University Hospitals Bristol NHS Foundation Trust

Use of Resources assessment report

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Date of publication:16 August 2019

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	**Outstanding**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Outstanding**

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/RA7/reports)

Are resources used productively?	**Good**

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

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 outstanding, because:

- At trust-wide level, we rated safe, effective, and caring as Good, responsive as Requires improvement, and well led as Outstanding.

- The trust was rated Good for use of resources. Full details of the assessment can be found on the following pages.

NHS Improvement

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Date of site visit:
11 April 2019

Date of NHS publication:
16 August 2019

This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous 12 months, our local intelligence, the trust's commentary on its performance, and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Are resources used productively?	**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 11 April 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Summary of findings

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

We rated Use of Resources as good as the trust generally benchmarked favourably at national level across all Key Lines of Enquiry (KLOEs) although it still had further to improve to benchmark consistently in the top quartile nationally. During our assessment, the trust demonstrated areas of best practice and had partnered with a local trust to support them in delivering sustainable services and with which it was developing plans to merge.

- At the time of the assessment, the trust did not meet the four constitutional standards (4-hour Accident & Emergency, 18-week referral to treatment, cancer-62 day and the diagnostic 6-week waits) although, except for A&E, the trust's performance benchmarked better than its peer group and the trust had consistently met the cancer 62-day wait standard up to and until February 2019.
- The trust benchmarked well on pre-procedure non-elective bed days, emergency readmission rates and Did Not Attend rates (DNAs) and had progressed with understing the main drivers of its higher elective prep-procedure bed days.
- The trust's delayed transfers of care (DTOC) had improved to lower than the national median although the trust's length of stay was in the highest quartile for elective admissions and second highest quartile for emergency admissions. The trust continued to focus on reducing length of stay through its trust wide productivity improvement programme, 'Working Smarter'.
- Overall, the trust benchmarked strongly on the people KLOE. The trust's total pay cost per weighted activity unit (WAU) was in the best quartile nationally with non-substantive staff cost per WAU benchmarking in the lowest 10% nationally although the trust had high medical cost per WAU which it needed to further understand.
- The trust had a low agency staff rate which was significantly below the national median and low vacancies across the trust. It used e-rostering and job planning to efficiently deploy its nursing, Allied Health Professionals (AHPs) and medical staff and had introduced a number of innovative workforce models to use its workforce flexibly.
- The trust's sickness rate and response rate to the annual staff survey were better than national benchmark although the trust's staff retention rate was consistently benchmarking below the national median despite actions taken by the trust.
- The trust provided a mixed picture on clinical support services. The trust had not provided all of requested information for the Model Hospital which therefore did not always allow us to compare performance. The trust benchmarked well on aspects of pharmacy (medicine cost per WAU, efficiency savings achieved), and pathology (cost per test, efficiencies achieved) with specific areas where the trust could improve. The trust needed to work to progress the proposed pathology network with local providers to deliver the priorities of the NHS Long Term Plan.
- There were aspects of the imaging services which benchmarked well although difficulties in managing capacity for cardiac CT and paediatric ultrasound had impacted the trust's ability to deliver the diagnostic 6-week wait national standard; there were delays in

replacing equipment during 2018/19; and the trust needed to engage with local providers to ensure consistency in the PACS system procured.

- The trust benchmarked very well on finance, human resources (HR) and information management and technology (IM&T) functions with the trust also a Global Digital Exemplar. The trust's non-pay cost per WAU was higher than the national median due to medicines costs whereas cost of supplies and services benchmarked better than the national median.
- The trust was part of a procurement consortium which performed well on prices achieved but improvements could be made on process with low percentage of non-pay spend on purchase order. Also, the consortium had not yet achieved Level 1 NHS Procurement Standard.
- Despite operating from seven hospitals, the trust benchmarked well on estates and facilities, had generated significant savings from this area and was aware of further opportunities to reduce costs. However, the trust had significantly under-delivered on capital spend over the last two years and needed to improve on capital programme delivery.
- The trust had a track record of financial surplus and held sufficient cash reserves to meet its financial obligations. The trust however needed to improve on the delivery of recurrent efficiencies to ensure it remained sustainable in the future and reduce its reliance on non-recurrent measures to deliver surpluses. The trust's contribution to whole system working to address the financial deficit the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership (STP) is collectively facing during 2019/20 is also critical so that patient care is delivered within the financial resources available to the STP.

