Royal Cornwall Hospitals NHS Trust

Use of Resources assessment report

Royal Cornwall Hospital
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Date of publication: 26/02/2020

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

Ratings

Overall quality rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Are resources used productively?	Good

Combined rating for quality and use of resources	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.

Combined rating for Quality and Use of Resources

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.

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Date of inspection visit: 12 Nov to 12 Dec 2019
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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?	Good

How we carried out this assessment

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

We visited the trust on 23 October 2019 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

Good

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

We rated Use of Resources as good. The trust had an overall cost per WAU which benchmarked in the lowest (best) quartile nationally and, since our last assessment in September 2018, the trust had continued to improve its use of resources in many areas, finding innovative ways to address the challenges it faced. Overall the trust benchmarked well on clinical services and people. Its pharmacy service was exemplar. There were

evidence its corporate functions provided good value of money. The trust was also set to improve its financial performance in 2019/20. However, the key area where the trust needed to focus were reducing its reliance on agency staff, continuing to work with its systems to address delayed transfers of care, deliver recurrent efficiencies and progressing with its estates strategy and development.

- This was the second use of resources assessment at this trust. Since our last visit in September 2018, the trust had made significant progress with the areas we had identified as requiring improvements. The trust had materially decreased the number of patients waiting more than 52 weeks from referral to treatment. The level of job planning was now in line with expectations. The trust had delivered its savings plans in 2018/19 and had reduced its backlog maintenance. However, the trust still had a low level of recurrent cost savings and continued to experience challenges to reduce its agency spend.
- The latest data available at the time of the assessment (2017/18) placed the trust's overall cost per weighted activity unit (WAU) in the lowest (best) quartile nationally, an improvement on prior year.
- At the time of the assessment, in October 2019, the trust was not meeting three of the four constitutional access standards, although its performance for 18-week referral to treatment (RTT) and 4-hour accident and emergency (A&E) benchmarked better than the national and peer medians and the trust met the 62-day cancer target.
- The trust benchmarked well against most clinical services metrics including pre-procedure elective and non-elective bed days, emergency readmissions, did not attend rate (DNA). The trust had progressed on several transformation programmes supported by its quality improvement approach and could demonstrate evidence of productivity improvements. The trust was also well engaged in the 'getting it right first time' (GIRFT) national programme.
- However, the number of delayed transfers of care (DTOCs) remained high despite actions taken within the trust and with its local health system partners and it needed to continue its effort to ensure patients did not stay in hospital longer than required.
- The trust had a pay cost per WAU for 2017/18 which benchmarked in the lowest (best) quartile nationally. Overall the trust demonstrated a focus on reducing its pay costs and support its staff as reflected in a good retention rate and improvement in its staff survey engagement.
- However, the trust continued to have a high agency spend (8.4% of its pay bill as at October 2019) which reflected operational pressures and difficulty to recruit staff substantively. The trust used innovative roles, e-rostering and job planning to deploy staff efficiently and effectively to maximise the use of its people resource. The trust was progressing with recruitment particularly through its overseas recruitment programme. However, the trust's sickness rate was higher than the national median indicating this was an area for improvement.
- The trust benchmarked well on clinical support services both in terms of costs (based on 2018/19 data) and value of the services. The trust was part of a pathology network with the cost per test being in the best quartile. The pharmacy service was regarded as an exemplar. The trust was part of an imaging consortium, but we noted areas where the trust could improve with regards to DNAs and progressing with the replacement of imaging assets.
- The trust's finance, human resources (HR) and procurement functions were efficient and delivered good value (based on 2018/19 data). The trust's information management and technology (IM&T) function costs for 2018/19 were high and the trust was an outlier in several areas showing room for improvement. The trust's estate was aging with a high level of backlog maintenance although within this context there was evidence the estates was managed efficiently. The estates team continued to look for opportunities to improve the environment and services provided to patients.
- The trust's financial position had improved on prior year and despite risks, the trust continued to forecast the achievement of its control total (£17.3 million deficit excluding central funding). The trust however had found it difficult over the last few years to deliver recurrent cost improvement plans (CIPs) considering its low overall pay cost per WAU and acknowledged that recurrent efficiency savings and productivity improvements would now have to come from more transformational programmes delivered within its local health system. The trust had made progress in developing and embedding patient level costing and use of benchmarking, activity and costing information by clinical divisions to identify savings and support decision making.

