Torbay and South Devon NHS Foundation Trust

Use of Resources assessment report

Torbay Hospital
Lowes Bridge
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Date of publication: 02/07/2020

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

Ratings

Are resources used productively?	Requires improvement

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.

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Date of inspection visit: 10 March to 2 April 2020
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This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Proposed rating for this trust?	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 .

We visited the trust on 12 February 2020 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

Requires improvement

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

We rated Use of Resources as requires improvement. The trust's overall cost per weighted activity unit for 2017/18 benchmarked in the highest (worst) quartile nationally. During our assessment, we found that the trust benchmarked well on aspects of clinical services and workforce and had in place several productivity programmes which were progressing. However, at the time of the assessment, the trust did not meet any of the four constitutional standards, being particularly challenged with elective and diagnostics access targets. Although the trust delivered cost effective clinical support and corporate services, there were concerns these were not always sustainable. The trust needed to invest significantly in its IT infrastructure and estates. Finally, the trust's financial position had deteriorated significantly over the previous year, as a result of the reliance on non-recurrent funding from commissioners and significant financial governance issues. This in turn limited its ability to invest in its infrastructure.

- This was the first time we formally assessed the trust for use of resources. However, the trust had taken part in an early pilot of these assessments in 2018 and we have referred to some of the findings in this report.
- The trust was one of the first fully integrated trusts in England and alongside acute services, it delivered community and social care services. Although the Model Hospital did not provide benchmarking information for social care services, we discussed with the trust how they benchmarked themselves and reviewed the information available to them.
- At the time of our assessment, the trust identified that the costing data submitted nationally and used to calculate costs per weighted activity units (WAU) for 2016/17 was materially erroneous. The 2018/19 costs per WAU had also only just been released and had not yet been fully analysed. As a result, our assessment focused on the 2017/18 cost per WAU. The 2017/18 overall cost per WAU was £3,654 which benchmarked in the highest (worst) quartile nationally. The 2018/19 cost per WAU at £3,579 ranked the trust in the second highest (worst) quartile nationally.
- We visited the trust slightly before the COVID-19 pandemics significantly impacted the NHS and as a result, our assessment did not take account of any actual or potential consequences on the trust's operations and finance.
- The trust had a mixed performance on clinical services. At the time of the assessment, the trust was not meeting any of the four constitutional standards with particular challenges in referral to treatment (RTT) and diagnostics performance. The trust's performance had been impacted by several equipment and infrastructure failures during the prior year. The trust had long length of stay for elective admissions and above average pre-procedure bed days. A recent review of adult social care had also identified areas where the local health system could deliver improvements.
- There were however areas where the trust performed well. The trust had a 'did not attend' rate which was amongst the best nationally as was the trust's day case rate. The trust had programmes in place to improve its productivity in its clinical services which had delivered improvements (e.g. theatres). The trust had engaged well with the Getting it Right First Time (GIRFT) national programme although it needed to take a more structured approach to the delivery of its GIRFT programme.
- The trust had an overall pay cost per WAU for 2017/18 which benchmarked in the lowest (best) quartile nationally and the trust had low costs per WAU for substantive and non-substantive staff. The trust had better retention rate than the national median as well as better than average results from its staff survey. However, its staff sickness benchmarked higher than the national median.
- The trust had worked to develop a workforce tailored to the needs of an integrated care organisation although the trust still needed to evidence the benefits it derived from its this. The trust was driving productivity of its workforce through the use of rostering tools in some areas but needed to embed a robust job planning system.
- The trust's clinical support services were variable. In many areas the services appeared cost efficient although this reflected effective delivery but with significant staff shortages which the trust had started to address. The necessary networking solutions to help address workforce pressures had been slow to progress due to dependency on improving IT infrastructure and delays in reaching agreement with local partners on ways forward. The sustainability and transformation partnership (STP) was however addressing this through a new STP digital strategy.

