

The Mid Yorkshire Hospitals NHS Trust

Use of Resources assessment report

Pinderfields Hospital
Aberford Road
Wakefield
WF1 4DG

Date of publication:
7 December 2018

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www.midyorks.nhs.uk

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

Ratings

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

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

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

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- The trust was rated requires improvement for Use of Resources.

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Pinderfields Hospital
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 WF1 4DG

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www.midyorks.nhs.uk

Date of site visit:
 10 July 2018

Date of publication:
 7 December 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 10 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 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. We rated the trust as Requires Improvement because it is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients.
- For 2016/17 the trust had an overall pay cost per weighted unit of activity (WAU) of £2,240 compared with a national median of £2,157. The trust spends more on pay and some support functions, eg payroll and Information & Management Technology per WAU than most other trusts. This shows the trust is less productive at delivering these services than other trusts as, on average, it spends more to deliver the same number of services.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2017/18, spending £30.4 million against a ceiling of £22.9 million, and is forecasting to miss its ceiling in 2018/19 with a planned spend of £25 million against a £19.9 million ceiling.
- For 2016/17 the trust had an overall non-pay cost per WAU of £1,309, compared with a national median of £1,301, placing it in the second highest (worst) quartile.
- The trust did not balance its budget in 2017/18, reporting a £20.3 million deficit including Sustainability and Transformation Funding (4.02% of turnover). Historically it has not delivered its financial plan, failing to achieve its control total in 2015/16, 2016/17 and 2017/18. The trust presented an underlying deficit of c£20 million which has been broadly consistent for a number of years. The main drivers identified by the trust include Private Finance Initiative funding costs driving a high cost/m2, agency premiums and high premiums for the Clinical Negligence Schemes for Trusts.
- Due to its underlying deficit position, the trust is reliant on external loans to meet its financial obligations and deliver its services.
- The trust did not deliver its planned Cost Improvement Plans (CIPs) in 2017/18 and is reliant on a high level (29%) of non-recurrent CIP to meet its target for 2018/19.
- The trust reported little progress had been made on consolidating its corporate services, meaning there remains room for improvement in this area.
- At the time of the assessment, the trust was not meeting the constitutional performance standards for Referral to Treatment (RTT) and Accident & Emergency (A&E).
- The trust reports a delayed transfers of care (DTC) rate for 2017/18 of 4.75% that is higher than the national average of 4.2% and higher than the trust's own target of 3.5%.

We also saw evidence of positive improvement:

- The trust performed above the national average for A&E during the winter of 2017/18, there was an improving picture for RTT with the trust moving from 81.2% to 85.1% between March 2017 and March 2018 and the trust had met the constitutional performance standards for cancer in 8 of the previous 12 months.
- For 2018/19 the trust has a planned deficit of £19.7 million excluding Provider Sustainability Funding (PSF), and a deficit of £5.4 million including PSF. This is in line with its control total as agreed by NHS Improvement. As at the end of the first three months in 2018/19, the trust is on track to deliver its plan.

- There is evidence that the trust works collaboratively with system partners across a number of areas including delivery of constitutional standards, medicines management and immunology testing. The trust has negotiated an Aligned Incentive Contract for 2018/19 which will allow decision making on an overall cost basis.
- The trust has Service Line Reporting in place and has been an early adopter of the NHSI Costing Transformation Programme using Patient Level Information Costing Systems (PLICs).
- The trust uses a consistent quality improvement methodology to identify and realise operational productivity benefits and provided many examples of projects where improved productivity has resulted in benefits to patients.
- The trust has demonstrated improvements to services relating to delivery of action plans informed by the Getting It Right First Time programme.
- The trust's high performance for radiographer-led reporting is recognised nationally as advanced practice and effective use of resources.
- As part of the Top Ten Medicines Programme the trust has over-delivered on nationally identified savings opportunities, achieving 138% of the savings target at March 2018 which is in the top (best) quartile nationally.
- The trust has implemented a number of new roles including Extended Scope Therapists who deliver independent clinics in orthopaedics, pain management, neurology and hand therapy.
- The trust has a comprehensive approach to job planning for doctors which was assessed by the National Carter Team in November 2016. The trust was rated as a grade 3, which is one below the highest (best) grade.

