Great Western Hospitals NHS Foundation Trust

Use of Resources assessment report

Great Western Hospital
Marlborough Road
Swindon
Wiltshire
SN3 6BB
Tel: 01793604020
www.gwh.nhs.uk

Date of publication: 30/06/2020

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?	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 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 of quality and resources remained the same. We rated it as requires improvement because:

- We did not undertake a well led inspection; therefore, we only took into account the ratings for the trust's acute location, Great Western Hospital.
- The overall ratings for the Great Western Hospital remained requires improvement.
- We rated safe and responsive as requires improvement, and effective, caring and well led as good.
- The trust was rated requires improvement for use of resources.

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Date of inspection visit: 11 February to 12 March 2020
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This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Proposed rating for this trust?	Requires improvement

How we carried out this assessment

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

We visited the trust on 15 January 2020 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Requires improvement

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

We rated Use of Resources as requires improvement. Since our last visit, the trust had made some progress particularly with addressing its diagnostic 6-week wait performance but much still needed to be addressed.

The latest data available (2017/18) benchmarked the trust's cost per weighted activity unit (WAU) in the best quartile nationally, however we also found that the trust's financial position had materially deteriorated since our last assessment driven by operational pressures and the difficulty in delivering sufficient cash releasing efficiencies. The trust had a low staff retention rate and its spend on agency staff continued to be high. The trust also did not meet three of the four constitutional standards at the time of the assessment. However, we noted some innovative practices at the trust which helped manage its clinical services productively. These included 'reverse streaming' in its emergency department. The trust also had strong programmes in place to continue to develop clinical support services networking.

- This was the second time we assessed the trust for use of resources. We previously assessed the trust in September 2018 and rated the trust 'requires improvement' for its use of resources. We had made several recommendations around the diagnostic 6-week wait standard, high agency spend, data anomalies impacting radiology 'did not attend' rates, elective length of stay, emergency re-admission rates and the need to increase analytical capability across the trust to better support decision making and planning but did not find evidence the trust had made significant progress on most of these.
- We found the trust had made progress with its diagnostic access performance, radiology 'did not attend' rates and to some extent around informatics. However, progress was still required on agency spend, emergency re-admission rates and elective length of stay and there remained some material issues with the trust's analytical capacity particularly around the use of service line reporting and costing. We noted as well, that the trust had not always progressed at pace.
- Based on the latest data available at the time of the assessment (2017/18), the trust had an overall cost per weighted activity unit (WAU) of £3,332 which benchmarked in the lowest (best) quartile nationally. At the time of our visit to the trust, the national cost collection index which benchmarked the relative costs to all NHS providers had been released. The 2018/19 cost per WAU was published subsequently to our visit. Further discussions with the trust, however, identified a material error in the trust's cost submission to national bodies which meant we were not able to comment on the 2018/19 cost per WAU. The trust was discussing the possibility to resubmit its data set to the Model Hospital at the time of writing this report.
- At the time of the assessment, the trust did not meet 3 of the constitutional standards (4-hour accident & emergency (A&E), 18-week referral to treatment and diagnostic 6-week wait) although the trust met the cancer 62-day standard and the trust had materially improved its performance on the diagnostics standard.
- The trust has introduced several innovative measures to address activity pressures on its emergency department with reverse streaming and reduce its elective length of stay and improved delayed transfers of care. Further work was still required to improve the A&E performance and drive down elective length of stay and delayed transfers of care. The trust continued to report higher than the national median emergency re-admission rates principally as a result of issues with the coding of activity.
- The trust had experienced data issues which had impacted its waiting list size with an increase during 2018/19. The trust had taken measures to improve its informatics and staff were now able to monitor activity live. The trust had also carried out a demand and capacity planning resulting in a more robust service delivery model.
- The trust could evidence progress with its theatre productivity programme and improvement following visits from the Getting It Right First Time (GIRFT) national programme. The trust also benchmarked better than national median on 'did not attend' rates.
- Based on 2017/18 data, the trust benchmarked well on overall pay cost per WAU being in the best quartile nationally. However, the trust was experiencing pay cost pressures in particular the continuous increase in agency staff costs which the trust had not managed to reduce during the year and which were driven, at least partially, by the need to staff escalation wards which the trust had not been able to close after the winter period. The trust had introduced enhanced nursing and allied health profession roles to help with recruitment issues. The trust did not benchmark well on staff retention with a turnover rate which was above the national median despite actions taken by the trust. It was noted that the sickness rate was however better than the national median.
- Costs for pathology, imaging and pharmacy were variable. There were however strong work programmes across the three services and plans in place to improve productivity, efficiency with a focus on the development of networks and closer working with local partners.
- The trust's human resources and information management & technology benchmarked generally well, providing value for money although there were areas for improvement. The cost of the finance function was high compared to the national median, but this was under review. The trust had developed a joint procurement function with a nearby trust and benchmarked overall well. The trust's estates were under a private finance initiative (PFI) but overall benchmarked well against peers.