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 benchmarked well against the clinical services metrics and its performance compared well to peers and national medians. The trust had progressed on productivity transformation programmes and was well engaged in the GIRFT programme. However, the number of delayed transfers of care remained high. The trust had taken actions internally but was now focusing on working collaboratively with its local systems partners to drive improvements.

- At the time of the assessment (September 2019 data), the trust was not meeting the constitutional operational performance standards for 18-week referral to treatment (RTT) (85.81%), 6-week diagnostics (96.10%) and 4-hour accident & emergency (A&E) (89.52%) but was meeting the 62-day cancer (88.79%) target. The trust's performance on A&E and RTT however was better than both national and peer medians and its performance on diagnostics was above peers.
- The trust provided evidence of their approach to quality improvement through their quality improvement ambassadors programme and demonstrated the benefits of this investment in the development of the same day emergency care unit with 27% of patient admissions now accessing care through this pathway and reducing pressures in the emergency department.
- There had been excellent management of elective surgery through a significant redesign of services that had taken place in the 12 months prior to our assessment which had resulted in a significant improvement in RTT performance (85.81%) against peer median (79.29%) and national median (84.4%) (as at September 2019) and the reduction of the number for patients waiting more than 52 weeks for treatment. We noted that the trust had progressed from having the highest number of 52-weeks waiters during our last assessment in September 2018 to 1 long waiter as at September 2019.
- The improvement in RTT performance was due to the development of day surgical activity at St Michael's Hospital. The trust had worked closely with the national GIRFT programme to review pathways and the approach to clinical risk and this fast-paced development work further demonstrated how the trust's quality improvement programme had underpinned cultural change and efficient, safe service delivery. The amount of change that had been delivered to improve productivity and efficiency to deliver an improvement of RTT of around 4.5 percentage points steadily over the previous 12 months was reflective of the way change and quality improvement was being led. Cancellations due to bed availability had slightly increased compared with previous year for the first 5 months (79 compared to 25), but that was much lower than the 183 seen in the same period in 2017/18. Overall theatre cancellations were slightly lower (1,004 compared to 1,064) and had reduced in percentage terms from 9.9% to 9.1%.
- Fewer patients were also coming into hospital unnecessarily prior to treatment compared to most other hospitals in England.
  - On pre-procedure elective bed days, at 0.07, the trust was performing in the lowest (best) quartile below the median when compared nationally – the national median was 0.12.
  - On pre-procedure non-elective bed days, at 0.57, the trust was performing in the lowest (best) quartile when compared nationally – the national median was 0.66.
- During our assessment the trust described its processes for improving clinical productivity (elective and non-elective) through a suite of quality improvement initiatives including ward accreditation, small tests of change, roll out of quality improvement training, the trust's 'being brilliant' strategy, embedding cultural change, admission avoidance programmes working alongside care homes and local authorities and protecting elective surgical beds and theatre lists. The trust had developed a financial framework with system partners, that was aimed at removing organisational barriers to facilitate the appropriate system ownership across pathways, for example, transfers of patient care through a prioritising system rather than the usual organisational efficiency focus. The trust continued to participate fully in specialty level initiatives to streamline pathways (e.g. dermatology level specialty work), Cornwall sustainability and transformation partnership projects such as musculo-skeletal, cardiology work with a local independent provider and the development of One Cardiology service and provided capacity to support this.
- However, despite this system focus formal delayed transfers of care (DTOCs) had increased from 35 to 44 per day over the first 4 months of 2019/20 although still an improvement on the monthly average for the last two years of 48 per day. The trust reported DTOC rate of 7.4% which was higher than the national median and the trust's own target. This was partly explained by the improvements that the trust had made in recording systems and proactive identification of patients who were medically fit for discharge, working closely through matron board rounds with assessments within 24 hours of admission (prior to the patient becoming a DTOC). There were ward referrals to STEPS reablement, and the trust was working with system partners to dispel myths and identify reasons preventing patients from moving on in the discharge pathway. Information on DTOCs and elective cancellations was readily available and monitored closely by the finance and performance committee and trust board.
- The trust was participating in the Embrace programme which was aimed at taking a whole system approach to delayed transfers of care, in the broader context of improving patient flow for over 65-year-old patients. In addition, the trust had led on the development of system wide benchmarking initiatives and worked on the high intensity users programme which had led to a reduction of over 70% in the identified cohort accessing the emergency department. There was genuine engagement with the Model Hospital which was driving a range of different conversations across the trust to reduce variations and improve. The trust had also commissioned work externally to

