University Hospital Southampton NHS Foundation Trust

Use of Resources assessment report

Southampton General Hospital
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Date of publication:
17 April 2019

This report describes our judgement of the Use of Resources and our combined rating for quality and resources for the trust.

Ratings

Overall quality rating for this trust	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Outstanding**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Good**

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/ RHM/reports)

Are resources used productively?	**Good**

Combined rating for quality and use of resources	**Good**

We award the Use of Resources rating based on an assessment carried out by NHS Improvement.

Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust.

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.

This is the first time that we have awarded a combined rating for Quality and Use of Resources at this trust. The combined rating for Quality and Use of Resources for this trust was Good because:

Our overall findings indicated that most areas made improvements.

We rated safe, responsive as requires improvement, well led as good, effective and caring as outstanding. On this occasion we rated three of the trust's acute services as good and one as requires improvement.

We rated well-led at the trust level as good.

• Urgent and emergency care: the rating improved to good overall, with outstanding in both effective and caring domains.

• Maternity: this was the first rating of the service as no longer combined with gynaecology. The rating was good overall at both locations with requires improvement for safe domain at Princess Anne Hospital.

• Outpatients: this was the first rating of the service as no longer combined with diagnostic and imaging, the rating was requires improvement overall for both locations with requires improvement for safe, responsive and well led.

• Medicine: the rating has improved to good overall with outstanding in caring and responsive domains and requires improvement in well led.

• Well led: is rated good overall which reflects a proportionate approach to our findings.

The trust was rated Good for use of resources. Full details of the assessment can be found on the following pages.

NHS Improvement

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Date of site visit:
08 January 2019

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This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous 12 months, our local intelligence, the trust's commentary on its performance, and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Are resources used productively?	**Good** ●

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the trust on 8 January 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Summary of findings

Is the trust using its resources productively to maximise patient benefit?	Good

We rated Use of Resources as good because our assessment found that on balance, across the five KLOEs the trust is achieving good use of its resources to enable it to provide high quality, efficient and sustainable care for patients:

- Around a third of the trust's activity is specialist in nature, commissioned directly by NHS England. This typically results in some of the use of resources metrics being impacted by higher costs compared to District General Hospitals. In our analysis we have therefore benchmarked the trust against a group of peer organisations with similar complexity of activity. The trust's total cost per WAU compares favourably with this peer group and the trust is also in the lowest (best) quartile nationally based on the 2017/18 data.
- During our assessment, we found that the trust had made progress in reducing the length of stay (LoS) of patients in the hospital, delayed transfers of care (DTOC) and 'did not attend' (DNA) rates.
- The trust was well engaged with the Getting It Right First Time (GIRFT) programme and had already delivered improvements through the programme.
- The trust had an overall pay costs per weighted activity unit (WAU) in the lowest (best) quartile nationally although this masked variation by staff groups. The trust provides services at regional level which contributes to the higher medical costs per WAU than national median.
- The trust had established processes to manage the deployment of staff using technology resulting in the trust operating within its agency spend ceiling. The trust faced challenges with staff vacancies but was making progress because of actions taken.
- The trust was also an exemplar in the management of staff sickness having a well-established wellbeing model for staff.
- The trust benchmarked strongly overall on clinical support services metrics in particular in pathology where the trust delivered a large range of complex tests. The trust's medicines cost per WAU was high, but this was explained as due to the provision of specific services using high cost drugs.
- The trust benchmarked in the lowest 10% cost per WAU across corporate services and our assessment found that overall, they delivered good services to the trust. The trust is also a Global Digital Exemplar and has a programme of digital investments. The trust's procurement function ranked high on the procurement league table and the trust had invested in the function to cover a wide scope. The trust also benchmarked well on estates and facilities costs.
- The trust had a track record at delivering surpluses, achieving a £41.2 million surplus in 2017/18 and on track to deliver a £29.4 million surplus in 2018/19. Despite a low total cost per WAU, the trust had planned to deliver 3.75% efficiency savings in 2018/19 and although it only had only achieved 63% at the end of quarter 3 it expected to accelerate the delivery of its savings during the last quarter.
- The trust had strong cash balances and met all its financial obligations and had significant capital development planned for future years.
- The trust was making good use of benchmarking and costing information to understand the financial performance of its services and identify areas to improve.