- The trust's financial position had deteriorated since our last visit and at the time of the assessment, the trust forecasted to materially under-deliver against its control total set by NHS Improvement and its plan. This resulted from cost pressures and a comparatively low level of cost improvement in the context of a lower than plan activity level and a fixed level of income. External reviews had identified several issues particularly around the identification and delivery of cost improvements. Service line reporting and the use of patient level costing were not well embedded in the trust as well. The trust had accumulated a high level of debt principally as a result of its private finance initiative estate. Due to its deficit position, the trust needed to manage its cash position tightly and received cash support from the Department of Health and Social Care. At the time of the assessment, the trust was developing a financial recovery plan.

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 was not meeting the constitutional standards for 4-hour accident and emergency, diagnostics 6-week wait and 18-weeks referral to treatment but was meeting the 62-day cancer target. The trust had a high rate of delayed transfers of care and elective length of stay but had introduced a new process which had started to deliver improvements. The trust had introduced an innovative way to reverse stream its patients in the emergency department which had allowed it to see more patients quickly. The trust had experienced data issues which had impacted its waiting list size and during the year the trust had improved informatics. The trust had driven some productivity improvements via its theatre productivity and GIRFT programmes.

- Using the most recent data available at the date of the assessment (February 2020), the trust was not meeting 3 of the constitutional operational performance standards for access: 18-week referral to treatment (RTT) performance was 78.6% (92% standard); accident and emergency (A&E) 4-hour performance was 79.4% (95% standard); and diagnostic 6-week wait performance was 2.2% (1% standard).
- The trust was however meeting the cancer 62-day wait standard with a performance of 87% (85% standard) and its performance had improved during 2019/20. The trust had only failed the standard 2 months since April 2019.
- The trust's A&E performance had deteriorated during 2019/20, similarly to the national performance. Since the trust's previous assessment, the trust had continued to focus on improving its A&E performance. The trust had implemented 'reverse streaming' which directed all patients presented with a minor condition to an alternative facility on-site. These were streamed back in the emergency department (ED) should their condition be more critical. The trust had then used the space left available within the ED to create a 'majors chair area' where clinically suitable patients could be managed by nurses. These improvements had helped the trust manage the periods when the ED was under pressure and increased the percentage of patients seen within 15 minutes from 40% to up to 70%.
- The trust had a delayed transfers of care (DToC) rate of 5.5% in October 2018 (latest data available) which was higher than the national median at 3.4%. More patients were also coming to the hospital unnecessarily prior to elective treatment compared to most other hospitals in England at quarter 3 2019/20. On pre-procedure elective bed days, at 0.17 bed days, the trust was performing in the highest (worst) quartile above the national median of 0.12 bed days. The trust however benchmarked at the level of the national median for non-elective pre-procedure bed days at 0.65. The trust had made progress to reduce its average elective length of stay during 2018/19 although for the six months to September 2019, it continued to benchmark in the worst quartile nationally and at 4.4 days was higher than the national median of 2.9 days.
- The trust had introduced a new process whereby the medical director, chief nurse, and chief operating officer reviewed the longest staying patients 3 times a week to support the prompt discharge of those patients with complex needs in the wider health system. This process had been received positively by doctors, had helped improve discharge pathways and resulted in a reduction in the number of patients staying at the trust for more than 21 days. The trust had also worked with local authorities on modelling pathways around reablement with some boroughs now quicker at taking and discharging patients although others were still struggling. At the time of the assessment, the trust was working with its commissioners to find a sustainable solution for those patients placed out of the area.
- The trust had high emergency re-admission rates at 9.70% against a national median of 7.94% at quarter 3 2019/20. The trust had undertaken an audit of the data and found errors in the coding of some admissions. Through its own internal audit, the trust could demonstrate a 5% improvement in its rate if admissions were coded appropriately. The trust continued to undertake 6 monthly audits of its data which were reported to its performance, people and place committee.

