EXPLANATORY MEMORANDUM TO

THE SOUTH LONDON HEALTHCARE NATIONAL HEALTH SERVICE TRUST (APPOINTMENT OF TRUST SPECIAL ADMINISTRATOR) ORDER 2012

2012 No. 1806

AND

THE SOUTH LONDON HEALTHCARE NATIONAL HEALTH SERVICE TRUST (EXTENSION OF TIME FOR TRUST SPECIAL ADMINISTRATOR TO PROVIDE A DRAFT REPORT) ORDER 2012

2012 No. 1824

1. This explanatory memorandum has been prepared by The Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instruments

2.1 The South London Healthcare National Health Service Trust (Appointment of Trust Special Administrator) Order 2012 ("the Appointment Order") authorises the appointment of a trust special administrator (TSA) to exercise the functions of the chairman and directors of the South London Healthcare National Health Service Trust ("the Trust"), and makes provision for the appointment of the TSA to take effect on 16 July 2012.

2.2 Appended to this memorandum is a report produced in accordance with the requirement set out in section 65B(5) of the National Health Service Act 2006 ("the 2006 Act") stating the reasons for appointing a TSA to the trust.

2.3 The South London Healthcare National Health Service Trust (Extension of Time for Trust Special Administrator to Provide a Draft Report) Order 2012 ("the Extension Order") extends one of the time periods within which the TSA appointed for the Trust must carry out certain duties.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None

4. Legislative Context

4.1 Section 16 of the Health Act 2009 inserted a new chapter 5A into the 2006 Act to provide for the Secretary of State to appoint trust special administrators (TSA) to failing NHS trusts and NHS foundation trusts. The legislation also sets out the functions of the TSA during the period of the appointment, in particular, provision is made for the TSA to prepare a draft report making recommendations to the Secretary of State on the action he should take in relation to the Trust, for consultation by the TSA with staff of the trust, commissioners of services and other interested parties on the draft report, for the preparation by the TSA of a final report to the Secretary of State, and a final decision by the Secretary of State in relation to the trust. These functions are to be carried out within time periods prescribed in the 2006 Act. During the administration, the TSA will also be responsible for ensuring

that the trust continues to operate effectively, delivering quality health care promptly to its patients.

4.2 Section 65B(1) of the 2006 Act gives the Secretary of State the power to make an order authorising the appointment of a TSA to run an NHS trust if the Secretary of State considers it is appropriate in the interests of the health service. An order can only be made after consulting that NHS trust, any Strategic Health Authority in whose area the trust has hospitals, establishments or facilities, and any other person who commissions services from the trust where the Secretary of State considers it appropriate.

4.3 A TSA is only likely to be appointed after previous performance interventions have been unsuccessful. The TSA is appointed by the Secretary of State and holds and vacates office in accordance with the terms of their appointment. When the TSA's appointment takes effect the chairman and directors of the trust are suspended from performing their duties as members of the board.

4.4 Section 65J(2) of the 2006 Act gives the Secretary of State the power to, by order, extend certain of the time periods prescribed in the 2006 Act within which the TSA must carry out specified duties if the Secretary of State considers it is not reasonable in the circumstances for the TSA to be required to carry out a specified duty in that period.

4.4 These Orders are the first orders that have been made under sections 65B(1) and 65J(2) of the 2006 Act.

5. Territorial Extent and Application

5.1 These Orders apply to England.

6. European Convention on Human Rights

As these instruments are not subject to either the affirmative or the negative resolution procedure and do not amend primary legislation, no statement is required.

7. Policy background

7.1 The Secretary of State is exercising his powers under section 65B of the 2006 Act to trigger the Trust Special Administrator's (TSA) regime ("the regime") with regard to the South London Healthcare NHS Trust by means of appointing a TSA to the Trust pursuant to the Appointment Order. The hospitals in the Trust have faced multiple problems for many years. The Trust lost over £1 million a week last year. Whilst there have been some recent improvements in care, patients still face some of the longest waits for operations in London.

7.2 The Trust is a significant outlier in respect of referral to treatment times being one of only two trusts in London failing to meet 90% admitted standard and the only trust to fail the non-admitted standard at the end of 2011/12. The Trust has a record of weak accident and emergency performance failing to achieve the 4-hour standard in 2010/11 and 2011/12.

7.3 Financially, the Trust is the most challenged in the country and had a £65 million in-year deficit for 2011/12 - the third consecutive year of deficits (£42million in 2009/10 and £36million in 2010/11). It has not yet had its plan for 2012/13 accepted by the Strategic Health Authority that includes an 8.3% cost improvement target. This is considered above the achievable threshold. There is also no plan underpinned by a clinical and organisational strategy that demonstrates long-term sustainability. The most recent downside model developed by the Trust reflecting a more realistic set of assumptions suggests it will achieve a deficit, before support for its PFI scheme, of between £45million and £70million a year over the next four years. This is not sustainable.

7.4 Strenuous efforts have been made to tackle the problems in the South London health economy. South London Healthcare NHS Trust was established in April 2009 as a merger of three challenged hospitals – Queen Elizabeth in Woolwich, Queen Mary's Sidcup, and Princess Royal in Bromley. Over the past two years the Trust has worked hard to deliver improvements in the standard of the quality of care, demonstrated by a considerable fall in mortality rates and the opening of a new stroke facility. Nevertheless, the merger has not delivered long term financial and clinical sustainability.

7.5 The Government is committed to all remaining NHS trusts achieving foundation trust status. Every NHS trust has agreed a Tripartite Formal Agreement with its Strategic Health Authority and the Department of Health that sets out a clear plan and timetable for achieving foundation trust status. The trust has been red rated on its Tripartite Formal Agreement since it was agreed due to the lack of a credible plan that demonstrates how the Trust can be clinically and financially sustainable. There is no realistic prospect of the Trust achieving foundation status in its current configuration.

7.6 The regime was created to deal decisively with trusts in difficulties. The Appointment Order will enable the Trust to be put under the control of a TSA, with powers to make recommendations on how to make the Trust sustainable. The chairman and directors of the Trust are suspended at the point the TSA's appointment takes effect. The TSA's draft recommendations to the Secretary of State on what action should be taken in relation to the Trust must be consulted upon, after which the TSA produces a final report for the Secretary of State and the Secretary of State will then take the final decision on what action to take in relation to the Trust.

7.7 The regime sets out a timetable that produces final recommendations to the Secretary of State within a usual timeframe of 120 days. In this case, the Secretary of State has exercised his powers under section 65J(2) of the 2006 Act to make the Extension Order to extend the time period within which the TSA must produce a draft report from 45 working days to 75 working days.

7.8 The reason for the Secretary of State considering that it is not reasonable in the circumstances for the TSA to produce a draft report within 45 working days is that the issues affecting the Trust are particularly complex, being long standing and being built on a history of trust mergers, changes in commissioning arrangements and affecting a range of providers in the Trust's area. In conjunction with this, this is the first use of the regime, and the TSA appointed to the Trust will have to deal with the very challenging situation at the Trust

without being able to draw on processes and learning developed by previous TSAs. The TSA will need to develop these processes from scratch. In addition, the future of Orpington services are about to be consulted upon. Assuming this goes ahead, the extension will give the TSA the opportunity to take the output from this consultation exercise into account when developing his recommendations. The complexity of the situation at the Trust, combined with this being the first use of the regime, and the opportunity to take into account responses to the planned consultation on Orpington, have led the Secretary of State to consider it to be appropriate to extend the 45 working day period in the Extension Order by an additional 30 working days.

7.9 The first administration of an NHS trust is expected to attract significant levels of public and media interest. The Government will be issuing a press notice to accompany the appointment of the TSA, which will cover the extension to the timetable.

