

# Salisbury NHS Foundation Trust

## Use of Resources assessment report

Salisbury District Hospital  
Odstock Road  
Salisbury  
Wiltshire  
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Date of publication: 1<sup>st</sup> March 2019

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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>Good</b> ●                 |
| <b>Are services safe?</b>                    | <b>Requires improvement</b> ● |
| <b>Are services effective?</b>               | <b>Good</b> ●                 |
| <b>Are services caring?</b>                  | <b>Good</b> ●                 |
| <b>Are services responsive?</b>              | <b>Good</b> ●                 |
| <b>Are services well-led?</b>                | <b>Good</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/RNZ/reports](http://www.cqc.org.uk/provider/RNZ/reports))

|   |               |
|---|---------------|
| <b>Are resources used productively?</b>                 | <b>Good</b> ● |
| <b>Combined rating for quality and use of resources</b> | <b>Good</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 good, because:

### Overall trust

Our rating of the trust improved. We rated it as good because:

- We rated effective, caring, responsive and well-led overall as good, and safe as requires improvement. We found that safety for patients had improved in urgent and emergency care, surgery and critical care. However; spinal services remained requires improvement. In rating the trust, we took into account the current ratings of the five core services not inspected this time. This meant due to our aggregation of ratings principles, the overall rating for safe remained requires improvement.
- At this inspection, the overall rating for spinal services remained rated as requires improvement. Urgent and emergency services and surgery had improved their rating from requires improvement to good. Critical care improved their rating from requires improvement to outstanding.
- We rated caring, responsive and well led in critical care as outstanding. We found significant actions had been undertaken to treat people in a safe manner. We found staff cared for patients with compassion. There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

On this inspection we did not inspect medical care, maternity, outpatients, end of life care, or services for children and young people. The ratings we gave to these services on the previous inspections in November 2015 are part of the overall rating awarded to the trust this time.

- We rated well-led at the trust as good. There was effective, experienced and skilled leadership, a strong vision for the organisation and embedded values. The leadership had the capacity and capability to deliver high-quality sustainable care. Leaders understood the

challenges to quality and sustainability and they were visible and approachable. There was a clear vision for the trust and strong values. Whilst we found that Non-Executive directors were well engaged we felt they would benefit from development and support to improve the constructive challenge they provide to the executive team.

- The strategic plans fitted with local integration plans for and the strategy was aligned to the wider health and social care economy. Overwhelmingly staff felt valued and supported, positive and proud to work for the organisation. There were cooperative and supportive relationships throughout the trust. There were however some pockets where staff did not feel as well engaged and supported and the trust leadership was keen to understand this and to make improvements. There was good governance and structures to assess the care provided and give assurance around quality. There were processes for managing risk, issues and performance. Information and data was of good quality. However; we found that some IT systems were not effective in enabling the monitoring and improvement of the quality of care, although plans to resolve this were being identified. The views of people using the service were considered, as were those of staff and stakeholders. The trust was committed to quality improvement and innovations. However; it is important that improvement principles and practices are given pace and prioritisation in order to be embedded within the organisation. The arrangements for the Freedom to Speak-up Guardian did not reflect the recommendations of the National Guardian's office. Work is needed on producing an integrated performance report that identifies where there may be variations and/or a need for change or improvement.
- Urgent and emergency services (alternatively known as accident and emergency services or A&E) were rated as good and had gone up one rating since the last inspection. We have rated safe, effective, caring and well-led key questions as good. Responsiveness remains requiring improvement. We had previously rated safe, responsive and well led as requires improvement. The service had made many improvements in response to the concerns we raised at our last inspection. For example, assurance systems had been implemented to ensure the identification and management of risks was undertaken and appropriate actions taken. We found staff had the right skills and knowledge to provide safe care and treatment for patients. Clinical education was used to support staff and patients. However, we found staffing challenges meant dedicated areas of the department designed for children and young people could not be opened. A lack of a standard operating procedure for the short stay assessment (SSAU) unit meant there was ambiguity over who should be referred to the unit. There were occasions when mixed sex accommodation breaches occurred within the short stay assessment unit, but these were not always recognised by staff and therefore not always reported.
- Surgical services were rated as good and had gone up one rating since the last inspection. We have rated all five key questions as good. We had previously rated safe and responsive as requires improvement at the last inspection. The service had made a number of improvements in response to the concerns we raised at our last inspection, we found that the service had improved compliance with The World Health Organisation (WHO) surgical safety checklist. Recent audits demonstrated that compliance for the general theatres was running at 100%. Staffing levels had improved following several initiatives which had been introduced to help aid recruitment of registered nurses across all wards. Staff were

