Imperial College Healthcare NHS Trust

Use of Resources assessment report

The Bays, South Wharf Road
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Date of publication:
23rd July 2019

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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
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. (See www.cqc.org.uk/provider/RF4/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:

- We rated safe and responsive as requires improvement, effective and caring as good.
- We rated well-led for the trust overall as good.
- The rating of well-led improved since our last inspection, but the ratings for each of the other key questions remained the same.
- The ratings for each of the trust's acute locations remained the same, except for Queen Charlottes and Chelsea Hospital where the rating had improved.
- Our decisions on overall ratings consider, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating; and
- the trust was rated good for Use of Resources.

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Date of site visit:
13 February 2019

Date of publication:
8th July 2019

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.

How effectively is the trust using its resources?	**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 13 February 2019 and met the trust's executive team (including the chief executive), non-

executive directors (in this case, the chair and the chair of the finance committee) 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?	Good

We rated use of resources as good because the trust takes a proactive, and innovative, approach to managing its financial and non-financial resources, which supports the delivery of high quality, sustainable care.

The trust has undertaken a comprehensive and consistent approach to quality improvement through the Speciality Review Programme (SRP). This programme has brought together costing data, Patient Level Information and Costing System (PLICS) data, income expertise, 'Get It Right First Time' (GIRFT) reviews and Model Hospital data to work with each specialty to create plans to optimise performance. This has meant that there has been a systematic approach to Cost Improvement Programmes (CIPs), job planning, electronic rostering and a number of other operational areas. In turn, this approach resulted in improvements in operational performance, efficiency and underlying financial performance.

While the improvements delivered are indicative of very good practice, the trust still has to ensure that the improvements are embedded and sustainable. For example, ensuring that CIPs and operational standards continue to be delivered recurrently through leveraging the SRP in the 2018/19 financial year.

- The trust notes that the SRP is by its nature is multi-factorial and has to cover a huge range of processes and areas and these elements are co-dependent and aim to deliver a transformed pathway. We saw evidence of this across the areas we reviewed as part of this assessment. For example, the trust has made improvements in its theatre productivity. This has been the result of a planned and comprehensive programme that encompasses: surgical orders (through the Cerner system), pre operative preparation, scheduling, theatre planning, in-theatre efficiency, recovery pathway and enhanced discharge. This has closed the theatre opportunity gap from 26% - <19%.
- Moreover, there has been up front investment in senior operational, Finance and Human Resources (HR) resource, and in a Quality Improvement (QI) methodology to support team working and change to enhance staff training, pathway and engagement. While functions such Finance benchmark as being more costly than national median, the trust can evidence the outcomes from this investment.
- Operational performance has significantly improved and is delivered on a consistent basis over the previous 12-18 months. The trust previously had a large number of patients waiting over 52 weeks for planned treatment such long waiters have now been eliminated. Similarly, Accident & Emergency (A&E) performance is now in the top (best) quartile and non-elective length of stay and bed days are comparable to the national median and peers.
- The trust's staff costs benchmark better than peers and can evidence excellent job planning processes and outcomes, and good use of rostering to efficiently deploy people. The trust's use of technology is innovative, and patient centred; for example, leading collaboration with system partners in sharing patient records and data to deliver better

outcomes for individual patients in North West London, and digitalisation of health records.

- The delivery of both strong operational standards and clinical improvements has been made while improving the underlying financial performance of the trust. The trust has reported a surplus in the prior year and is on course for an improved surplus in the current financial year 2018/19. On an underlying basis, while the trust notes a deficit, this has significantly reduced in each of the previous two years. The trust has delivered a large-scale CIP in each of the previous two years; £53.8m in financial year 2016/17 and 43.1m in financial year 2017/18. It is on track to deliver a CIP programme of £40.7m in the current financial year 2018/19. Moreover, nearly all of this has been delivered recurrently.
- There are however areas for improvement including improving Outpatient productivity and further reducing Did Not Attend (DNA) rates, continuing to improve theatre utilisation and delivering CIPs recurrently to reduce the underlying deficit as planned in financial year 2018/19.
- In addition, the critical infrastructure risk and backlog maintenance at the at the trust are the highest in the country. However, we note that the proportionally lower investment in estate is partly due to the trust waiting on funding options appraisals and approvals relating to strategic regional estates options for redevelopments, as well as approvals for capital loan funding relating to immediate estate priorities..

