Neutral citation number: N/A

Case Reference: EA/2021/0047

First-tier Tribunal
General Regulatory Chamber
Information Rights

Heard by way of CVP hearing

Heard on: 3, 4 and 5 May 2022

Decision given on: 09/06/2022

Before

TRIBUNAL JUDGE Stephen Cragg QC
TRIBUNAL MEMBER Rosalind Tatam
TRIBUNAL MEMBER Kate Grimley Evans

Between

THE ROYAL MARSDEN NHS FOUNDATION TRUST

Appellant

And

INFORMATION COMMISSIONER

DAVID ROWLAND

Respondents

Representation:
For the Appellant: Mr Robin Hopkins
For the Respondent: Mr Will Perry
For the Second Respondent: Mr Rowland and Mr Sid Ryan in person.

Decision: The appeal is Allowed.

Substituted Decision Notice: see below

REASONS

MODE OF HEARING

1. The proceedings were held on 3, 4 and 5 May 2022, by way of the Cloud Video Platform with all parties joining remotely. The Tribunal was satisfied that it was fair and just to conduct the hearing in this way.

2. Short CLOSED sessions were held to consider the CLOSED evidence of two of the witnesses, and short CLOSED submissions. A summary (or "gist") of the CLOSED sessions was provided to Mr Rowland (and Mr Ryan, for CHPI), and the gist is set out below.

3. The Tribunal considered an agreed open bundle comprising 166 pages, an authorities bundle, and written submissions.

4. The Tribunal also considered a CLOSED bundle.

BACKGROUND

5. David Rowland (on behalf of the registered charity, the Centre for Health and the Public Interest (CHPI)) submitted the following request to the Royal Marsden NHS Foundation Trust (the Trust) on 22 August 2019:-

> 1. In the Trust's annual report and accounts the following statement is made:
> "The margin delivered on our private patient income remains a vital source of support for NHS services to patients."
> (See page 36 https://shared-d7-royalmarsden-publicne-live.s3-eu-west-1.amazonaws.com/files_trust/s3fspublic/ Annual%20Report%202018-19.pdf)
>
> Please could you provide me with the margin achieved in relation to the Trust's private patient income for each of the following financial years:
> 2015/16
> 2016/17
> 2017/18
> 2018/19
> (For the sake of clarity I am asking how much of the Trust's annual private patient income is available as a surplus for NHS care following deductions for staff costs, capital costs, etc. I would like this information to be presented as a % of total private patient

income for each of the financial years set out above.)
2. Please could you provide me with the percentage of the Trust's total private patient income for each of the financial years 2015/16; 2016/17; 2017/18 2018/19 which is spent on fees for consultants who are employed by the Trust.

3. Please could you provide me with the number of consultants who received a payment by the Trust for carrying out private patient work for the financial years 2015/16 2016/17 2017/18 2018/19

4. Please could you provide me with the largest amount paid to an individual consultant employed by the Trust as a result of providing private patient services for each of the financial years 2015/16 2016/17 2017/18 2018/19

5. Please could you provide me with the total expenditure on consultants for the provision of NHS services in the financial years 2015/16; 2016/17; 2017/18 ; 2018/19 and the total number of consultants employed by the Trust in each of these years.

6. The Trust responded to Mr Rowland on 23 September 2019. It provided a response to parts two, three, four and five of his request but refused to provide the information requested at part one. The Trust cited section 43(2) of the Freedom of Information Act 2000 (FOIA) which relates to commercial interests as the reason for withholding this information.

7. The Trust provided an internal review on 30 October 2019 in which it maintained its original position, that section 43(2) FOIA applied to the withheld information.

STATUTORY FRAMEWORK

8. Section 1(1)(b) FOIA provides for a general right of access to information held by public authorities, upon request.

9. As stated above, the relevant exemption relied on by the Trust is in section 43(2) FOIA which, materially, reads as follows:-

43.— Commercial interests.
(1) …

(2) Information is exempt information if its disclosure under this Act would, or would be likely to, prejudice the commercial interests of any person (including the public authority holding it).

10. S.43(2) FOIA is not a provision conferring absolute exemption listed under s.2(3) FOIA. Therefore it is a qualified exemption, subject to the public interest assessment in s.2(2)(b) FOIA which provides that:-

> (2) In respect of any information which is exempt information by virtue of any provision of Part II, section 1(1)(b) does not apply if or to the extent that—
>
> (a) the information is exempt information by virtue of a provision conferring absolute exemption, or
>
> (b) in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

11. In relation to the test for prejudice in s43(2) FOIA, *Hogan v Information Commissioner* (EA/2005/0026, 17 October 2006) sets out useful principles. It was stated as follows:-

