# Sheffield Teaching Hospitals NHS Foundation Trust

## Use of Resources assessment report

Northern General Hospital, Herries Road,
Sheffield, S5 7AU

Tel: 0114 243 4343
www.sth.nhs.uk

Date of publication:
14 November 2018

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** ● |

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RHQ/reports)

| | |
|---|---|
| **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:

Our rating for the quality of the trust stayed the same. We rated it as good because:

- We rated responsive as outstanding and we rated safe, effective, caring and well-led as good.
- The Northern General hospital was rated as Good overall as both urgent and emergency care and end of life had improved. Responsiveness was outstanding at this site which was an improvement.
- In rating the trust, we took into account the current ratings of the other services not inspected this time.
- Our decisions on overall ratings took into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.
- We rated well-led at the trust level as good.

The trust was rated good for Use of Resources.

NHS Improvement

# Sheffield Teaching Hospitals NHS Foundation Trust

## Use of Resources assessment report

Northern General Hospital, Herries Road,
Sheffield, S5 7AU

Tel: 0114 243 4343
www.sth.nhs.uk

Date of site visit:
4 June 2018

Date of publication:

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 4 June 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair) and other senior management responsible for areas under this assessment's KLOEs.

## Findings

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

- We rated the trust's use of resources as Good.
- The trust is currently using its resources effectively in support of the delivery of services for patients and is currently performing well on the metrics considered in this assessment, being the best or second best quartile for the majority of these. The impact of this includes the trust realising benefits from innovative workforce models it has established in response to changing workforce trends, models which are contributing to strong benchmarking in relation to pay costs per WAU and high staff retention rates.
- The trust reported a surplus of £8.6 million in 2017/18 (including Sustainability and Transformation funding (STF)), £4.2 million better than the annual plan and is forecasting a surplus of £5.1 million in 2018/19 (including non-recurrent sustainability funding). The trust is not reliant on external loans to meet its financial obligations and deliver services. It is able to service its financial and debt obligations, pay its staff and suppliers, and sustain positive capital and cash funding positions.
- For 2016/17, the trust had an overall pay cost per WAU of £2,015, compared with a national median of £2,157, placing it in the second lowest (best) cost quartile nationally. This means that it spends less on staff per unit of activity than most trusts. The trust is in the second lowest (best) quartile for nursing, medical and AHP (Allied Health Professionals) cost per WAU.
- The trust has taken an active approach to managing its resources to provide clinical services that operate productively to maximise benefits to patients and use a quality improvement approach to identify opportunities to improve productivity further.
- Patients are less likely to require additional medical treatment for the same condition at this trust compared to others and it benchmarks positively against national Did Not Attend (DNA) averages. The trust consistently meets the 18-week Referral to Treatment (RTT) standard and is one of the top 3 performing acute trusts nationally for this standard.
- For staff sickness absence the trust has a lower rate than the national median and saw improvements during 2017/18 linked to new policies introduced in April 2017. The trust also has high staff retention rates in comparison to the national median and is in the top 4 performing acute trusts for this metric.
- The trust has reduced year on year the amount of expenditure on agency staff and was significantly below its ceiling in 2017/18. This delivery has been underpinned through the embedding of policies and procedures throughout the trust to manage this area of resourcing.
- In support of clinical services, the pharmacy team in the trust is an integral part of the clinical ward teams with the electronic prescribing and discharge summaries

contributing to effective patient discharge procedures and helping to reduce the length of stay for patients.

- For corporate services the trust benchmarks positively against key areas of resource management including i) turnover weighted finance, human resources and legal costs and ii) supplies and service costs.

**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 taken an active approach to managing its resources to provide clinical services that operate productively to maximise benefits to patients and use a quality improvement approach to identify opportunities to improve productivity further.

- Patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 6.97%, emergency readmission rates were slightly below the national median of 7.1% during 2017. The trust reported that access to advice from a senior clinician via a single point of access for acute and geriatric medicine had contributed to this positive position. The trust also reported success with admission avoidance schemes with nursing homes and the introduction of “OK to stay” plans developed by community matrons in conjunction with patients.

