Dartford and Gravesham NHS Trust

Use of Resources assessment report

Darent Valley Hospital
Darenth Wood Road
Dartford
Kent
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www.dgt.nhs.uk

Date of publication: 22 August 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	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RN7/reports)

Are resources used productively?	**Requires improvement**

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

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

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

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.

This is the first time that we have awarded a combined rating for Quality and Use of Resources at this trust. The combined rating for Quality and Use of Resources for this trust was good, because:

- Effective, caring, responsive and well led were rated as good.
- Safe was rated as requires improvement overall.
- The trust was rated requires improvement for use of resources.

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

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Date of site visit:
17 May 2019

Date of publication: 22 August 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 12 months, our local intelligence, the trust's commentary on its performance, and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Are resources used productively?	**Requires improvement**

How we carried out this assessment

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

We visited the trust on 17 May 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Summary of findings

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

We rated Use of Resources as requires improvement. During our assessment, we found that the trust had made significant progress: the trust had a low total cost per weighted activity unit (WAU); it benchmarked well on clinical services and clinical support services and some aspects of the people KLOE; and it had worked with its commissioners to develop a financial recovery plan. However, these improvements had not yet translated into a material reduction of the financial deficit position and there was evidence that further productivity improvements could be realised.

- The trust benchmarked well on clinical services. It met the 18-week referral to treatment target, the cancer 62-day wait and diagnostic 6-week wait.
- Patients were less likely to require additional medical treatment for the same condition at the trust. Fewer patients were coming into the hospital unnecessarily prior to treatment compared to most hospital in England and the trust treated a higher proportion of patients on a day case basis compared to the rest of England. The trust had also reduced the number of delayed transfers of care. The trust's did not attend (DNA) rates were low.
- The trust had a low staff cost per Weighted Activity Unit (WAU) compared nationally. It was using innovative roles effectively and e-rostering to deploy its nursing staff. The trust's sickness rate benchmarked well, and it had achieved a good result in the 2018 staff survey.
- The trust benchmarked well generally on clinical support services and demonstrated several examples of good practice in the way it used technology to support the delivery of clinical services.

However, it should be noted that:

- At the time of the assessment, the trust did not meet the 4-hour accident and emergency target.
- The trust had a comparatively high conversation rate of patients from day case to an inpatient stay and its emergency length of stay was higher than the national average with potential to make improvement.
- The trust experienced recruitment difficulties, particularly in specific areas. This consequently increased the trust's use of agency staff. The trust continued to spend on agency staff above the spend ceiling set by NHS Improvement. The trust had recently introduced a Zero Agency Group to drive down the use of agency staff, but it was too early to see a material improvement.
- The trust benchmarked high on medical cost per WAU and it needed to further investigate the drivers of this cost.
- The trust's corporate services, procurement and estates and facilities did not benchmark well compared with the national median. The trust recognised this position and had plans in place to reduce costs.

- In particular, the trust's procurement function was delivered in partnership with a large teaching hospital in London but did not appear to have made full benefit of the shared service arrangement. The trust's estates also operated through a Private Finance Initiatives (PFI) building which limited its ability to make radical and rapid changes to its infrastructure.

- The trust had not delivered its financial plan and control total for the last two years and was in a deficit financial position. The trust had a plan for 2019/20 to achieve an improved deficit position although this relied on the delivery of significant cost improvements, higher than what had been delivered in the previous two years and the trust had not achieved its cost improvement plans in the prior two years.

- The trust had worked with its commissioners to understand the drivers of their financial deficit position and had worked to develop a common recovery plan, and this remained to be delivered.

- The trust relied on cash support from the Department of Health and Social Care (DHSC) to meet its financial obligations although this was expected to reduce in 2019/20. The trust also had a large accumulated debt (principally due to its PFI building) which resulted in significant finance costs each year.

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

Overall, the trust benchmarked well on clinical services metrics and met all standards except the 4-hour A&E target. The trust needed to progress further on understanding the rate of conversion of day cases to inpatient and reduce its emergency length of stay.