However, it should be noted that:

- The trust did not meet any of the constitutional access standards although there had been some improvement in the 4-hour accident & emergency (A&E) performance at the time of the assessment.
- The trust was an outlier on several clinical services metrics which was partially explained by issues with the coding of clinical activities.
- Although the trust had a programme to review theatre productivity, it did not use external benchmarking information to support its programme and it acknowledged it could progress further on theatre productivity.
- The trust faces challenges with recruitment and retention but through several actions, had achieved some successes in recruitment although more could be done to improve staff retention.
- There were areas in pharmacy where the trust could deliver improvements such as the rate of switching to biosimilars and reduction in the number of medication incidents.
- Although the cost of corporate services was low, there were specific metrics where the trust did not benchmark well showing room for improvement in productivity.
- The trust had a high cost of supplies and services and a higher than median level of backlog maintenance.

How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?

At the time of the assessment, the trust did not meet any of the constitutional standards although its performance with the 4-hour accident & emergency (A&E) standard had improved. The trust had identified where it was an outlier on productivity metrics and was taking actions with improvements made with length of stay (LoS) and Delayed Transfers of Care (DTOC) and day case rate. The trust was also well engaged in the GIRFT programme but could use national data to improve its theatre productivity.

- At the time of the assessment in January 2019, the latest data available showed that the trust was not meeting the constitutional operational performance standards around 18-week Referral to Treatment (RTT) (86.4%), Cancer 62-day wait (75.4%), 4-hour Accident & Emergency (A&E) (90.7%) and the Diagnostics 6-week wait (2.37%)
- The A&E standard performance, however, represented a significant improvement on previous months.
- Patients were more likely to require additional medical treatment for the same condition at the trust compared to others. At 8.62%, emergency readmission rates were above the peer group median as at June 2018 (7.6%) and in the second highest (worst) quartile nationally. The trust had carried out an audit of elderly care non-elective readmissions which concluded that most readmissions were not linked to the cause of the primary admission. A cohort of surgical readmissions were part of a non-elective ambulatory care pathway and therefore should not have been counted as readmissions and the trust was developing a virtual ward to address this. The trust was focussing on patients readmitted within 7 days as a more indicative measure of issues with the original discharge.
- More patients were coming into hospital unnecessarily prior to treatment compared to other hospitals:

- On pre-procedure elective bed days, at 0.22, the trust was performing above the peer median as well as the national median (0.11) and in the highest (worst) quartile nationally.
- On pre-procedure non-elective bed days, the trust was performing higher than the national median (0.94 compared to 0.69), in the highest (worst) quartile nationally.

- The trust stated this was due to the coding activities and that the GIRFT programme deep dive visits had not highlighted any issues with regards to pre-procedure bed days. The trust did however have a population of patients attending the hospital from outside its local area (e.g. Channel Islands), who required to stay in the trust pre-operatively. The trust also mentioned that such patients also stayed in local hotels when appropriate.
- The trust had reduced its Length of Stay (LoS) for elective and non-elective activity by 0.1 and 0.4 days respectively in 2017/18. At the time of our assessment, the trust had also reduced the number of long staying patients (over 21 days) from 270 to 187. GIRFT data showed that the trust had the lowest LoS nationally for neurosurgery and it was the first trust in the country to offer day case neurosurgery.
- At the time of the assessment , the delayed transfers of care (DTOC) had reduced from 110 to 48 due to work undertaken by the trust and its partner organisations.
- The trust had a transformation board to oversee the improvement work in reducing LoS and used data (including comparison of clinician's performance) and quality improvement methodology (including statistical process charts) to identify outliers and areas for improvement. The trust had also reduced variation of practice between clinicians via the appraisal and job planning process.
- The trust had engaged extensively with the GIRFT programme which had helped identifying areas for productivity improvement. The trust had developed an internal methodology for implementing the findings from the GIRFT visits, led by the Medical Director. The trust gave the examples of adult diabetes and paediatric general surgery where they had used the GIRFT data to identify variation and acted to reduce it.
- The trust had a day case rate below the national median (at 73.5% vs 77.4%) and in the second lowest (worst) quartile nationally. The trust explained this resulted from the lowest complex activity being delivered by the local independent sector treatment centre. The trust had however used GIRFT data to identify variation between clinicians' practice resulting in changes and investments into certain specialties (eg urology and gynaecology) to improve the day case rate. The trust recognised its higher (20%) than average conversion of day case patients to inpatients and had been looking at ways to reduce this, including scheduling earlier lists and use of patient hotels where patients cannot be treated on the day but do not require admission.
- The trust's Did Not Attend (DNA) rate at 7.13% benchmarked slightly above (worse) than the national median (7.01%). The trust explained the rate had improved with the introduction of Netcall, a system which alerts patients by texts of their upcoming appointment and the trust was offering services in other regional hospitals to make it easier for patients to attend and reduce the DNA rate.
- The trust had a programme of work in place for theatre productivity led by their Quality Improvement team. The information shared with us during our assessment, however showed that the trust did not use external benchmarking information. The trust also acknowledged that they could progress further on improving theatre productivity.
- The Trust had engaged with Specialised Commissioners in work programmes focused on improving the efficiency and effectiveness of services and pathways. While these efforts had resulted in partial delivery of the financial savings required, these savings had

