To: Secretary of State

From: Matthew Kershaw

Cleared: Sir David Nicholson

Date: 20 April 2012

[redacted] SOUTH LONDON HEALTHCARE NHS TRUST (SLHT) AND THE UNSUSTAINABLE PROVIDERS REGIME (UPR)

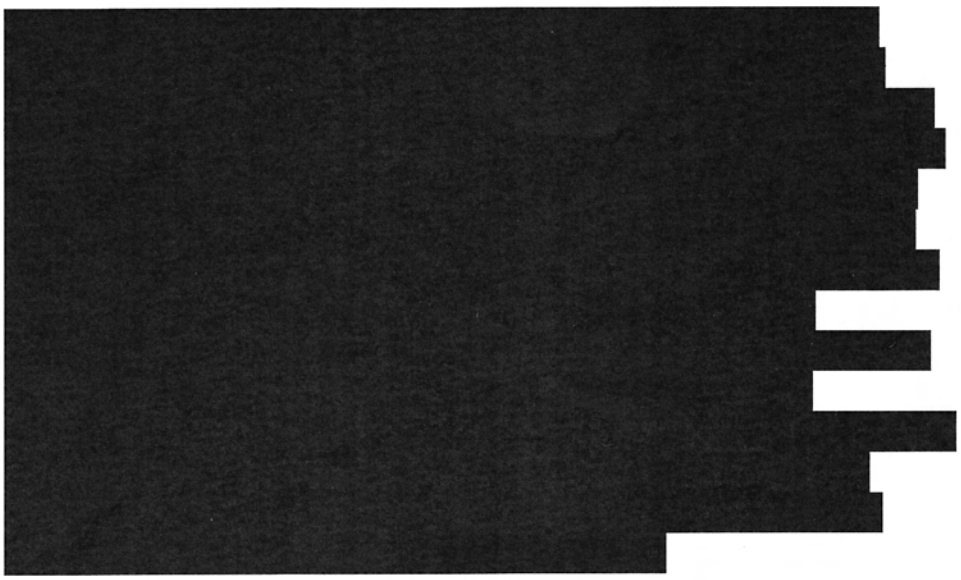
BACKGROUND

1. Following our meeting of 28 February 2012, it was agreed that the position of [redacted] and SLHT with regard to potential use of the UPR would be reviewed. This has now been completed and this paper sets out the recommendations to Ministers on both Trusts. The year end position against quality, finance and key access expectations as well as progress of their strategy to deliver sustainable services have been included in this review. Using this, a comprehensive picture of the two organisations is available to support the decisions that are required to ensure that services provided in both organisations are clinically and financially sustainable for the long-term.

2. Futhermore, this paper details what implementing the UPR will mean and when and how it could be implemented. It sets out who it is proposed would lead the first running of the regime and the broader policy of unsustainable providers nationally.

RECOMMENDATION

[redacted]