> 28. The application of the 'prejudice' test should be considered as involving a number of steps.
>
> 29. First, there is a need to identify the applicable interest(s) within the relevant exemption…
>
> 30. Second, the nature of the 'prejudice' being claimed must be considered. An evidential burden rests with the decision maker to be able to show that some causal relationship exists between the potential disclosure and the prejudice and that the prejudice is, as Lord Falconer of Thoroton has stated, "real, actual or of substance" (Hansard HL, Vol. 162, April 20, 2000, col. 827). If the public authority is unable to discharge this burden satisfactorily, reliance on 'prejudice' should be rejected. There is therefore effectively a *de minimis* threshold which must be met. ..
>
> 31. When considering the existence of 'prejudice', the public authority needs to consider the issue from the perspective that the disclosure is being effectively made to the general public as a whole, rather than simply the individual applicant, since any disclosure may not be made subject to any conditions governing subsequent use.
>
> 32…
>
> 33 …
>
> 34. A third step for the decision-maker concerns the likelihood of occurrence of prejudice. A differently constituted division of this Tribunal in *John Connor Press Associates Limited v Information Commissioner* (EA/2005/0005) interpreted the

phrase "likely to prejudice" as meaning that the chance of prejudice being suffered should be more than a hypothetical or remote possibility; there must have been a real and significant risk. That Tribunal drew support from the decision of Mr. Justice Munby in *R (on the application of Lord) v Secretary of State for the Home Office* [2003] EWHC 2073 (Admin), where a comparable approach was taken to the construction of similar words in Data Protection Act 1998. Mr Justice Munby stated that 'likely': *"connotes a degree of probability where there is a very significant and weighty chance of prejudice to the identified public interests. The degree of risk must be such that there 'may very well' be prejudice to those interests, even if the risk falls short of being more probable than not."*

35 On the basis of these decisions there are two possible limbs on which a prejudice-based exemption might be engaged. Firstly, the occurrence of prejudice to the specified interest is more probable than not, and secondly there is a real and significant risk of prejudice, even if it cannot be said that the occurrence of prejudice is more probable than not. We consider that the difference between these two limbs may be relevant in considering the balance between competing public interests (considered later in this decision). In general terms, the greater the likelihood of prejudice, the more likely that the balance of public interest will favour maintaining whatever qualified exemption is in question.

DECISION NOTICE

12. The decision notice (IC-44907-B6Z1) is dated 15 January 2021. The Commissioner's decision was that section 43(2) FOIA was not engaged, and the Trust was required to disclose the withheld information. The Commissioner explained the Trust's position as follows:-

> 20. The Trust maintains that evidence of the likelihood of prejudice already exists as it must negotiate on an ongoing basis with insurers and international embassies on the margins charged on services provided and on prescribed drugs. These margins are constantly under pressure. The Trust has standard mark-up percentages on specific services and provisions within its contracts that providers are able to compare across the market. This can lead to outliers (a value that differs significantly from other values in a set of data) being targeted and the Trust's margins being an area of focus in contract negotiations. Any driving down of prices consequentially means a drive down in the Trust's income. The Trust's view is that release of the requested information is more likely than not to weaken its negotiating position. This logic means that the Trust's competitors would use it to undercut its fees and as a bargaining tool, reducing its future margins to the detriment of the Trust.

13. After considering further arguments put forward by the Trust and Mr Rowland, the Commissioner concluded as follows:-

35. Although the Trust has provided some detailed arguments the Commissioner considers these relate to the need for private care income and the benefits of that income to its NHS patients and ongoing commitments, rather than how these will be materially affected by the release of the requested information. The Commissioner does not agree that those arguments have sufficiently demonstrated the commercial prejudice that would follow its release. In other words, the Trust has not established a direct and clear enough link. She considers that this specific information would not, in itself, cause prejudice. The Trust has not explained what specific information is in the public domain, other than in its internal review where it gave the example of patient numbers, that could be combined with this information in the prejudicial way it has indicated. The case has not been made that this information in itself could be used to drive down margins, either by those negotiating for its services, or by competitors aiming to undercut the Trust in providing similar services.

36. The Commissioner does not therefore accept that the criteria have been met and that the level of prejudice is real, actual or of substance. Consequently, as the exemption is not engaged she has not gone on to consider the public interest.

THE APPEAL AND RESPONSE

14. The Trust's appeal is dated 11 February 2021. The appeal says:-

> The Trust maintains – and will demonstrate in its evidence – that the public disclosure of the withheld information would have given rise to a very significant and weighty chance of real, actual and substantial prejudice to its ability to maximise its PP [Private Patient] income.
>
> In outline, this is for the following reasons:
>
> (1) PMIs [private medical insurers] would be highly likely to deploy the withheld information in their negotiations with the Trust, in order to secure better prices for themselves and thus less PP income for the Trust.
>
> (2) As indicated above, price is a crucial aspect of those negotiations. This applies to both services and drugs. PMIs already have access to granular information about prices, but not about costs and margins. Their negotiating position would be substantially strengthened if they had those additional insights about the Trust, and thus formed assumptions and perceptions about the likelihood of the Trust being willing or able to accept lower prices. Regardless of whether those assumptions and perceptions were correct, they would be used in negotiations to the Trust's detriment.
>
> (3) Paragraph 23 of the IC's decision contains the suggestion that such consequences would only arise if granular, service-by-service profit

margin data were published. That is wrong. If PMIs obtained data about the Trust's overall margins for its PP services, it would deploy that data in the ways outlined above.

