Buckinghamshire Healthcare NHS Trust

Use of Resources assessment report

Stoke Mandeville Hospital
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www.buckshealthcare.nhs.uk

Date of publication: 18 June 2019

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

Ratings

Overall quality rating for this trust	**Good** ●
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** ●
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/RXQ/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 safe, effective and responsive as good, caring as outstanding and well led as requires improvement.
- At Stoke Mandeville Hospital we rated five of the trust's services as good and one as outstanding. In rating the trust, we took into account the current ratings of the three services not inspected this time.
- At Wycombe Hospital we rated three of the trust's services as good and one as outstanding. In rating the trust, we took into account the current ratings of the three services not inspected this time.
- In the community services we rated two of the services as good and one as requires improvement. In rating the trust, we took into account the current ratings of the one service not inspected this time.
- We rated well-led for the trust overall as requires improvement.

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

NHS Improvement

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18 March 2019

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This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous 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?	**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 18 March 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. At the time we wrote this report, the trust had provided us with an initial set of data regarding its 2018/19 full year unaudited accounts. Where possible we have used this information and clarified when we relied on older information reflecting the trust's position and forecast at February 2019.

Summary of findings

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

We rated Use of Resources as requires improvement. The trust is demonstrating good productivity in certain areas and is focused on delivering improvements across the trust. However, it has a higher than median total cost per Weighted Activity Unit, a significantly deteriorating financial position in 2018/19 and poor track record at delivering efficiency savings which indicate that despite actions taken during 2018/19, further improvements are required to improve productivity and financial efficiency.

- In 2017/18, the trust had a total cost per WAU in £3,524 which is in the second highest (worst) quartile nationally.
- The trust benchmarks well on several key clinical services metrics such as Did Not Attend, pre-procedure elective and non-elective bed days. The trust is well engaged with the Getting It Right First Time (GIRFT) national programme with evidence of improvements delivered.
- At the time of the assessment, the trust did not meet two of the constitutional operational performance standards (4-hour accident & emergency and 18-week referral to treatment) although it performed above peer or national median. The trust met the other two standards (cancer 62-day wait and diagnostic 6-week wait).
- However, the trust's Delayed Transfers of Care (DTOC) rate and length of stay are higher than the national median although this is mainly driven by spinal patients with warranted long stay. The trust has taken a range of actions to continually drive these rates down although further improvement is required.
- The trust benchmarks well on sickness rate, has an embedded e-rostering system for nursing, midwifery and healthcare assistants and at the time of the assessment, most consultants had an active job plan. The trust has introduced innovative roles and is looking to review its nurse staffing structure to better align staffing and service needs and deliver efficiencies.
- The trust benchmarks well compared to the national median for non-substantive staff cost per WAU, has met its agency spend ceiling in 2017/18 and expects to meet it in 2018/19.
- However, the trust overall benchmarks in the second highest quartile nationally for overall pay cost per WAU and for all staff types. The trust has developed several actions to reduce costs across all types although this is an area for further improvement.
- The trust has taken actions to improve its staff retention rate although at the time of the assessment, it remained below the national median.
- The trust benchmarks overall well across most clinical support services. However, its pathology costs benchmark as relatively expensive and the trust has relatively high medicines costs due to slow uptake of biosimilars.
- However, the trust hasn't progressed a Managed Equipment Service for the pathology network and for its imaging service. The trust has a high imaging backlog and its MRI replacement programme is not sustainable.

