NHS

Office of the Trust Special Administrator

Appendix M

Finance, Capital and Estate Evaluation

Securing sustainable NHS services

Introduction

1. This appendix to the final report of the Trust Special Administrator (TSA) appointed to South London Healthcare NHS Trust relates to the whole of the final report. Understanding the current and projected financial status of the Trust and the health economy within which it works, is at the heart of the recommendations the TSA has developed and, therefore, the report.

2. This appendix provides more detail on the financial analysis that has been undertaken through the TSA process, including a review of the current position of South London Healthcare NHS Trust, projections for future commissioning intentions and provider positions, the implications of the TSA recommendations and some detail on specific recommendations.

3. The content within this appendix builds on the content from the work within the draft report and has been developed by the TSA team, with support from finance leads across south east London and the external support team. Work has been progressed at pace, with input from a wide range of individuals across the system, and will be developed further if the recommendations are accepted by the Secretary of State.

4. The appendix is divided into the following sections:
   - Current financial position within South London Healthcare NHS Trust;
   - Commissioning intentions for south east London;
   - Financial projections in a “do nothing” scenario;
   - Financial implications of the TSA recommendations;
   - Evaluation of estate opportunities; and
   - Overall financial evaluations.

Current financial position within South London Healthcare NHS Trust

Commissioning intentions for south east London

Financial projections in a “do nothing” scenario

Financial implications of the TSA recommendations

Evaluation of estate opportunities

Overall financial evaluations

Current financial position within South London Healthcare NHS Trust (1 of 2)

1. Since the TSA's draft report was published the TSA team has ensured that the underlying financial position of the Trust and the forecast financial outturn for 2012/13 has remained consistent with the financial baseline contained in that report.

2. At the end of November 2012 the South London Healthcare NHS Trust's forecast for the financial year 2012/13 remained a normalised deficit of £59.5m (figure 2). In-year recurrent cost improvement programmes (CIPs) are forecast to be £24.2m, slightly ahead of the £22.7m target identified in the draft report (figure 6). However, there remains considerable risk to the delivery of this financial position in the final quarter of the year.

3. The ongoing financial analysis has also identified areas of non-recurrent financial risk, which the Trust will have to address in the final part of the year.

4. The draft report listed the forecast net deficits for 2012/13 for each hospital as 11.0% for Princess Royal University Hospital, 16.3% for Queen Elizabeth Hospital and 15.2% Queen Mary's Hospital (figure 11). The most recent review, in November 2012, has seen a very small shift in those percentages to 11.2%, 16.7% and 14.9% respectively.

5. In order to develop an agreed baseline the Trust has gone through a process normalising its 2011/12 and 2012/13 income and expenditure (I&E). The adjustment between the various I&Es over this period are outlined in figures 1 to 10. The Trust has adjusted for one-off items in its actual results to produce a normalised 2011/12 I&E. This then forms the basis of a normalised 2012/13 I&E before further adjustments for performance in 2012/13 based on month 3 and for non-recurring items (normalisation). Figure 1 demonstrates how these adjustments fit together to provide the baseline.

6. The Trust forecasts a normalised I&E deficit for 2012/13 of £59.5m compared to a planned deficit of £58.8m. This is summarised in figures 2 and 3. In doing this, the following approaches were taken:
   - 2011/12 normalisation:
   - The 2011/12 normalised deficit is £17.8m lower than actual at £68.8m primarily due to a £16.9m impairment recorded in the accounts on the annual revaluation of the Trust's land and buildings.
   - The majority of remaining normalisation adjustments relate to the removal of non-recurrent RTT and MARS funding £7.7m (income) offset by the removal of associated costs totalling £5.1m of pay and £2.5m of non-pay.

Current financial position within South London Healthcare NHS Trust (2 of 2)

7. Figures 4 and 5 demonstrate the adjustments made to the Trust's recurrent outturn position from 2011/12 in developing its 2012/13 financial plan, a £58.8m deficit.

8. Subsequent to the TSA's appointment, the TSA team reviewed the Trust's performance to date in 2012/13 based on the most recent figures available at the time – the June 2012 management accounts. A summary of the results is at figure 6.

9. The review also considered the financial forecast outturn position for 2012/13 and figures 7 and 8 note the key adjustments from the plan.

10. As part of this analysis, a greater understanding was developed in relation to the forecast delivery of CIPs in 2012/13 (figure 9). An expected delivery shortfall of £15.4m is to be offset by a release of a contingency (£12.6m), an oncall provision (£1.3m) and by balance sheet flexibilities (£1.5m).

11. Such adjustments have a direct impact on the Trust's normalised financial position (the basis for all future modelling). This was reviewed (figure 10), resulting in the conclusion that the Trust's underlying normalised deficit in 2012/13 will be £59.5m.

12. Although the Trust is under no obligation to maintain its financial records on a "site-by-site" basis, the Trust in 2011/12 began on analysis on this basis to understand better the drivers of its deficit. The TSA team reviewed this methodology and developed a site-by-site analysis of the Trust's normalised position and this formed the basis of the detailed modelling (figure 11). Subsequent to the preparation of this, an independent due diligence report was prepared for the TSA that served to highlight the key risks and assumptions in this analysis. The report did not make any material recommendations and the analysis remains valid.

Figure 1: Basis of preparation – approach to normalising income and expenditure

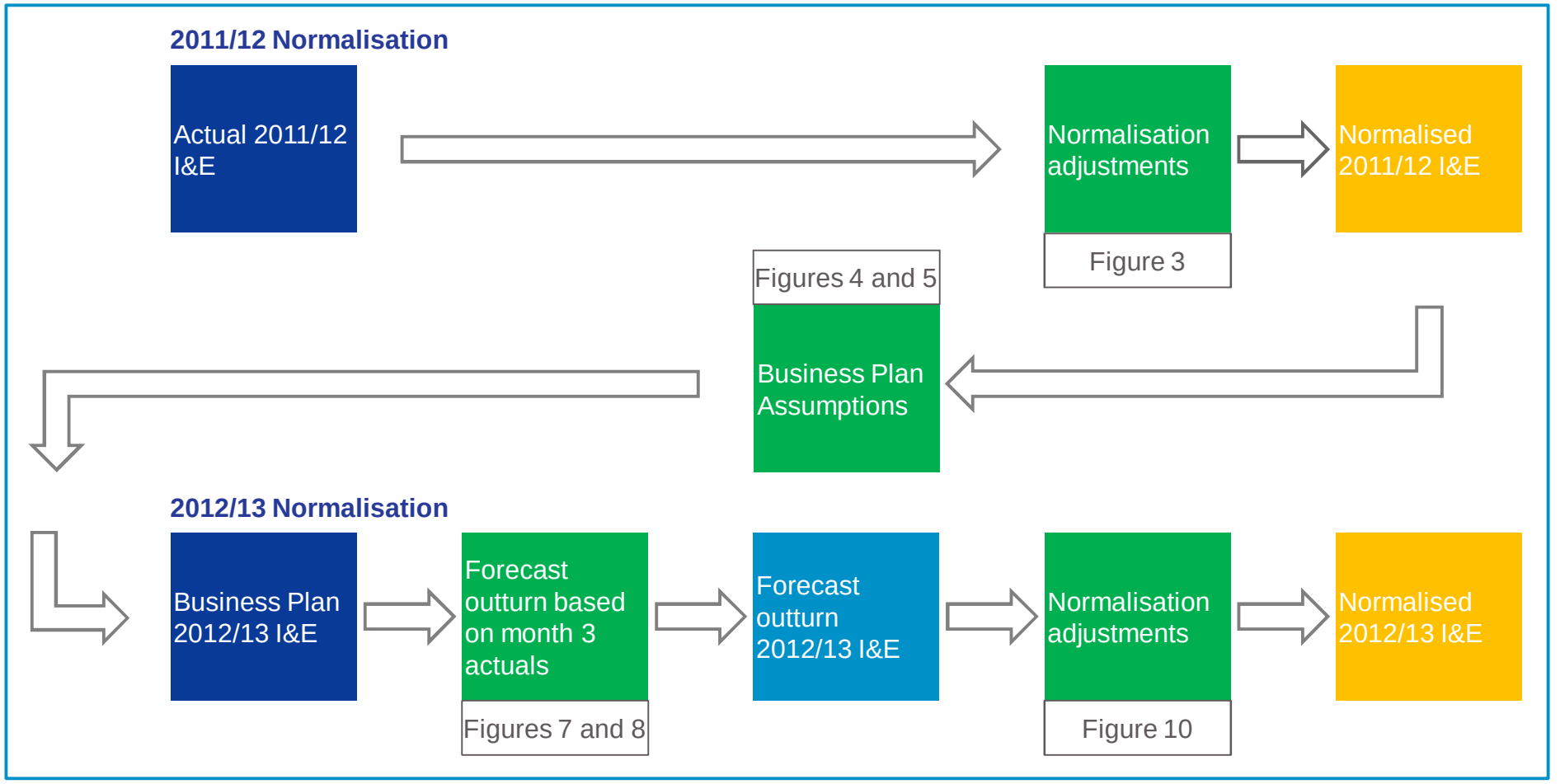


Figure 2: Normalised I&E 2011/12 and 2012/13

The Trust has calculated a normalised I&E deficit for 2012/13 of £59.5m compared to a reforecast deficit of £58.8m

Summarised I&E FY11/12 and FY12/13

£'000	FY11/12 Actual	FY11/12 Normalised	Normalised vs Actual Var	FY12/13 Reforecast	FY12/13 Normalised	Normalised vs Actual Var
NHS acute activity income	397,114	390,990	(6,124)	393,799	393,799	-
Education and Training income	16,358	16,358	-	13,884	13,884	-
Other income (incl. Private)	25,483	22,212	(3,271)	22,638	22,638	-
Total Income	**438,955**	**429,560**	**(9,395)**	**430,321**	**430,321**	**-**
Pay	(299,865)	(295,706)	4,159	(288,433)	(285,291)	3,142
Non-Pay	(158,392)	(153,907)	4,485	(154,965)	(154,965)	-
PDC	(8,458)	(8,458)	-	(8,853)	(8,853)	-
Depreciation	(13,717)	(13,717)	-	(13,196)	(13,196)	-
PFI Interest	(26,397)	(26,397)	-	(27,074)	(27,074)	-
Interest Receivable	49	49	-	51	51	-
Impairments	(16,904)	-	16,904	(130)	(130)	-
Reserves	(1,891)	(224)	1,667	3,480	(400)	(3,880)
Total Expenses	**(523,684)**	**(498,136)**	**25,548**	**(492,601)**	**(489,459)**	**3,142**
Net surplus (underlying)	**(86,620)**	**(68,800)**	**17,820**	**(58,800)**	**(59,538)**	**(738)**

Source: SLHT Management

For explanation of variances please see Figure 3 - Actual 2011/12 deficit to Normalised 2011/12 deficit, in the following pages

For explanation of variances please see Figure 10 - Reforecast 2012/13 deficit to Normalised 2012/13 deficit, in the following pages

Figure 3: Actual 2011/12 deficit to Normalised 2011/12 deficit

The 2011/12 normalised deficit is £17.8m lower at £68.8m compared to the actual deficit per the accounts primarily due to a £16.9m impairment recorded in the accounts on the annual revaluation of the Trust's land and buildings

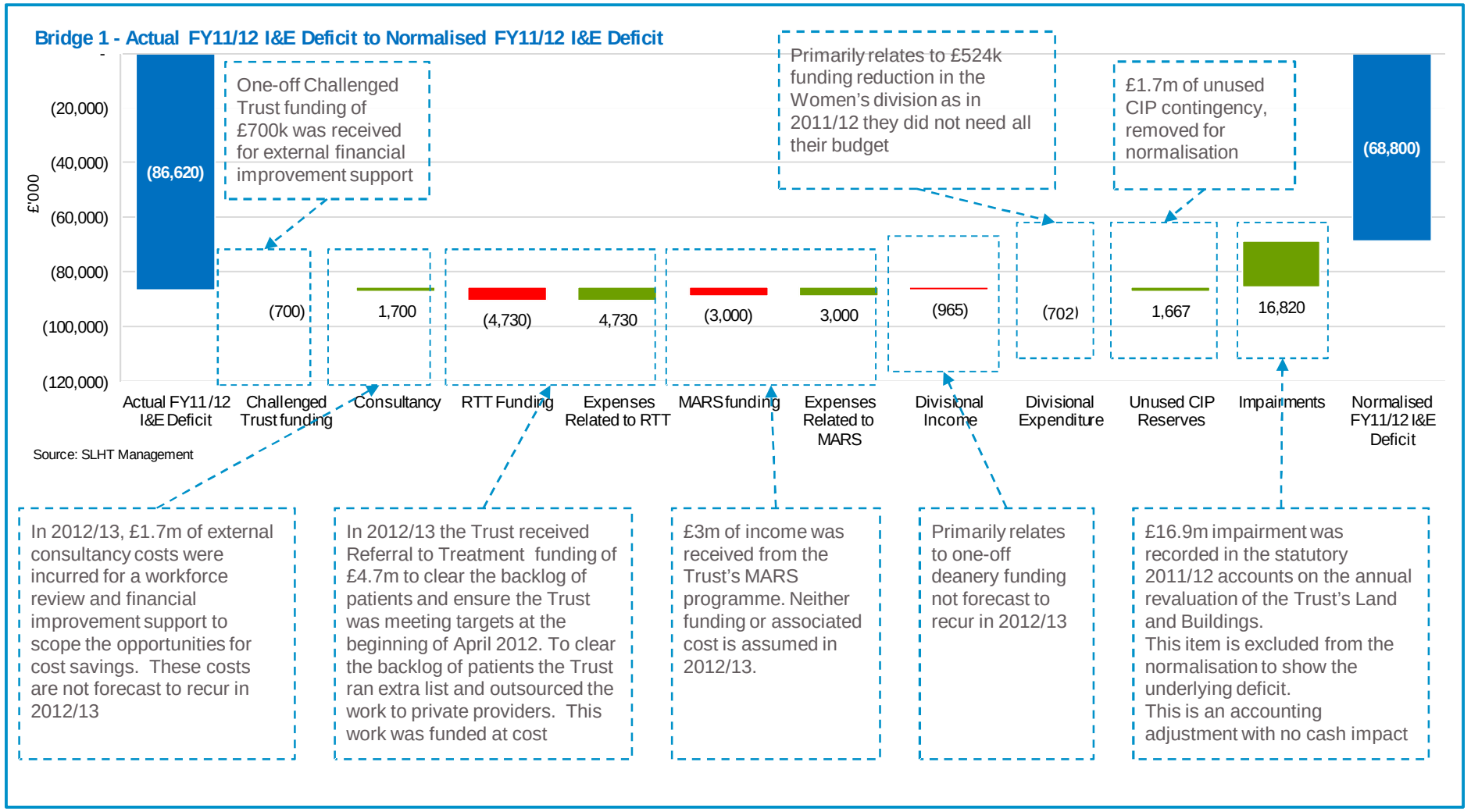


Figure 4: Normalised 2011/12 deficit to Business Plan 2012/13 deficit (1 of 2)

The 2012/13 Business Plan I&E and forecast deficit of £58.8m has been developed on the basis of the assumptions detailed in the Trust's Business Plan agreed with NHS London

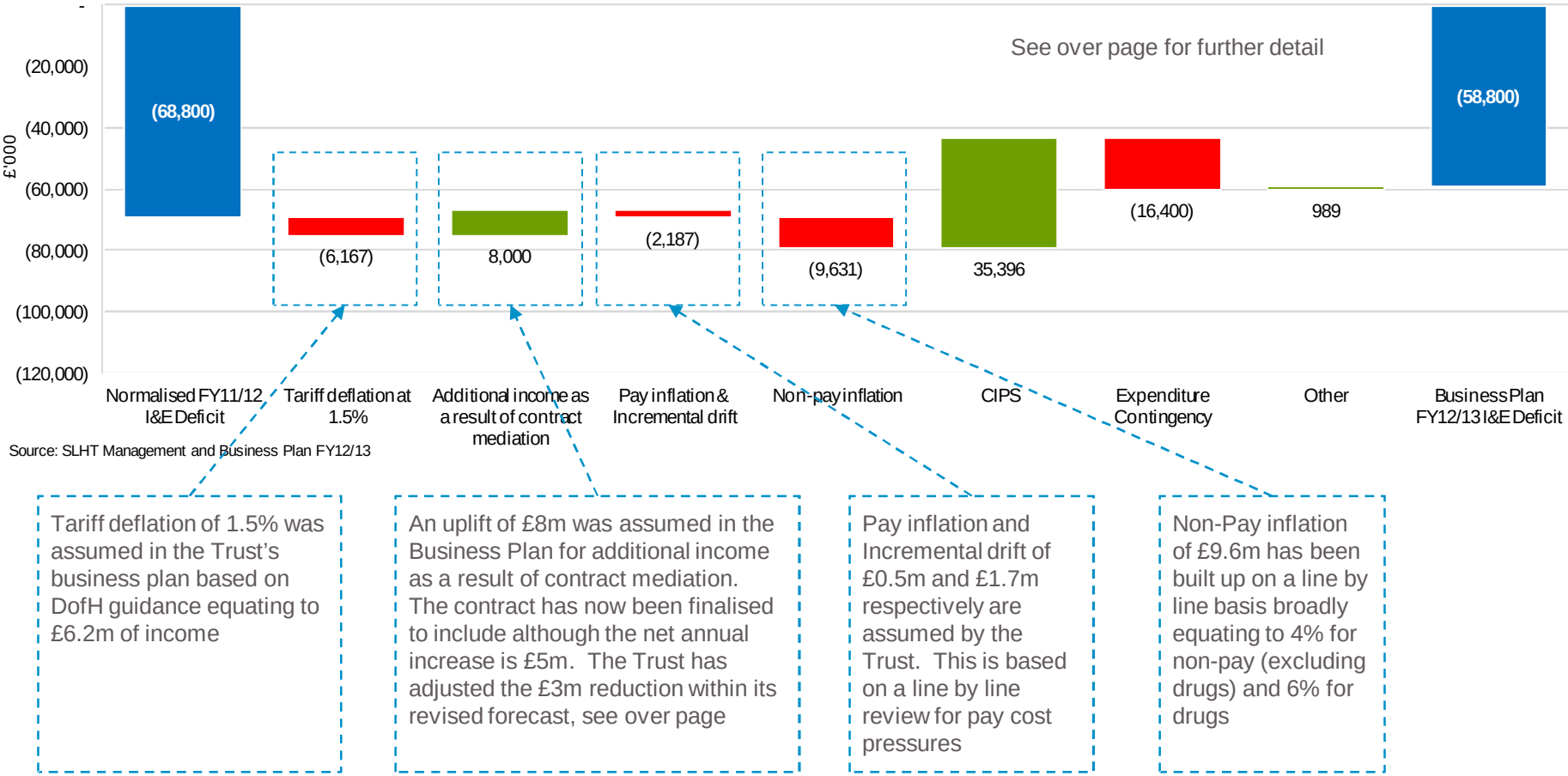
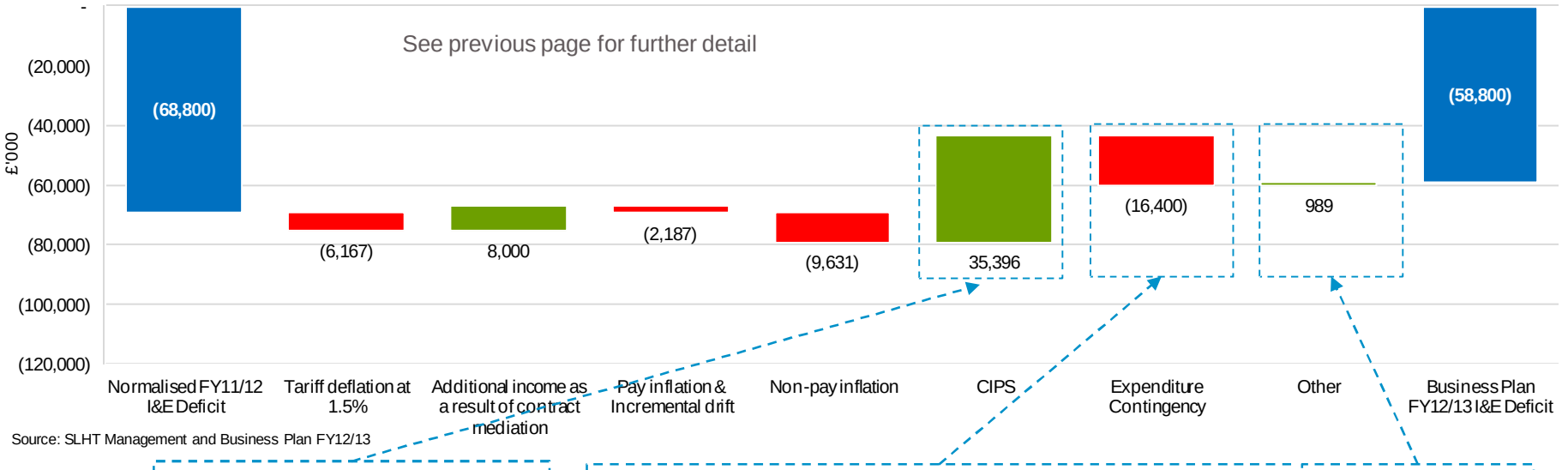


Figure 5: Normalised 2011/12 deficit to Business Plan 2012/13 deficit (2 of 2)

In its initial 2012/13 Business Plan the Trust has assumed £35.3m of CIP savings (subsequently adjusted downwards) and £16.4m of expenditure contingency



FY12/13 - CIP Plan £36.3m

	£'000
Surgery & Anaesthetics	10,724
Medicine	9,929
Diagnostics and Cancer	4,433
Family Health	5,014
Corporate	6,234
Total	**36,334**
Less: target increas in Apr'12	(938)
CIP target per Business Plan	35,396

Source: SLHT Management information

In 2012/13 the trust budgeted for £16.4m of expenditure contingency

FY12/13 - Budgeted Expenditure Contingency

	£'000	Per BP
a) iCare Implementation	3,500	
b) WCCS Division vacancies	2,400	
c) Additional theatres on QMS site	1,500	
1) Specific cost pressures in abeyance	**7,400**	
2) CIP Contingency Reserve	6,137	
3) Other Reserves	1,873	
4) Inflation Reserve	990	
Total Expenditure Reserves	**16,400**	

Source: SLHT Management information

Other comprises mainly the loss of margin on the termination of the Orpington Intermediate care beds, £0.5m and Paediatric CCNT contracts, £0.2m

Figure 6: Month 3 I&E 2012/13 actual vs. budget

In the three months to June 2012 the operating expenditure was £2.8m higher than budget primarily due to non-achievement of CIPs (measured against the £35.3m target before subsequent downward revision), however, the total deficit for the 3 months to June 2012 is in line with budget following a slight increase in income together with utilisation of expenditure contingency

