Western Sussex Hospitals NHS Foundation Trust

Use of Resources assessment report

Worthing Hospital
Lyndhurst Road
Worthing
West Sussex
BN11 2DH
Tel: 01903205111
www.westernsussexhospitals.nhs.uk

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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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Are resources used productively?	Outstanding ☆

Combined rating for quality and use of resources	Outstanding ☆

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 outstanding. Full details of the assessment can be found on the following pages.

NHS Trust

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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 twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Proposed rating for this trust?	Outstanding

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 27 June 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.

Findings

Outstanding

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

We rated the trust's use of resources as outstanding. The trust had a well embedded 'ward to board' quality improvement programme 'Patient First' which drove continuous improvement across the trust and was reflected in the trust's overall cost per weighted activity unit (WAU) benchmarking in the best national quartile, the trust's reference cost index (RCI) being consistently below 100 and the level of investment made to improve services. The trust benchmarked well with other NHS providers nationally across all the key lines of

enquiries and for operational standards while achieving an underlying surplus position. At the time of the assessment, the trust had built from its internal improvement approach and achievements to work collaboratively with lead commissioners and other organisations in its sustainability and transformation partnership (STP) to improve services for patients and address the system's financial challenge. The trust board was also the trust board for Brighton & Sussex University Hospital NHs trust, a trust experiencing significant financial and quality issues.

- Core to the trust's productivity was their quality improvement programme 'Patient first'. The trust's programme had been in place since 2015 and was recognised by staff as providing them with problem-solving tools and creating the leadership to continuously improve services for patients while also helping the trust to become more productive and efficient. Through the programme we saw a very strong commitment to improvement, linked to the trust's strategic aims, that ensured teams had the tools and techniques and support of their leaders to embed improvement. This had established a strong culture across the trust allowing front line staff to make the necessary improvements in their work for patient's benefits.
- The trust worked collaboratively with its STP partners to try and resolve shared financial and operational challenges. Following the successes of the 'Patient First' programme, the trust was, at the time of the assessment, in discussion with regard to setting up an academy to train staff across the STP to the method underpinning the 'Patient First' programme to deliver improvements.
- The trust and its commissioners had developed an aligned incentive contract (AIC) in place since 2017/18 which provided a joint framework to manage in common the risks identified at the locality level, particularly the significant funding gap. The infrastructure and ways of working developed for the AIC provided a way forward to an integrated care partnership (ICP) to improve services to patients in a constrained financial environment and had delivered savings with the repatriation of independent sector elective work and with medicines management.
- Since March 2016, the trust's board was also managing Brighton & Sussex University Hospitals NHS Trust (BSUH) which at that time was in special measures for quality and finance. During 2018/19 and under this management arrangement, BSUH had moved out of special measures for both quality and finance.
- The trust had a strong performance against the four constitutional standards (4-hour accident and emergency (A&E), cancer 62-day and the diagnostic 6-week wait) during 2018/19. The trust was not meeting the 18-week referral to treatment standard although it had delivered more elective care than during the previous year and had exceeded the annual levels of activity it had been commissioned to deliver. The trust's A&E performance had however recently deteriorated and the trust needed to focus on bringing back its performance in line with the standard.
- The trust benchmarked well on clinical services productivity. The trust had productivity programmes in place in outpatients, theatres, new models of care and flow which had allowed the trust to see more outpatients, increase its overall touch time in theatres, increase the number of elective care patients and reduced cancellations including during the winter period. This resulted in 96.5% of patients who would recommend the trust's services to family and friends.
- However, the trust performed in the worst quartile for emergency readmissions. The performance was partially distorted by the coding of planned readmissions or open access to same day emergency care units. The trust had however identified improvements could be made with patients readmitted for respiratory conditions and work had started to fact effect.
- The trust's overall pay cost per weighted activity unit (WAU) benchmarked slightly higher than the national median which reflected the trust's decision to invest in staff to improve the quality and access to its services in the context of low agency spend, maximisation of innovative skill mix opportunities and the trust's financial position improvement to an underlying financial surplus. The trust's medical and allied health professional costs per WAU however benchmarked in the second highest (worst) quartile nationally and the trust continued its effort to understand the drivers and take actions to reduce these costs. The trust had staff sickness and retention rates which were better than the national median and the trust attributed this to the support provided to staff and the positive culture developed through 'Patient First'.
- Overall the trust benchmarked relatively well on clinical support services although we noted some areas where the trust could continue to progress and derive further efficiencies. The trust had invested significantly on technology and digitisation to support its services to improve efficiency and access.
- The trust had the tenth lowest (best) non-pay costs per WAU in the country and it benchmarked well for corporate services. The trust could however further improve on its performance on the procurement league table and although the cost of running its estate was higher than the median, it scored in the top quartile for quality of the estate and facilities services.