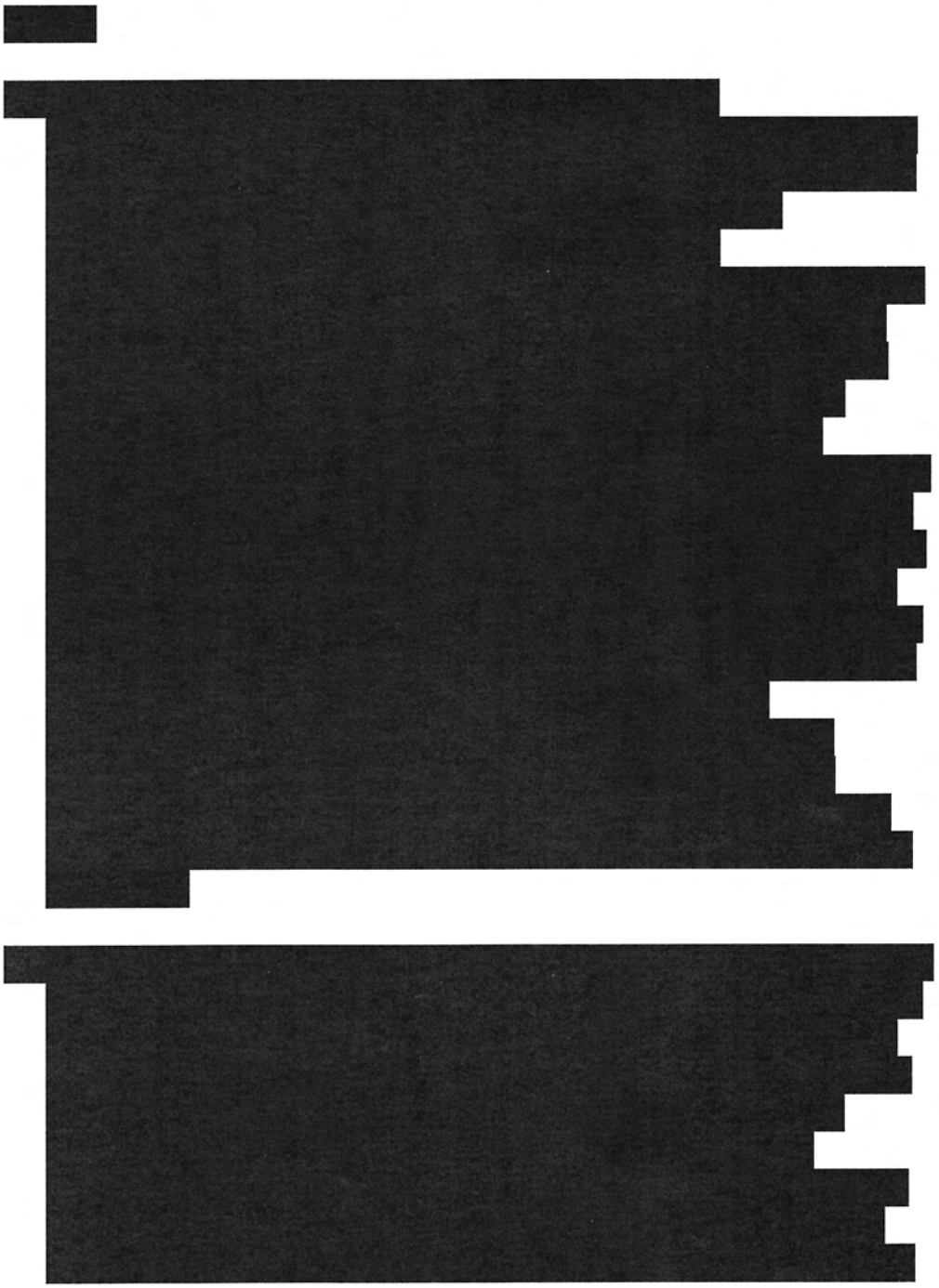


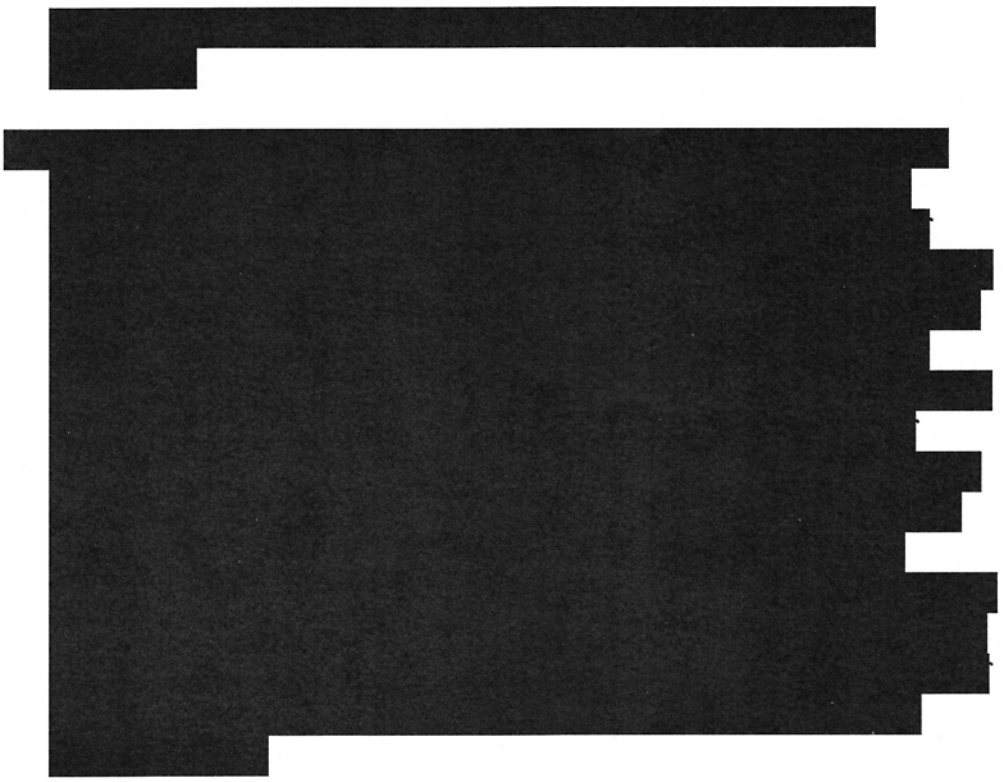
4. This position is not replicated at SLHT and therefore it is recommended that the UPR is considered for its first running at the Trust. The first step towards this would be a formal recommendation from the Chief Executive (CE) of the NHS that the Trust had met the necessary criteria and that the UPR should be enacted. The end of March performance in terms of A&E and finance, the position against the TFA milestones and most specifically the absence of a clear and robust clinical and financially viable strategy means the Trust will not be able to secure a sustainable future for its services within the existing configuration and organisational form. Enacting the UPR would help to address this in a way that every other previous attempt to create a sustainable provider system for South East London have failed to do.

