communities. The level of patient acuity and risk that can be contained in that setting is established by the location and by the form of the building. This means less opportunity for reconfiguration than Cygnet which has more inpatient hospitals in their own settings.

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[402] Parties' response to the issues statement.
[403] Parties' response to the issues statement, paragraph 2.25.
[404] Parties' response to the issues statement, paragraph 2.26.

10.18 Finally, CAS noted that the main driver for reconfiguration, low occupancy, has never been an issue as its rehabilitation facilities have always had occupancy levels of around [✂]%.

10.19 Cygnet confirmed [✂] for reconfiguration, although it emphasised, [✂]. It said it would generally expect one or two reconfigurations per year across its entire portfolio of 50 to 60 wards. In LTMH and PD specifically, Cygnet cited only three reconfigurations since 2012 (Brighouse from mixed LTMH to male LTMH, one ward in Kewstoke from male LTMH to female LTMH and another ward in Kewstoke from female low secure to female PD).

Our assessment

10.20 The Parties' internal documents [✂].

10.21 To consider the possibility of a loss of potential competition from reconfiguring existing wards, we applied the analytical approach described in paragraph 5.44 in the section on product market definition which showed that such reconfiguration is only likely where both:

(a) occupancy at an existing ward is low; and

(b) there is sufficient excess demand for the specialism and gender type to which the ward is being switched, to achieve a sufficient increase in occupancy.

10.22 As noted in Section 5 on product market definition, ward reconfiguration costs are likely to be significantly lower between genders and between specialisms that use the same physical environment, such as LTMH/PD. Below, we consider the potential for such reconfigurations and then go on to examine reconfigurations from LTMH/PD to other specialisms.

10.23 To identify possible wards which may be reconfigured we have first sought to identify PD or LTMH wards with lower occupancy, assuming that the incentives to reconfigure will be greater here.

10.24 There was no consensus between the Parties on the level of occupancy that would trigger consideration of reconfiguration. Cygnet explained that a decision to reconfigure depended on what was driving the fall in occupancy rather than any particular occupancy level. For example, government policy to move patients out of locked LD hospitals would support a case to reconfigure, even if occupancy levels were high. CAS said that with occupancy of around [✂]%, it has never had to consider reconfiguration.

10.25 As a starting point for further examination we have considered the Parties' wards with occupancy currently below 80%. 80% is likely to be higher than the occupancy below which the Parties would be likely to reconfigure; it is a cautious starting point:

(a) CAS Victoria House ([✂]% occupancy in 2016) – male LTMH.

(b) Cygnet Brighouse (occupancy – [✂]% (2014), [✂]% (2015), [✂]% (2016)) – male LTMH.

(c) Cygnet Bierley (occupancy – [✂]% (2014), [✂]% (2015), [✂]% (2016)) – female PD.

10.26 We note that Cygnet Bierley and Cygnet Brighouse overlap with CAS hospitals and are included in two of our local competitive assessments, following filtering. CAS Victoria House does not overlap with any Cygnet hospitals.

10.27 We have first considered the implications of these wards reconfiguring for our filtering and competitive assessment. Where the reconfiguration would make a difference, we have considered in more detail the likelihood of it actually happening.

10.28 For each we first repeated the filtering exercise to look at what would happen if capacity at each ward was allocated to each alternative specialism/gender combination (for example, if the ward is currently female PD, we considered what would be the implications of reconfiguring to male LTMH and to female LTMH). No new overlaps arising from these hypothetical reconfigurations would be included in our competitive assessment after the filtering.

10.29 The following changes would increase the Parties' market shares in overlaps we are already considering:

(a) Cygnet Brighouse switching from male LTMH to female PD would increase the Parties' share of supply (Cygnet Bierley/CAS Acer and Aspen). Cygnet Brighouse is 9 miles from Cygnet Bierley, 31 miles from CAS Aspen and 44 miles from CAS Acer.

(b) Cygnet Bierley switching from female PD to male LTMH would increase the Parties' shares of supply (Brighouse/CAS The Oaks and The Limes). Cygnet Bierley is 9 miles from Cygnet Brighouse, 30 miles from CAS The Oaks and 58 miles from CAS The Limes.

10.30 We consider the likelihood of Cygnet Brighouse reconfiguring to female PD is low, in particular because Cygnet Bierley has tended to operate with [✂]. Over the three-year period 2014 to 2016 this site has had [✂].

10.31 The likelihood of Cygnet Bierley switching to male LTMH also appears low, [✂] (as shown in paragraph 9.148 above). In addition, we note that Cygnet Bierley female PD is a more specialised Tier 4 service able to deal with more complex patients and charges higher prices for this service. Finally, following issues we understand go back to 2012, we note that Bierley's occupancy is [✂] after being rated Good by the CQC early this year. Past issues with trials of different approaches at Bierley which [✂] mean it is unlikely to be a good candidate for further change. It therefore appears unlikely that Cygnet would wish to convert this ward to treat male LTMH patients.

10.32 As a second step, we considered the possibility that the Parties might reconfigure from PD or LTMH to other specialisms in rehabilitation services, notwithstanding that the cost and difficulty of doing so is likely to be greater than reconfiguration 'within' PD and LTMH rehabilitation services.

10.33 In this regard, we note CAS' submission that it plans to expand in ABI, ASD and LD and note that its occupancy levels for these treatments across its sites were [✂]. Consequently, we believe it is unlikely that CAS would wish to reconfigure any wards providing these services to compete in PD and LTMH rehabilitation services. We also note CAS' statement that it does not reconfigure wards.

10.34 Cygnet explained that the cost of reconfiguration varies significantly. Two of the main factors are the costs of changing the physical space to comply with specifications and the length of time it takes existing patients to leave and new patients to be referred. Cygnet explained that in the early 2000s it undertook around 11 reconfigurations over three years. The most financially significant were going from low secure to more specialist services.

10.35 As well as the cost and disruption to occupancy, Cygnet explained that even where the physical environment does not change significantly, the reconfiguration process can be costly and lengthy due to the need to retrain staff in a new specialism. For example, in Kewstoke it was already a low secure service so the physical environment did not need to change that much to accommodate PD patients. However, several members of staff needed [✂] training. It compared a reconfiguration from PICU to acute which could be quicker and easier.

10.36 Limited expansion plans, the fact that only two wards have been reconfigured by Cygnet in the past five years and the absence of any current

plans for reconfiguration in LTMH/PD, lead us to conclude that reconfiguration by one or both Parties is unlikely to have occurred absent the Merger and led to greater competition.

Potential competition at a national level

10.37 We have considered whether the effect of the Merger on the Parties' expansion plans (over and above the specific expansion plans already assessed) may be expected to give rise to an SLC, for instance if it reduces their incentives to expand into new areas and thereby create further overlap areas.

10.38 The following conditions would all need to be met for this to occur:[405]

(a) Absent the Merger, the Parties would expand into local areas in which they are not currently present thereby creating new additional local overlaps (over and above their specific entry plans).

(b) The Parties' capability or intentions to expand are such that they would be substantially more likely than other competitors to enter these new overlap areas.

(c) Entry into new overlap areas absent the Merger would have led to greater competition.

10.39 We consider each of these three conditions below.

Likelihood of new overlaps

10.40 We considered evidence of additional planned expansion beyond specific sites. As a starting point, we note the Parties' response to our issues statement, set out in paragraph 10.7 that their respective expansion plans largely focus on different specialisms and treating patients at different stages in the care pathway.

10.41 The Parties submitted that Cygnet's plans are focused on high acuity services and CAS are largely focused on developing services in the community sector or rehabilitation services for ABI or ASD patients. This submission is consistent with their submission of [✂].

10.42 However, a recent CAS business plan, [✂], appeared inconsistent with CAS' submission that its [✂]. The business plan suggested [✂].

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[405] Retail Mergers Commentary, paragraph 1.21.

10.43 We asked CAS about this apparent discrepancy. CAS explained that [✂].This aligns with the fact that against moderate historical expansion, trebling capacity in one specialism seems unlikely at best.

10.44 CAS confirmed that it will revisit and revise expansion plans [✂]. It explained it wants to grow but how and where will be led by the 'demand matrix' of the market. According to CAS, this is driven by the demand from the NHS and the political agenda. For example, there have been recent changes in policy on LD to close beds and provide alternative community provision. Once it is clear demand is there, only then does CAS address other aspects of the matrix such as the finance and the ability to find a site and get planning permission. Expansion was described by CAS as [✂].[406]

10.45 CAS noted the prospect of a policy change to move people out of rehabilitation beds back into the community. A CQC Report 'The state of care in mental health services 2014 to 2017' published on 20 July, included a clear view that they want to revisit the appropriateness of inpatient services for certain rehabilitation patients. In light of this CAS intimated it would be [✂].

10.46 We have found no comparable information for Cygnet in internal documents. We asked Cygnet about its approach to identifying new areas for expansion.

10.47 Cygnet explained that it had not undertaken much expansion [✂].[407]

10.48 Cygnet submitted it is also driven primarily by demand and relationships in local areas. Like CAS, it is affected by changes in government priorities as these often translate into customer demands. It gave the example of the drive to improve the availability of more local PICU facilities.[408]

10.49 We also considered historical expansion into PD by the Parties. We note that both CAS and Cygnet have been active in expanding in female PD. CAS has opened all its female PD wards over the past five years: CAS Aspen, Acer and Alders (64 beds in total). Cygnet has opened two wards for female PD at Coventry and Kewstoke (27 beds in total).

10.50 We are satisfied by CAS' explanation of its internal document that [✂]. Although the historical pattern suggests that further expansion by CAS in PD might have occurred absent the Merger, [✂].

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[406] [✂]
[407] [✂]
[408] [✂]

10.51 [✂]. We therefore consider that the likelihood of this creating new overlaps between the Parties is low.

Entry more likely than by other competitors

10.52 We considered the scale of historical expansion of the Parties relative to other competitors. We note the Parties have been actively expanding in female PD and we have not identified other competitors with historic expansion in PD over the last five years.

10.53 We considered the scale of the Parties' current expansion plans in PD rehabilitation services relative to other competitors. The two other major providers currently offering female PD services are Priory and Elysium.

10.54 [✂]

10.55 [✂]

10.56 [✂]

10.57 [✂]

10.58 Out of the 11 competitors who responded to the part of our questionnaire covering expansion, five had expanded in the past five years, six had plans for future expansion (of varying levels of firmness), one had a vacant site where it had yet to decide and only four had no plans to expand.

10.59 Overall, while the Parties have expanded more than other competitors in PD in the past, we note that [✂].

10.60 Most of the changes and drivers in the market that encourage or facilitate expansion are provider-agnostic. Although there could be some factors that may make it easier for larger players, there are no specific reasons why the Parties would be more capable of further expansion in PD than other providers, absent the Merger.

Entry into new overlaps would lead to greater competition

10.61 As discussed in detail in paragraphs 9.37 to 9.61 above, we have found that the Merger may not be expected to result in an SLC in any overlaps between the Parties in female PD due to the substantial differentiation between the services they offer. There is no evidence that the Parties intend to shift the focus of their PD services in the future. As a result, in our view it is unlikely that entry by the Parties into new PD overlaps would lead to greater competition, even if they did arise.

Conclusion

10.62 Cygnet has [✂].

10.63 [✂] we have not found reasons why the Parties would be more capable of further expansion in PD than other competitors, absent the Merger. In addition, given the differentiation between the Parties, it is unlikely that entry by the Parties into new PD overlaps would lead to greater competition, even if such overlaps did arise. As a result, our view is that the Merger may not be expected to result in an SLC from a loss of potential competition between the Parties.

11. National effects

11.1 Above we concluded that the Merger may not be expected to result in an SLC from a loss of potential competition at a national level. This section examines whether the increased concentration and reduction in the number of major providers might be expected to result in an SLC from a loss of actual competition at the national level. This may be competition in innovation, expansion or investment, for example.