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

At the time of the assessment, the trust benchmarked well against its peers on the constitutional operational performance standards with the exception of the 4-hour Accident & Emergency target. It did not achieve the 18-week referral to treatment, cancer 62-day wait, and diagnostic 6-week wait targets at the end of March 2019 although the trust had consistently met the cancer 62-day wait standard up to and until February 2019. Its pre-procedure non-elective bed days and emergency readmissions were in the best national quartile. At the time of the assessment, the trust could further improve on long length of stay.

- At the time of the assessment in April 2019, the trust was not meeting the constitutional operational performance standards around 4-hour Accident & Emergency (A&E), 18-week referral to treatment (RTT), cancer 62-day and diagnostics 6-week wait. The trust also had 13 52-week wait breach patients, the majority relating to specialist paediatrics. Positively, the trust delivered against its trajectory for RTT performance and waiting list size at March 2019. The month of March 2019 was also the first month that the trust had not met the Cancer 62-day standard since June 2018.
- The trust's performance against the A&E target in March 2019 was 81.86% against a standard of 95% and national average of 86.60%.'Reporting performance is boosted by the trust's Children's and Eye Hospitals, with the Bristol Royal Infirmary (BRI) Type 1 A&E performance being 78.3% against a standard of 95% and national average of 79.5%.
- A review of the BRI A&E service had identified its key issues as being workforce, surge and crowding, and flow. The trust's capacity and demand work and Getting It Right First

Time (GIRFT) data had previously demonstrated that the BRI emergency department (ED) was not resourced to meet current levels of demand into the department and the trust had since filled two posts and was interviewing for an additional three in the adult ED and two additional ones in children's ED.

- Instances of 'surge' were frequent within the BRI ED which during surge periods had insufficient ED cubicle capacity, leading to crowding. To improve flow, the trust had commenced a three-year investment programme which had begun in 2018, the Acute Care and Surgical Care Assemblies, under the trust-wide productivity programme ('Working Smarter') to develop Same Day Emergency Care (SDEC) in surgical and ambulatory care. In year one of the programme (2018/19) the trust had increased the number of directly admitted GP patients to the Surgical Assessment Unit (SAU) and seen a decrease in length of stay. While the development of these programmes had helped to improve patient experience, attributable benefits to A&E performance had not yet been seen.
- At 0.31 days, the trust was an outlier for pre-procedure elective bed days (quarter 3 2018/19) compared to the national median of 0.19 days. The trust had further analysed to understand the drivers of this position. The analysis showed that the trust's high pre-procedure elective bed days resulted from specialist procedures with adult and paediatric haematology and oncology and bone marrow transplant. These accounted for 50% of pre-procedure elective bed days. In addition, cardiac surgery accounted for a further 17% of pre-procedure elective bed days.
- The trust benchmarked well on pre-procedure non-elective bed days at 0.49 days and was in the lowest (best) quartile nationally. The good performance was reported as the result of the trust's Working Smarter productivity programme through applying six organisational principles to ensure that it was able to proactively and efficiently manage demand and capacity to deliver both urgent and elective care.
- At 6.61% for quarter 3 2018/19, the trust performed well on emergency readmission rates and benchmarked in the highest (best) quartile nationally compared to the national median of 7.29%. The trust had worked with lead commissioners and system partners to establish an integrated care bureau and use of a Single Referral Form during discharge to make the assessment of patients' needs reduced the risk of readmission and delays to discharge and accelerated the assessment of the patient in the correct environment.
- The Did Not Attend (DNA) rate for the trust was very slightly better than the national median of 6.77% at 6.67% for quarter 3 2018/19. The trust had historically consistently been below the national median rate with the trust focusing on DNA reduction through a number of programmes, for example providing specific training to staff dealing with patients on the cancer two-week wait pathway.
- The trust reported a delayed transfers of care (DTOC) rate of 3.7% in 2018/19 which was lower than national average of 4.0%. DTOC rates had improved at the end of 2018/19 due to the development of the integrated discharge bureau. However, long length of stay still remained a challenge at the trust at the time of the assessment. The average length of stay for elective admissions was 4.0 days compared to the peer median of 3.5 days; average length of stay for emergency admissions was at 9.7 days compared to the peer median of 9.2 days. We concluded a better understanding of the drivers of this was needed, beyond recognition that as a specialist provider, a more complex patient case mix was likely to be a factor. The trust was continuing to focus on length of stay as part of its six organisational principles under its Working Smarter programme, ensuring the issuing of take home medication ('To Take Aways') in pre-packs were timely prepared, that it met the internal target for 33% of all discharges to go to the discharge lounge by 12 noon and that all wards adopted criteria led discharges.

