

Royal Devon and Exeter NHS Foundation Trust

Use of Resources assessment report

Barrack Road

Exeter

Devon

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Date of publication: 30 April 2019

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

Ratings

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

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RH8/reports)

Are resources used productively?	Good ●
Combined rating for quality and use of resources	Good ●

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

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

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- We rated safe, effective, caring, responsive, and well-led as good (including at trust wide).
- We took into account the current ratings of the six core services across the wonford location not inspected at this time. Hence, safe for the wonford site remained requires improvement.
- Honiton hospital was inspected for the first time.
- We took into account the ratings for the community health services also.
- The overall ratings for the acute location Wonford remained the same. The Mardon Neuro-rehabilitation Centre location rating improved.
- We did not aggregate the rating for the Mardon Neuro-rehabilitation Centre and Renal Services at Wonford location because these are additional services.

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

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Exeter
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EX2 5DW
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Date of site visit:
19 February 2019

Date of NHS publication: 30 April
2019

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

How effectively is the trust using its resources?

Good ●

How we carried out this assessment

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

We visited the trust on 19 February 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Summary of findings

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

Good ●

We rated Use of Resources as good because the trust is achieving good use of its resources to enable it to provide high quality, efficient and sustainable care for patients:

- The trust's total cost per Weighted Activity Unit (WAU) at £3,486 for 2017/18 was in line with the national median.
- The trust benchmarked well on several clinical services metrics such as emergency readmissions, non-elective pre-procedure bed days and Did Not Attend (DNA) rate.
- The trust's overall pay costs per WAU was at the level of the national median although this masked higher than the national median medical, nursing and Allied Health Professional costs per WAU and better than national median non-substantive staff costs per WAU.
- The trust had one of the 10 best staff retention rates nationally which it attributed to its staff listening and engagement activities which fed into its health & wellbeing plans.
- The trust reviewed its nursing and midwifery skill mix on a six-monthly basis and was making progress with the effective deployment of staff based on patients' needs, in particular with the implementation of the Allocate Safecare tool started in January 2019 and is expected to be fully implemented by Summer 2019.
- The trust had a non-pay costs per WAU in line with the national median.
- The trust benchmarked well on imaging costs and although its medicine costs were relatively high this reflected its pre-packaging unit and 7 day on ward pharmacy service.
- The trust had an ambitious clinically-led transformation programme (MY CARE), which is enabled by technology and due to go-live in 2020. The programme is expected to deliver significant improvements across the trust.
- Overall, the trust benchmarked well on corporate functions costs (Finance, Human Resources and estates and facilities costs) and was collaborating with other trusts to deliver some of its corporate services.
- The trust had overachieved its financial plan and control total in 2017/18 and was forecasting to achieve its control total for 2018/19. The trust had an embedded Service Line Reporting which it used across the organisation, in particular to identify opportunities for efficiency savings.
- The trust had a strong cash balance at January 2019 of £67.4 million although this included a large loan to fund the trust's MY CARE programme.
- As part of its two-year Operational Delivery Plan, the trust was focusing on delivering productivity improvements, using for example Model Hospital data and recommendations from the Getting It First Time (GIRFT) programme. This provided a mechanism for staff to engage on identifying and delivering productivity improvements.

However, it should be noted that:

- At the time of the assessment, the trust did not meet any of the constitutional access standards although its performance on the 4-hour Accident & Emergency (A&E) wait was one of the strongest in the South region.
- The trust had progressed in reducing its Delayed Transfers of Care rate, but it remained above its improvement trajectory.
- The trust had ongoing recruitment challenges which together with continuous growth in activity had increased its spend on agency staffing.

- The number of consultants with a job plan was below the national median and the trust recognised it needed to improve its job planning process.
- The trust recognised that further work was required to understand and mitigate the drivers of its high sickness rate, in particular in light of its very good retention rate and staff survey engagement rate.
- The trust needed to ensure the data set provided to the Model Hospital relating to some clinical support services and procurement were updated and complete to allow benchmarking.
- Although the trust had a track record of delivering surpluses it was trading with an underlying deficit and the trust only forecast to deliver 39% of its efficiency plan recurrently in 2018/19.
- The trust generated significant income from commercial enterprises although some of these were loss making.

