# Portsmouth Hospitals NHS Trust

## Use of Resources assessment report

Trust Headquarters, F Level
Queen Alexandra Hospital
Portsmouth
Hampshire
PO6 3LY
Tel: 02392286000
www.porthosp.nhs.uk

Date of publication: 29/01/2020

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

## Ratings

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

| | |
|---|---|
| Are resources used productively? | Good |

| | |
|---|---|
| Combined rating for quality and use of resources | Good |

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

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

## Use of Resources assessment and rating

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

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

## Combined rating for Quality and Use of Resources

Our rating of Use of resources was good because:

- The trust had a past record of delivering financial deficits but had strengthened its financial governance, was delivering against its financial recovery plan and was on track to improve its financial position in 2019/20. The trust benchmarked overall well on workforce productivity, clinical support services, corporate services and clinical services metrics. It had a total cost per weighted activity unit which benchmarked in the second-best quartile nationally for 2017/18.
- However, we noted a few areas where the trust could improve particularly around operational performance, agency staff spend, delivery of financial efficiencies and specific areas in clinical support services, estates and procurement.

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Date of inspection visit: 15 Oct to 14 Nov 2019
Date of publication: 29/01/2020

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? | Good |
|---|---|

## How we carried out this assessment

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

We visited the trust on 30 September 2019 and met the trust's executive team (including the chief executive), the chair and relevant senior management responsible for the areas under this assessment's KLOEs.

## Findings

Good

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

**We rated Use of Resources as good. The trust had a total cost per weighted activity unit (WAU) which benchmarked in the second-best quartile nationally for 2017/18. It had a past record of delivering financial deficits but had strengthened its financial governance, was delivering against its financial recovery plan and**

**was on track to improve its financial position in 2019/20. The trust benchmarked overall well on workforce productivity, clinical support services, corporate services and clinical services metrics. However, we noted a few areas where the trust could improve particularly around operational performance, agency staff spend, delivery of financial efficiencies and specific areas in clinical support services, estates and procurement.**

- The trust benchmarked comparatively well nationally on clinical services metrics such as pre-procedure elective and non-elective bed days, did not attend (DNA) rates, emergency readmission and day case rate. The trust's positive engagement with the Getting It Right First Time programme had delivered improvements in clinical productivity and the trust continued to seek productivity improvements through a number of programmes and working with its local health system. Although the trust was not meeting any of the constitutional standards, its performance had improved with the 18-week referral to treatment target and the trust had generally performed better than the national median and peers on the cancer 62-day target.
- The trust's pay cost per WAU benchmarked in the lowest (best) quartile nationally. The trust has good retention and sickness rates and was progressing in recruiting to fill its nursing vacancies. The trust had e-rostering and e-job planning in place and had developed innovative roles within its workforce.
- The trust benchmarked well on clinical support services. The trust was part of a planned pathology network and had been part of an imaging network for 10 years with 4 other trusts. The trust ran a pharmacy manufacturing unit which generated a profit for the trust. The trust had published a digital strategy and had used technology in several ways to drive productivity with evidence of effective software systems being developed internally.
- Overall the trust benchmarked well for its corporate services. The trust's procurement function had received an external award and had thoroughly reviewed the price it paid for the top 500 most frequently bought items. The estates costs per square metre were in the highest (worst) quartile as a result of the trust having a private finance initiative (PFI) contract although the PFI did lead to the trust being in the best quartiles for backlog maintenance and critical infrastructure risk.
- The trust had a past record of delivering financial deficits and was in the second year of a 3-year financial recovery plan. The trust had stabilised its financial position in 2018/19 and expected to deliver a material financial improvement in 2019/20. The trust had detailed service line reports in place, had implemented a delivery and programme management office to support the identification and delivery of its cost improvement plan and had reduced its consultancy costs.