- The trust was in surplus position and operated with an underlying surplus. The trust had a track record in delivering recurrent savings, supported by its ‘Patient First’ programme and robust assurance and governance processes. At the time of the assessment, the trust was on track to deliver its 2019/20 planned surplus and control total. The trust used service line reporting to manage its divisions’ financial position. The trust did not rely on revenue cash support and had invested internally generated cash into its capital programme. However, we noted that the trust’s creditor and debtor management showed room for improvement.

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

Overall, the trust benchmarked well on clinical services metrics and had a strong performance against the four standards during 2018/19. The trust had several productivity programmes across the trust which had delivered improvements in theatre productivity and increased activity throughput (elective and outpatients). Staff were empowered through the ‘Patient First’ methodology to continuously improve services for the benefits of patients which was reflected in the trust being in the top quartile for patient’s satisfaction. The trust had a high rate of emergency readmissions and had identified areas it could improve.

- At the time of the assessment, the trust met three of the four constitutional standards:
  - The trust’s performance for the 4-hour accident and emergency standard (A&E) had been over 90% since March 2018 and 94.1% for the 12 months of 2018/19. Performance in March 2019 was 95% and, at that point, the trust benchmarked in the top 10 trusts for type 1 main A&E units. However, more recently, the trust’s performance had dropped below the standard and the trust needed to focus on improving its performance.
  - The trust’s performance for the cancer 62-day standard in March 2019 was 84% (4% better than national performance despite referral growth of 18.2%) and had risen to 85% in May 2019 in compliance with the standard. The trust had halved the number of patients waiting more than 62 days in quarter 4 2018/19, from 136 patients in December 2018 to 79 in March 2019, and, at the time of the assessment, they were on track to deliver full compliance by September 2019.
  - The trust had consistently achieved the diagnostic 6-week wait during 2018/19, outperforming both national and peer performance. Its performance was 99.28% in May 2019 and it expected to continue to meet the standard during 2019/20.
  - The trust’s performance on the 18-week referral to treatment (RTT) standard was 84.3% in May 2019. Although the trust was not meeting the standard at the time of the assessment, the trust had delivered more elective care than the previous year by an additional 33,351 outpatient appointments and 1,257 elective day cases and inpatient stays and had exceeded the annual levels of activity it had been commissioned to deliver. We also noted, that they had improved their performance by 3.4% over the winter period while outperforming the national and peer A&E performance. They also had a robust plan to attain the 92% standard in 2019/20.
- The trust had several initiatives in place to reduce inappropriate admissions in A&E. It had a frailty team at the front door which ensured that the older population received the most appropriate care and were discharged swiftly following treatment where possible. ‘Consultant Connect’ was now live in four specialities to provide real time advice to GPs and to improve admission avoidance, the trust had a ‘One call’ team to provide phone advice, streaming and triage to GPs and other health care professionals.
- The trust had increased the number of patients seen in outpatient by 33,351 in 2018/19 through operational productivity improvements. This had been a key focus for the trust for the previous two years and it had now fully implemented e-referral, electronic referral tracking and virtual clinics. It had reduced the patient referral triage time from 28 to 8 days. The trust had tracked patients’ experience and reported that virtual clinics had been positively received by those patients who had used them.
- Readmission rates remained an area for improvement on which the trust was well sighted on and committed to making improvements. Patients were more likely to require additional medical treatment for the same condition at this trust compared to other trusts. Between December 2017 and December 2018, the emergency readmission rate was 9.38%, above the national median of 7.9% and in the highest (worse) quartile nationally. Trust analysis had proved that 29.8% of readmissions during quarter 4 2018/19 was due to emergency patient admissions which were counted as readmissions were planned returns or open access attendances to same day emergency care units. It also showed that 26% were in fact readmissions for different conditions. The trust had however identified that improvements could be made with patients readmitted for respiratory conditions and work had started both internally and with systems partners to improve the planning and support for frail patients with these conditions to reduce the risk of readmission.

