Calderdale and Huddersfield NHS Foundation Trust

Use of Resources assessment report

Huddersfield Royal Infirmary, Trust Headquarters
Acre Street, Lindley, Huddersfield
West Yorkshire, HD3 3EA

Date of publication: 20 June 2018

Tel: 01484342000
www.cht.nhs.uk

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

Ratings

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

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

Are resources used productively?	**Requires improvement**

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

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

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

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.
This is the first time that we have awarded a combined rating for Quality and Use of Resources at this trust. The combined rating for Quality and Use of Resources for this trust was good, because:

- We rated effective, responsive, caring and well-led as good and safe as requires improvement.
- At this inspection, we inspected six core services and rated five of them as good and one as requires improvement overall.
- In rating the trust we took in to account the current ratings of the services we did not inspect. We inspected and rated the maternity core service separately from gynaecology; therefore the previous rating for the combined services was not used.
- We rated well-led for the trust overall as good and this was not an aggregation of the core service ratings for well-led.
- The trust was rated requires improvement for Use of Resources.

NHS Improvement

Calderdale and Huddersfield NHS Foundation Trust

Use of Resources assessment report

Huddersfield Royal Infirmary, Trust Headquarters
Acre Street, Lindley, Huddersfield
West Yorkshire, HD3 3EA

Tel: 01484 342000
www.cht.nhs.uk

Date of site visit:
28 March 2018

Date of NHS publication:
20 June 2018

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.

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 Use of Resources assessment framework.

We visited the trust on 28 March 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the Deputy Chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Summary of findings

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

We rated the trust's use of resources as 'Requires Improvement' because this trust is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients.

- The trust reported a deficit of £14.7 million for 2016/17 (including £12.7 million Sustainability and Transformation Funding, STF) which was better than plan and the designated control total of £16.2 million deficit. In 2017/18 the trust is forecasting not to deliver its control total with a deficit of £31.4 million against a planned deficit of £15.9 million (due to a shortfall in STF of £7.4 million and under delivery of £8 million against its plan).
- In 2017/18 the trust is forecasting to save £2 million less than the £20 million target described in its Cost Improvement Programme, with 50% being recurrent contributing to the failure to deliver the 2017/18 control total. This means that going into 2018/19 the trust will need to find an additional £11 million of savings or there will be a worsening of the trust's underlying deficit position.
- The trust is reliant on cash loans in order to pay staff and deliver its services. The trust has a strategic plan to address this position and delivery of long term financial stability through reconfiguration of the two sites Huddersfield Royal Infirmary and Calderdale Royal Infirmary.
- The trust has a cost per weighted unit of activity (WAU) that indicates that the trust is less productive at delivering services than other trusts by showing that, on average, the trust spends more to deliver the same number of services.
- The trust spent £241.1 million on pay in 2016/17 with a pay cost per WAU in the highest (worst) quartile of trusts nationally which the trust does not expect to have improved in 2017/18. The trust spent £23.4 million on agency costs in 2016/17, which was £8.5 million more than the agency ceiling set by NHS Improvement. Although there was a reduction in agency spend in 2017/18, this is not reflected in an overall reduction in the trust's pay bill and the trust is spending more than the national average on agency as a proportion of total pay spend. The trust is also an outlier in terms of agency pay cap breaches meaning it pays above the nationally agreed rate for agency staff more frequently than most trusts.
- The trust evidenced they have invested in improvement measures and have clear processes for formal follow up and review of the impact. In the cases reviewed by the assessment team, the trust didn't have sufficient evidence to demonstrate measurable quantitative benefits and return on investment of these improvements. The trust was unable to evidence that interim benefits and milestones where monitored on these transformational improvements.

However:

- The trust has achieved improvements in the delivery of clinical services that demonstrated benefits to patients and work is ongoing to deliver further improvements.
- The trust continues to engage with the Getting It Right First Time programme.
- The trust has worked collaboratively with local partners to reduce delayed transfers of care and avoid unnecessary admissions to hospital. The trust's performance for pre-procedure elective bed days is within the top quartile (best) in England.
- The trust has evidenced that it is a learning organisation through its continual focus on improvement and reflection, and commitment to take decisions to withdraw resources if they cannot evidence the expected impact.

