University Hospitals Plymouth NHS Trust

Use of Resources assessment report

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Date of publication: 18/12/2019

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

Ratings

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

Are resources used productively?	Requires improvement

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 England and 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 England and 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 England and 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 requires improvement.

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

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

Proposed rating for this trust?	Requires improvement

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS England and 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 24 July 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.

Findings

Requires improvement

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

We rated Use of Resources as requires improvement. The trust had made some progress since our last assessment and continued to display several outstanding areas of practice. However, the actions taken by the trust to improve its productivity during the year and resolve, within its sustainability and transformation partnership (STP), some of the pressures it experienced externally had not resulted in a material improvement of the trust's operational performance and the trust's financial position had deteriorated.

- This was the second time we assessed the trust's use of resources. During our last assessment, in May 2018, we highlighted several areas where the trust could improve. We found that since the trust had reduced its rate of emergency re-admission to below the national median; the trust had progressed with the delivery of several productivity programmes (theatres, outpatients) which had resulted in productivity improvements; and the trust had a better understanding of the drivers of its high pre-procedure elective and non-elective bed days.
- However, we noted that the trust's operational performance continued to be poor for all constitutional standards and had deteriorated for the 4-hour accident & emergency, 18-weeks referral to treatment and cancer 62-day wait standards. The trust had also not made significant progress in reducing its medical cost per weighted activity unit (WAU).
- At the time of the current assessment (July 2019), the trust had improved its overall cost per WAU for 2017/18 and benchmarked marginally above the national median, in the second highest (worst) quartile nationally.
- The trust benchmarked well on several clinical services productivity metrics such as delayed transfers of care, 'did not attend' (DNA) rate and gave evidence of productivity improvements from its theatre and outpatients programmes. The trust also continued to be an exemplar in the way it engaged with the Getting It Right First Time (GIRFT) national programme with good evidence of productivity improvements and savings resulting from its work.
- The trust's overall staff pay cost per WAU benchmarked well compared to the national median reflecting good practice relating to rostering, use of innovative skills mix and one of the lowest rates of agency usage nationally. The trust's retention rate had also continued to improve and was better than the national median and the trust had improved its sickness rate on prior year to below the national median.
- The trust benchmarked well on pathology services and was part of a leading regional network and despite a high cost of medicines per WAU, this was driven by the trust's specialist activity and the trust had delivered a significant level of savings against the top ten medicines.
- The trust had a high non-pay cost per WAU driven by the cost of outsourced services. The trust benchmarked well overall on corporate services with a procurement service seen as a national exemplar and examples of savings achieved on facilities management through repatriation of services in house.
- The trust demonstrated robust processes and engagement with GIRFT and Model Hospital data which supported the identification of efficiency savings and the trust had service line reporting which was discussed with clinical divisions. Although the trust had low cash balances, it had robust processes in place which allowed it to continue to pay creditors promptly.
- The trust was also progressing with the development of a continuous improvement programme 'People First' based on 'lean' methodologies to complement the work it had already done on quality improvement which would help deliver further productivity improvements.
- However, we also found areas where the trust had not progressed materially or had deteriorated during the year:
  - The trust's operational performance for the 4-hour accident & emergency, 18-weeks referral to treatment and cancer 62-day wait standards had deteriorated during the year and its performance against the four constitutional standards benchmarked materially lower than peer and national performance.

- The trust had a higher than national average rate of standardised admissions, showing that the trust admitted more patients than nationally. However, some of the evidence presented at the time of the assessment indicated that this could be driven by factors internal to the trust which could be improved on rather than purely external factors.
- The trust had progressed work with its local health partners around the recognition of inequitable funding for Western Devon and to consolidate sub-scale specialist services where possible to help improve the trust's material underlying financial deficit. However, at the time of the assessment, work was still in progress and it was not clear to what extent and when this would materially benefit the trust's financial position.
- The trust's financial position had deteriorated during the year and the trust had not met its control total. Although the trust had achieved a reasonable level of savings, a significant part continued to be non-recurrent and it included local financial support income. The 2019/20 cost improvement plan (CIP) also included material gaps.
- The trust continued to have a very high medical cost per WAU (second worst nationally).

