

Gloucestershire Hospitals NHS Foundation Trust

Use of Resources assessment report

Alexandra House
Cheltenham
Gloucestershire
GL53 7AN

Date of publication: 7 February 2019

Tel: 08454 222 222
www.gloshospitals.org.uk

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

Ratings

Overall quality rating for this trust	Good ●
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Requires improvement ●
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/RTE/reports)

Are resources used productively?	Requires improvement ●
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Combined rating for quality and use of resources	Good ●
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We award the Use of Resources rating based on an assessment carried out by NHS Improvement.

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- we rated safe, effective, caring, and well-led as good; and responsive as requires improvement;
- we took into account the current ratings of the four core services across the two locations not inspected at this time. Hence, all core services across the trust are rated overall as good and one is rated as outstanding;
- the overall ratings for each of the trust's acute locations had improved.
- The trust was rated requires improvement for use of resources. Full details of the assessment can be found on the following pages.

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Date of site visit:
18 October 2018

Date of publication: 7 February 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 twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

The Use of Resources rating for this trust is published by CQC alongside its other trust-level ratings. All six trust-level ratings for the trust's key questions (safe, effective, caring, responsive, well-led, use of resources) are aggregated to yield the trust's combined rating. A summary of the Use of Resources report is also included in CQC's inspection report for this trust.

How effectively is the trust using its resources?

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 October 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

Requires improvement ●

We rated the trust requires improvement for use of resources. The current management team has inherited a major IT deployment which continued to have a detrimental impact on the financial and operational performance of the trust over the assessment period. This contributed to the trust delivering a £33 million deficit in 2017/18 and not achieving any of the access standards including being unable to report on the 18-weeks Referral to Treatment standard. The new management team has established a robust recovery plan and the underlying efficiency is better than national benchmarks, which provides the foundation for improved future performance.

- The trust recently exited Special Measures for financial reasons having made sufficient progress to stabilise its financial position and address its governance concerns. The trust was initially placed in special measures for financial reasons in October 2016 following unexpected and significant financial deterioration in reported income and expenditure performance.
- In December 2016, the trust initiated a TrakCare deployment, a new electronic patient management system. It became apparent during 2017/18 that there were significant challenges with the implementation of the system leading to substantial delays, additional costs and the trust's inability to track activity data supporting clinical income. This caused a material deterioration of the financial deficit in 2017/18. In response, the trust negotiated with commissioners to move to block contract payment during 2017/18 to partially protect its income and financial position.
- The trust delivered a £33 million deficit in 2017/18 (6.6% of turnover), £18.4 million adverse to its plan with the main driver being the data issues related to activity capture/coding and lower than expected income recovery resulting directly and indirectly from the TrakCare deployment. The trust is forecasting a £27.9 million deficit (excluding Provider Sustainability Funding) in 2018/19 which is an improvement on 2017/18 although the deficit is still above 5% of income. An analysis of the drivers of deficit indicates that the trust does not have a significant structural deficit (estimated around £5 million) with around half of the deficit within the trust's control, some recoverable once the TrakCare issues are resolved.
- Our assessment also showed that the trust needs to improve on the delivery of its cancer 62-day wait standard with a performance of 76.6% in October 2018 compared to an 85% target. The trust is in breach of the constitutional standard for 18-week referral to treatment but is not formally reporting on this due to data quality issues because of the TrakCare implementation. This impacts the number of 52 week wait breaches which the trust is committed to reduce.
- We also identified areas where the trust had made good progress or showed good performance:
 - The trust has developed a significant recovery programme to address the data quality issues arising from TrakCare, with ongoing support from NHS Digital and is making good progress to return to national Referral to Treatment time reporting by the end of the financial year;

- The trust's total cost per WAU is in the top quartile nationally indicating a high level of efficiency;
- The trust benchmarks in the lowest (best quartile) for emergency readmissions;
- The trust has engaged well with the Getting It Right First Time (GIRFT) programme and is now a national reference site for the programme;
- The trust has a good retention rate supported by investment in staff recruitment, induction, talent management, development and well-being;
- Despite challenges the trust is making very good use of its resources in imaging;
- The trust was taken out of Special Measures in November 2018 following evidence of progress in financial governance and grip and control;
- The trust delivered 5.1% of savings (£28.7 million) in 2017/18 through a planned financial recovery programme.