11.2 To determine and assess the impact of any national effects of the Merger we considered:

(a) the extent to which any of the parameters of competition are national and the impact of any national aspects we have not explicitly considered at a local level;

(b) Parties' and third party submissions on the effect of the Merger at a national level; and

(c) the impact of the Merger at an aggregate level.

Parameters of competition set or flexed nationally and other national aspects

11.3 Incentives to compete are driven by increasing the occupancy of wards, due to the revenue earned from attracting patients. Evidence from customers shows a consistent and strong preference to refer patients to local providers where possible, subject to these providers being of sufficient quality. The evidence in our inquiry consistently supports that the key parameters of competition are mainly varied locally.

11.4 As a result, our analytical framework and assessment reflects the fact that the incentives to compete are predominantly local. This includes the incentive to change even those parameters of competition set 'nationally'. In

the case of actual competition this means that an assessment of national competition is in practice an assessment of local competition in aggregate.[409]

11.5 We have been told that some providers address and adjust some parameters of competition centrally. For example, we understand some national providers have group-wide approaches to quality and [✂]. However, our investigation confirms that even if centrally-set or monitored, price and particularly quality, tend to vary locally.

11.6 Quality[410] is ward-specific and varies locally. How customers view individual facilities and their experience of placing patients there is key, and in general not a function of national factors such as brand.

11.7 Pricing also varies locally. For Cygnet, [✂].[411]

11.8 While the key parameters of competition are predominantly varied locally, we have received evidence that characteristics of larger providers may affect these parameters across hospitals, ie that there are national factors which may affect local competition. These include:

(a) ability to expand or introduce new services;

(b) the management of quality;

(c) recruitment, career planning, deployment, training and retention of specialist staff;

(d) reputation from operating in numerous local areas;

(e) innovation capability arising from scale, for example ability to trial and test new approaches/treatments;

(f) economies of scale and scope; and

(g) other management practices and culture etc.

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[409] See the Retail Mergers Commentary, paragraphs 1.13–1.17. Previous decisions considering the effect of a merger on centrally-set parameters of competition include: Holland & Barrett/Julian Graves (2009); Sports Direct/JJB Sports (2010); Poundland/99p (2015); and Ladbrokes/Coral (2016). All looked at the impact of the merger on centrally set parameters of competition through analysis of the aggregate of local competition, including in particular the extent to which local stores overlapped.
[410] See Section 8 on the nature of pre-Merger competition.
[411] See Section 8 on the nature of pre-Merger competition.

Parties' and third party submissions on the effect of the Merger at a national level

11.9 The Parties do not consider that national factors have a significant influence on local competition in relation to the supply of rehabilitation services. They refer to the phase 1 decision which states that commissioning generally takes place by customers at a local level, and all providers of rehabilitation services are reliant on these customers for patient referrals and funding.

11.10 The Parties point to the large number of smaller providers of rehabilitation services, 'which are highly regarded by commissioners and the CQC, and which compete effectively with the Parties for patient referrals.'[412]

11.11 In relation to the reputation of providers, the Parties told us that since hospitals are managed individually and assessed separately by the CQC, each hospital needs to develop its own reputation with customers, even if it forms part of a larger group. [✂], the Parties argued that just because a customer has had a good experience with one of the Parties' hospitals in the past, it does not guarantee that it will view its other hospitals in the same way (or vice versa).

11.12 The Parties do not consider that scale, financial strength or access to capital have any material bearing on the nature of competition at the local level. On scale, they point to the high number of smaller credible providers with no national presence. On cost, they submitted that the provision of rehabilitation services is highly dependent on clinical and nursing staff, which means that there are very few scale benefits at the national level.[413]

11.13 Customer evidence generally confirms that customers are motivated by the quality and standards of care of the facility and their experience of them. Brand and national presence is not a significant factor in their decision on whether and where to refer patient.[414]

11.14 Other providers and third parties pointed to several advantages of being a larger provider, both in scale and scope. They mentioned the benefits of an integrated care pathway providing cross-selling opportunities, an ability to take a longer-term view of finances and sustain short-term fluctuations in occupancy, the lower cost of capital and the ability to invest and innovate.[415]

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[412] Parties' response to the issues statement, paragraph 214.
[413] Parties' response to the issues statement, paragraph 216.
[414] See Section 7 on Customer behaviour and choice of facility.
[415] See paragraphs 12.40–12.55.

11.15 Although the large number of smaller credible providers suggests that economies of scale may be limited, we have received evidence from customers, competitors and third parties that there are benefits of scale and scope for larger providers. They have told us that these include cross-selling opportunities such as moving patients along the care pathway, cross-subsidies to address falls in occupancy or quality concerns, access to a larger pool of specialist staff and a better career offer for staff and access to capital and insulation against financial risks.

11.16 We have noted that benefits from scale may make expansion by larger providers somewhat easier and more likely than expansion by smaller suppliers.[416] We have taken account of these factors in our assessment of the possible impact of the Merger on competition through expansion in the section 10 above.

The impact of the Merger at an aggregate level

11.17 The Parties have told us it is unclear to them why a national competition theory of harm is relevant, or how it could be expected to occur in practice.[417] They cite the CMA's phase 1 decision that the Parties' combined shares of supply 'on a national basis are at a level below which the CMA will typically identify concerns'.[418]

11.18 Based on data provided by the Parties, we calculated that post-Merger the Parties would have an aggregate share of [20–30]% of the market for rehabilitation services. This is broadly consistent with the Parties' calculations. On the one hand, they may include some providers who are in practice less of a constraint on the Parties, but on the other, as noted by the Parties, they may fail to capture others who may be relevant (such as NHS providers in some cases).

11.19 The Parties would be the largest national provider in female PD and in both male and female LTMH. However, even the highest share would be below the level at which competition concerns typically arise. Furthermore, the national markets for rehabilitation services are still fairly fragmented with many smaller regional or local area providers, as evident from the analysis in our detailed local assessments.

11.20 More importantly, aggregate market shares do not necessarily give a good indication of competition at a national level as they aggregate multiple local

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[416] See section on the barriers to entry and expansion below at paragraphs 12.4–12.58.
[417] Parties' response to the issues statement, paragraph 230 and following.
[418] CMA phase 1 decision, paragraph 58.

markets and do not capture the extent to which different providers overlap and thus compete at a local level. For example, two providers that focus on different regions could in principle not overlap at all but still have a high combined aggregate market share at a national level.

11.21 In addition, we have found that the Parties do not compete closely in PD. As a result, in our view the market share above overstates the degree of competition between the Parties that may be lost due to the Merger.

Conclusion on national effects of the Merger

11.22 Post-Merger, the Parties would be the largest national provider in female PD and in both male and female LTMH. However, even the highest share would be below the level at which competition concerns typically arise. Overall, the national markets for rehabilitation services are still fairly fragmented with many smaller regional or local area providers. This is further evident from the analysis in our local competitive assessments.

11.23 The evidence in this investigation supports the absence of a substantial effect on competition at a national level at this time.

11.24 However, the CMA notes that this is the second major transaction in the market over the past 12 months.[419] During our inquiry, we have seen further acquisitions. As consolidation continues, the national and local dynamics and the relative importance of different competitive parameters are evolving and may evolve further.

12. Countervailing factors

12.1 In considering whether a merger is likely to result in an SLC, we will consider the responses of others in the market (rivals, customers, potential new entrants) to take into account 'countervailing factors'. These are factors specific to the merger which may ameliorate the effect of the merger on competition. Countervailing factors include entry by new providers, expansion by existing providers and the ability of customers to exercise buyer power. We will also consider the effect of any efficiencies identified by the Parties on competition as a result of the Merger.

[419] See Acadia/Priory.

Entry and expansion

12.2 A merger may encourage other providers to enter the market or existing providers to expand their operations and in that way reduce the potential harm to competition a merger may cause. In order to prevent an SLC from arising, entry or expansion must be likely, timely and sufficient.[420]

12.3 We investigated what barriers to entry and expansion exist to the supply of rehabilitation services.[421] We assessed potential candidates for entry/expansion in the local areas (see paragraphs 9.174 and 9.235) where we identified a potential competition problem before reaching a conclusion on the likelihood of entry and expansion and whether this would provide a sufficient competitive constraint on the Parties in a timely manner.

Barriers to entry and expansion

12.4 The Parties told us that the barriers to entry and expansion in the provision of mental health services vary depending on the stage of the care pathway. They stated that that the higher the level of security, and the acuity of the condition, the more significant the barriers.[422]

12.5 According to the Parties, there were barriers to entry to the provision of medium and low secure, acute and PICU services. They explained that high security requirements required purpose built/converted facilities, these were designed by clinicians and bespoke to the needs of patients, and often required significant investment. Further, they stated that building facilities for secure, acute and PICU services require planning permission,[423] and the higher the security levels of the service, the more stringent the planning requirements.[424]

12.6 The Parties submitted that barriers to entry are likely to be lower for rehabilitation services than secure services due to the reduced security requirements, and the slightly less resource-intensive nature of the care provided. [425]

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[420] Merger Assessment Guidelines, paragraph 5.8.3.
[421] Further details on the views of the Parties and third parties are provided in Appendix F.
[422] Merger Notice, paragraphs 26.1 & 26.2.
[423] See also Appendix B for more information on planning regulations.
[424] Merger Notice, paragraphs 26.1–26.4.
[425] Merger Notice, paragraphs 26.1–26.4.

12.7 We set out below the barriers to entry or expansion we have identified, the views of the Parties and the third parties on each and our assessment. Further details are provided in Appendix F.

Registration and licensing requirements

12.8 As set out above in the Legal and Regulatory section (paragraphs 2.8 to 2.23) and in more detail in Appendix B, mental health services are monitored, inspected and regulated in England by the CQC.[426]

12.9 The CQC reported that during October 2015 - March 2016, the time taken to complete the CQC registration process ranged from 40 to 62 days.[427,428] Every registered provider pays a single annual fee, which covers all CQC registration and compliance requirements for all locations.[429]

12.10 NHSI licenses and monitors all NHS providers to make sure that the required standards are maintained (see Appendix B for details). NHS provider licences are free, and it usually takes 20 working days to receive a decision, unless queries or concerns are raised.[430]

- *Views of the Parties and third parties*

12.11 The Parties told us that all new sites needed to meet the following regulatory requirements:

(a) CQC registration;

(b) application to NHSI for a licence;[431] and

(c) submission of a completed Information Governance toolkit[432] to the NHS (NHS Digital).[433]

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[426] The HIW regulates independent healthcare providers in Wales.
[427] See CQC (April 2017), Review of CQC's impact on quality and improvement in health and social care.
[428] The registration process requires submission of various details and documents, including a Statement of Purpose, References, Management policy/procedures, Safeguarding policy and procedures, Planning permission (optional), Building regulation (optional), Registered manager supporting evidence and Governance document. It also involves criminal record checks of relevant individuals. CQC: Providers' registration supporting documents.
[429] CQC website: Fees.
[430] Guidance: Independent providers of NHS funded services. 14 May 2014.
[431] The Parties stated that NHS contracts insisted that this was in place before referring patients.
[432] The IG Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments. Department of Health, Information Governance Toolkit.
[433] The Parties stated that some customers required this in their contract.

12.12 However, according to the Parties, the regulatory requirements did not amount to an 'absolute barrier to entry' for the provision of rehabilitation services (as they suggest they currently do for secure services).[434]

12.13 Competitors generally expressed the view that the CQC registration needed to provide rehabilitation services is granted relatively quickly. Further, they told us that there were limited regulatory requirements to reconfigure a ward to serve a different gender.[435]

- *Our assessment*

12.14 The evidence indicates that there are no regulations that limit the number of market participants but all providers of rehabilitation services must undergo a registration and licensing process. This involves limited financial expenditure (see Appendices B and F for details), and takes into account the number of locations of the applicant.

12.15 The time involved in CQC registration and obtaining an NHSI provider licence is relatively short, and there are plans to improve the registration process further.[436,437] Although providers need to apply for another CQC registration when reconfiguring their facilities, there is no fee for this, and based on submissions from the Parties and competitors (see Appendix F for details), the process is relatively straightforward in most cases.