- Positively, fewer patients were being admitted into hospital unnecessarily prior to treatment when compared to other hospitals nationally during the 12 months to December 2018, and the trust was one of the top performers nationally for a minimal preoperative length of stay (LoS).
  - On pre-procedure elective bed days, at 0.01, the trust had the best performance nationally with the national median at 0.17. This meant that 99.8% of patients were admitted on the day of surgery.
  - On pre-procedure non-elective bed days, the trust had achieved 0.63 and was performing better than the national median of 0.64. The trust was aiming to improve this further and had a robust ambulatory and same day emergency ethos.
- The trust was improving clinical productivity by working with the wider system and had strong relationships with system partners. The trust was ambitious to further remove non-productive activity and waste. Their experience had engendered confidence that the trust could further improve productivity by appropriate skill mix, redesign of patient pathways, use of technology and strong governance. The trust attributed the success for the efficiencies achieved previously to front line staff, and their continuous focus on quality improvements for patients. The trust had implemented a successful quality improvement programme, 'Patient First' which put the patient at the centre of all activity. This programme was extremely well embedded and lived at all levels of staff, from trust board to ward. The ethos of the programme was to ensure all activity delivered added value for patients, and that waste including time, activity and resources were driven out of everyday processes. The empowerment of staff under the 'Patient First' approach allowed them to think innovatively to improve services for patients, which resulted in efficiency improvements.
- The trust had an operational productivity programme that used benchmarking through model hospital, the 'getting it right first time' (GIRFT) national programme and Dr Foster benchmarking to inform opportunities which were followed through. The trust's Chief Executive chaired a collaborative of the system acute providers, and the STP had requested to be a pathfinder for the new national model of care called an Integrated Care Partnership (ICP), where NHS organisations worked together to meet the needs of their local population. The trust was also in discussion, at the time of the assessment, to develop an academy to introduce staff across the system partners to the 'Patient First' methodology to help drive service improvements and efficiencies across the system.
- The trust had successfully increased productivity over recent years. A theatre optimisation programme had improved overall touch time utilisation to 80.2% (April 2019) and to 85% in ophthalmology. This had enabled an increase of cases per list (from 2.2 in 2017/18 to 2.7 in 2018/19) and this converted to an extra 1,257 patients who received elective care in 2018/19. Same day cancellations had reduced by 15.3% in 2018/19 and positively improvements had continued over the winter period. This had been delivered through improvements to flow and increased theatre utilisation. The trust winter plan of resulted in a reduction of the use of an average of 40 beds during December to March 2019.
- The Did Not Attend (DNA) rate for the trust was one of the lowest when compared nationally and was 5.89% for the period December 2017 to December 2018. The trust was in the best quartile nationally. The trust had achieved this rate through a focused outpatient improvement programme that included a redesign of booking systems (meaning 100% of referrals were through an electronic referral system), changes to the outpatient processes and use of interactive text messages and reminder service.
- Overall delayed transfers of care (DTOC) for 2018/19 were 2.9%, better than the national standard of 3.5%. The trust had implemented several measures to improve their performance including strong process governance, discharge planning from admission, daily huddles and in-reaching from community integrated discharge teams to facilitate patients discharge. Discharges before midday had increased by 50% over 12 months to a rate of 25%. The trust also proactively worked with system partners through an established senior operational team that huddled daily, and regular monthly meetings to provide the governance to oversee trends in activity, plan forward and jointly manage known or anticipated risks. The local health system was working on expanding ambulatory care pathways and discharge to assess capacity. There were challenges regarding community capacity, and packages of care for social care patients and these were addressed at a system level.
- The trust was leading and driving change in the care of mental health patients and had introduced innovative practices such as the implementation of a mental health board, which included wider system partners, to improve the pathways for mental health patients.
- Patient feedback for 2018/19 was excellent and at February 2019 96.5% of patients recommended the trust's services to friends and family members and the trust benchmarked in the top quartile nationally. During 2018/19 formal complaints had also decreased from an average of 50 per month to 35.

