Appellant
Name of Witness: Marcus Thorman
First
Date: 19 July 2021

FIRST-TIER TRIBUNAL
(GENERAL REGULATORY CHAMBER)
INFORMATION RIGHTS

Appeal ref: EA.2021.0047

BETWEEN:

THE ROYAL MARSDEN NHS FOUNDATION TRUST

Appellant

and

(1) THE INFORMATION COMMISSIONER
(2) CENTRE FOR HEALTH AND THE PUBLIC INTEREST

Respondents

WITNESS STATEMENT OF: MARCUS THORMAN

I, **Marcus Thorman**, will say:

1. I am the Chief Financial Officer at The Royal Marsden NHS Foundation Trust ("the Trust"), The Royal Marsden, Fulham Road, London SW3 6JJ. I have held this post since January 2015. I am a CIPFA qualified accountant.

2. As the Chief Financial Officer, I am responsible for providing financial, economic and fiscal leadership to the Trust and for ensuring that the interests of patients are at the heart of all financial decisions. As a member of the Trust Board and Executive Team, I share responsibility for leading and managing the organisation, including setting the Trust's strategic direction, and ensuring effective stewardship and the highest standards of corporate governance.

3. I make this witness statement in support of the Trust's appeal against the decision IC-44907-B6Z1 issued by the Information Commissioner on 15 January 2021. That decision concerned a 5-part request made to the Trust on 22 August 2019 under the Freedom of Information Act 2000. The request concerned amongst other requests, the Trust's Private Patient ("PP")

income and expenditure on consultants over the preceding four financial years i.e. 2015 – 2016 to 2018 -2019.

4. The Trust provided the majority of the requested information but withheld information within Part 1 of the request for the margin the Trust achieved on its PP income over the specified financial years. The Trust argues that the disclosure of that information would be significantly harmful to its commercial interests, which would in turn be strongly contrary to the public interest.

5. In my statement, I seek to assist the Tribunal in understanding why the Trust has those very serious concerns about the disclosure ordered by the Information Commissioner. My statement is supplemented and supported by those of colleagues, who bring different perspectives to bear in support of the same overall conclusions.

Introduction to the Trust

6. It is crucial to appreciate at the outset that the Trust is an integrated service provider: some hospitals provide purely publicly-funded (NHS) services, some are purely private, but the Trust (and certain others) provides both in an integrated way.

7. Further detail is given by my colleague Nicholas van As whose statement I have read and agree with – please see paragraphs 5 – 17 of his statement.

8. In terms of commercial context for this appeal, the key issue is that the Trust provides its private care services in a competitive commercial marketplace, but it does so in the context of an integrated service model.

9. The private care service, as a result of its integration with the Trust's NHS services, specifically benefits from many tangible factors that are not available to the Trust's private sector competitors. Examples include:

    a. The shared benefits of the Trust's clinical governance model (e.g. access to multi-disciplinary teams);
    b. The shared benefits of research and development activity at the Trust;
    c. The access private patients have to clinical trials at the Trust;

d. The shared benefits of the Trust's ability to attract and retain the highest calibre workforce;
e. The shared benefits of the regulatory framework - Care Quality Commission ("CQC") inspection, NHS Improvement ("NHSI") financial regulation.
f. The higher overall quality of care that private patients receive as a result of the above.

10. The Royal Marsden Private Care offers an award-winning service, having won the LaingBuisson Best Private Hospital Award for three out of the previous four years.

11. The Trust's overall services have been rated 'Outstanding' by the CQC, and it is one of only a few providers of private care services to achieve such a rating. It currently operates across two main sites, in Chelsea and Sutton, from a Medical Day-care Unit at Kingston Hospital and from a centre in central London.

12. The Trust's integrated NHS and Private Care model, specialist team-based expertise and research capability give private care a significant clinical advantage over other UK private hospitals. The Royal Marsden Private Care ("private care") has been recognised as the UK's leading private hospital in the 2017, 2018, and 2020 LaingBuisson Awards because of the quality of its service.