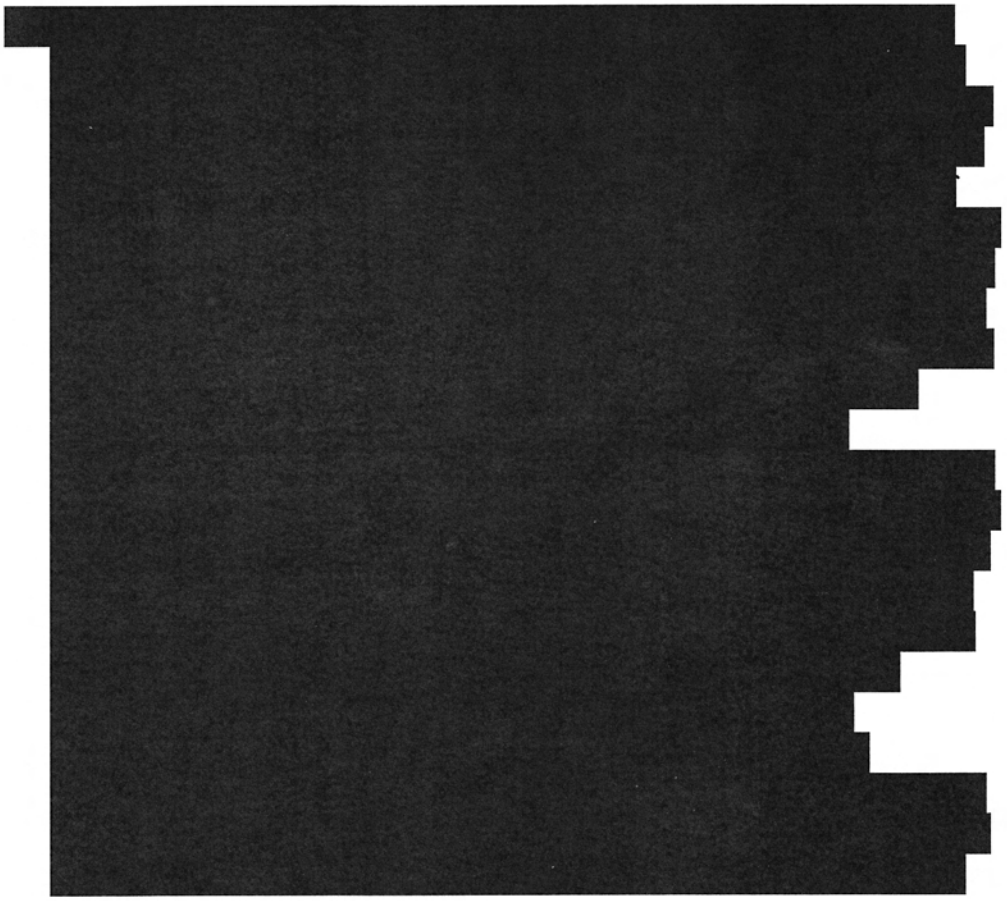
5. This submission provides more detail on the rationale for its use but there are four key issues which are the most compelling arguments supporting the use of the UPR. Firstly, that it facilitates a change in leadership with new powers not previously available, secondly, that it allows for more rapid service and organisational changes. Thirdly, that it helps to engage other providers in the solution and finally it sends an important signal of intent to the wider system. More specifically, that that there is a regime to address issues where it is clear that an organisation is unsustainable and that it will help to decisively and rapidly secure the services required by the population.

