East Sussex Healthcare NHS Trust

Use of Resources assessment report

St Annes House
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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	Good
Are services safe?	Good
Are services effective?	Outstanding
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Are resources used productively?	Requires improvement

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 of quality and resources was good and this was the first time we have had a combined rating for this trust. We rated it as good because:

We rated safe, responsive and well led as good and caring and effective as outstanding. Use of resources was rated as required improvement.

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?	Requires improvement

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 .

We visited the trust on 2 October 2019 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair and deputy Chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Requires improvement

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

We rated Use of Resources as requires improvement. The trust had exited special measures for quality and finance in 2018 and 2019 respectively, and at the time of our assessment, the trust could evidence good productivity in several areas. In particular, the trust benchmarked well on clinical services and had significantly reduced its reliance on agency staff. However, the information available at the time of the

assessment showed that despite improvements, the trust's costs remained higher than the national median and there remained opportunities to improve the way it used its resources regarding workforce, clinical support services and corporate functions. Although the trust had reduced its deficit – including through working with its local health system partners -, it still needed to increase the level of recurrent efficiencies it achieved and reduce its reliance on central cash support.

- This was the first time we carried out a use of resources assessment at the trust.
- The trust had been placed in special measures for quality in 2015 and for finance in 2016. Since then, the trust had significantly improved the quality of its services and its financial position leading the trust to exit special measures for quality in 2018 and finance in 2019. This had also resulted in improvements in productivity and use of resources in several areas across all 5 key lines of enquiries of our use of resources assessment.
- Based on the latest data available at the time of the assessment (2017/18), the trust had an overall cost per weighted activity unit (WAU) of £3,768 which benchmarked in the highest (worst) quartile nationally. Data for 2018/19 was not yet available at the time of our assessment so it was not possible to assess the impact of the trust's productivity and financial improvements during 2018/19 on the overall cost per WAU. However, a proxy metric such as the cost per WAU based on a sub-set of activity data (called 'HES-WAU') seemed to indicate that the trust had improved comparatively more than other trusts nationally in 2018/19.
- At the time of the assessment, the trust was not meeting 3 of the 4 constitutional operational standards. The trust was achieving the diagnostics 6-week targets and its operational performance compared generally well against peers and national medians for the 4-hour accident and emergency target (A&E) and 18-week referral to treatment target (RTT). The trust however, was underperforming against the cancer 62-day target against peer and national medians.
- The trust benchmarked well on most clinical services metrics, had improved its theatre productivity and was well engaged in the 'getting it right first time' (GIRFT) national programme. The trust however benchmarked higher than the national and peer medians for emergency readmissions and was investigating the drivers to this position.
- The trust's overall pay cost per WAU for 2017/18 (latest available data), benchmarked in the worst quartile nationally. The trust had improved controls over its pay costs resulting in the slowing down of its pay costs growth between 2017/18 to 2018/19 although it was not clear, at the time of the assessment, how this would impact future pay cost per WAU. However, we noted that the trust had significantly reduced its reliance on temporary staff, including agency. The trust had systems to deploy its staff efficiently and had introduced new roles to allow staff to work to the top of their licence. We however noted that the trust could progress further on job planning.
- The trust had developed a wide range of strategies to attract, recruit and retain staff although further work could be done to improve the trust's sickness rate to closer to the national median.
- Over the last few years, the trust had developed its culture around better collaboration and integration of teams and leadership around a shared agenda. The trust was now focusing on developing its continuous improvement approach.
- The trust benchmarked well compared to other trusts for pharmacy and pathology services and the trust had delivered efficiencies in both these areas for 2018/19 and planned to deliver further efficiencies in 2019/20. The trust's imaging service was cost effective but performed in the weakest quartiles in the benchmarking of DNA levels and reporting backlogs, particularly plain film although through the appointment of a new clinical lead, performance had improved, and historic issues had been tackled.
- The trust's non-pay cost per WAU benchmarked in the second highest (worst) quartile for the latest data available (2017/18). The trust had achieved significant savings in its corporate functions although there remained further opportunities. The trust was also investing significantly in its information management and technology systems. The trust had invested in its procurement function and was delivering material savings although further work could be done to improve on prices and system collaboration. The running cost of the estate benchmarked well against the peer benchmarks as did most of the qualitative scoring based on patient experience. The efficiency of use of space and the levels of backlog maintenance ranked the trust in the 4th quartile. The need for significant capital investment was highlighted in the recent estate survey and the Trust were actively pursuing options to secure the funding.
- Since entering special measures for finance in October 2016, the trust had strengthened its financial controls and governance. Together with its commissioners, it had developed a financial recovery plan for the local health system which it was on track to deliver at the time of the assessment and could demonstrate a reduction of its financial deficit year on year. The trust had delivered its cost improvement plan (CIP) in 2018/19. It also had implemented service line reporting and clinical divisions were using the information to support decisions and identify areas for cost improvements together with productivity metrics from the Model Hospital and GIRFT.