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

- Operational performance has significantly improved significantly over the previous 12-18 months across both the emergency and elective pathways. Both A&E and Referral to Treatment (RTT) performance have significantly improved. The trust previously had a large number of patients waiting over 52 weeks for planned treatment such long waiters have now been eliminated. However, the key focus on the trust will need to be on ensuring that the improvements are sustained over the next financial year and embedded as business-as-usual.
- A&E performance has improved in financial year 2018/19 and the trust's performance is now in the top (best) quartile. Emergency length of stay (LoS) is in the lowest (best) quartile nationally to January 2019. This performance has been delivered through greater focus on patient flow through the hospitals known as the Care Journey and Capacity Collaborative. The improvements delivered include:
    - Delivery of pathway efficiencies equivalent to creating an additional 35 inpatient beds
    - Trust-wide implementation of Red to Green (R2G) and SAFER staffing leading to improvements in the number of pre-noon discharges and a significant increase in utilisation of the discharge units. Average discharge time has been brought forward by 1.25 hours.
    - Expansion of AEC (Ambulatory Emergency Care) services; both in relation to service provision and growth with 18,000 people seen in financial year 2017/18, and a further increase of 30% in financial year 2018/19, helping reduce growth in emergency admissions
    - Expansion of the trust's frailty services – including Older Persons Assessment Liaison Service (OPAL), frailty at the front door, the "red bag" project in place to avoid admissions and reduce length of stay (LoS).

- The data suggests that patients are waiting slightly less time in hospital prior to emergency treatment compared to most other hospitals in England as of September 2018. On pre-procedure non-elective bed days, at 0.65 days, the trust is performing at about the national median of 0.66 days. The trust's average length of stay for emergency admissions (rolling for 6 months) to September 2018 is 11 days compared to the national median of 9.3 days.
- In addition, at 3.63%, emergency readmission rates are significantly better than the national median of 7.76% as at September 2018. This is the best performance for this metric nationally. This means patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally.
- In terms of elective activity, the average rolling length of stay over the 6 months to September 2018 is 3.8, which is worse than the national median of 3.0, and the London median of 3.8. Additionally, patients are waiting more time in hospital before their procedures compared to other trusts; pre-procedure elective bed days to September 2018 is 0.47 compared to the national median of 0.12. The trust has identified the causes of the higher pre-procedure LoS as being in Bone Marrow and Transplantation, Clinical Haematology, Cardiac Surgery and Thoracic Surgery. Implementing changes through the next phase of the SRP in this area is currently underway.
- The trust has however increased the aggregate theatre efficiency from 78% to 80%, over the current financial year 2018/19. The national theatre productivity programme analysis illustrates that the theatre efficiency opportunity gap moved from 26% to 19%. As noted above, this has a number of key strands including the Pre-Operative Assessment (POA) Transformation project. Completed work includes full pathway mapping, pathways from high performing trusts, stakeholder testing of new order Cerner pathways, work with QI to work on team function, training pathway stratification and commencement of POA Multi-Disciplinary Teams (MDTs).
- The other area that the trust has further room for improvement is in Outpatients. The trust's Did Not Attend (DNA) rate is 10.41% as at September 2018, compared to the national median of 7.32%. However, we note that the trust's performance has improved quarter on quarter in the current financial year (2018/19). The trust also compares favourably to London peers (10.67%). In addition to text reminders and hybrid mail systems which have now been rolled out, the trust has implemented more innovative technology and collaborates in this area with system partners including primary care. In October 2018, the trust completed its 'paper switch off' for electronic referrals, enabling all General Practitioners (GPs) outpatient referrals to be made through one system; this has provided standardisation of referral routes into the trust and improved communication between primary and secondary care. The trust has setup the majority of these service (where clinically appropriate) as directly bookable services, providing the GP and patient with the ability to book the appointment. In terms of further planned improvements, the trust is a key stakeholder in the North West London Outpatient Transformation Programme, aiming to redesign and optimise clinical pathways, reducing hospital attendances where clinically appropriate. trust clinicians have helped to design and approve clinical guidelines for the first five services (Cardiology, Dermatology, Gastroenterology, Gynaecology and Musculoskeletal), with implementation planning currently underway.
- The trust's engagement with and utilisation of the Get IT Right First Time (GIRFT) programme has been excellent. There is a comprehensive QI based approach through the SRP which uses GIRFT recommendations and visits as a key input.