FY12/13 Month 3 I&E year to date vs budget

£'000	YTD Month 3 FY12/13 Budget	YTD Month 3 FY12/13 Actual	Actual vs Budget Var
Contract (PbR & Non PbR)	93,222	93,222	-
Non Contract Activity	1,266	1,722	456
Other Central Income (Training)	3,751	3,499	(252)
Corporate	1,805	1,756	(49)
Divisional Income	5,299	5,975	676
Total Income	**105,343**	**106,174**	**831**
Corporate	(27,009)	(27,113)	(104)
Medicine	(27,439)	(28,410)	(971)
Surgery	(26,771)	(27,837)	(1,066)
Family Health	(13,707)	(14,019)	(312)
Diagnostics & Cancer	(12,543)	(12,923)	(380)
Operating Expenditure (excl. Reserves)	**(107,469)**	**(110,302)**	**(2,833)**
Expenditure Contingency (£16.4m)	(3,301)	(1,298)	2,003
Financial Charges: PDC	(2,213)	(2,213)	
Financial Charges: Depreciation	(3,412)	(3,412)	-
Financial Charges: PFI Charges	(6,769)	(6,769)	-
Financial Charges: Net Interest	(19)	(19)	-
Total Expenditure	**(123,183)**	**(124,013)**	**(830)**
Total Deficit	**(17,840)**	**(17,839)**	**1**

Source: SLHT Management

A

£0.8m increase in income due to net increases in non-contractual income across all of the divisions (note: NHS activity income is broadly in line with contract for the 3 months to June 2012 after deductions)

B

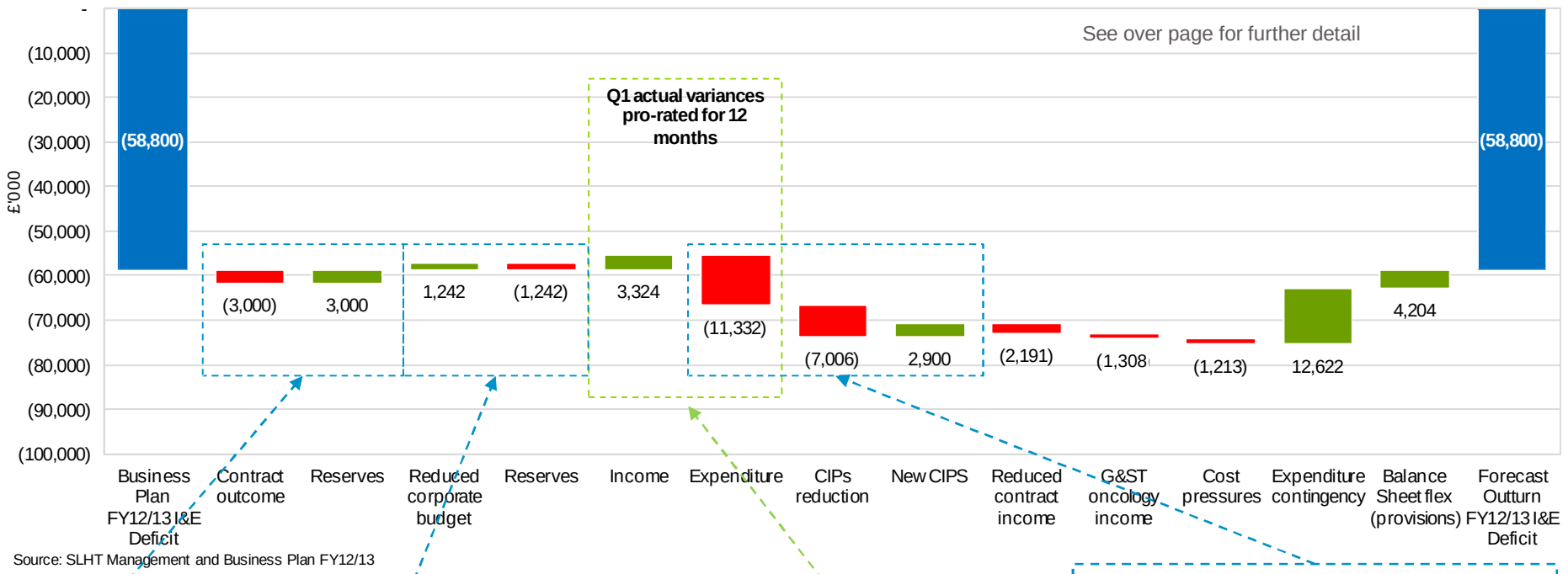
Net under-delivery of CIPs for the 3 months to June 2012 accounts for the majority of the operating expenditure variances to budget.

Expenditure contingency of £2m have been released in the 3 months to June 2012 to offset the under-delivery of CIPs, reflecting that not all of the expenditure contingency originally budgeted was used.

Figure 7: Business Plan 2012/13 deficit to forecast outturn 2012/13 deficit (1 of 2)

The key adjustments between the Trust's 2012/13 reforecast and the Business Plan are mainly the forecast reduction in CIP delivery, offset by expenditure contingency which have been utilised to maintain the I&E control total of £58.8m

Bridge 3 - Business Plan FY12/13 I&E Deficit bridged to Forecast Outturn FY12/13 I&E Deficit



Source: SLHT Management and Business Plan FY12/13

The Trust agreed its final contract total after its business planning process. As a result £3m less income was agreed. To mitigate this £3m of expenditure contingencies were utilised

The Trust has achieved a net £1.2m reduction its corporate budget primarily due to the reduction of Clinical Negligence Scheme for Trust charges. This favourable variances has been taken to contingency to offset forecast CIP under delivery.

To calculate a revised variation on Income and expenditure the Trust has pro-rated the 3 month income and expenditure variances to June 2012 for the full year
Income £831k (A see previous page) x 4 = £3.3m on a straight line basis
Expenditure £2,833k (B see previous page) x 4 = £11.3m on a straight line basis

The Trust has revised down its full year CIP target for the year to £20.9m (includes new CIPs of £2.9m)

CIP Target per Revised forecast

£'000	FY12/13
CIP Target	36,334
Reduction in CIP	(11,328)
Reduction in CIP	(7,006)
Sub-total	**18,000**
New CIP	1,552
Oncall provision release	1,348
Total CIPS	**20,900**

Source: SLHT Management information

Figure 8: Business Plan 2012/13 deficit to forecast outturn 2012/13 deficit (2 of 2)

The key adjustments between the Trust's 2012/13 reforecast and the Business Plan are mainly the forecast reduction in CIP delivery, offset by expenditure contingency which have been utilised to maintain the I&E control total of £58.8m

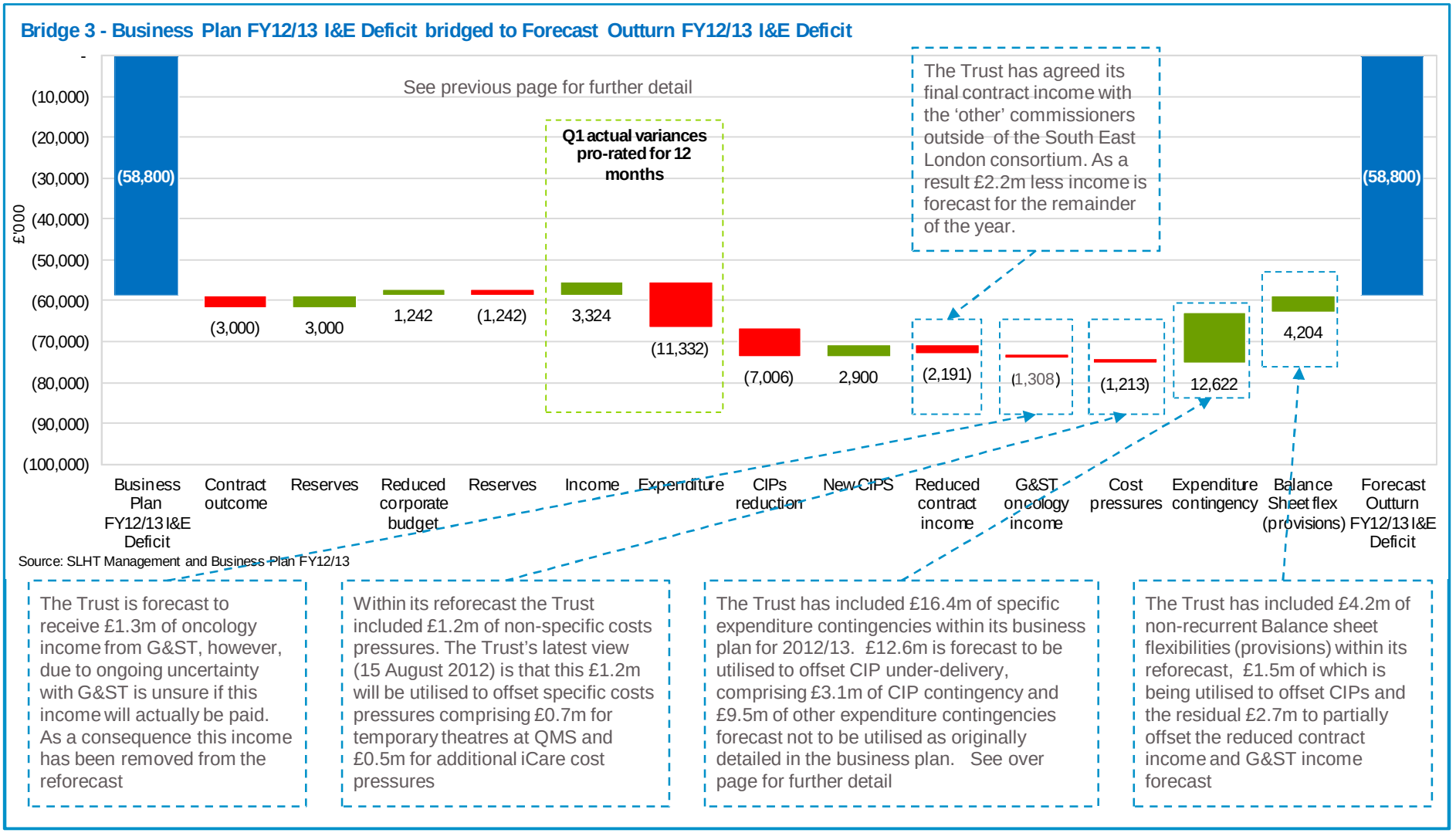


Figure 9: 2012/13 CIPs target summary

Net of unspent expenditure contingency and balance sheet flexibilities, the Trust is forecasting delivery of £20.9m of CIPs in order to hit its forecast control deficit total of £58.8m. However, the internal operational target is £25.9m, hence there is £5m of potential upside if this target is achieved

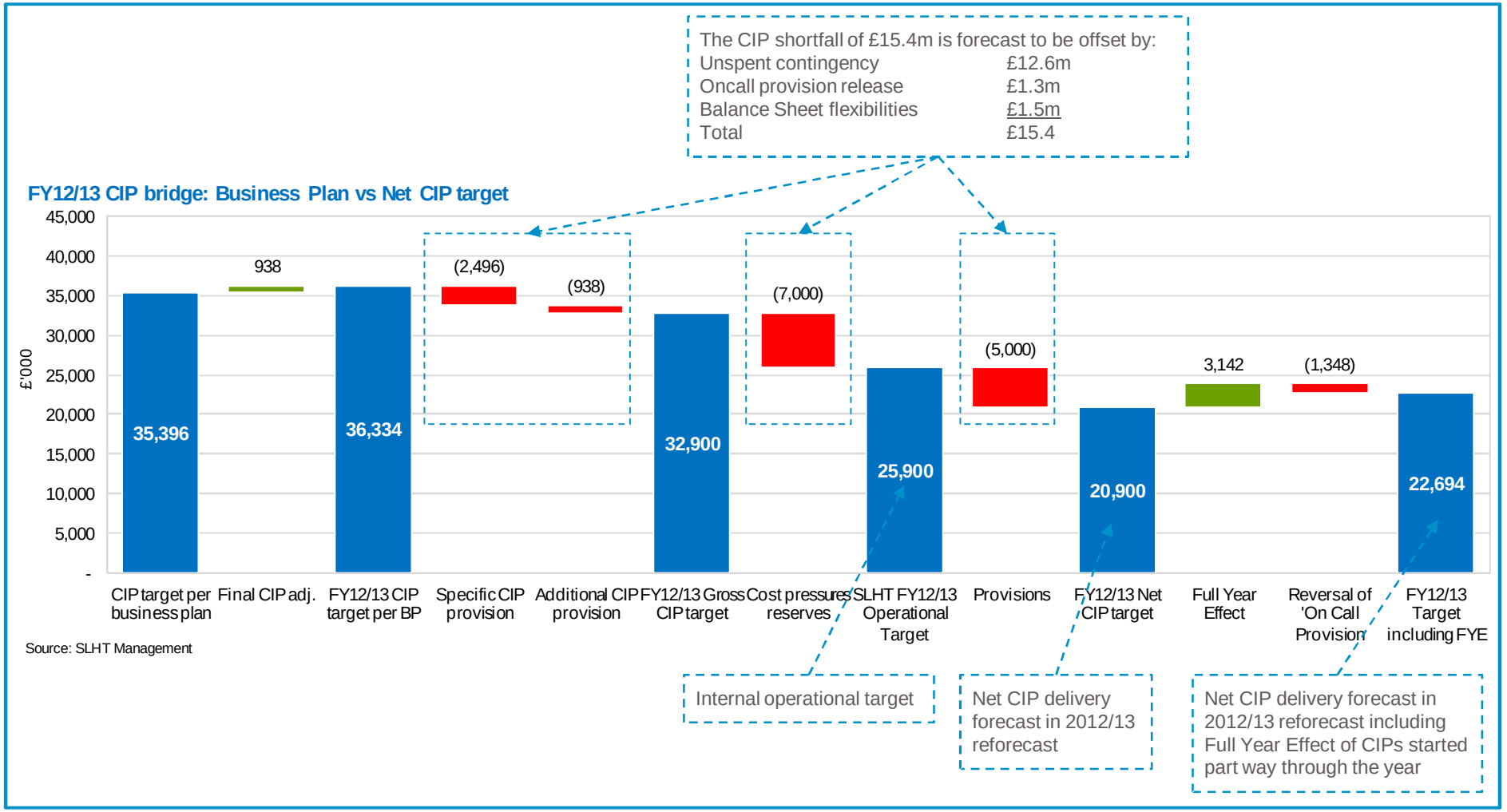


Figure 10: Reforecast 2012/13 deficit to normalised 2012/13 deficit

The 2012/13 normalised deficit is forecast to be £0.7m higher at £59.5m compared to the reforecast deficit primarily due to the removal of balance sheet provisions of £5.5m, partially offset by the full year effect of CIPs, impact £3.1m

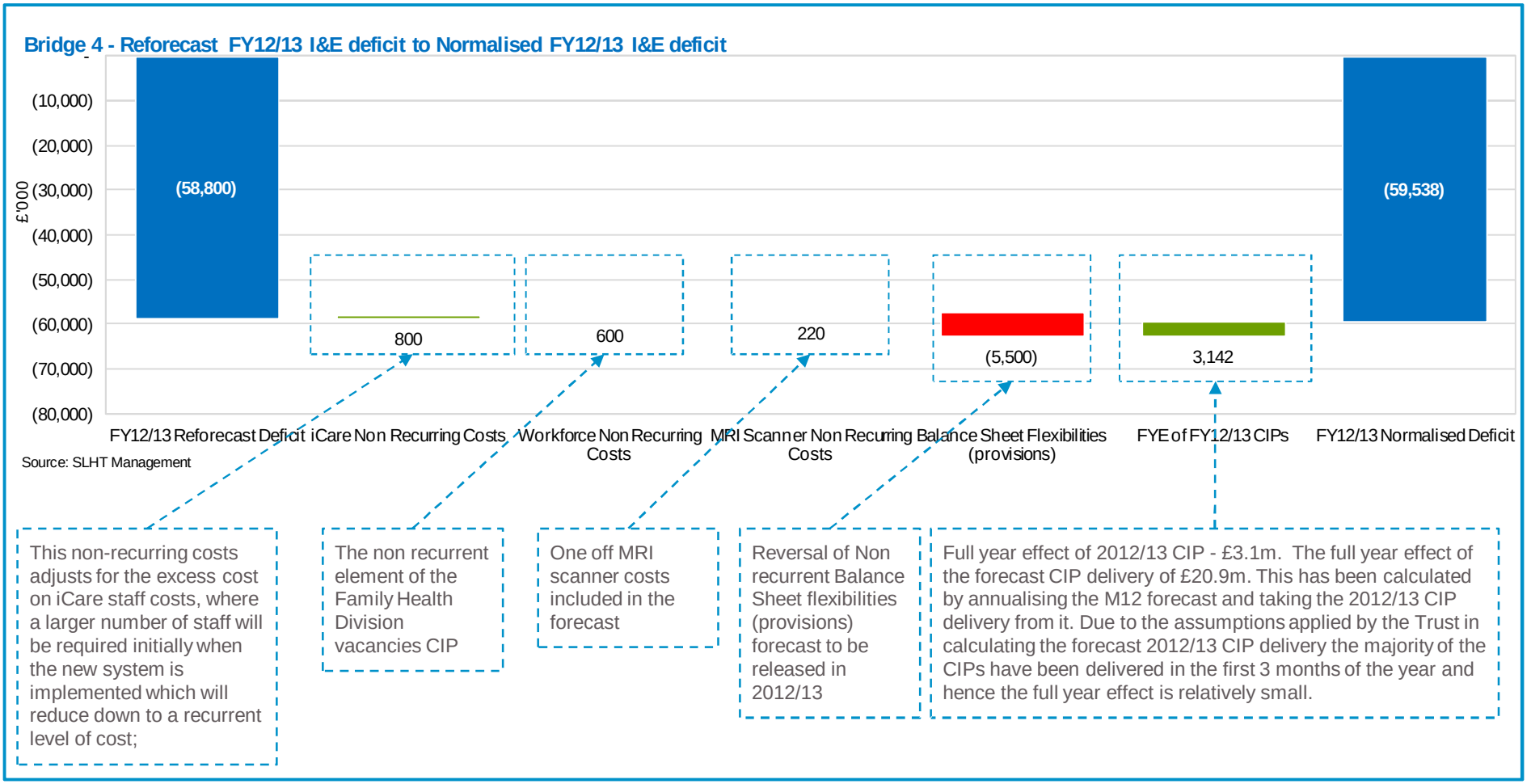


Figure 11: 2012/13 (forecast) normalised I&E by site

Units: £k, %

Income & Expenses	Princess Royal	Queen Elizabeth	Queen Mary's Sidcup	SLHT Total
Total income	**184,137**	**174,077**	**72,107**	**430,321**
Operating income	**184,137**	**174,077**	**72,107**	**430,321**
NHS acute activity income	168,643	163,234	61,922	393,799
Non NHS clinical income (inc private patients)	1,953	2,406	4,592	8,951
Research and Development income	92	112	52	256
Education and Training income	6,114	5,332	2,438	13,884
Other operating income	7,335	2,993	3,103	13,432
Non Operating Income	**0**	**0**	**0**	**0**
Income from NHS Charitable Funds	0	0	0	0
Other Non-Operating income	0	0	0	0
Operating expenses	**183,304**	**180,391**	**76,937**	**440,632**
Employee benefits expense (exc pathology)	111,938	110,555	46,628	269,121
Drug Expenses	12,469	14,581	6,484	33,534
Pathology (pay and non pay)	9,755	9,561	4,109	23,425
Other clinical supplies and services expenses	12,272	12,514	8,577	33,364
General supplies & services	757	661	3,210	4,629
Establishment expenditure	1,735	2,285	1,185	5,205
Premises and Fixed Plant	7,398	6,380	3,500	17,278
PFI operating expenses	19,658	16,718	235	36,611
Other Operating expenses	7,322	7,136	3,009	17,468
EBITDA	**833**	**-6,314**	**-4,830**	**-10,311**
	0.5%	*-3.6%*	*-6.7%*	*-2.4%*
Non-operating expenses	**21,136**	**21,980**	**6,110**	**49,227**
Impairments	0	0	0	0
PDC - Costs	3,139	2,862	2,852	8,853
Depreciation/Amortization	5,448	4,908	2,841	13,196
Interest (PFI&Other debt)	12,507	14,162	405	27,074
Other Non-operating expenses	43	48	12	102
Total expenses	**204,441**	**202,371**	**83,047**	**489,860**
Net surplus (underlying)	**-20,304**	**-28,294**	**-10,940**	**-59,538**
	-11.0%	*-16.3%*	*-15.2%*	*-13.8%*

SOURCE: South London Healthcare NHS Trusts' year-end forecast based on month 3 (31 July 2012)

Current financial position within South London Healthcare NHS Trust

Commissioning intentions for south east London

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Commissioning intentions for south east London (1 of 2)

1. Understanding local commissioning intentions for healthcare provision is key to projecting the provider positions into the future effectively. Therefore, throughout this process the TSA has worked with local commissioners to agree a set of projections for the next five years to inform the future financial status of the Trust and the health economy.

2. The current South East London PCT cluster comprises of six PCTs, which will replaced by six Clinical Commissioning Groups (CCGs) and NHS Commissioning Board in April 2013. In 2012/13 commissioners were allocated £2.98bn, which is expected to grow to £3.29bn by 2017/18 (see figure 12). Alongside this, their expenditure is forecast to grow from £2.99bn in 2012/13 to £3.29bn in 2017/18 due to demographic growth, changing demands and the price of care (see figure 12). This funding will be allocated between the CCGs, the NHS Commissioning Board and Public Health England from April 2013.