competent in meeting the assessed needs of patients. Staff took the time to interact with patients, and those close to them, in a respectful, compassionate and considerate way. Patients and their relatives/carers, where required, were actively involved in their treatment and care. We found patients could access care and treatment in a timely way.

- Critical care services were rated as outstanding and had gone up two ratings since the last inspection. We have rated the safe and effective key questions as good and responsive, caring and well-led as outstanding. The service had made many improvements in response to the concerns we raised at our last inspection, these included; there were now comprehensive systems to keep patients safe which took account of best practice. Rates of compliance with mandatory training now exceeded the trust target. The team had improved practices around infection prevention and control. There were now more effective systems for cleaning equipment and staff now used personal protective equipment consistently. Staff consistently checked safety equipment and recorded this had been completed. The service had improved patient records and nursing staffing numbers now met recommended staffing ratios. Mortality and morbidity reviews had embedded and were well attended. Governance arrangements had been recently reviewed. These now reflected best practice and mirrored the trust wide reporting protocols. The risk register was updated and now included all evident risks. There was compassionate, inclusive and effective leadership at all levels. Staff at all levels were empowered and encouraged to be leaders.
- Spinal services were previously rated as requires improvement. There has been no change in the overall rating, however; there have been some significant improvements. Safe and effective care remain requires improvement, caring remains good, responsive is now rated as good, this is an improvement from the previous rating of inadequate. Well led is rated as good which is an improvement from our previous rating of requires improvement. The service had made improvements in response to the concerns we raised at our last inspection, these included; systems, processes and practices were used to keep patients safe and these were understood by staff. Mandatory training targets were met by nursing and therapy staff and the service to control any risks of infection. Staff completed a holistic assessment of patients. Risk assessments were carried out and nursing and therapy care plans were completed to meet each identified area of need. There was a strong incident reporting culture in the spinal treatment centre. Staff had the right skills and knowledge to provide safe care and treatment for patients. However; concerns were identified at this inspection, included; staffing levels for medical, nursing, therapy and psychology staff. The spinal treatment centre had contributed to any databases for data collection and analysis purposes but not for measuring service quality.
- The trust was rated as good for use of resources. Full details of the assessment can be found on the following pages.

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Date of site visit:  
23 November 2018

Date of publication: 1 March 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?**

**Good** ●

## How we carried out this assessment

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

We visited the trust on 23 November 2018 and met the trust's executive team, the trust Chair and Chair of the Finance and Performance Committee 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?

Good ●

**We rated the trust good for use of resources as the trust demonstrates a good level of productivity evidenced by having the eighth lowest total cost per Weighted Activity Unit (WAU) in England. The trust however needs to demonstrate progress in addressing its deficit. Good progress on the trust's strategy for clinical services and integrated care, working closely with health and social care partners including those within its Sustainability and Transformation Partnership (STP) and its neighbouring tertiary centre, will be critical to further financial improvement.**