- At 6.69%, the DNA rate for the trust was lower than the national average of 7.7% during 2017. The trust has a programme of improvement work focussed on continuous improvement within outpatients including specific work to reduce DNAs for example the introduction of partial booking to allow greater patient choice and a text message reminder system.

- Changes to patient pathways and models of service delivery have enabled the trust to make improvements to efficiency and productivity. For example, the introduction of a urology assessment unit has eliminated the need for patients to attend the accident and emergency department by enabling direct access to the unit, reducing the number of non-elective urology admissions and subsequently contributed to an improved patient experience and the opportunity to close a 12-bedded ward providing a cost saving of £121,000 per year.

- The trust has also redesigned the stroke pathway and community services to support an earlier discharge from hospital for patients following a stroke which has resulted in a reduction of 28 acute beds and an overall reduction of 10 beds throughout the pathway and improved patient flow. The consolidation of nursing and therapy staff to one inpatient ward also contributed to an improvement on the Sentinel Stroke National Audit Programme score from a Level D (several areas require improvement) to a Level B (good or excellent in many aspects).

- The trust has worked with local partners to co-ordinate services across the local health and care economy to make best use of resources. For example, there has been partnership working with the Clinical Commissioning Group (CCG) and local GP practices to pilot a Clinical Assessment, Services, Education and Support (CASES) model which provides advice and guidance to GPs from consultants at the trust. This had led to reduced DNA outpatient appointments and more appropriate referrals to the seven specialities that account for around 50% of routine referrals to the trust. Evaluation of the pilot showed that 11% of referrals made through the CASES model between October 2016 and September 2017 were managed by GPs rather than being referred to secondary care.

- The trust explained that pre-procedure bed days are higher than the national median due to the tertiary and specialist nature of the services it provides. These patients are often complex with a higher requirement for pre-operative work up. The trusts surgical improvement work stream has commenced work to review all patient pathways within specialities to ensure patients are admitted at the most appropriate time and to improve the effectiveness of pre-operative assessments. The introduction of electronic pre-operative assessments for low risk patients has increased the availability of face to face assessment slots for patients who require a more in-depth assessment.

    - On pre-procedure elective bed days, at 0.27, the trust is performing in the highest (worst) quartile when compared nationally – the national median is 0.13.

    - On pre-procedure non-elective bed days, at 1.05, the trust is performing in the highest (worst) quartile when compared nationally – the national median is 0.81.

- The trust reported a delayed transfer of care (DTOC) rate of 5.8% which is higher than the national average of 4.2% and higher than the trust's own target rate of 3.5%. DTOC rates had been reducing between August and December 2017, however the trust had experienced increasing rates during January to March 2018 due to a challenging winter period with pressures in intermediate care, community services and limited availability of social care packages in the area. Focussed work involving key partners has been ongoing throughout 2017/18 including a Chief Executive led programme board and the development of in hospital and out of hospital work streams with a shared vision for the development of discharge and transfer pathways.

- The trust has engaged well with the Getting It Right First Time (GIRFT) programme and report a good level of clinical engagement. There have been 12 visits to the trust. Action plans have been developed following the GIRFT visits with three top priority actions for each of these. Achievements from the GIRFT programme include the development of a bespoke cataract centre which has improved patient experience alongside improving productivity by offering a one-stop clinic service and increasing the number of cases per list from six to eight.

- At the time of the assessment in June 2018, the trust was meeting the constitutional operational performance standard for Referral to Treatment (RTT). The trust was not meeting constitutional operational performance standards for Cancer waiting times, accident & emergency or diagnostic tests.

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

- For 2016/17 the trust had an overall pay cost per weighted activity unit (WAU) of £2,015, compared with the national median of £2,157, placing it in the second lowest (best) quartile which means it spends less on staff per unit of activity than most trusts. The trust is in the second lowest (best) quartile for both medical (£490 against a national median of £526) and nursing (£655 against a national median of £718) costs per WAU and benchmarks at the median for AHP cost per WAU (£127). The trust described how the management of pay costs is underpinned by each directorate developing their own workforce plans as part of the wider financial planning across the organisation.