However, during our assessment, we also found that:

- The trust's performance on the 4-hour accident and emergency (A&E) standard was worse than national and peer median during 2018/19 and the trust's performance on the diagnostics 6-week wait had deteriorated since July 2018 and at the time of the assessment was below the national and peer medians. Improvements could also be made with regards to delayed transfers of care at the trust.
- The trust's agency spend had continued to decrease but remained higher than the national median and its cap (maximum spend) set by NHS Improvement. The trust had e-rostering and job planning in place, however, further could be done to fully embed them to deploy staff more efficiently and more could be done to fully benefit from innovative roles.
- The trust had further opportunities to improve the productivity of its clinical support services (pathology and pharmacy services), procurement and estates.
- Although the trust was ahead of its cost improvement plan (CIP) at the time of the assessment, the trust still needed to progress to fully identify its cost improvement plan for 2019/20 and ensure it was able to meet its CIP target in a recurrent manner to support the improvement of its financial position. The trust had low cash and a high level of debt due to its private finance initiative (PFI) and accumulated revenue support from the Department of Health and Social Care (DHSC) due its past and current deficit position. The trust also needed to further embed its service line reporting.

**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 benchmarked favourably on most clinical services metrics and although the trust was not meeting any of the constitutional standards, its performance had improved with the 18-week referral to treatment target and the trust had

generally performed better than the national median and peers on the cancer 62-day target. The trust was progressing in improving its clinical productivity via several improvement programmes. However, the trust's performance with the A&E standard was worse than national and peer medians during 2018/19 and the trust still had to improve on the delivery of the diagnostics standard and delayed transfers of care.

- At the time of the assessment in September 2019 and based on the latest performance data available, the trust was not meeting any of the constitutional operational performance standards.
- The trust's performance against the 18-week referral to treatment standard was 82.6% (July 2019) which was below the standard. The trust had not met the target during 2018/19 and performed below the national and peer medians although its position had improved during the year. The trust had maintained its overall elective waiting list during the year and had 15 patients waiting more than 52 weeks for treatment. Since the beginning of 2019/20, the trust's performance had been variable, and its waiting list had increased by 5% although it had not recorded any long waiters (more than 52 weeks) and its performance at the time of the assessment was in line with peers.
- The trust had taken measures to improve its performance. It had used its theatres utilisation group to drive theatre efficiencies and increase productivity and had used a forward look process to identify any spare theatre capacity. This supported the trust's elective programme and helped maintain the waiting list size. There was also an ongoing system wide outpatient transformation programme which the trust expected would deliver efficiencies in outpatient booking. The trust had also engaged with Four Eyes consultancy to help drive theatre improvements.
- The trust had not met the 4-hour accident and emergency (A&E) target during 2018/19 and performed below the national and peer medians and at the end of March 2019, the trust had one of the worst performances nationally. Since May 2019 the trust had been participating in the clinical standards trial for emergency care standards and consequently had not been reporting against the A&E target for 2019/20. The trust had experienced issues with the flow of emergency patients within the hospital and had worked with its local partners and received support to improve its performance. The focus had been on front door processes to better manage sudden increases in the number of patients presenting at the emergency department and on reducing admissions.
- The trust operated in a challenged urgent care system with high numbers of medically fit for discharge (MFFD) patients occupying beds on the acute site and associated high levels of bed occupancy. High bed occupancy at the trust had a detrimental effect on emergency care performance. The trust had in place a comprehensive framework for system-wide urgent care performance improvement, as well as a trust focussed action plan to improve Emergency Department (ED) flow, reduce length of stay and improve bed occupancy. The system had invested in an integrated discharge service and supported the development of a same day emergency care model at the trust.
- The trust refreshed its specialty-based bed model twice a year and beds had been reallocated accordingly. For example, surgical bed capacity had recently transferred to medicine. The trust was taking a quality improvement approach to improvements in ED and had had ongoing support from NHS Improvement and the GIRFT programme. The trust had also had difficulty securing middle grade doctors in ED but had creatively used other roles e.g. emergency nurse practitioners to support clinical activities.
- During 2018/19, the trust had performed above the national and peer median and last met the cancer 62-day target in March 2019. Since that date the trust's performance had been variable but at August 2019, the trust had a performance of 83.07% which was better than national and peer medians. The trust had experienced pressures with specific tumour sites and endoscopy and surgical capacity issues. The trust had taken actions during the year e.g. template biopsies carried out under local anaesthetic as a day case surgery to increase throughput and to support urology pathways. The trust was also changing the way that scoping was done. The trust was training clinical nurse specialists to undertake scopes to increase throughput.
- The trust had last met the diagnostics 6-week wait standard in July 2018 and although performance had generally been in line with national and peer medians during 2018/19, the trust's performance had sharply declined after March 2019. As at July 2019, the trust's performance was 6.5% against a standard of 1% and the trust was materially below national and peer medians. The trust experienced unexpected staffing issues in the high-volume ultrasound service and expected to meet the target again during 2019/20. A significant contributor to poor performance was the ultrasound service which had been reliant on a locum workforce due to a high number of vacancies. Permanent staff were gradually being recruited to replace locums and to provide stable, consistent capacity.