- The trust's corporate services benchmarked well in cost efficiency terms in many areas although this did not always appear sustainable. Finance and information management and technology (IM&T) appeared too lean. The trust had underinvested in technology infrastructure and digital solutions and this needed to be addressed. The trust's estates presented significant challenges due to the unsuitability of many buildings and facilities infrastructure.
- The trust had not met its control total in 2018/19 and was forecasting to deliver a £18.8 million deficit, £15 million worse than its control total and plan for 2019/20. The trust operated with a significant underlying deficit and had relied for several years on non-recurrent funding from its commissioners which was no longer possible in the context of a financially challenged health system. Several external reviews had highlighted significant financial governance issues which the trust was only starting to address. The trust lacked a good understanding of its costs and service line financial sustainability. The financial position of the trust impacted the cash it had available to pay staff and suppliers as well as address the need for investments in its estates and IT infrastructure.

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

The trust had mixed performance in its clinical services. At the time of the assessment, the trust was not meeting the four constitutional standards with particular challenges in referral to treatment (RTT) and diagnostics performance. It had long length of stay for elective admissions and above average pre-procedure bed days. However, there were areas where the trust was performing well. Its 'did not attend' (DNA) rate was in the best quartile nationally as were day case rates. The trust had programmes in place to drive productivity in its clinical services although it had work to do to take a more structured approach to its GIRFT programme.

- The trust was not meeting the 95% 4-hour A&E standard at the time of our assessment. However, it had comparable performance to the national average (82.7% at October 2019, compared with the national average of 82.4%) and had an improving trend from a low point of 76.4% for January 2019.
- The trust recognised the challenges to delivering the urgent care standard and cited its estate and operational environment, staffing and maintaining a flow of patients out of the emergency department (ED) as the primary factors. The trust had secured funding for a new assessment area. Additionally, the trust was an accelerator site for the same day emergency care programme to support its ED performance and reduce crowding. The trust had focused on productivity improvements in its urgent care activities through workstreams to drive improvements in its emergency floor, wards and 'Home First' programmes.
- From the most recent available data at the time of the assessment (September 2019), the trust's 18-week RTT performance was 80.4% against the 92% standard being significantly worse than the national average of 84.5%. It is significant that in November 2018 the trust had to close two of its ten inpatient theatres due to failures of the air handling units. These theatres remained closed until October 2019. The loss of 20% of inpatient capacity and 50% of the ultra-clean air theatre capacity for orthopaedic procedures had a significant impact on the trust's operations.
- The trust worked to mitigate the effect of this and the total inpatient waiting list did not increase during this time. Booking processes were tightened and day cases extended to deliver more capacity. However, the trust had a long length of stay for elective patients, being in the worst quartile nationally, although it concluded this was in part a reflection of high day case rates, which were in the best quartile nationally, leading to more complex, longer stay cases being seen in its inpatient settings. Conversion rates from day case to an inpatient stay were in the lowest quartile nationally.
- The time that patients were coming into hospital prior to elective treatment was higher than the national average. The trust's pre-procedure elective bed days benchmarked at 0.13 days against the national median of 0.12 days at quarter 2, 2019/20, and for non-elective, the trust at 0.78 days was higher than the national median of 0.65 days.
- The trust had worked with Four Eyes Insight to support productivity gains in its theatres and data available at the time of our assessment for March 2019 placed the trust in the best quartile for touch time utilisation.
- The trust's performance against the diagnostic 6-week wait standard was very challenged at 90% as at October 2019 (99% national benchmark and 98.8% national average). Performance was most challenged in gastroscopy and colonoscopy. Some improvements had been achieved through additional capacity. The trust cited equipment failures impacting its ability to drive productivity in this area.
- Progress was being made in delivery of the cancer 62-day standard. The trust had performance close to the national average (78.9% compared to a national average of 79.8% for the most recent data at the time of our assessment, September 2019). The trust had made progress in reducing numbers of patients breaching the standard. In January 2019 there were 210 patients waiting over 62 days to start their treatment by December 2019 this had been reduced to 86. The trust was a wave 2 pilot site for the 28-day faster diagnosis standard (FDS).