- At the time of the assessment, the trust was not meeting the constitutional operational performance standards for 4-hour accident and emergency (A&E) (81.5% for April 2019) but was meeting the standards for 18-week referral to treatment (RTT), cancer 62-day wait and for diagnostics 6-week wait.

- With regards to A&E, the trust had experienced an increase in attendances, including from south east London with a high number of ambulance conveyances. The trust had received expert support during the winter and was focussing on improving the minor injury unit performance, reducing length of stay and bed occupancy to improve performance. However, at the time of the assessment, the trust did not have a trajectory which would return to the standard by the end of 2019/20.

- Patients were less likely to require additional medical treatment for the same condition at this trust compared to other trusts as readmission rates were significantly below the national median as at quarter 3 2018/19 (6.89%).

- Fewer patients were coming into this hospital unnecessarily prior to treatment compared to most other hospitals in England. On pre-procedure elective bed days, at 0.06, the trust was performing in the lowest (best) quartile when compared nationally – the national median was 0.13 days. On pre-procedure non-elective bed days, at 0.58, the trust was performing in the second quartile when compared to the national median of 0.66 days.

- The Did Not Attend (DNA) rate for the trust was low at 6.2% for quarter 3 2018/19. This was in the lowest (best) quartile nationally (national median is 7.32%). The trust utilised

text messaging and self-check-in stations in its outpatient settings to support the delivery of this performance.

- The trust reported a delayed transfers of care (DTOC) rate of 4.3% (October 2018), which was higher than the national median. This rate had improved by January 2019 however, to 2.2% following some targeted work with local system partners and this improvement had been sustained at the time of the assessment.

- The trust had engaged well with the GIRFT programme and action plans were in place to implement the recommendations. The involvement had been well led by the medical director and the GIRFT programme leadership had recognised this in their feedback to the trust.

- The trust provided refreshed information on their day case rates during the assessment (for procedures listed by the British Association of Day Surgery (BADS)) for all of 2018/19 and the overall total was 80.54%. This was better than the national median of 77.8% and the rates were significantly better on the Queen Mary Hospital site, where the trust only undertook planned (and no emergency) surgery.

- The trust showed a comparatively high rate of conversion of patients from day case to an inpatient stay (for BADS procedures) for quarter 2 2018/19 (21% compared to 7.0% national median). The trust had not focussed on this as a significant area of concern but agreed to examine the data further to identify areas to address.

- While the elective length of stay (LoS) was very low (1.3 days versus a national median of 3.0) the trust recognised that it did have some improvements to make in the emergency LoS (trust value was 9.7 versus a national median of 9.3.). The trust had developed a programme of work using improvement methodology to realise an opportunity to reduce LoS and reduce its amount of emergency bed capacity.

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

The trust spent less on staff per unit of activity than most trusts nationally. The trust was using innovative roles effectively and used e-rostering to deploy its nursing staff. The trust had good sickness rates with a well-developed health and wellbeing programme. However, the trust experienced difficulties in recruiting and retaining staff and continued to spend more than the ceiling set by NHS Improvement on agency staff. A recent analysis also showed that where the trust has lost activity, it had not always managed to reduce staffing accordingly.

- For 2017/18 the trust had an overall pay cost per WAU of £2,034, compared with a national median of £2,180, placing it in the second lowest (best) cost quartile nationally. This meant that it spent less on staff per unit of activity, than most trusts.

- The trust was in the second lowest (best) quartile for allied health professional (AHP) cost per unit of activity at £118 compared to a national median of £130.

- The nursing pay costs per WAU were £739, which benchmarked in the highest (worst) quartile against a national median of £710 although the trust had an average staff cost for nursing and midwifery which was lower than the national average (£33,918 versus £35,324). Care hours per patient day were higher than the national average at 8.4 versus 7.9 nationally. The trust stated that the higher costs were attributable to non-ward-based nurses (Band 7 and above grades) where nurses were undertaking extended roles such as clinical nurse specialists and advanced care practitioners to take on some of the

consultants' activities, allowing them to focus on clinical care. The trust had a comparatively high number of these posts which were being used to provide senior clinical workforce and skills. A recent review of the trust's drivers of deficit had also identified that where the trust lost activity, it had not always been successful at reducing its staffing correspondingly. This would also contribute to a high nursing and medical cost per WAU.