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

- In financial year 2017/18 the trust had an overall pay cost per Weighted Activity Unit (WAU) of £2,050, compared with a national median of £2,180, placing it in the lowest (best) cost quartile nationally. While this means that it spends less on staff per unit of activity than most trusts.
- Within this headline metric, the trust's pay cost per WAU is better than the national median for nursing professional staff group (£626, national median £710) but is worse than the median for the medical professional staff group (£554, national median £533).
- The trust is forecasting to spend £29.9m on agency staffing in financial year 2018/19 (4.4% of costs). This is a significant reduction from £51.4m (8.8% of cost) in financial year 2015/16 and £33.1m (5.5% of cost) in financial year 2016/17. The trust notes that agency spend is monitored at the bi-monthly Executive Committee for People (ExPOD) and that temporary staffing use and spend is monitored at monthly Divisional & Senior POD Team review meetings, which has resulted in reduced costs through continued focus in this area.
- The trust's staff retention rate as at November 2018 was 79.8% against a national median of 85.9%. However, this metric has remained relatively constant over time, and is comparable with other London trusts faced with a mobile local workforce; the London median is 80.9%. The trust has identified the Allied Health Professionals (AHP) staff group with the lowest retention at 76% (national median 86%) as an area for improvement and as appointed a new Chief AHP for the trust and is working on developing smoother routes for AHPs to continue their research careers. More widely on retention, the trust has established Careers Clinics and an Internal Staff Transfer Scheme for Nursing & Midwifery Staff to expand experience and knowledge and improve development and launched the 'Springboard Development' programme for band 5 & band 6 Nursing & Midwifery staff. In addition, the trust has also implemented automatic Student Nursing & Midwifery offers of permanent employment.
- The trust has deployed electronic rostering across all staffing groups, and these are approved at least 6 weeks in advance and reported regularly to divisional teams. A number of key metrics including roster approvals and finalisation metrics, weekly authorised leave analysis by type and sickness absence reasons are monitored by divisional teams and by a trust-wide multidisciplinary steering group which has been established to review and support rostering, benefits realisation and development. The outcomes of these processes are evidenced through the reduction in temporary staffing and low sickness rates notes above.
- Nursing & Midwifery managers receive ward level roster Key performance Indicators (KPIs) each month via the TRIFOLD report which also includes a range of workforce KPIs. The roster KPIs reported here cover different types of approved leave, under and over work of hours and sickness.
- The trust has moved from a position of 64% of Consultants with an active Job Plan in financial year 2016/17, to a position where 99.5% of Consultants have signed off job plans for financial year 2018/19. The trust notes that the current consultant job planning round is the third to be run using the SARD job planning system which has facilitated easier sign off by the Heads of Specialty and Clinical Directors. The process is overseen by a designated Associate Medical Director for Professional Development.
- The high rate achieved is due to a standard process the trust has developed including telephone and face to face support to consultants and clinical managers to aid completion, direct contact with any consultants without job plans and support with any issues they may have which prevent completion, up to engagement with the Associate Medical Director where appropriate. The trust notes that the combination of drop in sessions and team support on an individual basis has improved engagement with the process and that the Associate Medical Director for Professional Development) holds department level sessions with teams struggling with job planning issues.

- The trust can also evidence strong performance in the use of AHPs across sites. There has been strategic investment where there have been demonstrable benefits, supporting the longer-term implementation of the therapy career framework. In the absence of a nationally recognised staffing tool, the trust uses activity data, measurement of unmet need, professional judgement and expertise, and discussion with clinical and managerial specialty teams. The trust has created a Lead Therapy Quality Improvement role which has supported four work-streams supported the care journey collaborative. These were improved prioritisation; improved handover between therapy staff; upskilling of Occupational Therapy and Physio Therapy roles; and improved use of Cerner to record and report therapy activity.