- The trust's DTOC rate of 3.5 % compared reasonably to the national median of 3.4%. However, as a provider of integrated services, it was acknowledged that the DTOC rates might be expected to be lower than the national median. Work was underway using the 'red to green' days approach on complex discharges particularly needing support to leave hospital.
- The trust's emergency readmission rate of 10.4% benchmarked in the worst quartile compared to a national median of 7.9% (quarter 2, 2019/20). During the 2018 pilot use of resources assessment it was reported that the trust did not demonstrate a full understanding of the drivers behind readmission rates. The trust had completed a case note review to understand the drivers influencing readmissions. It was concluded there was some incorrect coding for repeat ambulatory care patients who were expected admissions, in line with care pathways, rather than readmissions and the trust could demonstrate that without the impact of these coding anomalies, the trust's readmission rate was significantly lower and closer to the national benchmark.
- The trust's 'did not attend' (DNA) rate was very low at 4.9% compared with a national average of 7.1% (quarter 2, 2019/20) which placed the trust in the best quartile nationally. The trust had consistently maintained a very low rate of DNAs over an extended period. The trust used text reminders and proactively contacted patients to ensure attendance and focused on avoiding face to face meetings unless necessary. Clinical teams had introduced a range of non-face to face pathways in outpatients with virtual clinics in place in several specialties.
- The trust had engaged with the Getting It Right First Time (GIRFT) national programme and had numerous specialty visits since 2017. However, the trust had yet to develop a structured trust-level approach to GIRFT, although an approach was under development to enable trust oversight and speciality-level accountability for GIRFT actions.
- The trust had tools to monitor the delivery of and spend on health and social care both within the trust's control and, with its commissioners and local authorities, across the system. Key metrics were reported to the trust board. The trust tracked patients awaiting social care packages. It also monitored weekly the services provided by the independent sector which were a cost pressure for the trust. An independent review of the adult social care had been carried out recently across the health system and recommendations were being considered for actions. The trust used benchmarking information from the Local Government Association to understand spend on social care and unit costs and looked to learn from other similar organisations both in England and Northern Ireland.

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

The trust had an overall pay cost per WAU of £2,014 in 2017/18 compared to the national median of £2,180, placing it in the best quartile nationally. The trust had a lower than average cost per WAU for its substantive staff and was in the best quartile for agency pay costs per WAU. It had better retention rates than the national median as well as better than average staff survey results although its sickness absence rate was worse than the national median. The trust had worked to develop a workforce tailored to the needs of an integrated care organisation although it was still to evidence the benefits derived. It was driving productivity in its workforce through use of rostering tools in some areas but had work to do to embed a robust job planning system.

- The trust's overall low pay cost per WAU was comprised of varying costs at individual staff group level. While the trust had lowest quartile substantive pay costs for its medical staff (£436 per WAU compared with a national median of £533) and nursing staff (£611 versus national median of £710) it was in the highest cost quartile for allied health professional (AHP) staff (£175 versus national median of £130).
- The trust reported that the high AHP cost per WAU was an intentional approach to grow the therapy workforce to provide care in line with the trust's integrated care model. The trust recognised that there was more work to do to understand the impact and outcome of this investment and how it worked within the wider workforce.
- In common with many NHS organisations the trust had undertaken a range of recruitment initiatives to improve its substantive workforce. Although the trust had a low agency cost per WAU at £52 per WAU compared with the national median of £107 per WAU, placing it in the lowest quartile, it was spending more on agency staff than the agency ceiling set by NHS Improvement, with a particular pressure in medical staffing. However, it had moved a substantial proportion of agency medics onto its staff bank, from a reported 84% of its temporary medical staff cost as agency to 42% at the time of our assessment.
- Additional activity to reduce agency spend included discussion across the wider Devon health system regarding the difficulty to recruit to consultant positions, considering physician associates roles and joint advertising.
- Other non-substantive staff costs, including bank staff across all staff groups, was in the lowest quartile at £85 per WAU compared with a national average of £157 per WAU.
- Spend on nursing above budget was reported to be driven by business pressures. With more stable emergency flow, it was anticipated that this would decrease in line with a reduction in escalation areas requiring additional staffing.

