County Durham and Darlington NHS Foundation Trust

Use of Resources assessment report

Address
Darlington Memorial Hospital
Hollyhurst Road
Darlington
County Durham
DL3 6HX
Tel: 01325 380100
www.cddft.nhs.uk

Date of publication: 3 December 2019

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

Ratings

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

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

Are resources used productively?	**Good**

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

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

Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- We rated safe as requires improvement and effective, caring, responsive and well-led as good.
- The overall ratings for each of the trust's acute locations improved to good.
- The trustwide well led rating was good, this was not an aggregation of the core service well led ratings.
- The trust was rated good for use of resources. Full details of the assessment can be found on the following pages.

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Date of site visit:
09 July 2019

Date of NHS publication: 3 December 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?	**Good** ●

How we carried out this assessment

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

We visited the trust on 09 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?	Good

- We rated the trust's use of resources as Good.
- The trust spends less on pay and other goods and services per weighted unit of activity (WAU) than most other trusts nationally, with an overall cost per WAU of £3,379 compared to a national median of £3,486. This indicates that the trust is more productive at delivering services than other trusts by showing that, on average, the trust spends less to deliver the same number of services.
- The trust failed to balance its budget in 2018/19, reporting a deficit of £15.9 million excluding Provider Sustainability Funding (PSF) (a £52k surplus including PSF). For 2019/20, as of the first quarter the trust is on track to achieve a year end deficit of £1.19m excluding PSF and Marginal Rate Emergency Tariff (MRET) funding (a £9.5m surplus including PSF and MRET).
- The trust's financial performance excluding PSF has deteriorated over the previous 3 years: £15.9m deficit in 2018/19; £9.1m deficit 2017/18; £7.5m deficit 2016/17.
- The trust had a cost improvement plan (CIP) of £34.7m (or 6.9% of its planned expenditure) in 2018/19 and achieved £28.5m (5.5% of actual expenditure). Therefore, an adverse variance of £6.2m. 43% of the achieved efficiencies were recurrent which has deteriorated from previous years recurrent delivery.
- The trust is reliant on external loans to meet its financial obligations and deliver its services.
- At the time of the assessment in July 2019, the trust was not meeting the constitutional operational performance standards around Referral to Treatment (RTT), Cancer and Accident & Emergency (A&E).
- Individual areas where the trust's productivity compared particularly well included clinical productivity, staff retention, corporate services and procurement. The trust evidenced several examples of innovative workforce models and collaborative working with neighbouring trusts. In addition, the trust reports a delayed transfers of care (DTOC) rate that is lower than the national average and consistently is one of the lowest nationally.
- However, opportunities for improvement were identified in emergency readmissions, Did Not Attend rates, sickness absence rates, nursing pay costs and estates and facilities. Although the trust benchmarked well on some aspects of radiology, the trust has substantial aged equipment and significantly higher than median costs for outsourcing and agency spend. In addition, the trust does not currently provide a 7 day pharmacy provision and noted this as an area of improvement.

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 not meeting the constitutional operational performance standards around Referral to Treatment (RTT) and Accident & Emergency (A&E). Cancer 62 day performance for the trust at the time of the assessment was also below the standard but has been consistently well above the national average for the previous 12 months.

