University College London Hospitals NHS Foundation Trust

Use of Resources assessment report

250 Euston Road
Fitzrovia
London NW1 2BU

Tel: 0203 456 7890
www.uclh.nhs.uk

Date of publication: 11 December 2018

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

Ratings

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

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

Are resources used productively?	**Good**

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

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

Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our

five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- We rated effective, caring, responsive and well-led as good, and safe as requires improvement.
- We rated 10 of the services inspected this time, as good overall. In rating the trust, we took into account the current ratings of the services not inspected this time.
- The trust was rated good for Use of Resources.

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Date of site visit:
8 August 2018

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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.

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 8 August 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair of the Finance and Investment 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 use of resources as good because the trust demonstrated it had used its resources effectively, enabling it to provide high quality, efficient and sustainable care for patients:

- The trust is actively managing resources to meet its financial obligations on a sustainable basis to deliver high quality care and good use of resources.
- While there is an overall good use of resources at the trust, evidencing and sustaining further improvements such as dealing with operational performance outcomes (particularly in Accident & Emergency), sustaining recent improvements in clinical areas, making progress on rostering and medical job planning, dealing with issues on management of estates costs and working through legacy arrangements in pathology remain challenges going forwards.
- The assessment of Use of Resources has been made with recognition of the high levels of specialist activity that the trust undertakes, which is materially above the median of all trusts and also, although to a lesser degree, above the median for other tertiary hospitals. The nature of this activity leads to expected higher costs in a number of the clinical support services and in particular diagnostic services, which we have adjusted for.
- Across domains, we highlight the following areas of outstanding practice, areas of good clinical practice and recent improvements in performance, and areas where further improvements can be made.
- We noted the following areas outstanding practice at the trust:
    - Effective management of Nursing staff costs through a combination of excellent practices. The trust's Nursing costs per weighted activity unit (WAU) is low but further note that the trust's Care Hours Per Patient Day (CHPPD) are in the upper (best) quartile.
    - Pushing through the efficiency agenda through innovative and inclusive methods. The trust drives financial efficiency and improvement through their internal programme of focused "special measures" regime for appropriate areas/divisions.
- The trust achieved its financial plan for financial year 2017/18 and is on track to deliver its financial plan for financial year 2018/19 as at Month 3 (June 2018). The trust has delivered its Control Total (CT) in each of the previous two financial years. However, we note that the trust has relied on non-recurrent measures to do so.
- In financial year 2016/17 the trust had an overall cost per WAU of £3,765 compared with a national median of £3,532, placing it in the highest (worst) cost quartile nationally. We note that within this, the trust is in the lowest (best) cost quartile for pay costs and the highest (worst quartile) for non-pay costs.
- The trust also demonstrated improvements over the previous 12 months in key clinical areas. These include reducing stranded patients and improving patient flow (particularly in non-elective pathways), job planning (including rolling out job planning to Clinical Nurse Specialists (CNSs) and Allied Health Professionals (AHPs). A key challenge for the trust will be to show that these improvements have embedded and deliver over the next 12 months.

- There are further areas where the trust has demonstrated good practice but can improve further to reach outstanding outcomes. These include improving the overall uptake of medical job planning, demonstrating innovative skill mix, workforce models and improving timeliness of supplier payments and cash management.
- The trust has been proactive in terms of outsourcing back office and clinical support functions, including pathology, payroll, financial ledger and pharmacy collaborations across the Sustainability and Transformation Partnerships (STP). However, in some areas the trust is somewhat constrained by legacy contracts and arrangements, which they previously agreed under prevailing circumstances. While we note these in the report (e.g. pathology arrangements), further improvements and efficiencies in these areas will need to be a key focus for the trust going forward.
- We note that the trust remains very challenged in some operational areas. It has significantly failed the Accident and Emergency (A&E) standard since April 2017, and failed the Cancer 62-day standard in both financial year 2017/18 and to date in financial year 2018/19. A&E performance in June 2018 was 84.25%, which was worse than the national median of 88.67% and was in the fourth (worst) quartile nationally. We note that in relation to Cancer, the trust's overall performance is made up of roughly equal volumes of shared referrals and internal pathways as a result of being a specialist treatment centre. The trust notes that it does not receive the majority of shared referrals within 38 days, which explains some of the variance to the standard.
- There are further areas where the trust has room for improvement, such as in electronic rostering and roster reporting, the management of estates and facilities costs and reducing pre-procedure elective bed days.