identify ways to discharge medically fit patients earlier by working with system partners to develop responsive pathways that pull patients out of hospital models and a shift from current the discharge acceptance model. However, considering current progress and system readiness, the trust needed to assess the benefit realisation of this piece of work.

- Patients were less likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 6.50%, emergency readmission rates were significantly below the national median as at quarter 4 2018/19.
- The 'did not attend' (DNA) rate for the trust was lower (6.45%) than the national median (6.96%) for quarter 4 2018/19 and had been stable over the previous 12 months following improvements to manage patient choice and offer more local surgical options and pre-assessments (e.g. at St Michael's Hospital). The improvement seen in the previous 12 months remained slightly short of the trust's best performance (6.23%) seen in June 2018.
- The trust management team and clinicians had been very engaged with the GIRFT programme with service managers and clinicians asking for input from the GIRFT implementation team. The national GIRFT team had carried out 18 deep dive visits at the trust in several specialties and the trust had been very proactive in organising governance over its GIRFT programme. There was evidence of improvements made from the GIRFT reviews including: patient experience for orthopaedic patients had been improved in terms of waiting times and patient pathways through the unit; and the trust was now accredited for care of veterans. The trust had engaged with the national GIRFT programme to pilot and implement new models of clinical care that were responsive to the needs of the local population, for example in developing elective surgical capacity in community hospitals.
- The trust had an excellent, in house developed, data system 'RADAR' providing good live data around services and this had supported the redesign of pathways which had been data led.

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

The trust benchmarked well on pay cost per WAU and against several people productivity metrics (retention, medical job plans) and demonstrated improvements on our prior year assessment. However, the trust's spend on agency staff had deteriorated materially due to operational pressure and difficulties to recruit substantive staff at pace. The trust's sickness rate also needed to improve.

- For 2017/18 (the latest data available) the trust had an overall pay cost per WAU of £1,933, compared with a national median of £2,180, placing it in the 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 lowest quartile for nursing cost per WAU, although a slight outlier for medical staff as it benchmarked in the second highest (worst) quartile for cost per WAU.
- The trust recognised the challenges that it faced due to workforce supply and geography and had developed a number of approaches to recruit staff such as local nursing training and the establishment of apprenticeship and vocational programmes, such as in theatres, where the trust had established a program to support unregistered staff to complete degree level training over two years, guaranteeing them (on successful completion) a role as a registered operating department practitioner.
- The trust benefited from a relatively stable and experienced medical workforce with low turnover which contributed to the higher medical cost per WAU (£557) compared to peer median (£529). The trust had sought to reduce its medical costs and address the challenges in recruiting to key roles through various measures. The trust had introduced specialist nurse roles to support demand for services and this was being reviewed by specialties, including cardiology, as a workforce model for the future. The trust was also looking to recruit associate specialists in areas where the trust experienced medical staff shortages and support their training route to become consultants and support the development of specialty doctors in the future. Associate specialists were already in place in trauma and orthopaedics and head and neck specialties.
- The trust had not met its agency spend ceiling as set by NHS Improvement in 2018/19 and was forecasting to miss its ceiling in 2019/20, having already spent its full annual budget (£13.1 million at the end of October 2019, compared to a full year plan of £12 million). As at October 2019, the trust had spent 8.4% of its total pay bill on agency staff since the beginning of the year compared to a national median of 4.3%, ranking as the 11th highest (worst) nationally. The trust had increased clinical workforce significantly in response to quality concerns raised through previous CQC inspections (119 whole time equivalent staff (WTE) during 2019/20). At the time it set out its operational and financial plan, the trust had anticipated that 50% of these vacancies could be filled substantively. However, due to delays in establishing its overseas staff supply this had not been achieved and was a key driver for the high agency usage. At 31 August 2019 the trust held 225 Band 5 nurse vacancies and had a vacancy gap against establishment levels of 11.7%. Since July 2017 when the trust was placed in special measures for quality, total staffing levels had increased by 540 FTE (10.6%).