12.16 Larger providers may be at a slight advantage in respect of being able to register many sites through a single CQC registration process.[438]

12.17 Overall, we found no regulatory issues that act as an insurmountable or costly barrier to entry.

Availability of clinical expertise and skilled staff

12.18 A recent report by the NHS Providers[439] finds that 'mental health trusts are struggling to find enough staff with the right skills to deliver existing services to the right quality, let alone being able to find new staff to extend services to new users or create new services.'[440] Similar concerns have been expressed

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[434] Response to the CMA's initial factual information request. 10 May 2017. Paragraph 21.2 (b).
[435] See Appendix F for details.
[436] See paragraph 2.17.
[437] CQC registration and the NHSI licence can be requested through the same form.
[438] Although we note that the registration fee varies with the number of locations of the applicant.
[439] NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS.
[440] The state of the NHS provider sector (July 2017) p7.

by the CQC in its recent report, where it stated that the number of NHS mental health nurses has declined by 12% between January 2010 and January 2017.[441]

- *Views of the Parties and third parties*

12.19 The Parties told us that rehabilitation services required a high level of clinical expertise, and training and development of staff was key. They stated that whilst it was possible to recruit staff with the relevant experience, in some areas this could be challenging, in particular for highly specialised services.

12.20 Third parties[442] expressed a similar view that a shortage of specialist staff, including qualified nurses was a barrier to entry and expansion, especially for smaller competitors.

- *Our assessment*

12.21 We found that the availability of qualified and experienced staff, especially mental health nurses is a barrier to entry and expansion in the provision of mental health services, including rehabilitation services.

12.22 Further, small providers might be at a disadvantage while trying to recruit staff, due to better stability of employment and potential career opportunities offered by larger organisations. Larger providers may also gain from greater flexibility in deploying their staff across their sites, depending on changing demand conditions.

Financial investment to enter, expand or reconfigure

Establishing a new mental health facility[443]

- *Views of the Parties and third parties*

12.23 According to Cygnet, the typical costs involved in establishing a mental health hospital in the UK varied depending on:

(a) the size of the hospital, and

[441] CQC (July 2017), The state of care in mental health services 2014 to 2017, p7.
[442] See Appendix F for details.
[443] This can include a new hospital or a new ward.

(b) the stage of the care pathway ie the higher the level of security, and the more acute the treatment required, the more significant the costs.

12.24 By way of a case study, Cygnet told us that the total cost of developing its most recent hospital, Cygnet Hospital Coventry,[444] was around £[✂].[445]

12.25 CAS provided us with [✂].[446]

12.26 One competitor[447] told us that the cost of creating an appropriate physical environment to provide rehabilitation services constituted a barrier to entry. However, another competitor[448] said that while there were initial investment costs to set up a rehabilitation hospital service, it did not consider these to be prohibitive.

- *Our assessment*

12.27 Setting up a new rehabilitation facility requires significant financial investment which could be a barrier to entry.

12.28 However, the evidence shows that the Parties have recently set up new facilities, and have plans to expand some of their existing facilities (see paragraphs 10.3 to 10.9). [✂]. This indicates that providers have been able to source the required capital to set up new facilities or expand existing ones.

12.29 We also note that the independent mental health hospital sector has seen a spate of M&A in the recent years (see paragraph 2.84). This suggests that whilst the financial investment required to set up a mental health facility providing rehabilitation services can be a barrier to entry, the sector remains attractive to potential buyers, and the providers can expect to recover their sunk costs, if they decide to exit the market.

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[444] Cygnet Coventry provides an all-female specialist mental health service with 56 beds. Services include a psychiatric intensive care unit (PICU), a specialised personality disorder service also catering for those with dual diagnosis disordered eating, and a locked rehabilitation unit. Cygnet Coventry Brochure.
[445] Cygnet told us that Cygnet Hospital Coventry was designed as a [✂].
[446] The location of this facility is about [✂]. According to the investment paper, the capital expenditure per bed was above the range of its recently completed services because of additional planning requirements/groundworks, and it being a specialised purpose-built facility that would be state-of-the-art when completed.
[447] [✂]
[448] [✂]

Reconfiguring a mental health facility

12.30 Instead of setting up a new mental health facility, providers can reconfigure existing facilities to provide other services, including rehabilitation services.

- *Views of the Parties and third parties*

12.31 The Parties stated that the financial investment required to reconfigure facilities constituted a barrier to entry.[449] They told us that reconfiguring a mental health facility involved three steps:

(a) discharging or relocating patients;

(b) re-training or recruiting staff, and adapting the building[450] if required; and

(c) admitting new patients.

12.32 According to the Parties, on average, reconfiguring a ward takes [✂].

12.33 Cygnet told us that the largest cost in reconfiguring a ward was usually the lost revenues due to the ward not operating at a financially feasible occupancy. Cygnet told us that the average EBITDA loss from reconfiguring its wards in the last four years was about £[✂].[451]

12.34 CAS estimated the typical costs of reconfiguring an existing facility to provide rehabilitation services to be approximately £[✂] per bed. CAS told us that in addition to capital expenditure, other expenses generally incurred for reconfiguring a ward were:

(a) recruitment costs when sourcing new staff;

(b) additional wages of an increased staff headcount required to handle the additional patients; and

(c) the cost to provide relevant training to the staff.

12.35 Competitors were generally of the view that it was relatively straightforward to reconfigure wards between genders and between some specialisms. For example, one competitor[452] told us that the difficulty of reconfiguring a facility

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[449] Merger Notice, paragraph 26.4.
[450] The Parties told us that depending on the type of reconfiguration, it may be necessary to retool the ward to provide a different living environment. For example, when reconfiguring an LTMH ward into a specialist ward (ABI, ASD, LD or PD) it would usually be necessary to convert some of the bedrooms into additional community space and specialist treatment rooms. Merger Notice, paragraph 13.27 (b).
[451] [✂]
[452] [✂]

depended on the specialism converted from and to. It stated that, for example, environmental work was usually required to reconfigure an LTMH ward to an ABI ward, while changing an LD ward to an LTMH ward normally required fewer environmental changes. Another competitor[453] told us that that existing providers of medium or low secure services could reconfigure a ward to provide rehabilitation services relatively easily if there was adequate demand.

12.36 According to one competitor,[454] there were some barriers to reconfiguring a hospital ward or bed, including financial restrictions, additional staffing, registration of the new service and loss of income, whilst the transfer of services took place.

- *Our assessment*

12.37 We found that, in addition to capital investment, reconfiguring a mental health facility involves loss of revenue[455] and additional expenditure to recruit and (re)train staff. Providers also incur opportunity cost on the invested capital during the reconfiguration.

12.38 As we discuss in paragraph 12.46, larger providers might be better equipped to reconfigure their facilities due to availability of financial resources. Overall, although reconfiguring an existing facility involves costs, it does not appear to be as significant a barrier as setting up a new rehabilitation facility.[456]

12.39 The incentive to reconfigure a facility depends on the relative profitability of providing the new service compared with the previous service. A key determinant of this relative profitability is the difference in occupancy that could be achieved through reconfiguration.[457] As we note in paragraph 5.47, providers would be unlikely to have the incentive to reconfigure in response to small changes in price or quality for a particular service, even if it was possible for them to do so.

[453] [✂]
[454] [✂]
[455] According to the Parties, the process of reconfiguring a ward typically involves discharging or relocating existing patients, retraining or recruiting staff and retooling the ward, and admitting new patients. This process according to the Parties is expected to take on average around [✂]. Merger Notice, paragraphs 13.26 & 13.27.
[456] See paragraphs 10.14–10.36 for our analysis of potential competition from reconfiguration of existing wards.
[457] See paragraphs 5.39 to 5.47 for an analysis of factors affecting reconfiguration decisions.

- *View of the Parties and third parties*

12.40 The Parties told us that larger providers may be able to benefit from certain cross-selling opportunities, for example referring patients from low secure to rehabilitation services. However, they stated that in general, the economies of scale in the supply of rehabilitation services were limited, and this was evidenced by the large number of small credible providers of rehabilitation services.

12.41 Responses from competitors indicated that larger providers:

(a) were able to take a longer-term view of their finances, and were better placed to take the financial risk of not making profits for a certain period after making an investment in a mental health site;

(b) could subsidise where services had a fall in occupancy or invest to maintain quality standards; and

(c) had the advantage of having more clinicians, who could be deployed to various sites.

12.42 One customer told us that there were some benefits of scale, and the size of some larger providers, to a degree 'insulated them from the worst that the market can do to them.'[458]

12.43 The CQC told us that one advantage of scale was that larger providers could put in place more infrastructure to support quality teams and internal independent quality inspections. Conversely, larger providers needed to focus on many locations, and there could be a point when economies of scale potentially became diseconomies of scale, viewed from a quality of service perspective.

12.44 LaingBuisson told us that there was an advantage to having a national network since it would allow a patient to be kept within the same business. It stated that larger providers might also have a lower cost of capital.[459]

12.45 LaingBuisson also told us that a larger provider could offer training and better career prospects to attract clinicians and be an attractive employer. It

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[458] [✂]
[459] Hearing with LaingBuisson. Paragraph 21 of summary.

might also have more flexibility in moving clinicians across sites, and 'manage quality on a more strategic basis'.[460]

- *Our assessment*

12.46 Larger providers might have some scale advantages in respect of being able to invest in and grow their services. Larger providers may also be better placed to bear the risk of not making a profit at a specific site for a certain period of time, and have better access to and lower cost of capital.

12.47 Larger providers could also benefit from economies of scope in respect of being able to offer a greater range of services along the care pathway. This was in fact part of the rationale for the Merger (see paragraph 4.3). However, our analysis of the competitive process[461] indicated that although pathway benefits are possible, currently these are likely to be limited.

12.48 We note that a large proportion of the Parties' costs relate to their site operations,[462] rather than to divisional or central costs, which suggests limited opportunities to gain from cost synergies can be expected from the Merger.[463]

Reputation and experience

- *Views of the Parties and third Parties*

12.49 The Parties told us that building a strong relationship with CCGs was an important success factor for providers, since CCGs were in control of patient referrals. The Parties argued that many small providers had demonstrated that they could develop strong relationships with CCGs in certain areas.

12.50 Third parties' responses indicated that being an existing provider in a certain area was an advantage due to:[464]

(a) established links with the local community;

(b) relationship with customers and practitioners; and

(c) knowledge of the market.

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[460] Hearing with LaingBuisson. Paragraph 26 of summary.
[461] See paragraph 7.10.
[462] [✂]
468 [✂]
[464] See Appendix F for details.

12.51 One competitor[465] told us that customers required providers to have an established reputation (in particular for PD) before placing patients. It also said that local customer support could be vital for the success of a new service since it might be possible to get references from other customers or to demonstrate successful similar hospitals in another geographic location.

12.52 Another competitor[466] told us that it was relatively easy for the NHS or private providers of secure services (for example) to switch to rehabilitation services without having a pre-existing presence in a particular area. But if an independent provider decided to open a new rehabilitation service in an area where it had existing provision, there would be some benefit from having knowledge of local market conditions in relation to commissioning and staffing.[467]

- *Our assessment*

12.53 Based on the evidence we have seen, whilst providers with a proven track record and reputation can gain patient referrals from established relationships with customers and knowledge of the local market, they need to go through an evaluation process and customers need to be satisfied about the potential providers' capabilities and facilities before referring patients.

12.54 We noted in paragraph 7.10 that the decision to allocate in rehabilitation services can in general be treated independently of the provider's position on other parts of the care pathway.

12.55 Reputation and experience are important factors and may be more important for specialised rehabilitation services (eg PD), but evidence suggested it is less of a barrier in less specialised areas.

Conclusion on barriers to entry and expansion

12.56 The evidence indicated that there are some barriers to entry and expansion in the provision of rehabilitation services, but in our view these are not sufficient to preclude the likelihood of entry.