TIMING

6. It is understood from previous discussions with Ministers that the first running of the UPR would only be possible from June 2012. The timings included in this submission outline how the UPR timetable would work with such a start time and to facilitate this a final decision to proceed from Ministers would be required by early May.







[redacted]

SLHT

11. Operational performance – the trust remains a significant outlier in relation to Referral to Treatment (RTT), the A&E four-hour standard and Venous Thromboembolism (VTE) assessment.

12. A&E – the Trust failed to meet the A&E all type operational standard for 2011/12 with a full year achievement of 93.47 per cent. Moreover, it only achieved the 95 per cent in one quarter (quarter 2) and the quarter 4 performance was ranked 235th nationally out of 274 as at 18 March 2012. Looking ahead to 2012/13, the Trust continues to have a low level of resilience to peaks in demand and patient activity. Processes need to be significantly strengthened at the 'front door' at Bromley and throughout the admitted pathway at Greenwich in order to ensure sustained performance against the operational standard.

13. RTT – SLHT is one of only two organisations within London that failed to meet the 90 per cent operational standard in 2011/12 and is the only London organisation that did not meet the non-admitted standard. Performance has improved in the past two months with the arrival of a new Chief Operating Officer (COO) and the most up to date data available (February 2012) shows the Trust at 89.95 per cent. The Trust is forecasting it will deliver the non-admitted 95 per cent standard on a sustainable basis from April 2012 and whilst admitted performance has improved, the Trust is not yet in a sustainable position and the necessary backlog clearance in quarter 1 of 2012/13 will temporarily depress performance before it then improves.

14. VTE – the Trust's VTE performance has improved from 25.9 per cent in April 2011 to 55.3 per cent in January and 72.58 per cent in February 2012 (the latest data available). Despite this considerable progress, the Trust remains the worst performer in London and a national outlier. It has agreed a trajectory to achieve the standard from May 2012.

15. Financial position – the Trust has a planned deficit for 2011/12 of £69.8million which it has achieved but this leaves the Trust with the largest in year deficit across NHS Trusts nationally. This required very significant sums from the PCT and broader system to maintain its underlying in-year financial viability. It has also only secured £20million of CIP savings against a target of £30million. In addition there has been an increase in non-elective activity of 6.7 per cent and as is the case for all providers there is little financial benefit of additional unplanned activity because marginal rates of delivering such activity is high. Poor activity planning and forecasting has thus restricted the Trust's ability to focus on and address productivity and efficiency and further contributes to the scale of the financial challenge facing the Trust. Overall the financial situation this year and the financial legacy that has been created since the Trust was created is sufficient in itself to enact the UPR. This is crucial as continued financial support to the organisation in its existing form using current systems and processes is inappropriate and will not address the underlying issues impacting on its financial sustainability. Providing more resource without a requisite improvement in outcomes gives SLHT and the broader NHS a dangerous signal that organisations with similar ongoing problems will be supported financially rather than addressing the core of the problem. This will increase the likelihood of more requests for support for unsustainable services and directly undermine the government's ambition for a fully sustainable independently accountable provider sector.