- An area of good practice was where ward-based nurses were undertaking shift by shift acuity and dependency scoring (which was published) and were using the Model Hospital metrics to inform their rostering, which was undertaken electronically. All rosters were published at a minimum of 6 weeks in advance, which was acknowledged as good practice nationally.

- The trust was using e-rostering and held challenge meetings monthly to review staff deployment and usage. The trust was training all Band 7 nurses on budget management and reliability training for acuity and dependency assessment.

- The trust was using a programme of work initiated by a neighbouring trust to help to ensure that staff were able to leave work on time and this had had positive effects on staff and staff engagement.

- The trust did not meet its agency ceiling as set by NHS Improvement for 2018/19 although it was planning to achieve its ceiling in 2019/20. In 2018/19, the trust agency spend was £9.6 million, £4.5 million higher than its ceiling and representing 6% of its payroll costs. In 2017/18, the trust's agency cost per WAU was also above the national median (£127 versus £107 nationally).

- The trust had instituted a 'Zero Agency Group' chaired by the Chief Executive, to drive down the use of agency staff and outputs from this had included capped hours controls, collaboration initiatives with other trusts around staff passports and a nurse cadet scheme. The trust also regularly benchmarked its costs and agency usage against other providers in Kent. A review in January 2019 by NHS Improvement had identified that there were good controls in place in the area of nursing agency usage. This was identified as an area of good practice which could be shared with other trusts.

- The trust had staff working in extended roles, including reporting radiographers, advanced care practitioners in nursing (in the emergency department and paediatrics) and extended scope practitioners in musculo-skeletal services. There were also assistant practitioners working in radiography.

- The trust had a high medical staff cost per WAU (£570 versus £531 nationally). The trust was carrying out work to examine this and was working on improving its job planning and implementing electronic rostering capability to manage this numbers down. The trust had engaged with other trusts to undertake peer challenge of clinical job plans. This was also to be seen in the context of high nursing costs where the trust explained the use of innovative roles helped focus medical resources.

- The trust highlighted recruitment difficulties in the specialties of emergency and medicine and that consequently these specialties were higher users of temporary staffing. The trust had a medical staffing bank however, which had been jointly procured with neighbouring trusts and were working on the implementation of a collaborative staff bank. All doctors were automatically enrolled onto the staff bank.

- Staff retention at the trust was slightly worse than the national average (84.4% compared to 85.9% nationally). The trust reported this performance was adversely affected by the

fact that the trust hosted the staff from the joint pathology venture with a local trust. Retention rates at the trust in nursing and midwifery (at 88.5% and 90.4%) were better than the national median.

- The trust had had a good result in the 2018 staff survey, with 67% of staff saying that they would recommend the trust as a place to work. This compared to a national rate of 62.6%.

- The trust had a well-developed health and wellbeing programme and a sickness absence rate of 3.9% which was significantly lower (better) than the national average. The trust held regular 'surgeries' for staff to discuss employment issues they were experiencing and had an early intervention approach to avoid the need for escalation.

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

The trust benchmarked well on clinical support services nationally which meant the trust was spending less on these services than other trusts and demonstrated a number of examples of outstanding practice particularly in the use of digital tools and pharmacy services to support patient care and efficient service delivery.

- The overall pathology cost per test at the trust benchmarked in the lowest quartile nationally as did the cost per capita and tests per capita metrics. The trust was part of a networked pathology service with Medway NHS Foundation Trust (North Kent Pathology Service (NKPS)) and was actively participating in a programme to bring all Kent and Medway Sustainability and Transformation Partnership (STP) pathology services into a single Kent-wide pathology network. The trust acknowledged recent operational challenges within NKPS and demonstrated that lessons learned had not only been applied to the current service but were also being shared and addressed within the wider pathology network programme. The trust was seeking to share early productivity benefits from the Kent-wide programme's review of "send away" tests prior to achieving the full benefits of service consolidation.