- The trust is using technology in innovative ways and has put in place the building blocks to provide a strong platform for further development of its digital maturity.
- The trust is within the top (best) quartile for the top ten medicines, demonstrating that it is working to maximise opportunities from savings in this area.
- The trust has a very strong model of CIP governance arrangements in its systems and processes which have been promoted as an exemplar for others to adopt. However, during 2017/18, the trust explained to us the need for management capacity to be redirected to focus on EPR recovery due to the financial implications of not addressing this being higher than not delivering the full CIP

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

- At the time of the assessment the trust was meeting the constitutional operational performance standards around Referral to Treatment (RTT) and Cancer. Although the trust did not consistently meet the national 4 hour Accident & Emergency (A&E) target, in February 2018 (latest published data) the trust achieved 87.5% which placed them 37th out of 139 acute trusts nationally.
- At 10%, emergency readmission rates are slightly above the national median of 9% between September 2016 and September 2017. The trust told us that the introduction of the Electronic Patient Record (EPR) had resulted in issues with data coding and that 2% of these readmissions should not be captured in this figure. Prior to the introduction of EPR, the rate of emergency readmissions was below 9%.
- Fewer elective patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals in England. For pre-procedure elective bed days, at 0.04, the trust is performing in the lowest (best) quartile when compared to a national median of 0.13.
- For pre-procedure non-elective bed days, at 0.84, the trust is performing above the national median of 0.78. The trust told us that the introduction of the EPR had resulted in issues with data coding. Prior to the introduction of EPR, pre-procedure non-elective bed days were 0.68.
- To reduce the time patients spend in hospital prior to their treatment, the trust had implemented changes to reduce the time patients waited for surgery for a fractured neck of femur and made changes to the general surgery rota. In the general surgery team, the time patients waited to see a consultant reduced from 18.25 hours to 5.3 hours (median) and consultant presence in theatre increased from 76% to 91%. The general surgery team won a Health Service Journal award in 2017 for this work.
- The Did Not Attend (DNA) rate for the trust was 7% between September 2016 and September 2017 which is the same as the national median. The trust has undertaken an outpatient productivity programme during 2016/17 and 2017/18 and implemented initiatives to improve DNA rates, including the use of a text messaging service and strengthening and implementing the access policy. The introduction of EPR had negatively impacted the DNA rate in the early stages (peaking at 8.34% in the second quarter of 2017/18) due to issues with data migration. The trusts rate was 6.8% during quarter 4.
- The trust reports a delayed transfers of care (DTOC) rate that is lower than average. The trust has worked with local partners to reduce DTOCs from 15% in 2015 to 2.9% between February 2017 and January 2018. This work has included integrating health and social care teams within the hospital and introducing a trusted assessor model in conjunction with both Local Authorities.
- There were a number of admission avoidance schemes in place including a community crisis intervention team with a two hour response time and a Quest for Quality project that was an initiative working with care homes.
- The trust has engaged with the Getting It Right First Time (GIRFT) programme. Reviews have been completed in orthopaedics, general surgery, obstetrics and gynaecology, ear nose and throat (ENT), ophthalmology, paediatric surgery and vascular surgery and action

plans have been developed to work to reduce unwarranted variation and associated costs. Work is in progress to improve theatre productivity. The trust has one of the lowest litigation costs for obstetrics in England and the GIRFT litigation team had visited this service to gather examples of good practice.

- The trust provided examples of work undertaken to improve clinical productivity, including the development of a frailty team at both hospital sites which demonstrated admission avoidance and reduced length of stay. This work had been achieved at no additional cost through reallocating resource and using a quality improvement network.
- Following an invited service review, the trust has been able to reduce the number of stroke rehabilitation beds by 16, whilst also opening two hyper acute stroke beds and improving the trust's Sentinel Stroke National Audit Programme (SSNAP) score from a Level D (several areas require improvement) to a Level B (good or excellent in many aspects).
- The trust's internal reviews for Dermatology and Neurology have identified the need for wider collaboration and will be an area of focus for 2018/19, with preparatory work having taken place across the West Yorkshire Association of Acute Trusts (WYAAT) to agree priorities for services requiring a sustainable solution over a larger footprint that individual organisations
- In year, the trust has made configuration changes on the recommendation of external Royal College reviews which focused on improving clinical outcomes and maximising best use of its workforce resources. This resulted in changes to the Cardiology, Respiratory and Elderly services. At the time of the visit the trust had not completed the post implementation review of these moves as they were scheduled for May 2018, however, it was recognised they created a platform for the trust to improve patient safety and overall use of resources within these services.