- The trust was innovating where it was difficult to recruit. It had recently recruited 37 overseas nurses and had nursing associates in place and was exploring nurse consultants where it was difficult to recruit medical consultants. The trust had increased apprenticeship uptake and, as at January 2020, the trust had approaching 300 staff undertaking apprenticeship programmes.
- The trust had established a workforce task and finish group to bring together and develop improvement plans for recruitment, temporary staffing (bank/agency) and e-rostering to ensure better visibility, cross functional alignment and in order to reduce the pay bill. To support the workforce position further, the trust had worked to improve its time to hire which it reported had reduced from 81 to 46 days over a six-month period, the improvement achieved through streamlining processes. The trust had around a quarter of its workforce approaching retirement age and was focused on proactively reviewing potential mitigations against the risk of future vacancy increases, such as retire and return and stepdown roles, talent management and succession planning.
- The trust was using an acuity-based approach to rostering and applied a 'SAFE' care model and alternative acuity models where available. Key performance indicators were in place to monitor the quality and improvement of rostering practice with a focus on efficiency and savings and the ratio of temporary staffing against substantive staff. Overall the trust had a better than average proportion of temporary staff at 3.8% compared to a national average of 4.0% (November 2019). E-roster for nursing was in place in all bed-based areas with theatres next in a staged roll out.
- The trust's staff retention rate was in the best quartile based on data available at the date of our assessment, with a rate of 89.5% as at December 2018. However, updated data for December 2019 was released after the assessment which placed the trust slightly better than the average which represented a deterioration on the previous position. The trust told us it utilised an appreciative inquiry approach in interviewing staff to understand what makes them stay working for the trust.
- Job planning was highlighted as an area for development in the pilot use of resources assessment in 2018 and there was a plan to roll out electronic job planning. The trust reported 98% of consultants now had a job plan. However, the robustness of the process was under review with a plan to make this a three stage sign off process. Details of the external review was not shared as part of the assessment process as the final version was not yet available.
- The trust's sickness rate was 4.5% as at end of September 2019 against the national average of 4.1% placing it in the second worst quartile. The trust's health and well-being approach was a focus for supporting staff and improving attendance.

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

The trust's costs for clinical support services were variable. In many areas financial efficiency appeared good as a result of services delivering effectively but with significant staff shortages which the trust had started to address The necessary networking solutions to help address workforce pressures had been slow to progress due to dependency on improving IT infrastructure and delays in reaching agreement with local partners on ways forward. The sustainability and transformation partnership (STP) was however addressing this through a new STP digital strategy.

Pathology

- Pathology cost efficiency had improved over the last 3 years and at the time of the assessment the overall cost per test of £1.36 (2018/19) benchmarked in the best quartile nationally. However, cellular pathology cost per test appeared to have increased and at £25.38 per test was in the second highest (worst) quartile nationally, largely due to difficulties securing enough staff and the need to outsource some work to a neighbouring trust.
- The level of pathology tests per capita of 23.87 appeared high (second highest (worst) quartile). However, this was based on a population served of 262,310 people and if adjusted using a more accurate population from the trust's business plan of 293,400 (and allowing for around 100,000 seasonal tourists) it would benchmark as low as 17.8 tests per capita, placing it in the lowest (best) quartile and below the national median of 23.9 tests. The trust had recognised there was still more to do to better manage demand. They however indicated that that they had applied the National Institute for Clinical Excellence (NICE) guidelines in their laboratory information management system (LIMS) in terms of demand management at which point some tests were excluded. Decision support was also applied at 'order comms' level although no tests were excluded which appeared to be national practice. Consultant biochemists also vetted any referral requests and South 1 pathology network they are part of, had recently agreed to review local practice and standardise re-testing intervals.
- The trust advised that it had low staffing generally in pathology compared with other sites (around 60%) and as a result had concerns about the sustainability of its service which it was trying to address through digitalisation and partnership working within the pathology network. Laboratory Medicine had also recently appointed to several vacancies including biomedical and science staff at band 5 to 7 and they were working to appoint additional

consultant microbiologists and haematologists. The trust provided training to 'grow its own' staff. However, the trust also recognised that with current changing practices (such as the expansion of GP work into weekends and evening) work needed to be carried out to understand the variation in staffing across the South 1 network and this was outstanding.
- The trust was part of the Peninsula Pathology network and assessment of the network progression in 2018 and 2019 showed strong engagement which was good to see. However, developing a joint network managed equipment service (MES) contract and installation of a new network laboratory information management system (LIMS) were now overdue but would be vital to enable the benefits of networking. A process was ongoing for the replacement of LIMS within the network. The trust had previously worked with another local trust on a MES procurement but had now agreed to take part in a South 1 network procurement exercise. The trust still had current contracts which were too costly to terminate early and was looking to decide on the best possible procurement start date.