- The trust imaging services benchmarked in the lowest (best) quartile for cost per examination (£39.55 compared to a national median of £49.93), and used skill mix effectively with radiographers reporting studies in a range of modalities and assistant practitioner roles. The trust had been more reliant on outsourcing of imaging activity than its peer group, but recent successful medical recruitment had enabled the trust to improve this and reduce temporary staffing expenditure. Recruitment of medical and AHP staff had been identified as an ongoing challenge and constraint to service delivery and further productivity improvement. The trust had begun to consider the benefits of collaborating with other service providers to deliver imaging services but had not yet developed any formal plans to network services.

- The trust's medicines cost per WAU at £253 was relatively low when compared nationally (£309). As part of the Top Ten Medicines programme, it was making good progress in delivering on nationally identified savings opportunities, achieving 137% of the savings target. The trust had made good progress in implementing prescribing by clinical pharmacists through delivery of a structured training programme. The trust's use of its pharmacy workforce, both clinical and technical, to support a wide range of clinical services and support to ward areas was noted as outstanding practice. It was acknowledged that the trust had submitted a strong application for capital funding for the introduction of an electronic prescribing and medicines administration (EPMA) system

and at the time of the assessment, the trust was awaiting the outcome of the bidding process.

- During the assessment, we identified that the trust had a particularly strong commitment to adoption of digital technology to improve care delivery, including a number of areas of outstanding practice. The trust's virtual ward service, including remote vital signs monitoring of patients was an impressive example of utilising technology to enhance patient experience and improve efficiency, enabling the trust to double the caseload of patients supported in their own homes. The trust had successfully implemented a patient portal to enable patients to access their own records, reducing administration costs, and it had begun work to redesign a range of clinical pathways enabled by digital tools. Other digital innovations being adopted by the trust included use of artificial intelligence (AI) in radiology with the "red dot" system to support clinical prioritisation and use of remote monitoring devices for recording heart rhythm. The trust had a clear plan for ongoing investment in digital technology as part of a wider STP digital investment programme.

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

At the time of assessment, the trust benchmarked unfavourably with the national median and its peer group with regards to its corporate services, procurement and estates and facilities costs. The trust acknowledged this position and had plans that will reduce costs in these areas in future years.

- For 2017/18, the trust had an overall non-pay cost per WAU of £1,401, compared with a national median of £1,307, placing it in the second highest (worse) cost quartile nationally. This represented a relative deterioration on the prior year compared nationally and suggested that the trust could have been be able to reduce its spending on supplies and services. The trust reported delivery of £3.5m of recurrent non-pay savings in 2018/19 which would translate as an improvement in the next publication of non-pay cost per WAU data.

- The cost of running the finance and human resources (HR) departments (respectively £0.903 and £1.37 million per £100 million turnover) were both higher than the national average. With respect to HR, the trust had invested in its occupational health service and generated commercial income from offering the service to other local employers. The trust performed in the bottom (best) quartile for time to hire and had sickness absence rates below the national median, both of which could be associated with the higher than average expenditure on the human resources function.

- The trust had evaluated a range of options for consolidation of corporate services but had concluded that these would not deliver better value. The trust had then committed to introducing automation into its finance function. The trust attributed the high cost of finance to recruitment difficulties necessitating significant levels of expenditure on high cost agency staffing in the function. These vacancies had now been filled and the trust expected the cost of its finance function to fall accordingly. The trust was using its collaboration with a London teaching trust to help improve the effectiveness of its clinical coding service and had invested in a clinical coding trainer role enabling a reduction in agency coding staff.