- The trust was increasing its utilisation of Model Hospital benchmarking to drive improvements in efficiency with a rolling programme of visits to divisions to support the identification of productivity gain opportunities underpinned by the trust-wide productivity programme, 'Working Smarter'.
- The trust cited a number of examples of efficiency delivery under its Working Smarter programme. This included a theatre productivity improvement where implementing "automatic sends" allowed 800 more elective operations; changes to the CT cardiac patient pathway to improve patient throughput by 66%.
- The trust had a number of visits from the Getting It Right First Time (GIRFT) programme and was increasing its engagement with the programme to deliver improvements. The trust had engaged internally with specialty leads, clinical directors and clinical chairs and work was progressing across a number of specialties to identify their GIRFT priorities. However, the trust still had to formally agree its GIRFT governance arrangement including ongoing clinical and executive leadership for GIRFT priorities. The trust anticipated this would be achieved via the trust's 'Working Smarter' programme, with oversight by divisional management but further work was needed here at the time of our assessment.

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

The trust benchmarked well on total staff costs per WAU, being in lowest (best) national quartile with the trust being in the lowest 10% for non-substantive pay cost per WAU. However, the medical staff cost per WAU, was in the highest (worst) quartile which the trust was investigating at a granular level. The trust was making use of innovative staffing models and was using e-rostering and job planning to plan and deploy staff efficiently. The trust however did not benchmark well on staff retention, being in the second lowest (worst) quartile nationally.

- For 2017/18 the trust had an overall pay cost per WAU of £1,986, compared with a national median of £2,180, placing it in the lowest (best) cost quartile nationally. The trust was in the first (best) quartile for Allied Health Professional (AHP) staff cost per WAU (£99) and in the second (best) quartile nationally for nursing staff costs per WAU (£657).
- However, the trust had high medical staff cost per WAU at £591 placing is in the highest (worst) quartile nationally. The trust acknowledged it needed to do more work to understand the reasons behind the high medical cost per WAU although it believed this was likely to be partly driven by the teaching, research & development and specialist activity delivered at the trust. The trust recognised it had a high level of junior doctors.
- The trust had implemented an acuity-based (Safe Care) approach to rostering, which was linked to its e-rostering system 'Allocate'. The trust had a clear process for requesting additional and temporary staff (Standard Operating Practice, whether bank or agency staff) with a Red, Amber, Green rating system, which provided an algorithm with a basic set of instructions to be followed at each stage. E-rostering had been in place for 7 years for nursing staff with rotas signed off on average 6 weeks in advance and had recently been implemented for AHPs, anaesthetists and clinical staff in the Emergency department. There were 72 different rotas in the trust and the trust planned to use e-rostering for medical staff in order to view the data at a granular level. The trust reported e-rostering information at a granular level which allowed it to learn from the triangulated data for themes, trends and clusters, which was captured on the nursing controls report. This allowed the trust to review nursing spend at a divisional level and enhanced the

understanding of nursing costs and reasons behind budget spend and created a greater visibility of critical staffing shortages.