(4) The consequence would be that the Trust would come under significantly greater pressure to accept less favourable prices, i.e. it would generate less PP income from PMIs than would otherwise be the case. Given the enormous importance of PMIs to the Trust's commercial position, even a relatively small reduction would have serious consequences for the Trust and its ability to provide high-quality services to all patients be they PP or NHS patients.

(5) To the best of the Trust's knowledge, integrated service providers do not currently publish their PP profit margins. The IC's decision (see paragraph 22) cites examples of PP profit margin information being published by two providers, namely The Christie Clinic LLP and Basildon & Thurrock NHS Foundation Trust. Neither of those are integrated service providers. Their PP profit margin data is not comparable to the PP profit margin data of the Trust and other integrated service providers. For example, integrated service providers benefit from shared resources across their activities (including access to research and development activity), lower rents and costs of capital and economies of scale. The public availability of PP profit margin data about competitors that are not integrated service providers is essentially irrelevant to the Trust's concerns about its negotiating position, as outlined above.

(6) Similarly, though to a less acute extent, the Trust would be exposed to a reduction in PP income from embassies if they formed the perception, based on the Trusts' PP profit margin data, that they could secure better terms from the Trusts competitors.

(7) The Trust also considers that its competitors would be better placed to undercut the Trust's prices and/or otherwise offer more favourable terms if they were equipped with insights into the Trust's PP profit margins.

15. In the event that the Tribunal were to find that s43(2) FOIA is engaged, the Trust said this about the public interest balance that would have to be considered:-

> There is …very weighty public interest in maintaining the section 43(2) FOIA exemption on the facts of this case. The Trust already publishes its accounts for its integrated service model overall, as well as audit and value for money reports. Any incremental public benefit from transparency about its 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, 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.

16. The response from the Commissioner stated as follows:-

> ….the Trust has failed to satisfy both the second Hogan question – i.e. some causal relationship between disclosure and commercial prejudice, and that this prejudice is "real, actual or of substance" – and the third question – i.e. regarding the likelihood or occurrence of prejudice. For example, beyond stating that "price is a crucial aspect" of negotiations between private insurers and the Trust, the Trust has not explained in any detail how insurers would be "highly likely to deploy the withheld information … in order to secure better prices for themselves". By way of another example, the Trust has not addressed in any detail the Commissioner's findings at §23 of the DN that the withheld information concerns aggregate profit margins and is not broken-down by specific services.

17. CHPI/ Mr Rowland made similar points in its response, for example:-

> The argument the Trust is making is that the disclosure of the requested information would provide "additional insights" about the Trust and that this would lead to those purchasing from the Trust to form "assumptions and perceptions about the likelihood of the Trust being willing or able to accept lower prices".
>
> The Trust argues that this would 'substantially strengthen' the negotiating position of purchasers, but this does not follow logically. Whilst more information about the nature of the Trust's business model may lead to a perception that the Trust would be prepared to negotiate, the decision as to whether to negotiate and whether it then reduces its prices following this negotiation, is entirely in the hands of the Trust.
>
> If an existing customer is so concerned by their perception of the Trust's aggregate profit margin that they ask to renegotiate, the most likely result is that the Trust declines. The Trust is in a strong position, because the only other alternatives are providers which the Trust's customers previous assessments have found to be of lesser quality and/or higher price, even if it is somehow preferable to switch to a provider making a different profit margin on the service.
>
> …

> The Trust is making a difficult argument that the public availability of a similar profit metric is irrelevant to RMT because it runs a different business model. This misses the basic point about transparency we were making, but accurately shows that any competitor seeking to gain unfair commercial advantage from knowing RMT's profit margin would find the figure similarly 'irrelevant' because they run radically different service models.

18. When making these submissions, neither the Commissioner not CHPI had seen the witness evidence subsequently filed by the Trust.

THE HEARING

19. The Tribunal heard evidence from four witnesses on behalf of the Trust. All provided witness statements for the hearing and were asked questions on behalf of the Commissioner, Mr Rowland and by the Tribunal.

20. Professor Nicholas van As is the Medical Director at the Trust and has held that post since January 2016. He is a qualified Consultant Clinical Oncologist. Professor van As explained the nature of the healthcare system at the Trust where NHS work, private work and research is all integrated. This means that care is allocated to patients on the basis of clinical need irrespective of whether they are NHS patients or private patients. It has never been the case that a private patient has taken a bed from an NHS patient with a higher level of clinical need.

21. Professor van As referred to his witness statement which says:-

> 8. The Trust is Europe's largest comprehensive cancer centre and rated as one of the leading cancer centres in the world, delivering outstanding levels of patient care. We treat more than 59,000 NHS and private patients every year, and more private cancer patients than any other UK centre.

22. He confirmed that the Trust provides outstanding levels of cancer care, with a strong brand and reputation, and a very high standing in research with an established academic partner, conducting hundreds of trials. It is ranked as outstanding by the CQC (Care Quality Commission). Its nearest competitors are UCLA and Guy's and St Thomas', but a difference is that the Trust specialises solely in cancer care.

23. There is also a different model at hospitals where private care is run by a private company, to which any profit goes. At the Trust all profit from private care is

reinvested in the Trust's work, thus benefitting the NHS, increasing the ability to secure state of the art equipment and care, which in turn attracts the best consultants. His witness statement explains:-

> 5.It is important to emphasise that the Trust's primary reason for providing Private Care services is to maximise benefit for its NHS patients and that, in terms of available space and clinical capacity, there is no 'zero-sum' equation between Private Care and NHS services at the Trust.