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 uses a consistent quality improvement methodology to identify and realise operational productivity benefits and provided many examples of projects where improved productivity has resulted in benefits to patients. For example, in end of life care a rapid process improvement workshop resulted in the development of a pathway including a discharge to assess model which has led to a reduction in length of stay for these patients by 2 weeks and 6 days and released on average 73 minutes of qualified nursing care time per patient. In community services the continence team redesigned their pathway and reduced the time waiting for an assessment from an average of 12 weeks to 98% of patients receiving a first contact within one day.
- During 2017/18, the trust finalised the reconfiguration of its services across the three hospital sites. This was a strategic change running from 2013/14 to 2017/18. The aim of the reconfiguration was to address safety, quality and the financial sustainability of the trust by making better use of its resources. An evaluation of the programme showed net savings of £5.6 million over the period of the reconfiguration, along with improvements in patient-focused quality of care metrics such as mortality rates and a reduction in length of stay. The programme also supported the removal of 100 extra capacity beds in use at the Pinderfields site during 2017/18 compared with the previous year.
- At the time of the assessment in July 2018, the trust was not meeting the constitutional operational performance standards around Referral to Treatment (RTT) and Accident & Emergency (A&E). However, the trust performed above the national average for A&E during the winter of 2017/18. There was an improving picture for RTT with the trust moving

from 81.2% to 85.1% between March 2017 and March 2018.

- The trust met the constitutional standards for cancer in 8 of the last 12 months.
- The trust works collaboratively with partners across the local health and care economy with work streams for planned and unplanned care. The planned care improvement group reduced the waiting list size by over 4,500 patients and increased non-face-to-face activity by 47% in 2017. E-consultation rates increased by 58% in 2017/18, reducing the reliance on outpatient clinic capacity and contributing to reduced waiting times. The trust is working with partners in the West Yorkshire Association of Acute Trusts (WYAAT) to develop sustainable future service delivery models.
- The trust has redesigned ambulatory care pathways to reduce the need for admission to hospital and to enable GPs to directly refer to ambulatory care, avoiding the need to attend A&E. The use of ambulatory care pathways increased by 57.9% between May 2017 and May 2018 reducing the number of patients who required a stay in hospital and GP referrals to A&E reduced by 24.6% during this time.
- The trust outpatient and theatre improvement programmes aim to improve productivity without incurring additional cost. During 2017/18, the theatre programme delivered £3.6 million of cost improvement programme (CIP) savings and the outpatient programme delivered £1.5 million of savings. As part of the outpatient programme the trust invested in a dedicated team of 2 whole time equivalent (WTE) staff responsible for filling outpatient slots at short notice, implemented the use of Did Not Attend (DNA) reports and introduced a two-way text reminder system. This resulted in over a 1% reduction in DNAs within the outpatient department, resulting in £489,000 delivery of CIP savings.
- Other programmes which have impacted on the trust's DNA rate include the use of text reminders in Children's Services. This resulted in an overall reduction in DNAs within the service of 10% when a further layer of a reminder call was added in.
- The DNA rate for the trust is in the lowest (best) quartile at 6.2% and below the national median of 7% for March 2017 to March 2018.
- The trust has received visits from the Getting It Right First Time (GIRFT) programme for seven specialities. Action plans have been developed using the recommendations from the GIRFT team which are reviewed on a six-monthly basis. Key achievements from the programme so far include an improvement in the RTT standard in orthopaedics from 67% in August 2015 to 92% in May 2018.
- Fewer elective patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals in England. However, non-elective patients spend more time in hospital prior to treatment.
 - On pre-procedure elective bed days, at 0.125, the trust is performing in the second lowest (best) quartile when compared nationally – the national median is 0.131.
 - On pre-procedure non-elective bed days, at 1.009, the trust is performing in the highest (worst) quartile when compared nationally – the national median is 0.812. The trust has introduced increased availability of acute and general surgery theatres at the weekend and implemented an escalation plan for the opening of a second theatre to address this.
- Patients are more likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 8% in March 2018, emergency readmission rates are above the national median of 7%, a reduction from 10% in March 2017. The trust is working collaboratively with partners to reduce the number of attendances at A&E from nursing and care homes by providing support from community staff within these homes.
- The trust reports a delayed transfers of care (DTC) rate for 2017/18 of 4.75% that is