- The trust is working in innovative ways to find technological solutions to improve patient access and flow through not only the hospital but the system as a whole.
- In 2017/18, the trust benchmarked well overall for corporate services and was working with other local providers to explore joint services. The trust has also invested in its Human Resources function to improve its nursing recruitment metrics. The trust's finance function costs are lower than the median which may represent an under-investment considering the financial issues it experienced during 2018/19.
- However, the trust performed poorly on the Procurement League table and the non-pay cost per WAU was slightly above the national median in 2017/18.
- For estates & facilities, the trust benchmarks above the national median for cost per square metre. Part of the trust's estate, which is not under a PFI scheme, attracts significant backlog maintenance.
- The trust has delivered deficits during the last three years and missed its control total in all 3 years. During 2018/19, the trust's financial position has deteriorated significantly and at the end of 2018/19, the trust has delivered a deficit of £34.9 million (excluding Provider Sustainability Fund (PSF)), 8.4% of its turnover and £32.9 million worse than plan. This compared to £7.9 million deficit in 2017/18.
- The deterioration is due to continuing under-delivery of the trust's Cost Improvement Plan (CIP), activity pressure as the trust has a block contract agreement with its main commissioners, estate compliance costs and pay overspends. During 2018/19, the trust identified financial governance and management issues which also contributed to its deterioration. The trust also relied on cash revenue support from the Department of Health and Social Care to allow it to meet its financial obligations during 2018/19.

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

The trust is beginning to demonstrate control over some key operational metrics which is demonstrated by improved performance in some of the clinical areas. In particular the trust performs well on Did Not Attend rate, pre-procedure elective and non-elective bed days. The trust requires further improvement regarding Delayed Transfers of Care and length of stay. The trust demonstrated good engagement with the Getting It Right First Time (GIRFT) programme with evidence of improvements.

- At the time of the assessment in March 2019, the trust was not meeting the constitutional operational performance standards around 18-week referral to treatment target (RTT) and Accident & Emergency standard (A&E).
- In December 2018, the RTT position has declined to 87.39%, lower than at any point since January 2017. This is lower than the required standard of 92% but higher than similar trusts nationally. The trust has sustained no 52-week breaches in 2018/2019.
- Performance against the national 4-hour A&E wait standard of 95% has not been met over the previous 12 months. However, the trust has seen sustained improvement in the standard to above 87% from July 2018 to January 2019 and has performed higher than the national median since September 2018. This improvement was supported through some innovative initiatives to treat patients in the community where possible, the implementation of an assessment and treatment pod in A&E and 7-day therapy services in A&E.

- The trust was meeting the constitutional operational performance standards for Cancer 62-day wait target and Diagnostic 6-week wait targets.
- The Did Not Attend (DNA) rate was 5.68% as at December 2018. The trust has seen continued improvement in this area since 2017/18 and has consistently performed better than both national and peer median since September 2017.
- The trust performed better than the national median for pre-procedure non-elective bed days, at 0.50 days. The trust is performing in the lowest (best) quartile below the median when compared nationally – the national median is 0.66 days. This means that the emergency patients in the trust are waiting less time prior to emergency treatment than most other hospitals in England. The trust's average length of stay (LOS) for emergency admissions (rolling 6 months) to September 2018 was 11.7 days which is in the fourth (worst) quartile and compares to a national median of 9.3 days and a peer median of 9.7 days is an area for improvement.
- In December 2018 the trust's pre-procedure elective bed days was at 0.14 days. This is in line with the national median, at 0.13 bed days. It is noted that pre-procedure bed days have reduced since September 2018. This is related to one specialty services that can cause some transient increases in the pre-procedure bed days. However, the trust's average length of stay for elective admissions (rolling 6 months) to September 2018 was 4.6 which is in the fourth (worst) quartile and higher than both the national and peer medians and is also an area for improvement.
- The trust reports a delayed transfers of care (DTOC) rate that is higher than the national and peer average at 4.7% in October 2018 compared to a median of 3.4%. The trust's high DTOC and length of stay rates are driven by the impact of spinal unit and community services which have warranted longer length of stay. However, the trust has measures in place to reduce DTOC and length of stay. These include co-located discharge and continuing healthcare assessors on site, assess to discharge policy implemented with a Home first philosophy, 'get up, get dressed and get moving' campaign for patients across the trust, twice weekly review of patients with a LOS over 7 days.
- The trust has good engagement across the integrated care system (ICS), in particular with the integration of local authority and health reablement and discharge teams expected by April 2019. However, work needs to continue to improve patient flow and reduce the levels of DTOC and the number of patients with extended admissions.
- At 8.83%, emergency readmission rates were above the national median as at March 2019. However, this represents an unusual performance with the trust having consistently lower readmission rates than the national median for the last eleven quarters.
- The trust has implemented a number of initiatives across their acute and community services to improve clinical efficiency including; theatre productivity programme which has delivered and sustained efficiencies over two years; the Deloitte benchmarking review of the outpatient diagnostic programme, which has provided the organisation with feedback on productivity opportunity, with the actions to be implemented in 2019/20; and implementation of a weekly executive conference call to review patients who have excessively long length of stay.
- The trust can demonstrate robust engagement with the GIRFT programme to support improvements in efficiency at speciality level. There is a clear governance structure with a GIRFT Board which is chaired by the Deputy Medical Director and multidisciplinary approach to developing and delivering the implementation plans. Examples of improvements are increasing the number of cataract cases from 4-5 to 7 per list and a