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 on several clinical services metrics. Although it was not delivering the constitutional access standards at the time of our assessment, readmission rates were relatively low, and progress had been made in reducing the Did Not Attend (DNA) rate. The trust had continued its strong record of engaging with the Getting it Right First Time (GIRFT) national programme to improve clinical productivity. We also noted good progress in certain metrics e.g. delayed transfers of care (DTOC) and stranded/super stranded patients.

- At the time of the assessment, based on the latest data available (April 2019), the trust was not meeting the constitutional access standards for 4-hour Accident & Emergency (A&E) (72.83%), 18-week referral to treatment target (RTT) (76.41%), cancer 62-day wait (72.58%) and diagnostic 6-week wait (91.88%).
- The trust's performance against the A&E standard had been low for a long period. It had not delivered the 95% standard in any individual month since March 2014 and during 2018/19 and at the time of the assessment, the trust's performance was below the national and peer medians and had not shown an improvement on prior year's performance. The trust cited emergency/non-elective activity growth and a requirement for more medical and nursing staff in the emergency department as the key factors impacting its performance. Other contributing factors included a significant vacancy factor for GPs locally and insufficient discharge processes from acute wards. At the time of the assessment, the trust was receiving support from NHS Improvement's emergency care intensive support team to improve its discharge processes.
- At the time of our previous assessment, the trust was not meeting the RTT, cancer and diagnostics standards and this continued to be the case at the time of the current assessment. Except for diagnostics, performance had deteriorated between both years despite actions taken by the trust to deliver improvements. Regarding the RTT standard, the trust had seen a growth in referrals which had increased its waiting list over its agreed recovery trajectory despite the trust increasing its outpatient and inpatient capacity to address this. The trust had also invested in additional mobile MRI scanning, echography and endoscopy capacity to address some of the diagnostic waits.
- The trust's performance for readmissions within 30 days had improved from the second highest (worst) quartile (7.83%) to the second lowest (best) quartile (7.19%) at the end of 2018/19 and benchmarked better than the national median of 7.73%. The trust was doing further work to improve the emergency readmission rate. Readmissions were reported monthly to service lines and the trust had identified issues with the way admissions were recorded by the children's assessment unit and this was being addressed. The trust had planned to implement an 'alert' tool to inform clinicians of patients readmitted or attending the emergency department who were previously admitted under their care within 60 days.
- The trust benchmarked in the worst national quartile for elective pre-procedure bed days at 0.25 compared to a national median of 0.12 (quarter 2 2019/20). The trust had identified that recording anomalies relating to two specific services drove this position (cardiac & thoracic surgery and haematology). For example, many patients were admitted for pre-procedure checks on the day before surgery and were then discharged to a local charitable facility to spend the night close to the hospital and this had wrongly been recorded as pre-procedure elective admissions.