Pharmacy

- At the time of visit, much of the trust's model hospital data was out of date or incomplete. Until recently, the trust had not submitted all elements of pharmacy data to NHS Benchmarking, but this had been addressed since January 2020.
- The trust's overall medicines cost per WAU at £391 was above the national median of £369 (with both high cost and non-high cost drugs being higher than the median) but as an integrated care organisation (ICO) the trust also provided pharmacy services to intermediate care and care homes making comparison to other acute trusts appear less favourable.
- The trust's 'top 10' medicines performance was good with savings for 2019/20 reported as £1.57m compared with a benchmark of £0.814 million and the trust benchmarked well for antibiotic consumption (4,128 total antibiotic consumption in DDD per 100 admissions compared to national median of 4,756).
- Electronic prescribing implementation had been slow but was at the time of the assessment at testing stage with implementation expected in February 2021. Lack of digital ordering systems ('order comms') and clinical decision support tools was flagged as an issue by GIRFT and was one of the trust's biggest issues for pharmacy. Addressing this was dependent on the planned procurement of a new trust networking infrastructure and the timeline for pharmacy 'order comms' delivery was not yet clear.

The trust had experienced significant pharmacist recruitment issues but had developed a successful foundation programme for junior pharmacists rotating though acute clinical specialties, mental health, intermediate care and primary care. 23 applications had been received following a recent advert which had resulted in the appointment of a full complement of 16 foundation pharmacists. **Imaging**

- The trust's backlog in CT and MRI had remained in the lower (best) quartiles over the last 3 years although consultant reporting productivity was low and benchmarked in the lowest (worst) quartile with 21 reports per PA compared to national median of 32. Consultant job planning data had been very out of date, but the trust had recently got all job plans up to date which was expected to be reflected in improved performance metrics going forward.
- In terms of radiographer reporting, it was promising to see X-ray backlogs in the lowest (best) quartile nationally (0.02% compared to national median of 0.15%) and a good level of auto reporting (12.5% compared to national median of 10.6%) despite aging X-ray equipment and a rate of radiographer vacancies in the second highest (worst) quartile (14.1% compared to national median of 11%). Whilst this suggested a highly efficient service run by radiographer staff, the trust had recognised the risk that staff may be under significant pressure given the high rate in staff vacancies.
- The trust had tried to address the challenges of recruitment by training its own staff at band 5 grade and developing them within the service. However, recruitment remained an issue (even for agency and locum staff) particularly in the areas of plain film radiography, CT scanning, MR scanning, admin and clerical and radiology support workers.
- A proportion of the trust's aged imaging equipment had been procured and replacements complete or progressing at the time of the assessment. CT, MRI and nuclear medicine projects were planned for commissioning through 2020.
- The trust was part of the South West region image sharing group. There was limited image reporting capability across the region which would impact on rapid diagnosis and delivery of radiology networks as required in the NHS long term plan by 2023 and cancer rapid diagnostic centres by 2020.

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

The trust's corporate services benchmarked well in absolute financial efficiency terms in most areas. However, corporate services were often facing significant workload challenges and could in fact be too lean, particularly in areas such as

finance and information management & technology (IM&T) support. Actions had been and were being taken by the trust to address this. Data gaps and underinvestment in IT infrastructure and digital solutions were an underlying theme for the trust along with major estates challenges due to the unsuitability of many of the existing buildings and facilities infrastructure. Despite this, it was recognised that corporate services staff in many areas were delivering well in the face of significant pressures.

Finance

- Overall, the finance function with a cost of £0.569 million per £100 million turnover in 2018/19 benchmarked in the second lowest quartile and below the national median of £0.653 million.
- The trust's finance function costs have not kept pace with increases in trust's income and service spend and considering the trust's financial position and the findings of several reviews highlighted in the next section of this report, the trust had recognised that the finance function may now be under resourced. The trust had recently created a new director of financial improvement role and other plans were in place to increase capacity where necessary.