been largely one-off in nature. Greater focus was required on transforming healthcare provision to ensure system sustainability.

How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?

The trust pay cost per WAU were in the lowest (best) quartile nationally although the medical cost per WAU benchmarks were in the highest (worst) quartile nationally reflecting specialist services and trust's investment in workforce. The trust had established processes to manage the deployment of staff using technology resulting in the trust operating within its agency spend ceiling. The trust faced challenges with staff vacancies but was making progress because of actions taken. The trust was an exemplar site on sickness management.

- For 2017/18, the trust had an overall pay cost per WAU of £1,997, compared with a national median of £2,042, placing it in the lowest (best) quartile nationally. This meant that it spent less on staff per unit of activity than most trusts. However, this masked differences between the cost per WAU by specific staff group. The trust was in the highest (worst) quartile for medical cost per WAU, although it benchmarked in the second lowest (best) quartile for nursing costs per WAU and the lowest (best) quartile for Allied Health Professionals (AHPs) costs per WAU.
- The trust benchmarked below (better than) the peer group median for the majority of medical and surgical. Where the medical cost per WAU was high, the trust provided specific reasons explaining higher costs such as the trust hosting additional staff to provide a regional service. The trust had also made a deliberate decision to invest resources in some specialties. For example, the trust had invested in radiology resulting in a higher than peer group number of doctors, to develop its 7-day service offer.
- The trust used GIRFT data to assess its staffing numbers for clinical services and had a well-established job planning process for clinicians. As part of this process, each specialty undertook a group job plan which was examined considering demand and activity data to help inform the overall workforce requirement per specialty. Job planning, which was supported by an agreed policy, was led by the clinical divisions and involved medical Staff Side representatives. At the time of the assessment, 90% of medical staff had up to date job plans, in line with the national benchmark.
- The AHP team undertook team and individual job planning which contributed to a low AHP cost per WAU. The trust had also introduced innovative roles including upskilling Healthcare Assistants to become Band 4 nurses and doctor assistants enabling doctors to spend more time with patients.
- The trust also ran a 'hospital at night' workforce model using medical support workers to assist junior doctors to manage their workload and employing pharmacy assistants to support wards in the administration of medicines, to release nursing time to care.
- The trust met its agency spend ceiling as set by NHS Improvement for 2017/18 and was forecasting to meet its ceiling in 2018/19. The agency staff costs per WAU were significantly below the national median (£51 versus £106), placing the trust in the lowest (best) quartile nationally.
- The trust made extensive use of technology to manage staff deployment (e-rostering, e-job planning and e-rota management) and held regular staffing meetings to identify gaps in rotas which were managed in partnership with the trust's bank provider for all categories of staff. Agency staff were only used where bank staff were unavailable. The trust also ran an annual staffing review process specifically for nursing and midwifery which covered all services to plan its workforce requirement.