- However, at the time of the assessment, the trust was still planning on delivering a material deficit (8.2% of turnover) and it needed to progress with the identification of its savings plan for 2019/20. The trust had also accumulated a significant debt with the Department of Health and Social Care (DHSC) as a result of its on-going financial deficit position and it continued to rely on cash revenue funding from DHSC.

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

The trust had mixed performance on clinical services. Performance against the NHS operational standards was relatively strong in some areas, such as referral to treatment and diagnostic waits compared to peer and national averages. A&E performance had deteriorated recently but had generally been better than the national position and cancer performance was significantly weaker than other trusts. However, the trust had made progress in reducing delayed transfers of care and had low average pre-procedure bed days. Emergency readmissions were high, but the trust was investigating the reasons for this. They were good arrangements in place to deliver improvements through the GIRFT programme.

- The trust generally compared well against peer and national medians for the 4-hour Accident & Emergency (A&E) standard of 95% over the last year, although performance, for the most recent month where comparative information was available (October 2019), had dipped to 81% which was below both national and peer medians.
- The trust reported important factors affecting its performance were significant challenges from increased demand and patient acuity. However, the trust had developed and implemented a near real-time bed monitoring system in A&E which it felt was supporting more responsive management and performance. It also highlighted a drive to ensure senior medical decision makers were available in A&E to maintain flow.
- The trust had experienced significant operational pressures and worked with the system to attempt to alleviate these pressures and was developing a transformation strategy with system partners. The trust should be commended for investing in same day emergency care pathways which were seeing approximately 30% of patients.
- The trust had consistently out-performed both peers and the national medians for the 18-week referral to treatment standard including addressing a dip in performance in September/October 2018. The trust's performance for the most recent period for which comparative information was available (September 2019) was at 90% against a target of 92% and against national and peer medians of 84.5% and 81% respectively.
- At the time of our assessment the trust had no patients waiting in excess of 52 weeks. The trust reported to us that it had a zero-tolerance approach to cancelled operations and worked hard to create the capacity to deliver planned activity at more challenging times. It identified its sustained focus on improving flow as a key driver in maintaining its performance on elective care.
- The trust performed better than the national median on day case rates at 82% versus the national median of 78% for the most recent data (March 2019) and its conversion to overnight stays at 9% was lower than the national median of 11% although slightly higher than the peer median of 8%.
- The trust achieved the diagnostic 6-week wait target of 99% for much of the last 12 months and was performing better than peers (96.6%) and national medians (98.4%) for the most recent comparative information (September 2019). However, the trust recognised it was experiencing challenges with the diagnostic target. This primarily related to ultrasound (sonographer capacity) and reliance on additional internal hours to deliver capacity.
- The trust was not achieving the 62-day cancer standard of 85%, although its performance had improved from a low point of 60% in September 2018 and had been closer to peer and national medians during recent months. However, performance had deteriorated for the most recent month for which comparative data was available (September 2019) at 70.5% compared with a national average of 79.4% and peer average of 78.8%. The trust had identified a significant increase in referrals as one of the key causes for the drop in performance. The trust had undertaken significant work to address this increase including weekly reviews of patient tracking lists and increased capacity in diagnostics and a urology investigations suite.
- The trust had made good progress in addressing delayed transfers of care which were historically some of the highest in the country but were more recently tracking below peers and the national medians. The trust was working more effectively with the wider system, including social care and community partners on a daily basis. It had developed a 'Medically Fit App' which provided medically fit for discharge patient information across its acute sites and indicated what further actions they were waiting for.
- The trust's pre-procedure elective and non-elective bed days were amongst the best in the country.
- The trust had worked with Four Eyes Insight as part of its theatres transformation programme. This work identified that in-session utilisation was good, although there were some areas, such as breast surgery, where productivity could be improved.