- Non-elective pre-procedure bed days, at 0.89 at quarter 2 2019/20 were higher than the national benchmark of 0.62 days. Since our prior year's assessment, the trust had identified that data quality was an issue where the date of the first procedure was not being recorded accurately by the clinical coding team. The expectation was that records would be monitored and corrected from June 2019 onwards and the latest data in the Model Hospital reflected a marked improvement although the trust remained in the worst quartile nationally at the time of the assessment.
- Working with its local health partners, the trust had improved its level of DTOCs with 8.1% in April 2017 reducing to 5.4% in March 2018 and reducing further to 2.9% at March 2019 compared to a national target of 3.5% and a national median of 3.4%. The trust had a dedicated integrated post with a local community interest company that ran community services in Plymouth. The trust had also worked on the '8 high impact' changes which included early discharge planning, patient flow monitoring, home first, seven-day services and enhanced care in care homes.
- The trust had established an improvement and productivity focused trust management executive meeting to drive several work programmes designed to improve productivity and act on the recommendations from the prior use of resources assessment. The four main workstreams focused on improving productivity in theatres, outpatients, urgent care and medical workforce as well as a focus on GIRFT improvement plans.
- The theatres programme, 'Operation PERSIST', had improved theatre productivity by 3%, with specific improvements made in two theatres. There had also been a significant improvement to pre-assessment processes with the number of patients processed a week improving by 25%.
- The outpatients programme had improved utilisation of appointment slots from 80% of appointments booked and 73% appointments attended when the programme started in December 2017 to 90.7% and 85% respectively in April 2019. This had been achieved by reducing patient non-attendance (through telephone and text reminders) and improving booking processes to reduce numbers of unused slots, as well as ensuring that outpatient clinics were set up to mirror consultant job plans and were run as efficiently as possible.
- The trust's outpatient DNA rate which was already in the best quartile in 2017/18 had improved further in 2018/19, from 5.76% to 5.32% and continued to benchmark in the lowest (best) quartile in 2018/19, compared to a national median of 6.96%.
- The trust's engagement with the GIRFT national programme continued to be excellent with the medical director overseeing the programme and a designated trust GIRFT lead who ensured structure, grip and traction with delivery of improvements. Clinicians appeared to appreciate the value of the GIRFT programme and were engaged with the programme with attendance at the GIRFT deep dives into specialties and subsequent follow 'touchpoint' meetings with the medical director. During our assessment, it was apparent that the data and findings of the GIRFT programme were used by the trust internally to drive local improvements.
- The trust had established a GIRFT programme board to provide an overarching governance structure for the trust wide response to GIRFT, giving guidance, and ensuring accountability in meeting the national programme objective of seeking to optimise improvement to clinical quality and outcomes. The trust's governance framework had been acknowledged as an exemplar within the national GIRFT programme. The trust had been chosen to be a pilot site for a GIRFT 'hot and cold' orthopaedic programme with an independent provider. The trust could demonstrate clear benefits from embedding GIRFT with evidence of improved quality and access leading to financial benefits. As an example, the review of the litigation pack for a 5-year period (2013/14 to 2017/18) showed two thirds of the medical and surgical specialities in scope (32 specialties) were below the national average for the cost per claim per activity. However, the positive movement between reports with obstetrics was noted, moving from a quartile 3 (red), to a quartile 1 (green – being the lowest (best) quartile).
- During our assessment, it was clear that the trust was taking numerous actions to improve its productivity and despite areas of good productivity (as set out above) and improvements on the prior year, the trust continued to perform below the four national constitutional standards, in particular with performance on A&E consistently below the national and peer median. We discussed with the trust to what extent its ability to be productive was disproportionately influenced by issues outside their immediate control which the trust considered.
- The trust's standardised rate of emergency patients admitted (SAR) (which estimates the admission rates relative to the national pattern of admissions and considers differences in population's age, sex and socioeconomic deprivation) was higher than the England average. This meant more patients were being admitted in the hospital than expected for the population's characteristics and although conversion rates from attendance to admission had remained consistent over the years, this conversion rate was 5% above the national average at the time of the assessment.
- The local health system had commissioned an external review of emergency demand which, however, had failed to attribute the activity growth to a single cause. There were, however, elements that had emerged as partially

responsible, mainly a higher elderly population in the Devon area, low GP provision and increased acuity for patients presenting to A&E. The review however had also concluded that a patient's chances of being admitted from A&E at the trust appeared to be determined by arrival time rather than the number of attendances. This pointed towards internal issues with admission thresholds at the trust which the trust needed to consider.

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

The trust benchmarked well on several areas of workforce productivity. The trust's overall staff costs were in the second lowest (best) quartile nationally and the trust had continued to reduce its use of agency staff during the year. The trust had a good retention rate, deployed its nursing staff in an efficient way and had implemented innovative roles to address staff gaps. However, the trust's medical costs were the second worst nationally with the trust having in place a medically led workforce model. Although the trust was containing its sickness rate, this was an area the trust could further improve.