- Overall RTT performance has been pressured since September 2018 as a result of pressures in high volume specialties. The trust demonstrated it has developed action plans for these services and submitted a trajectory to recovery in 2019. Performance in the last 3 months shows a trajectory of improvement (March 19 – 90.7%; April 19 – 91.1%; and May 2019 – 91.1%).
- A&E performance is a significant pressure for the trust and the standard has not been achieved in more than 12 months. The trust remains a significant distance from achievement (May 19 – 84.5%) and as per the trust plan, performance is not expected to achieve the standard in 2019/20.
- At 9.11%, emergency readmission rates are significantly above the national median of 7.73% for quarter 4 of 2018/19. This suggest that patients are more likely to return to hospital as an emergency within 30 days of initial discharge at this trust compared to other trusts. The trust provided evidence of readmission rates at or around the national average until 2017/18 when a change in Endoscopy coding from inpatients to outpatients significantly impacted the readmission rate. The trust reported the change removed c20,000 spells per annum from the denominator which resulted in an artificial increase in the readmission rate and therefore, accounts for the difference in the trust's rate compared to the national median.
- The trust provided evidence of a successful pilot in care homes using digital healthcare systems, enabling patients to be monitored remotely and supporting continuing care in the home. The pilot was across two care homes where visit rates reduced by 14% and 25%, and emergency admissions reduced by 30% and 20% respectively. The trust noted the reduction in overall emergency admissions will also lead to a reduction in readmissions and the intention is to extend the use of digital healthcare systems during 2019/20 following the successful pilot.
- Fewer patients are coming into hospital prior to treatment compared to most other hospitals in England.
    - On pre-procedure elective bed days, at 0.09, the trust is performing in the second lowest (best) quartile when compared to a national median of 0.12. One of the main drivers behind this rate is Plastic Surgery which the trust noted they have seen more of in the previous quarter and behaviours to get patients into hospital in advance of surgery in order to avoid last minute cancellations. The trust explained this is being addressed over the summer of 2019 with the optimisation work in bed configuration at University Hospital North Durham, following the successful transfer of vascular services to Sunderland. This is expected to reduce pre-procedure elective length of stay towards a best quartile position.
    - On pre-procedure non-elective bed days, at 0.47, the trust benchmarks in the lowest (best) quartile and below the national median of 0.66.
- The trust provided examples of improvements made to clinical productivity both locally and across the wider health economy, including:
    - With Integrated medical specialties, the trust has reduced length of stay and improved ambulance handover times for both North East Ambulance and Yorkshire Ambulance services. The emergency care workstream has delivered several improvements to clinical productivity including, criteria led discharge, improved primary care streaming, reduced delayed transfers of care, project #nextstephome with improved patient flow, and operational developments such as the discharge lounge and redesigned urgent care centres at both acute sites. The trust is also supporting South Tees Hospital NHS FT with the absorbing of activity from the temporary closure of A&E services at the Friarage Hospital.

- As an integrated provider of community services, the development of 'Nerve Centre' enables community hubs to view patients on acute wards and vice versa to support early discharge planning.
- In outpatients the trust has achieved improved clinical productivity with the use of tele health. The introduction of advice and guidance, virtual fracture clinics, straight to test clinics, tele dermatology and a single point of access for MSK were all given as examples of managing demand for outpatient services and ensuring clinical time is used effectively and efficiently.

- The Did Not Attend (DNA) rate for the trust is high at 8.43% for quarter 4 of 2018/19. The trust noted this is driven by historically high DNA patient groups in the specialties/services of; paediatrics, dermatology, nurse led clinics and continence services. The trust DNA policy highlights the overarching processes in the management of DNA's. The trust have introduced new service models in dermatology and virtual fracture clinics as part of reviewed Orthopaedic pathways, removing unnecessary outpatient appointments which have historically high DNA rates.
- The trust reports a delayed transfers of care (DTOC) rate in April 2019 of 0.34%, that is lower than the national average, lower than the trust's own target rate of 3.5% and is one of the lowest nationally. The trust attributed the improvement of DTOC rates between 2018/19 and 2019/20 to joint working with local authorities, criteria led discharge including a medical review each Friday, a trusted assessor programme and a virtual ward arrangement with the integrated community services to monitor patients under their care in hospital. The trust noted DTOCs are not impacting a lack of bed capacity and/or cancellations of elective operations. 45% of the trust's elective surgery takes place at Bishop Auckland Hospital and is therefore protected from a lack of beds arising from non-elective pressures.
- The trust is very well engaged with the Getting It Right First Time (GIRFT) programme and provided evidence from the North East, North Cumbria & Yorkshire Hub Director confirming this position. The trust's GIRFT programme is led through the project management office and each clinical specialty are developing action plans. A number of improvements have been made as a result, for example, reduced infection rates for fractured neck of femur and the introduction of hot biliary lists. The trust noted GIRFT continues to be a focus in the current year with visits concluded in Ophthalmology, Obstetrics & Gynaecology and Oral Maxillofacial.

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 £2,188, which benchmarks just above the national median of £2,180. This means that it spends slightly more on staff per unit of activity than most trusts nationally.
- For medical cost per WAU, at £438, the trust benchmarks below the national median of £533 and in the lowest (best) quartile nationally. However, for both Nursing and Allied Health Professional (AHP) cost per WAU, the trust is above the national median. For Nursing, the trust has a cost per WAU of £817 compared to national median of £710, placing it in the highest (worst) quartile; and for AHPs the trust has a cost per WAU of £138 compared to national median of £130, placing it in the second highest (worst) quartile.
- The trust provided evidence of their community service provision which totalled £52.1million in 2017/18, with nursing costs of £21.4million. The service provided almost 1.39million clinical contacts during 2017/18. This evidence was submitted in support of workforce metrics, as whilst the costings for this service are included in WAU metrics, the

community activity is not. With community costings removed, the cost per WAU metrics would improve. The trust was successful in October 2018 in being awarded a further community contract which has increased clinical contact activity by 47,000 contacts in 2018/19.