8. Consultation outcome

8.1 Pursuant to section 65B(4) of the 2006 Act, there is a statutory requirement for the Secretary of State, prior to making the Appointment Order, to consult the trust, any Strategic Health Authority in whose area the trust has hospitals, establishments or facilities, and any other person who commissions services from the trust where the Secretary of State considers it appropriate.

8.2 The main commissioners wrote to say that they shared the Secretary of State's concerns about the financial sustainability of many of the services provided by the Trust. They acknowledged evidence of rapid improvement in the accessibility and quality of care, but noted that the Trust is not financially viable beyond the short term. The commissioners advised that any strategy aimed at resolving the financial issues at the Trust needs to look at the whole health system for potential solutions. Looking at issues in the Trust alone will not resolve the factors causing the financial challenge. The commissioners offered their full support should the Secretary of State decide to trigger the unsustainable provider regime in relation to the Trust.

8.3 The Trust in its response, stressed the importance of the TSA having the remit and authority to look beyond the Trust and to maintain current standards of care. It stressed that the Trust now provides high quality services, but acknowledged that it is not able through its own actions to secure financial viability. The Trust accepts absolutely the timeliness of the intervention, but cares deeply that it is done in a way that solves the problem. The Trust is concerned that uncertainty created by the administration regime could reverse the recent gains that have been achieved. The Trust said that, if appointed, the TSA needs to have the powers and authority to look at a sufficiently wide range of options beyond the Trust itself. They also urged that the TSA should operate in such a way to safeguard current standards of care and retain the commitment of staff.

8.4 The SHA commented that applying the administration regime now – with its broad remit and timetable to which the TSA will work – is the best opportunity there is for securing access to high quality, financially viable health services for the people of south east London. The SHA emphasised that as part of his directions to the TSA, the Secretary of State should emphasise the need to take a broad strategic view, involving the whole of the south east London health economy.

8.5 The Government welcomes the generally supportive response to the consultation. The need for a solution to go beyond the Trust and involve the entire health economy was raised by all respondents to the consultation. The Secretary of State has powers to issue directions to the TSA under section 65H of the 2006 Act, to ensure that key stakeholders across the health economy are consulted on the draft report. The 2006 Act requires the TSA to attach to the final report a summary of all responses received to the draft report during the consultation. The Government notes the Trust's concern that the TSA should maintain the high standards of care and retain the commitment of staff. This has informed our decision to appoint a TSA with extensive experience of holding senior management posts within the NHS. This background will help to ensure that the Trust remains focussed on continuing to deliver high standards of care, and staff engagement will be a priority.

9. Guidance

9.1 There is guidance for TSAs on the DH website at http://www.dh.gov.uk/health/2012/07/statutory-guidance-tsa/

10. Impact

10.1 The urgency of the situation requires the Government to act promptly. There has not been time to produce an impact assessment on £3million to £4 million of external costs that are expected to be incurred on this administration. However, the Department of Health took into consideration the costs associated with the TSA administration as compared with the very large costs explained earlier in this Explanatory Memorandum associated with Trust as it stands.

10.2 The impact on public sector costs is not considered to be significant. The TSA is employed by the SHA, and where possible staff employed by the SHA and the Trust will be used to provide support to the TSA, in order to minimise costs.

11. Regulating small business

11.1 The legislation does not apply to small business.

12. Monitoring & review

12.1 The Department of Health made a commitment to review the operation of the administration regime after five years in the impact assessment that accompanied the Health Act 2009.

12.2 The TSA appointed pursuant to the Appointment Order is under a duty to provide the Secretary of State with a final report (after having developed and consulted on a draft report) about the action it recommends the Secretary of State should take in relation to this Trust, as provided for in Chapter 5A of the 2006 Act. If the Secretary of State's final decision is that the Trust is not to be dissolved, the Secretary of State has a duty to make an order specifying when the appointment of the TSA will come to an end. If the Trust is to be dissolved, then the TSA's appointment will end when the Trust is dissolved. In either case, the appointment authorised by the Appointment Order will end once implementation of the decision that follows the trust special administration process occurs.

12.3 This Extension Order provides for the time period in which the TSA appointed to the Trust must provide a draft report to be extended. Once this period has passed, and the trust special administration process for this Trust has ended, the Extension Order will have no ongoing effect, and can be revoked.

13. Contact

John Guest at the Department of Health Tel: [0113 254 6369 or email: John.Guest@dh.gsi.gov.uk can answer any queries regarding the instrument.

South London Healthcare NHS Trust

The Case for Applying the Regime for Unsustainable NHS Providers

July 2012

Executive Summary

1. The NHS is guided by the principles set out in *The NHS Constitution.* These include an aspiration to attain the highest standards of excellence and professionalism in delivering high quality care to all and, in doing so, a commitment to provide best value for taxpayers' money and the most sustainable use of finite resources[1].

2. All NHS Trusts have a duty to deliver these principles, however, for a variety of reasons, a small number of NHS Trusts across the country fall short. This is unacceptable and action must be taken to address Trusts that are failing to deliver clinically and financially viable services to patients.

3. South London Healthcare NHS Trust (SLHT) is one such Trust. Despite recent improvements in the quality of services, there is a long-standing history of underperformance, particularly around financial management and access standards, and a consistent inability to deliver high quality services whilst balancing income with expenditure.

4. A number of solutions have been implemented to try to resolve these problems and ensure the NHS in this area is able to provide consistent, high quality services to local patients and the public, within the designated budget. None have delivered the scale of change required to ensure clinically and financially viable services for patients and the people of south east London.

5. In the three years since its formation, SLHT has generated a total deficit of £154m. In the financial year 2011/12 it reported a deficit of £65m making it the most financially challenged Trust in the NHS. SLHT has no coherent and sustainable plan to resolve these issues. Over the next five years, from 2012/13 to 2016/17, the Trust projects a total accumulated deficit of £196m.

6. One of the major pressures on SLHT's financial position is the £89m annual cost of servicing the debt of its five PFIs, 18% of the Trust's annual turnover is spent on PFI contracts. Whilst key, even addressing this financial challenge will not be enough to deliver the Trust's long-term financial sustainability.

7. Despite SLHT's hospitals having, for many years, a number of performance issues in respect of delivery of clinical services, the Trust has made a number of improvements since 2009, including recently. However, the Trust still struggles to meet a number of key standards and with the significant financial challenges sustaining these improvements is unlikely.

8. The challenges facing SLHT are vast and complex. There is no clear and robust strategy in place to ensure that the Trust is able to secure a sustainable future for its services to patients within its existing configuration and organisational form.

9. It is therefore recommended that the Regime for Unsustainable NHS Providers, in which a Trust Special Administrator (TSA) is required to develop a solution within a prescribed timeframe, is applied to SLHT. Once appointed, the TSA will work across conventional or established stakeholder and organisational boundaries to develop a health economy-wide solution. This will bring about the transformational level of change needed to ensure clinically and financially viable services are secured for the people of south east London.

[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132958.pdf

Introduction

1. This paper provides an overview of the history and context, outlines previous attempts to resolve SLHT's challenges, analyses SLHT's financial and clinical performance challenges and concludes with why the UPR is the most suitable option for addressing SLHT's problems.

