I refer to the above and would like to express my views on some of the Preliminary Findings. I am the Chairman and one of the founders of KIMS Hospital Limited ("KIMS"), which will be one of the first independent tertiary private hospitals to be located outside of Central London. In March 2012 we were successful in raising £85m in debt and equity finance to build KIMS on a seven acre site in Maidstone, Kent.

Building commenced in April 2012 and will be completed in January 2014. KIMS will start treating patients in April 2014. KIMS will deliver complex surgical care, day treatment and outpatient consultation and diagnostics for a variety of clinical specialties, focussing in particular on cardiac, neuro-surgery complex orthopaedics and surgical oncology.

The hospital will be unique in offering clinicians working throughout Kent and in London the opportunity to provide complex treatments for their patients in a fully-equipped and properly-staffed setting, close to home and without the need for the patients and their families to travel to the Central London Hospitals. Historically patients living in Kent have had no alternative but to make this journey as currently their local hospitals (NHS or private) do not perform tertiary procedures, as evidenced by the fact that there are no private hospitals within the county with intensive care (ITU) beds.

Consequently local healthcare needs for the most demanding conditions will be met locally for the first time.

KIMS has been privately funded and will primarily treat private patients, but it will also treat NHS patients by agreement with the relevant NHS commissioning groups. One of the S106 planning conditions imposed on the hospital by Maidstone Borough Council specifically obliges KIMS to make available to the NHS up to 25% of its procedural capacity should the NHS commissioning groups wish to utilise the hospital's facilities.

KIMS will be the first new privately-operated Hospital in Kent for over 20 years and is designed to provide the very best standards of patient comfort and safety. Approximately 380 consultants have signed practising privileges agreements with KIMS pursuant to which they have agreed to transfer some or all of their existing private patient practices to the Hospital. Consequently, the people of Kent will be able to access complex tertiary private healthcare in the county and without the need for them or their families to travel to Central London. In many cases they will be treated by the same consultants that they would have seen in the Central London Hospitals.

As such, the premise behind KIMS, that of providing local competition to the London private tertiary hospital market that is currently dominated by HCA, would appear to deal with some of the Theories of Harm and therefore AECs identified in your preliminary findings. You identified two structural features in the provision of privately funded healthcare by hospitals, namely:

(a) high barriers to entry for full service hospitals; and

(b) weak competitive constraints in many local markets including central London.

You felt that together these features gave rise to an AEC in the markets for hospital services that are likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with PMIs.

Such a finding of course supports the basis for the establishment of KIMS with its intention to compete with the more expensive Central London hospitals and generally to increase competition by creating a full service hospital that will represent a local alternative for patients and their families. In addition, the PMIs have expressed support for KIMS given our ability to perform tertiary procedures at a price that will be less than that being charged by [redacted]

Further, the NHS Commissioning Groups, which currently spend significant sums sending NHS patients from Kent to Central London for tertiary procedures that are not currently available in Kent (whether NHS or private) should achieve significant savings if these NHS patients are commissioned to KIMS with reduced ambulance costs and a reduced Market Forces Factor uplift as against the National NHS Tariffs in Kent as compared to London.

The problem arises with your condemnation of consultant incentive schemes and, to an extent, consultants holding an equity stake in their hospitals. Without these, in all likelihood KIMS would never have happened.

As you recognise, there are significant barriers to entry for full service hospitals and, as I'm sure you will appreciate, it was extremely difficult for a new, unproven management team to raise £85m to build a new hospital. This could only be achieved by proving to our funders the fact that a large number of consultants supported the new hospital and were willing to transfer their private practices to it. It was essential that we were not seen as a start-up, but rather an amalgamation of existing businesses.

Clydesdale Bank agreed to contribute £34m of the £85m funding required. The funding came, however, with 2 particular conditions:

1. we must obtain from the consultants prior to financial close personal guarantees in respect of the Bank debt in the sum of [redacted]

2. we must obtain from the consultants after financial close a cash equity investment in the sum of [redacted].

Both of these were obtained. Of course, we would not have been able to secure these requirements without offering our consultants something in return. As such, the c70 consultants who agreed to give the personal guarantees were allotted, [redacted] of the equity in our PropCo (which owns the land and buildings) and in our OpCo (which will operate the Hospital pursuant to a lease from the PropCo), whilst the c80 cash investor consultants were allotted, pro rata to their investment, [redacted] of the equity in our PropCo and in the OpCo.

All of the consultants are very excited to be involved in a new hospital that will be, in their view, clinician-led although we have also recruited a first class management team. The consultants talk of KIMS as 'their hospital' and are excited by what can be achieved there. It is currently intended that every consultant who signs a PPA and starts work at KIMS will share in [redacted] of the equity in the PropCo and the OpCo.

Without this share ownership, KIMS, with all of its benefits to the local community, would (in all likelihood) never have happened.

In addition, KIMS is very keen to be a teaching Hospital and is likely to be accredited by [redacted]. We will be training nurses and healthcare professionals at KIMS and we are very keen for our consultants to improve their skills by research and development and to share these advancements with others by teaching. For example, all of the 5 major operating theatres at KIMS will have cameras to enable operations to be broadcast to other consultants, either those located at the KIMS seminar rooms or further afield.

In order to encourage the consultants to research, develop and teach, it is currently intended that a percentage of the income that the hospital generates from theatre procedures, imaging and pathology and that relates to a particular consultant's patient referral will be paid into a specially established trust with independent trustees. The consultant will thereby accrue credits into the trust from his referrals to the Hospital.

Thereafter, the consultant can, by way of a formal proposal, apply to the independent trustees for a grant against their accrued credits. Each consultant submission will only be awarded subject to established criteria, governance, compliance and the overall merit of the proposal being satisfactory in the view of the independent trustees.

You have condemned consultant incentive schemes, however, I believe that it is important that a blanket prohibition should not relate to schemes such as this that are intended to improve the skills of the consultants and therefore ultimately benefit their patients and medicine generally.

In summary, KIMS will provide the people of Kent with their only acute/tertiary private and NHS hospital, thereby providing them and their families with an alternative to travelling to Central London

for such tertiary medical procedures. We have overcome the barriers to entry highlighted in your report, but an essential part of achieving this has been consultant support, and this (and the funding) could only be secured by offering the consultants an equity stake in the new Hospital. The consultants regard KIMS as “their hospital” and are keen to use its facilities for research, development and teaching, and we are keen to support and help in funding this.

I should therefore be grateful if you would have due regard to the above when finalising your report next April. In the meantime, please do not hesitate to contact me if you have any queries regarding the above or KIMS generally.