- The trust had rebased consultant job plans five years ago to ensure they were consistently recording the type of activity planned. At the time of the assessment, not all job plans were electronic, although this was the trust's ambition. Job plans were driven by the service needs and were linked to capacity and demand planning and were refreshed annually. The trust had reviewed job plans to gain assurance over the consistency which showed in particular that very few doctors had more than 1.5 Supporting Professional Activities (SPAs) in their job plan. The trust had invested in job planning guidance, oversight and staff undertaking job planning received training.
- The trust benchmarked relatively well for sickness rate at 4.16%, below the national benchmark of 4.35% and benchmarked better than the national average for response rate to the annual staff survey. The trust had implemented a wide range of health and wellbeing interventions to support staff. For example, the trust has implemented the 'Happy App', which was used monthly in conjunction with the staff survey to triangulate themes, clusters and trends and identify where further actions could be taken to support staff.
- The trust's agency spend benchmarked well at 2.15% in February 2019 against a peer median of 3.51% and national median of 4.94%. The trust worked within a collaborative NHS partners agency consortium set up by the trust's Director of Nursing to reduce the usage of tier 3 and 4 (higher cost) staffing agencies. Medical e-rostering also included the creation of a locum bank which helped managing additional hours (e.g. locums) and ensured the safe working limits were maintained. The trust also continued its effort to increase the size of its staff bank as a first alternative to relying on agency staff. In addition, the trust had a staff passport in place with other neighbouring trusts, which was planned to become electronic in the future, allowing staff to work across other trusts.
- The trust had explored innovative workforce models with nurse associate roles in stroke services, advanced nurse endoscopist roles, medical clinical fellows and specialty and associate specialist doctors. The trust had developed an apprenticeship programme with 250 apprentices in a variety of roles including nursing, assistant nurse practitioners and leadership roles. The trust had also developed a band 4 nursing assistant role, increased the number of advanced clinical practitioners to compensate junior doctor vacancies to meet both the skill mix and clinical needs.
- The trust had an internal target to sustain vacancies below 5% throughout 2018/19 and in February, the trust's vacancy rate was 4.4%. The trust continued to focus on harder to recruit and specialist areas as part of its operating plan, including at divisional level. The trust was doing particularly well with the medical vacancy rate including clinical fellows as the trust was offering additional training and experience in specific areas (i.e. quality improvement and management training and experience). The trust was working with another local trust recruit doctors abroad in hard to recruit specialities.
- In December 2018, the trust had a retention rate of 84.2% which was below (worse) than the national median of 85.6% and the trust consistently benchmarked lower than the national rate. As at February 2019, the trust's staff turnover rate (based on substantive staff over a 12-month rolling period) was 13.3% which was higher than the trust's internal annual target of 12.3%. The trust had taken steps to better understand the reasons why staff left with wider issues picked up at both divisional and operational level and through the introduction of the HAPPI App. The trust also achieved a good engagement rate on the national staff survey for 2018, an improvement on prior rate and higher than the national average for acute providers.

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

The trust had not provided all of the data to NHS Improvement to populate the Model Hospital benchmarking which meant we relied on other sources to carry out our assessment in certain areas. There is a mixed picture across clinical services, benchmarking well overall in services such as pharmacy and pathology services with some specific areas for improvement. Imaging services had recorded poor performance on backlog rates which had contributed to the deterioration of the trust's performance against the diagnostics 6-week wait standard.