- Patients were less likely to require additional medical treatment for the same condition at this trust compared to other trusts during 2018/19. At 7.30%, emergency readmission rates were slightly below the national median as at quarter 4 2018/19 and although the rate had increased to 9.47% at quarter 1 2019/20, this was in line with peer and national medians.
- Fewer patients were coming into hospital unnecessarily prior to treatment compared to most other hospitals in England as at quarter 2 2019/20.
- On pre-procedure elective bed days, at 0.09%, the trust was performing in the lowest (best) quartile below the median when compared nationally – the national median is 0.12%.
- On pre-procedure non-elective bed days, at 0.66%, the trust was performing at the national median when compared nationally
- Clinical productivity was tracked internally and was managed via performance and accountability meetings. There was a rolling programme of clinical service reviews that focused on, amongst other things, Model Hospital indicators. The trust used its theatres utilisation group to drive theatre efficiencies and increase productivity, as mentioned above. At quarter 4 2018/19, the trust had a day case rate for the British Association of day cases surgery procedures which was 79% and was better than national and peer medians. The rate of conversion of day cases to inpatients was also in line with the national median and slightly higher than peers (11% compared to 10%). The trust was also part of an ongoing system wide outpatient transformation programme. The trust had also engaged with Four Eyes consultancy to help drive theatre improvements.
- The Did Not Attend (DNA) rate for the trust was 4.86% for quarter 2 2019/20 and benchmarked in the lowest (best) quartile nationally and compared with a national median of 7.14%. The trust explained this was driven by several digital solutions including a newly launched text message reminder service.
- The trust reported a delayed transfers of care (DTOC) 6-weeks average rate of 4.2% at the time of the assessment (end of September 2019) which was above the standard of 3.5%. The trust had enhanced oversight at weekly urgent care action groups, feeding into the local A&E delivery board chaired by the trust's chief executive. The trust and local system more regularly used the currency 'MFFD' rather than DTOCs when describing long length of stay issues and actions to address these.
- The trust had engaged well with the GIRFT national programme and had robust governance arrangements in place, with good examples of changes made as a result from GIRFT recommendations. For example, the trust had redesigned the ear, nose and throat (ENT) pathway and implemented a one stop cardiology clinic. Further opportunities to improve clinical effectiveness had been identified through the GIRFT programme in emergency medicine and diabetes. There was however, a perceived disconnect between service lines and the pace of the business case approval process which had been acknowledged by the trust executive team and was being addressed.

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

The trust's overall pay cost per WAU benchmarked in the lowest (best) quartile nationally. The trust had good retention and sickness rates, was progressing in addressing staff vacancies and used innovative roles although more could be done to fully benefit from them. The trust had recently introduced e-rostering and needed to embed it more fully to deploy staff more effectively. The trust had pay cost controls in place and had reduced its agency spend although further effort was required to bring its agency spend in line with the national median and its agency cap.

- For 2017/18, the trust had an overall pay cost per WAU of £1,961, compared with a national median of £2,180, placing it in the lowest cost quartile nationally. This meant that it had spent less on staff per unit of activity than most trusts.
- At £537 for 2017/18, the trust's medical cost per WAU benchmarked slightly higher than the national median of £533. The trust benchmarked in the second lowest (best) quartile for nursing cost per WAU at £654 compared to a national median of £710 and was in the lowest (best) quartile for allied health professionals (AHPs) cost per WAU at £96 compared to a national median of £130.
- The trust had controls on pay costs which included a centralised workforce panel and the clinical divisions had worked with the finance team to establish clear, funded establishments and tight control over changes.

