

# North Cumbria University Hospitals NHS Trust

## Use of Resources assessment report

Address:

The Cumberland Infirmary, Newtown Road,  
Carlisle, Cumbria  
CA2 7HY

Tel: 01228 523444  
www.ncuh.nhs.uk

Date of publication:  
22 November 2018

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

### Ratings

<b>Overall quality rating for this trust</b>	<b>Requires improvement</b> ●
<b>Are services safe?</b>	<b>Requires improvement</b> ●
<b>Are services effective?</b>	<b>Requires improvement</b> ●
<b>Are services caring?</b>	<b>Good</b> ●
<b>Are services responsive?</b>	<b>Requires improvement</b> ●
<b>Are services well-led?</b>	<b>Requires improvement</b> ●

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/RNL/reports](http://www.cqc.org.uk/provider/RNL/reports))

<b>Are resources used productively?</b>	<b>Requires improvement</b> ●
<b>Combined rating for quality and use of resources</b>	<b>Requires improvement</b> ●

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

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

## **Use of Resources assessment and rating**

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

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

## **Combined rating for Quality and Use of Resources**

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

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

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement and caring as good.
- We rated six of the trust's eight services as good and two as requires improvement. In rating the trust, we took into account the current ratings of the three services not inspected this time.
- We rated well-led for the trust overall as requires improvement.

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Date of site visit:  
02 July 2018

Date of publication:  
23 November 2018

This report describes NHS Improvement’s assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust’s performance over the previous 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.

**Proposed rating for this trust**

**Requires improvement** ●

### How we carried out this assessment

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

We visited the trust on 02 July 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 key lines of enquiry (KLOEs).

### Findings

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

Requires improvement ●

- We rated the trust's use of resources as requires improvement.
- The trust reports a positive position in reducing delays transfer of care (DTC) through significant effort and focus (April 2018: average 30 DTC patients vs. April 2017: average 60 DTC patients.) The trust has engaged with Newton Europe to support efficiencies in emergency care and coordinating services across the local health and care economy. Improvement work led by the Accident and Emergency Delivery Board has resulted in more than a 50% reduction in discharge delays over the last 12-month period.
- The trust now has a clear focus on job planning, with 140 Consultants having agreed job plans (56% of total Consultant workforce). Closer work with Cumbria Partnership NHS Foundation Trust and use of resources across the North Cumbria system is leading to improved productivity. Significant improvements in reducing length of stay are evidenced within paediatric services and also across the delirium/dementia pathways.
- The trust has significantly reduced the use of agency nurses to circa 18WTE each week and has increased the use of the bank which is run jointly with a neighbouring trust. Their work in relation to the development of a composite workforce has been successful, enabling more opportunity for career progression, breaking down potential barriers and supporting a stabilised workforce. Additionally, the trust has had a successful recruitment campaign resulting in an increase in nursing establishment of 150WTE across April/May 2018.
- The medical locum workforce is considerably lower than previous years. The percentage of agency medical spend against total medical spend has reduced as follows; 2015/16: 29.6%, 2016/17: 24.5% and 2017/18: 23.6%. This has been managed by implementing the composite workforce model but also by adhering to robust processes to manage locum spend.
- At 4.50%, the staff sickness rate is below the national median of 4.98% and the trust has demonstrated considerable improvement over the previous 12 months.
- Staff retention at the trust is a key focus, with a retention rate of 89% against a national median of 85.6% placing it in the highest (best) quartile nationally.
- The trust is using technology in innovative ways to improve operational productivity including, for example, the use of its Realtime system to support ED flow and reduced hospital delayed discharges. These measures, and the use of text messaging alerts, has supported reductions in the level of DNAs from 9% in April 2017 down to 6.9% in April 2018.
- The trust has a robust project management system fully embedded throughout its services to deliver the efficiency programme, and savings are fully aligned with those of the CCG.

However:

- For 2016/17, the trust had an overall pay cost per weighted activity unit (WAU) of £2,543 compared with a national median of £2,157, placing it in the highest (worst) quartile nationally. This means that the trust spends more on staff per unit of activity than most trusts. This indicates that the trust is less productive at delivering services than other trusts by showing that, on average, the trust spends more to deliver the same number of services.
- For 2016/17 the trust had an overall non-pay cost per WAU of £1,514 compared with a national median of £1,301 which places it in the highest (worst) quartile nationally.

