Royal Berkshire NHS Foundation Trust

Use of Resources assessment report

Royal Berkshire Hospital
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Date of publication: 07/01/2020

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

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

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

NHS Trust

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Date of inspection visit: 3 July to 1 August 2019
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This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous 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 Use of Resources assessment framework.

We visited the trust on 5 June 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Good

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

We rated Use of Resources as good. The trust demonstrated good use of resources in clinical services, workforce and areas of clinical support services and corporate functions, reflected in its overall position in the best quartile nationally for overall cost per weighted activity unit. The trust was also proactively engaged in working with its system partners through an integrated care system (ICS) and was developing its transformation strategy to further embed a culture of quality and productivity improvement. However, the

trust was trading with a material underlying deficit and had relied on several material non-recurring items, both on income and on costs, to achieve its control total in 2018/19. The basis of the trust's contractual relationship with its commissioners is under regular review and the 'unfunded activity' on a PbR basis in 2019/20,being delivered by the trust and the investment it has made to improve services for patients which are a driver to a significant part of the deficit. The cost/risk share contract being a better commercial arrangement than PbR each year will depend on whether the trust is performing under or over planned contract levels. The trust was however delivering well above national median performance in three of its constitutional access metrics as a result.

- The trust was part of the Berkshire West Integrated Care System (ICS) and worked closely with its commissioners and other NHS providers to manage resources, deliver against operational standards, and improve the health of the population they served. During our assessment, we found the trust benchmarked well on several areas, overall, demonstrating good use of resources, however with some other areas needed to progress further. At the time of the assessment, the trust was in the process of developing its transformation strategy based on a lean methodology to enable staff across the trust to continuously improve the productivity of services and quality of care.
- Based on the Model Hospital analysis, the trust had the fourth lowest total cost per weighted activity unit (WAU) nationally for 2017/18 and had improved significantly its relative position between 2016/17 and 2017/18, from the lower end of the best quartile. This relative productivity position contrasted with the trust trading with an underlying deficit estimated by the trust at £18.0 million (4.1% of turnover). At the time of the assessment, the trust had shared a draft of the review of its underlying financial position commissioned to an external firm and which indicated that the main driver was a gap between the recent investment in staff to improve access to services for patients and funding received for the services. The review was still being discussed internally (including the level of savings the trust could deliver) and work needed to progress to develop a financial recovery plan for 2019/20 and beyond.
- During our assessment, we discussed with the trust several data anomalies which impacted its costs per weighted activity units. The trust was able to quantify the impact of some of these data anomalies which indicated that although the trust's overall cost per WAU for 2017/18 was likely to be higher than as per the Model Hospital, it remained in the lowest (best) quartile nationally.
- The trust benchmarked well overall on clinical services. The trust was meeting the 18 week referral to treatment and cancer 62-day wait standards and had generally performed better than the national median on delivering the 4-hour accident & emergency target. The trust's pre-procedure elective and non-elective bed days were amongst the best in the country and the trust had low rates of emergency readmissions and delayed transfers of care. The trust also had a theatre productivity programme and it benchmarked well on day case rate, and length of stay. The trust was also well engaged in the Getting It Right First Time national programme with evidence of improvements.
- The trust evidenced areas of good practice on the effective management of its workforce reflected in the trust's pay cost per WAU benchmarking in the lowest (best) quartile. The trust had a very low agency spend as a proportion of total pay costs which placed it in the best national quartile. The trust benchmarked well for sickness rate and proportion of consultants with a job plan and was using e-rostering to deploy its nurses effectively.
- On clinical support services, there were areas where the trust benchmarked well on pharmacy services (efficiencies, systems and levels of stockholding). The trust was part of a pathology network which was relatively efficient.
- The trust had a relatively efficient procurement function and benchmarked overall well on human resources and finance functions. Although the trust benchmarked high on information management and technology, this reflected a lack of investment in prior years which the trust was remedying through being a fast follower of Global Digital Exemplar Programme.
- The trust had met its control total for the prior two years and had enough cash to deliver its financial duties and pay its staff and suppliers. The trust also had a relatively low debt. The trust had also started to implement its Finance Matters programme to improve financial understanding and practice across the trust and focus attention on financial performance.