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

The trust benchmarked well on several clinical services metrics. Although it was not delivering the constitutional access standards at the time of our assessment, readmission rates were low and progress had been made in reducing the De rate. The trust had engaged with the Getting it Right First Time (GIRFT) programme to improve clinical productivity.

- At the time of the assessment, based on the latest data available (December 2018), the trust was not meeting the constitutional access standards for 18-week referral to treatment target (RTT) (82.6%), cancer 62-day wait (78.6%), 4-hour Accident & Emergency (A&E) (90.8% in January 2019) and diagnostic 6-week wait (16.1%).
- Although the trust was not achieving the A&E target, it was one of the stronger performers across the South region. Regarding RTT, the trust had seen a growth in referrals which had increased its waiting list over its agreed trajectory and it had increased 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.
- Patients were less likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 5.9%, emergency readmission rates were significantly below the national median of 7.8% as at September 2018. The trust explained they had taken a pathway approach over the last three years and worked together with local system partners to reduce readmissions. The trust also undertook a monthly MDT meeting with each local cluster to learn the lessons from avoidable readmissions and share good practice to reduce the rate.
- The trust had fewer pre-procedure bed days (0.54) than the national median for non-elective (0.65) and more (0.15) for elective compared to the national median (0.13). The trust argued that the higher rate for elective pre-procedure bed days was impacted by data quality issues and that its enhanced preparation for surgery service had allowed a thorough review of patients eventually resulting in reducing admission prior to the day of surgery. The trust also considered that its dedicated triage units (e.g. medical, ambulatory care, paediatric assessment unit) have contributed to the low non-elective pre-procedure bed days.
- The Did Not Attend (DNA) rate for the trust was relatively low at an average at 7.1% for September 2018 compared to a national median of 7.3%.

- The trust reported a delayed transfers of care (DTOC) rate that was higher than its internal improvement trajectory although the rate had decreased between 2017/18 and 2018/19. The trust had taken actions to reduce the rate including using community staff to cover gaps in the domiciliary care market and offering 'guaranteed hours' domiciliary care winter funded scheme. The trust had also brought in agency workers from other areas, was focussing on re-enablement and had recently introduced an intermediate care model in three community hospitals.
- The trust had engaged well with the GIRFT programme with several deep dive visits done with specialties (13 over 2017 and 2018). The trust had a governance process in place to review the actions taken by specialties to implement the GIRFT recommendations and there was evidence of improvements made, e.g. in ophthalmology, general surgery.
- The trust was addressing clinical productivity via its two-year Operational Delivery Plan with a workstream lead by the Chief Financial Officer, focusing on clinical productivity across the trust which built from the data and findings of programmes such as the Model Hospital and GIRFT to identify where the trust is an outlier and can deliver better care as well efficiency savings. The programme prompted staff to engage with identifying and delivering productivity improvements.

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

The trust's total pay costs per WAU were in line with the national median. The trust had relatively low agency costs when compared nationally, but in 2018/19 had experienced an increase in agency use which it sought to address through better usage of bank staff and recruitment. The trust's staff retention rate was one of the best nationally although its sickness rate benchmarked in the worst quartile nationally. The trust was using e-rostering and job-planning to plan and deploy staff efficiently although it recognised that further improvements could be made with the job planning process.