50% increase in cemented hip replacements and a £0.2 million procurement saving in general surgery.

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

The trust's benchmarks in the second highest (worst) quartile for overall pay costs per WAU in 2017/18 with higher pay costs per WAU for all substantive staff types. The trust benchmarks well on non-substantive staff pay cost per WAU in particular agency staff. The trust has better than median sickness rates reflecting the work has done in this respect, but its retention rate remains higher than the national median. The trust has a number of actions in place to reduce costs, has embedded e-rostering for nursing, midwives and healthcare assistants and most consultants have an active job plan.

- For 2017/18, the trust had an overall pay cost per WAU of £2,201, compared with a national median of £2,180, placing it in the second highest (worst) cost quartile nationally. This means that it spends more on staff per unit of activity than most trusts.
- Within this headline metric, the trust's total pay cost per WAU is worse than the median for nursing (£808 compared to national median £710), Allied Health Professionals (AHP) (£178 compared to national median £130) and medical staff costs against the median (£543 compared to national median of £533), but benchmarks favourably for non-substantive staff costs (£222 compared to national median £274).
- Although the trust's Workforce Strategy is due for a review, the trust described a number of initiatives currently being implemented to support the challenges the organisation has with a high nursing vacancy and reduce the overall pay cost per WAU. This includes the introduction of new roles, national and international recruitment campaigns for nurses, nurse degree apprenticeships. The trust is also looking to review its nurse staffing structure to better align staffing and service needs and deliver efficiencies
- The trust met its agency ceiling as set by NHS Improvement for 2017/18 and is forecasting to meet its ceiling in 2018/19. As at February 2019, it is spending less than the national average on agency as a proportion of total pay spend (4.14% compared to a national median of 4.94%). It achieved significant reductions in the cost of agency and locum staff through weekly safe staffing meetings, skill mix reviews, the use of NHS professionals since May 2017 to manage the temporary staff booking.
- The high AHP pay costs per WAU can be attributed to this part of the workforce being integrated into services such as stroke and spinal. However, job planning for the AHP workforce is in development. Clarity in the roles, responsibility and deployment of the AHP workforce is an area to develop to enable the trust to realise any productivity that could gained by implementing new models of working.
- Staff retention at the trust shows improvement since July 2018 although the retention rate of 82.9% in November 2018 remains below the national median of 85.9%. The trust is engaged with the national retention programme and its approach focusses on the three points in career development: first year, mid-career 'itchy feet' and '50+'. The trust has implemented a new staff engagement programme, a talent management strategy and a refreshed preceptorship programme to support the improvement in staff retention.
- The trust has made progress with the use of e-rostering for nursing, midwifery and healthcare assistants (93 of 119 rosters are electronic). AHPs are not yet e-rostered but are included in wave three of the Healthroster roll-out programme, and plans are in place to review the medical e-rostering based on the anaesthetic e-roster programme.