- The trust spends less on pay and other goods and services per weighted unit of activity than most other trusts nationally, having the eighth lowest total cost per WAU in England (£3,159) for 2017/18. This indicates that the trust is more productive at delivering services than most other trusts, spending on average less to deliver the same volume of clinical activity.
- The trust is meeting all national standards except 4-hour Accident & Emergency (A&E) where the trust is performing below the national target but consistently above the national median performance.
- The trust performs strongly on several clinical services metrics, in particular regarding emergency re-admissions rate. The trust is reviewing its theatre and outpatients operations as part of a productivity improvement programme and is well engaged with the Getting It Right First Time (GIRFT) programme.
- The trust has invested into the culture development of the trust, seeking to work collaboratively with its local partners and strengthening financial management.
- The trust benchmarks very well on workforce productivity metrics with the total pay cost per WAU in the lowest quartile nationally for 2017/18. The trust is introducing innovative practices and workforce models to address the issues it is facing with recruitment and retention of staff.
- The trust benchmarks well on some key areas of clinical support services although more rapid progress is required to deliver 7-day services and renewal of IT systems.
- The trust has a low non-pay cost per WAU in 2017/18, benchmarking well on procurement nationally.
- The trust is trading with a deficit position and has required revenue financing support from the Department of Health & Social Care (DHSC) to meet its financial obligations. However, the trust is demonstrating progress with a reduction of its deficit and the requirement for cash support and delivery of significant savings.
- The trust experienced a major incident at the end of 2017/18 which heavily impacted the trust during 2018/19 and took significant executive time out of the operational management of the trust. Our assessment showed that, despite this incident, the trust continued to perform strongly against several productivity metrics and operational performance and deliver its strategy.
- We also found areas where the trust needed to demonstrate progress to reduce its length of stay, decrease its spend on agency staff, improve on staff retention, develop its digital maturity and deliver its financial recovery plan to achieve financial sustainability.

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

The trust has a good performance against the national median for the 4-hour A&E (A&E) standard and has consistently met the 18-week Referral to Treatment (RTT) access standard. It has improved its cancer 62-day wait performance, meeting the national standard since August 2018 and has consistently delivered the diagnostics 6-week wait standard with a slight deterioration in March 2018. The trust also benchmarks well with regards to emergency re-admissions, being in the lowest (best) quartile.

- At the time of the assessment (November 2018), the trust was maintaining a 4-hour A&E performance above the national median with a rolling 12 months average of 90% compared to a national standard of 95% and an average performance for the four weeks to the assessment date of 85.6%. Performance has improved above national and peer performance since March 2017 although there have been troughs in performance.
- The trust has improved its cancer 62-day wait performance since June 2018, meeting the 85% standard since August 2018 (87.77% in September 2018). There is some variation between specialties, with urology performance suffering from shortages in the consultant workforce and pathway challenges with tertiary providers.
- The trust has met the constitutional performance standard for access (RTT) since July 2017 and currently has no patients waiting more than 52-weeks for elective care. The trust is actively engaged in the GIRFT programme, with progress reported to the trust's management committee and the trust's Medical Director being the Champion for the programme. The GIRFT teams have carried out several visits in different specialities and the trust is demonstrating areas of improvement. For examples: the trust has ceased uncemented hips for over 70 year olds; it has ring fenced beds to protect elective activity; it is piloting OPA (a medical device used to maintain or open a patient's airway) induction in gynaecology to reduce length of stay for labour and a new pathway has been established for sub-acromial decompression to address very high rates identified by GIRFT.
- The trust's Medical Director is leading the theatres and outpatients productivity programme which aims to reduce cancellations and improve prompt starts. The programme is reviewing theatre booking schedules and has had success in delivering improvements in the main theatres in the areas of Orthopaedics. Productivity targets were set at 90% and are being delivered at 94%, although the Trust recognises there is more improvement to be made within day surgery services. Through the year, there has been improvement in underrun/overrun times, and touchtime utilisation.
- After an improvement in October 2018, the number of Delayed Transfers of Care (DTC) was above the target (38 compared to 14) at the time of the assessment. The number of Super Stranded patients was below (better) than the target but the number of stranded patients, at 114 was above the target of 90. Delays are mainly driven by a recognised system shortfall in step-down beds and packages of care in Wiltshire Health & Care community hospitals (South Wiltshire), Care at Home and capacity in community teams. A new review of stranded patients is in place and aims to achieve a more robust approach to discharge planning.
- Average Length of Stay (LoS) ranged between 14.37 to 16.65 days, which includes the spinal unit LoS within Medicine (7.6 days), against a target of 6.68 days. The trust has experienced high pressure on acute beds and Green to Go patients have increased since the beginning of October 2018, from 60 to 85 patients in November 2018.