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

- The trust's medicines cost per WAU (£458) is in the highest quartile nationally (national median £309). The trust's medicines is however lower than trust type peer median of £514 which is based on clinical output (which takes into account the higher proportion of specialist work undertaken by the trust).
- The trust can evidence that it has achieved a 121% against its savings targets on biosimilars to March 2018. The trust achieved this through agreeing and utilising NHS England (NHSE) Medicines Optimisation (MO), CQUIN (Commissioning for Quality and Initiative) and Clinical Commissioning Group (CCG) block contracts to enable benefits from switches and savings to be realised, specialist pharmacists proactively engaging with consultants to agree and plan any therapeutic switches and pharmacists attending clinics to support patient education for complex switches and addressing any issues in real time.
- In addition, the trust scores favourably against national benchmarks for stockholding (17 against national median of 21), electronic commerce ordering (97% against 94% national median). The trust has delivered these outcomes while maintaining a lean Pharmacy department, benchmarking favourably on cost (including Pharmacy cost per WAU £517 vs £533) against peers.
- The trust is working with partner organisations in North West London to deliver further efficiencies through collaborative working. This includes initiatives on a procurement and supply chain hub, centralised direct to ward stock deliveries and centralised stores facilities. The trust has invested in automation to improve service efficiency within the Pharmacy. Each main hospital site has a dispensing robot and automated Clinical Dispensing cabinet to improve stock management, safety and efficiency. This has included replacement robots for the Charing Cross site in 2018 and a replacement robot ordered for the Hammersmith site for 2019.
- The trust's radiology cost per report is £52 against a national median of £50. The trust can evidence good performance in relation to radiologist reporters, consultant job planning. For consultants, team job planning has been completed for all specialist teams. This has allowed greater visibility of the resource available to manage the workload and deploy the team more effectively. In addition, while the trust has a number of older machines, they can show increased utilisation over the previous 12 months; increased routine operational hours in Magnetic Resonance Imaging (MRI), Computerized Tomography and Position Emission Tomography Computerized Tomography has been put in place to meet demographic growth with some currently being supported as additional sessions. Moreover, introduction of "Duty Rota" to provide consultant support between 8am and 6pm on weekdays (introduced August 2018) and at weekends (introduced November 2018) has shown improvement to the reporting turnaround times.

- The trust can also evidence increased digitalisation of health records across the trust. In October 2018 the first speciality went paper free at the St Mary's site. 12 other specialties have followed and St Mary's site paper free is expected to be complete by mid-summer 2019. In April 2019 the paper free project will commence at Hammersmith Hospital. As a result of these the staffing numbers within health records are continually reviewed and reduced to mirror the reduction in health records provision; 20 Whole Time Equivalent posts have come out in financial year 2017/18 with a further 20 WTE identified as a CIP for financial year 2019/20 through further digitalisation.
- The trust's overall pathology cost per test is £1.62 against a national median of £1.86 and a peer median of £2.52. This is despite being in the early stages of the set up of North West London pathology (the Joint Venture delivering the service), and the resultant investment. The trust still has further areas to improve in relation to pathology including better demand optimisation.

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

- For financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,623 compared with a national median of £1,307. This places it in the fourth (worst) cost quartile nationally. The trust notes that it the overall non-pay costs are higher than peers due the cost of the trust's estate, including pay costs of outsourced functions and high cost drugs. This is considered in further detail below.
- The cost of the Finance function is £776,950 per £100m of turnover, against a national median of £676,480. The cost of the function has been a deliberate decision by the trust as they sought to improve support to clinical and operational teams to design and implement the SRP. Given the reduction in the underlying deficit and the operational outcomes noted above, the level of investment appears to be reasonable.
- The Human Resources (HR) function costs £532,940 per £100m turnover compares below the national median of £898,020. While this function is leaner than finance, the outcomes have been equally positive given the tight cost controls on agency costs andelectronic rostering as noted above. Costs relating to job planning, where the trust can also evidence good outcomes, are not included within this cost as it is funded from within the trust's Medical Directorate.
- The trust's Procurement Process Efficiency and Price Performance Score of 69.0, compares favourably to the lower national benchmark of 50.0, and the is broadly in line with the peer median of 69.6 but is still below the upper benchmark of 79.0. This suggests that the trusts procurement processes have been broadly efficient and that it has historically succeeded in driving down costs on the things it buys. The trust also is in 18th best overall for pricing in the country in the Procurement League Table for financial year 2017/18.
- In 2017/18 procurement delivered a CIP of £5m, and is on target to deliver the planned CIP of £4m for the current year. The trust also works across the system to deliver savings; across North West London the trust delivered savings on trauma (£260k for the trust) and dressings (£113k for the trust).
- Over the last 12-18 months the trust can evidence improvements from their investment in this areas including dynamic stock control ensuring the right quantity and mix of products are available to treat our patients, obsolescence is monitored, and where an increase in productivity is advised, reorder levels are adjusted accordingly. The trust notes that as a