24. Professor van As confirmed that the model he was describing where profit was returned to the NHS did not include fees paid to consultants for private work. This was billed separately by consultants to private patients and insurers. Consultants had a fixed number of sessions paid for under their NHS contract and were then free to work privately thereafter.

25. Professor van As said that the integrated model meant that there were more beds available for NHS patients made possible by the return of profit to the NHS system. He was concerned that disclosure of profit margins would threaten the model, but said that the detail of this was evidence to be given by financial colleagues. He said the integrated model provided benefits to both private and NHS patients.

26. Mr Marcus Thorman, is the Chief Financial Officer at the Trust and has held this post since January 2015. He is a CIPFA qualified accountant. In his witness statement, Mr Thorman referred to the change in the law in 2012 which allowed for a greater proportion of a Trust's income to be privately generated.

> 8. Moreover, transparency and openness on such matters was a pre-condition of Parliament granting the Trust the freedom to generate up to half of its income from private patient services.
>
> 9. Thus in 2011 when the then government introduced a major change in the law governing private patient income in the 2012 Health and Social Care Act its impact assessment stated that "To provide assurance and transparency, FTs [Foundation Trusts] will be required to produce separate accounts for NHS and private-funded services." This was to ensure that the benefits from the generation of private patient income were transparent and easily identifiable, and this expectation is reflected in Section 164 of the Act which imposes a duty on the Trust to provide information in its accounts on the impact of private patient income on the delivery of NHS services.

27. Mr Thorman said that the Trust provides all the information about income which is required by the 2012 Act under the new system. Para 11-12 of his statement says:

> 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 Laing Buisson Awards because of the quality of its service.

28. Mr Thorman also confirmed that the Trust has a pre-eminent position in providing an integrated oncology service, which is judged as outstanding by the CQC, but he agreed with Professor van As that there were other excellent services as well, including private services in NHS hospitals and stand-alone private services. These services were competing for privately paying patients.

29. Mr Thorman referred to para 20 of his statement to explain how the Trust costs its services:-

> 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.

30. Mr Thorman's point was that this method of costing results in showing a profit margin on private care which might be higher than would be achieved if other methods are used (which might be used by other private providers). This is the only way in which the Trust presents the figures at the time of the request. In addition, use of the integrated model can mean that profit margins can look high because of advantages achieved in terms of economies of scale, and the fact that a rental charge

is not made for accommodation and facilities used by private care, which are factors which might not be available to stand alone private providers. When shown figures for the private patients unit at other hospitals (Basildon was an example), Mr Thorman pointed out that these were stand-alone figures for the unit, which was not organised as an integrated model with the NHS.

31. The concern is that insurers will latch on to the margins shown and try to drive down price in negotiations. Although the Trust could explain that the margin results from the method used (as required by the NHS) the fear is that insurers will be uninterested in these arguments, and continue to use the figures as a downward lever. He referred to paragraph 23 of his statement:-

> 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.

32. Mr Thorman explained what might be the consequence of this at paras 53-54 of his witness statement:-

> 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.

33. Mr Thorman said that there would be no way of bridging the gap with increased NHS funding as realistically that would not be available. There is a risk that lower level and quality of services would mean that insurers would go elsewhere, and possibly consultants as well.

34. Mr Thorman said that the Trust does publish the aggregate profit margin that is achieved across both private and NHS care together. He explained that this is the same figure that other NHS and private care providers would publish and a distinction is not made in the figures between NHS and private care. He pointed out that many private providers also supply a percentage of NHS care in addition to private care.

35. Mr Thorman referred to the information available to the public which the Trust has duties to provide as set out in paragraphs 62 and 63 of his statement [D19-D21], which includes an annual audit, an annual report and financial statements, as well as internal (NHS) governance and scrutiny measures. Mr Thorman said that he believed that this was sufficient to provide accountability and transparency to the public about the Trust's activities. The information requested would be of much use to insurers as a lever, but not to CHPI and to members of the public as an indicator of performance and accountability because it fails to appropriately measure the total financial value of private care to NHS services.

36. He also said that it would be a lot of work for the Trust to provide the profit margin figures in a way which was comparable with the other private providers. NHS Improvement receive some margin information on an occasional basis, but he would not want it available publicly and subject to interpretation. The integrated model potentially makes the margin look higher partly because of economies of scale.

37. Mr Pedrick is Head of Commercial Finance Private Care at the Trust and has held this post since February 2017. He is qualified as a Chartered Accountant.

38. Mr Pedrick explained that the Trust has contracts with all the main insurers. The insurers (given the size and nationwide coverage of their membership) have a lot of power during negotiations, including the option of walking away from a contract negotiation and influencing referrals. Insurers are very driven by price concerns although other service and quality related factors are also important. The Trust has a strong brand and high quality but it is a very competitive market in London, and increasingly so since a Competition and Markets Authority report in 2012 concluded

that there were 'weak competitive constraints in central London' (as explained in Mr Pedrick's statement).