However, it should be noted that:

- At the time of the assessment, the trust was not meeting the diagnostic 6-week national standards and was performing below the national and peer medians.
- The trust's 'did not attend' rates were in the second lowest (worse) national quartile. The trust was now looking at technological solutions to improve the rate of patients' attendance at their appointment.

- The trust had not delivered its plan for pay costs in 2018/19 as a result of operational pressures and had delivered 45% less recurrent pay efficiencies than planned. Overall, the trust had delivered 62% of its overall recurrent cost improvement plans for 2018/19. The trust had made significant investments in staffing to improve access to services for patients but for which the trust did not receive a direct corresponding amount of funding from commissioners.
- The trust had a low staff retention rate. Also, its workforce model relied on a high proportion of consultants compared to comparable trusts.
- Although the trust used e-rostering to deploy its nursing staff, it acknowledged that further work could be done to improve the use of data coming out of the e-rostering system to forecast demand and capacity.
- The trust benchmarked high on medicines cost including non-high cost drugs and our assessment identified several areas where the trust could improve such as 7-day service and pharmacists prescribing.
- Imaging was an area where the trust had experienced issues which had contributed to the deterioration of the diagnostic 6-week wait standard. This related to equipment and workforce capacity leading to significant level of outsourcing.
- The cost of running the estate was high (in the most expensive quartile nationally) and the backlog maintenance was also at a similar relative level. The trust's capital programme was very limited for almost a decade whilst the trust was in financial recovery. A site master plan and a significantly increased capital investment programme were, at the time of the assessment, addressing the most pressing backlog issues which were also gradually improving the operating cost metrics.
- The trust had delivered its control total in 2018/19 supported by non-recurrent items, was operating with an underlying deficit and its 2019/20 plan relied on the delivery of a significant cost improvement plan which was not fully identified at the start of the year. The trust was working with a consulting firm to understand the drivers of its underlying deficit and develop a financial recovery plan.

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 well on clinical services. It had achieved the 18-week referral to treatment national standard consistently in all months from June 2015 and had no patient waiting in excess of 52 weeks. Historically, it had a strong track record in meeting the cancer 62-day wait and diagnostic 6-week wait targets but had experienced some challenges over the previous twelve months. Its pre-procedure elective and non-elective bed days were amongst the best in the country. However, the trust's 'did not attend' (DNA) rate had fallen into the third quartile and the trust acknowledged it needed to make progress in this area. The trust's readmission rate and delayed transfers of care (DTOC) rates were low. The trust had also performed well in meeting the 4-hour accident and emergency (A&E) target. The trust demonstrated a clear ambition to continue to improve its clinical services by using its resources effectively. The trust was in the process of developing a transformational strategy including system partners and this appeared in line with the direction the trust had established to date.

- The trust performed well across the constitutional standards for 18-week referral to treatment (RTT) target. The trust had consistently met the RTT standard and had consistently over-performed against the national median over the last twelve months.
- The trust had achieved the cancer 62-day wait standard in all months from June 2017 until August 2018 when its performance had dropped to 77.3% following a spike in urology referrals. The trust had attempted to mitigate this increase by increasing activity and using private providers to support the urology pathway to release trust capacity. At the time of the assessment, the trust had returned to a performance above the standard and expected to sustain this.
- The trust had generally performed well against the diagnostic 6-week wait target, however performance had fallen during the year due to an MRI breakdown. The trust had prioritised urgent and cancer diagnostics throughout the period, however, the latest data available at the time of the assessment showed the trust was not meeting the standard (95.65% in April 2019) and was performing below the national and peers' medians.
- At the time of the assessment, the trust's performance against the 4-hour A&E wait was 92.63% (May 2019) against a standard of 95%. The trust had however been performing above the national median since March 2018. The trust had experienced significant escalation and had worked with the system to attempt to alleviate these pressures.
- The trust had committed to working with its system partners to avoid admission, and should a patient be admitted the trust deployed its resources to facilitate rapid discharge. The trust accepted it had a high admission rate and a proportion of these were zero- and one-day's length of stays. However, it was felt this was a safe but resource intensive approach for short stay patients. The trust remained committed to getting patients where appropriate out of hospital promptly using medic and specialty huddles and a multidisciplinary approach to discharge.