- The trust's medicines cost per WAU (£443) in 2017/18 was in the highest (worst) quartile nationally and against the national median of £320. A higher medicines cost was however to be expected due to the levels of specialist activity that the trust undertook with particularly high numbers of tertiary oncology and haematology, hepatitis and gastroenterology patients. Comparison with trusts, which have more comparable levels of specialist activity and with a median of £487 showed that the trust compared favourably.
- At the time of the assessment, the trust did not subscribe to NHS Benchmarking, which provided a significant number of metrics supporting the medicines' component of the Model Hospital and as a result, other sources of information were used to inform this assessment. This showed that pharmacy services on a Sunday were limited to admission wards. The trust was working on options to improve staffing availability which was the constraining factor.
- In 2018/19, the trust had made efficiency improvements of 3.7% across those drugs paid for through national tariff, well above the national rate and ahead of the efficiency plan for the year.
- The trust had developed a bespoke electronic prescribing system in partnership with its information technology (IT) partner. However, taking this approach meant that the trust was less advanced than comparable trusts having only started the system's implementation in late 2017.
- For pathology services, the trust's cost per test was £1.22 for 2017/18 which placed the trust in the best quartile nationally, and below the national median of £1.86. In our view, significant further improvements in pathology productivity and efficiency were achievable. A national priority for pathology as per the NHS Long Term Plan and further NHS operational guidance for 2019/20, was the establishment of regional networks to improve efficiency as well as quality and resilience in pathology services. At the time of the assessment, the proposed pathology network the trust was part of had agreed a £340 million managed equipment service (MES) contract over 15 years starting in 2021 that was expected to deliver up to 9% efficiencies for all trusts in the network. This was a significant step in delivering the pathology network. The trust was already on the same Laboratory Information Management System (LIMS) as other members of the network and efficiencies needed to be driven through service reconfiguration and standardisation of operating practices through greater digitisation, automation and service reconfiguration. At the time of the assessment, centralisation of services across Bristol for histopathology, microbiology and genetics had already been implemented. Progress by the West of England Pathology Network of which the trust formed a part of pathology transformation more widely was, however, less progressed than others across England and this needed to be a priority for the trust and its partners in the network.
- At the time of the assessment, data from the Model Hospital suggested that the trust managed well the provision of testing across the population. The pathology efficiencies delivered in 2018/19 were, however, limited and below plan.

- The benchmarking data available at the time of the assessment showed a mixed picture for the trust's imaging services. The areas of stronger performance were in the efficiency of the service with better than median cost per report, low agency and overtime costs and low levels of required in-sourcing.
- The areas of poorer performance were in the DNA rates and of greater concern the backlog rates across CT scans and X-ray but not for MRI. This had contributed to the deterioration in the overall diagnostic 6-week wait standard performance since October 2018. The trust was, however, reporting a 30% increase in the number of CT scans, mainly due to internal referrals. The trust had purchased a replacement scanner to be available from the second quarter of 2019/20. There had been delays across the equipment replacement programme in 2018/19 and a more proactive use of in-sourcing could have prevented some of the backlog. Additional reporting capacity could potentially have been secured through radiographers reporting where the trust was at a particularly low level.

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

The trust has a non-pay cost per WAU above national median. The trust was part of a procurement consortium with other nearby trusts and was individually ranked 86th in the latest procurement league table (out of 133 trusts) with the process efficiency score being the area of relative weakness. The trust's finance, human resources (HR) and information management and technology (IM&T) functions were very efficient, benchmarking in the best quartile nationally. The trust benchmarked well on estates and facilities although it was noted that the trust had significantly under-delivered on its capital programme for two consecutive years.

