Completed acquisition by Riviera Bidco Limited of Dental Partners Group Limited

Decision on relevant merger situation and substantial lessening of competition

ME/6990/22

The CMA's decision on reference under section 22(1) of the Enterprise Act 2002 given on 23 August 2022. Full text of the decision published on 22 September 2022.

Please note that [✂] indicates figures or text which have been deleted or replaced in ranges at the request of the parties or third parties for reasons of commercial confidentiality.

SUMMARY

1. The Competition and Markets Authority (**CMA**) has found that the completed acquisition by Riviera Bidco Limited (**Riviera**) of Dental Partners Group Limited (**Dental Partners**) (the **Merger**) gives rise to a realistic prospect of a substantial lessening of competition (**SLC**) as a result of horizontal unilateral effects in the provision of NHS general dental treatments in two local areas in England.

2. Riviera, which owns and controls Rodericks Dental Limited (**Rodericks**), and Dental Partners are together referred to as **the Parties** or the **Merged Entity**.

3. Rodericks and Dental Partners are two of a relatively small number of large corporate dental groups active in the UK. They have grown in recent years, partly as a result of acquisitions. Over the last two years, for example, Rodericks acquired 46 dental practices and Dental Partners acquired eight dental practices. Rodericks and Dental Partners are the fourth and eighth largest corporate dental groups in the UK (by number of practices), respectively. Both Parties provide general and specialist dental treatment to NHS patients, as well as to private patients.

4. The CMA had jurisdiction to review the Merger because Rodericks and Dental Partners have a combined share of supply of over 25% (measured by share of sites or share of NHS treatments) in several local areas in the UK in which they overlap.

5. The CMA assessed the potential impact of the merger on competition for patients at the local and national level, as well as on competition between dental practices for NHS contracts tendered at the regional level. In relation to national competition for patients, the CMA found that the Parties would have a relatively small combined share of supply, and that there would remain several strong competitors (in particular other large corporate dental services groups operating at the national level). In relation to competition for regional NHS contracts, the CMA found that the Parties would have a low combined share of supply of contracts, that they are not close competitors (they rarely bid for the same contracts), and that there would remain sufficient other competitive bidders post-merger. The CMA therefore focused its assessment primarily on competition for NHS and private patients at the local level.

6. At the local level, the CMA considered the impact of the Merger on competition in the areas surrounding each of the Parties' dental practices (four miles for general dental treatments and five miles for specialist dental treatments). The CMA found that competition concerns would arise in any local area where the Parties overlap and would have a combined share of (i) 35% or more of the NHS dental treatments in the area, or (ii) 30% or more of sites offering private treatments in the area.

7. The CMA found that the Merger would not give rise to a realistic prospect of an SLC in the large majority of areas in which the Parties operate. The CMA did, however, find that it is or may be the case that the Merger has resulted, or may be expected to result, in an SLC as a result of horizontal unilateral effects in relation to the provision of NHS general dental treatments in each of two local areas defined as the areas within 4 miles of (i) Rodericks' Amber Valley dental practice and (ii) Dental Partners' Conisbrough dental practice.

8. The Parties accepted that the test for reference is met in respect of the provision of NHS general dental treatments in these two areas and requested that the CMA fast-track the case to a discussion of undertakings in lieu of a reference (**UILs**). The CMA accepted this request.

9. The CMA is therefore considering whether to accept undertakings under section 73 of the Enterprise Act 2002 (the **Act**). Riviera has until 31 August 2022 to offer an undertaking to the CMA that might be accepted by the CMA. If no such undertaking is offered, then the CMA will refer the Merger pursuant to sections 22(1) of the Act.

ASSESSMENT

PARTIES

10. Rodericks currently operates approximately 148 dental practices across England and Wales,[1] predominantly located in urban areas.[2] It provides a range of dental treatments for patients (fully or partially) funded by the National Health Service (**NHS**) and for private patients.[3] These include general dental treatments and a broad range of specialist treatments such as orthodontics, minor oral surgery, implants, and restorative dentistry. Rodericks is a subsidiary of Riviera, which is ultimately owned by funds managed by CapVest Partners LLP (**CapVest**),[4] a private equity firm.

11. Rodericks' UK turnover for 2021 was approximately £83.5 million.[5]

12. Dental Partners currently operates approximately 66 dental practices across England,[6] predominantly located in urban areas.[7] Dental Partners provides general dental treatments and a broad range of specialist dental treatments to both NHS and private patients. Pre-Merger, Dental Partners was owned by August Equity LLP, a private equity firm, and certain management shareholders (together, **AE**).

13. Dental Partners' UK turnover for 2021 was approximately £54.8 million.[8]

TRANSACTION

14. Riviera acquired the entire issued share capital of Dental Partners from AE on 29 April 2022, for approximately [✂].[9]

15. Rodericks submitted that the Merger will allow it to benefit from efficiencies of scale and cost synergies and to strengthen its management team.[10]

16. AE considered that it was an opportune time to sell Dental Partners and realise a return on its investment in the business, [✂].[11]

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[1] Final merger notice submitted by Wilkie Farr & Gallagher LLP to the CMA on 27 June 2022 (**FMN**), paragraph 8.
[2] FMN, paragraph 224.
[3] Rodericks also owns a specialist laboratory that makes a full range of appliances for mouth fittings used by dentists (Parties' response to question 17, CMA RFI 5 dated 27 May 2022).
[4] FMN, paragraph 70.
[5] FMN, Table 6.1.
[6] FMN, paragraph 9.
[7] FMN, paragraph 224.
[8] FMN, Table 6.2.
[9] FMN, paragraph 69.
[10] FMN, paragraph 73.
[11] FMN, paragraph 74.

PROCEDURE

17. The CMA commenced its Phase 1 investigation on 28 June 2022.

18. On 22 July 2022, the Parties accepted that the test for reference under section 22(1) of the Act is met on the basis that the Transaction raises a realistic prospect of an SLC arising from horizontal unilateral effects in the provision of NHS general dental treatments in each of two local areas which are defined as the areas within four miles of:

    (a) Rodericks Amber Valley, a Rodericks dental practice;

    (b) Dental Partners Conisbrough, a Dental Partners dental practice.

19. On the same date, the Parties requested the case to be fast-tracked to the consideration of UILs. As part of the request, the Parties agreed to waive their normal procedural rights during a Phase 1 investigation, including their right to an issues meeting and a discussion at a case review meeting, in relation to the provision of NHS general dental treatments in each of these two local areas.[12]

20. As set out in the CMA's guidance,[13] merger parties are able to waive their rights in relation to certain procedural steps within a merger investigation in order to enable a binding outcome to be arrived at more quickly. In agreeing to fast-track the case to the consideration of UILs, the CMA has, in keeping with the process set out in its Guidance, had regard to its administrative resources and the efficient conduct of the case and decided that it was appropriate to proceed to consideration of UILs.