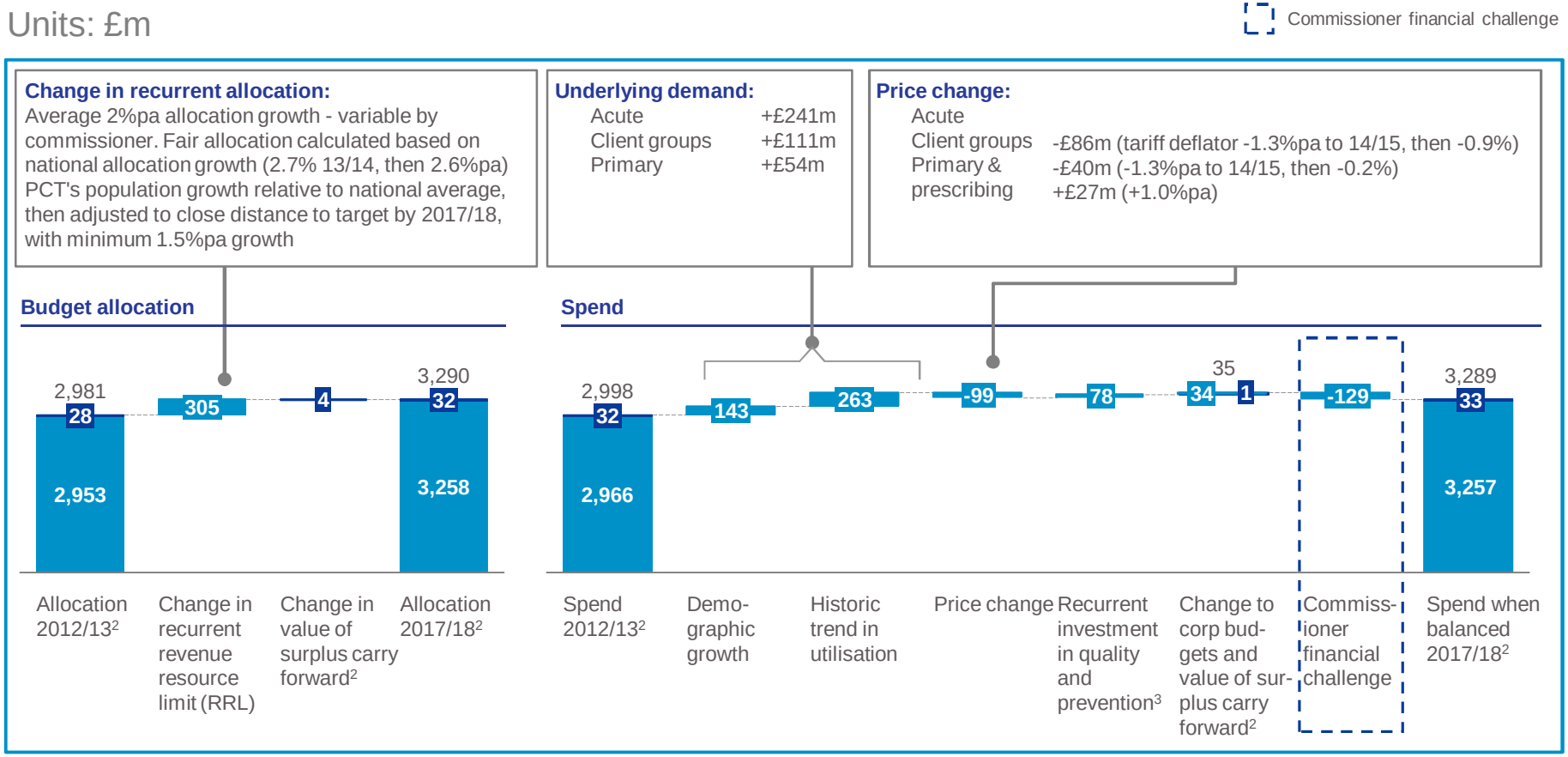
3. Over the next five years, the commissioners in south east London will face a Quality, Innovation, Productivity and Prevention (QIPP) challenge of £129m in required commissioner savings to ensure they stay within their resource limit by 2017/18 (see figure 12).

4. The TSA report assumes that the CCGs will meet this QIPP challenge over the next five years, based on forecast plans for the next three years that will deliver £81m, extrapolated for the remaining two years to reach £129m (figure 13).

5. In December 2012 the NHS Commissioning Board published its planning guidance for 2013/14. Initial analysis has demonstrated that commissioners in south east London will receive around £5.5m more income in 2013/14, than what was assumed in the TSA analysis. If no other assumptions were altered, this would have an impact of reducing the QIPP savings targets by £9.9m to £118.8m. However, the NHS Commissioning Board has indicated that the overall approach to allocations will be revisited in the coming year.

Figure 12: Commissioner allocation and spend projections to 2017/18

Units: £m



1 The commissioner gap analysis covers the full scope of old PCTs (including both CCG, NHS Commissioning Board and Public Health remit). Commissioner gap does not represent the complete provider challenge

2 Treatment of surplus carry-forward: 2012/13 and 2015/16 budget allocation includes carry forward from previous year, and 'change in non-recurrent allocation' includes change in the annual surplus over the period. Spend 2012/13 and 2015/16 includes setting aside 1% for carry forward into subsequent year, and 'Change in prescribing, corporate budgets and value of surplus carry forward' includes change in the annual surplus over the period

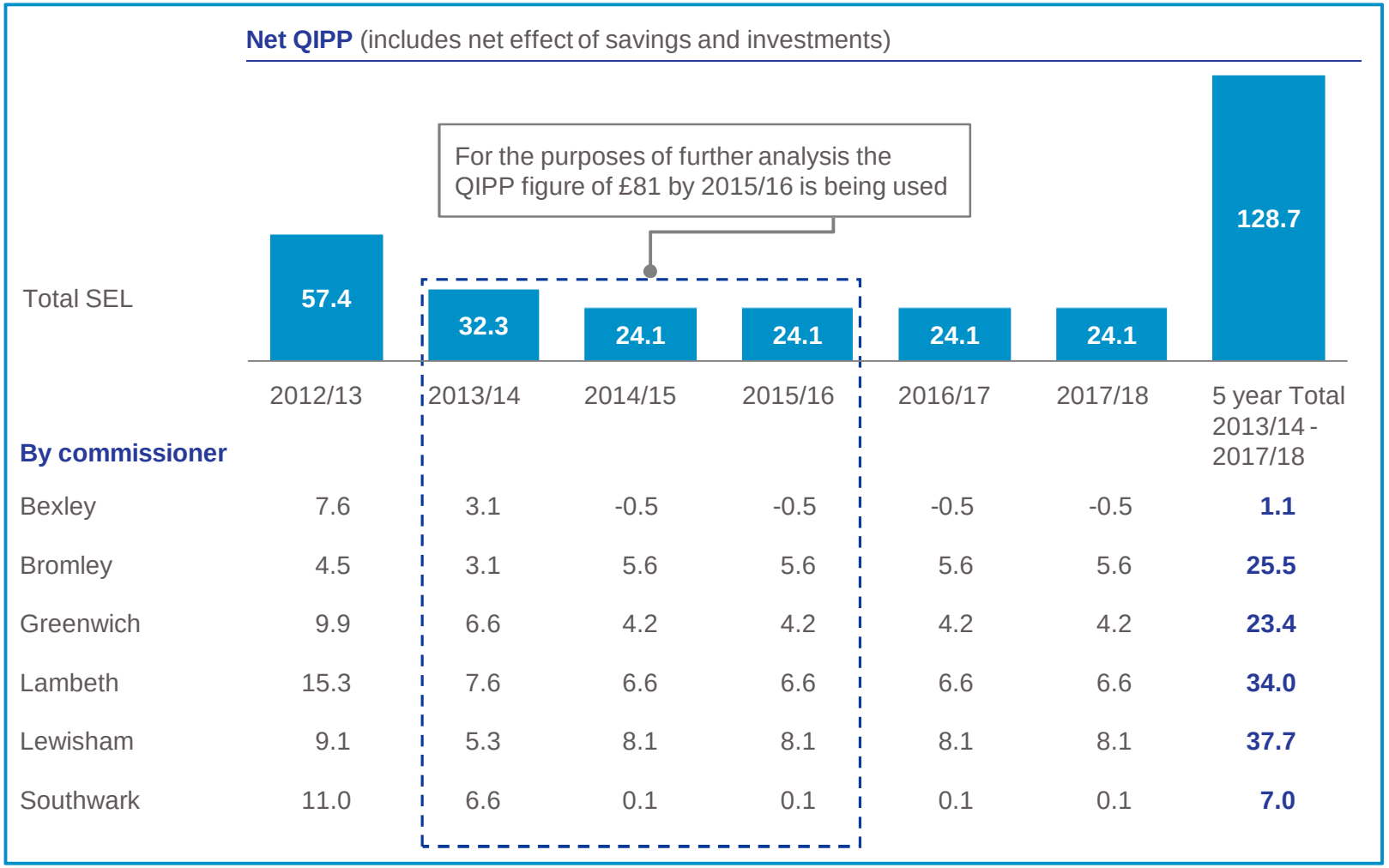
3 Estimated at 0.5% p.a. of RRL as recurrent investment

Note: Non-recurrent 2% has been excluded from both allocation and spend. Spend then includes a further £17m spend originally classified as non-recurrent that may become recurrent

SOURCE: SEL PCT Cluster 'Simple Operating Models'; TSA Commissioning forecast model

Figure 13: Commissioner QIPP challenge to 2017/18

Units: £m



By commissioner	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	5 year Total 2013/14 - 2017/18
Bexley	7.6	3.1	-0.5	-0.5	-0.5	-0.5	**1.1**
Bromley	4.5	3.1	5.6	5.6	5.6	5.6	**25.5**
Greenwich	9.9	6.6	4.2	4.2	4.2	4.2	**23.4**
Lambeth	15.3	7.6	6.6	6.6	6.6	6.6	**34.0**
Lewisham	9.1	5.3	8.1	8.1	8.1	8.1	**37.7**
Southwark	11.0	6.6	0.1	0.1	0.1	0.1	**7.0**

SOURCE: PCT simple operating plans 2012/13 – 2014/15 with adjustments described on overview page; TSA commissioner forecast model

Commissioning intentions for south east London (2 of 2)

6. During the TSA consultation a number of concerns were raised about the low level of QIPP being forecast for some boroughs and the impact of the split of resources between CCGs and the NHS Commissioning Board as part of the new commissioning arrangements from 2013/14. To reflect this, a scenario was developed whereby each current PCT area would have to make a minimum of 2% QIPP savings in each of the next five years. If this was to happen, a further £248m of savings would have to be achieved in the five-year period (figure 14). However, without detailed implementation plans it is not feasible to further develop the financial model in a robust enough way to map the impact on south east London's providers.

7. This outlines that there are potential upsides and downsides for commissioners, depending on how the assumptions are changed. The only potential known adjustment would be to reflect the additional income in 2013/14, but since this is only around £5.5m, any adjustment would not be material to the validity of the overall financial conclusions of this report.

8. However, in recognition of the potential impact of the assumptions used, a sensitivity analysis has been conducted (figure 14). The analysis has shown that the revised allocations could lead to a reduction in QIPP of around £10m, whist an assumption around the need to deliver a minimum of 2% QIPP a year increases the challenge by £250m.

9. The changing nature of the commissioning environment will continue to be a significant factor in the development of detailed implementation plans. At each stage, it will be necessary to re-confirm accurate activity assumptions based on updated information and refreshed commissioner plans.

10. Some CCGs have planned a higher level of QIPP in early years (2012/13 and 2013/14) than some of the TSA assumptions indicate might be necessary. However, this level and profile of QIPP was agreed with local commissioners as a balanced view of the risk and potential mitigations to the issues of a changing funding environment.

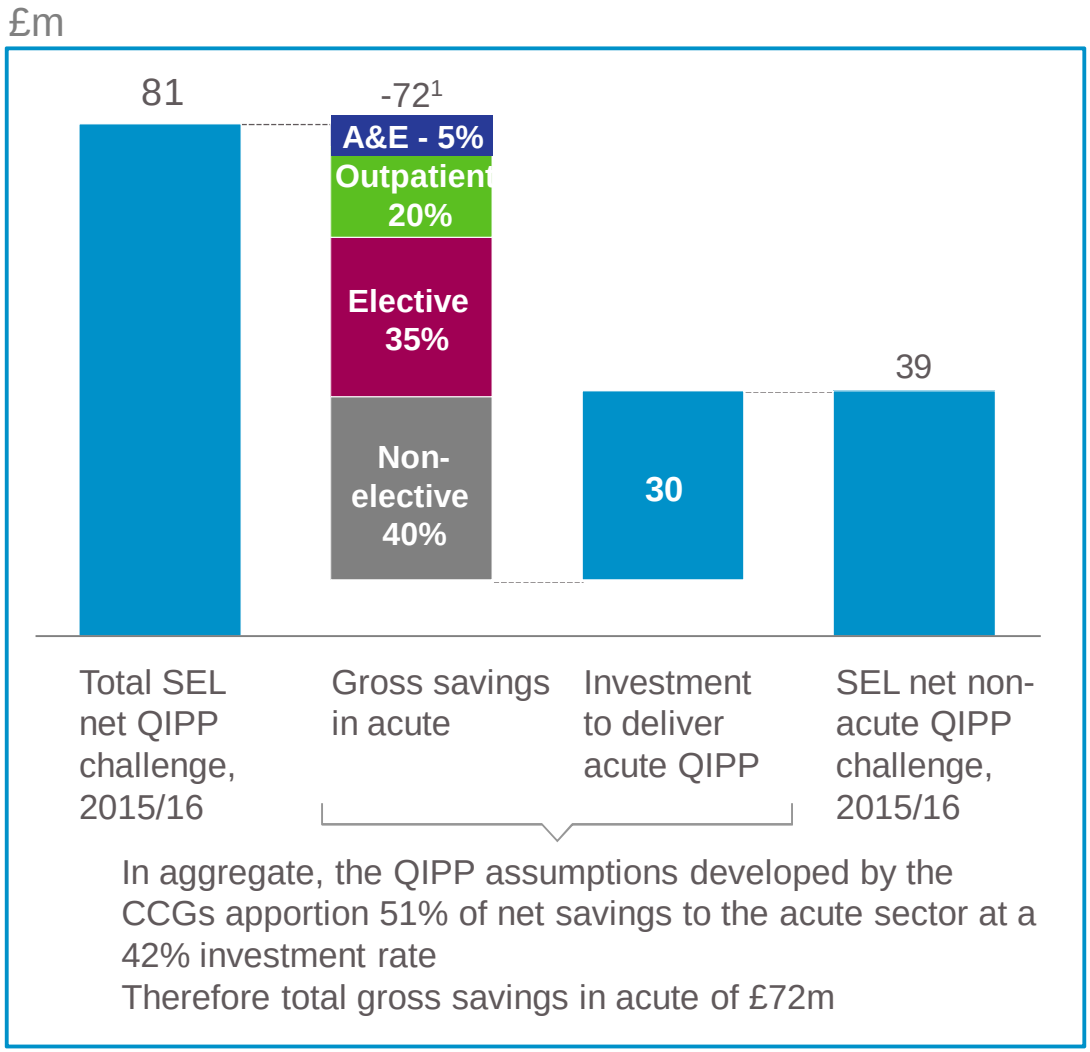
11. The TSA report focuses on the three-year period to 2015/16 and therefore the QIPP target of £81m. Taking into consideration the need for investment to deliver the QIPP savings, a gross figure of £72m savings will need to be delivered in the acute sector and £39m through non-acute savings. This will deliver an investment pot of £30m (see figure 15).

Figure 14: Sensitivity analysis on QIPP by CCG depending on A revised 2013/14 allocations and B 2% QIPP per annum

£m

	5 year QIPP totals				
			Impact vs. TSA assumption		
CCG	**Original**	**A Revised 13/14 allocations**		**B 2% QIPP per annum**	
Bexley	1.1	2.8	+1.7	44.6	+43.5
Bromley	25.5	21.2	-4.3	62.4	+36.9
Greenwich	23.4	22.6	-0.8	58.1	+34.7
Lambeth	34.0	28.6	-5.4	78.0	+44.0
Lewisham	37.7	34.2	-3.5	65.4	+27.7
Southwark	7.0	9.4	+2.4	67.7	+60.7
Total	**128.7**	**118.8**	**-9.9**	**376.2**	**+247.5**

Figure 15: Commissioner QIPP challenge to 2015/16 – acute, non-acute and investment requirements



1 Split by PoD based on work by CCGs

SOURCE: TSA Commissioner forecast model

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Overall financial evaluations

Financial projections in a “do nothing” scenario

1. Having understood the current financial position and the commissioning intentions for the coming years, the TSA team developed a financial projection for the next three years.

2. The financial projection for South London Healthcare NHS Trust has taken full account of commissioning intentions and an assessment of the Trust’s CIP opportunity for that period (described in appendix D) and is provided on a site-by-site basis (Princess Royal University Hospital – figure 16; Queen Elizabeth Hospital – figure 17; and Queen Mary’s Hospital – figure 18). The drivers behind the financial gap to 1% surplus for each of the hospitals has also been considered (Princess Royal University Hospital – figure 19; Queen Elizabeth Hospital – figure 20; and Queen Mary’s Hospital – figure 21).

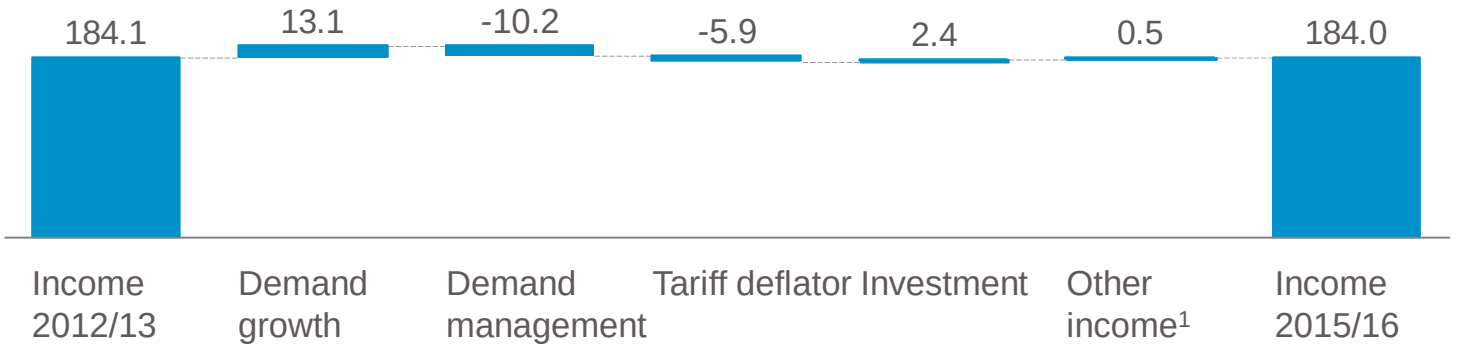
3. In addition to considering the financial position for the Trust, the TSA process reached an understanding of the context of the financial position of all the acute providers in south east London, as described in chapter 5 of the report. The position at Lewisham Healthcare NHS Trust was also completed (figure 22), as was a review of the drivers behind its financial gap to 1% surplus (figure 23).

4. During the TSA consultation some challenges were raised around the TSA income and activity projections, in particular the link between trusts incomes and commissioners QIPP challenges. Commissioners are not significantly reducing their spend with each trust as, at the same time as they will be managing demand there will be demographic and non-demographic growth in activity. Therefore the challenge for providers is predominantly coming from cost pressures and efficiency forecasts, not the commissioners’ QIPP challenges.

Figure 16: Income and expenditure forecasts for Princess Royal University Hospital

£m

Income forecasts 2012/13 to 2015/16



Surplus / deficit in 15/16:	**-£28.4m**
Gap to 1% in 15/16:	**£30.3m**

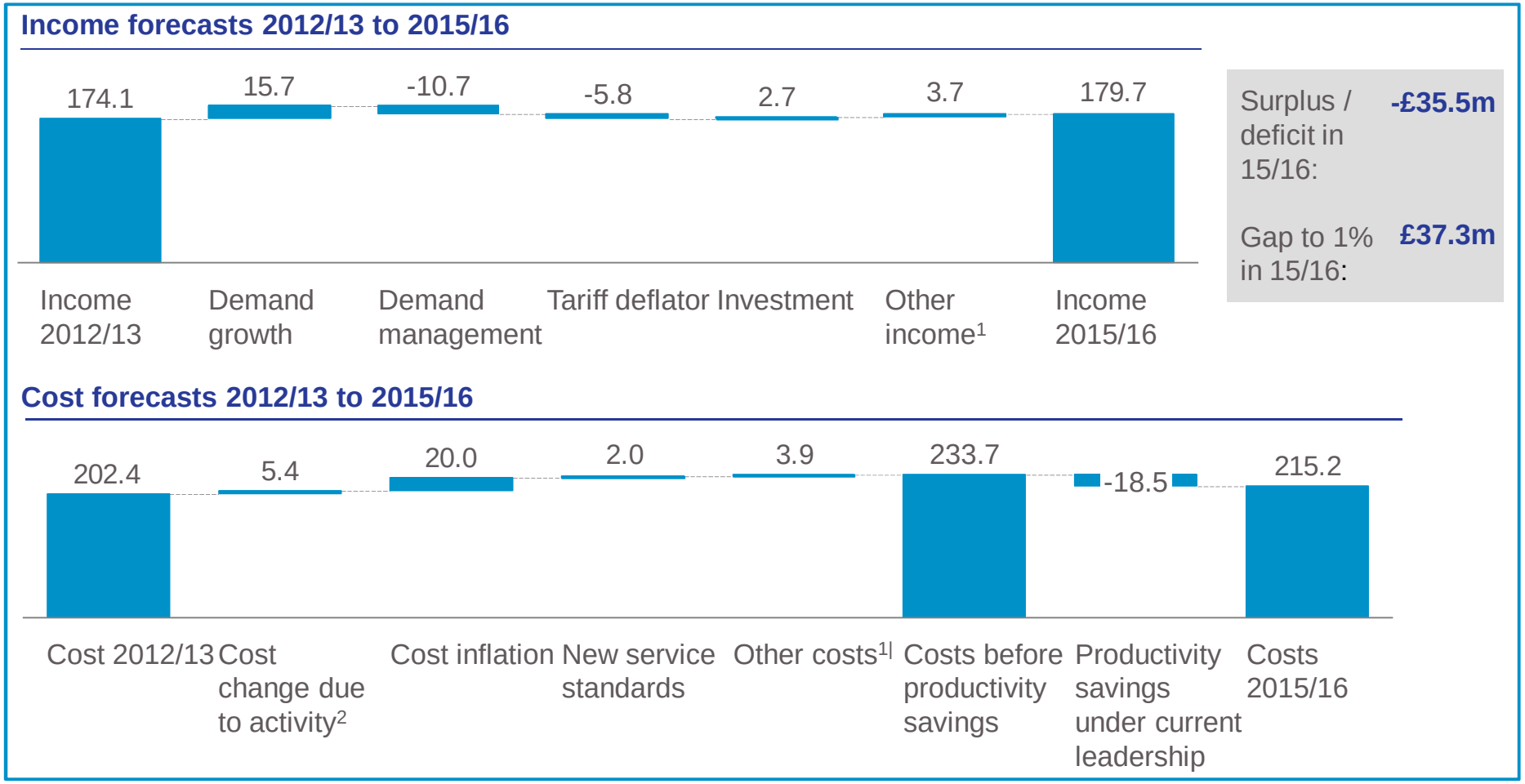
Cost forecasts 2012/13 to 2015/16

1 Includes impact of planned changes between QMS and other SLHT sites
2 Cost response estimated at 70% of the net change due to underlying demand under current setup, demand management, investment, R&D and education, non-NHS and other excludes tariff

