Brighton and Sussex University Hospitals NHS Trust

Use of Resources assessment report

Royal Sussex County Hospital
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Date of site visit:
5 October 2018

Date of publication:
8 January 2019

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

Ratings

Overall rating for this trust	**Good** ●
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ●
Are services responsive?	**Requires improvement** ●
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.

Are resources used productively?	**Requires improvement** ●

Combined rating for quality and use of resources	**Good** ●

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

Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines

our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

Our combined rating 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 of the trust improved. We rated it as good because:

The trust had made huge improvements since the new executive team had introduced improved systems of working. The trust had a new strategy, vision and values which underpinned a culture which was patient centred. The ‘Patient First Improvement System’ had empowered front line staff by equipping them with the lean tools, methods and a structured process which had helped to build and promote a culture of continuous improvement across the whole trust.

A new divisional structure had been created around the pre-existing directorate structure. This had strengthened the existing leadership and management arrangements of the clinical services.

Quality was a ‘golden thread’ running through the trust Patient First Strategy. In all the interviews undertaken on inspection this was evident in the use of data both quantitative and qualitative and how this was triangulated and reported through the Quality Steering Group to the Quality Assurance Committee and the trust board.

All staff we spoke with on inspection were clear about the trust's approach and priority to deliver high quality sustainable care to patients. Staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team. To support the roll-out of Patient First across the trust, a communications plan was developed and implemented. The plan was tailored to different audiences to best reach staff in different parts of the organisation. Staff spoke about feeling that the Patient First Strategy had given them the ability to all speak the same language.

The board received holistic information on service quality and sustainability. There was a programme of board visits to services and staff we spoke with told us that that leaders were approachable.

Staff felt equality and diversity were promoted in their day to day work. We spoke with the newly formed Black and minority ethnicity working group. The trust had held an event in May where over 200 members of staff had come together to discuss equality and Black and minority ethnicity issues and start the forming of a new strategy. The output of this meeting was three workstreams; communication, recruitment, and education. The group we spoke with told us that they had seen a dramatic change in the past 6-9 months. They described this as powerful, positive and feeling included in the strategy and change. Staff told us that although they had not always felt supported in the past since the new executive team had arrived they now felt confident that they could raise any concerns about staff behaviours towards them with their line managers, and they felt assured that their concerns would be listened to and acted on appropriately.

Staff felt respected, supported and valued. The executive teams and divisional leaders told us how they felt that improving the experience and engagement of their staff was fundamental to delivering a culture of high sustainable care and trust strategic objectives.

The trust's Patient First Improvement System empowered staff to make improvements and to be listened to and respected. In areas where 'Patient First' had been introduced the level of engagement and motivation had significantly improved as staff felt empowered to make improvements in their work. This was evident both on CQC engagement events at the trust and on inspection.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed. The trust had governance and management arrangements had been strengthened significantly since the management agreement with Western Sussex Hospitals Foundation Trust and NHS Improvement. These arrangements enabled all clinical and management staff to function in an effective and efficient manner through both line management arrangements and governance arrangements.

The board had invited the Good Governance Institute (GGI) carry out a review of the trust's quality governance structures, which resulted in 31 separate recommendations being made. The trust acted to address these issues and the Good Governance institute carried out a further review reporting on progress against these actions. A focus of this work has been to strengthen quality governance arrangements at divisional level.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. The trust reported regularly through its governance arrangements on progress against delivery of its strategy to the board, Trust Executive Committee and to other relevant committees. However, the structure needed more time to become fully embedded.

The trust executive team had worked hard to roll out Patient First Strategy across the trust. They had done this in a structured way by considering which areas of the trust would benefit the most from the methodology and training. There was no doubt that areas who had imbedded Patient first had made the largest impact on improvement. Although we were impressed at the speed and spread of improvement the trust needed more time to embed this methodology across the whole trust.

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

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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 ratings. All six trust-level ratings for the trust's key questions (safe, effective, caring, responsive, well-led, use of resources) are aggregated to yield the trust's combined rating. A summary of the Use of Resources report is also included in CQC's inspection report for this trust.

How effectively is the trust using its resources?	**Requires improvement**

How we carried out this assessment

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

We visited the trust on 5 October 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

We rated the trust's use of resources as requires improvement as although the trust has made good progress to stabilise the organisation over the period of the assessment, there are still areas where the trust needs to materially improve the way it uses its resources to deliver its services efficiently.