Key customers

13. Purchasers of the Trust's PP services fall into three main categories, referred to as "sponsor groups":
    a. Private medical insurers ("PMIs"): this group includes all of the major UK and international medical insurance companies. It accounts for more than half of the Trust's PP income.
    b. Patients sponsored by foreign embassies: this group entails a small number of embassies and accounts for more than a third of the Trust's PP income.
    c. Self-funding private patients.

14. Income from the Trust's primary private care customers is shown below, in absolute terms, and as a % of Trust revenue:

Sponsor	**2019/20 Income (£'000)**	**% of Private Care Insured Revenue**	**% of Private Care Revenue**	**% of Trust Revenue**
Aviva	£9,945	13%	8%	2%
AXA	£18,067	24%	14%	4%
BUPA	£34,332	45%	26%	7%
Other Insured	£13,840	18%	10%	3%
Total Private Care Insured Income	**£76,184**	**100%**	**58%**	**16%**
Kuwait Health	£31,536		24%	7%
Kuwait Oil	£7,212		5%	2%
Other Embassy	£8,168		6%	2%
Self-pay	£9,194		7%	2%
Total Private Care Income	**£132,295**		**100%**	**29%**
NHS Patient Income	£233,164			50%
Other Income	£97,557			21%
Total Trust Income	**£463,016**			**100%**

15. The Trust provides its PP services in a highly competitive market. I refer the Tribunal to paragraphs 8 and 12 of the witness statement of Shams Maladwala (Managing Director of Private Care at the Trust).

16. Additional evidence regarding the competitiveness of the London market is provided by the LaingBuisson annual report on Private Acute Healthcare – Central London, sixth edition, and by media coverage:

    a. LaingBuisson Private Acute Healthcare – Central London, sixth edition:

    "*The Central London private hospital market is undergoing a period of significant change, and together with the Outer London market it represents half the total private patient market by value in the UK. It also differs from the rest of the UK as the vast majority of revenues are from private patients, with only 1–2% from NHS patients.*"

    "Growth for the independent sector has mainly stemmed from the return of high earning embassy patients and Gulf company employees from the independent sector. London hospitals have been working hard to rebuild these relationships following the perceived high pricing of London facilities after the collapse of the oil price five years ago."

    "The private acute medical care market in Central London is estimated to have been worth £1.60 billion in calendar year 2018."

    ""The Central London hospital and clinic revenues represents c.41% of the national market for private patient revenues. Adding in an estimate for private patients in Outer London of £300 million, this means that the Greater London market accounts for c.48% of all UK private patient activity".

    "Independent hospitals and hospital owned clinics account for 75% of the Central London market, and NHS PPUs the remaining 25%, although the latter are gradually increasing their share over the years."

    "Across the market, UK Private Medical Insurance (PMI) continues to be the largest source of revenue for hospitals, accounting for 58% of hospital revenues."

    "In terms of the different specialties that make up the private acute market, oncology is now believed to account for over 25% of the market overall."

    "The increasing competition for consultants highlights the increasing costs that hospitals are having to take on, from governance and regulation to consumer marketing and business development to staff costs and numbers, all at a time when the prospects for significant revenue growth have been uncertain at best."

b. INDEPENDENT PRACTITIONER TODAY: DECEMBER 2020 – JANUARY 2021: page 44:

"*LONDON IS the engine of growth not only for the private patient market in England but it is also the core effort within the NHS when it comes to private patient services and incomes. Central London trusts have delivered the lion's share of revenues for the NHS PPU sector for many years, and these trends have continued, if not accelerated, in the last financial year*."

Integrated financial performance and the calculation of profit margins

17. This appeal concerns profit margin data on PP services. The Trust's concern is that the publication of that data would be harmful, given the commercial pressures of the competitive market in which it offers its private care services, as outlined above. I now explain how profit margin data works in this sector.