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

The trust had a pay cost per weighted activity unit (WAU) for 2017/18 which was slightly higher than the median reflecting investment in staff to improve services although the trust continued to focus on reducing pay costs, had a low agency spend and maximised innovative skill mix opportunities. The trust had staff retention and sickness rates which were better than the national median and excellent staff engagement which the trust's staff support and the culture created through the 'Patient First' programme contributed to sustain.

- For 2017/18 the trust had an overall pay cost per WAU of £2,187, compared with a national median of £2,094, placing it in the second highest (worst) cost quartile nationally just above the second-best cost quartile. The trust was aware of this fact and reported that the investment in staff allowed them to deliver care that was of higher quality and delivered better patient experience.
- The trust was in the second highest (worst) quartile for medical cost per WAU at £544 compared to a national median of £533. The two most significant medical variances were in obstetrics & gynaecology and paediatrics. Both services were provided on both trust's sites and required additional mid-grade doctors and consultants driving costs up. The trust had put several actions in place to reduce these costs including robust job planning and reducing the time for supporting professional activities (SPA).
- The cost per WAU for nursing staff was £706 compared to a national median of £710 and benchmarked in the second lowest (best) quartile nationally. The trust had invested in skilling up the non-registered nursing workforce to support qualified staff and reported a high usage of bands 2-3 staff. The trust complied with safer staffing guidance to ensure safe care delivery and assessed daily the inpatient acuity/dependency to allow nursing staff to be deployed effectively and efficiently to the areas of need.
- The cost per WAU for allied health professional (AHP) staff was in the second highest (worst) quartile at £142 compared to £119 nationally. The trust acknowledged this was an area for improvement. The trust had a high proportion of AHPs in senior roles which affected the overall cost of this staff group. The trust had made changes in some clinical pathways which resulted in AHPs with additional training now competently undertaking tasks previously completed by medical staff. The trust was, at the time of the assessment, leading work within the local health system to change clinical pathways to address challenges in dermatology and ear, nose and throat (ENT) services.
- The trust met its agency ceiling as set by NHS Improvement and was £4.2million below the agency ceiling in 2018/19 and was forecasting to meet its ceiling in 2019/20. It was spending less than the national average on agency as a proportion of total pay spend (3.45% compared to 4.5% nationally). It had achieved significant reductions in the cost of agency and locum staff through the implementation of several initiatives including:
  - the implementation of e-rostering (which covered 75% of staff compared to 33% nationally)
  - real time tracking of acuity and dependency to ensure the right number of nursing staff are available to provide safe care
  - efficient use of consultant time through 100% consultant e-job planning
  - the use of extensive workforce controls and market management
- The trust was maximising skill mixing opportunities ensuring that staff worked to the top of their professional licence. They had taken opportunities to review clinical care pathways to improve patient experience, release efficiencies and manage recruitment issues in several areas. For example, in rheumatology they had substituted a therapist with extended scope for a doctor. This supported retention of staff as it provided a career path for clinicians. Other innovative practice included specialist dementia training for health care assistants to provide them with the skills and competencies to provide high quality care to patients with cognitive impairment, and therefore removing the need for additional qualified nurses. The trust tracked the cost effectiveness of quality improvement initiatives in bed days as 'releasing time back to care'. In stroke care the trust had released 83 hours of nursing time and the improvements in the number of falls had resulted in a reduction of 13 beds per year.
- The trust implemented values-based recruitment, had adopted the principles of the workforce race equality standard (WRES) and were working with Health Education England on a best place to work programme. The trust offered a range of leadership programmes for all staff levels and recognized that developing positive relationship between staff and their manager was a key factor to retaining staff.
- Staff retention at the trust was good, with a retention rate of 86.2% in December 2018 against a national median of 85.6%, placing the trust in the second highest (best) quartile nationally. Turnover was low at 8% (January 2019) and many staff had been with the trust for several years with the result that they were experienced in their role and were able to support and train new starters and maintain the pervasive positive culture developed through 'Patient First'.
- The trust had a 100% retention rate for international recruitment. The trust had an established link with the Philippines and offered an established and very successful support package for new arrivals.

