Southport and Ormskirk Hospital NHS Trust

Use of Resources assessment report

Southport and Formby District General Hospital
Town Lane, Kew
Southport
Merseyside
PR8 6PN
Tel: 01704 547471
www.southportandormskirk.nhs.uk

Date of publication: 29 November 2019

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

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

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/RVY/reports)

Are resources used productively?	**Inadequate** 🔴

Combined rating for quality and use of resources	Requires improvement

Ratings

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 requires improvement, because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good. At this inspection we inspected eight core services. We rated six of the trust's services as good and two as requires improvement. In rating the trust, we took into account the current ratings of the four services not inspected this time. This means overall there are five services rated as requires improvement and seven services with overall ratings of good.
- We rated well-led for the trust overall as requires improvement.
- We were concerned that issues raised at our previous inspection in relation to medical wards had not been effectively addressed and mitigated in a timely

manner. Our concerns meant the rating for the safe domain for medicine went down to inadequate.

- Across the trust we were concerned regarding the completion levels of mandatory training for resuscitation (61%).
- At our last inspection we had concerns relating to the storage of hazardous materials. At this inspection we remained concerned.
- We identified concerns during our last inspection as we found the use of bed rails was not consistent with the trust's policy. Patients' needs were not always assessed, which represented a patient safety risk. We found similar concerns at this inspection.
- We were concerned regarding medicines, including medicines that were passed their expiry date and in relation to the way that controlled drugs were managed. We escalated this to the trust at the time of our inspection.
- At our last inspection during our reviews of records we identified that staff had not completed documentation for Mental Capacity Act, Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation plans appropriately. This represented a patient safety risk. We had similar concerns at this inspection.
- We were concerned regarding staff competencies including how they were evidenced. In relation to equipment, we were not assured that the trust had oversight as to whether staff were competent. We found gaps in records relating to competencies. Staff were also unclear regarding their roles and responsibilities in relation to capacity assessments.

However:

- During this inspection we improved the overall rating of urgent and emergency services, children and young people's services and the rating for effective in end of life care to good. Our overall hospital rating for the well-led domain was improved to requires improvement.
- Since our last inspection the trust had developed a strategy and a vision, which most staff were aware of.
- Our full inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website – https://www.cqc.org.uk/provider/RVY/reports
- The trust was rated inadequate for use of resources. Full details of the assessment can be found on the following pages.

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Date of site visit:
24 July 2019

Date of NHS publication: 29 November 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.

Are resources used productively?	**Inadequate** ●

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 patients. The assessment team has, according to the published framework, examin trust's performance against a set of initial metrics alongside local intelligence from N Improvement's day-to-day interactions with the trust, and the trust's own commenta performance. The team conducted a dedicated site visit to engage with key staff us key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; c support services; corporate services, procurement, estates and facilities; and financ KLOEs, initial metrics and prompts can be found in the Use of Resources assessm framework.

We visited the trust on 24 July 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

- We rated the trust's use of resources as inadequate.
- The trust has a significant deficit in relation to turnover and has an inconsistent track record of managing spending within available resources and in line with plans. Since 2017/18, the trust has been in Enhanced Financial Oversight with NHS Improvement and for the past year has had a Financial Turnaround Director. The trust does not have a plan to return to financial balance.
- The trust failed to balance its budget in 2018/19, reporting a deficit of £29 million. As of the first quarter in 2019/20, the trust is on track to achieve a deficit of £8.3 million (which includes £18.3m of PSF, FRF and MRET funding), however, delivery of the quarter 1 financial plan was reliant on non-recurrent benefits.
- The trust has a cost improvement plan (CIP) of £6.3m (or 3% of its expenditure) and is currently forecasting to deliver against its plans. 11.1% is planned to be non-recurrent. As at the end of quarter 1, the trust has delivered £0.4m (6.5% of the annual target). In addition, £2.5m of the annual target is still unidentified.
- The trust will not be able to meet its all financial obligations in 2019/20 without cash support from the Department of Health and Social Care. The trust has been reliant on external funding to meet its financial obligations and deliver its services for the past three years and currently has a liability of £103m of revenue support loans on the balance sheet.
- The trust spends more on pay and other goods and services per weighted unit of activity (WAU) than most other trusts nationally. This 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. This is reflected in their overall cost per WAU of £3,749 compared to a national median of £3,486.
- Underneath this headline metric, the trust's pay cost per WAU at £2,577, is above the national median of £2,180. In addition, this is coupled with a high number of vacancies across various staff groups, resulting in high agency usage and spend. However, the trust's non-pay cost per WAU, at £1,172 benchmarks below the national median of £1,307.
- Individual areas where the trust's productivity compared well included Delayed Transfers of Care, Did Not Attend rates, staff retention and procurement.
- However, opportunities for improvement were identified in clinical productivity, staff sickness rates, pay costs, agency spend, pathology, pharmacy and estates and facilities. Furthermore, the trust has a

significantly higher than median spend per £100m turnover across its corporate services.