- The trust entered Special Measures for quality reasons (QSM) in August 2016 following an inspection from the Quality Care Commission (CQC) where their trust was rated "inadequate" overall. Following a significant financial deterioration in the trust's forecast position in 2016/17, the trust was placed in Special Measures for financial reasons (FSM) in October 2016.
- In April 2017, the executive board from Western Sussex Hospitals NHS Foundation Trust (WSHFT) were appointed via a three-year management contract to replace the trust's executive team and provide executive leadership to the trust. This agreement allows for a two-year period of financial stabilisation, as recognised in the agreed control totals (£65.4 million deficit each year excluding Sustainability & Transformation Fund (STF) and Provider Sustainability Fund (PSF)), and to provide management with the headroom to address quality and performance issues.
- A decision was made by NHS Improvement in July 2018 that sufficient financial progress had been made by the trust to exit FSM. In 2017/18 and 2018/19, the trust's financial deficit was in line with the agreed control total with £63.8 million deficit (excluding STF) achieved in 2017/18 and £65.4 million planned in 2018/19 (excluding PSF).
- However, despite significant savings (3.1% in 2017/18 and 4.5% planned in 2018/19), the trust's deficit (excluding STF/PSF) has remained more than 10% of income. The trust has started to develop a medium to long term plan to achieve financial sustainability and the work currently undertaken shows that the trust is facing an increased deficit by 2023/24, even after the delivery of significant savings over several years, with over half of this deficit being structural in nature where the trust has limited ability to resolve.
- The overall cost per WAU for 2016/17 was £3809, placing the trust in the worst quartile nationally.
- During our assessment, we found that the trust had made significant progress since April 2017 in several areas:
    - The trust had significantly reduced the number of patients waiting more than 52 weeks from referral to treatment;
    - The trust had demonstrated good practice in several areas relating to workforce such as agency spend, staff engagement through the Patient First programme, sickness rate and recruitment;

- The trust had delivered improvements with its pharmacy service;
- Through its close collaboration with WSHFT, the trust had improved the cost efficiency of its corporate services (Information Management & Technology (IM&T), Human Resources (HR) and Finance);
- The procurement function which had been recently restructured, benchmarked well in terms of process and delivery with evidence of best practice and savings;
- The trust had met its control total in 2017/18 and was forecasting to achieve its 2018/19 plan;
- The trust had delivered a higher savings target than was included in the control total in 2017/18 (3.1% compared to 2%) and was on a path to deliver a more challenging target in 2018/19 (4.5%).

- However, our assessment also highlighted that:
  - The trust continued to face significant challenges with delivering the cancer 62-day wait, diagnostic 6-week wait and 18-week referral to treatment (RTT) constitutional standards and further work is required to improve flow across the trust to support the delivery of the A&E standard;
  - Further productivity improvements could be achieved with regards specific clinical support services and estate;
  - The trust's current planned deficit represented more than 10% of its income (excluding Provider Sustainability Funding (PSF)) and at the time of our assessment, the trust was working on a medium to long term plan to ensure it was sustainable;
  - The trust had a significant level of public debt adding pressure on its financial position and required revenue support from the Department of Health and Social Care (DHSC) to meet its financial obligations.

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

At the time of our assessment, the trust was not meeting the constitutional standards. The cancer 62-day wait continued to be a challenge to the trust with diagnostic delays being a significant contributor. The trust was not meeting the RTT standard but had significantly reduced the number of patients waiting more than 52 weeks from referral to treatment. The trust's performance against the productivity metrics was variable with progress required on length of stay (LoS) to support delivery of the A&E target.

- At the time of the assessment in October 2018, the trust was not meeting the constitutional operational performance standards around RTT, cancer 62-day and A&E.
- Trust wide A&E performance in July 2018 was reported at 85.23% against a trajectory of 84.3% (95% standard) to achieve 92% by March 2019. Although the trust had exceeded its trajectory for the first four months of the year and the Princess Royal Hospital (PRH) site has achieved the 95% standard since May 2018, at the time of our assessment, its performance was behind its trajectory.
- The establishment of an Emergency Ambulatory Care Unit at the Royal Sussex County Hospital (RSCH) site has contributed to a decrease in admissions via A&E from over 26% to below 24% against a sustained increase in new A&E attendances over the last 18 months with a 5.91% increase in the first 6 months of 2018/19 compared to the same period in 2017/18.