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

Following significant improvement work in the latter half of 2017/18, the trust now performs well against the national median for the 4-hour A&E (A&E) standard and has consistently met the diagnostic 6-week wait standard. It benchmarks well with regards to emergency re-admissions, being in the lowest (best quartile). However, the trust is not showing a sustained improvement in the delivery of the cancer 62-day wait standard and following the implementation issues with TrakCare it has been unable to report on 18-week referral to treatment standard performance since December 2016.

- At the time of the assessment (October 2018), the trust was maintaining a 4-hour A&E performance above the national average with a rolling average of 90.37% compared to the national standard of 95%. The trust's performance has improved and stabilised above national and peer benchmarks since October 2017 following the initiation of a task and finish group with significant clinical engagement. The Trust has implemented an initial assessment unit which receives all GP referrals as well as providing streaming and Frailty services from the acute floor. The trust has recognised there are further opportunities with the Minor Injury Unit and the assessment opportunities, alongside working with system partners to mitigate demand.
- The trust has had long-standing challenges in meeting the cancer 62-day wait performance standard and has not met this standard this year (76.6% in October 2018) against the 85% standard. At the time of the assessment in October 2018, the trust had made improvements in all specialties, however it was significantly impacted by Urology where the trust has struggled to deliver above 80% due to workforce capacity issues and demand growth. The improvement plan includes addressing backlog and long wait patients and the trust has implemented high impact actions such as 'straight to test' for lung and lower GI (gastrointestinal) with the support of the Cancer Alliance. The Trust has met the 2-week wait target for cancer in December 2018.
- The trust has not been able to report accurate performance for the access standard (18-week referral to treatment target (RTT)) since the deployment of TrakCare in December 2016. This is due to the inability to manage the data quality issues experienced at the time of the launch. RTT performance has deteriorated due to the absence of reliable waiting list data and necessary management focus on work to address the TrakCare system issues alongside performance recovery.

- The trust is now planning to return to reporting by the end of the financial year 2018. The backlog of data quality issues has now reached the lowest level it has been at and there is a robust plan on improving the use of the IT system to prevent further issues. This is the strongest level of control seen since 2016 and the trust has benefitted from the support of NHS Digital to identify priorities to address.
- The main impact is the volume of patients waiting 52 weeks or more for elective care. This is a consequence of lack of visibility of real patient waiting times, due the high volume of data validation that is required each month while the TrakCare system issues remain unresolved. The Trust is currently reporting approximately 100 per month. The Trust has remained committed to meeting the national requirement to reduce the long waits by 50% by the end of the year. The Trust expects to have reduced validation of the backlog caused by the transition to the new system, to a realistic volume by February 2019 to enable re-reporting of RTT.
- The trust has been achieving the diagnostic 6-week wait standard since October 2017.
- The trust has embraced the Getting It Right First Time (GIRFT) programme, establishing programme support and governance to oversee specialty action plans and share best practice. Following the trust's success with this programme, it is now a national reference site for Trauma & Orthopaedics (T&O) and has been shortlisted in the Health Service Journal's Efficiency Awards. In the past 12 months the Trust has improved 100% of the defined efficiency metrics for T&O including a sustained 53% reduction in its 'index measure' of the time to theatre for patients with upper limb trauma from the time of injury. The learning from this is now shaping other services' plans.
- The trust is collaboratively working with system partners and has reduced the Delayed Transfers of Care (DTC) level from 70 patients to 40 during 2018. In particular, the trust and the wider system have implemented an integrated discharge team with a single matron who co-ordinates social worker input and the integrated discharge team to allow patients to be discharged from hospital into onward care with fewer delays once they are medically fit.
- The trust performs well nationally in relation to emergency readmissions at 6.79% (Quarter 1 2018/19) being in the lowest (best) quartile nationally. The trust however recognises there is still more work to be done. It is implemented a 'Home First' programme to aid flow alongside discharge to assess work with social care. It is also working in partnership with Age UK and the Red Cross to create a better model of care delivery. The trust has developed positive relationships with nursing homes to support onward care, alert to patients deteriorating while awaiting packages of care.
- The trust's pre-procedure non-elective bed days at 0.92, is in the highest (worst) quartile nationally while the pre-procedure elective bed days at 0.12 days is in the second highest (worst) quartile nationally. This means a relatively high number of patients are admitted to beds before planned procedures compared with other trusts. The trust indicated that the low performance of the trust against the metrics is impacted by data quality from TrakCare although the trust recognises that further improvements can be made. This is also to be compared with the trust's non-elective and elective length of stay in August 2018 respectively of 8.3 days (lowest (best) quartile nationally) and 3.0 days (second lowest (best) quartile).
- The Did Not Attend (DNA) rate, at 7.38% for Quarter 1 2018/19, is in the second highest (worst) quartile nationally. Cancellation and DNA rates have been a challenging area for the trust, particularly because of the TrakCare issues and the resulting difficulties in obtaining reliable data on outpatients' appointments. Initiatives including texting patients