- The trust first introduced its 'Patient First' quality improvement methodology in 2015. The programme was owned at all levels in the organisation, and the behaviours modelled by all staff including the trust board. At the time of the assessment, 4,000 staff had received an awareness to the methodology (known as 'white belt') with another 495 trained to more advanced knowledge of the methodology, including 4 experts able to lead highly complex, system-wide change (known as 'black belts'). The trust was starting its 10th wave in 2019/20, after which the methodology would have been rolled out across the entire trust. The methodology provided the workforce with the tools and problem-solving skills and empowerment to drive continuous improvement. This helped to foster a culture, described as 'the way we do things here'. Staff put patients at the centre of all that they did and were encouraged to consider how to make changes that would lead to quality improvements.
- As at November 2018, the trust's staff sickness rate was 4.18%, below the national median of 4.35% and benchmarking in the second lowest (best) quartile nationally. The trust had a range of activities in place to support staff wellbeing including weekly exercise classes, competitions aimed at increasing staff activity, and mindfulness sessions to reduce stress and anxiety.
- Staff engagement was excellent. In quarter 4 2018/19, 92% of staff advocated the trust as a place to work (compared to a national average of 65%), and 97% advocated it as a place to receive care (compared to a national average of 80%). The trust identified its 'Patient First' programme as a key factor to staff engagement with the trust empowering staff at all levels to identify and implement continuous improvements for patients.

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

The trust's clinical support services costs per WAU ranked in either the second or third national quartile. The trust had invested relatively intensively in technology and digitisation in support of pathology, imaging and pharmacy which was both improving efficiency and access. Further efficiencies were achievable through the acceleration of collaboration and increased scale.

- The latest metrics for the trust's pathology services showed the cost per WAU for direct access testing of £3,894 was above the national median (£3,800) but below the peer median (£4,091). Other available data showed the overall cost per test to be better than both the national and peer medians. The trust had invested in a managed equipment service to ensure that equipment was kept up to date and the trust had also deployed a new laboratory information system (LIMS) in March 2018. Further investment was underway to extend the order communication system.
- To achieve further improvement in the efficiency of the pathology services, the trust, with its partners in national 'network 7' needed to progress their planning and implementation to achieve economies of scale which would likely result in the cost of direct access services reducing below national median levels. Progress on 'network 7' had however been significantly slower than other networks despite £19.7 million of approved capital funding. The trust had also initiated a 'demand optimisation project' in response to high historic levels of testing per 'request' and per head of population. This positive initiative was however proving more challenging than expected to implement and had resulted in an under-delivery of planned efficiency savings in 2018/19 but which the trust was planning to recover in 2019/20.
- The trust's radiology services benchmarked well for efficiency across nearly all metrics. The overall cost of an imaging report placed the trust in the second-best national quartile. This had been achieved by effective control over non-pay costs, the very effective use of radiographers in reporting, rigorous job planning of staff and investment in facilities to improve workflow although the trust materially underdelivered on its planned efficiencies in this area in 2018/19, primarily due to ongoing agency costs. There were challenges in terms of capacity with high levels of consultant vacancies (21% compared to the national median of 12%). The capacity challenges combined with a 6% increase in imaging demand had led to some historic reporting backlog. The trust had been investing in additional equipment capacity with £3.5 million invested over the past 3 years and were actively recruiting additional staff from overseas to help reduce the very high levels of agency staff in the imaging department. The most recent data showed that this investment had closed the capacity gap with overall diagnostic performance being better than the national median and good performance in imaging.
- The trust's pharmacy services benchmarked well against national efficiency metrics. The latest medicines cost per WAU was £303 against a national median of £309, ranking the trust in the second quartile. In 2018/19, the trust had delivered efficiencies very significantly above planned levels through the switching of drugs to biosimilar provision in line with the national median rate of switching and supported by investment in a biologics pharmacist.
- The trust was advanced in the deployment of technology and its digital strategy to support its pharmacy services being an early adopter of automated dispensing robots, the full deployment of an electronic prescribing and medicines