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

- For 2016/17 the trust had an overall pay cost per weighted activity unit (WAU) of £2,315, compared with a national median of £2,157, placing it in the highest (worst) cost quartile nationally. This means that it spends more on staff per unit of activity than most trusts. The trust is in the highest (worst) quartile for nursing cost per WAU, and the highest (worst) quartile for agency spend. The 2017/18 position has seen a growing pay bill, at the time of the visit this is forecast by the trust to be 1.7% above 2016/17 levels and there is no evidence that the cost per WAU will improve in 2017/18.
- In addition in January 2018, the trust reported a 14.2% increase in non-elective activity for 2017/18 compared to the same period in 2016/17 indicating that the pay cost per WAU is unlikely to have improved in 2017/18. This was 12.7% above the year to date planned activity levels and has had a corresponding impact on the staffing level required.
- The trust spent £23.4 million on agency costs in 2016/17, which was £8.5 million more than the agency ceiling set by NHS Improvement. In 2017/18 the trust has met its agency ceiling. The reduction in agency spend is not reflected in an overall reduction in the trust's pay bill and the trust is spending more than the national average on agency as a proportion of total pay spend. The trust is also an outlier in terms of agency pay cap breaches meaning it pays above the nationally agreed rate for agency staff more frequently than most trusts.
- In response to the Model Hospital data on cost per WAU, the trust commissioned a review of its nurse staffing model. The review identified opportunities to improve controls and increase skill mix opportunities within the registered workforce to reduce agency spend.
- In 2017/18 the trust has grown its internal staffing bank by 47%. It has seen an increase in average weekly bank hours from 756 in September 2017 to 2321 in March 2018. The trust has invested in a centralised flexible workforce team which has enabled increased oversight and analysis of agency usage and supported enhanced controls. The trust demonstrated that it is now taking different decisions to help reduce agency cap breaches

than it was 12 months ago. The trust has rationalised the number of agencies supplying staff and negotiated set rates for commission for supplying agency Doctors as well as medical, nursing and Allied Health Care Professionals (AHP).