- A&E performance at the RSCH has been challenged due to poor flow. The 3Ts development (which is a site re-development programme) is expected to address bed capacity constraints in the medium to long term. The trust has introduced measures including criteria led discharge, board rounds, estimated date of discharge (EDD) and Home First discharge to assess to reduce length of stay and improve flow.
- However, there is no evidence of a reduction in average length of stay figures for 2017/18 compared to the previous two years, although figures for elective admissions have been consistently below the national averages and those for non-elective are marginally better at specialty level.
- The trust has signed an Aligned Incentive Contract with CCGs and is not commissioned to deliver the 92% RTT constitutional standard in 2018/19. However, significant progress has been made in 2017/18 in eliminating the long waiting patient list from a total of 250 patients waiting 52 weeks or more to 2 in July 2018. However, the trust had not achieved its trajectory for reaching RTT performance of 86% in the same month.
- The trust's elective activity (including outpatients) has declined marginally (-0.2%) between 2017/18 and 2018/19. A more significant reduction in elective and day case activities has been counterbalanced by additional outpatient activities. The Surgical division has seen the highest negative variance in activity in 2018/19, within which the material variances are in MSK and Digestive Diseases.
- The trust is undertaking measures to increase elective throughput by addressing clinical workforce shortages and redesigning pathways, an agreement to provide an additional 60 beds/packages of care as part of winter planning and refurbishment at the RSCH site.
- The trust has not delivered the 85% cancer 62-day wait standard during 2018/19 with delays in diagnostic a contributing factor. Performance is challenged particularly in the specialties of Breast and Urology. Performance in June 2018 was reported as 70.94% compared the trust's trajectory of 81.9%. The trust is strengthening senior leadership to oversee and improve cancer performance.
- The trust has not delivered the 1% diagnostic standard during 2018/19 and performance in August 2018 was reported at 10.1%. The trust's performance is impacted by insufficient capacity and demand growth and the trust Board has identified diagnostic as an area of focus requiring recovery actions.
- Patients are more likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 8.31%, emergency readmission rates are above the national median (3rd quartile) as at June 2018, although reduction is evident from just below 10% a year ago. The trust has increased monitoring and control of readmissions and undertaken improvement initiatives in Cardiac surgery, A&E and Respiratory services. Data quality and coding practice errors have been discovered in several medical specialities which have been affecting reported readmission rates and these are being addressed.
- More patients are coming into hospital unnecessarily prior to elective treatment compared to most other hospitals in England. On pre-procedure elective bed days, at 0.12 days, the trust is performing in the 3rd quartile (mid to high 25%) and above (worse than) the median when compared nationally and against System Transformation Partnership (STP) peers (the national median is 0.11 days and peers median is 0.05 days). However, the trust performance is better when compared to peers selected by size/spend (peers by spend median is 0.18 day).
- On pre-procedure non-elective bed days, at 0.36, the trust is performing in the lowest (best) quartile and below the median when compared nationally (the national median is 0.69)

- The Did Not Attend (DNA) rate for the trust is 7.59% for Quarter 1 2018/19, which is slightly higher than national median of 7.02%.
- The trust reports a delayed transfers of care (DTOC) rate of 5.2% for the week starting 6 August 2018. That is higher than the trust's own target rate of 3.5%. However, DTOC rates have been improving between April 2017 (8.1%) due to measures indicated above under the A&E section. Non-clinical cancellations have been reduced between Quarter 1 2017/18 and Quarter 1 2018/19 from 3.6% to 1.7% at PRH and from 1.8% to 0.7% at RSCH.
- The trust's engagement with the GIRFT programme has been variable across clinical specialities. There have been 11 trust visits. Changes have been identified in pathway design and processes and improvements in clinical practice and use of prosthesis in orthopaedic surgery have resulted in £3.5 million savings.

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

The trust has demonstrated good practice in several areas such as agency spend, staff engagement through the Patient First programme, sickness rate and recruitment. However, the trust has the 8th highest medical cost per Weighted Activity Unit (WAU) in England and its Care Hours per Patient Day is one of the highest nationally demonstrating areas where further improvements can be achieved.