- The trust's performance against the diagnostic 6-week wait standard had deteriorated during the year. A recovery plan had been implemented resulting in improved management of diagnostic demand and capacity and actions were being undertaken to prevent further deterioration. This had led to the recovery from a low performance of 16% at July 2018 to an improved delivery of 2.2% at the time of the assessment against a national standard of 1%.
- The trust had experienced data quality issues which had impacted its waiting list size. It had increased by around 700 patients against a total waiting list size of 21,000. The trust had worked with external experts to carry a validation exercise to inform the development of a recovery plan. The trust had also restructured its services to bring closer working between informatics and operational teams and appoint an associate director of informatics. The trust had carried out a demand and capacity review with expert support which had informed the development of a robust delivery of services model. These measures resulted in more accurate and live monitoring information which staff could access and interrogate to make better decisions. The trust used a predictor tool to inform activity plans during its weekly RTT monitoring meetings.
- The trust had a theatre productivity programme which provided strategic direction and performance management of theatre utilisation. The trust monitored its performance against key performance indicators and showed an improving picture. The trust had worked with a consulting company to identify opportunities to improve theatre productivity (valued at £1.5 million savings) and the trust was considering how to progress these further at the time of our assessment.
- The trust's 'did not attend' (DNA) rate benchmarked in the second-best quartile nationally at 6.83% for quarter 2 2019/20 compared to a national median of 7.13%. The trust had continued to improve its processes, moved to digital communications with patients and introduced 'DrDoctor' an electronic booking system.
- The trust had embraced the 'getting it right first time' (GIRFT) programme as a primary driver for change with the methodology being embedded within the trust. The trust recognised GIRFT as a clinical engagement programme and the trust's GIRFT programme reported to a panel led by an associate medical director and the trust's director of nursing. The panel reviewed the action plans developed following visits from the GIRFT national team and monitored their delivery. The trust could evidence improvements in length of stay in orthopaedics and gynaecology following GIRFT visits.

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

The trust had a pay cost per weighted activity unit (WAU) for 2017/18 which benchmarked in the second lowest (best) cost quartile nationally although the trust had a high agency spend. Overall the trust pay bill was overspent year to date by £2.7 million (September 2019) (before allocation of financial reserved held centrally be the trust) Temporary staffing costs were contributing to the overspend. The trust had a low staff retention rate which was worse than the national median. The trust had focused efforts on improving this position through a range of initiatives including financial incentives and staff recognition schemes to ensure that exceptional work did not go unrecognised.

- For 2017/18 the trust had an overall pay cost per WAU of £2,165, compared with a national median of £2,180, placing it in the second lowest (best) cost quartile nationally. This meant that it spent less on staff per unit of activity than most trusts.
- The trust was in the lowest (best) quartile for medical cost per WAU at £452 compared to a national median of £533. However, medical agency costs had increased by 16% for the year to September 2019 compared to the same period in the previous year. There were 35 vacancies in medical staffing at the time of the assessment. The trust had maintained contact with their trainees to ensure that they were aware of employment opportunities and had taken steps to enhance the experience of medical staff through links with a London teaching trust. The trust had commenced an inhouse training programme for clinical fellows to provide a structured educational programme and to retain highly qualified medical staff.
- The cost per WAU for nursing staff was £785 compared to a national median of £711 and benchmarked in the second highest (worst) quartile. This reflected higher costs of clinical nurse specialist staff for elderly, orthopaedic and front door patients (amongst others). The trust had introduced new enhanced nursing roles where previous recruitment to a medical role had been unsuccessful. The trust acknowledged that e-rostering was not fully embedded and was an area for improvement. The trust complied with safer staffing guidance to ensure safe care delivery.
- The cost per WAU for allied health professional (AHP) staff was in the highest (worst) decile at £196 compared to £130 nationally. The trust had invested in a range of AHP roles including a senior community role and pharmacy technicians attached to wards to support ward medicines management. There were professional leads for each of the AHP disciplines (for example the stroke pathway) supported by improved recruitment and retention processes. The trust reported that AHP appointments had led to more flexible working arrangements.