History and context

Overview of south east London health economy

2. SLHT operates largely out of three sites: Princess Royal University Hospital (PRUH), Queen Elizabeth Hospital (QEH) and Queen Mary's Sidcup (QMS). The Trust serves a population of approximately one million people, employs around 6,300 people and has an annual income of c. £440m, making it the 16th largest NHS Trust, by income, in the country.[2]

3. The wider south east London health economy comprises:

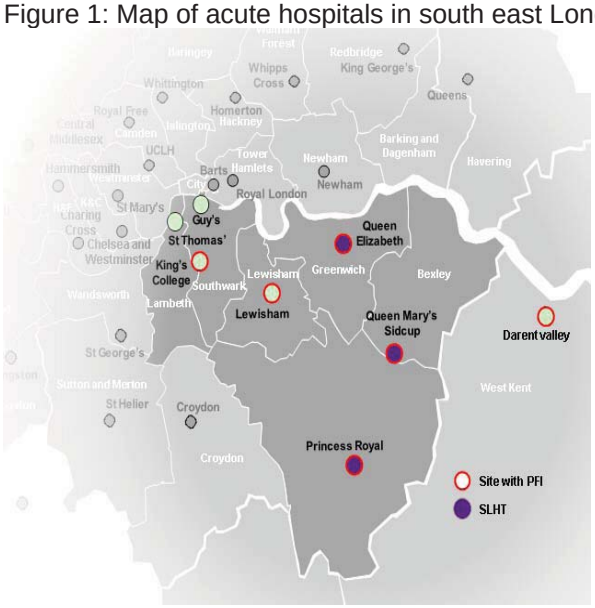
- One PCT Cluster, NHS South East London, that consists of six primary care Trusts (PCTs):
  - Bexley Care Trust
  - Bromley PCT
  - Greenwich PCT
  - Lambeth PCT
  - Lewisham PCT
  - Southwark PCT
- NHS South East London works with six proposed clinical commissioning groups (CCGs) (made up of 277 GP practices), each coterminous with their local authority. It has a commissioning budget of £2.3bn (of which £1.3bn is spent on acute care) for a population of c.1.8 million people.
- Two major teaching and research Foundation Trusts (FTs): Guy's and St Thomas' Hospital NHS Foundation Trust (GST) and King's College Hospital NHS Foundation Trust (KCH), operating from three sites.
- Two mental health FTs: South London and Maudsley NHS Foundation Trust (SLaM) and Oxleas NHS Foundation Trust.
- Two acute NHS Trusts: SLHT and Lewisham Healthcare NHS Trust (UHL).
- Four community services providers across the six boroughs: Southwark's and Lambeth's community services are provided by GSTT; Greenwich's and Bexley's by Oxleas NHS Foundation Trust; Lewisham's by Lewisham Healthcare NHS Trust; and Bromley's by Bromley Health Community Interest Company, a social enterprise.

[2] Audit Commission analysis of audited NHS financial statements

- One Academic Health Science Centre, Kings Health Partners (KHP), which is a partnership between GSTT, KCH, SLaM and King's College London.

4. Figure 1 shows the acute hospital sites across south east London. All hospital sites are easily accessible, as they are located on well-developed public transport routes. There are also significant patient flows from Bexley to Darent Valley Hospital (part of Dartford and Gravesham NHS Trust) in north west Kent. In the financial year 2011/12 Bexley Care Trust spent £190m on acute services, of which Dartford and Gravesham NHS Trust received £25m and SLHT received £90m.

Figure 1: Map of acute hospitals in south east London



5. In 2010/11 the two major teaching hospitals - GSTT and KCH - generated revenue of c. £940m[3] and c. £570m[4] respectively. Both organisations tend to generate a surplus. Given their size and clinical specialisms, GSTT and KCH create significant competition for SLHT, particularly in elective care.

6. No acute Trust in south east London has made a net surplus of more than 3.3% in the past three years and SLHT consistently reports the greatest deficit (see figure 2). In the next few years, in light of the constraints on public sector finances and the changing pattern of healthcare, it is anticipated all south east London acute Trusts will have financial challenges to address.

Figure 2: Summary financial position for SEL acute Trusts[5]

Currency: £ m	Guy's & St Thomas'			King's College Hospital			Lewisham			South London Healthcare			Total Health Economy		
	Income	Surplus / (deficit)		Income	Surplus / (deficit)		Income	Surplus / (deficit)		Income	Surplus/ (deficit)		Income	Surplus/ (deficit)	
2010/11	992	18	1.8%	586	1	0.1%	222	0	0	438	(44)	-10%	2,239	(26)	-1.1%
2009/10	943	2	0.2%	556	(1)	-0.2%	224	(1)	-0.4%	463	(44)	-9.4%	2.196	(44)	-2.0%
2008/09	845	19	2.2%	518	11	2.1%	174	6	3.3%	446	(21)	-4.8%	1.982	14	0.7%

[2] GSTT FT Annual Report and Accounts 2010/11(note: 2011/12 information not available for Guy's and St. Thomas and King's College Hospital)
[3] KCH FT Annual Report and Accounts 2010/11 and 2011/12
[4] Individual Trust report and Accounts 2008/09 – 2010/11

7. Local commissioners have also been managing financial pressures. In particular, Bexley Care Trust has struggled to deliver its statutory duty to break even. A recent NHS London review of PCT expenditure indicated that for the financial year 2012/13 NHS South East London will spend 45% of its planned income on acute care. This compares to the London average spend of 42%. (In contrast, in England, acute services account for 40% of total spend). The figures for the three PCTs that are SLHT's main commissioners are Bromley 47%, Bexley 45% and Greenwich 38%. This would indicate that the commissioners are not under-investing in acute services.

Figure 3: Summary of financial position of commissioners[6]

Currency: £ m	Lambeth		Southwark		Lewisham		Bexley		Bromley		Greenwich		Total Health Economy	
	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)
2011/12	687	7	558	6	553	5	357	2	520	6	492	5	3,168	31
2010/11	667	6	546	1	537	5	347	0	513	7	476	5	3,086	26
2009/10	4	1	523	1	508	0	322	0	478	0	448	1	2,913	3
2008/09	562	3	455	0	450	0	287	0	429	0	404	2	2,586	5

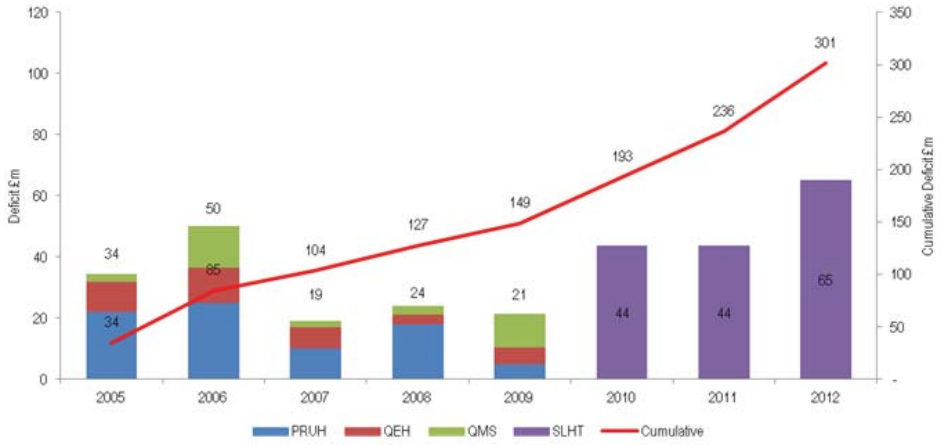
8. The consequence of the financial pressures in south east London is that each organisation adopts strategies that contain and resolve their own financial pressures, with insufficient regard to the impact on others. This has had a negative impact on SLHT and has strained relationships between organisations that need to work together effectively if they are to secure the best services for patients.

9. The pressures also act as a disincentive for organisations to engage with key strategic issues, since the cost of engagement and change can be viewed as prohibitive when seeking to contain short-term expenditure.

Overview of the history of SLHT

10. There is a long-standing history of underperformance (see figure 4), particularly around financial management and key access targets, within the hospitals that now make up SLHT, with a consistent inability to deliver high quality services within budget over the last eight years.