Human resources

- The trust's human resources (HR) function cost per £100 million turnover was £1.141 million in 2018/19 which was above the national median of £0.911 million and placed the trust in the highest (most expensive) quartile. However, the trust also provided external payroll functions for two other local NHS organisations and these costs were included in core HR figures making costs look higher.
- Education service costs benchmarked above the national median (£0.539 million compared to national median of £0.233 million placing the trust in the highest (most expensive) quartile. The trust believed this was as a result of inconsistencies in how the split between HR and education costs in the Model Hospital categories and were undertaking an exercise to validate their allocation. They believed that that if education costs were removed, core HR costs would show the trust as second lowest (less expensive) quartile.
- The trust had adopted a range of innovative education initiatives such as developing e-learning into domiciliary care and the care home sector. These were not commercially advantageous to the trust but were a good example of supporting wider partnership development.
- The trust performed well in the areas of time to recruit medical staff with an average time to recruit substantive medical staff of 69 working days – the sector median was 73 days (national median is 71 days) and sector/national lower quartile was 58 days. Performance was also good in terms of levels of employee relation cases (4 employee relation cases per 1000 headcount compared to a national median of 14), and cases were closed in an average of 8 weeks compared to the national lower quartile benchmark of 11 weeks).
- Improvements to these levels had largely been due to the trust realigning how it provided HR support, establishing a central people hub and supporting managers in clinical service areas.
- The trust was also offering a range of HR services externally, for example providing advisory services to 22 GP practices which was helping develop good working relationships across the local health area.

Information management and technology (IM&T)

- IM&T costs generally benchmarked well in cost terms against peers at £1.660 million per £100m turnover compared to the national median of £2.521 million.
- The trust commissioned an external review of health informatics services (HIS) which reported in January 2020. It found several areas posing risk to effective operational delivery for end users within the trust and to the successful delivery of several significant IT-enabled change projects. The review identified that much of the current IT infrastructure in place was outdated and required significant investment to fully support current and future requirements of the trust.
- The report estimated that the trust needed around £1.6 million of investment to enhance both capacity and capability of the HIS team and recommended significant capital investment in core infrastructure (between £8 million and £15 million over a 5-year period). These estimates excluded strategic clinical applications which were also in need of replacement and additional funding.
- The report also recommended improved management of IT programmes and portfolios better as a result of which the trust was implementing an enhanced portfolio management approach linked to the business plan to align digital investment in business plan with timelines and resources needed.

Procurement

- The trust collaborated well with other trusts in the South West region and this was evident by its good price performance score (59 compared to the national median of 4).
- However, the trust's overall process efficiency and price performance score of 39 was below the national median score of 69 placing the trust in the lowest (worst) quartile at quarter 4, 2018/19. There had been gaps in the submission of data, which in part had contributed to the poor ranking. IT solutions had now been deployed to enable alignment of data and calculation by the trust suggested their performance would be around 67.7, placing them in the upper (best) quartile.
- Whilst the function cost per £100 million turnover appeared high at £0.258 million compared to national median £0.208 million it was noted that the team's remit included social care procurement, which distorted the comparison with other trusts.
- The trust saw the effectiveness of inventory management as its biggest procurement challenge and a business case for a digital solution was being developed at the time of the assessment but was at an early stage and still needed to be integrated within the wider digital strategy.

Estates & facilities

- The trust faced many challenges with its ageing estate: £366 per square metre backlog maintenance and £23.8 per square metre critical infrastructure risk (CIR) which explained why it was selected for HIP2 funding. These challenges have led to impacts such as loss of theatre capacity and leaking roofs recently affecting performance at many levels.
- It is recognised that the estates and facilities management team were working well under extreme circumstances in delivering an operational estate at a cost of £355 per square metre (benchmarking in the second lowest (less expensive) quartile) and providing patient led scores for quality and safety that were above peer and national benchmarks. It was recognised that this was not sustainable and a change in work practices and shifts had been developed after engagement with staff. Improvements such as enhancing the focus on robust programme and project management had led to improved staff satisfaction levels. A consultation exercise on how to improve soft facilities management (FM) services had also just been undertaken and would focus on splitting functions such as catering and cleaning but was understood to have already led to improvement of standards.
- In addition to the future HIP2 scheme the trust was developing a wave 3 'transforming and developing urgent care' project to enhance the emergency department. However, this project was currently experiencing cost challenges largely due to over-estimating the suitability of parts of the existing estate. For example, a whole new mechanical and electrical infrastructure was needed at a cost of around £3 million which was not initially envisaged and for which the trust was seeking further funding.
- A strategic estates partner was appointed around 12 months ago to provide a range of enhanced capacity across areas such as planning, programme management, quantity surveying, development of outline business cases, access to capital etc.
- The need for a good CIR risk plan was recognised and one was now in place and being used to help prioritise the interim estates plan. Rigorous risk governance was in place with board level scorecard reporting and use of external reports to check there were no gaps and that the capital programme was being prioritised according to risk levels.