JURISDICTION

21. Each of Riviera and Dental Partners is an enterprise under section 129 of the Act. As a result of the Merger, the enterprises have ceased to be distinct for the purposes of sections 23(2)(a) and 26 of the Act.

22. The UK turnover for Dental Partners was £54.8 million FY 2021, therefore the turnover test under section 23(1)(b) of the Act is not met.

23. The Parties overlap in the provision of general dentistry services to NHS and private patients in the UK, with a combined share of supply above 25% in several local areas.[14] Accordingly, the share of supply test under section 23(3) of the Act is met.

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[12] *Guidance on the CMA's Jurisdiction and Procedure (CMA2-revised)*, January 2022 paragraph 7.1.
[13] *Guidance on the CMA's Jurisdiction and Procedure (CMA2-revised)*, January 2022 paragraphs 7.8-7.13.
[14] FMN, Table 15.1.

24. The Merger completed on 29 April 2022 and the CMA was first informed about it on the same date. The four-month deadline for a decision under section 24 of the Act is 29 August 2022.

25. The CMA therefore believes that it is or may be the case that a relevant merger situation has been created.

26. The initial period for consideration of the Merger under section 34ZA(3) of the Act started on 29 June 2022 and the statutory 40 working day deadline for a decision is therefore 23 August 2022.

COUNTERFACTUAL

27. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual). For completed mergers, the CMA generally adopts the pre-merger conditions of competition as the counterfactual against which to assess the impact of the merger. However, the CMA will assess the merger against an alternative counterfactual where, based on the evidence available to it, it believes that, in the absence of the merger, the prospect of these conditions continuing is not realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions.[15]

28. In this case, there is no evidence supporting a different counterfactual, and the Parties and third parties have not put forward arguments in this respect. Therefore, the CMA believes the pre-Merger conditions of competition to be the relevant counterfactual.

BACKGROUND

Types of dental treatment

29. Dental treatments are broadly categorised into general dental treatments and specialist dental treatments. General dental treatments cover a range of work that aims to protect and maintain oral health, such as routine consultations, teeth cleaning, fillings, and tooth extractions. Specialist dental treatments cater to specific patient needs, and include orthodontics, minor oral surgery, endodontics, restorative dentistry, prosthodontics, periodontics, and implants.

30. In the UK, patients can obtain dental treatments either (fully or partially) funded by the NHS or privately. There are only two types of specialist treatments that are funded by the NHS: orthodontics and minor oral surgery.[16]

[15] See *Merger Assessment Guidelines (CMA129)*, March 2021, from paragraph 3.12.
[16] FMN, paragraph 19.

NHS-funded treatment: competition for the award of NHS contracts

31. In England and Wales, a dental practice must have a contract with the NHS to provide NHS-funded treatment to patients. NHS commissioning entities tender these contracts, and dental practice operators bid for them.[17] The CMA has previously referred to competition for NHS contracts as 'competition for the market'.[18] Competition for the provision of dental treatments to NHS patients ('competition in the market') subsequently takes place at a local level between dental practices that have been awarded NHS contracts.

32. NHS contracts specify the number of NHS-funded treatments that a practice must aim to administer and the remuneration that the NHS will pay the practice for those treatments. These specified treatments are referred to as 'units of dental activity' (**UDA**s) for general treatment and, in the case of orthodontic treatment, 'units of orthodontic activity' (**UOA**s).[19]

33. NHS contracts also govern other aspects of a dental practice's conduct. These are explained further in paragraph 51 below.

Demand and supply

34. The Parties submitted that demand for NHS dental treatments in the UK outstrips supply.[20] The CMA received evidence suggesting that the NHS has experienced significant constraints in meeting demand. The constraints in the provision of dental treatments seem to have been exacerbated by the Covid-19 pandemic, a period during which many dentists took leave of absence due to stressful working conditions,[21] and in which treatments were either limited or suspended. This created a large backlog of treatments to be administered.[22]

35. The CMA also saw evidence that there has been a shortage of dentists willing to carry out NHS treatment in the UK for various reasons, including pay.[23] Dental practices face challenges in attracting and retaining dentists, and this can affect

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[17] FMN, paragraph 235.
[18] See, for example, the CMA's decision in the investigation of the completed acquisition by Oasis Dental Care (Central) Limited of JDH Holdings Limited, 28 July 2014.
[19] FMN, paragraphs 18 and 19.
[20] See Dental Partners, Annex 10.ii.01.PPTX attached to FMN, 16 February 2021, page 7- Dental Partners describes dentistry as a 'supply side business'. Also see Dental Partners, Annex 9.i.01.PDF, June 2021, page 15- 'patient demand outstripping NHS access, exacerbated by Covid-19 pandemic'.
[21] See, for example, Association of Dental Groups, Engand's Dental Deserts: The urgent need to "level up" access to dentistry (A report commissioned by the Association of Dental Groups), May 2022, page 9.
[22] See, for example, Association of Dental Groups, Engand's Dental Deserts: The urgent need to "level up" access to dentistry (A report commissioned by the Association of Dental Groups), May 2022, pages 10 and 12.
[23] British Dental Association, 1RFI3.2 BDJ Recruitment Whitepaper 2019 (003).PDF, 2019, pages 2-3. See also Dental Partners, Annex 10.ii.03.PDF, May 2021, page 58- '[✂] can be attributed to [✂] and dentists' shift to more private work'; and [✂], paragraph 4, which notes that the proportion of the average dentist's income stemming from private earnings have increased and overtaken that from NHS treatment over the years.

their ability to deliver NHS dental services.[24] As a result, dental practices (and/or their parent companies) focus on recruitment strategies to attract, engage, and retain staff, including through investment in training and development opportunities, career planning,[25] and investment into premises and equipment.[26]

36. While the CMA recognises that these supply-side constraints may to some extent weaken competition between dental practices to attract and treat NHS patients, the CMA considers that it is nonetheless important to protect existing and potential competition, particularly since these supply-side constraints may in time be resolved through reforms to NHS dental services. For example, the NHS recently announced its intention to increase patient access by reallocating UDAs/UOAs that have been awarded to practices that fail to meet their performance targets.[27]

Independent practices and corporate groups

37. Providers of dental treatment include independent practices and corporate groups.

38. Independent practices are typically run by a single individual or a small group of individuals. They are typically individual practices, although sometimes may form part of a small group of practices located in the same local area or region.