- Rostering metrics are monitored by divisional heads of nursing however productivity gains cannot be comprehensively realised until all staff are e-rostered. There is a robust e-roster team in place to support e-roster and Safecare roll out.
- Led by the Associate Medical Director the trust has 91% of consultants with a signed off and agreed electronic job plan. This has been part of an 18-month review programme.
- At 4.07% as at October 2018, staff sickness rates are better than the national average of 4.27%. This reflects the trust's work in prioritising health and wellbeing such as fast track physiotherapy service, in-house counsellor and a calendar of wellbeing activities. They use a case management approach which has supported the continued low sickness absence rates.

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 a good service for its patients. Its pathology costs benchmark as relatively expensive and the trust benchmarks well for imaging costs. The trust has relatively high medicines costs due to slow uptake of biosimilars and is working in innovative ways to find technological solutions to improve patient access and flow through not only the hospital but the system as a whole.

- The overall cost per test for pathology for 2017/18 was slightly higher than the national median at £1.91 against a national median of £1.86 (second highest (worst) quartile). However, the trust benchmarks well for overall cost per capita (£37.44 against a national median of £40.27) and for total tests per capita (19.8 against a national median of 22.6).
- The trust is actively collaborating with the South 4 Pathology Network to implement the recommendations from the Lord Carter Review into operational productivity in the NHS through delivery of a hub and spoke model and has submitted a strategic outline case to the Pathology Board. The trust has also appointed joint consultant posts with Oxford University Hospital NHS Foundation Trust to help improve collaboration and operational productivity.
- The trust has struggled to deliver Pathology Cost Improvement Plans (CIP) for 2018/19. At the end of January 2019, it had only delivered £15,000 savings. The trust needs to ensure more robust processes are in place to support CIP identification and ensure corrective processes are in place when CIPs are behind plan. The trust has not pushed to develop a joint Managed Equipment Service (MES) proposal in the network over this last period. This is an oversight as significant efficiencies can be delivered.
- The trust's imaging cost per test (£41.01) benchmarks well against other services and is in the lowest (best) quartile for 2017/18. One of the ways the trust has achieved this is by having a high reporting rate per reporting PA (97 compared to 46 for peers). The trust is proactively allocating consultants' workloads and ensures that processes are in place so that interruptions to workflow are minimal.
- The trust had a high backlog across its imaging activity (2017/18 highest (worst) quartile for CT and MRI). A replacement MRI programme will deliver two new MRI scanners in partnership with a local charity. This is not a sustainable equipment replacement proposal and the trust should consider options, including an MES contract for imaging equipment as a matter of urgency. The trust has also undertaken some service redesign projects which have allowed the trust to reduce waiting times for both prostate and lung cancer tests in 2018/19 with prostate cancer reducing from waits of 7 to 10 days down to 2 to 3 days.
- Imaging CIP delivery for 2018/19 has been an issue with the trust reporting no CIPs delivered as at January 2019 against an annual plan of £0.4 million.