- The trust's readmission rate benchmarked in the best quartile nationally. The trust attributed its performance to not sending patients home too early by using a multidisciplinary approach to care and system working. The trust had also built strong relationships with the voluntary sector to support discharge home.
- The trust's 'did not attend' (DNA) rate was in the third lowest (worse) quartile nationally. The trust recognised this position and had embarked on an outpatient transformation programme across the local health system over the past 2 years although this had not delivered the improvement expected to materially reduce the DNA rate. The trust was now focusing, through its commitment to a digital platform, to using technology such as text reminders and phone calls to reduce the DNA rate. It was also considering means to deliver remote appointments and improve its parking to make it more convenient for patients to attend appointments.
- To improve theatre productivity, the trust had introduced an improvement programme which including strengthening the theatre scheduling process with a clear forward view and setting staff leave commitments well ahead of time. The administration teams had been embedded into the clinical teams to better link theatre and clinical activity. This had been led by patient pathway management and coordinators and had delivered improvements in day case rates as well as brought staff development opportunities.
- The trust performed better than its peer group and national median in day case rate which was 82.4% compared to 77.8% nationally and its conversion to overnight stays was better than the national median at 4% compared to 7%. Additionally, the trust's average length of stays in elective (2.1 days for quarter 3 -2018/19) and emergency admissions (8.7 days for the same period) were better than the national median and peers (3.0 days and 9.3 days respectively).
- The trust had adopted the Model Hospital via a Central Model Hospital group chaired by the Medical Director. This had allowed intelligent gathering of information. The trust triangulated data with the Getting it Right First Time national programme which allowed the transition from a centrally driven initiative to business as usual. This data was now being developed so it could be adopted as part of the monthly performance reports.

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

The trust benchmarked well on staff costs per WAU, being in the third best in the country and in the lowest (best) quartile overall. The trust's pay costs had increased beyond plan in 2018/19 as a result of operational pressure although the trust had continued to control its agency staff spend. The trust had used e-rostering and electronic job-planning to plan and deploy staff efficiently and had a low sickness rate. Although the trust benchmarked less well on retention in key staff groups, it had measures in place to improve in these areas.

- The trust acknowledged that its performance with regards to several workforce productivity metrics was strong, although it explained this had been a long journey of improvement recovering from historical issues with some of the key opportunities still to be achieved by working as part of the wider system. The trust's overall pay cost per WAU benchmarked in the lowest (best) national quartile. Nursing and allied health professional costs per WAU benchmarked in the lowest (best) quartile nationally and its medical cost per WAU in the second lowest (best) quartile.
- In 2017/18, the trust's actual spend on staff costs were on plan, although they were £12.5 million or 5.5% above plan in 2018/19. The variance against plan in 2018/19 was partly the result of additional costs following a new settlement under the national Agenda for Change contract for staff (£4.1m). The remainder resulted from operational pressures experienced by the trust during the year. It is to be noted that the agency staff costs remained in accordance with the trust's plan that year. The trust delivered £8.8 million pay savings in 2017/18, 10.9% higher than it planned to do, although less than half (43%) were recurrent. In 2018/19, the trust under-delivered on pay savings (£4.6 million compared to £5.6 million) but a higher proportion was recurrent (67%).
- The trust's agency spend in 2017/18 was 6% lower than its agency ceiling and 3.6% lower in 2018/19. As at May 2019, the trust was spending 3.1% of its staff costs on agency, which benchmarked in the lowest (best) quartile nationally and compared with a national median of 4.5%. To deliver this the trust had worked with the NHS Improvement specialist team to ensure a consistent focus including weekly engagement by the executive team with care groups to challenge their decisions to take on agency staff and prompt them to review the long-standing agency staff. The trust had also adopted an innovative solution to the nursing workforce challenge by working across the system to minimise agency rates. The trust was part of a shared temporary nursing bank across Berkshire to increase shared staffing opportunities and value for money. Additionally, the trust and its partners had the ambition to expand this approach to the wider region.
- The trust had focused on maintaining controls on nursing costs and where possible forecasting capacity gaps, supported by a bespoke e-rostering system. The trust acknowledged that further work was required to improve the data with the ambition to improve its ability to forecast demand and capacity and therefore forecast nursing requirements.