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

The trust had not met its control total in 2018/19 and was forecasting to deliver a £18.8 million deficit, £15 million worse than its control total and plan for 2019/20. The trust operated with a significant underlying deficit and had relied for several years on non-recurrent funding from its commissioners which was no longer possible in the context of a financially challenged health system. Several external reviews had highlighted significant financial governance issues which the trust was only starting to address. The trust lacked understanding of its costs and service line financial sustainability. The financial position of the trust impacted the cash it had available to pay staff and suppliers as well as address the need for investments in its estates and IT infrastructure.

- The trust had not delivered its control total in 2018/19, was not forecasting to meet it in 2019/20 and its financial position had deteriorated. In 2018/19, the trust had not achieved its control total, delivering a £8.2 million deficit (excluding provider sustainability funding (PSF); £2.4 million deficit including PSF) which represented 1.9% of its turnover and was £3.7 million worse than its control total and plan. This was however after the trust received £8 million support from its commissioners under its risk sharing agreement, whereby the trust received compensation for non-achievement of its plan including un-earned PSF.

- In 2019/20, the trust accepted its control total to deliver a £4.1 million deficit (excluding central funding such as PSF). The trust revised its forecast midway through the year to a deficit of £18.8 million, £15 million worse than its plan and control total. The main drivers of the in-year deterioration were under delivery of income, temporary costs above expected levels, cost pressures in adult social care and continuous health care and under-delivery of its cost improvement plan (CIP).
- Several reviews were carried out during the latter part of 2019, on the trust's financial position and governance. These highlighted significant issues with financial governance and the trust's poor understanding of its underlying financial position and drivers of its deficit. The reviews noted a disconnect between the finance and operational teams, the reliance on non-recurrent funding and savings and poor financial practices. At the time of the assessment, a new chief financial officer had just joined the trust and the trust had started to deliver on some of the recommendations from the various reviews. The trust was working on its 2020/21 financial plan to improve its financial position.
- The reviews identified that the trust had operated with an underlying financial deficit since 2015/16. In 2018/19, the trust had an underlying deficit of £37.4 million which would deteriorate to £45 million at the end of 2019/20 (around 9% of turnover). The deficit was driven by inefficiencies compared to peers, poor delivery of recurrent cost improvements (including cash releasing efficiencies) and inability to contain the growing costs of social care and continuous healthcare. This was reflected in the continuous increase in the trust's national cost collection index from 99 in 2015/16 to 104 in 2018/19 (where 100 is the national median). The trust acknowledged that costs had grown faster than activity.
- The trust had not delivered its cost improvement plan in 2018/19 although it achieved savings of 4% of expenditure which was above the national requirement. However, only £8 million were delivered recurrently, £17.4 million less than plan. For 2019/20, the trust planned to deliver £20 million cost improvements (3.9% of expenditure), 87% recurrently. At the time of the assessment, the trust only forecasted to deliver £10.7 million savings (a £9.3 million shortfall) and only £3.9 million on a recurring basis (a shortfall of £13.6 million). The trust was improving its cost improvement infrastructure and approach. At the time of the assessment (February 2020), the trust had identified its £17.7 million cost improvement plan for 2020/21. The plan relied on several trust-wide transformation schemes which linked to the sustainability & transformation partnership (STP) programmes and had plans in place for 30% of its projects (£6.5 million).
- The trust had a risk share agreement contract with its main commissioners and had received substantial financial support from its commissioners for under-delivery of its financial plan including non-receipt of PSF. This had supported the trust's financial in the past. However, at the time of the assessment, the local health system was financially challenged and, with the trust's contract expiring in 2019/20, the trust and its commissioners were considering a new contract form supported by an agreed activity baseline.
- The trust had developed a commercial strategy in 2018 to generate income and a financial contribution to support the delivery of NHS activity. The trust had several commercial ventures and subsidiaries. Overall the trust forecasted to receive £22.7 million commercial income in 2019/20 (mainly from pharmacy sales) but including car parking, staff accommodation, catering etc. In addition, the trust expected to earn £1.1 million of private patient income.
- The trust had been an early implementer of patient level costing (PLICS) and of the national costing transformation programme in 2017/18. However, at the time of the assessment, the trust was not using service line reporting and PLICS and had concerns over data quality, in particular around activity capture. This also meant that the trust could not identify which of its services were financially unsustainable.
- The trust had a debt service rating of 4 (worst) in 2018/19 and 2019/20. The trust forecasted to have £104.6 million debt at the end of 2019/20 an increase of £15 million on 2018/19, driven by additional revenue cash support from the Department of Health and Social Care (DHSC) as a result of the trust's financial deficit. Most of the trust's debt was with the DHSC in the form of working capital facility, revenue support loans or capital loans. We trust had a significant backlog maintenance and critical infrastructure risk and needed to invest in its IT infrastructure and digital solutions. The trust had not been very successful at securing central funding for specific capital schemes in the past and needed to ensure that it maximised its opportunities to secure capital funding.
- The trust's liquidity rating was 3 (second worst) for 2018/19 and was expected to deteriorate to a rating of 4 (worst) in 2019/20. The trust relied on cash revenue support to pay its suppliers and staff and would require £15 million from DHSC in 2019/20. At the time of the assessment the trust paid most of its suppliers within the recommended 30 days of the best practice payment code with 88% by number of invoices and 83% by value paid within the target time.
- The trust had spent £0.5 million on management consultants between 1 April 2018 and 31 December 2019 to provide specialist support. However, the trust had also benefitted from several reviews (mentioned above in this report) which had been funded externally.