- For 2017/18 the trust had an overall pay cost per WAU of £2,180, which was the same as the national median. The trust medical staff costs per WAU (£563) and nursing staff costs per WAU (£760) benchmarked in the third highest (worst) quartile nationally and Allied Health Professionals (AHP) costs per WAU benchmarked in the highest quartile nationally. The trust however had non-substantive staff costs per WAU (£137) which benchmarked in the lowest (best) quartile nationally.
- The trust told us that one driver of the trust's high cost per WAU relate to the services provided to other trusts. The trust pays these individuals so this counts towards the trust's medical staff number, but the activity is recorded externally.
- The trust had experienced staff cost pressures because of significant increases in unplanned demand which meant the trust had increased its reliance on agency staff. The trust had taken steps to incentivise staff to join its staff bank through better bank pay rates and had progressed to address some of its recruitment issues. The trust also used the Allocate system to match demand and capacity and to better understand staffing requirements.
- The trust met its agency ceiling as set by NHS Improvement for 2017/18 and had an agency staff cost per WAU of £55 compared to a national median of £107, placing the trust in the lowest (best) quartile nationally. The trust was however forecasting to overspend against its ceiling in 2018/19 (£11.5 million spend compared to a ceiling of £8.7 million) although it continued to spend less than the national average on agency as a proportion of total pay spend (3.67% compared to 4.98%). The trust also explained that

in some instances, it delivered services for other providers which the trust was compensated for but resulted in inflated agency costs.

- The trust had taken actions to control its agency staff costs both in terms of supply and rota management. The trust had protocols in place to only use tier 1 (lower cost) staffing agencies when they had exhausted their staff bank and had worked with the STP to agree a common approach to reduce the use of high costs staff agencies.
- The trust had a high number of nursing vacancies (e.g. 150 band 5 nurse vacancies) and had introduced advanced roles and practices to reduce their impact. The trust monitored the number of staffs joining and leaving the trust each month to assess the continued vacancy level and plan accordingly. The trust had successfully recruited to overseas recruitment to fill in some of its vacancies and had developed a programme accredited with the University of Exeter to increase recruitment of Operating Department Practitioners and fill gaps in theatre nursing.
- The trust experienced challenges in the recruitment of junior doctors and consultants some of which were specific to the South West of England. The trust had seen a decrease in the number of consultant applications to vacancies although there was now a significant growth in the number of junior doctors. The trust had introduced innovative roles (e.g. physician associates, medical secretaries) to support consultants in focusing on patient interactions. The trust had achieved successes in the recruitment of middle grades doctors by diversifying the role to include elements such as research, ambulance services, sports medicine to make the role more attractive.
- The trust monitored the staff skill mix through a balanced scorecard and carried out a 6-monthly review of acuity and dependency to plan its staffing requirements. The trust provided the example of the Acute Medical Unit (AMU) as an exemplar where the trust had looked to deploy staff based on patient needs. Although the trust wanted to replicate this in other areas it felt it didn't yet have enough detailed information to do so. The trust had plans to implement Safecare in 2019 which would enable better deployment of staff based on patients' needs.
- For 2016/17, 79% of consultants had a job plan compared to a national median of 89%. The trust recognised that the low number reflected a cumbersome job planning process which needed to improve but the trust currently focused on improving the consistency of job plans.
- Staff retention at the trust was high, with a retention rate of 89.1% in July 2018 which placed the trust within the best 10 trusts nationally and better than the national median of 85.8%. The trust explained their achievement by a number of factors such as a strong focus on health and wellbeing, listening to staff to understand what was important to them, acting on their feedback and developing plans specific to staff categories (ie nursing) and divisions. The trust had also made a range of improvements such as health & wellbeing champions, access for staff to dieticians, flexible working, shift planning, supervision support. The trust also reported a good level of engagement in their annual staff survey.
- At 4.3% in June 2018, staff sickness rates were worse than the national average of 3.8% and the trust benchmarked in the highest (worst) quartile nationally. The trust recognised that it needed to do further work to fully understand the reasons behind the high sickness rate, in particular in light of high staff retention and engagement rates. The trust had identified key areas (eg long term sickness) and introduced measures to support managers and fed these into the development of its health & wellbeing plans.