Figure 4: Normalised deficit[7] of SLHT and its three predecessor Trusts for 2004/05 to 2011/12[8]



[6] South East London Cluster FIMS returns 2008-09 to 2010-2011

11. Over the last five years there have been repeated attempts, involving different types and scale of intervention, to address the deep-rooted challenges facing SLHT. Thereby ensuring that the NHS in south east London provides local patients with clinically and financially sustainable services into the future.

12. These interventions started with *A Picture of Health* (APOH) - a substantial commissioner-led service reconfiguration programme to transform health services. Starting in 2006, the original aims of the programme were to "examine how to ensure improved, affordable and sustainable health services across the six boroughs in south east London - Lambeth, Southwark, Lewisham, Bexley, Bromley and Greenwich". The review work was undertaken in the context of an underlying and growing financial deficit projected for the south east London health economy.

13. In 2007, in light of a lack of progress, NHS London and south east London's PCTs changed the scope of the programme so that it only covered the outer boroughs - Lewisham, Bexley, Bromley and Greenwich - recognising that it was this part of the health economy that faced the most pressing challenges.

14. Prior to public consultation, the preferred option for change that emerged - with the options endorsed by the National Clinical Advisory Team - would have seen the outer south east London provider landscape rationalised to create a 'borough' hospital (ie. QMS), a 'medically admitting' hospital (ie. UHL) and two 'admitting' hospitals (ie. PRUH and QEH). The 'borough' hospital would not have provided a full A&E service, but with the service re-modelled as a primary care-led urgent care centre. The 'medically admitting' hospital would have an A&E department that can admit patients who may need some emergency monitoring, but would not provide inpatient maternity or inpatient paediatric services.

15. Public consultation on the APOH proposals for change took place in early 2008. The considerable challenge of managing stakeholders' responses to these reconfiguration proposals - most significantly those who opposed the proposed changes to services at UHL, including a significant number of the Trust's clinicians - was a major factor in the decisions following consultation. In the summer of 2008, the PCTs decided that PRUH, QEH and UHL were to become specialist emergency centres with 24-hour A&E, maternity units and children's inpatients; QMS was to focus on planned surgery and become a base for community healthcare services, with a 24-hour urgent care centre (with the site losing its A&E, obstetrics unit and all children's inpatient beds).

16. Despite the implementation of the APOH decisions, the south east London health economy still faces some significant challenges. One of the reasons for the continued challenges in this area of London is that, despite being implemented more quickly than other agreed reconfiguration programmes in London, arguably APOH did not go far enough to transform services. Services were rationalised, which meant movement between sites; but without being able to reduce capacity at any sites and therefore no significant efficiencies have been realised.

17. On 1 April 2009, SLHT was established as a merger of three NHS Trusts: QEH, QMS and PRUH. The merger was then seen as a solution to achieve cost and operational synergies amongst three Trusts facing their own significant, individual challenges.

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[7] Adjusted for non-recurrent income and expenditure
[8] SLHT Annual Report and Accounts 2008/09 – 2010/11 and draft annual accounts 2011/12 (note for 2011/12 management accounts 2011/12 have been used, reported under UK GAAP)

18. Whilst the merger, alongside the service changes implemented through APOH, has delivered some improvements to the quality of care that patients receive, the financial benefits anticipated have not been realised[9]. Given the organisation is in such profound financial distress it is questionable that the improvements in the quality of care are sustainable.

19. The anticipated improvement in clinical and operational performance has not materialised from the merger, partly due to the failure to operate as a single, consistent organisation across all three sites, including maximising the efficiency of Trust estate. Furthermore, the expected stimulus to make wider changes in the health economy has not been brought about. SLHT's relationships with commissioners remains strained.

20. More recently, the Trust has had significant traditional financial turnaround support from external consultancies and turnaround specialists. Over the past 18 months alone, SLHT has engaged three different sets of management consultants, including McKinsey & Company, Ernst & Young and PricewaterhouseCoopers to advise on devising turnaround plans and performance improvement strategies. SLHT has been unable to implement these plans effectively, resulting in continued operational and financial inefficiency.

21. Decision-making also remains variable and distinct across the three sites, with many examples of where Trust-wide policies have not been standardised. HR policies remain in place from the three pre-merger Trusts. As such, there are variations in payments and terms and conditions across SLHT. These variations continue to undermine attempts to streamline corporate-level reporting.

22. In a recent analysis undertaken by NHS London[10] the productivity opportunity at SLHT was assessed to be considerable, at between £67m and £97m over four years when benchmarked against comparable NHS Trusts in England. However, even if SLHT's productivity opportunity is realised in full, it would still not be sufficient to close the financial gap and deliver financially sustainable services. The gap is estimated at just over £51m.

23. Lastly, and in addition to all of the interventions and support outlined above, the Trust has also seen a number of senior management changes and, whilst some of these have resulted in short-term improvements, these have not been embedded and have failed to deliver the long-term change required.

Detailed analysis of SLHT

Overview

24. The disposition of key services at the Trust's three main sites is outlined in figure 5. SLHT also operates from three further sites - Orpington Hospital, Beckenham Beacon and Erith Hospital - at which the Trust mainly delivers outpatient care.

[9] The King's Fund Report: Reconfiguring Hospital Services, Lessons from South East London, Keith Palmer 2011
[10] Acute Hospitals in London: Sustainable and Financially Effective, February 2012

Figure 5: Key services by main three sites[11]

PRUH	QEH	QMS
Full admitting A&E	Full admitting A&E	Non-admitting urgent care centre
24/7 surgical emergency admissions	24/7 surgical emergency admissions	
Obstetrics and midwife-led birthing unit	Obstetrics	Antenatal and postnatal outpatient care
Routine elective care	Routine elective care	Routine elective care
Inpatient paediatric service	Inpatient paediatric service	Outpatient paediatric service
Complex inpatient surgery	Complex inpatient surgery	Elective day surgery
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics
		Intermediate/ rehabilitation beds

Financial performance and reporting

Overview

25. Financial underperformance in SLHT and its predecessor Trusts has been a persistent issue over the last eight years. In the three years since its formation, SLHT has generated a total deficit of £154m. In the financial year 2011/12, only 10 of the 104 NHS Trusts in England reported a deficit; of these, SLHT had the largest at £65m (14.8% of the Trust's turnover) making it the most financially challenged Trust in the NHS. This was an increase of nearly 50% from £44m in the financial year 2009/10.

26. The Trust has constructed a Long Term Financial Model (LTFM) that projects SLHT will not achieve financial viability in the next five years. In every year of the model the Trust delivers a deficit (see figure 6), with a cumulative deficit over the five years totalling £196m. This is after an assumption that efficiency improvements totalling £113m per annum can be delivered. Achievement of this would require efficiency and productivity improvements beyond those made by the top performing organisations in the country. The downside case, which includes reasonable assumptions - CIP delivery of £84m, a reduced income assumption and a reduced assumption regarding transition financial support - projects a total accumulated deficit position of £343m.

27. The continued delivery of deficits with no plan for resolution is unsustainable and means that vital resources are, and will continue to be, diverted away from other parts of the NHS to maintain safe and high quality services at SLHT. In order to deliver long-term sustainable services for patients, the Trust, as part of the wider health economy, must work with its partners to develop models of care and clinical pathways that are both clinically and financially viable.

[11] http://www.slh.nhs.uk/?section=aboutus&id=84

Figure 6: SLHT Long term financial model 2012/13 – 2016/17[12]

Currency:£ m	2012/13	2013/14	2014/15	2015/16	2016/17	Total
Base case Income	429.7	449.8	456.6	456.6	456.6	**2,249.3**
Expenditure	(488.5)	(491.5)	(491.5)	(487.1)	(487.1)	**(2,445.7)**
Surplus / (Deficit)	(58.8)	(41.7)	(34.9)	(30.5)	(30.5)	**(196.4)**
Surplus / (Deficit) as a % of income	(13.7%)	(9.3%)	(7.7%)	(6.7%)	(6.7%)	**(8.7%)**
Downside case	(101.8)	(80.1)	(80.7)	(78.7)	(81.2)	**(343.8)**

Summary financial performance for the last three years

28. To understand fully the underlying financial challenges facing the Trust it is necessary to consider the recent financial performance of the Trust, how it has responded to the challenges it has faced since its establishment and its current financial position.