- The trust provided an example of the nursing workforce using an electronic rostering system which produces monthly reports to determine the current efficiency and

effectiveness of staff rosters at a particular time and provides evidence to inform any changes that might be required to keep an ongoing control of pay costs.

- The trust provided evidence on actions being taken to improve the productivity of its workforce. One of these actions is in Medicine and Pharmacy Services which, reflective of the national picture, is a workforce area with recruitment challenges with a net vacancy percentage of 12.77% of Registered Nurses (RNs) as at June 2018. The trust has introduced enhanced skills training for selected Band 2 clinical support workers with these additional competencies including venepuncture, cannulation, catheterisation, Aseptic technique, simple dressings and pressure ulcer prevention and management. This has enabled these tasks previously undertaken by the RNs to be carried out through this alternative approach, further improving clinical productivity of teams in the trust. Another initiative has been developed by the trust to train Band 4 assistant practitioners to level 5 diploma with an underpinning knowledge to support RNs and further support bridging the gap between RNs and clinical support workers. The trust noted the above workforce models are contributing factors to them being able to reduce the use of agency staff through the reduction in the requirement for RNs.

- The adoption of these new workforce models is also an example of how the trust is enabling an appropriate skill mix to be in place for how clinical work is being undertaken. To further promote and embed this approach the trust has designed a system displayed on wards which identifies key and frequently required clinical activities and aligns these with the staff groups which are able to carry these out, including the most junior level required. This has supported the trust to be improve productivity by reducing the amount of deliberation on tasks that are carried out in clinical settings given this clear delineation.

- The trust met its agency ceiling as set by NHS Improvement for 2017/18 and is forecasting to meet its ceiling in 2018/19. In 2017/18 agency spend was 40% below the NHS Improvement agenda ceiling (£11.0 million delivered against an £18.4 million ceiling) which continued the reducing trend from 2016/17 (£17.1 million) and 2015/16 (£26.5 million). It is spending less than the national average on agency as a proportion of total pay spend with the agency staff cost per WAU significantly below the national median (£56 vs £137), with the trust benchmarking in the lowest (best) quartile.

- The trust has achieved reductions in the expenditure on agency and locum staff through the introduction of a medical locum bank in addition to the use of fixed term contracts for medical staff.

- The trust maintains control of agency usage and spend through embedded governance processes including directorate level agency usage targets (which form part of directorate performance reviews), weekly review of usage by the Trust Executive Group and monthly review at the trust Boards Human Resources and Organisational Development sub-committee. It has a standard operating procedure in place which is explicit about the actions required when there is a requirement for additional staff and which includes what level of sign-off is required within the organisation.

- All nurses at the trust are on electronic rostering which mitigates the risk of staff rota gaps and the potential impact on quality and safety of care provided. The trust is currently working towards moving all other clinical professionals onto the electronic rostering system.

- All doctors have job plans which are agreed annually, reviewed and signed off by the trust Medical Director in the job planning meeting along with the relevant clinical director, operational director and head of medical HR. This is managed via an electronic job

planning system which provides instant visibility of job plans (for individuals, directorates and the trust) and enables reports to be generated to identify how medical staff resources are allocated.

- The trust stated they do not have any significant gaps in current staff rotas but look to proactively identify workforce groups where actions are needed to strengthen the resilience. This includes medical registrars which is generally viewed as a challenging area to work in given the volume and complexity of the workload. A practical action taken in response to this is the use of mobile phone messaging as a method for making internal bank staff contact details available where shifts are required to be filled at short notice.

- Staff retention at the trust is strong with a retention rate of 90% against a national median of 86%. The trust attributed this to a range of actions including innovative recruitment campaigns and offering stimulating professional opportunities including those as previously described in relation to progressive workforce models for Band 2 and Band 4 staff.

- At 3.93% (March 2018) staff sickness rates are better than the national average of 3.99%. This is an improved position for the trust from 2016/17 when the rate was at 4.6%. The trust attributed this to the implementation of a new staff sickness policy, which was implemented in April 2017 and which was developed with directorate HR leads. A key aspect of this updated policy is requirement for line managers across the organisation to strengthen their management of their team's sickness and absence which has resulted in this reduced rate across this 12-month period.