39. Mr Pedrick explained that insurers would be interested both in price at a granular level for individual services, for which he provided examples, but also on the overall profit margin, if that were available. Mr Pedrick was concerned that if the withheld information were disclosed that would present a misleading picture as it had not been compiled in the same way that other private providers would do, but that insurers would use it as a stand-alone metric of profitability, which was a key factor, and a lever in negotiations. Sponsors were supportive of the integrated model where profits went back to the NHS but were also seeking best value for money. Mr Pedrick was of the view that insurers would be successful in using the withheld information in driving down prices, and that they may sometimes 'play the long game' to get prices down in the longer term.

40. In relation to the section of the Trust's private work that was funded through foreign embassies, Mr Pedrick explained that this market was more volatile. Although there was more of an emphasis on tailored services, , they do compare the Trust's prices with other providers, which meant negotiations on cost sometimes follow the issuing of the list of prices for the forthcoming year. Price lists are tailored for the embassies. Mr Pedrick confirmed that there is a set price list for self-payers.

41. He said that the aggregate profit margin would be (if published) one indicator - not the sole factor - but a key factor in negotiations. Mr Rowland asked Mr Pedrick how the insurers negotiate with the consultant doctors. Mr Pedrick said the consultants had representatives. Generally, they are signed up with an insurer and there will be, for example, a Bupa rate or an AXA rate.

42. We also heard evidence from Mr Pedrick in a CLOSED session and a gist of this was supplied in OPEN which said:-

- RH [Mr Hopkins] asked DP [Mr Pedrick] to outline how the actual withheld data would be perceived and used by negotiating partners. DP explained their likely reaction and stance. He explained that this would risk would arise notwithstanding the Trust's reputation and any efforts the Trust could make to explain or contextualise this data.

- The Tribunal explored some of the closed paragraphs of DP's statement and whether they contained information that was not already made clear in open and that needed to remain closed. RH explained why the Trust maintained that each paragraph did contain information that needed to remain in closed in order not to reveal aspects of the withheld information, and that an exercise in opening up words or phrases that were also provided elsewhere in open evidence would be disproportionate. WP indicated that the ICO agreed with the Trust's arguments as to why these paragraphs should remain closed.
- WP [Mr Perry] asked DP about whether the Trust could make additional disclosures alongside the disputed information in order to mitigate the harm it says would be caused by disclosure of the disputed information. DP explained that the creation of alternative accounting data would be time-consuming and complex, and that the risks of harm would in any event not be entirely mitigated. In this regard, he said that there was no generally acknowledged way of reporting the profitability of integrated services (as discussed in open) and that a disclosure of the withheld information would be novel, in that such disclosures in respect of integrated facilities had not happened before.

- There was a 10-min pause when one of the Panel members' connection dropped out.

- WP explored with DP the dynamics affecting the setting of prices for embassy clients.

- WP explored with DP the range of possible outcomes in terms of the effect of disclosure on negotiations and the approximate probability DP assigned to each scenario. DP explained the outcomes he was confident would be a very high probability (which he put in the 60-100% likelihood range, based on his assessment and that of Mr Maladwala) and what the financial impact on the Trust would be if those outcomes materialised. He distinguished between the high probability outcomes and the medium- and lower-probability outcomes, developing paras 58 and 69 of his evidence.

- In response to questions from the Panel, DP explained why even the Trust's negotiating efforts could not prevent the detrimental outcomes predicted by the Trust from materialising. He also said that he had never seen any indication that PMIs were already able to arrive at approximate estimates for the withheld data. He was not aware of any instances of staff crossover involving Trust employees going to work for PMIs. As regards the Cavendish Square facility, DP said he understood that it was originally envisaged for private patients but was in fact used by NHS patients also.

- Finally, the Panel explored with RH and WP the gist it had proposed of the closed evidence session with MT.

43. Mr Maladwala is employed as the Managing Director of Private Care at the Trust and has held this post since March 2014. He has qualifications for MBA & BA Business Studies.

44. Mr Maladwala explained that he had previously worked for BUPA Cromwell where he was commercial director with a good understanding as to how insurer contracts were negotiated, although he had not been involved personally with negotiations between BUPA and an NHS Trust.

45. He explained that in his experience, at present, insurers do not try to estimate profit margins for integrated service providers because the industry benchmarkers, Laing Buisson, do not provide an analysis on this, and the integrated service providers are not required to provide this information by the statutory regime. If the withheld information were disclosed insurers would be very keen to apply it to negotiations. Any information they do not yet have would help insurers triangulate costs and provide an advantage in negotiations. He confirmed that profit margins were a very key indicator in this process.

46. In Mr Maladwala's view there was stagnation in the private oncology treatment market, and perhaps now an over-supply, especially in London, which also drives margins lower.

47. Mr Maladwala confirmed the position in paragraph 14 of his witness statement that:-

> 14. Insurers are very commercially focused and have a range of price and performance benchmarking information at a provider level which they use to negotiate rates and / or special network agreements. The last decade has seen insurers increasing their understanding of hospital costs and using this to press for cost reductions.

48. This is especially true in the current environment where prices for oncology services have increased by 40% in the last five years, and insurers are looking for more tools to ensure efficiency.