- The trust's overall pay cost per weighted activity unit (WAU) at £2,094 for 2017/18 benchmarked favourably compared to the national median of £2,180 placing the trust in the second lowest (best) quartile nationally. The trust's low overall staff cost was driven by nursing, corporate and non-substantive staff costs per WAU benchmarking in the best quartile nationally and low allied health professional (AHPs) costs per WAU benchmarking in the second-best national quartile.
- The trust attributed its low nursing staff cost per WAU to actions taken to deploy nurses efficiently based on patient acuity and supported by the trust having pioneered an award-winning safer staffing rostering software (Allocate) which the trust found had been a good return on investment.
- The trust's most significant challenge regarding staff costs remained the medical staff cost per WAU which at £672 compared to the national median of £533, was the second worst in England and had showed little improvement on our prior assessment. Although a significant amount of work had been undertaken to review job plans and improve 'housekeeping', the trust recognised the limited progress made to increase the direct clinical care professional activities in medical job plans from 71.5% towards the peer median (76.3%) and further ambition towards 80%. The trust had also seen a reduction in clinical activity with financial consequences as a result of the pension tax rules which had negatively impacted several clinicians leading them to reduce their activity. The trust also highlighted that the medical cost per WAU could be adversely impacted by the relatively high number of sessions delivered by military personnel at the trust. The trust, however, had continued to improve medical productivity through its programmes of work on theatres, outpatients and urgent care.
- The level of activity in each direct clinical care (DCC) activity was discussed, noting the potential impact of non-elective (emergency) pressure on theatre productivity and the relatively low level of elective activity then recovered through Waiting List Initiatives.
- Although we acknowledged the actions taken by the trust and some of the progress made with medical staff productivity, it remained unclear, at the time of the assessment, when these actions and improvements would reduce the medical staff cost per WAU. The pressure of the emergency department workload had led to an increased number of consultants across wards. Whereas other trusts could use registrars to perform some of the medical work, the trust, being a specialist centre, required a higher level of consultants. It was, however, noted that the trust had chosen a care model which required more senior decision makers and as the trust did not have junior doctors, this could lead to consultants working down their grade. We discussed with the trust the need to consider a different workforce model to reduce its medical costs.
- The trust had a retention rate of 88.5% at the end of December 2018, which was better than the national median of 85.6% and benchmarked in the highest (best) quartile nationally. This continued a trend of improvement over the previous three years, supported by wider staff engagement activities and development of specific retention plans.
- As at November 2018, the trust's sickness rate was 4.72% compared to a national median of 4.35% placing the trust in the second highest (worse) quartile nationally. The trust however, provided us with updated data at April 2019, showing it had improved its position to 4.41% in April 2019, slightly higher than at April 2018, when the trust's sickness rate was 4.25%. The trust had taken a number of actions to improve sickness rates including a health & wellbeing action plan with specific focus on stress related absences and a range of additional support measures for staff including access to an employee assistance programme which had been launched in April 2019 and was available to staff 24 hours a day, 7 days a week.
- The trust had further reduced its agency spend over the previous 12 months when the trust benchmarked in the best quartile nationally for 2017/18. The trust had spent £5.6m on agency staff in 2018/19 against the NHS Improvement ceiling of £8.2m, a reduction of £2.4m from the previous year. The trust's spend during 2018/19 represented 1.77% of its staff pay cost compared to a national median of 5.01% and placed the trust as the 8th lowest (best) nationally. The trust

had established an agency board to identify, implement and monitor actions to reduce spend. The trust had received excellent feedback from a visit of NHS Improvement's temporary staffing support team indicating the trust displayed best practice in several areas particularly its relationships with temporary staffing agencies and NHS Professionals, the trust's staff bank and its use of smart data. All agency spend at the trust was also framework compliant.

- The trust also resorted to international recruitment to fill in positions with a new intake of foreign staff coming in later in 2019/20 and into the following year with a further 134 posts expected to be filled in through international recruitment in 2020/21.
- The trust had a high level of nursing vacancies although most of these were backfilled with bank staff and the trust was able to fill 85% of its shifts. The trust deployed its nurses according to the acuity of patients in a responsive way which meant it did not follow a fixed ratio between qualified and unqualified nurses. The trust reviewed its staff in line with patients' acuity twice every day.
- The trust had strong links with the University of Plymouth and the Peninsula Medical School. It was noted that the trust would welcome 140 preceptees (potential nurses and midwives) in 2019/10, mainly from the University.
- The trust was one of 12 flexible working pilot sites approved by the Department of Health and Social Care (DHSC). During the year, the trust had implemented a new medical locum bank system which had improved the booking process. The trust had also introduced successful AHP roles in critical care and cardiac surgery to mitigate reductions in medical staff and was looking to expand these roles in 2019/20.
- The trust had an updated people strategy approved at its Board in February 2017 which described the trust's aspirations around three strategic focus areas:
  - Building a sustainable workforce,
  - Creating a great place to work, and
  - Developing and sustaining a culture of continuous improvement.
- The trust had an extensive programme of work in place to support the creation of a healthy culture based on, openness and transparency, and appreciation of excellence which was set out in its leadership approach agreed by its board of directors in November 2018. The trust also had a 'People First' programme which focused on the driver for its continuous improvement. Together these had delivered improved staff engagement and staff survey results year on year despite the pressure on non-elective activity and staffing.