in advance of appointments have had a positive impact on DNA rates and the trust is undertaking a reorganisation of the Central Booking Office to improve productivity.

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

The trust has a low total pay cost per weighted activity unit (WAU) driven by low nursing staff and Allied Health Professional (AHP) cost per WAU. Its medical staff cost per WAU is however higher than the national average. The trust has invested in advanced and specialist nursing roles. It has processes and systems in place to manage rotas and ensure clinicians have job plans. It is reviewing its people strategy and starting to engage with system partners to address common workforce challenges.

- For 2016/17 the trust had an overall pay cost per WAU of £2,040, compared with a national median of £2,157 placing it just outside the lowest (best) quartile nationally. This means that it spends less on staff per unit of activity than most trusts. The trust is in the lowest quartile for AHPs cost per WAU and the lowest quartile for nursing staff cost per WAU although it benchmarks in the highest quartile for medical staff cost per WAU being worst in the country.
- The trust indicated that the high medical cost per WAU is driven by the costs of the GP trainees the trust hosts for the Deanery and who do not undertake clinical activity for the trust. The Model Hospital also shows that the consultant cost per Full Time Equivalent (FTE) and consultant cost per WAU adjusted for medical output are both in the second lowest (best) quartile.
- The trust monitors the pay bill monthly to identify trends and understands the balance of substantive and temporary staffing spend including the split between agency and bank staff.
- As at September 2018, the trust's agency spend was £7.7 million and represented 4.5% of its total pay costs. For 2016/17 (the latest data available), its agency staff cost per WAU is £135 compared to national median of £137. However, the trust continues to operate above the overall annual NHS Improvement ceiling for agency expenditure. This is a challenging target and the trust has made significant progress, reducing spend in absolute terms from £21.8 million (2016/17), £16.7 million (2017/18) to a planned £13.6 million for 2018/19. The trust has actions defined to continue to reduce its spend on agency towards compliance with annual ceiling (£11.2 million in 2018/19). The trust has reviewed the rates offered to internal Bank staff to make them more attractive resulting in an increased pool of staff on the bank. It has also been successful at reducing spend on medical locums despite challenges with medical rotas through close monitoring of the use of locums.
- The trust conducts a consultant job planning process annually. 78% of consultants had a job plan at the time of this assessment compared to the national median of 89%, indicating further scope to improve. The trust is reviewing opportunities to improve job planning with on-going work in relation to Supporting Professional Activities (SPAs) and Direct Clinical Care (DCC), this is in conjunction with remodelling plans for how clinicians work in the emergency pathways specifically in the Trust's ambition for an Acute floor. To address vacancies the trust has a high number of non-training grade staff and is actively reviewing how it can build on this whilst also expanding the number of consultants.
- The Trust has recently implemented an e-rostering system (Health Roster) for nursing staff and midwifery staff. This is driving more efficiency of staff utilisation and allows for improved control in relation to managing the requirement for Agency costs.