- Whilst there had been clear actions demonstrated in delivering innovative models of training at the trust and new partnerships with academic organisations, clinical posts had been more challenging to fill than had been anticipated, and whilst bank usage had also increased with the trust investing in bank to make it more attractive to staff this had not met demand. The opportunity to develop a Cornwall system approach to bank was still to being established. The trust had however negotiated a reduction in agency cost rates through working with system partners and they were in the process of setting up a shared bank. Both long term and high cost agency staff were being actively encouraged to join the inhouse staff bank and the trust closely monitored agency spend and was taking mitigating actions to address an increasing dependency on agency workforce.
- The trust had focused on its social media profile to attract staff. There had been a recent successful overseas recruitment with 80 registered nursing staff in the pipeline and work was being undertaken to support new overseas staff to integrate well within the working environment and the local community.
- Change was being driven at all levels of the organisation through open forums, cultural reviews, move to a flatter structure (through the restructure of divisions and directorates implemented over the past year) and increased visibility and contact with staff from senior members of the executive team. This work had contributed to a 20% improvement in engagement score in the annual staff pulse survey compared to last year.
- The trust was reviewing workforce models around key skills mix required across professional boundaries. There were specialist nurse roles and registered operating practitioner as mentioned above as well as surgical care practitioners in general surgery and cancer who supported medical consultants with patient management. The trust had also opened their approach to clinical leadership across the organisation following the management restructure and had reinforced the triumvirate approach with clinical leadership roles now available to medical, nursing and allied health professionals, with a ward manager on the trauma ward coming from an allied healthcare professional background.
- E-rostering was established, and rosters were available on average 6 weeks in advance. The central roster system was being managed at a senior level in recognition of the need to reduce agency spend. The trust pro-actively balanced annual leave and training time while ensuring safe staffing and used key metrics to manage this uniformly across the trust.
- At the time of the assessment, the trust reported that 96% of medical job plans were in place and finalised with actions for the completion of the outstanding plans underway. Ratification meetings had been held with every care group and a report prepared by the job planning team with overall accountability with the trust medical director. The trust had achieved a significant improvement on the prior year (when around 60% of staff only had a job plan) through strong care group ownership, pathway redesign work and a clear escalation process where job plans could not be agreed.
- Staff retention at the trust was good, with a retention rate of 87.9% in quarter 4 2018/19 against a national median of 85.6% and we noted that the trust's staff turnover had decreased from 10.5% in July 2018 to 8.9% in August 2019. During our assessment, the trust described how staff were proactively identified and supported to access internal opportunities for different roles and development opportunities.
- At 4.15% to June 2019, staff sickness rates were worse than the national average of 3.96%. The trust had implemented a staff wellbeing programme at the beginning of 2019/20, however this had not yet had an impact on staff sickness levels.

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 both in terms of costs (based on 2018/19 data) and value of the services. The trust was part of a pathology network and demonstrated evidence of working across networks to deliver its services. The trust also made good use of technology to improve its services via innovations. At the time of the assessment, the trust was also on track to deliver £2.5 million savings in 2019/20 across its clinical support services.

- The trust's pharmacy service was an exemplar service, although, we noted the trust's medicines cost per WAU for 2018/19 was relatively high compared nationally but this was due to the trust's wholesaling activity and the provision of medicines to community localities.
- Following a joint bid and an upgrade of equipment, the trust was ready to deploy its EPMA (electronic prescribing and medicines administration) including at a nearby trust demonstrating it had robust medicines controls and was using technology in an innovative way to maximise productivity opportunities. This also reflected a long-term aim to link medicines policies across providers within the sustainable transformation partnership (STP). The trust demonstrated good e-commerce medicines ordering and stockholding, benchmarking better than the national median. The trust used Scan4safety which had allowed the safe dispensary of medicines by lower banded staff (Band 3 rather than Band 5) via automation.