- The trust had not met its agency ceiling as set by NHS Improvement for the past three years and was forecasting to miss its ceiling in 2019/20. The trust was aware that their nursing agency costs had increased by 4% and medical agency by 16% when comparing the to date cost as at September 2019 compared to the same period the previous year. As at December 2019, the trust had spent 5.15% of its pay bill on temporary staff, compared to 3.99% nationally (second worst quartile). Whilst there was a robust documented agency booking process within the trust 'engagement of temporary staff policy & procedure', agency costs continued to exceed the agency ceiling. Requests to staff escalation areas for bank and agency nursing staff had increased by 92.98 whole time equivalent (WTE) in the period April 2019-September 2019 compared with the same period in 2018.
- Overall the trust's pay bill was overspent for the year to September 2019 by £2.7 million. This excluded financial reserves held by the trust centrally which when allocated reduced the overspend to £1.1 million. The main driver was nursing (£2.5 million) and medical (£0.3 million) overspend. Temporary staffing costs had been the contributing factor to the overspend with nursing spend doubling when compared to the substantive pay underspend (September 2019). The divisions that had significantly contributed to the overspend were planned care and unscheduled care.
- Whilst all consultants had a job plan the trust acknowledged a lack of oversight and confidence in the alignment with service demand.
- Staff retention at the trust had been poor with a retention rate of 69.1% in December 2018 (latest data in Model Hospital) against a national median of 85.6% placing the trust in the lowest (worst) quartile. The trust had focused efforts to improve through:
  - New pay incentive schemes including a £500 bonus to encourage staff to work extra shifts through the staff bank (the trust's own internal staff agency). The trust estimated that for winter 2018/19 they had saved £221,000. This had been developed into the 'save for spring' scheme;
  - The introduction of 50 staff trained mental health first aiders to improve staff health and wellbeing;
  - Launch of the leadership forum in 2019 to develop and strengthen leaders within the trust;
  - Work through the equality and diversity programme included the Black, Asian and Minority Ethnic (BAME) group 'LGBTQ+ Staff' and the 'Patient Network', resulting in the introduction of NHS LGBTQ badges for staff, to recognise that the organisation was inclusive;
  - Health and Wellbeing staff initiative.
- Despite these actions, the trust's turnover at 1.62 % in September 2019 remained in the worst quartile nationally, higher than the national median of 1.34%.
- At 3.88% in September 2019, the staff sickness rate was better than the national average of 4.11%. The trust had implemented several initiatives including the launch of their new people strategy (2019-2024) and monthly sickness metrics for each division that triggered a deep dive response for negative outliers.
- The people strategy had been developed with staff, patients and governors through listening events and feedback. The trust described their ambition to be an organisation where quality improvement was at the heart of their strategy. Initiatives included:
  - The 'engage to change' programme developed to empower staff to develop their own quality improvement ideas and lead change projects;
  - The ideas programme giving staff the opportunity to continuously share ideas for positive change with senior management. The programme had so far been rolled out in several divisions across the trust; and
  - Staff recognition schemes to ensure that exceptional work did not go unrecognised.

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

The trust's costs for clinical support services were variable, benchmarking well for imaging, slightly higher for pharmacy. Pathology costs had improved with the cost per test now in the second lowest quartile and cost per capita in the best quartile nationally.. There were, however, strong work programmes and plans in place across all areas and a focus on the continued development of networks and involvement of partners to improve patient care and the efficiency of service delivery. Pathology services had focused on service reorganisation and developing partnership arrangements with two networks to drive efficiency and improvements. The trust recognised where progress was slow and was seeking to improve the pace of change, including in developing technical solutions to drive efficiencies.

Pathology

- There had been a gradual improvement in the overall cost per pathology test in the past three years, though the trust still benchmarked in the second highest quartile nationally (£2.14 per test compared to a peer median of £1.91 and a

national median of £1.86 in 2018/19). The trust had however analysed its cost per test and identified that the cost of the private finance initiatives estate contributed materially to the high cost per test. The trust was performing very well (in the top quartile) for cost per full time equivalent staff, cost per capita and total tests per capita. Total cost per capita was £32.25 compared to a peer median of £47 in 2018/19.
- Non-pay costs as a percentage of total costs were high compared to peers and the national median (63% against a peer median of 52% in 2018/19). The trust however reported that these were driven by 'send away' tests as a result of consultant vacancies in cellular pathology and were largely compensated by underspend on pay costs resulting from these vacancies. 'Send aways' were, however, a more expensive solution.
- The trust was an active member of the Southern 4 Pathology Partnership ('network 4') and had also entered into a joint managed equipment service (MES) contract with the Southampton and Isle of Wight regional network (Network 6). This was for 10 years from 2019. The trust acknowledged that this put them out of step with the network 4 MES, but that they weighed this risk against the work and progress made to date (achieving a £0.200 million of efficiency savings in the first year of the MES joint contract).
- Overall, while the trust service costs were higher than peers, they were on track at the end of October 2019 to achieve their pathology cost improvement target of £94,000 for 2019/20. They were actively engaged with networks, though were keen to increase the pace of transformation work with network 4. Progress on the laboratory information management system (LIMS) and automation had been slow, and an outline business case was being progressed.