- The trust referred to their ongoing positive staff survey findings which are used as further evidence of the impact of the actions taking to support and enable its workforce to be as productive as possible.

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

- The trust clearly recognises the fundamental importance of clinical support services in delivering high quality care, which is reflected in excellent performance against a range of metrics and the investment in systems and collaborative working. They provide specialist Pathology Testing for the STP and nationally.

- For pathology, the overall cost per test for the trust is £2.49 against a national median of £1.91, placing it in the highest (worst) quartile nationally. The trust explained this high cost was reflective of the highly specialised nature of testing performed. Examples of these are the specialist microbiology and cervical cytology testing that the trust undertakes for other local and regional hospitals.

- The trust is working collaboratively with the South Yorkshire and Bassetlaw Pathology Network to implement the recommendations from the Carter Review into operational productivity in the NHS of a hub and spoke delivery model at scale. The trust is actively engaged in this programme both at a local delivery level and at the Network.

- The trust has been innovative with Pathology workforce redesign with scientists taking on the roles traditionally undertaken by medics. The scientists' costs are included in the overall cost per test and the trust stated this is one of the additional drivers to the cost of £2.49 per test.

- There is an established history of working together with other NHS providers in South Yorkshire and Bassetlaw which is facilitating the development of further networked services. An example is the diagnostics workstream for this area which is supporting the Society of Radiographers Sonography trailblazer group. This should result in productivity improvements, through new delivery models and additional economies of scale for efficiency improvements, for the trust and the wider system.

- Medicines cost per WAU at £486 is above the national median of £320. The trust explained the costs are due to the relatively high costs incurred to support the extensive clinical services hosted by the trust and the clinical case-mix of the specialties serviced.

- The trust has strong clinical pharmacy leadership alongside which the pharmacy team described how their function is integrated into clinical ward teams. Electronic prescribing and discharge summaries are examples of how this integrated working is supporting improvements to discharge processes and the lengths of stay for patients.

- The trust is achieving above target against % Top Ten Medicines, delivering 115% of their target to March 2018. This is below the NHS Improvement regional comparator of 127%, these differentials explained by the relative clinical indications of the medicines being used by a specialist trust, which can impact on savings opportunities.

- The stockholding days for medicines reported by the trust is 19 days compared to a national median of 18.8 days. This position is slightly above (worse) the national median and consistent with peer organisations.

- There is a city-wide pharmacy group which looks to maximise the overall spend for the local health economy. This includes a locally agreed quality improvement scheme the trust are an active partner in and within which the trust has outsourced outpatient dispensing and homecare medicine where ongoing medicine supplies and, where necessary, associated care, are delivered direct to the patient's home with their consent. This has involved a wider range of products and services delivering a significant saving to local partner commissioners (£954K in 2016/17) with the primary aim of helping patients on discharge from hospital.

- The trust actively looks to develop their use of technology as demonstrated through the issuing of 4G laptops to community staff members to provide access to real time patient records and reduce the need to return to their office base. Patient facing time accounts for 56.8% of a nurse's time compared with the national average of 53.8% for all community service organisations.

- The trust has a transformation project team that has overseen the implementation of Lorenzo, the electronic patient record. A clinical portal has been introduced that gives clinicians access to all the systems used across the organisation. Whilst implemented it is too early to evaluate the clinical impact.

- The trust established, as a Spend to Save scheme to support the transition towards a paperless system to meet the challenge set by the Government and in response to the changing requirements of our patients; some patients would prefer to receive communication via email or SMS text message rather than a hard copy letter. The project has already made good strides towards this and realised cash releasing and process benefits in the five months since the first service, Cardiology, went live. The Xerox Hybrid Mail (XHM) Project is delivering standardisation, cash releasing and non-cash releasing savings. To date, £37,000 non-pay savings associated with postage, printing and

stationery savings have been made. In addition to these non-pay savings the equivalent of 3.2 wte admin and clerical resources staff hours have been released.

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

- The trust performs strongly across the full range of corporate, procurement, estates and facilities.