- The trust's pre-procedure non-elective bed days at 0.76, are slightly above (worse than) the national median (0.69 days) but show an improvement since quarter 2 2016/17. The trust reconfigured its medical wards in 2017/18 to increase its Acute Medical Unit capacity, enabling greater focus on timely review and treatment of patients admitted through the Emergency Department. It also revised its theatre timetable in June 2018, ensuring that there is now clear segregation between capacity for an Orthopaedic trauma list and elective lists. This ensures well planned, resourced and managed reduction of cancellations and achieves a more predictable workflow. The trust is also a specialist plastics centre susceptible to peaks in demand and acting as a back stop for another nearby trust with limited cover hours.
- Pre-procedure elective bed days at 0.05 are below (better than) the national median (0.11 days), and in the best quartile nationally. The trust has consistently performed well over the last two years.
- The trust has a Did Not Attend (DNA) rate of 5.4%, below the national median of 7.1% and within the upper quartile nationally. Although the trust is performing well, it is looking to further improve its productivity in this area in 2018/19 through the use of technology, including extended use of text reminders.
- Where there are fragile services the trust is working in partnership with the wider system (eg frailty and mental health) and is supportive of working with other areas to enable patients to stay in the same place.

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

The trust benchmarks well on pay costs, with all metrics in the best or second best quartile nationally. The trust is developing innovative workforce models and roles to address the challenges it has with staff retention and recruitment. Although it has robust measures in place, the trust continues to spend more than its ceiling on agency costs. The trust has invested into culture development which is likely to have played a role in helping staff to manage under pressure and remain resilient during the major incidents in 2018/19.

- For 2017/18 the trust had an overall pay cost per WAU of £1,949, compared with a national median of £2,180, placing it in the lowest cost quartile nationally. This means that it spends less on staff per unit of activity than most trusts.
- The nursing pay cost per WAU at £571 are lower than the national median of £711 and are in the lowest quartile nationally. The trust explained that this is mainly driven by measures taken to bridge areas where recruitment is a challenge. It has introduced new roles which provide career development pathways. For examples, staff are currently training to become Nurse Associates. It has also over-recruited on Nursing Assistants to alleviate nursing vacancy rates in the interim, maintain quality of care and minimise agency use.
- The trust carries out a skill mix review twice a year and has developed a Bridging programme to allow staff to step up to Assistant Practitioners roles. An example is in the Spinal Unit where it is moving to a more multi-professional rather than nurse focused workforce providing patients with better care.
- The medical cost per WAU at £506 is lower than the national median of £535 and is in the second lowest quartile nationally. The trust has appointed a new Head of Medical HR (Human Resources) whose remit covers productivity improvement through medical job planning. The trust has also introduced a new consistency panel to ensure job plans are consistent and follow the defined approach which includes rules relating to Supporting



Professional Activities (SPA) and private patient work. At the time of our assessment, 80% of consultants had a job plan in place compared to a national median of 89% and the trust acknowledged that assessing productivity through job planning was challenging as many consultants worked additional hours without remuneration. This indicates that further improvement and consistency in a trust-wide approach to job planning is needed.