- The trust ensured that all staff were members of the trust staff bank and had run e-rostering for all non-medical staff since 2009. The trust had joined with others in the Sustainability & Transformation Partnership (STP) area to create a single framework for the use of staff agencies, allowing a reduction in their use of the highest cost staffing agencies.
- The trust also ran a structured programme for clinical fellows and had a high fill rate of short-term vacancies from its internal medical staff bank for junior doctors which had helped reduced agency medical staff. The trust also had enhanced support for divisions to help manage resources required in the specialling of patients with dementia.
- Staff retention at 85.7% in September 2018 was slightly below the national median of 85.9%, placing the trust in the second lowest (best) quartile nationally.
- The trust faced challenges to address qualified nurse vacancies which to some extent reflected national issues. However, the trust had introduced a nurse degree apprentice programme to increase its recruitment with a cohort of 50 students commencing in October 2018. The trust also had a Recruitment and Retention group to identify initiatives and drive improvements. The trust had recruited nurses overseas and achieved some successes in recruiting from Southern Europe and the Philippines.
- The trust recognised that it had a high level of vacancies for radiographers (13.8%) had recruited staff from overseas as well as working with a Staff Side representative to establish the reasons for the high vacancy level. This had also led to the development of a managed equipment contract to improve the quality of the equipment used by the radiography teams.
- At 3.32% in 2017/18, staff sickness rates were better than the national average of 3.9% with the trust benchmarking in the lowest (best) quartile nationally. The trust had developed a case management model of intervention for long term sickness and had a well-functioning occupational health model. The trust was a spearhead site for good practice in this area and ran a well-established wellbeing model for its workforce.

How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?

The trust benchmarked strongly overall for clinical support services metrics in pathology where the trust delivered a large range of complex tests at an efficient average cost. The trust's medicines cost per WAU was high, but this was explained as due to the provision of specific services using high cost drugs. The Trust should continue to prioritise its programme of switching to biosimilars and to focus on the reduction of harm arising from medication incidents.

- The trust's medicines cost per WAU (£419) was in the highest (worst) quartile when compared against the national median but was in line with other trusts with similar clinical output (£425). One factor driving this higher cost was the escalating cost of medicines in the delivery of specialised commissioning services. The trust has a strong reputation in the treatment of melanoma with a requirement for particularly expensive drugs. The trust's rate of switching to certain biosimilars was slightly below the national median which was reducing the level of savings achieved, although within the top 10 medicines it was also noted that the potential for imatinib savings is limited due to the significant proportion of GIST patients.
- The trust had a very good grip over other components of medicines expenditure and usage with savings of £300,000 on low cost drugs targeted and being delivered this year. Stockholding benchmarked well, and the trust was actively looking at ways to improve this further by looking at STP-wide opportunities. The trust had a very comprehensive Medicines Management Strategy and proactively looked for ways to enhance patient

pathways, including early discharge. They had a programme to invest in technology including the development of an electronic aseptic management system. An area of focus for the trust remained the reduction of medication incidents supported by investment in a new pharmacy robot and two new aseptic suites. A 50% improvement had already been achieved.

- The metrics for the radiology services were good, other than the cost per report which was in the highest quartile and was being driven by the low number of reports per member of staff. It was recognised that there were significant opportunities for savings and the trust was targeting a cost improvement of £1.4 million this year. The trust had also made some clinically based decisions which increased the cost of the service but supported better outcomes such as the cancer MDT approach which was time-consuming but clinically important. The provision of the interventional radiology service was also inherently expensive. The analysis might also have been slightly distorted by the fact that the trust also supported services in Salisbury NHS Foundation Trust. The levels of backlog in imaging were low however the Trust was looking at more affordable ways to maintain capacity.
- The trust had a cost per test of £1.89 compared to a national median of £1.91 which placed the trust in the second lowest (best) quartile nationally. The trust's pathology services also benchmarked well across all efficiency metrics, which was a particularly strong performance given a relatively complex catalogue of testing that the trust undertook. The trust was looking to make further efficiencies and was currently out to tender on several contracts across the Hampshire network and would make savings in its microbiology service which it has brought back in-house. There would be significant Managed Equipment Service (MES) opportunities across the network however the trust also needs to position itself better to secure the network LIMs system at the next opportunity.

How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?