higher than the national average of 4.2% and higher than the trust's own target of 3.5%. The trust has worked with system partners with the aim to reduce DTOCs, however, rates have remained static during 2017/18. The trust has recently developed a ward-based discharge co-ordinator role and expects to see a reduction in DTOC rates in the future, however, the trust was unable to provide a business case demonstrating a financial appraisal and the expected benefits.

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 unit of activity (WAU) of £2,240, compared to a national median of £2,157, placing it in the second highest (worst) quartile nationally. This means that it spends more on staff per WAU than most trusts.
- For the same period, the trust is in the second highest (worst) quartile nationally for medical (£550 against a national median of £526) and nursing (£782 against a national median of £718) cost per WAU. This means that it spends more on both medical and nursing staff per unit of activity than most trusts.
- The trust benchmarks in the highest (worst) cost quartile for Allied Health Professional (AHP) cost per WAU for 2016/17 (£164 against a national median of £127). This means that it spends more on AHP staff per unit of activity than most trusts. In 2016/17 the trust delivered the occupational therapy service for the acute and community service as well as the local authority and Wakefield District housing service and noted this contributes to an increase in the cost per WAU for AHPs.
- The trust pay bill increased by £9.1 million between 2016/17 and 2017/18 and is planned to increase by a further £2.4 million in 2018/19. This shows that the amount the trust is paying for staff is increasing year on year.
- In 2017/18, the trust overspent against its planned pay bill by £17.2 million and at the end of May 2018, the trust had overspent against its planned pay bill by £0.2 million.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2017/18, spending £30.4 million against a ceiling of £22.9 million, and is forecasting to miss its ceiling in 2018/19 with a planned spend of £25 million against a £19.9 million ceiling. The trust spent 9.1% on agency as a proportion of total pay spend and whilst it plans to reduce this to 7.4% in 2018/19 this is higher than the national average.
- In the period June 2017 to May 2018 medical and dental staff accounted for 50.68% of the total agency spend. A review of the trust's medical agency spend in February 2018 demonstrated that 62.4% of the spend in medical and dental agency was within emergency and acute medicine.
- The trust engaged a Neutral Vendor in March 2018 to support access to external agency locums and manage the trust's internal medical staff bank. The trust's internal medical bank has increased from under 50 doctors in 2016/17 to 518 doctors in May 2018 and shows increased utilisation of nursing and medical bank staff between April 2017 and March 2018, with an extra 14.42 WTE medical bank staff and 24.11 WTE nursing bank staff used in March 2018. This has contributed to the increased pay bill for the trust.
- The trust uses e-rostering for all nursing staff and is rolling this out to all medical staff,

AHPs, therapists and community service staff including speech and language therapists.