- The trust's procurement function was delivered in partnership with Guy's & St Thomas' Foundation Trust (GSTT) through a shared service agreement. This partnership was halfway through a three-year transformation programme which was expected to deliver improvements and efficiency benefits in subsequent years. Existing processes were

relatively inefficient and tended not to successfully drive down costs on the things it bought. This was reflected in the trust's Procurement Process Efficiency and Price Performance Score of 42.1, which placed it in the second lowest (worst) quartile when compared with a national average of 47.9. The trust's position in the second highest quartile metrics for the percentage variance for top 100 products, and top 500 products also suggest that the trust was not getting the best prices from its procurement operations. The difference in the procurement league table position between GSTT (2nd place) and the trust (102nd place) indicated that there was a substantial opportunity for the trust to benefit further from the shared service arrangement. The trust reported that GSTT would be establishing a supply chain hub in Dartford and that this development would enable further opportunity for improvement.

- At £613 per square metre in 2017/18, the trust's estates and facilities costs benchmarked significantly above the national average. The trust's main hospital site Darent Valley Hospital was the first Private Finance Initiative (PFI) contract to include soft facilities management. This contract represented a significant proportion of the trust's expenditure on estates and facilities and limited its ability to make radical and rapid change. The trust leadership team were focussed on the upcoming opportunity to renegotiate aspects of the PFI contract (July 2020), and the performance management of its PFI partner.

- Where the trust was not constrained by the terms of its PFI contract, it had taken steps to reduce estates and facilities costs and had successfully negotiated with its commissioners to take on the costs of the lease for the community inpatient facility run by the trust from Elm Court. The trust was also renegotiating its lease for space on the Queen Mary's Sidcup site with a strategy to reduce the amount of space occupied, and to improve the utilisation of the facilities, including the development of a private patient service to increase commercial income. These actions would see a reduction in the cost per square metre and an improved estates and facilities cost per WAU.

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

The trust had not met its plan deficit and control total in 2017/18 and 2018/19 despite an increase in the level of cost improvements delivered including on a recurrent basis. The trust had a plan for 2019/20 which aimed to improve its financial position and deliver a break-even position after central funding. The trust relied on revenue cash funding to meet its financial obligations during 2018/19. The trust had worked with its commissioners to develop a financial recovery plan across both organisations to ensure its services were sustainable in the future

- In 2018/19, the trust had delivered a £19.9 million deficit (excluding Provider Sustainability Fund (PSF); £17.2 million deficit including PSF), £9.6 million worse than its plan and the control total set by NHS Improvement. This was a deterioration on prior year where the trust had delivered a £18.6 million deficit (excluding Sustainability & Transformation Fund (STF); £15.8 million including STF), £5.7 million behind its control total and plan. However, as a percentage of turnover, the 2018/19 deficit represented a similar level to 2017/18, with 7.5% deficit in 2018/19 compared to 7.4% in 2017/18.

- For 2019/20, the trust had a plan to deliver its control total of £11.7 million deficit (excluding central non-recurrent funding; breakeven position including central funding). This represented an improvement with the deficit excluding central funding representing 4.3% of income. As at the end of May 2019, the trust was on track to deliver its planned position.

- At the end of 2018/19, the trust had estimated its underlying financial position at £18.2 million (slightly better than its reported position). The trust had worked with its commissioners to develop a common understanding of their underlying financial deficit. The review which had reported in January 2019, showed that the main drivers of the trust's deficit were the cost of its PFI, operational estate costs and length of stay. The analysis showed that although circa 35% of the trust's deficit was structural in nature (eg PFI, cost of clinical claims) and circa 47% of the trust's deficit could be addressed through improved efficiency with the rest being strategic and requiring a different approach to improve. At the time of the assessment, the trust and its commissioners had just developed a financial recovery plan and identified a number of areas to drive efficiencies across the local health system.

- The trust had delivered £11.0 million cost improvements in 2018/19 (3.7% of expenditure) a significant improvement on prior year when the trust delivered £7.8 million savings (2.8% of expenditure) although materially lower than its plans for both years. The level of recurrent savings had also improved from £5.8 million in 2017/18 to £8.2 million in 2018/19. For 2019/20, the trust had a plan to deliver £12.7 million efficiency (4.5% of expenditure) from directorates schemes as well as transformational schemes identified through recent deficit review and benchmarking.