administration (EPMA) system in 2015 and e-prescribing in support of critical care and cancer services. The trust did not, at the time of the assessment, participate in the NHS benchmarking service which was the source for other pharmacy metrics held in the Model Hospital. Historic benchmarking data indicated that the trust performed less well than the national median for stockholding, percentage pharmacists actively prescribing and the provision of a 7-day service. The trust had however provided more recent information that would benchmark the trust materially better on stockholding and in the second-best quartile for the other metrics. The trust had increased provision to a 6-hour weekend service at Worthing hospital and 4-hour week-end service at St Richards with further hours being evaluated based on cost benefit analysis.

- The trust was an early adopter of technology and digitisation to support continuous development of its services and invested relatively intensively in these areas. As a result, more than 65% of all outpatients were, at the time of the assessment, seen with a digital record and through the development of a 'single results viewer', staff were able to rapidly access all patient records. The trust's digital maturity showed the trust to be in the upper quartile in most areas with the greatest future opportunity being in enabling remote assistive care.

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

The trust had a non-pay cost per WAU in the lowest (best) quartile, which had been achieved through rigorous control over medicines and supplies and service usage. The trust benchmarked well for its corporate services with the quality of its information technology (IT) capability being assessed as excellent based on internal surveys and external awards. The trust ranked marginally below average performance in the procurement league table and in the relative cost of running its estate but scored in the top quartile for the quality of the estate and facilities services.

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,073 (tenth best in England) compared to the national median of £1,301.
- The trust's supplies and services costs per WAU were £322 (second best quartile) against the national median of £364. For December 2018, the trust ranked 69 out of 136 trusts in the procurement league table published by NHS Improvement to assess the relative performance of non-specialist NHS acute providers' procurement departments. The trust's PPIB (purchase price index and benchmarking) tool usage score benchmarked well at 72.8 against a national median of 59.3. However, there was further scope for improvement with the percentage variance on the top 500 products at 11.7% compared to the national median of 10.2% (March 2019). The trust's procurement team was systematically reviewing PPIB variance data to reduce the variances and in 2018/19, it had delivered procurement efficiencies of more than £2 million which was above plan.
- The procurement function cost per £100 million turnover was high at £233.6 thousands compared to the national median of £206.2 thousands. The trust was an early adopter of a clinical procurement specialist role which had created a more efficient approach to the procurement of clinical products and the trust had a 'put away' materials management service that saved the trust clinical time. The trust was working on collaboration across the health system and was joint chair of the STP collaborative procurement steering group. A wider procurement hub was in place, however, not all trusts were actively participating and there was an opportunity to collaborate further.
- The cost of running the trust's finance function was low and had reduced since 2016/17 to £587 thousands per £100 million turnover compared to the national median of £715 thousands per £100 million turnover. The costs of the management accounts function and income and accounting function were low at £215 thousands and £38 thousands per £100 million turnover respectively compared to national medians of £262 thousands and £81 thousands. The trust had outsourced its accounts payable and receivable functions as an efficient approach.
- The trust had a low human resources (HR) function cost at £741 thousands per £100 million turnover that placed it in the lowest (best) quartile nationally and below the national median of £1,093 thousands per £100 million turnover. The cost of recruitment was low at £61 thousands per £100 million turnover compared to £107 thousands per £100 million turnover nationally and the trust also had an external advert cost per starter of £0.10 compared to £1.70 nationally. The trust had a diligent approach to recruitment, however, there may have been an opportunity to improve the time taken to hire clinical staff with the trust taking 73 days compared to a national lower quartile performance of 53 days.
- More than half of the trust's estate was built before 1975 and was spread over multiple sites which presented challenges to efficiencies. The trust's 2017/18 estates and facilities cost per square meter was £345 compared to a national median of £334 placing the trust in the second worst quartile nationally. Overall efficiency had improved over the past 12

months with efficiencies of 4.3% having been delivered in 2018/19. Both hard facilities management (FM) costs (£75 per square meter) and soft FM costs (£122 per square meter) were below the national median of £88 and £133 per square meter respectively. The key reason for the higher than national median cost per square meter was the finance costs of the capital investments.