major trauma centre it can be difficult to reduce dynamic stock to a level of 30 days due to requiring a large range and quantity of items to be on hand.

- The trust's estates and facilities (E&F) cost per m2 is £348, which compares against national median of £342, placing the trust in the second (best) quartile. The main challenge is the age and condition of the trust's estate. The critical infrastructure risk at the trust is the highest in the country at £669m (against benchmark value of £10m). Similarly, backlog maintenance value at the trust is £696m (against a benchmark value of £42m). The trust notes that it needs to maintain and provide services to ensure that it is safe and functional until major site refurbishments can be delivered. We have noted an increase in investment into the estate over the past few years, investment in this area is 0.73% of turnover which places the trust in 45th position nationally. We note that the proportionally lower investment in estate is partly due to the trust waiting on funding options appraisals and approvals relating to strategic regional estates options for redevelopments. The trust is also awaiting approvals for funding for additional loan funding to deal with immediate estates priorities. This is an area which will require continued close working with system partners and regulators to deliver improvements to mirror those being seen in operational performance.
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- In terms of operational improvement in the outsourced estates facilities over the past 12 months the trust can evidence: undertaking review of the Sodexo Facilities Management (FM) contract which is expected to deliver £700k, efficiencies in the transport contract amounting to £20k per month, establishing a new equipment library which has enable to reduce spend on high volume equipment and the maintenance requirements by £300k per annum. Additionally, the trust has increased income from the estate from £10m in financial year 2016/17 to approximately £12m in financial year 2018/19.
- The trust has achieved these through hiring additional finance capability where contract management expertise did not previously reside and through use of external experts for specific contract reviews. The trust has also recently commenced procurement of an Energy Performance Contract, to deliver energy savings with a specialist partner.

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

- The trust reported a deficit (including incentive payments such as Sustainability and Transformation Funding (STF) and Provider Sustainability Funding (PSF)) of £15.3m in financial year 2016/17. This improved to a surplus of £3m in financial year 2017/18. The trust is forecasting a surplus on this basis of £13.6m for the current financial year 2018/19. In each year, the trust has met its Control Total (CT).
- On an underlying basis, without the benefit of incentive payments or other one-off benefits, the 2018/19 position is forecast to be a deficit of £34m, on a turnover of £1,171m. Mirroring the trend of the reported position, this is an improvement from the underlying deficit of £50m in financial year 2016/17. The trust has a good understanding of the causes of the deficit; this includes a large structural deficit relating to estates as described above, and operational factors. The improvement illustrates that a number of the operational factors are being addressed through the SRP and CIP delivery.
- The trust has delivered a large-scale CIP in each of the previous two years; £53.8m in financial year 2016/17 and 43.1m in financial year 2017/18. It is on track to deliver a CIP programme of £40.7m in the current financial year. Moreover, nearly all of this has been

delivered recurrently; 84% in financial year 2016/17, 99% in financial year 2017/18 and 93% for the current year where the only non-recurrent CIP in financial year 2018/19 relates to estates and is worth £2m. The trust notes that as standard practice, non-recurrent CIPs are not signed off and the investment in the finance team and the SRP has ensured that divisions receive adequate support to scope and deliver recurrent, strategically aligned schemes.