SOURCE: TSA PROVIDER FORECASTS 2012/13 TO 2015/16

Figure 17: Income and expenditure forecasts for Queen Elizabeth Hospital

£m

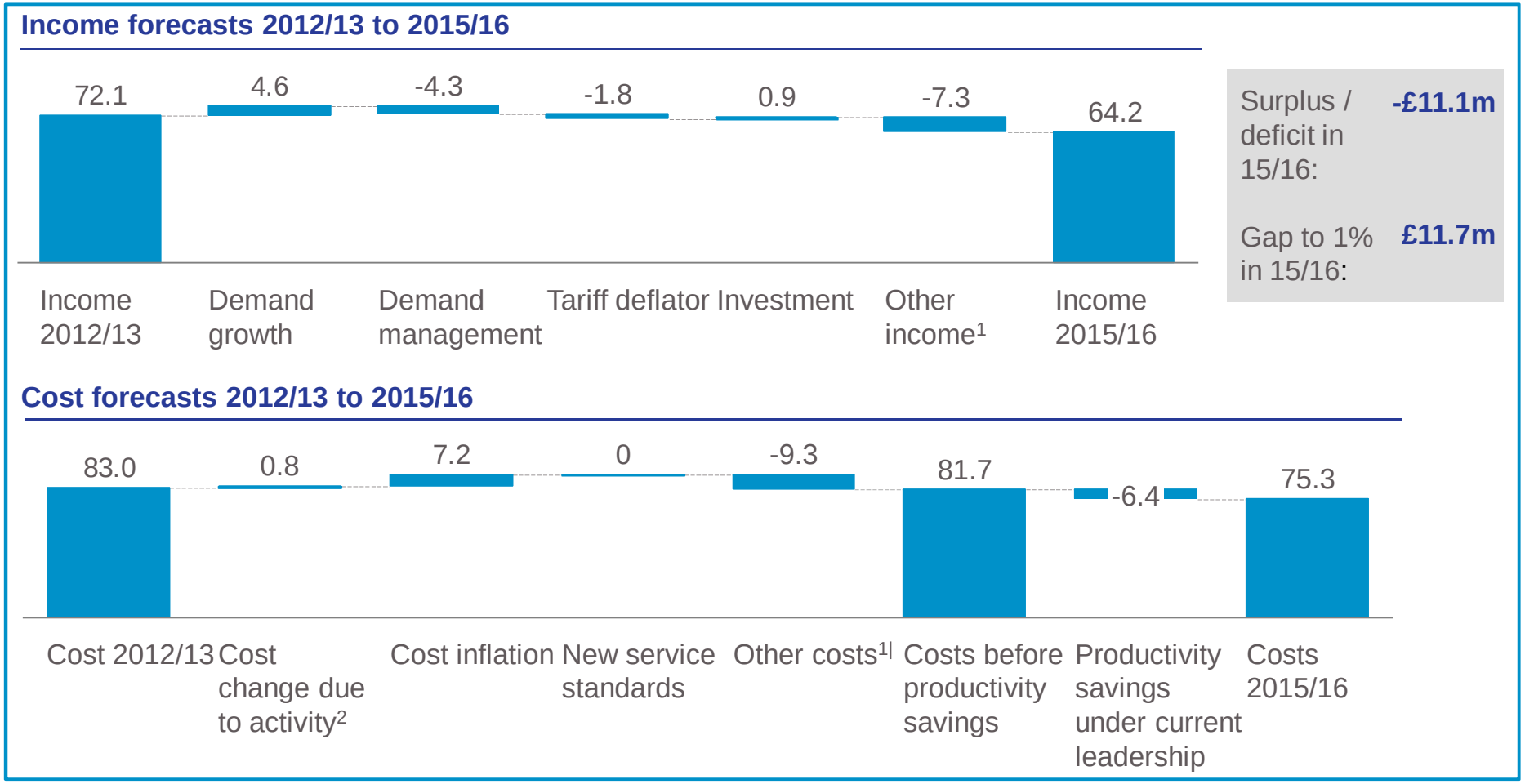


1 Includes impact of planned changes between QMS and other SLHT sites
2 Cost response estimated at 70% of the net change due to underlying demand under current setup, demand management, investment, R&D and education, non-NHS and other excludes tariff

SOURCE: TSA Provider forecasts 2012/13 to 2015/16

Figure 18: Income and expenditure forecasts for Queen Mary's Hospital

£m

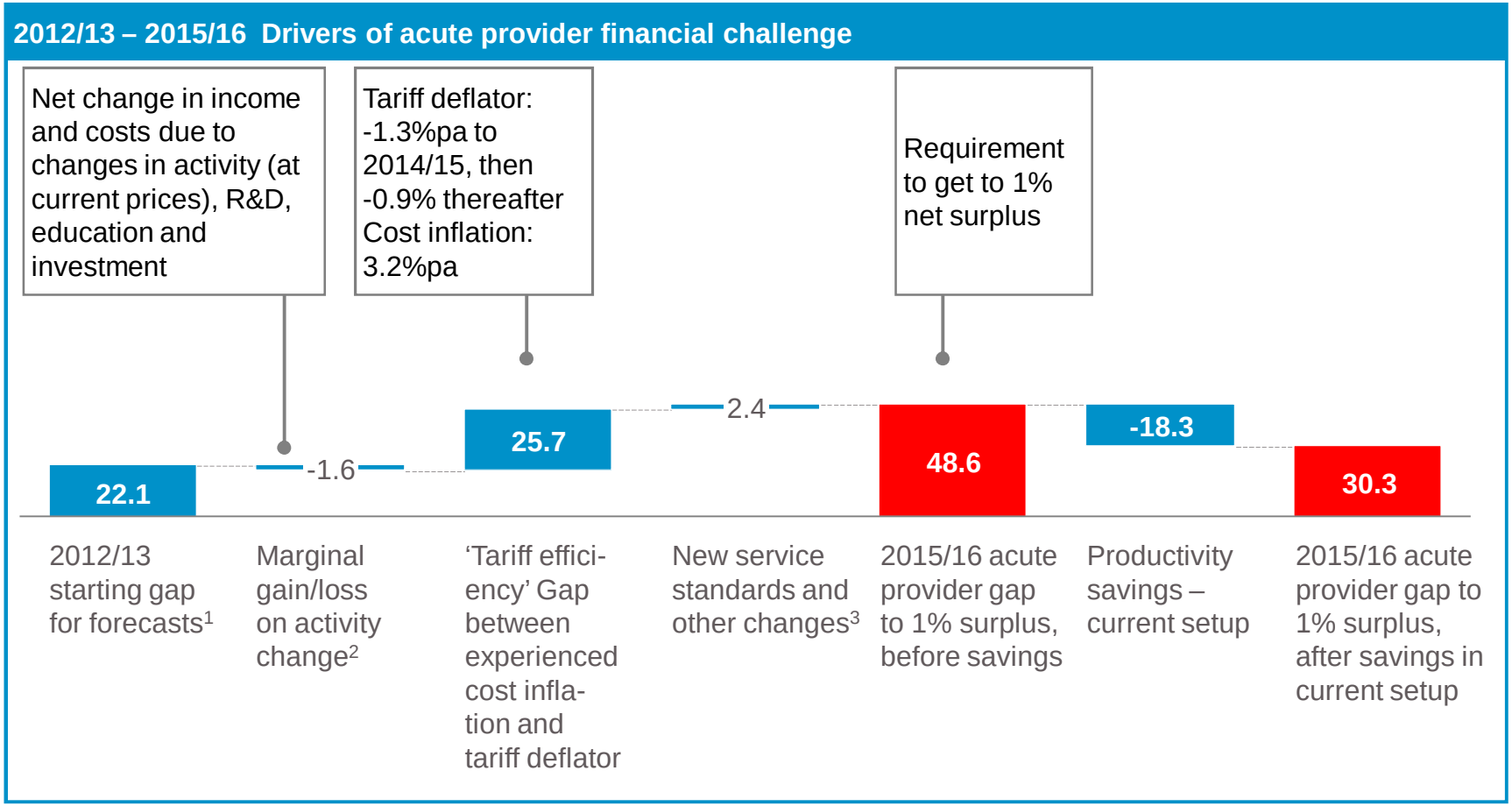


1 Includes impact of planned changes between QMS and other SLHT sites
2 Cost response estimated at 70% of the net change due to underlying demand under current setup, demand management, investment, R&D and education, non-NHS and other excludes tariff

SOURCE: TSA Provider forecasts 2012/13 to 2015/16

Figure 19: Drivers of the financial gap to 1% surplus for Princess Royal University Hospital

£m

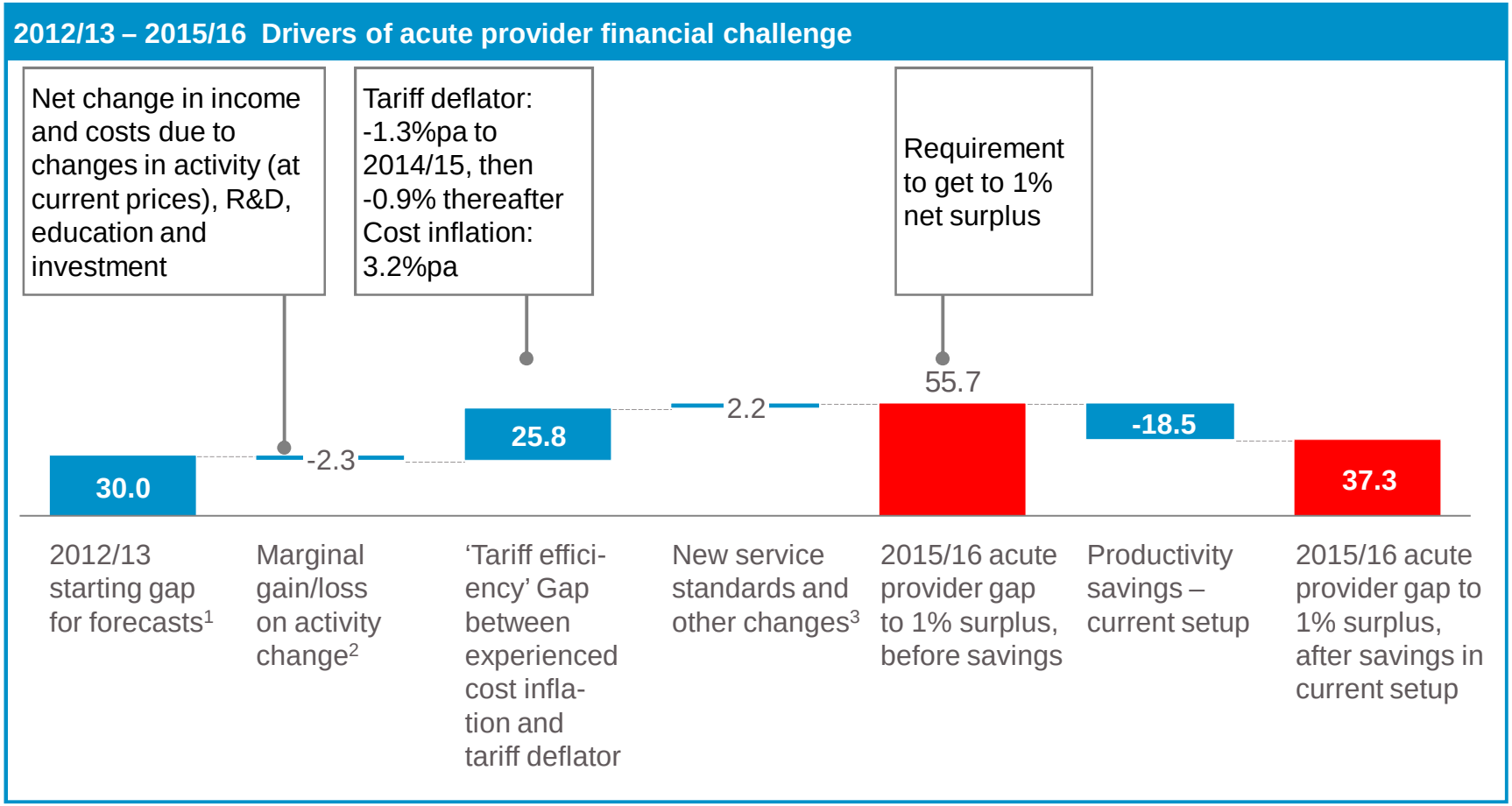


1 Starting point based on Trusts' 2012/13 normalised underlying income and expenditure plan;
2 Benefit from net increase in activity (income before price change) due to demand growth net of demand management, investment, R&D and education. Assumes 70% marginal cost with increase/ decrease in activity;
3 Includes additional consultant costs to meet new service standards and planned changes between QMS and other SLHT sites

SOURCE: 2012/13 normalised plan provided by Trusts (as of 24th August), TSA commissioner forecast model, TSA trust forecast model

Figure 20: Drivers of the financial gap to 1% surplus for Queen Elizabeth Hospital

£m

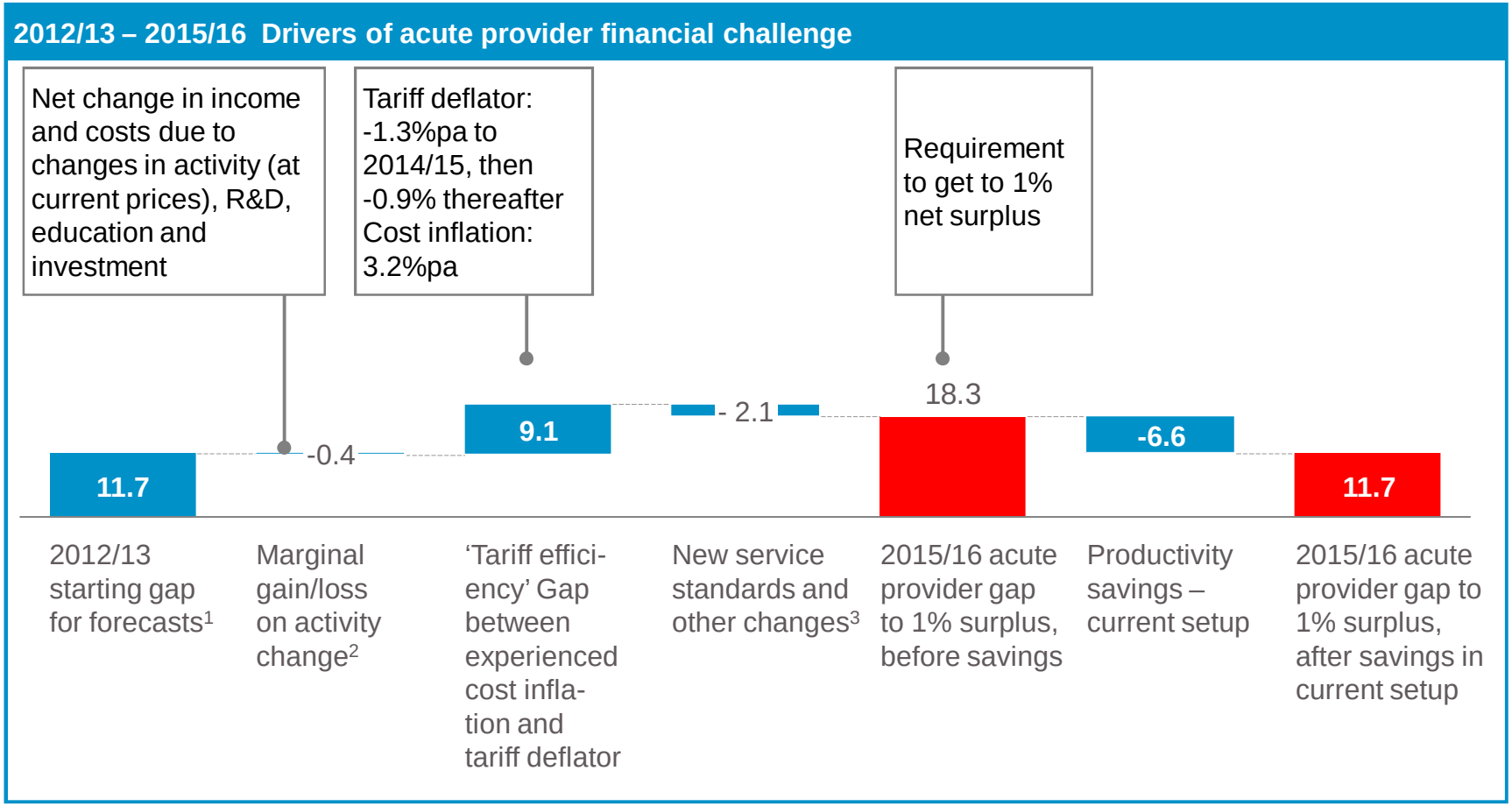


1 Starting point based on Trusts' 2012/13 normalised underlying income and expenditure plan;
2 Benefit from net increase in activity (income before price change) due to demand growth net of demand management, investment, R&D and education. Assumes 70% marginal cost with increase/ decrease in activity;
3 Includes additional consultant costs to meet new service standards and planned changes between QMS and other SLHT sites

SOURCE: 2012/13 normalised plan provided by Trusts (as of 24th August), TSA commissioner forecast model, TSA trust forecast model

Figure 21: Drivers of the financial gap to 1% surplus for Queen Mary's Hospital

£m

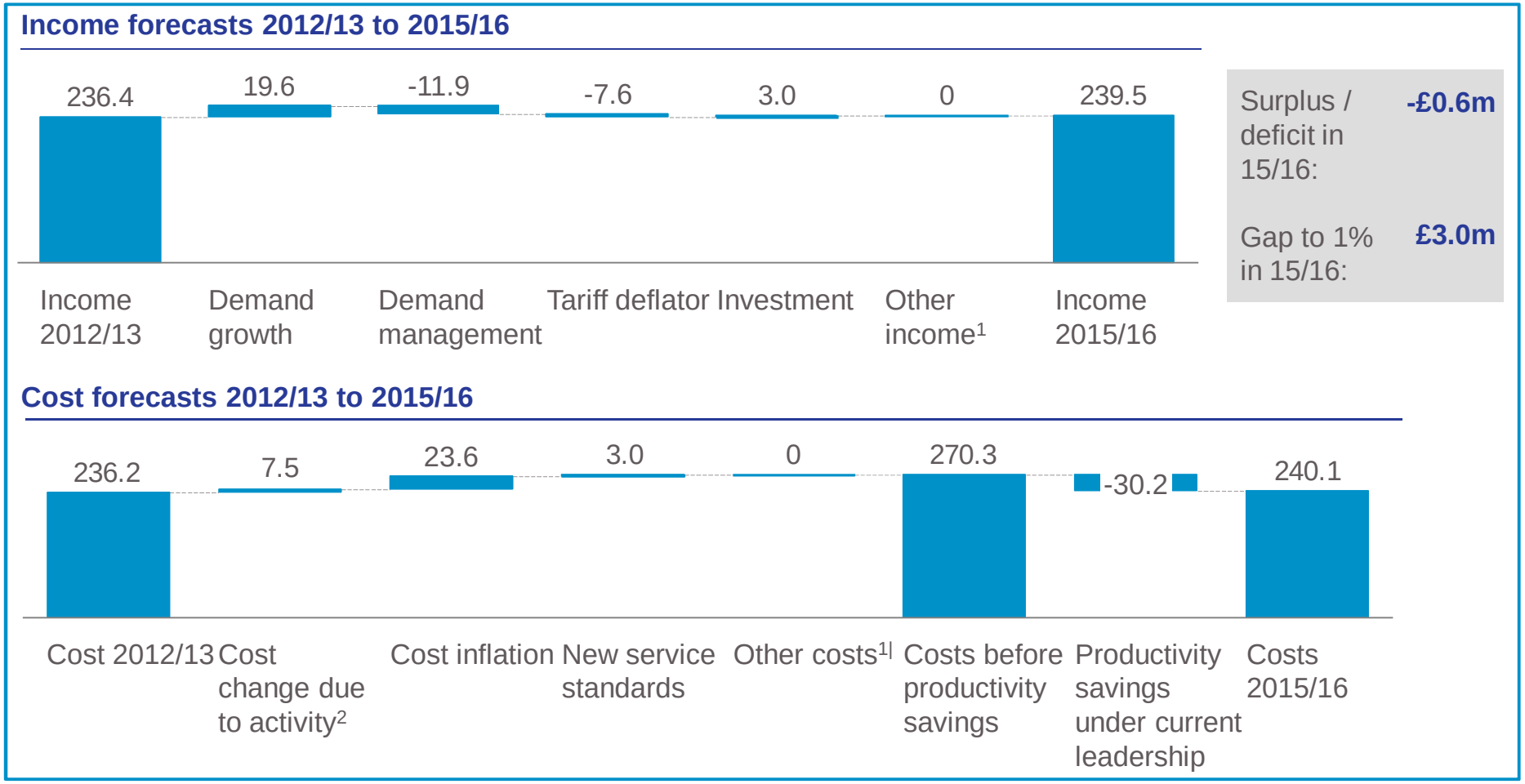


1 Starting point based on Trusts' 2012/13 normalised underlying income and expenditure plan;
2 Benefit from net increase in activity (income before price change) due to demand growth net of demand management, investment, R&D and education. Assumes 70% marginal cost with increase/ decrease in activity;
3 Includes additional consultant costs to meet new service standards and planned changes between QMS and other SLHT sites

SOURCE: 2012/13 normalised plan provided by Trusts (as of 24th August), TSA commissioner forecast model, TSA trust forecast model

Figure 22: Income and expenditure forecasts for Lewisham Healthcare NHS Trust

£m

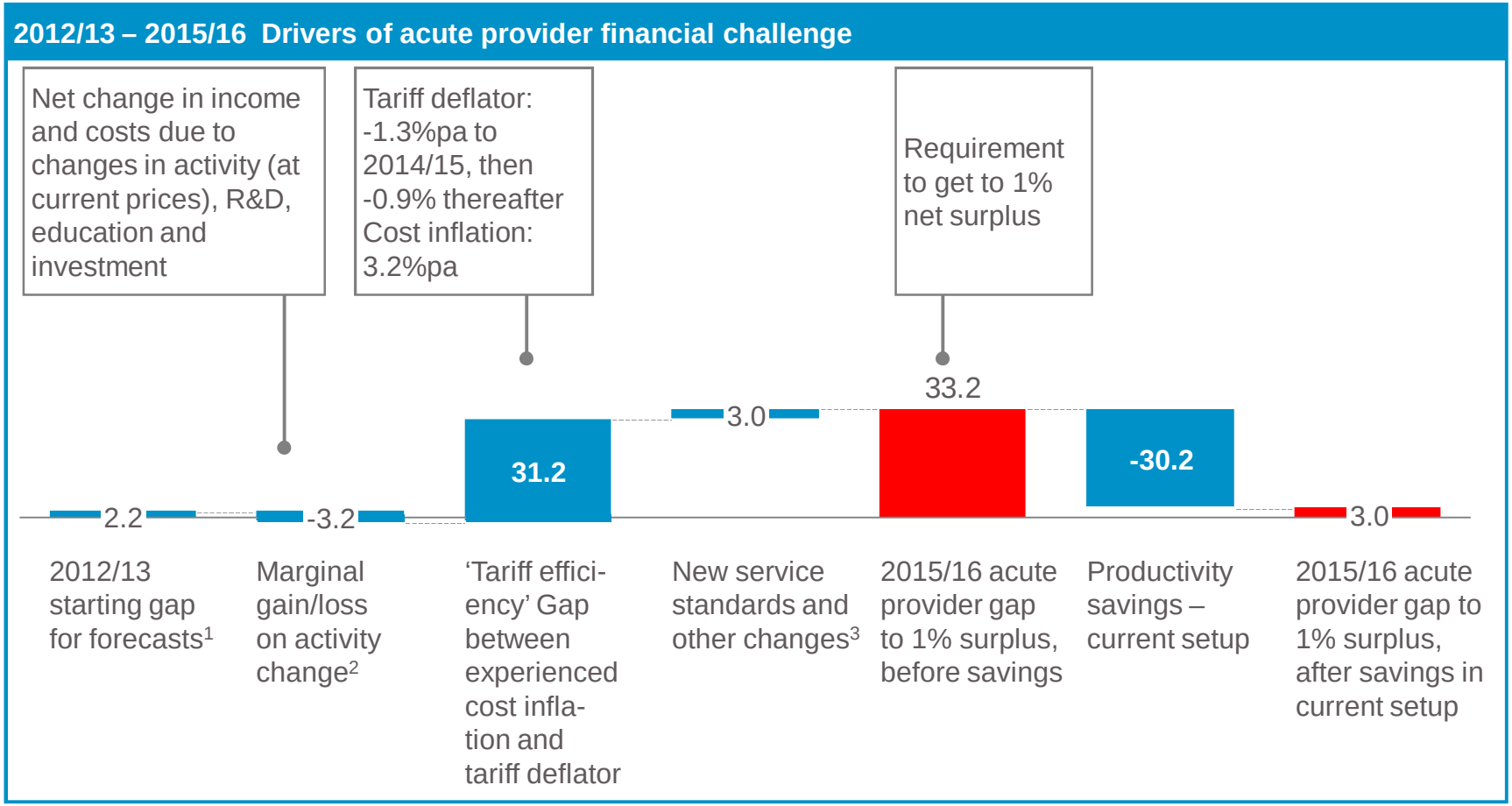


1 Includes impact of planned changes between QMS and other SLHT sites
2 Cost response estimated at 70% of the net change due to underlying demand under current setup, demand management, investment, R&D and education, non-NHS and other excludes tariff

SOURCE: TSA Provider forecasts 2012/13 to 2015/16

Figure 23: Drivers of the financial gap to 1% surplus for Lewisham Healthcare NHS Trust

£m



1 Starting point based on Trusts' 2012/13 normalised underlying income and expenditure plan;
2 Benefit from net increase in activity (income before price change) due to demand growth net of demand management, investment, R&D and education. Assumes 70% marginal cost with increase/ decrease in activity;
3 Includes additional consultant costs to meet new service standards and planned changes between QMS and other SLHT sites

SOURCE: 2012/13 normalised plan provided by Trusts (as of 24th August), TSA commissioner forecast model, TSA trust forecast model

Current financial position within South London Healthcare NHS Trust

Commissioning intentions for south east London

Financial projections in a “do nothing” scenario

Financial implications of the TSA recommendations

Evaluation of estate opportunities

Overall financial evaluations

Financial implications of the TSA recommendations (1 of 5)

1. The final report makes seven recommendations to secure sustainable NHS services in South London Healthcare NHS Trust and the wider south east London health economy. The recommendations are grouped into those that can improve the position of South London Healthcare NHS Trust (recommendations 1 – 4), those that go beyond the Trust itself (recommendations 5 and 6) and transition and implementation (recommendation 7).