Pharmacy

- The trust's medicines cost per WAU was above the national median, primarily as a result of high cost drugs (£391 compared to a national median of £369 in 2018/19). At the time of the assessment, the trust did not have an aseptic unit, so this was outsourced, leading to increased costs. The trust had made good progress in delivering on nationally identified saving opportunities in the top 10 medicines programme, achieving 107% against a national median of 121% in 2017/18. Data for 2018/19 and 2019/20 indicated steady improvement although there was a small shortfall for the drug adalimumab. The pharmacy team attended GIRFT meetings, where they were involved in review of the use of best value biologics.
- The trust had well developed processes for electronic ordering and stock management and handling. Stockholding was low at 18 days. Pharmacists time spent on clinical activity (where a higher value indicated greater productivity and safer, more effective care) was above the national median (81% compared to 77% in 2018/19), with a good percentage of pharmacists actively prescribing (77% compared to a peer of 79% and national average of 78%).
- The trust had, however, made less progress with the implementation of pharmacy coverage at weekends with no coverage in place. A strategic outline business case for a 7-day service was being submitted to the trust board in April 2020 for approval.
- The trust had implemented electronic prescribing with real time tracking of medicines in place 24 hours a day, 7 days a week. It had also implemented medicines optimisation pharmacists on acute general medical wards and was in the process of expanding this to all clinical areas.
- Medicines reconciliation within 24 hours of admission was low in 2018/19 (50% against a national median of 71%). The trust gave several reasons for this, citing a major upgrade of their electronic prescribing and medicines management (EPMA) which had led to considerable delays. They outlined that strategic outline pharmacy business case included a plan to improve medicines optimisation. They were also undertaking a review of job plans to further increase pharmacy ward presence in addition to a recruitment drive to backfill internal promotions.
- The number of patient antibiotic prescription reviews in 2018/19 was 90% and total antibiotic consumption benchmarked in line with the national average. The pharmacy team were well engaged in the cost improvement programme and outlined that there was a strong clinical interface, including working with primary and community care colleagues to implement their hospital pharmacy transformation plan.

Radiology

- Overall, there had been improvements in service and cost efficiency in imaging services with the total cost lower than peers and the national median (3% as a percentage of overall operating expenditure against a peer and national median of 3.7% in March 2019). The cost per report benchmarked in the best quartile (£39.99 compared to a peer cost of £50.24 in March 2019).
- 'Did not attend' (DNA) rates had improved across the board, in part, due to more accurate reporting. The trust was also overachieving on their in-year cost improvement programme target (achieving £0.155 million as at the end of October 2019, 2019/20, against a year target of £0.3 million).

- The trust had had a shortage of radiologists and radiographers though had recently reduced the vacancies rate for radiographers. They had also reduced agency, bank and overtime spend from 7.8% in March 2018 to 5.5% in March 2019 (lower than both their peers and a national median of 6%). Overall pay costs were in the second worst quartile (with 67.7% of cost compared to a national median on 66.6%).
- There was a backlog of plain x-ray and CT scans and substantially low plain x-ray radiographer reporting (5.7% in March 2019 compared to a 42.6% peer median and 30% national median). The trust outlined that they reported on all plain film x-rays and while the backlog was up to 2,000 at a time, they reported on 600 per day, so the proportion of those being achieved within the time frame remained high.
- The trust also had 0% rate of auto-reporting of plain x-ray and stated that they used both radiologists and radiographers in their reporting. This compared to a peer median of 11% and national median of 10.6%. The trust explained that they saw auto-reporting as poor practice and that they only auto-reported on images taken in theatres.
- A large amount of imaging equipment, including static x-ray machines, MRI machines, and Dexa machines (used to measure bone density), had reached replacement age simultaneously, as they had been purchased at the same time. An equipment replacement scheme was in place with final stages of a business case going through the approval process with NHS England and NHS Improvement. Replacement for an MRI scanner had been approved.

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

The trust's corporate services benchmarked well in terms of providing value for money in most areas with human resources (HR), information management and technology (IM&T) and procurement functions benchmarking in the second-best quartile nationally in 2018/19. The trust had worked to develop joint back office functions with a nearby trust for procurement which had provided opportunities to align strategies and processes to reduce costs and increase value for money. The cost of the finance function was high compared to the national median. This was currently under full review. The trust also scored in the second lowest (best) quartile for the cost of running its estates and facilities function, though cost per square meter had reduced substantially from January 2018 to January 2019.