- Whilst the trust's staff retention rate was in the lowest (worst) quartile, the trust was aware of this issue and had taken steps to address it. The primary issue was the retention of healthcare assistants and, to a lesser extent, allied health professionals. The trust had strengthened their recruitment programme for healthcare assistants, including an enhanced recruitment and selection process. The trust was also more upfront in the reality of the role and had highlighted the development opportunities. The trust had also identified retention issues within maternity services and had made significant progress in addressing shift gaps. In response to negative feedback from an external review, the trust had made changes to its rostering which had been well received.
- The trust experienced challenges in recruiting student nurses and it had worked with local colleges to develop cadetships and was looking to widen the geographical area for recruitment. The trust however recognised that further work was required in this area.
- The medical workforce of the organisation had a higher consultant ratio than other comparable trusts. This was a conscious decision to focus on a senior workforce and reflected that the trust also employed community consultants. The higher ratio was also needed to support 7-day services. The trust had introduced 7-day cover and had a consultant led ward round 7 days a week. This had improved discharges across the week but there were wider system issues preventing further progress.
- Medical job planning was undertaken electronically and as at April 2019, the trust reported that 99.6% of consultants and non-training doctors had an agreed job plan. Additionally, the trust had used Model Hospital and Getting it Right First Time to try (GIRFT) and develop consultant's productivity. One example was the work undertaken on theatre productivity. Clinicians were also well engaged in the GIRFT programme with a clear process of accountability in place including executive oversight.
- The trust performed well on sickness absence. It had a 3.3% sickness rate for the year to October 2018, which benchmarked in the lowest (best) quartile nationally. The trust attributed its low rate to a centralised human resources (HR) function with an employee relations team working across the whole workforce ensuring an ongoing and strong focus on cases of sickness absence. The trust had decided not to use the Bradford scores used in human resource management to measure absenteeism. The trust was committed to the health and wellbeing of its staff with dedicated support staffs. The trust had a robust Health and Safety committee and had established health and safety champions. These initiatives had helped reduce cluttering, embed safety at a local level and support staff to manage difficult situations with patients.
- The trust had experienced a relatively high number of never events at the time of our assessment. The trust board were fully sighted on these and were assured the circumstances demonstrated an open reporting culture where staff were aware of what never events were and the process to report them. Each event had a clear action plan to mitigate the risk of a re-occurrence and learn from them.

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

The trust showed a mixed picture on clinical support services. The trust was part of an exemplar pathology network which operated efficiently and bringing economies of scale to the network participant organisations. The trust had a higher than median cost per medicines including non high cost drugs. However, the trust had delivered significant medicines savings during 2018/19. The trust was progressing in addressing pharmacy organisational challenges although further progress, particularly relating to 7-day services, could be made. The trust had experienced significant issues with equipment breakdowns and staffing of its imaging services during 2018/19 which had impacted its performance on diagnostic access standards. The trust was in the process of addressing these issues with successes in resources.

- The trust's medicines cost per weighted activity unit (£358) in 2017/18 was above the national median of £320 but below the peer median of £363. The trust provided a range of specialist services including renal and HIV which drove a higher cost than the national median. The trust had undertaken an analysis to understand this impact. Further analysis of non-high cost drugs undertaken by the trust as at December 2018, showed that the trust's cost per WAU for this component was £227 compared to a national median of £202 with particular progress being made in the controls over antibiotic prescribing. The data on efficiencies delivered by the trust showed that in 2018/19 the trust delivered over double the planned medicines savings having delivered higher savings through switching to biosimilar drugs as compared with the national median (5% above). The trust implemented an electronic prescribing and medicines management (EPMA) system in September 2018 which was going to support the future end-to-end transformation of the service. Levels of stockholding were in the best national quartile.
- The trust had recognised and addressed organisational challenges within the pharmacy department and through changes had improved retention, recruitment and overall team engagement. There were still areas for improvement which were in progress or under review by the trust. 7-day clinical pharmacy services were only between October and

March with a business case for investment being prepared based on the improved patient discharge that this supported. The level of pharmacists prescribing had improved significantly over the past years, but it was acknowledged that this was still well below the national median level and the trust had been training 5 additional pharmacists.