39. Corporate groups, on the other hand, operate a considerable number of dental practices in various locations in different regions in the UK, and are typically owned by large corporations or private equity firms.[28] Corporate groups are therefore much larger than independent practices. For example, Rodericks and Dental Partners are corporate dental groups with approximately 148 and 66 practices respectively and are the fourth and eighth largest groups active in the UK by number of practices. Combined, they would be the third largest corporate dental group in the UK.[29] Bupa and MyDentist remain significantly larger than the Parties with approximately 484 and 600 practices respectively.

40. Corporate groups in the UK tend to pursue a strategy of growth by acquisition. For example, the Parties have grown considerably via acquisition. The CMA notes that in the previous two years Rodericks acquired 46 dental practices[30] and Dental Partners acquired eight dental practices.[31] Both Parties have proactive strategies to consolidate by acquisition, regularly identifying and targeting practices and groups

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[24] For example, see Dental Partners, Annex 10.ii.02.PPTX , 26 January 2021, page 5.
[25] CapVest, Annex 10.i.01.PDF , 2 July 2021, page 25.
[26] CapVest, Annex 10.i.02.PDF , 7 July 2021, page 15.
[27] B1802_First-stage-of-dental-reform-letter_190722.pdf (england.nhs.uk), page 4.
[28] For example, MyDentist, currently the largest corporate group of dental practices in the UK (by number of practices), is owned by Paloman Capital Partners. Portman Dental Care, one of the largest corporate groups in the UK, is owned by Core Equity Holdings. Bhandal Dental Practice appears to be the only large group of practices which is privately owned (see CapVest, Annex 9.i.03.PDF , November 2021, page 5).
[29] CapVest, Annex 9.i.03.PDF , November 2021, page 5.
[30] FMN, Annex 4a.
[31] FMN, paragraph 82.

of practices for potential purchase.[32] Other corporate groups such as Bupa and MyDentist have also made acquisitions in the last few years.[33]

FRAME OF REFERENCE

41. Market definition provides a framework for assessing the competitive effects of a merger and involves an element of judgement. The boundaries of the market do not determine the outcome of the analysis of the competitive effects of the merger, as it is recognised that there can be constraints on merging parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. The CMA will take these factors into account in its competitive assessment.[34]

Product scope

Competition for the award of NHS contracts

42. The NHS awards contracts separately for general dental services and for each of the two specialist dental treatments that qualify for NHS funding (orthodontics and minor oral surgery). To be awarded each type of contract, a dental practice must demonstrate that it has the resources and appropriately skilled and qualified dentists to administer the treatments covered by the contract. Not all dental practices have the resources and expertise to compete for contracts covering either of the two specialist dental treatments.

43. Contracts for general dental services and for the two specialist dental services generally differ in length. General dental services contracts are awarded in perpetuity, whereas specialist treatment contracts are awarded for a fixed term, typically of five years,[35] before being retendered. Contracts for specialist dental services are therefore subject to more frequent competition than general dental services contracts.

44. For these reasons, and in line with the CMA's decision in the investigation of the completed acquisition by Oasis Dental Care (Central Limited) of JDH Holdings

[32] See, for example, CapVest, Annex 10.i.02.PDF, 7 July 2021, page 21- [✂]. CapVest identifies [✂]. See also, Dental Partners, Annex 9.i.01.PDF, June 2021, page 7- refers to roadmap from FY17 to FY22 showing how Dental Partners has grown [✂].
[33] See for example Bupa Dental Care announces new acquisitions | Bupa.com and Acquisitions 2020 (mydentist.co.uk).
[34] *Merger Assessment Guidelines (CMA129)*, March 2021, paragraph 9.4.
[35] [✂], paragraph 3.

Limited in 2014 (***Oasis/Smiles***)[36], the CMA has considered the Merger in relation to competition for the market in the following product frames of reference:[37]

(a) Competition for the award of general dental NHS contracts.

(b) Competition for the award of orthodontic NHS contracts.

Provision of dental treatments to patients

45. In the context of competition between dental practices, the CMA considered whether the provision of dental treatments can be segmented by:

    (i) whether the treatments are provided to NHS patients or private patients; and

    (ii) the type of treatment, ie, between general and specialist dental treatments, and between each type of specialist dental treatment.

46. The CMA has considered these potential segmentations further below.

Patient type – NHS patients and private patients

47. In their initial submissions to the CMA, the Parties submitted that it can be left open whether there is a distinction between NHS and private patients as, in the Parties' view, no competition concerns arose even if NHS patients and private patients are considered separately.[38]

48. As a preliminary point, the CMA notes that the range of treatments available under the NHS is significantly more limited than that available privately. NHS treatments also cost much less than private treatments.

49. In its decision in *Oasis/Smiles*, the CMA assessed the provision of dental services to NHS patients and private patients separately.[39] It found evidence suggesting that the majority of patients had received NHS dental treatment and that, due to the higher price of private dental services, patients had limited ability and willingness to switch between NHS and private treatments.[40] On the supply-side, the CMA also noted in *Oasis/Smiles* that the conditions of competition were not the same for NHS treatments and private treatments.[41]

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[36] *Oasis/Smiles,* paragraph 42.
[37] The Parties also both compete for the award of minor oral surgery NHS contracts, but given the limited number of minor oral surgery contracts held by the Parties [✂] (FMN, paragraph 207) the CMA has not considered this further in this Decision.
[38] FMN, paragraph 199.
[39] *Oasis/Smiles,* paragraph 33.
[40] *Oasis/Smiles,* paragraph 31.
[41] *Oasis/Smiles,* paragraph 32.

50. In this case, the CMA saw third-party consultancy reports suggesting that, due to access constraints to NHS care,[42] a portion of NHS patients have switched to private dental services or are increasingly making use of a mix of NHS and private dental services (**mixed dental services**).[43] One of those reports also showed, however, that the majority of UK patients still use NHS dental treatments exclusively, and that the number of patients using private dental services or mixed services has increased only to a limited degree over the last 10 years.[44] One Dental Partners internal document also suggests that there has been an increase in demand for treatments that are not offered by the NHS (for example, cosmetic treatments) as a result of external factors such as social media.[45] This may also help to explain the increase in demand for private treatments, rather than any demand-side substitutability between private and NHS treatments.

51. On the supply-side, unlike private treatments, NHS dental treatments can only be provided by a dental practice that has been awarded a contract by the relevant regional NHS commissioning body. Dental practices must meet certain obligations under these contracts, such as staying open during specified hours, providing specified type(s) of treatment, operating in a particular area and meeting performance targets.[46] These contracts also set out the amounts that the NHS pays the relevant dental practices for the NHS treatments they provide.[47] With private dental treatments, dental practices are not subject to the same obligations or restrictions. The CMA therefore considers that there are limits to switching capacity between private and NHS dental treatments.