18. Given the integration of NHS, private care and research activity, the Trust publishes its overall profit margins only across its work as a whole. It does not publish breakdowns of its profit margins between the different aspects of its work.

19. Indeed, a consequence of the integrated service model is that the financial performance of either NHS, private care, or Research & Development ("R&D") cannot be considered in isolation. Each aspect of the service impacts the performance of the others, increasing efficiency via greater overall productivity, resource utilisation and economies of scale. The financial performance of each service aspect would be materially worse were they run in isolation. This is also true from the perspective of clinical services (as opposed to financial performance), as my colleague Nick van As (Trust Medical Director) explains in his witness statement.

20. Within the NHS, healthcare providers are required to report unit costs, applying a standard NHS costing methodology. As part of this method, the costs of shared resources and activity, including R&D, are apportioned between NHS and private care. Combined with income information, it is possible to derive a nominal 'profit' margin for either NHS or private care activity. This information is useful for price setting and for understanding and analysing the Trust's overall business. However, this costing method has been developed for a specific purpose – the setting of NHS wide activity tariffs – and it is only one possible method of costing. Other methods have the potential to produce materially different results.

21. Moreover, due to the integrated nature of the Trust's services, the results this method produces fail to appropriately measure either a) the total financial value of private care services to the Trust's NHS services or b) the margins that the Trust's private care services would achieve were they run at arm's length from, rather than integrated with, NHS services.

22. The calculated margins for NHS activity are higher than those that would be achieved were NHS services run in isolation from, rather than integrated with, private care services. This is because they do not reflect the added efficiency and economy of scale bestowed on NHS services by the greater overall productivity and resource utilisation that results from the integration of those services with private patient care.

23. The financial impact of this would be extremely difficult and complex to assess accurately, but any reduction in private care revenues would significantly increase the average costs of care, on a per patient basis, provided to both private and NHS patients. From a financial perspective, this is a crucial part of the Trust's case in this appeal: harm to its private care offering would cause harm to the finances of its NHS offering, because there would be less revenue to be invested and because the cost advantages to the NHS offering would be diminished.

24. Indeed, this is exactly the impact the Trust has seen since the onset of the COVID-19 pandemic, during which the average costs of care provided to NHS patients (on a per day/per admission basis) has risen by between circa 20% and 60% (excluding drugs), partly due to reduced private patient care activity. More simply put, the cost to the NHS of caring for NHS patients is lower because services are combined efficiently with private patient care – this is in addition to the benefit of being able to reinvest revenues from private patient care in NHS services.

25. Correspondingly, the calculated margins for private care activity are also higher than the margins that the Trust's private care business would achieve were it run separately from, rather than integrated with, NHS services. Not only would efficiencies and economies of scale be lost but also private patient care is reliant on shared clinical services, such as pathology and imaging.

26. Private patient care would be charged a mark-up for utilising these clinical services, were it to access them as an independent, arm's length provider. The Trust would also charge for use of its brand, the reputation behind which drives further financial benefit to the private patient service via the volume of patients it attracts as a result.

27. Consequentially, the only true margin, in terms of measuring the Trust's financial performance is that margin calculated by combining its NHS and private patient care income relative to the total cost of the integrated services provided. There is no fair or accurate way to separate them in a way that genuinely relates to their own underlying costs.

Other integrated service providers

28. The integrated service providers benefit from shared resources across their activities (including access to research and development activity) and economies of scale.

29. A number of other NHS providers also offer private care services under an integrated service model, but none approach the size of the service at the Trust in revenue terms, from either an absolute or relative point of view.

30. The Trust's service stands apart from these both clinically – it is the only specialist oncology service offering private care under an integrated model – and financially – as private care revenue forms a much greater % of the Trust's overall business, it is much more dependent, from a financial sustainability perspective, on the returns generated. Ultimately this translates to greater relative benefits for our patients.

31. To the best of the Trust's knowledge, other integrated service providers do not currently publish their PP profit margins.