- The trust's Did Not Attend (DNA) rate had improved from a high of 8.6% two years ago to 7% for September 2019 being the most recent data, which was marginally better than the national median of 7.1% but worse than the peer median of 6.4%. The trust reported that it had been active in managing DNAs through improved digital management of outpatients and some specialties were offering telephone appointments.
- Emergency readmissions were in the highest (worst) quartile as at September 2019 at 9% being higher than peers (8.7%) and nationally (7.8%). The trust was examining what was driving this situation and was looking at the patient pathway with a focus on frailty. The trust was also reviewing potential data issues surrounding readmissions of children.
- The trust utilised GIRFT to drive improvements. It had a GIRFT board in place with attendance from clinical, management, nursing and support functions. The trust had used the GIRFT recommendations to make changes in several areas including to the day surgery pathways, enhanced recovery protocols, pre-assessment procedures and hip prostheses. The trust had also revised its litigation process and claims were now reported at speciality governance meetings as they occurred. The trust had established a dedicated Intranet page and used GIRFT within its innovative improvement hub.

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

The trust's overall pay costs per WAU benchmarked in the worst quartile nationally for the latest data available (2017/18) although since the trust had taken measures to control its pay bill with evidence of improvements, particularly in relation to temporary staffing. The trust had systems in place to deploy its staff effectively and had introduced innovative roles although more needed to be done on job planning. The trust had measures in place to support, retain and recruit staff although this needed to translate into an improved sickness rate.

- Based on the latest data available (2017/18) the trust had an overall pay cost per WAU of £2,382, compared with a national median of £2,094, placing it in the highest (worst) cost quartile nationally. This reflected investments in quality made between 2015 and 2018 when the trust was in special measures for quality. We noted however, that the trust's pay bill growth rate had slowed down to 2.8% between 2017/18 to 2018/19. The proportion of substantive staff had increased (from 84% to 87%) and the use of temporary staff (including bank, locums and waiting list initiatives) had dropped from 16% to 13% between 2016/17 and 2018/19.
- The trust was in the second lowest (best) quartile for medical cost per WAU in 2017/18 at £503 compared to a national median of £533 and a peer median of £550. The trust faced difficulties to recruit medical staff which led to a high usage of expensive temporary staff. The trust had however managed to transfer several its locums onto its bank staff.
- The cost per WAU for nursing staff in 2017/18 was £859 compared to a national median of £710 and peer median of £742 and benchmarked in the highest (worst) quartile nationally. This was due to a staff classification issue and a decision to invest in specialist nurses to compensate for issues with medical recruitment. The trust had a high level of 'care hour per patient per day' compared to peers but the trust considered it an appropriate level, reflecting the high level of care required in specific specialties.
- The cost per WAU for allied health professional (AHP) staff was in the highest (worst) quartile at £159 compared to £130 nationally and £148 for the peer median. However, when adjusted for community services activity at the trust, the AHP cost per WAU was similar to the national median.
- The trust had reduced its spend on temporary staff (agency, bank, locums and waiting list initiatives) over the last two years from £13.8 million in 2017/18 to £8.7 million planned for 2019/20. At the time of the assessment, the trust did not use any agency healthcare assistants. The trust had met its agency spend ceiling as set by NHS Improvement in the last two years. Its agency spend as at the end of September 2019 was also materially below its ceiling. The trust had implemented stricter controls and monitoring over the use of agency staff with a panel meeting weekly to review requests for agency staff and medical agency staff requirements signed off by the medical director. The trust had transferred agency staff to its staff bank, aligned rates across the trust and developed a temporary workforce services team who supported clinical divisions to identify resourcing solutions. At the time of the assessment, the trust was also working across the sustainability and transformation partnership (STP) to develop a sustainable collaborative staff bank.
- The trust's rotas fill rate had been between 89.5% and 91.7% each month over the 12 months up to July 2019. The trust used Safecare and Healthroster tools to monitor 'live' resourcing levels to flexibly deploy its staff based on patient acuity with a review of staffing levels three times a day. At the time of the assessment, all nursing staff were on the e-rostering system and the trust was implementing e-rostering for doctors. Rotas were signed off 8 weeks in advance. The trust reported that the close monitoring and review of staffing levels had allowed them to close a ward during the summer months.