49. Mr Maladwala explained how insurers used directive referral pathways, by which they could control where insured patients received treatment, especially under corporate employer insurance schemes, and which reduced patient choice in a lot of cases. Thus simply because a patient wanted treatment at the Trust because of its reputation, this might not be available if the insurer could direct the patient elsewhere. Mr Maladwala accepted that insurers would be taking a flawed approach if they used the withheld information in negotiations, but any information on profit margins would strengthen

the insurers' position. Historical information would still be useful to them as long as it was reasonably recent. In relation to the Kuwait Health and Kuwait Oil markets then there is a lot more volatility in the market than there used to be, with more internal analytics being used by clients, and building comparisons with other health care providers; by way of example some patients from Gulf States are only being referred to hospitals outside London (on cost grounds).

50. Mr Maladwala confirmed that movement of staff between providers and insurers was rare and when it did occur then it was usual movement from an insurer to a provider not the other way round.

51. We also heard evidence from Mr Maladwala in CLOSED session (which was followed by brief CLOSED submissions) and the following is the gist that was then supplied in OPEN:-

- RH [Mr Hopkins] submitted that all closed paragraphs in SM's [Mr Maladwala] statement were rightly withheld from open session. RH did not ask SM any further questions.

- WP [Mr Perry] asked SM on what basis he was so confident that disclosure would result in the prejudice predicted. SM summarised evidence he had given in open with reference to the withheld information. SM explained he was confident that all, not just some, insurers would react in the ways predicted. WP put to SM SR's example from the open session about insurers demanding the Trust offers prices below those of the Trust's competitors. SM explained that this possibility would not stop insurers from seeking a commercial advantage in negotiations.

- In course of his answers, SM said disclosure of the withheld information would have implications for other PPUs, e.g. Great Ormond Street Hospital.

- RH's closing submission were: (a) the Tribunal must look at the specific content of the withheld information, (b) the Trust had produced compelling granular evidence about how commercial harm was likely to arise, and (c) the various mitigating steps proposed by the Commissioner and DR/SR (e.g contextualising or explaining the withheld information) would not succeed given the commercial context and the nature of the information.

- WP stated that he would need to take further instructions before making any closed closings submissions and indicated that, depending on the nature of those instructions, he might not need to make such submissions.

52. On behalf of CHPI, Mr Rowland also submitted a witness statement. He is the Director of CHPI and has previously worked as the Head of Policy and Research at the General Optical Council for three years, Head of Corporate Policy at the General Dental Council for three years and Head of Policy and Research at the General Social Care Council for five years. Prior to working in healthcare regulation he was a research fellow at the School of Public Policy, University College London, undertaking research into the Private Finance Initiative, social care markets, EU health policy and the management of the NHS, pandemic preparedness and Communicable Disease Control administration.

53. He has been the director of CHPI for two and a half years. CHPI is a non-party-affiliated think-tank, which seeks to subject health and social care policy to careful, evidence-based scrutiny, promote greater democratic determination and accountability in the organisation and delivery of healthcare, and advocate for probity, integrity and transparency in health policymaking. CHPI hopes that its work fills a gap in the analysis of UK healthcare policy, examining how health and social care services are delivered from the perspective of power and accountability, particularly in the interface between the public and private sector.

54. This means looking at how the state contracts with the private sector, where gaps in regulation may occur, and how the overall system is held to account in line with the NHS' founding principles. Mr Rowland states that:-

> Our primary interest is in understanding how financial flows within the NHS operate and how healthcare services are delivered in order to benefit patients. The sale of healthcare services by NHS Trusts to individuals paying privately (or via private medical insurance) is a controversial dimension to England's healthcare system which is founded on the principle of care being delivered free at the point of need, rather than on the patient's ability to pay.
>
> Due to the nature of this controversy, we consider it important for there to be maximum transparency in how NHS Trusts run private patient services, given that the justification for such commercial ventures lies in expanding the overall availability of services to NHS patients. Unless there is full transparency in relation to the operation of Private Patient Units there will always be a concern that these arrangements are being run in the interests of private organisations and individuals – for example the NHS consultants who receive remuneration for treating patients privately, those patients who are able to pay, and the foreign embassies who make use of NHS PPUs in London.

It's my view, as expressed in CHPI's Response to the Appeal, that disclosure of The Royal Marsden PPU profit margin would be in the public interest as it would help to clarify the public benefit of these commercial endeavours. Disclosure would aid an understanding of the following:

a. Transparency and Accountability - Contextualise the statements the Trust makes about the value of the PPU to its organisation.
b. Impact on the Trust - Show how profits from the PPU relate to the quantity and quality of core NHS services the Trust can provide.
c. Impact on the PPU - Provide insight into the PPU itself, and how the Trust reinvests profits into delivering more private healthcare.
d. Impact on National Policy - Allow us to assess the net benefit of the policy of PPUs to the NHS as a whole.

….

While we do not doubt the integrity of the Trust and its leadership team, we also do not consider that the regulatory system which is designed to ensure that the Trust exercises its statutory powers appropriately – including those elements cited by the Trust in making this appeal - can have the confidence of patients and the public unless there is full public transparency in relation to how NHS organisations generate and spend their revenue.