- For 2016/17, the trusts non-pay cost per WAU is £1,400 against a national median of £1,301, which places it in the second highest (worst) quartile. Like the majority of large teaching hospitals, the range and complexity of services; teaching and research costs; and hosted services contribute to higher than national median non-pay cost per WAU.

- The trust has consolidated all procurement functions with the exception of Estates and Pharmacy (which is part of the Yorkshire Pharmacy Procurement hub and spoke model). The trust has also jointly re-procured the financial ledger system with three other providers, delivering cash release savings of £115k per annum, with potential to avoid further costs of £109K.

- The 2016/17 the Supplies and Service cost per WAU is £360, which is below (better than) the national median £375.

- The trust is actively engaged in exploring further collaborations with neighbouring trusts and is actively working as part of the South Yorkshire & Bassetlaw Trust Directors of Finance network to align and consolidate corporate service functions.

- The trust has a 2016/17 finance cost per £100 million turnover of £430,900 which is below (better than) the national median of £743,324. At the time of the assessment, the trust was in the top 5 performing acute trusts for this metric, with the trust benchmarking in the lowest (best) quartile nationally.

- The 2016/17 Human Resource costs are below (better than) the national average, with costs per £100 million turnover of £708,580 compared to a national median of £1,005,507, with the trust benchmarking in the lowest (best) quartile nationally.

- The 2016/17 legal costs are below (better than) the national average with cost per £100m turnover of £51,930 compared to the national median of £95,196, with the trust benchmarking in the lowest (best) quartile.

- The trust's overall Price and Performance score (Q4, 2016/17) is 53.2 against a lower benchmark value of 50.0 and an upper benchmark value of 79.

- The total backlog maintenance is £266 per $m^2$ which is above (worse than) the national benchmark value of £189.

- The trust's 2016/17 estates cost per $m^2$ is £230 against a benchmark value of £344 which places it in the lowest (best) quartile.

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

- The trust has a strong track record of managing spending within total available resources and in line with plans, positive financial metrics including cash reserves, and examples of

innovative practice. The trust had relatively low saving aspirations and delivery, and a small but increasing underlying deficit in 2017/18.

- The 2017/18 year end position was £8.6m surplus (including STF). This was achieved through delivering a £18.5m deficit (1.7% of turnover) which was £4.2m better than the Control Total, enabling the trust to earn £27.1m STF.

- The 2018/19 annual plan meets the required Control Total of £21m deficit, and delivery of that plan would enable the trust to earn £26.1m non-recurrent sustainability funding to achieve an overall surplus of £5.1m.

- In 2017/18 the trust set a recurrent cost improvement plan (CIP) of £16m (1.5% of expenditure), which was lower than the two previous years and less than the 2% expectation set in national tariff and in the NHS Operational and Planning Guidance 2017-2019. It delivered £14.8m recurrent savings and £10.3m non-recurrent savings to give total savings of £25m (2.3% of expenditure). In percentage terms, this was the lowest plan and delivery of savings for similar sized trusts in England (in this case determined as trusts with an annual turnover in excess of £900m). A recurrent savings plan of £26.8m has been set for 2018/19.

- The trusts operating income was £13.8m better than plan, mainly as a result of improved clinical activity data capture. Total expenditure on staff was £19.7m worse than plan. However, effective agency and locum staff control arrangements were evidenced with the trust spending £7.4m less than the agency ceiling of £18.4m.

- The trust has an underlying deficit position, excluding non-recurrent sustainability funding, which deteriorated from £14.3m in 2016/17 to £22.1m in 2017/18. In 2018/19 the trust is planning for a £24.4m underlying deficit (2.3% of turnover), excluding non-recurrent sustainability funding. When considering the achievement of a sustainable financial position the trust stated that it is assuming continued receipt of an element of non-recurrent sustainability funding but acknowledged that this assumption is at risk and that they do not have a plan in place to mitigate this risk.

- The trust evidenced a proactive and systematic approach to identifying and realising efficiency opportunities using a range of methodologies including Service Line Reporting (SLR), Model Hospital, benchmarking, active participation in networks and local systems to access best practice, and an established internal service improvement methodology.