- The trust has not drawn down working capital or deficit funding support despite having a facility to do so, due to robust cash management. In addition, the trust has maintained positive cash balances while ensuring timely payment to suppliers. At Month 7 (October 2018), the trust is paying approximately 80% of suppliers within the parameters set by the Better Payment Practice Code (BPPC).

Areas of outstanding practice

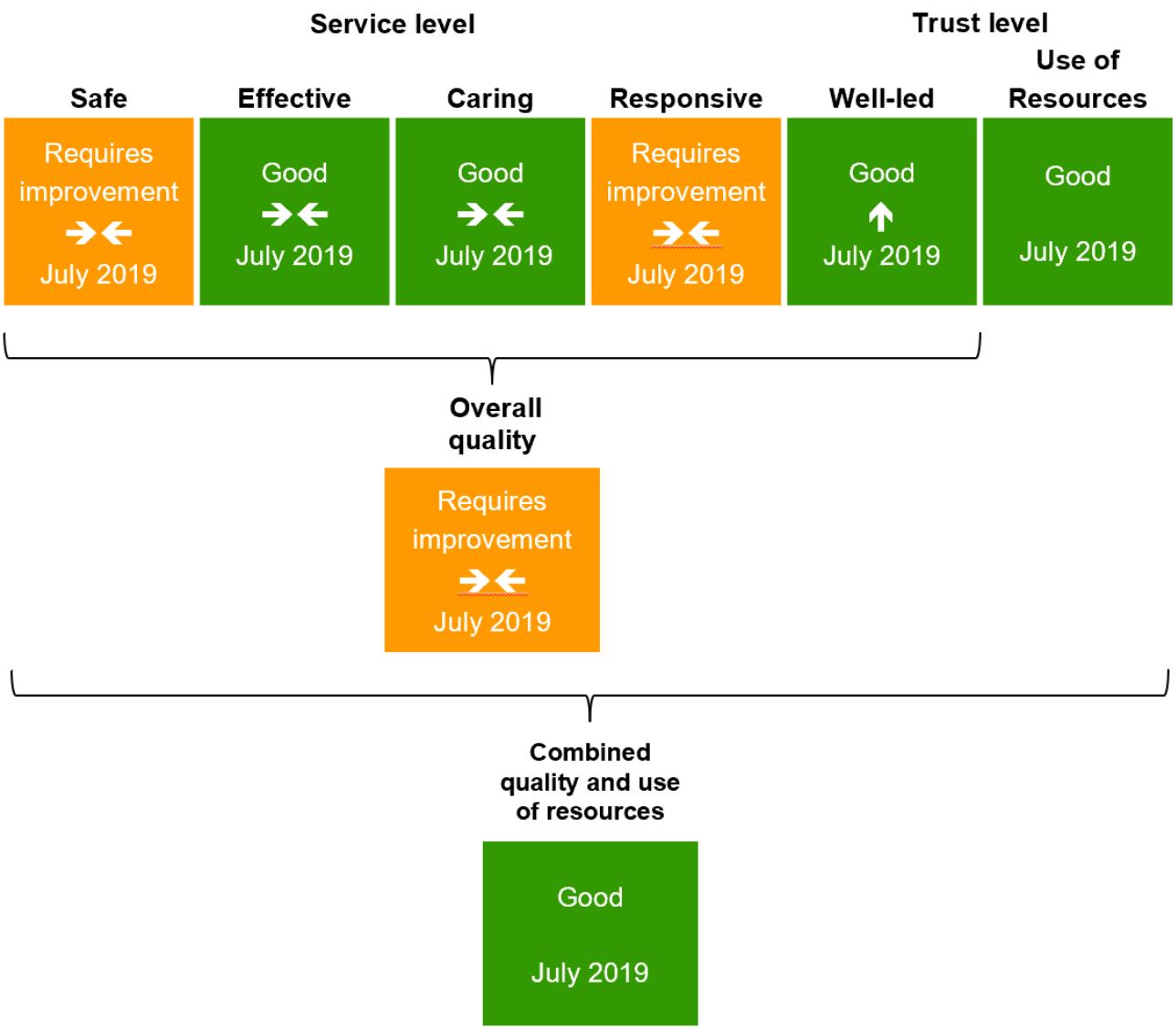
- The trust has undertaken a comprehensive and consistent approach to quality improvement through the Speciality Review Programme (SRP). This programme has brought together costing data, Patient Level Information and Costing System (PLICS data), income expertise, 'Get It Right First Time' (GIRFT) reviews and Model Hospital data to work with each specialty to create plans to optimise performance. This has meant that there has been a systematic approach to Cost Improvement Programmes (CIPs), job planning, rostering and a number of other operational areas. In turn, this approach resulted in improvements in operational performance, efficiency and underlying financial performance.
- In addition, at 3.63%, emergency readmission rates are significantly better than the national median of 7.76% as at September 2018. This is the best performance for this metric nationally. This means patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally.
- The trust is forecasting to spend £29.9m on agency staffing in financial year 2018/19 (4.4% of costs). This is a significant reduction from £51.4m (8.8% of cost) in financial year 2015/16 and £33.1m (5.5% of cost) in financial year 2016/17. On retention, the trust has established Careers Clinics and an Internal Staff Transfer Scheme for Nursing & Midwifery (N&M) Staff to expand experience and knowledge and improve development and launched the 'Springboard Development' programme for band 5 & band 6 N&M staff. In addition, the trust has also implemented automatic Student Nursing & Midwifery offers of permanent employment.
- The trust has deployed e-rostering across all staffing groups, and these are approved at least 6 weeks in advance and reported regularly to Divisional teams. The trust has moved from a position of 64% of Consultants with an active Job Plan in financial year 2016/17 to a position where 99.5% of Consultants have signed off job plans for 2018/19.
- On pharmacy, the trust scores favourably against national benchmarks for stockholding (17 against national median of 21), electronic commerce ordering (97% against 94% national median). The trust has delivered these outcomes while maintaining a lean pharmacy department, benchmarking favourably on cost (including pharmacy cost per Weighted Activity Unit (WAU) £517 vs £533) against peers.
- The trust has delivered a large-scale CIP in each of the previous two years; £53.8m in financial year 2016/17 and 43.1m in financial year 2017/18. It is on track to deliver a CIP