32. The largest NHS private care providers offering services under an integrated model are listed below, alongside PP income and Trust turnover data taken from each Trust's published annual accounts:

Organisation	**PP Income (£m)**	**% of Turnover**
The Royal Marsden NHS Foundation Trust	£ 132.3	29%
Great Ormond Street Hospital NHS Foundation Trust	£ 64.8	12%
Imperial College Healthcare NHS Trust	£ 53.8	4%

Royal Brompton and Harefield NHS Foundation Trust	£	45.6	10%
University College London Hospitals NHS Foundation Trust	£	21.8	2%
Royal Free London NHS Foundation Trust	£	20.4	2%
Kings College Hospital NHS Foundation Trust	£	18.9	1%
Chelsea & Westminster NHS Foundation Trust	£	18.9	3%

33. This point is important because it shows how distinctive the Trust is: harm to the commercial interests of its private care offering would have a much more substantial impact on its NHS offering than might be the case in other Trusts where private income contributes a relatively small proportion of overall income.

Basildon and Thurrock NHS Foundation Trust and the Christie Clinic LLP

34. The IC's decision (at paragraph 22), by way of arguing that publishing private patient specific profit margins would not damage the Trust's commercial interests, cites examples given by the complainant (the Second Respondent) of companies/entities who are required to publish profit margins and who are in competition with the Trust for the provision of cancer services. These examples are misleading. Neither the Christie Clinic LLP or Basildon and Thurrock NHS Foundation Trust are in competition with the Trust to provide private patient oncology services to patients in London. Moreover, neither are integrated service providers.

35. These bodies operate separate, non-integrated, private care units, for which they are statutorily obliged to publish separate financial performance information. They are not therefore relevant when considering the case for the Trust to publish PP profit margins relating to an integrated service, for which the Trust is not statutorily obliged to publish separate financial performance data. Their PP profit margin data is not comparable to the PP profit margin data of the Trust and other integrated service providers. They are statutorily obliged to publish this information for different reasons as set out below, which are not relevant to the Trust.

36. The Christie Clinic LLP, which is not an NHS provider, is a separate legal entity from the Christie NHS Foundation Trust ('the Christie'), being a jointly owned venture between the

Christie and HCA International Ltd. As a separate legal entity, the Christie Clinic LLP publishes annual accounts which show the profit margins achieved in relation to its business and this is the same as other commercial private care providers as referred to in the Laing and Buisson report (see below). Its profits are shared between its owners. These are not comparable to the Trust's margins, as they are for a separate legal entity operating exclusively private care services and not operating an integrated model and a portion of its profits are not reinvested in NHS services but are paid to a private investor.

37. Other NHS trusts, including for example, Guy's and St Thomas' NHS Foundation Trust, also partner with private companies to run standalone private care services. Usually, the arrangement includes provision for the private company to share in the profits of the standalone private care services.

38. Basildon and Thurrock NHS Foundation Trust ("B&T NHSFT") operate a standalone (non-integrated) private patient unit, for which, under international accounting standards, they are required to publish separate income and expenditure information, as it constitutes a separate 'segment' of its business, even though it operates as part of the same legal entity. The Trust and other integrated service providers are not required to publish such information about their private care services as these are not operated as separate segments but as integrated services.

39. This information can be used to calculate a 'contribution' margin, which is also published - this is distinct from a 'profit' margin as it considers only directly attributable income and expenditure and does not account for indirect costs such as overheads. No profit margin information is published regarding the profits of the standalone private patient unit at B&T NHSFT. Moreover, the turnover of the business unit, £5.8m in 2018/19, amounts to less than 5% of the Trust's private care turnover and the B&T NHSFT is not dependent on this turnover to the extent that the Royal Marsden depends on its private care income for its financial sustainability, as it forms less than 2% of its turnover.