- The cost of running the finance function benchmarked above the national average (£0.770 million per £100 million turnover compared to £0.705 million nationally). There were several finance sub-functions that the trust recognised could improve which were currently expensive and were not offering value for money. Income and contracting, costing, accounts payable and external audit all benchmarked in the top (worst) quartile. The trust stated that it outsourced parts of its finance function and recognised that it could improve in some areas. It was at the time of the assessment undertaking a full review and looking to re-negotiate the outsourcing contract (which expired in May 2020). It stated it was continuing to work towards a joined-up solution with a nearby trust.
- Overall HR costs benchmarked well against the national average (£1.075 million per £100 million turnover compared to the national median of £1.088 million). However, there were several sub-functions which benchmarked as high including the cost of recruitment (over twice the national median cost). The trust had been investing in recruitment and had improved the time it took to hire new staff. The trust's costs for organisational development in 2018/19 were substantially less than the national median (£29,000 per £100 million of turnover compared to £68,000 national median). They stated that this was a priority area this year, including working with a nearby trust, as outlined in their HR strategy. The cost of the occupational health service benchmarked at almost twice the national average. The trust stated that they were considering next steps and open to options. The service was reported to be valued by staff and they were considering bringing well-being and occupational health together to create a more streamlined service.
- Rostering was also twice the national median with higher costs a result of a slower roll out. This had been rolled out for nursing staff and the trust stated they had started to roll this out for non-medical staff. Overall, they had not yet realised the full function and capability of e-roster and had recently put in a bid to fund the roll-out of electronic rostering for the medical workforce.
- The total cost of IM&T transactional service function was £5.94 million in 2018/19 compared to £5.22 million in 2017/18. The trust benchmarked in the second lowest (best) quartile (for cost per £100 million turnover) spending £2.136 million against a national median of £2.521 million. However, the trust stated that there was a need to invest in this area with old servers and issues with power outages and lack of business continuity. A recent capital sum had enabled them to focus on tackling the core issues of improving the infrastructure and they had invested in increasing the number of handheld devices and docking stations.

- The trust spent a substantially higher amount on maintaining paper medical records than the national median (£0.351 million per £100 million turnover against £0.274 million) and printers (£0.117million per £100 million turnover against £0.067 million respectively). The implementation of electronic medical records had been slow, and the trust stated it was focused on increasing the pace of development and gain agreement with partners and the sustainability & transformation partnership (STP) on future arrangements.
- In relation to procurement, the trust performed well against most metrics. They were average on price performance for quarter 4 2018/19 compared to peers but in the second-best quartile for process efficiency. The trust was well engaged across the system and formed part of a shared resource with a nearby trust with a joint director of procurement and commercial services in post. The trust gave examples of how this collaboration had led to financial benefits (e.g.: securing a contract on cardiology kit) and reported that they had delivered over £3 million of savings in the previous two years.
- Through these new arrangements, they had improved their position in the procurement league table to 44th and recently achieved level 2 in the national procurement accreditation process. The joint arrangements with the nearby trust included a shared strategy with a focus on areas such as aligning standards, reviewing purchase to pay processes to improve efficiencies, sharing catalogues and best practice (including Scan4safety, a tracking system which the nearby trust was piloting at the time of our assessment).
- At £400 per square metre in January 2019, the trust's estates and facilities costs benchmarked in the second lowest quartile nationally. This was, however, an improved position from 2018 (where costs were £600 per square metre).
- When comparing the part of the estate funded through a private funding initiative (PFI), the trust benchmarked in line with peers and the national median for 2018/19 (£46 per square metre) on estate and property maintenance. However, the trust's finance costs per square meter (the largest cost) was comparatively worse than the national median with £339 per square meter compared to £239 but was significantly lower than peers (£396).
- In 2018/19 the trust had higher energy costs than its PFI peers (£35 per square metre compared to a peer median of £33 per square metre). The trust had entered into a 15-year partnership to deliver improvements to heating and lighting with 10,000 new LED lights recently installed and a new heat and power system being installed. The trust's costs for critical infrastructure risk and backlog maintenance benchmarked in the best quartile against peers as a result of the PFI building.
- There were some areas where costs were high against peers including soft facilities management (FM) costs, waste management and portering (2018/19 figures showed £444 per tonne on waste management compared to a peer median of £236; £198 per square metre on soft FM compared to peer median of £126 and portering costs of £23 per square metre compared to peer median of £33). Patient led assessment scores were lower than peers on all measures with patient food being well below the peer median (84.2% compared to a peer score of 90.1%). The trust stated that they had moved to a new provider and continued to review the quality of service provision.