- The emergency readmission rate, at 7.9% is above the national median. This means patients are more likely to require additional treatment for the same condition at this trust compared to other trusts.
- At the time of the assessment, the Did Not Attend (DNA) rate for the trust was 7.7% compared with a national median of 7.24%, placing it in the second highest (worst) quartile.
- The trust has comparatively high running estates and facility management costs, with their average running costs currently at £547 per m2 compared with national median of £308 per m2.
- The trust is a significant outlier with regard to its medicines spend, with a cost per WAU of £506 in comparison to a national median of £320.
- The trust recorded a deficit of £40.3m for 2017/18 (15% of turnover). The trust's cash balance at the end of 2017/18 was £3.6m and it is forecasting a closing cash balance of £1.4m at the end of 2018/19. The trust requires significant loans from the Department of Health for the full 2018/19 financial year amounting to £35.50m and is incurring £2.89m in annual interest.

**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 2018, despite improvement, the trust was not meeting all the constitutional operational performance standards around Referral to Treatment (RTT), Cancer and Accident and Emergency (A&E). The latest data (March 2018) identified RTT performance at 92% (target 92%), Diagnostics performance at 98.53% (target 99%) and Cancer 62 days screening service referral wait at 80% (target 85%). A&E Performance for June 2018 was reported at 92% against a national target of 95%.
- The trust is achieving the target for cancer 62-day urgent GP referral at 85.71% performance. The trust's A&E performance for April 2018 was 84.65% but this has improved consistently over the last 12 months and the trust's overall performance for June 2018 was 92% against the 95% standard (the national average was 90.7%). The trust as a whole ranks 55th out of 138 trusts in England.
- Patients are more likely to require additional treatment for the same condition at this trust compared to other trusts. At the time of the assessment the emergency readmission rate, at 7.9%, was slightly above the national median of 7%. The trust informed us they are focusing on ambulatory care to ensure patients are reviewed promptly. The trust provides outreach care into Kingston Court Care Home based on the Carlisle Hospital site which supports improvement work in reducing admissions to hospital whilst also providing higher quality care to the residents.
- More patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals on England.
  - On pre-procedure elective bed days, at 0.15, the trust is performing in the second highest (worst) quartile and above the median when compared nationally – the national median is 0.13.
  - On pre-procedure non-elective bed days, at 0.96, the trust is performing in the second highest (worst) quartile and above the median when compared nationally – the national median is 0.81.

- At the time of the assessment, the DNA rate for the trust was 7.7% against a national median of 7.24%. However, the trust DNA rate has been consistently reducing over the last 12 months. For example; surgery DNA rates are at the lowest for 12 months at 5.8% and medicine DNA rates are at 7.4% in 17/18, down from 7.8% in 16/17.
- The trust reports a positive position in reducing delays transfer of care (DTOC) through significant effort and focus (April 2018: average 30 DTOC patients vs. April 2017: average 60 DTOC patients.) The trust has engaged with Newton Europe to support efficiencies in emergency care and coordinating services across the local health and care economy. Improvement work led by the Accident and Emergency Delivery Board has resulted in a greater than 50% reduction in delays over the last 12 months. A number of initiatives have led to improvements including;
  - daily discharge huddles / reviews
  - introduction of hospital at home at Copeland
  - therapy led developments

The above work has also resulted in a sustained reduction in escalation beds.