16. One of the key elements of the rationale for the merged Trust was that each of the original Trusts had a history of weak financial and operational performance and were unsustainable in their current form. Despite progress since the merger this remains the overall position – the A&E, RTT and financial positions set out here provide this evidence.

17. The Trust has been red rated since the start of the TFA monitoring process and is designated as underperforming on both aspects of the Performance Framework (and within that challenged financially). In financial terms the in year deficit of £65million and inability of the system to afford the current level of demand going forward means that substantial change is required to ensure that the failure to deliver in-year run rate balance and the chronic long-term

financial position can be addressed. This overall underlying performance position is sufficient in itself to warrant use of the UPR and the scale of the change needed to resolve this cannot be under-estimated.

18. Strategic plan - it is clear from strategic reviews including A Picture of Health, commissioner led work on Queen Mary's, consultancy work led by external management consultants, NHS London's Safe and Financially Effective (SaFE) analysis and the recent South East London Simulation that the fundamentals of the South East London system do not support the current configuration. To this end, very substantial changes are required within SLHT and across the system to ensure long-term sustainability. It is evident from these previous initiatives that an alternative solution and mechanism to achieve this is required – it is our view that the UPR provides this and no alternatives exist that will deliver the necessary transformation within an appropriate timescale.

19. The current Trust management has not been able to set out a compelling strategy or plan to that effect and have been unable to secure the support of the key stakeholders. The Trust's plan, submitted at the end of December 2011, forecasts an annual deficit of £30million to £40million in five years on the base and downside cases respectively. In addition to the lack of an overall strategy, there has been no agreed solution proposed for the future of the Queen Mary's Sidcup site in Bexley despite the engagement of the Trust, PCT Cluster, the Bexley CCG and more recently externally appointed consultants. Both these issues could trigger the use of the UPR.

20. A TFA escalation meeting took place on 31 January 2012 as part the agreed national process. The conclusion of this was that the Trust would be further escalated to a meeting with the SHA CE and the Senior Responsible Officer (SRO) for Provider Development at the Department of Health when a decision about next steps would be taken. This will take place in early May following the meeting with you in late April but as the required progress against finance and access standards and TFA milestones has not been successfully delivered, this could be an opportunity to signal a move towards the UPR.

21. To date, the TFA process and other work led by the SHA indicates that the current organisational form is clinically and financially unsustainable for the long-term and changes will be needed to secure a viable plan and a leadership to support its development and implementation. Any long-term strategy will also require solutions with impacts out-with the existing SLHT organisational boundary. Solutions within the existing context have not delivered the required level of operational or strategic transformation and emerging work from the economy wide South London simulation event has demonstrated buy in from all parties – SLHT, other providers (NHS Trusts and Foundation Trusts (FTs)) and commissioners that will help to identify a long-term solution that has wide support. The proposal is that the most likely route to secure these changes and necessary support is through the UPR.

22. Such a solution is likely to impact on the service structure of all providers that could translate to changes in both elective and emergency services across South East London as a whole. Leadership of the process by a Trust Special Administrator (TSA) will help to secure and embed support for the process and ultimately the outcome that will generate strong responses from the public, other stakeholders and elements of the organisations themselves. Work has been commissioned to identify the powers that a TSA has now and after the system changes in April 2013 regarding the involvement of other organisations in this process. Whilst stopping short of compelling FTs to engage in the process, the involvement of a TSA increases the likelihood that such support will be forthcoming and importantly that innovative solutions could be proposed and acted upon. This further reinforces the rationale for the use of the UPR in this case.

WHAT IMPLEMENTING THE UPR MEANS?

23. The initial impact of enacting the regime is that it will reinforce the current informally held view that the scale of the operational and financial challenge facing the organisation and the lack of a long-term strategy means that it is clinically and financially unviable in its current form. Whilst not a significant step as the scale of challenge is widely understood, the formality of this position as a trigger for the UPR will be less known and accepted. To this end, the first action of the regime is to be publicly clear that the Trust is clinically and financially unviable along with the other 20 Trusts who self diagnosed this as part of the setting the TFA process and

that the UPR is the process by which a solution is to be found in this case.