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 is proactively managing its resources in the face of operational demands and has shown improvements across some metrics over the previous 12 to 18 months including reducing stranded patients and improving emergency readmission rates. However, the trust has further challenges to reduce Did Not Attend (DNA) rates, elective pre-procedure bed days and length of stay (LoS).
- The trust has failed the A&E standard since April 2017. A&E performance in June 2018 was 84.25%, which was worse than the national median of 88.67% and was in the fourth (worst) quartile nationally. Key issues set out by the trust are discharge and occupancy levels in wards, bed capacity and increases in patient dependency. The trust has developed a System Improvement Plan jointly with system partners to reduce delays and improve processes both in and out of the hospital. This includes embedding daily Clinical Utilisation Reviews (CUR), in order to track which inpatients no longer meet standardised criteria to require an acute bed, allowing focussed action to be taken in order to progress their care journey.
- The impact of these actions and their longer-term sustainability is not yet apparent. Stranded and super stranded patients have decreased from 52.4% and 24.8% in April 2018 to 48.3% and 21.7% in July 2018 but has not resulted in improved performance. The trust has a cohort of specialist patients who will necessarily have a longer Length of Stay (LoS), reducing the number of non-specialist acute Stranded Patients remains an opportunity for both the trust and wider system.
- At 4.13%, emergency readmission rates are significantly better than the national median of 7.19% as at March 2018. This means patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally.

- The Did Not Attend (DNA) rate for the trust was 9.9% in June 2018. While this is an improvement from 10.6% for the quarter ending March 2018, it remains higher (worse) than the national median of 7.24%. The trust recognises this as an area for improvement and has developed a risk algorithm to prioritise reminder calls and target resources towards patients that are most likely to not attend. Moreover, the trust expects to improve electronic patient communication with the implementation of a new Electronic Health Records System (EHRS) in financial year 2018/19.
- The trust has set out that it drives many clinical productivity improvements through its Productivity Delivery Group using actionable data in the hands of clinicians through the development of internal benchmark dashboards and the Get It Right First Time (GIRFT) programme. Examples of good practice include the trust's systemwide work on Musculoskeletal (MSK) service and the NeuroResponse model of care.
- The data suggests that more patients are coming into hospital prior to planned treatment compared to most other hospitals in England as of March 2018. On pre-procedure elective bed days, at 0.58 days, the trust is performing significantly worse than the national median of 0.13 days. While there will be certain specialities which necessitate earlier admission, given the overall elective mix of the trust, reducing this metric will need to be a key area of focus.
- However, on pre-procedure non-elective bed days, at 0.81 days, the trust is performing the same as the national median.
- The trust has not met the Referral to Treatment (RTT) national standard of 92% since quarter 2 (July to September) of financial year 2017/18. As of January 2018, the trust has reported 91% which is just below the national standard.