- The trust is working hard to improve clinical and non-clinical productivity. There is a clear focus on job planning with 140 Consultants (56%) having agreed job plans. The trust has implemented annualised output sessions to track delivery in clinical activity. Much improved information is now shared with Model Hospital and the trust is committed to using this information to reduce variation. Theatre productivity has been an area of particular focus for the trust with monthly productivity reports now produced. Whilst this is at an early stage, improvements in early starts and late finishes within the theatre setting are being evidenced.
- The trust is engaged with the GIRFT programme and has shared examples of good clinical engagement with the programme. Model Hospital data identifies both elective and non-elective length of stays (LOS) below national average (Elective: 2 days versus national average of 3 days and Non-Elective 8.6 days versus national average of 9.6 days. Early successes within this include hip and joint replacements (2015 LOS: 14 days. 2016: 13 days)). Plans to consolidate orthopaedic trauma onto one site are being taken forward to reduce variation and the trust is also seeking to spread improvements to medical ambulatory care and day case services.
- Closer work with Cumbria Partnership NHS Foundation Trust and use of resources across the North Cumbria system is leading to improved productivity. Improvements in reducing length of stay are evidenced within paediatric services and across the delirium/dementia pathways where data identifies that a potential 17 beds could be reduced during 2018/19 because of a reduction in length of stays for patients over 65 years. Whilst improvements in the musculoskeletal pathway have reduced inpatient admissions, psychological interventions for patients within the pain service are also leading to reduced waiting times.

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

- For 2016/17, the trust had an overall pay cost per weighted activity unit (WAU) of £2,543 compared with a national median of £2,157, placing it in the highest (worst) quartile nationally. This means that the trust spends more on staff per unit of activity than most trusts and highlights the ongoing challenges that the trust continues to experience in terms of workforce. The trust acknowledges that there is further work to be done in certain staff groups, including Allied Health Professionals (AHPs) as part of ongoing

developments for developing a composite workforce. The trust is in the second highest (worst) quartile for both AHP (£136 vs. national median of £127) and nursing (£917 vs. national median of £717) cost per WAU; however, it benchmarks in the second lowest (best) quartile for medical cost per WAU at £436 compared to the national median of £526 and these differences may reflect extended roles being undertaken by non-medical clinicians. However, it is unclear what the trust aims to achieve in terms of a target for WAU.

- The trust has now appointed an AHP lead, and a strategy is being devised to plan further developments to the AHP workforce and increase skill mix. This builds on current innovation e.g. the significant decrease in musculoskeletal referrals due to early screening by AHPs, with diversion of referrals directly to physiotherapy leading to less requirement for unnecessary secondary care intervention.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2017/18, (however the variance to target was marginal at £35k) and is forecasting to be £630k over its ceiling in 2018/19. In 2017/18, 7.8% of the total pay bill was spent on agency expenditure. It has achieved significant reductions in the cost of agency and locum staff since 2016/17 due to an increase in internal controls combined with the implementation of a composite workforce model.
- The trust has significantly reduced the use of agency nurses to circa 18WTE each week and has increased the use of the bank which is run jointly with a neighbouring trust. Their work in relation to the development of a composite workforce has been successful, enabling more opportunity for career progression, breaking down potential barriers and supporting a stabilised workforce. Additionally, the trust has had a successful recruitment campaign resulting in an increase in nursing establishment of 150WTE across April/May 2018.
- The reliance on medical locums is considerably lower than previous years. The percentage of agency medical spend against total medical spend has reduced as follows; 2015/16: 29.6%, 2016/17: 24.5% and 2017/18: 23.6. This is following the implementation of the composite workforce model but also by adhering to robust processes to manage locum spend. The high cost locum spends remain specifically within Haematology, Stroke and Maternity services. These reflect the fragility of these services regionally and nationally, hence very challenging workforce issues.
- Recruitment plans are reviewed weekly. This includes all renewals for locum spend having to be reviewed and signed off by the Medical Director and Executive team prior to a locum being arranged.
- In order to improve recruitment and create a sustainable workforce, the trust has implemented a range of actions including undertaking international recruitment, particularly from India, to support the medical workforce. The trust is also considering innovative ways to support recruitment processes. An example of this includes using Skype to help conduct interviews with candidates from abroad. A succession planning approach is also being embedded across all disciplines and roles, and the development of their Integrated Health Care System will act as an enabler to allow posts to be extended to 'system' roles as opposed to solely having an acute trust focus. This work has commenced and expected to develop as the IHCS develops.