- At 3.75% in year, the Trust's staff sickness rate is better than the national average of 4%.
- The trust has a forward vision of delivering the right sized and skilled workforce addressing the known shortages of professional staff. The trust has made rapid progress with its workforce strategy and is increasingly using an innovative skill mix with advanced clinical practitioners and clinical specialists to deliver its services with an increase in nursing and therapy specialist roles. This work is informing development of an overarching strategy for clinical services in development with lead commissioners that is ongoing.
- At 86.7%, the staff retention rate is the second highest (best) quartile nationally. The trust has invested heavily in its recruitment team and governance around induction and training is much improved, as is workforce data and information. There is also a renewed focus on talent management to support retention and development, and staff health and wellbeing is being treated as a priority. The trust's staff engagement score in the 2017 staff survey had however worsened compared with the 2016 survey, a critical area for the trust to understand and work with staff groups to improve. The Trust is using a range of actions to improve this, including a staff experience group and a focus on triangulating and responding to all feedback.
- The trust has significantly strengthened links with education providers over the last two years. It is working with education providers to understand the need and the current and expected gaps in the workforce. As a result, the education programme now maps to where staff should be deployed. The trust is also working with Health Education England and with local providers specifically around Radiology. A nursing assessment and accreditation system is helping to drive ward leadership and clarity about standards across the organisation. Practice placements are going well and the Trust views these as an important tool to recruit and retain staff. Nurse associates are coming to the Trust in increasing numbers and there are plans to grow adult nursing provision and to introduce cadetship roles and develop advanced clinician practitioner roles. A career pathway for nursing has been developed using a 10-year opportunity model.

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

The trust benchmarks slightly above the national medians for pharmacy and pathology services. Although this partially reflects above median levels of specialist commissioning services, there are areas where the trust could make further improvements. The trust is making efficient use of its resources in imaging despite challenges with demographic growth and age of the equipment.

- The medicines cost per WAU for 2017/18 is above the national median £364 compared to £320. The total medicines costs are the aggregation of 3 elements, 'high cost drugs', 'non-high cost drugs' and the operating costs of the pharmacy service.
- More high cost drugs are required by the trust due to the above median levels of specialist commissioned services (£90 million). The trust has however delivered above median levels savings in the cost of these high cost drugs, delivering 130% of the target across the 'top 10 medicines'.
- The trust has also made good progress in the overall cost of 'non-high cost' drugs. The trust tracks performance which shows it is in the most cost-effective quartile for these in-tariff drugs.
- The trust is on track to deliver further pharmacy savings of £300,000 in 2018/19. The trust's control of stockholding has improved from 27 days in 2016/17 to less than 23 days

over the review period, lower than southwest region comparators but still above the national median of 20 days and has also rationalised its manufacturing processes from 2 units to 1. The trust is now delivering 7-day services on both sites.

- There are however problems in the reconciliation between the pharmacy and finance systems which is being investigated by the trust to ensure more robust in-year grip and control. A £2.7 million cost pressure was identified by the trust for the prior financial year due to an underbudgeting of pharmacy costs which potentially highlights this issue.
- The trust's pathology service is close to national median efficiency metrics. The average cost per test is £2.17 compared with a national median of £1.86. Given the above median levels of specialist commissioned services delivered by the trust, which typically require more complex testing, this suggests that when adjusted the trust performs slightly better than national medians.
- The trust is now a full partner in the 'South 3' (West of England) Pathology Managed Equipment Service (MES) procurement process. This will ensure the trust maximises economies of scale and business continuity opportunities from being part of a larger procurement process. Continued engagement in this network is important to identify and plan how these efficiencies should best be released. Ahead of this, the trust has proactively and innovatively developed its services over the review period particularly in histopathology which has reduced the time critical reporting turnaround times for cancer patients. The trust's team has also introduced new technology to materially accelerate certain testing which is expected to save the trust approximately 2,000 bed days.
- The trust has challenges in its imaging services, driven by significant demographic increases, the backlog in the replacement of its diagnostic equipment and the shortage of staff - particularly radiographers.
- The national data shows the trust to be in the quartile with the highest backlog of testing across all 3 main imaging modes. The trust is however very efficient in the use of the resources it has available. The trust has undertaken detailed analysis of its imaging service with comprehensive benchmarking, which shows that the levels of activity are materially higher than national medians, particularly in CT and MRI scanning however the trust's expenditure on imaging services represents a lower % of total expenditure 3.3% compared to 3.9%. The average cost imaging cost per report is £35.46 compared to the national median of £50.38. This reflects the high number of reports delivered by each member of staff. The issue for the trust is capacity with particularly low numbers of radiographers compared to the national median – 87 compared to 137.
- The number of CT and Ultrasound scanners over 10 years old is in the highest national quartile. Investment is needed in new equipment through different structures given the tight capital investment constraints nationally. There are opportunities for the trust to improve resilience by reducing the number of sites operated from – currently 10. The trust's use of radiographers to report is also very low compared with national medians (11% compared to 23%) which would give some scope to increase capacity.