- The trust's pathology services were delivered through a joint venture - Berkshire and Surrey Pathology Services ('BSPS') which was one of the first pathology networks to have been established nationally. The network (national network 5) is a national exemplar and was delivering financial savings to the participant trusts through economies of scale and improved controls over areas such as reducing unnecessary testing which was reflected in the better than national median metrics for numbers of test per head of population.
- The trust's analysis showed that cost improvements (CIPs) of £550,000 had been delivered in 2018/19 with the resultant total pathology costs for the year being very marginally above plan. The cost per test metric showed the trust's cost to be marginally above the national median however this was at least partially explained by the complexity of testing, particularly in microbiology. The analysis of pay costs showed that the skill mix for the network is very cost effective (best national quartile).
- The trust had experienced significant increases in demand for imaging services (as was the national picture) but which had resulted in a deterioration in the diagnostic performance at the trust, particularly in relation to MRI scanning. The trust had plans to increase MRI capacity from 3 machines to 5 in 2019/20. The trust's equipment had also experienced relatively high levels of breakdowns in 2018/19 which was not explained by the average age of the scanners. The trust had also experienced a relatively high radiographer vacancy rate which had also constrained capacity, with the rate at the time of the assessment being 33%. The trust had focused on recruitment and was expecting 13 new starters by the end of August 2019 which would bring the imaging department up to full establishment. The trust had a very high level of outsourcing, which reflected the capacity issues and the need for an overnight service.
- The performance had also been adversely affected by the high DNA rates. Over the past year the rate had been 7.8% on average compared with national median of less than 3%. The trust was planning a roll-out of its text reminder service based on the success of the recent pilot.
- In terms of efficiency, the trust's imaging services rank close to the national median. The trust's cost per report was £51.29, slightly higher than the national median of £50.05 with the trust benchmarking in the second highest quartile nationally. Areas where the trust performed particularly well were in the use of extended roles with very good levels of plain x-ray reporting by radiographers and the control, over agency costs. The trust had also invested in technology to support home reporting for radiologists which was reflected in the very low levels of reporting backlog at the time of the assessment.

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

The trust had a higher than median supplies and services cost per WAU and ranked in the worst quartile in the procurement league table. However, with new procurement leadership in place, the trust had a however made progress during the year in improving its procurement operations in particular through better engagement with clinical teams. The Procurement league table position has consistently increased due to the leadership shown by new management and its level 1 accreditation in June 2019. The trust's corporate services operated efficiently overall except for information management and technology which had suffered from under-investment for a sustained period and was now a priority for investment as part of the Global Exemplar Programme. The trust benchmarked in the highest national quartile for estates and facilities costs reflecting a sustained lack of investment due to past challenged financial position of trust. The trust had developed and estates strategy and site plan which it had started to implement with some initial impact although benefits were expected in future years.

- For the financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,277 compared with a national median of £1,307 and a peer median of £1,245. The main costs are the medicines cost which is above national median (as discussed above) and higher than national and peer median costs for supplies and services. The trust had a supplies and services cost per WAU of £442 in 2017/18 which was well above the national median of £364 and the peer median of £347. Part of this will be explained by the effectiveness of the procurement function. The price performance component of the Purchase Price Index and Benchmark (PPIB) league table ranking was 126 out of 133. The relative performance in this area also resulted in a 35% under-delivery of procurement CIPs in 2018/19. Benchmarking showed that the trust invested much less in its procurement services than other trusts which was a contributory factor to the poor outcomes.