12.57 As noted in paragraph 12.21, finding qualified and experienced staff, especially mental health nurses, remains a key challenge for both existing and potential providers of all mental health services.

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[465] [✂]
[466] [✂]
[467] [✂]

12.58 We found that there are some advantages for larger providers, for example in relation to investing in the business, recruiting staff, offering services across the care pathway (economies of scope). However, we also noted that many smaller independent competitors continue to operate in the market.[468]

Buyer power

12.59 In this section, we consider the countervailing effect of buyer power. Buyer power refers to the ability of customers to use their negotiating strength to constrain the ability of the merged firm to raise prices or reduce quality. The existence of countervailing buyer power will be a factor in making an SLC finding less likely.[469]

12.60 The assessment of whether buyer power would be sufficient to address any effects of an SLC in the local area is however area specific and therefore has been captured in our local competitive assessment in the overlap area where we have found an SLC.

Views of the Parties

12.61 The Parties told us that whilst commissioning is managed by individual CCGs rather than NHSE, the National Tariff inflator/deflator set by NHSI acts as a benchmark that all CCGs use in negotiating prices.[470] In the Parties' experience, [✂].

12.62 The Parties told us that this was consistent with third party evidence. In particular they cited the LaingBuisson Report which suggests that 'the average adjustment to national tariff prices for 2015/16 was -0.5%, with similar reductions expected in following years across all NHS services subject directly or indirectly to NHS tariffs.' Accordingly, whilst customers may procure rehabilitation services individually, providers of rehabilitation services are subject to a broader constraint provided by NHS benchmarks which maintains pressure on prices.

12.63 The Parties told us that that CCGs can (and do) group together to commission rehabilitation services and that the prevalence of framework agreements is increasing. They told us that the CCGs on a framework agreement can make up a significant proportion of purchases at specific

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[468] We also note that there has been consolidation in the mental health services through M&A in recent years. See paragraph 2.84 and Appendix C.
[469] Merger Assessment Guidelines, paragraph 5.9.1.
[470] Parties' response to the issues statement, paragraph 2.38. See also Section 2 and Appendix B for more details on the National Tariff.

sites, effectively operating as a single customer, with prices and service standards set through competitive tender.[471]

12.64 The Parties also gave examples at specific sites where a single CCG can make up a large proportion of purchases.[472] For example, [✂].

12.65 The Parties also told us that as customers often refer patients to more than one of the Parties' sites (and therefore have visibility of the prices charged), in the event of a hypothetical price increase at a particular site, CCGs would be able to discipline the Parties in a number of ways, including by limiting referrals to other sites in other areas and/or for other specialisms (where there is no overlap between the Parties). According to the Parties, the option to discipline in this manner means that even where individual CCGs do not represent a significant proportion of revenues, they are able to exert significant buyer power if the Parties attempted to increase prices at specific sites.[473]

12.66 In addition, the Parties consider that customers have buyer power as they usually have a range of credible alternatives. First, there are numerous other independent providers to which a customer can switch, or threaten to switch, referrals. In Cygnet's experience customers often use this option to negotiate better prices.[474]

12.67 Second, NHS foundation trusts have the option to enter a joint venture to provide rehabilitation services in partnership with independent providers. For example, at its Godden Green site, Cygnet operates a male low secure service which is run in a joint working arrangement with Kent and Medway Partnership NHS Foundation Trust.

12.68 Third, NHS foundation trusts have the option to open or reconfigure their own facilities to provide rehabilitation services directly. Whilst at a national level there has been a decline in NHS provision, this has changed in recent years. In addition, at a regional level, the Parties cited a number of examples of NHS trusts expanding and improving their own inpatient rehabilitation services. The Parties provided a number of recent examples of NHS providers opening or reconfiguring rehabilitation facilities to react to regional demand. These are detailed in Appendix F.

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[471] Parties' response to the issues statement, paragraph 2.40.
[472] Parties' response to the issues statement, paragraph 2.41.
[473] Parties' response to the issues statement, paragraph 2.42.
[474] Parties' response to the issues statement, paragraph 2.43.

12.69 Accordingly, the Parties consider that customers and the NHS have the ability to constrain providers of rehabilitation services in a variety of ways through their 'strong countervailing buyer power.'[475]

Our assessment

12.70 The assessment of whether buyer power would be sufficient to offset any effects of an SLC in the local area is captured in our local competitive assessments where we provisionally found an SLC. Below we discuss our analysis of the relevant factors which informed these assessments.

Framework contracts

12.71 In our view, CCGs grouping together to commission rehabilitation services under a framework agreement may allow the customers using the framework agreement to improve their negotiating position. However, we note that even where framework contracts are in place their impact may fall some way short of generating the countervailing buyer power that would protect prices and quality for all customers referring to providers in that area (see Appendix F for examples based on the Parties' submissions).

Use of NHS benchmarks

12.72 The Parties told us that the National Tariff inflator/deflator set by NHSI acts as a benchmark that all CCGs use in negotiating prices (see paragraph 8.1(c) above12.61 above. As set out in paragraph 2.65, although there is no nationally set price for rehabilitation services, services and tariffs are negotiated and agreed locally, providers must comply with rules specified in the 'National Tariff Price 2017/18'.[476] 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.[477]

12.73 Examples provided by the Parties[478] suggest that the ability to use benchmarks effectively to reduce prices may depend on the concentration of the individual customer and the availability of local alternatives (among other factors). More widely, [✂].

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[475] Parties' response to the issues statement, paragraph 2.46.
[476] See the 2017/2018 and 2018/2019 National Tariff Payment System, published by NHSI and NHSE.
[477] 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%.
[478] See Appendix F.

12.74 While NHS benchmarks may create constraints for some providers, there is evidence of competition between providers leading to better outcomes for customers above and beyond the impact of national benchmarks or quality regulation. The Parties have provided examples[479] of how the threat of switching or actual switching can act as a constraint on pricing or quality. In our view this is likely to explain some of the variation in prices across customers, in particular [✂].

12.75 Based on the above, our view is that while NHS benchmarks are a factor that affects pricing, they do not remove the scope for competition on price or the potential for the Merger to adversely affect competition, such that they should be considered as a countervailing factor.

Customer concentration

12.76 We looked at customer concentration as a possible source of buyer power.

12.77 Customer concentration across the Parties' sites is varied (see Appendix F for examples). The Parties provided examples at specific sites where a single customer can make up a large proportion of purchases. However, we found customer concentration at other sites is lower. Consequently, customer concentration needs to be considered on a case-by-case basis in the local competitive assessments.

12.78 In addition, our view is that any buyer power exercised by those customers responsible for a greater number of referrals would not always be sufficient to protect other customers. To the extent that buyer power is used as a constraint to ensure quality at the site, quality for other customers may also be protected. However, as prices are often individually negotiated, discounts negotiated using a large customer's buying power would not naturally extend to other customers. It therefore does not appear in general that buyer power exercised by larger customers could be relied on to protect smaller customers.

12.79 The Parties' submitted that customers would be able to exercise buyer power by limiting referrals to their other sites in other areas and/or for other treatment types (where there is no overlap between the Parties).[480] However, given the large number of individual customers at the overlap sites, in our view it is unlikely that the Parties would be dependent on many of these individual customers across their network of hospitals.

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[479] For example, [✂].
[480] Parties' response to the issues statement, paragraph 2.42.

Consequently, it appears that many customers would not be able to discipline the Parties by limiting referrals to other sites in other areas.

Sponsoring of entry and self-supply

12.80 The Parties submitted that NHS trusts that have either entered joint ventures with independent providers to provide rehabilitation services or have opened new rehabilitation services themselves (see paragraphs 12.67 to 12.68).

12.81 We have heard from various third parties about new models of commissioning mental health services, currently being led by NHSE, which may have an impact on rehabilitation services in the longer term. These new models have objectives to reduce out-of-area placements (particularly for acute services) and, where possible and appropriate, to treat patients in less secure settings (for example, to move more patients from acute services to rehabilitation services and from rehabilitation services to community services).[481]

12.82 These new models are implemented through local Service Transformation Plans (STPs). It appears that STPs, where implemented, have the potential to substantially transform demand and supply for different services in the area. In this regard, Elysium submitted that: 'Where local areas are asked to devise STPs, these may or may not include independent providers and a provider could find that it ends up with a hospital in a geographical location that is no longer commissioned, without any consultation or offer to be involved in the STPs.'

12.83 The possibility of implementing a local STP or investing in NHS capacity may in principle imply buyer power (provided it is timely, likely and sufficient to negate an SLC). However, this needs to be assessed on an area-specific basis.

Conclusion on buyer power

12.84 Based on our analysis of the evidence as set out above, our conclusion is that buyer power is unlikely to be an effective countervailing factor in general. Where relevant we considered the effect of this potential countervailing factor in our local area assessments.

[481] We are currently aware of two examples of such interventions in East London and Sheffield.

Efficiencies[482]

12.85 The Parties told us that the Merger was likely to give rise to efficiencies and benefits for patients, predominantly by easing the transitions between different stages of the care pathway. They said that the Merger would broaden the reach of the Parties across the care pathway and enable a greater number of smoother transitions, which would be less disruptive for patients.[483]

12.86 However, as noted in paragraph 7.10, the decision to allocate patients in rehabilitation services can in general be treated independently of the provider's position on other parts of the care pathway. Therefore, although pathway benefits are possible, in order for these efficiencies to be taken into account in our assessment, we expect the Parties to provide evidence that the efficiencies claimed are a direct consequence of the Merger, are rivalry enhancing and timely, likely and sufficient to prevent an SLC from arising.

12.87 We have not received evidence from the Parties showing that any efficiencies that might be generated would enhance rivalry in the provision of rehabilitation services.[484] We have therefore not placed any weight on the effect of efficiencies in our assessment of the Merger.

13. Findings on the SLC test

13.1 As a result of our assessment we conclude that the Merger may be expected to result in an SLC within the market for the provision of hospital-based inpatient rehabilitation services for male LTMH patients in the East Midlands.

13.2 The SLC in this local area may be expected to lead to adverse effects for customers and patients in terms of prices being higher than they would otherwise be and quality being lower than it would otherwise be.

14. Remedies

14.1 This section considers our assessment of possible remedies to the SLC and its resulting adverse effects and sets out our decision on remedies.

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[482] As explained in our guidance, efficiencies can be taken into account in two ways: efficiencies may enhance rivalry, with the result that the Merger does not give rise to an SLC or they may result in relevant customer benefits which are taken into account when deciding on remedial action (section 41(5) of the Act). Merger Assessment Guidelines, paragraphs 5.7.2 & 5.7.3.
[483] Source: Merger Notice, paragraph 29.1.
[484] Merger Assessment Guidelines, paragraph 5.7.4.

14.2 Having concluded that the Merger may be expected to result in an SLC in the male LTMH market in the East Midlands, the CMA is required under section 35(3) of the Act to answer the following questions:

(a) Should the CMA itself take action for the purpose of remedying, mitigating or preventing the SLC or any adverse effects resulting or expected to result from the SLC?

(b) Should the CMA recommend the taking of action by others for the purpose of remedying, mitigating or preventing the SLC or adverse effects resulting or expected to result from the SLC?

(c) In either case, if action should be taken, what action should be taken and what is to be remedied, mitigated or prevented?

14.3 In deciding these questions:

(a) The CMA shall, in particular, have regard to the need to achieve as comprehensive a solution as is reasonable and practicable to the SLC and any adverse effects resulting from it (section 35(3)); and

(b) The CMA may, in particular, have regard to the effect of any action on any relevant customer benefits arising from the merger (section 35(4)).

14.4 As regards the need to achieve a comprehensive solution, the CMA's guidelines state the following:[485]

> … To fulfil this requirement, the [CMA] will seek remedies that are effective in addressing the SLC and its resulting adverse effects and will then select the least costly and intrusive remedy that it considers to be effective. The [CMA] will seek to ensure, [as outlined in paragraph 1.12], that no remedy is disproportionate in relation to the SLC and its adverse effects ...'