- To control the medical pay costs, appointments to 'difficult to fill' medical vacancies, above a certain level, were approved by the medical director after being first considered by the relevant division. This is to enable greater oversight over decisions to fill vacant clinical sessions, as well as exercising control over agreed rates of pay in order to keep pay costs down. The trust had introduced a policy to use standard rates for additional activity and lists which had started to bring down the cost of the medical force.
- The trust also had an established job planning policy which included a standard split between direct clinical care activity and supporting professional activity (8 to 2) which supported better medical productivity. 75% of medical consultants had a signed off electronic job plan at the time of the assessment, down from 90% in the prior year. This was due to delays in inputting signed off job plans in the electronic system and the emergency department having paused their job planning process to reconsider how to deliver their work. The trust was refreshing and relaunching their process to link job planning to changes to services which would then be reflected into individual job plans. The trust also had plans to introduce job planning for AHPs and other professional groups.
- In order to increase the productivity of its workforce, the trust had recently moved its nursing staff to Allocate (an electronic health roster system) and had plans to move all medical staff and AHPs onto the e-roster with anaesthetists being, at the time of the assessment, the only medical staff on Allocate. Rotas were signed off between 6 and 8 weeks in advance in accordance with best practice.
- Ward managers reviewed staffing on wards three times a day and the trust used e-rostering information to monitor key performance indicators on a monthly basis to inform staffing. The trust planned to implement Safecare later on in 2019/20 which would help to inform patient needs and progress discussions around innovative roles - at the time of the assessment, the trust relied on paper-based acuity monitoring. The trust anticipated that, with the implementation of Safecare, they would start predicting patients' needs and allocate staff more flexibly.
- The trust had not met its agency ceiling as set by NHS Improvement for 2018/19 and was forecasting to miss its ceiling in 2019/20 (£12.8 million). It was spending more than the national average on agency as a proportion of total pay spend (4.87% compared to a national median of 4.44% at August 2019). However, the trust was on a trajectory to reduce its agency spend from £21 million in 2018/19 to £16.2 million in 2019/20 and as at August 2019, the trust had spent £0.5 million less than planned on agency.
- The trust was focussing on reducing excessive agency spend by initially transferring agency staff to bank contracts before looking to convert bank staff contracts to substantive posts. The trust had re-procured its staff bank at the end of November 2018 which had led to an increase use of bank staff over agency staff. The trust had also seen a reduction in the use of high cost agency staff. The trust was working with its sustainability and transformation partners on a collaborative staff bank which was expected to go live soon after our assessment.
- The trust had invested significantly into an international recruitment campaign to fill in its nursing vacancies. The trust was on plan to recruit 250 overseas nurses during 2019/20 bringing the total of 530 nurses recruited internationally over the last year. The trust commented that their programme had been successful: nurses were supported to settle and achieve the necessary training and very few had left the trust. When the recruitment would be complete, the trust expected the nursing vacancy level to be less than 5%.
- The trust had experienced recruitment issues with AHPs (some reflecting national challenges) and had various actions in place depending on the type of specialty but acknowledged it still needed to see the benefit of these actions.
- The trust had invested in new roles to support existing ones and to provide a requisite skillset where required. This included a programme of advanced practitioners in critical care to substitute registrars with staff taken from a nursing and paramedic background. The trust was looking to extend this approach to other clinical areas. Other examples included a physician associate programme and band 4 nurses being able to replace band 5 nurses in theatres where it had invested in a robot. The trust however acknowledged it could do more to articulate how advanced roles could be better used across the trust and provide medical career pathways.
- The trust had been very active in developing new nurses locally through a first cohort of adult nurses, an apprenticeship programme, pre-nursing programmes with local colleges (e.g. nursing associates) and was working in partnership with its local university.

- At 3.72% in August 2019, staff sickness rates were better than the national average of 4.06%. Staff retention at the trust was also good with a retention rate of 86% in December 2018 against a national median of 85.6%. The trust had achieved this through workforce retention initiatives (supported by NHS Improvement) including band 5 roles flexibility, a ward managers' development programme and an increased focus on staff wellbeing.