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

The trust benchmarked well for pathology costs and benchmarked high for medicines cost. However, a higher cost for medicine was expected from a trust with high levels of specialist activity. The trust was using technology to improve access and productivity across the hospital.

- The trust had a low overall cost per test for pathology for 2017/18 at £1.64 (second lowest (best) quartile), reduced from £2.14 in 2016/17 and against a national median of £1.86. During 2017/18 the trust had gone live with a managed equipment service (MES) that had supported the reduction in costs.
- The trust had a low number of total tests per capita compared to national median (22.1 compared to 22.5), however this had increased from 2016/17 where the trust was at 17.3. The trust had worked with GPs across the region to make it easier for them to make referrals leading to the increase in the number of tests.
- The trust was part of the Peninsula Pathology network (South 1), whose Board had been established in December 2017 and was chaired by the Chief Executive of the trust. The network was one of the leading networks in the south of England and was leading the way with service redesign. The sustainability and transformation partnership (STP) had also approved funding for a region-wide digital histopathology solution with a draft business case due by the end of quarter 2 2019/20.
- The trust was leading the South West Peninsula Radiology Network (one of four national NHS Improvement pilots). As part of this, the trust had developed home working (for reporting) and seen a 25% increase in productivity in neuroradiology and was at the time of the assessment rolling this out to other areas.
- The trust had a high imaging cost per report at £66.30 for 2017/18 compared to the national median of £51.67. The trust had to use a considerable amount of high cost outsourcing in order to increase capacity in the short term. The 2017/18 data collection had highlighted a significant amount of imaging equipment was past its recommended age guidelines. However, the trust did not recognise this position and had most of its equipment within the recommended guidelines. The trust was working with the NHS England and NHS Improvement imaging team to improve the data collection for 2018/19.

- The trust's use of radiographers to report was low for % plain X-ray reports compared with the national median (1.2% compared to 22.9% for 2017/18). The trust had several radiographers in training which would give some scope to increase capacity and to improve productivity.
- The trust's pharmacy staff and medicines cost per WAU for the 12 months to September 2019 was high when compared nationally at £519 cost per WAU compared with the national median of £408 but was lower than the peer median of £531. The trust reported that it had a high volume of high cost drugs, which were pass through costs to commissioners, were at comparable levels to trusts with a high level of specialist activity and benchmarked favourably against peers with a cost per WAU of £417. We noted that of the £57.2 million medicines spend in 2017/18, 3.5% (£2 million) were for drugs not consumed by the trust and were offset by income from external organisations. The trust performed very well against the 'Top Ten Medicines' with savings of £3.08 million in 2017/18 against a target of £2.32 million (133% of target). The trust had continued to perform strongly in 2018/19, delivering an additional £2.46 million savings against the 'Top Ten' medicines.". This had been driven by the medicines utilisation committee with the use of biosimilars. There was limited additional benchmarking data available as the trust did not participate in NHS benchmarking, however, discussions with the trust highlighted there may have been opportunities to collaborate within the STP to make additional savings and the trust was working on exploring these. The trust however had not materially progressed with this due to safety issues which had been their focus to resolved.
- The trust was using technology to improve access to the hospital services and had introduced telephone clinics for patients where appropriate with 9.1% of all follow ups in 2018/19 performed via telephone. Virtual clinics were being used in ophthalmology and, in addition, the trust had been running a pilot Skype clinic where ear, nose and throat clinicians worked with a local GP practice group to discuss pre-arranged patients with the aim of maximising care in a GP setting. The trust reported that early indications from this work suggested referrals to secondary care could be reduced by 12%. At the time of the assessment, the trust was working on a project to implement e-communications with patients which would enable patients to log into a web portal and manage their care remotely.

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

The trust had a high overall non-pay cost per WAU mainly due to high levels of outsourcing and ranked 5th best out of 136 trusts in the procurement league table published by NHS England and NHS Improvement. The trust also benchmarked well for its corporate services and was deemed to be running an aging estate efficiently.