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

- Staff costs are generally well-controlled, demonstrated by pay cost per Weighted Activity Unit (WAU) and sickness levels. Staff turnover is improving and is close to the national median.
- In financial year 2016/17 the trust had an overall pay cost per WAU of £1,865, compared with a national median of £2,157, placing it in the lowest (best) cost quartile nationally. This means that it spends less on staff per unit of activity than most trusts nationally. The trust pay cost per WAU is better than the national median for nursing and medical professional staff groups. In addition, the trust is reporting agency costs within its agency ceiling.
- Agency spend is 1.6% of the total pay bill which is significantly below the national average of 4.7%. The agency cost per WAU is £35, which is the third lowest in the country, below the national median of £137 and places the trust in the lowest (best) quartile.
- Nursing and midwifery staff costs are managed effectively through a combination of good practice initiatives, with regular skill mix review through the Safer Nursing Care Tool and Birthrate plus. While the trust's Nursing costs per WAU is low, we further note that the trust's Care Hours Per Patient Day (CHPPD) are in the upper (best) quartile and the cost per patient day is in the upper (worst) quartile.
- Staff retention at the trust has been relatively constant over the 6 months to March 2018 and is close to the national median. The retention rate is 81.2% in March 2018 (national median is 85.6%). At 3.3% in February 2018, staff sickness rates are among the best nationally (national average of 4.4%). It should be noted that the sickness absence rate varies between staff groups with the sickness rate for midwifery higher than the national average at 6.5% and midwifery turnover is in the lowest (worst) quartile at 81%.
- Job plans by speciality is variable at the trust. Whilst some divisions show job plans for 100% of staff including Infection, Eastman Dental Hospital and a number of key divisions have much

lower levels of job planning. Notably, in Emergency Services where the trust is experiencing challenges delivering the 4-hour standard, the job planning rate is the lowest across the trust at 78%. We would expect that clear job plans are vital for improving engagement and performance in such challenged areas. The trust has plans to have 90% of job plans signed off electronically. To-date 31% have been signed off with a further 14% awaiting signoff.

- In addition, the trust's Clinical Nurse Specialists are job planned. Building job planning templates onto the trusts electronic system (SARD). The trust aims to transition existing job plans onto the system in the autumn. The trust has also developed a job plan template for Allied Health Professionals (AHPs) which is currently undergoing pilot testing.
- The Trust report four key rostering metrics at Board level and monitor ward-based performance through the exemplar ward dashboard, with some metrics included in the divisional board reports. From the evidence provided it was noted that a number of Key Performance Indicators (KPI's) were underperforming against target and it was unclear how efficiencies were being driven through improved rostering performance.
- The trust has set out a number of new staffing models and roles; for example, physician assistants, Advanced Nursing Practitioners (ANPs) in oncology, consultant nurses (including endoscopists) and consultant radiographers.

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

- The trust's medicines cost per WAU (£610) is high when compared nationally (£355). This metric is driven by the fact that the trust purchase medicines for other providers. While the income from onward sale means that this is overall cost neutral for the trust, the gross cost is reflected in the trust's accounts while the activity is reflected in other providers. The impact of non-trust drug charges is £126. Adjusting for this results in a medicine cost per WAU of £484, which is comparable with peers.
- The trust is able to evidence that it has achieved a 108% against its Top 10 Medicines savings targets including biosimilars to March 2018. The trust has pursued wider opportunities for savings including antimicrobials, anti-emetics and prednisolone. We note that these savings have been delivered despite the trust having a high case mix for patients treated with Imatinib, meaning that there is scope for fewer patients to switch from branded to generic medicines due to patent restrictions.
- The Model hospital metric shows the trust's cost per test to be in the most expensive quartile against peers. This information however relates to the specialist laboratories at the National Hospital for Neurology and Neurosurgery (NNHN) retained within UCLH and therefore a high cost would be expected. The bulk of the activity is delivered through a joint venture (JV) which the trust entered in 2015 with The Royal Free London NHS Foundation Trust and a private sector operator to develop a large automated laboratory with additional capacity to meet growing demand from the trust as well as to provide services to other trusts.
- The trust outsources the majority of their pathology services to Health Services Laboratories (HSL), a public-private joint venture partially owned by UCLH. The only pathology services retained within the trust are the specialist laboratories at the National Hospital for Neurology and Neurosurgery (NNHN).
- We note that the trust played a key role in setting up a pathology collaboration and rationalising services for North Central London (NCL), as well as planning for the future capacity. However, the joint venture has not managed to win some of the work that they expected to and their contract structures with the JV have resulted in a much higher than planned cost per test. HSL is currently re-baselining cost of tests as the transition phase has

come to an end and this may resolve much of the cost per test issue. In addition, the trust continues to negotiate with Clinical Commissioning Groups (CCGs) to improve contracting.