The trust benchmarked in the lowest 10% cost per WAU across corporate services and our assessment found that overall, they provided high value for money. The trust is also a Global Digital Exemplar and has a programme of digital investments. The trust's procurement function ranked high on the procurement league table and the trust had invested in the function to cover a wide scope. The trust also benchmarked well on estates and facilities costs. However, the trust also had a high cost of supplies and services and a higher than median level of backlog maintenance.

- For the financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,362 compared with a national median of £1,307. The factors driving this were high supplies and services costs and the high cost of medicines as discussed above. The trust however benchmarked better than national and peer medians for both estates and facilities and corporate services.
- The trust benchmarked in the lowest 10% cost per WAU across corporate services with lowest quartile costs in the finance, Human Resources (HR) and Information Management & Technology (IM&T) functions. The legal services function was the only one which benchmarked above the national median.
- Looking at the effectiveness of the corporate services provided, there were some below median performance metrics such as the average time to hire clinical staff which was 50% longer than the national median despite the investment in new HR systems in 2017/18. The trust had plans to shorten the time for pre-employment checks to improve this. The average time to resolve IT issues was also high compared to the national median. Finally, the investment in the service improvement/Programme Management

Office (PMO) was less than 50% of the national benchmark, which given the need to deliver continuous improvement may well have represented an underinvestment.

- However, overall the corporate services were delivering high value for money. The target of delivering a further significant Cost Improvement Plan (CIP) from this function in the current year appeared to be a challenge although it was clarified that this CIP included savings in other areas which were however attributed to corporate services initiatives.
- The trust is a Global Digital Exemplar (GDE) trust and received capital funding for this. The trust was investing in three core projects with benefits being tracked and reported to the Board by reference to cash savings and staff time saved. The evidence showed significant benefits accruing on both counts. The innovation in the delivery of juvenile outpatient clinics allowed patients to be seen anywhere in the country. Cancer follow up appointments were also increasingly being delivered virtually which could only be delivered from a solid IT platform.
- The trust's procurement function ranked 14th in the country (in the upper quartile) and had achieved Level 1 NHS Procurement and Commercial Standards in 2018. The assessment was that the team delivered high quality outcomes with the trust having invested more in this function than other trusts but with a wider scope which included a highly competent systems team who also looked after the finance function and some of the estate's functions.
- The procurement team was planning a £2.4 million CIP in the current year and had been focussing on opportunities in high value areas such as cardiology and orthopaedics over the past 5 years. One metric where the trust scored less well was in the relatively low percentage spend on purchase orders which was a potential control weakness. The trust had made the decision to invest in a new Oracle System which supported an end to end Enterprise Resource Planning (ERP) system and makes ordering without a purchase order much more difficult. The senior procurement team were very well engaged with the broader procurement agenda including the changes around NHS Supply Chain. The trust needed to continually monitor and benchmark its expenditure on supplies and services which as noted above, benchmarked above peer medians.
- The cost of running the estates and facilities compared favourably to the peer median (£316 per square meter compared to £367 per square meter). The trust had recently changed soft Facilities Management (FM) provider and although it had secured a competitive price it had also prioritised quality with a performance-based contract linked to clear metrics. The trust had invested in 'Patient Ambassadors' who were focused on looking at the domestic and catering services from a patient perspective. The tracking of the patient satisfaction showed that performance had been steadily improving.
- The trust was addressing the critical backlog maintenance issues, but the overall backlog (£377 per square meter) was well above national median (£186 per square meter). The trust also needed to invest in additional space for neurosurgery as well as plans for additional theatres and ICU capacity. The funding of the investment was primarily through the generation of surplus cash each year. The trust was however operating on a constrained site which made both expansion and reconfiguration extremely expensive. The trust had been in discussion with Southampton University to access more space. There were savings opportunities in energy which could be realised through investment.

How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

The trust had a track record of delivering surpluses and had a total cost per WAU in the lowest (best) quartile nationally which was an improvement on 2016/17. The trust forecasted achieving its cost improvement plan (CIP) despite being behind plan at the time of the assessment. The

trust had strong cash balances and was using patient level costing information to understand the profitability of its service lines and support decision-making.