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 in July 2019, the trust was meeting the constitutional operational performance standards around Referral to Treatment (RTT) (94.2% in April 19). The trust has maintained a continuous and sustained performance above 92% in the preceding 12 months.
- However, the trust was not meeting the constitutional operational performance standard for diagnostics or for Accident and Emergency (A&E). Although the trust has failed to meet the national 95% standard for A&E for the previous 12 months, it did perform above 85% for 8 months, with 2 months above 90%. The trust was able to describe improvements to support flow and improve patient safety, which included working with NHSI/E's Emergency Care Intensive Support Team (ECIST), the development of a CDU and the identification of cohorts of patients that don't need to be seen through A&E. The trust also highlighted the development of a business case to enhance their frailty provision supporting the front door and wider trust benefit. The trust recognised that further system integration is needed but the model was not described.
- The trust performance against the cancer 62-day standard has been variable over the previous12 months. The trust highlighted an increase of 32.5% in the number of patients referred over the last 5 years. The trust provided additional information describing their cancer improvement plan, which although is in its early phase, recognises the key areas of challenge and describes a number of actions that have already been completed.
- Patients are more likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 8.81%, emergency readmission rates are above the national median of 7.73% as of quarter 4 2018/19, placing the trust in the highest (worst) quartile). However, the trust has seen a reduction in re-admission rates from the previous quarter at 10.05%. The trust demonstrated it has worked proactively with ECIST, North West Ambulance Service and other system partners to improve internal and system pathways.
- More patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals in England.
    - On pre-procedure elective bed days, at 0.27 days, the trust is performing in the highest (worst) quartile when compared nationally – the national median is 0.12 days. The trust noted this was as a result of the demographics of their population, with a higher than average proportion of patients over 75. However, the trust was not able to provide a detailed breakdown to demonstrate this. The trust demonstrated it has introduced a number of initiatives to reduce pre-procedure elective bed days in certain specialities, for example; bringing patients in for bowel preparations ahead of the surgery date

and sending them home to return on the day of surgery, therefore avoiding the patients staying in hospital prior to the procedure.

  - On pre-procedure non-elective elective bed days, at 1.12 days, the trust is performing in the highest (worst) quartile when compared nationally – the national median is 0.66 days. Again, the trust reflected that there is a relationship between the age profile of their patients and the pre-procedure bed days metrics. The trust provided examples of developments introduced, such as; Same Day Emergency Care provision, a surgical admissions Unit (SAU) and an ambulatory care unit.

- The trust was able to demonstrate there is collaborative working with therapies across the system. The trust has introduced an ICRAS (Integrated Community Reablement Service) model to support early identification of patients who can undergo therapies in the community. As part of the wider frailty plan the trust has also appointed a head of older people's care.
- The trust demonstrated it has focused on patient safety and quality as the driver for improvement across several metrics for example, focussing on the implementation of the SAFER bundle, Red-to-Green bed days and a consultant of the week programme. In addition, the trust reconfigured and upgraded the Southport District General Hospital Emergency Department (ED), including for example; creating an ambulance triage bay, 3 ambulance unloading areas to facilitate a new forward wait area where initial treatment can be started, reconfiguration of the plaster room to provide an observation nurse base and a 3 bedded ambulant assessment area and an increase in the majors capacity from 11 to 14 dedicated cubicles. The trust noted this resulted in greatly enhanced patient experience and improved ambulance handover times. The trust has seen a 56% reduction in the number of ambulance handover delays over 60 minutes and reduced corridor care by 75%. The trust has also been able to demonstrate improvements in patient flow metrics and has seen a 6% reduction in stranded and 12% reduction in super stranded patients.
- The trust's Did Not Attend (DNA) rate of 6.84% is in the second lowest (best) quartile when compared to the national median of 6.96% for quarter 4 2018/19. The trust has seen a reduction in the DNA rate over the previous 12 months (from 7.54% in quarter 4 2017/18). The trust noted the implementation of a text reminder service and pre-consultation service has led to these improvements. The trust was also able to articulate the key hotspots for DNAs, for example; community paediatrics and ophthalmology. As a result, the trust is looking at the implementation of virtual clinics for ophthalmology and considering other targeted efforts for community paediatrics.
- The trust reports a delayed transfers of care (DTOC) rate of 1.6% (April 2019) that is lower than average and lower than the trust's own target rate of 3.5%. The trust has maintained the DTOC rates below the national standard for the previous 12 months. The trust has implemented executive senior leader sponsorship at a ward level and described the implementation of red-to-green days and collaborative work with commissioners to support