- All doctors had a job plan, although at the time of the assessment only 55% were fully signed off. The average supporting professional activities (SPAs) (i.e. non-direct patient contact) per doctor was 1.9 which was in line with guidance. The trust reported that 20% of its doctors were reducing the number of programmed activities (PAs) they worked from 12 to 10 as a result of changes to pension rules. This meant the trust had less doctor time to deliver its activity. The trust had plans to expand job planning to allied health professionals and eventually nurses.
- The trust's retention rate was 87.3% for December 2018 (latest data available) and benchmarked in the second highest (best) quartile nationally and its vacancy rate was 10.5% as at July 2019. The trust had developed a wide range of strategies at local and system level to attract and recruit its staff such as: generic rolling and enhanced recruitment; return to practice initiatives; partnership with higher education institutes to identify and recruit newly qualified professionals; preceptorship programme; and a partnership with Medacs to target the hard to recruit medical roles.
- The trust had implemented new roles in its acute and community teams and across non-professional and professional roles. These included integrated care support workers, frailty practitioners, clinical nurse specialists, consultant nurses/midwives, clinical pharmacists, assistant practitioners, physician associates, doctor assistants etc. The trust, however, recognised, that it needed to do more to promote these new roles internally and bring them more systematically into its workforce strategy and planning.
- As at September 2019, the trust's staff sickness rate was 4.16%, higher than the national median of 4.11% and benchmarking in the second highest (worst) quartile nationally. The trust had identified the main causes of illnesses as well as the most impacted staff groups. It had a health and wellbeing strategy in place to support both the physical and mental wellbeing of its staff, including an in-house occupational therapy team and a recently introduced employee assistance programme. The trust monitored the effectiveness of its strategy through staff engagement scores, patient outcomes and workforce metrics which showed a positive impact.
- Over the previous few years, the trust had developed its culture and leadership which had improved collaboration and integration of staff and services around a shared agenda. Together with the actions to support staff health and wellbeing had resulted in a noticeable improvement of the trust's staff survey in recent years.

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

The metrics for the trust's pharmacy and pathology services compared well with other trusts and with strong delivery of efficiencies in both these areas during 2018/19 and planned for 2019/20. The trust's imaging service was cost effective but performed in the weakest quartiles in the benchmarking of DNA levels and reporting backlogs, particularly plain film although through the appointment of a new clinical lead, performance had improved, and historic issues had been tackled.