- For the financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,389 compared with a national median of £1,307 placing it in the second worst median and a peer median of £1,329. The factors driving the higher than national median non-pay cost were the higher than average cost of medicines as discussed above but with better than peer median cost of supplies and services as discussed below.
- The trust had a 'supplies and services' cost per WAU of £379 in 2017/18 which was higher than the national median but well below the peer median. The price performance component of the league table ranking was 47th out of 133 which would have contributed to this strong performance against peers. The trust was on target to deliver the planned savings on procurement in 2018/19 with additional savings possible with the improvement of procurement processes.
- At the time of the assessment, the trust was in a procurement collaborative with two local NHS trusts that had been in place for the past 17 years. This had allowed the trusts involved to leverage scale in their procurement and reach a more efficient management of procurements. Key to benefits realisation was the standardisation of products where the consortium had been a leader. The trust's procurement performance was tracked through the procurement league table with the trust, as part of the consortium, being ranked well below the median at 86th of the 133 trusts (where rank of 1 is best).
- The main reason for the trust and the consortium's lower ranking was the process score component reflecting the low non-pay spend percentage through a purchase order of 47.1% against a national median of 84%. At the time of the assessment, the consortium was taking remedial action to improve the purchase ordering processes across areas such as estates. The trust and the consortium had yet to achieve Level 1 NHS Procurement Standard which was planned for later in 2019 but also highlighted the opportunity to improve on the procurement process.

- The trust was very efficient across all corporate services, ranking in the most efficient quartile for all three services – finance, HR and IM&T. The trust had delivered limited savings in 2018/19 across these services. However, benchmarking data at the time of the assessment showed that there may be opportunities to improve efficiency across accounts payable and accounts receivable in a shared service. Analysis also showed that the trust spent more on recruitment (including the external cost per advert per starter) and HR systems than comparator trusts. However, the staff satisfaction scores and agency spend position were significantly better than national and regional comparators.
- The trust was a Global Digital Exemplar with 'System C' as its partner in a programme, which it was on track to deliver and consisting of 20 modules which could be used across the health community over a two-year period together with a number of complementary digital transformation projects. Some of the achievements at the time of the assessment included technologies to deliver quality, safety and productivity improvements, such as technology to deliver electronic observations which supported more efficient and effective monitoring and 'Careflow connect', an integrated communication tool supporting enhanced workflow management. The trust was developing plans with a neighbouring partner trust to move to a shared electronic patient record system as an important step towards the planned merger with this organisation.
- The trust operated from eight main hospitals. The trust's estates and facilities metrics were however good, with the overall cost per square meter of £346 being lower than the national median of £379 and 2.3% below the peer median of £338.
- Both the 'hard' and 'soft' facilities management (FM) costs benchmarked better than the national median and particularly the hard FM. The trust had also controlled effectively its backlog maintenance with both the overall level and the critical infrastructure risk component being well below peer medians. The trust had achieved this strong performance by focusing on estates and facilities compliance, productivity and performance and using data to identify improvement opportunities. At the time of the assessment, the trust was on track to deliver over £1.1 million of cost improvements in 2018/19 and had undertaken a review of the catering services, which however scored high on patient satisfaction. The trust was aware of other opportunities to achieve efficiencies in cleaning, portering and waste management, without compromising service standards.
- The trust was able to make significant investment across its estate through the self-funding of a strategic investment capacity supported by delivery of historic revenue surpluses it had been able to reinvest as capital to support service improvement. In the previous two years the trust had experienced some significant areas of slippage in planned capital investment. In 2017/18 the trust had planned to invest £20 million of capital in strategic development schemes, however £17.9 million of this was deferred to future years. In 2018/19, the trust had planned to invest £47 million in its capital programme but again this had been significantly undelivered with an expected outturn of £25.6 million. The underspend was reported as due to logistical delays (e.g. planning and procurement) and all schemes were underway with a view to complete them during 2019/20.
- The trust had recently invested significantly at the BRI site in central Bristol which together with the sale of old and ageing estate had kept the backlog maintenance figure stable. The trust's investment in backlog maintenance remained relatively constant at 11-12% per year with the critical infrastructure risk decreasing between 2017/18 and 2018/19.