programme of £40.7m in the current financial year (2018/19). Moreover, nearly all of this has been delivered recurrently; 84% in financial year 2016/17, 99% in financial year 2017/18 and 93% for the current financial year (2018/19).

Areas for improvement

- In terms of elective activity, the average rolling length of stay over the 6 months to September 2018 is 3.9, which is worse than the national median of 3.0, and the London median of 3.8. Additionally, patients are waiting more time in hospital before their procedures compared to other trusts; pre-procedure elective bed days to September 2018 is 0.47 compared to the national median of 0.12. The trust has identified the causes of the higher pre-procedure LoS as being in Bone Marrow and Transplantation, Clinical Haematology, Cardiac Surgery and Thoracic Surgery. Implementing changes through the next phase of the SRP in this area is currently underway.
- The trust has further room for improvement in Outpatients. The trust's DNA rate is 10.41% as at September 2018, compared to the national median of 7.32%. However, we note that the trust's performance has improved quarter on quarter in the current financial year (2018/19). The trust also compares favourably to London peers (10.67%). In addition to text reminders and hybrid mail systems which have now been rolled out, the trust has implemented more innovative technology and collaborates in this area with system partners including primary care.
- The main challenge is the age and condition of the trust's estate. The trust notes that it needs to maintain and provide services to ensure that it is safe and functional until major site refurbishments can be delivered. We have noted an increase in investment into the estate over the past few years, investment in this area is 0.73% of turnover which places the trust in 45th position nationally. We note that the proportionally lower investment in estate is partly due to the trust waiting on funding options appraisals and approvals relating to strategic regional estates options for redevelopments. The trust is also awaiting approvals for funding for additional loan funding to deal with immediate estates priorities. This is an area which will require continued close working with system partners and regulators to deliver improvements to mirror those being seen in operational performance.

Ratings tables



Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term 'allied health professional' encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24 hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.

Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR) cost per £100 million turnover	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.

Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs
Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the

	associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Single Oversight Framework (SOF)	The Single Oversight Framework (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.