- The trust had reviewed this performance which it assessed as resulting from poor contract management of pricing and catalogue compliance. This was an area that the trust was working to improve with the support of NHS Improvement and in June 2019 the trust had achieved its NHS level 1 accreditation. Under new management, there was at the time of the assessment better engagement across the clinical divisions and the benefits were starting to come through with an improvement of 16 places in the PPIB ranking in May 2019. There were plans to collaborate to drive improved performance which were set out in the recently adopted procurement strategy, setting out the trust's plans to 2025.
- The trust was efficient overall across its corporate services, ranking in the most efficient quartile for human resources (HR) and the second-best quartile for finance. The information management and technology (IM&T) cost was however in the most expensive quartile with the trust being a fast follower of the Global Digital Exemplar Programme.
- The trust was in the middle of a programme to review and develop its corporate services both within the trust and through increased external collaboration. The finance function benchmarked well against the national median (£0.624 million per £100 million turnover against £0.715 million for 2017/18) with a reduction in total cost of over 12% from prior year. The higher costs were in the income and contracting function which the trust planned to be an area of improvement in 2019/20 following improved working with the trust's commissioners, reducing the levels of administration. The trust told us this was an area of focus for the trust in on-going benchmarking and on-going review of staffing levels.
- The HR function benchmarked particularly well (top quartile nationally) with high efficiency in nearly all areas. The quality metrics of the department were also strong in areas such as 'time to hire', appraisal rates, improving staff retention rates and good controls over agency costs. The trust was looking to increase collaborative working with the sustainability and transformation partnership (STP) across the people agenda.
- The IM&T costs were significantly above the national median (£3.413 million per £100 million turnover against £2.474 million). At the time of the assessment, the trust had an outsourced service and was planning an imminent sourcing review to identify opportunities to improve value for money. The trust had been investing heavily in its digital capabilities in recent years recognising that it had fallen behind with a combined revenue and capital investment of £24 million in 2018/19. The trust had invested significantly in its aging IT infrastructure, security and hardware replacement programmes. The progress the trust had made was recognised in its rapidly improving HIMSS (Healthcare Information and Management Society) stage rating, now at 5 (with 7 being the best). The benefits of this investment still had to fully materialise in reductions in other costs associated with paper records. The IM&T costs also included the business intelligence and clinical coding teams.
- The trust operated predominantly from the Royal Berkshire site following the consolidation project over 15 years ago, which brought together Battle Hospital and Royal Berkshire onto one site. It also operated from five other sites.
- The cost of running the estate 2017/18 was £410 per square meter which placed the trust (just) into the most expensive quartile nationally. Additionally, the trust was in the quartile with the highest level of backlog maintenance per square meter at £457 compared with a peer median of £233.
- The last significant investment at the trust delivered £125 million capital improvements, although these were identified as part of a full business case approved in 1993 and therefore, at the time of the assessment, it was over 25 years since any major investment. The trust linked the lack of past investments to its former poor financial position which had led to regulatory action and therefore capital was not available for estate investment, with a constrained year-on-year capital investment programme of approximately £6 million.
- At the time of the assessment, the trust had developed an estate strategy and development plans that aimed to address the current high estates and facilities costs.
- In some areas, the trust anticipated an almost immediate improvement. For example, the trust had made changes and improvements regarding waste management and linen (and continued to do so) and had new contracts in place. At the time of the assessment, the trust, however, did not expect any significant changes in 2019/20, although they were confident of delivering improvements in following years. This reflected the direct impact of the time lag for procurement, construction and reporting on timescales.
- During 2018/19, the trust had materially under-delivered on capital projects with a capital plan of approximately £40 million of which only £28 million had been delivered. This slippage was partly due to insufficient project management capacity and since the trust had increased the resourcing of its projects team from 2 to 13 project managers (using framework resourcing) to ensure faster delivery. The trust was also concerned that it may not achieve its control total for that year and hence receive its provider sustainability funding monies and therefore the trust board had decided mid-year to slow down its capital spending plans.

- The trust had planned to invest £14 million in Estates capital for 2019/20 (with the potential for an additional £6 million) including in facilities management to reduce recurring costs in this area. The trust had already delivered around £80k savings in the cost of water usage in the first quarter alone, through investment.
- As part of the recently completed site plan, the trust had classified its buildings using a red/amber/green rating for backlog maintenance, which allowed the trust to select which buildings to invest in and those where it was not economically suitable to do so.

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

The trust had met its control total over the last two financial years, although supported by non-recurrent costs and income benefits, and forecasted to deliver it in 2019/20. The trust, however, estimated it was trading with a material underlying deficit which it was working to address. The trust had past record of not delivering its cost improvement scheme although it had improved the level of recurrent savings. At the time of the assessment, the trust's cost improvement plan for 2019/20 was higher than previously delivered and included significant risks. The trust had introduced its 'Finance Matters' programme to strengthen financial robustness and focus across the trust. The trust was at the time of the assessment working with a consultancy firm to better understand its underlying financial position, deliver a recovery plan and strengthen its cost improvement plan. The trust had enough cash to deliver its financial duties and its debt was limited. The trust was developing a commercial strategy to maximise non-NHS income which it expected would contribute to its financial recovery.