- For 2016/17 the trust had an overall pay cost per WAU of £2,119, compared with a national median of £2,157. This means that it spends less on staff per unit of activity than most trusts.
- The trust is in the highest quartile for medical cost per WAU, which stands at £620 against a national median of £529 and a peer median of £539. The trust explained that is due to the requirement from commissioners to deliver specialist services which require high medical input and the trust being a Major Trauma Centre.
- The trust benchmarks in the 2nd best quartile for nursing cost per WAU (£704 against national median of £718 and peer median of £697) and in the 1st (best) quartile for Allied Health Professionals (AHP) cost per WAU (£103 against national median of £127 and peer median of £119).
- Whilst the overall nursing cost per WAU compares favourably to peers and the national median, the registered nursing cost per WAU is higher than peer group and national median. The trust also reports 9.2 Care Hours Per Patient Day (CHPPD) for August 2018, which is higher than national median of 8.0 and peer median of 8.1. The trust explains higher staff to patient ratios with the safe staffing requirements of nine small wards and higher acuity levels associated with the Major Trauma Centre.
- Pay growth has been contained at 1% between 2017/18 and 2018/19 with the trust addressing higher medical pay cost in top five specialities. Higher pay costs in general surgery in 2017/18 were associated with eliminating long waiting list. Savings have been identified in Obstetrics and Gynaecology through optimised job planning and in Urology through improved theatre utilisation.
- The trust met its agency ceiling as set by NHS Improvement in 2017/18 and is forecasting to achieve its ceiling in current year. The trust operates its own effective in-house Temporary Staffing function and uses lower proportions of temporary staff than peers as a result. Agency spend as a proportion of the total pay bill in September 2018 was 3.38%, better than the national average (5.17%).

- Vacancies are reported at below 10%, the trust's target as of September 2018. Extensive recruitment activity in the past 12 months has resulted in significant reduction of Health Care Assistants (HCAs) vacancies from 143 to 36. Innovative solutions have been introduced to reduce medical gaps, eg Clinical Fellow posts in Emergency Department and Cardiac Advanced Clinical Practitioners.
- Staff retention at the trust shows room for improvement, with a retention rate of 83.8% in July 2018 against a national median of 85.8%. The trust has focussed improvement efforts on HCAs, where turnover remains high at 16.1% in August 2018.
- Job planning for medical consultants has increased to 97%.
- The trust uses e-rostering systems (Roster Pro for nursing and midwifery and Kronos for Soft FM staff). Nursing rotas are prepared 6 weeks in advance and reviewed by E-rostering Clinical Leads. Medical staff are supported by Medical Rota Managers.
- The trust is actively piloting new roles including band 3 Senior HCAs, Band 4 Nursing Associates, Band 7 Trainee Advanced Practitioners, Band 8A Advanced Clinical Practitioners, Physician Associates, Paramedics in the Emergency, Clinical Fellows, etc., to optimise skill mixing and improve workforce utilisation.
- At 3.72% in June 2018, staff sickness rates are marginally better than the national average of 3.75%. The trust maintains focus on appraisal rates, which have exceeded 90% target and has introduced psychotherapy service via an in-house HELP team.
- In 2017/18, the trust launched 'Patient First' a programme of continuous improvement that empowers front-line staff to identify and drive through sustainable change for the benefit of patients. Staff are equipped with the training, tools and freedom to work out where the opportunities lie, and the skills and support to deliver on them. The trust indicated that the programme had been substantially rolled out and started to build a transformational culture. The trust cited the significant reduction of the number of patients waiting more than 52 weeks from referral to treatment as one key achievement from this approach.

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

The pharmacy service is under relatively new leadership, there has been a marked improvement in the Hospital Pharmacy Transformation Plan and the trust now benchmarks close to the national median across most metrics. Pathology services are delivered through a joint venture and benchmarking indicates there are potential areas for further productivity improvements. The imaging and diagnostic service is a particularly challenged area for the trust, particularly in terms of capacity to meet the growth in demand.