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

Overall the trust benchmarks well for its corporate services and the trust has evaluated the needs of the operations and is investing to support greater efficiencies across the trust. The finance function benchmarks in the second most efficient quartile. The Human Resources (HR) costs are also below the median even though the trust processes the payroll costs for the significant number of GP trainees that the trust hosts. The cost per payslip is particularly low.

The legal costs are well above the national median which reflects the in-house resolution of Clinical Negligence Scheme for Trusts (CNST).

- Overall the trust benchmarks well based on 2017/18 data for its corporate services with the cost/£100 million turnover being only marginally above the most efficient quartile nationally with a significant improvement in the efficiency of the finance and payroll functions from 2016/17. The trust has evaluated the needs of the operations and is seeking to optimise the resources within its corporate services functions.
- The functions which benchmark less well are payroll, procurement and legal. The higher payroll costs reflect the additional cost of the large number of GPs in training which the Trust hosts. Benchmarking of the cost per payslip shows the trust to be in the best performing quartile. The procurement costs are increased by the fact that the trust also provides this function for 2Gether NHS Foundation Trust. The legal costs are well above the national median which reflects the in-house model for resolution of CNST. The IM&T cost benchmarks in the best national quartile, however this does not include the costs associated with the implementation of TrakCare.
- The trust is ranked 23rd in the national procurement league table (2017/18 - top quartile) which is a significant improvement from the previous year. The performance metrics are in the top quartile for both the pricing achieved and for the quality of the processes in place. The trust also delivers shared procurement services for 2Gether NHS Foundation Trust. The pricing performance has continued to improve in 2018/19 and the trust has addressed the area of weakness - the percentage of transactions on eCatalogue which is now at 90%. The trust needs to refresh its procurement transformation plan and it has yet to achieve NHS Procurement & Standards Level 1. The trust is on track to deliver £1.6 million of procurement savings in 2017/18.
- The trust is in the process of a major Site Development Programme as a large part of the estate is old, disconnected and in a poor condition. Most of the estate has been developed with public funding with components operated under Private Finance Initiative (PFI) contracts. The cost of running the trust's estate are above the national median £377/m² compared to a peer median of £338/m² putting the trust in the third quartile for efficiency. The levels of backlog maintenance are also well above peer medians - £308/m² compared to the peer median of £230/m². The high annual estates costs are driven by the cost of the building maintenance £104/ m² compared to the peer median level of £84/m². The trust's soft Facilities Management (FM) services are however below the peer and national medians.
- The trust recognises the issues with its estate and is investing in critical risk areas, which is reflected in the relatively low levels of critical infrastructure risk with a further £4.5 million planned in 2018/19 to reduce the backlog. The trust also entered into a combined heat and power (CHP) contract which to date has delivered energy savings of £700k. The lack of access to capital investment funds is limiting the trust's ability to address its estates issues more rapidly.
- Benchmarking of the trust's PFI estate also shows relatively high costs of the hard FM service however this is substantially offset by better than peer median costs of all other costs including soft FM and financing.
- The trust established a wholly owned subsidiary in April 2018 to deliver its estates and facilities functions. The business plan sets out planned savings of £3.9 million in 2018/19 (revised down to £3.2 million) through the combination of tax savings and savings through a managed service delivery model within theatres.
- TrakCare recovery work described above has had a substantial cost. Part of the costs of implementing the system can be capitalised by the trust however it represents an on-

going drain on scarce capital funding. To date, the trust has capitalised over £8.7 million with a budget for 2018/19 of a further £1.7 million. There are also significant revenue costs associated with TrakCare which has created a £1.6 million cost pressure for 2017/18.