- The trust's medicines cost per WAU at £385 was high compared to the national median of £320 for 2017/18 (highest (worst) quartile). One key issue has been the lack of pace in the trust's adoption of biosimilars. The trust's Top Ten medicines performance percentage of savings target achieved for 2017/18 was 102%. Whilst this is above the benchmark, it ranks as 102 out of 120 trusts for 2017/18 so there is potential for improvement. The trust has engaged with consultants and patients to improve uptake of biosimilars through 2018/19 and at February 2019 it had made good progress with the transition to biosimilar adalimumab. The trust has also started an integrated medicines optimisation board with partners across the Integrated Care System (ICS) to drive efficiencies and projects that support both clinical and financial effectiveness and efficiencies.
- The trusts metrics on Model Hospital for pharmacy time on clinical activity for 2017/18 was low at 55% compared to the national median of 76%. Following our assessment visit, the trust has provided us with more up to date figures that show the trust's pharmacy time on clinical activity has improved to 73%. This has been achieved by a number of changes within the pharmacy department leading to increased time pharmacy staff are available for patient facing activity. These include changes to outpatient services, over-recruitment of junior pharmacist staff, further training of pharmacist prescribers and increased provision of pharmacy staff on wards on the weekend from 4 hours (national median) to 6 hours per day.
- The trust performance on electronic prescribing was limited and Electronic Prescribing and Medicines Administration (EPMA) implementation is seen as a priority with capital funding secured for implementation in 2018/19; the trust is aiming to roll out EPMA in late 2019.
- The trust was using technology in a number of innovative ways to improve operational productivity across the organisation and is focussing on improving this systemwide. The trust has an ambitious plan to implement a real time live bed management system across all sites and across the system enabling it to manage and improve flow across the system. A newly recruited Joint Chief Information Officer across the CCG, Council and the trust is supporting the delivery of the new system and has a wider agenda to drive integrated IT delivery across Buckinghamshire.

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

The trust has a non-pay cost per WAU slightly above the national median and performed poorly on the Procurement League Table. The trust benchmarks well for corporate services costs and benchmarks high for estates and facilities cost per square metre.

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,323 slightly above the national median of £1,307 (second highest (worst) quartile).
- The trust's supplies and services costs per WAU was £276 (second lowest (best) quartile) significantly better than the national median of £364.
- At quarter 2 2018/19, the trust ranked 117 out of 136 trusts in the procurement league table published by NHS Improvement to assess the relative performance of non-specialist NHS acute providers' procurement departments. The position for the trust is in part influenced by the amount of the trust spend that is not with NHS Supply Chain. By the end of quarter 3 2018/19 the trust had transferred a significant amount of its spend to NHS Supply Chain saving around £0.5 million on an annual basis and should lead to an improved procurement league table position going forward.

- Purchase price index and benchmarking tool (PPIB) data for 2017/18 suggests the trust could improve performance on the percentage variance from median price (3.8%) and percentage variance from minimum price (15.3%) against both national (2.2% and 10.6% respectively) and peer medians (2.2% and 10.6% respectively). Recent recruitment of a Deputy Head of Procurement will help to support this. The trust has held a monthly Clinical Product Selection Group chaired by the Chief Nurse to support product switches and CIP delivery.
- For 2017/18, the cost of running the trust's procurement function was low at £0.158 million per £100 million turnover compared to the national median of £0.206 million per £100 million turnover. The cost of the function has increased in 2018/19 and the Head of Procurement is working closely with NHS Supply Chain in support of the new operating model. The trust procurement team also collaborates well across the ICS with some contracts negotiated across the system.
- For 2017/18, the cost of running the trust's finance function was low at £0.681 million per £100 million turnover compared to the national median of £0.715 million per £100 million turnover which reflects an under-investment in the function. The trust has had an external review of its finance function that has highlighted old and outdated systems, processes, skill mix and culture as issues. These capacity and capability weaknesses resulted in the trust making a one-off financial adjustment of circa £5 million in 2018/19. The trust has an action plan to work through the recommendations of the review.
- The cost of running the trust's Human Resources (HR) function benchmarks well against other trusts at £0.794 million per £100 million turnover compared to a national median of £1.104 million per £100 million turnover. The cost of the recruitment team was high at £0.147 million per £100 million turnover compared to a national median of £0.107 million per £100 million turnover. The trust has actively invested in its recruitment function to improve its nursing recruitment metrics. The trust has improved its time to hire clinical and non-clinical staff which stood at 54 days in 2017/18, in the lowest (best) quartile nationally.
- The trust is collaborating with other trusts for payroll and is working with partners (ICS and Milton Keynes University NHS FT) to explore joint services in areas such as HR, finance, IT infrastructure and Business Intelligence.
- At £367 per square metre in 2017/18, the trust's estates and facilities costs benchmarked above the national median (£342). The trust benchmarks slightly higher than the national median for hard facilities management costs (£92 per square metre against £80 per square metre) and for soft facilities management costs (£137 per square metre against £127 per square metre).
- The trust has a part PFI and a part owned but aging estate that requires ongoing investment. The trust's backlog maintenance is high at £377 per square metre compared to £182 nationally. The trust's critical infrastructure risk at £50.98 million is nearly double the level of its peers with the amount of non-clinical space also high at 41.3% compared to the peer median of 31.3%. The trust described robust processes in place to mitigate against any risk arising from the backlog or the critical infrastructure risk.
- The trust has limited capital available and as a result is investing on its infrastructure based on its clinical strategy that is linked to its property strategy and was signed off by the trust's board in January 2019. The trust is looking at rationalising and consolidating under-utilised community properties as part of the joint estates strategy.
- During the year, the trust has reviewed the provision of its non-PFI estate services, working with clinical teams, looking for new and innovative delivery models and re-tendering services where relevant to drive efficiencies and better value for money. For example, the trust has restructured the self-delivered catering operation within its