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,408 (second highest (worst) quartile) compared to the national median of £1,301. However, this was an improved position from 2016/17 when the trust was in the worst quartile nationally and a high non-pay cost per WAU was expected with the high level of outsourced activity at the trust.
- The trust's supplies and services costs per WAU were £506 (highest (worst) quartile) against the national median of £364 and peer median of £446. Drivers for this performance (from the trust's non-pay deep dive) were pay elements within contracted services (circa £9.0 million, with pay assumed to be 60% of a £15.0 million contract) that if excluded from the cost per WAU would take the trust to a lower quartile (second worst quartile).
- For December 2018, the trust ranked 5th out of 136 trusts in the procurement league table published by NHS Improvement to assess the relative performance of non-specialist NHS acute providers' procurement departments. The trust's PPIB (purchase price index and benchmarking tool) usage score benchmarked well at 74.3 against a national median of 59.3 and the trust's percentage variance from median price and the percentage variance for the top 500 products were both in the best quartile nationally. The trust's chief procurement officer led the nationally contracted products programme and the NHS spend comparison tool on behalf of NHS England and NHS Improvement and was also, at the time of the assessment, the senior reporting officer for the Peninsula Purchasing and Supply Alliance.
- The procurement function cost per £100 million turnover was high at £366 thousands compared to the national median of £206.2 thousands. However, this had reduced from £418 thousands per £100 million turnover in 2016/17. The procurement function at the trust influenced a wide range of the non-pay expenditure compared to other trusts and included procurement across the commercial / income generation function, stock management and the Scan4Safety team. The trust had also launched the first online NHS procurement academy to develop staff skills in category management, negotiation and supply relationship management. The trust was a pilot site for the Scan4Safety programme (a barcode technology used to improve patient safety by tracing patients and treatments) with electronic ordering having saved 77 working days alongside delivering other quality and safety benefits.
- The cost of running the trust's finance function was low and had reduced since 2016/17 to £446 thousands per £100 million turnover compared to the national median of £676 thousands per £100 million turnover. The costs of the management accounts function, and income and accounting function were low at £181 thousands and £59 thousands

per £100 million turnover respectively compared to national medians of £262 thousands and £91 thousands. Some of the roles that traditionally sat in finance came under procurement at the trust and explained the higher cost of the procurement function. The trust made use of shared services in finance and hosted payroll services for the South West Ambulance service.

- The trust had a low human resources (HR) function cost at £949 thousands per £100 million turnover that placed it in the second highest (worst) quartile nationally and above the national median for the sector of £898 thousands per £100 million turnover. The cost of recruitment was low at £62 thousand per £100 million turnover compared to £107 thousands per £100 million turnover nationally and the trust also had an average time to recruit clinical staff at 20 days compared to 53 days for the national lower quartile benchmark. The trust had delivered a significant project to reduce this which had included moving all disclosure and barring service (DBS) checks online. Temporary staffing costs were high at £109 thousands per £100 million turnover compared to £63 thousands per £100 million turnover for the national median as the trust had captured the full cost of NHS Professionals Service whereas other providers had included some costs within recruitment. Recruitment function costs for the Trust were in the best quartile.
- The trust's estate and facilities cost per square meter benchmarked well at £328 per square meter compared to £334 for the national median. Over 64% of the estate dated from the 1970's and this led to the high backlog maintenance cost of £311 per square meter compared to £254 for the national median. At the time of the assessment, the trust was undertaking a 'Six Facet' survey and expected to see a rise in the value of its backlog maintenance. The trust had robust procedures in place to manage the critical risk arising from the high backlog maintenance.
- Both hard facilities management (FM) costs (£92 per square meter) and soft FM costs (£154 per square meter) were above the national median of £88 and £133 per square meter respectively.
- The trust had focussed on bringing back in-house areas of the trust's estates and facilities management that were previously outsourced. Waste management was one of those areas and the trust had managed to bring waste costs down to £235 per square meters compared to £251 for the peer median while also taking on more work from within the local health system. Hotel services was another area that the trust was bringing in house later in the year.