- The Allied Health Professionals (AHPs) cost per WAU at £105 compared to a national median of £130 is in the lowest quartile nationally. The trust is looking to utilise this staff group where recruitment is challenging and is currently looking to expand the contribution of therapist roles within discharge planning.
- The trust has strong controls over agency and bank spend where it uses Allocate eRoster with rotas signed off six weeks in advance for nursing teams with plans to roll this out to other staff groups. The trust decides on the appropriateness of agency staffing through twice daily staff meetings and the use of the Allocate Safe Care tool to identify gaps. The trust has recently contracted with a medical locum provider to increase the use of Direct Engagement (where the trust contracts directly with the temporary staff) in addition to joining a collaborative locum bank. The trust is also looking to grow the nurse bank to reduce reliance on agency nursing with the aim to reach a 95% rota fill rate.
- However, despite the actions taken, as at October 2018, the trust was over its agency cost ceiling given by NHS Improvement and agency costs represented 6.16% of its total staff costs compared to a national median of 5.06%. The trust was forecasting to spend £8.2 million on agency staff in 2018/19 compared to a ceiling of £5.7 million.
- The Staff Retention rate was 84.2% in July 2018. This is in the second highest (worse) quartile nationally with a national median of 85.8% demonstrating there is room for improvement although there has been a slight improvement over the last 12 months. The trust has identified staff retention as a focus area and increased the HR support to directorates on this issue, and is looking at novel ideas to bring nursing workforce in the area. The trust uses exit interviews/questionnaires to understand the reasons staff are leaving and have taken staff to the trust Board to relate their experience. The trust has taken several measures to address the issue such as 'Stay conversation' where staff can discuss with specific staff their concerns/issues. The trust plans to offer better career progression and training and development including working closely with their local college, developing a Health Campus and rolling out a clinical leadership programme linked to talent management.
- There are factors out of the trust's control which make retention and recruitment more challenging such as the low unemployment in the area and the perception of the town's attractiveness for younger staff. Recruitment difficulties are also being addressed through targeted recruitment campaigns, the investment of social media, the overseas recruitment pipeline, and return to practice.
- The trust has invested in culture development across the trust to bring a new focus on financial management, continuous improvement but also to work more jointly with its systems partners. This has given resilience to the organisation and staff which allowed them to work through the major incident they faced during 2018/19.
- The trust is working with system partners to co-ordinate its response to common workforce issues and has plans to develop a Workforce Action Board across the Sustainability & Transformation Partnership (STP) to cover health and wellbeing. It is looking to use digital solutions to allow staff who want to move more fluidly across NHS organisations within the Bath, Swindon & Wiltshire STP.

- Sickness absence rate at 2.71% compared to a national median of 3.76% is the lowest (best) quartile nationally. There are clear processes and guidance in place for managing sickness and absence and enabling better staff support.

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

The trust benchmarks well on clinical support services nationally which means the trust is spending less on these services than other trusts. Further progress is required with the implementation of the EPMA (Electronic Prescribing and Medicines Administration) system, 7-day services in pharmacy and new LIMS (Laboratory Information Management System) and Ordercomms systems in pathology.

- The overall cost per test for pathology for 2017/18 is £2.36 against a national median of £1.86 (second highest (worst) quartile) with increased costs expected from a large genetics laboratory that is the regional centre for the Wessex area. The trust is engaged with Pathology Network 6 to implement the recommendations from the Lord Carter Review into operational productivity in the NHS through delivery of a hub and spoke model. The trust urgently needs to invest in new LIMS and Ordercomms systems and recognises the need to prioritise these as part of the STP Wave 5 capital bids to obtain Department of Health & Social Care funding.
- The trust's overall cost per report for radiology benchmarks well against other trusts at £46.73 compared to a national median of £50.00 (second lowest (best) quartile) and has one of the lowest levels of Did Not Attend rates for all appointments across England. For 2017/18, the trust has a low percentage of Radiographers reviewing plain x-rays compared to other trusts nationally and following a workforce review linked to vacancies has now increased reporting capacity at the national level.
- The trust's medicines cost per WAU at £274 is low compared to the national median of £320 for 2017/18 (second lowest (best) quartile). The trust is achieving above target for the Top Ten Medicines delivering 124% of savings for 2017/18. However, improvements in clinical pharmacy services are required in specific areas to deliver against the Carter priorities and the trust is planning to pilot a 7 day on ward clinical pharmacy service in January 2019. Despite a priority of the trust's digital strategy, EPMA has not yet been implemented with the trust currently developing a bid to receive national funding. The trust has done a considerable amount of work to reduce its medicines stockholding from 31 days in 2016/17 to current levels of 21 days.
- The trust is using technology to improve access to the hospitals services and has introduced virtual access for fracture clinic and ophthalmology patients. Further work is being planned and the trust is presenting a revised digital strategy to the Board in February 2019.