system solutions. The trust was able to demonstrate some engagement with the Getting It Right First Time (GIRFT) programme, with a current focus on 2 specialities - orthopaedics and ophthalmology. As a result there have been some improvements and the trust cited the work in ophthalmology where there has been a 30% reduction in overdue follow up appointments.

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

- For 2017/18 the trust had an overall pay cost per WAU of £2,577, compared with a national median of £2,180, placing it in the highest (worst) quartile nationally. This means that it spends more on staff per unit of activity than most trusts.
- The trust benchmarks in the highest (worst) quartile for Allied Health Professional (AHP) and Nursing cost per WAU (£175 compared to a national median of £130 and £845 compared to a national median of £710 respectively). For Medical staffing, the trust benchmarks in the second highest (worst) quartile with a cost per WAU of £536 compared to a national median of £533.
- The trust noted a number of reasons for the high pay bill costs, including: high numbers of nursing staff at the top of pay bands due to the retention of their staff; high numbers of nurses retiring and returning to work (who would also be at the top of pay bands); a high number of band 3 nurses and in some cases, utilising band 3 staff to cover band 2 shifts to ensure safe staffing; senior clinicians acting down into roles to fill vacancies and the payment of overtime for those staff covering additional shifts to fill gaps in rotas. The trust also noted the medical data would include a substantial number of ‘golden hello’ payments which were designed to entice staff to work for the trust. The trust confirmed these are no longer in place and they expect this will reduce the pay bill by circa £230’000.
- Despite the high substantive pay bill costs the trust also has a significant number of vacancies across numerous medical specialities (including anaesthetics, radiology and emergency medicine) and within nursing. This has resulted in the trust utilising agency and temporary staff, as displayed in their agency cost per WAU of £139 compared to a national median of £107.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2018/19 and is forecasting to miss its ceiling in 2019/20. At month 4, the trust’s agency spend is £2m above agency cap. It is spending more than the national average on agency as a proportion of total pay spend (6.8% compared to 4.4%). In addition, the trust is utilising high cost agencies, however, it was noted that this was for patient safety reasons and required senior sign off.
- The trust demonstrated it has introduced robust processes regarding the use of agency staff, for example; clear escalation routes for sign off. The

trust reported they are actively looking to fill substantive roles, are growing their own internal bank and have dedicated recruitment processes in place for key areas such as medics and anaesthetics. In addition, the trust is engaging with local trusts within the system, for example, remote support is provided by a senior consultant at another site.