- The trust has demonstrated particular innovation in the use of SLR and Patient Level Information and Costing System (PLICS) across the organisation to inform efficiency improvement, aligned with GIRFT reviews and Model Hospital analysis. For example, savings of £1.9m were delivered through clinically-led initiatives in General Surgery non-elective pathways during 2017/8.

- The trust has minimal use of external consultants, reflecting previous investment in an internal Service Improvement Team.

- The trust maintained positive cash balances of £74.9m for 2017/18 and plans to have a cash balance of £71.2m by the end of 2018/9. It operates without the need for external loans and is able to service its financial and debt obligations, pay its staff and suppliers, and sustain positive capital and cash funding positions.

## Outstanding practice

- The trust uses a consistent quality improvement approach to identify and realise benefits to patients and productivity.

- The trust has introduced enhanced skills training for selected Band 2 clinical support workers to undertake clinical activities including venepuncture, cannulation, catheterisation, Aseptic technique, simple dressings and pressure ulcer prevention and management. Alongside using an established framework to identify the opportunities for this approach, the trust has been innovative in implementation of this approach through the identification of “champions” or “Super 2s” rather than train all of those in a clinical support worker role. This was to ensure that there were no patient safety concerns identified and to enable the training to be effective. As an example, pressure ulcer data for Medicine and Pharmacy Services has shown an improving quality picture as a result of this approach.

- Clinical support services in the trust are supported by innovative Pathology workforce models including scientists taking on the roles traditionally undertaken by medics. An example of this is in Histopathology where over the last 15 years, the trust has pioneered, implemented and scaled-up the number of Advanced Biomedical Scientist Practitioner (ABMSP) roles. As a result, the trust has ABMSP resources in place for Cervical Cytology, Ophthalmic Pathology, Specimen Dissection and Histology

- The trust was in the top 5 acute trusts nationally for the costs of its finance function (£430,900 per £100 million turnover compared to the national median of £743,324) effected by a range of actions including the re-procurement of their financial ledger system with three other trusts and working across the local hospital trust network to identify best practice and efficiency opportunities from these.

- The trust has demonstrated innovation in the use of SLR and PLICS to inform efficiency planning and directorate level longer term strategies for financial sustainability, with alignment to the outcomes of GIRFT reviews and Model Hospital analysis. For example:
    - the review of PLICS data from 2015/16 to identify the excess costs over tariff associated with Type II and Type III Intestinal Failure patients. This review was used to successfully negotiate additional for 2017/18 from commissioners for this activity;
    - within Palliative Medicine, there was a trend of decreasing bed utilisation during 2015/16 resulting deficit increase from 2015/16. In response to this and empowered with this analysis the directorate has monitored bed utilisation closely ensuring that by carrying out basic ward processes, allowing a bed to be ready when it becomes available, the utilisation has increased. This has led to this SLR now identifying a surplus in the specialty of almost £0.6m in 2017/18.
    - during 2017/18 a project within General Surgery to address a significant SLR deficit within non-elective activity which resulted in a £1.9m overall improvement through a range of clinically-led initiatives, such as the redesign of the abscess pathway giving a £0.4m improvement, and over £0.5m of cost savings resulting from the cessation of weekend/evening working and bringing work back ‘in-house’ from third party sub-contractors.

## Areas for improvement

- The trust has the opportunity to improve the efficiency of its pre-procedure actions for both elective and non-elective services for which the trust is currently in the highest (worst) quartile for both.

- The trust reported a (DTOC) rate of 5.8% which is higher than the national average of 4.2% and higher than the trust's own target rate of 3.5%. Whilst rates had been reducing between August and December 2017, the trust had experienced increasing rates during January to March 2018 due to a challenging winter period with pressures in intermediate care, community services and limited availability of social care packages in the area. There remains an opportunity therefore to recover and sustain its performance on this key delivery metric and this would be addressed through ongoing system working to develop and implement effective discharge and transfer pathways for patients.