Outstanding practice

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

- The trust has achieved a very low rate of DNAs over an extended period. It has put in place a range of measures including proactively avoiding follow up appointments unless necessary, promoting self-management and informative support 'Apps', using virtual clinics, text reminders and making more appointments available in community settings closer to patients' homes.

Areas for improvement

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

- The trust needs to continue the implementation of the reviews of its financial governance and position and work with its health system to develop a financial plan to bring the trust and the system back to sustainable financial balance.
- The trust needs to ensure it maximises its opportunities to secure short to medium term funding for its estates and IT strategy.
- The trust needs to progress with addressing the findings from the health informatics services review.
- The trust needs to continue to strengthen its infrastructure to deliver recurrent efficiency savings.
- The trust needs to develop further PLICS and service line reporting and embed its use across operational and clinical staff.
- The trust needs to consider what further investment is required in the finance team, considering the current financial governance issues and financial position.
- The trust needs to validate further the assertion that its high length of stay for elective patients is explained by higher day case rates resulting in more complex patients receiving inpatient care.
- The trust has analysed the impact of the attendances to ambulatory areas on its emergency re-admission rate. The trust needs to ensure that it has sufficient evidence that without this impact, the trust's rate of emergency readmission is on par or better than the national median and where necessary, develop a plan to improve performance.
- The trust needs to put in place better oversight and accountability for implementing the actions from GIRFT reviews. This will help support improved productivity and performance against RTT to and diagnostic standards which were particularly challenged.
- The trust needs to review to the effectiveness of its investments in its AHP workforce to understand the impact of this investment and how it fits within the wider workforce strategy.
- The trust needs to fully embed its medical job planning process ensuring this is comprehensive in scope, aligned to the wider trust objectives and subject to appropriate levels of scrutiny.
- The trust needs to secure the appropriate level of workforce or alternative for its pathology and radiology services.
- The trust needs to progress at pace with several digital solutions: image reporting capability, digital ordering system and clinical decision tools for pharmacy.
- The trust needs to ensure it is progressing at pace within the Peninsula Pathology network to accelerate the development and implementation of a managed equipment service contract (MES) and a new network laboratory information management system (LIMS).
- The trust needs to progress with a digital solution to improve inventory management.

Ratings tables

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

***** Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Service level

Safe	Effective	Caring	Responsive
N/A	N/A	N/A	N/A

Trust level

Well-led	Use of Resources
N/A	N/A

Overall quality

N/A

Combined quality and use of resources

N/A

Use of Resources report glossary

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

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

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

Term	Definition
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.