29. Figure 7 outlines the financial performance of SLHT since its formation on 1 April 2009 and shows a deterioration over the period. The key points are:

- Total revenue has declined by £23.7m (5.1%) over the three years. This decline took place between 2009/10 and 2010/11 and was linked to changes in commissioning intentions, the pace of which is likely to accelerate as CCGs assume control of commissioning.

- Operating costs have reduced by £32.2m (6.2%) over the three years. However, they increased between 2010/11 and 2011/12 by £40.9m (9%). This is a real terms increase and demonstrates that the Trust's cost base has risen, despite income remaining constant.

- Finance costs, which principally relate to the two whole hospital PFIs located at PRUH and QEH, have increased by £5.3m (25.2%) over the last three years.

- The total deficit has increased by £21.3m (49%) over the three years. Adjusting to reduce the impact of the impairment[13], the net deficit in 2009/10 and 2010/11 was c. £44m and in 2011/12 was £65m.

[12] Source: SLHT Long Term Financial Model 2011/12 – 2016/17 (31 December 2011)

[13] The 2009/10 deficit of £90.5m includes an impairment in the value of fixed assets of £46.8m, which relates to a reduction in the value of assets at SLHT's operational sites resulting from the impact of changes in the economic environment. In 2011/12, a similar impairment was £21.6m. Impairments are directly related to the value of the Trust's estates and they are not considered to be of a material nature when considering the overall financial performance of any Trust, since they are not related to the year-on-year delivery of patient services.

Figure 7: SLHT financial performance 2009/10 – 2011/12[14]

Currency: £ m	2009/10	2010/11	2011/12[15]	%change
Revenue from patient care activities	421.7	407.8	408.8	(3.1%)
Other operating revenue	40.9	30.0	30.1	(26.4%)
Total revenue	462.6	437.8	438.9	(5.1%)
Employee costs	(306.9)	(293.8)	(301.7)	1.7%
Non pay costs	(216.1)	(156.1)	(189.1)	(12.5%)
Total costs	(523.0)	(449.9)	(490.8)	(6.2%)
Investment revenue	0.0	0.0	0.0	
Other gains and losses	0.0	0.0	0.0	
Finance costs	(21.0)	(23.3)	(26.3)	25.2%
Surplus / (Deficit) for the financial year	(81.4)	(35.4)	(78.2)	(3.9%)
Public dividend capital dividends payable	(9.1)	(8.4)	(8.4)	(7.7%)
Retained Surplus / (Deficit) for the financial year	(90.5)	(43.8)	(86.6)	4.3%
Less 2009/10 and 2010/11 impairment and IFRS adjustment	46.8	0.0	21.6	53.8%
Normalised position	(43.7)	(43.8)	(65.0)	(48.7%)

Income

30. The majority of SLHT's income comes from the Bexley, Bromley and Greenwich PCTs. The Trust has seen its income reduced by £24m (5.1%) over the last three years (see figure 8), due to:

- tariff deflation;
- a reduction in other operating income of £10.8m; and
- some reduction in activity related income as commissioners developed services away from the acute hospital environment.

Figure 8: Breakdown of income 2009/10 – 2011/12[16]

Currency: £ m	2009/10	2010/11	2011/12[17]	%change
Primary Care Trusts	419.9	404.2	405.6	(3.4%)
Non NHS: Other patient care	1.8	3.6	3.2	77.7%
Total income from Patient Care Activities	**421.7**	**407.8**	**408.8**	**(3.1%)**
Other operating revenue	17.7	12.2	8.3	(53.1%)
Education, training and research	16.5	15.7	15.2	(7.9%)
Non-patient care services to other bodies	1.7	2.1	5.7	235.2%
Income generation	5.0	0.0	0.9	(82%)
Other operating income	**40.9**	**30.0**	**30.1**	**(26.4%)**
Total operating income	**462.6**	**437.8**	**438.9**	**(5.1%)**

[14] SLHT Annual Report and Accounts 2009/10, 2010/11 and draft annual accounts for 2011/12
[15] There may be a difference between the management accounts and audited accounts
[16] Source: SLHT Annual Report & Accounts 2009/10, 2010/11 and 2011/12.
[17] draft annual accounts 2011/12 – note, there may be a difference between the management accounts and audited accounts, but it is the latest available information

31. In line with the NHS elsewhere in England, south east London commissioners have developed plans that will see the delivery of care transferred from acute hospital settings to community settings, where appropriate. In parallel, a plan for developing and improving overall public health is being pursued, which potentially further reduces the need for hospital care and therefore may reduce SLHT's income further.

32. In addition to this, and building on evidence-based service change already undertaken across the capital, there is a powerful case for treatment of some complex conditions to be consolidated at 'centres of excellence'. It is therefore unrealistic for SLHT to expect to be able to generate significant additional income to support its underlying financial position. In reality, the Trust's income is likely to reduce and, therefore, SLHT has to look to reducing its cost base to match its income structure and the expected level of activity in future years.

33. Any organisation would find it challenging to react to changes in demand for services but, coupled with the other challenges facing SLHT, it is virtually impossible that this organisation can respond to these challenges in its current form.

Operating costs

34. SLHT's operating costs have fallen 6.2% overall in the last three years. However, all of the reductions were made in 2010/11. In 2011/12 costs rose by £40.9m, increasing the Trust's deficit.

35. In 2011/12, 61.5% of total expenses incurred related to employee costs (see figure 9). This puts SLHT in the top 20% of large acute Trusts in terms of proportion of total costs relating to employees. An independent report concluded SLHT has significant inefficiencies within its employment cost structure[18], which it has been unable to address.

Figure 9: SLHT Employee costs[19]

Currency: £ m	Staff cost			Number of employees		
	2009/10	2010/11	2011/12	2009/10	2010/11	2011/12
Total, excluding bank staff, locums and agency staff	268.1	259.4	262.4	5,771	5,431	5,367
Bank staff	17.8	18.5	22.2	432	741	789
Locum staff	2.7	3.1	4.0	11	24	20
Agency staff	18.2	12.7	13.3	299	302	187
Total bank, locum and agency staff	**38.7**	**34.3**	**39.5**	**742**	**1,067**	**995**
Total	**306.9**	**293.7**	**301.8**	**6,513**	**6,498**	**6,363**
% of expenses	58.7%	65.3%	61.5%			
% of bank, locum and agency staff	12.6%	11.7%	13.1%			

36. From 2010/11 to 2011/12 headcount costs increased by £8.1m (2.8%) to £301.8m. £3m of this increase was from the permanent staff base. The remainder was

[18] PwC Report, South London Healthcare NHS Trust, Workforce Review, 8 September 2011
[19] SLHT Management Accounts 2009/10, 2010/11, 2011/12

generated by additional spend on bank, locum and agency staff. Given the Trust's financial position, these additional pressures are unsustainable.

37. Temporary staff expenditure continues to be a problem for SLHT. For example, in 2011/12, agency staff costs were budgeted to be under £3.4m the actual cost was £13.3m; SLHT's target for agency usage is 1% of total workforce and yet, in 2011/12 it delivered 4%. Compared to its peers, SLHT has consistently underperformed on its levels of usage of temporary staff.