community services estate to deliver an enhanced evening meal hot service at Buckingham Hospital while reducing costs by circa £5 thousands per annum. The trust also re-tendered its water safety management contract achieving a 20% saving per annum over 5 years (circa £90 thousands per annum) and increased its statutory robustness.

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

The trust has delivered deficits and hasn't met its control total for the last three years up to 2018/19. Its financial position has significantly deteriorated during 2018/19 reflecting on-going poor delivery of Cost Improvement Plans (CIP), operational pressures as well as historical financial planning and governance weaknesses. The trust has accumulated significant debt from the Department of Health & Social Care (DHSC) as well as through it PFI schemes. The trust has strengthened its financial grip and control during the latter part of 2018/19 and has developed a plan for 2019/20 to improve its financial position and underlying deficit.

- In 2017/18, the trust delivered a £7.9 million deficit excluding Sustainability and Transformation Fund (STF) representing 1.9% of turnover and £5.9 million worse than its control total. This was a deterioration on the deficit delivered in 2016/17 and was driven by under-delivery of its Cost Improvement Plan (CIP) and operational pressures. The deficit position was also supported by non-recurrent items with the underlying position likely to have been worse. In 2018/19, the trust initially developed a plan which improved its financial position and met its control total with a deficit of £2.0 million (excluding Provider Sustainability Fund (PSF)).
- However, the trust's financial position has deteriorated significantly during 2018/19 as a result of CIP under-delivery, pay overspend, estates compliance costs and activity pressure as the trust has entered into a block contract with its main commissioners capping its income. During the year, the trust has also identified significant weaknesses in its financial governance, capability and capacity resulting in significant one-off financial adjustments (£5 million). The trust implemented a Financial Recovery Plan in November 2018, targeting further savings. However, for 2018/19, the trust has delivered £34.9 million deficit, 8.4% of its turnover and £32.9 million worse than plan.
- The trust has not delivered its CIP for the last two years resulting in low recurrent efficiency improvement contributing to its financial deterioration. In 2017/18, the trust achieved 3.1% savings, with 2.7% on a recurrent basis. In 2018/19, the trust planned to deliver £19.7 million CIP (4.5% of expenditure) however, at the end of February 2019, the trust was forecasting to deliver £12.8 million, 2.8% of expenditure, with £7.1 million recurrent (1.5%). The trust's CIP included £6.9 million of additional income (35% of total CIP) most of which haven't materialised due to the introduction of the block contract with commissioners.
- A new interim Finance Director joined part-year and introduced new financial grip and control measures to improve financial planning, efficiency delivery and financial performance management. This has led to improved executive ownership of efficiency improvement workstreams with more realistic schemes, some linked into the ICS work. However, following an external review of the finance function, the trust now needs to progress with the implementation of the recommendations.
- The trust recognises it needs to further develop its service line reporting (SLR) and patient level costing (PLICS) information and engage better with its clinical divisions. The

trust's ambition is to develop a reporting suite to support clinicians in leading on the financial recovery.