- The level of medicines reconciliation at the trust was at 64% compared to the national median at 74% although this was due to the difference in the system used to capture the information. During our assessment, the trust reported an actual achievement of 89% for all patients and the trust continued to investigate the reconciliation data to ensure it was accurate. The trust was investing in the pharmacy services supporting the emergency department to improve the achievement of the A&E standard.
- The trust's hospital pharmacy transformation plan was exemplar. The trust had completed 16 of the 28 objectives of the plan and transferred its strategic oversight to the Integrated Care System (ICS) to recognise the need to develop clinical services and meet the productivity priorities identified nationally by Lord Carter.
- The trust was making good progress against the medicines cost savings identified nationally and had delivered 139% of its Top 10 Medicines savings target in 2017/18 with further savings of £1.94 million delivered in 2018/19. The trust reported good patient engagement in switching to biosimilar drugs and were looking to switch Infliximab to generate further cost reductions.
- The trust's consumption of antibiotics was excellent with an antibiotic consumption in defined daily dose (DDD) per 1000 admissions significantly lower than the national median. It was further noted that the readmission rate for transfer of care had reduced from 15% to 8% for those patients who had community pharmacy involvement.
- All the pathology clinical service metrics were in the best or second to best quartiles, suggesting an efficient service. The overall cost per test at £1.39 for 2018/19 benchmarked well in the best quartile compared to the national median of £1.86. This resulted from the retender of the trust's managed service contract, a service skill mix review which had improved turnaround times by 50% and the delivery of significant savings through automation. The trust was working with general practitioners to improve controls, reduce plastics and improve data quality through automation with the Indexor programme, with the trust being one of the first sites to implement this system in the United-Kingdom.
- The trust was part of the South 1 pathology network with the strategic outline case for the network having been completed during the year prior to our assessment. The trust had worked to network the low volume specialist work. The longer-term plan focused on clinical effectiveness, repatriation, and the reduction in the number of sites where specialists testing performed would be a key part of the network's and full business case. The trust's laboratory had also just commenced a major refurbishment and automation programme that would drive further efficiencies.
- The trust worked collaboratively with other acute trusts across Devon as part of the Peninsula PACS (picture archiving and communication system) and CRIS (clinical radiology information system) consortium which enabled image sharing between sites. The consortium had run for three years a peninsula wide radiology on-call reporting network which had allowed shared learning. The trust continued to work across the county to deliver improvements to support urgent treatment centres and the emerging clinical assessment units.
- The trust's DNA rates for imaging services benchmarked worse than the national medians as at March 2019 and the trust now contacted patients ahead of their appointment to ensure their attendance or rebook. The trust had experienced gaps in its radiologist establishment but had managed to maintain capacity and had recently successfully recruited to six posts. The trust had aging assets and had an equipment replacement programme in place for assets aged ten years. The trust's imaging service had delivered £0.150 million savings in 2018/19 against a target of £0.093 million.
- The trust was progressing several innovative digital initiatives. The outpatient transformation programme covered 7 key projects which included video consultation across several specialties, and for Isles of Scilly patients and patient-initiated follow-up. The trust used a paediatric admissions whiteboard system (PAWS) providing an overview of patients throughout the service with triage scores to prioritise them. The trust had evidenced through a patient survey that this had improved patient experience.

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

The trust ran efficient finance, human resources and procurement functions and had several shared roles and services with other local providers and the trust continued to look for opportunities to develop shared services. The trust did not benchmark favourably on aspects of its information management and technology (IM&T) function showing this is an area for improvement. The trust had an aging estate with high backlog maintenance although it was well-run by the estate team who continued to seek opportunities to improve the hard and soft facilities management both in terms of costs and value of services.