52. Moreover, evidence from the Parties indicated that they view NHS and private dentistry as two separate business activities. For example, Dental Partners' 2021 Annual Report monitors NHS and private dentistry income separately.[48] The CMA has also found that the Parties employ distinct strategies in relation to each of them. For example, Dental Partners aims to predominantly be an NHS provider and fulfil its allocated UDAs and UOAs but, in the case of private treatments, it intends to grow year-on-year.[49] A Rodericks internal document indicates that the focus for the NHS is to ensure high delivery rates for treatments, while the strategy for private work is to offer a wider range of treatments to attract patients.[50]

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[42] Dental Partners, Annex 10.ii.03.PDF, May 2021, page 87.
[43] See Dental Partners, Annex 10.ii.03.PDF, May 2021, pages 87, 89 and 90, and CapVest, 017_Annex 13.i. - L.E.K Report.PDF, July 2021, page 69.
[44] See Dental Partners, Annex 10.ii.03.PDF, May 2021, page 89. In 2021, 65% of patients had NHS dental treatments (the figure was 76% in 2012). The portion of patients having private dental treatment increased between 2012 and 2021 by 2% only, while the portion of those having mixed treatments increased by 10% over the same period.
[45] Dental Partners, Annex 9.i.01.PDF, June 2021, page 18.
[46] FMN, paragraph 142.
[47] FMN, paragraph 149.
[48] Dental Partners, Annex 8.d.ii. - Dental Partners Annual Report.PDF, year ended 31 March 2021, page 2.
[49] Dental Partners, Annex 8.d.ii. - Dental Partners Annual Report.PDF, year ended 31 March 2021, page 2.
[50] Rodericks, Annex 8.e.i. - Rodericks Business Plan.PDF, 2022, page 2.

53. For these reasons, the CMA considers that NHS dental treatments and private dental treatments should be viewed separately.

Treatment type

54. The Parties submitted that it can be left open whether there is a distinction between general and specialist dental treatments as, in the view of the Parties, no competition concerns arise even if they are considered separately.[51]

55. In its decision in the investigation of the completed acquisition by Bupa Finance Plc of The Oasis Healthcare Group Limited in 2017 (***Bupa/Oasis***), the CMA assessed the impact of the merger in relation to general dental treatments separately from specialist dental treatments, and separately in relation to each type of specialist dental treatment.[52] In *Bupa/Oasis* the CMA observed that there were different treatments for different dental requirements, and therefore substitution between different types of specialist treatments was limited.[53]

56. Consistent with the observations made in *Bupa/Oasis*, and based on the evidence available to it, the CMA does not consider there is substitutability between different types of dental treatment.

57. The CMA notes that specialist treatments vary in complexity.[54] More complex treatments can typically only be carried out by dentists who have gone through specialist training programmes for a minimum of three years and passed a number of relevant exams.[55] While less complex treatments may not require the same level of rigorous qualifications, they require dentists with a level of additional training and experience to be able to perform such treatments safely and appropriately.[56] These factors suggest that switching capacity between different types of specialist dental treatment is likely to be very limited.

58. Furthermore, the range of treatment on offer on the part of different dental practices also indicates that substitutability is limited for different types of specialist treatment. All dental practices that responded to the CMA's questionnaire (**Dental Practice Questionnaire**) and offer specialist services indicated that they only offer a limited

[51] FMN, paragraph 199.
[52] *Bupa/Oasis,* paragraph 40. The specialist dental treatments considered were orthodontics, minor oral surgery, prosthodontics, periodontics, endodontics, restorative, and implants.
[53] *Bupa/Oasis,* paragraph 37.
[54] FMN, paragraph 117. Also see *Bupa/Oasis*, paragraph 38- third parties suggested to the CMA that 'within each specialism, there are simple treatments and more complex treatments'.
[55] FMN, paragraph 116.
[56] FMN, paragraph 116.

range of specialist services.[57] Most of the Parties' practices themselves each offer a limited range of specialist services.[58]

59. For these reasons, the CMA has found that general dental treatments should be viewed separately from specialist dental treatments and, in turn, each type of specialist service should also be viewed separately.

Conclusion on product scope

60. Based on the reasons set out above, the CMA has assessed the Merger in the following frames of reference for the provision of dental treatments to patients:

    (a) The provision of NHS general dental treatments.

    (b) The provision of NHS orthodontic services.

    (c) The provision of NHS minor oral surgery.[59]

    (d) The provision of private general dental treatments.

    (e) The provision of private specialist dental treatments in each of the following areas: orthodontics; minor oral surgery; prosthodontics; periodontics; endodontics; restorative; implants; sedation; and cosmetics.

Geographic scope

Competition for the award of NHS contracts

61. In *Oasis/Smiles* the CMA, on a cautious basis, assessed the impact of the merger on a geographic scope corresponding with the boundary of the relevant regional NHS commissioning body.[60]

62. The evidence available to the CMA does not suggest that any departure from the approach adopted in *Oasis/Smiles* would be warranted.

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[57] [✂] response to question 8 of Dental Practice Questionnaire dated 28 June 2021- [✂] only provides short term orthodontics, composite bonding and facial aesthetics. [✂] response to question 8 of Dental Practice Questionnaire dated 28 June 2021- [✂] only provides orthodontic treatments, cosmetics and CBCT Scanning. [✂] response to question 8 of Dental Practice Questionnaire dated 28 June 2021- [✂] only provides orthodontics, endodontics, implants, and periodontics.
[58] The Parties, ME-6990-22 RFI4.1 - Riviera_Dental Partners_ response.XLSX.
[59] The CMA notes that [✂] Dental Partners [✂] offers NHS minor oral surgery. The distance to the nearest Roderick's site offering minor oral surgery is 31 miles (Annex RFI4.1, 27 May 2022). Given the distance between [✂] Dental Partners [✂] and the nearest Rodericks the CMA has not considered this overlap further in this Decision.
[60] There are seven commissioning bodies each covering a distinct region in England. These regions are East of England, London, Midlands, North East Yorkshire, North West, South East, and South West.

63. Accordingly, the CMA has assessed the impact of the Merger in relation to competition for the award of NHS contracts in the boundaries of each regional NHS Commissioning body in England.

Provision of dental treatments to patients

Local competition

64. The Parties submitted that the impact of the Merger may be analysed on the basis of 80% customer catchment areas for each of the product frames of reference around the Parties' sites.