14.5 The CMA's guidelines set out four aspects to be considered in assessing the effectiveness of a remedy:[486]

(a) impact on the SLC and resulting adverse effects: where possible, the CMA will seek to restore competitive rivalry, through remedies that re-establish the structure of the market expected in the absence of the merger;

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[485] Merger Remedies Guidelines (CC8), paragraph 1.7.
[486] CC8, paragraph 1.8.

(b) appropriate duration and timing: the CMA prefers a remedy that quickly addresses competitive concerns, with the effect of the remedy sustained for the likely duration of the SLC;

(c) practicality: a practical remedy should be capable of effective implementation, monitoring and enforcement; and

(d) acceptable risk profile: the CMA will seek remedies that have a high degree of certainty.

14.6 Having considered the effectiveness of remedy options, the CMA will then consider the costs (including costs to the parties, third parties, the CMA and other monitoring agencies) of those remedies that it expects would be effective in addressing the SLC and resulting adverse effects.[487] In order to be reasonable and proportionate, the CMA will seek to select the least costly remedy or package of remedies that it considers will be effective.

Remedies options

14.7 Remedies are conventionally classified as either structural or behavioural. Structural remedies, such as divestiture or prohibition, are generally one-off measures that seek to restore or maintain the competitive structure of the market; they address the reduction in rivalry that results from the merger at source.[488]

14.8 The CMA's Merger Remedies guidelines explain that in merger inquiries, the CMA will generally prefer structural remedies, such as divestiture or prohibition, rather than behavioural remedies because:[489]

(a) structural remedies are likely to deal with an SLC and its resulting adverse effects directly and comprehensively at source in restoring rivalry;

(b) behavioural remedies may not be effective and may create significant costly distortions in market outcomes; and

(c) structural remedies do not normally require monitoring and enforcement once implemented.

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[487] CC8, paragraph 1.10: The CMA will generally attribute less significance to the costs of a remedy that will be incurred by the merger parties. For completed mergers, as in this case, the CMA will not normally take account of costs or losses that will be incurred by the Parties as a result of a divestiture remedy as these are avoidable costs, see also *Intercontinental Exchange Inc. v Competition and Markets Authority* [2017] CAT 6.
[488] CC8, paragraphs 2.5 & 2.6.
[489] CC8, paragraph 2.14.

Divestiture

14.9 Our remedy proposals (see the Remedies Notice, paragraphs 15 and 16) to address the SLC provisionally found were focussed on a structural remedy involving the sale and transfer of one or more of the Parties' LTMH sites in the East Midlands and the West Midlands.

14.10 Views were invited on the effectiveness, design and implementation of those potential remedies and in particular on:

(a) **The sites to be divested:** which and how many of the Parties' sites should be divested.

(b) **The composition of the divestiture package:** what elements of the operations at the divested sites should be included in the divestiture package and whether there should be a requirement for transitional arrangements for the provision of certain support services while the purchaser establishes itself. What implementation issues might be present that will need to be addressed.

(c) **The identification of suitable purchasers:** including whether there are specific considerations relevant to purchaser suitability, given the nature of the operations to be divested.

(d) **An effective divestiture process:** including the appropriate timescale for achieving a divestiture and what procedural safeguards would be needed to minimise any associated risk.

Other remedy options

14.11 In the Remedies Notice, we set out that in light of the various dimensions over which competition takes place in the provision of mental health rehabilitation services, the CMA did not consider that behavioural remedies would be effective in addressing the SLC provisionally found.

14.12 However, the CMA invited views on these remedy options (or a combination of them). In addition, the CMA requested views on any relevant customer benefits that might arise from the Merger.

14.13 We received written responses to the Remedies Notice from the Parties and from two competitors. We also held response hearings with the Parties and a number of third parties.[490] In addition, we contacted CCGs in the overlap areas to alert them to the Remedies Notice and seek their views. Neither the

[490] [✂]

Parties nor any of the third parties proposed an alternative practicable remedy to the ones set out in the Remedies Notice. Given this, we do not consider behavioural remedies further.

Assessment of a structural remedy

14.14 As explained in section 9, we found an SLC in the East Midlands male LTMH market. As set out in paragraph 15 of the Remedies Notice, a structural remedy to this SLC would require the divestiture of one or more of the Parties' seven sites in the East Midlands.

Views of the Parties and third parties on a divestiture remedy

14.15 The Parties [✂] considered that a structural remedy in the form of 'site divestiture in the relevant areas would be an effective remedy to the SLCs provisionally found and any resulting adverse effects should those provisional conclusions become final.'[491]

14.16 Third parties also considered that a structural remedy would be the best remedy option, and that a behavioural remedy would not be effective to address the competition concerns:

(a) [✂] view was that a structural remedy in the form of divestiture to a suitable purchaser would maintain current LTMH bed capacity.

(b) [✂] recognised the need for a divestiture remedy in this case but also pointed out the potential clinical impact on patients of implementing such a remedy.

(c) [✂] stated that the remedy should be structural and involve divestment.

Our view

14.17 Our view is that a structural remedy in the form of site divestiture will be an effective remedy to comprehensively address the SLC we have found. Such a remedy will need to be designed and implemented so that continuity of care for the patients is maintained at the divested site(s).

14.18 We now examine the key elements of designing and implementing an effective structural remedy. These are:

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[491] [✂] This was in the context of our provisional findings, in which we found SLCs in the East Midlands and the West Midlands.

(a) the scope of the divestiture package;

(b) identification of a suitable purchaser; and

(c) the divestiture process.

Scope of the divestiture package

14.19 In relation to the scope of the divestiture package, we consider:

(a) the site(s) to be divested; and

(b) the composition of the divestiture package.

Site(s) to be divested

14.20 In defining the scope of a divestiture package that will satisfactorily address the SLC, the CMA normally seeks to identify the smallest viable, stand-alone business that can compete successfully on an ongoing basis and that includes all the relevant operations pertinent to the area of competitive overlap.[492]

Views of the Parties

14.21 The Parties consider that the SLC in the East Midlands would be effectively remedied by the divestment of [✂]. [✂] on the basis that:

(a) the CMA's SLC finding extended only to one service, ie male LTMH rehabilitation services; and

(b) [✂]

14.22 The Parties argued that [✂] on the basis that:

(a) [✂]

(b) [✂]

(c) [✂]

(d) [✂]

14.23 For these reasons, the Parties' view is that [✂].

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[492] CC8, paragraph 3.7.

Views of third parties

14.24 Third parties were [✂] of the view that sale of specific wards within a larger site could cause difficulties for patients especially if it split a care pathway, and that sale of an entire site was the best option. They also stated that getting regulatory approval from the CQC for sale of specific wards within a multi-treatment site could be problematic:

(a) [✂] told us that divesting a single ward which is part of a larger site is practically very difficult. It said that that this may require multiple CQC licences on one site, and would also be difficult for patients in respect of splitting the care pathway.

(b) [✂] said that it was easier for stand-alone facilities to be divested since it was very difficult to separate a service from a site providing multiple services, and get the necessary regulatory approvals.

(c) [✂] stated that a structural remedy should include sale of a whole unit or sites since there needed to be a critical mass for it to be sustainable, and attract purchasers.

14.25 We noted the issues raised about divesting wards that form part of larger sites and considered them in our assessment of site(s) to be divested.

Sites in scope for divestment in the East Midlands male LTMH rehabilitation overlap

14.26 We identified seven potential sites, one or more of which could be divested to remedy the SLC.

(a) CAS sites:

(i) Storthfield House. This facility has 22 male LTMH beds.[493]

(ii) Sherwood House. This is a multi-treatment facility with 30 male LTMH beds, 17 LD rehabilitation beds and 9 beds in a residential care home.

(iii) The Limes. This is a stand-alone male LTMH facility, with 18 beds.

(iv) The Oaks. This is a stand-alone male LTMH facility with 36 beds.

[493] The Sycamores is a six-bed residential step-down facility located very near to Storthfield House and registered under the West Midlands Community Services. The Parties stated that given the close relationship between this facility and Storthfield House, [✂].

(v) St Augustine's. This is a stand-alone male LTMH facility with 32 beds.

(b) Cygnet sites:

(i) Derby. This is a multi-treatment site with 16 male LTMH beds, and a further 31 PD and low secure beds.

(ii) Lodge Brighouse. This is a stand-alone male LTMH facility with 24 beds.

Views of the Parties

14.27 The Parties stated that they should have the discretion to choose [✂] in the East Midlands. According to the Parties, having that choice would enable them to take account of the following:[494]

(a) potential service disruption risk;

(b) staffing structures, including proportion of permanent staff and degree of reliance on shared clinical staff;

(c) stability/stand-alone nature of the clinical care approach/model;

(d) degree of integration with the step-down facilities; and

(e) extent of each site's reliance on other sites for administrative support.

14.28 The Parties noted that two of the sites potentially in scope for divestiture ie St Augustine's and Lodge Brighouse were closer to the periphery of the 60-mile[495] catchment area.[496]

(a) In relation to St Augustine's, they pointed out that it was 52 miles from Storthfield House, and that according to the CMA 'The market shares when centred on CAS St Augustine's were not identified by our filtering as requiring further analysis'.

(b) In relation to Lodge Brighouse, the Parties noted that it was located 57 miles from Storthfield House, and given this and the CMA's focus on

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[494] Parties' response to the Remedies Notice, paragraph 1.3.
[495] According to the Parties 'it appears in respect of the East Midlands that the key concern for the CMA relates to the close geographical proximity of the Parties' sites within 20 miles of Storthfield House (Report Paragraph 9.174) and the high market share of the Parties (>70 per cent) within this area.' Parties' response to the Remedies Notice, paragraph 2.6a.
[496] Parties' response to the Remedies Notice, paragraph 2.6(b).

geographic closeness of competition, they did not consider this site to be relevant in relation to addressing the SLC.

14.29 Accordingly, the Parties submitted that the sites that would effectively address the SLC provisionally identified [✂]. On this basis, the Parties consider that any divestment undertakings should allow them to choose the [✂] of the following sites to divest:[497]

(a) The Limes;

(b) Sherwood House; and

(c) Storthfield House.

14.30 The Parties consider that given the availability of the [✂].[498]

14.31 The Parties told us that the most appropriate and proportionate [✂] because:

(a) [✂]

(b) [✂]

(c) [✂]

(d) [✂]

14.32 Accordingly, the Parties believe that the risk of disruption to patients would be expected to be lower if [✂].[499]

14.33 In relation to [✂], the Parties made the following additional submissions to the CMA:

(a) there is no evidence that a site needs to be 'centrally located' in order to provide an effective competitive constraint, and that the key factors affecting choice of site (other than distance from the patient's home address) are quality, price and service offering. Therefore, a central location is not relevant in the context of a locked secure rehabilitation service.

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[497] According to the Parties, this was on the basis [✂]. Parties' response to the Remedies Notice, paragraphs [✂].
[498] Paragraph 2.10.
[499] Parties' response to the Remedies Notice, paragraph 2.12.

(b) it would be difficult to argue that [✂] location is in some way inaccessible to customers and patients;[500]

(c) [✂] would not require any significant capital expenditure in order to continue to act as an effective competitive constraint following a divestiture and closure would not be required by a new owner to conduct any works;

(d) the high quality of service at [✂]was illustrated by [✂]occupancy rates, an overall Good CQC rating, and the fact that [✂].

14.34 The Parties also submitted that it would be disproportionate to require the Parties to divest a number of beds equal to the entire increment of Cygnet's East Midlands' sites given that one of Cygnet's sites, The Lodge Brighouse, is located on the periphery of the catchment area, and therefore provides only a limited, if any, constraint on the concentration of sites close to Derby and Mansfield.

Views of third parties

14.35 Third parties generally considered that the Parties should be provided discretion over which sites to divest.

(a) [✂] stated that parties should be allowed to choose the sites to be divested as long as they do not choose underperforming sites, as this which would defeat the purpose of the divestiture, and also be less attractive for potential buyers. It also stated that newer sites would be more attractive for a buyer since the buyer would be less likely to have to make further significant capital contributions.

