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Torbay and South Devon NHS Foundation Trust

Use of Resources assessment report

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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.

The Use of Resources rating for this trust is published by CQC alongside its other trust-level The trust has a significant level of backlog maintenance within its capital expenditure plan (£222 per square metre compared to a benchmark of £63 per square metre). Whilst the trust does not currently have the funding available to address all of this, it does have a prioritised risk-based capital plan, which is recognised at board level.

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 23 February 2018 and met the trust's executive team (including the interim chief executive), a non-executive director (in this case, the chair) and relevant senior managers responsible for the areas under this assessment's key lines of enquiry (KLOEs).

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Findings

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

We rated use of resources as good because the trust demonstrated that it has used its resources effectively to deliver care to patients in an integrated care setting.

- We rated the trust's use of resources as good.
- The trust was one of the first integrated care organisations in the country, and provides acute, community health and social care services.
- The trust is part of a mature Sustainability and Transformation Partnership (STP) and has agreed a risk share arrangement with South Devon and Torbay Clinical Commissioning Group (CCG) and Torbay Council to promote provision of health and social care within a community setting.
- The trust is forecasting achievement of its financial plan for 2017/18. This includes delivery of £41.7m CIP, of which, £29.2m is recurrent CIP, which is a significant increase on previous years.
- The trust has one of the lowest Did Not Attend (DNA) rates in the country at 5.5%.
- The trust's pre-procedure elective bed days are slightly lower than the national median and it has reduced its length of stay throughout 2016/17 and 2017/18 whilst also reducing its bed base by 99 beds across its acute and community hospitals.
- The trust benchmarks well nationally for workforce metrics including high retention and low rates of sickness.
- Overall cost per Weighted Activity Unit (WAU) is in the 1st (best) quartile when compared nationally.
- The trust has a significant level of backlog maintenance within its capital expenditure plan (£222 per square metre compared to a benchmark of £63 per square metre). Whilst the trust does not currently have the funding available to address all of this, it does have a prioritised risk-based capital plan, which is recognised at board level.

However:

- The rate of emergency readmissions within 30 days (10.68%) is high compared to the national average. The trust had identified this and is undertaking a case note review to understand the drivers of emergency readmissions, particularly to understand whether it is a consequence if its integrated care model. As such, the trust is not yet able to demonstrate a full understanding of the drivers behind this, including the link to discharges, or the potential impact on patient care.'
- The trust recognises that it could improve its granular understanding of activity within its integrated care model, specifically within non-elective and community care and the impact this has on its performance and use of resources.The trust reports that financing the introduction of community based IT systems will be critical in this endeavour.
- £10.5m of the trust's CIP achievement in 2017/18 will be non-recurrent.
- The trust is in the highest (worst) quartile against the national median for pre-procedure non-elective bed days at 0.99 days against the national median of 0.78.

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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 has low DNA rates and benchmarks in the lowest (best) quartile for this metric at 5.5%. Since 2015, the trust has provided a text reminder service for patient appointments and reduced booking follow up appointments significantly in advance.
- The trust has pre-procedure elective bed days of 0.12 days, which is slightly better than the national median of 0.13.
- The trust's A&E performance in December 2017 was 88% against the 95% target; it met its Quarter 3 STF agreed trajectory of 91%.
- The trust has a number of interventions in place to reduce attendance at A&E. These include: use of a phone application that tells patients the waiting times at other services; allowing patients deciding to go elsewhere to exit the hospital carpark without paying; GPs within one locality working with nursing homes; multi-disciplinary teams including social care; and seven day services.
- The trust has engaged with the Get It Right First Time (GIRFT) team and has also agreed to compare results by specialities with other providers within the STP.
- The trust has a 30 day emergency readmissions rate of 10.68% which is among the highest rates in the country. The trust has taken some action in this area by conducting a coding review, which concluded that data issues are not affecting performance against this metric. It is now undertaking a case note review to understand the drivers of emergency readmissions on an individual patient level. At the time of the assessment, this review was not complete and the trust was not able to demonstrate a full understanding of the drivers behind this, including the link to discharges, or the potential impact on patient care.
- The trust has pre-procedure non-elective bed days of 0.99 against the national median of 0.78. The trust is carrying out further analysis as to whether non-elective bed days are being overstated by patients transferring between community wards and its acute site.
- The trust's performance against the 62 day cancer metric has been declining from 83.3% in October 2016 to 77.7% in November 2017. The trust has experienced pressures particularly within urology and colorectal and is reviewing clinic templates and looking at ways to smooth capacity and demand across the patch including using diagnostic capacity from the independent sector.
- Referral to Treatment (RTT) performance was 82% in December 2017 against a national position of 87%. The trust is carrying out weekly reviews of patients in pressure areas and is re-directing resources accordingly, putting on additional sessions in urology and upper GI.
- Challenges were reported by the trust in diagnostic imaging capacity. This is linked to ageing equipment and a high risk of equipment breakdown which consequently reduces capacity and consequently the delivery of diagnostic standards. The trust has a defined equipment replacement programme, but this is dependent on capital availability.
- The trust reports that it faces workforce challenges within its histopathology service but feels it has proactively responded to these challenges through collaboration with neighbouring trusts and involvement in the delivery of a regional approach to service provision.