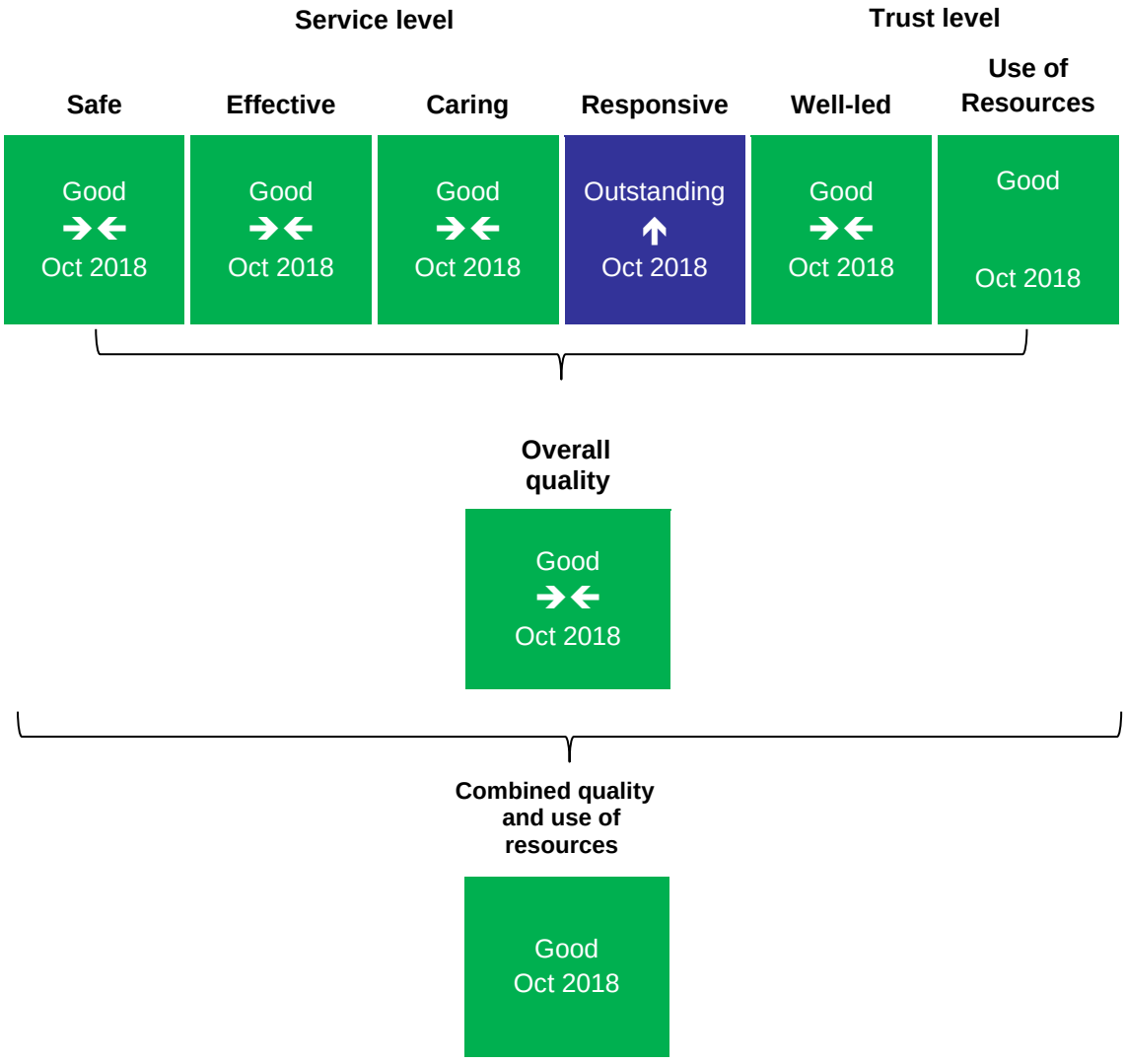
## Ratings tables

| Key to tables | | | | | |
|---|---|---|---|---|---|
| Ratings | 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 key question inspected | | | | | |

***** 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:



# 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. |

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| 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) | 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. |

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| cost per £100 million turnover | |
| 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 |

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| 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. |
| 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. |