- In 2017/18, the trust had reported a £41.2 million surplus (including Sustainability & Transformation Fund (STF)), £14 million higher than its control total of £27.1 million because of additional non-recurrent NHS funding. Excluding STF, the trust had achieved a surplus of £13.9 million (1.8% of turnover) against a control total of £9.3 million.
- In 2018/19, the trust had planned to deliver a £29.4 million (including Provider Sustainability Fund (PSF); £4.4 million excluding PSF) which was in line with its control total. At month 9 (December 2018), the trust was forecasting to deliver its planned surplus. The trust's position was however supported by non-recurrent income and expenditure items and the trust's underlying position was therefore a small deficit.
- In 2017/18, the trust had a cost improvement plan (CIP) of £32 million and had delivered £33.9 million (or 4.25% of its expenditure) of which 65% were recurrent savings. In 2018/19, the trust had a cost improvement plan of £32 million (3.75% of expenditure). At December 2018 (quarter 3), the trust was behind plan, having delivered 87% of its year to date target and 63% of its full year plan. The trust had implemented a Financial Recovery Action Plan since the summer 2018 and at the time of the assessment, the trust was forecasting to deliver its full cost improvement plan for 2018/19, 90% on a recurrent basis.
- The trust had strong cash reserves (£49.6 million) at the end of December 2018 and could consistently meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service and liquidity metrics. The trust did not rely on short term loans to maintain positive cash balances. The cash position was expected to support the trust in delivering its substantial capital expenditure programme to improve the hospital, including the refurbishment and expansion of the general Intensive Care Unit.
- The trust was producing Patient Level Costing System (PLICS) information which was used to inform the profitability of service lines. The trust provided examples where PLICS data had supported decision making and improvements. For example, the trust had used PLICS information to analyse patients with functional illnesses. The outcome had been discussed with Southampton CCG to set up a clinical psychology service within A&E to offer patients the support they required and therefore avoiding unnecessary hospital admissions.
- The trust had also produced 'opportunity packs' including benchmarking information for care groups to identify areas for productivity opportunities and linked to cost improvement plans and clinically driven transformation programmes.
- The trust had a small commercial team who sought opportunities to maximise commercial income such as car parking or the provision of medical services for cruise ships. Private patient activity was limited by the trust's current capacity although they continued to scan for opportunities such as in oncology.
- The trust didn't rely on management consultants or other external support services with spend limited on specific pieces where the necessary expertise was not available within the trust. In 2018/19, the trust was forecasting to spend £0.1 million on external consultancy.

Outstanding practice

During our assessment, we identified several areas of outstanding practice:

- The trust was a leader in developing day case neurosurgery.
- The trust produced a monthly pack for care groups setting out productivity and efficiency opportunities.
- The trust used dual qualified RMNs and RGNs on dementia wards.
- The trust was a spearhead for good practice in staff sickness management.
- The trust evidenced good management of consultant job planning including use of local staff side representatives.
- The trust's pathology services benchmarked very well considering the complex range of tests they undertook.
- The trust's soft FM contract with its suppliers was performance based with links to clear metrics.
- The trust used Patients Ambassadors to scrutinise the domestic and catering services from a patient perspective.

Areas for improvement

The following have been identified as key areas where the trust has opportunities for further improvement:

- There were several areas within the clinical services KLOE where the trust did not benchmark favourably compared to other trusts nationally:
    - The trust did not meet any of the constitutional access standards and should consider what further actions it needs to take to address patient access issues.
    - The trust had high readmissions rates and pre-procedure bed days rate partly driven by coding issues which needed to be resolved.
    - The trust had a high day case to inpatient conversion rate and needed to progress to reduce the conversion rate where possible.
    - The trust could consider widening the range of information it uses to assess its theatre productivity, in particular through external benchmarking.
- The Trust should continue to prioritise its programme of switching to biosimilars and to focus on the reduction of harm arising from medication incidents.
- The trust should consider whether it requires further investment in its programme management office considering it is benchmarking very low compared to the national median and its continuous improvement and efficiency savings agenda.
- The cost of External Legal services provided to the Trust benchmarked within the national median. However, the cost of the Trusts 'internal' legal services function benchmarked in the national upper quartile and the trust should consider the drivers of this higher cost and whether this represents an opportunity for further savings.
- The cost of supplies and services benchmarks above the national median, although the procurement function benchmarks well. The trust needs to continue to monitor its ordering processes to optimise stockholdings levels and minimise waste.