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

- The trust performs well against workforce metrics with a staff retention rate of 87.69% which is higher than the national median. In addition, the trust's sickness rate is 3.62% which is marginally below the national average of 4%. The trust reports that it is aware of

the age and retirement profile of its workforce and is reviewing potential mitigations against the risk of future vacancy risks. This includes recruiting nurses internationally and working collaboratively with the STP to support medical vacancy pressures specifically in areas such as histopathology. The trust has also engaged with the local voluntary and charitable sector, to offer training and access opportunities to students and those already working in care settings.

- The trust's total pay cost per WAU is £1,883, putting it in the lowest (best) quartile and within this total both medical and nursing costs per WAU are below the national average. The Allied Health Professionals (AHP) cohort pay cost per WAU is £155, putting it in the highest quartile, but the trust reports this is a planned consequence of the its integrated care model, which includes increasing multi-disciplinary teams in the community and advanced practice roles, which results in higher AHP to nursing ratios.
- The trust reduced its bed base by 41 acute beds and 58 community beds during 2016/17 and 2017/18 and this has allowed it to review and consolidate its staffing levels. The trust has remained within the agency ceiling set by NHS Improvement throughout 2017/18.
- The trust reduced its pay bill from 2016/17 and 2017/18 and has seen a reduction in its pay expenditure run rate of approximately £800,000 a month between April and December 2017.
- The trust is in the process of moving to an improved electronic rostering system for nursing, which includes a safety module that has the ability to monitor safe staffing and acuity levels on a twice-daily basis.
- The trust acknowledges that consultant job plans are an area it can improve by increasing the number of consultants with an agreed job plan. The trust is currently undertaking a review of the job planning approach to improve compliance and efficiency.

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

- The trust benchmarks within the lowest quartile against the national median for pathology costs per test at £1.40 per test against an average STP peer group cost per test of £2.05 per test. The trust reports that it has achieved this by utilising advances in technology, which have enabled staffing levels and skill mixes to be reviewed and adjusted.
- The trust delivered 128% of its savings target on the top 10 medicines between April to December 2017, putting it at the higher end of achievement in this area across the country. The Trust holds 20 days of stock and is planning to reduce this further to 15 days to better manage stock efficiency.
- The trust is increasingly using technology such as video-conferencing facilities for staff to staff communication across its wide geographic community locale. In addition, the trust has utilised this for patient contact and considering a wider roll-out of this approach.
- The trust uses a paper based system to record activity within its community services. The trust is exploring opportunities to implement technology in this area to improve efficiency but this is dependent on capital funding.The trust's acute and community systems are not fully integrated; the trust has a clinical portal in place to enable communication which is under on-going development.
- The trust does not use electronic prescribing other than within chemotherapy. The trust reports that a community wide electronic prescribing system has been procured and is in implementation.The trust's locality pharmacists are prescribers and all trained pharmacists will be trained as prescribers in the future. There remains, however, a time lag between pharmacists qualifying and becoming prescribers, which would support the trust to speed up discharge, improve uptake of medicines by patients and reduce medicine errors.

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

- The trust benchmarks within the highest (worst) quarter for total non-pay costs per WAU. It has asserted that this metric is adversely affected by the inclusion of costs associated with running a pharmaceutical manufacturing unit and the provision of adult social care which are not comparable to most other trusts. Taking these costs out would result in its non-pay costs reducing towards the national median.
- Based upon a national data collection looking at costs in 2015/16, the trust's finance cost per £100m of turnover is above the national average (in the third quartile). However, the finance costs reported by the trust include overheads for social care services and a pharmaceutical manufacturing unit which are not incurred by other trusts and should be excluded for the purposes of comparison. If these costs are removed the trust's finance costs benchmark favourably against other trusts.
- HR costs per £100m of turnover are below average but as with finance costs, these also include cost elements that should be removed for the purposes of comparison and so the true picture will be better than indicated.
- The trust report that it has in the past market tested outsourcing its corporate services functions but could not find a supplier that was able to provide the services more efficiently.
- The trust provides payroll services both in-house and for several other NHS and independent organisations in the South West and while its cost per payslip is higher than the national average this is skewed by the costs of payslips provided for other organisations.
- The trust benchmarks as average against the national median for procurement costs.The trust is part of the Peninsula Purchasing and Supply Alliance which delivers procurement support across the South West. Based on a set of procurement processes and performance measures, the trust lies above the national mean. On price metrics the trust performs well demonstrating that it pays lower than average prices for comparable goods and services. The trust's process metrics are weaker though, partly driven by a lower percentage of non-pay spend being submitted for national benchmarking. However, this figure is again distorted by the trust having significant non-pay social care costs which should be adjusted for. If adjustments were made, the trust would be much closer to the national mean.
- Based on 2016/17 data, overall estates and facilities costs per square meter was above the national average at £336 per square metre compared with £326 per square metre but this does include relatively higher cost and more dispersed community services facilities, some of which have now been closed and will be sold. This should bring the trust below the average in future years.
- Estates and Facilities Management is provided in-house and services such as cleaning are higher than the national average. This includes a 24 hour Deep Clean team that supports out of hours discharge and cleaning of beds and single rooms. The trust asserts that its small bed base necessitates a responsive in-house team to clean beds quickly for other patients to use.
- The trust has identified energy as an area where it can improve efficiency with potential opportunities of around £400,000 based on 2016/17 data. It is currently seeking a strategic estates partner who it hopes can help in this area.
- The trust has significant levels of backlog maintenance within its capital expenditure plan and this is an area of concern for the Board. This reflects the estate's age; specifically within theatres, the air-handling unit and the emergency department (ED). In addition, the trust highlighted cyber-security as an area requiring investment.
- The trust has limited its capital expenditure to available cash and has made an STP capital