- Additional analysis provided by the trust shows that the average cost per test for testing delivered through the JV to be £3.95 per test which is high in comparison to peer trusts with a similar case mix with the peer median of this group being £3.29. These trusts have not yet moved to a consolidated lab and we would have expected the JV to be delivering at a more efficient price point.
- The joint venture contract set prices for the initial 10 years of the contract, but at 85% implementation of the new operating model, the JV will be re-baselining prices and the trust expects at least a 10% reduction in cost of tests. The delay in reaching this point has resulted in higher than expected costs for the trust as the JV has performed below the initial planning assumptions. The performance of the JV is being closely monitored and influenced by the Board.
- The trust's model for its imaging service is through a combination of self-delivery and for large volume plain film reporting through an external provider. The Model Hospital shows a peer median cost per report of £50.06. Analysis by the trust indicates that their internal cost per report is at a similar level (£45.46) and that the outsourcing cost is £13.49 with a weighted average of £33.17. The range of cost is extremely wide according to complexity and the trust's service supports complex pathways such as the hyper acute stroke pathway, their significant interventional radiology department and the inclusion of substantial Nuclear Medicine volumes. Direct comparisons are currently difficult to make because of the complexity of this factor. The trust has provided evidence of interventions to improve operational productivity of their service and capacity, including Magnetic Resonance Imaging (MRI) protocol initiatives which are expected to reduce reporting time by 42% (which should reduce the amount of additional capacity that needs to be sourced and therefore total cost), and a Did Not Attend (DNA) rate reduction programme bringing DNA rates down as the trust's historic levels are in the worst performing quartile for Computed Tomography (CT) and MRI.
- We also note that the trust has demonstrated a number of new and innovative ways to improve productivity, including:
    - Developing an economic model for optimising patient assessment, working with Information Technology (IT) providers to develop a secure video live streaming solution from mobile devices worn by the assessing team wherever they are in the hospital and viewed remotely by the senior decision maker at any time of the day or night.
    - StrokePad – a dedicated electronic record to make capture of key information more effective during inpatient admission
    - Medication Text reminder service for Epilepsy patients.
    - Artificial Intelligence to plan radiotherapy treatment. The trust has created an algorithm which it notes can perform to the same standard as clinicians in less time. In a non-clinical environment, the algorithm can segment 20 areas of healthy anatomy on a scan in a few minutes. The next phase of the project is to test the system against clinicians in a real clinical setting within UCLH.
    - The trust notes it has significantly increased the number of virtual clinics and are putting in place new and innovative virtual delivery of care and diagnostic, for example the implementation of our Virtual Fracture Clinic, Skype for Business pilots.

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

- For financial year 2016/17 the trust had an overall non-pay cost per WAU of £1,900 compared with a national median of £1,301. This places it in the fourth (worst) cost quartile nationally. However, we note that a key driver of this metric is the trust's Private Finance Initiative (PFI),

which places a high cost burden on the trust. In addition, the trust sets out that due to various outsourcing contracts, its high non-pay costs are offset by lower pay costs.