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

The trust benchmarked well on clinical support services with some opportunities for further improvement present. The trust was part of a planned pathology network and had been part of an imaging network for 10 years which included 4 other trusts. The trust ran a pharmacy manufacturing unit which generated a profit for the trust, but the trust had other opportunities for improvement within its pharmacy service. The trust had developed its digital strategy and had used technology in several ways to drive productivity with evidence of effective software systems being developed internally, however there was further to go in respect of digital productivity in some areas to embed key productivity tools that were widely used elsewhere.

- The trust was placed within either the first- or second-best quartile for almost all of the pathology services metrics and achieved lower costs per pathology test than the national and peer medians the only notable exception being microbiology cost per test, which was in the third quartile at £5.68 per test against a national median of £4.36.
- The trust was part of the 'South 6' pathology network and was in the process of procuring a shared information system.
- The trust has been part of an imaging consortium with four other providers for more than 10 years and has a shared picture archiving and communication system. The trust benchmarks well against a range of staff and productivity metrics however there are some outliers that require the trust to check the accuracy of its data submissions. The trust does have a high proportion of older CT and ultrasound machines compared to the national average and the trust is considering how to replace these in light of changes in technology to the way patients are treated.
- Overall medicines cost per WAU was in the highest (worst) quartile at £451 for 2017/18 compared to a national median of £363. The trust was above the national median for high cost drugs and non-high cost drugs although this was partially due to the cost of the trust's pharmacy manufacturing unit which generated a profit for the trust. The trust's top 10 medicines performance was 108% but lower than most trusts (national median 118%) highlighting opportunity for improvement. The trust was also in the lowest (worst) quartile for the percentage of pharmacists actively prescribing.
- The trust had a digital strategy for 2019-2024 and shared examples of the way technology was being to drive productivity which included the development of a proprietary Bedview system to give trust wide visibility of patient information to improve decision making and patient safety. The trust had also developed a proprietary Minestrone system linked to Bedview to maintain patient records. The trust also made use of text reminders to patients and had developed a renal application for smartphones. However, the trust still needed to embed the use of e-rostering and e-job planning more fully to drive the effective deployment and utilisation of clinical staff.

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

Overall the trust benchmarked well for its corporate services and its procurement function, for which it had received an external award. It had thoroughly reviewed the price it paid for the top 500 most frequently bought items, but there was scope to increase compliance with purchase ordering to ensure that purchasing was controlled effectively. Based on benchmarking, the trust had an apparent opportunity to reduce its waste costs. The estates costs per square metre were in the highest (worst) quartile as a result of the trust having a PFI contract although the PFI did lead to the trust being in the best quartiles for backlog maintenance and critical infrastructure risk.

- The trust's total non-pay cost per WAU of £1,442 was above the national median of £1,307 and the peer median of £1,337.
- The trust's finance and human resources (HR) functions were £0.487 million and £0.341 million per £100 million of turnover respectively which put them in the lowest (best) quartile nationally. Additionally, the trust was in the first- or

second-best quartile for a range of more detailed metrics within these departments. The trust's information management and technology (IM&T) services were in the second lowest (best) quartile nationally. The trust had considered where investments across its corporate functions would improve them and had made investments in divisional finance managers, HR business partners, its analytics function and a project management office.

- The trust's procurement function was provided by NHS South of England Procurement Services and supplied a procurement, supply chain and commercial shared service. The Chartered Institute of Procurement & Supply had reviewed the function and had given it the 'gold' award for procurement excellence. The trust was in the second (best) quartile for price performance and process efficiency and had carried out a thorough review of the price it paid for the top 500 items procured across the NHS. However, there were areas where improvement could be made including the percentage of non-pay spend on purchase orders and the value of invoices matched to purchase order numbers, which were both below the national and peer median.
- The estates and facilities cost per square metre was £442 which placed the trust in the highest (worst) quartile nationally. This was driven by the cost of the trust's private finance initiative (PFI) funded buildings. However, the PFI estate did lead to very low backlog maintenance of £4 per square metre and critical infrastructure risk of £0 per square metre. The trust performed well on a range of other metrics but waste costs of £346 per tonne were much higher than the peer and national average of £238 per tonne, indicating an opportunity for efficiency.