- In 2018/19, the trust had delivered a £4.5 million deficit (excluding Provider Sustainability Funding (PSF); £15.6 million surplus including PSF) which represented 1.1% of its turnover. Although this was in line with the trust's control total, this was after NHS Improvement had agreed to a control total transfer being a £0.9m from ICS partner, Berkshire Healthcare, which had benefitted the trust and had allowed the system to receive the full amount of PSF which would have otherwise been lost. The trust's financial position was also supported by additional funding from commissioners (£2.0 million) and use of revaluation uplift (£7.0 million) in line with accepted accounting principles.. The financial position was similar to prior year where the trust delivered a £4.2 million deficit excluding Sustainability Transformation Fund (STF).
- For 2019/20, the trust had a plan to deliver a £1.5 million deficit excluding central funding (e.g. PSF) which represented 0.3% of its turnover. This was in line with its control total and would improve on its prior year position. The plan was supported by £16.9 million cost improvements. As at the end of July 2019 (month 4), the trust was £1.5 million behind its year to date plan but continued to forecast achievement of its planned financial position for the full year.
- The trust had not delivered its cost improvement plan (CIP) in 2017/18 and 2018/19 with the value of the cost improvements reducing from £15.3 million in 2017/18 to £14.1 million in 2018/19. However, we noted an improvement in the level of recurrent cost improvements, from 52% of the plan (£8.0 million) in 2017/18 to 71% (£10.0 million) in 2018/19. For 2019/20, the trust had a £16.9 million CIP (4.2% of expenditure), which included £3 million stretch target the trust had agreed to in order to meet its control total.
- The trust's CIP included schemes identified by the trust's three care groups as well as cross organisational schemes in particular around procurement, outpatient transformation, administration costs, patient flow and bed base flexibility and medicine optimization. The trust was also working on a transformation strategy which aimed to bring a more holistic quality improvement approach across the trust and support the continuous development of transformational schemes and savings. At the end of May 2019, the trust reported £6.2 million unidentified CIPs (37% of its CIP) which represented a significant risk to the trust's achievement of its 2019/20 plan and at the end of July 2019, the trust was behind its planned delivery by £0.6 million (87% of its year to date planned savings).
- The trust had identified that it was trading with an underlying deficit which it estimated to be £18.0 million (4.1% of turnover). At the time of the assessment, the trust had shared with us a draft analysis of its underlying deficit including the key drivers of its position. Although the review was still being discussed internally, it indicated that the trust had invested in staff recently to improve services and that where additional activity resulted from these improvements it was not always funded by commissioners to the full extent of 'payment by results' tariff in circumstances when activity demand is rising.
- At the time of the assessment, the trust was working with a consultancy firm to strengthen its cost improvement plan for 2019/20 (and beyond) and build a financial recovery plan to achieve financial balance by 2020/21. At this stage of the work, the trust anticipated that its financial recovery would rely principally around modernising nursing roles (through increased use of associate roles) and savings from investments in particular relating to estates and several higher risk commercial and clinical income streams (including through repatriation of activity from the private sector

and London NHS trusts). The trust also explained that with services changing, it needed to ensure that resources were aligned to delivery and that there was an opportunity to realign its cost base with demand and understand better the contribution made by each service. During the year, the trust had launched 'Finance Matters' an organisational change programme to achieve efficiency and improve financial control, which included a demand and capacity modelling across service lines which would link to contract planning. The trust had improved the service line information available to services as a result and given better visibility of service line reporting to its board. At the time of the assessment, the trust had not fully started using Patient Level Information and Costing System but was exploring pathway costing.