- E-rosters are signed off 6 weeks in advance. The trust shared an e-rostering efficiencies and opportunities report that had been presented to the Finance and Performance Group which provided a range of metrics on rostering by ward.
- Where divisions were overspending against their pay budget, the trust told us that there was a system for escalating oversight, although the trust was unable to evidence a reduction in pay spend as a consequence of this.
- The trust has a comprehensive approach to job planning for doctors which was assessed by the National Carter Team in November 2016. The trust was rated as a grade 3, which is one below the highest (best) grade. As at 6 June 2018, 90% of eligible doctors within the trust had a job plan that was fully signed off or in the sign off process.
- The trust has implemented a number of new roles across the trust including Extended Scope Therapists who deliver independent clinics in orthopaedics, pain management, neurology and hand therapy. The trust has band 4 Assistant Practitioners in post across several inpatient areas as part of the substantive workforce, increasing the number of band 4 posts from 28.77 WTE in 2017 to 37.16 WTE in 2018.
- Staff retention at the trust shows room for improvement, with a retention rate of 85.5% in February 2018 which puts in in the second lowest (worst) quartile nationally, just below the national median of 86%. In response to low nurse staffing retention rates, the trust developed a graduate nursing scheme for new graduates joining the trust. This has resulted in a significant reduction in the attrition rate for nurses within their first year, the trust lost 7 new starters from a cohort of 43 in 2016, and only 2 in 2017.
- The trust has reviewed their internal development offer for doctors, offering bespoke packages of development for staff grade doctors (MYDOC) and offering support for doctors who want to apply for a Certificate of Eligibility for Specialist Registration (CESR).
- The trust implemented a new sickness absence management system in April 2017 which focusses on reducing the amount of long term sickness (absences over 21 days) within the trust. Trust data indicates that there was a reduction in sickness rates from 4.5% to 4% when comparing April 2017 to April 2018. The trust has had an average of 992 fewer days lost to sickness per month since October 2017 compared to the 2016 position. However, when comparing sickness rates to the national position, (most recent available national data is January 2018 which is earlier than the trust's internal data) the trust's staff sickness rate was 5.8%, which was worse than the national average of 5%, placing it in the highest (worst) quartile. This means that although the trust has improved its position there is further work to be done.
- The trust introduced a rapid dedicated musculoskeletal (MSK) service for staff with rapid access to physiotherapists. Data collected by the trust indicates a decrease in absence due to MSK reasons from 1% in June 2017 to 0.45% in June 2018.

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

- The trust's overall cost per test in 2016/17, at £1.23, benchmarks in the lowest (best) quartile nationally. The trust has delivered the low cost per test by implementing on-call rota redesign and laboratory automation.

- As part of the trust's participation in WYAAT it has successfully centralised immunology testing at Leeds Teaching Hospitals NHS Trust. The trust recognises this is only 0.2% of activity and there is significant further opportunity for collaboration to drive additional improvements in productivity.
- The trust's high performance for radiographer-led reporting is recognised nationally as advanced practice and effective use of resources (ranked 4th nationally for levels of radiographer reporting). The trust employs 8.8 WTE reporting radiographers and 5 WTE consultant radiographers and has low bank and agency usage in this area.
- The trust's medicines cost per WAU for 2016/17, at £308, is lower (better) than the national median of £320. As part of the Top Ten Medicines Programme the trust has over-delivered on nationally identified savings opportunities, achieving 138% of the savings target at March 2018 which is in the top (best) quartile nationally.
- The trust has jointly implemented a Medicine Contracts Steering Group with its Clinical Commissioning Groups (CCGs) and is actively participating in the Yorkshire and Humber medicines collaboration.
- The trust was able to provide a comprehensive list of technology systems and solutions that support productivity, including 3 examples relating to DNAs as described previously.
- Understanding that the capital constraints within the trust mean that spend needs to be prioritised appropriately, the trust has developed a comprehensive three-year equipment replacement plan. This recognises that many machines are at/above the Recommended Useful Life and prioritises their replacement or repair on a risk-assessed basis.

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 £1,309, compared with a national median of £1,301, placing it in the second highest (worst) quartile. This represents an improvement on the previous year.
- For 2016/17 the trust had a human resources (HR) function cost per £100million turnover of £805,789 which is better than the national median of £874,010; a payroll function per £100million turnover of £100,454 which is worse than the national median of £94,230; and a finance function cost per £100million turnover of £583,099 which is better than the national median of £670,512. This means that the trust pays less for its HR and finance functions, and more for its payroll function than most trusts.
- Whilst the trust's HR function is a low cost compared to the national median, a number of HR quality metrics were worse than the national median, including the length of time it takes to recruit. The trust has improved its time to recruit (advert close to start date) from 122 days to 86 days in the last 12 months. However, there is no evidence that the 27% reduction in recruitment time described has led to improved total bank and agency spend, despite positions now being vacant for a significantly reduced amount of time.
- The trust told us that minimal work has been done to consolidate corporate services and this remains an area with further opportunities for improvement.
- For 2016/17, the trust's Information Management and Technology (IM&T) function benchmarked significantly above (worse than) the national median at £2,733,949 per

£100million of turnover. This means that overall the trust pays more for its IM&T functions than most trusts. In addition to the national benchmarking, the trust has commissioned its own benchmarking against a select group of peers which also highlighted certain areas where the trust was more expensive than its peer median.