- The turnover rate at the trust has increased from 11.9% in January 2017 to 13% in January 2018.
- The trust's vacancy rate has decreased from 6.2% in December 2017 to 5.8% in December 2018. There are vacancies in both the nursing and medical workforce.
- The trust cites the current dual site acute service model as a key reason for difficulties in recruiting and the large numbers of rota gaps for medical staff. The trust has a number of consultant vacancies including in medicine and interventional radiology.
- The trust has a portfolio of recruitment and retention initiatives which have resulted in a growth in the consultant workforce and a reduction in long term locum use from 31 in March 2017 to 18 at the time of our visit. The time taken to recruit to posts has also improved from 21.6 weeks in February 2016 to 10.1 weeks in October 2017. This is better than the national average.
- The trust has implemented a Certificate of Eligibility for Specialist Registration (CESR) programme as an opportunity to develop Consultants for the future and has invested in support programmes for doctors in training. Joint posts with a local provider have been advertised, however, interest has been limited.
- The cardiology, respiratory and elderly service reviews in 2017/18 have led to an improved ability to recruit to consultant posts.
- The trust has expanded the use of Advanced Nurse Practitioners (ANPs), Advanced Clinical Practitioners (ACPs), Nursing Associates and Advanced Radiographers. The trust has recruited a large cohort of Physician Associates across a range of specialities and in-year the focus has been on the training and development of these posts. The opportunity exists to review how these contribute to productivity and efficiency gains moving forwards.
- The trust is actively managing the apprentice levy and increasing its recruitment of apprenticeships. The use of an out-of-hours band 3 task force complimented by technology has enabled more productive usage of junior doctor capacity overnight. The use of band 3 and 4 Nursing Associates within theatres and the discharge lounge has allowed the reduction in Registered General Nursing posts in these areas. The trust has also undertaken a review of nurse bandings and job plans of ANPs in the orthopaedics service and ACPs in the Emergency Department resulting in increased activity.
- The trust has seen mixed success with its use of international recruitment as despite having made job offers to 85 nurses; to date the trust has 12 of these in post.
- The trust has invested in an e-rostering system. This is in place for the nursing workforce and is in the process of being rolled out for the medical workforce. This technology builds on and complements the work the trust has done around detailed job planning and demand and capacity modelling, including participating in an external demand and capacity review in 2017 with expertise from NHS Interim Management and Support (IMAS). Currently 70% of consultants have a job plan as evidenced by the information submitted by the trust in response to our KLOEs and 100% of AHP job plans are in place.
- An electronic staff record (ESR) is in use with an 86% staff uptake of the self-service functionality. The trust has used this technology alongside wellbeing programmes and improved return to work interviews to reduce long and short term sickness rates. The trust has seen a decrease in the sickness rate from 4.4% in February 2017 to 4% in February 2018 which is in line with the national average of 4%. The medicine division has the highest sickness rate across the trust at 4.72% in December 2017. This division also has a high vacancy factor and is monitored on the monthly trust workforce performance report.
- The trust has implemented an EPR which supports one clinical record that can be accessed anywhere in the hospital, community and by GPs. EPR implementation within the trust has initially had a detrimental effect on productivity and efficiency and this remains a challenge for the trust within outpatient productivity.

- Whilst the trust has provided evidence of investment in a number of different workforce initiatives, it was not always clear that the impact was fully understood or that sufficient evidence was available to be able to demonstrate the return on investment. Examples of this include initiatives such as the nursing bank pay uplift, the enhanced care team and the flexible workforce team.

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

- The trust is using its clinical support services in an effective way to deliver high quality services for its patients. Its overall cost per test is £1.23 which places it in the highest (best) quartile nationally below the median cost of £1.91. This has been supported by the trust not relying solely on consultant staff to deliver its Pathology service, instead employing Advanced Practitioners to deliver some of the tests. The trust has also made efforts to improve its recruitment and retention of staff by spending time with them and discussing what issues are relevant/important to them as a group.
- As a result of developments within the clinical support services the trust has been able to provide direct access services for blood sciences meaning that patient's results are available more quickly.
- The trust is collaborating with other service providers to deliver non-urgent pathology services, such as delivering a joint microbiology service with the Mid Yorkshire Hospitals NHS Trust which has supported the sustainability of these services across the wider footprint.
- The trust's cost per WAU for medicine is £316 which is better than the national average of £320. As part of the Top Ten Medicines programme it is making good progress in delivering on nationally identified savings opportunities, achieving 150% of the savings target (as at January 2018), against a peer median of 118% and a national median of between 80 – 100%.
- The trust Pharmacy team is able to implement drug switching opportunities and promote the use of biosimilar drugs. The trust stated that clinical involvement was a key enabler for this. This has been supported by the establishment of a Clinical Engagement Group which brings together consultant staff and pharmacists. The trust stated that they have worked well with patients, as evidenced by the number of patients agreeing to change their medicines.
- The trust is using technology in innovative ways to improve operational productivity. Examples include the development of the Nerve Centre – an IT system capable of capturing vital signs of patients and their location within the trust to aid and support patient flow; the development of a Self-Check-In system for patients attending the hospital which the trust explained is starting to have an impact in reducing administration and clerical staff input; and the development of a Knowledge Portal which allows managers to see at a glance the overall performance of key areas in the trust including outpatient productivity such as 'new to review appointments' and clinic utilisation levels.