- The latest available pharmacy benchmarking in June 2019, showed the trust's medicines cost to be above the national median at £397 per WAU compared to a national median of £363. The primary driver for this was the greater proportion of 'high cost pass-through drugs' at circa 80% associated with the trust's oncology, rheumatology and gastroenterology services. The trust had however controlled pricing effectively with well above national median levels of biosimilar switching which allowed the trust to deliver medicine cost improvements in 2018/19 at 80% above plan. The level of antibiotic prescribing was however above the national median levels with higher costs being incurred. The trust had made a proactive decision to use a broader spectrum antibiotic to tackle the levels of sepsis related mortality and to maintain effective control over c-difficile rates.
- The processes around the medicines service were better than national medians and improving with the 2-year programme to implement electronic prescribing and medicines administration (EPMA) started in March 2019. The areas for further progress were in the proportion of pharmacists prescribing which was still low at 25% and investment in a more comprehensive 7-day service which had recently been approved by the trust board. The trust worked effectively with the broader system in the delivery of the medicines optimisation programme and processes to facilitate the early discharge of patients. The trust had refreshed its pharmacy strategy in August 2019 (in its 3rd year) which included clear priorities.
- The metrics for the trust's imaging services showed variability in performance against the range of metrics recorded in March 2019. The DNA rates for all imaging modes continued to be a challenge for the trust with the levels being in the highest or second highest quartile in March 2019. Although several initiatives and enhanced monitoring had been put in place, the overall numbers had continued to increase during 2019 (although the rates for obstetrics and CT scans had improved).
- There were high levels of unreported plain film x-rays in March 2019 which were being investigated by the trust and reported on when we visited the trust in October 2019. A previous policy had not required that inpatient and

outpatient films be reported on unless requested. As a result of the investigation, 3,500 chest x-rays from the previous 5 years had been reviewed with no significant incidents to report. This however demonstrated that this policy was not a good use of resources, nor was it appropriate clinical practice. The policy had been amended to require reporting within 14 days. The levels of x-ray auto-reporting was also in the lowest national quartile.

- The overall cost per report was better than the national and peer medians however the cost of securing enough capacity through insourcing and agency costs were both in the highest national quartile. The trust acknowledged the need to strengthen the service. It had appointed a new clinical lead and committed to replace equipment and invest in additional capacity such as new MRI scanners. The Trust continued to face challenges in recruitment. There was good collaboration with the local system and the trust was evaluating a system wide picture archiving and communication system (PACS) investment. An imaging action plan had been established for 2019/20 through to 2022/23 with a focus on improving performance metrics in the face of staff shortages, significantly rising activity and constrained capital funding to replace equipment.
- The average overall cost per test for the trust's pathology services was better than both the national and peer medians (quarter 2 2018/19) as was the cost of the trust's blood science testing. The costs of cellular pathology and microbiology testing were however both above the national and peer medians. The trust had adopted different collaborative approaches to develop its services.
- The trust had delivered £1 million cost improvements in its pathology services in 2018/19 with most of this being achieved through the new managed equipment services (MES) contract. The trust had continued to improve efficiency in 2019/20 with the average overall cost per test having been reduced from £1.64 to £1.42 placing the trust in the best quartile. The metrics showed that the volume of testing for the served population was high. The trust worked with both its consultants and commissioners to minimise repeat testing. In the face of growing demand, the trust had put in place an enhanced colorectal pathway management using additional screening (faecal immunochemical tests) which had enabled the trust to achieve its diagnostic target.

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

The trust's non-pay cost per WAU benchmarked in the second highest (worst) quartile for the latest data available (2017/18). The trust had achieved significant savings in its corporate functions although there remained further opportunities. The trust was also investing significantly in its information management and technology systems. The trust had invested in its procurement function and was delivering material savings although further work could be done to improve on prices and system collaboration. The cost of running the estate benchmarked better than the peer median based on cost per square meter but worse when compared with activity. The two main issues to address were to improve the efficiency of estate utilisation which the trust had progressed in 2019/20 and to address the very high levels of backlog maintenance and overall investment in the estate that required significant capital funding. The quality of the services was rated well overall through the patient surveys.