24. The crucial message at this stage will be to ensure all stakeholders are aware that the process will create a sustainable future for services across South East London and secure the staff and facilities that are necessary to deliver this. Innovative solutions will be required to deliver the change and this will impact significantly on SLHT but also other providers within South East London where service changes are likely. This will require leadership by the TSA but crucially support from other providers and a key role for commissioners in securing agreement to the clinical strategy for South East London that meets the needs of their patients. The overarching implication of this is that SLHT will be at the forefront of national policy with the associated issues that this brings.

25. Once triggered, the first step as set out in the UPR guidance is to appoint a TSA to oversee the use of the regime. The TSA assumes responsibility for the Trust and as a matter of priority, decides who from the existing management team would remain to maintain service provision whilst the longer-term strategy is formulated and agreed. In this case it is proposed that the TSA would be the newly appointed CE supported by a new Director of Strategy, Planning and Development. Further detail on the broader team and the specifics of the arrangements are covered in paragraphs 33 to 39 below.

26. In terms of the outcome of the UPR, the purpose of the timetable as set out is to develop and discuss the full range of options and agree a final proposal outlining the long-term plan to be submitted to the Secretary of State for consideration. More specifically the outcome of the UPR will be to set out and agree a long-term service structure to protect and enhance services to the population of South East London. It will not initially describe the implementation process that follows agreement to the structure and this will be the key role of the Trust and its partners following the adoption of the TSAs recommendations by the SofS.

27. As this will be first use of the regime, it is important that there is comprehensive preparation for these potential options in advance. This has been supported in part by the use of a simulation study led by NHS London and PriceWaterhouseCooopers. This work has

involved commissioners and all providers and has explored plans that include reducing costs over and above productivity plans and a review of the portfolio of services and organisational form options. A positive outcome of this work is a broader understanding across providers and commissioners of the scale of the challenge facing the Trust. It has also been accepted that any sustainable solution will require change within SLHT but also across the health system in South East London. As a result, the support of the range of providers as well as commissioners and stakeholder organisations including CQC will be a key element of the UPR.

28. Specific scenarios have been developed that test the impact of changes to the elective and emergency care provision across South East London but also changes to pathology, back and middle office services etc. The primary design principles are that any proposal must meet the materiality test (a £5million savings threshold), the net gain test, improve the quality of care and help to deliver a capacity and therefore cost reduction for the South East London health economy. To this end, once finalised, the scenarios will include reference to rationalisation and configuration of current and future services, redistribution of services across providers and re-designating sites for new uses such as elective care and or diagnostics and day care.

29. The final report of this work coupled with previously commissioned work including the NHS London SaFE analysis will be important contributions to the analysis undertaken by the TSA but they will not be bound by any recommendations or conclusions within that report. Once appointed, the TSA will commission further work building on the current information that is available to ensure they have sufficient information, analysis and views to construct the robust and sustainable future for services in South East London.

THE UPR TIMETABLE – DATES AND PRACTICAL STEPS

30. At our last meeting it was decided that the UPR would not be enacted before late May 2012. The following sets out the broad timing and content of this work going forward so that this fits with the appointment of a new leadership team for the Trust who would take forward the UPR as TSA for SLHT and on a national basis as policy lead for the NHS Trust Development Authority (NTDA).

Specific dates will be formulated once the commencement date is agreed.

31. The timetable is illustrative in nature and the start could be moved back if that was necessary but this would clearly impact on the end point. Ideally any movement to the timetable would still allow the recommendation to be adopted by the Secretary of State before the end of March 2013, i.e. ahead of the full implementation of the changes set out in the Health and Social Care Act.