- The cost of running its Human Resources (HR) department is significantly lower in financial year 2016/17 than the national average (£0.47m compared to £0.89m per £100m turnover). The trust's workforce outcomes, including low sickness rates, also suggest that the HR function provides good value.
- The cost of running its finance department is marginally lower in financial year 2016/17 than the national average (£0.65m compared to £0.67m per £100m turnover).
- The trust has outsourced a number of transactional elements of their corporate functions including payroll to Shared Business Services (SBS) and financial ledger through NEP, which has allowed them to reduce costs. The trust is able to articulate how they drive financial efficiency and improvement through their internal programme of focused "special measures" regime for appropriate areas/divisions. Moreover, the trust can evidence robust Service Line Reporting (SLR) which apportions costs to divisions to drive accountability and provide incentives for improvement. Accordingly, it appears that good value is delivered through the finance function.
- There has been a significant strengthening of the procurement function over the review period. The trust had previously been reliant on interim staff within its procurement team but is now fully substantive. A business partnering model is in now in place which achieves greater clinical engagement and thereby is enabling the trust to drive increased efficiencies. UCLH also has a track record of collaboration which includes working with other similar types of trust and proactively looking for opportunities with other parties within their STP.
- This renewed focus is reflected in the strong increase in the level of Cost Improvement Programmes (CIPs) delivered as well as in the Procurement League table published for the 2017/18 financial year in which UCLH was ranked 31st out of all the non-specialist acute trusts (out of 136). The trust has shown particularly strong performance in the competitiveness of the prices achieved which is reflected in high (top decile) performance for several the pricing metrics (e.g. average variance to top 500 products and number of products achieving best price).
- The trust's estates and facilities cost per m2 is £740 for 2017/18, which is the second highest in the country, not accounting for central London location. The trust operates from 23 sites of which 33% by area is operated under PFI contracts. The trust has an ongoing programme of consolidation. Based on financial year 2016/17 data, the overall cost per square metre is in the top 5% in the country. Comparison has also been made of the PFI components with other acute trusts with material levels of PFI estate. This shows the facility management costs being incurred by the trust to be in the order of 37% more expensive overall than the median of this peer group, with the most material variances being cleaning - 75% above and estates and property maintenance – 11% above. The PFI contract provides for market testing and benchmarking every 5 years of the soft Facilities Management (FM) costs – the last being in 2015. The trust took professional advice in this process however, the benefits of this exercise are constrained by the specific provisions in the trust's PFI contract. The trust has plans to retender FM services once new phases of construction currently underway are complete.
- Analysis across the entire estate shows that these are also materially above the national median and peers. For the financial year 2017/18 Hard FM costs are 41% and soft FM are 15% above London peer medians with the key components of particularly high cost being the same as with the PFI components. Overall backlog is relatively low and critical infrastructure risk has improved to £8.32m for financial year 2017/18 (peer median £10.73m). We would expect this to further improve given the trust's ongoing capital programme; this will see the trust vacate older buildings and move to new builds.
- The Trust continues to use its estate effectively; financial year 2017/18 indicates that the trust

has 26.4% of non-clinical space below the peer median 31.9%. Accordingly, we note that the trust makes very effective use of its estate being in the top quartile.

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

- The trust achieved its financial plan for financial year 2017/18, is on track to deliver its financial plan for financial year 2018/19 as at Month 3 (June 2018). The trust has delivered its Control Total (CT) in each of the previous two financial years. However, we note that the trust is reporting an underlying deficit.
- Excluding Sustainability and Transformation Funding (STF), the trust reported a surplus of £26.0m in financial year 2017/18 against a CT of £4.9m deficit. The reported surplus includes proceeds from a land sale and other non-recurrent spending; adjusting for these results in an underlying deficit. However, the trust has a large Cost Improvement Plan (CIP) for financial year 2018/19 has further planned growth and accordingly plan to improve their underlying position. Moreover, we note that the underlying position between financial year 2016/17 and financial year 2017/18 has improved.
- The trust enforces strict criteria of what they can count as CIPs. The trust sets out that due to its internal guidance, a number of clinical income schemes have not been counted as CIP to ensure divisional focus on cost reduction and system costs. We note however that clinical income schemes are still encouraged to the extent that these contribute to the trust's bottom line and are delivered through productivity improvements.
- The trust's performance against CIP is broadly on plan. In financial year 2017/18 the trust reported delivery of £38.4m against a target of £46.9m. In addition to these schemes, the trust delivered several schemes which they did not report as CIPs including improved debt collection against overseas visitors, income improvements on the Queen Square site and income improvements in Cancer which have positively impacted the bottom line. The impact of these schemes is a further £12.5m, which mitigates for any non-delivery against reported schemes.
- For financial year 2018/19, the trust has a CIP target of £47m. This includes £8.7m on schemes aligned to areas the trust needs to improve including Pathology, Imaging and Estates and Facilities. In addition, the trust plans a further £13m bottom line improvement due to income schemes not reported as part of the CIP programme.
- The trust is not reliant on any external loans and has a positive cash balance. However, the trust only pays 75% of suppliers within 5 days, which is significantly less than the Better Payments Practice Code target of 95%. This is an area of focus for the trust who have set out that they are upgrading to a new finance and procurement system in October 2018, with the intention of improving timely payment.