- For the financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,380 (compared to £1,289 in 2016/17) although the 2017/18 figure is distorted by the significant impairment of the estate which added £115 to the non-pay cost per WAU. The trust had high costs for corporate administration and estates staff and other non-pay costs. The cost of medicines was also high but reflected the level of specialist work being undertaken by the trust. The trust had put in enhanced expenditure controls in October 2018 to reduce these levels.
- The trust had focused on corporate services efficiencies and reduced the costs by more than £2 million between 2017/18 and 2018/19, although this was against a savings plan of £3.5 million. As a result of the savings achieved, the trust had progressed from the most expensive quartile to the second most expensive quartile indicating, however, that there remained potentially substantial opportunities to improve further. The areas of greatest savings were in finance and governance & risk. Despite the significant improvement in efficiency the trust had reduced its CNST (clinical negligence) costs by £5 million over the past 3 years. The trust's human resources (HR) costs remained high which were partially explained by the decision to invest in occupational health. The trust had improved its efficiency of its day to day operations in information management and technology (IM&T) but had maintained the level of investment in technology development with an increased emphasis on digital and business intelligence to support operational development in key areas such as flow management and had a target to achieve a paper-light outpatient service. There had also been a drive to achieve a fully electronic document management system however the targeted savings for 2018/19 had not been achieved as the transition had taken longer than anticipated.
- With regards to procurement, the trust had achieved its savings target of £1.8 million in 2018/19 and had planned a similar level for 2019/20 which it was on target to achieve at the time of the assessment. The cost of the procurement team was at the top end of the second highest (worst) quartile based on trust size. This higher level of investment

was a conscious decision made by the trust to deliver the procurement savings programme (£1 million of investment delivering circa £2 million of savings per year). The trust ranked 86th of 133 trusts based on the most recently submitted data from the trust. Since then the trust had achieved its Level 1 NHS Procurement Standards which would be reflected positively in the next league table ranking. The trust still had a significant opportunity to improve on its price performance component which was worse than the national median. The trust collaborated on procurement across the sustainability and transformation partnership (STP) through a collaborative procurement hub rather than a shared function, but aggregated buying was not in place at the time of the assessment which should benefit the price performance component of procurement. The trust had implemented an enhanced cost control intervention programme ('T3') from October 2018 for both pay and non-pay expenditure with panels being put in place to review expenditure. The benefits of this would however not be reflected until the 2018/19 cost per WAU analysis became available.

- The trust operated from 5 main sites combining both acute and community hospitals. The total cost of running the estate was better than the peer median with the 2018/19 total cost per meter square being £358 compared to £373 with both the soft and hard facilities management (FM) components being better than the peer median benchmarks. The areas of opportunities identified through benchmarking were relatively limited and primarily within waste & sewage including recycling. The trust had overdelivered on its estates and facilities efficiency programme in 2018/19 by over 20% and delivered £1 million savings. An even more ambitious efficiency programme has been set for 2019/20 of £1.5 million with the forecast having been increased to £2.2 million. The primary areas of efficiency were being delivered through reducing the footprint of the Trust and delivering internal cost savings and operating efficiencies as well as reduced rental charges. The trust was relatively inefficient in the use of its estate with 46% being non-clinical space compared with a peer median of 31% although 11.5% of the difference represented staff accommodation against a peer median of 1.5% indicating the scope for footprint reduction. The inefficient use of the estate was reflected in the cost of the estate per WAU being marginally above the peer median benchmark.
- There were however very significant challenges with backlog maintenance levels with some of the highest levels in the country and three times the peer benchmark levels. Critical backlog maintenance was nearly 5 times the peer median benchmark. The rate of investment in the estate to address backlog was however only marginally less than peer levels. The trust had been successful in securing emergency capital funding which would address part of the critical infrastructure risk however the scale of the backlog maintenance required a radical solution given capital funding constraints with the trust having started to review options. Despite the challenges the quality scores achieved were predominantly better than peer medians based on patient surveys of the environment, food and access.
- The trust board were fully sighted on the estates issues and options were being actively evaluated and pursued to secure the significant capital funding required to address the issues identified in the recent estate survey report.

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 financial deficits resulting in the trust being placed in special measures for finance in October 2016. Since, the trust had developed a system financial recovery plan with its commissioners, improved financial controls and governance and, delivered its financial plan in 2018/19. The trust had exited special measures for finance in July 2019. At the time of our assessment, the trust was delivering its 2019/20 plan which showed a continuous improvement of its financial position. However, following years of financial deficit, the trust had accumulated a significant debt with the Department of Health & Social Care (DHSC) and continued to rely on revenue cash funding from DHSC.