- The trust highlighted they have improved roster efficiency, reduced sickness absence, and are now looking towards a reduced cost of tier 2 providers with support from NHS Improvement's agency & workforce team.
- The trust has established some alternative workforce models and invested in new roles to enhance skill mix, including the introduction of physician associates, nurse associates, ward pharmacists and a volunteer manager post.
- The trust utilities e-rostering within the majority of clinical areas with the exception of theatres, radiology and therapies. For those staff groups not currently using e-rostering, for example estates and facilities and admin and clerical staff, the trust was able to demonstrate plans in place to introduce this. The trust has also introduced a new rostering policy within which greater governance and rules have been implemented, allowing the trust to identify and fill gaps where possible.
- For medical staff, the Allocate system is used. All 165 consultants have a job plan; however, these are at various stages of the sign off process with 31 awaiting discussion, 106 awaiting sign off and only 18 having been fully signed off. The trust was able to evidence the development of detailed guidance on job planning and notes it is hoping to achieve 100% sign off within 12-18 months.
- Job planning has been introduced for AHPs, with all senior staff (band 6 and above) currently having job plans and with work underway to introduce this to lower bands in the future.
- Staff retention at the trust is good with a retention rate of 87.7% in December 2018 against a national median of 85.6%. More up to date data provided by the trust shows improvement with a retention rate of 88.57% in June 2019. The trust has achieved this via several mechanisms including the establishment of a People & Activity Group and a number of staff engagement and 'back to the floor' events held. The trust also participated in NHSI's Retention Direct Support Programme in 2018 which led to an improved nursing retention rate – 67.5% in March 2018 to 87.7% in December 2018 -moving them from the worst performing the in country to the second highest (best) quartile.
- At 6.09% in November 2018, staff sickness rates are worse than the national average of 4.35%, placing the trust in the highest (worst) quartile. However, the trust was able to provide more up to date data demonstrating an improvement in sickness absence rates, albeit this was increasing month on month at the time of the assessment: 4.48% in April 2019, 4.98% in May 2019 and 5.05% in June 2019.
- The trust explained the sickness absence policy has been revised and the trust has introduced a number of strategic workstreams together with robust

management. The workstreams include mental health first aid training, sickness absence training for line managers and the creation of a new Head of Health and Wellbeing post (in post from July 2019). The trust are also participating in NHSI/E's Health and Wellbeing programme to agree an action plan and are using data better to identify hotspots with a focus on Occupational Health on the back of this. The trust reported the biggest causes of sickness absence within the trust are stress (including non-work related), anxiety, and Musculoskeletal cases.

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

- For 2017/18 the trust's overall cost per test for pathology benchmarks in the second highest (worst) quartile, at £1.97 compared to a national median of £1.86. The trust outsource their pathology service to St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) under a 5 year fixed contract aimed at delivering £1.8m savings across the duration. Although these savings have been delivered, the trust were unable to evidence whether improvements could be done to reduce the overall cost per test metric and noted work was required to understand this further.
- The trust noted both they and STHK provide direct access pathology services to their local Clinical Commissioning Groups (CCGs) and therefore the overall cost per test is a combination of hospital tests and GP direct access tests, increasing the overall cost. However, the trust was unable to provide a breakdown to demonstrate the impact of this.
- With regards to imaging services, the trust has a cost per radiology report of £39.40 (2017/18) which compares better than national median of £50.05. The most recent published data demonstrated the trust had 25% of Consultant Radiologists posts vacant, which when benchmarked nationally, placed them in the highest (worst quartile) against a national median of 12.2%. At the time of the assessment, the trust also noted that the vacancy rate had since increased to 52% (10 establishment vs 4.8 in post). This has resulted in the trust paying higher than average outsourcing costs at 5.8% compared to a national median of 5.1%. The trust noted it is actively working with the Cheshire and Mersey Imaging Group to improve the vacancy position.
- The trust's medicines cost per WAU is very low when compared nationally at £183 against a national median of £320. The trust noted this is due to the specialities provided within the trust not requiring the use of many high cost drugs.
- As part of the Top Ten Medicines programme, it is making good progress in delivering on nationally identified savings opportunities, achieving 173% of the savings target up to March 2018 and an additional £737.11k up to March 2019. The trust has made some good progress in implementing switching opportunities for biosimilars; Etanercept (98%), Infliximab (97.64%) and Rituximab (95%). It was noted further work is required on

Adalimumab (47.4%), however, the trust also explained that 4% of patients had switched back due to tolerance of the new biosimilar.

- The trust's stockholding days is 25 which is above the national median of 21 days. The trust noted this is as a consequence of having two sites and ensuring medicines are available across each. The trust is in the highest (best) quartile for number of pharmacists actively prescribing at 55% compared to a national median of 35%. However, it is in the lowest (worst) quartile for number of Sunday on ward clinical pharmacy hours of service at 0 hours compared to national median of 4 hours. Whilst overall staff costs were described as low by the organisation, this has an impact on their ability to provide Sunday hours service and would require staff investment to improve.
- The trust is using some technology to improve operational productivity, for example; an interactive SMS messaging service to notify patients of appointments and reduce DNAs. The trust noted this is an area for improvement and were able to demonstrate a number of plans in place to introduce new technology into the organisation such as e-prescribing and electronic patient records.