- The trust was part of ICS Berkshire West, an established vanguard ICS, which was collaborating on several work streams to create the conditions for sustainability of services and finance. During 2018/19, the ICS had introduced a new blended' payment approach which consisted of a fixed payment and an innovative risk/gain sharing agreement, between the trust and Berkshire West CCG, as lead commissioner which however introduced an element of cap on the trust's income gain activity delivered whilst also introducing an element of income certainty if activity were to fall. The ambition for 2019/20 was therefore to develop a model to move to an efficient cost model for the fixed element of the blended payment.
- The trust received commercial income from private patients, commercial research (clinical trials) and development and retail and catering. The trust, in particular, ranked consistently within the top 5 district general hospitals across England for recruiting to new clinical trials for which it received an income. At the time of the assessment, the trust shared a draft of its commercial strategy which aimed to maximise these income lines in the future to benefit the trust as well as patients. The trust saw development of commercial income as a key element of its future financial recovery plan.
- The trust had a debt service cover rating of 1 (best) and a liquidity rating of 2 (second best) for 2018/19 which were expected to continue in 2019/20. The trust had £20 million more cash at the end of 2018/19 than planned and this was mainly due to a combination of under delivery of capital spend (£12 million)) and bonus PSF monies of £9.5 million. The trust did not rely on revenue cash support to meet its financial obligations. The trust was looking to develop monthly billing and had introduced key account managers to ensure that creditors were paid promptly. Cash forecasts were also now reported to the trust board. The trust's borrowings mainly comprised the outstanding balance (£17.2 million) of loans the trust received several years prior from the Department of Health and Social Care to fund two significant investments and which were being repaid.
- In 2018/19, the trust had spent £0.1 million on consultancy. This was however expected to increase significantly in 2019/20 with the trust having commissioned an accountancy firm to support the trust in understanding its underlying deficit, develop a financial recovery plan and implement the trust's quality improvement approach which was core to its transformation strategy. The planned cost in 2019/20 was expected to be funded by transformation monies to be received. The trust had governance arrangements in place to oversee the delivery of this significant piece of work(estimated around £0.9 million) and part of the consultancy fee was contingent to specific outcomes.

Outstanding practice

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

- The trust had one of the lowest agency spends nationally. The trust had also adopted an innovative solution to the nursing workforce challenge by working across the system to minimise agency rates.
- The Berkshire & Surrey Pathology Services the trust is part of has been recognised by Lord Carter as an exemplar network to deliver pathology services.
- The trust operates efficient human resources and finance functions which benchmark well both on cost and quality metrics.
- The trust has developed a programme ('Finance Matters') to improve staff engagement on financial matters across the trust to improve their understanding of costs and revenue and the trust's financial position.

Areas for improvement

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

- The trust has plans to increase its MRI capacity during 2019/20. The trust must progress at pace to ensure that it has enough capacity and appropriate equipment to deliver its services and in particular to support the improvement of its 6-week diagnostic performance.
- The trust is working with a consultancy firm to understand its underlying deficit, improve the deliverability of its cost improvement plan in 2019/20 and develop a financial recovery plan. The trust must ensure that:
  - it continues to work with the consultancy firm to clarify the drivers of its deficit and value of potential efficiency gains;
  - it works with its systems partners to ensure it has appropriately considered making further investments in resources in particular where additional activity resulting from these investments is not directly funded (noting the Royal Berkshire Foundation Trust/Berkshire West CCG risk/gain agreement).
  - the work with the consultancy firm delivers the anticipated benefits of the review including regarding identification and delivery of efficiency for 2019/20 and 2020/2021;
  - the trust has the capacity and capability to deliver the financial recovery plan coproduced with the firm.
- The trust should continue to drive improvements in procurement in terms of engagement with clinical divisions, contract management and catalogue compliance.
- The trust should continue to improve on specific areas of clinical services productivity, namely:
  - consider whether its rate of admission is justified and continue to seek to prevent admission where appropriate;
  - progress with its initiatives to reduce its DNA rate.
- The trust should continue to develop the use of its e-rostering data to improve its ability to forecast demand and capacity and nursing requirements.
- The trust should continue to develop initiatives to improve its staff retention rate which benchmarked in the lowest quartile nationally.
- The trust should continue to progress in increasing the number of prescribing pharmacists and its 7-day service availability.
- The trust should continue its effort to develop its service line reporting and patient level costing, including engagement with care groups and utilisation of this costing information to support its financial recovery and efficiency plan.

The trust has identified anomalies in its activity data submission for 2017/18 which was used to derive the trust's cost per WAU. The trust needed to continue to progress with data quality to ensure the Model Hospital correctly reflected its costs per WAU.

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
Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020

Trust level

Well-led	Use of Resources
Good Jan 2020	Good Jan 2020

Overall quality

Good
Jan 2020

Combined quality and use of resources

Good
Jan 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.