- Furthermore, the trust advised that the nursing skill mix in Community Services tends to be richer than equivalent Acute Services. For example, registrant band 6 on District Nurse qualification and HCA's at band 3, versus band 5 and band 2 respectively on acute base wards. The trust noted this will further be driving the increase in reported costs in Model Hospital.
- The trust met its agency ceiling as set by NHS Improvement for 2018/19 and is forecasting to meet its ceiling in 2019/20. It is spending less than the national average on agency as a proportion of total pay spend (2.9% compared to 4.4%). It achieved significant reductions in the cost of agency and locum staff through the introduction of in-house banks for nursing and medical staff supported by electronic eRostering (HealthRoster). In addition, the trust provided evidence of the successful recruitment strategy which is anticipated to reduce spend on agency and temporary staffing by £1.5million in 2019/20. The trust works collaboratively within the Integrated Care Providers on agency and bank staff and the working group is chaired by the trust Chief Executive.
- The trust evidenced the implementation of a workforce experience team designed to learn from the staff, improve and develop staff, build upon the high retention and recruitment rates, to drive reductions in temporary, agency and locum spend.
- The trust provided evidence of a number of innovative workforce models, including:
    - pharmacists in the delivery of new Rheumatology service pathways;
    - the development of nursing associates roles with revised safe staffing ratios and further intention to recruit 20 per year through an apprenticeship programme;
    - Physician associates;
    - the use of AHP's in physiotherapist pathways for MSK and in the front of house services to assist in the management of patient flow.
- The trust has successfully implemented HealthRoster into the organisation and across all clinical areas. The trust work to a timetable of rosters being produced at least 6 weeks in advance and rosters will cover a 4 week period with sign off via the Directorate Management Team. The roster policy references alignment to temporary/agency staffing policies/protocols with aims to minimise spend in these areas whilst ensuring appropriate staffing mix is achieved for each shift.
- E-job planning has been rolled out across the trust with 90% of consultants having a signed off job plan for 2019/20. Job plan data is captured within the E-job plan system enabling clinical and non-clinical activities to be timetabled. The trust noted it is envisaged that services will be able to monitor delivered activities against contracted, but at the time of the Use of Resources assessment the data was in its infancy, as synchronising between the necessary systems was being developed.
- The trust has a Job Planning Consistency Committee to assess consistency and quality of job plans, with a review of job plans taking place annually. A standard job plan has 75% of time aligned to Direct Clinical Care (DCC) and a core SPA (Specialist Programme Activity) of 1.5 PA's. Admin accounts for roughly 20% of DCC but with the planned investment and replacement of the trust electronic patient record this will reduce to 15%.
- Staff retention at the trust is good with a retention rate of 88.0% in December 2018 against a national median of 85.6%. The trust explained it has achieved this over the last 18 months with engagement from NHS Employers to identify best practice across the

country. The trust developed a retention strategy 'Retention Matters' which was co-developed with staff from all disciplines across the organisation. The strategy details activities across seven domains aligned to further improvements.

- At 4.74% in November 2018, staff sickness rates are worse than the national average of 4.35%. The trust acknowledged sickness is an area for improvement and have been working through a phased deployment of ESR Manager and Self Service, completed in June 2019. It was noted the improved reporting and capturing of sickness has increased the rate.
- Trust analysis shows the main reasons for sickness are stress/anxiety/mental health issues and muscular-skeletal problems. As a result the trust has developed a well-being pack detailing the support options available for staff and mechanisms to self-manage health and wellbeing. Increased Mental Health First Aid training for managers and awareness to staff has been made available to support a wider programme of work to develop referral pathways for staff suffering from mental wellbeing concerns. In supporting staff with their health and wellbeing the trust is actively recruiting a Clinical Psychologist and Occupational Health Physiotherapist.
- The trust cited the implementation of their people strategy, 'Staff Matter', as a key driver behind their workforce metrics. The strategy is themed under six enablers to provide an organisational culture by creating a workforce for the future: recruit and attract, develop talent, develop supporting infrastructure, maintain health and wellbeing, and support and embed a high performance culture.