To conclude, I would argue that in general the principle of financial transparency within the NHS should trump all other considerations relating to commercial confidentiality, particularly in this instance where the causal link between disclosure and commercial detriment has not been established.

55. By the end of the hearing we note that, following questioning of the Trust's witnesses, the Commissioner had changed his position on the appeal and was satisfied by the evidence of the Trust's witnesses that the exemption in s43(2) FOIA did apply, and that the public interest balance was that the information should not be disclosed The Tribunal notes that by the end of the hearing the Commissioner was privy to far more information about the Trust's position than was available at the time the decision notice was written. The Commissioner's change of position so late in the process is clearly not ideal, but we accept that the Commissioner can only reach conclusions on the evidence available at the time decisions are made.

56. The submissions of the Trust were essentially that the witness evidence presented clearly showed the prejudice that would be caused to the Trust's commercial interests, and that the public interest also favoured non-disclosure as a potential

lowering of profits would mean a reduction of services available to the NHS through the Trust's integrated model.

57. CPHI/Mr Rowland's skeleton argument, drafted with sight of the witness statements, and submissions at the hearing were not convinced of these arguments. It was argued that the closest the evidence comes to establishing a causal link between disclosure and commercial prejudice was that the aggregate profit margin would be deployed forcefully in price negotiations by Private Medical Insurers (PMIs) and that the withheld information would support them in their attempts to seek to reduce prices.

58. However, CPHI/Mr Rowland argued that just because PMIs might have a stronger negotiating position because of disclosure it did not follow that the Trust would directly lose income as a result. To establish a causal link between disclosure and detriment the Trust would need to show that it would have no choice but to reduce its prices once PMIs gained access to this information. It was pointed out that Mr Pedrick in his witness statement explained a number of strategies for countering the negotiating position of the PMIs which are evidently successful. Furthermore, the Trust asserted that the disputed information would not provide an accurate or fair reflection of the Trust's profit margin and that this data is 'not comparable' with other private companies that do disclose them. Despite this it as still argued that PMIs would use this supposedly unreliable information to "challenge the Trust's negotiating position". CPHI/Mr Rowland portrayed this assumption far-fetched, and that the Trust had failed to show how this challenge would cause it to reduce its prices and consequently lose income.

59. CHPI/Mr Rowland argued that there was a contradiction at the heart of the Trust's case. The Trust argued that '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'. Yet it simultaneously argued that PMIs would be able to draw such conclusions and cause significant commercial prejudice as a result. CHPI/Mr Rowland said 'We cannot see how the disputed information could be worthless for our purposes, but highly prized and highly damaging in the hands of PMIs'.

60. CHPI/ Mr Rowland accepted that disclosure might make negotiations more challenging but not to an extent that this would qualify as a commercial prejudice, as explanations could be provided to PMIs the possibility of substantial commercial prejudice is hypothetical and remote.

61. CHPI/ Mr Rowland argued that disclosure of an aggregated Trust-wide profit margin would be of little use to someone trying to establish whether the Trust is making what might be considered an 'excess' profit on any particular service. CHPI argued that how the Trust arranges and finances the delivery of its services (for example, by way of an integrated model) is immaterial to whether it should disclose the disputed information.

62. In submissions to the Tribunal, CHPI through Mr Rowland and Mr Ryan emphasised these points and argued that there was a strong public interest, in any event, in disclosure for reasons of transparency, accountability and the need to understand the benefits or otherwise of private patient units within the NHS. However, in CHPI/Mr Rowland's written arguments it had been accepted that if commercial prejudice which was real, actual or of substance could be established then 'we would accept that this is contrary to the public interest, given the potential risk to the viability and quality of NHS services'.

DISCUSSION

63. Applying the approach in *Hogan* it is our view that the withheld information is clearly statistical, commercial information, and there was little or no debate which queried this.

64. The major question for the Tribunal to decide is whether to accept the evidence of the Trust's witnesses that PMIs and others would or could use the withheld information to prejudice the Trust's commercial interests. In terms of the second *Hogan* test, the decision maker must be able to show that some causal relationship exists between the potential disclosure and the prejudice and that the prejudice is "real, actual or of substance" . We refer to PMIs below, but similar if less compelling arguments were made about the Trust's negotiations with embassies.

65. The general approach of the Trust's witnesses was that any information that provided PMIs (primarily) with details about overall aggregate profit margins would be a tool which would be used by PMIs in a negotiation situation. This was presented as being commercial common-sense, although of course as it had never happened before, there was a degree of speculation as to whether it would, in fact, come about. All of the Trust's witnesses had experience as to how the integrated model worked and how aggregated profit margins are calculated on the basis required by the NHS. Although Mr Maladwala had worked for BUPA, none of the witnesses had actually been involved in negotiations on behalf of PMIs, but Mr Pedrick and Mr Maladwala had worked on negotiations from the Trust point of view..

66. The Trust's witnesses accepted that it would be explained to PMIs that aggregate profits for the integrated model were calculated using a method that other private providers did not use, but nevertheless the view was that any leverage would be used by PMIs if there was a prospect of driving down rates.