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

The trust has a low non-pay cost per WAU and performs well on the procurement league table. The trust benchmarks well for estates and facilities cost per m2 but has a high level of backlog maintenance.

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,210 compared to the national median of £1,307 (second lowest quartile).

- The trust's supplies and services costs per WAU are £350 (second lowest quartile) against the national median of £364. For 2017/18, the trust ranked 33 out of 136 trusts in the procurement league table published by NHS Improvement to assess the relative performance of non-specialist NHS acute providers' procurement departments. The procurement department is a consolidated resource with Great Western Hospitals NHS Foundation Trust and has invested in systems and E-sourcing software and was a pilot site for the Scan4Safety programme.
- The Procurement function cost per £100 million turnover is high at £453.5 thousands compared to the national median of £209.9 thousands. However, the function at the trust influences a wide range of the non-pay expenditure compared to other trusts and includes procurement across the commercial / income generation function, Estates and Facilities and the Scan4Safety team.
- For 2017/18, the cost of running the trust's Finance department is higher than the national median and in the second highest (worst) quartile at £766 thousands per £100 million turnover with the cost of management accounts in the lowest (best) quartile. The trust has invested in financial turnaround capability in 2017/18 and finds it difficult to gain any benefits from economies of scale due to its small size and is therefore engaged with the NHS Improvement back office workstream to help deliver efficiencies. The trust is also reviewing its divisional financial support capability to see whether any further investment is required in this area.
- The trust has a low Human Resources (HR) function cost £962 thousands per £100 million turnover in the second lowest (best) quartile and below the national median of £1,104 thousands per £100 million turnover. The trust has invested in HR in the last 12 months given its challenges in workforce particularly with recruitment and retention.
- The costs of running the trust's payroll are high at £116.6 thousands per £100 million turnover and placing the trust in the second highest (worst) quartile compared to the national median of £99.3 thousands. However, the trust provides payroll services for several other trusts and has a low cost per payslip of £3.60 compared to national median of £3.72.
- The trust's 2017/18 estates and facilities cost per m2 is £255 compared to national median of £334 placing the trust in lowest (best) quartile. Both Hard Facilities Management (FM) (£45 per m2) and Soft FM (£78 per m2) costs are below the national median.
- For 2017/18, the trust has one of the highest backlog maintenance cost per m2 in England at £467 per m2 compared to the national median of £186 per m2. The costs have risen following an independent survey completed within 2017/18 that increased the values from 2016/17 by £434 per m2 from £33 per m2, reflective of the relative age and condition of extensive areas of the hospital estate. The trust has centralised its clinical services into newer accommodation with administrative services re-located in older part of the estates and has robust procedures in place to manage the critical risk arising from high backlog maintenance.
- The trust operates a wholly owned subsidiary laundry facility that provides services to other NHS trusts. Although, the cost per item is slightly above the national median at £0.36 compared to the national median of £0.34, the subsidiary contributes to the trust's finances.

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

The trust has the 8<sup>th</sup> lowest total cost per WAU nationally in 2017/18, an improvement from 2016/17. Although the trust has a deficit financial position in 2018/19 this represents an improvement on prior year and is supported by a challenging cost improvement programme (CIP). The trust relies on cash support from the Department of Health & Social Care (DHSC) to meet its financial obligations although the support required is expected to decrease this year. The trust manages a small portfolio of commercial enterprises which contribute positively to its financial position. However, the trust needs to further progress its financial recovery plan to ensure it is financially sustainable in the medium to longer term. Good progress on its strategy for clinical services and integrated care, working closely with health and social care partners including those within its STP and its neighbouring tertiary centre, is critical to this.