- For 2019/20, the trust has a control total and plan of £18.6 million deficit (excluding non-recurrent central funding, e.g. STF; 4.3% of income) which, if successfully delivered, will reduce its underlying deficit from £30 million to £23 million. The plan includes significant income growth which the trust still needs to fully agree with its commissioners and a £15 million CIP (3.2% of expenditure, mostly recurrent). Within the CIP, the trust still needs to identify £2.5 million savings and most schemes are still going through the development stage with few ready for implementation at the star of the year.
- The trust has a rating of 4 (worst) for capital service capacity. The trust has accumulated significant debt with the Department of Health and Social Care (DHSC) (£75 million) and through its PFI scheme. As a result, the trust incurred £9.9 million of finance costs during 2018/19 and this is expected to increase to £10.6 million in 2019/20. Since quarter 4 2017/18, due to the trust's deficit and lower receipt of STF than planned, the trust requires cash revenue support from the Department of Health & Social Care (DHSC) to deliver its financial obligations and received £25.9 million in 2018/19. As mentioned above, the trust has limited capital to invest in its ageing estate.
- The trust is actively looking to maximise its income. It has commissioned an external partner to improve its clinical coding quality and provide better clinical activity information and the trust has agreed with its commissioners to repatriate some of its activity currently delivered elsewhere. The trust has also appointed a Commercial Director to enhance and expand its Private Patient Income and commercial income.
- The trust utilises external consultants where it doesn't have the capacity or capability within the trust or when an objective review is required. The trust spent £1.4 million on consultants in 2017/18, principally to support the development of cost and theatre productivity improvements and clinical coding. In 2018/19, the trust expects to reduce its consultancy costs to £0.4 million principally through the continuation of its theatre and outpatient efficiency programme.

Outstanding practice

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

- The Did Not Attend (DNA) rate has consistently performed better than both national and peer median since September 2017.
- The trust has met its agency ceiling for the last two years and is spending less than the national average on agency as a proportion of total pay spend. It achieved significant reductions in the cost of agency and locum staff through weekly safe staffing meetings, skill mix reviews, the use of NHS professionals since May 2017 to manage the temporary staff booking.
- The trust has a newly recruited Joint Chief Information Officer across the CCG, Council and the trust who is driving integrated IT delivery across Buckinghamshire.

Areas for improvement

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

- The trust must continue to embed the financial grip and control measures introduced during 2018/19 to improve financial planning, efficiency delivery and financial performance management. The trust must deliver the recommendations from the review of the finance function carried out in 2018/19.
- The trust must progress with identifying the remaining schemes to close the gap with its CIP target and progress at pace to develop and start implementing schemes.
- The trust must work with its commissioners to ensure the income assumptions in its 2019/20 plan are agreed and achievable.
- The trust must progress with the development of service line and patient costing information to better engage with and support clinical divisions in delivering the financial recovery.
- The trust's LOS for elective and non-elective is higher than peer and national medians. The trust should continue to explore ways to reduce their LOS.
- Nursing cost per WAU is high. The trust should continue to review staffing needs, looking at services and models of care overall to drive down nursing costs.
- Job planning for the AHP workforce is in development. Clarity in the roles, responsibility and deployment of the AHP workforce is an area the trust should develop to realise productivity gains.
- The trust's staff retention rate is below national median, and the trust should continue to identify further actions to improve retention.
- The trust should consider options, including Managed Equipment Service proposals to procure equipment for the pathology network and, as a matter of priority, for imaging services.