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

- For 2016/17 the trust had an overall non-pay cost per WAU of £1,287 compared with a national median of £1,301, placing it in the second best cost quartile nationally and a better position compared to the trust's peer median of £1,309.
- The trust has a relatively high cost for its finance function with a cost per £100 million of turnover of £744,526 which is above the national median of £685,219. However, its Human Resources department costs are slightly lower than the national average with a cost per £100 million turnover of £637,367 in comparison to the national average cost of £761,285.
- In 2017/18, the trust opted to utilise its existing finance capacity levels to support development of a major business case proposal. The trust noted this resulted in the trust

not having to spend money on procurement of external advisers. However, the trust recognises the need to address the variations in cost moving forwards and has begun to work with the Operational Productivity team within NHS Improvement to develop plans to reduce some of its corporate service functions during 2018/19.

- The trust has started to work with other trusts to consolidate some of its service functions and as part of this has reached an agreement to move its Payroll services to Leeds Teaching Hospitals NHS Trust.
- The trust's Procurement Process Efficiency and Price Performance Score is 28.4, which placed it in the lowest (worst) quartile when compared with a national target benchmark average of 79 and a peer median 55.9. This means that the trust's procurement processes are relatively inefficient and tend not to successfully drive down costs on the things it buys. However, there is evidence which supports an improvement in this position. In 2016/17 the trust had a target saving of £2.4 million associated with it moving towards minimum pricing levels for the goods and services it purchases. In 2017/18 this target opportunity has reduced to £0.9 million implying an improved procurement position.
- The trust has a cost per WAU of £331 for its Supplies and Services against a national average of £375 and a peer cost median value of £354. The trust's procurement team are actively working with partners across the West Yorkshire Alliance of Acute Trusts to work more collaboratively in a number of procurement areas, including product switches and the purchase of non-consumable items of equipment.
- At £435 per square metre in 2016/17, the trust's estates and facilities costs benchmark is significantly above the national average of £351 per square metre. The trust explained the majority of this relates to the upkeep of properties which are not included in the previous PFI scheme agreed with the trust and which are becoming increasingly difficult to maintain. The trust has limited access to capital to fund remedial works.
- The trust has engaged specialist advisors to support discussion around the current PFI contract.
- The trust has evidenced that is it ensuring it receives best value for money when disposing of NHS estate that is no longer required to deliver health and care services. For example, it withheld the sale of a site when the final offer came in below what the property was worth.
- The trust has worked in partnership with four other trusts across West Yorkshire to develop a Joint Venture company proposal (wholly owned subsidiary company) which, if approved in August 2018, will deliver increased estates and Facilities Management benefits during 2018/19 and beyond for the participating trusts.

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

- The forecast position for 2017/18 is a deficit of £31.4 million, £8 million worse than plan, excluding Sustainability and Transformation Funding (STF), and £15.4 million worse than plan including the loss of STF. Loss of STF is due to financial and A&E performance being worse than plan.
- A key financial performance issue has been £11.3 million less clinical income from patient care activities than planned. The trust has demonstrated the clinical income loss to be primarily attributable to the impact of EPR implementation on productivity, and significant management activity and focus has resulted in most areas being restored to pre EPR productivity levels. The trust continues to work with its EPR partner to address the remaining issue of outpatient productivity.
- The original 2017/18 cost improvement plan (CIP) of £17 million was increased to £20 million following contract mediation, which is 5% of its expenditure. In recent years the trust has had a relatively strong track record of CIP delivery, over achieving CIP in 2016/17 by £0.98 million with 74% of the £15 million delivered recurrently. However, in 2017/18, the

trust is forecasting to deliver £2 million less than the £20 million in year plan with 50% being recurrent. This has resulted in an increase to the underlying deficit of the organisation. EPR implementation was evidenced by the trust to have had a direct impact on deliverability of some CIP schemes, such as outpatient efficiency, and was cited by the trust as having had an indirect impact through diversion of management capacity and focus.