38. The Trust's inability to contain temporary staff costs suggests a broader problem: a combination of the challenges of planning, rostering, staff utilisation and staff recruitment and retention. It demonstrates short-term operational planning, with permanent positions being removed, only to be replaced with more costly temporary staff. This has been a recurrent issue and one which SLHT has been unable to address. The lack of a clear plan for financial and operational viability and the worsening financial position compounds this issue, making the Trust an unattractive organisation for potential recruits.

39. Non-pay costs, before taking into account impairments, increased by 1.2% over the last three years (see figure 10); this is despite an £11.5m reduction in 2010/11.

Figure 10: Non-pay costs[20] 2009/10 – 2011/12

Currency: £m	2009/10	2010/11	2011/12[21]	% change
Supplies and services – clinical	68.9	70.9	83.3	(20.9)%
Premises	38.4	31.4	35.8	6.8%
Clinical negligence	10.6	11.2	13.3	(25.5)%
Supplies and services – general	13.3	12.7	12.8	3.8%
Establishment	5.2	5.2	5.1	2.0%
Other	19.8	13.3	7.8	60.1%
Total operating expenses excluding employee benefits and non-trading expenditure	**156.2**	**144.7**	**158.1**	**(1.2)%**
Impairments and reversals	44.1	(1.7)	17.5	
Depreciation	16.0	13.2	13.5	
Total operating expenses excluding employee benefits	**216.3**	**156.2**	**189.1**	

40. In 2011/12 non-pay costs, before taking into account impairments, returned to levels above those seen in 2009/10. The £13.4m (9.3%) increase was driven by a £12.4m increase in clinical supplies and services. Such an increase could either indicate a lack of control over the purchasing of such supplies, high inflation, or a failure to turn additional activity into income. It should be noted that income was constant between 2010/11 and 2011/12.

[20] SLHT Annual Report & Accounts 2009/2010, 2010/2011 and draft annual accounts for 2011/12
[21] There may be difference between the management accounts and audited accounts

Cost Improvement Plans (CIP)

41. In the last three years SLHT has generated CIP savings of £91.5m, equal to 19% of total costs. Despite these significant cost reductions, SLHT has a history of underperformance against budget for its CIPs (see figure 11). In 2011/12, only 68% of cost savings were achieved. The key reasons for this underperformance have been SLHT's limited ability to deliver successfully against plans that it has developed or to reflect long-term changes in demand. In such circumstances, plans are often short-term reactions to pressures and demonstrate a lack of planning and / or awareness of the impact of shifts in activity to the cost base.

Figure 11: Summary of CIP savings[22]

Currency: £m	2009/10	2010/11	2011/12
CIP – Forecast	30.4	51.5	30.6
CIP – Actual	24.1	46.7	20.7
% CIP actual vs forecast	79.3%	90.7%	67.6%
Actual CIP as % total costs	4.6%	10.4%	4.2%

42. The key drivers for CIPs in each year have been[23]:

- In 2009/10 61% of savings were generated from clinical cost reduction, half of which were from clinical headcount and staffing costs. This area was also one of the key drivers for the underperformance against the CIP (£3.4m). This indicates that in this area, a large target was set but the Trust was unable to deliver this target whilst ensuring that all services were safe for patients.

- The 2010/11 saving plan was the largest (as a proportion of total costs) in London. Key areas of focus were restrictions on temporary / agency staff and controls on discretionary spending.

- In 2011/12 SLHT underperformed by £9.9m against its CIP. The primary reason for this was the changing nature of activity and the desire to ensure services remain safe.

43. The absence of a clear long-term strategy for the Trust is reflected in the SLHT's CIP schemes. These tend, in the main, to be comprised of high numbers of low-value schemes, which are intrinsically harder to manage than a small number of high-value schemes. A recurrent theme of these programmes is a lack of success in tackling the strategic and transformational issues and requirements of the Trust based on overall productivity and efficiency, with instead a repeated focus on short-term savings'

Operational efficiency

44. NHS London analysis of productivity opportunities for acute NHS Trusts[24] concluded that SLHT had an opportunity of between £67m and £97m over a four-year period. Efficiencies were identified across all parts of the operations, including:

[22] SLHT Long Term Financial Plan 2011/12 – 2016/17 (31 December 2011)
[23] SLHT Long Term Financial Plan 2011/12 – 2016/17 (31 December 2011)
[24] Acute Hospitals in London: Sustainable and Financially Effective, February 2012

- Theatre utilisation - Day case rates consistently below the Trust's peer group average and national target at only 70% against a national theatre utilisation benchmark of 90%, making theatre utilisation at SLHT one of the lowest nationally. Internal analysis suggests that SLHT could potentially deliver current levels of activity with between two to nine fewer theatres.

- Medical productivity - SLHT's job planning process in relation to programmed activity (PA) for its consultant workforce does not correspond directly to demand. As such, there are significant operational inefficiencies with respect to additional PAs being contracted for and remunerated but not being fully utilised. An external review undertaken last year[25] estimated that over 200 PAs could be released by restructuring the demand planning framework and reducing unnecessary PAs.

- Nursing and midwifery productivity - SLHT's nursing and midwifery levels are 3.5% higher than comparator Trusts, which equates to a potential annual recurrent saving of between £4m and £13m. The Trust has higher than benchmark staffing levels for *Agenda for Change* bands 6 to 8d (the most senior nurses). The average number of nurses per shift, nurses per bed ratios and bank use figures are high across certain wards, and exceed recommended staffing levels set-out by the Royal College of Nursing[26].

- Length of stay and bed management - Work undertaken by the Trust suggests SLHT's current bed configuration is not effectively managed. The Trust's internal analysis suggested that the bed requirement could potentially be reduced by between 100 and 300 beds if managed more effectively and length of stay was reduced.

45. However, NHS London's analysis also[27] concluded that even if the Trust, in its current configuration, achieved 'best in class' productivity across its operations, it would still not be able to achieve a sustainable financial position in its current form. This shows that the underlying fixed cost base is too high and significant change is needed to the Trust's operational structures as well as to its productivity.

Cash flow

46. The operating cash position has deteriorated since 2009/10, with a £30.5m reduction in operating cash flow in 2011/12 to £64.4m (outflow) (see figure 12). This was driven by the significant deficit generated by SLHT during the year.

[25] EY Report, SLHT Financial Improvement Support, September 2011
[26] EY Report, SLHT Financial Improvement Support, September 2011
[27] Acute Hospitals in London: Sustainable and Financially Effective, February 2012

Figure 12: Cash flow 2009/10 – 2011/12[28]

Currency: £ m	2009/10	2010/11	2011/12
Net cash inflow / (outflow) from operating activities	(27.0)	(33.9)	(64.4)
Net cash inflow / (outflow) from investing activities	(12.6)	(14.3)	(16.3)
Net cash inflow / (outflow) before financing	(39.6)	(48.2)	(80.7)
Net cash inflow / (outflow) from financing	40.1	46.7	80.6
Net increase / (decrease) in cash and cash equivalents	0.4	(1.4)	(0.1)
Cash and cash equivalents at the start of the year	7.6	8.1	6.6
Cash and cash equivalents at the end of the year	**8.1**	**6.6**	**6.5**

SLHT would be insolvent without the significant additional public dividend capital that it has received (£182.9m in the three years to 2011/12).

Quality of financial information

47. As with all NHS providers, effective management is dependent on timely and accurate financial information which the Trust struggles to deliver. This is a key operational risk. For example, the Trust has had difficulty identifying detailed site-specific financial information and has not been able to implement a robust Service Level Costing information system.

48. The weakness of SLHT's financial information can be evidenced by the issues uncovered during the close and audit of the 2010/11 accounts. The draft financial statements for the 2010/11 audit were provided late, incomplete and contained a number of errors. The most pressing concern was the completeness and valuation of assets on SLHT's fixed asset register.