Ratings tables

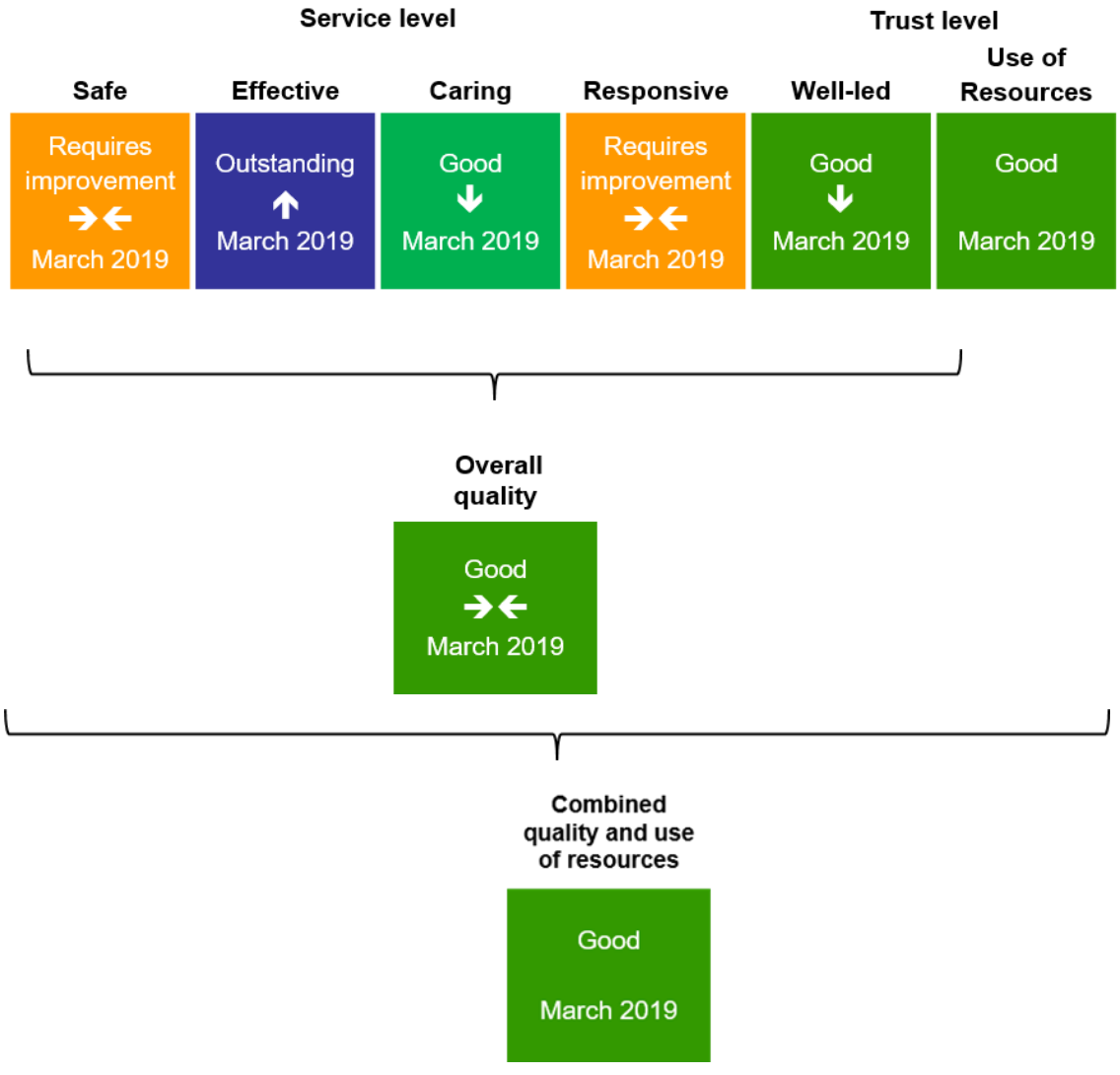
Key to tables				
Ratings	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**

Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = date key question inspected					

***** Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust



Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term 'allied health professional' encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.

Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for several reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR)	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.

cost per £100 million turnover	
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs

Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.