- A specific review of the trust's CIP governance arrangements by NHS Improvement on 8 June 2017 concluded that they have a very strong model, which has been promoted as an exemplar for others to adopt. This includes the associated Quality Impact Assessment (QIA) processes where there was evidence that QIA resulted in changes to schemes, for example, deferring a scheme to close a ward that had sub-optimal use of resources and 20% bed occupancy on the grounds of clinical safety within winter response plans.
- At the time of the visit the trust described how it has further improved its CIP planning processes, with a focus on increasing clinical engagement by involving Clinical Directors from the beginning of the CIP opportunities identification process. This had resulted in the trust being able to submit a draft 2018/19 plan in March 2017 with a CIP target of £18 million, of which £15 million of saving schemes had already been identified, 85% of which are recurrent.
- The trust recognises that its current configuration of two acute sites is not financially sustainable. This is supported by the findings of the Strategic Turnaround Plan developed by the trust with support from Ernst and Young in the period between October and December 2015. Operationally this places limitations on the trust's ability to make best use of resources. The future model is subject to uncertainty pending national consideration of the trust's business case, however, the trust has demonstrated that it understands the need for structural change in its decision making during 2017/18, including decisions on the targeting of capital investment into backlog maintenance and the centralisation of the pharmacy stores and the trust's aseptic unit.
- The trust is reliant on cash loans due to having an underlying financial deficit over a number of years, but demonstrated that it has robust cash management governance arrangements in place, supported by an improved forecast amount of 'cash in the bank to pay invoices. The Trust has improved its ability to pay invoices in time
- The trust evidenced the use of a variety of benchmarking data including Model Hospital, Service Line Reporting (SLR) and Patient Level Information Costing (PLICs) to explore areas for improvement. The trust also evidenced active participation in wider West Yorkshire and Harrogate partnership working to deliver efficiencies, including trust senior managers leading collaborative efficiency work streams spanning multiple organisations which had delivered savings in 2017/18. Specific examples included estates and pharmacy.
- The trust evidenced that it was seeking and delivering opportunities to maximise its non-clinical income. The trust has a significant commercial income from its Pharmacy Manufacturing Unit "Huddersfield Pharmacy Specials" (HPS) which supplies hospitals across England. HPS has a turnover of £9 million and has grown its contribution in 2017/18 by £0.45 million to a total of £2.75 million. The trust also has "The Health Informatics Service" (THIS) providing IT services and support to other NHS providers with a turnover of £5 million, making a contribution of £0.5 million. There was evidence that the trust is pursuing further opportunities, for example it had recently secured £2 million capital funding for a business case to enable THIS to become the lead provider for a national pathology exchange.
- The trust evidenced it has internal governance arrangements to scrutinise use of external

management consultants and focussed on expert advice required to pursue efficiencies such as, reducing agency costs and reducing PFI facilities management costs by £4.2 million. The trust demonstrated the use of partnership working to minimise costs, including joint commissioning of external expertise for the implementation of Special Purpose Vehicles. The trust has also taken steps to limit spending on external consultancy for development of a major capital business case by using internal and NHS Improvement support. The trust described close monitoring and management of external consultancies, for example, terminating a contract after 5 working days when the expected results were not being delivered.

Outstanding practice

- The way the trust Pharmacy team is able to implement drug switching opportunities and promote the use of biosimilar drugs is exemplary, achieving 150% of the savings target. There is a high level of clinical engagement and also public engagement which underpins the work the team is able to do.
- The use of innovative workforce solutions to drive efficiencies can be seen within the trust's Pathology service. The use of Advanced Practitioners to deliver some tests has enabled them to have a cost per test of £1.23, which is in the best quartile nationally.

Areas for improvement

- The trust has opportunity to improve exists in the pay cost / WAU at the trust, particularly in regards to agency staffing. The trust needs to demonstrate an improvement path towards at least a median cost per WAU.
- In 2017/18 the trust is forecasting to save £2 million less than the £20 million target described in its CIP, with 50% being recurrent. The trust needs to improve its identification of recurrent opportunities for savings and productivity in line with the opportunities identified in this report so that it can reduce its underlying financial deficit and bring financial performance back in line with its 5 year recovery plan.
- The trust needs to ensure it delivers the return on investment and maximises realisation of the benefits of the innovative technologies it has implemented, including a plan to maximise the opportunities provided by the EPR implementation and the overall digital maturity.
- Whilst the trust has provided evidence of investment in a number of initiatives it was not always clear that the impact was fully understood or that sufficient evidence was available to be able to demonstrate the return on investment. The trust must ensure that it has robust systems of measurement in place to track investments and enable timely decision making about their effectiveness.