49. Upon initial review, the audit team found a number of significant errors within the fixed asset register. In order to avoid qualification of its accounts, SLHT carried out a second review of its asset register and the audit team returned to re-test in September 2011. High levels of errors were still identified, showing inadequate monitoring and control of financial information despite the serious concerns already raised by the auditors. Additional errors were also found and are documented in SLHT's Annual Governance Report.

50. In addition, during the 2010/11 financial year end close the 2009/10 accounts needed to be re-stated. This was due to a number of material errors relating to asset disposals and re-valuations. These highlight severe weaknesses in SLHT's data and control environment. SLHT also has a history of inaccurate budgeting. In 2010/11, whilst the figures presented in figure 13 show a difference of £2.8m, this is a revised forecast, with the original forecast projecting a c. £25m lower deficit than was actually achieved.

[28] SLHT Annual Report & Accounts 2009/10, 2010/11, Management Accounts 2011/12

Figure 13: Accuracy of budgeting[29]

Currency £m	2009/10 Actual	2009/10 budgeted	Variance	2010/11 Actual	2010/11 budgeted	Variance	2011/12 actual	2011/12 budgeted	Variance
Total revenue	**462.6**	**440.4**	**22.2**	**437.8**	**438.9**	**(1.1)**	**438.9**	**410.4**	**28.5**
Operating expenses	(523.0)	(438.5)	(84.5)	(449.9)	(450.3)	(0.4)	(490.8)	(446.4)	(44.4)
Operating surplus (deficit)	**(60.4)**	**1.9**	**(58.5)**	**(12.1)**	**(11.4)**	**(0.7)**	**(51.9)**	**(36.0)**	**(15.9)**
Finance costs	(21.0)	(19.0)	(2.0)	(23.3)	(20.6)	(2.7)	(26.3)	(25.4)	(0.9)
Surplus/(Deficit)	**(81.4)**	**(16.4)**	**(65.0)**	**(35.4)**	**(32.0)**	**(3.4)**	**(78.2)**	**(61.3)**	**(16.9)**
Public dividend capital dividends payable	(9.1)	(13.3)	4.2	(8.5)	(9.0)	0.5	(8.4)	(8.5)	0.1
Retained Surplus/(Deficit) for the financial year	**(90.5)**	**(29.7)**	**(60.8)**	**(43.8)**	**(41.0)**	**(2.8)**	**(86.6)**	**(69.8)**	**(16.8)**
Less 2009/10 and 2010/11 impairment	46.8	0.0	46.8	0.0	0.0	0.0	21.6	0.0	21.6
Normalised position	**(43.7)**	**(29.7)**	**(14.0)**	**(43.8)**	**(41.0)**	**(2.8)**	**(65.0)**	**(69.8)**	**4.8**

51. The Audit Commission concluded[30] that there was inadequate challenge to the financial information at Board level, including:

- no discernible consideration given to a plan to reduce the historic Trust deficit;
- an unidentified £4m of cost savings inserted into the annual cost improvement programme, with no explanation as to how it would be achieved; and
- no evidence of a medium term financial plan, indicating a short term approach to financial planning.

52. In an environment where there are concerns about data quality, such a lack of challenge is concerning. A broader review of governance structures and reassessment of the role of the current Board members is required to build the necessary understanding of the problems affecting the Trust and what needs to be done to introduce a more robust approach.

PFI and estate management

53. One of the major pressures on SLHT's financial position is the £89m annual cost of servicing the debt of all its PFIs. The main PFI contracts are based at PRUH and QEH.

54. The cost of capital incurred by having financed QEH and PRUH through PFI schemes was assessed in the 2011 DH analysis of all PFI contracts that were deemed as potentially adversely impacting on a Trust's journey to long-term sustainability. This analysis found that 18% of SLHT's turnover was spent on PFI contracts. This was the largest percentage identified in the analysis compared to the average rate of 10.3%.

55. The cost of PFI contracts is significantly higher than if these were funded through standard government rates. Accordingly, SLHT's ability to control its cost base is

[29] SLHT Annual Report & Accounts 2009/10, 2010/11, Management Accounts 2009/10, 2010/11, 2011/12
[30] http://www.slh.nhs.uk/media/documents/slht-annual-report-and-accounts-1011.pdf

impacted, reducing the proportion of the cost base over which the Trust has direct control.

56. In February 2012, SLHT was one of seven NHS Trusts highlighted by the Secretary of State for Health as being potential candidates for access to a new £1.5bn fund, to provide a package of support. The DH analysis concluded that the PFI arrangements at SLHT meant costs of £21m were being incurred over and above what would be the case had the hospitals been constructed in the traditional manner and operating to an appropriate level of efficiency.

57. Whilst this is not, in itself, the only reason for the size of the Trust's financial deficit, it is a key factor as the commitment to these sites is fixed until at least 2030.

58. The additional funding is vital for the overall local health economy to become financially viable and stable. The challenge is for those funds to be made available as soon as possible to support the local health economy's developments in quality improvements. Otherwise, there is a high risk of cross-contamination whereby commissioners are obliged to act for the short term financial benefit, to support SLHT further, as opposed to supporting the much needed health economy wide service development. (The NHS South East London plan for 2012/13 proposes £10m overall support to SLHT from the non-recurrent resource allocation).

59. SLHT will only be able to access the £1.5bn if it can demonstrate an answer to the overall financial issue, as the PFI funding is key but insufficient on its own to deliver sustainability long term. As currently there is no plan in place, access to this additional funding is therefore at risk.

60. In addition to the overall PFI burden there are a number of areas of inefficiency in SLHT's estate management. These include:

- Lack of consolidation of clinical services across sites. The same services are provided across various sites rather than being reviewed and reconfigured to reduce inefficiencies.

- Lack of centralisation of back-office functions such as medical records. Currently a number of basic services are replicated across three sites, taking up excess space across the estate.

- Significant overlap between the PFI contracted facilities management and SLHT's own in-house facilities management staff. There are still 288 'full time equivalent' staff employed in relation to the in-house facilities management operation, despite 70% of SLHT's estate being operated under PFI schemes[31].

- Excess freehold space held by SLHT. Despite owning the freehold for a wide variety of properties, leasehold buildings are still being used. Similarly, a number of SLHT buildings are currently leased to social services (95 staff) for no income. The estimated annual rent, rates and utilities for these additional rented buildings totalled approximately £0.5m in 2011/12.[32]

[31] EY Report, SLHT Financial Improvement Support, September 2011
[32] Estates review – initial findings for discussion dated 2 September 2011

61. There has been no significant progress on reducing or rationalising the estate footprint. In view of the size of the Trust's PFI contracts and high 'buy out' costs, its estate rationalisation plan has focused on maximising activity at its two primary sites while reducing activity at QMS.

Clinical performance

62. SLHT currently meets 16 of the 23 key standards in the DH National Performance Framework. In the Dr Foster Hospital Guide published in November 2011[33], SLHT was one of a number of Trusts in London to perform well on three of the four mortality indicators - Hospital Standardised Mortality Ratio, Summary Hospital-level Mortality Indicator and deaths in low-risk conditions.

63. The positive sustained improvement in mortality rates may be attributed to service redesign, senior clinical involvement in decision-making and systematic scrutiny of mortality, as well as leadership and focus in this area, among other factors[34].

64. Despite SLHT's hospitals having, for many years, a number of performance issues in respect of delivery of clinical services, the Trust has made some improvements since 2009 and especially more recently. However, the Trust still struggles to meet a number of key standards and the sustainability of these improvements is unclear.