Areas of outstanding practice

- In financial year 2016/17 the trust had an overall pay cost per WAU of £1,865, compared with a national median of £2,157, placing it in the lowest (best) cost quartile nationally. This means that it spends less on staff per unit of activity than most trusts nationally. The trust pay cost per WAU is better than the national median for nursing and medical professional staff groups.

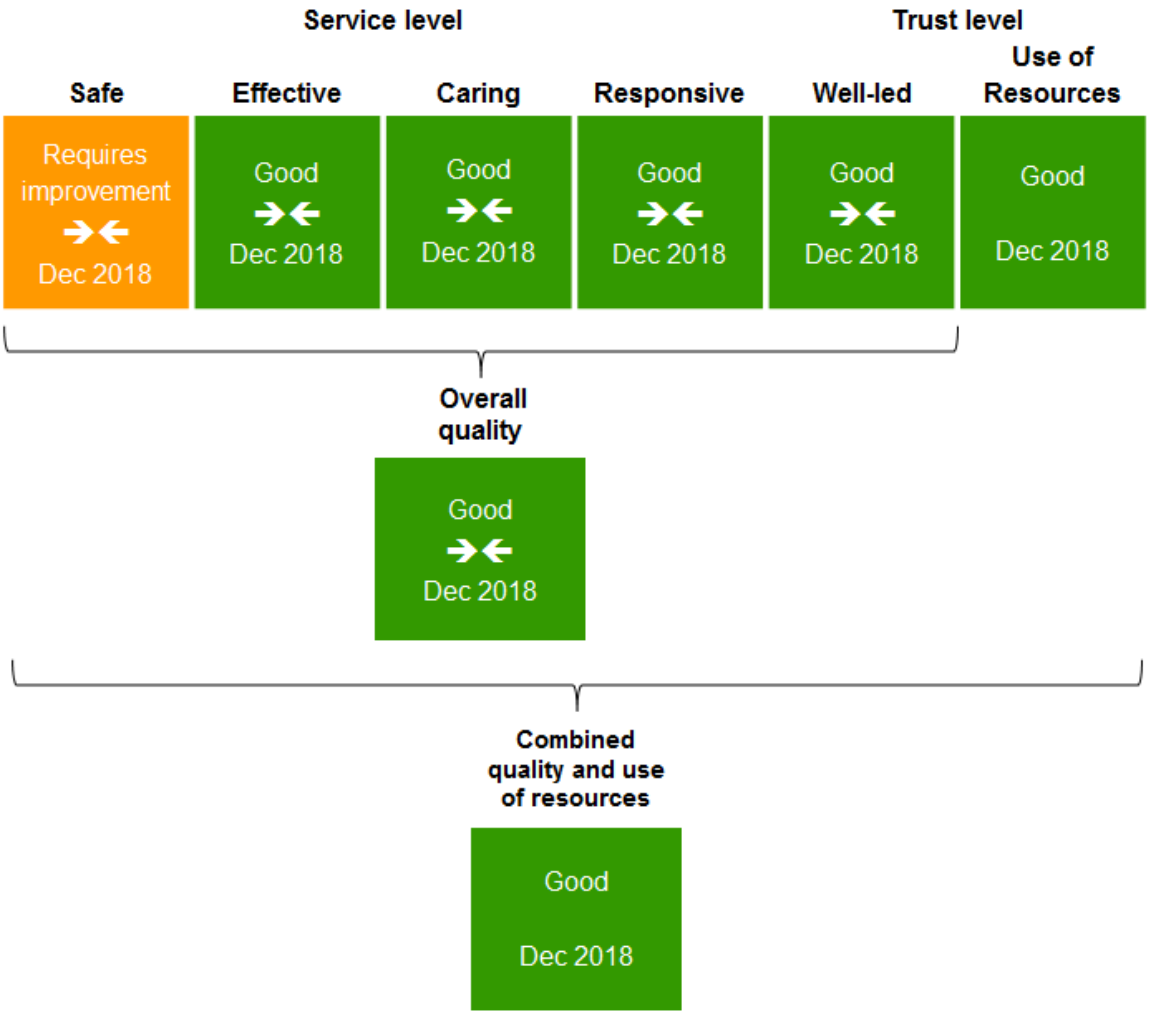
- Effective management of Nursing staff costs through a combination good practice. The trust's nursing costs per WAU is low but further note that the trust's Care Hours Per Patient Day (CHPPD) are in the upper (best) quartile.
- The trust's Clinical Nurse Specialists are job planned. Building job planning template onto SARD, transition plan for existing job plans to move onto the system in the autumn. The trust has also developed a job plan template for AHPs which is currently undergoing pilot testing.
- The trust has demonstrated a number of innovative ways to improve productivity, including developing an economic model for optimising patient assessment, StrokePad, Medication Text reminder service for Epilepsy patients and Artificial Intelligence to plan radiotherapy treatment.
- Pushing through the efficiency agenda through innovative and inclusive methods. The trust drives financial efficiency and improvement through their internal programme of focused "special measures" regime for appropriate areas/divisions.