- The trust is working collaboratively with their local University to ensure that students are placed within the trust and have clear pathways in place to support career development. This also allows the trust to develop and embed a motivated workforce for the future.
- At 4.50%, the staff sickness rate is below the national median of 4.98% and the trust has demonstrated considerable improvement over the previous 12 months which is also reflected by the positive staff feedback in staff surveys. Detailed examples were provided by the trust to demonstrate how innovative and efficient staffing models and roles are used to deliver high quality and sustainable care, including ensuring that there is an appropriate skill mix for the work being undertaken. A specific example includes the development of a therapy led ward which is due to open in the final half of the year and will focus exclusively on providing rehabilitation and discharge planning for those patients deemed appropriate. No medical investigations or medical interventions are provided on the ward, but patients remain the responsibility of the referring consultant. Patients on the ward who deteriorate and require medical investigation or interventions are transferred back to an acute base ward on the same day.
- Staff retention at the trust is a key focus, with a retention rate of 89% against a national median of 85.6% placing it in the highest (best) quartile nationally. The trust recognises the importance of investment in training and career development opportunities and acknowledges that further work is needed on its workforce retention strategy.
- The trust is also undertaking a significant amount of innovative work to support and engage local communities into their workforce. This includes work with the leisure industry workforce, using this resource to support gaps in domiciliary care (which is a particular challenge in the North Cumbria region).
- The trust is currently transferring to e-rostering, which is a challenge due to the current reliance on paper-based systems, with an ambition to have this in place by the next job planning round. This work has only started recently but has the commitment from across all teams to fully embed over the coming months.

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

- The trust is using its clinical support services to deliver high quality services for its patients. Its overall Pathology cost per test is £1.81 which places it in the second lowest (best) quartile nationally, just below the median of £1.91. The trust is part of the Cumbria and North-East Pathology Network programme and has been actively involved in the development of a Strategic Outline Case proposal to look at improving the delivery of services and reduce costs further.
- The trust has successfully consolidated the provision of its Pathology services down from two sites into one. Further scope for improvement exists but will be dependent on collaboration with other trusts.
- The trust is also networking with its partners regarding the provision of imaging services, particularly around its interventional radiology. The trust has already outsourced elements of its reporting services due to gaps in the consultant workforce, although it is acknowledged that there was further scope for efficiencies and service improvement through sub-regional collaboration including joint procurement.
- The trust is a significant outlier with regard to its medicines spend, with a cost per WAU of £506 in comparison to a national median of £320. That being the case, there is insufficient evidence about how the trust plans to drive down its overall drug costs, or

how it monitors the pricing of medicines i.e. the trust does not currently subscribe to “Define” in advance of a national solution being proposed.

- The trust delivered a significant level of drug savings of £800k for 2016/17 but this reduced to £336k in 2017/18 due to regional changes in the use of branded drugs and changes in its gain share arrangements with its commissioners.
- Looking at the performance of the top 10 medicines, the trust is performing well across a number of key biosimilar drugs with reasonable mechanisms of clinical engagement, although there are still one or two drugs where uptake could be further improved including, for example, Etanercept. The trust has agreed gain share arrangements with their commissioners to promote and incentivise the uptake of drug switches.
- The trust has a reasonably high percentage of pharmacists who are registered prescribers (32% of its current Pharmacy staff), and the trust felt that this was having a positive impact on improving patient flow and reducing patients’ average length of stay, although the trust could not provide any direct evidence to support this view.
- The trust is using technology in innovative ways to improve operational productivity including, for example, the use of its RealTime system to support emergency department (ED) flow and reduced hospital delayed discharges. The RealTime system integrates with existing systems such as the Trust’s Patient Administration System so that the trust can track, monitor and drive performance in real time, and in one place, all the information that clinicians need to manage patient journeys
- These initiatives, and the use of text messaging, has supported reductions in the level of DNAs from 9% in April 2017 down to 6.9% in April 2018. In addition, the use of e-prescribing is helping to deliver drugs to patients more quickly and efficiently.