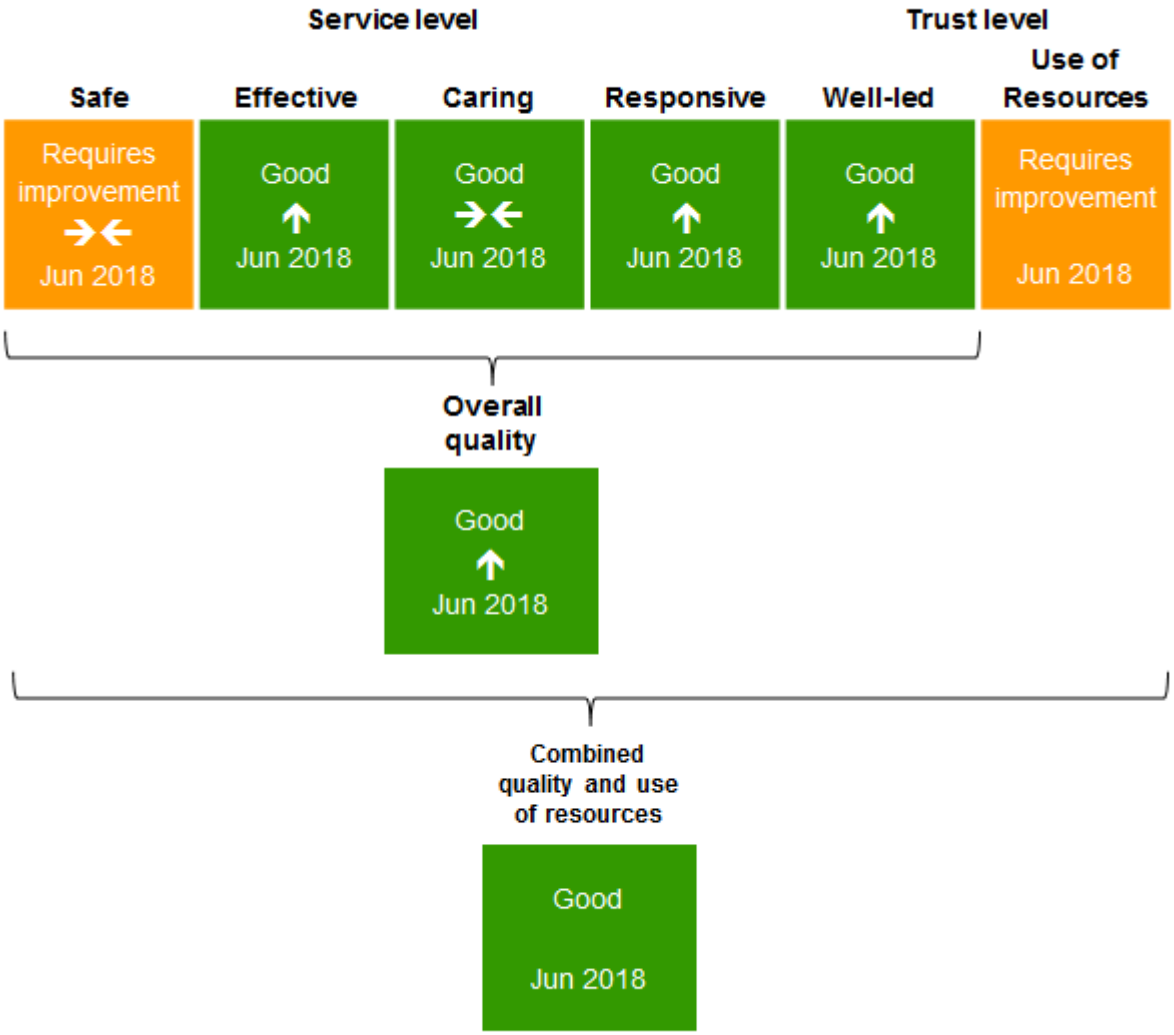
Ratings tables

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	A high level of DNAs indicates a system that might be making unnecessary

(DNA) rate	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.

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.