40. Other Trusts, most notably Moorfields Eye Hospital NHS Foundation Trust ("Moorfields"), also operate standalone private care services that are not under the umbrella of a separate legal entity, but for which it is required to publish separate income and expenditure information, as it constitutes separate segments of its businesses. These are rarer than either the integrated model which the Trust operates, or the separate legal entity model used by the Christie.

Private healthcare competitors

41. It should also be noted that the way in which surplus margins are calculated by the Trust is different to its private healthcare competitors, so it is not possible to translate this into a "like-for-like" comparison.

42. In the UK, LaingBuisson is regarded as "the" Private Healthcare industry specialist and provides market insights, results and views on policies and healthcare strategy. It releases an annual report in February each year that details the Central London Private Acute Healthcare market and individual provider performance.

43. The February 2020 report was 355 pages long and lists financial and operational performance details for all central London UK providers, including both private providers and private patient units ("PPU") within the NHS. The report includes a review of EBITDAR ("Earnings Before Interest, Tax, Depreciation, Amortisation of goodwill and Rent on leased land and buildings assets") performance for private providers (page 66 - Private Acute Healthcare – Central London, sixth edition).

44. EBITDAR is considered a standard financial calculation, as it has a defined method of calculation to allow for comparison across private companies. There is no section in the LaingBuisson report showing profitability results for NHS Private Patient Units (PPUs) as it is accepted that NHS PPUs are not able to calculate results in a similar manner, due to the integrated delivery models that they adopt.

45. The Trust's surplus margins are not calculated on an EBITDAR basis and should not be compared to margins that are calculated in that way.

46. There are also private healthcare providers (Spire Healthcare for example) who provide sub-contracted services to NHS patients alongside their services to paying patients. Those organisations do not, as far as the Trust is aware, publish separate profit margins for services provided to NHS and private patients. They publish only combined financial performance data, in the same way that the Trust publishes its combined financial performance.

Conclusions on private patient profit margin data

47. For the reasons I have explained above:

    a. The withheld information in this appeal (profit margin data for private patient work only) is not a fair or accurate reflection of the cost base for that work in the context of an integrated services model. To compare profit margin data for a purely private offering or a purely public offering with an integrated offering is misleading. The most accurate profit figure is the overall one for the Trust, which is published.

    b. The Trust only holds this notional profit margin data for its private services because it is required to report to its financial regulator, the total costs of private care activity when costed according to standard NHS costing methodology. That method is only one possible costing method and the results it produces fail to appropriately measure either a) the total financial value of private care services to the Trust's NHS services or b) the margins that the Trust's private care services would achieve were they run at arm's length from, rather than integrated with, NHS services.

    c. No other integrated service providers publish their profit margin data as split between public and private income, and in any event none are as reliant on private income as the Trust. Likewise, private healthcare providers who provide both private and NHS services, do not publish profit margin data, as split between NHS and private income.

       The comparators cited by the IC are in fact not comparators at all.

48. The Trust's concern is that the publication of the withheld information would cause it to be used in commercial negotiations in ways that are very harmful to the Trust's ability to secure the best prices for its services. The specific ways in which this would happen are explained in the witness statements of Shams Maladwala (Managing Director of Private Care at the Trust) at paragraphs 18 – 28 and David Pedrick (Head of Commercial Finance Private Care at the Trust) at paragraphs 21 onwards, with which I agree. Given their direct focus on those commercial negotiations, I do not seek to go over the same ground in my statement. Instead, I will provide my perspective as Chief Financial Officer on the effects of the envisaged reduction in income on the Trust's financial position overall.

Impact of a reduction in income

49. Mr Maladwala addresses the impact of a reduction in income on the Trust at paragraphs 29 – 34 of his witness statement and again, I refer the Tribunal to this.

50. The consequences of a loss of income also should be considered in the context of commitments already made by the Trust based on projected future private care revenue, including investments made in medical equipment, information technology, clinical research and the Trust's estate. These investments allow NHS patients access to the latest equipment and technology supporting their cancer treatment. The Trust is also committed to the ongoing running costs of the buildings and equipment in which it has invested. These commitments cannot be met without the funds generated by ongoing private patient care.