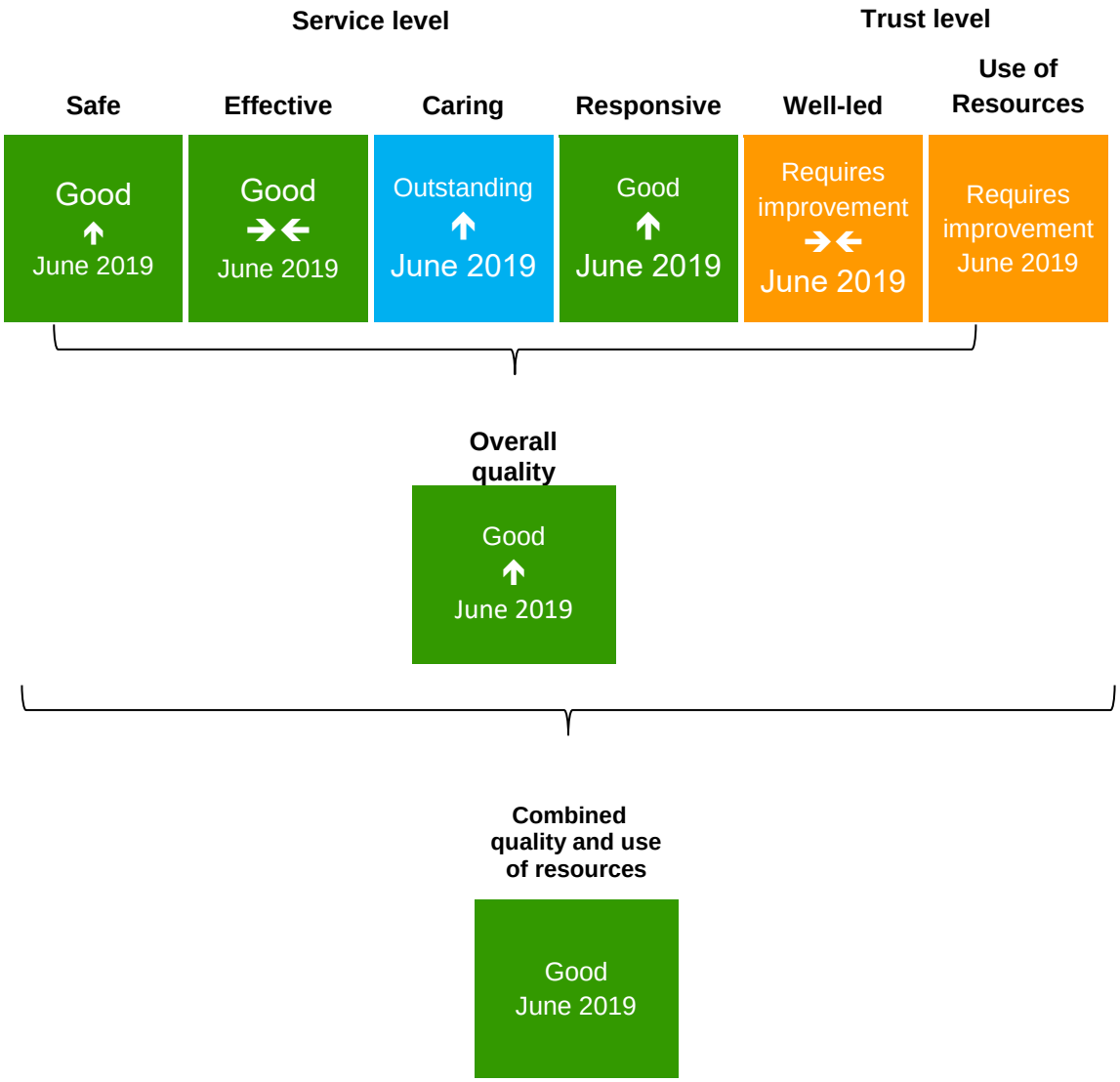
Ratings tables

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.