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

The trust had a total cost per WAU of £3,403 for 2017/18 which benchmarked in the second lowest (best) quartile nationally. The trust had not accepted its control total in 2018/19 and delivered a deficit which still represented a slight improvement on prior year. The trust had a 3-year financial recovery plan which it was delivering and had progressed with improving its financial governance and infrastructure during that year. For 2019/20, the trust was on plan to deliver a material improvement to its financial position although risks remained particularly with respect to the delivery of its cost improvement plan (CIP). The trust had a high level of debt due to its private finance initiative (PFI) and accumulated revenue support from the Department of Health and Social Care (DHSC) due its past and current deficit position.

- In 2018/19, the trust had not accepted its £4.1 million surplus control total given by NHS Improvement and planned to deliver a £29.9 million deficit which was an improvement on the £38.4 million prior year deficit. However, the trust did not deliver its ambitious cost improvement plan and experienced operational and other pressures and consequently the trust delivered a £37.9 million deficit (6.8% of turnover), a slight improvement on prior year and in line with its 3-year recovery plan.
- For 2019/20, the second year of its financial recovery plan, the trust had planned to deliver a £22 million deficit excluding central funding (e.g. provider sustainability funding) – a breakeven position including central funding – which represented 3.8% of its turnover. This was in line with its control total and would improve on its prior year financial position. At the end of August 2019, the trust was on track to achieve its full year plan although the trust was aware of potential risks with delivering fully its cost improvement plan (CIP) and mitigating operational pressures (including any pressures from winter activity levels). Over the last year, the trust had made significant improvements to its financial governance and actions were being progressed and overseen to mitigate these identified risks.
- The trust had set itself an ambitious CIP in 2018/19 of £35.5 million, 5.8% of expenditure and to be delivered recurrently. Although the trust did not achieve its saving target, it delivered £23.9 million savings, representing 3.9% of expenditure, 72% of which were recurrent. Savings delivered included £6.3 million from procurement as well as £8.6 million from workforce schemes.
- For 2019/20, the trust planned to deliver £24.1 million savings (3.8% of expenditure) to be delivered recurrently. During 2018/19, the trust had improved its governance and infrastructure to support the identification and delivery of its CIP. It had developed an in-house delivery unit and project management office and implemented an assurance framework with a CIP delivery board, divisional assurance meetings, well defined governance processes to progress schemes and had appointed a divisional director as clinical lead for finance. Savings included £11.1 million from purchasing and non-pay spend, £3.7 million from workforce schemes, £3.9 million from additional income and £2.3 million from pharmacy prescribing improvements – the rest being split across estates, productivity and technology schemes. At the end of the October 2019, the trust still needed to progress to fully identify its CIP with £2 million unidentified schemes and a risk adjusted value of £19.1 million (i.e. the value it would likely deliver). As at October 2019, the trust however reported being £0.6 million ahead of its year to date saving target, although only 55% had been delivered recurrently (£2.6 million less planned).