- The trust indicated that it had learnt from previous years to improve its cost improvement process and oversight. In particular, the trust recognised that it needed to shift its culture and make clinical directorates more accountable for the delivery of efficiency savings and indicated it had improved the level of information and support available to the divisions to deliver. The trust noted improved clinical engagement but still had further progress to make regarding setting up a project delivery unit and developing the support to clinical directorates.

- The information provided at the time of the assessment, also showed that the trust had only identified £7 million of its £11.0 million plan (64%), with transformational schemes lagging behind. At the end of May 2019, the trust was slightly behind its plan, having delivered £1.2 million savings compared to a plan of £1.3 million.

- The trust had accumulated £109.1 million debt by the end of 2018/19 which resulted in £15.9 million of finance costs that year (a small increase on prior year). Most of the debt related to the trust's PFI building (£63.8 million) although the trust also owed £34.9 million to the Department of Health and Social Care (DHSC) for cash support received during prior years.

- The trust relied on cash support from the DHSC to meet its financial obligations and pay its staff and suppliers in the immediate term. The trust had received £21.1 million cash support from the DHSC during 2018/19, as a result of its deficit position. Although the trust would initially require some additional support from the DHSC in 2019/20, it had planned to be able to repay this amount by the end of the year providing it delivered its 2019/20 planned financial position.

- The trust had service line reporting (SLR) and patient level costing (PLICS) in place. The trust used SLR during monthly performance reviews with divisions and gave examples where information had been used for decision making (eg to secure tariff increase for its hyper-acute stroke unit). The trust expected to progress further during 2019/20 to embed SLR/PLICS in directorates to improve understanding of the costs and income from services.

- The trust received commercial income from various sources including private patients, cark park and staff accommodation and the trust was actively looking at developing its commercial income where possible with opportunities to grow its private patient income.

- The trust had spent £0.6 million in 2018/19 on consultancy services, a decrease from prior year. The trust used consultancy services for targeted independent advice and assurance. For example, in 2018/19, it had received support to analyse the drivers of its deficit and develop recovery plan with its commissioners for the local health system.

Outstanding practice

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

- Ward based nurses undertook shift by shift acuity and dependency scoring which was published and were using the Model Hospital metrics to inform their rostering.

- The trust demonstrated good controls in the area of nursing agency spend which had been recognised by NHS Improvement.

- The trust had innovative digital solutions to improve care:
    - Virtual ward service, including remote vital signs monitoring of patients
    - Patient portal to enable patients to access their records
    - Use of artificial technology in radiology with the “red dot” system to support clinical prioritisation
    - Use of remote monitoring devices to record heart rhythm

Areas for improvement

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

- The trust must continue to work with its commissioners to implement their joint recovery plan to drive efficiencies across the local health system and materially improve their financial position.
- The trust must continue to work with the shared procurement function with GSTT to ensure it maximise the benefits from the shared service arrangement.
- The trust must ensure it progresses with reducing the cost of its estates in particular:
    - it maximises its opportunity to reduce the operational cost of its PFI when comes the opportunity to renegotiate aspects of the PFI contract in July 2020.
    - optimise the utilisation of the space at Queen Mary Hospital.
- The trust must continue to progress with embedding its approach to directorates accountability to deliver efficiency savings with improved SLR/PLICS information and the support from the finance functions.
- The trust must progress at pace to set up and fully embed its project delivery unit to ensure cost improvement schemes are progressed quickly and deliver the planned benefits.
- The trust should review its conversion rate from day cases to inpatient stays to understand the drivers and identify any areas to address.
- The trust should continue its effort to drive down the usage and cost of agency staff.
- The trust should progress to understand the drivers of its high medical cost per WAU and identify any areas to address to improve this cost. In particular, the trust should progress with job planning and electronic rostering of medical staff.
- The trust should progress at pace with assessing the benefits of collaborating with other providers on imaging, to develop a formal network, if appropriate.
- The trust should continue to identify opportunities to reduce the cost of its human resources and finance functions.