2. If collectively implemented these recommendations will have a recurrent financial impact of £86.1m by 2015/16. The allocations of this impact is provided in figure 24.

3. Delivering these recommendations at pace will require investment. This is projected to be £96m of non-recurrent expense and £55m of run rate support across the programme. There is also a capital requirement of £162m. Further details on these are included in this section.

Recommendation 1

4. Recommendation 1 is to improve the operational efficiency of the Trust. This is predicated on making operational changes within the existing configuration of the Trust. The detail on how these operational efficiencies have been identified and can be delivered is set out in chapter 4 of the report and in appendix D.

5. Following a second phase of work to develop the plans for delivering these efficiencies, the TSA concluded that the sites that make up South London Healthcare NHS Trust should deliver £74.9m (15.4%) of efficiency opportunities. A breakdown of how these savings will be made across each of the Trust's sites, by year, are provided in figure 25, with further detail in appendix D.

Figure 24: Summary financial impact of TSA Recommendations

Before TSA Recommendations

2012/13	Income	Cost	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	184.1	204.4	-20.3	22.1
QEH	174.1	202.4	-28.3	30.0
QMS	72.1	83.0	-10.9	11.6
Total	**430.3**	**489.8**	**-59.5**	**63.8**
Lewisham	236.4	236.2	0.2	2.2

2013/14 Full year effect

2013/14	Income	Cost	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	184.1	207.0	-22.9	24.8
QEH	173.1	205.7	-32.6	34.3
QMS	61.6	72.3	-10.7	11.3
Total	**418.8**	**485.1**	**-66.2**	**70.4**
Lewisham	236.9	235.9	1.0	1.4

2014/15 Full year effect

2014/15	Income	Cost	Deficit	Gap to 1%
PRU	183.7	210.4	-26.7	28.6
QEH	176.2	211.1	-34.9	36.6
QMS	62.7	74.4	-11.7	12.3
Total	**422.6**	**495.9**	**-73.3**	**77.5**
Lewisham	237.2	237.4	-0.2	2.6

2015/16 Full year effect

2015/16	Income	Cost	Deficit	Gap to 1%
PRU	184.0	212.4	-28.4	30.3
QEH	179.7	215.2	-35.5	37.3
QMS	64.2	75.3	-11.1	11.7
Total	**427.9**	**502.9**	**-75.0**	**79.3**
Lewisham	239.5	240.1	-0.6	3.0

2016/17 Post reconfiguration forecast

2016/17	Income	Cost	Surplus	Gap to 1%
PRU	227.6	220.1	7.5	-5.2
QEH/LEW	379.8	375.1	4.7	-0.9
Total	**607.4**	**595.2**	**12.2**	**-6.1**

Changes in I&E

	Rec 1	Rec 2	Rec 3	Rec 4	Rec 5	Rec 6			
2013/14	Further productivity	QMS site change	Estates	PFI support	Service Reconfiguration	Merger synergies	Total changes	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	4.9			10.5	0.0	0.6	16.0	-6.9	8.8
QEH	5.2	0.6		12.2	0.0	0.6	18.6	-14.0	15.7
QMS	2.1	-0.6	0.7		0.0	0.6	2.8	-7.9	8.5
Total	**12.2**	**0.0**	**0.7**	**22.7**	**0.0**	**1.8**	**37.4**	**-28.8**	**33.0**
Lewisham								1.0	1.4
2014/15									
PRU	8.5		2.8	10.7	-1.3	1.7	22.4	-4.3	6.2
QEH	9.9	0.6		12.2	0.0	1.8	24.5	-10.4	12.1
QMS	4.2	2.1	0.7		0.0	0.9	7.9	-3.8	4.4
Total	**22.6**	**2.7**	**3.5**	**22.9**	**-1.3**	**4.4**	**54.8**	**-18.5**	**22.7**
Lewisham								-0.2	2.6
2015/16 Full year effect									
PRU	12.6		4.0	11.8	1.7	3.2	33.3	4.9	-3.0
QEH	13.8	0.6		13.6	9.5	3.2	40.7	5.2	-3.4
QMS	5.2	3.9	0.7		0.0	1.3	11.1	0.0	
Total	**31.6**	**4.5**	**4.7**	**25.4**	**11.2**	**7.7**	**87.4**	**12.4**	**-5.9**
Lewisham					1.0		1.0	0.4	2.0

Note: The full year effect of the income adjustments are not considered until the post implementation forecast.

Figure 25: CIP breakdown for South London Healthcare NHS Trust

	New Schemes in Year		
£m	Base	Future Productivity	Total
2013/14			
PRU	6.0	4.9	10.9
QEH	6.0	5.2	11.2
QMS	2.1	2.1	4.2
Total	*14.1*	*12.2*	*26.3*
2014/15			
PRU	6.1	3.6	9.7
QEH	6.2	4.7	10.9
QMS	2.2	2.1	4.3
Total	*14.5*	*10.4*	*24.9*
2015/16			
PRU	6.2	4.1	10.3
QEH	6.3	3.9	10.2
QMS	2.2	1.0	3.2
Total	*14.7*	*9.0*	*23.7*

	Cumulative		
£m	Base	Future Productivity	Total
Cumulative			
PRU	18.3	12.6	30.9
QEH	18.5	13.8	32.3
QMS	6.5	5.2	11.7
Total	*43.3*	*31.6*	*74.9*

Financial implications of the TSA recommendations (2 of 5)

Recommendations 2 and 3

6. Both recommendations 2 and 3 provide benefit to South London Healthcare NHS Trust by improving the use of the Trust's estate. These opportunities were identified based on existing work that the Trust had undertaken in considering its own estate and through a wider review of estate utilisation in south east London, described later in this appendix.

7. In transferring the core part of Queen Mary's Hospital to Oxleas NHS Foundation Trust under recommendation 2 the use of the hospital estate will be optimised, with Oxleas able to invest in the site and transform it into a hospital that reflects the vision of local commissioners. Recommendation 3 supports the sale of the remainder of the Queen Mary's Hospital site, which is no longer required for NHS purposes.

8. In addition to the disposals of estate at Queen Mary's Hospital recommendation 3 proposes that the Trust should dispose of Orpington Hospital, that the lease it currently holds at Beckenham Beacon should be transferred to Community Health Partnerships and that the Trust should exit that site in full by 2015/16. This would allow Bromley CCG to develop a planned care centre on the site. An overview of the impact of these recommendations is provided in figure 26, with more details provided in chapter 4 of the report.

Recommendation 4

9. As part of the analysis of the Trust's current financial position, the costs of its PFI contracts and the impact they have on its financial position was undertaken.

10. The TSA recommends that the Department of Health provides direct support to the future operators of the PFI contracts, to cover the excess costs that are not recompensed by commissioners for the services provided within them. These costs should be provided for the life of the contracts.

11. The financial details related to this recommendation will be provided directly to the Secretary of State in confidence and are therefore not provided in this report. However, a summary of the proposed support schedule is provided in figure 27.

Figure 26: TSA Recommendations 2 and 3: Transforming QMS and effective utilisation of estate

	Description	Impact (capital and revenue)
QMS	Exit two ends of the site	Capital receipt assumption agreed based on independent estates advice. Figure not disclosed due to commercial sensitivity. £0.7m reduction in revenue costs
	Remaining site transferred to Oxleas and non-Bexley activity repatriated to other sites. Ophthalmic services for the outer South East London boroughs to be concentrated on the site.	Removes remaining £3.9m gap
Beckenham Beacon	SLHT currently provides services from Beckenham Beacon site and pay £1.7m per year for rent and rates Lease will be transferred to CHP on dissolution of SLHT As agreed with Bromley CCG – they will develop a planned care centre at Beckenham Beacon, with SLHT transferring their acute services back to PRUH over the next three years – allowing a saving of £1.7m by year 4	Range of £1.7m reduction in 'premises and fixed costs' for PRUH.
Orpington site	Planned exit from Orpington site	Capital receipt assumption agreed based on independent estates advice £2.3m revenue saving for PRUH

Figure 27: Proposed PFI support schedule

	Year		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
PFI Support Costs	QEH	£M	12.2	12.2	13.6	13.6	13.6	13.6	13.6	13.6	13.6
	PRUH	£M	10.5	10.7	11.8	11.8	11.8	11.8	11.8	11.8	11.8
	TOTAL	*£M*	*22.7*	*22.9*	*25.4*	*25.4*	*25.4*	*25.4*	*25.4*	*25.4*	*25.4*

	Year		2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2029/30	2030/31	2031/32
PFI Support Costs	QEH	£M	13.6	13.6	13.6	13.6	13.6	13.6	13.6	13.6	13.6
	PRUH	£M	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8
	TOTAL	*£M*	*25.4*	*25.4*	*25.4*	*25.4*	*25.4*	*25.4*	*25.4*	*25.4*	*25.4*

	Year		2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40
PFI Support Costs	QEH	£M	13.6							
	PRUH	£M	11.8	11.8	11.8	11.8	11.8	11.8	11.8	
	TOTAL	*£M*	*25.4*	*11.8*	*11.8*	*11.8*	*11.8*	*11.8*	*11.8*	

Financial implications of the TSA recommendations (3 of 5)

Recommendation 5

12. Recommendation 5 is required to deliver financially and clinically sustainable services in south east London and will see a set of service changes across the hospitals in south east London. This recommendation will provide benefit of £11.2m.

13. Details on the proposed changes are provided in chapter 5 of the report and appendix E. A summary of the approach for modelling the transfers is also provided in figure 28.

14. The recurrent impact of implementing these changes is in figure 29, which describes the change in operating margin and fixed cost for each hospital. These changes are based on a set of assumptions described in figures 30-32 (assumptions 1-3).

Recommendation 5 - Maternity

15. Recommendation 5 includes a proposal for the future configuration of maternity services in south east London. As described in chapter 5 of the report and appendix E, the TSA considered three models for maternity: four sites with obstetric-led units and co-located midwife-led units; four obstetric-led maternity units and five midwife-led units; and five sites with obstetric-led units and co-located midwife-led units. These options are described in more detail in figures 33 – 35.

16. These options have been evaluated against how they will deliver the London clinical quality standards for maternity and have been considered by the external clinical panel. A financial analysis has also been completed for each option, using the assumptions described in figures 36 and 37 and the approach to modelling the financial impact implications described in figures 38 and 39.

17. The TSA is recommending that south east London should have four obstetric-led units and five midwife-led units include one at University Hospital Lewisham. The development of a midwife-led unit at University Hospital Lewisham generates an net present value of £18.4m greater than the five-site option, but £3.7m less than the four-site option. The annual impact of the stand alone midwife-led unit will generate a cost pressure of c£1m for the University Hospital Lewisham site. These financial implications are outlined in figure 40.

Figure 28: Summary of approach for modelling clinical transfer

QMS

- Retains current community services (inc. Children's Development Centre), UCC outpatients, cancer & Macmillan
- Retains elective daycase surgery, including ophthalmology
- Adult elective inpatient and all paediatric inpatient services moved off site
- Dispose of the 2 ends of QMS site. Transfer blocks A, B, C, D and F to Oxleas

Lewisham

- Retains current elective daycase surgery, 85% of outpatients, and UCC
- Receives all elective non-complex inpatient surgery across SEL (except Guy's)
- Lewisham theatres operate at 12hrs a day, 6 days a week, 50 weeks a year and 90% utilisation
- Disperses all other services
- Retains Riverside, Ravensbourne and Ladywell buildings, 2.4 Ha (42%) of land area and disposes of all other estate

All other sites

- Receive complex elective, and non-elective services from Lewisham (except Guy's and QMS)
- Retain elective daycase surgery
- Provide elective non-complex inpatient surgery at Lewisham (except Guy's)
- Theatres operate at 12hrs a day, 6 days a week, 50 weeks a year and 85% utilisation (lower utilisation due to mix of complex and non-complex procedures on lists)

Throughput assumptions

- Assumes current bed occupancy rates, and 10% average length of stay reduction by 15/16
- Longer theatre opening hours (site specific – see above), and throughput rates in 12hr days of: 19 day case procedures, 8 non-complex elective inpatient procedures, or 5 complex elective procedures

Optimisation steps (reductions in new build capex are modelled, however shifts in activity, income and associated margin are not)

Lew-QEH

- Lewisham retains 75 'slow-stream' beds 1. Modelled as:
  - Lewisham retaining 70 non-elective beds that would otherwise move to QEH
  - Additional 8 beds moved from QEH to Lewisham to remove excess at QEH

PRU-KCH

- The combined excess beds of PRUH and KCH are assumed to have no capex requirements
- 39 beds from PRUH and 51 from KCH are assumed to fill Green park's capacity (services to be defined), while the remaining King's beds go to Lewisham

1 Currently these beds identified as rehabilitation (28 beds, provided for KCH); Intermediate care (20 beds); Longer-stay stroke unit (27 beds, patients from KCH and PRUH)

Figure 29: Impact of service reconfiguration after optimising services to minimise capital expenditure

Other trusts in SEL

£m

		LEW	PRUH	QEH	QMS	GST	KCH
Change in operating margin	Gain/loss in margin due to activity movement	-20.3[2]	3.6	7.1	n/a	0.6	8.4
	Consolidation savings	2.7	2.5	3.2	n/a	0.4	3.1
	Avoid cost of new service standards	3.0	0.0	0.0	n/a	0.0	0.0
Change in 'fixed costs'[1]	Reduction in costs due to disposal	22.6	0.0	0.0	n/a	0.0	0.0
	Additional cost due to new build	-7.0	-4.4	-0.8	n/a	-0.9	-4.3
Total		**1.0**	**1.7**	**9.5**	**n/a**	**0.1**	**7.2**

1 'Fixed costs' defined as establishment, premises, PDC, depreciation, PFI and other non-operating costs
2 Includes £1m of commissioner support for the MLU

SOURCE: TSA assessment

Figure 30: Assumptions for clinical productivity (1/3)

	Current assumption
Elective (non-specialist) theatre utilisation	QMS daycase: 10hrs a day x 6 days a week x 90% utilisation rate Lewisham elective centre: 12hrs a day x 6 days a week x 90% utilisation Other sites: 12hrs a day x 6 days a week x 85% utilisation (due to higher mix of complex work) 8 non-complex or 5 complex inpatient cases in 12 hrs 19 day case procedures in 12 hrs
Emergency theatre throughput	~ 25% cases in emergency surgical specialities go to theatre for surgery Currently checking if this would be higher for T&O admissions Assume additional activity can be accommodated in existing CEPOD lists (~6 a day if Lewisham activity redistributed)
Consolidation savings	When activity flows between sites 100% of the associated variable cost move and 90% of pay costs The 10% represent savings of consolidating services into larger clinical teams
Length of stay reduction	10% over 3 years

Figure 31: Assumptions for clinical definitions (2/3)

	Current assumption
Suitable/ Unsuitable elective surgery activity for an elective centre	Unsuitable elective surgery includes: – Specialist activity and complex procedures – Specialist elective surgery at King's is 14% of elective income, assume activity is proportional to this. Guys reported 38% of inpatient elective work as specialist, St. Thomas' reported 50% as specialist Complex procedures identified by clinicians as unsafe for an elective centre – U19 activity – U19s operated on by a non-paediatric surgeon assumed to remain at original sites – Patients rated as ASA4 and above – assumed to remain at original sites All remaining inpatient elective activity, less day case shift described below, is considered suitable for the elective centre
Daycase elective surgery	100% of current daycase activity remains at site of origin Assumed a shift in line with BADS recommendations from inpatient to day case activity per chapter – average of 8% across all chapters Shifted inpatient to day activity also remains at site of origin
Outpatient activity	85% of outpatient activity is assumed to remain on Lewisham site 100% of non-paediatric outpatient activity assumed to remain on QMS site

Figure 32: Financial assumptions for service change (3/3)

	Current assumption
Capex assumptions assumptions	General bed assumption (does not apply to Lewisham): Capital for first 62 beds at £225k per bed, beds above 162 at £1.2m per bed QEH have a £225k cost if built inside PFI Fixed costs are 12.5% of capital investment – Depreciation over 20 years (5%) – PDC (3.5%) – Rates and other estate costs (4%) Theatres £2m per theatre
Assumptions on 'fixed cost'[1] savings and additions	For Lewisham: – See figures showing detailed assumptions and calculation for Lewisham For QMS: – Before reconfiguration, reduce PDC and depreciation proportionately with reduction in net book value after disposing of two ends of the site – From reconfiguration, assumes all income and costs transfers to new organisation New fixed costs are 12.5% of capital investment – Depreciation over 20 years (5%) – PDC (3.5%) – Rates and other estate costs (4%)
Cost by site to meet new service standards at emergency sites	£3m for Lewisham £4m for SLHT

1 'Fixed costs' defined as establishment, premises & fixed plant, PDC, depreciation, PFI and other non-operating costs

Figure 33: Maternity option 1: 4 obstetric-led and co-located midwife-led units

Services provided	Obstetric delivery services with co-located midwifery-led services provided at StT, KCH, PRUH and QEH Antenatal and postnatal care provided at StT, KCH, PRUH, QEH and LEW (and/ or in the community) Each of the 4 obstetric providers to deliver antenatal and postnatal outreach clinics at LEW (and/ or in the community)
Midwifery staffing	1:30 midwife to birth ratio, as recommended by London clinical quality standards Supervision and specialist midwifery services in place at each site to support the services, as recommended by London clinical quality standards Community midwifery to support home births
Obstetric staffing	Consultant presence at 168 hours a week (24/7) on the all labour wards, as recommended by London clinical quality standards Out-of-hours consultant supported by a 3-tier medical rota (resident SHO, Registrar and Speciality Dr)
Anaesthetic staffing	10 consultant PAs/ sessions a week, as recommended by London clinical quality standards 24/7 access to a supervising consultant obstetric anaesthetist, as recommended by London clinical quality standards Separate consultant anaesthetist for elective section lists, as recommended by London clinical quality standards
Critical care	24/7 immediate availability and co-location of critical care levels 2 and 3 – full ICU units provided on the same sites as 24/7 acute emergency admitting hospitals
Other support services	As per the London Health Programmes' Quality and Safety Programme inter-dependency framework: - 24/7 immediate availability and co-location of anaesthetics; acute medical opinion/ assessment; adult critical care (levels 2 and 3); neonatal care; haematology/ transfusion/ blood bank; emergency imaging and reporting; acute pathology

Figure 34: Maternity option 1b: 4 obstetric-led units and 5 midwife-led units [recommended option]

Services provided	Obstetric delivery services with co-located midwifery-led services provided at StT, KCH, PRU and QEH: midwife-led unit at Lewisham Antenatal and postnatal care provided at StT, KCH, PRU, QEH and LEW (and/ or in the community) Each of the 4 obstetric providers to deliver antenatal and postnatal outreach clinics at LEW (and/ or in the community)
Midwifery staffing	1:30 midwife to birth ratio, as recommended by London clinical quality standards Supervision and specialist midwifery services in place at each site to support the services, as recommended by London clinical quality standards Community midwifery to support home births
Obstetric staffing	Consultant presence at 168 hours a week (24/7) on the all labour wards, as recommended by London clinical quality standards Out-of-hours consultant supported by a 3-tier medical rota (resident SHO, Registrar and Speciality Dr)
Anaesthetic staffing	10 consultant PAs/ sessions a week, as recommended by London clinical quality standards 24/7 access to a supervising consultant obstetric anaesthetist, as recommended by London clinical quality standards Separate consultant anaesthetist for elective section lists, as recommended by London clinical quality standards
Critical care	24/7 immediate availability and co-location of critical care levels 2 and 3 – full ICU units provided on the same sites as 24/7 acute emergency admitting hospitals
Other support services	As per the London Health Programmes' Quality and Safety Programme inter-dependency framework: - 24/7 immediate availability and co-location of anaesthetics; acute medical opinion/ assessment; adult critical care (levels 2 and 3); neonatal care; haematology/ transfusion/ blood bank; emergency imaging and reporting; acute pathology