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

The trust had a track record in delivering annual surpluses and had the financial resources to meet its financial obligations and pay its staff and suppliers. The trust continued to strengthen its approach to identifying, delivering and overseeing its cost improvement plan but had under-achieved its plan for the last two years, relying in 2018/19 on provisions and reserves to deliver part of its cost improvement plan. The trust's clinical divisions were therefore trading overall with an underlying deficit which resulted from pay cost pressures and under-delivery of efficiency savings. The trust was working with neighbouring partner trusts to develop a shared acute service strategy for the whole of the Bristol, North Somerset and South Gloucestershire geography which was positive and continued development and implementation with partners remained a top priority. The trust's contribution to whole system working to address the financial deficit the Bristol, North Somerset and South Gloucestershire STP was collectively facing during 2019/20 was also critical so that patient care was delivered within the financial resources available to the STP.

- The trust had a medium-term financial strategy to generate a surplus of 2% a year to repay its existing loans and to finance its strategic capital scheme and had a track record in delivering surpluses over several years. In 2017/18, the trust had delivered a surplus of £0.9 million, 0.1% of turnover (excluding Sustainability & Transformation Fund (STF); £19.9 million including STF) and the trust had met its control total.
- In 2018/19, the trust had improved its surplus position delivering a £4.5 million surplus, 0.7% of turnover and £1.5 million higher than its control total (excluding Provider Sustainability Funding (PSF); £29.9 million including PSF). The year-end financial position, however, included a £6.9 million overspend by clinical and corporate divisions compensated by additional in-year income (£3.3 million), financing costs under-spend (£1.2 million) and the use of reserves (£3.9 million).
- For 2019/20, the trust had a plan to deliver a £2.6 million surplus which was in line with the control total agreed with NHS Improvement (excluding one-off central allocations such as PSF, Marginal Rate of Emergency Tariff (MRET); £12.8 million surplus including one-off central allocations). The plan was underpinned by £16.9 million cost improvement plans to address the trust's £4.5 million underlying deficit (0.6% of turnover) at the end of 2018/19 and cover in-year cost pressures.
- The trust had a mixed record in delivering cost improvement plans (CIPs). In 2017/18, the trust had delivered £12.1 million savings (1.8%) slightly higher than its £11.9 million plan, 72% on a recurrent basis. In 2018/19, the trust had a £25.5 million CIP, 88% on a recurrent basis and at year end, the trust had reported delivering £26.0 million savings, £0.5 million better than plan and representing 4.0% of expenditure. However, this included £7.9 million of financial adjustments (provisions) and the use of strategic reserves which did not represent efficiency improvements and around half (£4.0 million) were used as a response to under-delivery of planned CIPs. Without these adjustments, the trust had delivered £18.1 million savings or 3.4% of expenditure.
- The level of savings delivered in 2018/19 (even taking account of the £7.9 million financial adjustments mentioned above), however, demonstrated an improvement on the prior year reflecting continued progress in strengthening the trust's process to identify, deliver and oversee productivity improvements and cost savings. The trust was widening the range of information used to identify savings opportunities, including the Model Hospital, Service Line Reporting, Reference Cost Index and external initiatives such as the GIRFT programme and was also considering several avenues to deliver savings through productivity improvement under the Transforming Care programme and through continued focus on cost controls. The trust also had a process to develop a pipeline of

schemes beyond one year which would help build the CIP for future years and manage the risk of in-year under delivery. The trust had also developed its Quality Improvement methodology with more than 500 staff trained across the trust.