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

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,172, compared with a national median of £1,307, placing it in the lowest (best) quartile nationally.
- The cost of running its corporate services departments are significantly higher than the national average for all functions. For 2017/18 the trust's finance function cost per £100m turnover of £1.10m, benchmarked above the national average of £676.48k, placing the trust in the highest (worst) quartile and second worst in the country when compared to other non-specialist acute trusts. In addition, the trusts IM&T cost per £100m turnover, at £4.75m, is significantly above the national median of £2.47m.
- The HR function cost per £100m turnover also benchmarks in the highest (worst) quartile, at £1.51m compared to a national median of £898.02k for 2017/18. The trust noted this is as a consequence of outsourced parts of the function (Occupational Health and Recruitment), which has since been brought back in house. The trust has worked collaboratively with regional and local partners to improve this position and has produced a two year transformation plan to address the areas identified within Model Hospital using benchmarked outputs to be delivered in 2019-21.
- The trust's procurement processes are relatively efficient and tend to successfully drive down costs on the things it buys. This is reflected in the trust's Procurement Process Efficiency (76.9 compared to the national median of 65.5) and Price Performance Score (68.7 compared to the national median of 47.9). However, the trust's supplies and services cost

per WAU, at £408, benchmarks above the national median of £365, suggesting there is room for improvement. The trust noted the size of the organisation and volume of products procured impacts their ability to reduce prices.

- At £321 per square metre in 2017/18, the trust's estates and facilities costs benchmark below the national average of £342. The trust benchmarks in the lowest (best) quartile for Hard Facilities Management (FM) costs (£61 per square metre compared to national median of £80 per square metre) and for Soft FM costs (£103 per square metre compared to national median of £127 per square metre).
- The trust's total backlog maintenance, at £46 per square metre for 2017/18 benchmarks below the national median of £182 per square metre. For the same period, at £29 per square metre, the trust's critical infrastructure risk was also below the national median of £81 per square metre.
- Whilst the above estates and facilities metrics are favourable, the estate is ageing and does present the trust operational challenges. The trust has not had a six facet survey completed since 1998 and, therefore, it is likely the estates and facilities metrics are not fully accurate. At the time of the assessment, the trust was able to demonstrate it had recently undertaken steps to reassess their estates and facilities department and have commissioned a six facet survey the validate the metrics.

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

- The trust has a significant deficit in relation to turnover and has an inconsistent track record of managing spending within available resources and in line with plans. Since 2017/18, the trust has been in Enhanced Financial Oversight with NHS Improvement and for the past year has had a Financial Turnaround Director. The trust does not have a plan to return to financial balance.
- Whilst the trust has shown some minor improvement in the last 2 years, the trust deficit (excluding PSF, FRF and MRET funding) is 14.8% of turnover. The trust will not be able to meet its all financial obligations in 2019/20 without cash support from the Department of Health and Social Care. The trust has been reliant on external funding for the past three years and currently has a liability of £103m of revenue support loans on the balance sheet.
- The trust rejected the control total in both 2017/18 and 2018/19, delivering positions of a £33.6m deficit in 2017/18 (21.4% of turnover and £18.6m worse than the rejected control total) and a £29m deficit in 2018/19 (17.2% of turnover and £15.3m worse than the rejected control total).
- In 2019/20 the trust accepted a control total of an £8.3m deficit (which includes £18.3m of PSF, FRF and MRET funding). As of quarter 1, the trust

is forecasting to meet the control total, although delivery of the quarter 1 financial plan was reliant on non recurrent benefits.

- The trust has a cost improvement plan (CIP) of £6.3m (or 3% of its expenditure) and is currently forecasting to deliver against its plans. As at the end of quarter 1, the trust has delivered £0.4m (6.5% of the annual target). In addition, £2.5m of the annual target is still unidentified.
- The trust delivered 90% (£6.8m) of planned savings in 2018/19 of which 18% was non-recurrent. In 2017/18 the trust only delivered 62.6% (£3.7m) of planned savings of which 18% was non-recurrent.
- The trust has invested in various systems to produce SLR information, but this has not been developed significantly enough to provide information to support financial decisions. The trust does not currently use costing data across its service lines.