Figure 35: Maternity option 2: 5 obstetric-led and co-located midwife-led units

Services provided	Maternity delivery services provided at StT, KCH, PRU, QEH, LEW* * Maternity services provided as a single service within a new Lewisham - Greenwich organisation, operating on two sites, with Lewisham providing an obstetric unit and co-located midwifery-led birthing unit, not co-located with a 24/7 acute emergency admitting hospital. Doctors in training posts supported by rotation across LEW and QEH. Service will be supported by a neo-natal unit on both sites (LEW and QEH). Antenatal and postnatal care provided at all five sites (and/ or in the community)
Midwifery staffing	1:30 midwife to birth ratio as recommended by London clinical quality standards Supervision and specialist midwifery services in place within at each site to support the services as recommended by London clinical quality standards
Obstetric staffing	Consultant presence at 168 hours a week (24/7) on the labour wards (incl. both LEW and QEH), as recommended by London clinical quality standards Out-of-hours consultant supported by a 3-tier medical rota (resident SHO, Registrar and Speciality Dr)
Anaesthetic staffing	10 consultant PAs/ sessions a week, as recommended by London clinical quality standards 24/7 access to a supervising consultant obstetric anaesthetist, as recommended by London clinical quality standards Separate consultant anaesthetist for elective section lists, as recommended by London clinical quality standards
Critical care	24/7 access to critical care levels 2 and 3 – StT, KCH, PRU and QEH LEW – access to level 2 critical care on site (part of elective centre model), with ability to provide short term level 3 care and supported transfer to QEH for longer term level 3 care. Obstetricians/obstetric anaesthetists on delivery unit provide specialist support to critical care unit.
Other support services	As per the London Health Programmes' Quality and Safety Programme inter-dependency framework LEW specific: - Level 2 neonatal services at LEW with full consultant neonatologist rota - Physician support: in-hours – physicians in elective centre; out-of-hours – physician on-call - Surgical support – provided by surgeon(s) on-call for the elective centre - Emergency imaging and reporting, acute pathology, haematology/transfusion/blood bank (24/7, immediate availability) - Pharmacy and other clinical support services will service both elective centre and maternity

Figure 36: Financial assumptions for maternity options

Summary of assumptions	
Activity	Number of births consistent across all options, dispersed based agreed dispersal model
Income	Consistent across all options. Income is set by number of births
Costs before adjustments	As developed in provider baseline for recommendation 5 analysis
Increase in fixed costs (4-sites)	Additional fixed costs at other sites @ 12.5% of additional capex to increase capacity
Critical care	Critical care provided by elective centre level 2 critical care unit, supported by obstetric consultants and anesthetists in the delivery suite
Additional obstetrics costs	Additional consultants and junior doctors required to meet 168hr standard across all sites. Assumptions: 21 consultants required plus 1 junior doctor per consultant. 2015/16 baseline consultants based on all obstetrics consultant costs divided by per consultant cost £200k, same approach for juniors
Additional neonatal costs	No additional neo-natal costs envisaged, over those in the baseline 5-site financial model on the understanding that all hospitals have neo-natal units meeting the London standards
Capital receipts	Full NBV of birth centre
Not included	
Potential additional workforce cost for 4-sites	Extra workforce cost to deliver hub and spoke model across 4 sites raised in workshops

Figure 37: Midwife-led unit assumptions[1]

	Assumptions
Births	21% of Lewisham births are currently at its co-located MLU Assume half of these births would occur at the future MLU (when it is no longer co-located with an obstetric unit) No other attendances and admissions at Lewisham
Income	Normal delivery, no complications tariff, £1,506 for 2012/13; tariff deflator (-1/3%, -1.3%, -0.9%) and MFF (21.25%) applied, giving income per birth £1,762
Variable costs	Delivery cost/birth £218, post-natal costs/birth £127, transfer costs and procedures/birth £86, based on NIHR, birthplace cost effectiveness analysis CNST cost per birth £800
Semi-variable costs	1 x band 7 midwife, 1 x band 6 midwife, 1 x band 2 HCA, 24 x 7, requires 11.7 WTE midwives and 5.8 WTE HCAs – based on Maidstone MLU 1.5 WTE band 3 admin staff Additional overheads at 15% of pay
Fixed costs	6% of current maternity floor space required for MLU (3 beds vs. 49) Current size 5,700 m2, future size 350 m2 Value £5000 per m2, annual cost 12.5%
Capital receipts	Size as for fixed costs estimate Value at £500 per m2

1 Outpatients for births dispersed from Lewisham continue at Lewisham, with income and costs incurred accordingly (no change to Phase 1 model)

Figure 38: Approach to modelling financials for midwife-led unit

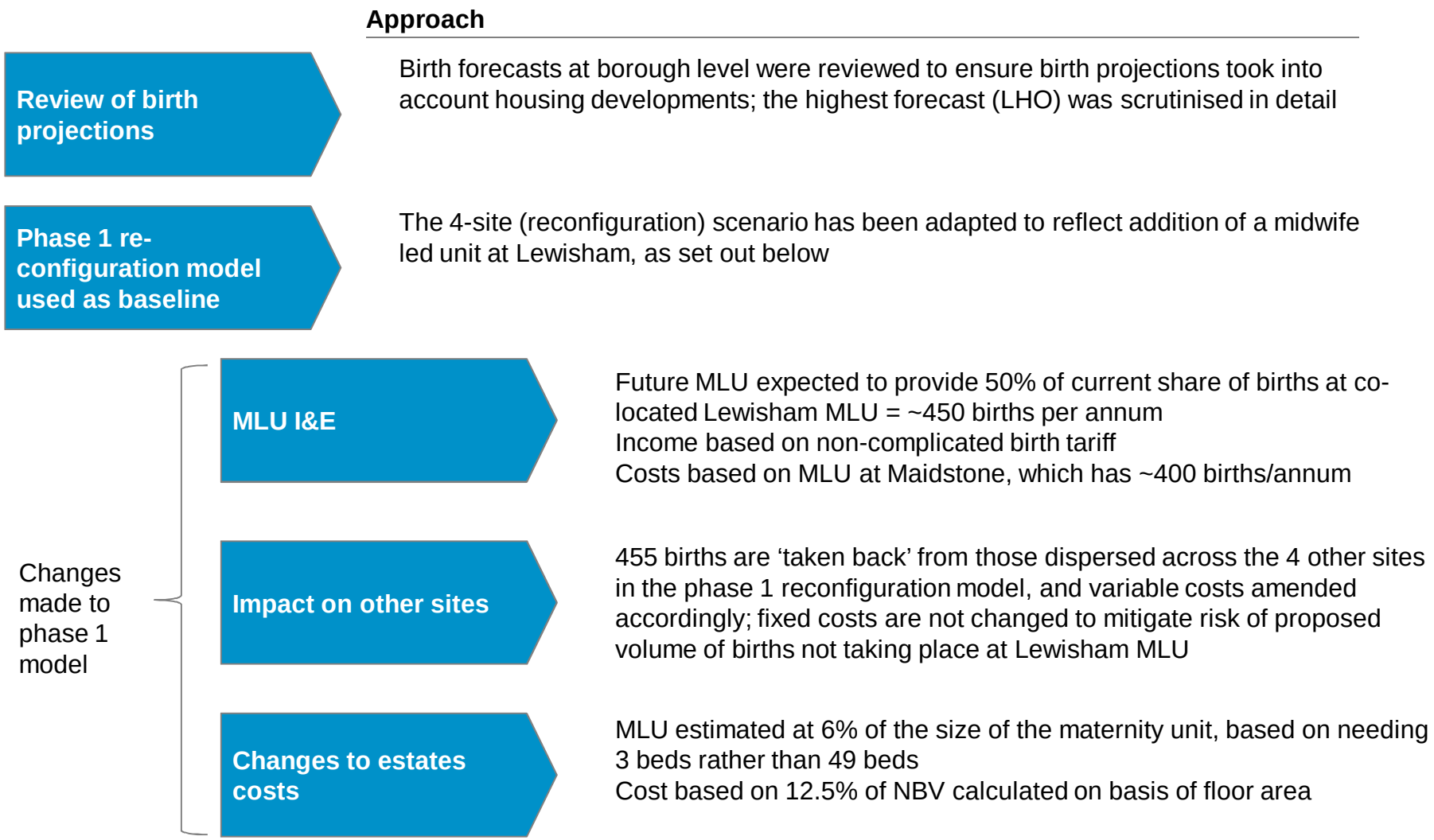


Figure 39: Approach to modelling financials for maternity options

	Approach	Primary insights
Phase 1 baseline 'do nothing' and re-configuration models	The baseline ("do nothing") 5-site scenario and 4-site (reconfiguration) scenario provided inputs to the model for activity, income and costs	The 5-site model costs ~£1.5m more per annum, before adding in critical care and additional consultant costs
Review of birth projections	Birth forecasts at borough level were reviewed to ensure birth projections took into account housing developments; the highest forecast (LHO) was scrutinised in detail	LHO forecast overestimates volume of births in 2011/12 vs. actuals: decision taken to continue to use phase 1 projections, which do take into account housing
Estimate of critical care costs	London standards for critical care reviewed to establish detail of requirements at Lewisham under 5-site model; proposal discussed with CAG and agreed by nominated clinicians	2-4 bed level 2 critical care unit at Lewisham estimated to cost ~£2m
Estimate additional consultant costs	Estimated number and cost of additional obstetric consultants and junior doctors needed for 4-site model and 5-site model to meet 168hr requirement	20 more consultants obstetricians needed to meet standard across 4-sites; 40 more if 5-sites

Figure 40: Financials for the proposed midwife-led unit

Lewisham MLU I&E	Scenario 2 2015/16
Activity	
Births	455
Bed days	114
Beds	3
Financials	
Income	802
Costs	
Variable	560
Semi-variable	1,005
Total variable + semi-variable costs	1,565
Operating Margin	**-763**
Fixed costs	86
Net income	**-849**

Variable costs include CNST payment £800/birth

SOURCE: Phase 2, MLU model

Financial implications of the TSA recommendations (4 of 5)

Recommendation 5 - Elective care

18. Recommendation 5 proposes that an elective centre be developed for south east London to provide non-complex inpatient cases. Details on how the proposal to establish a non-complex inpatient elective centre at University Hospital Lewisham was agreed are described in chapter 5 of the final report and appendix E.

19. Core to the approach was to calculate the activity appropriate for the elective centre, and the impact of providing that activity on a single site. Figure 41 describes the approach taken to calculating the activity to be performed at the elective centre and figure 42 outlines the assumptions used in the analysis. Alongside this, a financial analysis of the potential options for location of the centre identified that maximising the use of estate, and specifically its PFI building, would be the most efficient way of delivering an elective centre in south east London. Figure 43 indicates where the activity at the elective centre would originate from in 2015/16.

Estate implications

20. Delivering change of this scale will require investment in the buildings and estate, to ensure the right services are available in the right place. Figure 44 describes the overall capital investment required to support the implementation of this recommendation.

21. Figure 45 sets out how the estate at University Hospital Lewisham will be used in the future if this recommendation is implemented. Figure 46 provides more detail on the assumptions for the use of this estate. These changes assume fixed costs saving at the University Hospital Lewisham site of £22.6m (gross before re-investment), or £12m excluding depreciation, public dividend capital (PDC) and interest. The TSA's proposals would see an allowance for a further £7m of similar annual fixed costs to reflect the investment in the site. The TSA's proposals envisage around 60% of the total estate (gross internal floor area) of the University Hospital Lewisham site disposed of and a net reduction in fixed costs of around 34%, which is described in figure 47.

Figure 41: Structured approach to calculating activity appropriate for the elective centre and the impact on other south east London sites

	Approach
Established parameters for elective centre	Initial parameters for analysis established, such as; SEL non-complex activity not delivered at Guys expected to move to elective centre, day cases to remain at current sites, facilities such as HDU required, children not to be treated (due to need for special equipment and staffing)
List of procedures suitable for elective centre compiled	CAG reviewed a list of elective inpatient procedures to identify as suitable/ unsuitable for an elective centre Validated by medical director from SWL
Removal of under-19s	Proportion of IP elective surgery for which patients are under 19 calculated and removed from total volume of activity against 'suitable procedures'
Removal of activity for complex patients, ASA4+	Estimated split of elective in-patients by ASA categorisation, 1/2/3/4+ In discussion with clinicians, agreed assumption 100% of ASA1-3 patients could be treated at the elective centre, but no ASA4+ Combined the two assumptions to reduce activity level by estimated amount of ASA4+ activity unsuitable for elective centre
Account for expected shift to daycase activity	Estimate shift from inpatient to daycase applied to the activity allocated to come to the elective centre after the removal of the categories above (rationale that the suitable procedures and non-complex patients are most likely candidates for day case surgery in future) Average of 8% shift across chapters applied, based on difference between current inpatient procedures and BADS recommendations
Shift in applied to activity in phase 1 model	Shift in activity by site, as a proportion of total activity, applied to the numbers in the phase1 model to ensure consistency. Calculations provide outputs for activity shitting to the elective centre and the equivalent inflows/outflows at other sites in SEL

Figure 42: Assumptions for elective centre calculations

	Assumptions
Removal of U19 activity	The elective centre will not do any procedures on U19s, even if non-paediatric surgeon is performing the procedure U19 activity calculated using HES 2011/12 data at procedure level Lewisham's existing U19 activity reallocated across SEL according to distribution model used in Phase I
Removal of unsuitable activity	It will not be clinically safe to do some procedures at a 'cold' site Unsuitable procedures identified by Trust clinicians identified by CAG, and verified by SWL medical director
Removal of daycase shift	There will be a structural shift in elective activity from inpatient to daycase in the next 5 years Shift required to move SEL in line with BADS recommendations calculated at a chapter level, based on current daycase activity versus BADS recommended daycase activity Average shift across chapters: 8% No assumption made about further medical advances
Removal of ASA4+ patients	It will not be clinically safe to perform procedures on high risk patients at the elective centre, regardless of how simple the procedure Only patients rated as ASA4 and above are too high risk to be operated on at the centre External clinical panel estimated 2% of patients to be rated as ASA4+
Movement of semi-variable costs	When semi-variable costs are consolidated onto a site, efficiency gains are possible A productivity assumption of 10% is applied to all SV costs that move i.e. only 90% of SV costs move to the new site, 10% of SV costs are removed

SOURCE: Phase II reconfiguration model

Figure 43: Activity at Lewisham elective centre 2015/16 with site of origin

	Total IP elective activity in system	Phase I			Phase II[1]				
		Removal of 'specialist' activity	Removal of 'complex' activity	Phase I total	Removal of U19 activity	Removal of unsuitable activity	Removal of daycase shift	Removal of ASA4+ patients	Phase II total
Lewisham	**1,717**	-	-257	**1,459**	-115	-275	-109	-24	**1,193**
PRUH	**4,580**	-	-687	**3,893**	-120	-283	-189	-80	**3,908**
QEH	**2,852**	-	-428	**2,424**	-111	-237	-113	-48	**2,343**
GSTT	**27,189**	-11,621	-2,335	**13,233**	-2,287	-6,611	-1,261	-341	**16,691**
KCH	**9,054**	-1,268	-1,168	**6,618**	-608	-3,256	-603	-92	**4,495**
QMS	**2,004**	-	-	**2,004**	-37	-	-89	-	**1,878**
		Total suitable activity		**29,632**			Total suitable activity		**30,508**
		Less Guy's activity		**8,717**			Less Guy's activity		**11,271**
		Total elective centre activity		**20,914**			**Total elective centre activity**		**19,237**

1 Numbers removed from Total IP elective activity in system
SOURCE: SLHT Phase II elective model

Figure 44: Based on requirements for 2015/16 £161.6m of capital expenditure is needed to build new capacity in this option

	Capex at site £m	Supporting assumptions
LEW	55.9	See figure 46
PRUH	24.2	Estimated cost of developing the Green Parks unit to support maternity and emergency care developments No costs for bed capacity growth
QEH	14.0	1,300m^2 new space at £5,000/m^2=£6.8m capex IT developments to assist integration
STT	6.9	Trust estimation of capital costs for development of emergency care.
GUY	0	All bed, theatres and space requirements can be accommodated within existing configuration
KCH	34.5	Estimated cost of developing maternity and critical care No requirement for additional beds
QMS	26.1	Development of Mental Health centre of Excellence Works
Non-SEL	0	Move 23 beds outside SEL to Croydon Assume all bed, theatres and space requirements can be accommodated within existing configuration
Total	**161.6**	

SOURCE: TSA forecasts

Figure 45: Estate consolidation at University Hospital Lewisham

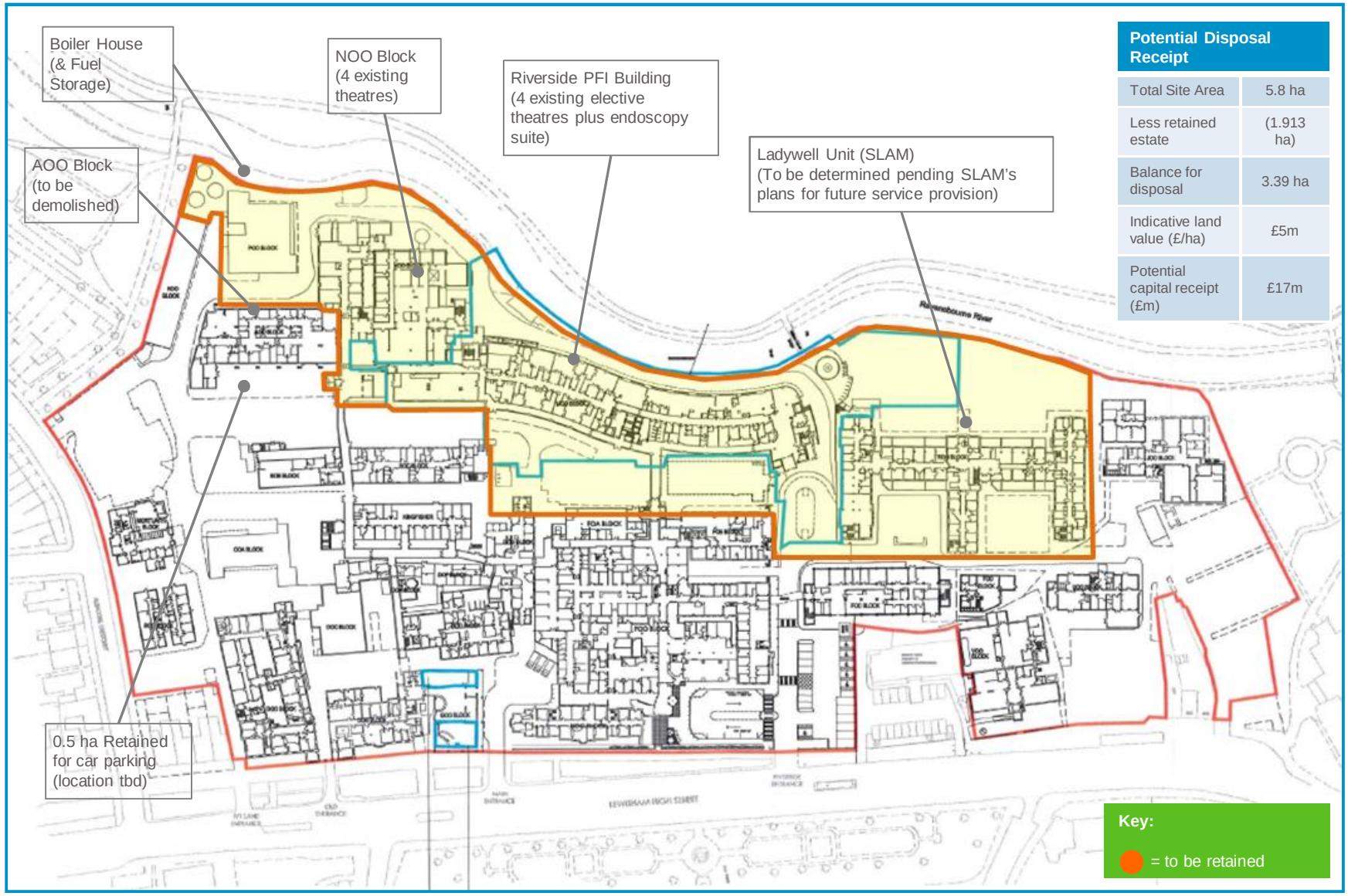


Figure 46: Details of Lewisham estates option

Capex estimate:

11,687 @ 4,000 £/sq m = £46.8m

Site infrastructure = £3m

Demolition of AOO block = £5m

Modular theatres = £1.1m

Total = £55.9m

Changes under Reconfiguration (building works in orange)

Floor	Riverside Building		Ravensbourne	
	GIA[1] (sq m)	Use	GIA[1] (sq m)	Use
7		Plant		
6	2,974	3 x 24 bed wards		
5	2,974	3 x 24 bed wards		
4	1,867	Outpatients + clinical admin (1)		
3	2,974	3 x 24 bed wards	1,100	4 theatres
2	2,400	6 theatres	1,100	Admin space (2)
1	2,400	6 theatres	1,050	Endoscopy suite
Ground	2,870	UCC + Radiology	1,200	Kitchens
	800	2 modular day theatres immediately adjacent to Riverside		
	Total works = 11,687 sq m + modular theatres		Total works = 2,150 sq m	

Notes:
1) 24 consulting rooms, 50 workstations @ 12 sq m per workstation
2) 91 workstations @ 12 sq m per workstation
3) Excludes any change or break costs associated with the PFI contract
4) Demolition of AOO block will require a detailed feasibility study. The cost adopted for demolition assumes worst case scenario.
5) Provision and operation of recovery space will be key to the success of elective theatres

1 Gross Internal Floor Area

SOURCE: TSA assessment

Figure 47: Estimated gross savings of £22.6m at University Hospital Lewisham due to asset disposal (does not include new costs due to investment in estate)

'Fixed costs'	Forecast cost 15/16, £k	Assumption	% of cost retained	Retained fixed cost, £k
Establishment	£2,344	% of income retained	67.0%	£1,570
Premises	£17,286	% of GIA[1] (including PFI) retained	35.1%	£6,067
PDC	£4,459	% of non-PFI NBV (incl. land) retained	16.0%	£715
Depreciation (non-PFI)	£7,860	% of non-PFI NBV (excl. land) retained	12.8%	£1,003
Depreciation (PFI)	£1,827	All retained	100.0%	£1,827
PFI Operating cost	£1,807	All retained	100.0%	£1,807
PFI Interest	£4,607	All retained	100.0%	£4,607
Other operating expense	£637	All retained	100.0%	£637

- £18,233k total fixed cost for retained estate
- £22,594k savings compared to current fixed costs

1 Gross internal floor area (GIA)

SOURCE: Lewisham estate data, TSA Financial model

Financial implications of the TSA recommendations (5 of 5)

Recommendation 6

22. Recommendation 6 proposes a set of organisational solutions that will support implementation of the rest of the TSA recommendations and therefore secure sustainable services, the details of which are provided in chapter 6 of the report and appendix F. Preliminary work has indicated that the organisational changes will provide further benefit of merger synergies of around £7.7m in the cost of services, compared with how they are currently provided by South London Healthcare NHS Trust.