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

The trust was using its clinical support services in an effective way to deliver a good service for its patients. Its pathology costs benchmarked as relatively expensive and the trust benchmarked well for imaging costs. The trust had relatively high medicines costs due to its pre-packaging unit and has 7 day on ward pharmacy services in place. The trust needs to ensure its data submitted to Model Hospital is updated as completely as possible.

- The overall cost per test for pathology for 2017/18 was slightly higher than the national median at £1.90 against a national median of £1.86 (second highest (worst) quartile). However, the trust benchmarked well for overall cost per capita (£37.00 against a national median of £40.27) and for total tests per capita (19.4 against a national median of 22.6).
- The trust hosts the South West NHS Genomics Medicines Centre and had not submitted any genetics data to the Model Hospital since 2015/16. The trust needs to ensure that the data is reported to Model Hospital to enable accurate benchmarking of the trust. The trust's Service Line Reporting (SLR) data for 2018/19 to December 2018 showed that the service is making a surplus for the trust.
- The trust was actively collaborating with the Peninsula Pathology Network to implement the recommendations from the Lord Carter Review into operational productivity in the NHS through delivery of a hub and spoke model. Several options were outlined in a Strategic Outline Case (SOC) that is currently with NHS Improvement for approval.
- The trust's overall cost per report for radiology benchmarked high against other trusts at £63.92 compared to a national median of £50.00 (highest (worst) quartile). The trust was reviewing the data to confirm that its submission to the Model Hospital is accurate and comparable. There are several fields on Model Hospital where the trust had not submitted any data and which prevented a comparison with the national and peer medians. The trust needs to ensure the data is submitted to update the Model Hospital and allow benchmarking.
- The trust had a high backlog across its imaging activity (2017/18 second highest (worst) quartile) and the trust was using a backlog reporting company to improve the position. At the end of January 2019, the position had improved but due to the increases in referrals over the last year (8% growth), more work still needs to be done in MRI and CT. The trust was reviewing options for additional CT and MRI equipment to be in place by Q1 of 2019/20 to further improve the position.
- For 2017/18, the trust had a low percentage of radiographers reviewing plain x-rays due to high radiographer vacancies. Following a successful recruitment campaign, the trust had filled all its radiographer vacancies and intended to see radiographer reporting increase for 2018/19.
- The trust's medicines cost per WAU at £376 was high compared to the national median of £320 for 2017/18 (highest (worst) quartile). This was expected due to the trust running an MHRA licensed prepacking unit that provides non-high cost medicines to external providers across the South and Wales. The service produced a surplus contribution to the trust's financial position.
- The trust was achieving above the target for the top ten medicines delivering 120% for 2017/18. The trust had also invested in its pharmacy service during 2018/19 and had further developed clinical pharmacy services on wards available 7 days a week.
- The trust had an ambitious digital strategy with an aim to promote clinically led transformation through the use of technology. The programme at the heart of it is called MY CARE which will include an Electronic Patient Record (EPR). The trust was aiming to launch MY CARE in June 2020 with delivery of a new electronic prescribing and

medicines administration (EPMA) and pathology system being linked to this. The trust was ensuring the software is interoperable with LIMs systems across the local health system as well as with EPR systems across GP services.

- The trust was also using technology to improve access to the hospital. Virtual follow ups were done across various specialities and as part of the system across the South West, the trust was supporting an app called NHS Quicker. This app allows patients to enter their symptoms and advises where and when is the most appropriate place to go.

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 non-pay cost per WAU in line with the national median and while Model Hospital data suggests the trust does not perform well on the procurement league table, the trust had resubmitted information that will move the trust higher up the table. The Trust benchmarked well for estates and facilities cost per m2 but must review its commercial income functions to ensure they are profitable.