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

The trust's financial performance had deteriorated since our last assessment in 2018. The trust had met its control total in 2018/19 and the trust had accepted its control total for 2019/20. However, it had identified pressures early on during 2019/20 and, despite mitigating actions and lower than plan activity, it expected to materially under-deliver against its 2019/20 plan. The trust had sought external support to review and improve its financial position which had identified significant issues including the ability to identify and deliver credible cash releasing efficiency savings. The trust's service line reporting was not embedded and recently the trust had identified material errors in its costing submission to national bodies which distorted its overall cost per WAU for 2018/19. The trust's cash position was under pressure and the trust required cash revenue support from the Department of Health and Social Care. The trust had a large debt mainly due to its private finance initiative estate and its deficit position.

- In 2018/19, the trust had delivered a £12.4 million deficit (excluding provider sustainability funding (PSF); £1.3 million surplus including PSF) which represented 1.4% of its turnover and was in line with its control total agreed with NHS Improvement. The 2018/19 financial position represented a deterioration on 2017/18, when the trust delivered a deficit of £10.5 million excluding transformation and sustainability funding (STF). The trust's 2018/19 financial position was supported by additional funding from commissioners to recognise activity pressures experienced during winter months.
- The trust accepted a control total of £11.5 million (excluding PSF, financial recovery fund (FRF) and MRET (central emergency rate funding); a breakeven position including PSF, FRF and MRET), an improvement on prior year. During the year however, the trust identified significant pressures due to escalation wards remaining open, staff vacancies and under-delivery of cost improvement plans (CIPs) which the trust tried to mitigate. However, in October 2019, the

trust revised its full year forecast, to a £20.3 million deficit excluding PSF, FRF and MRET (£16.3 million including) representing 6.06% of turnover. The revised position reflected increase spend (pay and non-pay) in the context of the delivery of lower than plan activity, exacerbated by the under-delivery of a comparatively small cost improvement plan (2.6% planned) and a block contract with commissioners fixing its level of income. The trust needed to review the capacity it needed to deliver its services without keeping escalation beds at premium costs open regularly.

- Since 2017/18, the trust had not delivered its cost improvement plans and only achieved comparatively modest cost improvements of 2.2% (2017/18), 2.6% (2018/19) and 2.2% (2019/20 forecast). At the time of the assessment, the trust forecasted to achieve £8.0 million of its £9.1 million plan for 2019/20 (79% recurrent) although two months from the end of the year, the trust still needed to deliver £2 million cost improvement (25% of its full year forecast).
- Considering the trust's difficulty to deliver its plan in 2019/20, the trust had commissioned a review of its financial position and cost improvement plan and appointed a director of transformation. Their work identified significant issues with spending controls and the infrastructure, governance and culture to identify, oversee and delivery cost improvements. The reviews also showed that the trust could make more use of tools such as the Model Hospital, service line reporting and GIRFT to drive efficiencies. This, particularly, had resulted in the trust's 2018/19 and 2019/20 CIP relying principally on a high number of transactional schemes rather than successfully delivering trust-wide transformational schemes. The trust had made changes to its infrastructure and governance and particularly, through budgeting, had clarified the accountability of divisions in delivering their budgets, including cost improvement plans.
- The trust had been operating with an underlying deficit for several years. The external review had estimated the underlying deficit to £11.5 million in 2017/18, deteriorating to £17.2 million in 2018/19 (5.4% of revenue). There was no estimate for 2019/20 on a comparable basis. The latest drivers of deficit analysis dated from the beginning of 2018/19 and highlighted PFI costs, activity mix, delayed transfers of care, difficulties to recruit and to deliver recurrent CIPs as the main drivers. At the time of the assessment, the trust was working on developing a financial recovery plan to address its financial position and addressing the recommendations of the external reviews.
- The trust received commercial income from several sources including car parking, property rental, staff accommodation and the treatment of private patients. The trust was actively seeking to develop its commercial income through its commercial strategy with plans around the expansion of its current retail offer within the trust's estate, advertisement and a potential solar panels scheme. The trust also generated around £4 million a year from its private patient activity.
- The trust had patient level costing information (PLICS) as well as service line reporting (SLR). However, the trust recognised it needed to embed and use the information more widely to support the trust and its divisions to understand their costs, make decisions and identify saving opportunities. The trust had successfully carried out pilots with three divisions to improve the use of PLICS data and was now looking to roll out to other divisions. As we finished our assessment, we also became aware that the trust's reference costs submission nationally contained a material error which distorted its national cost collection index (previously reference cost index) and its overall cost per WAU for 2018/19.
- The trust had a liquidity rating of 4 (worst) for 2018/19 which would improve to a rating of 1 (best) in its 2019/20 forecast. The trust relied on cash revenue support from the Department of Health and Social Care (DHSC) to pay its staff and suppliers. As a result of the deterioration of the trust' deficit, the trust anticipated to receive £23.8 million of cash support during 2019/20. The trust had also negotiated the upfront payment from commissioners to ease its cash position. Part of this cash would allow the trust to pay outstanding debts with suppliers. During the year, the trust had experienced a high level of issues with suppliers as a result of delayed payments driven by the trust's tightly managed cash position. This was reflected in the trust's low performance against the best payment practice code.
- The trust had a debt service cover rating of 4 (worst) for 2018/19 and 2019/20. At the end of 2018/19, the trust had outstanding debt of £153.4 million mostly as a result of its private finance initiative building (£107 million) and working capital and cash support from the DHSC (£37.3 million). The trust anticipated its debt to increase to £171.4 million in 2019/20 mainly due to additional cash revenue support from DHSC. The high debt meant the trust would spend £15.2 million in finance costs in 2019/20 (£14.9 million in 2018/19).
- The trust's spend on management consultant was due to increase in 2019/20 from 2018/19 (£0.8 million) and against its plan (£0.3 million) to £1.2 million, reflecting the level of support sought by the trust to address its deteriorating financial position.