- NHS Digital undertook two reviews of the implementation and subsequent recovery plan. The initial review in November 2017 found issues with governance, leadership, programme control and resources. A follow up review in October 2018 concluded that progress had been made in particular on data quality and core processes although acknowledged that the trust still had a significant amount of work to do to complete the recovery and develop sustainable and ongoing processes. In terms of this Use of Resources assessment, the trust has significantly improved its control over the implementation and the new management team has had to address very significant historic challenges. However, this is being achieved at a significant cost as highlighted above.

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

Since entering special measures for financial reasons in October 2016 and despite the impact of the TrakCare failed implementation, the trust has made progress to address its financial position. Its total cost per WAU, at £3,277 is in the lowest (best) quartile nationally. It is on a path to improve its underlying deficit in 2018/19 following delivery of a significant a Cost Improvement Programme (CIP). Despite progress, the trust still must recover its data quality issues relating to TrakCare, address its underlying financial deficit and it continues to rely on funding from the DHSC for capital and revenue.

- In 2017/18, the trust planned a deficit of £14.6 million after rejecting a surplus control total of £14 million (including £11.5 million Sustainability & Transformation Fund); however it delivered a deficit of £33 million for the year despite the delivery of a £28.7 million CIP (5.1% of expenditure). The trust's deterioration compared to its plan was principally driven by data issues related to activity capture/coding and lower than expected income recovery resulting directly and indirectly from the TrakCare deployment.
- The trust has submitted a plan to achieve a £26.9 million deficit in 2018/19 in line with its control total (excluding PSF; £18.8 million including PSF) which represents an improvement on prior year's performance despite some continuing impact from the TrakCare issues partly mitigated by the negotiation with the largest commissioners of a block payment for activity. The trust's plan is supported by a £30.3 million CIP (5.3% of expenditure; 92% recurrent) which is challenging and an improvement on the 2017/18 achievement.
- At the end of September 2018, the trust was £0.2 million ahead of its year to date plan and was forecasting to achieve a deficit of £27.9 million or 5.4% margin (excluding SPF; £22.7 million including STF), £1 million adverse variance to plan due to revised assumptions around agenda for change funding for its subsidiary. However, the current forecast outturn includes a £6.7 million risk around the delivery of its cost improvement programme which the trust is actively managing with the support of a consultancy firm in parallel to identifying further mitigating actions.
- At the time of writing this report, NHS Improvement had also received sufficient assurance of progress from the trust to improve its financial position, the TrakCare issues and financial governance to decide to remove the trust from Special Measures.

- At the end of 2017/18, the trust had a £31.7 million underlying deficit once one-off cost and income items are taken out. The trust recently commissioned a review of the drivers of its deficit (October 2018). The analysis, which includes several caveats around data quality, shows that around half of the deficit is attributed to opportunities within the trust's direct control, including lost income related to TrakCare which the trust should be able to address once TrakCare issues are resolved.
- With a low cost per WAU, the trust has achieved a relatively high productivity but continues to extensively use the Model Hospital, GIRFT and other data sources to identify CIPs and has benefited from working with a consultancy firm on addressing its £6 million gap in 2018/19. The trust has also invested in training more than 1,500 staff to lead improvement projects in their service area to maximise productivity.
- The trust recognises that it could benefit more from the local private patients' market but hasn't so far due to operational pressures.
- The trust has a weak cash position because of past and present deficits and it also doesn't generate sufficient funds to cover its capital requirements. As a result, the trust relies on external funding to cover its operational deficits, capital expenditure and financing costs. Excluding its PFI, the trust will have accumulated borrowings of £120.7 million at the end of 2018/19, most of which with the DHSC with a cost of £4.5 million a year. Until the trust can improve its deficit position, the trust's total borrowings will continue to increase continuing to add pressure to its financial position.
- The trust spend on consultancy has increased since 2016/17 from £2 million to £3 million expected in 2018/19 reflecting the need to bring in expert capabilities and capacity support redressing the trust's financial position and assist with the Trak Care recovery.