Areas for improvement

- The trust has failed to achieve financial targets in 2017/18 and 2018/19. The trust needs to understand and address its underlying financial deficit and agree a clinical and financial sustainable solution with commissioners for provision of services within the local healthy economy.
- At the time of the assessment, the trust was not meeting the constitutional operational performance standards around Cancer, Accident & Emergency (A&E) or diagnostic waiting times.
- The trust is an outlier for pre-procedure length of the stay for elective and non-elective which continues to present an opportunity for the trust to improve productivity.
- The trust's pay cost per WAU at £2,577, is significantly above the national median of £2,180. Despite this, the trust also has a high number of vacancies across various staff groups resulting in high agency usage and spend.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2018/19 and is forecasting to miss its ceiling in 2019/20. At month 4, the trust's agency spend is £2m above agency cap. It is spending more than the national average on agency as a proportion of total pay spend.
- Despite some recent improvements in sickness absence, further work is required to address the higher than average staff sickness levels.
- The trust benchmarks significantly above the national average for corporate services, including HR, Finance and IM&T cost per £100m turnover. The trust would benefit from a greater understanding of what is driving these costs and how they can be reduced.

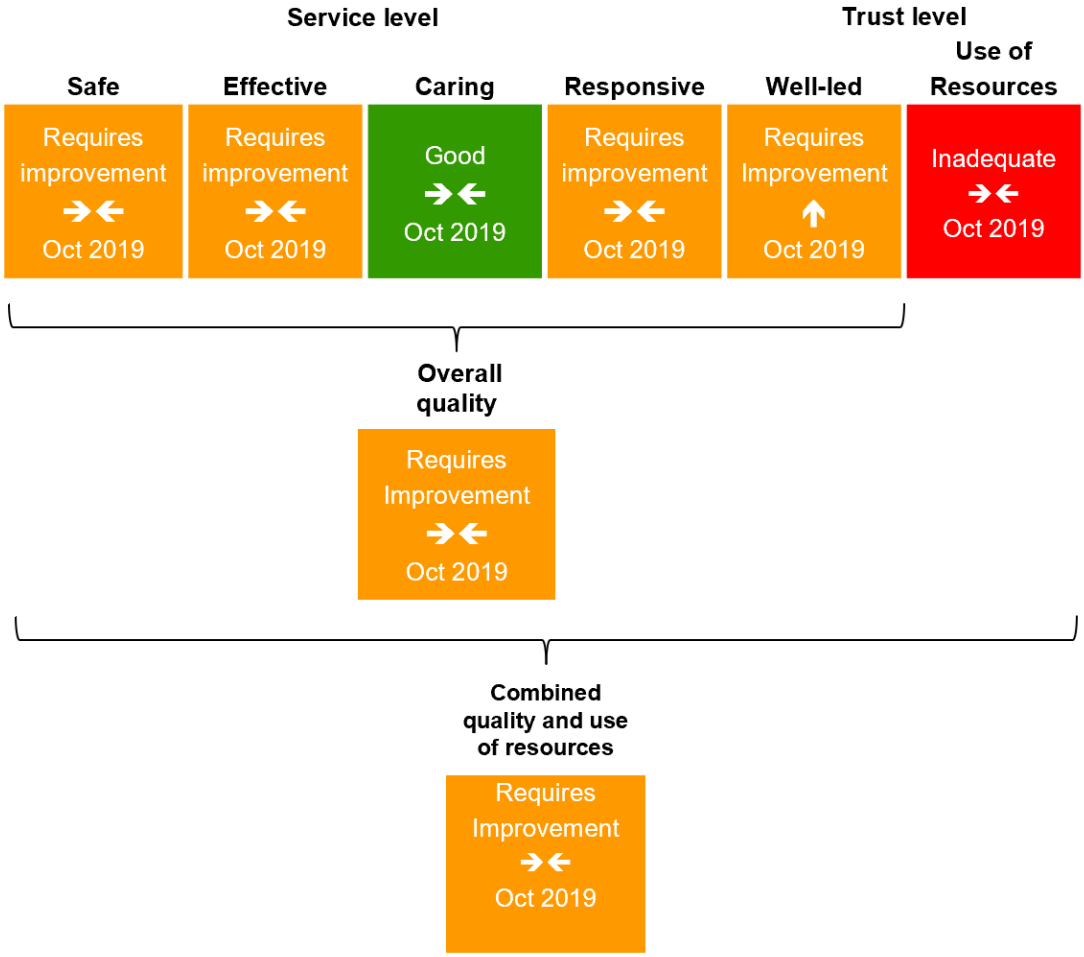
Ratings tables

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) 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.