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,414 compared with a national median of £1,307 placing the trust in the second highest (worst) quartile nationally. This represented a deterioration on the previous year although reflecting the impact of £9 million of outsourced hotel costs which if provided in-house would have been shown as pay and within the context of the trust's overall cost per WAU benchmarking in the best quartile nationally. If adjusted, the non-pay cost per WAU would have been £1,340, slightly higher than the national median.
- The trust ran an efficient finance function with a cost per £100 million turnover of £0.604 million compared to the national median of £0.704 million for 2018/19 with the trust benchmarking generally well on the cost of sub-functions. The trust had however invested recently in its finance team to align with and better support its new divisional structure. A recent survey had showed that the finance team was considered well engaged and integrated across the trust. We also noted that over 10% of payments were made with no human intervention and that the trust had a notable inventory management process.
- The cost of the trust's human resources (HR) function (£1.088 million per £100 million turnover) benchmarked in the second lowest (best) quartile nationally. The trust benchmarked favourably against several metrics although the cost of the recruitment function had increased from £0.174 million to £0.245 million and benchmarked in the highest (worst) quartile nationally with the national median at £0.109 million.. The trust had a slightly higher than median number of employee relations cases per 1,000 headcounts of 17.5 compared to a national median of 14.1. However, cases were closed promptly, on average within 6.2 weeks, which was in line with national lower (best) quartile performance.
- The trust shared several services with local partners including a joint finance director, joint chief information officer, jointly managed IT services, joint procurement services, shared occupational health services and co-located payroll services. The trust had a programme of work looking at further opportunities to consolidate or outsource its services. A the time of the assessment, the trust was considering sharing legal services and was starting a consultation and engagement process with staff. The trust hoped to learn from this exercise to inform further consolidation of its corporate services.
- The trust delivered an in-house information management and technology (IM&T) service and hosted this service for a nearby community trust. The cost of the IM&T function per £100 million turnover had reduced from £3.388 million to £2.993 million but still benchmarked above the national median of £2.521 million placing the trust in the second highest (worst) quartile nationally. Several sub-functions were significant outliers: applications purchase management, paper medical records, end user devices, data centre hosting and clinical coding. The trust acknowledged this position and planned to deliver around £1 million savings in 2020/21 once it would have implemented the e-Notes (digitisation of patient notes) project. Since our last visit, the trust had developed its digital strategy describing both the trust's digital aspirations and national requirements and the changes it needed to make to get there.
- The trust's procurement processes were efficient, and the trust performed well across price performance as reflected in the trust's position on the national procurement league table, where the trust ranked 40 out of 136 trusts. The cost of the procurement function per £100 million turnover was £0.204 million and benchmarked below the national median of £0.208 million and peer median of £0.211 million. The procurement function made good use of benchmarking services despite a low use of the purchase price index and benchmarking tool (PPIB). The trust had achieved level 1 of the NHS procurement standards in July 2018 and continued to engage with NHS England & NHS Improvement to prepare for its level 2 accreditation. The trust's percentage of non-pay spend on purchase order benchmarked in the worst quartile nationally and the trust was working with its estates department to address issues with its MiCAD property management software and focussing on the top 10 areas of high value spend.
- The trust was one of six country-wide reference sites for the Scan4Safety programme and the procurement function was leading automated inventory management system as part of this programme. This meant the trust was able to scan a product at the point of care and automatically re-order, receive and pay for it without human intervention. The trust's chief procurement officer was a member of the national benchmarking and analytics working group and members of the trust's procurement and finance teams also contributed to the on-going development of the NHSI spend comparison tool.
- The estates costs at £331 per square metre in 2017/18 benchmarked slightly below the national median of £342. The trust's estates team were delivering a well-run estate with challenges relating to the age of buildings and the location of services that impacted many of the metrics. In particular, the trust's backlog maintenance for 2017/18 was £446 per square metre, had increased from £415 per square meter in 2016/17 and compared to a national median of £254 per square meter and peer median of £182 per square meter. The trust had produced an estate optimisation plan and a strategic outline business case which had been approved resulting in the trust obtaining £11 million of capital funding within the STP to improve facilities at its under-used estate at West Cornwall and St Michael's hospitals. This

would allow the trust to maximise value from its estate and dispose of the parts no longer required to deliver clinical services thereby reducing estate running costs by around £0.8 million per annum and avoiding £9 million of backlog maintenance. The trust's total backlog maintenance liability was estimated at £32 million with several buildings beyond their economic life and no longer functionally suitable.