- The trust benchmarked well for most soft FM costs but was an outlier for cleaning costs at £49 per square meter that placed it in the fourth (worst) quartile nationally. The trust had decided to invest in this area to maintain low infection rates and rapid turnaround in ward areas to support patient flow. The quality metrics for the estate and FM services were high with the 'PLACE' (patient-led assessments of the care environment) score being in the best quartile nationally.
- The trust had invested above internal depreciation levels over the last few years to deliver improved facilities and address infrastructure and backlog maintenance risks. Backlog maintenance had reduced from above the national median in 2016/17 to £253 per square meter that was slightly under the national median of £254 per square meter in 2017/18. The critical infrastructure risk remained above the national median at £108 per square meter compared to £102 per square meter nationally. The trust had developed an estates master plan to ensure optimisation of its estate and reduce the backlog maintenance over the next 5 to 10 years. There were further opportunities to optimise activity across the trust's sites and reduce relatively high levels of under-utilisation at Southlands hospital with increased ambulatory care use. The trust had also invested in its estates staff through an 'academy' and achieved better staff retention than nationally.

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

The trust was in surplus position and delivered its control total in 2018/19 and had a plan in place for 2019/20 which would consolidate the trust's underlying surplus position. The trust had a well-developed and embedded quality improvement programme 'Patient First' and robust financial management processes which meant it had a track record at delivering its cost improvement plans including with a significant level of recurrent savings. The trust was working constructively with its commissioners through its aligned incentive contract which allowed a common management of risks with its commissioners and provided a path to an integrated care partnership across the health system. The trust had positive cash balances, did not require any central cash revenue support and was able to invest in its capital programme according to its priorities and level of risk. However, the trust could further improve on the management of its debtors and creditors.

- In 2018/19, the trust had achieved a £1.2 million surplus in line with its control total (excluding provider sustainability funding (PSF); £28.5 million including PSF) which represented 0.3% of turnover and an improvement on the £2.3 million deficit delivered in 2017/18. For 2019/20, the trust had a plan to deliver a surplus of £2.5 million surplus (excluding PSF and marginal rate emergency tariff (MRET)) representing 1.3% of turnover. As at the end of July 2019, the trust was on plan and continued to forecast the delivery of its full year plan.
- The trust had a track record to delivering its cost improvement plan (CIP). During 2018/19, it had delivered £18.2 million efficiencies, representing 100% of its cost improvement plan, 3.9% of expenditure with 96% delivered recurrently. This continued prior year delivery of similar level of savings including recurrently. For 2019/20, the trust targeted a lower level of savings (the lowest in the last five years), with a plan of £11.7 million, 100% recurrent and representing 2.5% of expenditure. The lower level reflected the trust's underlying financial position improvement into a surplus which it planned to sustain. The trust also argued this provided capacity for teams to focus on longer term efficiency programme which took longer to plan, implement and for the benefits to materialise
- Under its 'Patient First' programme, the trust had in place a robust methodology and assurance and governance processes to identify efficiency schemes, assess their impact on quality, track their delivery and report on the progress of the schemes. The trust had a strong focus on managing the delivery risk of its efficiency plan and for 2019/20 had an additional target to identify £1.3m 'headroom' (ie additional schemes) which would provide a mitigation against any under-deliver of its main plan and an early identification of schemes for the next financial year. The trust's efficiency plan included tactical schemes from all areas/divisions, continued reduction of temporary staffing and strategic initiatives to improve operational productivity across the trust (ie theatre productivity, new models of care). The plan also included 5% from specific income schemes such as the continued repatriation of independent sector activity to the trust. We however, noted that 41% of the plan relied on the medicine division and 25% were going to be achieved through procurement savings. As at July 2019, the trust had achieved its year-to-date savings target and continued to forecast the achievement of its yearly CIP.