Outstanding practice

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

- The trust is a national reference GIRFT site on Trauma & Orthopaedics and has been shortlisted in the Health Service Journal's Efficiency Awards.
- Histopathology services which have reduced the reporting turnaround time for cancer patients.

Areas for improvement

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

- Improving the cancer 62-day performance through delivery of existing or new initiatives
- Continuing to deliver the current Trak Care recovery plan so that the trust can resume reporting on the 18-week referral to treatment standard and track activity data accurately.
- Continuing to reduce the spend on agency staff to the level of the NHS Improvement ceiling.

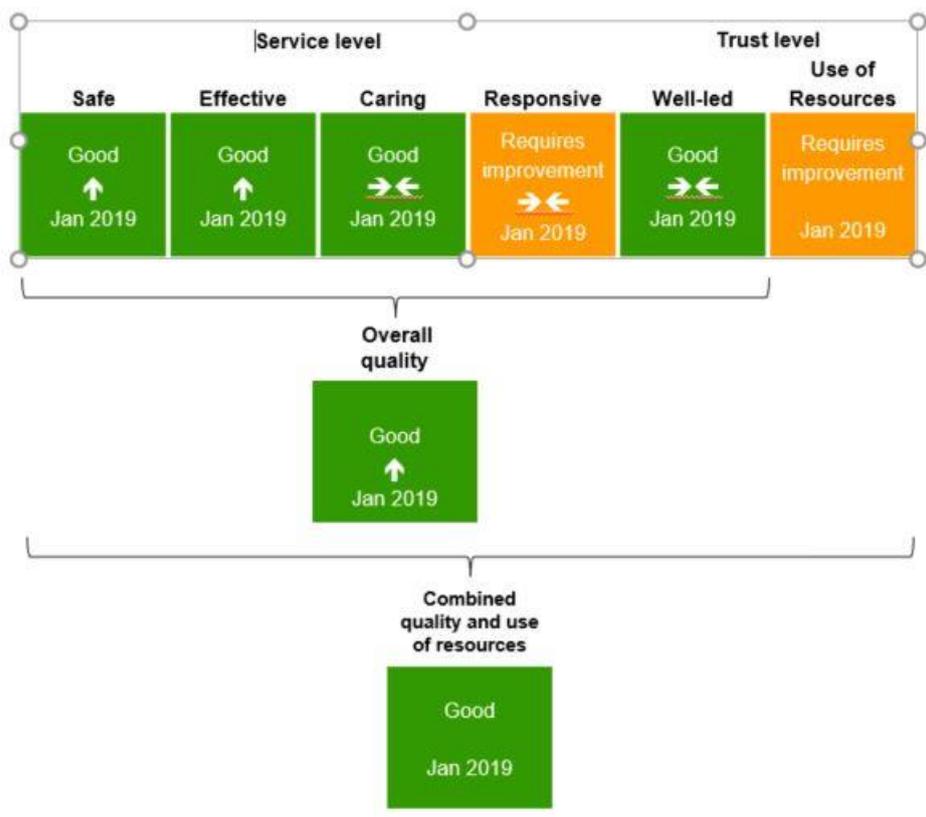
- Providing job planning information to the Model Hospital team for 2017/18 and continuing to improve compliance with the number of consultants with an active job plan.
- Completing the reconciliation between the pharmacy and finance systems.
- Developing a medium to long term plan to ensure it is financially sustainable based on the finding of the drivers of deficit review.

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.
Single Oversight Framework (SOF)	The Single Oversight Framework (SOF) sets out how NHS Improvement oversees NHS trusts and NHS foundation trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that trusts need to meet the requirements in the Framework.
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.
Sustainability and Transformation Fund (STF)	The Sustainability and Transformation Fund provides funding to support and incentivise the sustainable provision of efficient, effective and economic NHS services based on financial and operational performance.
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.