Outstanding practice

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

- The trust is one of the first NHS trusts to introduce 'reverse streaming' whereby patients coming with a minor condition are directed to the adjacent urgent care centre with clinical staff uniquely streaming them back to the emergency department should their condition be more critical.
- The trust has introduced a new process whereby the medical director, chief nurse, and chief operating officer review the longest staying patients 3 times a week to support the prompt discharge of those patients with complex needs in the wider health system. This process has been received positively by doctors, has helped improve discharge pathways and has resulted in a reduction in the number of patients staying over 21 days at the trust.

Areas for improvement

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

- The trust should continue to develop its analytical capability and particularly, the use of data to manage its operations and make decisions. We noted progress since our last assessment, but further work is required at pace.
- The trust needs to continue to drive the reduction of its delayed transfers of care, elective pre-procedure bed days and elective length of stay.
- The trust has identified that high emergency re-admission rates were driven by coding issues. The trust needs to address these issues and demonstrate a reduction of the re-admission rate closer to the national median.
- The trust has experienced data quality issues which have impacted its waiting list size. The trust has taken actions to improve its informatics, however the trust needs to demonstrate a reduction of its waiting list size.
- The trust's proportion of its pay bill spent on temporary staff is higher than the national median. The trust needs to drive a reduction of its spend on temporary spend, in particular the trust needs to review its demand and capacity planning and assess how to best resource the wards permanently required.
- The trust needs to improve the oversight of its consultant job planning process and progress with linking it to service demand.
- The trust's staff turnover rate benchmarks in the worst quartile in September 2019 and the trust needs to consider how it can bring this in line with the national median.
- The trust needs to continue its effort to reduce its cost of pathology test and pathology non-pay costs to bring them closer to the national median.
- The trust needs to progress with increasing pharmacy coverage at weekends with no coverage at the time of the assessment.
- The trust should continue to identify measures to decrease the pay costs of the radiology service to bring it in line with the national median. The trust should also ensure it has considered all opportunities for auto-reporting of plain x-ray.
- The trust needs to continue to seek opportunities to reduce the cost of its finance function.
- The report highlights above several areas in HR, IM&T and estates & facilities where the trust may have opportunities to reduce costs, consolidate services and improve patient experience. The trust needs to ensure it continues to explore these areas.
- The trust's financial position has deteriorated and the trust experienced issues in identifying and delivering cash releasing savings. The trust needs to develop a financial recovery plan at pace including the delivery of trust-wide transformational schemes to deliver efficiencies.
- The trust has commissioned several recent reviews of its financial position, operations and governance. The trust needs to ensure it addresses at pace the recommendations identified by these reviews.
- The trust needs to continue its effort to embed the use of service line reporting and PLICS data across its clinicians and divisions.
- The trust's reference cost submission to national bodies contained a material error which has distorted its national cost reference index and 2018/19 cost per WAU. The trust needs to ensure that it can submit correct data for 2019/20.

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
N/A	N/A	N/A	N/A	N/A	N/A

Overall quality

N/A

Combined quality and use of resources

N/A

Use of Resources report glossary

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

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

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

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