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

- For 2016/17, the trust had an overall non-pay cost per WAU of £1,514 compared with a national median of £1,301 which places it in the highest (worst) quartile nationally. This suggests the trust may be able to reduce its spending on supplies and services.
- Over the past 12-18 months, the trust has made a number of significant improvements in consolidating a number of its corporate service functions, particularly at Board level, via the collaborative working arrangements with Cumbria Partnership NHS Foundation Trust. This includes the establishment of a single executive team which has seen Board costs fall from £194k per month in April 2017 to £137k per month in April 2018. The trust intends to develop these arrangements further over a 5-year period by targeting a total reduction of £4m and are currently two years into this plan.
- The trust has outsourced both its Accounts Payable and Receivable functions along with its Payroll function, but all are currently operating at a comparatively higher cost when compared to national benchmark data. For 2016/17, the trust’s finance function cost per £100m turnover was £764,660 compared to a national median of £670,510 placing it in the second highest (worst) quartile nationally. For the same period, the trust’s HR function cost per £100m turnover was £1.22m compared with a national median of £874,010 placing it in the highest (worst) quartile. The trust is aware of this unwarranted variation and plans to review this as part of the above collaborative working arrangement.

- The trust is also an outlier with regard to its IM&T costs with a cost of £3.17m per £100m turnover as opposed to a national median of £2.27m. Again, the trust informed us they are aware of this and is looking to address this in a consolidated way alongside Cumbria Partnership NHS Foundation Trust.
- The trust's Procurement Process Efficiency and Price Performance Score is 55.6, which placed it in the middle quartile when compared with a lower benchmark of 50.0 and an upper peer benchmark of 79.0. The trust's procurement function has seen an improvement over 2017/18 with an improved ranking moving from a national position of 136th in April 2017 to a new position of 71st in April 2018. This has supported the delivery of £1.74m savings over 2017/18.
- The above has been supported by increased collaborative procurement working arrangements with two other regional trusts i.e. initially working with Northumbria Healthcare NHS Foundation Trust and more recently with University Hospitals of Morecambe Bay NHS Foundation Trust.
- The trust has strong clinical engagement in the procurement process and the procurement team has established a Clinical Delivery Group which considers how preferred products can be standardised and rationalised across the trust e.g. the procurement of orthopaedic implants.
- The trust's cost per WAU for Supplies and Services is £445 against a national average of £375 which means that the overall cost is comparatively more expensive than peers.
- The trust has comparatively high running estates and facilities management costs with their average running costs currently at £547 per m<sup>2</sup> as opposed to national median of £308 per m<sup>2</sup>. A significant part of this high cost is associated with the trust's current Private Finance Initiative (PFI) contract arrangement and the differences in running costs between the two main hospital sites (one being a new build). It should also be noted that the geographically dispersed nature of the population will constrain opportunities to rationalise services across the two sites.
- The trust is aware of these cost issues and has begun to implement a number of actions to address them, including a PFI restructuring process, CIC site plan and a planned reduction/consolidation in the number of peripheral trust properties, planned reduction in excess equipment repair/maintenance costs etc.
- At £15 per m<sup>2</sup> the trust's backlog maintenance costs is low in comparison to the national average of £156 per m<sup>2</sup>. This is due to the relatively new PFI building located on the Cumberland Infirmary and masks the trust's backlog maintenance cost requirement of £20m which relates mainly to its West Cumberland site.
- However, despite the comparatively high backlog maintenance costs for the West Cumberland Hospital site, plans are also being developed and implemented to reduce the backlog maintenance requirements on that site and reduce its current requirement for £20m capital investment down to £5m over 5 years.
- Energy costs are above the national median of £0.04kWh and present the trust with an opportunity to generate additional efficiencies by reducing costs down to this level. The trust was again aware of this issue which is due to the West Cumberland site running two outdated plants – a new plant is being developed which will see these decommissioned.
- The trust also has high soft facilities management costs for both laundry and portering services. The current cost for laundry is £0.81 per item against a median value of £0.33

per item and, although the trust informed us a data recording error has potentially overstated the savings opportunity, the trust recognised the scope for improvement.

- The trust's current space utilisation position is above the Carter recommendation of 35% and large areas remain unoccupied particularly on the West Cumberland site which is at 48%. The trust is again aware of this and making plans to consolidate as much usage as feasible on to the Cumberland Infirmary site.