- The trust had a history of delivering deficits over several years and it was placed in special measures for finance in October 2016. Together with its main commissioners the trust had developed a system financial recovery plan (December 2018) which they were delivering at the time of the assessment. Following the improvement of its financial position, the trust had exited special measures for finance in July 2019.
- In 2018/19, the trust had not accepted its £21.3 million deficit control total given by NHS Improvement and planned to deliver a £45 million deficit. This was an improvement on the previous year when the trust delivered £54.98 million deficit, including £3.5 million sustainability and transformation funding. The trust delivered slightly better than plan with a deficit of £44.8 million in 2018/19 but did not receive any provider sustainability funding that year, as it had not accepted its control total. The deficit represented 11% of turnover and was in line with the system financial recovery plan.
- For 2019/20, the trust had planned to deliver a £34 million deficit excluding central funding (e.g. provider sustainability funding) – £10.1 million deficit including central funding – which represented 8.2% of its turnover. This

was in line with its control total and would significantly improve on its prior year financial position. This included the delivery of £20.6 million cost improvement. At the end of September 2019, the trust was on track to achieve its full year plan although the trust was aware of potential risks to its plan including from the delivery of its cost improvement plan (CIP). Actions had been identified or were being progressed to mitigate the identified risks.

- In 2018/19, the trust had set itself a CIP of £19.3 million, 4.1% of expenditure, to be delivered recurrently and which the trust had fully achieved. During 2018/19 and part way through 2019/20, the trust had received the support of a recovery director to improve the identification, delivery and governance of trust's CIP. At the time of the assessment, the trust was looking to change its focus from reducing costs to improving efficiency. Clinical divisions received support to identify and deliver efficiencies and the trust had also invested in a continuous improvement programme underpinned by the QSIR (Quality, Service Improvement and Redesign) methodology. As at August 2019, 889 staff had been induced into the programme and the trust had 20 champions, 20 coaches and 1 advisor and it continued to roll out its programme to include more staff.
- For 2019/20, the trust planned to deliver £20.6 million savings (4.4% of expenditure) to be delivered recurrently. The trust's CIP included overarching programmes as well as a 3% efficiency applied to all expenditure budgets (£9.7 million). The trust had followed a bottom up approach working with service leads and informed by benchmarking, deep dive analyses and service level costing. The overarching programmes included back office (£0.3 million), grip and control (£1.5 million), income correction (£4.7 million), planned care (£0.6 million) and sustainable services models (£0.2 million). At the end of September 2019, the trust had delivered its savings plan on a year-to-date basis although the level of recurrent savings at 83% was less than plan. The trust had only identified £16.5 million of its schemes (80% of its full year target) but expected to deliver its full year CIP, although through non-recurrent measures.
- In September 2018, an external review of the trust's underlying financial position and the drivers of its deficit found that 40% of the trust's deficit was driven by inefficiencies, 43% by income factors and 17% from structural factors. At the time of the assessment, the trust reported that it had halved the deficit driven by inefficiencies and income factors. The trust was also working within its system to address the structural part of the deficit. The trust estimated that by the end of 2019/20 it would have reduced its underlying deficit from £54.2 million in 2017/18 to £29.8 million.
- The trust had patient level costing information (PLICS) and produced detailed service line reports including financial and productivity data, which was discussed with divisions and at the Finance Committee. This informed the strategy development for the 16 key specialties and was used to inform the cost improvement programme. The trust was also looking to strengthen its costing function at the time of the assessment.
- The trust had had difficult contractual relationships with its commissioners in part driven by poor recording and coding of activity delivered by the trust and income disputes. For 2019/20, the trust had entered into an aligned incentive contract (AIC) with its main commissioners. This contract provided better predictability of payment through an 'expected income guarantee' of £292 million together with a risk pool of £2.5 million held against fluctuations of elective and non-elective work. The trust had also worked with its two main commissioners to identify system savings ('QIPP') which included a joint approach and risk share. Although this was the first year, the trust could already see the benefits in a joint approach and joint commitment for commissioners and the trust to meet their control total, share risks and plan in common.
- The trust was pursuing a strategy to maximise its commercial income under the lead of the Director of Finance with growth sought in main patient activities (NHS and non-NHS), support services and use of infrastructure and commercial partnerships for current activities.
- For 2018/19, the trust had a debt service cover rating and a liquidity rating of 4 (worst) with the liquidity rating expected to improve in 2019/20 to 1 (best). The trust operated with very low cash balances (£2.1 million planned in 2019/20) as a result of continued deficit positions with the improvement of the liquidity rating in 2019/20 due to the deferral of loan repayment into 2020/21. Cash management had improved on 2017/18 when disputes with commissioners meant lower cash receipts which resulted in issues with suppliers. At September 2019, the trust had £9.1 million of cash, £6.4 million more than planned and its performance against the best practice payment code was close to the standard (90.2% of the value of invoices paid within 30 days).
- The trust had a history of past deficits which meant it relied on revenue cash support from the Department of Health and Social Care (DHSC) and expected to have accumulated a debt of £242 million at the end of 2019/20. The trust also continued to rely on both revenue cash and capital loans from the DHSC during 2019/20 when the cost of the debt would amount to £7.2 million. However, at the time of the assessment, the trust was part of a national pilot to consider converting its debt into public dividend capital which, if successful, would save the trust £3.8 million of financial costs for 2019/20.