65. Referral to treatment time (RTT) (admitted and non-admitted performance) continues to be an area of weakness for SLHT. It was the only Trust in London that failed to meet both the 90% and 95% standard for admitted and non-admitted waits throughout most of 2011/12. However, the Trust has made progress in clearing backlogs in recent months and data for May 2012 shows that the Trust is now meeting the RTT standards for admitted, non-admitted and incomplete pathways[35] and is on track to achieve the standards at speciality level by October 2012. Continuing to reduce backlogs will come at a financial premium that will be challenging to sustain in view of the wider financial pressures faced by the Trust.

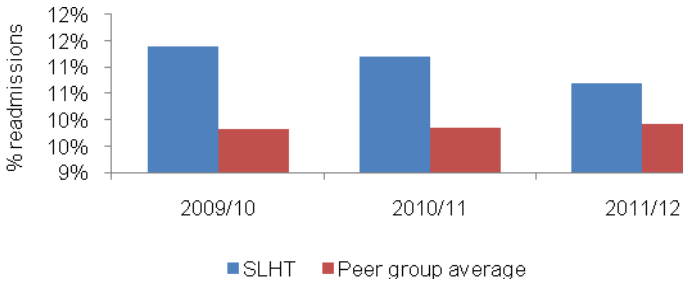
66. SLHT has a historical record of poor A&E performance and is consistently ranked in the bottom 10% of NHS Trusts for A&E wait times nationally. SLHT has consistently underperformed against its peer group for A&E wait times, reaching a low of 89% in Q3 of 2010/11 against the four-hour wait target. The Trust failed to meet the A&E 'all type' operational standard for 2011/12 - with 'all type' performance of 93.5% against the 95% standard.

67. Since February 2012 there has been a gradual improvement in A&E performance as a result of action taken to strengthen ambulatory care, elderly care support to the emergency care pathway and weekend medical cover, as well as ongoing support from the Emergency Care Intensive Support Team, all of which have had a positive impact on performance at both PRUH and QEH. The Trust met the A&E standard in Q1 of this financial year.

68. Re-admission rates, against a national peer group of comparable Trusts, have remained consistently high (as shown in figure 14):

[33] Hospital Guide 2011: Dr Foster Health, 28 November 2011
[34] SLHT Trust Board papers, 25 January 2012
[35] SLHT Trust Board papers, 25 April 2012

Figure 14: Comparable SLHT re-admission rates, 2009/10-2011/12[36]



69. The comparably high level of re-admissions at SLHT would lead to a significant amount in marginal tariff payments, estimated at c. £4.5m. There is little evidence to demonstrate that leadership arrangements to improve performance against this standard have led to any material improvements, or the necessary changes.

70. The prevention and treatment of Venous Thromboembolism (VTE) is a key safety priority and is a measure of the level of care in a hospital. SLHT has been one of the worst Trusts in the country for VTE. Its performance in Q3 of 2011/12, in which it delivered a 32% score, was the worst of all Trusts in the country against the standard of 90%. The Trust is still below the national benchmark and is performing well below its peers for this clinical measure, due to both recording and clinical process issues, but is expected to achieve the target in June 2012.

71. In 2010/11, SLHT was found by the Care Quality Commission (CQC) to be non-compliant with essential standards of quality and safety in eight areas. Since this review, further CQC visits have been made to all three of SLHT's sites, which have found that improvements have been made in most areas. All essential standards were met at QEH and PRUH, with all but one at QMS. The CQC had minor concerns across a number of areas at all three sites.

72. The efforts of the current leadership team in delivering improvements across key performance standards and the quality and safety of care should be acknowledged and commended.

73. However, there is clearly a significant risk that recent clinical and performance improvements cannot be sustained unless the financial challenge is addressed. As the root causes of the challenges are complex, site-specific and both internal and external to the Trust, any solution will require action across the whole local health economy to secure long-term financially and clinically sustainable services.

Why enacting the Regime for Unsustainable NHS Providers at SLHT is necessary

74. Over the last five years there have been repeated attempts, involving different types and scale of conventional intervention, to address the deep-rooted challenges faced not only by SLHT but the wider health economy in south east London. This has included a major commissioner-led review of service configuration, the merger of the three previous Trusts into one and numerous organisational reviews and management changes. None have succeeded in bringing about the required level of change to

[36] *Dr Foster website*

secure financially and clinically sustainable services for local patients. Furthermore, there is no strategic plan in place to address these significant and far-reaching challenges for the future.

75. Fundamental and transformational change is needed. This is change that would stretch beyond the organisational boundaries of SLHT, as the conventional options for addressing the complex, long-standing challenges faced by the Trust and the wider health economy have all been tried, but have failed to deliver the scale of change required.

76. It is therefore recommended that the Regime for Unsustainable NHS Providers (UPR) is applied to SLHT. The purpose and drive behind the regime is to have a resolute focus on implementing rapid, fundamental and transformational change within a significantly challenged Trust and across the whole health economy to ensure long-term sustainability, so that local people's access to high-quality healthcare services is protected.

77. The scope of the UPR, the ability to work across conventional or established stakeholder and organisational boundaries and the timeframe in which the Trust Special Administrator is required to develop a solution, means that it is the best mechanism to bring about the required level of change. This is needed now to secure long-term financially viable services and access to high-quality health care for the people of south east London.

Appendix A

Abbreviations	
A&E	Accident & Emergency
AHSC	Academic Health Sciences Centre
APOH	A Picture of Health
C. Diff	Clostridium difficile
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
COO	Chief Operating Officer
CQC	Care Quality Commission
DGH	District General Hospital
DH	Department of Health
EY	Ernst & Young LLP
FT	Foundation Trust
KHP	Kings Health Partners'
LTFM	Long Term Financial Model
McKinsey	McKinsey & Company
MRSA	Methicillin-resistant Staphylococcus Aureus
NTDA	NHS Trust Development Authority
PA	Programmed activities
PCT	Primary Care Trust
PFI	Private Finance Initiative
PRUH	Princess Royal University Hospital, Bromley
PwC	Pricewaterhouse Coopers
Q1	Quarter ending 30 June
Q2	Quarter ending 30 September
Q3	Quarter ending 31 December
Q4	Quarter ending 31 March
QEH	Queen Elizabeth Hospital, Woolwich
QMS	Queen Mary's Hospital, Sidcup
RTT	Referral to treatment
SEL	South East London
SoS	Secretary of State
SLHT	South London Healthcare NHS Trust
TFA	Tripartite Formal Agreements
Trusts	NHS Trusts
TSA	Trust Special Administrator
UHL	Lewisham Hospital NHS Trust
UPR	Unsustainable Provider Regime
VTE	Venous Thromboembolism

Appendix B

Trusts included in the Peer Group (per NHS London analysis)

1. East Kent (FT)
2. Gloucestershire (FT)
3. Heart of England (FT)
4. North Bristol
5. Portsmouth
6. SLHT
7. South Tees (FT)
8. Ashford and St Peter's
9. Aintree (FT)
10. Barnet and Chase Farm
11. BHRT
12. Blackpool, Fylde & Wyre (FT)
13. Bradford (FT)
14. Calderdale and Huddersfield (FT)
15. Colchester (FT)
16. County Durham and Darlington (FT)
17. Epsom and St Helier
18. Heatherwood and Wexham Park (FT)
19. Lancashire Care (FT)
20. Maidstone and Tunbridge Wells
21. Mid Essex Services
22. Morecambe Bay
23. Northern Lincolnshire and Goole (FT)
24. Northumbria (FT)
25. NWLH
26. Peterborough and Stamford (FT)
27. Royal Berkshire
28. Royal Bournemouth and Christchurch (FT)
29. Royal Cornwall
30. Sandwell and West Birmingham
31. Sherwood Forest (FT)
32. Stockport (FT)
33. West Hertfordshire
34. Worcestershire
35. Wrightington, Wigan and Leigh (FT)
36. Western Sussex