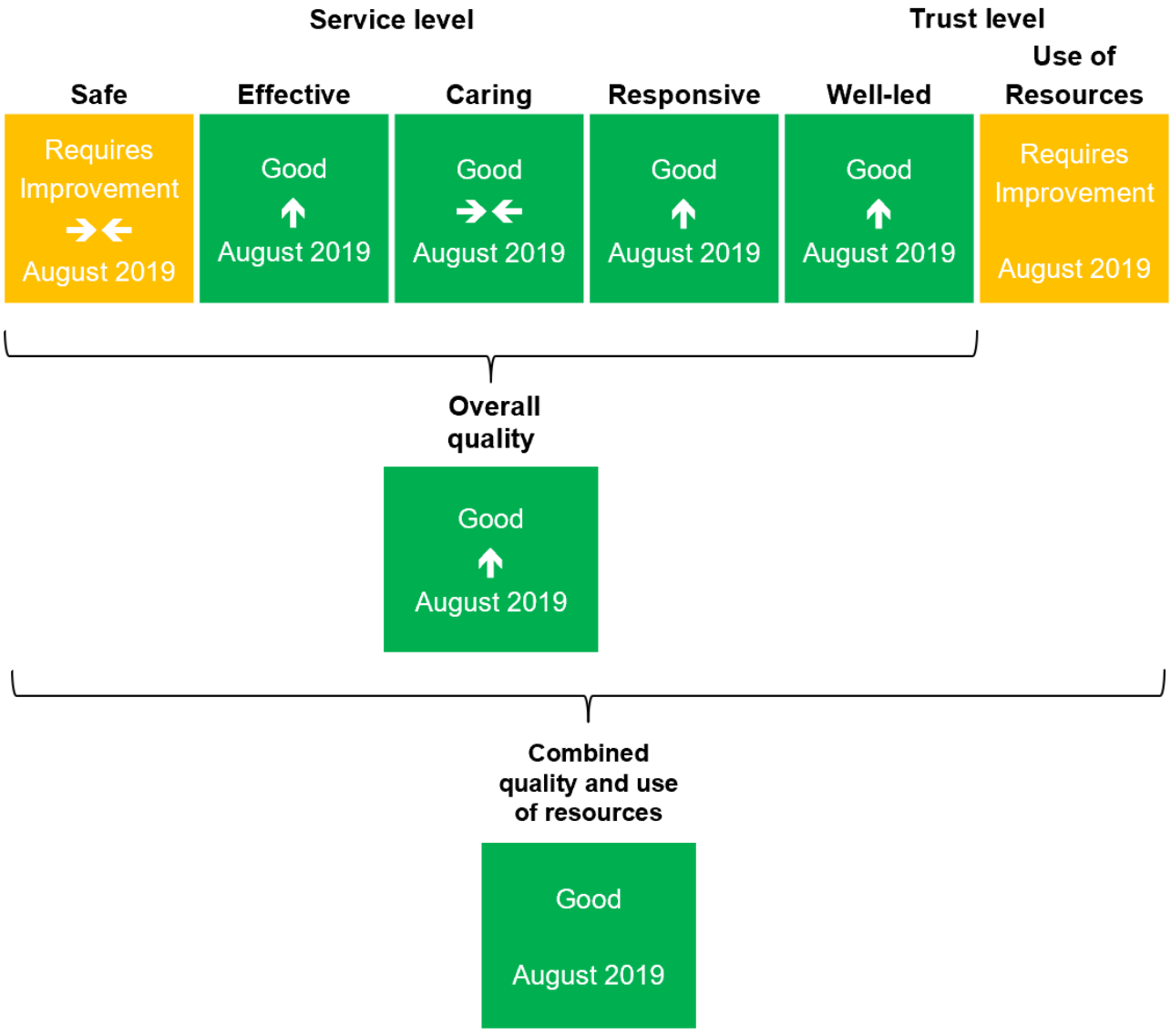
Ratings tables

Key to tables					
Ratings	Inadequate	Requires improvement	Good	Outstanding	
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = date key question inspected					

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

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

Ratings for the whole trust



Use of Resources report glossary

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

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

cost per £100 million turnover	
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs

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