- The latest Model Hospital data showed £1.98 million of productivity opportunities in hard facilities management areas such as energy and sewage and £0.235 million in soft facilities management opportunities in areas such as inpatient food and laundry. Part of the trust's soft FM services were outsourced and at the time of the assessment the trust was transferring some of these services back in house (catering and cleaning). The trust's patient led assessment score for food at 84.9% had slightly improved from prior year but was below the national benchmark of 90.4%. The trust was leading on a new patient food improvement initiative, bringing back in-house catering from their current contractor to develop a Cornwall food production unit to improve food standards and nutrition for patients.
- The director of estates for the trust was part of a Devon STP benchmarking group which looked at opportunities to reduce estates and facilities costs across the STP.

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

The trust had a total cost per WAU of £3,347 for 2017/18 which benchmarked in the best quartile nationally and had improved on the prior year. The trust's financial deficit position (excluding central funding) was set to improve in 2019/20 although with financial risks still to mitigate. The trust's efficiency plans relied on significant non-recurring items, a reflection on the low overall cost per WAU, and the trust had started to engage with its local health system over complex transformational programmes expected to deliver future productivity gains. The trust had progressed with the development of patient level costing and engagement with its clinical divisions over productivity improvement.

- In 2018/19, the trust had delivered a £19.7 million deficit (excluding provider sustainability funding (PSF); £3.7 million deficit including PSF) which represented 4.6% of its turnover and was £1 million better than its control total agreed with NHS Improvement. The 2018/19 financial position however, represented a deterioration on 2017/18, when the trust delivered a deficit of £9.9 million excluding transformation and sustainability funding (STF). This reflected operational pressures experienced during the year particularly regarding the staffing of the emergency department, the medical assessment unit and the additional capacity in orthopaedic at St Michael's Hospital.
- For 2019/20, the trust had a plan to deliver a £17.3 million deficit excluding central funding (e.g. PSF) - a breakeven position including central funding -, which represented 4.1% of its turnover. This was in line with its control total and would improve on its prior year position. As at the end of October 2019, the trust's financial position was slightly behind plan (£0.5 million) and the trust continued to forecast achievement of its plan although it still needed to mitigate up to £4 million of financial risks.
- The trust had delivered £11.6 million cost improvement during 2018/19, 96% of its plan and 2.5% of expenditure but only 31% (£3.6 million) delivered recurrently. For 2019/20, the trust had set a £14 million cost improvement plan (CIP) (2.99% of expenditure) with £8 million expected to be delivered recurrently (59%). As at October 2019, the trust was slightly behind its year-to-date plan (£0.1 million) although it also reported a shortfall of £2.3 million in identified schemes and had reduced the level of expected recurrent savings to 33%.
- The trust planned to reduce its underlying financial deficit to £25.7 million in 2019/20 despite a shortfall in recurrent savings. Savings shortfalls were mainly in nursing workforce, new care models, specialised commissioning, compensated mainly by savings AHPs and other workforce and estates and facilities. The trust had intensified its monitoring and management of saving schemes with its clinical divisions. With its overall cost per WAU benchmarking in the best quartile nationally, the trust acknowledged it needed to shift its focus from savings at divisional level to delivering efficiencies through larger and more complex transformational programmes particularly at system level (through, for example, changes to service models) which required time to plan, implement and deliver benefits. Care groups and corporate functions were challenged to think differently and focus on reducing waste, increasing efficiencies and reducing premium costs with the support of the QI Hub to ensure that plans were robust and went through a quality impact assessment. The system had started to work on identifying common issues and opportunities (e.g. the Embrace programme) although further work was required at system level which would benefit the trust's productivity and financial position.
- The trust had made significant efforts during the year to develop and use patient level costing (PLICS). The data available from the Model Hospital, GIRFT and PLICS were now combined to inform and support care groups' decision making. The trust's finance team also ran briefing sessions with care groups to better understand their contractual position and the impact of their decisions on activity and income. The trust had set up in January 2019 a costing

steering group which aimed to increase the knowledge, accuracy and awareness of costing information throughout the trust to empower staff to better understand their service and to improve patient care. The trust, was also working with partners in the local health system to develop benchmarking across the local health system with a view to improve services and deliver efficiencies