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,307 in line with the national median of £1,307 (second lowest (best) quartile).
- The trust's supplies and services costs per WAU was £366 (third highest (worst) quartile) in line with the national median of £364.
- For 2017/18, the trust ranked 101 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 data the trust submitted to NHS Improvement had gaps and errors resulting in the low league table position. The trust has now submitted new data to NHS Improvement. At quarter 2 2018/19 the trust ranked 36 out of 133, placing the trust in the second-best quartile nationally.
- Purchase price index and benchmarking tool (PPIB) data suggested good use of the spend analytics benchmarking tool, with the trust performing well on percentage variance from median price (1.9%) and percentage variance from minimum price (9.2%) against both national (2.2% and 10.6% respectively) and peer medians (1.9% and 9.5% respectively). The trust had an innovative approach to clinical engagement in procurement where it held meetings with clinical staff from each speciality together to try to ensure it had a uniform approach from clinicians.
- The procurement team worked collaboratively across the STP as part of the Peninsula Purchasing and Supply Alliance and work was underway to achieve level 2 of the procurement standards.
- For 2017/18, the cost of running the trust's finance function was low at £0.505 million per £100 million turnover compared to the national median of £0.721 million per £100 million turnover. The trust had worked hard to ensure the costs of its transactional finance function was as low as possible while maintaining a highly qualified staffing function for its work with clinicians.
- The cost of running the trust's Human Resources (HR) function benchmarked well against other trusts at £0.689 million per £100 million turnover compared to a national median of £1.104 million per £100 million turnover. The cost of the recruitment team was high at £0.186 million per £100 million turnover compared to a national median of £0.107 million per £100 million turnover. The trust's data on Model Hospital for time taken to close employee relations cases was incorrect. The trust has provided us with accurate information that shows the trust is less of an outlier (third highest (worst) quartile) but has

more work to do in this area. The trust was reviewing whether there is a need to invest further in the HR function to benefit from additional HR support.

- The trust was collaborating with other trusts for payroll and pharmacy and was considering whether there are any opportunities to consider further collaboration across the procurement functions. The trust needs to consider whether there are opportunities to collaborate further across the STP in other areas, so the system can benefit from economies of scale and productivity made elsewhere.
- The Trust's 2017/18 estates and facilities cost per square metre was £265 compared to national median of £334 placing the trust in lowest (best) quartile. Both Hard FM (£51 per square metre) and Soft FM (£114 per square metre) costs are below the national median.
- For 2017/18, the trust had a backlog maintenance cost per square metre of £187 better than the national median of £254. The trust described a robust rolling ten-year capital plan that enables it to ensure its equipment is kept up to date.
- The trust received commercial income for various services it supplies to other trusts. Laundry and Catering were areas where the trusts data suggested the enterprise were making a deficit contribution to the trust's financial position for 2018/19. The trust should review these areas and ensure productivity opportunities are enacted to make the service sustainable going forward.

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

The trust had a track record of delivering surpluses although this had been supported by non-recurrent measures and the trust was trading with an underlying deficit resulting from significant activity growth not reflected into financial settlement with commissioners. The trust was delivering a lower level of recurrent savings in 2018/19 than the prior year. The trust's cash position was healthy although included a significant loan to finance its MY CARE project over the next three years. The trust generated a significant amount of commercial income, not all of it contributing positively to the overall financial position of the trust.

- In 2017/18, the trust reported a surplus of £12.5 million (including Sustainability & Transformation Fund (STF)), £13.1 million higher than its control total and plan of £0.5 million deficit mainly because the trust received a one-off benefit from the settlement of a contractual dispute and from additional STF funding at the end of the year. Excluding STF, the trust had delivered a deficit of £4.3 million (0.9% of turnover) against a control total of £9.2 million deficit.
- In 2018/19, the trust had planned to deliver a surplus of £6.3 million (including Provider Sustainability Funding (PSF); £6.0 million deficit excluding PSF) which was in line with its control total. At January 2019, the trust was forecasting to deliver its planned surplus, although with the support of one-off measures and despite the under-delivery of its recurrent Cost Improvement Plan (CIP).
- In 2017/18, the trust delivered £21.9 million CIPs (4.3% of expenditure). In 2018/19, the trust planned to deliver a higher CIP (£23.3 million or 4.4% of expenditure) mainly through recurrent schemes although, at the time the plan was put together, 23% of the savings schemes had not been identified. At January 2019, the trust had revised its forecast downward, expecting to deliver £21.5 million CIPs (4.0% of its expenditure) with only 39% schemes delivered recurrently (£8.3 million), a reduction on 2017/18 where the trust delivered £13.5 million of recurrent savings.
- The trust traded with an underlying financial deficit position. The trust explained that it had seen a significant and consistent increase in activity which was not funded under its