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

- The trust is in deficit and has an inconsistent track record of managing spending within available resources and in line with plans.
- The trust delivered its pre-determined control total and reported a deficit of £40.3m which equates to 15% of its annual turnover of £271m for 2017/18, which included £11.7m STF.
- The trusts 'underlying' deficit for 2017/18 excluding STF amounted to £52m which represented 20% of its annual turnover (again excluding STF) of £259m.
- The trust has a long-term recovery plan in place which is embedded within the system wide ICS financial recovery strategy. The trajectory of savings within this strategy delivers financial balance to the system by 2021/22. However, this is initially dependent on a level of transitional funding which remains unconfirmed in terms of the amount and time frame.
- As at Q1, the trust is forecasting to deliver its planned deficit of £49.2m excluding the receipt of the full allocation of Provider Sustainability Finding (PSF) of £11.6m. The trust delivered 2017/18 cost savings of £12.86m (4.1% expenditure), slightly lower than the £13.47m cost savings delivered in 2016/17. Of this, £12.30m was delivered recurrently.
- At the time of our assessment the trust was forecasting to deliver the 2018/19 planned cost savings of £10.4m (3.4% of expenditure) of which none reflects income generation schemes. The trust is planning on delivering the full £10.4m on a recurrent basis.
- The trust has a robust project management system fully embedded throughout its services to deliver the efficiency programme and savings are fully cohesive with commissioning intentions. However, the trust has signalled significant risk in the 2018/19 operational plan which will need to be offset via the delivery of savings in excess of the current target.
- The trust's cash balance at the end of 2017/18 was £3.6m and it is forecasting a closing cash balance of £1.4m at the end of 2018/19. The trust requires significant loans from the Department of Health for the full 2018/19 financial year, amounting to £35.50m and incurring £2.89m in annual interest. The trust is not able to consistently meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service and liquidity metrics. In 2017/18 the trust had a poor capital service cover ratio of 4 which shows that the trust needs to sustain (and improve) the bottom-line position to meet the debt obligations.
- The trust recognises it has significant financial pressure partly as a result of the PFI contract and is actively working towards a more viable solution in both terms of value for money and financial efficiency.

- Whilst the trust has a good understanding of the main drivers pertaining to the financial deficit, for example the current inefficient PFI model plus the need to operate a 2 site model due to geographical constraints, it does not actively use costing information produced by the Patient Level Information and Costing System (PLICS) for the day to day operation of the trust and for making business decisions.
- The trust has agreed a block contract with its main commissioner for the 2017/18 and 2018/19 financial years in addition to a memorandum of understanding incorporating a system risk share arrangement across the local health economy. The system has a strong track record of utilising this arrangement to enable all organisations within the locality to meet statutory financial obligations.
- The trust does not rely heavily on management consultants or other external support services.

## Outstanding practice

Whilst, at this point in time, there remain a number of areas of concern including key operational standards and a reported deficit, it is important to note the significant progress the trust has made on its improvement journey since exiting from Special Measures and Success Regime arrangements, including creating an Integrated Health and Care Partnership across WNE Cumbria.

- As a result of this joint working approach and coordinating services across the local health and care economy the trust has reported a very positive position in reducing delays transfer of care (DTC) which is being sustained.
- The trust is also undertaking a significant programme of innovative work to support and engage local communities in their workforce, including work with the leisure industry workforce to support gaps in Domiciliary care.
- The trust has significantly reduced the use of agency nurses by increased use of a joint bank with a neighbouring trust. Work in relation to the development of a composite workforce has started to demonstrate improvements.
- The trust is using technology in innovative ways to improve operational productivity including, in particular, the use of its Realtime system to support ED flow.
- Finally, the trust has seen a considerable change in musculoskeletal referrals due to early MSK screening by AHPs.

## Areas for improvement

As mentioned above, the trust has historically been challenged in meeting key operational standards and is forecasting a significant deficit for 2018/19.