65. The CMA considers that competition between individual dental practice sites occurs on a local basis. On the demand side, location is one of the key factors for many patients in choosing which dental practice to attend for treatment.[61]

66. In the assessment of mergers in local geographic markets, the CMA's practice has typically been to identify the catchment area within which the majority of the customers of each of the merging Parties' sites are located, with the majority usually being defined as 80% of customers.[62]

67. For these reasons, the CMA considers that it should identify the appropriate catchment area within which competition between dental practices occurs.

National competition

68. The CMA believes that competition for the provision of dental treatments mainly takes place at a local level, as patients will typically consider options available closest to them in their local area. The CMA's assessment of the Parties' internal pricing strategies indicates that prices are ultimately determined at a local level by the dentists working at the Parties' dental practices. However, both Parties operate chains of dental practices in the UK, and the CMA has seen evidence to suggest that there is also a national dimension of competition, including as a result of a degree of baseline pricing, staff pay, and recruitment strategies being set at a national level.[63]

69. The CMA has, therefore, also considered competition for the provision of dental treatments to patients at a national level.[64]

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[61] See [✂] , paragraph 11. Furthermore, all dental practices that responded to the Dental Practice Questionnaire stated limited distances that their patients typically travel to reach their practices.
[62] This includes past mergers between companies operating dental practices. See, for example, *Oasis/Smiles*.
[63] FMN, paragraph 175. See also Parties response to question 6 of RFI 1 dated 13 April 2022.
[64] The CMA has not considered whether, at a national level, separate product frames of reference exist for each speciality and for NHS and private work. The evidence relied on by the CMA in the national competitive assessment did not tend to distinguish between different specialities or between NHS and private work. In

COMPETITIVE ASSESSMENT

70. The CMA has considered horizontal unilateral effects in relation to the following frames of reference:

    (a) Competition for the award of general dental and orthodontic contracts separately in each NHS commissioning region.[65]

    (b) The provision of NHS general, private general, and different types of NHS specialist and private specialist dental treatments separately in local areas.

    (c) The provision of NHS and private general and specialist dental treatments nationally.

71. The concern under these theories of harm is that the removal of one Party that previously provided a competitive constraint, would allow the merged entity to profitably raise prices or degrade non-price aspects of its competitive offering (such as quality, range, service, and innovation) on its own and without needing to coordinate with its rivals.[66]

Competition for the award of general dental and orthodontic contracts

72. The CMA considered whether the Merger might lead to reduced competition in relation to bids for NHS general dental and orthodontic contracts, as the relevant NHS commissioning entities would potentially have fewer providers that would bid for their contracts.

73. The Parties submitted that their combined share of supply in UDAs and UOAs does not exceed 10% in any NHS commissioning region and do not exceed 25% on a narrower basis (namely, within Clinical Commissioning Groups areas in which the Parties overlap).[67]

74. The CMA assessed bidding data from the Parties, which indicated that the Parties did not bid against each other for any significant award of general dental or orthodontic contracts in the last three years.[68]

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any event, the CMA does not consider that its findings in relation to competition at a national level would change regardless of how the product frame of reference is defined.

[65] Footnote 60 lists out the different regions in which distinct NHS Commissions operate.

[66] *Merger Assessment Guidelines (CMA129)*, March 2021, paragraph 4.1.

[67] FMN, paragraphs 234, 236, 241 and 243.

[68] However, the CMA recognises that the award of new UDAs and UOAs can be relatively rare and limited to instances where, for example, there is a new housing development or existing practices hand back its contracts to the NHS (FMN, paragraph 131).

75. [✂] to the CMA that supported the Parties' submissions that the Parties' combined share of supply in UDAs and UOAs in each NHS commissioning region would be low.

76. [✂]. These showed that a large number of other bidders participated in these processes. [✂] considered that both corporate groups, such as the Parties, and independent practices can compete when bidding for the award of general and orthodontic contracts. Finally, [✂] did not raise any concerns in relation to the Parties being close competitors, or a lack of alternative suppliers, in relation to these bidding processes.

77. On this basis, the CMA does not consider that there is a realistic prospect that the Merger will give rise to a substantial lessening of competition as a result of horizontal unilateral effects in the award of general and orthodontic contracts in each NHS commissioning region.

Horizontal unilateral effects in the provision of dentistry services at a local level

78. The Parties overlap in England in the local provision of each of the treatments identified in paragraph 60. The CMA considered each frame of reference separately for the purposes of assessing horizontal unilateral effects at a local level.

Use of a decision rule

79. The CMA considers that the appropriate approach to identifying any local areas in which the test for reference is met in this case is to apply a decision rule. This decision rule reflects the evidence that the CMA has gathered on how competition works and the existing competitive constraints on the Parties at a local level.

80. The Parties submitted that the use of a decision rule is not appropriate in this case, and that the CMA should, instead, apply an initial filter and then carry out more detailed local assessments for local areas failing that filter.[69] The Parties submitted that such an approach would be consistent with a number of prior dental mergers, and with the approach set out in the CMA's Merger Assessment Guidelines, which refer to using a decision rule only when the number of local areas requiring a detailed local assessment would be large, which the Parties submitted is not the case at hand.[70]

81. The CMA considers, however, that the use of a decision rule is appropriate in the context of this case. A decision rule facilitates the efficient conduct of the CMA's investigation and ensures that all local areas of overlap are assessed systematically

[69] Parties' submission dated 20 June 2022.
[70] FMN, paragraphs 359-364. The Parties submitted that if the CMA were to apply the Parties' proposed initial filtering thresholds, there would only be [✂] local areas requiring a detailed local assessment.

by reference to the same factors, rather than having regard to different factors in different local areas.[71]

82. Furthermore, as set out further below, the decision rule adopted in this case assesses the impact of the Merger in each local area based on the key parameters of competition in the markets where the Parties operate. The decision rule takes into account features of local competition, including proximity, relative competitor strength and (in the case of NHS treatments) capacity to compete for new customers. The CMA has not received evidence suggesting that there are specific additional parameters of competition that should be taken into account in any local area. As such, the CMA is satisfied, based on an assessment of the evidence taken in the round, that the decision rule identifies those local areas which give rise to a realistic prospect of an SLC.

Design of the decision rule

83. In considering an appropriate decision rule to use, the CMA considered:

(a) which competitor sites should be included in the effective competitor set;

(b) the appropriate catchment areas over which to consider competitive constraints;

(c) the appropriate measure to use in order to calculate the level of concentration in each local area; and

(d) the appropriate threshold(s) above which the CMA considers there is a realistic prospect of an SLC in each local area.