Non-recurrent support for implementation

23. Delivering these benefits will require transitional support as new arrangements are established. In addition to providing run-rate support to be agreed with the Department of Health (estimated £55m) during the period of transition, there will be non-recurrent costs to support in implementation of:
    - Recommendation 1: costs of implementing further productivity improvements (£3m)
    - Recommendation 2: costs of supporting the redevelopment of the Queen Mary's Hospital site and costs of transferring activity off the site (£6.7m)
    - Recommendation 5: costs of service change at Princess Royal University Hospital, Queen Elizabeth Hospital, Lewisham Hospital, St Thomas' Hospital and King's College Hospital, including all implementation costs (£40.8m)
    - Recommendation 6: costs of supporting the development of new organisations and the implementation of new and appropriate management structures and cultures (£45.5m)

24. These non-recurrent costs are set out in figure 48.

Figure 48: Non-recurrent costs of implementation recommendations 1, 2, 5 and 6

	2013-14				2014-15				2015-16				Total			
	Pru £m	QEH/ LEW £m	QMS £m	Total £m	Pru £m	QEH/ LEW £m	QMS £m	Total £m	Pru £m	QEH/ LEW £m	QMS £m	Total £m	Pru £m	QEH/ LEW £m	QMS £m	Total £m
Recommendation 1																
Future Productivity	0.5	0.3	0.2	1.0	0.5	0.3	0.2	1.0	0.5	0.3	0.2	1.0	1.5	0.9	0.6	3.0
Recommendation 2																
QMS Site Change	0.0	0.0	6.7	6.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.7	6.7
Recommendation 5																
Service Redesign	0.0	0.0	0.0	0.0	0.0	2.5	0.0	2.5	1.7	36.6	0.0	38.3	1.7	39.1	0.0	40.8
Recommendation 6																
Organisational Solutions	17.5	8.0	0.6	26.1	8.8	5.5	0.6	14.9	2.0	2.5	0.0	4.5	28.3	16.0	1.2	45.5
Total	*18.0*	*8.3*	*7.5*	*33.8*	*9.3*	*8.3*	*0.8*	*18.4*	*4.2*	*39.4*	*0.2*	*43.8*	*31.5*	*56.0*	*8.5*	*96.0*

Current financial position within South London Healthcare NHS Trust

Commissioning intentions for south east London

Financial projections in a “do nothing” scenario

Financial implications of the TSA recommendations

Evaluation of estate opportunities

Overall financial evaluations

Evaluation of estate opportunities (1 of 2)

1. As part of the initial assessment of South London Healthcare NHS Trust there was a detailed evaluation of its current estate usage. Alongside this the use of other estate across south east London was considered, both for hospitals and for community settings.

2. Figure 49 describes the key characteristics of the main hospital sites across south east London. As described as part of recommendation 5, to support the implementation of service changes, there will need to be capital investment across the hospitals in south east London (figure 50). Costs for developing this capacity have been calculated using benchmarked figures for space requirements and development costs, provided in figures 51 and 52.

Figure 49: Main hospital sites in south east London

Each site has unique characteristics in terms of tenure, current usage, age of buildings etc. Some of the key defining characteristics are listed below:

Lewisham

- Town centre site
- PFI building at rear of site
- Close neighbours with a stake in the future of the site (including SLAM and the local authority)

PRU

- Major PFI hospital
- Day surgery unit in freehold ownership of SLHT
- Mental health facility within PFI demise (Green Parks House)

QEH

- PFI refurbished hospital
- Two plots of under-utilised estate within the PFI demise

St Thomas'

- Central London site
- Major and specialist services (including children's hospital which has covenant issues as it was funded by the Trust's charity)

Guys

- Specialist hospital site
- Central London location
- High density occupation (high-rise)

KCH

- Major hospital site with focus on increasing acuity of treatment
- PFI assets on site
- Limited scope for expansion at land-locked site

QMS

- Under-utilised site in the green belt
- A series of land sales and other occupations have already been identified
- PFI intermediate care and day surgery facility on site

Figure 50: Summary of capital costs for implementation

Capital						
						Total
	Pru	QEH/ LEW	QMS	Kings	GSTT	Total
	£m	£m	£m	£m	£m	£m
Elective Centre	0	55.9	0	0	0	55.9
Kings Emergency and Maternity	0	0	0	34.5	0	34.5
A&E and Maternity	0	6.8	0	0	0	6.8
QM Mental Health	0	0	21.1	0	0	21.1
PRU	24.2	0	0	0	0	24.2
QMS Sundry	0	0	5.0	0	0	5.0
QEH / LEW IT	0	7.2	0	0	0	7.2
GSTT	0	0	0	0	6.9	6.9
Total Capital Costs	*24.2*	*69.9*	*26.1*	*34.5*	*6.9*	*161.6*

Capital Receipts					
					Total
	Pru	QEH/ LEW	QMS		Total
	£m	£m	£m		£m
Asset Disposal LEW	0	-17.0	0		-17.0
Sale of Orpington	-8.8	0	0		-8.8
Kent Women's Wing	0	0	-3.8		-3.8
Hyde Housing	0	0	-1.2		-1.2
Total Capital Receipts	*-8.8*	*-17*	*-5*		*-30.8*
Net Capital Spend					***130.8***

Gross Capital Spend by Type	Total
	£m
Maternity	36.0
Emergency	37.0
Mental Health	21.1
Elective Centre	55.9
Other	11.6
Total	*161.6*

Figure 51: Capital Investment – Unit Rates

Capital investment estimates were based on rates obtained from benchmarking. Recently completed schemes in the local health economy, nationally and DH guidance (in the form of HPCGs) were used as sources.

Capex Assumptions Adopted (1) (2)		
Use	**(sqm)**	**(£/sqm)**
Theatres	400	5,000
O/P	10	4,000
Maternity	n/a	5,000
A&E	n/a	5,000
Bed	45	5,000
Beds	**<=162 #**	**225,000 £/#**
	>162 #	**1,200,000 £/#**

Recently completed schemes		
Lewisham	**(sq m)**	**(£/sq m)**
Kingfisher	1,680	1,361 (8)
Dalton (suite 1)	662	579 (9)
Dalton (suite 2)	613	135 (9)
International suite	243	1,868 (9)
Nockolds House	900	500 (9)
BOC	1,592	1,146 (9)
Urgent Care Centre	2,636	4,493 (8)

Marginal Cost of Adding Capacity (6)			SLHT	SLHT	OXLEAS	OXLEAS	OXLEAS	Lewisham	GST	
			Princess Royal University Hospital	**Bedonwell Clinic**	**Goldie Leigh**	**Memorial**	**Green Parks (PRUH)**	**Lewisham Hospital**	**St Thomas's Hospital (5)**	**Average cost**
Capacity within Estate	No. beds	(#)	40	112	10		12	129	16 (4)	
	Cost / bed	£k	50	36	100		83	40		44
New Capacity	Cost / bed	£k			200	200		200 (3)	0	200

Reprovision of a Major Hospital (820 beds) (7)			
Estimate for St Thomas'			
Number of beds	(#)	820	
Area per bed	(GIA sq m)	175	StT GIA=159,000 (inc 16,500 for KCL R&T) with 912 beds
New build costs	(£ per sqm)	6,750	HPCG normal general hospital
Blended cost	(£ per sqm)	6,000	Assuming some beds in refurb space (3,100-6,000 £/sqm)
Floor area required	(GIA sqm)	143,500	
Capex to reprovide StT	(£m)	861	
Cost per bed	(£ per #)	1,050,000	
Southmead Hospital PFI. North Bristol			
Number of beds	(#)	820	70% single rooms
Area per bed	(GIA sq m)	139	GIA = 114,000 sqm
New build costs	(£ per sqm)	3,772	Excluding equipment, VAT, fees etc
Including on-costs	(£ per sqm)	6,427	equipment=15%, fees=15%, planning contingency=12%, VAT=20%,
Capex to reprovide StT	(£m)	922	
Cost per bed	(£ per #)	1,124,789	

Notes / Assumptions

1)	If additional beds<=162, £225k per bed; >162 £1.2m per bed
2)	Additional theatre 400 sqm, O/P room 10 sqm
3)	Assuming a new 32 bed ward inc. on costs and support facilities
4)	Old ward ("Somerset") can potentially be brought back into service. The cost is unknown and would impact on the Estates Strategy implementation.
5)	GSTT – Neither Guy's or St Thomas' Hospitals has capacity for additional new space
6)	Source: Trusts
7)	Source: GST analysis by Programme Director - Estate Development received by email 5th October 2012 1839
8)	New Build
9)	Refurbishment

Figure 52: Validation of area per bed figure

(1) Hospital Level - Cost Model Study for an Acute Hospital

40,000 sq m for 480 beds = 83.3 sq m per bed

(2) Ward Level - Cost Model Study for an Acute Hospital

24 bed ward, 50% single bed, ward + associated utilities, patient support, offices & admin and storage, 908.68 sq m = 37.86 sq m per bed

24 bed ward, 100% single bed, ward + associated utilities, patient support, offices & admin and storage, 973.44 sq m = 40.56 sq m per bed

Premises Cost Guides: Elemental cost model based on HBN 04-01 Adult In-patient facilities

Clinical space only 2,571 sq m, 48 beds = 53.56 sq m per bed

Overall space 2,789 sq m, 48 beds = 58 sq m per bed

Evaluation of estate opportunities (2 of 2)

3. The current use of community estate across south east London has also considered, in order to challenge and identify additional opportunities within the community estate to generate savings. Data on community estate was collected and cleansed to identify potential opportunities for consolidation and rationalisation. The summary of the data analysis is in figure 53.

4. The community estate within two miles of each acute site was also identified to test the scope for either expansion (to receive services that might be displaced from the hospital) or to consolidate and incorporate community services into the hospital (figure 54). This information was then validated with a number of site visits and meetings with estates leads and the Chief Officers of Bromley, Bexley, Greenwich and Lewisham CCGs.

5. Following this, the estates advisors agreed a number of conclusions about the use of community estate:
   - Most of the larger community buildings are LIFT schemes and appear under-utilised and capable of taking more activity, providing scope to consolidate sites and rationalise the community estate.
   - LIFT schemes are perceived to be expensive compared with cheaper, poorer quality accommodation, which is preferred by budget holders.
   - Under-utilised accommodation may be fragmented around individual buildings, requiring re-organisation and consolidation.
   - Of the 141 sites identified in the community estate portfolio, 59 are held freehold and have the potential to release capital on disposal. The remaining sites are held leasehold or on licences and are unlikely to generate a receipt on disposal. Nearly half of all freehold sites are less than 1,000m^2 GIA, which is typical of the whole portfolio.

6. Maps showing the location of each acute site in relation to the community sites are included for each Borough in figures 55 to 60.

Figure 53: Community estate - data analysis

Total Portfolio (excluding Learning Disabilities and Mental Health sites)

Floorspace GIA (sq m)	Total Properties	Total Floorspace GIA (sqm)	Av. Floorspace GIA (sqm)	Total Site Area (Ha)	Av. Site Area (Sqm)
0 – 1,000	82	34,242	418	7.82 (1)	954
1,001 – 4,000	40	64,116	1,618	18.52 (2)	4,631
>4,001	6	37,746	6,291	4.38 (3)	7,294
GIA not known	13				
Totals	**141**	**149,883 (5)**	**1,063 (4)**	**34.43 (7)**	**2,422 (6)**

Source: TSA data request return forms & SEL cluster return

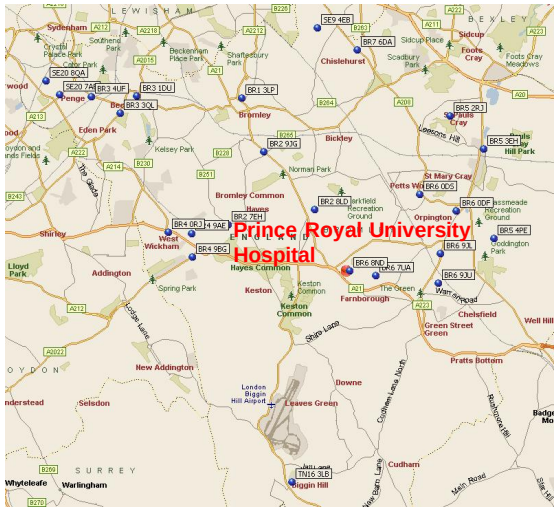
1. Site area data missing for 23 sites. Figure estimated on basis of data for known average site area. Data cleansed of SLAM properties from previously reported figures.
2. Site area data missing for 10 sites. Figure estimated on basis of data for known average site area. Data cleansed of SLAM properties from previously reported figures.
3. Site area data missing for 1 site. Figure estimated on basis of data for known average site area. Includes Dulwich Community Hospital which is 7,472 sqm GIA, 2.78ha site area.
4. Based on known floorspace for 128 sites
5. Figure estimated on basis of data for known average floorspace multiplied by total properties.
6. Based on 94 known site areas.
7. Figure estimated on basis of data for known average site area multiplied by total properties.

Figure 54: Community estate within 2 miles of acute hospitals

QMS	7 sites (4 freehold) All <1,000 sq m Some rationalisation of sites in Chislehurst but minor.
QEH	9 sites (1 freehold) Vanbrugh Centre to close and replace by Heart of Greenwich Some consolidation possible but no capital receipts.
PRU	5 sites (4 freehold) Bassetts Centre and House to be sold - £8-10m (incl. in forecast disposals) Orpington Hospital within 2 miles. No other consolidation.
Lewisham	19 sites (8 freehold) Potential to consolidate Kaleidoscope Centre (4,500 sq m) under-utilised – has capacity Waldron Centre (6,000 sq m) under-utilised – has capacity.
Guy's	20 sites (8 freehold) 2 freehold sites identified for sale (inc. in forecast disposals). Some capacity to consolidate further Bermondsey Centre (1,104 sq m) has capacity but not good quality.
St Thomas'	Overlap with Guys and KCH 18 sites (3 freehold) includes Lower Marsh offices
Kings	28 sites (9 freeholds) Dulwich Hospital – large site 50% vacant – total receipts £20m + Sunshine House, (3,575 sqm) under-utilised has capacity. Scope for some consolidation

Figure 55: Overview of community estate – Bromley

Key Characteristics		
Freehold sites	(#)	17
Leasehold sites	(#)	10
LIFT sites	(#)	1
Total	**(#)**	**28**
Net Book Value	(£m)	50
Premises Costs	(£m pa)	4.25
Identified disposal	(£m)	10.2
Backlog maintenance liability	(£k)	32
2 sites of >1,000 sq m GIA within 2 miles of PRUH		



Potential Opportunities

A number of disposal opportunities already identified including:

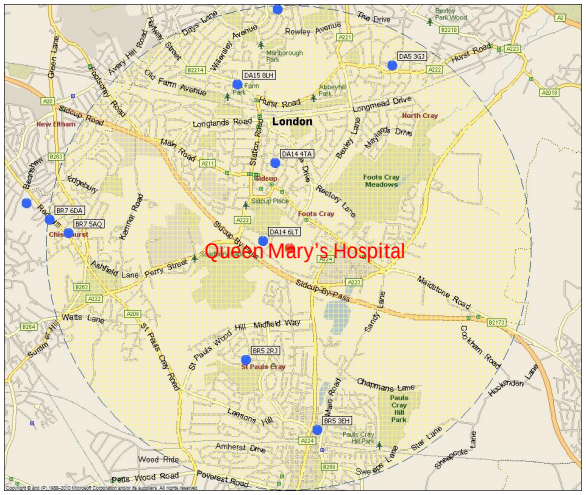
- Bassetts Centre (PCT HQ) c.£8m (NBV)
- Hawes Down Clinic £0.65m (NBV)
- Penge Clinic £0.75m (NBV)
- Beckenham Clinic £0.58m (NBV)

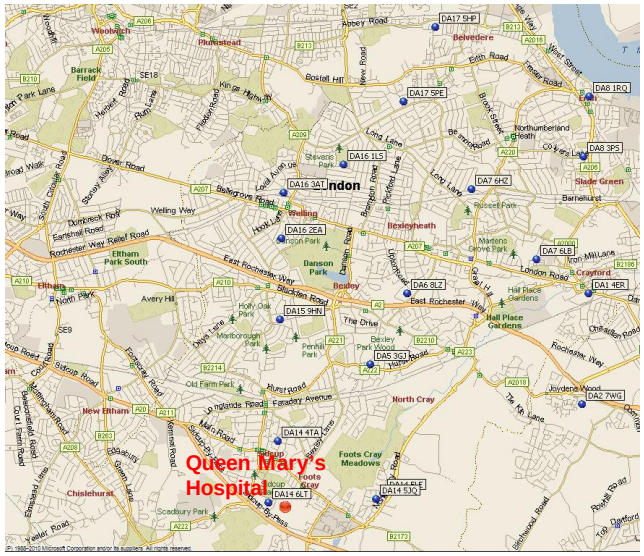
Beckenham Beacon (Lift Co). Potential to reduce SLHT occupation to <20% or vacate entirely.

Orpington Hospital – consulting on closure. Opportunity to move community services into Town Centre.

Figure 56: Overview of community estate – Bexley

Key Characteristics		
Freehold sites	(#)	9
Leasehold sites	(#)	11
LIFT sites	(#)	1
Total	**(#)**	**21**
Net Book Value	(£m)	12
Premises Costs	(£m pa)	1.161
Identified disposal	(£m)	0.6
Backlog maintenance liability	(£m)	0.8
No sites of >1,000 sq m GIA within 2 miles of QMS		





Potential Opportunities

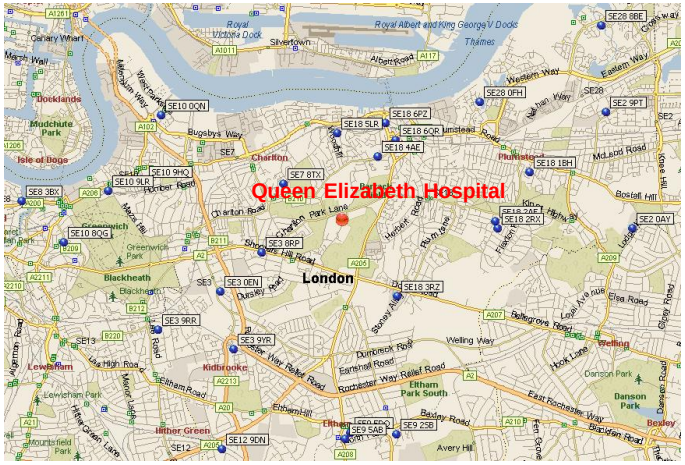
SLHT has withdrawn from Lakeside (LIFT Co) – scope to increase utilisation and local consolidation.

Erith Hospital (Oxleas) has potential for development or consolidation – 1.3 ha. Part PFI. SLHT occupies 1,427 sq m

Bedensfield – vacant site – Potential for GP or disposed of.

Figure 57: Overview of community estate – Greenwich

Key Characteristics		
Freehold sites	(#)	11
Leasehold sites	(#)	13
LIFT sites	(#)	1
Total	**(#)**	**25**
Net Book Value	(£m)	19.217
Premises Costs	(£m pa)	1.44
Identified disposal	(£m)	7
Backlog maintenance liability	(£m)	0.08
6 sites of >1,000 sq m GIA within 2 miles of QEH		



Potential Opportunities

Eltham Hospital development will allow the disposal of the Bevan Unit and reduce bed numbers (18) at QEH.

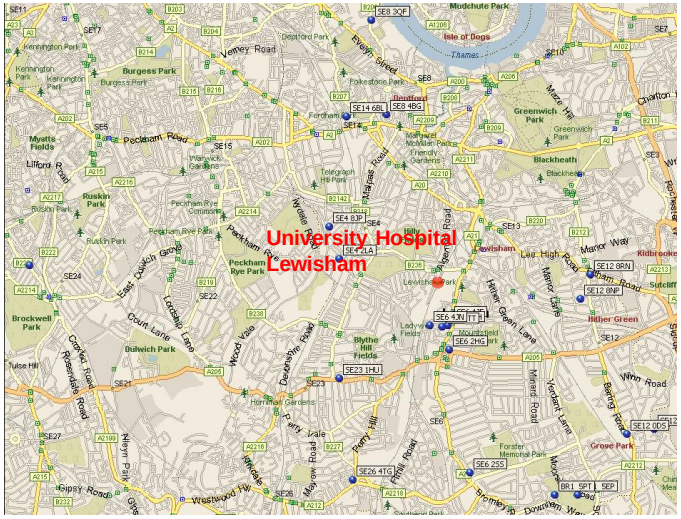
Memorial Hospital (F/H Oxleas) – opportunity for development and could take in-patient beds (92) from QEH (Oxleas House).

Market Street Health Centre and Plumstead Health Centre present and opportunity for rationalisation to improve quality of estate and utilisation.

Potential for consolidation with Bexley around Gallion's Reach / Lakeside

Figure 58: Overview of community estate – Lewisham

Key Characteristics		
Freehold sites	(#)	8
Leasehold sites	(#)	6
LIFT sites	(#)	1
Total	**(#)**	**15**
Net Book Value	(£m)	39.5
Premises Costs	(£m pa)	5.9
Identified disposal	(£)	Nil
Backlog maintenance liability	(£m)	1.8
11 sites of >1,000 sq m GIA within 2 miles of UHL		



Potential Opportunities

Potential opportunities to move Rush e.g. Green Primary Care Centre (GPs) into UHL

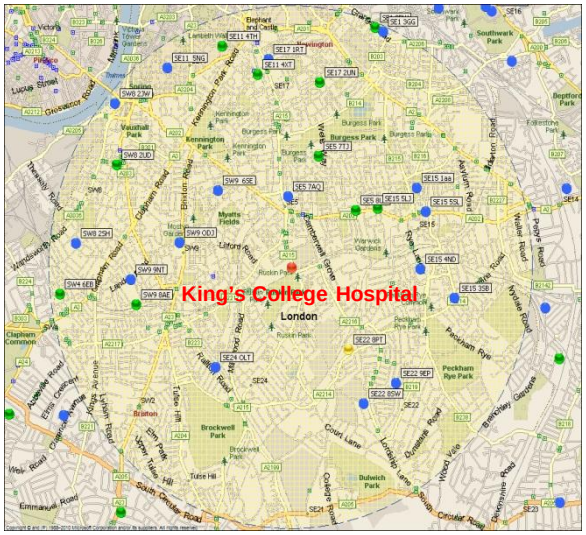
Cantilever House (CCG HQ) may move onto UHL (if space available) L/H with £350K pa premises costs

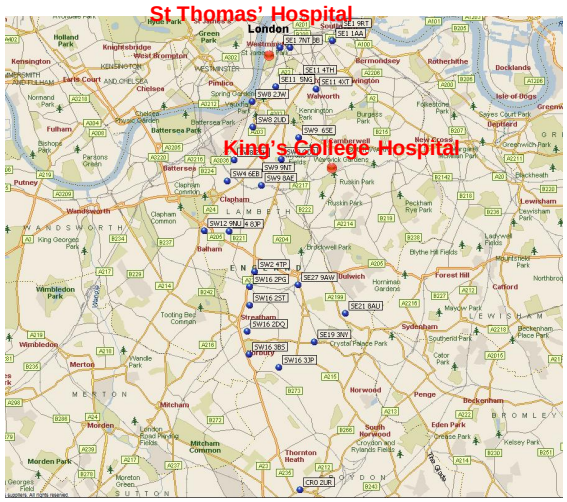
The Waldon Centre – Improved utilisation of activities to allow consolidation and capex savings – requires space utilisation study.

Marvels Lane Clinic – 50% due to be vacated. Opportunity to accommodate the source (Greenwich). Allow disposal of the source.