funding bid for ED provision.

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

- The trust did not achieve its £2.3m surplus control total in 2016/17 and reported an £11m deficit for the year. Within this position, the Trust delivered £11.4m CIP, of which, £7.8m was recurrent and £3.6m non-recurrent.
- The trust has improved its financial performance in 2017/18 and is forecasting delivery of its 2017/18 financial plan and £4.7m surplus control total. This position includes forecast delivery of £41.7m of CIP, £29.2m of which is recurrent.
- A project management office (PMO) is in place to monitor savings and efficiencies at system, trust and division levels and a business support manager sits within each division. The trust implemented a cost-efficient and focused approach to establishing its PMO utilising external support in a targeted way which has maximised the delivery of savings.
- The trust is part of a mature STP which includes joint management of control totals, system wide savings plans, a joint review of acute services and mutual support in areas of pressure. Providers and commissioners within the STP have recently taken part in an open book 'peer review' process involving agreeing principles for financial planning, sharing draft financial plans and giving and receiving feedback on these.
- The trust has significant levels of backlog maintenance within its capital expenditure plan and this is an area of concern for the Board. In addition, the trust has stated its requirement for capital funding to support digital technology solutions within both corporate and clinical support services that it believes will unlock capacity and efficiencies.
- The trust has Model Hospital Capital Service Capacity and Liquidity scores of 4; the lowest on the Single Oversight Framework. It has an £11m working capital facility that it has not accessed to date.
- The trust has a pharmacy unit that makes sterile injectables and Total Parenteral Nutrition (TPN) TPN compounds. The unit makes a significant commercial income contribution to the trust and has a growth business plan in the medium term. In addition, the trust has a retail pharmacy unit which is a wholly owned subsidiary.
- The trust has patient level costing (PLCs) in place but does not include PLCs or service level reporting within its monthly reporting on the basis that it could distract from the emphasis on integration.

Outstanding practice

- Over the last two years, the trust has developed its integrated care model, increasing capacity within multi-disciplinary health and social care teams working with patients in the community and engaging the voluntary and third sectors. The trust has reduced its length of stay within community hospitals whilst closing beds in both its acute and community hospitals.
- The trust effectively uses a text message alert system for appointments and has one of the lowest DNAs in the country.

Areas for improvement

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- The trust has an emergency readmissions rate of 10.68% which is higher than its peer average and had further work to do to understand the drivers of readmissions and to be assured that this does not reflect a high risk of harm to patients.
- The trust has a capital expenditure plan with significant levels of backlog maintenance of £222 per square metre against a benchmark of £63. The trust has limited capital funding available and should develop a risk-based prioritised list of capital projects. The trust is seeking a strategic estates partner that can assist it in identifying efficiency opportunities.
- The trust could improve its understanding of activity within its integrated care model and specifically within non-elective and community care.
- Reviewing and updating consultant job plans to ensure the effective and productive use of the consultant workforce is an ongoing area of work for the trust. The trust acknowledges that its systems for recording community and acute activity are not integrated and that digital mobile technology would enable community teams to record activity and notes in situ. The trust is working to secure capital investment in its IT infrastructure.

Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term ‘allied health professional’ encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service

	referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24 hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.
Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for 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.
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.

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Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs
Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Single Oversight Framework (SOF)	The Single Oversight Framework helps NHS Improvement identify NHS providers' potential support needs across five themes of quality of care, financial and use of resources, operational performance, strategic change, leadership and improvement capability.
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.

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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	The weighted activity unit (WAU) is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.