- The trust had a block contract with its main commissioners representing 69% of its patient income in 2019/20 which was part of the local health system single financial framework and allowed improved management of financial risks across the system. The trust was also ahead of plan, as at October 2019, with NHS England specialised commissioning, therefore earning more income than planned. The trust was looking at opportunities to maximise its commercial income particularly with regards to private patients and research & development opportunities. It had also taken steps to improve the financial position of its food production unit to support NHS services.
- The trust had a debt service cover rating of 3 (4 being the worst) for 2018/19 which was expected to improve to a 1 (best) by the end of 2019/20. The trust had accumulated £62.9 million debt as end of March 2019 of which £55.2 million related to revenue loans from the Department of Health and Social Care (DHSC). This was the result of past and current deficits. At the time of the assessment, the trust forecasted it would not require further revenue support loan in 2019/20 as a result of its planned breakeven position (including central funding). The trust however anticipated to receive £4.8 million from the DHSC to fund emergency capital schemes during 2019/20.
- The trust had a liquidity rating of 4 (worst) for 2018/19 and 2019/20 although at the time of the assessment, the trust had £13.6 million cash (higher than plan) due to the higher than plan PSF received in 2018/19 and more favourable working capital movements in 2019/20. The trust had achieved the best payment practice code target of 95% of creditors paid within 30 days in terms of the number of invoices paid but was slightly below in terms of value (90%).
- The trust used management consultancy services on an ad hoc basis when support was required. Although it had spent £0.366 million in 2018/19, it looked to spend around £0.200 million in 2019/20, a level similar to 2017/18.

Outstanding practice

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

- The trust is a pilot for the Scan4Safety national programme and has released more clinical time to patient care by reducing administrative processes, improving stock visibility and reducing wastage.
- The trust's pharmacy services continue to be an exemplar service, benchmarking well on several metrics demonstrated an efficient and well-run service
- The trust and its systems partners are engaged in a system benchmarking initiative to identify areas for improvement.
- The trust has an excellent, in house developed, data system 'RADAR' providing good live data around services and this has supported the data led redesign of pathways.

Areas for improvement

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

- The trust's delayed transfers of care were high with no material improvement over the last 12 months. The trust needed to continue to engage with its system partners to drive a reduction in delayed transfers of care.
- The trust spends a high proportion of its pay cost on agency staff and has not be able to reduce its reliance on temporary workforce. The trust must continue to work, including with system partners, to reduce agency spend. This includes implementing a shared bank at system level.
- The trust has achieved and planned a low level of recurrent cost savings. The trust must continue to identify recurrent savings, by working with its system partners to identify and deliver more complex and system-wide transformation programmes.
- The trust ran an aged estate with a high level of backlog maintenance. The trust should ensure that it continues to optimise the use of its estates and reduce backlog maintenance.
- The trust has commissioned external work to identify ways to discharge medically fit patients earlier. The trust should assess the benefit realisation of this work to ensure it provides agreed benefits.
- The trust has a higher than national median sickness rate. The trust should continue to work on reducing staff sickness.

- The trust experiences high ‘did not attend’ rate for imaging services. The trust should continue its effort to bring this rate in line with the national median.
- The trust is an outlier on several IM&T sub-functions and should look to bring these services in line with the national median.

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

Trust level

Safe	Effective	Caring	Responsive	Well-led	Use of Resources
Requires improvement ➔➔ Dec 2019	Good ↑ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ↑↑ Dec 2019	Good ➔➔ Dec 2019

Overall quality

Requires i

Dec 2019

Combined quality and use of resources

Requires improvement ➔➔ Dec 2019

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.