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

- At £1.38, the overall cost per test at the trust benchmarks in the lowest (best) quartile and below the national median of £1.86. The trust does however, have a higher testing per capita benchmark at 27.2 above the national median of 22.6, leading to a more positive cost per test.
- The trust is actively engaged in the programme to consolidate pathology services with the Chief Executive of the trust as the Senior Responsible Officer for the North East & North Cumbria Network. The trust is leading on the development of an outline business case for integrated pathology services with South Tees Hospitals NHS Trust and North Tees and Hartlepool NHS Foundation Trust. Whilst this is not in line with the national requirement for a single pathology network for the North East and Cumbria, the trust is actively trying to progress consolidation.
- The trust is an active participant in imaging network development. The Clinical Director for the Radiology service has undertaken the role of leader of the Imaging Network group and has delivered a recommended specification for integrated IT and a series of workshops and events to share best practice.
- The trust's total cost of imaging services is in the second lowest (best) quartile nationally at £14.17m (3.1% of expenditure). The overall cost per report at £41.81 benchmarks below the national median of £50.05.
- At the time of the assessment, the trust did not have any reporting radiographers identified in the data return. The trust noted that they have recruited a qualified reporting radiographer and are supporting a further one in training. The trust confirmed that this was now an accepted workforce strategy for the service.
- Vacancy rates for consultant radiologists are high at 24.2% compared to a national median of 12.2%. As a result the trust is paying significantly higher than median insourcing, outsourcing and agency costs to support the turnaround of reports. The trust

is part way through implementing the business case recommendation to support home reporting for radiologists which will enable the opportunity for repatriation of outsourced reporting work. This involves placing an equivalent standard work station at home to that in the trust imaging department. The trust has developed policies, guidance and protocol to support this new way of working with agreed reporting rate in home reporting sessions.

- The trust has substantial aged equipment with 89% of X-ray, 50% of CT, 50% of MRI and 56% Ultrasound equipment being over 10 years old. The trust demonstrated it has an ongoing programme to replace aged equipment that commenced in November 2018 replacing both CT and MRI scanners. It has entered into a managed service arrangement that is relatively innovative for imaging services.
- The trust's medicines cost per WAU, at £266, is relatively low when compared nationally. As part of the Top Ten Medicines programme, it is making progress in delivering on nationally identified savings opportunities, achieving £1.16m of savings to March 2019. The trust has made good progress in implementing switching opportunities for biosimilars where appropriate.
- The number of pharmacists actively prescribing was 86% in 2017/18 compared to a national median of 35%, however, the trust does not currently provide a 7 day clinical service pharmacy provision to wards. The trust noted a business case is in development for 7 day services.
- The trust was able to demonstrate a clear theme of using technology and innovation to improve productivity throughout the trust, for example:
    - The development of a simulation centre used to simulate real life situations for training and development and is used by other trusts across the region
    - Tele dermatology which is reducing referrals into the service with 20% now being returned to the GP or redirected to other specialties allowing dermatologists to use outpatients capacity more effectively
    - Virtual fracture clinics
    - Further development to the Nerve Centre system (patient observations and assessment system) to include fluid balance, nutritional and mental capacity and falls assessments, together with dementia screening. The trust demonstrated how the functionality of this system was being more fully deployed in clinical services to support sepsis identification, escalation and treatment
    - The Health Call system in the trust was evidenced as being effectively used to support patients' self-monitoring and dosing warfarin

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 £1,191, compared with a national median of £1,307. This shows the trust spends less on other goods and services per unit of activity than most other trusts nationally.
- The trust's finance function cost benchmarks in the lowest (best) quartile at £496.38k per £100m turnover compared to a national median of £676.48k per £100m turnover. However, the cost of running the Human Resources function benchmarks above average with a cost per £100m turnover of £907.21k compared to a national median of £898.02k. The trust noted services such as Medical Education and Rostering are included within the HR function cost, however, these do not fall within the remit of the Workforce and Organisation Development Directorate. The trust demonstrated it has introduced in house nursing and medical banks together with implementing a digital medical bank system (Circular Wave). In addition the trust provided evidence that the higher HR costs were supporting additional staff benefits, for example, included within the occupational health

spend are clinical psychologist and physiotherapists. The work undertaken by the trust in the occupational health team has been nationally recognised and information is available through a model hospital case study.