51. To the extent that the Trust is not able to implement its plans and commitments, its offering for both NHS and private patients would be diminished.

52. The Trust is currently committed to loan repayments of circa £4.5m a year until 2023 and £2m a year thereafter, until 2028. In addition to this, at the date of the last balance sheet, the Trust was already committed to £13m in non-charitably funded investments. There are also plans to upgrade IT infrastructure, to upgrade and replace medical equipment, and to invest in the Trust's estate, that will cost circa £100m over the next four years.

53. In order to meet these obligations in the event of a reduction in income, the Trust would most likely have to make cuts to the costs of care currently provided to its patients (NHS and private) (with a direct impact on the quality of care we are able to offer) or would need additional funding from the Treasury/Department of Health/NHS England & NHS Improvement.

54. Under current NHS funding regimes, the Trust is unable to increase the price charged to NHS commissioners for the provision of NHS care. In the event of reduced private patient income therefore, its only option would be to reduce both ongoing investment and ongoing running costs, if it is to remain financially viable.

55. The returns from the Trust's private patient care business also enable it to invest in research and development in fields that are essential to the treatment of cancer, such as genomic testing and robotic surgery, and to make key contributions in the field of education. These activities benefit patients both at the Trust and far beyond. Reduced income, therefore, would in turn mean that the Trust is unable to contribute as effectively to the wider ongoing "fight

against cancer", with the potential for negative impact well beyond the Trust and its immediate patient population.

56. The ability to fund research and provide access to cutting edge technology, also enable the Trust to attract and retain clinical staff of the highest calibre.

57. The Trust's PP care services are provided to maximise benefit for its NHS patients and any loss of this income will impact not only on the quality of the services being provided but also on the sustainability of those services, on the Trust's ability to invest in the latest technology, on its ability to contribute to research and education, and on its ability to retain high calibre staff.

The public interest in disclosure

58. Any incremental public benefit from transparency about the Trust's PP margins would be very limited. For example, the withheld information would not facilitate a fair comparison between the margins on "purely private" work and NHS work; this is because of the Trust's integrated services model, as outlined above and in Shams Maladwala's witness statement at paragraph 21, which means that the costs associated with its private and public services are inextricably interconnected. In that context, any transparency benefit to the public of the publication of the withheld information would be very limited.

59. It would also not facilitate any further assessment as to the Trust's overall efficiency, which is already assessed by various means as set out below.

60. As an NHS Foundation Trust, the Trust is subject to a range of different elements of regulation that provide overview and scrutiny of the services provided and the way that the Trust, as a public body, uses its resources.

61. As the Trust operates as a single integrated model there is no differentiation in the scrutiny provided to the NHS and Private Patient services provided. They are regulated as one single entity from a financial, clinical, and governance perspective.

62. The following scrutiny and oversight mechanisms result in published outputs:

    a. *Annual Audit*: The Trust is subject to an annual audit on the financial statements. This considers and reports on whether its accounts:

i. Give a true and fair view of the state of the Trust's affairs as of the year end date and its income and expenditure for the year then ended;
ii. Have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
iii. Have been prepared in accordance with the requirements of the National Health Service Act 2006.

b. *Annual report and value for money:* the Trust publishes its annual report on its website including its financial statements. The annual report includes a statement by the accounting officer (Chief Executive) which sets out the processes in place for ensuring economy, efficiency, and effectiveness of the use of resources within the Trust (P57 of 2019/20 annual report). The annual governance statement and accountability report are reviewed by the Trust's external auditors as part of their work and in their audit statement they confirm that '*the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statement'* and in addition the auditors had nothing to report by exception in relation to arrangements for securing economy, efficiency, and effectiveness in its use of resources (P68 of the annual report).