- The trust also had established reporting at divisional level and patient level costing had been in place for several years. At the time of the assessment, the trust was triangulating its service line data with tariffs (HRGs) to understand pathway costs to identify improvement opportunities working with its divisions.
- The trust had entered into an aligned incentive contract (AIC) with its main commissioner in 2017/18. The contract provided a mechanism to recognise systems risks (including the significant funding gap) transparently and set out a framework to manage these in common supported by robust arrangements to manage and oversee the necessary improvement programmes across both organisations to deliver the AIC's ambition to return the health economy to a financial surplus. The AIC had achieved several successes during 2018/19, particularly, the reduction of £10 million spend on independent sector spend representing and £2 million savings on medicine management.
- The trust had taken steps during 2018/19 to maximise the commercial income it received from residential accommodation, car parking and retain catering. The trust had also increased its overseas recovery by 50% between 2017/18 and 2018/19 to £0.5 million. We noted that the trust's private patient income had decreased over the last three years, from £6.6 million (2016/17) to £5.1 million (2018/19) reflecting the trust's need to balance the delivery of services between NHS and private patients.
- The trust had maintained positive cash balances and had debt service and liquidity ratings of 1 (best) in 2018/19. The trust did not rely on cash revenue support to operate. The trust had a prioritised capital programme aligned to its 'Patient First' programme and over the previous two years had invested above its internally generated capital to enhance its services. However, we also noted that the trust's performance against the best practice payment code showed room for improvement. The trust had made progress during 2018/19 to resolve issues originating from delayed payments from NHS debtors in 2017/18 and improved its credit control and debt management processes. At the time of the assessment, the trust was developing its cash management strategy.
- The trust did not extensively use external management consultancy services. In 2018/19, it had spent £0.4 million relating to work requiring specialist knowledge not available within the trust or where it was mandated to bring an objective view through an external review.

Outstanding practice

During our assessment we identified several outstanding practice areas. Below are some of the key or most innovative ones:

- The trust has a well-established and embedded continuous improvement programme, 'Patient First' based on a 'Kaizen' continuous improvement concept and 'Lean' methodologies which empowers front-line staff to make improvements themselves and deliver productivity improvements and efficiency savings.
- The trust's efficiency programme has a robust governance and assurance process and the trust has a track record of delivering recurrent cost improvements. In addition to a Kaizen office (to support the 'Patient First' programme), the trust has a well-established project management office which uses a robust set of tools and approach to manage the efficiency programme.
- The trust has an aligned incentive contract with its main commissioners since 2017/18. The contract provides a framework and infrastructure for collaborative working and, particularly, the recognition and joint management of risks across the two organisations.
- The trust leads and drives change in the care of mental health patients and has introduced innovative practices such as the implementation of a mental health board, which includes wider system partners, to improve the pathways for mental health patients.
- 65% of the trust's outpatients are seen with a digital record and through the development of a 'single results viewer', staff are able to rapidly access all patients' records.
- The trust has invested in its estates staff through an 'academy' and achieves better staff retention than nationally.

Areas for improvement

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

- The trust had higher than median medical and AHP costs per WAU. The trust should continue its effort to reduce the costs of these staff group to bring it closer to the national medians.

- The trust had a poor performance against the best practice payment code. The trust had progressed during the year and was developing its cash management strategy. The trust should ensure that it continues to progress with improving the time it takes to pay valid creditor invoices.
- The trust should continue to work closely with its partners from the pathology network 7 to progress their planning and implementation to achieves economies of scale and reduce the cost of direct access services.
- The trust should continue its effort to review its purchase price variance on the top 500 products to continue to reduce its percentage variance to the national median.
- The trust should consider options to optimise activity across the trust's sites and reduce the relatively high levels of under-utilisation at Southlands hospital.

Ratings tables

Key to tables					
Ratings	**Not rated**	**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 last rating published					

* 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

	Service level				Trust level	
	Safe	**Effective**	**Caring**	**Responsive**	**Well-led**	**Use of Resources**
	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019

Overall quality

Outstanding

Oct 2019

Combined quality and use of resources

Outstanding

Oct 2019

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.

Term	Definition
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 a number of 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) cost per £100 million turnover	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.

Term	Definition
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.

Term	Definition
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.