April and May 2012 – background work (but with no public discussion) continues on preparation for implementation of UPR. This will include work on Parliamentary orders, final UPR guidance for the NHS, information gathering from other sectors with administration regime experience, work with Monitor to ensure that this and the Monitor failure regime are consistent. There will also be specific work on SLHT finalising the detailed timetable, support to augment the leadership team and wider resource requirements as well as the background preparation building on the recent simulation study and previous work including the NHS London SaFE analysis. This phase itself will require dedicated input and it is proposed that input equal to at least two whole time equivalent staff are secured for this – one to lead on the technical aspects of the UPR and one to lead on the preparations for SLHT specifically. It is proposed that this work is undertaken under the auspices of the Provider Delivery team at the Department of Health and NHS London and therefore ultimately with David Flory and Dame Ruth Carnall as SROs. A procurement of external support for the UPR itself will also be run during this time and be completed in June but some external support to the DH and NHS London Director leads on this work to support the essential preparation will also be required in advance of this.

By early June 2012 – background work on relevant orders for Parliament enacting regime for selected Trusts completed in draft

By early June 2012 – publication of the UPR guidance to the wider NHS to increase awareness of the regime and its process

By end June 2012 – day 0 – the UPR formally commences with relevant orders and reports laid in Parliament and establishment of the CE as the TSA supported by relevant team. The new CE will also be the TSA for this work and National Lead for UPR with the NTDA.

By end June 2012 – day 1 - TSA work commences with strategy development building on the simulation output and a detailed assessment by the new leadership team. This rapid assessment will cover three elements of Trust's capability. Organisational assessment covering leadership, accountability and culture, assessment at service line level of financial and operational performance by site and finally a core process review led by the recently appointed COO including admissions, bed management, discharge planning and capacity and demand modelling. This will be an essential element of the preparation for the first running of the UPR. In addition within this period there will need to be dedicated time to construct the analytical, engagement and development process ahead of commencing the UPR proper. This work is pertinent to SLHT but will also have resonance to the wider UPR policy and how it may be applied in other situations. To this end, an additional resource will be required to support this and the rapid assessment and procurement of this external support will be completed during May and June.

The strategy development work will define the current issues, options for configuring services to maximise clinical, financial and operational performance, the requirements for delivering these in terms of people, equipment and estates, the supporting enablers of management infrastructure including IT and organisational capabilities and behaviours, organisational and financial arrangements and finally transition steps. This stage will also include an opportunity for contributions from other NHS providers locally as the impact of this work will be beyond the confines of SLHT. We will also encourage Independent Sector providers as well as other stakeholders to contribute to potential solutions to secure long term sustainability during this stage of the process.

The analysis phase necessary for the first running of the UPR and the opportunity for other providers to offer potential solutions through a formal process requires additional time. This has been included at this stage rather than before enacting the UPR so that it reinforces the TSA position and facilitates a wider range of options being formally considered before recommendation of a solution is made. It means that the first running of the UPR will require an additional six weeks on top of the 120 days included in the original policy. The regime only sets out a minimum time of 120 days, so extensions are possible and it is proposed that the Parliamentary orders will extend the time the TSA has to produce the draft report due to the needs of this case.

July - October 2012– TSA work on detailed options underway involving key stakeholders and external consultancy support as required

July – September 2012 – work continues on the national UPR work and specifically the potential roll out of the regime to a further Trust or Trusts. A specific timetable would be created for each use of the regime including the input from the NTDA lead on this work who would be the TSA from the SLHT work.

Mid October 2012 – day 80 - draft report and consultation plan published

By end October 2012 – day 85 - draft report consultation begins (

By end November 2012 – day 100 – 30 working day consultation ends

By late December 2012 – day 130 – final report submitted to SofS by TSA

By late January 2013 – day 150 – Secretary of State to decide on action taken based on the final report submitted by TSA. This takes account of Christmas and New Year Holidays and Parliamentary recess that runs to 8 January 2013.

32. The indicative timetable detailed above sets out the key steps and the timings included with the UPR guidance as well as the broader work that would be led by the new leadership team. One of the central elements of the regime is that it works to a fixed timetable that encourages decisions to be taken and this accounts for the firm deadlines included for decisions covering the long-term clinical and financial strategy for the organisation. This is one of the key benefits of the process but it does mean that any decision to use the UPR needs to be taken with the full support of the process which once started will work to the identify and recommend a clear conclusion for Secretary of State approval.