Particular areas of improvement highlighted within the assessment include:

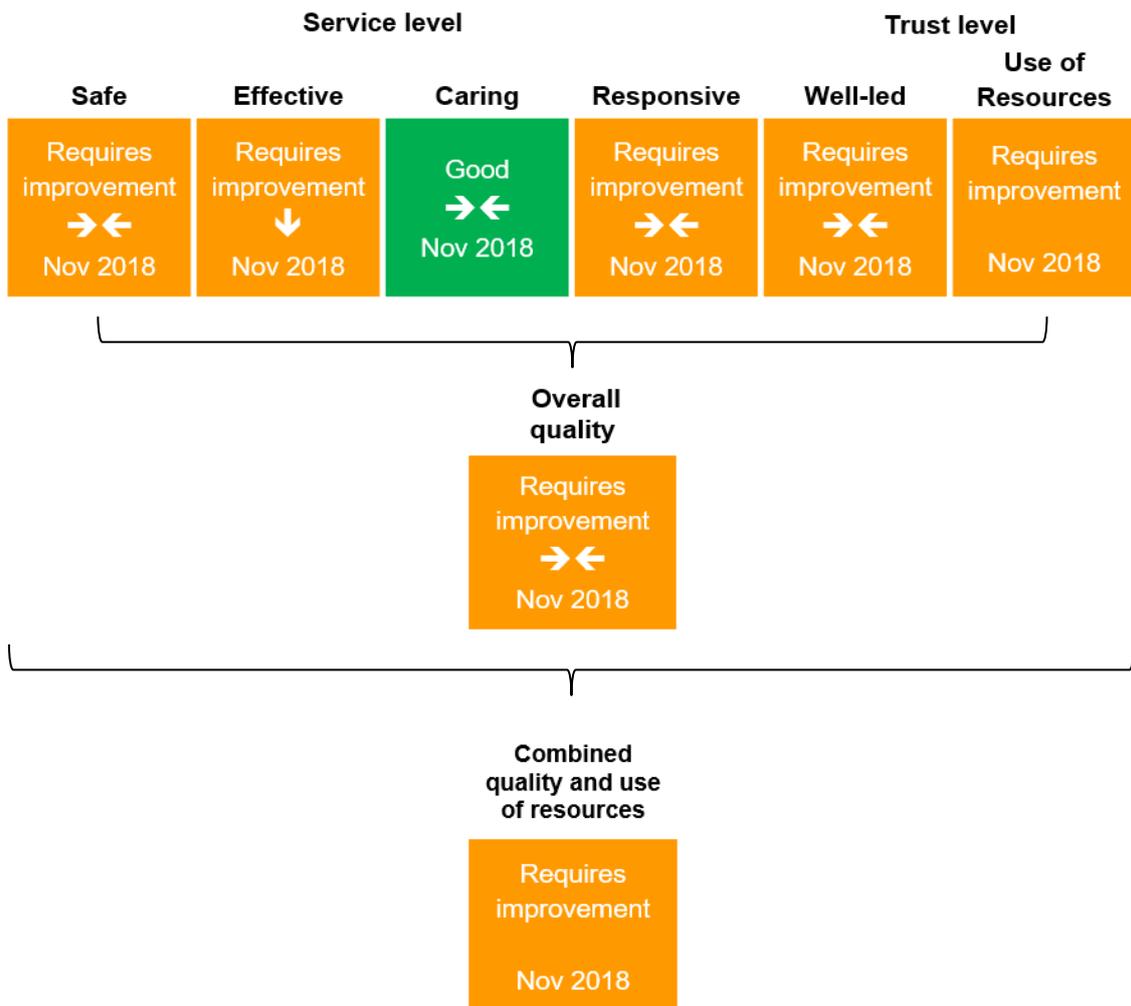
- The trust is an outlier with regards to its medicines spend and overall pay cost per WAU, with insufficient evidence to support what the trust is doing to help drive its overall costs down.
- Whilst the trust covers a large geography with disparate population which creates some constraints, estates and facility management costs are comparatively high.
- The trust reported a significant deficit of £40.3m for 2017/18 which is 15% of its turnover.
- The trust does not actively use costing information produced by PLICS for the day to day operation of the trust and for making business decisions.

# 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 helps NHS Improvement identify NHS providers’ potential support needs across five themes of quality of care, financial and use of resources, operational performance, strategic change, leadership and improvement capability.
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.