- The trust has an IM&T cost per £100m turnover of £1.44m, placing it in the lowest (best) quartile when compared to a national median of £2.47m. However, the trust has higher than median IMT costs associated with end user device and, the trust evidenced that this was owing to the trust being a very positive user of digital solutions. The trust is continuing to look for system consolidation and collaboration and actively uses benchmarking of data to inform plans.
- 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 and Price Performance Score of 85 for quarter 3 2018/19.
- The procurement team provides procurement services for other trusts both within and external to the North East region and are attached to the County Durham Procurement Consortium (CDPC). The trust's league table position in 2017/18 was 50, however, at the time of the assessment the trust had moved up to 22. The trust have also achieved Level 2 NHS Commercial and Procurement Standards.
- The Supplies and Services cost per WAU is at £340 compared to a national median of £364. The trust value for the PPIB price variance achieving the best price in the top 500 products is 14.6% against a peer median of 17.1%. The trust described the clinically led process and structure it has for the CIP programme and the effectiveness of the Product Review Group in ensuring value for money judgements of products. The trust has a nurse specialist working as a member of the procurement team. The trust was an early user of PPIB, however recent log ins have been less frequent with the trust stating that with CIP projects in implementation phase they have less cause to log in to the tool.
- At £407 per square metre in 2017/18, the trust's estates and facilities costs benchmark above the national average of £342, placing the trust in the highest (worst) quartile. The trust demonstrated it uses its data well to inform its estate plans. For example, information provided by the trust illustrating the reduction of estate and relocation of services with a corresponding reduction in lease and maintenance costs in past and current years through releasing estate for sale or cessation of rental.
- Both Hard Facilities Management (FM) and Soft FM costs are below the benchmark values, however further analysis indicates, the trust has a number of higher than benchmark costs across a number of areas including food cost per meal, portering and estates and property maintenance. The trust noted this is in part driven by the combination of PFI and distributed estate in community hospital sites, that for example require a 24 hour portering service and other fixed minimum costs that have to be maintained for safety reasons.
- The trust's total backlog maintenance, at £130 per square metre for 2017/18, is below the national median of £182 per square metre. For the same period the trust's critical infrastructure risk of £22 per square metre is below the benchmark value of £55 per square metre.
- The trust established a wholly owned subsidiary company in 2017 to provide estates, facilities management and procurement services to the trust. This is a subcontract arrangement with Queen Elizabeth Facilities Limited (a wholly owned subsidiary of Gateshead Health NHS FT) and illustrates collaborative working. The trust evidenced the effectiveness is in part due to the shared posts that are deployed, maximising the skills and knowledge utilisation to best effect. The trust manages its relationship with the company through quarterly contractual meetings in which activity and service performance as well as cost are reviewed. An example of the effectiveness of this forum

was evidenced through the centralisation of the sterile services onto one location at University Hospital of North Durham releasing estate at Darlington Memorial Hospital.

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

- In 2018/19 the trust reported a deficit of £15.9m excluding Provider Sustainability Funding (PSF) (a £52k surplus including PSF) against a control total and plan of £10.0m deficit excluding PSF and therefore an adverse variance of £5.9m.
- In 2018/19 the trust agreed a £10.0m deficit control total excluding PSF (an £8.1m surplus including PSF). During the year the trust advised high forecast risk against delivering the agreed control total and a system response with main commissioners to mitigate the position was agreed. However, due to financial pressures within commissioning, the agreed mitigations were unable to be transacted and the trust recorded a shortfall against target of £5.9m.
- The trust financial performance excluding PSF has deteriorated over the previous 3 years: £15.9m deficit in 2018/19; £9.1m deficit 2017/18; £7.5m deficit 2016/17.
- The trust has accepted its control total for 2019/20 and as of the first quarter, is on track to achieve a year end deficit of £1.19m excluding PSF and Marginal Rate Emergency Tariff (MRET) funding (a £9.5m surplus including PSF and MRET).
- The trust had a cost improvement plan (CIP) of £34.7m (or 6.9% of its planned expenditure) in 2018/19 and achieved £28.5m (5.5% of actual expenditure). Therefore, an adverse variance of £6.2m. 43% of the achieved efficiencies were recurrent which has deteriorated from previous years recurrent delivery of 50% 2017/18; 57% 2016/17; and 72% 2015/16. The trust delivered £26.9m (5.8% of its expenditure) of planned savings in 2017/18, or 80% of the planned level.
- The cash balance as at 31st March 2019 was £7.9m and the trust borrowed £22.6m in working capital loans across the financial year. Controls around cash management have been tightened in year and as a result the level of creditors has increased. The lowest cash balance the trust had during 2018/19 was approximately £1.5m.
- The trust implemented PLICs during 2017/18 but is not yet embedded within routine business decision making across the trust.
- The trust has had minimal reliance on management consultants, however the trust has used management consultants twice during 2018/19 to review Junior Doctors Rotas and Services. The trust's expenditure on consultancy was £650k in 2018/19 and £767k in 2017/18. The trust noted for 2017/18 this was in relation to external payroll processing charges for medical staff.
- In 2018/19 the trust agreed block contracts and established a joint system PMO to deliver efficiencies across the localities Whilst joint QIPP schemes remain in their infancy, there is evidence of a collective view and approach to financial recovery within the local health system. The trust's other income streams have been fully reviewed over the current and prior financial year to set increased targets where appropriate. This includes additional commercial income within the wholly owned subsidiary.