- The trust's supplies and services cost per WAU for 2016/17 was £287 which is below (better than) the national median of £375, meaning that the trust spends less on supplies and services than most trusts.
- The trust informed us they have not been able to obtain and submit procurement data for central analysis due to being unable to extract it from current systems and a delay in the roll out of new systems. This meant we were unable to look at this as part of this review.
- The trust told us that they do not have the resource to routinely access and use PPIB (the national product price comparison tool) data.. In the last 12 months the trust has also developed a central contracts database containing details of all contracts. It provides alerts for contracts due allowing the trust with more opportunities to ensure new contracts are best value for money.
- The trust explained it has a complex estates and facilities situation due to Private Finance Initiative (PFI) financing costs at Pinderfields and Pontefract. The estates and facilities cost per square metre for 2016/17 is £365 which is higher (worse) than the national median of £351.

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

- The trust delivered a deficit of £27.7 million in 2017/18 excluding Sustainability and Transformation Funding (STF), £11.9 million worse than the control total plan. The overall deficit for 2017/18 was £20.3 million deficit including STF (4.02% of turnover). Loss of STF was due to financial and A&E performance being worse than plan.
- Historically the trust has not delivered its plan. The trust presented an underlying deficit of c£20 million which has been broadly consistent for a number of years. Using Model Hospital data, the trust has assessed this underlying deficit to be driven by the PFI driving a high cost/m², agency premiums from the trust's high percentage of agency spend and high premiums for the Clinical Negligence Schemes for Trusts (CNST) as a result of a number of very old, high value claims at the trust.
- The 2017/18 variance from control total excluding STF was driven by £1.9 million loss of CQUIN (Commissioning for Quality and Innovation) income (linked to failed delivery of the 2016/17 control total), a £7.4 million gap in CIP delivery and overspends, particularly in agency premiums. The need for a high CIP in 2017/18 was driven by the loss of contribution to overheads from services lost to other providers and a reduction in funding outside of activity driven tariff from local commissioners.
- The trust identified risk to delivery of its control total early in the financial year. The trust had engaged with the Financial Improvement Programme (FIP) to help in the identification of CIPs, however, this did not identify the level of savings required.
- For 2018/19 the trust has a planned deficit of £19.7 million excluding Provider Sustainability Funding (PSF), and a deficit of £5.4 million including PSF which is in line with the control total agreed with NHS Improvement. The 2018/19 plan includes a CIP of £24 million, (4.4% of its expenditure). At the time of the assessment (July, at which May's data was available)

the trust was reporting delivery of the 2018/19 plan.