67. Mr Rowland and Mr Ryan argued that this was not a true reflection of what would happen in a negotiating situation and that PMIs could not properly negotiate on a basis that they knew did not provide them with the bargaining position claimed.

68. Although Mr Hopkins presented this as a straightforward decision for the Tribunal to find in the Trust's favour on this point, we are less sure about that because of the speculative nature of what will happen in negotiations, and we agree with the Commissioner that the Trust's witnesses express an overconfidence as to how PMIs would use this information if disclosed.

69. Nevertheless, we are satisfied that there is some causal relationship exists between the potential disclosure and the prejudice and that the prejudice is "real, actual or of substance". Having heard and read the evidence of all the witnesses, all with some expertise as to how the private medicine market works, it does seem to us that PMIs, and to a lesser extent embassies, would be interested in any commercial information that would enable them to negotiate a better deal with the Trust, and that the strong bargaining position and competitive market described by the witnesses makes that potential prejudice a real possibility. We accept that the second test in *Hogan* is met in this case.

70. The third step described in *Hogan* concerns the likelihood of occurrence of prejudice. The term "likely to prejudice" has been interpreted (as set out in *Hogan*) as meaning that the chance of prejudice being suffered should be more than a hypothetical or remote possibility; there must be a real and significant risk.. The degree of risk must be such that there 'may very well' be prejudice to commercial interests, even if the risk falls short of being more probable than not.

71. Thus, there are two possible limbs on which a prejudice-based exemption such as s43(2) FOIA might be engaged. Firstly, the occurrence of prejudice to the specified interest is more probable than not, and secondly there is a real and significant risk of prejudice, even if it cannot be said that the occurrence of prejudice is more probable than not.

72. In *Hogan* it was said that the difference between these two limbs may be relevant in considering the balance between competing public interests. In general terms, the greater the likelihood of prejudice, the more likely that the balance of public interest will favour maintaining the qualified exemption in s43(2) FOIA.

73. For the Trust it was argued that the evidence showed that it was more likely than not that the prejudice would occur, and that it is clear that PMIs would use the disclosed information to the commercial disadvantage of the Trust. In our view it is impossible to reach that conclusion about the level of risk, especially as we did not hear evidence from any witnesses who had taken part in such negotiations (although Mr Maladwala had conducted other types of negotiations regarding the integration of the Cromwell facility into the existing BUPA company services). . Nevertheless, we recognise the strength of the bargaining position of PMIs and that it may be difficult for the Trust to resist the use of any bargaining tool once it was available. It is hard to predict what would happen in negotiations and whether or not it would be possible to explain to PMIs that the disclosed information did not, in fact, give the leverage that might seem apparent. But, on the basis of the oral and written evidence of the Trust's witnesses, we do find that there is a real and significant risk of prejudice, even though we cannot say that the occurrence of prejudice is more probable than not.

74. We note that the risk to the Trust of missing out on contracts to provide services if it did not compromise to an extent once a bargaining point was used in leverage. We

accept the evidence that even a small compromise by the Trust caused by the disclosure of this information would be likely to lead to millions of pounds of lost revenue to the Trust. In the end, and in agreement now with the Commissioner, we find that the exemption in s43(2) FOIA is engaged, on the basis that disclosure would be likely to cause prejudice to the Trust's commercial interests (rather than that this prejudice 'would' occur).

75. Having reached that conclusion we must go on to consider the public interest balance if the information were disclosed even though it would be likely to prejudice the commercial interests of the Trust.

76. We accept CHPI's submissions that transparency and accountability of the Trust's finances, and the other factors referred in Mr Rowland's statement above (see paragraph 54) are issues in favour of disclosure. We accept that disclosure would be relevant within the ongoing debate about the appropriateness of private patient units in otherwise NHS hospitals. We accept that the fact that we have only found there is a risk of prejudice gives more weight to the public interest in disclosure.

77. However, we also accept the Trust's arguments that there are a range of sources of information about the finances and oversight of the Trust available to the public already. We also do understand the logic of the Trust's position that although the withheld information may be of some use to PMIs from a negotiating point of view, the withheld information would not add particularly to the sum of knowledge about the Trust's finances.

78. It seems to us, however, that the Trust's trump card when the public interest is considered is the fact that all profits from its integrated model of care are fed back into service provision by the Trust which can bolster the service funded by the NHS. Thus any reduction of profit caused by the disclosure of the information will cause a reduction of services provided by the Trust available under the NHS. In relation to this, we were told by the Trust's witnesses, and accept, that there is no prospect of the any shortfall in funding being met by the NHS. We have found that there is a risk of this happening if the information is disclosed and therefore there is a strong public interest in preventing it. On balance we find that the public interest is in favour of non-disclosure.

79. We have reached the above conclusions on the basis of the OPEN evidence, and the CLOSED evidence we have considered takes nothing away from the open conclusions we have reached. On that basis it has not been necessary to supplement our reasons with a closed annex.

80. On that basis, the appeal is allowed and a decision notice is substituted to the effect that the exemption in s43(2) FOIA applies, the public interest test favours non-disclosure, and the withheld information need not be disclosed.

Signed Tribunal Judge Stephen Cragg QC Date: 08 June 2022