current block contract arrangement with its commissioners. The trust had compensated the funding gap by non-recurrent financial measures to support its financial position, but it had now less opportunities to do so.

- The trust had introduced several measures to improve its financial position through several improvements. The trust's two-year Operational Delivery Plan includes a workstream focusing on improving the productivity across the trust, building on data (eg Model Hospital) and productivity programmes (such as GIRFT) and is led by the Chief Financial Officer. The trust had also reviewed its approach to develop its CIP for 2019/20, to increase its focus on transformational schemes, lowering the target given to divisions to achieve. The trust was also looking to better anticipate growth at specialty level in its 2019/20 operating plan to decrease the reliance on temporary staff
- The trust had strong cash balance (£67.4 million) at the end of January 2019, including a significant loan taken to fund the MY CARE programme. The trust estimated that excluding the loan it had an underlying cash position of around £20 million which was enough to enable the trust to meet its financial obligations and fund its capital expenditure.
- The trust's use of Service Line Reporting (SLR) was well embedded at divisional and speciality level and was used for a variety of purposes including to identify efficiency opportunities. However, SLR didn't extend to community services due to the quality of the data available. The trust had also introduced patient level costing (PLICS), and although this was not yet embedded within the organisation, it was available to clinicians and was used to identify themes for improvement and saving opportunities.
- The trust had forecast to earn £1.6 million income from the treatment of private patients in 2018/19, a slight decrease on 2017/18. The trust had several commercial enterprises which at month nine (December) year to date had generated £11.3 million income in 2018/19 and £0.5m surplus although several business lines were loss making. The trust understood the reasons for the poor financial performance of these lines and were considering several actions to improve their productivity and financial performance.
- The trust was forecasting to spend £0.8 million on consultancy in 2018/19. The trust used management consultancy on a targeted basis to provide specific or specialist support which was assessed on a case by case basis to determine their value for money.

Outstanding practice

During our assessment, we identified several areas of outstanding practice:

- The trust had achieved successes in the recruitment of middle grades doctors by diversifying the role to include elements such as research, ambulance services, sports medicine to make the role more attractive.
- AMU was held up as an exemplar regarding skill mix and acuity.
- The trust has emergency readmission rates significantly below the national median which has been achieved through taking a pathway approach, working together with local system partners and undertaking a monthly MDT meeting with each local cluster to learn the lessons from avoidable readmissions and share good practice to reduce the rate.
- The trust has one of the 10 best retention rates nationally which the trust attributes to its strong focus on listening and working with staff to understand their concerns and needs.

Areas for improvement

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

- The trust needs to progress with the reduction in DTOC rate to meet its improvement trajectory.
- The trust's spend on agency staff is forecasted to be above its ceiling for 2018/19. The trust needs to progress with reducing its agency spend to operating on or below its ceiling in 2019/20.
- The trust needs to improve its job planning process to increase the number of consultants with an active job plan to meet or exceed the national median.
- The trust needs to identify the reasons for its high sickness rate and implement appropriate actions to reduce it in line with the national median.
- The trust must ensure it provides accurate and complete data to the Model Hospital on genetics and imaging to allow benchmarking.
- The trust needs to improve on the time to close employee relations cases and consider whether further investment in the HR function is required.
- The trust should consider further opportunities to collaborate consolidating back office services across the STP.
- The trust should review its commercial enterprises to ensure productivity opportunities are enacted to make these services financially sustainable going forward
- The trust should ensure its CIP for 2019/20 is realistic, deliverable but stretching and have a clear plan as to how it will go back to a break even underlying financial position in the medium term.