- The trust's spend on external consultancy services was set to decrease in 2019/20 to £0.4 million from £1 million in 2018/19. During 2018/19, the trust had used consultancy services where skills and capacity were not available within the trust and had a recovery director to support the development and delivery of its cost improvement plan in the context of the trust being in special measures for finance.

Outstanding practice

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

- The trust uses InPhase to display real time information on performance in the emergency department including predicted attendances for the next 24 hours and occupancy across majors and resus areas. Breaches to the A&E standard is refreshed every 3 minutes allowing responsive management by the emergency department team, the supporting divisions and the site team. The trust has developed in house reporting which is displayed in clinical and management areas to provide greater visibility, increase ownership and help the trust to react promptly to operational pressures.
- The trust has developed in-house a Medically-Fit App which displays what medically fit patients are waiting for in terms of care and next steps to be discharged. It is updated at 11am every day and the discharge teams use the information to agree discharge plans with social care and community teams.

Areas for improvement

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

- The trust must continue to work with its system partners to address the strategic factors driving its deficit and with them continue to develop and deliver the system's long-term plan to ensure the sustainability of services going forward.
- The trust must continue to identify and deliver recurrent efficiencies to improve its underlying financial position focusing on transformational programmes.
- The trust has high emergency readmissions and should continue to investigate the drivers of this position and bring the readmissions rate closer to the national median.
- The trust has high pay cost per WAU for nurses. The trust needs to continue to monitor and seek to reduce its nursing cost to be more aligned with national and peer medians.
- Only 55% of doctors had a fully signed off job plan. The trust needs to ensure all job plans are updated, reviewed and signed off.
- The trust should continue to increase its retention and reduce its sickness rates and promote new innovative roles across the trust and bring them more systematically into its workforce strategy and planning.
- The report highlights several opportunities the trust should explore to improve the productivity of its pharmacy, pathology and imaging services.
- The trust should continue to explore the opportunities identified to deliver savings in its corporate functions, particularly around finance, governance and risks.
- The trust should continue to drive improvements on its price performance component (procurement function) to bring it closer to the national and peer medians.

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
Good ↑ Feb 2020	Outstanding ↑↑ Feb 2020	Outstanding ↑ Feb 2020	Good ↑ Feb 2020	Good ➔➔ Feb 2020	Requires improvement Feb 2020

Overall quality

Good ↑ Feb 2020

Combined quality and use of resources

Good Feb 2020

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.