- For 2019/20, the trust had a savings target of £16.9 million, 2.6% of expenditure and 85% recurrent. However, at the start of the year, the trust still had to identify £2.9 million (17%) of schemes to deliver its CIP.
- The trust was able to consistently meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its strong capital service and liquidity metrics. The trust was not reliant on short-term loans to maintain positive cash balances and had sufficient resources to cover the repayment of its previous loan (£5.8m in 2019/20). However, the high cash balance at the end of 2018/19 was partly driven by significant underspend on capital (£25.7 million compared to a plan of £47.1 million). The underspend was reported as being due to logistical delays (e.g. planning and procurement) and all schemes were underway with a view to complete them during 2019/20.
- The Trust has operated patient level costing for a number of years. At the time of the assessment, the trust was implementing a form of patient level costing that is compliant with the national costing transformation programme (CTP). The trust explained that it currently used Service Line Reporting and reference cost systems to support clinical divisions in identifying areas for productivity improvement. However, the trust needed to consider implementing PLICS as this was a national priority and would further support service improvement in the context of the work progressed by the trust in developing an acute strategy with local partner trusts.
- The trust received commercial income and had good processes to recover income from overseas patients. However, the trust reported that it wasn't actively pursuing additional commercial income due to capacity constraints and as this did not fit with its strategy which was focused on delivering clinical care to NHS patients.
- The trust spent £0.8m on consultancy costs in 2018/19. The trust did not rely on management consultants or other external support services to deliver its services and only used them for specific needs or where internal services could not undertake the work.

Outstanding practice

During our assessment we identified several outstanding practice areas:

- The trust had a Working Smarter programme based on its own Quality Improvement methodology, with in excess of 500 staff trained at the time of the assessment. The programme allowed multi-disciplinary teams to work together to deliver improvements across the trust. Achievements included improving the flow of emergency patients, optimising the trust's use of diagnostics, increasing the number of CT scans for cardiac patients and introducing a streamlined antenatal booking system for mothers-to-be.
- The trust's Chief Nurse had set up a collaborative NHS partners agency consortium to reduce the usage of tier 3 and 4 (higher cost) staffing agencies and had been selected for an innovation award by the Health Service Journal.

- The trust had an established process to continuously identify efficiency schemes and built a pipeline of vetted schemes beyond a year's horizon.
- The trust had implemented a Clinical Utilisation Review (CUR) tool, an evidence-based initiative which helped the trust to get patients to the right place to receive their care, to understand the internal or external delays in a patient's pathway, to communicate the delays to the people who could help.
- The trust had implemented electronic observations "Vitals". All adult patients had observations recorded digitally. The NEWS score visible across the trust, allowed to target the sickest patients. It included the ability to monitor pain and cannula scores.

Areas for improvement

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

- The trust had long length of stay and should continue to identify further actions (including within its 'Working Smarter' programme) to reduce length of stay across the trust.
- Despite a number of actions taken to improve its A&E performance these had not yet made an impact on the trust's performance. The trust must continue to progress at pace with its investment programme, the Acute Care and Surgical Care Assemblies, under the trust-wide productivity programme ('Working Smarter') to develop Same Day Emergency Care (SDEC) in surgical and ambulatory care.
- The trust was an outlier on medical cost per WAU. The trust should ensure it further investigates the drivers of the performance to assess whether this represents an opportunity for improvement.
- The trust should ensure it submits information to the NHS Benchmarking Group (which feeds through to the Model Hospital metrics for pharmacy and imaging) in order to allow benchmarking and identify efficiencies opportunities in particular regarding pharmacy and imaging.
- The trust should consider options available to ensure it is able to staff Sunday pharmacy service on wards.
- The trust should continue to engage in the West of England Pathology Network to support progress on a strategic outline case for Pathology transformation across this geography as early as practicable.
- The trust had significantly under-delivered against its capital programme in 2017/18 and 2018/19 as a result of logistical issues. The trust must ensure it has robust processes and arrangements in place to ensure its delivers on its capital programme going forward.
- The trust must work with local trusts to ensure there is an agreement on PACS system to allow image sharing across the local health system in accordance with national priorities.
- The trust should ensure that working with the procurement consortium, it improves the purchase ordering processes, in particular around estates.

- The trust should also consider how to develop PLICS to support clinicians in the identification of productivity opportunities.

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.

Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term 'allied health professional' encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.
Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also

	might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR) cost per £100 million turnover	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.

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

	financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
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.