- The trust delivered £17.3 million (70%) of its £24.7 million planned savings in 2017/18, 88% of which were recurrent savings. In 2016/17 the trust delivered £16.7 million (64.2%) of the planned £26 million CIP, 58% of which were recurrent.
- At the time of the assessment the trust had identified all of its 2018/19 CIP schemes, planning to deliver 29% non-recurrently. CIP targets were allocated out across a number of trust-wide schemes with the remainder being devolved to divisions to develop their own local schemes. Of the planned CIP target, £5.2 million remains high risk and the trust confirmed the board had requested that mitigation and alternative plans were developed to ensure the overall financial plan is achieved if the high-risk CIPs do not deliver as planned.
- The trust has Service Line Reporting (SLR) in place and has been an early adopter of the NHSI Costing Transformation Programme using Patient Level Information Costing Systems (PLICs). The trust told us this is used in detail within the divisions with Heads of Finance and Operational Managers and provided a storyboard of how this is reported internally.
- The trust has a number of years of underlying deficit and is therefore reliant on short term borrowing to meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service (0.03 – February 2018) and liquidity (15.46 days – February 2018) metrics. However, in 2018/19 the trust is not planning to grow this debt from revenue loans. At 31st March 2017 the trust had revenue borrowing (excluding PFI related borrowing) of £64m.
- The trust's Director of Finance has introduced fortnightly cash management meetings. This has resulted in a greater understanding of debts allowing a more successful approach to securing their recovery. The trust prioritised creditor payments and reduced payments it was making in advance throughout 2017/18 to manage working capital. The trust has also stopped paying for goods and services upfront on new contracts.
- The Acute Hospital Reconfiguration (AHR) has helped the trust move to more productive services, however, the trust recognises there is further opportunity for service reconfiguration to support service and financial sustainability and make best use of the peripheral sites. The trust is currently reviewing these services.
- The trust evidenced that it was working in partnership with local commissioners by agreeing an Aligned Incentive Contract (AIC) for 2018/19 which has provided the trust with a level of certainty on patient income and allows system decision making on an overall cost basis. It is expected this partnership working will enable improved use of resources and savings across the trust and its commissioners in 2018/19.
- The trust explained it remained focused on maximising all income streams, giving examples where additional income was secured in 2017/18 due to focussed attention on smaller contracts.
- Consultancy spend of £1.8 million was incurred in 2016/17, and £0.4 million in 2017/18. These costs were incurred as part of the FIP work on theatres and outpatient CIPs which ran throughout 2017/18. The consultancy was intended both to identify efficiency opportunities and help the realisation of these. The trust identified that FIP had not identified the degree of opportunities required to achieve the full CIP and therefore it did not commit to any further material consultancy spend in 2017/18. However, the trust confirmed this work had helped establish the 2017/18 trust wide CIPs focus on Outpatient and

Theatre productivity offsetting these costs.

Outstanding practice

- The trust has a consistent and embedded approach to quality improvement and uses this to identify and realise operational productivity benefits. The trust was able to provide many examples of projects where improved productivity has resulted in benefits to patients. For example, in end of life care a rapid process improvement workshop resulted in the development of a pathway including a discharge to assess model which has led to a reduction in length of stay for these patients by 2 weeks and 6 days and released on average 73 minutes of qualified nursing care time per patient. In community services the continence team redesigned their pathway and reduced the time waiting for an assessment from an average of 12 weeks to 98% of patients receiving a first contact within one day.

Areas for improvement

We identified a number of areas of improvement for the trust:

- The trust delivered a deficit of £27.7 million in 2017/18 excluding Sustainability and Transformation Funding (STF), £11.9 million worse than the control total plan. This is consistent with historical performance. The trust needs to deliver its financial plan in order to meet its control total in 2018/19.
- The trust plan includes a CIP of £24 million. The trust has identified 29% of the CIP plan to be delivered non-recurrently and £5.2 million remains high risk. The trust will need to prioritise identification and delivery of the full programme during 2018/19.
- The trust has seen a year on year increase in its pay bill over the past 3 years, despite putting in place a number of initiatives, and spends more on pay per weighted unit of activity than most other trusts nationally. The trust needs to demonstrate the impact of its initiatives on addressing the increasing spend on pay.
- Some of the initiatives reviewed as part of this assessment, such as the implementation of ward-based discharge coordinator roles, had limited evidence of financial appraisal and benefits identification. For others, such as AHR and the collaboration across WYAAT to centralise clinical support services, the full scope of the opportunity and/or identified benefits were not realised. The trust needs to develop and implement a consistent approach to identifying tangible benefits and monitoring and achieving realisation for all initiatives they decide to invest in.
- The trust provided examples of a number of comprehensive reports into its workforce position but there was little evidence as to how this data was being used to drive down pay spend. The trust needs to develop how it uses the comprehensive data and reports relating to its workforce to drive a reduction in overall pay spend.
- The trust provided a number of examples, including IM&T benchmarking and use of PPIB, where they were not using the benchmarking data available to them to drive efficiencies. The trust needs to take advantage of all the benchmarking data available to it in order to identify and target opportunities to improve its use of resources.