(b) [✂] suggested that the CMA should put in safeguards to ensure that the Parties could not intentionally run-down the sites that they were intending to sell.

14.36 [✂] told us that an effective divestiture remedy should involve a whole facility rather than specific wards to make it attractive for potential buyers. It was of the view that it might be difficult to find sufficient interested buyers to enable the divestment of Storthfield House.[501]

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[500] Given that (according to the Parties), [✂]
[501] It stated that a structural remedy should include sale of whole units or sites since there needed to be a critical mass for them to be sustainable, and attract purchasers.

14.37 Three CCGs[502] told us that they would be concerned about the divestment of certain sites because of the potential disruption and deterioration of the quality of care for the patients.

14.38 [✂] told us that it would not have any concerns if The Limes were to be divested since it was not 'centrally located', and they did not refer many patients to this site. They also expressed their view that The Limes needed some updating of its facilities.

Our assessment of sites to be divested in the East Midlands

14.39 In our competitive assessment (see paragraphs 9.126-9.127), we investigated the overlap between Cygnet Derby (Wyvern Ward) and Cygnet Lodge Brighouse and five CAS sites (Storthfield House, Sherwood House, The Limes, St Augustine's and The Oaks). To assess capacity shares in this overlap we centred on Storthfield House.

14.40 As we noted in paragraph 9.160, Cygnet Derby is a geographically close competitor to CAS Storthfield House, Sherwood House and The Limes, all within 20 miles' road distance of CAS Storthfield House. Within this 20-mile area, the Parties have a very high share of male LTMH beds ([60–70]%). Further, we said that in our view, this suggests that the Parties' market shares may understate the competitive constraint these sites impose on one another, in particular for customers located nearer to the Parties' sites.

14.41 In our assessment of sites to be divested, we have considered the following key factors:

(a) the extent to which the SLC is addressed by the proposed divestment;

(b) the ease of separating the male LTMH operations at a multi-treatment site; and

(c) the attractiveness of the sites to a purchaser.

14.42 To be effective any divestiture needs to be of a site of sufficient scale that it would be competing on the market with sufficient frequency to exercise constraint on the merged entity and that it should be close enough to the area where the loss of competition is expected to be greatest, for that constraint to be effective in that area.

14.43 Our view is that an effective remedy would require the divestment of any one of the Parties' following four sites: The Limes, Storthfield House, Sherwood

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[502] [✂]

House or Derby, which are located within close proximity of each other, and within 20 miles of Storthfield House. Such a divestiture will comprehensively address the loss of competition within the East Midlands catchment. In light of the factors set out in paragraph [14.42] above, we did not think that it was necessary for a divestiture to match the total increase of capacity from both Derby and the Lodge Brighouse.

14.44 We found that due to their more distant geographical location, the divestiture of any of the Parties' other three sites in the East Midlands ie The Oaks, St. Augustine's and Lodge Brighouse, would not be effective to comprehensively address the concentration of the Parties' male LTMH beds in the narrow area centred on Storthfield House.

14.45 We considered specifically whether divestiture of The Limes would be an effective remedy. The Limes is a stand-alone site, without any significant links with the other services or the sites of the Parties, and therefore its divestiture is likely to be relatively practicable and straightforward to implement without delay, which are key determinants for the effectiveness of a remedy.

14.46 At present, The Limes has an average length of stay of [✂], suggesting that it does not compete in the market as often as some other sites. However, the current use and corresponding [✂] average length of stay would not restrict the ability of a purchaser to adapt the current male LTMH services and compete more frequently as the patient profile evolves.

14.47 We also concluded that the divestiture of the Parties' LTMH operations at any one of the Parties following sites: Storthfield House, Sherwood House or Derby would also be an effective remedy to the SLC found. However, two of these sites are multi-treatment facilities, and the third, Storthfield House has a small connected residential step-down facility. Therefore, carving out specific LTMH operations at these sites is likely to cause practical difficulties and delays in implementing the divestiture. Therefore, in order to be effective and attractive to potential buyers, the entirety of operations (and not just the LTMH services) at one of these three would need to be divested if the Parties were to choose any of these options to comprehensively and effectively remedy the SLC.

14.48 Thus, our remedy provides flexibility to the Parties to divest either a single treatment (male LTMH) site, ie The Limes, or the entire operations (male LTMH and others) at any one of the following three sites: Storthfield House, Sherwood House or Derby. We anticipate that the Parties would be able to identify suitable purchasers for the site they choose to divest out of the above list within a reasonable period (see paragraph 14.112).

Composition of the divestiture package

14.49 In the Remedies Notice we invited views on the appropriate composition of the divestiture package.

Views of the Parties

14.50 The Parties agreed that an effective divestiture package would need to include the following elements and below we set out their summarised views:

(a) **Freehold site:** an attractive divestiture package is likely to include the transfer of any freehold property interests relating to a divestment site.

(b) **Physical facilities relating to the provision of the relevant mental health services provided at the site**: an effective divestiture package should include all the physical premises, fixtures and fittings and equipment normally present at the site, and that are required for the provision of the services.

(c) **Transfer of skilled staff:** [✂].

(d) **Transfer of existing customer contracts in respect of patients admitted to the facilities and the rights to fulfil these, including with relevant commissioners:** facilitation of the novation of customer contracts would be undertaken where possible. However, the Parties did not have sole control over the relevant consents, and noted that:

(i) transfer of some contracts will be subject to relevant regulatory authorisations etc. being transferred/updated or granted, as applicable;

(ii) [✂]; and

(iii) the majority of mental health care contracts contained a standard change of control provision enabling the customer to move the patients to a different provider on change of control, if they believe there is a risk to the patient's level of care. [✂]

(e) **Transfer of existing contracts with clinical staff including visiting consultants**: [✂]

(f) **Transfer of existing supplier contracts**: contracts which serve only the divested sites would be novated to any purchaser (assuming the consent of the service supplier is obtained). However, the Parties recognised that some purchasers may prefer to negotiate their own

supply arrangements and flexibility should be included in the remedy design to accommodate this.

(g) **Rights to use the relevant site or ward name (without the name of the Parties)**: the rights to use the names of the divestment assets if the buyer wished to retain them would be made available.

(h) **Access to relevant customer and patient data and patient records for the purposes of ensuring continuity of treatment**: access to all core patient history records as required by a purchaser to discharge its statutory and regulatory obligations would be provided. [✂].[503]

(i) **Rights to receive services and utilities currently being provided at the divested sites, such as gas, electricity, building access and services etc**: assistance may be required to transfer services and utilities to the purchaser.

14.51 The Parties made the following additional points in relation to the transfer of staff, regulatory approvals and transfer of shared vehicles.

- *Transfer of staff*

14.52 The Parties stated that [✂].

14.53 The Parties noted that [✂].

14.54 Further, they noted that [✂]. For example:

(a) [✂]

(b) [✂]; and

(c) [✂]

14.55 [✂]

14.56 They stated [✂]. According to the Parties, retaining this flexibility is also important in order to manage the impact of divestment from the perspective of individual staff members so that the Parties' have the opportunity to give due and proper consideration to the rights and wishes of employees. Where necessary, the Parties consider that appropriate interim arrangements for a period of [✂] months would be sufficient to ensure continuity in patient

[503] According to the Parties, [✂].

treatment plans in accordance with the terms of a transitional services agreement.

- *Regulatory approvals*

14.57 The Parties noted that where capable of being transferred, the divestiture package should include all or substantially all licences, permits, consents and authorisations issued by any governmental or regulatory organisation for the benefit of the divestment sites. However, they noted that these transfers are not solely at the discretion of the Parties, and will require regulatory approval. They pointed out that the change of registration to the buyer would need to be completed before effective ownership could transfer and would therefore be expected to be a condition to completion of any divestment, as would be standard practice for transactions in this sector.

- *Shared vehicles*

14.58 The Parties stated that the transfer of any shared vehicles should be subject to negotiation with the buyer depending on its own fleet requirements.

- *Transitional support services*

14.59 The Parties acknowledged that depending on the identity of the purchaser, an effective divestiture package may also need to include certain transitional measures, including in relation to existing supplier contracts. In particular, they noted that a number of significant supplier contracts are agreed [✂], and where a purchaser wishes to ensure continuity of supply on Day 1, the Parties would be willing to consider putting in place certain transitional arrangements for a short period (the Parties consider that any purchaser is unlikely to need such support for more than [✂] months).

14.60 The Parties stated that given the number of [✂], they do not consider that there is likely to be any need to provide extensive support services on a transitional basis to any acquirer. In the Parties' experience, the areas where some transitional support may be necessary is in relation to:

(a) Finance: [✂]-month limited scope transitional services agreement may need to be entered into to enable full migration of relevant data onto the buyer's systems;

(b) IT and communications: limited site-specific IT continuity support may need to be offered during the [✂]following completion;

(c) HR: the Parties do not anticipate that any transitional services would be required, with the exception of [✂] payroll assistance under Finance above;

(d) Procurement: the Parties do not anticipate that any transitional services would be required, with the exception of the supplier contracts mentioned above;

(e) Quality: other than general handover and guidance, the Parties said [✂] if this was of use to the buyer.

Views of third parties

14.61 Third parties agreed that the scope of the divestiture package as set out in the Remedies Notice was broadly comprehensive but made additional suggestions on how the scope could be further enhanced.

14.62 [✂] stated that it was important that both skilled and non-skilled staff were transferred to ensure that the divested sites continue to operate effectively. It also stressed the need to ensure that any patient information that was transferred was done securely. In relation to transitional arrangements, [✂], view was that an existing provider would need a transitional services agreement (TSA) for about [✂] months. As part of the transitional services, [✂] thought that some self-audit and self-assurance reporting arrangements would need to continue for a time.

14.63 [✂] stressed that the divestiture package should be configured to ensure that the occupancy at the divested sites is maintained especially in the initial [✂] months after the divestiture. It felt that key staff that had established relationships with the customers should be part of the divestiture package. According to [✂], records to enable the ongoing operation of the site, including risk reporting software, health and safety records and fire inspection records should also be included in any divestment requirement.

14.64 [✂] told us that the divestiture package should include skilled staff and existing supplier contracts. In respect of transitional arrangements, it felt that the purchaser should have access to customer and patients' data. Further, it stated that the hospital manager should be transferred as part of the divestiture, and data related to patient care, for example minutes of meeting with carer should also be transferred. It said there was less of a need to transfer any headquarters staff or regional management since the purchaser was likely to have something in place.

14.65 [✂] stated that it was important to include in the divestiture package the right people, to ensure the quality of service and viability of the business. It

stressed that all site staff needed to be transferred, including ward staff, HR and business development staff associated with the site. Further, any central staff that are key for the operation of the sites, should also be transferred. It stated that transfer of central and headquarters staff would depend on the requirements of the buyer. It also stated that in addition to the contracts listed in the Remedies Notice, it was important to include transfer of pharmacy services as part of the divestiture package. [✂] told us that that in addition to patient data, other data such as staff training, HR data, fire risk assessments, serious incident reports and maintenance schedules to adhere to building regulations should also be included in the divestiture package.

14.66 In respect of transitional services, [✂] stated that HR and recruitment services should also be included in the divestiture package. It felt that the duration of transitional arrangements would depend on the needs of the purchaser, but thought it should be [✂].

14.67 [✂] told us that any divestiture package should be comprehensive enough to ensure that the service can function effectively under a new owner immediately. It stated that carer records as well as patient records should be transferred, and 'nothing should be left behind.' In relation to transitional arrangements, it said that these would depend on the requirements of the buyer; if the purchaser was an existing provider, and there were only [✂] divestment sites, the need for a TSA was limited. However, for a new provider there would be a need for a TSA for [✂]months. It stated that the key to achieving a successful divestiture and functioning of the divested sites was for the incoming provider to have a good management team.

14.68 [✂] felt that transfer of skilled staff and hospital manager were the key components of a comprehensive divestiture package.