- In 2017/18, the trust reported a deficit of £11.4 million against a plan of £7 million deficit. The trust didn't accept its control total in 2017/18 so was not eligible to receive Sustainability and Transformation Funding. The adverse position was due to capacity and workforce challenges resulting from pressure on services and recruitment difficulties.
- For 2018/19, the trust has agreed a control total with NHS Improvement for a £9.0 million deficit (excluding Provider Sustainability Funding (PSF); £5.2 million deficit including PSF) and was £0.6 million behind plan as at the end of October 2018. The planned position represents a significant improvement on prior year financial performance.
- However, at the time of the assessment, the trust had identified several risks to its financial year end position around productivity, workforce, demand challenges and a shortfall in planned savings and was implementing several actions to reduce the gap to its plan.
- The trust has an ambitious cost improvement plan (CIP) of £12.2 million (or 4.9% of its expenditure) for 2018/19 and as at October 2018, the trust anticipated to deliver £10.7 million CIPs (4.2% of expenditure; 75% recurrent) for the year. This represents an improvement on prior year position. In 2017/18, the trust delivered £5.6 million (2.4% of its planned savings), of which 56% were recurrent.
- The trust has commissioned a consulting firm to assist with developing its CIP for the next 2.5 years (2017/18 to 2019/20) resulting in a significant increase in the level of planned savings in 2018/19 and has engaged a Transformation Director to strengthen the delivery of efficiencies and align this with wider service and performance improvement work so that improved quality and operational processes support improved efficiency. At as the end of October 2018, the trust was £0.5 million ahead of its efficiency plan.
- Despite having the 8<sup>th</sup> lowest total cost per WAU nationally for 2017/18 and a low reference cost index (RCI), the trust has been trading with an underlying deficit for several years, estimated at £12 million at the end of 2017/18. At the time of our assessment, the trust had drafted its Financial Recovery Plan highlighting the six strategies it envisaged to deliver to return to financial sustainability in the medium term. However further work was required to detail and deliver the plan. Effective partnership working on integrated models of care to shift care out of hospital and closer to patients' homes wherever appropriate, and to develop a clinical strategy for services across the Sustainability and Transformation Partnership (STP), are critical to progressing financial recovery work, recognising the trust is already among the most efficient providers nationally.
- The trust has relatively low cash reserves resulting from its current underlying deficit and is not able to meet its financial obligations without revenue support from the DHSC. However, the yearly requirement for revenue financing from the DHSC is looking to

decrease for the current year, from £11.4 million required in 2017/18 to £5.2 million in 2018/19.

- Service Line reporting is under-developed, and further work is critical in this area so there is robust data supporting clinical strategy development. However, this relies on investment in a new underlying finance IT system to enable this which should be an organisational priority.
- The trust is entrepreneurial, managing a small portfolio of commercial entities (subsidiaries or joint ventures) using a commercial framework to ensure they contribute to the trust's strategy and financial position. The trust had plans to set up a new subsidiary expected to contribute £1 million savings to the trust in 2018/19 which were delayed due to a national review of the benefits and regulatory framework of NHS providers' wholly owned subsidiaries. A recent internal audit report however showed the trust could improve on the recovery of overseas patients' income.
- The trust doesn't significantly rely on management consultants or other external support services and only uses their services to provide specific expertise or capacity where the trust doesn't have them internally. In late 2017/18, the trust commissioned a firm to bring additional capacity and expertise to support the development its short to medium term CIP as part of its financial recovery plan. In 2018/19, the trust is forecasting to reduce its spend on consultancy from £1.6 million in 2017/18 to £0.5 million.

## 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 pilot for the Scan4Safety national programme and has released more clinical time to patient care by reducing admin processes, improving stock visibility and reducing wastage.
- The trust has a low sickness absence rate compared to a national median. There are clear processes and guidance in place for managing sickness and absence and enabling better staff support.