Effective competitor set

84. The Parties submitted that the competitors with whom they compete are, with certain limited exceptions,[72] any dentist registered with the Care Quality Commission (CQC).[73]

85. In relation to NHS services, all dental practices must be registered with the CQC. The CQC monitors the quality of treatments, suitability of premises, and ensures

[71] In a number of recent CMA phase 1 decisions, the CMA has noted the risks of adopting a filtering approach where certain parameters of competition are taken into account only in the assessment of local areas that fail a filter, rather than systematically across all local areas of overlap (as this could undermine the results of the initial filter, for example, if other areas would have failed the initial filter had those factors been taken into account).
[72] In particular, the Parties submitted that they excluded CQC registered locations that offer dentistry but are not dentistry practices (for example, hospitals). Further, in relation to general dentistry, the Parties submitted that they excluded CQC registered locations that do not appear to offer general dentistry (for example, because they are marketed as an orthodontics centre). FMN, Annex 15.ix.
[73] FMN, Annex 15.ix.

that practices have qualified staff.[74] In relation to private dentistry, a practice must meet the requirements and standards of the CQC.[75]

86. The CQC has a dataset which contains all dental centres in England where care meets the requirements of the CQC.[76] For each practice in the CQC dataset identified as a rival by the Parties, the Parties have identified the treatments offered by that rival and whether the treatment is offered as an NHS or private service (or both). Given the above, for the purposes of the local competitive assessment, the CMA has considered any practice to be included in the CQC dataset and identified to be offering a particular treatment to be a competitor of the Parties in that given treatment.[77]

Catchment areas

87. In line with decisional practice, the CMA has determined the applicable catchment areas around the Parties' practices by calculating the average 80th percentile distance[78] (based on customer home location data) for 91 of Rodericks and Dental Partners' practices.[79] The average catchment area for each frame of reference is set out in Table 1 below:

[74] FMN, para 141.
[75] FMN, para 166.
[76] FMN, Annex 15.ix.
[77] With the exception of the dental practices as highlighted in footnote 72.
[78] See CMA, Retail Mergers Commentary, paragraph 2.20; The CMA considered whether it was appropriate to assess catchment areas separately for rural and urban areas, and, within urban areas, whether it was appropriate to assess catchment areas separately for urban areas within the M25 and urban areas outside of the M25. However, the Parties only have [✂] practices within rural areas, and only one overlap (on any reasonable basis) which does not appear to raise any conceivable competition concerns. In relation to urban practices within the M25, the Parties only have [✂] practices, and again, any overlap on a reasonable basis does not appear to raise any conceivable competition concerns. As such, the catchment areas calculated by the CMA (and overlaps identified) in this case all relate to non-M25 urban areas.
[79] This constitutes around half of the Parties' practices. Whilst data was not available for other practices the CMA notes that average catchment areas did not vary materially as individual catchment areas were calculated for additional sites.

Table 1: Catchment areas for each frame of reference

Service	Average catchment area, miles
NHS general	4
NHS orthodontics	5
Private general	4
Private orthodontics	5
Private minor oral surgery	7
Private cosmetics	5
Private implants	7
Private sedation	9
Private prosthodontics	5
Private restorative	5
Private endodontics	6
Private periodontics	5

Source: CMA analysis of Parties' data.

88. Table 1 shows that:

(a) The average catchment area for both NHS and private general dental treatments is four miles; and

(b) The average catchment area for specialist dental treatments varies between five and seven miles depending on the specific treatment (with the exception of private sedation).

89. Given the above, the CMA considered catchments for general dental treatments (both NHS and private) on a four-mile basis and catchments for specialist dental treatments on a five-mile basis. Evidence supplied by rival dentist practices and groups contacted by the CMA broadly supported these catchment area sizes. The CMA also carried out a sensitivity check and found that applying wider catchment areas for private dental treatments—seven miles for each specialist service, as well as nine miles for private sedation—resulted in no additional areas of concern.

Concentration measure(s)

- The Parties' submissions

90. In relation to private dental treatments, the Parties submitted that fascia counting and/or shares of sites within each local catchment area are appropriate

concentration measures.[80] In relation to NHS dentistry treatments, the Parties proposed fascia counting or shares of UDA/UOAs as appropriate concentration measures.[81]

- The CMA's analysis

91. The CMA considers that fascia count is likely to be an appropriate measure of concentration if brand is important to customers and customers choose between the fascia in their local area, irrespective of the number of stores that they have and where the offering at each individual store will be similar. Store count may be a good measure of concentration if brand is not very important or visible to the customer. Store count can also be a useful measure in cases where factors such as distance are an important driver of competition.[82]

92. The evidence gathered by the CMA indicates that, with regards private dental treatments, distance is a relatively important factor in a customer's choice of dental practice as compared to brand:[83]

(a) The Parties submitted that the main parameters of competition in relation to private treatments are the location of the practice and its proximity to the patient.[84] In relation to brand, the Parties stated that neither Rodericks nor Dental Partners prominently brand their practices and consider that any branding does not have an appreciable positive impact on customer choice.[85]

(b) Third parties indicated to the CMA that distance to the dental practice is an important consideration for patients.

(c) Internal documents show that location is important to customers. For example, a CapVest document states that patients typically choose their dentist based on proximity/location and convenience.[86] A Rodericks internal document highlights [✂].[87]

93. In light of the importance of location and the absence of evidence that brand is an important factor considered by patients, the CMA has chosen share of sites as a

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[80] FMN, paragraph 388.
[81] FMN, paragraph 368-369.
[82] CMA, Retail Mergers Commentary, 3.21-3.24.
[83] The CMA also considered whether it was appropriate to consider a share of supply based on staffing levels at each practice. Such a measure could provide an indication of a practice's current competitive strength and capacity to compete for new customers. However, due to data limitations (namely a lack of data on rivals' staffing levels, and the assumptions required to split staff between NHS and private work and between different specialities) the CMA decided not pursue such a measure.
[84] FMN, paragraph 173; In relation to NHS treatments, the Parties submitted that there is no price competition between practices and limited competition on non-price factors (FMN, paragraphs 145-146). For further details, see paragraph 103.
[85] Parties' response to RFI 5 dated 27 May 2022, Q12 and 13.
[86] CapVest, Annex 13.i. - L.E.K Report.PDF - Documents , July 2021 page 92.
[87] Rodericks, Annex 10.i.07.PPTX, May 2021, page 21.

concentration measure in the provision of private dental treatments in each local area.[88].