Figure 59: Overview of community estate – Lambeth

Key Characteristics		
Freehold sites	(#)	6
Leasehold sites	(#)	17
LIFT sites	(#)	3
Total	**(#)**	**26**
Net Book Value	(£m)	46
Premises Costs	(£m pa)	10.5
Identified disposal	(£m)	0.6
Backlog maintenance liability	(£m)	2
6 sites of >1,000 sq m GIA within 2 miles of KCH		





Potential Opportunities

Akerman House development will accommodate 3 GP practices and enable Myatts Field Health Centre and Railton Rd Health Centre to be disposed of.

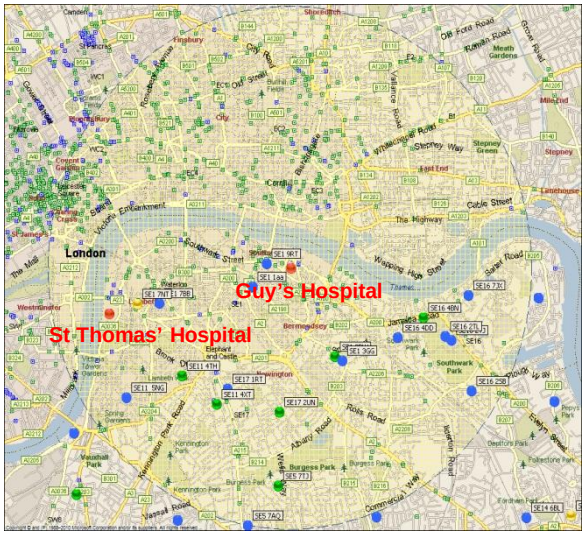
Lower Marsh – office function which is expensive but could be used more efficiently. Potential to relocate function and staff and release to save premises costs.

Wooden Spoon House – Child's Health Centre which is poorly located in the north of the Borough. Relocation to a better location and disposal might generate c.£7.5m of receipts.

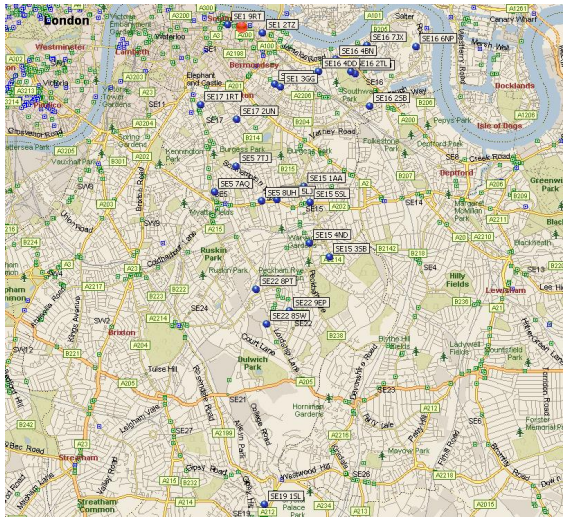
Pulross (ICC), Minnie Kidd House and Lambeth Community Care Centre all have intermediate care beds (78 in total). Some rationalisation is possible to enable a disposal of one or more sites.

Figure 60: Overview of community estate – Southwark

Key Characteristics		
Freehold sites	(#)	8
Leasehold sites	(#)	17
LIFT sites	(#)	1
Total	**(#)**	**26**
Net Book Value	(£m)	45
Premises Costs	(£m pa)	6
Identified disposal	(£m)	2
Backlog maintenance liability	(£m)	2.3
9 sites of >1,000 sq m GIA within 2 miles of Guy's		



Guy's Hospital



Potential Opportunities

Dulwich Hospital presents the biggest opportunity where 50% of the site could be sold following redevelopment. This could generate circa £10m of receipts.

Aylesbury Estate and Elephant & Castle – regeneration presents many opportunities to consolidate.

St Olaves Hospital – 2 sites have been identified for disposal.

Burgess Park – rationalising the 2 leases and surrendering one of them.

Gaumont House office – opportunity to consolidate by relocating services to the site or disposal of the lease.

Current financial position within South London Healthcare NHS Trust

Commissioning intentions for south east London

Financial projections in a “do nothing” scenario

Financial implications of the TSA recommendations

Evaluation of estate opportunities

Overall financial evaluations

Overall financial evaluation

1. In developing the recommendations, the financial implications of the recommendations for each of the hospitals, and for the system as a whole, has been evaluated. Within this, to support the financial evaluation of the merger of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, a detailed due diligence report has been prepared by an independent firm of accountants. This report will remain confidential pending the Secretary of State's decision on the recommendations.

2. Figures 61 – 64 provide the detailed forecast income and expenditure account for each year of the transition[1]. The first year following transition, 2016/17 is also presented. These detailed forecasts reflect the part year impact of some changes in recommendation 5.

3. When considering the overall financial benefit of the TSA recommendation a comparison has been drawn to do the "do nothing" option which would see the south east London health economy receive c.£75m recurrent financial support every year. A net present cost has been calculated based on a 3.5% discount rate for 20, 25 and 30 years (figure 65). The total support required by the south east London health economy is £1,082m, £1,230m and £1329m for the three periods (respectively). After the recommendations have been implemented the net present costs are £636.4 and £664.1 respectively. This cost is driven by the on-going PFI support that will end after 25 years as the contracts are terminated. The total net present cost of the PFI support is £289m (25 and 30 years). The net benefit to the tax payer is therefore £450m over a 20 year period, £566m over 25 years and £664m over 30 years.

1. These detailed forecasts reflect the part year impact of some changes in recommendation 5 and agreed to figure 26, subject to the in year impact of these and minor rounding errors.

Figure 61: Summary financial results for Princess Royal University Hospital

Princess Royal University Hospital Site: Income and Expenditure					
£m unless otherwise stated All amounts shown here are nominal	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**
Protected/Mandatory Clinical Revenue					
Elective	32.1	31.5	32.0	30.6	24.2
Non elective	77.3	77.9	78.4	87.4	95.5
Outpatient	37.4	37.3	37.5	38.0	38.5
A&E	8.2	8.2	8.2	9.1	9.9
Other clinical – Tariff	0.0	0.0	0.0	0.0	0.0
Other clinical – Non Tariff	3.7	3.8	3.9	4.7	5.5
Other block or Cost and Volume contract	0.1	0.1	0.1	0.1	0.1
Other block or Cost and Volume contract	0.0	0.0	0.0	0.0	0.0
Clinical Partnerships providing mandatory services (including S75 agreements)	0.0	0.0	0.0	0.0	0.0
Clinical income for the Secondary Commissioning of mandatory services	0.0	0.0	0.0	0.0	0.0
Other clinical income from mandatory services	10.3	10.4	10.6	11.9	18.4
Total	**169.2**	**169.2**	**170.8**	**181.9**	**192.2**
Non Protected/Non Mandatory Clinical Revenue					
Private patient revenue	2.0	2.4	3.8	4.0	4.1
Other non protected revenue	0.0	0.0	0.0	0.0	0.0
Total	**2.0**	**2.4**	**3.8**	**4.0**	**4.1**
Other Operating Revenue					
Education and Training	6.1	6.4	7.1	8.5	9.7
Research & Development	0.1	0.1	0.1	0.1	0.2
PFI Specific revenue	0.0	0.0	0.0	0.0	0.0
Other Operating Revenue	7.3	18.1	17.1	23.9	22.2
Other Operating revenue, Total	13.5	24.6	24.3	32.5	32.1
Operating Revenue and Income, Total	**184.6**	**196.2**	**199.0**	**218.4**	**228.4**

£m unless otherwise stated All amounts shown here are nominal	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**
Operating Expenses					
Employee Benefit Expenses	(119.2)	(118.3)	(121.1)	(128.1)	(132.8)
Drug expenses	(12.6)	(12.5)	(12.8)	(14.2)	(15.5)
Clinical supplies and services expenses	(12.3)	(12.3)	(12.5)	(13.9)	(15.2)
Shared services expenses	0.0	0.0	0.0	0.0	0.0
For non Ambulance Trusts only – Please specify	0.0	0.0	0.0	0.0	0.0
Other expenses	(20.2)	(18.7)	(14.6)	(14.2)	(14.6)
Secondary Commissioning Expenses	0.0	0.0	0.0	0.0	0.0
PFI operating expenses	(19.7)	(20.3)	(21.0)	(21.7)	(22.5)
Operating Expenses, Total	**(184.0)**	**(182.1)**	**(182.0)**	**(192.2)**	**(200.5)**
Surplus/(Deficit) from operations	**0.6**	**14.2**	**17.0**	**26.2**	**27.9**
Surplus/(Deficit) from operations margin	*0%*	*7%*	*9%*	*12%*	*12%*
Adjustment for donated asset income	0.0	0.0	0.0	0.0	0.0
EBITDA	**0.6**	**14.2**	**17.0**	**26.2**	**27.9**
EBITDA margin	*0%*	*7%*	*9%*	*12%*	*12%*
Non-Operating revenue					
Gain/(loss) on asset disposals	0.0	0.0	0.0	0.0	0.0
Income from NHS Charitable Funds					
Other Non-Operating income					
Non-Operating revenue, Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Non-Operating expenses					
Impairment Losses (Reversals) net	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	(5.5)	(5.4)	(5.4)	(6.7)	(6.7)
Interest expense on overdrafts and working capital facilities	0.0	0.0	0.0	0.0	0.0
Total interest payable on Loans and leases	(11.1)	(12.5)	(12.5)	(12.5)	(12.5)
PDC Dividend	(3.2)	(3.3)	(3.5)	(4.0)	(4.0)
Other Non-Operating expenses					
Non-Operating expenses, Total	**(19.8)**	**(21.3)**	**(21.5)**	**(23.2)**	**(23.2)**
Surplus (Deficit) before Tax	**(19.1)**	**(7.1)**	**(4.5)**	**3.0**	**4.8**
Tax expense/ (income)	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**(19.1)**	**(7.1)**	**(4.5)**	**3.0**	**4.8**
Net margin	*-10%*	*-4%*	*-2%*	*1%*	*2%*

Figure 62: Summary financial results for Queen Elizabeth Hospital

Queen Elizabeth Hospital: Income and Expenditure					
£m unless otherwise stated All amounts shown here are nominal	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**
Protected/Mandatory Clinical Revenue					
Elective	18.2	11.7	13.7	14.9	15.8
Non elective	74.9	73.0	74.4	86.1	96.1
Outpatient	36.5	36.5	37.9	39.3	39.9
A&E	12.1	11.9	12.1	13.4	14.4
Other clinical – Tariff	0.0	0.0	0.0	0.0	0.0
Other clinical – Non Tariff	7.5	7.7	7.9	9.1	10.1
Other block or Cost and Volume contract	3.7	3.8	4.0	4.1	4.1
Other block or Cost and Volume contract	0.0	0.0	0.0	0.0	0.0
Clinical Partnerships providing mandatory services (including S75 agreements)	0.0	0.0	0.0	0.0	0.0
Clinical income for the Secondary Commissioning of mandatory services	0.0	0.0	0.0	0.0	0.0
Other clinical income from mandatory services	14.0	14.3	14.7	16.4	17.7
Total	**167.0**	**158.9**	**164.6**	**183.2**	**198.2**
Non Protected/Non Mandatory Clinical Revenue					
Private patient revenue	0.0	0.0	0.0	0.0	0.0
Other non protected revenue	2.4	3.1	5.2	5.4	5.6
Total	**2.4**	**3.1**	**5.2**	**5.4**	**5.6**
Other Operating Revenue					
Education and Training	5.3	5.7	6.8	8.4	10.1
Research & Development	0.1	0.1	0.1	0.2	0.2
PFI Specific revenue	0.0	0.0	0.0	0.0	0.0
Other Operating Revenue	3.0	15.7	17.1	23.0	28.3
Other Operating revenue, Total	8.4	21.5	24.0	31.6	38.6
Operating Revenue and Income, Total	**177.8**	**183.5**	**193.8**	**220.2**	**242.3**

£m unless otherwise stated All amounts shown here are nominal	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**
Operating Expenses					
Employee Benefit Expenses	(119.7)	(113.2)	(119.7)	(131.6)	(142.2)
Drug expenses	(14.7)	(13.9)	(14.5)	(16.8)	(19.0)
Clinical supplies and services expenses	(13.2)	(12.5)	(13.1)	(15.2)	(17.2)
Shared services expenses	0.0	0.0	0.0	0.0	0.0
For non Ambulance Trusts only – Please specify	0.0	0.0	0.0	0.0	0.0
Other expenses	(19.9)	(19.6)	(19.0)	(19.1)	(20.3)
Secondary Commissioning Expenses	0.0	0.0	0.0	0.0	0.0
PFI operating expenses	(16.7)	(16.3)	(15.9)	(15.5)	(15.8)
Operating Expenses, Total	**(184.2)**	**(175.5)**	**(182.3)**	**(198.1)**	**(214.6)**
Surplus/(Deficit) from operations	**(6.4)**	**8.0**	**11.6**	**22.2**	**27.7**
Surplus/(Deficit) from operations margin	*-4%*	*4%*	*6%*	*10%*	*11%*
Adjustment for donated asset income	0.0	0.0	0.0	0.0	0.0
EBITDA	**(6.4)**	**8.0**	**11.6**	**22.2**	**27.7**
EBITDA margin	*-4%*	*4%*	*6%*	*10%*	*11%*
Non-Operating revenue					
Gain/(loss) on asset disposals	0.0	0.0	0.0	0.0	0.0
Income from NHS Charitable Funds					
Other Non-Operating income					
Non-Operating revenue, Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Non-Operating expenses					
Impairment Losses (Reversals) net	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	(5.1)	(4.9)	(4.9)	(5.2)	(5.2)
Interest expense on overdrafts and working capital facilities	0.0	0.0	0.0	0.0	0.0
Total interest payable on Loans and leases	(14.2)	(14.2)	(14.2)	(14.2)	(14.2)
PDC Dividend	(3.1)	(3.0)	(3.1)	(3.1)	(3.1)
Other Non-Operating expenses					
Non-Operating expenses, Total	**(22.4)**	**(22.1)**	**(22.2)**	**(22.5)**	**(22.5)**
Surplus (Deficit) before Tax	**(28.9)**	**(14.1)**	**(10.6)**	**(0.3)**	**5.3**
Tax expense/ (income)	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**(28.9)**	**(14.1)**	**(10.6)**	**(0.3)**	**5.3**
Net margin	*-16%*	*-8%*	*-5%*	*0%*	*2%*

Figure 63: Summary financial results for Queen Mary's Hospital

Queen Mary's Hospital: Income and Expenditure					
£m unless otherwise stated All amounts shown here are nominal	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**
Protected/Mandatory Clinical Revenue					
Elective	28.4	16.1	11.7	11.9	11.9
Non elective	1.4	(0.2)	0.0	0.0	0.0
Outpatient	22.3	21.7	21.1	21.7	21.7
A&E	0.9	0.7	0.7	0.8	0.8
Other clinical – Tariff	0.0	0.0	0.0	0.0	0.0
Other clinical – Non Tariff	0.0	0.0	0.0	0.0	0.0
Other block or Cost and Volume contract	0.1	0.1	0.0	0.0	0.0
Other block or Cost and Volume contract	0.0	0.0	0.0	0.0	0.0
Clinical Partnerships providing mandatory services (including S75 agreements)	0.0	0.0	0.0	0.0	0.0
Clinical income for the Secondary Commissioning of mandatory services	0.0	0.0	0.0	0.0	0.0
Other clinical income from mandatory services	1.6	1.6	1.6	1.7	1.7
Total	**54.6**	**40.1**	**35.2**	**36.0**	**36.0**
Non Protected/Non Mandatory Clinical Revenue					
Private patient revenue	4.6	4.6	4.6	4.6	0.0
Other non protected revenue	0.0	(1.1)	(4.6)	(4.6)	0.0
Total	**4.6**	**3.4**	**0.0**	**0.0**	**0.0**
Other Operating Revenue					
Education and Training	2.4	2.4	2.4	2.3	0.0
Research & Development	0.1	(0.6)	(2.4)	(2.4)	0.0
PFI Specific revenue	0.0	0.0	0.0	0.0	0.0
Other Operating Revenue	3.1	2.3	0.0	0.0	0.0
Other Operating revenue, Total	5.6	4.2	(0.0)	(0.1)	0.0
Operating Revenue and Income, Total	**64.8**	**47.8**	**35.1**	**35.9**	**36.0**

£m unless otherwise stated All amounts shown here are nominal	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**
Operating Expenses					
Employee Benefit Expenses	(43.9)	(32.6)	(21.4)	(21.5)	(21.5)
Drug expenses	(5.5)	(4.1)	(3.2)	(3.2)	(3.2)
Clinical supplies and services expenses	(8.6)	(6.6)	(5.3)	(5.3)	(4.9)
Shared services expenses	0.0	0.0	0.0	0.0	0.0
For non Ambulance Trusts only – Please specify	0.0	0.0	0.0	0.0	0.0
Other expenses	(9.2)	(6.7)	(3.4)	1.7	(0.7)
Secondary Commissioning Expenses	0.0	0.0	0.0	0.0	0.0
PFI operating expenses	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Operating Expenses, Total	**(67.5)**	**(50.2)**	**(33.4)**	**(28.6)**	**(30.5)**
Surplus/(Deficit) from operations	**(2.6)**	**(2.4)**	**1.7**	**7.3**	**5.5**
Surplus/(Deficit) from operations margin	*-4%*	*-5%*	*5%*	*20%*	*15%*
Adjustment for donated asset income	0.0	0.0	0.0	0.0	0.0
EBITDA	**(2.6)**	**(2.4)**	**1.7**	**7.3**	**5.5**
EBITDA margin	*-4%*	*-5%*	*5%*	*20%*	*15%*
Non-Operating revenue					
Gain/(loss) on asset disposals	0.0	0.0	0.0	0.0	0.0
Income from NHS Charitable Funds					
Other Non-Operating income					
Non-Operating revenue, Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Non-Operating expenses					
Impairment Losses (Reversals) net	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	(2.7)	(2.5)	(2.5)	(2.5)	(2.5)
Interest expense on overdrafts and working capital facilities	0.0	0.0	0.0	0.0	0.0
Total interest payable on Loans and leases	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
PDC Dividend	(2.7)	(2.5)	(2.5)	(2.5)	(2.5)
Other Non-Operating expenses					
Non-Operating expenses, Total	**(5.8)**	**(5.5)**	**(5.5)**	**(5.5)**	**(5.5)**
Surplus (Deficit) before Tax	**(8.4)**	**(7.9)**	**(3.8)**	**1.9**	**0.0**
Tax expense/ (income)	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**(8.4)**	**(7.9)**	**(3.8)**	**1.9**	**0.0**
Net margin	*-13%*	*-17%*	*-11%*	*5%*	*0%*

Figure 64: Summary financial results Lewisham Healthcare NHS Trust

Lewisham: Income and Expenditure					
£m unless otherwise stated All amounts shown here are nominal	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**
Protected/Mandatory Clinical Revenue					
Elective	29.8	41.9	42.6	44.4	69.0
Non elective	58.8	72.1	71.7	36.4	0.8
Outpatient	32.4	27.6	27.5	25.6	23.5
A&E	12.1	12.2	12.2	8.8	5.3
Other clinical – Tariff	1.4	0.0	0.0	0.0	0.0
Other clinical – Non Tariff	38.9	6.7	6.8	3.5	0.0
Other block or Cost and Volume contract	38.6	1.1	1.1	1.2	1.2
Other block or Cost and Volume contract	0.0	0.0	0.0	0.0	0.0
Clinical Partnerships providing mandatory services (including S75 agreements)	0.0	0.0	0.0	0.0	0.0
Clinical income for the Secondary Commissioning of mandatory services	0.0	0.0	0.0	0.0	0.0
Other clinical income from mandatory services	2.5	43.6	44.6	42.4	37.6
Total	**214.5**	**205.2**	**206.6**	**162.3**	**137.4**
Non Protected/Non Mandatory Clinical Revenue					
Private patient revenue	0.0	0.0	0.0	0.0	0.0
Other non protected revenue	1.2	1.3	1.3	0.7	0.0
Total	**1.2**	**1.3**	**1.3**	**0.7**	**0.0**
Other Operating Revenue					
Education and Training	11.3	11.3	11.3	5.7	0.0
Research & Development	0.3	0.2	0.2	0.1	0.0
PFI Specific revenue	0.0	0.0	0.0	0.0	0.0
Other Operating Revenue	8.7	33.2	33.6	17.1	0.0
Other Operating revenue, Total	20.2	44.8	45.2	22.9	0.0
Operating Revenue and Income, Total	**235.9**	**251.3**	**253.1**	**185.8**	**137.4**

£m unless otherwise stated All amounts shown here are nominal	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**
Operating Expenses					
Employee Benefit Expenses	(146.9)	(148.1)	(149.1)	(113.5)	(85.1)
Drug expenses	(14.8)	(13.8)	(14.0)	(9.5)	(6.6)
Clinical supplies and services expenses	(13.7)	(11.6)	(11.6)	(7.9)	(5.5)
Shared services expenses	0.0	0.0	0.0	0.0	0.0
For non Ambulance Trusts only – Please specify	0.0	0.0	0.0	0.0	0.0
Other expenses	(38.3)	(51.9)	(51.5)	(41.8)	(22.6)
Secondary Commissioning Expenses	0.0	0.0	0.0	0.0	0.0
PFI operating expenses	(1.8)	(1.8)	(2.1)	(2.1)	(2.4)
Operating Expenses, Total	**(215.6)**	**(227.3)**	**(228.3)**	**(174.8)**	**(122.3)**
Surplus/(Deficit) from operations	**20.4**	**24.0**	**24.8**	**11.0**	**15.1**
Surplus/(Deficit) from operations margin	*9%*	*10%*	*10%*	*6%*	*11%*
Adjustment for donated asset income	0.0	0.0	0.0	0.0	0.0
EBITDA	**20.4**	**24.0**	**24.8**	**11.0**	**15.1**
EBITDA margin	*9%*	*10%*	*10%*	*6%*	*11%*
Non-Operating revenue					
Gain/(loss) on asset disposals	0.0	0.0	0.0	0.0	0.0
Income from NHS Charitable Funds					
Other Non-Operating income					
Non-Operating revenue, Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Non-Operating expenses					
Impairment Losses (Reversals) net	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	(9.7)	(9.7)	(9.7)	(11.1)	(6.0)
Interest expense on overdrafts and working capital facilities	0.0	0.0	0.0	0.0	0.0
Total interest payable on Loans and leases	(5.1)	(5.4)	(5.4)	(5.4)	(5.4)
PDC Dividend	(4.5)	(4.9)	(6.3)	(6.4)	(3.4)
Other Non-Operating expenses					
Non-Operating expenses, Total	**(19.3)**	**(20.0)**	**(21.4)**	**(22.9)**	**(14.8)**
Surplus (Deficit) before Tax	**1.1**	**4.0**	**3.4**	**(11.8)**	**0.3**
Tax expense/ (income)	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**1.1**	**4.0**	**3.4**	**(11.8)**	**0.3**
Net margin	*0%*	*2%*	*1%*	*-6%*	*0%*

Figure 65: Summary Net Present Cost

	20 Years	25 Years	30 Years
Option	Currency: £ m		
Do Nothing	1086.1	1230.4	1328.5
TSA recommendations	636.4	664.1	664.1
Benefit	449.7	566.2	664.4