- The pharmacy service is under relatively new leadership and there has been a marked improvement in the focus on operational productivity and implementation of the Hospital Pharmacy Transformation Plan. The deployment of electronic prescribing is in the strategic plan for the trust.
- The trust now benchmarks close to the national median across most metrics and has been actively addressing the identified areas for improvement. The trust has delivered good savings (113%) across the 'Top 10 medicines' (primarily by switching to biosimilars).
- The cost per WAU is in the highest quartile - £451 compared with the peer median of £365. The overall drug spend is inflated by the high cost drugs associated with the trust's tertiary services including HIV and multiple sclerosis. Further interrogation of this suggests that

there are some coding anomalies between high and low-cost drugs which is distorting the interpretation.

- The wholly owned subsidiary outpatient dispensing service is operating efficiently. Progress is also being made in further developing clinical services across 7 days.
- Pathology services have been delivered through a joint venture (JV) with Surrey and Sussex NHS Foundation Trust for the past 3 years, which also delivers services to several other neighbouring trusts. The cost per test for the Frontier JV from 2017/18 data (£2.46) benchmarks in the top third of trusts when compared with the national benchmark (£1.87), however it is below the peer benchmark (£2.52). The benchmarking shows that the non-pay component of the service is materially above median benchmarks highlighting the opportunity for improved procurement if undertaken at greater scale, which moving to the recommended network would facilitate.
- The benchmarking shows a significant improvement in efficiency in Quarter 4 2017/18 and that the number of tests being undertaken per head of population is relatively high which may suggest an opportunity for demand management although it is recognised that GP demand management has been put in place.
- The trust is part of a planned wider network and has been successful in securing capital funding to develop a new hub laboratory in Haywards Heath. The trust with its JV partner is actively looking at ways to mitigate the risk of one of the proposed network trusts not joining.
- The imaging and diagnostic service is a particularly challenged area for the trust, particularly in terms of capacity to meet the growth in demand. The trust's backlog is in the highest quartile across all subcomponents with the overall diagnostic 6-week wait breaches in August being at 10.3% against a national target of 1% with particularly high levels in endoscopy (29%). The situation is compounded by highest quartile DNA rates in MRI and CT scanning.
- In terms of cost, the latest benchmarking information is based on 2016/17 and shows the trust to be in the most expensive quartile. This will be partially explained by the complexity of the testing being undertaken, particularly in the cost of reporting. Another driver to higher cost is the benchmarking in the number of reports per staff number which is in the lowest quartile performance. The final contributing factor is the age of the equipment with the trust being having particularly high percentages of 10 year plus CT equipment.
- The overall non pay cost per WAU was in the worst quartile nationally at £1690, set against a peer trust median of £1419.
- The trust board have identified diagnostics and to be a priority area for improvement and is acting to increase capacity and to manage demand in conjunction with the CCGs. Additional capacity is available through insourcing but should probably have been initiated earlier, particularly given the delays in endoscopy.

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

The procurement function has been recently restructured and benchmarks well in terms of process and delivery with evidence of best practice and savings. The trust's corporate functions operate in collaboration with Western Sussex Hospitals NHS Trust and benchmark well for cost efficiency, with the three services (IM&T, HR and Finance) in the best or second quartile performance. The trust is engaged in a major site redevelopment, the 3Ts programme, which will complete in 2025 and is creating significant risks in its delivery and financial impact. The performance metrics of the current estate are well below national medians which reflects the age and condition of the estate.