94. For NHS dental treatments, the CMA notes that in each local area data is available on the number of UDAs and UOAs allocated to each practice. The CMA considers that, in comparison to a share of sites measure, the number of UDAs and UOAs can provide an indication of a practice's current competitive strength and capacity to compete for new customers, given the number of UDAs and UOAs at a practice will reflect the relative size of that practice.

95. Given the above, the CMA has used the share of UDAs and UOAs as a concentration measure in the provision of general dental treatments and orthodontic dental treatment respectively to NHS patients in each local area.[89]

Concentration threshold

- The Parties' submissions

96. The Parties' submitted that, to the extent a decision rule is applied by the CMA, the following thresholds should be used to determine whether a SLC arises in a local area:

(a) For NHS dental treatments, post-Merger, the Parties' combined share of allocated UDAs exceeds 60%, or, there will be fewer than three independent fascia (ie a "3 to 2" fascia reduction).

(b) For private dental treatments, post-Merger, there will be fewer than four independent fascia (ie a "4 to 3" reduction), or, both of the following conditions are satisfied: there will be fewer than five independent fascia (ie a "5 to 4" reduction), and, the Parties' combined share of sites exceeds 50%.[90]

- The CMA's analysis

97. The threshold chosen for determining whether competition concerns arise is a case-by-case assessment taking into account all the facts and circumstances of a given case. In considering an appropriate threshold, the CMA notes that a starting point of 30% to assess competition concerns is broadly consistent with the CMA's recent

[88] CMA62, Retail Mergers Commentary, paragraph 3.24
[89] The CMA notes that UDAs and UOAs do not provide information in relation to the NHS minor oral surgery overlap. However, on the basis of the catchment areas described in Table 1 the Parties do not overlap in the provision of minor oral surgery.
[90] Submission from Parties, 20 June, paragraphs 1.6-1.7; The Parties further submitted that for any sites that fail a Decision Rule based on these thresholds, a further step should be applied in which sites that fail the Decision Rule are reassessed on the basis of their actual catchment area for a treatment, rather than the average catchment area for that treatment (Submission from Parties, 'Additional Clarifications and Submissions,' 21 July 2022). The CMA did not consider making such an adjustment appropriate given that any changes to the decision rule would have to be applied systematically across all local areas (and not just those that failed) and supported by sufficient evidence.

practice. The CMA has used higher thresholds in cases where there is significant evidence or analysis was available to support such a position and/or there was evidence of material out-of-market constraints.[91]

98. Given the above, the CMA's assessment of the appropriate threshold considered:

    (a) whether evidence in relation to market characteristics supports a higher or lower threshold (in particular, whether there is evidence available from recent and/or detailed CMA investigations in the same market);

    (b) whether the available evidence in relation to out-of-market constraints supports a higher or lower threshold;

    (c) whether the shares calculated may understate or overstate the Parties' position (and overstate or understate some competitors' strength) and, as such, whether this supports a higher or lower threshold; and

    (d) whether the nature of competition for NHS patients supports a higher or lower threshold in relation to NHS dental treatments.

99. With respect to market characteristics, the CMA did not receive evidence suggesting that a higher threshold would be appropriate in this case. The CMA also has not recently considered competition for dental treatments (either at phase 1 or phase 2).[92] The evidence the CMA has received from the Parties' submissions, the Parties' internal documents, and from third parties does not provide a basis to conclude in this case that there are different market characteristics for particular specialties.

100. In relation to out-of-market constraints, neither the Parties nor the CMA identified material out-of-market constraints in the provision of NHS or private dental treatments.

101. In relation to the relative strengths of the Parties and competitors, the Parties submitted that corporate groups do not have any particular advantage over independent practices. The Parties submitted that the ultimate ownership of a practice has no impact on customer choice and, while corporate chains may have national marketing budgets, independent practices are able to compete effectively on a local basis.[93] Based on the evidence available to it, however, the CMA

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[91] Completed Acquisition by VetPartners Limited of Goddard Holdco Limited, June 2022, paragraph 168.
[92] The last time the CMA investigated a merger between dental practice operators was in 2017 (The CMA's investigation of the completed acquisition by Bupa Finance Plc of the Oasis Healthcare Group Limited, 16 March 2017), which only concerned private dental treatments. The parties cited an OFT decision (Case ME/4926/11 Anticipated acquisition by a merger between the Carlyle Group and Palamon Capital Partners LP of Integrated Dental Holdings Group and Associated Dental Practices, decision of 10 June 2011) in support of adopting a 60% decision rule threshold for NHS treatments. That decision is over 10 years old and is out of step with more recent CMA decisional practice. The CMA has nonetheless considered whether a higher decision rule threshold can be justified for NHS treatments compared to private treatments, as set out at paragraph 103 below.
[93] RFI 5 response, Q8a.

considers that corporate groups may have a stronger competitive position than independent practices. For example, the Parties' internal documents indicate that corporate groups:

(a) are more likely to have capacity to serve patients;[94]

(b) typically offer a wider range of dental treatment;[95]

(c) have an enhanced ability to attract dentists by [✂];[96] and

(d) benefit from economies of scale that [✂].[97]

102. The CMA considers therefore that a share of sites measure (in the case of private treatments) and share of UDAs or UOAs measure (in the case of NHS treatments) may understate the competitive strength of corporate practices such as the parties, while overstating the competitive strength of third party competitors, which are predominantly independent practices.[98]

103. In relation to NHS dental treatments, the Parties submitted that there is no price competition between practices (prices are regulated or treatment is supplied free of charge) and non-price factors of competition (such as quality standards and opening hours) are also regulated. As such, the Parties submitted that the potential for competitive harm in relation to NHS dentistry is very limited.[99] The CMA notes that, while aspects of NHS dentistry are regulated, third party evidence indicates that NHS dentists do, to some extent, compete. For example, third parties noted that NHS dentists may compete by offering longer opening hours than the minimum required, and others may compete on the basis of quality.[100] In light of the more limited competitive interaction in the provision of NHS dental treatments, the CMA considers that the threshold for NHS dentistry should be, to a limited extent, higher than for private dentistry.