c. *Board of Directors*: The Trust is led by the Board of Directors which has overall responsibility for the performance and management of the Trust. This responsibility includes setting the overall strategy for the organisation and monitoring progress whilst ensuring resources are efficiently and economically utilised to meet the needs of its patients and the public. In order to carry out their duties and responsibilities, Board members convene at Board meetings. The Board meets three to four times a year in public to discuss the Trust's performance and strategic direction. Board reports which include performance and financial information, and other regulatory reports are available for information to the public on the Trust's website.

d. *Council of Governors*: As a Foundation Trust the Trust has an independent council of governors. The Council of Governors hold the Trust's Board of Directors to account and represent the views of fellow members of The Royal Marsden Foundation Trust and general members of the public. The Council of Governors have quarterly meetings which are open to the public. The Governors receive financial performance report

amongst others and can ask questions of the Board of directors. These reports are also available on the Trust's website for information.

e. *CQC inspection*: The Trust is subject to regulation and inspection by the CQC. This is over and above the regulation of private healthcare providers who are required to register with the CQC. This includes a well led inspection on an annual basis which includes: "Are there clear responsibilities, roles and systems of accountability to support good governance and management?" (CQC Key lines of enquiry W4). The Trust has been rated outstanding for being well led.

63. In addition, there are further internal governance and scrutiny measures that do not result in published output:

    a. Within NHS:

        i. *NHS Improvement*: The Trust is regulated by NHS Improvement ("NHSI") the independent regulator of NHS Foundation Trusts, whose role includes strong governance and accountability mechanisms in place for systems to ensure the NHS as a whole can secure the best value from its combined resources (What we do | NHS Improvement).
        ii. The Trust submits an annual financial plan to NHSI which includes all elements of income (including private patients) and associated costs. The Trust's performance against this plan is monitored on a monthly basis via a detailed financial submission to NHSI including explanations on variances. The Trust also submits a forecast position to NHSI on a quarterly basis.
        iii. The Trust is also required to submit its year end position and audited financial statements to NHSI which in turn submits these to the Department of Health.
        iv. In addition, the Trust makes an annual cost submission – the National Cost Collection (NCC) to NHSI. This submission looks at the cost of patient care at a detailed level (Patient level costing) on a fully absorbed cost basis. This submission is also used to inform the model hospital which allows NHS providers to compare unit costs and overall financial efficiency. The submission includes the total cost of private care activity. (There is therefore transparency internally within the NHS re private care profit margins as calculated under standard NHS costing methodology).
        v. *South West London Integrated Care System*: The Trust is part of the South West London ICS (South West London Health and Care Partnership) and its

performance is monitored via the ICS. The Trust makes monthly submissions on financial performance to the ICS and the ICS and NHSI will review and challenge any areas of concern.

b. Internal Scrutiny:

i. The Trust has an annual budget setting process and this, alongside the annual plan is reviewed and approved by the Board of Directors. Performance against this plan is overseen by the Board. The Audit and Finance Committee reviews performance against the financial plan and efficiency programme on a regular basis. Internal Audit undertakes audits each year, which they report to the AFC, and these include reviewing these processes. In addition to financially related audits, the internal audit programme also covers governance and risk issues. External Audit also review our Use of Resources and are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

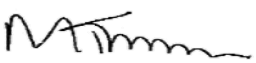
ii. As above, the cost of private care services is reported internally within the NHS, as is PP revenue. Therefore, the financial performance of this activity can be regulated internally.

iii. Financial performance is regulated by NHSI. Private Care activity is subject to the same regulation as NHS care, via CQC, and political oversight via DH.

64. The point I emphasise in conclusion is that the disclosure of the withheld information would not achieve any real public benefit, because of the difficulty in drawing any fair financial conclusions from this profit margin data, and because there is no gap in accountability or scrutiny when it comes to the Trust's private care work. The Trust asks the Tribunal to allow its appeal, because of the harm that disclosure would cause, and because the overall public interest strongly favours avoiding that harm.

65. I confirm that the facts in this statement are true.

Signed:



Marcus Thorman

Dated: 19 July 2021