- Benchmarking of the trust's procurement function across process and delivery metrics ranks the trust at 63 (from 135). The trust scored particularly well across the process metrics having achieved Level 1 NHS Procurement and Commercial Standards in Quarter 1 and are progressing towards Level 2 although have yet to submit their refreshed procurement transformation plan. The metrics however showed a less strong performance on the prices achieved based on a comparison with national and peer benchmarks.
- The procurement team is resourced to above median levels which is recognised by the trust and reflects the support to the capital redevelopment. The function has been restructured by the management team having implemented 'an integrated business partner model' to align with the clinical divisions.
- An example of leading practice is the benefit that has been derived from taking a new approach to the procurement of cannulas which was nominated for an HSJ award.
- The trust is on target for delivering £5.3 million of procurement led Cost Improvement Plans (CIPs) in 2018/19 which should be reflected in an improvement in the price performance metrics at the next benchmarking.
- The trust's back-office services are delivered in collaboration with Western Sussex Hospitals NHS Trust with a single board and the alignment of corporate services as far as is feasible in a non-merger situation. This allows greater synergies in areas such as IT and information governance but less in some of the HR functions.
- The corporate functions benchmark well for cost efficiency with each of the 3 components of HR, IM&T and Finance benchmarking in the best or second quartile for performance. There has been a significant improvement in the efficiency of corporate services between over the past 12 months (20% in IM&T and 18% in HR). The areas of relatively high cost are within the IM&T function relating to Applications Development and Paper Medical Records. The former reflects the investment in upgrading the trust's core systems following refresh of the IT Strategy. The high cost of paper records reflects the low level of digital maturity achieved by the trust across most of areas. The trust has also made a significant investment in coding as an initial diagnostic highlighted the weak capture of activity.
- The trust is engaged in a major site redevelopment, the 3Ts programme, which will complete in 2025. The initial stage – the helideck, was due to complete in June 2018 and has slipped to January 2019. The trust records that there has been significant overspend on the Stage 1 contingency which will put pressure on the overall programme. The risk is that the cost pressures in stage 1 occur in the later stages of the project when there is less opportunity for mitigation. The programme has been procured under the Procure 21 framework which provides for a structured route to arbitration as required. The trust is employing experienced consultants to provide support in the management of the project.
- The trust has identified future financial risks in terms of a capital funding gap of £25 million and a revenue funding gap. Some of this is within the trust's control but the mitigation on other significant components requires a system-wide solution, particularly in relation to the planned repatriation of elective activity.
- The performance metrics of the current estate are well below national medians which reflects the age and condition of the estate, part of which will be replaced by the new development. Elements of the existing estate have been provided under Public Financing Initiative (PFI) where the benchmarking shows the Facilities Management (FM) costs to be 15% above the median. The balance of the estate is traditionally funded, and the benchmarking shows the costs to be 20% above median benchmarks. The most significant opportunities are in cleaning, energy and hard FM. The level of backlog is in the highest quartile with the need for £25 million to be invested in high risk areas. The trust will need to find ways to reduce the very high running costs of the estate in parallel with the redevelopment to support financial improvement over the next 7 years.

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

Since October 2016 when the trust entered the special measures regime for financial reasons, the trust has made significant progress to stabilise and improve its financial position reflected in its exit from special measures for financial reasons (FSM) in July 2018. The trust has met its control total, improved financial controls and governance, is spending less on agency than the national median, is on a path to deliver its control total in 2018/19 supported by a challenging savings programme. However, at the time of our assessment, the trust's deficit excluding STF and PSF was still over 10% of its income; the trust required cash funding from the Department of Health and Social Care (DHSC) to meet its financial obligations and it had accumulated a high level of public debt.

- At the start of 2017/18, the trust agreed a two-year financial target with NHS Improvement setting the trust's control total at a £65.4 million deficit (excluding STF/PSF) for both 2017/18 and 2018/19, giving the trust time to stabilise its financial position while addressing its the significant quality and performance issues.
- In 2017/18, the trust over-achieved its control total with a deficit of £63.8 million excluding STF (£55.6 million including STF) and it is planning to deliver a deficit of £65.4 million in 2018/19 in line with its control total. The financial position is showing an improvement of the trust's EBITDA margin (a measure of the trust's operating profitability) from -7.5% in 2016/17 to -5.6% and -4.7% in 2017/18 and 2018/19 respectively.
- Having demonstrated substantial progress in regaining control over its financial position and improving financial controls and governance, the trust exited FSM in July 2018. In August 2018 (latest data available), the trust continued to deliver in line with its 2018/19 plan. However, despite evidence of progress, the trust's deficit excluding PSF continues to be significant and more than 10% of its income in 2018/19 (11.6% excluding PSF, 9.6% including PSF).
- The trust has established an internal Programme Management Office (PMO) and improved its processes to identify and manage the delivery of cost improvement initiatives which have allowed the trust to increase the level of efficiency savings: from 3.1% savings (£20 million, 96% recurrent) in 2017/18 against an initial target of 2% to 4.5% (£30 million) planned in 2018/19 (compared to a national average of 4.1% savings planned in 2018/19).
- However, the 2018/19 savings are at a level which is broadly the same as the additional cost pressures expected by the trust that year and, as a result, are not contributing to the reduction of the deficit from its 2017/18 level. At the time of our assessment, the trust was delivering savings in line with its plan and continued to forecast achieving its full year saving target.
- The trust has taken actions to protect its income. For 2018/19, the trust has agreed an Aligned Incentive Contract with local commissioners for 54% of its NHS patient related income which caps the trust's exposure to financial risks. It also has processes to monitor the performance of its contracts and ensure the timely escalation and resolution of issues with commissioners. The trust has also strengthened the coding of its activity and capture of high cost drugs and devices to ensure full income reclaim, although this relies on commissioners being able to afford this additional cost to them.
- The trust has undertaken work to understand the drivers of its deficit and its likely financial position in 2023/24. Despite a potential to deliver significant savings, the analysis shows that the trust's deficit position is likely to worsen with a large proportion being structural (ie over which the trust has limited control) driven by the impact of the 3Ts development, the financing costs of support loans and loss of training income. The impact of the 3Ts