104. Given the above, the CMA believes that the following thresholds are appropriate for the identification of local catchment areas in which the Parties overlap and there is a realistic prospect of an SLC arising in this case:[101]

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[94] PWC on behalf of August Equity Partners, Annex 10.ii.05.PDF, May 2021, page 18.
[95] CapVest, Annex 13.i. - L.E.K Report.PDF , 2 July2021, page 91.
[96] [✂], paragraph 26- support can come from other dental care professionals such as nurses.
[97] Dental Partners, Annex 9.i.01.PDF, June 2021, page 18. Also see [✂], paragraph 17- 'Corporate business costs can be distributed more broadly enabling high-scale purchase of material at lower cost.'
[98] RFI 5 response, Q8a.
[99] FMN, paragraph 144-150.
[100] [✂] response to question 8 of Dental Practice Questionnaire dated 28 June 2021 and [✂] response to question 8 of Dental Practice Questionnaire dated 28 June 2021
[101] In other cases, the CMA identified areas where there is a realistic prospect of competition concerns arising by identifying areas exceeding both a concentration threshold with an increment threshold of 5% or greater. The CMA notes that, in this case, the Merger gives rise to an increment exceeding 5% in all areas where the Parties' sites exceed the relevant threshold. As such, the CMA considers that it is not necessary to assess whether any increment less than 5% could lead to an SLC in this case.

(a) a 30% combined share of sites for private treatments; and

(b) a 35% combined share of UDAs/UOAs for NHS treatments.

Application of the decision rule

105. By applying this provisional decision rule,[102] the CMA found that the Merger would not give rise to a realistic prospect of an SLC with respect to private general or specialist dental treatments or NHS specialist dental treatments in the areas around any of the practices operated by the Parties. The CMA considers that there is a realistic prospect of a SLC arising from horizontal unilateral effects in the provision of NHS general dental treatments in the two local catchment areas listed in Table 2 (the **SLC Areas**). The Parties accepted that the test for reference is met in respect of the provision of NHS general dental treatments in these two local catchment areas.

Table 2: ***Combined shares of supply for the Parties' sites failing the decision rule***

Party	*Site*	*Frame of Reference*	*Share of UDAs, %*	*Increment, %*
Rodericks Dental Partners	Amber Valley Dental	NHS general	37	9
	Dental Partners Conisbrough	NHS general	39	18

Source: CMA analysis of the Parties' data.
Notes: UDA data based on 2019 UDA shares.

Conclusion on horizontal unilateral effects in the provision of dentistry services at a local level

106. On this basis, the CMA believes that the Merger is likely to give rise to competition concerns in two local areas surrounding the Parties' sites as detailed in Table 2.

Horizontal unilateral effects in the provision of dentistry services at a national level

107. The CMA considered whether the Merger could give rise to horizontal unilateral effects in the provision of dentistry services on a national basis, particularly as a result of the Parties being among the larger corporate groups.

108. The CMA found that there are many large and small rivals present in the provision of dentistry services across the UK. In particular, an internal document supplied by the Parties showed that:

[102] Given the lack of challenge by the Parties (see paragraph 19), the CMA considers the decision rule adopted in this case to be provisional.

(a) the Parties estimate there to be approximately 12,000 dental practices in the UK, of which 1,500 are owned by corporate chains;[103]

(b) there are four corporate groups with a national presence: Mydentist, Bupa, Portman and Rodericks. Rodericks is identified as being [✂], and Dental Partners is identified as [✂].[104]

109. On the basis of the internal document described above, the CMA estimates that the Parties will have a share of practices of less than 2% at the national level (with an increment of 0.5%). Post-Merger, the Parties' number of branches will remain materially less than Bupa and Mydentist.

110. Therefore, the CMA considers that the Merger does not give rise to competition concerns at the national level. The CMA notes that, in the event of further consolidation in the provision of dentistry services, it will consider whether competition concerns could arise at the national level based on the facts of that merger.

BARRIERS TO ENTRY AND EXPANSION

111. Entry, or expansion of existing firms, can mitigate the initial effect of the acquisition on competition, and in some cases may mean that there is no SLC. In assessing whether entry or expansion might prevent an SLC, the CMA considers whether such entry or expansion would be timely, likely and sufficient.

112. As set out above, the Parties accepted that the test for reference is met in respect of the SLC Areas and, accordingly, the CMA believes that entry or expansion would not be sufficient to prevent a realistic prospect of an SLC in the provision of NHS general dental treatments in the SLC Areas as a result of the Transaction.

THIRD PARTY VIEWS

113. The CMA contacted customers and competitors of the Parties, as well as other interested third parties. A few customers raised concerns regarding the effects of the Merger on patient choice. The CMA took into account these concerns where appropriate in its competitive assessment, including in the design of the decision rule that it applied in this case.

CONCLUSION ON SUBSTANTIAL LESSENING OF COMPETITION

114. Based on the evidence set out above, the CMA believes that it is or may be the case that the Merger has resulted, or may be expected to result, in an SLC as a

[103] CapVest, Annex 13.i. - L.E.K Report.PDF , 2 July2021, page 89.
[104] CapVest, Annex 13.i. - L.E.K Report.PDF , 2 July2021, page 89.

result of horizontal unilateral effects in relation to the provision of NHS general dental treatments in each of two local areas which are defined as the areas within four miles of:

(a) Rodericks Amber Valley, a Rodericks dental practice; and

(b) Dental Partners Conisbrough, a Dental Partners dental practice.

DECISION

115. Consequently, the CMA believes that it is or may be the case that (i) a relevant merger situation has been created; and (iii) the creation of that situation has resulted, or may be expected to result, in an SLC within a market or markets in the United Kingdom.

116. The CMA therefore believes that it is under a duty to refer under section 22(1) of the Act. However, the duty to refer is not exercised while the CMA is considering whether to accept undertakings under section 73 of the Act instead of making such a reference.[105] Riviera has until 31 August 2022[106] to offer an undertaking to the CMA.[107] The CMA will refer the Merger for a phase 2 investigation[108] if Riviera does not offer an undertaking by this date; if Riviera indicates before this date that it does not wish to offer an undertaking; or if the CMA decides[109] by 7 September 2022 that there are no reasonable grounds for believing that it might accept the undertaking offered by Riviera, or a modified version of it.

117. The statutory four-month period mentioned in section 24 of the Act in which the CMA must reach a decision on reference in this case expires on 29 August. For the avoidance of doubt, the CMA hereby gives Riviera notice pursuant to section 25(4) of the Act that it is extending the four-month period mentioned in section 24 of the Act. This extension comes into force on the date of receipt of this notice by Rivieira and will end with the earliest of the following events: the giving of the undertakings concerned; the expiry of the period of 10 working days beginning with the first day after the receipt by the CMA of a notice from Riviera stating that it does not intend to give the undertakings; or the cancellation by the CMA of the extension.

Sorcha O'Carroll
Senior Director, Mergers
Competition and Markets Authority
23 August 2022

[105] Section 22(3)(b) of the Act.
[106] Section 73A(1) of the Act.
[107] Section 73(2) of the Act.
[108] Sections 22(1) and 34ZA(2) of the Act.
[109] Section 73A(2) of the Act.