Outstanding practice

- Delayed transfers of care rates at the trust are amongst the lowest nationally at c0.34%. This has been achieved through integrated working with community services and the virtual ward; strong relationship working with local authorities; string criteria led discharge processes; and a trusted assessor programme.

Areas for improvement

- Financial performance (excluding PSF) which has deteriorated in the last 3 years. The trust needs to develop a plan to return to financial balance and remove the requirement for borrowing to meet its financial obligations.
- The trust should aim to reduce its dependence on non-recurrent CIP schemes.
- The trust is not meeting the performance standards for Referral to Treatment (RTT), Cancer or Accident & Emergency (A&E).
- The DNA rate is above the national median and although initiatives and policies are in place, the trust would benefit from further work in this area.
- At 4.74% in November 2018, staff sickness rates are worse than the national average.

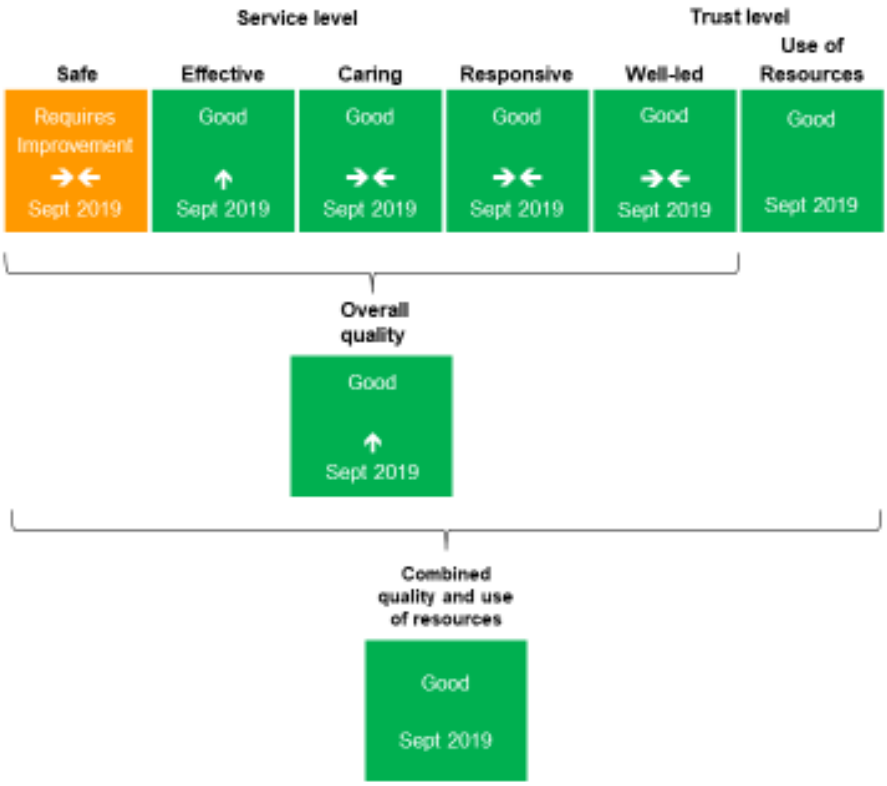
Ratings tables

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

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

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

Ratings for the whole trust



Use of Resources report glossary

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

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

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

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