development consist of the loss of private patient and specialist income expected to be gained from the development. At the time of the assessment, the trust was developing a medium to long term plan to bring the trust into financial sustainability.

- The trust's financial position is also impacted by increasing financing costs arising from debt accumulated to support its cash position and fund capital schemes. The trust's cash position has been weakened by several years of deficits and the trust requires revenue support loans from the DHSC (£55.1 million in 2018/19) to meet its financial obligations. At the end of 2017/18, the trust had accumulated £237 million in loans from the DHSC (both to fund revenue and capital), expected to increase to £320 million in 2018/19 and generating a £9.7 million financing cost that year. In addition, the trust receives public funding for the 3Ts project (£96 million in 2018/19) adding further financing costs pressure (£9 million in 2018/19).
- The trust is actively using the information in the Model Hospital but acknowledges that no Service Line Reporting is shared within the trust. The focus is now on developing a new Patient Level Information and Costing System (PLICS) which the trust expected to have implemented in October 2018.
- The trust has reduced its spend on consultancy from £4.5 million in 2016/17 to £1.5 million planned in 2018/19 reflecting the development of the trust's own capability to replace the use of external support required following its entry into the special measures regime.

Outstanding practice

- The trust has launched a continuous improvement approach 'Patient First' based on 'Lean' principles that supports and empowers staff to identify and solve problems and deliver improvements (small and large) in processes and pathways for the benefits of patients. The programme has already achieved successes and is expected to build a transformational culture across the organisation.
- Another example of leading practice is the benefit that has been derived from taking a new approach to the procurement of cannulas which was nominated for an HSJ award.
- The trust has successfully reduced its reliance on agency staff through the development of a Temporary Staff function which combined with e-rostering has allowed the trust to fill in gaps in rotas efficiently.

Areas for improvement

- Further work is required to improve flow across the trust to support the delivery of the A&E standard.
- The benchmarking shows that the non-pay component of the Pathology JV service is materially above median benchmarks. The trust should explore the opportunities for improved procurement if undertaken at greater scale.
- The number of pathology tests being undertaken per head of population is relatively high. The trust should explore potential opportunities for additional demand management (above that already in place through GPs).

- The imaging and diagnostic service is a particularly challenged area for the trust, and the trust is taking actions to increase capacity and to manage demand. Once this is delivered, the trust should analyse its productivity to continue to deliver improvements.
- The trust should continue to work with partners in the local health system to identify solutions to bridge the £25m funding gap of its 3Ts development project.
- The trust's financial position has stabilised. The trust however needs to continue to progress with the development of its medium to long term plan to ensure it is financially sustainable.
- The trust has identified several actions it can take to improve its cash and debt positions (eg model the impact of exiting FSM on financing costs, review the structure of the balance sheet, review of cash management processes, develop a cash management strategy). The trust now needs to explore and implement these further.
- Continue with the implementation of PLICS (including sharing with the wider organisation) to enable the wider use of the information across the trust to identify areas where profitability can be improved.

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 several 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.

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 to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources 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 (SOF) sets out how NHS Improvement oversees NHS trusts and NHS foundation trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that trusts need to meet the requirements in the Framework.
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.
Sustainability and Transformation Fund (STF)	The Sustainability and Transformation Fund provides funding to support and incentivise the sustainable provision of efficient, effective and economic NHS services based on financial and operational performance.
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.