Areas for improvement

- On pre-procedure elective bed days, at 0.58 days, the trust is performing significantly worse than the national median of 0.13 days. While there will be certain specialities which necessitate earlier admission, given the overall elective mix of the trust, reducing this metric will need to be a key area of focus.
- The trust has significantly failed the Accident and Emergency (A&E) standard since April 2017. A&E performance in June 2018 was 84.25%, which was worse than the national median of 88.67% and was in the fourth (worst) quartile nationally. Improving outcomes and performance must remain a key focus for the trust.
- The average cost per test for testing delivered through the Joint Venture (JV) to be £3.95 per test which is high in comparison to peer trusts with a similar case mix with the peer median of this group being £3.29. The comparison trusts have not yet moved to a consolidated lab and as such we would expected the JV to be delivering at a more efficient price point. reducing cost per test should remain a key priority for the trust.
- Analysis across the entire estate shows that these are also materially above the national median and peers. For the financial year 2017/18 Hard FM costs are 41% and soft FM are 15% above London peer medians with the key components of particularly high cost being the same as with the PFI components. Comparable trusts have completed or are more advanced in terms of re-negotiating hard and soft FM contracts. The trust has plans to retender FM services once the new phases of construction are complete. Accordingly, ensuring this is completed on a timely basis will be a pressing challenge for the trust.
- The trust only pays 75% of suppliers within 5 days, which is significantly less than the Better Payments Practice Code target of 95%. This is an area of focus for the trust who have set out that they are upgrading to a new finance and procurement system in October, with the intention of improving timely payment.
- Whilst, we note a number of areas of outstanding practice relating to workforce above, including the nursing and midwifery workforce expenditure being within budget. The Trust report four key rostering metrics at Board level and monitor ward-based nursing and midwifery performance through the exemplar ward dashboard, with some metrics included in the divisional board reports. From the evidence provided it was noted some of the KPI's were underperforming against target and actions being taken to address this were not

visible in the reports. We understand that the trust reviews and monitors rostering at a granular service level, however, reporting rostering performance from ward to Board, for all staff groups, including medical staff, will provide visibility of good performance and prioritisation of underperformance, thus enhancing oversight at board level to ensure roster performance is meeting agreed targets in line with national guidance and ensuring safe and efficient rostering.

Ratings tables



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

(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 (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR) cost per £100 million turnover	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.

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

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