THE NEW TRUST LEADERSHIP TEAM AND TSA

33. The current executive and non-executive team at the Trust have made progress with the quality and safety agenda but have not delivered the required improvements in performance and finance

and have been unable to agree and implement a strategy that demonstrates clinical and financial viability of the Trust for the long-term. As a result of this, it is proposed by the SHA that a new team be introduced to lead the Trust on a day to day and strategic basis, undertake the necessary preparation and lead the UPR.

34. To this end a new CE will be appointed on behalf of the SHA and the NTDA which will assume responsibility for the Trust in performance management and governance terms from June 2013. This CE would become the accountable officer for the organisation in the normal way and initially lead the work on the UPR. Whilst a new CE is one of the central elements of this plan, they will require a highly experienced and credible team to support them in running the organisation and in managing the UPR.

35. It is crucial that they are supported by senior clinical input and a lead non-executive. The clinician is fundamental to the UPR so that any solutions address clinical as well as financial and operational sustainability. They will need to be a senior, credible clinician with experience of clinical change and stakeholder management. In addition they must ensure local clinical buy-in to this work and to ensure solutions are clinically robust. Moreover they will have a fundamental role discussing potential solutions with other provider organisations, local commissioners and public and wider stakeholders. This will be a key appointment to communicate as part of the TSA team so that the clinical input is clearly demonstrated as central to the running of the UPR.

36. Although the non-executive lead will not fulfil the traditional role of a Chairman as the TSA would retain some of these responsibilities, they will be crucial to the work. One of their key tasks will be to support the development of the strategic plan, support the public engagement aspect of the regime and provide non-executive leadership to other non-executives. In addition, they will support and challenge the CE again as part of the TSA team. One key attribute to support this would be that the Chair would have strong commercial skills and experience to compliment and challenge the rest of the team.

37. In terms of the executive team, a new Strategy, Planning and Development Director will be appointed. This may not need to be a full time role but it is a pre-requisite of the proposal being pursued locally and in terms of the national leadership of the UPR.

In addition, the current COO and Deputy CE / Director of Nursing are central to improve operational and strategic outcomes at the Trust so will be key to the new leadership team. The position of the other executive director and the non-executive director posts will be reviewed as part of the six-week assessment and final decisions on further support will be taken at that time.

38. The new CE will need to augment current senior operational capacity to support the existing COO and provide them with the opportunity to contribute to the rapid assessment and development of the strategic plan. There may well also need to be changes to the clinical leadership both within divisions and corporately and this may also be a priority for the new CE as part of the assessment process. Flexibility to resource this internally and externally will be important.

39. In addition to the specific resources detailed above the scale of the change required at the organisation is such that organisational systems and processes will require fundamental improvement. It is proposed that if this UPR proposal is accepted a dedicated team to support the necessary policy thinking on the detailed implementation of the UPR is created under the auspices of Provider Development in the Department and NHS London. There will also be a need for external consultancy support when the UPR process starts to provide the necessary expertise and capacity to support the NHS clinical and managerial advice to the TSA. This would include administration and programme management expertise but also HR, communication and IT functions. This support will need to be procured in advance of enacting the regime so that time and resources are not wasted during the fixed timetable of the UPR. Securing this will be a priority of the new CE and will need to be resourced as part of the introduction of the TSA team.

CONCLUSION AND NEXT STEPS

40. The proposal to continue with the current leadership and overarching strategy for [redacted] at this time will be kept under regular review but means that the first running of the UPR is proposed to be SLHT for the very clear and compelling reasons set out in this submission. If adopted this will make a very significant contribution to the national policy on UPR and inform the ongoing work of the NTDA. The proposal includes a number of significant changes to the current provision in organisational and delivery

terms and as such the principles underpinning the UPR and the outcomes recommended by the TSA will need to be supported by officials and Ministers within the Department.

41. The outcome of this meeting, if all plans are agreed, would be changes to the leadership team in June 2012 and the commencement of a plan enacting the UPR for the first time.

Copy List:
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David Flory, NHS Deputy Chief Executive, Senior Responsible Officer for the Foundation Trust Pipeline and NHS Trust Development Authority
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