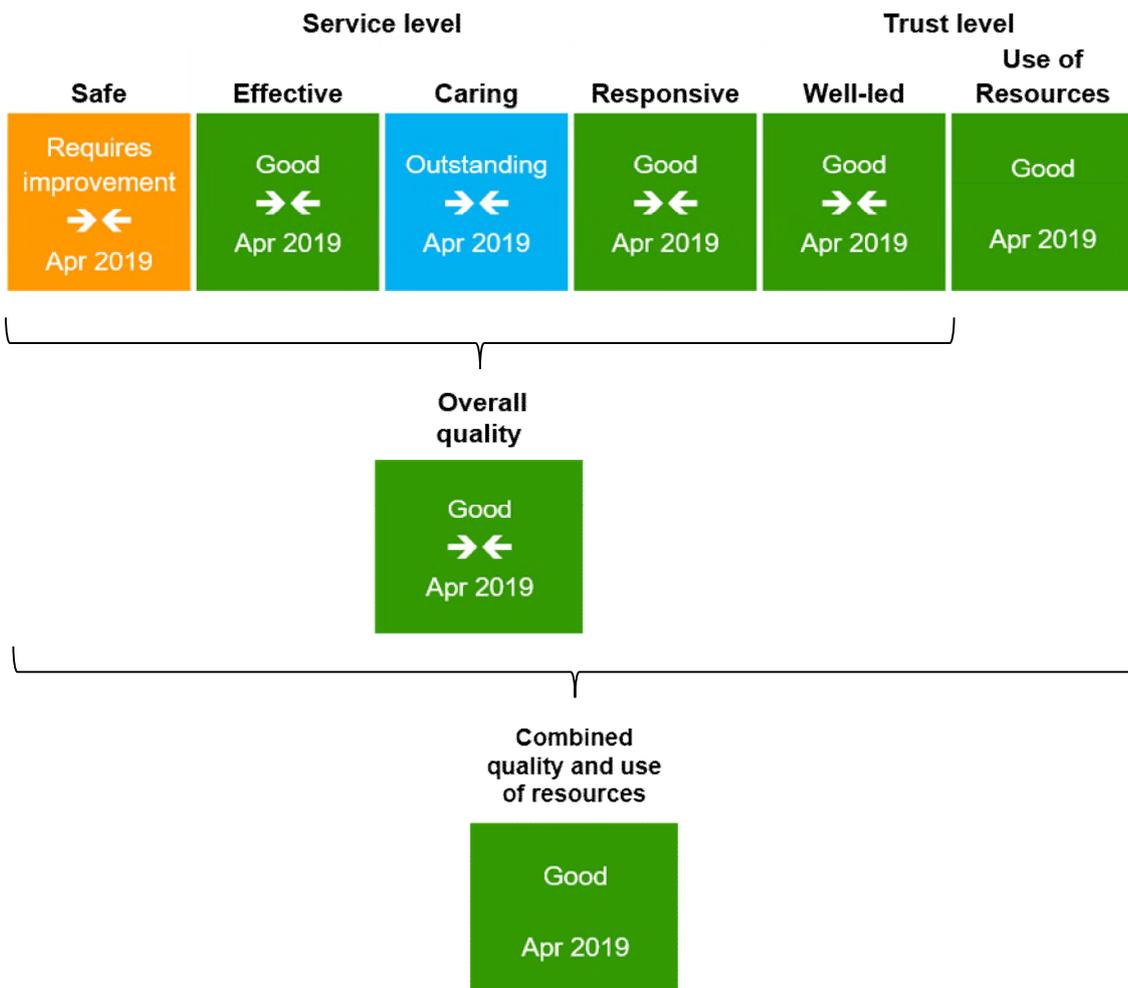
Ratings tables

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

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

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

Ratings for the whole trust



Use of Resources report glossary

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

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

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

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