## Areas for improvement

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

- Progressing with the reduction of length of stay.
- Reducing the spend on agency staff as far as practicable to the level of the NHS Improvement ceiling.
- Continuing to focus on improving staff retention through current or new initiatives.
- Developing the digital maturity of the trust. This includes investing urgently in new LIMS, Ordercomms systems and implementing EPMA.

- Developing further and delivering its financial recovery plan to be financially sustainable, supported by strategy work with partners.

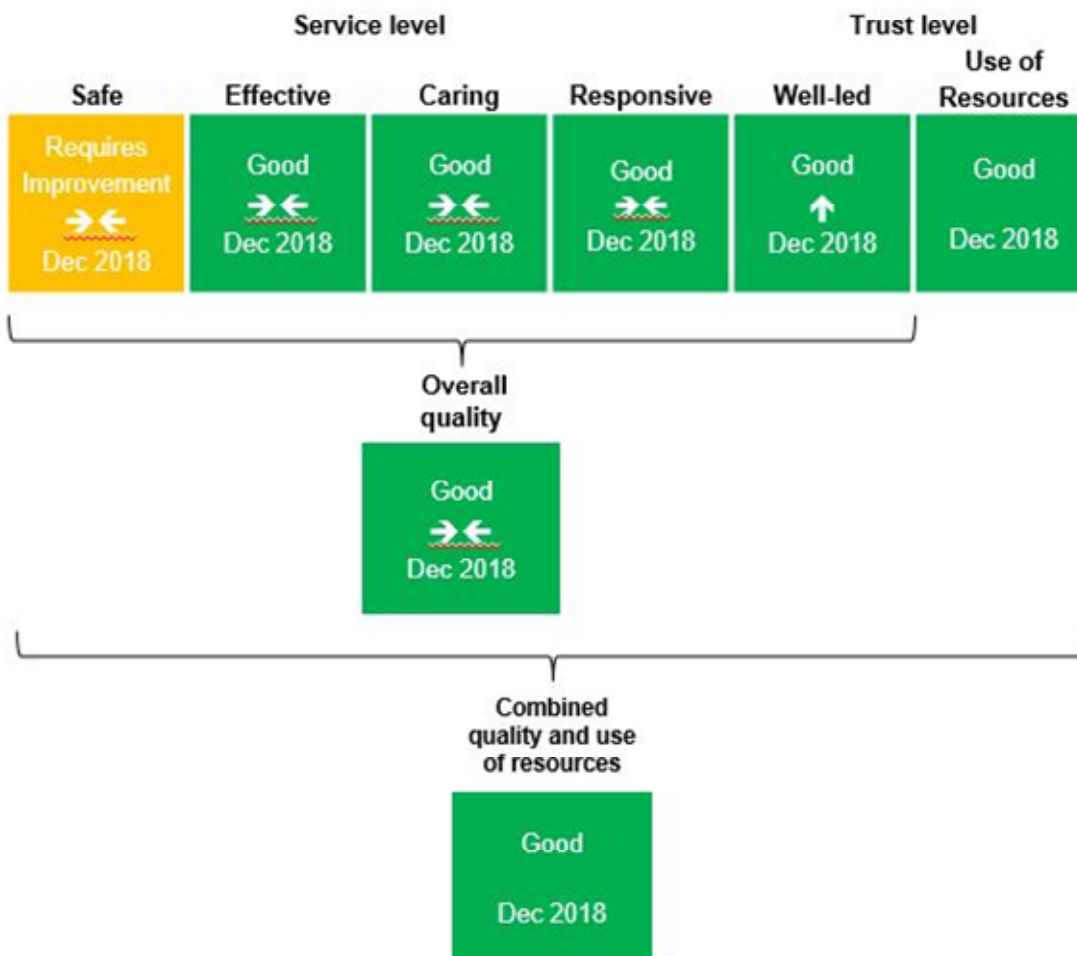
## Ratings tables

| 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.   |



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| 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.   |

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| 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.  |

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| 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 <a href="#">Single Oversight Framework</a> (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.  |