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 £3,501 for 2017/18 which benchmarked in the second highest (worst) quartile nationally although it compared better than in the prior year, marginally above the national median. However, during 2018/19, the trust's financial position had deteriorated to a £33.3 million deficit (excluding Provider Sustainability Funding) and the trust had not met its control total and its plan. The trust had continued to work with its local health partners to agree an equitable share of funding for the local population. It also had a strong focus on improving its productivity and identifying savings opportunities which it hoped to further improve through its continuous improvement programme 'People First'. The trust operated with low cash balances and relied on cash revenue support from the Department of Health and Social Care.

- In 2018/19, the trust had delivered a £33.3 million deficit (excluding Provider Sustainability Funding (PSF); £27.2 million deficit including PSF) which represented 6.6% of its turnover and was £17 million worse than its control total agreed with NHS Improvement. The variance was driven by under-delivery of planned savings and operational pressures. The 2018/19 financial position was a deterioration on 2017/18, which also resulted in a material reduction that year in the level of non-recurrent income received, particularly, from systems partners compared to the prior year.
- For 2019/20, the trust had a plan to deliver a £22.4 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 July 2019, the trust's financial position was on plan and the trust continued to forecast the achievement of its full year plan. However, we noted that the trust's plan included significant risks particularly in relation to the delivery of the cost improvements and the contribution the trust would have to make towards reducing the local health system's deficit which was still under discussion at the time of the assessment.
- The trust had set itself ambitious cost improvement plans in 2017/18 and 2018/19 and had achieved significant savings of £30.7 million (5.7% of expenditure) in 2017/18, 80% delivered recurrently and £23 million in 2018/19 (4.1% of expenditure) with 59% delivered on a recurrent basis. The main shortfall in 2018/19 related to planned staff costs reductions and additional income. The total savings achieved, however included £4 million of un-planned additional income received from commissioners in recognition of the pressures from increased urgent care activity during the year.

- For 2019/20, the trust had set itself a £25.6 million target saving (4.7% of expenditure) all to be delivered recurrently. The trust expected to save £8.5 million on pay costs, £10.8 million on non-pay costs through continued improvement in theatre and outpatient productivity, procurement savings, further reduction in agency spend and the development of alternative workforce models. The trust also anticipated £6.2 million of additional income.
- During the assessment, the trust demonstrated a strong focus on productivity through the use of GIRFT and Model Hospital data to identify areas for improvement and, at the time of the assessment, the trust was also developing its 'People First' practice, a quality improvement programme with a view to build from existing initiatives and embed a continuous improvement culture across the trust which would support future productivity improvement and financial efficiency.
- Although at the time of the assessment (July 2019), the trust was ahead of its cost improvement plan (£1.5 million additional savings achieved, although non-recurrently), the latest information provided by the trust for end of June 2019, showed that the risk adjusted value of the current plan for the year was £10.6 million with schemes identified to the value of £14.4 million compared to a target is £25.6 million.
- The trust estimated its underlying financial deficit to be £42.4 million at the end of 2018/19 which it planned to improve to around £26 million in 2019/20, providing the trust delivered its financial plan. The trust attributed this position to several factors, such as, the unequal funding across Devon which meant Western Devon received less than its fair share of funding. Although the local system had now formally recognised this issue, the method to redress this inequity was still being discussed and it was unclear how the trust would benefit from a change in allocation, particularly in 2019/20. Other factors included the pressure of non-elective activity reducing capacity to deliver more profitable elective activity, the area's demographics with a more elderly population not fully reflected in commissioner funding and specialist services delivered at a sub-optimal scale. The trust was also working with its system to address some of these issues, including working with local trusts to consolidate sub-scale specialist services where possible although this still had to deliver a material improvement to the trust's financial position.
- The trust had a well-established service line reporting and patient level costing from which the trust derived quality information to inform productivity opportunities, service developments and business cases. The trust used an app to allow business advisors to see income and cost information from summary to patient level enabling the data to be looked at in different ways to provide detailed analysis. The trust reported good engagement with clinical areas on this data and provided specific examples of how this detailed information had been used to support decision making.
- The trust earned income from research and development (R&D) activity, education, overseas cost recovery, private patients and corporate services and had a commercial strategy. At the time of the assessment, the trust was reviewing its commercial contracts to maximise income from these. With regards to private patients' income, the trust mentioned it prioritised NHS patients considering the capacity issues mentioned above. The trust's R&D activity was also expanding.
- The trust had a debt service cover rating and a liquidity rating of 4 (worst) for 2018/19 which were expected to continue in 2019/20. The trust operated with very low cash balances (£1 million planned) but had established processes to manage the position, had not relied on emergency cash from the Department of Health & Social Care (DHSC) and had higher than plan cash balances at the end of 2018/19 driven by delayed spend on its capital programme. Despite this low cash position, at the time of the assessment, the trust continued to achieve the best payment practice code target of 95% of creditors paid within 30 days.
- The trust relied on revenue cash support from the DHSC as a result of its past and current deficit positions. The trust had received £25.5 million in 2018/19 and expected to receive £16 million in 2019/20 although this would be partly repaid in year providing the trust delivered its financial plan. At the end of 2018/19, the trust had accumulated a debt with the DHSC of £107.7 million mainly from revenue cash funding which was expected to increase to £113.3 million by the end of 2019/20. This would cost the trust £2.6 million in financing costs in 2019/20. The trust had a significant capital programme planned for 2019/20 of £33.7 million (compared to £19.5 million spent in 2018/19) funded from internal as well as central and external resources. To ensure its was able to deliver this significant capital plan in a context of the operational pressures experienced, the trust prioritised its capital spend to ensure it had the capacity to deliver its plan.
- The trust had reduced its use of management consultants to £0.5 million in 2018/19 and £0.2 million planned for 2019/20. The trust only used management consultants for specific targeted projects focussed on use of resources developments relating to medical workforce and theatre productivity which had led to specific improvements.