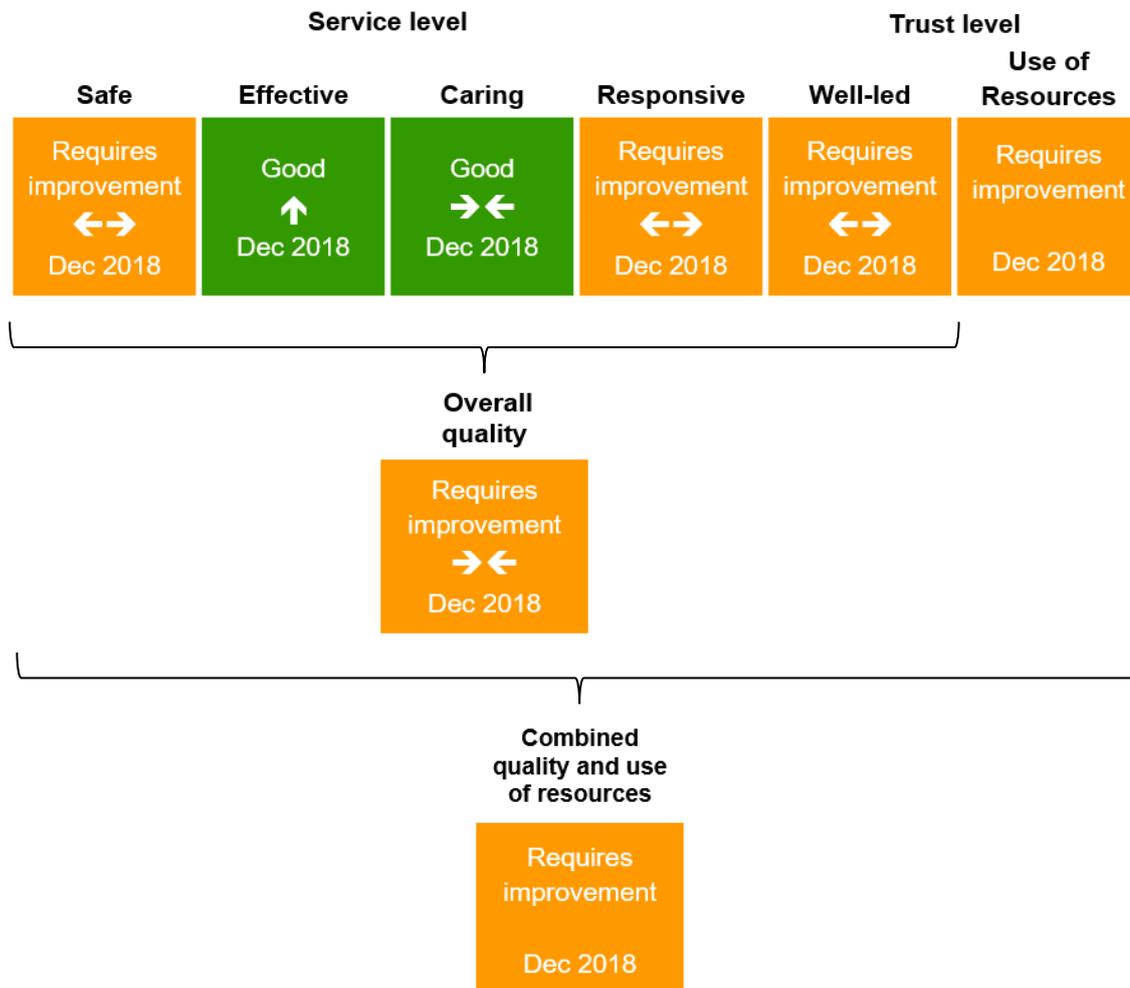
Ratings tables

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 | A high level of DNAs indicates a system that might be making unnecessary |

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| (DNA) rate | 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 (DTC) | A DTC 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. |

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| 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 |

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