14.69 [✂] stated that any transfer of care should be the least disruptive to the patient and should minimise any discontinuity of care. It felt that this could be best achieved by transferring the entire care team alongside the transfer of the patient. Further, robust measures should be in place to ensure that the handover of care is safely managed and all risks identified.

14.70 Similarly, [✂]said that it is imperative that the continuity of care is not lost and that patients, families, care coordinators, social care and commissioners are kept informed and involved at all stages. Further, there would need to be realistic time frames for each site so as not to destabilise patients.

14.71 [✂] told us that it would be concerned about any reduction in quality of care that would be detrimental to the patients requiring the locked rehabilitation services provided at the divested sites, and any change in contract terms or

price that would be detrimental to the CCG as a customer. Further, it stated that it [✂] would have significant concerns should the sale result in a change of clinical staff or management within these units. It would expect the current standard of length of stay and clinical outcomes to be maintained.

Our assessment of the composition of the divestiture package

14.72 In our view, the divestiture package should be comprehensive enough to ensure that the buyer is able to operate as a credible and viable competitor from the start and over the long term, and to ensure levels of patient care are maintained.

14.73 The divestiture package should also be designed to mitigate or minimise risks to the potential purchaser, especially in respect of its ability to serve the needs of its customers and patients in the future.

14.74 Having considered the views of the Parties and third parties, and taken account of the above risks, we consider that the specific details of the composition of the divestiture package should be established through commercial negotiation between the Parties and the potential purchaser, and subject to the CMA's approval. As a minimum, the Parties should offer to include the following core elements in the divestiture package:

(a) Freehold site or (if leasehold) rights to the lease.

(b) Physical facilities and assets related to the provision of the relevant mental health services provided at the site.

(c) Transfer of skilled staff and other staff [✂].

(d) Use best endeavours to novate all customer contracts and supply agreements to the buyer(s).

(e) Use best endeavours to transfer existing contracts [✂].

(f) Rights to use the relevant site or ward name (without the name of the Parties).

(g) Transfer of relevant customer and patient data and records (including carer data and records) for the purposes of ensuring continuity of treatment and to enable the purchaser to discharge its statutory and regulatory obligations.

(h) Transfer of other site related records held or maintained by the Parties, for example:

(i) HR records, including staff training;

(ii) fire risk assessments;

(iii) health and safety records;

(iv) serious incident reports including action taken;

(v) maintenance schedules to adhere to building regulations.

(i) Transfer of rights to receive services and utilities currently being provided at the divested sites, such as gas, electricity, building access and services etc.

14.75 In addition, it may be necessary for the Parties to offer to provide certain support services on a transitional basis, depending on the requirements of the purchaser, and we would expect the Parties to offer such transitional arrangements to the buyer. These services could include (but are not limited to) the following:

(a) [✂]

(b) [✂]

(c) self-audit and self-assurance reporting arrangements to ensure quality of patient care is maintained;

(d) essential supplies (eg medicines, catering etc), if not transferred as part of transfer of supplier contracts;

(e) provision of central support services such as finance, HR, IT and procurement.

14.76 The duration of any transitional arrangements will be subject to commercial negotiation with the purchaser, and need to be approved by the CMA. We would not expect the transitional arrangements to exceed [✂].

14.77 The price of any services to be provided by the Parties to the purchaser of the divested business as part of any transitional arrangements should be subject to commercial negotiation, and the CMA will review it as part of the approval of the terms of the divestiture.

Suitable purchaser

14.78 According to the CMA's guidelines, we will wish to satisfy ourselves that a prospective purchaser:[504]

(a) is independent of the Parties;

(b) has the necessary operational and financial capability to compete effectively; and

(c) is committed to competing in the relevant market and will not create further competition concerns.[505]

14.79 It is important that a suitable purchaser should be able to demonstrate the ability to provide continuity of care to the patients at the divested sites. The CMA will expect the purchaser to have, or be able to obtain without undue delay, all necessary licences and consents from any regulatory or other authority to purchase and operate the divested sites.

Views of the Parties

14.80 The Parties are of the view that an [✂].

14.81 According to the Parties, [✂].

14.82 The Parties expect that [✂]. The Parties do not consider, however, that it is necessary to require the purchaser to have experience of providing mental health rehabilitation services in East Midlands. [✂]

14.83 The Parties pointed out that the potential timeline for completion of a divestment will be impacted by the readiness of a purchaser to fulfil the regulatory obligations, which will include relevant sector experience.

14.84 The Parties consider that the divestiture process should be open to all prospective purchasers that meet the CMA's requirements. Accordingly, the Parties do not consider that it is necessary to state any additional prequalification requirements.

14.85 The Parties stated that other than potentially being subject to obtaining merger control approval, the purchaser will need to ensure that the CQC is notified of changes in ownership of any registered services, and would need to approve the re-registration under new ownership. It is expected that the

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[504] CC8, paragraph 3.15.
[505] This may be demonstrated by having an appropriate business plan and objectives for competing in the relevant market.

sequencing of the regulatory aspects of any divestment would be finalised in consultation with the CQC.

14.86 The Parties told us that [✂].

Views of third parties

14.87 [✂] told us that it would be useful but not essential for the purchaser to have knowledge of the local area. However, it felt that the purchaser needs to have experience of providing mental health services in hospital settings.

14.88 [✂] said that if the purchaser had previous relationships with the Commissioners, it would be more suitable. It also said that the purchaser should be able to continue the therapeutic approach being provided to certain existing patients of the Parties. [✂] felt that it was important that the purchaser had experience of providing the mental health services being provided at the divested sites, or was able to put together a management team with the relevant experience. In respect of regulatory approvals, it stated that a purchaser would need to have CQC registration and a Monitor (NHSI) license.

14.89 According to [✂], it did not matter if the purchaser was large or small, as long as it had the experience of providing services being provided at the divested sites locally or elsewhere.

14.90 [✂] said that the CMA should not specify a specific profile of the purchaser, ie national or local competitor; private equity or trade buyer, although it felt scale was important to ensure adequate clinical provision. It stated that it was desirable that the purchaser had experience in providing mental health services in the UK. It stated that from the customers' perspective it was important that the purchaser understood the provision of rehabilitation services. Further, it stated that it would be useful for the provider to be on the East Midlands Framework but this should not be a mandatory requirement.

14.91 [✂] also stated that the divested units should not be converted to low or medium secure, as this would undermine the remedies that the CMA had put in place in the same locations following Acadia's acquisition of The Priory Group and Partnerships in Care.

14.92 [✂] told us that the purchaser (whether it is trade buyer or private equity, large or small) would need to have resources and management expertise to run the business. It said that it would be better for the purchaser to have the experience of providing rehabilitation services, but that should not be a pre-condition. It also stated that it was more likely to be a UK rather than an

overseas provider, and that although it was not necessary to sell multiple sites to a single purchaser it would be easier to do so. Further, it said that the purchaser did not need to be on the East Midlands Framework but that it would be helpful.

14.93 [✂] told us that it would be concerned if the purchaser was a new provider without a track record in services being provided at the divested sites. It felt that a suitable purchaser should have a track record in providing LTMH locked rehabilitation services, and that local knowledge was relatively less important.

14.94 [✂] told us that it was 'not closed to a smaller provider taking on the provision' if it could be assured of the quality of service.

14.95 [✂] told us that the new provider should be able to provide a prospectus of care detailing therapeutic interventions in addition to recreational and vocational activities and all activities should be factored in to the contract. Further, it stated that the purchaser should have:

(a) a proven track record of delivering a high standard of care for LTMH patients;

(b) a good CQC rating;

(c) clear and explicit details of staffing levels and skill mix;

(d) a provision of a care and treatment prospectus, including assurances of regular multi-disciplinary team (MDT) reviews of care;

(e) a provision of regular feedback reports or progress reports; and

(f) a track record of a strong client focus and ethos.

14.96 [✂] told us that purchasers should have a background knowledge and operational experience of providing hospital based inpatient rehabilitation services so that the 'quality of care and safety at the divested sites is not compromised'.

Our assessment of suitable purchaser

14.97 In line with our guidance, we will need to satisfy ourselves that prospective purchasers can be readily identified[506] and that they are independent of the

[506] According to the guidelines, uncertainty as to whether a suitable purchaser will emerge will generally not be sufficient for the CMA to conclude that any form of divestiture remedy is not feasible. It is normally possible to implement divestitures, despite uncertainties, given flexibility in the disposal price. CC8, paragraph 2.19.

Parties; have the necessary operational and financial capability to compete effectively; and are committed to competing in the relevant market(s), in the short, medium and long term. Divestiture must not create further competition concerns.[507] In this case it is also key that the change of ownership safeguards continuity of patient care.

14.98 In order to be judged sufficiently independent, a purchaser would not normally be expected to have continuing links with the Parties after divestiture, as this may compromise the purchaser's incentives to compete (for example financial, ownership or management links).[508] However, we recognise that in this case, the purchaser may require access to certain key inputs (eg central services, training etc) from the Parties for a limited period of time, in order to ensure a smooth transition and enable the divestiture to be effective.

14.99 As part of our assessment of capability and commitment to the relevant market, we would expect a suitable purchaser to be able to evidence its ability to provide continuity of care to the patients at the divested site. Any suitable purchaser is expected to have experience of providing mental health services in the UK.

14.100 The CMA will expect the purchaser to have, or be able to obtain without undue delay, all necessary licences and consents from any regulatory or other authority to purchase and operate the divested sites. We intend to consult the CQC to inform our assessment of a suitable purchaser.

Effective divestiture process

14.101 An effective divestiture process should protect the competitive potential of the divestiture package before disposal, and enable a suitable purchaser to be secured in an acceptable timescale. Further, the divestiture process should also allow prospective purchasers to make an appropriate acquisition decision.[509]

Timeframe and method of sale

Views of the Parties

14.102 Although keen to ensure that any new arrangements were put in place as soon as practicable, the Parties were of the view that given the necessity of

[507] CC8, paragraph 3.15.
[508] CC8, paragraph 3.18.
[509] CC8, paragraph 3.20.

[✂], a structural remedy involving a divestment could take [✂] to put in place.

14.103 The Parties stated that they were aware of the CMA's preference to minimise the duration of the divestiture period. In determining that duration, they noted that CMA is generally required to balance:

(a) its requirements as regards reducing asset risk and giving rapid effect to the remedy; and

(b) the need to ensure that the Parties have enough time to achieve an effective disposal.

14.104 The Parties consider that a period of [✂] months would be appropriate to canvass suitable purchasers, and to facilitate adequate due diligence, in order to create an effective and appropriate divestiture package.[510]

14.105 The Parties consider that the most effective transaction structure is likely to comprise an asset sale rather than a share sale. This is driven by a number of factors, including the following:

(a) Parties do not operate each of their sites through separate legal entities;

(b) a share sale is likely to be more time consuming to implement;

(c) an asset sale would result in less uncertainty and disruption for staff; and

(d) a share sale would require the Parties to hive-off divestment assets into separate newly incorporated legal entities, which would trigger additional de-registration and re-registration of sites.

14.106 The Parties told us that a number of potential purchasers have registered expressions of interest since the publication of the provisional findings report. Consequently, the Parties are confident that they would be able to select a suitable purchaser within the timeframe set by the CMA. The Parties do not consider that any particular concerns would arise as regards

[510] The Parties stated that such period is not expected to result in appreciable asset risk given that: (a) the Parties have demonstrated their ability to maintain the value of the CAS business since it was acquired on 28 December 2016; (b) given that the Parties operate in a highly regulated sector, they would have limited incentive or ability deliberately to operate any of the potential divestiture assets in a manner in which might cause appreciable asset risk; (c) any potential asset risk would be further mitigated by providing the Parties with greater discretion to decide which sites need to be divested; and (d) the Parties would be willing to put in place appropriate procedural safeguards to minimise the risk associated with a divestiture process. Further, they stated that UHS/Cygnet are willing to put in place procedural safeguards needed to minimise the risk of loss of competitive potential of the divestment sites.

maintaining the attractiveness and viability of any divestment site pending completion of sale.