Outstanding practice

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

- The trust was an exemplar for its engagement with the Getting It Right First Time national programme and the governance structure it had in place to deliver improvements based on GIRFT recommendations.
- The trust had a robust process and governance in place, supported by a Model Hospital/GIRFT programme manager, to follow the trust's productivity as benchmarked in the Model Hospital and engage with clinical divisions to deliver productivity improvements.
- The trust had continued to improve on its agency spend and was the 8th lowest nationally in 2018/19. The trust was an exemplar for its relationships with agencies and NHS Professionals, the trust's staff bank and its use of smart data.
- The trust's procurement function ranked as 5th best nationally. The trust had also launched the first online NHS procurement academy to develop staff skills in category management, negotiation and supply chain management.
- The time taken by the trust to recruit clinical staff was the third lowest nationally. One of the drivers are the disclosure and barring service (DBS) checks being done online.
- The trust had a low rate of DNAs benchmarking in the best quartile nationally. Usually a week before an appointment, the patient or, in the case of children, their parent, will receive a call from their automated reminder service to confirm their attendance. At this point, the patient or parent will have the option to reschedule, if they wish. Where patients have provided the hospital with their mobile numbers, they will usually receive a text message two days before their appointment.

Areas for improvement

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

- The trust has a poor performance against the four constitutional standards and particularly the 4-hour A&E standard. The trust must continue to progress at pace to improve its performance.
- The trust must continue to work within its sustainability and transformation partnership to progress at pace with those drivers of its deficit it is able to influence particularly the resolution of the inequity of funding in Western Devon and consolidation of sub-scale specialist services.
- The trust has a high level of pre-procedure elective and non-elective bed days which are at least partially driven by recording anomalies. The trust should continue to improve on its recording to ensure that the metrics are not distorted and can be used to appreciate the level of trust's productivity.
- The trust has a higher than England average standard rate of emergency admission (SAR). The trust should continue to investigate the drivers of this to understand what is driven by internal practice at the trust rather than being due to external factors the trust cannot influence.
- The trust continued to have a very high medical cost per WAU. The trust should continue its effort to reduce this rate, particularly to improve the percentage of direct clinical care time.
- The trust should identify how it could improve its approach to ensure it is able to identify and deliver its cost improvement programme recurrently.

Ratings tables

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Service level

Safe	Effective	Caring	Responsive
Requires improvement →← Aug 2019	Requires improvement →← Aug 2019	Outstanding →← Aug 2019	Requires improvement →← Aug 2019

Trust level

Well-led	Use of Resources
Requires improvement →← Aug 2019	Requires improvement →← Aug 2019

Overall quality

Requires improvement →← Aug 2019

Combined quality and use of resources

Requires improvement →← Aug 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.