- At the time of the assessment, we noted that the trust had also developed a quality improvement strategy - which built on existing initiatives and projects – supported by an implementation plan with the aim to have a framework and infrastructure in place by the end of 2019/20.
- During 2017/18, an external review of the trust's underlying financial position and the drivers of its deficit categorised the drivers between those factors broadly in the trust's control, those it could influence but not control and those outside of its control to address. During 2018/19, the trust had made progress to address the findings of the review, stabilise its financial position and improve its financial governance. The trust anticipated to reduce its underlying financial position from an estimated £41.2 million deficit for 2018/19, to £20.1 million in 2019/20 provided it delivered its plan, including the planned level of recurrent savings.
- The trust had patient level costing information (PLICS) and produced detailed service line reports. At the time of the assessment, the trust had started to engage with clinical divisions and was developing its governance infrastructure to further embed service line reporting (SLR) with clinical divisions particularly with a view to identify areas for efficiency improvement. The trust provided examples where SLR information had been used to support business cases, contribute to national benchmarking and support discussions with commissioners on local prices.
- For 2019/20, the trust had developed an aligned incentive contract (AIC) with its main commissioners representing 68% of its clinical income. The AIC provided an expected income guarantee for the trust together with a risk management and sharing agreement between commissioners and the trust, joint forward planning, a transformation/risk management fund and a common set of behaviours to support the contractual relationships between the trust and its commissioners.
- The trust earned income from research and development (R&D), education and training, pharmacy sales, private patients and other provider to provider services. At the time of the assessment, the trust had sought expert advice from another NHS trust regarding potential commercial opportunities at the trust and was considering how to progress their recommendations.
- For 2018/19, the trust had a debt service cover rating and a liquidity rating of 4 (worst) with the debt service cover rating expected to improve in 2019/20. The trust operated with very low cash balances (£1.1 million planned in 2019/20) as a result of continued deficit positions. It had however established processes to manage the position including daily reviews and rolling cash forecast and had not relied on emergency cash from the Department of Health & Social Care (DHSC). At October 2019, it also had higher than plan cash balances driven by delayed spend on its capital programme. We noted that the trust's performance against the best practice payment code was low, but the trust provided evidence of its continued effort to reduce overdue payments to both NHS and non-NHS creditors.
- The trust had relied on revenue cash support from the DHSC as a result of its past and current deficit positions. The trust had received £34.8 million in 2018/19 but did not expect to receive any cash support in 2019/20. At the end of 2018/19, the trust had accumulated a debt of £349.8 million due to its private financial initiative estate and support from the DHSC. The trust expected the debt to reduce to £341 million in 2019/20. The trust incurred £20.7 million finance expenses to service the debt in 2018/19 and this was set to increase to £21.4 million in 2019/20.
- The trust's spend on external consultancy services was set to decrease in 2019/20 to £0.9 million from £2.6 million in 2017/18 and £2.7 million in 2018/19. During 2018/19, the trust had implemented an in-house project management office and transformation team which had eliminated the need for external support in this area.

## Outstanding practice

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

- The trust has developed a proprietary Bedview system to give trust wide visibility of patient information to improve decision making and patient safety and a proprietary Minestrone system linked to Bedview to maintain patient records.
- The trust has a system wide outpatient transformation plan that aims to increase efficiencies in outpatient bookings and maximise capacity for outpatients at the trust.

# Areas for improvement

Areas for improvement

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

- The trust needs to strengthen its operational performance particularly in relation to A&E and diagnostics.
- The trust must continue its effort to reduce the agency spend to be within its agency cap and more in line with the national percentage spend median.
- The trust must ensure it accelerates the identification of its cost improvement plan and delivers savings on a recurrent basis to support the improvement of its underlying deficit.
- The trust needs to embed the use of e-rostering and e-job planning more fully to drive the effective deployment and utilisation of clinical staff.
- The trust should consider how it can reduce its medical cost per WAU to be more in line with the national median and better use innovative and advanced roles within its workforce.
- The trust can investigate opportunities to reduce the cost of microbiology tests to bring it more into line with its peers and the national median.
- The trust can target increasing the uptake of medicines on the top 10 medicines list and increase the percentage of pharmacists actively prescribing.
- The trust can increase the percentage of non-pay spend on purchase orders and the value of invoices matched to purchase order numbers.
- The trust should investigate reducing waste costs per tonne to a level more in line with peers and national median.
- The trust should continue to embed its service line reporting with clinical divisions to support the identification of areas for efficiency improvements.
- The trust should investigate opportunities to reduce its length of stay together with bed occupancy.

# 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**

| Safe | Effective | Caring | Responsive |
|---|---|---|---|
| Requires improvement<br>Feb 2020 | Good<br>Feb 2020 | Good<br>Feb 2020 | Good<br>Feb 2020 |

**Trust level**

| Well-led | Use of Resources |
|---|---|
| Good<br>Feb 2020 | Good |

**Overall quality**

Good
Feb 2020

**Combined quality and use of resources**

Good

# 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. |