Views of third parties

14.107 [✂] stated that it would take [✂] to complete the divestiture as envisaged in the proposed structural remedy. According to [✂], it would take a minimum [✂]to complete the divestiture, and stated that the CMA should encourage the Parties to achieve a quick disposal to minimise any disruption for the patients and staff. [✂] stated that [✂] was an adequate period to achieve the proposed divestiture.

14.108 [✂] felt that the Monitoring Trustee should be kept in place during the divestment process, to ensure that key day to day running of the business continues as usual.

Regulatory approvals

14.109 [✂] pointed out the need to get CQC's approval for a purchaser to acquire and operate the divested sites. [✂] also mentioned need for CQC registration and an NHSI licence.

Our assessment of the divestiture process

14.110 In our assessment of the divestiture process, we have weighed the risk of not giving enough time to implement a smooth and effective divestiture versus the risk of uncertainty and disruption for customers and the Parties that may impede the Parties' ability to compete effectively and ensure continuity of care for patients. We have also considered the risks around the preservation of the divested business during the divestiture process.

14.111 Based on our assessment, we would expect the Parties to find a purchaser, exchange contracts, and subject only to any outstanding regulatory approvals, implement the divestiture within [✂] months of our final determination.[511] We would expect the Parties to inform us of any developments that could risk the completion of divestiture within this timeframe.

14.112 The divestiture is likely to be implemented through an asset sale.

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[511] Section 79 of the Act provides that a merger reference is finally determined on the acceptance of final undertakings by the CMA or the making of an order should undertakings not be agreed.

14.113 Although the Parties normally have an incentive to maximise the disposal proceeds of a divestiture, they also have incentives to limit the future competitive impact of a divestiture on themselves.[512] We note that an independent Monitoring Trustee is in place, and we would expect them to continue to monitor the Parties' operations during the divestiture process, and also report to the CMA on the progress of the divestment, to mitigate any such risk.

14.114 Absent exceptional concerns, our usual practice is not to require the appointment of a divestiture trustee at the outset of the divestiture process. If the Parties prove unable to identify a suitable purchaser by such a time that would enable them to complete the divestiture to a suitable purchaser within [✂] months of our final determination, we would expect to appoint a divestiture trustee. In that event, we would discuss with the divestiture trustee, which of the Parties' sites in the East Midlands overlap should be divested to achieve a timely and effective disposal.

14.115 We would expect the Parties to keep their customers and other key stakeholders (eg the CQC) suitably involved and informed of the divestiture plans and process, including on their choice of the site to be divested.

Conclusion on structural remedy

14.116 The CMA has identified an effective structural remedy involving divestment of any one of four of the Parties' sites in the East Midlands (see paragraphs 14.43-14.49) where an SLC has been found with the aim of restoring the competitive constraint that will be lost as a result of the Merger.

14.117 In line with the guidelines, we have assessed the effectiveness of this remedy along the following dimensions: (a) impact on SLC and resulting adverse effects; (b) appropriate duration and timing; (c) practicality; and (d) acceptable risk profile.[513]

14.118 The SLC which we found was due to the loss of competition from the Merger of two main providers of male LTMH services in the East Midlands. It is therefore appropriate for the remedy in this case to be targeted towards restoring this loss of competition. The CMA's view is that a structural remedy in the form of a site divestiture will comprehensively address the SLC which we have found.

[512] CC8, paragraph 3.4.
[513] CC8, paragraph 1.8.

14.119 Since the terms of divestiture would be defined by contractual terms, a structural remedy in the form of site divestiture would be easier to implement, and not require ongoing monitoring or enforcement by the CMA. A relatively quick divestiture, expected within [✂] months (subject only to any outstanding regulatory approvals) of our final determination, would further ensure that the remedy is effectively implemented.

14.120 The proposed divestiture package provides a core comprehensive list of elements to form the basis of negotiation between the potential buyers and the Parties. Further, while approving the Parties' choice of specific site to be divested, the purchaser, and the terms of divestiture, the CMA would satisfy itself of the commitment of the potential purchaser to the market, and in particular their ability to maintain the quality of patient care.

14.121 We recognise that there are some risks[514] associated with the structural remedy:

(a) the identity of any potential purchaser, and their ability to operate the divested site as an effective competitor;

(b) the possibility that existing customers might take the opportunity to break away from their contracts;

(c) the competitive capability of a divestiture package could deteriorate before completion of divestiture, for example through loss of customers or key members of staff; and

(d) the potential disruption to and deterioration of quality of care for the patients at the divested site.

These risks might also result in some disruption to the ability of the Parties to compete effectively, at least in the short term.

14.122 These risks can be managed effectively by ensuring that the divested site is sold to a suitable purchaser, the divestiture package is comprehensive, the divestiture process is effectively monitored, and the divestiture is speedily implemented.

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[514] The CMA's guidelines mention three broad categories of risks that may impair the effectiveness of divestiture remedies: (a) Composition risks—these are risks that the scope of the divestiture package may be too constrained or not appropriately configured to attract a suitable purchaser or may not allow a purchaser to operate as an effective competitor in the market; (b) Purchaser risks—these are risks that a suitable purchaser is not available or that the merger parties will dispose to a weak or otherwise inappropriate purchaser; and (c) Asset risks—these are risks that the competitive capability of a divestiture package will deteriorate before completion of divestiture, for example through loss of customers or key members of staff. CC8, paragraph 3.3.

14.123 We believe that these risks are effectively managed given the proposed remedy design and careful oversight of the divestiture process by the CMA and the monitoring trustee.

14.124 The Parties told us that a number of potential purchasers have registered expressions of interest since the publication of the CMA's provisional findings, which indicates a high likelihood of speedy implementation of the structural remedy. Given that interest in buying the divested business could come from a variety of competitors, the remedy should be capable of being implemented relatively quickly.

14.125 The Interim Order (IO) currently in place to prevent pre-emptive action[515] requires the Parties to hold the CAS business separate. The IO will cease to have effect on acceptance of final undertakings or making of a final order. However, we propose to replace the IO with revised interim measures which apply only to the assets in the East Midlands (the divestiture assets), thereby releasing the Parties from the hold separate obligations in respect of the rest of the CAS business reflecting the findings of this inquiry.

14.126 As the revised interim measures will cease to have effect on acceptance of final undertakings or the making of a final order, measures will be put in place to ensure that the divestiture assets are maintained until finally disposed of. We will incorporate appropriate measures into the final undertakings or final order to minimise any asset risks during the divestiture process.[516] These measures will remain in place until the relevant divestiture has been completed.

14.127 An independent monitoring trustee is in place, and will be retained to manage asset and purchaser risks. The monitoring trustee will ensure that the divestiture assets are not degraded during the divestiture process, and can compete effectively once the divestiture is completed. We will require the Parties to inform us immediately of any developments that could risk the completion of divestiture within this timeframe.

14.128 Overall, we conclude that a structural remedy involving the sale of any one of four of the Parties' sites in the East Midlands as explained in paragraphs 14.42-14.48 would be an effective remedy to address the SLC by restoring competition lost by the Merger.

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[515] Pre-emptive action means action which might prejudice the reference or impede the taking of any action which may be justified by the CMA's decisions on the reference: EA02 section 80(10).
[516] Since the IO or (if put in place), revised interim measures will cease to have effect on the acceptance of final undertakings.

Relevant customer benefits

14.129 In deciding the question of remedies, the CMA can also consider the effects of any remedial action on any relevant customer benefits in relation to the creation of the relevant merger situation concerned.[517]

14.130 The Act provides that a benefit is only a relevant customer benefit if it accrues or is expected to accrue, to relevant customers in the UK within a reasonable period from the merger and would be unlikely to accrue 'without the creation of that situation or a similar lessening of competition.'[518]

14.131 We have not received any representation or evidence from the Parties regarding the existence of any such relevant customer benefits or benefits for the patients arising from the Merger. None of the third parties pointed out any relevant customer benefits in this case.

14.132 We have therefore not placed any weight on relevant customer benefits in our assessment of the remedies.

Proportionality of the effective remedy option

14.133 The CMA seeks to ensure that no remedy is disproportionate in relation to the SLC and its adverse effects.[519] In making the assessment of proportionality, it is necessary to consider the costs of a remedy and whether there is a less intrusive or onerous remedy available.

14.134 In this case, we have identified a structural remedy in the form of site divestiture, which we expect to be effective in remedying the SLC. There are no effective alternatives to the structural remedy, and we are providing options that enable the Parties to minimise the cost of divestiture, ie by focussing only on the East Midlands SLC area, and allowing the Merger as a whole to proceed.

14.135 Our decision provides flexibility to the Parties in implementing the structural remedy. The cost of implementing and monitoring the divestiture are avoidable costs, and are therefore not relevant to the assessment of proportionality.[520]

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[517] Section 35(5) of the Act and paragraph 1.14 of CC8.
[518] Section 30(2) of the Act and paragraph 1.16 of CC8.
[519] CC8, paragraph 1.9.
[520] See CC8, paragraphs 1.10 and 1.32, *Intercontinental Exchange, Inc, v Competition and Markets Authority* [2017] CAT 6. In any event, we expect these costs to be relatively modest in this case.

14.136 Given the flexibility and the range of potential purchasers, we would expect the Parties to receive a fair price for the assets sold, and for any transitional services provided. We also note that this remedy would allow the Parties to provide services in catchment areas where no SLC has been found and at the sites in the East Midlands overlap which are not divested.

14.137 We have not identified any adverse effects of the remedy provided it is effectively implemented.

14.138 ,We therefore consider our proposed remedy to be proportionate to address the SLC.

Decision on the choice of remedy and implementation

14.139 Our decision is that the SLC we found in the provision of male LTMH services in the East Midlands catchment area can be remedied by divesting any one of the Parties' following four sites: The Limes, Sherwood House, Storthfield House or Derby. As explained in paragraph 14.47, if the Parties decide to choose to divest Sherwood House, Storthfield House[521] or Derby, the divestiture would need to be of the whole service portfolio at these sites, and not just limited to the male LTMH operations.

14.140 We consider that the details of the composition of the divestiture package should be established through commercial negotiation between the Parties and the potential buyer, and subject to the CMA's approval. As a minimum, the Parties should offer to include in the divestiture package the core elements outlined in paragraph 14.74.

14.141 In addition, we would expect the Parties to offer the necessary transitional arrangements which could include (but are not limited to) those outlined in paragraph 14.75. The duration of any transitional arrangements will be subject to commercial negotiation, the requirements of the buyer and the CMA's approval. We would not expect the transitional arrangements to exceed [✂] months.

14.142 The price to be paid by the purchaser should be based on commercial negotiation between the Parties and potential purchasers, but we would expect this to include:

(a) a one-off payment for the assets and rights divested; and

[521] In relation to Storthfield House, the divestiture would need to include the residential step-down facility, The Sycamores.

(b) ongoing payment for any transitional services.

14.143 The price of the services to be provided by the Parties to the purchaser of the divested business as part of any transitional arrangements should be subject to commercial negotiation, and the CMA will review it as part of the approval of the terms of the divestiture.

14.144 As part of our consideration of purchaser suitability and in line with the standard criteria set out in our guidance, the purchaser, which will need to be approved by the CMA, will need to demonstrate that it has capability, commitment and credible plans to provide male LTMH rehabilitation services at the divested site, and an ability to provide continuity of care to patients.

14.145 We expect the purchaser to have or be able to obtain, without undue delay, all necessary licences and consents from any regulatory or other authority to purchase and operate the divested sites.

14.146 We would expect the Parties to find a purchaser, exchange contacts, and subject only to any outstanding regulatory approvals, implement the divestiture within [✂] months of our final determination.

14.147 We expect to implement the structural remedy by seeking suitable undertakings from the Parties. We would expect to issue an order if we are unable to obtain satisfactory undertakings from the Parties.

14.148 We would expect the Parties to keep their customers and other key stakeholders (eg the CQC) suitably involved and informed of the divestiture plans and process, including on their choice of the site to be divested.